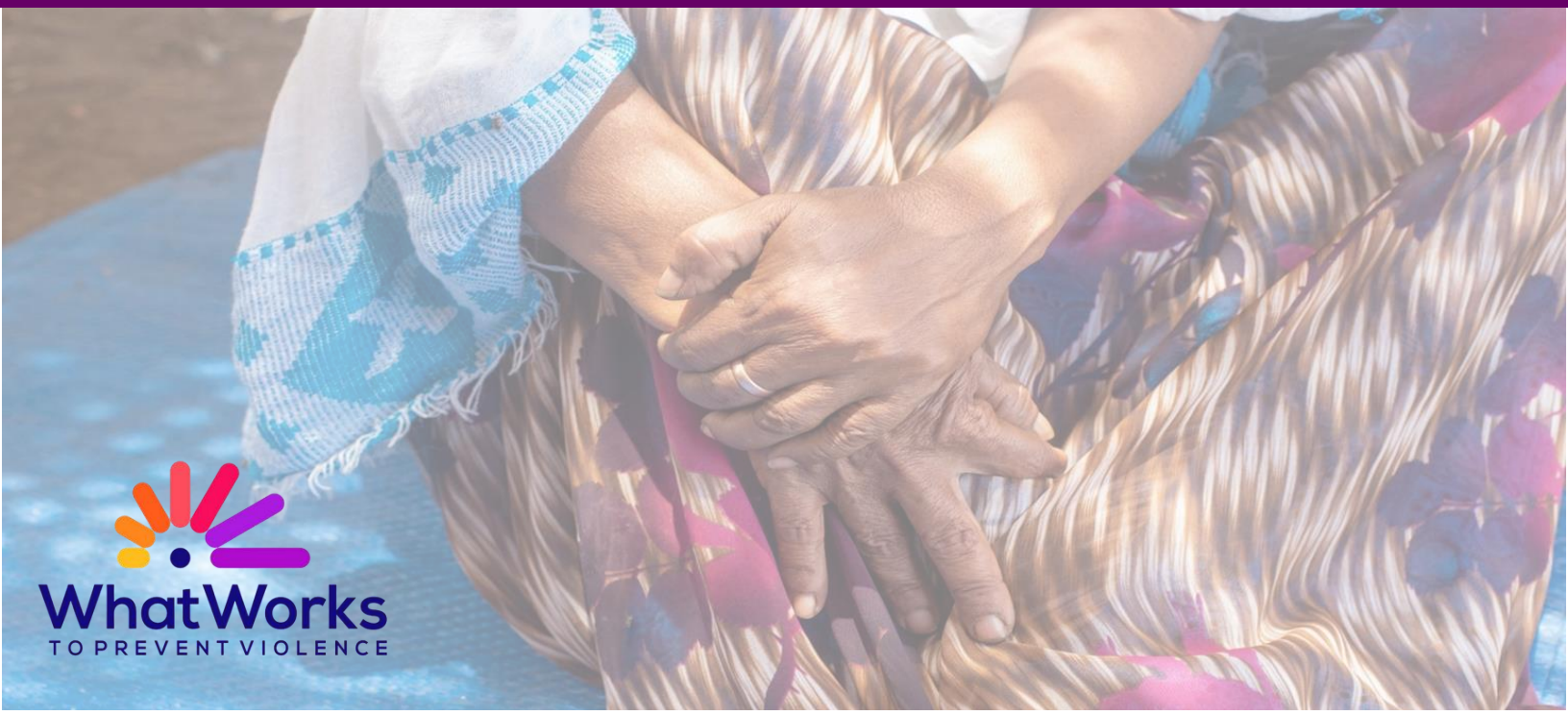

GBV Prevention in Refugee Camp Settings in Sub-Saharan Africa

Veronica Ahlenback

Query: Please review the latest evidence on GBV prevention* in refugee camp settings, with a focus on those most similar to the Tongogara Refugee Camp context**.

* Prevention refers to initiatives and activities aiming to prevent GBV from occurring in the first place such as addressing social norms and practices that contribute to GBV in communities (also known as primary prevention).

** Smallish, diverse, Sub-Saharan African contexts, and with a particular focus on reliance upon community structures for detection, prevention and response.

1. Overview

Gender-based violence (GBV) is a significant concern in refugee camps, where several factors have been identified as contributing to increased risk of violence including poverty and economic stress on the household, disrupted family and community support systems, minority status, and lack of safe access to food and water.[1] In addition to the conditions created by displacement, underlying root causes to GBV that are also present in camp settings include wider gender inequality, patriarchal norms and practices, alcohol and drug abuse, and men's controlling behaviours.[2]

A range of primary prevention approaches have been used in refugee camp settings across Sub-Saharan Africa (SSA) to tackle various drivers of GBV. Despite the evidence that interventions are being adapted and implemented in these settings, there remains a lack of evidence regarding the effectiveness and impact of these efforts. In the wider evidence base of what works to prevent violence against women and girls (VAWG),[1] there is limited evidence from humanitarian contexts to start with, and few of the studies that do exist from these settings have a specific focus on refugee camps. For example, a 2016 review of GBV prevention in refugee populations found that few studies provided evidence of effective strategies or interventions, suggesting that there is little research conducted on the effectiveness of GBV prevention efforts in refugee settlements and camps, or that evaluations of these programmes are rarely made publicly available.[3]

This rapid evidence review identified 16 GBV interventions in refugee camps in SSA where there was sufficient information to summarise the intervention. Most of these interventions are not evaluated, but have been included in this report since they provide wider lessons learned based on less rigorous research and assessments. This review confirms that the evidence gap from 2016 largely remains, although some emerging lessons for design and implementation can be drawn from the existing interventions. Despite attempts to find evidence primarily from smaller[2], diverse refugee camps in SSA, this review was unable to find much evidence and so interventions from a range of refugee camps settings in SSA is included – ranging from camps with about 10,000 residents to over 270,000. See Annex 1 for details about the intervention approach; timeframe; implementers; camp location and size; and any evidence on impacts and lessons learned for each intervention. The methodology for this review is detailed in Annex 2.

The review focuses on identifying approaches that have been tested and evidence of impact and effectiveness of these. It also includes lessons learned that may be of relevance to

[1] Some of the interventions are focused on VAWG, while some take broader approaches to GBV. This evidence review includes interventions that are framed as GBV as well as VAWG, which centres around approaches to prevent violence against women, girls and gender diverse people.

[2] The Tongogara refugee camp in Zimbabwe hosted 23,157 people as of August 2023. The evidence review has prioritised evidence from camp settings of similar size, but also included evidence from smaller and larger camps due to the limited evidence overall.

prevention efforts in similar camp settings. An overview of the interventions and evidence base is provided in Table 1. Key gaps in evidence include:

- Evidence of impact on GBV prevalence[3], including longitudinal or other follow-up research to understand the longer terms impacts and sustainability of interventions.
- Disaggregated data by gender, age and disability to better understand how interventions impacts the GBV risk faced by different population groups.
- Evidence on how interventions reach and engage women, girls and gender diverse people who face high risk of GBV and who are at risk of being left out of interventions if not intentionally targeted, including women and girls with disabilities, LGBTQI+ people, sex workers, and other population groups at high risk of violence.
- Documentation of how existing GBV prevention interventions (e.g. SASA!) have been adapted to refugee camp seatings, including the extent of fidelity to core elements and implementation approaches.

Table 1: Overview of interventions and evidence base

Intervention		Camp/ country	Approach	Type of evidence
1	Zero Tolerance for GBV 365	Tongogara refugee camp, Zimbabwe	Sensitisation sessions on GBV and SRHR with adolescent girls.	N/A
2	Sexual Exploitation and Abuse (SEA) Community Drama Club	Tongogara refugee camp, Zimbabwe	Awareness raising on SEA through dramas and distributing key messages; zero tolerance campaign targeting humanitarian workers.	N/A
3	Engaging Men and Boys through Responsible Practices to Prevent Gender-Based Violence against Women and Girls (EMAP)	Tongogara refugee camp, Zimbabwe	Workshops with women and men community members; marathon and yoga activities to highlight work.	N/A
4	Zero Tolerance Village Alliance, Uganda	Rwamwanja Refugee Settlement, Uganda	Engaging communities in committing to end SGBV, and supporting them to meet a criteria to be able to join an alliance of zero-tolerance villages.	Pre- and post-intervention design
5	Role Model Men (RMM)	Rhino and Imvepi refugee settlements, and Lamwo, Uganda	Training modules, mentorship, coaching and dialogue sessions with men and boys, encouraging personal reflection on power, masculinity, gender roles and social norms.	N/A

[3] Obtaining GBV prevalence data is not advisable in emergency contexts. However, research has showed that it is possible to collect data on GBV, including with survivors, in refugee camp settings if sufficient measures are put in place to mitigate ethical and methodological challenges (see e.g. McAlpine, A. et al, 2020). Data should only be collected where GBV response services are available, and safe and private locations are available for interacting with the respondents, ensuring the safety and wellbeing of research participants.

6	SASA! (multiple interventions in Uganda)	Various refugee camps including Bidibidy, Kyangawli, Kiryandongo, and Pagirinya, Uganda	Social norms change intervention engaging communities in a change process through four stages – start; awareness; support and action.	Evaluation of some of the earlier interventions
7	SASA! (Adjumani, Uganda)	Adjumani refugee settlement, Uganda	Social norms change intervention engaging communities in a change process through four stages – start; awareness; support and action.	Evidence from rapid assessments
8	Engaging Men in Accountable Practices (EMAP)	Bidibidi, Imvepi, Rhino Camp, Uganda	Male engagement in prevention of VAWG through a curriculum-based intervention with men and women (separately).	N/A
9	Girl Shine	Imvepi and Omugo refugee camps, Uganda	Adolescent girls' life skills and safe spaces intervention, coupled with parent and caregiver curriculum.	N/A
10	EMAP, Kenya	Dadaab refugee camp, Kenya	Male engagement in prevention of VAWG through a curriculum-based intervention with men and women (separately).	Lessons learned
11	COMPASS	Internally displaced and refugee camps in Ethiopia and DRC	Adolescent girls' life skills curriculum with some components to address the enabling environment.	RCTs
12	Zero Tolerance Village Alliance, Nigeria	Mohammed Goni International Stadium and Government Senior Science Secondary School camps, Nigeria	Community-activism: Engaging communities in committing to end SGBV, and supporting them to meet a criteria to be able to join an alliance of zero-tolerance villages.	Lessons learned
13	Girls Take the Lead (GTTL)	Gihembe and Nyabiheke refugee camps, Rwanda	Girl-friendly safe spaces with activities to build skills, engage men and boys, and financial literacy/savings.	Mixed-methods evaluation
14	Health and Empowered Youth Project, Rwanda	Mahama, Kigeme, Mugombwa, Kiziba, and Nyabiheke refugee camps, Rwanda	Activities for youth in schools and local communities, including life skills and income generating activities, school health clubs, and peer-education on SRH.	N/A
15	Improving Refugees' Access to Sexual and Gender Based Violence Prevention and Response Services in Kigeme and Mugombwa Camps	Kigeme and Mugombwa Camps, Rwanda	A muti-component approach consisting of SGBV community dialogues; boys' engagement in ending SGBV; mentoring and life skills support for adolescent girls; community-based socio-therapy; and referrals and dignity kits.	N/A
16	Building capacity for disability inclusion in GBV programming in humanitarian settings	Kinama, Mussasa and Bwagiriza camps, Burundi	Integration of disability inclusion in existing GBV activities; community awareness raising; home visits to women with disabilities.	Participatory evaluation

Key observations about the approaches that have been tried in refugee camp settings in SSA, and the existing evidence base include:

- **A wide range of programmatic approaches have been used** including social norms change approaches, strategies to engage men and boys, adolescent girls-centred approaches, economic and social empowerment approaches, peer-to-peer approaches, campaign and edutainment, and counter trafficking programmes. Interventions have also included elements of school-based approaches, using schools as a platform to implement activities, however no comprehensive school-based approaches were identified.
- **Most interventions are focused on sexual and gender-based violence (SGBV)** without specifying which types of violence that have been addressed. Few interventions specified that they focus on intimate partner violence (IPV), non-partner sexual violence (NPSV), child marriage, and sexual violence against adolescent girls. Two interventions targeted sexual exploitation and abuse (SEA). Most interventions have targeted refugee women and/or adolescent girls, without any targeted inclusion approaches. One intervention focused on disability inclusion in GBV programming in refugee camps in Burundi, and one intervention worked with young mothers. This review did not identify any GBV prevention interventions focusing on other structurally marginalised groups at high risk of GBV in refugee camps in SSA, such as LGBTQI+ refugees.
- **Few interventions have been rigorously evaluated** with randomised controlled trials or impact evaluations. With the exception of a few available evaluations, the evidence which this review identified is largely in the form of rapid assessments and documentation of lessons learned and good practice from implementation.

The range of interventions being implemented show that prevention programming is possible in refugee settings, however, there has been limited efforts to understand the impact of these interventions, as well as limited documentation of lessons learned from implementing these approaches in refugee camp settings (including where adaptations have been made of existing interventions in non-refugee settings). Despite the limited evidence, there are some emerging lessons learned for design and implementation.

<u>Lessons learned for design include:</u>

- **Design comprehensive programmes**, including for example community-based social norms change approaches, adolescent girls-focused approaches, and male engagement approaches – engaging the wider community in the programme.
- **Consider time and funding available, and the characteristics of the refugee camp** when selecting intervention approach, including the relative stability/ movement of populations in the camp. For example, more intensive approaches such as the SASA! Model requires longer timeframes and are more suitable for settings with relatively stable populations, while other approaches such as the Zero Tolerance Village Alliance (ZTVA) have been designed to be implemented in shorter timeframes of about a year.

- **Ensure sufficient time for inception, including to adapt approaches to the refugee setting,** taking into account for example diversity of communities and languages spoken in the camp.
- **Consider fidelity to original and proven interventions,** while adapting approaches and materials to the local context.
- **Document adaptations of existing interventions** to refugee camp settings, and share lessons learned for the benefit of future programmes.
- **Support meaningful engagement of refugee women and girls** in programme design, which can be done through engaging refugee women-led organisations.
- **Support adaptive and flexible programming** to allow for adjusting to potential changes in the refugee camp and the wider context.
- **Assess and mitigate against potential backlash and violence.** For example, if approaches engage women as community mobilisers, facilitators or other roles, or if economic interventions target women.
- **Design inclusive approaches** to reach those at highest risk of GBV and address the specific barriers they face.
- **Incorporate monitoring, evaluation and research** into the design of new programmes to understand what works and why, including documenting adaptations to refugee settings for wider learning, and the monitoring of risk of backlash and violence against women.
- **Assess GBV response services and ensure services are available** before starting implementation of any prevention activities. Consider if strengthening existing services can be embedded as part of the programme.
- **Consider approaches to work with refugee and host communities simultaneously in preventions,** and support the involvement of refugee women-led organisations in prevention work in the host community.

Lessons learned for implementation include:

- **Carefully select implementing partners** with experience addressing GBV, prioritising partnerships with refugee women-led organisations.
- **Consider personal characteristics, attitudes and background** in the recruitment of facilitators and key roles.
- **Provide training and ongoing support** to programme staff, including facilitators, to support quality implementation and motivation of staff.
- **Engage community workers and work within existing structures** in the refugee camps as this can facilitate trust and access to the communities, and help strengthen existing structures.
- **Engage with men and boys as partners** in violence prevention in ways that ensures accountability to women and girls.
- **Ensure coordination with other potential prevention programmes** in the refugee camp, and ensure complementarity.
- **Use age-appropriate approaches** that are suitable for the target group, including using participatory and youth-friendly approaches with adolescents.

- **Use accessible and user-friendly materials and approaches**, taking into account the diversity of languages in refugee camps and literacy levels.
- **Consider ways to support sustainability of outcomes** after the implementation has ended.

2. Approaches to tackle GBV in refugee camp settings

Different types of approaches have been used in efforts to prevent GBV in refugee camps in Sub-Saharan Africa (SSA). This review mapped previous and ongoing interventions dating back to 2010 (see Annex 2 for further details on the methodology). It identified 16 interventions, which are detailed in Annex 1, with an overview provided in Table 1. The mapping prioritised approaches that have been evaluated in order to identify evidence of effectiveness and impact, while also including non-evaluated interventions in order to identify a wider range of lessons learned. It should be noted that the mapping is based on a rapid desk-based evidence review, and it is likely that more GBV prevention efforts are being implemented in refugee camps in SSA, but that there is limited information on these available online.

Existing interventions approaches seek to address a range of types of GBV. However, specific forms of GBV are often not specified, but most interventions are described as targeting sexual and gender-based violence (SGBV) broadly. Few interventions specified that they focus on intimate partner violence (IPV) (interventions 4, 6 and 16), non-partner sexual violence (NPSV) (intervention 4), child marriage (interventions 9 and 11), and sexual violence against adolescent girls (intervention 14). Two interventions targeted sexual exploitation and abuse (SEA) (interventions 2 and 16). The below intervention approaches have been implemented in refugee camps in SSA with varied evidence of impact and effectives, where evidence is available at all.

Social norms change approaches: The overall evidence base for the effectiveness of social norms programming in humanitarian contexts, including in camp settings, is limited. However, there is some emerging evidence available from a small number of interventions. These approaches appear to be popular in refugee camp settings, including SASA! and the Zero Tolerance Village Alliance (ZTVA). In Uganda, UNHCR has implemented the two interventions in parallel – sometimes alongside other interventions as well.

- **The SASA! approach,** originally designed by Raising Voices and implemented by the Center for Domestic Violence Prevention in Uganda, was developed for development contexts, however, it has been adapted to humanitarian contexts and an increasing number of interventions are being implemented in refugee camp settings. The model uses a structured community engagement approach to guide communities through different stages of change, addressing underlying beliefs, social norms and attitudes that perpetuate GBV. An evaluation of UNFPA's support to SASA! in Uganda noted that efforts to evaluate the methodology in refugee settings in Uganda would be very valuable, considering the widespread interest for implementing SASA! in refugee settings.[4]

- **The Zero Tolerance Village Alliance (ZTVA)** was adapted to displacement contexts in Uganda and has further been implemented in Nigeria, Ethiopia and Zambia by UNHCR and partners.[5] The ZTVA approach has a shorter timeframe for implementation than other social norms approaches such as SASA!. The shorter implementation period has made it a popular alternative to the more time-consuming SASA! intervention in refugee camps, where population movements can pose a challenge to implementing longer-term community-based prevention initiatives. This evidence review only identified evidence from ZTVA in Uganda, where an evaluation (pre-and post-test without comparison group) found that the programme reduced negative attitudes and beliefs related to GBV; positively changed perceptions of community GBV norms; and reduced the occurrence of physical IPV (in men and women), sexual IPV (in men), non-partner physical violence (in men and women), and non-partner sexual violence (in women).[6] It also increased support for care-seeking for SGBV. The intervention did not change men's attitudes toward women's sexual autonomy in intimate partnerships, or reduce the occurrence of sexual IPV for women.

Box 1. Evidence from implementing SASA! in refugee settings in Uganda

The SASA! methodology is widely used in refugee contexts in Uganda, where it has been adopted for both refugee and host community structures to address root causes of SGBV and influence change in attitudes in the community.[7] It is often combined with other approaches such as EMAP, Zero Tolerance Village Alliances, and EA$E.[8] An assessment of GBV and VAC prevention and response in Uganda's refugee hosting districts however found that prevention interventions are fragmented and implemented in small scale. As assessment of SASA! in Adjumani refugee camp notes that SASA! can be implemented alongside other GBV prevention intervention, but stresses the need for coordination and complementarity.[9]

Evidence from several evaluations of SASA! in refugee settings in Uganda suggests that the approach has a positive influence on multiple GBV related outcomes. An evaluation of the earlier adaptations of SASA! to refugee camps in Uganda (interventions implemented around 2010-12) found that was a general perception among community members, implementers, and donors that the SASA! intervention was successful at preventing violence in the community and that awareness campaigns had improved knowledge of GBV.[10] In a 2018 evaluation of UNFPA's support to SASA!, 78% of the respondents reported 'change in the community attributable to SASA!'.[11] Assessments of a SASA! intervention in Adjumani refugee settlement, although not measuring direct impact on women's experiences of GBV, found that a significant share of community members spoke out and took action against GBV, supported someone experiencing or using violence, and changed their attitudes towards GBV.[12] For example: 79% had provided support to someone experiencing and using violence; 81% spread the message that violence against women is not okay; 84% of community members took action towards the prevention of violence against women; and 71% of respondents do not believe that violence in a relationship is normal.

Engaging men and boys: Several programmes to prevent GBV in refugee camps have engaged men and boys as a key strategy, often pursued as part of approaches to transform social norms that perpetuate GBV. This approach includes the 'Role Model Men and Boys' (RMM) programme

in refugee settlements in Uganda, and the 'Engaging Men and Boys through Responsible Practice to Prevent Gender-based Violence against Women and Girls (EMAP) in Zimbabwe, Uganda, and Kenya. There is limited evidence of the impact of these programmes on women's experiences of GBV, however, some men participating in these interventions have reported some positive changes.

- **Engaging Men in Accountable Practices (EMAP)** has been implemented in refugee camps of varied sizes in Zimbabwe, Uganda and Kenya (and possibly other settings that this review did not find information about online). Developed by IRC, EMAP is a one-year primary prevention intervention for conflict-affected communities. It uses an evidence-based curriculum and field-tested approach for engaging men in transformative individual behaviour change, guided by the voices of women. Men and women are engaged separately in discussion groups, where the priorities and concerns raised in the women's group feeds informs the discussions in the men's group. Interviews with boys participating in the intervention in Uganda found that several of them had previously viewed girls as only having domestic responsibilities, but shifted this view and started supporting their sisters to attend school, and empower women to get jobs.[13] In the Dadaab refugee camp in Kenya, men participants reported several positive outcomes, including taking actions to prevent SGBV in their communities, and that they had increased awareness of the challenges faced by women.[14] Women in the same intervention reported that EMAP had provided a relevant platform for women to voice their priorities and wishes.[15]
- **RMM:** This approach has been adapted from CARE's long-term Northern Uganda Women's Economic Empowerment Programme (NUWEP) to work with refugees and internally displaced men and boys in Uganda. RMM engages men and boys to reflect on constructions of masculinity in their contexts and how it affects their well-being and relationships. This includes reflecting on unequal power relations, gender roles, and social norms and how these impact the behaviour of women, girls, men and boys. In refugee camp settings, the intervention has been adapted to also a focus on cultural diversity and adapting to living in a new setting. The model has a strong focus on addressing men's mental health and psychosocial support needs, which is recognised as critical for addressing GBV and the risk of conflicts in the camps. The approach has not been evaluated.

Adolescent girl-centred approaches: The evidence base on GBV prevention programming targeting adolescent girls in refugee settings is limited, although a number of interventions have been implemented.[16] Existing interventions often include multiple components, where a common main approach is curriculum-based life skills approaches with girls, which are often implemented in girl-friendly or girl-only safe spaces. Such interventions include Girl Shine and the COMPASS programme, both developed by International Rescue Committee (IRC) for humanitarian settings. Another intervention falling under this category is the Girls Take the Lead (GTTL) programme by Plan International Rwanda.

- **Girl Shine**: Girl Shine is an intervention and a resource package which key elements include girl-only safe spaces and support groups, a mentor-led life skills program, and a parent and caregiver support group. Girl Shine has been implemented in refugee settings in Ethiopia and Uganda. In Uganda, a new module was developed to address child marriage. The evidence review did not identify any evaluation of Girl Shine in refugee settings.
- **COMPASS**: The COMPASS programme was implemented with adolescent girls living in displacement settings in Pakistan, DRC and Ethiopia. The intervention consists of life skills sessions for adolescent girls; parent/ caregiver discussion groups; and support to service providers to develop knowledge, capacity and skills regarding the specific needs of adolescent girls. Evaluations of the COMPASS programme in three countries found that the intervention had limited impact on girls' feelings of safety and exposure to GBV – suggesting that adolescent girl focused programming needs to be accompanied by wider gender transformative programmes with stronger focus on social norms and gender roles, which address power dynamics between men and women in the household and the community.[17]
- **GTTL:** This intervention, which was implemented in two refugee camps in Rwanda (with around 12-13,000 residents), sought to empower adolescent girls with a focus on building their social, personal and material assets, while increasing the awareness of adolescent boys on gender equality and ways to prevent violence. It used a combination of curriculum-based approaches delivered in girls-only safe spaces, male engagement approaches, and also had an economic empowerment component targeting girls and boys. An evaluation found that community stakeholders, parents and adolescent girls and boys perceived that the level of violence in the camps had decreased.[18] Girls and community members also said that the incidence of rape in the camps had reduced, and that some men and boys no longer used drugs or alcohol and had become less violent.

Box 2. Evaluation of the COMPASS programme in Ethiopia and DRC

The COMPASS programme was implemented with South Sudanese refugee girls aged 13-19 living in refugee camps at the Sudan/ Ethiopia border, and with girls aged 10-14 in DRC. Randomised controlled trails (RCTs) in the two countries found no impact on girls' experiences of GBV (sexual violence and child marriage) or feelings of safety that could be attributed to the programme.[19] However, some positive outcomes in terms of girls' social network and support were observed, including that girls who attended the life skills sessions were more likely to have more friends and having a trusted adult woman (non-family member) to speak to. Girls participating in the programme also had higher expectations for what the future held for them and their peers.

Economic and social empowerment approaches: Economic interventions, which can include a range of economic transfer approaches, have been recognised for their potential to reduce GBV, primarily in intimate relationships.[20] These are common interventions in humanitarian settings, responding to the immediate economic needs of refugees and displaced populations. Global evidence suggests that economic transfers can be effective in reducing women's experiences of

physical and/or sexual IPV. However, further research is needed to understand differences in experiences depending on who the transfer targets (e.g. women or men in the household), and whether economic transfers alone or combined economic and social empowerment interventions are most effective. None of the evaluations/ studies which have so far contributed to the global evidence-base on this approach are from refugee settings in SSA, and one cash transfer programme with displaced populations in Syria showed no impact on reducing IPV among women in the households receiving the transfer.[4] This review did not identify any evaluated interventions in refugee camps in SAA employing this approach.

An analysis of GBV prevention interventions in Uganda's refugee hosting districts noted that several organisations provide cash transfers, village saving and loan associations, vocational skills training, and livelihood support.[21] These were however not always coupled with social empowerment approaches, and there is limited evidence of the impact of various approaches on GBV. The analysis furthermore highlighted the risk of backlash, violence and other negative impacts on women participating in economic interventions, especially when these are not accompanied by components addressing social and gender norms related to women's economic participation.

This evidence review identified only one intervention with a combined economic and social approach to address GBV. The Health and Empowered Youth Project, implemented in several refugee camps in Rwanda, aims to prevent sexual violence and teenage pregnancy through activities in schools and local communities, and interactive radio shows.[22] Young mothers are also trained in life skills and income generation, and are offered loans to support their income generating activities. The intervention was still ongoing in 2023, and results or lessons learned not yet available.

Peer-to-peer approaches: Peer-to-peer approaches are used in various interventions. For example, the Zero Tolerance for GBV 365 in Tongogara refugee camp, Zimbabwe, used the 'Sista2Sista' approach where adolescent girls meet in groups to share information on issues such as GBV and SRHR, including learning to identify 'good' and 'bad' touches. No evaluation or lessons learned were available from this.

Campaigns and edutainment: Several interventions include elements of campaigns and awareness raising initiatives on GBV in refugee settings. For example, the Sexual Exploitation and Abuse Community Drama Club in Tongogara refugee camp, Zimbabwe, used a combination of approaches consisting of a drama club in schools, distribution of communication materials in the wider community, and a zero-tolerance campaign targeting humanitarian workers. The programme has not been evaluated, and no lessons learned from the intervention have been shared. The review did not identify any evidence on the effectiveness of using campaigning and

[4] See Kerr-Wilson, A. et al (2020) A Rigorous Global Evidence Review of Interventions to Prevent Violence against Women and Girls for a summary of the global evidence base on this approach.

edutainment approaches to prevent GBV in refugee camps, however, the global evidence base suggests that these approaches are not effective as standalone interventions.[23]

Countering trafficking programmes: In Rwanda, UNHCR and the Ministry in charge of Emergency Management (MINEMA) initiated a multi-year programme to prevent trafficking of women and girls in refugee camps in 2018.[24] Among other things, the programme has set up a helpline and provides shelter and dedicated services to human trafficking victims in the refugee camps, and UNHCR and government agencies work to detect and handle trafficking cases and attempt to trafficking. The review did not identify any evidence of the impact of this programme, or any other programmes to prevent trafficking in refugee camps in SSA.

School-based approaches: Two of the interventions – the Sexual Exploitation and Abuse Community Drama Club in Tongogara refugee camp in Zimbabwe, and the Health and Empowered Youth Project in Rwanda – implemented activities with adolescent girls and boys in schools in refugee camps. There are no lessons learned on implementing prevention programming through school-based approaches in refugee camps in SSA, however, these interventions demonstrate that this is a possible entry-point for programming. Global evidence suggests that school-based prevention approaches can be effective for reducing GBV when well-designed and executed[25], with evaluations showing impact on peer violence and dating violence in particular. School-based approaches have also been effectively implemented in humanitarian contexts with some promising results.[26]

3. Lessons learned from interventions

Evidence of what works to prevent GBV in refugee camps settings is limited. Despite evidence of prevention programming taking place, there are few evaluated interventions that can demonstrate evidence of impact. This review however also included non-evaluated interventions with less rigorous evidence in order to identify a broader range of lessons learned from design and implementation that may be of relevance for GBV prevention efforts in similar camp settings. Emerging lessons are summarised below.

Sufficient time for inception and implementation: The identified GBV prevention interventions varied timeframes, ranging from longer approaches such as SASA![5] (recommended timeframe is three years of implementation), to interventions which are designed to be implemented in a shorter timeframe of about a year, such as ZTVA. The time required to implement an intervention depends on the model being implemented, however, experiences from existing interventions highlight the importance of ensuring sufficient time for inception, including adaptation, and implementation. Global evidence from non-refugee camp settings suggests that community-based programmes to transform social norms require timeframes of 18-24 months (or longer), and that sufficient time must be allocated to inception activities such as adaptation, training of

[5] SASA! is designed to be implemented over three years. It is not clear how long the implementation timeframes have been where SASA! has been implemented in refugee camp settings, however, there have been cases where the approach has been condensed to fit shorter funding cycles.

partners and facilitators, and translation of materials.[27] While it is not possible to conclude from the current evidence base what length is required for implementation of similar interventions in refugee camps, there are reasons to caution against condensing timeframes of proven models. For example, the SASA! approach has in some cases been condensed for implementation in refugee camps, leaving insufficient time to go through all stages of the model with the communities.[28] Evaluators also noted concerns with insufficient time for adaptation the SASA! model to the refugee camp settings. Similarly, the implementation of COMPASS in Ethiopia was condensed due to challenges in the context, with evaluation findings suggesting that 8-10 month of implementation was too short to see impact on attitudes and norms.[29]

When selecting intervention approach, consider time and funding available, as well as how stable/ settled the communities residing in the camp are. An evaluation of SASA! in the Adjumani refugee settlement in Uganda highlighted the importance of fidelity to the multi-year approach if SASA! (three years of implementation). The guidance for implementing SASA! in humanitarian settings stresses the importance of recognising the programme's long-term approach, and recommends that implementers must secure at least 18 month of funding to start implementation, and refrain from shorter term implementation.[30] The SASA! intervention guidelines further recommends that SASA! should be implemented in relatively stable settings, where implementation over multiple years with relatively stable/ settled communities is possible.[31] If these conditions cannot be met, there are other, shorter programme approaches to consider such as the ZTVA approach, which has been highlighted as an alternative to longer-term social norms change approaches in refugee contexts with less stable populations.[32]

It is also important to consider how to support the sustainability of outcomes after implementation has ended. An evaluation of the GTTL programme in Rwanda found that while the establishment of Youth Savings Groups could be undertaken in a relatively short period of time, at least 12 months of continued support is recommended to be built into the programme timeline to increase the chances of sustainability of the efforts.[33]

Meaningful engagement of women and girls in planning and implementation: Previous evidence reviews, as well as existing guidance on integration of GBV interventions in humanitarian action[6], emphasise the need for active involvement of refugee women at all stages of GBV prevention programming.[34] A recent brief on key actions for the Global Refugee Forum identifies partnership and collaboration with refugee women-led organisations as a priority across all stages of GBV programming in refugee camps, as they are often at the frontlines of responding to and preventing GBV and have a critical role to play in programming.[35] IRC's Girl Shine programme has been recognised for being implemented in partnership with refugee women-led organisations in several settings, including in Kenya and Uganda.[36]

Lessons from several of the reviewed interventions similarly highlight the critical importance of engaging refugees from the early stages of a programme, including in the planning and design

[6] See the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action

stage. An evaluation of SASA! in refugee settings in Uganda noted that while SASA! engaged refugees throughout implementation, it could have done better in terms of engaging refugees in the planning stages of the intervention, which could have helped to set realistic objectives and planning appropriate activities.[37] Similarly, lessons from implementing EMAP in Dadaab refugee camp in Kenya noted the importance of working with the local communities in the adaptation phase to ensure that the intervention is appropriate to the context.[38] This may require hiring people with diverse language skills to be able to meaningfully engage the diversity of communities residing in the camps.

Comprehensive approaches: Several of the identified interventions are designed to be part of more comprehensive GBV programmes, rather than being standalone interventions. For example, in Kenya, EMAP has been implemented alongside other GBV interventions, including SASA!. It was found to be useful to sequence the interventions so that after completing EMAP, volunteers could transition into SASA! to continue their engagement to end GBV in the refugee camp.[39] An evaluation of SASA! in the Adjumani camp in Uganda similarly highlighted that the model can be implemented alongside other interventions such as ZTVA and EMAP, but stressed that this requires close coordination between the interventions to ensure complementarity of the approaches and activities.[40]

It is crucial to address GBV prevention, mitigation and response in a comprehensive way to ensure that while the root causes to GBV are addressed, the immediate risk factors that contribute to GBV specific risks in camps are addressed, and there is support to survivors of GBV. For example, in the ZTVA intervention in Nigeria, GBV mitigation measures were implemented alongside the process to engage communities to transform social norms that underpin GBV. Activities included nighttime supervision in areas of high risk of GBV, protection of women when collecting firewood, supervision at aid distribution sites; and assessments of GBV risks at the reception centre.[41]

Several interventions include components that address GBV response, such as strengthening the capacity of service providers, addressing barriers to support seeking such as stigmatising attitudes, and increasing awareness of response services. For example, interventions delivered through safe spaces, such as the GTTL programme, provides GBV services in these spaces. If response is not an embedded component of the intervention, prevention interventions should only commence when response services have first been established/ assessed. It must be factored into the planning that prevention interventions can lead to increased GBV reporting and support seeking in communities, and there is also a risk of backlash and violence against women and girls participating in the intervention – requiring preparedness of how to handle this among those delivering the intervention, and capacity of service providers in the community to respond to potential increases in service seeking.

Working with community workers: The existing evidence and lessons learned highlight the value of working with community workers in prevention interventions in refugee camps as this is seen to increase the acceptability of interventions and helping in gaining the trust from communities. One study noted that 'the community is able to understand much more from

refugee community case workers than from us because they live with them and understand the system and everything that happens there'.[42]

Implementation of SASA! in Ugandan refugee camps found that retention of community activists, who are critical to the implementation of the model, was a challenge. This was partly due to community activists taking up paid jobs and subsequently having limited time to engage on community activist activities in a voluntary role.[43] The identified interventions did not provide an allowance or any other incentives to the community activists, refugee leaders and other volunteers, and evaluations have recommended considering this for future programming to mitigate the risk of high turnover, after time and resources have been invested in training and supporting people to take on these roles.

Working with existing structures: An evaluation of SASA! in Uganda refugee camps highlighted that the implementers did well in terms of integrating the intervention with existing community structures (e.g. working with community social workers, gender task forces, youth groups and men-to-men support groups) as well as existing GBV response structures, which contributed to further strengthening structures for GBV prevention and response for the future.[44]

Well-trained and supported staff: Learning from implementation of GBV prevention intervention in refugee camps highlights the importance of well-trained and motivated staff. Thorough training and preparation, and ongoing coaching and mentoring once implementation has started have proved critical to success.[45] The EMAP intervention in Dadaab refugee camp in Kenya, for example, provided a 10-day training to all staff taking part in the implementation.[46] Reflection on personal attitudes and beliefs is a core aspect of the training, which was provided to all staff together, to support staff on their personal and collective change journeys. Refresher training is provided every year to address gaps created by staff turnover. Retention of staff has been identified as a challenge in prevention programming in refugee camps, which poses challenges to continuity and quality of implementation. The evaluation of COMPASS also highlighted the importance of considering facilitators' characteristics, attitudes and background in the recruitment. The intervention recruited young women to work as mentors for adolescent girls, who were from the same area as the intervention was implemented, and who demonstrated positive attitudes and acceptance of the core ideas of the intervention.[47]

Engaging the wider community (enabling environment): Learning from implementing adolescent girls-focused interventions in particular have stressed the importance of engaging the wider community to enhance acceptability of the intervention to begin with, but also for increasing the chances of transformative outcomes. The GTTL intervention in Rwanda found that parents' 'buy in' was fundamental for ensuring adolescent girls' participation in the programme.[48] Evaluations of adolescent girls' programming have also stressed the importance of addressing the enabling environment, as a focus on empowering adolescent girls alone will not reduce the perpetration of GBV, which requires addressing power imbalances and social norms that perpetuate GBV.[49] The 'Improving Refugees' Access to Sexual and Gender-based Violence Prevention and Response Services' in Rwanda appears to be an attempt to take a comprehensive

approach to adolescent girls-focused programming, as it combines approaches of community-based SGBV dialogues, male engagement, and community-based socio-therapy with life skills sessions and mentoring for girls.[50] However, this intervention has not been evaluated.

Risk of backlash and violence against women participants: Implementers and donors supporting SASA! in refugee settings have observed a risk of backlash against women, where some men felt that women were becoming 'too empowered' by the SASA! approach.[51] This was particularly noted when organisations worked with female community activists on sensitisation and capacity building activities, especially if women had not informed men in their household of their participation. Analysis of economic interventions targeting women have also noted that these interventions can expose women to increased GBV risks, especially when not being accompanied by a social empowerment approach.[52] Any GBV prevention efforts should be preceded by a thorough risk analysis, and a mitigation strategy put in place to reduce the risk of backlash, violence or other negative impacts. During implementation, the risk of backlash and violence must be carefully monitored so that potential backlash is identified early on and dealt with. Social empowerment components can be one way to address the risk of backlash and violence and improve the chances of transformative outcomes, as these often focus on building support for women's empowerment among husbands, family members and the wider community.

Risk of backlash against women workers and volunteers: A study in the Dadaab refugee camp noted that many of the female refugee community workers working to prevent and respond to GBV were themselves survivors of GBV.[53] Notably, some of the violence was linked to their roles as community workers, where one in three refugee community workers reported being hit with an object in the last 12 months as a result of their GBV work. This stresses the need for conducting risk assessments and establishing necessary safety and risk mitigation measures to ensure women's safety and wellbeing when taking up these roles. Programmes need to ensure that psychological support services are available to the community workers, recognising that many may be survivors themselves and that working on GBV issues comes with the risk of vicarious trauma.

Inclusive approaches: Most of the identified interventions in refugee camps in SSA did not appear to take intentionally inclusive approaches, and few provide any learnings in regards to reaching the most structurally marginalised communities at high risk of GBV with interventions. An exception is the 'Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings' initiative in refugee camps in Burundi. The project first conducted an assessment to understand barriers and enablers to disability inclusion in GBV interventions, and thereafter implemented pilot actions to promote inclusion in existing GBV activities in the camps. This included targeted Village Savings and Loan Associations (VSLAs) for persons with disabilities and their caregivers, community awareness raising, home visits to provide case management for persons with disabilities at risk of GBV, and recruiting women with disabilities as community mobilisers. A participatory evaluation of these efforts found that after these activities, women with disabilities felt less isolated, GBV practitioners reported increased confidence in adapting GBV

programming to be more inclusive and survivor-centred for women and girls with disabilities. This ultimately translated into increased engagement of women with disabilities in GBV programming.[54] There have also been efforts in Rwanda to improve the responsiveness to needs of refugees with communication disabilities in GBV prevention and response.[55] There is no evidence or lessons learned available from this project.

Accessible interventions (language and literacy): An assessment of GBV and VAC programming in refugee and host communities in Uganda emphasised that programmes must take into account the multiple languages spoken in refugee settings, as well as the low literacy levels among many refugee women and girls.[56] The assessment noted that communication materials and education sessions in English prevented many women and girls from accessing information. The low literacy levels also meant that there was a relatively small pool of women to take up community-based roles in prevention programmes that used community-based facilitators, volunteer health trainers, change agents and similar roles in the delivery of interventions. This was also observed in the implementation of ZTVA in Uganda.[57]Interventions in refugee camps must consider the diversity of communities and languages spoken, as well as literacy levels among participants.

Age-appropriate approaches: It is critical that approaches and materials used in interventions are appropriate to the audience, for instance taking into account the development phases that children and adolescents go through. For example, when implementing the GTTL intervention in Rwanda, the Men Engage curriculum needed to be adapted to be more youth-friendly, as younger boys found it difficult to grasp some of the content.[58]

Engagement of men: Lessons from interventions focused on male engagement (e.g. RMM in Uganda) highlight the importance of thinking through incentives and strategies to support men's participation. RMM in Uganda recommended that RMM models are linked to economic activities to enhance men's participation in the intervention – not only as a means to get men in the door, but also for tackling common mental health conditions such as depression by rebuilding men's hope for the future through economic empowerment. Lessons from the implementation of SASA! in Adjumani refugee settlement, Uganda, also highlighted the importance of well-trained facilitators for maintaining the interest of male participants, which was noted as a challenge in the context. While ensuring that support structures and mitigation measures are put in place for enhancing male engagement, it is recommended to have a mitigation plan in place for potential high drop-out rates of male participants.[59]

RMM in Uganda also found that men feared being stigmatised in the community due to their participation in the programme – highlighting the need to sensitise the wider community about the intervention to mitigate the risk of stigmatising attitudes towards men who participate. The fear of losing friends was found to be particularly pronounced among men refugees, many of who have already lost friends and family members duo to conflict and displacement.

Learnings from EMAP in Kenya highlights the importance of ensuring accountability to women and girls in male engagement-focused interventions. The EMAP approach is guided by its 'Accountable Practice' approach, which centres around honouring women's leadership and

developing male engagement in a way that ultimately seeks to improve the lives of women and girls. The sequencing of women's and men's groups is critical for this, where women's groups are running ahead men's groups, in order to gather women's views on various topics discussed, ensuring that women's voices and priorities guide the work with men.[60]

Working with host communities: There was limited evidence to suggest that existing prevention interventions have worked with refugee and host communities simultaneously. However, implementers of the RMM programme in refugee settlements in Uganda have highlighted that this approach has potential to work with men and boys in refugee and host communities to support improved relationships and social cohesion.[61] A recent brief on refugee women-led organisations highlights their key role and leadership in GBV prevention, alongside women's rights organisations in their host communities.[62]

Annex 1: Mapping of prevention interventions in refugee camps

1. Zero Tolerance for GBV 365	
Approach and activities	The Zero Tolerance for GBV 365 programme entailed a set of GBV interventions and aimed to increase coordination of GBV actors in Zimbabwe. The programme was not only focused on refugee camp settings, but included some activities with adolescent girls in Tongogara refugee camp. The activities in the refugee camps included sensitization sessions with girls on GBV, using the Sista2Sista approach where adolescent girls meet in groups to share information on issues such as GBV and SRHR. The discussions focused on perpetrators of GBV, learning to identify 'good', 'confusing' and 'bad' touches, discussing the consequences of early marriage, and identifying referral pathways for GBV reporting and services. UNFPA also distributed dignity kits to girls.
Timeframe	2017-2020
Implementers	UNFPA Zimbabwe with a number of implementing partners, see here.
Coverage	Zimbabwe (not specified), including Tongogara refugee camp which had about 10,000 residents at the time.
Type of GBV	Not specified
Evaluation methods	No evaluation found.
Impact on GBV	N/A
Other impacts	N/A
Lessons learned	N/A
Further information	UNFPA Zimbabwe (2018) Zero Tolerance for GBV, Newsletter Issue 1, October 2018 UNFPA ESARO (2018) Empowering and restoring dignity to vulnerable girls in refugee camps in Zimbabwe

2. Sexual Exploitation and Abuse Community Drama Club	
Approach and activities	Childline Zimbabwe has implemented activities to tackle sexual exploitation and abuse (SEA) in Tongogara refugee camp. The intervention used a combination of approaches consisting of a drama club in schools, distribution of communication materials in the wider community, and a zero-tolerance campaign targeting humanitarian workers. Existing Drama Club guidance was translated into Swahili and Shona, and 40 facilitators (21 males and 19 females) were trained to implement Drama Clubs in schools in the camp. The Drama Clubs aim to raise awareness on the risk of SEA in refugee camps through dramatisation of scenarios followed by discussion. The sessions are designed to run once a week for 5-6 weeks – each session lasting for an hour. In parallel to the Drama Clubs, Childline shared key messages on PSEA in the communities, including through distributing T-shirts, posters, pamphlets, videos, and radio shows, as well as well as SMS with 16 different messages. The intervention also raised awareness on existing reporting mechanisms for SEA in the camp.
Timeframe	2021
Implementers	Childline Zimbabwe

Coverage	Tongogara refugee camp, Zimbabwe
Type of GBV	SEA
Evaluation methods	No evaluation found.
Impact on GBV	N/A
Other impacts	N/A
Lessons learned	N/A
Further information	• ICVA (2021) Childline Zimbabwe 2021, PSEA Fund deliverables • Sexual Exploitation and Abuse (SEA) Community Drama Club Guide – Script Adaptation from experiences in the Tongogara Refugee Camp • UNHCR (no year) PSEA Community Outreach and Communications Fund

3. Engaging Men and Boys through Responsible Practices to Prevent Gender-Based Violence against Women and Girls (EMAP)	
Approach and activities	The Engaging Men and Boys through Responsible Practices to Prevent Gender-Based Violence against Women and Girls programme in Tongogara refugee camp sought to involve men in understanding and combatting the root causes of gender inequality and gender-based violence, using the Engaging Men in Accountable Practices (EMAP) approach. The evidence review has not identified any documents that described the intervention in more detail, however, stories from two youth leaders who participated as facilitators describe that they held a series of workshops with male and female community members on how to build a violence-free community. The sessions culminated in a community marathon held in conjunction with the 16 Days of Activism Against GBV and a session of yoga.
Timeframe	Not specified.
Implementers	UNHCR
Coverage	Tongogara refugee camp, Zimbabwe
Type of GBV	Not specified.
Evaluation methods	No evaluation found.
Impact on GBV	N/A
Other impacts	N/A
Lessons learned	N/A
Further information	Women's Refugee Commission (2021) GYAC 2020: Strengthening Refugee and Internally Displaced Youth Leadership and Responding to the COVID-19 Pandemic Story from a female youth leader participating in the EMAP programme: https://www.gryn.network/blog-2/refugee_stories_2/

4. Zero Tolerance Village Alliance (ZTVA), Uganda	
Approach and activities	The Zero Tolerance Village Alliance (ZTVA) model, originally developed for rural settings in South Africa, has been adapted and implemented in refugee settlements in Uganda. The intervention contains the following elements: • Community mapping and dialogue to identify key stakeholders and promote community ownership; • Establishment of stakeholder forum with representatives from different sectors in the community to support the implementation of the ZTVA; • Memorandum of Agreement to formalise the partnership between the stakeholder forum and the implementing partner. This sets out the criteria that the stakeholder forum will support the community to beet to be included in a ZTVA; • Training and sensitisation on SGBV targeting key community groups. This includes a peer training element to disseminate acquired knowledge; • Pledge-taking ceremony to recognise when the community has met the criteria to join a ZTVA. Men in the community are invited to take a public pledge to contribute to ending SGBV, and testimonies of change are shared; • Alliance identification and declaring the zero-tolerance status. This step is accompanied by a small allowance that the village can use to build a sense of community after joining the alliance.
Timeframe	2015-2016 (6 month testing); implemented in 2018/19 – unknown timeframe
Implementers	Population Council, Lutheran World Federation, TVEP, the Child Health and Development Centre (Makerere University), the Refugees Department (Office of the Prime Minister, Uganda), and UNHCR.
Coverage	Rwamwanja Refugee Settlement in Kamwenge District, Western Uganda. At the time of the intervention, Rwamwanja was hosting about 40,000 refugees. In 2020, the ZTVA intervention had been implemented in about 15 refugee villages in Uganda.
Type of GBV	Physical and sexual IPV and non-partner physical and sexual violence. The intervention addresses violence against women and men.
Evaluation methods	Pre- and post-intervention design without a comparison group. The evaluation of the first intervention in Rwamwanja included 340 men and 261 women and baseline, and 336 men and 299 women at endline.
Impact on GBV	Evidence indicates that the approach reduced negative attitudes and beliefs related to GBV; positively changed perceptions of community GBV norms; reduced the occurrence of physical IPV (in men and women), sexual IPV (in men), non-partner physical violence (in men and women), and non-partner sexual violence (in women); supported a more comprehensive understanding of rape; and increased support for care-seeking for SGBV. However, the model did not change negative male attitudes toward women's sexual autonomy in intimate partnerships, or reduce the occurrence of sexual IPV for women.
Other impacts	N/A
Lessons learned	The study found low levels of formal education, especially among women refugees, in the context. This highlights the need to use alternative communication tools and channels for distributing GBV information, noting that most information about GBV response/ services were only available in writing (e.g. on posters, leaflets etc.).
Further information	• Government of Uganda and World Bank (2020) *Gender-based Violence and Violence Against Children Prevention and Response Services in Uganda's Refugee-Hosting Districts*. Washington, DC: World Bank.

	• Undie , C. C. et al. (2016) Effectiveness of a community-based SGBV prevention model in emergency settings in Uganda: Testing the 'Zero Tolerance Village Alliance' intervention Population Council • Mballa, C. et al. (2020) UNHCR and Partner Practices of Community-based Protection across Sectors in the East and Horn of Africa and the Great Lakes Region

5. Role Model Men (RMM)	
Approach and activities	The Role Model Men (RMM) approach has been adapted from CARE's long-term Northern Uganda Women's Economic Empowerment Programme (NUWEP). It works with refugees (primarily form South Sudan) and internally displaced men and boys in Uganda. The approach mobilises men and boys to reflect on constructions of masculinity in their contexts and how it affects their well-being and relationships. This includes reflecting on unequal power relations, gender roles, and rigid social norms that impact on the behaviour of women, girls, men and boys. In refugee camp settings, there is also a focus on cultural diversity and adapting to living in a new setting. Participating men and boys are taken through a series of training modules, mentorship, coaching and dialogue sessions. This includes building basic counselling skills to support men to listen to another and provide mutual support. The intervention has a strong focus on addressing men's mental health and psychosocial support needs, which is recognised as critical for addressing GBV and the risk of conflicts in the camps. Through working with men and boys and change agents, the intervention aims to have impact on three levels: individual and personal level change; household and relationships; and peer and community relations.
Timeframe	N/A
Implementers	CARE Uganda
Coverage	CARE had in 2019 trained over 2,100 Role Model Men and Boys in Rhino and Imvepi refugee settlements in the West Nile region, Lamwo in Acholi sub-region – Northern and Southwestern Uganda. They have in turn mentored and supported over 11,000 peers.
Type of GBV	Not specified. At least 18 months are needed to train and support a cohort of RMM to take the approach forward independently.
Evaluation methods	No evaluation found.
Impact on GBV	N/A
Other impacts	N/A
Lessons learned	Learnings from implementing the RMM approach in refugee camps include: • Participating men reported fearing losing male friends and being stigmatised in the community due to their participation in the programme. This was particularly observed among refugees who have already lost many friends and family members due to conflict and displacement. This requires more attention from the onset to sensitise the wider community about the intervention and dismantle negative beliefs and misconceptions. • The original intervention in NUWEP targeted men in households, however, some refugee settlements have high levels of female-headed households who are at risk of GBV from men outside their household. Hence, the implementers have considered extending the approach to reach men in organised men's groups, to also have an impact on relationships and men's violence outside the household sphere. • RMM models should be linked as much as possible to economic activities to enhance men's participation and outcomes. Economic activities can provide an incentive for men's participation and is also seen as an important way to tackle depression and for rebuilding men's hope for the future.

	• Funding cycles of at least 18 months are needed to roll out the model and enable the intended behaviour change to unfold. • The adapted RMM approach has targeted men and boys in refugee communities. Implementers of this believes there is great potential in working with men and boys in refugee and host communities simultaneously, to support improved relationships between refugee and host communities.
Further information	• Government of Uganda and World Bank (2020) *Gender-based Violence and Violence Against Children Prevention and Response Services in Uganda's Refugee-Hosting Districts*. Washington, DC: World Bank. • UNFPA and CARE (2021) Empowering Women and Girls through CARE's Role Model Men (RMM) Approach • CARE Uganda (2019) Role Model Men & Boys of Uganda • CARE Uganda (2019) Positive Masculinities in a Refugee Context

6. SASA! (multiple interventions in Uganda)	
Approach and activities	The SASA! Approach was originally designed by Raising Voices and implemented by the Center for Domestic Violence Prevention in Uganda. SASA! was originally designed for a development context, however, the approach has been adapted for humanitarian settings, including in the Dadaab refugee camp in Kenya. SASA! has also been implemented in various refugee settings in Uganda, however, documentation of the adaptations and evidence of impact is not available for most of the interventions. It is worth noting that UNHCR has implemented SASA! in parallel with the Zero Tolerance Village Alliance (see intervention no. 4). Below provides information and lessons learned based on brief information in various reports and case studies (see 'further information' for sources). An evaluation of UNFPA's support to SASA! noted that considering the wide interest in implementing SASA!, concerted efforts to evaluate the methodology in refugee settings in Uganda would be valuable. SASA! aims to change social norms that underpin GBV. This uses a structured community engagement approach to guide communities through different stages of change, addressing underlying beliefs, social norms and attitudes that perpetuate VAWG. In short, the approach contains four phases: • **Start**: Includes learning about the setting though a baseline survey, establishing relationships, and selecting women and men participants. Invites the community to connect with their *power within*. • **Awareness**: Introduces power analysis and identifies men's *power over* women as a root cause to IPV, and analyses enablers for the violence to continue in communities. • **Support**: Builds momentum in the community through the concept of *power with* – encouraging collective action and responsibility to speak out against GBV. • **Action**: Cultivates the *power to* take action and formalises mechanisms to sustain new norms that reject violence and encourages balanced power. In 2020, Raising Voices launched the revised SASA! Together. This contains the same four phases but integrates learning from across settings where the approach has been implemented.
Timeframe	Various SASA! interventions have been implemented with different timeframes. The interventions identified for this review have been implemented since about 2010 to recently (and interventions are ongoing). The most recent mention of SASA! being implemented in refugee settings in Uganda

	is in UNHCR's 2022 annual report, which described that SASA! Together has been implemented in Arua, Moyo, Kyaka, Bidibidi, and Kampala.
Implementers	Multiple actors have implemented SASA! in refugee settings in Uganda including: UNHCR, UNFPA, Danish Refugee Council, Lutheran World Foundation, Humanitarian Initiative, Just Relief Aid, and American Refugee Committee.
Coverage	Multiple refugee settlements in Uganda of various sizes, including but not limited to Bidibidi (over 270,000 refugees), Kyangawli (over 125, 000 refugees), Kiryandongo (over 70,000 refugees) and Pagirinya (over 32,000 refugees).
Type of GBV	SGBV – primarily physical and sexual IPV
Evaluation methods	One evaluation of UNFPA's support to eliminating GBV (UNFPA Evaluation Office, 2018) includes some focus on SASA! in Uganda. An evaluation of U.S. Department of State Bureau of Population, Refugees, and Migration (DoS/PRM) fund2ed SASA! interventions implemented by American Refugee Committee (ARC) (see Glass and Doocy, 2013; and Holzaepfel and Doocy, 2014) notes results and lessons learned from the earlier SASA! interventions in refugee camps (implemented in 2010-12). This evaluation included literature review and 'field evaluation' (methods not specified).
Impact on GBV	An evaluation of the U.S. Department of State Bureau of Population, Refugees, and Migration supported SASA! interventions in 2013 (for interventions implemented 2010-12) noted that there was a general perception among community members, implementers, and donors that the SASA! intervention was successful at preventing violence in the community, however, it was challenging to capture tangible outcomes (Glass and Doocy, 2013). Key informants and documents reviewed suggest that SASA! awareness campaigns contributed to improvements in GBV-related knowledge and attitudes from one year to the next, but no objective quantitative evidence was presented on the effectiveness of the intervention with respect to changes in socio-cultural norms that promote or sustain GBV.
Other impacts	• The 2013 evaluation (Glass and Doocy) noted that some implementers and donors supporting SASA! observed a risk of backlash against women, where some men felt that women were becoming 'too empowered' by the SASA! approach. This was particularly noted when organisations worked with female community activists on sensitisation and capacity building activities, especially if women had not informed men in their household of their participation. Another observed reason for backlash was that SASA! may be perceived as supporting women's rights only, and taking rights 'away' from men. At the same time, the SASA! curriculum was recognised as being more 'welcoming' for men and boys in the communities than previous GBV interventions – the engaging nature of SASA! and its' questioning approach that encourages community action was noted as the primary factor that explained higher levels of community interest and participation. • In the 2018 evaluation of UNFPA's support to SASA!, 78% of the respondents reported 'change in the community attributable to SASA!'. (UNFPA Evaluation Office, 2018)
Lessons learned	An evaluation of the effectiveness of GBV prevention interventions with refugees in Uganda (see Glass and Doocy, 2013; and Holzaepfel and Doocy, 2014) noted the following lessons learned: • The SASA! approach requires longer implementation time to change attitudes, behaviours and social norms than the shorter funding cycles in humanitarian settings typically provide. This pushed some implementers to condense the intervention timeline and start the next phases of SASA! before the community was ready, which they recognised was not the recommended approach and may limit the impact.

	• The influx and departure of refugees in settlements can pose challenges to social norms change programmes like SASA! if there is a high turnover of refugees, which can make sustaining change processes difficult. • High turnover of community activists, who are critical to the SASA! model, was similarly a challenge. While some left the camps/ settlements, it was also noted that there were often competing demands on the community activists, such as the need to take up paid work which limits the time community activists can engage in volunteer commitments. The evaluated interventions did not provide allowance or any other incentives to community activists, refugee leaders and volunteers engaged in the interventions, and the evaluation recommended considering this for future programming. • The large and expanding geographic size of the refugee settlements, in particular Kyangwali, was noted as a challenge with respect to achieving coverage of GBV prevention activities, motivating the community activists, and ensuring support services are available for GBV survivors. • Facilitators noted that the flexible approach of SASA! in terms of timing of activities and engagement of community members worked well in the community settlements. • SASA! did well in terms of working with existing community structures (e.g. community social workers, gender task forces, youth groups and men-to-men support groups) as well as existing GBV response structures, which strengthened structures for GBV prevention and response for the future. • While SASA! engaged refugees throughout implementation, it could have done better in terms of engaging refugees in the planning stages of the intervention, which could have helped to set realistic objectives and planning appropriate activities. A UNFPA Evaluation/ case study (UNFPA Evaluation Office, 2018), which includes findings on SASA!, noted that: • There were some concerns that the SASA! methodology had been insufficiently adapted for the context of the refugee settlements – including concerns around the pace of the process in communities which change so rapidly, including through the rapid influx of new refugees. • Several implementing partners were not able to complete the four phases of SASA! due to short funding cycles.
Further information	• Government of Uganda and World Bank (2020) *Gender-based Violence and Violence Against Children Prevention and Response Services in Uganda's Refugee-Hosting Districts*. Washington, DC: World Bank. • UNHCR (2019) Sexual and gender-based violence (SGBV) prevention, mitigation and response – Promising practices • UNFPA Evaluation Office (2018) Evaluation of Support to the Prevention, response to and Elimination of Gender-based Violence and Harmful Practices: Uganda Case Study • Raising Voices (2018) Implementing SASA! in Humanitarian Settings: Tips and Tools • Holzaepfel, E. and Doocy, S. (2014) Chad, Malaysia and Uganda/Gender-Based Violence Prevention Programs with Refugees • Glass, N. and Doocy, S. (2013) Evaluating the Effectiveness of Gender-based Violence Prevention Programs with Refugees in Uganda

7. SASA! (Adjumani, Uganda)	
Approach and activities	See table above for an overview of the SASA! approach.

Timeframe	2015 – ongoing
Implementers	UNHCR with partners: American Refugee Committee (ARC), Agency for Cooperation on and Research in Development (ACORD), CARE, Danish Refugee Council (DRC), International Rescue Committee (IRC), Lutheran World Federations (LWF), Transcultural Psychosocial Organization Uganda (TPO), War Child Canada (WCC), UNFPA and UN Women
Coverage	Adjumani refugee settlement (around 200,000 refugees)
Type of GBV	SGBV – not specified.
Evaluation methods	Not available, however, assessments during the implementation have compiled lessons learned and initial results from the different SASA! phases.
Impact on GBV	N/A
Other impacts	A rapid assessment after 1 year and 5 months of implementation (after the start phase) found that: • 72% of community members claimed they had talked with their partner about how to improve their relationship in the preceding 12 months. • 79% of community members had provided support to someone experiencing or using violence. • 81% of respondents spread the message that violence against women is not okay, to at least one other person. • 68% of respondents had engaged with others to promote non-violent relationships between women and men. • 84% of community members took action towards the prevention of violence against women. A second rapid assessment after the second phase (awareness) found that: • 71% of respondents do not believe that violence in a relationship is normal. • 59% of respondents do not believe a man who disciplines his wife makes the family stronger. • 55% of respondents do not believe women should tolerate violence in order to keep the family together. • 70% of respondents do not believe a man has the right to hit a woman if the housework is not done to his satisfaction. • The increased knowledge in the community on the harmful use of power led to a general increase in reporting of SGBV incidents.
Lessons learned	Lessons learned from the data gathered in the first two phases of implementation in the Adjumani refugee settlement highlights that: • SASA! requires a multi-year approach – it is critical to secure multi-year funding for implementation and minimize risk of disruption in implementation. SASA! guidelines set out that the approach should only be implemented in relatively stable contexts. • It is critical to engage a range of stakeholders in implementation, and participating organisations have to be fully committed to the approach in terms of capacity, leadership, and resource allocation to achieve intended results. • Well-trained and motivated staff is critical to all stages of the implementation. Ongoing coaching and mentorship, and supporting the retention of staff is critical to maintain the quality of implementation. • SASA! can be implemented alongside other approaches such as EMAP and ZTVA – coordination and complementarity is critical. • The intervention initially struggled with male engagement, however men's active participation increased over time. Engaged and well-trained facilitators were critical in achieving this, but it is also important to have a plan in place to mitigate the impact of potential high turnover of male participants.

	• Given the risk of disruptions to programming in refugee contexts, having a contingency plan in place before starting implementation is critical. • SASA! requires a significant time commitment from community members participating in the intervention. This needs to be acknowledged and appropriate support/ incentives provided to support their participation which may take time away from engaging in income generating activities. • Regular coordination between partners is key to successful implementation – coordination should be factored into the workplan and be anchored in a clear place such as the SGBV coordination structure. • Prepare and plan for adaptations to the local context, languages, and population.
Further information	• UNHCR (2019) Sexual and gender-based violence (SGBV) prevention, mitigation and response – Promising practices

8. Engaging Men in Accountable Practices (EMAP) (multiple interventions in Uganda)	
Approach and activities	Engaging Men in Accountable Practices (EMAP) is a one-year primary prevention intervention for conflict-affected communities developed by the IRC. It provides staff in humanitarian settings with an evidence-based curriculum and field-tested approach for engaging men in transformative individual behaviour change, guided by the voices of women. The EMAP framework, 'Accountable Practice', provides a method and structure for honouring women's leadership and developing male engagement in a way that improves the lives of women and girls. EMAP is not intended to be a stand-alone intervention, rather is intended to be part of a larger prevention program. EMAP contains three components: • Four-week training of trainers • An eight-lesson women's curriculum • A sixteen-lesson men's curriculum
Timeframe	EMAP was implemented in 2018 and 2019 by UNHCR (specific timeframes not available).
Implementers	UNHCR and IRC
Coverage	Bidibidi (over 270,000 refugees), Imvepi (around 68,000), Rhino Camp (around 123,000)
Type of GBV	Not specified
Evaluation methods	N/A
Impact on GBV	N/A
Other impacts	Interviews with refugee boys participating in an EMAP intervention implemented by IRC highlighted that several of the boys had previously viewed girls as only having domestic responsibilities, but through the intervention they were encouraged to send their sisters to school and empower women to get jobs (see US Department of State, 2022).
Lessons learned	N/A
Further information	• IRC (2013) Part 1: Introductory Guide. Preventing Violence against Women and Girls: Engaging Men Through Accountable Practice (also see part 2 and 3) • UNHCR (2018) UNHCR Monthly Protection Update Sexual and Gender-based Violence (SGBV) – October 2018

	• UNHCR (2018) UNHCR Monthly Protection Update Sexual and Gender-based Violence (SGBV) – August 2019 • US Department of State (2022) Evaluating the Effectiveness of Programs for Protection of Refugee Youth in Urban Settings in Africa

9. Girl Shine, Uganda	
Approach and activities	Girls Shine is an intervention and resource package developed by IRC for humanitarian settings. It can be used in a variety of settings, including in refugee camps. Girl Shine has been designed to help contribute to the improved prevention of and response to violence against adolescent girls in humanitarian settings by providing them with skills and knowledge to identify types of GBV and seek support services if they experience or are at risk of GBV. Core Girl Shine elements include girl-only safe spaces and support groups, a mentor-led life skills program, and a parent and caregiver support group. The Girl Shine resource package contains four parts: • Girl Shine: Advancing the field – designing girl-driven gender based violence programming in Humanitarian settings (Part 1) • Girl Shine: Life skills curriculum (Part 2) • Girl Shine: Caregiver curriculum (Part 3) • Girl Shine: Mentor and facilitator training manual (Part 4) Uganda was selected a focus country for developing a new child marriage component of Girl Shine, including formative research and field testing of this new component of the intervention in Uganda in 2018-2021. The child marriage component was thereafter added to the Girl Shine programme and resource package.
Timeframe	There is limited information available, but Girl Shine appears to have been implemented by UNHCR and partners in refugee settings in Uganda in 2018-2019 (most recent mention of Girl Shine activities is in this UNHCR Factsheet from August 2019v)
Implementers	UNHCR and partners
Coverage	Refugee settings in Uganda, including Invempi (about 74,000 residents) and Omugo (by UNHCR in 2018)
Type of GBV	Different forms of GBV, including child marriage
Evaluation methods	No evaluation found.
Impact on GBV	N/A
Other impacts	N/A
Lessons learned	There is no evaluation or other documents with lessons learned available, however a learning brief from Irish Aid highlights some key considerations when planning to implement Girl Shine: • Girl Shine is only to be implemented after GBV response services have been established. • Consult with girls, girls' trusted female and male caregivers, service providers and community leaders to ensure Girl Shine is context driven and adaptable to acute emergency, protracted and recovery settings.
Further information	• GBV Responders' Network (no date) Girl Shine • Irish Aid (2019) IRC Women's Protection and Empowerment (WPE) Learning Brief

10. Engaging Men in Accountable Practices (EMAP), Kenya	
Approach and activities	EMAP is a one-year intervention originally developed by IRC. UNHCR has adapted the intervention to be implemented in Dadaab, Kenya. This was the first time EMAP was adapted to a refugee setting. EMAP is designed to prevent GBV through attitudinal change by supporting participants to reflect on, and take responsibility for their actions, as they become aware of existing power dynamics. The EMAP framework centres women's voices and leadership, and support participants to acknowledge women's and girls' rights and roles in their communities. Through the framework of 'Accountable Practice', the intervention aims to enhance male engagement in a way that improves the lives of women and girls. The work with women and men is guided by the EMAP curriculum, where men's and women's groups are created and guided through a series of sessions (separately). The women's groups start first so that women's priorities and views can be integrated into the discussions in the men's groups. As part of the curriculum, men are supported to develop action plans with concrete steps of how they can become better allies to women and girls. The intervention's objective is to reduce and gradually end all forms of SGBV and harmful traditional practices exercised against women and girls. EMAP is meant to be implemented in settings where services for survivors already exist, and is not intended to be a stand-alone intervention, but rather is intended to be part of a larger prevention program.
Timeframe	2015 – ongoing (as of 2019). As of 2019, 919 individuals (520 female, 399 male) had completed the EMAP intervention in Dadaab.
Implementers	UNHCR and partners (IRC, Danish Refugee Council, and Kenya Red Cross Society)
Coverage	Four camps (Ifo, Ifo2, Kambioos and Hagadera) in Dadaab, Kenya.
Type of GBV	SGBV (not specified)
Evaluation methods	N/A
Impact on GBV	N/A
Other impacts	• Most of the men who went through the discussions took actions to prevent SGBV in their communities. • In most intervention locations, men demonstrated the EMAP approach by partaking in skits, songs and drama productions during public celebrations, on how they relate to women in the community. • Men indicated that EMAP was eye opening, particularly as they came to understand the daily challenges women face when interacting with men. • Observations from the women's groups showed that EMAP presented a relevant community platform for raising marginalised voices in the community, and was an empowering forum for women to voice their priorities and wishes.
Lessons learned	• Having well-trained staff who understand the intervention is key to its success. Reflection on personal attitudes and beliefs is a core aspect of the EMAP training, recognising that change begins with self-reflection. The training lasts for about 10 days, and it is important that the entire EMAP staff group is trained together. Refresher trainings have been held each year to address gaps created by staff turnover. • It is important to ensure a single-sex, protective and confidential space for the women's and men's groups, where participants can feel safe voicing their opinions. • The sequencing of women's and men's groups is critical – it was imperative to discuss the risks women face with regards to SGBV in women's groups before activities with men began. In this way, women's concerns are given priority, and guides the work with men.

	• When adapting the intervention to different refugee settings, work with the local communities to ensure that the intervention is appropriate to the context. In Dadaab, community development workers speaking different languages that are common in the camps were recruited to support the intervention and interact with the men's and women's groups in their local languages, including in Somali, Oromo, Nuer, Dinka, Gambella and Congolese. • EMAP is designed to ideally be implemented alongside other prevention initiatives. In Dadaab, EMAP was immediate followed by SASA! It was found to be useful to sequence the interventions this way, as EMAP volunteers who were interested in continued engagement on ending SGBV could transition into the SASA! approach.
Further information	UNHCR (2019) Sexual and gender-based violence (SGBV) prevention, mitigation and response – Promising practices

11. Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces (COMPASS)	
Approach and activities	The COMPASS programme was designed by IRC to respond to the specific needs of adolescent girls in humanitarian settings and to address the gap in evidence of what works to promote the health, safety and empowerment of adolescent girls. The intervention was implemented with adolescent girls living in displacement settings in Pakistan, DRC and Ethiopia. In Ethiopia, the intervention worked with South Sudanese refugee girls aged 13-19, and with girls aged 10-14 in DRC. The COMPASS programme for adolescent girls and caregivers is composed of a combination of approaches, namely: • **Adolescent girls' life skills sessions:** weekly discussions with groups of adolescent girls in allocated safe spaces, facilitated by young female mentors. • **Parent/caregiver discussion groups**: monthly discussions with parents/caregivers of adolescent girls participating in the programme. • **Service provider support:** targeted training and ongoing support to develop knowledge, capacity and skills regarding the specific needs of adolescent girls, and particularly those who have experienced GBV.
Timeframe	2014-2017
Implementers	IRC
Coverage	The intervention was implemented in conflict-affected communities in Eastern DRC (not clear whether this was in camps settings), and in refugee camps at the Sudan/Ethiopia border, and Pakistan (not included in this review).
Type of GBV	GBV against adolescent girls including interpersonal violence and child marriage.
Evaluation methods	Randomised controlled trails (RCTs). The evaluations were conducted to understand whether the adolescent girls' skills sessions conducted as part of COMPASS had an impact on the girls' exposure to GBV and their social and health outcomes. In DRC, the evaluation also sought to assess the additional impact of the parents' group discussions on adolescent girls' exposure to GBV, their social and health outcomes, as well as on the attitudes of parents towards adolescent girls. The same outcomes were measured in both evaluations.
Impact on GBV	• There was no evidence that the intervention was able to reduce girls' exposure to sexual violence in DRC or Ethiopia. • There was no difference in child marriage between girls participating in the intervention and the control group in Ethiopia or DRC. However, in Ethiopia, there was a decrease in reports of child marriage among girls who had reported being married or living with a man at baseline.

	• While there was an overall reduction in girls' reported exposure to GBV in DRC from the beginning of the programme to the end of it, the evaluation could not demonstrate that this change came as a result of COMPASS. • In Ethiopia and DRC, the programme showed no overall improvement in girls' own attitudes to gender inequality (including that women should tolerate violence), no significant reduction in girls' perception that their families will blame them if they experience sexual violence or harassment, and no significant changes in reported experiences of GBV or girls' feelings of safety.
Other impacts	• In Ethiopia and DRC, the evaluations found that girls who attended the life skills sessions were more likely to have more friends (and increased quality of relationships), having a trusted adult woman (non-family member) to speak to, and girls reported a strong sense of companionship with the other girls in the programme. • Adolescent girls who participated in the programme had higher expectations for what the future held for them and their peers. For example, in Ethiopia, the number of adolescent girls who thought that girls should be 18 or older before having their first child or getting married doubled from the beginning to the end of the programme. • Adolescent girls in Ethiopia and DRC gave positive feedback about the safe spaces. For example in DRC, girls were more likely to report having a safe place to spend time with other girls as a result of the programme. • At the end of the programme, girls in DRC and Ethiopia were able to talk about many of the key messages in the life skills curriculum which focused on strategies for keeping safe.
Lessons learned	• The evaluations suggest that similar interventions need a stronger focus on social norms and gender roles in order to transform entrenched norms and attitudes, and should seek to address power dynamics in families as well as communities. • The evaluation in DRC found that the parents and caregivers involved in the programme were mostly mothers (based on self-selection), who may have limited power to influence household power dynamics and decisions that have an impact on girls' safety and wellbeing. • The implementation in Ethiopia was condensed due to unforeseen challenges. Evaluation findings suggests that 8-10 month of implementation is too short to see impact on attitudes and norms from this type of intervention. • Safe spaces gave adolescent girls a place to feel safe, learn, and make friends. Girls participating in the intervention said that they appreciated having a physical space where they could build friendships, have fun and develop skills. • The selection and training of mentors was critical in the delivery of the life skills sessions. The mentors were close in age to the adolescent girls (typically 18-19 years), and came from the same area, and were also selected based on their positive attitudes to the topics in focus. The mentors received ongoing training and supervision to enhance their understanding of GBV and their own acceptance of gender equality, as well as to strengthen their facilitation skills and comfortability addressing sensitive topics. • COMPASS overall proved to be feasible and acceptable in humanitarian settings. There were some initial concerns among parents about the intervention, however, this was addressed through community awareness raising, home visits, and meetings with community leaders, which resulted in a lot of interest and high attendance rates.
Further information	• Tanner, S. and O'Connor, M. (2017) A Safe Place to Shine: Creating Opportunities and Raising Voices of Adolescent Girls in Humanitarian Settings • Stark et al (2018a) Preventing violence against refugee adolescent girls: findings from a cluster randomised controlled trial in Ethiopia, *BMJ Glob Health, 2018:3*

	• Stark et al (2018b) Building caregivers' emotional, parental and social support skills to prevent violence against adolescent girls: findings from a cluster randomised controlled trial in Democratic Republic of Congo, *BMJ Glob Health, 2018:3*

12. Zero Tolerance Village Alliance (ZTVA), Nigeria	
Approach and activities	Also see intervention no. 4 for a description of the intervention elements. The intervention addressed GBV through engaging communities (termed 'villages') to identify both the challenges of GBV and the solutions needed – aiming to support ownership of the problem as well as the change process. The objective of the intervention was to empower communities to confront and change norms and behaviours around GBV through engaging all members of the community. In each camp, three smaller zones were identified to function as villages as per the ZTVA methodology. Implementation was led by the Stakeholder Forum, which comprises different sectors and groups of community members, with UNHCR and the local partner providing guidance and technical assistance. The group typically includes traditional leaders, religious leaders, business owners, women, youth and older people. The community members also selected community activists, monitors and liaison officers to lead the community mobilization efforts. A list of Stakeholder Forum-endorsed criteria must be met for the village to be accepted into the larger alliance of villages which have pledged zero tolerance to GBV. To reach that stage, the village was taken through a series of activities, including dialogues built on the principle of 'active citizenry', where people are equipped with knowledge about their rights, and through the process becomes empowered to exercise those rights. There were also community debates on GBV issues, and a door-to-door campaign and mass public awareness sessions on GBV. This included a 'one-teach-two' approach where members of the Stakeholder Forum and community activists who had received training on GBV messaging reached out to wider community members. The Stakeholder Forum met every two moths to discuss progress and priorities, and there were follow-up sessions with community leaders on the implementation of agreed action points.
Timeframe	June 2019–December 2020
Implementers	Borno Women Development Initiative (BOWD)
Coverage	Mohammed Goni International Stadium and Government Senior Science Secondary Schoo (GSSS) camps, Borno State, north-east Nigeria.
Type of GBV	GBV – not specified
Evaluation methods	Not specified. Results and lessons learned shared in a UNHCR publication (see further information).
Impact on GBV	N/A
Other impacts	• The community leaders shared information on GBV during their gatherings at least twice a month. • The Stakeholder Forum was able to operate increasingly independently as the intervention progressed – demonstrating their empowerment. • The Stakeholder Forum worked to hold GBV perpetrators more accountable rather than ignoring or excusing their behaviour per traditional norms. • In addition to prevention focused activities, a number of mitigation measures where implemented by ZTVA members, including night time supervision in areas of high risk of GBV;

	protection of women when collecting firewood; supervision at aid distribution sites; and assessments of the reception centre. • The intervention took a disability inclusive approach, where ZTVA members actively engaged persons with disabilities – supporting them to access services and activities. They also worked to address negative attitudes, prejudices and stigma against people with disabilities in the communities.
Lessons learned	• The ZTVA approaches requires shorter timeframes than many other social norms approaches (e.g. SASA!), which is arguably making it more feasible to implement in refugee contexts with less stable populations such as in the Borno State, where frequent population movements and attacks make it difficult to implement longer-term prevention methodologies. • The implementing partner received additional coaching to implement the ZTVA methodology, as it was the organisations first time using this approach. • Tips for replication includes to start implementing at a smaller scale if it is the first time an organisation rolls out the intervention and allowing sufficient time for partners to understand the methodology. • The intervention was partly implemented during times when COVID-19 restrictions were in place. The community activities were adapted to be implemented on smaller scale and in smaller groups.
Further information	UNHCR (2021) Learning from experience and seizing opportunities: UNHCR and partner practices in advancing gender equality in sub-Saharan Africa

13. Girls Take the Lead (GTTL): Building Assets of Adolescent Girls in Refugee Camps in Rwanda	
Approach and activities	The overall goal of the GTTL project was to empower and build assets of adolescent girls in two refugee camps in Rwanda, with a specific focus on their social, personal, and material assets. This sought to equip adolescent girls and boys with the critical assets necessary to protect them from violence. The programme specifically aimed to increase awareness of boys ages 15-17 on ways to promote gender equality and prevent violence. The concepts of gender equality and the negative effects of GBV were also introduced at community forums like parents' dialogue, evening sessions, and umuganda (community work), to support parents' buy-in into the intervention. GTTL was implemented through four main components – including both GBV prevention and response elements: • **Establishment of girl-friendly safe spaces:** Among other things, girls could access counselling and referral services at the spaces, report violence and abuse and talk with mentors and peers. • **Better Life Options and Opportunities Model (BLOOM):** A gender transformative life skills curriculum aiming to empower adolescents, particularly girls, which is delivered through the safe spaces. • **Men engage approach:** This component engaged men and boys as allies in preventing violence against girls and women. Boys are trained on ways to promote gender equality and prevent violence in their everyday lives. This aims to change attitudes and behaviours and shape the gender-based expectations and understandings of adolescent males in positive ways. • **Youth Savings Group and Enterprise Your Life:** An economic empowerment component equipping adolescent girls and boys to develop savings practices, build their financial literacy, and learn basic entrepreneurship skills.
Timeframe	2016-2019 (29 months)

Implementers	Plan International Rwanda with partners (Government of Rwanda, UNHCR, Nike Foundation)
Coverage	Gihembe (about 12,000 residents) and Nyabiheke (about 13,000 residents) refugee camps for Congolese refugees in Rwanda.
Type of GBV	Not specified.
Evaluation methods	Mixed methods evaluation. Pre and post-test surveys, and focus group discussions. Detailed methodology not available.
Impact on GBV	The following impacts on GBV were observed at endline: • Community stakeholders, parents and adolescent girls and boys said that the level of violence in the camps had decreased and many attributed this to an increase in awareness of the rights of girls. Boys and girls also said that the education and sensitization by mentors had contributed to reduced domestic violence by fathers. • Girls and community members were of the view that the incidence of rape in the camps had reduced since the project started, and participants also noted that some men and boys no longer use drugs or alcohol and had become less violent. • Girls in both camps mentioned that there has been a reduction in boy's spending money on alcohol and drugs, substances which they felt led to violent and disrespectful behaviour. • Girls reported increased awareness of the existing reporting systems available in the camps. • However, the post-test findings did not reveal any significant change in attitudes or behaviours of boys involved in the Men Engage programming.
Other impacts	Other impacts at the end of the programme included: • 94% of participating girls could identify at least one safe space as compared to 74% at baseline. • 94% of girls in the post-test were aware of ways to prevent pregnancy and 93% could identify signs of pregnancy, representing a 19% and 28% increase from the pre-test. • According to some members of the youth savings groups, there has been a decline in the number of risky activities undertaken by adolescents outside of the camp, an increase in financial literacy and economic activity established through savings. • Improvements in girls' personal self-esteem, increased ability in making healthy decisions about their life.
Lessons learned	• One of the key lessons learned is that male mentors needed ongoing training to enhance their facilitation skills, build additional knowledge on how to break down complex and deep rooted norms of gender based violence. In addition, the Men Engage curriculum needed to be more youth friendly as younger boys found it difficult to grasp some of the content. • Parents 'buy in' is fundamental in ensuring adolescents girls participation. This can be enhanced by engaging with parents on the youth savings groups and economic enterprises in collaboration with adolescents. It was observed that the more parents learned about the Men Engage approach, the more they began to accept and support the notion that gender roles could be different within the household. • While the program showed that the establishment of the Youth Savings Groups can be undertaken in a relatively short period of time, it is recommended that 12 months of continual support and mentoring of the groups is built into the activity implementation schedule to enhance prospects of sustainability.
Further information	• Global Compact on Refugees (no year) Building Assets of Adolescent Girls in Refugee Camps in Rwanda • Marketlinks (2018) Savings Groups Empower Refugee Girls

	• Plan International (2021) Engaging girls, boys and youth as active citizens: Plan International's Position Paper (case study on p. 20)

14. Health and Empowered Youth Project (2020-2023), Rwanda	
Approach and activities	This project aims to prevent sexual violence and teenage pregnancy through activities in schools and local communities, as well as interactive radio shows to tackle stigma. Young mothers are also trained in life skills and income generation, with several receiving loans between 50,000 and 150,000 RWF. The programme is being implemented in six refugee camps in the districts of Rusizi, Nyamasheke, and Karongi. In Gihembe and Mahama refugee camps, the activities include Economic Empowerment Support to the First-Time Young Mothers (FTYM), Life Skills and Sexual and Reproductive Health Mentorship through Peer Educators, and School Health Clubs. Special focus is bring provided to Adolescents & Youth Living with Disabilities in Refugee Camps, as well as prevention and response services to GBV.
Timeframe	2020-2023
Implementers	Rwanda Biomedical Centre, Imbuto Foundation, Good Neighbors International, ALIGHT, and African Humanitarian Action. Funded by UNFPA and the Korea International Cooperation Agency (KOICA)
Coverage	Refugee camps of Mahama, Kigeme, Mugombwa, Kiziba, Nyabiheke, and their host communities in districts of Rusizi, Nyamasheke, and Karongi.
Type of GBV	Sexual violence against adolescent girls
Evaluation methods	Not evaluated (implementation still ongoing in 2023)
Impact on GBV	N/A
Other impacts	N/A
Lessons learned	N/A
Further information	• UNFPA (2021a) 'Empowering adolescents and young people to end teenage pregnancy and sexual violence in Rwanda', UNFPA News Release, 2 July 2021. • UNFPA (2021b) Empowering young people in Gihembe and Mahama refugee camps to reach their full potential, UNFPA News Release, 20 September 2021 • UNFPA Rwanda (2022) 'Renewed Hope to access education, health and economic opportunities in Nyamagabe District', UNFPA Rwanda, 31 January 2022.

15. Improving Refugees' Access to Sexual and Gender-based Violence (SGBV) Prevention and Response Services in Kigeme and Mugombwa Camps, Rwanda	
Approach and activities	The intervention focuses on SGBV prevention and response. It aimed to make refugees more aware of the negative consequences of SGBV, enhance active community involvement in SGBV prevention and response, and ensure appropriate support to SGBV survivors. The programme engaged SGBV community mobilisers in prevention as well as response activities. • **SGBV dialogues:** Community mobilisers held weekly dialogues with refugees on SGBV prevention, including on topics such as teenage pregnancy, the importance of education for

	girls, drug and alcohol abuse, and women's roles in decision-making at home and in communities. • **Male engagement:** Boys aged 12-17 joined one-day trainings focused on positive masculinities, gender roles, and the importance of male engagement in SGBV prevention. • **Mentoring and life skills for girls:** 40 women between 20-35 were trained as mentors who provided life skills sessions to adolescent girls in the two camps. This focused on illiterate and out of school girls, pregnant girls and those who are mothers, girls who are heads of households, and those who had expressed that they wanted to leave the camps to take up begging or domestic work. The sessions followed a curriculum which focused on communication skills, interpersonal relationships, family, gender roles, reproductive health and teenage pregnancy, GBV, entrepreneurship and financial management. The life skills sessions and mentoring were accompanied by income generating. • **Community-based socio-therapy:** 24 socio-therapists were trained to provide group-based training to refugees focused on connecting the individual process of psychological healing with peace building at the community level. • **Referrals and dignity kits**: 96 dignity kits were distributed to women refugee survivors of SGBV. The community mobilisers supported survivors access to services and reporting.
Timeframe	2015 – unknown. The description of the approach above is based on reporting from 2015, however, the approach appears to still be implemented as similar activities are described on UNHCR Factsheets from Rwanda as late as in June 2023.
Implementers	UNHCR with partners UN Women and Plan International
Coverage	Mugombw and Kigeme camps, Rwanda. The camps currently host about 11,000 to 15,000 refugees each.
Type of GBV	SGBV (not specified)
Evaluation methods	No evaluation.
Impact on GBV	N/A
Other impacts	N/A
Lessons learned	N/A
Further information	• CERF (2015) Resident Humanitarian Coordinator Report on the use of CERF Funds Rwanda – Underfunded Emergency Round I 2015 • UNHCR (2023) Mugombwa Refugee Camp, Rwanda – Factsheet June 2023

16. Building capacity for disability inclusion in GBV programming in humanitarian settings, Burundi	
Approach and activities	The project included three phases: • **Group discussions** with women and girls with disabilities and female caregivers to identify GBV needs and capacities, as well as barriers and facilitators to access and inclusion in activities. • **Implementation of pilot actions** to promote disability inclusion in existing GBV activities, including targeted Village Savings and Loan Associations (VSLAs) for persons with disabilities and their caregivers, community awareness raising, home visits to provide GBV case management for persons with disabilities at risk, and recruiting women with disabilities as community mobilisers.

	• **A participatory evaluation** to identify effective strategies and positive practices.
Timeframe	2013-2015
Implementers	Women's Refugee Commission (WRC) and International Rescue Committee (IRC)
Coverage	Kinama, Mussasa and Bwagiriza camps, Burundi, which are relatively small camps ranging from around 6,000-10,000 people living in each camp.
Type of GBV	Sexual violence, intimate partner violence, and sexual exploitation
Evaluation methods	Participatory evaluation, including group discussions with Congolese refugees with disabilities and their caregivers (161 participants), interview with a girl with disabilities and her caregiver (1 interview — 2 people), consultations with humanitarian actors (13 people)
Impact on GBV	• Women with disabilities felt less isolated and shared the importance of support with other survivors of violence, caregivers and others. • GBV practitioners reported increased confidence in adapting GBV programming to be more inclusive and survivor-centred for women and girls with disabilities. • Increased engagement of women with disabilities in GBV programming.
Other impacts	• Strengthened peer networks and social capital – adolescent girls reported that organised activities were a useful way to meet other girls with disabilities, share ideas, discuss their hopes. • Increased representation and participation in other community activities.
Lessons learned	• Importance of initial group discussions in understanding the needs and priorities of women with and without disabilities, and caregivers. • Need for staff training, particularly in how to communicate effectively with women with more severe difficulties in communication, or with psychosocial and intellectual disabilities.
Further information	• Clugston, N. and Fraser, E. (2022) VAWG in Burundi: Evidence Review, Violence against Women and Children Helpdesk, December 2022 • WRC and IRC (2015) Towards inclusion of refugee women with disabilities and care-givers of persons with disabilities in existing women's protection and empowerment programming provided by IRC in Burundi, Making it Work Good Practices

Annex 2: Methodology

This rapid research query has been conducted as systematically as possible, under tight time constraints (6 days researcher time). The methodology for this review involved a literature review using searches on Google and relevant electronic databases.

Search terms included: violence, violence against women, violence against children, violence against women and girls, VAWG, gender-based violence, GBV, intimate partner violence, child marriage, trafficking, sexual exploitation, sexual abuse, sexual harassment, SEA, SEAH, child abuse, physical abuse, non-partner sexual violence, rape, AND refugee camps, refugee settlements, refugee contexts, humanitarian settings, crisis settings AND evidence, systematic review, reviews, programmes, interventions, evaluation, best practice, good practice, what works, lessons learnt, AND prevention

To be eligible for inclusion in this rapid mapping, reports had to fulfil the following criteria:

- Focus: Prevention of GBV in refugee settings in SSA, with focus on (but not limited to) relatively smaller refugee camps.
- Geographic focus: Sub-Saharan Africa
- Time period: From January 2010 to present.
- Language: English

Limitations:

- Availability of evidence: There is limited documentation of the impact of different programmatic approaches on preventing GBV in refugee camps in SSA. This query only reviewed evidence that is available in the public domain, and there are likely a few examples of evaluated programmes and lessons learned that are not publicly available.
- Limited time: This report is based on a rapid mapping conducted under tight time constraints (6 days).
- Geographical/language limitations: This review looked exclusively at reports and research produced in English. There may be evidence and examples of programmes that are produced in other languages, which this review has not identified.

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