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TO PREVENT VIOLENCE

Violence Against Women and Girls
in Conflict and Humanitarian Crises



Violence, uncertainty, and resilience among refugee women and community workers:

.....
An evaluation of gender-based violence case management
services in the Dadaab refugee camps

Cover image: Juliette Delay/IRC

The photos in this report do not represent women and girls who themselves have been affected by gender-based violence nor who accessed services.



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Acronyms

AMREF	African Medical and Research Foundation
APHRC	African Population and Health Research Center
DRA	Department of Refugee Affairs (Kenya)
EMAP	Engaging Men through Accountable Practice
FGM	female genital mutilation
GAD	Gender and Development Unit
GBV	gender-based violence
GBVIMS	Gender-Based Violence Information Management System
GVHC	Gender, Violence and Health Centre (London School of Hygiene & Tropical Medicine)
IASC	Inter-Agency Standing Committee
INGO	international non-government organisation
IPV	intimate partner violence
IRC	International Rescue Committee
KES	Kenyan shillings
LSHTM	London School of Hygiene & Tropical Medicine
MSF	Médecins Sans Frontières
NGO	non-governmental organisation
NPV	non-partner violence
PRC	Peace and Reconciliation Committee
PSU	Psychosocial Unit
PTSD	post-traumatic stress disorder
SGBV	sexual gender-based violence
TAG	Technical Advisory Group
UNHCR	United Nations Refugee Agency
VAWG	violence against women and girls
WFP	World Food Programme
WHO	World Health Organization
WPE	Women's Protection and Empowerment

About the partners

What Works to Prevent Violence against Women and Girls in Conflict and Humanitarian Crises Research Consortium

What Works to Prevent Violence against Women and Girls in Conflict and Humanitarian Settings is an international multi-disciplinary partnership led by the International Rescue Committee with George Washington University's Global Women's Institute and CARE International UK. Academic and research partners include the London School of Hygiene & Tropical Medicine, the Africa Population and Health Research Center, in Nairobi, Kenya, and Forcier Consulting in Juba, South Sudan.



London School of Hygiene & Tropical Medicine (LSHTM)

The Gender, Violence & Health Centre (GVHC) at the LSHTM is a multi-disciplinary research group that works to reduce gender-based violence through cutting-edge science. The GVHC consists of more than 25 researchers with expertise on violence against women, violence against children, engaging men against violence, labour exploitation and human trafficking. It has leading experts in epidemiology, health economics, and intervention evaluation, with cross-faculty methodological working groups on approaches to impact analyses, evaluation methods, and multi-disciplinary approaches to evaluate complex interventions. The GVHC works closely with local, national and international partners around the world to conduct action-oriented research and generate scientific knowledge and evidence around gender-based violence and health that aims to improve the lives of women, children, adolescents and men.

GVHC is a lead partner in the flagship global DFID-funded *What Works to Prevent Violence Against Women* programme, building knowledge about what works to prevent and respond to VAWG in humanitarian and low and middle-income country contexts, as well as guiding research on the economics, cost-effectiveness, and scale-up of violence prevention programmes.



African Population and Health Research Center (APHRC)

APHRC is an international non-profit research institute committed to generating an Africa-led, Africa-owned body of evidence to inform decision-making for effective and sustainable responses to the most critical challenges facing the continent. Headquartered in Nairobi, it has been an independent, registered institution since 2001, emerging from a fellowship programme started by the Population Council in 1995.

APHRC has four key mandates: i) generate scientific knowledge aligned to local and global development agendas, ii) develop and nurture the next generation of African research leaders, iii) engage with decision-makers using evidence to drive optimal development and implementation of policies, and iv) create operational efficiencies in systems and processes for maximum programmatic impact.

APHRC's priority research areas include: aging and development; education and youth empowerment; health and systems for health; maternal and child wellbeing; population dynamics and sexual and reproductive health and rights, including sexual and gender-based violence; and urbanisation and wellbeing.



International Rescue Committee (IRC)

IRC responds to the world's worst humanitarian crises and helps people whose lives and livelihoods are shattered by conflict and disaster to survive, recover, and gain control of their future. At work in over 40 countries to restore safety, dignity and hope, the IRC leads the way from harm to home.

IRC was one of the first humanitarian organisations to launch specific programmes for survivors of VAWG, implementing VAWG programmes in refugee settings and other conflict-affected communities. The IRC has been working in Kenya since 1992, providing health care, women's protection, governance and rights, and nutrition services to hundreds of thousands of refugees and the Kenyan communities that host them. Within the Dadaab refugee camps, IRC has been implementing gender-based violence (GBV) services in the Hagadera camp since September 2010.



CARE International (CARE)

CARE is a development and humanitarian agency with the goals of reducing poverty at the household level and providing relief in emergencies.

CARE commenced its humanitarian work in Kenya in 1968. Since then, it has built a substantial development and humanitarian programme, targeting around two million people in Kenya per year. It carries out major programmes in refugee assistance, health, water and sanitation, financial inclusion, adaptation to climate change, disaster risk reduction, agricultural value chains, and humanitarian/emergency response. CARE is a lead partner of the United Nations Refugee Agency (UNHCR) and the World Food Programme (WFP) for water, sanitation, and hygiene; food distribution and logistics; and formal primary education in Dagahaley refugee camp in Dadaab. It has been implementing GBV services in Dadaab since 1998. Until 2010, CARE took the lead in all GBV prevention and response activities in the three camps in Dadaab: Hagadera, Ifo, and Dagahaley. However, due to the refugee influx of 2010/11, the camps expanded and other partners took over management of GBV in other camps while CARE retained Dagahaley camp.

Executive summary



Violence against women and girls (VAWG) is now recognised as a serious and widespread global health issue. During a humanitarian crisis, the risk of such violence is heightened, often continuing after the early phases of a crisis – reports of gender-based violence (GBV) are common in camps for refugees and displaced populations. However, there is limited evidence on how to provide effective response services to survivors of violence in humanitarian contexts. One approach – comprehensive case management – builds on existing evidence from other fields and contexts (social work, legal, healthcare) as well as years of field experience by humanitarian agencies to improve survivors' health and psychosocial outcomes.¹⁻⁴

In the Dadaab refugee camps, the International Rescue Committee (IRC) and CARE International (CARE) have developed a comprehensive case management approach to address the needs of GBV survivors. Both humanitarian agencies implement programmes in Dadaab that aim to both respond to and prevent GBV. A cornerstone of this work has been to develop a broader implementation of traditional GBV outreach, community mobilisation, and case management to include task sharing with refugees known as refugee community workers. These refugee community workers are trained by IRC and CARE to carry out specific aspects of outreach, service delivery, and referral support to assist national humanitarian staff.

To date, there has been limited research on this broader GBV case management plus task sharing approach in the context of a refugee camp setting. To address this key gap in evidence, the London School of Hygiene and Tropical Medicine (LSHTM) and the African Population and Health Research Centre (APHRC), in collaboration with IRC and CARE, have sought to assess this model to understand its feasibility, acceptability, and influence on wellbeing, health, and safety outcomes among female survivors of GBV accessing care. Additionally, the research sought to better understand the context of GBV in a refugee camp context, including the distinct violence that refugee community workers face in their dual role of community members and GBV activists living side-by-side with survivors and perpetrators of violence. Data for this mixed-methods study were collected in the Dadaab refugee camps between 2014 and 2017, which coincided with a temporary decision to close the camp and repatriate Somali refugees.

The research confirms the magnitude and complexity of the violence that women and girls experience in the camps in Dadaab. Both service providers and women accessing IRC and CARE services reported that VAWG is common, with intimate partner violence (IPV), rape, sexual exploitation, and early and forced marriage reported as the most common forms. In the year leading up to this study, 47% of women accessing the GBV centres for case management reported experiencing IPV and 39% reported experiencing non-partner violence (NPV).

In addition, the study highlights the specific risks, challenges, opportunities and rewards experienced by refugee community workers in providing GBV response services and programmes in Dadaab. Solely related to their work as GBV caseworkers, one in three refugee community workers reported experiencing non-partner violence in the last 12 months. Additional burdens reported included heavy workloads, challenging and at times violent community resistance, logistical challenges of transportation within the camp, and slow and sometimes ineffective referral systems. Overall, national staff and refugee community workers reported a good working relationship, but some national staff expressed tensions related to the accuracy of translations by refugee community workers, while refugee community workers expressed the desire for long-term recognition of their work through certification. Despite this, 93% of refugee community workers stated their work was rewarding or extremely rewarding.

This research confirms that these factors must also be considered within the wider context of GBV response as these refugee community workers are refugees themselves, already facing extreme conditions related to long-term displacement, likely to have experienced violence themselves, and carrying their own personal responsibilities to family members and other dependants.

Survivors reported that the GBV case management model with task sharing was satisfactory. 82% reported that their interactions with refugee community workers had a positive effect and 66% reported that working with refugee community workers was helpful. However, having refugee community workers deliver services to their own community was not without its challenges, and survivors raised issues on confidentiality, mistranslations, and perceived biases based on clan differences.

This study confirmed the influential role that contextual factors play in case management and the importance of a strong referral service network. The research was conducted during a time of unexpected upheaval and disruption in Dadaab, following the announcement of a (now-delayed) camp closure three months into data collection with survivors, along with associated verification and repatriation exercises. The research was therefore able to capture some of the wider contextual influences of this political upheaval on women's access to GBV-related care in the camps. Additional qualitative research helped interpret how anxiety and fear among the refugees influenced camp morale, women's reporting to the GBV centres, and access to referral agencies. Priorities of both the camp population and service providers (GBV and referral services) shifted greatly during this time of uncertainty and affected when and how women were accessing services.

Research on case management services is complex. Case management is not a linear process but rather one with inter-related components that are highly dependent on the needs of the individual survivor; the implementation of related services, the staff delivering the services, and the wider context within which the services operate. This research explored these components, and measured changes in outcomes among survivors who consistently accessed case management and referral services. In this study, most women did not return for follow-up case management visits, limiting conclusions on the influence of case management on outcomes. Among the cohort, no significant changes were noted in levels of hope for the future, coping strategies, perceptions of safety, or physical health. However, improvements in mental health outcomes were found over time and, promisingly, women with the greatest psychological health needs appeared to access the services more frequently than those with lower mental health service needs, suggesting that the Dadaab case management model successfully reached the women with the greatest need for psychological support.

Recommendations have been developed to address the challenges raised by both service providers and women accessing GBV services in Dadaab. Below is a selection of key recommendations to donors, policy makers, practitioners, and researchers.

- **GBV case management must be delivered in line with best practices** – specifically the 2017 *Interagency GBV Case Management Guidelines*^b – to ensure quality and safe GBV case management is provided and to limit any negative practices that increase risk to service providers, refugee community workers, and survivors.
- **GBV services should transition to a complete task sharing model where refugee community workers are trained in the 2017 *Interagency GBV Case Management Guidelines*, and female refugee community workers are leading case management and psychosocial support for survivors.** Given the dual status of refugee community workers as both community members and service providers, agencies must also ensure that there are mechanisms in place to ensure refugee community workers' safety and wellbeing. Barriers to employment and promotion for female national staff and female refugee community workers must be mitigated by recruitment and training practices.
- **Funding for specialised GBV prevention and response services in protracted crises must be prioritised** to adequately meet the needs of women and girls in relation to quality case management, psychosocial support, and follow-up. Additionally, specific funding is needed for prevention work to address long-term behaviour change with regard to gender and social norms.
- **The development of GBV case management models in humanitarian settings, particularly around task sharing and the use of refugee community workers, should be supported further** to improve the adaptation of this model and related learning in complex, challenging, and changing humanitarian settings.
- **Researchers should build on the existing body of evidence** to further understand how this model of care would work in other humanitarian settings and the adaptations necessary for it to function, as well as to capture secondary outcomes of GBV case management. Researchers should work closely with implementing humanitarian agencies to ensure that research design accounts for programming and contextual expertise and ethically measures the effects of the relevant intervention.
- **Longitudinal research following survivors in humanitarian settings over several years is needed** in order to understand the longer-term impact of accessing care and the effect of community-level interventions to reduce barriers to accessing care.

^b The 2017 *Interagency GBV Case Management Guidelines* is a resource developed by the Gender-based Violence Information Management System (GBVIMS) Steering Committee to build capacity on GBV case management, information management, and strengthen the links between these in order to improve services provided to GBV survivors. This resource aims to set standards for quality, compassionate care for GBV survivors in humanitarian settings, with particular focus on the provision of case management services.



Introduction

Around the world, violence against women and girls is a pervasive issue and is both a cause and consequence of gender inequality.

Gender-based violence (GBV) is defined by the Inter-Agency Standing Committee (IASC) as: “An umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. The term is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence. This 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.” The IASC GBV Guidelines emphasise the need for GBV research to centre on women and girls and reinforce linkages between GBV prevention and gender equality.⁵ This research uses this definition of GBV with a focus on violence against women and girls as originally defined by the 1993 UN Declaration on the Elimination of Violence against Women: “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”.⁶

During humanitarian crises, women and girls’ risk of exposure to multiple forms of violence is heightened but there is limited evidence on how conflict and displacement drive different forms of violence,⁷ and how best to prevent and respond to VAWG in these contexts.⁸ Reports of violence are common in camps for refugees and displaced populations, especially among women and girls. Single/unmarried women, young girls or adolescents, and newly arriving female refugees (who often have less secure housing and fewer social networks) have been shown to be particularly at risk of violence.^{9–12} The limited evidence from humanitarian settings highlights that women and girls are subjected to multiple forms of violence including rape, sexual exploitation and violence, harmful cultural practices such as female genital mutilation (FGM), and early and forced marriage. Evidence also points to high levels of intimate partner violence (IPV).^{13,14}

One of the key interventions to support GBV survivors is comprehensive case management. Case management in the social service sector has been widely used in higher-income countries and is considered a core service provision for people who need care. It is an approach for integrating services around the needs of an individual and encompasses psychosocial care and managed referrals to medical, legal, and other services. Non-governmental organisations (NGOs) and women’s groups have adapted this approach to develop

GBV case management services that are appropriate for humanitarian crisis settings. In 2015, the Inter-Agency Standing Committee published guidelines for implementing gender-based violence services in humanitarian settings.⁵

In the Dadaab refugee camps in Kenya, two humanitarian agencies, IRC and CARE, are implementing individualised comprehensive case management using a task sharing approach where service delivery is led by skilled NGO staff and specific responsibilities are assigned to trained refugee community workers. The IRC delivers GBV response services solely using female national staff and refugee community workers, while CARE offers survivors a choice of female or male GBV responders. Task sharing is defined as “delegating new tasks to existing or new cadres with either less training or narrowly tailored training.”¹⁵ The World Health Organization (WHO) Task Shifting Global Recommendations and Guidelines suggest that it can be an efficient approach for improving access to health services; it has been shown to be a successful model in health interventions (e.g. HIV programmes, child malnutrition, mental health).^{15,16} However, to date it has not been evaluated in programmes that address GBV in humanitarian contexts.

The high prevalence of violence across crisis settings coupled with limited resources has necessitated the development of a task sharing model to strengthen and expand access to GBV-related services that are cost-effective and scalable. Task sharing is being implemented to help address some of the barriers that prevent GBV survivors from accessing response services. For example, trained refugee community workers can help to address some of the cultural, linguistic, and outreach gaps that may prove difficult for national staff (who are often not from the same country as refugees and additionally may have less access to the target population). However, given the sensitive, confidential, and skilled nature of delivering GBV services for survivors, there have been questions about whether task sharing is an acceptable and effective approach to meet the needs of GBV survivors.

To date, there are no rigorous evaluations of GBV response services in a refugee camp using case management with task sharing components. This research sought to understand how this case management model functions within the Dadaab refugee camps by examining its multiple inter-related components and perspectives, including the needs and perspectives of the individual survivor; the use and implementation of related programmatic elements, the experiences of the staff delivering the services, and the wider context within the camps.

Dadaab refugee camp background

Dadaab is located in Garissa County in north-east Kenya. The Dadaab refugee complex, one the world's largest refugee camps, is home to 246,551 refugees from nine countries (as of May 2017)¹⁷, although Somalis constitute a majority of the refugees hosted in the camps. The complex was comprised of five camps (Ifo, Hagadera, Dagahaley, established in 1991/92 to host Somalis fleeing the Somali Civil War; and Ifo 2 and Kambioos, established in 2011 during the great famine) but in mid-2017 the number of camps decreased to four.^{18,c}

The complex is managed by the Government of Kenya and the United Nations Refugee Agency (UNHCR), with various other local and international agencies supporting the provision of services including health, education, water and sanitation, and protection of the refugees. Due to prolonged regional insecurity and conflict, drought, and famine in Central and East Africa, Dadaab has continued to experience an influx of refugees from Somalia and other countries. Like many other refugee camps, it is characterised by lack of adequate access to basic amenities, food, and water; along with poor sanitation, living, and economic conditions.^{11,19}

The Dadaab refugee camp has long been a controversial topic in Kenya, with conflicting views on the responsibility of hosting such a large refugee population, alongside the threat of terrorist attacks due to alleged ties to Al-Shabaab among the Dadaab refugee population. Plans for the closure, or at least reduction in numbers, of the camp have been ongoing for several years. In November 2013, UNHCR and the Kenyan and Somali governments signed a tripartite agreement for the voluntary return of Somali refugees.²⁰

Ongoing discussions led to the announcement by the Kenyan Government of a camp closure in May 2016. A verification exercise was launched within the Dadaab camps to collect up-to-date information on the camp population after which repatriations of refugees to Somalia increased. In February 2017, the camp closure was halted. However, the announcement and subsequent verification and repatriation activities were made during the Phase II data collection period for this study and – as the findings in this report will show – had an impact on the delivery and uptake of GBV services and the retention of women in the research study.

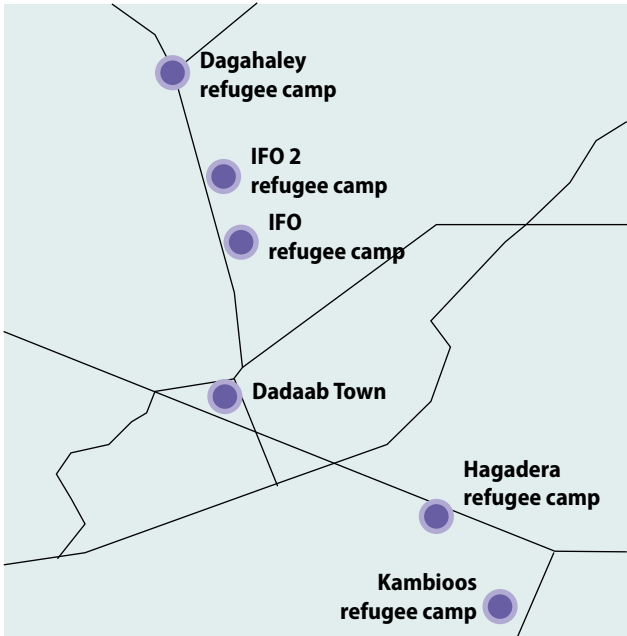


Figure 1. Map of Dadaab complex and individual camps

c In January 2017, the Kambioos camp consolidation process was started, with residents moved to Hagadera camp. The Kambioos camp is now fully closed.

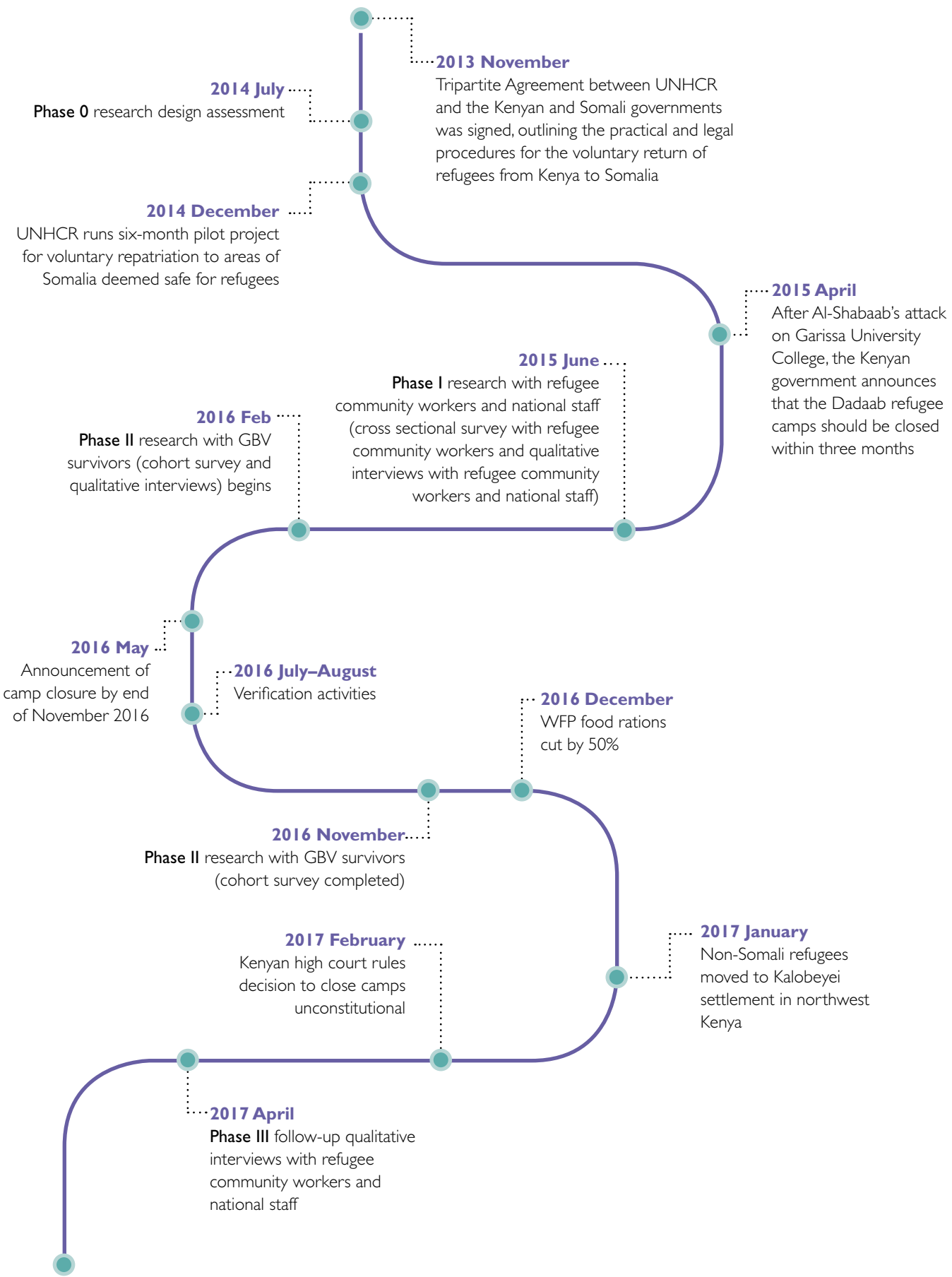


Figure 2. Timeline of key events in Dadaab in relation to research activities

Gender-based violence response model: Individualised comprehensive case management with task sharing

The 2017 *Interagency GBV Case Management Guidelines*^d define **GBV case management** as “a structured method for providing help to a survivor.¹ It involves one organisation, usually a psychosocial support or social work actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process. Case management has also become the primary entry point for survivors to receive crisis and longer-term psychosocial support, given the lack of more established health and social support service providers in humanitarian settings.”¹

There are six steps in the case management process: introduction and engagement; assessment; case action planning; implementing the case plan; case follow-up; and case closure.

Case management, in the social service sector, has been used for decades as an intervention and core service provision for people in crisis. Generally, it aims to influence positive health and psychosocial outcomes that support survivors’ ability to regain immediate health, safety, and overall functioning. In the context of responding to GBV, case management is considered a critical intervention for the healing and recovery of GBV survivors.¹

Rationale for GBV case management with task sharing

IRC and CARE provide GBV case management services in Dadaab in response to the harmful physical, emotional, and social consequences of GBV. Reflecting the reality that GBV survivors are overwhelmingly women and girls, both agencies target their GBV service delivery towards women and girls, although services are available for anyone requesting assistance, including men and boys. Their GBV case management models are underpinned by a survivor-centred approach, where the survivor’s experiences, needs, and rights are at the centre of decision making, allowing for the survivor to be in control of her own recovery and empowerment.¹

Additionally, IRC and CARE have added a task sharing component to the GBV case management approach in Dadaab. Task sharing is defined as “delegating new tasks to existing or new cadres with either less training or narrowly tailored training”²¹ – in this instance, to refugees from the community known as refugee community workers (refugee community workers).

Task sharing is hypothesised to provide a number of benefits to service provision:

- Refugee community workers can provide greater access to the refugee population. Increased accessibility to services is key in light of known under-reporting and under-utilisation of GBV services, particularly in low income countries.²² Recruitment of refugee community workers from different ethnicities/clans/nationalities within a camp means they can help address some of the cultural, linguistic, and outreach gaps that NGO staff – who are often not from the same country as the refugees – may have difficulty addressing. Additionally, it ensures that marginalised communities are also reached. Refugee community workers can also improve physical access – for example, where security may be an issue that limits NGO staff movement – and can provide an immediate first response as they are embedded within the target community.
- Task sharing with refugee community workers can increase the acceptance and ownership of GBV interventions by the community and for the community, and builds community understanding and capacity to tackle VAWG.
- Task sharing can extend the limited human resources of agencies to deliver comprehensive GBV case management, especially where they are serving large populations.
- Lastly, task sharing builds the capacity of the individual refugee community worker, giving them marketable skills for future employment should they be relocated or repatriated.



Individualised comprehensive case management model and process in Dadaab camps

In Dadaab, IRC and CARE implement the case management model in a similar fashion.

GBV case management services are delivered within **support centres** that are private spaces run by IRC and CARE. These centres are separate from the community at large, but are located within broader service centres, so that women and girls^e can access GBV response services confidentially and without fear of stigma. They are one-stop centres that include a medical examination room where clinical care for sexual assault survivors is provided by trained medical personnel.

IRC’s GBV centre is located in Hagadera within the IRC-run hospital compound. CARE’s GBV centre is located within their NGO compound in Dagahaley, which is shared with Save the Children International, and next to a Médecins Sans Frontières (MSF) hospital. Both of these areas are separate to the camp blocks^f where refugees live and are embedded within other sector services to improve confidential and discrete access. Entry is restricted to those accessing services.^g

IRC and CARE national staff, also known as officers, are skilled GBV case managers and counsellors delivering professional GBV response services. National staff are Kenyan nationals with educational and professional backgrounds in counselling or social work.

At the IRC, national GBV prevention and response staff fall under the mandate of the Women’s Protection and Empowerment programme (WPE). Female national staff exclusively implement GBV response programming including GBV case management in GBV centres and psychosocial support activities in community-based safe spaces for women and girls. Both female and male national staff implement GBV prevention programming such as community outreach or mobilisation programmes engaging women, men, girls, and boys.

^d The 2017 *Interagency GBV Case Management Guidelines* is a resource developed by the Gender-based Violence Information Management System (GBVIMS) Steering Committee to build capacity on GBV case management, information management, and strengthen the links between these in order to improve services provided to GBV survivors. This resource aims to set standards for quality, compassionate care for GBV survivors in humanitarian settings, with particular focus on the provision of case management services.

^e Both IRC and CARE GBV centres provide services for survivors who are 18 years or above, as well as those under 18 who are married, teenage mothers, or heads of households. Girls who do not meet these criteria are referred to child protection services.

^f Dadaab refugee camps are arranged in grids, with lettered sections and numbered blocks – for example, Section A, blocks A1, A2, A5; Section B, blocks B1, B2, B7; and so on.

^g IRC and CARE also run separate spaces for women and girls outside these GBV centres, which fall outside the specific scope of GBV case management. IRC runs women’s safe spaces within the camp blocks. These are private spaces where women and girls can report protection concerns, engage in dialogue sessions, participate in empowerment activities, and connect with the other women in the community. CARE has similar spaces with the camp blocks for adolescent girls and separately has trained female volunteers to run a women’s empowerment resource centre for women to gather, build relationships, and discuss issues.



Sven Torfinn/CARE

CARE's national staff involved in GBV service provision fall under their larger Gender and Community Development sector which is divided into two groups: gender officers from the Gender and Development Unit (GAD) who manage GBV prevention, case management, and referrals; and psychosocial officers from the Psychosocial Unit (PSU) who manage counselling and community capacity building in relation to psychosocial issues. At CARE, both types of national staff/officers can be female or male – the survivor is given a choice as to whether she would prefer female or male national staff to assist her.

Refugee community workers are female and male refugees who are trained and employed^h via Dadaab's incentive worker programme. Specific tasks are shared with the refugee community workers so that together the team can provide a tailored package of care to women and adolescent girls accessing their services, as well as GBV outreach and community mobilisation activities within the community (see Annex 1).

At IRC, female refugee community workers are trained to deliver response services within the GBV centres, by providing translation for women and girl survivors and supporting female national staff with case management sessions, psychosocial activities, and formal referrals. At CARE, as with national staff, GBV survivors can choose whether they want to be assisted by a female or male refugee community worker at the GBV centre. Female and male refugee community workers are trained to deliver similar services.

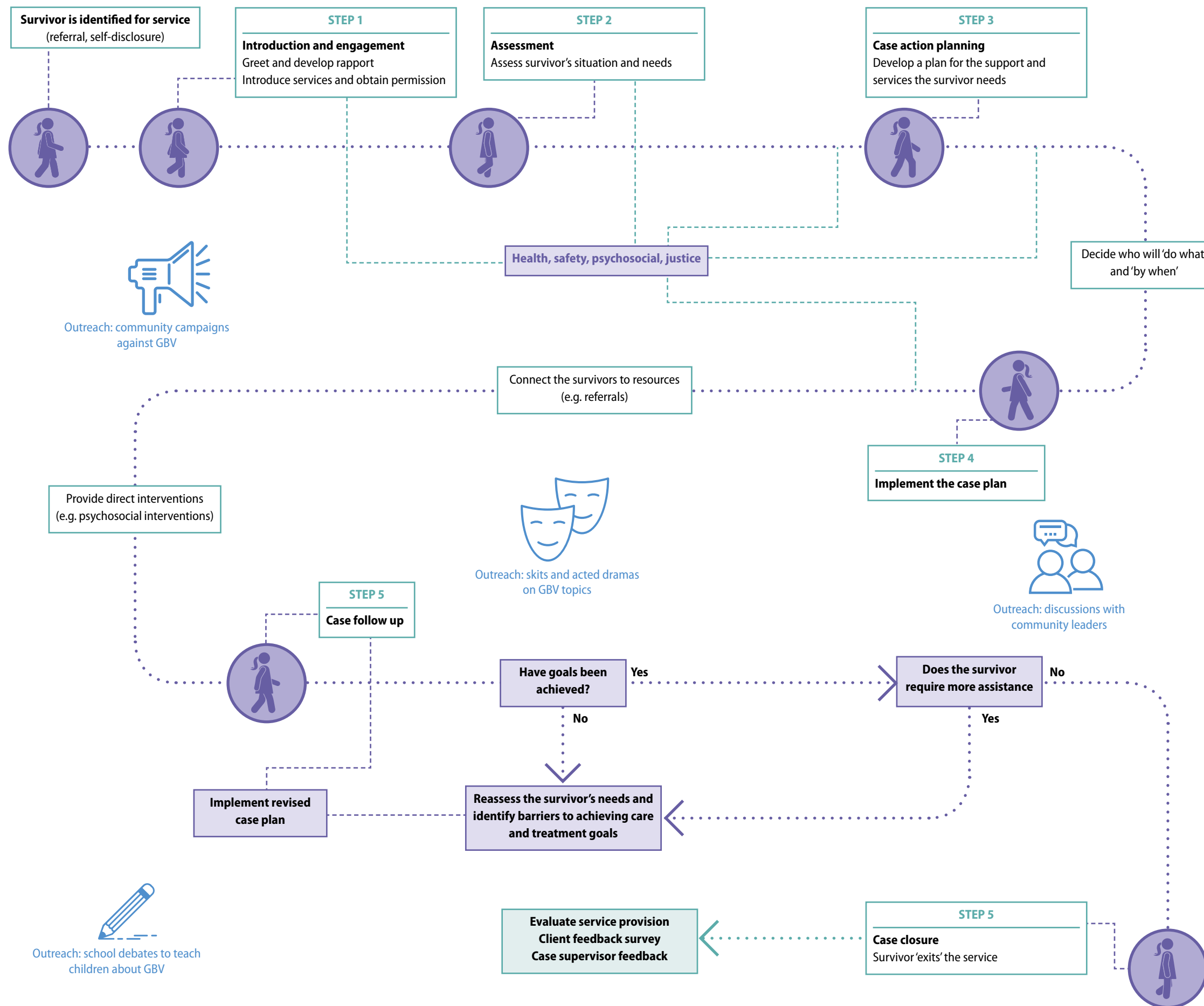
To ensure women and girls can access GBV response services, both female and male refugee community workers supported by IRC and CARE provide regular information to the community to promote understanding of the benefits of timely access to GBV response services. During these community outreach activities, both female and male refugee community workers may receive disclosures from GBV survivors. All refugee community workers receive training on psychological first aid to ensure they can listen and link GBV survivors to GBV case management appropriately.

Outreach and community mobilisation activities within the camp blocks include community conversations, public bazaars, school debates, focus group discussions and skits/acted dramas on different GBV topics. The refugee community workers engaged in outreach also work with community leaders, including those engaged in traditional justice mechanisms, to inform and influence actions that may otherwise limit women and girls' access to justice and broader GBV response services. This study did not assess the effectiveness or implementation of outreach and community mobilisation activities.

Sample of refugee community worker tasks

- Lead mass community campaigns against GBV
- Facilitate dialogue with key groups in the community such as youth or community leaders
- Raise awareness of GBV services in the camp
- Provide translation during individual case management sessions
- Issue material support such as dignity kits to the survivors
- Escort survivors to referred agencies or hospital

^h Refugee community workers' salaries are paid in accordance with UNHCR standards on refugee wages in Kenya. For staff in Dadaab, these range from Kenyan Shilling 8,850 to 11,050 per month depending on staff grade and experience.



STEP 1: A woman can self-refer, or with her consent be referred to the GBV centre by refugee community workers, other service providers, or community groups.

STEP 2: An initial assessment is carried out by a female (IRC)/chosen (CARE) national staff member with the support of a female (IRC)/chosen (CARE) refugee community worker for translation purposes and to build rapport and ascertain the woman's situation, immediate safety, and needs.

STEP 3: Based on this assessment, the female (IRC)/chosen (CARE) national staff will develop a case action plan together with the survivor; obtaining her consent to make any referrals to other service providers. The aim of the referral pathway is to offer the survivor as many options and entry points to care as possible, in order to provide access to services that work for her. Common referrals in Dadaab from both the IRC and CARE GBV centres are to: UNHCR, who have the overall protection mandate in Dadaab and also manage a number of services including ration card registration and resettlement; the Department of Refugee Affairs, who manages refugee registration in collaboration with UNHCR; the Refugee Consortium of Kenya for legal assistance; as well as the police, hospitals, and other NGOs focusing on other needs including legal aid, shelter, livelihoods, assistance for minorities' rights, and assistance for sex workers. National staff provide referral cards for survivors to access these services.

STEP 4: Next, the national staff will support the implementation of the case plan together with the refugee community workers, providing psychosocial care directly and/or within the community safe spaces, assisting her in obtaining quality services which are not provided from the GBV centre directly, and providing material goods directly where possible (such as hygiene kits which include sanitary napkins, bathing and washing soap, bathing towels, and underwear; sleeping materials; floor mats; mosquito nets; and plastic tarpaulins as temporary roofing materials).

STEP 5: If the survivor chooses to continue accessing GBV case management services, national staff conduct case follow-up meetings at the GBV centre. On average, women visit the GBV centres three to four times per case. Additionally, refugee community workers conduct phone and/or home visits, where appropriate and safe to do so. The action plan is revised and updated accordingly, depending on the woman's needs. Survivors are linked to women and girls' safe spaces in their communities and can continue to receive group psychosocial support and follow-up. Case conferences are held as needed to ensure that service providers effectively coordinate multi-sectoral services.

STEP 6: A case for a specific incident of GBV is only closed when the survivor determines she no longer requires more assistance in relation to that incident and she has the coping and management skills required to deal with its consequences. A case closure meeting is held with the survivor by a female (IRC)/chosen (CARE) national staff with the assistance of a female (IRC)/chosen (CARE) refugee community worker who provides translation.

Figure 3. Overview of GBV case management model in Dadaab¹ with GBV outreach and community mobilisation activities

Aim of the study and research questions



Research aim

This study aims to understand how the GBV response model of comprehensive case management with task sharing works to influence access to care, wellbeing, and health and safety among GBV survivors in the Dadaab refugee camps. The findings will be used to strengthen GBV services provided by humanitarian agencies in Dadaab and other contexts.

The research questions and specific objectives were:

Research Question I: What is the context of GBV in the Dadaab refugee camps?

- To explore the nature, risks, protective factors, and consequences for different types of GBV in a refugee camp context, including refugee community workers' experiences of violence.

Research Question II: What are the roles and experiences of IRC/CARE national staff and refugee community workers who deliver GBV response services in the refugee community?

- To explore the perceptions, motivations, skill sets, and experiences of refugee community workers who deliver GBV response services in Dadaab; and
- To explore national staff roles and relationships with refugee community workers, workload, perceptions and motivations, safety issues, barriers/enablers to achieving their goals, improvements they would like to see, gendered attitudes, and outcomes for survivors of violence.

Research Question III: Is a comprehensive case management approach using task sharing to deliver GBV response services acceptable and feasible for improving the health, wellbeing, and safety of GBV survivors in a refugee camp?

- To explore the patterns of usage and barriers to GBV-related care;
- To explore how GBV survivors perceive the effectiveness of the IRC/CARE GBV response services; and
- To document self-perceived changes in outcomes over time related to wellbeing, safety, and health.

Capturing a changing context

To capture the effect of the changing context in the Dadaab camp due to the announcement of the camp closure and the verification and repatriation exercises that took place in the middle of the data collection, follow-up interviews were added to capture the perspectives of the refugee community workers and national staff delivering services. These follow-up interviews aimed to explore:

- The feelings and concerns of refugee community workers and national staff in regard to the verification and increasing repatriation activities;
- Refugee community worker and national staff perceptions and experiences of how the verification and increasing repatriation activities affected their roles and subsequently the delivery of GBV services; and
- The ways that GBV service provision adapted to the changing environment within the camp.



Juliette Delay/IRC

Methodology



Study design and rationale

A convergent parallel mixed methods study design was used, where both quantitative and qualitative data were collected. An iterative approach was applied to enable the data to be triangulated by directly comparing the qualitative and quantitative findings for corroboration and validation purposes. Consequently, a more nuanced understanding of the GBV response model was developed from the perspectives of the recipients of the intervention and those who were responsible for delivering it (i.e. women survivors, national staff, and refugee community workers). Figure 4 presents the qualitative and quantitative components in this study design.

Setting, target population and eligibility criteria

Setting:

- Two refugee camps in Dadaab, Kenya: Hagadera and Dagahaley

Target populations and eligibility criteria:

- Service providers:** National staff and refugee community workers employed at the time of the study;
- Survivors:** Women 18+ years old and emancipated adolescent girl minors (15–18 years old) accessing GBV response services between 23 February and 23 November 2016ⁱ;

Sampling frame and recruitment

Two sampling frames were developed – one for staff and one for survivors.

GBV staff: The sampling frame was comprised of all current national staff and refugee community workers involved in GBV outreach, community mobilisation, and response delivery. All refugee community workers were interviewed for the cross-sectional survey in Phase I and a purposively selected sample of refugee community workers and national staff were selected in Phases I and III for qualitative in-depth interviews based on their sex, role in the agency and duration of service.

GBV survivors: A consecutive sample^j of eligible women accessing GBV services was invited to participate in the quantitative cohort survey and qualitative in-depth interviews in Phase II. Qualitative in-depth interview selection was based on various criteria including age, education, marital status, and length of stay in the camp, to ensure a range of perspectives.

Interviewer recruitment and training

Interviewers fluent in English and Somali were recruited to conduct interviews and surveys in Dadaab. For Phase I of the study (surveys and interviews with GBV service providers), four experienced Somali-speaking research assistants (two female and two male) were recruited as interviewers. For Phase II of the study (surveys and interviews with GBV survivors), four female interviewers were recruited. All interviewers took part in a two-week long training in GBV research and data collection. The training topics ranged from GBV definitions, forms, context, and service delivery in Dadaab, to research ethics and good interviewing skills. Phase III qualitative interviews were conducted to capture the changing context of the camp due to the verification and repatriation activities. LSHTM and IRC research team members conducted these interviews with refugee community workers and national staff in English.

All study tools were piloted and revised before they were used for data collection. Regular data quality checks and follow-up with the interviewers throughout data collection period allowed the project team to ensure that high quality data were being collected.

Ethical research procedures

This study was approved by the Ethics Committee at LSHTM and the Scientific Review Committee of the African Medical and Research Foundation (AMREF). In addition, UNHCR reviewed and approved the study.

Ethical research procedures were put in place at all stages of the research from research design, tool development, training and supervision of the field interviewers, data collection procedures, data analysis to the final dissemination. All procedures were established to ensure that participation in the research did not further traumatise or burden the research participants or GBV response staff.

To limit any time burden on survivors related to their participation in the research, the quantitative cohort questionnaires was developed using an iterative approach. In Phase I, a cross-sectional survey was administered to all refugee community workers. In addition to collecting data on their background and experiences, the research team tested sensitive questions – on violence, migration history, and potentially difficult questions to translate such as mental health scales – in the refugee community worker survey, with the intention of repeating these measures in the survivor cohort survey. Based on the preliminary findings of the refugee community worker survey, quantitative questions were further refined and used in the survivor cohort survey in Phase II.

To prevent re-traumatisation, only questions considered relevant to answering the research aim were included in the questionnaire. For example, questions on violence were limited to specific types of acts shown by other research to capture the range of physical and sexual violence likely to have been experienced by a woman from either her male intimate partner or a male or female non-partner. As this study was designed to assess women's use of GBV services and took place among women who had been living in the camps for a number of years, specific traumatic events related to living in a conflict were not posed in this study (such as abduction or fleeing your village because it was attacked). Rather, overall lifetime and recent experiences of physical and sexual violence and early and forced marriage were assessed for all research participants.

To ensure that no unnecessary burden was placed on women, all women were initially screened by the case managers and only introduced to the research team if they met the eligibility criteria. The interviewers then re-confirmed that the women met the eligibility criteria before starting the informed consent process. Recruitment procedures were designed based on GBV national staff input.

Verbal informed consent was obtained from all interviewees for their participation in the study and for the audio recording of their responses. Participation in the study was voluntary; staff and interviewers emphasised that participation would in no way affect access to services. Confidentiality was assured and ensured by conducting the interview in a private space, safeguarding access to the quantitative data through limited access to the server and dataset (research staff involved in data analysis only), and the use of unique alphanumeric identifiers for all quantitative and qualitative interviewers. All in-depth interviews were audio-recorded with the permission of the respondent. Participants were not compensated monetarily; however, for longer interviews, they were provided with a light snack and drink. All field research staff received training in confidentiality, conducting interviews on sensitive topics, and responding to distress that may arise during the interview process, which included follow-up counselling with trained psychosocial officers if requested by the women. Field research staff did not provide counselling.

Regular data quality checks also encompassed safeguarding of the research participants. Initially, for Phase II of the research two female interviewers were hired to conduct both the quantitative and qualitative interviews. However, after piloting and an assessment of the quality of qualitative interviews it was noted that the interviewers did not have sufficient experience initiating probes and responding to some of the disclosures made by survivors during the qualitative interviews. Therefore, it was decided that more experienced interviewers would be required for the in-depth interviews with women survivors. Consequently, an additional two female qualitative interview staff were recruited from a local research organisation and trained to administer the in-depth interviews with survivors accessing GBV services.

ⁱ All women (15 years or older) accessing IRC and CARE GBV services between 23 February and 23 November 2016 were eligible to participate in the research. However, due to camp procedures and ethical considerations on research among minors (under 18 years old), several limitations were put in place for recruitment:

- Any woman who was a single head of household within the camp would be invited to participate.
- Women under 18 years but married would be considered emancipated minors and therefore eligible to participate. Consent from their parents and/or spouse would not be sought as this may further expose them to violence.

Although eligible, no emancipated minors took part in this research.

^j Consecutive sampling: All eligible women who presented for care during the study period were invited to enroll in the longitudinal cohort. This non-probability sampling method sought to include all women who met the eligibility criteria.

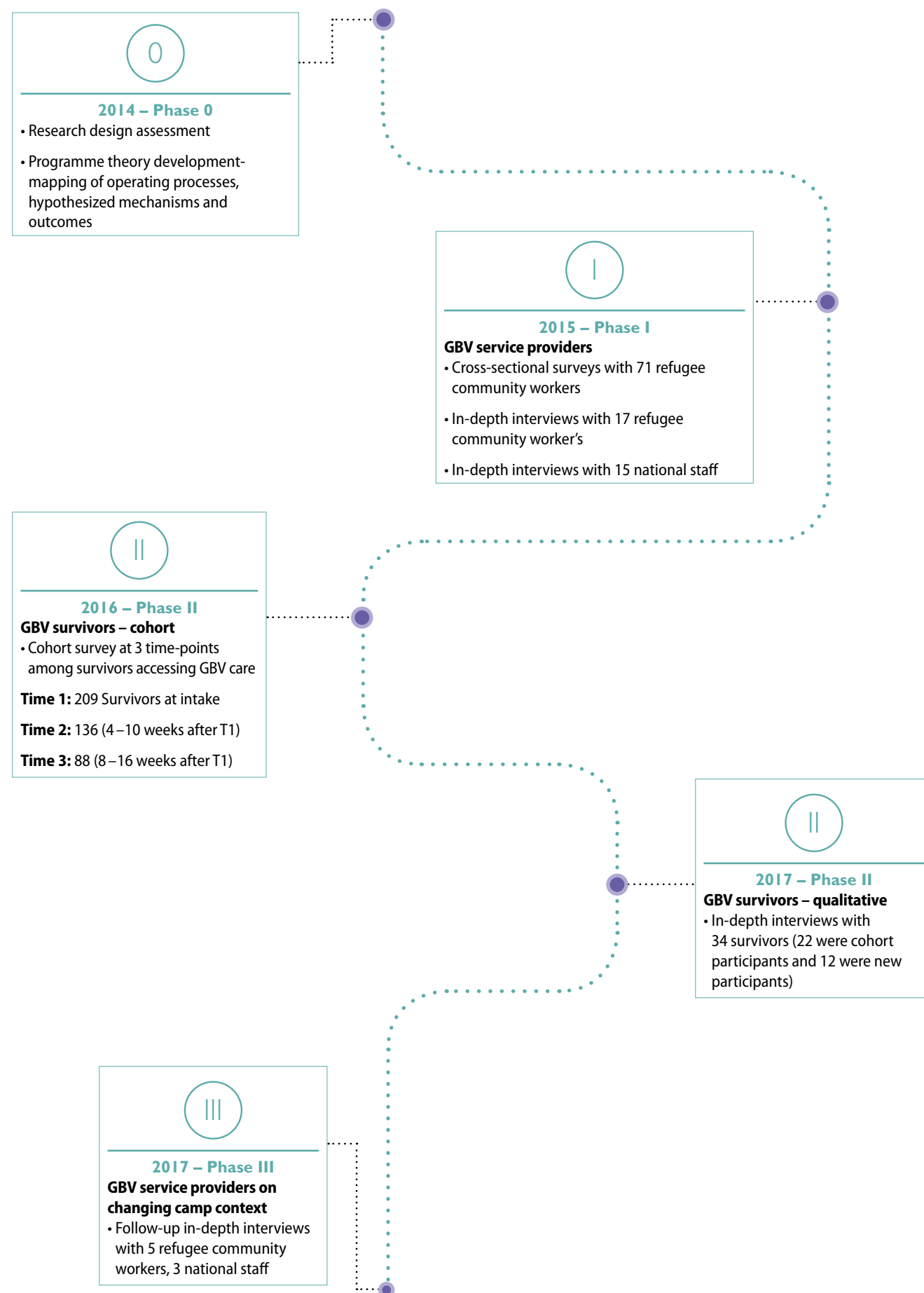


Figure 4. Data collection overview by research phase

Data collection methods

0 PHASE 0: Research design assessment and intervention mapping

A research **design assessment** was conducted in July 2014 with staff from LSHTM, APHRC, the IRC What Works Headquarters team, IRC Kenya and CARE. National staff shared an overview of GBV-related work in the Dadaab refugee camps. Preliminary research discussions and field visits were held to refine the research objectives and further understand the programming and research context. Meetings and focus group discussions were held with all GBV national staff and refugee community workers in order to reach a preliminary understanding of the programming, their responsibilities, and GBV survivors' needs.

The primary finding of the feasibility assessment was that both IRC and CARE were implementing task sharing of GBV case management services as a key programmatic approach and that this enabled them to better reach GBV survivors in the camps. However, there were perceived challenges and risks in implementing GBV case management with staff members recruited from the same refugee population as the survivors, including confidentiality, capacity, and ethnic minority tensions.

The conclusion after the research design assessment was that there was a need to understand the process of how, and why, the Dadaab models worked in order to understand how to facilitate scaling up and adaptations for other humanitarian crisis settings. This research project aimed to help develop and assess a process of sharing key GBV response-related tasks with refugee community workers that can generate learning for other contexts.

To understand how the GBV case management services worked and the hypothesised outcomes, an intervention mapping of standard operating processes was conducted. A template was developed to map the programme theory to document how the GBV service providers implemented case management activities and their understanding of how the services contributed to health and wellbeing outcomes among survivors accessing services. The mapping of the programme captured the inter-related components of the case management process, key contextual factors including people and organisations involved, mechanisms influencing outcomes among survivors accessing services, barriers and facilitators including other actors involved in the service delivery, and the influence of the case management process on potential outcomes. These findings were used to define the specific contextual issues, key mechanisms, and potential outcomes among survivors accessing case management services that were measured in the quantitative and qualitative research tools.

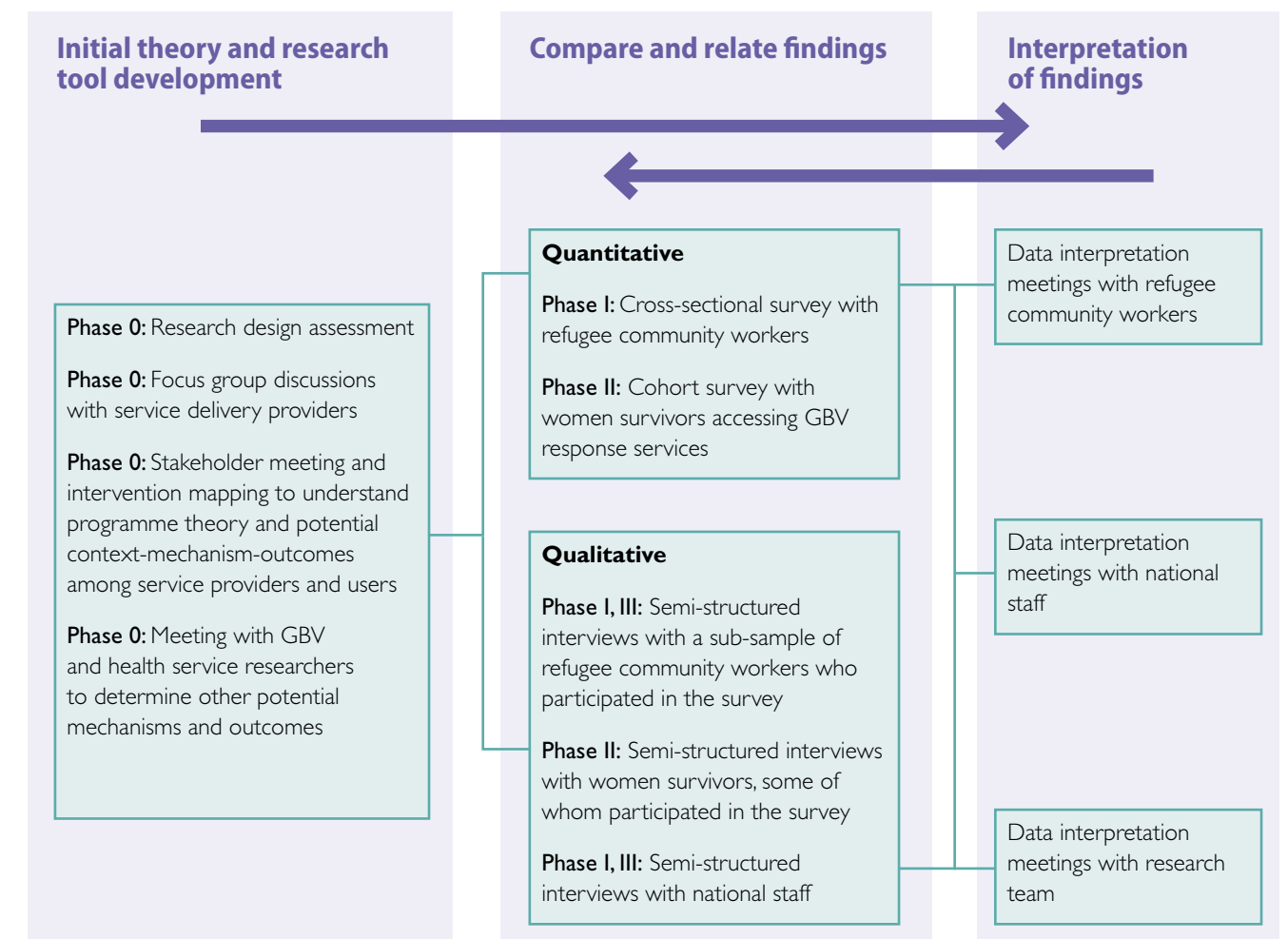


Figure 5. Convergent parallel design and research design components

I PHASE I: National staff and refugee community workers perspectives

To understand the context of GBV in the refugee camp and the GBV response approach, service providers were interviewed first, using quantitative and qualitative methods. The following were conducted: a cross-sectional survey with all refugee community workers and in-depth semi-structured interviews with refugee community workers and national staff. Data were collected in June 2015.

(1) Cross-sectional survey: refugee community workers

All currently employed refugee community workers were eligible and invited to participate in the cross-sectional survey. (N=71: 26 females, 45 males).

The refugee community worker cross-sectional survey was designed to capture the profile and experiences of the refugee community workers delivering GBV services. The survey was developed by the research team with feedback from the Technical Advisory Group (TAG)^k and field staff. The questionnaire was developed in English, translated into Somali and back translated using a group translation method. The questionnaire was then pilot-tested in the two selected Dadaab camps (Hagadera and Dagahaley) and revised accordingly.

Data were collected on demographics, experiences of violence, migration history, gendered attitudes, and work experiences including salary, client load, trainings, job satisfaction, and work-related tasks. Violence associated with work such as 'being attacked by another refugee because of your GBV work' and health status including current physical and mental health and any disabilities were also assessed.

(2) In-depth interviews: National staff and refugee community workers

A purposively selected sample of national staff, refugee community workers (who also participated in the cross-sectional survey), and Peace and Reconciliation Committee (PRC)^l members were invited to participate in the in-depth qualitative interviews. A variety of national staff were selected to participate in the in-depth interviews based on length of service provision and roles such as field coordinators, caseworkers, outreach officers, psychosocial counsellors, and economic empowerment/life skills coaches. Refugee community workers were similarly recruited to include those with varying lengths of service and roles such as GBV supervisors, GBV community workers with varying levels of work experience, and para-counsellors. This sampling approach was used to ensure that a range of perspectives were included.

A total of 35 in-depth interviews were completed with 15 national staff (6 female and 9 male), 17 refugee community workers (10 female and 7 male), and 3 PRC members (1 female and 2 male).

The interview guide was developed with input from the TAG and relevant researchers and organisations. The guide was translated into Somali prior to interviewer training. A similar approach was used for the subsequent phase of work.



Frederic Courbet/CARE

II PHASE II: GBV case management clients – GBV survivor perspectives

Phase II data collection activities were conducted in two stages: the survivor cohort survey from February to November 2016, when two quantitative interviewers were based in Dadaab, one in each camp; and qualitative interviews in January 2017, with two qualitative interviewers visiting Dadaab for a two-week period.

(1) Cohort survey: Survivors

A prospective cohort survey of female GBV survivors accessing IRC and CARE services was conducted over a nine-month period (three data collection points, no randomisation or control group). The follow-up surveys were conducted to descriptively assess trends over time in the primary evaluation outcomes and patterns of service use (medical, legal, psychological, etc.) until the close of their GBV centre case files, and to assess the longer-term impact after the close of their case files. The time periods for the cohort were based on the average time women appeared to access services for each new case, feedback from the service providers on the likelihood women would return for an interview, and the limited period (nine months) that data could be collected from survivors.

The cohort survey was completed by a total of 209 female survivors at T1, 136 at T2, and 88 at T3. Data were collected on Android tablets and uploaded to a secure server at the end of each day.

Time (T) periods for survivor cohort survey

Time 1 survey (T1):

Within a few days and up to 2 weeks after the woman reported a new incident/case at the GBV centre

Time 2 survey (T2):

4–10 weeks after the initial recruitment date

Time 3 survey (T3):

8–16 weeks after the initial recruitment date

(2) Qualitative interviews: Survivors

Purposively selected clients were interviewed to assess their perceptions of the GBV service delivery model and their relationships with the service delivery staff. Survivors were selected based on various criteria, which included their age, education, marital status, and length of stay in the camp, to ensure a range of perspectives. Interviews were completed with 34 women (17 accessing IRC's services in Hagadera, 17 accessing CARE's services in Dagahaley). Of the 17 from IRC, 13 were returning respondents (cohort survey data were collected from them in 2016), and 4 were new respondents (newly reporting clients who had never participated in the study and from whom no cohort survey data had been collected). Of the 17 from CARE, 9 were returning respondents, and 8 were new respondents.

^k The Kenya TAG is a group of experts from UN agencies, humanitarian organisations, government ministries, research institutions, I/NGOs, women's and civil society organisations, and other stakeholders working on VAWG with experience in research and developing policy. The role of the TAG is to provide technical input on research questions, ethical and safety measures, and dissemination and uptake strategies.

^l The PRC was a volunteer-led group set up by UNHCR for the purposes of community mediation and disbanded earlier in 2017. The PRC partnered with various agencies across the Dadaab camps, engaging in issues of humanitarian protection including GBV, child protection, and registration. Through these partnerships, PRC members received training on gender awareness, GBV and the concept of the survivor-centred approach to representation and care, referral services in Dadaab for survivors, the importance of supporting survivors' access to justice through the formal legal system, and the dangers of mediation, amongst other topics.

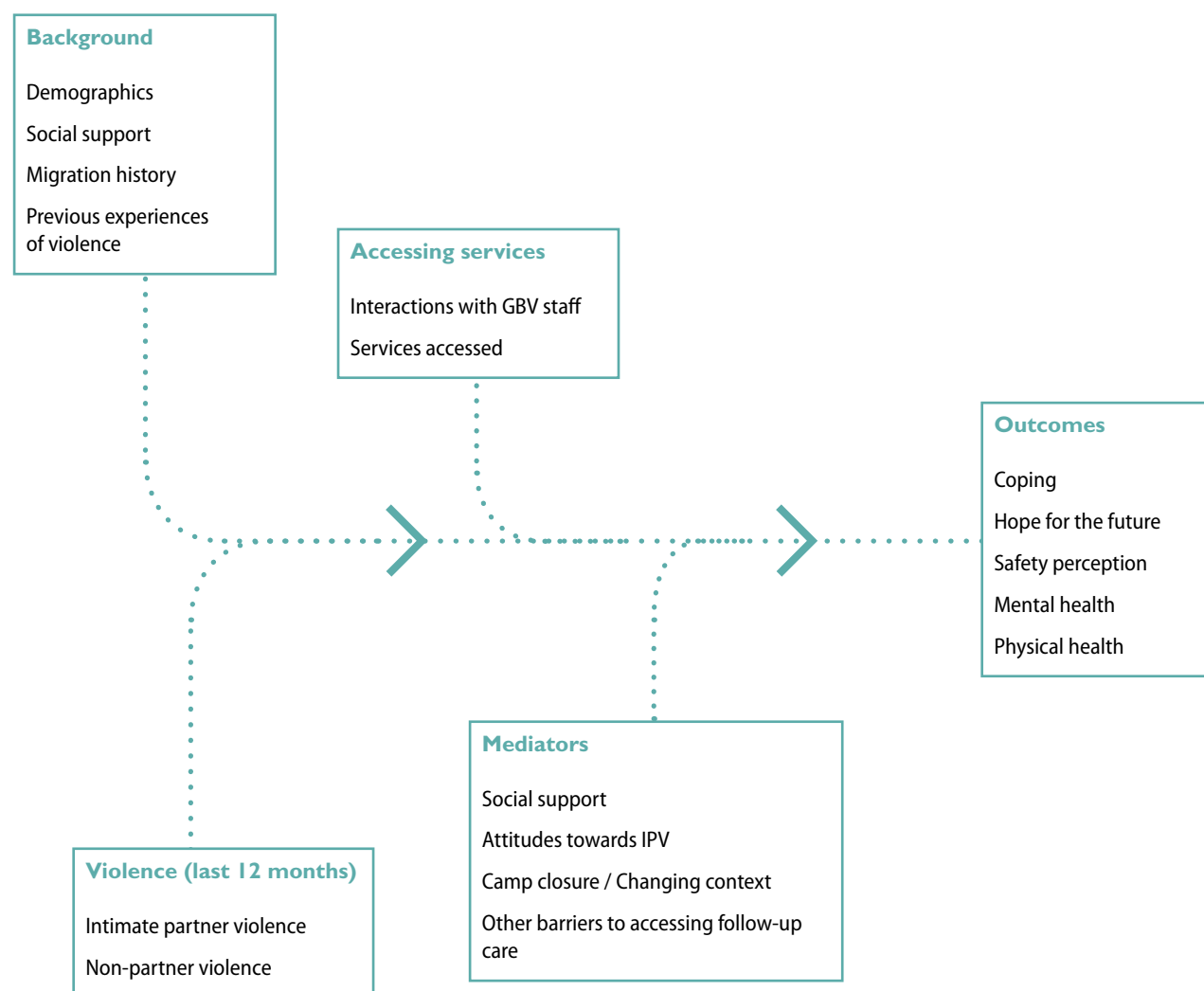


Figure 6. Framework for female survivors accessing GBV case management in Dadaab

PHASE III: Capturing a changing context: Impact of camp closure on GBV case management

(1) Additional qualitative interviews: National staff and refugee community workers

As the research spanned three years, several significant changes occurred within the camp, including the Kenyan Government's announcement that the Dadaab refugee camps would be closed. To capture the changing context, follow-up qualitative interviews were conducted with refugee community workers and national staff near the end of the data collection period.

Five refugee community workers (two female and three male) and three national staff (one female and two male) participated in semi-structured interviews in mid-April 2017. Purposive sampling was used to select participants based on gender, role (refugee community worker/national staff), and agency (IRC/CARE).

Analytical framework

Using the findings from the Phase 0 mapping, frameworks were developed to highlight the main themes to be explored in this study. Figure 6 presents the survivor framework used to understand the different factors hypothesized to influence women's decision to access services and potential mediators influencing wellbeing outcomes. The framework depicts hypothesised links between exposure, covariates, and potential outcomes among survivors. Quantitative and qualitative data were collected on the domains presented.

Further details on the outcomes and covariates measured in the quantitative survey and the data analysis procedures are provided in the Annex.

This report will present how women used the services, barriers that may have prevented them from fully accessing services, and an overview of outcomes that may have changed over time if services were accessed.



Sven Torfinn/CARE

Results

Demographics

This study collected data on demographics from the survivors accessing the GBV services and the refugee community workers providing the services.

Characteristics of the survivors accessing GBV services

Women enrolled into the study were aged between 18 and 66 years old and the mean age of the cohort at study intake was 29. Nearly all women in the cohort identified as Muslim (99%). Over half the women were currently single or had a partner who was absent (55%) and most women had a least one child, with only 20% reporting no children that they were responsible for at the first interview. Most women did not earn an income before Dadaab (60%) and this did not change significantly in Dadaab. More than half (61%) of women reported a low monthly income of between 0 and 4500 Kenyan Shillings (KES)^m at intake to the study. Finally, 62% of the cohort reported being unable to either read or write.

Migration history

Eighteen women (9%) were born in Dadaab, though the majority had arrived at the camp in the past 10 years. Of the total, 94% of women reported having Somali nationality. Most were born in South Central Somali (86%), and the majority of the cohort belonged to one of the four majority Somali clans (62%).

Table 1. Characteristics of survivors at intake (cohort survey)

Characteristics of survivors accessing GBV services	Time 1 (baseline) (N=209)
Age, mean (range)	29 years (18–66)
Length of encampment, mean	11.5 years
Somali nationality	94%
Muslim	99%
Currently living with a partner	45%
Care for 4+ children	41%
No monthly income	58%
Moderate / Severe anxiety	41%
Moderate / Severe depression	36%
Probable PTSD	3%
Born in Dadaab	9%

Characteristics of the refugee community workers providing GBV services

The refugee community workers who live and work in the Dadaab camp are part of the same wider community as the GBV survivors who access services at IRC and CARE. They have their own gendered migration history and experiences in the camp, as well as unique experiences as refugees in Dadaab delivering GBV services. A total of 71 refugee community workers were interviewed with more males (63%) employed compared to females (37%). The majority were between 20 and 30 years old and 42% had completed some secondary school. A higher proportion of the male refugee community workers had completed some secondary education or higher (67%) compared to the female refugee community workers (46%). Overall, there was a more age-diverse group of female refugee community workers (aged 20–59) than male refugee community workers (all 20–39). Over half (65%) were currently married. A majority (71%) of all refugee community workers had one or more children to care for and nearly half (48%) reported additional caring responsibilities for a disabled, elderly, or long-term ill individual (31% female, 58% male).

Migration history

Most of the refugee community workers have a long history in Dadaab, with 85% having lived in Dadaab continuously for 6 years or more, and 75% having lived in Dadaab for more than 15 years. Many had spent more than 20 years in the Dadaab camps with most reporting leaving their home country between 1990 and 1999 (76%). People left their homes for a variety of reasons primarily related to civil war, insecurity, or post-election violence (96%). Four refugee community workers (6%) were born in Dadaab.

Table 2. Refugee community worker demographics

	Female N=26	Male N=45	Total N=71
Nationality			
Somalia	89%	93%	92%
Ethiopia	12%	4%	7%
South Sudan	0	2%	1%
Education			
No schooling	4%	0	1%
Some or all primary	50%	33%	39%
Some or all secondary	39%	44%	42%
More than secondary	8%	22%	17%
Religion			
Muslim	96%	96%	96%
Christian	4%	4%	4%
Age			
20–25	31%	29%	30%
26–30	35%	52%	45%
31–34	8%	18%	14%

^m 4500 KES is equivalent to £33 (in August 2017).

Research Question I:
What is the context of GBV in the Dadaab refugee camps?

Data were collected from female GBV survivors, refugee community workers, and national staff to understand the context of GBV in the Dadaab camps. Prevalence data on violence experienced were collected from both survivors and refugee community workers. Qualitative data were collected from survivors, refugee community workers, and national staff on the nature and risks of GBV in the camps, the changing nature of violence and the influence on GBV services of the camp closure announcement in May 2016, and the impact of the verification activities and repatriations that took place between 4 July and 10 August 2016. This section will present an overview of the types of violence experienced within the camps.

Experiences of GBV among survivors
accessing GBV services

In the cohort survey, more than half of the survivors (61%) surveyed reported intimate partner violence (IPV) – emotional, physical and/or sexual – in her lifetime, while nearly half (47%) of women experienced IPV in the 12 months prior to their baseline interview. (See Annex 2 for violence questions.)

Among the cohort, in the past year sexual violence by an intimate partner was reported by 11% of respondents, while emotional violence was the most commonly reported IPV subtype (43%). Of the cohort, 15% reported IPV that occurred before their arrival to Dadaab refugee camp with 3% reporting sexual violence and 8% reporting severe physical violence. While 60% of women reported experiencing non-partner violence (NPV) – physical and/or sexual – in their lifetime (56% physical violence and 17% sexual violence), 39% reported a NPV experience in the 12 months prior to the study intake (36% physical violence and 6% sexual violence). Of the participants born outside of Dadaab (N = 191), 24% reported experiencing acts of physical and/or sexual NPV before their arrival in Dadaab (23% physical violence and 7% sexual violence). Few women accessing the centre (9%) reported experiencing both IPV and NPV violence.

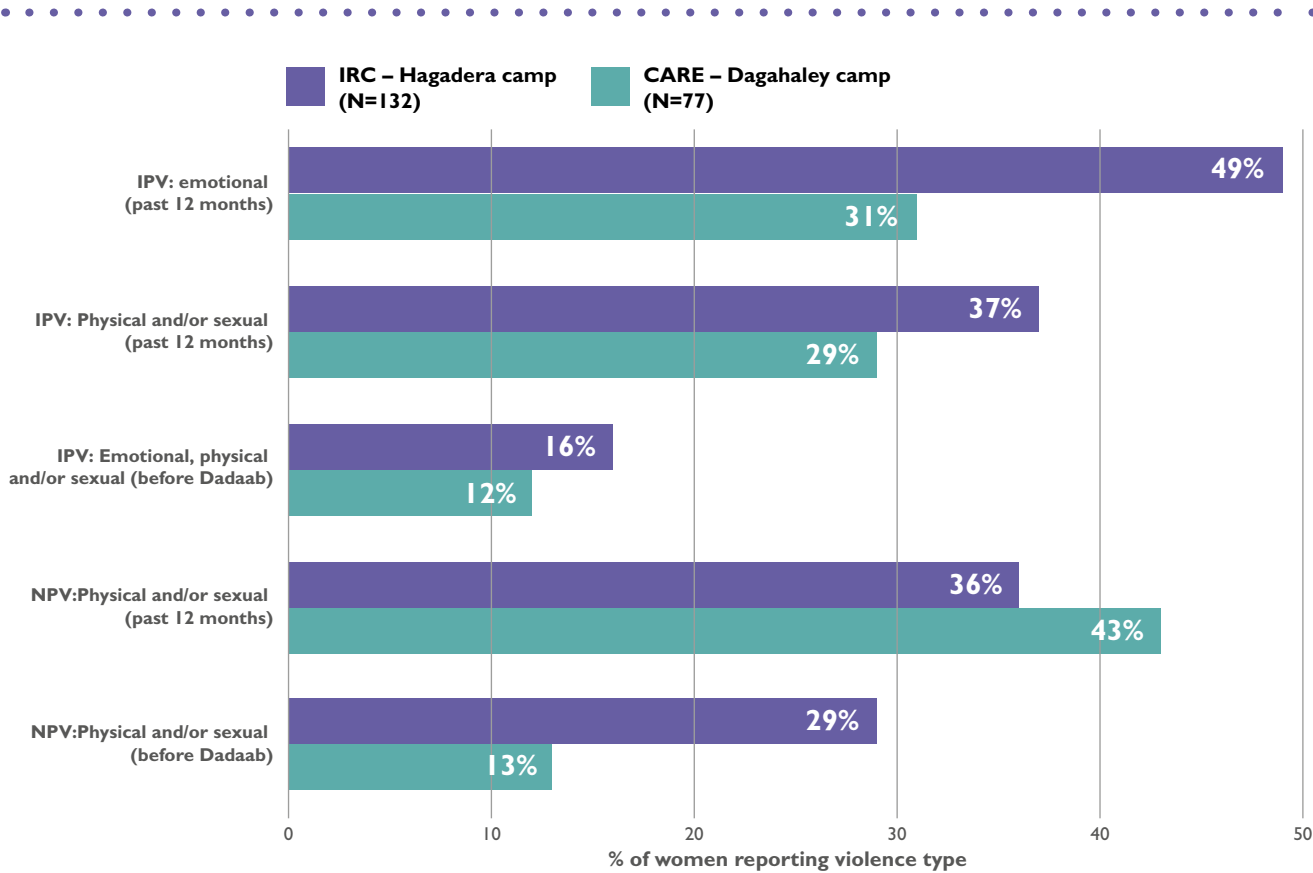


Figure 7. Survivor experiences of Intimate Partner Violence (IPV) and Non-Partner Violence (NPV) in the last 12 months. Reported at Time 1 interview

61%
of women reported intimate partner
violence in her lifetime

47%
of women reported intimate partner
violence in the last 12 months

The following are examples of reasons for attending GBV centres by women who did not report an incident of intimate partner or non-partner violence:

- Husband/ex-husband does not recognise child as his, and/or does not provide for family financially;
- Husband did not acknowledge wife in resettlement papers and she fears she will be left behind in Dadaab if his application is successful;
- A young woman fears for her safety because of a man who waits for her on the side of the road and harasses her daily.
- Family threatens a woman with violence as they do not agree with her marriage.
- Community members are violent to a woman because of her medical condition.

Women were asked to recall who, within Dadaab, perpetrated specific acts of violence against them. The reported perpetrators of NPV within Dadaab included: male friends/ neighbours (24%), strangers (sex unspecified) (17%), male family members (16%), and female friends/neighbours (15%). Those who had a weapon used against them during an attack (e.g., knife, gun) reported perpetrators including: strangers (sex unspecified) (35%), male friends/neighbours (18%), male combatants (1%), female family member (6%), and male family member (6%).

In the qualitative interviews, survivors reported that men were the most common perpetrators of violence against women and girls in the camps. They reported that perpetrators of violence and abuse were typically known to the survivor; usually previous male partners and/or their families (mostly brothers of the ex-partner), or the current husbands of women who were married at the time of the interview [IPV], with physical assaults as the most common incident reported.

“It happens a lot here. Girls are physically beaten and raped ... forced to marry men they don’t want.”
–Survivor; 20 years

“It happens when you get married and you get divorced. The ex-husband moves to Somalia and threatens you through texts every day and night.”
–Survivor; 20 years

Single or unmarried women and young girls were reported as being at greater risk of violence from strangers [NPV], particularly physical assaults and rape, especially when adult relatives were not present. Although high rates of IPV were disclosed, marriage was reported as a protective factor against rape and other forms of violence from non-partners.

“They [women] feel insecure. Like me, because I have seven daughters and I have no one to protect us. They are in danger of rape or being physically beaten. Because of that, my security isn’t good.”
–Survivor; 37 years

Other factors that were reported to increase women’s experience of violence included marrying a man not approved by the woman’s family or from a different clan, membership in minority clan, and disability.

Gender norms and rights related to violence against women

All survivors were asked at the first interview (T1) a series of questions on gender norms related to IPV against women. Women who experienced IPV in the last 12 months were more likely than women who had not experienced IPV to agree with all reasons presented justifying male physical violence against their female partner (Table 3). The trend was less clear however when they were asked about sexual violence by an intimate partner. The association between violence and a woman's belief that physical violence against her was justifiable was statistically significant for most reasons listed apart from gossiping with the neighbours and refusing sex. Other research has shown that self-blame can be a common reaction to IPV by the survivor, can increase levels of psychological distress, and is relied upon by perpetrators to maintain the cycle of violence.^{23,24} These associations may be indicative of the internalisation of inequitable norms among women who have experienced violence. Further research is needed to understand the reasons why these norms are prevalent, their association with disclosure, and how they can be changed.

Refugee community workers were asked similar questions on gender norms in the cross-sectional survey. Most refugee community workers disagreed with justifications for male physical violence against their female partner and agreed with other gender equitable statements. However, given the lack of variation between the responses, it is likely there was some reporting bias and it was not clear if refugee community workers were reporting what they believed they should say rather than their actual beliefs. Refugee community workers receive extensive training on gender norms as part of their work and many are involved in awareness raising activities.

Table 3. Survivor opinions on gender norms and rights related to violence against women at service intake, among women who have experienced or not experienced intimate partner violence (IPV) in the last 12 months

Question	IPV (N=98)	No IPV (N=111)	Total (N=209)	p-value*
In your opinion, does a man have a reason to hit his wife if: (reporting yes %)				
she neglects the children	37%	22%	29%	0.016
she argues with her husband	36%	22%	28%	0.024
she disobeys him	37%	14%	25%	<0.001
he finds out that she has been unfaithful†	32%	14%	23%	0.003
she gossips with the neighbours instead of taking care of the children	29%	17%	23%	0.048
she does not prepare the meals on time	30%	14%	22%	0.008
she burns the food	27%	14%	20%	0.029
he suspects she has been unfaithful	26%	14%	20%	0.044
she refuses to have sex with him	26%	13%	19%	0.017
she does not complete her household work to his satisfaction	21%	8%	14%	0.006
In your opinion, a woman can refuse to have sex with her husband if: (reporting no %)				
she does not want to	46%	49%	47%	0.693
she suspects that he has been unfaithful	39%	55%	47%	0.019
he refuses to use condoms	33%	41%	37%	0.190
he is drunk	31%	33%	32%	0.674
he mistreats her	26%	34%	30%	0.170
she knows that he has been unfaithful	27%	32%	30%	0.351
she is sick	25%	29%	27%	0.480

*P-value reported from a Pearson's X2 test for association.
†Percentages and p-values are calculated from non-missing data. IPV category has 98 non-missing responses.

Experiences of violence among GBV service providers: National staff and refugee community workers

In the cross-sectional survey among refugee community workers, IPV was not frequently reported. Refugee community workers were more likely to report an experience of NPV than one of IPV. During their time in Dadaab, a third of all refugee community workers (33% total: 39% females, 23% males) reported having faced some form of physical violence (being hit with a fist or other object, kicked) and one in five (23% women, 20% men) reported having a weapon (e.g. knife or gun) used against them. NPV before Dadaab was also reported, with 16% of all refugee community workers reporting being hit or kicked by a non-partner (23% female, 11% male), and 10% reporting a weapon being used against them (15% female, 7% male). Sexual violence was reported by female refugee community workers: 3 women reported being forced to have sex since living in Dadaab and 4 female refugee community workers experienced forced sex before coming to Dadaab. No male refugee community workers reported an experience of sexual violence in his lifetime.

In qualitative interviews, GBV service providers (national staff and refugee community workers) acknowledged that GBV was common in the refugee settlements, with women and girls most likely to experience violence. Forms of GBV that were reportedly common in the community included intimate partner violence, rape, sexual exploitation, and early marriage. The service providers perceived the key drivers of GBV in the community to be poverty, the low status of women, cultural norms that justify violence against women and girls, illiteracy, lack of economic opportunities, and ethnic or clan clashes. Highlighting the role of women's status in the community, one refugee community worker noted:

“Yeah, it is a patriarchal society where they feel that the women are subordinate to men and they have no say in the community ... We also look at the women, who are not empowered economically, so that most of the time they depend on men to pay family bills.”

–Refugee community worker, female

In the view of one national staff member, men justified perpetrating violence against women because of shifting power dynamics and lack of economic opportunities in the refugee context:



“I can say in this temporary settlement here, people have been disturbed from their normal lives, some of the men have been ripped of their power such as providing for their families. They had their jobs, then they come here ... Most agencies are shifting focus from men to women and children. These men don’t have jobs to provide for their families, they don’t have a way of ensuring the wellbeing of their families, so we end up with a situation where the men feel powerless and the only way they know how to exercise their power or how to release their disappointments [is] by violating the women.”

—National staff, female

Substance abuse was also mentioned as a contributing factor for GBV in the refugee camp, although it was rarely reported in the survivors’ cohort surveys. Respondents noted that miraa [also called khat, a plant native to the Horn of Africa and used as a stimulant by local communities] was commonly used among men in the refugee camps. Miraa use reportedly can make individuals aggressive, violent, or abusive and, in combination with the high level of unemployment and loss of sense of power, was perceived to be linked to men’s use of violence against women and girls in the camps.

During the repatriation activities, national staff reflected on how family disputes over repatriation would sometimes result in violence:

“Dadaab is a unique situation. Some people who are Kenyan come close to the camp to benefit from the services. So you find that the local people intermarried with the refugees in Dadaab. Maybe the husband is local, the wife is refugee ... The husband will say I am Kenyan, you are not going anywhere with my children. And from those disputes, sometimes violence erupted and if the wife wanted to go sometimes the husband decided to abandon them, not provide for them, deny them resources and so forth, to punish them for the wife deciding against the husband ... Sometimes you find that a few members from the family say they want to go back, but others would say no, we have three or four children going to school and in Somalia we are not having such services. So it divided families.”

—National staff, male

The offer of a repatriation package with its financial incentive appeared to divide some families over whether or not to return to Somalia. Survivors’ accounts suggest that the male heads of the family were usually in favour of accepting the repatriation package, whereas women and children preferred to remain in Dadaab where they felt safe and had access to resources and education, and where young boys were not at risk of being recruited by Al-Shabaab. This created many disagreements over whether to repatriate, as well as arguments over the custody of the children when parents disagreed:

“The physical violence and the psychological violence increased during that period because one, men wanted the women to go because they were receiving some [financial] incentive from UNHCR and they wanted to force these women to go. So when the women hesitate or resist to go, she becomes battered and sometimes there was even the issue of men divorcing the women and fleeing with the children.”

—National staff, female

“Most of the men found it a way of benefitting and were just going because they were receiving one hundred dollars [per family member] at that time. If you have a family of ten, that will be a thousand dollars. So for the men they were never really concerned for the situation that their women were fleeing in Somalia. Women were concerned about their wellbeing and that’s why most of them were hesitant to go back to Somalia.”

—National staff, female

GBVIMSⁿ data from the IRC in Hagadera shows that there was a small increase in incidents of GBV in the month immediately following the verification exercises (September 2016)^o. It should be noted, however, this cannot be attributed directly to the announcement of camp closure or the verification/repatriation exercises.

ⁿ The Gender-Based Violence Information Management System (GBVIMS) is a data management system that enables those providing services to GBV survivors to effectively and safely collect, store, analyse, and share data related to the reported incidents of GBV.

^o This number represents the number of reported cases, does not represent prevalence and only reflects those who consented to share their information.

Research Question II:
What are the roles and experiences of national staff and refugee community workers who deliver GBV response services in the refugee community?

Research Question I establishes the GBV context in Dadaab, highlighting the issues that women and girls are facing. Research Question II explores the experiences of the service providers in providing care for GBV survivors. It presents how GBV case management task sharing is implemented in Dadaab and explores the experiences of both national staff and refugee community workers in delivering these services. Findings will be drawn from the refugee community worker cross-sectional survey (Phase I, June 2015) and qualitative interviews conducted with national staff and refugee community workers (Phase I, June 2015; Phase III, April 2017). Data have been analysed to understand the different roles and responsibilities for national staff and refugee community workers, and to reflect on challenges to GBV service delivery from the service provider perspective.

Refugee community workers roles and responsibilities

In the cross-sectional survey, the refugee community workers reported undertaking a range of work-related tasks: nearly all reported offering some form of psychological first aid in the community (90%), facilitating initial referrals to the GBV centres (85%) and later referrals from national staff (83%), conducting outreach activities through information provision (79%), working with community groups such as the Peace and Reconciliation Committee (79%) or the *Kadhi* (Islamic civil courts) (71%), and conducting other community awareness activities (78%). Less than half of all refugee community workers reported working with the *Maslaha*^p (44%).

^p The *Maslaha* is a traditional dispute resolution (mediation) system comprised mainly of Somali male elders – generally above the age of 40, educated in religious matters and holding respected positions such as religious leaders, clan heads, or block/section leaders. Within the Somali community, where clan and family have a strong influence on decision-making, the *Maslaha* has great authority. There is pressure within the community in Dadaab to resolve GBV incidents using community-based or traditional practices, additionally fuelled by limited confidence in formal justice mechanisms. This has produced a parallel traditional system of addressing GBV within the community where family members – usually male – represent and make decisions for the survivor, resulting in late or no reporting to GBV support centres, other health services, or the police, as well as negative outcomes for women and girls such as forced marriage to the perpetrator of sexual violence, tolerance of IPV, and blaming women's and girls' behaviour as the cause of the GBV.

Some tasks were reported by more male refugee community workers compared to female refugee community workers and vice versa. IRC uses female refugee community workers for translation and support during case management sessions at the GBV centre for example, whereas CARE gives the GBV survivor the choice between engaging with a female or male refugee community worker. For example, more women reported providing national staff with counselling support in the GBV centres (77% women, 49% men) and assisting with intake at the GBV centres (50% women, 38% men). On the other hand, a higher proportion of male refugee community workers reported undertaking community awareness activities (91% men, 54% women) and organising community sensitisation activities such as neighbourhood forums (73% men, 42% women).

Due to differences in the ratio of female and male refugee community workers between the two agencies and the differences in organisational policies regarding how trainings and specific tasks are allocated (based on sex, education background, training, etc.) and the small sample size, associations with survivors' use of services or ultimate outcomes could not be ascertained. However, this research noted that, in line with best practice guidelines, a higher proportion of female refugee community workers are engaged in direct response with female survivors and more male refugee community workers appear engaged in outreach and mediation activities.

Refugee community worker job training and preparedness

Refugee community workers reported receiving a variety of trainings, including GBV and gender training, psychological first aid, community development, and community mobilisation facilitation such as SASA!^q methods. Among the refugee community workers at IRC, the majority were trained in psychological first aid (96%), gender/GBV topics (93%), and community development/mobilisation (82%). Additionally, some of the refugee community workers at IRC were trained in child protection (36%) and computer skills (7%). At CARE, the type of trainings completed were similar, with most refugee community workers trained in GBV and gender (96%), psychological first aid (74%), and community development/mobilisation (70%). Again, some CARE refugee community workers had additional training in child protection (48%) and computer skills (41%).

Some of the variations in training are due to differences in organisational hiring policies and structure. For example, CARE previously required a higher education qualification requirement than IRC for new refugee community workers which may have influenced their ability to complete training in areas such as computer skills.^r Also, CARE's GBV centre has specific psychosocial counselling roles (para-counsellors) for some, but not all, refugee community workers. IRC trains all refugee community workers to deliver basic psychological first aid at either the block or GBV centre level, but does not train refugee community workers to provide any type of counselling beyond psychological first aid.

Just over half of the refugee community workers reported that they felt prepared for nearly all their work (56%), and they asked for further training in community development and mobilisation, counselling, GBV response, and gender. Refugee community workers brought up other areas in which they wanted additional training, including monitoring and evaluation skills (13%) and EMAP^s training (6%).

Overall, female refugee community workers had the highest percentages of feeling prepared to handle all cases (78% at IRC, 88% at CARE). This is in line with the 2017 *Interagency GBV Case Management Guidelines* which proposes that female caseworkers are preferable for programmes established to specifically address violence against women and girls in order to protect the emotional and physical safety of the survivors. Male refugee community workers reported being predominantly involved in community activities and therefore may have felt less prepared to handle some cases of violence they encountered in the camps.

Most refugee community workers were satisfied or very satisfied with the support they received from national staff. In fact, nearly 100% of refugee community workers were satisfied with support they received from their immediate supervisors.

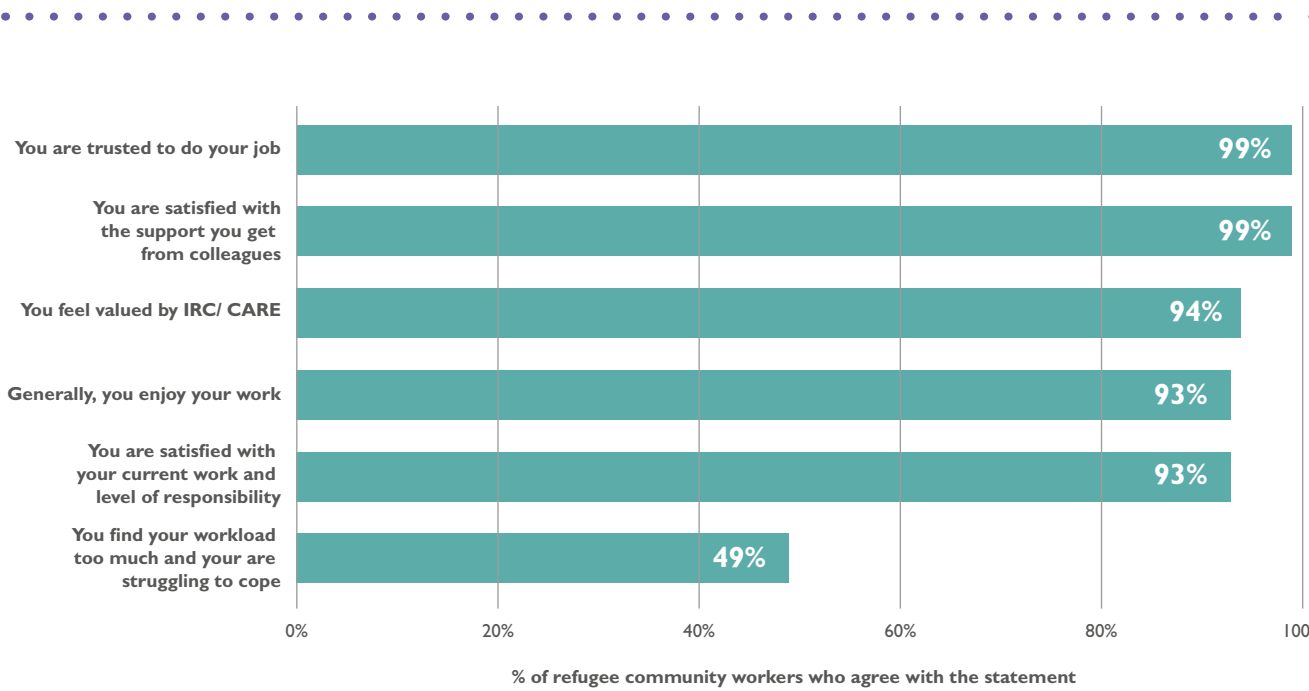


Figure 8. Refugee community worker job satisfaction (N=71)

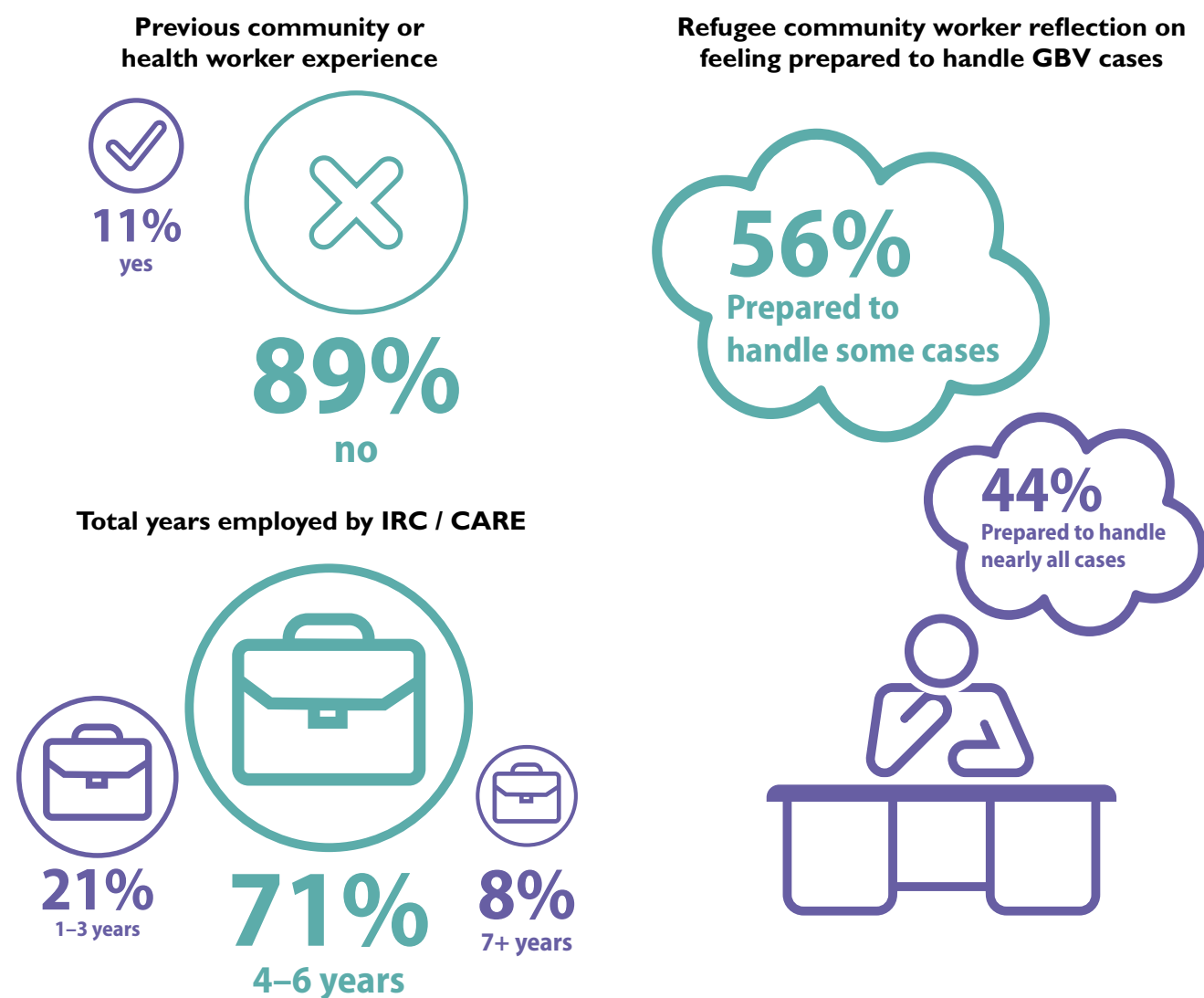


Figure 9. Refugee community worker work experiences

q SASAI (Start, Awareness, Support, and Action) is a methodology developed by Raising Voices that takes a systematic approach to changing knowledge, attitudes, skills, and behaviours that community members hold about GBV, HIV, power, and activism. These changes occur through four corresponding phases: Start, Awareness, Support, and Action.

r CARE's refugee community worker hiring policy requires recruits to have completed Form 4 (secondary school) for the "unskilled refugee community worker" category. "Skilled refugee community workers" recruited into more senior positions are required to have higher educational qualifications. It should be noted however that CARE implements an affirmative action policy for recruiting female refugee community workers, where the education requirement can be reduced or waived. At the time of this research, IRC did not have any education requirements for refugee community workers, but this has recently been reviewed and the minimum requirement is now completion of Form 4.

s EMAP (Engaging Men through Accountable Practice) is an intervention to reduce violence against women and girls through the engagement of men in challenging personal gendered attitudes that negatively affect women and girls and contribute to VAWG. It is informed by voices of women and girls.

Working conditions and challenges for refugee community workers and national staff

In the cross-sectional survey, the vast majority of refugee community workers reported working 30 or more hours a week, with one in six working 50 hours or more. In the month preceding the survey, all but one reported supporting NPV cases, with half of refugee community workers supporting six or more such cases each. All refugee community workers supported IPV cases in the past month, with two thirds of respondents each supporting six or more cases. Most refugee community workers reported spending on average between half an hour and an hour in each of their meetings with a GBV survivor; and 67% of all refugee community workers reported that their team was not large enough to handle all of the GBV cases. Just under half agreed that they were fairly paid for the work they did, perhaps reflecting their perception of a heavy workload. Gendered differences were found, with only a third of female refugee community workers agreeing that they were fairly paid, compared to over half of male refugee community workers.

In the qualitative interviews, refugee community workers reported that their heavy workload (as a result of the high incidence of GBV cases and limited number of staff available to deal with the cases) was a challenge. National staff reported similar difficulties to the refugee community workers, including a heavy workload and lengthy work hours.

There were additional factors, not related to the job, which affected staff working conditions. In the quantitative survey, when asked about a typical day, refugee community workers reported a range of responsibilities in addition to those related to their work, with women reporting more domestic tasks such as preparing meals (100% female, 13% male),

washing clothes (92% female, 44% male), cleaning their home (69% female, 29% male), and going to the market (92% female, 69% male). Men more often reported being responsible for activities further from the home such as collecting rations (77% female, 91% male) and going to the hospital (50% female, 78% male).

National staff spoke about the additional burdens on women and how this affected the workforce:

"... most people who report [GBV] are women, so the number of women [refugee community workers] should be higher. But women are also challenged, especially those who are married, because a lot of the days their husbands expect them to execute their home duties to a level which can affect the way they work ... but we try our best to support them and also make sure that that staff is able to execute their duties in the best environment possible."

—National staff, male

The work was not without its challenges for national staff who spoke of the additional difficulty of long absences from their home and family:

"... three quarters of your time you spend away from your family. You would wish to know how they are faring, but all you do is just communicate with them from a distance ... you make them worry especially when they know you are working in such an insecure place where your security is not guaranteed 100% ... and you find that that is a challenge ... there are some times that you can be called because your child is sick, but you can't just go because of the work."

—National staff, female

Refugee community workers attended to 611 IPV survivors and 571 NPV survivors in the last four weeks



Figure 10. Workload description and distribution of cases handled by refugee community workers in the last four weeks (N=71)

Interactions between refugee community workers and national staff

Both national staff and refugee community workers highlighted the complementary nature of their relationship. National staff noted that their work was often made easier by refugee community workers, who are involved in translation, referral to the GBV centres, and outreach, including chairing and supporting community support and violence prevention groups. The refugee community workers found it beneficial to work with the national staff, since they received training on several important skills related to GBV work from the national staff and often received counselling and support for their own social and emotional issues.^t

When asked about the benefits of task sharing with refugee community workers to deliver GBV services, national staff said:

“One thing is acceptability of our programmes in the community. The community is able to understand much more from [refugee] community case workers than from us because they live with them and understand the system and everything that happens there. Number two is that the community is able to have some level of trust in what we offer ... If the [refugee] community case workers do not address the issues in the best way possible, then the community cannot even trust us to a point of even coming to the office. That has also made us work very well, and again, it has really assisted the community ...”
–National staff, male

“We work together very well. The national staff are very nice ... All of them are good.”
–Refugee community worker, female

Challenges to GBV response service delivery

Notwithstanding the good relationship between national staff and refugee community workers, GBV service delivery in Dadaab presents a number of challenges, some specific to the nature of each job role. The most commonly reported of these are highlighted below.

Refugee community worker gender roles
The qualitative interviews highlighted that there is some confusion about the role that female and male refugee community workers can and should play in GBV prevention and response. Male refugee community workers emphasised an understanding that women are more easily able to understand or relate to issues relating to violence against women and that speaking to male refugee community workers may further exacerbate IPV, but nonetheless male refugee community workers wanted to be more involved in direct case management, psychological first aid, and counselling.

“Another key challenge we face for those of us who are men is that when we go to the community to meet victims, say of domestic violence, you know, she can be freer talking to a fellow woman. We are not well equipped to deal with victims of the opposite sex.”
–Refugee community worker, male

“In terms of capacity building, sometimes we have to see the officer in charge when dealing with a client because we don’t have enough knowledge and skills to carry out our work properly. If we had this necessary knowledge, we will be more independent from the officers thus doing our work properly ... we need more training on counselling ... we need more training like case management, so that when the officers are not on the ground, we are able to handle even the cases ... even in the future when we go back to our country, we will be able to perform these duties well.”
–Refugee community worker, male

While the 2017 *Interagency GBV Case Management Guidelines* highlights the importance of female staff delivering case management, national staff raised concerns about the lower education and literacy levels among women, which they believed hindered their ability to be fully involved in GBV service provision and outreach activities. As education and literacy levels are often used to justify why women should not be hired or promoted, this underlines the importance of capacity strengthening for national staff to improve their understanding of the importance of international best practice and guidelines, and of demystifying case management and psychosocial support services, which are empathy-based services and therefore do not require high-level literacy skills. Training programmes can, and should, be adapted for all literacy levels. In addition, programmes should be encouraged to implement well-established women’s leadership and empowerment approaches that could support female refugee community workers to lead outreach activities and community dialogues.

“... you find that sometimes even translation becomes a problem when you are dealing with them [female community staff]. Facilitation of some community forums [by female community staff] also becomes a problem because they have been brought up not to stand before people and talk to them.”
–National staff, male

These biases are further reflected in the quantitative data where 27% of the female refugee community workers reported feeling only ‘a little bit comfortable’ expressing their opinions in staff meetings.

Community resistance
Despite humanitarian agencies operating GBV prevention and response programming for 19 years in Dadaab camps, there is still community resistance to tackling GBV.

In the cross-sectional survey, two thirds of refugee community workers reported community resistance to their GBV work. They perceived the local elders to be the most resistant to the GBV work.

In the qualitative interviews, refugee community workers recounted that the community often viewed them as cultural saboteurs who have deserted local customary practices or supported western values. Refugee community workers reported often facing criticism for raising awareness about GBV and harmful customs such as female genital mutilation (FGM), IPV, and forced marriage in the camp. One refugee community worker stated:

“Yes there is a lot of resistance especially in FGM which they say is a common practice in their culture ... they feel that you are going against their culture, and others say the religion allows FGM ... We also have early marriages ... early marriage is a common problem within the community here. There are parents who would like to marry off their children very early because of material gain ...”
–Refugee community worker, male

Refugee community workers reported that elders in the community often encourage women not to report violence to the GBV centres or go for follow-up psychosocial counselling sessions. Instead, the elders ask the woman’s family and the perpetrator’s family to settle the GBV case at the community level with their involvement. Often, this means that the men from both families meet with the elders to discuss the exchange of a “token” or price to make peace and the woman is left to accept whatever outcome they decide. If she returns to the GBV centre after the elders handle the case, this can be viewed as a sign of disrespect to the elders dealing with the case.

In the cross-sectional survey, a small proportion (10%) reported that “youth” were also perceived as being resistant to the GBV work, representing a backlash against women and girls who are seen as increasing their power and safety through the GBV prevention and response activities. National staff explained that some male youth resent GBV work being conducted as they feel it empowers women and girls at their expense and displaces them as future heads of households.

^t National staff and refugee community workers have daily team meetings / debriefs. Additionally, both IRC and CARE provide regular, external professional counselling for national staff and refugee community workers to help them cope with work pressures, provide an avenue for self-care, and, where relevant, help staff deal with their own experiences of violence.

39%
of female refugee
community workers



70%
of male refugee
community workers



were threatened because of their work

.....

Refugee community workers as both community members and service providers

Refugee community workers find themselves in the sensitive position of being both service provider and part of the community, a sensitivity that is in part exacerbated by community resistance as described above. This can affect how they negotiate relationships with clients and national staff. One national staff member stated:

“We use the community workers because they know the language, but ... they could be communicating something to the clients, but that’s not the exact message intended ... then there could be vested interest whereby you are communicating one thing to the client but because of the interest the community worker has with the client they communicate something that is totally different ...”

–National staff, female

“The key challenge is that they come from the same community ... the attitude and the culture still affects them. Also, for the issues of culture, is it clannism ... you see a community development worker who is not willing to approach another clan, or the other clan is not willing to come and approach this community development worker for fear that this person would be biased ...”

–National staff, male

Another national staff member highlighted the pressure that refugee community workers can feel in handling issues through traditional systems to show they are not against community establishments:

“Sometimes you are not sure whom they are working for; are they working for [the] community [or] are they working for [GBV organisation]? They will refer survivors to community leaders and the Maslaha, and you get to hear the case when things have gone really bad.”

–National staff, female

Violence and fear among refugee community workers and national staff

In the qualitative interviews, national staff explained how general insecurity in Dadaab affected their mobility and underscored the need for refugee community workers:

“Security is a challenge of late that is why we don’t go to the field as national staff. We use our refugee incentive workers [refugee community workers] who are able to go to the blocks and reach people one on one ... we are not freely able [to move around outside the camps] ... So matters of insecurity, no free movements limits us a lot ... the feeling of insecurity because of what happens around.”

–National staff, female

Despite being able to move more freely within Dadaab and to access communities during outreach activities, refugee community workers reported persisting safety and security concerns because of the job. In the cross-sectional survey, the majority of CARE (88%) and IRC (84%) refugee community workers felt that their personal safety was treated seriously at work. Even so, a third of female refugee community workers and a quarter of male refugee community workers reported being injured in the last 12 months as a result of a work-related task. The type of injury was not specified. However, when asked about violence by other refugees because of their GBV work, threats of violence were common (39% female refugee community workers, 70% male refugee community workers) including being hit with an object by another refugee because of their work (42% female refugee community workers, 22% male refugee community workers). In addition, 83% of all refugee community workers reported feeling unsafe working with GBV survivors in the community sometimes/all of the time (77% female refugee community workers, 87% male refugee community workers).

In the qualitative interviews, refugee community workers and national staff reported threats of violence and stigma from the larger community as a major challenge in their work as GBV services providers. One refugee community worker reported:

“... the community will sometimes even attack you, for example...there was a certain campaign that we carried out about FGM ... and some people stoned us. I was beaten ... my teeth got broken as you can see ... we got support from CARE ... they were with us. I was taken to the hospital with two other women. So you see, you cannot mention FGM. They say it is our culture.”

–Refugee community worker, female

42%
of female refugee
community workers



22%
of male refugee
community workers



**were hit with an object
by another refugee**

.....

Barriers to referrals with other agencies

In the cross-sectional survey, most refugee community workers reported sharing the task of referrals with the national staff. The majority of refugee community workers reported providing the initial referral to the GBV centres (85%) and later facilitating any necessary external referrals to other agencies or community mechanisms made by the national staff (83%). Most refugee community workers (75%) escorted clients to these follow-up referrals. These referral pathways presented challenges of their own.

In the qualitative interviews, concerns were expressed, particularly by national staff, about the inter-agency referral systems which were noted as being weak, slow, and at times ineffective. One national staff member stated:

“Maybe what I can say is the referral pathways, because you find that at some point you would like to refer a client to a certain organisation for her to receive more help, but you find that the response is not immediate ... you may find that she comes back saying that they haven’t been helped ... or that there were other challenges ... That is the key limitation I can remember.”

–National staff, female

Challenges with the referral system were exacerbated by the announcement of camp closure. During the verification and repatriation activities, some staff, for example from UNHCR and the Kenyan Department for Refugees (DRA), were withdrawn from their routine work, as they were required to work on the verification and repatriation. This had an impact on the referral process, as there were fewer people to respond to email and telephone referrals.

One participant suggested that the situation had affected the funding of services with the result that some staff worried about job insecurity and left to find employment elsewhere. New staff were not recruited and this had an impact on the provision of services.

“When donors hear that most of the refugees are repatriating, it is like the funding goes down. So most of the staff among GBV partners also left. Because they are feeling like now the camp is

going to be closed, maybe our job security is not assured, so they were going to look elsewhere for job opportunities. And you see many of them left at the same time because of that announcement, and left work unattended and looking for new people also takes time. We find that we now have very few staff to attend to the GBV cases. The GBV cases are on the increase. The people who need counselling services are also many due to the stress and anxiety being caused by these issues of repatriation and the [family] disputes that are arising. Dadaab has lost many of the staff who are well experienced in working with particular agents to provide services for GBV survivors.”

–National staff, male

Instances were also described in which guards at referral agency gates prevented women from accessing services. One national staff member reported that although they provided GBV training to the guards, they were less sensitive in dealing with women at the gates. This was often explained in terms of the lack of coordination between the contracted security firms and the implementing humanitarian organisations. Additionally, due to the fast turnover of security staff, it was often difficult to provide GBV training to all guards in the camps.

“Refugee community worker: So far, there were some cases that were unable to be helped because of the gate into the UN.

Interviewer: Can you explain why?

Refugee community worker: Yes. Because the guards are not all the same. The guards at the gate, some of them were asking for bribes, like money, some of them were asking about exchanging, maybe having sex with them to give them jump time to get in.

Interviewer: To get in front of the queue?

Refugee community worker: Yes. So there were some girls coming back to us and saying for almost one year they are having the same referral card.”

–Refugee community worker, female

Even when women managed to attend referral appointments, it took longer than usual for staff to see them:

“Our biggest problem is UNHCR. If they [the GBV centre staff] send [someone] to the UNHCR offices, the guards at the gate won’t allow you in. If they allow you, you have to go through waiting halls one after the other. Sometimes you come back in the evening tired and with no appointment letter or without getting what you want.”

–Survivor, 37 years

National staff adapted new strategies to address this by coordinating with the relevant protection officer to meet a small group of women at the agency gates and escort them inside:

“We have changed the referral mechanism. We send the client’s email to [the] UN protection person. We also send a number if they have a telephone. So the UN person calls them. So we just tell them go today ... clients will go the UN main gate [and] the gender staff would call ... UNHCR protection, they ask, [the women] do you have a referral? They show their referral cards, so they enter.”

–Refugee community worker, female

Impact of the camp closure announcement on refugee community workers and national staff

Unsurprisingly, the announcement that the camp was to be closed affected refugee community workers on a deeply personal level since the announcements pertained to them as well. This prevented them from fully engaging in their work as they were also participating in the verification and repatriation process. They also experienced conflicting feelings about whether or not they should remain in Dadaab. Their accounts closely mirrored the concerns of people in their community to whom they were providing support. This included a fear of forceful repatriation, returning to a country that they knew little of as they had grown up in Dadaab, having few prospects of employment and education in Somalia, losing access to much needed medical care, fear of violence (including GBV), and dealing with family disputes about whether or not to leave.

“My biggest worry was about the repatriation, especially when I heard from the interior minister of the government of Kenya saying that these refugees will be repatriated back to Somalia forcefully ... When I was coming to this camp I was around five to six years [old]. There’s nothing I know about Somalia ... My family had encountered a lot of problems in Somalia like my uncle was killed, all our properties were looted ... Some of my family members were even raped on the way. Now my father passed away. I was his firstborn. If today I’m taken to Somalia, I don’t know where to go, where to start my life, where even to go and fetch water, I don’t know ... There is also the issue of Al-Shabaab, you will either join them or they will kill you.”

–Refugee community worker, male

Their accounts resonate with those of national staff, who referred to the “demoralisation” of the refugee community workers that they managed during this period and the refugee community workers’ need for additional support.

“Even our community workers at some point, they became demoralised, they were also not able to deliver what was required of them. Because we depend on them, they are the people that reach out to the community. Many times during our morning meetings that was one of the things that we could greatly talk about. I can say that it was a challenge because the same people that we expect to meet with the women and community and talk to them about issues of GBV, they are facing the same challenges because they come from the same community.”

–National staff, female

Additionally, some refugee community workers were unable to work as usual because they also had to engage in the verification process. One participant reported taking three days to deal with her own verification. This resulted in shortages of staff and growing caseloads.

Job satisfaction and motivation

Despite the challenges faced on a daily basis, job satisfaction levels were generally high. At IRC, over half of the female refugee community workers and over a third of the male refugee community workers reported finding their work “extremely rewarding”; at CARE, a quarter of women and half of the men said the same. Overall, most refugee community workers felt trusted, valued, and satisfied, and reported enjoying their work.

The qualitative interviews with the refugee community workers and the national staff suggested that GBV staff were often motivated by the need to help survivors improve their situation. National staff frequently noted being motivated by their need to put their expertise into practice in helping survivors and people in need. Refugee community workers were also motivated by the need to support their community members to live better lives, noting that they felt obliged to educate their community about GBV and, in the process, reduce its incidence. Some also mentioned financial rewards in the form of salaries as a key motivation to continue doing GBV work as it allowed them to help their own families.

In the view of one refugee community worker:

“I feel very proud because I am helping my community; I am helping my girls, my daughters, my sisters and mothers.”

–Refugee community worker, female

One national staff remarked:

“... I’m very happy to see that a client has moved from one level to another level ... or is now able to move on with life. One thing that I feel excited about, and very much appreciative of, is that community members from day one have really appreciated what I do ... I have seen a lot of success stories ... from a very bad situation, after a while, some have really improved ...”

–National staff, male



Sven Torfinn/CARE

Research Question III:
Is a comprehensive case management approach using task sharing to deliver GBV response services acceptable and feasible for improving the health, wellbeing and safety of GBV survivors in a refugee camp?

Research question III sought to understand the survivors’ perspective of the GBV care they received in Dadaab.

A cohort of women accessing GBV services was followed over a period of nine months (February–November 2016). GBV survivors were asked about how they used the services including the type and frequency of interactions with refugee community workers and national staff, potential facilitators and barriers to accessing follow-up care, and the perceived effectiveness of the services. Data on health, wellbeing, and safety outcomes were also collected.

A total of 209 women across the two centres were enrolled into the cohort. Of these, 132 women were recruited from the IRC centre in Hagadera and 77 were recruited from the CARE centre in Dagahaley. Loss to follow-up was high: potential reasons for this are discussed as part of the analysis.

This section presents findings from the quantitative cohort study. Data from qualitative interviews with staff and refugee community workers are also used to provide insight and commentary on the key findings from GBV survivors.

GBV response service usage

In the cohort survey, most women reported that they had attended the GBV centres previously for other experiences of violence. For both IRC and CARE, a new case file is opened for each incident of violence. One in three survivors accessing IRC services for a new case from February 2016 had visited the GBV centre in the four weeks before the first interview (for a different experience of violence). Of the women surveyed at CARE’s GBV centre, 87% had at least one visit prior to the first interview.

GBV case management often entails repeat visits to provide ongoing support, including assessments, safety planning, psychological support, and other follow-up. However, in this study, survivor return visits to the GBV centres were limited, with less than a third (30% at IRC and 32% at CARE) returning for a follow-up visit in the 4 to 10 weeks after the first intake interview. There was no difference in the number of follow-up visits between women who reported experiencing IPV or NPV. A large proportion of women (more than 70%) did not return for follow-up case management visits or continued contact with refugee community workers, within or outside of the GBV centres.

Interviews and data validation exercises with GBV centre staff provided some insight into why few women continued to access services after the first intake visit. In some instances, as reported above, women may have been pressured to withdraw from the GBV centre and resolve cases (particularly in relation to IPV) within the family or through traditional dispute resolution in the community. In other cases, the lack of continued engagement could be attributed to women not receiving the assistance they had hoped for – for example, a referral to UNHCR for resettlement to a third country that is neither their country of origin nor Kenya; a referral for transfer to another camp; or material support. However, it is likely that the risks entailed in accessing GBV response services – fear of movement around the camp, backlash from the community and family rejection, and stigma affecting GBV survivors – may have been significant factors.

Qualitative data from Phase III showed that the dramatically changing context of repatriation activities in the camp was a significant factor for the unexpected drop in service uptake. This shift led to a change in priorities due to the verification and repatriation exercises, with fear of retaliation by perpetrators as another factor.

In the qualitative interviews related to the verification and repatriation, the GBV staff referred to the changing priorities of refugees, who were now focussed on their most fundamental and basic needs. Their immediate needs for food and shelter for themselves and their families took priority over dealing with their individual experiences of violence and continuing their case management visits. Repatriation, which was persistently rumoured to be mandatory, was perceived as a greater threat than their GBV cases, which may explain the low levels of follow-up.

“Yes, our follow-up was not easy. When they are out of reach we send our community workers to them. So you will find that you call the woman and she is not able to come. When they ask women ‘how is the situation for you?’ [referring to the violence case] all they could report was the repatriation, the repatriation, the repatriation. They could not give an exact follow-up about the case because it was not any concern for them at that time. Sometimes we sent our community workers to their home, especially during the verification exercise, they could not find anyone at home ... Everyone was like ‘why should I follow-up with my case and yet the government of Kenya wants to kick me out. I think I should first deal with what is pressuring me so much, the issue of repatriation. How am I really going to live?’”

–National staff, female

“The priorities of the refugees’ life changed, so concentrating less on the services we are offering them to the issue of repatriation because they were talking about giving them some package, and when it comes to issues of money, everybody becomes interested.”

–National staff, male

Further evidence of the repatriation’s impact on follow-up GBV case management visits can be found in the refugee community workers’ reports of the difficulty of holding outreach and community mobilisation activities. Refugee community workers reported that group sessions designed to deliver messages about GBV were disrupted and became impromptu sessions to alleviate the fears of the community.

“It has really affected [work]. When we are talking about physical assault or maybe GBV and reporting prevention and response, they will ask ‘what have you heard about UNHCR and repatriation? I said okay, we’ll talk about it later, but this is what we are talking about now. So already it has affected my work because they will tell me, ‘you are telling us something which we are not even concentrating on’.”

–Refugee community worker, male

“When this repatriation issue began, it had a great impact on our routine activities. People, their attention, people became demoralised when they heard of this ... Especially in the outreach team ... when we tried to have a certain activity in the blocks, it was not as successful as the way it used to be because this time people’s minds are absent somehow. When you invite a group of people to have a focus group discussion with them, the majority are busy talking about repatriation ... Maybe you are talking about the importance of reporting rape, sexual assault cases within 72 hours, let’s say. Someone will even raise his hand and say ‘please can I interrupt you. Now you are working with these organisations, when are we going back to Somalia?’ I say ‘I’m just like you, I don’t know’. Then you continue, you will see three or four of them talking aside and saying ‘you know I heard from UNHCR last night saying there’s forceful repatriation’.”

–Refugee community worker, male

Refugee community workers also reported dwindling numbers in some of the group activities they were running, suggesting that some people had returned to Somalia.

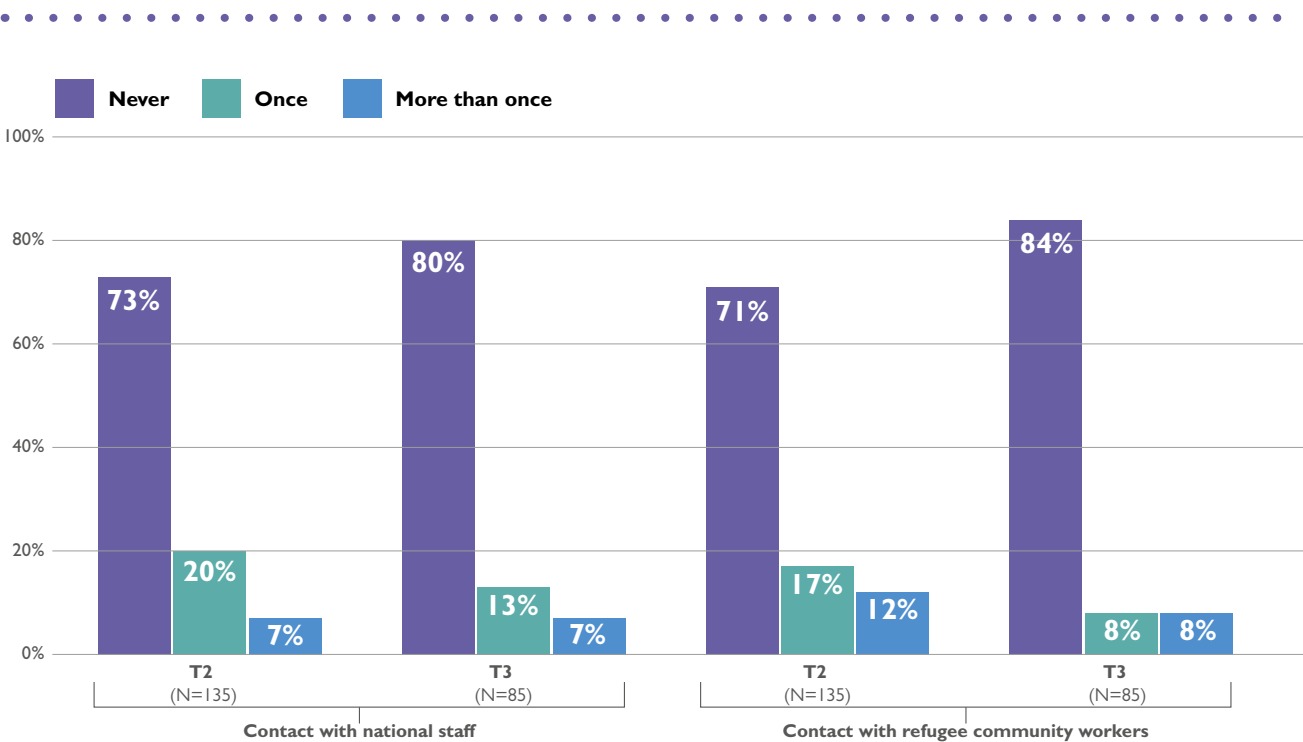


Figure 11. Frequency of contact with refugee community workers and national staff at follow-up, four weeks prior to Time 2 and Time 3 interviews

Women’s entry point to the GBV centres

The survivor cohort survey explored potential facilitating factors encouraging women to access GBV services. When asked how they first heard of the GBV services, nearly a third of women reported hearing about it from a community group^t, followed by referrals from other agencies such as the health centre/hospital or police (25%) and information from family, friends, and neighbours (21%). Among the women, 12% reported hearing about it through outreach from a refugee community worker in the community, which, while low, may reflect overlap with outreach from community groups. Only 2% of women reported hearing about it from a community leader. It is not known how family, friends, and neighbours heard of the GBV services but this may be attributable to outreach activities run by each agency or through contact with a refugee community worker.

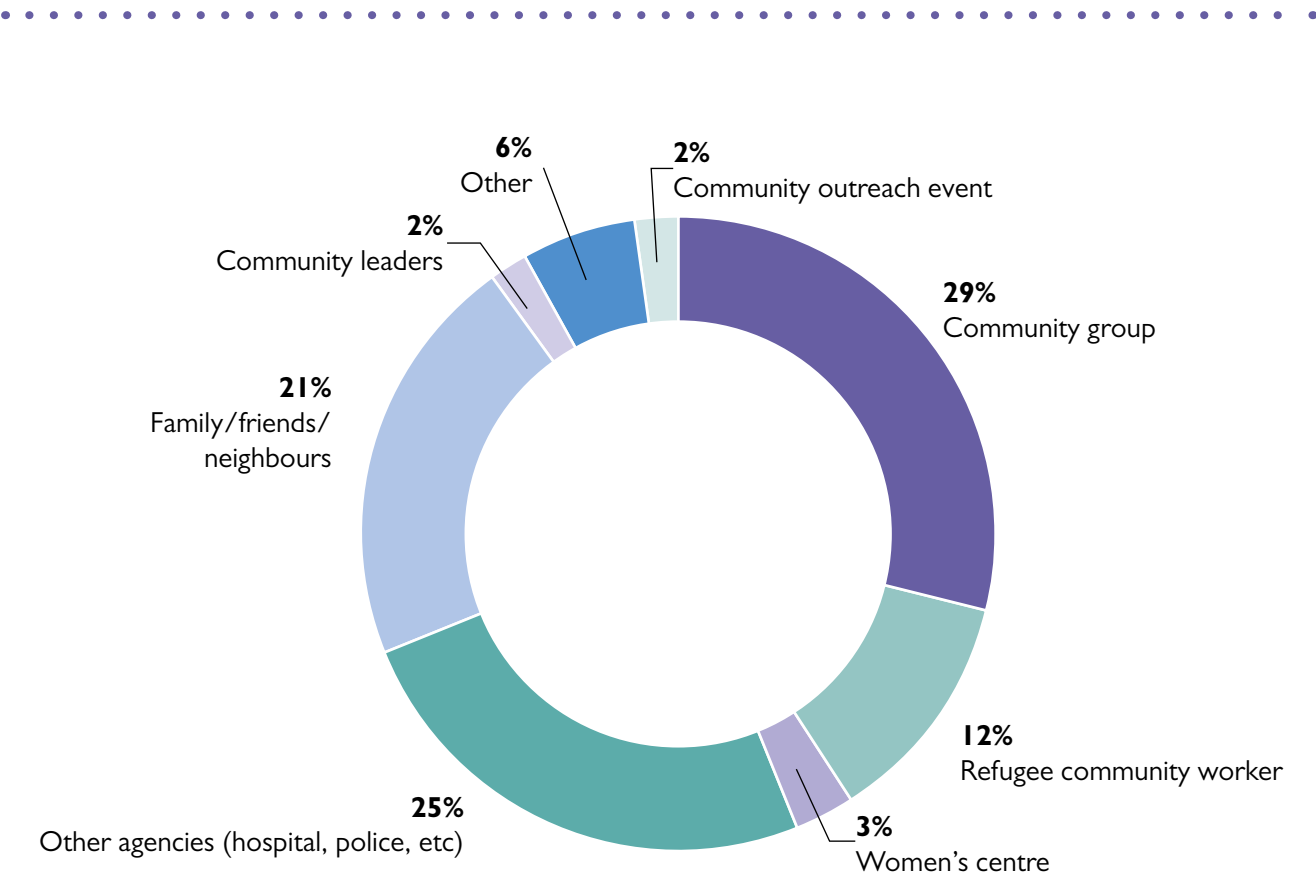


Figure 12. Where survivors heard about GBV services (IRC and CARE combined)

^t There are a number of volunteer community groups, in addition to the PRC, who advance GBV prevention and response agenda in Dadaab. These include Youth Against FGM, Safe Home Volunteers, Ex-Circumcisers, and Men Action Groups. These data were not disaggregated by specific community group type but are representative of the types of groups that would fall under this category.

Survivor interaction with refugee community workers and national staff

Women were asked about the frequency and types of contact that they had with refugee community workers and national staff. There was little difference between the agencies (IRC and CARE) in the frequency of contact with refugee community workers. A higher proportion of women attending CARE services reported meeting with a national staff member at Time 1. This discrepancy at Time 1 with national staff contact at IRC may be attributable to differences in scheduling the research interviews. The first research interviews were not always immediately held after a woman’s first case management appointment (due to her availability or the interviewers’ schedule, for example).

Among the women who did report accessing refugee community worker assistance, translation services were the most frequently reported assistance used (29% at T1, 17% at T2, 6% at T3 among all women). Across all time points, only three women (1%) reported refugee community workers accompanying them to referral appointments; six women (3%) reported receiving emotional support/psychological first aid from a refugee community worker either in a group setting or informally in the camp; and one woman reported that a refugee community worker accompanied her to a traditional forum. As informal refugee community worker contact is not officially recorded, the research team attempted to collect indicators of counselling-related activities accessed over the follow-up period, but few women reported receiving psychosocial support or case management directly from the refugee community worker. These indicators appear to suggest that the primary function of refugee community workers was to provide interpretation between the participants and the national staff. Nearly all of the survivors (92%) accessing services reported using a refugee community worker interpreter for at least one meeting.

These descriptions by survivors of the services provided by refugee community workers differ considerably from how they describe their own activities. When asked (before the repatriation activities) about work responsibilities and regular tasks, 90% of refugee community workers reported counselling (informal and formal) as a regular work activity. It is possible that women engaging with refugee community worker assistance did not consider their contact with refugee community workers outside of the centre as counselling and so counselling indicators from the survivors’ perspective are low. The same may apply for accompaniment to referral appointments, which perhaps was simply considered as support by a fellow community member as opposed to an official task of a refugee community worker. More likely, the verification and repatriation activities shifted priorities and available time for both survivors and GBV staff, suggesting that the pattern of usage captured in the survivor cohort study does not reflect previous (or future) periods of service provision and instead reflects a period of dramatic change within the Dadaab refugee camps during which the usual GBV case management model of care was disrupted.

Alongside changing priorities and concern related to the repatriation, women’s expectations of how refugee community workers could assist appeared to shift. Some requested a referral to UNHCR for resettlement even when it was not appropriate. When refugee community workers could not meet women’s requests, this occasionally resulted in ill feelings towards the refugee community workers.

“The majority of them, they want UNHCR ... 90% when they report a case because they have in mind that UNHCR can offer them a resettlement. So people are saying ‘it’s you who’s denying us, why aren’t you giving us a referral to UNHCR?’ ... They complain about us because they say ‘you mistranslate my case that’s why this officer is refusing to give me a referral to the UNHCR’. Yeah she will just blame you. When you are walking in the market, she’s just looking at you like a bad person.”
–Refugee community worker, female

Table 4: Proportion of survivors who met with a refugee community worker, by time period and agency

	IRC – Hagadera camp			CARE – Dagahaley camp		
	Time 1 (N=132)	Time 2 (N=85)	Time 3 (N=51)	Time 1 (N=77)	Time 2 (N=50)	Time 3 (N=34)
Contact with a refugee community worker	32%	31%	20%	35%	26%	12%
Contact with a national staff member	27%	26%	18%	90%	28%	24%

Perceived effectiveness of the GBV services and the task-sharing approach

In the qualitative interviews, women mentioned the GBV centres and police stations – rather than reporting to the *Maslaha*, other community leaders, or within the home – as the places they felt safe reporting violence and seeking and getting help for GBV incidents. Women reported satisfaction with the treatment they received from the centre’s staff, feeling comfortable with both female and male staff and speaking highly of the counselling and support received.

Many of the women reported valuing their interaction with national staff. They appreciated that the information shared with them was kept confidential. Respondents also appreciated the role of the refugee community workers, noting that they conducted check-in visits in the women’s homes and were their intermediary with national staff. In the survivor cohort survey, eight out of ten women reported that their interactions with the refugee community workers had a ‘positive effect’, and two thirds reported that working with them was “helpful”.

As well as emotional support, respondents were also appreciative of the material items they were given, including mattresses, mosquito nets, *jikos* [small cookers], basins, soaps etc.

“They gave me peace of mind which is the most important thing someone can offer, and they gave me [a] mosquito net.”
–Survivor, 38 years

In the survivor cohort survey, when asked what they would change about the GBV services, the majority of women reported “nothing”. However, in the qualitative interviews, women reported feeling less comfortable sharing sensitive information with fellow refugees in the camps and being mistreated due to clan differences. Some reported that the refugee community workers did not translate their messages clearly to providers. This last point corresponds with national staff concerns that translations did not always accurately reflect the conversation.

Feasibility and acceptability of accessing GBV care

In the qualitative interviews, women frequently identified shame as a major barrier for not seeking services for experiences of GBV, particularly in the case of rape. Other barriers reported included fears of future attacks, fears that one’s partner or husband would know that they have been reported and retaliate, feeling that there is really nothing that could be done to help them, and some concerns about confidentiality among women accessing formal GBV care. In the view of one woman:

“There are some people who have a bad view of people seeking help from agencies. Sometimes you feel like it’s better to stay with your problems than come [to the GBV centre] and be hurt in the process.”
–Survivor, 20 years

Inadequacies in the referral process may have also impacted the acceptability of the service provision in Dadaab:

“I came to the gate at the UN but they [the security guards] denied me entrance. I came back with another letter from Save the Children but they still denied me entrance. Now I am thinking of joining the repatriation process to go back. They [the security guards] ask for [Kenya Shillings] 200 [equivalent to USD 2.00]. Where will I get 200 when I only get 50 per working day?”
–Survivor, 20 years

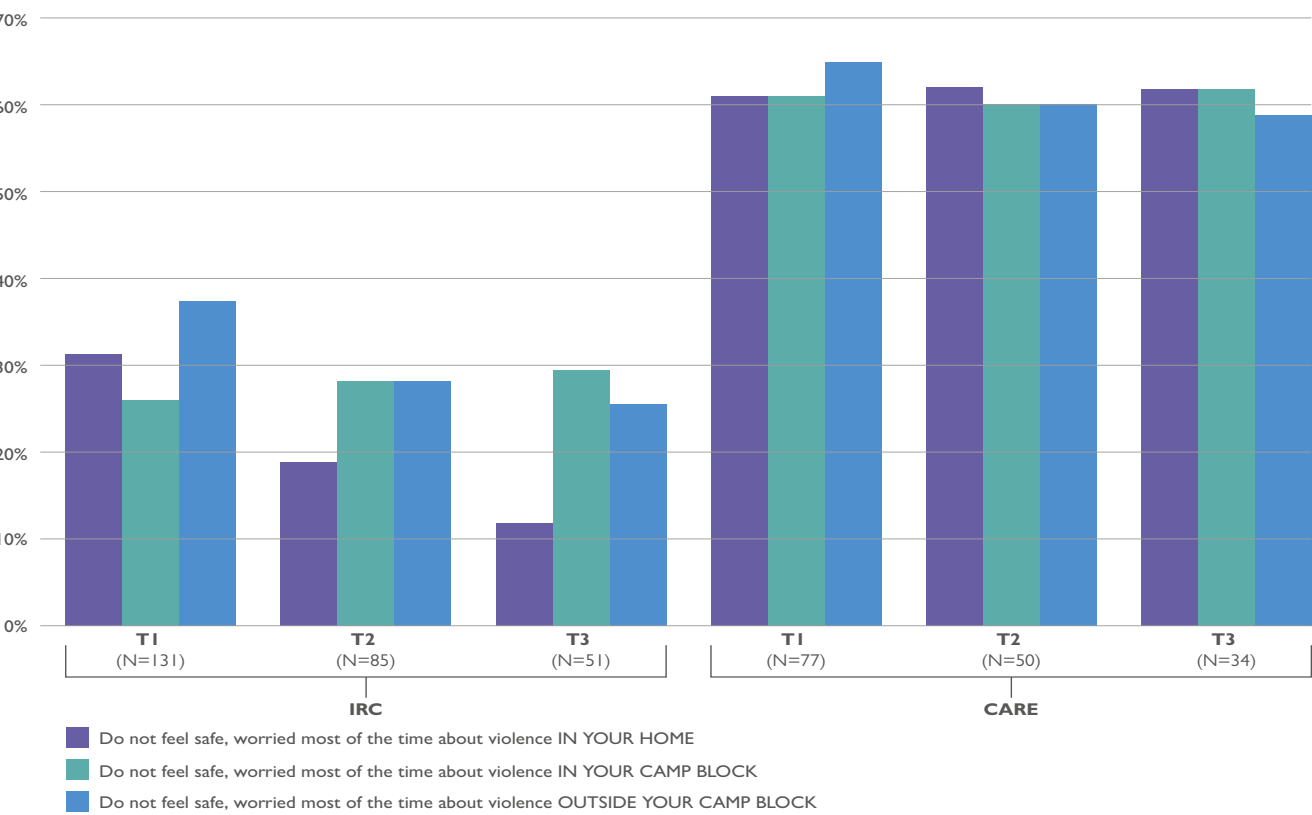


Figure 13. Survivors’ perception of safety by time period, agency, and location

Social support

In the survivor cohort survey, social support for accessing services was low. Less than half of the women attending the GBV services reported receiving some level of support from friends, family, partner, or religious leaders. Across all time periods, the majority of women who reported support received it from friends or neighbours, although this support was far from certain (only 38% of women reporting that friends or neighbours supported them). Very few women (3%) reported that their religious leaders supported the decision to attend GBV services. The qualitative data further elaborated on this.

In the qualitative interviews, women frequently mentioned that after experiences of GBV, they felt safest seeking help from agencies (including GBV centres), the police station, or going directly to hospital. Some women did mention seeking help from elders or community block leaders. One woman, however, reported that elders made matters worse due to their cultural beliefs:

“Usually the elders, they put the blame on the woman claiming that she should be taking her husband’s orders and be submissive to him at all times.”
–Survivor, 35 years

Others sought support from family and friends:

“Some seek advice from these [GBV] offices, and others from family and friends. It eases the pain and reduces carrying the burden of shame.”
–Survivor, 23 years

Influence of GBV services on survivor safety, health, and wellbeing outcomes

The research examined how accessing services influenced safety, health and wellbeing outcomes among female GBV survivors. However, due to loss of follow-up for the reasons described and the small sample size, the analysis is limited. Descriptive trends are presented in this report.

The average time between the first interview (T1) and the third interview (T3) was 15–24 weeks. Trends were assessed over time.

Safety

In the survivor cohort survey, women reported high levels of fear when asked about areas of the camp that they avoided. Among women attending IRC GBV services in Hagadera, levels of fear were high with most women reporting that they avoided going out alone, visiting some areas of the camp, or using public transportation services.^u Women from Dagahaley attending CARE services reported slightly lower levels of fear across all time periods.

^u Within Dadaab, public transport services include motorbikes, informal taxis, and small vans or buses.

The opposite scenario was found when asked about their perception of safety in their home area within the camp and in the larger camp, with women from Hagadera reporting lower fear levels overall compared to women from Dagahaley and some improvement in feelings of safety at home. This suggests that there were safety differences between the two camps. The specifics were not captured in this study and warrant further exploration.

As the GBV response services are unable to change the structural and contextual factors within the camp that led to these high levels of fear, there was little change in perceptions of fear between the three interviews suggesting that the fear of violence, including GBV, remained in the lives of women attending services. As available safe shelter is limited and relocation of women to another location is only possible in the most severe cases, fear of violence remains a reality in the lives of women living in Dadaab, especially those living in situations of IPV. Both IRC and CARE implement broader GBV prevention and risk mitigation activities in the camps which aim to reduce GBV and improve women's and girls' safety; however, it is clear from this feedback that women remain afraid due to a number of issues, including entrenched gender inequality, lack of responsiveness to GBV from other humanitarian actors, and repatriation concerns. Case management services are not a holistic response to GBV per se: rather, they need to work in collaboration with a multi-sectoral response structure that includes quality protection and safety services. As these are often missing or can be of very poor quality in camp and other humanitarian settings, GBV response services cannot address the full range of a survivor's needs, their feelings of safety in particular.

In the qualitative interviews, many of the GBV survivors discussed how violence occurred in both the home and public places. They attributed the pervasiveness of GBV in the camps to women's poor social status, overcrowding, weak security in the camps, poverty, and cultural norms and practices.

Women reported IPV by male partners and violence by other male relatives, meaning women did not feel safe in their homes:

“I’m married with kids. As Somali, you know we do arranged marriages. I was given out while we were still in Somalia and I was just 15 years old. We had a son together, thank God. They used to abuse me and beat me. Then I was young and I didn’t know much about life or anything for that matter. My father use to beat me, my husband and other in-laws use to abuse me physically.”

–Survivor, 21 years

Violations and violence reportedly also occurred in a variety of spaces, both at night and during the day in the refugee camps. One woman spoke of the lack of security:

“Mostly it happens at night, there is not much security and especially at night and it happens at home/ blocks.”

–Survivor, 25 years

Survivors reported being attacked while walking at night, fetching water at the camp taps or collecting firewood in the bush, or using toilet or washroom facilities outside the home. Single mothers, unmarried women, and women with absent male partners also reported not feeling safe in their own homes at night, since they lived alone and felt there was no one to protect them. As one woman detailed in her account:

“It didn’t happen to me just once, they [the attackers] came several times to my house. You know, the problem is with a woman who lives alone, because there is no one to protect her. These rape cases happened more than four times ... and I have proof, I can show you ... they have affected me and my children, and even when my daughter goes to school, she is insulted. My son is also insulted when he is fetching water. One time, I was attacked and raped. As this was happening, I screamed and the neighbours came to my aid and the attackers ran away. One of the attackers stabbed me with a knife on my leg and I can show you. Now everyone in the block knows my business and the attacks. My problems have affected my family, my son fought with other kids because of the insults and he lost two teeth and one is broken. I was counselled for over a month ...”

–Survivor, 34 years

She went on to say:

“... this one night my child got sick and started vomiting and had diarrhoea, so I was cleaning after him. The toilets being outside, I had to go out and that was when I was attacked. I tried to beg them [the attackers]. They raped me, and as they were on the act, a car passed and the light flooded my house, so they ran away.”

–Survivor, 34 years

In some instances, survivors expressed agency in self-preservation, by developing strategies and skills to mitigate the risks of future victimisation and violence. These strategies tend to limit women's mobility and autonomy, and include staying indoors especially at night, avoiding going out alone, and staying away from spaces considered dangerous.

Respondents suggested that the safety of women could be enhanced through improved camp security to mitigate the risk of GBV, ensuring the protection of the most vulnerable women and girls in the camps, and transforming the social norms and systemic inequality that sustain GBV. Survivors discussed the importance of religion and prayers as key to peace and security in the community. Of all survivors, 90% reported that they had sought comfort in their religion or spiritual beliefs in the last four weeks.

Hope for the future

The survivor cohort survey collected data on women's levels of hope for the future. Overall, there was little change between time periods. Along with women's low levels of engagement with the GBV case management follow-up process, the low and unchanging levels of 'hope for the future' may reflect their anxiety and uncertainty about the future given the threatened repatriation and camp closures. Women accessing IRC services reported higher levels of hope through all time periods, suggesting that there may have been differences in the camp populations, or potentially other factors including differences in the GBV case management approach. Further monitoring, evaluation, and research are needed to better understand the role that GBV case management can play in survivors' wellbeing outcomes, including hope for the future.



Sven Torfinn/SV

Coping

Coping responses to stressors are associated with psychological adjustment and wellbeing and are defined as the process of executing a response to a difficulty or challenge in one's life.²⁵ Data on levels of coping were collected among all GBV survivors accessing services over time to assess the influence of the case management services on coping responses.

As with levels of hope, overall, there was little change between the time periods for any of the coping domains measured. However, the coping scale paints a picture of the women's wellbeing at the time of the survey in relation to their experiences of violence past and present as well as uncertainty about their status in the camp. The lack of change over time in women's baseline coping mechanisms may reflect the fact that women were generally not returning to continue the GBV case management process.

When asked about their current circumstances in general, women reported low levels of denial of their current situation, with almost all agreeing with the statement that they accepted their reality (96%). Levels of self-blame varied, with a quarter blaming themselves a little or a lot (26%). Self-distraction was a coping response reported by approximately half of the women (48%), although few reported being able to positively reframe their situation (78% did not do this). Survivors accessing GBV services differed in the degree to which they engaged in planning (54% did this a little or a lot) or seeking advice and support from others (50%) as a coping strategy. These results suggest that the women accessing services had the tools to develop and use coping mechanisms, but this did not always result in a change in their circumstances. Further research is needed to understand how coping mechanisms in combination with GBV case management may influence women and girls' wellbeing over the longer term.

Physical health status

The **survivor cohort survey** also assessed women's physical health at the time of the interview. These health outcomes may or may not have been related to the violence that the women experienced. However, other research has shown that health outcomes such as headaches and back pain are common among survivors of IPV.²⁶ It was hypothesised that access to case management services, which include psychological and medical care, may have an effect on physical health outcomes. Pain was reported by most women at the first interview with 29% reporting stomach pains and most suffering from back pains (69%). Levels of pain did not change significantly between time periods. In addition, 65 women reported being pregnant at the time of the interviews. This lack of change in physical health status between interviews may also be reflective of women not attending follow-up or referral appointments because they were occupied with repatriation-related activities or unable to access the medical facilities. In addition, the repatriation activities may have exacerbated their health issues.

Disability and basic functioning were also assessed to help understand the needs of survivors accessing the GBV services and identify ways the services could be adapted to ensure that everyone could gain from the GBV case management approach. Three-quarters of women reported having some degree of difficulty with basic tasks including mobility, seeing, hearing, and communication. Nearly half (47%) reported that they had difficulties analysing problems to find a solution and difficulties learning new things. However, most did not report having any difficulty maintaining friendships and getting along with others. Mobility issues and difficulties with physical abilities such as walking long distances may have contributed to women's inability to access services and attend follow-up case management appointments. Difficulties with communication and learning a new task may have influenced women's ability to navigate the referral system.

71% felt tired or had little energy

69% had back pain

56% had trouble falling asleep, staying asleep, or sleeping too much

55% had pain in her arms, legs, or joints

38% were bothered by menstrual cramps or other problems with her period

29% had stomach pains

11% had pain or problems during sexual intercourse

75% had difficulties with everyday tasks*

47% had difficulties learning a new task or analysing problems

14% had difficulties with interpersonal relationships†

Figure 14. Survivors' physical health difficulties, pain and disability in the last four weeks at Time 1 (N=209)

* Seeing, Hearing, climbing stairs, walking long distances, other mobility issues, remembering or concentration, getting dressed, communication (understanding or being understood)

† Dealing with people you do not know, maintaining friendships, getting along with people who are close to you

Mental health status

The survivor cohort survey assessed women’s current mental health at the time of the interviews. Symptoms associated with depression, generalised anxiety disorder, and post-traumatic stress disorder (PTSD) were assessed in order to examine trends over time among women accessing GBV response services. At study intake (T1), 41% of the women had scores consistent with at least moderate anxiety disorder and 11% had scores that indicated severe anxiety. Similarly, 37% of women had scores that indicated at least moderate depression and 13% had scores consistent with moderately severe or severe depression. Only six women presented with probable PTSD at study intake (3%).

Improvements in mental health outcomes were found with average scores decreasing over time (see Figure 15). On average, women reported a raw score of 14 (rounded to the nearest integer) on the PTSD scale at baseline (range 0–48,) which translates to an average of 4–5 symptoms that ‘extremely’ bothered them or seven symptoms that bothered them ‘a lot’ over the last four weeks. Among women reporting depression, an average raw score of eight at baseline (range 0–27) was found which translates to an average of 2–3 symptoms experienced ‘nearly every day’ over the last two weeks or four symptoms experienced ‘more than half of the time’ over the last two weeks.

Similarly, the average score for the anxiety scale at baseline was nine (range 0–21) which translates to an average of three symptoms experienced ‘nearly every day’ over the last two weeks or 4–5 symptoms experienced ‘more than half of the time’ over the last two weeks. For women who attended all three interviews, the average raw score at the final interview (T3) decreased to 11 for the PTSD scale, six for the depression scale and seven for the anxiety scale; this translates as a reduction in one symptom which was previously experienced ‘more than half of the time’ for anxiety and depression in the last two weeks and ‘extremely’ bothered them for PTSD in the last four weeks.

As with the other outcomes examined, given the small sample size, limited number of follow-up case management visits, and high levels of attrition, this study cannot attribute changes in mental health status to the case management process. However, promisingly women with the greatest psychological health needs appeared to access the services more frequently than women with lower scores, suggesting that the Dadaab case management model successfully reached the women with the greatest need for psychological support.

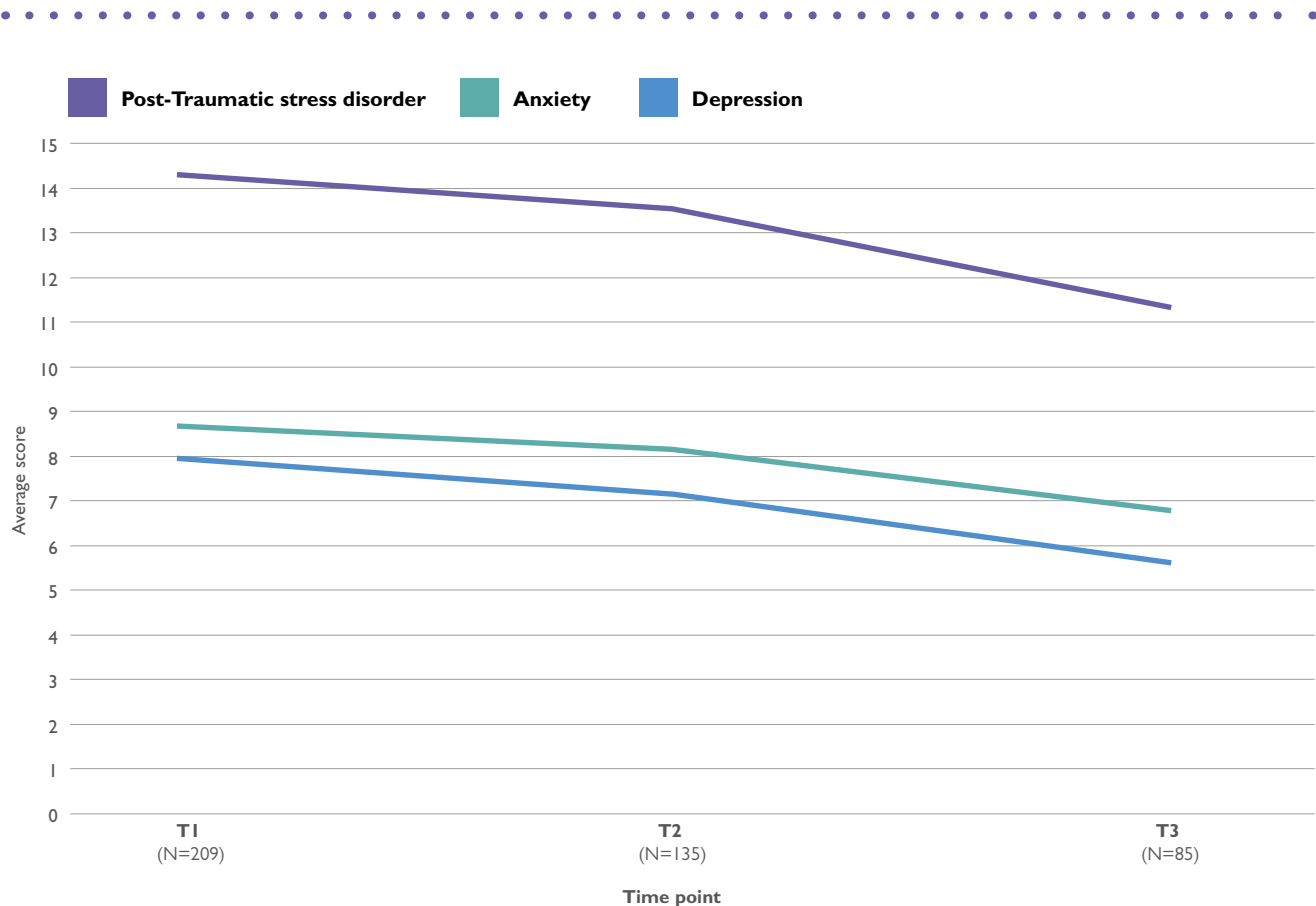


Figure 15. Survivors’ average mental health scores by scale and interview time period
Raw scores presented. These do not represent a clinical diagnosis, only trends over time in probable symptomology for each outcome in relation to women in the total study sample. Symptoms of post-traumatic stress, anxiety and depression symptoms were self-reported at each time point. Improvements were found between T1 and T3 overall.



Sven Torfinn/CARE

Limitations

Research on case management is complex. Case management is not a linear process but rather one with inter-related components that are highly dependent on the needs of the individual survivor; the implementation of related programmatic elements, the staff delivering the services, and the wider context within which the services operate. This research explored these inter-related components and context, and additionally measured changes in outcomes expected as indicators of success among survivors who consistently accessed case management and referral services. The impact of the case management approach was not assessed, as an experimental design could not be used. Randomisation to an alternative treatment group or a control group was not logistically or ethically feasible. In addition, as a large sample size was unlikely to be obtained, the effect sizes of any treatment outcomes were likely to be small. However, the results of this study allow for the refinement of a promising intervention, identification of approaches for adaptability and scale-up through an understanding of the barriers and facilitators for access and service delivery; and the development of research tools that can be used for similar interventions and follow-up evaluations at a later stage.

Recruitment in the cohort and follow-up case management visits were low. Using service use data from previous years (500 women accessed GBV services in 2012), the study initially set out to recruit 400 women into the cohort.²⁷

However, during the study period the Kenyan Government announced its intention to close the Dadaab refugee camp. Though the camp remains open, the announcement resulted in an increase of refugee repatriation and demands on time for refugees in the camp who were required to participate in verification activities. Ultimately, 209 women were recruited into the study and 83 completed all three scheduled questionnaires (40% response rate). Therefore, power to detect associations from the outcome data was limited.

Loss to follow-up in a humanitarian crisis setting is often inevitable given the nature of the context. In this case, Phases II and III coincided with the start of the UNHCR repatriation and verification activities. As a result, women who may otherwise have attended the GBV services and enrolled in the study did not attend as they were busy with mandatory repatriation-related activities, and women who did attend GBV services and completed one interview could not return for follow-up GBV case management services and/or follow-up research interviews.

In addition, for the qualitative research, the number of follow-up interviews is small and may not reflect the full range of views and experiences of refugee community workers, national staff, and survivors. Purposive sampling is not free from bias, and interpretation of the findings is limited to the specific setting of Dadaab refugee camps.



Peter Biro/IRC

Conclusions

This study sought to understand how the GBV response model of comprehensive case management with task sharing worked to influence access to care, wellbeing, and health and safety among GBV survivors in the Dadaab refugee camps.

This research examined one of the key components of GBV response service delivery in the Dadaab refugee camps: GBV comprehensive case management services delivered by refugee community workers alongside national staff. In addition, as the threat of camp closure and repatriation occurred during the course of the study, this research was able to capture how a GBV response programme adapted to a changing context. Together with an analysis of the context and of the underlying mechanisms that influenced outcomes among survivors, the findings will enable those providing GBV services in Dadaab to improve their programming and identify areas that need attention when the programme is replicated and adapted in other humanitarian settings.

Research Question I: What is the context of GBV in the Dadaab refugee camps?

- Both service providers and female GBV survivors reported that violence against women and girls is a common occurrence within the camps. IPV, rape, sexual exploitation, and early and forced marriage were reported as the most common forms of GBV in the qualitative interviews. GBV survivors reported that male perpetrators of violence were typically known to them. Among the cohort of women accessing GBV services, 60% experienced physical and/or sexual non-partner gender-based violence in their lifetime, and 39% in the past year. Overall, 61% reported an experience of IPV (emotional, physical and/or sexual) during her lifetime and nearly half (47%) in the 12 months prior to their baseline interview.
- A third of all refugee community workers (39% females, 23% males) reported having faced some form of physical violence (being hit with a fist or other object, kicked); and one in five reported having a weapon used against them. While female refugee community workers are working to prevent and respond to GBV in the camps, they are often also themselves survivors of GBV. Of female refugee community workers in the study, 42% reported an experience of NPV (physical and/or sexual) in the last 12 months, while 15% had experienced sexual violence perpetrated by a non-partner before arriving in Dadaab. One in three refugee community workers reported being hit with an object in the last 12 months as a result of their GBV work in the community.
- There are specific drivers of violence against women and girls in Dadaab. As in other settings, gender inequality constitutes the underlying cause of VAWG in Dadaab. Specific contextual drivers in Dadaab include a lack of security in the camp, lack of economic opportunities, and harmful social norms that limit women and girls' power in relationships and in the wider community.

Research Question II: What are the roles and experiences of the IRC/CARE national staff and refugee community workers staff who deliver GBV response services in the refugee community?

- IRC and CARE have not yet shifted to a full task-sharing model for GBV services and outreach in Dadaab but rather practise one that is complementary. GBV case management is being delivered by qualified national staff with support from refugee community workers (primarily by female refugee community workers at IRC and either male or female refugee community workers at CARE). Outreach and community mobilisation is led by refugee community workers (female and male) with support from national staff.
- National staff and refugee community workers overall reported a good working relationship. Refugee community workers are seen as essential to providing expanded GBV care in a refugee camp. They are able to provide outreach, carry out community mobilisation, work with local leaders, and help address some of the language and cultural barriers. They are viewed as a valuable resource for improving the accessibility of GBV responses in a refugee camp context. In particular, female refugee community workers are seen as playing a vital role in working directly with GBV survivors who may feel more comfortable disclosing and discussing GBV-related issues with another woman.
- The national staff and refugee community worker relationship was not without tensions. National staff raised concerns linked to refugee community workers being both part of the organisation and part of the community, describing for example mistranslations due to existing prejudices or instances of refugee community workers supporting community-driven solutions that could perpetuate negative practices. They also raised concerns about the lower education and literacy levels among female refugee community workers, which they believed hindered these women's ability to be fully involved in GBV service provision and outreach activities. At the same time, under a third of the female refugee community workers reported feeling only 'a little bit comfortable' expressing their opinions in staff meetings, highlighting national staff's own biases on education, literacy levels, and recruitment.

- The 2017 *Interagency GBV Case Management Guidelines* emphasise that women should deliver case management and psychosocial support and accompany survivors to referrals, but there remains confusion about what tasks female and male refugee community workers should be delivering, with male refugee community workers requesting additional training and support to deliver case management services and psychosocial counselling.
- Refugee community workers expressed a high level of job satisfaction with 46% reporting that her/his work was extremely rewarding and 46% as a little bit rewarding. However, both refugee community workers and national staff highlighted the need for additional training, particularly around translation, on delivering case management, and on providing psychosocial support. They also expressed a desire to receive a certificate that could be presented outside the camp documenting their training and work.
- A number of barriers to delivering high-quality GBV response services were noted. These include heavy workloads (particularly for female refugee community workers who must balance their work with carrying out the majority of household chores); safety and security concerns; community resistance to their playing the perceived role of "saboteurs" of traditional practices; lack of clear understanding of the different roles that men and women refugee community workers should play; difficulties with transportation within the camp; and challenges with the referral process.
- The atmosphere in the camp as a result of the camp closure announcement led to women interrupting their GBV case management process and hindered their ability to access referrals. Refugee community workers were unable to deliver their typical GBV outreach and community mobilisation activities as the uncertainty of the future impacted both GBV survivors and refugee community workers. Referral procedures were modified to help address some of the referral process issues that arose. Additionally, refugee community workers were pressured to refer survivors to UNHCR for repatriation and were resented when this was not possible, which further impacted women accessing the GBV centres.

Research Question III: Is a comprehensive case management approach using task sharing to deliver GBV response services acceptable and feasible for improving the health, wellbeing and safety of GBV survivors in a refugee camp?

- In line with data provided by service providers, survivors mainly worked with refugee community workers as translators and interpreters, rather than receiving psychosocial support or case management directly from refugee community workers.
- Overall, women reported that the GBV services were acceptable and feasible. Women indicated overall levels of satisfaction with the service and few reported the need for any major changes. However, GBV survivors highlighted a number of challenges and concerns including questions about confidentiality of the service; community resistance to accessing GBV services; and fear of violent retaliation for visiting services (exacerbated by a concern of being repatriated to Somalia and having less protection and support there than in the camps).
- The lack of reported follow-up GBV case management visits suggest that women are facing additional barriers to accessing care. These may include shifting priorities (concern over the repatriation activities), mobility restrictions due to fear of moving across the camp to the GBV centre, limited decision-making power, and other responsibilities. Low levels of social support from family, friends, and community along with low acceptability of seeking GBV services may have also influenced women's ability to return for follow-up meetings. These barriers indicate that aspects of the intervention need to be strengthened to address these issues.
- Fear and worry over safety in the camp remained high for all women, reflecting the heightened stress and fear they experienced related to the repatriation process and suggesting that the threat of GBV remained for most women.
- Among the survivor cohort, no significant changes were noted in levels of hope for the future, coping strategies, perceptions of safety, or physical health. However, improvements in mental health outcomes were found over time; and, promisingly, women with the greatest psychological health needs appeared to access the services more frequently compared to those with lower mental health service needs, suggesting that the Dadaab case management model successfully reached the women with the greatest need for psychological support.

Recommendations

Practitioners

- Transition GBV services to a complete task sharing model where refugee community workers are trained in the 2017 Interagency GBV Case Management Guidelines, and female refugee community workers are leading case management and psychosocial support for survivors.** Refugee community workers are a valuable resource for increasing access to women and girls seeking GBV services, improving awareness and understanding of both cultural and religious practices, providing input into how to implement GBV prevention and response work locally, and providing additional staff resources where gaps may exist due to funding shortages. However, there are also challenges involved in the refugee community worker role that will need to be addressed to ensure that the model is acceptable and feasible, including minimising distress through psychological support for refugee community workers, and ensuring competence to deliver the services as intended in order to ensure the maximum benefits and minimum risks of this shift to complete task sharing.
- Ensure mechanisms are in place for the safety and wellbeing of refugee community workers.** Given the multiple identities of the refugee community worker as an NGO worker, a member of the community, and often a survivor of GBV themselves, organisations need to ensure that safety planning and reporting processes are in place for both work and non-working hours. Tailoring programming to the local context and placing more emphasis on community engagement may reduce some of the backlash for refugee community workers. Support should be made available to help cope with job pressures and community resistance. This research has shown that this is even more crucial during times of uncertainty for the camp and refugee population as a whole.
- Recognise that female refugee community workers are also likely to be survivors of GBV and ensure that psychosocial support is available.** Experiences of violence and gender inequality are often a motivating factor for refugee community workers to take on this work and additional support and training may be required to support them with their own trauma and experiences of GBV while they are working in the community to support other survivors of GBV.

- Implement the 2017 Interagency GBV Case Management Guidelines and monitor delivery to prevent perpetuating negative practices.** Guidelines should be translated into local languages or adapted for low literacy to ensure that case management practices are safe and respect confidentiality for survivors, staff, and refugee community workers. Adherence to the guidelines will limit negative practices that increase risk to service providers, survivors, and refugee community workers.
- Address barriers to employment and promotion for female national staff and female refugee community workers.** As outlined in the 2017 *Interagency GBV Case Management Guidelines*, female staff and refugee community workers should be delivering case management and psychosocial support. Further, at least one female refugee community worker should be involved in all outreach and community mobilisation activities to ensure that GBV survivors have the option of speaking/ disclosing to a woman if they would prefer. Organisations should consider how to support female workers through flexible working hours, adequate maternity and paternity leave, adequate pay for this skilled service, and training and leadership development schemes specifically targeted to women. Further, hiring practices should include flexible and inclusive approaches to numeracy and literacy entry requirements, and should take previous community-level work experience into consideration, in order to address the disparity between female and male education levels and employment opportunities.
- Provide targeted training and continual professional development for refugee community workers.** The training most often requested by refugee community workers was to improve their counselling skills, while national staff emphasised the need for more advanced interpretation and translation skills for refugee community workers. Finally, structured training and support around gender norms and women's leadership should be delivered to all refugee community workers to ensure that female refugee community workers feel safe and supported to take leadership roles. Certificates should be provided for all training in order to support future career development and professional growth for refugee community workers.
- Safely document informal GBV case management.** Given refugee community workers' daily work both in the GBV centres and the community, documenting the type of contact refugee community workers are providing (safely, ethically, and confidentially) would assist with tracking workload and GBV case management activities for GBV survivors.

In addition to recommendations related to refugee community workers and task sharing, a number of steps are recommended for GBV case management in Dadaab more generally.

- Strengthen referral pathways.** Work with UNHCR security guards to ensure they are trained in protection against sexual exploitation and violence and in the importance of safe and timely access to services for survivors. Set clear expectations on the role that the UNHCR guards play in facilitating access.
 - Invest in community outreach to address issues of community acceptance and low support levels to survivors.** At a minimum, organisations should increase efforts to raise awareness of GBV and the importance of supporting survivors of GBV to access services, while reducing stigma. In particular, target messages towards elders, religious leaders, and youth in Dadaab. Social norms and behaviour change programming (e.g. SASA! and EMAP) should also be considered in order to tackle pervasive negative social norms causing and condoning violence against women and girls.
 - Ensure community-based women's safe spaces that deliver group psychosocial support are available where possible.** The barriers to accessing case management in GBV centres highlights the needs for community-based spaces that women can easily and safely access for follow-up support.
- ## Donors and policymakers
- Prioritise funding for specialised GBV prevention and response services in protracted crises.** Long-standing camp settlements such as Dadaab present particular risks for women and girls. Of the women that participated in this research, 87% had already visited the GBV clinics for at least one prior experience of violence. Due to competing needs across the humanitarian field, situations like Dadaab continuously face funding shortfalls. GBV programming is inadequately resourced, with not enough well-trained staff and community workers to meet the community's needs in relation to quality case management, psychosocial support, and follow-up, particularly for women who experience ongoing forms of GBV such as multiple incidences of IPV. Additionally, specific funding is needed to address long-term behaviour change in gender and social norms at the community level as part of violence prevention.
 - Fund and promote localised in-depth roll outs of the 2017 Interagency GBV Case Management Guidelines¹ to reach all actors involved in GBV case management services, including refugee community workers.** These should be adopted across all emergencies as the key standards to ensure that high-quality and safe GBV case management is provided, with female national staff and refugee community workers leading response and psychosocial support for survivors. Financial resources for in-depth trainings and other capacity-building activities of staff and refugee community workers (or other community members involved in GBV response) are often deprioritised in emergencies, compromising the adherence to international standards and best practice.

- Support the further development of the GBV case management models in humanitarian settings.** Case management is the cornerstone of GBV response services; this research illustrates how case management can be adapted for refugee settings such as Dadaab. Support is needed to further develop GBV case management approaches in complex humanitarian settings. This may mean funding innovative or pilot programmes where organisations are adapting case management approaches in different ways, along with supporting knowledge sharing and the development of good practice in GBV case management, particularly around task sharing and the use of community workers.
- Support approaches that strengthen the capacity of grassroots and refugee women and of women's movements to deliver GBV services.** Humanitarian agencies should ensure that services are delivered in partnership with women to ensure accessible, high quality, and sustainable GBV prevention and response activities.

Researchers

- Adopt a flexible and collaborative research design approach that values programming and contextual expertise.** Given the challenges of including a control population for research related to case management (due to the ethics of withholding care), researchers should work closely with the programming team to design research that can measure intervention effects in ethical and effective ways.
- Additional research is needed to understand how this model of care would work in other humanitarian settings and the adaptations necessary for it to function effectively.** This research demonstrated that GBV case management with some level of task sharing, is an acceptable and feasible model of care in a refugee camp. The study captured the key mechanisms influencing how the care was delivered during a period of repatriation activities using a mixed-methods approach. More research is needed to understand how the task sharing case management model works in other humanitarian contexts, including in urban settings.
- Develop and test measures that capture the short and long-term outcomes of GBV case management.** Researchers should build on this and other current work^v to develop monitoring and evaluation tools to measure psychosocial wellbeing and stigma in GBV response activities.
- Longitudinal research following survivors over longer periods (several years) in humanitarian settings is needed** in order to understand the longer-term impact of accessing care and the effect of community-level interventions on barriers to accessing care.

^v Such as the HIF-funded research Raising the bar for routine M&E in GBV programs: Measuring psychosocial well-being and felt stigma outcomes, being conducted by IRC in Dadaab.

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February 2018

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Annexes

Annex 1: IRC and CARE refugee community worker responsibilities

IRC	
GBV RESPONSE TEAM ROLES	PREVENTION TEAM ROLES
• Welcome survivors as first point of contact at GBV centre • Record all cases that come to GBV centre in the intake book • Provide translation during case management • Conduct follow-up by phone • Support filing of clients' forms (intake and follow up) • Issue material support/dignity kits to the survivors • Translate during listening sessions in the women safe spaces • Conduct listening sessions and provide feedback • Assist in clinical care (translation, taking lab samples, collecting results) • Escort survivors to referred agencies or hospital • Support national staff in translation during group therapy session in women safe spaces • Other tasks not related to case management such as safety audits	• Lead mass community campaigns during key calendar events • Conduct focus group discussions in the community • Facilitate meetings with community activists/SASA! • Lead dialogues with community leaders • Conduct home assessment for vulnerable women • Oversee the daily running of activities in women and girls' safe spaces • Lead life skills sessions with adolescent girls in the safe spaces • Participate in the daily morning meeting for briefs and updates • Support EA\$E activities at the women and girl centres • Escort survivors to service providers where access or security is a challenge • Conduct community mobilisation and awareness initiatives SASA! & EMAP
CARE	
GBV RESPONSE TEAM ROLES – GAD	GBV PREVENTION TEAM ROLES – GAD
• Record and triage cases to be attended by national staff • Refer non-GBV cases to appropriate service delivery outlets • Provide translation during individual case interviews by national staff • Escort GBV cases to referral points and translate for them • Conduct follow up visits and needs assessment for survivors at the block level • Mobilise survivors for follow up case management sessions • Maintain an up-to-date data system for all clients and activities • Update clients' records and ensure their confidentiality • Compile sexual GBV (SGBV) reports and performing office duties as assigned	• Hold block-based discussions in the community on sexual GBV • Facilitate and carry out quarterly anti-SGBV campaigns • Facilitate peer counselling sessions among youth, men and women on SGBV issues • Facilitate sport activities to promote youth participation in anti-SGBV activities • Conduct workshop/ training on human rights, communication skills and effects of SGBV/FGM • Conduct intergenerational dialogues on SGBV among community members • Conduct monthly meetings for anti-SGBV support groups to ensure continuation • Conduct home visits to support groups and community members supporting abandonment of FGM • Conduct meetings with anti-SGBV support groups to monitor field based activities conducted by the same • Compile and update data for anti-SGBV support groups • Identify gaps and emerging issues in the community on SGBV • Identify and verify vulnerable SGBV survivors for receipt of material and non-food items.

PSYCHOSOCIAL RESPONSE ROLES – PSU	PSYCHOSOCIAL OUTREACH ROLES – PSU
• Register new clients • Provide translation during individual and group counselling by national staff • Conduct follow up visits for clients at the block level • Provide individual counselling at household level in the community • Maintain an up-to-date data system for all clients and activities • Update clients' records and ensure their confidentiality • Compile reports and perform office duties as assigned	• Conduct community mobilisation and sensitisation on psychosocial issues • Conduct focus group discussions s on different psychosocial issues emerging in the community • Organise/conduct life skills workshops for specific groups (e.g. youth) • Organise/facilitate weekly peer counselling clubs activities; recruit and register new club members • Identify community members for counselling support committees and orient/train them on basic counselling skills and other psychosocial topics • Attend counselling support committee meetings and monitor their activities • Assist professional counsellors to monitor support groups activities

Annex 2: Violence exposure measures and coding

Questions and categories used to measure intimate partner violence and non-partner violence are listed in the table below. Physical violence is divided into moderate and severe acts, and sexual violence is divided into physically forced and coerced sex. The frequency and time period of the act are assessed for each positive response.

	Subtype	Question
Intimate Partner Violence	Emotional Violence	1. Has your partner ever become angry when you speak to other men? 2. Does your partner insist on knowing where you were at all times? 3. Does your partner ever forbid you from seeing your friends? 4. Has your partner ever done something to frighten or intimidate you? (For example, in the way s/he looks at you or by yelling or breaking something?)
	Physical Violence (moderate)*	1. Has your partner ever slapped you or thrown something that could hurt you? 2. Has your partner ever pushed or shoved you? 3. Has your partner ever hit you with his hand or with something else that could hurt you?
	Physical Violence (severe)†	1. Has your partner ever kicked, dragged or beaten you? 2. Has your partner choked you or burned you intentionally? 3. Has your partner THREATENED to use a gun, knife or other weapon against you? 4. Has your partner ACTUALLY used a gun, knife or other weapon against you?
	Sexual Violence	1. Has your partner ever forced you to have sex by using threats or intimidation (not physical violence)? 2. Has your partner ever physically forced you to have sex when you did not want to?
	Physical Violence	1. Has anyone who is not your intimate partner ever beaten you with a fist, or kicked you, or hurt you with a stick or other object? 2. Has anyone who is not your intimate partner ever used a gun, knife or other weapon against you?
	Sexual Violence	1. Has anyone who is not your intimate partner ever forced you to have sex when you did not want to, for example by threatening you, holding you down, or putting you in a situation where you could not say no?

*Moderate physical IPV has occurred when a woman reports more than one event of any moderate physical act of IPV.

†Severe physical IPV has occurred when a woman reports at least one event of any severe physical act of IPV

Annex 3: Outcomes and covariates

Plausible primary outcomes and explanatory variables were determined by the research and GBV service provider teams. A preliminary framework was developed and then refined by the IRC and CARE teams. Quantitative measures were developed to capture change over time among women who accessed the GBV services.

Using the GBV survivor cohort data we examined changes between T1, T2, and T3 of the following primary outcomes among GBV survivors accessing survivors:

1. Safety perception/insecurity and fear
2. Mental health (last four weeks) [PTSD, Depression, Anxiety]
3. Physical health (last four weeks)
4. Violence – IPV (last four weeks)
5. Violence – NPV (last four weeks)
6. Hope for the future
7. Coping abilities

The measures are described below:

Covariate – Violence type: The violence explored in this research included IPV (physical/sexual), and non-partner violence (physical/sexual). By ascertaining the different forms of violence by time period, this research was able to capture data from individuals who may have been exposed to multiple forms of violence and collect data on potential perpetrators. Measures were adapted from the WHO Multi-Country Study on Domestic Violence. The specific questions used to measure the acts of violence experienced were posed to refugee community workers (cross-sectional survey) and survivors (cohort). (See Annex 2 for violence exposure measures and coding).

Time period: The time period indicates the period during which violence might have been experienced. Individuals may have been exposed to violence during multiple time periods in their lifetime. Therefore, participants were asked if the violence occurred in the last 12 months, last four weeks, and before they moved to Dadaab.

Covariate – Social support: Levels of social support available to female survivors was assessed using an adaptation of the Social Support Scale. Women were asked if in the last four weeks there was someone in her life who: (1) helps you feel better when you are faced with difficulties; (2) accepts you completely, including your best and worst qualities; (3) cares about you, regardless of what is happening to you; (4) helps you feel better when you are feeling sad; (5) consoles you when you are upset. Women were categorised as receiving some or no support. Survivors were asked these questions at each time period.

Outcome – Perceived safety including insecurity and fear: In addition to specific forms of violence experienced, this research also included measures to assess feelings of insecurity and fear that may occur in a refugee camp setting. These events included forced confinement and coercion, and war-like conditions such as having to flee your village and fear for your life. Refugee community workers and survivors were asked these questions.

Outcome – Hope for the future: The Adult Hope Scale²⁸ was used to assess women's hope for the future. The scale was administered at three time points to assess changes over time. The mean level by time period was calculated.

Outcome – Coping: The BRIEF COPE scale was used to assess changes in problem solving and emotional coping skills over time.

Outcome – Mental health: Three mental health outcomes were assessed – depression using the PHQ-9, anxiety using the GAD-7, and Post-Traumatic Stress (PTSD) using a sub-scale of the Harvard Trauma Questionnaire (HTQ). All three are widely used scales based on the participants self-report of symptoms. Raw scores and trends are reported in this report.

Annex 4: Data analysis overview

Quantitative data analysis

Data preparation

Two datasets were prepared for analysis and composite measures were created (i.e. sex, age groups, educational level, marital/cohabitation status, children, ethnic group, camp, years in camp, caring responsibilities, years working as refugee community worker, violence types experienced (partner; non-partner), health, coping, social support level, etc.)

Pooling of data for analysis

Data collected from the two GBV centres were combined for the first round of analysis. Sub-group analysis by GBV centre was examined descriptively to identify if there are any differences that could affect the interpretation of the statistical analysis as well as inform individual programmes.

Statistical Methods

Summary tables were created for relevant refugee community worker cross-sectional variables and the survivor cohort variables (frequency tables). Continuous variables were summarised with descriptive statistics (n, mean, SD). Where appropriate, 95% confidence intervals are presented. Categorical data are presented with frequency counts and percentages for each category. All data was organised by data collection time period (T1, T2, T3), and by gender as appropriate for the refugee community worker data. Descriptive trends were analysed and presented in this report.

Qualitative data analysis

All in-depth qualitative interviews conducted with refugee community workers and female GBV survivors during Phases I and II respectively were conducted in Somali, recorded, and translated/transcribed into English. Phase I interviews with national staff were conducted in English. The research team members individually reviewed five interviews in order to develop a coding structure for organising and extracting themes from the interviews, guided by the research questions and the key themes emerging from the data. The team then agreed on the codes and finalised a code sheet, which was shared with the larger research team for review and input. Following Creswell's analysis model,²⁹ the code sheet was used by one coder, who coded 3 interviews prior to a meeting with the team to review and provide feedback. All transcribed interviews were then coded with NVivo using the codebook. In addition to using a deductive approach drawing on the topic guide, we also used an inductive approach allowing themes to emerge from the data. This approach promotes the detection of common themes in the data to emerge through the continual investigation of narrative data for categories, linkages, and properties.^{30,31} Quotes are used in the analysis to illustrate key themes.

Additional refugee community worker and national staff semi-structured interviews in Phase III were conducted in English. Thematic content analysis was used to present the key elements of participants' accounts. This approach uses inductive and deductive coding to provide a map of the content and topics within the interviews, and is a way of summarising the variation and regularities within the data.^{31,32} This stand-alone method was chosen as it is a useful approach for answering questions about the salient issues for particular groups of people or identifying typical responses. One LSHTM researcher read four of the transcripts to explore the range of accounts generated and examined how refugee community workers and national staff discussed the key issues, as well as recurrent topics, experiences, events or views. The researcher compared various accounts gathered to classify re-occurring or common themes. The list of codes developed from this process was then applied to the rest of the data. This was complemented with an inductive approach, which allowed new themes to be added to the coding framework as they emerged through re-reading of the transcripts.³³ Extracted data relating to demographics and other background characteristics were stored in Excel.

Data interpretation

Preliminary data analysis from Phases I and II was presented to IRC and CARE refugee community workers and national staff in 2016 and 2017 respectively to elicit their feedback on the findings. The feedback was used to inform the data interpretation and conclusions presented in this report.



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