

JICA RI Research Project CONFLICT AND GENDER-BASED VIOLENCE

The help-seeking pathways and barriers: Case of South Sudanese Refugees in Uganda

FIELD RESEARCH REPORT



August 2019

**The Help-seeking Pathways and Barriers:
Case of South Sudanese Refugees in Uganda
Field Research Report
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Abbreviations

DRC	Danish Refugee Council
DV	Domestic violence
FGDs	Focus group discussions
GBV	Gender-based violence
GPC	Global protection cluster
IDP	Internally displaced person
IPV	Intimate partner violence
JICA	Japan International Cooperation Agency
LWF	Lutheran World Federation
NGOs	Non-governmental organizations
OPM	Office of the Prime Minister
RL	Refugee leader
RWC	Refugee Welfare Council
SGBV	Sexual and gender-based violence
SP	Service provider
STD	Sexually transmitted diseases
UN	United Nations
UNHCR	The United Nations High Commission for Refugees
UNSCR	United Nations Security Council Resolutions
VAW	Violence against women
WCC	War Child Canada
WPS	Women, Peace and Security

Executive Summary

Background. Gender-based violence (GBV) is one of the most prevalent risks to people (primarily women and children) affected by conflict. Though GBV is rooted in pre-conflict conditions, the circumstances within the refugee settlement exacerbate such problems, thereby demanding more concrete plans of actions such as the United Nations Security Council Resolution 1325 on Women, Peace and Security.

Research Question. Despite the existence of refugee policies (in countries hosting refugees) geared towards the prevention, protection and recovery from GBV, there are still many existing and potential barriers that discourage GBV survivors from seeking out and reporting such cases. This report addresses important questions on refugees' recognition of violence, their pathways in help-seeking, and the identified barriers to receiving further assistance. In addition to these are inquiries on the obstacles for providers of support and services, and their recommendations on how to improve service delivery for those affected by GBV.

Methods. The data collection utilized a field research method. Data was collected in Uganda from among South Sudanese refugees and relevant support/service providers in 6 refugee settlement districts. Capitalizing on research instruments such as focus group discussions and interviews, the researchers gathered data from 153 FGD participants, 122 individual refugee interviewees, and 72 refugee leaders and service providers.

Result 1: Recognition of GBV. Refugee participants recognize the presence of GBV that is directly related to conflict and under the living conditions as a refugee. GBV transpires in areas of conflict like South Sudan, where SGBV against women is perpetrated as a form of retribution for male members from hostile political or ethnic groups. Likewise, GBV happens in the refugee settlement, often observed as domestic violence (DV) or Intimate partner violence (IPV), as well as sexual violence from strangers. DV is influenced by the shift in conventional gender roles between partners who move into the settlement.

Result 2: Help-seeking behavior and pathways.

Although it is recognized that any form of GBV must be punished, there are still some interviewees who claim that DV, including sexual violence, should be kept a secret within the family. About 68.9% of the refugee interviewees think that “sexual violence between partners is a crime and perpetrators should be punished;” and almost all interviewees agree that survivors have the right to seek help regardless of whether the violence has happened within the family (92.6%) or not (96.7%). Despite the impression that refugees can seek help easily, the FGDs and interviews reveal that help-seeking outside the community is difficult. GBV survivors need immediate (medical support), and accessible (counseling from family and friends) assistance, which they receive from within the refugee settlement, and only if it was deemed necessary would they seek help from people or institutions outside of the refugee community.

Result 3: Barriers to help-seeking. Both the refugees and service providers (SPs) are aware of the existing barriers for survivors to gainfully access help-seeking. The “fear of stigma” attached to GBV inhibits survivors from seeking help. SPs reiterate that the stigma of victimhood (80.6%) and the possible reprisals attached to it (84.7%) are the main constraints on them seeking any form of help. This barrier is followed by “low expectations of service,” where survivors have pre-conceived notions about receiving poor quality GBV support and services. These two main barriers are followed by “lack of information” and “logistical challenges” as the primary impediments to help-seeking among GBV survivors.

Result 4: Obstacles for service providers. Both RLs and SPs confirmed that the social stigma attached to GBV makes it hard for them to reach out to survivors. Conversely, the absence of trust from survivors stood as another challenge for extending assistance to survivors. In terms of their resources, the limited capacity for proper services, as well as the occasional overlap in the support and services offered, as well as the occupational risks to service providers, weakens the service delivery for GBV survivors. SPs confirmed that the continuity

of programs and services affects the effectiveness of the services they can offer.

Result 5: Resources needed by service providers.

SPs need resources that can help them in carrying out efficient service delivery. Direct resources, which have a direct impact on survivors, include counseling and mediation, awareness and educational training for refugees, as well as various forms of support services (medical, legal, faith-based). Supplementary resources included logistical equipment (like bicycles) and several kinds of training for service providers.

Recommendations. In addressing the challenges in providing aid for help-seeking and recovery of GBV survivors, the study recommends the following (1) understanding of GBV as a diversified form of violence that demands comprehensive and context-based support for each case, (2) tackling the gender norms that induce the fear of stigma, (3) strengthening the refugee community’s capacity to respond to GBV cases, and (4) building trust between survivors and service providers through equipped facilities and transparency of pathways and training to realize survivor-centered approach.



Refugee settlement in Adjumani

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CHAPTER 1

INTRODUCTION

1.1 Research Background

1.1.1. GBV and conflict

In situations of armed conflict, there are frequent reports that gender-based violence (GBV)¹ has been committed against civilians and soldiers as a means of warfare. Women and children are particularly exposed to the risks of violence. Violence is not an accidental side effect of war but a crime against the individual and an act of aggression against an entire community or nation. Acts of violence may be conducted with the primary intention of not only maiming or killing just one person but crippling life through the control of an entire socio-political process. GBV does more than damage the body of the victims; it also leads to significant psychological harm, which can be further exacerbated by the many social barriers to seeking help. Moreover, survivors in conflict-affected areas frequently do not receive sufficient physical protection or economic support. Nordstrom recognizes such GBV against unarmed civilians as an attack directed equally against both personal identity and cultural integrity [Nordstrom 1991].

GBV is often rooted in pre-conflict conditions. However, the occurrence of armed conflict heightens the risk of GBV incidents between partners or strangers, within the family, and inside or outside of refugee settlements. Such incidents result from the continued availability of weapons, post-traumatic stress of ex-soldiers, and refugee frustration over the lack of adequate housing,

employment and basic services. The increase in violence is not limited to sexual or physical violence but may also include psychological harm, which can occur both inside and outside of the domestic sphere.

Recent reports have confirmed the presence of sexual violence against men and boys in conflict-affected regions. According to these reports, male survivors are often unfortunately left out of the scope of research on GBV, and they miss out on assistance due to people's lack of acknowledgment of such cases. As a result, sexual violence against men and boys is a low priority compared to that of women and children [Chynoweth 2017], partly due to the fear of the stigma attached to it.

1.1.2. International normative framework WPS and the humanitarian system on GBV

In 2000, the United Nations adopted the United Nations Security Council Resolution (UNSCR) 1325 on WPS (Women, Peace and Security). This resolution reaffirms:

the important role of women in the prevention and resolution of conflicts, peace negotiations, peace-building, peacekeeping, humanitarian response and in post-conflict reconstruction and stresses the importance of their equal participation and full involvement in all efforts for the maintenance and promotion of peace and security.(p.1)

It was the first UN resolution to recognize the importance of women's participation and the need to

incorporate gender perspectives into peace and security efforts. The resolution emphasized the need for special measures to protect women and girls from all forms of violence, including GBV.

Subsequently, other relative declarations have been adopted to enhance the Women, Peace and Security (WPS) agenda, including UNSCR 2106, which specifically focuses on sexual violence in conflict. This resolution was innovative in terms of explicitly referring to men and boys as survivors or targets of conflict-affected violence. By November 2018, 78 countries had adopted the national action plan (NAP) for the implementation of UNSCR 1325 and declared their support for special measures to protect women and girls from GBV.

Under the humanitarian cluster system, there is a Global Protection Cluster (GPC), which provides inter-agency policy advice and guidance in cooperation with United Nations agencies, inter-governmental and non-governmental organizations. The GPC establishes GBV as a specific area of responsibility. Within the GPC, policies and activities to reduce GBV are facilitated and managed by the United Nations Population Fund (UNFPA), which has published several publications and developed tools related to GBV. There are also regional/country-based GBV clusters under the humanitarian protection cluster including Uganda, where the United Nations High Commissioner for Refugees (UNHCR) has initiated the management of the clusters at both the national and regional levels. There are also a region-based GBV cluster meetings. For the case of Uganda, the ones in the West Nile region are particularly important, as this is an area where many South Sudanese refugees are settled.

1.1.3. GBV in the South Sudan conflict

South Sudan has had a long experience of receiving external aid in response to the constant conflicts it has continually suffered, which began more than 70 years. Attacks against civilians, including GBV, have been a defining feature of these conflicts. Between 2015 and 2017, 4,870 incidents were recorded through the GBV Information System (GBV-IMS), including gang rapes and abductions of women and girls at military checkpoints, as well as during the collection of firewood or food. As of October 2016, nine out of ten women, a total of approximately 475,000 women, are at risk of GBV [UNHCR 2015].

1.1.4. GBV and refugee policy in Uganda

The risk of GBV was an important factor in forcing thousands of South Sudanese to escape their home country, and cross into neighboring countries, such as Ethiopia, Kenya and Uganda. UNHCR estimated that there were 1.9 million internally displaced persons (IDPs) in South Sudan by December 2017, and more than 2 million people had fled to neighboring countries for fear of such violence and attacks. From among these countries, Uganda is hosting the highest number of South Sudanese refugees.

With women and children comprising 86% of residents in refugee settlements, protection against GBV is absolutely indispensable. Many South Sudanese refugees fled to Uganda following the crisis in July 2016, with nearly 1.03 million refugees as of December 2017, which increased further to 1.06 million by the end of June 2018². The Ugandan government has tried to increase the areas set aside for refugee settlements in order to accept the growing number of residents and newcomers.

The Ugandan government has already adopted national frameworks to initiate the provision of protection and assistance to refugees, which include consideration of GBV cases. In 2016, a country-based Sexual and Gender-Based Violence (SGBV) Taskforce was established in coordination with UN agencies, as well as local and international NGOs. This taskforce aims to prevent and to respond to GBV in the refugee context, as the number of survivors of sexual violence has reportedly increased. From among the displaced and settled refugees in Uganda, 5,001 incidents (4,487 females at 90%) were reported. The most prevalent forms of GBV included physical assault (1,640 reported incidents, or 33% of the total), psychological/emotional abuse (1,210 at 24%), rape (1,035 at 21%), denial of resources (551 at 11%), sexual assault without no penetration involved (308 at 6%) and forced/early marriage (257 at 5%) [GBV IMS 2017].

The taskforce is composed of the Office of the Prime Minister (OPM)'s Refugee Department, the Ministry of Gender, Labour and Social Development's Department of GBV, UN agencies (UNHCR, UNFPA, and UN Women), national/international NGOs and service providers from legal, social and health/psychological sectors. Moreover, the National Development Plan (NDP II) containing the Settlement Transformation Agenda (STA) was adopted in 2017. This outlined the resilience and self-reliance of refugees, while aiming to strengthen it further. Thus, multi-sectoral and diversified organizations are engaged in supporting the GBV policy for refugees settled in Uganda.

However, due to its sensitivity, refugee host governments like Uganda, have faced the challenges in handling GBV and in setting up an efficient policy for protection and recovery that can lead to improved GBV situations.

Drawing from the perspectives of the South Sudanese refugees in Uganda, this research seeks the development of a more appropriate system for providing support to GBV survivors. It therefore includes a range of recommendations on more efficient and effective policymaking measures, as well as ways of enhancing capacity and cooperative linkages with multi-support service providers.

1.2 Objectives of the research

While the number of reported GBV survivors has been increasing, many cases are still insufficiently monitored and addressed. The main reason for this is not due to the lack of support services. Rather, people do not actively report cases for various reasons. As a result, the true number of incidents remains unknown and is potentially considerably higher than has actually been reported. This raises the question of why, despite the presence of GBV services and referral systems, survivors do not seek help. To answer this question, *the research project aims to identify existing and potential barriers that discourage GBV survivors from seeking help and reporting cases*, drawing from the cases and experiences of South-Sudanese refugees in Uganda. The research established three working research questions:

- 1) How do refugees define women's rights and violence against women, and what distinctions are made between the different forms of violence?
- 2) What are the behaviors and pathways for help-seeking among GBV survivors, including the support and service roles of relevant individuals, service providers, agencies and institutions?
- 3) What are the identified barriers to help-seeking and receiving of further assistance by GBV survivors?

Possible barriers could be categorized as follows:

- a. Fear of stigma based on social norms: acceptance of violence, restrictions on women's mobility
- b. Logistical challenges: accessibility, distance, cost, working hours of assistance
- c. Lack of information/knowledge: lack of awareness of services, lack of knowledge regarding the importance of services, lack of knowledge of norms
- d. Low service expectations: expected gain (help from family, friends, others in the host communities, aid workers) is lower than the cost to receive service.

These above-mentioned objectives aid in the understanding of the availability and quality of services for survivors of violence, as well as geographic coverage, coordination among providers, monitoring, and evaluation. Moreover, they can help to identify what prompts GBV survivors to seek help.

As the study highlights these insights from South Sudanese refugees in Ugandan settlements, it also intends to present a balanced understanding of the current status of GBV support and help-seeking among refugees. Thus, supplementary inputs from relevant service providers and refugee leaders were acquired and analyzed to enrich this study, and thereby provide

practical and sustainable recommendations in improving service delivery for GBV survivors.

To realize these objectives, the research project sought pragmatic advice from researchers and specialists in GBV support, as well as in conflict and area studies. In addition, the JICA-RI research team in Japan kept in touch with relevant national/international organizations and institutions in Uganda such as OPM, UNHCR and Makerere University to coordinate and follow up on the research process and findings.

To gather appropriate data for this study, a *field research method* was employed, adopting research instruments such as focus group discussions (FGDs) and individual interviews. To gather such qualitative data, participants were selected through a snowball sampling technique by research members of War Child Canada (WCC), which is the research consultant in charge of implementing field research for this project. Figure 1.2 illustrates the methodological flow of this study.

This combined research background, together with its overarching objectives, highlights the need to pay attention to not just identifying GBV in conflict-affected areas but finding effective measures to develop and appropriate service delivery. The study is intended to serve as a valuable tool for both scholars and practitioners in the field.

The research project aims to identify existing and potential barriers that discourage GBV survivors from seeking help and reporting cases, drawing from the cases and experiences of South-Sudanese refugees in Uganda.

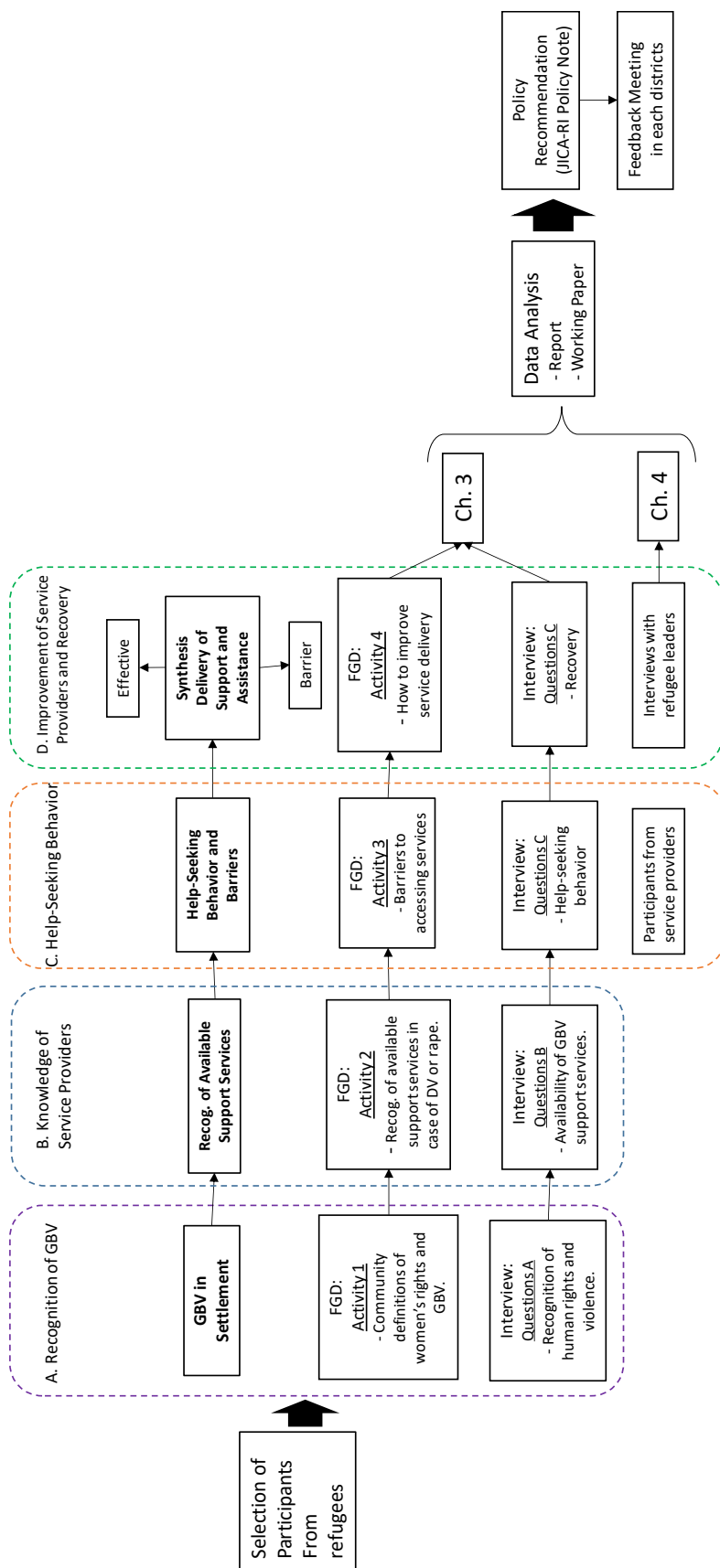


Figure 1.1 Research design framework

CHAPTER 2

IMPLEMENTATION OF RESEARCH

This chapter presents the technical details of the implementation of this project—its conception, methodological structure, and the research tools used.

2.1 Research Implementation Process

2.1.1. Team structure and partnership

This research project was carried out in partnership with Makerere University, Office of Prime Minister (OPM) and the Office of the United Nations High Commissioner for Refugees (UNHCR), and Japan International Cooperation Agency (JICA). The JICA-RI research team entrusted War Child Canada (WCC)³ as the local partner to conduct the initial field research as well as the focus group discussions (FGDs) and interviews (See Figure 2.1).

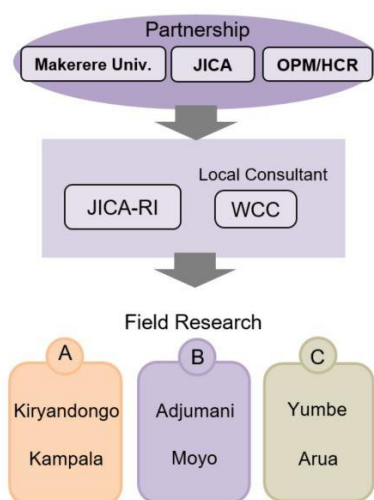


Figure 2.1 Partnership and implementation framework

To accomplish all relevant data-gathering tasks, the JICA-RI research team and WCC formed three research teams (namely A, B, and C) and assigned them to be directly in charge of conducting field research in each of the six districts (see Figure 2.2). JICA-RI oversaw all teams and conducted monitoring through the project leader of the field research. This structure was arranged and designed to obtain comprehensive data gathering.

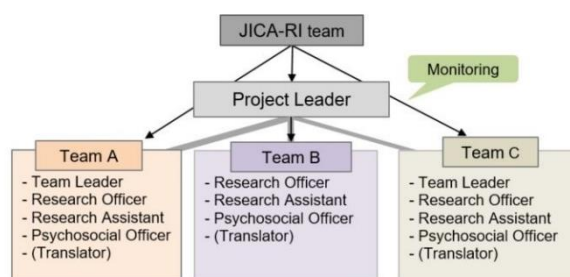


Figure 2.2 Field research team structure

2.1.2. Team training

The key research tools are the informed consent forms, FGD guides and individual interview questionnaires. Research team members attended a 4-day training session on how to carry out the data gathering. Day 1 was for sharing the aims and objectives of the research project and the detailed implementation plan. Day 2 was for the training and lectures, provided by external consultants, on cultural and gender sensitivity using WHO guidelines. Day 3 and 4 were handled by two experienced technical staff from WCC, who explained the practice and procedures of the research, including ethical and safety considerations. In this part of the training, the importance of obtaining consent from

participants—for taking photographs and for using video and audio recording devices—were explained.

2.1.3. Implementation schedule

The administrative permissions for field research from relevant authorities and actors such as the Office of the Prime Minister (OPM), UNHCR, Refugee Welfare Council and the settlement leader were obtained prior to the implementation of the research. Field research was carried out in two phases: (1) a pilot phase from 19 February to 14 March 2018, and (2) a final phase from 15 March to 5 April 2018.

During the pilot phase, teams A to C were assigned to conduct FGDs and individual interviews in Kiryandongo, Adjumani and Yumbe, respectively. For the second phase, teams A to C were in charge of Kampala, Moyo and Arua. All of these field research sessions were implemented under the direction of the team leader (TL) and the JICA-RI research team. Table 2.1 summarizes the implementation process of each team.

2.2 Selection of Participants and Settlements

2.2.1. Selection of refugee settlements

The local consultant, WCC, was entrusted by the JICA-RI research team to conduct the field research at six sites: Adjumani, Arua, Kampala, Kiryandongo, Moyo and Yumbe.⁴ (see Figure 2.3)

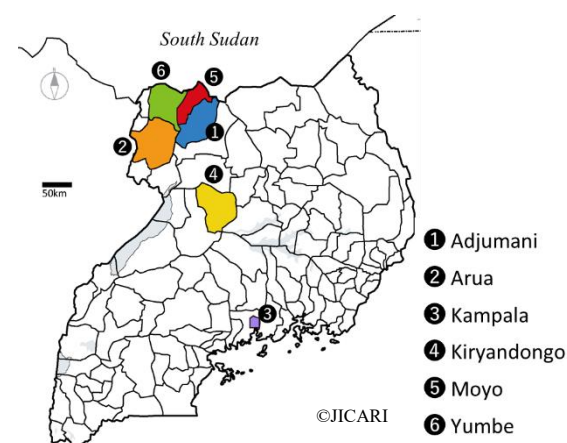


Figure 2.3 Location of research districts

Table 2.1 Implementation Schedule

	Phase I : Preparation	Phase II : FGDs and Interviews		Phase III: Outputs
	Aug.2017	Pilot Phase Feb.2018	Final Phase Mar.2018	May.2018
JICA-RI Research Team	<ul style="list-style-type: none"> Preparations for research Publicly offer local consultants 	<u>Attended to:</u> <ul style="list-style-type: none"> Team Training in Kampala. FGDs and Interviews in Adjumani, Kiryandongo, Yumbe. 	Participant observation and Interviews in Adjumani	<ul style="list-style-type: none"> Feedback MTG Research Presentation Additional Interview
WCC Uganda: Project Leader (1)	Apply for Public Offer	Formulate Research Teams and Initiate Field study		
		Overall Management		
Team A Leader (1) Research Officer (1) Research Assistant (1)		<u>Move to Kiryandongo</u> <ul style="list-style-type: none"> FGDs Individual Interviews 	<u>Move to Kampala</u> <ul style="list-style-type: none"> FGDs Individual Interviews 	Feedback MTG
Team B Leader(1) Research Officer (1) Research Assistant (1)		<u>Move to Adjumani</u> <ul style="list-style-type: none"> FGDs Individual Interviews 	<u>Move to Moyo</u> <ul style="list-style-type: none"> FGDs Individual Interviews 	Feedback MTG
Team C Leader (1) Research Officer (1) Research Assistant (1)		<u>Move to Yumbe</u> <ul style="list-style-type: none"> FGDs Individual Interviews 	<u>Move to Arua</u> <ul style="list-style-type: none"> FGDs Individual Interviews 	Feedback MTG

As of March 2018, the number of refugees in Kiryandongo was less than 60,000, while the other five districts totaled between 100,000 and 300,000 individuals⁵. The largest number of refugees is settled in Yumbe, with 287,801 people. The settlements in Adjumani, Kiryandongo and Siripi (inside Arua) were established between the end of the 1980s and the middle of the 1990s. Yumbe, Moyo and Imvepi (another settlement in Arua), were newly established in 2016 and 2017. These areas were selected as research sites because of the large concentration of South Sudanese refugees. This study includes South Sudanese participants from both the urban (Kampala) and rural areas, fairly old and recently established, as well as large and small refugee settlements. These combinations provide a diverse population for this study.

2.2.2. Inception meetings

Inception meetings were organized by WCC in each district to secure cooperation with key stakeholders, including OPM and UNHCR, and other key service providers such as the District Community Development Office, Lutheran World Federation, Save the Children, Danish Refugee Council, local government representatives, refugee welfare committees, WCC staff placed in target settlements, etc.

The research team explored the socio-cultural dimensions with key stakeholders and found that the relationship between refugees and the host community is generally positive in each settlement. In Moyo, intermarriages were observed, host and refugee residents communicate in common languages, mixed groups of refugees and host women walked to forage for firewood for security, land has been shared, and they even hold social events together.

Nevertheless, some opposing ethnic groups who escaped from the violence in their home country are forced to live together in the same settlement in their asylum country and continue to cause trouble. In the case of South Sudanese refugees in Uganda, conflicts are sometimes reported between Dinka and Nuer.⁶ Considering such sensitive tensions between antagonistic ethnic groups, the research team members were trained to pay careful attention to ethnic differences and avoid the use of terms such as “defilement”⁷ or “rape,” especially in front of other participants and settlement residents.

FGDs and interviews were arranged with careful consideration of the social and psychological risks and benefits to the participants and interviewees. Prior to conducting FGDs and individual interviews, participants were required to affirm their consent to take part in the study. Furthermore, the research was conducted in the presence of translators, who were selected from among refugees in order to avoid any linguistic misunderstandings.⁸

Gender-based violence (GBV) issues are a substantially private matter for individuals. Thus, the research teams took a great deal of care to avoid subjecting GBV survivors/victims to any trauma during the research. Although the research team was composed of both male and female staff, given the study’s sensitivity, female interviewers were assigned to female participants, and translators were selected from each of the respective settlements.

The objective of the research and the potential use of the obtained data were sufficiently explained. A psychosocial officer also accompanied each research team to provide mental care or support or to introduce referral agencies to provide further support services when necessary.

2.2.3. Limitations

The participants involved in the FGDs and the interviewees represent a cross-section of South-Sudanese refugees from different ethnic groups and backgrounds. Considering such a diversity of individuals and the changing situations in the refugee settlement, the research team did not seek to provide a generalized understanding of refugee backgrounds or experiences, nor did it aim to analyze the experiences of any specific ethnic groups.

2.3 Research Tools: FGDs and Individual Interviews

Three research tools were developed by JICA-RI, and all research tools were translated from English into major spoken languages among the South-Sudanese refugees in targeted settlements: Juba Arabic, Bari, Dinka, Nuer, Luo and Zande.

Tool 1. Participant information sheet, which consists of questions to collect basic information about individual participants for both the FGDs and interviews.

Tool 2. Focus group discussion (FGD), which is a prepared guide based on four activities, designed to develop into discussions.

Tool 3. Individual interview, which is comprised of a semi-structured set of questions for individual interviews.

2.3.1 Tool 1: Participant information sheet

The participant information sheet provides the basic demographic details of all the participants. Box 2.1 summarizes the key information obtained from the participants. These data are needed to describe the population engaged in this research activity.

- | |
|--|
| <ul style="list-style-type: none">■ Demographic details■ Sex, age, marital status■ Household size and gender roles■ Engagement in income-generating activity and household income■ Reason of displacement and period of settlement■ Educational level |
|--|

Box 2.1 Participant information collected by Tool 1

2.3.2 Tool 2: Focus group discussions

2.3.2.1 Introduction of FGD to the participants

FGDs were organized for men and women separately. Before proceeding to the FGDs, the facilitator read out the consent form, either in English or the local language, to all the participants. Then, verbal or written consent from each participant was obtained. The members of the research team introduced themselves, followed by the translators and the participants. The facilitator explained the purpose of the FGDs. It was reiterated that the purpose of the research is related to the concerns and needs of refugees for GBV support services by exploring experiences of violence and the availability of support services to those seeking help in the community. Subsequently, the facilitator shared the ground rules, including basic courtesy when someone who has different ideas is speaking.

2.3.2.2 Activities

The FGDs consisted of four activities designed to engage the participants in exploring the diverse dimensions and wider experiences of GBV. The maximum time allowed for each activity was 30 minutes.

Activity 1 was focused on the participants' definitions of women's rights and GBV through brainstorming and prioritizing and discussion steps for categorizing various types of violence that South Sudanese refugees have recognized. During the brainstorming session, the

facilitator asked the participants to list the various types of violence they had experienced in their lives. After this, discussion followed to learn from the participants the most common violent actions in their settlement or common experiences of violence that have been perpetrated by a stranger/intimate partner. Participants were also asked about actions they considered normal or not in an intimate relationship or in the settlement, the type of violence that had prompted them to seek help and where/who they were expected to seek help from. The facilitator provided a list of violent acts of violence against women (VAW) and GBV from WHO, UNHCR and UNFPA as a reference.

Activity 2 focused on help-seeking options and behaviors by asking the participants to illustrate a “help-seeking pathway map.” Participants were divided into two groups and were asked to look over one of two hypothetical GBV scenarios. Group 1 was given the story of “Martha,” a survivor of repeated physical violence by her husband (see Box 2.2). Group 2 was given the story of “Tabitha,” a rape survivor by a non-intimate male acquaintance (see Box 2.3).

Each group was given questions on how and where Martha and Tabitha would proceed to seek support services in their community. The facilitator was present to guide in developing a visual “map” of the available support services in their community. These hand-drawn maps highlight the available support services and possible choices about access to services.

Activity 3 was focused on the barriers to accessing support services for GBV survivors. Drawing from Martha and Tabitha’s stories, participants discussed the various support, information and health care services that the two women could access and receive if they ever sought support. In this activity, facilitators asked participants to discuss how common it is in their settlement that a person like Martha and Tabitha would/would not seek support and the reasons why. In addition, participants argued over the different influences on survivors of GBV according to age and the difficulties for women to find out where they can go for help. In addition, facilitators confirmed whether everyone in their settlement knew about organizations/institutions that offer support services and how people could find out about these services. After the discussion, participants marked on their “help-seeking

Martha’s Story

(a survivor of repeated physical violence by her husband)

Martha lives in a 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 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 does not want to. Martha thinks this has been getting worse after they moved to the settlement. Martha has tried talking to him, but it is like talking to a wall. She has put up with this situation for a long time and has not told anybody. She does not know what to do.

Modification added to the original text from Fawcett GM, Heise L, Isita-Espejel L, Pick S. Changing community responses to wife abuse: A research and demonstration project, Iztacalco, Mexico. *American Psychologist*, 1999;54(1):41-49.

Box 2.2 Martha’s Story

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. However, 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 quickly return home 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.

Stephen Mawa, "Women face 'unspeakable' sexual violence in South Sudan" from UNFPA News on 5 August 2016, <http://www.unfpa.org/news/women-face-unspeakable-sexual-violence-south-sudan> (as of Feb 2017).

Box 2.3 Tabitha's Story

pathway map" some of the barriers that women face in seeking particular services in the refugee settlements using colored notes. The process clarified what forms of GBV exist in the settlement and how refugees can access and receive support, when such problems arise.



Women's FGD in Adjumani

Activity 4 was focused on how to improve support service delivery. Participants raised ideas on how to improve access and the quality of support/referral services. They identified the top two or three important options for their settlement and discussed a ways of improving them.



Men's FGD in Yumbe

2.3.3 Tool 3: Individual interviews

2.3.3.1 Target participants and preparation

Men and women from the six research districts were randomly selected to participate in individual interviews. As with the FGDs, participants were first briefed about the research study, its objectives and use of the data. Interviewees were asked to affirm their consent before they proceed with the interview.

2.3.3.2 Components of the questionnaire

An interview sheet with guided questions, developed and prepared by JICA-RI, was used for this research. This questionnaire is composed of three major parts:

A. Recognition of human rights and violence

The questions in this section concern the ways in which refugees perceive and understand human rights, based on their conditions and their personal experiences of violence. This part is composed of three sections:

- A.1. Individual beliefs about violence
- A.2. Beliefs about violence and rights to seek help
- A.3. Personal experiences of violence

Interviewees were asked about their stand on multiple types of physical violence, emotional violence and economic violence within or outside the family. If needed, interview participants could be asked to elaborate on their answers. In case the interviewees had difficulty responding to the questions, the facilitator could provide some examples of violence, like physical violence, sexual violence, emotional/psychological violence, and economic violence, as references.

B. Availability of GBV support services

This part was composed of five questions to understand the refugees' knowledge of available support services, particularly access to services, quality of existing services, kind of services they need, and people or

organizations that provide support to GBV or sexual and gender-based violence (SGBV) survivors/victims. These questions could clarify the existing level of GBV support services available to South Sudanese refugees and their personal awareness and priorities in terms of seeking support both from inside and outside the settlement.

C. Help-seeking behavior and recovery

This section contains open-ended questions about GBV survivors' help-seeking behaviors. The questions probe interviewees on the pathways of help-seeking and the barriers that exist between the survivors and the GBV support services. Along with the questionnaire, the interviewer elicited self-stories or stories about another person related to GBV and their help-seeking experiences. People who had direct or indirect experience of GBV were voluntarily asked to retell their stories. In cases where the interviewees had no knowledge of an actual GBV incident, the interviewer was able to use the guide questions as a hypothetical case to discuss the potential help-seeking process.

2.4 Additional Research (2019): Interviews with Service providers and Refugee Leaders

This whole research was primarily intended as a means of understanding GBV help-seeking and recovery based on focus group discussions and interview responses of South Sudanese refugees in Uganda. Upon the completion of the initial interviews with refugees, analysis of the data, and a review of key points that were confirmed during the preliminary study, the research team decided it would be necessary to collect further interview data to substantiate this study from the perspective of GBV support/service providers.

Based on the study's research design framework (see p. 5), the study is intended to provide valuable recommendations to practitioners in the field of GBV as well as policymakers focused on conflict-affected areas. Hence, this additional data gathering was executed to complete the study.

2.4.1 Participants

Service and support providers include individuals and members of institutions engaged in delivering support and assistance to GBV survivors. The study categorizes two main types of providers: refugee leaders (RL) and service providers (SP). These classifications were made based on the results of the FGDs and their descriptions of help-seeking pathways, as well as refugee awareness of available GBV support services. These discussions have established the important roles of these providers to victims in seeking and availing themselves of GBV support. The refugee leaders (RLs) may include individuals with locally acknowledged influence among other individuals in the settlement. They may include church leaders, host community leaders, refugee leaders, block leaders and community elders. On the other hand, service providers (SPs) involve individuals affiliated with various institutions, either Ugandan or international organizations, that cater to the needs of GBV survivors. These may include members of Ugandan police, health practitioners, various NGO workers, protection officers, and social workers, to name a few. By having these two categories, the study can cover both the individual and institutional service and support providers that matter in the survivors' help-seeking.

2.4.2 Interviews

The two main streams of interviews were classified based on the type of GBV cases, (1) domestic violence (DV) or intimate partner violence (IPV) and (2) Sexual violence by a stranger. This additional research covers the same six districts that were engaged in the initial part of the study. Based on the results of the FGDs (particularly the refugee's recognition and experience of GBV) and to optimize data gathering, service/support providers from Arua, Adjumani and Kampala were assigned interview questions related to DV/IPV, while those in Moyo, Kiryandongo, and Yumbe were assigned questions related to Sexual Violence by strangers. The study assumes that the frequency of reported and known incidents of DV/IPV or Sexual violence by strangers in the selected districts is correlated to help-seeking support required from these providers (see Appendix J).



Interview conducted during the research

Gender-based violence (GBV) issues are a substantially private matter for individuals. Thus, the research teams took a great deal of care to avoid subjecting GBV survivors/victims to any trauma during the research.

CHAPTER 3

REFUGEES' PERSPECTIVES ON GBV AND HELP-SEEKING IN CONFLICT-AFFECTED AREAS

Gender-based violence (GBV) can transpire in any geographical location or social condition. People in conflict-affected areas are not exempted from the exposure to such forms of violence or the challenges of help-seeking and recovery.

This study conducted focus group discussions (FGDs) with 153 male and female participants (73 male and 80 female), and 122 individual interviews (57 male and 65 female) to generate and aggregate data on (1) the details of refugees' perceptions of violence, (2) preferred help-seeking pathways and (3) recognized barriers to gaining help and support.

3.1 Recognition of Human Rights, Violence and GBV

The participants in the individual interviews were asked about their beliefs regarding violence and the right to seek help through eight (8) or nine (9) statements to confirm whether or not they subscribed to these ideas (Figures 3.1 & 3.2).

3.1.1. Individual beliefs about violence

In terms of the participants' individual beliefs about violence, *it is clear that, regardless of gender, they have a negative reaction to any form of violence* and that 96% considered “women to have a right to report any

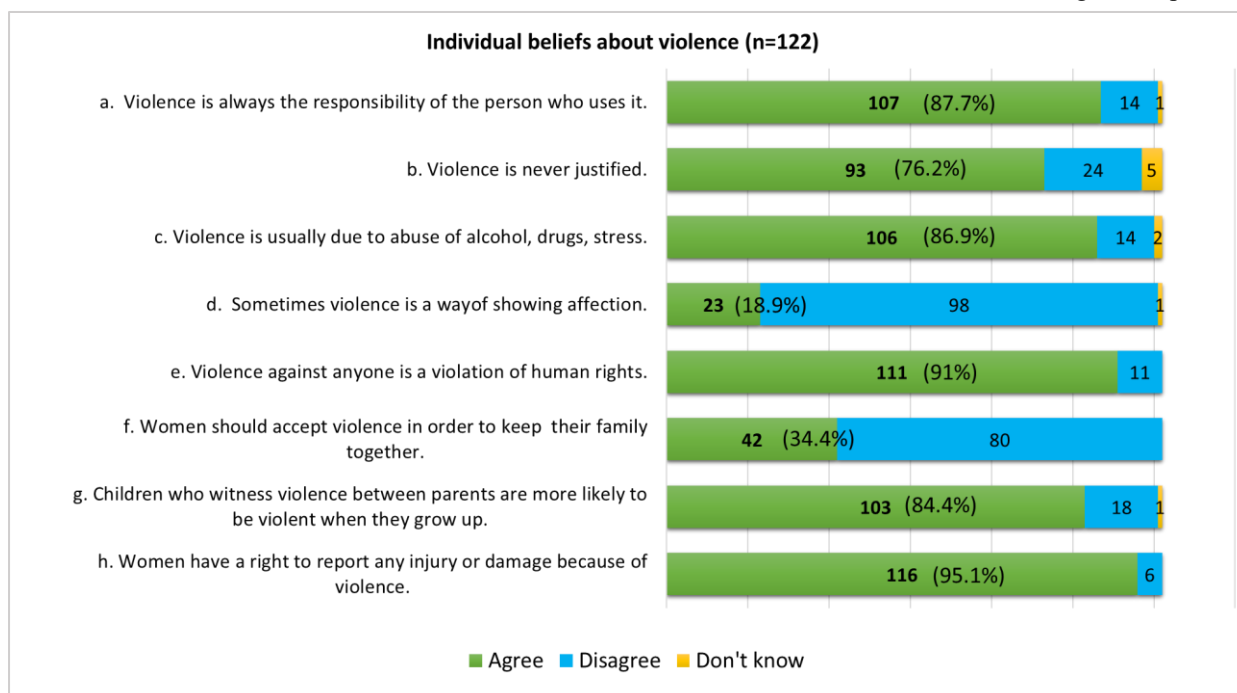


Figure 3.1 Individual beliefs about violence

injury or damage because of violence” (Figure 3.1). A small gap in the recognition between men and women can be confirmed for items (a), (b) and (g), which indicates that male participants have a slightly more affirmative response concerning the use of violence than females. Nevertheless, the majority of refugee participants share an unfavorable opinion of violence and recognize that women have the right to report any damage or injury.

3.1.2. Beliefs about violence and the right to seek help

Figure 3.2 shows the interview participants’ recognition of criminality, secrecy, as well as the right to seek help for GBV inside/outside the family.

Recognition of criminality of sexual violence inside or outside the family

Statements (a) and (b) show the participants’ recognition of the criminality of and punishment for sexual violence inside/outside the family. In comparing the results of these two statements, most participants (90.2%) recognized the criminality of sexual violence from a non-family member, and “agree” on the need for

punishment of the perpetrator as well. About 70% of the participants recognized the criminality and punishment of sexual violence between partners, and 39.3% of the same group thinks “sexual violence between partners is relationship matter.” This confirms that **20% of the participants consider the violence from a family member does not necessarily need punishment**. Also, it revealed that slightly more male participants respond negatively to sexual violence, whether inside or outside the family than females.

Secrecy of GBV inside/outside the family

Statements (c) and (d), which relate to participants’ support for secrecy about GBV inside/outside the family, are not limited to sexual violence as in the previous statements. The majority of participants disagree with the need for secrecy following GBV, whether it is caused by a family or non-family member (72% for GBV from non-family and 56% for GBV within the family). However, these responses clearly showed participants’ cautious attitudes towards the disclosure of such an issue, especially when it concerns GBV among family members, even though the most of them still advocated

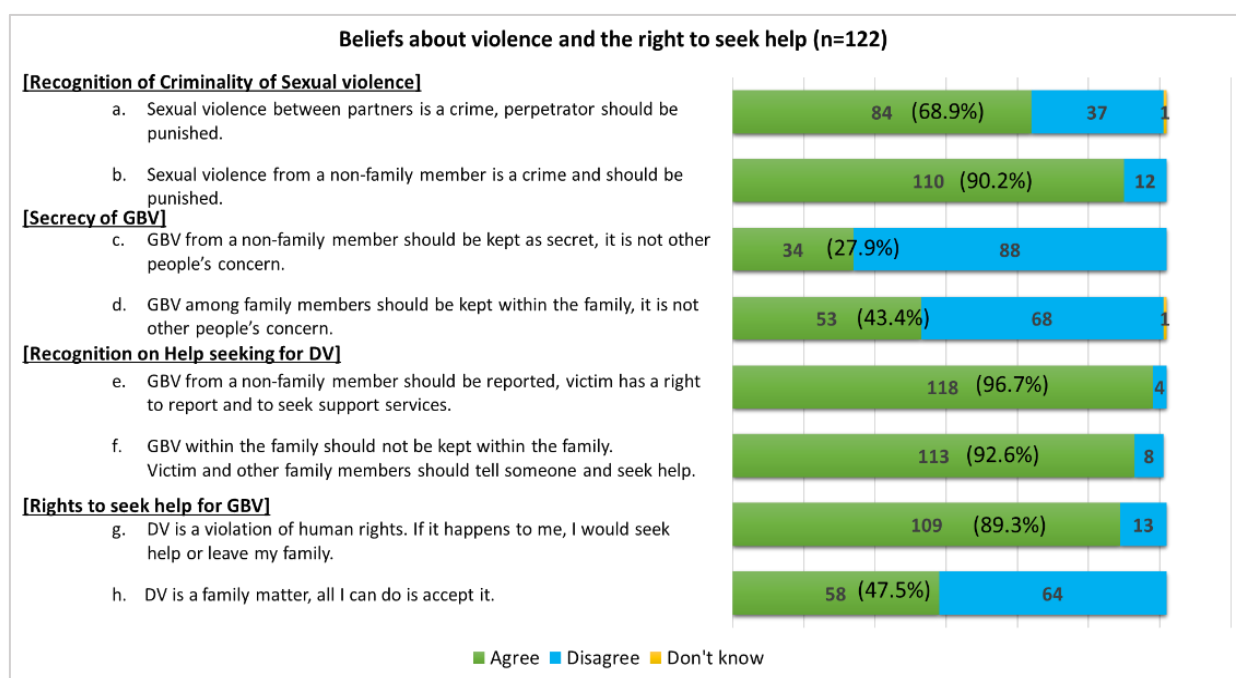


Figure 3.2 Beliefs about violence and the right to seek help

for its criminality as in previous questions.

Right to seek help for GBV inside/outside the family

Statements (e) and (f) show participants' recognition of the right to seek help for GBV. *Nearly all of the male and female participants indicated that GBV should be reported, regardless of whether it is perpetrated by family or non-family members and acknowledged the necessity of seeking help. In particular, they tend to consider GBV by non-family members as more crucial for help-seeking*, which shows a similar tendency to the responses to statements (a) and (b). Moreover, slightly more female participants confirmed the need to seek support services than male participants.

Recognition on help-seeking for DV

Statements (g) and (h) focus specifically on participants' recognition of DV, which indicates violence among family members. The results for these two statements noticeably reflect their psychological conflict and difficulties in seeking external help for domestic issues. *Most participants (90% of females and 91% of males) confirmed that DV is a violation of human rights and stated that they would seek help in cases where it occurs. Nevertheless, 48% of the total—almost half of the participants—agreed that DV is a family matter and all they can do is to accept it.* Taking into consideration the gap between male and female responses for statement (h), more men were hesitant to disclose domestic matters or their victimhood to those outside the family.

3.1.3. GBV for refugees

During individual interviews, *two main categories of violence were indicated 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 is represented by forced recruitment to be soldiers. Such stories show that the brutal acts of violence extend to ordinary people's daily life under conflict and, in that situation, women easily become the targets of violence, and sexual violence against women is frequently perpetrated by strangers as a form of "retribution" for male members in their familial or ethnic groups. Appendix H provides some selected stories of GBV in conflict-affected areas as recounted by refugees in the settlement.

As for category 2, DV—which 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—was frequently reported during individual interviews as well as FGDs. During 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 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 females⁹; however, participants also discussed violence committed by females against males. 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. In addition, young adults and children are often referred to as casualties of early or forced marriages, child abuse and defilement.

The occurrence of the abovementioned cases is not just contained within the refugee settlements but also occurs 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.

3.2 Help-seeking Behaviors and Pathways

3.2.1. Availability of GBV support services

The majority of the female and male interviewees confirmed awareness of the existence of GBV support; a large majority indicated they know where to access support and services (see Figure 3.3).

The interviewees mainly identified the police, NGOs, community leaders, health/medical centers, and hospitals as GBV survivor-support providers that they are aware of. This response reflects participants' awareness of institutionalized agencies as logical sources for assistance and support. These agencies are highly visible in the settlements, as refugees confirmed their presence in the local area (see Figure 3.4).

Each key institution identified by participants provides specific forms of support and services. The police are the agents for filing legal complaints. They are the institution that was sought out to deliver justice for GBV survivors. Various NGOs are present to provide specific support and services, like medical, mental, legal and other relevant services. Some NGOs operate as mediators between the survivor and the services available outside the refugee settlements. Local medical institutions provide health (and even psychological) support to survivors, as most reported GBV cases unfortunately result in physical injuries. All of the above-mentioned institutions taking the role of providing various support services are classified as GBV service providers. They are institutions, organizations and agencies that support a GBV survivor's help-seeking. There are also individual sources of support for survivors, like the refugee leaders (block leaders, church and religious leaders, RWC leaders and committees), who are the immediate points of contact accessed by GBV survivors. Their administrative roles in the

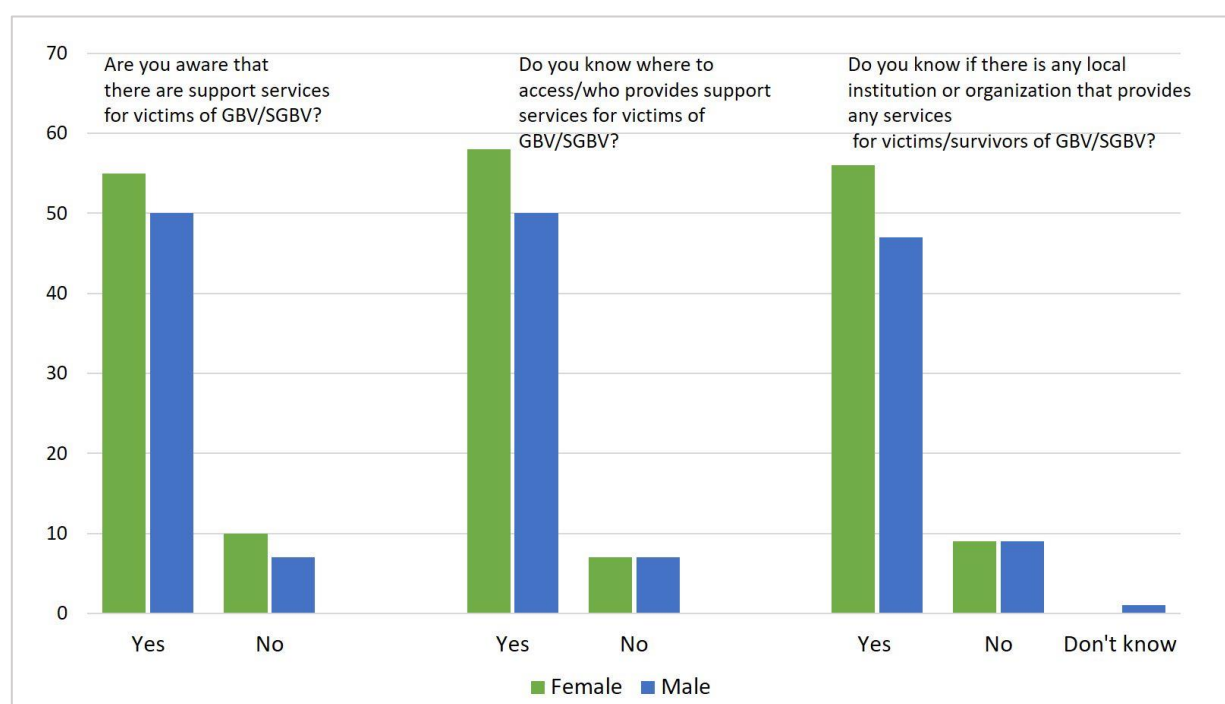


Figure 3.3 Awareness of GBV support

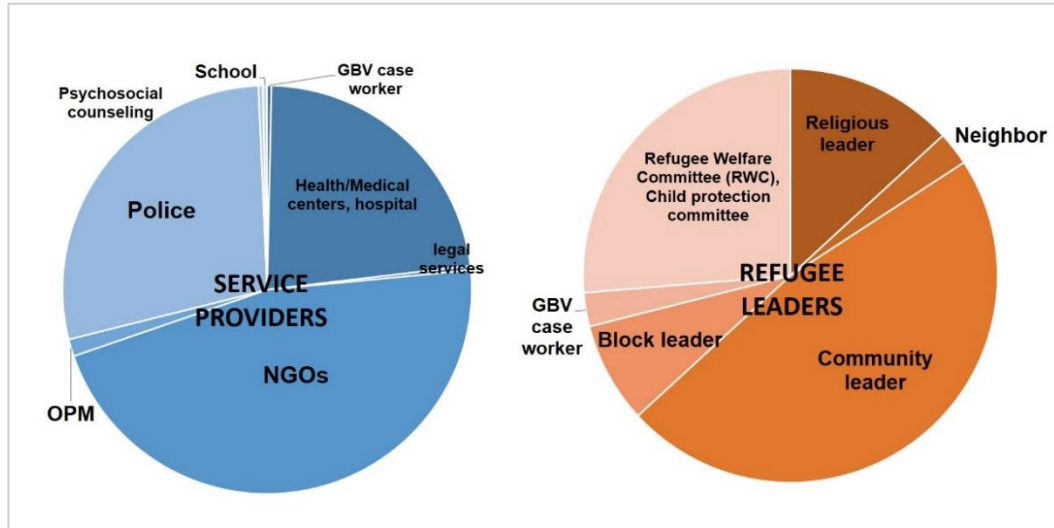


Figure 3.4 Service providers and refugee leaders identified by participants

settlements confirm their actual visibility at the local level and, thus, they are identified sources of help from within the settlement.

Despite knowledge of these support systems, the frequency of those availing such support is not overwhelmingly high (see Figure 3.5). There are still participants who prefer not to get help after suffering from GBV.

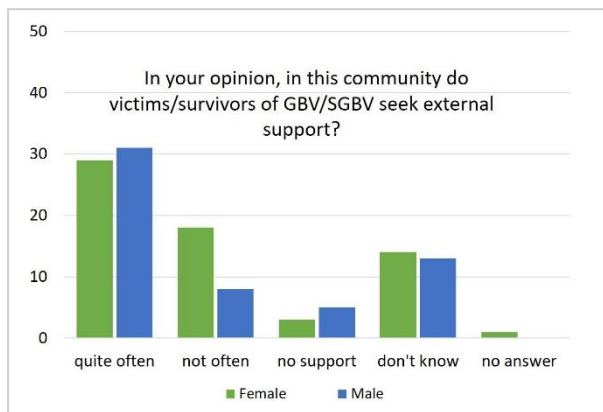


Figure 3.5 Frequency of help-seeking

3.2.2. Pathways for help-seeking

Figures 3.6 and 3.7 illustrate the general tendencies in help-seeking developed by the FGD participants. These figures reflect the significant social actors and institutions present in their decision-making rationale for both the DV and rape (by stranger) cases of GBV.

The church is a recurring point for help-seeking that is not in the standardized humanitarian referral system in general. It primarily provides counseling or a spiritual support role for the survivors.

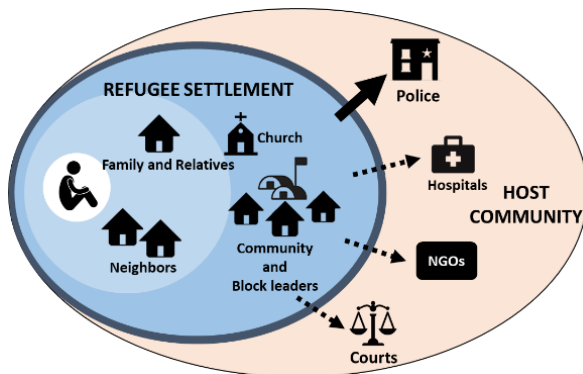


Figure 3.6 Pathways in help-seeking for cases of DV

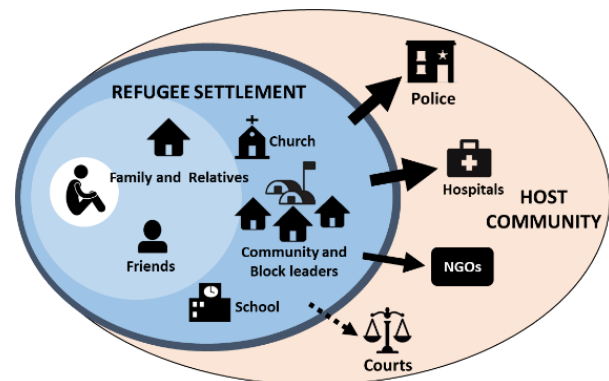


Figure 3.7 Pathways in help-seeking for cases of rape and defilement (by stranger)

Based on results from the FGD, people gauged the necessity of seeking help depending on the severity of the injuries. If a survivor incurs serious injuries from either rape (by a stranger) or DV, his/her family and refugee settlement leaders decide whether the survivor needs to be referred to the police and hospital or not. ***Generally, those requiring medical attention—including cases resulting from rape, assault, and defilement—are easily identified instances that require help to be sought outside of the refugee settlements. However, cases of DV and rape (by a stranger) often pass through a more subjective gauge. Despite the awareness of help-seeking pathways, actualizing them remains a challenge. While they are aware that GBV cases require help-seeking, some would choose not to avail themselves of it.***

3.2.3. Story of a DV survivor

The sequence in the pathway for help-seeking in the case of DV (Martha's Story), according to FGD participant, starts with her confiding in her family, relatives or neighbors. The primary task is to resolve the issue within the immediate social circle (inside the refugee settlement). For serious cases, the community leader determines if the survivor requires professional support outside of the refugee settlement, and the leader reports the case to the police and demands an investigation. In addition, they might request medical assistance from the hospital in cases where the survivor needs medical treatment. In contrast, NGOs and courts are not considered important agents for seeking help. ***FGDs revealed that they prefer to seek support from NGOs for rape cases rather than DV cases.***

3.2.4. Case of a rape and defilement survivor

A similar order is followed in the pathway described by participants for a rape and defilement survivor (Tabitha's Story). However, once it has been decided

that the survivor would seek help, a number of legal and medical procedures must be followed. Some social actors will be involved, including the police, humanitarian organizations/NGOs, and the OPM. This may even reach the judicial level, if needed.

3.2.5. Options for help-seeking

For both cases, the survivor's primary options for help-seeking can be found within the available help and support providers within their settlement. The survivor optimizes all the support he/she can get from members of the settlement. Hence, the survivor's case becomes the settlement's case. The decision to seek help outside of the refugee settlement is often influenced by settlement leaders, elders and church leaders. In practice, survivors do not directly seek help from external aid providers. ***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 refugee settlement.***

3.2.6. Kinds of received support

Despite the differences between the two cases, all clusters agree that action should be taken immediately. GBV (or even any form of injustice) demands a quick response. 75.6 % of participants who acknowledged having experienced GBV accessed support. However, ***it is important to note that they primarily sought help from their family, friends and someone in the community rather than from the local police and aid workers.*** This tendency was the same across all other participants of individual interviews, even for those who answered the hypothetical cases.

The awareness of GBV support and services and existing providers confirms their knowledge of the available services. While certain social institutions (police, medical and NGOs) are the obvious preferred sources

for various support services, counseling (plus psychosocial support) is the kind of support they hope to receive. However, the terms ‘counseling’ or ‘psychosocial support’ are sometimes used to mean consulting with friends, church or community leaders about the incident, not necessarily receiving special psychological care from experts or agencies. In this regard, it could be assumed that, despite the knowledge of existing support from the host community and NGOs, their first point of contact for help-seeking is not outside of the refugee community but rather those in their settlement.

3.3 Barriers to Help-seeking

Even though the natural tendency is to seek help, survivors of GBV often decided not to avail themselves of any help or support services. Between the survivors and the various forms of support needed are barriers that are rooted in a range of complex factors. 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 to provide services. Figure 3.8 visually represents the scale of each barrier, and the reasons they hinder help-seeking among GBV survivors.

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 and get help. In addition, other people understand DV as a natural part of the domestic partnership. As examined in Section 3.1, it is considered private, and therefore should not be discussed beyond the confines of the household. *Secondly, the low expectations of the service providers come 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. The lack of information and logistical challenges are not as significant compared to the other two barriers discussed above. 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 how international organizations, NGOs and local service providers could help GBV survivors. This results from the frequent advocacy activities, and their active participation in GBV education. However, this may not 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

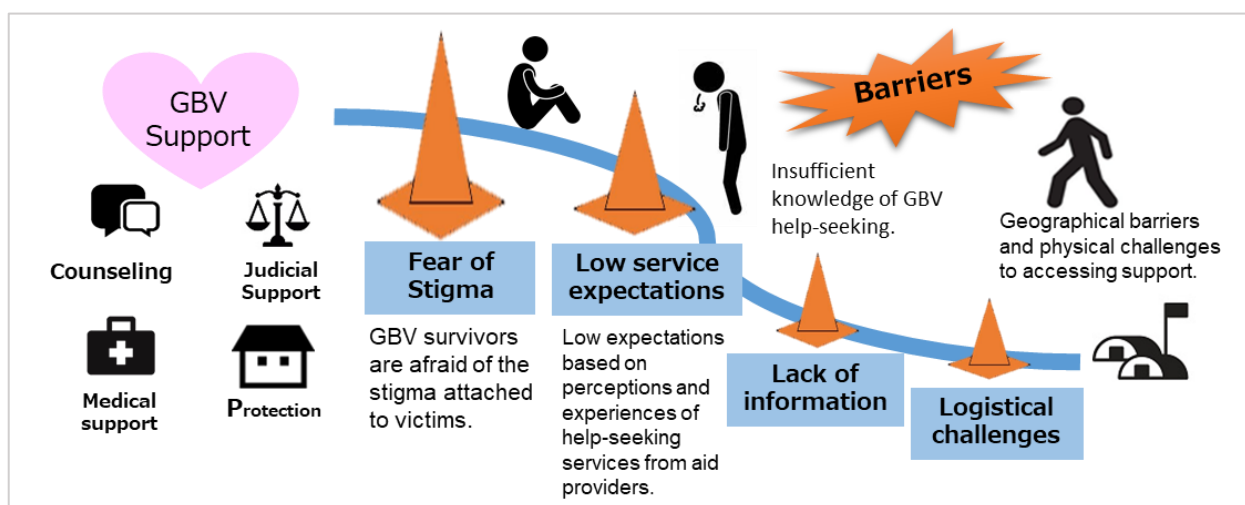


Figure 3.8 Barriers to GBV help-seeking

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.

3.4 Summary of findings

The FGDs and interview participants primarily identified DV as a form of GBV and confirmed that any form of violence must be punished. Nevertheless, many participants indicated that domestic violence (DV) or intimate partner violence (IPV), including sexual violence between familial members, should be kept as a secret within a family.

For the second key theme, help-seeking behavior and pathways (discussed in Section 3.2), participants set out the different help-seeking pathways according to the

degree of harm and existing conditions. They referred to community leaders or churches as the primary and most familiar institutions at 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.

For the third key theme, barriers to help-seeking, the four identified barriers were confirmed to hinder the help-seeking of survivors, yet at varying degrees. The barriers to help-seeking include the geographical distance and physical difficulty in accessing the services and support—in addition to fear of stigma, lack of information and low expectations of service providers. These barriers affect the help-seeking behavior and pathways of GBV survivors (See Appendix C).

***Despite knowledge of these support systems,
the frequency of those availing such support is not overwhelmingly high.
There are still participants who prefer not to get help after suffering from GBV.***

CHAPTER 4

SERVICE PROVIDERS' PERSPECTIVES ON GBV AND HELP-SEEKING IN CONFLICT-AFFECTED AREAS

4.1 Help-seeking Pathways and Barriers for GBV Support and Services

Effective support and service delivery for gender-based violence (GBV) survivors demand active participation from both the refugee leaders and the individuals or institutions delivering the service. This section discusses the perceived pathways in help-seeking and barriers for survivors from the point of view of the service providers (SPs) and refugee leaders (RLs). In addition, it also includes the support and service providers' own barriers and needs in responding to GBV.

4.1.1. How survivors reach RLs and SPs

The logistical process of help-seeking starts when the survivor (attempts to) reach out to support and service providers.

Alone or accompanied : As shown in Figure 4.1, which details how the survivors contact SPs or RLs, most survivors go to support or service providers alone. However, there are still those who reach out to the SPs together with a leader from their community (in some cases, the RLs). As highlighted in Chapter 3, GBVs help-seeking decisions are influenced by settlement leaders, church leaders and community elders.

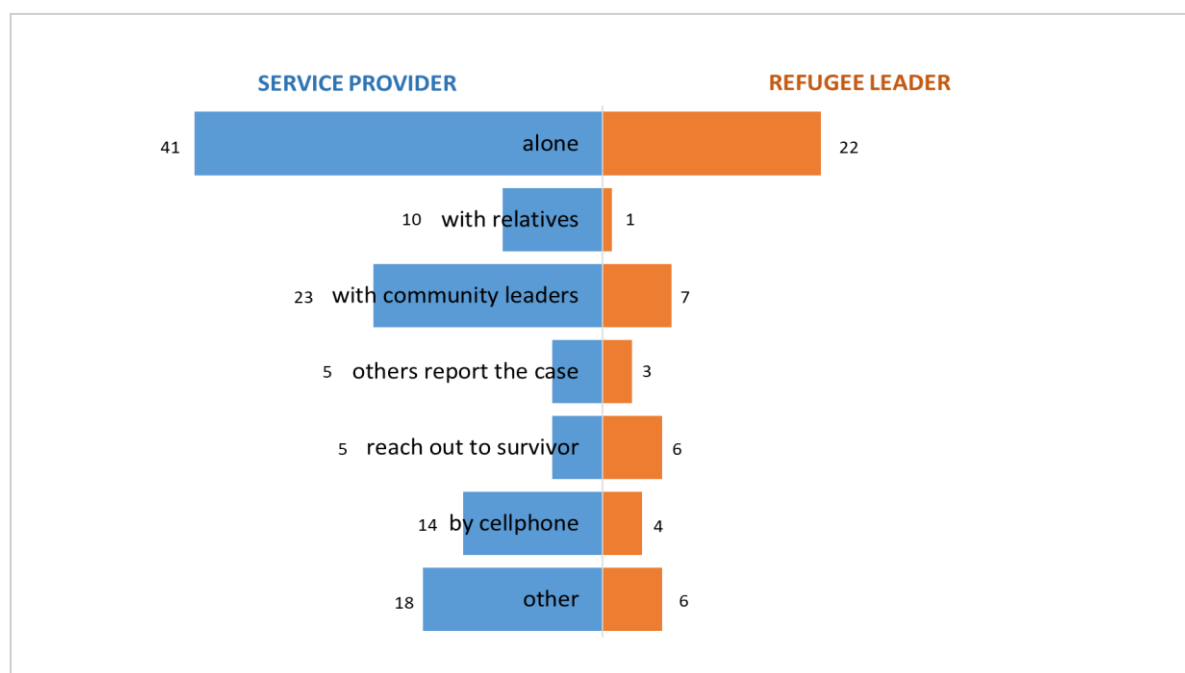


Figure 4.1 How survivors first contact support or service providers

Mode of transportation: Survivors go to SPs mainly on foot, while a few are able to access the SP stations or offices by motorcycle (see Fig. 4.2). Logistical factors are negligible when going to RLs, since these leaders live within the refugee settlements. They are more accessible to the survivors, and in some cases, survivors already have a direct personal relationship with the RLs.

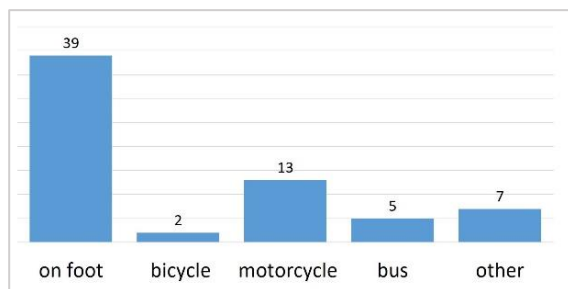


Figure 4.2 How survivors travel to SP office or station

As for SPs, survivors reach out to them in designated outposts, stations or clinics. *Given the distances of these services from their place of residence, logistical challenges often arise.*

4.1.2. Services offered

A. Differences in SP and RL services

Some refugees are likely to already have an idea in mind regarding the kind of services they would like to receive from the individuals and institutions they approach. Figure 4.3 shows the primary support offered by RLs and SPs.

Refugee leaders mainly offer counseling, mediation and referral services. As for the service providers, depending on the nature of the organizations or institutions, they offer quite similar services to the RLs for GBV responses, including psychosocial support, case management, legal support, medical, protection, and welfare.

There is a noticeably much greater variety of services offered by SPs than RLs. These services depend on the nature of the SPs. For example, case management is

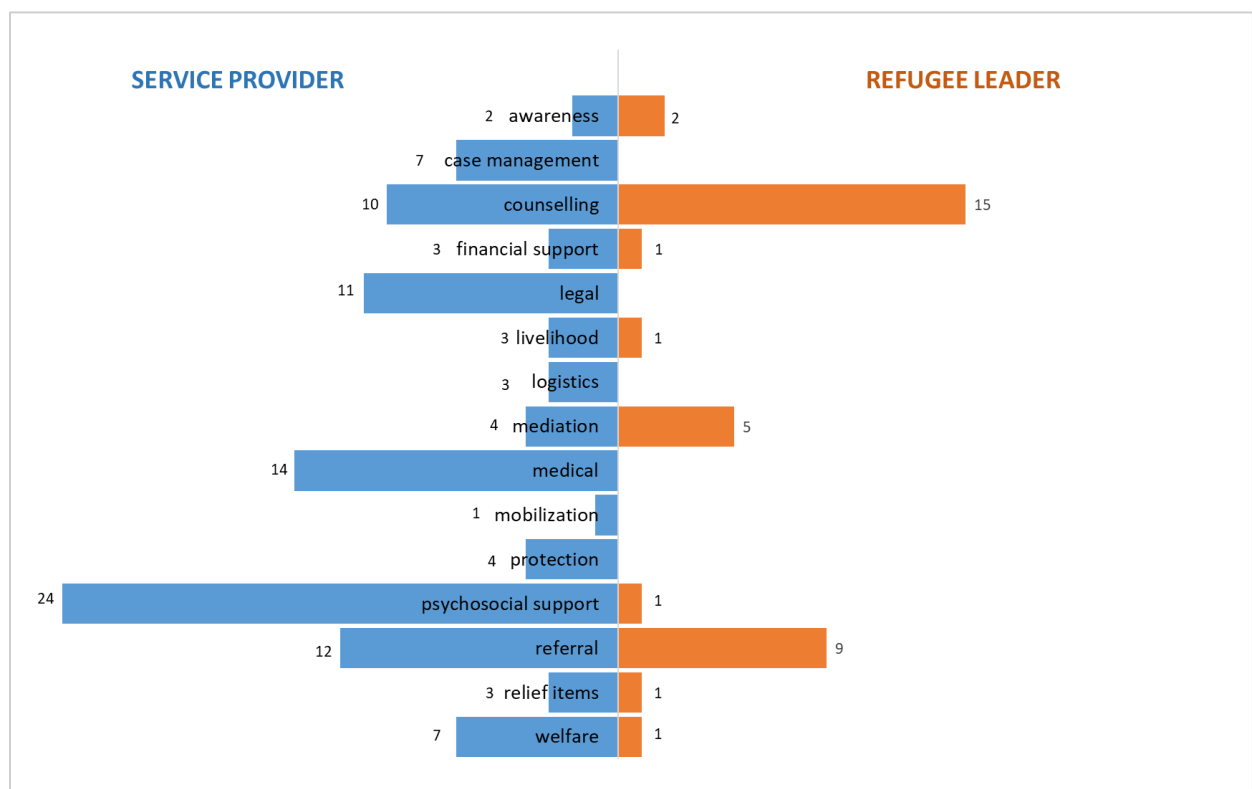


Figure 4.3 Services offered by SPs and RLs

handled by the police and OPM, and medical assistance is provided by hospitals and MTI. In some cases, medical officers are required to go to court to testify.

B. Meaning of ‘Counseling’

In the case of RLs, their three main functions (counseling, mediation and referrals) mirror those conducted by SPs. However, counseling and mediation from RLs are critical if the case is to be referred to the various SPs.

Counseling is a necessary procedure in responding properly to a GBV case. However, ***it should be noted that RLs and SPs might have different understandings when referring to the term “counseling of survivors.” Counseling for RLs may simply mean a detailed listening session for the problem.*** However, for the SPs, counseling would require professional training in psychosocial support for the healing of survivors. Even between SPs, there may be disparities in the way that the term is understood, and it could either refer to a detailed listening session for case management or it could refer

[DV Case in Arua]

Interviewer: When she comes to report a case of GBV to you, what will be the first thing you will ask her?

RL: I [will] first greet her and welcome her, sit her down, and then I leave her to rest. Then from there I ask what has happened? Why have you come to me today at this time, maybe in the late hours?

Interviewer: [You asked] What has happened?

RL: Yeah, what has happened?

Interviewer: How about some additional information? Don't you think you could also ask her name for example?

RL: [I did that] once. Because assuming I [speaking as the survivor] have come and [as] much as we are all refugees, but you might not know much about me [survivor], the details about me so I should be able to provide to you. So what are some of those questions that you would expect me to tell you so that you can get to know me? I [speaking as RL] will ask you, who was with you in that time when the problem occurred? Maybe the witness, who are the witnesses? That problem ...Yes. I will ask you to come with that man who is a witness so I will also call the witness from my side then we begin to discuss. (Refugee leader).

[DV case in Kampala]

Interviewer: Do you face difficulties in handling GBV survivors?

SP: [on the disappearance of some SPs] ...I mean it [GBV intervention at a higher level] is an issue but sometimes what I find a bit concerning is when agencies [stops providing services]and suddenly there is a gap. Then somebody starts moving into that area and provides services, and to me it is unclear whether all agencies are providing advanced levels of psychosocial support and psychological interventions. Counseling is a bit of an issue for me. For me, counseling should be done by somebody trained in it and not by a caseworker who is doing usual day-to-day case management. But many have referred to counseling as something that case workers are doing. So, it's also an issue of understanding what you can and can't be providing as an NGO in the settlements. Ummm so yeah...that is a huge challenge over there....Ummmm yeah. (International NGO worker)

Box 4.1 Examples of SP and RL participants discussing counseling about DV case

to psychosocial support for mental care purposes.

C. Police and medical personnel responses

Among other duties, the **police** provide a service designed to provide justice to GBV survivors, and therefore follow certain bureaucratic procedures when responding to cases. The story below shows how a DV/IPV case is processed and referred appropriately.

[DV/IPV Case]

Interviewer: What kind of services do you provide for DV/IPV survivor?

SP: We make sure their statements are recorded, then we also bring the other one, the offender here. Once we have recorded, if the situation [DV/IPV case] needs a medical form we also give a medical form to the hospital, which can be filed, then we show that we [police] at least have our records and these ones go to court.

Interviewer: Could it be [possible] that you also handle the medical and legal issues?

SP: We used to refer [GBV cases] to the Police Health Centre 3, which is there in the barracks, and then their forms are filled there [Police Health Centre] because the hospital is congested. We get the services very fast, then from there, they can be referred to any [other] hospital because [that hospital] may be congested. But with our principle, 24 [hours], making sure that if its sexual assault, it must be done from there. (Police)

On the other hand, *medical or health officers* respond to cases in a more collaborative manner. GBV with evident proof of violence demands immediate medical action. However, this is not intended to be the final phase of help-seeking as other forms of services and support are needed to respond fully to a case of sexual violence committed by a stranger:

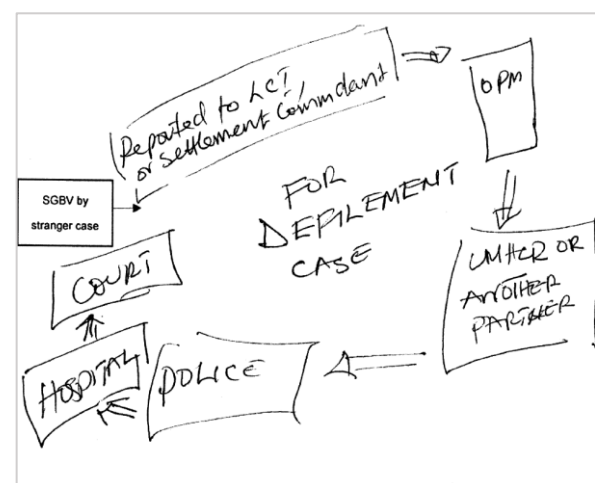
[For a case of sexual violence committed by a stranger]

Interviewer: What kind of services do you provide for SGBV by stranger survivor?

SP: We provide medical assistance and we refer [the survivor] for psychosocial services. These are strangers [who commit the sexual assault], and you [referring to the survivor] don't know the person. When the person [perpetrator] has raped you, we [SPs] ensure we treat it as an emergency. And we do our part, if you come alone we assess everything; if you come with the police we do our part and we collaborate with other partners like the police, and religious leaders (Clinical officer).

4.2 Help-seeking Pathways: Providers' Views

All 72 service and support providers drafted the likely pathway for help-seeking for the GBV survivors for cases of either DV/IPV or sexual violence committed by a stranger.



Sample help-seeking pathway diagram during FGD
(sexual violence case in Moyo)

In comparison with the refugees' responses, two key similarities surfaced. Figure 4.4 illustrates a general pathway for help-seeking, where help is initially sought from within the settlement, and (if necessary) from the

people or institutions in the host community. This generalized pathway in help-seeking reflects the presence of both the refugee leaders and the service providers, with the RLs as the source of support from inside the settlement and the SPs from the host community.

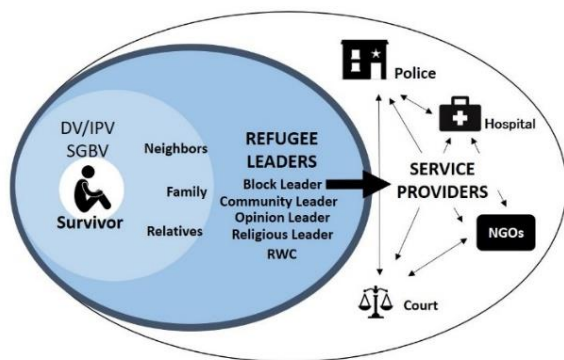


Figure 4.4 Help-seeking pathway (support or service provider POV)

This description of service delivery by service providers matches the discussion of the survivor's help-seeking pathway by refugees (see Section 3.2.2). Refugee leaders may advise or accompany the survivors to the appropriate services.

Below are accounts of help-seeking pathways based on the experiences of both the refugee leaders and service providers for GBV related cases:

Interviewer: [For sexual violence committed by stranger case] What would my experience be like from the time I arrive here [RL's home or office]? What information would I be asked to provide?

RL: First of all, I would set the climate environment conducive for us to share with you. Thereafter, I will ask you what exactly is the root cause of the problem, or the purpose for your coming to me. Then you tell me, thereafter I will be able to handle it in the way you expect. And I am sure it may not really be something you might

need, but I will guide you in whatever is necessary so that you can decide on that issue. I will ask you [these] kind of question that I will want you to explain more. Those ones will become automatic eventually. First of all, when you are raped, and you come to me for help, what I will ask is when did that event happen? How many people attempted to rape or raped you? Was it one person or two? If you do not know the number, I would still keep asking you: What were the incidents that led to that rape? Then you will be able to explain, and thereafter I can now tell you or advise you in the best way, so that you can seek medical attention because this one is an urgent issue that may not take a lot of time. (Refugee leader).

Interviewer: What kind of services do you provide for SGBV survivor?

SP: Only sexual, gender-based [violence services] Yeah we do [provide services]. For us, we provide psychosocial support and then we refer [them] to the health, police. Then police refer [them] to the health center because after, for us, after providing the psychosocial support. But you find, sometimes, before you provide psychosocial support, you find it already it in a different step. You find that it has gone to health center it has gone to [the] police, so it is you [who has] to follow up to go and provide psychosocial support after providing other services. (Social worker)

Interviewer: [For DV/IPV case] So how did you help them [GBV survivors]? You were saying you referred the case but how did you help them exactly?

RL: As I said, if I take on the case and it looks as if it will be something I cannot manage, I will forward it to RWC2. The RWC2 also has a cabinet. He will again call these people for a meeting. After tackling the issue, in case RWC2 is defeated, he is going to forward it to the RWC3... This is the LC3 in Uganda. Then from there, they have to settle the issue. In some cases, the issue still has no

solution for it, and that is when they will now forward it to the police, to the commandant. What I tried to do was to solve the issue, which was solved and they are now at peace (Refugee leader).

Thus, even SPs are aware of this unwritten system of having the survivors reach out to them **with** someone from the settlement (such as RLs).

4.3 Survivors' Barriers to Help-seeking: Providers' Views

Framed within the four key barriers to help-seeking for GBV survivors (fear of social stigma, logistical challenges, lack of information and low service expectations), as identified and analyzed in Chapters 3, support/service providers are also aware of such restrictions on accessing help-seeking services. Table 4.1 details these barriers through nine (9) help-seeking-related statements. RLs and SPs were asked their position on relevant statements about the survivors'

perceptions of help-seeking barriers.

Social stigma and low service expectations were the main barriers to accessing help, followed by the lack of information and logistical challenges. On the other hand, both refugee leaders and service providers did not agree that refugees do not have enough time to report GBV cases. They assume that there are other reasons involved in this procrastination. Stories on each of these barriers, together with some insights from RLs and SPs are available in Appendix K.

To reiterate, the barriers identified in this section are the assumed *challenges for survivors in seeking help* from the SPs and RLs' point of view. These results confirm the similarity to refugee accounts in assumed and observed barriers to accessing GBV support for survivors and providers. Beyond these barriers, support and service providers experience other challenges in their support or service delivery.

Table 4.1 Support and service providers' opinions on survivors' barriers to help-seeking (n=72)

Barriers	Statements	Agree (%)	Disagree (%)
Fear of stigma	1. Survivors worry about reprisals	84.7	15.3
	2. Survivors fear of stigma	80.6	19.4
Logistical challenges	3. Survivors do not have time	22.2	76.4
	4. Survivors do not have money	52.8	47.2
	5. The services are far	52.8	47.2
Lack of information	6. Victims cannot find a place to go for help	33.3	66.7
Low service expectations	7. It takes a long time to receive help	62.5	36.1
	8. There are not enough staff	56.9	43.1
	9. Services are inadequate	69.4	30.6

Note: The missing percentages for statements 3 and 7 are from the participants who did not state their position on either statements.

4.4 Support and Service Providers' Obstacles to GBV Service Delivery

Support and service providers hold mandated (for SPs) or community-acknowledged responsibilities (for RLs) of addressing GBV cases of refugees in the settlement. In the course of the interviews, the individuals gave details of the obstacles they face in effectively responding to GBV cases. After compiling their answers, the following key themes surfaced as problematic or challenging issues for service providers [see Appendix L for details]:

- a. **Social stigma associated with GBV:** As repeatedly mentioned in the previous chapters, survivors see social stigma as a deeply rooted problem that hinders help-seeking. Some of the RLs and SPs said that victims (survivors) prefer to keep quiet, fearing other people's gossip.
- b. **Capacity to provide services:** Both RLs and SPs acknowledged that the existing services are insufficient to fully support the survivors. Given the difference of their roles and functions in relation to GBV survivors, RLs are expected to solve the problem within the settlement and connect refugees to the services outside of the settlement. On the other hand, SPs are expected to support survivors based on their expertise and institutionalized functions. However, their institutional assignments limit the scope of the services they can provide.
- c. **Overlaps in the support or services:** In delivering services effectively, the overlaps in functions and roles, which have both advantages and disadvantages, are worth mentioning. This overlap works positively as an opportunity to make more channels available for help-seeking and expedite cases where the resolution can be achieved within the settlement. However, some cases demonstrated that such an overlap could also be a drawback, especially for SPs. One reason for this is that some services require a streamlined approach through each stage of reporting the incident, obtaining medical evidence, and filing a formal case or complaint. This issue of overlaps in service delivery—particularly where mediation is required in cases—can either lengthen or shorten the process of solving the problem. Whichever direction it may go, the survivor may again be a casualty of such (non-)overlaps.
- d. **Risks to SPs:** SPs are not exempt from certain risks, which can be a considerable occupational hazard for helping GBV survivors. Risks to support and service providers are not limited to physical threats and assault. *Some of them may experience psychosocial trauma from having to listen to stories of GBV in detail.* Recounting the details of the violence is necessary for documenting and reporting the case. However, it cannot be helped that some SPs may be emotionally affected by these narratives.
- e. **Absence of trust of survivors:** Reporting violence is already a challenge for GBV survivors. This is further aggravated by survivors who do not fully cooperate with support/service providers. In the process of help-seeking, this weakened cooperation from survivors can be a result of the (a) absence of trust, and (b) the survivor's continued dependence on the perpetrator. The guarantee of privacy when reporting a case is a pivotal factor for the survivor's full cooperation. It builds the trust necessary for the survivor to have a strong conviction about seeking justice. However, the fear of disrupting/breaking

existing relationships may abruptly end the case without finding justice for such violence.

- f. **Need for sustainable support:** The continuity of programs and projects has a significant impact on the effectiveness of service delivery. The ending of certain programs, which are generally anchored in specific institutions and agencies, affects the referral system of the RLs and SPs. In particular, RLs are considered to be the immediate point of contact for the GBV survivors, who introduce the appropriate agencies for necessary additional services. The (abrupt) disappearance of such a connection may terminate the pathway of help-seeking indefinitely. RLs may have a difficult time in re-establishing a new network to tap for GBV service delivery. Seemingly, SPs experience the effect of unsustainable help-seeking services. The constant transfer of SPs means the re-adjustment and rebuilding of trust with their new community. This may even result in a change in their actual functions.

4.5 Resources Necessary to Improve GBV Service Delivery

Despite the challenges in coping and responding to GBV cases in the settlement, efficient service delivery is still necessary, and must continue to operate through RLs and SPs. The resources to respond effectively to the GBV survivors can be classified into two main categories: (1) direct resources, and (2) supplementary resources.

Direct resources include those that have a firsthand impact on survivors. This may include training for refugees, supplies and related resources that GBV survivors can directly receive, as well as access from the support/service providers. As discussed in Section 5.4,

SPs and RLs are aware of their limited capacity to provide services, and the overlap in support and services from among service providers. Beyond this, the survivor's trust of RLs and SPs is an integral factor that can embolden them to seek help. Addressing these challenges, together with the need to provide more sustainable support to survivors, can have a direct impact on the survivor's help-seeking.

In the course of the interviews, SPs were asked about the kind of resources they intend to provide for GBV survivors. Figure 4.5 summarizes these key categories of help that they wish to provide to survivors. ***Counseling is the leading service they think survivors need, followed by awareness, educational programs and training.*** Legal and various forms of support account for a fraction of these services, possibly because these services are relatively institution-specific (e.g. medical support comes from health agencies). Others would include a variety of services they mentioned in the course of the interviews—such as shelter, recreation and activities, welfare, economic and livelihood improvement, capacity building and life skills—that can be directly beneficial to survivors.

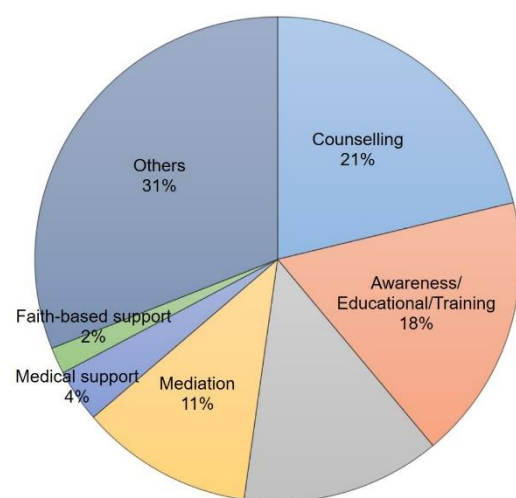


Figure 4.5 Resources directly needed by GBV survivors according to support and service providers interviewed

However, not all of these are currently provided to GBV survivors. Often, the challenges in fulfilling this direct support to survivors emanates from certain institutional restrictions, which may well be financial in nature.

Interviewer: *Why aren't you able to [provide that service] now?*

SP: *Livelihood support, but it's taken to be a role of implementing partners, and when you look at the budget there is a category that is designed for specific people (Community service officer).*

Alongside these direct resources are the *supplementary resources* needed to enhance and improve the providers' support and services. These resources do not reach the survivors directly but are rather utilized to carry out more effective service delivery. Service providers are faced with various challenges that affect the implementation of their roles, primarily in terms of their skill-related capacities to provide services as well as the risks to their personal safety. Figure 4.6 presents a comparison of the resources needed by SPs and RLs to help GBV survivors effectively.

Both SPs and RLs understand the value of trainings and their contribution to the improvement of services.

The SPs and RLs who were interviewed aspired to undertake trainings in a wide variety of areas, which are presented in Figure 4.7. RLs are interested in having a clearer understanding of GBV. This could help them respond to the cases more appropriately, particularly DV/IPV cases.

Consequently, SPs are more interested in pursuing training related to the handling of sexual violence committed by strangers.

Interviewer: *Is there anything else you would like to add?*

SP: *[Referring to the kind of training needed] If we can train more people about SGBV—not only the refugees but also the host community—if the community can be sensitized on the causes of GBV down in the community, then we will have a beautiful country (Clinical officer).*

SPs requested specific trainings on themes such as counseling, medical/clinical training, case management, and legal issues, among others. The demands of RLs for

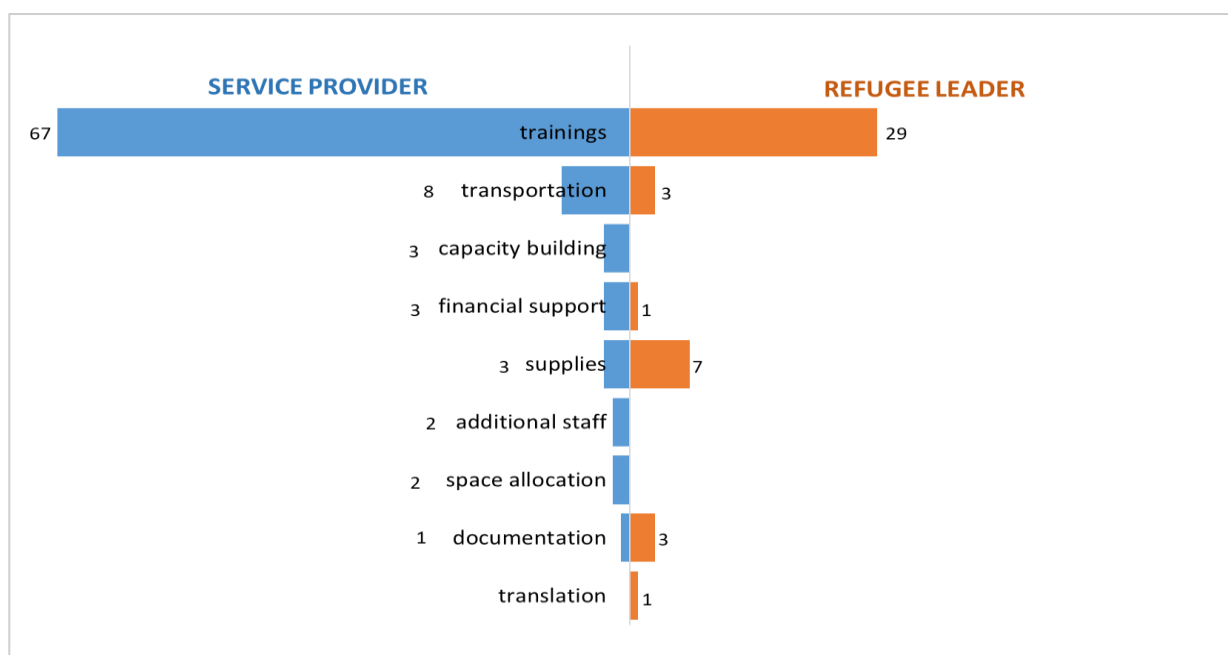


Figure 4.6 Resources needed by service and support providers according to interviewees

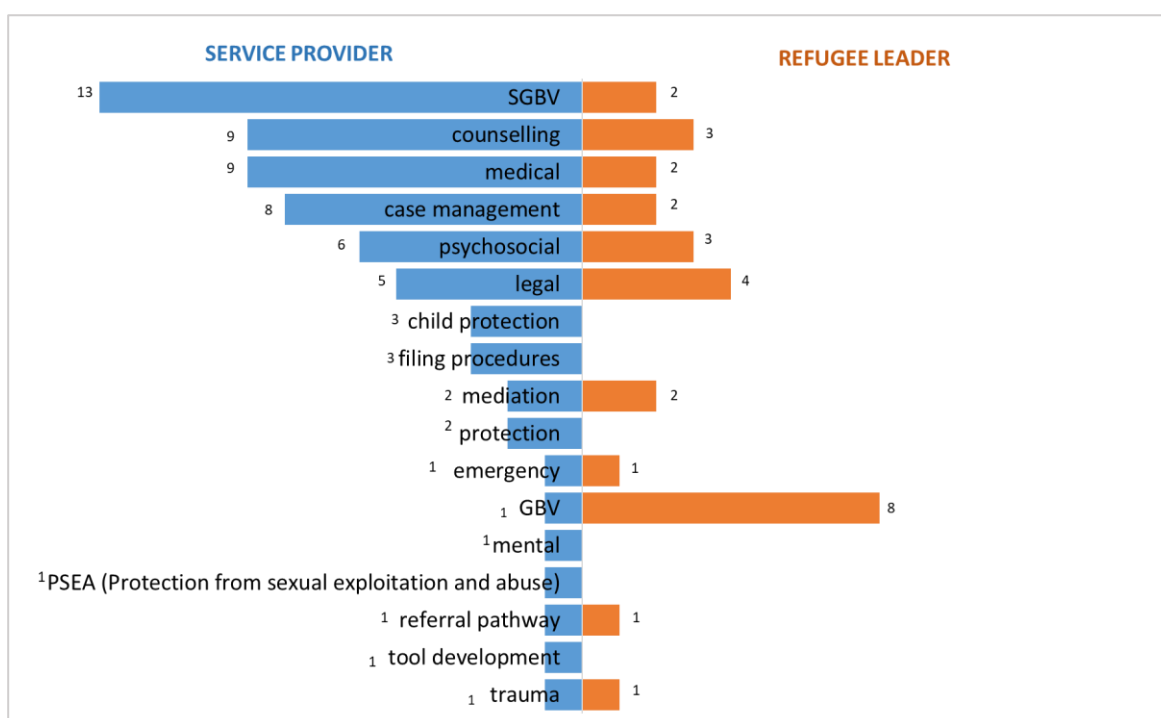


Figure 4.7 Training themes requested by RLs and SPs

training are concentrated on enhancing their skills to fulfill their role as a first point of contact for GBV survivors.

Besides training, SPs and RLs acknowledge the need for additional logistical tools for service delivery. RLs repeatedly mentioned the convenience of using a bicycle. They associate this potential for increased mobility with their capacity to respond faster. SPs are also aware of these needs, and therefore request additional staff and space for counseling. Some SPs see the need for additional staff members—particularly medical staff—to respond to cases. In addition, further space is needed to help SPs conduct counseling, shelter and related tasks. These two forms of resources are complimentary in carrying out GBV help-seeking services and support. The availability of appropriate resources to help survivors can encourage further help-seeking and consequentially motivate service providers to function effectively.

4.6 Summary of Findings

This chapter looked at GBV help-seeking pathways and barriers from the perspective of refugee leaders and service providers.

In terms of the help-seeking pathways, service providers and refugees are aware of the individuals and institutions involved in responding to GBV cases such as DV or sexual violence by strangers. There is also an unwritten yet observed pathway of seeking help primarily from people within the community (RLs) and thereafter reaching out to the appropriate institutions/organizations outside the settlement (SPs).

In terms of the survivors' barriers to help-seeking, service providers and refugee leaders are also aware of such constraints for the GBV survivors. Particularly, the fear of stigma and low service expectations surfaced as the primary barriers to seeking help. On the other hand, SPs and RLs see these low expectations of GBV services through the experiences of extended time taken in

receiving services, inadequate services, and an inefficient referral system.

Along with the survivors' barriers are service providers' obstacles to GBV service delivery. Among these obstacles are the inability to provide GBV services effectively, insufficient capacity to deliver services, the overlap in available support/services, occupational hazards for SPs, the absence of trust from the survivors, and the need to deliver sustainable support.

This chapter confirms the existing pathways and barriers for survivors as understood by service providers as well as the obstacles in carrying out effective GBV support/service delivery. It may fill a gap by providing more information about the existing needs of individual service providers and institutions to carry out help-seeking for GBV survivors.

GBV Awareness signboard at the refugee settlement in Adjumani



Interview with refugee leader

CHAPTER 5

CONCLUSION

This chapter weaves together all the data collected from this study and synthesizes the discussions from the refugee participants and the support and service providers. It presents a comparisons of pathways and barriers to help-seeking and the recommendations for creating better survivor-centered support.

5.1 Examining differences between refugees and the service providers' views regarding help-seeking pathways and barriers

5.1.1. Help-seeking pathways

The help-seeking pathways reveal the presence of various social actors and the varying degrees of social relations and interactions. Both the refugee participants and the service providers are aware of these “unwritten” yet commonly observed pathways of help-seeking, where help is sought first from within the community and then afterward from the host community.

Figures 3.9 and 3.10 show the refugee pathways for help-seeking in both domestic violence (DV) and rape/defilement cases, respectively. These results is similar to the help-seeking pathways observed by SPs and RLs (Figure 4.4). *The process starts with the case being raised and attempts to be resolved it within the refugee settlement before it reaches the relevant institutions and organizations in the host community.*

Both refugees and SPs and RLs identified certain factors that matter as survivors navigate through their help-

seeking pathways. Among the factors considered by refugees include the severity of the injuries incurred, the influence of the settlement leaders, timing, reason, expected support, and the desired effect of help-seeking. From the point of view of SPs and RLs, the limitations of the service or support provider, the referral system, and the expected results affect the whole process of GBV help-seeking.

5.1.2. Barriers to help-seeking

Both the refugee participants and service providers acknowledge the presence of various barriers to help-seeking. *There is a consistency in the fear of stigma and low service expectations as the primary hindrances to a survivor seeking help.* Logistic and information shortages were considered to be relatively low in the list of help-seeking barriers. However, SPs identified linguistic challenges and illiteracy as reasons for the survivor's lack of knowledge about help-seeking. This is contrary to the refugee participants' claims of full awareness of the GBV referral system. The gap in this response is perhaps because a majority of the refugee participants — have at least a basic knowledge of the GBV referral system through awareness campaigns by NGOs, and are more vocal in expressing their observed or actual experience of GBV. However, from the SPs' side, their direct contact with survivors made them more aware of the existence of those who cannot understand and seek help—these are the actual “people left behind.”

5.2 Recommendations

5.2.1 GBV manifests as “diversified violence using gender as a weapon.” In addition to emergency responses, comprehensive support is necessary to address the social-economic issues

As shown in Chapter 3, two categories of violence were principally identified by refugee participants: (1) violence that can be directly attributed to conflict, and (2) violence occurring under the living conditions as refugees. Category 1, which was experienced in South Sudan, includes rape and violence related to forced recruitment as soldiers. Such experiences of sexual violence in South Sudan show how easily women become the targets of violence. Sexual violence against women is frequently perpetrated by strangers as a form of “retribution” against male members from hostile political or ethnic groups (see Appendix H).

Category 2, Domestic Violence/Intimate Partner Violence (DV/IPV) and sexual violence from strangers can encompass multiple forms of violence—such as physical, economic, and emotional violence—that transpire within refugee settlements. Forced or early marriage, forced sexual relations between partners or with others, rape near water collection points or while fetching wood, sexual trouble among out-of-school youth, and defilement were frequently mentioned during interviews and focus group discussions (FGDs) (see Appendix C). The identified abuses and violence are generally inflicted by a male on a female person, but participants were aware of and discussed violence by women against men. This can occur when the wife, who arrives first at the resettlement, is registered as the head of the household. The husband, who arrives later, is dissatisfied with the shift in the conventional gender

roles of “head of household” to “dependent” This triggers DV between partners.

GBV in conflict areas is not only contained within the refugee settlements but can occur between the refugees and host community members. In urban areas, especially, refugees often come across host-community residences and refugees from other countries, with some disputes occurring. In such cases, refugees can feel that their refugee status makes them more susceptible to humiliation and exploitation.

It should be noted that the violence discussed above is firmly linked with various factors, such as gender norms, poverty and the stressful living conditions that occur when people are living in asylum. Hence, dealing with violence on the surface through emergency responses insufficient for survivors to recover from the trauma and prevent a recurrence of the incident. *Together with emergency responses, long-term developmental approaches—such as livelihood support, poverty-reduction activities, and education for building an inclusive and peaceful society—will help a survivor’s recovery and prevent other incidents of GBV.* Comprehensive but context-based support for each case is necessary.

5.2.2. Tackling the gender norms that induce the fear of stigma

As seen in Chapter 3 (Sec. 3.1), the interview shows that almost participants have a belief that violence, whether committed by family or non-family members, should not be accepted and should be punished. However, there are some different nuances between violence when committed by someone from within the family or someone from outside. Even though, 68.9% of the interviewees think “sexual violence between partners is

a crime and the perpetrator should be punished,” 39.3% of the same group of participants also think “sexual violence between partners is a relationship matter ⁹.” Moreover, the percentage of participants who agree that “sexual violence between partners is a crime” is 68.9%, which is lower than the percentage of those who agree that “sexual violence from a non-family member is a crime and should be punished (90.2%).” Although it is recognized that any form of GBV must be punished, more than a few participants claimed that DV including sexual violence should be kept a secret within the family.

Regarding the right to seek help, almost all interviewees agree that survivors have the right to seek help, no matter whether the violence happened within the family (92.6%) or not (96.7%). When asked about their own/other’s experiences of GBV/Sexual Violence, 75.6% sought and accessed GBV support. Despite the impression that people can seek help easily, the FGDs and detailed interviews revealed that refugee respondents have difficulty seeking help outside the community. Based on the interviews, those who sought help primarily received ‘counseling’ (a detailed listening session by close relatives and friends) and medical support. These kinds of needs can be found immediately (such as medical support) and are accessible from within the refugee settlement (counseling from family and friends). However, long-term assistance - such as legal support, economic assistance, and education - is scarce, as it is not accessible in the refugee settlement.(see Appendix F)

This raises the question of why survivors are not seeking help beyond ‘counseling’ by close relatives. The research found that “the fear of stigma” is a primary reason why survivors do not seek help. This is the most common predicament attached to being a survivor—especially in cases of rape. In the interviews with SPs,

we found that most SPs agreed that survivors worry about the stigma of victimhood (80.6%) and any reprisals that may be attached to it (84.7%). This impedes them from reporting or seeking help. Particularly in cases of the rape of young girls or women, help-seeking is seriously associated with stigma. Survivors are afraid of becoming the subjects of rumor, excluded or avoided by members of the community. There may also be suspicions of HIV/AIDS. At a familial level, parents do not want to acknowledge that their daughters have been “used by a man.” More than the physical and mental damage, parents fear that their raped daughter will lose her opportunity to live in the community as a woman—without education, marriage, or children. In addition, FGD participants mentioned that survivors who have a strong feeling of shame may choose not to report GBV and take their own lives. Similarly, male survivors fear stigmatization by community members. It was acknowledged that there are also male survivors of rape and DV. However, cases of this are rarely reported. In the case of DV where men are subjected to violence, it is assumed that they are too embarrassed to report incidents and are demoralized by the thought of being judged as a weak husband. In cases of sexual violence, male survivors may not speak out to avoid speculation about homosexuality.

These data confirm that it is critically important to tackle the transformation of gender norms that are related to the fear of stigma in order to promote help-seeking. Despite fully understanding that GBV should not be justified and that people have a right to seek help as ideal norms, in practice, some existing gender norms impede help-seeking. The stigma associated with GBV is deeply rooted in various layers of spaces – individual and personal relationships as well as community and societal spaces. As we can see from the following comment from an SP, both service providers and the refugee community

need to break away from the conventional way of thinking:

Sexual violence is an old concept and women have been looked at as second-class citizens; (socially, economically and politically). This perception must be changed through training. (Education Project Officer)

5.2.3. Strengthen the refugee community's capability to respond to GBV

The field research confirmed a general pathway to help-seeking as follows. Both refugees and SPs are aware that the survivors will initially seek help from within the refugee community (family, community leaders, or church members) and, only if deemed necessary, will they seek help from the people and institutions outside of refugee community such as the police, medical staff, and NGOs.

Regardless of whether the case is DV or sexual violence by a stranger, the survivor's primary options for help-seeking are within their settlement; it is difficult for them to seek help directly from external service providers. The survivor's problem is considered to the settlement's community problem. Thus, *the decision to seek help from outside the refugee settlement is often decided by the family and community leaders*. As shared by the RLs interviewees, having a clearer understanding of GBV and enhancing their skills as the first point of contact for those seeking help will contribute to the GBV response and problem solving. In general, the church is not in the standardized humanitarian referral system; but it plays a critical role as a primary provider of counseling or spiritual support, which survivors need. The church involvement of GBV referral process will assist not only care for the survivor but also correcting perpetrator's conduct. In this regard, *it is crucial for aid providers to*

consider the need to provide capacity-building opportunities to refugee leaders and church officials to respond to the GBV case utilizing a survivor-centered approach.

It is crucial to build the capacity of female community leaders to protect and refer survivors while avoiding secondary harm by contact with male service providers. However, it is also important to consider ways to deal with male survivors. Another unsolved problem is the lack of suitable methods for providing GBV services to survivors among Muslim refugees.

5.2.4. Build trust between survivors and service providers through appropriately equipped facilities and transparency of pathways, and training to realize survivor-centered approach

The relatively large barrier next to the fear of stigma was "low expectation of service." The survivor's pre-conceived notion (both from direct and indirect experience) of poor service affects the help-seeking pathway. Monetary demands from police officers to file a case are one of the main issues, along with delayed and protracted assistance. According to the interviews, some organizations do not follow up on cases. In most health centers, medicines or drugs are always out of stock. Bribes and corruption can be demanded before services are provided. Generally, in the case of rape, health centers do not give medical support without police written form to report called P3. Such experience may undermine the development of a trusting relationship between refugees and service providers. We heard concerns about trust from the side of SP and RL. Some SPs were concerned about the language barrier and the delicate relationship between survivors and refugee leaders.

The cultivation of good practices is important in building trust between the refugee community and service providers and promoting help-seeking. Both SPs and RLs understand the value of training and its contribution to the improvement of their services. According to the RL interviewees, RLs are interested in having a clearer understanding of GBV and how they can solve problems like those involved in DV/IPV cases. On the other hand, SPs are more interested in training to handle sexual violence committed by a stranger as well as specialized skills, such as medical and psychosocial care, case management and legal support. In addition, since we found some SPs are suffering trauma as a result of listening to sexual violence stories and may also have fears of reprisal, they also requested specific training to deal with such worries.

Besides training, SPs and RLs acknowledge the need for additional logistic tools for service delivery. RLs have repeatedly mentioned the importance of using a bicycle to increase mobility and respond faster. SPs requested additional staff as well as space for counseling, where they can maintain privacy and protection.

In addition to the support training and other materials requested above, we suggest introducing transparency into the pathway of help-seeking. The current GBV referral system is comprised of a collection of services that not linked organically. Some suggested an overlap of services. *Building a more transparent operation system for GBV response will improve motivation for help-seeking.*

5.3 Context-specific Support for GBV survivors in Refugee Settlements

The research fulfilled the initial tasks of analyzing the

reasons that GBV survivors in the refugee settlement area hesitate to seek help by identifying the survivors' pathways and barriers to help-seeking. GBV exists everywhere and, regardless of whether it is in a conflict-affected area or a 'normal' context, violence in such forms continues to occur. Even with the existence of such a referral system and the availability of various service providers, help is not always or fully sought. The research asserts that the unique condition of being refugees in settlement areas should strongly be taken into account. The refugee context is enmeshed with conflict-related threats to their safety, needs, and dignity that may not be present in normal settings. Thus, the immediate response to GBV is insufficient. Provisions for long-term support are necessary (such as poverty alleviation, education, and relocation) to completely help survivors as they recover.

5.4 GBV Research is not a taboo

One point that was clarified through this research is that GBV is not a "taboo" subject. Contrary to expectations, all the male and female refugee participants had a high awareness of the GBV issue, and it was feasible to obtain their cooperation for the research study. In every FGD, refugee participants did not refuse to answer, nor were they interrupted. Rather, they exceeded the allotted time for discussion, as if they seem to want the research team to know about their insights even to issues as sensitive as sexual violence. Prior to this field research, the research team had made efforts to gather useful information, giving full consideration to the local context (including inception meetings with relevant actors). As a precautionary measure, while asking about individual experiences during the interviews, a social-psychological staff member was on stand-by and emergency contact details were collected in the

interest of privacy. These were done in anticipation of any issue that may arise during the data gathering process. ***The research team did not encounter any rejection or hostility from the refugees in the course of the interviews.*** In our consideration of such issues, we are unable to determine whether this research on GBV sets a higher bar than other research that has been conducted in this area.

5.5 Further studies

This study on GBV help-seeking in conflict-affected areas up opens the possibility of exploring other aspects in responding to GBV crises. Among the themes that can further be explored are:

Optimizing the research tools. The study was able to collect substantial results through combined methodological tools of descriptive data gathering

(information sheets), focus group discussions (FGDs), and interviews (both for refugee participants and for service providers). This triangulation of research tools attempts to gather more comprehensive details on the GBV survivors' needs from the perspectives of the refugees in the settlements and the service providers present in the research areas.

Support and service providers and male survivors.

The disparity between the male and female survivors that seek help reinforced the common notion that GBV is a form of violence committed by men against women. However, when asked of any knowledge of violence by women against men, both refugee leaders and survivors affirmed that this exists, yet men rarely report such violence. Despite such a reality, support/service providers can only initiate action when the people come out and seek help.

Notes

1. GBV does not specify a certain type of violence but covers every type of violent act, including physical, emotional/psychological, economic and sexual violence perpetrated against a person's will, whether male or female, and based on gender norms and unequal power relationships.
2. UNHCR. *Refugees operational portal*. <https://ugandarefugees.org/en/country/uga> (Last access date: 29/07/2019)
3. WCC is an authorized NGO based in Toronto, which has prior experiences in providing access to justice and protection. It has been providing services to GBV survivors since 2005 as a partner of UNHCR. With the establishment of such partnership, WCC has been hosting South Sudanese refugees in Uganda since 2014 under a signed Memorandum of Understanding (MOU).
4. Due to its fairly new establishment as a settlement site and its distance from the other districts, Lamwo was not selected for this study.
5. UNHCR. *ibid*.
6. In June 2018, a dispute between two male refugees of Dinka and Nuer occurred while watching a World Cup football match. This led to sporadic violent attacks, resulting in four fatalities and 19 injuries in Arua.
7. The term "defilement" is frequently used within the local community to signify sexual relations with a minor, whether it is consenting or not. This is based on a common recognition that minors are not capable of making a sound decision about their sexual behaviors.
8. A consent form, which was developed by JICA-RI and endorsed by the Mildmay Uganda Research Ethics Committee, was read out to participants in English and the most appropriate local language in each district.
9. The study does not disregard the fact that female-perpetrated violence against males exists. However, for the most part of this report, GBV concerns male to female cases.
10. Some participants agreed to both statements.

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Finally, the views and interpretations expressed in this report are the results of the author's analysis that not necessarily represent those of the organizations or persons mentioned.

This report is available online on the JICA-RI website.
Supplementary appendices of this report will be provided online.

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