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Linking Research to Action for Children in Humanitarian Contexts: Synopsis of the 2022 Uganda Humanitarian Violence Against Children and Youth Survey (HVACS) Findings and Data-to-Action Workshop

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Linking Research to Action for Children in Humanitarian Contexts

Synopsis of the 2022 Uganda Humanitarian Violence Against Children and Youth Survey (HVACS) Findings and Data-to-Action Workshop

Filling Gaps in Evidence to Enhance Sexual and Reproductive Health and Rights among Vulnerable Populations in Refugee Settings in the East and Horn of Africa

The Population Council leads the Baobab Research Program Consortium in close partnership with the Population Council Kenya and the African Population and Health Research Center. Situated in the East and Horn of Africa, this Africa-based and African-led consortium is filling critical evidence gaps to reduce inequities in sexual reproductive health and rights among vulnerable populations in humanitarian settings.

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In collaboration with:

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During the data collection process, we were generously supported by five UNHCR implementing partners in Uganda, which provided psychosocial care to survey respondents in need of it. We deeply appreciate the organisations that played this important role, including the Danish Refugee Council, Humanitarian Assistance and Development Services, International Rescue Committee, Lutheran World Federation, and Medical Teams International. The Violence Against Children and Youth Survey and its humanitarian version are products of the Together for Girls partnership, which comprises the U.S. Centers for Disease Control and Prevention (CDC) and other partners. We are fortunate to have had Together for Girls and CDC walk with us throughout this journey, providing pre- and post-survey technical guidance and input in a wide-ranging sense, including co-facilitation of the Data-2-Action workshop by CDC. Our sincere thanks go to both institutions. We are also deeply thankful for the data collection teams – composed of refugees and host community members – and study participants who contributed to the generation of evidence shared in this report.

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List of Abbreviations

APHRC	African Population and Health Research Center
CDC	Centers for Disease Control and Prevention
CI	Confidence Interval
CPMS	Minimum Standards for Child Protection in Humanitarian Action
CSO	Civil Society Organisation
D2A	Data-to-Action
EHAGL	East and Horn of Africa and the Great Lakes
FCDO	Foreign, Commonwealth and Development Office
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
HIV	Human Immunodefiency Virus
HVACS	Humanitarian Violence Against Children and Youth Survey
INGO	International Non-Governmental Organisation
MGLSD	Ministry of Gender, Labour and Social Development
NGO	Non-Governmental Organisation
ODK	Open Data Kit
OPM	Office of the Prime Minister
PSU	Primary Sampling Unit
PSW	Para-Social Worker
RPC	Research Programme Consortium
STI	Sexually Transmitted Infection
TfG	Together for Girls
UK	United Kingdom
UNHCR	United Nations High Commissioner for Refugees
VAC	Violence Against Children
VACS	Violence Against Children and Youth Survey(s)
WHO	World Health Organisation

Executive Summary

The Violence Against Children and Youth Surveys (VACS), led by national governments with technical assistance from the U.S. Centers for Disease Control and Prevention (CDC) as part of the Together for Girls (TfG) partnership, have documented the magnitude and prevalence of sexual, physical, and emotional VAC in more than 20 low- and middle-income countries, with a view to informing national prevention and response programs in development settings. This report presents key findings from the first-ever VACS conducted exclusively in a humanitarian context – specifically, in refugee settings in Uganda. The report couples these findings with proceedings of a dissemination workshop for humanitarian sector stakeholders to identify priorities and devise actions in response to the survey results along with what we know from existing literature.

The overall goal of this humanitarian VACS (HVACS) study is to enhance the well-being of children in refugee settings in Uganda by providing data that can be used to inform VAC prevention and response efforts in these contexts. Conducted from March to April 2022, the Uganda HVACS was a representative household survey of 13- to 24-year-old females and males drawn from all 13 refugee settlements in the country. The survey employed the standard VACS methodology, which involves a three-stage random sampling approach.

Key findings on VAC in refugee settings in Uganda include the following:

- There is a high prevalence of violence against children in refugee contexts in Uganda.
- Children's first experience of violence often occurs subsequent to their arrival in refugee contexts
- Physical violence is the most common type of violence experienced by children.
- Girls experience twice the rate of sexual violence as boys over time.
- Intimate partners and peers are the most common perpetrators of children's first incident of sexual violence.
- The first incident of sexual violence in childhood largely occurs outdoors, as opposed to within homes.
- Boys experience high rates of injury as a result of physical violence.
- Certain sub-groups of children are particularly vulnerable to experiencing violence compared to others, including children who witnessed violence in the home, those living with disabilities, and those who were married or cohabiting.
- Children in refugee settings in Uganda have relatively high knowledge of where to seek help for violence, but are unlikely to disclose and to obtain help or care.
- Survivors of childhood violence experience devastating consequences, including a greater likelihood to perpetrate violence, experience mental health problems, and engage in risk-taking behaviours compared to their peers who had not experienced violence.
- There are high levels of endorsement of retrogressive traditional norms among children and young people in Uganda's refugee settings.

From June 14-16, 2023, these findings were disseminated and deliberated upon at a workshop convened for decision-makers and program implementers in the humanitarian sector in Uganda. The report ends with the proceedings of this workshop, which led to the identification of interventions to be implemented in refugee settlements in Uganda before the end of 2025.

Introduction

Violence against children (VAC) is a human rights violation and public health problem with profound impacts that cycle through the lifespan and across generations.

Global estimates indicate that past-year violence (physical, emotional, or sexual) is experienced by approximately one billion children younger than 18 years (Hillis, Mercy, Amobi, & Kress, 2016). As in many countries, VAC remains a significant issue in Uganda. Uganda's 2015 VAC Survey (MGLSD, 2015) – a national, cross-sectional household survey of children and young adults aged 13 to 24 years – was originally developed to focus on development (non-refugee) settings. This survey indicates that, nationally, three-quarters (75%) of females and males aged 18 to 24 have experienced sexual, physical, and/or emotional violence in childhood. A high prevalence of these violence forms is also observed in the past 12 months among those aged 13 to 17 (females: 50%; males: 66%). The 2022 Uganda HVACS is the first-ever representative study to estimate the prevalence of sexual, physical, and emotional violence against children and youth in refugee settlements. Results of this survey can be used to identify risk and protective factors for violence and abuse to develop effective prevention strategies to enhance SRHR.

While children and adolescents are disproportionately represented among forcibly displaced people – an estimated 38% to 43% out of nearly 80 million (Chiang et al. 2020) – there are limited data on their experiences of violence in these contexts, and the evidence base on this issue is frail (Stark & Landis, 2016). Yet, practice-based data pinpoint children in humanitarian settings as being particularly vulnerable to violence due to the fact that many within these contexts are unaccompanied minors, without the protection that families can provide, among other reasons (Mballa et al., 2020). Furthermore, new stressors faced by caregivers in their new environment can render children more vulnerable to home-based violence (Cerna-Turoff et al., 2021).

Knowledge around what works and what doesn't when it comes to preventing and responding to VAC in humanitarian settings is hampered by limited information on its magnitude and nature. As the authors of a review of population-based approaches to measuring VAC conclude:

> Findings from our review reveal a weak evidence base by which to determine the scale, nature and impact of violence against children in emergency settings. Without reliable data, humanitarian actors are limited in their ability to design effective prevention and response initiatives to address the forms of violence experienced by children, and to ensure that sufficient resources for needed programming are put in place. Humanitarian efforts around the world are to be lauded, but if they apply a tourniquet to the wrong injury, they are destined to be ineffective (Stark & Landis, 2016, p.135).

The Violence Against Children and Youth Surveys

The Violence Against Children and Youth Surveys (VACS), led by national governments with technical assistance from the U.S. Centers for Disease Control and Prevention (CDC) as part of the Together for Girls (TfG) partnership, have documented the magnitude and prevalence of sexual, physical, and emotional VAC in more than 20 low- and middle-income countries, with a view to informing national prevention and response programs (Chiang et al. 2016). Despite the precedent for understanding the extent of VAC from the perspectives of adolescents and pre-adolescent children, interest in the systematic documentation of similar experiences of children in humanitarian settings is just emerging, following the development of guidance for the implementation of the VACS in such contexts (Chiang et al. 2020).

Uganda hosts the largest number of refugees in the East and Horn of Africa, with children below the age of 18 years comprising more than half of the refugee population (Office of the Prime Minister and UNHCR 2021). Estimates by the Office of the Prime Minister of the Government of

Uganda show that there were slightly over 1.5 million refugees in the country as of October 2023 (OPM, UNHCR, & GoU, 2023). Females comprised 51%, while children below the age of 18 years made up 58% of the refugee population in the country. Uganda also hosts the largest number of unaccompanied child refugees in the world – about 41,000, as of June 2020 – with most below the age of 15 years (UNHCR 2020). Unaccompanied minors are likely to be exposed to various forms of VAC due to their vulnerable situation and are unlikely to receive care/support (ibid.).

Overall, close to two-thirds (61%) of the refugee population in Uganda are from South Sudan (OPM, UNHCR, & GoU, 2021). However, the distribution of refugees by country of origin varies across settlements. Most refugees in Adjumani, Bidibidi, Imvepi, Kiryandongo, Palabek, Palorinya, and Rhino settlements are from South Sudan, while most refugees in Kyaka II, Kyangali, Lobule, Nakivale, Oruchinga, and Rwamwanja settlements are from the Democratic Republic of Congo (OPM & UNHCR, 2023),

This report presents key findings from the first-ever VACS conducted exclusively in a humanitarian context – specifically, in refugee settings in Uganda. The survey is referred to as the 'Uganda Humanitarian VAC Survey' (HVACS). The report couples these findings with proceedings of a dissemination workshop for humanitarian sector stakeholders to identify priorities and devise actions in response to the survey results along with what we know from existing literature.

Study Goal and Objectives

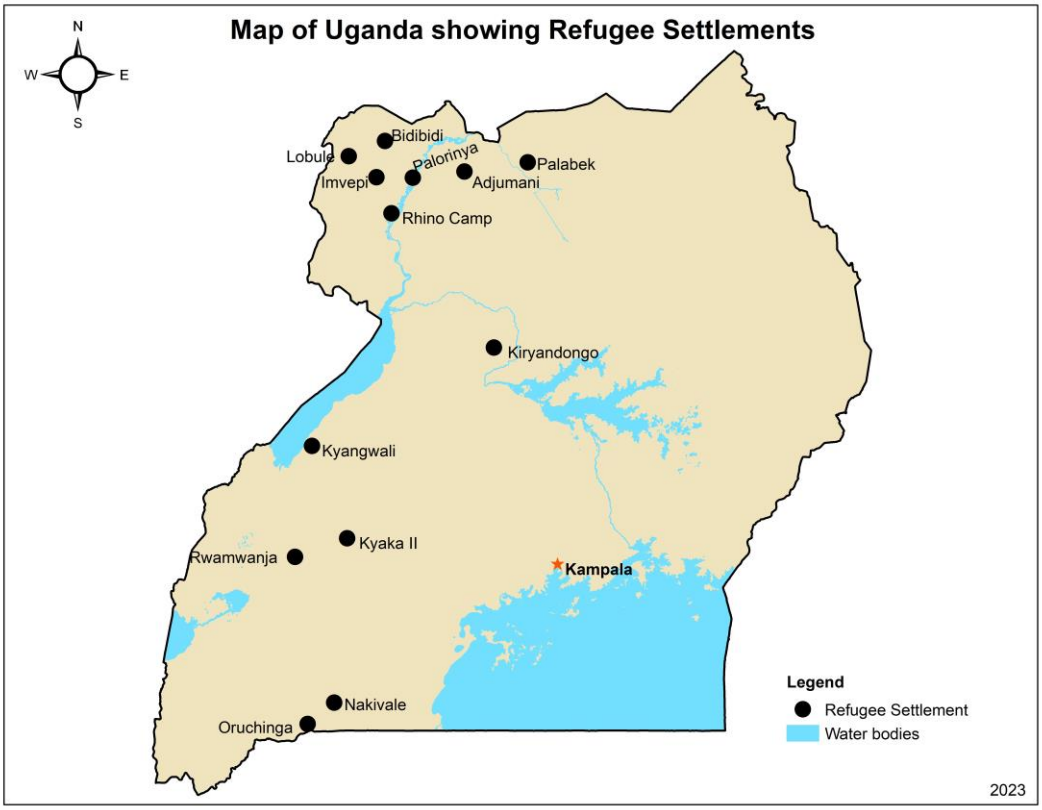
The overall goal of this study is to enhance the well-being of children in refugee settings in Uganda by providing information that can be used to inform violence against children prevention and response efforts in these contexts. The study specifically aims to:

1) Use the population-based, systematic, well-established method of the Violence Against Children Surveys (VACS) to measure the prevalence, nature and consequences of sexual, physical and emotional violence against children in refugee settings in Uganda, and contribute to existing surveillance systems in this context;
2) Provide national baseline data on VAC in refugee settings in Uganda;
3) Convene a muti-sectoral meeting to develop data-driven policy and programming responses based on the VAC data; and
4) Spur the implementation of appropriate interventions stemming from the VAC data and multi-sectoral meeting.

Methodology

Study Sites and Population

The Uganda HVACS was conducted from March to April 2022. It was a representative household survey of 13 to 24-year-old females and males drawn from all 13 refugee settlements in the country (depicted in the map below), namely: Adjumani in Adjumani District, Bidibidi in Yumbe District, Imvepi in Terego District, Kiryandongo in Kiryandongo District, Kyaka II in Kyegegwa District, Kyangwali in Kikuube District, Lobule in Koboko District, Nakivale in Isingiro District, Oruchinga in Isingiro District, Palabek in Lamwo District, Palorinya in Moyo District, Rhino in Madi-Okollo/Terego Districts, and Rwamwanja in Kamwenge District.



Ethical Considerations

The Uganda HVACS was approved by the Population Council Institutional Review Board (Protocol 986 dated October 21, 2021) and Mildmay Uganda Research Ethics Committee (MUREC), REF 0310-2021 dated November 24, 2021. The research was also granted regulatory approval by the Uganda National Council for Science and Technology (UNCST) – REF SS1130ES dated January 10, 2022.

Participants provided verbal consent to participate in the research. Interviewers read out the informed consent document (programmed in Open Data Kit [ODK] within data collection tablets) to potential participants. Participants were then given an opportunity to verbally indicate their willingness to participate in the research. The interviewers then recorded an electronic signature in the tablet to confirm that they read and personally explained to the participant the nature of the research. This approach was adopted to protect the privacy of participants, given that a signed

informed consent document could be used to link a participant to the study and thus breach their privacy.

Participants ages 18-24 years and emancipated minors ages 13-17 years provided individual consent. For dependant participants ages 13-17 years, interviewers first obtained permission from parents or primary caregivers to talk to the eligible participant before obtaining assent from the participants. However, the parents/caregivers were given limited information about the objectives of the research to protect participants whose parents/guardians could be the perpetrators of violence. Specifically, the study was introduced to parents/guardians as one that focused on the 'Health and Life Experiences of Children and Young People in Humanitarian Settings in Uganda,' rather than as a 'Violence Against Children and Youth' survey. Emancipated minors were defined under the survey as respondents aged 13 to 17 years who had assumed adult roles and responsibilities, including household headship, marriage, and/or procreation. Such respondents provided informed consent for study participation.

Minimising harm to survivors is a key ethical tenet of the implementation guidance around conducting HVACS. While attention to harm reduction is critical for research on violence in general, it is particularly so for research on children and youth in humanitarian contexts, whose circumstances engender additional vulnerabilities (Chiang et al., 2020). A response plan for respondents whose participation in the study triggers trauma is a hallmark of the VACS. The HVACS implementation guidance mandates that prompt counselling; strong, voluntary referrals (except in contexts of mandatory reporting) for sustained services; and geographic proximity of support agencies be in place in advance of the survey as part of the response plan in humanitarian settings.

Under the Uganda HVACS, UNHCR implementing partners in charge of child protection and gender-based violence service provision in each settlement were identified, and caseworkers affiliated with these organizations (who regularly provided psychosocial support to young survivors) were incorporated into each data collection team. Each data collection team included at least one caseworker who accompanied the team throughout the fieldwork period and provided immediate counselling to study participants who required it, in addition to referrals for further care when necessary. General psychosocial support was also offered to any member of the household from which the respondent was recruited. Additionally, a directory of services specific to each settlement was made available to survivors identified through the survey. These directories were a collation of community services offered by government and non-governmental humanitarian agency services in each settlement, along with the contact information of the focal points concerned. A deliberate effort was made to include a range of available services in various sectors to ensure that the directories were not seen as referral information for violence. This strategy was geared toward ensuring that the focus of the study was known only to the interviewee. Interviewers were trained to highlight VAC-related services in the directory for participants at the end of the interview.

Recruitment and Training

In the standard VACS, female interviewers conduct interviews in enumeration areas (EAs) selected for female samples, while male interviewers conduct interviews in EAs selected for male samples. The VACS also use interviewers with experience in conducting household surveys on sensitive topics such as gender-based violence or HIV and consider other aspects such as language skills and cultural context (Chiang et al., 2016). The interviewers and their team leaders undergo intensive training on the study design, ethics, and procedures that entails a one-week training session solely for team leaders and a two-week training session for team leaders and interviewers combined.

The Uganda HVACS considered similar aspects in the selection and training of interviewers in the study. A total of 26 team leaders (16 females and 10 males) and 56 interviewers (34 females and 22 males) were identified and recruited for the survey in collaboration with UNHCR and OPM to ensure adequate representation of experienced refugees and host community members. One-

third (33%) of the team leaders and interviewers were refugees, while the rest were from host communities. In addition, UNHCR facilitated the secondment of 32 case workers (23 females and nine males) from its implementing partner organizations to the study to offer counselling and/or referral to study participants requiring these services. The partners were specifically mandated by UNHCR to offer child protection and/or gender-based violence services in each refugee settlement at the time of the HVACS data collection. A total of five UNHCR implementing partners played this role under the HVACS, namely: the Danish Refugee Council, Humanitarian Assistance and Development Services, International Rescue Committee, Lutheran World Federation, and Medical Teams International.

The case workers seconded to the survey by UNHCR implementing partners participated in a two-day refresher training, which included sessions on values clarification related to VAC, VAC as a health and human rights issue, guiding principles for health workers working with children and youth in the context of violence, communication skills, the role of caseworkers in the study, UNHCR referral pathways for child protection and gender-based violence, and the general study procedures. Six study coordinators (four females and two males) were also recruited and trained together with the research teams to lead community entry and fieldwork coordination. Two of these study coordinators were dedicated to coordinating the provision of psychosocial support by case workers to respondents during fieldwork.

Team leaders and interviewers were assigned to communities based on their knowledge of the main local languages spoken in each settlement. Care was taken to ensure that interviewers who happened to be residents in refugee settlements were not assigned to zones in which they resided.

The training for the research teams was followed by a two-day field pre-test of the study tool and procedures in zones that were not sampled for inclusion in the survey before the commencement of data collection. The survey tool was programmed on ODK survey software and administered using tablets to allow for safe and electronic transmission of the data to a secure cloud server.

Tool Development, Adaptation and Piloting

The Uganda HVACS drew on the questionnaire adaptations outlined in the implementation guidance for conducting a VACS in humanitarian settings (Chiang et al., 2020), including the introduction of new questions on whether each type of violence experienced (sexual, physical or emotional) occurred before or after arriving in the refugee settlement. Similar to standard VACS, the Uganda HVACS further collected information on perpetrators, the consequences of violence, and harmful practices such as child marriage. The HVACS implementation guidance indicates that additional questions could be incorporated into the survey to extend understanding of the humanitarian context concerned (ibid.). Accordingly, the Uganda HVACS collected additional information on knowledge and experience of female genital mutilation (FGM) as well as on disability status based on indicators developed by the Washington Group on Disability Statistics. The training for the research teams was followed by a two-day field pre-test of the study tool and procedures in zones that were not sampled for inclusion in the survey before the commencement of data collection. The pre-test provided assurance that the questions in the study tool were intelligible and acceptable to potential participants.

The study tool was translated from English into the local languages of Kinyabwisha, Kiswahili, Acholi, and Juba Arabic, as these were the most commonly used languages in the settlements.

Sampling

The survey employed the standard VACS methodology: A three-stage sampling process was used to identify and recruit females and males aged 13-24 years for individual interview. The first stage entailed a random selection of zones (primary sampling unit) from each of the settlements. A split sampling design was used whereby, in each settlement, zones sampled for female interviews were distinguished from those sampled for male interviews. Fifty-six zones (28 for female and 28

for male interviews) were randomly sampled from the list of 109 zones that was provided by UNHCR and the Office of the Prime Minister (OPM). In the second stage, a fixed number of households (193 for female zones and 134 for male zones) was randomly selected from each of the sampled zones. In the third stage, one eligible 13-24-year-old participant was randomly selected from each sampled household and provided assent/consent to participate in the survey.

Data Collection

Data collection took place from March to April 2022. Female interviewers conducted interviews in female zones, while male interviewers conducted interviews in male zones. Survey participants responded to questions covering demographics; socioeconomic status; parent relationships; education; general connectedness to family, friends, and community; marital status and relationships; sexual behaviour and practices; transactional sex; pregnancy; HIV status; experience of sexual, physical, and emotional violence; health problems associated with exposure to violence; and utilisation of violence services. In addition, the survey included questions on disability (assessing difficulty performing basic universal activities related to movement, sight, hearing, communication, self-care, and cognition) and female genital mutilation/cutting (FGM/C). Those who experienced any form of violence were also asked whether the incident occurred before or after arriving in the refugee settlement. For survey participants ages 18 to 24, the main interest was on experiences of violence during their childhood (before age 18), rather than about their current or adulthood experiences.

Response Rate

A total of 5,087 households were sampled from 28 randomly selected primary sampling units (PSUs) for females, and 1,338 females completed the survey. The sample sizes were determined for females and males separately to detect the prevalence of any form of childhood sexual violence among 13-17 years and 18-24 years at 95% confidence level and 4% margin of error. The overall female response rate was 46.6% (53.3% household response rate and 87.5% individual response rate). A total of 3,556 households were sampled from 28 randomly selected PSUs for males, and 927 males completed the survey. The overall male response rate was 50.6% (56.2% household response rate and 90.1% individual response rate). These response rates reflect challenges related to locating sampled households, which is expected in refugee settings. However, upon identification of sampled households, the likelihood of eligible participants consenting to survey participation was high for both females and males.

Analysis

All analyses were descriptive and accounted for the complex survey design by applying weights to the estimates. This report includes highlights of key indicators from the HVACS, focusing on experiences of violence among 18-24-year-old females and males during childhood (prior to age 18) as well as experiences of violence among 13-17-year-olds in the past 12 months preceding the survey. Analysis of circumstance information (e.g., perpetrator, whether they told someone, whether they sought services) for 18-24-year-olds focused on the first incident prior to age 18 while for 13-17-year-olds, it is on the most recent incident. To evaluate whether differences between any groups or subgroups were statistically significant and not due to random variation, 95% confidence intervals (CIs) were compared to determine whether they overlapped. The CI overlap method is a conservative method that determines statistical difference by comparing the CI for two estimates — if the CIs do not overlap, then the estimates are considered statistically or significantly different and not due to random chance. For the purpose of this report, some differences between sub-groups that are statistically significant are noted in the text as significantly different. Where CIs overlap, this is not explicitly noted as significantly different.

Definitions

Household: This refers to a person or group of persons who live and eat together, sleep under the same roof, and share resources and household responsibilities. Households are not always clearly defined, such as the case of a man with multiple wives who each have a home structure and children of their own (in this case, each wife would be considered as having her own household, unless, for instance, the husband spends most nights in her home); or multiple families living under one roof (in this case, each family is regarded as a separate household); or a group of people who are not related by blood but meet the aforementioned criteria (this would be regarded as a household). People living together, if not pooling resources, etc., are not regarded as a household.

Childhood: This refers to the state of being below the age of 18, based on the definition by the United Nations Convention on the Rights of the Child of 1989, which defines a "child" as "any human being below the age of 18 years" (United Nations General Assembly, 1989, article 1).

Child marriage: This refers to any formal marriage or informal union between a child under the age of 18 and an adult or another child. It was measured as the proportion of ever married respondents 18-24 years old who were first married before age 18.

Abduction: This refers to the unauthorized removal of the respondent from the custody of biological parents or legally appointed caregivers. In the Uganda HVACS, questions are posed about lifetime experience and timing (i.e., before or after arrival in a refugee setting) of personal abduction, and about the abduction experiences of family members or people close to the respondent and the timing associated with these.

Violence: The World Health Organisation defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, or another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (Krug et al., 2002).

Sexual Violence: Sexual violence encompasses a range of acts, including completed non-consensual sex acts, attempted nonconsensual sex acts, and abusive sexual contact. In the Uganda HVACS, questions were posed on four forms of sexual violence. Forms of sexual violence include:

- *Unwanted Sexual Touching*: If anyone, male or female, ever touched the participant in a sexual way without their permission but did not try to force the participant to have sex. Touching in a sexual way without permission includes fondling, pinching, grabbing, or touching on or around the participant's sexual body parts.
- *Unwanted Attempted Sex*: If anyone ever tried to make the participant have sex against their will but did not succeed (sex or sexual intercourse includes vaginal, oral, or anal sex). They might have tried to physically force the participant to have sex or they might have tried to pressure the participant to have sex through harassment or threats.
- *Pressured or Coerced Sex*: If anyone ever pressured the participant to have sex, through harassment or threats and did succeed in having sex with the participant.
- *Physically Forced Sex*: If anyone ever physically forced the participant to have sex and did succeed in having sex with the participant. In addition, questions were included about sex when a person was too drunk to give consent or say no. Although this is considered a form of sexual violence, it was not included in the sexual violence combined indicator because this question is new to the questionnaire and has not been fully tested or used in an African context.
- *Alcohol-Facilitated Forced Sex*: If participants ever had sex when they were too drunk to say no.

Physical Violence: Participants were asked about physical acts of violence perpetrated by four types of potential perpetrators: 1) Current or previous intimate partners, including a romantic partner, a boyfriend/girlfriend, or a spouse, 2) Peers, including people the same age as the

participant not including a boyfriend/girlfriend, spouse, or romantic partner. These might be people the participant may have known or not known including siblings, schoolmates, neighbours, or strangers, 3) Parents, adult caregivers, or other adult relatives, and 4) Adults in the community such as teachers, police, employers, religious or community leaders, neighbours, or adults the participant did not know.

For each perpetrator type, participants were asked about four measures of physical violence: Has (1) an intimate partner; (2) a peer; (3) a parent, adult caregiver, or other adult relative; (4) an adult in the community ever:

- Slapped, pushed, shoved, shook, or intentionally threw something at the participant to hurt them.
- Punched, kicked, whipped, or beat the participant with an object.
- Choked, smothered, tried or attempted to drown, or burned the participant intentionally.
- Used or threatened the participant with a knife, gun or other weapon.

Emotional Violence: The behaviours measured for emotional violence varied according to the perpetrators. To assess emotional violence perpetrated by parents, adult caregivers or other adult relatives, participants were asked whether:

- The participant was told that they were not loved or did not deserve to be loved.
- The participant was told they (perpetrator) wished the participant had never been born or were dead.
- The participant was ridiculed or put down, for example told that they were stupid or useless.

To assess emotional violence perpetrated by intimate partners, participants were asked if they had ever been treated the following way by a current or former romantic partner, boyfriend or spouse:

- Insulted, humiliated, or made fun of in front of others.
- Kept the participant from having their own money.
- Tried to keep the participant from seeing or talking to their family or friends.
- Kept track of the participant by demanding to know where the participant was and what the participant was doing.
- Made threats to physically harm the participant.

To assess emotional violence by peers, participants were asked whether a person the participant's own age had done the following in the past 12 months:

- Made the participant feel scared or feel really bad because they were calling the participant names, saying mean things to the participant, or saying they did not want them around.
- Told lies or spread rumours about the participant or tried to make others dislike the participant.
- Kept the participant out of things on purpose, excluded the participant from their group of friends, or completely ignored the participant.

Female Genital Mutilation/Cutting (FGM/C): This refers to the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons. In the Uganda HVACS, FGM/C was considered a form of violence, and questions were asked about whether the respondent had ever experienced FGM/C, what kind, at which age, and at what time (i.e., before or after arrival in a refugee setting), and at the hands of whom.

Standard VACS: This refers to the original Violence Against Children and Youth Survey, which was developed for implementation in development settings, as opposed to humanitarian settings.

Key Findings

This section briefly presents key highlights from the Uganda HVACS findings in narrative form. More detailed information (including graphs, percentages, and their accompanying descriptions) may be found in the Annex.

There is a high prevalence of violence against children in refugee settings in Uganda
Nearly half of females and males aged 18-24 years having experienced at least one form of violence (sexual, physical or emotional) before age 18. In addition, about a third (32%) of females and 40% of males aged 13-17 years experienced at least one form of violence in the past 12 months. We caution against making direct comparisons between the magnitude of VAC in Uganda's refugee settings and that of the national context for the following reasons: 1) the difference in time frames between data on national VAC prevalence (available from the 2015 National VACS [MGLSD 2015]) and the 2022 Uganda HVACS – a 7-year period; 2) sampling frame differences: the sampling frame for the national VACS was based on the 2014 Uganda population and housing census (comprising Ugandans, primarily), while the sampling frame for the HVACS was based on the 2022 refugee population (composed primarily of South Sudanese in addition to others displaced from their countries of origin); 3) The array of interventions that have been carried out across Uganda in the 7-year period between the two surveys: any differences in the magnitude of violence could be due to temporal variations in the prevalence of violence in response to the intensity of interventions to address VAC or the lack thereof; and 4) As displacement places refugees at more obvious exposure to violence, refugee contexts tend to benefit from emergency prevention and response initiatives that might mitigate some of the risks of violence at a greater level than national settings.

Children's first experience of violence often occurs subsequent to their arrival in refugee contexts
The majority of females and a considerable proportion of males in the 18-24-year-old age range experienced their first incident of sexual, physical, or emotional violence *after* arriving in a refugee settlement.

Physical violence is the most common type of violence experienced by children in refugee settings in Uganda
Physical violence is the most common type of violence against children experienced by both females and males across age groups (i.e., both the 13-17 and 18-24 age ranges). However, males are more likely than females to experience physical violence in childhood (*see* Annex, Figures 1 and 2).

Girls experience twice the rate of sexual violence as boys over time in refugee contexts in Uganda
Although females and males experience similar levels of sexual violence in the 13-17-year-old age range (7%), females aged 18-24 are twice as likely as their male counterparts to have experienced sexual violence in childhood: 19% of females compared to 10% of males (*see* Annex, Figures 1 and 2). Females also tend to experience sexual violence earlier in life than their male counterparts: 38% of females experienced their first incident of sexual violence when they were 13 years or younger, while most males (69%) experienced their first incident of sexual violence when they were between 16 and 17 years old. Those who experienced such violence in childhood went on to face multiple incidents of this form of violence over time.

Intimate partners and peers are the most common perpetrators of children's first incident of sexual violence in refugee settings in Uganda
Across age groups, perpetrators of violence against children are mostly people that are known to the children concerned, including parents or adult relatives, adults in the community, an intimate partner, classmates/schoolmates, or friends. However, the most common perpetrators of the first incident of sexual violence in childhood among females and males aged 18-24 years were intimate partners (i.e., current or previous spouses, boyfriends, girlfriends or romantic partners – *see* Annex, Figure 8). Among 13-17-year-olds, the most common perpetrators of the most recent

incident of sexual violence in the past 12 months preceding the survey were classmates or schoolmates among females, and friends among males (*see* Annex, Figure 9).

The first incident of sexual violence in childhood largely occurs outdoors in refugee settings in Uganda

Across age groups, the first incident of sexual violence in childhood among females and males largely occurred in outdoor locations, such as on a road/street, in a market/shop, in school, by a lake/river or other body of water, or in a field/other natural area (see Annex, Figures 11 and 12), as opposed to within homes.

Boys experience high rates of injury as a result of physical violence in refugee settings in Uganda

About a third of females and two-thirds of males who experienced physical violence in childhood reported that they had an injury as a result of their first childhood experience of physical violence. Significantly more males than females aged 18-24 years who experienced physical violence in childhood experienced an injury as a result of physical violence by peers, parents/caregivers/adult relative, and adults in the community. These same patterns were found among males and females aged 13-17 who had experienced physical violence in the past 12 months. On the other hand, almost half of the females aged 18-24 years who experienced physical intimate partner violence in childhood experienced physical harm or injury as a result.

Certain sub-groups of children are particularly vulnerable to experiencing violence compared to others in refugee settings in Uganda

Children who witnessed violence in the home, those living with disabilities, and those who were married or cohabiting experience higher proportions of various forms of violence compared to others. Findings show that this is the case across age groups, except when it comes to those who were married or cohabiting, where the association was found for females and males in the 18-24 age range, specifically.

Children in refugee settings in Uganda have relatively high knowledge of where to seek help for violence, but are unlikely to disclose their experience of violence, and to obtain help or care

Knowledge of where to seek help for violence was relatively high, with males being much more likely to have such knowledge than their female peers. However, most children who experienced violence neither disclosed their experiences, nor sought help/care. This was the case across age groups.

Survivors of childhood violence in refugee settings in Uganda experience devastating consequences

Compared to children who have not experienced violence, those who have experienced violence are more likely to: 1) *perpetrate violence* (across age groups, those who experienced sexual violence were more likely to have perpetrated some form of violence against others in their lifetime, and males aged 18-24 who experienced physical violence in childhood were more likely to perpetrate physical intimate partner violence); 2) *experience mental health problems* (across age groups, except for girls aged 13-17 who experienced physical violence in the past 12 months); and 3) *engage in risk-taking behaviours* (i.e., specifically, females aged 18-24 years who experienced sexual violence in childhood, or who were currently sexually active, while also having experienced emotional violence in childhood). (*See* Annex, Figures 13-25)

There are high levels of endorsement of traditional norms among children and young people in Uganda's refugee settings

Across age groups, a high proportion of children and young people have unprogressive views about gender, sexual behaviour and intimate partner violence. A high proportion believe that wife-beating is acceptable, for instance, and females are more likely to hold this particular belief than males (*see* Annex, Figure 26).

Discussion

How do the 'standard' VACS and Uganda HVACS compare?

The Violence Against Children and Youth Surveys (VACS) are nationally-representative surveys designed to measure the burden of sexual, physical, and emotional violence experienced in childhood, adolescence and early adulthood. The VACS focus on females and males aged 13–24 years, and as of 2023, 26 countries had implemented a VACS. However, the first VACS designed to measure the same forms of violence in humanitarian contexts was only completed in 2022, with the current report providing a summary of the findings from this survey. Prior to generating the Uganda HVACS data, several presumptions were understandably made about children in humanitarian settings, including that they were likely to be at greater risk for experiencing violence, and that the risk factors for experiencing violence would most likely be exacerbated among children in these contexts (Stark & Landis, 2016; Nace et al., 2021). These presumptions are reasonable, given the weakening of familial and community cohesion that succeeds conflict or displacement (Stark & Landis, 2016; Lustig et al., 2003), along with the loss of livelihoods in these circumstances (Stark & Landis, 2026; Bruck and Schindler, 2009).

However, direct comparisons between the magnitude of VAC in Uganda's refugee settings and that of the national context cannot be made for various reasons. While data on VAC prevalence in Uganda are available from the 2015 National VACS (MGLSD 2015), this survey and the 2022 Uganda HVACS rely on different sampling frames. In particular, the sampling frame for the national survey was based on the 2014 Uganda population and housing census (comprising Ugandans, primarily), while the sampling frame for the HVACS was based on the 2022 refugee population (composed primarily of South Sudanese in addition to others displaced from their countries of origin). Furthermore, the two surveys were conducted almost seven years apart, and any differences in the magnitude of violence could be due to temporal variations in the prevalence of violence in response to the intensity of interventions to address VAC or the lack thereof. Additionally, the humanitarian crisis due to displacement places refugees at a greater risk of violence and, therefore, requires emergency responses that might mitigate some of the risks of violence compared to national settings.

Nonetheless, some of the Uganda HVACS findings do suggest that the prevalence of violence against children in refugee settings is high, particularly in comparison to the prevalence of this phenomenon before the children under study relocated to refugee contexts. For instance, the majority of females and a considerable proportion of males in the 18-24-year-old age range experienced their first incident of sexual, physical, or emotional violence *after* arriving in a refugee settlement. Specifically, after arrival in a refugee settlement, 73% of females and 53% of males experienced their first incident of sexual violence; over two-thirds (67%) of females and 43% of males experienced their first incident of physical violence in childhood; and 89% of females and 43% of males experienced their first incident of emotional violence (see Annex, p. 34 [sexual violence], and p. 35 [physical and emotional violence].

The challenges of direct comparisons notwithstanding we can compare overall patterns observed in the HVACS data vis-à-vis the VACS carried out in multiple countries. For example, a recent article examined peer-reviewed literature (50 peer-reviewed journal articles with data from 11 countries) based on VACS data between 2009 and 2020 (Nace et al., 2021). This article found that VACS data from Tanzania, Cambodia, Kenya, and Eswatini show that girls are twice as likely as boys to experience sexual violence – a pattern which is also found in the Uganda HVACS data. The same article highlighted a study based on VACS data in Haiti, which found that the prevalence of physical violence was particularly high. Uganda HVACS data show a similar pattern, with physical violence being the most common form of violence experienced by children. However, while in Haiti, girls and boys experienced similar levels of such violence, in refugee settings in Uganda, boys were more likely to experience physical violence than girls.

Experience of violence by children has been associated with mental health issues among the survivors (Seff & Stark, 2019; Annor et al., 2020); risk-taking behaviours and violence perpetration (Annor et al., 2020); and engaging in HIV risk behaviours (Sommarin et al., 2014) in non-humanitarian settings. Similarly, findings from the Uganda HVACS demonstrate that in comparison to children who did not experience violence, those experienced violence were more likely to perpetrate violence themselves, experience mental health problems, and engage in risk-taking behaviours.

Systematic review evidence has shown that children with disabilities are up to four times more likely to experience all forms of violence, and up to three times more likely to experience sexual violence compared to their peers without disabilities (Jones et al., 2012). There is however limited evidence on these associations in humanitarian settings. Our results do similarly reveal that children and youth with disabilities are more vulnerable to violence in childhood compared to those without disabilities, and that those with disabilities were over two times more likely to experience childhood sexual violence compared to those without disabilities.

Furthermore, a common pattern within VACS data sets in several African countries (such as Uganda, Kenya, Rwanda, and Malawi), involves a worrisome discrepancy between the large proportion of children who experience violence and the proportion of such children who seek and then manage to obtain services. This pattern is repeated within the Uganda HVACS data. More information is needed on why this discrepancy exists. Through a smaller, follow-up qualitative investigation in 2024, Baobab will be delving into this issue to gain a better understanding of the barriers to services access in the lives of child survivors, drawing on the voices of children who have experienced violence in refugee communities in Uganda, along with perspectives of key stakeholders.

What do the Uganda HVACS findings mean for programming and policy?

Overall, findings from the Uganda HVACS confirm that VAC in refugee settings is pervasive, with half of males and close to half of females aged 18-24 in the refugee settlements experiencing either sexual, physical, or emotional violence during childhood. The prevalence of such forms of violence is even higher among children aged 13-17 – at 65% for males and 49% for females. A disaggregation of these forms of violence draws attention to how experiences of sexual violence evolve as children transition from childhood to adulthood: females in the 18-24-year-old age range experience sexual violence at twice the rate of their male counterparts, despite the prevalence by sex of participants being similar at ages 13-17. This suggests that intensified sexual violence prevention efforts are required during the childhood years to stem the tide of increased sexual violence exposure among girls as they grow older.

Data disaggregation also places a spotlight on types of VAC that are less well understood or explored in African contexts – specifically, physical and emotional violence. The study results indicate that physical violence is reported much more by males than by females, regardless of age range. On the other hand, exposure to emotional violence fluctuates across gender and age, being reported more by females at ages 13-17 and much more by males in the 18-24-year-old age range. These two forms of violence also co-occur more frequently than any other type of violence during childhood in general. These realities highlight the need for interventions that can appropriately respond to physical and emotional violence in refugee contexts. Such interventions should include models and approaches for attending to child survivors, including boys, given their greater vulnerability, especially to physical violence (as compared with girls who are more vulnerable to sexual violence at a young age), along with curricula, guidance, and training for service delivery providers who have been accustomed to focusing primarily on the clinical management of rape (Undie et al., 2016, 2019).

Results from the Uganda HVACS demonstrate that children in refugee settings are more likely to know where to seek care for violence than they are to disclose their experience of violence and to seek care/help. Disclosure of sexual and physical violence was notably low among respondents of all age groups. These results suggest that VAC services are under-utilised in refugee contexts

and that interventions are needed to promote disclosure and help-seeking among this population. Children aged 13-17 may also require special support to access the VAC services they need.

Awareness-raising interventions could help to dispel any notions (among community members and program implementers alike) that some forms of violence are less serious than others, while further attention is given to developing models for responding to nascent forms of sexual violence. The Uganda HVACS results can inform targeting of the most vulnerable, where funds for programming are limited. The results demonstrate that sub-groups such as children with disabilities, those who are married/cohabiting, and those who witnessed violence in the home tend to be at greater risk of experiencing violence. This reality can provide a starting point for targeting.

The findings also point to a wide pool of perpetrators for each violence type, ranging from peers, classmates, and intimate partners to strangers, parents/caregivers, other relatives, and adult community members. The vast majority of perpetrators are people known to the survivors. These factors signal the importance of community-wide approaches that promote the allyship of all community members in violence prevention.

With regard to policy, the findings provide decision-makers in Uganda's humanitarian settings with a baseline that covers all refugee settlements in the country, and that presents rigorous, population-level data on lifetime experience of VAC, in addition to past 12-month experience of the same from females and males aged 13-24 years (Chiang et al., 2016). As VAC cuts across multiple sectors, the Uganda HVACS lends an opportunity to policymakers to respond to the findings as they see fit. A workshop to facilitate such a response is described later in the 'Results Dissemination and Uptake' section of this report.

What do the Uganda HVACS findings mean for research?

Multiple lessons have been learned for conducting research on VAC in humanitarian settings. The high level finding for researchers is that robust surveys that have traditionally excluded from humanitarian settings can be conducted in refugee contexts. In carrying out research in humanitarian contexts on sensitive issues, the success factors for ethical, rigorous research include robust guidance, strong partnerships, the involvement of humanitarian populations, close attention to ethics, and careful community entry. These lessons will inform the second-ever Humanitarian Violence Against Children and Youth Survey, which is expected to commence in refugee camps in Ethiopia in December 2023.

What are the limitations of the Uganda HVACS?

Uganda's refugee policy is considered the most progressive in the world, as it grants refugees the right to work and significant freedom of movement (Momodu 2018). The policy centres on the actual settlement of refugees. Consequently, once registered at transit centres, refugees are transferred to settlements, as opposed to camp settings, and provided with land (1.25 acres per household for housing and agriculture) to re-establish their lives.

This progressive policy poses a unique challenge to the Uganda HVACS that is foreign to the standard VAC surveys generally and other refugee settings specifically. The policy allows for increased mobility of households in Ugandan refugee settings, which resulted in a low response rate at the household level. The overall response rates (both household and individual response rates) are over 80% in most countries where the standard VACS have been conducted (Chiang et al. 2016). For the Uganda HVACS, the overall response rates were much lower. The low household response rates reflect challenges related to locating sampled households, which is expected in refugee settings. However, upon identification of sampled households, the likelihood of eligible participants consenting to participate in the survey was high for both females and males. Nonetheless, the question of whether the sample of respondents represents a select group does arise. Selection bias may also have arisen as a result of solely identifying respondents within

households in refugee settlements and excluding those in other living situations such as in institutions or.

In addition to this limitation of the VACS in general, Nguyen and colleagues (2018) also describe two other potential limitations of the VACS, which are relevant to the HVACS, namely: the cross-sectional nature of the study, which limits our ability to identify causal relationships, and the social desirability bias brought about by self-reported data. However, these limitations are noted as potentially leading to the underestimation of VAC (Nguyen et al., 2018; Nace et al, 2021) – and if so, the high prevalence of violence against children demonstrated by the HVACS provides an important and worrisome benchmark for investigating these issues among children in other refugee settings.

Results Dissemination and Uptake

Introduction

To create space for deliberation upon the Uganda HVACS findings and link research to action for child and youth survivors in refugee settings, the Baobab Research Programme Consortium held an initial, virtual dissemination meeting on February 17, 2023, that brought together the Office of the Prime Minister's (OPM's) Department of Refugees and UNHCR to learn about and consider the study results. Given the importance and urgency of the findings, OPM decided to bring together humanitarian stakeholders from across various sectors to have the same opportunity to learn about and deliberate upon the Uganda HVACS results.

Accordingly, from June 14-16, 2023, OPM's Department of Refugees and Baobab co-convened a Data-to-Action (D2A) workshop in Kampala, with support from the Ministry of Gender, Labour and Social Development (MGLSD); UNHCR; and the U.S. Centers for Disease Control and Prevention (CDC) headquarters staff. State officials from the Government of Uganda, civil society organisations (CSOs) and international partners participated in this workshop.

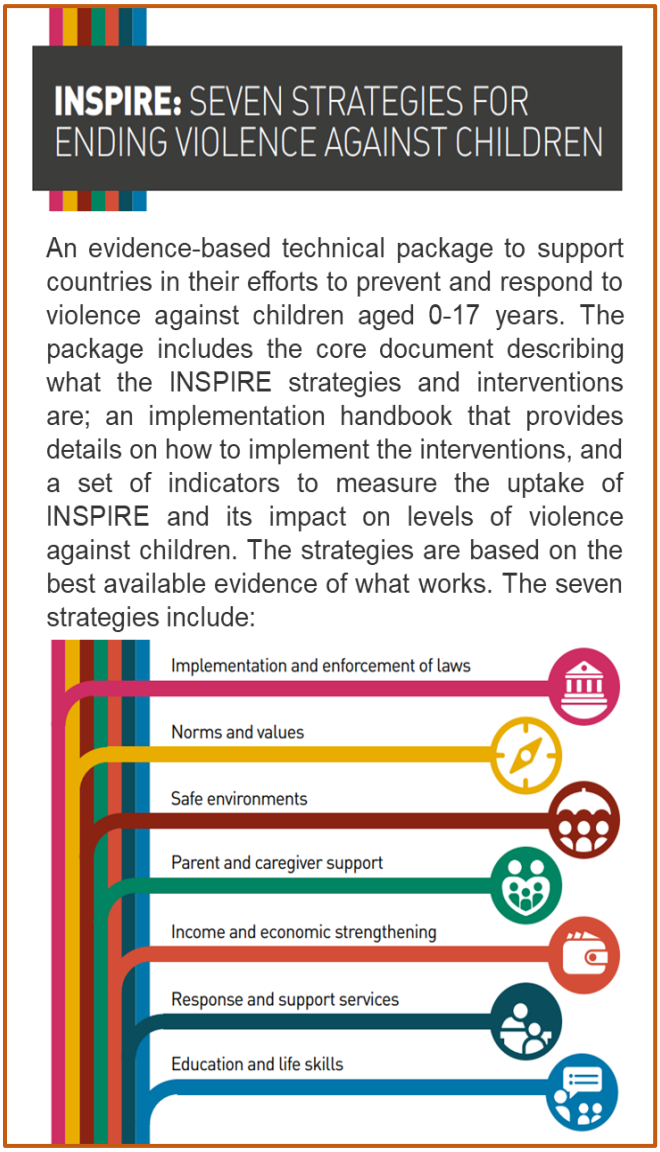
HVACS D2A workshops aim to support countries in creating violence prevention priorities directly informed by HVACS data. These priorities are created by linking HVACS data to the suite of evidenced-based and prudent practices using the INSPIRE: Seven Strategies for Ending Violence Against Children technical package. The INSPIRE technical package was developed and endorsed by 10 international organisations under the leadership of the World Health Organisation (WHO, 2022). Each letter of the acronym, 'INSPIRE' represents one of the strategies for ending VAC. The INSPIRE package aims to support countries and communities in achieving Sustainable Development Goal Target 16.2 on ending violence against children.

The outcomes of the D2A workshop are data-driven, evidence-based priorities and actions to prevent and respond to violence against children (VAC) in humanitarian settings in Uganda, with a specific focus on refugee contexts. The priorities will help complement existing policies and plans related to VAC prevention in Uganda and help fill in gaps that address humanitarian populations.

Data to Action: Using HVACS Data, Evidence-Based Solutions and Partnerships to Drive National Action

Sponsored by the U.K. government and led by the Baobab Research Programme Consortium with support from the Together for Girls (TfG) partnership, the 2022 Uganda HVACS materialised through a collaborative effort involving several partners. The Uganda OPM, Department of Refugees, provided critical and practical guidance on conducting surveys in refugee settings in Uganda, and lent staff to support community entry and to provide troubleshooting assistance in every region of the country. The UNHCR EHAGL Regional Bureau played a facilitative, catalytic role, linking Baobab to the UNHCR Uganda country operation, and promoting the collaboration at the country level. In turn, UNHCR Uganda lent technical assistance on sampling techniques in refugee contexts in Uganda, and for ensuring efficient mechanisms for psychosocial support to study participants during data collection. Related to this, five UNHCR implementing partners in Uganda were involved in the provision of home-based psychosocial care to survey respondents in need of it, coupled with referrals for continued care beyond the data collection period: Danish Refugee Council, Humanitarian Assistance and Development Services, International Rescue Committee, Lutheran World Federation, and Medical Teams International. The Violence Against Children and Youth Survey and its humanitarian version are products of the TfG partnership, which comprises the U.S. Centers for Disease Control and Prevention (CDC) and other partners. TfG and CDC provided pre- and post-survey technical support and guidance for the overall study, as well as for the HVACS D2A Workshop, with CDC also co-facilitating this workshop in Kampala, Uganda.

This strong focus on capturing the attention of key stakeholders, forming strategic partnerships, and working with or leveraging existing expertise from key partners, has strengthened Baobab's work in both the generation of research and the use of evidence to inform policy and programming in refugee settings.



In 2016, the World Health Organisation and partners released **INSPIRE: Seven Strategies for Ending Violence Against Children**, a technical package that includes evidence-based strategies with demonstrated success in preventing and responding to violence in childhood. [1] These strategies aim to create the safe, nurturing environments and relationships that allow children and youth to thrive. In Africa, scientific research on the prevalence and incidence of violence and exploitation of children, adolescents, and young adults is still in its nascent stages in most countries. This is particularly the case in humanitarian contexts, where Violence Against Children and Youth Surveys have not been conducted before now, despite the need for robust evidence in these settings.

The 2019 Minimum Standards for Child Protection in Humanitarian Action (CPMS) and the 2016 INSPIRE package are complementary and mutually reinforcing (CP AoR, 2020). They both advance similar approaches and principles for ensuring the safeguarding of children, while considering several similar cross-cutting operational characteristics. Drawing on both could therefore potentially result in better outcomes for children in humanitarian contexts. For some settings, INSPIRE interventions can be employed to support the implementation of certain CPMS standards. In turn, key actions under the CPMS provide useful guidance for INSPIRE intervention implementation. During the Uganda HVACS D2A workshop, participants were introduced to both INSPIRE and the CPMS, and used both to determine actions in response to the HVACS findings.

Data to Action Workshop in Uganda: Overview

The 2022 Uganda HVACS provided robust and critical information on the prevalence and context of VAC to inform policy and programmatic decision-making. The Government of Uganda, CSOs and international partners held a Data to Action workshop in Kampala from June 14-16, 2023, to create violence prevention priorities directly informed by the HVACS data, and to translate HVACS findings into prioritised and actionable next steps by linking the HVACS data to the **INSPIRE: Seven Strategies for Ending Violence Against Children** technical package and the **Child Protection Minimal Standards (CPMS).** This technical package provides a source for evidence-

[1] For more information on the INSPIRE Technical Package, visit the website at https://inspire-strategies.org

based violence prevention programming that countries can utilise in the operationalisation of their relevant domestic relevant policies, such as the National Child Policy and the National Child Policy Implementation Plan in Uganda. By linking the HVACS data to the INSPIRE technical package, the workshop provided a crucial link between data and action by asking stakeholders across sectors to interpret and respond to findings from the HVACS. The outcome of the D2A workshop entailed data-driven, evidence-based prioritisation of actions and recommendations for Uganda to prevent and respond to violence against children in humanitarian settings. All recommendations put forward were complementary to the existing Uganda National Child Policy, along with the National Child Policy Implementation Plan.

The D2A workshop consisted of a review of the HVACS data, coupled with sector-specific breakout sessions to prioritise areas of concern and develop strategies to respond to those findings of concern based on the INSPIRE technical package. The workshop was conducted over three days in Kampala, and brought together state officials from various ministries, and representatives or delegates from International Non-Governmental Organisations (INGOs), Non-Governmental Organisations (NGOs), CSOs, UN bodies, the Foreign Commonwealth and Development Office of the United Kingdom, other Embassies, CDC, and the Baobab Research Programme Consortium (RPC), comprising the Population Council, Inc., the Population Council, Kenya; and the African Population and Health Research Center. Over 70 participants were in attendance on any given day, with an even gender split, as outlined below.

	Day 1 14th June	Day 2 15th June	Day 3 16th June
Ministry of Gender, Labour and Social Development	15	16	12
OPM Uganda and Other State Officials	11	06	05
OPM Settlement Commandants	07	10	11
iNGOs, NGOs, and CSOs	26	32	28
UNHCR, UN Women	02	05	05
FCDO, Other Embassies	02	-	-
CDC	02	02	02
Baobab RPC	12	12	11
TOTAL	**77**	**83**	**74**
Female	37	42	40
Male	40	41	34

Following brief opening and welcoming remarks by Mr. Charles Bafaki, Commissioner for Refugees, OPM Uganda, participants were given an opportunity to introduce themselves, their affiliations, and sectors of work. Guided by their specialties, participants were divided into four sectors – Child Protection, Gender-Based Violence (GBV), Health, and Education – and assigned to sector-specific tables/groups. As expected, the largest contingent was working in Child Protection, followed by GBV, Health, and then Education. Participants would sit in these designated tables for the entire workshop, allowing for sectoral deep dives as guided by various workshop exercises.

Photo: Commissioner for Refugees, OPM, giving remarks

Day One of the D2A workshop was spent on context-setting. Participants were introduced to the objectives of the workshop and then taken through the global context of violence against children and youth. The local context of violence against children and youth in Uganda was also presented, covering some of the data from the Uganda National Violence Against Children and Youth Survey (VACS), as well as an introduction to the first-ever representative VACS conducted exclusively in humanitarian settings (Uganda HVACS) that had been completed by the Baobab RPC. The Ending VAC Focal Person within the Ministry of Gender, Labour, and Social Development then took the audience through highlights from the Uganda National Child Policy and the National Child Policy Implementation Plan with the objective of showing that national action planning and implementation around VAC was already underway in Uganda, with the D2A workshop positioned to enrich existing plans by filling gaps in evidence to inform actions centred on refugee populations. Representatives from the CDC provided an overview of the INSPIRE package and the CPMS, including taking participants through an orientation activity consisting of a treasure hunt, to better acquaint the audience with these key global resources providing multisectoral guidelines for implementing, adapting, coordinating, and monitoring interventions to prevent and respond to VAC. Copies of these documents were made available for participants to refer to as needed through the next series of workshop activities. To familiarise participants with the findings, the day's proceedings ended with sector-specific discussions, following presentations on the definitions, prevalence, perpetrator types, age at first experience, negative health consequences of, and risk behaviours associated with childhood experiences of sexual, physical, and emotional violence from the Uganda HVACS data. A UNHCR representative gave the closing remarks by going over a summary of the day's achievements and discussions and providing a preview of the following day's activities.

Education Sector Group

Child Protection Sector Group

GBV Sector Group

Health Sector Group

Photos: Participants grouped into sector-designated tables.

On **Day Two**, and following more detailed presentations on risk factors, health outcomes, and perpetration of sexual, physical, and emotional violence against children and youth from the Uganda HVACS dataset, as well as findings for 6 of the 7 INSPIRE strategies, including ***N for norms and values; S for safe environments; P for parent and caregiver support; I for income and economic strengthening; R for response and support services; and E for education and life skills;*** and, excluding ***I for the implementation and enforcement of laws,*** the rest of the day was spent on sector-specific breakout exercises. One laptop with an Action Planning Worksheet for Humanitarian Settings in Uganda template was handed out to each sector for electronic collection and reporting of responses from each of the four groups. During **Breakout Exercise 1**, participants were asked to consider national priorities and/or policies in their sectors, specifically in the context of the National Child Policy and Implementation Plan, and then select the top 2 priority indicators (per sector) that needed to be targeted for addressing VAC in humanitarian settings (from a list of 15 key indicators from the Uganda HVACS findings provided to participants). To better understand the violence prevention and response landscape, and inform future efforts, **Breakout Exercise 2** included mapping existing humanitarian violence prevention and response efforts for each of the 2 priorities identified in Breakout Exercise 1 against the INSPIRE/CPMS strategy groupings, including highlighting where gaps in delivery existed. At the end of both exercises, a combined total of 8 priority indicators were selected from the original list of 15 key indicators. During a plenary session, each sector presented their justification for the selection of their priority indicators, and existing efforts focused on prevention, or response, or both.

Left: Abdul Ramadhan, Refugee Settlement Commandant (OPM) – workshop delegate.
Right: Andrés Villaveces, CDC representative and one of the facilitators at the D2A Workshop

On **Day Three**, the final day of the D2A workshop, sector groups continued work on their Action Planning Worksheet for Humanitarian Settings in Uganda. **Breakout Exercise 3** entailed choosing relevant INSPIRE strategies and approaches that could be used to bolster interventions related to their selected priority indicators in humanitarian settings, and discussing any potential barriers or opportunities and collaborations that could impact the implementation of these selected strategies. The final **Breakout Exercise 4** entailed participants discussing the more immediate next steps in addressing selected priority indicators and planning for INSPIRE implementation by considering who the focal agency or lead partner ought to be, and which supporting ministries/organisations/agencies would need to be engaged. As on the day prior, all sectors presented the results of these discussions to other sectors. As deliberations came to a close, facilitators reviewed key priorities and actions identified from the workshop and presented multi-sector priorities for VAC prevention in humanitarian settings based on the mapping of CPMS standards and pillars onto INSPIRE strategies.

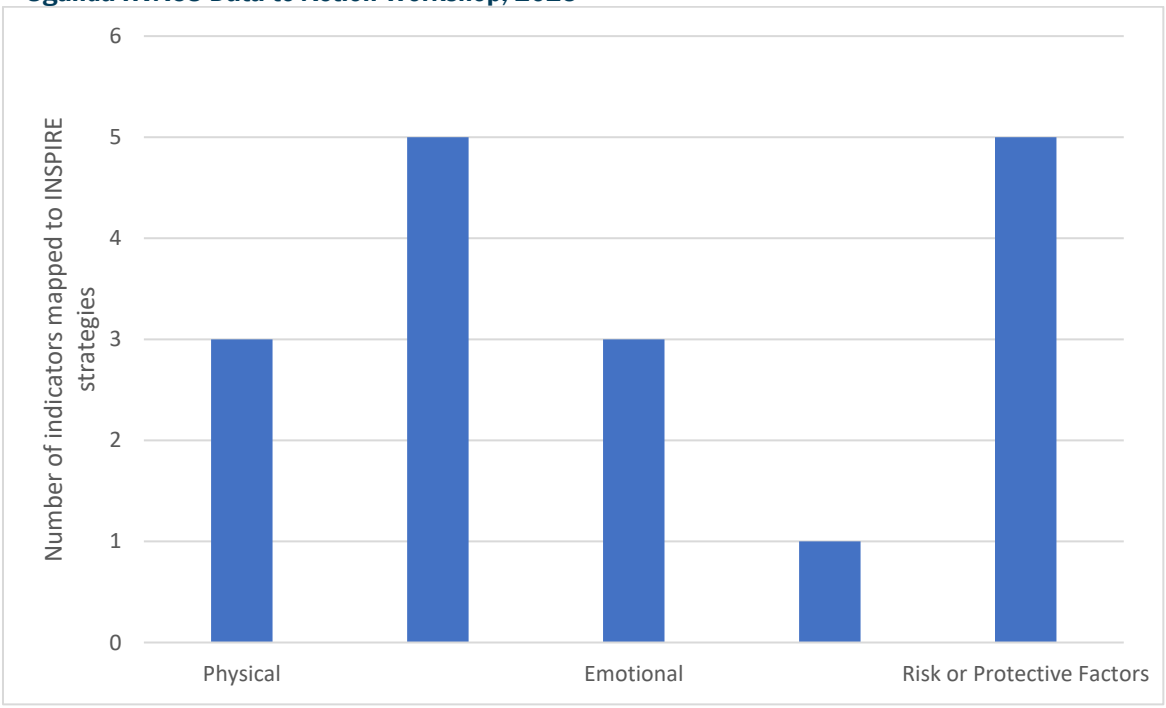
Priority Setting: Using HVACS Data and INSPIRE Strategies to Develop Data-Driven, Evidence-Informed Priorities to Address VAC

The D2A workshop provided an opportunity for key violence prevention stakeholders to convene and identify evidence-based violence prevention priorities to protect the children of Uganda. **Humanitarian stakeholders from the Child Protection, Education, GBV and Health sectors identified a total of eight key priority areas from the HVACS results on which to centre future national action on VAC prevention, while addressing risk factors/behaviours and health consequences of violence.** These priorities are listed in the Table below.

Priority Indicators by Sector	
	Child Protection
1.	Parental monitoring and supervision
2.	First incident of sexual violence happened after arriving in the settlement before age 18 (among respondents ages 18-24)
	Education
3.	Physical discipline and verbal aggression by caregivers (in the past 12 months)
4.	Not currently enrolled in school (access to education)
	Gender-Based Violence
5	Endorsed harmful gender norms
6.	Sought services for sexual violence
	Health
7.	Sexual violence (sexual violence by any perpetrator before age 18)
8.	Mental Distress in the past 30 days for victims of sexual violence (Anxiety and Depression)

Sexual violence emerged as a recurring priority issue, that is, the top 2 issues selected as priorities in each sector for informing future actions across all sectors except for Education.

Figure 1: Number of priorities that address types of violence or characteristics associated with violence – Uganda HVACS Data-to-Action Workshop, 2023



Once participants identified VAC priorities informed by the HVACS results, the INSPIRE Technical Package provided a source for evidence-based violence prevention planning. Each priority identified by sectors is addressed by one or more strategies, approaches and interventions outlined in the INSPIRE technical package. Figure 2 below provides a summary of the VAC priorities identified by each sector and how each priority links to strategies outlined in the INSPIRE technical package.

Figure 2: Violence Against Children priorities and INSPIRE strategies by sector – Uganda HVACS Data-to-Action Workshop, 2023

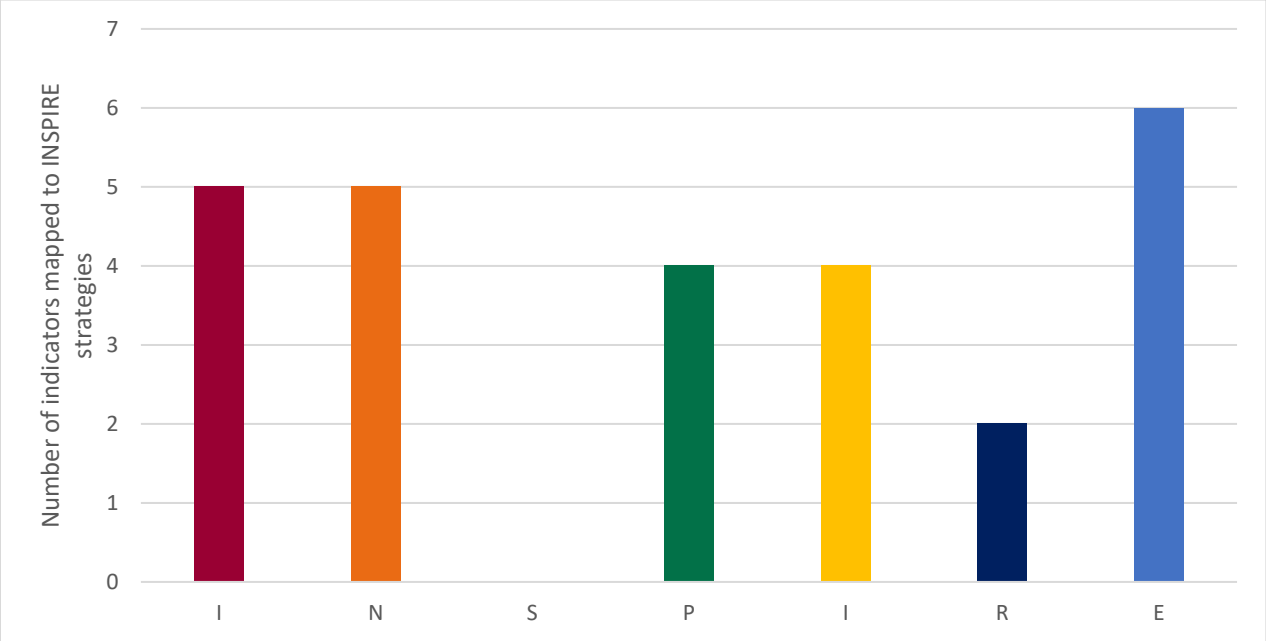
HVACS Priority Indicators for the Prevention of Violence Against Children and Youth	Sector Represented	LINKED STRATEGIES INSPIRE						
		I	N	S	P	I	R	E
1. *Parental monitoring and supervision*	Child Protection							
2. *First incident of sexual violence happened after arriving the settlement before age 18*	Child Protection							
3. *Physical discipline and verbal aggression by caregivers (in the past 12 months)*	Education							
4. *Not currently enrolled in school (access to education)*	Education							
5. *Endorsed harmful gender norms*	GBV							
6. *Sought services for sexual violence*	GBV							
7. *Sexual violence (sexual violence by any perpetrator before age 18)*	Health							
8. *Mental distress in the past 30 days for victims of violence (anxiety and depression)*	Health							

INSPIRE represents seven strategies to prevent violence against children that stand for: **I**= Implementation of laws**; N**= Norms and values; **S**= Safe environments; **P**= Parent and caregiver support; **I**= Income and economic strengthening; **R**= Response and support services; **E**= Education and life skills

The VAC priorities and accompanying INSPIRE strategies identified during the D2A workshop support data-driven, evidence-based priorities to prevent and respond to VAC and provide a roadmap to complement Uganda's National Child Policy Implementation Plan.

In response to the Uganda HVACS findings, the most recommended INSPIRE strategies on the part of humanitarian stakeholders (see Figure 2) were related to 'Education and life skills,' followed by 'Implementation of laws,' and then 'Norms and values'; and subsequently by 'Parent and caregiver support' and 'Income and economic strengthening' in equal measure; and lastly, by 'Response and support services.' No recommended strategies focused on 'Safe environments.'

Figure 3: Number of violence prevention priorities mapped to INSPIRE strategies based on data from the 2022 Uganda HVACS



INSPIRE represents seven strategies to prevent violence against children that stand for: **I**= Implementation of laws**; N**= Norms and values; **S**= Safe environments; **P**= Parent and caregiver support; **I**= Income and economic strengthening; **R**= Response and support services; **E**= Education and life skills

There was broad alignment between the selected INSPIRE priority indicators and the Minimum Standards for Child Protection in Humanitarian Action (CPMS). Pillars 1, 2, and 4 of the CPMS contain standards that are largely operational in nature and that are already known to correspond perfectly to the INSPIRE priority indicators (*see* Figure 4). Pillar 3 of the CPMS, however, focuses on programming issues. The INSPIRE priority indicators corresponded with almost all the standards within Pillar 3.

Figure 4: Correspondence between the selected priority indicators mapped to the CPMS standards and pillars based on data from the 2022 Uganda HVACS

Child Protection Minimum Standards			Selected Priority Indicator							
Pillars	Standards		1	2	3	4	5	6	7	8
1	1	Coordination								
1	2	Human resources								
1	3	Communications and advocacy								
1	4	Programme cycle management								
1	5	Information management								
1	6	Child protection monitoring								
2	7	Dangers and injuries								
2	8	Physical and emotional maltreatment								
2	9	Sexual and gender-based violence								
2	10	Mental health and psychological distress								
2	11	Children associated with armed forces and armed groups								
2	12	Child labour								
2	13	Unaccompanied and separated children								
3	14	Socio-ecological approach to child protection programming								
3	15	Group activities for child wellbeing								
3	16	Strengthening family and caregiving environments								
3	17	Community level approaches								
3	18	Case management								
3	19	Alternative care								
3	20	Justice for children								
4	21	Food security and child protection								
4	22	Livelihoods and child protection								
4	23	Education and child protection								
4	24	Health and child protection								
4	25	Nutrition and child protection								
4	26	Water, sanitation and hygiene (WASH) and child protection								
4	27	Shelter and child protection								
4	28	Camp management and child protection								

During the workshop, sectors identified several challenges to addressing selected priorities and implementing VAC prevention programming in humanitarian contexts, including limited human and financial resources; the high cost of some interventions; partners' tendency to work in silos; barriers to service access, coupled with limited follow-up and referral in case management; the sustainability of approaches; language barriers; and online misinformation. Alongside these challenges are opportunities, such as the convening power of the OPM, UNHCR, and other UN agencies, and the existing humanitarian working groups established by these agencies to mitigate silo-working and financial inefficiencies. These convenings (made up of service delivery

and research organisations, alike) can also help to match implementing partners to evidence and evidence-based approaches that are appropriate for low-resource settings and sustainable. The availability of the HVACS data also help to prioritise the most pressing VAC issues.

Integration of Recommendations from the Uganda HVACS into the National Child Policy Implementation Plan

The Government of Uganda, led by the Office of the Prime Minister (Department of Refugees) and the Ministry of Gender, Labour, and Social Development plan to use the priorities identified during the D2A workshop to inform key follow up activities.

An initial step involved the establishment of institutional coordinating mechanisms (within the government and with supporting agencies outside of the government (bilateral, multilateral, and cooperating agencies). The MGLSD was identified as the lead government agency for coordinating activities, with support from OPM. A range of activities to be undertaken in response to the HVACS findings through the end of the National Child Policy Implementation Plan period were also identified by stakeholders. These have been organised thematically in the Table below.

Leading coordination:	Ministry of Gender, Labour, and Social Development (MGLSD) with support of the Office of the Prime Minister and international coordinating institutions
Other participants:	Implementing partners comprising the National Child Protection and GBV Sub-Working Groups, including representatives at the national and local levels
Timeline:	2 years (through end of 2025)

Activities Proposed for Implementation in Response to the Uganda HVACS Data

	Dissemination Activities
1.	Development of materials to promote the further dissemination of the HVACS findings, internally and externally, including to regional and global humanitarian actors
2.	Dissemination of the National Parenting Guidelines
3.	Use of community radio stations for dissemination to communities
4.	Harness OPM's convening power and OPM's coordination meetings as platforms for the dissemination of the results
	Partnership Activities
1.	Coordination with: Government: Ministry of Education and Sports; OPM-Community Service Department; Local Government Departments of Community Service and Probation Offices UN agencies: UNICEF, UNHCR, UNESCO, UN Women, INGOs, CSOs
2.	Programme/project design and proposal-writing
3.	Resource mobilisation and advocacy for resources (financial and human resources)
	Information-Gathering Activities
1.	Mapping of existing actors to promote synergies
2.	Assessment and status of the functionality of existing structures
	Intervention Activities
	Training Interventions
1.	Relevant training of providers in various sectors (health, social, others) by partners in areas relevant to the HVACS findings
2.	Enriching Psychological First Aid training curricular to be reflective of the HVACS findings
3.	Training of Trainers and key stakeholders in education (e.g., headteachers, teachers, School Management Committees, Parent-Teacher Associations) in response to the HVACS findings
4.	Formation and training of parents and caregivers on positive parenting approaches

5.	Establishment and training of community structures to work with
	Non-Training Interventions
1.	Establishment of school clubs
2.	Aligning Child Protection Committees with Child Wellbeing Committees
3.	Roll-out of the National Framework for Alternative Care
4.	Identification of unaccompanied minors and facilitating and monitoring alternative care arrangements
5.	Orientation of new arrivals and continuous community awareness creation on children's rights and responsibilities toward them
6.	Use of child protection referral posters at reception centers (highlighting the available services)
7.	Provision of survivor-centered multisectoral response services, including psychosocial support, legal representation, juvenile justice, and ensuring safety and security
8.	Implementation of *SASA!* (Start, Awareness, Support, and Action!) prevention model

Immediate Implementation Plans to Respond to VAC in Refugee Settings

In follow-up to the D2A workshop, the Baobab RPC has been in discussions with the MGLSD and OPM leading to the identification of **an intervention that will help address several of the activities proposed for implementation in response to the Uganda HVACS (see Table above), while also addressing the top 5 (out of 6) INSPIRE strategies recommended by humanitarian stakeholders at the D2A workshop (see Figure 2), as explained in further detail below.**

The intervention will be piloted in Kiryandongo Settlement and District, which has yet to benefit from the MGLSD's national Para-Social Worker (PSW) Training Programme.

PSWs are community-based 'first responders' who provide prevention and response services related to child and community-based protection. Their main roles and responsibilities revolve around the identification of cases, conducting home visits, providing counseling services, referral of cases to service points, and the provision of immediate, first-line response services. Once identified and carefully selected by Sub-County Child Wellbeing Committees, they take part in a 21-day training session, led by the MGLSD and drawing on the national training manual for PSWs (MGLSD, 2023). The training sessions focus on a variety of subject areas, including case management; childcare and protection; GBV; mental health/psychosocial support; positive parenting; counseling; self-care; and assessment, interview and data collection skills and management. Up to 120 PSWs are expected to be trained in Kiryandongo, with a composition of about 60% refugee PSWs and 40% host community PSWs, in alignment with stipulations for refugee and host community engagement by the Office of the Prime Minister.

As part of the Baobab intervention, a subset of the PSWs will be trained on additional modules and assigned to selected primary schools to proactively identify child survivors of sexual violence through a systematic screening exercise. Child survivors identified through this process will receive school-based psychosocial support, with acute cases being accompanied to one-stop GBV centres for comprehensive care. The care of such survivors will be coordinated through a collaborative process between school-based PSWs and their peers operating at the household level. Prior to the school-based screening exercise, parents will be sensitised to the planned intervention through parent dialogues held in collaboration with the schools. Feedback and recommendations from parents will be fed into the intervention design. Parents of child survivors identified through the screening process will also be offered psychosocial support, as needed, in addition to support for improving parent-child communication around sexual violence.

Notably, this intervention attends to all of the needs alluded to in the 'Training Interventions' activities enumerated in the Table above, including provider training covering multiple sectors (in this case, social/community, health, and education); enhancing psychological first aid training;

the engagement of parents on positive parenting approaches; and the establishment and training of community structures. Furthermore, this intervention, which is expected to be piloted between 2023 and 2024, also addresses the 'Non-Training Interventions' activity focused on the provision of survivor-centered, multisectoral response services.

The intervention also draws on 5 out of 6 of the INSPIRE strategies most recommended by humanitarian stakeholders, as outlined in the Table below:

INSPIRE Strategies Recommended by Humanitarian Stakeholders	Relation to Baobab Intervention
Education and life skills	The screening intervention will be school-based (with a household-based complement), given that over 90% of children in Uganda's refugee settlements are enrolled in primary school. The household-based component will ensure that child survivors identified at school are also properly support at home, while also ensuring that the needs of out-of-school children are not overlooked.
Implementation of laws	Child survivors who report experiencing acute forms of sexual violence (e.g., rape) will be linked to comprehensive care at one-stop centres, which offer a multi-sectoral response to violence, including linkage to the police/justice sector which implements the
Norms and values	The intervention involved multiple activities to shift negative norms that provoke and sustain violence against children, including promoting open dialogue about sexual violence across the community by sensitising students, dialoguing with parents (community leaders and school personnel are included in these dialogues as well), and screening students to provide a platform for disclosure, counselling child survivors who disclose (short- and long-term counselling, as needed).
Parent and caregiver support	The intervention involves fostering the support of parents/caregivers for child survivors through school-based parent dialogues and psychosocial support for parents of child survivors. Parents of child survivors are also provided with support to cope with the situation, strengthen parent-child communication, and to be advocates/champions for their children.
Response and support services	Children who disclose experiences of sexual violence during the screening process are immediately counselled and provided with further care through accompanied referrals to one-stop centres, if needed.

Technical and financial support for the piloting and evaluation of this intervention will be provided by the Baobab RPC through U.K. Aid funding.

References

Annor, F.B., Gilberta, L.K., Davila, E.P., Massetti, G.M., Kressa, H., Onotu, D., Ogbanufe, O. 2020. Emotional violence in childhood and health conditions, risk-taking behaviors, and violence perpetration among young adults in Nigeria. *Child Abuse & Neglect, 106:* 104510.

Brück, T. & Schindler, K. (2009). The Impact of Violent Conflicts on Households: What Do We Know and What Should We Know about War Widows?, Oxford Development Studies, 37:3, 289-309, DOI: 10.1080/13600810903108321.

Cerna-Turoff, I., Fischer, H.-T., Mansourian, H., & Mayhew, S. 2021. The pathways between natural disasters and violence against children: A systematic review. *BMC Public Health* 21 (1249): 1-17.

Chiang L., B. Fernandez, K. Falb, G. Massetti, D. Ligiero, and N. Behnam. 2020. *Measuring Violence Against Children in Humanitarian Settings: Implementation Guidance for a Humanitarian Violence Against Children and Youth Survey (HVACS)*. Washington, DC: Together for Girls.

Chiang, Laura F., Howard Kress, Steven A Sumner, Jessie Gleckel, Philbert Kawemama, and Rebecca N Gordon. 2016. "Violence Against Children Surveys (VACS): towards a global surveillance system." *BMJ Injury Prevention* 22 (Issue Suppl 1):1-16.

CP AoR (Global Child Protection Area of Responsibility), Global Partnership to End Violence Against Children, the Alliance for Child Protection in Humanitarian Action, UNHCR, and UNICEF. 2020. Minimum standards for child protection in humanitarian action & INSPIRE strategies: A guide to complementarity and use in humanitarian action (2020). ACPHA. Geneva, Switzerland.

Hillis, S., Mercy, J., Amobi, A., & Kress, H. 2016. Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics, 137*(3).

Jones L, Bellis MA, Wood S, Hughes K, McCoy E, Eckley L, Bates G, Mikton C, Shakespeare T, Officer A. 2012. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. Lancet. Sep 8;380(9845):899-907. doi: 10.1016/S0140-6736(12)60692-8.

Krug, E., Dahlberg, L., Mercy, J. et al. 2002. World Report on Violence and Health. Geneva: World Health Organization.

Lustig SL, Kia-Keating M, Knight WG, Geltman P, Ellis H, Kinzie JD, et al. 2004. Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry.* 43(1):24–36.

MGLSD (Ministry of Gender, Labour and Social Development) [Uganda]. 2015. *Violence against Children in Uganda: Findings from a National Survey, 2015*. Kampala, Uganda: MGLSD and UNICEF.

Momodu, S. 2018. *Uganda Stands Out in Refugee Hospitality*. Available at: https://www.un.org/africarenewal/magazine/december-2018-march-2019/uganda-stands-out-refugees-hospitality [Last accessed: November 3, 2023].

Nace, A., Maternowska, C., Fernandez, B., & Cravero, K. (2021): The Violence Against Children Surveys (VACS): Using VACS data to drive programmes and policies, Global Public Health, DOI: 10.1080/17441692.2021.2010116.

Nguyen, K. H., Kress, H., Villaveces, A., & Massetti, G. M. (2018). Sampling design and methodology of the violence against children and youth surveys. Injury Prevention, 1–7. https://doi.org/10.1136/injuryprev-2018-042916.

Office of the Prime Minister (OPM) & UNHCR. 2021. *Uganda Refugees and Nationals by District*. Available at: https://data2.unhcr.org/en/country/uga [Last accessed: March 18, 2021].

OPM & UNHCR. 2023. Uganda-Refugee Statistics July 2023. Available at: https://reliefweb.int/report/uganda/uganda-refugee-statistics-july-2023 [Last accessed: November 8, 2023].

OPM, UNHCR, & GoU (Office of the Prime Minister, UNHCR, Government of Uganda). 2023. *Uganda Comprehensive Refugee Response Portal: Uganda Refugees and Nationals by District*. Available at: https://data2.unhcr.org/en/country/uga [Last accessed: November 8, 2023].

Seff, I., & Stark, L. (2019). A sex-disaggregated analysis of how emotional violence relates to suicide ideation in low- and middle-income countries. *Child Abuse & Neglect, 93,* 222–227. Sommarin C., Kilbane T., Mercy J., Moloney-Kitts M., Ligiero D. (2014). Preventing Sexual Violence and HIV in Children. *Journal of Acquired Immune Deficiency Syndromes*, 66(Suppl. 2), S217-S223.

Stark, L., & Landis, D. (2016). Violence against children in humanitarian settings: A literature review of population-based approaches. *Social Science & Medicine, 152,* 125–137.

Undie, C., Birungi, H., Namwebya, J.H., Taye, W., Maate, L., Mak'anyengo, M., Katahoire, A., Kazungu, D.A., Kusasira, D., Mirghani, Z., & Karugaba, J. 2016. Screening for sexual and gender-based violence in emergency settings in Uganda: An assessment of feasibility. Nairobi: Population Council. https://knowledgecommons.popcouncil.org/departments_sbsr-rh/645/.

Undie, C., Ngebeh, J., Namwebya, J.H., & Karugaba, J. 2019. Practice-based learning: Observations on One-Stop Centers in refugee settings. Sauti/VOICE Program Brief no. 5. Nairobi: UNHCR EHAGL Africa Bureau and Population Council. https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1095/.
WHO (World Health Organization). (2022). Violence Against Children [Fact Sheet]. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/violence-againstchildren.

UNHCR (United Nations High Commissioner for Refugees). 2020. *Child Protection Dashboard: Uganda Refugee Response Plan (RRP) 2020-2021*. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/Child%20Protection%20Dashboard%20Q2%202020.pdf [Last accessed: November 16, 2021].

UNHCR Regional Bureau for the East and Horn of Africa and the Great Lakes Region. 2020. Available at: https://data2.unhcr.org/en/situations/rbehagl [Last accessed: May 19, 2021].

WHO (World Health Organisation). 2022. *Violence Against Children*. Available at: https://www.who.int/news-room/fact-sheets/detail/violence-against-children [Last accessed: December 28, 2023].

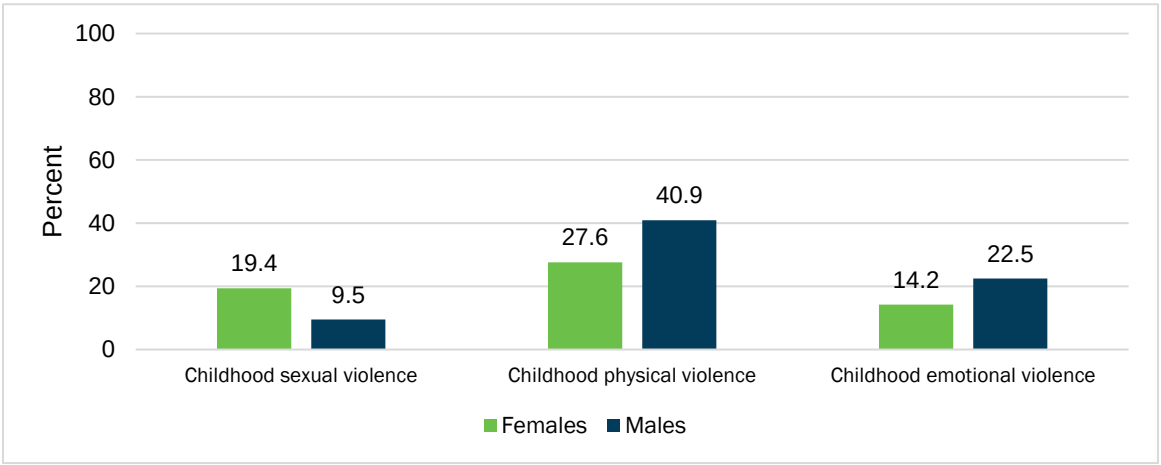
Annex

Prevalence of violence against children

Prevalence of VAC among 18-24-year-olds

Prevalence of sexual violence
• About one out of five females (19.4%) and one out of ten males (9.5%) aged 18-24 years experienced sexual violence before age 18. • Among those who experienced sexual violence in childhood, about 1 in 3 females (37.7%) experienced the first incident when they were 13 years or younger; 68.8% of males experienced the first incident when they were between ages 16-17 years. • Of those who experienced sexual violence in childhood, about 2 out of 3 (62.7%) females and more than half (55.5%) of males experienced multiple incidents.
Prevalence of physical violence
• Physical violence was the most common type of VAC among both females and males aged 18-24 years. Significantly more males than females experienced physical violence prior to the age of 18 (40.9% versus 27.6%). • Of those who experienced physical violence in childhood, 13.7% of females and about 1 in 5 males (18.3%) had their first experience between the ages of 6 and 11.
Prevalence of emotional violence
• Fourteen percent of females and one in four males (22.5%) experienced emotional violence from a parent, adult caregiver, or other adult relatives in childhood. • Among those who experienced emotional violence before the age of 18, at least one in five (21.2%) females and one in four (25.7%) males experienced the first incident before the age of 11.

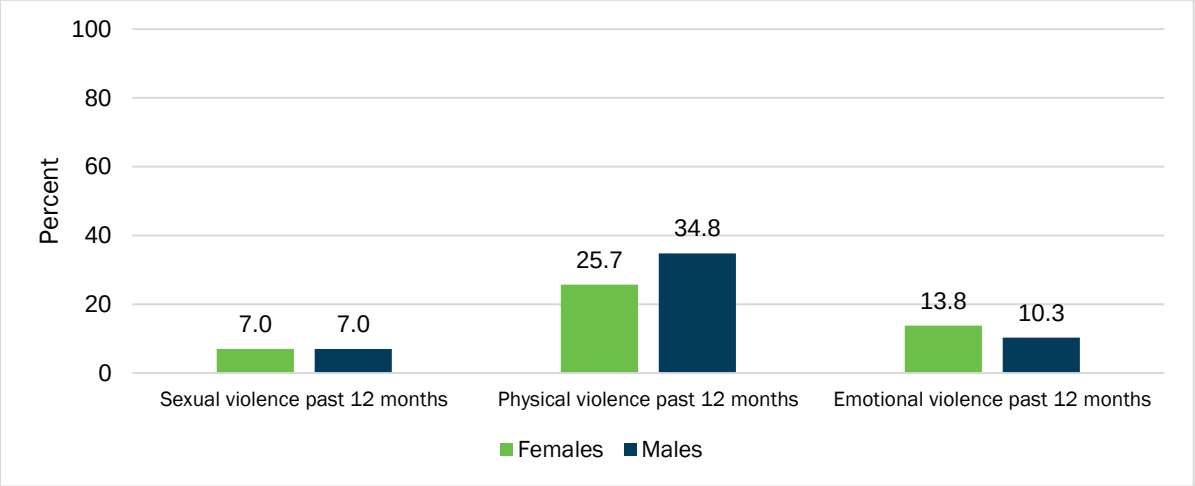
Figure 1: Prevalence of sexual, physical, and emotional violence prior to age 18, among 18-24-year-olds – Uganda Humanitarian Violence Against Children and Youth Survey (HVACS), 2022



Prevalence of violence in the past 12 months among 13-17-year-olds

Prevalence of sexual violence
• Seven percent of females and males aged 13-17 years experienced sexual violence in the 12 months preceding the survey.
Prevalence of physical violence
• About 1 in 5 females (25.7%) and 1 out of 3 males (34.8%) aged 13-17 years experienced physical violence in the past 12 months.
Prevalence of emotional violence
• Fourteen percent of females and 1 in 10 males (10.3%) aged 13-17 years experienced emotional violence from a parent, adult caregiver, or other adult relatives in the past 12 months.

Figure 2: Prevalence of sexual, physical, and emotional violence in the past 12 months among 13-17-year-olds - Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Overlap of forms of violence against children

Overlap of forms of VAC among 18-24-year-olds

Overlap of sexual, physical, and emotional violence in childhood
• Forty three percent of females and 49.6% of males aged 18-24 years experienced at least one form of VAC (sexual, physical, or emotional) before age 18.
• Eight percent of females and 6.9% of males aged 18-24 years experienced both sexual and physical violence during childhood.
• The overlap of physical and emotional violence was 9.2% for females and 16.1% for males.
• Three percent of females and 4.7% of males aged 18-24 years experienced all forms of violence (sexual, physical, and emotional) during childhood.

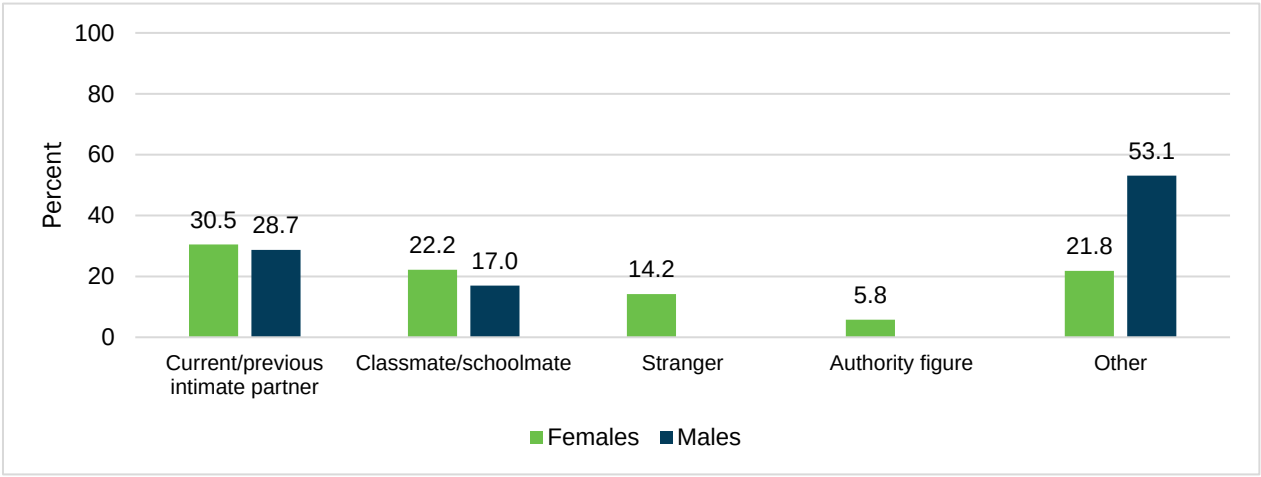
Overlap of violence forms in the past 12 months among 13-17-year-olds

Overlap of sexual, physical, and emotional violence in the past 12 months
• About 1 out of 3 (32.0%) females and 40.0% of males aged 13-17 years experienced at least one form of violence (sexual, physical, or emotional) in the past 12 months. • Seven percent of females and males aged 13-17 years experienced both physical and emotional violence in the past 12 months. • Four percent of females and 3.0% of males aged 13-17 years experienced both sexual and physical violence in the past 12 months. • Three percent of females and 0.8% of males aged 13-17 years experienced all forms of violence (sexual, physical, and emotional) in the past 12 months.

Perpetrators of violence against children

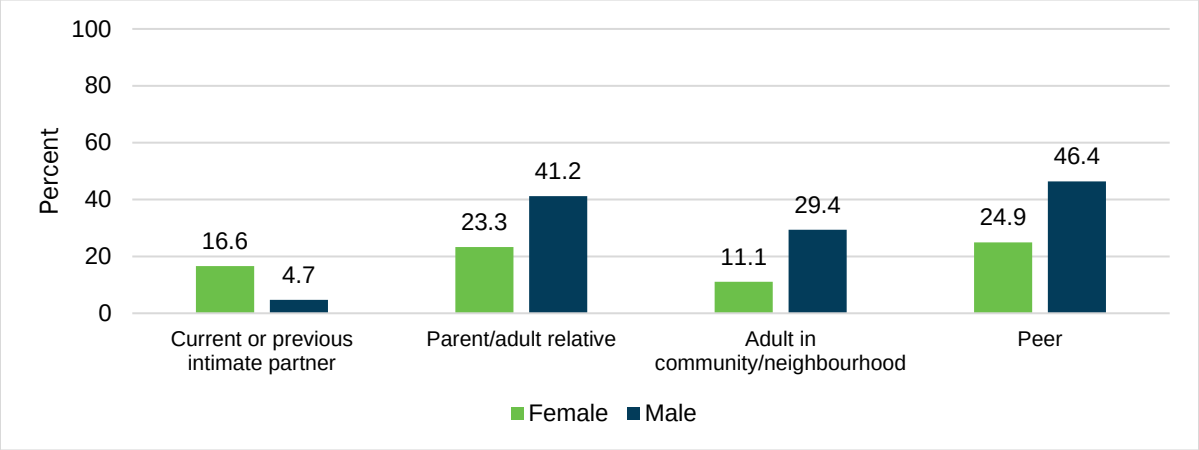
Perpetrators of sexual violence
• Among 18-24-year-olds who experienced childhood sexual violence, current or previous intimate partners (including a romantic partner, a boyfriend/girlfriend, or a spouse) were the perpetrators of the first incident for 30.5% of females and 28.7% of males. • For more than half (54.2%) of females and 12.8% of males aged 18-24 years who experienced sexual violence in childhood, the perpetrator of the first incident was 5 years older or more.
Perpetrators of physical violence
• The prevalence of physical violence in childhood was 24.9% for females and 46.4% for males for peer physical violence; 23.3% for females and 41.2% for males for parent or adult relative physical violence; 11.1% for females and 29.4% for males for adult in the community or neighbourhood physical violence; and 16.6% for females and 4.7% for males for current or previous intimate partner physical violence. • Significantly more females than males aged 18-24 years experienced the first incident of physical violence in childhood from an intimate partner (16.6% versus 4.7%).

Figure 3: Perpetrators of the first incident of sexual violence prior to age 18 among 18-24-year-olds who experienced sexual violence – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Note: Authority figure includes teacher, security officer, employer, community/religious leader, aid worker or medical professional.

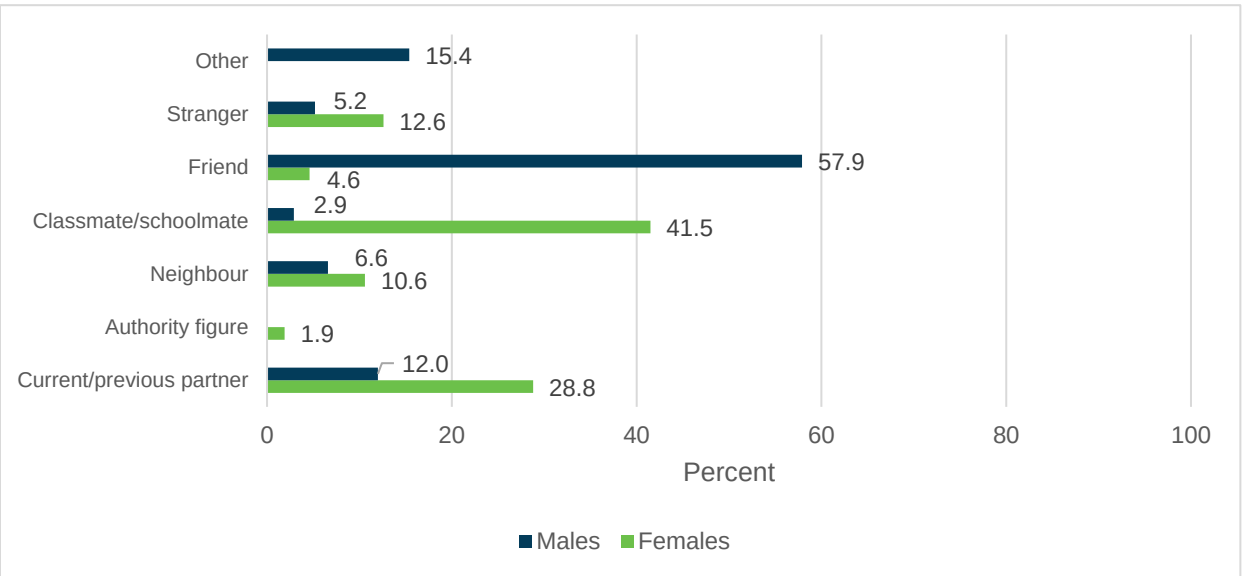
Figure 4: Prevalence of physical violence prior to age 18 by perpetrator – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Perpetrators of violence in the past 12 months among 13-17-year-olds

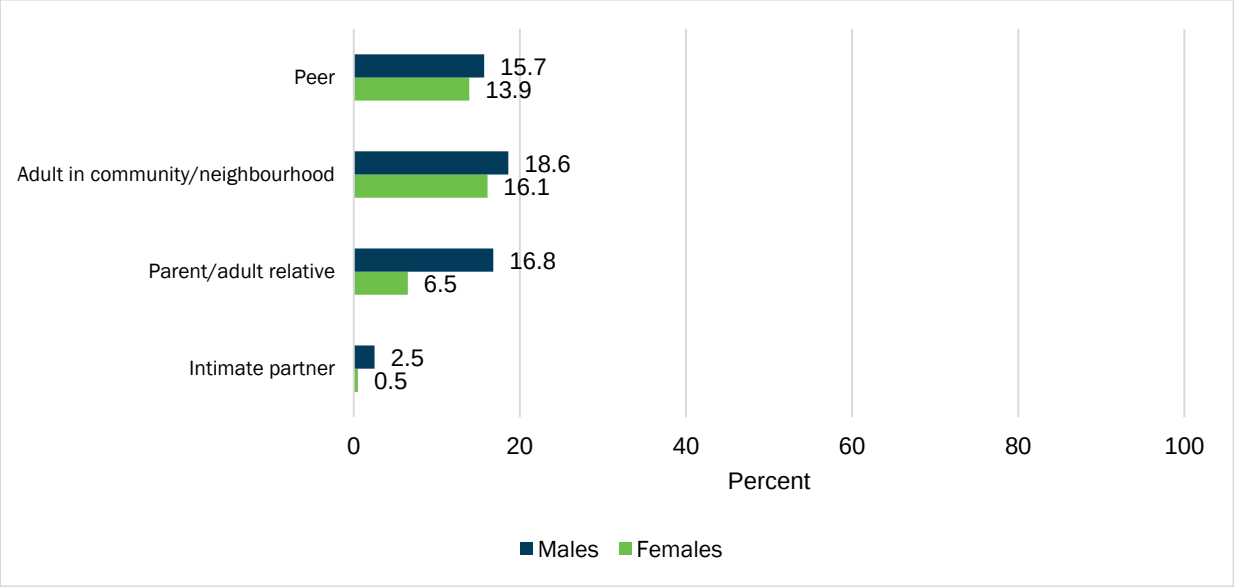
Perpetrators of sexual violence
• Among 13-17-year-olds who experienced sexual violence in the past 12 months, common perpetrators of the most recent incident were classmates or schoolmates for 41.5% of females, current or previous partners for 28.8% of females, and friends for 57.8% of males. • A higher proportion of females (30.5%) than males (6.1%) aged 13-17 years who experienced sexual violence in the past 12 months indicated the perpetrator of the most recent incident was 5 years or older than them.
Perpetrators of physical violence
• The prevalence of physical violence in the past 12 months was 13.9% for females and 15.7% for males for peer physical violence, 16.1% for females and 18.6% for males for adult in the community/neighbourhood physical violence, and 6.5% for females and 16.8% for males for parent/adult relative physical violence.

Figure 5: Perpetrators of sexual violence in the past 12 months among 13-17-year-olds who experienced sexual violence – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Note: Authority figure includes teacher, security officer, employer, community/religious leader, aid worker or medical professional.

Figure 6: Perpetrators of physical violence in the past 12 months among 13-17-year-olds who experienced physical violence – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Contexts of violence against children

Contexts of sexual violence against children

Context of sexual violence in childhood among 18-24-year-olds
• The first incident of sexual violence in childhood among females and males aged 18-24 years mostly occurred in locations outside the home such as on a road/street, market/shop, school, lake/river or other body of water, and field/other natural area (67.5% among females and 56.7% among males). • For both females and males aged 18-24 years, the first incident of sexual violence in childhood occurred either in the evening (47.3% among females and 46.0% among males) or in the afternoon (30.1% among females and 38.3% among males). • Among those who experienced sexual violence, a higher proportion of females than males aged 18-24 years experienced the first incident in childhood after arriving in the refugee settlement (73.3% versus 53.2%).
Context of sexual violence in the past 12 months among 13-17-year-olds
• Most females and males aged 13-17 years experienced the most recent incident of sexual violence in outside locations such as on a road/street, market/shop, school, lake/river or other body of water, and field/other natural area (84.6% among females and 71.6% among males). • For both females and males aged 13-17 years, the most recent incident of sexual violence occurred either in the evening (47.0% among females and 59.2% among males) or in the afternoon (44.3% among females and 32.0% among males).

Figure 7: Location of first incident of sexual violence in childhood among 18-24-year-olds who experienced sexual violence – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

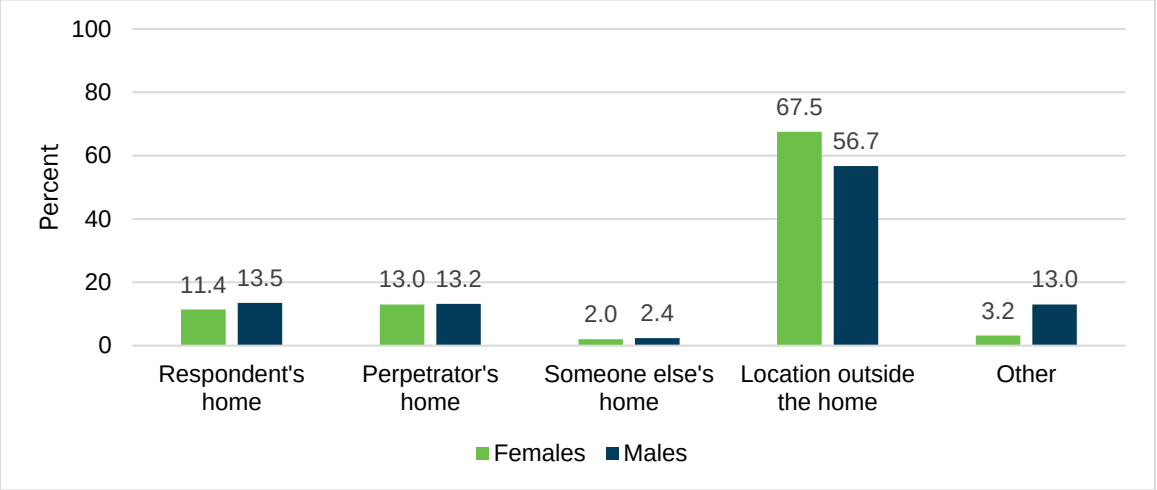
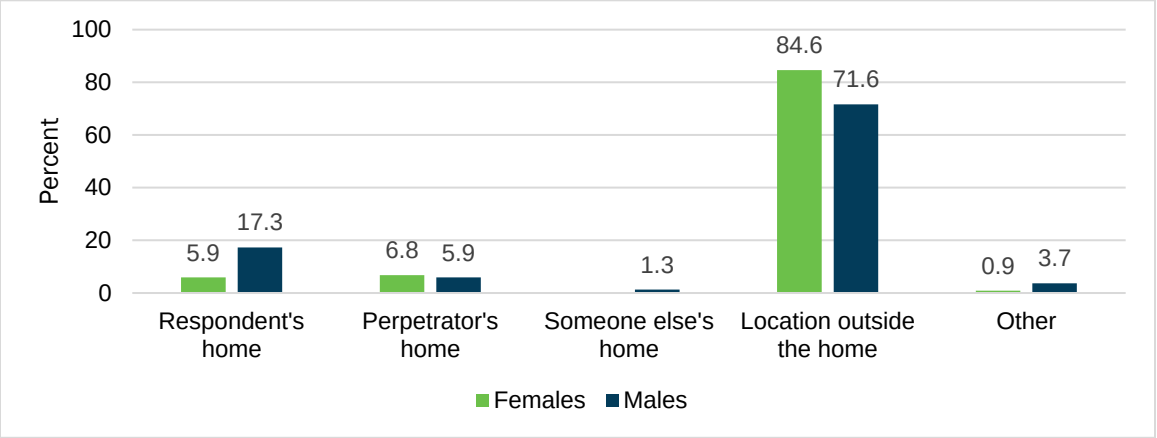


Figure 8: Location of most recent incident of sexual violence among 13-17-year-olds who experienced sexual violence – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Contexts of physical and emotional violence against children

Context of physical VAC among 18-24-year-olds
• More than two-thirds (66.6%) of females and 43.3% of males who experienced physical violence in childhood experienced the first incident after arrival in the refugee settlement.
Context of emotional VAC among 18-24-year-olds
• Among those who experienced emotional violence, a higher proportion of females than males experienced the first incident in childhood after arriving in the refugee settlement (88.6% females versus 42.6% males).

Witnessing and perpetration of violence

Witnessing physical violence

Witnessing physical violence in childhood among 18-24-year-olds
• A higher proportion of males than females aged 18-24 years witnessed physical violence at home during childhood (43.9% versus 33.0%). • About 1 in 4 females (23.5%) compared to 41.5% of males witnessed physical violence in the neighbourhood during childhood.
Witnessing physical violence in the past 12 months among 13-17-year-olds

- A higher proportion of females than males aged 13-17 years witnessed physical violence at home (58.0% versus 41.5%) or in the neighbourhood (70.1% versus 61.7%) in the 12 months preceding the survey.

Prevalence of lifetime perpetration of physical violence among 18-24-year-olds

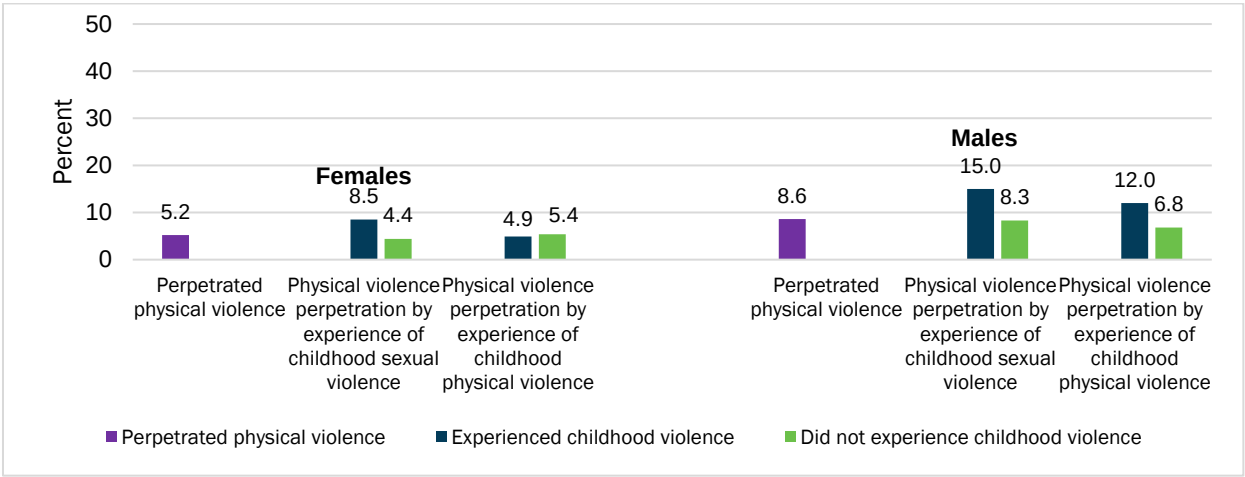
Perpetration of physical violence among 18-24-year-olds

- Among 18-24-year-olds, a higher proportion of males than females ever perpetrated physical violence (8.6% versus 5.2%).
- The proportion of females and males aged 18-24 years who perpetrated physical violence in their lifetime was higher among those who experienced sexual violence in childhood than among those who did not experience sexual violence in childhood (8.5% versus 4.4% among females and 15.0% versus 8.3% among males).
- Among males aged 18-24 years, the proportion who perpetrated physical violence in their lifetime was higher among those who experienced physical violence in childhood than among those who did not experience physical violence in childhood (12.0% versus 6.8%).

Perpetration of intimate partner violence among 18-24-year-olds

- Among 18-24-year-olds who ever had an intimate partner (current or previous), a higher proportion of males than females perpetrated physical intimate partner violence (10.8% versus 4.7%).
- Among 18-24-year-olds who ever had an intimate partner, 7.2% of those who experienced sexual violence in childhood perpetrated intimate partner physical violence compared to 3.8% of those who did not experience sexual violence in childhood.
- Among 18-24-year-old males who ever had an intimate partner, 12.4% of those who experienced physical violence in childhood perpetrated physical intimate partner violence compared to 9.6% of those who did not experience physical violence in childhood.

Figure 9: Lifetime perpetration of physical violence by experience of childhood violence among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Prevalence of lifetime perpetration of physical violence among 13-17-year-olds

Perpetration of physical violence among 13-17-year-olds

- Among 13-17-year-olds, 2% of females and 1% of males had ever perpetrated physical violence.
- A similar proportion (6%) of females and males aged 13-17 years who experienced sexual violence in the past 12 months perpetrated lifetime physical violence compared to those who did not experience sexual violence in the past 12 months (1% of females and a similar proportion of males).

Disclosure and service-seeking behaviour

Disclosure and service-seeking behaviour among 18-24-year-olds who experienced sexual or physical violence

Disclosure and service-seeking for sexual violence among 18-24-year-olds
• Seventeen percent of females and 30.6% of males aged 18-24 years who experienced childhood sexual violence told someone about the experience. • More than half (54.8%) of females and 73.0% of males aged 18-24 years who experienced childhood sexual violence knew of a place to seek help. • Only 5.1% of females and 17.2% of males aged 18-24 years who experienced childhood sexual violence sought help. • Only 3.4% of females and 17.1% of males aged 18-24 years who experienced childhood sexual violence received help.
Disclosure and service-seeking for physical violence among 18-24-year-olds
• A higher proportion of males than females aged 18-24 years told someone about their experience of physical violence in childhood—among those who experienced physical violence during childhood, only 6.3% of females and 9.0% of males told someone about their experiences. • Over half (51.7%) of females and 70.2% of males aged 18-24 years were aware of at least one place where they could seek help. However, only 3.4% of females and 1.0% of males sought help for physical violence experienced during childhood, while 2.1% of females and 1.0% of males received help. • Females aged 18-24 years who experienced physical violence during childhood and told someone about their experiences most often told a relative (52.9%), followed by a service provider or authority figure (21.7%) and friends or neighbours (17.9%).

Disclosure and service-seeking behaviour among 13-17-year-olds

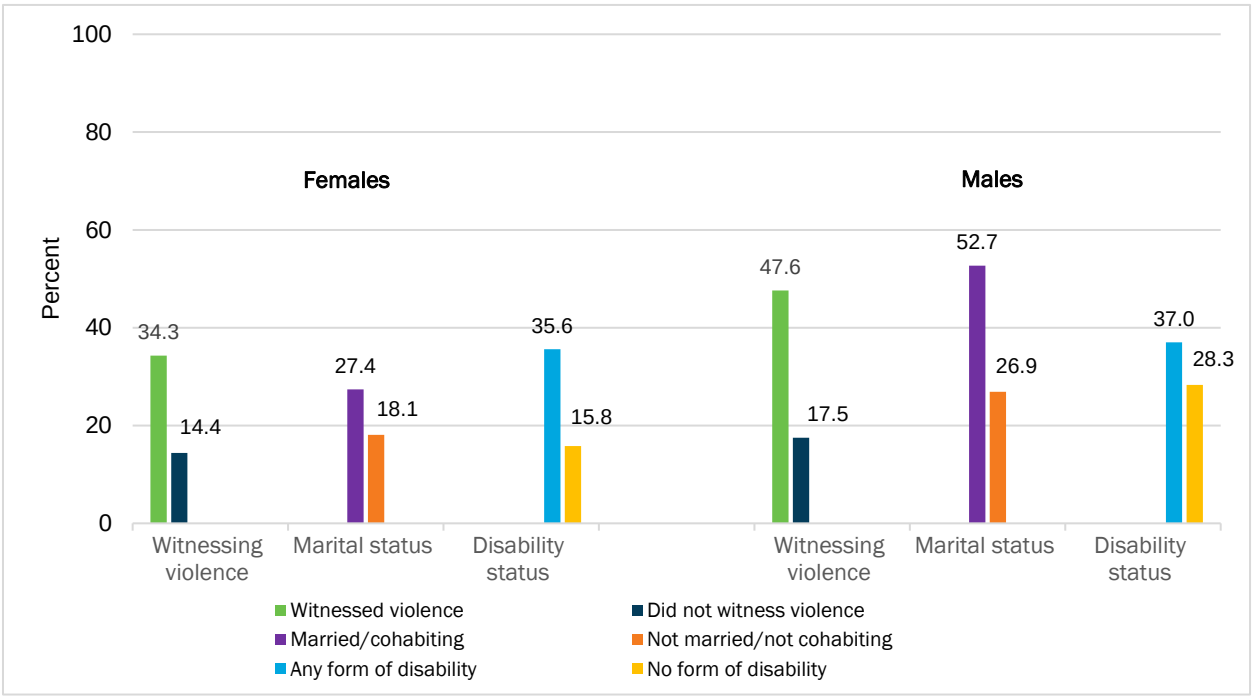
Disclosure and service-seeking for sexual violence among 13-17-year-olds
• Only 6.4% of females and 5.7% of males aged 13-17 years who experienced sexual violence in the past 12 months told someone about the experience. • About 1 out of 3 (30.4%) females and 70.9% of males aged 13-17 years who experienced sexual violence in the past 12 months knew of a place to seek help. • Only 1.7% of females and no males aged 13-17 years who experienced sexual violence in the past 12 months sought and received help.
Disclosure and service-seeking for physical violence among 13-17-year-olds
• Among 13-17-year-olds who experienced any physical violence in the past 12 months, only 2.5% of females and less than 1% of males told someone about their experience. • About 4 out of 10 (41.2%) females and almost half (48.7%) of males aged 13-17 years who experienced physical violence in the past 12 months were aware of places where they could seek help. • Less than 1% of females and males aged 13-17 years who experienced physical violence in the past 12 months sought and received help.

Factors associated with experiencing sexual or physical violence in the past 12 months

Factors associated with experience of sexual or physical violence among 18-24-year-olds

Factors associated with violence among 18-24-year-olds
• Females aged 18-24 years who witnessed violence in the home during childhood were significantly more likely to experience sexual or physical violence in the past 12 months compared to those who did not witness violence at home (34.3% versus 14.4%). • Males aged 18-24 years who witnessed violence in the home during childhood were significantly more likely to have experienced sexual or physical violence in the past 12 months than those who did not witness violence at home (47.6% versus 17.5%). • A higher proportion of females and males aged 18-24 years who were married or cohabiting experienced sexual or physical violence in the past 12 months compared to those who were not (27.4% versus 18.1% among females, and 52.7% versus 26.9% among males). • A higher proportion of females aged 18-24 years with any form of disability experienced sexual or physical violence in the past 12 months compared to those without any form of disability (35.6% versus 15.8%). • Among males aged 18-24 years, 37.0% of those with any form of disability experienced sexual or physical violence in the past 12 months, compared to 28.3% of those without any form of disability.

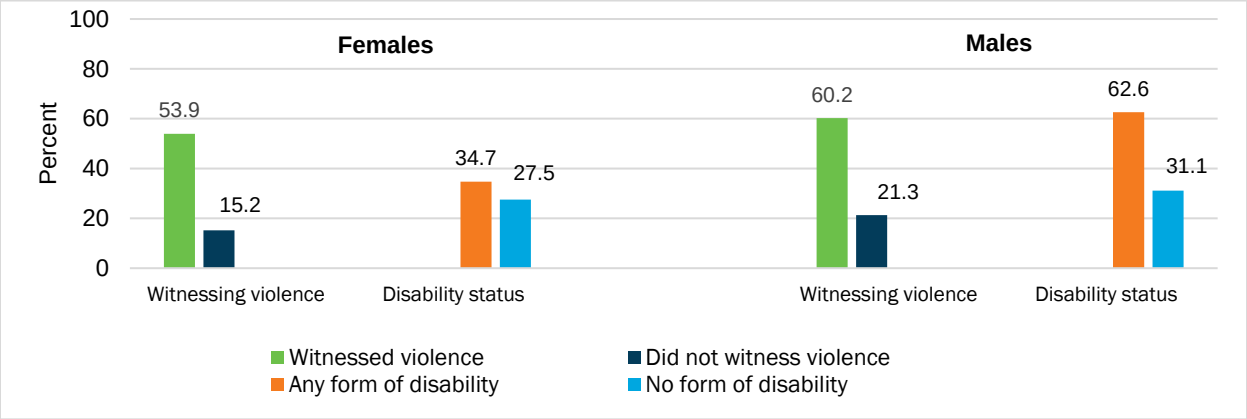
Figure 10: Factors associated with experience of sexual or physical violence in the past 12 months among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Factors associated with experience of sexual or physical violence among 13-17-year-olds

Characteristics associated with violence among 13-17-year-olds
• Among 13-17-year-old females, those who witnessed violence in the home were significantly more likely to experience physical or sexual violence in the past 12 months (53.9%) compared to those who did not witness violence at home (15.2%). • Males aged 13-17 years who witnessed violence in the home were significantly more likely to have experienced physical or sexual violence in the past 12 months than those who did not witness violence at home (60.2% versus 21.3%). • About 1 out of 3 (34.7%) females aged 13-17 years with any form of disability experienced sexual or physical violence in the past 12 months compared to 27.5% of those without any form of disability. • Among males aged 13-17 years, the proportion who experienced sexual or physical violence in the past 12 months was higher among those with any form of disability compared to those without any form disability (62.6% versus 31.1%).

Figure 11: Experience of sexual or physical violence by witnessing violence and disability status among 13-17-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Injuries and health conditions associated with violence against children

Experienced injury as a result of physical violence

Injury as a result of physical violence in childhood among 18-24-year-olds
• About 1 out of 3 females (30.0%) and 2 out of 3 males (62.9%) who experienced physical violence in childhood were injured as a result of their first childhood experience of physical violence. • Significantly more males than females aged 18-24 years who experienced physical violence in childhood experienced an injury as a result of physical violence perpetrated by a peer (58.4% among males and 3.2% among females). • A higher proportion of males than females aged 18-24 years who experienced physical violence in childhood experienced an injury, as a result of physical violence perpetrated by parent/caregiver/adult relative (43.0% among males and 26.7% among females) or an adult in the community (38.3% among males and 26.4% among females). • Almost half of the females aged 18-24 years (48.4%) who experienced physical intimate partner violence in childhood experienced physical harm or injury as a result of physical violence by the intimate partner.
Injury as a result of physical violence in the past 12 months among 13-17-year-olds
• About 1 out of 3 females (34.1%) and 2 out of 3 males (62.9%) aged 13-17 years who experienced physical violence in the past 12 months experienced an injury as a result of the physical violence. • A higher proportion of males than females aged 13-17 years who experienced physical violence in the past 12 months experienced an injury as a result of physical violence was by a peer (59.0% among males and

37.6% among females), a parent/caregiver/adult relative (43.9% among males and 30.6% among females), or an adult in the community (39.9% among males and 24.5% among females).

Experience of violence and mental health outcomes among 18-24-year-olds

Experience of sexual violence in childhood and mental health outcomes among 18-24-year-olds

- A higher proportion of females aged 18-24 years who experienced sexual violence in childhood experienced mental distress in the 30 days preceding the survey (81.6% versus 70.4%), intentional self-harm (14.5% versus 7.4%), and having ever thought of suicide (23.0% versus 7.6%), compared to those who did not experience sexual violence in childhood.
- A higher proportion of males aged 18-24 years who experienced sexual violence in childhood experienced mental distress in the 30 days preceding the survey (86.2% versus 77.7%), intentional self-harm (25.0% versus 4.1%), and having ever thought of suicide (35.5% versus 4.9%), compared to those who did not experience sexual violence in childhood.

Experience of physical violence in childhood and mental health outcomes among 18-24-year-olds

- A higher proportion of females aged 18-24 years who experienced physical violence in childhood had ever experienced self-harm (10.4% versus 6.5%) or had ever thought of suicide (12.5% versus 8.9%), compared to those who did not experience physical violence in childhood.
- A higher proportion of males aged 18-24 years who experienced physical violence in childhood experienced mental distress in the 30 days preceding the survey (83.5% versus 74.1%), or had ever thought of suicide (13.4% versus 3.8%), compared to those who did not experience physical violence in childhood.

Experience of emotional violence in childhood and mental health outcomes among 18-24-year-olds

- A higher proportion of females aged 18-24 years who experienced emotional violence in childhood had experienced mental distress in the past 30 days preceding the survey (77.4% versus 71.9%), intentional self-harm (20.4% versus 6.5%), or had ever thought of suicide (21.3% versus 8.9%), compared to those who did not experience emotional violence in childhood.
- A higher proportion of males aged 18-24 years who experienced emotional violence in childhood had experienced mental distress in the past 30 days preceding the survey (81.0% versus 77.1%), self-harm (11.2% versus 6.4%), and had ever thought of suicide (19.4% versus 3.7%), compared to those who did not experience emotional violence in childhood.

Figure 12: Mental health, self-harm, and suicide ideation by experience of sexual violence in childhood among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

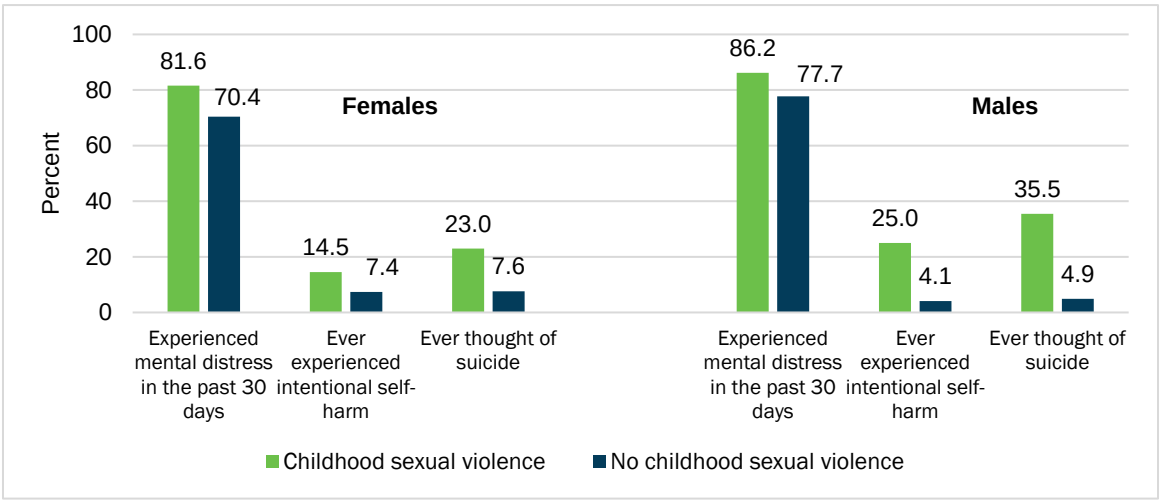


Figure 13: Mental health, self-harm, and suicide ideation by experience of physical violence in childhood among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

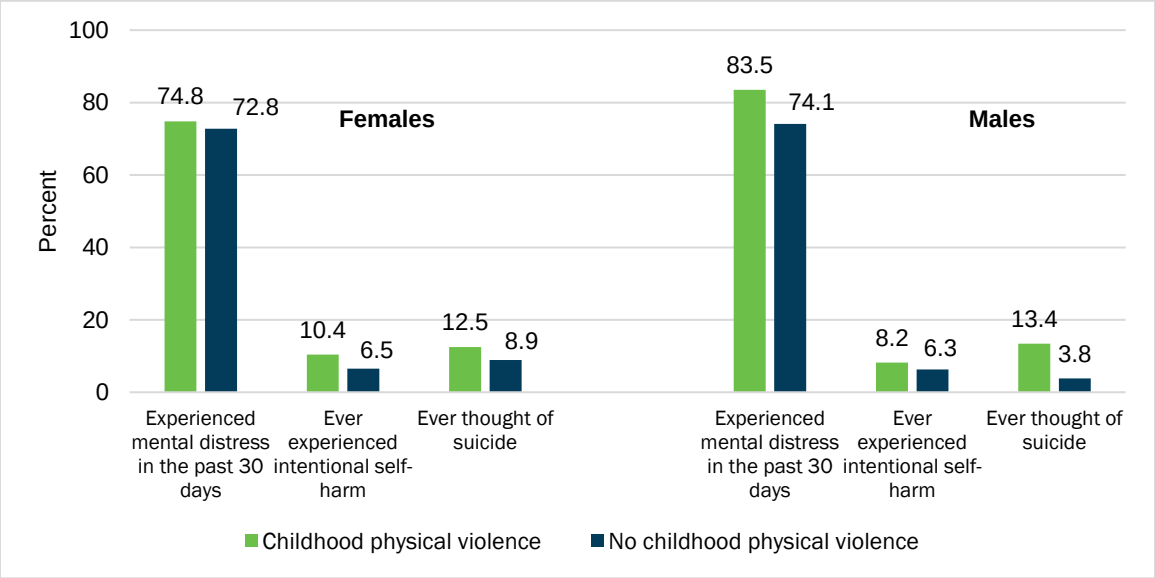
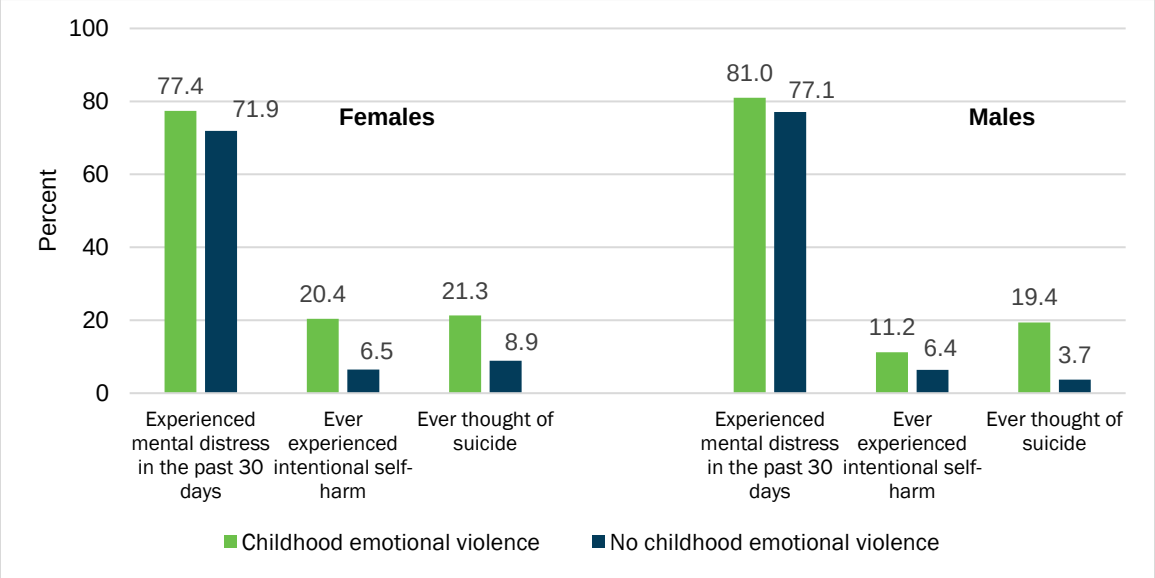


Figure 14: Mental health, self-harm, and suicide ideation by experience of emotional violence in childhood among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Mental health by experience of violence in the past 12 months among 13-17-year-olds

Mental health by experience of sexual violence in the past 12 months among 13-17-year-olds

- A higher proportion of females aged 13-17 years who experienced sexual violence in the past 12 months had experienced mental distress in the 30 days preceding the survey (85.9% versus 52.1%), self-harm (19.0% versus 3.9%), or had ever thought of suicide (20.4% versus 3.5%), compared to those who did not experience sexual violence in the past 12 months.
- A higher proportion of males aged 13-17 years who experienced sexual violence in the past 12 months had experienced mental distress in the 30 days preceding the survey (74.9% versus 71.1%), self-harm (8.0% versus 4.7%), or had ever thought of suicide (8.7% versus 5.6%), compared to those who did not experience sexual violence in the past 12 months.

Mental health by experience of physical violence in the past 12 months among 13-17-year-olds
• Among females aged 13-17 years, the proportion who experienced intentional self-harm or had ever thought of suicide was higher among those who experienced physical violence in the past 12 months than among those who did not experience physical violence in the past 12 months (9.7% versus 3.8% for intentional self-harm, and 13.5% versus 2.4% for suicidal ideation). • Among males aged 13-17 years, the proportion who experienced mental distress in the 30 days preceding the survey (79.6% versus 66.9%) or who had ever thought of suicide (10.8% versus 2.9%) was higher among those who experienced physical violence in the past 12 months, compared to those who did not experience physical violence in the past 12 months.
Mental health by experience of emotional violence in the past 12 months among 13-17-year-olds
• A higher proportion of females aged 13-17 years who experienced emotional violence in the past 12 months experienced mental distress in the 30 days preceding the survey (74.2% versus 50.9%), had self-harm (10.2% versus 4.2%), or had ever thought of suicide (13.9% versus 3.2%), compared to those who did not experience emotional violence in the past 12 months. • A higher proportion of males aged 13-17 years who experienced emotional violence in the past 12 months experienced mental distress in the 30 days preceding the survey than those who did not experience emotional violence in the past 12 months (80.8% versus 70.4%).

Figure 15: Mental health, self-harm, and suicide ideation by experience of sexual violence in the past 12 months among 13-17-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

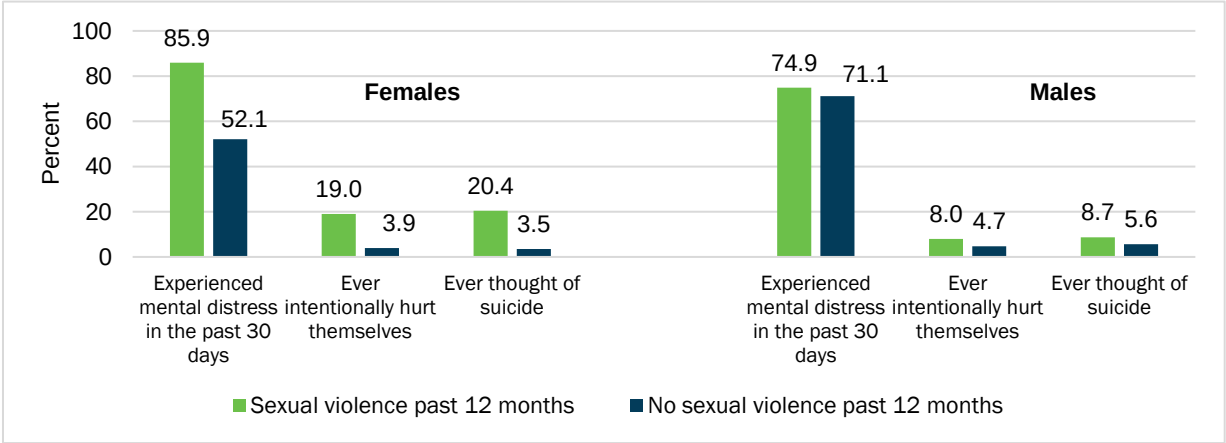


Figure 16: Mental health, self-harm, and suicide ideation by experience of physical violence in the past 12 months among 13-17-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

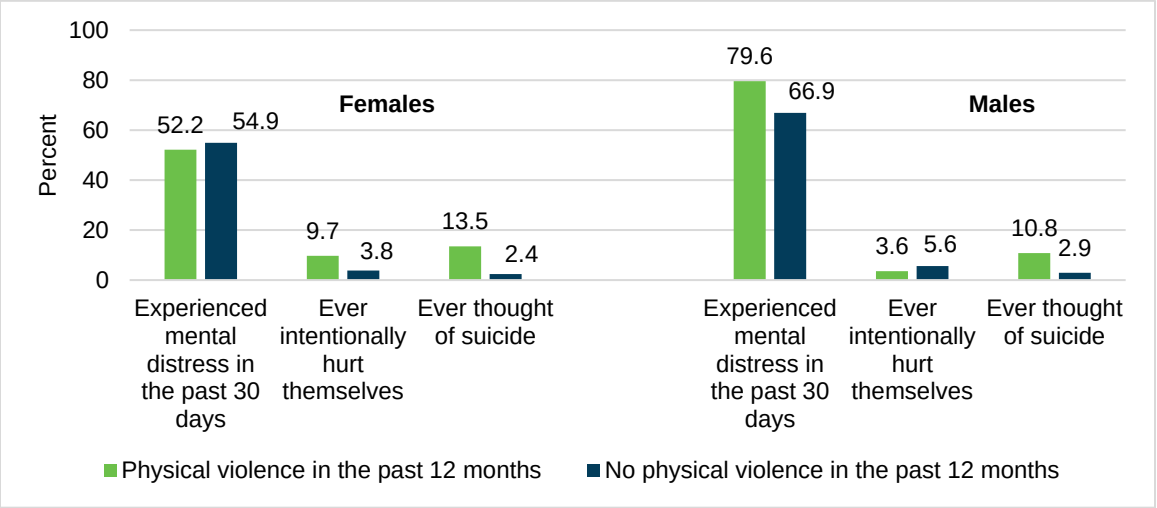
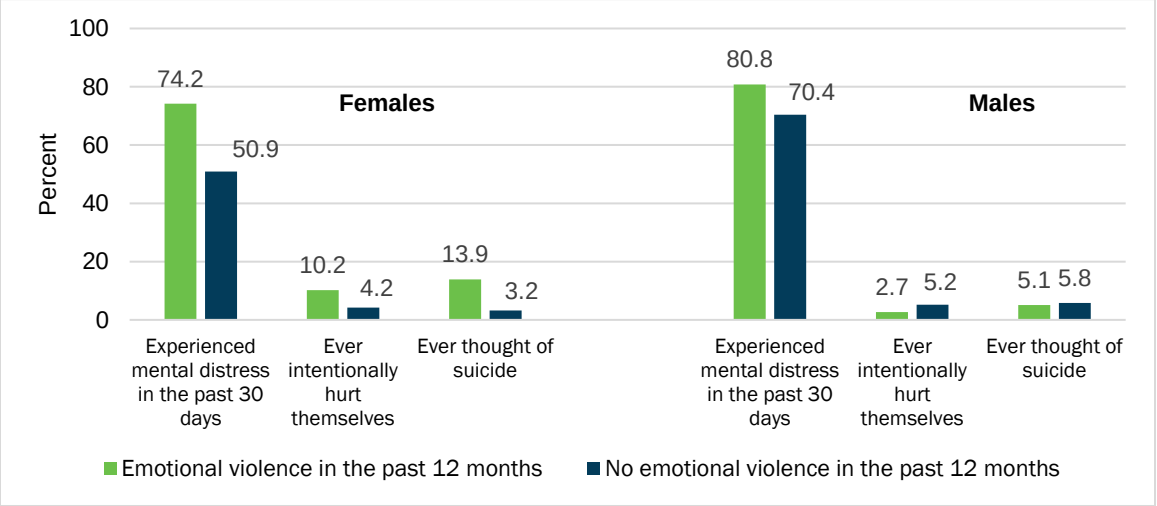


Figure 17: Mental health, self-harm, and suicide ideation by experience of emotional violence in the past 12 months among 13-17-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Experience of violence and risk-taking behaviour among 18-24-year-olds

Experience of violence and sexual risk-taking among 18-24-year-olds
• A higher proportion of females aged 18-24 years who experienced sexual violence in childhood had multiple sexual partnerships and transactional sex in the past year compared to those who did not experience sexual violence in childhood (5.8% versus 0.9%, respectively for multiple sexual partnerships, and 9.0% versus 4.3%, respectively for transactional sex). • A higher proportion of females aged 18-24 years who experienced emotional violence in childhood had multiple sexual partnerships in the past 12 months compared to those who did not experience emotional violence in childhood (5.6% versus 1.4%, respectively).
Experience of violence and substance abuse and STIs among 18-24-year-olds
• A higher proportion of females and males aged 18-24 years who experienced sexual violence in childhood had ever had symptoms of sexually transmitted infections (STIs) or been diagnosed with an STI, compared to those who did not experience sexual violence in childhood (44.1% versus 21.2% among females, and 51.9% versus 30.5% among males).

- Similarly, a higher proportion of females and males aged 18-24 years who experienced physical violence in childhood had ever had symptoms of an STI or been diagnosed with an STI, compared to those who did not experience physical violence in childhood (31.7% versus 20.7% among females, and 44.0% versus 23.5% among males).
- A higher proportion of males aged 18-24 years who experienced emotional violence in childhood had ever had symptoms of an STI or been diagnosed with an STI, compared to those who did not experience emotional violence in childhood (50.5% versus 27.4%), while for females, the proportion who experienced STI symptoms or had been diagnosed with an STI was similar for those who had or had not experienced emotional violence in childhood (25% in each group).
- Males aged 18-24 years who experienced physical violence in childhood were significantly more likely than those who did not experience physical violence in childhood to engage in binge drinking (4.6% versus 0.7%) and to smoke cigarettes (8.0% versus 0.8%).

Figure 18: Sexual risk-taking by experience of sexual violence in childhood among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

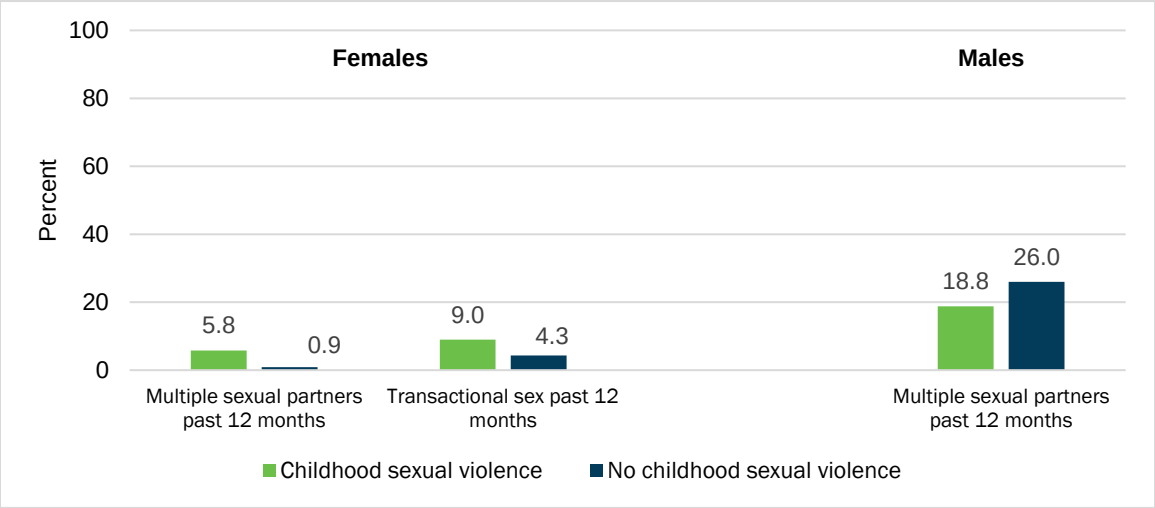


Figure 19: Sexual risk-taking by experience of physical violence in childhood among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

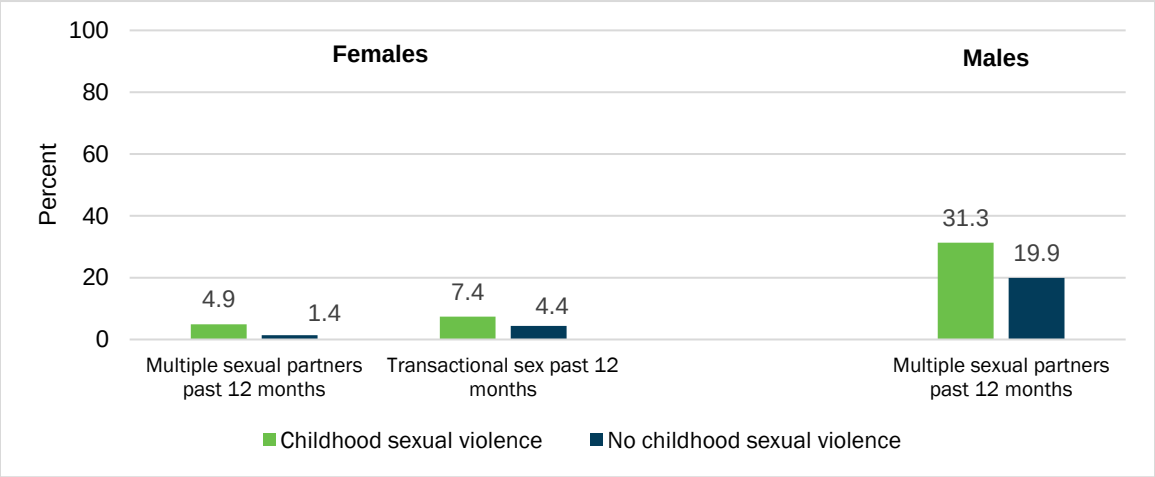


Figure 20: Sexual risk-taking by experience of emotional violence in childhood among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022

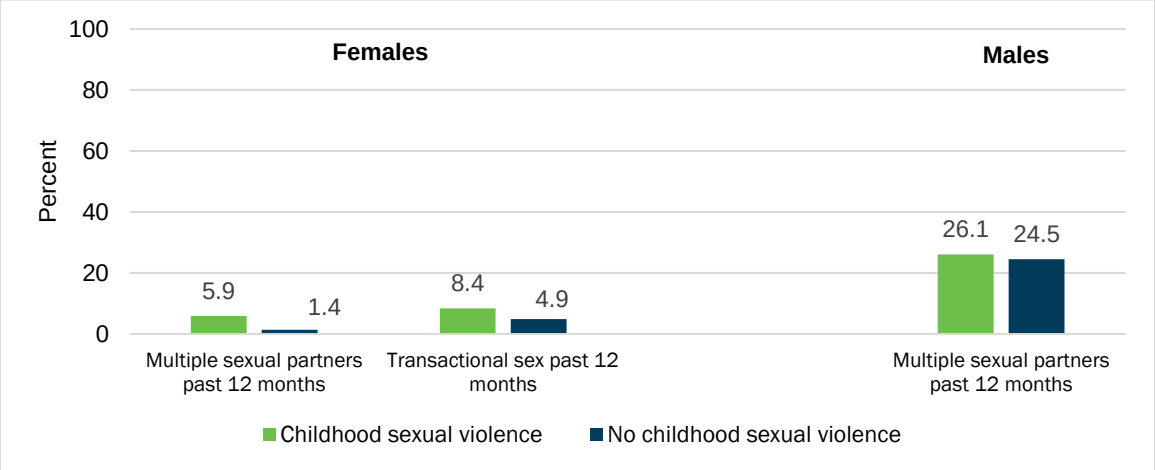
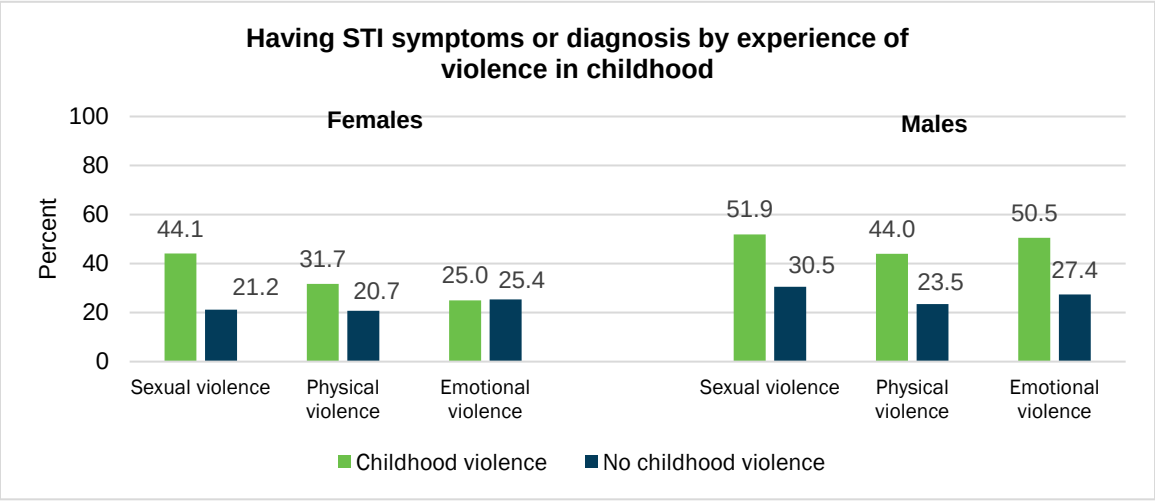


Figure 21: STI symptoms or diagnosis by experience of sexual, physical, and emotional violence in childhood among 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022



Prevalence of other forms of violence against children

Prevalence of child abduction among 13-17-year-olds
• Males aged 13-17 years were five times more likely to have ever been abducted compared to females. About 1% of females and 4.8% of males aged 13-17 years had ever been abducted.
Prevalence of child marriage among 18-24-year-olds
• Four out of 10 females (39.8%) and 16.4% of males aged 18-24 years had ever been married. Among those who had ever been married, 1% of females and none of the males were first married before the age of 15. • About 1 out of 3 (36.5%) ever married females and 12.3% of ever married males aged 18-24 years were first married before the age of 18.
Knowledge and prevalence of female genital mutilation/cutting (FGM/C)
• About 3 out of 10 females (30.0%) aged 18-24 years and 13.4% of females aged 13-17 years had heard of female genital mutilation/cutting (FGM/C). • Among those who had heard of FGM/C, 1.6% of females aged 18-24 years and 2.5% of those aged 13-17 years had experienced FGM/C.

Attitudes and beliefs related to gender and violence

Attitudes and beliefs related to gender and violence among 13-24-year-olds and 18-24-year-olds
• Among females, 58.6% of 13-17-year-olds and 56.8% of 18-24-year-olds indicated that it was acceptable for a husband to beat his wife for one or more reasons food. The proportion was higher for females ages 13-24 years than males. • Among males, 46.8% of 13-17-year-olds and 47.1% of 18-24-year-olds indicated that it was acceptable for a husband to beat his wife for one or more reasons. • Among 13-17-year-olds, about 8 out of 10 females (79.0%) and males (83.5%) endorsed one or more harmful traditional beliefs about gender, sexual behaviour and intimate partner violence. These included beliefs about traditional roles of men and women in sexual relationships as well as beliefs about justification of wife-beating on certain grounds. • Among 18-24-year-olds, 82.0% of females and 90.6% of males endorsed one or more harmful traditional beliefs about gender, sexual behaviour and intimate partner violence.

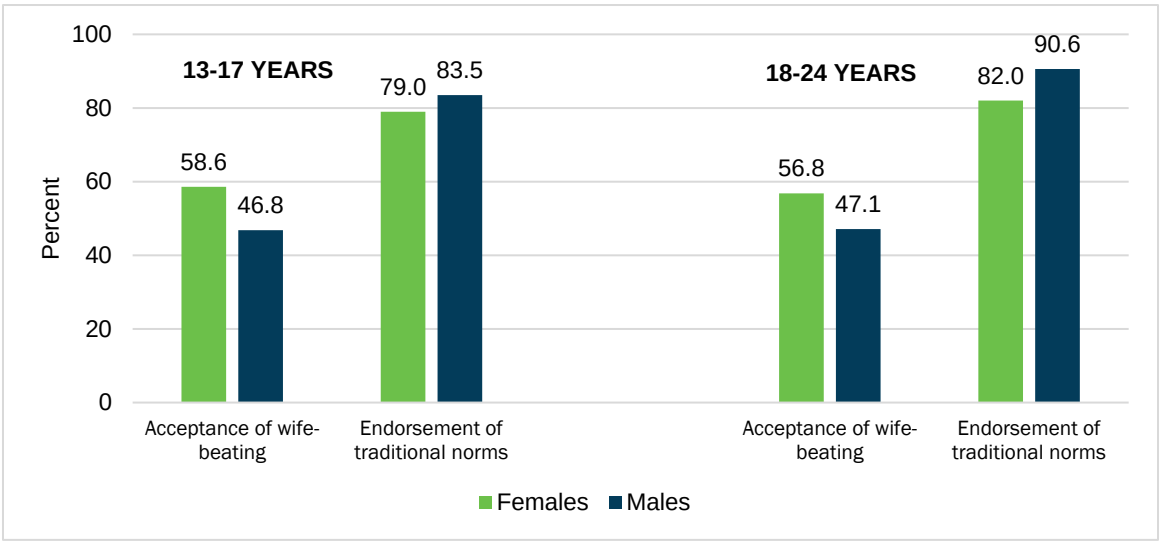



Figure 22: Endorsement of traditional norms about gender, sexual behaviour, and intimate partner violence among 13-17- and 18-24-year-olds – Uganda Humanitarian Violence Against Children Survey (HVACS), 2022