

Community based programmes in the field of Sexual and Gender Based Violence

Refugees living in refugee camps have specific characteristics. Their community and family structures are often destroyed and living in a refugee camp causes an increase in social tension. Cultural notions and practices are under pressure and families lose their function as a safety net and support system. These changes of social mechanisms are most of the time accompanied by discomfort, distress, agitation and violence.

Disrupted family structures

The daily hardship and the changes in gender relationships in the refugee camps are risk factors for one of the most radical types of violence: domestic violence. In an earlier study we found that when women in the refugee camps got food from the UNHCR, men experienced this support as a loss of their social status because this support implicate that they are not able to take care of their families. This loss of the 'breadwinner' status may cause frustrations among the men, and under these unfavourable circumstances, easily resulting in beating their wives. Men under these circumstances feel humiliated and have difficulties to deal with the awareness campaigns on women's rights.

Apart from violence also cultural practices and traditions can be perceived as harmful for the well-being of people in refugee camps; e.g. widows are forced to marry the brother of their late husbands and have no cultural options to refuse. In our earlier study in refugee camps in Burundi, Rwanda and Tanzania, we also found that refugees and care providers described various types of (sexual) violence.

Addressing the violence

A cultural relevant way to address the disrupted social mechanism that may cause these domestic conflicts is via family mediation, but due to their flight from their home countries, families are separated and this traditional way of conflict solving in cases of domestic violence is no longer available for many refugees.

Although different type of violence were observed, people in the camps, expressed that most refugees stay quiet. Having sex outside marriage is regarded as shameful and often the women or girls are blamed. Most women would not make their problems public and kept quiet as they were too afraid of being denounced. Acts of *Sexual and Gender based Violence* (SGBV) evoke shaming and blaming, social stigma, and often rejection by the victim's family and community. Stigma and rejection can be especially severe when the victim speaks about or reports the incident. Any available data, in any setting, about SGBV reports from police, legal, health, or other sources will represent only a very small proportion of the actual number of incidents of SGBV.

Sexual and gender-based violence (SGBV) units in refugee camps

The programs of the SGBV units are similar across camps. SGBV units provide programs in the field of peace education, reproductive health, gender and human rights, and girls' education. The staff of the SGBV units is a mix of professionals and volunteers, and most of them are refugees. From the moment they come into contact with a refugee who has experienced violence, they follow a protocol. First they accompany the refugee to the health centre for a medical examination and treatment, and for psychological assistance. They motivate the refugee to report the event to the police. The village leader, area leader and camp committee can support such a person, by taking the perpetrator to the police and to offer help, if necessary, with income-generating activities.

The SGBV units offer practical support, legal aid, and counselling for individuals, couples and families. Camps with child protection units organise individual counselling for girls who have been raped (reported cases of boys being raped are very rare) and counselling for the family. The children also have group meetings to regain their self-esteem.

For many health care workers and community workers it is often difficult to raise the question with refugees of violence and if it is involved in their complaints, especially sexual violence. However, the camp authorities will give shelter to persons who are rejected by their relatives.

Up to now the focus of the SGBV units is on the victims of violence, regarding health care and support. However, as we have seen during our assessment and in other research, the consequences of the violence, such as the social condemnation, the social exclusion, teasing or other forms of violence, is considered as more difficult to deal with than the original violence the victim experienced. This social behaviour is related with the cultural discourse of a community, which is constructed from cultural assumptions, cultural notions of femininity, masculinity, sexuality, gender identity and roles, values of personal responsibility of men and women, power relations, how to control the environment, how daily life should be arranged, and an orientation toward the future. Such cultural discourse has the function of a “cultural script, a kind of social character”, directing individual’s narratives, behaviour and the making of meaning. It might be inclusive and protective of its members; but it might also be socially controlling, making it difficult for people who experienced violence. This is even more the case within cultural groups where social harmony is more important than autonomy.

It can be argued whether the current protocol used by the SGBV units adequately takes into account the social cultural consequences of the sexual and gender based violence, that is, the current protocol may be too much focused on dealing with the experienced aversive event and less focussed on the current and mid-term consequences of that event for both the victim and the social network.

Research Objective

As a consequence of these social processes the SGBV units should not only be individual oriented (as is normal in most Western societies) *but* also on the refugee community. The goal of this research is to develop a community-based and cultural sensitive intervention to improve the social acceptance and community support.

It requires interventions based on the refugee group that include awareness of the existed judgment and prejudiced against people who experienced SGBV. It requires active involvement of men in efforts to prevent SGBV and active interference to stop SGBV. This requires coordinated multisectoral action. These interventions are as part of the overall goal is to improve the health status and wellbeing of refugees residing in Tanzania, Rwanda and Burundi.

Action Research

We work according to the so called Action Research Method. Action research is ‘finding an adequate solution for a common perceived problem by doing’. In this research we work together with workers of the SGBV unit, the UNHCR and other implementing partners as well as with leaders, key persons and other members of the refugee population to define what is regarded as the best (culturally accepted) way to improve the social acceptance of victims, the social disapproval of perpetrators and to improve community support. This requires an active collaboration of researcher and the people of the SGBV unit in the camp.

HealthNet TPO considers community (also refugee communities) approach as an integral component of maintain and strengthen health and well-being. Interventions on the groups behaviour and, often unconscious, cultural notions can have a beneficial effect on health without the interference of formal health care; its focus is to improve well-being by making the social environment more responsible for the wellbeing of their social group. It is about empowering people to restore or create social responsibility for violent expressions of their members. This much more socially oriented action should and can be undertaken by local people within the communities where they live or are forced to live.

This approach describes and analyses the individual and collective mechanisms that ensure or hinder acceptance and support of people who suffer from SGBV and that tackle perpetrators on their conduct. By doing this we not only focus on factors threatening well-being and health of the people who suffer from SGBV, the *risk factors*, but also investigate variables of *protective factors* among groups and individuals (e.g. coping skills, self-efficacy, agency and social support). The approach aims to incorporate the knowledge and opinions of people in the planning and management of development projects and programmes.

Below we present an outline of several activities that we conduct as part of this action research. These are indicative steps and might change throughout the study and implementation of the intervention. A certain amount of flexibility in the research activities is important to allow for adjustments based on findings in the second step of the study, namely the perceptions of the workers of the SGBV units about how to influence the unwanted cultural behaviour.

Step 1: A literature review on the different community approaches in the field of SGBV done in different social and cultural settings. Literature reviews take into account publications, documents and grey literature specific to this topic.

Step 2: The first visit (2 weeks) of the researcher to the camp to create in-depth conceptual understanding of the aspects that hinder people who experienced SGBV to fully participate in their societies. It needs a broader perspective that provides insight into how gender and gender relations are experienced as a hindrance for well-being and social participation. Methods used: discussions with the workers of the SGBV, UNHCR staff, focus group discussions with groups of women, men, adolescent girls and boys, teachers, together with in-depth semi-structured interviews with key-informants, community and religious leaders, informal talks and participant observations. Indicators are described.

Step 3: The development, together with the people of the SGBV units and camp leaders, of social interventions based on the outcomes of step one and two. Participation in the development of interventions is an important contributor to *empowerment* of the SGBV units and the beneficiaries.

Step 4: Training of the workers on the new approach.

Step 5: The Introduction and improvement of the interventions by doing and refining. This is a continuing process and will, after the researcher's first visit be followed with the use of email and Skype communication. For the evaluation of such social interventions the described indicators are used to evaluate the impact of interventions.

Step 5: During the second visit (2 weeks) of the researcher the intervention and the indicators will be evaluated with the group of beneficiaries and people of the SGBV unit and other workers in the camp. Further training and Training of Trainers

Step 6: The process will be documented as the final intervention and guidelines will be developed.

Rwanda

The action research is conducted in the Gihembe in Rwanda, because many workers speak English (a necessity since the researcher does not master French) and the camp is close to the Town Byumba, which gives less daily travel time.

Researchers

Marian Tankink (PhD), Medical Anthropologist and Senior Researcher, has done extensive research into issues related to coping sexual violence against women, both among

women in Uganda and refugee women from South Sudan, Afghanistan and Bosnia-Herzegovina in the Netherlands.

Prof. dr. Ivan Komproe, as director of HealthNet TPO R&D department and professor in collective trauma at Utrecht University, will play an advisory role to this project. His key areas of expertise are research methods, research designs, analyses of multisite, extensive and complex data sets and the evaluation (efficacy, effectiveness and cost/benefits) of interventions addressing the impact of organised violence, armed conflict and poverty on the mental health and psychosocial wellbeing on both individual and community level within complex emergencies.