

‘They Say Our Work Is Not Halal’: Experiences and Challenges of Refugee Community Workers Involved in Gender- based Violence Prevention and Care in Dadaab, Kenya

CHIMARAOKE IZUGBARA

African Population and Health Research Center, Nairobi, Kenya; School of Public Health, University of Witwatersrand, South Africa
coizugbara@gmail.com

STELLA MUTHURI

African Population and Health Research Center, Nairobi, Kenya

SHERU MUUO

African Population and Health Research Center, Nairobi, Kenya

CAROLYNE EGESA

African Population and Health Research Center, Nairobi, Kenya

GIORGIA FRANCHI

International Rescue Committee, UK

ALYS MCALPINE

London School of Hygiene & Tropical Medicine, UK

LORAIN BACCHUS

London School of Hygiene & Tropical Medicine, UK

MAZEDA HOSSAIN

London School of Hygiene & Tropical Medicine, UK

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Notwithstanding the growing centrality of refugee community workers (RCWs) in the current response to gender-based violence (GBV) in the Dadaab refugee camps, they remain poorly studied. Using interview data, we explored the work-related experiences and challenges as well as GBV-related beliefs of RCWs. Whilst they demonstrated elevated knowledge of the forms and drivers of GBV in their community, some of the RCWs did not deem early marriage, female genital mutilation and wife-beating to be GBV acts. In their work, RCWs were motivated by compassion for survivors as well as a sense of

community service, but they faced challenges such as insecurity; poor pay; opposition and violence by community members; tense relationships with and suspicion by professional providers; and limited skills and preparation in GBV management. RCWs' GBV-related beliefs and work experiences underscore the challenges of programming in a complex humanitarian space and offer insights for strengthening their contribution in GBV care and service delivery.

Keywords: GBV, Refugee camps, Humanitarian contexts, Refugee community workers, Dadaad, Kenya

Introduction

While humanitarian actors continue to respond to the worsening incidence and magnitude of disaster situations and emergencies, researchers have relentlessly highlighted the regularity and high burden of gender-based violence (GBV) in such contexts (Stark *et al.* 2010; Murray and Achieng 2011; Stark and Ager 2011; Aubone and Hernandez 2013; Krause 2015). Defined by Bloom (2008: 14) as 'violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society', GBV is common during emergencies. According to the United Nations High Commissioner for Refugees (UNHCR) (2015), emergencies and humanitarian situations put people at heightened risks for abuse, exploitation and violence, often on account of their gender. Similarly, institutions, community support mechanisms and systems for the physical and social protection of individuals are often weakened or destroyed during emergencies, intensifying gendered vulnerabilities. The Inter-Agency Standing Committee (2015) notes that, throughout any emergency, many acts of GBV occur in the form of rape, sexual harassment, trafficking, sexual slavery, harmful traditional practices (female genital mutilation (FGM), forced early marriage, honour killings, forced seclusion, etc.), domestic violence and other forms of intimate partner violence (IPV). The sexual and GBV that ensue during conflict, flight and encampment often reveal a continuum with widening patterns that reflect increasing complexity of survivor vulnerabilities, perpetrator structures and humanitarian conditions (Krause 2015).

Prevention and response to GBV in emergencies, including health care, psychological and social support, security and legal redress usually require the coordinated efforts of many actors, sectors and agencies (International Rescue Committee (IRC) 2011; Inter-Agency Standing Committee 2015). At the same time, activities must be in place to address the causes and drivers of GBV in such settings (Holmes and Bhuvanendra 2014). However, many humanitarian settings are characterized by a dearth of professional staff to support affected population's access to GBV care and services (Ehiri *et al.* 2014; Holmes and Bhuvanendra 2014). The race to meet the needs of GBV survivors in humanitarian contexts, provide them with much-needed services

and counselling support and implement community-based GBV prevention and education activities has led to the enlistment, training and deployment of refugees themselves to support GBV service provision in refugee camps. While this practice has been associated with health benefits for refugee populations (Ehiri *et al.* 2014), the work-related experiences and challenges of refugee community workers (RCWs) themselves and their understandings and beliefs regarding GBV remain poorly interrogated.

In the current article, we explore the experiences, challenges, motivations and GBV-related beliefs of RCWs delivering GBV services in the Dadaab refugee complex, Kenya. RCWs are an increasingly critical cadre of humanitarian personnel in the context of GBV prevention and care in Dadaab. Working under the supervision of professional GBV service providers, they have emerged as key to the effectiveness of the existing GBV response in the refugee camps, performing tasks such as linking and retaining GBV survivors in care, community outreach and education, and GBV survivor referral and follow-up. Evidence on RCWs' GBV-related beliefs and work experiences and challenges can potentially inform efforts to strengthen their contribution and involvement in GBV care and service delivery.

The Context

The Dadaab refugee complex, located in northern Kenya, currently hosts about 250,000 refugees from about nine countries (UNHCR 2015). The complex—the largest refugee camp globally at the time of data collection—is managed by UNHCR, with operations supported by several foreign and local governmental and non-governmental organizations, including the government of Kenya. The camp was originally established in the 1990s to host about 90,000 refugees—mainly Somalis fleeing the collapse of the Somali Republic, chronic political uncertainty and prolonged sub-regional insecurity and conflict (Abdi 2005; IRC 2011; UNHCR 2015; Chkam 2016). These early refugees were settled in the Dagahaley, Hagadera and Ifo camps within the Dadaab complex. However, in the 2000s, following persistent drought, famine, renewed fighting in south and central Somali, heightened sub-regional insecurity and a rise in levels of displacement in the sub-region, Ifo II and Kambioos camps were opened to accommodate more refugees (Lindley 2011). The camps are generally characterized by poor living and economic conditions as well as diminished 'self-esteem' of refugees resulting from prolonged encampment (Abdi 2005). Research has also linked the Dadaab refugee camps to both transnational promotion of health and improved livelihoods as well as global terrorism and insecurity (Horst 2002; Abdi 2005; Newhouse 2015; Chkam 2016). Somalis form the majority of refugees in the Dadaab complex.

GBV is particularly common in the Dadaab refugee camps (IRC 2011; Murray and Achieng 2011; Aubone and Hernandez 2013). Acts of IPV comprised over half of the cases of violence recorded by the IRC and CARE

International in 1998 (Crisp 2000). More recent studies indicate an increased prevalence of non-partner violence in Dadaab, with continuing cases of IPV, early and forced marriages, FGM, survival sex and growing reluctance to report GBV owing to fears of further attack, rejection and stigmatization (IRC 2011; Hough 2013). Widespread feelings of insecurity also exist in the camps, exemplified by pervasive sentiments of susceptibility to non-partner attacks and assaults, which particularly hinder the free movement of women and girls. Single women, aged 35 or less, women and girls in households without a traditional male protector and provider, and adolescent girls are common targets of GBV acts in Dadaab. Newly arriving female refugees who are less familiar with the camps and have insecure housing and fewer strong networks and social support mechanisms are also at elevated risk for attacks in the camps (Murray and Achieng 2011; Hough 2013).

During this research, the two main providers of GBV response services in Dadaab, IRC and CARE relied on RCWs to expand access to GBV services in the refugee camps. RCW roles are multifaceted and evolving, and include promoting service-seeking behaviours among GBV survivors, facilitating access to services through referrals, accompanying survivors to visits as required, facilitating GBV-related educational campaigns in the community and engaging fellow refugees to build community support and promote positive behaviour change regarding GBV. The involvement of RCWs in GBV service provision has been linked to increased numbers of women and girls presenting for, and receiving, care (Murray and Achieng 2011). Like community health workers (CHWs), RCWs are themselves refugees who have been trained to serve as a link between their community members and GBV care centres. RCWs take on particular tasks in the continuum of GBV services provision—a phenomenon that holds immense promise for rapidly filling the workforce deficit, easing work load on professional staff, improving access to services and strengthening service delivery (Viswanathan *et al.* 2009).

As noted earlier, existing studies have paid little attention to RCWs. This is despite recent calls for more critical insights on the roles, lives and influences of the different key actors in contemporary refugee contexts, which have been viewed as key to understanding and addressing the drivers of the declining standards of humanitarian support (Aubone and Hernandez 2013; Hough 2013; Kaleda 2014; Kumssa and Jones 2014; Newhouse 2015; Jansen 2016). The lack of robust evidence on RCWs in relation to the work and services they offer is therefore critical, and hinders efforts to appreciate their construction of their work, their motivations, the challenges they face and the interventions that are needed to bring to scale their contributions to GBV care provision and prevention.

Further, the urgent need for evidence on lay care providers continues to be highlighted in recent studies. For instance, studies among lay CHWs have shown that they face critical challenges that affect their capacity to deliver on their duties (Glenton *et al.* 2013) and that many of them sometimes question the very health messages they are expected to teach their community and,

every so often, spread personal unempirical values, beliefs, knowledge and attitudes that interfere with the delivery of supportive services to community members. In South Africa, CHWs involved in the home management of hypertension strongly believed that the condition is best managed by traditional medicines and home-brewed beer. They also taught community members that relying on Western medicine to treat hypertension caused one to deteriorate more rapidly (Sengwana and Puoane 2004). Another study established that CHWs serving a poor urban area did not always have the requisite knowledge and beliefs to make a positive impact on prevention and management of diabetes (Puoane *et al.* 2005; Hughes *et al.* 2006). Overall, these studies raise the need for more information on lay care providers in relation to their work and services.

The current study specifically asks: What are RCWs' views on GBV and its drivers? What are their experiences delivering GBV prevention and response services in the refugee camps? And what challenges do they face in delivering services to their communities? Answers to these questions can expand understanding of this unique category of service providers, offer insights on issues and challenges regarding their work and services, and provide a basis for raising the quality and effectiveness of the services that they offer.

Methods

Data for this article was elicited from in-depth individual interviews conducted with 20 (nine male and 11 female) purposively recruited RCWs. These RCWs were employees of IRC and CARE in Hagadera and Dagahaley refugee camps in Dadaab, Kenya. Purposive recruitment ensured the participation of RCWs of different genders, ages and levels of experience. Interviews with RCWs were conducted by four (two males and two females) bilingual (English- and Somali-speaking) interviewers. The interview language depended on the preference of the respondent.

The interviewers were trained on qualitative interviewing by a team of GBV researchers from the African Population Health Research Center and the London School of Hygiene & Tropical Medicine (LSHTM). The training lasted two weeks and covered the study tools, interviewing techniques and ethical issues in GBV research. Interviews typically lasted an average of one hour, were all audio-recorded and held in environs and spaces free of the attention, threat of sanctions and pressure of non-participants. The tools were also piloted with a sample of RCWs in Dadaab. Data collection took place in June 2015 and lasted for three weeks.

Interviews conducted in Somali were first translated into English and then transcribed. Interview transcripts formed the study data. The transcripts were compared to the taped interviews by a member of the research team. First, the interview data was concurrently, but independently, coded by one of the authors and another qualitative researcher, relying on Creswell's (2013) version of grounded theory and analysis. Following a technique used by

Table 1

Socio-demographic Characteristics of the Respondents	
	RCWs (%) (<i>n</i> = 20)
<i>Age</i>	
20–30	66.7
31–40	25.0
41 and above	8.3
<i>Sex</i>	
Male	45.0
Female	55.0
<i>Education level</i>	
Primary	18.2
Secondary	63.6
College	18.2
<i>Marital status</i>	
Married	63.6
Single	27.3
Divorced	9.1
<i>Years in GBV-related work</i>	
Less than 1 year	13.1
1–3 years	21.7
4–6 years	60.9
7 and more years	4.3

Izugbara and Egesa (2014), the study team met with the coder to review the coding outcomes, ensure inter-coder concordance and agree on a codebook that mirrors the thematic groupings of the interview questions and the key issues emerging from the data. Based on the jointly developed codebook, transcribed interviews were then manually coded. Both a deductive approach that drew on the topic guide and an inductive method that allowed themes to emerge from transcribed data were used to facilitate the detection of key and common themes in the data. Continual and iterative investigation of the study responses and narratives enabled us to identify categories, linkages and properties in the data (Baptist and Befani 2015). Direct quotes are used in the analysis to illustrate topical matters.

The study was reviewed and approved by the Ethics Committee at the LSHTM, the Ethics and Scientific Review Committee of the African Medical and Research Foundation (AMREF) and the UN Refugee Agency (UNHCR). Informed consent was obtained from all interviewees for their participation in the study and for the audio-recording of their responses. Socio-demographics of the respondents are shown in Table 1.

Findings

Gender-based Violence-related Knowledge and Beliefs

Responding RCWs demonstrated extensive awareness that acts of GBV, and indeed other forms of violence, occurred with regularity in the refugee camps. In addition to knowing at least one refugee who had experienced one or more acts of GBV in the last year, most of the RCWs had also provided services to at least two different GBV survivors or performed community-level GBV-related activities in the six months prior to the study. These services and activities included referring survivors for GBV services, community support for GBV survivors, facilitating community education on GBV, linking survivors to care and providing informal counselling to survivors in the community. Beliefs that GBV was rife in the camps existed alongside narratives, indicating that it was common for survivors to suffer repeated abuse and violation at the hands of the same perpetrator or others. In the view of one RCW:

GBV is very common here, particularly among us Somali refugees. Sometimes, you find that the same woman is beaten several times by her husband and keeps coming back to the center for service and treatment.

Some responding female RCWs had themselves suffered IPV and other forms of GBV in the camp. One female RCW reported that her male neighbour pestered her for years and ultimately attempted to rape her. Several male and female RCWs knew family members and close relatives who had suffered acts of GBV in the camps.

According to RCWs, GBV in the refugee camp took a variety of forms and occurred in a range of places: at home, outside the home, within the camps, in public places and in private spaces. Common forms of GBV in the study communities were identified as intimate and non-partner violence, rape, physical assault, denial of resources, forced seclusion, harassment, stalking, FGM, and early and forced marriage. Women and girls were considered the common sufferers of these acts. RCWs were aware of instances where perpetrators of violent acts were husbands and fathers of survivors, men previously married to survivors and men whose advances to survivors were turned down. They knew women and girls who lived in seclusion on the orders of their husbands and fathers. Rape and other forms of sexual exploitation also reportedly occurred in the camps and several RCWs knew refugees who had threatened to hurt, rape, kill and beat up other camp residents. However, GBV acts against men were considered rare.

Fears of violence and attacks were considered widespread in the camps and few, if any, refugees were considered exempt from the threat of GBV. For the RCWs, widespread threat of violence was largely responsible for the inability of many residents, particularly women and girls, to move freely in the camps, report violence, and seek and obtain essential services. GBV-related deaths

and morbidity were also viewed as common in the camps. Narrative data indicates that acts of GBV were exacerbated by inter-clan conflicts in the camps during which men from competing Somali clans attacked each other as well as women from rival clans. In such situations, violence was perpetrated against women to humiliate their husbands, fathers, male relatives and their entire clan. Research indicates that, during periods of violent inter-group conflicts, women's bodies and sexuality are sites where men frequently assert power and dominance, expressed through rape, coerced sterilization, enforced nudity and other forms of genital violence, including mutilation (Steiner *et al.* 2009; Manjoo and McRaith 2011).

The asserted regularity of GBV and other violent acts in Dadaab notwithstanding, RCWs generally believed that GBV incidents were declining. Acts of violence reportedly occurred more frequently and with more fatalities in previous years. Explanations for the decline in violence focused on improved security in the camps, growing community GBV education and awareness, more empowerment of refugees, diminished influx of new refugees and reduced inter-clan clashes in the camps. GBV services were reported to be increasingly available and accessible in the camps, resulting in better treatment, care and outreach to survivors. While participating RCWs felt their work had increased community awareness and openness on GBV issues, they suggested that most cases of GBV in Dadaab go unreported and undocumented. Only a few cases, usually the critical and recurrent ones, reportedly reach the GBV centres. Many persons who experienced GBV in the camps reportedly lived in silence or they did not consider their experiences as abuse. Narratives linked the low uptake of GBV services among the refugee population to local norms that sanctioned GBV, concerns that using service and reporting abuse would expose survivors to more violence, fears of stigmatization by the community and lack of awareness of the existence of GBV services in the camps. Corroborating the low uptake of services among GBV sufferers in the camps, an RCW noted that 'the women who come to the GBV centers are only a small number of those who experience GBV in these camps'.

While the RCWs generally understood the meaning and implications of GBV, many of them did not view early marriage, FGM and wife-beating as constituting acts of GBV. RCWs who held such beliefs appealed to specific interpretations of Islam and Somali culture to justify their stance. 'In Islam, there are roles for women and there are roles for men. If women fail to play their part, it is fine to have them beaten,' noted a female RCW. And yet another male RCW declared that 'Islam permits hitting or beating the wife lightly'. RCWs also appealed to Somali culture to rationalize GBV, with one respondent noting that 'Somali culture advocates that a girl should be married at 13 years old and she should go through FGM'. In most cases, RCWs weaved intricate narratives linking wife-beating, seclusion, deference to men, early marriage and FGM with women's respect, status, dignity, morality and role. As one RCW put it, men protect women's honour in Islam by correcting

them physically. Put differently, it was to the good and in the interest of women to have husbands or male guardians who can discipline them when they go wrong. To another respondent, FGM and child marriage helped to address promiscuity among women and preserve women's honour and dignity.

RCWs demonstrated a rich knowledge of the complex and intersecting drivers of GBV in the camps. Poverty and unemployment were high in the camps, and men were said to resort to violence to manage boredom and frustrations, control women and prove their masculinity. One RCW noted that refugee men often do not earn incomes and have difficulties establishing themselves as an income provider for their families. This respondent linked GBV in the camps to a pervasive sense of loss of power and dignity among refugee men. RCWs maintained that refugees lived powerless and undignified lives. They are fed by humanitarian agencies, are idle and have little control of their lives and future. Many of them were separated from their extended networks and families, could not leave the camps and survived at the mercy of humanitarian workers. There was also a recognition that the low status of women in Somali culture contributed to GBV in the camps. The cultural norms reportedly expect women to defer to men and envisage men's use of physical force to discipline their wives. Data indicated the interconnectedness and critical influence of intersecting social factors such as clan membership, poverty, weak network, short duration of camp residence and gender in creating overlapping and interdependent systems that put refugee women and girls at risk of GBV. In general, RCWs noted that the risks for violence were elevated among women who lived alone, arrived newly in the camps, were disabled, were from smaller clans, lived in insecure housing and unsafe parts of the camps, and did not have family members or strong networks in the camps.

RCWs also observed that substance abuse, particularly *khat*, was common among men and boys in the camp. Use of *khat* reportedly increased abuse and violence by men. Other widely identified drivers of GBV in the camps included women's low levels of empowerment, male domination and pervasive illiteracy.

Experiences and Motivations of RCWs

The RCWs in our study described their work as important and acknowledged having learned a lot from their training. Prior to their recruitment as RCWs, many of them were unemployed, knew little about GBV and its dynamics, and did not feel that they were contributing substantively to their communities. Employment, for many RCWs, freed them from the boredom of refugee life and put them in good stead to participate in improving lives in the camps. Given high levels of unemployment and difficulties in finding jobs in the camps, RCWs considered themselves privileged to be receiving compensation for their work. Though their earnings were generally viewed as paltry,

RCWs agreed that it was better than nothing in a context of pervasive joblessness and near-exclusive reliance on humanitarian agencies for upkeep and livelihood. Many of respondents noted that the stipends were a major motivation in their work.

Male and female RCWs spoke of the empowering effect of their work. Training by CARE and IRC had exposed them to new information and skills to reach out to GBV survivors, refer them for services and support them through the care-seeking process. Overall, RCWs believed that their work contributed to the wider goals of social development, progress, security and health in the camps. Due to their work, they were known and respected in the community. This contrasted with the plight of other unemployed refugees who were often idle, did not earn any income, contributed little in terms of services to the community and sometimes relied on *khat* to deal with the tedium of camp life. Female RCWs were particularly pleased with the opportunity to work. Some of them had sisters, mothers and relatives who had suffered or suffer from GBV. Their work offered them the opportunity to prevent future abuse, violence and oppression of women. Many of them felt empowered by working, teaching fellow refugees, helping others and earning their own incomes. A female RCW noted: 'I feel very proud because I am helping my community. I am helping my girls, my daughters, my sisters, and mothers.' Feelings of pride, power, altruism, community service and contribution to the protection of lives and prevention of violence were frequently mentioned motivations among RCWs.

Responding RCWs acknowledged the immense support they received and enjoyed from the professional GBV staff at IRC and CARE, who were considered generally willing to teach and support RCWs. They (professional staff) reportedly valued the role of RCWs in supporting survivors to access services and care, and following them up to ensure they received the full cycle of care. Many RCWs were persuaded of their indispensability as intermediaries in linking survivors to GBV-related care. They reported that their cultural similarity with survivors was critical in linking and retaining survivors in care. Without their support, very few people would seek GBV services in the camp. They are the ones who go into the community and houses to convince and offer survivors the confidence to seek services. Professional GBV service providers in the camps were often non-Somalis, did not speak Somali, could not enter the houses of the refugees in the camp, go into the community to teach about GBV and mobilize survivors, and could not conduct follow-up sessions with survivors who had initiated care. The camaraderie and respect of professional GBV service providers were motivating for RCWs. 'We depend on each other and there is respect. It's a two-way traffic. We need them and they need us,' noted a RCW. Working closely with other service providers in the camp also empowered RCWs to navigate the care system. They could more easily seek and obtain specialized and quality care, counselling and support for their own health, social and emotional issues.

Challenges of RCWs

Evidence that RCWs enjoyed their duties notwithstanding, they faced several work-related challenges. Opposition by community members topped the list of reported challenges among participating RCWs. Narratives indicated that RCWs were often disparaged by refugees who believed they taught values that were un-Islamic and against the Somali culture. One RCW noted:

Yes, there is a lot of resistance especially regarding FGM which they say is a common practice in the culture ... they feel that we are going against the culture, and others say the religion allows FGM and wife-beating.

Another RCW maintained: 'Early marriage is a common problem within the community here. Many parents like to marry off their children very early ... and they do not like us to speak against it.' These beliefs reportedly brought RCWs in constant confrontation with fellow refugees, who perceived them as advancing views that challenged age-long cultural and religious values. In one trenchant acknowledgement of this confrontation and resistance by the community, one respondent noted:

They mock us in the community, saying that our work is not halal [religiously sanctioned or approved]. They say we are causing families to break by advocating for women's rights. At some point, I had to go to a Sheikh (religious authority) for advice and he assured me that my work and income are very genuine and halal.

Opposition towards RCWs by community members was sometimes violent. One female RCW was waylaid and attacked by the same man who battered the GBV survivor whom she had been supporting. In another instance, one husband threatened a RCW who referred his abused wife to the GBV centre. In yet another case, a RCW recalled how a group of RCWs was mobbed during a community GBV prevention and education outreach event:

The community will sometimes attack you, for example ... there was a certain campaign that we carried out about FGM ... and some people stoned us. I was beaten ... my teeth were broken as you can see ... you cannot mention FGM and other things. They say it is our culture.

Aggressors reportedly justified assaults on RCW by claiming they support foreign and un-Islamic values, promote gender equality and encourage women to disobey, challenge or leave their husbands. RCWs frequently received threats from persons in the camps. One male respondent noted:

I have experienced threats myself which I have reported to the police. I was threatened through the phone. I was even told that my head would be chopped off. But this did not stop me from doing my work. I want my community to be free from violence.

Attacks and threats limited RCWs' capacity to their work, move freely in the camp and deliver services effectively.

Insecurity was another commonly reported challenge among RCWs. The camps were noted to be increasingly unsafe due to the activities of religious radicals, terrorists and Islamists. Inter-clan violence in the camps also often involved deadly violence and vendettas. To avoid embroilment in inter-clan rivalries, some RCWs preferred to only serve GBV survivors from their own clans. Further, due to inter-clan rivalry and suspicion, some survivors only sought services from RCWs of their own clans. One RCW noted:

There are many challenges. One of them is the clan system. This hinders me from serving my community. People from other clans are reluctant to bring a case to me because they say I will be unfair to them. For others, it is the pride for their clan, so they are choosy and search for someone else from their clan to solve the case.

Another RCW observed: 'clannishness is a major challenge ... some people have bias against me because I don't belong to their clan.'

Other critical challenges reported by the RCWs were extended work hours, scorching weather, poor pay, tensions between GBV agency staff and RCWs, and poor career prospects. There were also widespread concerns regarding job and career security and a desire for higher-level training in GBV services, particularly in counselling and case management. RCWs reported challenges in serving GBV survivors of the other gender, with one male RCW noting:

Another key challenge we face as men is that when we go to the community to meet survivors, say of domestic violence, you know, she can be freer talking to a fellow woman. We are not well equipped to deal with female survivors.

There were also complaints regarding the lack of access to critical work resources, including phones, airtime, uniforms, and bicycles and motorbikes to enable to them move rapidly within the camp, effectively conduct follow-up meetings and promptly respond to the needs of people who need GBV services.

Discussion and Conclusion

RCWs have burst upon the humanitarian scene as an important human resource for addressing GBV services provider shortages, effectively reaching the most vulnerable groups of underserved refugees and bridging the gap between mainstream GBV service providers and refugee communities. As with other lay health workers, realizing this potential calls, *inter alia*, for critical insights into how they constitute their work as well as the challenges they face performing it. While RCWs will not replace professional GBV care and services providers, there is evidence from the current study that they are emerging as frontline workers who understand their community and are

trusted by fellow refugees. The positive role of lay health workers in improving outcomes for community members is amply documented and increasingly recognized (Perry *et al.* 2014). The RCWs in this study appear to have established themselves as true ‘in-between’ staff who are building the trust of Somali refugees in GBV service use; tracking patients’ progress and care plans; and facilitating referrals, counselling, community education and support services to GBV survivors in the camps.

While the RCWs demonstrated a strong understanding and awareness of the effects, drivers, dynamics and implications of GBV, they did not all accept that child marriage, FGM and wife-beating are acts of GBV. RCWs’ knowledge of the health, social and economic effects and impact of GBV could inform the development of future capacity-building and training programmes for them. Recent research has underscored the importance of a motivated and knowledgeable lay community health work force that understands the importance of the issues they are addressing in their community. In sub-Saharan Africa, the use of lay CHWs with a clear understanding of the far-reaching implications of the HIV epidemic has been key to the scale-up of HIV community engagement efforts and reducing HIV stigma and deaths at community levels (Zachariah *et al.* 2009). In Kenya, a community-based family-planning project involving the use of CHWs who themselves were users of family-planning services, including vasectomy, helped promote the rapid acceptance of modern family-planning services at the community level (Null *et al.* 2016).

On the other hand, lay CHWs sometimes also hold and spread beliefs that contradict scientific ideas of the very health issues they are employed to help communities prevent or deal with. This situation often arises from the complexities in the social situations within which health workers operate. Puoane *et al.* (2005) found that South African CHWs who were expected to be knowledgeable about obesity and to teach communities about non-communicable disease prevention and healthy nutrition endorsed obesity and associated it with health, dignity, respect, confidence, beauty and wealth. In a high HIV and related stigma context such as South Africa, being underweight signified an HIV-positive status, which CHWs did not want to be associated with. The evidence that many RCWs hold contradictory orientations and opinions regarding GBV reflects their status as culture bearers who feel obliged to defend their cultural and religious beliefs (Glenton *et al.* 2013). More importantly, however, this finding raises an urgent need for additional training for RCWs.

The challenges faced by RCWs in doing their work are multifaceted, ranging from community backlash and resistance, insecurity and Somali clan politics, to poor remuneration, disrespect by professional GBV workers and limited career prospects. Existing studies on lay care providers have noted similar challenges and how they reflect the complexities of lay health work in most societies. Glenton *et al.* (2013) highlight how easily CHWs can be attacked and assaulted by members of the communities they serve, feel

dissatisfied with their pay levels, feel disrespected by professional providers, fear blame if care was not successful, feel they have few opportunities to voice complaints and have little prospects for career growth. In some studies, lay health workers reported the training they received to be insufficient, low-quality, irrelevant and inflexible (Alcock *et al.* 2009; Haq and Hafeez 2009; Siu and Whyte 2009; Glenton *et al.* 2013). Daniels *et al.* (2005) found that being a lay health worker was stressful and exposed many CHWs in South Africa to challenges that they could not easily manage and affected the quality of the services they provided. The refugee context has been described as a uniquely disempowering and stressful space characterized by personal, structural and other forms of destabilizing crises for both refugees and humanitarian workers (Abdi 2005; Ehiri *et al.* 2014; Newhouse 2015). It is a space where a complex web of actors, often from different backgrounds, interact, sometimes with unpredictable outcomes (Newhouse 2015). Improving the capacity of RCWs to effectively deliver their work and duties requires interventions that are sensitive to the complexity of their contexts and address their myriad work-related challenges.

Taken together, our findings highlight the unfinished business of harnessing the potential of the RCW workforce as well as the complexities that surround the GBV care role of RCWs in Dadaab. Indeed, while RCWs offer immense opportunities for addressing the important question of GBV response in Dadaab, they also face many critical challenges in their performance and ability to properly serve their community. These findings raise the need for interventions to address these challenges and call for additional research to understand and identify important improvements in community competence and skills that will enable RCWs to develop, from the outset, sustainable capacity as transformers and change agents able to effectively understand and engage community discourses, address resistance and tackle widely held norms and values that impede gender equality and the elimination of GBV.

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- ABDI, A. M.** (2005) 'In Limbo: Dependency, Insecurity, and Identity amongst Somali Refugees in Dadaab Camps'. *Refuge: Canada's Journal on Refugees* 22: 6–14.
- ALCOCK, G. A., MORE, N. S., PATIL, S., POREL, M., VAIDYA, L. and OSRIN, D.** (2009) 'Community-based Health Programmes: Role Perceptions and Experiences of Female Peer Facilitators in Mumbai's Urban Slums'. *Health Education Research* 24: 957–966.
- AUBONE, A. and HERNANDEZ, J.** (2013) 'Assessing Refugee Camp Characteristics and the Occurrence of Sexual Violence: A Preliminary Analysis of the Dadaab Complex'. *Refugee Survey Quarterly* 32: 22–40.
- BAPTIST, C. and BEFANI, B.** (2015) 'Qualitative Comparative Analysis: A Rigorous Qualitative Method for Assessing Impact'. In *Coffey "How To" Note*, pp. 1–7. Available at: <http://www.coffey.com/assets/Ingenuity/Qualitative-Comparative-Analysis-June2015.pdf>.
- BLOOM, S. L.** (2008) 'Domestic Violence [online]'. *Encyclopedia of Gender and Society*, SAGE, http://www.sage-ereference.com/gender/Article_n121.html (accessed January 2018).
- CHKAM, H.** (2016) 'Aid and the Perpetuation of Refugee Camps: The Case of Dadaab in Kenya 1991–2011'. *Refugee Survey Quarterly* 35: 79–97.
- CRESWELL, J. W.** (2013) *Qualitative Inquiry and Research Design: Choosing among Five Approaches*. Thousand Oaks: Sage.
- CRISP, J.** (2000) 'A State of Insecurity: The Political Economy of Violence in Kenya's Refugee Camps'. *African Affairs* 99: 601–632.
- DANIELS, K., HENDRIEN VAN ZYL, H., CLARKE, M., DICK, J. and JOHANSSON, E.** (2005) 'Ear to the Ground: Listening to Farm Dwellers Talk about the Experience of Becoming Lay Health Workers'. *Health Policy* 73: 92–103.
- EHIRI, J. E., GUNN, J. K., CENTER, K. E., LI, Y., ROUHANI, M. and EZEANOLUE, E. E.** (2014) 'Training and Deployment of Lay Refugee/Internally Displaced Persons to Provide Basic Health Services in Camps: A Systematic Review'. *Global Health Action* 7(1): 23902.
- GLENTON, C., COLVIN, C. J., CARLSEN, B., SWARTZ, A., LEWIN, S., NOYES, J. and RASHIDIAN, A.** (2013) 'Barriers and Facilitators to the Implementation of Lay Health Worker Programmes to Improve Access to Maternal and Child Health: Qualitative Evidence Synthesis'. *The Cochrane Library* 10: 10.1002/14651858.CD010414.
- HAQ, Z. and HAFEEZ, A.** (2009) 'Knowledge and Communication Needs Assessment of Community Health Workers in a Developing Country: A Qualitative Study'. *Human Resources for Health* 7: 59.
- HOLMES, R. and BHUVANENDRA, D.** (2014) *Preventing and Responding to Gender-based Violence in Humanitarian Crises*. London: Humanitarian Practice Network (HPN), Overseas Development Institute.
- HORST, C.** (2002) 'Vital Links in Social Security: Somali Refugees in the Dadaab Camps, Kenya'. *Refugee Survey Quarterly* 21: 242–259.
- HOUGH, C.** (2013) 'Understanding Refugees' Concepts of Sexual and Gender-based Violence'. *Forced Migration Review* 43: 81–83.
- HUGHES, G. D., PUOANE, T. and BRADLEY, H.** (2006) 'Ability to Manage Diabetes—Community Health Workers' Knowledge, Attitudes and Beliefs'. *Journal of Endocrinology, Metabolism and Diabetes of South Africa* 11: 10–14.
- INTER-AGENCY STANDING COMMITTEE** (2015) *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*. Geneva: Inter-Agency Standing Committee.
- INTERNATIONAL RESCUE COMMITTEE (IRC)** (2011) *Gender-based Violence Rapid Assessment, Dadaab, Kenya*. New York: IRC.
- IZUGBARA, C. O. and EGESA, C.** (2014) 'The Management of Unwanted Pregnancy among Women in Nairobi, Kenya'. *International Journal of Sexual Health* 26: 100–112.
- JANSEN, B. J.** (2016) "'Digging Aid": The Camp as an Option in East and the Horn of Africa'. *Journal of Refugee Studies* 29: 149–165.

- KALEDA, C.** (2014) 'Media Perceptions: Mainstream and Grassroots Media Coverage of Refugees in Kenya and the Effects of Global Refugee Policy'. *Refugee Survey Quarterly* 33: 94–111.
- KRAUSE, U.** (2015) 'A Continuum of Violence? Linking Sexual and Gender-based Violence during Conflict, Flight, and Encampment'. *Refugee Survey Quarterly* 34: 1–19.
- KUMSSA, A. and JONES, J. F.** (2014) 'Human Security Issues of Somali Refugees and the Host Community in Northeastern Kenya'. *Journal of Immigrant & Refugee Studies* 12: 27–46.
- LINDLEY, A.** (2011) 'Between a Protracted and a Crisis Situation: Policy Responses to Somali Refugees in Kenya'. *Refugee Survey Quarterly* 30: 14–49.
- MANJOO, R. and MCRAITH, C.** (2011) 'Gender-based Violence and Justice in Conflict and Post-conflict Areas'. *Cornell International Law Journal* 44: 11–30.
- MURRAY, S. and ACHIENG, A.** (2011) *Gender-based Violence Assessment, Hagadera Refugee Camp, Dadaab, Kenya*. New York: IRC.
- NEWHOUSE, L. S.** (2015) 'More than Mere Survival: Violence, Humanitarian Governance, and Practical Material Politics in a Kenyan Refugee Camp'. *Environment and Planning A* 47: 2292–2307.
- NULL, C., SIVASANKARAN, A. and SMITH, K.** (2016) *Improving Uptake of Family Planning Services in Western Kenya: Evaluation Findings and Key Learnings*. Washington, DC: Mathematica Policy Research.
- PERRY, H. B., ZULLIGER, R. and ROGERS, M. M.** (2014) 'Community Health Workers in Low-, Middle-, and High-income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness'. *Annual Review of Public Health* 35: 399–421.
- PUOANE, T., FOURIE, J., SHAPIRO, M., ROSLING, L., TSHAKA, N. and OELEFSE, A.** (2005) "'Big is beautiful"—an Exploration with Urban Black Community Health Workers in a South African Township'. *South African Journal of Clinical Nutrition* 18: 6–15.
- SENGWANA, M. and PUOANE, T.** (2004) 'Knowledge, Beliefs and Attitudes of Community Health Workers about Hypertension in the Cape Peninsula, South Africa'. *Curationis* 27: 65–71.
- SIU, G. E. and WHYTE, S. R.** (2009) 'Increasing Access to Health Education in Eastern Uganda: Rethinking the Role and Preparation of Volunteers'. *Health Education Journal* 68: 83–93.
- STARK, L. and AGER, A.** (2011) 'A Systematic Review of Prevalence Studies of Gender-based Violence in Complex Emergencies'. *Trauma, Violence, & Abuse* 12: 127–134.
- STARK, L., ROBERTS, L., WHEATON, W., ACHAM, A., BOOTHBY, N. and AGER, A.** (2010) 'Measuring Violence against Women Amidst War and Displacement in Northern Uganda Using the "Neighbourhood Method"'. *Journal of Epidemiology and Community Health* 64: 1056–1061.
- STEINER, B., BENNER, M. T., SONDRUP, E., SCHMITZ, K. P., MESMER, U. and ROSENBERGER, S.** (2009) 'Sexual Violence in the Protracted Conflict of DRC Programming for Rape Survivors in South Kivu'. *Conflict and Health* 3(3): 1–9.
- UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)** (2015) *Refugees in the Horn of Africa: Somali Displacement Crisis*. Geneva: UNCHR.
- VISWANATHAN, M., KRASCHNEWSKI, J., NISHIKAWA, B., MORGAN, L. C., THIEDA, P., HONEYCUTT, A., LOHR, K. N. and JONAS, D.** (2009) *Outcomes of Community Health Worker Interventions*. North Carolina: RTI International–University of North Carolina Evidence-based Practice Center.
- ZACHARIAH, R., FORD, N., PHILIPS, M., LYNCH, S., MASSAQUOI, M., JANSSENS, V. and HARRIES, A.** (2009) 'Task Shifting in HIV/AIDS: Opportunities, Challenges and Proposed Actions for Sub-Saharan Africa'. *Transactions of the Royal Society of Tropical Medicine and Hygiene* 103: 549–558.