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Field Report

The role of psychosocial support in coping with incidents of gender-based violence among Rohingya refugees

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Abstract

Gender-based violence (GBV) remains a significant risk and everyday reality for Rohingya women and girls displaced in Cox's Bazar district, Bangladesh. Women and girls face challenges in securing their safety, accessing information and services and negotiating decision-making. Restrictions on movement, cultural and social norms, low literacy and numeracy and reduced community and legal protections increase women and girls' exposure to GBV. The current camp situation in combination with their experiences in Myanmar contribute to increased vulnerability to GBV. The aim of this paper is to highlight the role of psychosocial support in coping with incidents of GBV among the Rohingya refugees by exploring two particular cases. DanChurchAid (DCA) have found that useful approaches in this context have included the use of basic techniques for relaxation to help promote calmness in moments of anxiety and panic, plus reinforcement of positive coping strategies such as prayers, spending time with trusted people and engaging in productive activities (e.g., life skills training). This engagement has enabled Rohingya survivors of GBV to build relationships with other women, feel more relaxed and confident and able to respond effectively to issues affecting their lives.

Keywords: gender-based violence, survivor, women and girls, safe space, case management

INTRODUCTION

DanChurchAid's (DCA's) humanitarian intervention in Cox's Bazar, Bangladesh, began in September 2017 through partnership with a national organisation called COAST Trust providing safe spaces for women and girls, hygiene promotion, water and sanitation and non-food item distribution. The extent of the need led DCA to scale up the activities and commence direct intervention of projects in Rohingya camps in December 2017. DCA has since directly supported refugees through case management, individual and community-based psychosocial support, provision of dignity kits, education in emergencies, livelihoods and disaster risk reduction.

According to the Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (Inter Agency Standing Committee, 2015), '*gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females*' (p. 5). It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private.

GBV remains a significant risk and everyday reality for displaced Rohingya women and girls in Bangladesh. In the camps, they face additional gender-related challenges in securing their safety, accessing information and services and negotiating decision-making. Additionally, women and girls experience harassment and abuse within the camp from other community members. DCA's group discussions with refugees and individual conversations with survivors have revealed that lack of lights at night, insufficient number of toilets and security contribute to increase risks of GBV. The camp situation, combined with experiences in Myanmar and the experience of forced migration itself, contributes to an increased vulnerability to GBV for Rohingya women and girls.

DCA therefore recognises that psychosocial support interventions in GBV programming are an essential

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Submitted: 15 May 2019 **Revised:** 5 August 2019
Accepted: 6 September 2019 **Published:** 29 November 2019

Access this article online

Quick Response Code:

Website: www.interventionjournal.org

DOI: 10.4103/INTV.INTV_16_19

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How to cite this article: Shair, D. I., Akhter, K. S., & Shama, A. (2019). The role of psychosocial support in coping with incidents of gender-based violence among Rohingya refugees. *Intervention*, *17*(2), 238-242.

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complement to the services provided by other actors at the camp level in order to ensure that the needs of women and girls affected by the crisis are addressed in a holistic way. The services offered by DCA's GBV programme include both prevention and response activities. Prevention activities include capacity-building on GBV issues for other actors in the response, the installation of street lights to facilitate safe movement and the distribution of essential materials such as dignity kits and solar lanterns. The distribution of materials also acts as an entry point for women and girls to access GBV responses in a safe and less stigmatising manner. At the camp level, harassment of women and girls is addressed through community sessions, especially targeting men and boys. These sessions aim to increase knowledge about types, causes, consequences, preventive techniques and responses to GBV. This is a continuous process as monthly mapping of risks are conducted to inform prevention strategies.

DCA also offers services through Women and Girls Safe Spaces (WGSS) which are designed only for women, where any female over the age of ten can come and participate in activities or request specific services. Different types of relaxation techniques are included in the WGSS programme that help women and girls to cope with daily challenges. Also, there are learning sessions aimed at improving life skills (e.g., problem solving, stress management, confidence building, leadership), numeracy and literacy and skills necessary for earning a livelihood (e.g., tailoring, handicrafts, community garden). Besides these, recreational and creative activities provide opportunities for women and girls to come and work together as a team.

GBV case management services are also provided at the WGSS. Case management is a structured method for providing help to a survivor. It involves a case worker taking responsibility for making sure that issues and problems facing a survivor are identified, that survivors are informed about all the options available to them and that they are supported to make a decision, which is then followed up in a coordinated way (Inter-Agency Standing Committee, 2017). Sometimes referral systems to other agencies or actors are activated to provide additional support where the interventions provided by the case worker are not sufficient. A small number of women require professional support from trained professionals, such as psychologists, who can provide more advanced mental health interventions.

This paper aims to highlight the ways in which DCA's integration of psychosocial support into GBV programme in the Rohingya refugee context has contributed to the recovery of GBV survivors. Through two case studies, we will explore the types of psychosocial response which have been found to be particularly beneficial in terms of strengthening the wellbeing, resilience and coping strategies of female Rohingya survivors of GBV.

DESIGN, METHODOLOGY AND APPROACH

The information reported here was gathered through both focus group discussions with women and individual interviews with survivors of violence. Such information-gathering exercises are conducted on a regular basis to inform the development of DCA programme; the data was not collected purely for research purposes.

Twelve focus group discussions were conducted with women and girls in six safe spaces in order to understand the dynamics of violence and how best DCA can engage women and girls in sharing information and awareness to others who are unable to visit the spaces due to restrictive cultural practices which deny women and girls an opportunity to move freely. Following these discussions, five persons volunteered to participate in follow-up individual interviews to understand more about how the integration of PSS approaches into the GBV programmes contributed to their wellbeing as an individual and community. The stories of two of these women are reported in this paper.

The follow-up interviews were conducted by case workers who the women were already familiar with, in a private room in the WGSS. At the beginning of the interview, participants were briefed about the purpose of the interview. It was made clear that their participation was voluntary and they could decline to answer any question or terminate the interview at any point. Interviewees gave verbal consent to participate and signed a consent form to release their stories anonymously. A semi-structured questionnaire was used to conduct the interview which included questions on the following: their experiences of violence in Myanmar and in camps; the effects of those experiences on their emotional and social wellbeing; their coping strategies at the time of the violence and at later times; the support they received from DCA and their reflections on this; the reactions and roles of the community that influenced their condition; and their current status in terms of wellbeing. The questions were asked and answered in the Rohingya language and later translated into English. To enhance confidentiality, no recording devices were used and notes written of the interview were stored securely.

To avoid re-traumatisation, the interviews were conducted by case workers who were already working with the women who could provide emotional and practical support where necessary. Following each interview, discussions were held about further support required and the options available.

CASE TYPE 1: SEXUAL ASSAULT

Fatema (pseudonym) is a 30-year-old Rohingya refugee woman. She came to seek refuge in Bangladesh in August 2017 and has been living in the camps for the last 20 months. Like many other Rohingya refugees, she has witnessed gruesome violence perpetrated against her loved ones. Also, like many other women and girls who fled from their home country to seek refuge, she has been a survivor of GBV herself. Even though these incidents affected her greatly, she agreed to share her story with the world as a way of encouraging other GBV survivors to give hope and motivate others that through support from family and community recovery is possible.

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When the attacks against the Rohingyas began in Myanmar, Fatema's husband was abducted by the armed forces and she could not trace him anywhere. As the situation grew more fearful, she decided to flee the country for the safety of herself and her two children. The only way to reach Bangladesh safely was to cross the border river using a boat made of plastic bottles. This was the common way by which many refugees crossed. On her way, not only did she witness people from her community being killed in front of her, dead bodies lying on the ground near her home and people floating on the river, but she also lost her young son.

The loss of such a young child left her unable to move. But the thought of her other child being taken to safety gave her the strength to continue her journey. It took them two weeks to reach Bangladesh. As she arrived, she lost the child in the crowd. She spent hours looking for her child and came across a driver who offered to help her. The driver took her into his vehicle and after driving for a while, three other men got into the vehicle. These men and the driver took the woman to a place far away where not a single person could be seen. Fatema understood what was going to happen to her and started to beg them to release her. But her plea did not have any effect on them. The men took turns and raped her several times inside the vehicle. They showed no mercy, took her jewellery and left her there.

Even though she was bleeding severely, she was unable to sense the pain. Her body was psychologically numbed to the physical pain. The only thought that kept her in her senses was to find her child at any cost. She could barely move, so she kept praying and begging to God to reunite her with her lost child. This spiritual connection gave her the strength to remain conscious. Eventually, some other refugees came across her and took her to safety. She got a shelter of her own, but remained extremely distressed. She felt unable to travel in any kind of vehicle and had a hard time trusting anyone.

Fatema, like many GBV survivors, had a variety of psychosocial needs. If these are considered within the framework of the MHPSS intervention pyramid (Inter-Agency Standing Committee, 2007), her status as a single woman within the camp left her particularly vulnerable in terms of meeting her basic needs (food, shelter, medical care) in ways which did not expose her to further risk of harm. A number of agencies were responsible for providing these services and DCA advocated with them to ensure that Fatema was able to access them safely.

Fatema was not only isolated, but was finding it difficult to build relationships due to the emotional and psychological effects of her experiences. The DCA WGSS was designed to address exactly this issue. WGSSs address both the second level of the MHPSS pyramid, through enabling women to build relationships with each other, and often provide level 3 services (focused, non-specialised supports) as well as referrals for specialised services (level 4) where necessary. Fatema learned from volunteers and outreach teams that there were people in the DCA WGSS who would listen to her and try to help her to cope. She came to talk to one of the GBV case workers and with time and patience she was able to share her story and the incidents of violence that were perpetrated against her and her family.

Though she shared that her son was lost, there was need to activate the community and family support through tracing and reunification with other actors which was successful as the child was found in one of the relatives' houses.

Fatema continued to receive emotional support from the facilitator and then received individual counselling from a psychosocial counsellor within the WGSS. Individual counselling opened a door for her where she found a trusted person to share her feelings with. She was also referred to medical services for her physical health care needs.

As part of psychosocial support (PSS), she started attending relaxation sessions inside the WGSS that helped her to acquire some basic techniques to calm herself in moments of anxiety and panic. She was also supported to identify some of her existing positive coping mechanisms to deal with her past and present challenges. Strategies she found helpful included praying, spending time with trusted people and involving herself in productive activities. DCA also, with Fatema's permission, included close family members and support system in sessions on the effects of GBV and the key roles they could play in supporting Fatema's holistic healing. Relevant issues included how to prevent stigmatisation, how to provide effective emotional support and the importance of just being physically present whenever needed.

Fatema also participated in these awareness sessions on GBV and started taking life skill lessons focused on issues including stress management and communication skills. Her regular participation in these PSS activities, including support groups, plus the ongoing follow-up from her case manager, has contributed significantly to her recovery. Fatema mentioned her progress herself. She said that she previously found it difficult to talk to other women in the centre, but is now more relaxed, comfortable and confident in talking to other people. This ease in communication represents significant progress from her previous state of being unable to trust others enough to build relationships with people in her community and to reach out to them for help.

CASE TYPE 2: PSYCHOLOGICAL VIOLENCE

This case study describes a situation in which both sexual and psychological violence occurred. Nuri (pseudonym), a 21-year-old woman, used to live with her big family of 17 in Myanmar. When many Muslims all over the world were celebrating one of their biggest festivals, Eid-Ul-Adha, the Rohingya people of Rakhine state were praying for their lives.

Just after the festival, Nuri and her family started to hear gunshots. As the armed groups started to approach their

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homes, they turned the lights off to hide. They passed the night in terror. When dawn came, her brother went out to pray in the local mosque. He was captured outside the house on his way to the mosque. His hands were chopped off and later his throat was slit. The whole family witnessed the event and cried in silence. The story of the incident spread and the people of the village started to flee. Nuri's family did the same. They first spent two days hiding in the jungle and later took shelter in a relative's house. Soon the armed group arrived at this house and started to call people out of the house. The group threatened to burn the house down if anyone remained inside the house. The owner of the house was forced to bring people out of the house. As people come out, the attackers started to separate men and women. They tied all the men by their hands and feet. This was the last time Nuri saw her husband alive. She is unable to recall fully the events of the night, including exactly how her husband was killed; this form of disrupted memory is not unusual following extremely distressing events (Loftus, 1993). Her mind chose to block this traumatic memory.

Right after these women witnessed the murders of their loved ones, the attackers snatched their jewellery. In the name of searching, the group of men started to touch the women inappropriately. Nuri, the mother of a small baby and pregnant with another child, lost the ability to think. She thought that dying would be better for her. She felt lonely and afraid. She gave up the hope of seeing another day. But the face of her baby gave her the strength to stand up and get to safety. The thought of taking her baby, her unborn child and herself to safety gave her the determination to continue her journey to Bangladesh.

She found safety for herself and her children in Bangladesh, but did not find the peace that she was seeking. She had started to come to the DCA WGSS regularly, but men of the community did not approve of her moving around the camp on her own, especially for a widow who had no male family member to accompany her. They started following her, harassing her and did not miss an opportunity to discourage her from coming to the WGSS. They threatened her to ban her from the community if she kept moving around without a burqa and umbrella. All of these incidents - the loss of her husband, concern about the wellbeing of her new-born baby and the health of her other child, adapting to a new environment and the general safety concerns in the camp - accumulated, increasing her stress. She started to feel more and more disturbed every day. She started to use prayer and visiting other relatives as coping mechanisms, but always felt there was something holding her back. She came to the conclusion that the inability to share her 'thousands of thoughts and sorrows' with someone had started to affect her mental health.

Inside the WGSS, she learned that there were female case workers trained to deal with such cases. She started seeing the case worker and shared her story. At the initial period of the conversation, the caseworker found her to be withdrawn, unable to concentrate and deprived of sleep. The empathy and the unconditional positive regard, coupled with a client-centred approach, gave Nuri great comfort. The case worker planned different types of PSS activities for Nuri. She was referred for individual counselling where she was encouraged to continue with her existing coping mechanisms. She started to practise relaxation techniques like deep breathing and visualisation. Nuri thinks that these techniques helped her calm herself in moments of anxiety. She also got involved in sessions which focused on understanding and handling her emotions, building self-esteem and confidence and stress management. These sessions helped Nuri to function in her daily life in spite of the presence of countless stressors in a dynamic humanitarian environment. She found her involvement in recreational activities like pillow passing games as opportunities to enjoy her time with other women. Nuri has been taking lessons to learn tailoring and making handicrafts, so that she can use this skill one day to earn money.

Nuri believes that these activities have helped her to plan a better life for herself and her children. She is determined that she is now able to make her own decisions and take care of herself and children in times of need. Now, she is more comfortable to develop a closer and healthier relationship with other people in the community. She believes that maintaining a channel of communication with the community, even if they have different perspectives, can help her to have a comparatively secure life in the camp. She not only has a positive outlook towards her life, but has started to imagine hopeful lives for her children as well.

SURVIVORS' PERCEPTIONS OF CASE MANAGEMENT SERVICES

In June 2019, DCA conducted a satisfaction survey to evaluate the services offered to survivors affected by GBV and to assess their level of satisfaction. The aim of the survey was to enable DCA to improve their own services to better meet the needs of survivors and to identify areas in which the capacity of partner organisations can be strengthened. The '*survivor satisfaction*' form is completed through an interview with the survivor, child survivor and his/her caregiver if appropriate. With the permission of the survivor, a caseworker/caseworker's supervisor conducted each interview.

Of the cases which had been completed (closed), 71% were very satisfied with the case management services received, and particularly appreciated speedy referrals to other actors, such as health, shelter, legal support and security. Respondents liked that caseworkers accompanied them to different service-providers as it gave them more confidence, and sped up processes. The case management service was also found to have the effect of encouraging survivors to visit WGSSs more often, so they were able to benefit from a wider range of support. The main source of dissatisfaction was the length of time involved in the case management process, plus the absence of formal legal systems and security services.

CONCLUSION

The Rohingya population is distinct from other displaced populations due to their oppression before their 2017 displacement, which included being denied citizenship

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under the 1982 Myanmar nationality law. Reports of mass killing were extremely disturbing (Human Rights Watch, 2013). My observation is that their history and recent experiences in Myanmar have reduced their trust in authorities and systems and they continue to find it difficult to trust those who provide services in the camp.

This is especially true of GBV survivors, since GBV was not an issue which was acknowledged or discussed among the Rohingya population in Myanmar, and there is still considerable stigma associated with the experience. This applies to those who experienced GBV in Myanmar, those who were abused during their flight and those who experience harassment and abuse within the camp. In our experience, GBV survivors living in the camp find it extremely difficult to open up to anybody. This requires DCA to focus more on building relationships with women in the Rohingya community, developing trust and providing services which are open to all women. Through appropriate, need-based programming, DCA hopes that those who have experienced GBV will feel able to disclose their experiences and seek and help.

Within DCA, we have found PSS to be a crucial element of a coordinated GBV response. Through psychosocial and mental health support, survivors are empowered to regain proper functionality and enhance healthy re-integration and inclusion into the community. It should be noted that GBV survivors may present differently at different times of the intervention continuum, based on different features of their experience and of the intervention itself. It is important therefore that a range of different PSS approaches and mental health treatment modes are available for use by competent staff.

As demonstrated in the case studies, the combination of a community-based approach and individualised approach to prevention and response of GBV issues in the community results in more holistic healing. It is well recognised that all actors responding to humanitarian crises should engage affected communities in the healing processes (Inter-Agency Standing Committee, 2007), since strong social relationships form a crucial part of recovery from distressing events (Hobfoll et al., 2007). One way of doing this is by creating or strengthening available community structures which can act as networks of support for survivors. This can be facilitated by humanitarian response agencies and other state actors designing services that put all those affected by crisis at the centre of their response activities. As first responders, community members must be involved through voluntary active and structured participation including project conception design, implementation, monitoring and exit strategies.

Any organisation implementing a project in the community and with the community must be aware of the community's presence and possible influence during implementation. The influence could be motivated by different socio-economic, political and even cultural dynamics at play at any given time in the implementing environmental landscape. For example, a political change could almost immediately have a very significant change on policy issues that touch on human rights and protection for an implementing partner (e.g., the denial of citizenship rights of the Rohingya population passed as law). The community dynamics and other factors that can influence successful implementation requires structured continuous re-evaluation (even at small levels) to be built into the project cycle.

The wellbeing of Rohingya women and girls must be prioritised to protect their dignity and promote recovery from GBV experiences. PSS activities which can contribute to this include individual counselling/emotional support sessions, art therapy sessions for young girls and women, all staff and volunteers employing unconditional positive regard towards the women and girls they work with, emotional support groups, recreational activities such as decoration, gardening, sewing and embroidery, educational sessions (literacy classes, awareness and psychoeducation sessions) and life skills sessions. The provision of these at WGSSs, which are open to all women, ensures that services are provided in a non-stigmatising way. Interventions are tailored based on the needs of the individual survivors, while strengthening community and family support systems. Responding to the needs of the GBV survivors must aim to balance individual support in response to GBV with prevention activities to address root causes and contributing factors, aiming to reduce harassment and GBV within the community.

Financial support and sponsorship

DCA recognises the contribution of all donors (DANIDA, UNICEF, Ministry of Finance Affairs of Finland and Finn Church Aid) supporting provision of services to GBV survivors in the Rohingya Humanitarian Response.

Conflicts of interest

There are no conflicts of interest.

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