

Project Evaluation Report

Prevalence of SGBV and Impact of TPO Psychosocial Support Model and Livelihoods Interventions on Mental Health Recovery of SGBV Survivors in Emergency in the West Nile Region.



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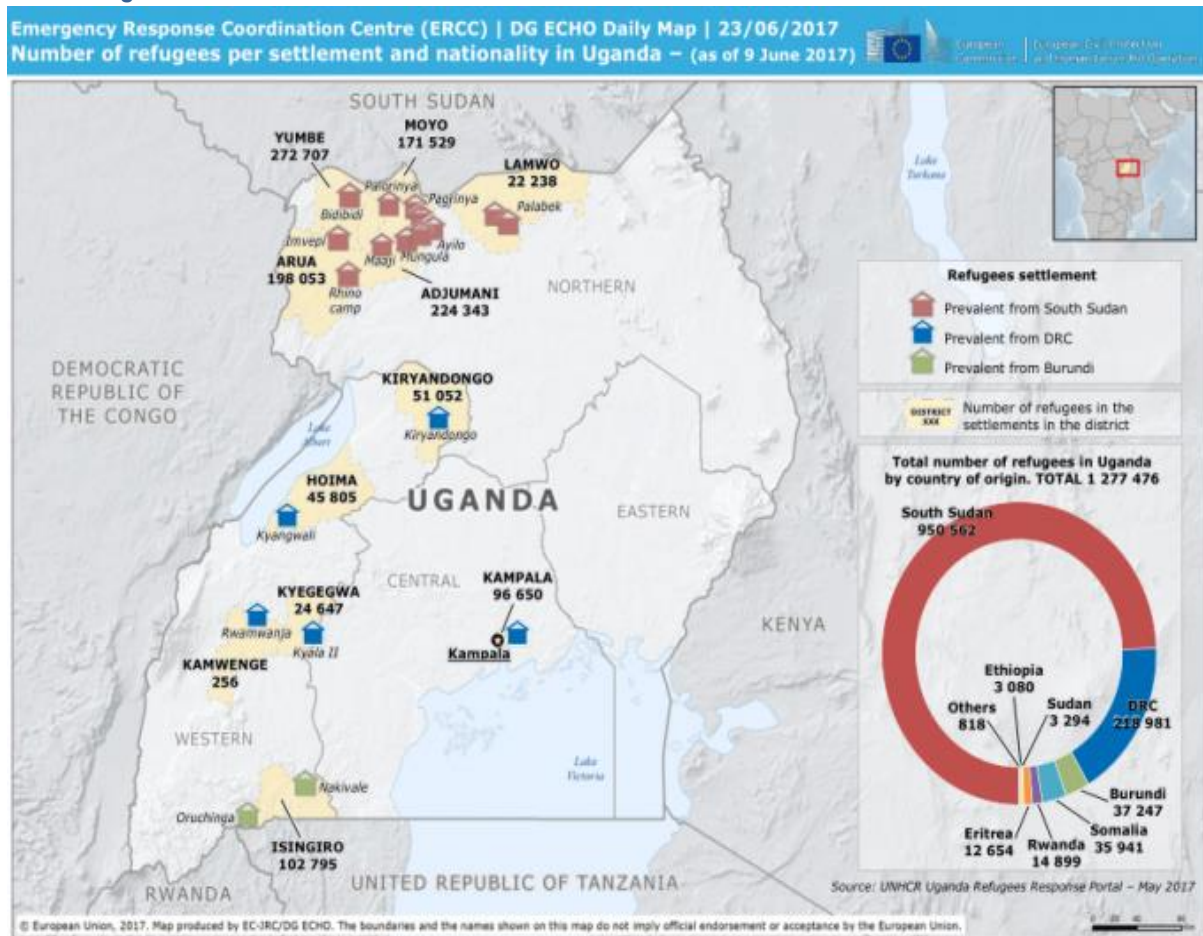
December 2019

Acronyms

ARC	American Refugee Council
AWYAD	African Women and Youth Action for Development
CBT(T)	Cognitive Behavioral Therapy for Trauma
CFPU	Child and Family Protection Unit of the Police
CHS	Core Humanitarian Standards
CPC	Child Protection Committee
DCDO	District Community Development Officer
DFID	Department for International Development
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GALS	Gender Action Learning Systems
IASC	Inter-Agency Steering Committee
IEC	Information, Communication & Education
IGAs	Income Generating Activities
INGOs	International Non-Governmental Organizations
IRC	International Rescue Committee
KII	Key Informant Interview
LC	Local Council
LWF	Lutheran World Federation
MH	Mental Health
MHPSS	Mental Health Psychosocial Support
MTI	Medical Teams International
NURI	Northern Uganda Resilience Initiative
PFA	Psychosocial First Aid
PSEA	Prevention of Sexual Exploitation and Abuse
PTSD	Post Traumatic Stress Disorder
RWC	Refugee Welfare Committee
SASA	Start, Awareness, Start, Actions
SGBV	Sexual Gender Based Violence
SOPs	Standard Operating Procedures
TOR	Terms of Reference
TPO	Transcultural Psychosocial Organization
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
VPAs	Volunteer Psychosocial Assistants
VSLAs	Village Saving and Loans Associations
WFP	World Food Program
WHO	World Health Organization
WV	World Vision

Project Location Map

Map Showing TPO-Uganda UN WOMEN Trauma Care & SGBV Project Implemented in Lamwo, Adjumani and Obongi Districts.



Source: Operational Presence Uganda Refugee Response Plan (RRP) 2019-2020

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Acknowledgements

This project evaluation was supported by TPO-Uganda in partnership with UNWOMEN. Our sincere gratitude goes to all those who provided us with guidance, insights and technical support to accomplish the task. Our special thanks go to TPO-Uganda Country and Field Office teams who made mobilization and participation of relevant field-based stakeholders to this assessment possible; OPM, UNHCR, UNWOMEN, LWF, SORUDA, MTI, DLGs, Police among others.

More specifically our gratitude goes to Dinnah Nabwire-Program Learning Advisor, Jocknus Bitekere-Project Coordinator and Michael Muwairwa M&E Manager who provided technical support, insights and contextual documents. We also recognize the role and commitment of TPO-Uganda Field Officers: Sam Wanyama, Suzan Apeduno and Norah Nabwire together with their teams, for mobilizing Research Assistants and coordinating the entire field data collection process. We would also like to appreciate all respondents in the survey, FGDs, and KIs who made themselves available and contributed their thoughts that made the exercise a success

Furthermore, our appreciation goes to the Ulinzi Innovations Consult Limited (ULICO) team on this assignment that included; Denis Nuwagaba, Arinaitwe Fatuma, Najjingo Dorothy and Adam Atama who carried out field data collection exercise from the three districts (Adjumani, Obongi and Lamwo), analysis and report writing. Great thanks to other ULICO Team members; Fredrick Luzze, Zacharia Kasirye, Frederick Luzze, Obedy Nuwagaba, Kashungwa Charles and Robert Adupa for the technical and peer review support provided throughout the exercise inception and report writing sessions.

God bless you all.

Denis Nuwagaba (**Lead Consultant**)

Executive Summary

INTRODUCTION

TPO-Uganda in partnership with UN WOMEN have been implementing a series of MHPSS and livelihood support interventions to support Refugees and Host communities improve their wellbeing since 2016. The project provided support to South Sudanese refugees and host communities to access psychosocial support and trauma care. In addition, the project provided minimal livelihoods support to selected beneficiaries and created referral linkages for other services. The project was aimed at strengthening and sustaining recovery and social functioning for sexual and gender-based violence survivors in Emergency Northern and West Nile Regions.

The TPO Uganda /UN Women MHPSS and SGBV Project had the following key deliverables that included: Strengthening access and utilization of gender-based violence survivors to quality mental health and psychological support services; Build and strengthen the role of community support structures to prevent and respond to gender-based violence and adverse conditions; Enhance the economic Integration of GBV survivors among refugees as part of empowering them to engage in the local economy and lead more dignified livelihoods.

THE EVALUATION OBJECTIVES

The overall purpose of the evaluation was to establish the prevalence of SGBV, measure the effectiveness of the TPO psychosocial support model on mental health recovery and the impact of livelihoods interventions on the recovery for sexual and gender-based violence survivors in Emergency West Nile Region. The specific objectives included: Establishing the prevalence of sexual gender-based violence in humanitarian West Nile including forms and linkages with conflict related sexual violence; Articulating the MHPSS dynamics around SGBV and conflict-related sexual violence among refugees in relation to the MHPSS interventions by TPO-Uganda; Assessing the effectiveness of livelihoods onto MHPSS interventions in the context of addressing sexual and gender-based violence and conflict related sexual violence in emergencies.

THE EVALUATION METHODOLOGY

The evaluation was cross-sectional in design and adopted a mixed-methods approach: primary and secondary data (both qualitative and quantitative). The assessment was conducted in Palorinya Refugee Settlement in Obongi District; Nyumanzi, Agojo and Baratuku Refugee Settlements in Adjumani District and Palabek Refugee Settlement in Lamwo District. Specific zones and blocks were selected from each zone where the project was implemented and a few CBT groups from the previous (2018) project cycle were interviewed for comparison purposes.

Quantitative methods entailed use of a survivor survey that was administered to a total of 360 CBT group members and 60 respondents for control group (Respondents from the settlements not directly targeted by TPO) while qualitative data entailed collection of data from a total of 10 FGDs drawn from Refugee Welfare Committees (RWCs), Child Protection Committees (CPCs), Local Council I Committees, CBT groups, TPO-Uganda Social Workers and Clinical psychologists, Prevention of Sexual Exploitation and Abuse (PSEA) taskforce and Volunteer Psychosocial Assistants (VPAs). Qualitative methods further involved key informant interviews with a total of 37 purposely selected respondents that were drawn from TPO project staff, partner NGO/INGO/ UN Agency staff, cultural leaders as well as district officials in the host districts. Other qualitative methods employed included: Administering pre and post assessment to 60 respondents to compare recovery changes realized in the lives of SGBV survivors that can be attributed directly to project interventions; use of observation methods to observe livelihood initiatives undertaken by project beneficiaries and collection of most significant change stories.

THE FINDINGS

Most common SGBV form of abuse in the settlement: Overall, physical violence (90%) was the most SGBV form of abuse throughout the settlements, followed by sexual abuse (65%) and socio-economic violence (45%)

Perceptions about sexual abuse as a form of SGBV: Overall, rape (65%) was perceived as the most prevalent form of sexual abuse; followed by child sexual abuse/defilement (45%) and sexual harassment (31%).

Forms of Harmful traditional practices: Overall, early marriage ranked highest with regard to harmful traditional practices at 71%, followed by forced marriage (42%), honor killing/child sacrifice (11%) and infanticide and neglect (7%).

Social-economic deprivation: Overall, discrimination and denial of opportunities was the most common of abuse at 77%, followed by obstructive legal practices (16%), lack of support from men (10%) and social exclusion/ostracism based on sexual orientation (9%).

Forms of SGBV suffered by project beneficiaries: Overall, rape (58%) was indicated as the most prevalent form of SGBV suffered by the project beneficiaries (61%) and control group (29%). Followed by sexual harassment (32%) suffered by CBT beneficiaries (33%) and control group (29%), child sexual abuse/defilement/incest (7%) suffered by CBT beneficiaries and control group at 6% and 14% respectively, forced marital sex (6%) suffered by 3% and 29% for CBT beneficiaries and control group respectively while sexual exploitation/forced prostitution (1%) was the least indicated at 2% and 0% for CBT beneficiaries and control group respectively.

Forms of emotional and physical violence: Overall, emotional and psychological violence ranked highest (60%) with victims at 60% and 42% for CBT and control group respectively, followed by physical assault (39%) indicated by CBT beneficiaries and control group at 39% each respectively, followed by beating (6%) indicated by CBT beneficiaries and control group at 6% and 3% respectively while trafficking/slavery was the least mentioned (1%) indicated by CBT beneficiaries and control group at 1% and 0% respectively.

Social-economic violence: Overall, inability to have means to provide for personal or household sustenance was reported as the main form of abuse (69%) indicated by 67% and 100% of CBT beneficiaries and control group respectively, followed by discrimination and denial of opportunities at 26% and indicated by 27% and 0% for CBT beneficiaries and control group respectively while social exclusion/ostracism based on sexual orientation was the least mentioned (1%) indicated by 3% and 0% of CBT beneficiaries and control group respectively.

Main perpetrators of SGBV: Overall, spouses (71%) were reported to be the main perpetrators, followed by parents (20%), youth (8%), neighbors (6%), persons of authority such as the police and settlement administration (5%) while traditional leaders (4%) were reported as the least perpetrators.

Prevalence of SGBV among Project Beneficiaries: Overall, 75% of respondents reported that they had been victims of any form of SGBV or from psychosocial distress while 25% said they had not.

Incidence of SGBV abuse: Overall, only 5% of respondents indicated that the incidence of SGBV abuse had happened in South Sudan or before 2016, the year 2017 had a high percentage of SGBV cases (32%) and there was a drastic fall in abuse to 13% in 2018 and resumption of rising cases from 2018 to 2019.

Psychosocial effects of SGBV: Development of anger and hatred (40%) was indicated as the most psycho-social effects of SGBV, followed by feeling of worthlessness and betrayal/abandoned (37%), fearful/anxiety (36%), shame/stigma (29%), suicide (26%) while the proportion of respondents that indicated withdrawal constituted 12%.

Repeated incidence of SGBV abuse: Only 27% of the respondents reported that they had suffered similar abuse in the course of their participation in the TPO program compared to 73% who had not.

Livelihood support given to beneficiaries: 42% of the respondents indicated that they had received some kind of livelihood support from TPO while 58% had not.

Mental and psychosocial services offered by TPO: 84% of the respondents indicated that they received information on mental health issues, 69% had received PSS first Aid/counseling from TPO social workers, 38% screening, 20% home visits/care/meditation, 16% were supported to report and seek redress while only 5% had received support in livelihoods.

SGBV Programing Challenges:

The assessment revealed a number of programming challenges that included: Underreporting of SGBV cases, increasing mental disorders and excessive, limited access to basic necessities, inadequate partners' financial constraints leading to reduction in staff physical presence at the field, inadequate support to SGBV community structures, material support at the women centers and routine SGBV, Inadequate support for the police, Probation and Social Welfare Department, inadequate access to justice for SGBV survivors, limited socialization

opportunities in refugee settlements, reduced access to vocational trainings and livelihood opportunities, limited resources for capacity building of the community structures, long distances to food distribution that increases risks of exposure to SGBV, release of perpetrators without proper community sensitization, limited access by girls to secondary school education, constraints leading to reduction in staff physical presence at the field level.

LESSONS LEARNT:

The emerging lessons from this evaluation are: (i) TPO's implementation CBT model addressed the real needs of the beneficiaries and was embraced by the refugee and host communities; (ii) Mainstreaming of SGBV into MHPSS programming was spot on since it enabled TPO not only meet the real needs of women and children living in a patriarchal society, but also, helped deal with the root causes of SGBV; (iii) There was strong evidence that the engagement of men and boys especially in CBT processes was crucial in reducing incidences of abuse and also quickening the healing process; (iv) Mobilization of women into groups was also seen to be galvanizing their voices, tapping into benefits of peer support, self-esteem and opening up; (v) There was also evidence that some of the early gains of CBTT were addressing other community social problems such, alcohol abuse, child abuse and animosity between different ethnic communities among the refugees and between the refugees and host communities; (vi) Engaging SGBV/MH survivors in profitable livelihood endeavors alongside CBT was contributing to the early recovery process as the women not only got occupied (diverted away from stressing factors) but also helped to contribute to the sustenance of their family; (vii) There are all indications that the refugees were not returning in the short run; (viii) There was a tendency of 'territorialism' with different organizations focusing on their allotted settlements and with limited coordination especially among MHPSS/SGBV actors, creating gaps in the comprehensive service package; (xi) High level of sensitization about other forms of SGBV broadened the scope of SGBV incidences being reported especially social and economic abuse that would never have been raised by the survivors before being enlightened and empowered; (x) The definition of SGBV seemed to be elastic depending on the level of awareness about the concept by the community.

KEY RECOMMENDATIONS:

The following are the key recommendations that emerged from the assessment:

- TPO should significantly scale up livelihoods interventions especially given its impact on recovery and prevention of relapse among SGBV/MH survivors and also that the context in the settlements is really no longer of an emergency nature but rather requires long-term sustainable interventions
- TPO should consider more engagement of cultural and religious leaders, men/boys, and the experimentation of approaches that are more effective in creating behavioral change especially at family level such as GALS
- There is need to scale up men involvement by addressing fears that men hold about changing power relations in households and communities by involving them in SGBV/MH related interventions and designing activities specifically tailored for men to help them deal with consequences of especially conflict related emergencies and displacements
- TPO should strengthen involvement of relevant stake holders including; relevant government departments, beneficiaries and implementing partners at planning and implementation stages
- The ME system and tracking indicators for SGBV and livelihoods for TPO need to be strengthened to effectively track changes in the lives of project beneficiaries
- There is therefore need to train more staff and/or enroll more VPAs, role model men to support implementation and enhance sustainability.

1.0 Chapter One: Introduction

1.1 Introduction

On behalf of the TPO-Uganda/UN WOMEN partnership project entitled “Support to Refugees and Host communities to access Psychosocial Support and Trauma Care, Ulinzi Innovations Consult Ltd conducted an assessment with a general objective to establish the prevalence of SGBV, measure the effectiveness of the TPO psychosocial support model on mental health recovery; and the impact of livelihoods interventions on the recovery for sexual and gender-based violence survivors in Emergency Northern and West Nile Regions¹ The report is divided into four chapters: **Chapter One** covers Background to the assessment, purpose, objectives and scope respectively. **Chapter Two** discusses the methodology design, data collection tools and analysis methods. **Chapter Three** presents assessment findings and last but not least is **Chapter Four** that highlights Conclusions, Lessons learned and Recommendations.

1.2 Background to the TPO-Uganda /UN Women MHPSS & SGBV Project

TPO-Uganda is a Rights-Based NGO that works in partnership with communities, civil society, the private sector and government to empower communities improve their mental health and socio-economic wellbeing in a sustainable way.²

Since 2014, TPO-Uganda in partnership with UN WOMEN has been at the forefront of providing the much-needed mental health psychosocial support services to pre and post conflict SGBV survivors including women, girls and men in multiple refugee settlements and host communities in Uganda in particular.

Inspired by the belief that women have a right to live a dignified life free from violence as endorsed by international agreements such as the 1993 *UN Declaration on the Elimination of Violence against Women* and the *UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*, the UN WOMEN in partnerships with governments, sister UN agencies, civil society organizations, NGOs and other institutions supports interventions geared towards ending violence against women. The UN WOMEN emphasis is on; increasing awareness of the causes and consequences of violence; strengthening capacity of partners to prevent and respond to sexual and gender-based violence; promoting the need to change negative cultural beliefs of men and boys plus advocating for gender equality and women's rights³.

The one-year UN WOMEN/TPO/partnership project (January-December, 2019) under review, provided support to South Sudanese refugees and host communities to access psychosocial support and trauma care. In addition, the project provided minimal livelihoods support to selected beneficiaries and created referral linkages for other services. This was aimed at strengthening and sustaining their recovery and social functioning.

The project was implemented in Obongi (Palorinya settlement), Adjumani (Nyumanzi, Agojo, Baratuku, Mungula 1 and Mungula 2 settlements) and Lamwo (Palabek settlement) districts, and targeted a total of 3,600 beneficiaries of which 10% were men and the rest were women and girls; The beneficiaries were, equally distributed across the three districts (Lamwo: 1200, Adjumani: 1200, Obongi: 1200) and 30% of the targeted beneficiaries were from the host community. The OPM refugee demographic analysis⁴ in the above refugee hosting districts indicated that women and girls formed 53% (203141) of the total population (383,059), while men and boys took 47% (179,918). The statistics further indicated that women and children formed 78% of the total population leaving 22% men. From these, the project target and study population were derived.

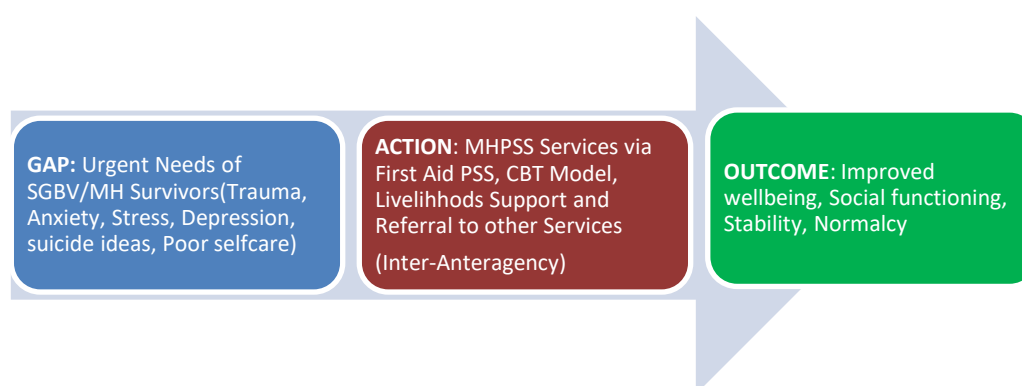
¹ Original TOR altered by TPO to emphasize measurement on mental health recovery as the priority with livelihoods only coming as a secondary element to be measured.

² <https://www.tpoug.org/>

³ <https://www.unwomen.org/en/what-we-do/ending-violence-against-women>

⁴ Government of Uganda Office of The Prime Minister Uganda: Refugees & Asylum Seekers as of 30-November-2019

Figure 1: TPO-Uganda/UN WOMEN MHPSS and SGBV project logical framework/theory of change.



The TPO-Uganda /UN Women MHPSS & SGBV Project had the following key deliverables;

1. Strengthen access and utilization of gender-based violence survivors to quality mental health and psychological support services.
2. Build and strengthen the role of community support structures to prevent and respond to gender-based violence and adverse conditions.
3. Enhance the economic Integration of GBV survivors among refugees as part of empowering them to engage in the local economy and lead more dignified livelihoods.

1.3 Assessment Objectives

1.3.1 General Objective

The purpose of the assessment was to establish the prevalence of SGBV, measure the effectiveness of the TPO psychosocial support model on mental health recovery; and the impact of livelihoods interventions on the recovery for sexual and gender-based violence survivors in Emergency West Nile Region⁵

1.3.2 Specific Objectives

- a) To establish the prevalence of sexual gender-based violence in humanitarian West Nile including forms and linkages with conflict related sexual violence
- b) To articulate the MHPSS dynamics around SGBV and conflict-related sexual violence among refugees in relation to the MHPSS interventions by TPO-Uganda.
- c) To assess the effectiveness of livelihoods onto MHPSS interventions in the context of addressing sexual and gender-based violence and conflict related sexual violence in emergencies.

⁵ Original TOR altered by TPO to emphasize measurement on mental health recovery as the priority with livelihoods only coming as a secondary element to be measured.

2.0 Chapter Two: Methodology

2.1 Study Design and Approaches

The assessment adopted a descriptive and cross-sectional design that combined both qualitative and quantitative data collection methods. The selection of this design was based on the need to take advantage of the benefits accruing from using a combination of data collection methods for easy triangulation and corroboration of findings. To instill a sense of ownership, the assessment was participatory in nature characterized by active engagement of TPO-Uganda project staff, key partners as well as SGBV and Mental Health Survivors. Gender and Human Rights Based Approaches were also observed during execution of the assignment. Due to the sensitivity nature of the questions and hesitation of participants to give response regarding sexual and gender-based violence, the assessment also employed a perception survey questioning approach which allowed the respondents to provide responses to issues that did not necessarily victimize them.

2.2 Study Population and Study Area

The assessment was conducted in Palorinya Refugee Settlement in Obongi District; Nyumanzi, Agojo and Baratuku Refugee Settlements in Adjumani District and Palabek Refugee Settlement in Lamwo District. Under each settlement, specific zones and blocks where the project was implemented were selected for inclusion in the assessment. For comparison purposes, a few CBT groups from the previous (2018) project cycle were interviewed to gain deeper insights on the effectiveness of livelihood interventions on recovery from SGBV and Mental Health disorders. Interviews were also held with host community leaders, staff from UN agencies, INGOs providing MHPSS services in the settlements and relevant district and government departments' staff among others.

2.3 Sampling and Sample Size Determination

As was specified in the proposal for this assignment, quantitative data was collected using a survey questionnaire that was administered to SGBV and MH survivors who benefited from CBT sessions. A control group of women and men not benefiting from CBT was also included for comparison purposes. The survey⁶ covered 30% of the villages/zones in the three refugee settlements which were purposefully selected to allow for factoring in different contexts such as; remoteness (distances away from service centres), level of service coverage, performance (best and worst performing villages), longevity in the project and ethnic composition among others. From the total project beneficiaries 3600 (1200 in Adjumani, 1200 in Moyo and 1200 in Lamwo districts). A sample size of 361 respondents was determined using the R.V. Crecy and D. W. Morgan (1970) sample size determination model as indicated below:

Krejcie and Morgan (1970) sample size estimation model was developed using the following formula:

$$S = X^2NP(1-P) / d^2(N-1) + X^2P(1-P)$$

Where: S= required sample size

X² = the table value of chi-square for one degree of freedom at the desired confidence level

N = the population size

P = the population proportion (assumed to be .50 since this would provide the maximum sample size)

d = the degree of accuracy expressed as a proportion (.05)

The sample was divided by three to give sample size of 120 per settlement. For comparison purposes, a control group of 20 respondents was considered per settlement and for each settlement, a list of groups served as the primary sampling framework from which groups were selected randomly. At a secondary level, respondents were selected using simple random technique from each of the selected groups.

⁶ Sample of conceptual framework to be adopted for the assessment

2.4 Preparatory Data Collection Processes

The process of data collection entailed the following components;

2.4.1 Development of Assessment Matrix

An Assessment Framework Matrix to address the key questions as specified in the TOR (**Annex I**) was developed by the Consultants and this helped to further expound on the objectives and scope of the assignment in order to provide a wider interpretation of the assessment parameters, determine data sources and the data collection methods. During the development of the assessment matrix, reference was made to the project indicators in the logical framework. The assessment matrix was also used to inform the development of data collection tools.

In addition, a sustainable livelihood framework DFID (2000) was adopted to guide the assessment process. This framework is in line with the TPO-Uganda/ UN Women logical framework, and focuses on the vulnerability context, transforming interventions and processes that can lead to a desired livelihood outcome (**Annex II**).

2.4.2 Documents review and Design of data collection tools

Closely referring to the assessment matrix and documentary review findings, the Consultants designed data collection tools (**Appendix III**) in consultation with TPO-Uganda staff. This stage involved identifying project performance indicators, developing an analysis plan, identifying respondents, selecting an assessment sample and developing data collection tools. The study methodology was also guided by reviewing relevant project documents that included project proposal, project reports and other policy/technical reference materials.

2.4.3 Recruitment and orientation of Research Assistants

At each of the TPO- Uganda field offices, a team of research assistants (2 females, 1 male) were identified and trained on data collection tools. The criterion for selection was based on key requirements including conversance with the local language, availability for the whole duration of the data collection exercise and possession of basic interviewing knowledge and skills. Gender consideration was also given priority in this selection for both males and females. A pre-test of the survey tool was conducted to assess the appropriateness of the questions, consistency and user friendliness of the tool. Observations and concerns from the process were then used to make final corrections to the tool. Daily data check review meetings were conducted to rectify gaps and ensure consistency. A field survey schedule and guide were developed with clear instructions to the study team for consistency and harmony in the data collection exercise. During the data collection exercise, the Research Assistants were closely supervised by the consultants during the data collection process.

2.5 Data collection and analysis

2.5.1 Quantitative Survey

A quantitative survivor survey was conducted to a total of 360 CBT group members and 60 respondents for control⁷ and results were equally distributed in all settlements.

2.5.2 Qualitative data Collection

The following qualitative methods were used to collect data;

Focus Group Discussions (FGD): A total number of 10 FGDs comprising of 6-12 participants were conducted and participants were drawn from Refugee Welfare Committees (RWCs), Child Protection Committees (CPCs),

⁷ Respondents from the settlements not directly targeted by the TPO project.

Local Council I Committees, CBT groups, TPO-Uganda Social Workers and Clinical psychologists, Prevention of Sexual Exploitation and Abuse (PSEA) taskforce and Volunteer Psychosocial Assistants (VPAs).

Key informant Interviews (KII): A total of 37 KIIs were conducted and these were purposively selected due to their extensive experience on the matters of SGBV/MHPSS and their current roles in the settlement or community. Key informant respondents were drawn from TPO project staff, partner NGO/INGO/ UN Agency staff, cultural leaders, and district officials in the host districts.

Pre and post assessment: In a bid to compare recovery changes realized in the lives of SGBV survivors that can be attributed directly to project interventions, 60 respondents were randomly selected from the sample and baseline data from the project database was compared to end line values. The assessment specifically focused on four parameters that included; anxiety, trauma, depression and general wellbeing.

Observation: The assessment employed observation method particularly with regard to livelihood initiatives undertaken by project beneficiaries. This process mainly involved conducting visits to households of selected beneficiaries to witness the livelihood projects undertaken by project beneficiaries. At health facilities, the evaluation team observed the quality of services being provided to SGBV survivors including taking into consideration whether the environment was conducive or not.

Stories of Most Significant Change: Stories of Most Significant Changes were collected to illustrate and capture the impact of project interventions in the lives of project beneficiaries. Specifically, stories of recovery from mental health disorders, GBV recovery, impact of livelihood on mental health and psychosocial wellbeing and men involvement were collected. Institutional success stories such as PSEA and LCs were also collected. These stories were also used in triangulating information derived from other sources and to provide vital information regarding project outcomes, benefits, lessons learned and challenges.

2.6 Data Entry, Analysis and Quality Assurance

A data excel sheet was prepared to facilitate data entry efforts to ensure that all relevant data was promptly entered, tabulated and analyzed using an SPSS software package. Summaries were generated as frequencies and presented in tabular formats and charts. Content analysis was also applied to qualitative data collected and the data was sorted according to evaluation parameters and results areas. This helped to ascertain the relative occurrence of the responses for the various results. Data interpretation also entailed comparison of baseline results to capture the changes that had occurred in the life time of the project so as to inform development of findings, conclusions, and recommendations.

2.7 Ethical Consideration

The Evaluation team observed ethical standards in data collection process through seeking informed consent from respondents and relevant authorities prior to any interview and also clearly explaining the purpose of the evaluation. The right to privacy and confidentiality was also taken care of in the data collection process.

2.8 Assessment limitations

- 1) It was observed by the assessment team that the project's livelihoods component interventions were relative to the other components quite limited and were only implemented towards the end of the project. This made it difficult to validate as to whether the project's livelihood components had had a significant impact on the mental and psychosocial wellbeing of the project beneficiaries. To address this challenge, the assessment team chose to include respondents from the previous (2018) project cycle that enabled the team to gain insights on the impact of livelihoods on the mental and psychosocial wellbeing of the beneficiaries.

- 2) Given the time available for the assessment team to accomplish the assignment, it became difficult to do a comprehensive assessment on the prevalence of SGBV which should have been done at an inter-agency level and should have drawn a bigger sample not only targeting the SGBV survivors supported by the project. To compensate to this, the assessment team did an extensive literature review on the subject matter and also adopted a perception inquiry approach to gain a more comprehensive picture. This also helped obtain views of many of the SGBV survivors who found it sensitive to discuss SGBV issues especially their own sexual abuse experiences.
- 3) Due to diversity of cultures of the refugees, different languages were being used and this posed a challenge to the assessment team as it required use of multiple translators that slowed down the process. However, the TPO field staff were essential in identifying translators to support the assessment team and with extra effort, the team was able to reach 97% of the planned survey respondents. Amin (2005)⁸ argues that response rate results $\geq 50\%$ are representative of a survey population.
- 4) The team also found some challenges concerning the unavailability of vital data and information. For example the number of SGBV cases handled and referred to other partners could not easily be established. In addition, there was a shortfall in data regarding tracking the impact of livelihood interventions on the recovery of the survivors.

⁸ Amin, M.E (2005). *Social science research, Conception, Methodology and analysis*.
Kampala Makerere University Printery

3.0 Chapter Three: Findings of the Assessment

This chapter discusses the assessment findings on prevalence of SGBV, the immediate outcomes and lessons of TPO psychosocial support model on mental health recovery and the potentials of livelihoods to sustain the recovery for sexual and gender-based violence survivors in Emergency Northern and West Nile Regions.

3.1 Prevalence of sexual and gender-based violence in humanitarian West Nile including forms and linkages with conflict related sexual violence.

In the UNFPA Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (2015), Gender-based violence (GBV) is defined as an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. Globally, GBV as a widespread international public health and human rights issue is gaining attention. In contexts of a humanitarian crisis, many factors can exacerbate GBV-related risks. These include—but are not limited to—increased militarization, lack of community and State protection, displacement, scarcity of essential resources, disruption of community services.

SGBV comes in different forms that includes; Sexual Violence (Rape, child sexual abuse, Defilement and incest, forced sodomy, sexual exploitation/ survival/transactional sex, sexual harassment, sexual violence as a weapon of war/torture); Physical Violence (Physical Assault, Trafficking, slavery); Emotional and Psychological violence (Abuse/humiliation, confinement); Harmful Traditional practices (FGM, Early Marriage, Forced Marriage, Honour Killing/maiming, Infanticide and neglect, denial of education for girls) and Socio-economic violence (Discrimination/denial of opportunities, social exclusion/ostracism based on sexual orientation, Obstructive legislative practice that denies access to enjoyment of rights by say women). It is against this categorization that the prevalence of SGBV in the three settlements was premised.

According to the national prevalence study conducted by the Ministry of Gender, Labour and Social Development in 2008⁹, 39% of women and 11% of men have ever experienced sexual violence and 60% of women and 53% of men have experienced physical violence since the age of 15. The UNHCR Five Year Inter-Agency SGBV Strategy for Uganda (2016-2020) acknowledges that, SGBV in Uganda is a widespread human rights issue in both refugee settlements and among national population and calls for urgent concerted efforts. From documentary review, it is a well-documented fact that both research on SGBV and efforts to prevent and tackle it remain inadequate. Although SGBV is a widespread phenomenon, the prevalence of sexual violence in conflict is increasingly receiving attention in the humanitarian assistance and protection fraternity because of the intricate relationship between the two.

Particularly, refugees are at a heightened risk of SGBV due to forced displacement and other factors. Data from a mixed-method interagency SGBV baseline assessment with more than 1,000 South Sudanese refugee participants conducted in West Nile in August 2015, reflects a disturbingly high prevalence of SGBV¹⁰. At least 44% knew someone who had experienced SGBV in the past 6 months, almost half of which were physical violence. This confirms results of an earlier study that found 45% of the refugee community members being exposed to SGBV since arrival. In general, prevalent forms and types are intimate partner violence (IPV) / domestic violence, physical violence, early/child marriage, economic violence, rape, defilement and other types of sexual violence.

In addition, the same study¹¹, established that perpetrators of self-reported SGBV are 53.5% men, 33.5% women, 10% boy, 2.6% girl and 0.4% humanitarian workers. Confirming a culture of silence, 90% of the respondents perceived that there were community members who did not report SGBV. Reasons given were; stigma, shame, fear of family and distance from services, cost of services and considering SGBV as a private matter. The study

⁹ Ministry of Gender, Labour and Social Development (2008). National Situational Analysis of Sexual and Gender Based Violence and its Impact on Increased Vulnerability of Women to HIV /AIDs in Uganda. Kampala: MGLSD.

¹⁰ ACB (2015). Interagency SGBV Assessment of South Sudanese Refugees in West Nile, Uganda. Kampala, ACB. (draft report)

¹¹ Ibid

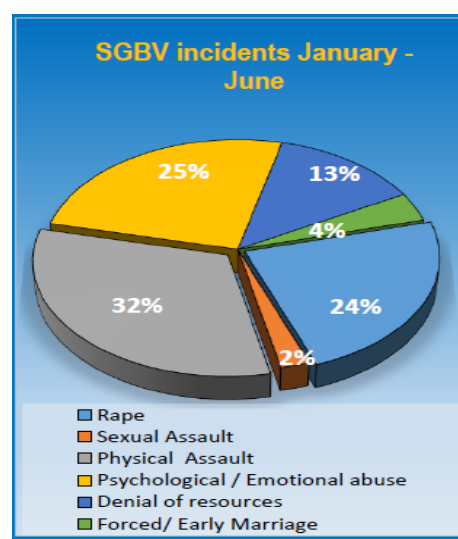
further found many attitudes among the community that endorsed violence as a normal means of men establishing control over their wives and children. Conflict sexual violence, or conflict SGBV, refers to incidences of SGBV that occur during armed conflicts by state or non-state actors, and includes rape, defilement, sexual exploitation as well as early and forced marriages¹².

When dealing with SGBV, it is important to note that most refugees in Uganda originate from countries like South Sudan where they had already grossly suffered from conflict related violence/SGBV, and where justice and law systems were broken or non-existent. Often, more violence is inflicted on the refugees as they flee from their countries of origin. So even if they may be staying in a relatively peaceful settlement context, it is important to consider that such refugees already bear severe effects of SGBV and conflict related violence.

According to the UNHCR 5-Year Interagency SGBV Strategy Uganda (2015-2010), major challenges to addressing SGBV include deep rooted negative attitudes and behaviors in the communities of concern towards gender and power equality. As a result, there is wide-spread acceptance of practices such as forced and child marriage, wife beating and punishment of children by many communities as well as frequent discrimination of SGBV survivors and their families. Under reporting, widespread impunity, inefficiency of the response system also stands out mainly as a result of negative attitudes and behaviors that contribute to a culture of silence and concealment. This is further aggravated by the inefficiency of the law enforcement and justice systems, the lack of access to and quality of response systems, the fear and lack of protection for survivors and witnesses, weak coordination and the overstepping of authority by local and traditional courts engaging in capital offences. As a result, most of the perpetrators go un-punished and impunity is rampant.

At a programming level, the strategy highlights challenges such as poor multi-sectoral coordination between the medical, MHPSS, security and judicial response sectors; Lack of a long-term and coordinated approach to SGBV programming; Gaps in mainstreaming of SGBV across sectors; Weak implementation and gaps in the applicable legal framework as well policies; gaps in resources and capacities, high staff turnover as well as weak and parallel information management systems and data.

Figure 2: SGBV Incidents among Refugees January to June-2019



Findings indicate there was a presence of humanitarian actors led by UNHCR engaged in addressing SGBV in all gazetted refugee camps and settlements in Uganda. According to the Uganda Refugee Response Plan (RRP) 2019-2020 the Performance Snapshot Report across the refugee settlements indicates that 3,788 SGBV survivors (67%) received appropriate multi-sectoral support out of the targeted 5,620 individuals.

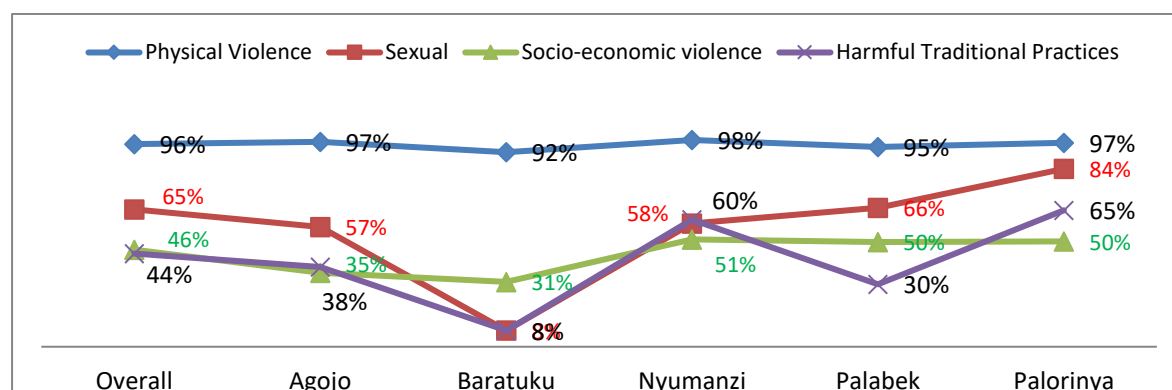
The RRP also indicated that 9% of the victims are male, while the bulk are females. Physical assault (32%), Psychological/Emotional abuse (25%) and Rape (24%) were the most common forms of SGBV reported.

In the assessment survey, when respondents were asked what they perceived to be the most common SGBV form of abuse in their settlement, physical violence stood out to be the most prevalent throughout the settlements with over 90% affirmation. This was followed by sexual abuse which tended to vary from one settlement to another. For example, while Baratuku had only 8%, Palorinya had 84% of the respondents that indicated that sexual abuse was rampant. Harmful traditional practices ranged from 8% in Baratuku to 65% in Palorinya while socio-economic violence ranged from 31% in Baratuku to 50% in Palabek and Palorinya

¹² Lindsay McClain Opiyo and Claire Jean Kahunde (November 2014) Establishing the Extent of SGBV Revictimization among Female Survivors of Conflict SGBV in Northern Uganda Report Summary on a Baseline Study and Pre-Project Assessment on Redress for SGBV on Conflict-Related Wrongs

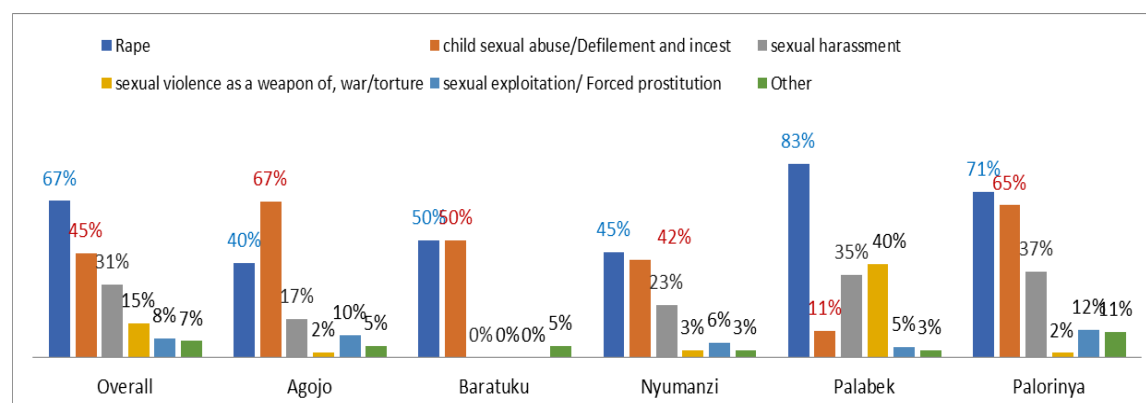
respectively as illustrated in **Figure 3** below. From a programmatic point of view, Palorinya and Palabek still have big intervention gaps.

Figure 3: Prevalence of Violence among Beneficiaries Living in the Settlements



Regarding perceptions about sexual abuse as a form of SGBV, rape or nonconsensual sex stood out to be more prevalent ranging from 40% in Agojo to 83% in Palabek. From FGD interviews, it was explained by respondents that there are high cases of rape in Palabek, this can be partly attributed to the host communities where women get exposed as they search for firewood a very scarce commodity and new refugee entrants with untamed behaviors that come into the settlement.

Figure 4: Perceptions of prevalence of Sexual Violence



Cases of child abuse, defilement and incest tended to rank high ranging from 11% in Palabek to 65 in Palorinya and 67 % in Agojo. In Agojo, it was observed that there were no strong actors implementing child and youth protection type of activities. From FGDs with the RWCs and LCs, it was mentioned that due to cultural and socio-economic pressures, the children and young female adolescents were engaged in illicit sex especially when they went to night clubs and lodges; this was mostly reported in Agojo, where young people had un prohibited access to night clubs and lodges exposing them to risks such as rape, and sexual harassment as illustrated in the quotation below;

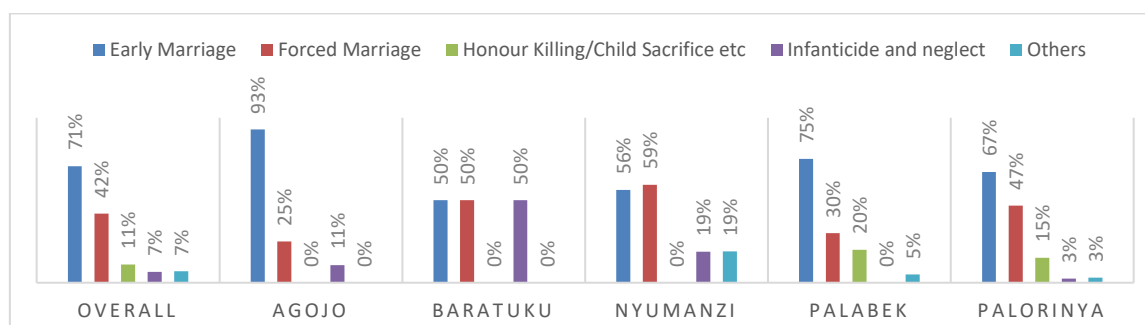
"We have a problem with the youth because there are very few programs to occupy them leaving them redundant. The many lodges and night clubs where youth have access without restrictions including adolescent girls exposes them to alcohol, drugs and sexual abuse...For example there was a defilement case where a boda-boda young man 26 years from the host community defiled a P.6 girl". (KII- Officer in-charge of Agojo Settlement Police Station).

Regarding harmful traditional practices early and forced marriage, ranked highest at 71% and 42% respectively. Early and forced marriage were perceived to be common in many cultures in the West Nile region as it seemed to

be deeply rooted in cultural myths/practices that do not condemn defilement and early marriage. Reference was made to the eastern equatorial tribes where girls are booked for wives at the age of 6 years and marriage at 12 and 15 years. This was viewed as contradictory to UNCRC and Uganda Laws. In a report made for World Vision¹³; it was observed that in some communities such as the Lugbara in Uganda and also among the Bari people group in South Sudan had a practice of forcing young pregnant girls into marriage with their abusers to avoid family calamities such as; accidents, snake bites, or even death. A forced early marriage also brought prospects of dowry, that made it difficult for cases to be reported to the police and seek redress as quoted below;

"I was raped by a man and got pregnant; my parents reported the case to the Police, however, on learning that I had conceived from the rape, my parents instead preferred that I get married to the man in exchange for dowry. Despite the fact that I got mental distress from the rape, I am still in this marriage and have even had a second child." (Interview with a 21-year-old SGBV survivor in Agojo Settlement.)

Figure 5: Forms of Harmful traditional Practices



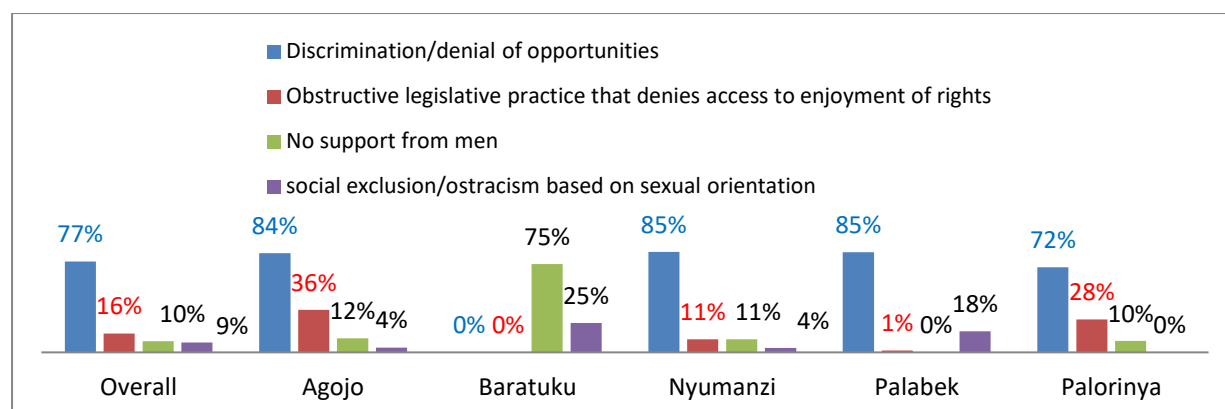
Child neglect was common both in the refugee and host communities but for different reasons. Among the refugees, it was noted that most of the households were headed by women and the elderly while most of the men had stayed back in South Sudan or frequently returned to check on their properties and farms. It was also noted from the FGD discussions that many household heads including women also frequently made trips to other settlements or even back to Sudan leaving the children unattended. As a result, many children were living as child headed families for long periods thus exposing them to a range of protection risks. From the host community, it was reported that many men abandoned their families to cohabit with refugee women motivated by the fact that the refugees were benefiting from a range of relief items especially food.

"My neighbor always leaves her children alone at home as she goes dancing. The children are left with no food to eat the whole evening and I am the one who gives them something small to eat..." (Female Survivor in Palorinya Settlement.)

In regard to social economic deprivation, 77% of the respondents mentioned discrimination and denial of opportunities as the most common of abuse followed by obstructive legal practices that deny access to employment at 16%. In communities that are largely patriarchal, many roles especially productive work and property ownership are segregated by gender. In Baratuku though, it was noted that due to the harshness of the environment, poor road network and a history of flooding, many of the refugee families registered there, were actually not staying in the settlement but only occasionally converged to pick their relief rations. This implied that only the very poor and vulnerable households usually headed by women that had no alternative stayed in the settlement and perhaps had little choice on the type of activities that they did for subsistence.

¹³ Documentation of Lessons Learnt on "Enhancing Child Protection through Accelerated Community Action to End Child Marriage and Strengthening Community Coping Mechanisms for Children Affected by the South Sudan Refugee Crisis Project in Arua, Yumbe & Adjumani Districts October 2018.

Figure 6: Social economic deprivation



Access to productive assets, work and income generating opportunities was highlighted as one of the causes of SGBV especially domestic violence. In the refugee settlements, many men who commanded a lot of respect and status and were in control of household livelihoods find themselves redundant and powerless in the refugee settlements. This is exacerbated by the fact that many Humanitarian actors including those providing relief assistance such as food, tended to focus and deliver their support through females.

"We have had challenges with all the support given to us going through women alone. For example, brewing of beer is one of the common incomes generating activity that women participate in and sorghum provided by WFP is one of the raw materials. Therefore, the rations are diverted or sold to the host communities leading to fights in the home." Alcohol which is brewed by women has also been a strong factor in causing domestic violence given that the many men are redundant and do not have money to pay for the alcohol." (KII male survivor in Palorinya settlement)

It was further noted that men and women lost their riches (Cattle, businesses, land and other properties) from the war back home during the conflict and have not been able to replace them. This has caused more imbalances in power parity and thus leaving the men feeling unrecognized as they try to make ends meet. And as a result, this has caused more violence in form of assault and abuses.

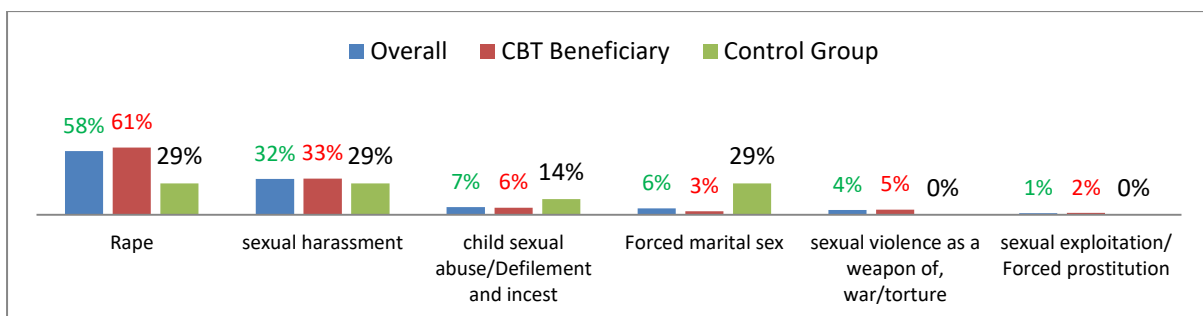
"The lack of engagement in economic activities for men in the refugee settlements makes them dependents on their wives for survival and loans. Again, this is one of the main causes of SGBV especially when the men fail to pay back. There is therefore great need for the Humanitarian actors to plan programs that economically empower men." CDO Palabek Kaal Sub-County.



Preparation of locally made brew from where women earn some income, but was mentioned as a source of violence between men and women.

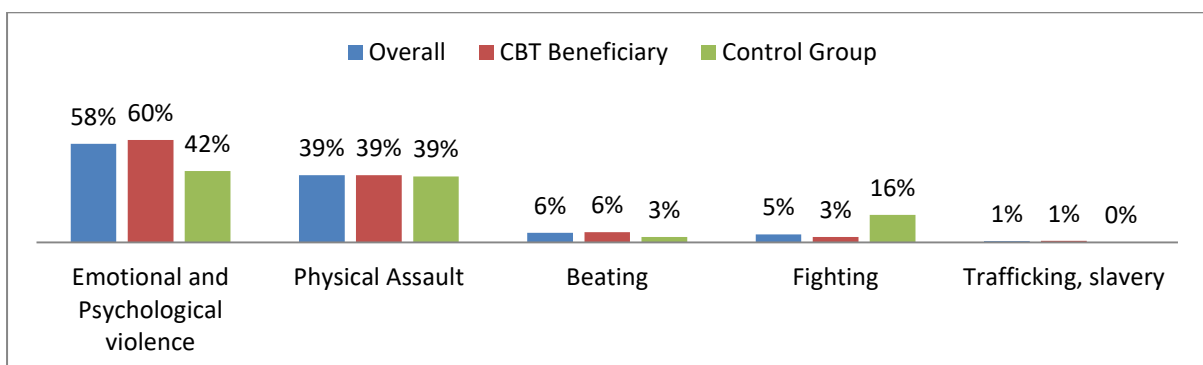
As indicated in **Figure 7** below, rape featured as the most prevalent form of SGBV suffered by the project beneficiaries (61%) compared to 29% of the control group. The implication of this finding is that beneficiaries that had suffered rape were more likely to seek for support compared to the other forms of sexual abuse, especially sexual harassment.

Figure 7: Forms of SGBV suffered by project beneficiaries



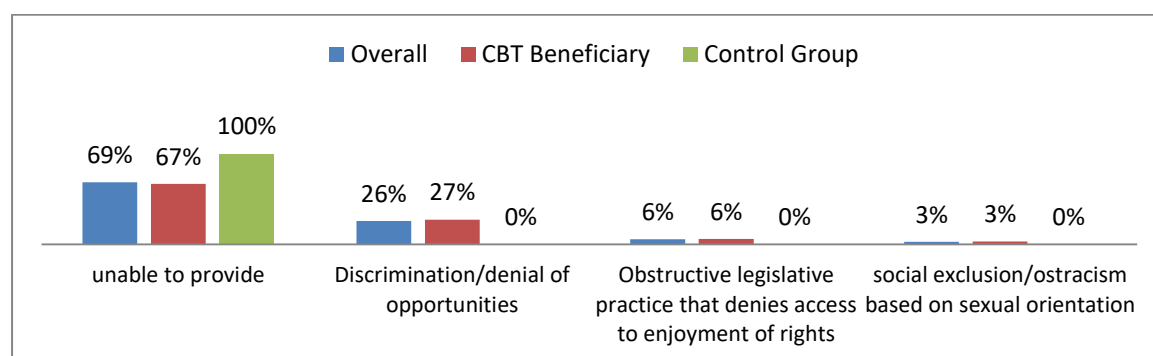
Emotional and psychological violence ranked highest with 60% of the CBT beneficiaries compared to the 42% of the control group mentioning that they had been victims of this form of abuse. This was followed by physical assault and related forms of abuse such as beating and fighting.

Figure 8: Forms of Physical and emotional violence.



Regarding socio-economic violence the inability to have means to provide for personal or household sustenance stood out as the main form of abuse, followed by discrimination or denial of opportunities as illustrated in the **Figure 9** below;

Figure 9: Socio-Economic Violence

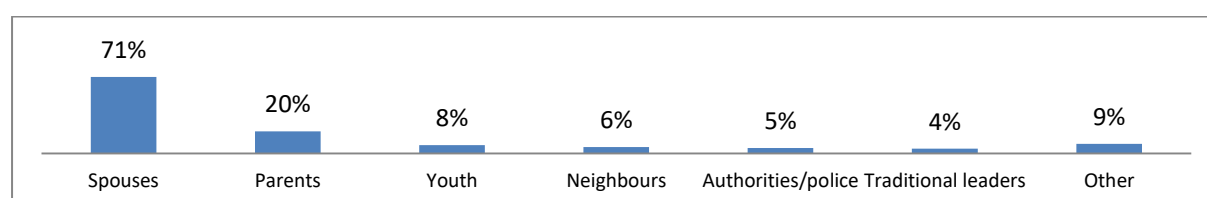


The above findings are corroborated by data obtained from the Uganda Police (CFPU) officers in Lamwo-Palabek and Obongi- Palorinya settlements showing that domestic violence and assault ranked high for example out of 96 cases in Palabek, 26(27%) were domestic violence while 19(20%) of the reported cases were on assault. In Palorinya, although the percentage of domestic violence was much lower, 193(60%) were cases of assault reported. Defilement cases in Palorinya, were also high at 44(14%)

Perceptions regarding who the main perpetrators of SGBV were, indicated spouses (71%), parents (20%), youth (8%), neighbors (6%) and persons of authority such as the police and settlement administration (5%) and traditional leaders (4%). Perpetrators grouped under 'others' included; teachers, drunkards and family members. The main implication of this finding indicates that most SGBV happens in a context of a family or household and it is therefore important to take this into consideration when designing SGBV interventions. In addition, it is important to consider involvement of men and boys in any SGBV interventions. In patriarchal societies, men in particular are not only the key vanguards of culture (including negative practices) but also take advantage of their positions of power and privilege to perpetuate abuse against women, girls and boys.

"Men are the main perpetrators of SGBV especially defilement and rape. Unfortunately, it is difficult to apprehend them since after committing crimes; they cross back to South Sudan or seek protection from their families and clans. It is also common for the abusers to relocate and re-register in as new refugees in other settlements." (Child and family protection Unit Officer In charge-Palabek settlement. Police Station).

Figure 10: Perpetrators of SGBV

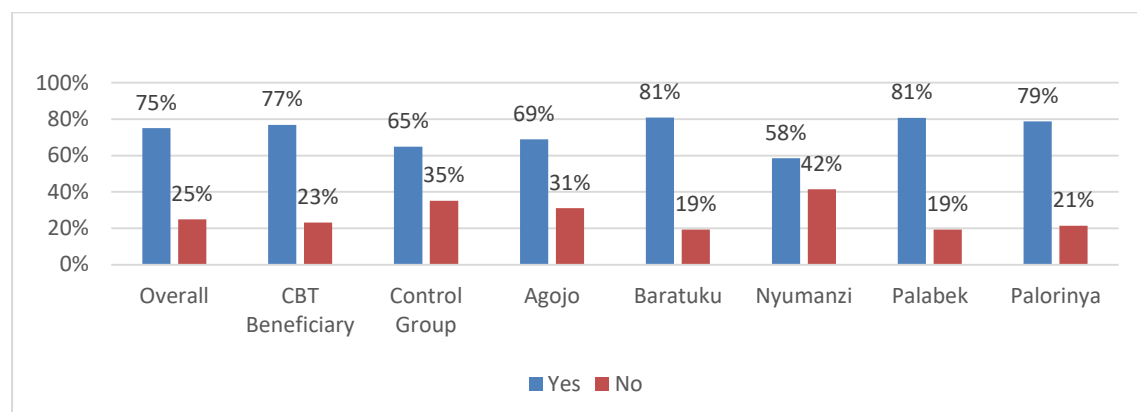


Equally, given that many of the cases of SGBV are rooted in cultures of refugees and host communities, engaging change agents such as local chiefs and religious leaders who can influence cultural practices is also important. As a good practice, it was observed, that TPO-Uganda had already moved in this direction by supporting the formation of male groups such as "Salvation group" in Palorinya-Obongi and involving spouses in CBT.

When the respondents were themselves asked if they had themselves been victims of any form of SGBV or from psychosocial distress, 75% said yes while 25% said no. Incidents of SGBV ranged from 58% in Nyumanzi to 81% in Baratuku. This high level of prevalence is not reflective of the refugee and host community populations since it

was extracted only from women recruited by the project where having been a victim of SGBV was one of the inclusion criteria. Findings however also validate the fact that targeting by the project was mainly focused on SGBV Survivors.

Figure 11: Prevalence of SGBV among Project Beneficiaries



When respondents were asked to state when the SGBV abuse happened, only 5% mentioned that the incident happened in South Sudan or before 2016. The assessment team observed that 2017 had a high percentage of SGBV cases (32%) and this could be attributed to an increased inflow of the refugees following new outbreak of conflict in South Sudan. This was immediately preceded by a drastic fall to 13% in 2018 and resumption of rising cases from 2018 to 2019. This trend corroborates with the data tracking the inflow of refugees from South Sudan which indicates a rise in the number of refugees crossing into Uganda from 2018 and has continued to rise in 2019 as illustrated in the **Figure 12** below;

Figure 12: When SGBV Abuse Incident Happened

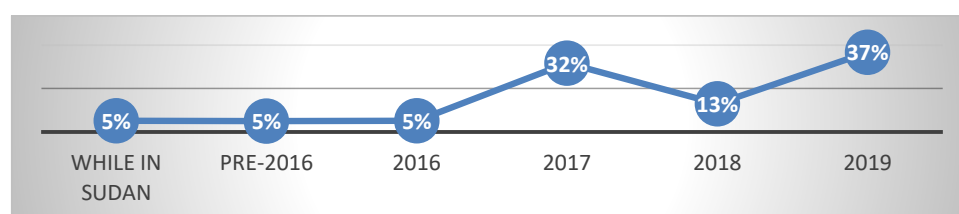
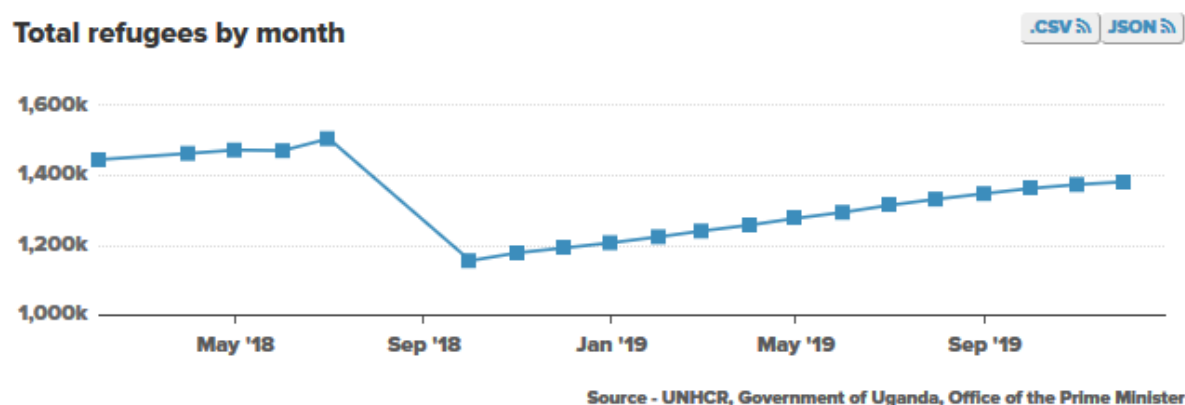


Figure 13: Trends of Refugee influx



It is important to note, that in settlements because of the high level of sensitization and community dialogue about other forms of SGBV other than sexual abuse, the high indication of prevalence of SGBV could be more as a result of awareness of SGBV broadening the forms of SGBV to even include social and economic abuse, that would never have been raised by the survivors before being enlightened and empowered. For example, through FGDs, participants confessed that some of the culturally accepted SGBV abuses especially early/forced marriage, wife beating and rape within marriage among others were hardly recognized especially back home in South Sudan. The respondents also revealed that observance of the Ugandan Laws and propagation of women and children rights were very important factors in raising awareness and vigilance against SGBV. The figurative representation in the upwards trends of SGBV, may actually be a reflection of increased awareness and reporting.

SGBV Humanitarian Actors should explore intervention approaches that can impact on the negative cultural myths beliefs, and practices without running the risk of contradicting the Core Humanitarian Standards (CHS). For example, using the Human Rights approach may help focus on the need for communities to respect, protect and fulfill the individual rights of especially women and children. Such interventions should specifically have provisions for strengthening the capacity of legal duty bearers such as local government, settlement administrators and the police. In respect to the Police, it was observed that most police officers were in need of further training in SGBV and that there was need to support community policing approaches to deal with issues such as low resource base and being seen on the ground.

Description of SGBV Actors and Interventions: The assessment observed that there were a number of SGBV Humanitarian actors in all the three locations covered by the assessment. Relative to other sectors, it can be deduced that the SGBV sector was better covered at least in a numerical sense as is illustrated in the table below;

Table 1: Distribution of Health/Nutrition, Livelihood and SGBV actors by location

District	Health and Nutrition ¹⁴	Livelihoods	GBV
Adjumani	05	11	07
Lamwo	07	07	09
Obongi	07	07	09

Source: UNHCR Data Portal

In the three settlements apart from TPO-Uganda, other humanitarian actors in SGBV/MHPSS included; LWF, IRC, ARC, AWYAD, Healer Uganda, Live Again Uganda, Thrive Gulu, MTI, CARE, WV, War Child Canada¹⁵, Refugee Law Project-Makerere University, Tutapona, WV and Save the Children among others. It was noted that these different SGBV/MH actors were allocated to different zones of the settlements and were implementing a range of interventions that included awareness raising, distribution of dignity Kits, lanterns, establishment of protection house and complaint desks, legal aid services, psychosocial first aid (PFA), medical treatment, establishment and training of community structures (e.g. PSEA, CPC, SGBV Task force) using approaches like SASA, functional adult literacy, commemorating international days like 16 days of activism and World Refugee Day and installing security lights at risky points among others. The local governments through the probation and welfare department and the Uganda Police –Child and Family Protection Unit (CFPU) also played a crucial part in supporting SGBV/MH survivors. In collaboration with OPM and UNHCR, the SGBV/MH actors at the different settlement locations had also developed Standard Operating Procedures (SOPs) and Referral pathways.

According to UNFPA Minimum Standards for Prevention and Response to SGBV in Emergencies (2015); A referral pathway is a flexible mechanism that safely links survivors to supportive and competent systems of care, such as medical care, mental health and psychosocial services, police assistance and legal and justice support. Referral systems should be established based on a coordinated mapping and/or assessment of services and understanding of actors' capacities. The quality of services should also be documented and monitored over time to ensure they are functional and meet minimum standards of care, in line with the GBV guiding principles. It is important that referral systems prioritize survivor safety and confidentiality and respect survivors' choices, recognizing that even with all services in place, survivors may still choose not to access care.

¹⁴ MHPSS Actors included under Health

¹⁵ For access to Legal services

Figure 14: SGBV Referral Pathways



In regard to TPO programming, it was observed that the intricate relationship between SGBV and MHPSS was taken into consideration and was being addressed mainly by focusing on dealing with the psychosocial distress resulting from SGBV by addressing it through the CBT approach, counseling and clinical psychology treatment and support. Other issues such as legal redress and livelihood for SGBV survivors were mainly referred to other actors although it was noted that there was need to strengthen documentation, tracking and follow up of cases referred.

Although in all settlements there were Inter Agency SGBV working group, collaboration needs to be strengthened since it was observed that there was a tendency for the different SGBV actors to be 'protective' of 'territories' allocated to them hence stifling collaboration and coordination.

SGBV Programing Challenges

The assessment team through documentary review and KIs identified a number of challenges affecting the effective implementation of SGBV interventions. Below is a compilation of challenges put together by UNHCR and its SGBV partners which in the opinion of the team was more comprehensive¹⁶.

Table 2: Challenges to SGBV programming in Refugee and Host Communities

- **Underreporting of SGBV cases** due to fear of reprisals and/or mistrust on getting supported if reported.
- **Limited staffing at government facilities and police posts** continues to affect service access by survivors.
- **Increasing mental disorders and excessive alcohol abuse** compounded by inadequate mental health interventions.
- **Limited access to basic necessities** including sufficient hygiene kits leads to negative coping strategies that increase the risk of SGBV.
- **Partners' financial constraints leading to reduction in staff physical presence at the field**, support to SGBV community structures, material support at the women centres and routine SGBV

¹⁶ UNHCR Monthly Protection Update Sexual and Gender Based Violence (SGBV) September 2019

awareness activities. This results in reduced SGBV case intake and community engagement. Efforts are being made to strengthen the capacity of community structures to ensure sustainable approaches for SGBV prevention and response.

- **Access to justice for SGBV survivors** is still a gap with inadequate knowledge and support for legal processes, logistical support to police for timely case management support and rejection of medical examination (PF3 filled) by non-governmental health facilities. Efforts are being made to engage district health officers, police and court to harmonize medical examination practices.
- **Girls have limited access to secondary school education.** This is propagated by various factors that increase the dropout rate of school girls further contributing to the risk of child marriage and other forms of SGBV.
- **Release of perpetrators** without proper community sensitization which jeopardizes the safety of survivors and reporting of SGBV cases.
- **Limited socialization opportunities in refugee settlements** leading youth to resort to Video Halls for entertainment. Communities have identified these spaces as hot spots for SGBV. There is an urgent need for alternative recreation opportunities that enable youth engage in constructive and meaningful ways.
- **Reduced access to** vocational trainings and livelihood opportunities increases vulnerability of women and girls to sexual exploitation and abuse.
- Inadequate counseling space (outreach programme) for GBV and other critical protection cases
- **Inadequate support for the police, Probation and Social Welfare Department** during case follow-up.
- **Some Refugee Welfare Council (RWC's) are surpassing their jurisdiction** and managing cases outside their limits. There is need for capacity building training for community leaders on case management
- Resources for capacity building of the community-based structures to enhance SGBV prevention and response are poorly facilitated. This creates gaps in SGBV identification and reporting.
- There is a gap in male engagement and support to male survivors by partners being exhibited by the lack of comprehensive case support and follow up on male survivors and low engagement of men and boys in routine SGBV prevention activities.
- Long distances to food distribution increases risks of exposure to SGBV.

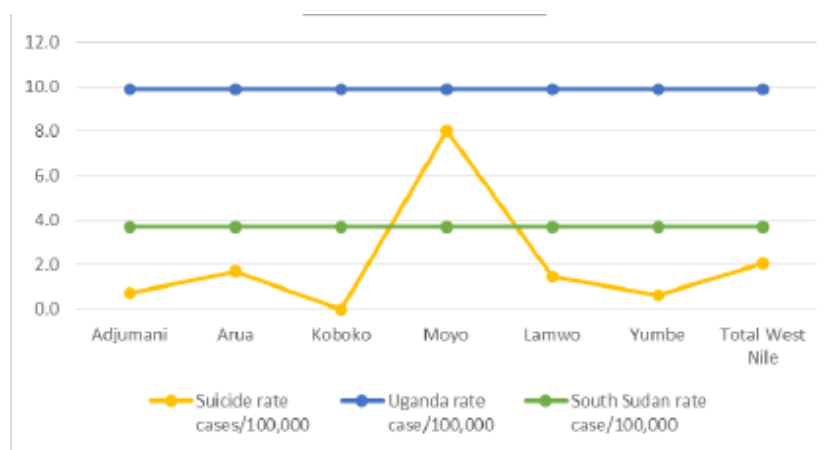
3.2 MHPSS Dynamics around SGBV and Conflict-Related Sexual Violence among Refugees in Relation to the MHPSS Interventions by TPO Uganda

The Inter-Agency Standing Committee IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) define MHPSS as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder¹⁷. There exists a strong intricate relationship between SGBV especially conflict-related sexual violence among refugees and their psycho social wellbeing and mental health. As is observed in the IASC MHPSS Guidelines (2007), armed conflicts cause significant psychological and social suffering to affected populations and although, these impacts may be acute in the short term, they can also undermine the long-term mental health and psychosocial well-being of the affected population.

A recent WHO study estimates that one in five people in (post)-conflict settings suffer from depression, anxiety disorder, PTSD, bipolar disorder or schizophrenia¹⁸ WHO therefore asserts that the need for mental health and psychosocial support (MHPSS) in the context of forced and protracted displacement is immense and needs to be responded to in a comprehensive and coordinated manner; and that Mental health and psychosocial problems pose a threat to individuals, families and communities and can result in immediate, mid- and long-term consequences (including significant intergenerational effects).

In the Uganda Refugee Response, it is rightly recognized by humanitarian actors that there are high needs for MHPSS amongst refugee communities. For example, during the joint inter-agency Multi Sector Needs Assessment (MSNA)¹⁹, 22% of refugee households reported that at least one member was in psychological distress or scared. The same study also identified poor psychosocial functioning among children, associated with poor community child protection structures and issues such as mistreatment and neglect of (foster) children, early marriage or teenage pregnancy.

Figure 15: Comparative Analysis of Suicidal Rates in the Settlements in Uganda and South Sudan



Needs for MHPSS were similarly identified by refugee communities during the 2018 participatory assessment. Participants highlighted an increased rate of suicides and mental health disorders amongst refugee communities, combined with a lack of or limited access to MHPSS services in some refugee-hosting locations²⁰.

According to this study, generally, it was established that suicidal rates in refugee settlements were less compared to host communities and within the country of origin (South Sudan). In Palorinya Settlement, 42 cases (29 attempted suicide, 13 complete) were recorded between January-September 2019. Implications from this finding

¹⁷ Although the terms mental health and psychosocial support are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches. Aid agencies outside the health sector tend to speak of supporting psychosocial well-being. Health sector agencies tend to speak of mental health, yet historically have also used the terms psychosocial rehabilitation and psychosocial treatment to describe non-biological interventions for people with mental disorders (IASC 2007).

¹⁸ 'New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis', The Lancet vol 394, issue 10194, p 240-248, 20 July 2019.

¹⁹ ACB (2015). Interagency SGBV Assessment of South Sudanese Refugees in West Nile, Uganda. Kampala, ACB. (draft report)

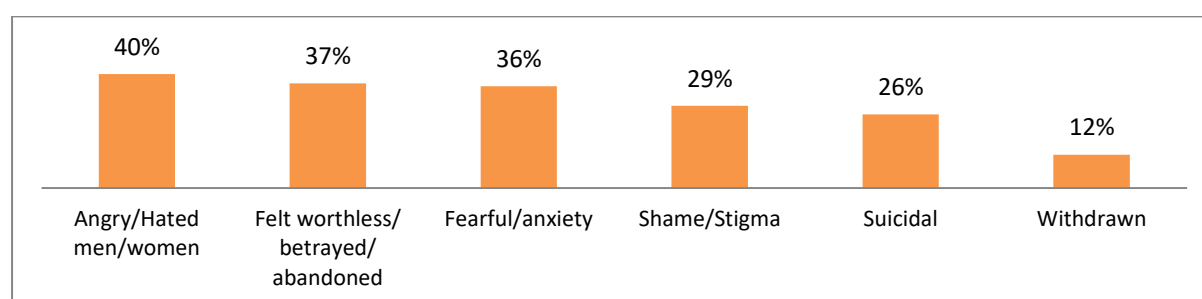
²⁰ Interagency assessment of measures, services and safeguards for the protection of women and children against sexual and gender-based violence among refugees in Uganda (UNHCR/OPM 2018)

suggest that the MHPSS interventions among the refugees were effective in reducing the incidence of psychosocial distress and mental health disorders, compared to host communities where MHPSS interventions were very limited or absent.

As already more exhaustively discussed in the preceding section of the report on the prevalence of SGBV, it was established that SGBV and conflict-related sexual violence were among the main causes of psychosocial distress and mental health disorders. In a number of interviews, it was noted that men, women and children observed gruesome murder/ rape/defilement of the relatives used as a weapon of war. The memories of such sights carry bad dreams, thoughts and feelings that have caused mental distress.

In **Figure 16** below, 40% of the SGBV survivors interviewed for the survey indicated that they had developed anger and hatred, 37% felt that they were worthless, betrayed, and/or abandoned. 36% felt fear and anxiety. 29% shame and stigma. 26% had suicidal tendencies while 12% felt withdrawn/isolated.

Figure 16: Psychosocial effects of SGBV



The percentage of survivors exhibiting suicidal tendencies among the project beneficiaries appears high at 26% perhaps due to the fact that the sample population was drawn from CBT attendance and not from the general population. So, it is likely that being a victim to SGBV was a motivating factor for beneficiaries to enroll in the CBT program.



TPO-Uganda Project Officer in Lamwo District with Volunteer Psychosocial Assistants (VPAs) who were a critical community structure towards the success of the CBT Model.

On the whole, it was observed that MHPSS was the main thrust of the project and clearly this is where TPO-Uganda had its niche and comparative advantage. This project in particular, integrated SGBV as a component of TPO's MHPSS programming. In **Table 3** below; shows activities achieved against planned targets which indicate that the project was successfully implemented except for activities such as post-treatment assessment for women who complete CBT sessions and family mediation and home-based care which were on-going by the time of the assessment.

Table 3: Project Planned activities Versus Results Achieved

Activity	Target	Achieved	%	Comment
Provide Psychological First Aid for new arrivals at boarder points	800	823	103%	Target exceeded. Palabek settlement in Lamwo District received new refugees.
Train PSS Assistants Volunteers in Basic Psychosocial helping skills and concepts of GBV	12	12	100%	Activity achieved as planned.
Screen women for SGBV and stress related disorder	3600	3200	89%	On track: Activity Partially achieved and slowed by limited timelines.
Select and provide advanced PSS (CBT) to women who post clinically have significant scores for stress related disorders	3000	3000	100%	Activity achieved as planned. A total of 250 groups on CBT graduated. Post assessment on-going to establish levels of recovery.
Post-treatment assessment for women who complete CBT sessions.	3000	2084	69%	On track: Activity Partially achieved and slowed by limited timelines. On-going
Carry out family mediation and home-based care	1200	615	51%	Activity partially achieved: It's on-going.

As regards to increasing access to quality PSS and trauma care services for survivors, TPO effectively implemented the CBT approach which was the main service delivery strategy for TPO-Uganda. Through the CBT model, TPO was able to reach 3,000 survivors organized into 250 CBT groups across the three settlements. Each group was made up 12 survivors who underwent therapy sessions over a 10 weeks period. The sessions facilitated by TPO social workers/Clinical Psychologists covered; psycho education, relaxation exercises, trauma narrative, skills building to face fears, co-joint session on involving other family members and enhancing coping mechanisms, managing anger session as well as a complementary parenting session which was very much appreciated by the participants because of its relevance.

Other activities that the survey respondents indicated that they had participated in included; stress management techniques, trauma sharing and management, anger management, body exercise, home visits, forgiving sessions, sharing problems and ideas with other members, music dance and drama, peer to peer support advice, conflict management, peace building sessions, and mediation, storytelling and experience sharing, children protection and First Aid among others.

TPO was acknowledged as the leading psychosocial support service provider in the three district settlements, and host communities among partners. Satisfaction and appreciation of TPO interventions in trauma care, SGBV prevention and response was expressed at all levels as elaborated below;

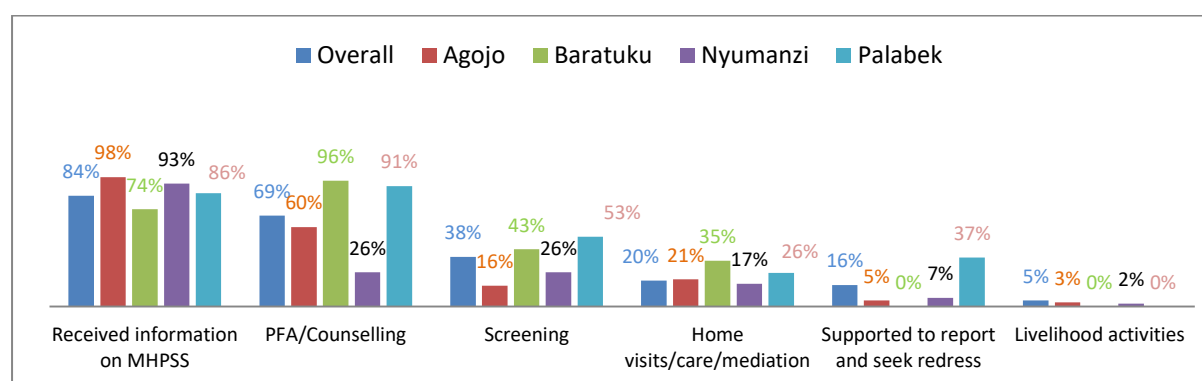
"TPO-Uganda is visible in MHPSS, creating awareness about GBV, case identification, referral and response. TPO-Uganda is a key partner right at the boarder entry, they help in screening the refugees. TPO's Cognitive Behavioral Therapy (CBT) has greatly helped the survivors to share testimonies for peer support, they have helped us reduce alcohol taking in the settlement and have introduced livelihoods to facilitate survivors' recovery

from traumatic experiences as they engage meaningfully in productive activities. We encourage other partners to explore the use of CBT model because it has been effective on MHPSS". (Protection Assistant OPM, Palabek Settlement.)

The assessment findings showed that TPO carried out Psychological First Aid (PFA) for new refugee entrants at the boarder points particularly in Palabek Settlement in Lamwo which continues to receive new refugees. According to project staff, this process was an ice breaker for TPO to initiate subsequent SGBV/MH interventions within the settlements. Psychosocial First Aid also created rapport and provided necessary information about available services including CBT for the persons of concern. Refugee Welfare Committee, LCs, Counselors and friends also played a key role in providing relevant information and enhancing referral.

The findings showed that 84% of the respondents indicated that they received information on mental health issues. 69% had received PSS first Aid/counseling from TPO social workers. 38% screening, 20% home visits/care/mediation and 16% were supported to report and seek redress and only 5% had received support in livelihoods. In **Figure 17** below, fewer respondents from Baratuku (74%) reported that they had received information on MHPSS. Nyumanzi on the other hand reported a much smaller percentage (26%) of the beneficiaries who had received PFA/counseling compared to Baratuku (96%) and Palabek (91%) at the time of the assessment. Palabek had a high percentage of beneficiaries that reported (53%) screening compared to the rest of the settlements because as already reported, TPO was engaged in continuous screening of new arrivals at the point of entry.

Figure 17: Mental and psychosocial services offered by TPO



Other types of support included Livelihood activities (5%), material support (4%), medical assistance (2%) and referral to other service providers (2%) and financial assistance (1%). Livelihoods are discussed in detail under objective 3. From the assessment survey, it was established that TPO had successfully helped many SGBV survivors to recover from psychosocial distress and mental health disorders and to resume their normal social functioning.

The assessment team observed that TPO carries out pre and post SGBV/MH survivor screening to assess the level of recovery for clients recruited into the CBT process. Screening is used as a method for admission of survivors for CBTT, case management, referral, follow up and graduation. With the support of the TPO Clinical Psychologists, the assessment randomly selected 60 survivors among the survey sample in Lamwo, Adjumani and Obongi districts for analysis using four indicators that included: anxiety, depression, trauma and general well-being. Below is a **Table 4** that summarizes the pre and post recovery rating;

Table 4: Results of recovery for selected SGBV survivors

Settlement	Anxiety		Depression		Trauma		General wellbeing	
	TPO Pre-Test	TPO Post-Test	TPO Pre-Test	TPO Post-Test	TPO Pre-Test	TPO Post-Test	TPO Pre-Test	TPO Post-Test
Agojo	36%	3%	31%	1%	39%	1%	75%	8%
Oliji	32%	10%	38%	6%	31%	7%	70%	12%
Palabek	73%	38%	69%	27%	61%	30%	70%	29%
Parolinya	75%	1%	65%	2%	59%	1%	80%	2%
Overall	61%	15%	55%	10%	53%	11%	75%	13%

Source: TPO-Uganda MHPSS MIS 2019

Across the four parameters, Palorinya and Agojo, exhibited the most significant change with almost all SGBV/MH disorder survivors showing full recovery. Palabek on the other hand, exhibited a high percentage in post assessment and this is attributed to the fact that Palabek is the newest of the three settlements and still receives new refugee entrants. Regarding social functionality from the survey, respondents were asked to assess themselves on a scale of 1-5 concerning their recovery along five parameters that included; Functioning, Subjective well-being, Mental Distress, Social behaviour and Social connectedness.

Table 5: Assessment of Client Wellbeing

#	Dimension	Scale				
		1	2	3	4	5
1	Functioning	0%	5%	18%	39%	37%
2	Subjective well-being	1%	5%	16%	36%	42%
3	Mental Distress	1%	6%	14%	34%	46%
4	Social behaviour	1%	3%	12%	34%	50%
5	Social connectedness	1%	2%	7%	31%	58%
Overall		1%	4%	13%	35%	47%

Findings from this process indicate that overall, 47% of the survivors rated themselves to be fully recovered while only 5% felt that they still had bid functionality issues across the board. Social connectedness at 58% was the area that most survivors felt they had improved. This achievement is commendable and attributed to CBT group approach which should be recommended for replication in similar conflict related situations.

Case Studies for Successful Stories of Recovery

TPO/UN Women Project Restored me from Dark Days to Light: The story of Tulia John a PVA Palabek Settlement.



Am called John Tulia,30 years, a father of two children, I left my family behind. I came from South Sudan to Uganda after the 2013 war. I had a flourishing business which I lost during the war. Life in the settlement at first was hopeless, people used to kill others and suicide cases were common. Police used to come in the morning till evening to subdue crime. Because of trauma I resorted to alcohol. Since I lived alone with nobody to care I almost ran mad. At one time I was imprisoned in Kitgum for 3 months.

My turning point was when I became a translator for TPO and later, I became a Psychosocial Support Volunteer Assistant (PVA). TPO removed me from dark days and restored my life" I am now a resource person and the eye of the community, I identify people with mental health issues, and other health challenges and refer them to health facilities for treatment and care. SGBV is still present, you hear of women and men fighting in homes over marital rape, selling of food and using all proceeds to buy alcohol. The men are also facing violence from women and my role is to mediate and call TPO staff to come in where cases are more complex. TPO and

other NGOs tend to focus on women and men have no voice. Let TPO continue the good work on MHPSS and SGBV response and strengthen collaboration with legal projects to access services for survivors.

"I Survived Forced Marriage-TPO/UN Women Empowered Me as a Community Leader" A Narrative by Abuk Elizabeth Dau, Nyumanzi Settlement.



It is a cultural belief and practice in South Sudan for young girls to be forced into marriage so that their families get herds of cattle. When I was a girl still in school a man was designated by my parents to marry me but didn't like him. I presented my own man-the one I loved but he was rejected. I moved out with my man. My husband got a job and we gave birth to our first child. When the war broke out, he lost the job and we came to Uganda- Nyumanzi Settlement. With my Senior Four Certificate, I secured a teaching position with Window Trust School but the pay was meagre, then moved on to LWF as an Incentive Worker.

Later I joined TPO/UN Women Project as PSS Volunteer Assistant (PVA) I received -3 days training in MHPSS and SGBV and my role as a Community Leader entails; translation for TPO field staff during CBT sessions, community mobilization and awareness creation, I counsel women undergoing problems and refer more complex cases beyond my ability to TPO staff (John) who in turn works with other organizations to handle such cases. Am proud because TPO/UN Women Project has given me confidence and guidance on how to handle life challenges. I can do better for my children's education. I have hope about life now. I like the project because it brings together women of different ages to learn and support each other. Women have learnt to control their anger. In the past women used to take a lot of alcohol and fight but this has greatly reduced. Previously, we used to get 10-15 cases of GBV in a month, but nowadays get like 5-7 cases. Women now know their responsibilities at home level. It has made us to be happy to know our roles like taking our children to school, feeding children, maintaining good hygiene and sanitation in our homes.

I appreciate TPO/UN Women for the good work but request the following: a) I request TPO to give me a book, pen to facilitate my reporting and bag, b) We need more CBT groups because more women have expressed a need to join at least add 4 groups to the current 11 for my block, c) Can add two staff to support John, 7 blocks are too big to be handled by one person, d) strengthen livelihoods aspect by building business skills of survivors and start up grants to keep women busy not to relapse and for self-reliance and e) My kind request is that the same program for men is considered. Men need counselling because, some think if they drink alcohol problems will disappear. Men beat women thinking that it's a solution. If TPO/UN Women Project bring men on board it can reduce SGBV. I am called Abuk Elizabeth Dau, 26 years mother of three (6, 4 and 2 years)

"TPO/UN Women Message of Hope Saved Me from Committing Suicide"-Ajieth Malual Deng, 68 Years Nyumanzi Settlement.



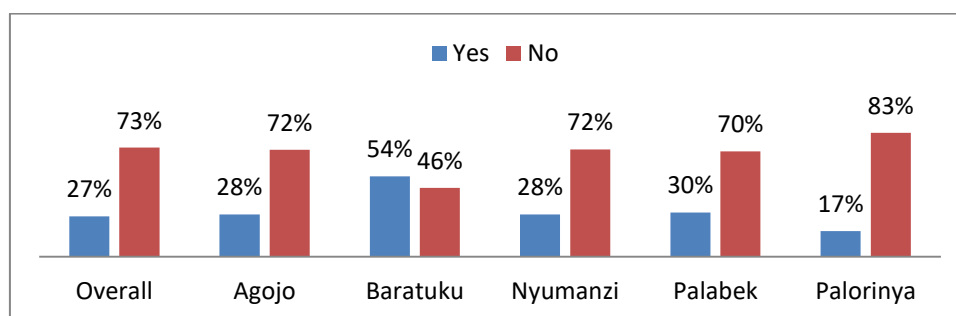
My life was full of problems. I took care of two orphans who lost both their parents in South Sudan during the war on top of my own children that made a total of 9 members, a very big family size. When we crossed to Uganda and started living in Nyumanzi Settlement my husband who was alive later passed on. I would think a lot, get confused and started thinking about committing suicide. I doubted how I could manage such a big family alone as a widow with no source of income and very small food rations. That was around the same time when TPO/UN Women team came to Nyumanzi settlement and mobilized us to form groups. They started teaching us how to overcome life challenges. From there I appreciated that life in a long journey with ups and downs- taking one's life (suicide) is not a solution. Our minds in South Sudan were contaminated with a lot of problems and TPO/UN Women role was to help us clear our past and start new beginnings with hope. If TPO/UN Woman had not come I would be long dead. You wouldn't have found me alive.

I am proud about TPO/UN Women because their message of hope saved my life. Being with the Orphans and caring for them is a better option I took. I know that If I have life and work hard do a small income generation activity and can support them. I have grown some vegetables like sukuma wiki, egg plants in the backyard of my hut and if someone gives me money, I can sell some and use the rest for our home consumption.

I advise women going through such problems like mine of caring for many orphans as widows to be firm and to know that problems are a normal part of our lives. The world is rotating, when you are alive you can make many things possible. We should trust in God. If God is with us, our problems can be solved.

When respondents were asked whether the incidence of SGBV abuses were repeated in the course of their participation in the TPO program, in **Figure 18** below, only 27% of the respondents reported that they had suffered similar abuse while 73% had not. This is a very important finding and gives credit to the intervention since it implies that participants in the CBTT programs were empowered to protect themselves and/or perhaps the perpetrators especially spouses had been transformed. The assessment however noted that the most repetitive abuse was physical violence due to alcoholism, redundancy and lack of IGAs.

Figure 18: Recidivism of SGBV incidents



From the survey, 14% of the respondents indicated that their spouses had been invited to CBT sessions or were engaged in other CBT groups. Of these, 82% of the spouses participated in these sessions and 89% of these showed positive/changed attitudes. From the FGD interviews, examples of transformed attitudes and behaviors included spouses planning and making household decisions together and reduction in alcohol abuse among others, as illustrated in the quotations below;

"My husband used to be very stressed over the loss of his medical equipment in South Sudan. Often he would be depressed and would not provide for the family. After joining the CBT group, I would share with him the information obtained from the CBT sessions. Now he has accepted the situation, got a job and has returned to college in Uganda". (Female Survivor, Baratuku Settlement).

"I had problems with my wife. We used to fight every day. At one time we even separated and she left for me the children. I felt desperate and tried to kill myself by starving and when this didn't work, I used a rope to hang myself. I was just lucky that some people found me and cut the rope and took me to the hospital. That's when my neighbors advised me to join TPO men's group. A lot has changed, I advised my wife to join the group we are together and live happily. I got a job of food distribution." (Male Survivor, Salvation Group Palorinya Settlement).

Despite the above, the assessment noted that 86% of the respondents indicated that their spouses were not invited nor were they in other CBT groups. Some participants did not even share information gained from CBT due to fear and rudeness of their spouses. Other respondents also informed the survey that they attend CBT sessions in hiding. This affected the multiplier effect of the project and contributes to the repetitive mental health issues as illustrated below;

"I am here right now but if my husband found out about this, he will beat me. All the time I come for the sessions, I lie to him that I am going for immunization or taking the child to the hospital. I would wish for TPO to pay me a visit but this can only be done at the neighbor's home. I wish TPO could create men's groups so they learn about SGBV" Female Survivor in Baratuku settlement)

"Men at the fore front in fighting SGBV"-The Men's Salvation Group Experience, Palorinya Settlement.

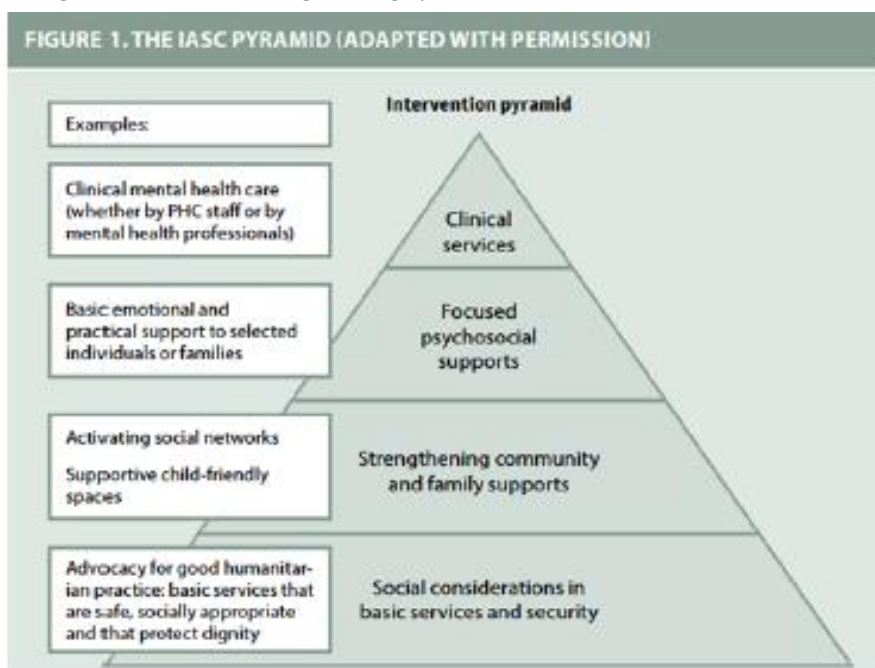


I was a Head Teacher with 14 years' experience. During the war in South Sudan, I lost my 3 brothers a medical doctor, a secondary school teacher and a tutor in a technical school. I also lost all my property including the cattle. I came here alone in the settlement and was running crazy. I had taken a decision to strangle myself because life had become meaningless. It was at this critical time in my life that TPO staff (Doreen) came to our settlement. A neighbor who knew about my desperate situation told me about TPO and I joined men's Salvation Group.

While undergoing the CBT sessions, I realized many of us were undergoing similar traumatic conditions. That's when I dropped the idea of taking my life and joined community efforts to counsel those facing similar challenges. We move around communities to resolve SGBV cases, counsel individuals to restore hopes. In one case, over disagreements between a man and wife on sharing proceeds from a maize harvest the wife wanted kill all children and disappear. Salvation Group intervened just in time and succeeded in counseled the couple.

They now live happily. In another case, two co-wives who lost their husband in South Sudan learned

Figure 19: IASC MHPSS Programming Pyramid



TPO has for over a number of years been implementing MHPSS projects in the refugee settlements and is largely perceived by other Humanitarian actors as the intervener that offers services especially clinical services, which are placed on top of the MHPSS interventions pyramid.

The assessment had learnt that TPO had in the past been instrumental in supporting the capacity of other actors especially the government health centres and hospitals to provide mental health services for both refugees and host

communities. This was especially true for Adjumani Hospital. Currently, it appears TPO in the UN WOMEN's project, plays a more limited role in the provision of clinical services (as reported in the past)²¹ Using screening tools such as the Beck Inventory for depression, Beck Inventory of Anxiety, PTSD (Post Stress Traumatic Disorder) GAF and Audit, TPO screens SGBV/MH survivors at arrival, in the settlement and host communities. Clinical interventions are limited to individual therapy, supervision, clinical analysis, case management and referrals. Cases that need further management and medical treatment are referred to IRC and Lacor hospital in Gulu for Lamwo, MTI in Moyo and Adjumani hospital in Adjumani.

CBT can be placed at the second top most tier on the MHPSS pyramid which focuses on providing focused psychosocial support. Although the TPO had in the past known for building capacity of community and institutional structures to provide MHPSS, in the UN WOMEN's project in the three districts there were limited interventions at level three of the MHPSS interventional pyramid. Findings from this assessment, indicate that TPO had mapped out existing structures, established new ones (VPAs), and as well built their capacity to prevent and respond to issues of SGBV and mental Health. One of the tapped in and significant groups (also in line with the UN secretary General Bulletin 2003²²) was the Prevention of Sexual Exploitation and Abuse (PSEA) group. This group was playing an important role in Palorinya settlement in prevention and response to MH and SGBV issues.

On the other hand, information from key informants and FGDs pointed to the need capacity building and refresher trainings for community-based structures (LCs, RWCs, PSEA, CPCs and VPAs), provision of mobility support, IEC materials, record tracking and reporting tools. This would promote ownership, accountability and sustainability of the project. Through a focus group discussion held with LC1 committees and Key informant interviews with partners and district officials in the different settlements/districts, the assessment confirmed the need to engage the local leaders and partners in reducing mental health and SGBV issues. This is because the local leaders have direct contact with the community, better understand the language, context and dynamics around SGBV. Engaging the partners also helps in ensuring survivors access to integrated services.

²¹ Report on The Mid Term Review f The TPO Uganda, Comic Relief Funded Project "Protecting South Sudanese Refugee Children In Uganda Through Building Family Resilience. July 2016 TPO/ War Child UK.

²² ST/SGB/2003/13²² Report on The Mid Term Review the TPO Uganda, Comic Relief Funded Project "Protecting South Sudanese Refugee Children in Uganda Through Building Family Resilience. July 2016 TPO/ War Child UK.

During the assessment, it was also observed that through inter-agency mechanism coordinated by OPM and UNHCR, TPO links survivors to other specialized partners for services offered on small scale and not offered such as WASH, health care, livelihoods and legal protection services among others. Though a certain level of coordination existed among partners in 3 district settlements of Adjumani, Obongi and Adjumani; the service package, coverage, referral tracking and feedback mechanism remained a challenge. Overall only 8% of the clients interviewed mentioned that they had been referred to other providers of specialized services.

In Lamwo-Palabek settlement, it was also noted that integrated outreaches with other partners were carried out and this allowed for easy dissemination of information on MH/SGBV and this enhanced referrals. It was also established that TPO had created a 10% men consideration in CBT approach. These men especially in Palorinya had become a referral point for cases happening in the settlement. They have played a critical role in awareness creation on mental health issues plus mediating SGBV cases in their villages/zones and beyond to address overwhelming demand of TPO's PSS service. During the assessment, when these men were interviewed, they indicated that TPO never tracks these referrals and also, they needed support in form of training, identification and transport means as they move around the whole settlement.

“TPO is our referral partner on PSS...they have excellent capacity in handling mental health issues. I make referrals to TPO and they are always willing to help. During joint partner activities in the settlement, TPO is always on board to provide awareness and counseling sessions on mental health. TPO should increase its visibility in the settlements about their good work”. (Senior Legal Officer, War Child Canada, Lamwo District).

3.3 Effectiveness of livelihoods on MHPSS interventions in the context of addressing sexual and gender-based violence and conflict related sexual violence in emergencies.

Armed Conflicts, displacements and humanitarian emergencies typically affect household livelihoods and lead to the loss of productive assets as was the case of South Sudan Refugees living in Uganda. The World Health Organization's (WHO) definition for mental health includes reference to an individual's ability to work productively and fruitfully and to make a contribution to his or her community.' WHO further observes that good mental health is linked to engagement and productivity (WHO, 2015)²³.

The above observation is corroborated by a number of studies that show that livelihoods and mental health programming are mutually reinforcing. For example, according to the World Bank, mental health is an important psychological capability that enables individuals to thrive in their livelihoods, as successful livelihood activities require a variety of social, cognitive and emotional capabilities. (World Bank, 2015)²⁴. Such capabilities are a source of agency, just like financial capital or access to markets, though these are psychologically based and acquired through socialization²⁵. The same study also observes that the more assets someone has the less vulnerable they are. People struggling with distress may find it hard to take full advantage of the opportunities that development interventions offer. From the assessment, respondents reported that lack of means to support themselves and their families often caused distress which lead to relapse. The Inter-Agency Standing Committee's (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings recommends integrating MHPSS into livelihoods programmes and further notes that livelihoods can act as a basic and community psychosocial support for everyone and, in particular, for persons affected by armed conflict.

The evaluation Team noted that TPO had supported livelihoods activities in the three districts. However, the livelihood component was relatively small in terms of magnitude and package. The project was designed to target 109 groups out of the 250 CBT groups reached by TPO. It was observed that there was only one livelihood officer to cater for all the three districts. This could cause delay in the livelihood activities for example; trainings of all the graduated groups in livelihoods must be done by one person. Future programming needs to consider increasing on the number of livelihoods officers to support the activities and cause the desired impact. Nonetheless, TPO as a matter of approach exploited its relationship with other Humanitarian actors to refer as many groups as possible for livelihood support. It was observed that as part of the project design, the selection of livelihoods beneficiaries depended on CBT post assessment recovery results.

It was established that for groups to be supported, they must have gone through CBT trainings and graduated. Whereas there was a fear by TPO that introducing livelihood activities early would disrupt the CBT sessions, the assessment observed that this was a missed opportunity since research has shown; that including a livelihoods component to mental health programming could have psychological benefits for participants, and similarly, including a mental health component to livelihoods programming could improve the livelihoods outcomes for participants. This is further emphasized by findings from KII interviews as elaborated in the quote below;

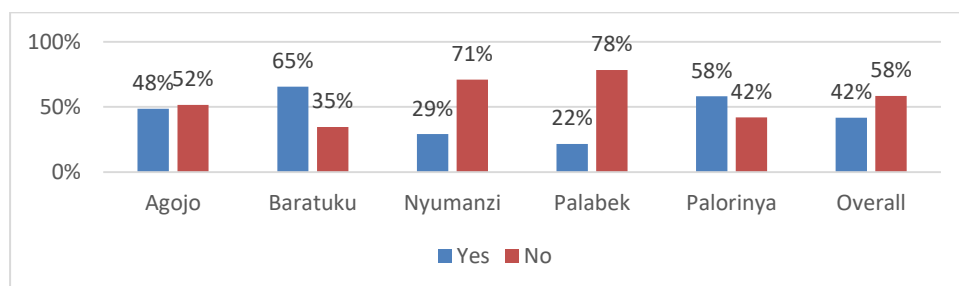
"If funding can allow, livelihoods should be strengthened to complement the good work TPO is doing in mental health and psychosocial support care. There is need for special focus on livelihoods into refugee programs to facilitate stabilization and sustainable mental recovery; (Protection Associate, Community-Based Protection UNHCR Adjumani.)

²³ WHO 2015.

²⁴ World development report 2015: Mind, society, and behaviour. Washington, DC: World Bank

²⁵ Algan, Beasley, Vitaro&Tremblay,2013; Heller et al., 2015 Mind,

Figure 20: Livelihood support given to beneficiaries



As indicated in **Figure 20** above, 42% of the respondents indicated that they had received some kind of livelihood support from TPO, while 58% had not. Baratuku (65%), had the highest percentage of respondents that mentioned that they had received livelihood support. This was followed by Palorinya (58%) and Agojo (48%) respectively. Specifically, for Palorinya, the respondents interviewed were carried from the previous project and were already supported with the startup grant. These were supported mostly in petty trade items like silver fish, soap, sugar and onions among others. When further asked about the impact of livelihoods towards their recovery progress, 81% of the respondents from Palorinya indicated that there was great improvement on their psychosocial wellbeing. This was attributed to the fact that they were able to take care of their basic needs for example paying school fees for their children and that they were also able to make informed decisions together with their spouses.

Table 7 below, indicates benefits that accrued from SGBV survivors' participation in profitable livelihood initiatives, with 33% indicating that they were able to provide for their families, while 12% indicated being less stressed.

Table 6: Benefits from Engaging in Profitable Livelihood activity

Benefit from Engaging in Profitable Livelihood Activity	# of Respondents	%
Able to take care of family basic needs	99	33%
Stress free with less thinking	37	12%
Better living with positive mind	24	8%
It keeps me busy and changed my well being	19	6%
It has improved on my financial status	18	6%
Improved standard of living	15	5%
Reduced dependence on the rations & husband	15	5%
Other	42	14%

Other benefits mentioned included; being able to live in harmony with others, strengthened marriage and created many friends; thus, improved social cohesion and networking.

During the entrepreneurial training, the livelihood officer and social workers oriented the groups about the saving principle and encouraged them to start VSLAs. The assessment team learnt that survivors took up the initiative to start up these VSLAs on their own. This was identified as a great self-help strategy towards accessing finances for the survivors. The team also observed that although these VSLAs were in existence, there was need for more trainings and guidance on better performance. The assessment also gathered that the interest rates charged on VSLA loans were too high (14%) to be affordable and later on support development of sustainable businesses in this context. The items provided by TPO as startup grants, were instead converted into cash which was later injected into VSLAs to continue the membership and also increase money for borrowing. There is need for follow up on the VSLAs to evaluate their performance and their impact on the survivors.

It was however observed that excluded CBT groups were uncomfortable about the exclusion from livelihood support. During FGD with TPO staff, it was strongly recommended that all graduated CBT groups be considered for livelihood support to facilitate their mental recovery and stability.

Table 7: Summary of Activities on livelihood integration for mental recovery of SGBV survivors

Activity	Target	Results	%	Comment
Mapping to identify livelihood opportunities and partners within the settlements for referral.	NIL	NIL		<i>Activity done as planned.</i>
Create linkages and referrals for graduated CBT groups to livelihood opportunities and agri-business enterprises	36	51	141%	<i>TPO exceeded their targets. A total of 51 groups linked to NURI- Adjumani (13), SORUDA-Lamwo (13) and MERCY CORPS-Moyo (25) and the process on-going.</i>
Support vulnerable graduated CBT group members to engage in socio-economic activities and self-help groups and initial startup grants	109	109	100%	<i>TPO has trained 109 of 250 groups in business management, developed business plans awaiting support from TPO by December 2019.</i>
Conduct an impact assessment on the effectiveness of MHPSS and economic interventions on recovery targeting previous UNW project beneficiaries				<i>Activity done</i>

Findings established that for groups to be supported, they provide a business plan of what they intend to do. Those interviewed, indicated that a needs assessment was done. However, the plans were changed to what TPO could provide. Respondents further indicated that sometimes what was given by TPO did not work out because it was not originally in their interest. Interviews with TPO staff revealed that since the package was small, the budget was limited to retail business that were considered to perform better and were comparatively more consistent than those supported in other business ventures. However, the Evaluation Team had no hard evidence about the above assertion. Results suggest the need for more research on the kind of livelihoods that was more suited to the refugee settings in Northern and West Nile Regions.

It was established that TPO had done few referrals to livelihood organizations like SORUDA, Mercy Corps, and NURI, among others. For instance, 300 CBT beneficiaries were linked to Mercy Corps and supported with agricultural inputs. This helped broaden the scope of the package of interventions available for the SGBV survivors and created a basis for a more comprehensive impact on their mental health and psychosocial wellbeing these showed change in the mental health issues. The others referred to SORUDA and NURI, were still in the process of being supported. On a positive note, Adjumani-based NURI Extension Supervisor acknowledged that CBT group members selected for livelihoods support demonstrated stable minds and readiness to embark on economic rehabilitation. It should be noted however, that although these referrals were made, there is still low monitoring by TPO to assess whether those supported in livelihoods had got any change in terms of SGBVs and mental health recovery.

Some of the survivors interviewed, showed that they accessed finances through doing farm work for the host community, selling firewood and selling the food ration. When asked why they sold their food, they explained that they needed cash to purchase non-food items that had not been provided in the assistance package. These included alcohol, medical care, sanitary needs and other types of food among others. Finding themselves in a situation where they have no access to land and IGAs, some have resorted to illegal practices for example survival sex, alcoholism, leading to more SGBVs and mental health issues.

The SGBV survivors perceived engaging in profitable livelihood as a key panacea to their condition. As indicated in **Table 9** below, when asked what they would like TPO to improve on in their future programming for refugee and host communities, 52% mentioned being financially helped to start group business, 8% mentioned more support for livelihood activities and vocational training, while 6% wanted TPO to support women with business skills and capital.

Table 8: Beneficiary recommendation

Beneficiary Recommendations	%
TPO help us financially to start business as a group	52%
More counselling and CBT sessions	14%
TPO should support us with livelihood activities	8%
TPO should engage in vocational training to support the group	8%
Support women with business skills and capital	6%
TPO should enroll more groups for CBT training	5%
TPO should provide our children with school fees	3%

"TPO-Uganda/UN Women Project got me out of Isolation-Sharing my story has helped other women to cope with difficulties" Sarah Aber, Palabek Settlement



I lost my father, grandfather and witnessed many friends, neighbors being killed during the war that left me traumatized. As we ran for safety, my husband fell and broke his spinal code and is confined to a wheel chair. Life became so hard because of thinking too much. I would keep indoors, crying and confused. Then came TPO in 2018, I was recruited into the CBT group because of my situation. Through 10 sessions we learnt many things and what I liked most was how to manage emotions. On graduation, we were trained how to manage a small business and I was selected as secretary. Our group was given sugar and soap as a business startup material.

TPO staff regularly follow us and support to ensure we remain on track. Our business has expanded and we have additional items like spices, silver fish and onions. I can borrow some money from the group to buy medicine for my husband, my family take a balanced diet and can buy school requirements for my children. I am proud that my life has changed from darkness to light; I now freely interact with neighbors and share my experience to help others cope with difficult situations. Recently a neighbor lost a child and as a group went were by her side to support her remain strong despite the challenging condition. I request TPO to provide our husbands with livelihoods support to enable them meaningfully contribute to meeting family needs.

4.0 Chapter Four: Lessons learned, Conclusions and Recommendations.

4.1 Lessons Learned

A number of key lessons learned and good practices were identified and are highlighted here below;

- TPO's implementation of CBT model addressed the real needs of the beneficiaries and was embraced by the refugee and host communities. There is an impressive appreciation of what TPO does and a great level of participation of the survivors in the CBT groups. During the assessment, the team observed and confirmed from the respondents and implementing partners, that TPO has helped them a lot especially in mental health issues and requested for more interventions and scale up.
- Mainstreaming of SGBV into MHPSS programming was spot on since it enabled TPO not only meet the real needs of women and children living in a patriarchal society, but also, helped deal with the root causes of SGBV. The project design also helped address the intricate relationship between SGBV and MHPSS. In societies that are predominantly patriarchal most SGBV issues affecting especially women are rooted in cultural beliefs, myths and practices which require concerted and protracted interventions like CBTT in order to obtain behavioral change both among the victims (mindsets) and the systems that perpetrate abuse against women rights.
- There was strong evidence that the engagement of men and boys especially in CBT processes was crucial in reducing incidences of abuse and also quickening the healing process. Men also were effective as proactive change agents as was cited in the example of the "Salvation Group" in Palorinya settlement. The engagement of boys despite being children in events and processes that affect women should not be ignored. From FGDs, it was learnt that boys in the Dinka community were greatly respected and consulted over domestic issues since they held decision making powers especially in the absence of adult men in the household. On the other hand, the assessment established that screening of beneficiaries for CBT sessions could have left out a key population group, the girls; who were targeted in the project document but not reached. The need for MHPSS/SGBV services remains relevant to this group; moreover, they were reported to be critically vulnerable to SGBV.
- Mobilization of women into groups was also seen to be galvanizing their voices, tapping into benefits of peer support, self-esteem and opening up. Leadership skills led to women empowerment and opened up to new opportunities that enhanced gender balance and equality. For example, women were taking on leadership roles as a result of affirmative action-oriented initiatives of the project that ensured women representation such as PSEA, RWCs, VPAs, and CPCs, among others. From a business perspective, through VSLA women were mobilizing investment capital, were engaging in petty business and were significantly contributing to meeting basic needs in their families. It was thus observed that most petty businesses were being run by women. Nonetheless, there are still significant gaps in long-term sustainable livelihoods and employment interventions.
- There was also evidence that some of the early gains of CBTT were addressing other community social problems such, alcohol abuse, child abuse and animosity between different ethnic communities among the refugees and between the refugees and host communities. Findings from the survey indicated that there was increased shared decision making at family level, reduced alcohol abuse and promoting peaceful co-existence among spouses. For example, when respondents were asked whether they had more control and the processes accrued from their participation in livelihood activities, 75% replied in affirmative. This is an indication of improvement in power relations at household level.
- It was observed that engaging SGBV/MH survivors in profitable livelihood endeavors alongside CBT was contributing to the early recovery process as the women not only got occupied (diverted away from stressing factors) but also helped to contribute to the sustenance of their family. This gave them a sense of purpose, self-fulfillment, importance and esteem in life. However, it is important to note that for every initiative done to empower women/girls, efforts should also be made to support the men/boys in order to avoid negative effects that come with drastic change in the power relations.

- The strong teamwork amongst the organization staff, use of pictorial information education communication (IEC) materials during the CBT sessions as well as the strength of the social workers created a good working relation between the social workers and the target beneficiaries. For example; one social worker for Nyumanzi was even given a cultural name John Deng Ajak, loosely translated as *“one who brings happiness”* by the survivors.
- Although TPO has a skeleton staff on ground, working with community-based structures like PSEA and VPAs, made it possible for the project to realize their targets. The assessment team learned that there was need to move away from emergency response to sustainable longer-term programming since there are all indications that the refugees were not returning in the short run. However, to realize sustainability further capacity building for the support structures for example religious leaders, VPAs, PSEA, RWC, CPC, role model groups and community structures is critical.
- Although there existed an SGBV Interagency Working Group, SOPs and an established referral pathways, it was observed that there was a tendency of ‘territorialism’ with different organizations focusing on their allotted settlements and with limited coordination especially among MHPSS/SGBV actors, creating gaps in the comprehensive service package as is recommended in the MHPSS intervention pyramid. For example, it was noted that in Adjumani (Agojo settlement), there was little enthusiasm for different SGBV actors to work together to synergize and create requisite program linkages. Equally, it was also established from KILs that collaborations with relevant district departments and cultural and religious leaders did not appear to be strong, yet this would be critical for enhancing sustainability and ownership of the project interventions.
- As already noted in the findings, the definition of SGBV seemed to be elastic depending on the level of awareness about the concept by the community. It was observed that high level of sensitization about other forms of SGBV broadened the scope of SGBV incidences being reported especially social and economic abuse that would never have been raised by the survivors before being enlightened and empowered.

4.2 Conclusions

Although many SGBV and MHPSS humanitarian actors working in Refugee and Host communities in the West Nile region have done a commendable job in addressing SGBV and MHPSS, the prevalence of SGBV particularly sexual violence is still high. In a context of armed conflict due to the intricate relationship between the two concepts, a high prevalence of SGBV is a known contributing factor to mental health and psychosocial distress. TPO by integrating SGBV into MHPSS programming where it already has both a niche and programming comparative advantage, was a bold and effective way of addressing refugee and host community needs. The success stories, lessons learned and best practices of this project should be shared and replicated.

The fact that recent studies reveal that levels of suicide tendencies were less in refugee populations compared to host communities both in Uganda and South Sudan indicates that MHPSS interventions models by the different actors have been able to have a positive impact on the mental and psychosocial wellbeing of targeted populations. However, SGBV programming still faces major challenges that include among others deep rooted negative cultural attitudes and behaviors in the communities regarding gender and power equality, leading to wide-spread acceptance of practices such as forced and child marriage, wife beating and punishment of children by many communities as well as frequent discrimination of SGBV survivors and their families. Under reporting, widespread impunity, inefficiency of the response system also stands out and also contributes to a culture of silence and concealment. This is further aggravated by the inefficiency of the law enforcement and justice systems, the lack of access to and quality of response systems, the fear and lack of protection for survivors and witnesses, weak coordination and the overstepping of authority by local and traditional courts engaged in capital offences. As a result, most of the perpetrators go un-punished and impunity is rampant. Findings suggest a need for effective SGBV programming to squarely address the above issues to create the desired impact.

Findings from the assessment indicated engaging in profitable livelihoods by SGBV survivors was a very important component of SGBV programming since it contributes to recovery and prevention of relapse. It was however noted that livelihood interventions were only included in the project on a very small scale and implemented towards the end of the project. This according to the assessment team was a missed opportunity and for any future similar project, substantial investment must be put to promoting livelihood. On the whole, this model was successful and with a few modifications should be scaled up and replicated to address the enormous need to similar interventions.

4.3 Recommendations

The following recommendation are proposed by the Assessment Team to inform future programming

- For future similar projects, TPO should significantly scale up livelihoods interventions especially given its impact on recovery and prevention of relapse among SGBV/MH survivors and also that the context in the settlements is really no longer of an emergency nature but rather requires long-term sustainable interventions. Livelihoods interventions thus should be integrated in CBT at the earliest opportunity possible, and focus on none farm based interventions given the scarcity of land. Integration of livelihoods interventions with a value addition element as well as vocational training and skilling youth should also be given due consideration. This will reduce dependency levels on hand outs and create better mental health sustainability to the survivors.
- In order to be more effective in influencing deep rooted cultural and religious beliefs that propagate SGBV, TPO should consider more engagement of cultural and religious leaders, men/boys, and the experimentation of approaches that are more effective in creating behavioral change especially at family level such as GALS. Such methods have been known to empower individuals to break negative cultural beliefs, myths, attitudes and practices.
- There is need to scale up men involvement by addressing fears that men hold about changing power relations in households and communities by involving them in SGBV/MH related interventions and designing activities specifically tailored for men to help them deal with consequences of especially conflict related emergencies and displacements. Fortunately, the project already has best practices for engaging men that could be rolled out to create desired impact.
- TPO should strengthen involvement of relevant stake holders including; relevant government departments, beneficiaries and implementing partners at planning and implementation stages. This will allow the government and partners to advise and coordinate their activities better with the organization. This will also allow easy advocacy and lobbying to enhance new policies that will facilitate or create an enabling environment for the refugees to attract more international and local investors as well as increase private sector engagement.
- The ME system and tracking indicators for SGBV and livelihoods for TPO need to be strengthened to effectively track changes in the lives of project beneficiaries. In addition, there is need to harmonize the data collection and reporting tools with the government and other stakeholders. Results in many areas for example the cases mediated by the role model men, SGBV case management and referral, VSLA industrial indicators among others were not efficiently captured.
- Although mainstreaming of SGBV into MHPSS was commendable, there is still need to build capacity of TPO staff and other community structures on SGBV. As indicated in the findings, the number of Social Workers/Livelihood Officers recruited to support the MHPSS and livelihood programs was insufficient. For example, there was one Livelihood Officer who coordinated livelihoods component across the three districts, Adjumani reported that it had only 2 Social Workers and 2 Community Psychologists interns that who offered regular support and supervision-in an expansive geographical area. There is therefore need to train more staff and/or enroll more VPAs to support project implementation in future.

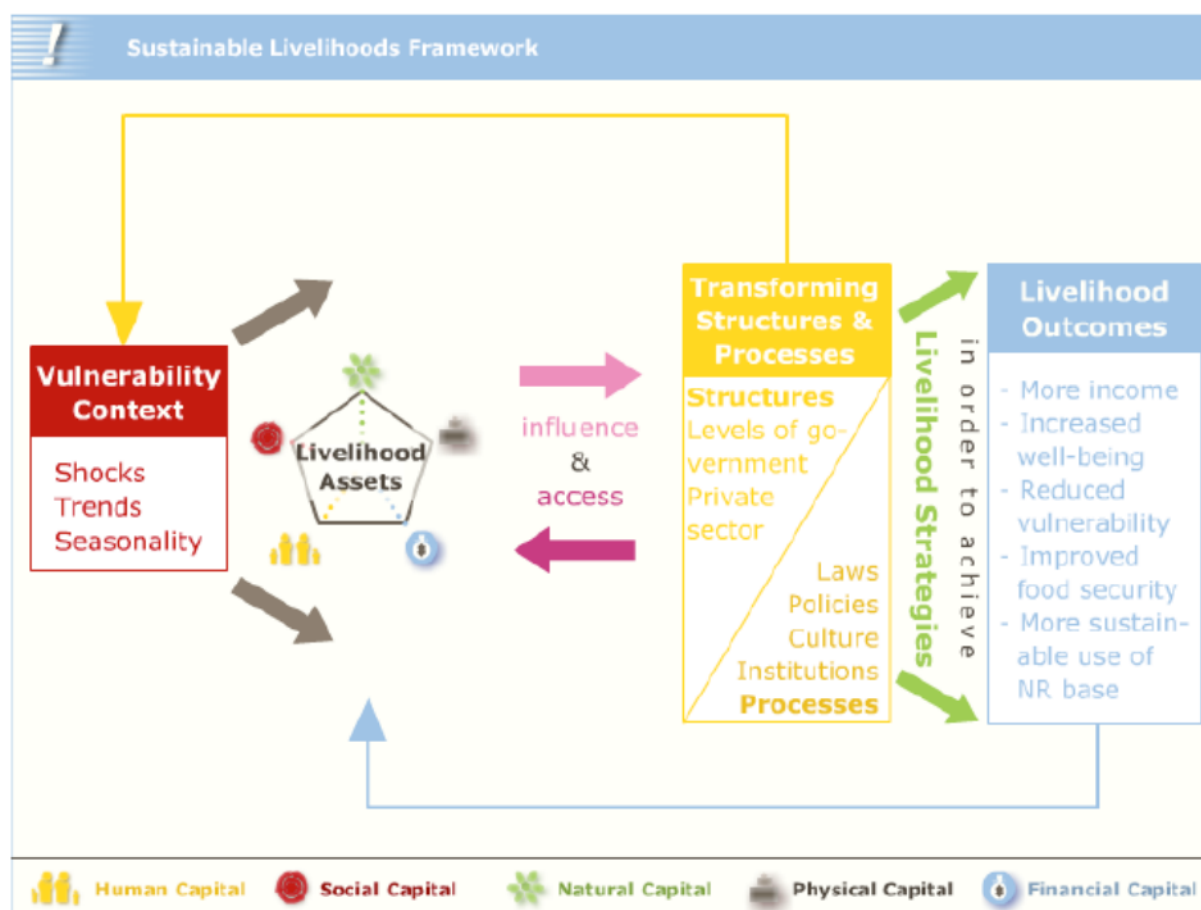
APPENDICES

Appendix 1: Terms of Reference



TPO Terms of
Reference for UNWC

Appendix 2: DFID Livelihoods Model



Source: DFID (2000)

Appendix 3: Selected crimes 2019 from the CFPU Palabek Settlement Lamwo district

Type of crime	Aug	Sep	Oct	Nov	Total
Rape	2	2	3	4	11
Child Desertion	2	1	3	1	7
Defilement	2	2	0	1	5
Domestic Violence	6	5	11	4	26
3. Child neglect	3	3	0	1	7
Assault	0	7	6	6	19

Child trafficking	0	1	0	1	2
child Abuse	2	1	0	0	3
Missing Children	3	2	3	3	11
Attempted suicide	0	5	0	0	5
child to child Sex	0	0	0	0	0
Total	20	29	26	21	96

Appendix 4: Data on selected crimes 2019 Morobi Police Post, Palorinya Settlement - Obongi District

Type of crime	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
Rape	0	0	1	0	0	0	0	1	0	1	0		3
Indecent Assault	0	0	0	0	0	0	0	0	0	0	1		1
Defilement	4	3	4	4	4	6	1	4	4	4	6		44
Domestic Violence	0	0	0	2	4	3	3	4	0	5	4		25
Child neglect	2	2	0	1	0	0	0	2	0	0	0		7
Assault	28	29	36	39	19	11	0	5	9	7	10		193
Threatening Violence	1	5	2	2	3	5	3	2	3	3	0		29
child sacrifice	0	0	0	0	0	0	0	0	0	0	0		0
Attempted Suicide	2	0	1	2	3	0	1	0	0	0	1		10
Suicide	0	0	0	0	0	1	0	0	0	0	0		1
child to child Sex	0	0	1	0	0	0	0	0	1	0	0		2
Total	37	39	45	50	33	26	8	18	17	20	22	0	315

Appendix 5: Data on Mental health cases reported by MTI managed health facility – Palorinya settlement in Obongi district

Condition	Sex	June	July	August	Sept	Oct	Nov	Total
Bipolar Disorders	M	1	1	2	3	3	1	11
	F	5	1	4	4	3	4	21
Epilepsy	M	55	41	45	36	46	38	261
	F	46	40	0	34	39	33	192
Depression	M	2	0	1	1	0	1	5
	F	2	1	2	3	2	1	11
Schizophrenia	M	2	1	5	6	3	2	19
	F	0	1	1	0	0	1	3
ADHD (Attention-deficit hyperactivity disorder)	M	4	0	2	0	1	0	7
	F	1	1	0	2	4	0	8
Others (Substance abuse, self-harm e.t.c)	M	10	8	1	0	9	5	33
	F	11	10	0	0	10	4	35
Total		139	105	63	89	120	90	606

Appendix 6: List of KII TPO and Partner Staff:

S/N	Name	Sex	Designation	Contact
TPO -Uganda Field Staff Lamwo, Adjumani and Moyo/Obongi Districts				
1	Susan Apeduno	F	Project Officer, (Lamwo)	0782362824
	Norah Nabwire	F	Project Officer (Adjumani)	0782070385
3	Mary Abuze	F	Finance Officer (All locations based in Obongi/Moyo)	0776009213
4	Jocknus Bitekere	M	Project Coordinator (All locations based in Obongi/Moyo)	0777567307
5	Rubangakene Felix	M	M&E Officer (All Locations based in Obongi/Moyo)	0779197488
6	Oneka Charles	M	Livelihoods Officer (All locations based in Adjumani)	0785547634
7	Dinnah Nabwire	F	TPO-Uganda HQ	
8	Muwairwa Michael	M	M&E Manager-TPO-Uganda HQ	0773241076
TPO-Uganda Field-Based Implementation Partners				
1	Aloyo Margaret	F	Refugee Welfare Committee III Palabek Settlement (Lamwo)	0782567854
2	Onyango Geoffrey Okene	M	CDO Palabek Kal S/C Lamwo District	0775594612
3	Simon Oboth	M	Senior Regal Officer War Child Canada (Lamwo)	0777066676
4	Byasali Kabi	M	Protection Assistant OPM, Palabek Settlement (Lamwo)	0777397022
5	Atto Florence	F	Officer in Charge Family and Child Protection Unit, Palabek (Lamwo)	0773170446
6	Edema Ricahrd Dracuri	M	Principal Asst CAO Adjumani	0782315200
7	Bazil Andevu	M	Extension Supervisor NURI, Adjumani	0785630062
8	Mokomiko Gorreti	F	Probation Officer, Adjumani District	0770655378
9	Mawadri Ramadhan	M	DCDO, Adjumani District	0772841354
10	Deogratus Acidiri	M	Protection Associate-Community-Based Protection UNHCR, Adjumani District	0775825592
11	Benson A. (CPL)	M	Officer in Charge Agojo Settlement	0770501146
12	Awio William Angello	M	Chairperson Refugee Welfare Committee, Agojo Settlement, Adjumani District	
13	Jessica Letio Carl	F	Project Assistant Lutheran World Federation Nyumanzi Settlement, Adjumani District	0772681557
14	Akuku Godfrey Ikuana	M	Livelihoods Program Assistant, Mercy Corps Moyo/Obongi District	0779577734
15	Milton Oworinamwe	M	Officer in Charge, Morobi Uganda Police Post Zone 2&3, Palorinya Settlement	0785283527
16	Ouma Lawrence	M	Clinical Officer, Medical Teams International Luri Health Unit Palorinya Settlement	0779709724
17	Tako Geoffrey	M	DCDO, Obongi District	0772964931

Appendix 7: LIST OF KII PARTICIPANTS: TPO Project Beneficiary Impact Narratives

S/N	Name	Sex	Designation/Location
1	Tulia John	M	PVA, Zone 5B Palabek Settlement
2	Sarah Aber	M	Project beneficiary Zone 5B Palabek Settlement
2	Ochira Michael	M	PVA, Zone 5A Palabek Settlement
3	Lalam Sunday	F	Palabek Settlement
4	Omwony Binnaisa	M	Religious Leader Zone 5A, Block 5B Palabek Settlement
5	Alfred Okwera	M	Cultural Leader, Zone 5A, Block 5B Palabek Settlement, Lamwo
6	Abuk Elizabeth Dau	F	PVA Block A, Nyumanzi Settlement, Adjumani
7	Ajieth Malual Deng	F	MH beneficiary Block A, Nyumanzi Settlement, Adjumani
8	Nyariak Machour Kulang	F	Block C Nyumanzi Settlement, Adjumani
9	Dima Modesto	M	LCI Chairman, Ebiamgbwa Village Adjumani
10	Gordon Wori Jansur	M	Zone 1, Block 4 Belamering Settlement
11	Cechilia Muja	F	Zone 1 Block 1 Belamering Settlement
12	Esther Kideni	F	Zone 1 Block 7 Belamering Settlement
13	Scovia Lumang Taban	F	PVA Zone 2 Luri Village Parabek Settlement

Appendix 8: LIST OF FGD PARTICIPANTS

Category of Respondents: TPO-Uganda Field Staff, Lamwo District					
S/N	Name	Age	Sex	Designation	Contact
1	Gloria Akullu		F	Social Worker	0785924074
2	Richard Omoya	42	M	Social Worker	0782947218
3	Odongpiny Wilfred	31	M	Social Worker	0777074515
4	Simon Sembiro		M	Clinical Psychologist	0786634775
Category of Respondents: TPO-Uganda Field Staff, Adjumani District					
	Name	Age	Sex	Designation	Phone Contact
1	Ikayi Annet	24	F	Intern Psychologist	0772486345
2	Violet Kirungi	23	F	Intern Psychologist	0778638842
3	Alushi Joy B	29	M	Social Worker	0778544884
4	Kucha John	30	M	Social Worker	0777391242
Category of Respondents: TPO-Uganda Field Staff, Obongi District					
1	Asiimwe Scovia		F	Clinical Psychologist	0782187528
2	Zaria Nakubulwa		F	Social Worker	0782086871
3	Kyakuwa Elizabeth		F	Social Worker	0776711494
4	Wanyama Sam		M	Project Officer	0783879205
5	Okema Julius Ongom			Social Worker	0782155164
Category of Respondents: Child Protection Committee Zone 5A, Block 5B Palabek Settlement					
	Name	Age	Sex	Designation	Contact
1	Omony Binnaisa	38	M	Focal Person	
2	Lamwoka Joyce	29	F	Member	

3	Aciru Ajelina	45	F	Member	
4	Kashara Betty	30	F	Member/Finance	0776134217
5	Anena Julie	26	F	Member	0789109565
6	Juma Hillary	23	M	Member	
7	Judith A.	25	F	Secretary	

Category of Respondents: Prevention of Sexual Exploitation and Abuse Task Force

	Name	Age	Sex	Designation	Phone Contact
1	Woda Edward Wani	31	M	Chairperson	0781478220
2	Taban James	35	M	Member	0788749900
3	Betty Kope	33	F	Member	0787681587
4	Jacob Modi Peter	37	M	Member	0785995366
5	Bajo Santino	38	M	Member	0772677722
6	Scovia Lumang Taban	20	M	TPO Volunteer PSS Asst	0783244482
7	Francis Longa Gale	48	M	Block Leader	0780293428

Category of Respondents: Volunteer Psychosocial Assistants (VPA), Palorinya Settlement

	Name	Age	Sex	Designation	Phone Contact
1	Wori Bosco Gonda	32	M	VPA Palorinya Settlement	0788843233
2	Chaplain Sekwat	45	M	VPA Palorinya Settlement	0788601524
3	Scovia Lumang Taban	20	F	VPA Palorinya Settlement	0783244482
4					

Category of Respondents: Refugee Welfare Committee, Zone 6 Block 2 Palabek Settlement

	Name	Age	Sex	Designation	Phone Contact
1	Olaya Paul Jackson	33	M	Chairperson RWC II Zone 6	0782246262
2	Acayo Martha	45	F	Vice Chairperson RWC Block 4	
3	Oboma Joseph Okuma		M	Chairperson RWC 1 Block 2	0776318525
4	Obote Milton		M	Secretary General Block 6	0775330635
5	Nyafuka Ruay	30	F	Women Representative	
6	Jacjline Aciro	25	F	Youth Representative	
7	Lokung Peter		M	Chairperson RWC 1, Block 4	0776153806
8	Attack Joseph	32	M	Chairperson RWC 1 Block 7	
9	Opira Bosco	29	M	Chairperson RWC 1	0780732890
10	Labeng Charity	36	F	Vice Zone Chairperson	0778906079
11	Okot James	29	M	Youth Chairperson	0775462329
12	Ocaya James	35	M	Secretary Zone 6 Block 4	0777327025
13	Akwero Evaline	28	F	Women Leader Zone 6 Block 5	

Category of Respondents: Women Respondents in Palabek Settlement Zone 5B block 7

	Name	Age	Sex	Designation	Phone Contact
1	Amony Christine	25	F	CBT Member	
2	Anacy Jane	25	F	CBT Member	
3	Lakot Jane	32	F	CBT Member	
4	Lavet Alice	27	F	CBT Member	
5	Evaline Amito	24	F	CBT Member	

5	Macline Ayaa	55	F	CBT Member	
6	Lakot Lina	52	F	CBT Member	
7	Mourine Abalo	29	F	CBT Member	
8	Lawuru Elda	24	F	CBT Member	
9	Akumu Rose	60	F	CBT Member	
10	Achiro Santa	60	F	CBT Member	
11	Santana Labou	70	F	CBT Member	
12	Atto Concy	29	F	CBT Member	
13	Melisa Tereca	40	F	CBT Member	
14	Rebecca Ijok	25	F	CBT Member	
15	Joska Atto	50	F	CBT Member	

Appendix 9: LIST OF RESEARCH ASSISTANTS

SN	NAME	SEX	TPO-Uganda Filed Office	CONTACT TEL
01	Okwera Agness	F	Lamwo District	0782511190
02	Atero Janet	F	Lamwo District	0774746977
03	Ochola David Akuro	M	Lamwo District	0772319417
04	Anzoyo Alice	F	Adjumani District	0701855880
05	Josephine Unzia	F	Adjumani District	
06	Lupai Alfred	M	Obongi District	
07	Simia Philomena	F	Obongi District	
08	Nansambya Topista	F	Adjumani District	0778757627
09	Mapkwe Allan Godfrey	M	Adjumani District	07805566318