Assessing the Safety of Refugee Women and Girls in Burundi: SGBV Analysis Report

Background

Assessments[1] conducted in 2010 showed reason for considerable concern regarding rates of SGBV in refugee settings in Burundi — including rape, sexual assault, sexual exploitation and intimate partner violence — and identified concerns in terms of weak coordination mechanisms, limited access to immediate services and longer-term legal remedies. In response, the IRC – in partnership with UNHCR – launched a program for prevention of and response to SGBV in refugee contexts in 2011. As part of this program, the IRC receives cases of rape, sexual assault, physical assault, forced marriage, denial of resources, services and opportunities, and psychological violence against women and girls - perpetrated mostly by intimate partners and other community members. As of October 2011, IRC documented a total of 268 SGBV cases.

The Joint Assessment Mission (JAM) follow-up assessment in 2011 also pointed out certain physical structures as contributing factors to SGBV, including the location of latrines and the lack of lighting in certain areas, particularly within camps.

In August 2011, the IRC conducted an SGBV Safety Audit Assessment in Gasorwe, Musasa and Bwagiriza refugee camps, and the Butare refugee site. A total of 480 (234m & 246f) refugees between the ages of 10 and 65 were involved in different discussion groups. The purpose of the assessment was to identify SGBV security concerns in the camps, including perspectives from different sections of the population, and share results with UNHCR, partners and refugees structures for appropriate actions.

Objectives & Methodology

The assessment was undertaken with the following objectives:
1. To identify SGBV security risks in the camps
2. To analyze, make recommendations and share results with appropriate actors for relevant actions
3. To involve refugees and partners in the assessment, planning and implementation of SGBV safety initiatives in the camps

The assessment was a community-based activity targeting various groups of the refugee population, including children, youth, adult women, men and people with disabilities through discussions in separate groups based on age, sex and social status.

IRC staff implementing the survey used the Focus Group Discussion (FGD) approach, following an SGBV rapid assessment guide, covering questions on SGBV safety issues and services available for survivors. The assessment was conducted in the local languages of the target population to increase their ability to respond to questions.

Based on World Health Organization (WHO) ethical considerations for data collection, IRC ensured the respect, safety and confidentiality of participants throughout the assessment period. Consent was obtained from refugees before participating in group discussions. Confidentiality and respect for any decisions not to answer specific questions were honored throughout the process. IRC did not collect any identifying information about the participants, including names, locations and contact numbers.

Analysis of Results

[1] Joint Assessment Mission (JAM) 2010, IRC SGBV Rapid Assessment 2010.

SGBV Risks

In this section, results are described in the aggregate, as applies to all settings. Where there are significant differences per site, these are broken down below.

All discussion groups mentioned SGBV as a significant risk for women and girls. Specific types of SGBV mentioned are as follows: physical violence (91% of groups), denial of resources, opportunities and services (71.8%), rape (69%), forced marriage (56%), sexual assault (43%) and emotional violence (28%). 50% of groups in Bwagiriza camp specifically mentioned sexual exploitation as a form of violence present in the camp; this was not explicitly mentioned elsewhere. It is interesting to know that in three of four settings – with the exception of Gasorwe – rape is not mentioned by the adolescent girls' group as a prevailing form of violence; given that adolescent girls are most often the victims of rape and other forms of sexual violence, this absence seems unusual. Potential explanations include the fact that girls may not feel comfortable speaking outright about rape – although they did mention sexual violence in other forms – that confusion remains regarding the different forms of SGBV, or that they simply do not name their experience as rape when the perpetrator is known to them.

Girls below 18 years of age are considered by 72% of groups to be particularly vulnerable to SGBV, due to their limited control over decisions made about them, while 69% of groups view widows as vulnerable. Elderly women, orphaned girls, individuals with disabilities and women engaging in trade are also mentioned as having a higher risk of experiencing SGBV. Although individuals with disabilities were considered to be especially vulnerable to SGBV by several discussion groups, this was never mentioned by the group with special needs themselves. Similarly, only two out of four groups of adolescent girls recognize increase risk for adolescent girls, while the majority of other discussion groups note an increased risk for this section of the population. While information is inadequate to ascertain the reason behind these trends, it may indicate that either these groups are unaware of the higher risks they face, or that these risks are so pervasive as to become normalized in their everyday lives.

Participants also identified groups that enjoy a greater protection against SGBV due to their position, status, support and/or power in their communities. These groups include married women (mentioned by 78% of groups), elderly women – although other groups mentioned elderly women as being particularly vulnerable – and rich women. Site-specific information is described below. The widespread belief that married women are safer than unmarried women is in direct contradiction with cases received; in 2011, 51.5% of all survivors supported in the four sites evaluated in this safety audit had experienced intimate partner violence, with the percentage reaching as high as 63% in Gasorwe camp.

In all settings, refugees were able to identify areas or factors of high SGBV risk for women and girls, including latrines located at a large distance from houses, darker areas due to lack of lighting facilities, overgrown areas in the camps, bars serving alcohol inside and outside camps and centers of trade outside camps.

Women and girls already take protective actions by avoiding movement at night, outside the camps and in overgrown areas. It was also mentioned by several groups that if women and girls dress correctly they can avoid SGBV. Unfortunately, experience working with survivors in other contexts shows that this is not the case, and that inappropriate clothing is simply used as an excuse by perpetrators who also commit such acts against women and girls wearing clothes that are considered appropriate. Participants also mentioned that communities can protect women and girls by increasing awareness on SGBV, reporting perpetrators of SGBV and holding them accountable for their actions. However, accountability for perpetrators is not yet a reality, as shown below.

Response

As well as the situation in terms of SGBV, the survey also assessed the type and quality of response available for survivors, as perceived by different groups of the population. 100% of groups stated that community leaders including neighborhood chiefs, committee leaders and religious leaders are first points of contact in case of security

concerns. In general terms, groups cited IRC, AHA, UNHCR, police, community leaders, family members, COPED and hospitals outside the camps as providers of services for survivors of SGBV.

Specifically concerning medical services, groups identified several facilities where survivors could seek help in all sites. AHA was cited by 78% of groups in all sites; other facilities mentioned include district hospitals, local community health centres and the Burundian Association for Family Well-being (ABUBEF). Some groups mentioned receiving medical care at home, while others said that they simply prayed for their health to improve.

The survey also revealed that refugees are aware of psychosocial support, including counselling services, which exist for survivors in the camps; 91% of groups mentioned IRC, which indicates strong yet imperfect awareness among communities of the case management and psychosocial support services provided by IRC. 53% of groups mentioned community leaders and 68%of 32 groups mentioned police as providing other services to survivors. Additional actors providing support to survivors according to participants included HCR protection, the Association for the Defense of Women's Rights (ADDF), AHA and ONPRA.

However, despite the services available, of which refugees seem to be largely aware, many participants stated that survivors do not report SGBV cases. The reasons include fear of rejection by the family or husband, humiliation, cultural impediments, the impunity of perpetrators, individual trauma and isolation. These concerns are reinforced by perceptions of families' reactions to SGBV survivors; anger against the survivor was a common denominator, present in all settings. In the majority of groups, it was noted that most families blame, beat, isolate and maltreat women and girls for sexual violence against them; on a more positive note, some families give advice, provide material support and refer the survivor for supportive services, although supportive families seem to be in the minority. These responses show that additional work and awareness-raising is needed around the emotional needs of survivors. In addition, given that 'families' include individuals such as community leaders and religious leaders, we can expect these harmful responses from other important sectors of society; sectors which, importantly, are mentioned elsewhere as being first points of contact for survivors.

When questioned about actions taken against SGBV perpetrators, the majority of groups mentioned that perpetrators are imprisoned during a short period. Several groups mentioned that authors are made to pay fines to the family of the victim, one group stated that perpetrators have sometimes been beaten, and several groups noted that such cases are solved 'amicably' – that is, a solution is mediated at the community level.

Site-specific Concerns

Gasorwe

In Gasorwe camp, rape, physical violence and psychological violence are at the forefront of incidents perceived to be occurring in the camp, and are mentioned by all eight discussion groups (rape is mentioned by slightly more individuals than the other two types). Forced marriage is seen as a risk by girl children, adults of both sexes, special needs groups and community leaders, sexual violence in general is perceived as a risk by all groups except male children, and denial of resources and opportunities is considered a problem by all groups except female children. All groups mentioned personally knowing others who had experienced between three and six different forms of SGBV (much higher than other sites, where the average was one form).

Perceived vulnerable groups in Gasorwe include girls under 18 years of age, women engaging in trade and widows. Conversely, elderly women and married women are seen by most groups as enjoying greater safety from SGBV, despite the fact that married women constitute 63% of survivors reporting to the IRC. Adolescent girls also mention members of the church choir as being safer from SGBV; no further explanation is given on why this is the case.

Latrines and showers far from housing areas are considered dangerous, as are trade centres outside camps. Participants mentioned neighbourhoods without electricity, and both young and adolescent boys cited churches as risk areas. Bars outside the camp are considered dangerous by both male and female children.

All groups mentioned AHA and the Gasorwe health centre as places to access medical care for SGBV. Several groups also mentioned the Muyinga and Kiremba hospitals, and ABUBEF. For psychosocial support, every group cited services provide by both IRC and community leaders; additional services were identified as being provided by ONPRA and the police.

Musasa

Among different types of violence mentioned in Musasa camp, physical abuse is overwhelmingly the most frequent, followed by rape and forced marriage. Rape is mentioned as a concern by young boys and girls, special needs groups and community leaders, but not by adolescent or adult groups of either sex. However, the majority of participants in all groups mention personally knowing someone who has been a victim of rape; this discrepancy could potentially be explained by the fact that many refugees were victims of rape during conflict in the DRC, before coming to Burundi. Denial of resources and opportunities is mentioned by young boys and adults of both sexes, while sexual violence is cited by both adolescent groups.

All groups in Musasa mention girls (10 – 19 years) as being particularly vulnerable to SGBV, and all groups except adolescent boys also mention widows among vulnerable groups. Orphaned girls are considered susceptible to SGBV by all groups except adolescent boys and men. Married women are overwhelmingly considered to be safer from SGBV, despite being the victims of 52% of reported SGBV cases; rich women and elderly women are also mentioned as groups who have increased protection.

In Musasa, 62.5% of groups perceive uninhabited areas of the camp and pathways between neighbourhoods as unsafe; others believe that video clubs (houses where videos are played) are dangerous. Areas without electricity, latrines placed at a distance from houses and overgrown areas are also cited as risk areas.

The majority of groups are aware of health services provided by AHA; all groups also cite the Muyinga hospital as somewhere to receive medical treatment. All groups were aware of psychosocial support services provided by IRC and support provided by the police. Half of the groups mentioned community and religious leaders as providing psychosocial support.

Bwagiriza

In Bwagiriza, rape is mentioned as a form of SGBV by the greatest number of individuals, although only by four groups in total: both groups of children, adult women and community leaders. Physical violence is cited by all groups, and sexual violence in mentioned by all groups bar female and male children. Sexual exploitation is mentioned by both children's groups, adolescent boys and adult men. Bwagiriza is the only camp where sexual exploitation is explicitly mentioned, although the occurrence of sexual exploitation may be included under other categories in other sites. Most participants in every group mentioned personally knowing someone who had been raped.

Widows are cited by all groups consulted as being particularly vulnerable to SGBV. Girls, orphaned girls, and people with disabilities are also mentioned. Elderly women are perceived by both groups of children to be at particular risk of SGBV, but are given by both adolescent boys and adult men as being less at risk than other groups. Girls living with both parents and married women are mentioned as also being more protected from SGBV.

In Bwagiriza camp, children of both sexes, adolescent girls and individuals with specific needs consider that the passage between Bwagiriza I & II is unsafe, especially during periods where there are less people around. Seven of eight groups cite insufficient lighting as a security risk, and children consider that latrines far from living quarters are dangerous. Adolescents mention the trading centre outside the camp as a risk area, and both adults and adolescents consider overgrown areas to be dangerous.

In terms of services available, IRC is mentioned by 100% of groups as a first port of call. AHA, UNHCR, the Police and COPED are also mentioned in general terms. Specifically in terms of health, AHA is cited by all groups, while IRC is mentioned by all groups except children as a health-care provider; this may indicate some confusion in the services offered by different organizations. For psychosocial support, all groups mention the availability of counseling, younger children note that legal assistance is available, and older respondents cite advice by the community as a

psychosocial service. Most groups noted that SGBV cases are mediated at community level; Bwagiriza is the only camp where this is explicitly mentioned.

Butare

In the Butare site, denial of resources and opportunities, often closely related to domestic violence, is cited by all eight discussion groups. It is closely followed in frequency by rape and physical violence. Also mentioned are psychological violence and forced marriage, by the children's and adolescent girls' groups.

In Butare, those considered to be vulnerable groups include: widows, women with disabilities, orphaned girls, adolescent girls, and women in general. Conversely, married women, rich women and educated women are considered to be the least at-risk groups. Once again, statistics belie this interpretation, as 52% of all cases received involved intimate partner violence; this discrepancy may indicate that refugees in Butare continue to normalize domestic violence and therefore do not cite it as a risk. Adult women mentioned movements at night as well as the sale or use of alcohol as being particular risk factors. Three groups mentioned that movements in the Batwa neighbourhood were dangerous for women and girls, while others mentioned that water points and trade centres outside the camp were risk areas. Male children and adolescent girls consider that houses inhabited by boys are dangerous; interestingly, adult men believe that there is no risky area for women and girls.

Only three groups mention AHA as a point of call for medical services, while four groups mention the referral hospital. Two groups cite the Butare health centre. Six groups refer to IRC psychosocial services, four mention ADDF, five cite community leaders as a resource, and all eight groups state that police provide additional services for survivors.

Recommendations

Based on the security issues identified for women and girls in the camps, IRC would like to recommend the following action points to UNHCR, implementing partners and refugee structures:

Physical Concerns

1. Ensure physical safety by providing solar lamps in public places including water points, latrines and transition areas between neighbourhoods or sections of camps;
2. Ensure safety of latrines and showers by installing doors and appropriate locks where these are not currently present, and constructing additional latrines closer to residential areas;
3. Prevent the use of unoccupied houses by ensuring that are adequately locked, or destroyed;
4. Mobilise refugees to cut back overgrown areas around camps;
5. Establish areas of trade within camps to prevent women and girls being forced to travel outside camps;
6. Increase amount of water available to prevent women and girls being forced to travel outside camps to look for water;
7. Increase the number of well-trained and monitored police officers and security patrols at night.

Social Issues

1. Mobilize communities to develop and implement security plans to protect women and girls, particularly at night. Provide support for this implementation;
2. Organize and provide technical and material support to community volunteers as watch groups against SGBV who will monitor activities at water points, latrines, un-used areas, and transition areas between neighborhoods or sections of camps (particularly between Bwagiriza I & II);
3. Monitor films shown in camps and time of shows, ensure that security patrols survey these areas;
4. Provide socio-economic opportunities for women and girls in the camps to reduce dependency and vulnerability to violence;
5. Further explore trends uncovered by the survey including why adolescents and special needs groups do not recognize the risks they face, and why members of the church choir in Gasorwe are perceived as being less at risk from SGBV;
6. Work with community leaders, women and girls around recognizing domestic violence as a problem within

communities.

Capacity building

1. Continue and increase SGBV awareness for community leaders as a first point of call for most SGBV concerns and provide guidance about appropriate and safe responses in these cases. Ensure that community leaders understand the dangers inherent in community mediation of SGBV cases;
2. Increase awareness-raising sessions on prevailing forms of SGBV – physical violence, denial of resources and services, rape, forced marriage, emotional violence and sexual exploitation, as well as where and how to report cases. Include information about perpetrators being most often known to the survivor rather than strangers;
3. Increase awareness-raising sessions for communities to encourage families to support survivors, hold perpetrators accountable, and break the silence around SGBV;