



Refugee Law Project

WORKING PAPER 25
AUGUST 2017

HIDDEN REALITIES

Screening for Experiences of Violence amongst War-Affected
South Sudanese Refugees in northern Uganda



Chris Dolan



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¹ Names withheld for security purposes



LIST OF ACRONYMS

CRRF	- Comprehensive Refugee Response Framework
IASC	- Inter-Agency Standing Committee
IP	- Implementing Partner
MUAC	- Middle Upper Arm Circumference
OPM	- Office of the Prime Minister
RLP	- Refugee Law Project
RRRF	- Regional Refugee Response Framework
RWC	- Refugee Welfare Council
UNHCR	- United Nations High Commissioner for Refugees



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1 RESEARCH SUMMARY

Present humanitarian practice is to wait for survivors of conflict-related sexual violence to come forward for assistance. Most do not, resulting in prolonged suffering and unwarranted obstacles to individual and household recovery and self-reliance in the medium term, and obstacles to peace-building and post-conflict recovery in the longer term.

This project explored whether a systematic approach to screening for experiences of violence (sexual, physical and psychological) is possible in a range of humanitarian settings (just arrived and longer-term, rural and urban) and, if so, what kinds of levels of disclosure are found, what are some of the factors influencing disclosure positively and negatively, and what might be the cost of addressing the most urgent needs.

The fieldwork, conducted in five different sites hosting south Sudanese refugees, sampled a total of 938 adult South Sudanese refugees (46% male, 54% female), with data captured directly on electronic tablets and daily uploaded to a centralized database. Acholi and Madi were the largest group of respondents, followed by Nuer and Dinka.

The study found that systematic screening is possible and is welcomed by survivors and seen as a positive departure from existing practice of no stakeholders asking them what happened to them before they ever reached Uganda. Questions are particularly welcome when linked to adequate referral mechanisms for complex conditions arising from violence.

Access in humanitarian settings require careful negotiation, and the screening process itself is labour and time intensive and reliant on skilled and trained personnel. Given the sensitivity of the experiences touched on, screening cannot be rushed, should explore the full range of experiences of violence rather than only sexual violence, and should include questions on physical functionality, pain and scarring, as well as psychological and social functionality. These cross-reference and thereby enhance possibilities of disclosure. Screening should not be conducted unless counselling support is in place, together with basic referral options.

Levels of physical and sexual violence disclosed in this project (e.g. 22% of women and just under 4% of men disclosed experience of rape), are high although they still do not reflect full disclosure. Patterns of violations are also quite gender specific. 20% of those screened were referred for further support, with 6% referred for private medical investigations and treatment through RLP.

If extrapolated to the refugee population as a whole, they suggest that in the current refugee crisis of approximately 1 million South Sudanese refugees in Uganda, a minimum of 22,000 adults could be identified and in need of medical support if the harms from these largely untreated injuries are to be minimized.

Even these relatively high disclosure levels almost certainly still reflect under-reporting insofar as disclosure is undoubtedly still influenced and qualified by a number of factors, including the time and timing of screening, the skill level of the interviewer and the language used, the ethnic composition of the settlement, the plausibility of referral options, the time-gap between incidence and disclosure. Reporting levels would almost certainly increase once the connection between disclosure during screening and subsequent medical support became clear. The average costs of screening can be brought down through further development of the screening tool and full integration into referral processes.

Screening is thus a critical step in significantly reducing under-reporting of existing experiences and conditions. It offers an important starting point in understanding incidence and prevalence patterns. It suggests that humanitarian actors need to increase their attention to the response to existing conditions, even as they work to prevent further violations in the humanitarian setting. To maximise on this potential, screening should be combined with more effective and widely publicized treatment options as well as community level work to maximise support to identified survivors.



Setting up the RLP tent in Palabek Kal



2 INTRODUCTION

Should we screen or should we leave it?

Present humanitarian practice is to wait for survivors of conflict-related violence (including but not limited to sexual violence) to come forward for assistance. The Inter-Agency Standing Committee's 2015 *Guidelines for Integrating GBV Interventions in Humanitarian Action*, for example, encourage humanitarian workers to assume that sexual violence is present in humanitarian emergencies, but offer no guidance on how to establish existing prevalence in a given population as the basis for informing appropriate referral pathways and response mechanisms so as to minimize harm to survivors.

In the absence of a systematic identification process, many survivors of violence, particularly of sexual violence, either do not seek assistance at all, or do so without disclosing the real source of the harm. Since 2014 Refugee Law Project has routinely screened all refugees (male and female) seeking assistance from our Kampala office for experiences of sexual violence (SV). The results of screening more than 3,000 refugees from DRC, Rwanda, Burundi and Somalia have critically re-shaped our programming (approximately 2 out of 3 women and 1 out of 3 men report experiences of SV) and suggest that experiences of sexual violence are one of the key factors driving the decision to flee.

Lack of disclosure results in prolonged suffering and unwarranted obstacles to individual and household recovery and self-reliance. In the absence of prevalence data for a given population, humanitarians fall back on stereotypes and assumptions about forms of violence. Resultant programming is likely to reflect gaps in understanding and awareness. For example, assumptions that sexual violence is all about penetrative rape will disadvantage victims of genital tortures such as tying, burning and mutilation. Failure to ask about family and friends who have been killed or lost before or during flight results in inadequate attention to psychological trauma. Services are likely to be skewed towards those who are assumed to be at risk with nothing in place for those assumed to be invulnerable.

In discussion with the medical service providers to whom we refer clients in need of major medical intervention, the plea has repeatedly been 'please can you try and find them [survivors of severe violence] earlier... before the infections become so entrenched and the scarring so irreversible'.

Until a precedent for systematic screening in emergency settings is established and rigorously documented, humanitarians will continue to under-prioritise sexual violence response and prevention interventions, particularly for men and boys, and to justify this by saying it is impossible to find out who is a victim.

Until screening is done in a gender-inclusive fashion, it will be difficult to shift mainstream thinking and paradigms about gendered distribution of the harms caused by various forms of Gender-Based Violence, including sexual violence - despite our awareness that traditional patterns of non-disclosure are likely to seriously distort and undermine a complete understanding of who needs help in any given context.

With the adoption of the *New York Declaration for Refugees and Migrants* on September 19, 2016,² with its emphasis on “helping refugees thrive, not just survive”, and with the ongoing development of a *Comprehensive Refugee Response Framework* to be finalized in 2018, there has never been a better time to highlight the importance of a more systematic response to experiences of violence.

Why is screening important in the northern Uganda emergency?

At the time the proposal was first developed (mid-2016), the most recent and largest influx of refugees from South Sudan into Uganda was just beginning. In the subsequent twelve months Uganda’s well established reputation as a hospitable destination for refugees from around the Great Lakes region³ came under intense pressure; the population of refugees leapt from approximately 600,000 in June 2016, to over 1.2 million in May 2017, and the number continues to grow.⁴ By mid-June the number of registered South Sudanese had risen to 898,864, 70% of the total refugee population.⁵ With no signs of imminent resolution of conflict in South Sudan, and with high risk of renewed fighting in eastern DRC, numbers looked set to hit 2 million by the end of 2017. In the absence of any viable peace process in South Sudan, a large proportion of these are likely to stay in Uganda for a number of years.⁶

A population of 2 million refugees would amount to close to 5% of Uganda’s total population. In key refugee hosting districts (Adjumani, Moyo) refugees represent more than 50% of the total population. Having a significant proportion of adult refugees unable to be self-reliant due to unaddressed injuries and legacies of violence in the country of origin, poses a challenge to governmental and non-governmental service providers – but if left unaddressed is liable to pose serious challenges to the well-being of refugees and hosts alike, which in turn may jeopardise a situation of hard-won stability and security.

The current process for registration of new arrivals is manual. It is followed by a very short medical screening: all children 0-5 are measured for malnutrition (Middle Upper

2 <http://www.unhcr.org/new-york-declaration-for-refugees-and-migrants.html#CRRF>

3 Refugees originate from DRC, South Sudan, Burundi, Somalia, Eritrea, Ethiopia and Rwanda

4 For an example of press coverage from 2016, see <http://www.monitor.co.ug/SpecialReports/Refugee-influx-takes-toll-Adjumani-/688342-3377066-egy602z/index.html>

5 For up-to-date figures, go to <https://ugandarefugees.org>

6 As of 10 May 2017 South Sudanese refugees comprised 898,864 of the total, or 70% followed by Congolese refugees 227,413 (18%), Burundians 45,993 (3.7%), Somalis 42,826 (3.4%); Rwandese 17,147 (1.4%) and others 20,227 (1.6%).

Arm Circumference - MUAC), vaccinated for measles and polio, and given Vitamin A tablets. All arrivals are de-wormed and a nutritional status assessment is done for all to identify any acute malnutrition issues. Such cases are referred for care within the settlement. Any other critical illnesses are referred to the nearest local health centre.

During our visit to Kuluba we were shown the UNHCR Guidance on the use of Standardized Specific Needs Codes for those registering Persons with Specific Needs (PSNs).⁷ This guidance contains multiple codes related to experiences of violence, including: Family Unity (FU-TR, FU-FR), Multiple Displacements (LP-MD), Detained in Country of Origin (LP-DO), Torture (TR) including Psychological or physical impairment due to torture (TR-PI), Forced to egregious Acts (TR-HO), Forced to Witness Violence to others (TR-WV), Survivor of SGBV in Country of Origin (SV-VO), SGBV during flight (SV-VF), Forced or early Marriage (SV-FM), Survival Sex (SV-SS). However, nobody was being asked questions about any of these dynamics, and nobody was disclosing to those registering Persons with Specific Needs (PSNs).

Against this backdrop, in which medical screening is primarily focused on young children, and in which there is no opportunity for disclosure of specific experiences of violence, the urgency of developing more in-depth methods for the early identification of such experiences of violence is apparent.⁸ This research was therefore designed to test the viability of screening at or near the point of arrival in the midst of a mass influx, both to inform medium-term SGBV programming for the South Sudanese refugee population and to demonstrate the importance of such screening more generally.

2.1 RESEARCH AIMS

- To show the importance in humanitarian contexts of responding to the injuries refugees carry with them from their country of origin, even as steps are put in place to prevent further violations
- To shape practices of data-collection regarding sexual and other forms of violence, hence establishing trends and essential steps in discussion of prevention of (sexual) violence in conflict

2.2 RESEARCH TOOL

The screening tool is structured into four modules which form a logical sequence. It is possible for the screener to toggle backwards and forwards between modules if necessary. In the course of the research the tool was modified twice.

⁷ UNHCR Guidance on the Use of Standardized Specific Needs Codes (June 2009), pp 1-12

⁸ The development of a 'Global Compact on Refugees' (http://www.unhcr.org/news/briefing/2017/7/595f41694/sharing-responsibilities-large-refugee-movements.html?mc_cid=1899e72d43&mc_eid=f-b55c2c7c4) makes such tools more urgent than ever

Module 1: Basic administrative and bio-data

This includes legal status of respondent, language of interview (this was added in V3), interviewer identity number, location of interview, consent, followed by basic bio-data of the respondent – age, ethnicity, date of arrival, marital status, number of persons (children and relatives) being taken care of, education level. To capture the wide diversity of living arrangements refugees find themselves in, particular attention was given to marital status and also to the question of children; as such, respondents were asked first how many biological children they had, then how many of those children were with them in the current situation, as well as how many other children they were taking care of (first children with whom they were biologically related, then foster children with whom they had no biological connection). In the final version, respondents were also asked if this was their first experience as a refugee in Uganda.

Module 2: Current Situation

This begins with a broad open-ended question about what happened to the respondent to make them decide to leave their place of origin. In addition to allowing the interviewer to select from a drop-down box containing events that may appear in an individual narrative (e.g. shooting, burning, abduction etc.) it then probes into how those experiences have impacted/are impacting on the respondent physically in terms of a) key functionalities (sitting, walking, eating, etc.) b) locating current pain anywhere in the body c) identifying scars that corroborate the respondent's testimony.

The module also examines the respondent's psychological state in terms of sleep patterns, anxiety and suicidal ideation. In Versions 1 and 2, questions drawn from internationally recognised instruments for identification of depression were initially utilised, but these did not work well. For example, when asked whether there were things they used to enjoy doing in the past that they no longer enjoy, most respondents referred to loss of livelihoods. In Version 3, therefore, respondents were asked to select from a drop-down list of non-income generating activities that many people enjoy (e.g. watching football with friends), followed by a question about which of those they still enjoy doing. The list included sexual activity. The final version of the module also includes a question about triggers of stress and anxiety.

Module 3: Specifics of Experiences of Violence

This module explores, sequentially, a number of forms of violence. Beginning with physical violence ranging from slapping and kicking to cutting, stabbing and strangulation, it also considers whether or not the respondent has been detained and if so, for how long. A number of specific forms of sexual violence are explored, ranging from witnessing the rape of others, through forced nudity, masturbation, unwanted touching, being used as a mattress while others are raped on top of you, genital harm, different forms of rape (anal, vaginal, oral, rape with objects, single or gang perpetrator), sexual slavery, forced marriage, forced to perpetrate sexually violent acts, forced pregnancy and termination, survival sex, forced bestiality. This is followed by questions on how experiences of sexual violence have impacted on relationships

with spouses, wider family, and community.

Module 4: Patterns of Disclosure and Access to Services

This module asks about which authority structures and which health service providers the respondent has reported or disclosed to, and, where they have done so, which experiences they chose to disclose. It also explores reasons for non-disclosure, as well as looking at whether any testing for HIV and other Sexually Transmitted Infections has been done. In Version 2 questions were clarified and added about whether the person wished to be referred for medical or psychosocial support, and in Version 3 a question was added asking the respondent to give feedback on how s/he felt about the screening process.

Screening tool system design

After the research team agreed on the questions to be asked as well as their sequence, work started on developing an electronic screening tool that would be installed on tablets. The tool comprises of two parts;

- Data collection
- Data upload

Data collection

This part has the electronic forms used to capture the responses from the respondents. It is a web application running on a browser installed on the tablets; in this case Google Chrome. It comprises a series of web pages with navigation buttons allowing the interviewer to move from one question to another during the interview.

During a screening session, the application stores the information being entered in a cache (temporary storage) until the end of the session when all this information is written into a file that is saved onto the tablet. Each file is saved uniquely with a file name comprised of the date the interview, name of interviewer, country of origin and gender of the respondent, location of screening, and time of interview, e.g. 7-Mar-2017-AgaboWinnie-SouthSudan-M-Ayiloli-15-10. The electronic forms were developed using Hyper Text Markup Language (HTML), and JavaScript (Jquery) was used to validate and verify the data entered

Data upload

This part enables the upload of each screening file into the database from which a spreadsheet is generated for data analysis at any given point in time.

A Graphical User Interface through which the uploading process is done was developed using Hyper Text Markup Language (HTML), with Hypertext Preprocessor (PHP) and JavaScript (Jquery) doing the validation & verification of the data input as well as the generation and downloading of the spread sheet.

The database storing the uploaded files was developed using *mysql*. *Xampp* is used as the server to query the database.

Identification and Training of Community Interpreters

RLP's existing community interpreters were not skilled in the languages required for this piece of work. We therefore requested assistance from Danish Refugee Council in identifying potential community interpreters from Adjumani and Kiryandongo. A total of 14 individuals (5 women, 9 men) were proposed by DRC and were brought to Kampala for a two-day training. This covered a number of issues, including interpreting in first person rather than third ("I was attacked" rather than "He says he was attacked"), awareness of body language and seating arrangements, confidentiality, discussion of specific cultural sensitivities, identification of correct terminology for words and ideas that are frequently taboo, such as penis, masturbation, rape, etc. Self-care and peer support dynamics were also discussed.

Choice of Screening Sites

In all, six locations were identified in consultation with DRC, UNHCR and OPM: Ayilo II and Maaji II in Adjumani district, Pagirinya in Adjumani district (recommended by OPM and UNHCR), Kampala city (to see if there were any major differences between urban and rural respondents), Palabek Ogili in Lamwo district (as a very new settlement), and Kiryandongo (as a long-standing settlement that has hosted south Sudanese over many decades). Ayilo, Maaji and Pagirinya, all fall within Adjumani district, where the total refugee population at 227,425 is 55% of the total population in the district.⁹

- 1) Ayilo II (population 10,835)¹⁰ is about 25km from Adjumani town and was opened on 6 July 2014.¹¹ Majority are Dinka (5 blocks) and Madi (1 block).
- 2) Maaji II (population 17,234)¹² is about 30 km from Adjumani town and is predominantly inhabited by Nuer and Dinka.
- 3) Pagirinya (population 21,000) is approximately 29 km from Adjumani town and was launched in June 2016 after Maaji I & II reached capacity.¹³
- 4) Kampala city (refugee population 96,816 – 6% of total population). Under Uganda's refugee policy direct assistance to refugees is provided only to those settled in refugee settlements. Those opting for urban areas such as Kampala are described as 'self-settled'.

9 Figures in this section, unless otherwise stated, are taken from <https://ugandarefugees.org/region/west-nile-adjumani/>, last visited 11 July 2017

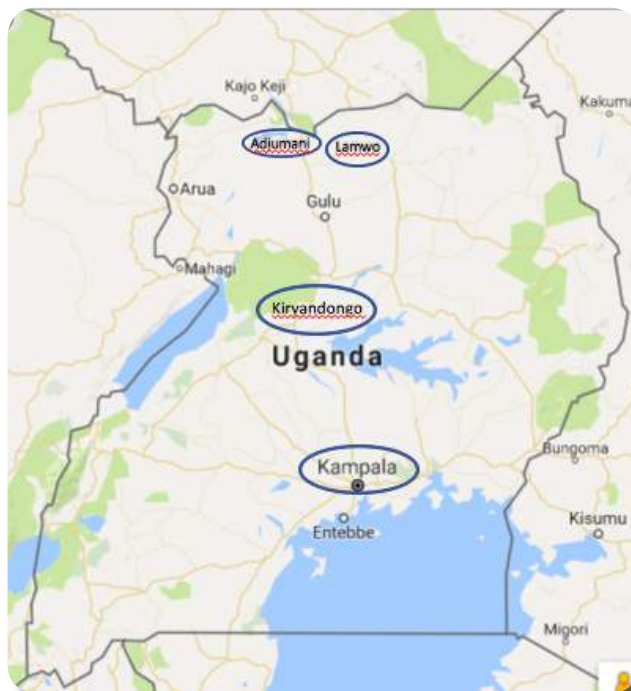
10 OPM statistics, June 2017

11 http://solidaritysummit.gou.go.ug/sites/default/files/FactSheet_Adjumani.pdf accessed 11 July 2017

12 OPM statistics for June 2017

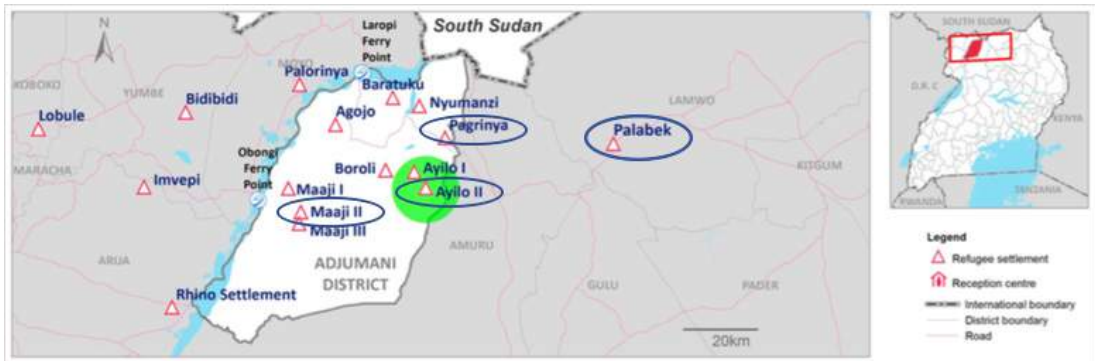
13 As of 7 September 2016, Lutheran World Federation reported the population at 21,000 <https://www.lutheranworld.org/news/more-support-needed-refugees-uganda> accessed 11 July 2017

- 5) Palabek Ogili (refugee population 27,850 – 17% of total population in the district as of mid-June 2017, but only 7,000 at the time the data collection was done in April 2017) is approximately 110 km from Adjumani, 40km from Kitgum, and 104km from Gulu. At the time of the fieldwork the roads had only just been cut through the bush and had not yet stabilized; the access road to one of our data collection sites was washed away overnight. There was no stable mobile phone network coverage. WASH was being covered by Oxfam, LWF, Caritas. Shelter by LWF. Health and Nutrition by IRC. NFIs by LWF, Education by AVSI, Protection by Oxfam, SGBV by ACORD and UNFPA. Family tracing by ICRC. Livelihoods by Caritas, LWF, Oxfam, AVSI. MSF were doing health and WASH but pulled out at the end of the third week.
- 6) Kiryandongo (refugee population 55,684 (of which 55,245 South Sudanese) – 17% of total population in the district) lies approximately 120km south of Gulu and 230km north of Kampala. Much of current case-load of South Sudanese arrived from 2014 onwards. DRC has community based paralegals to identify cases, working in English, Arabic, Dinka, Madi.



Map 1: Uganda showing Kampala, Kiryandongo, Lamwo and Adjumani districts.

(Source of basic map: Google maps)



Map 2: Adjumani district showing Ayilo II, Maaji II, Pagrinya and Palabek (Lamwo district) sites. (Source of basic map: UNHCR)

Access in the settlements

In each settlement, access was assured through the combination of permissions from the Office of the Prime Minister coupled with introductions to local Refugee Welfare Council leaders by our partner organisations (DRC, LWF, ACORD).

Data Analysis

The project collected a number of forms of data, both quantitative and qualitative. The most important in terms of establishing levels of disclosure in different settings and by different groups was the quantitative data-base established using the screening data collected during the fieldwork. This included 938 valid records. A further source is the spreadsheet of 190 referrals made, both to implementing partners and to RLP's own medical service providers.

The most important in terms of capturing our developing understanding of the screening process and the identification of potential modifications to the screening tool and the overall approach to screening was the detailed notes kept of all the daily team de-briefs described above.

Quantitative

The spreadsheet was cleaned manually, with three records removed. Basic quantitative analysis of the screening responses was done in Microsoft Excel using a combination of filters.

Qualitative

The de-briefs were reviewed manually, with particular attention to any suggestions made for modifications to the methodology.



In Palabek Ogili, one heavy rainfall washed away a newly constructed road overnight, preventing the screening team from accessing the site



3 RESULTS

- **Rates of disclosure of sexualized violence are lowest amongst newly arrived refugees, increasing with length of stay in the first year, and then dropping off from the second year onwards**
- **Screening of newly arrived populations is possible – but requires careful training of community interpreters, as well as presence of counsellors on any screening team**
- **Men report higher levels of physical violence than women**
- **Women report higher levels of sexual violence than men – but are less likely to get tested for HIV**
- **Levels of disclosure of sexual violence are lower than where trust levels are well established**
- **Levels of bodily pain and physical dysfunction are high among both women and men**
- **Some symptoms (e.g. anal pain, pain in private parts, lower abdominal pain) have some association with experiences of sexual violence – and appear at higher levels than reports of sexual violence**
- **Many respondents welcomed the opportunity to share their experiences: 2/3 had not done so before, and only 10% had reported to anybody in the country of asylum**
- **1 in 5 respondents required further support for unaddressed physical injuries and/or psychological trauma**

3.1 What Do the Screening Data Tell Us?

Key results from Module 1: Bio-data of Respondents

Ethnic and Geographic Profile of Respondents

CHART 1: % OF RESPONDENTS BY ETHNICITY

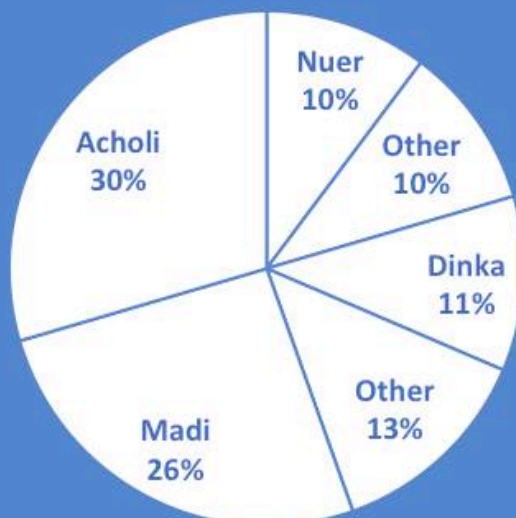
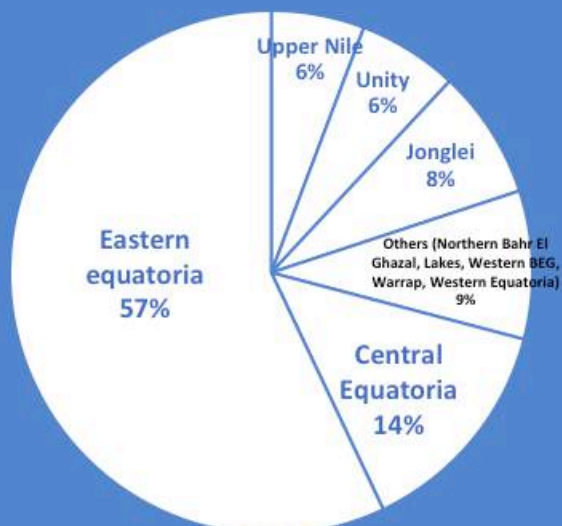


CHART 2: % OF RESPONDENTS BY STATE OF ORIGIN



Both Charts 1 and 2 above reflect the fact that the ethnic distribution within settlements is a function of the age of the settlement (older settlements, such as Kiryandongo are more likely to have a more mixed population) and, to an extent, of its geographical location (Palabek, for example, is located directly across the border from the place of origin of most of its inhabitants, Pajok).

Age and Gender Profile of Respondents

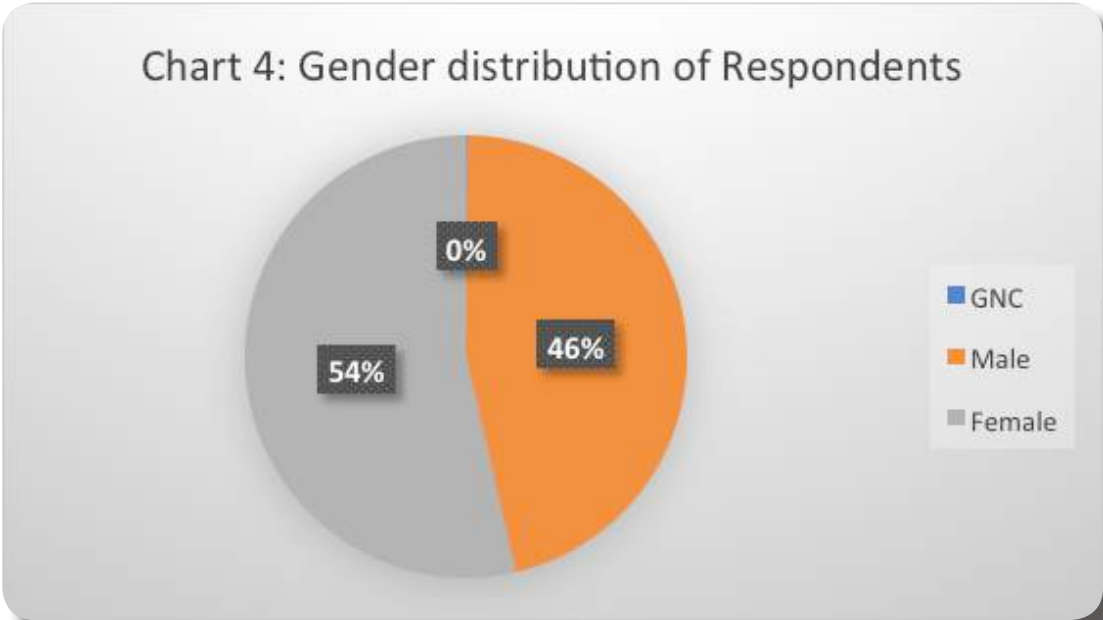
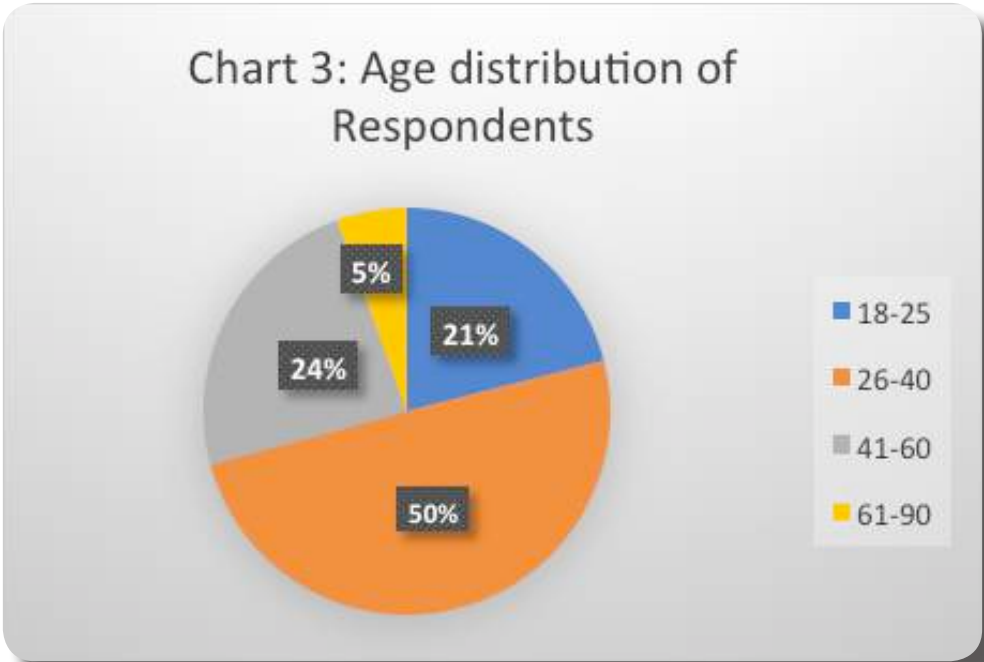
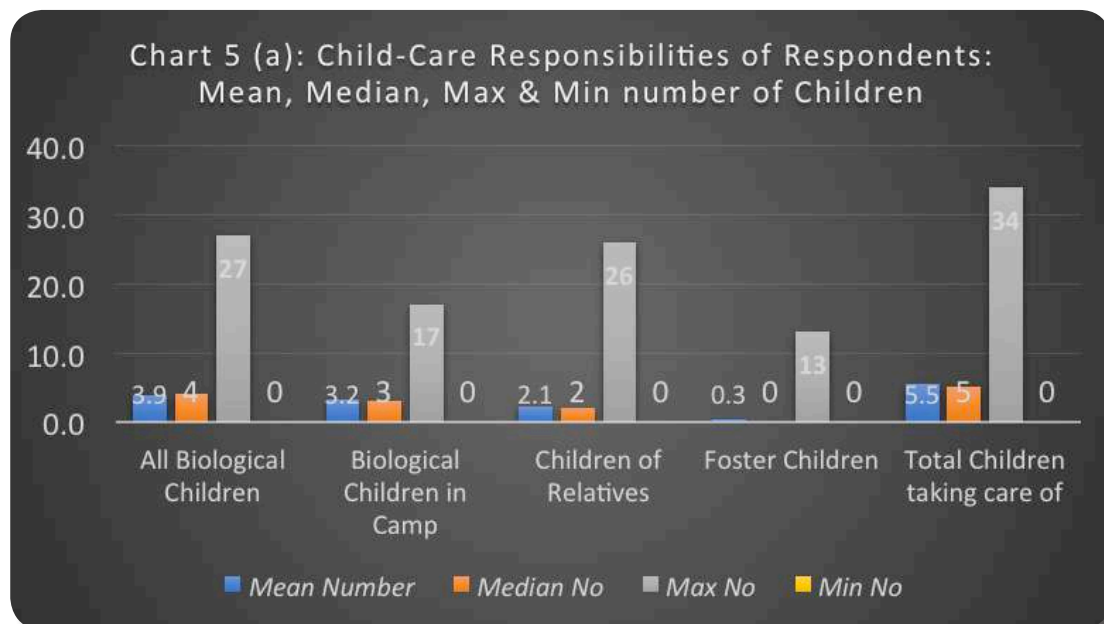
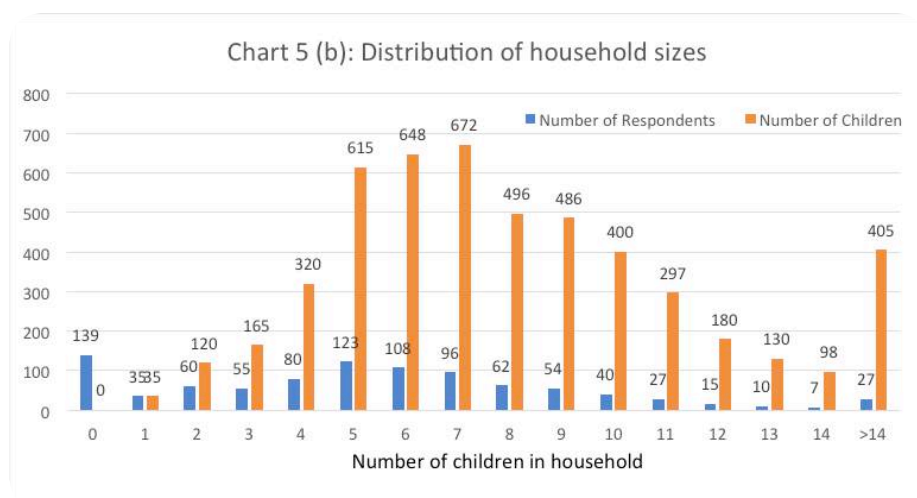


Chart 3 shows that the respondents were largely below the age of 40, with only a small proportion (5%) above the age of 61. The gender distribution of respondents coincidentally reflects the overall gender distribution given by UNHCR.

Child-care responsibilities of Respondents



This table shows that while respondents had an average of 4 children each, they only had 3 of their 4 children with them in the settlement. However, in addition to their own children, they were taking care of an average of 2 additional children of relatives, bringing the average number of children they were taking care of to 5. This begs the question of where the biological parents of such children are: can they be located back in South Sudan, in another refugee settlement, or are they deceased?



Only 3.7% of women respondents (19 out of 503) reported having no biological children. Of these, two thirds (13) were taking care of children they had not given birth to.

By contrast, 32.7% of men respondents (142 out of 434) reported having no biological children. Of these, one third (49) were taking care of children they had not fathered.

Marital Status of Respondents

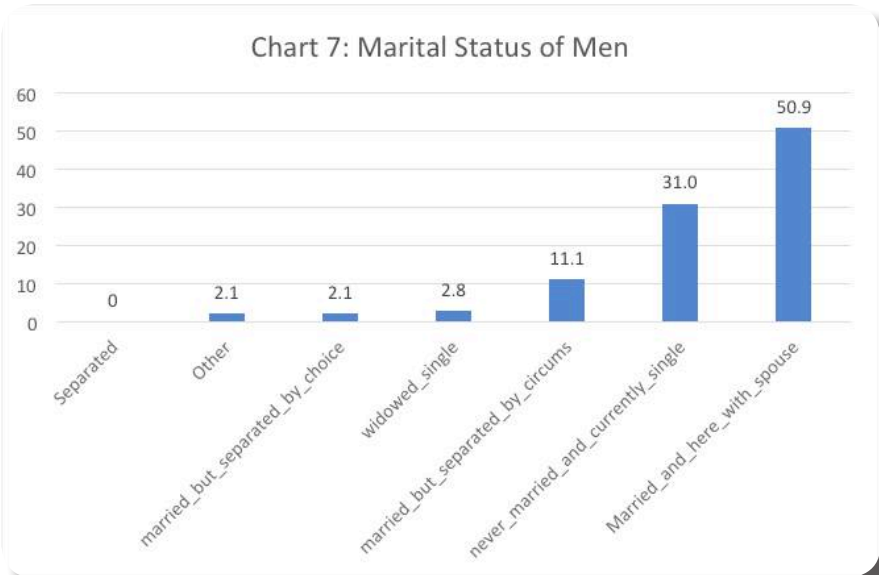
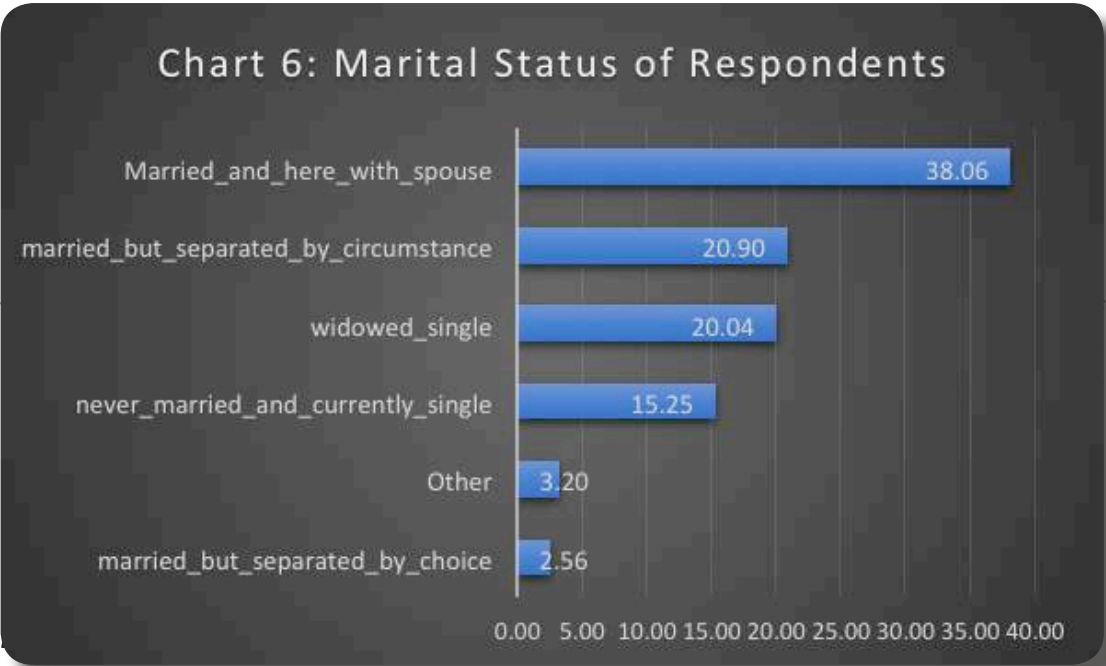
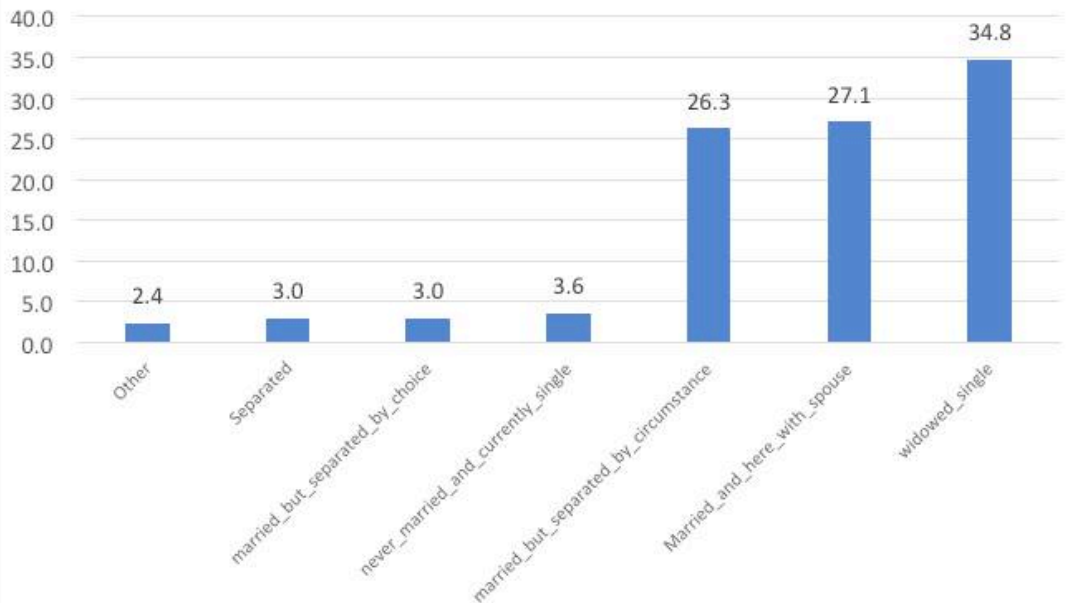


Chart 8: Marital Status of Women



Charts 6,7 and 8 indicate major differences between men and women in terms of marital status. While 31% of men reported that they had never married and were currently single, this was only true of 3.6% of women screened. Equally, while only 2.8% of men reported being widowed, this was the status of 34.8% of the women. Women were also more likely than men to have been separated from their husbands by circumstances (26.3% compared to 11.1%). Whereas 51% of men reported being in Uganda with their spouse, this was true of only just over one quarter (27%) of women.

Educational Profile of Respondents

Chart 9: % having partially or fully completed each educational level - by gender

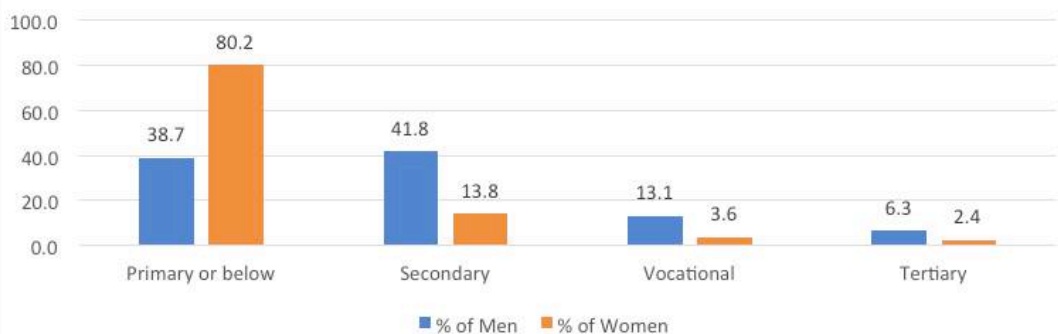


Chart 9 again shows sharp disparities by gender. 80% or four out of five women had completed only primary schooling or below. Only 13.8% had some secondary schooling, less than 4% had received vocational training, and only 2.4% had some tertiary education. By contrast, men with primary or less represented only 38.7% of all male respondents. 41.8% had some secondary schooling, 13.1% some vocational training, and 6.3% some tertiary education.

Module 2: Causes of Flight and Current Situation

Experiences of Physical Violence

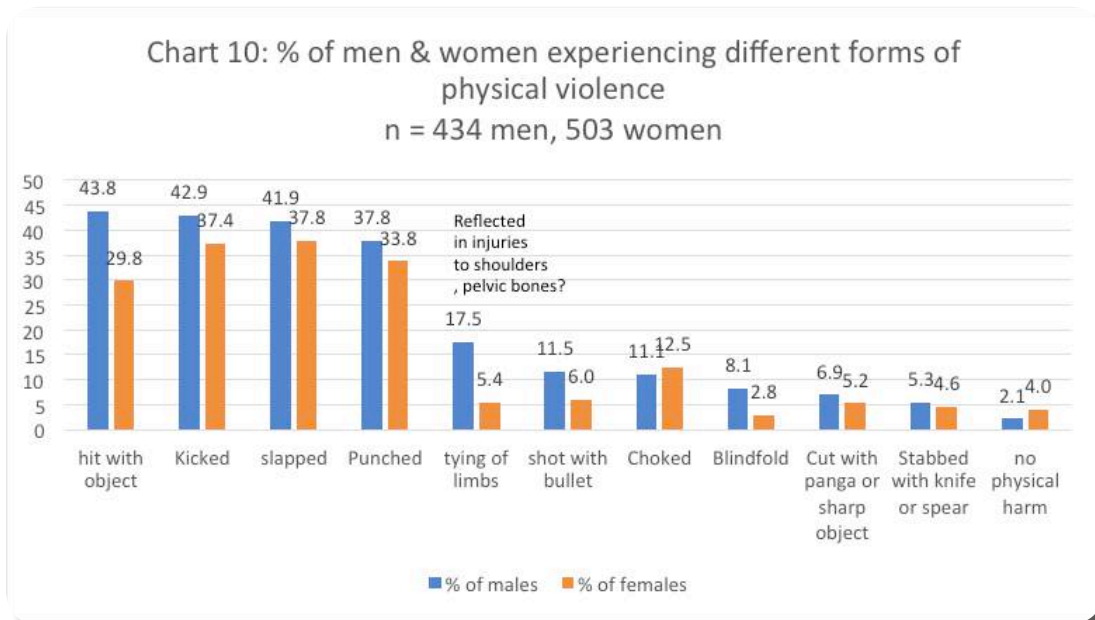
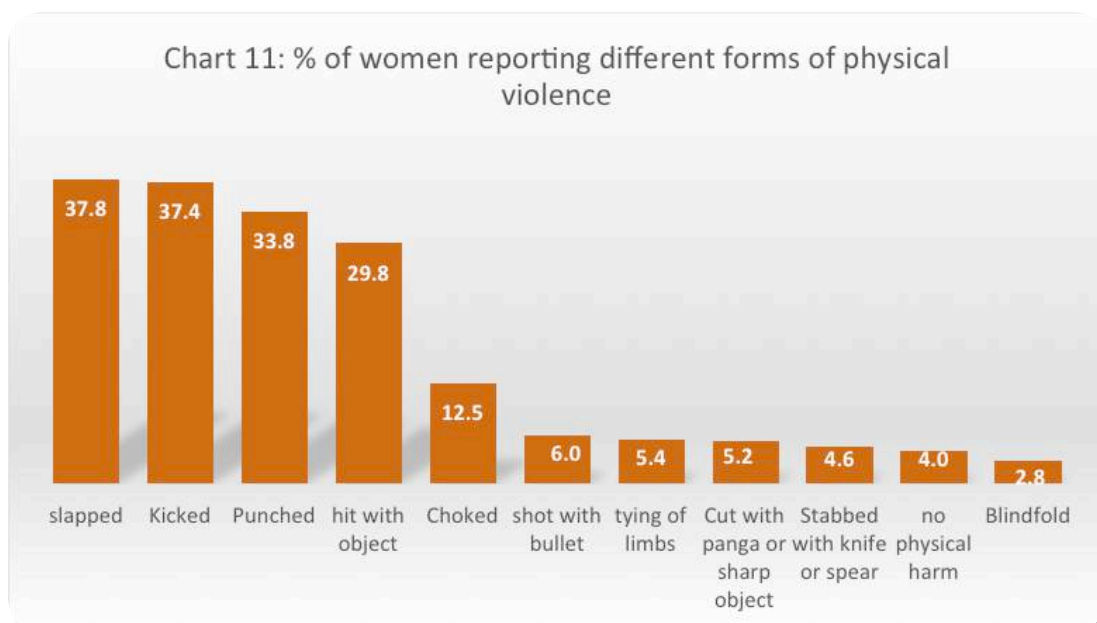
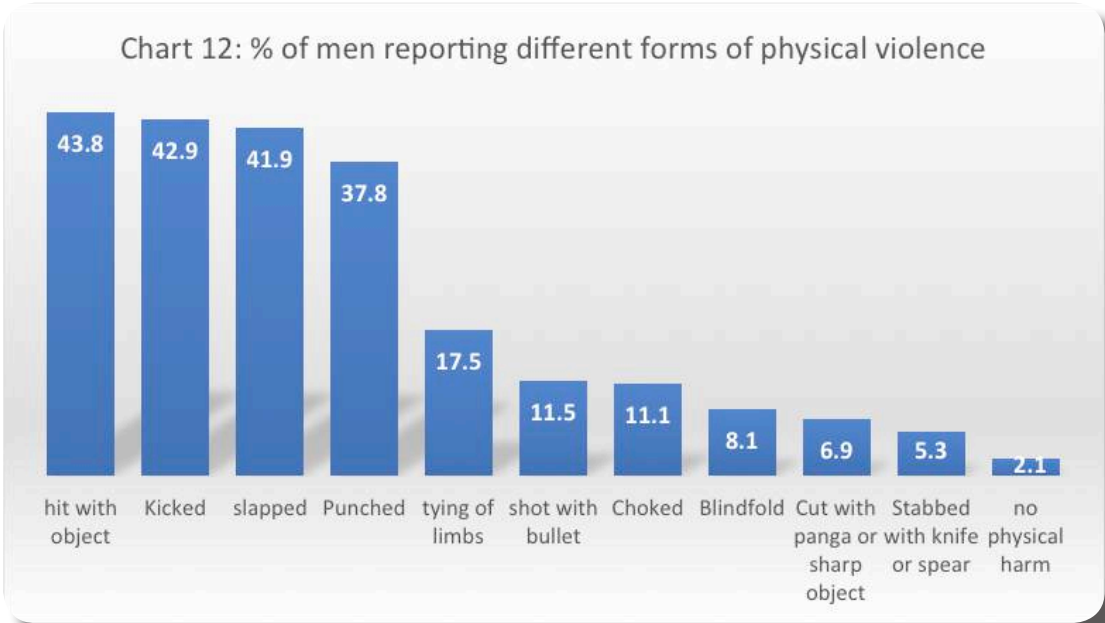
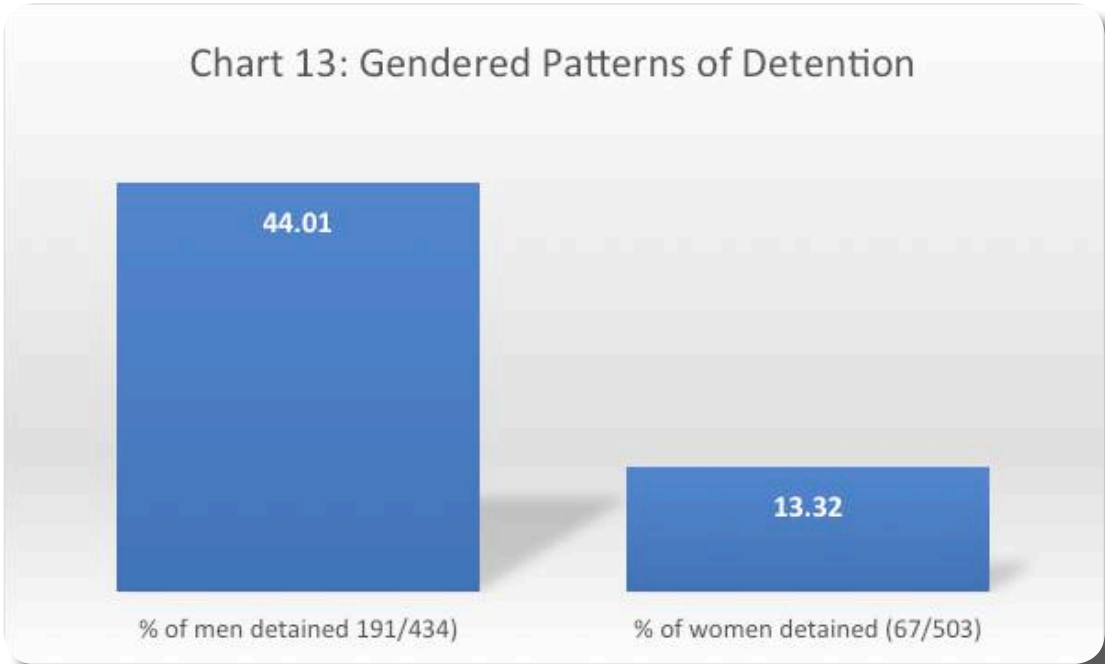


Chart 10 suggests that, with the exception of choking, men are more liable to physical violence than women. Overall, only 4% of women and 2% of men report being completely unharmed.

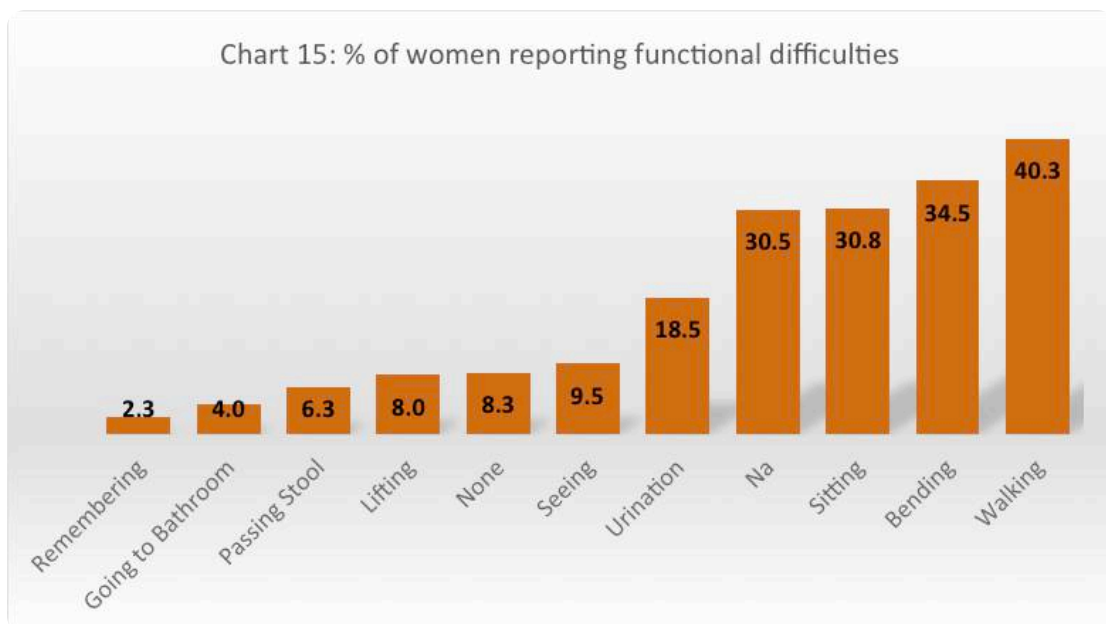
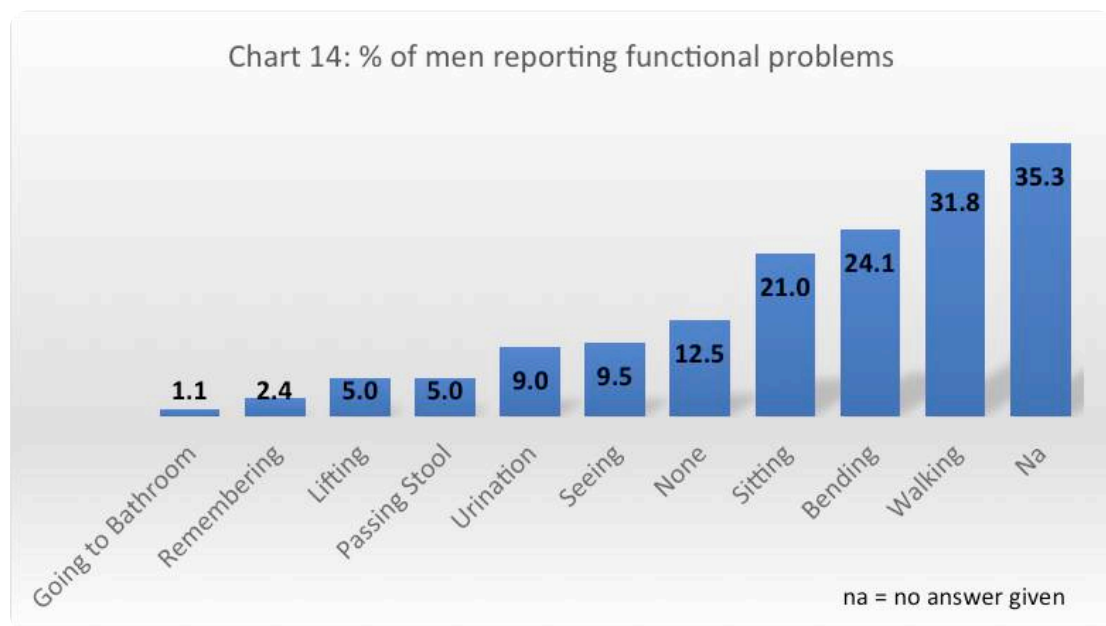




Gendered Patterns of Detention



The high levels of detention of men are part of the explanation for high levels of physical violence experienced by men.

Loss of Functionality

The relationship between specific experiences of violence and various functional differences requires further exploration. For the purposes of this paper we explored only whether there was any visible difference between those who had and those who had not disclosed rape, and reported difficulties with urination and passing stool. The findings are set out in Charts 16 and 17 below.

Chart 16: Relationship between men reporting rape and reporting difficulties with urination and/or passing stool

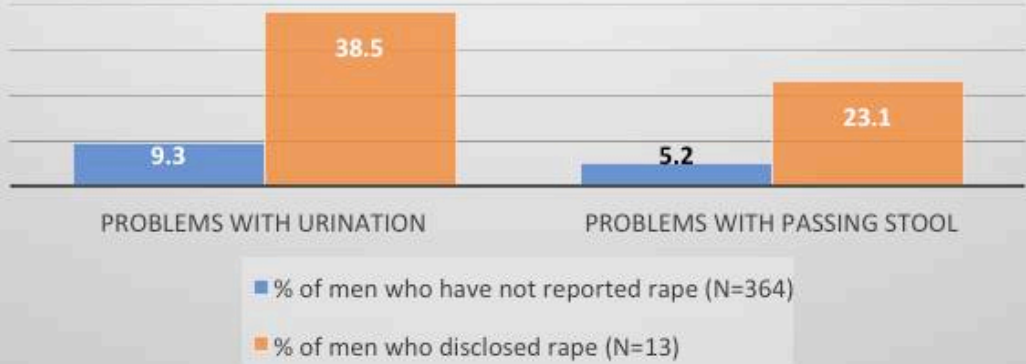
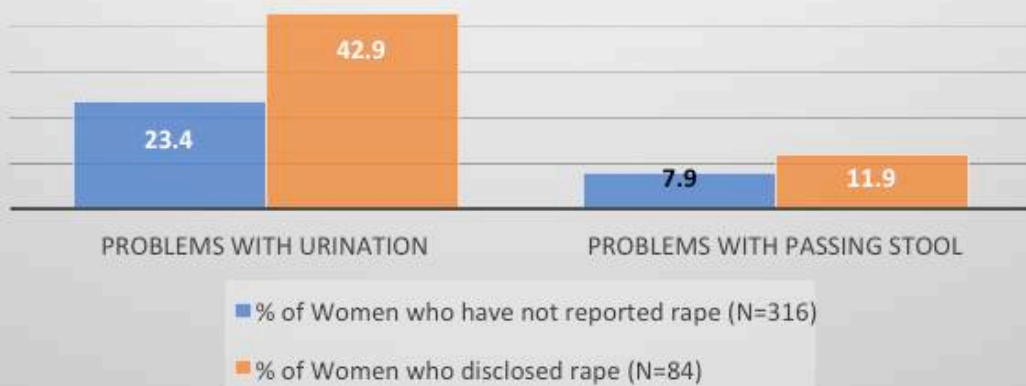
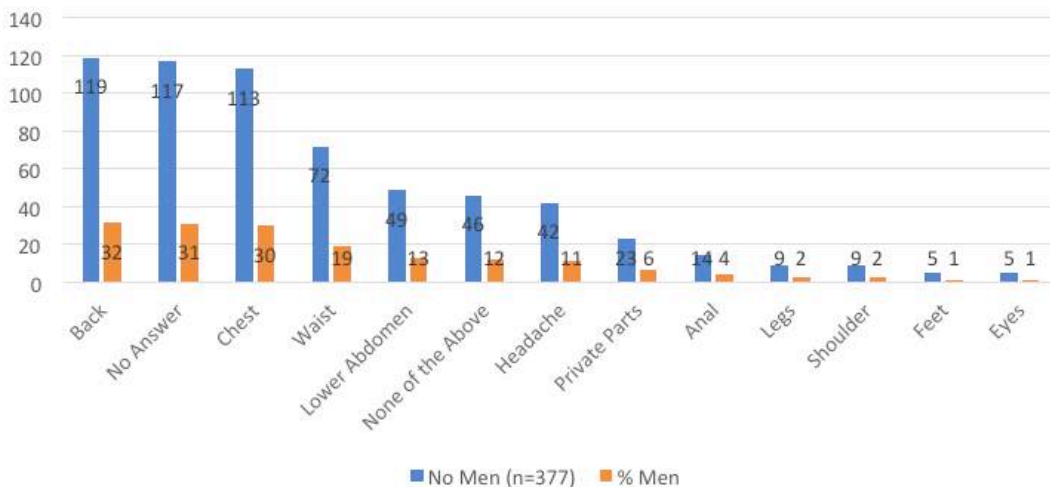
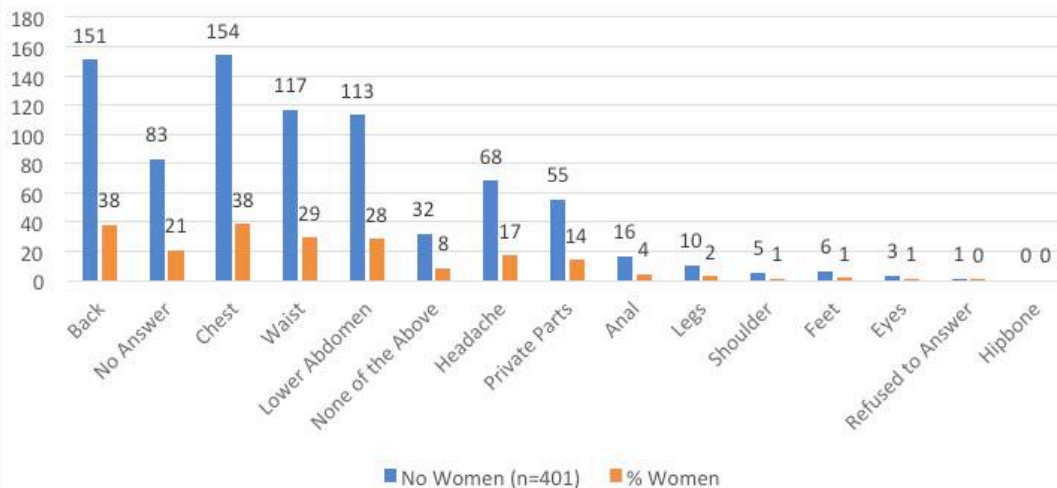


Chart 17 : Relationship between women reporting rape and reporting difficulties with urination and/or passing stool

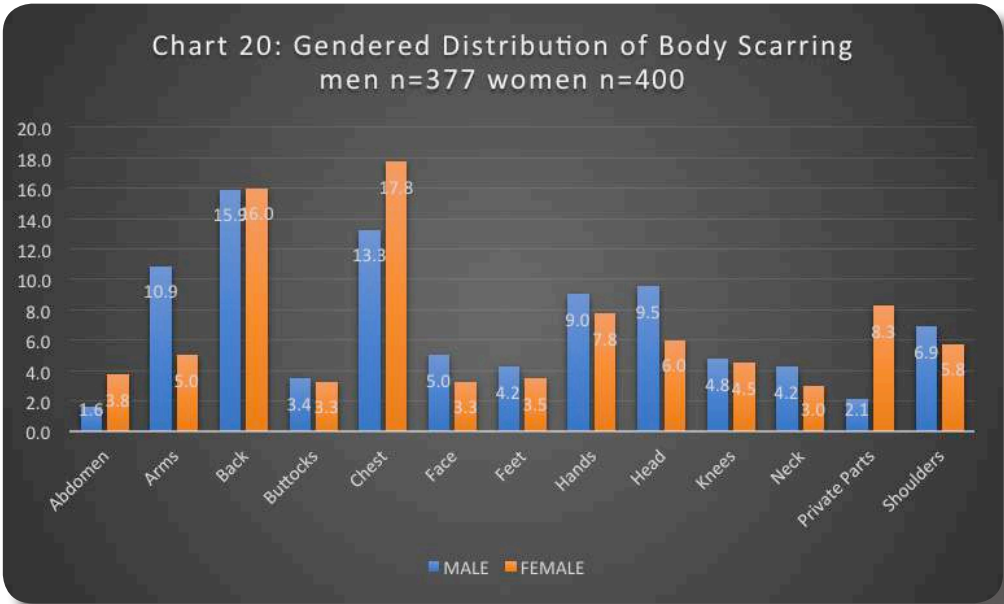


The difference in levels of men reporting difficulties urinating and passing stool alongside reporting rape are very evident, though the numbers involved make this suggestive rather than a strong statistic. The gap between reported difficulties with urination and passing stool amongst women who had not disclosed rape and women who had is far smaller, but nonetheless clear.

Pain in the Body**Chart 18 : % of men reporting pain in specific parts of the body****Chart 19: % of women reporting pain in specific parts of the body**

These two charts suggest that women and men experience similar distributions of pain, with the highest levels experienced in back and chest, followed by waist and lower abdomen, followed by headache, pain in the private parts, and anal pain.

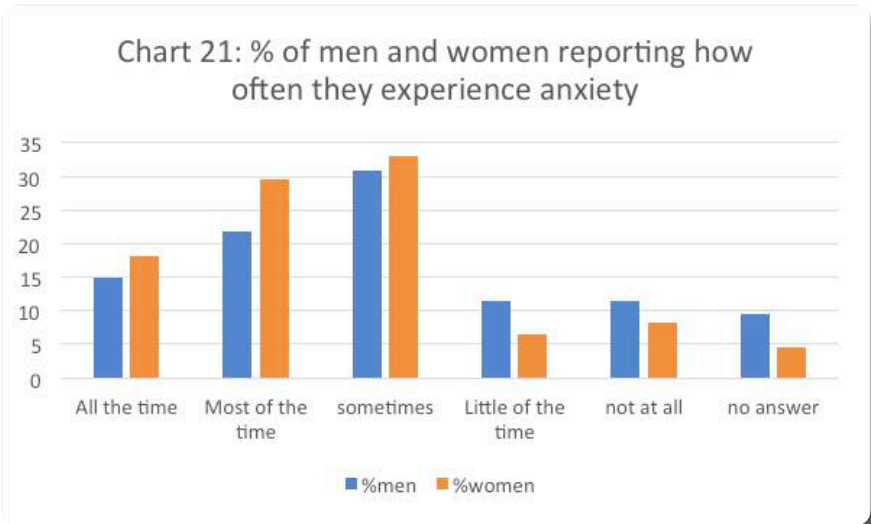
Scarring



The distribution of bodily scarring closely initially mirrors the distribution of body pains, with back and chest ranking highest. Thereafter it diverges; men’s reports of scarring on the arms, for example, are closely linked to practices of tying the limbs of men in detention. Given that more than 2 in 5 men have experienced detention there are correspondingly high levels of scarring on the arms. Women, on the other hand, report nearly four times the level of scarring on the private parts compared to men.

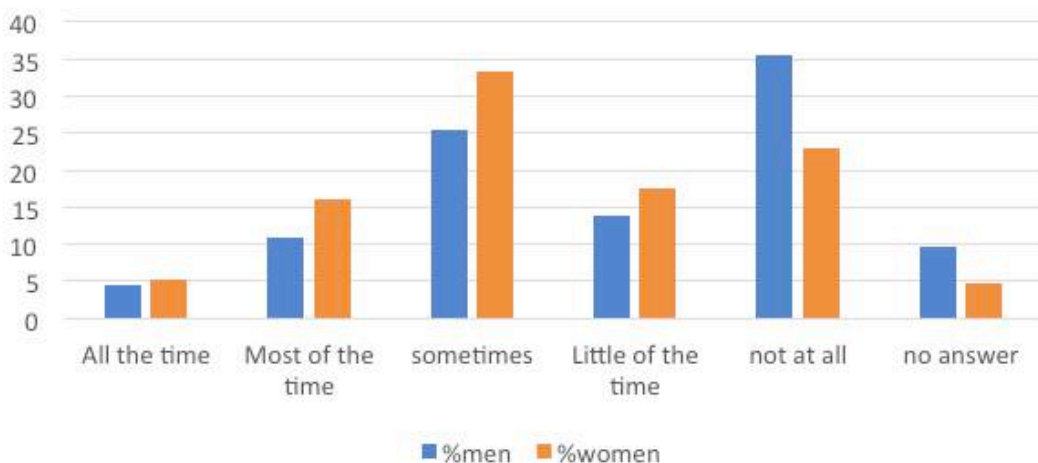
Psychological Impacts

Anxiety



Suicidal Ideation

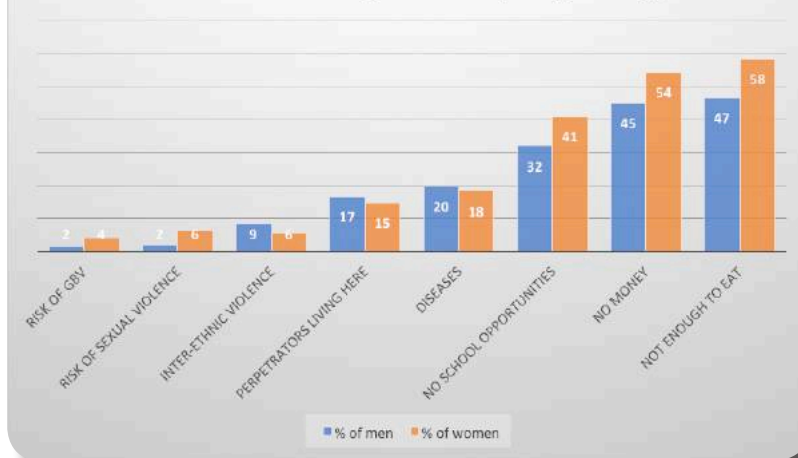
Chart 22: % of men and women reporting how often they have suicidal ideation



Both Chart 21 and 22 indicate that women are more likely than men to report high levels of anxiety and suicidal ideation. While those reporting constantly feeling suicidal represent just under 5% of men and 5% of women respondents, it is striking that 25% of men (1 in 4) and 33% of women (1 in 3) report sometimes feeling suicidal. Further analysis is needed to see how these feelings relate to past experiences of violence and current feelings of insecurity in the country of asylum.

Sense of Insecurity in Country of Asylum

Chart 23: Reasons for feelings of insecurity in Uganda by gender



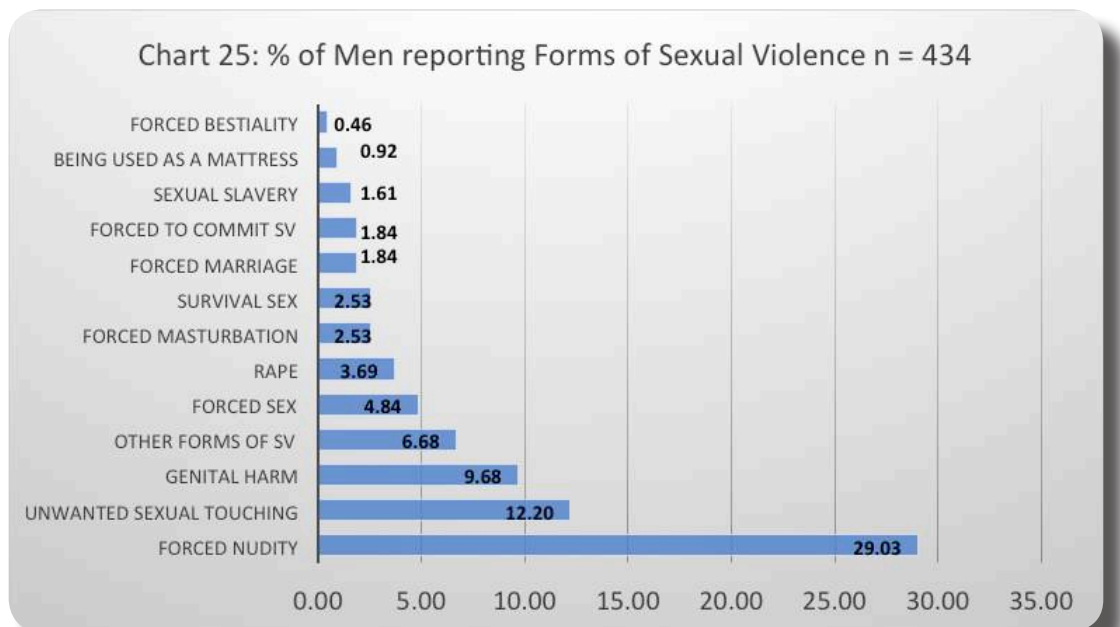
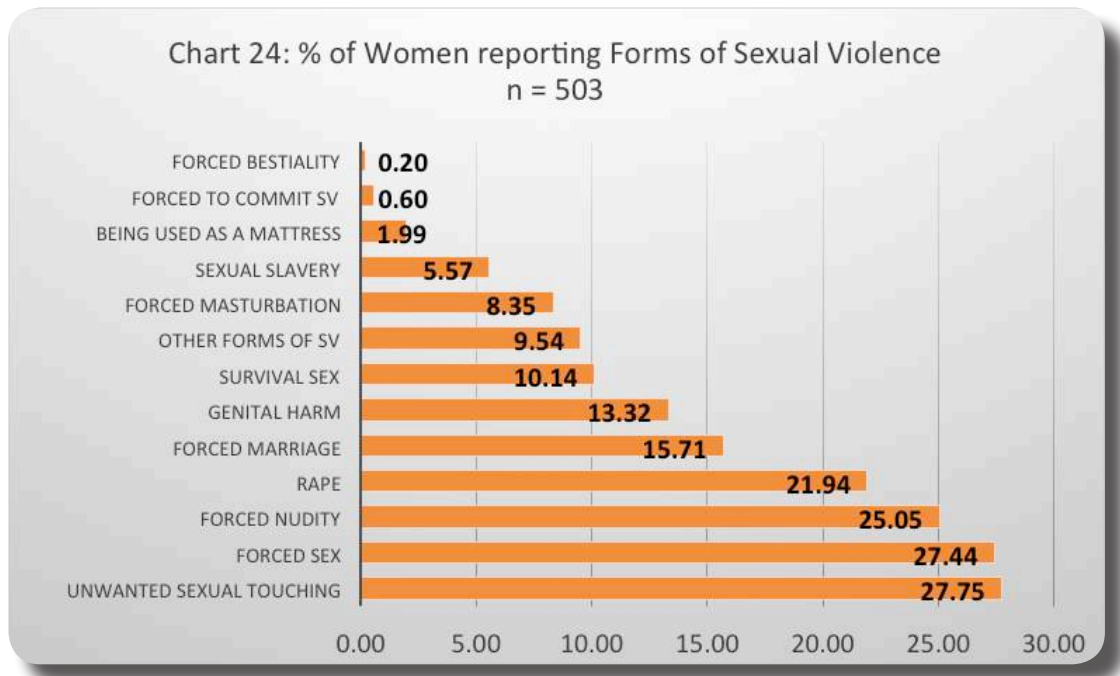
All respondents were asked whether or not they felt secure now that they were in Uganda. When asked for reasons behind their feeling of insecurity, there were a number of standard answers, as well as an ‘other’ option. Of the 376 men who answered, 187 (49.73%) responded that they still felt unsafe. Amongst the 400 women who answered, 190 (47.5%) responded that they still felt unsafe.

The above table shows the various reasons given for feelings of insecurity. Each column shows the percentage of those respondents who said they still felt insecure gave this as one of the reasons. With the exception of the risk of sexual violence and risk of inter-ethnic conflict, women’s and men’s concerns follow the same overall pattern, though at different levels.

Women feel at higher risk of sexual violence and other forms of GBV than men, while men feel more at risk (though only slightly more so than women) of being identified and harmed by former perpetrators who are either living in or visiting the refugee settlements. Men appear slightly more concerned than women that they will be exposed to disease while in Uganda, but slightly less concerned than women about opportunities for schooling, access to cash, and access to food.

Module 3: Experiences of Sexual Violence

% of women and % of men reporting different forms of sexual violence

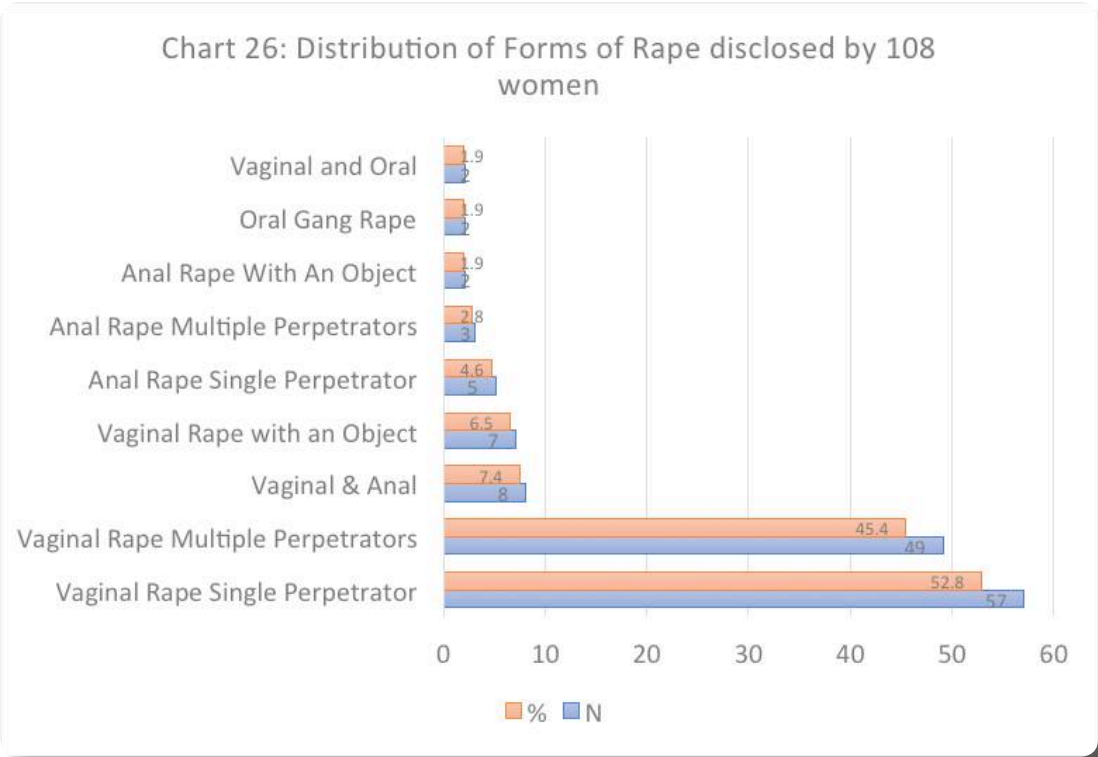


Charts 24 and 25 show far higher levels of disclosure by women than by men and in many ways the overall pattern conforms to expectations. Only 0.6% of women reported being forced to commit sexual violence against others, compared to 1.84%

of men. 5.57% of women reported experiencing sexual slavery, compared to 1.61% of men. Reported levels of survival sex amongst women, at 10.14% were four times higher than amongst men (2.54%).

The extremely high levels of rape and genital harm reported by women should be cause for alarm, given the range of psychological and physical difficulties that these can cause. The levels of sexual violence reported by men, while considerably lower than those disclosed by women, should nonetheless give serious food for thought as to how best to identify such cases and make services available. While the percentages may look small, when extrapolated to the entire South Sudanese refugee population they number in the thousands rather than the hundreds, and as such surely merit some attention. The case for such attention is further reinforced if it is recognised that these levels of disclosure reflect what was in effect a pilot project in which some of the invisible facilitators of disclosure, such as word of mouth, had not yet had a chance to influence disclosure levels in an upwards direction.

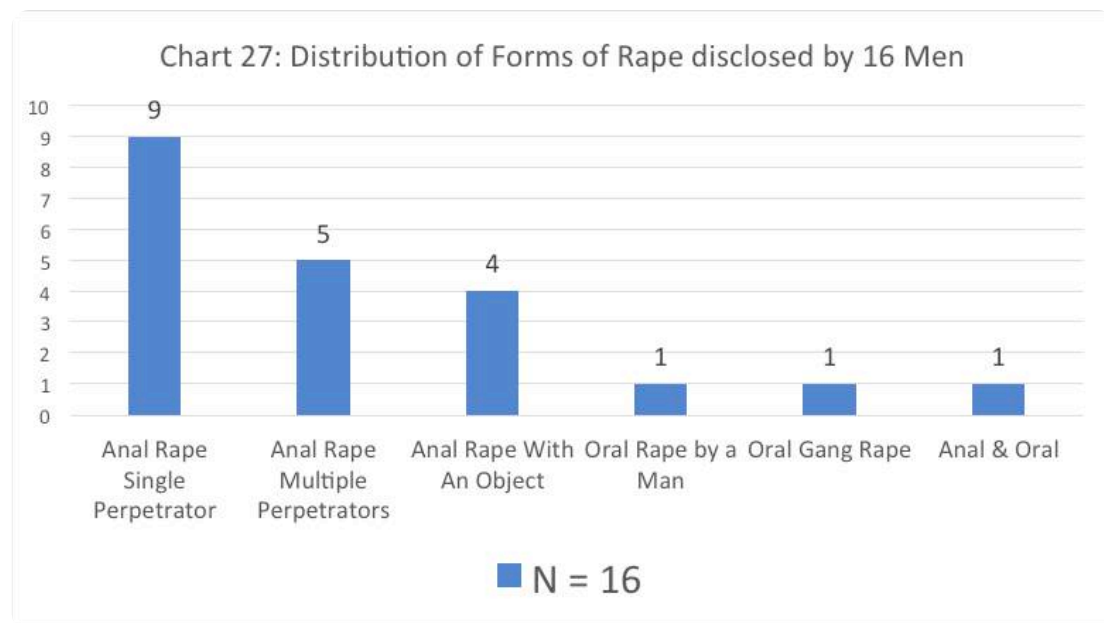
Distribution of Forms of Rape



Where respondents disclosed rape, further questions were asked about the way in which the rape occurred. As Chart 26 sets out, more than half of all women survivors (52.8%) reported being vaginally raped by one individual, but 45.4% reported having been gang raped vaginally. 7.4% reported being raped both vaginally and anally, and 6.5% reported vaginal rape with an object. Oral and anal gang rape were comparatively,

lower at 1.9% and 2.8% respectively. Anal rape of women is not, though uncommon if one considers that 4.6% of women reported being raped anally by a single perpetrator, and 7.4% both anally and vaginally.

Among men, the number disclosing rape (16) was too small to make a statistical analysis, but Chart 27 makes clear that anal rape by single and multiple perpetrators, or with an object, is more common than oral rape.



% of men and women disclosing rape – by ethnicity

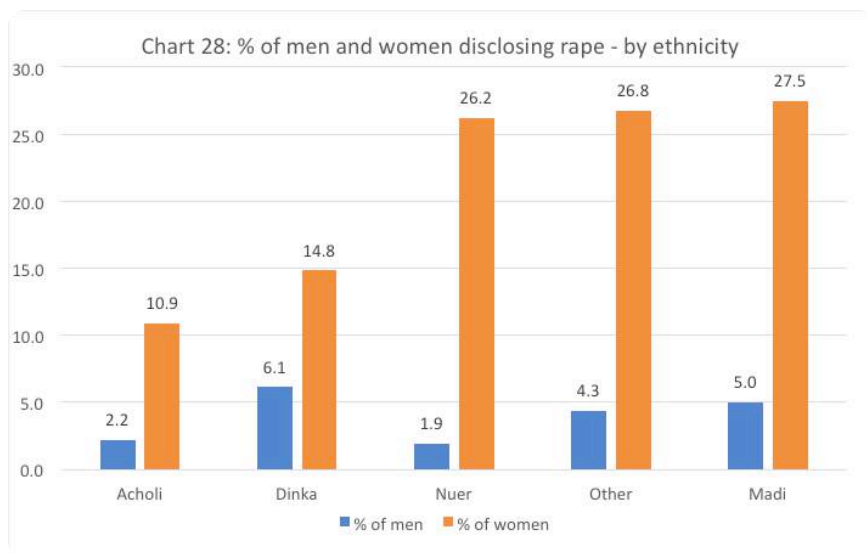
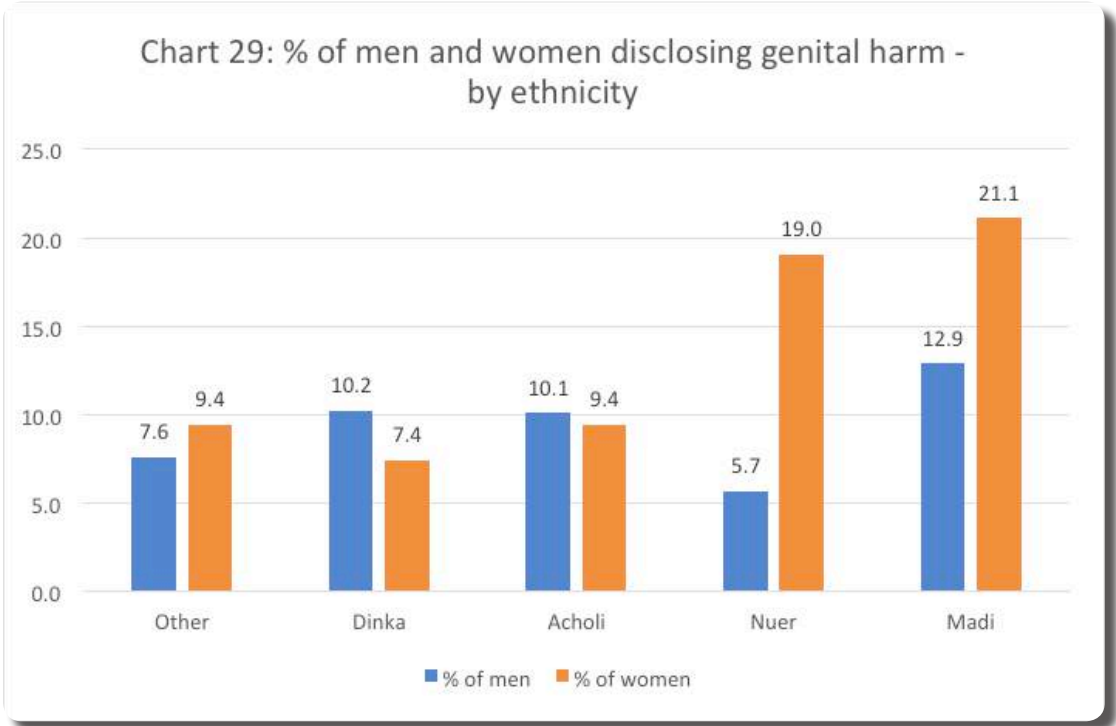


Chart 28 suggests some stark differences in levels of vulnerability by different ethnic groups. However, disclosure levels are affected by the length of time since arrival in the country of asylum. Given that many of the Acholi interviewed had only arrived within the previous month, this suggests that the levels of disclosure are pushed down by the fact of only just having arrived, and are likely to rise once the Acholi refugees are more settled, and that there should be a longer gap between arrival and screening.



Women’s disclosure of experiences of rape is consistently higher than men’s. Even among the Dinka, women’s disclosure at 14.8% is more than double that of men at 6.1%. In terms of genital harm, however, a higher percentage of Dinka and Acholi men than women disclose genital harm.

Distribution of Perpetrators of Rape

Clear identification of perpetrators of rape by their victims is often very hard to do; perpetrators from different armed groups and armed forces often wear very similar uniforms and may speak the same languages. In this screening exercise, however, 40% of women survivors identified South Sudanese government soldiers as the perpetrators. Amongst men, the numbers were too small for statistical analysis, but nonetheless, 10 of the 16 victims identified Government soldiers as their perpetrators (see Charts 30 and 31 below).

CHART 30: DISTRIBUTION OF PERPETRATORS OF RAPE AGAINST 108 WOMEN

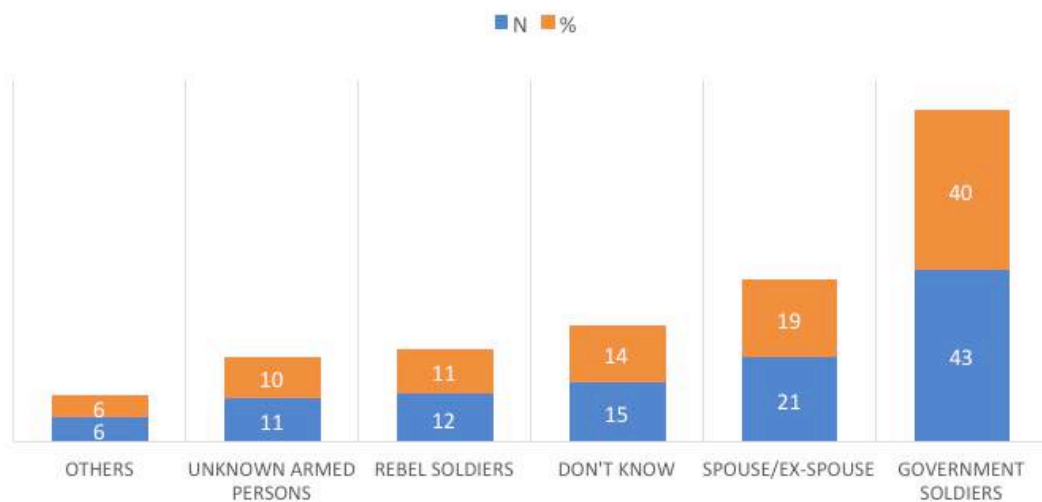
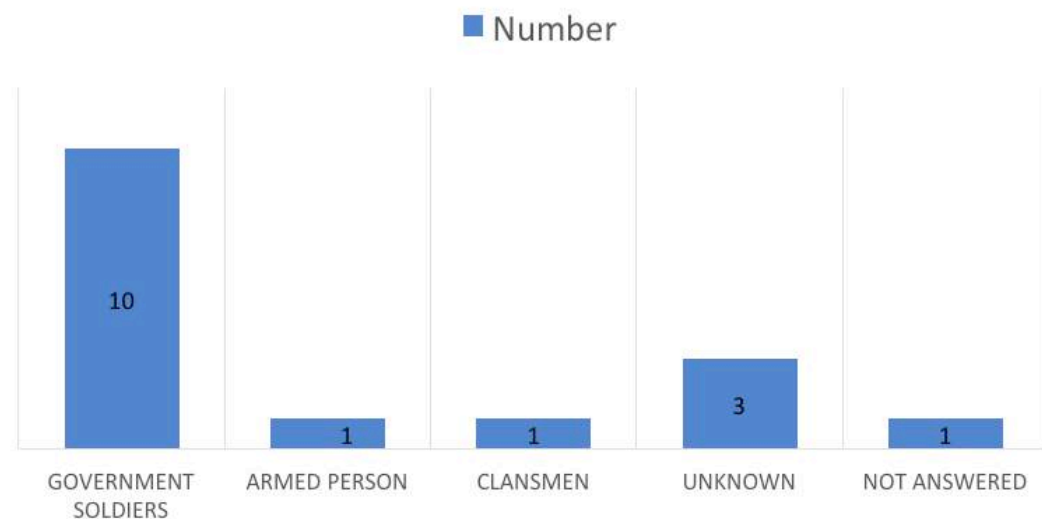
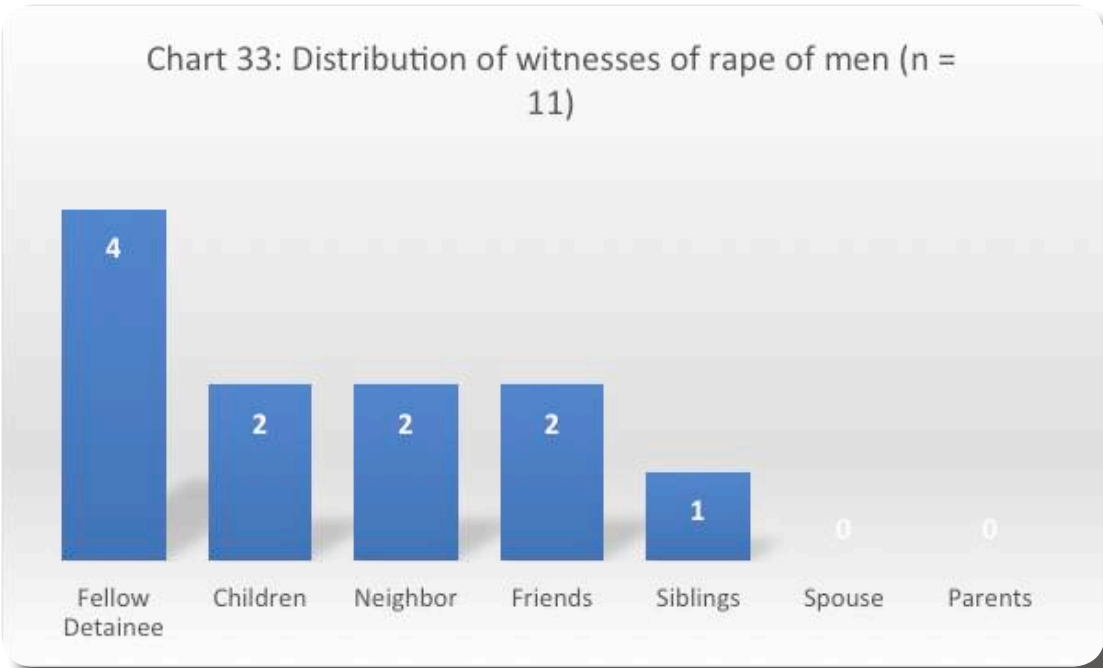
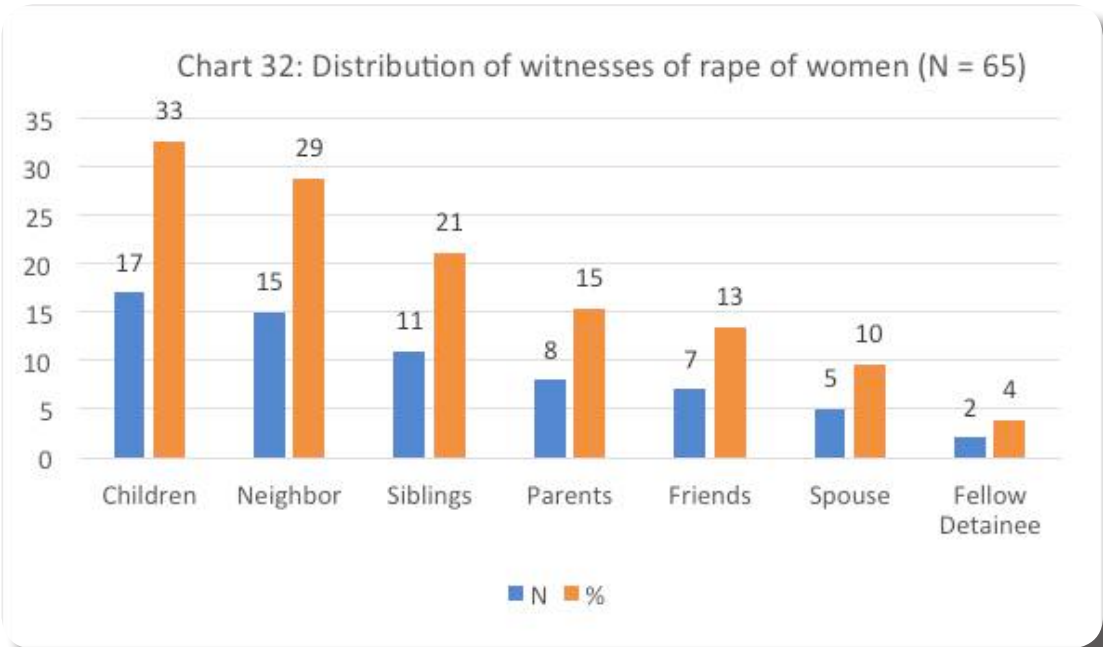


CHART 31: DISTRIBUTION OF PERPETRATORS OF RAPE AGAINST 16 MEN



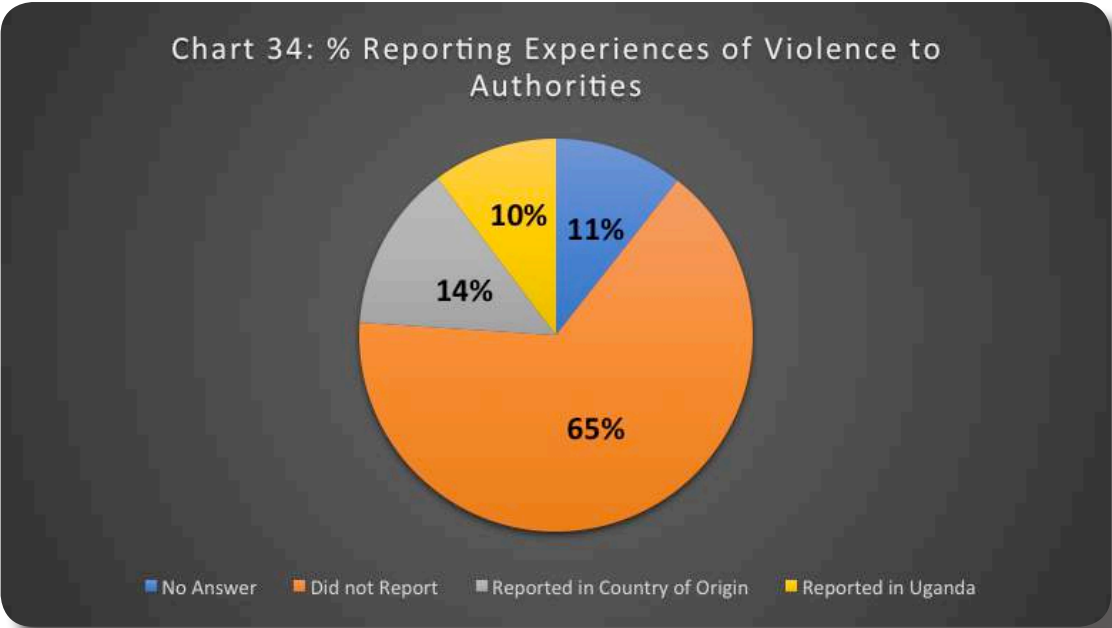
Who witnessed the rape(s)?



Again, the charts show quite distinct gendered patterns. Whereas for women, the primary witnesses of their rape are their own children (33%), for men it is fellow detainees (who only account for 4% of the witnesses of rape of women). None of the

men reported that their rape had been witnessed by a spouse or parents, whereas 5% and 8% of women victims said their rape had been witnessed by their spouse and parents respectively.

Module 4: Reporting



They key figure here is that only 10% of respondents had reported their experience of violence once in Uganda. This shows that under-reporting is a major problem in these humanitarian contexts.

How respondents felt about the screening process

- “I hope this shall reach everyone suffering in this camp”.
- “You should continue with this exercise, you should also encourage other organisation UNHCR and OPM to do the same”
- “May God bless you for choosing me for this opportunity and bless you for taking your time to ask me all those questions. Amen”
- “I need help in terms of medication and the orphans that am keeping now because am now old”
- “You should continue with the survey as there are many people with worse cases than mine”
- “It should continue since our cultures prevent us from opening about our experiences”
- “This survey should be taken to schools. Due to many issues that young people have in them and have not found where to share, their performance in class is badly affected”

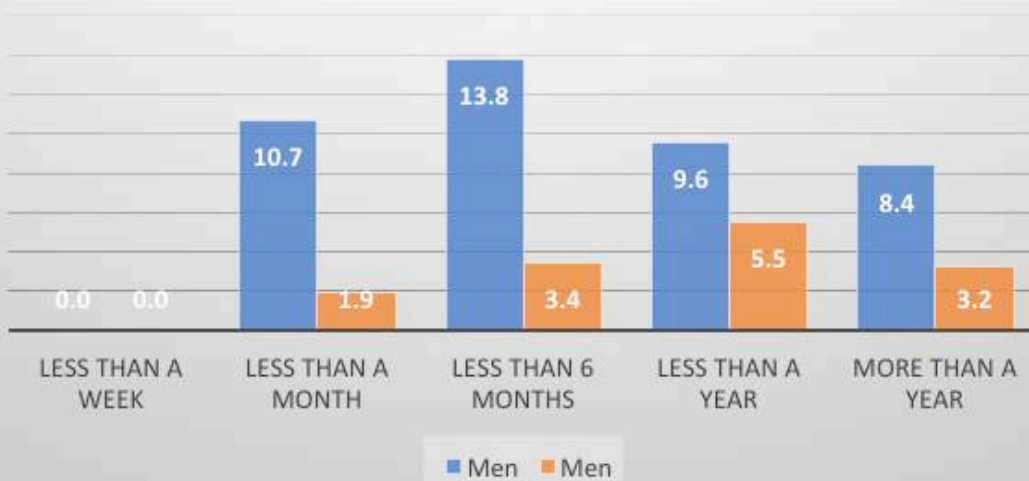
3.2 What did we learn about the process?

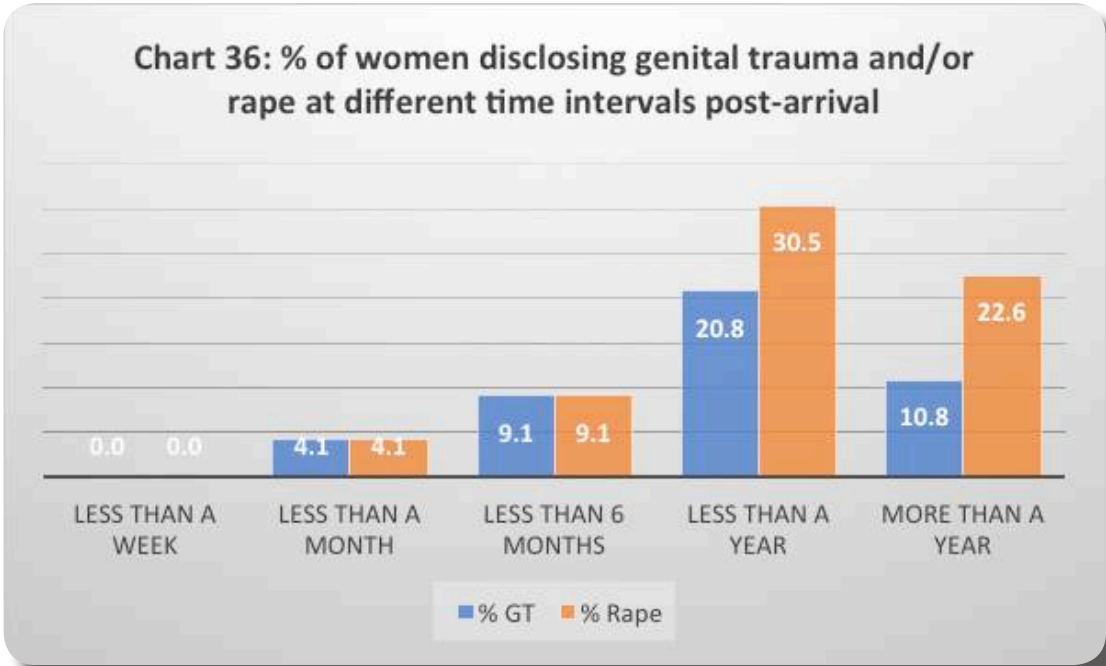
A number of factors were examined to see if they impacted on disclosure rates by respondents. The clearest relationship appears to be that between time of arrival and disclosure.

The impact of time since arrival on disclosure rates

Relationship between Rates of Disclosure and length of time in country of asylum										
	Men					Women				
	N	Genital trauma	Rape	% GT	% RAPE	N	Genital trauma	Rape	% GT	% Rape
Less than a week	5	0	0	0.0	0.0	1	0	0	0.0	0.0
Less than a month	103	11	2	10.7	1.9	97	4	4	4.1	4.1
Less than 6 months	29	4	1	13.8	3.4	22	2	2	9.1	9.1
Less than a year	146	14	8	9.6	5.5	197	41	60	20.8	30.5
more than a year	155	13	5	8.4	3.2	186	20	42	10.8	22.6
TOTAL	438	42	16	9.6	3.7	503	67	108	13.3	21.5

Chart 35: % of men disclosing genital trauma and/or rape at different time intervals post-arrival





These results suggest that, where no prior screening has been done, the period when both men and women are likely to disclose rape is 6-12 months after arrival. Men appear most likely to disclose genital trauma if screened within the first 6 months of arrival, whereas women appear most likely to disclose genital trauma if screened between 6-12 months of arrival in country.

In our sample, the number of people screened within a week of arrival (6) was too small to be able to generalize, but the overall trend for both men and women appears to be that the 6-12 month period is the most likely to produce disclosure. This could be due to a number of factors such as i) having to deal with immediate pressures to secure shelter and food in the first few months after arrival ii) lack of familiarity with organisations and services available iii) still dealing with the shock of what happened and not ready to disclose, etc.

Referrals

A total of 190 persons (93 male, 97 female), representing 21.4% of men screened and 19.3% of women screened or approximately 1 in 5 of all persons screened of both genders, were referred for further support as a result of the screening. While the majority of these were made to existing Implementing Partners, a total of 27 men and 32 women, representing 6.2% of men and 6.4% of women screened, were referred by RLP for private treatment to either St Mary’s Hospital, Lacor in Gulu (47 cases) or Ntinda Family Doctors in Kampala (12 cases).

The referrals outside the existing Implementing Partner framework were made in three scenarios:

- a) The person had already sought medical help for a condition related to experiences of violence, but this had brought no change
- b) The person's condition required in-depth assessment, including scans and/or x-rays, and these were not readily available through the existing medical services
- c) The person's condition required operations of a kind that were not readily available through the existing medical services

The medical treatment, support to these 59 patients and their attendants,¹⁴ and transport between settlement and treatment facility, cost a total of \$3,382 representing an average cost of \$57/referral. The highest cost for medical treatment was \$196, the lowest \$13.

The types of injuries disclosed by men that were deemed to require referral included: Swelling in the genitals due to torture and beating and tying of the private parts and/or to rape; Difficulties in urinating due to torture/genital tying/genital beating/rape; erectile and other sexual dysfunction due to rape; abdominal swellings due to rape; rectal prolapse due to rape; itching/swelling of the anus and/or hemorrhoids due to rape; abdominal, chest and waist pains following rape; hepatitis B exposure due to sexual violence; multiple injuries (e.g. head, chest, shoulder, collar-bone, thigh, knee, arm, retained bullets etc.) arising from violence.

For women, injuries disclosed that required referral included: Vaginal and anal itching, rectal prolapse and swelling in the private parts due to rape; Reproductive health problems and possible STIs suggested by abdominal pain/vaginal swellings/discharge of smelly fluids/vaginal and anal tearing/difficulties passing both urine and stool; miscarriages; abnormal periods accompanied by a lot of pain, excessive bleeding and longer durations (10+ days); body pains (eg. chest and waist pain, lower back pain, hip pain, lower abdominal pain and chest pain with features of Pelvic Inflammatory Disease as a result of torture and sexual violence, leg pains); Back injuries as a result of torture and trauma to the back and lower limbs and sexual violence; Waist injuries due to torture where the victims was stepped on; Swelling in the chest around the breast as a result of being stabbed on the chest using bayonet; complications sustained as a result of bomb blasts in South Sudan.

¹⁴ In Ugandan hospitals it is standard practice for those admitted to be accompanied by someone, whether a family member, friend or paid individual, to ensure that her/his needs are attended to (e.g. helping with bathing, going to bathroom, washing clothes, ensuring food and drink are available, etc.)



4 CONCLUSIONS

Systematic screening is possible and is welcomed by survivors and seen as a departure from existing practice, particularly when linked to adequate referral mechanisms for complex conditions arising from violence. Access in humanitarian settings require careful negotiation, and the screening process itself is labour and time intensive and reliant on skilled and trained personnel.

Screening for experiences of violence, particularly sexual violence, cannot be rushed. The original idea of screening was to be able to identify within a matter of minutes and through a very limited number of questions. However, if a person is a victim of a particular kind of experience, the sensitivity of the experiences that are being looked for (notably sexual violence) makes a rushed approach inappropriate and likely to do harm to the client.

Recognising that the person being screened is likely to have suffered multiple experiences of violence, some of which intersect, the screening should explore the full range of experiences of violence rather than only sexual violence.

Questions on physical functionality, pain and scarring, as well as psychological and social functionality are important in their own right, and also as a cross-reference to what the person has or has not disclosed. For example, a respondent may find it easier to talk about rectal pain than about having been raped anally and this allows the person screening to then probe into the causes of that pain. However, it is important not to jump to conclusions about the source of a particular pain. Rectal pain, for example, cannot be taken as a proxy indicator of anal rape.

Levels of violence disclosed (e.g. 22% of women and just under 4% of men disclosed experiences of rape), are high and, extrapolated to the refugee population as a whole, imply that tens of thousands of refugees require concerted interventions to minimize the harms from these largely untreated injuries. However, they almost certainly reflect under-reporting insofar as disclosure is undoubtedly still influenced by a number of factors, including the time and timing of screening, the skill level of the interviewer and the language used, the ethnic composition of the settlement, the plausibility of referral options, the time-gap between incidence and disclosure.

Screening is nonetheless a critical step in significantly reducing under-reporting and offers an important starting point in understanding incidence and prevalence patterns. To maximise on this potential, it should be combined with more effective and widely publicized treatment options as well as community level work to maximise support to identified survivors.

Screening, if done correctly and in conjunction with adequate referral mechanisms, creates a positive cycle of disclosure. Those who have disclosed and been assisted a will in some instances make peer referrals of other cases they are aware of. Extending screening to the entire adult refugee population may not be necessary, even supposing it were viable. Once a supportive environment has been established, a percentage of cases will be identified through dynamics that are a no-cost and self-perpetuating product of the screening and treatment process.

Implications for Humanitarian GBV Interventions

Systematic screening is a cost-effective intervention which, done correctly, has direct benefits to some of the most traumatized members of refugee populations, as well as to their households and families. In addition to strengthening the protection of vulnerable individuals and promoting their rights, it also greatly enhances the prospects of self-reliance and integration.

In terms of developing humanitarian systems, systematic screening allows for evidence-based quantification and targeting of resources required, evidence-based training of humanitarian staff, as well as providing a baseline against which the performance of Implementing Partners can be assessed.

From a justice perspective, the capacity to build an evidence base of different forms of violence experienced by specific populations originating from specific areas in the country of origin is an important opportunity in terms of building an understanding of patterns of violence.

What would be the cost of screening all adults?

This exercise screened just under 1,000 adults of whom 6% were referred for medical attention not readily available through settlement-based IPs. The research grant, coupled with the costs of medical treatment for the most acute cases of physical injury, cost approximately \$50,000, an average of approximately \$50 per person screened.

UNHCR statistics indicate that 37% of the total South Sudanese refugee population are adults aged 18 and above. That equates to 370,000 out of a total case-load of 1 million. Of these 46% (170,200) are male and 54% (207,200) are female.¹⁵

At an average of \$50/person, it would cost US \$18.5 million to screen every single adult and treat the medical needs of 6% of respondents identified as survivors, equivalent to just 3.3% of the total budget of US \$558.2million put forward by UNHCR for Uganda in 2017.

15 <http://reporting.unhcr.org/sites/default/files/UNHCR%20Regional%20Dashboard%20on%20South%20Sudan%20situation%20-%202015%20June%202017.pdf> accessed 16 July 2017

These figures are necessarily approximations: Further enhancement of the screening tool to reduce the time spent on each screening would bring the cost per screening down, but increased familiarity with and awareness of the benefits of the screening process, would result in an increase in numbers disclosing serious health challenges requiring intervention, thus pushing the treatment costs up as a proportion of the overall cost. Furthermore, it is not necessary to screen 100% of the population; if 25% of the adult population could be screened, at a cost of less than \$5 million, it would have an important ripple effect throughout the entire refugee population.



5. FUTURE IMPACT

- Our findings imply that the current thinking that it is not advisable to attempt to assess levels of harms experienced by refugees is incorrect and needs to change
- The fact that it is possible and, as the nature of the harms identified makes clear, desirable to make such assessments given that the otherwise unaddressed harms are physically, psychologically and socially debilitating and at times life-threatening, implies that screening should be mainstreamed into the early phases of a refugee crisis such as the South Sudanese situation.
- The results also throw considerable light on otherwise contentious issues such as ‘which gender is the biggest victim of a particular type of violation?’ and thus hold the promise of an evidence-based discussion of the nature of gender based violence in conflict settings
- For UNHCR, the implication of this work is that it is possible to put some numbers to the various already existing ‘specific needs codes’.

Questions for Future Research

- a) “How do the findings of this research compare and contrast with the knowledge, attitudes and practice of a range of humanitarian stakeholders regarding conflict-related violence in general, and conflict-related sexual violence in particular?” This could be a simple multiple choice questionnaire administered using hand-held tablets.
- b) “Which would be the most effective and appropriate type of software and background applications for collecting and analyzing screening data? This technical research could be done in partnership with UNHCR statisticians who are already producing regularly updated reports on key statistics such as total numbers of refugees in each country, the ratio of male to female, etc.
- c) “Who would be best equipped to conduct such screening?”; should it be mainstreamed into the work of existing Implementing Partners or, alternatively, should it be a stand-alone process conducted by an organization with particular skills in this area of work?



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NOTES

This image shows a full page of primary-ruled paper. It features approximately 28 horizontal dotted lines spaced evenly down the page, providing a guide for handwriting practice. The paper is otherwise blank, with no margins, text, or other markings.



NOTES

This image shows a full page of a document template designed for handwritten notes or essays. It features approximately 28 evenly spaced horizontal grey lines across the entire width of the page. The margins are consistent on all sides, providing ample space for writing. There are no pre-printed questions, headings, or other markings on the page.

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