PREVALENCE AND CORRELATES OF SEXUAL AND GENDER BASED VIOLENCE AMONG REFUGEES IN KAKUMA REFUGEE CAMP, TURKANA COUNTY, KENYA

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DECLARATION OF ORIGINALITY FORM

This thesis is my original work and has not been presented to any other examination body.

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ABSTRACT

Introduction: Sexual and Gender-Based Violence (SGBV) is a major public health and human rights problem worldwide. Refugees and Internally Displaced Persons (IDPs) who are affected by armed-conflict are at increased susceptibility to some sexual and gender-based violence. In Kenya, the extent of this challenge in humanitarian settings has not been explored.

Broad Objective: To determine the frequency and correlates of Sexual and Gender-Based Violence (SGBV) in Kakuma refugee camp, Turkana County, Kenya.

Methodology: A mixed method cross-sectional study was used. A total of two hundred and ninety-three (293) refugees were selected using a multistage cluster method. A researcher designed questionnaire was used to assess the participant's socio-demographic characteristics. A SEVEN ITEM Assessment Screen to Identify Survivors Toolkit for Gender Based Violence (ASIST- GBV) was used to screen the participants on their experience of sexual and gender-based violence. A further two (2) Focus Group Discussions (FGDs) and four (4) Key Informant Interviews (KIIs) with women & girls and relevant stakeholders respectively were conducted to corroborate quantitative data. Data collected was double-entered into MS-Access software and errors were checked before data was analyzed using SPSS software.

Results: The overall prevalence of SGBV in the entire camp was 79.9 percent; with the old Kakuma refugee camp recording a higher prevalence of 85.4 percent than Kalobeyei (58.3percent) integrated settlement. Over half of the residents (55.3 percent) had faced threats to violence with almost an equal number (53.9 percent) having experienced actual physical

violence. Age (p=0.023), income per month (p=0.025), marital status (p=0.02) length of stay in the camp (p=0.029) and the camp of residence (p<0.001) were significantly associated with SGBV at bivariate analysis. After adjusting for all factors that were associated with SGBV at the bivariate level at P<0.10, participants who were aged 18-24 years were about three (3) times more likely to report SGBV (A.O.R. 3.09, 95% C.I. 1.28-7.44; p=0.012) as compared to those aged 15-17 years. Those who were previously married were about twenty (20) times more likely to report SGBV as compared to those who were single (A.O.R. 20.8, 95% C.I. 2.04-212.20; p=0.010). Refugees residing in Kakuma camp were about four (4) times more likely to experience SGBV (A.O.R. 4.02, 95% C.I. 1.75-9.25; p=0.001) as compared to those who were living in Kalobeyei settlement. There were no considerable differences in reporting SGBV (p>0.05) in terms of income, length of stay in the camp and alcohol use.

Conclusions: There is generally a high frequency of SGBV in Kakuma refugee camp and Kalobeyei Integrated settlement. Women and young girls bear the brunt of this vice with men and/or boys being the main perpetrators. The factors highly associated with SGBV include age, being formerly in marriage and living in the main Kakuma refugee camp.

Recommendations: To lessen the danger of exposure of women and girls to SGBV, interventions that build the capacity of women to raise their household income need to be put in place. More women need to be sensitized and educated on SGBV and reporting procedures made less lengthy and tedious.

LIST OF ACRONYMS

ASSIST-GBV	Assessment Screen to Identify Survivors Toolkit for Gender Based Violence
DRC	Democratic Republic of Congo
IDP	Internally Displaced Persons
FSW	Female Sex Workers
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
KNH	Kenyatta National Hospital
LGBT	Lesbians, Gay, Bisexuals and Transgender
SGBV	Sexual and Gender Based Violence
UK	United Kingdom
UNHCR	Unite Nations High Commission for Refugees
UNFPA	United Nations Population Fund
UN	United Nations
UoN	University of Nairobi
USAID	United States Aid for International Development

DEFINITION OF OPERATIONAL TERMS

Refugee: Someone who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country**.**

Gender: This refers to the socially construed and accepted roles, norms of women and men and the relationships between the two, and it varies from society to society and can be changed.

Violence: Is the "intentional use of physical or sexual force and/or power, threats or actual, against a person or groups of persons that either result in injury, death, psychological harm and denial of opportunities.

Sexual and Gender Based Violence is the violence that is directed at an individual based on his or her gender identity. It includes physical, sexual, verbal, emotional, and psychological abuse, threats, coercion, economic or educational deprivation, either in public or private.

1.0 CHAPTER ONE: INTRODUCTION

1.1 Background

Sexual and Gender Based Violence (SGBV) is a global public health and human rights concern and prevalent and generally endured forms of human rights violations. It globally cuts across nations, class, race, ethnicity, and religion (Larsson, 2017). SGBV is defined as any physical, sexual and psychological violence that occurs in the society. It includes sexual abuse, battering, marital rape, dowry-related violence, female genital mutilation and other harmful practices to a person based on his or her ascribed gender (Cappa et al., 2019; I.-A. S. Committee, 2015; Holmes et al., 2017; Palermo et al., 2013). The common forms of sexual and gender-based violence includes various abuses such as exploitation, sexual threats, assaults, humiliation, molestation, incest, domestic violence, torture, involuntary prostitution, and attempted rape (United Nations Population Fund (UNFPA) 2013).

Many factors can amplify the risks of experiencing SGBV during humanitarian crises. Some of these factors may include lack of community and state protections, militarization, scarcity of essential resources, displacement, disruption of community services, disrupted relationships and weakened infrastructure and changes in cultural and gender norms. The crumple of social and family support structures, financial unsteadiness and strained associations with the host communities have also been found to increase vulnerability to SGBV (I.-A. S. Committee, 2015). Such crises lead to increased prevalence of SGBV(Tanabe et al., 2015).

Most of the studies on the pervasiveness of SGBV have been conducted on women, and seldom on men. For instance, statistics by United Nations (UN) shows that an estimated 35%

of women globally have experienced some form of violence by a partner or a non-partner at some given point in their lives (Fulu et al., 2013). However, a national study conducted in Uganda found up to 70% of women had experienced physical and/or sexual violence from spouses in their life (Stark & Ager, 2011). From physical to sexual and psychological violence, the magnitude of GBV is alarming (Palermo et al., 2013).

The prevalence is higher in Europe among civil war victims fleeing Eastern Europe and the Middle East. For instance, a study by Hynes and Lopez found that refugee women and girls experienced 69.3 percent sexual violence compared to a paltry 11.0 percent lifetime prevalence for European girls and women (Hynes & Lopes Cardozo, 2000).

In 2005, a W.H.O multi-country study established that women in third world countries of Bangladesh, Tanzania, Peru and Ethiopia experienced twice as much incidences of SGBV than those in Japan (Garcia-Moreno et al., 2006).

In recent times, Intimate Partner Violence (IPV) which is mostly not reported, and rape, which has been used as a tactic for war in humanitarian crisis, have emerged as critical forms of SGBV which call for international attention by the global community (I. R. Committee, 2015; Manjoo & McRaith, 2011). While data is very limited on the extent of SGBV in Africa, estimates indicates that it poses a human rights, health, and development risk (Women in et al., 2018).

In Kenya, the experience of SGBV varies with age and sex. The 2010 Kenya Demographic and Health (KDHS) Survey revealed that roughly 25% of women between the age of 15 and 49 years old had gone through some form of physical violence while 7percent experienced

sexual violence (Kenya National Bureau of Statistics, 2010). This is contrary to the 2014 KDHS where women and men at the age of 15-49 years old had 14percent and 8percent sexual violence respectively. More females (32percent) than males (18percent) were found to have gone through sexual violence before they attain the age of 18 while physical violence was mostly experienced by males (73percent) than females (66percent) (Kenya National Bureau of Statistics, 2014).

In the 2014 KDHS survey, which featured mainly on married or ever married respondents, older women (40-49) years were more likely to experience and report sexual violence (17percent) than young women (7percent) aged (15-19) years. The areas of residence had great influence on exposure of men to physical violence with more men in rural (47percent) than urban (39percent) reporting physical violence. The regional variation showed higher overall rates of both physical and sexual violence in Western Kenya (55.6percent) and the lowest being North Eastern Kenya (12.1percent). Physical violence was higher in Western (51.6percent), Nyanza (49.5), Nairobi (46.1percent) and Eastern regions (40.6percent) while sexual violence rates were higher in Western (25.3percent), Nairobi (21.8percent), Nyanza (19.4percent) and Eastern (12.9percent) regions respectively (KNBS, 2015).

The statistics from these two Kenya health demographic surveys point to a rising trajectory of both sexual and physical violence particularly among the most populous regions in Kenya. This is notably seen in high rates of violence among teenagers before the age of 18 years.

Kakuma refugee camp was established in 1992 to address the issues of the "Lost Boys of Sudan" who had fled from South Sudan to Ethiopia, during the second liberation war in South

Sudan. On that year, big groups of South Sudan refugees in Ethiopia fled to Kenya due to the fall of the government of Ethiopia. The population of the camp has since continued to increase with arrival of refuges from Ethiopia, Somalia, Eritrea, Sudan and the Democratic Republic of Congo (DRC), Rwanda, Burundi and Uganda.

At the end of June 2018, the total population of Kakuma refugee camp and Kalobeyei integrated settlement stood at 185,582 registered refugees and asylum-seekers. The settlement design in the Main Kakuma camp comprises of four sections namely Kakuma 1, 2, 3 and 4. Each section is further divided into blocks and blocks sub-divided into zones. Each zone has several households with mixed nationalities. The Kalobeyei integrated settlement camp is grouped into villages 1 to 3, which are then divided into compounds, each consisting of several households. For purposes of this study, the household will be our sampling unit.

1.2 Problem Statement

Sexual and Gender-Based violence is one of the greatest protection concerns facing emigrant populations in the world today, Kenya included. The risks of SGBV encountered by displaced persons living in camps increases over time because of the disruption of the family system, weak protection and coping strategies combined with the loss of household income and other means of social support networks (Clark, 2003).

Kenya hosts one of the largest refugee camps in Africa with refugees from east, central and the horn of Africa. Whereas the occurrence of SGBV in refugee camps in Kenya is documented by United Nations High Commission for Refugees (UNHCR) and the Kenya government Department of Refugee Affairs (DRA), there are no official statistics on the

prevalence and correlates for SGBV in Kakuma. This may be as a result of lack of studies on this subject or that the available official statistics may be an underestimation due to a large number of unreported cases (USAID, 2016).

In Kenya, as in other Sub-Saharan countries that host refugees, the lack of accurate estimates and up-to-date statistics on the magnitude of the problem and the factors associated to this problem hinders appropriate planning for screening and interventions for refuges despite their increased vulnerability to SGBV (Palermo et al., 2013; Refugee Consortium of Kenya, 2018). This study fills this gap by estimating the prevalence and correlates of SGBV among refugees in Kakuma using easy to administer and validated screening instruments.

1.3 Study Justification

Gender Based Violence whether sexual, physical, or psychological can lead to various long-term psychological consequences for victims such as anxiety, depression, symptoms of post-traumatic stress disorder, low self-esteem, suicidal behavior, emotional detachment, antisocial behavior and fear of intimacy (Mechanic et al., 2008; Overstreet et al., 2015; Pico-Alfonso et al., 2006; Semiatin et al., 2017). These psychological consequences coupled with physical (body injuries) consequences underscore the need for early screening; help seeking and intervention for victims and survivors. It is therefore critical that the extent of the problem be established especially in humanitarian settlements where the prevalence is likely to be high.

Findings from this study provide baseline information on the burden of SGBV in Kakuma refugee camp. This information will help the Kenya government and UNHCR with accurate statistics on the prevalence and correlates of SGBV in the camp, which will inform policy

formulation and direction on how to institute holistic and multifaceted programs on prevention and reduction of gender-based violence in refugee settings.

1.4 Study Objectives

1.4.1 General objective

To determine the prevalence and correlates of sexual and gender-based violence among refugees in Kakuma Refugee camp, Turkana County, Kenya.

1.4.2 Specific Objectives

1. To identify the socio-demographic characteristics of victims and survivors of SGBV in Kakuma Refugee camp
2. To find out the prevalence of SGBV in Kakuma refugee camp
3. To identify other factors associated with the occurrence of SGBV among refugees in Kakuma refugee camp.

1.5 Research Questions

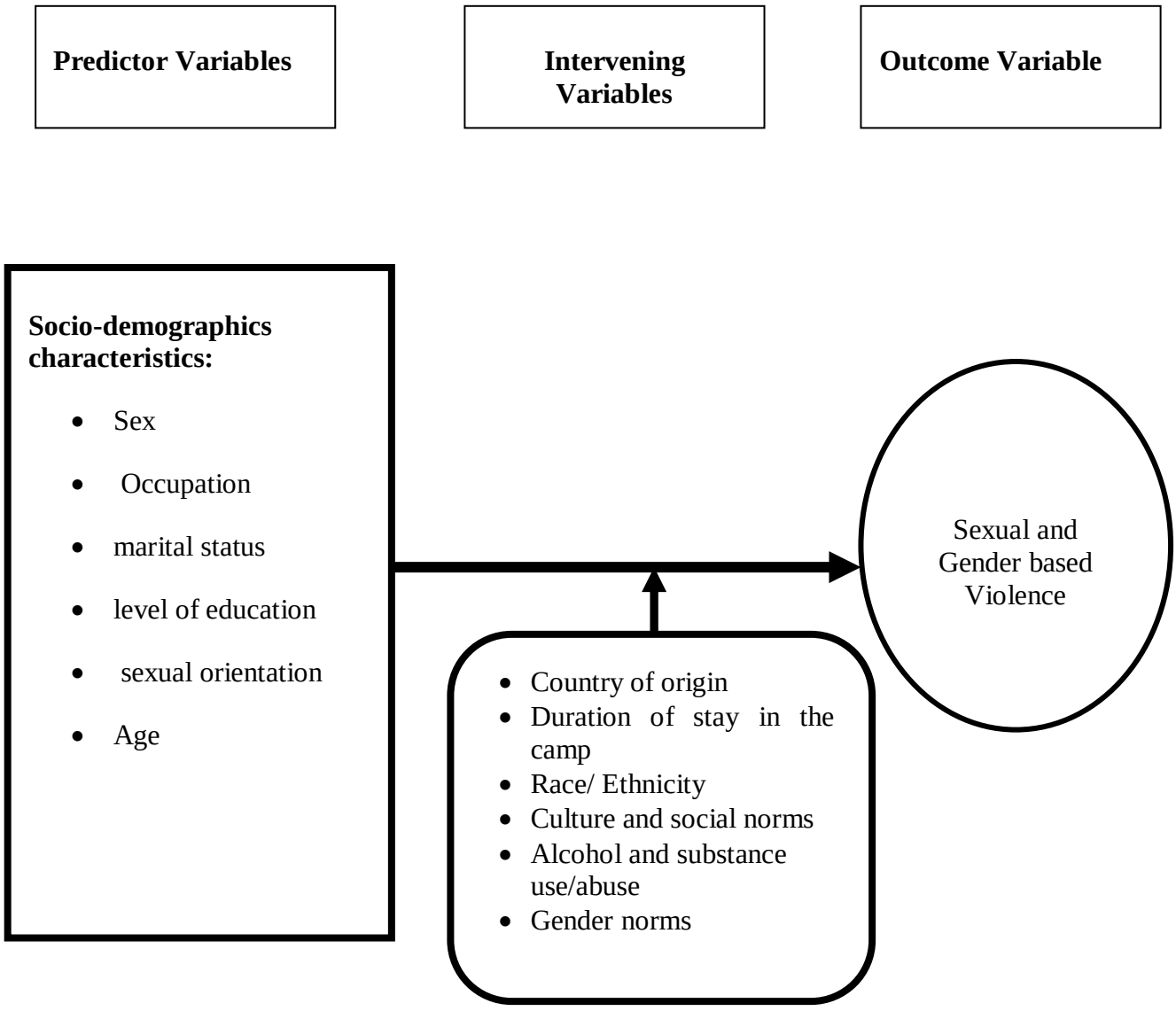
1. What are the socio-demographic characteristics of SGBV victims and survivors in Kakuma refugee camp?
2. What is the prevalence of SGBV among refugees in Kakuma refugee camp?
3. What are other factors associated with the occurrence of SGBV among refugees in Kakuma refugee camp?

1.6 Conceptual Framework

Based on literature review, duration of stay in the camp, race, ethnicity, existing cultural and social norms have been shown to moderate or buffer relationship between socio-demographic

characteristics and their risk or experience of sexual and gender based violence (Christian et al., 2018; Decker et al., 2015; Herrero et al., 2017; Leddy et al., 2018). Other individual characteristics like use/abuse of alcohol and other substances confounds the relationship between the predictor variables and the outcome variables (Leddy et al., 2018).

Figure 1: Conceptual Framework



2.0 CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This section provides a detailed review of literature on description and prevalence of Sexual and Gender Based Violence (SGBV), and the factors associated with the occurrence of gender-based violence in humanitarian settings.

2.2 Sexual and Gender based Violence

Sexual and GBV can further be defined as the physical, sexual and psychological violence occurring in the family and in the community, including battering, sexual abuse of female children, dowry-related violence, marital rape, Female Genital Mutilation (FGM) and other traditional practices harmful to women. The common forms of sexual and gender-based violence include a wide variety of abuses that consist of sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution, torture, and attempted rape (United Nations Population Fund, 2013)

2.3 Prevalence of Gender-Based Violence

There are several definitions that have been developed in relation to gender-based violence. It is, however, critical to note that all these definitions encompass physical, sexual and psychological abuse against a particular individual in the society (USAID, 2014). Gender-based violence is a major concern in the world as it is not only associated with psychological and physical harm, but it can result in the death of the victim. It is also associated with a wide range of mental disorders like anxiety and mood disorders and victims of gender-based violence have been linked with substance use disorders (Walsh et al., 2015).

Globally, women are the primary victims of sexual & gender-based violence with at least 35percent of them being victims of either physical or sexual violence or non-partner sexual violence. Additionally, at least 68percent of women in the world have been victims of sexual and physical violence from their partners in their lifetime. In essence, at least one in every five women in the world have experienced of sexual and gender-based violence across their lifetime (USAID, 2014).

According to UNFPA, (2018), the majority of the victims encounter forced and unwanted pregnancies, unsafe abortions and are highly likely to contract HIV and other Sexually Transmitted Infections (STIs) and eventually death. This shows that the prevalence is on a sharp increase.

A European study conducted in 28 countries in 2017 revealed that at least 45percent-55percent of the women were harassed from the age of 15 thus translating to a total of 83-102 million women (Latcheva, 2017).

A study in Eastern Uganda on post conflict IPV showed an overall prevalence of any form of IPV to be 43.7percent (male 43.7percent, female 44.9percent). However, the rates of IPV for the same Eastern (Iteso) region in the Uganda Demographic Health Survey (UDHS, 2011) indicated similar results for males (43.6percent) but a higher rate (71.3 percent) for females.

In Ivory Coast, a study by Hossain et al., (2014) found out IPV in rural communities healing from internal strife to be 49.8 percent among females who have ever had partners and 19.8percent among males. Similarly, the rates of IPV in conflict ridden DRC among women who had partnered and/or cohabited was 68.25 percent (Tlapek, 2015).

In Shimbela refugee camp which houses the Eritrean war immigrants based in Ethiopia, the 12 month and lifetime prevalence was found to be 25.5 percent and 31.0 percent, respectively. Slapping, throwing of objects, and beating were commonly reported. These forms of physical violence were attributed to being a farmer, a Muslim and having a drunkard partner (Feseha & Gerbaba, 2012).

Among Internally Displaced Persons (IDPs) in South Sudan, most abuses have been documented to take place within the context of intimate relationships (61 percent), followed by child marriages (13 percent) and sexual violence against children at (11 percent). In Maban County, most survivors suffered physical assault (45 percent), emotional abuse (18percent), resource and opportunity denial (11 percent) with forced marriages accounting for 5 percent (Rivelli, 2015).

In a study done in Somalia, the proportion of men and women was 22.2 percent and 15.5 percent, respectively. IPV among adult women was higher (35.6 percent) than non-partner (16.5 percent). Among adult men, 31.2 percent had experienced physical violence while 21.7percent of them reported to have perpetrated sexual and physical violence against women. This study identified the correlates and factors for perpetuation of both IPV and non IPV to be displacement, exposure to parental violence, belonging to minority clan and violence during childhood (Andrea L Wirtz et al., 2018).

In both Ethiopia and Democratic Republic Congo (DRC) similarities in the overall prevalence (51.62 percent) in the two study sites during the regional census data for young people in Africa were established. Forced sex (21.07 percent, 17.87 percent) for DRC and Ethiopia

respectively while unwanted sexual touching was 19.77 percent and 23.96 percent respectively for the two countries mostly reported form of sexual violence. The commonest form of physical violence was beating (DRC 34.43 percent, Ethiopia 30.47 percent) which was mostly perpetrated by the boyfriend/husband (DRC 29.84 percent, Ethiopia 40.54) and parents/caregivers (DRC 46.77 percent, Ethiopia 26.25 percent) (Stark et al., 2017).

The above rates of IPV in conflict and post conflict countries are higher than those of non-conflict countries. In a South African study on physical violence on married and cohabiting adults, it was found that the rate of physical IPV in females was 29.35 percent compared to 20.9 percent in males (Gass et al., 2011).

It is however important to note that these issues are more prevalent in Africa largely due to culture. SGBV is also exacerbated by the deeply rooted gender inequalities that exist among African countries. African cultures also give men more power contrary to their counterparts in other countries, which is a major attribute to the occurrence of gender-based violence in the society (Decker et al., 2016). Additionally, African countries believe that men must express dominance and masculinity which further fuels sexual & gender-based violence in society (Schwitters et al., 2015).

In Uganda, as study indicated that at least 48percent of the women experienced a given form of violence (Schwitters et al., 2015). Additionally, a good depiction of marriage is that which produces offspring and as such, women who are infertile or sub-fertile find themselves at high risk of being subjected to ridicule, violence and rejection from in-laws and from their intimate partners (Kiss et al., 2015)

In Kenya, a study found a 30 percent prevalence of gender-based violence. (Haberland et al., 2016), men were the main perpetrators of this vice in the society with factors such as culture and abuse of alcohol being majorly associated with SGBV. In Mombasa, Kenya, women with severe alcohol abuse problems was a high risk of sexual and intimate partner violence (Wilson et al., 2016). Memiah et al., (2018), in another Kenyan study noted that women aged between 20-29 years who were married and with no religious affiliations were likely to experience intimate partner violence. Moreover, among women who had more than one partner and were receiving gifts from their partners reported that the violence directed towards them was justified.

2.4 Factors Associated with Gender-Based Violence

2.4.1 Individual Factors

2.4.1.1 Age

Age has been found to be associated to SGBV with younger individuals being at higher risk. A study revealed that young women were at higher risk of intimate partner violence (Peterman et al., 2015). Similarly, Guedes at al, (2016) found out that the occurrence of violence against women and children intersected during adolescence.

Child abuse, female genital mutilation, child marriage and sexual violence is mainly prevalent among young women of 10-24 years (Yount et al., 2017). A Spanish retrospective study revealed that half of the respondents had experienced both current and previous forms of intimate partner violence with a majority of them being the youngest ones (Viejo et al., 2018).

In Nepal and India, 23 percent of women in the childbearing age had experienced physical violence while 14 percent has been exposed to sexual violence. This study also revealed that husbands who abused alcohol and were mistrustful of their spouses meted public humiliation and physical abuse to them (Pandey, 2016). According to WHO, girls aged 15-19 and young women have a 29.4percent and 31.6percent life time prevalence of both physical and sexual intimate partner violence respectively (WHO, 2013). A systematic review by Lundgren & Amin, (2015) concluded that intimate partner violence and sexual violence was major concern and more prevalent among adolescent boys and girls aged 10-19 years.

2.4.1.2 Gender

Long held ascribed gender roles in the society, which place women and girls in lower standing and positions in society expose them more to violence (Watts & Zimmerman, 2002). Herrero et al, (2017) posits that the society's expectation of men to prove masculinity and authority over women is highly linked to intimate partner violence.

Among the Syrian refugees who fled to Lebanon, women and adolescent girls were found to be at high risk of physical, sexual and gender-based violence in the urban and settlement areas of refugee camps compared to their male counterparts (Lilleston et al., 2018) .

In a study on women within the child bearing age in Nepal, men were found to be the main perpetrators of gender-based violence (Pandey, 2016). To address this, a study which aimed to examine the violence prevention strategies, revealed that the involvement fathers and young men in SGBV interventions bears results (Tolman et al., 2017). A different study also revealed that the extent of perpetration of intimate partner violence by men was likely associated with

those who had permissive attitudes on violence against women, old age and inequitable gender attitudes (Fleming et al., 2015).

2.4.1.3 Occupation

Occupation of SGBV victims is a major contributor to gender-based violence in society. Female sex workers are at high risk of gender-based violence largely due to the client demands. In essence, the risk for SGBV is highly correlated with an increase in the client demands i.e. unprotected sex and the length of time engaged in sexual activity (Schwitters et al., 2015). A study conducted in Palestine revealed that married women are subjected to harsh forms of physical, psychological and economic abuse due to the discriminatory laws of the country and due to the traditional practices of the region. The women also reported that they were subjected to physical and psychological abuse from the Israeli soldiers at the border checkpoints (Baldi, 2018).

Additionally, among Female Sex Workers (FSWs), SGBV was associated with the inconsistency in condom use with the client, being offered better pay for sex without the condom and mistreatment when seeking health services. These women also received little or no protection at all from the law enforcers (Decker et al., 2016). A study conducted in Uganda revealed that commercial sex workers were at high risk of rape and other gender-based violence initiated by the clients with notable attributes being the time taken engaging in unprotected sex, the duration of work as a sex worker and alcohol consumption (Schwitters et al., 2015). Other studies have noted that gender-based and sexual violence is more common

among female sex workers as compared to Male Sex Workers (MSW) (Decker et al., 2016; Latcheva, 2017).

2.4.1.4 Marital Status

In Uganda, a study done on IDPs revealed that married women and those in other intimate relationships were at a higher risk of experiencing gender-based violence with IPV being generally taken as normal occurrences in the camps (Ager et al., 2018). Similarly, another study in the DRC established that women who expressed an approach of acceptance towards intimate partner violence and those who were in monogamous marriages were highly likely to suffer from abuses from their spouses (Tlapek, 2015).

The inability to sire children and/or cases of secondary infertility among married women makes them to be highly subjected to beating and other form of intimate partner violence by their spouses (Stellar et al., 2016).

2.4.1.5 Race and ethnicity

There are studies which reveal that women of color are at higher risk of being exposed to gender-based violence unlike the white (Baldi, 2018; O'Neal & Beckman, 2017a). Another study also noted that women, LGBT and people of colour are more likely to experience gender-based violence both from the state and in their interpersonal relationship (Gill, 2018).

2.4.1.6 Sexual Orientation

A majority of the studies and statistics on gender-based violence have only focused on the experiences of women and heterosexuals with less efforts put on the fate of transgender individuals (O'Neal & Beckman, 2017b). However, it is critical to note that the perpetrators of

gender-based violence also target gender non-conformity, expression, identity and the perceived sexual orientation. Poor policies on the protection of transgender population and stigma associated with are among the main contributors to gender-based violence directed towards this population (A. Wirtz et al., 2018). Another study also found out that trans-sexual are at high risk of discrimination and also face significant barriers to acquiring health services due to the identity of their gender (Christian et al., 2018).

Similarly Platt and Milam, (2018) noted that the transgender population is highly likely to face discrimination as a result of their gender non-identity. These populations also face barriers in relation to the use of public facilities and are likely to face harassment or even incarceration from breaking the societal laws.

2.4.2 Societal Factors

2.4.2.1 Culture and social norms

In UK, gender-based violence is a cultural challenge contrary to masculinity as both genders whether minority or majority can be engaged in gender-based violence either as victims or as perpetrators (Dustin, 2016). Bishwajit, Sarker, & Yaya, (2015), stated that socio-cultural roots impede the implementation of strategies that are aimed at limiting the occurrence of gender-based violence in society.

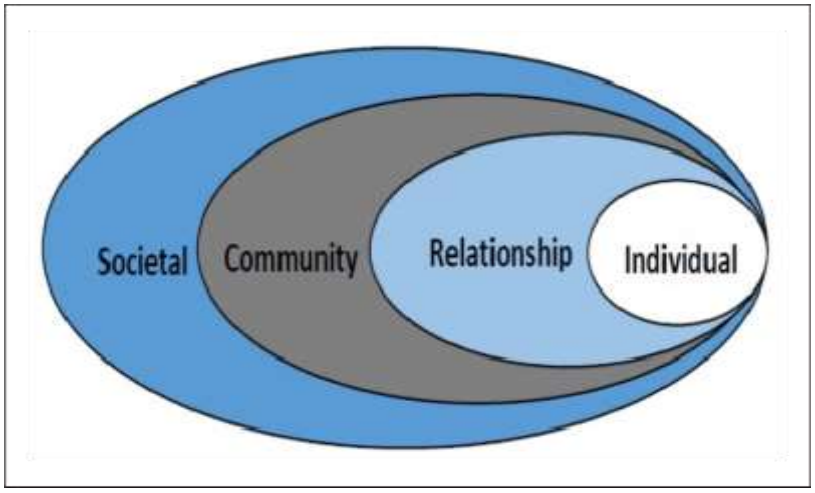
2.3 Theoretical Framework

2.3.1 Social Ecological Theory

This is a theory-based framework that helps to understand the relation between human being and the settings and contexts in which the person is actively involved. It was developed by

Heise et al., (1999) to establish the correlation amid personal, situational and socio-cultural factors linked to gender-based violence and abuse.

Figure 2: Theoretical Framework



SEM theory is applied in this study in order to comprehend diverse factors allied to SGBV. This theory posits that the growth of violent behaviours is associated with individuals, relationship, communal and societal factors.

In essence, violence does not occur because of a single cause but due to a number of causes which are tied with the four spheres of influence. These factors contribute to changes in the individual's attitude, behaviours and choices. The interrelationships that exist between these spheres can influence an individual's way of life all through the course of their life.

Additionally, the society is influenced by political, cultural, social, economic and psychological aspects, all of which play a role in the occurrence of sexual and gender-based violence in the society. These aspects also play an important role in understanding how the four ecological aspects can result in gender-based violence.

The context in which SGBV occurs in humanitarian settings and refugees' camps is primarily informed by the breakdown of the social support structures, loss of livelihood, continued hostilities and political differences which are carried over to the host countries. The relationship with the host communities in their new set up provides a fertile ground for perpetuation of violence.

3.0 CHAPTER THREE: STUDY METHODOLOGY

3.1 Study Design

This was a cross-sectional analytic study that used a mixed method approach to collect data to evaluate the prevalence and correlates of Sexual and Gender Based Violence (SGBV) among refugees in Kakuma Refugee camp, Kenya.

3.2 Study Area description.

Kakuma refugee camp is in Kakuma town, Turkana West Sub-County, Turkana County, in North-Western Kenya. This is the second largest county in Kenya with a land mass of 77,000 square kilometers and a population of 855,399,000 (KNBS, 2010). The total population of the main Kakuma camp is 151, 733 while that of Kalobeyei Integrated settlement is 34,849, with South Sudan (54 percent) and Somali (22 percent) nationalities being the majority. The other nationalities include DRC (7 percent), Sudan (6.5 percent), Burundi (4.7 percent), Ethiopia (3.8 percent) while others are below one percent (UNHCR, 2018).

3.3 Study Population

Household members, both male and female aged between 12-60 years were the respondents. The distribution of the respondents for the quantitative survey was based on the total population size of both Kakuma refugee camp and Kalobeyei settlement. In the main Kakuma camp, one block from each of the four sections was included while in Kalobeyei, two compounds, from each of the three villages was included in the study. To corroborate the quantitative findings, key informant interviews were conducted with relevant stakeholders. These stakeholders included the International Rescue Committee (IRC), Danish refugee

Council (DRC), Kenya Police, Opinion leaders and Refugee Affairs Secretariat. Further focus group discussions were conducted with community opinion shapers, young refugee girls and women.

3.3.1 Inclusion criteria

1. Must have lived in the camp for more than one year
2. Aged between 12-60 years
3. Willing to consent to participate in the study
4. Those with formal refugee status

3.3.2 Exclusion Criteria

1. Those not willing to consent to participate
2. Those who had lived in the camp for less than one year
3. Those living in the camp but do not have a formal refugee status
4. Those below 12 and above 60 years
5. Those severely sick to comprehend the tools and those with severe disability.

3.4 Sampling

3.4.1 Sample Size Determination

Sample size for this research was determined using the Fischer's formula below.

$$n = \frac{z^2(p)(q)}{d^2}$$

Where

n=sample size

p =Proportion of the population with the desired characteristics

Z=standard normal deviate at 95% confidence level

q=1-p

d= degree of precision

Using an estimated prevalence of 21.4%found in a study conducted in Ethiopia (A L Wirtz et al., 2016), and precision of 5%, the sample size for this study was arrived at as shown below using Fishers et al formular;

$$n = \frac{(1.96)^2 * (0.214) \times (0.786)}{(0.05)^2} = \mathbf{258}$$

A minimum of **258** participants were therefore needed for the study to be representative. Taking cognizance of the special circumstances of the refugee camp, an assumed 20percent non-response rate was considered with a sample size of **310** increased.

Since the camp hosts more than 10,000 refugees, the calculated sample size was not subjected to finite reduction.

3.4.2 Sampling Strategy

Based on the organization of refugees' settlement at the camp, multistage cluster sampling method was used to identify the respondents. Kakuma refugee camp comprises of the Main Kakuma Camp and Kalobeyei Integrated settlement.

The main Kakuma Refugee Camp is divided into four sections: Kakuma 1 to 4. Each section is further subdivided into zones which are then sub-divided into blocks. The blocks consist of

several households of mixed nationalities. All the four sections within Kakuma Refugee camp were included in the study for equal representation. Simple random sampling was used to select one zone each from the four sections. Thereafter, one block was randomly selected from each of the four zones. Once in the block where households are set up in rows and numbered, numbers of all the household were written in small pieces of paper, put in a hat and the number to be interviewed were randomly picked. The first household to be interviewed was picked by throwing a stick with one sharp end and the house pointed by that end was the first one to be interviewed.

The Kalobeyei Integrated settlement comprises of three villages, with each village further divided into several neighbourhoods. Simple random sampling was used in selecting villages and neighbourhood and the same procedure was used to select one compound from each of the neighbourhoods from where data collection was done.

The number of households that were included in the study from the selected blocks and compounds was based on the proportion of the population of both Kakuma (82percent) and Kalobeyei (18percent) against the overall camp population. Kakuma was therefore assigned 211 respondents while Kalobeyei was allocated 47. Based on the number of the blocks and compounds that were selected, each block in Kakuma was allocated 47 respondents while in Kalobeyei, each compound was assigned 23 respondents.

3. 5 Consenting Procedure

The procedure for obtaining consent from the willing respondent was carried in a private room and/or space within the household. The principal investigator and the trained research

assistants sought consent from the respondents in the language they understood well. The consent documents, translated into Kiswahili, were read to the potential participants, key issues concerning confidentiality were explained to them and questions raised were answered to their satisfaction. In cases where the respondent was not conversant with Swahili, research assistants who were conversant with English, Swahili and the dominant local refugee language assisted in the translations. The respondent and the researcher each kept a copy of the signed consent form.

3. 6 Variables

3. 6.1 Predictor Variables

Socio-demographic characteristics (Age, Sex, occupation, marital status, level of education, sexual orientation)

3. 6.2 Intervening/Moderating Variables

- Country of origin
- Area of residence in the camp
- Duration of stay in the camp
- Race/ Ethnicity
- Culture and social norms
- Alcohol and substance use/abuse
- Gender norms

3. 6.3 Outcome Variable

- Sexual and gender-based violence

3.7 Data Collection

Quantitative and qualitative data collection methods were used. The quantitative data was collected using questionnaires with assistance from principal investigator and trained research assistants. Key informant interviews and focus group discussion were done with relevant stakeholders involved in SGBV related interventions in the camps and refugee community members (women and girls) to corroborate quantitative data. The qualitative data collection was guided by a structured interview schedule.

3.8.1 Data collection Instruments

Quantitative data was collected using the following tools:

1. A ***researcher designed*** socio-demographic questionnaire to obtain participants' socio-demographic and economic characteristics as covered in the literature review. This also captured the refugee history including the country of origin and residence in the camp.
2. Assessment Screen to Identify Survivors Toolkit for Gender Based Violence (ASIST-GBV). ASIST-GBV is a seven-question screening tool for SGBV (A L Wirtz et al., 2016). The tool has been used for screening and identifying SGBV survivors in confidence and capably amid Colombian IDPs and Ethiopian refugees.
3. Focus group discussion and Key informant interview guides.

3.8.2 Recruitment and Training of Research Assistants

The researcher selected research assistants from Kakuma Refugee camp and Kalobeyei settlement and represented all the nationalities. They needed to be literate in English, Swahili

and demonstrate fluent understanding of the language of the communities they come from. Each of the research assistant satisfied the requirement of good conduct and community service as set by UNHCR and its partners. The research assistants underwent a two-day training to understand the content of the data collection tools, orient them on the basic administration skills and how to adhere to ethical issues.

3. 8.3 Pre-testing of Study Tools

After training the research assistants on the administration of the data collection tools, the pre-test was conducted in two blocks and compounds that did not form part of the study. The key issues tested included clear understanding of the tools, community & household entry procedure, approach of seeking consent and skills for handling hostile refugee members. The pre-test results were presented in a plenary, role plays simulated, errors arising corrected and preparation for each block and compound maps done.

3.8.4 Data Collection Process

Data collection took ten (10) days with each team of research assistants developing maps of the blocks and compounds to collect data from by clearly showing the organization of the households.

When each team arrived in the selected blocks and/or compounds, the research assistants with the help of a guide introduced themselves, explained the purpose of their visit and confirmed by the show of their accreditation badges from RAS and UNHCR that they had permission to undertake data collection.

Regarding qualitative data collection, the principal investigator approached the key organizations involved in SGBV services to nominate officers who were responsible for these interventions to take part in the key informant interviews. Community opinion leaders, selected refugee women and girls were identified with assistance of Refugee Affairs Secretariat, which manages the camp, to participate in the focus group discussions with representation from all the blocks and villages.

3.9 Quality Assurance Procedure

The research assistants were identified through the Refugee Affairs Secretariat Camp manager. Those selected were people of high integrity, knowledgeable and able to enhance buy in and acceptance by the refugee community. The research assistants went through a intensive two-day training and thereafter conducted a pre-test of the tools. The results of the pre-test were used to identify the gaps in understanding and administration of the tools.

During the actual administration of the ASSIST-GB tool, daily briefing in the morning and later debrief in the evening was held, where each questionnaire was critically looked into for any omissions, gaps and mistakes. Areas that required more clarification were discussed during the morning briefing session.

3.10 Data Management

The filled in questionnaires from the two camps were collected, counter checked for accuracy and the identified gaps were discussed with the research assistants for correction at the end of each day.

All the interviews from KII and FGDs were audio recorded. The audio recordings were then transcribed and translated by and professional transcriber conversant with Swahili and English.

3.11 Data Analysis and Presentation

The SPSS software was used to analyse quantitative data. The distribution of the discrete variables data was demonstrated by use of frequency tables, pie and bar charts. For continuous variables, means and standard deviations were computed. Key themes emerging from the qualitative data were summarised using thematic analysis according to the study objectives. Key quotes were identified to support the themes, and these were used to corroborate the quantitative study findings.

3. 12 Ethical Considerations

Ethical clearance was sought and received from the KNH/UoN Ethics Review Committee vide Ref: KNH-UoN-ERC/A/409 dated 1st November 2019. Further clearance was obtained from the Turkana County Government Ministry of Health to satisfy the requirement of the office of the Refugee Affairs Secretariat and UNHCR to conduct a study in Kakuma refugee camp, within their stipulated guidelines on how such activity is normally carried out within the refugee/humanitarian settings.

This study posed minimal risks, if any, to the refugee community since it was basically screening for SGBV. The lead researcher and research assistants were obligated to initiate appropriate referrals to nearest SGBV service provider, in the event any emotional discomfort arose during data collection. Parents and/or guardians consented on behalf of their children

after understanding the nature of the study.

3.13 Study Results Dissemination Plan

Study results will be presented to relevant refugee agencies such as UNHCR and other INGOs working in humanitarian setting in Kakuma through scientific publications in peer review journals and workshops.

3.14 Limitations of the study

Several limitations were encountered during the study, foremost among them the unwillingness by men to participate in both household interviews and FGDs. Disruption of the normal day to day operations of the refugee camp by the Covid-19 outbreak lead to refusal by some households to take part in the interviews. In mitigation, some key informant interviews were conducted virtually via the mobile phone (telephone interview) while for the FGDs, the researcher provided facemasks to the participants and ensured enough space to allow the prescribed social distancing and other MOH Covid19 regulations. With these provisions, enough participants agreed to participate in the household interviews and FGDs.

The main assessment tool used in the study has not been used among men. However, since it has questions on both genders, we used it to screen for SGBV among both gender. Currently, we could not identify any tool that has been specifically designed to screen for SGBV among men.

4.0 CHAPTER FOUR: RESULTS

4.1 Response Rate

A total of 292 respondents took part in the study translating to a 94.1 % response rate.

4.2: Socio-demographic Characteristics

Socio-demographic characteristics of the respondents were assessed including sex, age, level of education, marital status, country of origin, duration of stay in the camp and history of alcohol and substance use. Almost all respondents were females (96.6 percent) with a mean age of 25.9±9.2 years. Over one-third (37.9 percent) of the respondents were from South Sudan followed by Somalia (22.9 percent) with the lowest number (1.5 percent) coming from Rwanda. Slightly over two-thirds (67.6 percent) were Christians with the rest being Muslims as shown below. The social-demographic characteristics are summarized below.

Table 1: **Socio-demographic Characteristics of the Respondents**

Parameter	**Category**	**Frequency (N=293)**	**Percentage (percent)**
Gender	Female	283	96.6
	Male	10	3.4
Age	15-17 Years	37	12.6
	18-24 Years	127	43.3
	25-34 Years	73	24.9

	35-44 Years	41	14.0
	45-60 Years	15	5.1
Age	Mean; Median; SD; Range	25.9; 23.0; 9.2; 15-60	
Country	Burundi	29	9.9
	DRC	24	8.2
	Ethiopia	35	11.9
	Rwanda	5	1.7
	South Sudan	111	37.9
	Somali	67	22.9
	Uganda	10	3.4
	Sudan	12	4.1
Religion	Christian	198	67.6
	Muslim	95	32.4
Education Level	None	77	26.3
	Primary	122	41.6
	Secondary	86	29.4
	College	5	1.7
	University	3	1.0
Occupation	Farmer	16	5.5
	Trader/Business	41	14.0

	Casual Laborer	27	9.2
	Professional	6	2.0
	Student	115	39.2
	House Work	88	30.0
Income per Month	Below 1,000Ksh	151	51.5
	1,000 to 5,000Ksh	117	39.9
	5,001 to 9,999Ksh	15	5.1
	Above 10,000Ksh	10	3.4
Marital Status	Single	127	43.3
	Married	117	39.9
	Formerly Married	49	16.7
Length of stay in the camp	1-2 Years	10	3.4
	3-5 Years	114	38.9
	6-10 Years	82	28.0
	More than 10 Years	87	29.7
Camp of residence	Kakuma	233	79.5
	Kalobeyei	60	20.5
Alcohol use	No	272	92.8

	Yes	21	7.2
Substance Use	No	282	96.2
	Yes	11	3.8

To have an in-depth understanding of the magnitude of SGBV and associated factors, two FGDs and four KIIs were also conducted. Findings from the interviews and discussions are infused in the quantitative findings.

4.2 Prevalence of SGBV

The frequency of sexual and gender-based violence in the past one year was assessed using multiple indicators. The overall prevalence of SGBV in the entire camp was 79.9 percent. Kakuma refugee camp had the highest prevalence (85.4 percent) while Kalobeyei Settlement recorded a prevalence of over fifty (58.3 percent).

Over half (55.3 percent) of the respondents had experienced violence threats and almost an equal number (53.9 percent) had experienced physical violence. Generally, more than three-quarters (79.9 percent) had some form of violence and over two-thirds of these (71.4 percent).

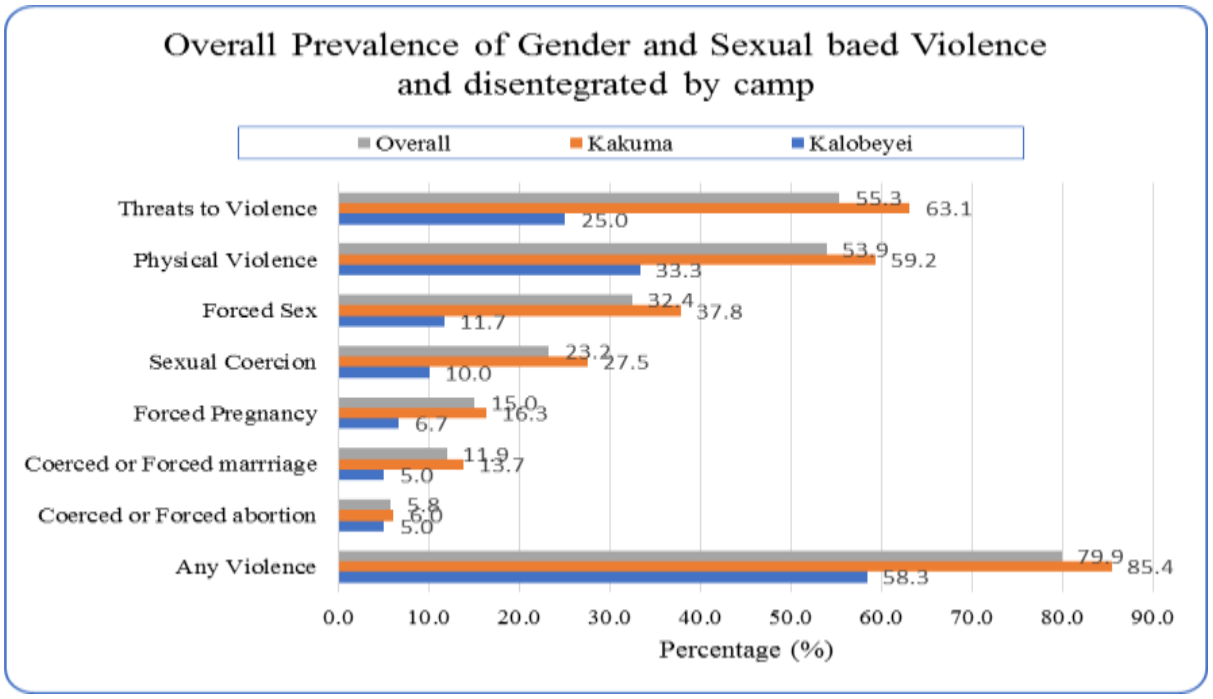
The prevalence of the various forms of each of the indicators of SGBV in the ASSIST SGBV-tool is summarized in the following table 2 while the visualization of the prevalence is shown by the next figure 3.

Table 2: ***Prevalence of Sexual and Gender Based Violence***

Sexual and Gender Based Violence items (SGBV)	**Frequency (N=293)**	**Percentage (%)**	**95%C.I.**
1. In the past year, have you been threatened with sexual or physical violence in your home or outside of your home?	162	55.3	(49.5-61.1)
2. In the past year, have you been punched, slapped, hit, kicked, choked, hurt with a weapon in your home or outside of your house?	158	53.9	(48.1-59.4)
3. In the past year, have you ever been forced to have sex with someone against your will?	95	32.4	(27.0-37.5)
4. In the past year, have you ever been forced to have sex in order to have shelter, eat or have sex for essential services because you or someone in your family would be in physical danger if you refused?	68	23.2	(18.1-28.0)
5. In the past year, were you physically forced to become pregnant against your will?	44	15.0	(11.3-19.1)

6. In the past year, were you coerced or forced into marriage?	35	11.9	(8.5-15.4)
7. In the past year, were you forced to have an abortion?	17	5.8	(3.4-8.9)
Any Violence	234	79.9	(74.7-84.3)
If yes to any of items 1 to 7, the woman has screened positive for gender-based violence.			
8. Would you like to talk to someone about women who have gone through gender-based violence? **(N=234)**	167	71.4	(65.0-76.9)

Figure 3: Prevalence of Sexual & Gender Based Violence Disaggregated by Camp of residence.



Similarly, findings from the qualitative interviews show that there is generally a high prevalence of SGBV in Kakuma refugee as remarked by one of the Key Informant representing an International NGO providing health services in the camp:

> "*On average, I will say we treat about 300 – 360 clients of sexual assault and others forms of GBV-". (KII-International NGO)*

According to one of the International NGO providing health care services, the most common forms of SGBV are Intimate Partner Violence (IPV) followed by rape, denial of economic resources and physical violence. There are also cases of sexual exploitation where women (especially those who are single) result in the exchange of sex for money in order to sustain their families. Some communities encourage arranged underage marriages where they sell off their girls to richer families for money. The organization further reported that many of the cases are not reported and are settled in-house.

The other forms of abuse occurring among school going girls include inappropriate touching by boys, which falls under sexual and/or physical harassment, as reported by girls;

> ***"****The boys touch our breasts and buttocks in the market, and because of fear of embarrassment, you don't complain'' (FGD participant-Young women)*

Women and children are the most susceptible and vulnerable to rape in Kakuma refugee camp and Kalobeyei settlement as reported by participants in the FGD. Orphaned young girls and children who have no guardians to protect them are also more targeted in this form of violence.

"Children especially orphans are also victims of violence. They have no food, no education support", and is mostly associated to poverty, *"cha kwanza sisi kina mama hatuna kazi, hiyo ndio sababu. Kazi ina saidia sana. Unajua mama hana pesa ya kusaidia familia' (FGD – Refugee women)"*

Sexual violence meted on children of single mothers by men whom they cohabit with for economic gains is more rampant as reported by one woman;

"Kama wewe akuna bwana, na kwa sababu ya shida unakubali mzee ingine ndio asaidie Watoto, huyo mzee hapana penda Watoto wako. Hata wengine wanalala na Watoto wasichana kwa sababu si wake. Hii ni mambo mbaya. Unakaa kwa sababu yeye ankupa chakula" (FGD- Refugee Women).

The local host community was blamed for most acts of violence against girls and women through house breaking, beatings and sexual assault on particularly women led housed.

"*The Turkana men, who come to the camp to buy food, do casual work and sometimes attend IRC hospital, identify homes with no men and attack us at night. The beat women who want to protect their girls and rape them. This is more common in Kalobeyei settlement*." (FGD Women).

An interesting twist in cases of SGBV against the Local host community was reported by the Women Empowerment Protection unit of IRC. Though isolated, a number of Turkana women seeking casual work in the camp have suffered gang rape with the assailants disappearing into the refugee camp.

"Our case workers during community meetings have come across cases of host community women who have been sexually assaulted during their search for menial work especially by middle level income refugee households." (KII, IRC)

4.3 Factors Associated with SGBV

Association between various socio-demographic characteristics and SGBV was assessed. Age (p=0.023), income per month (p=0.025), marital status (p=0.02) length of stay in the camp (p=0.029) and the camp of residence (p<0.001) were significantly associated with SGBV. The country of origin, education and religion as well as occupation and alcohol use were not significantly associated with SGBV.

Table 3: Socio-Demographic Factors Associated with Sexual and Gender Based Violence

Variable	**Category**	**Overall (N=293)**	**SGBV**		χ^2	**d.f**	**p-value**
			No (n=59; 20.1%)	**Yes (n=234; 79.9%)**			
Sex	Female	283(96.6%)	55(19.4%)	228(80.6%)	2.54	1	0.111
	Male	10(3.4%)	4(40.0%)	6(60.0%)			
Age	15-17 Years	37(12.6%)	14(37.8%)	23(62.2%)	11.39	4	**0.023**
	18-24 Years	127(43.3%)	23(18.1%)	104(81.9%)			
	25-34 Years	73(24.9%)	12(16.4%)	61(83.6%)			

	35-44 Years	41(14.0%)	5(12.2%)	36(87.8%)			
	45-60 Years	15(5.1%)	5(33.3%)	10(66.7%)			
Age[†]	Mean±SD	25.9±9.2	25.2±11.2	26.1±8.7	-0.63	291	0.528
Country of Origin	Burundi	29(9.9%)	5(17.2%)	24(82.8%)	11.67	7	0.112
	DRC	24(8.2%)	4(16.7%)	20(83.3%)			
	Ethiopia	35(11.9%)	6(17.1%)	29(82.9%)			
	Rwanda	5(1.7%)	0(0.0%)	5(100.0%)			
	South Sudan	111(37.9%)	31(27.9%)	80(72.1%)			
	Somali	67(22.9%)	9(13.4%)	58(86.6%)			
	Uganda	10(3.4%)	0(0.0%)	10(100.0%)			
	Sudan	12(4.1%)	4(33.3%)	8(66.7%)			
Religion	Christian	198(67.6%)	44(22.2%)	154(77.8%)	1.65	1	0.199
	Muslim	95(32.4%)	15(15.8%)	80(84.2%)			
	None	77(26.3%)	15(19.5%)	62(80.5%)			
Education Level	Primary	122(41.6%)	25(20.5%)	97(79.5%)	2.02	4	0.732
	Secondary	86(29.4%)	17(19.8%)	69(80.2%)			
	College	5(1.7%)	2(40.0%)	3(60.0%)			
	University	3(1.0%)	0(0.0%)	3(100.0%)			
Occupation	Farmer	16(5.5%)	2(12.5%)	14(87.5%)	1.31	5	0.933
	Trader/Business	41(14.0%)	7(17.1%)	34(82.9%)			

	Casual Laborer	27(9.2%)	5(18.5%)	22(81.5%)			
	Professional	6(2.0%)	1(16.7%)	5(83.3%)			
	Student	115(39.2%)	24(20.9%)	91(79.1%)			
	House Work	88(30.0%)	20(22.7%)	68(77.3%)			
Income per Month	Below 1,000Ksh	151(51.5%)	40(26.5%)	111(73.5%)	9.35	3	**0.025**
	1,000 to 5,000Ksh	117(39.9%)	16(13.7%)	101(86.3%)			
	5,001 to 9,999Ksh	15(5.1%)	3(20.0%)	12(80.0%)			
	Above 10,000Ksh	10(3.4%)	0(0.0%)	10(100.0%)			
	Above 1,000	142(48.5%)	19(13.4%)	123(86.6%)			
Marital Status	Single	127(43.3%)	29(22.8%)	98(77.2%)	12.13	2	**0.002**
	Married	117(39.9%)	29(24.8%)	88(75.2%)			
	Formerly Married	49(16.7%)	1(2.0%)	48(98.0%)			
Length of stay in the camp	1-2 Years	10(3.4%)	2(20.0%)	8(80.0%)	4.59	3	0.204
	3-5 Years	114(38.9%)	28(24.6%)	86(75.4%)			
	6-10 Years	82(28.0%)	18(22.0%)	64(78.0%)			
	More than 10	87(29.7%)	11(12.6%)	76(87.4%)			

	Years						
Length of stay in the camp†	Mean±SD	7.8±4.9	6.5±4.3	8.1±5.0	-2.20	291	**0.029**
Camp of residence	Kakuma	233(79.5%)	34(14.6%)	199(85.4%)	21.75	1	**<0.001**
	Kalobeyei	60(20.5%)	25(41.7%)	35(58.3%)			
Alcohol Use	No	272(92.8%)	58(21.3%)	214(78.7%)	3.33	1	0.068
	Yes	21(7.2%)	1(4.8%)	20(95.2%)			
Substance Use	No	282(96.2%)	58(20.6%)	224(79.4%)	0.87	1	0.352
	Yes	11(3.8%)	1(9.1%)	10(90.9%)			

Note: †-Independent samples t-test

Young women who participated in one of the FGDs reported that there is lack of knowledge among many women on where to report cases of rape and sexual abuse and that woman are not allowed to attend SGBV forums. Further, community members support violence against women and see it as "normal".

> ***"****The Community also supports men in violating women rights. The elders believe that boys have a right to harass girls" (FGD; Adolescent refugee girl).*

Stigma and the fear of banishment from one's community in the camp were found to be responsible for non-reporting of several SGBV incidents.

> *"The only reason for not reporting is stigma from the community, by being blamed for reporting issues considered normal occurrence. We also have cases of people who*

refuse to give evidence because of fear of the backlash from the community" (FGD; refugee women).

There is also a high level of discrimination against the women and girls as noted by one of the young women in the FGDs.

"it is common here in the camp for parents to discriminate girls in favor of boys. Anything bad is said to be done by girls" (FGD; Young women).

Inadequate security in the camp came out during the discussions with women and young girls and was seen as one of the factors associated with increased violence.

4.4 Independent Predictors of SGBV

After adjusting for all factors that were allied to SGBV at the bivariate level at P<0.10, participants who were aged 18-24 years were about three (3) times more likely to report SGBV (A.O.R. 3.09, 95% C.I. 1.28-7.44; p=0.012) as compared to those aged 15-17 years. No significant differences in terms of reporting SGBV were found in other age categories (p>0.05).

Participants who were formerly married were about twenty (20) times more likely to report SGBV as compared to those who were single (A.O.R. 20.8, 95% C.I. 2.04-212.20; p=0.010). No significant difference recorded amid those who were single and those who were married in reporting SGBV incidences.

Respondents who were residing in Kakuma were about four (4) times more likely to experience SGBV (A.O.R. 4.02, 95% C.I. 1.75-9.25; p=0.001) as compared to those who were living in Kalobeyei settlement. In terms of income, length of stay in the camp and alcohol use,

there was no significant differences found in regards of reporting SGBV (p>0.05). These findings are summarized in table 4 below.

Table 4: Independent Predictors of Sexual and Gender Based Violence

Variable	**Category**	**A.O.R**	**95% C.I. A.O.R.**		**Sig.**
			Lower	**Upper**	
Age	15-17 Years	Ref.			
	18-24 Years	3.09	1.28	7.44	**0.012**
	25-34 Years	2.23	0.69	7.21	0.179
	35-44 Years	1.40	0.33	5.94	0.652
	45-60 Years	0.31	0.06	1.65	0.168
Income per Month	1,000 and Below	0.70	0.34	1.45	0.331
	Above 1,000	Ref.			
Marital Status	Single	Ref.			
	Married	1.18	0.49	2.83	0.716
	Formerly Married	20.80	2.04	212.20	**0.010**
Length of stay in the camp	Mean±SD	1.02	0.94	1.10	0.678
Camp of residence	Kakuma	4.02	1.75	9.25	**0.001**
	Kalobeyei	Ref.			
Alcohol Use	No	3.93	0.48	32.33	0.203
	Yes	Ref.			

Note: Ref-Reference category; C.I.-Confidence Interval

Findings from the FGDs showed that most communities in the camp have normalized rape and sexual abuse mainly because girls and women are regarded as property, as reported by participants in the FGDs and the key informants;

> ***"****katika community yetu, hata bwana yako akikuchapa bila sababu, wazee wanasema hiyo ni kawaida. Wanakataa wewe kupiga ripoti kwa polisi"(FGD;Refugee Women).*

The intolerance among most communities living in the camp arising from suppressed political and economic differences back home was pointed out by most key informants working for INGOs. Such animosities flare up from minor differences in the camp like loss of a football match, with the traditional antagonist fighting each other, women and children bearing the greatest brunt. The cultural and traditional practices include total control of community power by some sections of the community as well as cultural power imbalances.

> *"Cultural and traditional practices like total control of community power by sections of the community, that encourage and reinforce such violations" (KII, International NGO)*

Women reported that most men and/or household heads who are unable to meet the needs of the family, resort to displace their frustrations on women and children who are weak members of the household. Due to economic hardships, women usually accept to cohabit with men for financial support. Some other women are left without food as their husbands use their money for alcohol.

"We are suffering. Our men withdraw money from the "Bamba pesa" card, which is meant to supplement the food rations from WFP. They use the money for alcohol. Women are left without food in the house. (FGD; Refugee woman).

FGM and immediate marriage of Somali girls was found to be common. The resistance against sensitization against SGBV by fellow refugee volunteers was more common among the Muslim members of the refugee as pointed out by one women during FGD:

"I am a volunteer Refugee Community Worker (RCW) trained on case management and counselling. When women come to me for assistance, their husbands follow them, reprimand them for seeking my services".

The violence meted on people with different sexual orientation was by the Somali community was of more intensity though not documented. They are treated as being anti religion and attacked at night, as put by one FGD participant;

"*The men who marry men were chased away by Uganda government. When they came to Kakuma refugee camp, they were not welcomed by all communities, people abused them, laughed at them and no one was ready share anything with them. When they pass near the Mosque, Somali boys throw stones to them calling them evil men."*

The political and tribal differences back at home between most communities in the camp have been used to settle long held animosity in the camp through intentional violations of young

girls by rival youth. As pointed out by one of the girls FGD participant, this has become a driver for SGBV.

"I am afraid of boys from other communities from South Sudan. They beat us and try to rape us when we go out of the camp to fetch firewood. If you don't accept a man rquest for marriage, he can rape you, which is shameful to me and my community. Some times my community fights back and many people fight back."

5.0 CHAPTER FIVE: DISCUSSION

This study sought to determine the prevalence and correlates of sexual and gender-based violence in Kakuma refugee camp which includes Kalobeyei settlement in Northwestern Kenya. The findings revealed a higher level of SGBV among the refugee populations in the camps standing at 79.9 percent with the commonest forms of violence being IPV, rape, denial of resources and physical abuse, which is very much consistent with earlier reports by the (UNFPA) (2013), which noted that the most common forms of SGBV were sexual threats, assaults, humiliation, domestic violence, attempted rape, torture and attempted rape. This prevalence is higher than what has been reported by other studies, ranging from 35 percent globally to about 75 percent in East Asia and Sub-Saharan Africa (Amanda, 2019; Kwiringira et al., 2018; UNHCR, 2020).

The multivariate analysis identified age, marital status, gender and camp residence as the underlying factors that were significantly associated with SGBV in the camp. However, poverty and/or low household income levels, insecurity, alcohol abuse, culture and restrictive reporting procedures were highlighted as contributing to violence during focused group discussions with women, girls and other stakeholders.

The study avers that being a girl and of young age increased the risk of experiencing violations such as FGM, removal from school and early marriage as evidenced by a multi-country study in Ethiopia and DRC where more than a half of teenage girls reported experiencing at least one form of violence victimization in the past 12 months (Stark et al., 2017). The clandestine marriage of young girls was deep rooted in the South Sudan and

Somali, the two main communities in Kakuma refugee camp. This study posits that the economic crisis faced by many refugees in the camp as a result of loss of family support was responsible for coerced child marriages. Young girls get married as a way to cushion the families financially while among the predominantly Muslim Somali community, teenage girls are married off to avert early sexual debut or violence with the aim of preserving purity. Additionally, the need to preserve girls' "purity" in order to attract high bride price in form of cattle and money, which is dearly held by the Dinka and Nuer communities, was found to be a driver for poor parents in the camp to marry off their daughters to rich suitors from South Sudan and Europe (Yount et al., 2017).

The community expectation on men and women in such unions favours men regardless of the circumstances. Women are socialized to stick to their marriages despite acts of violence and women who divorce or separate from their spouses because of violence are regarded as rebellious and anti-cultural. When such women enter subsequent relationships, they are bound to suffere acts of SGBV because of the low status accorded to them by the community. This could be the reason why women who were previously married but were not in stable relationship currently were twenty (20) times more likely to experience one form of SGBV compared to currently married and single women. Contrary to previously married women experiencing intimate partner violence in Kakuma refugee camp, married women in urban refugees in Uganda reported 45.5 percent and 54.5 percent respectively experiences of one form of violence and poly-victimization of IPV (Logie et al., 2019). Among most communities in the camp, ever raped women and still in marriage normally faces the wrath of

her husband's family and is often subjected to beating for it is believed that she was party to the rape incident. This is similar to what women in three cities in South Sudan experienced post 2013 conflict where the greatest risk of physical and sexual violence was from current and previous intimate partners (Ellsberg et al., 2020).

Culture and gender dynamics add another layer of vulnerability to girls and young women in Kakuma refugee camp. This socialization coupled with most young people having grown up in violent family relationships back in the country of origin, especially their mothers suffering under their fathers, has contributed to normalization of SGBV in the camp. Moreover, gender inequality, need for expression of masculinity and dominance play a huge role in "normalization" of SGBV in the African context (Decker et al., 2016); Herrero et al, 2017; (Schwitters et al., 2015). As indicated above, these acts, despite the various UN and national governments laws that address SGBV within refugee settings, have continued to be propelled by restrictive cultural and patriarchal norms which treat women and girls as property which can be exchanged with money and cattle, whose ownership infers the man with absolute power over their reproductive rights, movement, education and employment of the women. Additionally, the cultural way of seeking justice for SGBV survivors through elders' and "Maslaha" courts seems not to hand over punitive measures, as offenders are fined money or livestock. This is premised on the fact the traditional court system deems compensation given to the victims as enough to pacify the violence suffered. This has been found to perpetuate acts of violence especially on individuals without supportive family and community relations (Hossain et al., 2018).

The influence of culture and religion on the people's behaviour and what is widely acceptable practice especially among the Muslim communities in the camp has helped in aiding underground violation like FGM, the segregation, humiliation and physical abuse of people perceived to be LGBT (Platt & Milam, 2018), especially during the Covid-19 containment period (Bettinger-Lopez & Bro, 2020). The commonly held belief and teachings among the Muslim refugee community that practice that deviates from mainstream religion which allows FGM, that which advocates for women empowerment, is foreign, hell bent to incite women against men and dilute the people culture as also note by (Izugbara et al., 2020)

Contrary to the expectation of most refugees, the safe "heaven" that Kakuma refugee camp ought to, it has turned out to be a source of tribulations because of the violence attributed to insecurity and other acts in the camp. Camp residence and insecurity are intertwined as contributors to SGBV in the camp, with both the camp management and the refugee themselves influencing the degree and level of violation. The current set up of the camp still increases the risk of violence mostly to women and girls despite the decongestion through the setting up of Kalobeyei settlement. This is because of the overcrowding in most blocks and zones, poorly lit and bushy pathways, close proximity of common ablution blocks for both sexes at the reception centers for new arrivals and competition of social amenities like water points. The same was confirmed by a study on the sources of insecurities among Oromo and Ethiopia women in Kakuma Refugee camp, which revealed that women felt more insecure in most areas within the camp, with those in Kalobeyei reporting that due to the temporary nature of their houses, cases of robberies and rape meted to women headed homes are

common (Trujillo et al., 2020). The perpetrators of violence against young girls and women were mostly people known to them, relatives, immediate family members or neighbors in the same block or village in the refugee camp. We postulate that this could be due to the structural organization in the camps where people from same countries/communities live in the same block or village in camp, mostly with their close relative. This can be explained by the fact that almost three quarters of violence against women takes place in the context of relationships that are intimate, as well as due to early marriages, which render the victims powerless and without options (Rivelli, 2015).

While the police service is charged with securing the refugees, acts of physical violence, illegal detention and bribe seeking area abound in the camp especially during Covid-19 containment measure execution. The mistrust of refugee community on some health care workers, UNHCR security personnel and the Kenyan police is responsible for failure of some victims of SGBV to report incidents of violations due to the tedious and sometimes humiliating process of confirming incidents like attempted and actual rape (Kwiringira et al., 2018). On the other hand, refugees disregard of camp regulations like venturing out of the camp, especially girls and women to fetch wood fuel, expose themselves to violence by fellow refugees and host community. Although the host community is blamed for house breaking and physical violence of refugee women and girls as they move out of the camp, the violence meted on Turkana residents who access the camp to provide casual Labour, buy cheaper food stuffs and commodities is mostly undocumented.

Since violence is a product of societal factors, the study attributed the high prevalence of physical violence to the engrained inter-ethnic differences among most refugees back at the country of origin. For instance, the political turmoil in South Sudan in 2013, was reported by the camp authorities as responsible for several fights between South Sudan Dinka and Nuer tribes. These rivalries, is a great driver of targeted violation of young girls particularly through attempted or actual rape by young men from the opposing tribe ostensibly to punish the girls and shame the other community, a practiced that is very common in the post 2013 South Sudan (Ellsberg et al., 2020). Similarly, social strata among the Somali community, where some clans are deemed to be lesser that other was found to be correlated with perpetuation of acts of physical and verbal abuse, which confirms findings by (Andrea L Wirtz et al., 2018) where the exposure to physical violence was associated with being from a minority clan among others.

The settlement of refugees in a different country means that the traditional role of men of leading, protecting and feeding the family is disrupted by the loss of employment and family property. The loss of occupation and economic power results in low status, reduced dignity, and overall low social power in the community. This shift in gender roles leads men to vent their frustration to women through intimate partner violence and dominance. This illustrates that SGBV is not only about a result of frustration but rather, an assertion of power that men have over women leading to discrimination. (Annan & Brier, 2010; Rylko-Bauer & Farmer, 2017) .

Conclusion

In Kakuma refugee camp and Kalobeyei integrated settlement, young women between 18 and 24 years are the most vulnerable to SGBV and the risk reduced with increase in age.

Based on the Social Economic Model (SEM), the occurrence of SGBV was found to be influenced by societal factors such as political differences and/or rivalry amongst different nationalities in the camp, insecurity from the host Turkana community, patriarchal and restrictive cultural practices and place of residence in the camp. The individual factors which increased risk of experiencing SGBV included age, marital status and gender with denial of economic resource and low household income lowering bargaining power of the would-be victims of violence. Together with relations with camp security management and police services, these factors determined whether an individual would experience acts of violence either from people known to them, of the same nationality, from the host community and/or from security apparatus.

The findings of this study conclude that both men and women in the refugee community subscribe to the gender inequality norms which insubordinate women and girls to men and are responsible for the continued prevalence of SGBV in the camp as confirmed by one participant in women FGD "*when our men beat us, there is nothing we can do because they have paid dowry and elders do not allow women to report to the camp management*". The practice of dowry payment and wife inheritance confer absolute power to men over women and allows men to chastise them when they transgress allowable limits. Worse still, the traditionally accepted mode of justice and conflict resolution by Elders courts, among the

South Sudan and Somali “Maslaha” courts, have been used to defeat justice by encouraging retribution through payment of fines in form of money and livestock. These have been found to be not punitive enough to deter perpetrators while making the victims live in the same compound with the aggressors (Hossain et al., 2018). These too, are responsible for repeated violence since the aggressors know that with the payment of a fine and small dowry, they can have such girls as their women.

I also aver that the lack of employment, reduced source of income due to disruption of family support structures has resulted to most families continued dependence on food rations from WFP, which in turn has eroded the traditional role men to fend for the family, leading to reduced social status of men in the community. The end result is that men end up displacing frustrations and anger to women and resort to marrying off their young girls to cushion the family financially.

The study also concludes that despite the presence of health care services for SGBV survivors, most of them are unfriendly, delivered in open places with minimal confidentiality to the survivors. Coupled with the longer waiting hours and rigorous reporting procedures (Hossain et al., 2018), most survivors decline to seek medical care and justice and resort to live with their aggressors, a fact that drives repeated violation. Additionally, most victims of SGBV, despite knowledge and awareness of availability of response and prevention services, fail to seek for medical and justice because of the stigma associated with being violated, ostracization by the community as a result of reporting to authorities and threats to violence by aggressors.

This study posits that the current population of Kakuma and Kalobeyei integrated settlement, the pressure on social amenities, the minimal trust by the refugee community on the security agencies and the very porous nature of the camp are in themselves contributors to insecurity in particular to women and girls. The above insecurity situation is made worse by the poor relationship between the refugees and the host community.

Recommendations

A holistic approach to prevent and control the high prevalence of SGBV in Kakuma refugee camp must address the individual and societal factors that drive violence perpetuation. This should target the factors like age, gender, marital status, poverty, insecurity and camp residence that were highly associated with SGBV.

1. Interventions that build the capacity of women and young girls to reduce exposure to violence, like life skills education, economic empowerment, training and sensitization on the negative health effects of SGBV, what measures to take in the event of violent incidents and including reducing exposure to risk of violence should be instituted in Kakuma refugee camp.

2. The patriarchal, cultural and religious believes that justify propagation of violence against girls and women, must be addressed through the involvement of the elderly men and women, who are the custodians of practices such as FGM and early marriage of young girls. These myths and misinformation can be debunked and addressed by

civil society groups within the camp through social media, sensitization meeting for both men and women, and promotion of role models of successful refugee girls and women.

3. To reduce inequities and raise social standing of women, it will be prudent to promote the inclusion of women in refugee community's leadership roles and decision-making processes right from the household, zone, block to the bigger unit level. The avenues to achieve this will include general community sensitization on laws and policies guarding violence and discrimination, promoting UN and National policies that encourage equity and equality of all refugees regardless of the country of origin.

4. The management of the camp should put in place deliberate efforts to heal deep rooted tribal and political differences between rival communities from the same country through involvement of the community and religious leadership, encouraging mixed settlement within zones and blocks, and institutionalizing social activities amongst the various communities in the camp.

5. A functional refugee community set up that allows for early detection, reporting and referral, access to medical and justice by survivors of SGBV, needs to be put in place and be supported by the security and health service providers. These key stakeholders must strive to reduce waiting time and simplify the reporting procedure which should be in a friendly and confidential environment.

6. The relationship between the refugee and the host community is very important in cultivating cordial co-existence between the two groups. The camp management and the local host community administration need to come up with programs that cater for the common needs of both communities, and where possible, extend some corporate social responsibility to the local host community.

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REFERENCES

Ager, A., Bancroft, C., Berger, E., & Stark, L. (2018). Local construction of gender based violence amongst IDPs in Northern Uganda. *Conflict and Health, 12*, 10.

Amanda, S. (2019). *Sexual and Gender-Based Violence Against Arab Women Refugees: Yazidi Minority in Northern Iraq.*

Annan, J., & Brier, M. (2010). The risk of return: Intimate partner violence in Northern Uganda's armed conflict. *Social Science and Medicine*. https://doi.org/10.1016/j.socscimed.2009.09.027

Baldi, G. (2018). *Between patriarchy and occupation: violence against women in the occupied Palestinian Territiorities*. Libellula Univeristy Press.

Bettinger-Lopez, C., & Bro, A. (2020). A Double Pandemic: Domestic Violence in the Age of COVID-19. *Domestic Violence Report, 25*(5), 85–86.

Bishwajit, G., Sarker, S., & Yaya, S. (2015). Socio-cultural aspects of gender-based violence and its impact on women's health in South Asia. *F1000Research, 5*.

Cappa, C., Van Baelen, L., & Leye, E. (2019). The practice of female genital mutilation across the world: Data availability and approaches to measurement. *Global Public Health*, 1–14. https://doi.org/10.1080/17441692.2019.1571091

Christian, R., Mellies, A., Bui, A., Lee, R., Kattari, L., & Gray, C. (2018). Measruing the health of an invisible population: Lessons from the colorado transgender health survey. *Journal of General Internal Medicine, 33*(10), 1654–1660.

Clark, C. (2003). *Gender-based violence research initiatives in refugee, internally displaced,*

and post-conflict settings: Lessons learned.

Committee, I.-A. S. (2015). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.* https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

Committee, I. R. (2015). *Intimate Patner Violence in Humanitarian Settings*. http://educationcluster.net/wp-content/uploads/sites/3/2015/04/Private-Violence-Public-Concern-2015.pdf

Decker, M., Latimore, A., Yasutake, S., & Haviland, M. (2015). Gender-based violence against adolescent and young adult women in low and middle income counntries. *Journal of Adolescent Health*, *56*(2), 188–196.

Decker, M., Lyons, C., Billong, S., & Niindam, I. (2016). Gender based violence against female sex workers in Camerron. *Sex Transm Infect*, *92*(8), 599–604.

Dustin, M. (2016). Culture or masculinity?Understading gender-based violence in the UK. *Journal of Poverty and Social Justice*, *24*(1), 51–62.

Ellsberg, M., Ovince, J., Murphy, M., Blackwell, A., Reddy, D., Stennes, J., Hess, T., & Contreras, M. (2020). No safe place: Prevalence and correlates of violence against conflict-affected women and girls in South Sudan. *PLoS ONE*, *15*(10 October 2020), 1–24. https://doi.org/10.1371/journal.pone.0237965

Feseha, G., & Gerbaba, M. (2012). Intimate partner physical violence among women in Shimelba refugee camp, northern Ethiopia. *BMC Public Health*, *12*(1), 125.

Fleming, P., McCleary-Sills, J., Morton, M., Leyton, R., & Heilman, B. (2015). Risk factors

for men's lifetime perpetration of physical violence against intimate partners. *PLOS ONE*, *10*(3).

Fulu, E., Warner, X., Miedema, S., Jewkes, R., Roselli, T., & Lang, J. (2013). *Why Do Some Men Use Violence Against Women and how Can We Prevent It?: Quantitative Findings from the United Nations Multi-country Study on Men and Violence in Asia and the Pacific*. UNDP, UNFPA, UN Women and UNV Bangkok.

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*(9543), 1260–1269.

Gass, J. D., Stein, D. J., Williams, D. R., & Seedat, S. (2011). Gender differences in risk for intimate partner violence among South African adults. *Journal of Interpersonal Violence*, *26*(14), 2764–2789. https://doi.org/10.1177/0886260510390960

Gill, A. (2018). Survivor-centered research: Towards an inersectional gender-based violence movement. *Journal of Family Violence*, *33*(8), 559–562.

Gracia, E., & Herrero, J. (2006). Public attitudes toward reporting partner violence against women and reporting behavior. *Journal of Marriage and Family*, *68*(3), 759–768.

Guedes, A., Bott, S., Garcia-Moreno, C., & Colombini, M. (2016). Bridging the gaps: a global review of inteersections of violence againnst womenand violence against children. *Global Health Action*, *9*(1).

Haberland, N., Ndwiga, C., McCarthy, K., & Makanyengo, M. (2016). Addressing intimate partner violence and power in relationship s in HIV testing services. *Unites States*

Agency for International Development Project.

Heise, L., Ellsberg, M., & Gottemoller, M. (1999). *Ending violence against women*. John Wiley and Sons.

Herrero, J., Torres, A., Rodriguez, F., & Juarros-Basterretxea, J. (2017). Intimate partner violence against women in the European union: The infleunce of male partners traditional gender roles and general violence. *Psychology of Violence*, *7*(3), 385.

Holmes, V., Farrington, R., & Mulongo, P. (2017). Educating about female genital mutilation. *Education for Primary Care : An Official Publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors*, *28*(1), 3–6. https://doi.org/10.1080/14739879.2016.1245589

Hossain, M., McAlpine, A., Muthuri, S., Bacchus, L., Muuo, S., Kohli, A., Egesa, C., Pearson, R., Franchi, G., & MacRae, M. . (2018). *Violence, uncertainty, and resilience among refugee women and community workers: An evaluation of gender-based violence case management services in the Dadaab refugee camps*.

Hossain, M., Zimmerman, C., Kiss, L., Kone, D., Bakayoko-Topolska, M., Manan K A, D., Lehmann, H., & Watts, C. (2014). Men's and women's experiences of violence and traumatic events in rural Côte d'Ivoire before, during and after a period of armed conflict. *BMJ Open*, *4*(2), e003644. https://doi.org/10.1136/bmjopen-2013-003644

Hynes, M., & Lopes Cardozo, B. (2000). Sexual violence against refugee women. *Journal of Women's Health & Gender-Based Medicine*, *9*(8), 819–823.

https://doi.org/10.1089/152460900750020847

Izugbara, C., Muthuri, S., Muuo, S., Egesa, C., Franchi, G., McAlpine, A., Bacchus, L., & Hossain, M. (2020). '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. *Journal of Refugee Studies*, *33*(3), 521–536. https://doi.org/10.1093/jrs/fey055

Kenya National Bureau of Statistics. (2010). *Volume 1A-Population Distribution by Administrative Units*. The 2009 Kenya Population and Housing Census. https://www.knbs.or.ke/2009-kenya-population-and-housing-census-volume-1a-population-distribution-by-administrative-units/

Kiss, L., Schraiber, L., Hossain, M., Watts, C., & Zimmerman, C. (2015). The link between community-based violence and initimate partner violence: The effects of crime and male aggression on intimate partner violence against women. *Prevention Science*, *16*(6), 881–889.

KNBS. (2010). *The 2009 Kenya population and housing census - Population Distribution by Administrative Units*. *IC*, 218. http://www.knbs.or.ke

KNBS. (2015). *Kenya Demographic Health survey (KDHS 2014)*.

Kwiringira, J. N., Mutabazi, M. M., Mugumya, F., Kaweesi, E., Munube, D., & Rujumba, J. (2018). Experiences of Gender Based Violence among Refugee Populations in Uganda: Evidence from Four Refugee Camps. *Eastern Africa Social Science Research Review*, *34*(1), 291–311. https://doi.org/10.1353/eas.2018.0010

Larsson, M. (2017). Violence against women - an unacceptable global burden. In *Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives* (Vol. 14, p. 91). https://doi.org/10.1016/j.srhc.2017.11.004

Latcheva, R. (2017). Sexual harrassment in the European Union. *Journal of Interpersonal Violence*, *32*(12), 1821–1852.

Leddy, A., Underwood, C., Decker, M., & Mbwambo, J. (2018). Adapting the risk environment framework to understand substance use, gender-based violence and HIV risk behaviours among female sex workers in Tanzania. *AIDS and Behavior*, *22*(10), 3296–3306.

Lilleston, P., Winograd, L., Ahmed, S., Salame, D., & Alam, D. (2018). Evaluation of a mobile approach to gender-based violence services delivery among Syrian refugees in Lebanon. *Health Policy and Planning*, *33*(7), 767–776.

Logie, C. H., Okumu, M., Mwima, S., Hakiza, R., Irungi, K. P., Kyambadde, P., Kironde, E., & Narasimhan, M. (2019). Social ecological factors associated with experiencing violence among urban refugee and displaced adolescent girls and young women in informal settlements in Kampala, Uganda: A cross-sectional study. *Conflict and Health*, *13*(1). https://doi.org/10.1186/s13031-019-0242-9

Lundgren, R., & Amin, A. (2015). Adressing intimate partner volnce and sexual violence among adolescents: Emerging evidence of effectiveness. *Journal of Adolescent Health*, *56*(1), S42–S50.

Manjoo, R., & McRaith, C. (2011). Gender-based violence and justice in conflict and post-

conflict areas. *Cornell Int'l LJ*, *44*, 11.

Mechanic, M. B., Weaver, T. L., & Resick, P. A. (2008). Mental health consequences of intimate partner abuse: a multidimensional assessment of four different forms of abuse. *Violence against Women*, *14*(6), 634–654. https://doi.org/10.1177/1077801208319283

Memiah, P., Mu, T., & Prevot, C. (2018). The prevalence of intimate partner violence, associated risk factors and other moderrating effects. *Journal of Interpersonal Violence*.

O'Neal, E., & Beckman, L. (2017a). Intersections of race, ethnicity and gender: Reframing knoweldge surrounding barriers to somcial services among Latina intimate partner victims. *Violence against Women*, *23*(5), 643–665.

O'Neal, E. N., & Beckman, L. O. (2017b). Intersections of race, ethnicity, and gender: Reframing knowledge surrounding barriers to social services among Latina intimate partner violence victims. *Violence against Women*, *23*(5), 643–665.

Overstreet, N. M., Willie, T. C., Hellmuth, J. C., & Sullivan, T. P. (2015). Psychological intimate partner violence and sexual risk behavior: examining the role of distinct posttraumatic stress disorder symptoms in the partner violence–sexual risk link. *Women's Health Issues*, *25*(1), 73–78.

Palermo, T., Bleck, J., & Peterman, A. (2013). Tip of the iceberg: reporting and gender-based violence in developing countries. *American Journal of Epidemiology*, *179*(5), 602–612.

Pandey, S. (2016). Physical or sexual violence against women of child bearing age within marriage in Nepal: Prevalence, causes and prevention strategies. *International Social Work*, *59*(6), 803–820.

Peterman, A., Bleck, J., & Palermo, T. (2015). Age and intimate partner violence: an analysis of global trends among women experiencing victimization in 30 developing countries. *Journal of Adolescent Health*, *57*(6), 624–630.

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health*, *15*(5), 599–611.

Platt, L., & Milam, S. (2018). Publlic discomfort awith gender appearance-inconsistent bathroom use : the oppressive bind of bathroom laws for transgender individuals. *Gender Issues*, *35*(3), 181–201.

Refugee Consortium of Kenya. (2018). *"Refugee Insights", Refugee Consortium of Kenya-legal aid and policy development centre (10th): 2-18*. https://www.rckkenya.org/

Rivelli, F. (2015). *SOUTH SUDAN/GENDER BASED VIOLENCE RESEARCH ON SEXUAL ASSAULT*.

Rylko-Bauer, B., & Farmer, P. E. (2017). Structural Violence, Poverty, and Social Suffering. In *The Oxford Handbook of the Social Science of Poverty*.

Schwitters, A., Swaminathan, M., Serwadda, D., & Muyonga, M. (2015). Prevalence of rape and client initiated gender-based violence among female sex workers : Kampala , Uganda. *AIDS and Behavior*, *19*(1), 68–76.

Semiatin, J. N., Torres, S., LaMotte, A. D., Portnoy, G. A., & Murphy, C. M. (2017). Trauma exposure, PTSD symptoms, and presenting clinical problems among male perpetrators of

intimate partner violence. *Psychology of Violence*, *7*(1), 91.

Stark, L., & Ager, A. (2011). A systematic review of prevalence studies of gender-based violence in complex emergencies. *Trauma, Violence, & Abuse*, *12*(3), 127–134.

Stark, L., Asghar, K., Yu, G., Bora, C., Baysa, A. A., & Falb, K. L. (2017). Prevalence and associated risk factors of violence against conflict-affected female adolescents: A multi-country, cross-sectional study. *Journal of Global Health*, *7*(1). https://doi.org/10.7189/jogh.07.010416

Stellar, C., Garcia-Moreno, C., Temmerman, M., & van der Poel, S. (2016). A systmatic review and narrative report of the relationship between infertillity, subfertility and intimate partner violence. *International Journal of Gynecology and Obstetrics*, *133*(1), 3–8.

Tanabe, M., Schaus, K., Rastogi, S., Krause, S. K., & Patel, P. (2015). Tracking humanitarian funding for reproductive health: a systematic analysis of health and protection proposals from 2002-2013. *Conflict and Health*, *9*(1), S2.

Tlapek, S. M. (2015). Women's Status and Intimate Partner Violence in the Democratic Republic of Congo. *Journal of Interpersonal Violence*, *30*(14), 2526–2540. https://doi.org/10.1177/0886260514553118

Tolman, R., Walsh, T., & Nieves, B. (2017). Engaging men and boys in preventing gender-based violence. *Preventing Intimate Partner Violence*, *71*.

Trujillo, A., Id, L., Farrell, K., Id, G., Penney, N., Shamsudin, A., & Id, R. O. (2020). *PLOS MEDICINE Exploring sources of insecurity for Ethiopian Oromo and Somali women*

who have given birth in Kakuma Refugee Camp : A Qualitative Study. 1–19. https://doi.org/10.1371/journal.pmed.1003066

UNFPA. (2018). *Gender-based violence*. United Nations Population Fund.

UNFPA. (2019). *Gender-based violence*.

UNHCR. (2018). *Kakuma Camp Population Statistics by Country of Origin, Sex and Age Group*.

UNHCR. (2020). *MONTHLY OPERATIONAL UPDATES. March*, 1–9.

United Nations Population Fund(UNFPA). (2013). *UNFPA Annual Report 2013*. https://www.unfpa.org/publications/unfpa-annual-report-2013

USAID. (2014). *GBV definition, prevalence and Global Statistics*. United States Agency for International Development.

USAID. (2016). *Gender-based violence initiative synthesis report*. *May*. https://aidsfree.usaid.gov/sites/default/files/aidsfree_gbvi_synthesis_rpt.pdf

Vann, B. (2002). *Gender-based violence: Emerging issues in programs serving displaced populations*.

Viejo, C., Valenzuela, G., & Ruiz, R. (2018). Adult partner violence and previous violence experiences: Retrospective study with women victims of gender-based violence. *International Journal of Psychology and Psychological Therapy*, *18*(2), 179–192.

Walsh, K., Keyes, K., Koenen, K., & Hasin, D. (2015). Lifetime prevalence of gender-basaed violence in US women: Associations with mood/anxiety and substance use disorders. *Journal of Psychiatric Research*.

Watts, C., & Zimmerman, C. (2002). Violence against women: global scope and magnitude. *The Lancet*, *359*(9313), 1232–1237.

WHO. (2013). *Global and Regional Estimates of Violnce aganist women. Prevalence and Health effects of IPV and SV*.

Wilson, K., Deya, R., Masese, L., & Simoni, J. (2016). Prevalence and correlates of intinate partner violence in HIV-Positive women engaged in transactional sex in Mombasa, Kenya. *InternationalJournal of STD and AIDS*, *27*(13), 1194–1203.

Wirtz, A., Poteat, T., Malik, M., & Glass, N. (2018). Gender-based violence against transgender people in the United States: A call for research and programming. *Trauma, Violence and Abuse*.

Wirtz, A L, Glass, N., Pham, K., Perrin, N., Rubenstein, L. S., Singh, S., & Vu, A. (2016). Comprehensive development and testing of the ASIST-GBV, a screening tool for responding to gender-based violence among women in humanitarian settings. *Conflict and Health*, *10*(1), 7.

Wirtz, Andrea L, Perrin, N. A., Desgroppes, A., Phipps, V., Abdi, A. A., Ross, B., Kaburu, F., Kajue, I., Kutto, E., Taniguchi, E., & Glass, N. (2018). Lifetime prevalence, correlates and health consequences of gender-based violence victimisation and perpetration among men and women in Somalia. *BMJ Global Health*, *3*(4), e000773. https://doi.org/10.1136/bmjgh-2018-000773

Women in, International, & Security. (2018). *Sexual- and Gender-Based Violence in Refugee Settings in Kenya and Uganda* (Issue March).

Yount, C., Krause, K., & Miedema, S. (2017). Preventing gender-based violence in adolescent girls in low income countries. *Social Science and Medicine, 192,* 1–13.

APPENDICES

PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: The prevalence and Correlates of SGBV in Kakuma refugee camp, Turkana County

Investigator: Ngala Peter Ekuleu, University of Nairobi.

Introduction:

I would like to tell you about a study being conducted by Ngala Ekuleu, a Masters of Public Health student at the school of Public Health, University of Nairobi. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. Once you understand and agree to be in the study, I will request you to sign your name on this form. You should understand the general principles which apply to all participants in a medical research: i) Your decision to participate is entirely voluntary ii) You may withdraw from the study at any time without necessarily giving a reason for your withdrawal iii) Refusal to participate in the research will not affect the services you are entitled to in this Kakuma Refugee camp. We will give you a copy of this form for your records.

May I continue? YES /NO

This study has approval by The Kenyatta National Hospital-University of Nairobi Ethics and Research Committee protocol **……..**

WHAT IS THIS STUDY ABOUT

The purpose of this study is to find out the burden of Sexual and Gender based violence in Kakuma Refugee camp and what factors are associated with it. Participants of this study are people who are bonafide residents of this camp with official refugee status as per UNHCR rules.

The participants will be asked provide primary information about themselves including nationality, duration of stay in the camp, education status, occupation, whether married or not and age. Thereafter, the researcher will want to find out your knowledge and experience on SGBV. During this process, the researcher will NOT record your name/identity. The selection of the participants for this study will be selected randomly from Kakuma and Kalobeyiei camps.

WHAT WILL HAPPEN IF YOU DECIDE TO BE IN THIS RESEARCH STUDY?

If you agree to participate in this study, the following things will happen: You will be interviewed by a trained interviewer in a private area within your house, where you feel comfortable answering questions. The interview will last approximately 30 Minutes.

ARE THERE ANY RISKS, HARMS DISCOMFORTS ASSOCIATED WITH THIS STUDY?

Medical and Public Health research has the potential to introduce psychological, social, emotional and physical risks. We will keep everything you tell us as confidential as possible. We will use a code number to identify you in a password-protected computer database and will keep all of our paper records in a locked file cabinet. Also answering some questions in

the interview may be uncomfortable for you. If there are any questions you do not want to answer, you can skip them. You have the right to refuse the interview or any questions asked during the interview. We will do everything we can to ensure that this is done in private.

ARE THERE ANY BENEFITS BEING IN THIS STUDY?

There is no direct benefit to you from participating in the study. However, we hope that, in the future, other people might benefit from this study because it will allow us to learn more about the prevalence of SGBV and factors associated with its occurrence among the refugee community. This information can be used by the UN agencies and other actors supporting people in crisis to come up with policies, laws and interventions to prevent and control occurrence of SGBV and mitigate its effects.

WILL BEING IN THIS STUDY COST YOU ANYTHING?

Participating in this study will not cost you anything apart from the 40 minutes or so of your time.

WILL YOU GET REFUND FOR ANY MONEY SPENT AS PART OF THIS STUDY?

We shall not provide any monetary refund for participating in the study.

CONFIDENTIALITY AND PRIVACY

The information you provide will be treated confidentially and only authorized members of the research team will have access to it. You will be assigned a unique study ID and no names will be written on the interview forms. **Your name or other personal information will not be used in any reports or shared with anyone else**. We will use the information for research purposes only.

WHAT IF YOU HAVE QUESTIONS IN FUTURE?

If you have further questions or concerns about participating in this study, please call or send a text message to the principal investigator at +**254 725527553 or email at ngala.ekuleu@gmail.com**. For more information about your rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No**. 2726300 Ext. 44102 email: uonknh_erc@uonbi.ac.ke.**

WHAT ARE YOUR OTHER CHOICES?

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

CONSENT FORM (STATEMENT OF CONSENT)

Participant's statement

I have read this consent form or had the information read to me. I have had the chance to discuss this research study with a study counselor. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

I understand that all efforts will be made to keep information regarding my personal identity confidential.

_____ _____

(Signature/ Thumb Print of Participant) (Date)

_____

(Participant's name – printed)

FOR PARENTS/GURDIANS CONSENTING FOR CHILDREN

Name of the Child: _____

Parent's signature: _____

Parents Name : _____

Relationship with child: _____

Date: _____

Statement of Person Who Obtained Consent

The information in this document has been discussed with the participant or, where appropriate, with the participant's legally authorized representative. The participant has indicated that he or she understands the risks, benefits, and procedures involved with participation in this research study.

_____ _____

(Signature of Person who Obtained Consent) (Date)

_____

(Name of Person who Obtained Consent - printed)

Sample Research Consent Form- KII AND FGDS

I am PETER NGALA EKULEU a MPH student at University of Nairobi. As part of my degree requirements, I am completing a research study and I would like to include you in the study. I can also be contacted by email **ngala.ekuleu@gmail.com**, or mobile phone on +**254 725527553.** For more information about your rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No**. 2726300 Ext. 44102 email: uonknh_erc@uonbi.ac.ke.**

Your written consent is required to participate so that I can confirm that you have been informed of the study and that you agree to participate. You are free to decline to answer any questions that you are uncomfortable with. All information obtained in this study will be kept confidential; a random number will be assigned to you, for the protection of your name and identity.

The purpose of the research is to understand the extent and factors associated with sexual and gender-based violence at Kakuma refugee camp. You will be asked to partake in an interview, which shall be recorded electronically. After this interview has been transcribed the audio shall be discarded. This is not an exam or a test and there is no right or wrong answers. Please answer the questions as honestly as you can. The interview should take about 30 to 45 minutes to complete.

The risk to you as a research participant in this study is considered low. Questions asked will be non-emotive, un-personal. You will not be asked to talk about your performance. The

benefits from this study are to give you an opportunity to talk about an important subject as a key stakeholder. Information obtained from this study will be used in informing appropriate interventions for sexual and gender-based violence especially among refugees. There shall be no compensations given for participation in this study.

My Consent to Participate:

By signing below, I consent to participate in this study.

_____ _____

(Signature of the Participant) (Date)

_____ _____

(Signature of the Researcher) (Date)

Participant Number to be used on all other documents: _____

ASSENT DOCUMENT

Project Title: **PREVALENCE AND CORRELATES OF SEXUAL AND GENDER BASED VIOLENCE IN KAKUMA REFUGEE CAMP, TURKANA COUNTY, KENYA**

Investigator(s): **NGALA PETER EKULEU Bsc.PH**

We are doing a research study. A research study is a special way to find out about something. We are trying to find out the extent and factors associated with sexual and gender based violence in Kakuma refugee camp.

Permission has been granted to undertake this study by the Kenyatta National Hospital-University of Nairobi Ethics and Research Committee (KNH-UoN ERC Protocol No. _____) .

If you decide that you want to be in this study, you will be asked to answer some questions by researchers using questionnaires or be invited to participate in a discussion with other people of your age range and gender. These assessments can take 20 -30 minutes.

We want to tell you about some things that might hurt or upset you if you are in this study. Some of the questions during assessments may be sensitive and could make you uncomfortable. However, you can choose not to answer any questions that you do not want to

answer, for any reason.

When we are done with the study, we will write a report about what we found out. We won't use your name in the report.

If you want to be in this study, please sign or print your name.

I, _____, want to be in this research study.

(Child's name)

_____ _____

(Sign or print your name here) (Date)

DATA COLLECTION INSTRUMENTS

1. SOCIO-DEMOGRAPHIC QUESTIONNAIRE

NO	Question	Response	Code
1	SEX **(SEX)**	F=1 M=2	**[ ]**
2	AGE **(AGE)**	Number	**[ ]**
3	Country of Origin	Name:	
4	Religion **(RELIG)**	1. Christian 2. Muslim 3: Other (specify)	**[ ]**
5	Education level **(EDULEV)**	1. None 2. Primary 3. Secondary 4. College 5. University a) First degree b) Masters c) Doctorate 6. Other (specify)	**[ ]**

6	Occupation **(OCCUP)**	1. Farmer 2. Trader/Business 3. Casual labourer 4. Professional 5. Student 6. Other (specify)	**[ ]**
7	Marital status **(MARST)**	1. Never married 2. Married 3. Separated/divorced. 4.. Widowed	**[ ]**
8	Average income/pocket money per month **(INCM)**	Amount	**[ ]**
9	Duration of stay in the camp (yrs)	1.	
10	Residence in the camp ()		
11	Alcohol Use (Yes/No)		
	Other Substances (Yes/No) If Yes, Please Specify……		

2. ASIST-GBV screening instrument

Please Tick Appropriately

QUESTION	YES	NO
1. In the past year, have you been threatened with physical or sexual violence by someone in your home or outside of your home?		
2. In the past year, have you been hit, punched, kicked, slapped, choked, hurt with a weapon, or otherwise physically hurt by someone in your home or outside of your house?		
3. In the past year, were you forced to have sex against your will?		
4. In the past year, were you forced to have sex to be able to eat, have shelter, or have sex for essential services (such as protection or school) because you or someone in your family would be in physical danger if you refused?		
5. In the past year, were you physically forced or made to feel that you had to become pregnant against your will?		
6. In the past year, were you coerced or forced into marriage?		

7. In the past year, were you coerced or forced to have an abortion?		
If yes to any of items 1 to 7, the person has screened positive for gender-based violence. If positive screen, please ask:		
8. Would you like to talk to someone or learn more about services for women who have experienced gender-based violence?		

Key Informant Interview Guide

1. Please tell me the main mandate of the organization you work for.

   ……

   ……

   ……

   ……..

2. Does your organization have a Sexual and gender based violence component in it work?

   ……

   ……..

3. In your opinion, what are the commonest forms of Sexual and Gender Based Violence (SGBV) in Kakuma refugee camp?

   ……

   ……

   ……

   ……

   ……

   ……

4. Which groups of people are the main victims of SGBV?

   ……

   ……

   ……

   ……

5. Who are the main perpetrators of SGBV in the camp?

   ……

   ……

   ……

   ……

   ……

6. Why does SGBV happen in the camp? What factors influence the occurrence of SGBV?

   ……

   ……

   ……

   ……

   ……

7. How does the refugee community respond/handle cases of SGBV?

   ……

   ……

   ……

   ……

8. In your work, do you come across cases of repeated occurrence of SGBV against particular individuals, groups of people and/or more cases occurring within a particular area, block or village in the camp?

   Yes……..No……..

If yes, please give brief explanation/example

……

……

……

……

What could be the reasons for this?

……

……

……

……

9. What services does your organization offere to victims of SGBV?

……

……

……

……

……

10. In your opinion, what measure, interventions or programs can be put in place to address SGBV?

……

……

……

……

FOMU YA HABARI NA RIDHAA YA WASHIRIKA.

MADA YA UTAFITI: ***MAAMBUKIZI NA UWIANO WA DHULUMA ZA NGONO NA JINSIA KATIKA KAMBI LA WAKIMBIZI LA KAKUMA ILIYOKO ENEO KAUNTI YA TURKANA*****.**

MCHUNGUZI: ***NGALA PETER EKULEU, CHUO KIKUU CHA NAIROBI.***

DIBAJI.

Ningetaka kuwaeleza kuhusu utafiti unaofanywa na **Bwana Ngala Peter Ekeleu**, mwanafunzi wa shahada ya uzamili kwa afya ya umma katika chuo kikuu cha Nairobi. Madhumuni ya fomu hii ni kukupa taarifa itakayokusaidia kufanya uamuzi kama utakuwa au hutakuwa mshiriki katika utafiti huu. Kuwa huru kuuliza swali lolote kuhusu madhumuni ya utafiti huu. Kitakachotendeka iwapo utashiriki, hatari na faida za kushiriki, haki zako kama mshiriki na lolote lile linalohusiana na utafiti huu au lolote ambalo alieleweki katika fomu hii. Utakaporidhishwa na majibu yetu ndipo utafanya uamuzi kama utashiriki au la. Utaratibu huu ndio unajulikana kama ‘utoaji idhini’. Utakapoelewa na kukubali kuwa mshirika katika utafiti huu utahitajika kuandika jina lako na kutia sahihi katika fomu hii. Unapaswa kuelewa kanuni za jumla zinazofuatwa na washirika wote wa utafiti wa matibabu;

UAMUZI WA KUWA MSHIRIKI NI KWA HIARI.

Unaweza kujitoa kwenye tafiti wakati wowote bila kulazimika kupeana sababu yeyote ya kujitoa.

Kutoshiriki katika utafiti huu hutaathiri huduma unazopewa katika kambi la wakimbizi la Kakuma. Tutakupa nakala ya hii fomu kama kumbukumbu yako.

NAWEZA ENDELEA? NDIO/LA

Utafiti huu umeruhusiwa na maadili ya Hospitali kuu ya Kenyatta ikishirikiana na chuo kikuu cha Nairobi na kamati ya utafiti itifaki nambari-

UTAFITI HUU UNAHUSU

Uchunguzi huu unalenga kupata au kujua mzigo wa dhuluma za ngono na jinsia katika kambi la wakimbizi la Kakuma na sababu zinazohusishwa nazo. Watakoashiriki huu utafiti ni wakaaji halisi wa Kambi hili, walio na hadhi rasmi ya kuwa wakimbizi kulingana na kanuni za muungano wa kimataifa unaopigania haki za wakimbizi UNHCR.

Watakaoshiriki wanatakiwa kupeana habari zao za msingi pia uraia wao, muda waliokaa katika kambi, kiwango cha elimu, taaluma yao, kama wako katika ndoa au la na umri wao. Baada ya hapo mtafiti atataka kujua maarifa uliyo nayo kuhusu dhuluma za ngono na jinsia na jinsi ulivyoadhirika. Katika harakati hizi mtafiti hatanakili jina lako wala kukutambulisha. Uchaguzi wa watakaoshiriki utafanywa nasibu kutoka kambi la Kakuma na Kalobeyiei.

KUTATOKEA NINI KAMA UTAAMUA KUSHIRIKI KATIKA UTAFITI HUU?

Kama utakubali kushiriki katika utafiti huu utahojiwa na mtaalamu kwenye chumba binafsi utakapoweza kujibu maswali faraghani. Mahojiano yatachukua muda wa dakika thelathini.

JE KUNA HATARI, MADHARA AMA USUMBUFU UNAOHUSISHWA NA UTAFITI HUU?

Utafiti wa aina hii unao uwezo wa kuanzisha hatari za saikolojia, kijamii, hisia na kimwili. Mmojawapo ya hatari ni kuweka siri zako wasi. Habari utakazotoa kwetu tutaziweka kama siri iwezekanavyo.Tutatumia msimbo kukutambulisha katika tarakilishi iliyolindwa na nywila. Nakala za kumbukumbu zitahifadhiwa vyema kwenye droo iliyofungwa. Pia kujibu maswali mengine inaweza kuwa si jambo la kurudhisha kwako, kama kuna swali hautaki kujibu una huru wa kulipita. Unao uhuru wa kukataa kuhojiwa au kujibu swali/maswali mengine wakati wa mahojiano.

Tutafanya juu chini kuhakikisha habari yako utakayotupa haitajulikana.

JE KUNA MANUFAA YA KUSHIRIKI HUU UTAFITI?

Hakuna manufaa ya moja kwa moja kwa kuwa mshirika katika huu utafiti, hata hivyo tunatumaini kuwa habari utakazotupa zitatufaidi siku za usoni kwani tutaweza kujua Zaidi kuhusu maambukizi na uwiano wa dhuluma za ngono na jinsia na sababu zinazohusishwa na kitendo hiki katika jamii ya wakimbizi. Habari hizi zinawezatumika na Mashirika ya umoja wa mataifa na yale mashirika yanayosaidia watu katika maeneo yaliyokumbwa na migogoro kutengeneza sera na sheria na kujua jinsi watakavyoingilia ili kuzuia na kudhibiti matukio ya dhuluma za ngono na jinsia na kupunguza madhara yake.

JE KUSHIRIKI HUU UTAFITI UTAKUGHARIMU?

Kushiriki katika huu utafiti hutakugharimu chochote ila tu ule muda utakaotupa kwa mahojiano.

JE KUNA FEDHA UKAYOPEWA KUSHIRIKI HUU UTAFITI?

Hakuna fedha zozote utakazopokea kushiriki huu utafiti.

USIRI

Habari utakazotoa zitawekwa kwa usiri sana. Watakaokuwa na fursa ya kuzifikia ni watu maalum walioko katika kikundi kinachohusika katika kufanya utafiti huu. Zaidi ya hapo hatatumia jina lako ila utapewa nambari ya kipekee ya kukutambulisha katika fomu za mahojiano. Jina au habari zako za kibinafsi hazitatumika katika repoti au kujulikana. Habari utakayotoa itatumika katika utafiti pekee.

JE KAMA KUNA MASWALI YATAKAYOIBUKA USONI?

Kama utakuwa na maswali zaidi au wasiwasi wowote kutokana na kuwa mshiriki katika huu utafiti unaweza wasiliana nasi kwa njia ya kupiga simu au kuandika ujumbe kwa mchunguzi mkuu kupitia nambari ya simu +254725527553 au utume barua pepe kwa ngala.ekuleu@gmail.com. Kwa habari zaidi kuhusu haki zako kama mshirika katika huu utafiti wasiliana na katibu au mwenyekiti wa kamati ya maadili ya utafiti ya hospitali kuu ya Kenyatta wakishirikiana na chuo kikuu cha Nairobi,nambari ya simu 2726300 ext 44102 au kupitia barua pepe uonknh_erc@uonibi.ac.ke.

CHAGUO MBADALA???

Uamuzi wa kuwa mshirika katika huu utafiti ni wa kujitolea. Una huru wa kukataa kushiriki au kujiondoa katika utafiti bila udhalimu au kupoteza dhamana yoyote.

RIDHAA (KAULI YA RIDHAA)

Kauli ya mshiriki.

Nimesoma hii fomu ya ridhaa/nimesomewa hii fomu ya ridhaa. Nimejadiliana na mshauri wa utafiti kuhusu huu utafiti, nimejibiwa maswali kwa lugha ninayoelewa. Nimeelezwa hatari na manufaa ya kushiriki huu utafiti,nimeelewa kuwa kushiriki huu utafiti ni kwa kujitolea na ninao uhuru wa kujiondoa wakati wowote ule. Nimekubali kwa hiari yangu kushiriki katika huu utafiti.

Nimeelewa kuwa kutafanywa juu chini kuhakikisha habari nitakayotoa au utambulisho wangu utawekea siri.

Sahihi ya mhusika_____ tarehe_____

Jina la mhusika _____

Kwa Mzazi anayetoa ridhaa kwa niaba ya mtoto

Jina la Mtoto: _____

Sahihi ya Mzazi: _____

Jina la Mzazi : _____

Uhusiano na Mtoto: _____

Tarehe_____

Kauli ya mchunguzi

Ujumbe uliopo katika hii fomu umejadiliwa na mshiriki au mwakilishi wa kisheria wa mshirika. Mshirika amekubali kuwa ameelewa hatari, manufaa na utaratibu unaohusishwa kushiriki huu utafiti.

Sahihi ya mchunguzi _____ tarehe_____

Jina la mchunguzi. _____

Consent form- KII and FGDs- SWAHILI

Naitwa **PETER NGALA EKULEU** mwanafunzi wa Shahada ya Uzamili kwa Afya ya Umma katika chuo kikuu cha Nairobi. Kufanya utafiti ni mmojawapo ya masomo katika kuhitimu Shahada na ningetaka uwe mmoja wa washiriki. Unaweza kuwasiliana nami kupitia barua pepe **ngala.ekuleu@gmail.com** au nambari ya simu +**254 725527553**

Utaandika hati ya kukubali ili kudhibitisha kuwa umeelezwa kuhusu utafiti huu na umekubali kushiriki. Unaweza kakataa kujibu swali lolote ambalo ujihisi huru kujibu. Habari utakazopeana katika utafiti zitawekwa kwa usiri. Jina lako halitatumika ila tutatumia nambari ya kipekee, hautatambulika.

Nia ya utafiti huu ni kuelewa kiwango na mambo yanahusiswa na dhuluma za kingono na jinsia katika kambi ya wakimbizi ya Kakuma. Utahojiwa, mahojiano hayo yatarekodiwa kwa njia ya kielektroniki. Baada ya kunakili rekodi za mahojiano, rekodi za sauti zitafutwa. Huu si mtihani kwa hivyo hakuna jibu si sawa, jibu maswali yote kwa kweli. Mahojiano haya yatachukua dakika thelathini au arobaini na tano.

Hatari ya kushiriki utafiti huu ni hafifu sana. Maswali yatakayoulizwa hayataibua hisia zozote wala si binafsi. Hautaulizwa kuhusu utendakazi wako. Umuhimu/Manufaa ya utafiti huu ni kuwa unapata fursa ya kuzungumzia swala muhimu kama mshikadau. Habari tutakazokusanya katika huu utafiti zitatumika kutafuta njia mwafaka ya kakabiliana na

dhuluma za kingono na jinsia hasa katika kambi za wakimbizi. Hakuna fidia utakayopewa kushiriki katika utafiti huu.

Hati ya kukubali.

Kwa kutia sahihi, nakubali kuwa mshiriki katika utafiti huu.

Sahihi ya Mshiriki _____ *Tarehe*_____

Sahihi ya Mtafiti _____ *Tarehe*_____

ASSENT FORM- SWAHILI

MCHUNGUZI: NGALA PETER EKULEU (CHUO KIKUU CHA NAIROBI)

Project Title: **PREVALENCE AND CORRELATES OF SEXUAL AND GENDER BASED VIOLENCE IN KAKUMA REFUGEE CAMP, TURKANA COUNTY, KENYA**

Utafiti ni njia spesheli ya kujua mambo.

Uchunguzi huu unalenga kupata au kujua mzigo wa dhuluma za ngono na jinsia katika kambi la wakimbizi la Kakuma na sababu zinazohusishwa nazo.

Utafiti huu umeruhusiwa na maadili ya Hospitali kuu ya Kenyatta ikishirikiana na chuo kikuu cha Nairobi na kamati ya utafiti, itifaki nambari-

Ukikubali kuwa mshiriki katika huu utafiti utaulizwa maswali na watafiti kupitia njia ya dodoso au kualikwa katika majadiliano na watu wa umri na jinsia sawa. Makadirio haya yatachukua muda wa dakika ishirini mpaka thelathini.

Tunataka kuashiria kuwa kuna maswali yanayoweza kusonenesha au kukuudhi ukichagua kuwa mshiriki. Katika makadirio kuna masuala nyeti yatakayogusiwa ambayo hayaridhishi. Hata hivyo sio lazima ujibu swali lolote hutaki kwa sababu yoyote ile.

Hakuna manufaa ya moja kwa moja kwa kuwa mshirika katika huu utafiti, hata hivyo tunatumaini kuwa habari utakazotupa zitatufaidi siku za usoni kwani tutaweza kujua Zaidi kuhusu maambukizi na uwiano wa dhuluma za ngono na jinsia.

Utafiti huu utakapofikia kikomo repoti ya matokeo itaandikwa na jina lako halitatumika.

Si lazima kushiriki utafiti huu, uamuzi ni wako. Una huru wa kujiondoa katika utafiti iwapo utaki kuendelea.

Ukikubali kuwa mshiriki tafadhali tia sahihi au jina lako.

Mimi_____ nakubali kuwa mshiriki katika utafiti huu.

(*Jina la mtoto*)

Sahihi _____

*Tarehe.*_____

SOCIODEMOGRAPHIC QUESTIONNAIRE

Nambari	**Swali**	**Jibu**	**Msimbo**
1	Jinsia	Mwanamke( ) Mwanamme( )	
2	Umri (Miaka)		
3	Dini	Mkristo( ) Mhindu( ) Mhisilamu( ) Nyingine(Fafanua)	
4	Kiwango Cha Elimu	Hakuna( ) Msingi( ) Sekondari( ) Chuo( ) Chuo Kikuu( ) Nyingine(Fafanua)	
5	Kazi	Mkulima( ) Mwanabiashara( ) Kibarua( ) Mtaalamu( )	

		Mwanafunzi( ) Nyingine(Fafanua)	
6	Umeoa/Olewa	Sijaolewa( ) Nimeolewa( ) Tumetengana( ) Nimetaliki( ) Mjane( )	
7	Wastani Wa Kipato Kwa Mwezi	Kiwango	
8	Uraia		
9	Muda Uliopita Ukiwa Kwa Kambi		
10	Mkaaji Wa Kambi		
11	Unatumia Pombe (Ndio/La)		
	Unatumia Madawa Mengine (Ndio/La)(Kama Ndio Bainisha)		

ASIST -SGBV

SWALI	NDIO	LA
1. Mwaka uliopita ulitishiwa kupigwa au kudhulumiwa kingono na jamaa au mtu asiye wa familia		
2. Mwaka uliopita uliwahi pigwa, pigwa ngumi, pigwa teke, pigwa kofi, nyongwa au pigwa kwa silaha au kuumizwa mwili kwa njia yoyote na jamaa au mtu asiye wa familia?		
3. Mwaka uliopita ulilazimishwa kushiriki ngono pasipo hiari yako?		
4. Mwaka uliopita ulilazimika kushiriki ngono ili kupata chakula, malazi au mahitaji mengine muhimu(kupata ulinzi au shule) sababu utahatarisha maisha yako au ya mmojawapo wa jamaa zako usiposhiriki ngono?		
5. Mwaka uliopita ulilazimishwa au kulazimika kuwa mjamzito bila hiari yako?		
6. Mwaka uliopita ulishinikizwa au lazimishwa ndoa?		
7. Mwaka uliopita ulishinikizwa au lazimishwa kuavya mimba? *Kama majibu uliyopeana kutoka swali la 1 hadi la 7 ni NDIO, mhusika ni muadhiriwa wa vurugu za ngono na jinsia. Kama*		

mhusika ameadhirika muulize kama;		
8. Ungetaka kuongea na mtu yeyote au kujulishwa huduma zinazopewa wanawake waliokumbwa na vurugu za ngono na jinsia?		

FOCUSED GROUP DISCUSSION (FGD) SCHEDULE- SWAHILI

1. Kupitia yaliyokupata kibinafsi, ni njia gani watu wanazodhulumiwa nazo kingono na jinsia katika hii kambi?

   Chunguza dhuluma za kingono, kuumizwa mwili, ukatili kutoka kwa mpenzi na unyanyasaji wa watoto.
2. Ni katika hali au mazingira gani hizi dhuluma utendeka? Unaweza eleza kwa kifupi yaliyokutendekea? Ulihisi vipi?
3. Je kunazo sababu zilizofanya udhulumiwe?

   Chunguza udhaifu wao (kuwa mwanamke, kukosa ajira, uyatima, jamii/ukoo duni, utumiaji dawa za kulevya au umri mdogo)
4. Baada ya kudhulumiwa ulichukua hatua gani? Familia na jamii walichukulia vipi kukiukwa kwa haki zako?

Asante.

IN DEPTH INTERVIEW (IDs) SCHEDULE.

1. Je unafahamu dhuluma za kingono na jinsia? Ni aina gani za dhuluma unazojua/ ulizoshuhudia zikifanyika au ukasikia zinafanyika katika kambi ya Kakuma/Kalobeyiei?
2. Umewahi dhulumiwa? Kivipi?
3. Unaweza simulia kwa kifupi kilichotendeka? Ulikuwa wapi wakati huo? Ulikuwa unaenda wapi? Mlikuwa na nani?
4. Je ulihisi vipi? Ulichukua hatua gani? Ulimjulisha mmeo, mzazi, rafiki, jirani au mwalimu?
5. Je ni sababu gani au mambo au tamaduni gani unazofikiria zinachangia kudhulumiwa kwa watu au wewe binafsi?

Asante

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

KNH-UON ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

APPROVED 01 NOV 2019 KNH/UoN-ERC

Ref: KNH-ERC/A/409

1st November, 2019

Peter Ekuleu Ngala
Reg. No. H57/88406/2016
School of Public Health
College of Health Sciences
University of Nairobi

Dear Peter,

RESEARCH PROPOSAL: PREVALENCE AND CORRELATES OF SEXUAL AND GENDER BASED VIOLENCE IN KAKUMA REFUGEE CAMP, TURKANA COUNTY, KENYA (P653/07/2019)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and approved your above research proposal. The approval period is 1st November 2019 – 31st October 2020.

This approval is subject to compliance with the following requirements:

a. Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b. All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
c. Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
d. Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
e. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
f. Submission of an *executive summary* report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website http://www.erc.uonbi.ac.ke

Yours sincerely,

PROF. M. L. CHINDIA
SECRETARY, KNH-UoN ERC

c.c. The Principal, College of Health Sciences, UoN
The Director, CS, KNH
The Chairperson, KNH- UoN ERC
The Assistant Director, Health Information, KNH
The Director, School of Public Health, UoN
Supervisors: Prof. Joyce Olenja (UoN), Dr. Susan Nyawade (UoN)

COUNTY GOVERNMENT OF TURKANA

OFFICE OF THE GOVERNOR

Telegraphic address
County Secretary, Turkana
Fax: .....
E-mail: countysecretary@turkana.go.ke

THE COUNTY SECRETARY
P.O. BOX 11 - 30500
LODWAR

REF: CS/ GEN/VOL.3 (65)

Ref. No. .....

Date. **26th November, 2019** ..... 20 .....

The Camp Manager
Refugee Affairs Secretariat
KAKUMA
Attn: Kasili Mutambo

Dear Sir,

SEXUAL AND GENDER BASED VIOLENCE IN KAKUMA REFUGEE CAMP STUDY REF P 653/07/2019

This is to request your organization to allow Mr. Ngala Ekuleu to conduct the above study in Kakuma Refugee Camp. The Officer works with the Ministry of Health as a Public Health Officer and is currently a student at the School of Public Health at the University of Nairobi (UoN). This study has received Ethical approval from the Ethics and Review Committee of Kenyatta National Hospital and UoN (KNH- ERC/AQ/409) copy attached for your reference.

The objective of this study is to determine the prevalence and correlates of Sexual and Gender Based Violence (SGBV) in the Kakuma Refugee Camp. The study results will inform further development of policies and enhance programmatic interventions that address SGBV among the refugee populations and the surrounding host community. It will further strengthen Health and Social research work between Turkana County Government. Ministry of Health Sanitation and other partners working with the Refugee Community in Kakuma.

The purpose of this letter is therefore, to request your organization to assist the Officer to conduct this study. Any assistance accorded to him will appreciated.

Yours Sincerely,

ROBERT LOYELEI
FOR: COUNTY SECRETARY/ HEAD OF THE COUNTY PUBLIC SERVICE
Copy to:

County Chief Officer- Health and Sanitation

County Chief Officer- Lands, Energy, Housing and Urban Areas Management

TURKANA COUNTY GOVERNMENT

MINISTRY OF HEALTH SERVICES AND SANITATION

County Health Executive,
Turkana County,
P.O Box 11 – 30500, Lodwar
When replying please quote.....

Located at the Ministry of
Housing Building – Nawoitorong

19th November, 2019

HEAD OF SUB – DELEGATION,
UNITED NATIONS HIGH COMMISSION FOR REFEGEES,
KAKUMA.

Dear Sir,

RE: SEXUAL AND GENDER BASED VIOLENCE IN KAKUMA REFUGEE CAMP
STUDY REF P653/07/2019

This is to request your organization to allow Mr. Ngala Ekuleu to conduct the above study in Kakuma refugee camp. Mr. Ngala works with the Ministry of Health as a Public Health Officer and is currently a student at the School of Public Health at the University of Nairobi (UoN). This study has received Ethical approval from the Ethics and Review committee of Kenyatta National Hospital and UoN (KNH-ERC/A/409) copy attached for reference.

The objective of this study is to determine the prevalence and correlates of Sexual and Gender Based Violence (SGBV) in the Kakuma refugee camp. This study results will inform further development of policies and enhance programmatic interventions that addresse SGBV among the refugee populations and the surrounding host community. It will further strengthen health and social research work between Turkana County Government and UNHCR and its partners.

This is therefore a polite request to give the officer the permission and assistance to conduct this study. Thank you in advance.

Truly yours

19 NOV 2019

Dr. Gilchrist Lokoel
For: Chief Officer
MINISTRY OF HEALT SERVICES AND SANITATION
TURKANA COUNTY GOVERNMENT

RESTRICTED

			SUDANESE
11.	**SARAH KHALIF JAMA**	**KKM 1**	**SOMALI**
12.	**SADIA HUSSEIN**	**KKM 1**	**SOMALI**

However, you are required to adhere to the regulation of the camp during the visit.

Kind regards,

THE CAMP MANAGER
P. O. Box 57- 30601
KAKUMA, KENYA
10 APR 2020
RAS KAKUMA CAMPS & KALOBEYEI SETTLEMENT

KASILI MUTAMBO
CAMP MANAGER- KAKUMA CAMPS AND KALOBEYEI SETTLEMENT

NGALA PETER EKULEU
School of Public Health
College of Health Science
University of Nairobi(UON)
P. O. Box 19676 -0200.
Nairobi

The Area Coordinator
Danish Refugee council (DRC-Kakuma)
Kakuma

14th April 2010

Dear Sir/Madam;

RE: STUDY ON SEXUAL AND GENDER BASED VIOLENCE IN KAKUMA AND KALOBEYEI REFUGEE CAMPS STUDY REF P653/07/2019.

I am a Post Graduate student at the University of Nairobi in my final year on Master of Public Health. My research study is on the prevalence and the correlations of Sexual and Gender based Violence (SGBV) in Kakuma refugee camp and Kalobeyei settlement camp.

The purpose of this study is to determine the magnitude and determinants of SGBV and the results will be shared with the UNHCR and other partners dealing working in Kakuma Refugee camp and Kalobeyei Settlement. This is an envisaged to inform a review of the existing policies and interventions to prevent and control problem among the refugee community.

This is therefore a humble request for Key Informant Interview (KII) with staff dealing with SGBV.

Thank you in Advance.

Ngala P Ekuleu,
H57/88406/2016.

Cc

Director, SoPH , UoN
CO, Ministry of Health, Turkana County

NGALA PETER EKULEU
School of Public Health
College of Health Science
University of Nairobi(UON)
P. O. Box 19676 -0200.
Nairobi

14th April 2010

The Senior Field Coordinator
International Rescue Committee
Kakuma Refugee Camp
Kakuma

Dear Sir/Madam;

RE: STUDY ON SEXUAL AND GENDER BASED VIOLENCE IN KAKUMA AND KALOBEYEI REFUGEE CAMPS STUDY REF P653/07/2019.

I am a Post Graduate student at the University of Nairobi in my final year on Master of Public Health. My research study is on the prevalence and the correlations of Sexual and Gender based Violence (SGBV) in Kakuma refugee camp and Kalobeyei settlement camp.

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This is therefore a humble request for a Key Informant Interview (KII) with your programme staff working on SGBV.

Thank you in Advance.

Ngala P Ekuleu,
H57/88406/2016.

Cc

Director, SoPH , UoN
CO, Ministry of Health, Turkana County