Community-based GBV mobilisation & prevention

Lessons from CARE International in Uganda

This Knowledge Model paper on community based GBV mobilization and prevention forms one of a series of papers developed by CARE International in Uganda to provide an evidence base of promising practices and models to inform future long-term development and humanitarian programming. The Knowledge Model papers identify lessons learnt and provide recommendations to inform the implementation approach of the recently developed Women and Youth Resilience Project (WAYREP). WAYREP is funded by the Austrian Development Agency (ADA) and aims to strengthen the resilience of refugee and Ugandan women, girls and youth to live a life free from violence in rural and urban contexts in West Nile and Northern Uganda.

Uganda: Understanding the context

The incidence of gender-based violence (GBV) experienced by women and girls is high in Africa and the rates reported in the Great Lakes countries of the Democratic Republic of Congo (DRC), Uganda, Burundi and Rwanda are among the highest on the continent. National statistics for Uganda show that 50% of ever-partnered women aged 15-49 years old have experienced physical and/or sexual intimate partner violence at least once in their lifetime, while 30% have experienced physical and/or sexual intimate partner violence in the last 12 months[1].

Since 2013, Uganda has experienced a huge influx of refugees displaced as a result of ongoing conflicts in neighbouring countries of South Sudan and the DRC. Uganda is currently hosting over 1.3 million refugees living within its borders[2], most of whom are from South Sudan but also from the Democratic Republic of Congo, Burundi, Rwanda and Somalia. Over 80% of South Sudanese refugees are women and children although registration data indicate that in more recent times the profile of new refugee arrivals in Uganda has varied to include more men, particularly young men[3]. Levels of GBV, including the use of rape as a weapon of war and the abduction of girls to be used as sex slaves, have been extremely high throughout the conflict in South Sudan, with the incidence of cases of sexual violence reported to have risen since July 2016. Cross-border research carried out by CARE International in South Sudan and Uganda in 2017

[1] Uganda Bureau of Statistics. 2018. *Uganda Demographic and Health Survey 2016.* Kampala, Uganda & Rockville, Maryland, USA: UBOS & ICF.
[2] UNHCR. September 2019. Uganda Comprehensive Refugee Response Portal. Available at: https://data2.unhcr.org/en/country/uga
[3] CARE Uganda. 2017. 'Lifesaving Shelter, Gender-based Violence and Sexual and Reproductive Health Support for South Sudanese Refugees in Uganda 2018 - 2020'. Project proposal, CARE Uganda.

documents the complex and cumulative experiences of GBV and protection risks that South Sudanese women and girls face when fleeing their homes in South Sudan, while crossing the border into Uganda and living as refugees in settlements in Uganda[4]. Although accurate data for the proportion of women and girl refugees experiencing GBV committed in South Sudan are not available, it is clear that there are thousands of GBV survivors in the West Nile refugee settlements in need of support for the violence and trauma they have experienced, including many children and adults who were forced to witness the rape of their relatives.

Refugee and host community women and girls living in and around the West Nile refugee settlements face on-going and complex GBV and protection risks in those settings due to a combination of factors, including poverty and limited livelihood opportunities, poor access to basic services and harmful socio-cultural norms[5]. Many women and girls are subjected to sexual violence at GBV "hot spot" or at-risk locations such as water points at night, in the marketplace, at bars, in the bush where they collect firewood and/or on the way to school. Poverty and the lack of livelihood opportunities in the settlements creates tension within households and compounds the already high level of vulnerability of the refugee population to risks of exploitation, resulting in the emergence of negative coping strategies such as child marriage and transactional sex to meet basic needs for household survival. Changes in gender roles, whereby many refugee women are registered as heads of households for distributions and are taking up productive work such as construction and petty trade in order to meet the basic needs of their families, while men are unable to perform their socially prescribed role as the provider and protector of their families due to limited livelihood opportunities, have resulted in feelings of frustration and powerlessness among men, which are also reported to be a significant driver of GBV in the settlements. Other factors contributing to the incidence of GBV in the refugee settlements include: the widespread use of alcohol and addictive substances by men, women and youth as a negative coping strategy for their trauma and psychosocial distress; inter-ethnic tensions and host/refugee conflict associated with mounting pressures on resources such as water, firewood and health services; and sexual exploitation and abuse (SEA) of refugee communities by aid workers, contractors and volunteers[6].

Beyond the refugee settlements, the demographic reality of Uganda is one of a youthful and rapidly expanding population, characterized by high rates of rural to urban migration for both nationals and non-nationals seeking better employment and access to services in the urban centres. It is projected that by 2050, 50% of Uganda's population will be living in urban areas, however the urban population living in slums is currently estimated at 60%, with one out of four young people already living in urban areas[7]. Conditions in urban slum areas are very challenging, with limited opportunities for employment, poor access to basic services of accommodation, water and healthcare, and widespread security risks. As a result of these challenges, urban communities face traditional as well as new forms of GBV and exploitation, including widespread problems of gambling, substance and alcohol abuse, with women and girls often turning to transactional or commercial sex to secure their livelihoods[8]. Urbanization is also increasingly compounded by displacement as Uganda's progressive refugee policy allows for free movement of refugees, with towns and cities hosting growing numbers of refugees. Urban refugees are expected to be self-reliant and so do not receive humanitarian assistance, unless they are registered as living in a settlement. Urban refugees who are not registered have no legal status in Uganda and so are at greater risk of trafficking, SEA and exploitative forms of labour. Urban refugees in addition to being exposed to the same challenges that are faced by the urban poor, experience a double burden of adapting to new culture, learning a new language, and overcoming stereotypes.

CARE International in Uganda (CARE Uganda) has a successful track record of programming for community based GBV mobilization and prevention in rural settings. Given the growing refugee, urban and young population in Uganda, CARE Uganda has identified the need to expand and adapt the community based GBV mobilization and prevention model to reduce the risks of GBV for women and girls in urban and humanitarian settings. WAYREP has accordingly been designed as an intervention that aims to 'strengthen the resilience of refugee and Ugandan women, girls and youth to live a life free from violence in Uganda'. The project will provide targeted gender transformative livelihood and

[4] CARE Uganda. 2017. 'GBV Experiences of South Sudanese Women and Girls on the Run to Uganda: A Case Study from Busia to Imvepi, Arua District, Uganda'. CARE Uganda.
[5] CARE Uganda. 2017. 'CARE Rapid Gender Analysis: South Sudan refugee crisis, West Nile'. CARE Uganda.
[6] *Ibid.*
[7] CARE Austria. 2018. Women and Youth Resilience Project (WAYREP) Programme Document. CARE Uganda.
[8] *Ibid.*

protection support to vulnerable women and girls in the urban centres of Gulu and Arua and in the refugee settlement of Omugo to promote increased self-reliance and personal wellbeing for project participants, their families and surrounding communities[9].

The Community-based GBV Mobilisation and Prevention Model

CARE Uganda's comprehensive community based GBV mobilization and prevention model is based on an integrated combination of activities implemented with individual women and girls and men and boys, as well as activities implemented with a range of community structures[10], with local governance structures and service providers, and with partners and other stakeholders at project and national levels. In this way the community based GBV mobilization and prevention model incorporates elements for the five key programming approaches identified in the POWER! framework for GBV programming in the Great lakes sub-region (see Figure 1)[11], which in turn can be mapped to the domains of change in agency, relations and structures of CARE's Gender Equality Framework. Key entities involved in implementation of the model include, community-based facilitators (CBFs), case managers and service providers (see discussion below).

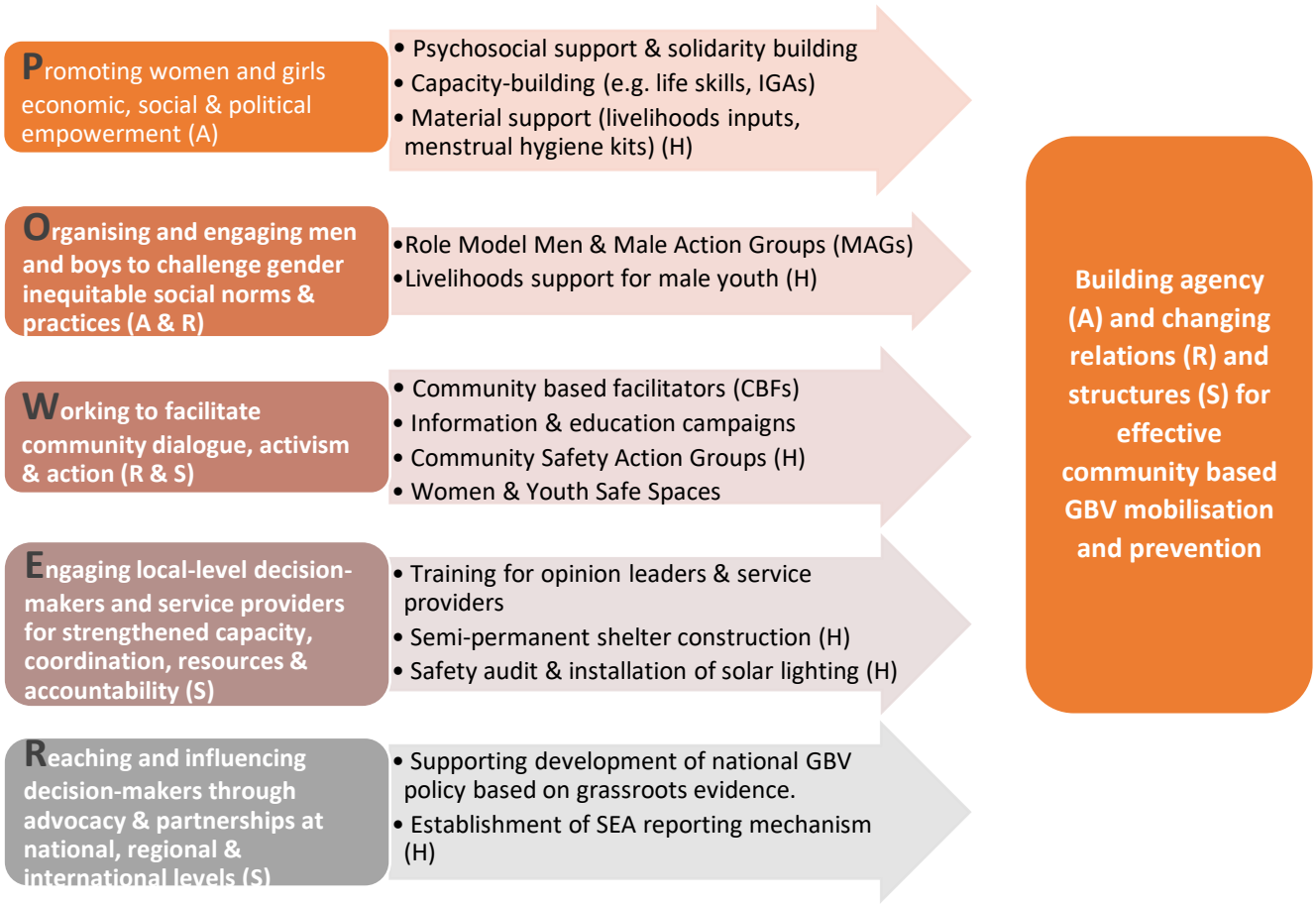

Figure 1: The CARE Uganda community based GBV mobilisation and prevention model mapped to the programming elements of the Great Lakes POWER! Framework

The development of this model has been informed by CARE Uganda's experience of women's empowerment programming in Northern Uganda since 2007, through a series of programming initiatives funded by NORAD and ADA[12]. The earlier phases of this programming focused largely on promoting women's economic empowerment through the establishment of Village Savings and Loans Associations, which experience highlighted the importance of

[9] *Ibid.*
[10] These community structures are referred to as the "circles of support/ influence" in the SASA! methodology for community mobilisation to address GBV.
[11] Gillingham, S. 2018. 'A Life Free from Violence: An evidence-based value proposition for CARE's Gender-Based Violence programming in the Great Lakes region'. Consultancy report for CARE - East, Central and Southern Africa Regional Office (ECSARO).
[12] The first phase of the Women's Empowerment Programme in Northern Uganda was implemented from 2007 to 2009, the second from 2010 to 2012. These interventions were followed by the 2013 – 2016 Northern Uganda Women's Empowerment Programme (NUWEP) funded by NORAD, and – most recently – the 2016 – 2019 Learning for Change programme funded by ADA.

addressing the high levels of GBV in the post-conflict setting of Northern Uganda as part of a holistic approach for women's empowerment and the need to involve men and boys and the wider community in challenging and changing social norms relating to women's empowerment and gender-based violence. Experience from the later Northern Uganda Women's Empowerment Programme (NUWEP) and Learning for Change (L4C) then showed the importance of promoting women's leadership for GBV prevention and response by means of an integrated approach including the provision of psychosocial support (see also CARE Uganda's Women and Girls' Leadership Knowledge Model Paper).

CARE Uganda's community based GBV mobilization and prevention model starts accordingly involves a strong focus on the provision of **psychosocial support (PSS)** for women and girls who are survivors of or at risk of GBV. This aspect of the model speaks to the programming element for **promoting women and girls' economic, social and political empowerment** of the POWER! Framework (see also CARE Uganda's Women and Girls Leadership Knowledge Model paper). The PSS provided takes different forms. One form of PSS is therapeutic whereby community-based facilitators (CBFs) who are trained on issues of gender equality and GBV – including the referral pathway - provide information on rights and access to services and basic counselling to GBV survivors. A second form of PSS involves a broader intervention to build the confidence and self-esteem of all women and girls with a focus on strengthening their power within. The VSLAs which have been the principal platform for CARE Uganda's women's empowerment programming in Northern Uganda (see CARE Uganda's Women and Girls' Economic Empowerment Knowledge Model paper) have proved to be an effective mechanism for the targeting and delivery of programming interventions relating to GBV, SRH and women's leadership. Membership of the VSLA also delivers psychosocial benefits for women who have experienced trauma or violence by in terms of building confidence and self-esteem at the individual level as well as providing a social network and safe space where women can share experiences and support each other[13]. In addition to a strong focus on PSS, CARE Uganda's programming for community-based GBV mobilization and prevention in the West Nile refugee settlements and in Northern Uganda has also incorporated **capacity- and skill-building interventions** (e.g. financial literacy and business development training provided through the VSLA), and **material support provided in the form of livelihoods inputs and/or menstrual hygiene kits**. These interventions are designed to address some of the particular barriers and constraints that refugee women and girls face and which shape their vulnerability to GBV (see lessons learnt discussion below)[14].

The community based GBV mobilization and prevention model also includes a strong focus on **organizing and engaging men and boys (EMB) to challenge gender inequitable social norms and practices** based on the Role Model Man (RMM) approach developed by CARE in Northern Uganda[15]. The RMM approach as developed in Northern Uganda involves mobilising and engaging men and boys, who are selected by their communities, in **a process of structured and self-critical reflection and facilitated dialogue based on peer-to-peer learning and support** to understand and champion concepts of positive masculinity and gender equality[16]. The approach initially targeted the spouses of women participants of VLSAs to ensure their support for their wives' participation in those groups and changes in intra-household relationships, but has increasingly evolved into an approach targeting individuals and groups of households that have psychosocial challenges (e.g. GBV survivors, problems of alcoholism and substance abuse, mental health issues, extreme poverty etc.). Each RMM is responsible for facilitating peer-to-peer reflective dialogue and providing male mentorship with a support group of ten neighbouring households identified as being vulnerable to problems of GBV, alcohol abuse, extreme poverty etc. By working on a regular basis with both the male and female members of support group households the RMM's activities are designed to address the psychosocial distress issues of both men and women, as well as promoting changes in attitudes and behaviours relating to gender roles and power relations[17]. In this way the EMB approach involves working with men on three levels: with men as clients with their own emotional and PSS needs; with men as supportive partners or allies for promoting maternal healthcare and family planning; and with men as agents of social change in their communities. Impacts from the implementation of the RMM

[13] CARE Austria. 2017. 'CARE Austria Framework Program Phase III – Program Overview and Lessons Learned from Uganda.' ADA, CARE Austria
[14] CARE Uganda. 2018. 'Integrated WASH, shelter and protection response to newly arrive South Sudanese refugees and host communities in Yumbe (Bidibidi), Arua (Rhino & Imvepi) and Moyo & Adjumanyi (Palorinya) Districts, Uganda'. Internal end-line evaluation, ECHO HIP, CARE Uganda.
[15] The Role Model Men approach developed in Northern Uganda drew on learning and resources developed by the CARE Balkan's Young Men and Boys Initiative.
[16] CARE Uganda. 2016. Northern Uganda Women Empowerment Programme: Description of the Engaging Men and Boys (EMB) Model. Learning brief, CARE Uganda.
[17] *Ibid.*

approach in Northern Uganda include reduced tolerance for GBV at community level, men abandoning violent behaviours and women and girls achieving increased levels of economic, social and political empowerment[18].

In relation to the third programming element of the POWER! framework of working to facilitate community dialogue, activism and action, **community-based facilitators (CBFs) play a key role in the implementation of the CARE Uganda community-based GBV mobilization and prevention model**[19]. CBFs are selected from the community by means of a transparent, participatory and accountable process involving community members and then receive training on GBV and SEA issues and basic counselling techniques. Their role includes organising community sensitization campaigns with women, men and youth using tailored IEC materials on issues of GBV and gender equality during household outreach visits and community dialogues, as well as sports and drama activities. These activities are designed to reach everyone in the community, including key stakeholders such as traditional and religious leaders, VSLA members and service providers such as healthcare workers and teachers who can also act as multipliers or disseminators. The CBFs also provide support to GBV survivors, which can include linking survivors with trained case managers and/or relevant service providers, thereby enabling survivors' access to comprehensive case management services involving PSS, legal support, medical care and material support. CBFs also provide the first point of information ensuring accessibility and utilization of maternal and child health services in the refugee settlements (GAC evaluation).

As such, the CBFs form a cadre of local activists, who lead the process of community engagement and mobilization for the prevention of GBV and promotion of gender equality. For example, activists for CARE Uganda's Women and Adolescent Youth Empowerment and Rights (WAY) programme, which is currently being implemented across eight districts of Northern and north-west Uganda, are using an adapted version of the SASA! Approach developed by the Ugandan NGO Raising Voices (see Box 1) to work with and through a range of community structures on creating demand for GBV and SRH services.

BOX 1: OVERVIEW OF SASA!

SASA! (the KiSwahili word for "now") is **a community mobilization methodology for addressing the link between violence against women and HIV/AIDs** by exploring the central question "How are you using your power?" The SASA! methodology provides **an approach for changing the social norms that perpetuate women's vulnerability to violence and HIV**. It is structured around four stages of community mobilization that enable organisations to effectively and systematically facilitate a process of behaviour change in the community. **The four stages of change are**:

- **Start:** During this first phase, violence against women and HIV/AIDS are introduced as interconnected issues and community members begin to foster *power within* themselves to address these issues.
- **Awareness:** In the second phase, community members experience a growing awareness about how communities accept men's use of *power over* women, fuelling the dual pandemics of violence against women and HIV.
- **Support:** Throughout the third phase, community members discover how to support the women, men and activists directly affected by or involved in these interconnected issues, by joining their *power with* others'.
- **Action:** In the fourth and final phase, community members explore different ways to take action, using their *power to* prevent violence against women and HIV.

Source : http://raisingvoices.org/sasa/

In terms of engaging local-level decision-makers and service providers for strengthened capacity, coordination, resourcing and accountability - the fourth programming element of the POWER! framework – **most of CARE Uganda's interventions implementing the community-based GBV mobilization and prevention model have included capacity-building and training inputs for local decision-makers and service providers** on gender equality and GBV issues and approaches for protection and response, often in connection with activities for engaging men and boys and/or activities to promote women and girls' leadership, and with a focus on promoting the effective implementation of policies, laws and bye-laws. Projects implemented by CARE and partners in the West Nile refugee settlements with funding from ECHO and Global Affairs Canada have established a client-based case management approach, involving

[18] Wu, D., Baron, R., Martins, S., and Shannon, R. 2016. 'Man in the Mirror: Reflections on men and boys engaging in gender work in development'. CARE International.
[19] Gillingham, S. & Isharaza, G. 2013 'Findings of the Great Lakes Advocacy Initiative Final Qualitative Evaluation in Uganda'. Briefing note for CARE Uganda.

the **recruitment of trained GBV case managers** to work alongside and with the CBFs in supporting access to counseling and medical services for GBV survivors. For example, the ECHO-funded project for integrated Water Sanitation and Hygiene (WASH), shelter and protection response to newly arrived South Sudanese refugees and host communities implemented by CARE Uganda and partners in 2017/2018 provided training and support for 73 service providers across three refugee settlements in West Nile (Rhino camp, Bidibidi and Imvepi) to establish a case management model for coordinated access to health, PSS, protection and legal services for GBV survivors. The end-line evaluation for this project found that "*combining activities aimed at mitigating and preventing incidents with training for service providers to improve response was effective as a holistic strategy"*[20]. The establishment of community structures such as Women and/or Youth safe spaces and Community Safety Action Groups (CSAGs) has also contributed to strengthening capacity for GBV mobilization and prevention in the West Nile refugee settlements (see discussion of lessons learnt from humanitarian programming below).

Finally, implementation of CARE Uganda's community-based GBV mobilization and prevention model has also involved **reaching and influencing decision-makers through advocacy and partnerships at national, regional and international levels.** By using evidence generated from grassroots programming experience in Northern Uganda, and by supporting the participation of vulnerable populations in advocacy processes at multiple levels, CARE Uganda supported the development and adoption of the national-level GBV policy. CARE's contribution to this process included influencing the development and piloting of a GBV information management system in Northern Uganda; supporting the development of guidelines for the establishment and management of a GBV shelter in Gulu; and enabling the development of the local level Gulu District GBV Action Plan[21]. Since 2014, CARE Uganda's humanitarian response programming in the West Nile refugee settlements has been carried out in collaboration with UNHCR and several international and national partner NGOs. Projects implemented by CARE Uganda in partnership with Oxfam, Save the Children, IRC and CEFORD have influenced decision-making processes for aspects of the humanitarian response relating to the shelters provided for persons with special needs, investments in infrastructure (solar lighting) at GBV hotspots, and SEA reporting processes.

Lessons Learned

CARE Uganda's community based GBV mobilization and prevention model was developed through programming with rural communities. Since 2014 however, CARE Uganda has been implementing and adapting the model in the context of the humanitarian response to the influx of South Sudanese refugees in West Nile region. Most of the projects implemented by CARE Uganda to date in the West Nile refugee settlements have involved a strong focus on GBV prevention and response activities with adult women and men and female and male youth. For example, the ADA-funded Integrated Emergency Response Program for South Sudanese Refugees and Host Communities in Imvepi Settlement, Arua District included interventions for shelter, livelihoods support and protection from GBV and SEA, while the ECHO-funded project for refugees and host communities in Yumbe, Arua, Moyo and Adjumani districts included interventions for WASH, shelter, and GBV protection[22]. CARE Uganda is also currently implementing a five-year Women, Adolescents and Youth rights empowerment project (WAY) funded by UNFPA with refugee and host communities across 8 districts, including Arua and Gulu. The lessons learned and knowledge generated through adapting the model to suit the needs of women and youth target groups in the humanitarian context provides a useful base of evidence to inform the implementation approach for WAYREP. To date however, CARE Uganda does not have programming experience of implementing the community based GBV mobilization and prevention model in an urban context, which will be a new direction for programming through WAYREP. The analysis of lessons learnt from the adaptation of CARE Uganda's model for community-based GBV mobilisation and prevention in the urban and context therefore draws primarily on interviews and discussions held with programme and partner staff during the in-country visit carried out as part of the research process for the meta-analysis.

[20] CARE Uganda. 2018. 'Integrated WASH, shelter and protection response to newly arrive South Sudanese refugees and host communities in Yumbe (Bidibidi), Arua (Rhino & Imvepi) and Moyo & Adjumanyi (Palorinya) Districts, Uganda'. Internal end-line evaluation, ECHO HIP, CARE Uganda.
[21] CARE Uganda. 2017. 'Contribution, Attribution: CARE's 10-year long effort in advocating for Uganda's National Gender-based Violence Policy'. CARE Uganda.
[22] CARE Uganda & ADA. 2017. 'End line evaluation of Integrated Emergency Response Program for South Sudanese Refugees and Affected Host Community Members in Imvepi Settlement, Arua District'. CARE Uganda, ADA.

Working in humanitarian contexts

What aspects of the model have contributed to its success in humanitarian contexts?

The community-based GBV mobilization and prevention model provides a holistic approach for addressing GBV issues – its strength lies in its focus on the integrated implementation of activities at multiple levels by engaging with individual women and men, as well as working with couples and with the wider community, including a focus on engaging decision-makers and service providers at the local level and beyond. The model's comprehensive approach is important and effective in providing the foundation for the positive changes in knowledge, skills, beliefs, attitudes and behaviours that are needed to enable women and men to build healthy and harmonious relationships and so to live lives free from violence. For example, the end-line evaluation of the ADA-funded Integrated Emergency Response Programme in Imvepi settlement, Arua district, reported marked increases in the proportions of adult men, women and male youth respondents rejecting intimate partner violence against women based on a sample survey of 304 refugees[23]. The ADA evaluation also reported markedly more gender equitable attitudes by the end-line among men and women relating to the division of domestic responsibilities for housework, cooking and childcare. Similarly, the end-line evaluation of the ECHO-HIP funded Integrated WASH, Shelter and Protection response project across the settlements of Bidibidi, Rhino Camp, Imvepi and Palorinya reported significant increases from baseline to end-line in the proportions of women and men feeling 'very safe' or 'safe enough' in their settlement (an increase of 33 percentage points among female and 46 percentage points among male respondents), as well as a reported decrease in the incidence of different forms of harmful behavior and violence since the start of that project[24].

Key aspects of the model that have contributed to these successes include:

Firstly, **the model's focus on PSS for both women and men is highly relevant for both the immediate, survival needs of refugees almost all of whom have experienced trauma, as well as for their longer-term recovery and development.** Refugee women who participated in the Focus Group Discussion for the meta-analysis highlighted the importance of women being able to meet and engage in collective IGAs such as baking or sewing as a way of addressing their "psychological torture". These comments are consistent with the finding of the 2019 Rapid Gender Analysis conducted by CARE in Omugo settlement which highlighted the need for mainstreaming of PSS across all programming as a means of building resilience and promoting the uptake of services[25]. Access to psychosocial services for trauma and depression was reported as a factor that made life easier for female survivors of violence during the end-line evaluation of the Integrated WASH, Shelter and Protection Response project implemented by CARE, Save the Children, Oxfam and CEFORD (a local NGO) with refugees and host communities across four refugee settlements. The same end-line evaluation also found that adolescent girls reported 'counselling' as the number one service they would like more of.

The RMM approach is also being adapted for the humanitarian context with an increased emphasis on addressing the PSS needs of men, based on the understanding that ignoring men and boys' needs over the longer term in contexts

Adapting the Community-based GBV Mobilisation & Prevention Model for Humanitarian Programming

- **Psychosocial support** is a critical need, including for men as part of EMB approach, and for youth many of whom have had limited education and are unemployed.
- **RMM reaching out to Male Action Groups** in recognition of the social composition of settlements.
- **Engaging traditional and cultural leaders,** as well as formal leaders, is key for creating an enabling environment.
- **CBFs need to be selected from within the community** they work with.
- **IEC materials need to be in appropriate languages**.
- **Ensuring confidentiality is vital** to encourage reporting of GBV and uptake of referral services.
- **Shelter and WASH initiatives are important aspects** of the community based GBV mobilisation & prevention

[23] *Ibid.*
[24] CARE Uganda. 2018. 'Integrated WASH, shelter and protection response to newly arrive South Sudanese refugees and host communities in Yumbe (Bidibidi), Arua (Rhino & Imvepi) and Moyo & Adjumanyi (Palorinya) Districts, Uganda'. Internal end-line evaluation, ECHO HIP, CARE Uganda.
[25] CARE Uganda. 2017. 'Rapid Gender Analysis: South Sudanese refugee crisis, West Nile, Uganda.' CARE Uganda.

of displacement carries the risk of seeing renewed conflict at all levels, including SGBV[26]. Given the fear of social stigma among refugees, who have already lost friends and family due to conflict and displacement, and the prevailing lack of trust among different sections of the refugee community, CARE Uganda's approach for engaging men and boys in the West Nile settlements is intentionally focused on sensitizing the entire refugee community. CARE Uganda projects such as Norwegian Ministry of Foreign Affairs' Shelter and Livelihood Assistance to South-Sudanese Refugees (NMFA) project are targeting adolescents and young men as prospective RMM in recognition of the growing numbers of unmarried or unaccompanied young men in the settlements, whose psychosocial well-being, attitudes and behaviours must be addressed to reduce the incidence of GBV in those settings. The RMM in the refugee settlements are encouraged to engage with their peers at locations where male youth congregate, e.g. markets, motorbike taxi ranks etc. and are being supported to reach out to Male Action Groups (MAGs) rather than households to promote the wider outreach of their activities across the refugee communities characterized by high numbers of female-headed households. CARE is now starting to identify and train RMM within the hosting community with a view to promoting collaboration on positive masculinity between refugee and host community men and boys, which approach is expected to have a catalytic effect on reducing the risk of conflicts between the two communities.

Another key factor contributing to the effectiveness of the model in the West Nile refugee settlements has been the **use of volunteers selected from the same community as the target groups they work with** in conjunction with ongoing accompaniment and mentorship from CARE staff**.** The activities of the CBFs and other volunteers (e.g. Voluntary Health Trainers etc.), who speak Kakwa and/or Arabic which are the languages spoken by the majority of South Sudanese refugees, in delivering information and education campaigns, providing counselling, case management and referral services, and engaging with community leaders, have contributed positively to the pace, fidelity and acceptability of GBV protection activities. **Evaluations of CARE Uganda projects implemented as part of the humanitarian response have consistently highlighted the use of community volunteers as a key element of the comprehensive case management approach which has been crucial for increasing the reach and acceptance of messaging relating to GBV and SRH issues in the refugee settlements, and effective in encouraging survivors to seek GBV support**[27].

CARE Uganda's programming experience in the refugee settlements also highlights the positive contribution of the Women and Youth safe spaces and GBV information desks as mechanisms for strengthening the referral pathway and enabling GBV survivors to access counselling and other services. However, the risk of stigma associated with visits to the publicly sited GBV information desks was identified, leading to the recommendation that it would be preferable for those desks to offer multiple services while also including a private space for confidential conversations relating to GBV or other sensitive issues[28]. The Women and Youth safe spaces have also provided the mechanism for **engaging adolescent girls in productive and educational activities**; and **piloting the use of Ruby cups for menstrual hygiene management** with 100 women and girl refugees, which was found to have provided a highly cost-effective intervention delivering multiple protection benefits (e.g. reducing the risk of school drop-out among adolescent girls, the risk of women and girls engaging in transactional sex to enable them to buy sanitary protection, enabling women and girls to engage in IGAs).

In addition to the above activities at individual and community levels, **CARE Uganda's community-based GBV mobilization and prevention interventions in the refugee settlements have included working with UNHCR and development partners to address the safety and protection of vulnerable people with special needs (PSNs)[29] through shelter and WASH related activities.** CARE has undertaken the construction of semi-permanent shelters with lockable doors and window for PSNs, which shelters have provided increased safety and protection of beneficiaries from theft and sexual assault, as well as enabling beneficiaries to engage in productive livelihood activities outside their homes. Projects implemented by CARE Uganda in partnership with Oxfam, Save the Children, IRC and CEFORD have carried

[26] CARE Uganda. 2016. Northern Uganda Women Empowerment Programme: Description of the Engaging Men and Boys (EMB) Model. Learning brief, CARE Uganda.
[27] See, for example: CARE Uganda & ADA. 2017. 'End line evaluation of Integrated Emergency Response Program for South Sudanese Refugees and Affected Host Community Members in Imvepi Settlement, Arua District'. CARE Uganda, ADA.
[28] CARE Uganda. 2018. 'Integrated WASH, shelter and protection response to newly arrive South Sudanese refugees and host communities in Yumbe (Bidibidi), Arua (Rhino & Imvepi) and Moyo & Adjumanyi (Palorinya) Districts, Uganda'. Internal end-line evaluation, ECHO HIP, CARE Uganda
[29] People with special needs include GBV survivors, pregnant and lactating women and people living with disabilities.

out safety audits involving the mapping of GBV hotspots (water points, markets and early childhood development centres) and the provision of solar lighting in high risk locations. Project evaluations have found that the collaborative safety audits and resulting infrastructural investments have improved safety at those locations and reduced the incidence of GBV[30].

What have been the challenges of the model in humanitarian contexts?

The language barriers and low literacy levels of many women and girls in the refugee/ displacement context present key challenges for the delivery of effective messaging on GBV and SRH issues and enabling access to services by refugee women and girls. IEC materials such as messaging boards that are in English are not accessible to the majority of refugee women and girls who speak only Arabic and/or tribal languages. The limited number of refugee women and girls with good English language and literacy skills also means that there is a relatively small pool of potential candidates for the community-based roles (e.g. CBFs, Volunteer Health Trainers, Change Agents) that are critical for delivery of the community-based GBV mobilization and prevention model. Use of translators for the delivery of trainings and capacity-building inputs is reported to have been a partially effective solution to this issue. In more general terms, the intersectionality of ethnic, gender and socio-economic vulnerabilities and inequalities all tend to reinforce dynamics of female submissiveness and male dominance which shape vulnerability to violence[31].

Poverty is a key driver of GBV in the humanitarian context. However, livelihood support interventions involving the establishment of group based IGAs (e.g. a mixed group of men and women running a grinding mill, a women's group involved in making bead jewelry) have been of limited effectiveness in promoting women's economic empowerment in the refugee settlements to date[32]. **There is a critical need for increased livelihood opportunities and self-reliance to enable refugee women and girls, men and boys to meet their basic needs and live beyond relief, as the foundation for addressing the social tensions that often lead to GBV.** CARE Uganda's programming in the West Nile refugee settlements to date has not included a strong focus on VSLA. The widespread emergence of self-organised women's savings groups in the refugee settlements however indicates strong demand for an approach that integrates the promotion of women and girls' economic empowerment in this way as part of the community based GBV mobilization and prevention model.

The persistence of strongly patriarchal, conservative norms in a context where violence has become normalized presents on-going challenges for the effective implementation of the community based GBV mobilization and prevention model in the refugee settlements. As documented in CARE Uganda's Knowledge Model paper on Women and Girls' Leadership, women and girls who are perceived by the wider community as transgressing cultural norms on what is socially acceptable behaviour can face the risk of violent backlash, as a result of rumours and malicious gossip. This risk has implications for the willingness of GBV survivors to report incidents of GBV; their willingness to take up referral services; as well as for the security of women CBFs and other volunteers who are working to promote community dialogue, activism and action on GBV and SRH issues. RMM in the refugee settlements have also experienced negative reactions from their peers and families to the progressive attitudes and behaviours they are encouraged to model. The existence of traditional justice systems for handling GBV cases in the refugee settlements can also present a challenge for meaningful GBV prevention and response, as traditional 'solutions' sometimes involve forced marriage of the survivor and perpetrator, and/or the payment of compensation to the survivor's family, without addressing the survivor's needs for PSS, medical care and justice.

[30] See end-line evaluations for the ADA funded Integrated Emergency Response Program in Imvepi Settlement, the GAC funded Lifesaving Shelter, Protection and Health Support project in Omugo Extension, Rhino Camp, and the NMFA funded project for Shelter and Livelihood Assistance also in Omugo Extension.
[31] Rujumba, J. & Kwiringira, J. 2018. 'Interagency Assessment on Measures, Services and Safeguards for the Protection of Women and Children against SGBV in Uganda'. Consultancy report for UNHCR.
[32] Interview with Carol Aol, WLiE coordinator, CARE Uganda (11/09/2019).

Working in urban contexts

To date, **CARE Uganda has little direct programming experience of implementing the community based GBV mobilization and prevention model in urban contexts** so this will be a new programming direction for WAYREP. Civil society organisations that are engaged in programming for GBV prevention and response in urban settings include Raising Voices – the NGO that developed the SASA! Methodology; the Centre for Domestic Violence Prevention (CEDOVIP) which piloted the use of SASA as an approach for the prevention of domestic violence in Kampala; and InterAid - a national level NGO which has been implementing multi-sectoral programming covering sectors of health, education, livelihoods and HIV/ AIDS with urban refugees in Kampala since 1995. Urban programming by these organisations currently focusses mainly in Kampala, and **the municipal authorities of both Gulu and Arua identified the lack of programming by development partners for GBV prevention and response in those urban centres as a critical gap that urgently needs to be addressed** in view of their growing populations.

There are some local NGOs engaged in GBV prevention and response in Gulu town, but the scale of their urban programming is reportedly limited and the programming models they are using are closely aligned with those of CARE Uganda[33]. For example, Thrive-Gulu is a local CSO that has been working in Gulu town since 2012 to promote trauma healing based on a holistic programming approach that involves providing counselling to individuals, families and groups, and promoting empowerment through VSLA and adult literacy interventions. Programming by Thrive Gulu also includes a community-level GBV prevention and response component implemented by community activists who are training in reporting, referral and case management of GBV cases[34]. The organization is now expanding its programming to include youth empowerment programming and to work in rural areas around Gulu town.

What aspects of the model can contribute to its success in urban contexts?

The following **enabling factors** were identified by CARE Uganda programme staff and stakeholders as being favourable for the implementation of the community based GBV mobilization and prevention programming model by WAYREP in Gulu and Arua towns:

- **The municipal authorities for Gulu and Arua are interested in working collaboratively with organisations such as CARE Uganda on the development of gender transformative programming approaches for GBV prevention and response.** The Community Development Officers from both towns recognised that there is some existing capacity at the municipal level for programming for GBV prevention and response while also highlighting the need for additional resources and capacity-building.
- **Local GBV action plans have been developed for both Gulu and Arua districts** articulating each district's vision, development goal, strategic objectives, strategies and areas for priority investment in programming for GBV prevention and response. For example, the local action plan for Arua district identifies strategic objectives for: reducing GBV cases; strengthening the capacity of local institutions to effectively and efficiently prevent and respond to GBV; supporting the mainstreaming of GBV interventions in all sectors of the District budget; and supporting monitoring, evaluation and learning. The proposed implementation strategies of the plan

Adapting the Community-based GBV Mobilisation & Prevention Model for Urban Programming

- **Psychosocial support** which could include adult literacy skills training will be a key entry point in urban settings.
- **Integrate approaches for promoting Women and Girls' Economic Empowerment** (e.g. VSLA, youth skills training) with flexible sequencing adapted to the needs of the target groups.
- **Build on the findings of the stakeholder mapping** to identify key structures to work with and through for community mobilisation and engaging target groups.
- **Support the strengthening of the referral pathway** by working with relevant urban service providers (e.g. police, health centres).
- **Support the development of a coordination mechanism at municipal level** to promote effective, collaborative working with municipal authorities and other stakeholders.

[33] Interviews with Geoffrey Oyat, Senior GBV Programme Manager, Gulu Women's Economic Development & Globalization (GWED-G, 05/09/2019), and Brenda Akidi, Senior Empowerment Manager, Thrive Gulu (05/09/2019).
[34] *Ibid.*

include a focus on empowering women and girls, men and boys to report GBV cases, and capacity-building to promote the institutionalization of gender transformative approaches. As such, **the local action plans at district level provide potentially useful frameworks for structuring WAYREP's implementation of the community-based GBV mobilization and prevention model in partnership with the municipal authorities.**

- There are **existing community-level structures in Arua and Gulu towns (e.g. slum dweller associations and refugee associations)** which would potentially provide the starting points for identifying, reaching and mobilizing the target groups of vulnerable women and youth (refugee, non-national and national) for WAYREP activities. In particular, it may be useful for the project to engage with local cultural and religious leaders through **the Arua Municipal Development Forum**, which meets monthly to discuss development issues affecting the municipality and which includes religious representation for Muslim and Christian groups as well as representatives from slum dweller associations, media, academic, business and partners[35].

What are likely to be the challenges of the model in urban contexts?

WAYREP target groups include refugees in Arua and Gulu towns, however identifying and locating refugees in those urban contexts is likely to be challenging as there is no formal mechanism for registering and managing refugees outside of the settlements and Kampala[36]. As noted in the Rapid Gender Analysis for Arua and Gulu towns, there are also different types of migrants in the towns, who are not refugees but who share the same ethnic and socio-economic profile to the WAYREP refugee target group, i.e. they are poor and not Ugandan. The experience of the Rise Up for Refugees project in Kampala identified additional potential challenges (security and legal issues) of working with migrants and unregistered refugees who do not have legal status in Uganda.

Language is also a challenge for programming with refugees and non-national GBV survivors who do not speak English or the local language, and who may therefore struggle to communicate with project staff and service providers, such as health workers, particularly in urban contexts where it may be more difficult to find people with the necessary language skills to provide translation support.

Poor people from both refugee and Ugandan national target groups in urban contexts are highly mobile, and this has several implications for programming in urban settings. It means that rates of drop-out by participants from project activities are likely to be higher than in rural settings, which needs to be taken into account for targeting and beneficiary selection. It also presents challenges for the delivery of group-based interventions, as vulnerable people in urban settings often don't have the same in-depth knowledge of their fellow community members as people in rural communities. **The risks of joining and working in a group are therefore higher in urban settings and it takes more time and investment to build trust within the group.**

Neither Gulu or Arua town have an established and operational GBV referral pathway, although local authorities have defined the referral pathway on paper in both districts. In Gulu town there is a GBV shelter, run by Action Aid – an international NGO – which provides shelter and PSS to GBV survivors. However, given that most prevention interventions are being implemented in rural areas outside Gulu municipality, awareness of the existence of the GBV shelter among the urban population is limited. Furthermore, the Gulu shelter does not support male GBV survivors, while in Arua, there is no GBV shelter at all. The Rapid Gender Analysis that was recently conducted by CARE Uganda in Arua and Gulu towns as one of the formative studies for WAYREP also found that **health, justice and legal services and resources for GBV survivors are insufficient in both contexts.** The lack of resources reflects the fact the budgets for and allocation of such services in those towns are based on demographic data that does not include refugees and non-nationals.

[35] Interview with Geoffrey Edema, Community Development Officer, Arua Municipality (09/09/2019)
[36] CARE Uganda. 2019. 'Rapid Gender Analysis and Gender Based Assessment in Arua District and Gulu Town'. WAYREP formative study (in draft). CARE Uganda.

Programming implications for WAYREP

CARE Uganda's programming experience with the population of the West Nile refugee settlements has shown that the community based GBV mobilisation and prevention model is relevant and effective in a displacement context. Given that many of the drivers of GBV (e.g. poverty, conservative social norms, highly vulnerable and mobile populations) are common to both the humanitarian and urban contexts, it seems reasonable to expect that the model can also be effectively adapted to address GBV in the urban context. Aspects of model that are designed to meet life-saving and urgent needs in the humanitarian context include its focus on the establishment of community-based support structures (CBFs, women's spaces, GBV information desks), and investment in solar lighting and shelter for PSNs. At the same time the model includes activities for engaging men and boys, training service providers to promote improved access to services by GBV survivors, and work with local opinion leaders, all of which aim to create an enabling environment for GBV prevention and response as part of longer-term sustainable solution.

WAYREP is designed to promote increased self-reliance of Ugandan and refugee community members in West Nile and Northern Uganda, particularly women and female youth. Working with refugee and national women and female youth by means of the community-based GBV mobilisation and prevention programming model will contribute to: Outcome 1, 'Enhanced safe, sustainable and dignified livelihoods/incomes for women and female youth', specifically their increased capacity to engage in economic activities; Outcome 2, 'Reduction of the acceptance and tolerance of GBV in target areas', and Outcome 3, 'Enhanced psychosocial support for survivors of GBV and abuse and exploitation', specifically in building their confidence and hope for the future. Based on this meta-analysis, programming implications for WAYREP to consider as it refines its implementation approach include:

Integrate the promotion of livelihoods opportunities and economic empowerment for vulnerable women and youth as a foundational element of the community-based GBV mobilisation and response model: Formative research for WAYREP (the Urban Rapid Gender Analysis) shows that refugees and the urban poor have low and irregular incomes and that poverty is a key driver of GBV. To engage these target groups effectively in programming for community based GBV mobilization and prevention WAYREP will need to find implementation strategies that enable women and youth to invest their time as participants in project activities while also meeting their day-to-day basic needs for survival. These strategies could include the provision of a multi-purpose cash transfer component over a defined period as a stepping-stone to enable project participants who do not have established IGAs to participate in and benefit from the project's activities for promoting resilience and empowerment, with the intention of enabling participants to ultimately "graduate" by becoming VSLA members. PSS, which could include an adult literacy and/or language training component, would also form a key part of this foundational stage.

Establish Community Spaces as the central mechanism for delivering a flexible "menu" of programming interventions for resilience and empowerment: Community Spaces structured along the same lines as Women's Spaces but available for use by men and boys could serve as multi-functional structures run by community-based Change Agents (or Community-based Facilitators) to deliver an integrated "menu" of programming interventions for resilience and empowerment. The menu of available interventions could include adult literacy groups, PSS and counselling, and women's leadership support, VSLA/ YSLA trainings, GBV case management and referral, and engaging men and boys activities. Change Agents would need to be selected to ensure representation of the target groups using the space, i.e. to include a mix of refugee and Ugandan female, male and youth facilitators.

Emphasize engaging men and boys activities with youth as a key element of programming for community based GBV mobilisation and prevention: Male Change Agents would receive RMM training as the basis for undertaking outreach activities - including the provision of PSS - with Male Action Groups through the Community Spaces. Unemployed male youth in urban and refugee settings would be specifically targeted for inclusion in the Male Action Groups. Participants of the MAGs should also be targeted for youth skilling trainings to enable them to develop IGAs as the basis for building long-term sustainable livelihoods. Couple seminars or seminars involving participants of the MAGs and their wives or female relatives should form part of the RMM training to mitigate the risk of backlash against men and boys demonstrating attitudes and behaviours that are supportive of gender equality.

Engage with existing formal and informal leadership structures, including cultural and religious leaders, to ensure their buy-in and support for community based GBV mobilisation and prevention: In practical terms, the starting point for this process could be the development of a Memorandum of Understanding by WAYREP with the municipal authorities of Arua and Gulu towns, that would speak to the existing GBV local action plan for each municipality, and that would provide an operational framework for project implementation in partnership with the municipal authorities. At the local level, the project will need to identify who are the key opinion leaders (including local government structures, service providers and cultural leaders) to engage with for a process of community-wide sensitisation and mobilisation. Capacity-building inputs with those opinion leaders on GBV and gender equality issues – which could involve the use of training resources developed by the Learning for Change programme - should form part of that initial process of engagement. The community mobilisation process would then involve engaging women, men and youth in identifying and discussing their respective needs and priorities as the basis for action planning for activities to be delivered through the Community Spaces. The process would involve a strong focus on exploring and challenging attitudes and social norms relating to gender roles and GBV.

Develop a WAYREP Learning and Communication System: WAYREP represents a unique opportunity to achieve deep impact at significant scale and therefore the production of knowledge and a strong learning agenda should be at the heart of the project's implementation. Developing a clear and focused learning and communication system around a set of core learning themes (based on assumptions and knowledge gaps) to generate evidence will support this. Learning themes relating to the community-based GBV mobilisation and prevention model could include: 1) A comparative analysis of the implementation approach and effectiveness of the model in urban and humanitarian contexts. This analysis would explore how the model can best be adapted for urban programming – what needs to change in terms of its implementation with different target groups (refugee and Ugandan national), how and why; 2) An analysis of the outcomes delivered by the adapted 'light touch' SASA! Approach being implemented through the WAY programme as compared with the standard SASA! model; 3) A cost-benefit analysis of how different interventions for promoting menstrual hygiene management by women and girls (e.g. Ruby cups as compared with the production of sanitary pads) contribute to reductions in GBV.

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CARE INTERNATIONAL

CARE is an international humanitarian aid organisation fighting global poverty, with a special focus on empowering women and girls to bring lasting change to their communities. CARE International has implemented development and humanitarian assistance projects in Uganda since 1969, targeting the most vulnerable communities, with a special focus on poor women and girls, who are the most at risk of rights' abuse and exploitation. Reaching 705,000 direct beneficiaries to date, our three programs, across 62 districts, consistently address the key drivers of poverty and social injustice in Uganda, namely prevailing gender inequality, widespread corruption and poor governance, and lastly the growing threat of climate change.

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