Security challenges
NAIROBI
Thomas Tsoungui, UNHCR Regional Service Center, Nairobi
Nairobi Headquarters of UNEP and UNHABITAT

➢ Nairobi is home to 51 UN AFP’s and the UNON.
➢ With 1394 international staff members ..............
➢ 2010 national staff members ..............................
➢ 8002 family members ......................................
## General Threat Assessment SRM 6

### Nairobi: Security Level: Moderate

<table>
<thead>
<tr>
<th>Category</th>
<th>Threat Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armed Conflict</td>
<td>Minimal</td>
</tr>
<tr>
<td>Terrorism</td>
<td>Substantial</td>
</tr>
<tr>
<td>Crime</td>
<td>Substantial</td>
</tr>
<tr>
<td>Civil Unrest</td>
<td>Substantial</td>
</tr>
<tr>
<td>Hazards</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
One of the challenges for UN in NRB is Crime.

Robberies, Burglary, Carjacking, Thefts: UN staff have been affected in the past.

- Steady increase of use of force to subdue victims—(firearms/weapons)
- Majority of carjacking take place late hours,

- Use of Taxis—advice to use UN recommended companies(JIM cab, PEWIN, etc.)
Assailants interested with Money/ATM Cards, wallets, Computers, phones, jewelry; watches.

Or use Victim’s Car as a get away or to target the next victim.

UN/Diplomatic staff perceived to have money and likely to be targeted.
Increased Robbery Threat in Nairobi CBD

A sharp increase in street robberies has been reported in the Nairobi CBD area. Targets are often injured if they resist, while phones, jewelry, handbags and laptops are taken. These incidents have occurred openly during the day and after dark.
Terrorism

- Terrorism is a threat in Kenya/Nairobi.

- Since West gate mall attack in 2013, Al Shabaab has planned and carried out complex attacks in Garissa and Nairobi.

- Targets – Soft targets, Social places, Places of worship, Malls, Police stations etc.

- **Assessment:** AS still retains Capability and Intent to launch attacks on SOFT Targets in Nairobi, coastal & other counties.
Civil Disturbance:

- Civil demonstrations are common in Nairobi. Whether organized or spontaneous there is always the potential for escalation into violent confrontations.

- Students, Workers, Hawkers, Civil/political societies
Hazards:

- The Most significant Hazards are Road Traffic Accidents
- Cholera outbreak
WHO TO CALL IN CASE OF AN EMERGENCY

Primary: UN Security Control Room Gigiri 24/7
Mobile: +254 (0) 720 629 999
Mobile: +254 (0) 733 629 999

Back-up: UNHCR Branch Office Nairobi
Mobile: +254 (0) 728 602 555

Thomas Snr FSA: +254 734 333 180
Current approved companies as per the Travel Security Information for Nairobi:

- Pewin Cabs, Tel: 0727-776 761
- Jatco Taxis, Tel: 0725-280 000
- Jim Cab Services, Tel: 0735-555 559
- Apollo Tours Ltd, Tel: 0723-794 249
- Amicabre Travels Ltd, Tel: 0710-760 055
The Global Compact on Refugees (GCR)
CRRF

Celine Mersch, RRC, UNHCR
New York Declaration for Refugees and Migrants
Adopted by all 193 UN Member States on 19 September 2016

“\ We acknowledge a shared international responsibility to manage large movements of refugees and migrants in a humane, sensitive, compassionate and people-centred manner.”

[para 11]
The New York Declaration calls upon **UNHCR to develop and initiate** the application of the Comprehensive Refugee Response Framework (CRRF).

The objectives are to:

1. **Ease pressure** on host countries
2. Enhance **refugee self-reliance**
3. Expand access to **third-country solutions**
4. **Support conditions** in countries of origin for safe and dignified return
The CRRF – what is new?

• A systematic “whole of society” approach, involving a broad range of actors and new partnerships.
• Sustainable and predictable responses, including early engagement of development actors.
• Investment of private sector, and innovative approaches in the way we respond to refugee movements.
• Long-term planning for solutions, and early engagement of development actors at the outset of refugee movements.
• Governments are in the lead, and UNHCR’S role as catalyst to develop and initiate comprehensive responses in specific situations
• Greater inclusion of refugees in the communities that host them.
Roll-out of CRRF

Detailed information is available at the CRRF Global Digital Portal: www.globalcrrf.org
Support to CRRF

➢ Development donors have mobilized more than **USD 6.5 billion** in support of the objectives of the CRRF over a multi-year period, excluding humanitarian aid

➢ **World Bank**: USD 2 billion under IDA18 sub-window + GCFF

➢ **Bilateral development donors** (EU, GER, UK, SWE, DNK, JPN, KOR, NDL, CAN, ESP) self-reported an investment of more than USD1 billion in development contributions to CRRF roll-out countries in support of comprehensive responses over a multi-year period.

➢ In addition, USD 3.5 billion for CRRF-alike situations (e.g. Syria Situation)
**Examples of progress by sector (1)**

<table>
<thead>
<tr>
<th>Laws</th>
<th>Education</th>
<th>Health</th>
</tr>
</thead>
</table>
| • Djibouti: access “on par with nationals” - to rights and services (bank accounts) | Kenya, Rwanda: access to national schools  
Rwanda: employment of teachers  
South Sudan, Uganda, Kenya: national education plans  
Djibouti Declaration | • Uganda: MoH leads service delivery central/district levels; Nat. Integrated Health Response Plan  
• Rwanda, Kenya: Inclusion into national health insurance  
• South Sudan: Hosts accessing more comprehensive care incamps |
| | | |
Examples of progress by sector (2)

- **Regional**: EAC statement of CP good practices
- District Child Officers/government **social workers** handle individual cases of refugee children (Kenya, Uganda, Tanzania)
- **Guidelines** for Alternative Family Care of Children includes specific chapter on refugee children (Kenya)
- New **social work curriculum** to include refugee children (Rwanda, Tanzania)

- **Uganda**: refugees’ access to land and mobility led to improved refugees’ and host communities’ livelihoods and increased investments by international community
- **Rwanda**: joint strategy for Economic Inclusion of Refugees
- **Ethiopia** Economic Opportunities creating opportunities for 100,000 people, of which 30% will be for refugees with funding support from international community
The Global Compact on Refugees (GCR)

• Global Mechanism for international cooperation: **Global Refugee Forum**
• Mechanisms to support a comprehensive response in specific situations: national arrangement, comprehensive plan, support platform, regional and sub-regional approaches
• Areas in **need of support**:
  – Reception and admission (e.g. early warning, preparedness and contingency planning; safety and security; registration and documentation)
  – Meeting needs and supporting communities (e.g. education, livelihoods, health, fostering good relations and peaceful coexistence)
  – Solutions (voluntary repatriation, resettlement, complementary pathways, local integration, other local solutions)
Thank you

http://www.globalcrrf.org
An introduction to the Africa Regional SGBV Network

1st UNHCR-Population Council Joint Regional Workshop
Sauti/VOICE Project

Chi-Chi Undie
March 4-8, 2019
Nairobi, Kenya
The Africa Regional SGBV Network

**net-work**

ˈnet, wɜːrk/

• ‘A group of people or organizations that are closely connected and that work with each other.’

• ‘A group of people who exchange information, contacts, and experience for professional ... purposes.’
What it is

- Made up of SGBV-focused service delivery organizations (‘Network partners’)
- Previously focused on East and Southern Africa – now includes the Horn of Africa, too
- Working together to respond SGBV on a regional level in health facilities, schools, police stations, communities, policy
- A platform for learning, exchange, and strategic dissemination
Why it came about

- In response to the lack of response interventions
- Has since incorporated prevention interventions
What it does
(The ‘network approach’)

• Technical assistance for SGBV interventions
  – Design
  – Implementation monitoring
  – Evaluation and documentation
  – Strategic dissemination
  – Capacity-building
    • For intervention implementation and evaluation
      – Strategic convenings
      – Partner meetings
      – Partner learning/exchange activities
Where it has worked

(PHASES I to III: 2006-2018)

- Ethiopia
- Kenya
- Malawi
- Rwanda
- Senegal
- South Africa
- Swaziland
- Uganda
- Zambia
- Zimbabwe
What it’s doing now

Sauti/VOICE Project
(PHASE IV: 2018-2020)

✓ Focusing exclusively on refugee settings

✓ Moving more tested SGBV interventions into refugee settings

✓ Expanding the network to encompass refugee settings

✓ Applying the ‘network approach’ within refugee settings
The ‘Sauti’/VOICE Project:

Vio-
Olence Response and Prevention through
Information
Communication, and
Evidence
Sauti/VOICE Project Objectives

- Foster a regional response to SGBV in humanitarian settings by harnessing the resources of the Africa Regional SGBV Network
- Amplify the voices of implementing partners in humanitarian settings by showcasing their evidence-based approaches
- Inform SGBV programming and policy in humanitarian settings
UNHCR countries under the Sauti/VOICE project

(PHASES I to III: 2006-2018)

- Djibouti
- Ethiopia
- Rwanda
- South Sudan
- Sudan
- Tanzania
- Uganda
- Zambia
Workshop Objectives

• Introduce participants to a selection of tested SGBV interventions
• Give participants a chance to deliberate on the available interventions that would best meet some of their needs, given their available resources
• Foster coalition-building among participants
• Provide a platform for initial training in the chosen interventions (‘Training of Trainers’)
• Provide a platform for mapping out next steps under the VOICE project (TA, monitoring, learning visits, etc.)
‘Overview of Selected Interventions’ Session: What to pay attention to

- Well ... everything!
  - Intervention rationale
  - Intervention components
  - Type of professionals/IPs required for intervention implementation
  - Type of representation present in this room for your country (for subsequent in-country training, or for implementation)
A word about the selected interventions

- Prevention
  - Fewer models
  - Less of an evidence-base

- Response
  - What's been tested
  - What works
  - Not a competition

mutually inclusive!
Thank you
THE ZERO TOLERANCE
VILLAGE ALLIANCE

Fiona Nicholson
1st UNHCR-Population Council Joint Regional Workshop
Sauti/VOICE Project
Nairobi, Kenya
4.3.19
The Challenge:

Widespread SGBV, and evidence that rights-based campaigning, has a negligible impact on behaviour. Reasons identified as being primarily the fear of social and cultural censure exacerbated by a lack of “agency”.

The Solution:

Bring the entire village on board! Make it socially unacceptable to abuse women and children. Revive the spirit of “ubuntu”!
The ZTVA is a community-based *SGBV prevention* model that draws on *Achievement Motivation Theory* and *Labelling Theory*

**Achievement Motivation** (criteria that the village **must** meet):
- Thematic dialogues to reach a broad cross-section (±20%) of the community
- Over-arching all teaching is the principle of “Active Citizenry”
- Dialogues facilitated by Community Activists, drawn from the community, then trained
- Dissemination of info leaflets, promoting “each one teach two” movement
- Stakeholder Forum / Service Provider dialogues to clarify legitimate entitlements;
- Establishment of a “safe house” to provide immediate but temporary safety

*When the criteria have been met*, the village is welcomed into the Alliance at an Award Ceremony at which men, led by the Chief and before a Magistrate.

**Labelling:**
- Take a public pledge of intolerance towards violence and stigma
- Receive a “badge of honour”
- Sign a “roll of honour” honour from which they can be removed if pledge is breached.
EFFECTIVENESS OF ZTVA:
In Rwamwanja Settlement, Uganda, the intervention reduced the occurrence of:

- Physical intimate partner violence (IPV) for women (from 69% to 38%) and men (from 6% to 2%)
- Sexual IPV for men (from 4% to 0%)
- Non-partner physical violence in the last one month for women (from 12% to 4%) and for men (from 34% to 6%)
- Non-partner sexual violence in the last one month for women (from 13% to 5%)

OF NOTE:
*Community ownership* is crucial to the sustainability of the intervention; from onset it must be managed by a Stakeholder Forum elected by the community, with the NGO providing TA only.
SUBSEQUENT TO TESTING IN 2012 (South Africa) and 2016 (Uganda) BY THE POPULATION COUNCIL:

- 6 villages are now members of the ZTVA in South Africa
- 6 CBOs in South Africa and one in Uganda have been trained on the ZTVA model
- ZTVA was adapted for refugee settings in Uganda and has since been implemented in 11 villages by UNHCR and its partners
- A spin-off to the ZTVA, i.e. the Zero Tolerance School Alliance, has been by PopC, and rolled out by TVEP in 10 more schools, funded by Nelson Mandela Children’s Fund, the EU, and Action Aid
THANK YOU FOR LISTENING…

Fiona Nicholson
SGBV & CBO Mentoring Specialist
Enhancing children’s access to comprehensive post-rape care services in Kenya

Anne N4th March 2019
LVCT Health

Our Vision

• Healthy Societies

Our Mission

• To use research, capacity improvement and policy reform actions for equitable HIV, sexual and reproductive health services to reach the most vulnerable

Our work

• GBV and SRH services
• HIV testing and counseling
• HIV prevention
• HIV care & treatment

• Strengthening health systems for services delivery
• Policy and advocacy
Who we target

- Survivors of sexual violence
- PLHIV
- MSM/SW
- Young women and girls
- Adolescents
Our Approach

LVCT’s Hatua model

- **EVIDENCE TO ACT**
  - research
  - evaluation
  - piloting

- **PLATFORMS TO ACT**
  - policy reforms
  - systems strengthening
  - civil society & partner advocacy

- **FIELD OF ACTION**
  - service delivery
  - mobilization
  - client satisfaction
INTERVENTION ONE:
Improving the Collection, Documentation, and Utilization of Medico-Legal Evidence

Presented by Michael Gaitho
Situation before intervention

- Lack of effective mechanism for handling forensic evidence
- Lack of equipment and tools for documentation of medicolegal evidence
- Little attention for examination and documentation of SV
- Limited multisectoral effort
Our Intervention Model

- Capacity building of police on national protocols for documenting obtained evidence
- Capacity building of HCP on existing national protocols on collection and handling of evidence
- Developing a locally-assembled rape kit
- Data review of hospital and police records on sexual violence survivors

Improving collection, documentation, utilization
Program outcomes

• Evidence collection: Improvement in intervention site where health care providers (HCP) were trained on need and importance of correct forensic evidence collection procedures, and were issued with locally-assembled rape kits

• Joint training of police and HCPs on documentation improved utilisation of post-rape care & police medical examination forms

• Evidence collection at a centralised location reduces survivor trauma
Current use of the intervention

- Rape-kit developed as part of this intervention is the only kind available in Kenyan govt health facilities

- Kenya’s National guidelines now include:
  - Chapter on forensic evidence management
  - IECs developed under this intervention
  - Rape kit content list

- Multi-sectoral training approach (for health providers and police) adapted by Kenya’s Sexual Offences Implementation Taskforce
INTERVENTION TWO:

CASE MANAGEMENT MODEL FOR CHILD SURVIVORS OF VIOLENCE

Presented by: Anne Ngunjiri
Rationale

Kenya’s health care system was not designed to meet the needs of the largest proportion of SV service-seekers: children below age 18.

- Fragmented PRC services
- Health providers not equipped
- Timely care not sought
- No SOPs to guide service delivery
Our Intervention Model

- **Capacity building of HSP**
- **HSP debriefing and supervision**
- **Case management approach to pediatric PRC**
- **Development and implementation of SOPs**

Optimal PRC Service delivery
Case Management Approach

- Roles and responsibilities
- Skills and knowledge
- Capacity Building
- Recruitment and remuneration
- Case Advocate Support
Program outcomes

- Case advocates were appreciated by caregivers, survivors and health care workers due to the following benefits:
  - Fast tracking children’s access to PRC and other services
  - Easing the movement of children and caregivers within health facility
  - Assisting children and caregivers to communicate with health service providers
  - Improving timeliness and completeness of services offered by the health care providers
Current use of the intervention

- Case management model adopted by one County Hospital in Kenya
THANK YOU

www.lvcthealth.org
Micheal.Gaitho@lvcthealth.org
Anne.Ngunjiri@lvcthealth.org
Screening for SGBV in health facility contexts in Nairobi, Kenya

Margaret Mak’anyengo, Kenyatta National Hospital
Chi-Chi Undie, Population Council
1st UNHCR-Population Council Joint Regional Workshop
Sauti/VOICE Project
Gender-Based Violence Recovery Centre (GBVRC)  
Kenyatta National Hospital

Mission: To provide comprehensive, accessible, quality care to survivors; enhance advocacy; provide training and research; and participate in national planning and policy in relation to SGBV issues

- Teaching, referral, research
- National planning & policy formulation in health
- Established GBV Centre of Excellence in 2008
- Over 10,000 GBV cases attended to
Intervention Rationale

✓ High prevalence of SGBV
✓ Low reporting by survivors
✓ Hidden population of survivors in health facilities
✓ Survivors often want to be asked, often want care
✓ Linkages between SGBV and other health issues
✓ Proliferation of One-Stop Centers in the region – often vacant, though
Intervention description

✓ 1-day provider training session to screen for SGBV, using tool
  ▪ Current exposure to physical, psychological, sexual IPV and life-time exposure to non-partner sexual violence

✓ Routine screening of clients

✓ ‘Warm’ referral of survivors to One-Stop Response Center for SGBV care
Findings

- Improves survivor detection rates
- Increases uptake of SGBV services
- Survivor- and provider- ‘approved’
Current use of the intervention

- ECSA-HC Health Ministers’ Resolution on SGBV screening (2012)
- ECSA-HC training manual on SGBV screening
- Institutionalization of the intervention at KNH, and in humanitarian settings
- Successful adaptation of the intervention to meet the needs of child survivors in school and health facilities
- Adoption of child screening tool by Kenya MoH for use in public health facilities (in process)
Thank you
The ‘Tree of Life’ Approach to Psychosocial Support

Divina James and Felix Jeronimo

1st UNHCR-Population Council
Joint Regional Workshop
Sauti/VOICE Project
4th March, 2019
About REPSSI

- Regional Organization
- Working mainly in East and Southern Africa (+beyond)
- Technical Advisor to SADC on Psychosocial Support
- REPSSI is also the secretariat for RIATT-ESA – the most effective regional advocacy platform for children and HIV in the region
- REPSSI to influence policies and guidelines in the region
About REPSSI Cont’d

Our vision: All girls, boys and youth enjoy psychosocial and mental wellbeing.

Our theory of change is that the psychosocial and mental wellbeing of girls, boys and youth, and specifically their hope, dignity and happiness, are dependent upon nurturing, resilient families and communities.

_Psychosocial support is a critical enabler for health, education, social and development outcomes_
About REPSSI Cont’d

Working on evidence based tools and advocacy, REPSSI provides:

- Tools
- Training and courses
- Research
- Monitoring and Evaluation
- Influencing the inclusion of PSS in National policies and guidelines
- Partnerships
The ‘Tree of Life’ (TOL) as a Psychosocial Support Tool

- TOL enables individuals to tell the story of their lives in a way that makes them stronger and hopeful about the future.

- Based on narrative practices and is a narrative therapy tool.

- Uses the tree as a metaphor to represent different aspects of our lives.

- Opens space and opportunities to tell, hear and explore stories of hope, shared values, and connections to those around the individual – both alive and deceased.

- Tool designed for children age 5 to 20 years, but is relevant to adults when adapted to demonstrate their connectedness to other people in their lives.
Intervention Description

- Participants (can be non-specialized staff) receive training over a 3-day period.
- The training builds capacity of participants to use Narrative Therapy, which views problems as separate from people, and assumes that people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives.
- Survivors are given the tools to ‘re-tell’ or ‘re-author’ their stories, using the parts of a tree as an analogy to tell the story of one’s life, in a way that they want it to be heard.
- The TOL-guided counselling can be offered to survivors as a group, or as individuals.
- The intervention strengthens survivors’ coping skills and psychological well-being.
Uptake of ‘Tree of Life’ Approach

- Currently being used in refugee settings to respond to psychosocial needs of SGBV survivors (UNHCR Rwanda and its implementing partners)
- Currently being used at the Gender-Based Violence Recovery Centre (Kenyatta National Hospital, Kenya) for psychosocial response
- Currently being considered for national uptake by the Kenya Ministry of Health as a psychosocial response to child survivors of sexual violence
Find us on social Media

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https://twitter.com/REPSSI

https://www.youtube.com/user/ChannelREPSSI

https://www.linkedin.com/company/repssi

https://www.instagram.com/reppsimedia/
THANK YOU
METHODOLOGY FOR ZTVA IN RWAMWANJWA REFUGEE SETTLEMENT, UGANDA

Mildred Ouma, UNHCR Uganda

Presentation made at the 1st UNHCR-Population Council Joint Regional Workshop
4 March 2019 at Trademark Hotel Nairobi
Overview of Zero Tolerance Village Alliance (ZTVA) methodology

• Methodology has been implemented in Rwamwanja in 11/45 villages since 2015.
• Implemented in a specific village aiming to reach all the villagers by forming and training different community groups and individuals.
• A group is selected and trained who then become Community Activists and also train another 480 members over a course of six-months with messages on gender norm changes.
• The activities are coordinated by the Stakeholders Forum consisting of village leaders from different groups and areas.
• At the end, an oath taking ceremony takes place with the trained members promising to help combat SGBV.
• The strength of the methodology lies on its focus to changing the community behavior. The sensitization is intensive, coordinated and community driven.
• Even though there is lack of recent data on its effectiveness, very positive responses have been received from the community and other stakeholders.
Process of formation of ZTVA Model

- The selection of the village is based on analysis of SGBV trends in the settlement obtained through KAP surveys and GBV IMS Data and is preceded by a meeting with Government (OPM), and UNHCR to discuss the selected village.

- A meeting is then held with selected village/ leaders during which a stakeholders forum comprised of various community leaders totalling 30-40 male and female is formed.

- The stakeholders forum, facilitated by LWF selects the community liaison Officer to lead the implementation in the village and is answerable to LWF and the community.

- A community mapping of the village is then done to include all assets considered essential to the successful implementation of the model. The mapping and timelines are endorsed by the Stakeholder Forum and provide details of specific target areas and the total number of people to be trained/engaged.

- Community workshops and meetings then follow over a course of implementation.
Pledge-taking ceremony & awarding of ZTVA membership

• When all the activities are complete, a public function is held where the trainees take a public pledge and sign a roll of honor to proactively address the eradication of gender-and child-based violence, as well as HIV-based stigma, in the village.

• Badges of Honour are given to participants who take oath to never make any act of SGBV and agree to name and shame those who commit any SGBV offence while budes of carriage are given to any one for speaking out against abuse or violence during implementation.

• A sign post bearing the name of the village is planted in the village after the pledge taking ceremony declaring it SGBV free.
Final steps

• **End line evaluation**: done to assess the impact of the project

• **Project documentation**: The successes, challenges and lessons learned from the project are documented to guide roll-out to other sites and assess viability of expansion to other operations.

• **Project sustainability**: Steps are taken to ensure that the stakeholder forum takes lead in every activity of the project and this is made clear from the start by involving them in the whole process. Meetings with stakeholder forum continue to discuss the challenges after project closure and find solutions to these issues.
Thank you