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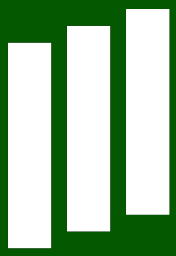

WOMEN'S
REFUGEE
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Communities Care: An Integrated Community-Based Sexual and Gender-Based Violence Intervention in Adjumani, Uganda

Baseline Evaluation Report

August 2024

Makerere University School of Public Health (MakSPH) promotes the attainment of better health for the people of Uganda and beyond through public health training, research, and community service. MakSPH works closely with government, industry, business, development partners, and the community to develop practical initiatives that are responsive to and engage communities through the use of social and participatory action research, community empowerment ideologies, and partnerships to drive public health, scientific, and technological progress across East Africa and the world at large.

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

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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 the MakSPH (Investigators: Dr. Barbara E. Kirunda Tabusibwa, Dr. Christine Nalwadda, Dr. Roy William Mayega, Lydia Kabwijamu and Ronald Ssenyonga) and WRC (Investigator: Katherine Gambir) teams. Julianne Deitch and Lily Jacobi of WRC reviewed the report. We are grateful to Diana Quick of WRC for editing 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 Uganda, Reproductive Health Uganda, and the other NGO partners and officials of local government units. Their participation and insights made this research possible.

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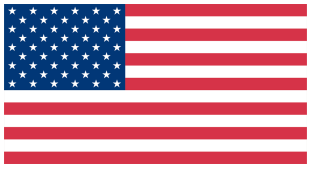

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Executive Summary

Introduction

This baseline assessment was conducted prior to the implementation of *Communities Care*: an integrated community-based referral and sexual and gender-based violence (SGBV) sensitization intervention for refugees and host community members in Adjumani district, Uganda. The baseline assessment aimed to assess SGBV knowledge, attitudes, and practices (KAP) of adolescents (13-19 years) and adults (20-59 years) and the extent to which community members have access to sexual violence (SV) prevention and care services to receive medical and psychosocial care if needed among refugee communities and host populations in Adjumani district. The baseline data will be used as a comparison to endline data after seven months of the *Communities Care* intervention to understand changes in KAP related to SGBV, care-seeking behavior, and gender equality, and access to timely, quality medical and psychosocial care as a result of the intervention.

Methods

A mixed methods study was conducted in two sites (intervention and comparison) consisting of refugee settlements and host communities located in the Adjumani district of the West Nile sub-region of Uganda. Quantitative data was collected using a household survey among 1,662 individuals aged 13-59 years residing in the intervention and comparison sites. Qualitative data was collected using semi-structured key informant interview (KII) guides and participatory focus group discussions (FGDs). Thirty-one FGDs were conducted; 15 in the comparison site and 16 in the intervention site, with a total of 238 participants. The FGDs were conducted among groups stratified by age and sex: adolescent girls (13-14 years), adolescent girls (15-19 years), young women (20-24 years), women (25-59 years), adolescent boys (13-15 years), adolescent boys (16-19 years), young men (20-24 years), adult men (25-59 years), and adult males (20-59 years). Fourteen KIIs were conducted with members of the project community advisory board (CAB), project staff, health workers, service providers and community resource persons such as village health technicians and community leaders. Other participants included representatives of the local government, and nongovernmental organizations (NGOs) engaged in SGBV service provision.

All data collection tools were translated into the predominantly spoken languages within the study sites, namely Madi, Acholi, Dinka, and Arabic. Data collection tools are available upon request. KIIs with participants were conducted in the language the participants preferred or best understood. Quantitative data was analyzed using STATA. Qualitative data from KIIs and FGDs were audio-recorded and transcribed verbatim and translated to English. 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 content analysis. Thematic network analysis was used to generate relevant themes associated with community understanding of GBV, gender equality, and SV. Key themes were further explored across study sites and key informant (KI) affiliation or community subgroup to explore linkages and discordances in the data.

Key Findings

Knowledge of and attitudes toward GBV

Overall, over half (52%) of participants reported having ever heard of the term gender-based violence. By site, 57.3% of respondents from the comparison site had ever heard of the term GBV compared to 47.6% from the intervention site. Among FGDs, most participants illustrated a general

sense of what GBV is and its consequences. Most participants alluded to men as perpetrators of GBV and to women as victims. Physical violence and emotional mistreatment were the most mentioned types of GBV. Compared to men, women were more likely to mention IPV and economic abuse as types of GBV. Stratified by age, younger adolescent girls (13-16 years) demonstrated more knowledge of GBV than their male peers. Many participants noted that GBV was exacerbated by poverty, alcohol use, and food insecurity.

Knowledge of and attitudes toward SV

Less than half (44%) of the participants demonstrated a more comprehensive understanding of SV compared to GBV. When asked about their understanding of SV, FGD participants across groups used words such as rape, nonconsensual sex, and defilement to describe SV. Among the adult participants, IPV was also described as a form of SV. Similar to FGD discussions on GBV, men were more often portrayed as perpetrators of SV compared to women. However, a few participants indicated that men were also victims of SV. These participants clarified that men rarely report or seek care for SGBV in general due to cultural constructs around masculinity.

Knowledge and access to GBV and SV programs and services

KAP survey data revealed that community members across sites were least likely to be aware of available GBV and SV programs and services compared to any other services (e.g., water, sanitation, and hygiene (WASH), food, shelter, legal, mental health and psychosocial support (MHPSS), and safe spaces). Only 5% (n=83) of participants reported being knowledgeable about the availability of GBV programs/services in their community, while only 2.1% (n=35) reported being knowledgeable about available SV programs/services in their community. However, FGD and KII data demonstrate that community members have knowledge of the different actors engaged in GBV care services provision and how to report or seek care. Some of the frequently mentioned GBV actors by the FGD participants include institutions such as health facilities, police, Office of the Prime Minister (OPM), and humanitarian international NGOs. Safe spaces were the least mentioned service available in the community by the participants, irrespective of data collection method.

Participants' commonly mentioned services available in their community for GBV and SV included WASH (79.4%, n=1314), mental health (71.9%, n=1190), food (50.8, n=840). Some participants knew that getting tested and treated for sexually transmitted infections (STIs) (36.7%, n=364) was a common service for people who experience SV. Despite FGD participants' knowledge of existing actors and services, they raised a number of barriers to care seeking, namely fear of stigma, lack of or delay of disclosure, and challenges around access to critical information.

Gender equality and attitudes toward GBV

The survey also revealed that attitudes toward GBV measured on the Gender-Equitable Men (GEM) scale was relatively positive. About three-quarters (74.5%; 24.8/33) of the respondents had a high support for equitable gender norms. However, this varied significantly when participants in the intervention site were compared to those in the comparison site (81.5% vs 67.9, $p<0.001$). Attitudes toward equitable gender norms in intimate relations or differing social expectations were found to be positive and not significantly different between the intervention and comparison sites.

Safety and well-being

Overall, KAP survey participants across sites rated their sense of safety and well-being to be high (83.3%). Disaggregated by site, the sense of safety was higher among community members in the intervention site (85.3%) compared to those in the comparison site (80.8%). There was consensus among the qualitative participants that women, girls, and people with disabilities were especially

vulnerable to SGBV compared to men and boys. A fenced household and a male-headed household were viewed as signs of enhanced safety for household members. Some KII participants, especially health workers, expressed fear of delivering medical and psychosocial care at the community level. The fear among health workers stemmed from previous experiences of resistance and threats of violence they faced when they offered follow-up care to community members, particularly during community provision of reproductive health services like family planning services. In contrast, village health teams (VHTs) also illustrated confidence in providing community-based SV care because they were selected by their communities as community-based service providers and were therefore esteemed within the communities, and expressed confidence that they could be trained to safely offer SGBV services within their community.

Conclusion

- Overall, the majority of community members from the KAP survey were more aware about GBV with, notably, a higher proportion of community members in the comparison site being aware than those in the intervention site. Varied differences in the level of awareness about GBV were observed among male and female refugee populations across the sites.
- The different forms of GBV cited by all participants included economic abuse through denial of resources, psychological abuse, IPV, and physical abuse. With regard to causes of GBV, poverty was cited as the most common. Other causes from the qualitative findings highlighted food insecurity, denial of resources (specifically access to school/school fees), and alcohol use by women and men.
- Much as the research demonstrated relatively negative attitudes toward GBV among community members across the sites and across sex and age groups, FGD data indicates that SV, particularly IPV, and to a lesser extent child marriage, are a norm among refugee and host communities.
- SV is considered acceptable within the boundaries of marriage, but also seen as negative and shameful. Notably, a high degree of stigma is experienced by perpetrators and survivors of SV by community members. Additionally, survivors of SV are challenged with a myriad of barriers in accessing care and services, including access to legal recourse. SV is rarely reported to either the local courts or the police because of the cultural misconceptions and stigma that are prevalent among the community members.
- Community members had a higher level of awareness of SV than of GBV. However, the levels of awareness of SV varied significantly across sites, with respondents from the intervention site having a higher level of awareness than the comparison site.
- Similarly, a higher level of knowledge of SV than of GBV was observed among community members in both sites.
- Overall, community members had positive attitudes toward gender equality. A majority of community members across both sites demonstrated positive attitudes toward gender equality. However, this varied significantly between sites with participants in the intervention site reporting higher support for gender equality than those in the comparison site.
- Overall, community members across sites were familiar with the available SGBV response services in their community, but less aware of available SGBV prevention programs. Additionally, community members had very limited access to available SV services.

- Substantial common barriers that impeded access to SGBV services to community members included fear of stigmatization, delayed GBV disclosure and care seeking, and barriers around the implementation of the community sensitization activities.
- The sense of safety and well-being was rated to be high in both sites, but higher among community members in the intervention sites than in the comparison site. However, there are concerns about safety and well-being of vulnerable populations, particularly women, girls, and people with disabilities, in both sites.

Recommendations

To improve the SGBV awareness and knowledge among community members, the community care program should consult members of the project community advisory board (CAB) to create key messages and develop SGBV community activities tailored to refugee and host community members according to their age, refugee status, ethnicity, disability status, and gender.

- Information about SGBV should clarify misconceptions about GBV and SV, particularly among adolescents, such as the perception that one person rejecting the other's admission of or request for affection is a form of SV.
- Activities should enhance community members' knowledge about the different types of GBV, including SV, in addition to causes and consequences, emphasizing where to access care and the importance of seeking timely care.

Regarding efforts to address member attitudes toward SGBV, prevention programming should train key community stakeholders (e.g., community and traditional leaders) to dismantle harmful perceptions about the diversity of people who experience various forms of SV through participatory community engagement activities.

- Activities may use participatory approaches, such as theater and role play, to demonstrate survivor-centered approaches to support survivors of SV. Scenarios portrayed in these activities should demonstrate incidents of child marriage and IPV, and how to respond to disclosures and refer survivors to appropriate support and care.
- Such activities may provide a nonjudgmental platform for community members to discuss how existing community norms, including traditional norms, can be adjusted to better support survivors of SV by offering alternatives to child marriage and internal household resolution of IPV, such as access to quality, appropriate, confidential medical and psychosocial care and access to multi-sectoral services, such as justice and legal redress, child protection, livelihoods, education, and shelter, among others.
- Activities should provide concrete information about where survivors can receive quality, appropriate, and confidential support and care in the community.
- Social outreach, public awareness campaigns, and community-focused education should engage key community stakeholders (e.g., community and traditional leaders) to provide community members with accurate information about their legal rights to redress and justice.

To change community members' attitudes toward gender equality:

- Prevention programming should focus on gender-transformative activities to promote more positive gender norms among community members to address the underlying drivers 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, such as women need permission from the male head of household to leave the home.
- » Activities can ensure accountability to women and girls by consulting CAB members and adolescent themselves to elicit input on the design and content of activities.

Community member access to SGBV services

- SGBV prevention activities
  - » Community dialogues and other community sensitization activities should hold sessions disaggregated by gender, age, and ethnicity to ensure that a psychologically safe space is available to community members in all their diversity to discuss their experiences, priorities, and concerns as they relate to SGBV and gender equality. Necessary accommodations should also be made to create an inclusive environment for people with disabilities and other diversity factors.
  - » Community engagement and social-behavioral communication and change programs and activities should be designed to prevent SGBV, including the design and dissemination of information, education, and communication materials tailored to the specific needs of community members in all their diversity to increase community members' knowledge about the consequences of SV; the importance of seeking timely care; and where to access care and services.
  - » Community awareness campaigns should be designed to dismantle harmful gender norms and discriminatory practices that perpetuate stigma around survivorhood to address barriers to disclosure and care seeking.
  - » Activities should be delivered in a variety of communication platforms (e.g., print, radio) in all languages spoken and understood by community members.
  - » The timing of activities should be tailored to the lived experiences and realities of different community groups.
- SGBV response activities
  - » Village health teams (VHTs) should be trained on survivor-centered approaches and be equipped with the necessary supplies (e.g., emergency contraceptive pills [ECPs]), respond to a disclosure of SV by a community member, and provide timely response, such as providing psychological first aid, basic wound care, administering antibiotics for presumptive treatment of STIs, and administering ECPs. VHTs should also be trained on life-threatening danger signs and when to refer survivors to emergency care. VHTs should also be trained to obtain informed consent and assent from community members to refer them to multi-sectoral services, particularly health facilities.
  - » The *Communities Care* program team should ensure that there are functional, safe, and quality referral pathways in place to refer survivors to multi-sectoral services that meet their distinct needs and priorities (e.g., access to justice, shelter/safe spaces, education, livelihoods, etc.). VHTs should be trained to support survivors to use these referral pathways.
  - » To the extent possible, the *Communities Care* program should ensure that health facility staff and other SGBV referral service providers (e.g., safe spaces/shelters) are trained to provide survivor-centered care, including responding to disclosures without bias regardless of the survivor's gender identity, gender expression, sexual orientation, age, or disability status, and ensuring that survivors have sustained access to safe spaces/shelters.

Regarding the community sense of safety and well-being

- VHT visits to female-headed households should be conducted by female VHTs to bolster women's sense of safety.
- Prevention activities may consider allocating resources toward strengthening community members' sense of safety and well-being, such as building fences around households, installing solar panels to provide better lighting, or establishing community-led safety teams. Such activities should be designed with community members, particularly women, adolescent girls, and people with disabilities, to ensure these mitigation approaches meet their needs, lived experiences, and priorities. These activities should also target the most at-risk locations mentioned by community members—water collection points, roads, marketplaces, night clubs, and households.
- Prevention activities may also explore community members' understanding of safety and well-being to develop more holistic, community-based approaches to enhance overall safety and well-being for all community members.
- Prevention activities should not only engage men and boys as perpetrators of SGBV, but also as allies and partners in preventing SGBV and mitigating risks. VHTs should be trained to respond to SGBV disclosures from male survivors using survivor-centered approaches. As such, VHTs should also be trained on a safe, functional, and appropriate referral pathway for male survivors.

Safety aspects during the community provision of SV care

- VHTs should enhance their trust and rapport among community members by discussing and responding to their immediate needs and priorities to the best of their abilities and sharing information and resources about less sensitive topics, rather than initiating discussions about SGBV at first contact.
- VHTs should travel in mixed-gender pairs when conducting program activities to enhance their personal safety.
- Project staff should develop and train VHTs on a safety protocol that outlines risks, mitigation strategies, and response mechanisms to uphold the safety of VHTs during program activities. VHT supervisors should probe about safety concerns and risks during one-on-one and group supervisory sessions with VHTs to address any issues in a timely manner.

Introduction

The Women Refugee Commission (WRC) and its partner in Uganda, Reproductive Health Uganda (RHU), planned to implement an integrated community-based medical and psychosocial care and sexual and gender-based violence (SGBV) gender-transformative intervention for refugees and host community members in Adjumani district, Uganda. This intervention is called the *Communities Care* project. Prior to implementation of *Communities Care*, WRC, together with Makerere University School of Public Health (MakSPH), conducted a baseline study to document the current status of the project indicators among South Sudanese refugees and host committee members living in the intervention and comparison sites. This report documents the baseline research process and findings, and document differences between the intervention and comparison communities prior to the start of the intervention. The baseline study is part of a multi-country quasi-experimental study aimed at evaluating the effectiveness and safety of the *Communities Care* model in humanitarian settings.

Background

SGBV is a persistent global public health concern that primarily affects women and girls. However, people of all genders and sexual orientations experience SGBV, including men and boys and people with diverse sexual orientations, gender identities, gender expressions, and sex characteristics (SOGIESC). Children and adolescents are particularly at risk of certain forms of SGBV (Starrs et al., 2018). SGBV, including intimate partner violence (IPV), continues to be pervasive and heightened in humanitarian emergencies (UNOCHA, 2019). Between 40 percent and 60 percent of women affected by crisis experience SGBV (WHO, 2021, Vu et al., 2014, Black et al., 2019, Chernet and Cherie, 2020). In West Nile sub-region, one of the refugee-hosting sub-regions of which Adjumani District is part, 55 percent of women reported having ever experienced IPV and about 31 percent had ever experienced IPV (UBOS, 2021). A recent survey among South Sudanese refugee communities in Obongi and Adjumani Districts also reported that 56 percent of women with partners had experienced physical or sexual domestic violence and 66 percent had experienced some form of domestic violence. Among survey respondents, an estimated 40 percent of women had experienced domestic violence in the previous 12 months (Kirunda et al, 2020).

Despite the high incidence of SGBV in humanitarian settings and its serious health consequences, the availability and accessibility to medical and psychosocial care for survivors of SV is often limited (Shanks and Schull, 2000). Refugees face greater barriers to receiving adequate care due to blockages and overburdened health systems in humanitarian settings (Vu et al., 2014, Liebling et al., 2020). For women and young girls specifically, existing gender norms and expectations, stigma, lack of knowledge of where to seek care, poverty, and language barriers further curtail their care seeking in cases of SGBV (Murphy et al., 2020; Ivanova et al., 2019).

While the impact of SGBV on the lives of survivors is well documented (Starrs et al., 2018; Lowicki, 2013), many survivors do not access SGBV services (Tirado et al., 2020; Ivanova et al., 2019). 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 timely access to an adequate response and prevent more devastating 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 in humanitarian crises remains.

Objectives of the baseline assessment

The overall objective of the baseline assessment was to assess the baseline knowledge, attitudes, and practices (KAP) of adolescents (13-19 years) and adults (20-59 years) related to SGBV and gender equality and the extent to which community members have access to SV prevention and care services to receive medical and psychosocial care if needed among refugee communities and host populations in Adjumani district. The data collected would generate evidence to inform evidence-based planning, implementation, and form a basis for monitoring and evaluation of the intervention. Specifically, the objectives were:

1. To assess SGBV KAP among adolescents and adults in refugee and host communities within Adjumani district.
2. To assess attitudes related to gender equality among adolescents and adults in refugee and host communities within Adjumani district.
3. To assess attitudes related to GBV among adolescents and adults in refugee and host communities within Adjumani district.
4. To assess the extent to which community members have access to SV prevention and care services to receive medical and psychosocial care if needed.

Methods

Study design, site, and population

A baseline study using mixed methods was conducted in two sites consisting of both refugee settlements and immediate host communities located in Adjumani district of the West Nile sub-region of Uganda. Currently, this sub-region has 16 refugee settlements and hosts the second highest refugee population in Uganda (UNHCR, 2022). The intervention site, the larger of the two refugee settlements, is composed of seven blocks, each of which is composed of six clusters (42 clusters in total) and a total population of approximately 52,000 people. The intervention site was selected because of the availability of health facilities and because RHU planned to implement the intervention in this location based on their existing programming. The comparison site is composed of six blocks, each with six clusters (36 clusters in total) and has a total population of 42,000 people. The comparison site was selected because its population demographics were similar to that of the intervention site and there was no other current or planned SGBV programming in the location.

Mixed methods used included a household KAP survey and qualitative methods, including key informant interviews (KIIs) and participatory focus group discussions (FGDs). The survey sample population comprised 1,662 individuals aged 13 years to 59 years residing in Adjumani district. Qualitative assessments included participatory FGDs with community members and KIIs of stakeholders engaged in SGBV service delivery and program implementation. Of the 31 FGDs conducted, 15 were in the comparison site and 16 in the intervention site, yielding a total of 238 participants. Fourteen KIIs were conducted with members of the project community advisory board

(CAB), health workers, service providers and community resource persons such as village health team members (VHTs) and community leaders. Other KII participants included representatives of the local government and NGOs engaged in SGBV service provision.

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Sampling procedure

Multistage cluster sampling strategy was employed to select household respondents for the KAP survey. Probability proportionate to size (PSS) methodology was used to select approximately 22 clusters for data collection in each of the two study sites. Sixteen clusters in each study site were selected from among refugee communities and six clusters were selected from the adjacent host communities. Within each cluster, 36 participants were selected for the survey. In each household, a respondent who met the eligibility criteria was selected using simple random sampling. Eligibility was defined as being a resident of either the intervention or comparison site, aged 13 years and over, and consenting or assenting to participate in the study. People were excluded from the study if they were critically ill or deemed unable to answer questions due to living with cognitive disabilities and insufficient communication support that precluded them from assenting or consenting to participate in the study.

Participants for qualitative methods were purposefully selected. Participants for KIIs were purposefully selected by the research team based on their role in the project. Project-affiliated VHTs and VHT supervisors were selected to participate in addition to community advisory board (CAB) members for a sample size of up to 15 key informants (KIs). Participants for FGDs were purposefully selected for both the intervention and comparison sites based on the eligibility criteria, which included age, refugee status, and sex. Data was collected among groups stratified by age and sex: adolescent girls (13-14 years); adolescent girls (15-19 years); young women (20-24 years); women (25-59 years); adolescent boys (13-15 years); adolescent boys (16-19 years); young men (20-24

years); and adult men (20-59 years). The target sample size for FGD was four FGDs across each subgroup, totaling 32 FGDs with 238 participants.

Data collection methods and tools

The quantitative and qualitative data was collected concurrently from October 26, 2022, to November 12, 2022. Male enumerators interviewed boys and men while female enumerators interviewed girls and women. The baseline household survey assessed KAP regarding available services, SGBV, and gender equality, as well as SV care-seeking behavior using an interviewer-administered questionnaire uploaded to smartphones. The KAP survey tool included the Gender Equitable Men's Scale (GEM) scale to measure attitudes toward gender norms in intimate relationships or differing social expectations for men and women. The GEM scale has also been used with men and women in countries globally, including Uganda (Barker, 2000; Barker, 2001; Instituto Promundo and Instituto Noos, 2003; Pulerwitz and Barker, 2008) and has been validated among Ugandan youth (Vu et al 2017). The KAP survey also included an adapted version of a scale used to measure community members' attitudes toward GBV among Syrian refugees (Schmidt, 2015). Additionally, one-on-one KIIs were conducted to collect information on the views of service providers, VHTs, VHT supervisors, RHU project staff, and other key community resource persons (e.g., local government authorities) using a semi-structured interview guide. Participatory group activities (FGDs) with adolescent boys and girls and women and men were also conducted to gain deeper understanding of community norms, priorities, attitudes, and care-seeking behavior around SGBV, and perceptions of safety and well-being using a semi-structured discussion guide.

All research and data collection tools are available upon request. Research tools were developed by WRC and contextualized by MakSPH and the CAB. The CAB comprised 14 community stakeholders (e.g., service providers, local government authorities, community members, members of Adjumani local government, and representatives from different organizations engaged in SGBV service provision) in Adjumani district. All study tools were translated into the predominant languages within the study sites namely Ma'di, Acholi, Dinka, and Arabic. Interviews with participants were conducted in the language the participants preferred or best understood. The FGDs and KIIs were audio recorded.

Data management and analysis

Quantitative data was collected on smart phones using electronic questionnaires programmed with Open Data Kit (ODK) software. Back-to-back encryption was implemented to protect the respondents' data. The final datasets were uploaded in MakSPH's secure and password-protected server after cleaning. Descriptive and analytical statistics are presented, with means (SD), medians (IQR), and counts (percentages). Probability values and confidence intervals from proportion and mean differences are also reported from proportion tests and two group t-tests. At baseline there was no need to adjust the estimates for time and thus the choice of the statistical tests in this report. We shall, however, adjust for time changes in the indicator estimates in the endline analysis. The proportions test and chi-square were computed for the overall cross tabulations between the intervention and comparison sites and not individual comparisons. In instances where respondents provided more than one answer, adjustment for multiple response was done. To adjust for clustering in the study design, fitted hierarchical linear regression models were run to estimate an adjusted difference in means. See Appendix 2 for additional information on indicators and scales.

Qualitative data from KIIs and FGDs were audio-recorded and transcribed verbatim and translated into English. 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 content analysis. Thematic network analysis was used to generate relevant themes associated with community understanding of GBV, gender equality, and SV. 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 Katherine Gambir of WRC, USA, and Dr. Barbara E. Kirunda Tabusibwa, Dr. Christine Nalwadda, Dr. Roy William Mayega, Lydia Kabwijamu, and Ronald Ssenyonga of MakSPH, Uganda. The field team was composed of 26 research assistants (14 men and 12 women).

Ethics

Ethical approval was obtained from the MakSPH Research Ethics Committee (SPH-2022-263:) and the Uganda National Council of Science and Technology (HS2438ES) prior to conducting the study. Approvals were also obtained from OPM and UNHCR District Office and Adjumani District Local Government. The research team obtained written 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 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, 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.

Findings

Study participants

A total of 1,914 people participated across data collection activities. **Table 1** shows the breakdown of the overall number of respondents by data collection method and study site.

Table 1: Number of participants in the data collection activities

	Number of participants in the study site		Intervention site
Data collection method	**Intervention site**	**Comparison site**	**Total**
KAP Survey	892	770	1,662
FGDs	116	122	238
KIIs	14	0	14
Total participants			**1,914**

KAP survey participants

The 1,662 household members were nearly equally distributed across the two sites (53.7% in the intervention site vs. 46.3% in the comparison site). In line with the sample design, 64.8 percent of participants were from the refugee communities while 35.2 percent were from the host communities. The average age did not statistically differ significantly among participants across the two sites (25.9, SD 11.6 in the intervention site vs. 25.6, SD 11.8 in the comparison site). Two-thirds (65.1%, n=1,082) of the participants were South Sudanese refugees. There were slightly fewer males (45.1%) than females (54.9%) although the proportions of males were similar across the intervention

and comparison sites. A significantly higher percentage of respondents in the comparison site reported a disability compared to the intervention site (7.5% versus 3.1%, respectively); and respondents in the comparison site reported higher levels of education. (**Table 2**).

Table 2: Demographic characteristics of KAP survey participants

Characteristics	Overall		Group				Two proportion tests	
			Intervention site		Comparison Site			
	n	%	n	%	n	%	% difference (95% CI)	p-value
All	1,662	100	892	53.7	770	46.3		
Age in years: mean (SD)	25.8 (11.6)		25.9 (11.6)		25.6 (11.8)		0.3 (-0.8, 1.4)	0.609*
Age group								
13 to 19 years old	691	41.6	366	41.0	325	42.2	1.2 (-6.2,8.6)	0.722
13-14	*214*	*12.9*	*119*	*13.3*	*95*	*12.3*		
15-17	*269*	*16.2*	*131*	*14.7*	*138*	*17.9*		
18-19	*187*	*11.3*	*112*	*12.6*	*75*	*9.7*		
20 to 49 years old	907	54.6	484	54.3	423	54.9		
50 to 77 years old	85	5.1	46	5.2	38	5.1		
Nationality								
South Sudanese	1,082	65.1	606	67.9	476	61.8	6.1 (0.4,11.8)	0.012
Rwandese	2	0.1	0	0	2	0.3		
Ugandan	578	34.8	286	32.1	292	37.9	5.8 (-2.0,13.6)	
Sex								
Male	749	45.1	398	44.6	351	45.6	1.0 (-6.1,8.1)	0.693
Female	913	54.9	494	55.4	419	54.4	1.0 (-7.4,5.5)	
Marital status								
Single/Divorced/ Separated	880	52.9	491	55	389	50.5	4.5 (-11.1,2.1)	0.065
Married/Cohabiting	782	47.1	401	45	381	49.5	4.5 (-2.5, 11.5)	
Disabilities								
No	1,576	94.8	864	96.9	712	92.5	4.4 (-6.7,2.1)	<0.001**
Yes	86	5.2	28	3.1	58	7.5	4.4 (-4.9, 13.7)	
Highest level of education								
None	229	13.7	153	17.2	76	9.9		<0.001**
Pre-school/Nursery	7	0.4	3	0.3	4	0.5		
Primary	1,180	71	575	64.5	605	78.6		
Secondary	226	13.6	147	16.5	79	10.3		
Higher or university	20	1.2	14	1.6	6	0.8		

*For the ungroup age, we used a t-test for differences and p-value
** P-values <0.05 indicate statistical significance

Qualitative participants

Thirty-one FGDs were conducted, including 16 in the intervention site and 15 in the comparison site, with a total of 238 participants. Among participants, 126 (52.9%) were female. The numbers of participants were approximately equal across sites. FGDs were composed of about 7-10 participants. The majority of adolescents aged 13–19 years were enrolled in school. Among the 20–24-year-old groups, most of the female participants were married whereas male participants in this age group were not.

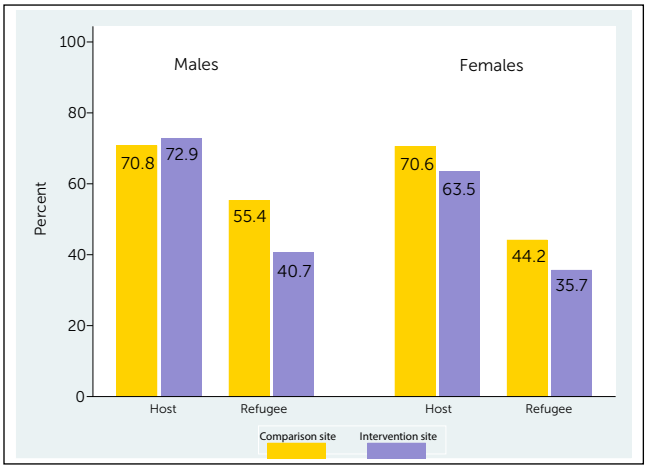
Fourteen KIIs were conducted in the intervention site. Of these, seven members were from the CAB, two VHTs and two VHT supervisors (non-RHU staff), and three RHU project staff. The CAB comprised community resource persons, community leaders, and representatives of the local government and NGOs engaged in SGBV service provision.

Awareness, knowledge of, and attitudes toward gender-based violence and SV among community members

Awareness and knowledge of GBV

Overall, about half (52.1%; n=866) of community members who participated in the KAP survey reported being aware of the term "gender-based violence"; however, community members in the comparison site were more likely to be aware of the term (57.3%; n=441) compared to those in the intervention site (47.6%; n=425; p<0.001). However, further data disaggregation by community, settlement, and subgroup indicated varied awareness of GBV among community members regardless of site. Host community members were more likely to be aware of GBV compared to their refugee counterparts (see Figure 1) with community members in the intervention site being least likely to report having heard the term. Male respondents across sites were more likely to be aware of GBV compared to female respondents; approximately half (55.4%; n=195) of refugee men in the comparison site reported having heard of GBV compared to 44.2% (n=273) of refugee women in the comparison site (**Figure 1**).

Figure 1: Awareness about GBV compared by sex and by type of community



Compared to KAP survey data, FGDs provided nuanced details into the refugee community members' knowledge and understanding of GBV across age, gender, and site. FGD participants shared that GBV is prevalent within the refugee communities. While young adolescent boys (13–16 years) shared limited responses when asked about their understanding of GBV, their adolescent girl peers in both sites mentioned a range of characteristics, including mistreatment, abuse of

rights, denial of a person's will, and parent's refusal of basic needs as examples of GBV. Parents as perpetrators of GBV emerged most strongly among younger adolescent girls. Adolescent girls cited mistreatment of girls by adults, especially those who are orphans or those who live with caregivers who are not their biological parents.

> "The reason I drew [this] is because if you are staying at other people's home because your people are not around [Respectful way to talk about the dead], the person you are staying with can mistreat you. They can for example take their children to school, and they don't take you to school and she beats you and abuses you- all sorts of abuses and makes you work." (FGD, Adolescent girls 13–14, Comparison site)

Compared to younger adolescent boys and girls, older adolescents irrespective of sex across both sites exhibited a stronger understanding of GBV. They described GBV most frequently as violence perpetrated against a person based on their gender. Most of the older adolescent participants emphasized that GBV was perpetrated against women by men.

> *"As I said, it [GBV] is the act being carried out in the community by a man, or a woman being beaten by her husband and her rights being neglected."* (FGD, Adolescent girls, 15–19, Intervention site)

Young adults (20–24 years), especially women, spoke even more fervently about GBV as being abuse perpetrated against women by men. They most often mentioned the sexual types of GBV, including mentions of SV, such as women being raped by men and IPV. At the same time, some participants mentioned other forms of GBV:

> *"GBV is an abuse of the female gender by the male gender. It can be socially, sexually, economically, and also physically."* (FGD, Adult women 20–24 years, Intervention site)

Adult participants in both sites shared more nuanced descriptions of the different types of GBV compared to younger groups. The adults, irrespective of sex, were more descriptive in their description of the different types of GBV. For example, some participants described GBV as conflict between the man and the woman in the home, IPV, economic GBV, and neglect or abuse of children, including child marriage. This was slightly different from the younger groups who primarily focused on child abuse and child marriage. More so than other groups, adult participants shared that GBV can be perpetrated against one of two genders—men or women.*

> *"Gender-based violence is denying the right of the person whether a man or a woman."* (FGD, men 25+ years, Comparison site)

Types of GBV

Participants across age groups mentioned different forms of GBV, including economic abuse through denial of resources; psychological abuse; IPV; and physical abuse. Physical GBV was often described in terms of physical violence between male and female couples or parents and children. Psychological violence was mentioned in terms of emotional torture caused by frequent use of abusive words or quarrelling between people, especially husband and wife or parents and children. IPV was discussed by adolescent girls irrespective of age and older participants. IPV was often described as synonymous with SV.

* At the time of data collection, same-sex sexual activity was criminalized with a maximum of life imprisonment in Uganda. In 2023, the government passed the 2023 Anti-Homosexuality Act, which restricts the ability of LGBTQI+ Ugandans to participate in public life and engage in civil society. Under the Act, punishments for same sex relationships range from life imprisonment to the death penalty.

> *When you are dating and he asks for sex and you refuse, it may cause a fight between you or a rape*. (FGD, older adolescent girls 15–19 years, Comparison site)

Economic GBV was viewed in terms of conflict that arose because of failure to provide or denial of economic or basic resources. Economic GBV was commonly described in terms of GBV that arose when men failed to provide basic needs or denied their female partners opportunities to venture outside the home to earn a living. In some cases, economic GBV was discussed as denial of food:

> *[H]arassment between a male and female can either be socially or economically. A man does not necessarily have to fight you but can refuse to give you what to eat [food] at home or even threaten you sexually*. (FGD, young female adults 20–24 years, Comparison site)

Some interpretations of GBV extended beyond the technical definition of GBV. In one of these interpretations, adolescents, particularly older adolescent girls, described refusal of a love proposition by a person of the opposite sex as a form of GBV. One FGD group of 15–19-year-old girls in each site described GBV as one person rejecting the other's admission of or request for affection.

> *"Participant 1: Gender-based violence is when a boy asks a girl for love, and she refuses.*
> *Moderator: Why did you say so?*
> *Participant 1: Because the boy is forcing the girl into love/ marriage.*
> *Participant 2: GBV is when a girl refuses to fall in love with a boy.*
> *Participant 3: GBV is when a boy composes his love for a girl and she refuses.*
> *Participant 3: GBV is when a boy tells a girl I miss you.*
> *Moderator: Okay. Now, I am going to ask you. Why do you say when a boy tells a girl about love is gender-based violence?*
> *Participant 1: Because when the girl refuses it becomes gender-based violence."* (FGD, Adolescent girls,15–19, Comparison site)

Causes of GBV

Overall, poverty emerged as a common theme across groups when they discussed causes of GBV. Discussion groups among younger adolescent girls cited intersections of food insecurity, poverty, denial of resources (specifically access to school/school fees), and physical abuse against children and women. On the other hand, adolescent boys' discussions focused on physical abuse between a man and a woman, alcohol food insecurity drives GBV by forcing a woman into use by women and men, and poverty. Younger adolescent girls referenced physical abuse by both adult women and men, including parents and stepparents, as factors that drive GBV.

> *"The reason I drew this is because for example if you stay with someone like your uncle's wife. And you are left to stay with her. And then you do something at home and then leave it half done because you have to go somewhere like school for example. In the event that you actually did this thing without anyone asking you to and then it goes bad in your absence, she [the uncle's wife] will beat you when you return. And in case you go to school and you are chased home for money. She can decide not to take the remaining balance to school."* (FGD, Adolescent girl, 13–14, Intervention site)

Among adult groups, one adult women group and two adult men groups in the intervention site cited food insecurity and poverty as drivers of GBV. Another adult women group cited lack of food

in the home causing violence between husbands and wives. Participants within this group also cited inability of parents to provide basic needs, such as food for their children, as a form of GBV. An FGD of adult men discussed how food insecurity drives GBV by forcing a woman into sex work:

> *"He is saying, the root cause of the word gender-based violence is, it can be hunger.*
>
> *[H]e said, when…the man has, when there is no access to food, that thing can cause someone to, gender-based violence is like when you force, when you force someone, the person who is not interested. So, the cause of gender-based violence is when she is a prostitute"* (FGD, adult men, 25+, Intervention site)

Attitudes toward GBV

Overall, study findings indicate that community members across both sites do not approve of GBV. **Table 3** summarizes findings on attitudes toward GBV. A score of 72 indicates attitudes that are extremely unacceptable of GBV, while a score of 24 indicates attitudes that are extremely high accepting of GBV. Findings were not significantly different between the intervention (60.1) and comparison sites (60.4) nor between age groups. We also found that females (61.9) were significantly more accepting of GBV than males (58.9).

Table 3: Attitudes toward GBV among community members

Characteristics	Overall			Group				
				Intervention site		Comparison Site		
	n	mean (SD)	p-value	n	mean (SD)	n	mean (SD)	p-value
Attitudes toward GBV scale - (ranges between 24 and 72)								
Overall	1,662	60.3 (11.7)		892	60.1 (12.0)	770	60.4 (11.5)	0.605
Sex								
Male	769	61.9 (11.3)	<0.001	*413*	*62.0 (12.3)*	*356*	*61.8 (10.0)*	0.807
Female	893	58.9 (12.0)		479	58.5 (11.5)	414	59.3 (12.5)	0.320
Age								
13-19	670	60.5 (11.6)	0.739	362	60.9 (11.9)	308	60.1 (11.2)	0.373
20-49	907	60.3 (11.9)		484	59.8 (12.2)	423	60.8 (11.4)	0.205
50+	85	58.1 (11.6)		46	57.1 (9.8)	39	59.4 (13.4)	0.365

*Attitudes Toward GBV Scale [1], Cronbach's alpha -0.741

Although the attitudes toward GBV scale demonstrated relatively negative attitudes toward GBV among community members in both sites across sex and age groups, FGD data indicates that SV, particularly IPV, and to a lesser extent child marriage, are a norm among refugee and host communities. FGDs also revealed that both perpetrators and survivors of SV are stigmatized by community members. Survivors of SV face a myriad of barriers to accessing care and services, including access to legal recourse. FGD participants also noted that within the refugee settlements,

SV was rarely reported to either the local courts or the police. Discussing IPV outside of the home was particularly perceived as taboo. According to FGD participants, SV was perceived as a challenge within a marriage that had to be tolerated or accepted by wives given that the husband's family paid a dowry to his wife's family.

> *"[T]here is no option for that [justice for the survivor] since the man has paid the dowry, so he can rape anytime he feels like without anybody being concerned. Because it is their bedroom issue and so they have to solve their issues on their way."* (FGD, young female adults 20–24, Comparison site)

Although FGD participants described SV as a norm within marriage, it was also viewed as negative and shameful. Participants cited derogatory names used by community members to label perpetuators of SV within families. At the same time, negative and derogatory terms for survivors of SV were also commonplace in the community, indicating a high degree of stigma associated with experiences of SV. Participants explicitly noted that derogatory words such as "prostitute," "angwech," "victim," and "bitch," among others, are used describe or label survivors at the community level while "gangster" and "crew" were labels given to perpetrators of SV.

> *"In the community anyone who has been raped is considered as a worthless person*." (FGD, young adult female 20–24, Intervention site)
>
> "*She is called a prostitute."* (FGD female 15–19, Comparison site)

A discussion with 20–24-year-olds in the intervention site listed additional terms that are used to describe perpetrators of SV.

> *R6: They're called criminals.*
>
> *R1: They are called hunters.*
>
> *R3: For the women who are married and still continue looking for young boys are called sugar mummies.*
>
> *R3: For the men who are marry and still continue looking for young ladies/girls are called sugar daddies*. (FGD, young male adults, 20–24 years, Intervention site)

Discussions revealed that the brunt of stigma associated with SV weighed heavily on females compared to males. Participants shared that following SV involving at least one minor, the dominant community norm is that the adolescent girl is often blamed for the incident, and some adolescent girls are forced to marry the perpetrator.

> *"If it's a lady being defiled or raped in our culture, that person is expected to pay dowry and the girl is given to him to marry after paying the dowry. Because no one will marry her again after being raped so that is why they've to give her to the man."* (FGD, Adult Female,25+, Comparison site)

Child marriage emerged as a subtheme among participants (13–24 years) across both sites. Adolescent participants described scenarios where adolescent girls were forced into child marriages for economic reasons, or married to the perpetrator. Participants explained that when SV occurred, there were two possible judicial pathways to address it: 1) through the legal processes in Uganda; or 2) through the local courts. While the legal processes involved courts and police, the local courts were based on traditional norms and processes. Traditionally among the Dinka (the prominent ethnicity among South Sudanese refugees), when a young girl was sexually violated, the perpetuator was fined six cows and was expected to marry the girl (survivor). Whereas some participants noted

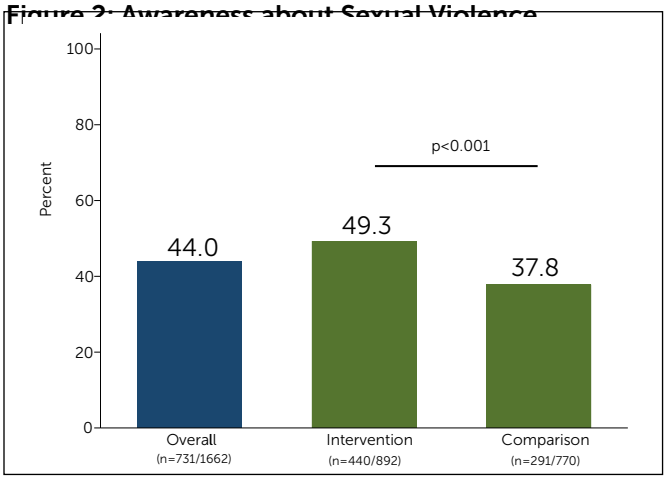
that this practice was slowly receding since their displacement to Uganda, other participants protested that local courts still existed, and, in some cases, the parents of the girls returned the girls to South Sudan to settle the cases through traditional procedures or force them into child marriages.

> *"In our culture, if you're caught [having sexually violated a girl], you will be taken to the elders, and they'll fine you to pay [6] cows in their court. You can also be forced to marry the girl because you would have spoilt her reputation and no one else would marry her."* (FGD, adolescent boys, 15–19, Intervention site)

Awareness of Sexual Violence

Quantitative and qualitative data demonstrated higher awareness of SV compared to GBV among community members. As discussed in the section above, community members across groups engaged in more robust conversations about SV compared to GBV. These discussions indicate a high level of awareness of SV. Overall, 44 percent (n=731) of KAP survey participants responded that they had heard the term "sexual violence"; however, knowledge differed across sites (p<0.001). Approximately half (49.3%; n=440) of community members in the intervention site reported awareness of SV compared to 37.8% (n=291) of community members in the comparison site (See **Figure 2**).

Figure 2: Awareness about Sexual Violence



Knowledge of Sexual Violence

Quantitative and qualitative data also demonstrated higher knowledge of SV than of GBV among community member participants in both sites. FGD data indicated that SV was understood as nonconsensual sex or forced sex. Participants used words such as "defilement," "rape," or "sex with an underage girl" to define or exemplify SV. Among adult participants, IPV was defined as a form of SV. In such cases, participants stated that irrespective of an existing romantic relationship, nonconsensual sex was defined as SV:

"It [sexual violence] is to forcefully get someone down [forcefully have sex with someone]. Even your wife, if she says I'm tired, you shouldn't try to force her. Even a young girl you have met because we are men, if she has not accepted you, you shouldn't put her down by force. So, to me, that is what sexual violence is." (FGD, adult males, 25+ Comparison site)

Among the younger adolescents, SV was most often perceived as child marriage and unwanted touching of girls' feminine parts, such as the buttocks and breasts.

"Sexual violence includes raping and defilement and caused when a boy forces the girl into sex

and as well touch their private parts and sometimes their buttocks." (FGD, Adolescent boys 14–16 Intervention site)

The quantitative results revealed that community members have an acute technical knowledge of SV, including consequences, available services, and type of services received. Overall, almost all (98%; n=1629) of survey participants cited at least one consequence of SV. The most cited consequences were related to health, such as STIs, including HIV, and physical injury (n=332; 61.1%), followed by mental health and psychosocial consequences, such as shame, stigma, depression, anxiety, and/or suicidal thoughts (n=173; 3.19%). Similarly, almost all participants (98.6%; n=1639) knew of at least one service that people who experience SV receive when accessing care. The most common services reported by participants related to receiving testing and treatment for STIs in a timely manner (n=364; 36.7%), followed by receiving medication for the prevention of pregnancy (n=219; 22.1%), and receiving care for injuries (n=180; 18.1%). See **Table 4**.

Table 4: Knowledge of the Consequences of SV

Characteristics	Overall		Group				
			Intervention site		Comparison Site		
	n	%	n	%	n	%	p-value
Can you mention the consequences of sexual violence?							
None/don't know any	11	2	4	1.2	7	3.3	0.021
Health consequences, such as STIs, HIV, and physical injury	332	61.1	204	62.2	128	59.5	
Mental health and psychosocial consequences: shame, stigma, depression, anxiety, suicidal thoughts	173	31.9	*110*	*33.5*	*63*	*29.3*	
Others	27	5	10	3	17	7.9	

Attitudes toward gender equality

The GEM scale measures attitudes toward gender equality. The scores range between 11 and 33, where a mean or average of 11 indicates that respondents have extremely negative attitudes toward gender equality (do not agree with it), while a mean score of 33 indicates that respondents have positive, or agreeable, attitudes toward gender equality

Overall, moderately positive attitudes toward gender equality were recorded (mean=24.8) by community members who participated in the KAP survey. **Table 5** presents the average scores on the GEM Scale by participant group. Community members in the intervention site demonstrated higher support for gender equality (26.9) compared to those in the comparison site (22.4), $p<0.001$). Overall, males had slightly higher positive attitudes toward gender equality than females (25.0 versus 24.7). There were no differences in attitudes toward gender equality between age groups.

Despite moderately positive attitudes toward gender equality using the GEM scale, FGDs revealed that unequitable gender norms and power dynamics were nevertheless a norm (see **Appendix 1**). Qualitative data illustrated inequitable gender norms that devalue female decision-making and authority, including diminishing agency in mobility and health care-seeking behaviors. KIs frequently mentioned that the decision to leave the home, seek care for women and children in the household, especially adolescent girls, was vested within the men of the household. KIs discussed that the lack

of decision-making authority among women inevitably negatively impacted women and children's access to health care and other pathways to access information and resources for SGBV.

> *"The parents influence the decisions [for adolescents] and for the women, the men influence the decisions... the man tells you [the woman] not to go to a health center and you will not go so he makes the decision and you will not go. The man will also tell you not to report to any local council or authority. So, the man makes the decision."* (KII, female health worker, Intervention site)

Table 5: Attitudes toward gender equality among community members

Characteristics	Overall			Group				
				Intervention site		Comparison Site		
	n	mean (SD)	p-value	n	mean (SD)	n	mean (SD)	p-value
Attitudes toward gender equality on the GEM scale (ranges between 11 and 33)								
Overall	1,662	24.8 (6.7)	<0.001	892	26.9 (4.1)	770	22.4 (8.2)	<0.001
Sex								
Male	769	25.0 (6.5)	<0.001	*413*	*27.0 (4.2)*	*356*	*21.8 (8.4)*	0.807
Female	893	24.7 (6.9)		479	26.8 (4.0)	414	22.9 (8.1)	0.320
Age								
13-19	670	24.5 (6.9)	0.739	362	26.8 (4.2)	308	21.8 (8.3)	0.373
20-49	907	25.0 (6.6)		484	27.0 (4.1)	423	22.8 (8.1)	0.205
50+	85	25.0 (6.9)		46	27.4 (2.6)	39	22.2 (9.1)	0.365

Community member access to SGBV services

Community member knowledge of and access to available SGBV services

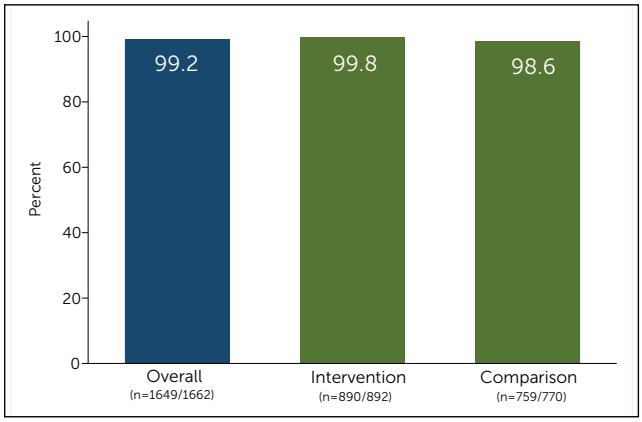
Overall, study data indicates that community members across sites were somewhat familiar with SGBV response services available in their communities; while they were much less aware of available SGBV prevention programs. Findings also indicate that community members have very limited access to available SV services.

KAP survey data revealed that community members across sites were least likely to be aware of available GBV and SV programs and services compared to any other services (e.g., food, shelter, legal, MHPSS, and safe spaces). Overall, only 5 percent (n=83) of participants reported being knowledgeable about the availability of GBV program/services in their community, and only 2.1 percent (n=35) reported being knowledgeable about available SV program/services in their community (see **Table 3**). However, almost all (99%; n=1649) participants in both study areas reported knowledge of services available in their community that provide support for people who experience GBV (see **Table 6**).

Table 6: Knowledge of GBV Services among Community Members							
Characteristics	**Overall**		**Group**				
			Intervention site		**Comparison Site**		
	n	**mean (SD)**	**n**	**mean (SD)**	**n**	**mean (SD)**	**p-value**
Know of any services in your community that provide support for victims of GBV							
Yes	1,649	99.2	890	99.8	759	98.6	0.005
No	13	0.8	2	0.2	11	1.4	
Aware of currently available services in your community							
WASH (water, sanitation, hygiene)	1,314	79.4	761	85.3	553	72.5	p<0.001
Food	840	50.8	509	57.1	331	43.4	p<0.001
Shelter (plastic, sheets, poles)	247	14.9	131	14.7	116	15.2	0.0769
Safety/security	449	27.1	268	30	181	23.7	0.004
Legal services	313	18.9	202	22.6	111	14.6	p<0.001
Mental health or psychosocial support	1190	71.9	717	80.4	473	62	p<0.001
Safe spaces	138	8.3	105	11.8	33	4.3	p<0.001
Gender-based violence programs/ services	83	5.0	53	5.9	30	3.9	0.062
Sexual violence programs/services	35	2.1	22	2.5	13	1.7	0.282

Almost half (44%; n=731) reported being aware of any service available in their community that can provide support if they or another community member experiences SV (see **Figure 3**). Notably, community members in the intervention site (49.3%; n=440) reported higher awareness of available services for survivors compared to those in the comparison site (37.8%; n=291; p<0.001).

Figure 3: Aware of existing services if you or a community member experienced SV



KAP survey findings indicate that community members' access to available SV services was even more limited. One third (36.7%) of the participants believed that survivors of SV had services like accessing tests and treatment for STIs in a timely manner, while other services were less likely to be accessed by survivors, such as emergency services (5.6% in the intervention site; 6.5%,

the comparison site) and referral services (e.g., advanced medical care, legal services, shelter, psychological support) (14.2% in the intervention site; 15.7% in the comparison site) (see **Table 7**).

Table 7: Services available for survivors of sexual violence							
Characteristics	**Overall**		**Group**				
			Intervention site		**Comparison Site**		
	n	**mean (SD)**	**n**	**mean (SD)**	**n**	**mean (SD)**	**p-value**
Services that people who experience sexual violence receive when they access any care (multiple response question)							
Get tested and treated for sexually transmitted infec-tions in a timely manner	364	36.7	237	37.9	127	34.5	0.521
Receiving medication for the prevention of pregnan-cy	219	22.1	133	21.3	86	23.4	0.715
Receive emergency services	59	5.9	*35*	*5.6*	*24*	*6.5*	0.489
Receive care for injuries	180	18.1	109	17.4	71	19.3	0.747
Receive referral services (e.g., advanced medical care, legal services, shelter, psychological support)	141	14.2	98	15.7	43	11.7	0.534
None	14	1.4	8	1.3	6	1.6	0.874
Other	16	1.6	5	0.8	11	3	0.657

Overall, FGDs with community members corroborated these findings. Only a few FGD participants mentioned SGBV prevention or awareness activities; however, they were able to name different actors engaged in SGBV service provision. The FGD participants across both sites highlighted some health education and community awareness-raising activities focused on SGBV that happened within their communities. In a discussion with women 25 years and more, a woman exemplified the benefit of community sensitization on SGBV:

> *"We came to know of sexual violence after some trainings. For us who never went to school, we take it normal [we accept sexual violence as normal] but now that we are aware of it [sexual violence and its consequences], we need our fellow women to be educated."* (FGD, adult women 25+ Intervention site)

The SGBV community activities reportedly engaged community members and staff from different NGOs or community leaders to discuss SGBV or how to address domestic conflicts through peaceful resolution, as explained by the KII below:

> "*The community activists are always there to do community awareness on GBV. They do awareness within the community. Then they are also there to report, to refer cases to us, yes, they refer cases. They also give information on referrals to survivors."* (KII, Female, SGBV case worker, NGO, Intervention site)

KIIs based in the intervention site mentioned that GBV services were offered through static facilities (e.g., health facilities), while community outreach and follow-up for GBV cases were delivered at the

community level, such as home visits. Follow-up care was delivered when needed by VHTs or other parasocial workers at the community level.

Some of the SGBV actors engaged in response who were frequently mentioned by FGD participants include: government institutions, such as health facilities, police, OPM; humanitarian international nongovernmental organizations (INGOs) such as Lutheran World Federation, Save the Children, and Plan International; and community-based actors, such as camp leaders, cultural leaders, parents, and friends. Participants across groups also discussed how and to whom survivors disclose SV cases and to whom and how they seek SGBV care.

> *"We have people, we have leaders in the community. Cluster leaders, block leaders and camp leaders and then the police. So, when something happens in the cluster or block, we first follow protocol and each group keeps referring until it reaches the highest level, which is the police."* (FGD, adult men 25+, Comparison site)

> *"[F]irst of all, the person being raped or the victim is taken to the health center, first to seek for medical attention and then later, if the person who did that [the perpetrator] is found, then the person [the perpetrator] has to pay for what he or she has done."* (FGD, adolescent girls 15–19, Intervention site)

Barriers to accessing and delivering SGBV prevention and response services

Despite FGD and KII participants' reports of available, albeit limited, SGBV services and structures, they also emphasized substantial barriers that impeded access to delivery of such services within the community. The commonly mentioned barriers included fear of stigmatization, delayed GBV disclosure and care seeking, and barriers around the implementation of community sensitization activities.

Fear of stigmatization

Fear of stigmatization was the most frequently discussed barrier to accessing and delivering SGBV prevention and response services among FGD and KII participants. In discussions with health workers and FGDs with adult women, it was noted that irrespective of sex, stigma around being associated as a survivor of SGBV greatly curtailed care seeking and SGBV disclosure. According to participants, adolescent girls feared stigma that would implicate their future marriage prospects, while the men feared stigma associated with "emasculation." KIIs with health workers highlighted that even within health facilities, women sometimes never explicitly mentioned that they were seeking care for SGBV-related issues.

> "*They do not report, they just come with an aim of 'I want family planning not to get pregnant,' so when you ask them, that is when they will tell you. Or someone comes with lower abdominal pains and when you go and check, you will find someone with a bruise and when you ask what happened, that is when they will tell you 'This and this happened.' They do not come directly saying 'this happened to me at home, I need help.' Someone will just come for a service, 'I need you to check for me an STI, I have pain here, I need you to check for me my private parts,' but they will not come and tell you directly. But when you probe more, it is when they will tell you this and this happened. It is not something they will report often*." (KII, health worker, female, Intervention site)

Notably, a few KIs noted that men very rarely sought care for SGBV because of fear of stigma perpetuated by deeply rooted gender norms around masculinity. KIs noted that even when the men exhibited physical signs of violence, they still concealed their experiences of SGBV because of the

gender norms that posit that men should be strong while women are weak and victims. According to gender norms in the community, KIs explained, men are not supposed to be beaten by women or other members of the household.

> *"Even the men are affected but it's not easy for the men to report sexual violence for obvious reasons….I mean, you are a man then you go and say the woman has beaten you or sexually harassed you. For cultural orientation you want to be a man and you don't want everyone to know that your wife has beaten you or sexually harassed you,"* (KII, male, health worker, Intervention site)

FGD and KII participants across sites noted negative community attitudes toward household visits that aimed to follow up with SGBV survivors. Some KIs who are health workers recalled first-hand experiences of resistance from community leaders during household visits, primarily within male-headed households. These KIs explained that this resistance was strongly due to the stigma associated with health worker visits and the cultural sentiments that men and cultural leaders had autonomy to handle issues of SGBV within their homes and communities respectively without interference from "outsiders."

> *"Sometimes the community leaders may come in and say, 'you go back to the facility and wait for this person there in the facility.' Or they will tell you, 'We already handled this case' and yet you really expected that you have to follow up your clients and give them the better services they have. For them, they think that when they have completed their case, the health aspect should also end there and yet we really need to follow up this case to ensure there is completion of treatment, to ensure there is completion of everything***." (**KII, female, health worker, Intervention site)

Furthermore, KIs mentioned that community members who witnessed or had information about a SGBV case rarely reported or disclosed the case for fear of being labelled as "reporters." In this setting, "reporters" are discriminated against and blamed for any intentional or unintentional consequences of disclosure, such as stigma experienced by the survivor or arrest of the perpetrator.

> *"People do not report those cases. That is why I told you sometimes you may hear a case, maybe a child of 17 or 18 years is pregnant. If you try to interview the girl, you will hear that maybe it was through sexual violence that this lady got pregnant and of which no one reported the case. Even the neighbors themselves, they fear to report those cases. Why, because the community will blame them*." (KII, female, SGBV case worker, NGO, Intervention site)

Delayed SGBV disclosure and care-seeking behavior

According to the KII participants, delayed SGBV disclosure often resulted in delayed care seeking, and thus lack of timely, and at times, lifesaving care. KIs mentioned that some family members may initially prefer to settle SGBV cases between themselves and the perpetrator's family and would only report to police when this unmediated negotiation failed or in case the perpetuator did not fulfill their obligations as agreed by the families. According to KII and FGD participants, SGBV survivors, especially women and girls, rarely disclosed SGBV, particularly IPV. Non-disclosure was attributed to community norms that IPV is perceived as an internal household issue that should be handled between husband and wife. Furthermore, disclosing SGBV outside the home could result in conflict initiated by the brothers of the female hoping to avenge their sister's distress, or fear of intimidation or harassment by the perpetrator's family or other community members.

> *"Parents can also stop us from going to places like the police. Instead, they settle on their own." (*FGD, female 15–19, Comparison site)

> *"Sometimes people just shy away even when they know they have been raped. Others keep quiet about it because of fear. Once people (the community) get to know then they'll follow you*." (FGD, young female adults 20–24 Comparison site)

KII participants noted that in other instances, care-seeking delays accrued due to how the case is handled between the police and the health facility. Although VHT members are mandated to refer the survivor directly to the health facility, they may refer them to the police first, impeding access to time-sensitive care. This referral pathway was noted as causing precarious delays to offer effective medical interventions such as the provision of post-exposure prophylaxis (PEP) or ECPs.

> *"Sometimes we have had referrals direct from the community health workers but most of them go through police and we feel sometimes it really delays our case management as a health facility... we need to give you PEP early, we need to give you the pills early and sometimes when they follow that process, it takes a long time. You find sometimes a case first has to go through police, sometimes they might even sleep at police and that is all time wasted before they bring for you the client here. Maybe when the client is brought to us, we give our prophylaxis treatment and then the rest continues*." (KII, female, health worker, Intervention site)

KIs who served as members of the CAB and those who were health workers provided additional information about the SV referral pathway. They noted that community stakeholders, including themselves, have a clear understanding of the SGBV referral pathway, but noted that many community members are not aware that one exists. Although participants in the FGDs shared that SGBV cases should be reported to the police, block leader, or the OPM† settlement offices, some KIs highlighted that the district lacks an updated referral pathway. Participants added that in some locations, there was no clear information about where or whom to report cases of SGBV. Further, as noted above, ambiguity exists around the timing of reporting cases to the health facility and the police, which may result in devastating consequences for survivors.

> *"Even the refugees and also issues of stigma in some cases where a girl is raped, she may not want to come up and in some locations, they may not know where to report so the referral pathway is not clear."* (KII, female, member of CAB)

> *"As a district, we don't have an updated GBV referral package whereby if you are confronted with a survivor of SGBV you may not know where to refer this person*." (KII, female, representative of the local government)

Safe spaces or shelters for women and girls were rarely discussed during the FGDs and KIIs. In the few instances that they were mentioned during FGDs of adolescent girls, very few adolescent girls reported knowledge of them. When safe spaces or shelters were mentioned during the adult women FGDs, participants expressed dissatisfaction with how their cases were handled at the shelters.

> *"Ever since we came here to this camp, nothing has ever been done to me. I am a survivor. [Name of NGO] has tried to protect me, but they have always brought me*

† In Uganda, the office of the Prime Minister (OPM) is the line ministry mandated to lead and enhance National Response Capacity to Refugee Emergency Management http://urrms.opm.go.ug/refugeemanagement.html. By virtue of this mandate, the OPM has entrenched its structures in all settlements in Uganda.

> *back home where I have my husband. So, I don't see this protection. I go to police when my husband beats me, they take me to reception, and nothing happens. They have tried and still brought me back home where my husband who beats me still beats me now. So, all this comes in as protection but they don't help."* (FGD, adult women 25+, Intervention site)

Some KIs noted that the few existing safe spaces available in the community rarely offered psychosocial services to facilitate reintegration of survivors within the community. Therefore, women who had used the shelters encountered immense challenges when they left the safe space and returned to the community.

> *"The protection house we have is full because of issues like sexual [and] gender-based [violence] issues. They are overwhelmed. If you stay there for two or three months, you are brought back to the community. When a person from the protection house comes back to the community, they will be seen differently and the community will be asking questions like where they were and why they are back… The people brought to protection house need to be followed up and given psychosocial support even when they leave."* (KII, VHT, male, Intervention site)

KIs who are VHTs mentioned a barrier related to program design that hinders community members' SGBV disclosure and care seeking. VHTs noted that during community sensitization activities on SGBV, sessions were rarely disaggregated by age and gender. As such, these community sensitizations or awareness-raising events were perceived to exacerbate the power differentials by gender and age and curtail adolescents and women from freely expressing themselves. In turn, adolescents and women were not comfortable disclosing cases of SGBV or seeking care. Compounded with gender norms around expectations that women and girls should not speak out in the community about sensitive topics such as SGBV, and that men who disclose SGBV are weak or "emasculated," KI data suggests that no one in the community, regardless of gender or age, is comfortable discussing SGBV, let alone disclosing a case.

> *"When they are calling the people during community awareness creation, they don't categorize or put these youth separate. The youths, especially those in adolescent age who can't talk in the presence of others, they fear. At least they should be separated when they are creating awareness, they should sit in these categories of the age. This category of age should be here and the other there. Also, give them the person [facilitator] they are comfortable with, somebody who is like them."* (KII, VHT, female, Intervention site)

> *"One of the challenges is culture; like if we call the community and sensitize about GBV cases, you see in the context of our culture a woman cannot be open. She cannot open up in a community or cannot open up about her case. Even the men cannot open up, they don't want the case to be known. If it happens to be a fight where we can see and ask, you find the man cannot explain even the woman who got injuries cannot talk."* (KII, VHT, male, Intervention site)

Findings illuminated community members' barriers to accessing information delivered through radio talk shows. Whereas the radio had potential to reach many people at the same time with SGBV information, KIs noted that not every household in the settlement has access to a radio or phone to engage in the sessions. Other barriers to accessing SGBV information via radio talk shows mentioned by the KIIs included language barriers and the time of the day during when the health

education sessions were aired. The timing rarely favored female participation.

> *"When you are at the radio station, you find it is only men asking questions. Given the timing, you find women may be busy, yet these are programs everyone should listen to, but in my experience, during the time of disseminating information on the radio, men are the ones asking questions, meaning the majority of the audience may be left out. At home not everyone has a phone or knows when the program is there, but the men are at an upper hand because they have their phones all the time and are less busy. The women can be reached at the community, but in terms of coverage, information can be given in the media for general community consumption. But particularly for women, it can be given at a community level, where much of the information can be consumed.* (KII, female, member of CAB)

Sense of safety and well-being

Community members' sense of safety and well-being

KAP survey participants across sites (83.3%) rated their sense of safety and well-being to be high, although sense of safety and well-being was rated higher among intervention site participants (85.3%) than among comparison site (80.8%) participants (see Table 4). In contrast, qualitative data indicate that community members across sites are concerned about community safety and well-being, particularly the safety and well-being of women, girls, and people with disabilities. In the few instances safe spaces were mentioned, participants who self-identified as GBV survivors expressed concern about their safety and well-being despite accessing safe spaces. These participants shared that they were frequently taken back home (by safe spaces staff), where they were subjected to recurrent violence from their perpetrators.

Within the settlements, a fenced household coupled with a male-headed household was viewed as a sign of higher security and safety for the household members. However, many households were routinely female-headed because men often traveled back to South Sudan. In such scenarios, despite fencing, female-headed houses were viewed as at risk for SV:

> *"When you visit the settlements, you will find a homestead is fenced locally. That is a sign of security at home, but what puts them at risk is that many of those households are headed by women and the men have gone away, so any man who wants to be brave can do anything to the girls who have grown up."* (KII, female, member of CAB)

The majority of qualitative participants acknowledged that women, adolescent girls, and people with disabilities were more vulnerable to SGBV than men, adolescent boys, and people without disabilities within the household and across community spaces. According to participants, SGBV risk was exacerbated by the COVID-19 pandemic, in addition to existing gender norms and power dynamics that view women as "weak" compared to men. When asked about areas or places that increased SGBV risk, many respondents mentioned water collection points, roads, marketplaces, night clubs, and within the home.

> *"GBV is generally caused by power abuse; men tend to use the power they have to disadvantage other sexes like the women. The men feel they are powerful, so in due process they end up inflicting pain mostly on the vulnerable people. But here I am talking about the women who are marginalized."* (KII, male, local government representative, Intervention site)

Qualitative data revealed that young girls were commonly at risk of child marriage. Among KIIs and FGDs with adolescents, participants highlighted that among the Dinka, young girls were usually

married off to older men with or without their consent. According to these discussions, when local authorities within the settlement obstructed child marriage, the adolescent girl was sometimes lured back to South Sudan by their family to complete the marriage transaction under the false pretext of educational opportunities.

> *"Generally, the people who are vulnerable are the girls and the women. Based on the Dinka culture, most women are so vulnerable. Among some clients that we interact with, you find that the parents or the relatives get like 100 cows without the girls' knowledge and take the things to South Sudan. When they are here you just hear that 'you come to South Sudan, maybe we got for you a scholarship' and when the girl goes, they just take her straight to the kraal and hand over the cattle. After they have already exchanged the cows, some can manage to escape but those who cannot are those who really never went to school."* (KII, female, member of CAB)

Table 8: Sense of safety and well-being in the community

Characteristics	Overall		Group				Two proportion tests
			Intervention site		Comparison Site		
	n	mean (SD)	n	mean (SD)	n	mean (SD)	p-value
Rate your sense of safety and well-being in your community:							
Insecure	279	16.8	131	14.7	148	19.2	
Secure	1,383	83.2	*761*	*85.3*	*622*	*80.8*	0.014

Safety aspects during the community provision of SV care

KIs were asked about their perspectives on safety during community provision of SV care by VHTs. In response, KIs shared mixed reactions. Overall, VHT respondents shared that they did not currently face any safety concerns when offering services for SV within their communities, nor do they anticipate any concerns. During KIIs, VHTs expressed that the title of "VHT" implicitly offered them security to provide services within their community because they were selected by their community members and could access any home to offer a variety of services.

> *"My security is okay... My role as VHT is to help the community, I am volunteering and helping on their behalf so what I am doing is for their benefit and the drugs I use are not harmful. So even if I move at night and they know it's me, their VHT, there is no case labeled against me*." (KII, VHT, male, Intervention site)

However, VHTs also acknowledged that they must conduct their GBV-related work judiciously. They specifically mentioned that to avoid confrontations with community members, they had to be mindful of how they approached any GBV-related discussion during home visits. They expressed preferences for indirect ways of eliciting GBV-related information, such as during home visits to follow up on a GBV case, or to disseminate information about GBV.

> *"When I go to the household, I can give some information for some questions. We can hide how we ask it, we can bring it as a related question but not directly... like if you ask what is your opinion toward this case? When we say what is your opinion, they think we want the wife or man to leave their partner. Also, when asking about the involvement of the relatives,*

you cannot say who are those who supported or are actors to this case? When asking them, we twist it differently because they think we want to arrest the actors." (KII, VHT, male, Intervention site)

Discussion

Overall, the baseline study suggests that community members have moderate awareness and knowledge about SV and to a lesser extent GBV, with adolescents having the least knowledge. Although the quantitative data clearly show that community members largely do not approve of SGBV and have moderately strong positive attitudes toward gender equality, qualitative data revealed that SGBV, particularly IPV and child marriage, and unequitable gender norms and power dynamics were nevertheless the norm. Study findings also suggest that community members across sites were somewhat familiar with SGBV response services available in their community; however, they were much less aware of available SGBV prevention programs and have severely limited access to SV services. Finally, while the majority of KAP survey participants reported their sense of safety and well-being was high, qualitative data illustrate that community members across sites are concerned about community members' safety and well-being, particularly of women, adolescent girls, and people with disabilities. These key findings are discussed below and accompanied by recommendations to inform the design of the *Communities Care* program among refugee and host communities in Adjumani District, Uganda.

SGBV awareness and knowledge among community members

Across sites, approximately half (52.1%) of community members reported being aware of the term "gender-based violence"; however, levels of awareness varied by community, settlement, and subgroup. GBV awareness levels were higher in the comparison site than in the intervention site, and awareness levels were lower among females (49.6%) than among males (56.8%).

Host community members were more likely be aware of GBV than their refugee counterparts, and the intervention site participants, especially women, were least likely to report having heard the term. Overall, study findings demonstrated a higher level of comprehension of SV than of GBV among community member participants in both the intervention and comparison sites. During FGDs, adult participants in both sites shared more nuanced descriptions of the different types of GBV compared to their adolescent counterparts, particularly adolescent boys. KIIs and FGDs indicate that GBV, particularly IPV, were perceived as internal household issues that require tolerance among survivors and must be managed inside the home. Similarly, participants in both sites exhibited solid knowledge regarding the causes and consequences of GBV and SV. Qualitative participants mentioned poverty, food insecurity, and gender power imbalances as key drivers of GBV. The most frequently mentioned consequences of SV by KAP participants were STIs, unwanted pregnancies, and stigma.

Recommendations for the *Communities Care* program

- Community awareness activities should consult CAB members to create key messages and develop SGBV community activities tailored to refugee and host community members according to their age, refugee status, ethnicity, disability status, and gender.
  - » Information about SGBV should clarify misconceptions about GBV and SV, particularly among adolescents, such as the perception that one person rejecting the other's admission of or request for affection is a form of SV.
  - » Activities should enhance community members' knowledge about the different types of GBV, including SV, in addition to causes and consequences, emphasizing where to access care and the importance of seeking timely care.

Community member attitudes toward SGBV

Although the quantitative data clearly show that community members largely do not approve of SGBV, the overall study data show that SGBV is nonetheless a community norm. FGD data indicate that SV, particularly IPV, and to a lesser extent child marriage, are norms among host and particularly refugee communities. FGDs also reveal that both perpetrators and survivors of SV are stigmatized by community members, which contributes to the many barriers that survivors of SV face in disclosing their experience of SV and therefore accessing timely and quality care and services. Qualitative data illustrate that stigma associated with SV particularly impacted adolescent girls compared to men and boys. FGD participants shared examples of adolescent girls being blamed for SV perpetrated against them, and shared experiences of adolescent girls being forced to marry the perpetrator. FGD data illustrate that child marriage and IPV are viewed by the refugee community as internal family matters that should be addressed within the household. FGD discussions around child marriage were more ambiguous. Some participants noted that the traditional Dinka process that requires the perpetrator to pay six cows and marry the adolescent girl survivor to the perpetrator was becoming less common, while others expressed that it is still a norm.

Recommendations for the *Communities Care* program

- Prevention programming should train key community stakeholders (e.g., community and traditional leaders) to dismantle harmful perceptions about the diversity of people who experience various forms of SV through participatory community engagement activities.
  - » Activities may use participatory approaches, such as theatre and role play, to demonstrate survivor-centered approaches to support survivors of SV. Scenarios portrayed in these activities should demonstrate incidents of child marriage and IPV, and how to respond to disclosures and refer survivors to appropriate support and care.
  - » Such activities may provide a nonjudgmental platform for community members to discuss how existing community norms, including traditional norms, can be adjusted to better support survivors of SV by offering alternatives to child marriage and internal household resolution of IPV, such as access to quality, appropriate, confidential medical and psychosocial care; and access to multi-sectoral services, such as access to justice and legal redress, child protection, livelihoods, education, and shelter, among others.
  - » Activities should provide concrete information about where survivors can receive quality, appropriate, and confidential support and care in the community.
  - » Social outreach, public awareness campaigns, and community-focused education should engage key community stakeholders (e.g., community and traditional leaders) to provide community members with accurate information about their legal rights to redress and justice.

Community member attitudes toward gender equality

Although quantitative data indicate moderately strong positive attitudes toward gender equality, qualitative data revealed that unequitable gender norms and power dynamics were nevertheless the norm. During FGDs, community members discussed the myriad of ways that female decision-making and authority were devalued compared to men's. KIIs emphasized that the lack of decision-making authority among women and girls deterred care-seeking behavior and access to information and resources for SGBV among women and children in the household, especially among adolescent girls.

Recommendations for the *Communities Care* program

- Prevention programming should focus on gender-transformative activities to promote more positive 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 disaggregated by gender and address dominant patriarchal norms, such as women needing permission from the male head of household to leave the home.
- » 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.

Community member access to SGBV services

Study findings suggest that community members across sites were somewhat familiar with SGBV response services available in their community; however, they were much less aware of available SGBV prevention programs. Despite demonstration of awareness about available SV services, quantitative data illustrate that community members have severely limited access to those services, particularly emergency services, referral services (e.g., advanced medical care, legal services, shelter, psychological support), care for injuries, and receiving medication for pregnancy prevention, and to a lesser extent timely testing and treatment of STIs. Despite qualitative reports of available, albeit limited SGBV services and structures, they also emphasized substantial barriers that impeded access to delivery of such services within the community. The commonly mentioned barriers included fear of stigmatization, delayed GBV disclosure and care seeking, and barriers around the implementation of community sensitization activities.

Recommendations for the *Communities Care* program

- SGBV prevention activities
  - » Community dialogues and other community sensitization activities should hold sessions disaggregated by gender, age, and ethnicity to ensure that a psychologically safe space is available to community members in all their diversity to discuss their experiences, priorities, and concerns as they relate to SGBV and gender equality. Necessary accommodations should also be made to create an inclusive environment for people with disabilities and other diversity factors.
  - » Community engagement and social-behavioral communication and change programs and activities should be designed to prevent SGBV, including the design and dissemination of information, education, and communication materials tailored to the specific needs of community members in all their diversity to increase community members' knowledge about the consequences of SV; the importance of seeking timely care; and where to access care and services.
  - » Community awareness campaigns should be designed to dismantle harmful gender norms and discriminatory practices that that perpetuate stigma around survivorhood to address barriers to disclosure and care seeking.
  - » Activities should be delivered in a variety of communication platforms (e.g., print, radio) in all languages spoken and understood by community members.
  - » The timing of activities should be tailored to the lived experiences and realities of different community groups.
- SGBV response activities
  - » VHTs should be trained on survivor-centered approaches and be equipped with the necessary supplies (e.g., ECPs) to identify a survivor, respond to a disclosure of SV by a community member, and provide timely response, such as providing psychological first aid, basic wound

care, administering antibiotics for presumptive treatment of STIs, and administering ECPs. VHTs should also be trained on life-threatening danger signs and when to refer survivors to emergency care. VHTs should also be trained to obtain informed consent and assent from community members to refer them to multi-sectoral services, particularly health facilities.
  - The *Communities Care* program team should ensure that there are functional, safe, and quality referral pathways in place to refer survivors to multi-sectoral services that meet their distinct needs and priorities (e.g., access to justice, shelter/safe spaces, education, livelihoods, etc.). VHTs should be trained to support survivors to use these referral pathways.
  - To the extent possible, the *Communities Care* program should ensure that health facility staff and other SGBV referral service providers (e.g., safe spaces/shelters) are trained to provide survivor-centered care, including responding to disclosures without bias regardless of the survivor's gender identity, gender expression, sexual orientation, age, or disability status, and ensuring that survivors have sustained access to safe spaces/shelters.

Sense of safety and well-being

Community members' sense of safety and well-being

Findings regarding the community members' sense of safety and well-being were mixed. While the majority of KAP survey participants (83.3%) reported their sense of safety and well-being to be high, qualitative data illustrate that community members across sites are concerned about community members' safety and well-being. Community members and KIs discussed that certain subgroups—women, girls, and people with disabilities—were at heightened safety risk, particularly for SGBV, and less likely to have positive well-being compared to other subgroups. Participants also mentioned that members of female-headed households were at an elevated risk for SV. In contrast, a fenced, male-headed household signified high security. The following physical locations were the most frequently mentioned by community members as elevating a person's risk for SGBV: water collection points, roads, marketplaces, night clubs, and households.

Recommendations for the *Communities Care* program

- VHT visits to female-headed households should be conducted by female VHTs to bolster women's sense of safety.
- Prevention activities may consider allocating resources toward strengthening community members' sense of safety and well-being, such as building fences around households, installing solar panels to provide better lighting, or establishing community-led safety teams. Such activities should be designed with community members, particularly women, adolescent girls, and people with disabilities, to ensure these mitigation approaches meet their needs, lived experiences, and priorities. These activities should also target the most at-risk locations mentioned by community members—water collection points, roads, marketplaces, night clubs, and households.
- Prevention activities may also explore community members' understanding of safety and well-being to develop more holistic, community-based approaches to enhance overall safety and well-being for all community members.
- Prevention activities should not only engage men and boys as perpetrators of SGBV, but also as allies and partners in preventing SGBV and mitigating risks. VHTs should be trained to respond to SGBV disclosures from male survivors using survivor-centered approaches. As such, VHTs should also be trained on a safe, functional, and appropriate referral pathway for male survivors.

» Safety aspects during the community provision of SV care

Although VHT KIs affirmed that they did not experience any existing safety issues when offering SV services in communities and did not anticipate any concerns, they emphasized the need to offer SGBV services judiciously. Some VHTs mentioned that SGBV-related work required tact and care given it is a sensitive topic among community members. Further, among project staff who participated in KIIs, verbal arguments and threats of physical violence perpetrated by men against VHTs were mentioned as a concern when VHTs conducted community family planning education campaigns.

Recommendations for the *Communities Care* program

- VHTs should enhance their trust and rapport among community members by discussing and responding to their immediate needs and priorities to the best of their abilities and sharing information and resources about less sensitive topics, rather than initiating discussions about SGBV at first contact.
- VHTs should travel in mixed gender pairs when conducting program activities to enhance their personal safety.
- Project staff should develop and train VHTs on a safety protocol that outlines risks, mitigation strategies, and response mechanisms to uphold the safety of VHTs during program activities. VHT supervisors should probe about safety concerns and risks during one-on-one and group supervisory sessions with VHTs to address any issues in a timely manner.

Conclusions

- Overall, the majority of community members from the KAP survey were more aware about GBV with, notably, a higher proportion of community members in comparison site being more aware than those in the intervention site. Varied differences in the level of awareness about GBV were observed among male and female refugee populations across the sites.
- The different forms of GBV cited by all participants included economic abuse through denial of resources, psychological abuse, IPV, and physical abuse. With regard to causes of GBV, poverty was cited as the most common. Other causes from the qualitative findings highlighted food insecurity, denial of resources (specifically access to school/school fees), and alcohol use by women and men.
- Much as the attitudes toward GBV demonstrated relatively negative attitudes toward GBV among community members across the sites, sex and age groups, FGD data indicates that SV, particularly IPV, and to a lesser extent child marriage, are norms among refugee and host communities.
- SV is considered acceptable within the boundaries of marriage, but also negative and shameful. Notably, a high degree of stigma is experienced by perpetrators and survivors of SV by community members. Additionally, survivors of SV are challenged with a myriad of barriers in accessing care and services, including access to legal recourse. SV is rarely reported to either the local courts or the police because of the cultural misconceptions and stigma that are prevalent among the community members.

- There was a higher level of awareness of SV compared to GBV among community members. However, there were significant varied levels of awareness of SV across sites, with the intervention site having the higher level of awareness compared to the comparison site.
- Similarly, a higher level of knowledge of SV in comparison to GBV was observed among community members in both sites.
- Overall, community members had positive attitudes toward gender equality. The majority of community members across the sites demonstrated positive attitudes toward gender equality. However, this varied significantly across sites with participants in the intervention site reporting higher support for gender equality compared to those in the comparison site.
- Overall, community members across sites were familiar with the available SGBV response services in their community, but less aware of available SGBV prevention programs. Additionally, community members had very limited access to available SV services.
- In spite of the limited SGBV services and structures, substantial common barriers that impeded access to these services to community members included fear of stigmatization, delayed GBV disclosure and care seeking, and barriers around the implementation of the community sensitization activities.
- The sense of safety and well-being was rated to be high, but higher among community members in the intervention site compared to those in the comparison site. However, there were concerns about safety and well-being of vulnerable populations, particularly women, girls, and people with disabilities.

Study Limitations

First, due to budget limitations, FGDs were not conducted among host community members; therefore, the FGD data only reflects the perspectives of refugees and cannot be generalized to host community members. However, the KAP survey was administered to host community members, and provides early insights into some of the issues that were further explored using qualitative data collection methods.

Second, in a few cases, both quantitative and FGD data were collected through interpreters. The use of interpreters may have introduced social desirability bias among some participants. Additionally, given that SGBV issues are sensitive among community members, it is possible that some study participants were inclined to give responses they deemed socially desirable. However, social desirability was minimized by selecting experienced data collectors who were thoroughly trained in research ethics.

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Appendix 1: Tables

Attitudes toward Gender-Based Violence								
	Intervention site: n (%)				Comparison site: n (%)			
Indicate whether you agree or disagree with the statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
The marriage of a woman under the age of 18 is acceptable	25 (2.8)	80 (9.0)	562 (63.0)	225 (25.2)	51 (6.6)	141 (18.3)	405 (52.6)	173 (22.5)
The husband and wife must make decisions together about how the money will be spent in the home	279 (31.3)	530 (59.4)	65 (7.3)	18 2.0)	214 (27.8)	393 (51.0)	133 (17.3)	30 (3.9)
Violence against women is acceptable in certain circumstances	23 (2.6)	78 (8.9)	621 (70.7)	156 (17.8)	27 (4.0)	97 (14.5)	447 (66.7)	99 (14.8)
Violence against girls is acceptable in certain circumstances	17 (1.9)	73 (8.3)	634 (72.2)	154 (17.5)	18 (2.7)	106 (15.8)	451 (67.3)	95 (14.2)
Violence against men is acceptable in certain circumstances	11 (1.3)	56 (6.4)	657 (74.8)	154 (17.5)	32 (4.8)	72 (10.7)	457 (68.2)	109 (16.3)
Violence against boys is acceptable in certain circumstances	8 (0.9)	91 (10.4)	636 (72.4)	143 (16.3)	30 (4.5)	95 (14.2)	448 (66.9)	97 (14.5)
Violence against LGBTIQ+ people is acceptable in certain circumstances	89 (10.1)	195 (22.2)	518 (59.0)	76 (8.7)	79 (11.8)	154 (23.0)	378 (56.4)	59 (8.8)
If a woman is exposed to violence, she will seek help from a trusted person	220 (25.1)	584 (66.5)	62 (7.1)	12 (1.4)	172 (25.7)	420 (62.7)	71 (10.6)	7 (1.0)
If a girl is exposed to violence, she will seek help from a trusted person	186 (21.2)	629 (71.7)	56 (6.4)	6 (0.7)	122 (25.9)	314 (66.7)	33 (7.0)	2 (0.4)
If a woman is exposed to violence, she will seek help from specialized service providers	174 (19.8)	658 (75.0)	40 (4.6)	5 (0.6)	110 (23.4)	323 (68.6)	35 (7.4)	3 (0.6)
If a girl is exposed to violence, she will seek help from specialized service providers	140 (16.0)	681 (77.7)	46 (5.2)	10 (1.1)	108 (22.9)	312 (66.2)	46 (9.8)	5 (1.1)

Gender Equitable Men (GEM%) Scale								
	Intervention site: n (%)				Comparison site: n (%)			
Indicate whether you agree or disagree with the statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
Domain of Violence								
There are occasions when a woman deserves to be beaten	51 (5.7)	109 (12.2)	483 (54.1)	249 (27.9)	36 (4.7)	95 (12.3)	439 (57.0)	200 (26.0)
A woman must tolerate violence to keep her family together	124 (13.9)	283 (31.7)	353 (39.6)	132(14.8)	103 (13.4)	187 (24.3)	372 (48.3)	108 (14.0)
It's okay for a man to beat his wife if she is unfaithful to him	100 (11.2)	180 (20.2)	449 (50.3)	163 (18.3)	103 (13.4)	139 (18.1)	409 (53.1)	119 (15.5)
A man can beat his wife if she doesn't want to have sex with him	43 (4.8)	133 (14.9)	487 (54.6)	229 (25.7)	47 (6.1)	70 (9.1)	497 (64.5)	156 (20.3)
If someone insults a man, he must defend his reputation with force if necessary	48 (5.4)	167 (18.7)	515 (57.7)	162 (18.2)	57 (7.4)	114 (14.8)	482 (62.6)	117 (15.2)
The use of violence by a man against his wife is a private matter that should not be discussed outside the couple	112 (12.6)	283 (31.7)	374 (41.9)	123 (13.8)	102 (13.2)	186 (24.2)	374 (48.6)	108 (14.0)
Sexual relations								
It is the man who decides what kind of sex to have	102 (11.4)	269 (30.2)	439 (49.2)	82 (9.2)	97 (12.6)	216 (28.1)	371 (48.2)	86 (11.2)
Men are always willing to have sex	121 (13.6)	321 (36.0)	341 (38.2)	109 (12.2)	103 (13.4)	282 (36.6)	320 (41.6)	65 (8.4)
Men need sex more than women	127 (14.2)	337 (37.8)	338 (37.9)	90 (10.1)	102 (13.2)	258 (33.5)	330 (42.9)	80 (10.4)
A man needs other women even if things with his partner/wife are fine	171 (19.2)	256 (28.7)	368 (41.3)	97 (10.9)	116 (15.1)	211 (27.4)	344 (44.7)	99 (12.9)
There is no talk of sex, it is simply done	73 (8.2)	220 (24.7)	493 (55.3)	106 (11.9)	56 (7.3)	195 (25.3)	420 (54.5)	99 (12.9)
I am disgusted when I see a man act like a woman	213 (23.9)	363 (40.7)	247 (27.7)	69 (7.7)	167 (21.7)	261 (33.9)	290 (37.7)	52 (6.8)
A woman should not initiate sex	128 (14.3)	317 (35.5)	361 (40.5)	86 (9.6)	91 (11.8)	239 (31.0)	351 (45.6)	89 (11.6)

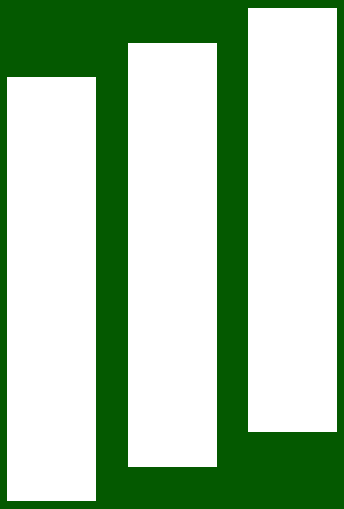
Gender Equitable Men (GEM%) Scale								
	Intervention site: n (%)				Comparison site: n (%)			
Indicate whether you agree or disagree with the statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
A woman who has sex before getting married does not deserve respect	188 (21.1)	192 (21.5)	392 (43.9)	120 (13.5)	137 (17.8)	153 (19.9)	357 (46.4)	123 (16.0)
Reproductive health								
Women who carry condoms with them are easy	155 (17.4)	280 (31.4)	360 (40.4)	97 (10.9)	137 (17.8)	240 (31.2)	300 (39.0)	93 (12.1)
Men should be outraged if their wives ask them to use a condom	88 (9.9)	301 (33.7)	396 (44.4)	107 (12.0)	77 (10.0)	242 (31.4)	378 (49.1)	73 (9.5)
It is the woman's responsibility to avoid becoming pregnant	149 (16.7)	246 (27.6)	417 (46.7)	80 (9.0)	108 (14.0)	221 (28.7)	368 (47.8)	73 (9.5)
Only when a woman has a child is she a real woman	147 (16.5)	249 (27.9)	395 (44.3)	101 (11.3)	130 (16.9)	180 (23.4)	364 (47.3)	96 (12.5)
A real man produces a son	102 (11.4)	120 (13.5)	460 (51.6)	210 (23.5)	74 (9.6)	93 (12.1)	450 (58.4)	153 (19.9)
Household chores and elements of daily life								
Changing diapers, bathing and feeding children is the mother's responsibility	281 (31.5)	316 (35.4)	224 (25.1)	71 (8.0)	287 (37.3)	281 (36.5)	154 (20.0)	48 (6.2)
A woman's role is to take care of her home and family	241 (27.0)	457 (51.2)	139 (15.6)	55 (6.2)	212 (27.5)	399 (51.8)	119 (15.5)	40 (5.2)
The husband must decide to buy the main household items	186 (20.9)	330 (37.0)	302 (33.9)	74 (8.3)	170 (22.1)	325 (42.2)	231 (30.0)	44 (5.7)
A man should have the final say on decisions in his home	233 (26.1)	299 (33.5)	275 (30.8)	85 (9.5)	212 (27.5)	294 (38.2)	212 (27.5)	52 (6.8)
The woman must obey her husband in everything	323 (36.2)	315 (35.3)	190 (21.3)	64 (7.2)	256 (33.2)	299 (38.8)	165 (21.4)	50 (6.5)

Appendix 2: Additional Information on Indicators and Scales

In addition to descriptive and analytical analyses, several scales and indices were created and analyzed. The GEM scale on attitudes toward GBV was summarized and Cronbach's alpha calculated to be 0.741 (see table 3). The GEM scale includes 24 items in two subscales. The 17 items in Subscale 1 measure "inequitable" gender norms (e.g., "It is the man who decides what type of sex to have") and the 7 items in Subscale 2 measure "equitable" gender norms (e.g., "A couple should decide together if they want to have children"). Responses were scaled as: Agree =1; Partially Agree =2; and Do Not Agree=3 for the inequitable subscale and scores were inverted for the equitable subscale, resulting in a higher score for greater gender equity. Scores of the inequitable norm and the equitable norm subscales were calculated separately and can be combined or used individually. We used the categorized bands in the interpretation: Low Equity = 1–23; Moderate Equity = 24–47; and High Equity = 48–72. For the indicator addressing knowledge of any services in the community that provide support for survivors of GBV, we computed this from those respondents who had reported awareness of any related services.

Acronyms and Abbreviations

ASRH	Adolescent sexual and reproductive health
CBO	Community-based organization
CDO	Community development officer
CEFMU	Child, early, and forced marriage and unions
CMR-IPV	Clinical management of rape and intimate partner violence
COVID-19	Coronavirus disease 2019. Also known as severe acute respiratory syndrome coronavirus (SARS-CoV-2)
CP	Child protection
CPC	Child protection committees
CSE	Comprehensive sexuality education
CSO	Civil society organization
DHIS	District health information systems
DHT	District health team
ECPs	Emergency contraceptive pills
GBV	Gender-based violence
GoU	Government of Uganda
INGO	International nongovernmental organization
IPV	Intimate partner violence
KI	Key informant
KII	Key informant interview
LMIC	Low- and middle-income countries
MakSPH	Makerere University School of Public Health
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
NGO	(National) nongovernmental organization
OPM	Office of the Prime Minister
PFP	Private for profit
PNFP	Private not-for-profit
SGBV	Sexual and gender-based violence
SOGIESC	Sexual orientation, gender identity, expression, and sex characteristics
SPEREC	School of Public Health Research Ethics Committee
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
SV	Sexual violence
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNCST	Uganda National Council of Science and Technology
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VHT	Village health team
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
WRC	Women's Refugee Commission



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