BIDIBIDI REFUGEE SETTLEMENT

SGBV SUB-WORKING GROUP

SGBV GAP ANALYSIS REPORT, SEPTEMBER 2017

ACKNOWLEDGEMENT

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ACRYNOMS

CFPU	Child and Family Protection Unit
CMR	Clinical Management of Rape
CP	Child Protection
ECP	Emergency Contraceptive Pill
HIV	Human Immune Virus
IEC	Information, Education and Communication
NGO	Non-Governmental Organization
PSEA	Prevention of Sexual Exploitation and Abuse
PSN	Persons with Specific Needs
RWC	Refugee welfare Council
SASA	Start Awareness Support Action
SGBV	Sexual Gender Based Violence
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
UN	United Nations
VSLA	Voluntary Saving and Loan Association

1. Back ground information

Bidibidi refugee Settlement is hosting 285,014 South Sudanese refugees. Among this population 53% are female while 71% children below the age of 18. Sexual Gender based violence (SGBV) prevention and response are facilitated by ARC, IRC, CARE for general case management, War Child Canada for legal aid, TPO for psychosocial support, World Vision & Save the children for child protection and others mainstreaming SGBV in livelihood (DCA, Mercy Corps &ADRA) and health sector (MSF, RMF, IRC, MTI) with support from OPM, UNHCR, UNFPA, UN Women, UPF and YDLG.

Since the adoption of *UN Security Council Resolution 1325 on Women, Peace and Security* in 2000, and subsequent resolutions there has been increased attention on GBV issues in humanitarian setting. To ensure systematic and streamlined SGBV programing, the SGBV sub-working ground coordinated by OPM and UNHCR planned and conducted a SGBV gap analysis across the five zones in Bidibidi aimed at gathering information to have a comprehensive understanding of existing SGBV services, gaps, needs and opportunities. Information generated from a gap analysis will present SGBV service status, inform strategic intervention and guide allocation of resources or activity implementation.

Objective

1. To map out SGBV services in Bidibidi (extend of reach)
2. To explore the extent to which SGBV is mainstreamed in other sectors
3. To identify key SGBV service gaps and needs
4. To identify existing opportunities for SGBV response and prevention

2. Methodology

Design: Interview guides and observation check lists were developed with support from the SGBV taskforce members, reviewed and approved for use by the SGBV sub-working group members. The analysis was conducted incorporating health, education, protection, community service, WASH and livelihood sectors using both qualitative and quantitative methods of data collection. SGBV safety audit conducted by IRC in zone 1 to 4, the GBV in Emergencies (GBViE) Minimum Standards and other documents were used for references.

Sample: Involving all sectors, data was collected from 6 health facilities (Bidibidi HCIII (zone 1), Koro HCIII (zone 2), Yoyo HCIII (zone 3), Bangatuti HCIII and Bolomoni HCIII (zone 4) and Ariwa HCIII (zone 5). Interviews were conducted with 135 community members including refugee leaders, women, men,

boys and girls, teachers and nationals while 4 focused group discussions were conducted with community members across the zones.

Data collection: The assessment was conducted over a period of two weeks using observation, the SGBV gap analysis check list, interview guide and UNFPA Survivor records checklist for health facilities. Information collected was analysed by each zone/sector team lead and consolidated to form the general view.

3. Summary of findings

Gaps

I. Protection and community engagement

a) Lack of quick access to disaggregated data for persons of concerns e.g. women at risk etc.
b) Limited knowledge of existing SGBV/protection and child protection SOP and referral pathway
c) Lack of protection/SGBV information education and Communication materials (posters, billboards, brochures) across all zones
d) Low levels of community knowledge on SGBV prevention and response with reported high number of abuses, concealing of abuses, late reporting of incidents and negotiation of some criminal cases like defilement/rape.
e) Lack of protection shelters for men, women and children within the settlement and unstructured community protection mechanism
f) Community education strategies such as SASA!, male engage not well streamlined
g) Minimal police presence with logistic challenges, lack of detention facilities/separate holding cells and female police officers in most police post (only 3 female police officers across the zones)
h) Low male engagement activities and minimal structured youth engagement activities
i) No assigned PSEA focal person in some organisations
j) Poor information feedback to community members and leaders
k) Some refugee leaders are not trained on SGBV prevention and response especially newly structured levels (RWC 2) or elected leaders
l) Unclear / streamlined community based strategies to monitor protection/SGBV related risks/ issues.
m) Inadequate solar street lights and domestic lights across the zones

II. Health

a) Lack of designate focal points for SGBV survivor support in most health facilities
b) Poor follow-up of survivors by case workers to ensure completion of treatment
c) Psychosocial support and counselling services not well integrated in some government-run facilities with no counsellors
d) No separate consultation room for survivor support, general examination rooms at the OPD or procedure rooms are used.
e) Poor survivor's records management. Most facilities have no safe lockable spaces to keep confidential records such as survivor case histories. Information is in patient books, papers, OPD registers and patient's admission forms.
f) All facilities have laboratory technicians who can conduct various tests as requested. However, apart from the 2 government facilities, the rest have no microscopes to conduct further investigations and analysis of samples and no colposcopy (magnifying glass) to examine the cervix and tissues of the vagina and vulva
g) Lack of dignity kits for survivors such as examination gowns, emergency pads or hygiene kits
h) Stock outs of drugs, PEP and ECP in some facilities through they try to replenish from government ART supplies, and thus the combination of TDF-3TC-EFV is used in most facilities as the new line of PEP treatment. Some medical personnel highlighted that, the Lamuvidine and Zidovudine combinations of PEP are no longer preferred w outdated as per Uganda HIV treatment guidelines.
i) Poor adherence to minimum standards in some facilities for holistic survivor support. Review of available survivor records showed that, some survivors of sexual violence didn't receive the complete examination and treatment as per the protocols.
j) Variance in documentation practice with some facilities relying on PF3, others using admission forms, OPD registers and patients note books while others use those derived from their own programming.

III. WASH/Shelter

a) Low consultation and participation of women and girls in WASH infrastructure planning/ design and committees (e.g. water user committees, hygiene promoters etc.)
b) Irregular distribution of sanitary and hygiene materials

c) Poor menstrual hygiene disposal practice within homes and institutions such as schools, health facilities, markets etc.
d) Poor lighting of water points, communal latrines (zone 1-village 12), village routes/pathways and institutions accessed at night.
e) Inadequate number of household latrines and lack of latrines for most PSN shelters especially zone 1, 2 and 4

IV. Food security / Livelihood

a) Targeted livelihood support mostly benefiting women at risk (widows, SGBV survivors, teenage mothers, lactating mothers, female headed household, etc.) with minimal focus or support to vulnerable men and boys (single parents, older persons at risk, those with disabilities etc.)
b) Lack of community participation in gender-sensitive livelihoods needs assessments and market analysis conducted
c) GBV prevention and response not integrated in most livelihoods programmes
d) Delays in food distribution and missing names on food logs increasing risks to exploitation and abuse of women and children

V. Education

a) Inadequate number of Wash facilities for learners and teachers in most schools
b) Lack of changing rooms for girls
c) Unstructured strategies and programs to keep girls at school
d) Minimal SGBV school outreach activities conducted

4. Recommendations

1. OPM to support quick access to disaggregated data for planning and service delivery to persons of concern
2. Increase logistical and capacity support to police by increasing number of police officers especially female officers, strengthening child and family protection unit (CFPU) in all outpost, improving transport (number of vehicles/motor bikes and fuel), trainings, staff welfare and stationaries among others.
3. UNHCR, partners and SGBV-Sub working group to review the existing SGBV SOP, referral pathway and develop IEC materials for immediate dissemination to community members/leaders, institutions, other sectors and protection desks.

4. Install more solar street/communal lights at water points, communal latrines, village routes/pathways, institutions accessed at night and consider distribution of domestic lights to zones/families that did not receive.
5. Review and streamline SASA! , male engage models/ strategies being used. Conduct training of staffs/volunteers/activists and have well-structured implementation stages/phases.
6. Improve community education/outreaches/sensitisations using more engaging and innovative methods to help increase community understanding and knowledge on SGBV.
7. Mainstream SGBV in all sectors by training of other sector staffs on SGBV, involvement in sector planning/meetings, encouraging involvement of women, girls and boys in activity planning among others.
8. Strengthen community protection mechanism and establish protection shelters for men and children within the settlement
9. All partners to identify, assign and communicate the PSEA focal person in their organisations.
10. Improve on feedback mechanism to leaders, community members and survivors.
11. Conduct SGBV prevention and response trainings/refreshers for all community structures including Refugee Welfare committees/Neighbourhood Watch/ women committees, community groups, opinion leaders and strategic stakeholders including police, health workers, sub-county/district leaders and other partners.
12. Conduct regular distribution of hygiene materials, sanitary pads and strengthen menstrual hygiene and waste disposal practices.
13. Review food distribution system, address delays, missing names on food logs and improve food security.
14. Design and implement well-structured SGBV school awareness, distinct programs to keep girls at school and child friendly SGBV referral pathway.
15. Increase targeted support to men and boys to reduce vulnerability.
16. Health sector to ensure all facilities have WHO CMR guidelines, adhere to treatment protocols and minimum standards for clinical management of rape survivors.
17. UNFPA/UNHCR and partners to support Training of Trainers (TOTs) on Clinical Management of Rape and also support CMEs in health facilities on quarterly basis for improved survivor medical support
18. Health partners should ensure each health facility has a room for survivor support, with improved data management using lockable cabinet to keep information confidential.

19. Health sector to liaise with DHO to ensure facilities have history and medical examination forms, consent forms and medical examination certificates from the MOH to standardize survivor information documentation
20. Case management partners need to work closely with health workers, ensure survivors return to the facilities for further reviews with well documented process, strengthen protection support/services to teenage mothers and pregnant girls especially access to reproductive health services at the women/girls/youth spaces.
21. Each health facility to allocate at least 2 focal points (male and female) from a pool of trained medical staff, who can be available and contacted at any time for survivor support.
22. UNFPA to continue monitoring availability of drugs and supplies for survivor management, and strengthen advocacy for improved medical/psychosocial support

5. Details of findings

a) General protection

Bidibidi refugee settlement protection response is supported by three lead protection partners (IRC, ARC & World Vision) and 6 SGBV prevention and response partners (CARE, IRC, ARC, TPO & WCC) providing direct case management, targeted material support, psychosocial support , community education and capacity building in coordination with UNHCR, OPM and other Sectors.

Interviews and focused group discussions with community members and leaders indicated very good physical presence of partner protection staff and easy access to protection facilities and some services with protection information support points/desks established in most of the villages in all zones though noted with concern was the issue of lack of timely feedback and slow response on protection concerns by referral partners.

Also raised were concerns on limited access to information by all and the use of minimal medium of communication. Much as community awareness and trainings are regularly conducted, a good proportion of the population normally miss out of some information because of school, other commitments and not being part of the target groups. Unfortunately the dissemination of information, education and communication materials in local languages (e.g. posters, bill boards, flyers, brochures, paintings on SGBV, general protection and referral pathway) is very low to enable access to information by persons who miss out on community awareness sessions.

Much as several awareness on SGBV prevention and response have been conducted by partners, according to the community leaders interviewed, the levels of community knowledge on SGBV is still

low attributing it to the number of unreported cases, reluctance or inability of survivors to seek support and difficulties in explaining SGBV concepts. Many respondents attributed it to negative cultural practices that condone violence and the length of time required to change or influence positive attitudes and behaviours.

Good focus has been put on the establishment of safe space for women and girls with 12 functional women and girls centres managed by IRC- UNHCR funding and 4 Adolescent girls' centres managed by IRC- UNFPA funding. Key gaps are noted on the lack of safe space for men and boys across the zone and lack of women and girl's centres in zone 5 which has none. For comprehensive gender sensitive programing and to enable positive behavioural change through male engagement, it's important to provide safe space for women, men, boys and girls.

Related to safe spaces is the issue of meaningful engagement of women, men, boys and girls. It was evident that there were many supported and active women groups across the zones with routine activities including social-cultural, VSLA, livelihood and agriculture. Because of this it has been very easy for partners to quickly target and support women groups. However male engagement is still very low across the zones with very few men/boys groups and targeted support for male refugees. Male mostly benefit from the support for the general population with very few targeted support for men and boys. On a good note male community members have formed many community based groups such as football clubs/teams, cash for work groups, farmer groups and others which requires partner support. These groups pose great opportunities for male engagement activities through which SGBV prevention activities could be expanded.

In relation to physical protection, there is no protection house within the settlement but 1 protection shelter for SGBV survivors operated by IRC based in Yumbe which is currently responding to all female physical protection needs. For immediate physical protection needs, the community relies on community based protection mechanism through the child protection committees, neighbourhood watch, community leaders and women leader's structures. Critical physical protection cases are referred to police which is greatly challenged by lack of detention or holding facilities and transport challenges for immediate transfer. Bidibidi refugee settlement has no physical protection facility for men and boys, all the police posts within the settlement has no separate detention facilities for male and female and the available police holding cells have no separate structures for children and adult and some for male and female.

Access to police was noted as a critical gap in all the zones. Much as Bidibidi received some police vehicles and has police posts nearby or within all the zones, there were general concerns on the response capacity of the police with highlighted challenges of few police officers, lack of female police officers (only 2 in zone1 and zone 2), inactive child and family protection unit, transport challenges in relation to lack of fuel, very few and sometimes broken down motor bikes, inadequate stationaries and challenges of detention facilities which affects protection and SGBV case management. On a good note majority of the police officers have been trained on SGBV response and prevention and are closely monitored by senior police officers.

On access to individual registration and documentation, more than 80%[1] of the refugees have been biometrically registered and are accessing necessary services. However the gap analysis report indicates some noted challenges of missing names of registered persons of concern on food logs and some complaints of altered information like date of birth and addresses, none registration of family reunification cases among others which pose challenges to access to services. According to the community leaders, OPM is continuing to verify and respond to most of these cases, however this has been centralised in Bidibidi OPM office with a need to decentralise this compliant and response mechanism at zone levels.

Timely access to desegregated PoC data was also noted as a challenge to proper planning and projection of services for targeted beneficiaries. Positive Bidibidi conducted an interagency PSN assessment coordinated by OPM and UNHCR for which data will greatly support planning for targeted support.

b) Community service

Women representation and participation in community leadership is improving at 25%. According to September 2017 refugee statistics report[2], 53% (149,909) of the total population (285,014) are female out of which 33% (49,897) are above 18 years. However the level of knowledge and skills of these women leaders are low compared to the male. Most of the zones indicated concerns of inability of most female leaders to read and write however majority noted that they are very good leaders though

[1] Bidibidi OPM biometrics status update during September Bidibidi interagency meeting.
[2] Registration Unit, UNHCR RO Kampala – Uganda September 2017 refugee statistics package. Source: OPM

challenged with communication skills. When well-trained these leaders will be well equipped to better support their community.

Community participation in assessments and planning is noted to be low. Most community members were only able to identify the interagency participatory assessment conducted in March 2017 and the SGBV safety audit conducted in 2016. There were concerns of lack of community participation in partner's activity planning thus resulting into misappropriation of resources. Some actors have not conducted baseline surveys while the issue of lack of feedback on regular data collection by partners was continuously raised.

Access to basic services was reported as good though with complaints of delayed distribution of food, sanitary wears/dignity kits, and farm inputs among others.

Noted with extreme concern was the inadequate lighting of the community. Community members in some zones e.g zone 4 did not receive domestic solar lights while the number of existing community street lights are very low, this poses risks of attacks during night.

c) Health

The health sector SGBV Gap assessment focused on level three health facilities, looking into their capacity to provide quality Clinical Care services to survivors of SGBV within the settlement. The health facilities assessed included; Bidibidi HCIII (zone 1), Koro HCIII (zone 2), Yoyo HCIII (zone 3), Bangatuti HCIII and Bolomoni HCIII (zone 4) and Ariwa HCIII (zone 5). Due to the short time frame and poor roads as a result of culverts washed away, two health facilities were not assessed, i.e. Swinga and Yangani HCIII, the assessment covered the quality of medical support to survivors of SGBV are aggregated into six key areas i.e. Protocols, Personnel, Furniture or setting, Supplies (for basic health facility), Drugs (meets the minimum initial service package for RH) and availability and use of forms. The findings in these six areas are thus presented as follows;

Availability and use of medical protocols for management of survivors

The medical protocols recommended globally for management and support to survivors of SGBV include the WHO Clinical Management of Rape (CMR) guidelines developed in collaboration with

UNHCR and UNFPA. In Uganda, the National Guidelines for HIV treatment are also referenced in administration of post-exposure prophylaxis for prevention of HIV infection within 72 hours.

The findings reveal two key issues;

- About 3 facilities in Bidibidi were found to have the WHO CMR guidelines distributed together with UNFPA Reproductive Health Kit No.3. All facilities at least have the new National Guidelines for HIV treatment that provides guidance for the new line of PEP treatment given to survivors i.e. TDF-3TC-EFV. All facilities received posters showing steps in medical treatment of survivors, some have them displayed in the maternity or OPD units.
- However, the use of these protocols as key reference documents for effective clinical care for survivors and for continuous medical education/mentoring is limited. This was evidenced by the fact that, some protocols are kept far from the medical examination rooms.

Trained personnel

According to Ministry of Health in (MOH) Uganda, there are three cadres of medical personnel legally authorized to provide documented medical attention to survivors of SGBV. This also to aid in collection of forensic evidence and access to Justice. The cadres include; Medical Officers, Clinical Officers and Midwives, mainly operating from level three facilities upwards.

The assessment findings reveal that;

- All the level three facilities assessed have at least two medical staff trained in 2016 and 2017 on general SGBV prevention and response and specific post-rape management i.e. Clinical Management of Rape (CMR). The cadres trained vary per facility and include; Midwives, Clinical Officers, Nurses, Doctors and nursing assistants.
- Trained personnel are available any time as some stay within the facilities, are also on call and interpreters are available in some facilities in case of language barrier
- However, most facilities have no designate focal points for survivor support, this could jeopardize the need to ensure confidentiality at all times for survivors and even their records. There is risk of survivors having to tell their stories many times before they can find help.
- All partner-run facilities have counsellors within the facility, including psychiatric clinical officers and nurses and counselors, who can provide counseling and mental health support. However, Government facilities serving the settlement do not have any counselors, they rely on group support counseling provided by people living with HIV/AIDS.

Furniture and settings

As stipulated in the MISP guidelines and CMR training protocols, the ideal is to normally ensure a separate consultation/examination room for survivor, which is like a one-stop center within the facility, not necessarily labelled but for purposes of upholding the guiding principles.

In terms of settings, the assessment found that;

- Except of Bolomoni HCIII which also serves Imvepi settlement, all other facilities have no separate consultation room for survivor support, some use general examination rooms at the OPD, while others use procedure rooms. This means the rooms are always occupied, considering the volume of patients to be seen daily. It also jeopardizes the quality of medical examination provided and the time to collect/document evidence as all patients have to be seen before end of the day.

- Medical examination equipment and supplies such as examination beds/table, autoclaves, weight scales etc. are available but in different sections or units of the facility. Thus, there is risk that some procedures may be skipped as survivors have to move from one location to another in order to access all the services.

- Most facilities have no safe lockable spaces to keep confidential records such as survivor case histories. Information is in patient books, papers, OPD registers and patient's admission forms. As such, survivor information can be found by anyone at any time. This can pose a security and safety issue for survivors, mainly from perpetrators if they get to know they have been reported

- All facilities have laboratory technicians who can conduct various tests as requested. However, apart from the 2 government facilities, the rest have no microscopes to conduct further investigations and analysis of samples and no colposcopy (magnifying glass) to examine the cervix and tissues of the vagina and vulva

Availability supplies

Supplies looked at are mainly those that are used for basic health facility i.e. level III and where possibility of collecting much forensic evidence is low

- Facilities have medical instruments and equipments such as speculum for vaginal exam, resuscitation equipment, instruments for repair of tears and suture materials

- Facilities also have capacity to conduct required tests such as pregnancy, STI, HCG.

Most of these instruments and equipment are available at the maternity units, since that is where they are mainly used for reproductive health.

While it is good practice to have such instruments and equipments in the maternity units, an area also recommended in most cases for survivor support when there are no separate rooms. It could also raise a question; what happens if survivor is male? Can they still be examined at the maternity unit?

- Few facilities have gowns for covering survivors during medical examination, most don't even have even sanitary pads in case of need to change. This limits collection of forensic evidence such as clothes survivors were wearing at the time of the incident.

Drugs (meeting the minimum initial service package in emergencies) and other services

As stipulated in the WHO CMR guidelines, the MISP guidelines for reproductive health in emergencies and MOH CMR training guide, the following drugs and services are recommended as a full package for management of survivors of SGBV as;

- PEP (Post-exposure Prophylaxis) e.g. Zidovudine, Lamuvidine
- STI treatment e.g. Azithromycin, Cefixime
- ECP (Emergency contraception pills) i.e. Levenorgestrol
- HCG tests, STI tests, HIV tests
- Vaccines i.e. Hep B, Tetanus toxoid
- Antibiotics for wound treatment and other dressing

The assessment found that;

- All facilities assessed have drugs for management of survivors, although some specific ones stipulated in the MISP and WHO CMR protocols such as Cefixime for STI treatment are not so commonly available in facilities, but other options are available locally.
- Stock outs of PEP and ECP was found a major gap, although some facilities try to replenish from government ART supplies, thus the combination of TDF-3TC-EFV is now used in most facilities as the new line of PEP treatment. Some medical personnel highlighted that, the Lamuvidine and Zidovudine combinations of PEP are no longer preferred w outdated as per Uganda HIV treatment guidelines.

- Review of available survivor records showed that, some survivors of sexual violence didn't receive the complete examination and treatment as per the protocols. There is need for medical workers to ensure adherence to minimum standards in their facilities for holistic survivor support.
- Follow-up of survivors to ensure completion of treatments is weak as sighted by health workers, survivors don't return for review or follow-up tests, for instance in the case of HIV prevention where tests are to be conducted at 4 weeks, 3 months and 6 months to rule out any infection.
- Psychosocial support and counseling services are not well integrated within the facilities, particularly government-run were there are no counselors to provide counseling.

Availability and use of forms

Some of the survivor medical history documentation forms used for survivors include; the GBVIMS standard medical history intake forms, the MOH History and Examination form among others. Other documents used in survivor support include the referral pathways or mechanisms, consent forms and medical certificates etc. The findings reveal the following;

- Medical history intake and documentation of survivor information in the health facilities is still generally poor and lacking in some cases. Some facilities could not locate the medical records of survivors, claiming to have statistics of cases handled with the data clerks. This makes it difficult to track survivor records and the quality of services provided to clients.
- Where documentation of survivor history and medical examination has been done, there is no uniformity in the documents used across the facilities. Some facilities rely solely on PF3 forms, others use their admission forms, OPD registers, patients note books and while others use those derived from their own programming.
- While MOH has developed survivor History and Examination forms to improve documentation and support legal redress, these forms are not available in all the facilities, thus variance in the current documentation practice.
- Almost all facilities lack consent forms for medical examination of survivors who seek support in the facilities, others have relied on verbal consent, which can be difficult to verify. There are no medical certificates to provide to survivors, as these can be used as part of legal documents to support access to justice.

- Referral pathways/mechanism document is available in some facilities, printed and disseminated by IRC, some facilities do not also have and have not seen. However, there is The current referral mechanism is so linear than cyclical e.g. from partner to police to facility, police or home are also not used to effect referral mechanism. There is a one way referral from police to facility

Good practice case study – Bolomoni HCIII (zone 4)

Except of government facilities, all NGO-run health facilities in Bidibidi settlement currently operate in temporary structures, which are not well set and susceptible to weather conditions. While the plan by UNHCR to construct permanent health facilities is underway, Bolomoni HCIII has established within the semi-permanent structures, a good system of survivor management and support within the facility that can be replicated to other facilities as 'good practice'.

- There is a one stop room referred to within the facility as, "SGBV Clinic", where all history taking, medical examination, treatment and counseling take place. This has minimized the need for survivors to move from one unit to another to access services, thus confidentiality is key
- Within the same room, there is a safe lockable cabinet where survivor medical records are kept confidentially, thus minimizing the risk of exposing survivors to further harm should anyone land on their information
- At least there is a midwife allocated to the SGBV clinic on daily basis, but also rotated to ensure full support to reproductive health work within the facility. The clinic is supported by a team of staff who also conduct outreaches to create awareness of services available at least once in a week.

d) WASH

Concerns were raised on the existing family infrastructures with no doors. According to the community leaders most of the houses constructed have no doors and poorly covered windows, this possess risks of intrusion and targeted attacks on women and girls without male protection. Some complaints of intrusion were reported with perpetrators claiming being too drunk and just entering any open door to take shelter. Theft of properties are high due to lack of safety/security from locked doors.

Most PSN shelters are in very dilapidated stage and because of their inability to construct their own shelter, many have been exploited to repair existing shelters and remains at risk of attacks and exposure to bad weather conditions.

Community structures such as food distribution points, community centres/former biometric centres etc. have very poor latrines/sanitation facilities which are unmarked, unisex, some without doors, with very poor privacy and no lighting. Because of this, there has been report of open defecations in some of these areas and lack dignity for persons of concern.

Menstrual hygiene management remains a challenge with reported complaints of lack of emergency sanitary materials in schools, lack of wash rooms/changing rooms in most institutions including schools, health centres, police and offices.

Access to dignity kits by women and girls of reproductive age are normally disrupted by irregular distribution and most times incomplete sanitary kits package. In most only pads and soap are distributed.

Some reusable pads (AFRIPADS) were distributed by partners however the management by beneficiaries pose some health risks. In two of the focused group discussions, some women noted that due to the infrastructure design, some girls and women prefer to dry their reusable pads inside (under beds, on Jerricans or out of sight), this may not enable proper drying and pose health risks. It's important that adequate soap is always distributed to enable hygiene maintenance.

e) Food security and livelihood

Issues were raised on targeted livelihood support. Some community members noted the lack of flexibility by partners to support the right target groups due to strict reliance on backdated information. Given that PSN status do change, sometimes the wrong target group are supported while living out those in dire need at that particular period. There was also a concern of lack of inclusiveness of target group in regards to age, gender and diversity. According to the respondents, most often young boys, single fathers and the elderly are less targeted.

Actions to integrate GBV prevention and response to livelihoods programmes are minimal, most projects are not gender sensitive or do mainstreamed with minimal attention on understanding and mitigating protection/SGBV risks that results from some targeted livelihood activities.

Issues of food security and sustainable sources of household income were presented, most women noted the shifted burden of maintaining the family on women as some of the men remained or returned to S.Sudan while the men within the settlement are equally vulnerable due to lack of sustainable economic activities. Also noted was the issue of allocation of farm lands with majority complaining of lack of farm tools and seeds, other zones/villages had not yet been allocated farm lands while others seemed uninterested in agriculture.

Much as some community members benefit from the established livelihood projects by different partners, majority of the population within the settlement are not engaged in productive and sustainable economic activity thus increasing their levels of dependence on humanitarian aid.

f) Education

Enormous efforts have been put by education partners is ensuring provision of education during emergencies, as the settlement transitions from emergencies some key protection issues in education are yet to be addressed.

According to the findings from the analysis, there are still gaps in latrines coverage with inadequate number of Wash facilities for learners and teachers in most schools. Also raised were concerns of maintaining dignity of users of temporary latrines due to their dilapidating states with some occasional sharing of male and female latrines due to need of decommissioning of others.

Most schools have no changing rooms for girls and the available structures does not provide room or privacy to support a girl with a changing need.

Most schools have many clubs with very good peer support and educational programs, however most schools have not yet planned or established well-structured strategies and programs to keep girls at school. Many partners conduct school activities which however are not coordinated and mainstreamed into the educational system to ensure sustainability and clear measurement of outcome.

To mitigate risk of SGBV, many community awareness and trainings are conducted within the communities, however school going children tent to always miss out on these programs because of school engagements. Minimal SGBV/protection school outreach activities are conducted to bridge the knowledge gap and ensure equal participation and access to prevention information by learners.

SGBV SERVICE MAPPING

ZONE 1

Case management: IRC

Psychosocial support: TPO, IRC

Health: RMF HC III Bidibidi

Legal assistance: IRC

Police: Bidibidi police post

Women's centre: 2 (village 1& 4)

Support services: PLAN

Solar lights: 35

ZONE 2

Case management: IRC

Psychosocial support: TPO, IRC

Health: IRC HC III Village 7&

Legal assistance: IRC

Police: police post village 3

Women's centre: 3 (Village 5, 6 & 7)

Support services: ADRA village 4, PLAN

Solar lights: 48

ZONE 3

Case management: IRC, CARE

Psychosocial support: TPO, IRC

Health: Yoyo HC III, RMF HC III Village 7&5

Legal assistance: IRC

Police: Kululu police post close to v7

Women's centre: 4 (Village 11, 8, 3 & 1)

Support services: PLAN

Solar lights: 57

ZONE 4

Case management: IRC, CARE

Psychosocial support: TPO, IRC

Health: RMF HC III Village 1&5, MSF village 9

Legal assistance: IRC

Police: Odravu police post

Women's centre: 3 (Village 1, 4 & 5)

Support services: PLAN

Solar lights: 37

ZONE 5

Case management: ARC, WCC

Psychosocial support: ARC

Health: Ariwa HC III, IRC HC III Yangani SC clinic Ariaw 1, IRC outreaches Embechi, Okubani

Legal assistance: IRC

Police: Ariwa & Yangani police post

Women's centre: None

Solar lights: 47

ANNEX
Assessment tool

BIDIBIDI REFUGEE SETTLEMENT

SGBV WORKING GROUP, 2017

SGBV GAP ANALYSIS TOOL

Back ground information

Bidibidi refugee Settlement is hosting 272,206 South Sudanese refugees. Among this population 86% are women and children, 53.3% female and 68% children below the age of 18. Sexual Gender based violence (SGBV) prevention and response are facilitated by ARC, IRC for general case management, War Child Canada for legal aid, TPO for psychosocial support, World Vision & Save the children for child protection and others mainstreaming SGBV in livelihood (DCA, Mercy Corps &ADRA) and health sector (MSF, RMF, IRC, MTI) with support from OPM, UNHCR, UNFPA, UNWomen, UPF and YDLG.

Since the adoption of *UN Security Council Resolution 1325 on Women, Peace and Security* in 2000, and subsequent resolutions there has been increased attention on GBV issues in humanitarian setting. To ensure systematic and streamlined SGBV programing, its's important to have a comprehensive understanding of existing SGBV services, gaps, needs and opportunities. Information generated from a gap analysis will inform strategic intervention, avoid duplication of service and to support allocation of resources.

Objective

5. To map out SGBV services in Bidibidi (extend of reach)
6. To explore the extent to which SGBV is mainstreamed in other sectors
7. To identify key SGBV service gaps
8. To identify key SGBV service needs
9. To identify existing opportunities for SGBV response and prevention

Methodology

1. Document review (PPA/MoU, Work plans)
2. Key informant interview (questionnaire, check list)
3. Observation (check list)

Sector checklist

Sector	Yes	No	Comments (include statistics/frequency, status, observations, gaps and any other relevant information)
1. General Protection			
Access to and use of disaggregated refugee data (sex, age, vulnerability) for planning and service delivery			
The use of SGBV SOP for programming and referrals			
Dissemination of information on SGBV/Protection referral pathway.(posters, bill boards, meetings, dialogues, trainings)			
Availability and access to Safe space for women and girls, men and boys			
Equal access to assistance and services for women and men			

Protection house/shelter			
Information help desks			
Free Legal Aid services for SGBV survivors (women and girls/boys and men)			
Legal Aid staff trained on SGBV guiding principles			
Access to police			
Separate holding cells for male and female			
Availability of female police officers			
Security personnel trained in SGBV prevention and response disaggregated by function and sex			
Security sector integrated in SOPs and referral pathways			
Community based strategies in place to monitor SGBV-related risks			
Safety audits conducted, how often?			
All humanitarian staffs ad volunteers sign a code of conduct			
PSEA focal points assigned			
Access to individual registration and documentation			
All humanitarian staffs and volunteers sign child protection policy			
2. EDUCATION			
Separated male and female wash facilities for learners			
Separated male and female wash facilities for teachers			
Changing rooms for girls			
Existing distinct strategy to keep girls at school			
School hygiene, health and life skills education clubs established and functioning			
Access to sanitary materials at school			
Assessment on safety of roads to schools/learning places conducted			
Community/school awareness or outreaches conducted			
Teachers trained on code of conduct and SGBV			
Teachers signed code of conduct			
3. HEALTH AND NUTTRITION			Comments (include if available in nearby facility, distance, gaps etc)
Protocol			
Written medical protocol in the language understood by the medical service provider			
Personnel			
Trained health workers on clinical management of rape/ SGBV (on call 24hrs a day)			
Availability and accessibility of health workers for medical examination of SGBV survivors			
Furniture or Setting			
Privacy(separate consultation room)			
Examination table			
Light (preferably fixed)			
Access to Autoclave to sterilize equipment			
Weighing scale and height chart for children			
Magnifying Glass (Colposcopy)			
Access to Laboratory facilities with a microscope and trained technician			
Safe, locked space to store confidential records			

Dignity (separate toilet for female and male)			
Supplies (for basic health facility i.e. where treatment is done and possibility of collection of evidence limited)			
Speculum			
Resuscitation equipment for anaphylactic reactions			
Sterile medical instruments for repair of tears and suture materials			
Gown, cloth or sheet to cover survivor during examination			
Sanitary materials (pads or local cloths)			
Pregnancy tests			
Drugs (Meets the minimum initial service package for reproductive health(MISP)			
For treatment of STI as per protocol e.g. Azithromycin, Cefixime			
For Post exposure prophylaxis (PEP) of HIV transmission as per protocol e.g. Zidovidine, Lamivudine			
Emergency contraception pills and or Copper bearing IUD as per national protocol			
Tetanus Toxoid, tetanus immunoglobulin			
Hepatitis B Vaccine			
Local anaesthesia for suturing			
Availability and use of Forms			
Forms for recording post-rape care			
Consent forms			
Medical examination certificate			
Referral pathway			
✓ Psychological and social support systems ✓ Referral system ✓ Private case management and counselling spaces			
4. SHELTER			
Safe pathways inside the settlements			
Active community watch teams			
Availability of solar street lights in risky areas			
Availability of house hold lights			
Proximity and easy access to food/general distribution point			
5. COMMUNITY ENGAGEMENT			
Access to information on all humanitarian services			
50% representation of women in leadership			
Participatory needs assessment conducted			
Establish community complaints and feedback mechanism			
Availability of well-structured and supported women/youth/girls/male groups			
Outreach strategies to ensure women and girls participation developed (i.e. time and location of meetings, is it safe? Accessible? Compensation of time?			
Existence of community, political and religious leaders trained as SGBV prevention and response advocates			
Strategies to engage men and boys in prevention and response in place			
IEC materials are locally relevant, translated, acceptable and appropriate			
6. WASH			
Women and girls consulted for WASH infrastructure design			
Separate and marked male and female community/households latrines			
Participation of women on WASH committees			

Menstrual hygiene management(disposal practice, appropriateness of hygiene materials)			
Lighting of sanitation facilities and water collection routes/points			
7. FOOD SECURITY / LIVELIHOOD			
Targeted livelihood support for women (widows, SGBV survivors, teenage mothers, lactating mothers, female headed household, etc.)			
50% representation of women in all livelihood program			
Selection criteria and common indicators for cash transfer programming is gender sensitive			
Livelihoods programmes mapped and integrated into SOPs and referral pathways			
Gender-sensitive livelihoods needs assessments and market analysis conducted			
Actions to integrate GBV prevention and response to livelihoods programmes developed			
GBV focal points participates in livelihood sector meetings			