Highlights from the First-Ever Violence Against Children and Youth Survey in a Humanitarian Setting

Abstract

Background: Violence against children (VAC) has garnered attention as a priority issue, in part, due to the Violence Against Children and Youth Surveys (VACS). Although children are disproportionately represented among forcibly displaced people, VACS are a novelty in humanitarian settings.

Objective: This paper presents the approach to the first-ever humanitarian VACS (HVACS) implementation in Uganda, in addition to providing an overview of the results of this novel survey, along with their implications.

Participants and setting: Participants included 1,338 females and 927 males aged 13-24 years living in refugee settlements in Uganda.

Methods: This was a cross-sectional representative household survey conducted in all 13 refugee settlements in Uganda between March and April 2022. A three-stage sampling process was used to identify participants. Descriptive analysis was conducted, involving the application of sample weights to obtain estimates that are representative of the study population.

Results: VAC in refugee settings is pervasive, with females being more likely than males to experience sexual violence and males being more likely than females to experience physical violence. VAC perpetrators were mostly people who were known to child survivors. Whereas knowledge of where to seek help for violence was relatively high (more so for males compared to females), the levels of disclosure and help-seeking were very low for both groups.

Conclusion: Robust surveys that have traditionally excluded humanitarian settings can be conducted in these contexts. Data emanating from such surveys are critical for developing

appropriate guidance on interventions to appropriately address major public health issues, such as VAC.

Keywords: Violence; children; youth; refugee setting; Uganda

Background

Globally, violence against children (VAC) is now well-recognized as a major public health, human rights, and development issue worthy of attention and concerted action. Similar to violence against adults, VAC is no respecter of gender, class, ethnicity, and other statuses (Pinheiro, 2006). In addition to affecting a large proportion of children (with an estimated one out of two children worldwide experiencing some form of violence every year [WHO, 2020]), VAC is strongly associated with physical (Chiang et al., 2016), sexual (WHO, 2022), and mental (Hillis, Mercy, & Saul, 2017) health consequences, along with a range of health risk behaviors (WHO, 2022). VAC has a complex, layered, and cyclical effect not only on its survivors, who face higher risks of repeated abuse and violence perpetration in the future but also on the wider society, which pays a much higher economic cost, for example, than that invested to prevent VAC in the first place (Chiang et al., 2016).

In addition to other studies, the current legitimacy that VAC has garnered as a priority issue is in no small part due to the Violence Against Children and Youth Surveys (VACS). The VACS are population-based household surveys that measure the magnitude, context, and consequences of sexual, physical and emotional violence in childhood, adolescence, and young adulthood. To date, 26 VACS have been completed in sub-Saharan Africa, South-East Asia, Latin America and the Caribbean, with technical assistance from the U.S. Centers for Disease Control and Prevention (CDC) and other partners as part of the Together for Girls partnership (TfG, n.d.).

The VACS are situated in low- and middle-income countries and provide nationally representative data on violence against children and youth, which in turn inform national

prevention and response actions. The VAC survey scales the limitations of other surveys that capture violence against children by providing data on demographics and education, expanding the scope of perpetrator types and locations of incidents, collecting data on risk factors, protective factors, and consequences of violence as well as access to services for survivors (Chiang et al. 2016). The VACS carried out to date have generally excluded humanitarian-affected populations.

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

In response to these gaps and realities, in 2020, Together for Girls, the CDC, and the International Rescue Committee, along with other partners, developed guidance for implementing Humanitarian Violence Against Children and Youth Surveys (HVACS) (Chiang et al., 2020). This paper outlines core principles for adapting the original VACS (developed for non-humanitarian, non-displaced populations) to the realities of humanitarian settings. The paper presents highlights from the process of operationalizing the HVACS implementation guidance in refugee settings in Uganda. The HVACS fills gaps in evidence on VAC in humanitarian contexts, extending global understanding of such violence while also facilitating evidence-informed response to VAC in such contexts by governments and other actors (e.g., the UN

Refugee Agency [UNHCR]). The core principles outlined in the HVACS implementation guidance revolve around issues such as study design and sampling considerations, VACS questionnaire adaption, interviewer training, community entry, and ethical considerations. This paper delves into similar areas below, laying out how the guidance featured in the approach to the HVACS implementation in Uganda, in addition to providing an overview of the results of this novel survey.

Methods

Study design and sample

The standard VACS are nationally representative, cross-sectional household surveys of children and young adults ages 13-24 years (Chiang et al. 2016). Uganda's first-ever standard VACS was carried out in 2015 (MGLSD, 2015).

The Uganda HVACS was an adaptation of the standard VACS design, drawing on recent HVACS guidance for such adaptation within humanitarian settings (Chiang et al., 2020). Specifically, and in line with this guidance, a 'stand-alone' HVACS was conducted – that is, the survey focused solely on refugees without the inclusion of the host population in the study sample. The stand-alone approach to the HVACS was deemed most appropriate for Uganda, given the clear geographic location of many refugees in distinct settlements from which a representative sample of refugees could easily be drawn.

In summary, the Uganda HVACS was a representative, cross-sectional household survey of children and young adults ages 13-24 years from all 13 refugee settlements in the country. The settlements included Adjumani in Adjumani district, Bidibidi in Yumbe district, Imvepi in

Terego district, Kiryandongo in Kiryandongo district, Kyaka II in Kyegegwa district, Kyangwali in Kikuube district, Lobule in Koboko district, Nakivale in Isingiro district, Oruchinga in Isingiro district, Palabek in Lamwo district, Palorinya in Moyo district, Rhino in Madi-Okollo/ Terego districts, and Rwamwanja in Kamwenge district.

Sampling

The standard VACS uses a three-stage cluster and split sample design (Chiang et al., 2016). The three-stage cluster design entails sampling a specific number of enumeration areas (EAs) from a country's national sampling frame, selecting a fixed number of households from each sampled EA, and sampling one individual aged 13-24 years from each sampled household (ibid.). The split sample technique, on the other hand, involves drawing male and female samples from different EAs (ibid.). This approach serves to protect the confidentiality of participants and helps eliminate the chance that a perpetrator of sexual assault and the associated survivor of the opposite sex would both be interviewed in the same community.

The Uganda HVACS employed the standard VACS sampling design, as recommended in the HVACS implementation guidance, where feasible (Chiang et al., 2020). A three-stage sampling process was used to identify and recruit females and males aged 13-24 years for individual interview. The first stage entailed a random selection of zones, as defined by UNHCR, as the primary sampling unit from each of the settlements. A split sampling design was used whereby, in each settlement, zones selected for the female sample were distinguished from those for the male sample. Fifty-six zones (28 for female and 28 for male samples) were randomly sampled from the list of 109 zones that were provided by UNHCR and the Department of Refugees under the Office of the Prime Minister (OPM). In the second stage, a fixed number of households

(193 for female zones and 134 for male zones) was randomly sampled from each of the sampled zones. In the third stage, one eligible 13-24-year-old participant was randomly selected from each sampled household.

Recruitment, training, and data collection

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

The Uganda HVACS considered similar aspects in the selection and training of interviewers in the study. A total of 26 team leaders (16 females and 10 males) and 56 interviewers (34 females and 22 males) were identified and recruited for the survey in collaboration with UNHCR and OPM to ensure adequate representation of experienced refugees and host community members. One-third (33%) of the team leaders and interviewers were refugees, while the rest were from host communities. In addition, UNHCR facilitated the secondment of 32 case workers (23 females and nine males) from its implementing partner organizations to the study to offer counselling and/or referral to study participants requiring these services. The partners were specifically mandated by UNHCR to offer child protection and/or gender-based violence services in each refugee settlement at the time of the HVACS data collection. A total of five

UNHCR implementing partners played this role under the HVACS, namely: the Danish Refugee Council, Humanitarian Assistance and Development Services, International Rescue Committee, Lutheran World Federation, and Medical Teams International.

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

The study tool was translated from English into the local languages of Kinyabwisha, Kiswahili, Acholi, and Juba Arabic, as these were the most commonly used languages in the settlements. Team leaders and interviewers were assigned to communities based on their knowledge of the local language. Care was taken to ensure that interviewers who happened to be residents in refugee settlements were not assigned to zones in which they resided.

The training for the research teams was followed by a two-day field pre-test of the study tool and procedures in zones that were not sampled for inclusion in the survey before the commencement of data collection. The survey tool was programmed on Open Data Kit (ODK) survey software

and administered using tablets to allow for safe and electronic transmission of the data to a secure cloud server. Data collection was conducted between March and April 2022.

Community Entry

Community entry for the Uganda HVACS involved engaging with Uganda's Office of the Prime Minister (Department of Refugees) and UNHCR to discuss the study, build or bolster relationships, and obtain technical guidance and advice on study implementation. Discussions with UNHCR began at the regional level with the UNHCR East and Horn of Africa and Great Lakes (EHAGL) Regional Bureau, which in turn introduced the study team to the UNHCR country operation in Uganda. This led to an introduction to the relevant Working Groups (WGs) guiding program/research implementation and uptake (and, typically, led by UN organizations) in the settlements, such as the Child Protection Sub-Working Group and the Assessment Technical Working Group. These WGs harmonize the work being conducted in the settlements, helping to prevent the duplication of effort and to achieve synergy between the work of humanitarian actors. The HVACS questionnaire was shared with both WGs for review to ensure that the questions were appropriate for the study population.

To further ease community entry, OPM staff from the country's four regions participated in the data collection training sessions and ensured the study's introduction to settlement Commandants and Refugee Welfare Councils (RWCs) prior to fieldwork. RWCs are settlement-based, non-political replica of the local council government in Uganda (made up of elected refugee leaders, representative of the refugee population concerned, who report to OPM, UNHCR, and other humanitarian actors on all settlement matters), organized into three tiers (Levels 1, 2, and 3) (Okello & Sebunya, 2022). The research team specifically visited the RWC at Level 1, the

lowest tier, which was considered as being closest to the ground, given their oversight of the lowest level community unit (a zone or block). As a security measure, the RWCs linked the data collection team to community guides to accompany interviewers into the study zones to approach households.

Measures

The Uganda HVACS collected information to measure experiences of sexual, physical, and emotional violence based on similar indicators used in the standard VACS. Sexual violence included experiencing unwanted sexual touching, attempted forced sex, pressured or coerced sex, or physically forced sex. Measures of physical violence included being slapped, pushed, shoved, shaken, having something thrown at one, being punched, kicked, whipped, beaten with an object, choked, smothered, attempted drowning, being burned intentionally, or threatened with a knife, gun or other weapon. Emotional violence was measured as being told that one was not loved or did not deserve to be loved, being told they wished one had never been born or were dead, or being ridiculed or put down, for example, by being told that one was stupid or useless.

In addition, the Uganda HVACS drew on the questionnaire adaptations outlined in the implementation guidance for conducting a VACS in humanitarian settings (Chiang et al., 2020), including the introduction of new questions on whether each type of violence experienced (sexual, physical or emotional) occurred before or after arriving in the refugee settlement. Similar to standard VACS, the Uganda HVACS further collected information on perpetrators, the consequences of violence, and harmful practices such as child marriage. The HVACS implementation guidance indicates that additional questions could be incorporated into the survey to extend understanding of the humanitarian context concerned (ibid.). Accordingly, the

Uganda HVACS collected additional information on knowledge and experience of female genital mutilation (FGM) as well as on disability status based on indicators developed by the Washington Group on Disability Statistics.

Analysis

Similar to the standard VACS, analysis of the Uganda HVACS data considered the complex survey design by applying sample weights to obtain estimates that are representative of children and young adults living in refugee settlements. The sample weights were calculated as the product of the inverse of the probability of sampling zones, households within zones, and individuals within households adjusted for non-response at the household and individual levels as well as the population of children and young people ages 13-24 years living in the settlements as provided by UNHCR. Analysis was conducted separately for participants aged 13-17 years and 18-24 years and for females and males. As with standard VACS, estimates on the prevalence of childhood exposure to violence among survey participants ages 13-17 years were based on their experiences in the past 12 months preceding the survey, while estimates for survey participants ages 18-24 years were based on their experiences during their childhood (before age 18) rather than on their current or adulthood experiences. Estimates are presented together with 95% confidence intervals to assess whether differences between sub-groups are statistically significant. Despite the separate analyses by sex and age group, all HVACS participants responded to the same questions, except for those relating to pregnancy and FGM, which only applied to females.

Ethical considerations

The Uganda HVACS was approved by the Population Council Institutional Review Board (Protocol 986 dated October 21, 2021) and Mildmay Uganda Research Ethics Committee (MUREC), REF 0310-2021 dated November 24, 2021. The research was also granted regulatory approval by the Uganda National Council for Science and Technology (UNCST) – REF SS1130ES dated January 10, 2022. Participants provided verbal consent to participate in the research. Interviewers read to potential participants the informed consent document that was programmed in ODK. Participants were then given an opportunity to verbally indicate their willingness to participate in the research. The interviewers then recorded an electronic signature in the tablet to confirm that they read and personally explained to the participant the nature of the research. This approach was adopted to protect the privacy of participants, given that a signed informed consent document could be used to link a participant to the study and thus breach their privacy. Participants ages 18-24 years and emancipated minors ages 13-17 years provided individual consent. For dependant participants ages 13-17 years, interviewers first obtained permission from the parents or primary caregivers to talk to the eligible participant before obtaining assent from the participants. However, the parents/caregivers were given limited information about the objectives of the research to protect participants whose parents/guardians could be the perpetrators of violence. Specifically, the study was introduced to parents/guardians as one that focused on the 'Health and Life Experiences of Children and Young People in Humanitarian Settings in Uganda' rather than as a 'Violence Against Children and Youth' survey. Emancipated minors were defined under the survey as respondents aged 13 to 17 years who had assumed adult roles and responsibilities, including household headship, marriage, and/or procreation. Such respondents provided informed consent for study participation.

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

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

strategy was geared toward ensuring that the focus of the study was known only to the interviewee. Interviewers were trained to highlight VAC-related services in the directory for participants at the end of the interview.

Results

Response rates

A total of 5,087 households were sampled from 28 randomly selected zones for females, and 1,338 females completed the survey. The household response rate for females was 53.3%, while the individual response rate was 87.5%, giving an overall female response rate of 46.6%. For males, a total of 3,556 households were sampled from 28 randomly selected zones, and 927 males completed the survey. The household response rate for males was 56.1%, while the individual response rate was 90.1%, resulting in an overall response rate of 50.6% (Table 1).

Table 1: Response rate, Uganda HVACS 2022

Indicator	Females	Males
Number of sampled zones	28	28
Households		
Number of sampled households	5,087	3,556
Number of completed household listing	2,711	1,996
Household response rate (%)	53.3	56.1
Individuals		
Number of sampled individuals	1,530	1,029
Number of completed individual interviews	1,338	927
Individual response rate (%)	87.5	90.1
Overall response rate (%)	46.6	50.6

Prevalence, disclosure and help-seeking for sexual violence

Prevalence of childhood exposure to sexual violence (before age 18) among young people aged 18-24 years was higher among females compared to males (19% and 10%, respectively). However, a similar proportion of females and males aged 13-17 years had ever experienced

sexual violence (11% and 12%, respectively) or experienced sexual violence in the past 12 months preceding the survey (7% among females and a similar proportion among males; Table 2). The most common type of sexual violence was unwanted sexual touching for both females and males and across the two age groups (before age 18 among 18-24-year-olds and in the past 12 months preceding the survey among 13-17-year-olds; Table 2). In addition, the most common perpetrators of sexual violence were those who were known to the survivors, including intimate partners and classmates/schoolmates for both females and males across the two age groups (Table 2). Strangers also comprised a substantial proportion of perpetrators of sexual violence among females across both age groups (between 13% among 18-24-year-olds and 14% among 13-17-year-olds).

Table 2: Prevalence of childhood exposure to sexual violence, Uganda HVACS 2022

Indicator	Females % (95% CI)	Males % (95% CI)
	Prevalence of childhood exposure to sexual violence among 18-24-year-olds	
Experienced sexual violence before age 18	19.4 (9.5 – 35.7) (N=622)	9.5 (5.9 – 15.2) (N=395)
Type of sexual violence before age 18	(N=622)	(N=395)
Unwanted sexual touching	13.0 (4.8 – 30.8)	7.8 (4.9 – 12.4)
Unwanted attempted sex	10.5 (5.1 – 20.7)	5.0 (2.6 – 9.4)
Physically forced sex	8.1 (5.6 – 11.5)	2.3 (1.0 – 5.2)
Pressured sex	10.8 (6.4 – 17.6)	1.4 (0.5 – 3.7)
Perpetrators of first incident of sexual violence	(N=122)	(N=45)
Spouse/partner	30.5 (11.5 – 59.6)	28.7 (15.2 – 47.6)
Authority figure[a]	5.8 (2.8 – 11.5)	**
Class/schoolmate	22.2 (10.6 – 40.7)	17.0 (8.4 – 31.3)
Stranger	14.2 (8.8 – 22.1)	**
	Prevalence of sexual violence among 13-17-year-olds	
Ever experienced sexual violence	10.7 (6.1 – 18.2) (N=713)	11.6 (6.5 – 19.6) (N=522)
Experienced sexual violence in the past 12 months	7.0 (3.8 – 12.5) (N=713)	7.0 (3.8 – 12.3) (N=522)
Type of sexual violence experienced past 12 months	(N=713)	(N=522)
Unwanted sexual touching	6.5 (3.3 – 12.3)	6.0 (3.5 – 10.2)

Unwanted attempted sex	0.5 (0.1 – 1.9)	**
Physically forced sex	0.1 (0.0 – 0.6)	1.1 (0.3 – 4.5)
Pressured sex	0.4 (0.1 – 2.1)	0.7 (0.1 – 4.9)
Perpetrators of most recent incident of sexual violence	(N=36)	(N=33)
Spouse/partner	28.8 (9.4 – 61.3)	12.0 (3.2 – 36.1)
Authority figure[a]	1.9 (0.2 – 15.1)	**
Neighbor	10.6 (4.5 – 23.2)	6.6 (1.5 – 25.1)
Class/schoolmate	41.5 (19.0 – 68.3)	2.9 (0.6 – 12.7)
Friend	4.6 (1.0 – 18.7)	57.9 (32.7 – 79.6)
Stranger	12.6 (3.3 – 37.8)	5.2 (0.9 – 25.5)

Notes: [a]Authority figure includes: includes teacher, security officer, employer, community/religious leader, aid worker or medical professional; ** Unreliable estimate (relative standard error is greater than 50%), estimate is suppressed; CI – confidence interval; *Source:* Uganda HVACS (2022).

Disclosure of sexual violence was low for both females and males across the two age groups (ranging from 6% to 31% depending on age group and sex of participant) although it was much lower among 13-17-year-olds who experienced sexual violence in the past 12 months than among 18-24-year-olds who experienced sexual violence before age 18; Table 3). There was, however, a higher level of knowledge of where to seek help compared to the level of disclosure among both males and females across the two age groups, although a higher proportion of males compared to females knew of where to seek help. Help-seeking for sexual violence was also very low for both females and males across the two age groups (ranging from 2% to 18% depending on age group and sex of participant; Table 3).

Table 3: Disclosure and help-seeking for sexual violence, Uganda HVACS 2022

Indicator	Females % (95% CI)	Males % (95% CI)
	Disclosure and help-seeking for sexual violence prior to age 18 among 18-24-year-olds	
	(N=122)	(N=45)
Told someone about violence	17.1 (11.8 – 24.0)	30.6 (18.0 – 46.9)
Knew of a place to get help	54.8 (36.0 – 72.3)	73.0 (59.6 – 83.2)
Sought help	5.1 (1.8 – 14.0)	17.2 (5.6 – 42.1)
	Disclosure and help-seeking for sexual violence in the past 12 months among 13-17-year-olds	
	(N=36)	(N=33)
Told someone about violence	6.4 (1.5 – 22.8)	5.7 (0.9 – 27.8)
Knew of a place to get help	30.4 (12.9 – 56.2)	70.9 (50.2 – 85.5)
Sought help	2.0 (0.3 – 13.2)	**

Notes: ** Unreliable estimate (relative standard error is greater than 50%), estimate is suppressed; CI – confidence interval; *Source:* Uganda HVACS (2022).

Prevalence, disclosure and help-seeking for physical violence

Prevalence of childhood exposure to physical violence among young people aged18-24 years was higher among males compared to females (41% and 28%, respectively; Table 4). The prevalence of physical violence in the past 12 months preceding the survey among 13–17-year-olds was similarly higher among males compared to females (35% and 26%, respectively). Among both females and males aged 18-24 years, the most common perpetrator of the first incident of physical violence experienced before age 18 was a peer (25% and 46%, respectively), followed by a parent or adult caregiver (23% and 41%, respectively), an intimate partner for females, and an adult community member for males (Table 4). The most common perpetrator of physical violence experienced in the past 12 months by 13-17-year-old females and males was an adult community member (16% and 19%, respectively), followed by a peer for females, and a parent or adult caregiver and peer for males (Table 4).

Table 4: Prevalence of childhood exposure to physical violence, Uganda HVACS 2022

Indicator	Females % (95% CI)	Males % (95% CI)
	Prevalence of childhood exposure to physical violence among 18-24-year-olds	
Experienced physical violence before age 18	27.6 (22.2 – 33.8) (N=622)	40.9 (31.4 – 51.3) (N=522)
Perpetrators of first incident of physical violence	(N=622)	(N=395)
Intimate partner[a]	16.6 (13.5 – 20.1)	4.7 (2.9 – 7.6)
Parent/adult caregiver	23.3 (18.9 – 28.2)	41.2 (28.6 – 55.1)
Adult community member	11.1 (6.9 – 17.2)	29.4 (19.1 – 42.2)
Peer	24.9 (18.5 – 32.6)	46.4 (35.0 – 58.2)
Witnessing physical violence before age 18	(N=622)	(N=395)
In the home	33.0 (27.7 – 38.7)	43.9 (32.8 – 55.6)
In the community	23.5 (18.1 – 30.0)	41.5 (31.8 – 51.9)
	Prevalence of childhood exposure to physical violence among 13-17-year-olds	
Ever experienced physical violence	37.8 (27.0 – 50.0)	60.7 (51.4 – 69.3)
Experienced physical violence in the past 12 months	25.7 (18.2 – 35.0) (N=716)	34.8 (24.3 – 47.0) (N=532)
Perpetrators of most recent incident of physical violence	(N=716)	(N=532)
Intimate partner[a]	0.5 (0.1 – 3.6)	2.5 (0.3 – 16.3)
Parent/adult caregiver	6.5 (3.5 – 11.6)	16.8 (11.5 – 23.8)
Adult community member	16.1 (10.5 – 24.0)	18.6 (11.6 – 28.4)
Peer	13.9 (8.7 – 21.4)	15.7 (10.1 – 23.8)
Witnessing physical violence in the past 12 months	(N=716)	(N=532)
In the home	58.0 (45.5 – 69.5)	41.5 (25.3 – 59.6)
In the community	70.1 (50.3 – 84.4)	61.7 (48.9 – 73.1)

Notes: [a]Among those ever partnered (18-24 years: N=472 for females and N=245 for males; 13-17-year-olds: N=110 for females and N=86 for males); CI – confidence interval; *Source:* Uganda HVACS (2022).

Witnessing physical violence in the home or community is another indicator of prevalence of this type of violence. The proportion of young people aged 18-24 years who witnessed physical violence in the home or community before age 18 was higher among males compared to females (Table 4). In contrast, the proportion of those aged 13-17 years who witnessed physical violence in the home or community in the past 12 months preceding the survey was higher among females compared to males (Table 4).

Similar to the observed pattern following sexual violence, disclosure and help-seeking for physical violence were very low for both females and males and across the two age groups (physical violence experienced before age 18 among 18-24-year-olds and in the past 12 months among 13-17-year-olds). Knowledge of where to seek help for physical violence was higher compared to the level of disclosure and help-seeking for both females and males across the two age groups (Table 5).

Table 5: Disclosure and help-seeking for physical violence, Uganda HVACS 2022

Indicator	Females % (95% CI)	Males % (95% CI)
	Disclosure and help-seeking for physical violence prior to age 18 among 18-24-year-olds	
	(N=158)	(N=127)
Told someone about violence	6.3 (2.5 – 15.2)	9.0 (3.4 – 21.5)
Knew of a place to get help	51.7 (29.2 – 73.6)	70.2 (58.3 – 79.9)
Sought help	3.4 (1.3 – 8.7)	1.0 (0.2 – 6.0)
	Disclosure and help-seeking for physical violence in the past 12 months among 13-17-year-olds	
	(N=176)	(N=156)
Told someone about violence	2.5 (0.9 – 6.7)	0.9 (0.1- 6.3)
Knew of a place to get help	41.2 (31.2 – 52.0)	48.7 (31.9 – 65.9)
Sought help	0.6 (0.1 – 3.4)	0.4 (0.1 – 3.2)

Notes: CI – confidence interval; *Source:* Uganda HVACS (2022).

Prevalence of emotional violence

A higher proportion of males compared to females aged 18-24 years reported experiencing emotional violence from a parent, adult caregiver, or other adult relative before age 18 (23% and 14%, respectively; Table 6). In contrast, a slightly higher proportion of females compared to males aged 13-17 years experienced emotional violence from a parent, adult caregiver or other adult relative in the past 12 months preceding the survey (14% and 10%, respectively; Table 6).

Table 6: Prevalence of emotional violence among 13-24-year-olds

Indicator	Females % (95% CI)	Males % (95% CI)
Emotional violence among 18-24- year-olds [a]	(N=622)	(N=395)
Experienced emotional violence before age 18	14.2 (9.6 – 20.5)	22.5 (17.7 – 28.2)
Emotional violence among 13-17- year-olds	(N=716)	(N=532)
Ever experienced emotional violence[b]	23.8 (19.1 – 29.3)	25.4 (17.4 – 35.5)
Experienced emotional violence in the past 12 months [a]	13.8 (8.7 – 21.3)	10.3 (6.5 – 16.0)

Notes: [a]Emotional violence by a parent, adult caregiver or other adult relative; [b]Emotional violence from anybody; CI – confidence interval; *Source:* Uganda HVACS (2022).

Overlap of types of violence experienced in childhood

Half of males and 43% of females aged 18-24 years experienced any type of violence (sexual, physical, or emotional) prior to age 18, while 5% of males and 4% of females experienced all the three types of violence in their childhood (Table 7). Physical and emotional violence were the most common forms of overlap of types of violence experienced before age 18 by both females and males (9% and 16%, respectively). Among 13-17-year-olds, 65% of males and 49% of females reported ever experiencing any type of violence while 40% of males and 32% of females experienced any type of violence in the past 12 months. Similarly, physical and emotional violence were the most common forms of overlap of types of violence experienced in the past 12 months by females and males aged 13-17 years (Table 7).

Table 7: Overlap of types of physical violence experienced in childhood, Uganda HVACS 2022

Indicator	Females % (95% CI)	Males % (95% CI)
	Overlap of types of childhood violence among 18-24-year-olds	
Experienced any type of violence before age 18	42.6 (31.1 – 54.9) (N=622)	49.6 (42.7 – 56.6) (N=522)
Multiple types of violence	(N=622)	(N=395)
sexual and physical violence	8.3 (4.5 – 14.8)	6.9 (3.7 – 12.6)
sexual and emotional violence	4.6 (1.9 – 10.5)	5.1 (2.2 – 11.3)
physical and emotional violence	9.2 (6.3 – 13.2)	16.1 (10.6 – 23.6)
sexual, physical, and emotional violence	3.3 (1.5 – 7.4)	4.7 (1.9 – 11.2)
	Overlap of types of childhood violence among 13-17-year-olds	
Ever experienced any type of violence	48.9 (39.9 – 58.0) (N=716)	65.0 (56.1 – 73.0) (N=532)
Experienced any type of violence in the past 12 months	32.0 (22.5 – 43.2) (N=716)	40.0 (29.9 – 51.0) (N=532)
Multiple types of violence	(N=716)	(N=532)
sexual and physical violence	4.2 (2.1 – 8.3)	3.0 (1.4 – 6.6)
sexual and emotional violence	0.6 (0.2 – 2.4)	1.0 (0.3 – 3.3)
physical and emotional violence	7.0 (4.7 – 10.3)	7.0 (3.7 – 12.8)
sexual, physical, and emotional violence	3.0 (1.4 – 6.3)	0.8 (0.2 – 2.3)

Notes: CI – confidence interval; *Source:* Uganda HVACS (2022).

Setting for incidents of childhood abuse

About three-quarters (73%) of females and 53% of males aged 18-24 years who experienced sexual violence before age 18 underwent their first incident after arriving in the refugee settlement (results not shown in a table). Two-thirds (67%) of females and 43% of males aged 18-24 years who experienced physical abuse before age 18 underwent the first incident after they arrived in the refugee settlement. The pattern was similar for emotional abuse, with 89% of females and 43% of males aged 18-24 years who experienced such abuse before age 18 undergoing the first incident after arriving in the refugee settlement (results not shown in a table).

Discussion

Despite the recognition of VAC as a predicament in humanitarian contexts, and the utility and global spread of the Violence Against Children and Youth Surveys, the latter are still a novelty in humanitarian settings. This paper documents the process of drawing on existing implementation guidance to conduct the first-ever humanitarian VACS. Focusing on refugee settlements in Uganda, the paper demonstrates that robust guidance, strong partnerships, the involvement of humanitarian populations, close attention to ethics, and careful community entry are helpful for delivering a successful HVACS.

Findings from the Uganda HVACS confirm that VAC in refugee settings is pervasive, with half of males and close to half of females aged 18-24 in the refugee settlements experiencing either sexual, physical, or emotional violence during childhood. The prevalence of such forms of violence is even higher among children aged 13-17 – at 65% for males and 49% for females. A disaggregation of these forms of violence draws attention to how experiences of sexual violence evolve as children transition from childhood to adulthood: females in the 18-24-year-old age range experience sexual violence at twice the rate of their male counterparts, despite the prevalence by sex of participants being similar at ages 13-17. This suggests that intensified sexual violence prevention efforts are required during the childhood years to stem the tide of increased sexual violence exposure among girls as they grow older. In the immediate term, while not overlooking males, response efforts targeting older (ages 18 and above) female survivors of sexual violence, in particular, are needed, given their higher level of risk for this kind of violence over time.

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

Results from the Uganda HVACS demonstrate that children in refugee settings are more likely to know where to seek care for violence than they are to disclose their experience of violence. Disclosure of sexual and physical violence was notably low among respondents of all age groups. These results suggest that VAC services are under-utilized in refugee contexts and that interventions are needed to promote disclosure and help-seeking among this population. Children aged 13-17 may also require special support to access the VAC services they need. The low service uptake by respondents reporting sexual violence could also be related to the fact that much of the sexual violence reported entailed unwanted sexual touching, and respondents may have believed that services were not available for forms of sexual violence outside of rape.

Awareness-raising interventions could help to dispel any notions (among community members and program implementers alike) that some forms of violence are less serious than others, while further attention is given to developing models for responding to nascent forms of sexual violence.

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

A unique challenge to the Uganda HVACS that is not experienced in the standard VAC surveys was the mobility of households which resulted in a low response rate at the household level. The overall response rates (both household and individual response rates) are over 80% in most countries where the standard VACS have been conducted (Chiang et al. 2016). For the Uganda HVACS, the overall response rates were much lower. The low household response rates reflect challenges related to locating sampled households, which is expected in refugee settings. However, upon identification of sampled households, the likelihood of eligible participants consenting to participate in the survey was high for both females and males. The most common reason for failure to locate sampled households was the relocation to other places not designated as refugee settlements for reasons such as job-seeking, repatriation, migration to urban centers for access to better services, education, engaging in cross-border business activities, and the desire to live around those with similar cultural backgrounds. Some households could also not be

located because of discrepancies between the names used in official UNHCR documents and the colloquial names used in the community.

An important question that is not answered in this paper is how the magnitude of VAC in refugee settings compares with the national setting. In Uganda, data on the prevalence of VAC in the national setting are available from the 2015 National VACS (MGLSD 2015). However, the estimates from this national survey and the HVACS are not directly comparable for several reasons. First, each study relies on different sampling frames. In particular, the sampling frame for the national survey was based on the 2014 Uganda population and housing census (comprising Ugandans, primarily), while the sampling frame for the HVACS was based on the 2022 refugee population provided by UNHCR, which comprises population figures pertaining to time periods that are eight years apart (and to a population composed primarily of South Sudanese and others displaced from their countries of origin). Second, the two surveys were conducted almost seven years apart, and any differences in the magnitude of violence could be due to temporal variations in the prevalence of violence in response to the intensity of interventions to address VAC or the lack thereof. Third, the humanitarian crisis due to displacement places refugees at a greater risk of violence and, therefore, requires emergency responses that might mitigate some of the risks of violence compared to national settings.

Conclusion

Robust surveys that have traditionally excluded humanitarian settings can be conducted in these contexts with proper guidance, strong partnerships, the involvement of humanitarian populations, close attention to ethics, and careful community entry. Data emanating from such surveys are

critical for developing appropriate guidance on interventions to appropriately address major public health issues, such as violence against children.

Funding

This work was supported by the UK Aid from the UK Foreign, Commonwealth and Development Office (FCDO) through the Baobab Research Programme Consortium.

Role of Funding Source

FCDO did not play any role in the design of the research, collection, analysis and interpretation of the data, writing the manuscript, or the decision to submit the manuscript for publication.

Declaration of interest

The authors declare that they have no conflict of interest.

References

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

Chiang, L.F., Kress, H., Sumner, S.A., Gleckel, J., Kawemama, P., & Gordon, R.N. (2016). Violence Against Children Surveys (VACS): towards a global surveillance system. *BMJ Injury Prevention* 22 (Issue Suppl 1):1-16.

Hillis, S.D., Mercy, J.A., & Saul, J.R. (2017). The Enduring Impact of Violence Against Children. *Psychology, Health & Medicine* 22(4):393-405.

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

Mballa, C., Ngebeh, J., De Vriese, M., Drew, K., Parr, A., & Undie., C. (2020). UNHCR and Partner Practices of Community-Based Protection across Sectors in the East and Horn of Africa and the Great Lakes Region. Nairobi: UNHCR and Population Council.

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

Okello, O. & Sebunya, H.N. (2022). Refugee Welfare Councils as Spaces for Political Participation of Refugees in Uganda. Kampala, Uganda: Konrad Adenauer Stiftung website. Accessed 24 August 2023, https://tinyurl.com/4xhmu7jc.

Pinheiro P.S. (2006). World Report on Violence Against Children. Geneva, Switzerland: United Nations.

TfG (Together for Girls). n.d. About the Violence Against Children and Youth Surveys [Fact Sheet]. Together for Girls. https://www.togetherforgirls.org/en/about-the-vacs.

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

Undie, C., Ngebeh, J., Namwebya, J.H., & Karugaba, J. (2019). Practice-based learning: Observations on One-Stop Centers in refugee settings. Sauti/VOICE Program Brief no. 5. Nairobi: UNHCR EHAGL Africa Bureau and Population Council. https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1095/.

WHO (World Health Organization). (2022). Violence Against Children [Fact Sheet]. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/violence-against-children.

WHO. (2020). Global Status Report on Preventing Violence Against Children. Geneva: World Health Organization.