Gender Based Violence Assessment
Hagadera Refugee Camp
Dadaab, Kenya

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To all the women, men, girls and boys who gave their time and energy so graciously to answer the never ending stream of questions in yet another assessment. Many thanks also to colleagues within IRC's GBV programme whose hard work and mobilization skills made this possible.

Photo by Victoria Shepard, IRC Grants, Kenya

List of acronyms

BCC	Behavioral Change Communication
CCSAS	Clinical Care of Sexual Assault Survivors
CFS	Child Friendly Spaces
CPST	Community Peace and Security Teams
CRM	Complaints and Reporting Mechanism
DRA	Department of Refugee Affairs
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GBV	Gender-based Violence
HAP	Humanitarian Accountability Partnership
IASC	Inter-Agency Standing Committee
IMS	Information Management Systems
IP	Implementing Partners
IRC	International Rescue Committee
KAP	Knowledge Attitudes and Practices
KII	Key Informant Interviews
LWF	Lutheran World Federation
MDG	Millennium Development Goals
NCCK	National Council of Churches of Kenya
NFI	Non Food Items
NRC	Norwegian Refugee Committee
PLWHA	People living with HIV and AIDS
PRC1	Post Rape Care Form 1
RCK	Refugee Consortium of Kenya
SC-UK	Save the Children UK
SEA	Sexual Exploitation and Abuse
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
TFG	Transitional Federal Government
ToR	Terms of Reference
ToT	Training of Trainers
UNHCR	United Nations High Commissioner for Refugees
VAW	Violence against Women
WFP	World Food Programme
WHO	World Health Organisation
YEP	Youth Education Project

Executive summary

A. Overview of Gender Based Violence in Hagadera

- The scale of the refugees fleeing across the Kenyan border continues to overwhelm the available resources in the area; in 2007, Kenya closed the border with Somalia yet thousands continue to pour across it clandestinely. Hagadera Refugee Camp has a population of approximately 115,114[1] refugees escalating from 93,586[2] since September 2010.
- Overcrowding has led to a great strain on camp resources and systems with growing insecurity, a lack of shelter and limited services. War and displacement heighten women and girl's vulnerability to gender-based violence (GBV), in particular sexual violence, as physical and social systems for protection break down and norms regulating social behavior are weakened. Women and girls are at risk of GBV during forced migration and within camp settings, with newly arrived females and female headed households particularly vulnerable. In the camps GBV can take many forms including rape, domestic abuse, early and forced marriage, forced divorce, female genital mutilation (FGM), socio-economic abuse and the denial of a woman's right to make choices about her reproductive health.
- Since the IRC began GBV programming in September 2010, there has been a notable increase in the number of survivors accessing GBV services, with an average increase of over 50% between September 2010 and March 2011 from baseline. However, reporting of GBV remains limited, in particular sexual violence, widespread practices such as blaming the survivor, shame, stigma, fear of reprisals and threats of rejection by families and the community are powerful deterrents to reporting. This leads to a situation where the majority of survivors do not receive appropriate care with potentially life-threatening consequences. A lack of knowledge among refugees about the consequences of GBV also limits reporting and utilization of appropriate and timely health care.

B. Nature of GBV in Hagadera

- Domestic violence is widespread and to some degree acceptable in the community. The mutually reinforcing relationship between economic insecurity and domestic violence is apparent. Common causes of domestic violence are linked to poverty, a lack of resources, limited opportunities for employment and women's unequal role in the household.
- Sexual violence appears to be more prevalent than reported cases indicate. On average, two adult cases are reported monthly to IRC GBV but discussions with the community reveal severe under reporting. Sexual violence and the threat of sexual violence permeate the lives of women's and girls'. They fear assault going to the bush to collect firewood, when walking in the blocks unaccompanied by men especially in the early morning or evening and at night in their homes. Young girls without a male relative to protect them on the way to and from school are also vulnerable to assault and this often acts as a barrier to attending school. Rape is reportedly more common among female new arrivals, who are highly vulnerable often lacking strong familial protective mechanisms, living in flimsy easily accessible structures.
- While the occurrence of sexual violence, both in Somalia and on the way to Dadaab is acknowledged, there is a reluctance to report or seek medical attention. The influx of new arrivals, overcrowding and a general lack of security remain serious concerns and emphasise the need to protect women and girls.

C. Most at risk

Weak familial support, a lack of strong clan ties and male relatives are risk factors that increase women and girls vulnerability to GBV, in particular, sexual violence. Although many women and girls fear multiple forms of violence, some are more vulnerable than others. In Hagadera, adolescent girls are particularly vulnerable to multiple forms of GBV, other groups most at risk are:

- Single mothers with children out of wedlock
- Divorcees, widows and female headed households
- Unaccompanied girls whose parents are dead or those not living with their parents
- Newly arrived females who have limited knowledge of the formal and informal systems in the camp
- Women who are raped experience stigma and are vulnerable to other forms of violence

D. Contributory factors

- ***Overcrowding:*** Overcrowding in the camps has reached unprecedented levels, with the rapid and continuous influx of refugees doing little to alleviate the congestion and consequent insecurity. New arrivals, many of them unaccompanied females, lack safe shelter and live in tents on the margins of the

1 UNHCR Population Statistics 1 May 2011
2 UNHCR Population Statistics 3 September 2010.

camp; this fails to offer any protection exposing them to risks of physical insecurity and abuses. To date in 2011, over 37,186 refugees have been registered in Dadaab; despite ongoing discussions between UNHCR and the Government of Kenya the situation looks likely to continue until a solution is reached. As camp services buckle under the strain of the growing number of refugees, competition for basic amenities like shelter, water and sanitation facilities magnifies.

- ***New arrivals:*** Taking into consideration the longevity of the conflict in Somalia, where sexual violence is reportedly prevalent, many have been exposed to violence either in Somalia or enroute. A related issue is access to camp based services for GBV survivors who experienced violence prior to arrival in the camp, which represents a vacuum in service delivery and utilization. Few cases present for either medical or psychosocial support for sexual violence experienced prior to arrival. Although screening of new arrivals at registration includes questions on protection concerns, including GBV, more information including IEC materials and briefings could be provided on available services, follow up and support in the longer term as many may too overwhelmed to seek services at point of registration. Concern at being identified as a GBV survivor and the potential stigma and discrimination that often accompanies sexual assault coupled with a lack of knowledge of and confidence in the GBV services as well as fear of repatriation limit reporting among new arrivals.

- ***Insufficient police capacity:*** UNHCR has been working with the government to increase police numbers in Dadaab and much investment has been made by many actors in building police capacity on GBV in particular, Refugee Consortium of Kenya (RCK), UNHCR, CARE and Save the Children (SCUK); however, gaps in dealing with GBV remain. Insufficient police capacity to respond to GBV cases, a lack of adequately trained officers and few female police, knowledge of and confidence in the formal system, all prohibit women from reporting. A lack of trust between refugees and police for reporting GBV prevails; many do not report for fear of reprisals (from perpetrators, community and family). Police patrols in the camp are insufficient to address the security needs especially at night which leads to a situation where few leave their homes after dark. Even with these precautions, women and girls are reportedly sexually assaulted at night. The lack of police presence, capacity and expertise impedes the protection of women and girls. Unsuccessful investigations follow up and failures to prosecute GBV cases contribute to an environment of impunity that marginalizes survivors, discourages reporting and help seeking behavior.

- ***Exploitation and Abuse:*** Complaints of sexual exploitation and abuse were extensive and transcended all service providers from health, food distributions, to the police, across schools and the resettlement process. The inadequacy of existing complaints and reporting mechanisms is evident, limited knowledge on the reporting systems, accountability; follow up and feedback were identified as barriers to reporting.

- ***Economic insecurity:*** Poverty and financial insecurity are catalysts for both domestic violence and sexual assault. Economic deprivation is both a type of violence and contributory factor to other forms of GBV. A lack of resources to support the household, limited opportunities for employment and the 'idleness' of men contribute to GBV in Hagadera. The loss of livelihoods, absence of opportunities and resultant frustrations is apparent among men and women and contributes to divorce, which makes female headed households more vulnerable to other forms of GBV. Women usually take overall responsibility for their family and divorce can lead to conflict over family plots that place women in a vulnerable position.
  Women's empowerment is hindered by a wide variety of obstacles including poverty, economic dependency, illiteracy, limited participation in decision-making processes, and lack of access to social services. Existing women's networks and support systems are limited but emerging, there are growing numbers of women's groups that can be strengthened.

- ***Lack of decision making power:*** Deeply entrenched discriminatory attitudes and practices further exacerbate GBV in Hagadera. The patriarchal nature of Somali society, which account for nearly 98% of the population, results in males remaining the dominant decision makers in the public sphere with women continually under represented. At the household level, a strong tradition persists of maintaining the low status of girls and women and this extends through marriage practices and throughout society as a whole.

- ***Firewood collection:*** Resource shortages lead many women to engage in risky behaviours like going to the bush for firewood but this places them at an increased risk of sexual assault. The risks associated with firewood collection are well documented in Dadaab and led to a number of actors providing fire wood and promoting fuel efficient stoves to reduce the need for firewood. Despite some fuel-related protection strategies in place, these are insufficient to combat the on-going risk of sexual assault; the need to go to the bush to collect firewood was consistently identified as a key risk factor for sexual assault.

- ***Education:*** While there have been routine improvements in the access to education, young girls are still less likely to attend school than young boys and also more likely to leave early with marriage the immediate option. Half of all school-age children remain out of school, growing enrolment figures are met with high levels of early school leavers. As such, girls' opportunities to continue their education and develop their knowledge and skills are severely limited with implications for their reproductive health, education and long-term livelihoods.

E. Responses to GBV

- The Maslaha, the traditional mediation system, is constituted on an adhoc basis and the composition varies, it is male dominated, clan based and a powerful mechanism for dispute resolution despite its lack of formal structure. There is tension between this and the formal judicial structures that often operate in parallel and opposition of each other and most cases are not reported to police but resolved using the Maslaha system. Although efforts have been made to integrate the Maslaha into the existing GBV referral network and ensure cases of sexual and domestic violence are not dealt with by them, this has had limited success with most cases of domestic violence and some sexual violence incidents still resolved by them. GBV, including sexual violence, is commonly treated as a private matter that should be resolved within the family or community using traditional processes rather than within the formal judicial system.
- The clan/family is the first response for cases of domestic violence; it is only when these have been completely exhausted might a survivor approach agencies or the police. For cases of sexual violence, if the perpetrator is unknown and the survivor is unable to identify him, it is unlikely that any action will be taken or that it will be reported at all, many will not even seek medical attention or disclose the assault to anyone. Many believe that if sexual assault occurs, it must be reported to the police if they are to access health services. This results in many survivors not receiving appropriate medical treatment and leads to harmful health consequences further contributing to stigma and discrimination within the community.
- A lack of confidence in the formal judicial systems deters reporting. Perceived barriers to reporting include inadequate follow up by the police, low levels of successful prosecutions and alleged police corruption. The inadequacy of the formal judicial system also contributes to a high level of cases solved by the elders.
- This means that many survivors conceal the assault and are unwilling to seek adequate medical attention and most cases are settled outside the formal legal system. Attrition rates of survivors from the hospital through to the police and judicial system is high. Few cases are reported and there are even fewer convictions. The duration between sexual assault and reporting varies but if reported, in many cases it is brought directly to the police before medical treatment is received which indicates that the community prioritizes this rather than the health concerns of the survivor.

F. Potential programming priorities and recommendations

- Effectively preventing and responding to GBV requires both the coordination and commitment from a wide range of actors, in particular, the community structures.

a. Improve GBV and health coordination within IRC

- Internally within IRC, efforts to enhance GBV and health coordination need to be sustained; progress has been made on improving the relationship with clinical services. Centralized service provision of clinical and psychosocial care in the Support Centre has increased the confidentiality and coordination of these. GBV and wider gender equality issues that influence access to and utilization of GBV and reproductive health services should be mainstreamed across all the health components including HIV, Community health, nutrition and clinical services

b. GBV Coordination and referral systems

- Although notable achievements have been made in strengthening GBV coordination, in particular, moving the GBV Working Group meetings to the camp level to increase community participation, more efforts are required to enhance interagency coordination and community ownership of GBV programming. All service providers involved in the referral network should provide detailed information on services available, processes and time lines to ensure survivors have access to the most comprehensive information that allows them to make informed choices about their course of action.
- ***Institutional capacity development and training:*** Assessing the effectiveness and utilization of GBV related services across health, psychosocial, legal and security should be ongoing. These could strengthened through appropriate training and capacity building of partners and the community based on survivor feedback and evaluation of services provided.
- ***Improving the relationship with the police:*** Issues related to the police and related barriers to reporting demand attention. Attempts to improve the effectiveness of the police need to be magnified to enhance the quality of services available to GBV survivors.

- ***Strengthening of complaints and reporting mechanisms in Hagadera:*** The inadequacy of existing complaints and reporting mechanisms for exploitation and abuse were evident throughout the assessment. This is a serious concern; the need to develop locally appropriate and effective systems both within IRC and across other agencies operating at the camp level is a priority. Strengthening institutional capacity to properly develop systems to receive complaints, conduct transparent investigations and provide adequate follow up and feedback in a timely manner is required. Promoting and facilitating a sharing of information, skills and knowledge across partners, at both the camp and Dadaab level, will be an important dimension to strengthen coordination, capacity to address complaints and prevent abuses occurring. The planned visit by Humanitarian Accountability Partnership (HAP) in May 2011 should contribute to the development of a joint complaints and reporting mechanism at the camp and interagency level and build on previous support from HAP in 2010.

c. Strengthening community participation in developing solutions to GBV

- ***Engaging with traditional mediation and justice systems:*** Traditional dispute-resolution mechanisms are often the most accessible and preferable to survivors, however, they inadequately protect the rights of women and girls. Engaging key groups, particularly traditional and religious leaders are critical.
- ***Community mobilisation and outreach***: Effective interventions aimed at preventing GBV must engage and be lead by the community and build on local systems and structures to ensure solutions to GBV are community owned. Programmes must go beyond raising awareness and contribute to community driven behaviour change. The need to develop a targeted approach for engagement is fundamental to addressing GBV by supporting behavior change and increasing understanding and utilization of services.
- ***Working with men:*** Effectively engaging men and boys in violence prevention efforts and developing strategies to improve spousal relationships at the house level are important. Recommendations from the community were focused on initiating programmes to engage men to improve marital relationships and educate family members on GBV.

d. Increasing access to opportunities for women and girls through social and economic empowerment

- ***Capacity building and organisational strengthening of existing women's groups****:* Although in their infancy, women's groups are emerging. Groups like 'Together Women' and others would benefit from institutional strengthening and capacity building to grow their management and organisational structure.
- ***Supporting women's economic empowerment:*** The linkages between GBV, economic insecurity and poverty are well recognised. Promoting women's protection through strategic interventions including economic opportunities and access to education are critical to reducing vulnerability to GBV.
- ***Support for adolescent girls programming:*** As outlined in the findings, adolescent girls experience particular vulnerabilities; a lack of current initiatives for girls, coupled with the need to engage them early during this critical phase in their development to better prevent violence before it occurs, and adequately equip them with the skills to lessen their risk to violence, is important.

e. Addressing the protection concerns of women and girls across all sectors

- ***Safe shelter provision for new arrivals:*** Until a more permanent solution is found to house new arrivals, responses need to take into consideration the protection concerns of the new arrivals. The need to provide a safe environment to reduce many of the structural causes of GBV is a priority, in particular, for newly arrived female headed households who have limited access to safe shelter, latrines and water. The current inadequacies in the provision of shelter, the lack of a safe and protected environment including access to basic amenities require more attention. High levels of female headed households are subsisting in unsafe areas where there have been routine threats from youth and the host community.
- ***Shelter provision for GBV Survivors:*** GBV survivors also have unique protection needs which are often related to the provision of shelter (both temporary and permanent) that are a serious concern. Temporary shelter solutions for GBV survivors are limited; IRC and LWF often utilize informal networks, through the women's affairs committee (female section leaders) and other community based structures to identify temporary shelter, although this is ad hoc and not always reliable or suitable for extreme cases.
- ***Safe fuel strategies:*** The specific risks that women and girls experience collecting firewood require interagency and community based responses**.** At the community level, firewood patrols were recommended by the community to reduce the risk of women and girls. These could be organized through the Community Peace and Security Teams (CPST) to improve security while collecting fuel outside of the camp. However, longer term solutions need to be explored and firewood collection also contributes to tensions with the host community and ongoing environmental degradation. Alternative energies including solar, could be further assessed for their appropriateness in the Dadaab context.

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1 Background

1.1 Overview

Somalia has suffered from a protracted conflict and decades of misrule since the early 1990's and the collapse of Siad Barre's regime. The atrocities committed in the process of ousting Barre's regime in 1991, and the subsequent clan-based power struggles led to the displacement of hundreds of thousands of Somalis, scattered across neighbouring countries including Kenya. Escalations in displacement were witnessed following Ethiopia's overthrow of the Islamic Courts Union in December 2006 and again since 2009 with ongoing fighting between the Transitional Federal Government (TFG) and insurgent forces. The scale of the refugees fleeing across the Kenyan border continues to overwhelm the available resources in the area; in 2007, Kenya closed the border with Somalia yet thousands continue to pour across it clandestinely. The Dadaab refugee complex, consisting of three camps, Ifo, Dagahaley and Hagadera, originally built to house 90,000, currently host a total of 344,401[3] refugees, mainly from Somalia,. The camps are becoming increasingly overcrowded as the population continues to soar with a growing influx of Somali refugees forced out by deteriorating security conditions in Somalia. Hagadera Refugee Camp is located Garrissa County in North Eastern Province, Kenya has a population of approximately 115,114[4] refugees escalating by 13% from 93,586[5] since September 2010. Overcrowding has led to a great strain on camp resources and systems lending to growing insecurity, a lack of shelter and limited services. War and displacement heighten women and girl's vulnerability to gender-based violence (GBV), in particular sexual violence, as physical and social systems for protection break down and norms regulating social behavior are weakened. Women and girls are at risk of GBV during forced migration and within camp settings, with newly arrived females and female headed households particularly vulnerable. Violence and tolerance for violence are much higher in displacement settings since even before the conflict erupted, women and girls especially those living in rural areas, had limited protection and socio-economic opportunities.

In the camps, GBV can take many forms such as rape, domestic abuse, early and forced marriage, forced divorce, female genital mutilation (FGM), socio-economic deprivation and the denial of a woman's right to make choices about her reproductive health. Violence against women and girls is pervasive and the exact nature and scope of GBV cases in Hagadera is difficult to capture accurately as the majority of cases remain unreported. GBV is universally under reported and in the Hagadera context, rape is stigmatized, degrading not only the survivor but her entire family, and the focus is usually on concealing the assault rather than seeking medical or legal redress. Reporting of GBV is limited, in particular sexual violence, approximately 2-3 incidents of sexual assault are reported monthly by adult survivors in Hagadera. In 2009, 157 adult GBV cases were reported, 14 of which were sexual violence, 37 GBV cases involving under 18's were reported with 18 relating to sexual violence (sodomy, defilement and sexual assault). Again, widespread practices such as blaming the survivor, shame, stigma, fear of reprisals and threats of rejection by families and the community are powerful deterrents to reporting. This leads to a situation where the majority of survivors do not receive appropriate health care with potentially life-threatening consequences. A lack of knowledge about the health consequences of GBV also limits reporting and access to appropriate and timely health care.

1.2 Population Demographic Information

As of May 1, 2011 the population in Hagadera stood at 115,114[6] persons, 52% of the population is under 18 years and 97.2% of the population is Somali and 2.8% Ethiopian.

Age Group	Female	Male	**Total**
	in numbers	in numbers	in numbers
0-4	9,107	9,572	**18,679**
5-11	12,546	13,489	**26,035**
12-17	7,248	8,867	**16,115**
18-59	25,859	24,536	**50,395**
60 and >	1,949	1,941	**3,890**
Total:	**56,709**	**58,405**	**115,114**

3 UNHCR Population Statistics 1 May 2011
4 UNHCR Population Statistics 1 May 2011
5 UNHCR Population Statistics 3 September 2010
6 UNHCR Camp statistics 1 May 2011

1.3 Aim of the assessment

The overall aim of the assessment was to provide a more nuanced understanding of GBV in Hagadera camp by identifying priority concerns and needs, potential entry points for community mobilization and support, as well as opportunities and challenges for further engagement at the community and inter-agency levels. The assessment also had a parallel objective of assessing the progress of current GBV services, both formal and informal, and is intended to guide IRC's GBV programming in Hagadera in response to the needs of the community. (For detailed information on methodology and objectives of the assessment, see **Annex 1: Terms of Reference**)

2 Introduction

2.1 What is Gender Based Violence (GBV)

"*Gender-based Violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed gender differences between males and females*[7]*"*. It is any act or threat of harm inflicted on a person because of their gender. GBV is rooted in gender inequality and discrimination and although not exclusive to women and girls, it disproportionately affects females, transcending culture, class and race across all societies. The United Nations Declaration on the Elimination of Violence against Women defines violence against women (VAW) as "*any act of gender-based* [8]*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*" GBV violates the principles of international and regional human rights eroding the social and economic fabric. It is one of the most systematic and widespread human rights violations worldwide and a pervasive public health issue and is manifested in many forms.

Globally, acts of GBV are globally grouped into five categories:

i.) *Sexual violence*;
ii.) Physical violence;
iii.) Emotional and psychological violence;
iv.) Harmful traditional practices and
v.) Socio-economic violence.

GBV affects all aspects of women's and girl's physical, emotional, psychological and social well-being. Women and girls are at risk of various forms of violence at all ages, from prenatal sex selection before they are born to forced marriage through to the abuse of widows and elderly women. Particular groups of women and girls may be more vulnerable and experience multiple forms of violence as a result of discrimination and socio-economic exclusion. According to the UN Secretary General's in-depth study on VAW (2006) [9], on average at least one in three women is subjected to intimate partner violence in the course of their lifetime. Unequal gender relations and discrimination are at the core of GBV that cannot be understood in isolation from the social structures and gender norms that influence women's vulnerability to violence. While GBV is a universal problem, it is most pervasive in less developed countries[10]. Deeply entrenched discriminatory cultural traditions and practices perpetuate gender inequalities and the prevalence of GBV. Poverty, marginalisation, economic insecurity and a lack of education are all recognised contributing factors for increased violence against women and girls. Contributing factors like war and displacement also heighten vulnerability to GBV. Armed conflicts exacerbate inequalities between women and men, and discrimination against women and girls. Women and men experience conflict, displacement, and post-conflict settings differently due to culturally determined gender roles and responsibilities. Sexual violence[11] is increasingly recognised as a systematic weapon of war and has received growing attention in recent years yet this has not been matched with tangible declines. During conflict and displacement, physical and social systems for protection breakdown and norms regulating social behaviour are weakened; however, violence against women and girls in crisis is a magnification of such violence in peacetime. Violence and tolerance for violence are also much higher in post-conflict situations. For instance, "*Rates of interpersonal violence remain high even after the hostilities have been stopped, because violence becomes more socially acceptable*[12]*"*

2.2 Costs and consequences

GBV results in a multitude of costs and consequences having both immediate, to longer term and inter generational effects. There are impacts at the individual level, across communities and wider society which translate to costs at the national level. The physical, psychological and social consequences of GBV are diverse and the widespread stigma associated with sexual violence renders women isolated and vulnerable.

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[7] Inter-Agency Standing Committee (IASC) (2005:7) Guidelines for Gender-based Violence Interventions in Humanitarian Settings Focusing on Prevention of and Response to Sexual Violence in Emergencies

[8] The terms GBV and VAW are frequently used interchangeably; GBV highlights the gender dimension of these acts; the relationship between females' subordinate status in society and their increased vulnerability to violence.

[9] http://www.un.org/children/conflict/machel/english/811-ending-gender-based-violence-and-sexual-exploitation.html#note362

[10] (2009:1) Keeping Gender on the Agenda: Gender Based Violence, Poverty and Development. An Issues Paper from the Irish Joint Consortium on Gender Based Violence.

[11] In conflict/post-conflict and emergency settings, the term sexual and gender-based violence (SGBV) is commonly used.

[12] Helen Jones (2005) Visible Rights: Watching Out for Women in Surveillance & Society 'People Watching People' (ed. Wood) 2(4): 589-593

GBV, and in particular sexual violence, is universally under reported and the majority of survivors do not receive appropriate health care with potentially life-threatening consequences. Fear of reprisals, social stigma, rejection and lack of knowledge about the health consequences and the availability of services lead to underreporting. Health consequences can include severe emotional and physical trauma, unwanted pregnancy, unsafe abortion, pregnancy complications and sexually transmitted infections (STI), including HIV/AIDS. The link between GBV and HIV is well-documented and research indicates that the risk of HIV following forced sex is higher than following consensual sex. Violence has costs[13] for women and their families in terms of safety, security, sustainable livelihoods and wellbeing that are magnified in poorer households. High rates of violence against women and girls combined with a culture of fear obstruct women's participation in political, social and economic life. GBV adversely affects human, social and economic development and the impacts of GBV include escalating costs for health care, social services, policing and an increased strain on the justice system. Failing to engage with the causes and consequences of GBV has long-term detrimental consequences on peace building and development. Globally, GBV remains a major obstacle to poverty reduction, hindering development and undermining progress towards the achievement of the Millennium Development Goals (MDGs).

2.3 A framework for institutionalizing effective protection from GBV

The protection of women and girls through the promotion of gender equality and women's empowerment is fundamental to addressing GBV. Programming must challenge the social, cultural, and political determinants of violence to transform gender norms and attitudes that condone violence and put in place appropriate mechanisms to end impunity and affect long term behaviour change. Appropriate strategies require an in-depth understanding of the factors that contribute to and influence the type and extent of GBV. Interventions need to address the conditions across different levels which affect women and girls' risks of violence and reinforce the protective factors that decrease the likelihood of experiencing violence including education, skills training, economic resources and social norms that promote gender equality.

While interventions vary according to emergency/conflict, post–conflict or development stages, effective short and long-term protection from GBV must take place at three levels to institutionalise structural, systemic and individual protection[14].

1. ***Structural level (primary protection):*** Preventative measures are required to ensure rights are recognised and protected through international, statutory and traditional laws and policies.
2. ***Systemic level (secondary protection):*** Systems and strategies to monitor and respond when those rights are breached through statutory and traditional legal/justice systems, health care systems, social welfare systems and community mechanisms.
3. ***Operative level (tertiary protection):*** Direct services to meet the needs of survivors who have been abused, treating and rehabilitating survivors and facilitating their re-adaptation to society.

Prevention activities have been found to reduce many of these causal factors, but require in-depth understanding of the causes and contributing factors in tandem with strategies to negate them. Prevention is a long term process and requires good monitoring so that strategies can be changed over time to maximize effectiveness. For every act of GBV, there is a perpetrator and a survivor. Prevention strategies must target both potential perpetrators and potential survivors.

Response tends to converge under four interrelated continuums, to support a multi-sectoral approach.

1. ***Health*** (Emergency contraception/ treatment of injuries and STIs);
2. ***Psychosocial*** (Emotional support and counseling/ Income generation and skills training programmes)
3. ***Security*** (Police report/ Investigation/Arrest/Charges with the court)
4. ***Legal Justice*** (Formal and traditional/Application of appropriate laws to hold perpetrators accountable)

[13] Joint Consortium on Gender Based Violence (JCGBV) (2010) *Gender based Violence, Poverty and Development: GBV*." *results in immediate costs for households and communities draining resources both through expenditure on health care and formal and informal justice systems as well as lost income through an inability to work which have direct impacts on poverty and hunger.."*

[14] Adapted from A. Jamrozic and L. Nocella (1998) *The Sociology of Social Problems: Theoretical Perspectives and Methods of Intervention*, Cambridge University Press, Melbourne.

3 Situational Analysis

3.1 Dadaab context

Department of Refugee Affairs (DRA) and UNHCR are responsible for the overall management of Dadaab Refugee Camps. On September 1, 2010, the IRC assumed responsibility for GBV programming in Hagadera from CARE International. The IRC GBV programme is designed to improve women's and girls' access to camp-based services, address the factors that lead to their vulnerability and contribute to a coordinated response to GBV by different actors. In Hagadera, there is a well developed referral system and a number of organizations involved in GBV related service provision, namely:

- **Save the Children UK** for child protection and psychosocial support to under 18 years old;
- **Lutheran World Federation (LWF)** for camp management including general safety and shelter;
- **IRC Heath** provide clinical care for sexual assault survivors and those requiring medical care for GBV;
- UNHCR for protection concerns including GBV;
- **The Kenyan Police** for legal solutions to GBV;
- **Refugee Consortium of Kenya (RCK)** provide legal aid to GBV survivors to support them to pursue legal options
- **National Council of Churches of Kenya (NCCK)** work with women at risk due to sex trade and refer cases to IRC health and psychosocial actors

In addition to this, there are a variety of actors involved in broader service provision to the community including but not limited to **Education**: LWF and Windle Trust; **Food Security:** WFP; **Livelihoods**: CARE and NRC; **Shelter**: LWF; **Water and Sanitation**: CARE; **Latrine construction**: NRC.

The **Inter-Agency Standing Committee (IASC) Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence in emergencies (2005)** provide minimum standards that all humanitarian actors must take, from the earliest stages of an emergency, to prevent sexual violence and provide appropriate assistance to GBV survivors. This is designed to promote multi-sectoral coordination to ensure access to prompt, confidential and appropriate services to GBV survivors and the development of effective protective mechanisms to prevent GBV. Effective prevention and response require minimum standards across protection, health, shelter, education and security as well as effective information education and communication strategies to educate about GBV.

3.2 GBV coordination

At the Dadaab level, GBV is coordinated through a GBV Working Group that includes GBV, health, legal and security actors meeting monthly. Recently, this body has been decentralized to the camp level where monthly meetings are held with membership expanded to include community leaders, youth and women's representatives in efforts to increase community participation in GBV programming. The Dadaab level group now meets quarterly and the emphasis is on increasing community involvement in GBV programming at the camp level. Standard Operating Procedures (SOP) have been in place since 2005 and were developed in collaboration with community leadership and implementing partners and these are continually revised. However, there is inconsistent knowledge of these among relevant actors and their corresponding roles and responsibilities in part due to high staff turnover. Within the SOP's, there are opportunities to strengthen best practice with regards to confidentiality, consent, information sharing and survivor centered approaches. Awareness of the GBV SOP's is limited outside of the GBV working group with little focus on the communities' role in addressing GBV as outlined in the SOP's but there are plans to roll these out again at the community level. Despite the cooperative referral network in place, community participation in this and developing solutions to GBV could be improved. Information on the referral system is not widely known in the community and needs to be properly communicated to improve knowledge, access to and utilization of services.

In 2008, UNHCR rolled out the GBV Information Management Systems (IMS) among GBV partners in Dadaab to promote best practice in the collection, storing, management and sharing of GBV information. In December 2010, an Information Sharing Protocol was developed by GBV partners (IRC, CARE, SC-UK and UNHCR) to facilitate the sharing of non-identifying information and to safeguard survivors' confidentiality. At the camp level, IRC convene twice monthly case conferences to discuss cases that require interagency coordination, develop solutions and improve the existing referral network between IRC, SCUK, LWF, UNHCR and the police. Although a very useful forum, this could also be strengthened. At the community level, there is limited monitoring and evaluating of existing services and information on the effectiveness and responsiveness of prevention measures, judicial response and social support structures. Community based protections to GBV are inconsistent across the camp and need to be strengthened.

3.3 Protection- Legal

Despite national legislation to support equal rights, in practice, women in Hagadera experience a plethora of legal and societal discrimination. Women's rights are limited by Sharia law and the traditional systems which take precedence. The persistence of certain cultural norms, traditions and stereotypes, as well as de jure discrimination regarding their role in society, perpetuates violence against women and girls. Female headed households are even more vulnerable and actively discriminated by traditional systems and practices. The Sexual Offenses Act (2006) was enacted to ensure protection of adults and children who suffer sexual assault and there is also the draft National Policy on Human Rights and a National Family Protection Bill in Parliament (2010) which if passed will criminalize marital rape in Kenya. In 2010, Film Aid developed a film in collaboration with the refugee community to educate them on services available, GBV referral networks and sensitize the community on legislation. Trainings are provided by a variety of agencies to ensure information is disseminated to the community on existing legislation, services and referral systems/protocols. However, there are gaps in knowledge at the community level; many of those interviewed had limited understanding of the referral networks or services available. The Kenyan judicial system is alien to most refugees who lack an understanding of these structures and their rights. Pursuing legal remedy is not viewed as a viable option due to limited confidence in the formal judicial processes which lack local legitimacy. The dominant clan structure of the community results in most GBV cases being resolved by community clan elders, traditional and religious leaders, and the maslaha (the traditional mediation system). Whether utilizing traditional dispute resolution mechanisms or formal legislative frameworks including the Kadhi[15]; women's access to justice remains limited. The failure to protect the community and punish perpetrators makes GBV widely tolerated and underreported, with a prevailing culture of silence that renders women and girls unable to seek help, access health care or other services.

3.4 Protection- Security

Many GBV survivors do not request to be referred to the police; many incidents of sexual violence are not presented for medical treatment and are settled outside the formal legal system. There is conflicting information circulating in the community which deters accessing clinical care for sexual assault including a belief that cases **must** be reported to the police if medical care is sought. Insufficient police capacity to respond to GBV cases, a lack of adequately trained officers and female police staff, knowledge of and confidence in the formal system, all prohibit women from reporting. Distrust between refugees and police for reporting GBV cases prevails and many women and girls do not report for fear of reprisals from perpetrators, community and family. In Hagadera, there are currently 28 police officers to maintain security for a population exceeding 115,000 people as well as the local host community and UNHCR has advocating with the government to increase police coverage in Dadaab. There is only one female police officer, who is the GBV focal point. Recent attempts have been made by the Government of Kenya to increase the number of female officer nationally and the ratio across the country is relatively low. Complaints of corruption, abuse and mistrust characterize perceptions of the police within the refugee community. Inadequate police patrols, especially at night, contribute to overall insecurity. Refugees feel very unsafe at night, and women are reportedly attacked in their homes, other risk factors identified by women include firewood collection, inadequate supply of water, schools located long distances away from some blocks, the growing incidence of youth gangs, bandits and alleged presence Al Shabaab. A peace education programme is being implemented by NCCK to promote peaceful coexistence and Community Peace and Security Team (CPSTs) offer community level policing in the blocks. Ongoing host community tensions also contribute to insecurity exacerbated by the continuing registration of new arrivals and overcrowding within the camp.

3.5 Human Resources

Codes of conduct are in place for Implementing Partners (IP) and UNHCR to prevent Sexual Exploitation and Abuse (SEA). All IRC staff sign the code of conduct and the mandatory reporting policy, however there is a need for trainings on these to ensure they are institutionalized at all levels. Efforts have been made in recent months with additional technical support from HAP to strengthen the complaints and reporting mechanisms at the interagency level and develop a locally appropriate system across agencies and within the community. This has yet to be realized and requires increased attention both within the community, across IRC and at the interagency level. In 2010, HAP spent three months in Dadaab to strengthen accountability and provide support at both the organizational and interagency level. Key outcomes focused on the development of an interagency accountability working group to lead the process with recommendations for the creation of a Complaints and Reporting Mechanism (CSM). In May 2011, HAP will return for a mission to Dadaab to lead

[15] Kadi is a Muslim magistrate who has the power to adjudicate civil disputes according to Islamic law, Shariah law. Jurisdiction is limited to questions of Muslim Law relating to personal status, marriage, divorce or inheritance.

the development of a joint CRM at the camp and interagency level and provide additional technical support to partners in Dadaab.

3.6 Water and Sanitation

As outlined, overcrowding has led to a strain on camp resources, with the availability of water being a casualty of the situation. The ongoing drought in the Northeastern province does little to quell the need for basic resources. In Hagadera, some respondents identified a lack of operational tap stands and the need to walk longer distances as a contributing to conflict in the home and insecurity for women; CARE and UNHCR are currently trying to resolve this in certain sections. Currently, each person receives approximately 17 liters of water per day as compared to the SPHERE standards of 20 litres/day/person at a minimum. Often refugees are sharing their water ration with livestock, commercial and construction activities lowering the volume of water available for direct domestic use. The number of latrines is inadequate to meet the growing needs of the rapidly expanding population. Those that are available need constant replacement and there is limited space available for new construction, in particular, where new arrivals are situated on the periphery. Tensions with the host community prevent the construction of permanent ones in these areas.

3.7 Food Security and Nutrition

Food distributions are twice monthly and many women have ration cards in their own names. Reported abuse of cards is high, with regards to other family members showing up to benefit from distributions, in particular, in domestic disputes where women are on their husband's cards. Many interviewed suggested that some men leave the cards or rations in the shops to use as credit to buy mirra. Many complained of the inadequacy of rations to meet basic needs and some sell parts of food rations to earn cash to buy other items. Exploitation and abuse was also reported in the distribution of food which is a concern that needs to be confirmed. In addition, some women and girls reported threats of attack on the way to and from distribution sites.

3.8 Shelter, site planning and non- food items

Overcrowding in the camp has reached unprecedented levels, with the rapid and continuous influx of refugees doing little to alleviate the congestion and consequent insecurity. New arrivals, many of them unaccompanied females, lack safe shelter and live in tents and makeshift tukuls on the periphery of the camp; this fails to offer any protection exposing them to risks of insecurity and abuse. Until a permanent solution is agreed with the Government of Kenya in relation to the new camps, this situation may continue to worsen in coming months.

In Hagadera, there is no temporary safe house, some serious GBV cases are occasionally placed in the transit centre temporarily, however, this also houses new arrivals occasionally and is not appropriate. There is one safe house, the Safe Haven in Ifo, which is available for extreme cases. GBV survivors also have unique protection needs which are often related to the provision of shelter (both temporary and permanent) that are a concern. Temporary shelter solutions for GBV survivors are limited; IRC and LWF often utilize informal networks, through the women's affairs committee (female section leaders) and other community based structures to identify temporary shelter, although this is ad hoc and not always reliable. There have been a number of cases where the individual hosting the survivor has come under threat and harassment. Temporary shelter for GBV cases that cannot be dealt with at the community level need to be more easily accessible including options to deal with survivors who are facing extreme insecurity. Shelter solutions for GBV survivors who wish to remain in the camp are limited if they do not have access to plots, since December 2010, a minimal number of cases have received shelter in response to GBV related issues. Those that were prioritized for shelter, received tents and were given space in I11 where there are growing concerns about the safety and security in this area.

UNHCR provide sanitary materials to women and girls of reproductive age and other agencies also provide additional supplies through their networks. Lack of access to fuel is a residual problem that places women and girls at increased risk of assault when they go to the bush to collect firewood. To mitigate the need for this, GIZ provides some firewood yet this is insufficient to meet the needs of the community. Environmental strategies have been introduced to reduce to use of natural resources. A number of agencies are involved in promoting the utilization of fuel efficient stoves, in particular, to vulnerable groups including female headed households in the camp. Several tree nurseries have been established but insufficient to address the rapid degradation of natural resources in Dadaab.

3.9 Health

The IRC operates a 120 bed capacity hospital that provides inpatient as well as outpatient services. Emergency obstetric care is provided through the maternity ward where medical care is available with an operating theatre for emergency surgical interventions on a 24 hour basis. The IRC operates four health posts located in the community each with a catchment population of approximately 20,000 beneficiaries offering

outpatient services to both adults and children, maternal and child health clinics where antenatal and post natal follow up are done, and children also receive vaccinations. The health posts operate laboratories that perform simple investigations; mainly antenatal profiles to pregnant women attending the antenatal clinics. Maternal mortality and morbidity remain a concern in Hagadera, although progress has been made in increasing skilled attendance at delivery and in antenatal care attendance with 90% of deliveries occurring in a health facility and 94% attended by skilled staff. There has been a general improvement in the various reproductive health indicators with 95% of women completing the recommended four antenatal visits. However, strong traditional and cultural beliefs hamper timely referral to health facilities and consent for procedures, anemia in pregnant women and hypertensive disorders in pregnancy remain significant problems. Complaints over the availability of the ambulance are high, many women wait until a critical stage to go to the hospital and this can lead to complications. HIV prevalence is low in Dadaab, at 0.8% against a national prevalence of 7.4%. Levels of awareness on HIV is low with few people seek counseling and testing services since there are high levels of social stigma experienced by people living with HIV and AIDS (PLWHA). The IRC implements a community health program that serves as a link between the health programmes and the community. Currently (March 2011), there are 86 community health workers, 13 family health care providers, 11 EPI vaccinator and 1 disease surveillance clerk. Through the community health programme, new arrivals in the community are identified and screened for health concerns.

Over 80 clinical and non- clinical IRC staff have been trained on the Clinical Care of Sexual Assault Survivors (CCSAS) and protocols were established and communicated to staff. A centre providing both clinical care and psychosocial support to survivors constructed by CARE has recently been operationised to improve confidentiality and quality of treatment for survivors. This is a centralized location where survivors can receive appropriate treatment in a safe environment. An internal referral system was developed with the health programme and will be supported by Information Education and Communication (IEC) materials with staff and the wider community.

3.10 Psychosocial

IRC GBV provides psychosocial support to adult survivors and SC UK to child survivors. IRC's GBV programme is implemented through a holistic, survivor-centred approach using women's centres as the entry point into the community. IRC has recently constructed the first of two women's centre in the community that will serve as a safe space for women and girls to access education, skills building and training as well as providing a place to access psychosocial support and GBV services. This broader access to activities and services acts to decrease the strong cultural stigma attached to being identified as a survivor of gender-based violence. Utilising a case management approach, the IRC coordinates GBV activities with other service providers and ensures that clients are informed to make decisions in their own best interests. Psychosocial support is delivered by trained GBV counselors who manage cases with the aim of empowering the survivor as she chooses her course of healing and recovery. Respecting confidentiality and the survivor's wishes, IRC staff coordinates the client's consent-based referrals to health, protection, and legal services to ensure that they receive the best available support, reducing the harmful consequences of violence and preventing further harm. Counselors also follow-up with survivors to support them implement their safety plans and ensure they are receiving appropriate services and care. In order to increase awareness of GBV and strengthen protective mechanisms and services available to women and girls, the IRC works with 20 community workers that serve as a link between the GBV programme, women's centres, and the community. The community workers encourage health seeking behaviours among GBV survivors, facilitate access to services through referrals, conduct informational outreach and educational campaigns, as well as discussions at the camp level to build community support and promote behaviour change.

SCUK have two Child Friendly Spaces (CFS) in Hagadera. Care livelihoods and NCCK offer livelihoods support and training to vulnerable women and NRC have a Youth Education Project (YEP) targeting males and females. Although there is an active youth umbrella, women's networks are still in their infancy but emerging. Inadequate income generating activities contributes to increased risk of violence and there are few opportunities in terms of return, jobs income for the future that leaves people frustrated.

3.11 Education

While there have been routine improvements in access to education, young girls are less likely to attend school than young boys and also more likely to leave early with marriage the immediate option. A number of initiatives including the World Food Programme (WFP) and interventions from CARE and SCUK has contributed to improvements in girl child attendance and completion rates. Despite this, half of all school-age

children remain[16] out of school and growing enrolment figures are met with high levels of early school leavers. In Hagadera, educational disparities reflect gender inequalities that begin at birth and proceed to primary school increasing sharply in secondary school. With the increase in population, the education infrastructure cannot absorb the number of school-age children. Presently, the ratio of classroom per student is 1:103. Secondary school enrolment, 2,692 (627 Girls), represent 7%[17] across the three camps. There are four YEP vocational training centers run by NRC with a capacity to accommodate 600 students per year (150 per camp and one in Dadaab town). For safety reasons and cultural beliefs, girls access to education is also restricted due to distance to the school and fear of attack enroute to school. The opportunity cost, in terms of participating in domestic labour, also limits attendance. The high illiteracy rate among females means they are more disadvantaged in developing productive and entrepreneurial skills. There are very few opportunities for post primary education and a lack of jobs in general.

3.12 Information, Education and Communication (IEC)

There are a wide range of Behavioral Change Communication[18] (BCC) materials and strategies used in Hagadera with varying degrees of success, mostly focusing on FGM. Knowledge about FGM has increased significantly, yet the practice remains common. Across the camp, there is a lack of a consistent BCC strategy to guide materials and messaging. Limited knowledge on the GBV referral systems and services available indicates an unmet need for information campaigns and trainings at the community level to be complemented with appropriate IEC materials on the referral pathway in the local language and with pictures to increase understanding of the referral network. IRC's BCC Manager recently conducted a GBV BCC assessment of available BCC strategies and materials used both within the camp and across other IRC programs to examine their effectiveness, and appropriateness within the Somali community.

Key findings from this assessment will be important in supporting the GBV programme develop culturally relevant communication materials, address gaps in information dissemination and ensure messages are consistent and promote positive behavior change related to GBV. From the GBV BCC assessment, target groups identified radio, billboards, posters, community discussions at the block level by agency workers and mobilization and information dissemination at the market and distribution centres as the most effective channels of communication with some variance across target groups. The need to support the creation of an inter agency team to coordinate the dissemination of messages was apparent to minimize duplication, reduce confusion among the community and ensure consistency across messaging. The community also expressed high interest in directly developing messages and materials with agencies to ensure these are culturally sensitive and display appropriate images and messages. The need to avoid negative imagery like depicting an act of sexual violence was highlighted. This focus on promoting positive images to support non violence and behavior change is a key element of the SASA! approach, a behavior change communication methodology developed by Raising Voices in Uganda to address GBV that will be utilized by the GBV programme in Hagadera.

16 In 2010, enrolment in primary schools was approximately 41% of the population of school-age children (3-13 years).
17 Total of population is 38,641.
18 Behaviour Change Communication (BCC) involves using communication and dialogue to help people move through the process of behaviour change, from being unaware of a problem to practicing sustained behaviour change.

4 Findings

4.1 Gender Based Violence in Hagadera

Violence against women is widespread and pervasive including early and forced marriages, psychological, physical and sexual violence. The exact nature and scope of GBV in Hagadera is difficult to measure given the high level of underreporting, especially for sexual violence. Focus Group Discussions (FGD) and Key Informant Interviews (KII) revealed that many forms of GBV are endemic, but overall the types of GBV perceived to be most prevalent were:

Perceived forms of violence	
Domestic Violence	"*Some men believe women are goods that they bought"* Female FGD
Forced Divorce	*"Divorce leads to stigma, you had a name before but now you become the divorcee'; the children may also be grabbed as a result of divorce; the man may withdraw his support for the family"* Female FGD *"Forced divorce never happened in Somalia, now men in the camps are idle and have nothing to do, they leave the woman and child"* Female FGD
Rape	*"At the household level, girls may go to the bush to collect firewood and be raped, the police do not make strict follow up and girls fear reporting these cases. This may increase the cases that are taking place as there is no punishment"* Adolescent Girls FGD *"Women cannot go to the bush for fear of rape, not enough fire wood is provided and they have to go though, at nighttime many women feel unsafe, fear men will attack them at night'* Female FGD
Forced and early marriage	*".. girls have two choices, either to be blessed or cursed by her parents, the blessing is the marriage and the curse is refusing the marriage and then she is turned out and runs away after been beaten by her parents"* Adolescent girls FGD *"a man with cash comes to the father with money, sometimes the mother and daughter do not want her to marry but the father forces her anyway"* Female FGD
FGM	*"FGM is harmful in the Somali community"* Female FGD *"In class 3 or 4, girls are taken to be cut and it makes education to be difficult"* Adolescent male FGD
Marital rape	*'When a husband and wife don't agree, men use force, women won't tell anyone. If the parents of the girl are supporting the marriage, they cannot seek help. In Somali culture, if a husband rapes there are no rules governing this."* Female FGD
Wife inheritance	"*Forced inheritance- it happens but not as much, the brother will offer to care for the wife, it's forced sometimes"* Female FGD
Economic abuse	*"Lack of financial security- mothers are not able to provide for their family*" Male FGD
Denial of opportunities	*"There's a belief that the girl will be married and will go to the husbands family, this stops parents sending girls to school" Adolescent female FGD*
Sexual exploitation and abuse	*"Teachers ask for sexual favours at school"* *"Sometimes at school during exams, the teachers say I will make you number one in the class if…"* Adolescent female FGD *"At the distribution sites, you are told you can be first in the line if….."* Female FGD

Specific vulnerability of Adolescent girls

In Hagadera, adolescent girls are particularly vulnerable to multiple forms of GBV. For girls, adolescence brings isolation and a confinement to the private sphere as they are withdrawn into their homes for their protection; they are more likely to experience violence such as FGM, sexual exploitation, rape, forced and early marriage. Limited extracurricular activities, weak support systems, and expectations to assist with household chores also restrict girls' opportunities to develop skills and participate in education. Girls are expected to contribute heavily to household chores which limit their capacity to succeed in school. *'There are few girls in school, busy at home and working, this means they perform badly in exams and can't compete with boys as they are overburdened".* In addition, the opportunity cost of sending girls to school often takes precedence.

"Parents believe that if girls go to school, they will marry and help with their husbands' family and not with theirs" Adolescent male FGD

Fear of attack on the way to and from school and the absence of a male relative to accompany girls can at times prevent girls attending. "*If there is one daughter in the family and she is going to school, she can't go as there is no family member to protect her".* Adolescent girls in FGD's alluded to sexual exploitation within the education system where male teachers reportedly demand sexual favours for good exam marks. Girls who do not attend school are often engaged in domestic chores but many work outside the home in tea shops or selling products at the market, cooking and cleaning in other people's houses which can also increase their risk of sexual assault and exploitation.

In the predominately Somali community, women and girls signify family honour and their behaviour is controlled to protect this, their weak status is directly related to these gender biased socio-cultural and religious barriers. *"When parents see their daughters talking to boys, they suspend the girls from school because they suspect she has a relationship with the boys she was talking to"* Adolescent female FGD

Having children out of wedlock is heavily stigmatized and young girl's interactions with men are restricted. However, pregnancies out of wedlock do occur and can often lead to young girls been abused and turned away from the family home. With no family protection, these girls face severe difficulties in surviving and are often abused and harassed and some are forced to relocate to other camps to escape this.

"*Her whole family will be stigamtised by her having a child out of wedlock and the family might be abused. If they have had a relationship and the pregnancy comes, the man might deny. The dowry price is very low if she is pregnant"* Male FGD

4.2 Nature and Scope of Violence

4.2.1 Domestic violence, economic abuse and forced divorce

Domestic violence was identified as widespread and to some degree acceptable in the community. The mutually reinforcing relationship between economic insecurity and domestic violence was also apparent. Common contributing factors to domestic violence were linked to poverty, a lack of resources, limited opportunities for employment and unequal decision making between men and women. According to FGD's and interviews, levels of domestic violence in Hagadera are endemic, with younger women more vulnerable. Violence and intimidation from ex-husbands/partners is also of great concern, with abuse continuing even after divorces are granted. Chewing mirra, financing this and the idleness among men in the camp setting were also identified as triggers for violence in the household. Interestingly, both male and female FGD participants highlighted the payment of the bride price and polygamy as driving forces for domestic violence. (See 4.2.3 early and forced marriage)

"Domestic Violence is caused by economic problems- if a father takes the ration card and collects the rations and brings to the shop for credit to pay bills, this leads to domestic violence." Female FGD

Related to the issue of domestic and psychological abuse is forced divorce which is reportedly common. Females in FGD's noted it can result *"if you are suspected of affairs, if you fail to clean the home….: the stigma for divorce depends on why she has been divorced."* Increasing rates of abandonment, separation and divorce were noted. Although prevalent, divorced women are stigmatized and increasingly vulnerable economically as many husbands refuse to support the family and they which are at higher risks of other forms of GBV including sexual violence as they lack male protection. Although less common, forced wife inheritance was also identified as a problem.

"Divorced women are vulnerable, if they are still producing they may marry again, but the second husband may not accept the other children and refuse to support them." Female FGD

4.2.2 Sexual violence

According to FGD's, sexual violence, including rape, defilement (child sexual abuse) and sexual assault is more pervasive than reported cases indicate. On average, two adult cases are reported monthly to IRC GBV programme but discussions with the community reveal underreporting. Sexual violence and fear of sexual violence permeate the lives of women's and girl's, they fear assault going to the bush to collect firewood, when walking in the blocks unaccompanied by men especially early morning or evening and at night in their homes. Young girls without a male relative to protect them on the way to and from school are also vulnerable to assault and this often acts as a barrier to attending school.

'Women are just like raw meat, if they go out alone, they will be raped" Female FGD

Going to the bush to collect firewood was consistently identified as one of the principal risk factors for sexual assault. *"The distribution of firewood is not enough; women don't have enough money to buy it and are raped when they go to the bush"* Male FGD

Rape is also reportedly more common among female new arrivals, who are highly vulnerable often lacking strong familial protective mechanisms, living in flimsy structures that are easily accessible. Some of the new arrivals are living on the outskirts of the camp lacking basic amenities including adequate water and sanitation.

"Rape was lower but now it is getting higher as there are growing numbers of new arrivals, overcrowding and a lack of firewood and this increases rape" Female FGD

Marital rape was also frequently mentioned by men and women but it is shrouded in secrecy and few would ever openly admit experiencing it in the community or seek support. Some noted that many cite domestic abuse in thinly veiled attempts to address the problem of marital rape.

'When a husband and wife don't agree, men use force, women won't tell anyone. If the parents of the girl are supporting the marriage, she cannot seek help. In Somali culture, if a husband rapes there are no rules governing this..." Female FGD

4.2.3 Early marriage

Marriage arrangements are signified by the payment of the *'bride price'* that can often lead to considerable age differences between bride and groom, due to the wealth demands. Polygamy is supported by Islamic Sharia law; certain conditions apply to polygamous marriages, such as the equal treatment of all wives, but these are not always observed. Women have low levels of protection within the family or right to choose a partner, girls are generally married at a young age (approx.15 years) with forced marriage common. Levels of education across the camp are low and half of all school-age children remain out of school with young girls less likely to attend school than young boys and more likely to leave early due to early and/or forced marriage. As such, girls' opportunities to continue their education and develop their knowledge and skills are severely limited. This has implications for their reproductive health, education and long-term livelihood options.

"There's a belief that the girl will be married and will go to the husbands family, this stops parents sending girls to school" Adolescent Male FGD

Financial difficulties are often a stimulus to this process and the 'bride price' is an important mechanism to alleviate poverty. Early marriage can lead to situations where a girl's health is compromised from early sexual activity; the girl is deprived of formal education and forced into marriage at a young age with early pregnancy having disastrous consequences on her health. Many young girls become pregnant soon after puberty. The 'bride price' was frequently identified as a leading cause of violence and young women without strong familial support are more vulnerable. Girls have little or no choice in situations like this and are expected to marry who their parents' choose for them. Both young and older women noted that arranged marriages by parents, and which are not consensual, contribute to domestic violence and subsequent vulnerability.

'All responsibility goes to the parents, if they want a girl to marry, she has no choice' Adolescent females FGD

4.2.4 Female genital mutilation/cutting (FGM/C)

FGM is widely practiced in Hagadera and while there have been sustained campaigns targeting this practice, it remains ubiquitous. FGM was identified as one reason why girls are not in school, *"in class 3 or 4, girls are taken to be cut, and it makes continuing education difficult".* Some participants noted that uncircumcised girls and their families living in the camps suffer discrimination at the community level and have difficulties marrying. Marked improvements have been made in galvanizing support from religious leaders to address FGM, highlighting it as a traditional rather than religious practice. While awareness on the negative consequences of FGM are present, these have not resulted in tangible declines in the practice, traditional beliefs permeate including that *"(with FGM)... a woman is protected from promiscuity, she will be good and not involved in prostitution."* Those interviewed who are residents from the early 1990's had a greater willingness to identify FGM as a harmful practice compared to those who arrived in the last few years or more recently, but this recognition fails to translate into behavior change. FGM can also make sex painful for many women and this may lead to conflict in the home with marital rape common. Health staff interviewed also noted that FGM complicates the care and treatment of GBV survivors, some forms of FGM seals or narrows the vaginal

opening and is ripped during sexual assault. It increases the possibility of internal injuries and heightens vulnerability to the transmission of STI's including HIV.

4.2.5 Sexual Exploitation and Abuse

Complaints of sexual exploitation and abuse were extensive and transcended all service providers from health, to food distributions, to the police, across schools and the resettlement process. The inadequacy of existing complaints and reporting mechanisms was evident, limited knowledge on the reporting systems, accountability, follow up and feedback were all identified by participants as barriers to reporting.

"It happens most of the time at the health posts, schools and the girls don't know where to report" Adolescent female FGD

Of particular concern was the magnitude of which these abuses are reportedly occurring including

- *"Sometimes school during exams, the teachers say I will make you number one in the class if…:*
- In the police*, "we'll arrest someone if..."*
- At the distribution sites *'you can be first in the line if...*
- *"At resettlement for the cases to be referred"*

4.3 Most at risk

Although many women and girls fear multiple forms of violence, some are more vulnerable than others. In Hagadera, adolescent girls are particularly vulnerable to multiple forms of GBV, other groups most at risk are:

- Single mothers with children out of wedlock
- Divorcees, widows and female headed households
- Unaccompanied girls whose parents are dead or those not living with their parents
- Newly arrived females who have limited knowledge of the formal and informal systems in the camp
- Women who are raped experience stigma and are vulnerable to other forms of violence

Within the community, specific locations were identified where women and girls are at higher risk including when they go to the bush to collect firewood, at the tap stands in the early morning and in the market. Distribution stands, health posts, schools and police stations were also highlighted as places where women and girls are vulnerable to violence which highlights concerns of exploitation and/or insecurity en route and at these places should be addressed. Attacks are also common in the home at night; women and girls without any male protection are particularly vulnerable. Some blocks lack access to appropriate water and sanitation facilities and they have to walk longer distances to access these and participants in these locations identified this as a risk factor for attack especially at nighttime. Young girls also highlighted increased vulnerability to assault during calendar events.

Generally, late at night and early morning were also identified as times when women and girls are vulnerable to sexual assault. Both male and female participants were reticent to discuss the likelihood of rape among men and boys but some stated that if it occurred, it would be unlikely to be reported unless the survivor was a very young boy.

4.4 Causes and contributory factors for violence

The population in Hagadera is highly heterogeneous with variance across ethnicity, time of arrival and clan. Despite this, there are some common contributory factors for the multiple forms of GBV present in the camp.

4.4.1 Overcrowding and lack of security

Camps are becoming increasingly over crowded as many people continue to flood across the border daily to escape the worsening insecurity in Somalia. Some participants identified the overcrowding in Hagadera as contributing to sexual assault. As the camp services buckle under the strain of the growing number of refugees, competition for basic amenities like shelter, water and sanitation facilities magnifies. Increasingly, new arrivals, many of them unaccompanied females, lack safe shelter and live in tents on the margins of the camp; this fails to offer protection exposing them to risks of physical insecurity and abuses. Since January 2011, over 37,000 refugees have been registered in Dadaab. Despite ongoing negotiations between the Government of Kenya and UNHCR on opening the new camps, the situation looks likely to worsen in the coming months.

"People are living here together; they are not closely related and have learned to live together. If a rape happens in the block at night, sometimes no one goes immediately to help for fear of attack because they are not a relative" Female FGD

The need to provide a safe environment to reduce many of the structural causes of GBV was highlighted, in particular, for new arrivals who have limited access to safe shelter, latrines and water. Until more permanent options are found to house new arrivals, responses need to take into consideration the specific protection concerns of the newly arrived women and girls.

4.4.2 Insufficient police capacity

UNHCR has been working with the government to increase police numbers in Dadaab and much investment has been made by many actors in building police capacity on GBV in particular, RCK, UNHCR, CARE and SCUK, however, gaps in dealing with GBV remain. Insufficient police capacity to respond to GBV cases, a lack of adequately trained and female police officers, knowledge of and confidence in the formal system, all prohibit women from reporting. Police patrols in the camp are insufficient to address the security needs especially at night which leads to a situation where few leave their homes after dark. Even with these precautions, women and girls are reportedly sexually assaulted in the blocks and in their homes at night. The lack of police presence, capacity and expertise impedes the protection of women and girls from violence. Unsuccessful investigations follow up and failures to prosecute GBV cases contribute to an environment of impunity that marginalizes survivors and discourages reporting and help seeking behavior

4.4.3 Lack of economic security

Poverty and financial insecurity were identified as catalysts for both domestic and sexual violence. Economic deprivation was emphasized as both a type of violence and contributing factor to other forms of GBV. A lack of resources to support the household, limited opportunities for employment and the 'idleness' of men contribute to GBV. In displacement settings, traditional gender roles change as men are no longer the principal provider for the family, normal family and community protections and support systems also break down which can lead to increases in violence in the household. The loss of livelihoods, absence of opportunities and resultant frustrations were apparent among men and women. In Somalia, men were used considered the household heads providing for the family and were engaged in farming, rearing animals, trading and business while women also cultivated crops and sold products at the markets and had small enterprises. In the camp, there are limited economic opportunities and employment, the vast majority of men and women are unemployed, although some men make a living pushing wheel barrows, collecting firewood to sell and work for agencies while some women are able to supplement the family income washing clothes and cleaning for others. The daily lives of women are punctuated with domestic work and attempting to get some meager income. The lack of livelihoods and an overdependence on rations inadequate to sustain households past their immediate needs often contribute to arguments at the household level which can escalate into violence. These can result in divorce, which also leads to increased vulnerability among female headed households to other forms of GBV. Women usually assume overall responsibility for their family and divorce can lead to conflict over household plots and ration cards that place women in a risky position. The need to increase opportunities for livelihoods and income generating activities was apparent across all groups. Female participants requested support in education, employment and skills training to afford them some level of independence. Resource shortages also lead many women to engage in risky behaviours like going to the bush for firewood to assist the family fuel needs placing them at an increased risk of sexual assault.

Young girls who are out of school often find employment selling products at the market, working as house maids or at food distributions which can also increase their vulnerability to exploitation. Young men, especially those not engaged in education, were identified as perpetrators of sexual violence *'girls go to the bush, men who are not married due to a lack of finance are more likely to go and rape women'* The inability to provide the 'bride price' limit opportunities for marriage and reportedly leads some youth to commit sexual assault.

"In Somalia, before the war, there were less rape cases and here, more youth are idle and chewing mirra" Female FGD

4.4.4 Collecting firewood

The risks associated with firewood collection are well documented in Dadaab and led to a number of actors providing firewood and promoting fuel efficient stoves to reduce the need for firewood. However few effective fuel-related protection strategies are in place to combat the on-going risk of sexual assault. The need to go to the bush to collect firewood was consistently identified as the key risk factor for sexual assault among women and girls. Safe access to cooking fuel is critical for survival, however, women and girls, spend a significant amount of time collecting wood and are placed at a high risk of attack. While women and girls engage in firewood collection to fulfill immediate basic needs, if and when men are engaged, the activity tends to be economically motivated. Men who have access to donkey carts collect wood and sell it at the market. Women

often buy it to prevent putting themselves at risk and use food rations to pay for this, but many women are unable to afford it.

When asked why men did not accompany their daughters or wives to protect them while collecting firewood, responses converged on cultural beliefs *"In our culture men cannot carry firewood on their back, if they do not have a cart, women go alone"* and on physical threats to men if they accompany women to the bush.

"Men do not accompany women for fear of been injured. Many fear the perpetrator will kill the husband and rape the wife if he accompanies her, it the two of us go, who will care for our children, it's better one goes and another remains behind." Male FGD

4.4.5 Lack of decision making power

Discriminatory attitudes and practices further exacerbate GBV in Hagadera. The patriarchal nature of Somali society results in males remaining the dominant decision makers in the public sphere with women continually under represented. At the household level, a strong tradition persists of maintaining the low status of girls and women and this extends through marriage practices and throughout society as a whole. Most women are not allowed to speak freely in the community *"you are told you are a woman, go away. Women always fear some sort of violence".* Their role in the family, community and wider society and therefore ability to influence decisions is subjugated by men. Women's empowerment is hindered by a wide variety of obstacles including poverty, economic dependence, illiteracy, lack of participation in decision-making processes, and lack of access to social services such as health and education. This is compounded by their lack of access to justice making GBV widely tolerated and underreported. With poor education levels, high illiteracy and few marketable skills, women face many challenges in developing their productive capacities and entrepreneurial skills. Women's weak rights render them highly vulnerable, impoverished and actively discriminated against under religious and customary laws.

Existing women's networks and support systems are limited but emerging and there are growing numbers of women's groups in Hagadera. Some of these come under 'Together Women', a women's umbrella, however, many groups also fall outside of this. Many women are also busy in the home and this prevents them from joining women's groups without some visible and immediate benefit. During this assessment, few women interviewed participated in a women's group. The need to strengthen existing women's groups and promote female participation in decision making was apparent.

Profile: Together Women

In 2007, women from different sections of the camp come together to form Together Women. They have a training centre located on the outskirts of the camp near the police station and provide skills training in tye & dye, embroidery, looming. They are also involved in ***'ayuuta'***, a savings and loan scheme for members. They started themselves with some assistance from UNHCR, CARE and LWF. Currently, they have 160 members with 20 group leaders that all come together under the Together Women umbrella.

Membership criteria include the need to be over 20 years, not in full time education, displaying a willingness to learn and participate on a voluntary basis. The group is also involved in assisting new arrivals with information and basic needs. The limited institutional capacity of 'Together Women' is a barrier to increasing membership; they cannot currently absorb all the women's groups in the camp and lack strategic leadership and direction. Their training venue is also very small and can only house a few women. In February, they trained 30 women, from 3 groups, across a number of sections on tye and dye. However, material is expensive and the market is limited. They target and work with vulnerable women and would benefit from additional support to strengthen their organizational capacity.

4.4.6 Lack of male protection

Weak familial support, in particular for women from minority clans and those without male relatives place females at increased risk of GBV. FGD participants noted that women without male relatives are among the most at risk. This is a diverse group and can include female headed households, widows, divorcees, single mothers and new arrivals who have come ahead of their husbands and brothers. Newly arrived young girls are also vulnerable to abuse and lack the normal protective support which limits girl's access to education and opportunities. They also lack knowledge of available services and at times are housed by distant relatives who may abuse them.

4.4.7 Polygamy

The practice of polygamy is culturally acceptable and was identified as a leading cause of domestic violence, desertion and divorce. Men often have more than one family, their ability to support their families is severely

limited and this contributes to violence against women. In Hagadera, there are high levels of divorce which can expose women to other forms of violence and threats. Despite its frequency, divorce is stigmatized and this coupled with financial insecurity can lead some women to remain in abusive relationships.

4.4.8 Violence in Somali and enroute to Dadaab

Violence in particular, sexual violence, is increasingly recognized as a weapon of war used to terrorise and humiliate. Taking into consideration the longevity of the conflict in Somalia, where sexual violence is reportedly prevalent, many in Hagadera have been exposed to violence either in Somalia or en route to Dadaab. While the occurrence of sexual violence, both in Somalia and on the way to Dadaab was acknowledged, participants in the FGD's highlighted a reluctance to report or seek medical attention. Those who arrived in the early 1990's noted marked improvements in the levels of security for women and girls in recent years as compared to the levels of sexual violence in the camps during the late 1990's. However, they also cautioned that the influx of new arrivals, overcrowding and a general lack of security threatened gains that have been made. Concern over the recent alleged abuses by the Kenyan police resonated across discussions emphasized the need for further action to protect women and girls.

"In 1991, there was a lot of violence in the camps, it got better but this year we remember 1991. Women are still not safe outside or inside the camp. If you flee from your country, you are crossing the border and violence starts from there. A woman is not safe coming from the border and can be raped either by the police or by bandits. UNHCR need to register at Liboi or stop registration all together to keep women safe." Female FGD

A related issue is access to camp based services for GBV survivors who experienced violence prior to arrival in the camp, which represents a vacuum in service delivery and utilization. Few cases present for either medical or psychosocial support for sexual violence experienced prior to arrival. Screening of new arrivals needs to systematically include GBV staff to provide information on available services, coordinate follow up and offer support. Concern at being identified as a GBV survivor and the potential stigma and discrimination that often accompanies sexual assault coupled with a lack of knowledge of and confidence in the GBV services as well as fear of repatriation limit reporting.

"…we went to the transit centre and to the women there (after the recent incident) and they said they had been raped too. They refuse to go to the hospital as they don't want to be identified." Female FGD

"Locals and the police attack women, you cannot come with goods and women are raped, you hide it as you are ashamed, when you get to the camp you settle away from others you travelled with. Many fear police will send them back to Somalia- fear of stigma and reporting" Male FGD

4.5 Attitudes towards survivors of sexual assault

Widespread practices such as blaming the survivor, shame, stigma, fear of reprisals and threats of rejection by families and the community are powerful deterrents to reporting. Cultural stereotypes and traditional beliefs also prevent women, girls and their families from reporting rape and defilement with potentially life-threatening consequences. A lack of knowledge about the consequences of GBV also limit reporting which can include severe emotional and physical trauma, unwanted pregnancy, unsafe abortion, pregnancy complications and sexually transmitted infections (STI), including HIV. There was also consensus that many women are hesitant to, and do not report rape or physical abuse or seek remedial health services, for a variety of reasons.

Family members block leaders, and neighbors are often the first responders and if an incident is disclosed, determine how cases will be dealt with. However, although some women and girls may want sexual assault dealt with through judicial channels, they often lack familial and community support and fear stigma and discrimination. The disconnect between the survivors wishes, their families decisions, and the ultimate course of action taken was highlighted and this places the survivor's health at risk. The collective decisions that are often required to pursue either the formal or traditional judicial systems fail to adequately respond to the health needs of the survivor with the focus on crime more than the health consequences.

"Many girls that experience violence go immediately to their parents to tell them. Parents try and resolve it with the perpetrators family and if this doesn't work they go to the police" Adolescent Female FGD

Seeking health services and pursing legal (formal/informal) channels is often determined by whether or not the perpetrator can be identified and if there were any witnesses. Unless, it can be proved beyond reasonable

doubt that rape actually took place, families do not report or seek medical attention. For young women, the consequential impact on marriage prospects also affects reporting.

When asked how sexual assault survivors are treated by the wider community, prevailing levels of discrimination and stigma were identified.

- *'Men won't marry her, she's no longer a lady, she's broken."* Female FGD's
- *"Depends on the situation, she may be able to marry, but pregnancy out of wedlock is a shame, if it is pregnancy out of rape, she is sometimes forced to marry the perpetrator"* Female FGD's
- "*Sometimes the raped woman is blamed, if she goes out at night, they say that she planned for it and she was the cause"* Male FGD

4.6 Responding to GBV

4.6.1 Traditional mediation systems and structures

The traditional dispute resolution mechanism known as the Maslaha comprises of Somali males in the communities including religious leaders, community elders and block/section leaders. The Maslaha is constituted on an ad hoc basis and the composition varies, but the system is clan based and a powerful mechanism for dispute resolution despite its lack of formal structure.

"Without us nothing can be solved in the community" FGD Community Elders

There is a loose criteria for selection to participate in the Maslaha including if a person is a head of the clan; educated; a strong orator; or over 40 years old. There is tension between these and the formal judicial structures that often operate in parallel and opposition of each other and there is a perception that most cases are not reported to police but resolved using the Maslaha system in Hagadera. Although efforts have been made to integrate the Maslaha system into the existing GBV referral network and ensure cases of sexual and domestic violence are not dealt with by them but referred to the police, this has had limited success with most cases of domestic violence and some sexual violence incidents still resolved by them. GBV, including sexual violence, is commonly treated as a private matter that should be resolved within the family or community using traditional processes rather than within the formal judicial system. It is only the most serious cases that come to the attention of the police, usually those involving children or rape, which may explain the comparatively high numbers of child GBV cases reported. A 2010 GBV Knowledge Attitudes and Practices (KAP) survey by Film Aid indicated about 42.4% of the GBV survivors interviewed sought justice from the traditional conflict resolution mechanism. These systems are present across the camp and the most common resolutions involve monetary compensation where a fine is paid with a promise not to re-commit the crime. Maslaha elders identified conflict resolution and peacekeeping as their main roles, negotiating in cases of physical assault and family disputes. The elders interviewed who participate in Maslaha emphasized that they are not involved in resolving cases of rape, defilement or extreme discrimination based on clan/tribe.

"New arrivals may be more likely to use Maslaha, rape cases cannot be solved by Maslaha, in the past, 4 cows were paid in Somalia, and she is forced to marry the perpetrator if pregnant" Female FGD

These traditional justice systems are quite effective at dealing with certain issues, they are inexpensive, efficient and their rulings are adhered to some extent. However, they are not recorded or monitored, are male dominated and those in decisions making roles are open to manipulation. There are very real concerns for how women and girls are treated and they often contradict international laws especially on the rights of women and children. The family calls the elders and the men of both sides meet and discuss; compensation is agreed and paid. The survivor is not involved in the process and the male family members make the decisions and these may disregard the wishes of the survivor.

"Before it reaches the bigger clan, the immediate family tries and resolves it, it often begins with the neighbor who will intervene and go to the family. A meeting will be held, husband and wife are not present at the meeting, the council of elders represents them in the general meeting, and after a decision is made they come together and forgive each other. Representatives from both sides collect information, physical and emotional evidence and say what they have observed." FGD Community Elders

"If a husband beats his wife and there is a physical injury, he pays money and slaughters a goat for the victim to eat……..first we try and solve family disputes on a cultural basis and have rules to deal with this, if this fails it is brought to the Kadhi/religion" FGD Community Elders

The need to preserve the integrity of the family unit was highlighted, and although divorce is increasingly common in Hagadera, community elders emphasized the importance of keeping families together often at the cost of the woman's well being. It is only after repeated episodes of violence that divorce would be proposed. Those interviewed recognized the increased vulnerability of divorced women and the negative effects on the household, especially if husbands refuse to support the family ('pay the family bill').

"Often there is continuous negotiation done for the children, the husband is warned by the elders, if this doesn't work, they divorce. Under Islamic Sharia, the husband has to pay the family bill, if it doesn't happen and he fails to provide for the children, the children go to the fathers family' FGD Community Elders

Although elders interviewed denied that rape and defilement were dealt with by Maslaha, reports from police and other agencies involved in GBV indicate that many cases are resolved at the community level. At times, these may have initially been reported to the police but are retracted when the clan elders become involved. A number of male and female FGD's noted that cases of sexual assault are at times dealt with by the Maslaha and resolved in the following manner

"The maslaha system settles disputes through compensation. For survivors of violence, the perpetrator is asked to pay a number of goats (usually about ten) or for replacement clothes (about Kshs 5,000 ($80)) to the survivor's family" Male FGD

The elders outlined how rape cases were solved in the past in rural Somalia:
"The perpetrator was captured, if he admits rape, he used to pay dowry and other fees- four camels or the equivalent to the dowry and one more camel- xaal- to assist the healing of the victim. If he denies it, he will be asked to swear on the holy Koran, if he swears his innocence the man is allowed to go, it may happen that he lies but then God will punish him. …if she gets pregnant, the child is innocent and a man will marry her; our religion discourages rape'" FGD Community Elders

Responses to GBV vary and are dependent on the type of violence, if the perpetrator is known.

4.6.2 Domestic Violence

The clan/family is the first response for cases of domestic violence; it is only when these have been completely exhausted might a survivor approach agencies or the police. Again, this highlights the need to have strong family support systems to advocate and protect the rights of the survivor.

" Women go to their families for help, they then go to the clan of the husband and negotiate with the husband's family, the husband will be forced to slaughter a goat and to pay if she has injuries, if he beats her again and if it is the 3rd time, he is forced to divorce her and is fined money. This goes to her and her family- it's a good way to deal with it"

Some male and female FGD's felt that domestic violence is best solved at the clan level, if elders fail; it may go to the police and local Kadhi before being directed to the Regional Kadhi that comes to Hagadera monthly. Women who do not have support from elders are more likely to go to report to the police or Kadhi directly.

The Maslaha identified challenges in resolving GBV cases due to the presence of agencies and stressed the need to integrate the traditional structures into the formal systems, *"…. Elders listen to the husband and wife and reach a decision to resolve the issue; they both agree but then the wife reneges. She may come to the GBV office and report it and then the elders may think it has been resolved at the community level but then referrals are made to the agencies and elders are unaware of this. IRC needs to ask elders if it has been resolved at the community level, we need to work together more".*

4.6.3 Sexual assault

For cases of sexual violence, if the perpetrator is unknown and the survivor is unable to identify him, it is unlikely that any action will be taken or that it will be reported at all, many will not even seek medical attention or disclose the assault to anyone. Many believe that if sexual assault occurs, it **must** be reported to the police if they are to access health services. This leads to a situation where survivors do not receive appropriate medical care and treatment and can result in harmful health consequences which also contribute to further stigma and discrimination within the community.

"Many are raped and it's not reported, they do not want it shared for fear of attention and do not want to share the information" Female FGD

FGD's demonstrated enormous variance when asked how cases of sexual assault are dealt with, many noted that the Maslaha would resolve these while others argued legal action would only be taken if the perpetrator is known. There were also differences across groups depending on ethnicity and time of arrival with new arrivals from 2006 onwards having less confidence in and knowledge of the formal legal processes; the Oromo community was more resolute about reporting to the police. The age of the survivor and relationship to the perpetrator were also important factors in whether legal or even medical channels are pursued. There appears to be more of a willingness to report cases involving child survivors to both health, psychosocial and legal channels. Some FGD's noted that if the perpetrator is part of the family, cases will be dealt with at the clan level. Young women are also more likely to be blamed for sexual assault *'we as Somali are different, with different practices, we blame the woman".*

'If a woman goes to the bush, she will be attacked, the rapist won't care if she is pregnant or not. When she returns she will be abused and discriminated" Female FGD

Male respondents were more supportive of dealing with GBV cases, even sexual violence, through the maslaha, while females noted that although they may be able to assist with less serious cases of domestic violence, the police were best placed to resolve rape cases rather than through the Maslaha. However they raised concerns about perpetrators bribing the police when cases are taken there.

"The police station is a much better place to deal with rape cases for women, women will get justice in front of the law." Female FGD

4.7 Barriers to reporting and accessing care

4.7.1 Police

A lack of confidence in the formal judicial systems deters reporting. Perceived barriers to reporting include inadequate follow up by the police, low levels of successful prosecutions and police corruption. The police are tasked with issuing P3 forms to all survivors free of charge and referring all cases to IRC hospital for treatment, medical examination and completion of the P3 form. Some participants interviewed stated that the police can demand KSH 400 to have a case recorded in the occurrence book. Language barriers and survivors being requested by the police to bring witnesses were also highlighted as obstacles to reporting. Many fear the repercussions of reporting in particular community discrimination and abuse from the perpetrator if formal legal systems are utilized. The absence of a properly trained translator to work with the police and issues of confidentiality were also identified.

"The survivor has to identify the perpetrator, she may need witnesses and the man can be released after bribing, if the perpetrator is financially fine, they pay money to the police and to the family" Male FGD

The inadequacy of the formal judicial system also contributes to a high level of cases solved by the elders. Women and girls who have experienced sexual violence face a lot of discrimination.

"The perpetrator is fined; this is negotiated between the clans. Parents go to the clan of the perpetrator, discuss and negotiate with family members, the victim or perpetrator is not involved. The survivor is usually represented by other women, they go and look for proof, the mother and women verify proof (see if vagina is damaged) 44 goats if it is proven that the perpetrator did it, he is shamed. The man only faces problems for some days, girls for a long time; it's difficult for the girl to marry in the community then" Male FGD

"There can be an agreement between clans to pay a dowry for the women, usually 4 camels, it doesn't help the survivor as it goes to the clan and there's still stigma" Female FGD

Other barriers identified were that the family may hide the perpetrator or intimidate the survivor if they attempt to take legal action; this accentuates the need to have strong clan ties in the community.

4.7.2 Barriers to accessing health care and psychosocial support

"Girls/women feel shy to go to the police, fear others will find out and no one will marry her" Adolescent Male FGD

This leads to a situation where survivors conceal the assault, are unable to seek adequate medical attention and most cases are settled outside the formal legal system. Attrition rates of survivors from the hospital through to the police and judicial system is very high. Few cases are reported and there are even fewer

convictions of perpetrators. The duration between sexual assault and reporting varies but if reported, it is usually brought directly to the police before medical treatment is received which indicates that the community prioritizes this rather that health concerns of the survivor. Specific barriers were identified in accessing health care and psychosocial for GBV including the need to have a referral letter to access the hospital compound, insensitivity of the guards and being requested to disclose reasons for accessing the hospital which few are willing to do. The prevailing belief that survivors must report to the police to access health care need to be addressed. Efforts have been made to address some of these barriers including training guards and developing an internal referral system within the health programme from health posts to the hospital to promote confidentiality of reporting, but more needs to be done. Participants in Oromo block noted that they do not have a health post and cannot access Out Patients Department (OPD) easily; they are referred to the health post in E6 but are then directed to the OPD. IRC provides case management including psychosocial support, yet access can be impeded by its location in the hospital compound, the women's centres also serve as a reporting point for GBV. An internal referral system is finalized and communicated to staff and the community to ensure information is available. Trainings of guards on survivor sensitivity is ongoing but challenging with the continual turnover of G4S guards.

A related issue is the discrepancies that often arise when clinical staff fill in the P3 forms which are linked to the Post Rape Care Form (PRC1) and is intended to mirror the information on the PRC1 for judicial proceedings. However, P3's often fail to adequately capture the medical evidence required for legal prosecution. A training was held in 2010 to address some of the gaps and to improve understanding among doctors and police. More trainings are planned in 2011 to further address the problem.

5 Conclusions and recommendations

Effectively preventing and responding to GBV requires both the coordination and commitment from a wide range of actors, in particular, the community structures. The following conclusions and recommendations cut across both the institutional and programming levels within the IRC GBV and health programmes and also other partners in Hagadera. In particular, this assessment highlighted the need to work within recognized structures and frameworks at the community level to address the root causes of GBV and ensure that local networks are not undermined, reducing their ability to safeguard and protect women.

5.1 Improving GBV and health coordination within IRC

Internally within IRC, efforts to enhance GBV and health coordination need to be sustained; progress has been made on improving the relationship with clinical services. Centralised service provision in the IRC Support centre will increase the confidentiality and coordination of these services.

- High quality clinical care for sexual assault provided in line with WHO guidelines with refresher trainings on Clinical Care of Sexual Assault tool provided to staff to maintain skills.
- More staff within the GBV and health programme trained on trauma counseling and HIV adherence.
- Somali speaking nurses identified as GBV liaisons to work with the reproductive health doctor to provide care and treatment to sexual assault survivors.
- IEC materials developed to demonstrate treatment courses for sexual assault survivors and encourage strict follow up by the GBV and health team.
- The number of health staff should be increased (at least Community Health Workers) and all should be trained on monitoring and referring GBV cases in line with the internal referral system.

GBV and wider gender equality issues that influence access to and utilization of services should be mainstreamed across the health programme components (HIV, Community health, nutrition, clinical services)

- Joint campaigns on gender related issues should be carried out by IRC's community health and GBV workers and partners to increase outreach and ensure consistency across messaging.
- Informational and educational campaigns on the importance of accessing health care within 72 hours for sexual assault survivors is a priority to dispel myths surrounding the availability of services.
- GBV awareness-raising and behavior change activities will be coordinated with community health and at the health post to strengthen referrals, increase access to and utilization of services and emphasize the linkages between GBV and public health outcomes.
- Information should also be provided on GBV related services to new arrivals during the health screenings conducted by the community health programme. During registration, new arrivals are asked about experiences of violence; few currently report these or access appropriate care. More efforts are required to ensure they have access to information about available services.

5.2 GBV Coordination and referral systems

Although notable achievements have been made in strengthening GBV coordination, in particular, moving the GBV Working Group meetings to the camp level to increase community participation, more efforts are required to enhance interagency coordination and community ownership of GBV programming. The lack of awareness on the existing services (health, psychosocial, legal and protection) was a recurring feature throughout this assessment. Gaps in knowledge on the harmful health consequences of GBV, the existing referral systems and support available highlight the need for sustained and targeted campaigns to address this. Knowledge and awareness among young girls and new arrivals, in particular, are of great concern given their vulnerability to both physical and sexual assault and exploitation.

I. Improving GBV coordination

- A participatory revision of the current SOP's that includes community leadership structures and all partners would increase awareness and ownership. The roles and responsibilities within the procedures also need to be more specific and clearly communicated. A workshop to roll out the SOP's across agencies and the community is also a priority; this is planned by UNHCR in June 2011.
- Participatory annual reviews could also complement the current revisions.
- Identifying a core steering committee to attend the monthly GBV meetings at the camp level from community leaders, religious leaders, CPST's and representatives from Youth, Women and Disability groups would help ensure continuity of membership at the meetings.

II. Strengthening camp level referral systems and case conferences

- All service providers involved in the referral network need to provide detailed information on services available, processes and time lines to ensure survivors have access to the most comprehensive information that allows them to make informed choices about their course of action.

- At the camp level, improving the effectiveness of the existing referral system in particular, confidentiality of, consent based referrals and information sharing need to be improved. Referrals using the interagency referral form should be sent in password protected documents with accompanying agreed upon interagency referral cards to ensure easy and safe referral of cases.
- A ToR for case conferences should be developed to enhance the efficacy of these which should be reserved for cases demanding interagency action to explore solutions and holistic support for survivors.
- Appropriate IEC materials should be developed to ensure the referral systems by IRC and GBV partners are communicated to the wider community in local language and with pictures/diagrams through a variety of channels identified from the GBV BCC assessment, namely billboards strategically located across the camp within the market, distribution centre and health posts and radio programmes.
- As lead of health and GBV sectors in Hagadera, the internal confidential system of referral across health and GBV needs to be finalized, communicated and shared widely.

III. Institutional capacity development and training

- Assessing the effectiveness and utilization of GBV related services across health, psychosocial, legal and security should be ongoing with efforts made to strengthen this through appropriate training and capacity building of the partners and the community based on community and survivor feedback.
- At a minimum, relevant staff involved in the provision of services to GBV survivors across all sectors should be trained on the IASC guidelines, survivor centred approaches and basic counseling.
- Trainings for the police, community leaders and maslaha should focus on Kenyan legislation, human rights, gender, gender sensitive mediation and survivor centered approaches as well as basic counseling.
- At the camp level, trainings need to be coordinated and complementary among agencies and their target groups. Avoiding over burdening one or two groups (like section leaders or religious leaders) and expanding trainings to community based structures, both formal and informal. These trainings should focus on GBV services available, relevant legislation to allow information to be dispersed more widely.
- Stronger follow up by both police and agencies on cases is also a priority with a need to improve feedback to survivors in a timely manner.

IV. Improving the relationship with the police

Issues related to the police and barriers to reporting demand immediate attention. Efforts to improve the effectiveness of the police need to be magnified to enhance the quality of services available, in particular:

- Information campaigns on the availability of existing services and ensuring survivors of sexual assault are aware they can access health care independently of reporting to the police and have confidence in the confidentiality of these services.
- Construction of a gender reporting desk at the police station to promote confidentiality and privacy for GBV survivors.
- Working with the local community, the police and UNHCR to address reports of corruption, abuse and inadequate responses.
- Increasing the visibility of the police in the camps and linking them to the camp structures to improve community/police relations.
- Addressing bottlenecks in service provision including ongoing difficulties between the police, clinical staff and GBV agencies in the documentation of sexual assault. The P3 form needs to reflect information on the PRC1 form and should be sufficient to document the medical information required to pursue legal prosecution of sexual assault. Planned trainings in 2011 by RCK should include, doctors, the magistrate and prosecutor as well the police.
- Extending police trainings beyond police GBV focal points to ensure the skills, knowledge and understanding of appropriately handling GBV cases are widely available within the police and coordinating trainings across agencies.
- Ensuring the availability of adequately trained translators at the police station to handle GBV cases, RCK have trained community paralegals and they may be a good resource to assist at the police station.
- Continued advocacy with the Kenyan Government for the deployment of increased numbers of female police in Hagadera.

V. Strengthening of complaints and reporting mechanisms in Hagadera

The inadequacy of existing complaints and reporting mechanisms for exploitation and abuse were evident. This is a serious concern and demonstrates the need to develop locally appropriate and effective systems both within IRC and across other agencies operating at the camp level. Strengthening institutional capacity to properly develop systems to receive complaints, conduct transparent investigations and provide adequate follow up and feedback in a timely manner is required. This demands increased investment in staff training on protection issues, exploitation and abuse, and extensive communication with the community to ensure

systems/ tools developed are utilized and context appropriate. Promoting and facilitating a sharing of information, skills and knowledge across partners, at both the camp and Dadaab level, will be an important dimension to strengthen interagency coordination and capacity to address complaints and prevent abuses from occurring. The HAP mission planned in May should address some of these issues and promote a better coordinated and responsive CRM at the camp and interagency level.

5.3 Strengthening community participation in developing solutions to GBV

I. Community mobilisation and outreach

Effective interventions aimed at preventing GBV must engage and be lead by the community and build on local systems and structures to ensure solutions to GBV are community owned. Programmes must go beyond raising awareness and contribute to community driven behaviour change. The need to develop a targeted approach for engagement is fundamental to enhancing GBV knowledge that supports behavior change and increasing understanding and utilization of services. The need to strengthen links between the elders, youth and women to work together to prevent violence and keep the community safe was also identified. The desire to create an environment where GBV was not tolerated was evident, with specific recommendations centred on increasing community mobilisation efforts against violence and the formation of women's committees to protect and support women.

- Community mobilization activities will be strengthened by adopting the SASA! methodology, developed by Raising Voices, to facilitate attitudinal and behavioral change that enhance the community's capacity to prevent violence and promote gender equality.
- A training of trainers (ToT) in SASA! for GBV staff is needed and additional technical support sourced from Raising Voices to strengthen the application and effectiveness of the methodology.
- Community mobilization should include elders, community and religious leaders, men and women to build on local systems to ensure community owned solutions and a supportive environment for women's empowerment and protection is developed.
- Taking into account limited police presence in the blocks, the creation of a neighbourhood watch scheme was also recommended as was increasing police patrols especially at night.

II. Working with men

Effectively engaging men and boys in violence prevention efforts and developing strategies to improve spousal relationships at the house level are important. Recommendations from the community were focused on initiating programmes to engage men to improve relationships between spouses and educate family members on GBV. IRC GBV has identified a number of trends in reported cases from certain sections, namely a high proportion domestic abuse cases perpetrated by men. This could provide a platform to pilot approaches to work with men in the context of improving family relations in the areas of highest need. However, it is important that this is an instrument to bring about an end to violence against women and girls and does not become an end in itself. Support from community, traditional and religious leaders and male advocates and existing men's groups will be important to provide role models that respect women and are able to share power within their family and community.

III. Engaging with traditional mediation and justice systems

Traditional dispute-resolution mechanisms are often the most accessible (and preferable) to survivors, however, they inadequately protect the rights of women and girls. Engaging key groups, particularly men, as well as traditional and religious leaders is critical.

- Efforts to integrate the informal structures, including the maslaha, into the existing referral system could increase reporting and health seeking behaviours among GBV survivors. Greater knowledge and understanding of the informal architecture is required; a study to map out traditional systems and structures in the community is needed to identify potential entry points for engagement with these groups.
- Trainings on gender sensitive mediation, GBV legislation and survivors centered approaches should be provided to elders in the community to promote confidentiality and respect for survivors within these systems.

5.4 Increasing access to opportunities for women and girls through social and economic empowerment

I. Capacity building and organisational strengthening of existing women's groups

Although in their infancy, women's groups are emerging in Hagadera. Groups like 'Together Women' and others would benefit from institutional strengthening and capacity building to grow their management and organisational structure. IRC's Civil Society Capacity Development Coordinator would be a useful resource

for the GBV programme in this process and could conduct an assessment of existing groups and develop and capacity development plan to increase their work within the camp and consolidate women's groups under a strong umbrella.

II. Supporting women's economic empowerment

The linkages between GBV, economic insecurity and poverty are well recognised. As highlighted earlier, economic vulnerability is a key driver of GBV and promoting women's economic empowerment is fundamental to reducing vulnerability to GBV. Promoting women's protection through strategic interventions including economic opportunities and access to education are critical to reducing vulnerability. Economic empowerment plays a significant role promoting access to and control over resources and decision making. Livelihood support, such as microfinance and skills training is protective against GBV and contributes to increased security at the household level. Economic interventions need to pay attention to the gender dynamics of decision making in households which may potentially increase violence[19]. Existing income generating activities in Hagadera are limited and markets for traditional products produced like tie and dye and weaving are saturated. Viable livelihood opportunities that have a market value need to be properly explored through a market survey to examine the opportunities that exist. The need to support vulnerable groups, (unwed mothers, those with children borne out of rape, abandoned women etc.) by linking them to livelihoods and support structures is required to reduce their risk and address immediate survival concerns.

III. Support for adolescent girls programming

As outlined in the findings, adolescent girls experience particular vulnerabilities; a lack of current initiatives for girls, coupled with the need to engage them early during this critical phase in their development to better prevent violence before it occurs, and adequately equip them with the skills to lessen their risk to violence, is important. A safe space for girls to meet, separate from boys, is a basic building block for empowerment and positive change in the lives of young girls. IRC Women's Centres will provide a safe space where adolescent girls can meet in a protective environment with supportive networks through mentors, build life skills, and knowledge on basic literacy and reproductive health. This pilot should contribute to the development of protective mechanisms that help prevent violence before it happens, while also sharing information about services and options available to girls that may experience violence. Newly arrived and unaccompanied adolescent girls and those who failed to finish primary were identified as among the most vulnerable.

Complimentary to this is improving girls' access to quality and safe education which can reduce vulnerability to violence. It serves as a protective factor for increasing knowledge, skills and opportunities, averts early/forced marriage, and reduces the potential for domestic violence. Higher educational levels are also associated with better employment opportunities which also serve as protective factors. Sustained efforts are required to increase formal and non formal educational opportunities for young girls through affirmative policies in schools and awareness raising at the community level.

5.5 Addressing the protection concerns of women and girls across all sectors

I. Safe shelter provision for new arrivals

Until a more enduring solution is found to house new arrivals, responses need to take into consideration the protection concerns of the new arrivals. The need to provide a safe environment to reduce many of the structural causes of GBV is a priority, in particular, for newly arrived female headed households who have limited access to safe shelter, latrines and water; all of which are below the minimum SPERE standards.

- The current inadequacies in the provision of shelter and the lack of a safe and protected environment including access to basic amenities are a concern. High levels of female headed households are subsisting in unprotected areas where there have been threats from youth and the host community.
- Risks of GBV, in particular, sexual violence, are well documented in other situations like this, in which the physical protections are lacking. The high level of female headed households housed on the periphery, the lack of security and protections afforded by proper housing/shelter are risk factors for GBV, especially among new arrivals. Many of these lack knowledge on services available to respond to incidences of GBV and basic information on camp based services.
- Current responses include the provision of tents and shelter materials which fail to meet the needs of the population. Provisions of basic Non-Food Items (NFI's) are inadequate to meet the growing demands.

[19] Women's Refugee Commission (2010) PERIL OR PROTECTION: The Link Between Livelihoods and Gender-based Violence in Displacement Settings

- GBV prevention can be maximized if shelters are safe and secure and meet internationally agreed-upon standards. The provision of appropriate and safe shelter strengthens physical protection as well as meeting basic needs.

II. Shelter provision for GBV Survivors

GBV survivors also have unique protection needs which are often related to the provision of shelter (both temporary and permanent) that are a serious concern. Temporary shelter solutions for GBV survivors are limited; IRC and LWF often utilize informal networks, through the women's affairs committee (female section leaders) and other community based structures to identify temporary shelter, although this is ad hoc and not always reliable. There have been a number of cases where the individual hosting the survivor has come under threat and is harassed. Shelter solutions for GBV survivors who wish to remain in the camp are inadequate, since December 2010, a minimal number of cases have received shelter in response to GBV related issues. Those that were prioritized for shelter, received tents and were given space in I11 where there are growing concerns about the safety and security in this area.

- Temporary shelter solutions for GBV survivors need to be identified. Community based options should be formalised and a list of willing people to house survivors identified. The location of these houses/places needs to be safeguarded to protect those hosting survivors.
- Protocols for the use and management of possible community safe houses should be explored and developed for safety reasons and to manage the capacity and expectations of the community.
- At the interagency level, IRC, UNHCR and LWF need to develop more options for survivors who cannot be hosted in the community due to insecurity and should be able to expedite these alternatives as required.
- The GBV Support centre within the IRC compound, which provides clinical care and psychosocial support, could temporarily accommodate survivors with medical concerns as a result of GBV, but protocols on its use need to be developed.

III. Safe fuel strategies

The specific risks that women and girls experience collecting firewood require interagency and community based responses and protection.

- GIZ firewood distributions are unable to meet the needs of the growing community. The uptake and effectiveness of fuel efficient stoves could be assessed to see its impact on reducing the need to collect wood and mitigating the threats. Options to expand nurseries could also be explored to meet the needs of the burgeoning population.
- Contents of the food basket could be reviewed to include foods that consume less fuel to cook.
- At the community level, firewood patrols were recommended by the community to reduce the risk of women and girls. These could be organized through the CPST's to improve security while collecting fuel outside of the camp. However, longer term and durable solutions need to be found. Firewood collection contributes to tensions with the host community and ongoing environmental degradation.
- Alternative energies should be assessed for their appropriateness in the Dadaab context including solar power.

Annex 1: Terms of Reference

1.1 Terms of reference

The GBV assessment was designed to inform strategic direction and programming priorities of the GBV programmes over the coming years and feed into the development of a GBV Sector Strategy for IRC in Hagadera.

Specific objectives were intended to:

- Identify the various types of GBV, specific risk factors, vulnerable groups and the needs of women and girls in Hagadera, as well as GBV survivors, including how these may have evolved in recent years;
- Map key actors and institutions at the community and inter-agency levels that are involved in GBV prevention and response;
- Examine both the methods and effectiveness of existing formal and informal services and structures as perceived by the community, including health, psychosocial, legal, and security; and the different barriers to accessing these with the aim of identifying progress, challenges and lessons learnt;
- Identify informal networks and systems that deal with GBV-related issues, both directly and indirectly, and assess their limitations and potential opportunities for engagement by the IRC GBV program;
- Assess potential risks within the existing provision of humanitarian services[20] that fail to protect or exacerbate the safety and security risks of women and girls.

1.2 Methodology

The assessment and methodology utilized a number of internationally recognized tools and resources; The Inter-Agency Standing Committee (IASC) *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence in emergencies (2005)* provide a standard for assessing sexual violence issues in emergency assistance with guidelines and standards for planning, establishing, and coordinating humanitarian interventions to prevent and respond to GBV during the early and stabilized phase of an emergency. Specific GBV assessment tools (Focus Group Guidelines (FGD's) and Key Informant Interviews (KKI's)) were adapted from the Gender-based Violence Area of Responsibility Working Group *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings,* (*2010),* Reproductive Health Conflict Consortium's *Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation (2004).* In addition, the assessment team followed the research guidelines and standards outlined in the World Health Organization's *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* (2007).

The assessment team, which comprised of two groups of four GBV staff (facilitator, translator, observer and note taker) conducted 13 sex and age disaggregated focus group discussions (FGD's) with girls, women, boys and men with between 8-12 participants randomly selected across the camp, reaching approximately 140 people. Specifically,

Target group	Males	Females
15-18	1	2
19-24	1	2
25-49	1	3
50+	0	1
Women's groups	0	1
Elders/Maslaha	1	0
Total	4	9

Focus group questions focused on roles of women and men in the camp, daily activities, safety and security concerns, types of violence towards girls and women, risk factors for girls and women, help seeking behaviours and attitudes of GBV survivors as well as knowledge of and barriers to existing services . In addition, section leaders were also consulted and interviews were held with a number of agencies working in Dadaab to better understand the general situation and services in the camp, specifically health, water and sanitation, shelter, education and protection. KKI's were conducted with camp leadership, elders and religious leaders as well as a number of agencies including UNHCR, IRC health, SCUK, Film Aid, LWF and NRC.

[20] Assessing protection needs using the IASC Guidelines for GBV Interventions in Humanitarian Settings (2005); Sphere Standards

1.3 Timing

Research was conducted from January 19th – February 10th 2011. A two day training was held prior to the assessment for IRC's GBV community staff to plan for the GBV assessment, mapping out formal and informal institutions and stakeholders to approach, in addition to the training of staff on participatory assessment techniques including FGD's and KKI's. Other issues covered included creative facilitation skills and ethical, safety and security considerations prior to reviewing and field testing the tools.

1.4 Limitations

An obvious limitation is that the nature of the research is sensitive and prone to being underreported and talked about; specific types of GBV are not openly recognized nor spoken about in Hagadera, in particular, rape within marriage. In addition, lack of local language skills of the facilitators, including use of a translator and being an 'outsider' may have limited disclosure. Social bias is always a real concern, some level of triangulation may have negated the effect of this and FGD's proved valuable to generate consensus. The recent high profile GBV case involving members of the police also influenced the findings and focus of the assessment. Community fatigue with research and assessments was apparent. Timing of the research was also limited and not all sections were visited and those that were, were randomly selected.

1.5 Ethics

In order to safeguard the confidentiality of participants and encourage open discussion on GBV, no participant names were requested or documented during the GBV assessment. IRC GBV staff visited blocks prior to the assessment to mobilize participants and obtain informed consent verbally beforehand, providing information on the purpose of the study and ethical principles of privacy, confidentiality and voluntary participation (see annex 2: Informed Consent). Participants were discouraged from sharing intimate personal details of experiences of violence and additional support from GBV staff was made available after the FGD's were conducted.