

Linking, Aligning, and Convening

Gender-Based Violence and Violence Against Children

Prevention and Response Services in

Uganda's Refugee-Hosting Districts



The Republic of Uganda
Office of the Prime Minister



WORLD BANK GROUP

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Suggested citation

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.

State and Peacebuilding Fund



The State and Peacebuilding Fund (SPF) is a global fund to finance critical development operations and analysis in situations of fragility, conflict, and violence. The SPF is supported by Australia, Denmark, France, Germany, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom, and International Bank for Reconstruction and Development.



Contents

ACKNOWLEDGMENTS	V
ACRONYMS	VI
EXECUTIVE SUMMARY	VII
1 INTRODUCTION	1
Forced Displacement in Uganda	2
Refugee Policy framework in Uganda	2
Development Response to Displacement Impact Project (DRDIP)	3
GBV and VAC in the Context of Displacement	4
2 METHODS	6
Objective and Scope of the Assessment	8
Design	8
Study Sites and Participants	8
Research Team and Training	9
Data Collection Methods	9
Data Management and Analysis	10
Ethical Aspects	10
Limitation	11
Data Validation	11
3 ASSESSMENT RESULTS	12
Scope of the Problem	14
Key Risk Factors OF GBV and VAC in refugee-hosting communities	20
GBV and VAC Response Services in Hosting and Refugee Communities	30
Referral Pathways	49
Information Systems	51
Monitoring and Evaluation	52
Assessment of GBV and VAC Prevention Programs	52
4 CONCLUSIONS	58
5 RECOMMENDATIONS	64
REFERENCES	68
APPENDIXES	70
A List of Documents Reviewed	72
B Services Provided in Refugee and Hosting Communities	74
C Organizations Providing GBV Prevention Services	77



BOX

3.1	Bottlenecks in the Referral Pathway.....	50
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FIGURES

1.1	Refugee Versus Host Population by District.....	2
3.1	Legal and Justice Actors and their Roles	37

MAP

2.1	Refugee-Hosting Districts in Uganda	8
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TABLES

3.1	Risk Factors of GBV and VAC in Refugee-Hosting Communities	25
3.2	Health Facilities in Refugee Settlements and Host Communities in Study Districts.....	31
B.1	Number of Institutions Mapped	74
B.2	Availability of Health Services for Gender-based Violence and Violence Against Children.....	74
B.3	Availability of Essential Medicines	75
B.4	Availability of Medical Equipment	75
B.5	Accessibility to GBV and VAC Services at Health Facility Level	76
B.6	GBV- and VAC- Related Services Provided by Police	76



Acknowledgments

This report is an output of the Uganda Development Response to Displacement Impacts Project (DRDIP), supported by the World Bank. The team leading the research includes Margarita Puerto Gomez, Senior Social Development Specialist, and Varalakshmi Vemuru, Lead Social Development Specialist.

The report was prepared by the Applied Research Bureau (ARB) research team, under the leadership of Paul Bukuluki, PhD. Special thanks are due to Tina Musuya, Ronald Kalyango, Aloysious Nnyombi, Alex Bagabo, Kato Francis, and Robert Bakanoma for their contributions to the preparatory processes, fieldwork, and writing of this report.

The project implementation support team for the Uganda DRDIP provided invaluable support and feedback. The team was led by Dr. Robert Limlim, Project Director in the Office of the Prime Minister; Charles Bafaki, former Project Manager; Michael Nsamba, Safeguards Officer; Caro Breda Lorika, Environmental and Social Specialist; and Jane Ekapu, Acting Secretary Equal Opportunities Communication.

Special thanks are extended to Ismael Ddumba-Nyanzi for technical assistance to the study. We would also like to

thank Jeanne Ward, International GBV Consultant, Pelucy Ntambirweki, Independent Child Protection Consultant, the United Nations High Commissioner for Refugees (UNHCR), and United Nations International Children's Emergency Fund (UNICEF) Uganda for reviewing and providing constructive feedback on drafts of this report.

In addition, we gratefully acknowledge guidance, input, and comments from Elaine Chee, Social Development Specialist; Michael Christian Mahrt, Senior Social Development Specialist; Pamela Chebiwott Tuiyott, Senior Social Development Specialist; and Diana Jimena Arango, Senior Gender Specialist. We are grateful to Benjamin Reese, Senior Operations Officer, and Zewditu Haile, consultant from the forced displacement program in Uganda for their invaluable inputs. We also thank Damalie Evalyne Nyanja, Program Assistant, and Kate Kanye, Consultant, for their logistical support; and Laura Johnson for editing and design.

And finally, our heartfelt thanks go to all our study participants for giving us their time and for generously sharing their views, opinions, and experiences as they relate to the key issues presented here.



Acronyms

CBSD	community-based service department	NWOW	New Way of Working
CID	criminal investigation department	PF3	Police Form 3: Medical Examination of an Injured Person
CFPU	child and family protection unit	PF3A	Police Form 3A: Medical Examination of a Victim of Sexual Assault
CSO	civil society organization	ReHoPE	Refugee and Host Population Empowerment
DPP	Directorate of Public Prosecution	RSA	resident state attorney
DRDIP	Development Response to Displacement Impacts Project	RWC	refugee welfare committee
GBV	gender-based violence	SGBV	sexual and gender-based violence
HC	health center	UN	United Nations
IPV	intimate partner violence	UNHCR	United Nations High Commissioner for Refugees
km	kilometer	UNICEF	United Nations Children's Fund
LLC	local council court	VAC	violence against children
M&E	monitoring and evaluation		
NGO	nongovernmental organization		



Executive Summary





Uganda currently hosts the third-largest refugee population in the world, and the largest in Africa. In May 2020, the country was hosting about 1.4 million refugees and asylum seekers, mostly in the West Nile, Northern, and Western parts of the country.¹ The majority of these refugees are from South Sudan and the Democratic Republic of Congo. Women and children comprise 82 percent of Uganda's overall refugee population, about 56 percent of refugees are below the age of 15, and 25 percent are younger than five years of age (World Bank 2019).

Gender-based violence (GBV) and violence against children (VAC) are key protection concerns for refugees and host communities alike, with women and girls disproportionately affected. The United Nations High Commissioner for Refugees (UNHCR) recorded 4,297 cases of GBV in 12 refugee settlements between January and November 2019.² In addition, the 2016 Uganda Demographic and Health Survey reveals a high prevalence of GBV in districts that host refugees.

The Development Response to Displacement Impacts Project (DRDIP) is a World Bank-funded project that seeks to address the impacts of forced displacement in communities hosting refugees in 11 districts in Uganda. DRDIP provides access to basic social services, expands economic opportunities, and enhances environmental management targeted at both refugees and host communities. DRDIP conducted a rapid assessment in 11 of the 12 refugee-hosting districts to: (1) identify key risk factors for GBV and VAC and to examine the intersections between them, with an emphasis on host communities; (2) map existing GBV and VAC prevention and response services in both refugee and host communities, including the effectiveness of existing referral pathways; and (3) provide recommendations to align and link the GBV and VAC prevention and response services provided in refugee settlements and host communities. The contributions of this assessment will strengthen GBV and VAC risk management associated with the implementation of DRDIP. Data for this assessment were collected before the COVID-19 outbreak, but subsequent

data show an increase in GBV and VAC, exacerbated by confinement measures, particularly adolescents girls and women at risk of intimate partner violence.

This assessment complements the UNHCR-led interagency assessment that focused on GBV and VAC in 11 refugee settlements (UNHCR and OPM 2019). The DRDIP analysis includes a comprehensive mapping of services for GBV and VAC prevention and response across the key sectors of health, police, justice, and social services in refugee settlements and host communities. In addition, qualitative data were collected through focus group discussions with refugees and local populations; interviews with key informants, including duty bearers such as health workers and police officers; and consultations with local stakeholders.

SUMMARY OF FINDINGS

GBV and VAC are prevalent in both refugee and host communities. The assessment reveals that GBV and VAC are pervasive in refugee-hosting communities, and it identifies perceived drivers and risk factors associated with victimization. Notably, sex, age, disability, substance abuse, financial stress, physical environment (e.g., location, porous border, and environmental degradation), and discriminatory social and gender norms are identified as key risk factors for violence against women and children in the host communities. Economic hardship and substance abuse are the most commonly mentioned factors in the study's qualitative findings. Additionally, domestic violence, violence in schools, and a lack of child-friendly and accessible services to report and respond to violence against children increase boys' and girls' risk of victimization.

In general, risks of GBV and VAC in communities hosting refugees are similar to those documented in refugee settlements (see UNHCR and OPM 2019a; GWI, LWF, and Makerere University 2019; Sengupta and Calo 2016). However, women and children in situations of forced displacement face specific vulnerabilities associated with poverty, food insecurity, aid dependency, and trauma that can exacerbate their risks to violence and constrain their ability to look for help and access services. According to

1. According to UNHCR, Government of Uganda, Office of the Prime Minister (2020): <https://data2.unhcr.org/en/country/uga> [accessed May 21, 2020].

2. Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/73839.pdf>.



UNHCR, socioeconomic status and ethnicity influences case reporting, and survivors who have access to resources or means of livelihood are more likely to report GBV³ than the deprived refugees. Reporting is also limited among the more conservative communities, such as Somalis and Eritreans. The assessment also reveals that poverty and a lack of safeguards drives children into the hands of abusers and perpetrates harmful practices, such as early marriage (UNHCR and OPM 2019a: 18).

Understanding the intersections between GBV and VAC is crucial to comprehensively addressing risk factors. GBV and VAC share similar risk factors that tend to be mutually reinforcing. For example, children in households where women experience intimate partner violence (IPV) are at higher risk of VAC. This has long-term implications because children exposed to violence are more likely to become survivors or perpetrators in adulthood. In addition, social norms that deem such violence normal, acceptable, or even justified perpetuate GBV and VAC. The assessment documents a high rate of acceptance for physical violence as a form of “disciplining” women and children.

GBV and VAC prevention and response in refugee and host communities remain inadequate. First, effective GBV and VAC case management continues to be undermined by the lack of accessible, integrated services and reporting mechanisms; weak institutional capacity across sectors (justice, health, education, and social welfare); and the absence of effective coordination of services in all refugee-hosting districts. For example, the medical services and the justice system, including the police and courts, are profoundly ill-equipped to support and assist survivors. Moreover, the long distances from areas affected by displacement to where services are offered often prohibits optimal access to services.

GBV and VAC survivors in host communities are often unable to access an essential package of multisectoral services, including health, psychosocial support, and justice/legal services. In some cases, utilization is limited to seeking one of the available services. For example, a

survivor may seek health care but may not follow up on referrals to law enforcement or psychosocial services, which is attributed to gaps and bottlenecks in the existing referral systems, including a lack of standardized referral protocols, poor case tracking, and limited follow-up with survivors to ensure they are promptly receiving needed services. Poor initial experiences and perceptions among survivors regarding the quality and safety of services are also identified as barriers to follow-up care and/or utilization of other referrals across study sites.

Services for women and children survivors of violence in refugee settlements are provided by UNHCR, other United Nations (UN) agencies, and implementing partners (e.g., nongovernmental organizations, or NGOs) in coordination with the Office of the Prime Minister. The humanitarian response to the protection of GBV survivors tends to generate parallel structures for the provision of services, which are not always aligned or integrated with national systems, hampering the standardization of procedures, protocols, and interventions among service providers, and undermining local capacity to address GBV and VAC in a sustainable and integrated manner.

Effective prevention of GBV and VAC also requires several interventions at the individual, interpersonal, community, and societal level. The few prevention programs that are being implemented in refugee and host communities are low-scale, fragmented, and dispersed. Evidence-based approaches to reduce the key risks of violence identified in this assessment, such as economic and social empowerment of women and adolescent girls, have not been systematically undertaken over time.

Despite the recognition of overlapping risks and interventions, GBV and child protection programming in refugee and host communities still follows distinct trajectories, each with its own funding streams and actors. While there are important and strategic reasons to separate advocacy and programming for women and children, it is important to identify opportunities for leveraging programming where there are linkages, particularly around intersecting risk factors.

3. UNCHR (2016) uses the term sexual and gender-based violence, or SGBV.



RECOMMENDATIONS

1. Integrate GBV risk mitigation and prevention in the development response to forced displacement. The humanitarian-development nexus provides a broader framework for the protection of women and children in protracted situations of forced displacement. Nonetheless, development projects, depending on their scope, can also exacerbate existing risks of GBV, or can create new ones, unless appropriate safeguard measures are put in place. For instance, projects can cause shifts in gender dynamics between community members and within households (World Bank 2018). Therefore, development projects such as Uganda DRDIP should consider any potential negative impacts and embed measures across the program to mitigate risks related to GBV, sexual exploitation and abuse, and VAC that could result from project activities or that already exist in the community. Such measures might include the establishment of grievance redress mechanisms that can effectively refer GBV/VAC cases; community mobilization efforts; and the training of project stakeholders on GBV and VAC risk identification and mitigation across sector interventions, including health, education, water and sanitation, access to energy, and livelihood programs.

2. Strengthen and enhance multisectoral services at all levels. Effective GBV and VAC case management continues to be undermined by weak institutional capacity across sectors, including justice, health, and social protection, and by limited referral services for survivors. Measures should be implemented to strengthen the local response capacity to ensure that survivors can access quality essential services, such as medical/health services, psychosocial support, justice and policing services, legal aid, and shelter. Specific activities could focus on strengthening the case management capacity of GBV and child protection actors as well as the coordination among duty bearers through training and mentorship; ensuring that the different institutions have the facilities and logistical resources they need to effectively execute their mandates; and strengthening coordination and referral mechanisms. Where possible, capacity of local leaders and refugee welfare committees (RWCs) should be built so they can appropriately refer cases of GBV and VAC to formal services as required by the referral pathways.

3. Scale up evidence-based community violence prevention approaches using a systemic approach. The assessment shows several risks factors for VAC and GBV at different levels of the socioecological framework, including discriminatory social and gender norms that generate and perpetuate violence against women and girls. These risk factors need to be addressed through multipronged prevention interventions reflective of recent evidence of what works (DFID 2015). Prevention efforts could focus on changing social norms that underpin VAC and GBV, engaging men and boys, supporting economic and social empowerment for women and adolescent girls, and promoting positive parenting practices. For example, evidence-based community mobilization and social norm change approaches, such as the SASA! methodology,⁴ should be adapted or contextualized and implemented by district/local government structures for scale and sustainability. Effective implementation and institutionalization may require building the capacity of government structures and duty bearers, such as probation social welfare officers and community development officers, through training and mentorship. Similarly, school-based violence prevention programs, such as Raising Voices' "Good School" toolkit could be replicated in both refugee and host communities. This program could also contribute to the rolling out of the "Reporting, Tracking, Referral and Response Guidelines on Violence Against Children in Schools," developed by the Ministry of Education and Sports in 2014.⁵ Finally, promoting women's and girls' empowerment through livelihood support and economic opportunities is critical to reducing risk factors of violence at the household level in both hosting and refugee communities.

4. Consider and address intersections between GBV and VAC. The nexus between GBV and VAC highlights the need for greater collaboration and integrated programming to addresses both forms of violence. There is a need to break

4. The SASA! methodology utilizes a structured community engagement and phased approach to address underlying beliefs, social norms, and attitudes that perpetuate violence against women and girls. A cluster randomized controlled trial of the SASA! methodology in Uganda revealed a 52 percent reduction in intimate partner violence against women in SASA! communities.

5. The ministry's guidelines complement the child-friendly-schools model and are designed to improve reporting by children and school officials of incidents of violence against children/girls and to be integrated with the broader district referral and response systems.



conceptual “silent spaces” across GBV and child protection programming, while also recognizing that in some instances the two fields need dedicated approaches, by focusing on areas overlap where possible (e.g., addressing shared risk factors such as social norms that underpin both forms of violence and training service providers to address both GBV and VAC). In addition, an assessment is needed of the added value of coordinating efforts at preventing and responding to these forms of violence in an integrated manner.

5. Bridge the humanitarian-development divide in GBV and child protection programming. The gap between the humanitarian and development responses to addressing GBV- and VAC-related risks must be reduced using deliberate efforts to align violence prevention and response interventions with national systems and local structures. The Comprehensive Refugee Response Framework provides

important entry points and opportunities for humanitarian and development actors to work together toward developing a more integrated and sustainable approach to GBV and VAC prevention and response. For example, humanitarian and development partners could develop district-level capacity to ensure integrated information and reporting systems, referral pathways, and case management. In addition, the humanitarian-development nexus and commitment to the New Way of Working (NWOW)⁶ also provides an opportunity to work collaboratively and align funding and financing modalities to strengthen district-level and national systems to address the protection needs of refugee and host communities—with a greater focus on sustainability.

6. The New Way of Working, or NWOW, is an approach promoted by the UN Joint Steering Committee to advance humanitarian and development collaboration. The approach calls on humanitarian and development actors to work together collaboratively, based on their comparative advantages, toward “collective outcomes” that reduce need, risk, and vulnerability over multiple years (UN OCHA 2017).



1

Introduction





FORCED DISPLACEMENT IN UGANDA

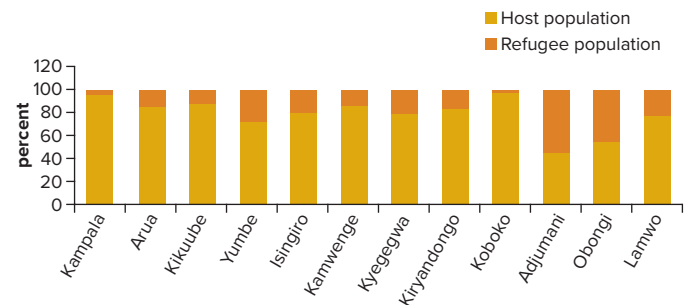
Uganda is the largest refugee-hosting country in Africa and the third largest worldwide. The official statistics from the Office of the Prime Minister and the United Nations High Commissioner for Refugees (UNHCR) estimate that by May 2020, Uganda was hosting over 14 million refugees and asylum seekers. Women and children comprise 82 percent of the overall refugee population in Uganda. Refugees are concentrated in 12 districts in a total of 134 Ugandan districts, including the capital city of Kampala. Six of these districts—Adjumani, Arua, Koboko, Obongi, Yumbe, and Lamwo—are located in the West Nile and northern subregions. The five southwestern districts hosting refugee settlements are Kiryandongo, Kikuube, Kyegegwa, Kamwenge, and Isingiro.¹

Uganda's long-standing open-door refugee policy and geographic proximity to countries experiencing conflict and political instability, such as South Sudan and the Democratic Republic of Congo, means that the country will probably continue to receive refugees. The prolonged and steady arrival of refugees has far-reaching implications. Refugee-hosting areas are among the poorest and least-developed areas of Uganda, struggling with their own development challenges, including poverty and unemployment, deficits in human capital development, weak social service delivery, and limited access to basic infrastructure. The influx of refugees into such areas has increased pressure on already strained public services, natural resources, and local infrastructure; exacerbated existing vulnerabilities; and rendered the population in refugee-hosting areas less resilient to economic and environmental shocks (Miller 2018). The impact of these challenges has increased due to the protracted situation of many refugees who do not foresee a time when they will be able to return to their country of origin and therefore remain dependent on the refugee response. Studies also show that the presence of refugees affects the coping abilities of host communities, especially where such communities have limited social capital, less diverse livelihoods, and low levels of assets (Zhu et al. 2016; Miller 2018). Available evidence also indicates that

1. Obongi and Kikuube are newly created districts cut from Moyo and Hoima, respectively, which had not yet been created at the time of data collection.

FIGURE 1.1

Refugee Versus Host Population by District



Source: <https://data2.unhcr.org/en/country/uga>.

refugees are vulnerable to a vast array of protection risks particular to the refugee contexts, including the threat of sexual and gender-based violence (Holloway, Stavropoulou, and Daigle 2019). Against this backdrop, refugee-hosting districts are now recognized under the vulnerability criteria of Uganda's National Development Plan 2015/16–2019/20, which prioritizes them for development interventions. Further, the potential of refugees to contribute to the social and economic development of the country is gaining increasing recognition, particularly if their skills are harnessed and utilized to improve livelihoods, incomes, and productivity.

REFUGEE POLICY FRAMEWORK IN UGANDA

The 2006 National Refugee Act and the 2010 Refugee Regulations are the two major regulatory frameworks that govern the refugee situation in Uganda. These entitle refugees to documentation (e.g., identity cards, birth certificates, and death certificates) and to the same rights as Ugandan nationals in terms of access social services (e.g., health, water and sanitation, and education); the right to land for agricultural use and shelter; the right to work (e.g., start a business or seek employment); freedom of movement; the right to receive fair justice; and the principle of family unity. Further, the 2010 regulations require the Commissioner for Refugees to ensure the integration of



refugees into local communities; sensitize host communities to coexistence; and liaise with national, local, and regional planning authorities to ensure that refugee concerns and related matters are considered, particularly those relating to sustainable development and environmental plans. The Refugee Act prioritizes assistance to women, children, and persons living with disabilities, including their integration into host communities.

In addition, the country's policy approach to refugees is embedded and articulated in various policy documents and strategies. For example, the second National Development Plan (2015/16–2019/20) provides for refugee management and protection as a priority through the Settlement Transformation Agenda, which provides for the expansion of services such as health, education, water, and sanitation for refugees and refugee-hosting areas (UN, GoU, and World Bank 2017). The agenda recognizes that refugee-hosting areas require special attention due to the added demands of hosting displaced populations and emphasizes the need to integrate refugee service structures with the government. It also provides a clear entry point for a range of actors to support both the objectives of refugee self-reliance through development interventions and as a basis to support host communities. Building on this, the government of Uganda, in collaboration with United Nations (UN) agencies and the World Bank, launched the Refugee and Host Population Empowerment (ReHoPE) strategic framework in 2017 to foster a multiyear, multisectoral program that would bridge humanitarian and development approaches and actors (UN, GoU, and World Bank 2017). ReHoPE aims to ensure that humanitarian action is embedded in a long-term development approach. It emphasizes building institutional capacity to deliver appropriate, accessible, cost-effective, and affordable services to all people in refugee-hosting districts in ways that build resilience and self-reliance among both refugee and host communities.

The government's ReHoPE strategy is integrated into the UN Development Assistance Framework for Uganda (UNDAF 2016–20). In addition, the Office of the Prime

Minister launched the Comprehensive Refugee Response Framework on March 24, 2017, adapting most of the principles and objectives set out in annex 1 of the New York Declaration on Refugees and Migrants to the Ugandan context. The framework is a multistakeholder coordination model for refugee matters focused on humanitarian and development needs of both refugees and host communities.² The framework in Uganda encompasses five mutually reinforcing pillars: (1) admission and rights; (2) emergency response and ongoing needs; (3) resilience and self-reliance of refugees; (4) expansion of solutions through resettlement and complementary pathways; and (5) voluntary repatriation. It also includes cross-cutting issues on gender equality, women's empowerment, nondiscrimination, and accountability to affected populations.

Notwithstanding Uganda's progressive refugee policy, a 2016 World Bank study determined that refugees and their host communities remain vulnerable due to underlying poverty and vulnerabilities exacerbated by weak social services delivery, poor infrastructure, and limited market opportunities (World Bank 2016).

DEVELOPMENT RESPONSE TO DISPLACEMENT IMPACT PROJECT (DRDIP)

The World Bank-funded DRDIP, implemented by the Office of the Prime Minister in 11 districts in Uganda, addresses the impacts of forced displacement on refugee-hosting communities. Targeting both refugees and host communities, DRDIP's development objective is to improve access to basic social services, expand economic opportunities, and enhance environmental management. Specific sub-projects under DRDIP are focused on improving social and economic infrastructure and services, environmental and natural resource management, and livelihoods.

2. Like the ReHoPE strategic framework, the CRRF seeks to strengthen the resilience and self-reliance of host communities and refugees through multisector and coordinated interventions.



GBV AND VAC IN THE CONTEXT OF DISPLACEMENT

Gender-based violence (GBV) and violence against children (VAC) are widespread in Uganda. The 2016 Uganda Demographic Health Survey found that, among women ages 15–49, 51 percent had experienced physical violence and 22 percent had experienced sexual violence in their lifetimes (UBOS and ICF 2018). Further, nearly 10 percent of girls ages 15–19 and almost 20 percent of women ages 20–24 report having ever experienced sexual assault, with more than half reporting having had such an experience in the year preceding the survey (UBOS and ICF 2018). In addition, harmful practices such as child/early marriage and female genital mutilation are still prevalent in some parts of Uganda. More than 15 percent of ever-married women (ages 20–49) were married by age 15; 49 percent by age 18 (UBOS and ICF 2018).

VAC is also pervasive in many settings, including homes, schools, and communities. According to the National Violence Against Children Survey, one in four girls (25 percent) and one in 10 boys (11 percent) reported having experienced sexual violence in the 12 months preceding the survey. Four in 10 girls (44 percent) and six in 10 boys (59 percent) ages 13–17 had experienced physical violence. And more than one in five children ages 13–17 report having experienced emotional abuse (MGLSD 2017a).

Research suggests that GBV and VAC can be exacerbated in contexts of displacement. Notably, the 2016 Uganda Demographic Health Survey reveals a comparably high prevalence of GBV across subregions where refugee-hosting districts are located.³ For example, in the West Nile subregion, 63.8 percent of women ages 15–49 have ever experienced physical, sexual, or emotional violence by their current or most recent spouse/partner compared with the national average of 51 percent. More than 43 percent had experienced intimate partner violence (IPV) in the 12 months preceding the survey (UBOS and ICF 2018).

3. The five subregions where the refugee-hosting districts are located are: West Nile (Arua, Adjumani, Koboko, Obongi, and Yumbe districts); Northern (Lamwo district); Bunyoro (Kiryandongo and Kikuube districts); Tooro (Kamwenge and Kyegegwa districts); and Ankole (Isingiro district).

In addition, several studies in Uganda have documented a high prevalence of GBV among refugees (GWI, LWF, and Makerere University 2019; Care International 2018; Kwiringira et al. 2018; Refugee Law Project 2017). A mixed-method study conducted by the Global Women's Institute at George Washington University shows that almost 65 percent of South Sudanese refugee women had ever experienced IPV; and 43 percent of those women had experienced it in the year preceding the survey (GWI, LWF, and Makerere University 2019). Further, UNHCR recorded 4,297 cases of GBV in 12 refugee communities between January and November 2019.⁴ Eighty-seven percent of the survivors were female, 13 percent male. Child survivors accounted for 14 percent of reported cases. However, the actual number could be higher because many survivors are hesitant to report incidents of violence due to social stigma, shame, and fear of reprisal.

While data for this assessment were collected before the COVID-19 outbreak, subsequent data show an increase of GBV and VAC in refugee and host communities, exacerbated by confinement measures and mobility restrictions. Nationally, 3,280 cases of GBV, including IPV, were reported to the police between March 30 and April 28, 2020, while in 2019, an average of 1,137 domestic violence cases were reported per month. UNHCR mentioned that the number of sexual and gender-based violence (SGBV) cases, particularly IPV, has increased 55 percent during the COVID-19 crisis. Furthermore, inadequate livelihoods due to the current COVID-19 preventive measures, alcoholism, and the loss of social protection provided by schools have contributed to the increased vulnerability to SGBV.

The high prevalence of GBV and VAC in the context of forced displacement has been generally linked to the breakdown of protective mechanisms and support networks, post-traumatic stress following experiences of violent events, changing gender roles, inadequate access to basic services, limited access to economic and livelihood opportunities, and predisplacement norms (Wirtz et al. 2014; Horn et al. 2014; Vu et al. 2014). For example,

4. Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/73839.pdf>.

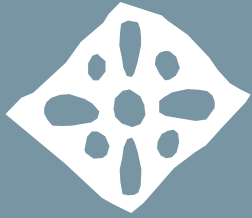


refugees arriving in Uganda perpetuate their social norms, which often include harmful practices, such as female genital mutilation and child marriage.

In Uganda, there is limited information regarding the drivers of GBV and VAC and the points of intersection between them in refugee host communities.⁵ In addition, there are limited data on the nature and quality of existing services to address GBV and VAC, including referral pathways, in both

refugee and host communities. Notably, a recent inter-agency rapid gender analysis and GBV assessment in five refugee settlements (Holly 2018: 3) underscores the need to assess the GBV referral pathways and investigate the extent to which service providers are aware of and enforce the standard operating procedures for GBV case management and referral pathways. Furthermore, there is limited alignment and integration of GBV and VAC prevention and response services in refugee settlements with district- and national-level protection and case management systems.

5. There are few studies have documented the drivers of GBV and VAC in refugee settlements (see UNHCR and OPM, 2019; The Global Women's Institute et al, 2019; Sengupta & Calo, 2016).



2 Methods





OBJECTIVE AND SCOPE OF THE ASSESSMENT

The World Bank, in coordination with the Ugandan Office of the Prime Minister and Ministry of Gender, Labour and Social Development, as well as the United Nations High Commissioner for Refugees (UNHCR), conducted an assessment of the key drivers, risk factors, and intersections between gender-based violence (GBV) and violence against children (VAC), as well as a mapping of prevention and response services in refugee-hosting communities and settlements for 11 districts in Uganda. As part of that effort, this study seeks to:

- ◆ Identify the contextual and specific risks of GBV and VAC in the 11 refugee-hosting communities and examine existing intersections;
- ◆ Map the availability and accessibility of GBV and VAC prevention and response services in both refugee and host communities, including scope, geographic coverage, types of providers, and reporting mechanisms and support systems for survivors;
- ◆ Assess the adequacy and quality of GBV and VAC prevention and response services, including referral mechanisms, against best practices, as articulated in international and Ugandan protocols, standard operating procedures, and guidelines (e.g., multisectoral capacity and coordination with other agencies, including humanitarian actors); and
- ◆ Identify opportunities to align GBV and VAC services in refugee and host communities to national systems, and to reduce the gap between humanitarian and development responses.

This assessment complements a UNHCR-led interagency assessment focused on GBV and VAC in refugee settlements (UNHCR and OPM 2019). The UNHCR-led assessment focuses on measures, services, and safeguards for the protection of women and children against GBV among refugees in Uganda.

DESIGN

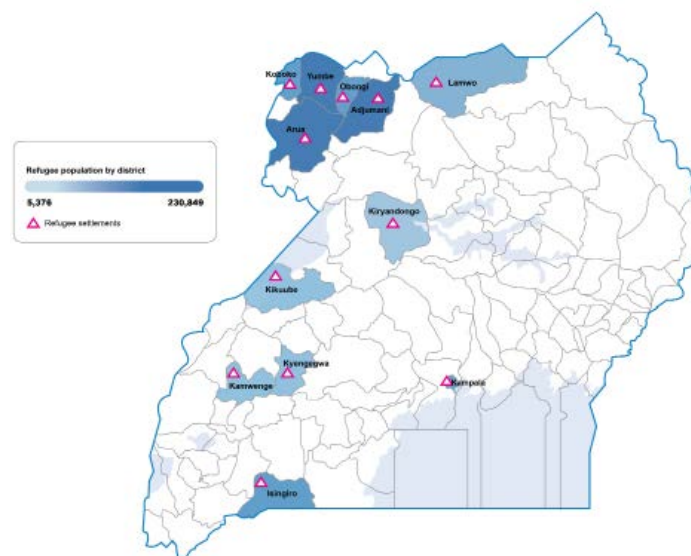
This assessment uses a predominantly qualitative approach. Primary data were collected using in-depth interviews with key informants, focus group discussions, and consultations with local stakeholders and development partners on preliminary results. The assessment also includes a mapping of services for GBV and VAC prevention and response across the key sectors of health, police and justice, and social services for both refugee settlements and host communities.

STUDY SITES AND PARTICIPANTS

The assessment was conducted in 11 out of the 12 refugee-hosting districts in Uganda:⁶ Arua, Adjumani, Kiryandongo, Isingiro, Kamwenge, Kyegegwa, Lamwo, Moyo, Yumbe, Koboko, and Hoima⁷ (map 2.1). The study sites are purposively selected to reflect the sociocultural diversity of

MAP 2.1

Refugee-Hosting Districts in Uganda



6. The 12th refugee-hosting district, Kampala, is left out because it largely hosts urban refugees. The interest of this assessment is more inclined toward communities hosting refugee settlements.

7. Obongi and Kikuube are newly created districts cut from Moyo and Hoima, respectively, which had not yet been created at the time of data collection.



refugee-hosting communities. In all cases, subcounties and communities residing within a 15-kilometer radius of the refugee settlements are considered hosts.

Study participants include: (1) representatives from government structures across key sectors—social services, health, justice, and policing; (2) community protection structure members from village health teams and child protection committees and from para-social workers; (3) adult community members (female and male); (4) children in and out of school, ages 13–17; and (5) nongovernmental organizations (NGOs) involved in GBV and VAC prevention and response.

RESEARCH TEAM AND TRAINING

A team of 21 researchers with backgrounds and training in social sciences, public health, gender, and social work collected data between August and December 2018. Team members received three days of training on the purpose and objectives of the assessment, conducting GBV and VAC research, research ethics, interviewing techniques, and qualitative and quantitative data management procedures. The data collection team was divided into three subgroups based on fluency in the local languages of the various refugee-hosting communities. Each subgroup, comprising a supervisor and five data collectors, was assigned at least three refugee-hosting districts. Female researchers were assigned to interview female study participants. Community leaders at all local council levels, as well as camp commandants, assisted in the mobilization of study participants.

DATA COLLECTION METHODS

Desk review

Field data collection was preceded by a review of relevant literature, including protocols and standards on GBV and VAC. The desk review helped provide contextual information on GBV and VAC, existing legal and policy frameworks, practice standards, and guidelines, which informed the development of the data collection tools and provided an

analytical frame of reference (see appendix A for a full list of reviewed documents).

Institutional mapping

The assessment includes a mapping of institutions engaged in providing GBV and VAC prevention and response services across the key sectors of health, police and justice, and social services, using a specifically designed institutional mapping tool. The purpose was to assess the services provided as well as institutional capacities. The mapping was conducted using a preprogrammed tool on Survey CTO on Android tablets. Internal checks were included to ensure the completeness and logic of entries and the consistency of responses.

In-depth interviews with key informants

In-depth interviews were conducted with selected key informants, including representatives from various GBV service providers at the district and community level across key sectors, such as social services, health, justice, safety, and security. Interviewees included representatives from government departments and agencies at the district level (n=60) as well as NGOs (n=25). The discussions were primarily around risk factors for GBV and VAC and the availability, access, and quality of GBV and VAC prevention and response services.

Focus group discussions

Forty-four focus group discussions were conducted with various categories of participants across 11 refugee-hosting districts, including members of community structures involved in GBV and VAC prevention and response at the community level, such as child protection committees, village health teams, and para-social workers; adult community members; and children in and out of school. The focus group discussions were conducted in the local language, with detailed notes written in English. Each focus group discussion, comprising 8 to 10 people, elicited collective views about GBV and VAC in terms of vulnerability, risk factors, experiences, case management, and perceived benefits of reporting. To mitigate the potential for participants to feel inhibited, focus group discussions of women were



moderated by women, and those for men were moderated by men. Research assistants were trained in data collection techniques.

DATA MANAGEMENT AND ANALYSIS

Qualitative data

All audio recordings were transcribed and simultaneously translated into English. Transcripts were entered and coded using Dedoose (version 4.5), a web-based qualitative data analysis tool. The research team developed a code structure using systematic and inductive procedures to generate insights grounded in the views expressed by the study participants. The team coded the interview transcripts using the constant comparison method, which ensures themes are consistently classified and that also allows for the expansion or refinement of existing codes based on the objectives of the assessment. Select verbatim quotations

are included in this report to demonstrate the accuracy of interpretation, to deepen understanding, to provide a narrative for the findings, and to enhance the voice of women and children.

Quantitative data

Quantitative data were synchronized on a daily basis with an online server managed by Applied Research Bureau. Data were downloaded daily for storage and review by the data validation team. Daily monitoring checked the quality of the data and confirmed the receipt of completed questionnaires on the cloud server. Data were checked for accuracy and outliers. Inconsistencies were communicated to the field teams and resolved by calling back respondents. The data from the server were imported into Stata (version 13) for analysis. The analysis of the data is primarily descriptive.



ETHICAL ASPECTS

The study was conducted in accordance with guidelines for safe and ethical research on violence against women (Watts et al. 1999) and against children (Powell et al. 2013). The research process and methods were also consistent with the World Health Organization guidance and other best practices on researching sexual violence in emergency settings. Prior clearance was sought from the Office of the Prime Minister, UNHCR, and district-level authorities for the field data collection. All researchers were trained in research ethics and passed the Collaborative Institutional Training Initiative Human Research curriculum. They were also trained on how to safely refer women and children requesting assistance to available local services and sources of support.

Adults

Participation was voluntary, and informed consent was obtained from all study participants. Participants were discouraged from sharing intimate personal details about their experiences with violence; anyone who wanted to discuss such experiences was provided with a list of local GBV services and were offered the opportunity to speak with someone immediately.

Children

Informed consent was also obtained from children (ages 13–17), as well as their parents, guardians, or teachers, prior to their participation in this study. They were provided

information on the purpose of the study and ethical principles of privacy, confidentiality, and voluntary participation in an age-appropriate manner, including ensuring that the children understood how their personal information would be used before their consent was solicited.

LIMITATION

The assessment relies heavily on qualitative data. As such, the findings are not generalizable but are rather illustrative.

DATA VALIDATION

The study's findings were validated at three national-level meetings with the Office of the Prime Minister, UNHCR, the United Nations Children's Fund (UNICEF), and UN Women; as well as at regional-level, one-day workshops held in each of the four regions where the study districts are located. These validation meetings were attended by policy makers, service providers, and administrators, including representatives from the national offices relevant to GBV and VAC prevention and response. The validation workshops also included the research team and representatives from the World Bank and the Office of the Prime Minister. Feedback from the validation meetings informed revisions to the report. Recommendations generated by participants in validation workshops with stakeholders were synthesized with those that emerged from the assessment findings to produce a final set of recommendations that can inform programming.



3

Assessment Results







SCOPE OF THE PROBLEM

Gender-based violence in refugee-hosting communities

This section highlights the context and forms of gender-based violence (GBV) in host communities, highlighting the prevalent forms—intimate partner violence (IPV), socioeconomic violence, sexual violence, and harmful customary practices. Information was collected during interviews with key informants and focus group discussions with refugees and local populations.

Intimate partner violence

IPV is the most common form of GBV identified by the study, with young women perceived as the most vulnerable among the group interviewed. Physical violence—mainly in the form of beating, punching, kicking, throwing objects, or pushing—is very common but rarely reported.

“The common form of violence is men beating up their wives and chasing them to go and sleep in the bush ... this is so common in this village.”

– Focus group discussion (male), Kyegegwa

“We have witnessed cases of women who have been beaten by their husbands and some of them wounded, traumatized.”

– Key informant interview (female), Hoima

While most male participants claimed that they do not condone physical violence against women, a few justified its use in response to wifely “disobedience,” or perceived it as a necessary disciplinary measure to maintain control “over domestic affairs.”

“She just gets me so jealous. I keep telling her, over and over again, but do you think she listens? I keep telling her, look, don’t speak to these other men. Do you think she listens? No. I think she’s doing this deliberately to get at me. She knows I get angry when she talks to other men. But she still does it.”

– Focus group discussion (male), Adjumani

IPV also manifests in the form of “emotional violence.” Examples include a husband scolding his wife, using coarse or humiliating language, shouting or screaming, threatening to take away her children, marrying another woman, or sending her back to her family or place of origin. In addition, participants note that many men and women use a “cold war” approach, where they ignore their spouse for prolonged periods of time.

“Some men use abusive language toward their women.

A man can return home and find his wife resting in bed; he takes offence in this and begins to abuse her.”

– Focus group discussion (female), Yumbe

Sexual violence perpetrated by an intimate partner is also widespread but remains largely shrouded in silence because in most communities, it is not necessarily conceptualized as a form of GBV or as a violation. One key informant describes how most women do not speak about such incidents.

“It is only when they can’t bear it any more ... they open up.”

The reluctance to discuss intimate partner sexual violence seems to stem from the cultural expectations of wifely loyalty and obedience to a husband.

“Some women have shared about how their husbands come home while drunk and force them into sex.”

– Focus group discussion participant (female), Hoima

“They say that before having sex with your husband you are supposed to agree as a couple, but the other doesn’t care. You be in deep sleep you hear him enter. And you can’t talk about this anywhere, now how do you start telling the chairman that the man raped you? Yet he is your husband, you just keep quiet, you can’t even tell a friend about it.”

– Focus group discussion (female), Kyegegwa

In many cases, IPV is attributed to alcohol use, infidelity or perceived infidelity, power imbalances, and gender norms.



Testimonies indicate that in most cases rape/forced sex occurs when a husband has consumed alcohol; others report that physical violence is the price a woman pays for refusing her husband's sexual advances. In some communities, the use of family planning by a woman without the permission of her husband is reportedly a source of family dispute. However, IPV is not restricted to married partners. Physical violence and sexual coercion within premarital relationships are reportedly widespread. It is common for a boyfriend to sexually harass his girlfriend, including verbal harassment, unwanted touching, forced kissing, and forced sex.

Unfortunately, many members in the community perceive IPV as a private matter; and women are sometimes blamed for the violence inflicted upon them, contributing to a culture of impunity and adding to the stigma that deters many women and girls from seeking medical services or legal redress. In most focus group discussions, male and female participants agreed that a man does not have the authority to perpetrate violence against his wife, but at the same time, during almost all of them, women and men qualified this assertion by suggesting that it is acceptable for a man to perpetrate violence against his wife if he is provoked, if the violence is "mild," or if it is only occasional rather than regular.

Socioeconomic violence

Socioeconomic violence is prevalent in refugee-hosting communities and reportedly reinforces physical, sexual, and emotional violence. The denial of women's and girls' land and inheritance rights, including the illegal deprivation of widows' and orphans' assets, remains rampant. Property-grabbing is reportedly common, including the eviction of widows from their lands and homes and the stripping away of their possessions.

"There is a woman who lost her husband. She had worked hand in hand with her man to achieve all that they achieved. A few days after the burial of her husband, the relatives claimed the property and she was left with nothing. She remained working hard and looking after her three children."

– Key informant interview (female), Adjumani

Participants reported that, regardless of a woman's contribution to her household's income, the husband tends to monopolize the money, and he is likely to use the money for personal interests, including alcohol consumption.

"I normally see most families that have harvested their produce like maize, there are misunderstandings because the man wants to sell on his own but also the woman wants to know why the man is selling. If the man is a drunkard, he will become rude and even beat the woman. They can even reach a point of divorce."

– Focus group discussion (male), Kiryandongo

Sexual violence

Qualitative findings reveal that women and girls are at risk of being harassed or experiencing multiple forms of violence by community members other than intimate partners and family. Common forms of violence include verbal and sexual harassment, such as "unwanted touches." Study participants also mentioned defilement as being common. Most associate such perpetration with men and boys from their own or a surrounding village; some specifically cited male refugees, powerful men with authority, and men who have consumed alcohol as the predominant perpetrators.

"Refugee men are not to be trusted. What I know is that they move in groups in the nights and it is worse when they have taken alcohol; they harass and sometimes rape women and girls."

– Focus group discussion (female), Yumbe

Focus group participants noted that sexual violence and the fear of it permeates the lives of women and girls who fear being assaulted when going into the bush to collect firewood or fetching water unaccompanied, especially in the early morning, in the early evening, and at night.

Harmful customary practices

Early/child marriage—a formal or informal union before the age of 18—is widespread in the host communities, fueled in part by parental pressure for daughters to marry early to bring in bridewealth. Unfortunately, individuals at the community level rarely denounce early/child marriage. In



some cases, marriages are conducted across the border in South Sudan, where law enforcement and community sanctions are weak. Monitoring and interventions are extremely difficult because survivors are beyond the jurisdiction of the Ugandan authorities.

“They go back to Sudan and they go and get married there and come back. Even when we were called to Gulu for a workshop where the same issue was raised as here.”

– Key informant interview (male), Adjumani

“There was a girl from that side of Madi. This is a man planned to give a daughter to a man without the knowledge of the girl. Now when these people organized to give the girl, she realized it and refused to go. Then after, they decided to give the youngest sister of the girl to the man. So, it happens like that.”

– Key informant interview (female), Adjumani

Some communities in Isingiro District expect a new bride to have sexual intercourse with her father-in-law; and an impotent man can transfer his marital rights to his brother.

“In some families, the father-in-law sleeps with the daughters-in-law. In instances where one’s husband is impotent, the brothers take up his wife and have children, at times against the will of women.”

– Key informant interview (male), Isingiro

In the West Nile districts of Yumbe, Moyo, Koboko, and Arua, incidences of widow inheritance are reported among refugee and host communities. Participants reported that, although the practice has declined over the years, a few cases still occur in the communities, especially among the Dinkas, the Kuku, and the Bari from South Sudan.

“When a woman loses her husband, she is inherited. I have personally seen three cases where a widow was inherited. One of them even gave birth for the man who inherited her.”

– Focus group discussion (male), Moyo

“Another form of violence is widow inheritance. When a woman’s husband passes on, she is inherited by a relative who may be married at that time. What happens then is that these two women begin to fight among each other for the man’s attention.”

– Focus group discussion (male), Arua

“The relatives do not only inherit the wife but also take away the property that the husband has left behind for his family. This leaves the woman and her children suffering and in pain.”

– Key informant interview (male), Moyo

“Culturally, when a woman loses her husband, his brother or another relative is to inherit her so that they can raise the orphaned children together.”

– Focus group discussion (female), Yumbe

Violence against children in refugee-hosting communities

According to the collected narratives, violence against children (VAC) is widespread in host communities. Children encounter violence in many settings—at home, at school, and in the wider community/public spaces. Such experiences are interconnected; and the same child can experience multiple forms of violence in multiple settings. The most prevalent forms of VAC and their contexts across study sites are highlighted below.

Physical violence

Notably, most physical violence against children occurs in the context of their being disciplined, especially by a parent, sibling, or teacher. Within the home setting, some of the reasons given for physically punishing a child include disobedience, perceived disrespect, stealing, lying, and answering back. In schools, behavior that commonly evokes corporal punishment includes making noise in class, failing to complete homework or assignments, arriving to class late, answering questions incorrectly, receiving poor grades, or going outside without permission.



“There is a belief that the African child understands best after being beaten, which is not true. We are trying to talk to parents to reduce the beating of the children.”

– Key informant interview (male), Arua

“There is a lot of caning in schools, private schools mainly ... when a child fails an exam that is a cane. Any slight mistake, caning. So physical violence is too much in homes and schools.”

– Key informant interview (male), Kiryandongo

Participants reported that peer-to-peer violence is widespread among children in host communities, including bullying and physical assault with and without weapons. Bullying involves repeated physical or psychological harm, often taking place at school or in other settings where children gather. More research is needed to better understand the nature and dynamics of bullying in refugee settlements and communities. Participants also cited cases of physical violence against children by strangers. Some incidents occur in the context of or as an extension of conflicts over resources—particularly water and firewood—in the wider community, especially between refugee and host populations.

Sexual violence

Qualitative findings indicate that children are exposed to diverse forms of sexual violence, including unwanted sexual advances, harassment, and assault. For example, cases of rape, attempted rape, fondling, and unwanted sexual touching are reportedly common in both refugee and host communities. A perpetrator is usually a person on whom the child relies for care and protection, such as a parent, a relative, or a teacher.

“There are some men who drink alcohol and when they get drunk, they chase their wives out of the house, and if the girl child remains in the house, the man defiles her, it is not common, but we receive such cases at times.”

– Key informant interview (police officer), Kyegegwa

Reported incidents of rape and sexual assault by a stranger or person unknown to the survivor in refugee settlements and host communities include acts of rape involving two or more perpetrators.

“We have registered several cases where girls have been raped, for example, last week a girl was sent for medicines by the mother but on her way, she was grabbed by a group of men and was raped; the rescuer was only able to get the last perpetrator yet she was still in primary school. This was a really sad incident.”

– Key informant interview (female), Hoima

“Sometimes the girl can be raped/defiled in the camp. Sometimes the fellow refugees rape her because they know she has no parents to protect her. Such cases are so common among refugees.”

– Focus group discussion (female), Arua

However, such cases are rarely reported to health care providers or law enforcement. There are a variety of reasons why children underreport their experiences with sexual violence, including feelings of guilt, shame, fear of not being believed, and even fear of being reprimanded.

Psychological violence

Psychological violence is common in host communities, including shouting, cursing, name-calling, belittling, threatening with abandonment, locking someone out of the house, and whippings. Emotional violence often coexists with other forms of violence. For example, participants reported that a child who experiences physical or sexual violence is probably also exposed to some level of emotional abuse.

“There are children who are orphans and live with their relatives, while others live with their stepparents. These children are shouted at and humiliated when they make a mistake. The words told to them are so unfair. Demeaning words, such as ‘you are useless,’ ‘can’t you work to make your own money?’”

– Focus group discussion (child), Hoima



“Some guardians, for example, aunts and stepmothers, if they are not provided for by your father, they start insulting you of how your father is not providing for them. Even if you start reading, they will insult you that you are not bright. This makes you very worried.”

– Focus group discussion (child), Adjumani

“It is very common, especially for the girls. What happens is that when she asks for help from her father; he has nothing, the mother has nothing. She, therefore, finds a man outside who can offer her the money and ends up offering him sex.”

– Focus group discussion (female), Adjumani

Neglect

Study findings reveal that neglect—the ongoing failure to meet a child’s basic needs—is rampant in the study settings, especially in Adjumani, Arua, and Moyo districts. Study participants indicated that the basic needs of orphaned children, unaccompanied children, children not living with their biological parents, and children with disabilities are, for the most part, neither met nor prioritized.

“When I ask aunt for the money she just quarrels, and I don’t know why she doesn’t want to give me school fees. Sometimes they don’t give me food at home and sometimes I have to sleep hungry until I come to school and get some food from my friends who come with some of it at school. If I don’t look for my water, I will not bathe that day.”

– Focus group discussion (child), Kiryandongo

“There are high cases of child neglect in our community. Parents refuse to provide for their children the necessities and they refuse to take the children to school and even the hospital, so if nothing is done in the community, the children are not okay.”

– Focus group discussion
(village health team member), Kamwenge

Neglect affects all domains of child development—physical, psychological, emotional, behavioral, and social. It also exposes children to further victimization, including dropping out of school, early marriage, and exploitative labor. Participants for this study offered examples of the link between girls engaged in transactional sex and their being neglected by their parents.

Child labor and exploitation

Child labor is common in host communities. Participants reported that children work across many sectors and types of jobs, including commercial agriculture, fishing, mining (tin mining and stone quarrying), and cattle rearing. Children work on tobacco farms; labor in sand mines in Arua District; fish in Hoima, Kiryandongo, Arua, and Moyo districts; and participate in tin mining and stone quarrying in Isingiro District.

“The common concerns are forced labor by mainly tobacco growers and also rice farmers. During the time for school, they are told to tend to these farms. There are cases of rape that are never reported. Defilement is also here. And when you go to the landing sites there are many children engaged in fishing.”

– Focus group discussion
(community structure member), Hoima

“Another one is fishing. Because we are next to the river most of the children spend a lot of time there fishing in the river Nile.”

– Focus group discussion (male), Kiryandongo

Some mentioned that children are being trafficked from the study communities to urban areas to provide cheap labor in the informal sector and for commercial sexual exploitation. The children are introduced to the informal job market in housekeeping positions or as bar and restaurant attendants:



“Girls are being used as housemaids; they are taken to other districts to work as housemaids.”

– Focus group discussion
(community structure member), Hoima

“Most parents refuse to pay for the girl’s school fees and offer their children to brokers who take girls to Kampala to work as maids.”

– Focus group discussion (child), Kamwenge

Most of these children are being compelled to engage in work not suitable for their age. Working conditions and arrangements are intolerable, and children endure long working hours as well as hazardous and abusive working environments.

“Some parents give their children big jerry cans to go and fetch water; if you bring it back when it’s broken because you dropped it, they beat you. They tell you to bring a full jerry can, yet you are feeling pain in the chest.”

– Focus group discussion (child), Hoima

“There are parents who give children so much work to do. When the parent has burnt charcoal, they give it to the child to carry on their head and take to the market for selling. Other parents put heavy foodstuffs such as cassava and sweet potatoes on the child’s head for the child to take for sale. This food is so heavy for the child to carry and it ends up breaking them.”

– Focus group discussion (female), Adjumani

Harmful traditional practices

EARLY/CHILD MARRIAGE

Child marriage, although illegal in Uganda, remains prevalent in host communities. For example, sometimes families opt to marry their daughters to ease the pressure on scarce resources in the household or for other pecuniary benefits. Unfortunately, there are limited sanctions or censure against parents who marry their daughters off or for the adult men who marry children. This is especially true in Arua, where some parents reportedly see nothing wrong with the marrying off of young girls. Rather than seek litigation when early/forced marriage occurs, families tend to agree on compensation or a dowry. In the West Nile region,

some such marriages are conducted across the border in South Sudan, where law enforcement and community sanctions are weak.

“Early marriages are still so high in the district. Initially, it was mainly among the Bakiga, but now it has spread over. Girls as early as P.6 are married off. It is thought they are old enough to get into marriage.”

– Key informant interview (male), Isingiro

“The girls are 13–15 years, some are in school but at times the parents of the boy go to the parents of the girl when she is at school and they tell them that they would like to marry their daughter, the parents get excited that their daughter has gotten a husband when it is still early, when she comes back from school, the parents tell her to go and get married and stop her from studying.”

– Focus group discussion
(village health team member), Kamwenge

Some participants, especially those living in the West Nile region, blame the high incidence of child marriage on the lack of support given to teenage mothers to stay in or return to school. Due to the stigma attached to teenage pregnancy, some young girls opt for marriage over returning to school.

“The moment a girl accidentally gets pregnant, that is the end of her school. There are very few parents who will say that after delivery the girl should go back to school and parents don’t bother about the girls even when they get married early because they look at it as a source of wealth. The other thing is that these girls are not assertive, they have low self-esteem, they will think that after that has happened to them, people will undermine them not knowing that accidents can happen and you can learn from them.”

– Key informant interview
(local government officer), Moyo



INFANT ORAL MUTILATION

Infant oral mutilation—a traditional practice involving the “gouging out” of an infant’s unerupted teeth—is reported in some study settings. Crude methods to remove these are employed using tools that are not sterile.

“I usually interact with parents that choose to cut the gums of their children and remove the tooth buds. They do think that these cause illness in children.”

– Key informant interview (female), Kamwenge

KEY RISK FACTORS OF GBV AND VAC IN REFUGEE-HOSTING COMMUNITIES

This analysis of risk factors for GBV and VAC is guided by the socioecological model, according to which they are an outcome of the interaction of multiple factors at four levels: individual, interpersonal, community, and societal (Heise 1998, 2012).

Risk factors for GBV

The two most important risk factors that emerged in this study are economic hardship and alcohol abuse. In many instances, these two issues are inexorably linked. Other major factors include marital conflict resulting from infidelity or contraceptive use, social norms that justify violence against women and girls, a lack of economic opportunities, weak social support systems, and poor enforcement of laws. Such factors are also associated with psychosocial problems, including trauma, particularly in settings where social support systems are weak. Some of these factors are discussed below.

Individual and interpersonal factors

SEX, AGE, AND DISABILITY

Participants reported several individual-level risk factors for GBV, including sex, age, health, and disability status. Across all host communities, GBV tended to be perceived as a problem solely encountered by women. In addition, adolescent girls and young women are also perceived to be at highest risk of exposure to GBV. Participants’ narratives reveal that women with disabilities are also more exposed

to GBV, including IPV, than those without a disability. Unfortunately, economic and physical dependence on perpetrators hampers their ability to end violent relationships.

“We say that women with disabilities are more at risk of violence because in some homes they have been abandoned and discriminated by their relatives. Some of them are considered a burden to the household.”

– Key informant interview (female), Kiryandongo

HOUSEHOLD CONFLICT

The reason most frequently cited by married women and men for domestic violence is action by the wife that displeases the husband, such as “disobedience” or “unfaithfulness.” For example, some participants identified provocation or disobedience of the wife as a key underlying reason for marital violence, suggesting that women invite violence by not behaving appropriately.

“I will agree with what this man has said, women have been over empowered, a woman can be in a meeting or training with the husband, and a man says something, the woman stands up immediately and attacks the man, she abuses him and they end up fighting in public, such scenarios are very common here.”

– Focus group discussion
(village health team member), Kamwenge

“The other is the issue of family planning, which is causing domestic violence, because if the woman goes to the hospital and gets it without her husband’s knowledge, and when he finds out he is very bitter.”

– Focus group discussion (male), Kiryandongo

“In families where the couples earn a salary when the woman has a job and the man does not and the end of the month the woman gets the money, her husband wants to control the money, yet the woman does not want it. It is same as when the woman earns more than the man still the man wants to have a say on her money and this too brings up quarrels.”

– Focus group discussion (male), Kiryandongo



POVERTY AND FINANCIAL INSECURITY

Poverty and financial insecurity were identified as risk factors for GBV. During in-depth interviews and focus group discussions, poverty was linked to both the perpetration of violence and the risk of experiencing it. For example, some participants observed that the lack of resources to support the household, limited opportunities for employment, and the “idleness” of men contribute to GBV in many of the refugee-hosting communities. The absence of livelihood opportunities and resultant frustrations are identified as particular triggers of household violence.

“The frustration of not being able to provide for the family often results in anger that could be directed toward the spouse, especially when she comments or requests him to meet her needs.”

– Key informant interview (female), Kyegegwa

“When people are poor, they are usually short-tempered and can easily take actions they don’t mean like beating up their wives. Just asking for food could result in violence.”

– Key informant interview (male), Koboko

Financial dependence on families, which increases in a displacement context, tends to limit a woman’s ability to leave an abusive partner. For example, a woman is more likely to remain in an abusive relationship if she thinks the costs of enduring the relationship are less than the costs she would incur in ending it. In some circumstances, women become vulnerable to sexual exploitation due to poverty. For example, some women may engage in transactional sex with men to support individual and family survival. In turn, transactional sex leaves already vulnerable women susceptible to further exploitation and violence by multiple partners.

UNEQUAL POWER RELATIONS

Participants discussed the link between unequal power relations and IPV. In the context of intimate relationships, these gendered power relationships impact a woman’s ability to access and control resources, as well as her involvement in decision-making processes. Participants report that,

due to unequal power relations, men usually have control over money earned through the sale of household agricultural produce as well as other financial compensation gained from paid labor.

“Men can go and sell agricultural produce in the market and to avoid being questioned by the wife—he goes home drunk and beats up the wife.”

– Focus group discussion (female), Yumbe

“If there are conflicts, it is because all the burdens of the home are on the woman. And the men keep everything, do not share, and take other wives—that’s how the violence begins. When there are too many chores, the woman cannot manage her field, she is forced to work on another’s field. And the man either deserts the home, or he hits you.”

– Focus group discussion (female), Hoima

ALCOHOL AND SUBSTANCE ABUSE

Participants discussed the link between alcohol abuse and GBV. Alcohol use is specifically linked to both the perpetration of violence and the risk of experiencing it. Alcohol consumption by men, for example, is linked to the perpetration of both physical and sexual violence.

“Marital rape cannot fail to be common where men drink so much. When a man returns home and has taken alcohol, you must give him whatever he wants; be it food, be it sex; anything or else you earn a beating. It is also not good when women deny their men sex because many men here go out and get other women to satisfy them.”

– Key informant (female), Adjumani

Participants observed that drinking alcohol may place women in settings where the chances are higher that they will encounter a potential offender. Similarly, substance abuse was mentioned as a contributing factor for GBV in refugee and host communities. Participants noted that substances such as opium and marijuana are commonly used among men in the study settings. Participants say such use makes individuals aggressive, violent, or abusive; and, in



combination with the high level of unemployment, consider it linked to men's use of violence against women and girls.

MULTIPLE CONCURRENT PARTNERS

Having multiple concurrent partners is identified as a risk factor for GBV. Notably, participants report that some men with multiple and concurrent sexual partners become violent when their female partners question their fidelity, and/or sometimes force regular partners to have sex when these partners resist their advances.

Community factors

ATTITUDES TOWARD SEXUALITY AND RELATIONSHIPS

Qualitative findings indicate that, in most communities, many men and women do not consider nonconsensual sex within a dating relationship or marriage to be rape. Such a view is linked to the assumption that men are entitled to have sex with their partners when and how they wish.

Men and boys, as well as women and girls, reportedly believe that a man is entitled to have sexual relations with his female intimate partner without her consent or, as one participant describes, "putting them in that mood to have sex." The perception that men have sexual rights over women is said to be linked to the traditional practice of paying bridewealth for a wife, which is equated with men having ownership of their female partner and therefore being entitled to sex with her.

"Women are supposed to be submissive and they are supposed to do everything at home ... and when you're tired but your husband wants sex, you have to give in. And if you don't, violence ensues because you have not fulfilled what the other person wants."

– Key informant interview (male), Kiryandongo

SOCIAL NORMS

Participants discussed how different social norms increase the risk of GBV in refugee-hosting communities, including ones that link masculinity to male dominance, support or tolerate aggression and violence, accept male violence to resolve family conflicts, stigmatize or blame survivors, and accept or expect that violence and abuse in a domestic context be treated as a private concern. The expectation that men be dominant and powerful and that women be

passive and subservient in relationships can lead to the acceptance of IPV.

"We think that it's normal when he hits me, he loves me. We are not aware that the person is supposed to respect you."

– Focus group discussion (female), Kiryandongo

"In Bunyoro, we know that a woman is not supposed to say anything when the man is talking. When a man says go, you must go. You are not supposed to refuse."

– Key informant interview (male), Hoima

"Even some women themselves, by the way, think if they are not beaten by the husband, then their husbands do not love them. In the evening when they are fetching water, you hear them saying that I don't know what has happened to my husband. He has not slapped me for the last two weeks."

– Key informant interview (male), Lamwo

"There is a Rutooro saying that 'ibega tirikira mutwe' meaning that 'a shoulder can't be taller than the head.' A woman is the shoulder and the man is the head. ... A man is the president of his home. He can do anything that he wants."

– Focus group discussion
(village health team member), Kyegegwa

Qualitative findings also reveal social norms that prioritize a family's privacy or a family's or perpetrator's reputation above the well-being of the survivor. For example, in some communities, social norms dictate that families must settle their conflicts privately, or at least at the village level, and that women must support the opinions of the head of the family. Consequently, "amicable" settlements are often preferred because survivors and their families consider the social consequences of formal reporting to be problematic.



“We have a culture here in Arua and it is believed that if a woman reports her husband to police she has brought a bad omen to the whole family and she has to cleanse the family by bringing two goats, 100 kilograms of flour, a jerry can of waragi (local brew). This has discouraged women from reporting since they don’t have all these items necessary for cleansing the homes.”

– Key informant interview (female), Arua

“When a woman reports the husband to the police she brings a disgrace to the whole family, the children get sick or die plus other family members so in cases of violence they fear to report their husbands to bring such misfortune to their homes.”

– Key informant interview (male), Koboko

SOCIAL AND PHYSICAL ENVIRONMENT

Participants blamed the high levels of GBV, especially in refugee communities, on the breakdown of protective mechanisms and social norms that regulate behavior in stable communities. They discussed the link between the physical and social environment and GBV in various host and refugee communities. For example, women and girls are exposed to violence on their journey to water collection points or when collecting firewood. Participants reported that the refugee influx in some districts has resulted in a sudden and massive demand for scarce natural resources and has put even more pressure on woodland resources. The depletion of forest resources, for example, means that women and girls have to walk long distances in unsafe areas to collect firewood for household energy consumption, exposing them to violence.

“There is no doubt that there is massive environmental degradation. This means that the communities will not be able to get firewood with ease. They will have to walk long distances where they will find men with all wrong intentions, some are raped, and others survive.”

– Focus group discussion
(community protection structure member), Arua

“We struggle with what they can get as a percentage, it is supposed to be 16 liters of water per day for each individual if it is stable it is supposed to 20 but currently in Kyangwali, because of the number that has increased for an emergency, it is about 10 when you find women and children lining up for the water on the tanks either you find the woman has delayed there and the husband asks why did you cook late so fighting’s begin ... these women also go to the forest illegally to fetch firewood they sometimes find men there who try to rape them.”

– Key informant interview (male), Hoima

WEAK SOCIAL SUPPORT SYSTEMS AND ENFORCEMENT OF LAWS

Participants observed that weak law enforcement and a lack of adequate social support systems for survivors of violence contributes to a culture of impunity, increasing the risk of GBV. Participants reported that GBV survivors face numerous barriers and challenges to disclosing and reporting abuse, accessing support and services, and navigating intersecting legal processes and social support systems, including the social stigma associated with disclosure of domestic violence, lack of accessible shelters, and cultural beliefs that support keeping the family together and not disclosing “private” matters.

“Someone breaks the law and is not apprehended. This person will continue being violent toward the spouse. The spouse shall also not report the case since she well knows that nothing will be done.”

– Key informant interview (female), Koboko

“The police will arrest the perpetrator especially if the case is serious physical injuries. But they will tell you to go back and sort your things. That family thing should not be brought to police. They can even abuse you and say that you are stubborn; you don’t respect your husband and other things. How can a real woman report her husband?”

– Focus group discussion (female), Isingiro



TENSION BETWEEN REFUGEE AND HOST COMMUNITIES

The varied interactions between host and refugee populations present GBV-related risks, including those between employer and employee, trader and consumer, patron and client, marriage, and friendship. The power embedded in such relationships renders some vulnerable to GBV, particularly women.

Further, the emergence of relationships between members of the host population and refugees, particularly marriage, may affect the quality of earlier relationships. This is especially the case, for example, when a man from a host community abandons his family to start a new one with a woman from a refugee camp/settlement. Marriages in communal Ugandan societies, including those in refugee-hosting communities, are unions between families rather than individuals, which means that such new relationships can escalate tensions between host communities and refugees, and can lead to physical and emotional violence.

“They are up to 18 settlements with big number; some settlements with a population bigger than in town so many men have shifted to these settlements under a disguise that they are looking for employment. Now what happens, there are single women, some women go for men then the men also go for the women and then they marry them and they abandon their family.”

– Key informant interview (male), Adjumani

It is also common for participants in the host community to blame refugees for nonpartner sexual violence occurring in their areas.

Risk factors for VAC in refugee-hosting communities

Study participants discussed several factors that increase the risk of violence against children at the individual, interpersonal, community, and societal levels, summarized in table 3.1 and discussed in more detail below.

Individual-level factors

AGE AND GENDER

Participant narratives reveal that young children are more likely to experience violence at the hand of a primary caregiver or other family member, while older children are more likely to be victimized by a person outside the home or family setting. Study participants also shared their views about the gendered nature of violence. Girls are reportedly at higher risk than boys of experiencing sexual violence.

“If a girl is defiled, she would be defiled because she is female. At the same time, girls could be discriminated against and neglected by the family because of their experience.”

– Key informant interview (female), Adjumani

ILLNESS OR DISABILITY OF THE CHILD

Participants further offered thoughts on how children with disabilities may experience heightened vulnerability.

“The most at-risk child is the one with disabilities. I have worked on several cases where the wife gives birth to a child who later turns to be a disabled person. Such people are discriminated and stigmatized here.”

– Key informant interview (male), Isingiro

“Disabilities have led to family breakdown. Fathers have abandoned the mothers with their children. This has made some mothers engage in casual labor, they end up locking up the children inside the houses to go and work. At the end of the day, these children are neglected. These children are also blamed for causing the bad experiences the parents may be going through.”

– Key informant interview (female), Kiryandongo

Children with specific health conditions are, by comparison, considered more vulnerable to specific forms of violence. For example, in Lamwo District, children with nodding syndrome are frequently sexually assaulted by older men and bullied by boy children. Further, these children often experience neglect, remaining at home by themselves for long periods of time. Their parents and communities frequently discriminate against children with these conditions, preferring to prioritize the needs of other children.



“Another issue that is responsible for GBV or VAC is that we have a lot of mental health cases because nodding conditions are very prevalent. So, they suffer greatly with sexual violence because of their mental status.”

– Key informant interview (female), Lamwo

Family- and interpersonal-level factors

POVERTY AND FINANCIAL STRESS

Participants also report that VAC risks are greater when families are under stress from poverty. Notably, poverty, particularly the inability to meet basic needs, increases

family stress, resulting in higher rates of alcoholism and domestic violence. The stress on families may also undermine the mental health of parents, exacerbate depression, and result in their abusing their children. Poverty is also linked to family tensions, dysfunction, and separations—all of which heighten children’s vulnerability to violence. Participants noted how poverty can sometimes increase pressure on children to work under exploitive conditions to meet their basic needs or to support their parents in meeting the needs of the household.

TABLE 3.1
Risk Factors of GBV and VAC in Refugee-Hosting Communities

Level	Risk factors for GBV	Risk Factors for VAC
Individual	• Sex, age, and disability • Heath status, including trauma • Harmful use of alcohol and drugs	• Sex, age, and disability • Heath status, including trauma • Lack of awareness of individual and collective rights • Harmful use of alcohol and drugs
Interpersonal	• Alcohol and substance use • Marital tension and conflict • Family structure • Financial stress • Unequal power relations	• Parental beliefs and practices • Alcohol/substance abuse • Financial stress • Quality of the relationship between parent and child • Domestic violence
Community	• Physical environment (location, environmental degradation, and porous borders) • Low social cohesion and transient populations • Easy access to alcohol • Financial and material poverty	• Physical environment • Poor social cohesion and transient populations • Easy access to alcohol • Lack of culturally appropriate and accessible services to report and respond to violence against children • Violence in schools
Societal	• Gender inequality • Social and gender norms • Weak legal and social support systems • Weak law enforcement • Weak institutional capacity to respond to violence	• Social and gender norms • Absent or inadequate social protection • Weak governance and poor law enforcement



“Children work because the rate of poverty is very high here. Parents are not able to provide for their children all the basic needs. Most fathers love to drink alcohol and end up forgetting about their children. That is a big problem here.”

– Key informant interview (male), Adjumani

“There are families where you find a man having like 8 children, but with only one room, which is shared by the man and his wife plus the children. When the man comes back he will want to have sex with his wife amidst children, this makes the children learn bad manners and they start practicing what they see their parents do.”

– Focus group discussion (male), Kyegegwa

Further, in both refugee and host communities, poverty is linked to the commercial sexual exploitation of girls. Participants reported that poverty pushes girls into relationships with older men for the promise of money or gifts. These findings are similar to those in the 2019 interagency GBV assessment conducted among refugees. It reveals that poverty and a lack of safeguards drives children into the hands of abusers and perpetuates harmful practices, such as early sex and marriage (UNHCR and OPM 2019: 18).

“Defilement happens where girls who are 14 years to 16 years get defiled. It is the problem of money that leads them to get defiled. Because of poverty, men can sleep with girls and provide for basic needs. Some of these men get married to these girls before they are 18 years of age, and automatically it becomes defilement.”

– Key informant interview (male), Adjumani

Qualitative findings also indicate that some poor families are forced to live in overcrowded conditions, which often results in children sharing sleeping spaces with sexually active adults. This may put children at risk of experiencing and/or witnessing sexual violence.

“Poor housing facility of one room is exposing the children to high risks of engaging in sex early since most families sleep in one room with the children and their beds are separated by just a curtain so in most cases when the parents are engaging in sexual intercourse the children are hearing or even seeing and they are tempted to practice what they see with their fellow children.”

– Key informant interview (female), Moyo

BELIEFS AND NORMS REGARDING PHYSICAL PUNISHMENT

Social norms regarding physical discipline remain among the most prevalent risk factors for physical violence in refugee-hosting communities. Norms around the physical punishment of children center around the belief that parents and teachers should use violence as a means of control and discipline. Participants report, for example, that most parents and teachers approve of and continue to use spanking and other forms of physical punishment as disciplinary measures. Reasons for approval are rooted in beliefs linking the use of physical punishment with positive or neutral outcomes, such as “I was spanked and I am okay,” “spanking improves child behavior,” and “spanking is more effective than other forms of discipline.”

“Corporal punishment is still acceptable in schools, not only in schools even in homes. There we need to do a lot of work against physical violence. While some teachers and parents believe that children can listen when talked to, many still believe that physical punishment is the most effective form of discipline.”

– Key informant interview (male), Isingiro

“Inadequate knowledge about child rights! Because if you know the rights of this child you will not abuse his/her rights but you will have a reflection that this should not happen. So the inability to handle child’s rights is because many parents still believe in the African purpose of the child because I think when you are beaten you cannot hear or see from the buttocks.”

– Key informant interview (female), Adjumani



INTIMATE PARTNER VIOLENCE

Several participants discussed the link between IPV and children's exposure to violence. For example, exposure to IPV is linked to the use of violent methods (including shouting, striking, and slapping) to correct a child's behavior.

"When a woman and a man are fighting, the children are also affected. When a father is beating his wife, the children may also be beaten."

– Focus group discussion (female), Koboko

"Violence between adults affects children so much. When the man has not given the woman anything at home, the children are also affected especially about how they will survive or what they will eat. What happens is children step in to help their mothers you find a child working beyond their capacities like carrying the jerry can to help the mother."

– Focus group discussion (female), Kamwenge

ALCOHOL AND OTHER SUBSTANCE ABUSE

Participants discussed the link between alcohol/substance abuse and VAC. At the family level, participants reported that children with parents or caregivers who abuse alcohol or drugs are significantly more at risk of abuse, including sexual abuse. Participants also reported that family interactions are degraded by alcohol abuse, which affects communications between parent and child, as well as general parenting practices.

"When I ask for money, my father tells me that he is going to use it for alcohol. When my father drinks, he chases us away from home and uses bad language toward my mother. My mother has a very young child whom she goes away with."

– Focus group discussion (child), Koboko

"When it comes to Sunday, it is a market day here, men and boys are involved in substance use and take so much alcohol. Because of that, they end up defiling and abusing young girls."

– Focus group discussion (child), Yumbe

Alcohol consumption makes adolescent girls and young women more vulnerable to sexual abuse. The contexts of alcohol consumption, such as bars, can also facilitate sexual negotiations. For example, participants reported that older men in the community buy girls alcohol to lure them into sexual activity.

"The older men buy them alcohol and when they get drunk, they sleep around with them. It is very risky because you do not know what someone's intentions for you are."

– Focus group discussion (male), Adjumani

Attitudes and norms about adolescents and young women who drink and accept drinks from men compounds the problem. Many believe it is legitimate for a man to force sex on such a woman; they do not consider that to be rape. The belief that if a girl accepts a drink from a man, he has paid to have sex with her remains widespread.

"If you buy a drink for a woman and you don't go and sleep with her, it means she has drained you."

– Focus group discussion (male), Hoima

Community-level factors

PHYSICAL ENVIRONMENT

Qualitative findings indicate that the physical environment in which children live or spend their time can increase their risk of experiencing violence. The commercial sexual exploitation of children is more common in refugee-hosting districts near border areas or in urban areas/towns. Participants reported incidents of children in West Nile getting married across the border in South Sudan, and because of the porous borders, the Ugandan authorities have no control over the situation.



“In South Sudan, if a girl is above 14 years, she is ready for marriage which is not right in Uganda ... parents negotiate for dowry without her will and those dowries are paid without her knowledge. At the end of the day, after paying dowry, they will plan to kidnap this girl to be taken back to South Sudan ... This girl will come back married and when she has delivered. So that is the nature and because of the porous borders, this is very frequent. So, when such things happen, as [Office of the Prime Minister] it is very hard for us to get that information because they conceal the information.”

– Key informant interview (female), Adjumani

Study participants from several communities identified particular “hotspots”—areas where children are at very high risk of abuse, such as water collection points, firewood collection areas, and recreational spaces (e.g., shack cinema/video halls, and night clubs). They reported that children are at high risk of assault when they go to the bush to collect firewood or if they fetch water unaccompanied, especially in the early morning hours and at night.

“One thing I would like to talk about is the films and discos that children go to. They leave home and go to the trading centers and are exposed to drinking. After drinking, many things happen to them.”

– Focus group discussion (child protection committee member), Kiryandongo

“When people go to markets at night they become vulnerable and even young girls who go to fetch water in the late hours of the evening, are vulnerable to rapists and various cases have been reported in Yumbe.”

– Key informant interview (female), Yumbe

Societal-level factors

SOCIAL NORMS

Harmful practices, such as child marriage, are normalized in some communities. Economic vulnerability exacerbates some of these norms. For example, in some cases, children are married off because families cannot afford to meet their basic needs or in the hopes of obtaining bridewealth. Some

participants discussed the link between bridewealth and coping in times of economic hardship and food insecurity.

“Sometimes parents fail to get money to educate their children. The children stay at home and when they get a boy they go away. The parents get money and the child gets married. Some parents when the girl gets a boy to marry her, they force her to get married to get money or even reduce the burden because of the poverty at home.”

– Focus group discussion (male), Kyegegwa

Intersections between GBV and VAC

Assessment results point to intersections between GBV and VAC, which is consistent with previous studies. First, this study reveals several shared risk factors between GBV and VAC, including alcohol and substance use, family conflict, poverty, social norms regarding gender roles, and norms that deem violence acceptable. In addition, the experience of household violence reflects inequitable gender and age-related power dynamics. For example, women and children are more likely than men to experience household conflict or violence.

GBV and VAC are repeatedly found in connection to the division of and expectations associated with household responsibilities. With regard to GBV, violence stems from men perceiving women as not performing their expected gendered responsibilities, such as meal preparation. Similarly, a perceived lack of contribution to household responsibilities also result in VAC. In these instances, a range of adult caregivers, including mothers, fathers, and extended family members, perpetrate violence against children.

In addition, IPV is found to be closely linked with both physical and psychological violence against children (see the previous section). Focus groups and interviews reveal that IPV and VAC commonly overlap within the same household. Notably, children in households where women are abused are perceived to be more likely than other children to experience harsh physical discipline. This is consistent with



findings from other studies in Uganda, which show that IPV and VAC co-occur and can become profoundly intertwined, creating cycles of abuse in the family (Devries et al. 2017; Namy et al. 2017).

Given these intersections, building a close collaboration between GBV interventions and child protection systems is essential. The evidence implies that policies and programs need to be more integrated, and coordinated strategies are needed for addressing violence against women and children. For example, service providers who assist abused women should also assess the safety and well-being of children, and take steps to provide them with appropriate care. Conversely, those who provide services to children who are survivors of abuse should consider the possibility that IPV may be co-occurring in the home, and develop appropriate responses.

GBV and VAC risk factors for refugees

The recent interagency assessment led by the United Nations High Commissioner for Refugees (UNHCR) reveals several risks of GBV and VAC specific to the refugee context (UNHCR and OPM 2019). The main risks include poverty and limited access to livelihood opportunities; predisplacement norms that emphasize female submissiveness and normalize masculine aggression, dominance, and control; exposure to trauma, alcohol, and substance abuse; normalization of violence; and changing gender roles or shifting gendered division of labor occasioned by displacement. Regarding the last, men's inability to live up to their most fundamental gendered role as providers and the corresponding increase in women's participation in economic activities is particularly mentioned as heightening the risk of IPV. Notably, men's perceived failure to provide for their families and a "feeling of disempowerment" prompts some to use violence as a way of reaffirming their manhood, especially if they feel challenged by a woman.

Reception, registration, and refugee status determination services are key to ensuring the effective protection of refugee women and girls. Registration legitimizes the status and rights of refugees and entitles them to protection from violence. Responsible entities are accountable for

their registration. However, limited capacity among border authorities and reception staff, as well as coordination shortfalls among key partners, creates delays and backlogs in the registration process and issuance of documentation. Mechanisms and pathways that allow refugees to report complaints and receive feedback about reception, verification, registration, and refugee status determination are limited; they need to be strengthened and better coordinated.

Findings also indicate that, at present, there is very little information available to women and girls at the reception centers about GBV and how they can access services. At times, information is shared through megaphones, but GBV-related messages get lost amid a flurry of other information that new arrivals receive. In some reception centers, informational GBV handouts are distributed, which describe GBV, its root causes, and its consequences to survivors, their families, and society. This approach is fundamentally flawed and will do little to promote reporting and accessing services by survivors. The handout is written in highly technical English, and some of its pictorial messages are confusing or inappropriate.

Further, despite the widely publicized reports of sexual and other forms of GBV in South Sudan and other countries, there has been surprisingly little effort to identify survivors upon their arrival in Uganda or to meet their immediate health needs at the reception centers. The vast majority of the existing GBV prevention and response programs are dedicated to incidents that may occur in the Ugandan refugee settlements themselves. During the interviews, UNHCR staff said they are aware of this gap and are brainstorming solutions to identify survivors and give them care.

Further, UNHCR, the Office of the Prime Minister, and other partners involved in the screening of refugees at the reception centers need to review their procedures for identifying people with specific needs. At present, representatives from several agencies sit at one table and ask refugees questions to determine their vulnerability. At the reception center, screeners are often of mixed gender, reducing the possibility that a woman or separated child would report a case of GBV or VAC.



GBV AND VAC RESPONSE SERVICES IN HOSTING AND REFUGEE COMMUNITIES

The multifaceted nature of GBV and VAC necessitates myriad strategies to respond to the diverse manifestations of violence and the various settings in which it occurs. GBV and VAC response services fall under four interrelated categories, delivered under a multisectoral framework.

- 1. Health/medical services.** GBV survivors, including women and girls, need access to quality, life-saving health care services, with an emphasis on the clinical management of rape.
- 2. Mental health and psychosocial support.** GBV survivors need access to quality mental health and psychosocial support focused on healing, empowerment, and recovery.
- 3. Protection: safety/security services.** Safety and security measures need to be in place to prevent and mitigate GBV and to protect survivors.
- 4. Legal/justice response.** A GBV response involves investigative services, prosecution, formal and informal justice, legal aid, assistance, and counseling.

GBV response services

KEY FINDINGS

- ◆ GBV cases are often unreported or reported late. The primary reasons identified for nonreporting include fear of reprisal; pressure from family members; safety concerns, especially when the abuser is a spouse or family member; lack of confidence in the legal system; and stigma.
- ◆ Lower-level health facilities in refugee and host communities lack trained staff and necessary medical supplies to treat survivors of violence, particularly sexual violence. Most survivors are unaware of the benefits of seeking prompt

medical attention and, as a result, report weeks or months after the event.

- ◆ The capacity to diagnose and treat trauma-related GBV remains low in most health facilities located in refugee and host communities.
- ◆ Most police staff in refugee-hosting districts have not received GBV-related training.
- ◆ Referrals and linkages between health care facilities and community-based services remain particularly weak.
- ◆ Only a small fraction of GBV cases are prosecuted through the legal system, and even fewer result in a conviction. Factors hindering the prosecution of GBV cases include costs associated with accessing justice and distance to courts.
- ◆ Access to legal aid services is a challenge. While some nongovernmental organizations (NGOs) offer legal services, they are overstretched, with limited geographic scope.
- ◆ All justice, law, and order sector institutions have serious logistical and human resource deficiencies, negatively affecting their capacity to discharge their functions effectively and efficiently. Because of problems associated with access to the formal criminal justice process, many survivors and their families rely on informal justice mechanisms.

Health/medical services

Access to high-quality, confidential, and integrated health care services is a critical and life-saving component of a multisector response to GBV. Services include HIV counseling and testing, treatment of acute injuries; provision of postexposure prophylaxis (PEP) for HIV; presumptive testing and treatment of sexually transmitted infections; provision of emergency contraception for eligible survivors;



TABLE 3.2

Health Facilities in Refugee Settlements and Host Communities in Study Districts

	Facility Level				Total
	Hospital	HC IV	HC III	HC II	
Refugee settlements	0	2	31	28	61
Host communities	2	9	57	67	135
Total	2	11	88	95	196

HC = health center.

trauma counseling; safety planning; referrals to support services, such as the police, emergency shelter, mental health, and economic empowerment programs; and medical examinations for the collection of forensic evidence. Health providers are also mandated to collect medical and legal evidence to corroborate the accounts of survivors and help identify perpetrators. These services should be delivered in a confidential and nondiscriminatory manner that considers the survivor's gender, age, and any specific needs.

Across all study sites, health services for refugees and host populations are provided based on an integrated approach. The integration process is guided by the Uganda National Integrated Response Plan for Refugees and Host Communities and the UNHCR's Global Strategy for Public Health (2014–18). These plans operationalize integration by linking humanitarian and development programming and interventions. Notably, health services are provided by public and private health facilities as well as by health NGOs,⁸ such as Medical Team International, with referrals directed to the nearest district or regional hospital.⁹ Cognizant of the pressure that the increased refugee population would place on public health facilities, UNHCR and partners have supported infrastructure expansion in some facilities and equipped them with the requisite supplies and staff across the study districts. In some districts, service delivery has been expanded through the establishment of health facilities by the Uganda Development Response to Displacement

Impacts Project (DRDIP), UNHCR, and development partners. For example, in Yumbe, 16 health facilities have been established in the refugee settlement since 2017. These facilities, established in line with Ministry of Health guidelines, report to the ministry through the district.

An overall total of 196 health facilities were mapped in refugee and host communities across the study district (61 in refugee settlements and 135 in host communities, as shown in table 3.2). The study establishes that health care services are generally available for GBV survivors and are free in almost all health facilities visited in the refugee settlements and host communities. However, the scope of services varies across facility levels (see table B.2). Further, the presence of NGOs and humanitarian organizations providing health services in refugee settlements makes health care more accessible to refugees. Although there is a certain degree of integration of access to health services for both hosts and refugees, there is still a reluctance among host communities to use health facilities primarily set up for refugees in the settlements.

HEALTH SEEKING AMONG GBV SURVIVORS

GBV survivors, especially survivors of sexual assault (including rape) require immediate medical response to heal injuries, administer medication to prevent or treat infections, and prevent unwanted pregnancies (where local laws allow). However, findings indicate that most survivors do not seek medical assistance following a GBV incident. Even among those who do, misconceptions of the nature of risk faced and the necessary preventative treatment results in late reporting. While treatment within 72 hours is needed,

8. United Nations High Commissioner for Refugees and/or individual donor organizations provide funding to NGOs to implement a part or the entirety of a health service delivery system focused on the refugee population.

9. Integration of services is considered an opportunity to improve access to health services and ultimately the standard of living for both refugee and host communities.



particularly to administer PEP, survivors may present themselves much later. Decisions to not seek care and delays in care seeking often mean that evidence is lost and that cases requiring PEP go untreated.

Participants discussed several challenges related to health seeking. First, most survivors are unaware of the benefits of seeking prompt medical attention and, as a result, report weeks or months after an event. Educational campaigns may, therefore, help inform the refugee and host community about the urgency of clinical care to effectively treat sexual violence. Second, health centers are often located far from the refugee and host communities, with limited transportation options allowing them access to treatment. A lack of trust in service providers, limited community awareness of available services, and a fear of stigmatization by community members are other active deterrents to GBV survivors seeking help.

POOR CASE MANAGEMENT CAPACITY, ESPECIALLY IN LOWER-LEVEL HEALTH FACILITIES

The study's findings indicate that the range and quality of medical services available to GBV survivors vary greatly across the study sites and facility levels. The GBV health infrastructure is well-developed in higher-level facilities—e.g., hospitals and health center (HC) IVs¹⁰—but poorly developed in lower-level health facilities—HC IIIs and IIs—where the bulk of GBV cases are recorded. The lower-level facilities lack staff trained in the clinical management of rape as well as the necessary medical supplies to treat survivors of violence, particularly sexual violence, including a shortage of sexual assault forensic evidence kits, PEP, emergency contraception, pregnancy test kits, and medications for the treatment of sexually transmitted infections. Due to this lack of capacity, case management is still very poor in the

lower-level health facilities. For example, more than half (39 out of 67) of the HC IIs in host communities do not have emergency contraceptives in stock; and the majority (55) do not have private consultation rooms or standard operating procedures, guidelines, or protocols on GBV.

Survivors who seek services at these lower-level health facilities are often referred to higher-level facilities (HC IV and referral hospitals) to meet their needs, especially for medical examinations and the collection of forensic evidence. This assessment finds that when referrals are made to a survivor who is a refugee, that survivor is often escorted to or otherwise assisted in accessing services at higher-level facilities, which is not always the case for survivors in host communities.

“Because of contraceptive stockouts, as well as how clinics are structured, GBV survivors are often unable to receive all post-GBV services in one location. They may receive an exam in one department, for example, and then be referred to another department for contraceptive needs. In the case of stockouts, survivors may have to visit a different clinic entirely. Visiting multiple locations can be difficult logistically and emotionally, especially in the absence of a good case management system and can lead to delays in receiving essential care.”

– Key informant interview (female), Kiryandongo

Findings also show that despite interventions aimed at recruiting and retaining health workers, there are still challenges regarding their number, skills mix, retention, and motivation. In all surveyed health facilities, staffing levels remain below standard, particularly in rural and hard-to-reach areas where most of the refugee settlements are situated. In refugee-serving health facilities, partners have tried to supplement existing government staff by recruiting more personnel and, in some cases, topping off the salaries of government staff to incentivize them and improve retention and performance. This support notwithstanding, the health centers remain overcrowded due to the large catchment population that they serve, with hours-long waiting times before health care is provided. In addition, some donors, such as the World Health Organization and the United

10. The government health service in Uganda is structured into national and regional referral public hospitals, general hospitals, and health centers. The health centers are divided into four levels (HC I to HC IV). HC I, the lowest level, comprises a village health team or individual health volunteer (who may or may not be formally trained) who links the community to the national health service. HC IIs, also known as dispensaries, are parish-level facilities that serve roughly 5,000 people each, led by an enrolled nurse who works with a midwife and two nursing assistants. HC III facilities, which serve a subcounty of approximately 20,000 people, supervise community health workers and the HC IIs within their jurisdiction. HC IVs are district hospitals that serve counties of about 100,000 people each; they offer the highest level of services in the district.



Nations Population Fund, have funded some trainings for health workers on the management of GBV cases, but the lack of sufficient government financing is hampering the ability of districts to expand the training to reach all health providers.

MEDICO-LEGAL SERVICES

Survivors who interface with the health care system should also receive medico-legal services, including the collection of forensic evidence from GBV survivors and completion of the medico-legal/GBV incident report forms (Police Form 3, or PF3)—both of which are necessary for prosecution. The police form provides medical evidence in cases of GBV. The medical examination and documentation of forensic evidence is the responsibility of a medical officer (doctor) at a regional or district hospital and/or a clinical officer or midwife at an HC IV or HC III. However, findings indicate that 9 out of 31 HC IIIs in the refugee settlements, particularly those that are privately run by NGOs, did not authorize their staff to independently complete PF3. In practice, the forms filled out by such clinicians would need to be stamped by a public health facility as part of the procedure.

Allegations of corruption were also made against some medical personnel for receiving payments to complete Police Form 3. Some health providers are reportedly afraid of retribution by perpetrators if they complete the requisite police form to report an incident of violence; and many others are reluctant to testify in court, or they consider the court process laborious and costly.

“Cases in court take too long to end and health workers have to be in court several times. Most of them even move long distances and incur expenses. So many health workers do not want to fill [Police Form 3] to avoid the processes of going to court. The government put in place a fund for health workers working on the case, however, it’s not enough and process of getting it is also not clear to most of the health workers.”

— Key informant interview (female), Arua

LIMITED FOLLOW-UP FOR SURVIVORS, AFFECTING THE CONTINUITY OF CARE

Most survivors never receive follow-up care by health workers after their initial contact with health care facilities. Health workers either do not have the time to conduct follow-up visits due to limited staffing and heavy workloads or they do not see this as their mandate or duty. This restricts the providers’ ability to track survivors and provide post-GBV care services, including family planning counseling on short or long-term contraceptives.

“When survivors get out of here, everything is like we are finished with them. Most of the survivors do not come back and we are not able to follow-up. They always sit back and solve their cases at home.”

— Female health worker, Moyo

REFERRALS

Beyond immediate medical attention, survivors of violence need services including mental health and psychosocial support and legal assistance. Among the GBV-related duties of health workers is the referral of survivors to services in other sectors to improve survivor outcomes.

Overall, the study findings show that bidirectional referrals occur between the health facilities and the police in both refugee settlements and host communities. Survivors who present or register/report at the health facilities are referred to the police for legal/justice support, including obtaining PF3 and Police Form 3A (PF3A), depending on the form of violence they have been exposed to. Similarly, survivors who report to the police are often referred to health facilities for medical assistance and medico-legal support, including the completion of the form. Regardless of the first point of reporting, survivors are required to return the form, which provides proof of abuse—a necessary element for prosecution.

Nonetheless, respondents report challenges in implementing the GBV referral guidelines effectively. Health providers and police are aware that survivors should be referred to health clinics within 72 hours; however, survivors do not always have the time or financial resources to travel from



the police station to a health clinic, especially when they are geographically distant from one another. Health referrals to the legal system are also constrained, especially in refugee settlements where the presence of police and the judiciary is limited or nonexistent. The study findings also indicate that referrals and linkages between health care facilities and community-based services remain particularly weak.

"I only notice that the police and the health facilities working together on these cases, probably because of the forms that the health workers have to fill yet they can only be found at the police stations... I have not observed much happening beyond these two sectors, women need things like counseling, but police rarely refer them [to the community development officer]."

– Key informant interview (male), Hoima

Mental Health and Psychosocial Support

Psychosocial support interventions are essential components of the comprehensive package of care that aims to protect or promote psychosocial well-being and to prevent or treat trauma among survivors of violence. According to the National Guidelines for the Provision of Psychosocial Support for Gender-based Violence Victims/Survivors, quality psychosocial services should be survivor-centric; build individual and community resilience; support positive coping mechanisms; and draw on family, friends, and community members (MGLSD 2017b). The guidelines emphasize that such services be provided by specialized trained personnel, such as counselors, police officers, nurses, social workers, psychologists, and psychiatrists—preferably of the same sex as the survivor—and that they should be provided soon after the incident.

CLINICAL MANAGEMENT OF GBV-RELATED TRAUMA

In refugee and host communities, trauma-related services for survivors are accessed mainly through the public health care system. However, the capacity to diagnose and treat trauma-related GBV remains low in most public facilities. Most facilities lack key personnel who can handle such issues, such as medical social workers, psychiatrists, psychotherapists, and clinical psychologists. In such clinical settings, the mental health and psychosocial needs of

survivors of sexual violence are overlooked. For example, government-operated and NGO-supported health facilities usually focus on the physical effects of sexual violence, such as pregnancy and HIV, and pay less attention to mental health and psychosocial effects. At most facilities, whatever counseling is offered does not involve the deeper therapeutic engagement needed to facilitate mental health and psychosocial recovery. Notably, none of the visited health facilities is applying structured therapeutic interventions, such as cognitive-behavioral treatment therapy for trauma.

"At Health Center III, even counseling services are not there because health workers don't have the capacity. They can talk about it just basing on the general knowledge they have but they don't have that exact knowledge we expect of them to support these people."

– Key informant interview (male), Hoima

Study findings indicate that most survivors do not receive clinical counseling beyond their first contact with health care providers, partly due to poor or nonexistent follow-up efforts by health and mental health professionals, distance to health care facilities, and associated costs. It is therefore not surprising that when questioned about GBV programming gaps, participants across the board said that the largest is psychosocial services to address trauma.

Findings indicate that there are a few NGOs dedicated to providing professional psychiatric assistance and trauma counseling. However, they have had difficulty securing funds, gaining implementing partner status with UNHCR, and/or receiving authorization from the Office of the Prime Minister to operate in the settlements. UNHCR and the Office of the Prime Minister should immediately prioritize partnership applications related to the provision of counseling to refugees.

PSYCHOSOCIAL CARE AND COUNSELING

The Ministry of Gender Labour and Social Development's guidelines on psychosocial support require that interventions adopt a family- and community-centered approach to strengthen the networks around survivors and minimize



their risk of further harm. Community structures, including religious groups, as well as community, clan, and political leaders, are critical to supporting the psychosocial recovery of survivors.

Study findings indicate that survivors receive varying degrees of counseling services from the statutory duty bearers with whom they come into contact at the district, subcounty, and village level, including police—especially from officers in the child and family protection unit, probation officers, district- and subcounty-level community development officers, and local council authorities. GBV-related counseling requires a deep knowledge of the underlying causes of violence and of the various forms of violence, as well as the use of trauma counseling techniques to establish safety and to control trauma-related symptoms. However, most of the statutory duty bearers have received no training, nor have they received an adequate induction into how to provide GBV survivors with immediate and longer-term psychosocial counseling as part of a mental health and psychosocial services package.

Several NGOs support refugees and provide psychosocial services to refugee survivors of GBV. Some, such as the Lutheran World Federation, Transcultural Psychosocial Organization, Médecins Sans Frontières, International Rescue Committee, CARE International, Danish Refugee Council, TUTAPONA Trauma Rehabilitation, and the American Refugee Committee, use a variety of approaches focused on providing psychosocial support to GBV survivors, including individual and group counseling, especially in refugee settlements. Discussions, however, reveal that psychosocial care services have limited scope of coverage and resources to meet the survivors' needs in their entirety.

Informal (community-based) counseling is available and easily accessible to survivors in each of the study districts. For example, most survivors go to their family or friends for supportive counseling and emotional support regarding their experiences. In addition, community-based structures, such as child protection committees, para-social workers, community activists, and village health teams, play a key role in providing psychosocial support services to survivors,

including offering counseling, advising survivors to seek support, and linking survivors to NGOs for further help. However, some of these structures, especially in host communities, lack adequate training and knowledge in handling the various psychosocial effects associated with exposure to violence.

SAFE SPACES FOR WOMEN

Organizations such as the International Rescue Committee, the American Refugee Committee, and CARE International, among others, in partnership with UNHCR, have set up women-friendly spaces (or female-friendly spaces) in refugee settlements. These are safe areas where women can access resources, support, basic services, social networks, and referrals to additional services. Women—and sometimes girls—can socialize and rebuild their social networks, acquire relevant skills, and receive information about a wide array of issues, including women's rights, health, and services. The facilities and services available at these spaces vary greatly from one to another; each offers a nonstandard package of services. A key priority is the establishment of additional such safe spaces in refugee settlements because the existing ones are insufficient to respond to the demand.

"These women centers are managed by the partners in different zones. In zone 1 and 2 we have IRC [International Rescue Committee], CARE is in zone 4, ARC [American Refugee Committee] zone 5. Women at these centers do crafts, charcoal stove making, there is a lot that they do in that they forget about what happened."

— Key informant interview (male), Arua

Across each of the host communities, there are no shelters or safe spaces identified that would allow survivors to temporarily remain in secure conditions if it would not be safe for them to return to their place of residence.

In situations when formal protection systems are weak or nonexistent, informal community-based protection mechanisms can play an important role in ensuring women's and girls' safety and security. However, options for the safety and protection of survivors and their families who are at



risk of further violence and who wish to be protected at the community level are severely limited.

Protection (security/safety) services

Survivors of GBV are often at high risk of further violence by their perpetrator(s) or others. Safety and security measures are therefore an essential component of any comprehensive package of care for GBV survivors.¹¹ Failure to properly ensure the safety and protection of survivors and those at risk of violence negates any subsequent actions.

In Uganda, ensuring the safety and protection of GBV survivors is primarily the responsibility of the police. Protection-related responsibilities begin with the early identification of crime and continue throughout the justice continuum. For example, any decision regarding arrest, detention, or release of a perpetrator must consider the safety of the survivor and her family. In addition, as the receivers and investigators of reports of GBV, police play an important role in providing information, safety, and protection to survivors and witnesses. Further, the police play a key role in directing or linking survivors to service providers who can assist them in obtaining protection orders, restraining orders, and barring orders through criminal and civil court processes. Police are also generally responsible for enforcing any violations of such orders.

Overall, findings indicate that the capacity and number of police officers remain inadequate to effectively respond to the physical security of GBV survivors in refugee and host communities (see detailed discussion in the next section). For example, in both refugee and host communities, there is a lack of facilities and infrastructure to effectively investigate cases and protect survivors. Ineffective investigations and a failure to prosecute GBV cases contribute to an environment of impunity that marginalizes survivors and discourages reporting and help-seeking behavior.

In addition, community policing activities are not reaching the refugee and host communities. This creates the perception that the only time the police show up is to execute

an arrest. It is only then that the police presence is felt, but not through community policing activities or other police activities, such as patrols. Indeed, there is a general lack of police visibility in the refugee settlements, which portends a security risk.

Justice and legal aid services

Access to justice can be an empowering and essential part of a survivor's healing process. Several statutory structures and institutions are involved in ensuring justice for GBV survivors at the district level, including the police, health care providers (who collect scientific evidence in cases of assault or sexual violence), the community-based services department, the directorate of public prosecution and courts of judicature, and local council courts (see figure 3.1). The roles of these actors are articulated in several legal and statutory instruments and policies.¹² These structures serve both refugees and host communities.

Within the settlements, the refugee welfare committees (RWCs), comprising elected refugee leaders, also play a key role in ensuring access to justice for refugees, including the referral of survivors to the formal actors outlined above. For example, cases are first reported to the RWCs, which serve as the foundation of the coordination of reporting; it is the RWC leader who decides if a case should be addressed at the RWC level or reported to the formal justice actors.

Specific gaps in the legal/justice response to GBV in refugee and host communities are described below.

CASE REPORTING

Overall, study participants said that GBV cases are often unreported or reported late. As discussed earlier, the primary reasons for nonreporting are fear of reprisal, especially pressure from family members, and safety concerns if the abuser is a husband or family member; low confidence level in the legal system; lack of accountability of perpetrators; and the stigma and social isolation associated with being a survivor. Women who report violence may

11. Safety refers to physical safety, security, and a sense of psychological and emotional safety among people experiencing a high level of distress.

12 The legal environment of Uganda is robust, including laws relevant to the governing of GBV-related cases, such as the Domestic Violence Act, Penal Code Act, Marriage and Divorce Act, Land Act, Evidence Act, Children Act, Refugee Act, and the Constitution of Uganda.

be blamed for exposing the perpetrator and “getting him in trouble.” In some cases, a woman is reluctant to report her spouse or partner because she cannot afford to lose the financial support he provides.

“Too often, women view violence, including sexual violence, as a fact of life. Under these circumstances women sometimes choose or are pressured by their families or communities, not to report sexual violence to authorities.”

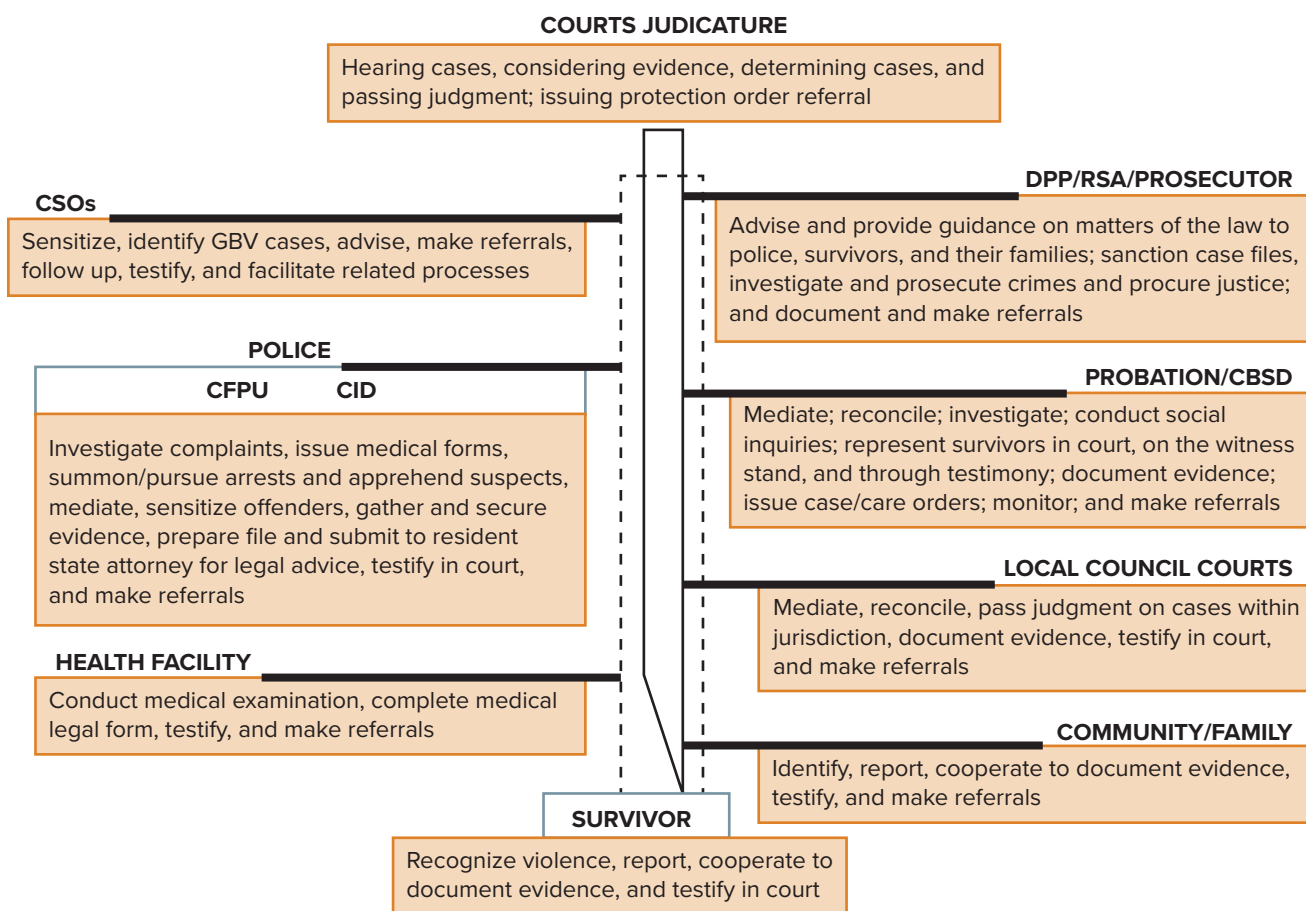
– Key informant interview (male), Kyegegwa

“They never say, “My husband is beating me.” [Why is that?] Scared, they are afraid. And if you have kids and your husband leaves you and you don’t have a job, how are you going to support your children? Women with children won’t get away from their husbands when they get abused because they are ones with financial support or the ones who pay the bills.

– Key informant interview (male), Koboko

FIGURE 3.1

Legal and Justice Actors and their Roles



CBSD = community-based service department; CFPU = child and family protection unit; CID = criminal investigation department; CSOs = civil society organizations; DPP = Directorate of Public Prosecution; RSA = resident state attorney.



When a survivor does press charges, she is often prevailed upon to withdraw them. The common practice is to settle cases outside the formal justice system. Even when the police insist on investigating and prosecuting a case, there is often intense pressure on the survivor and her family to resolve the matter—i.e., settle the case—informally. Survivors and their families are usually encouraged to accept compensation as a better option than pursuing elusive justice.

“The condoning of GBV is expressed by the community in some cases by not cooperating with the Police to give up offenders, even when the life of victims is in danger”

– Key informant interview (female), Adjumani

“People would want to report cases of abuse and violence. ... but they also weigh the costs such as transport for the complainant and sometimes for a witness and the uncertainty of the outcome against the material gain offered by the perpetrator ... they decide to come to an agreement with the perpetrator.”

– Key informant interview (male), Isingiro

Local leaders, including RWC members, sometimes even hide severe GBV cases—such as defilement and child marriages. The absence of a witness protection law in Uganda has aggravated this problem, which in some cases has forced complainants to withdraw their cases out of fear. In addition, for survivors living in remote villages, physical access to the legal system may be difficult. If a survivor does not live near a police station, the travel required to report a crime (as well as to seek medical treatment) can be a significant obstacle.

INVESTIGATION AND PROSECUTION OF GBV CASES

The successful prosecution of GBV offenses heavily depends on effective investigations that take a holistic approach to the gathering of evidence. The legal framework in Uganda mandates that the Uganda Police Force conduct effective investigations and evidence collection for cases of GBV. Across all surveyed districts, there are 137 police posts and stations. Study findings show that police capacity for fulfilling this mandate across the study

sites continues to be riddled with deficiencies, ranging from human resource gaps to a lack of logistical resources for effectively carrying out their role, such as a lack of transportation.

Across all the study sites, the police do not have adequate human resources and do not meet international standards in terms of the ratio of the police officers to population. For example, according to the district police commander, Isingiro district has only 199 police officers, 55 of which are in the settlements. According to population demographics, there is only one police officer for every 2,780 people, far below the internationally recommended ratio of one to 450.

“The police in the refugee settlements are understaffed and some even have no means to arrest perpetrators, no transport and no holding cells. This has influenced community member’s reluctance to report cases and also the increased reliance on community structures which in most instances do not serve the interests of the survivor and might lead to revictimization.”

– Key informant interview (female), Adjumani

In addition, there are serious deficits in the number of women police deployed in the refugee and host communities. Across all study sites, only 16 percent of police officers are women, which limits the police services available to women. According to one woman participant in a focus group discussion in Nakivale:

“We also want policewomen on board at the police station, we always find men when at the time we have problems as women and want to talk to fellow women.”

Another woman respondent in Isingiro remarked:

“The challenge I have is that the police stations don’t have women whom we can open up to when we have our complaints. When you come to the police station its only men we find there and usually they don’t have time for us.”



Participants reported that many of the police officers are inadequately trained in or oriented with GBV and/or have not received GBV sensitivity training to ensure appropriate investigations or to support traumatized survivors. For example, over half of the police posts (27 out of 46) and 15 out of 47 police stations in the host communities have reportedly not attended any specialized GBV or child protection (VAC) training over the last 12 months, which may be attributed to the frequent transfers and rotations. Some participants report that police officers are often indifferent to the plight of survivors and are less inclined to meet them at a location where their privacy can be respected, and that survivors are often retraumatized by having to repeat their stories multiple times.

“Survivors may experience secondary victimization when attempting to report a rape; for example, survivors have been asked to give statements in public areas of police stations, officers have not believed them and refused to take statements, and officers have blamed the victim for what they were wearing, being intoxicated, or being out late at night.”

— Key informant interview (female), Kyegegwa

Further, the lack of facilities and infrastructure makes it hard to effectively investigate cases and protect the survivors in both refugee and host communities. For example, several police stations and posts lack counseling or interview rooms that guarantee privacy. When GBV survivors go to a police station, information is first taken at the main desk, which is often surrounded by people waiting to see a detainee or to lodge a complaint.

“I do not have space, but I sometimes improvise. There is a dairy shop around here [adjacent to the station structure] where I request for space when there are many people in this office. So, I take the survivors there and speak to them ... and counsel them. Sometimes they get better and resolve the issue and others don't and so we refer them to the main police station for further management.”

— Key informant interview (police officer),
Isingiro District

In addition, several police stations and posts lack basic equipment, such as vehicles, medical examination forms, and paper, which are necessary for conducting an effective GBV investigation. In addition, several police stations lack the capacity for collection, analysis, storage, and presentation of forensic data, further compromising their ability to assemble convincing evidence that will sustain a GBV case. The lack of transportation is cited as one barrier to the successful investigation and follow-up of cases. Without means of transportation, police officers cannot move from one place to another, a prerequisite for them to efficiently discharge their functions. Yet even those that have access to a form of transportation still face fuel-related challenges. For instance, the district police commander of Isingiro is only given U Sh 900,000 for fuel expenses each month with which to run operations in the entire district.

In addition, specialized equipment, including scene-of-crime officer kits, are in short supply, constraining the ability of investigative officers to collect evidence at the scene of a crime, affecting the investigation of GBV—among other—cases. For example, at some police posts, officers reportedly did not even have the forms used to record and collect evidence in GBV cases.

Study findings also indicate that most of the police posts and stations have no facilities for handling survivors of GBV, especially as far as psychological support and rehabilitation are concerned. For instance, at most police posts and stations, there are no special shelters, nor are there special interview spaces for the survivors in or outside the settlements. When the need arises, interviews are conducted using improvised space.

To improve the handling of GBV cases, some police stations have created gender desks. For example, at Arua Central Police Station, five officers run the desk. Unfortunately, they have not received any special training on how to handle such cases. A few officers have attended workshops on the subject but none have received specialized training. Moreover, due to constant rotations, the police station loses officers with experience and training.



The Directorate of Public Prosecution is mandated to direct police to investigate GBV cases, including cases of sexual violence; provide advice and guidance to the criminal investigation department on conduct of investigations, decisions to prosecute, and what charges to register; provide legal assistance and support to GBV survivors; and ensure effective and expeditious prosecution of perpetrators. The directorate is represented at the district level by resident state attorneys and resident state prosecutors. However, the performance of the Office of the Director of Public Prosecutions is affected by human resource deficiencies. While the staff in the resident district state attorney's office must deal with several cases other than GBV, some district offices only have two or three staff members. For example, Isingiro district has one state attorney and one prosecutor. These officers are overstretched. In some cases, they are required to appear at different courts at the same time, which is clearly not realistic.

In addition, resident state attorneys often lack the resources to complete their work expeditiously. For example, due to transportation constraints, most prosecutors are not able to meet with witnesses in preparation for court hearings. Sometimes, GBV survivors must testify in court without receiving any pretrial guidance from a prosecutor. Further, prosecutors and resident state attorneys do not conduct their own investigations—they rely on police investigations, which are often ineffective due to multiple challenges, as previously noted.

Another highlighted challenge is the absence of witness protection programs. State capacity to protect survivors and witnesses from retaliation during criminal trials is virtually nonexistent across study communities. The silencing of survivors by family and community members further weakens the chances of a perpetrator being prosecuted and convicted. Survivors often experience societal pressure to resolve cases through community leaders, particularly when the perpetrator is a family member.

"Amid all the challenges; there is the aspect of withdrawals. The survivors will beg to withdraw, and you find that you become handicapped because even in court, witnesses will be required and if the survivor is not willing to come forward to testify, there is not much this office can do."

– Key informant interview (female), Adjumani

"Witnesses of GBV cases rarely come up to testify, and it is quite difficult since they are threatened in the community ... for it's an offence to report."

– Key informant interview (male), Moyo

In cases of rape, participants reported that the burden of proof is normally with the prosecution. However, due to the lack of effective referral and coordination mechanisms between the police force (investigators), the Directorate of Public Prosecution (prosecutors), and other criminal justice service providers, many GBV cases are not successfully prosecuted in a court of law.

LEGAL AID AND SUPPORT SERVICES

Legal services are an essential part of the survivor-centered approach and should be part of a safe, nonstigmatizing, multisector response to GBV. Legal aid services staffed by trained personnel should be accessible to GBV survivors and integrated into the general GBV referral system. Overall, access to legal aid services also remains a challenge in both refugee and host communities. In particular, access to state-funded legal aid mechanisms (e.g., the State Brief Scheme, Law Development Centre clinics, and pilot programs such as Justice Centers Uganda) is very limited in refugee and host communities across the 11 districts covered by this assessment.

Some legal aid service providers—such as the Humanitarian Initiative Just Relief Aid, FIDA, Lutheran World Federation, Refugee Law Project, War Child Canada, Care and Assistance for Forced Migrants, and Uganda Law Society—actively promote access to justice for GBV survivors, especially by assisting in the litigation of cases



by watching briefs,¹³ offering free legal representation, and advising police on the presentation of cases and the profiling of evidence. Some have trained paralegals to provide legal aid support to GBV survivors. These organizations are overstretched, however, and they have resource challenges. In addition, the organizations have concentrated their legal services on refugees, which defeats the integrated approach of ReHoPE and the Comprehensive Refugee Response Framework, which requires that services in the areas with refugees be provided in an integrated manner. There are also questions regarding the sustainability of these services, which are largely project-based and rely on donor funding.

TRIAL AND SENTENCING

The magistrate courts have jurisdiction over hearing and determining cases of domestic violence, but many sexual offenses and GBV-related murders are heard at the High Court. The High Court, the Court of Appeal, and the Supreme Court of Uganda may also hear and determine GBV cases on appeal or if the offense is particularly grave. However, the effectiveness of the courts of judicature across the study sites is affected by the limited financial and human resources at their disposal. For example, the limited number of judicial officers contributes to a backlog of cases, which affects the speed of dispensing justice. The paucity of judicial officers means that survivors, whether from a host or refugee community, are forced to appear in court multiple times; and such delays also mean additional expenses for survivors. For example, the magistrate's court in Isingiro, which serves the entire district of 100,000 people, has only one grade-one magistrate—whose court has only nine support staff members. The chief magistrate who oversees Isingiro High Court is the chief magistrate of Mbarara; he is overstretched because he also acts as the registrar of the Mbarara High Court circuit. Also, at the time of data collection of this study, there had been no chief magistrate in Moyo for over six months; cases could therefore not be prosecuted.

13. A watching brief is a method normally used in criminal cases by lawyers to represent clients who are not a direct party to the suit and to function as an observer. The method is normally used to help protect the rights and interests of the victim of a crime or to protect a defendant from malicious prosecution.

Findings show that only a small proportion of reported GBV cases go to court, and many that do fail to reach a conclusion. While the court may want to try GBV cases as required by the law, such efforts can be thwarted by the conduct of the prosecution, expert witnesses (police and medical), or the survivor. This study finds that some survivors reportedly decide to withdraw their cases for a variety of reasons, but especially societal pressure and financial remuneration.

Participants claimed that some court processes and rules are not centered on the needs of GBV survivors. For example, a survivor of sexual violence may testify and/or give evidence openly, recounting her experience. This subjects the survivor to intimidation—especially by the defense attorney—as well as further stigmatization. In some cases, a survivor must deliver her statement multiple times, often under extreme duress and in response to discriminatory and biased comments and questioning.

Further, some trial practices, such as the confrontation of a survivor by the alleged perpetrator and lengthy trials, may have a particularly negative impact on survivors, enhancing the risk of retaliation and intimidation, and more generally resulting in the survivor's loss of trust in the justice system. Participants also report that under the adversarial system of litigation, a survivor of GBV is not shielded from the public or her attacker. There is no requirement that such trials be heard in private (“in camera”), with such a decision dependent on the judge or the persuasiveness of the prosecutor.¹⁴ Compounding the problem, survivors of rape and other GBV cases are often represented by inexperienced state attorneys.

Court-issued sentences and penalties are reportedly “too lenient” for some GBV-related cases, rarely deterring perpetrators from committing additional GBV-related crimes. In some instances, a perpetrator is merely “cautioned,” or asked to apologize to the survivor. No specific legislative

14. Measures to ease the pressure on survivors at trial usually revolve around ensuring nondisclosure of their identities to the media or the general public; limiting abusive and gratuitous questioning of survivors at trial; and ensuring that survivors can provide the best possible evidence at trial. This reduces the trial-related pressures on a survivor while also complying with a defendant's right to a fair trial. Prosecutors must be vigilant during a trial and raise objections to any inappropriate questions or comments directed toward a survivor by the defense.



provisions exist for the mandatory counseling or rehabilitation of perpetrators.

Finally, study participants cite a lengthy litigation process as a barrier to accessing justice. Two key informants reported that the average timeframe for the completion of a GBV case in court is three years. Most complainants give up before the process is concluded due to time and cost constraints, resulting in the collapse of their cases.

ACCESS TO COURTS

Physical access to the courts remains a challenge. Most of the refugee and host communities in the 11 districts studied are in remote rural locations, far away from courts of law, posing challenges related to accessing the courts and the costs associated with seeking justice. For instance, the distance from Imvepi Settlement to Arua Town, where the courts are found, is 80 kilometers (km), the distance from the Rhino refugee settlement is 70 km, both by gravel road access. Similarly, Nakivale is 65 km from Mbarara and 35 km from Isingiro Town. Oruchinga refugee settlement is 70 km Isingiro Town and is also only accessible by gravel roads. In Arua, for example, the chief magistrate indicated that because of the distance, sometimes by the time refugees get to court, their cases have been adjourned.

To bring the justice services closer to beneficiaries in these locations, some organizations are working closely with the judiciary to use mobile courts, where the officer moves into the settlement and conducts court proceedings from there. Reportedly, these courts not only bring justice services closer to the people but also educate communities on legal procedures and the law. For example, mobile courts have been introduced in all zones of the Bidi-Bidi Settlement to overcome the logistical challenges faced by refugees. The local magistrate is brought in from Yumbe and creates a makeshift temporary courtroom at a selected site in the settlement. However, some informants observed that mobile courts are only cost-effective if properly planned and if preparatory work is finalized to ensure that the proceedings are on schedule.

Participants also discussed the difficulties refugees face in accessing justice services arising from language barriers. Article 28 of the Ugandan constitution requires everyone charged with a criminal offence “be informed immediately, in a language that the person understands, of the nature of the offence.” This is in addition to the right to “be afforded, without pay by that person, the assistance of an interpreter if that person cannot understand the language used at the trial.” Findings, however, indicate that translation and interpretation services at police stations and in courts of law for the benefit of the ethnically diverse community of refugees are limited.

To address this gap, both UNHCR and the Refugee Law Project have trained interpreters in several languages, including English, French, Kiswahili, Lingala, Kirundi, Kinyarwanda, Somali, Tigrinya, Juba Arabic, Dinka, Nuer, Acholi, and Madi. As one informant noted:

“Skilled interpreters can make the difference between an individual client accessing justice, health care, psychosocial support, and being turned away.”

However, as commendable as the work of both UNHCR and Refugee Law Project is, there still appears to be a high demand for translators and interpreters to be integrated into the formal state institutions that provide services to refugees, such as the justice, law, and order sector and local governments.

The cost of accessing justice involves a variety of expenses that users of justice services must incur, including formal fees (such as legal and court fees), costs associated with the medical examination, and transportation. Survivors are often asked to pay for their medical expenses and their transportation costs to the police station during an investigation. The poverty that afflicts some members of the refugee and host communities makes it hard for them to afford such expenses. Additionally, police request payments to handle cases. One focus group participant in Kyegegwa, for instance, decried the prevalence of the practice:



“The police ask for money before they handle your complaint. I lost the trust I had for them and I would rather take my complaint to the church elders.”

Similar sentiments were expressed in Arua:

“It is better not to report cases to police because we think the cases will not be solved fairly. Sometimes they ask for money to solve the issue. So, we better report them to clan leaders.”

As a result, when the complainants cannot afford the additional costs requested by officers to handle the case, some GBV cases go unresolved. In some instances, those who seek services from police confront challenges related to informal procedures, for example, paying in food for a suspect who has been reported to the police:

“Yes, I have reported my case to the police station. After reporting my case the person was put in prison, but the police told me that I should be bringing for the prisoner food every time all else he will be released. So, when I missed one day, I found the prisoner had been released and the next day he was at my door laughing at me and said that you stopped bringing for me food and now I have been released. In other words, the police did not help us.”

LOCAL COUNCIL COURTS

Local council courts (LCCs) are supposed to be established in every village, parish, town, division, and subcounty in Uganda.¹⁵ They are mandated with providing client-centered counseling to GBV survivors; recording complaints, including a survivor’s age, sex, and relationship to the perpetrator; hearing GBV cases; and ordering any of the following, depending on the nature of the case: caution and apology to the survivor; community service; compensation; reconciliation; declaration; restitution; and referral to police and the magistrate court if the perpetrator is a repeat offender, is likely to inflict further harm on the survivor, or if the degree and nature of the violence against women and girls warrant the involvement of the police and formal courts.

The LCCs are not mandated with trying cases related to sexual abuse and exploitation, but they are often the first and preferred point of help for survivors and have therefore become the primary point of reporting. However, the LCCs—typically the first authorities to hear of a GBV case—are embedded in discriminatory social norms. These entities often deliver prejudiced decisions against women, adjudicate cases beyond their authority, fail to refer GBV cases to police, and encourage GBV survivors to keep disputes within their family. In some communities, the LCCs have not been established; cases are frequently just disposed of by an individual local court rather than formally convening the LCC.

INFORMAL JUSTICE MECHANISMS

As a result of the problems associated with access to the formal criminal justice process, many survivors and their families rely on informal justice mechanisms. These informal mechanisms derive their power from social groups or community structures, including specific ethnic or faith communities, rituals, and traditions; indigenous governance systems; and local community organizations. The informal justice mechanism often has at its center leaders or decision makers who are chosen by the community. These leaders may preside in settings much like a court or may operate in an altogether different type of environment, such as a community gathering place or a private home. In host communities, the preferred informal mechanism includes religious and cultural leaders. Refugees mostly rely on RWCs to resolve cases of GBV.

Overall, the informal justice mechanisms are perceived to be less corrupt, less costly, more flexible, and able to provide fast resolution to disputes. These mechanisms are accessible to and preferred by many survivors. Both refugees and members of host communities think that the outcomes of the informal justice mechanisms are of better quality than those of the formal mechanisms.

However, informal justice mechanisms may vary widely in terms of their consistency with a survivor-centered approach, and may reflect discriminatory cultural, gender, and social norms—especially as such mechanisms may derive their authority from community structures. Most of

15. This is according to the Local Council Courts Act of 2006 (section 3).



their members have limited exposure to gender-transformative learning and human-rights-sensitive training. They can reemphasize gender norms that may not be in tandem with gender equality and human rights for survivors. They tend to reinforce existing harmful social norms and may retraumatize survivors. Proceedings are neither recorded nor monitored, and some decision makers can be manipulated. For example, some RWCs reportedly ask for payment before they will sit to resolve a case.

Response services for violence against children

Child survivors of VAC and their families have specific needs that require tailored responses and specialized services. These unique needs must be considered in all aspects of a VAC response.

KEY FINDINGS

- ◆ Cases of VAC are heavily underreported and underprosecuted.
- ◆ Most of the health facilities in refugee-hosting areas do not have facility-level protocols for the clinical management of sexual violence; lack staff trained on the clinical care of sexual assault survivors, such as how to adapt medical examinations and treatment for children; and often lack all of the medical supplies required to provide comprehensive care.
- ◆ Late reporting of cases inhibits a survivor's timely access to services, especially for sexual assault, because many refugees and locals are unaware of how important the early reporting of cases is.
- ◆ The follow-up care needs of survivors are often neglected. Follow-up with survivors after their first visit is generally suboptimal.
- ◆ There is limited guidance on how to adapt case-response services and psychosocial

interventions designed for adult survivors to meet the specific needs of children.

- ◆ The psychosocial response to VAC cases at the health-facility level remains poor, especially in host communities.
- ◆ Police and other justice, law, and order sector actors in these locations are constrained in terms of facilities to handle the cases, especially psychosocial support. Informal justice structures, such as religious and cultural structures and RWCs (in refugee settlements), are relied on to resolve VAC cases. However, the best interests of the child are rarely the primary consideration in the decision-making process.
- ◆ There are serious gaps in terms of dealing with children who come into conflict with the law. Most visible gaps relate to the lack of adequate facilities in the districts to deal with such juveniles, including detention and rehabilitation facilities.

Health/medical services

Access to specialized health care and treatment is an essential component of a holistic care response to child survivors of violence. Child survivors require medical services that are appropriate for their sex, age, culture, and community context. Child survivors in the study areas mainly access medical or health services at public health facilities,¹⁶ where the nature and quality of services vary greatly (see appendix B). Services are available for free to UNHCR-registered refugees.

Overall, assessment results show that most of the health facilities lack adequate infrastructure to offer comprehensive sexual violence-related services; do not have facility-level protocols for the clinical management of sexual violence; lack staff trained on the clinical care of sexual

16. Both government and development partners provide health services in refugee-hosting areas. In host communities and refugee settlements, health service provision is dominated by the government.



assault survivors, such as how to adapt medical examinations and treatment for children; and often do not have all the medical supplies required to provide comprehensive care. For example, some lower-level health facilities in the host communities are unable to provide services according to the guidelines due to a lack of supplies, including emergency contraceptives, sexual assault forensic evidence kits, and disposable clothing to give to survivors whose clothing must be collected as evidence. Respondents from all study districts report frequent stockouts of emergency contraceptives. This leaves survivors, especially adolescent girls, vulnerable to early and unwanted pregnancies, HIV, and other sexually transmitted infections.

Assessment results indicate that some providers treat violence as a clinical problem and therefore rarely refer survivors to other critical services for healing and recovery. In addition, most facilities lack youth- or child-friendly spaces that offer confidentiality and privacy.

Participants reported that most of the survivors rarely seek medical services or do so too late to receive key interventions, such as emergency contraception or PEP. Decisions to not seek care and delays in care seeking often mean that evidence is lost and survivors are left open to the risk of unwanted pregnancies and sexually transmitted infections. Lastly, the follow-up care needs of survivors are often neglected. Findings reveal that there is hardly any follow up of survivors after the initial contact with the health facility. Health workers either do not have time to conduct follow up due to limited staffing and heavy workloads or do not see this as their mandate or duty.

Mental health and psychosocial support

Exposure to violence can lead to serious psychological health impairment. Children exposed to violence, particularly sexual abuse, need access to age-appropriate mental health and psychosocial support interventions to promote their healing and recovery. However, in both refugee and host communities, access to specialized services is limited. Guidelines on the clinical care of survivors require health workers to provide practical care and support to survivors, including diagnosing and treating any VAC-related trauma. However, this study finds that the psychosocial response to

VAC cases at the health-facility level remains poor, especially in host communities. The clinical treatment of trauma requires that specialized services be delivered by qualified mental health professionals, such as counselors, medical social workers, psychiatrists, psychotherapists, and clinical psychologists, but most facilities in the study settings lack such human resources (see appendix E).

At the community level, child survivors of violence and their families receive varying levels of counseling services from the district, subcounty, and village-level statutory duty-bearers, including health workers, police, probation and social welfare officers, community development officers, teachers, local council authorities, and RWCs. In settings where NGOs have established GBV and child protection programs, field staff provide basic psychosocial interventions for child survivors of sexual abuse, including life skills training and activities to support their reintegration into society and community life, as well as supportive counseling offered during the case management process.¹⁷ While these interventions are essential, they are rarely incorporated into comprehensive child sexual abuse and trauma treatment frameworks to promote sustained health and healing outcomes. Most of the field staff who directly respond to child survivors are not trained mental health workers; they have limited skills and knowledge regarding the assessment or response to symptoms of trauma that a child might exhibit.

Community-based structures, such as para-social workers, child protection committees, and village health teams, play a key role in providing psychosocial support services to survivors, including counseling, advising them in seeking legal support, and linking them to NGOs for additional help. However, members of these structures are not sufficiently trained in or knowledgeable about the handling of the various mental and psychosocial effects associated with exposure to violence nor the basic types of psychosocial interventions needed to ensure that children and their families receive correct information about abuse and have the opportunity to explore their thoughts and feelings

17. Some of these NGOs include the Lutheran World Federation, Transcultural Psychosocial Organization, Médecines Sans Frontières, International Rescue Committee, CARE International, Danish Refugee Council, and Save the Children.



about the information—a process often referred to as “psychoeducation.”

Most actors responding to cases of VAC, whether in a clinical or nonclinical setting, have limited skills needed to ensure that a child’s best interests are considered when determining response and treatment, including how to interview and communicate with the child, the inclusion of (nonoffending) family members in the healing process, the short- and long-term safety needs of the child, appropriate confidentiality and informed consent procedures, and the upholding of a child’s right to participation and information. Guidance is limited on how to adapt case response services and psychosocial interventions designed for adult survivors to meet the specific needs of girls and boys.

CHILD-FRIENDLY SPACES FOR CHILDREN

Child-friendly spaces have become a widely used approach to protect and provide psychosocial support to children. Notably, some organizations, such as Save the Children, Danish Refugee Council, and Lutheran World Federation, have established child-friendly spaces in refugee settlements in response to the psychosocial support needs of children. Children from host communities can also access these spaces. Children can use these spaces to spend time with others, to draw, to play, and to reflect on their experiences. Children who require specialized support are identified and referred or linked to relevant service providers and other child protection actors. Psychosocial support is provided to children who need it.

“We usually do a child participatory assessment to know the issues affecting them and how they want to improve them as children. We engage them in sports; we engage in focus group discussions with adolescent girls just to have them talk about issues that affect them and how best they themselves can handle these issues.”

– Female key informant, Kyegegwa district

However, the outcomes or impact of child-friendly spaces, especially the social and emotional well-being of children, has not been rigorously evaluated in the context of forced displacement.

Justice and legal aid services

Access to justice is essential for the protection of the rights of children. The key duty bearers and actors in the formal justice system include police, health care providers (who collect scientific evidence in cases of assault and sexual violence), the community-based services department, the directorate of public prosecution and courts of judicature, and local council courts (see figure 3.1). Religious, cultural, and other informal justice structures, as well as RWCs (in refugee settlements), are also relied on to resolve VAC cases. Overall, access to justice remains a challenge for children exposed to violence in refugee and host communities. Some of the gaps and challenges are discussed below.

CASE REPORTING

Assessment results show survivors of VAC rarely report their experiences or interface with the formal justice system for a variety of reasons, including lack of trust or faith in the formal justice system, lack of access to legal aid services, and fear of reprisal from perpetrators. Unsuccessful investigative follow-up and failure to prosecute GBV cases contribute to an environment of impunity that marginalizes survivors and discourages reporting and help-seeking behavior. In addition, widespread practices, such as blaming the survivor, shame, stigma, fear of reprisals, and threats of rejection by family and the community, are powerful deterrents to reporting. The insensitive attitudes of police officers and lack of follow-up action also deter survivors and families from coming forward or prevent them from pursuing a case.

Findings indicate that many survivors, their families, and communities prefer to settle VAC cases out of court. In some cases, girls are pressured to keep quiet about the violence to protect the perpetrator; in other cases, parents will exploit the situation for financial gain: instead of reporting an incident to authorities, parents might tell the perpetrator to “come and negotiate.” In such cases, even when the police insist on prosecuting a case, not much is achieved because the survivor will not come to court to provide testimony, frustrating the process.



“Survivors in the settlements are silenced by the fear of stigmatization and fear of retaliation from perpetrators and the situation is compounded by a general mistrust of the systems and community leaders. The absence of a witness protection law in Uganda aggravated this problem, which in some cases forced complaints to withdraw cases because of fear.”

– Male key informant, Kyegegwa

Findings show the number of police officers in most settlements to be inadequate for responding to the needs of an increasing population; and a dearth of female officers in particular remains a barrier to children coming forward to report incidents of sexual assault.

INVESTIGATIONS AND PROSECUTION OF VAC CASES

Overall, the capacity to conduct investigations is weak; and the dismissal rate for cases of violence against women and girls is far higher than the conviction rate, resulting in impunity for perpetrators of VAC. Poor institutional capacity significantly compromises the quality of police investigations. Participants reported that the police lack adequate personnel and resources to consistently conduct effective investigations and evidence collection for cases of VAC.

“When these matters [GBV or VAC cases] are brought, at times you find they don’t succeed because of poor investigation or at times you find witnesses are not summoned, which is the work of the police to summon these witnesses, and sometimes cases are dismissed on such grounds.”

– Key informant interview (justice, law, and order sector representative), Kiryandongo

“We are supposed to educate the refugees and neighboring communities to avoid VAC and to report cases when they occur; but we do little because of lack of resources. Even the little we do is not continuous but only when we have facilitation from partners. Sometimes we do not have transport to do community sensitization or even to follow-up the case. As a result, people lose interest and abandon the cases ...”

– Key informant interview (police official), Nakivale

The police are perceived as being lax in pursuing evidence. For example, some participants report that the police rarely visit crime scenes and even more rarely capture perpetrators or follow up on cases. It is also common for police to refer survivors back to their families or local leaders to solve problems.

There are also several challenges related to the collection of forensic evidence, particularly for cases of sexual violence. The first concerns timing, which is critical. Ideally, evidence should be collected within the first 72 hours after an assault. However, many survivors are late in reporting incidents. Such lapses of time impact the collection and quality of evidence. Therefore, even once initiated, the prosecution of a sexual violence case can be plagued by a lack of evidence.

Survivors can also hamper the effective investigation of VAC cases. For example, there are reported cases of a girl-child survivor of sexual violence refusing to cooperate with the police, insisting that she will not leave the station until her “husband” is released.

LEGAL AID AND SUPPORT SERVICES

Both refugee and host communities face challenges to accessing legal aid services. While access to legal services is a general problem in Uganda, it is worse in refugee-hosting districts. Uganda does not have a state-funded legal aid system that is designed for children.

A few legal aid service providers play an important role in the provision of legal aid and survivor-support services at the district and community level, providing legal aid services that include in-person (with attorney) legal counseling or referral via settlement-based help desks; mobile clinics; a toll-free hotline; alternate dispute resolution (mediation), including training community leaders on mediation techniques; and representation in court for civil or criminal cases. Volunteers are recruited and trained to support legal referrals and provide information about services in communities. War Child Canada conducts mediation and trains communities and community leaders to distinguish between criminal cases that must be addressed through the formal system and cases that can be mediated. In addition,



a legal advocate for the organization prepares and guides the survivor in the court process and advocates on behalf of the survivor throughout the legal process. To address the specific needs and constraints of the refugee community, War Child Canada introduced mobile legal clinics to avoid refugees needing to travel long distances and/or incur travel costs to access services. However, there are questions regarding the sustainability of these services, which are largely project-based and reliant on donor funding.

TRIAL AND SENTENCING

Study participants reported that some practices, such as lengthy trials and the confrontation of a survivor with an alleged perpetrator, may have a particularly negative impact on survivors, increasing the risk of retaliation and intimidation, and possibly resulting in the survivor's loss of trust in the justice system. Contexts where access to legal aid services for survivors is limited and ad hoc aggravates this situation.

Distances to courts of law also remain a problem for survivors in refugee and host communities. To address this problem, the judiciary has initiated the mobile court system in the refugee settlements to enhance access to justice, especially for refugees. Whether they are sustainable without foreign donor support is another question.

INFORMAL JUSTICE MECHANISMS

Religious, cultural, and other informal justice structures, as well as RWCs (in refugee settlements), are relied on to resolve cases of VAC. Their services are perceived as more closely meeting the needs of child survivors than the criminal justice system in terms of the immediacy with which they resolve problems, their focus on mediation and resolution rather than arrest and punishment, and their affordability.

Nonetheless, these mechanisms pose many risks to survivors. Participants report that the actors in the informal justice systems have a limited appreciation of international human rights standards and that this affects the delivery of justice. Issues of gender discrimination are evident both within the composition of the administrative structures and the actual operations of the informal justice systems. In addition, they are not systematically or effectively linked to

formal systems and tend to handle cases outside their jurisdiction, increasing the risk that they will impose their own interpretation and position rather than protect the rights and needs of survivors. Such an approach can inadvertently pave the way to impunity. For example, interviewed groups discussed how cultural leaders prefer to deal with cases of incest and rape through mediation with the family; in case of rape, the family of the perpetrator is often invited to financially compensate the family of the survivor without offering further redress.

"However, accessing justice still meets challenges in both settlements. The largest challenge is an adequate understanding of the laws and rights afforded to refugees in Uganda by RWC leaders, the first actor notified after a crime had been committed. Often RWC leaders would respond by utilizing cultural and traditional customs from their country of origin to address a case."

– Key informant interview (justice, law, and order sector representative), Adjumani

CHILDREN IN CONFLICT WITH THE LAW

The justice, law, and order sector institutions across study sites continue to face challenges in meeting the needs of vulnerable groups in both host and refugee communities, especially children in conflict with the law.

It is an international norm that children in conflict with the law should be separated from adults in detention facilities. Such facilities should be adequate and conducive to the child's well-being and should take into consideration the vulnerability and fragility of children. This standard is not met in refugee and host communities, where juvenile detention and rehabilitation facilities are inadequate or entirely absent.

At Isingiro Police Station, there is what should be a separate detention room for juveniles, but the area's children and family protection unit uses this same space during the day for its office; it is only transformed into a cell at night. Children in custody are monitored only to the extent that they cannot leave the precinct station. At Kashwojwa Police Post within the Nakivale refugee settlement, detained children are kept in the space next to the reception desk.



There are no remand homes in any of the study districts, except Arua. It is therefore common to have children detained alongside adults, increasing their risk of exposure to multiple forms of violence. Even in Arua, where there is the Arua Regional Remand Home, the police still face challenges when dealing with children in custody. Even when a court remands a child to the home, there is no guarantee that a staffperson will come to collect the child, even when requested to do so.

The courts lack the infrastructure—such as cameras—needed to appropriately try children accused of crimes, or to interview child witnesses who are victims of crime. There are also gaps in the way cases involving juvenile offenders are handled by the police. In some cases, children are reportedly tried as adults, and thereby denied the rights and procedures that would apply to them under the Children’s Act, which establishes family and children’s courts with friendly procedures and defines more conducive penal measures for children.

Participants also indicate that, in some cases, police officers falsify the ages of children, recording them as being above the age of 18 so that they will be tried as adults. This subjects children to criminal justice procedures that are inconsistent with their vulnerability. If convicted, children face criminal sanctions that are neither appropriate nor in their best interest.

The probation and social welfare services in the district, which are necessary for handling cases that involve children, are inadequate. Under the Children Act’s, probation and social welfare officers are expected to present to the court a social inquiry report on a child who is on trial. The report is supposed to indicate “the social and family background, the circumstances in which the child is living and the conditions under which the offence was committed.” Unfortunately, such reports are rarely prepared or presented.

REFERRAL PATHWAYS

KEY FINDINGS

- ◆ There is lack of standardized referral protocols with clear accountability and feedback mechanisms for stakeholders from health, social welfare, legal, and law enforcement sectors, as well as from members of local councils, community leaders, and psychosocial support providers.
- ◆ Referral mechanisms for GBV and VAC are not functioning adequately and are perceived to be ineffective at ensuring a continuum of support for survivors of violence.
- ◆ Survivors are reluctant to seek services; and services are poor or nonexistent at certain referral points.

Programming experiences show that survivors must be linked to health, mental health, psychosocial, legal/justice, and security services through case management.¹⁸ This necessitates inter- and intrasector coordination, including the creation and monitoring of referral pathways, information sharing, and participation in regular meetings with representatives from the various sectors.

The National Referral Pathway for Prevention and Response to Gender-based Violence Cases in Uganda (MGLSD 2013) outlines roles and responsibilities of the key duty bearers and actors and what services are available at different referral points. At the district level, key actors in the referral process include the community-based service department, the district health department, clinical providers, police, local councilors (locally elected officials), courts, NGOs, religious and cultural leaders, and donors. All duty bearers along the referral pathway are obliged to ensure timely access to services by survivors.

¹⁸ Case management provides a system for coordination among all actors involved with a survivor so that everyone can work together and understand their respective roles. Regardless of how many or how few services are available in a community, and who provides them, coordination is essential.



BOX 3.1

Bottlenecks in the Referral Pathway

- ◆ Separate multisectoral guidelines exist to address GBV and VAC in schools, but there are no multi-sectoral guidelines to address GBV and VAC in all settings other than those in “Reporting, Tracking, Referral and Response Guidelines on Violence Against Children in Schools” (Ministry of Education and Sports 2014).
- ◆ There is a poor understanding of the importance of urgent bidirectional referrals, specifically between police and health, or how important it is to determine if a case involves sexual violence (and is therefore to be considered a criminal case).
- ◆ There are varying understandings around what the entry point into the referral system should be.
- ◆ Religious leaders and teachers are often not involved in conversations around reporting, which is viewed as a constraint.
- ◆ Financial costs related to reporting and accessing services at referral points remain a key impediment. They include travel and other costs associated with accessing services from various service points.

Stakeholders in both refugee settlements and host communities noted that some mechanisms exist to refer and link GBV and VAC survivors to services. For example, bidirectional referrals occur between the health facilities and the police. In addition, health and legal service providers and duty bearers, especially in refugee settlements, sometimes refer survivors to other providers (mainly NGOs) for psychosocial and livelihood support and other social services. In refugee settlements, referrals are accessed primarily as walk-in clients at various service points through NGOs/ United Nations officers, RWCs, and focal persons for GBV, as well as toll-free hotlines that women and girls can call if they need support.

However, in both refugee and host communities, referral mechanisms do not function adequately and are perceived as ineffective at ensuring a continuum of support for survivors of violence. Some of the identified gaps include the lack of standardized referral protocols with clear parameters of responsibility, accountability, and feedback mechanisms, particularly in host communities; poor case tracking; and limited follow-up of survivors to ensure that they promptly receive needed services. Existing protection mechanisms remain fragmented, often creating parallel

and duplicate mechanisms for different categories of survivors, with insufficient integration of multisectoral guidelines and standard operating procedures for GBV and VAC. Formal referral networks that integrate across services are virtually nonexistent. Consequently, most survivors are unable to access an essential package of multisectoral services—health care, mental health care, psychosocial support, and justice/legal services.

Further, given that GBV providers in refugee settlements are overwhelmingly NGOs specializing in a variety of services, linkages between them and other critical components of the governmental sector are even more crucial. Nearly all of such NGOs have cases referred to them and refer cases to other providers regularly and constantly. However, the overwhelming portion of referral arrangements are “informal” and primarily based on networks among individuals across organizations and institutions rather than formalized institution-to-institution protocols. Further, referral pathways in the settlements are disconnected from those at the district level.

Study findings also indicate challenges related to the reluctance of survivors to seek services and concerns over



the quality of services at various referral points, especially in the government system. Some participants claimed, therefore, that referral is a problem, not in terms of the lack of a system but in the lack of ability to ensure the delivery of quality services. Implicit in all recommendations is the need to ensure that services and sites throughout the referral chain are appropriate and responsive to the needs and realities of women and children experiencing violence.

Further, the current application of the 70:30 principle, which requires that 30 percent of the refugee response be allocated to host communities, remains unclear and inconsistent. For example, participants reported that some service providers in refugee settlement are occasionally constrained by organizational policies requiring them to provide specific services solely to refugees.

“I need to attach an attestation card [refugee reference number], it needs to be signed. Survivors must have a number identifying them as a refugee, implying that a survivor who is a national even when referred may not have that leverage.”

— Key informant interview (female), Isingiro

In terms of coordination mechanisms, all districts have a combination of disparate coordination groups, including ones addressing female genital mutilation, trafficking in persons, gender, children, specific groups of vulnerable children, GBV, and general protection. Such groups are often promoted and supported by various development partners, with limited government coordination.

INFORMATION SYSTEMS

Currently, Uganda’s data collection systems are fragmented and used only sporadically in the refugee-hosting districts. The Ministry of Gender Labour and Social Development has taken steps to improve GBV data and reporting through the development and implementation of the national GBV database, also managed by the ministry. The database aims to collect, store, and analyze GBV incident data across all districts. It uses the GBV incident report form to ensure that consistent data are collected by all actors (e.g., police,

health facilities, community development departments, and others). Since 2012, UNHCR and partners have used a GBV management information system—GBVMIS—in multiple refugee settings; however, there is no interoperability between that system and the GBV database.

In the health sector, GBV is reported using the Health Management Information System’s “105 form,” which records GBV under the category of trauma or injury. The form also collects data on sexually transmitted infections and miscarriages due to GBV. However, the form does not link the provision of emergency contraceptives or contraceptive use with the experience of GBV, nor does it collect data on the number of unintended pregnancies that result such incidents. This disconnect results in a lack of reliable data on the number of GBV cases, the provision of health and family planning services, referrals, and family planning outcomes—all of which limits the ability of decision makers to plan and allocate resources to GBV and family planning programs. The Uganda National Child Helpline is used for collecting of VAC-related incident administrative data, but it has not been effectively rolled out in all districts. On the other hand, UNCHR began rolling out the Child Protection Module in proGres V4 in refugee settlements in 2019—a parallel child protection case management information and incident tracking system.¹⁹

Participants recommended that these case management systems be merged, harmonized, and linked with other systems, including, EMIS, the education management information system; OVCNIS, the orphans and vulnerable children management information system, also managed by the Ministry of Gender Labour and Social Development); CRVS, civil registration and vital statistics, supported by UNICEF; and justice, law, and order sector institutions—Uganda Police Force, Directorate of Public Prosecution, and the judiciary—which themselves need to be linked and integrated with one another. Integration and/or harmonization of data systems and collection processes will not only reduce fragmentation and improve reporting but will also support more effective and coordinated responses to

19. UNHCR Monthly Protection Update Child Protection is available at <https://reliefweb.int/report/uganda/unhcr-monthly-protection-update-child-protection-cp-november-201>.



incidents of violence against women and girls and move toward the formation of a single data protection system.

MONITORING AND EVALUATION

Participants expressed the need for better monitoring and evaluation (M&E), especially of GBV and VAC programs in both refugee and host communities. Calls for improved M&E also reflect concerns and questions about the quality of the services being delivered. There is an overall perception among the key informants interviewed that current M&E of GBV and child protection interventions is focused on outputs, while little is known about the quality of the services provided or of the outcomes and impacts of programs. Information on the effects of existing programs is also seen as limited, irregular, and not sufficiently systematic to demonstrate linkages between services, referral pathways, and outcomes. The findings underscore the need for GBV interventions to be followed up on, not just with impact evaluations, but also with in-depth analyses of the mechanisms for success or failure. This would allow for a better understanding of scalability, viability, and impact of contextual factors, including program implementation (e.g., expertise and human resources), as well as buy-in from donors, local leaders, and affected populations.

ASSESSMENT OF GBV AND VAC PREVENTION PROGRAMS

GBV prevention programs

KEY FINDINGS

- ◆ There is limited adherence/fidelity to implementing and scaling up models of GBV prevention that have been rigorously evaluated through national systems and local structures.
- ◆ GBV risk mitigation and prevention strategies are not widely embedded in existing services and institutional responses.

- ◆ Economic empowerment programs are not always coupled with gender/social norm change components to reduce potential negative consequences.
- ◆ Despite the recognition of overlapping risks and intervention opportunities, GBV prevention and child protection programming continues to occur separately or in silos in both refugee and host communities.

Preventing GBV—to stop it from happening in the first place—is a key priority in the context of host and refugee communities. Effective GBV prevention requires holistic interventions to tackle the multiple drivers of GBV at the different levels of the socioecological model. The mapping reveals that most of the GBV prevention interventions mainly center on changing values and norms that underpin GBV through community mobilization and awareness-raising and economic empowerment for women and girls (see appendix C).

Awareness-raising interventions

A wide range of NGOs are implementing activities aimed at increasing community awareness of GBV and promoting gender equality and nonviolence in both refugee and host communities. Activities include mass media campaigns; the distribution of information, education, and communication materials; and community-based education sessions. Mass media campaigns often employ one or more platforms, such as television and radio (announcements and programming), print media (including newspapers, billboards, posters, and flyers), and cellular text messaging. For example, the Action for Human Rights and Education Initiative–Uganda is currently running the “We Can” campaign in the West Nile districts of Arua, Koboko, Yumbe, Moyo, and Adjumani. The campaign is aimed at changing social attitudes and beliefs that promote the perpetration of GBV. The campaign utilizes an innovative model that links awareness-raising with the creation of a mass movement of people (“change-makers”) who publicly denounce GBV. Each change-maker commits to recruiting 10 others into the mass movement. There are currently over 17,000 change-makers in the West Nile region.



In addition, some programs work with religious and community leaders, as well as a broad range of other actors, to foster community discussions on GBV issues and increase awareness of existing GBV services—often as part of broader community-based GBV prevention programs. The assessment shows that working with cultural and religious leaders as change agents rather than as target audiences for partner interventions expands the community resource base, promotes efficient resource use through the utilization of existing trusted systems, and promotes sustainable programming.

Some programs are focused on addressing the low levels of legal literacy by advancing knowledge about the laws regarding violence against women and girls; harmful practices; and rights, laws, and policies regarding sexual and reproductive health. Most of the programs target communities, duty bearers, and religious and cultural leaders, with a particular emphasis on reaching women and girls facing intersecting forms of discrimination. Common approaches include ensuring that relevant laws are simplified and translated and using multimedia and innovate approaches, such as drama, brochures, radio, social media, and curriculum supplements, to disseminate key laws.

Findings, however, reveal several gaps and challenges. First, most of the awareness-raising activities are neither rigorously planned nor grounded in well-articulated theories of change. In addition, the effectiveness of awareness-raising and sensitization programs are limited by funding cycles that only allow for short-term interventions promoting behavioral changes. Sustaining behavior change is often problematic after the funding for project activities ends. Further, while awareness-raising efforts are creating a demand for services, access to services remains a challenge. Several service-related gaps—such as lack of safe spaces for survivors at police stations and a lack of essential health supplies—prevent people motivated by an awareness program from receiving actual GBV services. In such circumstances, communities can begin to lose confidence in the program’s messaging and integrity.

Language barriers and low literacy levels among many women and girls in the refugee/displacement context present key challenges to the delivery of effective messaging on issues such as GBV and sexual and reproductive health that would enable their access to services. Information, education, and communication materials that are in English, such as messaging boards, are not accessible to many refugee women and girls from several ethnic groups spanning national boundaries. The limited number of refugee women and girls with language and literacy skills also means that there is a relatively small pool of potential candidates for community-based roles (e.g., community-based facilitators, volunteer health trainers, and change agents), which are critical to the delivery of the community-based GBV mobilization and prevention model. The use of translators for the delivery of training and capacity-building inputs has reportedly been a partially effective solution.

Social norm change

Community mobilization has also been employed by some organizations to transform the social norms that foster violence against women. This approach relies on building up networks of people and leaders within communities who will work together to create an environment in which violence is no longer seen as socially acceptable. For example, UNHCR and partners (e.g., Danish Refugee Council, Lutheran World Federation, and Humanitarian Initiative Just Relief Aid) have been supporting interventions aimed at behavior and social norm change, utilizing evidence models including the SASA! methodology,²⁰ which utilizes a structured community engagement approach to guide entire communities through the stages of change in addressing underlying beliefs, social norms, and attitudes that perpetuate violence against women and girls.²¹

20. The SASA! methodology utilizes a structured community engagement and phased approach to address underlying beliefs, social norms, and attitudes that perpetuate violence against women and girls. A cluster randomized controlled trial of the SASA! methodology in Uganda revealed a 52 percent reduction in intimate partner violence against women in SASA! communities.

21. Evidence has shown that standalone programming solely targeted at men are less effective. Placing the responsibility for change on men alone perpetuates gender inequality. Placing a duty on men for social norms change further reinforces patriarchal values, beliefs, and practices that promote male privilege and the perceived role of men in society. Hence, there is a need for a whole-society approach that engages all key segments, such as traditional and religious leaders, boys and men, and women and girls, to promote positive skills and behavior change through enhanced accountability at the individual, relationship, and community levels.



Other evidence-based models, such as the “Zero Tolerance Village Alliance” intervention, have also been adapted and implemented in refugee settlements. Evidence indicates that this type of model is effective at moderating negative gender attitudes and beliefs related to GBV; positively changing perceptions of community GBV norms; reducing the occurrence of physical IPV (for men and women), sexual IPV (for men), nonpartner physical violence (for men and women), and nonpartner sexual violence (for women); engendering a more comprehensive understanding of rape; and increasing awareness of GBV interventions (Undie et al. 2016). However, the model is less effective at changing negative male attitudes toward women’s sexual autonomy in intimate partnerships (Undie et al. 2016).

Overall, most behavioral and social norm change activities among refugees are not embedded in a comprehensive approach toward addressing core drivers and risk factors of GBV and VAC, nor are they adapted to national systems and structures. In addition, while the use of evidence-based models is commendable, less attention has been given to the issue of intervention fidelity, rendering some of the models less effective. Lastly, sustained behavior and norm changes are constrained by the constant influx of refugees.

Engaging men and boys

Several organizations have targeted men and boys as agents of change in challenging established gender norms. Interventions by these organizations focus on promoting gender-equitable relationships between men and women by engaging men in discussions that explore rigid and harmful ideas of masculinity, enable critical reflection about gender roles and norms, challenge the unequal distribution of resources, and redress power imbalances.

The approaches range from participatory group education to using peer-based methodologies. For example, CARE International in Uganda uses the “Role Model Men and Boys” approach to explore constructions of masculinity in its contexts and how it affects well-being and relationships. Participants reflect on unequal power relations, gender roles, and rigid social norms that impact the behavior of women, girls, men, and boys. Selected men and boys are

taken through a series of training modules, mentorship, coaching, and dialogue sessions. Over 2,100 men and boys have been trained in this program across the refugee settlements of West Nile region and Lamwo in Acholi sub-region, northern and southwestern Uganda, who have then mentored and supported over 11,000 other men and boys.

Socioeconomic empowerment

Economic vulnerability is a key driver of GBV, and promoting women’s economic empowerment is fundamental to reducing vulnerability. Several organizations, including the Lutheran World Federation, the Danish Refugee Council, AVSI, BRAC, Oxfam, and CARE International, are implementing activities focused on addressing the socioeconomic vulnerabilities that predispose women to GBV in refugee settlements. Activities include the provision of cash transfers, village savings and loan associations, life skills training, vocational skills training, and livelihood support. Some organizations combine two or more approaches to address multiple socioeconomic insecurities. For example, the Lutheran World Federation’s support to women farmer groups uses a combination of cash grants, seed vouchers, and training to improve agronomic practices with a village savings and loan association start-up.

Other organizations have built innovative mechanisms to address gaps in specific approaches to women’s socioeconomic empowerment. For example, based on the gaps in the village savings and loan association methodology, CARE International decided to link women and youth groups to formal financial services that are less prone to risks of fraud and collapse. An evaluation of the CARE program reveals that beneficiary groups continue to work with formal financial institutions even after support initiatives end. The model has been adopted by other promoters of village savings and loan associations, although some of these organizations rushed the linkage approach, putting women and youth groups at risk of being exploited by formal financial institutions (CARE International 2018).

Nonetheless, economic empowerment programs are not always coupled with gender/social norm change components to reduce potential negative consequences. In



addition, there are only a few programs that directly target men. Because of the complexity of gender identities and relationships, the failure to engage men in women's economic empowerment interventions can sometimes lead to negative impacts on beneficiaries.

Participants suggested that it is important for economic empowerment programs to target family members and husbands with specific training aimed at challenging established gender norms and to encourage mutual understanding among household members and behavioral change among men in support of their wives or other female relatives seeking economic empowerment or creating a business. The promotion of positive masculinities can lead to the creation of healthier relationships and a more gender-equal division of tasks.

VAC prevention programs

Several organizations have taken steps to address the drivers of VAC in both refugee and host communities. Approaches to prevention cluster into four areas, outlined the INSPIRE package:²² (1) changing norms and values; (2) parent and caregiver support; (3) education and life skills training; and (4) income and economic strengthening (see appendix C for a complete list).

Changing norms and values

Changing attitudes and norms is key to preventing VAC in refugee and host communities. Cognizant of this, several organizations are undertaking interventions aimed at raising awareness and reducing social tolerance for VAC. The main methods and approaches employed include the distribution of information, education, and communication materials; group-based education; and community-based campaign activism. Regarding the latter, some organizations have established or support existing community-based child protection structures—such as RWCs, para-social workers, child protection committees, and peacebuilding committees—to mobilize and engage communities in identifying and addressing protection risks.

However, there is currently a lack of robust evidence about the effectiveness, cost, scalability, and sustainability of such community-based child protection mechanisms.

Parenting and caregiver support

Some parenting programs have been implemented to reduce VAC and promote child development, especially in refugee settlements. NGOs such as the Association of Volunteers in International Service, Lutheran World Federation, Agency for Technical Cooperation and Development, Redeemer Children's Home, Save the Children, and the Danish Refugee Council have developed and implemented parenting programs, usually delivered in groups. Sessions focus on issues such as brain development, empathy, positive communication, positive discipline, supportive guidance, and routines. Parents and caregivers have the opportunity to share their feelings and fears about child care and are guided on how to be more tolerant and accepting of children, a norm that helps prevent VAC.

AVSI developed and implemented a parenting training program in Kyangwali and Omugo Refugee Settlements to equip both young and older parents with parenting skills, to help them understand who they are, reflect on their parenting responsibilities, and adopt positive (authoritative) parenting behavior. AVSI utilizes a parenting skills model that comprises five modules built on the hypothesis that parenting skills training increases knowledge among participants, which translates into improved parenting behavior and ultimately results in the improved well-being of children, including those living in extreme conditions of poverty, abuse, and conflict.

One key informant who attended the training reported that the program has led to a considerable reduction in harsh parenting practices and improved parent-child relationships.

22. The INSPIRE package includes seven strategies that together provide an overarching framework for ending violence against children.



“I used to beat my children. I was confident that the only way to teach them something was by using physical punishment, but I was wrong. Today my relationship with them has changed. My children don’t fear me anymore and I enjoy spending time with them. I tell stories about our home and what we left there; I want them to be responsible because they are the future of our country.”

– Key informant interview (female), Kikuube District
(formerly Hoima District)

Nonetheless, the assessment did not come across any parenting program that is combining parenting education with norm trainings, even though there is evidence suggesting that such programs improve parent-child interactions and reduce abusive punishments. These programs have not been rigorously evaluated to determine how exactly they reduce VAC.

Economic empowerment of vulnerable households

Organizations such as the Danish Refugee Council and Save the Children implement household economic strengthening interventions to reduce the economic vulnerabilities of families and empower them to provide for the essential needs of the children under their care. This includes providing cash transfers and income-generating activities to families. Notably, existing interventions loosely combine income and economic strengthening with training in positive parent-child relationships. The interventions do not systematically integrate gender equity, gender-transformative activities, or social norm training and, according to some study participants, consequently put children at greater risk of victimization.

“The work our partners do is great. When one tells a story about what they are doing, the first impression is that they strengthen the families, but if you go deep to find out how the income is being used, you will find that girls are still being marginalized. Though income increases, they still prefer to take boys to school and girls are married off.”

– Key informant interview (female), Isingiro district

Ensuring safe and enabling school environments

Access to quality education can protect against both victimization and perpetration of certain forms of violence. Therefore, a few programs have been developed to promote educational access and quality of learning for children in refugee and local host communities—in line with the Uganda Education Response Plan for refugees and host communities. Specific interventions have focused on constructing new classrooms, building gender-sensitive sanitation facilities, training teachers, and providing scholastic materials. However, the need remains enormous. For example, where schools are present, they are few, congested, far away, and have a high student-to-teacher ratio, leaving learners demotivated and hampering retention and progression.

“NGOs have done a lot with training teachers in keeping children free from violence ... I am happy that DRDIP is coming in to address the issue of infrastructure in schools because partners have done little in ensuring that the existing infrastructure promotes the safety and well-being of learners.”

– Key informant interview (male), Adjumani

Some programs have focused on ensuring safe and enabling school environments, including using peer-based methodologies to empower children, educating them about their rights and responsibilities, training senior men and women teachers on VAC prevention and response, training teachers on alternatives to corporal punishment, and working with schools to enforce the professional code of conduct for teaching and nonteaching staff. A few interventions focus on developing children’s life skills and building knowledge around safe behaviors. For example, the International Rescue Committee is implementing the Girl Shine model and resource package in Imvepi and Omugo refugee settlements. The intervention provides girls with the skills and knowledge required to identify types of GBV and seek support services if they experience or are at risk of GBV.²³

23. Available at <https://resourcecentre.savethechildren.net/library/girl-shine>.



However, less has been done to train and mentor program staff and teachers to adapt their learning environment, equip schools, and adapt their learning materials to be inclusive. Participants also observed that most of the programs focus on improving access and quality of primary education. There are very few postprimary education initiatives in refugee and host communities.

Family tracing and reunification

Child-family separation is known to increase the risk of VAC. In refugee-hosting communities, the Ugandan government's district-level community-based service department facilitates and supports family tracing and reunification of separated children. However, the department is understaffed and underfunded, posing challenges to the process, which involves substantial logistical requirements that should be sustained over a long period of time. Within refugee settlements, family tracing and reunification programming for separated children is mostly done by the International Committee of the Red Cross.

Alternative care for unaccompanied and separated children

All unaccompanied or separated children are identified and registered upon arrival at the various reception centers; they are then referred to designated child protection partners for a best-interest assessment. In the study communities, most are placed in foster care arrangements. UNHCR neither encourages nor promotes the institutional care of unaccompanied or separated children.

Working with the district-level police, child and family protection units, and the probation and welfare officers, organizations such as Inter-AID identify and place children with foster parents. Social workers assess foster parents and the care arrangement through interviews and home visits and provide counseling to the foster parents on their roles and responsibilities. Foster parents and receiving communities receive support in the form of regular monitoring visits as a follow-up by child protection staff and caseworkers. For example, Inter-AID operates a foster parenting program that places children with families, which is often followed by the building of houses for these families. Several unaccompanied and separated children have been placed with foster families with excellent results.

"We also get children to foster parents. However, for example, if a refugee child says that they don't want to stay with a foster parent, we get them another one immediately because we have children who do not have parents and in case we find out that the child is suffering in the hands of one guardian we can always assign them another."

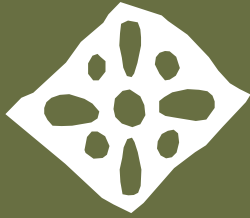
– Key informant interview (male), Kiryandongo

"We have formed various parent support groups within the community, and these support the implementation of our child protection activities. We have foster parents for unaccompanied refugee children. So, for the foster parents and other parents and caregivers especially for the refugee families, we bring them together in parent support groups and we always engage them in dialogues and train them on parenting after identifying their challenges."

– Key informant interview (female), Kiryandongo

However, participants identified several gaps and challenges in providing care for unaccompanied or separated children. For example, some participants reported that foster families often receive inadequate support; potentially hampering child protection outcomes. In addition, children in foster care are often discriminated against within the foster family, such as being assigned domestic tasks and not having access to schooling. Cash grants provided to foster families can create tensions and increase the risk of IPV. Lastly, the assessment showed that effective foster care for unaccompanied or separated children requires improved cultural sensitivity and additional support and training for professionals and foster families to be able to adequately support the complex needs of these children.

Participants acknowledged the need to organize better support for foster families given the context and their vulnerability, noting that families might not be ready or equipped to receive children who have experienced trauma. They recommended that the refugee community be involved in the identification of foster families and pointed to the need for more robust monitoring mechanisms and capacity to follow up on cases and to identify and prevent cases of abuse and violence.



4

Conclusions







Gender-based violence (GBV) and violence against children (VAC) are widespread in refugee-hosting communities. The assessment shows that GBV and VAC are pervasive in refugee-hosting communities and identifies perceived drivers and risk factors associated with victimization. The most common form of GBV is intimate partner violence (IPV). In general, the drivers of GBV and VAC in the host communities are similar to those documented in refugee settlements in Uganda (see UNHCR and OPM 2019; Global Women’s Institute et al. 2019; Sengupta and Calo 2016). For example, poverty and the lack of livelihood opportunities, substance abuse, and cultural and gender norms are identified as key drivers of GBV and VAC in both refugee and host communities.

GBV and VAC are closely interlinked. The rapid assessment identifies several intersections between GBV and VAC, consistent with other studies. For example, poverty, alcohol, and substance abuse are linked to violence against children, as well as with IPV. In addition, both GBV and VAC are buttressed by social norms that appear to deem such violence normal, acceptable, or even justified. IPV is also found to be closely linked with both physical and psychological violence against children. Findings indicate that children in households where women experience IPV are perceived to be at a higher risk of VAC. Despite the recognition of overlapping risks and intervention opportunities, GBV and child protection programming continues to occur separately or in silos in refugee and host communities, with different funding streams and actors. For example, different partners are implementing parallel norm changes for GBV and VAC even where there are strong normative overlaps, which is very inefficient.

GBV and VAC prevention and response in refugee and host communities remains inadequate. Overall, effective GBV and VAC case management continues to be undermined by the lack of accessible, integrated services and reporting mechanisms; weak institutional capacity across sectors (justice, health, education, and social welfare); and the absence of effective coordination of services in all refugee-hosting districts. For example, medical services and the justice system, including police and the courts, are

profoundly ill-equipped to support and assist survivors. Moreover, the long distances from the settlements to where the services are offered often prohibit optimal access to such services. Consequently, most survivors are unable to access an essential package of multisectoral services—health care, mental health care, psychosocial support, and justice/legal services. In some cases, utilization of services is limited to seeking one of the available services—for example, a survivor may seek health services but may not follow up on referrals to law enforcement or psychosocial services. This is attributed to gaps and bottlenecks in the existing referral systems, including the lack of standardized referral protocols, poor case tracking, and limited follow-up with survivors to ensure they promptly receive needed services. Poor initial experiences with service providers and perceptions among survivors regarding the quality and safety of services are also identified as barriers to follow-up care and/or utilization of other referrals across study sites. Specific identified gaps in terms of prevention and response are described below.

Health sector response. Access to high quality, confidential, and integrated health care services is a critical and life-saving component of a multisector response. However, findings indicate that the majority of survivors in both hosting and refugee communities rarely seek medical assistance. Even among those who do seek health care, misconceptions around the nature of risk faced and the necessary preventative treatment results in late reporting. In addition, most of the lower-level facilities lack staff trained in the clinical management of sexual assault survivors and the necessary medical supplies to treat survivors of violence, particularly sexual violence. In most cases, survivors are referred to higher-level facilities—health center (HC) IVs and referral hospitals—many of which are located far from the refugee and host communities, creating a barrier to accessing services. Follow-up services are scarce; after the initial treatment, most survivors are never contacted again.

Mental health and psychosocial support. Respondents identified a dearth of psychosocial services to address trauma as the largest GBV-related programming gap, particularly in host communities.





The capacity to diagnose and treat trauma associated with exposure to violence remains low in most health facilities located in refugee and host communities. Most facilities lack key personnel who can handle such issues, such as medical social workers, psychotherapists, and clinical psychologists. In addition, there is limited use of structured therapeutic interventions, such as cognitive-behavioral treatment therapy for trauma across government and nongovernmental organizations. Child-friendly spaces have become a widely used approach to protect and provide psychosocial support to children, but their outcomes or impact, especially on the social and emotional well-being of

children, has not been rigorously evaluated in the context of forced displacement.

Safety and security (protection) services. The capacity of the police to prevent, investigate, prosecute, and punish GBV crimes and to protect and support survivors remains low across the study sites. Most police stations and posts lack adequate personnel and resources to effectively address the security and safety needs of VAC and GBV survivors. The problem is exacerbated by the absence of a robust system that allows survivors to access safe shelter when they do not feel safe returning to their place of residence.



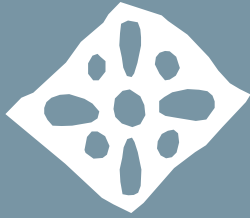
Justice and legal aid services. Only a small fraction of GBV and VAC cases are reported and prosecuted through the legal system; even fewer result in conviction. Factors hindering the prosecution of GBV cases include challenges arising out of the initial phases of GBV-related investigation, costs associated with accessing justice, and distance to courts. All justice, law, and order sector institutions have serious logistical and human resource deficiencies, which negatively impacts their capacity to effectively and efficiently discharge their functions. For example, the quality of police investigations is hampered by a dearth of officers with specialized skills in handling GBV cases and a lack of basic equipment, such as vehicles, medical examination forms, and paper, which are necessary for conducting an effective GBV investigation. In addition, access to legal aid services also remains an enormous challenge. While some nongovernmental organizations are offering legal services, they are overstretched and mainly support the refugee communities. Finally, because of problems associated with accessing the formal criminal justice system, many survivors and their families do not report cases, or they rely on informal justice mechanisms.

Coordination and referral systems. Problems of coordination across all the different actors and sectors constitute another key obstacle to effective GBV and child protection programming. In addition, while the role of referrals in facilitating access to multisectoral GBV services is recognized, the effectiveness of the referral system across study sites continues to be undermined by the lack of standard protocols that stipulate clear roles and responsibilities, insufficient resources, inadequate services at referral points, and the reluctance of survivors to seek services. Even the proximity of these institutions to address GBV and VAC remains an issue.

Weak and parallel information management systems and data. Information management systems for GBV and VAC are fragmented and sporadically utilized in the refugee-hosting districts. In addition, the overall perception among the key informants interviewed is that current monitoring and evaluation of GBV and child protection interventions focus on outputs, while little is known about the quality of the services provided or the outcomes and impacts of programs.

GBV and VAC prevention programs. Effective prevention of GBV and VAC requires multiple interventions at multiple levels (individual, interpersonal, community, and societal). While some prevention programs exist in refugee and host communities, participants identified several gaps. For example, only a few interventions focus on addressing VAC and GBV drivers at various levels through an integrated and multipronged approach. In addition, there are few socioeconomic empowerment programs for women and adolescent girls. Finally, there remains a limited body of evidence on the effectiveness of GBV and VAC prevention programs, interventions, and strategies, especially among refugee populations.

Funding gap and donor-driven funding. In the absence of strong government investment in GBV prevention and response, donors and nongovernmental organizations are filling the funding gap by implementing GBV projects and/or providing direct funding to district governments, particularly in refugee communities. District authorities greatly appreciate and value donor-funded projects, and many respondents reported that close coordination with donors and NGOs enables them to implement GBV and child protection programs. However, the sustainability of these donor-driven programs is an issue.



5

Recommendations







1. Mitigate and prevent GBV and VAC risks in development responses to forced displacement. Awareness is growing that the humanitarian model of care and maintenance is unsustainable over the long term and that forced displacement requires a development response to complement humanitarian assistance. However, emerging evidence indicates that if appropriate safeguard measures are not instituted, development projects can exacerbate existing risks of GBV and VAC or create new ones. For example, projects create changes in the communities in which they operate and can cause shifts in power dynamics between community members and within households. Therefore, development projects such as Uganda DRDIP should consider the potential negative impacts and implement measures across the program to mitigate any VAC and GBV-related risks that could result from project activities or exacerbate those that already exist in the community.

2. Strengthen and enhance multisectoral services at all levels. Effective gender-based violence (GBV) and violence against children (VAC) case management continues to be undermined by weak institutional capacity across key sectors of justice, health, education, and social welfare. Specific activities could focus on strengthening the case management capacity of GBV and child protection actors and duty bearers across these key sectors to ensure that survivors access quality essential services, including:

- ◆ Provide technical training and mentorship to build the capacity of duty bearers and actors to manage, coordinate and refer survivors to relevant services; improve confidentiality and cultural sensitivity in the delivery of services; and adhere to existing national and international standards, guidelines, and protocols (see appendix A). At a minimum, relevant staff involved in the provision of services to GBV and VAC survivors in the areas of health, psychosocial support, legal advice, and security should be trained in survivor-centered and trauma-informed approaches.
- ◆ Ensure that the various actors and institutions have the facilities and logistical capabilities they need to effectively execute their mandates.

- ◆ Strengthen coordination and referral mechanisms that are necessary to support effective case management and to ensure that survivors are identified, that their needs are correctly assessed, and that they receive cross-sectoral support. Protocols should be developed and implemented to establish clear referral and accountability mechanisms within and across sectors so that survivors know where to go to receive assistance, and that they receive it promptly. In addition, the coordination mechanism among and between multi-sectoral and interagency GBV and child protection actors should be strengthened at the local level.
- ◆ Build community capacity where possible, especially among local leaders and refugee welfare committees so that they can handle cases of GBV and VAC appropriately and refer cases to formal services as required by the referral pathways.

3. Scale up evidence-based family and community-based violence prevention mechanisms in both refugee and host communities. The range of drivers and risk factors for VAC and GBV at the various levels of the socioecological framework needs to be addressed through a multipronged approach, reflecting recent evidence of what works. Such an intervention could aim to:

- ◆ Change social norms that deem violence against women or violence against children to be acceptable through community-based violence prevention programs. Evidence-based community mobilization and social norm change approaches such as the SASA! methodology should be adapted or contextualized and implemented by district/local government structures for scale and sustainability. This may require, over the short and long-term, building the capacity of government structures and duty bearers, such as probation social welfare officers and community development officers, through training and mentorship to ensure effective implementation and institutionalization.
- ◆ Develop and implement parenting programs to prevent intimate partner violence and child maltreatment that teaches parents to build nurturing relationships with their children and to use appropriate nonviolent



discipline as key to the prevention of violence against women and girls. Such programs should build on and take into account the Ministry of Gender Labour and Social Development's national parenting guidelines as well as those of United Nations (UN) agencies.

- ◆ Support economic and social empowerment for women and adolescent girls because the relationship between violence against women and girls with poverty and economic insecurity are well documented. Promoting women's protection through strategic interventions, including livelihood and economic opportunities, is critical to reducing GBV vulnerability. Adolescent girls experience specific vulnerabilities, and evidence-based interventions focused on building the livelihoods and life skills of adolescent girls, such as the BRAC's Empowerment and Livelihoods for Adolescents model, could be adapted or contextualized and then implemented under the livelihood component of the Uganda Development Response to Displacement Impacts Project (DRDIP).
- ◆ Develop and implement school-based violence prevention programs because school environments in refugee and host communities remain hot spots for VAC. They also provide ideal environments for challenging harmful social and cultural norms (standards or patterns that are typical or expected) that tolerate violence toward others (e.g., GBV). School-based violence prevention programs should focus on developing children's life skills, building knowledge around safe behaviors, challenging social and cultural norms, promoting equitable relationships, and developing the skills of teachers to promote positive interactions with children. Some nongovernmental organizations (NGOs) and UN agencies have piloted successful school-based violence prevention programs, such as the UNICEF's child-friendly-schools model and Raising Voices' "Good School" toolkit, which could be easily replicated and scaled up in refugee and host communities. These programs should also support the roll-out of the Ministry of Education and Sports' "Reporting, Tracking, Referral and Response Guidelines on Violence Against Children in Schools" (2014).²⁴

4. Consider and address intersections between GBV and VAC. The nexus between GBV and VAC highlight the need for greater collaboration and integrated programming to address both forms of violence. There is a need to break conceptual "silent spaces" across GBV and child protection programming while also recognizing that in some instances the two fields call for dedicated approaches focused on areas of common ground, when possible (e.g., addressing shared risk factors—including social norms—that underpin both forms of violence and preparing service providers to address both GBV and VAC). In addition, efforts should be made to assess the added value of coordinated efforts to prevent and respond to these forms of violence in an integrated way.

5. Bridge the humanitarian–development divide in GBV and child protection programming. The gap between the humanitarian and development responses to addressing GBV- and VAC-related risks must be reduced through deliberate efforts. The Comprehensive Refugee Response Framework underscores the need to shift from a mainly emergency focus to a more sustainable, integrated approach that addresses immediate humanitarian needs as well as to longer-term investments toward recovery and development. It also provides important entry points and opportunities for humanitarian and development actors to work together to contribute to the building of an integrated protection system that ensures a more integrated and sustainable GBV and VAC prevention and response. For example, humanitarian and development partners could work together to ensure the integration of information systems and reporting in addition to referral pathways and case management. The humanitarian–development nexus and commitment to the "New Way of Working"²⁵ provides another opportunity for humanitarian and development actors to work collaboratively (i.e., to break down silos), including aligning funding and financing modalities to strengthen district- and national-level systems to address the protection needs of refugee and host communities.

24. The ministry's guidelines complement the child-friendly-schools model and are designed to improve reporting by children and school officials of incidents of violence against children/girls and to be integrated with the broader district referral and response systems.

25. The New Way of Working, or NWOW, is an approach promoted by the UN Joint Steering Committee to advance humanitarian and development collaboration. The approach calls on humanitarian and development actors to work together collaboratively, based on their comparative advantages, toward "collective outcomes" that reduce need, risk, and vulnerability over multiple years (UN OCHA 2017).



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Appendixes







APPENDIX A. LIST OF DOCUMENTS REVIEWED

National level

Legal and Policy Documents

- ◆ Children's Act Cap 59, amended in 2016
- ◆ Local Government Act, 1997
- ◆ Police Act, 2000
- ◆ Penal Code Act, Cap 120, as amended
- ◆ Local Council Courts Act
- ◆ Constitution of the Republic of Uganda 1995, as amended
- ◆ Sexual Offences Bill, 2011
- ◆ Domestic Violence Act, 2010
- ◆ Magistrates' Courts Act, 2007 (amendment)
- ◆ Prevention of Trafficking in Persons Act, 2009
- ◆ Employment Act
- ◆ National Policy and Action Plan on Elimination of Gender-Based Violence in Uganda, MGLSD, 2016
- ◆ National Strategic Plan on Violence Against Children in School, 2015–20, and guidelines on the reporting, tracking, referral, and response of violence against children in school

Statutory instruments

- ◆ The Domestic Violence Act Regulations, 2011 (Statutory Instruments No. 59)
- ◆ The Children (Family and Children Court) Rules (Statutory Instrument No. 592)
- ◆ Employment (Sexual Harassment) Regulations, 2012 (Statutory Instrument No. 15)

Standards, guidelines, and regulations

- ◆ Ministry of Gender, Labour and Social Development. 2013. *Guidelines and Procedures for the Operation of Shelters in Uganda*.
- ◆ *Medico-legal Manual*, 2014
- ◆ FIDA-U and the Judicial Studies institute. 2011. *Judicial Training Manual on Sexual and Gender-Based Violence*.
- ◆ Center for Domestic Violence Prevention (CEDOVIP) and Uganda Police Force. 2007. *Responding to Domestic Violence: A Handbook for the Uganda Police Force*.
- ◆ Raising Voices. 2008 *SASA! Activist Kit for Preventing Violence against Women and HIV*.



International level

- ◆ Convention on Elimination of all Forms of Discrimination Against Women, 1979
- ◆ United Nations Convention on Rights of the Child, 1989
- ◆ Declaration on Elimination of Violence Against Women, 1993
- ◆ United Nations Security Council Resolutions 1325 and 1820

Standards, guidelines, and protocols

- ◆ Inter-Agency Standing Committee (IASC). 2005. *Guidelines for Gender-Based Violence Intervention in Humanitarian Settings*. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.
- ◆ Sphere Association. 2018. *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, Fourth Edition*. Geneva. www.spherestandards.org/handbook.
- ◆ International Rescue Committee (IRC) and the United Nations Children's Fund. 2012. *Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings*. <https://resourcecentre.savethechildren.net/library/caring-child-survivors-sexual-abuse-guidelines-health-and-psychosocial-service-providers>.

- ◆ World Health Organization. 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*. RHR/14.26, field testing version (September).
- ◆ World Health Organization and United Nations High Commission for Refugees. 2004. *Clinical Management of Survivors of Rape: Developing Protocols for Use with Refugees and Internally Displaced Persons*.
- ◆ International Conference on the Great Lakes Region (ICGLR). 2006. *Protocol on Sexual Violence against Women and Children*. <http://www.peaceau.org/uploads/final-protocol.sexual-violence-en-rev-2.pdf>.

Other documents

- ◆ Butchart, A., and S. Hillis. 2016. *Inspire: Seven Strategies for Ending Violence Against Children*. World Health Organization.
- ◆ International Rescue Committee. Updated 2014. *GBV Emergency Toolkit*.
- ◆ United Nations Children's Fund. 2014. *Communities Care: Transforming Lives and Preventing Violence*.



APPENDIX B. SERVICES PROVIDED IN REFUGEE AND HOSTING COMMUNITIES

TABLE B.1

Number of Institutions Mapped

District	Health Facilities		Legal/Justice Actors		Civil Society Organizations	Schools	Total
	Refugee Settlement	Host Community	Refugee Settlement	Host Community			
Adjumani	14	13	11	7	6	2	53
Arua	11	6	9	5	20	2	53
Hoima	5	7	3	8	8	1	32
Isingiro	1	18	1	19	7	2	48
Kamwenge	0	13	0	14	5	2	34
Kiryandongo	3	7	2	7	3	2	24
Koboko	1	13	4	11	9	2	40
Kyegegwa	2	7	1	7	9	2	28
Lamwo	2	16	1	10	5	2	29
Moyo	6	17	4	4	12	2	45
Yumbe	18	16	3	8	23	2	70
Total	61	135	38	101	102	21	469

TABLE B.2

Availability of Health Services for Gender-based Violence and Violence Against Children

	Refugee Settlement			Host Community			
	HC IV (n=2)	HC III (n=31)	HC II (n=28)	Hospital (n=2)	HC IV (n=9)	HC III (n=57)	HC II (n=67)
Forensic examination and documentation	2	19	11	2	6	48	25
HIV testing services.	2	31	28	2	9	54	55
Postexposure prophylaxis	2	30	18	2	9	53	16
Pregnancy testing	2	31	26	2	9	53	46
Emergency Contraception	2	31	24	2	9	47	43
Abortion counseling and information	2	30	27	2	7	44	48
Postabortion care	2	30	22	2	9	47	44
Vaccination for hepatitis B and tetanus	2	31	27	2	8	47	42
Screening for sexually transmitted infections	2	31	27	2	9	53	48
Treatment for sexually transmitted infections	2	31	25	2	9	53	57
Trauma counseling	2	31	27	2	8	52	44
Evaluation and treatment of injuries	2	30	27	2	9	54	51
Referrals	2	31	25	2	9	51	54
Completion of medical form	2	22	20	2	9	53	28
Legal representation	2	17	8	1	9	31	12

HC = health center.



TABLE B.3
Availability of Essential Medicines

Essential Medicines	Refugee Settlement			Host Community			
	HC IV (n=2)	HC III (n=31)	HC II (n=28)	Hospital (n=2)	HC IV (n=9)	HC III (n=57)	HC II (n=67)
Emergency contraceptive pills	1	25	20	2	7	37	26
Postexposure prophylaxis to prevent HIV	2	28	14	2	9	52	12
Antibiotics to prevent and treat sexually transmitted infections	2	31	26	2	8	53	56
Antibiotics for wound care	2	31	22	2	7	54	56
Hepatitis B vaccine	1	27	14	2	4	24	18
Tetanus toxoid	2	28	23	2	7	51	49
Analgesia (e.g., Panadol, aspirin)	2	30	26	2	7	54	57

TABLE B.4
Availability of Medical Equipment

Essential Equipment and Supplies	Refugee Settlement			Host Community			
	HC IV (n=2)	HC III (n=31)	HC II (n=28)	Hospital (n=2)	HC IV (n=9)	HC III (n=57)	HC II (n=67)
HIV rapid test kit	2	30	26	2	9	53	52
Pregnancy test kit	2	31	24	2	9	50	28
Speculum (preferably plastic and disposable, only adult sizes)	2	26	19	2	8	44	22
High vaginal swabs	2	20	7	2	5	29	8
Needles and syringes	2	30	25	2	7	55	44
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, and soap)	2	27	26	2	7	52	47
Paper bags for collection of evidence	0	9	9	1	1	15	5
Paper tape for sealing and labeling containers and bags	1	15	9	1	4	20	6
Sterile medical instruments (kit) for repair of tears, and suture material	1	27	17	2	7	42	20
Autoclave to sterilize equipment	2	28	18	2	6	36	23



TABLE B.5

Accessibility to GBV and VAC Services at Health Facility Level

	Refugee Settlement			Host Community				
	Hospital (n=0)	HC IV (n=2)	HC III (n=31)	HC II (n=28)	Hospital (n=2)	HC IV (n=9)	HC III (n=57)	HC II (n=67)
Does the facility offer interpreters for refugees who may not speak English or the local language?								
Yes	0	0	28	14	0	5	33	18
No	0	2	3	14	2	4	24	49

GBV = gender-based violence; HC = health center; VAC = violence against children.

TABLE B.6

GBV- and VAC- Related Services Provided by Police

Service	Refugee Settlements		Host Communities		
	Station (n=5)	Post (n=33)	District (n=8)	Station (n=47)	Post (n=46)
Statement-taking and documentation	33	5	44	46	7
Investigation	32	5	40	46	7
Collection of forensic evidence	18	4	25	30	7
Storage of forensic evidence	16	4	18	13	7
Ensuring the safety of the survivor	28	5	34	35	6
Witness protection	26	5	28	26	5
Issuing the police medical report form	29	5	39	39	7
Psychosocial counseling	28	5	39	43	6
Others	4	0	5	6	1

GBV = gender-based violence; VAC = violence against children.



APPENDIX C. ORGANIZATIONS PROVIDING GBV PREVENTION SERVICES

Name of CSO/NGO	Services Provided							
	Increasing the Political Participation and Influence of Women	Economic Empowerment and Livelihoods for Women	Promotion of Sexual and Reproductive Health and Rights	Incorporation of Men and Boys as Agents of Change	Transformation of Norms and Behavior	Behavior Change Communication	Raising Community Awareness of and Sensitization Toward GBV	Parental Education Programs and Support Groups for Families Affected by Domestic Violence
Adjumani District								
Tutapona							✓	
Danish Refugee Council			✓	✓	✓	✓	✓	✓
Refugee Law Project	✓						✓	
War Child Canada			✓	✓	✓	✓	✓	
Save the Children				✓	✓	✓	✓	✓
Windle Trust Uganda			✓	✓		✓	✓	
Arua District								
Danish Refugee Council		✓		✓	✓	✓	✓	✓
Médecines Sans Frontières							✓	
AVSI International Services of Volunteers Association		✓	✓		✓	✓	✓	✓
FIDA Uganda							✓	
Save Children			✓				✓	
Oxfam		✓	✓				✓	✓
Child's Voice							✓	
International Aid Services							✓	
Care International	✓	✓	✓	✓	✓	✓	✓	✓
Transcultural Psychosocial Organization			✓		✓	✓	✓	
Andrea Foods International	✓	✓	✓	✓	✓	✓	✓	
Rural Initiative for Community Empowerment				✓			✓	
Youth With a Mission			✓	✓	✓	✓	✓	
Welthungerhilfe		✓		✓	✓	✓	✓	✓
PAG Social Development Services			✓		✓			✓
Plan International Uganda							✓	
ZOA West Nile Program	✓	✓		✓		✓	✓	
Humming Bird Action for Peace and Development		✓			✓	✓		
Caritas Arua		✓	✓	✓	✓	✓	✓	

(continued)



Name of CSO/NGO	Services Provided							
	Increasing the Political Participation and Influence of Women	Economic Empowerment and Livelihoods for Women	Promotion of Sexual and Reproductive Health and Rights	Incorporation of Men and Boys as Agents of Change	Transformation of Norms and Behavior	Behavior Change Communication	Raising Community Awareness of and Sensitization Toward GBV	Parental Education Programs and Support Groups for Families Affected by Domestic Violence
Hoima								
Kwatanima Women Farmers Group	✓	✓	✓	✓	✓	✓	✓	✓
Action Africa Help (AAH)			✓					
Humanitarian Initiative Just Relief Aid (HIJRA)	✓	✓		✓	✓		✓	✓
Windle International Uganda							✓	
Lutheran World Federation			✓				✓	✓
Norwegian Refugee Council (NRC)								
American Refugee Committee		✓					✓	✓
Save the Children							✓	
Isingiro								
American Refugee Committee	✓	✓	✓	✓		✓	✓	✓
Care and Assistance for Migrants (CAFOM)		✓	✓			✓		
HIJRA Humanitarian Initiative Just Relief Aid		✓		✓	✓	✓	✓	✓
Refugee Law Project (Legal aid)	✓	✓	✓		✓	✓	✓	✓
Windle International Uganda							✓	
Kamwenge								
Lutheran World Federation	✓	✓		✓	✓	✓	✓	✓
Save the children							✓	
ACCORD	✓	✓	✓	✓	✓	✓	✓	
World Vision		✓	✓	✓	✓	✓	✓	✓
Kiryandongo								
Danish Refugee Council	✓	✓		✓		✓	✓	✓
Save The Children							✓	
Real Medicine Foundation (RMF)		✓	✓			✓	✓	✓
Agency for Cooperation in Research and Development (ACORD)		✓	✓	✓	✓	✓	✓	✓

(continued)



	Services Provided							
Name of CSO/NGO	Increasing the Political Participation and Influence of Women	Economic Empowerment and Livelihoods for Women	Promotion of Sexual and Reproductive Health and Rights	Incorporation of Men and Boys as Agents of Change	Transformation of Norms and Behavior	Behavior Change Communication	Raising Community Awareness of and Sensitization Toward GBV	Parental Education Programs and Support Groups for Families Affected by Domestic Violence
Koboko								
Community Empowerment and Rehabilitation Initiative to Development (CERID)		✓		✓	✓	✓	✓	✓
PICOT		✓					✓	✓
ACAV							✓	
Humanitarian Assistance and Development Services	✓	✓	✓	✓	✓	✓	✓	✓
AFORD			✓				✓	
Koboko Civic Society Network	✓	✓	✓	✓	✓		✓	✓
Kids Uganda							✓	
Kyegengwa								
ACORD			✓				✓	✓
CEDO				✓		✓	✓	✓
Danish Refugee Council	✓	✓		✓	✓	✓	✓	
Oxfam					✓	✓	✓	✓
Save the Children					✓		✓	
Windle International Uganda							✓	
World Vision							✓	
Lamwo								
War Child	✓			✓	✓	✓	✓	
Lutheran World Federation		✓			✓		✓	✓
American Refugee Committee			✓	✓	✓	✓	✓	✓
Transcultural Psychosocial Organization	✓	✓	✓	✓	✓	✓	✓	✓

(continued)



Name of CSO/NGO	Services Provided							
	Increasing the Political Participation and Influence of Women	Economic Empowerment and Livelihoods for Women	Promotion of Sexual and Reproductive Health and Rights	Incorporation of Men and Boys as Agents of Change	Transformation of Norms and Behavior	Behavior Change Communication	Raising Community Awareness of and Sensitization Toward GBV	Parental Education Programs and Support Groups for Families Affected by Domestic Violence
Moyo								
ADRA		✓					✓	
MTI			✓	✓	✓	✓	✓	
Moyo Babies Home							✓	
Lutheran World Federation	✓	✓	✓	✓	✓	✓	✓	✓
Windle International							✓	
Redeemer Children's Home	✓	✓	✓	✓	✓	✓	✓	✓
ACTED	✓	✓		✓			✓	
Global Women Water Initiative	✓	✓	✓	✓	✓	✓	✓	✓
Moyo Aids Heros Association		✓	✓	✓	✓	✓	✓	
Genex Agro Business		✓					✓	
Yumbe								
Danish Refugee Council		✓		✓		✓	✓	✓
Save the Children							✓	
Windle International							✓	
Real Medicine Foundation		✓	✓					
War Child Holland	✓	✓	✓	✓	✓	✓	✓	✓
Plan International							✓	
Catholic Relief Services							✓	
War Child Canada							✓	✓
Transcultural Psychosocial Organization							✓	
International Rescue Committee	✓	✓	✓	✓		✓	✓	✓
Red Cross Uganda	✓	✓	✓	✓		✓	✓	✓
ACORD	✓	✓	✓	✓		✓	✓	✓
DCA		✓					✓	
American Refugee Committee		✓	✓	✓	✓	✓	✓	✓
Mercy Corps		✓		✓	✓		✓	
Norwegian Refugee Council	✓	✓			✓	✓	✓	
World Vision							✓	

CSO = civil society organization; GBV = gender-based violence; NGO = nongovernmental organization.



This work was supported by the State and Peace Building Fund,
the Disaster Risk Finance for Resilient Livelihoods—the Global Trust Fund between
SIDA Headquarters and the World Bank, and the Government of Norway.

