ChildFund Uganda



Sexual Reproductive Health Needs Assessment Among Adolescents and Youth in Refugee and Host Communities in Obongi District. Research Report

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Table of Contents

Acknowledgment 2
Abbreviations/Acronyms 4
Abstract 5
Summary Findings: 5
Section One: Background 6
1.1 Introduction 6
1.1 Uganda's refugee management approach 8
1.2 Objectives 10
1.3 Overview of methodology 10
1.3.1 The study design 10
1.3.2 Data collection and analysis 11
1.3.3 Quality control 12
1.3.4 Ethical considerations 13
1.3.5 COVID-19 Infection Prevention Measures 13
1.3.6 Research limitations 13
1.3.7 Study area 14
1.4 Gender, norms and practices by refugees 14
1.5 Contextualizing AYSRH and SGBV in refugee settlements 16
Section Two: Research Findings 18
2. 0 Social demographic characteristics of household participants 18
2. 1 Sexual and Reproductive Health Knowledge among adolescents and youth 20
2.1 Adolescent and youth knowledge of SRH 20
2.2 Adolescent and Youth attitudes towards SRH 28
2.3 Adolescent and Youth practices 31
2.4 Adolescent and Youth experiences with SRH 36
Section Three: Adolescent and Youth Knowledge of SGBV 37
3.1 knowledge about SGBV by Adolescents and Youth 37
3.2 Adolescent and Youth attitudes towards SGBV 39
3.4 Adolescent and Youth experiences with SGBV 45
Section Four: Service delivery gaps 48
4.1 Decision making gaps 50
Section Five: Existing interventions by implementing partners and targets 51
Section Six: Conclusion 55
SECTION SEVEN: REFERENCES 57
i. FGD guide for adolescents and youth 61
ii. Key informant interview guide 63
iii. Questionnaire - Quantitative Tool 65

Background to:

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Acknowledgment

The study focused on assessing SRH and SGBV knowledge, attitudes, and practices among adolescent girls and boys (ages 13-19) and youths (ages 20-24) in Palorinya Refugee Settlement and host communities in Obongi district, West Nile, Uganda. It was conducted in June 2022 involving several stakeholders including Office of the Prime Minister, UN Agencies, Development Partners, Child Fund Uganda, Makerere University Institute of public Health, Local Government Officials, health facilities, schools, local leaders, parents, adolescents and youth who were both from refugee settlements and host communities.

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This study report is a product of the views and perceptions of various stakeholders interviewed. The results and conclusions presented in this report represent the consultants' analysis of respondents' views and perceptions and not necessarily those of Child Fund International- Uganda.

Abbreviations/Acronyms

ANC	Antenatal care
ASRH	Adolescent Sexual and Reproductive Health
DRC	Democratic Republic of Congo
FCA	Finnish Church Aid
FGD	Focus Group Discussion
FP	Family Planning
HC	Health Centre
IP	Implementing Partners
IUD	Intrauterine Device
KI	Key Informant
KIIs	Key Informant Interviews
LWF	Lutheran World Federation
M&E KML	Monitoring and Evaluation, Knowledge Management and Learning
NGOs	Non-Governmental Organizations
ODK	Open Data Kit
OPM	Office of the Prime Minister
PAG	Pentecostals Assemblies of God
PNC	Postnatal Care
STDs	Sexually Transmitted Diseases
SRH	Sexual Reproductive Health
SGBV	Sexual Gender Based Violence
STIs	Sexually Transmitted Infections
TV	Television
RWC	Refugee Welfare Committee
UNFPA	United National Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UTIs	Urinary Tract Infection
VHT	Village Health Team s
WFP	World Food Programme
WOS	Windows operating system
YSRH	Youth Sexual and Reproductive Health

Abstract
The main objective of the study was to assess SRH and SGBV knowledge, attitudes, and practices among adolescent girls and boys (ages 13-19) and youths (ages 20-24) in Palorinya Refugee Settlement and host communities in Obongi and stratify the findings across socio-demographics and influencing factors to generate evidence for future programming for refugee adolescents and youth.

Summary Findings:

- Majority (67%) of participants were females and about 40% were aged below fifteen years.
- Majority (63%) completed primary education and almost 10% having no formal education. Most of these adolescents and youth were still in school (69%), although many of them were in primary school irrespective of age, some aged up to 24 years were still in primary school due to Accelerated Education Program (AEP) being implemented in the settlements.
- Adolescent and young people who were single or unmarried were 74%. While of those who were married, 61% got married between 16 – 19 years of age.
- A total of 20% had never heard about SRH, majority being girls below 15 years (p-value <0.001).
- The main sources of information on SRH is schools (52%), radio (45%) and peers (34%).
- Majority of the young people (76%) had heard about family planning (76%) and knew condoms (95%) as one of the contraceptive methods with the sources of their information being the health facility (67%), radio (50%) and peers (40%).
- Only 6% did not know about STIs. Those who know about STIs mentioned HIV/AIDs (92%), syphilis (57%) and gonorrhea (44%) as the most common in their communities.
- 25% participants believe that there is no harm to have sex intercourse below 18 years, while 11% did not know whether it was okay or not to have sex intercourse while below 18 years.
- More than 18% of the participants believe that when you have sex for the first time, you do not get HIV/AIDS, but 25% did not know.
- Many (10%) don't believe that it is bad to get pregnant before 18 years, while 10% don't think that abortion is harmful and 9% don't feel that menstruation is normal for a girl or not.
- A total of 26% have been pregnant with 24% saying it was not intentional and to manage the situation, majority delivered although four of them (3%) aborted.
- Many participants (40%) had never used contraceptives. Those who had ever used contraceptives, majority (85%) used condoms, 11% used emergency and 3% used injection.
- A big proportion of participants (85%) stated that SGBV occurs in the community and the perpetrators are both men (76%) and women (11%) while 13% didn't know the perpetrators.
- Significant number (60%) believe that a woman is not justified to refuse sex with husband/partner for any reason and 41% of respondents believe that woman must fulfil the sexual desires of her partners any given time.
- Of 13% who had seen SGBV, 91% said domestic violence was the most common form of SGBV, forced marriage (38%), rape (20%), sexual abuse and exploitation (11%) and trafficking 12%).
- Majority (82%) did not report SGBV anywhere and the few who reported, it was to local leaders, family members and police.

Section One: Background

1.1 Introduction

The last decade has seen a proliferation of refugees worldwide. By the end of 2015, the United Nations High Commissioner for Refugees (UNHCR) recorded the global population of forced displacement at 65.3 million with 33% (21.3 million persons) officially classified as refugees. As of 2016, Uganda in particular, was home to more than 872,946 refugees, mostly from South Sudan, Burundi and the Democratic Republic of Congo (UNHCR, 2017) and 4 years later (2020) the number had almost doubled to 1,434,708 refugees (UNHCR, 2020) making Uganda one of the largest refugee asylum countries worldwide and the largest in Africa. In Uganda, refugees are hosted in settlements spread throughout the whole country, with 61.7% South Sudanese and 29.3% Congolese from the DRC, and women and children making up 81% of the refugees (Madanda, 2021). Of all refugees hosted by Uganda by June 2021, 53% lived in the West Nile Refugee Settlements of Rhino, Imvepi, Lobule, Bidi Bidi, Parolinya and Adjumani (Ibid). Across West Nile, Northern region and other regions, the influx of refugees has increased the strain on a chronically overburdened health system among other essential services including SRH.

The Uganda Refugee Act, 2006 allows refugees freedom of movement and seeking for employment anywhere within the country, though in order to benefit from UNHCR assistance, they are still bound to the settlements, located in remote and marginal areas (Kaiser 2006; Kreibaum, 2014). The Uganda Refugee Act, 2006 allows refugees freedom of movement and seeking for employment anywhere within the country, though in order to benefit from humanitarian assistance, they are still bound to the settlements, located in remote and marginal areas (Kaiser 2006; Kreibaum, 2014). Those who settle in other areas such as towns and cities receive minimum services as they are deemed capable of catering for themselves. Therefore, free services are dully offered to refugees in settlements. The Uganda Refugee Act. 2006 aims at promoting local integration of refugees and merging public services for Ugandans and the refugees (Fielden, 2008), hence, allowing refugees' access to public social services, which are largely free (UNHCR, 2017). Consequently, together with the international community, Uganda has had to simultaneously provide emergency aid and long-term development support (Kreibaum, 2014).

However, due to the increasing refugee population, it has become increasingly difficult to raise enough funds for the provision of services to refugees in Uganda. For instance, by March 2018, UNHCR and its partners had only managed to raise 8% of the total required budget for the provision of services to refugees (UNHCR, 2018) and by the fourth quarter of 2021, only 49% of the total Uganda budget had been funded (UNHCR, 2021). The government of Uganda on the other hand is contributing only 20 percent of the drugs, which covers 50 percent of the general health needs, including those of refugees. This leaves the remaining 80% to be provided by development partners and donors hence high degree of donor dependence, which is evidently unsustainable (Rowley, Burnham, & Drabe, 2006). This not only affects service delivery, but it also makes planning impossible.

Perhaps just as troubling as the sheer magnitude of displaced people is the growing number of refugees living in protracted displacement, defined as a situation where "refugees continue to be in exile for 5 years or more after their initial displacement with no prospects for return in the foreseeable future" (Jacobsen 2002; Crisp 2003; UNHCR, 2016). Prolonged displacement forces refugees to live their lives in limbo and puts them at risk of further hardships as aid and support decrease over time (Aleinikoff, 2015). This creates concerns regarding refugee health and delivery of health services, a critical essentiality to life (UN General Assembly, 2015; UNHCR, 2017).

There is evidence that in refugee settlements, there is a lack of prioritization of sexual and reproductive health (SRH) challenges faced by refugee adolescents and youth (Ivanova et al. 2019:2) who continue to face difficulty accessing reproductive health services such as voluntary, informed, and affordable family planning services; pre-natal care, safe motherhood services, assisted childbirth from a trained attendant, prevention and treatment of sexually transmitted infections (STIs) including HIV and AIDS (Bukuluki et al. 2021), prevention and treatment of violence against women and girls, safe and accessible post-abortion care and sexual health information, education, and counseling (Thompson, 2016).

There is a large information gap that exists due to the fact that information on sexual and reproductive health (SRH) is given in the context of socio-cultural beliefs (Spiegel, 2017) where matters to do with sex are not discussed between a parent and child in public.

In a study carried out by Ivanova, Rai and Kemigisha (2018) in one of Uganda's refugee settlements, it was found out that health workers are not youth-friendly; in most cases, they simply judge and condemn adolescents for irresponsible behavior. Because adolescents fear being embarrassed, they stay away and engage in risky behavior such as unsafe abortions. It is when it turns out to be life-threatening that young people, especially girls go to health facilities seeking post-abortion treatment (The Health Digest, 2016). This has resulted in adolescents and youth practicing self-medication or seeking help from fellow peers who are equally ill-informed (UNHCR, 2000) and going to traditional health providers which put high risk to the health of the young people.

Further, another recent study by Kwiringira et al. (2018) on the experiences of sexual and gender-based violence (SGBV) in refugee settlements in Uganda revealed that sexual and gender-based violence (SGBV) is a disturbing reality among refugee populations although it is underreported. Due to fear of shame and the belief that SGBV is a private matter, and the costs of reporting, SGBV has remained a silent epidemic with the majority of survivors being females (Rujumba and Kwiringira, 2018:4). The survivors of SGBV are exposed to sexually transmitted diseases such as HIV, early or unwanted pregnancy due to early and forced marriage and related complications, poor psychological health, chronic pain, physical disability and substance abuse and sexual violence (including rape and defilement) (Rujumba and Kwiringira, 2018).

The contextual realities in these settlements where refugees are socialized to accept SGBV and even protect perpetrators and protection agencies have limited capacity to address the underlying causes and different dimensions of SGBV, coupled with limited access to livelihood opportunities for both females and males (ibid) there is a fertile ground for violence against women to thrive.

1.1 Uganda's refugee management approach

Refugees have been hosted in Uganda since the 1950s. Uganda operates an 'open door policy' to refugees fleeing their countries of origin and seeking asylum. The 'open door' approach is nurtured in the legal framework related to hosting refugees in the country. For instance, the Refugee Act 2006 aims at responding to the challenges faced by refugees and host communities, gives refugees

freedom to move out of the settlements in search of employment, health care or visiting relatives anywhere within the country, which promotes local integration of refugees but also integration of the public services for Ugandans and the refugees (Fielden, 2008). Although this has led to the country being praised the world over, it is increasingly creating a strain on its resources and competition among refugees and host communities for the scarce resources (Bukuluki, P., Kisakye, P., Mwenyango, H. and Palattiyil, G. 2021).

Studies carried out in Uganda's refugee settlements show that the situation of adolescents and youth is still poor and their vulnerability remains high, leading to poor sexual and reproductive health outcomes. For instance, although the refugee numbers have been increasing, there is limited prioritization of the adolescents nor youth in refugee settings and their SRH needs are neglected (Ivanova, et al. 2019). Due to unfriendly services or lack of confidentiality, access to SRH services at health facilities is limited, hence health centres are underutilized sources of SRH services and adolescent girls have limited knowledge on SRH issues (Mankani, 2011, Patel et al., 2014, Ivanova, et al., 2019:8).

Compared to adolescent nationals, refugee adolescents in Uganda have low knowledge on family planning and STIs (Ivanova, Rai & Kemigisha, 2018). Girls reportedly become sexually active as early as 10 years and often exchange sex for money (Women's Refugee Commission and UNHCR report (2011). Moreover, adolescent sexual and reproductive health (ASRH) and youth sexual and reproductive health (YSRH) are strongly influenced by a range of social, cultural, political, and economic factors and inequalities which increase adolescents' vulnerability risks and pose barriers to their access to SRH information and services (Svanemyr et al., 2015:7).

Further, the refugees do not operate in a vacuum, the host communities' social, cultural norms, beliefs, values and practices and the host nation's legal, political and social conditions influence the refugees' beliefs, norms and practices during the interactions, intermarriages, staying and working together and the quest to conform with the law. The interrelationships are influenced by decisions made in consideration to these norms and practices. The entrenched patterns of social and cultural practices, lack of information and lack of appropriate SRH services are some of the contributors to sexual and reproductive ill health.

1.2 Objectives

This study aimed at assessing SRH and SGBV knowledge, attitudes, and practices among adolescent girls and boys (ages 13-19) and youths (ages 20-24) in Palorinya Refugee Settlement and host communities in Obongi district. Specifically, the study had the following objectives:

1. To establish the SRH/GBV knowledge, beliefs, risks, perceptions, practices, and experiences among refugee adolescents (ages 13-19) and youths (ages 20-24) in Palorinya Refugee Settlement and host community.
2. To stratify the findings by socio-demographic characteristics and influencing factors to identify potentially underserved and vulnerable populations among refugees in Palorinya Refugee Settlement and host community.
3. To identify sexual reproductive health service delivery gaps at the health facility and community levels.
4. To map out initiatives, programs, and lessons learned that are implemented in targeted communities.

1.3 Overview of methodology

1.3.1 The study design

This was a cross-sectional mixed-methods design study, involving proportional stratified sampling techniques and linking common themes across a household survey and semi-structured interviews to facilitate a comparison of qualitative and quantitative data. The study combines different forms of data collection sources: primary sources involving fieldwork using individual and participatory group data collection research methods such as Focus Group Discussions (FGDs), Key informant interviews (KIIs), and household survey. Triangulation of research methods is used to guard against misinterpretations (Van der Haar et al. 2013:23) as different participants have their own experiences and realities, and hence, have different perceptions and understanding of SRH issues that they could share.

The study targeted refugee adolescents aged 13-19 years and youths aged 20-24 years in both refugee and host communities in Palorinya refugee settlement. Proportionate stratified sampling enabled us to select a proportionate number of households from each of the five zones of the settlement as shown in Table 1 below. The selection criteria for respondents considered gender,

age (13-19 years old and 20-24 years old), willingness to participate in the study, informed consent from parent/caregiver, and assent for minors.

Table 1: Households and Population of Palorinya Refugee Settlement

Zone	Block	No. Households	Refugee Population
Zone two	Morobi	8,543	36,056
Zone three	Dongo West	6,349	25,635
	Dongo East	3,078	12,974
Basecamp	Basecamp	3,341	15,718
Zone one	Belemaling	2,400	10,632
	Budri	1,839	7,310
	Chinyi	4,938	20,182
	Total	**30,488**	**128,507**

Source: *Uganda Refugee Statistics: UNHCR January 2022*

The sample size was calculated using Yamane's sample size formulae to determine the number of respondents for this study.

$$\mathbf{n} = \left[\frac{N}{1+N e^2} \right]$$

Where ***n*** is the sample size, **N=30,730,**[1] is the population value which is the total study population comprising of households. *e* is the desired error margin (statistically set between 1-5%).

To cater for the design effect (clustering effect), the calculated sample size was multiplied by 2. In total the study reached 801 households (participants) including 592 adolescents and 209 youth as well as 21 key informants and 11 focus group discussions.

1.3.2 Data collection and analysis

For the quantitative data collection, we used smart mobile phones programmed using XML file format using ODK (Open Data Kit) software. ODK operates on phones and computers with Android operating systems and allows for data export into the Windows operating system (WOS). Data was entered offline and only connected to the internet for uploading. Further, hosted the data for this study on a cloud account whose URL address downloaded on smart phone via Store Play application. The questionnaire was designed using validated tools: Reproductive Health Assessment Toolkit for Conflict-Affected Women, (CDC, 2007) and Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings, (UNFPA and Save the Children, 2009).

[1] UNHCR, July 2021 projection of youths aged 15-24 years in Palorinya Refugee Settlement.

The analysis plan of the quantitative data was guided by the specific objectives of the needs assessment. Data was analyzed using STATA version 15.0. Analysis involved generation of frequencies, percentages, means (with standard deviation) and medians (with interquartile range). Groups were compared using chi square and fisher's exact tests of independence.

The qualitative data was translated carefully into English not to alter meaning. Then data was typed, and transcripts edited, and code definitions developed based on the objectives of the study. Codes were grouped into categories and then themes identified as stipulated by Graneheim and Lundman, (2004). We thereafter coded to identify themes and analysed the data using atlas ti qualitative data analysis software version 7 (atlasti.com). To accurately identify themes, we read through the verbal findings for evidence suggesting processes, actions, assumptions and consequences (Straus & Corbin, 2008). We present an analytic narrative with data extracts, that is, quotations from participants for each of the themes identified themes as we discuss the report in detail.

1.3.3 Quality control

The overall management and supervision of the evaluation was vested with the Lead Consultant, who was supported by two associate consultants with training in Statistician/Health or Social sciences and with field experience in collection of survey data. This constituted of a qualitative expert and a statistician. Quantitative and qualitative Research Assistants with previous experience of conducting qualitative evaluation work in Palorinya Refugee Settlements were recruited and dedicated to collect the quantitative and qualitative data of the study. All field staff were conversant of the local languages and culture (Kuku/Bari).

In addition, all field staff underwent training in the data collection methods, data collection tools, and use of ODK-based data collection. In the field, the data collectors were closely supervised by the Lead consultant and one of the associate consultants. The data collection tools were pretested for validity and reliability one-week prior the commencement of the field work. Prompts were enabled in ODK to ensure all fields were filled prior submission.

This study documents the lived experiences of the adolescents and youth and points out recommendations for successful service delivery in relation to refugees and forced migration in general.

1.3.4 Ethical considerations

Ethical clearance was obtained from Institutional Review Board (IRB) of Makerere University-School of Public Health Research Ethical Committee (MakSPH- REC) and thereafter from Uganda National Council for Science and Technology (UNCST), the government board in charge of clearing all research projects in the country. This enabled the research team to further seek for ethical clearance for the assessment from The Office of the Prime Minister (OPM) Representative at the settlement level – Settlement Commandant. At the zonal level within the settlement, permission to conduct the assessment was obtained from the zonal Refugee Welfare Committee (RWC) chairpersons. No individual identifier information was collected on the data collection forms, and all data collection staff signed a data confidentiality form prior fieldwork. The collected data was stored in a password secured computer with access rights assigned to the Lead consultant and one of the associate consultants responsible for managing the collected data. Prior enrolment into the assessment, all participants aged 18 years and above provided written informed consent. For participants below 18 years, informed consent was obtained from their parents or guardians, or caretakers followed by their assent. Child fund availed the field teams with a letter of introduction to facilitate entry into the field at national, district and community levels.

1.3.5 COVID-19 Infection Prevention Measures

Prior to field work, all field staff were trained and provided with Standard Operating Procedures (SoPs) on prevention of transmission of COVID-19. Each field staff was provided with face-masks and a litre of alcohol-based disinfectant. During the face-to-face interviews, both the interviewees and interviewers wore face masks.

1.3.6 Research limitations

Interviews and FGDs were conducted by a team of 14 research assistants in Kuku language. This is because 99% of the refugees in the settlement are Kukus from South Sudan (UNHCR, 2022). Key informant interviews were conducted in English. As the translation may lead to loss of

meaning, the team sought to minimize this by conducting a pre-data collection training and pre-test of data collections tools to develop a shared understanding of the research tools, purpose and process, methods, context, ethics, and note taking. The team also met every evening to discuss the salient issues coming out as well as addressing translation or any other issues.

1.3.7 Study area

Palorinya settlement is located in Obongi district and is currently hosting approximately 128,520 South Sudanese refugees (UNHCR, 2022) and has a total surface area of 37.58 square kilometers. The young people (adolescents and youth) (15 – 24 years) comprise 25% (32,535) of the total refugee population and face most of the SRH challenges enumerated above.

COVID-19-related lockdowns and school closures exacerbated the situation by closing or limiting safe spaces and essential services to thousands of young women and adolescents around the country (Madanda, 2021:24). Thus, the unmet need for sexual and reproductive services in the settlement has been characterized by an increasing prevalence of teenage pregnancies.

Therefore, to inform future programming for provision of SRH services, there was need to carry out research to generate evidence to inform effective program planning and implementation within Palorinya Refugee Settlement that is applicable to similar settlements across the region.

1.4 Gender, norms and practices by refugees

The refugees' socio-cultural practices have negatively affected access to reproductive health knowledge, information and services and consequently have promoted risky behaviors among both girls and boys. There has been increased health risks due to gender norms that affect young refugees' reproductive health and the dynamics of sexual behavior; like who initiates sex, who can refuse, how contraceptive use is negotiated (Bukuluki et al. 2021). There is evidence that adolescent refugee girls are at increased risk of death from pregnancy and childbirth complications and adolescent refugee boys especially the unaccompanied, face vulnerabilities such as sexual abuse, exploitation, violence, aggressive and risky behaviors (such as alcohol and drug use) (Bukuluki et al. 2021, Inter-agency working group for reproductive health in crises, 2019). Cultural norms and practices bar discussions about responsible sexual behavior either at home, at school,

or in other community settings, hence, lack of clear information about the consequences of sexual intercourse. Therefore, much of the 'sex education' that adolescents receive filters through misinformed or uninformed peers.

Settlements are characterized by low age at marriage, poverty, low value and self-esteem of girls, low level of education and low level of contraceptive use, early childbearing, sexual abuse and assault. This is due to norms and cultural practices inhibit the open discussion of sexuality issues, adolescents do not get information and are left to make uninformed SRH choices and decisions. Therefore, integrating adolescent and youth services into mainstream health care stops them from seeking these services due to fear of reprisal, shame, or embarrassment, socio-cultural barriers, structural barriers such as long distance to service points or long queues or lack of confidentiality, (Bukuluki et al. 2021) hence affecting the demand and utilization of SRH services. It is also noted that there are cultural sensitivities surrounding provision and utilization of sexual reproductive health services to young people; confidentiality, a non-judgmental environment, easy accessibility, and a service provider of the same sex are all extremely important to getting refugee adolescents and youth to accept services (UNHCR 1999).

Further reproductive health services targeting adolescents and youth such as information on comprehensive HIV care and treatment, STI management, guidance and counseling, life skills, teenage pregnancy and family planning are often based in schools and therefore do not reach vulnerable out of school adolescents. For girls who drop out of school, early pregnancy and marriage is common (UNHCR, 2018).

The refugees face protection issues, including sexual and gender-based violence, and violent assault perpetrated by other refugees and members of the host community, which threaten the security of refugees, especially women and girls. For instance, collecting firewood outside of the settlement as a cultural practice that put women and girls in charge of collecting firewood and cooking, puts girls and women at risk, as they reportedly often experience sexual violence leading to early pregnancy, early marriage or sexually transmitted infections including HIV/AIDS, when gathering firewood for cooking (Madanda, 2021).

Lack of adequate water sources in refugee settlements has caused delays at water points due to long queues which has resulted into domestic violence when women spend long hours at the water points and fail to attend to the domestic chores such as preparing meals in time or childcare (Madanda, 2021).

Rujumba and Kwiringira, (2018:16) identified different forms of SGBV in refugee settlements including forced marriage, child marriage, denying children (especially girls) school, inadequate sanitation and hygiene facilities in schools, rape (including marital rape) and stigmatization of women who do not give birth to boys. It was also found out that survival sex, where one has sex with another person because the person is giving financial support is condoned, although due to gender norms, the young girls who are involved in the exchange of sex for money or favors with older men, have no power to negotiate safer sex.

Due to high rates of school dropout many adolescents engage in early marriages - a practice that exposes them to risky behaviors- as a form of psychosocial therapy and because whoever starts a new household is recognized by UNHCR and starts to receive support independent of the parents. Such refugees do not use family planning with reasons such as wanting to replace the children killed during the wars/conflicts back home and that since they do not know when they will ever go back home, they produce many children as insurance, so that in future some may go back home.

1.5 Contextualizing AYSRH and SGBV in refugee settlements

Adolescent sexual reproductive health (ASRH) is defined as a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes specifically applied to adolescents (Bukuluki et al. 2021, UNHCR 2019) whereas sexuality comprises of sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (Ibid). These are expressed and experienced differently in refugee settlements due to the breakdown of family, community, social norms, loss of parental supervision, lack of schooling and recreational activities, frustration, boredom, insecurity of refugee life, and uncertainty about the future, leading to risky behaviors, including violence, drug abuse, and unprotected sex (UNHCR, 2000).

Adolescence is a distinct and important biological and social stage of development and is a period of transition from childhood to adulthood (Bukuluki et al. 2021). This study focuses on adolescents (13 – 19 years) and youth (20 – 24 years) because they are groups that are dependent on the parents and guardians and whose decisions are sometimes neglected and are most times not planned for during service delivery in forced displacement situations (Bukuluki et al. 2021). They experience many physical and psychological changes and always either want to experiment or experience and or find out certain life 'norms' and have unique needs. These two groups if not managed well, can easily engage in risky behaviors with disastrous consequences including drug abuse, prostitution, teenage pregnancy, abortion and transmission of sexually transmitted diseases including HIV/AIDS (UNHCR, 2019) which may lead to disability and or death.

Demographic and socio–economic statuses of refugees are a great influence on their livelihoods (UNHCR, 2017) and on reproductive health service accessibility and utilization. Establishing the socio-economic characteristics in regard to the study is therefore important. Notably, gender, age, level of education, personal skills, and association with social groups are deemed relevant in access to health services and pursuit for human rights. For example, children are totally dependent on older people (parents and guardians) for livelihood. Female refugees are also often more vulnerable than their male counterparts. On the other hand, level of education and personal skills can be useful assets for those pursuing gainful employment. These can be a critical determinant of socio-economic status which influences accessibility and utilization of reproductive health services and related opportunities (UNHCR, 2017).

Section Two: Research Findings

2. 0 Social demographic characteristics of household participants

Eight hundred and one adolescents and young people participated in this study and majority (67%) (538/801) were females and about 74% (592/801) were adolescents aged between 13 and 19 years. The highest number of participants were of Kuku tribe (70%) (562/801) and almost all of them (92%) (740/801) are South Sudanese. A minority had completed university education (1%) (7/801) and majority (63%) (508/801) completed only primary level education with almost 10% (68/801) having no formal education. Most of these adolescents and youth were still in school (69%) (556/801) and therefore single or unmarried (74%) (593/801), although many of them were in primary school irrespective of age, some aged upto 24 years but still in primary school. We noted that those who were married (61%) (125/206) got married between 16 – 19 years of age. This is due to displacement where those who were in school back in South Sudan had to stop schooling for some years and when they settled in this settlement, then they had to resume schooling. Those engaged in apprenticeship included many of those learning non-formal skills training such as tailoring, carpentry, mandazi making and hair dressing. Given that religion plays a psychosocial support and counselling role, almost all of them were religious with majority being born again or Pentecostal Christians (40%) (319/801) and Catholics (37%) (297/801).

However, most of the adolescents in refugee settlements lack skills due to inability to access training, attend school and sometimes language barrier. Those who were born in Uganda start school and learn the language of instruction and progress on well. But those who come to Uganda having started school from their home countries find a problem learning a new language and most times fail to continue and drop out of school or keep repeating classes. Those who drop out of school either get married immediately or remain in their villages; unskilled, unemployable and exposed to all sorts of malpractices.

The table below indicates the distribution of the 801 individuals who participated in the household survey across the seven zones.

Table 1. Profile of household respondents

Characteristic	Total (N=801)	Percentage
Age		
13-15	313	39.1
16-19	279	34.8
20-24	209	26.1
Gender		
Male	263	32.8
Female	538	67.2
Highest level of education		
None	68	8.5
Primary	508	63.4
Secondary	178	22.2
Vocation/Tertiary	40	5.0
University	7	0.9
Current occupation		
In School	556	69.4
Employed	51	6.4
Apprenticeship	24	3.0
Others	170	21.2
Monthly income		
< 50,000	603	82.9
50,000- 100,000	85	11.7
100,1000- 150,000	25	3.4
150,1000-200,000	11	1.5
200,1000-250,000	1	0.1
above 250,000	2	0.3
Marital status		
Single/Never Married	593	74.1
Married	161	20.1
Separated/divorced	43	5.4
Widowed	2	0.3
Others	1	0.1
Age at first marriage		
Below 13	1	0.5
13-15	52	25.2
16-19	125	60.7
20-24	28	13.6
Religious affiliation		
Catholic	297	37.1
Anglican	138	17.2
Muslim	19	2.4

Characteristic	Total (N=801)	Percentage
Pentecostal/Born Again/PAG	319	39.8
Other (specify)	28	3.5
Country of Origin		
South Sudan	740	92.4
DRC	0	0
Uganda	61	7.6
others	0	0
Tribe		
Kuku	562	70.2
Kakwa	43	5.4
Madi	88	11.0
Dinka	19	2.4
Nuel	0	0
Others	89	11.1

2. 1 Sexual and Reproductive Health Knowledge among adolescents and youth

2.1 Adolescent and youth knowledge of SRH

We asked whether the participants had ever heard about SRH and a total of 20% had never heard about it **(Figure 1)**, the chi square analysis in **table 3** found a significant relationship (p-value < 0.001) between age of the participant and having heard about SRH, with the majority (75%) (123/164) of those who reported not having heard about SRH being in the age group of 13-15 years. The study also found a significant relationship (p-value < 0.001) between current occupation and having heard about SRH, with those still in school reporting the highest percentage of 52% (418/637). This agrees with what key interviews with parents and teachers revealed that due to socio-cultural norms, sexuality and reproductive health issues are not discussed with young people and therefore they do not have access to accurate and appropriate information about SRH until much later in life when they find out from peers or science classes in upper primary school.

Figure 1. Proportion of young people aged 13-24 years who heard about SRH.

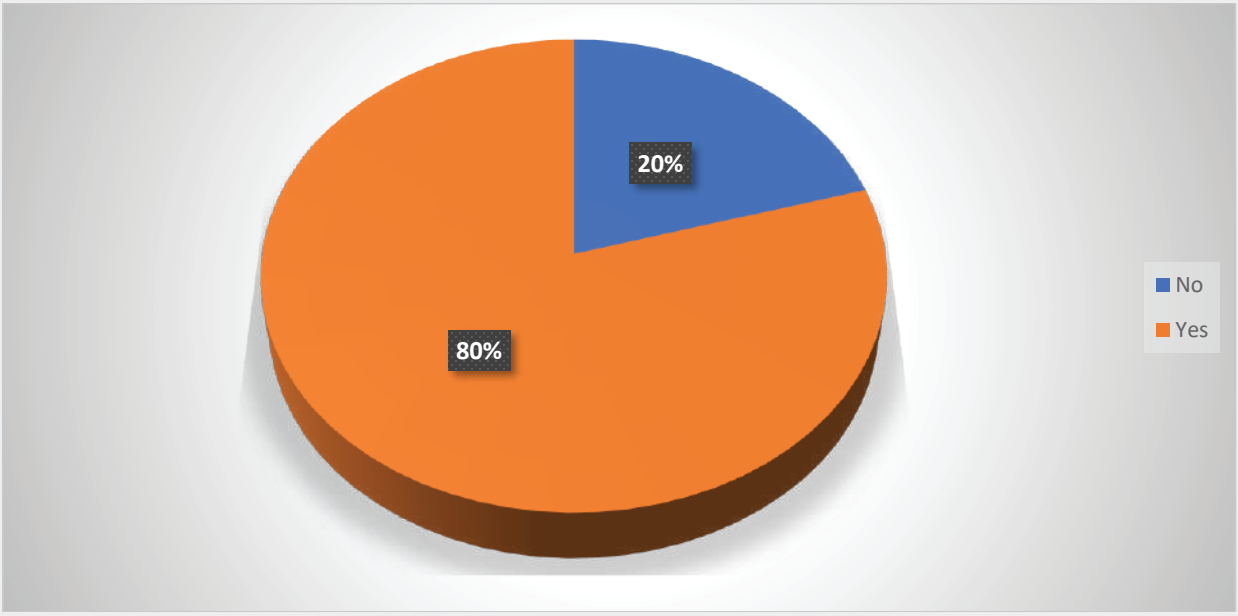


Table 3: young people (13-24 years) who heard about SRH

Characteristic	Heard about SRH		
	Yes	No	p-value
Age			<0.001
13-15	190	123	
16-19	250	29	
20-24	197	12	
Gender			0.730
Male	211	52	
Female	426	112	
Tribe			0.727
Kuku	442	120	
Kakwa	37	6	
Madi	69	19	
Dinka	15	4	
Nuel	0	0	
Others	74	15	
Current occupation			<0.001
In School	138	418	
Employed	3	48	
Apprenticeship	1	23	
Others	22	148	

When asked about the source of information on SRH, participants pointed out schools (52%) (419/801), radio (45%) (358/801) and peers (34%) (270/801) as the major sources of information on SRH. We also asked them the age for first sexual activity, and majority (28%) (221/799) said it is below 15 years. Those who were able to wait and have their first sexual encounter above twenty years were only 2% (14/799). Those who had ever had sex had their first sexual activity with boy or girl friend (95%) (413/433). We, however, noted that some had first sex with relatives 2% (8/433), uncle 0.2% (1/433) and teachers 3% (11/433). Given that majority had their first sexual encounter with people they loved, the major reason for having sex for young people was identified as love (57%) (458/801), although many (43%) (346/801) said it was due to peer pressure and others (14%) (115/801) was because they were given some gifts and many of the participants were sexually active, 35% had sex in less than one month. As earlier pointed out, discussion about SRH was barred by socio-cultural norms and majority preferred not to discuss SRH with any one at all (26%) (206/801) while others preferred to discuss SRH with peers and siblings (58%) (466/801). This was also reinforced in the interviews with one of the parents who said: *"Most adolescents are in school and norms do not encourage us to talk about sexuality and reproductive health, they get that information from school" (*KI in Zone one*)*

The parents pointed out that talking to a child about sexuality was shameful and would seem as if the parent wants her child to engage in sexual matters. They hoped that the sexual issues could be discussed at length with teachers who are equally entangled in the same cultural norms and also do not open up to discuss sex related issues in-depth with pupils and students except those topics in the school curriculum. This is the reason the young people indicate school as their major source of SRH information, although many get the information from radio and peers in that order. The organizations (NGOs) who work in the settlement also give SRH information to the young people (25%) (199/801). However, evidence from literature shows that in humanitarian settings, adolescent sexual and reproductive health (ASRH) needs are either ignored or neglected (Inter-agency working group for reproductive health, 2019).

Table 4: Knowledge of Adolescents and Youth on Sexual and Reproductive Health

Knowledge question	Responses	Frequency	Percentage
Heard about SRH from which source?			
	Radio	358	44.7
	TV	9	1.1
	School	419	52.3
	Peers/Siblings	270	33.7
	Parents	48	6.0
	Religious Institutions	7	0.9
	Newspapers	10	1.2
	Traditional Leaders	8	1.0
	Local Leaders	85	10.6
	NGO	199	24.8
	Other	13	1.6
At what age did you first have sex?			
	Never	368	46.1
	Below 13	15	1.9
	13-15	221	27.7
	16-19	181	22.7
	20-24	14	1.8
With whom did you have your first sex?			
	Relative	8	1.9
	Boy/girl friend	413	95.4
	Uncle	1	0.2
	Teacher	11	2.5
Why do young people have sex?			
	Peer pressure	346	43.2
	Pleasure	167	20.8
	Love	458	57.2
	Gifts	115	14.4
	Other	122	15.2
When was the last time you had sex?			
	< 1 month	152	35.2
	1 month -3 Months	96	22.2
	4 Months- 6 Months	89	20.6
	>6 Months	95	22.0

SRH information and contraceptive use

Majority of the young people who had heard about family planning (76%) and knew condoms (95%) as one of the contraceptive methods, the source of their information being the health facility

(67%), radio (50%) and peers (40%). Participants also knew pills (32%) and injectable (31%) as other methods, although some identified abstinence (11%) as one of the contraceptive methods they knew. Indeed 49% had ever used condoms, although some said they have never used any method (36%) while others use abstinence (25%). Asked about where they can obtain contraceptive commodities like condoms, the young people in FGD said *'condoms can be obtained from a health facility'*.

We note that one of the issues that affects enjoyment of reproductive health services is service provision. This does not only include the ability of public and private service providers to provide a variety of quality reproductive health services, but also addressing factors that may inhibit an individual from accessing and utilizing these services. These factors may include lack of information on the services, affordability, confidentiality, convenience, treatment of service providers, and availability of the supplies.

Table 5: SRH information sources

Knowledge question	Responses	Frequency	Percentage
Who would you discuss sexual issues with?			
	None	206	25.7
	Parents	99	12.4
	Siblings/Peers	466	58.2
	Teachers	75	9.4
	Religious Leader	16	2.0
	Aunt/Uncle	21	2.6
	Other	86	10.7
Have you heard of family planning/contraceptives before?			
	No	195	24.3
	Yes	606	75.7
If yes, mention a contraceptive you know?			
	Condoms	573	94.6
	Implants	135	22.3
	Injectable	186	30.7
	IUD	13	2.1
	Pills	192	31.7

	Abstinence	67	11.1
What is your source of information on contraceptives?			
	Health Facility	404	66.7
	Radio	305	50.3
	TV	10	1.7
	Social Media	43	7.1
	Parents	37	6.1
	Peers	237	39.1
	Teachers	152	25.1
	Others	11	1.8
What method(s) of contraceptives have you used before?			
	None	215	35.5
	Abstinence	149	24.6
	Condom	295	48.7
	Implants	15	2.5
	Injectable	18	3.0
	Pills	52	8.6

Like in many communities, young people have myths and perceptions about use of family planning and contraceptives. The adolescents and youth pointed out different perceptions about family planning use including:

- *"When you use family, it brings a lot of blood during menstruation" (FGD1)*
- *"When you use pills, you bleed a lot (abnormal)" (FGD3)*
- *"I have used family planning method of implants but up to now I have not conceived again" (FGD3)*
- *"I have heard about the 3 months injectable that it makes her grow very thin and this made her leave using it. Injectables makes one thin and can menstruate the whole month" (FGD with married male youth)*
- *"Others say the needle can disappear in the body" (FGD with adolescent girls)*
- *"When you inject family planning medicine you will not have children in future" (FGD 1)*
- *"Some people say family planning makes you not give birth in future" (FGD2)*

Knowledge about sexually Transmitted Infections by the young people

When asked about STIs they knew, 6% of participants did not know any of them. However, some young people know STIs such as HIV/AIDs (92%), syphilis (57%) and gonorrhea (44%) and recommend abstinence (64%) as the measure for preventing STIs. Majority (91%) know that

treatment can be got from health facilities or private clinics (13%). Less than 10% did not know how HIV is transmitted while about 20% did not know at what age a girl starts menstruating.

In FGD with adolescents in Zone two, one of the adolescents pointed out that:

> *"We should avoid sharing clothes because the clothes can have sweat and transfer the AIDS".*

This shows that there is scanty information about HIV/AIDs transmission and that there is need to educate the adolescents to enable them to acquire appropriate information.

It was also confirmed by the Secretary for Refugee Welfare Committee of zone three who said;

> *"I want to say that the young people do not know much about reproductive health issues because even if you involve them in a meeting on their challenges, they will only mention livelihood activities" (KI, Zone three).*

Although this does not implicate that they do not know, it brings out the general outlook of the community where SRH issues for the adolescents and youth are not prioritized, perhaps that is the reason they also do not talk about them, knowing that they will not be considered anyway.

Table 6: Knowledge about sexually Transmitted Infections by the young people

Knowledge question	Responses	Frequency	Percentage
Which STIs do you know			
	None	46	5.7
	HIV/AIDS	734	91.6
	Syphilis	453	56.6
	Gonorrhea	356	44.4
	Chlamydia	9	1.1
	Chancroid	3	0.4
	Other	9	1.1
What can be done to prevent STIs?			
	Abstinence	515	64.3
	Avoid contact with infected persons	331	41.3
	Stay with one partner	225	28.1

Knowledge question	Responses	Frequency	Percentage
	Contraceptive use	237	29.6
In this community, where would you get STIs services including Treatment?			
	Health Centre	731	91.3
	Private Clinic	101	12.6
	NGOs	119	14.9
	Other	2	0.2
How is HIV transmitted?			
	Unprotected Sex	612	76.4
	Sharing of sharp objects	603	75.3
	Unscreened Blood transfusion	74	9.2
	Others. Specify	3	0.4
	Don't know	57	7.1
	Other	20	2.5
In this community, where do you get services for HIV/AIDS?			
	Health Centre	752	93.9
	Private Clinic	104	13.0
	NGOs	153	19.1
	Others. Specify	1	0.1
	Don't know	35	4.4
At what age do girls get their first menstruation?			
	<13	164	20.5
	14-16	472	59.0
	>16	15	1.9
	Don't know	149	18.6

Although one of the RWC leaders pointed out that the youth have nowhere to get SRH services and do not care much about it, the young people pointed out different ways of getting the services.

> *"They do not have where to get SRH information from or they cannot go to health center to get it. What they do they continue with their ways. They do not go for HIV testing. Even sometimes you would wonder if these youths were aware of STDs live HIV"* (KI with RWC leader in zone 1)

When the youth were asked in FGDs about what they do to get SRH services, they enumerated the following:

- *"We go to the health centers e.g. Iduwa HC, Kali HC, Lulu in this Zone two and to Medical Teams International (MTI) offices"*
- *"We have our youth groups who present our issues to the community leaders"*
- *"We report to leaders who refer us to NGOs and leaders identify the young girls and they can report to the organizations"*
- *"Talk to school women teachers at school. At school we talk to senior women teachers who sometimes advise us to keep away from sex, and teach us how to make local pads out of clothes"*

Further, the adolescents and youth were asked who should deliver SRH information and services to them. They enumerated them as follows:

- *"Partners (NGOs) and community leaders should be empowered to handle this assignment. One person is not sufficient. E.g. VHTs are overwhelmed with work"*
- *"The NGO and other partners because if its local leaders, people will not take them serious" (FGD 1)*
- *"For me in my home, it's me who delivers for them information for both my boys or girls" (FGD 3)*
- *"Basic SRH services do not come from medical workers but from social workers. It could be a partner who could have such a program in their implementation. If there is a need for medical attention, we can do referrals" (KI1)*

2.2 Adolescent and Youth attitudes towards SRH

Participants were asked if there is no harm to have sexual intercourse below 18 years, 25% agreed, although 11% did not know whether it was okay or not to have sex intercourse while below 18 years. This gap needs attention as such attitudes perpetrate the continued occurrence of child marriages and risky sexual behaviours in refugee settlements. This was reinforced by the agreement by participants that it is a taboo to talk about sexual matters in public (62%) and therefore adolescents believe that it's okay to engage in sexual activities.

Given that we interviewed adolescents from 13 years, some did not have information on SRH although it would be good that at that age, appropriate information is given to them. For instance, 10% did not believe that it is bad to get pregnant before 18 years, 10% did not think that abortion is harmful and 9% did not feel that menstruation is normal for a girl or not.

Equally important is that about 23% of the participants agreed that getting married before 18 years is harmless and 18% did not think that having sex shows love for your partner or not. This calls

for change of attitude towards focusing on the dangers of early marriage both biologically and psychologically to the girl but also being against the laws of Uganda.

The participants said that access to contraceptives is not easy (22%) although 36% did not know, perhaps they were not sexually active or they lacked information which calls for urgent establishment of mechanisms for disseminating SRH information to the adolescents and youth in Palorinya settlement.

More than 18% of the participants also believe that when you have sex for the first time, you do not get HIV/AIDS, but others did not know (25%). This information gap is amidst the fact that about 7% of the participants believe that early childbearing is not dangerous to the girl. Also 24% had no perception whether contraceptive use prevents pregnancy and 36% had no believe of whether contraceptives are harmful to one's health or not. More than 24% did not know whether the health workers behave well towards adolescents seeking SRH services or not. A possible explanation could be that many have never go to health facilities to seek for SRH services, but should be prepared and given information early enough that it is acceptable to seek for SRH services and health workers are there to serve them impartially with a non-judgemental attitude.

The table below explains all these:

Table 7: Attitudes of adolescents and youth towards SRH

Attitude and Perceptions questions	Agree		Disagree		Don't know	
	Freq	%	Freq	%	Freq	%
There is no harm in having sex before 18 years?	196	24.6	512	64.2	90	11.2
It is a taboo to talk about sex in public in this community?	492	61.5	232	29.0	76	9.5
There is no harm in getting pregnant before 18 years in this community?	184	23.0	534	66.8	82	10.2
There is no harm when girls abort	38	4.8	686	85.8	76	9.5
Having menstruation is normal for a girl	720	90.0	14	1.8	66	8.3
Getting married before 18 years is harmless	180	22.5	559	69.9	61	7.6
I would report my partner to authorities if he forced me to have sex	457	57.2	196	24.5	146	18.3
Sex shows how you love your partner	358	44.8	207	25.9	235	29.4
Access to contraceptives is easy in this community?	343	43.0	171	21.4	284	35.6
You do not get HIV/AIDS when you have sex the first time	141	17.6	461	57.6	198	24.8
I find the behaviour of Health workers towards adolescents seeking SRH services to be acceptable to me	535	66.9	73	9.1	192	24.0
A woman must fulfil the sexual desires of her partner at any given time	359	44.9	254	31.8	187	23.4
All contraceptives are harmful to my health	136	17.0	377	47.1	287	35.9
Sometimes, the woman deserves to be beaten by her partner	168	21.0	586	73.3	45	5.6
Early childbearing is dangerous (Probe below 18 years of age)	709	88.9	55	6.9	34	4.3
Contraceptive usage prevents pregnancy	578	72.3	31	3.9	191	23.9

2.3 Adolescent and Youth practices

According to the findings of the study, 42% of adolescents and youth were in sexual relationships **(Figure 2),** with age and monthly income having a statistically significant relationship (p-value<0.001). When compared to those younger (below 16 years) and with higher monthly incomes, older respondents and those with lower monthly incomes were more likely to be in a sexual relationship **(Table 8).**

Figure 2. Proportion of respondents in a sexual relationship

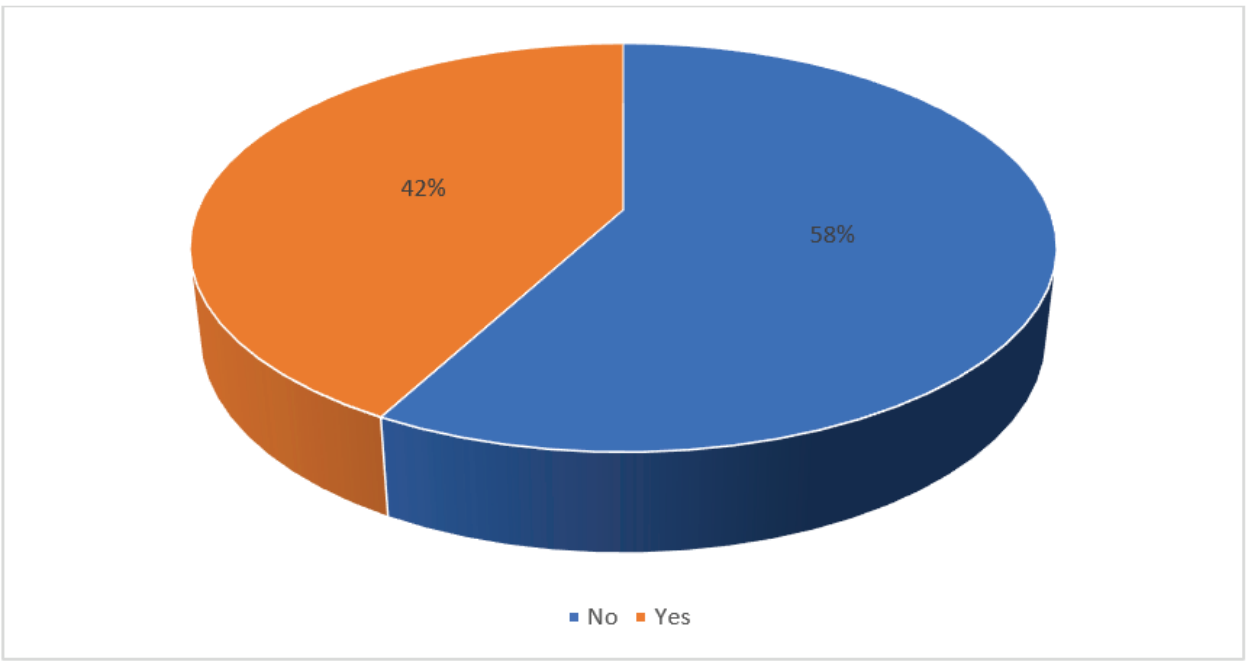


Table 8. Bivariate analysis of being in a sexual relationship and participant demographic characteristics

Characteristic	In a sexual relationship		
Age	**Yes**	**No**	**p-value**
13-15	33	279	<0.001
16-19	156	121	
20-24	147	62	
Gender			
Male	116	145	0.351
Female	220	317	
Monthly income			
< 50,000	213	389	<0.001
50,000- 100,000	60	25	

100,1000- 150,000	20	5	
150,1000-200,000	9	2	
200,1000-250,000	1	0	
above 250,000	2	0	
Tribe			
Kuku	222	337	0.151
Kakwa	20	23	
Madi	44	44	
Dinka	6	13	
Nuel	0	0	
Others	44	45	

From **Table 9** below;

More than 36% of those in sexual relationships do not use any type of sexually transmitted infection protection. This is because more than 60% agreed that purchasing a condom is frowned upon in the community, despite the fact that more than 67% were unaware of their partners' HIV status. Furthermore, more than 63% agreed that getting pregnant was common, and approximately 28% agreed that induced abortion was performed.

When 538 female participants were asked if they had ever been pregnant, 26% said yes. Out of 138 females who reported a history of pregnancy, more than 24% said it was not intentional, and the majority (94%) delivered, with four (3%) aborting. The majority of deliveries (85%) took place at the health center, with about 11% taking place at home. Because the government encourages births in health centers with the assistance of skilled attendants, this should be promoted among refugees and encouraged to continue.

The majority (85%) of the 308 who had ever used contraception to prevent pregnancy used condoms, 11% used emergency contraception, and 3% used other contraception methods. Condom use is highly promoted in the settlement, and parents complained that condoms are distributed in health facilities (74%), schools (9%), and sometimes they can be shared amongst peers (49%) or the community (10%), and she was concerned that this culture encourages promiscuity in their children, but NGOs were not listening to parents. As a result, condoms are easily accessible in the settlement, even if one does not visit the facility. If they cannot be obtained freely, they can be purchased at private clinics.

Despite the apparent availability of condoms, about 50% did not use one during their first sexual encounter, possibly due to a lack of friendly corners (53%) in the community where adolescents and youth can freely obtain information as well as commodities such as condoms. As a result, the majority (59%) reported getting sexual and reproductive health information from school friends (54%), health centers (30%), and television/radio (27%). Parents and social media are sources of information at 7% and 5%, respectively, but they are less common in the community due to cultural norms and a lack of employment and income.

Whereas other studies identified parents as a major source of SRH information to young people, they were not a major source in this community due to strong socio-cultural norms and practices. The table below depicts the percentages of responses on various SRH practices.

Table 9: SRH Practices of adolescents and youth

Practice question	Freq	percentage
In this community, buying condoms is seen as something bad		
No	314	40.2
Yes	467	59.8
In this community, getting pregnant is common		
No	293	36.9
Yes	501	63.1
In this community, carrying out induced abortion is common		
No	577	72.5
Yes	219	27.5
In my community, girls are treated differently during their menstruation		
No	649	81.4
Yes	148	18.6
Have you ever been pregnant?		
No	383	71.3
Yes	138	25.7
No response	16	3.0

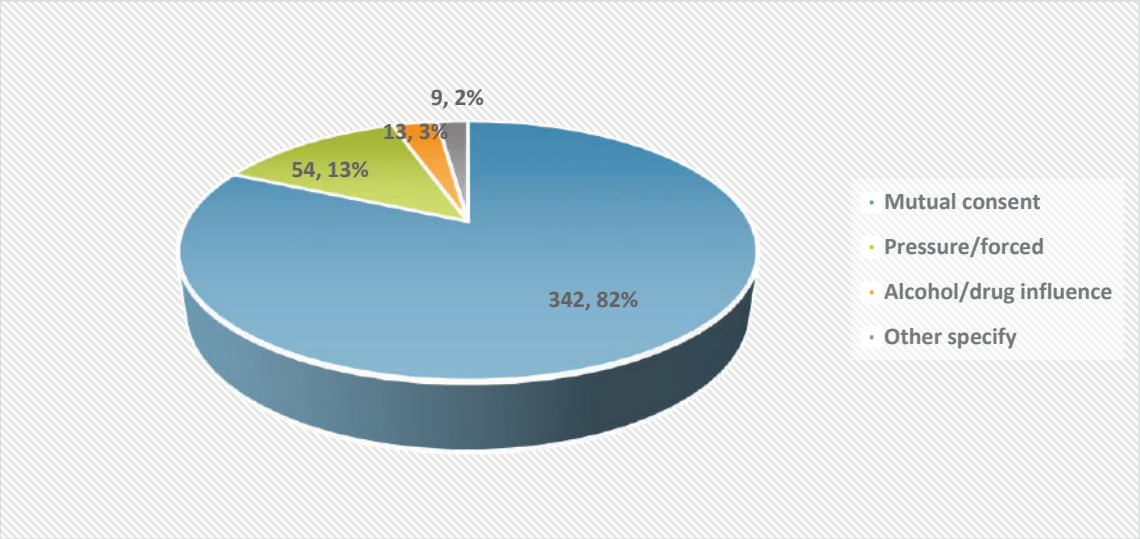
Practice question	**Freq**	**percentage**
If Yes; Was it intended?		
No	33	23.9
Yes	105	76.1
How did you manage the situation?		
Delivered	129	93.5
Aborted	4	2.9
No response	5	3.6
Practice question	**Frequency**	**percentage**
Where did the abortion above take place?		
At home	15	10.9
Health centre	117	84.8
Private clinic	2	1.4
Relative's home	1	0.7
Other (specify)	3	2.2
If delivered, which services did you get before and after: Antenatal care (ANC), postnatal care (PNC) or family planning (FP)?		
Yes, ANC	123	95.3
Yes PNC	92	71.3
Yes FP	41	31.8
None	4	3.1
Have you ever used contraceptives before to prevent pregnancy?		
No	480	60.9
Yes	308	39.1
Which contraceptives have you ever used?		
Condoms	262	85.1
Emergency contraceptive	34	11.0
Injection	1	0.3
Other specify	9	2.9
Where did you obtain contraceptives from?		
Don't know	215	69.8
Peer	150	48.7
School	26	8.4

Practice question	**Freq**	**percentage**
Health facility	227	73.7
Youth friendly space	27	8.8
Outreach post	2	0.6
How far from here is the nearest facility / venue where you get your contraceptives from?		
1 km	474	60.3
2-3 km	257	32.7
4-5 km	54	6.9
Above 5km	1	0.1
Did you use a condom during your first sex?		
No	213	51.1
Yes	204	48.9
Have you ever visited adolescent-friendly corners before?		
No	425	53.2
Yes	374	46.8
Practice question	**Frequency**	**percentage**
Where do you obtain information on Sexual and Reproductive health issues currently?		
Friends	436	54.4
School	470	58.7
Parents	58	7.2
Hospital	237	29.6
Social media	41	5.1
Television/Radios	214	26.7

2.4 Adolescent and Youth experiences with SRH

The reasons for having sex include mutual consent (342), pressure (54), alcohol/ drug influence (13) and others (9).

Figure 3. Reason for having sex



Section Three: Adolescent and Youth Knowledge of SGBV

3.1 knowledge about SGBV by Adolescents and Youth

About 12% of the young people who participated in this study had not heard about sexual and gender- based violence especially females (CP 0.471) below 15 years (p-value <0.001) and 83% of the participants agreed that SGBV occurs in the community and the perpetrators are both men (76%) and women (11%) and 13% did not know the perpetrators. Among the participants, 14% had experienced SGBV in the last one year, which confirms what earlier studies had found out about existence of SGBV in the refugee settlements.

About 60% of the young people did not know the safe days during the menstruation cycle, although it was pointed out that majority of the girls get pregnant below 18 years of age (83%) with about 10 percent getting pregnant below 15 years. When asked about what they think should be appropriate age for marriage, about 10% did not know while about 8% said below 18 years.

Perhaps this is due to the existing norms that encourage early marriage among the Kuku culture hence young people seeing it as normal. Also, the young people said there is abortion in the community (42%), but 15% did not know where girls seek post- abortion care while 42% said they seek post abortion care from private clinics. Given their income levels and knowing that the percentage of the young people have no known income generating activities, it becomes difficult for such girls to pay for services at private clinics. But the fear to be seen at the public health centers hence resorting to private health clinics if they can pay.

However, in FGD with young people, it was pointed out that after abortion, girls who go to health centres are treated and given medicine:

> *"Nurses give them medicine to feel better when blood starts to flow too much, the parents of the girls take them to the health facility for care and from there the girl is taken to Moyo hospital and given medicine for the girl and even if the baby comes out dead, the mother may survive" (FGD 5)*

The young people also said that there is SGBV in their community (83%), and also pointed out that the main perpetrators of SGBV were men (76%), although some (13%) did not know the perpetrators but about 14 percent had experienced SGBV in the last one year.

One of the leaders said that the most common types of SGBV included sexual violence, defilement and couples fighting for different reasons. He was quick to add however that defilement is usually not reported, as…

> *"…when it happens, the two families will not report. They sit and agree to pay say 100,000= or a goat. When they fail to agree, they come to report but this may be very late, no evidence left (KI RWC- Zone three). He added "Shortage of food causes GBV Food ratio has been reduced to 70% whence causing conflict at house level. Women are now selling their cloths to feed their children. They don't have enough land to cultivate"*

It came out clearly that defilement is downplayed as long the perpetrator pays money or any other form of compensation. The RWC leader explained this as being due to high poverty levels and the cultural belief that whoever has sex with a girl irrespective of age, should marry her as no one will be willing to marry a girl who is someone else's wife. This affects the life of the adolescent who may be forced to get married at a tender age.

The RWC leader also added another cause of SGBV thus;

> *"The denial of resources where our refugees rely on food from WFP but a man will receive the food and sell all of it and go for drinking alcohol"*

And FGD with youth added that, *"Drunkenness is rampant".*

Figure 4. Proportion of young people aged 13-24 years who heard about SGBV

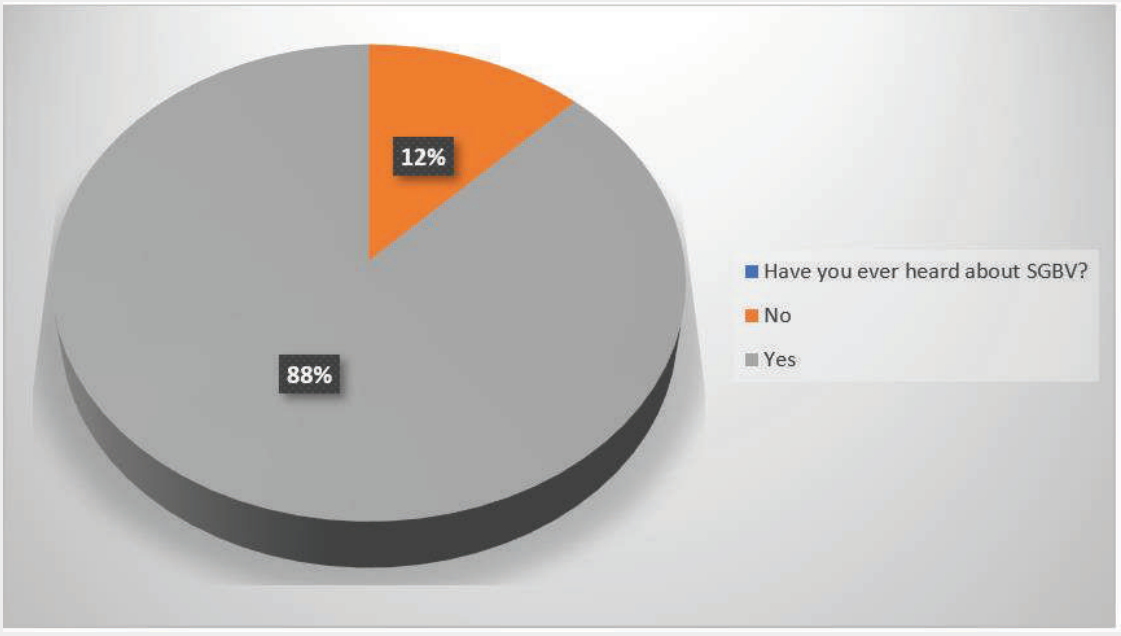


Table 9: Knowledge about SGBV

Characteristic	Heard about SGBV		
Age	**Yes**	**No**	**p-value**
13-15	244	69	<0.001
16-19	253	24	
20-24	204	5	
Gender			
Male	233	29	0.471
Female	468	69	
Monthly income			
< 50,000	513	88	0.032
50,000- 100,000	80	5	
100,1000- 150,000	25	0	
150,1000-200,000	11	0	
200,1000-250,000	1	0	
above 250,000	2	0	
Tribe			
Kuku	490	70	0.867
Kakwa	37	6	
Madi	76	12	
Dinka	18	1	
Nuel	0	0	
Others	80	9	

3.2 Adolescent and Youth attitudes towards SGBV

Respondents when asked whether a man/boy is justified to hit his wife/girlfriend, 14.4% agreed as opposed to 85.6% who disagreed. Although the reasons for beating could be varied, this attitude of the young people insinuated that there is an information gap to deal with urgently. It also shows the extent of entrenchment of cultural norms and practices in the society, hence necessitating urgent attention to be able to promote women's rights. Relatedly, 60% believe that a woman is not justified to refuse sex with husband/partner for any reason and likewise there is a significant number 41% of respondents believe that woman must fulfil the sexual desires of her partners any given time. These shows that existence of a significant believe in SGBV among adolescent and young people in refugee settlement and host communities.

Table 10: Attitudes about SGBV

SGBV QUESTIONS	Male	Female	All young people	
	%	%	N	%
A woman must fulfil the sexual desires of her partner at any given time				
No	28.3	71.7	452	59.2
Yes	38.3	61.7	311	40.8
Is a wife/woman justified in refuting having sex with her husband/partner for any reason?				
No	33.2	66.8	458	59.6
Yes	31.6	68.4	310	40.4
It is sometimes justifiable for a man/boy to hit his wife/girlfriend				
No	32.6	67.4	682	85.6
Yes	34.8	65.2	115	14.4
Is a woman justified to beat her husband or partner for any reason?				
No	33.7	66.3	700	88.1
Yes	27.4	72.6	95	11.9
Women often experience violence from their partners after sharing their HIV-positive status				
Agree	34.2	65.8	590	73.8
Disagree	29.9	70.1	107	13.4
Refused to answer	27.5	72.5	102	12.8
If a man takes alcohol regularly, he is more likely to use violence against his wife/partner				
Agree	32.5	67.5	735	91.9
Disagree	34.8	65.2	46	5.7
Refused to answer	36.8	63.2	19	2.4
Defilement cases in this community are rare				
Agree	31.9	68.1	526	65.8
Disagree	35.4	64.6	226	28.3
Refused to answer	29.8	70.2	47	5.9

3.3 Practices about SGBV by Adolescents and Youth

For those who had ever experience SGBV, they were asked where they reported and majority said they did not report anywhere (52%), perhaps for fear of being accused of perhaps inviting the violence. Some of them said they reported to local leaders (33%) and police (22%). However, some reported to their parents (14%). This could be because local leaders are very near and speak the same language and although volunteers, they were elected to serve. This was pointed out by one of the Refugee Welfare Committee Chairperson thus:

> *"we do not earn of serving our people, we are volunteers but we were elected to serve our people and we have to do it"* (KI, Secretary RWC, zone III)

There is need to establish a reporting pathway so that adolescents and youth could know where to report first and what action could be taken. Failing to report could be due to the feeling that nothing could be done any way or because they know even if you report, following up the case until its concluded is not easy for most of the refugees. As one leader pointed out, it is very expensive to follow a case reported at police or in the courts of law because of the transport costs and long duration it takes to be concluded. However, a parent equally said that "in our kuku culture, when a man plays sex with a girl, he is forced to marry her" irrespective of the age of the girl, and hence there is no reason to report.

Although majority said they had not seen anyone who had experienced SGBV (87%), they had seen domestic violence as the most common form of SGBV. Other forms of SGBV identified included forced marriage (38%), rape (20%), sexual abuse and exploitation (11%) and trafficking 12%). All the participants had not seen or heard about forced sex in marriage because this is not reported due to socio-cultural norms and practices. Indeed, when asked about existing support structures/ institutions in the community, majority pointed out RWC leaders (78%), police (72%) and health facilities (38%). Others pointed out NGOs/CBOs (31%). This implies that there is need to capacitate the RWC leaders with knowledge and skills to be able to identify SGBV cases and report or handle where possible. Short of that, SGBV will continue happening in the settlement and non will be concerned.

Table 11: Practice about SGBV

Practice question	Responses	Frequency	Percentage
Does SGBV occur in this community?			
	No	138	17.3
	Yes	662	82.8
Who are the main perpetrators of SGBV in this community?			
	I don't know	104	13.0
	Men	609	76.2
	Women	86	10.8
Have you ever experienced SGBV in the past 1 year?			
	No	691	86.4
	Yes	109	13.6
Where did you report?			
	No where	57	52.3

Practice question	Responses	Frequency	Percentage
Does SGBV occur in this community?			
	No	138	17.3
	Yes	662	82.8
Who are the main perpetrators of SGBV in this community?			
	I don't know	104	13.0
	Men	609	76.2
	Women	86	10.8
Have you ever experienced SGBV in the past 1 year?			
	No	691	86.4
	Police	24	22.0
	Parent	15	13.8
	Peers	3	2.8
	School/Teacher	3	2.8
	Religious Leader	5	4.6
	Local Leader	36	33.0
	Traditional Leader	2	1.8
	NGO/Development Worker	4	3.7
	Government Official	0	0.0
	Employer	0	0.0
Have you seen anyone who has experienced SGBV in this community?			
	No	700	87.4
	Yes	101	12.6
What forms of SGBV have you seen in this community?			
	rape	20	19.8
	Sexual Exploitation and Abuse	11	10.9
	Sexual Harassment	11	10.9
	Domestic Violence	92	91.1
	Early and Forced Marriage	38	37.6
	Trafficking	12	11.9
	Forced Sex in Marriage	0	0.0
What are support structures/institution for SGBV in this community?			
	Police station	577	72.0
	Health facility	301	37.6
	Local Leaders	622	77.7
	Religious Leaders	65	8.1

Practice question	Responses	Frequency	Percentage
Does SGBV occur in this community?			
	No	138	17.3
	Yes	662	82.8
Who are the main perpetrators of SGBV in this community?			
	I don't know	104	13.0
	Men	609	76.2
	Women	86	10.8
Have you ever experienced SGBV in the past 1 year?			
	No	691	86.4
	NGO/CBOs	244	30.5
	Traditional Leaders	46	5.7
	School/Teachers	60	7.5
	Family Member	83	10.4
	Other	13	1.6

Although majority of the participants had never experienced SGBV, a few (4%) (28/801) had **(Figure 5).** The attention therefore has to be put on those few to ensure psychosocial support and a well-managed healing process. To note is that more women than men experienced SGBV, which agrees with the views of parents and leaders that due to socio-cultural norms, women are placed in a lower status compared to men and experience more SGBV.

Figure 5. Ever experienced any form of forced sexual intercourse

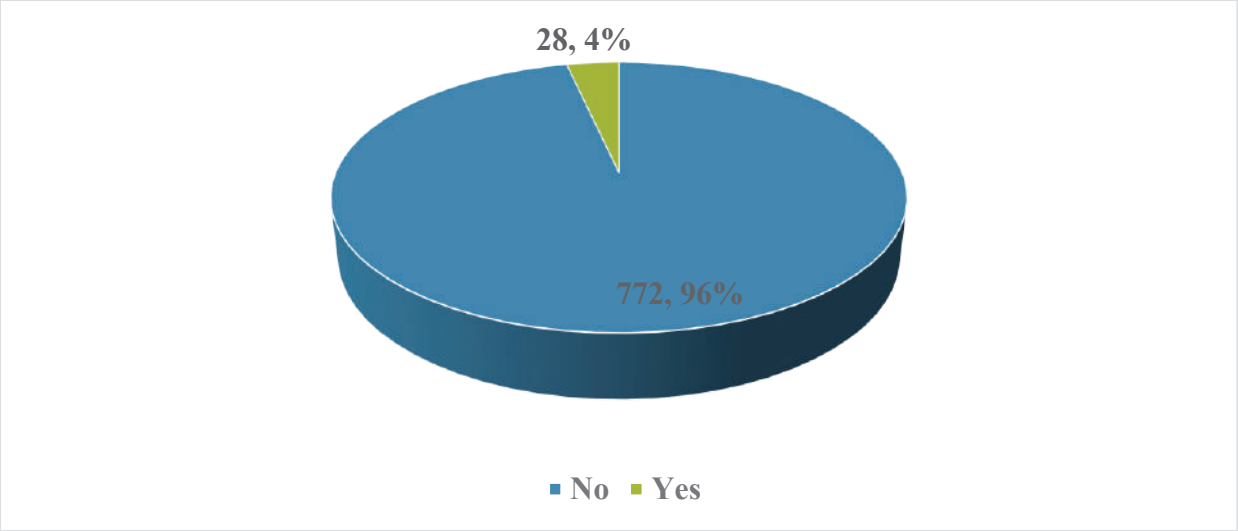


Table 12 : Bivariate analysis of those who experienced any form of forced sexual intercourse and participant demographic characeristics

Characteristic	Ever experienced any form of forced sexual intercourse		
	Yes	No	p-value
Age			<0.001
13-15	3 (1.0)	310 (99.0)	
16-19	9 (3.2)	269 (96.8)	
20-24	16 (7.7)	193 (92.3)	
Gender			<0.001
Male	1 (0.4)	261 (99.6)	
Female	27 (5.0)	511 (95.0)	
Monthly income			0.006
< 50,000	18 (3.0)	584 (97.0)	
50,000- 100,000	3 (3.5)	82 (96.5)	
100,1000- 150,000	2 (8.0)	23 (92.0)	
150,1000-200,000	2 (18.2)	9 (81.8)	
200,1000-250,000	1 (100.0)	0 (0.0)	
above 250,000	0 (0.0)	2 (100.0)	
Tribe			1.000
Kuku	21 (3.7)	540 (96.3)	
Kakwa	1 (2.3)	42 (97.7)	
Madi	3 (3.4)	85 (96.6)	
Dinka	0 (0.0)	19 (100.0)	
Nuel	0	0	
Others	3 (3.4)	86 (96.6)	

Table 13. SGBV experiences of adolescents and youth in Palorinya refugee settlement

SGBV QUESTIONS	Male	Female	All young people	
	%	%	N	%
Did forced sexual intercourse happen in the last 12 months?				
No	7.1	92.9	14	50.0
Yes	0.0	100.0	14	50.0
What kind of person forced you into having sexual intercourse?				
Spouse	0.0	100.0	7	25.0
Another regular partner	0.0	100.0	2	7.1
Acquainted Casual partner	0.0	100.0	1	3.6
Partner	10.0	90.0	10	35.7
Stranger	0.0	100.0	2	7.1
Family member	0.0	100.0	1	3.6
Schoolmate	0.0	100.0	1	3.6

SGBV QUESTIONS	Male	Female	All young people	
	%	%	N	%
Teacher	0.0	0.0	0	0.0
Friend	0.0	100.0	4	14.3
Neighbour	0.0	0.0	0	0.0
When you were forced to have sexual intercourse against your will, did you or a family member report to any authority?				
No	4.4	95.6	23	82.1
Yes	0.0	100.0	5	17.9
If yes, where was the case reported? **CIRCLE ALL THAT APPLY**				
Family members	0.0	100.0	1	25.0
Youth group	0.0	0.0	0	0.0
Local leaders (LC I)	0.0	100.0	2	50.0
Police	0.0	100.0	1	25.0
Courts of law	0.0	0.0	0	0.0
Clan/Elders	0.0	0.0	0	0.0
NGO (specify)	0.0	0.0	0	0.0
Other (Specify)	0.0	0.0	0	0.0
If reported to family members, did they report the case to the authorities?				
No	0.0	100.0	1	20.0
Don't know	0.0	0.0	0	0.0
Yes, youths' groups	0.0	0.0	0	0.0
Yes, local leaders (LC I)	0.0	100.0	3	60.0
Yes, police	0.0	100.0	1	20.0
Yes, courts of law	0.0	0.0	0	0.0
Yes, NGO (Specify)	0.0	0.0	0	0.0
Yes, other (Specify)	0.0	0.0	0	0.0
What happened after reporting the case? **(Interviewer, check ALL mentioned, but do NOT read out)**				
Nothing	0.0	100.0	1	20.0
I was punished for reporting	0.0	100.0	1	20.0
Apprehended the culprit	0.0	0.0	0	0.0
Fined the culprit	0.0	100.0	4	80.0
Referred to higher courts	0.0	100.0	2	40.0
Handled as a family matter	0.0	0.0	0	0.0
Any other	0.0	0.0	0	0.0

3.4 Adolescent and Youth experiences with SGBV

It was also established that girls are forced to have sexual intercourse sometimes by spouses (25%), partners (36%) and friends (14%). Also, to note is that even a family member, school mate and strangers forced some girls to have sexual intercourse. When they were forced, majority (82%) did not report anywhere and the few who reported, it was to local leaders, family members and police respectively. Those who reported to family members, the latter eventually reported to local leaders and police. But some did not still report anywhere. After reporting, perpetrators were fined (80%),

referred to courts (40%) and worse still, victim fined (20%). There were some who said nothing was done (20%). Fining the victim agrees with what Madanda (2021) found out in Bidi Bidi settlement, that cultural norms place a woman at the receiving end and blame her for whatever she goes through thinking that she invited it, otherwise she should have kept herself safe. For instance, in a recent study by Madanda (2021) in Bidi Bidi Settlement found out that the South Sudanese refugees view sexual and gender-based violence as "norms" and frequently blame the girls and women if it occurs. If a girl or woman is raped or sexually abused while moving alone in the night or in some other isolated place/bush, she is seen as having invited the trouble over herself – rather than holding the perpetrator accountable (Madanda, 2021:24).

Infact majority of the participants (60%) said that a woman is not justified to refuse to have sex with a partner for any reason and about 15% said it is justifiable for a man/ boy to beat his wife/ girlfriend and 12% said that a woman is equally justifiable to beat her husband or partner for any reason. Reasons for beating a spouse / partner could include alcoholism and sharing of HIV status where more than 74% agreed that women often experience violence from their partners after sharing their HIV -positive status.

The key informant interviews revealed that some of the causes of sexual and gender based violence include alcoholism, drug abuse, denial of food items provided to the households, lack of sexual satisfaction which leads to quarrels and fights, poverty, misunderstanding which may arise when a parent punishes a child and another parent does not agree or when a woman uses family planning methods without the knowledge of the man, norms and cultural beliefs and practices including those that give more power to the man and less power to the woman. In some instances, redundancy has caused violence since most youth do not have work and spend their time drinking alcohol and using drugs and gambling.

Table 13: Adolescent and Young People Experiences about SGBV

SGBV QUESTIONS	Male	Female	13-19 years	20-24 years	All young people	
	%	%	%	%	N	%
A woman must fulfil the sexual desires of her partner at any given time						
No	28.3	71.7	82.1	17.9	452	59.2
Yes	38.3	61.7	58.8	41.2	311	40.8
Is a wife/woman justified in refuting having sex with her husband/partner for any reason?						
No	33.2	66.8	71.6	28.4	458	59.6
Yes	31.6	68.4	74.5	25.5	310	40.4
It is sometimes justifiable for a man/boy to hit his wife/girlfriend						
No	32.6	67.4	74.9	25.1	682	85.6
Yes	34.8	65.2	67.0	33.0	115	14.4
Is a woman justified to beat her husband or partner for any reason?						
No	33.7	66.3	73.9	26.1	700	88.1
Yes	27.4	72.6	72.6	27.4	95	11.9
Women often experience violence from their partners after sharing their HIV-positive status						
Agree	34.2	65.8	69.3	30.7	590	73.8
Disagree	29.9	70.1	78.5	21.5	107	13.4
Refused to answer	27.5	72.5	95.1	4.9	102	12.8
If a man takes alcohol regularly, he is more likely to use violence against his wife/partner						
Agree	32.5	67.5	73.9	26.1	735	91.9
Disagree	34.8	65.2	65.2	34.8	46	5.7
Refused to answer	36.8	63.2	94.7	5.3	19	2.4
Defilement cases in this community are rare						
Agree	31.9	68.1	74.3	25.7	526	65.8
Disagree	35.4	64.6	68.1	31.9	226	28.3
Refused to answer	29.8	70.2	95.7	4.3	47	5.9

Section Four: Service delivery gaps

There is no specific organization working on SRH and targeting the adolescents and youth in the settlement. Most adolescents and youth experience SRH challenges such as rape and sexual abuse, unwanted pregnancy, early and forced marriage, abortion as well as effects of SGBV in households. It was found out that some organizations offer services as components of SRH such as counselling, sensitization on the dangers of early pregnancy and family planning services offered by MTI. Further, LWF carries out sensitization and awareness raising on early pregnancy, child nutrition, dangers of abortion, where to report cases of abuse and use of family planning in the community and FCA does the same in schools. It was found out that lack of an organization responsible for implementation of SRHR in the settlement has led to scattered service delivery.

As pointed out by local leaders, some parents neglect their children when they go back to South Sudan to take care of gardens or go to host communities to dig and spend months there. The children left in the settlement most times do not access enough food and forced to accept gift from men. This puts them in compromising situations and experience of risky behaviours that affect their sexual health. The reasons for abandoning the family by men was given as lack of employment opportunities in the settlement and hence men remaining redundant which forces them to go and seek for work. Other reasons given include reduced rations of food by World Food Program (WFP) up to 70% which does not last for a whole month.

Different NGOs implementing activities in the settlement have some components of SRH but no specific NGO on SRH. Some SRH services such as condom distribution, family planning services and treatment of sexually transmitted diseases (STDs) are provided at the health facilities by MTI, yet the young people prefer to get services in confidence. Evidence from the field shows that there is a need for targeted programming and activities geared towards addressing the SRH needs of the young people and empowering them to manage their sexuality and reproductive health as well as norms change to accommodate discussions on matters related to sexuality and reproductive health in this community.

Community concerns such as discos in the community which attract the young people can be addressed and awareness raising on dangers of early marriage and early pregnancy can be handled if there is a specific empowerment program.

There is also need to intensify sexuality education both in schools and community but also implementing interventions geared towards breaking cultural norms barriers especially bad practices that encourage risky sexual behaviours and attitude change so that there is complete child protection. Programs to stop and reduce early pregnancy are needed including SRH clubs in schools and community as … *"basic sexual and reproductive health services do not come from the medical workers but from social workers at community level and if there is need for medical attention, then we can do referrals"* (KI- OPM Community Services Officer).

Given that at the community level there are community activists working as volunteers who visit households in case there is reported violence, there is need to streamline their work under a specific organization so that their renumeration is standardized. Currently they work with different organizations but they prefer working with those which give them some incentives. Therefore, programs fail to be implemented by these activists if the organization does not have a budget to pay them or motivate them by providing with gum boots, umbrellas, soap, airtime or bicycles. *"we therefore need to streamline SRH issues in all interventions targeting the youth in this settlement but above all, have a stand-alone program on SRH for adolescents and youth"* (KI -OPM Community Services Officer).

One of the parents identified service delivery gaps including lack of confidentiality at the health centers. She said "t*he youth are supposed to go to the health facility but they fear since the community does not appreciate use of family planning by young people hence they would be questioned and there is no confidentiality at the health facility"* (Parent). She added that *"most of the girls who are defiled, go to police and end up at the private clinics since they do not have privacy at the health centers especially the rape cases and even those who would use condoms cannot get information or even get counseling or access family planning privately at these centers".* There is therefore need to put in place youth- friendly corners for them at the health centers.

4.1 Decision making gaps

One hundred sixty-one married participants were asked some questions about decision making going for healthcare, visiting relatives or buying of assets. The results show that women have less decision-making opportunities compared to men. In all the three questions, less than 7% said a woman only could make decisions on such issues. Refer to the results in the table below.

Table 14: Household Decision Making and SGBV

Aspects of decision-making roles	**Males**	**Females**	**All young people**	
(For married couples only) Who makes the decision whenever you want to go for health care in any health facility?	**%**	**%**	**N**	**%**
Husband only	14.3	9.8	18	11.2
Wife only	0.0	8.9	10	6.2
Jointly husband and wife	85.7	81.3	133	82.6
(For married couples only) Who makes the decision whenever you want to visit your family and relatives?				
Husband only	24.5	10.7	24	14.9
Wife only	2.0	5.4	7	4.4
Jointly husband and wife	73.5	83.0	129	80.1
Someone else (specify)	0.0	0.9	1	0.6
(For married couples only) Who decides on major purchases that your household makes?				
Husband only	18.4	17.9	29	18.0
Wife only	2.0	4.5	6	3.7
Jointly husband and wife	79.6	76.8	125	77.6
Someone else (specify)	0.0	0.9	1	0.6

Section Five: Existing interventions by implementing partners and targets

Table 15: Initiatives and programs that are implemented in targeted communities.

Institution	Initiatives, programs, and lessons learned	Targeted population
LWF	• Handles GBV cases including reporting and representing survivors in courts of law, • Promotes adolescent health in the community • Management of menstruation through distribution of pads, panties, soap • Trains about how to make local/ reusable pads target P.5-P.7, • Distributes soap, and clothes during Christmas season • Distributes clothes, mattress, soap, money (UGX 400,000/=) for both the baby and young mothers 17 years and below • LWF does child protection and it did an assessment on pregnancy and reported that it is high	Adolescents and youth
Windle International	An education partner and creates awareness on early marriage in schools	youth
OPM	Handles overall coordination and monitoring of organizations in the settlement and community policing and awareness raising on refugee rights, responsibilities and laws	
MTI	• Partly does SRH because they only attend to you at the facility – no staff for community outreach • Do counselling and treatment of STDs • Do medical examination for rape victims • Give ART to victims of rape and drugs to prevent pregnancy • Refer rape and SGBV survivors to police with a medical form • Monitor health issues in community through VHTs	
Save the Children (stopped working)	They talk about early marriages, pregnancies, how to protect children also helps young boys /girls. They talk about dangers of marrying early and how to avoid it by being in school	Adolescents
Red cross	Gives girls pads/pants in schools starting from P.4-P.7 and those who are in secondary	Adolescents
Fin church Aid	• They identify girls who got pregnant and follow them to carry out awareness and mobilize them to go back to school • Have constructed breastfeeding rooms/clinics in secondary schools for child mother to breastfeed before going to class, but they lack food • Offers psychosocial support to these girls	adolescents
Police	Handles SGBV cases	All
Child Fund Uganda	Handles child protection	Youth

Institution	Initiatives, programs, and lessons learned	Targeted population
Care International	SRH, stakeholder engagement, SGBV prevention awareness, referrals,	Adolescents
Palm Corps funded by Stromme International	'Bonga' program for life skills training, livelihoods training (phone repair, carpentry, hair dressing, mechanics, tailoring, building)	Target drop out youth
CEFORD	Para-counsellors on SGBV and training on vocational skills	youth
Plan International	SGBV, SRH,	
Isra Aid	Prevention and response to GBV	Adolescents
RWC	Takes SGBV cases to police	
Community psychosocial support organization (CPSO)	Health education, counselling, psychosocial support	Youth and adults
Community leaders (VHTs, LC1s)	Handle domestic violence	All people

Summary of Recommendations from participants:

Recommendation	Quotation
Support on destructions from discos in community	*"We have night discos in the community which attract schoolgirls to go and dance and they are raped from there. Even some girls and boys sneak from boarding schools to go and dance and s/he gets problems from the disco"*
Increase parents' responsibility	*"We need to increase parents' responsibility so that they do not leave the children in the settlement alone in households and also cater for the basic needs of their children"*
Sensitization about dangers of early pregnancy	*"The youth and adolescents need to be told the dangers of unwanted pregnancy by parents and teachers for those in schools and after partners should come to our community to sensitize them"* (Boy) *"Let the organizations come to blocks and teach those young boys or girls the changes after early pregnancy/abortion so that the cases reduce"* (FGD girls)
Organizations should do continuous sensitization during follow-ups visits for the girls who have produced and other girls	*"Proper following has to be done for the victims because when the girls get pregnant at early age, the organizations like LWF give them requirements like Soap, pants, always, buckets and this encourages more girls to get pregnant at early age because they also want to be given those items"* (FGD girls)
Provide condoms	*"For these young boys the condoms should be given door to door"*
Continuous provision of food stuffs and support	*"For young mothers food stuffs should be provided e.g. Porridge ,Rice, Beans, Meat"*
Frequent supply of pads and other menstrual supplies	*"Let the organizations give us our needs like pads, pants, soap at least many to push us for many months, but they sometimes give only 3 pads*" (FGD girls) *"Supplies of Emergency contraceptives, FP commodities, anti-biotics to treat UTIs, and STIs, examination kits because police bring clients, but we can't take some samples"* (KI Medical worker)
Strengthening community engagement activities (sports)	*"The NGO/ IPs should provide sports to keep the adolescent and youth busy including livelihood activities and skills training like group gardens of onions, cabbage, tomatoes"* (KI Parent) *"Strengthening community engagement activities. MTI does occasionally and yet we need to do it on an ongoing basis so that the population picks it out"* (KI medical worker)
Community awareness (through outreaches)	*"The services should reach the young people and not to look for them. we need to do community outreaches and take these services to the community and schools and inform them of the services they can access"* KI-RWC *"Teaching on SRH and Reproductive rights and SGBV and Form Barazas for community dialogues"*
Strengthening community systems in place and referral pathways	*"We need to work with the community and partners to establish which systems are in place including the Pathways. This need strengthening and disseminate to wider usage*" (KI) *"We need a link to service providers e.g. the case of VHTs for the health sector. We need the same for SRH e.g. to avoid mismanagement ofsexual abuses" (MTI)*
Training leaders (capacity building)	*"There are always changes in leadership and there is always a need to train them in all areas of GBV and SRH challenges especially block leaders (RWC)"* (KI RWC) *"There is a dire need for training and massive sensitization to prevent abuses by emphasizing Rights and Duties"* *"At the community level RWC need to be trained to address SGBV at the community level"*
Need for refresher courses for health workers in the settlement	*The health workers need refresher courses for the old trained personnel because there are new emerging SRH challenges.(MTI)*
Training of boys and girls with hands on skills to keep them busy	*"There is need to empower the youth to be self-sustaining rather than giving them skills that are not responding to the needs of the community"*

Toll free line	*"A toll-free line nearby is needed where abuses can be reported"*
Need for sensitization and awareness in schools	*"We need to do sexuality education in schools, this is key for protection and parents fear to tell their children that please use condoms. They only tell them to abstain but me know they later on go for sex"* (KI)
More trainings on how to make pads	*"We want more training on how to make our own pads and how to do other business to get money for buying our own pads" (FGD Girls)*
Need for separate facilitators' for SRH	*"We need separate facilitators on SRH to create awareness and provide relevant information"* (KI Teacher) *"Senior teachers need special training and dedicated assignment and deployment regarding GBV and SRH"* (KI Teacher) *"SRH is not being addressed squarely by any institution"*
Community engagement of men is important	*"Community intervention engaging male engagement is needed now"*
Lack of partners in area of skilling of the child mothers	*"Resources are not enough, and we have limited programs for child mothers to go back to school e.g. infrastructure in schools, support of parents to teenage mothers, etc. more needed"* (KI -IP) *"Parolinya lacks partners in area of skilling of these child mothers to sustainability and develop livelihoods. The reason why they run back to school to be continue being provided for"* (KI -IP)
Need for Mobile courts nearby	• *"For SGBV, the distance to courts is long, we require mobile courts nearby. We also need to discuss with partners to establish the root causes of SGBV such as access to resources, culture, domestic violence, etc. Then you need to suggest practical interventions on how to change this mentality" (UNHCR).* • *"You need to propose programs that others are not doing so that there is no duplication. We need to add value. Also, if cases are increasing is it because of interventions or because of increased reporting. Look into different perspectives from different angles so that you are not producing what is already known"*
Need for sexuality education and awareness in schools and community	• *"We need to do sexuality education in schools, this is key for protection and parents fear to tell their children that please use condoms, they only tell them to abstain but I know they, later on, go for sex"* • *"We have no NGO doing this. This could be addressed if we had programs in schools where we have the biggest number of these youth and adolescents". (*Parent)

Section Six: Conclusion

Refugee adolescents and young people, who comprise approximately 80%, are still largely under-served in refugee settlements with SRHR services. Given that there is a growing funding gap in humanitarian response to refugee influx globally, there is limited prioritization of sexual and reproductive health of young people in refugee settlements. The funding received is majorly allocated to life saving sectors including prevention and treatment of diseases and less on SRHR. Further, refugees come to the country of asylum without any assets since they are running away from war situations and have to live precarious lives as look forward to humanitarian aid. Their cultural norms and practices influence their ability to access and utilize SRH services.

To improve the quality of reproductive health care, there is need to change the existing gender norms particularly those relating to adolescents and youth. Whereas the young people need to know how reproductive health issues affect them, the adults need to understand how gender stereotypes place girls and boys at high risk.

It is only when we accept that SRH needs of refugee adolescents and youth are affected by their social context and age that we can be able to offer appropriate and adolescent or youth-friendly services and be sure of accessibility and utilization by the adolescents and youth.

This assessment found out that SRH care is delivered within the mainstream health care services such as offering services at the maternity wards of health centers which discourages the adolescents and youth to seek for these services for fear of being seen and judged. It was strongly recommended that an organization be sought to offer SRH services to the young people in an adolescent / youth-friendly environment within the settlements. This would enable the young people to talk freely and seek for information and commodities needed to improve their sexual and reproductive health.

It was also suggested that *"organizations should recruit peer trainers who are fellow youth based on communities as it is believed that a fellow youth can talk and make other youth understand them. The health education in communities should also be done by other groups like health clubs*

who also talk to fellow youth - peer to peer talk on SRH in communities and school" (RWC chairman).

To reduce on the SGBV cases, there is need to tackle the root causes such as cultural practices and norm change, distribution of resources, increased sources of livelihoods and income, domestic violence and continuous counselling and psychosocial support in the settlement.

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i. FGD guide for adolescents and youth

Introduction
Study: ***SRH and SGBV Needs Assessment among adolescents and Youth in Palorinya Refugee settlement and Host Communities***

Introduction:
The objective of this study is *to assess SRH and SGBV knowledge, attitudes, and practices among adolescent girls and boys (ages 13-19) and youths (ages 20-24) in Palorinya Refugee Settlement and to stratify the findings across socio-demographics and influencing factors to generate evidence for future programming for refugee adolescents and youth*. The data collected shall be used for purposes of programming.

General Instructions

- *This discussion will contribute toward the generation of evidence-based data for future refugee programming and management to benefit refugees in Uganda.*

- **General information about the participant**

Gender	
Age	
Ethnicity	
Level of education	
Marital status	
Main occupation	
Leadership roles	
Religion	

1. Which institutions are involved in the promotion of sexual and reproductive health of adolescents and youth in this community? (**Probe**: Organization, what they do & whom they target?)
2. What are the socio-cultural norms or practices that **help boys and girls to enjoy their SRH? What about those that hinder SRH?**

(**Probe**: culture, religion, tradition, values and social norms, and customary law)

3. How are sexually Transmitted Infections transferred from one person to another?
4. What can adolescents and youth do to keep themselves safe from STIs?
5. What STIs/HIV services are available in this community? (**Probe** for counseling, testing, psychosocial support, treatment, etc)
6. What are some of your SRH needs? (**Probe:** for girls and boys for MNCH/Nutrition, FP, Abortion, Counselling and psychosocial support, SGBV, STI/STDs etc**)**?
7. What do adolescents and youth do to get the SRH services they want? Explain? (**Probe** for adolescent friendly corners)
8. Are you satisfied /unsatisfied with the SRH services provided? Explain?
9. What information do you have about Family Planning? (**Probe** for misconceptions)

10. As young people, do you know where to access SRH commodities like condoms and contraceptives? **Probe**: Where, Who provides the services? How far from here? Have you been able access these commodities every time you need them?
11. What kind of information regarding sexuality and reproductive health do young people have?
    a) Where do they get that information from?
    b) How appropriate and accurate is that information?
12. Who should deliver SRH services to young people?
13. When an adolescent or youth does not get SRH service from those providing free services, what does he or she do? A) Where do they go to get that service?
14. What are the menstrual needs of adolescents and youths in your community?
15. What was your experience the first time you had menstruation? (**Probe** for how girls are treated by the community)
16. What challenges do adolescents and youths face during menstruation?
17. What services do women need during pregnancy?
18. What services do mothers need after child delivery?
19. What challenges are faced by adolescents as a result of early pregnancy?
20. Which methods do you know that are used to carry out abortion?
21. What Post Abortion care services are available in this community?
22. When an adolescent or youth is faced with an SRH challenge, where do they report it?
23. Which other stakeholders are involved in the sexuality education and reproductive health service delivery for young refugees?
    a) What roles are these stakeholders playing?
    b) What needs to be improved/what are your recommendations?

SECTION B: SGBV

24. Which forms of SGBV against adolescents and youth occur in this community?
25. What are some of the causes behind sexual and gender-based violence in this community?
26. Who is most vulnerable to sexual and gender-based violence in this community and why?
27. What challenges are faced by adolescents and youths who marry before 18 years (**Probe** for girls and boys)
28. What are the main programs or actions established in the community to respond to or prevent sexual violence against adolescents and youth? What are the challenges?
29. What is the referral system established here for cases of sexual violence?
30. Are you satisfied with the SGBV management services available? Explain
31. Is there anything that should be done to help provide better services to adolescents and youth? What would you recommend?
32. Do you have any questions for me?

Thank you for your participation.

ii. Key informant interview guide

INTERVIEW GUIDE FOR PARENTS, LEADERS & NGO STAFF

Study: ***SRH and SGBV Needs Assessment among Adolescents and Youth in Palorinya Refugee settlement and Host Communities***

Introduction:
The objective of this study is *to assess SRH and SGBV knowledge, attitudes, and practices among adolescent girls and boys (ages 13-19) and youths (ages 20-24) in Palorinya Refugee Settlement and to stratify the findings across socio-demographics and influencing factors to generate evidence for future programming for refugee adolescents and youth*. The data collected shall be used for purposes programming.

General Instructions

- *This discussion will contribute toward the generation of evidence-based data for future refugee programming and management to benefit refugees in Uganda.*

- **General information about the participant**

Gender	
Age	
Ethnicity	
Level of education	
Marital status	
Main occupation	
Leadership roles	
Religion	

1. What role do you play in provision of sexual and reproductive health (SRH) and Sexual and Gender Based Violence (SGBV) services in this community?
2. Which institutions are involved in the promotion of SRH of adolescents and youth in this community? (**Probe:** Organization, what they do & whom they target?)
3. What are the sexuality/SRH-related cultures/beliefs of this community (**Probe:** ***pregnancy-related cultures or beliefs***)?
4. What are the socio-cultural norms or practices that **help, or hinder** boys or girls enjoy their SRH? (**Probe**: **culture, religion, tradition, values and social norms, and customary law)**
5. What are some of the SRH needs do adolescents and youth have (**Probe for girls and boys)**?
    i. How have they been met/which services can they access or not access?
    ii. Where can youth access these services?
6. What do adolescents and youth do to keep themselves safe from reproductive health problems? (**Probe:** unwanted pregnancy, STIs, early marriage, abortion)
7. What role do the refugee youth play in SRH service delivery?
    i. What do they do?

8. Do you think adolescents and youth know who is involved in ensuring that their SRH needs are met (girls/ boys)? Explain?
9. Should young people aged below 18 years be accessing SRH commodities like condoms and contraceptives? Why / why not?
10. What do adolescents or youth do to get the SRH services they want? Explain?
11. Do you think youth are satisfied or unsatisfied with the SRH services provided? Explain?
12. What kind of information regarding sexuality and reproductive health do young people have?
    i. Where do they get that information from?
    ii. How appropriate and accurate is that information?
13. Who should deliver SRH services to young people?
14. When a youth does not get SRH service from those providing free services, what does he or she do? Where do they go to get that service?
15. When an adolescent or youth is faced with an SRH challenge, where do they report it?
16. Which other stakeholders are involved in the sexuality education and reproductive health of young refugees?
    i. What roles are these stakeholders playing?
    ii. What roles are the youth playing?

SECTION B: SGBV

17. What are the main problems that adolescent girls and young women face in the community?
18. What type of violence occurs in your community? Does sexual violence affect adolescent girls? young women? **Probe**: How? **Types:** *forced sexual intercourse, unwanted sexual touches.*
19. What is the situation of sexual and gender-based violence like in this settlement? (**Probe:** community attitudes towards SGBV and examples of SGBV)?
20. What are some of the causes behind sexual and gender-based violence in your community?
21. Who is most vulnerable to sexual and gender-based violence in your community and why?
22. What happens to adolescent girls if they experience sexual violence?
23. What are the main programs or actions established in the community to respond to or prevent sexual violence against adolescents and youth? What are the challenges?
24. Are there any platforms where adolescent girls and young women can go to report sexual violence? Do they have capacity? What are the challenges? (**Probe:** established referral system)
25. What type of health services are available to adolescent girls and youth who experience sexual violence?
26. What does your institution do to respond to and prevent sexual violence against adolescent girls and young women?
27. Is there anything that should be done to help provide better services to these adolescents and youth? What would you recommend?

Thank you for your participation.

iii. Questionnaire - Quantitative Tool

Questionnaire Number	

Date of interview	DD-MM-YYYY: [_|_]-[_|_]-[2 | 0 | 2 | 0]
Interviewer's name	

Introduction
Study: SRH Needs Assessment among adolescents and Youth in Palorinya Refugee settlement and Host Communities.

Introduction:
The objective of this study is *to assess SRH and SGBV knowledge, attitudes, and practices among adolescent girls and boys (ages 13-19) and youths (ages 20-24) in Palorinya Refugee Settlement and to stratify the findings across socio-demographics and influencing factors to generate evidence for future programming for refugee adolescents and youth.* The data collected shall be used for purposes of programming

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENT

ID No.	Question	Response	Code	Skip to
Q101	What is your age in completed years?	13-15 16-19 20-24	0 1 2	
Q102	What is the gender of the respondent?	Male Female	0 1	
Q103	What is your highest level of Education?	None Primary O Level Vocation/Tertiary University	0 1 2 3 4	
Q104	What is your current occupation?	In School Employed Apprenticeship Others…….	0 1 2 3	If (0) skip Q106
Q105	What is your monthly income?	<50,000 50,000- 100,000 100,1000- 150,000 150,1000-200,000 200,1000-250,000 Above 250,000	0 1 2 3 4 5	
Q106	What is your marital status?	Single/Never Married Married monogamous Married polygamous Separated/divorced Widowed Others Specify……..	0 1 2 3 4 5 6	If (0) skip Q108
Q107	How old were you when you first got married? **(If not married skip)**	Below 15 13-15 16-19 20-24	0 1 2 3	
Q108	What is your religious affiliation?	Catholic Anglican Muslim Pentecostal/Born Again/PAG Other (specify)…….	0 1 2 3 4 5	
Q109	What is your country of Origin?	South Sudan DRC Uganda Others…….	0 1 2 3	
Q110	What is your tribe?	Kuku Kakwa Madi Dinka Nuel Others……..	0 1 2 3 4 5	

KNOWLEDGE OF ADOLESCENTS ON SEXUAL AND REPRODUCTIVE HEALTH

ID No.	Question	Response	Code	Skip to
Q201	Have you ever heard about SRH?	**No** **Yes**	**0** **1**	**If (0) skip Q202**
Q202	If yes, from which source?	Radio TV School Peers/Siblings Parents Religious Institutions Newspapers Traditional Leaders Local Leaders NGO Others. Specify…….	0 1 2 3 4 5 6 7 8 9 10	
Q203	At what age did you first have sex?	<13yrs 13-15yrs 16-19 20-24yrs	0 1 2 3	
Q204	With whom did you have your first sex	Relative Boy/girl friend Uncle Teacher Other	0 1 2 3 4	
Q205	Why do young people have sex?	Peer pressure Pleasure Love Gifts Other specify…….	0 1 2 3 4	
Q206	When was the last time you had sex?	< 1 month 1 month -3 Months 4 Months- 6 Months >6 Months	0 1 2 3	
Q207	Who would you discuss sexual issues with?	None Parents Siblings/Peers Teachers Religious Leader Aunt/Uncle Others specify	0 1 2 3 4 5 6	
Q208	Have you heard of family planning/contraceptives before?	No Yes	0 1	Q211
Q209	If yes, mention a contraceptive you know?	Condoms Implants Injectable IUD Pills Abstinence Others. Specify……..	0 1 2 3 4 5 6	
Q210	What is your source of information on contraceptives?	Health Facility Radio TV Social Media Parents	0 1 2 3 4	

ID No.	Question	Response	Code	Skip to
		Peers	5	
		Teachers	6	
		Other specify	7	
Q211	What method(s) of contraceptives have you used before?	None	0	
		Abstinence	1	
		Condom	2	
		Implants	3	
		Injectable	4	
		Pills	5	
		Others. Specify	6	
Q212	Which STIs do you know	None	0	If (0) skip to Q214
		HIV/AIDS	1	
		Syphilis		
		Gonorrhoea		
		Chlamydia		
		Chancroid		
		Other Specify		
Q213	What can be done to prevent STIs?	Abstinence	0	
		Avoid contact with	1	
		infected persons	2	
		Stay with one partner	3	
		Contraceptive use	4	
Q214	In this community, where would you get STIs services including Treatment?	Health Centre	0	
		Private Clinic	1	
		NGOs	2	
		Others. Specify	3	
Q215	How is HIV transmitted?	Unprotected Sex	0	
		Sharing of sharp objects	1	
		Unscreen Blood transfusion	2	
		Others. Specify	3	
		Don't know	4	
Q216	In this community, where do you get services for HIV/AIDS?	Health Centre	0	
		Private Clinic	1	
		NGOs	2	
		Others. Specify…….	3	
		Don't know	4	
Q217	At what age do girls get their first menstruation?	<13	0	
		14-16	1	
		>16	2	
		Don't know	3	
Q218	What are the safe days during menstruation cycle	1-8 days	0	
		9-15 days	1	
		20-28 days	2	
		I don't know	3	
Q219	At what age do girls get pregnant in this community?	<15	0	
		15-18	1	
		>19	2	
		I don't know	3	
Q220	What should be the appropriate age for marriage?	<15		
		15-18		
		>19		
		I don't know		

ID No.	Question	Response	Code	Skip to
Q221	In this community, have you heard about girls who have carried out abortion?	No Yes	0 1	If (0) skip Q220
Q222	Where do girls seek assistance after abortion?	Health Facility Private Clinic TBAs Relative I don't know	0 1 2 3 4	
Q223	Have you ever heard about SGBV?	No Yes	0 1	
Q224	Does SGBV occur in this community	No Yes	0 1	
Q225	Who are the main perpetrators of SGBV in this community?	I don't know Men Women	0 1 2	
Q226	Have you ever experienced SBGV in the past 1 year?	No Yes	0 1	If no skip to Q227
Q227	Where did you report?	No where Police Parent Peers School/Teacher Religious Leader Local Leader Traditional Leader NGO/Development Worker Government Official Employer		
Q228	Have you seen anyone who has experienced SGBV in this community?	No Yes	0 1	If no, skip to Q229
Q229	What forms of SGBV have you seen in this community?	Intimate partner violence Domestic violence Physical violence Early/child marriage Economic violence Rape Defilement Trafficking Forced Sex in Marriage Other (specify)….	0 1 2 3 4 5 6 7 8 9	
Q230	What are support structures/institution for SGBV in this community?	Police station Health facility Local Leaders Religious Leaders NGO/CBOs Traditional Leaders School/Teachers Family Member Health Facility Others, Specify……..	0 1 2 3 4 5 6 7 8 9	

Attitude and perceptions of adolescents on sexual and reproductive health

	Attitude statement	Agree	Disagree	Don't Know
Q301	There is no harm in having sex before 18 years**?**			

Q302	It is a taboo to talk about sex in public in this community?			
Q303	There is no harm in getting pregnant before 18 years in this community?			
Q304	There is no harm when girls abort			
Q305	Having menstruation is normal for a girl			
Q306	Getting married before 18 years is harmless			
Q307	I would report my partner to authorities if he forced me to have sex			
Q308	Sex shows how you love your partner			
Q309	Access to contraceptives is easy in this community?			
Q310	You do not get HIV/AIDS when you have sex the first time			
Q311	I find the behavior of Health workers towards adolescents seeking SRH services to be acceptable to me			
Q312	A woman must fulfill the sexual desires of her partner at any given time			
Q313	All contraceptives are harmful to my health			
Q314	Sometimes, the woman deserves to be beaten by her partner			
Q315	Early childbearing is dangerous (Probe below 18 years of age)			
Q316	Contraceptive usage prevents pregnancy			

The practice of adolescents' sexual and reproductive health

ID No.	Question	Response	Code	Skip
Q401	Are you in a sexual relationship?	No Yes	0 1	If (0) skip to Q403
Q402	Which method do you and your partner use for protection against STIs?	Condom No Protection Others. Specify…..	0 1 2	
Q403	In this community, buying condoms is seen as something bad	No Yes	0 1	
Q404	Do you know the status of your partner?	No Yes	0 1	
Q405	In this community, getting pregnant is common	No Yes	0 1	
Q406	In this community, carrying out induced abortion is common	No Yes	0 1	
Q407	In my community, girls are treated differently during their menstruation	No Yes	0 1	
Q408	Have you ever had sex?	No Yes	0 1	If 0, ski to Q411
Q409	At what age did you first have sex?	Below 15 15-18 above 19	0 1 2	
Q410	What was the reason for your first sex?	Mutual consent Pressure/Coerced Alcohol/drug influence Other specify	0 1 2 3 4	

ID No.	Question	Response	Code	Skip
Q411	Have you ever been pregnant?	No Yes No response	0 1 2	For Girls only
Q412	If Yes; was it intended?	No Yes	0 2	
Q413	How did you manage the situation?	Delivered Aborted No response	0 1 2	
Q414	Where did the action above (Q413) take place	At home Health center Private clinic Relative's home Other (specify)	0 1 2 3 4	
Q415	If delivered, which services did you get before and after: Antenatal care (ANC), postnatal care (PNC) or family planning (FP)	Yes, AC Yes PNC Yes FP None Other (specify)	0 1 2 3 4	
Q416	Have you ever used contraceptives before to prevent pregnancy?	No Yes	0 1	If (0) skip to Q416
Q417	Which contraceptives have you ever used?	Condoms Emergency contraceptive Injection Other specify	0 1 2 3	
Q418	Where you obtain contraceptives from?	Don't know Peer School Health facility Youth friendly space Outreach post Others specify…….	0 1 2 3 4 5 6 7	
Q419	How far from here is the nearest facility / venue where you get your contraceptives from?	1 km 2-3 km 4-5 km Above 5km		
Q420	Did you use a condom during your first sex?	No Yes	0 1	
Q421	Which contraceptive did you use in your sexual encounter?	Condoms Emergency contraceptive Injection Other specify	0 1 2 3 4	
Q422	Have you ever visited adolescent-friendly corners before?	No Yes	0 1	

ID No.	Question	Response	Code	Skip
Q423	Where do you obtain information on Sexual and Reproductive health issues currently?	Friends School Parents Hospital Social media Television/Radios Other specify	0 1 2 3 4 5 6	

SEXUAL AND GENDER-BASED VIOLENCE

No	Question	Response	Code	Skip
Q501	Have you ever experienced any form of forced sexual intercourse (i.e. someone having sex with you against your will)?	No Yes	0 1	3
Q502	Did this happen in the last 12 months?	No Yes	0 1	
Q503	What kind of person forced you into having sexual intercourse?	Spouse Relative Another regular partner Acquainted Casual partner Stranger Family member Schoolmate Teacher Friend Neighbour	1 2 3 4 5 6 7 8 9 10	
Q504	When you were forced to have sexual intercourse against your will, did you or a family member report to any authority?	No Yes	0 1	If (0) skip Q505, Q506, Q507
Q505	If yes, where was the case reported? **CIRCLE ALL THAT APPLY**	Family members Youth group Local leaders (LC I) Police Courts of law Clan/Elders NGO (specify)…… Other (Specify)……	1 2 3 4 5 6 7 8	
Q506	If reported to family members, did they report the case to the authorities?	No Don't know Yes, youths' groups Yes, local leaders (LC I Yes, police Yes, courts of law Yes, NGO (Specify) Yes, other (Specify)	1 2 3 4 5 6 7 8	
Q507	What happened after reporting the case? **(Interviewer, circle ALL mentioned, but do NOT read out)**	Nothing I was punished for reporting Apprehended the culprit Fined the culprit	1 2 3 4	

No	Question	Response	Code	Skip
		Referred to higher courts	5	
		Handled as a family matter	6	
		Any other	7	
		(Specify)……	8	
Q508	A woman must fulfil the sexual desires of her partner at any given time	No	0	
		Yes	1	
Q509	Is a wife/woman justified in refuting having sex with her husband/partner for any reason?	Yes / No / Don't know	1 / 0 / 2	
Q510	It is sometimes justifiable for a man/boy to hit his wife/girlfriend	Yes / No / Don't know	1 / 2 / 3	
Q511	Is a woman justified to beat her husband or partner for any reason?	Yes / No / Don't know	1 / 0 / 2	
Q512	Women often experience violence from their partners after sharing their HIV-positive status	Agree ……1 Disagree _____2 Refused to answer…._____.9		
Q513	If a partner takes alcohol regularly, he is more likely to use violence against his wife/husband/partner	Agree ……..1 Disagree_____ 2 Refused to answer…._____.9		
	Defilement cases in this community are rare			
Q514	**(For married couples only)** Who makes the decision whenever you want to go for health care in any health facility?	Husband only	1	
		Wife only	2	
		Jointly husband and wife	3	
		Someone else	4	
		(specify)……	5	
Q515	**(For married couples only)** Who makes the decision whenever you want to visit your family and relatives?	Husband only	1	
		Wife only	2	
		Jointly husband and wife	3	
		Someone else	4	
		(specify)……	5	
Q516	**(For married couples only**) Who decides on major purchases that your household makes?	Husband only	1	
		Wife only	2	
		Jointly husband and wife	3	
		Someone else	4	
		(specify)……	5	

THANK YOU SO MUCH FOR YOUR TIME

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