By seeing with our own eyes, it can remain in our mind': qualitative evaluation findings suggest the ability of participatory video to reduce gender-based violence in conflict-affected settings

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Abstract

Gender-based violence is pervasive and poses unique challenges in conflict-affected settings, with women and girls particularly vulnerable to its sequelae. Furthermore, widespread stigmatization of gender-based violence promotes silence among survivors and families, inhibiting access to services. Little evidence exists regarding effective gender-based violence prevention interventions in these settings. Through Our Eyes, a multi-year participatory video project, addressed gender-based violence by stimulating community dialogue and action in post-conflict settings in South Sudan, Uganda, Thailand, Liberia and Rwanda. The present qualitative analysis of project evaluation data included transcripts from 18 focus group discussions (n = 125) and key informant interviews (n = 76). Study participants included project team members, representatives from partner agencies, service providers and community members who either participated in video production or attended video screenings. Study findings revealed that the video project contributed to a growing awareness of women’s rights and gender equality. The community dialogue helped to begin dismantling the culture of silence gender-based violence, encouraging survivors to access health and law enforcement services. Furthermore, both men and women reported attitude and behavioral changes related to topics such as wife beating, gender-based violence reporting and girls’ education. Health education professionals should employ participatory video to address gender-based violence within conflict-affected settings.

Introduction

Gender-based violence (GBV) and harmful traditional practices (HTP) are embedded within communities around the globe [1]. GBV includes sexual, physical, emotional, psychological as well as socioeconomic violence [1]. HTP encompass specific forms of GBV, such as forced or early marriage, that have become entrenched within a particular culture [1]. Women and girls, comprising the overwhelming majority of victims, are most vulnerable to GBV’s social, economic and health consequences [1]. GBV contributes to gynecological disorders, sexually transmitted infections (i.e. HIV/AIDS) as well as maternal death [1]. Furthermore, GBV impacts women’s economic productivity, disrupts educational attainment and reinforces existing gender inequities within societies [1, 2], thereby perpetuating the cycle of female poverty.
For individuals living in post-conflict settings, factors such as sociocultural norms of gender inequality, the breakdown of the family unit, the dismantling of community services and the absence of law enforcement increase women’s risk for GBV and HTP [1]. Although it is difficult to measure the incidence and prevalence of GBV in humanitarian settings [3–5], researchers suggest that displaced communities perceive GBV as relatively common and accepted [6]. Moreover, in post-conflict settings, GBV cases are often underreported, largely due to economic dependence, fear, stigma and sociocultural norms [5, 7]. For many displaced women and children around the world, this culture of silence further complicates an already precarious situation.

Researchers suggest that, in order to be effective, GBV reduction strategies must take an ecological perspective, whereby individuals are influenced by household members, their social networks, the local community and society at large [3, 8–10]. Focusing solely on the individual is specifically ineffective in refugee settings which are characterized by close interactions among community members. Multilevel influences, such as verbal conflict within marriage, unyielding gender roles, male entitlement over women, law enforcement and physical design of communities, are believed to contribute to GBV [8, 9].

There is a current call for public health professionals to reduce GBV through the implementation of community-based prevention programs [6]. Unfortunately, a paucity of evidence exists regarding the effectiveness of GBV prevention interventions [5, 6, 11]. Although some community-based interventions have been identified as effective mechanisms to stimulate GBV-related attitudinal and behavioral change [12, 13], most do not target the unique contextual environment associated with conflict and displacement. The present study mitigates the research gap by analyzing evaluation data from Through Our Eyes (TOE), a participatory video project implemented in post-conflict settings in five countries. TOE used community-generated videos to raise awareness and share vital information about GBV.

**Methods**

**TOE participatory video project**

TOE—a collaborative effort between the nongovernmental organizations (NGOs) American Refugee Committee (ARC) and Communication for Change—began in Liberia in 2006. TOE later expanded to South Sudan (2007), Rwanda (2008), northern Uganda (2009) and the Thai–Burma border (2009). The intended audience included individuals such as returnees (refugees returning to their home country), internally displaced persons (IDPs) and former displaced persons living in post-conflict settings. In Rwanda and Thailand, community members lived in refugee camps, whereas in Liberia, South Sudan and Uganda, they resided in conflict-affected communities. TOE was an important part of a larger ARC program that provided medical, psychological, legal and economic services to the refugee community, with special attention placed on ensuring access to GBV survivors. ARC and its partners also implemented trainings to sensitize providers and community leaders about GBV.

TOE applied a participatory video approach whereby communities created films to address local concerns and spark constructive dialogue. This approach was informed by the work of the Brazilian educator and activist Paulo Freire, who stressed that people should be regarded as agents of social change who can teach themselves through a process of raising questions and engaging in dialogue [14]. In total, more than 150 videos were created in the local language and over 25 000 community members attended video playback sessions [15].

The design of TOE included processes to ensure community participation and buy-in. Local partnerships, both formal and informal, supported project activities in each implementation site. Partners included, but were not limited to, government ministries, HIV/AIDS awareness organizations, religious leaders and youth and women’s groups. (Table I) The teams which developed the videos consisted of in-country ARC staff, partner agency representatives and community members. These
teams received a comprehensive training which covered GBV and HTP, participatory video as well as skills regarding facilitating group discussions. During the training, participants learned a step-by-step process for producing community-generated videos that included activities such as developing locally relevant storylines, creating storyboards (simple drawings which follow the storyline and are used to help plan the filming of scenes) and basic filmmaking and editing skills [16]. Although most videos were appropriate for a general audience, some were tailored to specific groups (i.e. married couples, police officers, health care and social service providers). Project teams worked with community members to identify relevant topics, recruit local actors and promote the video playback sessions. The vast majority of videos that communities developed focused on women and girls, with topics including gender rights, treatment of girls and women and health consequences of GBV (specific examples available in Table II). The first playback session of a video generally occurred in the neighborhood where it was filmed. Additional playbacks occurred in other areas of the community.

TOE’s participatory approach emphasized the need to engage communities in reflection and discussion about the videos. As a result, video playback sessions, which typically lasted 20 min, were followed by group discussions lasting 60 min. These discussions stimulated dialogue about GBV as people shared their personal experience and perceptions.

**Data collection and analysis**

We analyzed qualitative data from the TOE end-of-project evaluation, originally collected between December 2010 and February 2011. These data came from five evaluation sites (one per country) which were selected based upon four criteria: geographic accessibility, level of security, low presence of other NGOs and population size (more than 2000 people). The dataset used in this study comprised a total of 94 transcripts from 18 focus group discussions and 76 key informant interviews. Eligible study participants included video team members, representatives from partner agencies, service providers and community members who either participated in video production or attended video playback sessions.

Interview guides were tailored according to type of respondent (i.e. video team members, service...
As focus groups were limited to community members, only one discussion guide was developed. Interviews and focus groups explored respondents' experience with TOE, personal observations related to community-level changes, perceived impact of TOE, feedback on TOE’s strengths and challenges as well as recommendations for the future.

Focus groups and interviews were conducted in the local language by members of the participatory video teams (some of whom were in-country ARC staff). These individuals spoke the local language, appreciated the sensitive nature of GBV and HTP, could refer respondents to services and received training about qualitative research. All interviews and focus groups were audio-recorded and later transcribed into English. All participants consented verbally, with guardian consent obtained for all individuals <18 years of age. Participant names and any personal identifiers were removed from the transcripts. The Office of Human Research at the George Washington University approved this current study.

The first two authors applied a grounded theory approach when analyzing the data for this study [17]. We did not approach the dataset with

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Table II. Themes addressed in Through Our Eyes video playback sessions November 2009 to January 2011

<table>
<thead>
<tr>
<th>Theme of film</th>
<th>Liberia</th>
<th>Rwanda</th>
<th>Southern Sudan</th>
<th>Thailand</th>
<th>Uganda</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s empowerment</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Gender equality/equitable gender norms</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
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<td>Women's right to inherit property</td>
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<td>10</td>
<td>0</td>
<td>0</td>
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<td>10</td>
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<td>Treatment of girls and women</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Education of girls</td>
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<td>0</td>
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<td>8</td>
<td>8</td>
<td>17</td>
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<td>15</td>
<td>1</td>
<td>13</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Choice of own marriage partner</td>
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<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Widow inheritance</td>
<td>0</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>18</td>
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<tr>
<td>Sexual exploitation and abuse</td>
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<td>20</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>25</td>
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<tr>
<td>Wife-beating/spousal abuse</td>
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<td>2</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>10</td>
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<td>GBV services</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GBV response services (general)</td>
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<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Police/legal action against GBV perpetrators</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Medical care for GBV/rape survivors</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>7</td>
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<tr>
<td>Not treating rape as a family matter</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Male involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male role in family care and support</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Mens’ role in preventing GBV</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Partner/spouse relationship</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mutual respect among partners/spouses</td>
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<td>0</td>
<td>0</td>
<td>9</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Sharing decision-making in couple</td>
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<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Sharing economic resources in home</td>
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<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholism/links to GBV</td>
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<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>HIV/AIDS awareness</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>27</td>
</tr>
<tr>
<td>Links between GBV and HIV</td>
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<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Early/unwanted pregnancy</td>
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<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General GBV prevention</td>
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<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Theme unspecified</td>
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<td>13</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>127</td>
<td>57</td>
<td>50</td>
<td>27</td>
<td>275</td>
</tr>
</tbody>
</table>

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predetermined themes, but rather used an iterative process to identify predominant cross-cutting themes related to GBV, HTP and women’s rights. We created a coding scheme based upon these themes. We then used ATLAS.ti 6 to organize the aggregated interview and focus group discussion data according to our coding scheme.

**Results**

Focus group discussions included 125 community members who ranged in age from 12 to 80 years. These discussions were categorized into four groups: younger men (<35 years old), younger women (<35 years old), older men (>35 years old) and older women (>35 years old). Key informant interviews (n = 76) included 18 video team members, 6 representatives from partner agencies, 22 service providers, 16 video team members and 14 community members who attended the video playback sessions. Key informants ranged in age from 18 to 65 years. (Tables III and IV provide additional demographic information.)

As previously described, TOE engaged communities to develop, film and screen videos. A service provider from Rwanda described the benefit to this approach, stating, ‘It is always good when people are involved in things that they feel they are part of and be able to have a big role to play. This raises their interest and participation more than initiatives from abroad’. The participatory approach of creating locally produced films was integral to the videos’ credibility. For example, one of the camp leaders from Rwanda observed, ‘When a person who had never been a victim of GBV watches the testimonies in the videos, such person is shown the reality and there is an effect as they change and start encouraging others to fight against GBV’.

Individuals experienced real-life situations vicariously as they watched their peers on screen and listened to their peers share personal testimonies in the group discussions. For example, a service provider in Thailand stated ‘...we know ourselves from watching the video as if though we are looking at ourselves in the mirror’. A pastor in Thailand who had been involved in the production of several TOE films further commented, ‘By seeing with our own eyes, it can remain in our mind’.

Even with the appeal and credibility of TOE, some respondents shared that GBV and HTP persisted. For example, one male video team member from South Sudan reported, ‘Violence is our common problem here and is the greatest disease’. A female video team member from Rwanda similarly described the remaining presence of domestic violence within her community:

‘There aren’t still many instances of gender-based violence and harmful traditional practices in our community, but some women are still beaten by their husbands. There are some people who still believe that a woman is their property and beat them like they are beating a

<p>| Table III. Characteristics of key informant interview participants (n = 76) |
|-----------------------------------------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Count</th>
<th>Percent of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>3</td>
<td>3.95</td>
</tr>
<tr>
<td>20–29</td>
<td>23</td>
<td>30.26</td>
</tr>
<tr>
<td>30–39</td>
<td>19</td>
<td>25.00</td>
</tr>
<tr>
<td>40–49</td>
<td>20</td>
<td>26.32</td>
</tr>
<tr>
<td>&gt;50</td>
<td>11</td>
<td>14.47</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>42</td>
<td>55.26</td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
<td>44.74</td>
</tr>
</tbody>
</table>

<p>| Table IV. Characteristics of focus group discussion participants (n = 125) |
|-----------------------------------------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Count</th>
<th>Percent of sample</th>
</tr>
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<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>41</td>
<td>32.80</td>
</tr>
<tr>
<td>20–29</td>
<td>28</td>
<td>22.40</td>
</tr>
<tr>
<td>30–39</td>
<td>19</td>
<td>15.20</td>
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<td>40–49</td>
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<td>18.40</td>
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<tr>
<td>&gt;50</td>
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<td>11.20</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>59</td>
<td>47.20</td>
</tr>
<tr>
<td>Female</td>
<td>66</td>
<td>52.80</td>
</tr>
</tbody>
</table>
There are also some women who are still being forced into sexual intercourse against their will by their husbands’.

Apart from these accounts, countless respondents credited the TOE with improvements in women’s rights and gender equality as well as in the culture of silence.

**Increasing awareness of women’s rights and gender equality**

Respondents reported that the video project increased awareness about women’s rights. One female respondent from Rwanda stated, ‘The video project has enabled me to realize that I am equal and just like any ordinary man’. Males also reported how the video project allowed them to more clearly understand their own rights and responsibilities as well as those of women. A male partner agency representative from Rwanda described:

‘In the past, a man would be so ignorant to think that a woman was below the law and would treat her in any way he wants, but now a man treats a woman as someone who can give him advice… and who should be treated equally in the affairs of the family’.

In addition to the individual recognition of rights, respondents described how the video project fostered changes in family gender dynamics. One male respondent from Rwanda described this change and stated, ‘The husband and wife were usually in conflict, and unity was impossible in the family. But now because of the effects of the community video project teachings, there is mutual respect and unity between the man and woman’. Male respondents provided personal testimonies of how the video project increased their knowledge about GBV, with many reporting changes in their attitude and behavior toward their spouse. A male video production participant from Rwanda reported that the project encouraged him to treat his wife more equitably. He reported, ‘The lesson I learned is that I should be exemplary and handle my home in the best way possible by treating my partner well instead of handling her like an animal or someone who is valueless’. He later continued, ‘Take me as an example of change. I have learned that I should treat my wife well and equally by not hurting her like I used to, when I would beat her up on returning home while drunk. I no longer beat her’.

Similarly, a male respondent from Liberia described how the video project was responsible for the newfound peace in his relationship. He stated:

‘I too never knew that denying the woman her right was GBV, but I know now and my home is peaceful…I actually thought that when your wife goes against you the best thing to do was to discipline her by beating her or stop supporting the home, which of course after witnessing the playbacks, it helped me to change from that’.

Women and youth also reported improved communication within the family. A partner agency representative from Liberia commented, ‘The project helped me to know how to relate to my husband and my family. It has had positive effects on me’. A female respondent from South Sudan further explained, ‘…in the past we used to fear sharing with the men but since you introduced this program we no longer fear men and we have a voice in our homes’. One youth from Uganda similarly remarked, ‘My father used to fight and beat my mother everyday…nowadays he doesn’t beat her, after watching the video’.

In addition to improved communication and reduced violence within the family, women experienced a greater sense of personal freedom. One respondent from South Sudan commented, ‘…women are no longer restricted. They are granted freedom of movement as a result of this video show’. A respondent from Uganda described how her ability to socially interact with others increased after her husband watched the video. She explained, ‘[He] never wanted me to interact with other women, but it started last year…he told me that I should feel free and interact with whoever I want, though I should know how to protect myself’. Respondents suggested that these changes
in marital gender dynamics extended beyond the confines of homes and communities, and alluded to a societal transition toward gender equality. A female respondent from Rwanda explained, ‘We came here with various ancient traditional practices such as where men would rule their families by force but now most of these have changed because men have realized that women are their equals’. At the same time, one youth from Rwanda expressed the need for continued activism. He stressed, ‘I believe the expected changes occurred especially in the victims of GBV, as the women now realize their potential and rights. But it is not yet 100%. There is need for greater efforts for more change’.

Respondents also reported that the video project fostered more equitable treatment of male and female children. One male respondent from Rwanda summarized, ‘In the past, our community used to look at the boy child as the only important child within the family but now even the girl child is regarded as important as the boy child’. He further asserted, ‘Today, both the boy and girl children are equal’. Some of the more poignant evidence of equitable treatment included changes in perceptions and practices related to the education of girls as well as early and forced marriage. According to a youth from Uganda, the video project enabled parents to realize the importance of girls’ education:

‘The numbers of girls in schools here have increased more than that of boys, but in the past, before ARC brought this program, if you go to any school the numbers of boys were more than that of girls . . . The video that ARC brought has improved the level of education among girls’.

Some respondents from Rwanda and Uganda even reported how the video project led to a decrease in coerced sexual relationships between school teachers and female students. One male respondent from Rwanda reported, ‘We have seen that school authorities, such as teachers, that used to involve students in sex activities promising them good academic grades or points stopped due to the presence of the GBV project near the schools’.

Respondents also reported that the video project affected families’ perceptions and intentions regarding early and forced marriage. A male community member from South Sudan who participated in video production stated, ‘. . . people used to force their children to get married at early ages but now there are changes from that. They have realized that it’s better to send their children to school before marriage’. A partner agency representative from Liberia explained a similar shift within her own community. She quoted a peer of hers stating, ‘[early marriage] will never happen to any of my daughters as long as I know it’. In Rwanda, a video team member reported, ‘. . . this culture of forced marriages has been eradicated and now a couple agrees mutually to get married together’.

She later revealed, however, that families did not uniformly experience this change and that some parents still believed in early marriage.

Respondents also provided examples of how their local community supported the reduction of forced marriage within the video project sites. A community member from Rwanda who participated in video production described the important role that community leaders played in the reduction, or perceived elimination, of this practice. He stated, ‘. . . the culture of forced marriages does not exist anymore since a lot of efforts have been invested by the local authorities and the involvement of our partners’. Moreover, respondents discussed how communities began to perceive forced marriage as a punishable criminal act and even cited specific interventions by law enforcement. In Uganda, one female youth explained, ‘I did not believe that early marriage would stop . . . nowadays if they get to know that you are marrying off a young girl, that marriage will be nullified’.

**Dismantling the culture of silence**

Respondents felt that the video project encouraged individuals, families and communities to take action against the stigma surrounding GBV and to more willingly report GBV cases and utilize locally available services. Contrary to the prevailing socio-cultural norms which dictated acceptance of GBV,
respondents reported that the video project provided the fundamental knowledge to combat this culture of silence within communities. A female video team member from Rwanda, who explained that the video project enabled survivors to recognize that they had experienced GBV, stated that previously ‘most thought such acts were normal and would live with them’. A service provider from Rwanda concurred, stating ‘...now every member of this community has an idea what gender-based violence cases are and they are able to identify the bad practices that they need to change’.

Respondents also described ways in which the video project influenced their attitudes and behaviors in response to GBV cases. For example, some respondents discussed how GBV became viewed as a reportable and punishable offense. One female youth from Thailand pointedly stated, ‘If the girls are troubled by the boys, and if they don’t like them, they can make a complaint to the security’. A female respondent from Rwanda described how her behavior changed after participating in the video playback sessions. She stated, ‘I realized that if a man abused or violated me at home and tried to harm me or my children, I would then report my case to GBV office in the camp so that justice is done. I have learned to break the silence and report GBV cases’. Similarly, one male youth from Rwanda described the right to report, and even discussed how this right extended into familial GBV cases:

‘People have now learned that keeping silent about GBV cases is bad. Everyone is now aware that even if it is the father or mother of the victim who committed the crime, no one is supposed to keep silent and not report...You should report that culprit to the concerned authorities’.

Some participants, on the other hand, reported specific instances in which families remained silent. One male representative from a partner agency in Rwanda described this situation: ‘There are still cases of families keeping silent about the GBV issues within their families and just solving them in their own way which is a big concern...’ Despite this example, more respondents agreed that community reporting of GBV increased after the initiation of the video project. A male from Rwanda remarked:

‘There is change due to the coming of the GBV project...Before, the victims would keep quiet and not talk about their problems because of fear. But now, they have broken the silence and report the cases to the GBV authorities who follow up on the issues and bring justice to the victims’.

Coupled with shifts in the culture of silence was an increase among survivors to report GBV and seek treatment services. A service provider from South Sudan described how GBV reporting was essentially nonexistent before the video project: ‘There were no cases of rape and sexual assault reported in the hospital because people did not know where to seek help and other services’. She continued, ‘The most important change I have seen is that survivors come earlier for treatment and the reason being the awareness created outside there by the community video project’. A male video team member from Rwanda commented, ‘...now more people especially the victims of GBV are coming to the GBV offices to meet counselors to be advised and given justice after reporting their cases’.

While respondents associated the video project with increased reporting and use of services, they also described how it fostered and influenced interpersonal dialogue about GBV. In other words, the breakdown of the culture of silence allowed for greater compassion and communication. One youth from Liberia explained her own transformation and increased sensitivity towards GBV victims: ‘I used to laugh at rape victims, but after the playbacks and video shows, I have become a counselor to them’. Some respondents reported how the video project strengthened their confidence to engage in GBV-related conversations. A female partner agency representative from Liberia explained, ‘I am now able to talk to people on GBV and to talk to someone with problems. I am a person who used to be very shy to talk to people until I came in contact with the video project’. Respondents also reported that the video project stimulated
communication among family members. An elder male from Rwanda explained how it encouraged families to have honest discussions about sexual violence. He stated:

‘Before the community video project started, you could find that parents feared to talk to their children about gender-based sexual harassments, but because of the effects of the community video project, the parents have learned to freely talk to their children about sexually related issues’.

There were, however, some reports of a persisting culture of silence. For example, a female video team member stated, ‘The only challenge we still have here in our camp is the culture of silence. Keeping quiet about GBV cases has not yet been eradicated. Though the cases have reduced the cultures of forcing young girls into marriages and wife beating are also still an issue’. A partner agency representative from Rwanda, nevertheless, alluded to a societal transition away from silence, commenting, ‘This culture of keeping silent is slowly being eliminated through opening up of the victims who talk about their experiences’.

**Discussion**

This study illustrates the capacity of participatory video to help improve awareness, change attitudes and reduce behaviors related to GBV and HTP. Respondents remarked that community-generated videos were viewed as credible and appealing. After analyzing the transcripts, it became apparent that the videos influenced change through two main modalities. First, TOE appeared to have contributed to changes regarding the awareness and practice of women’s rights and gender equality at the individual, household and community levels. Second, TOE’s use of participatory video fostered dialogue and encouragement of GBV reporting and service utilization and as a result, helped to begin dismantling the culture of silence.

Respondents from our study reported some persistence of GBV and HTP, along with their harmful effects on women’s well-being and freedom. These results support findings from Pavlish and Ho [18], which revealed that unequal power balances can negatively impact women’s rights. Whereas previous research found that patriarchal norms may remain unchallenged by women [12], our study provided evidence to suggest that female refugees and IDPs began to challenge norms related to GBV and HTP through the awareness and empowerment instilled from TOE. As women gained greater decision-making power, they gained the ability to take control over their health and life. This change was particularly evident during discussions regarding marriage and relationships between husband and wife. For example, some respondents reported that exposure to the early marriage video contributed to changes in attitudes and even some observed reduction in the actual practice. In addition, supplemental institutional efforts at the community level likely strengthened female agency in relation to early and forced marriage. It is this type of multi-level synergy that researchers have stressed as essential to making a lasting impact toward GBV eradication [2, 6].

Respondents’ discussions about family dynamics illuminated the transitioning role of women in the studied communities. In particular, as men began to understand and appreciate women’s rights,—many declared changes in their intention and behavior regarding beating their wife. Thus, the importance of male buy-in and involvement was readily apparent. Study findings similarly supported the integral role that men play in successful GBV programming. Men not only participated in video production and playback sessions, but they also reported personal behavior changes and involvement in GBV advocacy efforts. TOE’s ability to positively influence men’s behavior was most apparent in the quotes from self-admitted GBV offenders who reported transformation from perpetrators to advocates for GBV reduction. The above findings support this literature, which asserts that male engagement is crucial in GBV reduction activities [7, 19].

Participant responses suggested that children may also benefit from the reduction of violence between husband and wife. The respondent who reported,
‘My father used to fight and beat my mother every
day . . . nowadays he doesn’t beat her after watching
the video’, revealed how children were cognizant of
the abuse in their homes. Therefore, the video pro-
ject may have special implications for children in
the community as well. Previous research has
suggested that individuals who witness domestic
violence as children are at an increased risk to
become perpetrators or victims [8, 20]. By reducing
domestic violence in the home, a participatory video
project such as TOE may have the potential to
reduce childhood exposure to domestic violence
and conceivably break the generational cycle of vio-
lence for some families.

Reports about women’s increased mobility and
access to education further indicated improvements
around women’s rights. The acquisition of these pre-
viously denied rights exemplifies the beginnings of a
shift in socio-cultural norms related to the female
status and role in society. Similar to women’s rights,
multi-level changes transpired regarding the culture
of silence. As the women became more able to rec-
ognize various forms of GBV, they often refused to
tolerate these behaviors in their homes. Furthermore, women began to report violence to
authorities and use community-based GBV services.
The female respondent who recounted, ‘I have
learned to break the silence and report GBV cases’
reflects a fundamental step towards overcoming stigmatization and silence within communities. As
described by some respondents, however, the cul-
ture of silence continued to persist in some familial
cases of GBV and HTP, indicating an area for future
research and intervention. Although a total cultural
shift is incomplete, respondents’ acknowledged in-
dividual attitudinal and behavioral change, interper-
sonal discussion, advocacy and increased GBV
reporting to authorities. These shifts suggest that
the culture of silence may be starting to dismantle.

While women offered testimonies of ways in
which they began to confront GBV, other respond-
ents offered examples of local institutions that fol-
lowed suit by encouraging survivors to report cases
of GBV and access services. These examples sug-
gest the possibility that the videos tailored to police
and health and social service providers were also
effective in training them on appropriate treatment
and protocols for assisting survivors of GBV. These
findings complement previous literature which
stresses the importance of collaborating with local
community-based structures to enhance GBV re-
porting and develop coordinated responses against
violent practices [21].

We encountered three primary limitations while
conducting our study. First, given that we used
an existing dataset for analysis, the opportunity to
conduct follow-up interviews with respondents and
elicit additional information did not exist. Neverthe-
less, we meticulously reviewed all trans-
cripts to ensure discovery and comprehension of
meaningful quotations and responses. Second, coun-
try teams did not conduct data collection and tran-
scription in a uniform manner across the five study
sites. For example, more probing occurred in the
data collection of Rwanda and Uganda. As such,
the results from this study most heavily represent
participant responses from these two countries.
Finally, it is possible that self-report bias during
the data collection phase may have contributed to
the overwhelming positive results of this study. The
majority of respondents reported some personal con-
nection to the video project, whether it was through
participating in video production, attending a video
playback session or delivering GBV-related ser-
vices. It is possible that these individuals had greater
exposure to and reaped greater benefits from the
video project than those who did not actively par-
ticipate. Moreover, individuals who agreed to par-
ticipate in the evaluation may have also been
generally more receptive or open minded about
changing current trends related to GBV. Personal
involvement and receptivity, therefore, may have
influenced participants’ perception of how the
video project impacted them personally as well as
their community. Future evaluations of GBV efforts
should, therefore, consider conducting more rigor-
ous evaluation of program effects. For example, had
we had access to service utilization data, we would
have been better able to triangulate participants’
claims of increased utilization of GBV services.
Moreover, with either pre-intervention data or a
comparison group we would have had the ability
to feel more confident that the changes that individuals described were attributable to the video project.

Regardless of the above limitations, the current study suggests that participatory video methods can stimulate social and behavior change in conflict-affected settings and offers four recommendations for public health professionals working in such settings. First, public health professionals should consider employing participatory video as a key component of GBV reduction programming in humanitarian settings in other countries. With the success evidenced in TOE’s five countries, it is possible that participatory video will offer a similar capacity to reduce GBV in other countries. Such videos offer displaced communities access to media that is tailored to their culture, is accessible to all literacy levels and draws the attention of leaders and authorities to priority concerns of the community. To further increase impact, organizers of participatory video programs should maximize the number of playback sessions and encourage discussion outside of the playback sessions to stimulate sustained community dialogue and extend the program’s reach. Scaling up this type of intervention, however, poses certain challenges, such as the need to cultivate skilled facilitators and to train community teams in principles of effective video storytelling. At the same time, the necessary video equipment is relatively inexpensive and the resulting videos and discussions can be adapted to varied settings. Second, public health professionals involved in GBV reduction projects in humanitarian settings should implement rigorous program evaluations in order to strengthen evidence-based research and inform more effective programs. Third, collaboration is needed among the public health community, community leaders and policymakers to ensure that GBV programming efforts are complemented by policy efforts within communities. Shifts in the culture of silence would not have been possible without the enforcement of laws and access to non-judgmental social services. Therefore, public health professionals should establish partnerships with local authorities in order to obtain the needed political support, produce a more integrated approach to reduce GBV in conflict-affected settings and ultimately propel women’s rights forward. Finally, additional research is needed to better understand familial cases of GBV. As previously described, some respondents reported the continued presence of GBV and the culture of silence within families. Therefore, further exploration is required in order to comprehensively address GBV in conflict-affected settings.

In order to reduce the disparate morbidity experienced by female refugees and IDPs, it is important to evaluate existing interventions that attempt to decrease GBV and HTP in conflict-affected settings. Overall, our study fills a gap in the literature and provides evidence that the video project enhanced women’s rights and mitigated GBV and HTP within its implementation sites. Furthermore, our findings indicate that participatory video projects can prompt community discussion, mobilize behavior change and affect the perception of women’s roles and responsibilities at various levels of the ecological spectrum. As violence against female refugees and IDPs continues to persist, we encourage continued research and action by the public health community in order to reduce the GBV burden for these vulnerable populations.

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