Executive Summary

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

Gender-based violence (GBV) and violence against children (VAC) are key protection concerns for refugees and host communities alike, with women and girls disproportionately affected. The United Nations High Commissioner for Refugees (UNHCR) recorded 4,297 cases of GBV in 12 refugee settlements between January and November 2019.[2] In addition, the 2016 Uganda Demographic and Health Survey reveals a high prevalence of GBV in districts that host refugees.

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

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

SUMMARY OF FINDINGS

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

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

1. According to UNHCR, Government of Uganda, Office of the Prime Minister (2020): https://data2.unhcr.org/en/country/uga [accessed May 21, 2020].
2. Available at https://reliefweb.int/sites/reliefweb.int/files/resources/73839.pdf.

UNHCR, socioeconomic status and ethnicity influences case reporting, and survivors who have access to resources or means of livelihood are more likely to report GBV[3] than the deprived refugees. Reporting is also limited among the more conservative communities, such as Somalis and Eritreans. The assessment also reveals that poverty and a lack of safeguards drives children into the hands of abusers and perpetrates harmful practices, such as early marriage (UNHCR and OPM 2019a: 18).

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

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

GBV and VAC survivors in host communities are often unable to access an essential package of multisectoral services, including health, psychosocial support, and justice/legal services. In some cases, utilization is limited to seeking one of the available services. For example, a survivor may seek health care but may not follow up on referrals to law enforcement or psychosocial services, which is attributed to gaps and bottlenecks in the existing referral systems, including a lack of standardized referral protocols, poor case tracking, and limited follow-up with survivors to ensure they are promptly receiving needed services. Poor initial experiences and perceptions among survivors regarding the quality and safety of services are also identified as barriers to follow-up care and/or utilization of other referrals across study sites.

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

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

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

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

RECOMMENDATIONS

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

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

3. Scale up evidence-based community violence prevention approaches using a systemic approach. The assessment shows several risks factors for VAC and GBV at different levels of the socioecological framework, including discriminatory social and gender norms that generate and perpetuate violence against women and girls. These risk factors need to be addressed through multipronged prevention interventions reflective of recent evidence of what works (DFID 2015). Prevention efforts could focus on changing social norms that underpin VAC and GBV, engaging men and boys, supporting economic and social empowerment for women and adolescent girls, and promoting positive parenting practices. For example, evidence-based community mobilization and social norm change approaches, such as the SASA! methodology,[4] should be adapted or contextualized and implemented by district/local government structures for scale and sustainability. Effective implementation and institutionalization may require building the capacity of government structures and duty bearers, such as probation social welfare officers and community development officers, through training and mentorship. Similarly, school-based violence prevention programs, such as Raising Voices' "Good School" toolkit could be replicated in both refugee and host communities. This program could also contribute to the rolling out of the "Reporting, Tracking, Referral and Response Guidelines on Violence Against Children in Schools," developed by the Ministry of Education and Sports in 2014.[5] Finally, promoting women's and girls' empowerment through livelihood support and economic opportunities is critical to reducing risk factors of violence at the household level in both hosting and refugee communities.

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

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

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

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

5. Bridge the humanitarian-development divide in GBV and child protection programming. The gap between the humanitarian and development responses to addressing GBV- and VAC-related risks must be reduced using deliberate efforts to align violence prevention and response interventions with national systems and local structures. The Comprehensive Refugee Response Framework provides important entry points and opportunities for humanitarian and development actors to work together toward developing a more integrated and sustainable approach to GBV and VAC prevention and response. For example, humanitarian and development partners could develop district-level capacity to ensure integrated information and reporting systems, referral pathways, and case management. In addition, the humanitarian-development nexus and commitment to the New Way of Working (NWOW)[6] also provides an opportunity to work collaboratively and align funding and financing modalities to strengthen district-level and national systems to address the protection needs of refugee and host communities—with a greater focus on sustainability.

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