Universidad de los Andes
Escuela de Gobierno Alberto Lleras Camargo

WOMEN'S REFUGEE COMMISSION

Communities Care: An Integrated Community-Based Sexual and Gender-Based Violence Intervention in Uribia, Colombia

Baseline Evaluation Report

August 2024

Universidad de los Andes School of Government (UniAndes) seeks to promote the analysis and debate of major policy national and international issues, becoming a meeting point between civil society, government, and public opinion. Research and consulting at the Alberto Lleras Camargo School of Government is multidisciplinary and transversal to the areas of public policy, public management, and public leadership in order to address public issues relevant to the social and economic development of the country and the region, and the quality of life of the population. https://uniandes.edu.co/en

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, youth, and other people who are often overlooked, undervalued, and underserved in humanitarian responses to displacement and crises. We work in partnership with displaced communities to research their needs, identify solutions, and advocate for gender-transformative and sustained improvement in humanitarian, development, and displacement policy and practice. Since our founding in 1989, we have been a leading expert on the needs of refugee women, children, and youth and the policies that can protect and empower them. www.womensrefugeecommission.org.

Acknowledgments

This baseline study is the result of a collaboration between the Women's Refugee Commission (WRC) and Universidad de los Andes School of Government. It was made possible through the generous contributions of the United States Department of State. The opinions, findings and conclusions stated herein are those of the authors and do not necessarily reflect those of the United States Department of State.

This study is part of a multi-country research initiative under WRC's Communities Care Project, a multi-country sexual and gender-based violence (SGBV) innovation project aimed at expanding access to quality and timely sexual violence medical and psychosocial care in humanitarian settings.

The report was written by María Cecilia Dedios Sanguineti, Ángela María Guarín Aristizábal,Mariana Martínez Gómez, María Camila García Durán, and Ariana Catalina Torres García of Universidad de los Andes School of Government and by Katherine Gambir of WRC. Lily Jacobi and Julianne Deitch of WRC reviewed the report. We are grateful to Diana Quick of WRC for editing and designing the report.

We would like to thank the community members, including the Project's Community Advisory Board members, who volunteered their time to participate in the study, as well as the Project's implementing partner in Colombia, Profamilia, and the other NGO partners and officials of local government units. Their participation and insights made this research possible.

This report was funded by a grant from the United States Department of State. The opinions, findings and conclusions stated herein are those of the author[s] and do not necessarily reflect those of the United States Department of State.

Contact

For more information, contact Lily Jacobi, senior advisor, Sexual and Reproductive Health and Rights Program, Women's Refugee Commission, LilyJ@wrcommission.org.

Women's Refugee Commission
15 West 37th Street, 9th Floor
New York, NY 10018
(212) 551 3115
info@wrcommission.org
womensrefugeecommission.org

Contents

Introduction

Profamilia, in partnership with the Women's Refugee Commission (WRC), is undertaking the *Communities Care* project in Uribia, La Guajira, Colombia. The project plans to establish community-based referrals for sexual violence (SV) survivors and to implement a sexual and gender-based violence (SGBV) gender-transformative intervention for refugees and host community members. Uribia is a town of the La Guajira department in northern Colombia, near the Venezuelan-Colombian border.

Communities Care is an SGBV prevention and response intervention entailing two components: (a) community-based referrals to facility-based care for survivors of SV and (b) community sensitization activities using gender-transformative approaches. To address the first component, community health workers (CHWs) are equipped to identify and refer SV survivors to facility-based care, according to their needs. The second component refers to community activities, including group sessions and home visits, aimed to deliver information about SV, its consequences, the benefits of seeking help, and information on where to find care and support. The *Communities Care* project will be implemented over eight months in an informal settlement located in Uribia.

The project includes a monitoring and evaluation component consisting of a mixed-methods, quasi-experimental design to assess the effect of the *Communities Care* intervention. The evaluation aims to determine the efficacy, feasibility, and safety aspects of the *Communities Care* model in a humanitarian context. Evaluation data was gathered prior to program implementation (baseline) and post-intervention (endline) at both the intervention site and a nearby control site, enabling comparison. Monitoring data will be collected throughout the implementation period.

Prior to implementation of *Communities Care*, WRC, together with Universidad de los Andes (UniAndes) School of Government research team and the Centro Nacional de Consultoría (CNC), conducted a baseline study to document the characteristics of individuals and the baseline level of key intervention outcomes across both the intervention and comparison communities. This report documents the baseline research process and findings.

Background

Gender-based violence (GBV), including SV and intimate partner violence (IPV), is a persistent problem in humanitarian settings (Call to Action on Protection from Gender-Based Violence in Emergencies, 2020; Vu et al., 2014; Horn, 2010; Watcher et al., 2018; Holmes and Bhuvanendra, 2014). In Colombia, La Guajira is the department with the second-highest number of Venezuelan migrants, due partly to its proximity to the Colombian-Venezuelan border and illegal access routes. A survey among Venezuelan refugees and displaced people found that 13% of women reported experiencing GBV during transit while noting that GBV is significantly underreported (International Organization for Migration, 2021). In the same survey, 35% of women reported physical violence, 36% verbal or psychological violence, and 10% SV (International Organization for Migration, 2021).

Despite the need to care for survivors of SV in humanitarian contexts, such as La Guajira, data shows that prevention and response programs for SGBV are either lacking, inaccessible, or insufficient (Ivanova, Rai, and Kemigisha 2018). La Guajira lacks sufficient institutional support and economic resources to prevent and respond to GBV (OIM, 2021). Moreover, La Guajira is home to one of the

largest Indigenous communities in Colombia, the Wayuu community, which represents 20.2% of the national Indigenous population. Almost all (97.5%) of the Wayuu population in Colombia lives in La Guajira (National Administrative Department of Statistics, 2021). A paucity of data exists on the health and well-being of Wayuu communities. Health services are concentrated in the larger cities, and health facilities lack the capacity to provide care in the Indigenous language (Ministerio de Salud y Protección Social, 2016).

To facilitate care seeking behavior and uptake of timely SV care, innovative approaches such as the *Communities Care* community-based SV care model among others have been developed, with the aim of improving community-level access to timely, quality SV response and prevent further consequences such as HIV and other sexually transmitted infections (STIs) and unwanted pregnancies (Polis et al. 2007). Whereas evidence from pilots of this model conducted in Myanmar, Somalia, and Southern Sudan have adduced promising results for feasibility of a post-rape community-based care model, evidence for the model's effectiveness and safety concerns is still lacking (Tanabe et al., 2013; Glass et al., 2018; Glass et al., 2019; Kohli et al. 2012). The need to further test the model for SGBV in humanitarian crises remains.

Objectives of the baseline assessment

The overall objective of the baseline assessment was to compare and contrast knowledge of and attitudes toward SGBV and gender equality and the extent to which community members have access to SV prevention and care services—and receive medical and psychosocial care if needed—in two communities (intervention site and comparison site), both located in the city of Uribia in La Guajira, Colombia. This comparison will generate evidence that will inform evidence-based planning and implementation and form a basis for monitoring and evaluation (M&E) of the *Communities Care* intervention in Uribia. Specifically, to assess the below outcomes based on participants' site, age, sex, relationship status, and migration status:

1. To assess knowledge of and attitudes toward SGBV in refugee and host communities within the intervention and comparison sites.
2. To assess attitudes related to gender equality in refugee and host communities within the intervention and the comparison sites.
3. To assess the extent to which refugee and host communities within the intervention and comparison sites have access to SV prevention and care services to receive medical and psychosocial care if needed.

Methods

Study design

The project includes a M&E component consisting of a mixed-methods, quasi-experimental design to assess the effect of the *Communities Care* intervention. The evaluation aims to determine the efficacy, feasibility, and safety aspects of the *Communities Care* model in a humanitarian context. Evaluation data was collected before program implementation (baseline) and will be collected after the intervention (endline). Monitoring data will be collected throughout the implementation period. The quasi-experimental evaluation design includes a longitudinal component of pre- and post-intervention quantitative and qualitative data collection at the community level in addition to key informant interviews (KIIs) with project staff, CHWs, community advisory board (CAB) members,

and other key stakeholders. The question answered by this design is not only whether the site that received the intervention had an improvement or change, but also whether the intervention site improved or changed more than the site where the intervention was not received. Pre-intervention data collection will allow the identification of any systematic differences between the intervention and comparison sites. This information will help inform the analysis to estimate the effect of the intervention, controlling for systematic baseline differences between sites.

Setting and population

Data was collected in the intervention and the comparison sites. Names and identifying information of the two communities are confidential to protect the identity of the communities. Both sites are located inside the city of Uribia in the department of La Guajira, Colombia, and both are informal settlements. According to the latest projections of the National Administrative Department of Statistics (2020), Uribia has the highest incidence rate of municipal multidimensional poverty in La Guajira: 92.2% of its population lives in multidimensional poverty. In this evaluation, multidimensional poverty was a measure that spanned fifteen outcomes throughout five dimensions: educational conditions of the household, childhood and youth conditions, health, work, access to public household services, and housing conditions.

These sites were intentionally selected based on the availability of health facilities, low availability of community-level provision of medical and psychosocial care for survivors of SV, and due to their similar demographic composition, which includes Venezuelan migrants and a large Wayuu population.

Sampling procedure

Quantitative sample

The non-random selection of participants followed a different strategy at each site. In the intervention site, nine community assemblies were conducted to collect basic demographic and contact information for people who intended to participate in the intervention and the research activities. This list of potential participants included 554 people. The anonymized list of community members who indicated interest in participating in the intervention and research activities, included each person's sex, marital status, and age, and was shared with the CNC. The CNC randomly selected 330 research participants from the list, following quotas per subgroups established by the research team. This yielded the study sample in the intervention site. The sample in the comparison site was obtained using the National Geostatistical Framework of the National Administrative Department of Statistics. The CNC used the same quotas as in the intervention site to obtain the sample of 330 participants in the comparison site.

The research team defined specific quotas for the selection of a total of 660 participants (330 in each site) as follows: a) a minimum of 50% of migrants; b) at least 26% of people between 13 and 19 years old, 61% of participants between 20 and 49 years old, and 13% of participants older than 50; c) at least 32% men and 58% women. The inclusion criteria for participants were 13 and older, living in the sites, and providing informed consent to participate for adults and informed assent for adolescents. The exclusion criteria were being under 13 years of age, not living in the selected sites, and not providing informed consent or assent to participate.

Qualitative sample

The qualitative sample was selected through an intentional sampling strategy. More specifically, we used homogenous purposive sampling and purposive maximum variation sampling. Homogenous purposive sampling was used to identify key informants (KIs), given their crucial role in the

intervention implementation or their role in the community. Key informant (KI) interviews (KIIs) were conducted with the following subgroups: a) CHW supervisors (n=2); b) CHWs (n=10); and c) CAB members, and community, traditional and religious leaders (n=21; 12 in the intervention site and 9 in the comparison site). The CAB comprises community members who have intimate knowledge about community member norms and behaviors. Their role in the evaluation is to provide feedback and suggestions to the M&E and implementation component, ensuring that all tools are culturally and contextually appropriate. Three types of community leaders were recruited in the intervention site, according to the leadership structure in the community: (a) female leaders trained by local nongovernmental organizations (NGOs) on GBV prevention; (b) community leaders belonging to the CAB; and (c) institutional leaders belonging to the Health Secretariat. In the comparison site, community leaders consisted of (a) locally chosen leaders, (b) religious and Wayuu leaders, and (c) institutional leaders belonging to local government and NGOs.

Participatory focus group discussions (FGDs) were conducted with community members. FGD participants were selected by inviting survey participants to FGDs. A total of n=31 FGDs were conducted (n=15 in the intervention site for a total of 105 participants and n=16 in the comparison site for a total of 111 participants). FGDs had an average of seven participants from the following subgroups: 1) adult and young women (not Wayuu); 2) adult women (Wayuu); 3) young women (Wayuu); 4) young men (Wayuu); 5) adult men (Wayuu). Approximately half (51.4%; n=58) of participants self-identified as Venezuelan migrants, and 62% were female (n=134). See **Table A1** in **Appendix A** for more details about the number of participants in FGDs.

Study instruments

Research tools were co-developed by WRC and UniAndes and validated by the CAB, which comprised 21 community stakeholders in both sites. All study tools were translated into the predominant languages within the study sites, namely Spanish and Wayuunaiki.

The quantitative data was collected through a knowledge, attitudes, and practices (KAP) survey. This survey was designed to understand community members' knowledge, attitudes, and practices about GBV, SV, health-seeking behaviors, service availability, and service uptake. The KAP survey also includes a demographic section.

Three qualitative instruments were developed for the evaluation, two interview guides and one FGD guide as described below:

1. KIIs guide (intervention staff): The semi-structured interview guide was designed to understand project staff and CHWs' experience delivering the intervention and the staff's understandings of and attitudes about GBV and SV. These interviews were implemented in the intervention community only with CHWs, project supervisors of CHWs, and implementation staff.
2. KIIs guide (community leaders): The semi-structured interview guide sought to explore the community leaders' knowledge and attitudes about SV, their knowledge of GBV services and programs, and the institutional capacity to prevent and respond to SV. These interviews were implemented in the intervention and the comparison site.
3. FGD guide (community members). The semi-structured FGD guide comprises three participatory group activities and was designed to explore the communities' understanding of the concept of GBV, gender, and SV; health-seeking behaviors; knowledge and attitudes about SV; and priorities in relation to SV.

Data collection

Both the quantitative and qualitative data was collected in the intervention site and the comparison site between August 12 and September 17, 2022. The CNC led and oversaw data collection in both sites. Following IRB approval, the CNC team was trained by the research team (UniAndes and WRC) on the objectives of the study, research ethics, and data collection instruments. Field teams included interpreters to support data collection in Spanish and Wayuunaiki, the language of the Wayuu communities. Male enumerators interviewed boys and men while female enumerators interviewed girls and women.

Incentives were provided to participants in the data collection process to offset their time and costs for participating in research activities as follows: those who answered the survey received $15,000 Colombian Pesos (COP) / $3.5 USD while FGD participants received $30,000 COP / $7 USD as this activity was lengthier. The supervisors, coordinators, and CHWs did not receive any incentive to participate in the study.

Data management and analysis

Quantitative data was collected on smart phones using electronic questionnaires programed with Open Data Kit (ODK) software. Back-to-back encryption was implemented to protect the respondents' data. The finalized datasets were stored in a secure, password protected cloud-based software only available to the research team. Descriptive statistics and tests of differences were conducted to understand whether there are statistically significant differences between the intervention and the comparison site. These significant differences are indicated in the text in parentheses and in the tables and figures by showing the statistical significance of tests for differences as follows: ***p<0.01, **p<0.05, * p<0.10. We use 0.05 as the most commonly used threshold for statistical significance but also included a more stringent (0.01) and a more relaxed threshold (0.10). All the analyses were conducted in Stata 17.

Qualitative data from KIIs and FGDs was audio-recorded and transcribed verbatim, and translated to Spanish, as needed. The research team developed, piloted, and implemented a codebook using an iterative process. Any discrepancies between coding were resolved through discussion-based consensus and adaptations to the codebook. Each transcript was uploaded to NVivo 12 Plus (QSR International Pty Ltd, 2020) for thematic analysis. Thematic network analysis was used to generate relevant themes associated with community understanding of GBV, gender equality, and sexual violence (Braun and Clarke 2021). Key themes were further explored across study sites and KI affiliation or community subgroup to explore linkages and discordances in the data.

Research team composition

The research team comprised co-principal investigators Dr. María Cecilia Dedios Sanguineti and Dr. Ángela María Guarín Aristizábal, research assistants Mariana Martínez Gómez, María Camila García Durán, and Ariana Catalina Torres García of UniAndes, Colombia, and principal investigator Katherine Gambir of WRC, USA. The field team was composed of 2 male and 7 female research assistants.

Ethics

Ethical approval was obtained from the Universidad de los Andes Research Ethics Committee (certificate n. 1506) prior to conducting the study. The research team obtained informed consent and assent prior to all data collection activities. Names and other identifying information used for recruitment were recorded in a separate document from the study data and this document was

shredded immediately following data collection. The study team provided an information sheet for each respondent with the research team's contact information, and directions for anonymous reporting channels as per safeguarding policies. Activities were audio-recorded with the respondents' consent. Any names mentioned during the research activities were deleted during transcription. The IRB package approved by the Ethics Committee of UniAndes included a psychological first-aid protocol for CNC staff. Additionally, a referral pathway was available for participants who reported cases of SGBV and for those who required referral to emergency mental health services.

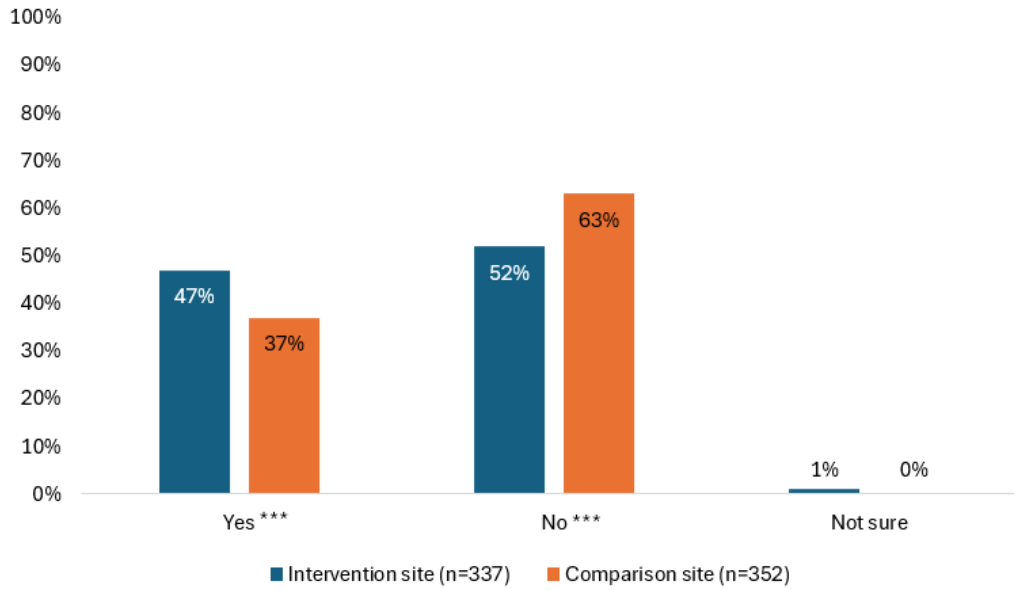
Results

The sections below present the main findings at baseline. This information of both the intervention site and the comparison site will generate evidence that will form a basis for M&E of the *Communities Care* intervention in Uribia. Quantitative and qualitative results are presented sequentially, according to organizing themes. We present figures summarizing key survey results. The demographic and socioeconomic characteristics of survey participants can be observed in **Appendix B.**

Community members' KAP about GBV and SV

More than half of survey participants reported never having heard of the term "gender-based violence" (51.93% in the intervention site and 62.78% in the comparison site) (p<0.01) (See **Figure 1**). At the same time, they considered GBV to be not common in their communities (See **Figure 4**). We found statistically significant differences between the percentage of participants in the intervention site and the comparison site a) who have heard the term GBV (yes/no), b) who consider limitations of movement as an action included in GBV, and c) who consider that GBV in the community is very common and not common.

Figure 1: The person has heard the term "gender-based violence" (by site)



Statistical significance of tests for differences by site * p<0.10, ** p<0.05, ***p<0.01

During FGDs, GBV was defined across sites as mistreatment, with some discrepancies and varied comprehension of GBV across subgroups. Participants described that GBV could be directed toward women, men, children, the LGBTQI+ community, Venezuelan migrants, or any other person in the

community. Women and men of all ages in both sites described mistreatment in various ways and identified different types of it as described below.

Most women and adolescent girls suggested that mistreatment mostly affects women and is perpetrated primarily by husbands. Wayuu women often described mistreatment as situations that are triggered by alcohol use by the husband. Male participants described GBV as "violence" directed toward both men and women. They also mentioned how GBV occurs in situations when the man of the couple is intoxicated by alcohol.

Types of GBV

Despite the high percentage (over half) of participants reporting that they did not know what GBV is, the qualitative data in both sites shows a nuanced understanding of the phenomenon. GBV is recognized by participants as a concept that encompasses different types of violence: psychological, physical, economic, emotional, and sexual, as well as with pressure to do things or to limit a person's freedom of movement . Analyzed side by side, qualitative results highlight participants' nuanced definitions of GBV that were limited in the KAP survey due to its structured design and it being an individual—and not a collective—data collection activity.

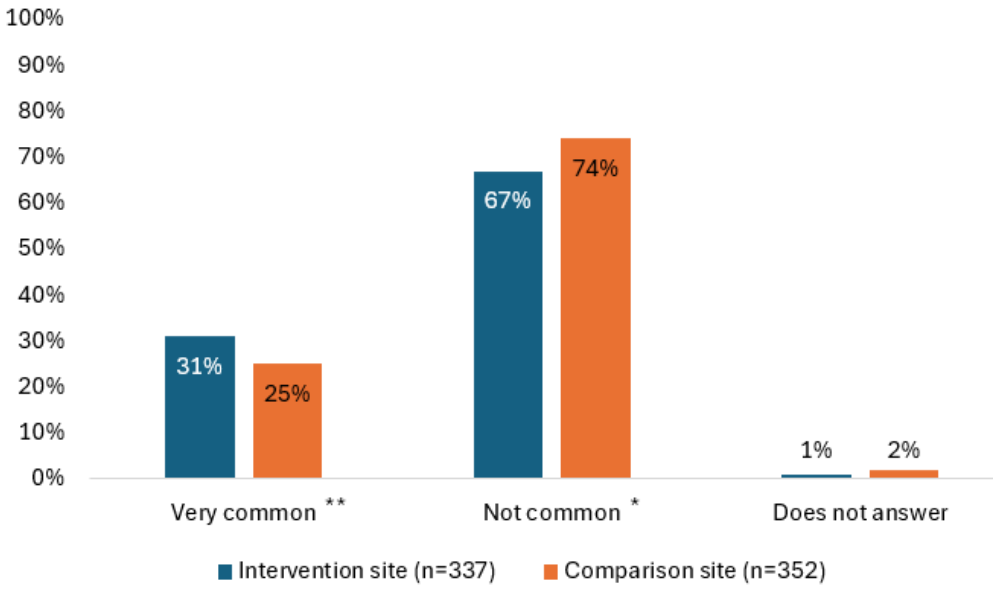
> For me, gender violence is, there are many forms of gender-based violence; it is discrimination, physical violence, verbal violence, psychological violence.
> (FGD with Adolescent Wayuu Girls_Comparison site)

Female FGD participants mentioned physical and psychological violence as the most common types of GBV, and the ones that affect women the most. During FGDs, female participants shared past experiences of physical violence with ex-partners as a way of exemplifying their understanding of GBV:

> At least I was a person... With my first partner, with the first father of my children, I was a woman who was always being beaten, every week, he couldn't arrive drunk because he would come to hit me right away, and that's why I separated from him.
> (FGD with Non-Wayuu Adolescent Girls and Adult Women_Intervention site)

Many women and adolescent girl participants defined GBV as psychological violence, adding that it happens often and recurrently to women and girls in their community. This finding contrasts with findings from the survey where participants indicated that GBV is not common in their communities. Survey participants indicated that GBV was not common in their communities (67.36% in the intervention site vs. 73.58% in the comparison site) ($p<0.01$), and more participants in the intervention site (31.45%) than in the comparison site (24.72%) indicated that GBV is very common in their community ($p<0.05$) (See Figure 2). Overall, over 65% of participants responded that psychological violence against adolescent girls or adolescent boys, physical violence against adolescent girls or adolescent boys, or SV against adolescent girls or adolescent boys were not common. In contrast to findings from the survey, at least one FGD of adult women and of adolescent girls, indicated that GBV, specifically psychological violence, was common in their communities. Among FGD adult and adolescent women participants, psychological violence occurs when their partners yell at them, use derogatory words to describe their bodies, or when their partners underestimate or humiliate them. They mentioned that psychological violence affects women by destroying their self-esteem, which in turn can motivate self-harm or, in some instances, suicide.

Figure 2. How frequent is GBV in your community? (by site)



Statistical significance of tests for differences by site * p<0.10, ** p<0.05, ***p<0.01

In the comparison site, adolescent Wayuu girls discussed GBV extensively. This subgroup in particular was more emphatic in portraying GBV as SV, for example, one participant expressed that:

> It [GBV] is when a woman is raped
> (FGD with Adolescent Wayuu Girls_Comparison site).

In addition, this subgroup of adolescent girls also discussed violence against girls who experience sexual exploitation in the context of selling sex:

> It [GBV] is when a woman tells the girl to go do this and the girl doesn't want to do it... As if she were selling her body.
> (FGD with Adolescent Wayuu Girls_Comparison site)

Wayuu adult women participants also defined GBV as violence against children and intrafamily violence. They discussed GBV as violence against children exercised by adults or even violence exercised by their own mothers, as indicated by this participant: "When, for example, if the mother does not like me to do that and what she does is to scold him and hits him [the child]" "Cuando por ejemplo si la madre no le gusta que haga eso y lo que hace es regañarlo y lo golpea [al niño]" (FGD with Adult Wayuu Girls_Comparison site). They also understood GBV as intrafamily violence, which they defined as confrontations and violence between couples and between close family members. Non-Wayuu women were the only ones to refer to GBV as bullying. They referred to bullying in two ways: physically harming a person because of their gender and as verbal abuse from a husband to his wife.

In the comparison site, male participants generally did not generate debate around GBV. Wayuu adolescent boys and adult men approached the discussion in a much shorter and simpler way. In general, no counter positions or a debate around the topic were identified in any subgroup of male participants; however, when an adolescent Wayuu boy participant tried to express his position contrary to that of another participant the conversation turned harsh. In response, the FGD moderator reminded participants about the need to respect everyone's opinion, trying to keep the discussion from escalating.

In the intervention site, most Wayuu adult men defined GBV as what should not be done, for example, when asked about their understanding of GBV, they answered

> Do not mistreat women in the home, children...
> (FGD with Adult Wayuu Men_Intervention site).

In this subgroup of Wayuu adult men, the idea of GBV as mistreatment was related to the mistreatment of young people. They shared examples such as young people mistreated by the police because they are drug users or young people who are mistreated even though they are innocent. Young Wayuu men defined GBV as beating a woman and embraced the idea of a "weak gender."

The subgroup of non-Wayuu adolescent girls emphasized the importance of considering psychological violence as a type of GBV and also mentioned domestic violence as another type of GBV. Adolescent Wayuu girls defined GBV as not adhering or behaving according to the gender [sex] one is assigned at birth. An adolescent Wayuu girl explains:

> Also, gender violence is when they violate the gender with which they were born
> (17_adolescent Wayuu girl_Intervention site).

According to participants in this FGD, when a person does not fulfill the gender roles of his/her sex in the household, this is seen as a type of GBV towards one's partner or family. For example, GBV happens when a woman does not wash, iron, or cook or when a man does not work, bring money home, or assume authority attitude at home.

Community leaders

During KIIs with community leaders and other key stakeholders, reported prevalence and norms around GBV were mixed; however, KIIs across sites reported that migrants and the Wayuu community take differential approaches to addressing cases of GBV. A Wayuu leader explained that Wayuu families rarely file a complaint when violence occurs, because problems within the couple should remain private, while migrants were perceived as more likely to seek help from the authorities and seek psychological and orientation services.

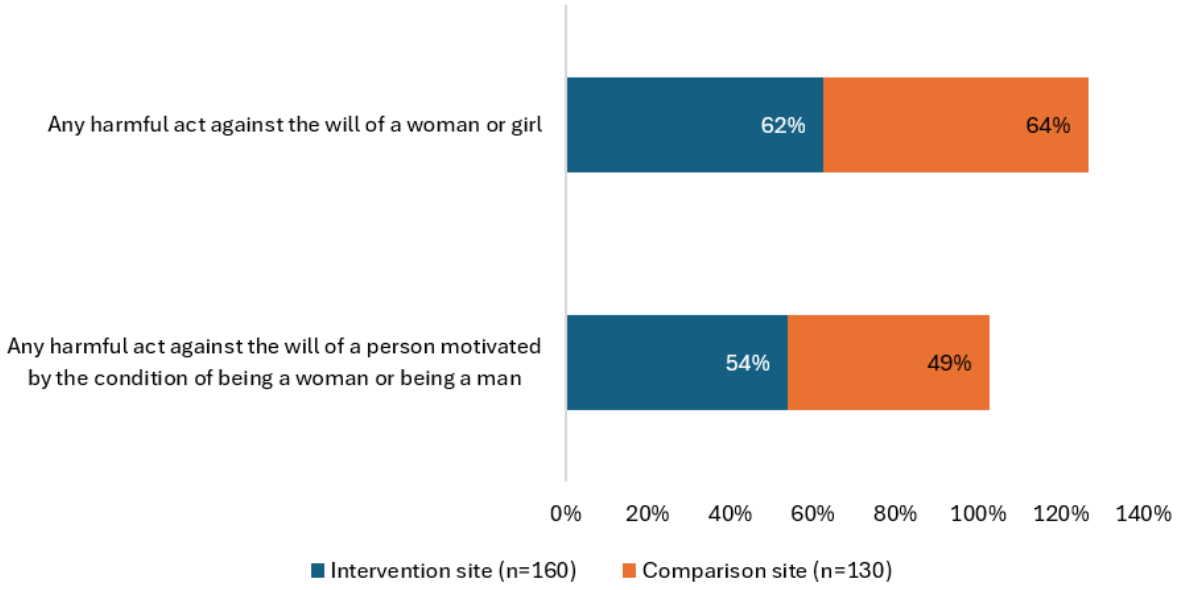
In the intervention site, KIIs suggest that GBV was perceived as normal by many people in the community, especially for people close to the idiosyncrasy, customs, and culture of the Wayuu community. Community leaders described that in the Wayuu culture the man is in charge and the woman is expected to follow. GBV is most often addressed by the Wayuu law, that is, not through state institutions. The Wayuu law indicates that when an act of violence occurs, the families talk, reach an agreement, and charge a monetary value for reparations. Mentions of the Wayuu culture in relation to GBV were discussed mainly in the context of the intervention site rather than the comparison site. Further, some community leaders considered that GBV was very rare in their community, and that it had diminished considerably over time.

In the comparison site, community leaders identified different types of violence in their definition of GBV: physical, sexual, economic, and psychological violence. Some leaders could not identify cases of GBV and said that GBV was very uncommon in their blocks. In contrast, some leaders mentioned that GBV is the norm. Finally, leaders identified a change in attitudes toward GBV and linked it to GBV training and awareness-raising activities in the community, that is, violent acts that were previously normalized were beginning to be identified by the community as crimes or violent acts that should not occur.

Similar to the qualitative findings where participants indicated that GBV is understood as mistreatment

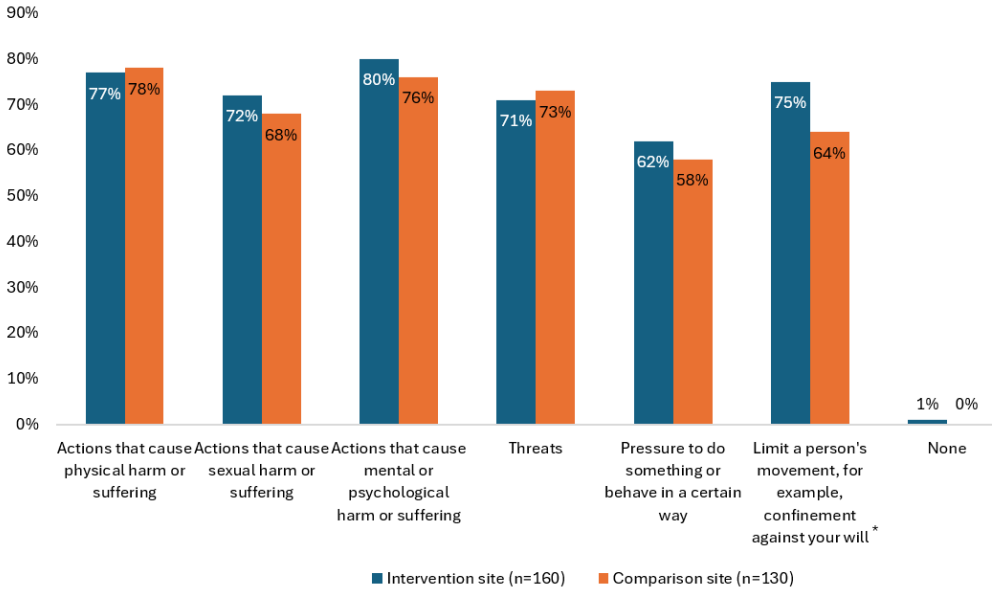
and other types of violence directed toward women and girls and to a lesser extent toward men and boys, almost two-thirds of all survey participants responded that GBV is related to any harmful act against the will of a woman or girl (62.35% in the intervention site and 64.12% in the comparison site) (See **Figure 3**). Participants could select more than one response. Approximately half of all participants (53.7% in the intervention site vs. 48.85% in the comparison site) also considered that GBV is related to any harmful act against the will of a person motivated by the condition of being a woman or being a man. Over 75% considered that actions that cause physical harm or suffering (76.54% in the intervention site vs. 77.86% in the comparison site) and actions that cause mental or psychological harm or suffering (79.63% in the intervention site vs. 76.34% in the comparison site) are GBV. A similar percentage of participants also responded that actions that cause sexual harm or suffering (72.22% in the intervention site vs. 67.94% in the comparison site) and threats (70.99% in the intervention site vs. 72.52% in the comparison site) are also GBV. We found differences between participants who said that limiting a person's movement is a type of GBV (74.69% in the intervention site vs. 64.12% in the comparison site) ($p<0.01$) (See **Figure 4** for additional details).

Figure 3. Definition of GBV (by site and among those who have heard the term)



Statistical significance of tests for differences * $p<0.10$, ** $p<0.05$, ***$p<0.01$
Categories are not mutually exclusive. Excluding responses for the "Other" and "None" categories <1%

Figure 4. Actions considered as GBV (by site and among those who have heard the term)



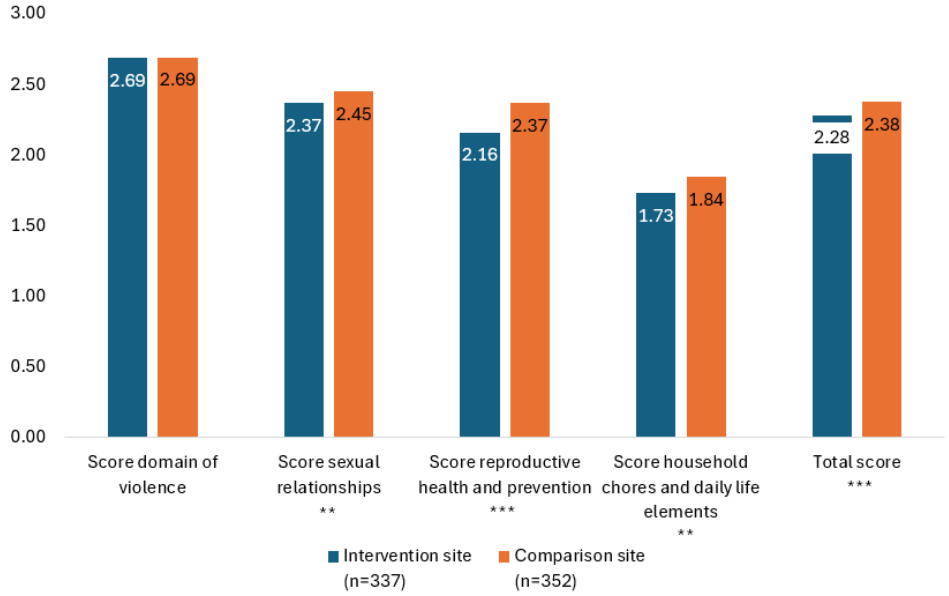
Statistical significance of tests for differences * p<0.10, ** p<0.05, ***p<0.01
Categories are not mutually exclusive. Excluding responses for the "Other" and "None" categories <1%

Attitudes toward gender equality and GBV

Gender equality

The GEM scale measures attitudes toward gender norms in intimate relationship across four domains: violence; sexual relationships; reproductive health and disease prevention; and household chores and daily life elements. The scale total score and domain scores range from one to three; a higher score means higher gender-equitable attitudes. Across all domains, participants from the comparison site had slightly higher gender-equitable attitudes according to the total gender equality scale score (2.38 in the comparison site vs. 2.28 in the intervention site) (p<0.01) (See Figure 5 GEM scale scores by domain and total [by site]). For the violence domain, participants from both sites had the same general score (2.69), indicating relatively high gender-equitable attitudes in this domain. In the domain of sexual relationships, we found statistically significant differences between sites. Participants from the comparison site had a higher overall score than participants from the intervention site (2.45 vs. 2.37), meaning higher gender-equitable attitudes in the domain of sexual relationships (p<0.05) (See **Figure 5**). Results showed similar trends in the domain of reproductive health and disease prevention (2.37 vs. 2.16) (p<0.01); and household chores and daily life elements (1.84 vs. 1.73) (p<0.05).

Figure 5. GEM scale scores by domain and total (by site)



Statistical significance of tests for differences by site * p<0.10, ** p<0.05, ***p<0.01

As for attitudes toward GBV, the research team collected information with an adapted version of the Attitudes Towards Gender-Based Violence Scale used by the International Rescue Committee in Jordan (2015). This scale addresses the following domains: child marriage; household financial decision making; violence against cisgender heterosexual women, girls, men, and boys, and LGBTQI+ people; disclosure of violence; and survivors' access to services.

Findings indicate that, overall, violence against cisgender heterosexual women, girls, men, boys, and LGBTQI+ people was not accepted by participants. Over 86% of people in each community indicated that they "disagree" with the following statement: *"Violence against LGBTQI+ people is acceptable under certain circumstances."* Similar percentages apply for the statements about women (over 92% disagree), girls (over 95% disagree) and men (over 92% disagree). Furthermore, most participants considered that a woman or girl exposed to violence will seek help from a person she trusts or from specialized groups or services. There were statistically significant differences between the intervention site and the comparison site for the following variables: violence against girls (no answer), violence against men (disagree and no answer), violence against LGTBQI+ community (agree), and in the question regarding a woman seeking help from a person she trusts (agree and no answer); however, the differences were small—no more than 4%. (See **Figure 6** for the intervention site and **Figure 7** for the comparison site).

Figure 6. GBV attitudes (Intervention site)

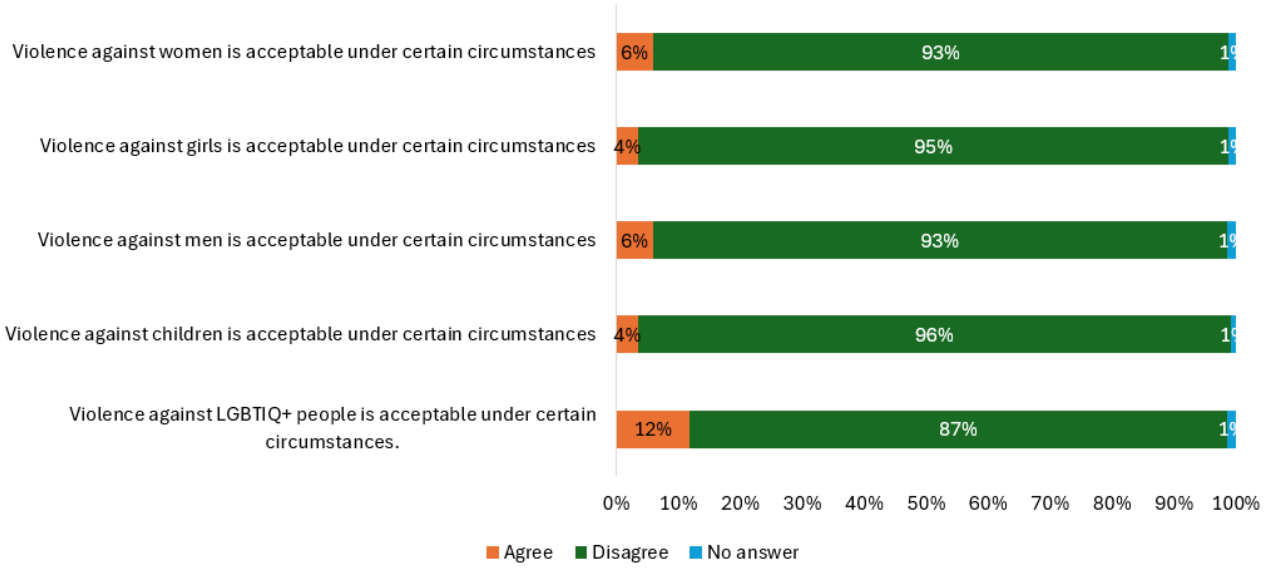
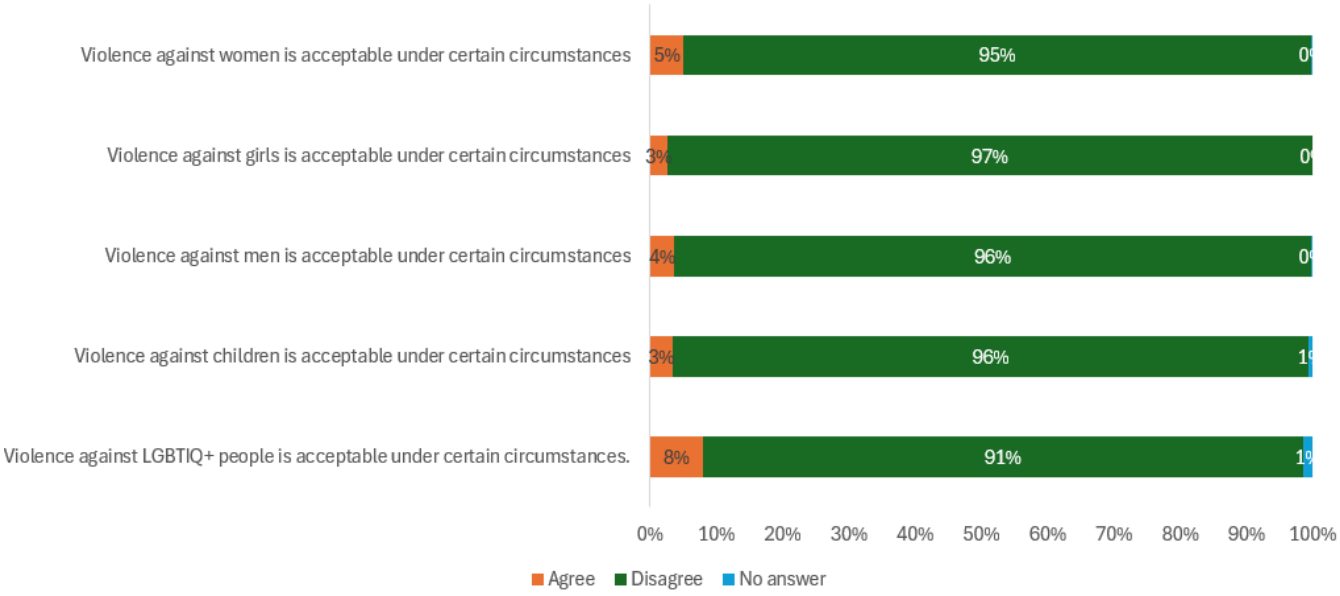


Figure 7. GBV attitudes (Comparison site)



Over 80% of participants across communities disagreed that marriage with a woman less than 18 years was acceptable. Most of the sample (around 90%) considered that the husband and wife must make decisions together about household spending. Slightly more participants from the comparison site in comparison to the intervention site disagreed with the statement "Violence against men is acceptable under certain circumstances" (92.58% the intervention site vs. 96.02% the comparison site) ($p<0.10$).

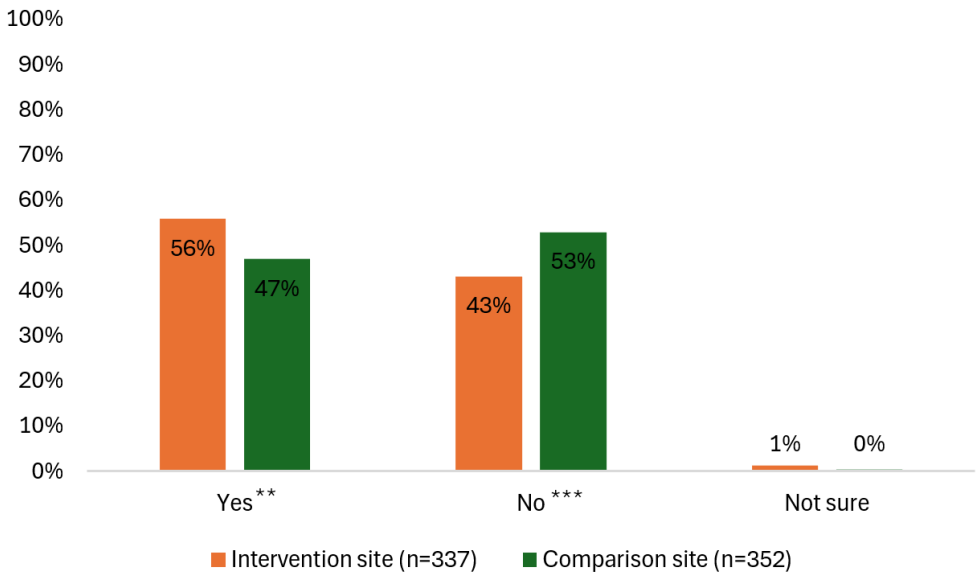
Participants were also asked if they believed that if a woman or a girl is exposed to violence she would seek help from a person she trusts or from other service providers. Between 80% and 90% of respondents agreed with these statements. More participants from the comparison site in

comparison to the intervention site expressed agreement with the statement regarding a woman seeking help from a person she trusts in case of violence (80.12% the intervention site vs. 85.80% the comparison site) ($p<0.05$).

Knowledge and awareness of SV

FGD data indicates that all participants understand what SV is. However, only around half of survey participants reporting having heard the term "sexual violence" (55.79% in the intervention site vs. 47% in the comparison site) ($p<0.05$) (See **Figure 8**). More than half (57%) of participants reported that SV was not common in their community. More participants from the intervention site (23.74%) compared to the comparison site (16.76%) ($p<0.05$) reported that SV was very common at school, and slightly more participants from the comparison site reported that SV was not common at work (80.12% in the intervention site vs. 85.23% in the comparison site) ($p<0.10$). Among those participants who selected specific places in the community where SV was common, the most frequently reported places were in public open spaces (35.31% in the intervention site vs. 28.41% in the comparison site) ($p<0.10$) and in the stream (*"el arroyo"*) (37.39% in the intervention site vs. 26.14% in the comparison site) ($p<0.01$).

Figure 8. The person has heard the term sexual violence (by site)



Statistical significance of tests for differences between sites * $p<0.10$, ** $p<0.05$, ***$p<0.01$

During FGDs, "sexual violence" was the only term that all participants claimed to understand and for which they were able to provide various examples in contrast to "gender-based violence" and "gender." In both sites, a core idea was that SV means forcing a person to have sex. Through different expressions, all participants of all ages refer to SV as forced sex, rape, or sex without consent. Participants across subgroups mentioned SV as a type of GBV. Community members understood SV as an action mainly perpetrated by men against women. Women from both sites and from all subgroups described that SV mostly occurs in intimate partner relationships where the abuser is the husband, boyfriend, or partner. Most women associated SV with physical violence, such as beatings and physical harm.

In the comparison site, adolescent Wayuu girls report cases of requests for intimate photos as part of SV; it is the only subgroup where this activity is mentioned. In contrast, adult Wayuu women are more emphatic about the SV suffered by children in the community. Wayuu adolescent boy participants expressed similar sentiments about SV perpetrated against children in their community. They shared that SV against children could also be accompanied by murder:

> Sexual violence is when minors are abused; they tell them to get a piece of candy and take it away, rape and kill them. (FGD with Adolescent Wayuu Boys_Comparison site)

Non-Wayuu adult and young women also discussed rape of children in the community as a form of SV, and particularly mention teachers as perpetrators of SV against students. The discussion of teachers as perpetrators of rape is only observed in the subgroup of non-Wayuu adult and young women. In the subgroup of adult Wayuu men, participants discussion about SV focused on marriage between younger girls and older men. They referred to the change in the Wayuu custom of the dowry, when the family of the bride provides money or valuables to the groom's family. When referring to the age difference between bride and groom, one participant explained that he would consider it GBV if a young woman is forced to marry an old man despite her wishes.

> ...if the girl leaves him and wants to be the wife of an older guy, that is not sexual violence, but if the older person of forty-something, fifty, gets married asking for her hand and if she does not want that to be her husband, to be her partner there is already and that is sexual mistreatment. (FGD with Adult Wayuu Men_Comparison site)

> The girls themselves are already fighting, saying that they are not goats, that they are not cattle. (FGD with Adult Wayuu Men_Comparison site)

In the intervention site, Wayuu men and young adults considered that the people affected by SV are women only. They never mentioned men as at-risk or survivors of SV. At first, they defined SV in terms of what should not be done. One participant expressed: "Sexual violence, that women should not be forced to be intimate with men" (FGD with Adult Wayuu Men_Intervention site). Then, it became evident that, culturally, it is necessary to pay if an older man gets involved with a young woman. The payment is made to avoid jail, because large age differences are recognized as abuse:

> P6: The payment. This is how it works here.

> P8: Here, for example, I have a cousin. In the ranchería I have a situation. The girl is 15 years old and the man is 39 years old. What did my, one of my uncles say? He said, if you don't pay, you go to jail. Because, well, the girl is a minor and the man is almost 40 years old. It is already sexual abuse. Now, for example.

> P9: Sexual abuse, even if it is given voluntarily, is sexual abuse.

> P8: Of course, exactly, and that, then, in order for him (the uncle) to leave her with him, he has to pay (for) the poor girl because if she is sued, he will go to jail. He has to, obligatorily he has to pay, a fee, as he says (FGD with Adult Wayuu Men_Intervention site).

Later in the discussion, the older Wayuu men in this conversation affirm that physical violence is common; however, due to fear of the police, it is less common than before; however, "before" was not defined. During the conversation, they gave several examples of physical violence (e.g., a man who hits a pregnant woman because he believes she was unfaithful). They also give examples of physical violence by intoxicated men. Finally, the men say that culturally, when a woman is beaten, the

following actions should be taken: the man should pay the woman's male relatives , and the woman should lock herself up for five days and take a bath so that this situation does not happen again.

SV was also defined in the intervention site as an act of humiliation. Adult and young women associated SV with humiliation between partners. Men may humiliate women, and women may humiliate men. Humiliation was understood as subjugating another person by exerting power over them. This asymmetry of power allows the perpetrator to make the other person feel bad about themselves. In particular, non-Wayuu women emphasize SV against children and mention that it can also be carried out by a woman:

> P2: But did you know that... We are always blaming the man. The man is the one who rapes the woman, the man is the one who rapes the boy, the man is the one who rapes the girl, the man, the man? Did you know that women also rape children?
>
> P6: Yes, there are also women who rape children. Who harass them... Just like men look for women. (FGD with Non-Wayuu Adolescent Girls and Adult Women_ Intervention site)

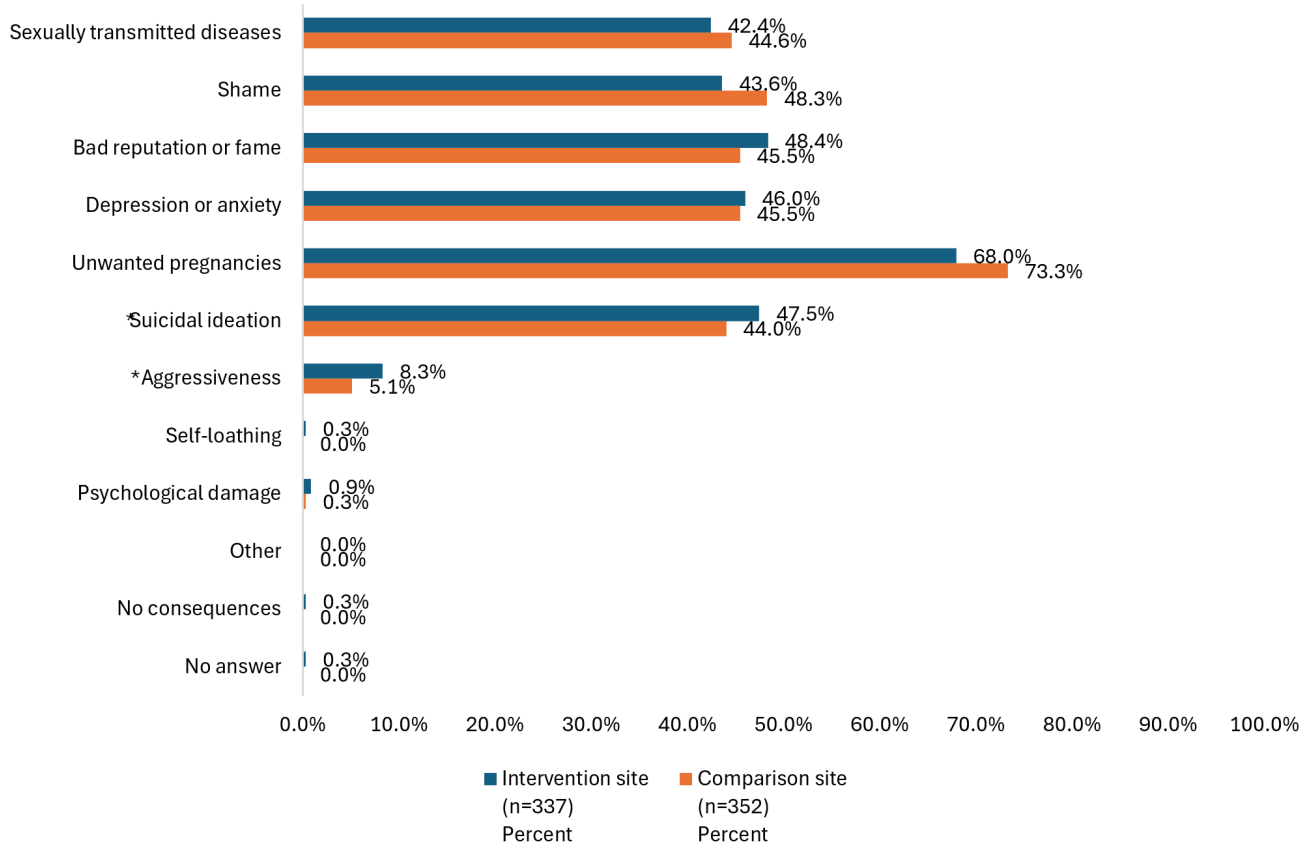
To deepen understanding an d priorities regarding SV, participants were asked to rank their concerns about SV. Notably, priorities were organized around the issue of insecurity. The intervention site's main concerns were centered around safety needs, precarious public services, and poor institutional presence. Even though the exercise was focused on SV, participants associated concerns with problems such as insecurity, unlit streets, and drug use, in addition to their concern about SV and the rape of children. A cross-cutting message from FGDs is that people do not feel safe in their community. The risk of SV was just one of the many layers contributing to the feeling of insecurity. Similarly, concerns in the comparison site reflect three central themes: a lack of physical and institutional infrastructure (lack of police and public lighting); risks faced by children; and GBV (mistreatment of women and between partners). Concerns across the intervention site and the comparison site are very similar; however, the concern about risks faced by children including kidnapping, and physical and sexual abuse were more pronounced in the comparison site. These results show the multiple unsatisfied basic needs of these communities living in complex humanitarian contexts with a high degree of monetary and multidimensional poverty.

Consequences of SV and benefits of seeking help

The survey instrument asked participants about the potential consequences of SV as well as about the risks and benefits of seeking help in cases of SV. We found statistically significant differences between sites in the following variables: having heard the term SV; frequency of SV in different settings; the report of aggressiveness as a consequence of SV; and the report of several benefits and risks of seeking help in cases of SV.

Regarding the consequences of SV, most participants on both sites mentioned unwanted pregnancies (67.95% in the intervention site vs. 73.3% in the comparison site) as the most common consequence. Over 40% of participants in both sites responded that STIs, shame, bad reputation or fame, depression or anxiety, and suicidal ideation were also consequences of SV. Slightly more participants in the intervention site than in the comparison site mentioned that aggressiveness was also a consequence (8.30% in the intervention site vs. 5.11% in the comparison site) ($p<0.10$). Only one person in the intervention site reported that there were no consequences of SV (See **Figure 9,** p. 17).

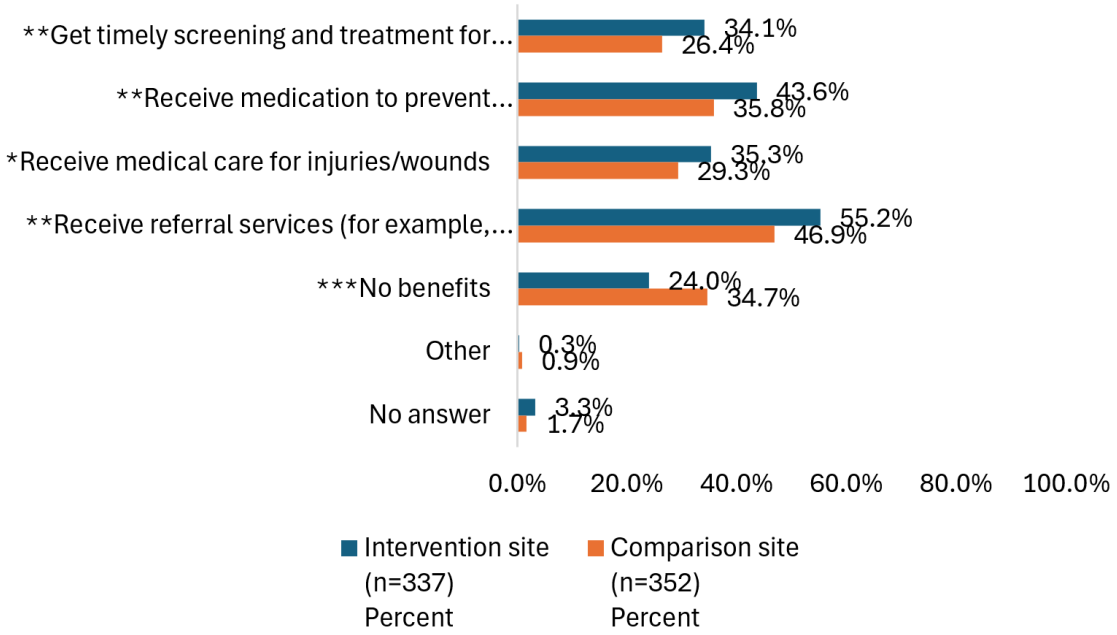
Figure 9. Consequences of sexual violence (by site)



Statistical significance of tests for differences by site * p<0.10, ** p<0.05, ***p<0.01
Categories are not mutually exclusive

We found statistically significant differences between the sites in all the perceived benefits of seeking help in cases of SV. The most reported benefits on both sites were receiving referral services (55.19% in the intervention site vs. 46.88% in the comparison site) (p<0.05) and receiving medication to prevent pregnancies (43.62% in the intervention site vs. 35.8% in the comparison site) (p<0.05). Overall, more participants from the intervention site reported benefits. Additionally, more participants from the comparison site expressed that there are no benefits of seeking help (34.66 in the comparison site vs. 24.04% in the intervention site) (p<0.01) (See **Figure 10**, p. 18).

Figure 10. Perceived benefits of seeking help in cases of sexual violence (by site)

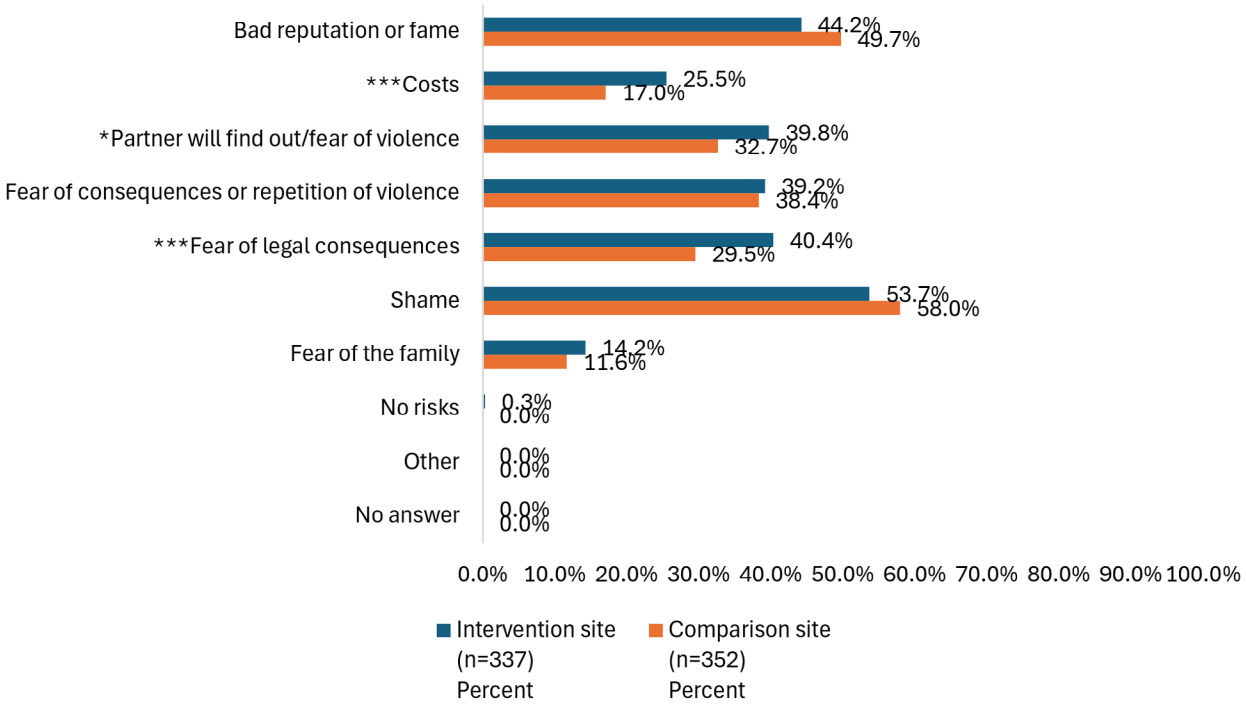


Statistical significance of tests for differences by site * p<0.10, ** p<0.05, ***p<0.01
Categories are not mutually exclusive

In relation to the risks of seeking help in cases of SV, the most frequently reported risks were shame (53.71% in the intervention site vs. 57.95% in the comparison site), and bad reputation and fame (44.21% in the intervention site vs. 49.72% in the comparison site). More participants in the intervention site than in the comparison site reported other risks such as costs (25.52% in the intervention site vs. 17.05% in the comparison site) (p<0.01), fear of the partner finding out/fear of violence (39.76% in the intervention site vs. 32.67% in the comparison site) (p<0.10), and fear of legal consequences (40.36% in the intervention site vs. 29.55% in the comparison site) (p<0.01), or did not answer the question (5.93% in the intervention site vs. 1.14% in the comparison site) (p<0.01) (See **Figure 11**, p. 19.).

In contrast to the information provided by community members about GB V, leaders were shy and reluctant to talk about SV. Leaders in both sites struggled to speak openly about SV and mainly mentioned cases of SV against children and the consequences of SV and help-seeking behavior. In the intervention site, leaders described that many adults remain silent when they learn about the sexual abuse of a child because often a family member is the perpetrator. One leader stated that SV is not reported because of a lack of trust and generalized fear among community members. Children are afraid and lack a trusted adult to express themselves. Male children stay silent fearing that they will be ridiculed and stigmatized. Leaders risk their personal safety when they learn about a case of SV as community members may see them as those encouraging victims to report their case to the authorities.

Figure 11. Perceived benefits of seeking help in cases of sexual violence (by site)



Statistical significance of tests for differences by site * p<0.10, ** p<0.05, ***p<0.01
Categories are not mutually exclusive

Leaders made it evident there is no trust or security in the community to talk about these issues even in the hospital:

> That's why they say that women are a bit reluctant to seek help and don't say anything, they are afraid of being discriminated against at the hospital, they say "oh, you must have asked for it." They don't go to the emergency room because they are told "no, you must have asked for it" or "your husband raped you because you didn't want to be with him." And it shouldn't be like that. (Leader_Intervention site)

In the comparison site, community leaders identified key factors that prevent Wayuu families from seeking help—conflict between involved families that may lead to violence or the involvement of the law which is seen as a negative outcome. Second, Child Welfare separates the children from their family until the situation is clarified, which families want to avoid. Thirdly, because the hospital is far away, it is nearly impossible to keep a case of SV private and anonymous. Seeking help is seen as a public admission of victimization.

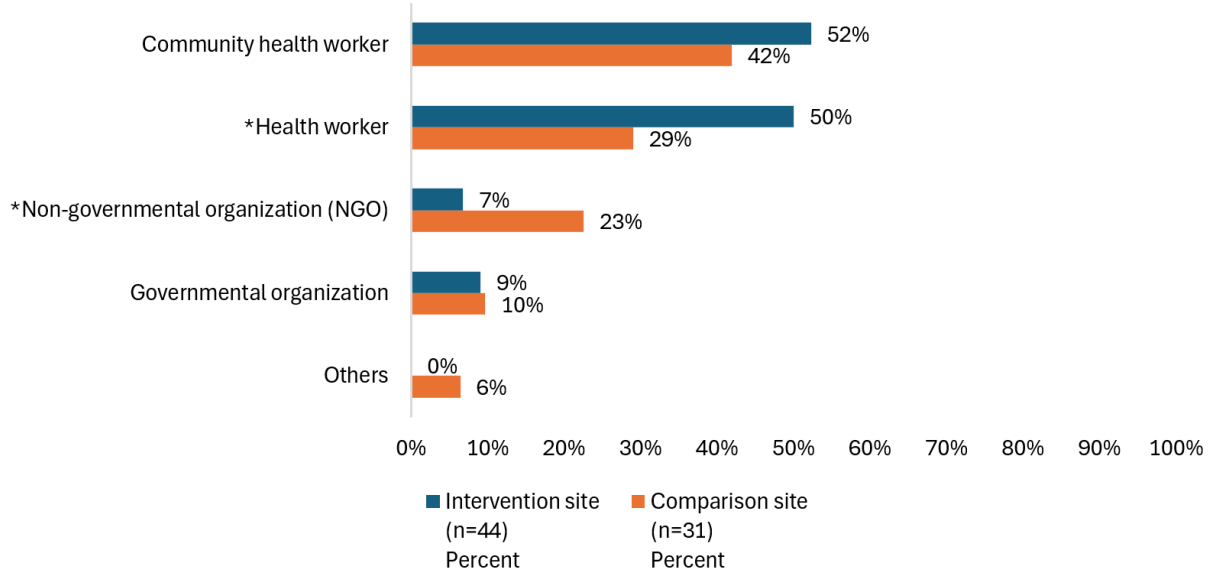
Community member awareness of and access to available GBV information and services

FGD analysis suggests that in the intervention site, people mainly seek information and services related to GBV at home with their own family members. They also may reach to the president of the self-organized governance system of the community, called Community Action Boards in Colombia, or go directly to the house of other community leaders. In the comparison site, participants also identified this latter site as a place to obtain this information. When explored in the KIIs with community leaders in both sites, many stated that even though they can facilitate referrals in cases

of GBV, their experience working on GBV is limited to a few formal trainings that were facilitated by local NGOs. In the comparison site, one leader identified herself as very knowledgeable in the topic of women and GBV. She explained that she worked for two weeks with a group of women to identify strategies to reduce violence and empower women in the community.

One main difference between the two communities is that participants in the comparison site frequently mentioned the headquarters of the NGOs as places where they can obtain information and services related to GBV. This was evident in both the FGDs (all subgroups identified these sites in their discussions) and KAP results. For example, in the comparison site, 22.6% of participants who had accessed GBV services in the past 12 months, indicated that an NGO provided the service compared to only 6.8% in the intervention site ($p<0.10$) (See **Figure 12)**.

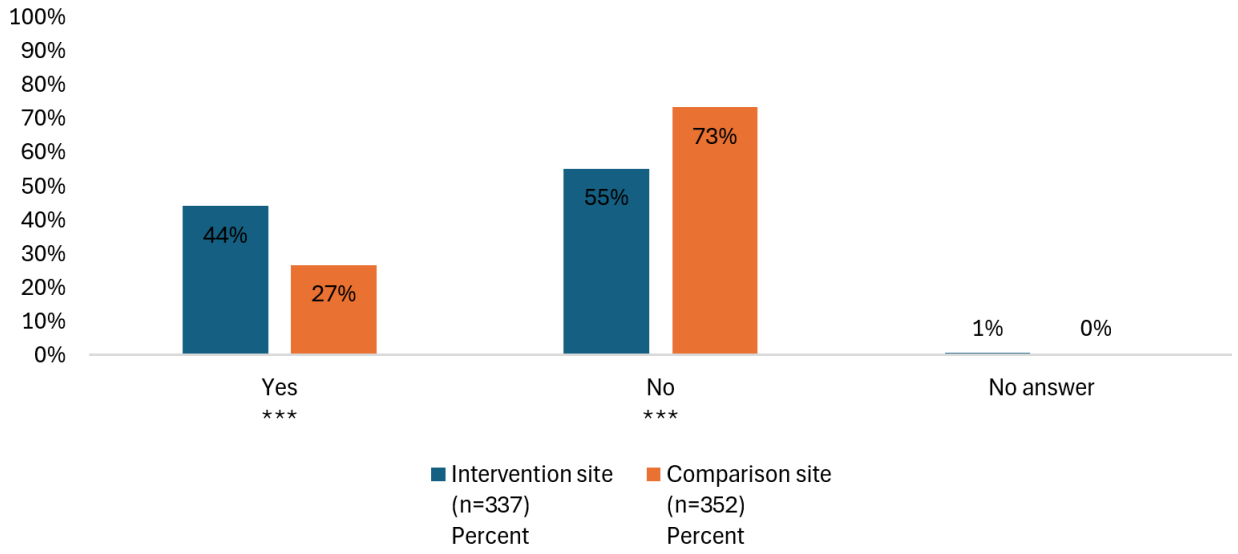
Figure 12. Person or institution that provided the service related to GBV (if person has accessed GBV services in the past 12 months, by site)



Statistical significance of tests for differences by sites * $p<0.10$, ** $p<0.05$, ***$p<0.01$
Categories are not mutually exclusive

Despite the fact that participants in both the intervention site and the comparison site identified key places that provide GBV-related information and services, many participants across communities also stated that there are no places in the community specifically designed to disseminate this information. In both sites these statements were mainly shared by women. KAP results confirmed this general lack of knowledge regarding available services in both communities if a person experiences GBV. This was significantly larger in participants from the comparison site (55.19% the intervention site vs. 73.3% the comparison site) ($p<0.01$) (See **Figure 13,** page 21).

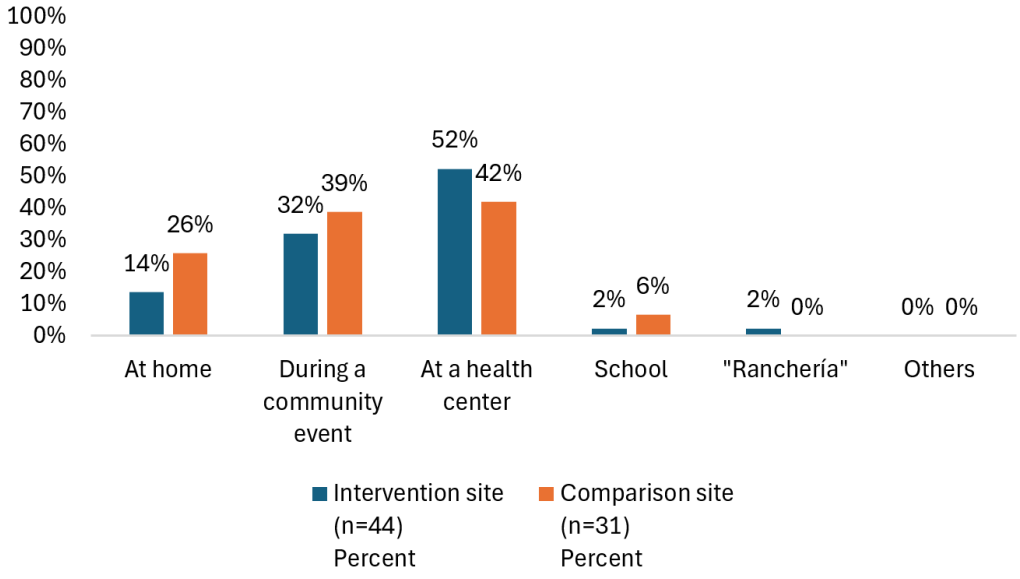
Figure 13. Knowledge of available services in the community if person experiences gender-based violence (by site)



Statistical significance of tests for differences between sites * p<0.10, ** p<0.05, ***p<0.01

Among participants who reported participation in any GBV-related program in the last 12 months (68.75% the intervention site vs. 63.27% the comparison site), services seemed to be provided mostly by CHWs and health workers (See **Figure 12**). These GBV services were mainly delivered at health centers (52.27% the intervention site vs. 41.94% the comparison site) and during community events (31.82% the intervention site vs. 38.71% the comparison site) (See **Figure 14**). Nearly half of the participants who have accessed these GBV programs reported being fully satisfied with the services received (45.45% the intervention site vs. 51.61% the comparison site) while the other half are either partially satisfied or not satisfied.

Figure 14. Place where the service was provided (if the person has accessed GBV-related services)



Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01
Categories are not mutually exclusive

When asked about other services or programs available in the community (not only related to GBV), medical assistance was the most reported service in both the intervention site and the comparison site (52.35% the intervention site vs. 42.55% the comparison site). This was followed by education (51.01% the intervention site vs. 38.3% the comparison site) ($p<0.10$), food distribution (38.26% the intervention site vs. 32.98% the comparison site), and mental health or psychological services (38.26% the intervention site vs. 29.79% the comparison site). Those who reported knowing any service were asked if they had accessed any of them in the prior year. Medical assistance was the most frequently accessed service on both sites (54.69% the intervention site vs. 42.86% the comparison site).

Barriers to accessing GBV information and services

During FGDs, participants were asked about the characteristics of individuals in the community who face barriers to accessing GBV information and services. In both sites, children and people who have no interest in the topic were among the most frequently mentioned characteristics. In the intervention site, participants also frequently mentioned: people who cannot read or write and people who only speak Wayuunaiki. Among four FGDs in the intervention site, participants stated that GBV services do not exist in the community; therefore, no particular characteristics were analyzed in depth. In contrast to the intervention site, the analysis by subgroups in the comparison site emphasized the lack of interest on the topic and that the leaders are the only people in the community who have access to services. Young and adult non-Wayuu women was the subgroup that identified more characteristics linked to barriers to accessing GBV information and services.

Community member access to available SV services

When asked about SV services available to community members, FGD participants across sites mentioned the same places they previously identified as those that provide GBV-related services. In the intervention site, participants mentioned their own households as well as the home of the president of the Community Action Board. In the comparison site, participants mentioned the headquarters of NGOs and the houses of leaders. There was one key difference between subgroups in the intervention site: adult Wayuu women and adolescent girls identified only their own households and Wayuu adult men identified only the house of the president of the Community Action Board. Several FGDs across both sites likewise stated that access to this type of information in the community does not exist. This finding is confirmed with KAP results. Regarding the knowledge of available services in the community if a person experiences SV, most participants reported a lack of knowledge, especially participants from the comparison site (62.31% the intervention site vs. 75.85% the comparison site) ($p<0.01$). In both sites, the most reported SV-related service provided in the last 12 months was education (51.59% the intervention site vs. 48.81% the comparison site), followed by medical assistance in the intervention site (42.06% the intervention site vs. 33.33% the comparison site), and by food distribution in the comparison site (37.30% the intervention site vs. 36.90% the comparison site).

Barriers to accessing SV information and services

During FGDs, participants were asked about the characteristics of individuals in the community who face barriers in accessing SV information and services. Across both sites, people who lack interest in the topic was among the most frequently mentioned characteristic. In the intervention site, people who only speak Wayuunaiki was also frequently mentioned. In five FGDs no particular characteristics were mentioned since participants affirmed that no one has access to this information and services. In contrast, non-Wayuu women agreed that everyone in the community has access to this

information. This subgroup also identified lack of interest and being a child as two characteristics that limit access to these services in the intervention site. In the comparison site, children were also frequently mentioned as not having access to SV information and services. In three FGDs participants stated that these services and information do not exist in the community; therefore, no particular characteristics were identified. Overall, across both sites, in terms of places where SV information and services are available and characteristics of individuals who do not have access to these services, findings indicate that community members do not differentiate between SV and GBV.

Participants were also asked to identify barriers community members face in accessing SV information and services. Across both sites, lack of interest, only speaking Wayuunaiki, and lack of information centers, institutions, and professionals to provide support on the issue were among the most frequently mentioned obstacles. Participants in the intervention site also frequently mentioned low level of schooling. In the intervention site, barriers discussed by men centered on lack of interest, low schooling, and lack of professionals and care centers. On the other hand, women, in addition to mentioning these barriers, also mentioned barriers such as fear, shame, age, fear of mockery and Wayuu law. In the comparison site, adult men participants mentioned being a victim of mockery and shame as a barrier, while adult women participants did not mention this barrier.

Facilitators to accessing SV information and services

Across sites, NGOs were among the most frequently mentioned facilitators to accessing SV information and services. Participants in the intervention site also frequently mentioned foundations and NGOs, the school, the president of the CAB, and the hospital. Participants frequently mentioned that there was no one who provided information and services on SV. The analysis by subgroups shows how adult and adolescent men identify fewer information providers and emphasize that there is no access to this type of information in the community. Men identify their close circles of people as key sources of information; in contrast, adult women and adolescent girls focus more on institutions such as schools, the police, hospitals. In the comparison site, participants also frequently mentioned the leaders who conduct meetings. Participants identified multiple nongovernmental entities as *possible* facilitators of access to information and services on SV; however, they did not specify that these entities currently offer services and information about SV in the community.

Main intervention outcomes at baseline

The main intervention outcomes include 1) sense of safety and well-being in the community; 2) percentage of community members who are knowledgeable about GBV; 3) percentage of community members who report knowledge about SV, including the consequences of SV; 4) percentage of community members who report knowledge about the benefits of seeking help for survivors of SV; 5) percentage of community members who report knowledge about the available services in the community if a person experiences a) GBV and b) SV; 6) attitudes toward GBV; and 7) attitudes toward GBV and accessing services.*

* To calculate attitudes toward GBV and accessing services, the 11 questions that make up the adapted version of the Attitudes Towards Gender-Based Violence Scale applied on survey participants were divided into two sub-scales. The first one (attitudes towards GBV) includes five items (questions C-G). Each item had three possible answers: no response (99 –recoded to missing), agree (01), and disagree (02). To score the scale we added the participants' answers (maximum possible score of 10 if they answered all the questions) and divided this into the number of questions answered (excluding missing or no response). Following this, the scale score had a minimum score of one and a maximum of two. The higher the score, the higher the disagreement with GBV. This means, for example, that a participant with a score of 1 agrees more with GBV attitudes (e.g., believes that violence against others is acceptable), while a participant with 2 points disagrees more with GBV attitudes.

Below we present the outcomes for each group of interest including: by site (the intervention site vs. the comparison site), by age group (adolescents 13-19 years old) vs. adults (20 and older), by sex (women vs. men), by civil/relationship status (living with their couple or married vs. single—including separated or widowed), by migration status (Venezuelan migrants vs. non-Venezuelan migrants—including Colombians, those with double nationality, and Colombians who have returned).

By site

Figure 15 shows the main outcomes by intervention and comparison site. We found statistically significant differences in percentage of community members who reported a high sense of safety and well-being in the community; having heard the term GBV, in those who report benefits of seeking help for survivors of SV, and in those who report available services for people who experience GBV or SV. The sense of safety and well-being in the community was higher in the comparison site (67.05%) than in the intervention site (63.5%) ($p<0.10$). Less than half of the participants have heard the term GBV in both sites (47.48% in the intervention site and 36.93% in the comparison site) ($p<0.01$). When asked about the benefits of accessing care or services when someone has experienced SV, more participants in the intervention site (72.4%) reported at least one benefit compared to participants in the comparison site (62.78%) ($p<0.01$).

The larger statistically significant differences between sites were the percentage of participants who reported knowing of any service available in the community that can provide support to someone who has experienced GBV. A higher percentage of participants in the intervention site (44.21%) compared to those in the comparison site (26.7%) reported knowing of any service available in the community that can provide support to someone who has experienced GBV ($p<0.01$). Finally, we asked participants if they knew of any available service in the community that could provide support if someone experienced SV. Over a third (37.39%) of participants in the intervention site reported knowing at least one service, in comparison to less than a quarter (23.86%) of participants in the comparison site ($p<0.01$).

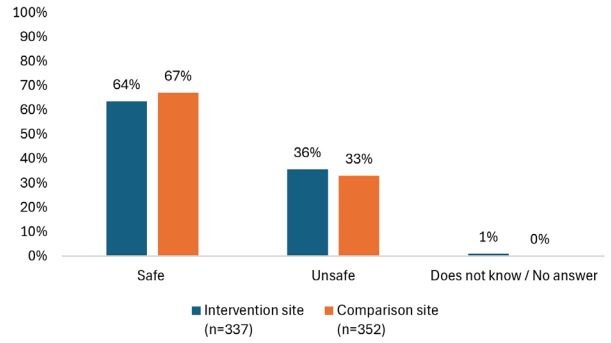
The mean score of the attitudes toward accessing services scale in the comparison site was 1.88, which was slightly higher than the mean score in the intervention site (1.86), which suggests that community members in the comparison site have a higher support for survivors of GBV accessing services compared to those in the intervention site. The internal consistency (Cronbach's alpha) of this scale was 0.75 in the intervention site and 0.79 in the comparison site.

The second sub-scale (attitudes toward accessing services) had four items (questions H-K), each of them with three possible answers: no response (99 –recoded to missing), disagree (01), and agree (02). To score the scale we added the participants' answers (maximum possible score of 8 if they answered all four questions) and divided this into the number of items answered. The scale score had a minimum score of one and a maximum score of two, where a higher score means higher support for survivors of GBV accessing services.

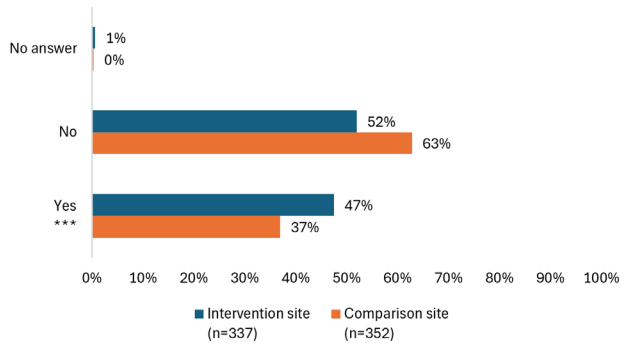
The complete scale (including the 11 items) and the first sub-scale (attitudes toward GBV) yielded a poor Cronbach's alpha across all subgroups, meaning poor internal consistency—or reliability—of the scale. However, the second sub-scale (attitudes toward accessing services) yielded an acceptable Cronbach's alpha in all sub-groups as it exceeded a Cronbach's alpha of 0.70 (Revicki, 2014). Across all subgroups the score ranged between 1.85 and 1.89. We report results for the second sub-scale only.

Figure 15. Key outcomes (by site)

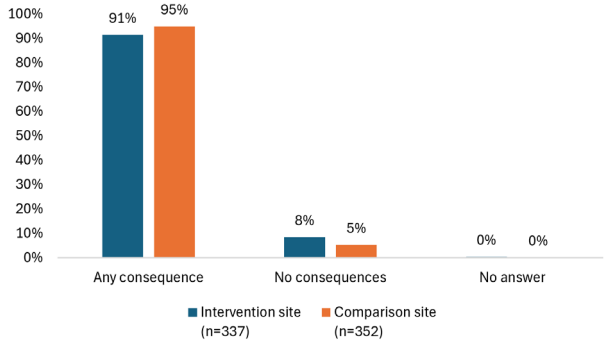
Community member's sense of safety and well-being



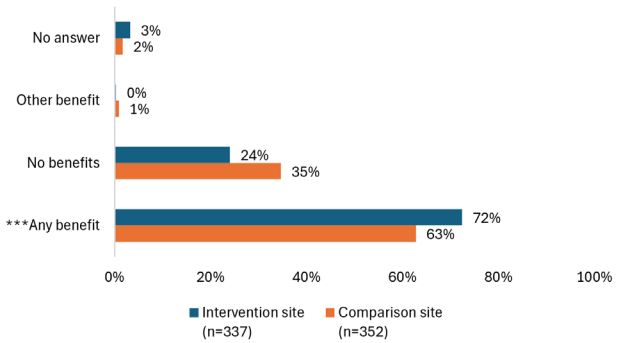
Percentage of community members who report awareness of GBV



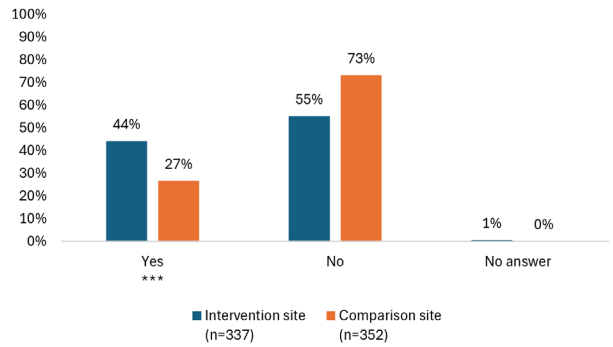
Percentage of community members who report knowledge about the consequences of SV



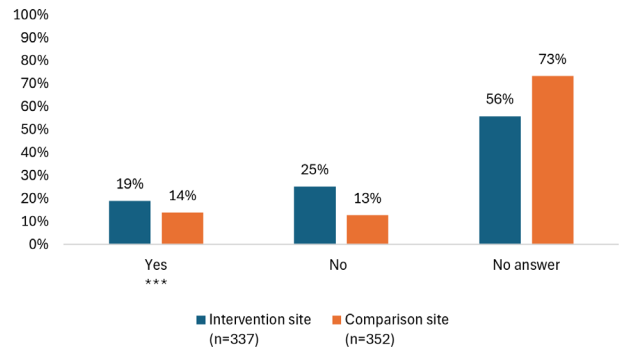
Percentage of community members who report knowledge about the benefits of seeking help for survivors of SV



Percentage of community members who report knowledge about the available services in the community if a person experiences GBV



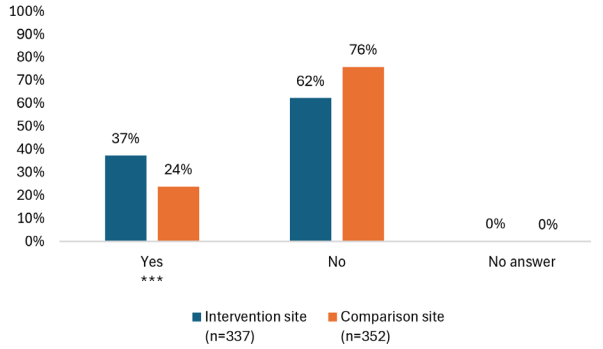
Percentage of community members who have accessed any of the available services in their community



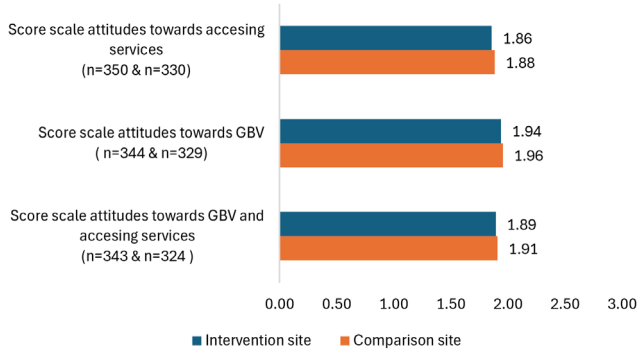
Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

Figure 15. Key outcomes (by site)

Percentage of community members who report knowledge about the available services in the community if a person experiences sexual violence



Attitudes toward GBV and accessing services



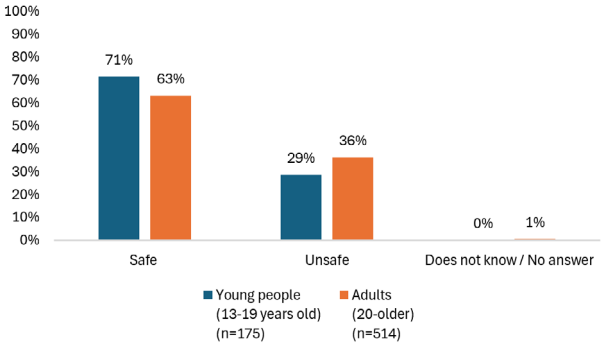
Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

By age

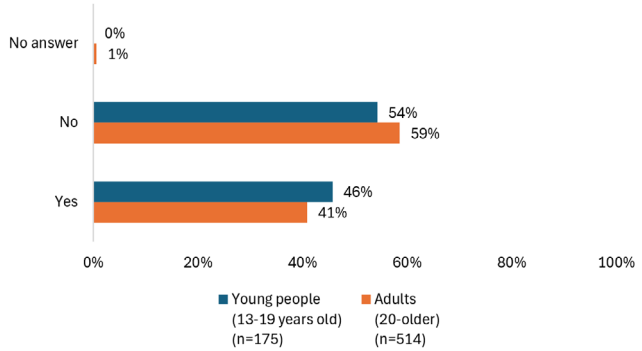
Figure 16 shows the main outcomes by age. When comparing by age we did not find significant differences in any of the outcomes. The mean score of the attitudes toward accessing services scale in young people was 1.88, which was slightly less than the mean score of adults (1.87). The Cronbach's alpha of this scale was 0.71 in young people and 0.78 in adults.

Figure 16. Key outcomes (by age)

Community member's sense of safety and well-being



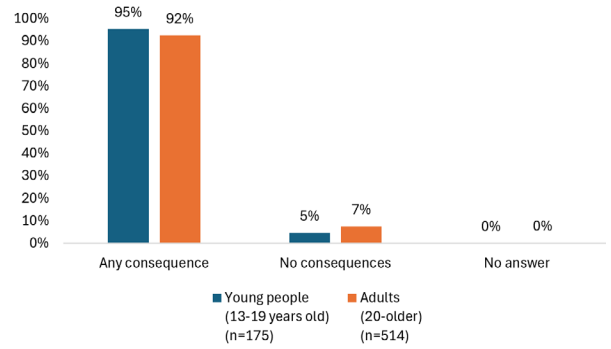
Percentage of community members who report awareness of GBV



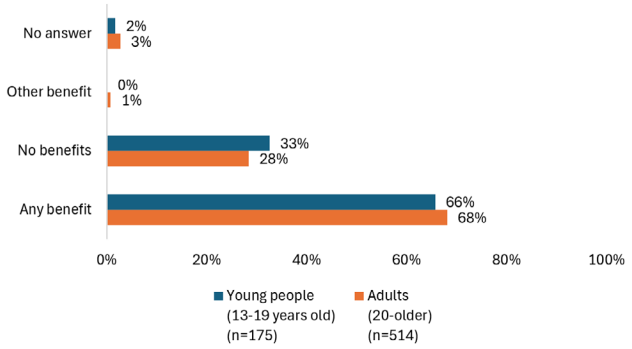
Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

Figure 16. Key outcomes (by age)

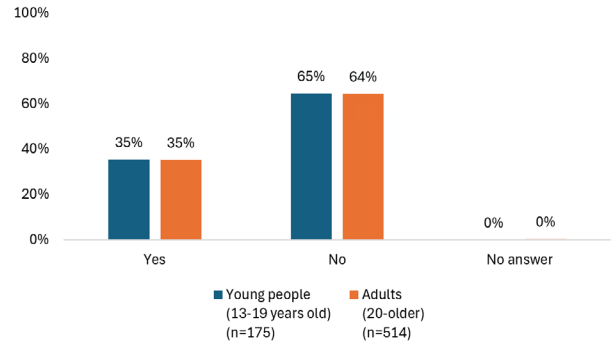
Percentage of community members who report knowledge about the consequences of SV



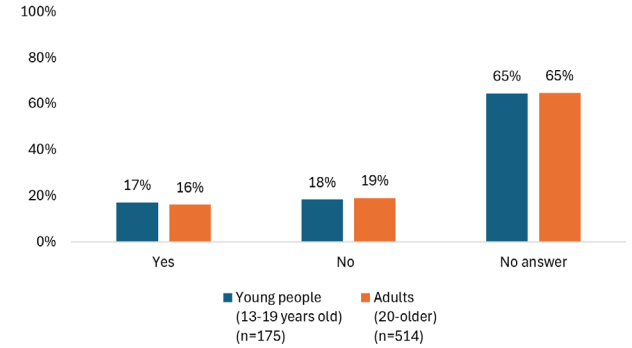
Percentage of community members who report knowledge about the benefits of seeking help for survivors of SV



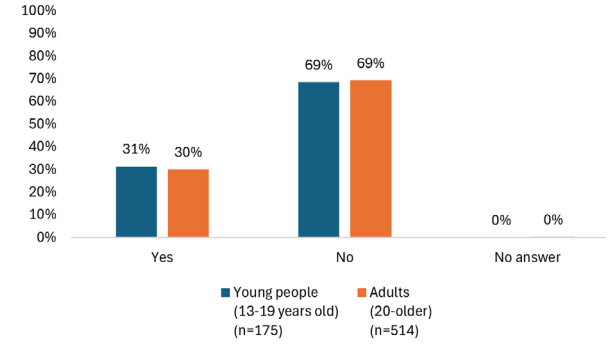
Percentage of community members who report knowledge about the available services in the community if a person experiences GBV



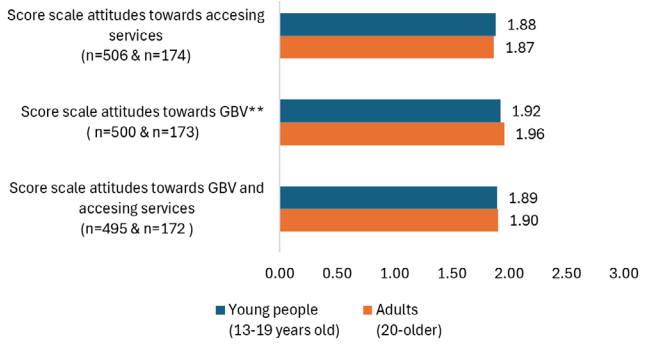
Percentage of community members who have accessed any of the available services in their community



Percentage of community members who report knowledge about the available services in the community if a person experiences sexual violence



Attitudes toward GBV and accessing services



Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

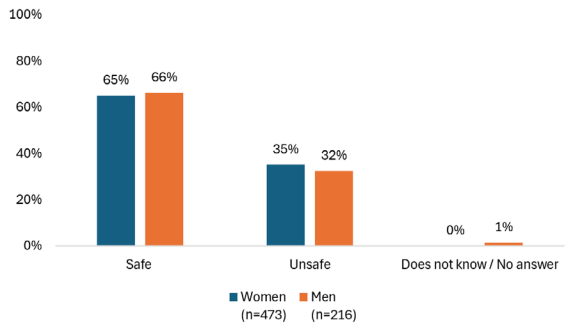
By sex

Figure 17 (page 28) shows the main outcomes by sex (female and male). We found statistically significant differences in the results of the outcomes: percentage of community members who report knowledge about the available services in the community if a person experiences a) GBV and b) SV, in the percentage of participants who have accessed GBV services, and in the sense of

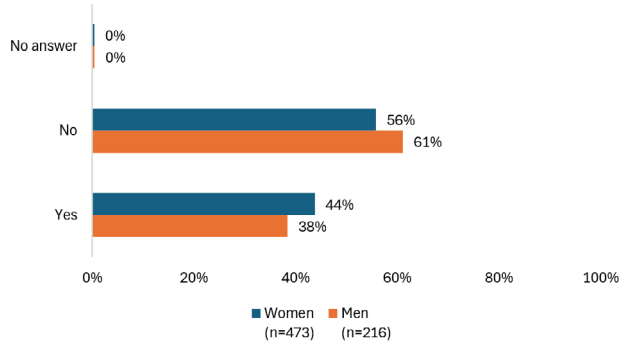
security and well-being. Overall, more female participants reported knowing any service available in the community that can provide support in case of GBV (38.48% female vs. 28.24% male) ($p<0.05$), and reported knowing services available to support people who have suffered SV (34.04% female vs. 22.69% male) ($p<0.01$). Women had slightly higher scores in the attitudes toward accessing services scale (1.88 in women vs. 1.85 in men), meaning higher support from female participants for GBV survivors accessing services. The Cronbach's alpha of this scale was 0.77 among female participants and 0.76 among male participants.

Figure 17. Key outcomes (by sex)

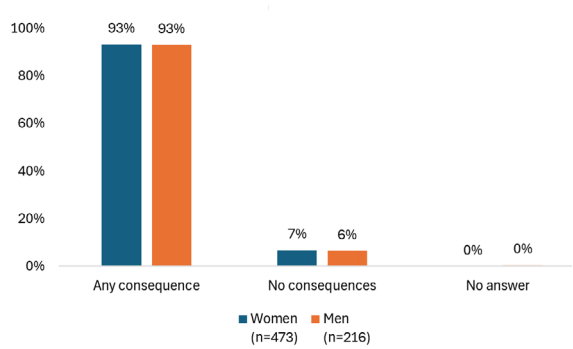
Community member's sense of safety and well-being



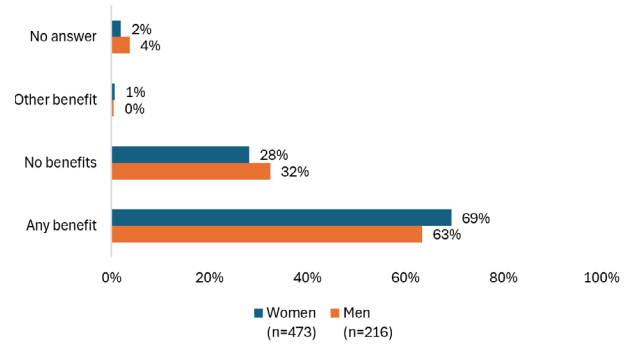
Percentage of community members who report awareness of GBV



Percentage of community members who report knowledge about the consequences of SV



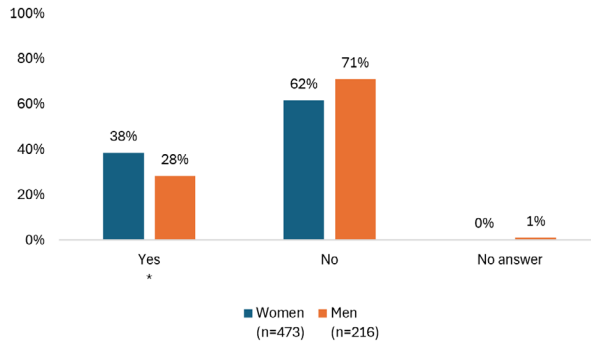
Percentage of community members who report knowledge about the benefits of seeking help for survivors of SV



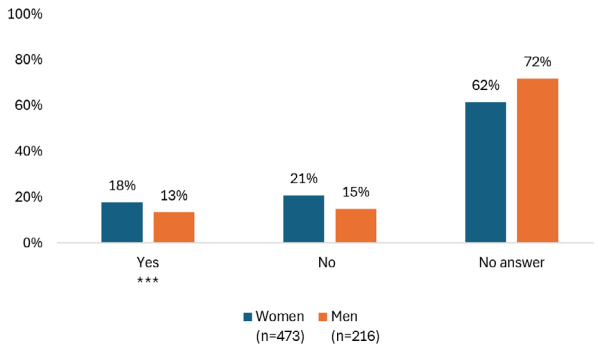
Statistical significance of tests for differences by sites * $p<0.10$, ** $p<0.05$, ***$p<0.01$

Figure 17. Key outcomes (by sex)

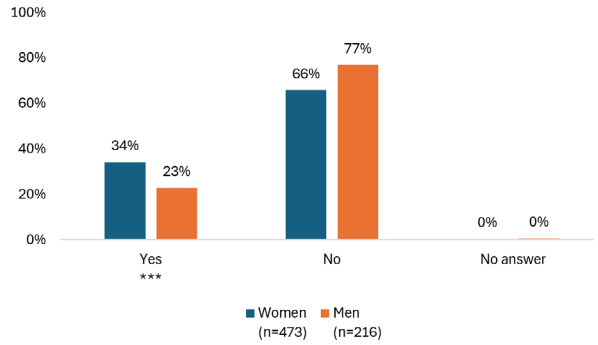
Percentage of community members who report knowledge about the available services in the community if a person experiences GBV



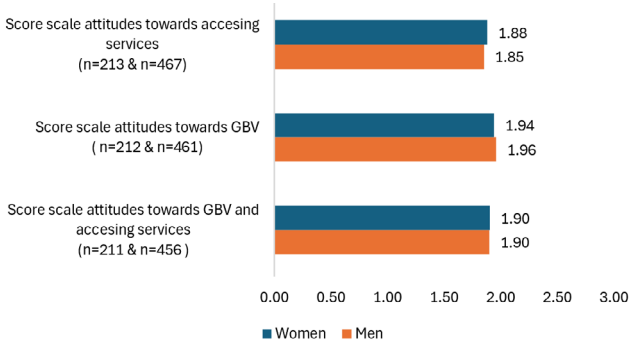
Percentage of community members who have accessed any of the available services in their community



Percentage of community members who report knowledge about the available services in the community if a person experiences sexual violence



Attitudes toward GBV and accessing services



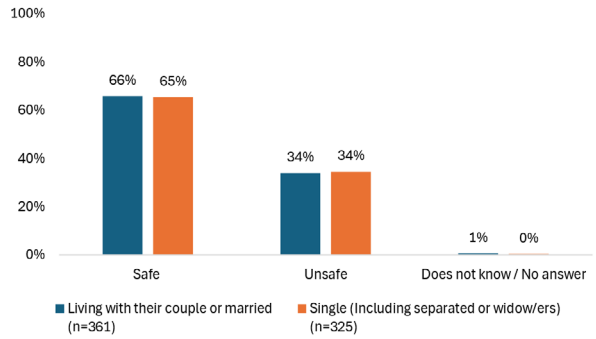
Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

By relationship status

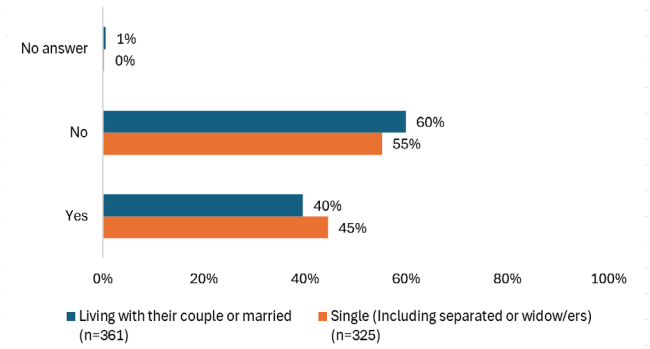
Figure 18 (page 29) shows the main outcomes by relationship status, comparing participants who live with their partners (regardless of the time they have been living together) or who are married, to single people (including those single, separated, or widowed). We did not find significant differences in any of the outcomes. The mean score of the attitudes toward accessing services scale was the same for participants who live with their partner and for single participants (1.87). The Cronbach's alpha of this scale was 0.78 in the first sub-group and 0.76 in the second one.

Figure 18. Key outcomes (by relationship status)

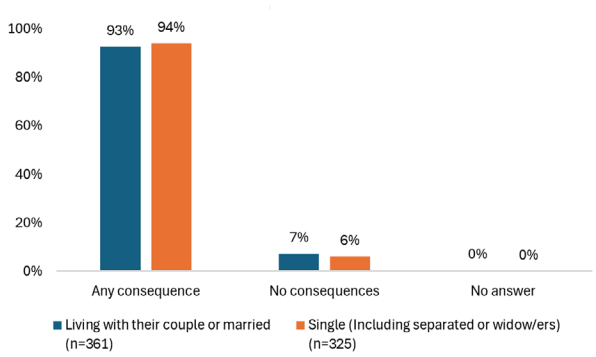
Community member's sense of safety and well-being



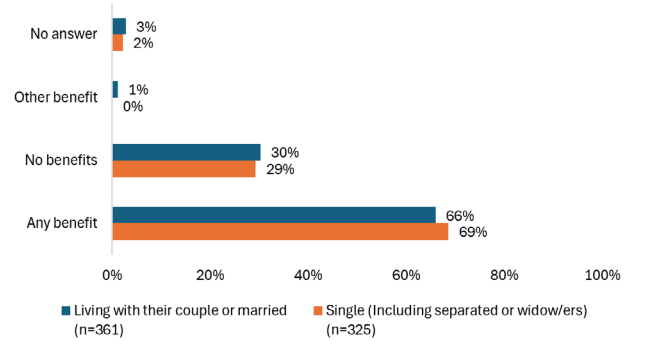
Percentage of community members who report awareness of GBV



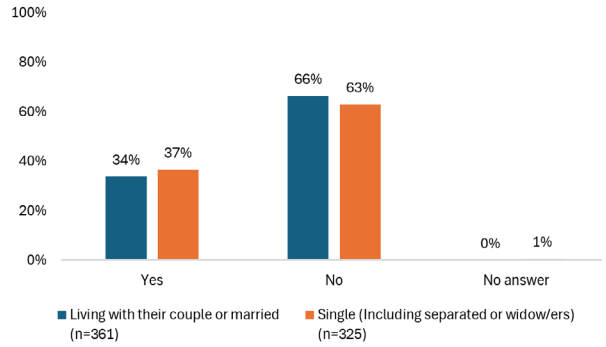
Percentage of community members who report knowledge about the consequences of SV



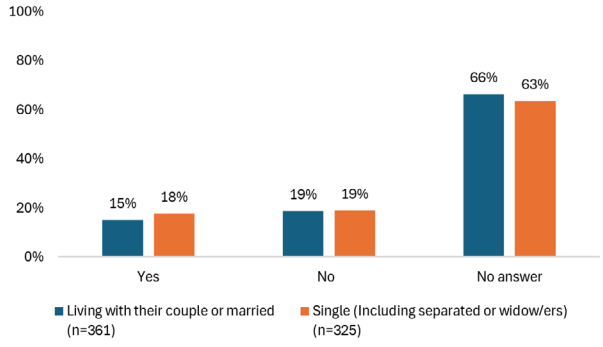
Percentage of community members who report knowledge about the benefits of seeking help for survivors of SV



Percentage of community members who report knowledge about the available services in the community if a person experiences GBV



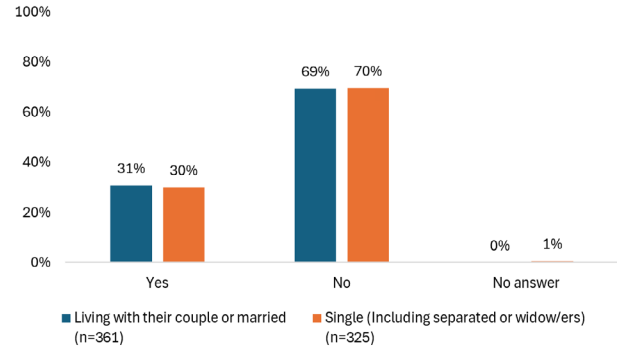
Percentage of community members who have accessed any of the available services in their community



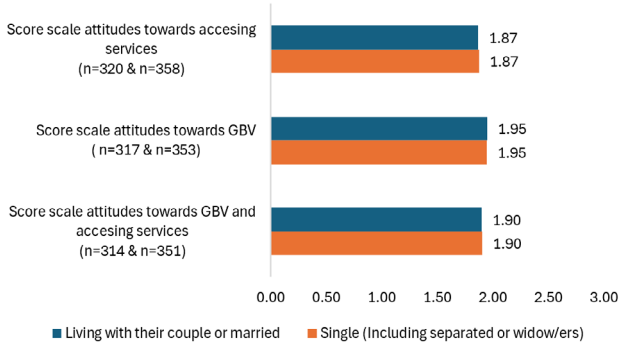
Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

Figure 18. Key outcomes (by relationship status)

Percentage of community members who report knowledge about the available services in the community if a person experiences sexual violence



Attitudes toward GBV and accessing services



Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

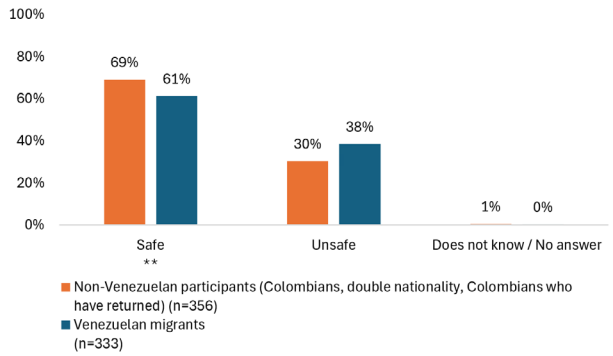
By migration status

Figure 19 shows the main outcomes by migration status, comparing Venezuelan migrants to non-Venezuelan participants (i.e., Colombian population, people with double nationality, and Colombian citizens who have returned to the country). We found statistically significant differences in two outcomes: the sense of safety and well-being in the communities, and the percentage of participants who have heard the term GBV. The sense of safety and well-being in the community was higher among non-Venezuelan participants (69.1%) compared to Venezuelan migrants (61.3%) (p<0.05). A higher percentage of Venezuelan migrants reported having heard the term GBV in the past (46.3%) as opposed to non-Venezuelan participants (38.2%) (p<0.10)

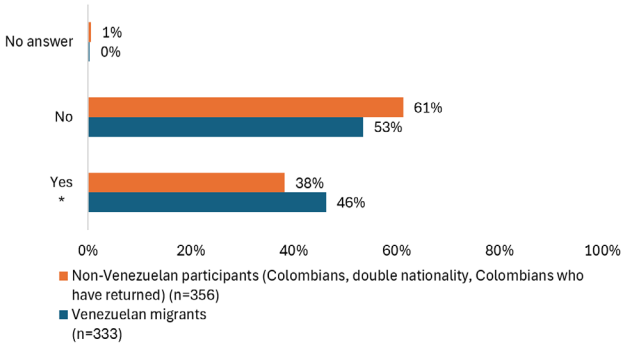
The mean score of the attitudes toward accessing services scale was higher in Venezuelan migrants (1.89) than in non-migrants (1.85) (p<0.10). The internal consistency (Cronbach's alpha) of this scale was also higher in Venezuelan migrants (0.81) than in non-migrants (0.73).

Figure 19. Key outcomes (by migration status)

Community member's sense of safety and well-being



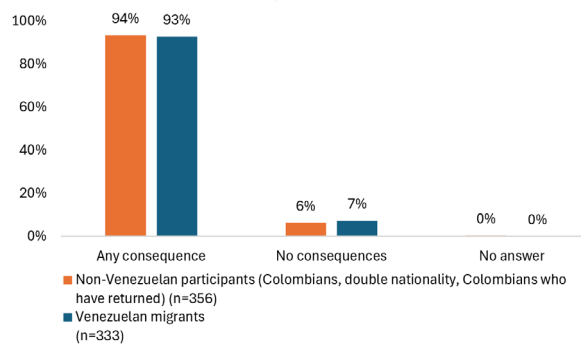
Percentage of community members who report awareness of GBV



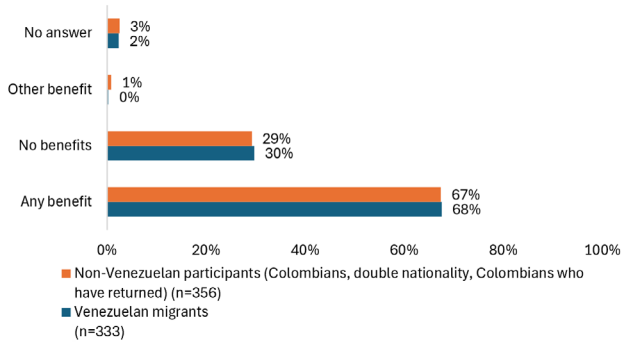
Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

Figure 19. Key outcomes (by migration status)

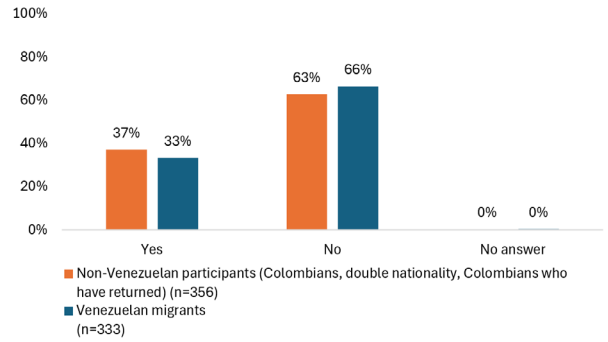
Percentage of community members who report knowledge about the consequences of SV



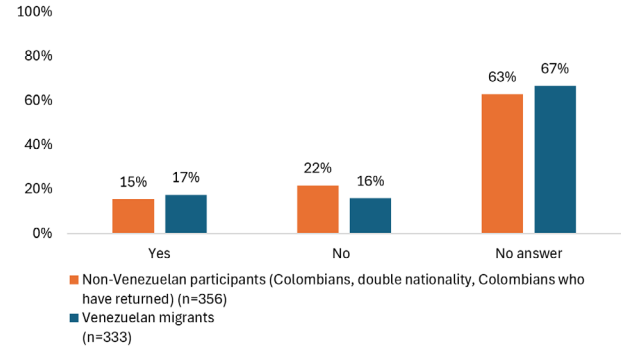
Percentage of community members who report knowledge about the benefits of seeking help for survivors of SV



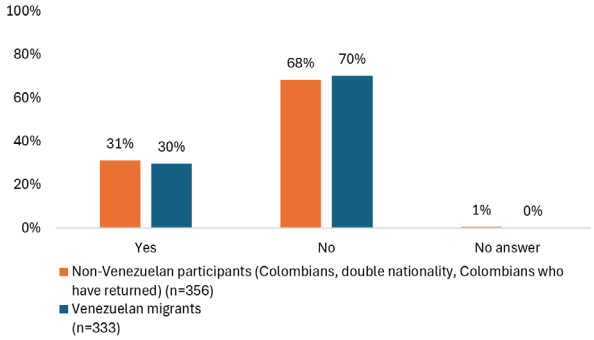
Percentage of community members who report knowledge about the available services in the community if a person experiences GBV



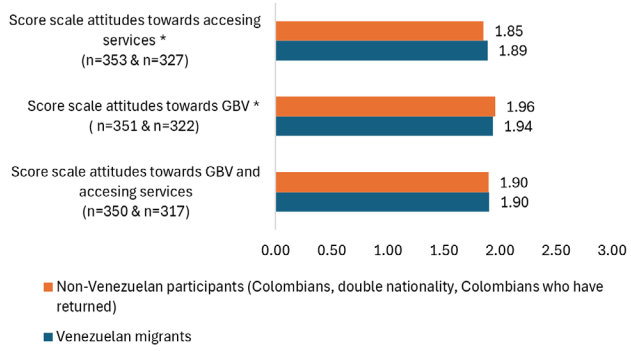
Percentage of community members who have accessed any of the available services in their community



Percentage of community members who report knowledge about the available services in the community if a person experiences sexual violence



Attitudes toward GBV and accessing services



Statistical significance of tests for differences by sites * p<0.10, ** p<0.05, ***p<0.01

Community leaders' capacity to respond to SV

In general, the community leaders interviewed across sites self-reported very high scores when asked about their capacity to respond to cases of SV in their community. Overall, community leaders in the comparison site self-reported a higher capacity to respond to cases of SV in their community than those in the intervention site. In the intervention site, the average leader rating was 7.3; the

highest score reported was 10 and the lowest was 5. In the comparison site, the average leader rating was 7.9; the highest score given was 10 and the lowest was 4. Leaders who self-assessed themselves with high scores explained they have received training on gender issues, and are very interested in the issue. In addition, they try to address the needs or issues community members communicate to them. Leaders who self-reported low scores expressed that they needed additional training as they consider they lack knowledge on many relevant topics that would help them address SV in their community.

Discussion

In this section, we focus on four main takeaways about attitudes toward gender equality, perceptions of SV and GBV, access to services, and the perceived benefits and risks of seeking help in two settlements located in Uribia, La Guajira. First, participants from both sites demonstrated mixed attitudes toward gender-equitable norms. Participants across sites exhibited rich and nuanced perspectives on equality, showing a preference for gender equality and equal intimate relationships overall, but a distribution of household chores that align with gender-inequitable norms. Second, while there is consensus on the definition of SV, understandings of GBV vary and there are contrasting perspectives regarding its prevalence, with some individuals perceiving GBV as highly common while others consider it to be uncommon. Third, there appears to be a lack of clarity in both communities about which SV and GBV services are available or where to find them. Fourth, participants most frequently cited receiving referral services and medication to prevent pregnancy as benefits of seeking help for SV. Shame, reputational damage, fear of partner violence, and legal consequences were the most frequently mentioned risks associated with seeking help for SV. These four key themes are discussed below alongside implications for the design of the *Communities Care* intervention.

Mixed attitudes toward gender-equitable norms

Findings indicate mixed attitudes toward gender-equitable norms among community members. While qualitative data indicates that gender inequality and gendered power dynamics are norms in the community, quantitative data indicates that community members have positive attitudes toward gender equality within intimate relationships. Qualitative data across sites indicates that community members are expected to fulfill roles that are dictated by gendered expectations about how men and women should behave in the community. For example, men are expected to be the primary decision-makers and income generators in the household. Qualitative data revealed that key positions of power in the community, such as the presidency of the Community Action Board and other leadership roles, are typically held by men. In contrast, women are responsible for all matters related to the household (e.g., caretaking, household chores). Further, Wayuu participants indicated that women were also expected to contribute financially to the household. According to Wayuu participants, non-compliance with these gender roles was perceived as a form of violence toward one's family or close others and was most often punishable by psychological or physical violence.

Despite qualitative data that illustrates community members' adherence to inequitable gender norms, findings from the GEM scale demonstrate that, overall, participants had positive attitudes toward gender equality in intimate relationships. The mean GEM score in both communities was below 3, which is the highest score in gender-equitable attitudes under this measure. Participants from the comparison site had higher gender-equitable attitudes in this domain compared to those

in the intervention site, as well is in the domain of *reproductive health and disease prevention*, and *household chores and daily life elements*. Participants across both sites had similar attitudes in the domain of *violence.* The lowest score across the four domains was the *household chores and daily life elements* domain (the intervention site 1.73 and the comparison site 1.84).

Recommendations for the *Communities Care* intervention

- Prevention programming should focus on gender-transformative activities to promote more equitable gender norms among community members to address the underlying driver of SGBV in the community-gender inequality.
    - Activities should work toward transforming unequal power relations and systematic discrimination against women and girls.
    - Activities should engage male and female community members and address dominant patriarchal norms, especially in the domestic sphere, such as that men are the primary decision-makers in the home, while women are responsible for household chores.
    - Activities can ensure accountability to women and girls by consulting CAB members and adolescents themselves to elicit input on the design and content of activities.

Higher level of knowledge about SV than GBV

The quantitative and qualitative data illustrate that awareness of GBV and SV definitions is a nuanced issue across communities and subgroups. On the one hand, in the survey, less than half of all participants responded that they knew the term GBV, while slightly more participants stated that they were aware of what SV means. There were statistically significant differences between communities: more participants in the intervention site reported knowledge of the term GBV and SV, and more females than males had heard these terms. These differences may be due to a reluctance to discuss these topics in public and could be partially explained by a stronger presence of GBV-focused NGOs in the intervention site than in the comparison site. Moreover, during FGDs, some participants across subgroups and communities stated that they did not know what GBV is. Nevertheless, other participants, who stated having heard the term, presented diverse definitions of GBV. A core notion was the idea of GBV as "mistreatment," which can be directed at women, men, children, the LGBTQI+ community, Venezuelan migrants, or anyone in the community. In both sites, GBV was also understood as a concept that encompasses different types of violence: psychological, physical, economic, verbal, and sexual. In the survey, where specific answer options were provided and participants could select more than one option, most participants responded that GBV was a type of violence that has to do with any harmful act against the will of a woman or girl, or of a person motivated by the condition of being a woman or being a man, physical harm, mental or psychological harm, and sexual harm or suffering. For most participants threats and/or intimidation fall within the definition of GBV.

In contrast to GBV, there was consensus across all subgroups regarding the definition of SV. Particularly, participants of all ages and genders stated that they understood the term and referred to SV as forced sex, rape, or sex without consent. In the survey, most participants identified consequences of SV. Most participants in both communities agreed that unwanted pregnancies were the most common consequence of SV (67.95% in the intervention site vs. 73.3% in the comparison site). Only one participant reported that SV does not have any consequences.

Regarding the subjective estimates of GBV and SV frequency, the survey revealed that most participants in both sites do not consider GBV to be common in their communities. Overall, over 65% participants responded that psychological violence against adolescent girls or boys or men, physical

violence against adolescent girls or boys or men, or SV against adolescent girls or boys or men were not common. In stark contrast, the qualitative data from all subgroups yielded extensive conversations about the high frequency of GBV and SV in their communities and detailed descriptions of cases participants knew about. Given available data about GBV and SV in humanitarian settings (Vu et al., 2014; Norwegian Red Cross and ICRC, 2022; Stark, Seff, and Reiss, 2021), it is surprising that survey participants responded that SV and GBV are not common in their communities. This is a phenomenon worth exploring in future studies and highlights the importance of accompanying quantitative instruments with qualitative data collection, the latter allowing for a deeper and more nuanced understanding of topics that are taboo or carry any stigma in the community.

Lastly, the majority of survey participants stated that violence against women, girls, men, children and LGBTQI+ people is not acceptable. When asked about the acceptability of violence against men, more participants in the comparison site disagreed with this statement (92.58% the intervention site vs. 96.02% the comparison site) ($p<0.10$) when compared to the intervention site. Regarding violence against LGBTQI+ people, more participants from the intervention site agreed that it is acceptable under certain circumstances (11.87% the intervention site vs. 7.95% the comparison site) ($p<0.10$). Although the LGBTQI+ population is recognized as also being at risk of GBV, this population was not the focus of the discussions in the FGDs.

Recommendations for the *Communities Care* intervention

- Community awareness activities should consult CAB members to create key messages and develop community activities tailored to community members according to their age, gender, migration status, and ethnicity, among other diversity factors.
    - Activities should enhance community members' knowledge about the different types of GBV, including SV, in addition to causes and consequences.
    - Information about SGBV should clarify misconceptions about GBV, including SV, while respecting and acknowledging the participants' perspectives, shaped by personal and contextual histories. The project team should actively explore participants' interpretations of these terms and tailor activities accordingly, fostering a collaborative approach.
    - Activities should address stigma associated with GBV, including SV, including engaging men to challenge their understanding of who can be a survivor to dismantle stigma and shame associated with being a male survivor.
    - Project staff should collaborate with any existing LGBTQI+ civil society organizations or informal groups to develop advocacy campaigns to promote gender-equitable norms and dismantle patriarchal norms that perpetuate homo-, trans-, and queer-phobia.

Conflicting findings regarding availability of GBV and SV services and access

Study findings indicate conflicting knowledge of available GBV and SV services among participants. On the one hand, more than half of the survey participants reported not knowing of any available services in the community if a person experiences GBV (55.19% the intervention site vs. 73.3% the comparison site) ($p<0.01$). Similarly, most participants across sites reported not knowing of any SV-related service in their communities (62.31% the intervention site vs. 75.85% the comparison site) ($p<0.01$). On the other hand, participants in FGDs mentioned specific sites, such as NGO offices, in which community members could receive GBV- and SV-related information and services. In the intervention site, for example, different subgroups stated the importance of community leaders' households, as well as their own family homes, to seek help after experiencing SV. In the comparison site, participants identified many NGOs that provide GBV and SV assistance or information. In the

intervention site, far fewer NGOs were identified by participants. This could indicate that in the comparison site there has been a greater number of interventions by NGOs. This discord in findings across methods may be attributed to the design of the data collection instrument. The survey did not ask participants where community members seek help after experiencing SV, but rather where they could access these services. Family or community leaders were not listed as response options on the survey. Notwithstanding, the FGDs revealed that GBV is generally perceived as a private or family issue that should be addressed within the home or at the community level.

Approximately two-thirds of KAP survey participants reported that they accessed programs or services related to GBV in the past year (68.75% the intervention site vs. 63.27% the comparison site). Also, more than one-third of participants in both sites stated that their communities provide SV services through education (51.59% the intervention site vs. 48.81% the comparison site) and medical assistance (42.06% the intervention site vs. 33.33% the comparison site. As mentioned above, FGD participants shared the names of NGOs and other GBV service providers in the community in addition to informal support systems (eg., family, community leaders); however, participants across all sites and subgroups also mentioned that services and information about GBV and SV did not exist in their communities. Key barriers in accessing these services mentioned by participants included being part of a vulnerable group (children, older adults, and people with disabilities), only speaking Wayuunaiki and therefore not being able to read and write in Spanish, and not being interested in these topics. In the intervention site, the analysis by subgroup suggests that men centralize the barriers as lack of interest in the topic, low schooling, and lack of available GBV and SV services, whilst women, in addition to mentioning these barriers, also mentioned fear, shame, age, and Wayuu law as key barriers.

Recommendations for the *Communities Care* intervention

- *SGBV prevention activities*
    - Project staff should conduct a mapping of the available institutional services and support available for GBV survivors in the community to update the GBV referral pathway, which should be shared with community members during community awareness activities as confidential, quality, and safe services that can complement existing informal support networks (e.g., family members, community leaders).
    - Community awareness activities should enhance community members' knowledge about where to access SV care and the importance of seeking timely SV care, including medical and psychosocial care.
    - Activities should engage family members and community leaders in culturally relevant activities, such as weaving and storytelling, to transform their perceptions and attitudes towards GBV and promote service seeking behavior to improve community members' access to timely medical and psychosocial care, among other services (e.g., legal aid, shelter, child protection, livelihoods).
    - CHWs conducting household visits should build trust and rapport with household members by first discussing non-stigmatized issues that are most relevant to them. GBV, including SV, should not be discussed with mixed couples to prevent potential safety risks.
- *SGBV response activities*
    - Project staff should coordinate referrals with existing services addressing GBV and SV, such as child protection services, health facilities, and other service providers delivering legal aid, food, shelter, livelihoods, and education, among others.

- CHWs should be trained to manage disclosures of GBV during household visits and community awareness activities, including for adolescents under 18 years, and be equipped with the appropriate resources and tools to provide confidential, quality, timely referrals.

Consequences of SV and benefits of seeking care

Participants across research methods reported several benefits and risks associated with seeking help in cases of SV. The most reported benefits of seeking care for SV survivors among survey participants were receiving referral services (55.19% in the intervention site vs. 46.88% in the comparison site) ($p<0.05$) and receiving medication to prevent pregnancies (43.62% in the intervention site vs. 35.8% in the comparison site) ($p<0.05$). Overall, more participants from the intervention site reported benefits. Additionally, more participants from the comparison site expressed that there are no benefits of seeking help (34.66 in the comparison site vs. 24.04% in the intervention site) ($p<0.01$). The most frequently reported risks associated with seeking helping in cases of SV included shame and tarnished reputation. More participants in the intervention site than in the comparison site reported other risks such as cost, fear of the partner finding out / fear of violence, and fear of legal consequences.

Recommendations for the *Communities Care* intervention

- *SGBV prevention activities* should address modifiable risks and manage non-modifiable risks of seeking care for SV.
  - Community level and household activities (when appropriate) should provide information about the benefits of seeking timely care after SV using verbal messaging and information, education, and communication (IEC) materials presented in Spanish and Wayuunaiki.
  - Community awareness raising activities should convene subgroups of community members (e.g., adolescent girls, adolescent boys, adult men, and adult women) to deliver tailored messaging to address the unique and overlapping barriers to accessing SV care, emphasizing accurate information about confidentiality and cost of services.
- *SGBV response activities*
  - Project staff should engage GBV and child protection service providers, and other GBV referral service providers, to ensure that services are confidential and survivor-centered.
  - CHWs should be equipped to identify survivors in all their diversity, including adolescents, people living with disabilities, and people who only speak Wayunaikii.
  - CHWs should be trained to provide multi-sectoral referral services (e.g., legal aid, shelter, food, livelihoods, medical, and psychosocial) according to the needs and preferences of the survivor.

Study limitations

A few limitations to the baseline study exist. First, some participants spoke Wayunaaiki only, which required a translator and later transcription and translation into Spanish. Therefore, human error in translation may have occurred which affected the research team's interpretation of the data. The team mitigated this risk by hiring trained translators that are also part of the Wayuu community with experience participating in data collection activities about sensitive topics, such as GBV and SV. A second limitation of this study pertains to the effect of using pre-determined concepts such as GBV and SV in the survey instrument. Participants sometimes interpret, understand, define, and label concepts differently within their cultural context. This variance in understanding may have contributed to challenges in effective communication and mutual comprehension during the data

collection process and therefore potentially influencing the accuracy of analysis. To mitigate this risk, qualitative data collection was carried on through focus groups and interviews. Qualitative instruments were designed to explore participants' definitions of GBV and SV concepts in depth and giving them space to convey their understandings of GBV and SV in their own terms. Lastly, the accuracy of this study could be affected by the specific migration phenomenon presented in La Guajira, where the intervention site and the comparison site are located. After all, the historic presence of Wayuu people in this region in conjunction with the crisis in the nearby country Venezuela accounts for a constant changeability in the population of the two sites (Consuegra, 2022).

Conclusion

Overall, participants in both sites had comparable demographics and socio-economic characteristics at baseline. Age, languages spoken, marital status and living with a disability will be controlled for in the endline analysis given that they had statistically significant differences across the two sites. Participants from the intervention site and the comparison site demonstrated rich and nuanced perspectives on GBV and, to a greater extent, SV and gender equality. However, their perspectives regarding distribution of household chores aligned more closely with traditional gender roles and qualitative data illustrates that gender inequality, GBV, and SV, particularly IPV, are nonetheless community norms. A consensus on the definition of SV existed among participants, while understandings of GBV varied. Knowledge about which SV and GBV services were available or where to access them varied across participants, with some reporting no SGBV-related services available in their communities. Access to SV and GBV services was perceived as challenging among participants, particularly for children, older adults, people with disabilities, and community members who only spoke Wayuunaiki. Participants frequently indicated that receiving referral services and medication to prevent pregnancy were the most common benefits of seeking help for SV. Shame, reputational damage, fear of partner violence, and undesired legal consequences were the most frequently cited risks for seeking help for SV among participants. This characteristics from both the community that will receive the *Communities Care* intervention and the comparison site at baseline will inform evidence-based planning and implementation and serve as a basis for the M&E of the program in the near future.

References

Ascanio, Adriana C.C. 2022. "Changes in the cross-border mobility of the Wayúu people in the context of the Venezuelan crisis". *Jangwa Pana* 21 (2): 107-122. https://doi.org/10.21676/16574923.4594.

Braun, Virginia & Victoria Clarke. 2021. *Thematic Analysis: A Practical Guide*. London: SAGE Publications Ltd.

Call to Action on Protection from Gender-Based Violence in Emergencies. 2020. "Call to Action on Protection from Gender-Based Violence in Emergencies: Road Map 2021-2025".https://reliefweb.int/report/world/call-action-protection-gender-based-violence-emergencies-road-map-2021-2025.

Drewnowski, Adam. 2022. "Food insecurity has economic root causes". *Nature Food 3* (8): 555-556. https://doi.org/10.1038/s43016-022-00577-w.

Glass, Nancy, Nancy Perrin, Amber Clough, Amelie Desgroppes, Francesco N. Kaburu, Jaela Melton, et al. 2018. "Evaluating the communities care program: best practice for rigorous research to evaluate gender based violence prevention and response programs in humanitarian settings". *Conflict and Health* 12 (5). https://doi.org/10.1186/s13031-018-0138-0.

Glass, Nancy Nancy Perrin, Mendy Marsh, Amber Clough, Amelia Desgroppes, Francesco Kaburu, et al. 2019. "Effectiveness of the Communities Care programme on change in social norms associated with gender-based violence (GBV) with residents in intervention compared with control districts in Mogadishu, Somalia". *BMJ open* 9 (3). https://bmjopen.bmj.com/content/bmjopen/9/3/e023819.full.pdf.

Holmes, Rebecca and Dharini Bhuvanendra. 2014. "Preventing and responding to gender-based violence in humanitarian contexts". Humanitarian Practice Network 77. https://assets.publishing.service.gov.uk/media/57a089b2ed915d3cfd0003a8/GBV_in_emergencies_NP_77_web.pdf.

Horn, Rebecca. 2010. "Responses to intimate partner violence in Kakuma refugee camp: refugee interactions with agency systems". *Social Science & Medicine 70* (1): 160–168. https://doi.org/10.1016/j.socscimed.2009.09.036.

International Organization for Migration. 2021. "Venezuela Regional Response — Gender-based Violence and Risk Factors for Migrant and Refugee Women from Venezuela during the Migration Journey". https://reliefweb.int/report/colombia/venezuela-regional-response-gender-based-violence-and-risk-factors-migrant-and.

International Rescue Committee. 2015. "Meeting their needs: Results from a Knowledge, Attitudes and Practices (KAP) Survey on Gender Based Violence and Reproductive Health in the Mafraq and Irbid Governorates, Jordan". https://data.unhcr.org/en/documents/details/70981.

Ivanova, Olena, Masna Rai and Elizabeth Kemigisha. 2018. "A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa". *International Journal of Environmental Research and Public Health 15*(8): 1583. https://doi.org/10.3390/ijerph15081583.

Kohli, Anjalee, Maphie T. Makambo, Paul Ramazani, Isaya Zahiga, Biki Mbika, Octave Safari, et al. 2012. "A Congolese community-based health program for survivors of sexual violence". *Conflict and Health* 6 (6). https://doi.org/10.1186/1752-1505-6-6.

Ministerio de Salud y Protección Social. 2016. "Perfil de Salud de la Población Indígena, y medición de desigualdades en salud". https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/PSP/Perfil-salud-pueblos-indigenas-colombia-2016.pdf.

National Administrative Department of Statistics. 2020. "La información del DANE en la toma de decisiones de los departamentos: La Guajira". https://www.dane.gov.co/files/investigaciones/planes-desarrollo-territorial/050220-Info-Gobernacion-La-Guajira.pdf.National Administrative Department of Statistics. 2021. "Informes de Estadística Sociodemográfica Aplicada: Información sociodemográfica del pueblo Wayúu". https://www.dane.gov.co/files/investigaciones/poblacion/informes-estadisticas-sociodemograficas/2021-09-24-Registro-Estadistico-Pueblo-Wayuu.pdf.

Norwegian Red Cross and International Committee of the Red Cross. 2022. ""That never happens here": Sexual and gender-based violence against men, boys and/including LGBTQI+ people in humanitarian settings". https://reliefweb.int/report/world/never-happens-here-sexual-and-gender-based-violence-against-men-boys-andincluding.

Polis, Chelsea B., David A. Grimes, Kate Schaffer, Kelly Blanchard, Anna Glasier, Cynthia Harper. "Advance provision of emergency contraception for pregnancy prevention (full review)". 2007. *The Cochrane Database of Systematic Reviews* (2). https://doi.org/10.1002/14651858.CD005497.pub2.

Revicki, Dennis. 2014. "Internal Consistency Reliability". In: *Encyclopedia of Quality of Life and Well-Being* Research, edited by Alex C. Michalos, 3305-06. Dordrech: Springer. https://doi.org/10.1007/978-94-007-0753-5_1494.

Stark, Lindsay, Ilana Seff and Chen Reis. 2021. "Gender-based violence against adolescent girls in humanitarian settings: a review of the evidence". *The Lancet: Child and Adolescent Health* 5 (3): 210-222. https://doi.org/10.1016/S2352-4642(20)30245-5.

Tanabe, Mihoko, Keely Robinson, Catherine I. Lee, Jen A. Leigh, Eh M. Htoo, Naw Integer, et al. 2013. "Piloting community-based medical care for survivors of sexual assault in conflict-affected Karen State of eastern Burma". *Conflict and Health 7* (12). https://doi.org/10.1186/1752-1505-7-12.

Vu, Alexander, Atif Adam, Andrea Wirtz, Kiemanh Pham, Leonard Rubenstein, Nancy Glass, et al. 2014. "The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis", *PLoS Curr* 18 (6). https://www.researchgate.net/publication/262229579_The_Prevalence_of_Sexual_Violence_among_Female_Refugees_in_Complex_Humanitarian_Emergencies_a_Systematic_Review_and_Meta-analysis.

Wachter, Karin, Rebecca Horn, Elsa Friss, Kathryn Falb, Leora Warb, Christine Apio, et al. 2018. "Drivers of Intimate Partner Violence Against Women in Three Refugee Camps". *Violence Against Women 24*(3): 286-306. https://doi.org/10.1177/1077801216689163.

Appendix 1

Number of focus group participants in the intervention site and the comparison site

Table A1: Number of focus group participants in the intervention site and the comparison site			
Intervention site			
Subgroups	**Number of focus groups**	**Number of participants**	**Number of migrants**
Adult and young women (not Wayuu)	3	19	14
Young women (Wayuu)	3	21	12
Young men (Wayuu)	3	20	11
Adult men (Wayuu)	3	22	6
Adult women (Wayuu)	3	23	11
Total number of focus groups	15		
Total number of participants	105		
Total number of migrants	54		
Comparison site			
Adult and young women (not Wayuu)	3	19	11
Young women (Wayuu)	3	22	12
Young men (Wayuu)	3	18	12
Adult men (Wayuu)	3	22	10
Adult women (Wayuu)	4	30	13
Total number of focus groups	16		
Total number of participants	111		
Total number of migrants	58		

Appendix 2

Demographic characteristics

This section provides a detailed account of the KAP survey participants' demographic characteristics. A total of 710 people participated in the baseline study. **Table 1** shows the breakdown of the overall number of participants by data method and study site. Comparisons across sites were carried out to determine whether there are statistically significant differences in demographic characteristics across sites. **Table 2**, below, shows the results of this comparison for statistically significant results and key demographic variables.

Table 1: Number of participants in the data collection activities			
	Number of participants in the study site		
Data collection method	**Intervention site**	**Comparison site**	**Total**
KAP Survey	337	352	689
FGDs	105	111	216
KIIs	12	9	21

Overall, we found significant differences between the intervention and comparison sites for the following demographic categories: language spoken; marital status; sexual orientation; and disability status as observed by the surveyors. We did not find significant differences in age, relationship to household head, migration status, self-identification as Wayuu, sex, self-identified gender, and self-reported disability status.

The mean age among the intervention site's participants was 32 years, only one year older than the mean age for participants of the comparison site (31 years). The age range of the intervention site's participants was from 13 to 75, and of the comparison site's participants was from 13 to 82. The sample had 88 adolescents (13-19 years) in the intervention site, of which 32 identified as boys and 56 identified as girls. In the comparison site there were 87 adolescents, 32 boys and 55 girls. Only 13.06% of participants from the intervention site and 11.93% of participants from the comparison site were 50 years or older.

Most participants self-identified as Indigenous (89.91% in the intervention site and 86.93% in the comparison site), and the majority self-identified as Wayuu (the Indigenous community of La Guajira) (89.02% in the intervention site and 86.36% in the comparison site).

The marital status of participants varied across the two study sites. The most common marital status in the intervention site was people who were not married but had lived with their partner for more than two years (40.36%), while about a third of participants (31.53%) in the comparison site had this marital status ($p<0.05$). The most common marital status in the comparison site was single (34.66%). More people reported being married in the comparison site (17.05%) compared to the intervention site (8.61%) ($p<0.01$). On both sites, over 70% of respondents have children. Among participants aged 13-19, 5.14% were married across sites .

Survey participants were mostly female (67.95% in the intervention site and 69% in the comparison site) who self-identified with the sex assigned to them at birth. Only one participant from the intervention site (0.3%) said that they did not identify with the sex that was assigned to them at birth and identified themself as "other gender." One participant from the same site refused

to answer this question (p<0.10). The majority of participants reported that they felt romantic, sexual, or emotional attraction for people of the opposite sex (96.74% in the intervention site and 97.73% in the comparison site). Four participants from the comparison site reported that they felt attracted to people from both sexes (1.14%) (p<0.05).

Living with a disability was much more commonly reported or observed in the intervention site than in the comparison site (p<0.01). Visibly identifiable disabilities were reported by the surveyors and not by the participants. This methodological decision was based on the experience of previous data collection activities in the region. Two participants from the intervention site were identified as people living with blindness (0.59%), two participants were identified as people living with deafness (0.59%), and one participant was identified as living with muteness (0.3%). In the comparison site, only one participant was identified as living with deafness (0.28%). Other disabilities were self-reported by the participants. The most frequently reported was difficulty understanding or learning reported by 82 participants in the intervention site (24.33%) and 28 (7.95%) in the comparison site. The second most common self-reported disability was difficulty going outside without help or company, reported by 45 (13.35%) participants in the intervention site and 11 (3.13%) in the comparison site. We found statistically significant differences in all the self-reported disabilities (p<.001).

Table 2: Demographic characteristics by intervention site and comparison site

Variable	n	Intervention site (n=337) Percent/mean	n	Comparison site (n=352) Percent/mean	Test of differences
Age (mean)	337	32	352	31	0.200
Age range					
13-19 years old	88	26.11	87	24.72	0.674
20-29 years old	82	24.33	110	31.25	0.043**
30-39 years old	64	18.99	72	20.45	0.630
40-49 years old	59	17.51	41	11.65	0.030**
50 or older	44	13.06	42	11.93	0.656
Ethnic background					
Indigenous	303	89.91	306	86.93	0.222
Gypsy (Rom)	0	0.00	0	0.00	
Raizal from San Andrés, Providencia, and Santa Catalina	0	0.00	0	0.00	
Palenquero(a) from San Basilio	0	0.00	0	0.00	
Afrocolombian	3	0.89	3	0.85	0.957
None of the above	31	9.20	43	12.22	0.200
Self-identified as Wayuu	300	89.02	304	86.36	0.289
Languages spoken (+)					
Sp*anish*	261	77.45	320	90.91	0.000***
English	2	0.59	4	1.14	0.441
Wayuunaiki	286	84.87	292	82.95	0.495

Statistical significance of tests for differences * p<0.10, ** p<0.05, ***p<0.01
(+) Categories are not mutually exclusive.

Table 2: Demographic characteristics by intervention site and comparison site					
Other	0	0.00	0.00	0.00	
Marital status					
Not married and have lived with their partner for less than two years	10	2.97	15	4.26	0.363
Not married and have lived with their partner for more than two years	136	40.36	111	31.53	0.016**
Married	29	8.61	60	17.05	0.001***
Divorced or separated	32	9.50	37	10.51	0.657
Widow(er)	14	4.15	7	1.99	0.101
Single	113	33.53	122	34.66	0.755
Refused	3	0.89	0	0.00	0.083*
Person has children	236	70.03	254	72.16	0.538
Sex, gender, and sexual orientation					
Sex					
Male	108	32.05	108	30.68	0.700
Female	229	67.95	244	69.32	0.700
Other	0	0.00	0	0.00	
Self-identified with sex assigned at birth					
Yes	335	99.41	352	1.00	0.157
No	1	0.30	0	0.00	0.318
Refused	1	0.30	0	0.00	0.318
Gender identity					
Trans man	0	0.00	0	0.00	
Trans woman	1	0.30	0	0.00	0.318
Other	0	0.00	0	0.00	
Refused	335	99.41	352	1.00	0.157
Romantic, sexual, emotional, or affective attraction					
Same sex people	1	0.30	0	0.00	0.318
Opposite sex people	326	96.74	344	97.73	0.429
People from both sexes	0	0.00	4	1.14	0.045**
Refused	10	2.97	4	1.14	0.092*
Disabilities					
Dichotomous indicator: whether the person reported/presented at least one disability	107	31.75	36	10.23	0.000 ***
Disaggregated by disability:					
Total blindness? (By observation)	2	0.59	0	0.00	0.157
Total deafness? (By observation)	2	0.59	1	0.28	0.541
Muteness? (By observation)	1	0.30	0	0.00	0.318
Difficulty moving or walking on your own?	43	12.76	8	2.27	0.000***
Statistical significance of tests for differences * p<0.10, ** p<0.05, ***p<0.01 (+) Categories are not mutually exclusive.					

Table 2: Demographic characteristics by intervention site and comparison site					
Difficulty bathing, dressing, or feeding yourself?	29	8.61	5	1.42	0.000***
Difficulty going outside without help or company?	45	13.35	11	3.13	0.000***
Difficulty understanding or learning?	82	24.33	28	7.95	0.000***
Statistical significance of tests for differences * p<0.10, ** p<0.05, ***p<0.01 (+) Categories are not mutually exclusive.					

Socioeconomic characteristics, migration experiences, and nationality

Table 3 presents key socioeconomic characteristics, migration experiences, and nationality of the participants by site. Overall, most participants reported capability to read and write and had completed their primary and most of their secondary education. However, few of them finished school or attended higher education institutions. The main socioeconomic activity of participants was household chores. Food insecurity was highly prevalent in both communities, and participants reported that they had to frequently limit or reduce their meals per day. Almost half of the participants have always lived in Colombia. The other half came from Venezuela, have Venezuelan nationality, and use Venezuelan IDs.

We found statistically significant differences between the intervention site and the comparison site for the following variables: main activities during the last week (options included looking for a job and doing household chores); education level (option none); percentage of people who know how to read and write in both communities; percentage of people who did not have enough food or resources to buy food during the last seven days; mean days in which the household had to a) rely on less preferred and less expensive foods, b) restrict consumption of food by adults so that minors could eat, c) reduce the number of meals per day; time in Colombia; nationality; and identity documents (specifically, identity card, temporary protection permit, and migration card).

As an additional indicator correlated with socioeconomic status, the survey also asked participants if they did not have enough food or resources to buy food in the seven days prior to the survey. Even though food security is not a perfect proxy for socioeconomic status, there is a correlation between the two and prior work suggests that food insecurity is linked to low wages, adverse social and economic conditions, among other factors associated with lower socioeconomic status (e.g., Drewnowski, 2022). A greater number of participants in the intervention site (77.15%) compared to those in the comparison site (65.91%) reported not having enough food or resources to buy food ($p<0.01$). Participants who reported this situation also stated that during the past seven days, they had to rely on less preferred and less expensive food (mean days 3.73 in the intervention site and 3.35 in the comparison site) ($p<0.05$), restrict food consumption in adults so that children could eat (mean days 3.23 in the intervention site and 2.53 in the comparison site) ($p<0.01$), or reduce the number of meals per day (mean days 4.17 in the intervention site and 3.68 in the comparison site) ($p<0.05$).

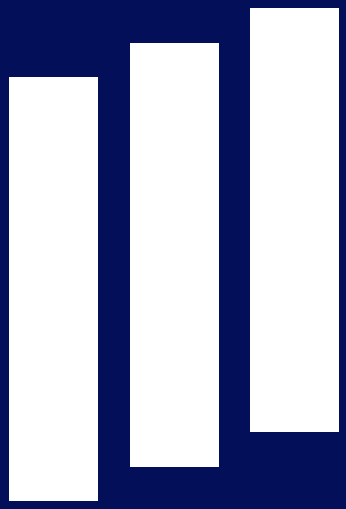
More than 55% of participants in both sites have not lived always in Colombia (56.97% in the intervention site vs. 55.68% in the comparison site). All these participants (n= 192 in the intervention site and n= 196 in the comparison site) came from Venezuela and, therefore, have Venezuelan nationality (80.21% in the intervention site and 88.78% in the comparison site) ($p<0.05$), with only a few holding Colombian nationality (15.10% in the intervention site and 9.18% in the comparison site) ($p<0.10$), and a minority holding double nationality (4.69% in the intervention site vs. 2.04% in the comparison site).

Table 3. Socioeconomic characteristics, migration and nationality by the intervention and the comparison site					
Variable	**n**	**Intervention site (n=337) Percent/mean**	**n**	**Comparison site (n=352) Percent/mean**	**Test of differences**
Socioeconomic characteristics					
Main activity last week					
Work	89	26.41	96	27.27	0.799
Looking for a job	14	4.15	5	1.42	0.030**
Study	76	22.55	68	19.32	0.298
Household chores	105	31.16	136	38.64	0.039**
Permanently unable to work	13	3.86	15	4.26	0.789
Other activity	40	11.87	32	9.09	0.235
Education level					
None	57	16.91	34	9.66	0.005***
Preschool	2	0.59	6	1.70	0.170
Primary (1st - 5th grade)	106	31.45	115	32.67	0.733
Secondary (6th - 9th)	114	33.83	134	38.07	0.247
Secondary (10th - 13th)	51	15.13	57	16.19	0.702
Higher or university	7	2.08	6	1.70	0.720
Person knows how to read and write					
Yes	266	78.93	306	86.93	0.005***
No	70	20.77	46	13.07	0.007***
Refused	1	0.30	0	0.00	0.318
In the last 7 days this household did know have enough food or resources to buy food					
Yes	260	77.15	232	65.91	0.001***
No	77	22.85	120	34.09	0.001***
In the last 7 days, how frequent (mean days) did the household (if yes in previous question) (+)					
Relying on less preferred and less expensive foods	260	3.73	232	3.35	0.029**
Borrowing food or relying on help from friends or family	260	2.62	232	2.53	0.592
Limit the size of food portions	260	4.07	232	3.93	0.463
Restrict consumption of adults so that minors could eat	260	3.23	232	2.53	0.001***
Reduce the number of meals per day	260	4.17	232	3.68	0.017**
Migration and nationality					
Person has always lived in Colombia					
Yes	145	43.03	156	44.32	0.733
No	192	56.97	196	55.68	0.733
Time in Colombia (mean months) (if person had not always lived in Colombia)	192	65.75	196	51.09	0.000***
Statistical significance of tests for differences * p<0.10, ** p<0.05, ***p<0.01 (+) Categories are not mutually exclusive.					

Table 3. Socioeconomic characteristics, migration and nationality by the intervention and the comparison site					
Place of origin (if person had not always lived in Colombia)					
Venezuela	192	100.00	196	100.00	
Nationality (if person had not always lived in Colombia)					
Colombian	29	15.10	18	9.18	0.075*
Venezuelan	154	80.21	174	88.78	0.020**
Double	9	4.69	4	2.04	0.150
Identity documents (if person had not always lived in Colombia) (+)					
Colombian ID	45	23.44	37	18.88	0.273
Venezuelan ID	164	85.42	164	83.67	0.636
Special Permit to Stay -PEP (Valid or expired)	42	21.88	45	22.96	0.799
Passport	1	0.52	2	1.02	0.574
Certificate	11	5.73	9	4.59	0.614
Civil Registration	11	5.73	9	4.59	0.614
Temporary Migrant Status	10	5.21	17	8.67	0.180
Identity Card	9	4.69	3	1.53	0.074*
Temporary protection permit	0	0.00	17	8.67	0.000***
Migration card	0	0.00	3	1.53	0.082*
Other	0	0.00	1	0.51	0.318
Statistical significance of tests for differences * p<0.10, ** p<0.05, ***p<0.01 (+) Categories are not mutually exclusive.					

Acronyms and Abbreviations

CAB	Community advisory board
CNC	Centro Nacional de Consultoría
CHW	Community health worker
FGD	Focus group discussion
GBV	Gender-based violence
GEM	Gender-Equitable Men (scale)
HIV	Human immunodeficiency viruses
IPV	Intimate partner violence
IRB	Institutional review board
KAP	Knowledge, attitudes and practices (survey)
KI	Key informant
KII	Key informant interview
LGBTQI+	Lesbian, gay, bisexual, transgender, queer or questioning, and intersex
M&E	Monitoring and evaluation
NGO	Nongovernmental organization
SGBV	Sexual and gender-based violence
STI	Sexually transmitted infection
SV	Sexual violence
WRC	Women's Refugee Commission
UniAndes	Universidad de los Andes



WOMEN'S REFUGEE COMMISSION

Research. Rethink. Resolve.

WRCOMMISSION

WOMENSREFUGEECOMMISSION

WOMENSREFUGEECOMMISSION

WRCOMMISSION

WRCOMMISSION

WRCOMMISSION

Women's Refugee Commission | 15 West 37th Street | New York, NY 10018

212.551.3115 | info@wrcommission.org | womensrefugeecommission.org