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Conflict and Gender Based Violence: The Role of Aid in Help-Seeking and Recovery Process for Victims

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Chigumi Kawaguchi*

Abstract

Gender-Based Violence (GBV) has been recognized as a significant challenge among communities forcibly displaced by armed conflict, such as those living in refugee camps. Since the adoption of United Nations Security Council Resolution 1325, significant progress has been made by the international community and UN member countries in responding to GBV. However, providing support *only* to those who positively seek help is insufficient, and there is a need to develop more effective ways to extend support to those who face such difficulties, as well as prevent future incidents of GBV from occurring. This paper identifies help-seeking pathways in order to overcome the barriers to securing help in refugee communities. First, the paper develops a model of help-seeking based on an adapted version of the ecological model to understand help-seeking. Second, the model is appraised in relation to the data gathered from twelve focus group discussions (FGDs) with South Sudanese refugees in six refugee settlement areas in Uganda. The paper identifies the factors underpinning GBV and help-seeking, help-seeking pathways, and barriers to help-seeking. GBV survivors often decide not to avail themselves of any help or support services, mainly due to fear of stigma resulting from socio-cultural norms and low expectations of services. The help-seeking pathway reveals that the community leaders or churches are the primary and most familiar institutions with which to seek support, rather than through support by humanitarian agencies or the host community. The conclusion contributes recommendations toward the development of a modified help-seeking model for GBV survivors and services, specifically in conflict-affected refugee conditions.

Keywords: South Sudan, Uganda, refugees, gender-based violence (GBV), help-seeking

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The author conducted this study as a part of the JICA Research Institute (JICA RI) research project ‘Conflict and Gender-based Violence: The Role of Aid in Help-seeking and Recovery Process for Victims’. The project commenced in April 2017. The research data for this paper comes from the field research component for the project, gathered by the author and War Child Canada in Uganda between February and March 2018. The research would not have been possible without the precious support of the members of the War Child Canada research team.

1. Introduction

Displacement is one of the consequences of armed conflict. Many displaced individuals, regardless of whether they are refugees or internally displaced persons (IDPs), experience human rights violations across the different phases of displacement due to their heightened vulnerability in such volatile situations. In such conditions, gender-based violence (GBV) is one of the most prevalent human rights violations that displaced persons face. Although the term 'GBV' is an umbrella term for any harmful act based on socially ascribed gender differences perpetrated against a person's will (IASC 2015), it is sometimes used synonymously with violence against women and girls (VAWG). In this paper, the term 'GBV' is used to refer to *physical, sexual, and psychological violence that targets individuals or groups on the basis of their gender or sex* (UNHCR 2003, 10; UNGA 1994; CEDAW 2017).[1] Discussion around GBV has focused on women and girls and has only recently started paying attention to violence against men and boys. In this regard, this paper includes GBV against both women and men in our discussion.

GBV can occur in every phase of displacement. According to UNHCR (2003, 20), there are risks of GBV during conflict, in the country of asylum, and during repatriation and integration. Drastic changes in social conditions during the displacement cycle, including separation from one's family and community, difficulties in obtaining food, firewood and water, and sheltering in unsecured dwellings, puts them at a greater risk of sexual exploitation and abuse (IASC 2015; Freedman 2016; Amnesty International 2017). Within this context, GBV places additional heavy costs on displaced individuals and families, as well as whole communities and societies. The negative impacts of GBV on an individual may affect a community's recovery, and thus should be given a high degree of importance from the perspective of peacebuilding as well as humanitarian and human rights.

At the international level, discussions concerning GBV have grown over the past twenty years. The Committee on the Elimination of Discrimination against Women (CEDAW) categorized GBV as a form of discrimination against women and provided a full definition in General Recommendation No. 19 of 1992.[2] In 1993, the UN Declaration on the Elimination of Violence against Women (DEVAW) was adopted, recognizing the need for a clearer and more comprehensive definition of violence against women. The DEVAW (UNGA 1993) document referred to "any act of gender-based violence" (in Article 1) against women and requested that its member states increase their commitment toward its elimination. GBV against women *in conflict-affected situations* has gained more attention globally due to the reporting of mass sexual violence during conflict in Sierra Leone (1991-2001), Bosnia and Herzegovina (1992-1995), Rwanda (1994), Democratic Republic of Congo (1996), Liberia (1989-2003), and Kosovo (1998-1999).[3] Along with these reports, there have been substantial efforts by NGOs and feminist groups such as the Women's International League for Peace and Freedom (WILPF). They directed international political attention toward 'women, peace and security' by broadening it to include women's participation in the peace process and highlighting the inadequate efforts towards the response to and prevention of GBV.[4] These efforts resulted in the landmark United Nations Security Council Resolution S/RES/1325 on Women, Peace and Security (WPS) in 2000, as well as subsequent resolutions including the United Kingdom's initiative on Preventing Sexual Violence in Conflict Initiatives (PSVI) (from 2013 G8 Summit) and the Sustainable Development Goals—especially Goals 5 (gender equality) and 16 (peace and justice). The ensuing UNSC resolution 1820 included GBV against men and boys in conflict situations. These developments motivated both scholars and practitioners to conduct new projects on GBV in conflict-affected situations as experienced by refugees and IDPs in camps, as well as in post-conflict communities.

Until the early 1990s, there was little research or analysis on GBV among forcibly displaced populations (Hovil 2018, 278). The number of academic studies of GBV in

conflict-affected communities, including refugee settings, has increased over the last 20 years.[5] In addition to research on the development of GBV intervention in humanitarian settings, there has been growing interest among researchers and policymakers on how best to prevent and protect displaced people from GBV. Many of these studies have been undertaken from a medical perspective, followed by gender, refugee and humanitarian studies (for example, see Fisher, Nadler, and De Paulo 1983; Cornally and McCarthy 2011; Horn 2010a, 2010b; Wirtz et al. 2013; Odwe, Undie, and Obare 2018).

This research has attempted to contribute to the enhancement of GBV service providers' capability to provide assistance, the development of services that are more comprehensive, along with the creation of more sophisticated tools for data collection and analysis. However, the abovementioned literature frequently includes an assumption that GBV survivors will seek help if adequate services are provided. As Wirtz et al. point out, these are "passive systems that rely on survivor-initiated reporting and service-seeking" (Wirtz et al. 2013, 2). If this is indeed the case, there are questions over how we close the gap between the true and reported (or help-sought) numbers of survivors (Keygnaert, Vettenburg, and Temmerman 2012; Palermo, Bleck, and Peterman 2013; Freedman 2016; Protection Cluster 2016, 11[6]).[7] Ways to increase the utilization of services should therefore be an important area of study. Only after understanding why some survivors cannot or do not seek help can the improvement of the passive system be considered.

This paper examines refugee help-seeking behaviors and pathways in refugee settings in Uganda by developing an adapted model of help-seeking that combines the ecological model with help-seeking theory.

South Sudanese refugees in Uganda were selected because of the high risk of GBV among the refugees, especially after the violent clashes that occurred in the summer of 2016. The spread of instability throughout the country triggered a mass influx of refugees to neighboring countries due to village attacks, physical and sexual violence, persecution, and

forced recruitment to the military. As a result, the number of refugees and asylum seekers from South Sudan as of February 2018—during this project's period of field research—was about 1,053,598 (UNHCR 2018). Within this conflict-affected situation, various forms of GBV were reported, including gang rapes, mass rape, demands for sex in exchange for food or safe passage for survival, sexual slavery, early and forced marriage, forced recruitment and abuse of children, and high prevalence of intimate partner violence (IPV). Such incidents occurred not only inside South Sudan but also in refugee-hosting areas and urban displacement sites (Protection Cluster 2016, 11). International assistance provided for South Sudanese GBV survivors was relatively high compared to other crisis regions.[8] The humanitarian assistance system in refugee settlements by the Ugandan government and international humanitarian agencies was well organized. Thus, the paper regards it as a suitable place to observe GBV help-seeking behavior of the GBV-assistance system.

The next section provides the analytical framework by examining the ecological approach and help-seeking theory. Section 3 explains the GBV response system and structure in refugee settlements in Uganda, while Section 4 describes the methods used in the field research. Section 5 presents the results and, finally, Section 6 concludes the paper and proposes an agenda for further research.

2. Development of analytical framework: The ecological approach and help-seeking theory

This section introduces the analytical framework to understand the help-seeking behavior and its contributing factors by using two previous research frameworks on GBV: the ecological approach and help-seeking theory.

2.1 Ecological approach

The ecological approach has been developed by social science researchers as a useful tool through which to better understand and inform the analysis of GBV. The recognition that violence against women could not be explained by reference to a single factor prompted feminist scholars to reconceptualize violence "as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors" (Heise 1998, 263-264). As Heise's work demonstrates, the ecological model reveals GBV as the product of multiple causal layers of factors (Heise 1998; Dutton 2011; UNHCR 2003; Horn 2010b). Over the years, informed by different disciplines, the ecological approach has been further developed to identify the drivers of violence through four contexts or levels: the *'individual'*, the *'inter-personal"* (including family, friends, intimate partners and peers), the '*community'*, and '*society'*. The space of *'community'* is composed of both formal and informal social relationships, including neighborhoods, schools, workplaces and group identities, while *'societal'* encompasses the space where general norms, beliefs and policies that influence (encourage or inhibits) violent behavior are found (Heise 1998).[9] As elaborated below, the ecological model is useful not only for revealing/exposing the drivers of GBV but also as a tool to identify the factors that promote and inhibit the help-seeking behavior of survivors.

2.2 Help-seeking theory: Understanding help-seeking behavior and pathways as a complex decision-making process

There is an enormous amount of literature on help-seeking in general, with a substantial portion of this focusing specifically on *GBV* help-seeking among survivors. Much of this material has been produced/generated by researchers in the field of psychiatric medicine, psychology and women's health. Although there is a growing body of research by social scientists working with survivors of GBV, only a little of this examines help-seeking behavior

among survivors in conflict-affected situations (Hovil 2016; Porter 2016). Moreover, there have been few studies that examine GBV survivors' help-seeking behavior in relation to international humanitarian and local service providers in conflict-affected situations.

Through fieldwork, Horn (2010a) examines the 'hierarchy of responses' to IPV in Kakuma Refugee Camp in conjunction with interactions among refugees and humanitarian agencies. Wirtz et al. (2013) focus on refugees in Ethiopia to identify female GBV survivors' help-seeking behavior in relation to service utilization through qualitative research. Besides these studies, Odwe, Undie, and Obare (2018) conducted research in Uganda among refugees, both male and female, to identify favorable and unfavorable 'attitudes' toward help-seeking through a cross-sectional survey. While Horn's work does not focus on individual 'help-seeking behavior', it identifies the dual system of IPV response, demonstrating the unique relationship between refugees and the humanitarian community. It suggests that it is necessary to consider the embedded power structure in refugee settings that constitutes an important factor in help-seeking behavior. The research by Wirtz et al. (2013), on the other hand, is concerned with individuals and potential barriers to help-seeking. Barriers identified include perceived and experienced stigma, lack of awareness of services, and the reluctance by mothers to leave children unattended while they seek help.

The work of Undie, and Obare (2018) centers on identifying subjective factors that determine help-seeking based on the individual's past GBV experience and knowledge. It shows that refugee women who have progressive attitudes towards GBV believe violence should not be tolerated in the community, have no experience of violence in the past, and are aware of post-exposure prophylaxis have a favorable attitude toward help-seeking. The findings by both Wirtz et al. and Odwe, Undie, and Obare are almost the same as the individual, interpersonal (family and community), and societal factors articulated in the ecological approach, which should be considered as positive and negative factors of help-seeking. Nevertheless, they have not considered the uniqueness of refugee settings in full, a point on

which Horn elaborated. While an understanding of the social structures in refugee settings and the factors of ecological spaces—individual, interpersonal and societal—is important, as both need to be considered when identifying help-seeking behaviors in refugee settings, there is a missing link in understanding help-seeking as a process.

Help-seeking is a complex decision-making process (Cornally and McCarthy 2011). Additional components need to be considered in understanding GBV survivors' help-seeking behavior in refugee settings in order to provide useful recommendations for service improvement. According to Cornally and McCarthy (2011), help-seeking consists of three components: the problem, the helper, and the recipient, with help-seeking defined as a process of interaction between them to solve the problem.[10] In the context of this paper, the problem is GBV, the helper is the service provider, and the recipient is the survivor. Any analysis of help-seeking needs to focus on how they interact to address survivors' needs and improve the situation that has resulted following an incident of GBV. This may include seeking shelter for protection, medical assistance, legal case management, or activities as simple as finding somebody to whom a survivor's story can be shared. The help-seeking behavior of GBV survivors begins immediately after the incident until they reach out to individuals or services to improve their condition.

Cornally and McCarthy (2011) identify three 'antecedents' to help-seeking. This begins with problem recognition and definition, and if the decision to act is made, then the process of selecting a source of help will start. These are the antecedents to help-seeking behavior. Liang et al. (2005) examine the theory of help-seeking in conjunction with IPV. They criticize the general help-seeking model, as described by Cornally and McCarhy (2011), in terms of its linearity and the centrality of the cognitive process. According to Liang et al. (2005), the three antecedents are not distinct stepwise stages, but rather factors that interact with one another, and that individual, interpersonal and sociocultural factors in the ecological approach will influence these antecedents.

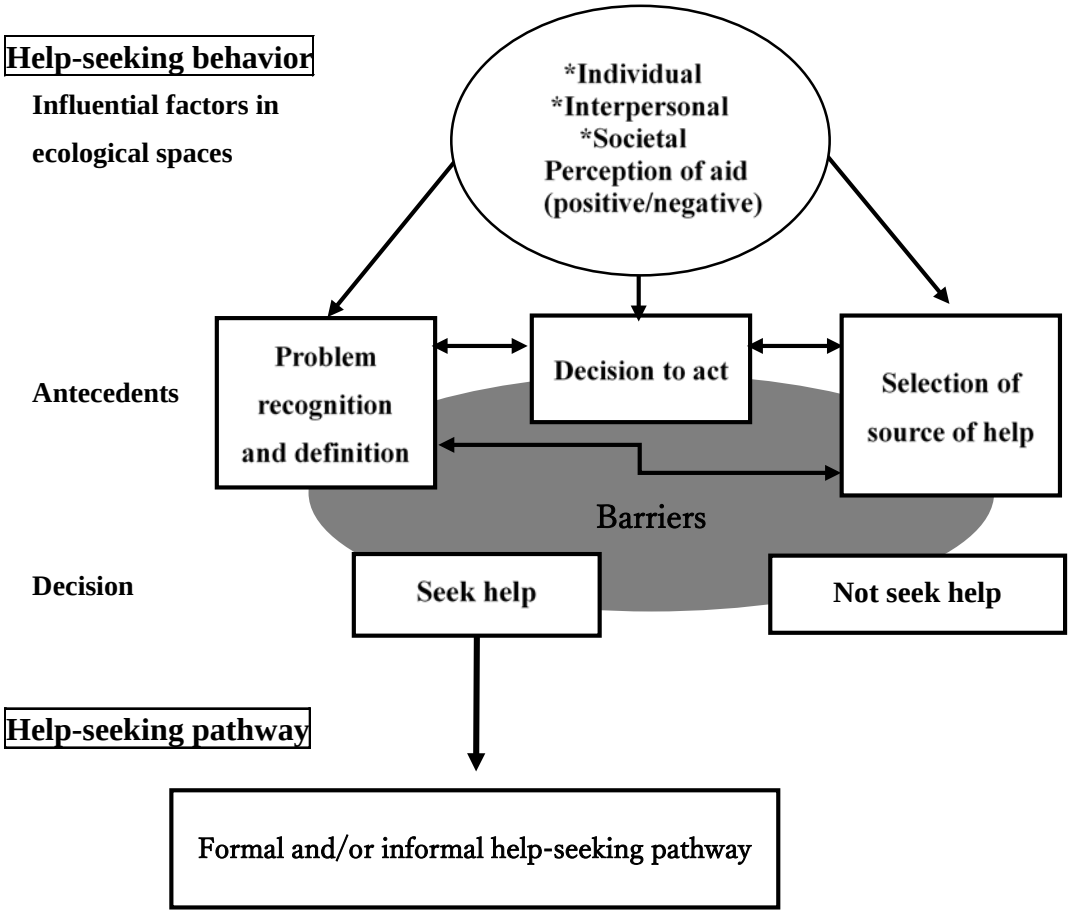
It is also useful to refer to the threats-to-self-esteem model of help-seeking (Fisher, Nadler, and De Paulo 1983), which includes the element of 'aid'—humanitarian aid and local public services around refugee settings in this paper's context—as an influential factor in ecological spaces. The model demonstrates that positive and negative perceptions of aid will lead to help-seeking or non-help-seeking accordingly (Fisher, Nadler, and De Paulo 1983). A positive perception of type and provider creates a high degree of self-support toward receiving help and support, while a negative perception of aid and services can result in a high threat to a help-seeker's self-esteem, resulting in low help-seeking or increased refusal of help and support offered (Wacker and Roberto 2008). In short, perceptions of aid and service provision influence the antecedents for help-seeking.

Figure 1, developed by considering the theories and points discussed above, reorganizes the ideas described here into a modified or adapted model of help-seeking, to depict a non-linear but complex decision-making process of help-seeking. Figure 1 captures the help-seeking model from two aspects: help-seeking behavior and the help-seeking pathway. The boundary between help-seeking behaviors and pathways is decision. The help-seeking behavior has three parts: influential factors, antecedents and decisions. In reference to previous studies, four influential factors are assumed here: individual, interpersonal, societal, and perceptions of aid. While individual, interpersonal, societal factors, and perceptions of aid and services influence the three antecedents, these antecedents are inter-influential. The decision to seek or not seek help will be the result of this disorganized and complex interaction of barriers. Barriers identified include such as fear of stigma, logistical challenges, lack of information, and low expectations of services. The barriers depicted as a grey circle in Figure 1 influence both antecedents and decisions.

The help-seeking pathway has been included in Figure 1. The help-seeking pathway is a track or route from point A to B to receiving GBV support or services. For example, the route from the place of the incident to the survivor's home, and from the home to the local clinic.

The pathway is created after the survivor has made their decision to seek help. Under the standardized international GBV response system in a humanitarian cluster, the ideal pathway is the GBV 'referral system' at the refugee camp level, which is often set up by humanitarian agencies. While the referral system can be seen as rather formal and objective, a more subjective and informal referral system can also be identified. Both formal and informal pathways may be considered as sources of assistance that influence help-seeking decisions. The following section will examine the formal GBV response and referral system in refugee settlements in Uganda, followed by an analysis of the settlement level's subjective and detailed help-seeking pathway as identified in the field research. Through the process, this paper elaborates on the adapted model of help-seeking.

Figure 1: A modified model of help-seeking



Source: Adapted by the author from Fig 1. Liang et al. (2005, 73); Wacker and Roberto (2008); and Fig 1. in Cornally and McCarthy (2011, 284).

Note: *marked factors are in the ecological spaces from 'Ecological approach'

3. GBV response system and structure in refugee settlements in Uganda

The GBV response system for refugees in Ugandan settlements follows a structured scheme of inter-agency support across various social levels. The following discussion outlines the structural interactions between various individuals and institutions in responding to GBV.

The United Nations High Commission for Refugees (UNHCR) works as the lead agency for refugee settlements in Uganda. UNHCR works with various implementation partners, international and local non-governmental organizations (NGOs) for GBV protection

as well as camp coordination. The Ugandan government has adopted a unique tolerance policy for refugees and co-administers the refugee settlements with UNHCR through the Office of the Prime Minister's (OPM) on-site settlement management teams, each led by a Ugandan Settlement Commander. The Ugandan government provides security and safety to refugees as part of the host community's responsibility. In addition, selected refugee members officially represent each zone/settlement from the refugee population, called Refugee Welfare Councils (RWC). The OPM is responsible for overseeing all refugee-related matters administrated by government agencies, international organizations (IOs), NGOs at the metropolitan and settlement level. At the settlement level, the OPM Settlement Commander oversees the RWC. As a result, there are three components in the system: the Ugandan government's control through the OPM administration, UNHCR's operational control of humanitarian agencies, and the refugee's self-governance system of RWCs, which all work to manage the refugee settlements.

In terms of responding to GBV, OPM is the counterpart of the Humanitarian Coordination Group. The so-called protection cluster is led by UNHCR, and the GBV sub-clusters are co-led by UNHCR and UNFPA (United Nations Population Fund).[11] Various international NGOs work within the protection cluster. In 2016, the SGBV (Sexual and Gender Based Violence) Task Force for Refugees was established in Uganda, composed of the Refugee Department, the Department of GBV in the Ministry of Gender, Labour and Social Development (MGLSD), IOs such as UNHCR, UNFPA, and UN Women, international and national NGOs, as well as health and psychosocial and legal service providers. At the national level, these sectors work together as part of a multi-sector approach for GBV prevention and response. At the settlement level, especially for settlements in the West Nile region, they have a local GBV referral system that is unique to each settlement.

The RWCs are a refugee's administrative community structure in the settlements. They are mainly made up of South Sudanese members who perform similar functions. They were

originally established in the 1950s when Rwandans arrived and settled in Uganda. The settlement commandants at that time thought that it was very important for the community to have their own leaders to help them resolve simple issues. The RWCs are a bridge between the international and Ugandan service providers and the refugee community. Leaders are selected by election among residents of each settlement, and they serve as volunteers to address settlement-specific issues, such as ensuring food is distributed properly, and mediating community-based conflicts, including GBV incidents. They have executive members for various issues, such as security and mobilization, women's affairs, education and children's affairs, youth and sports, assisting with disability and persons with specific needs, environment and production, as well as health, water and sanitation. There is also a group work related to GBV, such as a SGBV committee (in Yumbe and Adjumani), and a GBV task force (in Moyo and Arua), which is composed of executive members, religious leaders and community activists. There are some female leaders in charge of gender and children's affairs. RWCs manage themselves; however, their electoral candidates and important decisions must be approved by the OPM. Urban refugee communities do not have such RWC structures, but they are incorporated into the Ugandan local councils instead (Zakaryan and Antara 2018).

Concerning international community activities at the settlement level, there is a standardized SGBV response system, which designates the UNHCR as the cluster lead agency for protection. SGBV response is the sub-cluster of the protection cluster, with different actors working together in four different areas (health/medical, psychosocial, legal and justice, safety and security) under the multi-sectoral approach for GBV prevention and response (UNHCR 2003). The actors who are involved in the framework vary depending on the context or settlement. However, in the multi-sectoral approach, local service providers and experts (doctors, traditional health practitioners, police, security forces, lawmakers, and teachers) are also involved. This ideal model is modified to suit each local context. Hence, each district has a different GBV referral system. According to the multi-sectoral approach for GBV, each

refugee community should be a part of the approach, so in the case of Uganda, the RWC has assumed this role.

4. Field research[12]

To identify the GBV help-seeking behaviors and pathways in the refugee settings, qualitative data was collected through FGDs as well as individual interviews with aid workers in Uganda.[13] As mentioned in *the WHO Safety and Ethical Guidelines for Researching Violence Against Women* (2007), focus group discussions are a powerful method for collecting information and are well-suited to exploring norms, beliefs, practices and language, more than actual behaviors or details of individual lives (WHO 2007, 132).[14]

Twelve focus group sessions were held between February and March 2018 in Kampala, Kiryandongo, Adjumani, Moyo, Yumbe and Arua.[15] In all six districts, two sessions were held—one for males and the other for female participants (Table 1). The selection of settlements/zones and mobilization were made in close consultation with War Child Canada (WCC), along with the local OPM offices and RWCs. The WCC research team members are experienced in mobilizing community members for GBV awareness at each site. The selection of research sites and mobilization of participants could not be fully randomized because of the local context and limitations on movement and communication for the researchers. Given these constraints, we chose the six districts based on the following criteria: communities had diverse ethnic groups, urban and rural representation, time of arrival in the settlement (after 2015, 2016), and their condition as protracted refugees (living as refugees for more than ten years). As a result, ten ethnic groups were identified,[16] urban refugees in Kampala and rural refugees in other areas; protracted refugees in Kampala, Kiryandongo, and Arua. The aim of this research was *not to draw conclusions about the beliefs or experiences of the different ethnic*

groups; instead, the priority was to ensure that the results include representatives from as many ethnicities as possible.

Purposive sampling was made to gather the participants for this research. Because of the sensitivity of the issue, male GBV experiences are hard to identify beforehand. Hence, the selection of male participants (possibly both survivors and perpetrators) was heavily reliant on the community leader's decision. In the case of female participants, the full extent of typical case sampling was conducted, since we know that, based on prior information, many female refugees have experienced some form of GBV. A typical case is a woman who has struggled with GBV in her daily life with conflict as well as in the settlement. A more unusual case is a woman who has experienced serious GBV either during the conflict or in the settlement. GBV victims were not actively recruited for these FGDs. However, given the prevalence of violence under conflict-affected situations in South Sudan, it was likely the groups would include GBV victims or those whose family members or relatives were survivors.

Table 1: Participants of focus group discussions

District	Ethnic groups	Gender	Age	N
Kam_M	Dinka, Bari, Nuer	Male	18-50+	14
Kam_F	Dinka, Bari, Nuer	Female	18-50+	14
Kir_M	Dinka, Bari, Acholi	Male	18-50+	13
Kir_F	Dinka, Bari, Acholi	Female	18-49	13
Adj_M	Dinka, Madi	Male	18-50+	10
Adj_F	Dinka, Madi	Female	18-29	14
Moy_M	Acholi, Kuku	Male	18-49	10
Moy_F	Bari, Kuku	Female	18-49	13
Yum_M	Bari, Kakwa, Pojulu, Acholi, Kuku, Zande	Male	18-50+	14
Yum_F	Bari, Acholi, Pojulu, Acholi	Female	18-50+	13
Aru_M	Dinka, Kakwa, Nuer, Nubi	Male	18-50+	12
Aru_F	Kakwa, Kuku, Pojulu	Female	18-49	13
			Total	153

Source: Author

The total number of participants was 153 individuals. All groups were single-sex, with the age ranges of 18-29 comprising 39% (60; M/23, F/36) of the participants, 30-49 comprising about 55% (85; M/43, F/42), and 50+ comprising about 6% (9; M/7, F/2). Based on marital status, 9% were divorced/separated (14; M/3, F/11), 80% were married (123; M/61, F/61), 9% had never married (14; M/9, F/5), and 2% were widows (3; all female). About half of the participants, 75 individuals (M/54, F/21), lived with their partners and about 86% (132; M/56, F/75) lived with their children. About 80 % (122; M/65, F/56) were heads of households, but only 44% (M/30, F/14) of them were involved in income-generation activities. About 64% (99) came to the settlement after 2016.

The facilitators, who were responsible for introducing and managing the discussion, were chosen from each WCC team (composed of three staff and a psychosocial officer), and all were Ugandans. One or two translators were chosen from the same gender and community as the participants for each FGD group. The facilitator spoke in English and interpreters translated the instructions from English into each community language, such as Acholi, Juba Arabic, Kuku, Madi, Nuer and back into English. In some FGDs, a consecutive interpretation style was used, but in others, especially in groups using several languages, the interpreter sat next to their community members and spoke. For each FGD, it took from two to more than three hours to complete the whole workshop due to the interpretation and the volume of activities. However, the participants' overall motivations remained consistently high.

Consent for recording the discussion for the purpose of academic research was explained and confirmed by the facilitator with interpretation before each FGD started. The FGD guide was initially developed by the author[17]and was further revised through discussions with research project members and GBV experts. Three activities were conducted to examine recognitions (norms, beliefs), experiences, attitudes and behaviors around GBV: (a) recognition of GBV and the critical GBV issues/incidents, (b) help-seeking pathways (to who, when, and how help is sought), and (c) barriers to help-seeking. The first part of the FGD was

comprised of a brainstorming exercise. The second part was a workshop based on two different stories (see Appendix)—a case of domestic violence and a gang-rape story. Participants were divided into two groups and each worked on one story (see Appendix). The domestic violence case was based on Fawcett et al.'s (1999) paper about a woman, Martha, who suffered abuse from her husband, Victor. With some modifications made by the author, four scenarios with a set of questions for each case were developed to stimulate participants' discussion on Martha's decision-making pathway (see Appendix A). The gang-rape story was adapted from the United Nations Population Fund (UNFPA) website and was about a woman, Tabitha, who was abused by several men at home (UNFPA 2016, see Appendix A). A set of guide questions were also prepared to develop participants' discussions. The discussions ended with the participants' visual representations of the help-seeking pathways for each of the stories. For the third activity, the participants were asked to discuss the barriers to help-seeking for GBV/SGBV victims.

5. Results[18]

Through the 12 FGDs in different settlements with various ethnic groups—both male and female—the paper finds that the term 'GBV' is interpreted and understood in almost the same way in every settlement. It is understood as some form of violence between males and females, especially in the family: *"GBV is the misunderstanding between husband and wife in a family" (Male FGD in Arua, 2018).* GBV by a stranger—especially rape—is clearly understood as a form of GBV in the settlements. However, after having lived in the settlement for more than two years, we found that their main GBV-related concern is domestic violence (DV) rather than GBV in situations of conflict or displacement. DV behaviors are associated with male-dominated norms as well as the power shift between partners in the unique situations of the settlements.[19]

5.1 GBV experiences

During the individual interviews, two main categories of violence were revealed by refugee participants: (1) violence directly attributed to conflict, and (2) violence in the living conditions of refugees. While category 2 is a set of diversified types of violence that can occur inside/outside the family, category 1 includes both GBV and non-GBV types, of which the latter includes forced recruitment to be soldiers. The stories from category 1 show that the brutal acts of violence extend to ordinary people's daily lives within conflict and, in such situations, women can easily become the targets of violence. Moreover, sexual violence against women is frequently perpetrated by strangers as a form of 'retribution' for male members in their familial or ethnic groups.[20]

As for category 2, DV was frequently reported during individual interviews as well as FGDs. DV can encompass multiple forms of violence, such as physical, economic, forced/early marriage, forced sexual relations, or accelerated quarrels leading to murder inside the family within the refugee settlement. During the FGDs, male participants talked about forced sexual relations between partners (especially between husband and wife) not as GBV but as a family matter, in which the "wife has an obligation to accept the husband's request." However, some of the female participants said that forced sex between a wife and husband is a form of violence that must be punished or rectified.

In all the identified cases, abuse and violence are generally inflicted by the males toward the females. However, participants also discussed violence committed by females against males. For instance, the rising frustration of men in the changing power balance in settlement households has been reported as a unique phenomenon of GBV (especially DV) in displaced environments (Ekayu 2017). The strong norms of patriarchy observed in the South Sudanese community promotes men as having the obligation to protect the family and males as having a

strong power to make decisions for their families (Kane at al. 2016). In situations where a wife arrives at a refugee settlement before her husband, she may register as the head of household and begin to assert the power to run the family as the main breadwinner. When the husband arrives at a later date, he feels he has failed to meet his social obligations to protect the family (Protection Cluster 2017; Ekayu 2017). This frustration can spark DV between the wife and husband, violence against women by men, as well as emotional and economic violence against men. As such, the change in the power balance between partners in the settlement—often in the form of a shift from male to female household leadership—triggers GBV between partners. This kind of GBV is exacerbated due to the refugee situation, as women take more control and men feel emasculated. In such cases, male against female GBV can be considered to 'empower' males through violence. In addition, young adults and children are often referred to as casualties of early or forced marriages, child abuse and defilement.

The abovementioned cases may extend beyond the refugee settlements, occurring between the refugees and host community members. Some other forms of GBV, like humiliation and exploitation, are influenced by their refugee status. With the presence of various social actors in and out of the settlement, violence from strangers can also occur.

5.2 Factors influencing the incidence of GBV

An act of GBV by a perpetrator is influenced by various factors from each of the spaces identified in the ecological approach—individual, community (or interpersonal) and societal space. For every space, there are factors that can either enable or impede the GBV action.

At the individual level, traditional norms, especially for South Sudanese women who live within a strongly male-dominant cultural norm, have learned to perform submissive roles and to accept violence in the family. During the FGDs, simply being a male (husband/father) means they are considered to be a promoter of GBV. Specifically, participants described how

GBV is the result of misunderstanding between the husband and wife (especially in the Female and Male FGDs in Adjumani, Female and Male FGDs in Arua, and the Female FGD in Yumbe). In addition, GBV incidents could result from being the head of household (both female and male), or having access to more power than others. This includes those who work for NGOs, officials in the host community, guardians, and stepparents. On the other hand, orphans comprise a group significantly more vulnerable to GBV. It was difficult to find an inhibitor of GBV during the FGDs; however, increasing knowledge of human (women's) rights through advocacy work by NGOs, the existence of a GBV reporting system through the refugee community to NGOs and the host community, and the Ugandan legal system all seem to function as inhibitors of GBV.

At the family or interpersonal level, violence against females is often induced by internalized acceptance of the 'male superiority-female inferiority' dichotomy in the family (Reed 1954), which manifests in domestic violence or IPV. The South Sudanese male-dominant norms, conflict, and displacement seem to increase the tendency toward violence at this level. While there might be undeclared GBV toward males, we did not come across any accounts of this during the FGDs.

At the community level, in addition to male-dominant norms and practices of the South Sudanese community (marriage as a family matter, dowry, early marriage, 'booking girls', or the pre-arranged selection of young girls as future brides), and relations with the local host community are considered factors that influence GBV risk and increase the cost of help-seeking for local services (sexual exploitation, commercial sex because of poverty). Even with the Ugandan government's unique and tolerant policy toward refugee acceptance, the growing refugee population in the settlements has become a burden for the local community, affecting medical services and school facilities, for example. Other factors that affect the rising GBV risks include the production of local alcohol inside the settlements, operation of discos near the settlements, gatherings of out-of-school youth groups, and leaving the settlement to

collect firewood and water. On the other hand, institutions such as churches in the refugee communities, the RWCs, and the GBV referral system based on cooperation with RWCs, NGOs and the host-community, could act as inhibitors of GBV.

At the societal level, masculine culture and norms are influential factors for help-seeking behavior, as they are the cause of GBV. Ugandan domestic laws and refugee policies that are related to GBV are well organized and reflect the goals of WPS. For example, FGD participants know that they have to obey the Ugandan laws that prohibit early marriage and talked about the practice of investigating and arresting the perpetrators.

In sum, South Sudanese refugees in Uganda live within a unique ecological framework that is influenced by a mixture of GBV norms at the international, Ugandan and South Sudanese societal, community, family and individual levels.

5.3 Factors influencing help-seeking among GBV survivors

There are numerous aspects of refugee life that have the potential to influence help-seeking behavior. As mentioned above, the field research shows that there are both promoting and inhibiting factors related to help-seeking actions in the refugee settlements in Uganda.

In the individual and family space, individual knowledge of GBV services through advocacy activities is considered to be a factor that promotes help-seeking behavior. On the other hand, the individual and the family's feelings of shame, fear of stigma, and internalized acceptance of violence against females inhibits the survivors' help-seeking behavior. Self-help systems for GBV within the family and relatives play an important role as promoting and inhibiting factors. Since they are the people likely to be immediately consulted, they are expected to have the capacity to provide some kind help for survivors. Thus, the survivors' access to further help is in their hands. These matters are all affected by the fear of social stigma and the acceptance of male dominance, especially in the family.

In the community space, institutions, such as the refugee communities' churches and the refugee self-association RWCs, manage the GBV referral system based on cooperation with the RWC, NGOs, and the host-community to promote GBV help-seeking behavior. However, the same institutions in the refugee community and RWC could also be considered as inhibitors. The power of decision-making of refugee leaders is strong. Their power to determine whether the survivors should seek outside support makes them function as inhibitors. The community governance system works as both a promoting and inhibiting factor for help-seeking between the survivor and outside aid workers. In addition, the refugee community's practice of male-dominant norms and the stigma related to the survivors' social status (like losing respect or marriage opportunity) become inhibiting factors for help-seeking behavior.

In the societal space, as previously mentioned, medical facilities and the police and other authorities are the expected promoters of help-seeking. Unfortunately, they are also a likely source of barriers to help-seeking. In addition, global humanitarian policies overseen by the international humanitarian community, which directs settlement management and protection assistance activities, are also based on the WPS. The 'new' norms acquired through advocacy activities by NGOs and IOs on women's rights and GBV, including those related to the local referral system, can influence refugees' actions in positive ways in regard to GBV. Of course, the existence and practice of the GBV referral system on the ground also influences their help-seeking behavior.

5.4 Formal help-seeking pathways: Systematic stepwise GBV response

As mentioned in the overview of the fieldwork, Activity 2 intends to identify refugees' help-seeking options through scenario workshops and pathway drawing (see example below). Each FGD group described a systematic response procedure through illustrations. The workshop confirmed that the GBV case is first dealt with in the family space, including neighbors and

friends. From there, they will bring the issue to the community space. In the community space, there are informal and formal problem-solving mechanisms. Among the informal mechanisms are the church and elders.

In cases where the survivors sustain serious injuries, or cases that could not be resolved at this level, the cases will be dealt with using the formal mechanism—the RWC structure. The first contact point is the block leader, or sub-leader/secretary for each level, who is in charge of women's affairs, protection, disability, and assisting persons with specific needs, etc. The RWC chairman at level 1 will report the case to the level 2 chairman when they cannot handle the result of the case. The RWC I leader will ask for further support from the host community and NGOs if there is severe injury or assault or the case is difficult to handle. The RWC II leader by himself or with the OPM calls the police and takes the survivor to a health/medical center. If transportation support is necessary, the RWC leader calls by using a mobile phone or visits an NGO contact person (depending on where the incident occurred) to seek help. As described, refugees' help-seeking pathways for GBV response are very systematic and stepwise, especially inside of refugee communities. Inside of the refugee communities' response system, RWC leaders are the key to connecting the survivors with GBV response services. As a leader who maintains the governance of refugee settlements and acts as a bridge between the refugee community and service providers, the RWC leader is a key person that enables or hinders survivors in receiving GBV services. While a knowledgeable RWC leader's role and the stepwise system inside of the refugee community are useful, it has to be noted that its decision-making is based not only on international norms but also traditional norms and might go against the survivor's demands. This is the response to Martha's story (DV case) during the FGDs.

Female FGD participants in Adjumani responding to Martha's Story (DV)

[The survivor should] first report to the church, then to the cluster/block/square/opinion/leaders and elders of the clan to make Victor change his behavior. However, if it involves bleeding/injuries, Martha can go to the health center for treatment. Some women may decide not to report [the incident] to the police when they have received good medical treatment. Basically, they believe Martha should not leave Victor since they have three children, and the advice from the leader can make his behavior change (from female FGD in Adjumani, 2018).

The shared help-seeking pathway in the refugee community shows what the RWC leaders have learned during a GBV advocacy training session conducted by NGOs, as expected in the international standardized multi-sectoral referral system (see Figures 2 and 3). They have a good knowledge of each NGO's role, and the person-in-charge of each GBV response area, such as security, health, psychosocial and legal support. In addition, they clearly understand that refugees are able to report incidents to the police, receive local health care services, and approach the court system for justice.

At the same time, low expectations of such services were observed. FGD participants said that sometimes police officers ask for or receives bribes to write a P3 form (a formal report of the case prepared by the police), do not investigate or follow up on the case, or that the medical center or hospital does not have sufficient facilities or medicine to provide treatment. Even if survivors want to seek justice under the law, it can be difficult to pursue legal action. Thus, some are resigned to not seeking help from such sources. Having said that, their answers demonstrate that the ideal help-seeking pathway is well understood by the refugees in all settlements.

Figure 2: A public sign for GBV Referral in Adjumani

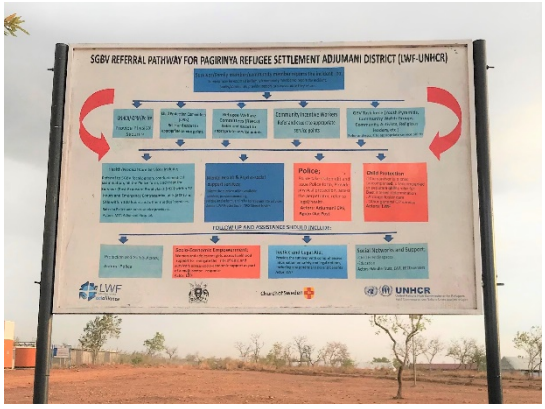
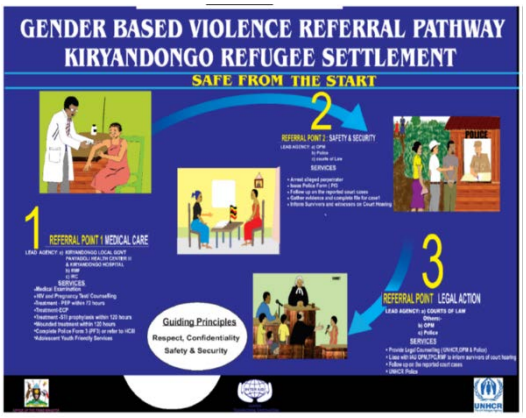


Figure 3: GBV Referral pathway in Kiryandongo



Source: Photos taken by author.

5.5 Informal help-seeking pathways among refugee communities

During the FGD discussions, the participants discussed the formal help-seeking pathway that they were taught by humanitarian NGOs. However, compared to the help-seeking pathway, the practice of drawing help-seeking maps revealed a more community-centric approach. Based on these drawings, the first help-seeking option following a GBV incident is the family, followed by relatives, church leaders, and elders. After this comes the block leader, RWC I, and RWC II leaders in their community. Finally, it goes further outside of the community, as mentioned above. The main difference between the official referral system and the drawn maps is the presence of the church (as shown in the drawing below). Since many of the South Sudanese refugees are Christians with strong faith and their everyday life behaviors are deeply connected with the church's doctrine, they believe that survivors should first consult with the church not only for protection or consultation of life direction but also for mental care and to seek forgiveness and a blessing from God. Sometimes, a religious leader also takes the position of RWC leader. However, it is worth noting that refugees place the church at the center of mental support in the GBV help-seeking pathway, and this is what is missing from the existing referral system.

Figure 4: The hand drawn map at Yumbe (male_FGD)

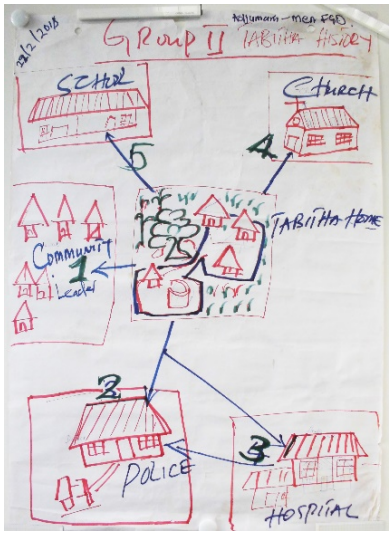
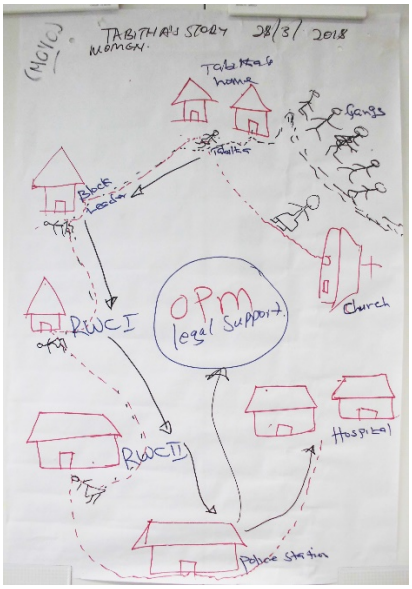


Figure 5: The hand drawn map at Moyo (female FGD)



Source: Photos taken by the author during the FGDs

Female FGD in Adjumani responding to the case of rape and defilement (Tabitha's Story)

Tabitha can get help from God, from her mother, from friends, a counselor at the health center, or the hospital. In the drawing the pathway, the church comes first, then the home and OPM, and the hospital. It is a long distance from home to the OPM and the hospital is very far. If a girl is raped or defiled, their parents will choose to keep it a secret. She may receive advice to forget what has happened, since culturally, rape is not recognized in South Sudan, even though many girls did experience this during transit and in South Sudan. If the incidents are recognized, she has to live in shame with insults, abuse, and lose opportunities for education and marriage. Losing her virginity will minimize her opportunities for marriage (moderator of FGD in Adjumani, 2018).

In total, the systematic stepwise GBV response system reflects the situation of refugees in the settlement, which is administered by a multiple-governance structure. The first governance layer is refugee community self-association-RWCs. The second governance layer is by local and the central government of Uganda, NGOs and IOs which provide support to refugees. This multiple governance structure in the refugee settlement is reflected in the GBV help-seeking pathway made available in each settlement. This is designed to ensure that survivors are not left behind without support.

5.6 Barriers to help-seeking

The third activity of the FGD was intended to validate the four hypothetically expected barriers to GBV help-seeking, such as fear of stigma, logistical challenges, lack of information, and low expectations of services. Consistently enough, from the 12 FGDs, the fear of stigma has the strongest influence as a barrier to help-seeking. The typical case of social stigma is rooted in the

fear of being ostracized and the fear of insults from other community members when he/she is exposed as a survivor of rape. The following quotes demonstrate how the South Sudanese community looks at rape:

- She will not be the same girl*: Male participants see Tabitha's future as dark. They see that Tabitha, as a rape survivor, might be damaged physically (e.g. HIV, STD, unreproductive) and mentally (traumatized, frequent mood changes, feelings of isolation, lacking communication). As a result, her future will be affected - no education, no marriage, no children, and she may end up killing herself (Male FGD in Kiryandongo, 2018).*

- Since rape is not recognized as a crime (in South Sudan)*, Tabitha and her family would be afraid of being embarrassed in the community. Parents don't want to acknowledge that their daughters have been "used by a man" so they hide their experience from the community rather than seeking external help. In particular, they hide the fact that their daughter is no longer a virgin, which may compromise her chances of getting married and deny the parents a dowry (Male FGD in Adjumani, 2018).*

- Recovery of virginity*: Usually when a girl is raped or defiled, their parents will choose to keep it a secret; if the girl is old enough she will practice sitting on burning charcoal covered with a saucepan for about one month for her genitals to get fixed, if she is young then her mother will instruct her to do it (Female FGD in Adjumani, 2018).*

There are also fears of reprisal. In the case of rape survivors, there were instances where victims have been threatened by the perpetrators. Thus, they do not report the case.

Complaints were also made about physical barriers, but these were relatively less important than fear of stigma. For instance, the language barrier (lack of interpreters), long distances and limited transportation to the hospital and police, and financial constraints to pay the costs were some examples given by the FGD participants. In sum, these are logistical challenges resulting from the placement of service agencies a long distance from the refugee

settlements. These challenges are worse for rape survivors with injuries, who need to travel to access help.

The barriers resulting from the scarcity of information or lack of knowledge were not described much in the FGDs. This might be because the participants are composed of many leaders who are refugees with ‘experience’ of advocacy programs, who have substantial knowledge of each NGO’s function, and who are very familiar with politics in the settlement through their long experience of displacement.

Together with this, there are other narratives, which could be classified as barriers based on low expectations of institutions carrying out services. The low expectations of services comes from previous instances where essential agencies failed to deliver assistance. Money requested by police officers for the P3 form to record a case is one of the main issues that delays and hinders justice for survivors. Especially in the case of rape, survivors need to show the P3 form to receive medical support. Sometimes police request money for transportation to hospital. There were also complaints about hospital capacity, insufficient medicine, and lack of staff and facilities—especially when a rape case requires emergency treatment. During the FGDs, there was a sense of hopelessness about pursuing cases in the law courts. Comparatively, complaints about NGO services were less frequent than about services in the local community. However, some participants raised the issues of delayed responses of NGOs, especially in cases of severe injury. Because of the above experiences, refugees assumed that they would not receive adequate services if they reported the case outside of the community. One survivor even thought that there was no benefit in reporting the incident. While each settlement has a well-recognized GBV response system, it is a white elephant if it does not function as expected. In this regard, external support to build capacity in the host community’s ability to respond to GBV is necessary.

In addition to this finding, it is important to recognize the importance of taking DV as a serious security issue, because it may sometimes go beyond verbal fights or quarrels between

partners, and result in assault or heavy physical injury. Of course, saving lives is very important. However, DV should be considered not only as a family matter but also a concern for the community's security and the ability of security management to handle such threats. GBV, especially DV, might be considered as a low-key issue either in peacetime or within the conflict in South Sudan. However, in refugee settlements, it is connected to the matter of security governance in the settlement. This attitude can be attributed to a refugee's living as a 'lodger' or 'guest' in Uganda, where they have to be very careful about minor security issues whether they are related to GBV or not. In this sense, close cooperation between refugee associations (RWCs), local community services (such as the police), and international aid workers is expected to work as both a security management and protection system.

Regarding the help-seeking pathway, it became clear that there is a difference between the refugee's pathway diagrams and the formal GBV response system. The former is community-centric; the latter is based on international standards. In the drawings, institutions in refugee communities, such as the RWC and churches, are expected to play an important role in GBV response. These institutions were explicitly identified in the maps. As a result, international assistance for GBV should be taken seriously in supporting the RWCs and the church, as well as capacity building and material support for the local government policing and health services.

6. Conclusions: The adapted model of help-seeking reconsidered

This section examines all the key findings, along with the suggested adapted model of help-seeking, as shown in Figure 1. The barriers to help-seeking are rooted in a range of complex factors. According to the field research, GBV survivors often decided not to avail themselves of any help or support services. These barriers to help-seeking can be clustered into

four key categories: (1) fear of stigma, (2) logistical challenges, (3) lack of information and knowledge, and (4) low expectations of institutions that provide services.

Fear of stigma is the most common predicament attached to being a victim of DV or rape by a stranger, making it a primary reason why victims do not report or receive help. In addition, other people perceive DV as a natural part of the domestic partnership. The basic factors underlying GBV-related acts are likely to be affected by the prevailing nature of male-centered gender norms. As examined above, the incident is frequently considered to be private, and therefore should not be discussed beyond the confines of the household.

Secondly, low expectations of service providers derive from previous instances where assigned agencies failed to deliver appropriate assistance. Monetary demands by police officers to file a case are one of the main issues, along with delayed and prolonged assistance, as mentioned in the report by Ekayu (2017). The lack of information and logistical challenges are not as significant compared to the other two barriers discussed above in this research. However, these factors have been repeatedly mentioned in reports by international organizations and NGOs (Ekayu 2017; Protection Cluster 2016, 2017; Care International 2014). The knowledge issue comes from the lack of awareness as to where and from whom to seek help. Not everyone has been educated in the referral mechanisms for help-seeking. Nonetheless, most FGD participants claim to understand the referral system in each district very well, and are able to identify ways that IOs, NGOs and local service providers can help GBV survivors. This community knowledge results from frequent advocacy activities and active participation in GBV education. However, this cannot be said for everyone who lives in the settlement. The logistical challenges come from the physical distance needed to travel to visit help agencies, the language differences among particular ethnic groups, and the lengthy process of getting help. The combination of these barriers can discourage GBV victims and survivors from seeking help.

The field research found that the formal pathways of the referral system are very well understood among the refugees. However, they recognized that there are different help-seeking pathways according to the degree of harm and existing conditions. For both the DV and gang-rape case studies, the survivor's primary options for help-seeking can be found within their community rather than through support by humanitarian agencies or the host community. They referred to the community leaders or churches as the primary and most familiar institutions with which to seek support, while in cases of serious injury or murder, they mentioned the need to contact the police, hospitals, and NGOs outside of the refugee settlement. The survivors seem to abandon the idea of reaching them and instead optimize all the support they can get from members of the settlement. The decision to seek help outside of the refugee settlement is often influenced by settlement leaders, elders and church leaders, whose actions are often based on male-centered gender and family norms.

Again, we can see here the influences of influential factors in ecological spaces. In practice, survivors do not directly seek help from external aid providers, and physically they often cannot. There is a constant gap in help-seeking that separates the support from the immediate family and refugee settlement, and from the actual GBV service providers outside of the refugee settlements. Such complex and self-aware processes in help-seeking behavior can be explained and understood well by using the adapted model of help-seeking as a theoretical framework.

As a result of the help-seeking decision, the pathway identified through the field research demonstrates its complexities and non-linearity (not so much stepwise as interactive) in addition to the difference between formal and informal pathways. In the pool of limited literature on GBV survivors' help-seeking behaviors in refugee settings, this paper can contribute suggestions toward the development of a modified help-seeking model for GBV survivors, specifically in conflict-affected refugee conditions. Moreover, an examination of the model in-field practice from the case of the South Sudanese refugee settlements in Uganda can

contribute to theorizing on GBV help-seeking as well as the utilization of GBV response services.

It should be noted that the FGDs showed mixed messages toward the role of the refugee community's GBV response. For example, if the matter of GBV can be solved between the victim's family and the perpetrator (supposedly another refugee) through community reprisals or compromise, then they are unlikely to report this outside of the refugee community. Considering the significant role of the community in refugee settings and male-dominant gender norms, it seems natural to conclude that help-seeking behavior (reporting and punishing) depends on the family and community's decision-making. To maintain security and order through the community's voluntary efforts sometimes makes it difficult for outsiders to respond, even though such practices might lead to other GBV incidents as a result of the dissemination of the practice of impunity. To provide enough support to survivors and to prevent other GBV incidents, and not to create a 'neglected GBV survivor', self-help efforts within a closed community space might have limitations and risks. In this regard, a more open and effective protection and prevention system involving the three tiers of the refugee community, host community and international aid community are required. This may lead to a more comprehensive approach (a whole of society approach) in providing support for neglected GBV survivors.

Further studies should focus on an exploration of the interactions between the host community and refugee community and their influences on the help-seeking behavior of survivors and their surroundings. The findings would not only contribute to the GBV research in refugee settings but may also improve refugee responses in host communities. It is hoped that the findings presented in this paper—varieties of GBV and help-seeking pathways in refugee settlements—will contribute to better understandings of GBV prevention and response.

Notes:

[1] Nowadays, especially in international organizations' activities, the term sexual and gender-based violence (SGBV) is also frequently defined as GBV, as described above. However, this paper regards sexual violence as a part of GBV, as well as other forms of violence based on gender.

[2] The definition was updated in 2017 in CEDAW General Recommendation No. 35. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GC/35&Lang=en See also CEDAW General Recommendation No. 30 on women in conflict from November 2013, which deals specifically with the intersection of CEDAW/WPS. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GC/30&Lang=en

[3] See "GBV Facts and Stats" from the Inter-Agency Working Group on Reproductive Health in Crisis website. http://iawg.net/areas-of-focus/gender-based-violence/gbv-facts-stats/ (accessed 15 January 2018).

[4] For a critical examination of WPS and its support movement see Otto (2015).

[5] Asgary, Emery, and Wong (2013) conducted a systematic review of the literature in 2011, which dealt with the prevention and treatment of GBV among refugees and IDPs. From various databases, they found 1,212 articles and 1,106 articles on the prevention and treatment of GBV, respectively. However, they concluded that none of these had met the criteria to fully evaluate the GBV response. Stark and Ager's (2011) systematic review of prevalence studies of GBV during complex emergencies found 129 hits with selected key terms such as GBV, incidence, complex emergencies, although only 10 study articles were found to have met the purpose of their review. In a systematic literature review of program evaluations for the prevention of and response to sexual violence among female refugees between 2000 from 2016, Robbers, Leila and Morgen (2017) identified 1422 articles in the published literature related to sexual violence, interve,ntions, displacement and refugees. After screening the documents, the authors selected 29 articles that matched their analytical purpose. Finally, Tappis et al. (2016) conducted a review of the literature between 2006 to 2015 that addressed strategies for primary prevention of GBV and their effectiveness among refugee populations. They identified 618 articles and then selected 393 that matched their criteria.

[6] As the report made by the Protection Cluster in South Sudan pointed out, the stigma and violence often associated with reporting acts of GBV, as well as survivors' limited access to reporting mechanisms and services, influence the reporting of actual GBV incidents.

[7] However, the paper by Palermo, Bleck, and Peterman (2013) does not deal with cases from refugee settings, demonstrating the vast under-reporting of GBV experiences in developing countries.

[8] According to the Global Humanitarian Assistance Report 2015, South Sudan was the largest country to receive GBV-related aid in 2014. The amount was 212 million dollars, or nearly one-fifth of the total

amount of GBV aid disbursed in 2014 (Development Initiatives 2016, 85).

[9] On the other hand, Michau et al. (2015) applied the ecological framework to a program designed to transform spaces away from the power of violence to more favorable environments that prevent violence through various tools. Michau's usage of the ecological framework is beneficial in illustrating the power transition tool in each space, as well as checking for missing aid practices in the general GBV context.

[10] Cornally and McCarthy (2011) use the terms 'task', 'problem', 'helper' and 'recipient'. The author of this paper has paraphrased them to match the context of this paper.

[11] The humanitarian cluster approach was composed of eleven different sectors of humanitarian action, such as protection, health and food security. The humanitarian clusters are groups of humanitarian organizations, both UN and non-UN, and each cluster has a lead organization. For more details, see https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach

[12] Limitations of the field research: Due to the limitations in logistics, communications, resources, a fluid schedule, and security in the settlement area, the authors and research team experienced difficulties in conducting the FGDs. While the FGDs embraced the ethnic diversity of South Sudanese refugees in Uganda, it was not possible to use representative or random sampling methods. Since it was not possible to access statistical information on refugees or GBV survivors before the FGDs or assess the social context in the refugee settlements, mobilization of the participants was highly dependent on the contact person (normally a refugee leader); thus, it was difficult to control this from the research side, except for numbers, age ranges, and sex. It was also possible to include people other than survivors of GBV. As a result of the selection process, mobilization might have prioritized English speakers—in particular, those who already understood the standard GBV context and the international response system. In addition, there were some limitations in the mobilization and the number of participants: a sample size of 153 (81 females, 72 males) comprises only a small proportion of the total number of South Sudanese refugees in Uganda. For these reasons, the results of FGDs should not be considered as representative or generalized to all South Sudanese refugees. There were also some technical limitations that may have affected the accuracy of the interpretation/interpretation process during the FGDs. Even though most of the participants have heard of and are familiar with the term 'GBV' in English, the term has been translated into different expressions to suit the translator/interpreter's own understandings of GBV (i.e. fighting, quarreling, hitting between men and woman). These interpretations sometimes carry a risk of leading and controlling discussions based on their usage. Another reason why the process of interpretation/interpretation leads to difficulties in collecting data on FGD is the unique power structure between English speakers and non-English speakers among refugees. Normally, English-speaking refugees are more educated than others, and since they have a close connection with the OPMs and NGOs, they are more likely to have received many advocacy trainings before. That kind of power structure between translator/interpreter and others is sometimes reflected in the discussions, especially in the male FGDs.

[13] The author conducted several individual interviews with aid workers, and the research team also gathered information about the GBV situation in the refugee areas before and after the field research

meetings with aid agencies. Moreover, the systematic individual interviews with aid workers were conducted during early 2019 by JICA RI in the same area. The results of the research with aid workers have not been included in this paper. For the results, please see Kawaguchi, Chigumi (2019), "The Help-Seeking Pathways and Barriers: Case of South Sudanese Refugees in Uganda." https://www.jica.go.jp/jica-ri/research/peace/l75nbg00000bwayb-att/GBV_field_research_report.pdf

[14] This research methodology was developed in consultation with experienced GBV experts and received ethical approval from Ethical Committees in Japan and Uganda.

[15] For more detailed data on the field research, see Kawaguchi (2019).

[16] They are Acholi, Bari, Dinka, Madi, Nuer, Nubi, Kuku, Kakwa, Pojulu and Zande.

[17] The USAID report on GBV in Tanzania (McCleary-Sills et al. eds., 2013) was very useful in developing the guidelines.

[18] Unfortunately, not all of the data can be included in this paper. Please refer to Appendix C in Kawaguchi (2019) for detailed data from the FGDs in six districts.
https://www.jica.go.jp/jica-ri/ja/publication/booksandreports/l75nbg00001937uj-att/Appendices.pdf

[19] GBV is a well-embedded social and cultural practice in South Sudanese society, which results in gender inequality and discrimination against women and girls. The belief that they are subordinate to men becomes a part of their everyday lives. The colonial remnants of patriarchy, the traditional dichotomy (men as protectors and breadwinners and women as caretakers of the family), polygamy (men having multiple wives at the same time), *levirate* (the institution of widow inheritance), female genital mutilation (FGM), forced marriage, wife-beating, and sexual harassment became common forms of violence against women (Edward 2007, 80-81). In addition, children are raised to obey and respect their parents, and, male adults, such as husbands, fathers and elders. The practice of sons preserving the family line renders daughters powerless and fully submissive to male relatives (husbands, male in-laws), especially in married life. A woman who cannot deliver a male child often becomes the target of conflict, violence, insults from in-laws, adultery or second wife seeking by the husband (Edward 2007, 82). According to their marriage system, once a woman marries in exchange for a dowry, she becomes a family asset. Intertwined with this are the legacies of conflict and traditions, and customs in the South Sudanese community. GBV happens to displaced people and appears in the form of early marriage, high tolerance for domestic and intimate-partner violence, and marriage as a solution for rape (D'Awol 2011; Amnesty International 2017).

[20] The Appendix of Kawaguchi's report (2019) provides some selected stories of GBV in conflict-affected areas, as recounted by refugees in the settlement.

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Appendix

Martha's Story

(A survivor of repeated physical violence by her husband)

Martha lives in refugee settlement with her husband Victor and three children, a three-year old, a two-year-old son, and a five-year-old daughter. She is a housewife. Sometimes, she has wanted to leave Victor because he does not give her enough housekeeping money and does not let her work because he gets jealous. He insults and hits her, and sometimes he forces her to have sex even though she doesn't want to. Martha thinks this has been getting worse after they moved to the settlement. Martha has tried talking to him, but it's like talking to a wall. She has put up with this situation for a long time and hasn't told anybody. She doesn't know what to do.

Modification added to the original text from Fawcett, G. M, L. Heise, L. Isita-Espejel, and S. Pick. 1999. "Changing Community Responses to Wife Abuse: A Research and Demonstration Project, Iztacalco, Mexico." *American Psychologist* 54 (1), 41-49.

Tabitha's Story

(A survivor of rape by a non-intimate male acquaintance.)

When the fighting broke out, Tabitha and her mother had taken shelter in a church. After four days of incessant gunfire, silence fell around them, and word arrived that the armed parties had called for a ceasefire. Still, she stayed in the church for two more days. But slowly, as the city returned to life, people began to return to their homes. Others took the opportunity to flee. She and her mother planned to leave the country. But without money, they would not get far. Tabitha decided to return home quickly for some travel documents and a stash of jewelry. She

was relieved to see that some of her neighbors had also returned, and that her home had not been ransacked. But as she packed her suitcase, she heard screaming. She looked out the front door and saw two women being chased by five men.

"I saw them heading straight to our house," she later recounted. She tried to lock the door, but it was too late. "One of the men forced it open and hit me hard on the face with a pistol. Suddenly his dirty hands were all over me, pinning me down and ripping off my clothes, shouting, 'Stop fighting or I will shoot you!' The next minutes played out like hours…The pain was so much I blacked out." Tabitha awoke in agony. She and the other women had been gang-raped.

Mawa, Stephen. 2016."Women Face 'Unspeakable' Sexual Violence in South Sudan." UNFPA News on, August 5. http://www.unfpa.org/news/women-face-unspeakable-sexual-violence-south-sudan

Abstruct (in Japanese)

要約

ジェンダーにもとづく暴力(Gender-Based Violence)は、難民キャンプなど、武力紛争によって強制的に避難せざるを得ないコミュニティにおける重要な課題と認識されている。国連安保理決議 1325 が採択されて以来、GBV の対応は大きな進展を遂げてきた。しかし、積極的に救援を求める人々に対応するだけでは不十分であり、救援を求めることが出来ない人々に対応を拡大し、GBV を予防するためのより効果的な方法を開発する必要がある。そのため本稿は、難民コミュニティにおいて GBV 被害者が救援を求める経路、そして救援を求める際の障壁は何かを特定することを目的とする。第 1 節では、被害者が他者になんらかの支援を求める行動「救援要請行動（help-seeking behavior）」を理解するために、既存の救援要請モデルの修正を試みる。第 2 節では、ウガンダの 6 つの難民居住区で行なった南スーダン難民との 12 のフォーカス・グループ・ディスカッションから収集されたデータを、救援要請修正モデルを通じて分析する。その結果、GBV 被害の現状、救援要請の動機、救援要請経路、そしてその障壁を特定した。GBV 被害者は、主に社会文化的規範に起因するスティグマと提供サービスに対する期待値の低さのために、救援を断念することが理解された。また、救援要請経路においては、人道支援機関やホストコミュニティよりも、難民コミュニティリーダーや教会に救援を求める傾向にあることが理解された。この救援要請修正モデルは、GBV 被害者の救援要請経路やその障壁を理解することを通じて、紛争影響を受けた難民状況において、ホストコミュニティや国際社会が提供する GBV 対応の改善を考えることに貢献する。

キーワード: 南スーダン、ウガンダ、難民、ジェンダーに基づく暴力(GBV)、救援要請

Working Papers from the same research project

"Conflict and Gender Based Violence: The Role of Aid in Help-Seeking and Recovery Process for Victims"

JICA-RI Working Paper No. 205

The Variety of People in Refugee Settlements, Gender and GBV: The Case of South Sudanese Refugees in Northern Uganda

Yuko Tobinai