INTEGRATING MHPSS ACROSS CORDAID THEMATICS (IMPACT) STUDY

THE REPORT

LASPNET
TPO UGANDA Restoring Hope, Transforming Lives
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Executive Summary.....3
Chapter 1: Background 5
1.1 Introduction.....5

Chapter 2: Approaches used in the study.
2.1 Research Objectives:.....6
2.2 Survey Research Objectives:.....6
2.3 Methodology.....4
2.3.1 Quantitative survey..... 4
2.3.2 Qualitative surveys.....7

Chapter 3: Policy framework on SGBV in Uganda.....8
3.1 Previous research on GBV in refugee settings.....8
3.2 Existing legal and policy framework on SGBV.....9

Addressing GBV issues in humanitarian setting 11

Chapter 4: Key Findings.....15

Summary of insights from the survey.....20
Recommendations: What needs to be done to support MHPSS in refugee situations.....21

List of Figures

Figure 1: Types of SGBV faced.....15
Figure 2: Other forms of GBV experienced.....16
Figure 3: Institutions one report SGBV concerns in your community and trusted institutions (%).....17
Figure 4: Services available where one reported (%).....18
Figure 5: Current security concerns.....19

List of Tables

Table 1: Selected sample compared to the district population 5
Table 2: Experience of SGBV in West Nile (Percent).....22
Table 3: Awareness of SGBV in the community (Percent).....23
Table 4: Where can you report SGBV issues and trust for institutions (Percent).....24
Table 5: Knowledge about where to Report SGBV and type of services offered (Percent).....25
Table 6: Availability of institutions addressing SGBV (Percent).....26
Table 7: Security concerns in the community (Percent).....27

EXECUTIVE SUMMARY

Sexual and Gender-based Violence (SGBV) is a global social, and public health concern that inflicts harm on women, girls, men, and boys and severely violates human rights. SGBV remains rampant in Uganda. Refugees have a heightened risk of experiencing SGBV due to the protracted nature of forced displacement. Relatedly, SGBV incidents in refugee settlements and host communities are attributed to cultural beliefs and security lapses. Other factors fueling SGBV include the lack of trust among couples, land wrangles, economic pressures, unaddressed trauma, substance abuse, and a general breakdown of society's core functions.

Majority of the SGBV incidents are not reported and as such, go unpunished. Partly this due to the limited awareness of how and where to report the perpetrators. Survivors prefer to use informal justice systems—such as cultural leaders; traditional leaders and the refugee welfare committees (RWCs) instead of formal justice systems including Police and courts of law. This is because the latter structures are perceived as challenged by the language barrier; corruption; lengthy procedural formalities. Ultimately, SGBV has a bearing on survivors and their families' emotional and mental well-being and social and economic aspects.

Against the above background, LASPNET, CORDAID and TPO conducted a study in refugee settlements in West Nile to examine how Mental Health Psychosocial Support (MHPSS) interventions can be mainstreamed in existing services for (S)GBV survivors faced with a humanitarian environment in Uganda.

A survey was conducted in refugee settlements among host communities in 4 districts of West Nile i.e. Adjumani, Arua, Moyo and Yumbe. The survey sought to (i) Establish the extent and frequency of violence (prior and after displacement); (ii) Establish the availability and access to health, psychosocial and legal services by SGBV survivors; (iii) Assess past and current safety and security concerns; and (iv) Determine the expectation of SGBV survivors regarding addressing SGBV. The survey entailed a quantitative household survey that targeted survivor of SGBV and targeted Focus Group Discussions (FGDs) and key informant interviews (KIIs).

Key findings

Most of the victims who experienced SGBV did so within six months of displacement. Sexual assault and rape (including gang rape and marital rape) are the most frequently cited forms of SGBV experienced. A few of the respondents reported ever experiencing sexual exploitation, including incest and harmful sexual practices, e.g. female genital mutilation. Such crimes affect the emotional well-being and mental health of survivors.

The most frequently cited conditions that increase the threat of SGBV are the collection of firewood and visiting recreation centres. Specifically, late-night movement from recreation centres expose women to insecurity incidents.The most frequently cited reason behind SGBV incidents is the minimal economic opportunities in the refugee environment. These are compounded by inadequate security during market days—especially during evening markets. Furthermore, refugee settlements are characterised by a limited presence of Police and other security personnel.

Excessive consumption of alcohol is also a significant driver of SGBV incidents. Most of the alcohol and substance abuse—especially by youth of marijuana, mayirungi and cannabis—takes place recreation centres. Inadequate food rations—compared to family sizes of refugee households was also listed as the driver of SGBV. The lack of food and money exposes girls to prostitution as hunger threats can trigger incidents of sexual exploitation. Some of the food rations may also be sold off by spouses, leading to family necessities' mismanagement and precipitating violence.

There is a preference for informal channels to address SGBV incidents that breeds impunity among perpetrators. Most of the SGBV incidents are not reported to authorities but other informal institutions such as elders and cultural leaders. The limited reporting of SGBV incidents to authorities may be explained by the non-availability of institutions that can enforce sanctions and the trust of such institutions. For example,

institutions such as legal aid service providers are few and located mainly in urbanised centres. The limited proximity presents a limitation for survivors to use such formal institution. Informal institutions are also frequently cited as the main avenue preventing women from experiencing SGBV. Cultural and religious leaders are used extensively to prevent SGBV.

Regarding safety and security within settlements, respondents indicated hardly any separate toilets for women and men. Also, most of the toilets have no locks. Furthermore, there is not enough security lighting in the settlement. Indeed, it is mostly in Yumbe district, where 15% of the respondents indicate enough lighting. Refugees are significantly more likely to live in crowded conditions, i.e. either living with individuals there do not know or single mothers living with an unknown person or mothers separated from their children. The leading security concern mentioned by the respondents was going out alone at night. Going out alone is closely followed by collecting firewood. Beyond SGBV hot spots, several respondents mentioned being looked-at inappropriately given the crowded conditions as a significant security threat.

Recommendations for action

Alongside ongoing efforts to address SGBV, we call upon Government, Development Partners and Civil Society – to take the following actions:

Address the excessive consumption of alcohol.

1. Provide mental health and counselling services to GBV survivors. The mental health and psychosocial services should be one of the first services offered prior to any referrals to justice institutions. Also, the provision of mental health and psychological support to SGBV survivors would address the fears of lodging formal SGBV complaints.
2. Provide counselling services on alcohol and substance abuse and the provision of rehabilitation centres for alcohol addicts.
3. Step-up the overall security within refugee settlements.
4. Extend police services within the refugee settlements.
5. Increased use of community policing and the conduct of mobile police patrols at night.
6. Expand employment opportunities with refugee settlements.
7. Address both the amount provided for food rations offered to refugee and the timeliness of rations.
8. Provide additional safe spaces to create awareness regarding available responses to SGBV incidents.
9. Operate toll-free lines that can encourage more reporting and address the associated stigma of reporting.
10. Address the current poor quality of available legal aid services– especially concerning following up of reported cases.
11. Provide witness protection and related legal services.

CHAPTER 1: BACKGROUND

1.1. Introduction

Sexual and Gender-based Violence (SGBV) refers to any sexual act perpetrated against a person's will and based on gender norms and unequal power relationships.[3] The vice includes physical, emotional or psychological and sexual violence and denial of resources or access to services. SGBV is a global social, and public health concern that inflicts harm on women, girls, men, and boys and severely violates human rights. SGBV remains rampant in Uganda. According to the 2019 Uganda Police Annual, Crime Report 2019 revealed that Police registered 13,693 domestic violence cases involving 14,232 victims. At least 70% of the victims were female adults, while male adults comprised 20.4 %, and the rest were juveniles. Furthermore, the report noted that a total of 13,682 children were defiled during the same year, of whom, 13,441 were female juveniles; and 1,531 women were victims of rape. [4]

Refugees have a heightened risk of experiencing SGBV due to the protracted nature of forced displacement.[5] Relatedly, SGBV incidents in refugee settlements and host communities are attributed to cultural beliefs and security lapses.[6] Other factors fueling SGBV include the lack of trust among couples, land wrangles, economic pressures, unaddressed trauma, substance abuse, and a general breakdown of society's core functions.

Majority of the SGBV incidents are not reported and as such, go unpunished. Partly this due to the limited awareness of how and where to report the perpetrators. However, in instances where the survivors are armed with knowledge and information of where to report, they prefer to use informal justice systems–such as cultural leaders; traditional leaders and the refugee welfare committees (RWCs)–to formal justice systems including Police and courts of law. This is because the latter structures are perceived as challenged by the language barrier; corruption; lengthy procedural formalities. Often such formalities have an associated financial cost which the survivors cannot afford.[7] Furthermore, law enforcement agencies (e.g., police, judges, and prisons) operating in refugee settlements have inadequate capacity to discharge their functions and respond to SGBV cases effectively.[8]

Ultimately, SGBV has a bearing on the emotional and mental well-being and social and economic aspects of survivors and their families. In combating SGBV in refugee settings, both international and local entities have joined efforts to pursue several interventions. Against the above background, LASPNET, CORDAID and TPO conducted a study in refugee settlements in West Nile to examine how Mental Health Psychosocial Support (MHPSS) interventions can be mainstreamed in existing services for (S)GBV survivors faced with a humanitarian environment in Uganda.

The rest of the research report is organized as follows. In Chapter 2, we describe the approach used in conducting the study, including the study objectives. Chapter 3 examines the existing legal and policy framework on SGBV and provides a literature review on past studies in Uganda. Chapter 4 discusses the approaches used to address GBV in humanitarian settings. Chapter 5 provides the key findings from the survey conducted in West Nile. Chapter 6 summarizes the study's insights, while Chapter 7 provides the recommendations on what needs to be done to support mental health services in refugee settings.

3 https://emergency.unhcr.org/entry/60283/sexual-and-gender-based-violence-sgbv-prevention-and-response Accessed on 1st June 2020.
4 Police Crimes Report (2019) https://www.upf.go.ug/wp-content/uploads/2020/04/Annual-Crime-Report-2019-Public.pdf?x45801 .
5 Ministry of Gender, Labour and Social Development (2008). National Situational Analysis of Sexual and Gender Based Violence and its Impact on Increased Vulnerability of Women to HIV /AIDs in Uganda. Kampala: MGLSD.
6 Report on Rule of Law, Access to Justice and Security needs in Refugee settlements and host communities in Arua and Isingiro districts (February 2019).
7 Report on Rule of Law, Access to Justice and Security needs in Refugee settlements and host communities in Arua and Isingiro districts (February 2019) page 79
8 Government of Uganda and United Nations (2019) Interagency Assessment of measures, services and safe guards for protection of women and children against sexual and gender-based violence among refugees in - page 4

Chapter 2: Approaches used in the study.

2.1 Research Objectives:

The overall research project objective is to develop an integrated, adaptive package of interventions that connect Mental Health Psychosocial Support (MHPSS) activities to a continuum of services for (S)GBV survivors in Uganda.

The project Specific objectives were to;

- To generate grounded, programme-relevant insights on (S)GBV survivors' needs in West Nile regarding both refugee and host community/populations.
- To co-produce with refugee and host communities' actionable solutions for delivering an integrated package of support to (S)GBV survivors that connect/ integrates at a minimum.

2.2 Survey Research Objectives:

As part of the project, a survey was conducted in 4 districts.
The survey Specific objectives were to;

1. Establish the extent and frequency of violence (prior and after displacement);
2. Establish the availability and access to health, psychosocial and legal services by SGBV survivors.
3. Assess past and current safety and security concerns
4. Determine the expectation of SGBV survivors regarding addressing SGBV.

2.3 Methodology

The research adopted a descriptive research design using both quantitative and qualitative approaches. This choice was made to enable triangulation during analysis. The study was conducted using several steps to address the project objectives. These include: (i) undertake literature review; (ii) design research tools (quantitative survey tools, FDG guides, and KIIs questionnaire); (iii) train supervisors and research assistants to collect data on SGBV during refugee situations in an ethical and survivor-centred way; (iv) undertake data collection in West Nile, i.e. conduct interviews with different demographic categories on the changes they want to see within their communities to better prevent and respond to SGBV related to fragile and conflict-affected settings; (v) in partnership with key stakeholders in the refugee community, e.g. RWCs and other CSOs, design multi-sectoral, community-based interventions for select villages in data collection sites to improve service provision for survivors.

2.3.1 Quantitative survey

Based on the information provided in terms of reference, the household survey targeted survivors of SGBV. A team of research assistants administered the survey to individuals aged 15-49 years in the selected households. Efforts were made by the research assistants to conduct interviews separately without the presence of other household members. This was meant to ensure that survivors are not either stigmatised or suffer any harm post-interview. The survey was conducted in four districts of Adjumani, Arua, Moyo and Yumbe. A structured questionnaire was administered to the sampled households. Information to be collected in the survey included: (i) household displacement history, if any; (ii) household demographic characteristics; (iii) Extent and frequency of violence (prior and after displacement); (iv) identity of the perpetrator; (v) availability of health services near the settlement; and (vi) availability of psychosocial and legal services near the community. Also, information was collected on distressful events after the displacement including (i) domestic violence; (ii) respondents hearing someone was raped after the displacement; (v) respondent hearing someone had sustained injuries from domestic violence after the disaster, and (vi) past and current safety concern (both within the community and at the household level). Furthermore, information was collected on what survivors expect to see concerning addressing SGBV.

Table 1 below shows the sample size concerning the number of *households in the respective district. Nonetheless, as mentioned earlier, the selection was mainly guided by the resources available.*

Table 1: Selected sample compared to the district population

District	Refugee Population	Number of households	Selected Sample	Number of sampled households/1000
Yumbe	232,742	41,626	100	2.40
Arua	186,450	143,483	80	0.56
Adjumani	214,363	25,894	100	3.86
Moyo/ Obonji	151,304	63,722	80	1.26
Sources: Refugee population is from the Uganda Refugee Portal. Number of households is from the 2014 National Census.				

2.3.2 Qualitative surveys

The quantitative survey was supplemented with a qualitative component comprising targeted Focus Group Discussions (FGDs) and key informant interviews (KIIs). The qualitative component provided additional in-depth contextual findings, perceptions and distress after displacement, and recommendations to safety concerns of women and girls in refugee settlements. We propose to conduct 16 FGDs–4 from each of the four districts of Adjumani, Arua, Moyo and Yumbe. At least one of the following categories of stakeholders was covered in each district and most importantly separately.

- Adult women
- Adult men
- Adolescent girls
- Adolescent boys

2.4 Ethical consideration to be observed.

In the design of the survey instruments, the following ethical considerations were taken into account, emphasised during the training of research assistant and placed visibly on the survey instruments: i.e. (i) informed consent; (ii) voluntary participation; (iii) do not harm; (iv) confidentiality; and (v) anonymity. Each household questionnaire will have the following introduction at the beginning of the questionnaire as

"Hello, my name is ……..……I am visiting you on behalf of LASPNET, TPO and CORDAID. We are assessing the needs of S/GBV survivors among refugees and the host communities. The information collected will help the civil society organisations plan better for the refugee and host communities. It would be appreciated if you would be prepared to answer a few questions. It will only take a few minutes of your time. All information collected will remain confidential. Participation in this survey is voluntary. However, we hope that you will participate in this survey since your views are important. At this time, do you want to ask me anything about the survey?

Do you agree to take part in this survey?	*1=Yes*	*2=No (End interview)*

CHAPTER 3: POLICY FRAMEWORK ON SGBV IN UGANDA

3.1 Previous research on GBV in refugee settings.

Beyond the general population, several studies including reports from the Ministry of Gender, Labour and Social Development (MGLSD) indicate that refugees have a heightened risk of experiencing SGBV due to the protracted nature of forced displacement.[9] The 2019 LASPNET Report on Rule of Law, Access to Justice and Security needs in Refugee settlements and host communities in Arua and Isingiro districts validates this. The report alludes that SGBV remains rampant within refugee settlements and host communities in Arua and Isingiro.

In combating SGBV in refugee settings, key among the existing interventions includes the 5-year Strategy developed by UNHCR to attain an SGBV-free community in refugee situations. The Strategy envisages the adoption of survivor-centred, multi-sectoral prevention and response. Furthermore, the Strategy articulates challenges raised in combating SGBV that relate to limited resource allocation and decision making—where SGBV issues are not prioritised and not provided the required urgency concerning integration and mainstreaming. The UNHCR strategy identifies some of the opportunities that can be utilised in addressing SGBV and these include: recognition of the challenges and willingness to address SGBV by all stakeholders including the Government of Uganda (GoU), UNHCR, partner agencies as well as communities of concern. Also, there is a progressive applicable legal and policy framework regarding SGBV and conducive to refugee security, protection space and 'out of camp' conditions in Uganda. Finally, there is a strong focus on community participation and community-based protection; and many organisations and strong partnerships, including inter-agency coordination and collaboration.[10]

Besides, other critical interventions that are vital in combating SGBV in refugee settlements and host communities include: mainstreaming SGBV prevention and response and cross-sectoral coordination (including education, child protection, WASH, shelter, livelihood, food security); provision of safe environments and safe access to domestic energy and natural resources; Ensuring adequate lighting in off-grid areas; Protecting children of concern against SGBV; improve working with male survivors and engaging men and boys; protecting persons with specific needs including persons with disabilities, older persons and LGBTI from SGBV; Improving data management, information sharing and M&E; promoting humanitarian, ethical standards for service providers and persons of concern; Improving exchange on good and evidence-based practice and ensuring the implementation of the Strategy and development and implementation of local multi-sectoral action plans.[11]

According to the 2019 JLOS Annual Performance Report, UN Women and UNICEF supported the Uganda Police Force to develop Standard Operating Procedures to manage gender-based violence against children cases. UN Women helped the Judicial Training Institute to develop a Gender-Based Violence training manual for judicial officers. These documents were launched during the 16 days of Activism against Gender-Based Violence on November 25 2019 – December 10 2019.

Other interventions have entailed supporting justice institution to resolve SGBV cases. For example, in partnership with the United Nations' Population Fund (UNFPA), the Judiciary piloted special sessions to fast track disposal of SGBV cases in 14 courts. This resulted in the disposal of 788 cases against the target of 650 cases in just one month from November 12 to December 15 2018. Also, the 2019 JLOS Annual Performance Report indicates that sessions were targeted at improving the experience of survivors/victims of SGBV as they interface with the criminal justice system through emphasis on victim-centred and gender-sensitive approach; promotion of a coordinated and integrated approach among the role-players in the chain of justice; and strengthening of the investigation, prosecution and adjudication functions in the management of sexual offences. Overall, SGBV court sessions highlighted the need for the development, adoption and implementation of criminal procedures to prosecute persons accused of crimes of sexual violence that are sensitive to the emotional state of

9 Ministry of Gender, Labour and Social Development (2008). National Situational Analysis of Sexual and Gender Based Violence and its Impact on Increased Vulnerability of Women to HIV / AIDs in Uganda. Kampala: MGLSD.
10 Ibid 10-11
11 Ibid 12-19

the victims and survivors of such crimes. Under the ongoing follow-up project, a consultant funded by UNFPA is undertaking a study to inform the establishment of particular SGBV courts /procedure.[12]

3.2 Existing legal and policy framework on SGBV

Violence against women has come to be understood as a form of discrimination and a violation of women's human rights, making it a subject of a comprehensive legal and policy framework at the international and regional levels. States have clear obligations under international law to enact, implement and monitor legislation addressing all forms of violence against women. However, significant gaps remain despite the enactment of various legislative provisions to specifically address violence against women. This is attributable to limited scope and coverage and non-enforcement of the laws enacted. Worth noting is that there are several international, regional and national laws that establish State responsibilities for national parties on women's rights and eliminate violence against women.

3.2.1 International Legal framework

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979); The Convention is a human rights treaty that affirms women's reproductive rights and targets culture and tradition as influential forces shaping gender roles and family relations. Under the Convention, states parties agree to take appropriate measures against all forms of trafficking in women and the exploitation of women. Some of the key provisions that speak to SGBV include **Articles 1**, which recognises that violence against women is a form of discrimination. **Article 2,** which mandates State parties to adopt appropriate legislation and other measures to prohibit all discrimination against women and establish legal protection of women's equal rights. Article 5 requires State Parties to take steps of eliminating prejudices. Countries that have ratified the Convention are also committed to submit national reports, at least every four years, on measures they have taken to comply with their treaty obligations.

Relatedly, the **Committee on the Elimination of Discrimination Against Women; General Recommendation No.12 (1989)** called on States Parties to include in periodic reports to the Committee updates on laws and measures adopted to eradicate violence; the existence of support services for women who are the victims of aggression or abuses; statistical data on the incidence of violence of all kinds against women and on women who are the victims of violence. While Uganda ratified the Convention, concerning having required statistical data, there is underreporting of acts of GBV. Specifically, information regarding GBV is not collected as part of regular statistical reporting except for criminal cases captured by the annual police crime report. Partly this is due to the limited functionality of National GBV (NGBV) database developed in 2015. On the other hand, different agencies providing access to justice for GBV victims run parallel systems and do not necessarily feed into the database.

Sustainable Development Goals (Goals 5 and 16) These aim to achieve gender equality and empower all women and girls by ending all forms of violence in public and private spheres and eliminating harmful practices such as child marriages among others. There are challenges in attempts to actualise these goals in Uganda. Specifically, there is insufficient progress on structural issues at the root of gender inequality, such as legal discrimination, unfair social norms and attitudes, decision-making on sexual and reproductive issues and low levels of political participation undermining the ability to achieve Sustainable Development Goal 5.[13]

3.2.2 Regional Legal Framework

The June 2008 Goma Declaration on Eradicating Sexual Violence and Ending Impunity in the Great Lakes Region recognises that SGBV represents a severe threat to national and regional peace and security and increases HIV/AIDS propagation. Thus, State Parties have to protect the citizens from all forms of human rights violations, including SGBV, since its cost on the economic and sustainable development of the GLR is very high. In addition, the Declaration acknowledges that all survivors of SGBV, despite their social-political status, including internally displaced persons (IDPs) and refugees, are entitled to protection, justice and rehabilitation. The declaration categories sexual violence as a war crime. In a subsequent Kampala declaration 2011 on SGBV, the regional government committed to fighting sexual violence and setting up support centres for women. A significant gap concerning this particular Declaration is that limited protection and envisaged rehabilitation centres are generally not yet available to the victims.

From a human rights perspective, the 2003 Maputo Protocol provides that every woman shall be entitled to respect of her life, integrity, and security of her person. Article 4 of the 2003 Maputo Protocol underscore

12 2019 JLOS Annual Performance Report page 68
13 Economic and Social Council, Special edition: progress towards the Sustainable Development Goals, July 2019

the need to support women faced with violence. The Protocol explicitly calls upon States Parties shall take appropriate and effective measures to:

- enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;
- adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women;
- identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence;

3.2.3 National Legal Framework

1995 Constitution of the Republic of Uganda as amended; It contains several provisions that declare the country's commitment to building a better future by establishing a socio-economic and political order through a popular and durable national Constitution based on the principles of unity, peace, equality, democracy, freedom, social justice and progress.

Domestic Violence Act, 2010. The 2010 Domestic Violence Act (DVA) defines domestic violence as any act which

"harms, injures or endangers the health, safety, limb or well-being, whether mental or physical, of the victim or tends to do so and includes causing physical abuse, sexual abuse, emotional, verbal and psychological abuse and economic abuse; harasses, harms injures or endangers the victim with a view to coercing him or her or any other person related to him or her to meet any unlawful demand for any property or valuable security; has the effect of threatening the victims or any person related to the victim by; or otherwise injures or causes harm, whether physical or mental, to the victim".

The DVA provides for the protection of victims of domestic violence and seeks to punish the crime perpetrators. In addition to the DVA, Uganda has other laws targeting other vices that can exacerbate violence. These include the 2010 Female Genital Mutilation Act and the 2010 Trafficking in Persons Act. The limited funding challenges the DVA implementation to the duty bearers identified by the Act (CEDOVIP, 2013). At the same time, the DVA performance is affected by the diversity of duty bearers (i.e., e.g. Police, courts, health facilities, and schools) –all with other national mandates prioritisation and budgeting for domestic violence interventions.

The 2016 National Policy on Elimination of Gender-Based Violence and Action Plan; recognises that GBV is a multi-sectoral problem, which requires a multisector approach to implementation at all levels. The mandated Government Ministries, Departments and Agencies (MDAs), including Central and Local Governments, are therefore expected to identify gender-based violations and budget for the relevant interventions within their budget ceilings to support prevention response, as stipulated in the National Action Plan. The policy allocates responsibilities regarding preventing GBV and providing care and support services to GBV survivors to several public institutions. The duties for the Ministry of Health under the NGBV include: (i)providing medical services such as post-rape treatment;(ii)building staff capacity to provide counselling for GBV victims/survivors; (iii) mainstreaming GBV issues into the day-to-day functions of the ministry;4 (iv) build capacity of health personnel on readiness to provide court evidence on GBV issues when needed; (v) mobilise adequate resources for GBV programmes; (vi) establish emergency measures in dealing with GBV victims/survivors; and (vii) establish forensic services to support medico-legal services for GBV cases.

Gaps in implementation

- Limited capacity to fully implement the DV Act. For example, health workers lack expertise in examining and documenting evidence using the revised Police Form 3.
- Limited funding for GBV activities such as community sensitisation sessions, capacity building for the duty bearers. Given these efforts, however, more investment in GBV activities is required, stretching beyond direct sensitisation to addressing the effects of GBV such as health-related implications.
- Lack of indicators for monitoring and evaluation of gender mainstreaming: This has made it difficult to assess the impact attributable to gender mainstreaming efforts. In addition, there is an absence of gender auditing, which limits the tracking of compliance with the regulatory and policy frameworks by different actors.
- Absence of a one-stop Centre for institutions implementing GBV interventions in the country
- Gaps in the implementation of gender mainstreaming initiatives: At the national level, some sectors still lack guidelines for gender mainstreaming and where they are existent, the sectors do not utilise them which results into uncoordinated efforts which affect planning and budgeting for GBV activities in the respective sectors.

Addressing GBV issues in humanitarian settings

Concerning addressing GBV issues in humanitarian settings, the United National Population Fund (UNFPA) developed a minimum standard for prevention and response to GBV in emergencies.[14] These stands call for ensuring that health actors, MHPSS actors, justice actors, legal aid services, staffed by appropriately trained personnel are integrated into SOPs and included in the general (S) GBV referral/case management system. Also, the standard call for information sharing and coordination between health, MHPSS, legal/justice sector and GBV working groups, including identifying joint actions to provide quality health, MHPSS, legal services to (S) GBV survivors. Finally, the standards require that a GBV focal point is represented in health, MPHSS and legal/justice sector meetings and activities and also that a health, MPHSS legal/justice sector focal point participates in GBV meetings as appropriate.

With respect to use of existing community resources to improve mental health and strengthen access to justice, the UNFPA Minimum standards advocate for following actions: (i) drawing upon the community and/or family support networks; (ii) building on Survivor perspective of what constitutes justice in her/his particular situation; (iii) building on survivor perspective of what constitutes justice in her/his specific situation; and (iv) building on the unique local context injustice and legal aid services. Besides, the standards require the presence of the following institutions to support access justice and health care access: (i) women's centres and activities, e.g. women's groups, adolescent girls' groups and mother's groups; (ii) Formal and non-formal educational activities; (iii) female police officers and other personnel or police units who are specially trained to respond to (S) GBV; and (iv) judicial officers who are specially trained to respond to (S)GBV.

Regarding collaboration between local and international CSOs, the UNFPA standards advocate for collaborating with local legal aid organisations with legal aid staff that are (S)GBV trained; and collaborating and linking to informal or traditional community-based mechanisms. The document provides the following case studies as an example of how collaboration can be achieved based on a survivor-centred and rights-based approach to GBV prevention.

- *Collaboration with the Lutheran World Federation in the adoption of the Youth Pyramid Structure. This model, developed by the Lutheran World Federation, empowers community members to realise their potential to identify SGBV problems and devise sustainable solutions through youth-led anti-violence activities. Anti-violence activities led by the youth activists include SGBV awareness creation; providing psychosocial support to survivors; promoting immediate reporting of violence using music, dance and drama (MDD); and prevention efforts (e.g., through self-defense lessons). It has been implemented in Adjumani Settlement in Uganda, in close partnership with implementing and operating organisations, as well as local government.*[15]

- *Collaboration with the Lutheran World Federation on the adoption of the **'Zero Tolerance Village Alliance'** model, a tool for engaging men and boys. It was implemented by the Lutheran World Federation in Rwamwanja Refugee Settlement (Uganda) with technical support from TVEP. Evaluation of the model confirmed the effectiveness of the model increasing awareness of SGBV interventions; moderating negative gender attitudes and beliefs related to SGBV; engendering more comprehensive knowledge of rape; reducing the occurrence of physical IPV (for men and women), sexual IPV (for men), non-partner physical violence (for men and women), and non-partner sexual violence (for women); and positively changing perceptions of community SGBV norms.*[16]

The minimum standards also call for the adoption of a 'Do no harm' approach: A 'do no harm' approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.[17] Conflict sensitivity minimises the negative and maximises the positive impacts of interventions on peace and conflict dynamics.[18] The standards outline the following measures that should be taken into account when delivering health, mental health and justice/legal aid services.

14 UNFPA, 2015. Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.
15 Mirghani Z., Karugaba J., Martin-Archard N., Undie C., and Birungi H., 2017. Community Engagement in SGBV Prevention and Response: A Compendium of Interventions in the East & Horn of Africa and the Great Lakes Region. Nairobi, Kenya: The Population Council Inc.
16 Further information on this intervention and its evaluation may be found here: http://www.popcouncil.org/uploads/pdfs/2016RH_SGBVPreventionUgandaZTVA.pdf.

Do No Harm-S(GBV) health response services	Do NO Harm-Mental Health response services
■ Pregnant women survivors need special counselling and referral to specialised gynaecological services. CMR Prescribed drugs should not have any side effects (or contraindications) on the pregnancy; ■ Adolescent girl survivors need counselling and treatment in a non-judgmental and nondiscriminatory;Male survivors have specific needs regarding treatment and care that should be addressed by health care providers. It is essential that health staff members understand and are trained to identify indications of GBV in men and boys;[19] ■ Child survivor services should be provided in a nondiscriminatory manner, with the informed consent of the child or their caregiver. Confidentiality, while respected, is also limited by the mandatory requirement to report all cases of child abuse, following local protocols. The best interests of the child and their immediate care and safety should be the primary consideration in all decisions.[20] Children should be interviewed and treated in an environment where they feel safe, using child-friendly communication techniques.[21] Children should participate in decisions that affect their lives,	■ First responders need to: provide a safe, calm environment; listen supportively; demonstrate compassion and non-judgment; provide reassurance without making false promises; and promote access to medical care and other support; ■ Implement programmes that offer survivors and other vulnerable women and girls the opportunity to participate in non-stigmatising, community-based activities that reduce their isolation. ■ Work collaboratively and support a coordinated response, including one overall coordination group on MHPSS. ■ Tailor MHPSS assessment tools to the local context and collect and analyse information to determine the type of response required. ■ Recognise that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and need specialised support. ■ Pay attention to the different psychosocial and mental health needs of women, girls, boys and men and modify support services accordingly. ■ Facilitate the development of community-owned and community-managed programmes that build local capacities and strengthen the resources already present in affected groups. ■ As appropriate, use local cultural and social practices to support people's social well-being and mental health, supplemented by international approaches. ■ Build government capacities and integrate mental health care for survivors into existing general health services.

Do NO Harm-Justice/Legal Aid

Legal services are an essential part of the survivor-centred approach and should be part of a safe, non-stigmatising multisector response to GBV

Survivors should not accrue any legal costs or costs related to transportation and accommodation to access legal services.
Provided in compliance with statutory laws and international standards;

- Able to provide the survivor with comprehensive information on safety and legal options, including any potential risks and benefits, while also ensuring psychosocial, material and practical support and protection;
- Integrated into safe 'one-stop centres' with legal, medical and counselling services where possible;
- Staffed by personnel trained on the GBV guiding principles;
- Accessible in terms of location (travel time and confidentiality), cost (free or low cost), population group (adolescents or persons with disabilities, language and translation) and security (offer protection to survivors when needed);
- Able to mitigate stigma and the risk of survivors' re-victimisation; and
- Able to address the needs of male and female survivors.

17. The Sphere Project, Humanitarian Charter and Minimum Standards in Humanitarian Response, http://www.spherehandbook.org/en/the-humanitarian-charter/
18 Christian Aid, 2018: Gender Based Violence Programming in Contexts Affected by Violence and Conflict. A learning paper | Ireland, June 2018.
19 UNICEF/IRC. 2012. Caring for Child Survivors of Sexual Abuse Guidelines
20 UN Convention on the Rights of the Child, 1990, article 3(1).
21 UNICEF/IRC. 2012. Caring for Child Survivors of Sexual Abuse Guidelines.

Beyond the do no harm approach, the standards also propose several cross-cutting areas. For example, there is a specific call to provide services and support that are appropriate to the survivor's age and development. Besides, there is a call for supporting the development of Standard Operating Procedures (SOPs) and referral mechanisms and protocols to respond to GBV cases using a survivor-centred approach. Furthermore, service providers need to understand and identify male survivors of GBV to deliver services that are responsive to the specific needs of men and boys. On the other hand, women and girls need access to safe spaces that enable them to obtain information, support and services in humanitarian situations.[22] The establishment of the safe space requires: working with women and girls to identify a space that they perceive as safe; and involving women and girls in mapping their community, marking which times and places are safe and which are not. Finally, activities for adolescent girls in safe spaces should be segmented by age and consider the specific needs of population subsets (e.g. adolescent pregnant girls, girls in schools, girls out of school, girl-headed households, etc.).

3.4 How should interventions in support of an integrated approach to (S) GBV incorporate intersectional gender analysis and operationalise a gender-transformative strategy?

Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations ('race'/ ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected structures of power (e.g. laws, policies, state governments, other political and economic unions, religious institutions, and media). Through these processes, interdependent forms of privilege and oppression are created and shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy.[23]

To adequately address gender violence, intersectional approaches consider that the various axes of oppression such as race, class, and gender, are integral. Oppression and subordination occur and intersect along with every level of identification, of which gender is just one.[24]

In her essay entitled Domination and Subordination, Jean Baker Miller discusses the idea of permanent inequalities, in other words, those that are ascribed at the time of birth and function upon a person for the rest of his or her life.[25] According to Miller, specific categories of people dominate over socially defined subordinate groups, where the prescribed dominant group dictates and controls those who have been identified as subordinate.[26] While the dominant class defines normal, the subordinate class internalises these named definitions, struggling to survive within a world in which the norms of the dominant class do not match their reality.[27] Subordination and domination tend to function most clearly and most impactful along the lines of gender, race, and class.[28]

3.6 How best can (S)GBV survivors are empowered to be at the forefront of implementing agreed solutions and holding duty bearers accountable to achieve a more supportive environment? I.e. what approaches can be co-designed/innovated to engage (S) GBV survivors meaningfully.

According to UNFPA, this is the Community-based approach. UNFPA defines it as follows: "a community-based approach ensures that affected populations are actively engaged as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct consultation with women, girls and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions and build on existing community-based protection mechanisms" [29].

Women and girls are key actors in their protection, and they must be consulted as part of the process of identifying protection risks and solutions. The participation of affected populations, especially women and girls, will ensure their voices are heard from the onset of an emergency. Participation empowers women and girls and promotes a space for them to share their views. Likewise, it is also important to engage men and boys as agents of change to prevent and mitigate gender-based violence and to ensure that GBV services are appropriate to the needs of male survivors[30].

22 UNFPA, 2015. Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.
23 Christian Aid, 2018: Gender Based Violence Programming in Contexts Affected by Violence and Conflict. A learning paper | Ireland, June 2018.
24 Allen, Sophie, "The Importance of an Intersectional Approach to Gender-Based Violence in South Africa" (2018). University Honors Theses. Paper 526.
25 Miller, J. B. (1976). Domination and Subordination. In P. S. Rothenburg (10th ed.), Race, Class, and Gender in the United States (91-97). New York: Worth Publishers.
26 ibid
27 idid
28 Allen, Sophie, "The Importance of an Intersectional Approach to Gender-Based Violence in South Africa" (2018). University Honors Theses. Paper 526.

3.5 How best can (S) GBV survivors can best be empowered to be at the forefront of implementing agreed solutions and holding duty bearers accountable to achieve a more supportive environment?

According to UNFPA[31], this can be achieved through the following interventions:

- Apply participatory techniques when conducting assessments by involving affected women, girls, boys and men, including persons with disabilities, older persons in identifying priority needs of their communities
- Map communities for existing community-based services, capacities and coverage, as some might have weakened or disappeared in the emergency setting. It is essential that programs use local skills and capabilities wherever possible, engage men and boys to advance gender equality, including preventing gender-based violence[32].
- Build mechanisms into programmers to allow for input and feedback by programmer beneficiaries.
- Identify strategies to overcome constraints to the participation of women and girls and specific underserved groups (e.g. timing, locations, the safety of activities, etc.).
- Strengthen the capacity of local partners to conduct outreach around access to services, implement effective GBV-related programming, and influence cultural norms that contribute to the perpetuation of GBV. Training may be provided for a variety of stakeholders including traditional/religious leaders and institutions; and community-based organisations;
- Engage community, political and religious leaders as advocates for GBV prevention and response.

3.7 What approaches can be co-designed/innovated to engage (S) GBV survivors meaningfully?

Behaviour change communication (BCC) is a process that utilises media messaging, community mobilisation and interpersonal communication to influence the knowledge, attitudes and practices of individuals, families and communities[33]. Specific to GBV, BCC campaigns aim to share relevant and action-oriented information to influence individual and community behaviours and practices around gender, rights and equality. GBV-related BCC campaigns during emergencies support the creation of an environment in which positive gender and social norms can flourish and have a positive impact on GBV prevention and response. BCC interventions may reduce stigma and encourage the use of services, for example[34]

- Key stakeholders who should be included in intervention design, implementation and evaluation have women, girls, boys and men, community leaders and gatekeepers and Police and Judiciary. Community ownership of BCC interventions ensures long-term impact and motivation for change.

29 UNFPA, 2015. Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.
30 ibid
31 ibid
32 UNFPA Strategic Plan (2014-2017), Annex 1, Output 11
33 UNICEF. 2004. Behaviour Change Communication in Emergencies: A Toolkit. New York: UNICEF, http://www.unicef.org/ceecis/BCC_full_pdf.pdf
34 UNFPA, 2015. Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.

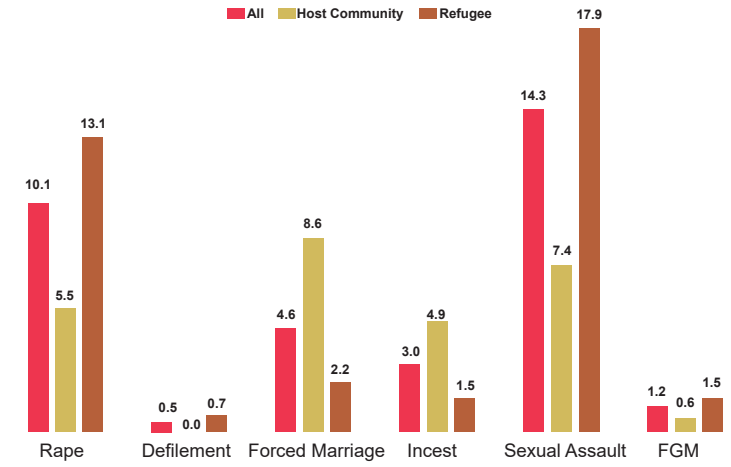
Chapter 4: Key Findings

This Chapter presents the findings of the study, which, as indicated in Chapter one above, are based on information obtained through the household survey from the districts of Adjumani, Arua, Moyo and Yumbe.

Experience of SGBV is widespread in refugee settings in the West Nile region. Table 1 shows that at least 54.6 % of the respondents have ever experienced SGBV, and many of them experienced this within six months of displacement. It is also worth noting that refugees have a higher disposition to experiencing SGBV–59% compared to 47.2 % for members of the host community. Based on location, residents of the districts of Adjumani and Moyo are more likely to experience SGBV with reported rates in the two districts above 64%. Furthermore, respondents in the middle age category, i.e. 25-44 years were significantly more likely to report ever experiencing SGBV, i.e. 61.6% and this may signify life cycle effects, these category of respondents are more likely to have been married longer. Beyond individual experience, at least 35% of the respondents report that other members of the household have been affected by SGBV. Respondents in Adjumani are also more likely than not to report that other members of the family have also experienced SGBV (52%). As such, SGBV is a widespread challenge in West Nile and cuts across socio-economic and demographic groups.

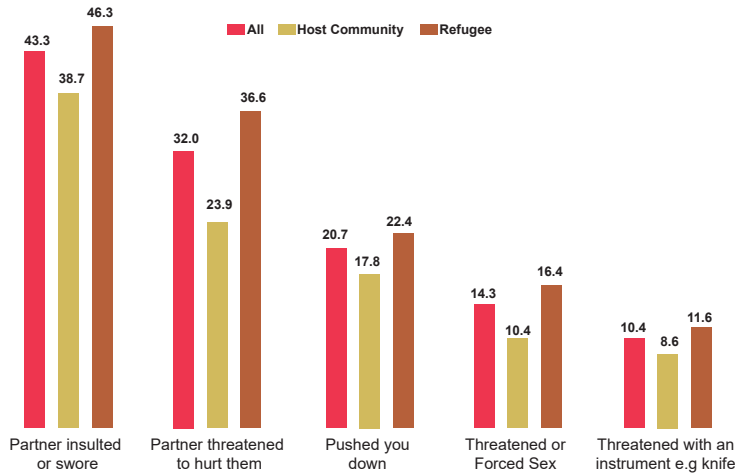
Concerning the type of SGBV experienced, Figure 1 shows that sexual assault and rape (including gang rape and marital rape) is the most frequently cited. Among refugees, 17.9% report ever experiencing sexual assault while 13.1 % report experiencing rape. On the other hand, respondents from the host community indicate that forced marriage is the leading type at 8.6%, followed by sexual assault (7.4%) and rape (5.5%). A relatively smaller proportion of respondents reported ever experiencing other forms of SGBV–notably sexual exploitation including incest and harmful sexual practices, e.g. female genital mutilation. Table 1 also shows that the use of violence is an everyday occurrence among displaced men in South Sudan. In particular, the experience of SGBV is significantly higher among South Sudanese than Ugandans, i.e. 60.4% vs 42.9%. Concerning the type of SGBV, sexual assaults more common among South Sudanese than their Ugandan counterparts, i.e. 16.7% vs 9.3%. However, the Ugandans are more likely to report forced marriages and incest compared to their South Sudanese counterparts.

Figure 1: Types of SGBV faced (%)



Beyond SGBV, the survey captured whether respondents have ever experienced other forms of GBV that are not directly sexual. Both emotional and physical violence is most prevalent among the refugee community. Figure 2 shows that 43.3% of the respondents indicate facing emotional violence, i.e. partner insulted or swore at them while 32% report that the partner threatened to hurt them. A lower proportion report ever experiencing physical violence, i.e. partners pushed them down–22.4% for refugees and 17.8% for the host community. At least one out of every ten respondents report being threatened physically with an instrument, e.g. with a knife or gun.

Figure 2: Other forms of GBV experienced



The survey inquired from respondents what conditions or environments increase the threat of SGBV in the community. Table 1 also shows that the collection of firewood (46.5%) and recreation centres (44.5%) are listed as the leading hotspots for SGBV. Indeed, among the host community, 62.6% report recreation centres as the area that increases the threat of SGBV. Other hot spots include very far away gardens (33.2%), market centres (32.9%), the use of separate housing facilities for families, e.g. sleeping in separate tarpaulins (26.3%) and to a limited extent food distribution centres (14.7%). Market centres pose a significant threat to individuals in host communities than among refugees.

The most frequently cited reason behind SGBV incidents is the minimal economic opportunities in the refugee environment. Table 1 shows that 74.2% of the respondent cites the lack of employment which disposes some men into a state of idleness as the leading driver of SGBV under displacement conditions. Nonetheless, there is some variation in the stated reasons by refugee status and location. Among refugees, the three most frequently cites reasons are employment (75%), lack of food and water (69%) and a lack of security (53.4%). The qualitative responses list several forms of insecurity experienced. First, there is not enough lighting in the settlements. This is compounded by inadequate security during market days—especially during evening markets.

Furthermore, refugee settlements are characterised by limited presence of Police and other security personnel. Relatedly, there are few and distant police posts. Also, several respondents indicated that there are no neighbourhood watch committees in the settlements. Secondly, late-night movement from recreation centres expose women to insecurity incidents.

Among the host community, the ranking is employment, lack of security and then lack of food and water. In Arua district, the lack of food and water is the most frequently cited reason (72.2%) followed by employment and security at about 60%. Above responses are partly linked to the hotspots. In the qualitative responses, inadequate food rations compared to many family members was frequently listed as the driver of SGBV. The lack of food and money exposes girls to prostitution as threats of hunger can trigger incidents of sexual exploitation. In other instances, some of the food rations are sold off by spouses leading to mismanagement of family necessities.

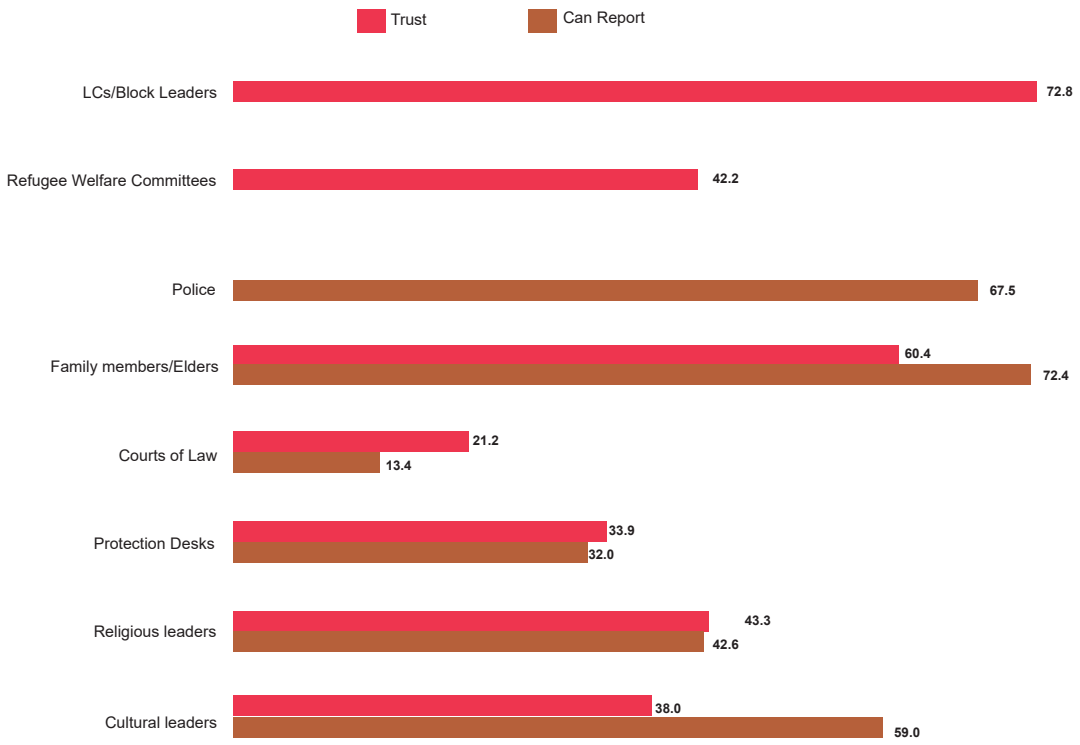
Another challenge linked to unemployment and idleness relates to alcoholism and substance abuse. In the qualitative reactions, respondents listed excessive consumption of alcohol as a significant driver of SGBV incidents. Most, of the alcohol and substance abuse—especially by youth of marijuana, mayirungi and cannabis—takes place recreation centres. Besides, it was mentioned that there numerous opportunities for celebrations where men get drunk.

There is extensive knowledge of how to report SGBV issues in the community. Table 4 shows that over 80% of the respondents indicate knowing how to report SGBV issues. Refugees are slightly more aware where to report SGBV issues than their counterparts in the host community, i.e. 82.8% vs 76.4%. Furthermore, respondents interviewed from Moyo indicate the highest knowledge at 90.8%. Despite the widespread knowledge, only 27.3% of the respondents who have ever experienced and an SGBV incident indicate ever reporting, and these are mainly from the refugees compared to host communities. Members of the host community predominantly report to elders (14.1%) whereas refugees use several institutions, including elders (22%), RWCs (17.9%) and Police (17.2%). Concerning districts, persons that are resident in Ajdumani nearly exclusively use elders (42.1%) to address SGBV issues.

The limited reporting of SGBV incidents to authorities may be explained by the non-availability of institutions which can enforce sanctions as well as the trust of such institutions. At least 74% of the respondents indicate

having LCs/Block leaders within the community. These are followed by police posts (50%) and protection desk (31%). The relatively large presence of protection desks among the refugee community (44%) may explain the nearly twice more reporting of SGBV incidents among the refugee community than the host community. Furthermore, refugees are more than three times more likely to report the availability of women centres than the host community (29.5% vs 8%).

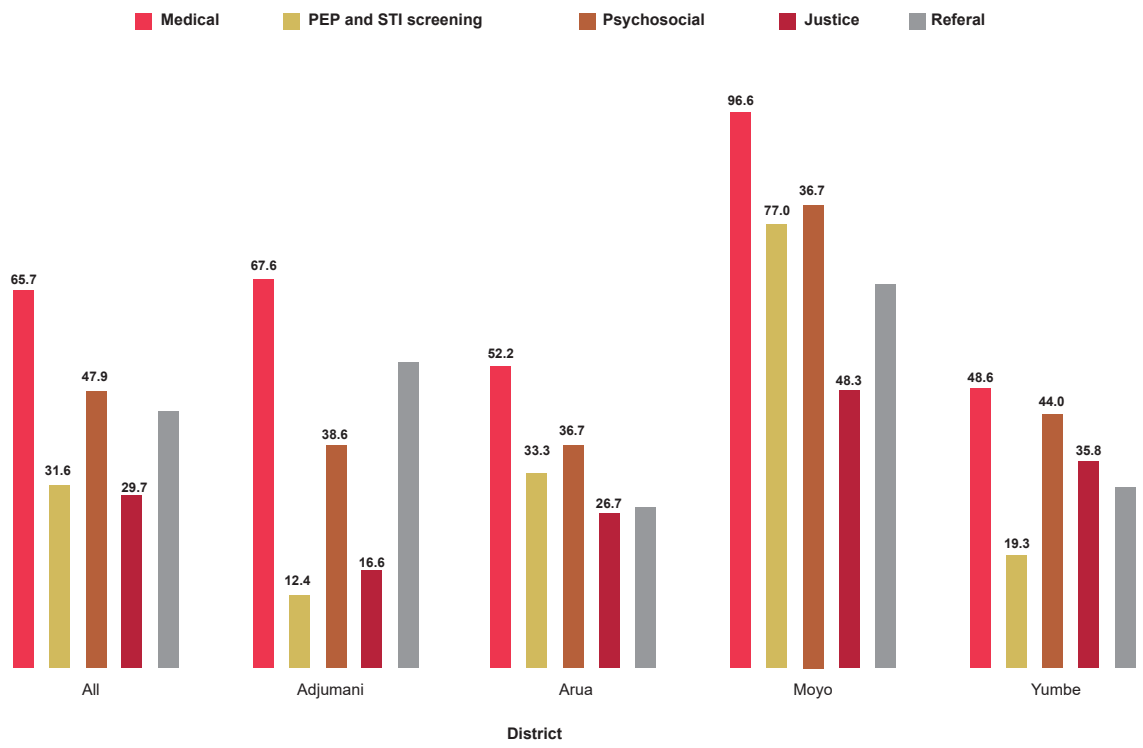
On the other hand, there appears to be a preference for the use of informal means to report SGBV incidents. Figure 3 shows that the most frequently cited institution for reporting SGBV are family members or elders, especially among members of the host community (78.5% vs 68.3%). This is followed by Police, cultural leaders and religious leaders, i.e. 67.5%, 59%, and 42.6% respectively. Generally, there is extensive awareness of informal systems than formal systems. Only 32% and 13.4% report awareness of Protection desks and Courts of Law respectively. The high understanding of informal institutions is partly linked to trust issues. Family members/elders are among the most frequently cited institution as most trusted.



Furthermore, apart from Police, it is mainly informal institutions that are involved in preventing women from experiencing SGBV. Nearly two-thirds of respondents from the host community indicate that it is cultural and religious leaders are used extensively to prevent SGBV. Refugees use a combination of institutions, i.e. block leaders, protection desks as well as cultural leaders. Concerning institutions where one can report SGBV, family members/elders are the most frequently cited institution where one can report SGBV concerns 72.4% overall, 78.5% among host and 68.3% among refugees. Elders are closely followed by police 67.5% and cultural leaders (72.4%). Also, protection desks are cited by refugees (45.1%) and host community (10.4%).

When one reports an SGBV incident, several services can be acquired. Figure 4 shows that apart from medical services, e.g. PEP and STI screening, the other services offered when one reports SGBV case are referral (44.7%) and justice (29.7%). The chart also shows that in comparison to other districts, more services are available in Moyo than in other districts. For example, there are more referrals in Moyo (66.7%) compared to Adjumani (53.1%), Yumbe (31.2%) and Arua (27.8%). Furthermore, Moyo also has more psychosocial care.

Figure 4: Services available where one reported (%)

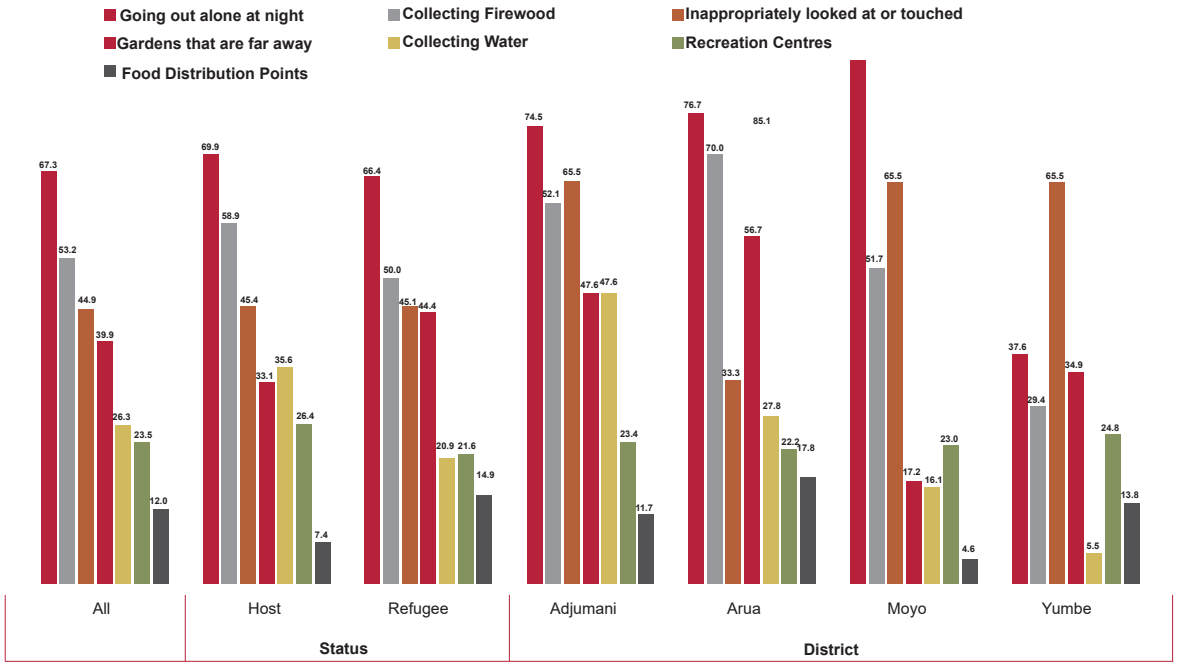


Given the rising threat of SGBV, the survey inquired about the overall security situation in the communities, especially regarding communally used infrastructure, e.g., sanitation facilities. It is worth noting that there are hardly any separate toilets for women and men. Table 6 shows that only 4.5% of the refugee respondents indicate the presence of separate toilets. Also, most of the toilets have no locks. Only 21.3% of the refugees' report having locks on toilets and these are mainly from Yumbe.

Furthermore, there is not enough security lighting in the settlement. Indeed, it mostly in Yumbe, where 15% of the respondents indicate the presence of enough lighting. Refuge settlements also have more access to safe spaces for women and compared to host communities (7.4%). It is also in Yumbe, where respondents indicate the presence of safe spaces for women and children. Overall, refugees are significantly more likely to live in crowded conditions, i.e. either living with individuals there do not know or single-mothers living with an unknown person or mothers separated from their children.

The respondents had several current security concerns. Figure 5 shows that the leading problem was going out alone at night, and 67.3 % listed this as a concern. Concerning location, going out alone is a significant concern in Moyo (74.5%), Arua (76.7%), and Adjumani (74.5%) compared to Yumbe (37.6%). Going out alone is closely followed by collecting firewood, and in this case, the respondents of Arua most frequently report this as a security concern (70%). Beyond SGBV hot spots, several respondents mentioned being looked-at inappropriately given the crowded conditions as a significant security threat (39.9%), and this was most mentioned in Adjumani and Moyo (65.5%). Water collection is also a cause for concern in Adjumani (47.6%).

Figure 5: Current security concerns



SUMMARY OF INSIGHTS FROM THE SURVEY

Summary of insights from the survey

1. Most of the victims who experienced SGBV did so within six months of displacement.
2. Sexual assault and rape (including gang rape and marital rape) are the most frequently cited forms of SGBV experienced. A few of the respondents reported ever experiencing sexual exploitation, including incest and harmful sexual practices, e.g. female genital mutilation. Such crimes affect the emotional wellbeing and mental health of survivors.
3. The most frequently cited conditions that increase the threat of SGBV are the collection of firewood and visiting recreation centres. Specifically, late-night movement from recreation centres expose women to insecurity incidents.
4. The most frequently cited reason behind SGBV incidents are the minimal economic opportunities in the refugee environment. These are compounded by inadequate security during market days–especially during evening markets. Furthermore, refugee settlements are characterised by a limited presence of Police and other security personnel.
5. Excessive consumption of alcohol is also a significant driver of SGBV incidents. Most, of the alcohol and substance abuse–especially by youth of marijuana, mayirungi and cannabis–takes place recreation centres.
6. Inadequate food rations–in comparison to family sizes of refugee households was also listed as the driver of SGBV. The lack of food and money exposes girls to prostitution as threats of hunger can trigger incidents of sexual exploitation. Some of the food rations may also be sold off by spouses leading to mismanagement of family necessities and precipitating violence.
7. There is a preference for the use of informal channels to address SGBV incidents which breeds impunity among perpetrators. Most of the SGBV incidents are not reported to authorities but other informal institutions such as elders and cultural leaders. The limited reporting of SGBV incidents to authorities may be explained by the non-availability of institutions which can enforce sanctions as well as the trust of such institutions. For example, institutions such as legal aid service providers are few and located mainly in urbanized centres. The limited proximity presents a limitation for survivors to use such formal institution.
8. Informal institutions are also frequently cited as the main avenue preventing women from experiencing SGBV. Cultural and religious leaders are used extensively to prevent SGBV.
9. Regarding safety and security within settlements, respondents indicated that there are hardly any separate toilets for women and men. Also, most of the toilets have no locks. Furthermore, there is not enough security lighting in the settlement. Indeed, it mostly in Yumbe district, where 15% of the respondents indicate the presence of enough lighting.
10. Refugees are significantly more likely to live in crowded conditions, i.e. either living with individuals there do not know or single mothers living with an unknown person or mothers separated from their children.
11. The leading security concern mentioned by the respondents was going out alone at night. Going out alone is closely followed by collecting firewood. Beyond SGBV hot spots, several respondents mentioned being looked-at inappropriately given the crowded conditions as a significant security threat.

Recommendations: What needs to be done to support MHPSS in refugee situations

Government

1. To address the excessive consumption of alcohol, there is a need to institute by-laws that restrict the operating times for bars and recreation centres.
2. There is a need to step-up the overall security within refugee settlements. Interventions can take the following forms: installation of security lights to provide sufficient lighting at night and the provision of an adequate number of security personnel at the police posts.
3. There is a need to extend police services within the refugee settlements, i.e. nearer to the communities.
4. There is a need for increased use of community policing and the conduct of mobile police patrols at night.

Development partners

1. Expand employment opportunities with refugee settlements. This can take different forms, including the provision of loans and grants, support towards the formation of socio groups for economic empowerment and savings.
2. Concerning economic sustenance, there is a need to address both the amount provided for food rations offered to refugee and the timeliness of rations.

Civil society organisations (CSOs)

1. Provide mental health and counselling services to GBV survivors. The mental health and psychosocial services should be one of the first services offered prior to any referrals to justice institutions. Also, the provision of mental health and psychological support to SGBV survivors would address the fears of lodging formal SGBV complaints.
2. Encourage SGBV survivors to speak out beyond family and elders and eventually report to authorities to address the impunity related to SGBV issues. There is a need to sensitise women and young girls on where and how to report SGBV incidents and the need to avoid managing all SGBV incidents at the family level.
3. Provide additional safe spaces to create awareness regarding available responses to SGBV incidents.
4. Operate toll-free lines that can be used to encourage more reporting as well as address with the associated stigma of reporting.
5. Expand opportunities for legal aid services as well as address the current poor quality of available legal aid services–especially concerning following up of reported cases.
6. To reduce idleness among the youth, there is a need to engage the youth through other activities, e.g. by introducing drama groups that can educate the youth.
7. CSOs should introduce interventions that provide counselling on alcohol and substance abuse as well as the provision of rehabilitation centres for alcohol addicts.
8. CSOs should provide witness protection and legal services. They should also consult survivors of SGBV and explore opportunities for setting up trauma support centres in refugee settlements.

Annexe

Table 2: Experience of SGBV in West Nile (Percent)

	All	Status		Country Of Origin		District				Gender Head		Age group				Literacy	
		Host	Refugee	South Suda	Uganda	Adjumar	Arua	Moyo	Yumbe	Male	Female	< 25 year	25-34 Years	35-44 Years	44+ Years	Illiterat	Literate
Have You Ever Experienced S	54.6	47.2	59.0	60.4	42.9	69.0	25.6	64.4	51.4	50.7	58.9	55.8	56.3	61.6	45.0	56.2	53.5
For those indicating ever experiencing SGBV, Have You Ever Experienced Sgbv Within 6 Months After	56.8	41.6	64.8	64.1	40.6	66.0	35.7	44.6	65.5	58.8	54.8	69.0	51.3	71.8	36.4	66.7	58.3
Types of SGBV faced																	
Rape	10.1	5.5	13.1	10.7	8.1	8.3	0.0	10.3	21.1	10.8	9.1	7.7	15.6	11.2	3.3	9.6	15.8
Defilement	0.5	0.0	0.7	0.7	0.0	0.0	0.0	0.0	1.8	0.4	0.5	0.0	0.7	0.8	0.0	0.6	0.0
Forced Marriage	4.6	8.6	2.2	3.0	7.5	5.5	2.2	8.0	2.8	5.8	3.3	1.9	3.7	4.8	6.7	2.8	7.0
Incest	3.0	4.9	1.5	1.9	4.3	6.2	1.1	2.3	0.0	4.0	1.9	0.0	3.0	5.6	1.7	3.4	1.8
Sexual assault	14.3	7.4	17.9	16.7	9.3	26.2	4.4	13.8	5.5	12.1	16.7	11.5	9.6	24.0	10.8	15.7	16.7
FGM	1.2	0.6	1.5	1.5	0.6	2.8	0.0	1.1	0.0	0.9	1.4	0.0	3.0	0.8	0.0	2.2	0.9
Has Any Other Member Of Your Household Been Affected By SGBV	35.0	32.4	36.7	37.5	31.9	52.0	21.7	28.6	17.0	33.0	37.2	53.6	12.0	45.5	43.4	40.8	26.2
Other Type of GBV faced																	
Partner insulted or swore	43.3	38.7	46.3	48.3	34.4	60.7	14.4	55.2	34.9	41.7	45.0	26.9	47.4	60.0	28.3	41.6	47.4
Partner threatened to hurt them	32.0	23.9	36.6	37.3	21.9	56.6	8.9	27.6	21.1	29.1	35.4	42.3	29.6	47.2	15.0	35.4	31.6
Pushed you down	20.7	17.8	22.4	22.1	17.5	30.3	3.3	29.9	14.7	24.2	17.2	5.8	22.2	31.2	15.0	21.3	19.3
Threatened or Forced Sex	14.3	10.4	16.4	16.6	10.0	17.2	6.7	27.6	5.5	13.9	14.8	13.5	11.9	17.6	14.2	11.8	15.8
tened with an instrument e.g. knife	10.4	8.6	11.6	11.8	7.5	17.9	5.6	10.3	4.6	10.8	10.0	1.9	9.6	15.2	10.0	9.6	9.6
Other forms of GBV	0.9	1.8	0.4	1.1	0.6	0.0	1.1	0.0	2.8	0.4	1.4	0.0	0.7	0.8	1.7	1.1	0.9
What conditions/environments increase the threat of SGBV in your community																	
Fetching Water	29.0	33.7	26.1	24.1	36.0	33.8	32.2	21.8	25.7	34.5	22.5	15.4	36.3	30.4	24.2	34.8	34.2
Collecting Firewood	46.5	45.4	47.0	49.6	41.6	60.7	45.6	46.0	28.4	42.6	50.7	61.5	44.4	49.6	39.2	42.7	51.8
Recreation Centres	44.5	62.6	34.0	30.7	67.7	52.4	30.0	64.4	31.2	49.3	39.2	32.7	44.4	44.8	49.2	42.1	51.8
Separate Housing Facilities	26.3	29.4	24.6	25.2	28.6	30.3	24.4	48.3	5.5	26.5	25.8	26.9	25.9	23.2	29.2	23.0	34.2
Very far away gardens	33.2	34.4	32.1	30.7	35.4	44.1	44.4	18.4	20.2	33.6	32.5	30.8	37.0	31.2	31.7	31.5	35.1
Market Centres	32.9	43.6	26.9	26.7	43.5	40.7	37.8	17.2	32.1	36.3	28.7	15.4	34.1	28.8	42.5	36.0	32.5
Food Distribution Centres	14.7	11.7	16.8	18.1	9.3	15.9	20.0	11.5	11.9	13.9	15.3	13.5	14.1	17.6	12.5	18.0	12.3
Other reasons	6.0	6.7	5.6	5.9	7.5	4.8	5.6	5.7	8.3	8.1	3.8	1.9	8.9	6.4	4.2	3.4	8.8
Why has SGBV increased under displacement																	
Lack of employment	74.2	72.4	75.0	78.1	68.9	90.3	63.3	86.2	51.4	71.3	78.0	71.2	71.9	85.6	67.5	75.3	74.6
Lack of food and water	59.0	41.7	69.0	69.3	39.8	53.1	72.2	57.5	56.0	57.4	60.8	67.3	58.5	65.6	49.2	62.4	51.8
dolescents separated from families	45.9	36.2	51.9	49.3	39.1	57.9	44.4	52.9	25.7	45.7	45.9	53.8	38.5	56.8	39.2	44.9	50.0
Lack of Security	52.5	51.5	53.4	55.6	47.8	60.7	61.1	54.0	33.9	51.6	53.1	50.0	51.9	56.0	50.0	56.7	50.0
Other reasons	16.6	23.3	12.7	15.6	19.9	3.4	23.3	25.3	22.0	18.8	14.4	11.5	17.8	14.4	20.0	12.4	20.2

Table 3: Awareness of SGBV in the community (Percent)

	All	Status		Country Of Origin		District				Gender Head		Age group				Literacy	
		Host	Refugee	outh Sud	Uganda	Adjuman	Arua	Moyo	Yumbe	Male	Female	< 25 year	25-34 Years	35-44 Years	44+ Years	Illiterate	Literate
Did You Know How To Report SGBV Issues In Your Community?	80.4	76.7	82.8	83.3	75.8	80.7	76.7	90.8	75.2	75.8	85.2	86.5	84.4	80.8	72.5	76.4	78.9
orms of SGBV have you heard about after displacement																	
Trafficking	9.0	12.9	6.7	6.6	13.1	8.3	17.8	9.2	2.8	13.0	4.3	3.8	8.1	8.8	11.7	10.7	9.6
Sexual Harassment	44.2	49.7	41.4	40.6	51.3	41.4	24.4	85.1	33.0	48.4	39.2	38.5	41.5	48.8	44.2	42.1	55.3
Someone was raped	47.7	56.4	42.9	47.2	50.0	57.9	35.6	63.2	33.0	46.6	48.8	32.7	49.6	50.4	49.2	47.2	51.8
Someone sustained injuries from GBV	63.4	67.5	61.2	62.4	65.6	73.1	61.1	75.9	43.1	63.7	63.2	61.5	62.2	62.4	66.7	63.5	64.9
General level of awareness of SGBV: Have you heard of the following forms of SGBV 6 months after displacement																	
Partner insulted or swore at them	77.0	81.0	74.3	76.4	77.5	89.7	67.8	86.2	59.6	78.0	76.1	69.2	82.2	78.4	73.3	82.0	74.6
Threatened to hurt them	65.2	74.2	59.7	62.7	69.4	79.3	64.4	74.7	39.4	65.0	65.6	59.6	64.4	70.4	63.3	68.5	64.0
Threatened with instrument	49.5	51.5	48.9	51.7	46.9	67.6	34.4	64.4	27.5	49.8	49.3	55.8	40.7	64.0	41.7	51.7	50.0
Pushed down by partner	45.4	50.3	42.9	46.1	45.0	64.1	25.6	64.4	22.9	43.0	47.8	51.9	44.4	54.4	34.2	46.1	47.4
Physically assaulted	46.1	50.3	44.0	44.3	50.0	62.8	30.0	73.6	16.5	48.0	44.0	50.0	45.2	48.8	42.5	45.5	52.6
Threatened or forced sex	33.2	32.5	34.0	33.2	33.8	46.9	21.1	57.5	6.4	34.1	32.1	44.2	26.7	40.8	27.5	33.7	36.8
Child sexual abuse and exploitation	30.2	32.5	29.1	28.8	33.1	33.1	13.3	52.9	22.9	30.5	29.2	30.8	35.6	31.2	21.7	29.2	34.2
Sexual abuse in schools	19.1	22.7	17.2	17.0	23.1	20.0	22.2	33.3	4.6	19.7	18.2	15.4	17.8	14.4	26.7	16.3	24.6
Community Violence	37.1	32.5	39.6	39.5	32.5	17.2	64.4	56.3	24.8	37.2	36.8	26.9	35.6	31.2	49.2	27.5	41.2
Watching Girls secretly when bathing or getting dressed	16.4	12.3	18.7	18.5	12.5	20.7	14.4	28.7	1.8	16.1	16.3	19.2	15.6	12.8	19.2	18.0	14.0
Watching Boys secretly when bathing or getting dressed	4.4	6.1	3.4	3.3	6.3	4.8	5.6	8.0	0.0	4.5	4.3	3.8	5.9	1.6	5.8	4.5	5.3

Table 4: Where can you report SGBV issues and trust for institutions (Percent)

	All	Status		Country Of Origin		District				Gender Head		Age group				Literacy	
		Host	Refugee	South Suda	Uganda	Adjuman	Arua	Moyo	Yumbe	Male	Female	< 25 year	25-34 Years	35-44 Years	44+ Years	Illiterate	Literate
Which institutions can you report SGBV concerns in your community																	
Police	67.5	72.4	64.6	62.4	76.3	69.7	84.4	77.0	43.1	66.8	68.4	71.2	56.3	72.8	73.3	66.9	70.2
Cultural leaders	59.0	63.2	56.7	55.0	66.3	75.2	52.2	71.3	33.9	66.4	50.7	59.6	50.4	66.4	60.0	66.9	57.0
Religious leaders	42.6	49.7	38.1	41.3	43.8	35.9	51.1	73.6	19.3	44.8	40.2	34.6	47.4	44.8	38.3	43.3	41.2
Protection Desks	32.0	10.4	45.1	48.3	5.0	24.8	50.0	27.6	30.3	23.3	41.6	42.3	31.9	32.0	28.3	24.2	28.1
Courts of Law	13.4	9.8	15.7	13.7	13.1	4.1	17.8	25.3	12.8	13.9	12.0	15.4	11.9	14.4	11.7	14.0	15.8
Family members/Elders	72.4	78.5	68.3	68.3	78.1	86.2	55.6	93.1	50.5	75.3	69.4	75.0	68.1	76.8	71.7	75.3	74.6
Which institutions do you trust most to address SGBV issues																	
Courts of Law	21.2	22.8	20.4	18.5	26.3	8.3	33.3	42.5	11.9	22.0	20.6	21.2	20.7	19.2	24.2	17.4	28.1
LCs/Block Leaders	72.8	80.2	68.8	66.8	83.8	75.2	84.4	89.7	47.7	75.8	69.9	78.8	68.9	74.4	73.3	74.2	71.9
Protection Desks	33.9	11.1	47.2	49.1	7.5	26.2	46.7	33.3	33.0	23.8	44.5	30.8	36.3	37.6	28.3	29.8	26.3
Refuge Welfare Committees	42.2	11.1	61.0	63.8	5.6	44.1	52.2	51.7	23.9	31.4	54.1	51.9	34.1	53.6	35.8	42.7	31.6
Cultural/ Customary leaders	38.0	37.0	39.0	38.4	38.1	48.3	28.9	70.1	7.3	39.9	35.4	44.2	29.6	45.6	35.8	44.4	37.7
Religious leaders	43.3	50.6	38.7	38.4	51.3	33.1	48.9	78.2	23.9	46.2	40.2	32.7	51.1	41.6	40.8	42.7	44.7
Family members	60.4	60.5	60.2	57.6	65.0	77.9	48.9	73.6	35.8	61.9	58.4	71.2	54.1	73.6	48.3	67.4	60.5
Other	5.8	8.0	4.5	5.2	6.9	0.7	8.9	6.9	9.2	8.1	3.3	7.7	4.4	4.8	7.5	4.5	8.8
When people experience SGBV, where do they seek assistance																	
Speak to friend or family member	79.0	85.2	75.1	75.2	85.1	77.2	85.6	92.0	65.1	82.9	75.2	80.8	74.6	80.0	82.6	77.0	78.1
Local Council (LC)/Block Leaders	72.4	72.8	72.1	71.5	73.9	84.1	51.1	90.8	59.6	74.3	70.0	75.0	74.6	80.0	60.3	78.7	76.3
Health Facility for medical assistan	62.4	54.3	67.3	65.2	57.8	63.4	56.7	96.6	38.5	66.2	59.0	71.2	59.7	70.4	54.5	58.4	68.4
Refugee Welfare Committee	39.2	6.8	58.4	60.4	3.1	39.3	54.4	43.7	22.0	29.7	49.5	55.8	29.1	44.8	38.0	36.5	31.6
Psychosocial support from NGOs	31.3	15.4	41.3	41.1	15.5	29.0	37.8	57.5	9.2	30.6	32.4	30.8	26.9	39.2	28.9	29.2	36.0
Protection Desk	30.9	4.9	46.5	47.4	3.1	26.9	50.0	18.4	30.3	23.4	39.0	38.5	31.3	31.2	27.3	23.6	25.4
Other	12.0	14.2	10.8	11.9	12.4	11.0	8.9	19.5	10.1	12.2	11.9	9.6	11.2	17.6	8.3	9.6	18.4

Table 5: Knowledge about where to Report SGBV and type of services offered (Percent)

	All	Status		District				Gender Head		Age group				Literacy	
		Host	Refugee	Adjuman	Arua	Moyo	Yumbe	Male	Female	< 25 year	5-34 Year	5-44 Year	44+ Years	Illiterate	Literate
Do You Know How To Report an SGBV Incide	81.57	74.23	86.19	88.28	78.89	81.61	75.23	75.34	88.04	76.92	85.19	86.40	74.17	79.21	81.58
Have You Ever Reported An SGBV Incident Within 6 Months After Displacement?	27.3	19.0	32.6	34.5	16.9	26.4	27.5	28.8	25.4	34.6	26.1	37.6	14.2	35.6	23.7
Where did you report															
Police	12.9	6.1	17.2	24.1	14.4	5.7	2.8	9.9	16.3	21.2	8.9	16.0	10.8	14.6	7.9
Elders	18.9	14.1	22.0	42.1	4.4	16.1	2.8	18.8	19.1	23.1	14.1	30.4	10.8	23.6	16.7
Refuge Welfare Committees	13.1	5.5	17.9	25.5	10.0	2.3	8.3	11.2	15.3	23.1	9.6	19.2	6.7	16.9	7.0
Protection Desks	8.3	1.2	12.7	18.6	5.6	4.6	0.0	7.2	9.6	1.9	7.4	14.4	5.8	8.4	5.3
Women Centres	10.1	1.8	15.3	13.8	4.4	2.3	16.5	8.5	11.5	1.9	15.6	10.4	6.7	10.7	7.9
Other	4.6	8.0	2.6	4.1	3.3	10.3	1.8	8.1	1.0	11.5	3.7	5.6	1.7	2.2	11.4
What types of services are available when one reports a SGBV case															
Medical	65.7	60.7	68.3	67.6	52.2	96.6	48.6	66.4	65.6	75.0	65.2	64.8	64.2	59.6	72.8
PEP and STI screening	31.6	30.1	32.5	12.4	33.3	77.0	19.3	36.3	26.8	40.4	29.6	28.8	33.3	23.6	40.4
Psychosocial	47.9	32.5	57.5	38.6	36.7	80.5	44.0	51.6	44.0	50.0	54.1	48.0	40.0	35.4	60.5
Justice	29.7	30.1	29.9	16.6	26.7	48.3	35.8	35.0	24.4	28.8	23.0	34.4	33.3	29.2	24.6
Referral	44.7	48.5	42.9	53.1	27.8	66.7	31.2	41.3	48.8	53.8	42.2	48.8	40.0	48.9	40.4
Other	1.6	3.1	0.7	1.4	0.0	1.1	3.7	1.8	1.4	0.0	0.0	1.6	4.2	0.6	1.8

Table 6: Availability of institutions addressing SGBV (Percent)

	All	Status		District				Gender Head		Age group				Literacy	
		Host	Refugee	Adjuman	Arua	Moyo	Yumbe	Male	Female	< 25 year	5-34 Yea	5-44 Yea	44+ Years	Illiterate	Literate
Are any of the following institutions available in your community?															
Police Station/Post	50.2	50.3	50.4	47.6	53.3	50.6	51.4	45.7	55.5	57.7	45.9	52.8	50.0	55.6	41.2
Legal Aid Service Providers	9.7	4.9	12.3	5.5	26.7	3.4	5.5	9.4	10.0	13.5	7.4	10.4	10.0	7.9	7.0
Mobile Health Clinic	13.4	1.8	20.5	13.1	30.0	2.3	9.2	7.2	20.1	19.2	8.9	14.4	15.0	11.8	7.0
Psychical Care	28.1	14.7	36.6	20.7	45.6	44.8	11.0	25.1	31.6	30.8	25.9	25.6	32.5	23.0	34.2
Protection Desks	30.6	8.0	44.4	26.2	53.3	19.5	26.6	22.4	39.7	30.8	30.4	32.0	30.0	24.2	23.7
LC/Block Leader	74.0	73.6	74.3	55.2	76.7	87.4	86.2	72.6	75.6	67.3	72.6	71.2	81.7	67.4	77.2
Women Centre	21.2	8.0	29.5	14.5	34.4	24.1	17.4	21.1	21.5	19.2	27.4	20.0	16.7	19.7	26.3
Other	1.8	1.2	2.2	0.0	6.7	2.3	0.0	1.3	2.4	1.9	0.7	2.4	2.5	1.7	0.0
Which institutions are involved in preventing women from experiencing SGBV															
Police	81.6	86.5	78.7	68.3	86.7	85.1	92.7	83.9	78.9	76.9	83.0	76.8	86.7	71.9	86.0
Cultural Leader	60.8	68.1	57.1	66.9	54.4	83.9	41.3	65.9	55.5	73.1	57.0	65.6	55.0	65.7	59.6
Religious Leaders	53.0	66.3	45.5	39.3	57.8	93.1	36.7	58.3	47.4	46.2	53.3	52.0	56.7	52.8	55.3
Protection Desk	38.9	18.4	51.5	36.6	58.9	32.2	31.2	31.4	47.4	59.6	31.9	44.8	32.5	36.5	29.8
LASPs	29.7	28.8	30.6	6.9	50.0	60.9	19.3	30.0	29.2	38.5	28.9	24.0	32.5	25.3	31.6
Health Facility/hospital	49.1	42.9	53.0	39.3	48.9	87.4	32.1	50.7	47.4	59.6	47.4	48.0	47.5	43.8	58.8
Psychosocial Care/Counsell	37.3	30.1	42.2	26.2	43.3	59.8	30.3	37.2	36.8	23.1	43.7	38.4	34.2	29.2	43.9
LC/Block Leader	57.1	56.4	57.5	74.5	57.8	49.4	39.4	59.6	55.0	57.7	49.6	60.0	63.3	57.3	60.5
Others	2.8	1.8	3.4	0.0	8.9	1.1	2.8	2.7	2.9	1.9	2.2	1.6	5.0	0.6	3.5

Table 7: Security concerns in the community (Percent)

	All	Status		District				Gender Head		Age group				Literacy	
		Host	Refugee	Adjuman	Arua	Moyo	Yumbe	Male	Female	< 25 years	25-34 Year	35-44 Year	44+ Years	Illiterate	Literate
Are There Separate Toilets For Men And															
Yes	3.0	0.6	4.5	3.4	5.6	3.4	0.0	3.6	2.4	7.7	1.5	0.8	5.0	2.8	4.4
No	61.7	19.0	87.7	60.7	71.1	50.6	64.2	41.7	82.7	71.2	60.0	70.2	50.0	58.4	45.6
Host Community	35.3	80.4	7.8	35.9	23.3	46.0	35.8	54.7	14.9	21.2	38.5	29.0	45.0	38.8	50.0
Are There Locks On The Toilets?															
Yes	14.8	3.7	21.3	16.6	6.7	2.3	28.4	10.3	19.2	5.8	17.0	20.2	10.0	15.7	14.0
No	48.7	12.9	70.9	47.6	70.0	46.0	35.8	35.0	63.5	73.1	40.7	50.8	45.0	43.8	35.1
Host Community	36.5	83.4	7.8	35.9	23.3	51.7	35.8	54.7	17.3	21.2	42.2	29.0	45.0	40.4	50.9
Is There Enough Light In The Settlemen															
Yes	5.5	0.6	8.6	2.8	2.2	1.1	15.6	3.1	7.7	1.9	8.9	5.6	2.5	5.6	3.5
No	58.0	16.0	83.6	61.4	74.4	47.1	48.6	42.2	75.0	76.9	48.9	65.3	52.5	53.9	45.6
Host Community	36.5	83.4	7.8	35.9	23.3	51.7	35.8	54.7	17.3	21.2	42.2	29.0	45.0	40.4	50.9
Are There Safe Spaces For Women And C															
Yes	29.6	7.4	43.3	17.2	35.6	29.9	41.3	26.0	33.2	28.8	36.3	28.2	23.3	27.0	30.7
No	34.2	9.2	49.3	46.9	41.1	18.4	23.9	19.7	49.5	50.0	22.2	42.7	31.7	32.6	19.3
Host Community	36.3	83.4	7.5	35.9	23.3	51.7	34.9	54.3	17.3	21.2	41.5	29.0	45.0	40.4	50.0
Are there neighbourhood watch committees in the community	55.1	44.2	61.8	50.0	57.8	47.1	66.1	53.2	56.7	61.5	51.9	57.7	52.5	53.4	55.8
Have you experienced conditions of overcrowding?															
Living with individuals you did not know	35.0	4.9	53.7	55.2	35.6	33.3	10.1	22.0	49.3	51.9	26.7	48.8	23.3	32.6	30.7
Single Mothers Living with unknown persons	25.1	2.5	39.2	37.2	12.2	29.9	16.5	16.6	34.0	34.6	21.5	37.6	11.7	32.0	18.4
Mothers separated from their children	13.8	0.6	22.0	18.6	18.9	18.4	0.0	9.9	18.2	11.5	11.1	28.0	3.3	12.4	11.4
Which of the following security concerns affect you															
Inappropriately looked at or touched	44.9	45.4	45.1	65.5	33.3	65.5	11.9	40.4	49.8	36.5	43.0	56.0	39.2	41.6	50.9
Going out alone at night	67.3	69.9	66.4	74.5	76.7	85.1	37.6	66.8	67.9	59.6	63.7	73.6	68.3	65.7	70.2
Collecting Firewood	53.2	58.9	50.0	62.1	70.0	51.7	29.4	52.5	54.1	51.9	47.4	59.2	54.2	51.7	54.4
Collecting Water	26.3	35.6	20.9	47.6	27.8	16.1	5.5	27.8	24.4	23.1	17.8	35.2	27.5	33.1	25.4
Gardens that are far away	39.9	33.1	44.4	47.6	56.7	17.2	34.9	36.3	43.1	36.5	45.2	37.6	36.7	43.3	38.6
Food Distribution Points	12.0	7.4	14.9	11.7	17.8	4.6	13.8	11.2	12.9	13.5	8.1	16.8	10.8	14.6	9.6
Recreation Centres	23.5	26.4	21.6	23.4	22.2	23.0	24.8	24.2	22.5	17.3	22.2	27.2	23.3	21.9	28.9
Other	2.5	1.2	3.4	0.0	2.2	4.6	4.6	2.7	2.4	1.9	4.4	0.0	3.3	1.1	2.6