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Barriers and facilitators to care-seeking among survivors of gender-based violence in the Dadaab refugee complex

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Abstract: *In humanitarian settings, timely access to care is essential for survivors of gender-based violence (GBV). Despite the existence of GBV support services, challenges still exist in maximising benefits for survivors. This study aimed to understand the characteristics of violence against women and explore barriers and facilitators to care-seeking for GBV by women in two camps within the Dadaab refugee complex in Kenya. A mixed-methods design was used to study women accessing comprehensive GBV services between February 2016 and February 2017. Women were recruited into a cohort study (*n = *209) and some purposively selected for qualitative in-depth interviews (*n = *34). Survivor characteristics were descriptively analysed from baseline measures, and interview data thematically assessed. A majority of women were Muslim, of Somali origin, had been residents in the camp for more than five years, with little or no formal education, and meagre or no monthly income. From the survey, 60.3% and 66.7% of women had experienced non-partner violence or intimate partner violence in their lifetime respectively. Facilitators to accessing GBV services by survivors included awareness of GBV services and self-perceived high severity of acts of violence. Barriers included stigma by family and the community, fear of further violence from perpetrators, feelings of helplessness and insecurity, and being denied entry to service provision premises by guards. Women in the Dadaab refugee camps face violence from intimate partners, family, and other refugees. There is an urgent need to address drivers of GBV and the barriers to disclosure and access to services for all survivors of GBV.* DOI: 10.1080/26410397.2020.1722404

Keywords: gender-based violence, services, care-seeking, refugee, humanitarian settings, Dadaab, Kenya

*These authors contributed equally to this work.

#SM, SKM, MKM, AM, LJB, MH, and CI made substantial contributions to the study design and acquisition of data. SM and MKM led analysis of the quantitative data. SM, SKM, and HO led analysis of the qualitative data. SM and SKM led the writing of the manuscript and contributed equally to its development. MH and CI were co-principle investigators for the study. All authors were involved in the interpretation of data and drafting and revising the manuscript.

Background

Common forms of gender-based violence (GBV) include physical, emotional, sexual, and economic violence,[1] which may be perpetrated by current or former partners, also known as intimate partner violence (IPV), or by a non-partner, also known as non-partner violence (NPV). Several factors are associated with an increased risk of GBV including extreme poverty, minority status, lack of access to food and water, and disrupted family and community support systems, among others.[2] Facing a significantly higher risk than that of men and boys, women and girls also suffer greater physical and mental health consequences.[3] Globally, it is estimated that 1 in 3 (35%) women have experienced physical and/or sexual violence in their lifetime, with some of the highest estimates reported in sub-Saharan African settings.[4] In Kenya alone, among women aged 15–49 years, physical and/or sexual IPV ever experienced and in the prior 12 months was estimated at 41% and 26% respectively.[5] In Somalia, one in five men and one in seven women reported physical or sexual violence victimisation during childhood. Among women, 35.6% reported adult lifetime experiences of physical or sexual IPV and 16.5% reported adult lifetime experience of physical or sexual NPV.[6]

Emergency and humanitarian situations expose individuals, particularly women and girls, to a heightened risk for GBV, including rape, sexual harassment, harmful traditional practices (female genital mutilation (FGM), forced early marriage, and honour killings among others), domestic violence, socioeconomic abuse, and the denial of a woman's right to make choices about her reproductive health.[7] Humanitarian emergencies also reduce the capacity of societies and institutions to meet the care needs of GBV survivors, and intensify the vulnerability of survivors to further victimisation.[7–11] GBV vulnerability is heightened owing to a collapse of cohesive family and community structures, and a lack of access to sexual and reproductive health services.[12] Camp settlements also inherently result in a loss of self-esteem due to a high dependency on external assistance (loss of autonomy), insecurity and cross-community conflict, and minimal realistic prospects for change.[13] However, more structured environments, such as refugee camps, may offer an opportunity to provide GBV services if there is adequate interest, investment, and evaluation of the services for improvement.[14]

The Dadaab refugee complex is one of the world's largest refugee settlements and was home to about 225,557 refugees as of April 2018.[9] Dadaab is located in the North-East of Kenya and was established in the 1990s to host Somalis fleeing the Somalia Civil War. Due to prolonged regional insecurity and conflict, drought, and famine, Dadaab continued to experience an influx of refugees from Somalia and other countries such as Ethiopia, South Sudan, and Sudan, Democratic Republic of Congo, Burundi, Rwanda, Uganda, Eritrea, and others. However, Somalis constitute a large majority of refugees in the complex.[15] Similar to many other refugee camps, Dadaab is characterised by poor living conditions and lack of adequate access to basic amenities, such as food, water, and decent shelter.[16] For a period, the complex consisted of five camps, namely: Hagadera, Dagahaley, Ifo, Ifo II, and Kambioos, although Ifo II and Kambioos have now been closed. The complex is managed collaboratively by the Government of Kenya and the United Nations High Commissioner for Refugees (UNHCR), with various other local and international organisations providing a range of services to the refugees.

GBV is particularly common in the Dadaab refugee complex. Young, single, or unmarried women, girls, and newly arriving female refugees (who are often assigned to less secure housing structures and have fewer social networks) are often at elevated risk of violence.[7,8,17] However, reporting of GBV remains low. Shame, stigma, fear of reprisals, and threats of rejection by families and the community are powerful deterrents to reporting. Limited knowledge among refugees about the health consequences of GBV may further limit reporting and utilisation of appropriate and timely health care.[7] Regrettably, delayed or inappropriate care for GBV leave those affected with potentially life-threatening or life-long consequences.

In the current study, we engaged two humanitarian agencies that were offering individualised comprehensive case management (ICCM) services to GBV survivors in Dadaab – the International Rescue Committee (IRC) operating in Hagadera camp and CARE operating in Dagahaley camp. These agencies have been operating in Kenya for over twenty years, with their humanitarian work covering areas such as the provision of health care or medical services, food and nutrition, education, human rights advocacy, and support for community initiatives among others.[18,19] Service provision

was handled by two categories of workers: professional staff, locally referred to as "officers" (skilled GBV case managers and counsellors) and Refugee Community Workers (RCWs), also known as "incentive workers". The latter are refugees trained and employed via the incentive worker program in the camps to encourage service seeking among GBV survivors, facilitate access to services through accompanying survivors to visits, carry out educational awareness raising campaigns in the community, and engage fellow refugees in promoting positive behaviour change around GBV in the community. This task-sharing model eases the work load of professionally trained staff and holds promise for expansion of services to GBV survivors.[7,20]

This study aimed to understand the characteristics of violence against women, describe the survivors seeking GBV support services from IRC in the Hagadera camp and CARE in the Dagahaley camp, and explore the barriers and facilitators to accessing care for survivors in the Dadaab refugee camps.

Methods

Study design and setting

The study is a convergent parallel mixed methods design using quantitative (survey) and qualitative (in-depth interviews) methods.[21] The study was implemented in the Hagadera and Dagahaley refugee camps within the Dadaab Refugee Complex in Kenya between 2016 and 2017.

Study population and sampling

Women (aged 18 years and above) and emancipated female minors (15–17 years old) reporting a new incident/case to the response teams at the IRC or CARE GBV service centres were eligible participants for the study. However, no emancipated minors were encountered as having reported a new GBV case for the duration of the study, therefore analyses included women aged 18 years and above. Further, since the primary users of the existing GBV services were women and girls (accounting for over 95% of the cases reported to the two centres), male survivors were not included in this study.

Recruitment for the quantitative survey (conducted from February to November 2016) entailed IRC's and CARE's professional staff referring eligible survivors who had reported a new GBV case to the research team after their immediate care needs had been addressed. These survivors were then given more information about the study by the research team and asked if they wanted to participate. This non-probability sampling method sought to include all women who met the eligibility criteria. In total, 209 participants were recruited from the IRC and CARE GBV centres.

Selection for qualitative in-depth interviews (conducted in February 2017) was purposive[22] and based on various criteria including age, education, marital status, and length of stay in the camp, to ensure a wide range of perspectives. A similar referral process was used for the recruitment of respondents for these interviews; however, professional staff were closely guided by the research team to ensure that women referred met the predetermined criteria. Respondents comprised women reporting new GBV cases (these survivors had not completed the quantitative survey) and returning survivors (who had completed the quantitative survey in the previous year). This was done to capture perspectives from those who had already been exposed to the study and those who had not, and to identify potential bias. To trace the latter group of women, the research team worked with RCWs to get in touch with these respondents in the blocks where they lived, to invite them to return for the qualitative interviews. In total, 34 (12 new and 22 returning) participants were recruited.

Data collection and analyses

For both the survey and in-depth interviews, data were collected in a quiet, private room within the IRC and CARE GBV centres by trained English and Somali speaking interviewers based in Dadaab, one in each camp. All field research staff received training on confidentiality, conducting interviews on sensitive topics, and responding to distress that may arise during the interview process, which included referral for follow-up counselling with trained psychosocial officers when needed or upon request by the women. Participants were not compensated monetarily; however, for longer interviews, respondents were provided a light snack and drink.

The survey interviews were conducted over a nine-month period in 2016, and were carried out within a few days and up to two weeks after the survivor had reported a new case at the GBV centre. The same survivors were called back to complete a second and third survey over the following months to assess trends over time in their

health, safety, and coping outcomes, patterns of service use, and longer term impact after case closure, data that are currently being analysed.[23] The research team relied on phone calls and well trained RCWs to help recontact survivors to return for follow-up interviews. While RCWs assisted in calling back participants, to protect their privacy the interviews were conducted in private safe spaces, with no RCWs close by to hear the details of the interview. It is important to note that this paper presents descriptive data from the baseline survey of 209 survivors and in-depth qualitative interviews with 34 women.

The survey questionnaire, available in English and Somali, was used to collect data on socio-demographic information, family and migration history, physical and mental health, norms and rights, experiences of intimate and non-partner violence, safety in the camps, intervention exposure, social support, hope, and coping mechanisms.

Measures

Experiences of Non-Partner Violence (NPV) and Intimate Partner Violence (IPV) were captured using questions adapted from the World Health Organization's multi-country study on women's health and domestic violence against women to determine emotional, physical and sexual IPV and physical and sexual NPV.[24] Participants who reported having a current or previous partner were asked whether their current or most recent partner had ever perpetrated specific acts of emotional, physical, and sexual violence against them or had perpetrated these acts in the previous 12 months. Emotional IPV included any instance where a woman's partner: (1) became angry when she spoke to other men; (2) insisted on knowing where she was at all times; (3) forbade her from seeing friends; (4) acted in a frightening or intimidating way; or (5) threatened to hurt them or someone they cared about. Physical IPV was recorded where participants were slapped, had something thrown at them, were pushed or hit with a hand or other object or were kicked, dragged, beaten, choked, burned intentionally, threatened or assaulted with a gun/knife/other weapon perpetrated by their partner. Physical NPV was recorded where individuals reported being: (1) beaten with a fist, kicked or hurt with an object; and (2) assaulted with a gun, knife or other weapon by a non-partner. Sexual IPV was defined as any experience of forced sex by an intimate partner while sexual NPV was any act of forced sex by a non-partner. Experiences of violence in their lifetime as well as in the past 12 months were captured.

Data were collected on an ODK electronic data capture platform using Android tablets, and uploaded to a secure server daily. Descriptive data analysis was carried out to characterise the GBV survivors, including their socio-demographic characteristics and lifetime or more recent experiences of different types of violence as reported in summary tables. Categorical data were presented with frequency counts and percentages for each category.

The qualitative in-depth interview (IDI) guide, deliverable in both English and Somali, was used to explore issues such as the context of GBV in the camps, support or care received after experiences of violence, and the barriers and facilitators to care-seeking. Overall, 34 interviews were conducted in 2017, 17 from each of IRC and CARE, with 22 returning and 12 new respondents. The interviews were audio recorded with permission from the participant and the audio files translated and transcribed in English. The research team developed a coding structure that was used to organise and extract themes from the interviews, guided by the key research questions and issues emerging from the data.[22] All transcribed interviews were coded in NVivo® using a codebook. Further details regarding the methods and analyses are available in a report by Hossain et al.[23]

Results

Socio-demographic characteristics of survivors

Survey participants

Women enrolled in the quantitative study were between ages 18 and 66 years old, with a mean age of 29 years. A large majority of women in the cohort identified as Muslim (99.0%), just over half (55.0%) had no current partner (never married, partner missing [location unknown], widowed, or divorced), and more than two-thirds (68.4%) of women reported a low monthly income of less than 5000 Kenyan Shillings (approximately 50 USD). Socio-demographic characteristics of women surveyed by type of violence experienced are summarised in Table 1.

In-depth interview (IDI) participants

As shown in Table 2, among the respondents, qualitatively interviewed, 82.3% were between

Table 1. Socio-demographic characteristics %(*n*) of survey respondents by type of violence experienced as reported by the survivor

Characteristics	None[1] (*n* = 26)	NPV (*n* = 55)	IPV (*n* = 57)	NPV & IPV (*n* = 71)	Total survey respondents (*n* = 209)	*p*-valuee
Age (years)						
18–24	46.2 (12)	40.0 (22)	42.1 (24)	28.2 (20)	37.3 (78)	0.568
25–34	30.8 (8)	32.7 (18)	38.6 (22)	47.9 (34)	39.2 (82)	
35–44	15.4 (4)	16.4 (9)	15.8 (9)	18.3 (13)	16.7 (35)	
45+	7.7 (2)	10.9 (6)	3.5 (2)	5.6 (4)	6.7 (14)	
Nationality						
Somalian	92.3 (24)	94.5 (52)	96.5 (55)	93.0 (66)	94.3 (197)	0.679
Ethiopian	3.8 (1)	3.6 (2)	0.0 (0)	2.8 (2)	2.4 (5)	
South Sudanese	3.8 (1)	0.0 (0)	0.0 (0)	1.4 (1)	1.0 (2)	
Kenyan	0.0 (0)	1.8 (1)	3.5 (2)	2.8 (2)	2.4 (5)	
Education level						
Madrasa[2]/no formal	15.4 (4)	12.7 (7)	24.6 (14)	19.7 (14)	18.7 (39)	0.084
Finished primary/some primary	65.4 (17)	80.0 (44)	73.7 (42)	74.6 (53)	74.6 (156)	
Some secondary and above	19.2 (5)	7.3 (4)	1.8 (1)	5.6 (4)	6.7 (14)	
Partnership status						
Never married	19.2 (5)	21.8 (12)	0.0 (0)	1.4 (1)	8.6 (18)	0.000
Married (monogamous)	38.5 (10)	23.6 (13)	40.4 (23)	31.0 (22)	32.5 (68)	
Married (polygamous)	11.5 (3)	7.3 (4)	21.1 (12)	9.9 (7)	12.4 (26)	
Partner missing[3]	23.1 (6)	36.4 (20)	38.6 (22)	53.5 (38)	41.1 (86)	
Widowed/divorced	7.7 (2)	10.9 (6)	0.0 (0)	4.2 (3)	5.3 (11)	
Primary source of income						
Do not earn money	61.5 (16)	70.9 (39)	54.4 (31)	50.7 (36)	58.4 (122)	0.670
Casual labourer	23.1 (6)	16.4 (9)	26.3 (15)	31.0 (22)	24.9 (52)	
Food service/cook	3.8 (1)	1.8 (1)	5.3 (3)	7.0 (5)	4.8 (10)	
Domestic worker	0.0 (0)	5.5 (3)	5.3 (3)	4.2 (3)	4.3 (9)	
Other	11.5 (3)	5.5 (3)	8.8 (5)	7.0 (5)	7.7 (16)	
Monthly income (Kenya Shillings)						
None	30.8 (8)	29.1 (16)	24.6 (14)	16.9 (12)	23.9 (50)	0.303
1–2500	19.2 (5)	25.5 (14)	14.0 (8)	16.9 (12)	18.7 (39)	
2501–5000	15.4 (4)	29.1 (16)	29.8 (17)	23.9 (17)	25.8 (54)	
5001–7500	15.4 (4)	9.1 (5)	12.3 (7)	15.5 (11)	12.9 (27)	
7501+	19.2 (5)	7.3 (4)	19.3 (11)	26.8 (19)	18.7 (39)	

(*Continued*)

Table 1. Continued

Characteristics	None[1] (*n* = 26)	NPV (*n* = 55)	IPV (*n* = 57)	NPV & IPV (*n* = 71)	Total survey respondents (*n* = 209)	*p*-valuee
Length of stay in Dadaab (years)						
Less than 5	11.5 (3)	20.0 (11)	22.8 (13)	18.3 (13)	19.1 (40)	0.201
6–10	53.8 (14)	36.4 (20)	35.1 (20)	42.3 (30)	40.2 (84)	
11–20	15.4 (4)	21.8 (12)	26.3 (15)	9.9 (7)	18.2 (38)	
21–30	11.5 (3)	21.8 (12)	12.3 (7)	25.4 (18)	19.1 (40)	
Missing	7.7 (2)	0.0 (0)	3.5 (2)	4.2 (3)	3.3 (7)	
Family members in Dadaab						
None	34.6 (9)	47.3 (26)	36.8 (21)	42.3 (30)	41.1 (86)	0.347
1–3	15.4 (4)	21.8 (12)	29.8 (17)	31.0 (22)	26.3 (55)	
4+	50.0 (13)	30.9 (17)	33.3 (19)	26.8 (19)	32.5 (68)	
Partner's age						
18–24	11.5 (3)	1.8 (1)	7.0 (4)	2.8 (2)	4.8 (10)	0.383
25–34	23.1 (6)	20.0 (11)	26.3 (15)	32.4 (23)	26.3 (55)	
35–44	15.4 (4)	12.7 (7)	19.3 (11)	16.9 (12)	16.3 (34)	
45+	7.7 (2)	23.6 (13)	24.6 (14)	16.9 (12)	19.6 (41)	
Missing	42.3 (11)	41.8 (23)	22.8 (13)	31.0 (22)	33.0 (69)	
Partner education level						
Madrasa/no formal	38.5 (10)	49.1 (27)	49.1 (28)	33.8 (24)	42.6 (89)	0.129
Finished primary/some primary	34.6 (9)	38.2 (21)	40.4 (23)	38.0 (27)	38.3 (80)	
Some secondary and above	26.9 (7)	12.7 (7)	10.5 (6)	28.2 (20)	19.1 (40)	
Total survey respondents	12.5 (26)	26.4 (55)	27.4 (57)	34.0 (71)	100 (209)	

[1]Some of the women reporting a new case to the GBV centre were seeking material support for their families rather than reporting an incident of violence.
[2]Madrasa is an Arabic word for a type of religious school designed for the teaching of Islam. These schools may on occasion offer teach other subjects.
[3]Partner's location is unknown

ages 21 and 40 years, over half (55.9%) had no formal education and were not currently married (67.7%), with many (85.3%) having lived in Dadaab for over eight years or since birth. Only one of the respondents indicated that they were not of Somali origin.

Awareness and experiences of GBV

At baseline, more than half of women accessing GBV services in the camps reported a lifetime experience of non-partner violence (NPV) (60.3%). Acts of NPV experienced included being beaten with a fist or kicked (52.6%) or having a weapon used against them (25.8%) as shown in Table 3.

Among 192 (91.9%) of survey participants who reported having a current or previous partner, 128 (66.7%) experienced IPV in their lifetime while 98 (51.0%) experienced IPV in the last 12 months. Of those who had current or previous relationships, 117 (60.9%) reported that their

Table 2. Socio-demographic characteristics %(*n*) of in-depth interview respondents reporting to the IRC and CARE GBV centres

Characteristics	IRC (*n* = 17)	CARE (*n* = 17)	Total IDI respondents (*n* = 34)
Age (years)			
<21	11.8 (2)	5.9 (1)	8.8 (3)
21–30	41.2 (7)	64.7 (11)	52.9 (18)
31–40	35.3 (6)	23.5 (4)	29.4 (10)
>40	11.8 (2)	5.9 (1)	8.8 (3)
Education			
No formal education	64.7 (11)	47.1 (8)	55.9 (19)
Some or completed primary	23.5 (4)	35.3 (6)	29.4 (10)
Some or completed secondary	11.8 (2)	17.6 (3)	14.7 (5)
Marital status			
Never married	0.0 (0)	11.8 (2)	5.9 (2)
Currently married	35.3 (6)	29.4 (5)	32.3 (11)
No current partner[1]	64.7 (11)	58.8 (10)	61.8 (21)
Arrival in Dadaab			
Before 2000	17.6 (3)	29.4 (5)	23.5 (8)
2000–2009	70.6 (12)	41.2 (7)	55.9 (19)
After 2009	11.8 (2)	17.6 (3)	14.7 (5)
Born in Dadaab	0.0 (0)	11.8 (2)	5.9 (2)
Total IDI respondents	50 (17)	50 (17)	100 (34)

[1] No current partner includes widowed, divorced, separated, and partner missing (location of partner is unknown).

partner demonstrated controlling behaviour and 105 (54.7%) reported having experienced physical and/or sexual IPV in their lifetime, with specific acts summarised in Table 4.

In the in-depth interviews with women on the types of intimate partner and non-partner violence they had experienced or witnessed in the camps, they reported physical, sexual, emotional, and economic violence, with physical assault and rape being the most commonly reported forms of violence in the community. Women reported that sexual violence was mostly perpetrated by non-partners. Among the women enrolled in the cohort survey, 17.2% and 16.3% of those who had experienced NPV in their lifetime had been forced to undress or forced to have sex respectively. One woman reflected on the burden of such violations

Table 3. Lifetime %(*n*) and past 12 months %(*n*) experience of non-partner violence as reported by the survivor

Type of NPV	Lifetime experience of NPV	Past 12 months experience of NPV
Beaten with a fist/ kicked/hurt	52.6 (110)	33.0 (69)
Used a gun/knife/ other weapon against respondent	25.8 (54)	8.1 (17)
Forced to undress/ stripped	17.2 (36)	6.7 (14)
Forced to have sex	16.3 (34)	6.2 (13)
Total respondents	60.3 (126)	38.8 (81)

noting that " … *there is so much (rape). In my block the other day a 10-year-old girl was left at home and her mom went to the market. A man knocked and asked for water to drink as the young girl bent to fetch the water he raped her and ran away when the neighbours came because of the little girl screaming.*" (Survivor, 35 years).

When asked about factors that increase vulnerability to violence, women reported that unmarried women and young girls were particularly at risk for NPV, including physical assaults and rape, because they were often left alone and unprotected. According to one single mother, "*They [women] feel insecure. Like me, because I have seven daughters and I have no one to protect us. They are in danger of rape or being physically beaten. Because of that, my security isn't good.*" (Survivor, 37 years).

In the survey, reports of physical violence, which included being hit or beaten, were mostly perpetrated by current or former husbands/partners of survivors. Among the 192 respondents who reported having a current or previous partner, 52.1% indicated that they had been slapped or had something thrown at them, and 39.1% reported having been kicked, dragged, or beaten, and 13.0% were forced to have sex. One interviewee noted that "*There are troublesome people who disregard women's rights. There are so many women who have been raped, beaten by their husbands, or disrespected.*" (Survivor, 26 years).

In some instances, survivors expressed agency in self-preservation, by developing strategies and skills to avoid future victimisation and abuse. These strategies included staying indoors, especially at night, avoid going out alone, and staying away from spaces considered dangerous. Respondents suggested that the safety of women could be enhanced through improved camp security, ensuring the protection of the most vulnerable women in the camps, and increasing GBV education for both men and women. Prayers and

Table 4. Lifetime %(*n*) and past 12 months %(*n*) experience of controlling behaviour, physical and sexual intimate partner violence as reported by the survivor

Type of IPV	Lifetime experience of IPV	Past 12 months experience of IPV
Controlling behaviour (by partner)		
Became angry when respondent spoke to other men	32.3 (62)	21.9 (42)
Insisted on knowing whereabouts always	40.6 (78)	29.2 (56)
Forbid respondent from seeing friends	31.8 (61)	21.9 (42)
Frightened/intimidated respondent	38.5 (74)	25.5 (49)
Threatened to hurt respondent /someone she cared about	41.7 (80)	30.2 (58)
Physical and sexual IPV		
Slapped/thrown something at respondent	52.1 (100)	33.3 (64)
Pushed/shoved respondent	33.3 (64)	22.4 (43)
Hit respondent with his hand or something else	47.9 (92)	31.3 (60)
Kicked/dragged/beat	39.1 (75)	26.0 (50)
Choked/burned respondent intentionally	21.4 (41)	14.1 (27)
Threatened to use a gun/knife/other weapon	18.2 (35)	11.5 (22)
Used a gun/knife/other weapon	8.3 (16)	5.7 (11)
Forced to have sex by using threats/intimidation	14.1 (27)	10.4 (20)
Physically forced to have sex	13.0 (25)	9.4 (18)

Table 5. Care-seeking practices and experiences %(*n*) among survivors reporting to the IRC and CARE GBV centres

Behaviour or experience	
Number of different GBV cases reported to IRC/CARE (in last 12 months)	
None	44.0 (92)
One	36.4 (76)
More than one	5.3 (11)
Missing	14.4 (30)
Number of visits to IRC/CARE for case management (in the last 4 weeks)	
None	46.4 (97)
One	44 (92)
Two	5.3 (11)
More than two	4.3 (9)
Family or friends aware that respondent sought services from IRC/CARE	
No	46.9 (98)
Yes	50.2 (105)
They did not know	2.9 (6)
Family supported respondent's decision to seek help from IRC/CARE	
No	4.3 (9)
Yes	37.8 (79)
They did not know	26.3 (55)
No family/husband or partner	24.9 (52)
Missing	6.7 (14)
Friends supported respondent's decision to seek help from IRC/CARE	
No	24.4 (51)
Yes	29.2 (61)
They did not know	42.1 (88)
Missing	4.3 (9)
Respondent sought help from elsewhere other than IRC/CARE or their staff	
No	87.6 (183)
Yes	12.4 (26)
Most useful aspects of the case management received from IRC/CARE	
Case documentation	13 (27)
Counselling	30.3 (63)
Material support	4.3 (9)
Medical assistance	4.8 (10)
Referral to agencies/police/court/other	15.8 (33)
None	31.7 (66)

intervention by God were also mentioned as key to peace and security in the community.

GBV care-seeking practices and experiences

Among the women surveyed at baseline, as shown in Table 5, 112 (53.6%) reported visiting the IRC or CARE GBV support centres one or more times in the four weeks prior to the date of the interview and receiving some type of case management support. During in-depth interviews, women indicated that agencies were the primary place to seek help for GBV. The most frequently visited agencies were the IRC or CARE GBV offices and the UNHCR.

Only half (50.5%) of all 209 respondents indicated that their family or friends were aware that they were seeking services from IRC or CARE, a third of those women (37.8%) reported that their family supported this decision, and 29.2% that their friends supported this decision. Beyond seeking assistance from the IRC or CARE GBV support centres, few (12.4%) respondents indicated seeking help from other places or people (such as other agencies, family members, friends, elders, or religious leaders). This was confirmed by findings from the in-depth interviews, which revealed concerns with inappropriate management of cases and further victimisation by these other potential sources of support. "*Usually the elders, they put the blame on the woman claiming that she should be taking her husband's orders and be submissive to him at all times.*" (Survivor, 35 years). However, some women noted positive aspects of seeking help from other places such as police stations and hospitals. Survivors indicated that attendance at one agency facilitated referrals to other organisations that could offer additional support to women, demonstrating inter-agency cooperation and coordination. One woman noted that: "*They [women] like to get support from the GBV office or the UN and those other places*" (Survivor, 37 years), while another remarked that "*I went to the police station and they transfer you to the hospital and then they refer you to GBV offices*" (Survivor, 30 years). In contrast, it emerged that some women preferred not to disclose their experiences of GBV and therefore did not receive any help or support from agencies. As stated by one woman, "*There are some [women] who are too scared to share and others are not.*" (Survivor, 25 years).

Barriers to care-seeking among GBV survivors

When women were asked what prevented them from seeking GBV care, accounts from the in-depth interviews revealed multiple barriers that respondents faced when accessing care at the GBV centres. Major barriers women faced included feeling stigmatised by their families or other community members, feeling helpless over their situation, being fearful of future violence, insecurity in the camps, and being denied access to GBV service premises by guards. Additional barriers included fears that their case and information may not be kept confidential, and a lack of knowledge of how and where to seek help from existing GBV services.

Stigma played a particularly significant role in determining whether women sought GBV care or not, for instance, deep-rooted sociocultural norms on the role of women in protecting marriage and family privacy was a barrier to seeking care. "*If a woman is attacked by her husband and she reports it, people will be like she went to accuse her husband*." (Survivor, 25 years). Narratives suggested that popular beliefs in the camps constructed rape and physical assault from non-partners, as the ultimate violation of women, and as incidents which "*loose*" women experienced. In some instances, women who experienced rape in the camps were viewed as having brought it on themselves or as deserving it. The stigma associated with this violation made it difficult to report rape, seek help, and stay integrated within the community or other potentially supportive networks. "*People gossip, they talk about everyone and if they find out, they will talk ill of you. They will even talk about you at 'the tap' [where people meet and fetch water].*" (Survivor, 20 years). Yet another stated that "*I couldn't tell anyone other than my mother, I didn't even tell my sisters [about the rape]. You become demoralised and you lose appetite and you will lose your dignity in the eyes of the people. Your friends will be advised to stay away from you because they believe you are a prostitute.*" (Survivor, 22 years).

Feelings of shame about the abuse and helplessness underpinned much of the women's reluctance to discuss their experiences with others. The general lack of support from the community appeared to compound this. As stated by one woman, "*When one is faced with this misfortune, some [*people*] in the society use that against them. She will be a different person the rest of her life, she will feel helpless and there is lack of support in all aspec*ts" (Survivor, 25 years). Another emphasised that "*there is no difficulty other than worry, fear and ashamed of what happened*" (Survivor, 26 years).

Fear of retaliation by the perpetrator was also a barrier to women seeking GBV care and services. This was linked to issues of confidentiality, and the perpetrator finding out that the woman had reported the incident through formal channels, resulting in threats and escalating violence. Perpetrators in such cases often included husbands and other community members to whom survivors had to return. "*If your husband gets to know that you visited the GBV office he will ask you why you went there and beat you. So, we have that fear. My husband threatened me so I did not come to GBV centre until today when we are separated*" (Survivor, 23 years). Qualitative data also showed that perpetrators used threats of violence to prevent women from reporting them and to keep them silenced. In some instances, women were only able to seek services after separation with the abusive partners or following relocation away from their attackers.

Although the refugee camp agencies played a key role in facilitating care-seeking practices among women who had experienced GBV, some women expressed frustrations gaining access to and fully benefitting from the services of the organisations to which they were referred. Some respondents reported that the guards at the UNHCR gates either denied them entry or asked for bribes to allow them access to the facility. One of the survivors narrated her experience seeking help from the UNHCR, following a referral: "*I came to the gate at the UN but they* [the security guards] *denied me entrance. I came back with another letter from the agency, but they still denied me entrance. Now I am thinking of joining the repatriation process to go back [to Somalia]. They ask for [Kenya Shillings] 200 [*equivalent to USD 2.00*]. Where will I get 200 when I only get 50 per working day?"* (Survivor, 20 years). Another complained about long waiting times before one was able to get assistance. "*Our biggest problem is at UNHCR, if they send us to the UNHCR offices, the guards at the gate won't allow you in. If they allow you, you have to go through 'halls' one after the other. Sometimes you come back in the evening tired and with no appointment letter or without getting what you want"* (Survivor, 37 years).

Women also expressed fear of confidentiality breaches by RCWs, who are fellow refugees also living in the camps. "*The workers here have been working for long and they know the clients. They have been living with each other over 20 years in the camp and they know people so they share your information. I would love for them to be changed and others to be brought.*" (Survivor, 20 years). Survivors further raised issues with incorrect translations by RCWs offering language interpretation support during their interaction with professional staff, and perceived biases based on clan differences with respect to service delivery by the RCWs.

Facilitators to care-seeking among GBV survivors

Among women accessing services at the GBV centres, the most common facilitators to care seeking expressed in the qualitative interviews were knowledge of the GBV services and support available to survivors, as a consequence of the awareness creation activities organised by the GBV agencies, and a high self-perceived severity of the act(s) of violence experienced.

The GBV awareness creation activities in the camps were reported as a major facilitator to care-seeking. These activities made women aware of where to go for assistance. "*The organisations called women and educated them on GBV, that's how I got know about the services of GBV office*" (Survivor, 27 years). Survivors shared positive sentiments about the GBV services received at the GBV centres either from personal experience or from what was known in the community. This seemed to contribute to their willingness to seek these services. "*… the organisation treated me well. I haven't been mistreated at the GBV centre or other referral agencies in Dadaab. They gave me great check-up and good medication and the counselling was good. They advised me well*" (Survivor, 35 years).

A high self-perceived severity of the violence experienced by survivors and its devastating effects encouraged women to seek help. This was attributed to the GBV awareness creation activities in the camps and the increasing acceptance that some cultural, and often violent practices, were not beneficial to women. One woman acknowledged that it was "*the magnitude of the problems I faced that brought me here since it was my first time*" *(Survivor, 20 years),* while another noted that "*the problems we face are what gives us courage*" and that "*the confidence I have with this office will make me come back.*" (Survivor, 32 years).

Overall, among women accessing care, the qualitative findings showed that they valued the services they had received from the GBV centres, and the respectfulness of the GBV service providers handling their cases. The women appreciated the follow-up and check-in visits from RCWs in their homes. Women spoke highly of the counselling

and support they received at the GBV centres. As recounted by one woman, "*they gave me advice and counselling which helped me a lot and they told me to be patient and if future opportunities came forward, they would help me in any way they can*" (Survivor, 30 years). Another notes that "*They gave me peace of mind which is the most important thing someone can offer, and they gave me a mosquito net.*" (Survivor, 38 years). Women were also particularly appreciative of the material items they were given. "*Yes, I got a lot of services from them for example they gave me food stuffs like pasta, soap, mosquito net, and jiko [*cooking stove]*"* (Survivor, 32 years)

Discussion

This study provided insights into the context of GBV and care-seeking behaviours for survivors in the Dadaab refugee complex, with the research findings confirming the magnitude and complexity of GBV experienced by women and girls in Dadaab. These findings closely mirror global evidence[4] as well as evidence from other humanitarian settings.[10,25] Respondents, comprising of survivors in care, noted that violence against women and girls was common, and reported more instances of intimate partner violence than non-partner violence in the last 12 months.

Even though emancipated female minors reporting new GBV cases were eligible participants, none were encountered during the study. However, interviews with women revealed that girls as young as 10 years of age encountered GBV in the camps. It is possible that these young girls were not able to reach the GBV centres, perhaps due to fear of retaliation by perpetrators or lack of support seeking help from family members, among others. During the study period, CARE enhanced their community outreach activities to deal with some GBV cases in the blocks where refugees live. Perhaps such avenues for GBV case management, targeting minors, may be a helpful approach to ensure that these young girls receive help.

Family, friends, and the community can be important sources of support for women who have experienced GBV. However, for many of the women who had been violated by their partners, and especially in a setting such as Dadaab – where women are seen as responsible for familial harmony – they were unable to rely on these sources for support. Relatives and the wider community may, in fact, encourage these women to reunite with their abusers. Related to both intimate and non-partner violence, women reported feeling stigmatised, helpless about their situation, and fearful of further violence from family and/or other community members. Consequently, access to free, effective, survivor-centred care and social support services is vital.[26]

The study findings suggest that multi-sectoral approaches should be employed in both the prevention of GBV and provision of care to survivors in humanitarian and other settings. This may be achieved, for instance, through use of the Gender-Based Violence Information Management System (GBVIMS), an inter-agency initiative governed by a Steering Committee made up of representatives from UNHCR, UNFPA, IRC, and UNICEF. This system is aimed at improving data collection about the availability, utilisation and effectiveness of services across all key sectors responsible for VAWG response.[27]

Michau and colleagues propose that violence against women and girls in low- and middle-income countries can be prevented through interventions that target the key driver of violence in these settings – unequal gender-power relations – and the way these inequalities shape individual and collective attitudes, norms, and behaviours.[28] Similarly in humanitarian settings, the importance of programmes that include women's economic and social empowerment, and participatory programming to foster gender equity between women and men, has been emphasised.[29]

The individualised comprehensive case management model that was implemented by IRC and CARE in the Dadaab refugee camps had components that were highly focused on the needs of the individual survivor, implementation of a wide-ranging set of services, using trained staff to deliver the services, and a consideration of the wider context within which the services operated. Despite these, the study found some gaps. For example, while RCWs were tasked with encouraging service seeking behaviour among GBV survivors as well as facilitating access to services in their own community, survivors raised issues of confidentiality, mistranslations, and perceived biases based on clan differences with respect to service delivery by the refugee community workers. Some of these barriers have previously been recognised in the literature. In Haiti, logistics, infrastructure, language, and community factors were identified barriers to effective engagement

with communities on GBV prevention following the displacement of people after a massive earthquake.[30] The barriers explored in this study may be tackled through the provision of additional training to RCWs on case management guidelines and best practices as recommended in the final study report.[23]

The study highlighted the success of the GBV awareness raising campaigns in the community, and suggests that intensification of such events, including those that focus on social norm change, specifically targeting gender-power relations, as well as sharing information on what services are available for GBV survivors, would be a great way to reap more benefits to this end. For instance, education about the severity of health risks associated with GBV may be a motivating factor for care-seeking, in a context where a high self-perceived severity of the act of violence is a facilitator to seeking help. Governments, international development agencies, non-governmental organisations (NGOs), local institutions including faith-based and women's rights institutions, and community groups, can all play a part in both challenging and changing social norms. This work would require change at many levels throughout society. Strategies at the community level may include individual and group activities with community members, influential individuals, community groups, and increasingly, perpetrators. A number of local and women's rights organisations have existing expertise in this area of work. Further, a growing awareness of GBV as a development and humanitarian issue has led to mounting interest and resource support from international NGOs and aid funders.[26]

In addition, the study identified some of the structural barriers women faced accessing referral services and moving around in what they felt was an insecure camp. The security of women accessing GBV services, referral services, or returning home (or to alternative accommodation) after an incident needs to be addressed. Vulnerable women and girls, as well as the communities that support them, need to know their rights, know where to seek protection, and know where to access services. Survivors need to trust the services and providers, and be encouraged and supported to seek help. Without such interventions, even the best programmes are likely to fail in their ultimate goal, which is preventing, reducing, and mitigating the impacts of violence against women and girls, as well as the longer term impact on families and communities. Programming must most centrally support women to access services.[3]

This study was not without limitations. First, interviewing survivors who are already in care is arguably a more ethical approach; however, caution must be taken in the interpretation of the findings since the study aim – to explore barriers and facilitators to care seeking – was conducted among women who are already using GBV services. Second, the participants of this study were all residents of two Dadaab refugee camps and as such are not representative of all refugee settlements in Kenya or elsewhere. Nevertheless, the findings of this study may have important implications for programming in other refugee camps. Third, despite taking time to explain that there were no immediate benefits to participants, some respondents still had hope that they would get some material support from the researchers after participating in the study. Interviewers had to take time to explain that the project was not going to give them any material goods, rather, that the findings of the study may help improve GBV programming in Dadaab. Fourth, during the study period, CARE enhanced their community outreach as a measure of dealing with GBV cases within the blocks where refugees live, as opposed to solely conducting GBV response services within the GBV centre. While of significant benefit to the refugees, this reduced the number of women reporting new cases at the centre, and consequently, the number of potential participants for the study. Lastly, there were several interruptions following a directive by the Kenyan Government to shut down the refugee camp and encourage repatriation back to Somalia. The resulting refugee registration and verification exercises caused a refocusing of efforts by many women and families towards registration and other related activities, contributing to a reduced number of women reporting to GBV facilities.

Conclusions

Issues explored in this study include the potential for the refugee context to exacerbate GBV; the unique intersectionality and complexity of systems and factors that sustain GBV in the camps; the role of the fear of repeat violence, stigma, and/or threats of violence in preventing survivors from benefitting from the full potential of existing GBV services; the survivors' agentive practices for

avoiding further victimisation; and a need for strengthened coordination of the different services offered to survivors of GBV, among others. Female GBV survivors in the Dadaab refugee camps generally valued the existing GBV services they received and considered it responsive to their needs, suggesting that the individualised comprehensive case model of care is promising and can be adapted to other humanitarian contexts with attention to some of the barriers and facilitators to accessing care. There emerged clear opportunities to improve care-seeking, including education on the severity of health risks associated with GBV, alongside strengthened safety and protection mechanisms for survivors. Further research is needed to understand the long-term impact of accessing care.

Ethics approval and consent to participate

This study was reviewed and approved by the Ethics Committee at the London School of Hygiene and Tropical Medicine in the United Kingdom, and the Ethics and Scientific Review Committee of the African Medical and Research Foundation in Kenya (Protocol Reference Number P173-2015). Informed consent was obtained from all interviewees for their participation in the study and for audio-recording the qualitative interviews.

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Data availability statement

The datasets and transcripts generated and analysed during the current study are not publicly available due to the sensitive nature of the research and the uniqueness of the study population. An anonymized quantitative dataset may be made available by the principle investigator (MH) on reasonable request.

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Résumé

Dans les contextes humanitaires, l'accès ponctuel aux soins est essentiel pour les victimes des violences sexistes. En dépit de l'existence de services de soutien, des obstacles persistent pour que les victimes en retirent tous les avantages. Cette étude souhaitait comprendre les caractéristiques de la violence contre les femmes tout en explorant les obstacles et les facteurs qui facilitent la demande de soins des femmes victimes de violences sexistes dans deux camps situés dans le complexe de réfugiés de Dadaab au Kenya. Des méthodes mixtes ont été choisies pour étudier les femmes ayant eu accès à des services complets en cas de violences sexistes entre février 2016 et février 2017. Les femmes ont été recrutées dans une étude de cohorte ($n = 209$) et certaines sélectionnées pour des entretiens qualitatifs approfondis ($n = 34$). Les caractéristiques des victimes ont été analysées de manière descriptive à partir de mesures de référence et les données des entretiens évaluées de manière thématique. Une majorité de femmes étaient musulmanes, d'origine somalienne, résidaient dans le camp depuis plus de cinq ans, étaient peu ou pas instruites et disposaient d'un revenu mensuel modeste ou inexistant. D'après l'enquête, 60,3% et 66,7% des femmes avaient déjà connu des violences infligées par une personne autre que leur partenaire ou des violences conjugales respectivement. Les facteurs facilitant l'accès des victimes aux services de soutien comprenaient la connaissance des services et la perception personnelle de la gravité des actes de violence. Les obstacles incluaient la stigmatisation par la famille et la communauté, la crainte de nouvelles violences de la part des coupables, les sentiments d'impuissance et d'insécurité et le refus d'entrée dans les locaux par des gardes. Les femmes dans les camps de réfugiés de Dadaab font face à des violences conjugales, familiales et de la part d'autres réfugiés. Il est urgent de s'attaquer aux facteurs des violences sexistes et aux obstacles qui contrarient la révélation de ces actes et l'accès aux services pour toutes les victimes.

Resumen

En entornos humanitarios, el acceso oportuno a los servicios de salud es esencial para sobrevivientes de violencia de género (VG). Pese a la existencia de servicios de apoyo a sobrevivientes de VG, aún existen retos para maximizar los beneficios para sobrevivientes. El objetivo de este estudio era entender las características de la violencia contra las mujeres y explorar las barreras y los facilitadores de la búsqueda de atención por VG por mujeres en dos campos dentro del complejo de refugiados de Dadaab, en Kenia. Se utilizó un diseño de combinación de métodos para estudiar a las mujeres que acceden a servicios integrales relacionados con VG, entre febrero de 2016 y febrero de 2017. Se reclutaron mujeres para que participaran en un estudio de cohortes ($n = 209$) y algunas fueron seleccionadas intencionalmente para que participaran en entrevistas cualitativas a profundidad ($n = 34$). Las características de las sobrevivientes fueron analizadas de manera descriptiva según las medidas de referencia, y los datos de las entrevistas fueron evaluados por temática. La mayoría de las mujeres eran musulmanas, de origen somalí, residían en el campo desde hace más de cinco años, tenían poca o ninguna formación académica y escaso o ningún ingreso mensual. Según la encuesta, el 60.3% y el 66.7% de las mujeres habían sufrido violencia infligida por una persona que no era su pareja o violencia infligida por su pareja, a lo largo de su vida respectivamente. Ejemplos de facilitadores para acceder a los servicios de atención a sobrevivientes de VG eran: conocimiento de los servicios y autopercepción de la gravedad de los actos de violencia. Ejemplos de barreras eran: estigma por la familia y la comunidad, temor de continuar sufriendo violencia por los perpetradores, sentimientos de impotencia e inseguridad, y negación de entrada a las instalaciones de prestación de servicios por los guardias. Las mujeres en los campos de refugiados en Dadaab enfrentan violencia infligida por sus parejas, familia y otros refugiados. Existe una necesidad urgente de abordar los impulsores de VG y las barreras para denunciar la violencia y acceder a los servicios para todas las sobrevivientes de VG.