GENDER-BASED VIOLENCE KNOWLEDGE, ATTITUDES AND PRACTICES SURVEY IN SOUTH SUDAN

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Publisher: International Organization for Migration
17, route des Morillons
P.O. Box 17
1211 Geneva 19
Switzerland
Tel: +41 22 717 91 11
Fax: +41 22 798 61 50
Email: hq@iom.int
Internet: www.iom.int

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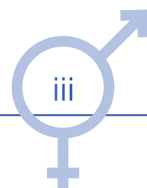
GENDER-BASED VIOLENCE KNOWLEDGE, ATTITUDES AND PRACTICES SURVEY IN SOUTH SUDAN

Empowered lives.
Resilient nations.



Foreword

Gender-based violence (GBV) causes long-lasting and detrimental impacts on the physical, psychological and social well-being, safety and sovereignty of the individual, family and everyone it affects. Effects of such violence is further compounded by inadequacy, and lack of access to quality and appropriate health-care and psychological support, as well as lack of appropriate security, redress and access to justice. But as with anything, the first step towards solutions is to quantify and qualify the problem more fully to identify how vulnerable populations are being affected, what their responses are, and what needs to be done further to alleviate the situation of those affected. The stakeholders involved in this research were numerous, and together have implemented a study, the first of its kind and magnitude in the country, resulting in concrete recommendations on how to improve GBV interventions in the future. This is a major step forward in informing GBV prevention and response activities in the country.

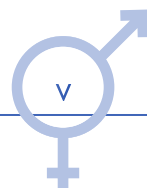
We would like to express our deepest appreciation to the International Organization for Migration (IOM) for leading this exercise, and we are looking forward that these recommendations are streamlined across all GBV work in the country.

Many thanks and regards,

Ms Awut Deng Acuil
Minister
Ministry of Gender, Child and Social Welfare

Dr Riak Gai Kok
Minister
Ministry of Health

Dr Esterina Novello Nyilok
Chairperson
South Sudan HIV/AIDS Commission



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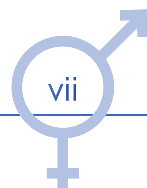
Our special thanks go to the data collection institutions, Ipsos Limited and Tango research firm, for their technical and human resource participation in the study. Thank you to the research team who showed impressive determination to ensure the study's success despite a few security challenges and threats, which proved that there is a great need for GBV interventions that we hope this study will provide for. Our thanks go to all the women, girls, men and boys who participated in the study. We hope this information will contribute to improving their lives.

We would like to extend special appreciation to the lead consultant Dariusz Dziewanski, for his dedication and commitment to conduct this large-scale sensitive survey in a humanitarian crisis setting. The leadership of the GBV sub-cluster, including the Strategic Advisory Group members who provided technical input to the whole study, also deserves acknowledgement.

Funding was generously provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria through UNDP as the principal recipient.



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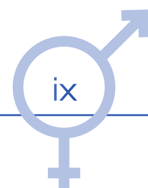

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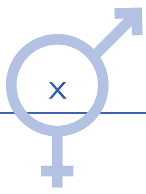

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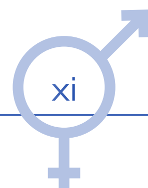

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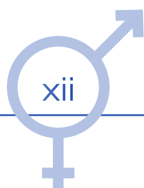

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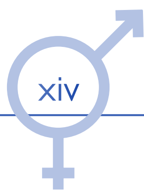
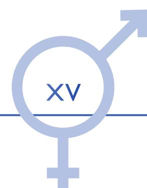
Acronyms and abbreviations

AIDS	Acquired immunodeficiency syndrome
CHW	Community health worker
CRSV	Conflict-related sexual violence
FGD	Focus group discussion
FSW	Female sex worker
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IDP	Internally displaced person
IMC	International Medical Corps
IOM	International Organization for Migration
IPV	Intimate partner violence
KAP	Knowledge, attitudes and practices
KII	Key informant interview
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MGCSW	Ministry of Gender, Child and Social Welfare
NBS	National Bureau of Statistics
PHCC	Primary health-care centre
PHCU	Primary health-care unit



PoC	Protection of civilians
SASA!	Start, Awareness, Support, and Action!
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNSCR	United Nations Security Council Resolution
VAWG	Violence against women and girls
WASH	Water, sanitation and hygiene
WHO	World Health Organization



Executive summary

Gender-based violence (GBV) is pervasive throughout South Sudan. The renewed fighting in 2016 has only worsened the deep suffering and humanitarian needs of civilians, with conflict seriously exacerbating gendered violence. GBV has devastating impacts, resulting in long-term physical, psychological and social traumas that can affect individuals, families and communities for decades. The effects of such violence are further compounded by lack of access to appropriate medical and psychological support, as well as lack of appropriate security and justice.

To help understand the problem of GBV in South Sudan, the International Organization for Migration (IOM), with the help of its national and international partners,[1] undertook a large-scale study of the knowledge, attitudes and practices (KAP) related to GBV in the country. The study aimed to collect baseline information across a number of states – Western Bahr el Ghazal, Central Equatoria, Eastern Equatoria, Western Equatoria, Upper Nile and Unity – about current KAP regarding GBV, sexual and reproductive health (SRH) and gender norms among key populations of humanitarian concern, including internally displaced persons (IDPs) in protection of civilian (PoC) sites, host communities and female sex workers (FSWs).

The research methodology utilized both primary and secondary sources. Primary research relied on both quantitative and qualitative data, interviewing women and girls 16 years and over. A household survey sample was designed to produce representative statistics for populations in host communities and PoCs, using two-stage cluster sampling, while snowball sampling was chosen as an appropriate sampling strategy for FSWs. The study also utilized key informant interviews with stakeholders from the national level to capture high-level dynamics of GBV and SRH, as well as stakeholders operating within PoCs and host communities to

1 In particular, the study was done in close collaboration with the Ministry of Health and the Ministry of Gender, Child and Social Welfare, as well as with the South Sudan gender-based violence (GBV) sub-cluster.

draw from local-level experiences. Focus group discussions were also carried out with men and women in PoCs.

The key findings and recommendations from the research study are outlined below:

Experiences and perceptions of violence and safety

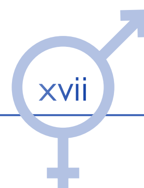
- There is a high level of intimate partner violence (IPV) perpetrated against women and girls. About 75.2 per cent (n = 2,105) of the respondents had experienced any kind of IPV ranging from threats to forced sexual acts. FSWs were the most likely to be affected by violence in intimate relationships.

- Approximately 46 per cent reported at least one incident of GBV against a female in the household within the last year (n = 3,084), with FSWs more likely to report a GBV incident in their household than IDPs in PoCs and respondents from host communities. Due to high levels of stigma, risks of retaliation from perpetrators and normalization of GBV, it is probable that actual prevalence of all types of GBV are likely to be higher than those reported.[2]

- Rape was reported to have been perpetrated against women and girls in sampled household by over one quarter of the respondents within a one-year recall period. Higher rates of reporting of rape, rather than other forms of GBV, indicate conflation of rape with the term GBV, and lack of recognition of other forms of GBV including child marriage and forms of IPV.

- Bride price was used to formalize the majority of marriages among respondents (69.4%, n = 2,048). The study showed a strong causal link between the payment of bride price and the frequency of GBV in a relationship.

2 World Health Organization (WHO), *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* (WHO, Geneva, 2007), p. 1.



- Location of reported GBV incidents in PoC sites were predominately at water points (for rape and psychological abuse), during firewood collection (for rape) or in their home (for physical violence). The majority of incidents of GBV among host communities and FSWs occurred in the home for psychological and physical abuse or in a public place/on the street for rape and psychological abuse.

Prevention and mitigation

Prevention of GBV can only be achieved by addressing the root causes at the individual, relationship, family, community, society and institutional levels. Harmful gender norms, perpetuating inequality and lower social status and power differences between men and women, combined with the normalization of violence, are significant factors driving GBV.

The following gender norms and attitudes are held among women and girls in the target communities:

- Avoiding pregnancy is primarily a woman's responsibility; however, in contradiction, a woman cannot refuse sex if her partner wants it. By extension, 52 per cent do not believe that rape can take place in marriage, and 49.4 per cent disagreed that a wife can ask her husband to wear a condom.

- The majority believe that male dominance in marital sexual relations is justifiably enforceable through violence if she refuses to have sex with him, if she neglects the children or argues with him or leaves the house without first asking his permission.

- Worsening economic conditions as a result of conflict were reported to be causing stresses in the household, which may result in violent behaviour by men seeking to exert power and express frustration as a result of their growing marginality. Other factors also contribute; for instance, alcohol abuse was cited during qualitative research as another key factor in IPV, and to a less extent, rape.

- Many respondents hold attitudes that justify rape and blame victims. More than half of the respondents agree that women can contribute to rape by being alone with a man and/or by wearing revealing clothes.

- There is a high level of disagreement that men (47.2%, n = 2,930) or boys (45.7%, n = 2,920) can experience rape.

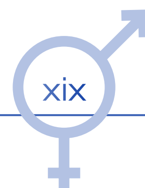
- More than 4 in 10 respondents agreed that child marriage is acceptable to solve the financial problems of the family. Fifty-seven (57) per cent (n = 3,115) disagreed or strongly disagreed that the practice can negatively affect the health of a girl.

- The majority of women and girls interviewed were aware of the term "GBV", and moreover, IDPs in PoCs were most likely to affirm this. This likely indicates more of a familiarity with humanitarian language, since most equated GBV with different types of violence or suggested definitions of violent acts by males against females, without linking violent behaviour to patriarchal structures or unequal gendered power relations.

Support-seeking behaviour and response

- Women and girls who experience GBV are commonly afraid of further violence from perpetrators, lack trust in service providers and think "nothing could be done". This indicates a lack of awareness among respondents about the consequences of GBV, potential support services for recovery and raises concerns about GBV service provision. Qualitative findings indicate that women and girls are concerned about confidentiality particularly among health providers and the police.

- Despite these concerns, the vast majority (82.7%, n = 1,037) of women and girls reported that GBV incidents against women and girls in their household in the last year were reported to a service provider. More than half of the respondents first disclosed GBV incidents to police, while approximately a quarter went to a health facility first, followed by psychosocial actors.



- About 88.4 per cent (n = 2,324) of all respondents indicated some awareness of physical and mental health services. Both IDPs in PoCs and FSWs were considerably more likely to know of the availability of such services. Almost 7 in 10 of all respondents cited hospitals as a place that women and girls could seek GBV services; followed by primary health-care centres (PHCUs) and primary health-care units (PHCCs). Less than 1 in 10 linked traditional healers or religious healers to GBV response.

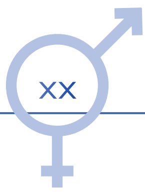
- Two thirds of the respondents said they had heard of SRH, and most of these respondents indicated that they also knew of some SRH services in their community. People generally related definitions of SRH only to the provision of contraception and notions of safe sex. Although formal health-care services were most likely to be accessed by women and girls for SRH, respondents who sought support through the informal health system were more satisfied.

- At present, the provision of GBV and SRH response services in South Sudan is patchy and inconsistent due to shortages in funding, with resources often concentrated in urban centres or in PoCs.

- A significant number of respondents stated that the incident had been reported within a few hours for physical and psychological violence; however, the timing of reporting was more likely delayed among survivors of rape (57.6% reporting immediately). IDPs in PoCs were the least likely to report an experience of GBV immediately, with 16.3 per cent waiting some weeks or months.

The situation of female sex workers

Because of the clandestine nature of the sex industry, little information exists about FSWs in South Sudan. This study, however, aims to contribute to the understanding of sex workers, and to develop effective GBV and human immunodeficiency virus (HIV) prevention and response strategies for this group in South Sudan.



- The vast majority of FSWs stated they undertook sex work a month before the survey, with over half having done so more five or more times.

- There are relatively higher rates of GBV reported among FSW households, particularly different forms of IPV, potentially a reflection of the more precarious financial and social position of this target group.

- Sex work comes with a significant cost to physical safety, with almost 6 in 10 FSWs reporting they had ever been subjected to physical and sexual violence because of the work they do. More than one third had been arrested, and almost half reported being refused protection by police and other security actors, which indicates that this group is particularly vulnerable to interactions with security forces that violate their rights.

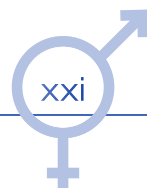
- In terms of SRH, the vast majority of FSWs reported having been tested for HIV in the last year; however, it is important to note that snowball sampling is likely to have skewed the sample to those already in contact with service providers. Of the almost half whom tested HIV positive, the overwhelming majority were receiving some form of treatment. Most FSWs interviewed also reported condom usage with their most recent paying client.[3]

Recommendations

The Government of South Sudan – including the Ministry of Justice, Ministry of Defence, Ministry of Health and Ministry of Gender, Child and Social Welfare (MGCSW) – with the Health cluster, GBV sub-cluster and other international partners, should collaborate on the following efforts:

- This research confirms there is a high level of experienced incidents of GBV by women and girl respondents – from rape, to child marriage and different forms of IPV – as well as high

3 It should be noted that because FSWs were drawn from networks connected to the activities of IOM and its partners, research is likely to oversample those respondents who are familiar with GBV and the services available to respond to it.



level of perceived risk of different forms of physical, psychological and sexual violence both inside and outside the PoCs. Therefore, GBV programming should be broadened beyond the PoCs to expand and provide more sustainable services to more inaccessible populations. Health partners are recommended to ensure resources for increasing the scope of access to clinical management of rape services in hospitals, PHCCs and PHCUs at the same time addressing quality of service provided.

- Although there is a good level of knowledge about GBV service availability within the formal health-care system, there is still limited understanding of consequences, the importance of seeking services early and there are significant concerns around safety and confidentiality of services. Therefore, there is a need for investment in continued awareness-raising efforts on GBV and for capacity-building for multisectoral service providers to enable them to provide safe, confidential and survivor-centred services. Furthermore, there is a need to develop, disseminate and monitor the implementation of the referral pathway and standard operating procedures.

- There is limited understanding of the different types of GBV, conflating it with sexual violence, yet other types of GBV – including different forms of IPV and child marriage – are common and culturally condoned. There is a critical need for more awareness-raising on what GBV is, its forms and consequences among communities, local authorities and traditional leaders, as well as service provider staff and outreach workers.

- Sociocultural beliefs in bride wealth and child marriage predispose women and girls to GBV. Therefore, there is a need to strengthen work with traditional institutions, leaders and government actors to systematically address these issues.

- There are high levels of risk of violence in PoCs in water, sanitation and hygiene (WASH) facilities and when IDPs go in search of firewood. There is a need for GBV, WASH and shelter/non-food item actors, in particular, to work together to reduce risks of GBV at WASH facilities. The Humanitarian Coordinator

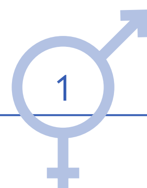
and Cluster coordinators need to reinforce practical efforts for accountable and tangible mainstreaming of GBV risk mitigation both inside and outside of the PoCs, to ensure that services and humanitarian assistance are safe and accessible for women and girls.

- High reported rates of GBV are compounded and perpetuated by a high level of acceptance of harmful gender norms and normalization of violence. Investment in primary prevention of GBV is crucial, utilizing and adapting evidence-based approaches.

- GBV survivors report particular concerns about retaliation from perpetrators. Investment in initiatives to address the culture of impunity and survivors' safety concerns are paramount. This includes the systematic training of police officers to develop capacities to handle GBV cases that are survivor-centred, strengthen safety measures and procedures and provide legal aid.

- FSWs are consistently more at risk of GBV than other groups. There is a need for integrating FSWs into broader GBV programming, utilizing the understanding of their specific vulnerabilities and capacities. Working with the clients and the police will also be a key element of efforts to reduce GBV and other forms of violence against sex workers.

- There is a high level of social denial that GBV, particularly sexual violence against men and boys, is committed in South Sudan. While further research is called for in this area, GBV programming should also invest in addressing attitudes among service providers and the community that contribute to lack of reporting among male survivors of GBV.



Introduction

Gender-based violence (GBV) is defined as "an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. The term "gender-based violence" is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence. […] The term is also used by some actors to describe some forms of sexual violence against males and/or targeted violence against [lesbian, gay, bisexual, transgender and intersex] LGBTI populations, in these cases when referencing violence related to gender-inequitable norms of masculinity and/or norms of gender identity."[4]

The renewed civil violence in December 2013 exacerbated the pervasive risks and incidents of GBV across South Sudan. A recent study across Central, Eastern and Western Equatoria, Jonglei, Lakes, Upper Nile and Warrap states found that 58.5 per cent of the respondents believed that sexual and gender-based violence is a problem in their communities.[5] For the first three quarters of 2017, the South Sudan GBV sub-cluster reports only 2,670 cases supported by partners across the country. It is important to note these figures do not indicate prevalence data, and are acknowledged to be the tip of the iceberg by the sub-cluster. However, analysis of this data indicates that 95 per cent of GBV survivors reporting are female, and 19 per cent children.[6] All types of GBV have devastating impacts, resulting in long-term physical, psychological and social traumas that can affect individuals, families and communities for decades. The effects of GBV are further compounded

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4 Inter-Agency Standing Committee (IASC), *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC, 2015), p. 322.

5 Security Research and Information Centre, *Endline Study on Peace, Security and Sexual and Gender Based Violence in South Sudan: Final Report*. Study commissioned by the United Nations Development Programme's Community Security and Arms Control Project Democratic Governance and Stabilization Unit (2017), p. 46.

6 GBV sub-cluster meeting, 7 December 2017.

by lack of access to appropriate health-care and psychological support, as well as a lack of appropriate security, redress and access to justice.

In the *2017 Humanitarian Needs Overview: South Sudan*, the United Nations Office for the Coordination of Humanitarian Affairs describes GBV as "endemic", saying that "urgent action is needed to prevent these incidents and provide timely and holistic support to survivors."[7] This emphasis reinforces the requirement to adhere to global humanitarian standards regarding the centrality of protection,[8] and the requirement of humanitarian actors to treat GBV as a life-saving intervention both before and in immediate emergency response.[9] This includes the requirement to take action to identify and reduce risks in the provision of assistance and establish minimum GBV response services, including delivering the minimum initial service package for reproductive health in crisis.[10]

To support adherence to the humanitarian requirement to prevent and respond to GBV, the International Organization for Migration (IOM), with the help of national and international partners[11] and with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, undertook a large-scale study of the knowledge, attitudes and practices (KAP) related to GBV in South Sudan, primarily focused on violence against

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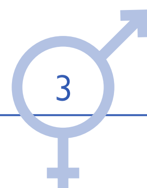
7 United Nations Office for the Coordination of Humanitarian Affairs South Sudan, *2017 Humanitarian Needs Overview: South Sudan* (2017), p. 24.

8 IASC, The Centrality of Protection in Humanitarian Action: Statement by the Inter-Agency Standing Committee (IASC) Principals (2013). Available at https://interagencystandingcommittee.org/principals/content/centrality-protection-humanitarian-action.

9 IASC, 2015.

10 Inter-Agency Working Group on Reproductive Health in Crisis, Minimum Initial Service Package for Reproductive Health in Crisis Situations (2011). Available at http://iawg.net/minimum-initial-service-package/.

11 In particular, the study was done in close collaboration with the Ministry of Health and the Ministry of Gender, Child and Social Welfare, as well as with the GBV sub-cluster.



women and girls (VAWGs).[12] The research objectives were: firstly, what ways of thinking and behaving contribute to GBV in South Sudan among target populations; and secondly, what knowledge gaps, attitudinal factors, behaviours and structural issues inhibit prevention and response to GBV in South Sudan. The results of the study are expected to, in particular, inform current GBV programming under the Global Fund HIV prevention programme, focusing on prevention, referrals and linkages to services. Therefore, the primary focus of the research regards health.

Answering the research questions requires a quantitative and qualitative profiling of the KAP driving GBV, setting these against a contextualized understanding of how they contribute to different forms of violence. Taking both global- and country-level data on reported cases of GBV, the majority of those affected are female; therefore, all quantitative survey respondents and the majority of qualitative interview participants were female. In certain instances, however, research does consider GBV targeted at men and boys, especially as this applies to conflict-related gendered violence. This KAP study was comprised of extensive quantitative and qualitative research focusing on the experiences of women and girls in a number of states across the country: Western Bahr el Ghazal, Western Equatoria, Central Equatoria, Eastern Equatoria, Upper Nile and Unity. In particular, the study aimed to collect baseline information about current KAP related to GBV, sexual and reproductive health (SRH) and gender norms among key populations of humanitarian concern: internally displaced persons (IDPs) in protection of civilian sites (PoCs), host communities and female sex workers (FSWs). The study looks to provide information about the level of knowledge among the target populations regarding available services and referral pathways, and to define reporting and service-seeking behaviours regarding GBV and SRH.

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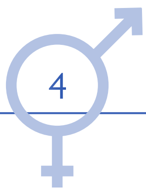
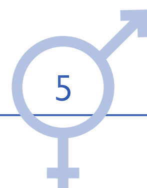
12 Violence against women (and girls) is defined by the Convention on Elimination of Discrimination Against Women during the Committee on Elimination of Discrimination Against Women, Eleventh Session (1992), General Recommendations No. 19 as "gender-based violence in the form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men". Article 1 of the Convention defines discrimination against women. The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. GBV may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.



The report contextualizes research findings by providing a background to GBV issues in South Sudan. Then, before outlining findings, it presents the methodology used to collect data, and its limitations. The bulk of the report is made up of key findings that summarize: (a) experiences and perceptions of violence and safety; (b) prevention and mitigation; (c) support-seeking behaviour and response; and (d) the situation of FSWs. The report concludes by connecting key findings to policy and programming recommendations and providing some final thoughts for further research on GBV in South Sudan.



Background

In South Sudan, GBV is pervasively affecting women, men, girls and boys throughout the country. But while both males and females are at risk of GBV, the vast majority of those impacted are women and girls.[13] National-level statistics and standardized research on GBV in South Sudan is limited. However, recent qualitative and quantitative studies indicate both a high level of incidents, high perceptions of risks and wide range of different physical, sexual and emotional forms of GBV. A recent study conducted on behalf of the United Nations Development Programme across Central, Eastern and Western Equatoria, Jonglei, Lakes, Upper Nile and Warrap states found that 58.5 per cent of the respondents believed that sexual and gender-based violence is a problem in their communities.[14] Other localized research reinforces these findings, such as a study by CARE International in South Sudan in Jonglei, Unity and Upper Nile states, which found that 25 per cent of the respondents said they had experienced physical abuse and 7 per cent reported forced sex.[15] A 2015 estimate by the United Nations Population Fund (UNFPA) in two locations in Unity and Lakes states found that 32,000 women and girls were at risk of sexual violence on 1 to 15 July 2015.[16] A recent inter-agency study led by Oxfam showed that for sexual violence, 51.3 per cent of those reporting having experienced rape or sexual assault identified police or soldiers as the main perpetrators, followed by strangers (35.9%).[17]

13 GBV sub-cluster, Gender Based Violence Factsheet, 27 November 2015.

14 Security Research and Information Centre, 2017, p. 46.

15 CARE International, *The Girl Has No Rights: Gender-Based Violence in South Sudan* (CARE International South Sudan, Juba, 2014), p. 6.

16 United Nations Population Fund (UNFPA) South Sudan Country Office, Situation Report No. 63 (as of 01 to 15 July 2015).

17 Oxfam International, “South Sudan Gender Analysis: A snapshot situation analysis of the differential impact of the humanitarian crisis on women, girls, men and boys in South Sudan, March–July 2016”, Joint Agency Consolidated Gender Analysis, March 2017. Available at https://oxfamilibrary.openrepository.com/bitstream/handle/10546/620207/rr-south-sudan-gender-analysis-060317-en.pdf;jsessionid=00E71BC8174C0FD5ADD5F1EBD8D2E 461? sequence=1.

GBV is rooted in the discriminatory social norms and power inequalities between males and females that favour patriarchal gender relations that undermine the personal, emotional and economic well-being of women and girls.[18] GBV is both a means to reinforce and a result of unequal patriarchal social structures sustaining the unequal power and value afforded to male and female on the basis of biological sex and gender identity. Development indicators that are used to calculate the national gender gap, such as literacy rates, maternal mortality and adolescent births, are concerning. Women and girls' access to education and other empowerment opportunities are little to none, contributing to their increased risks of exposure to sexual violence.

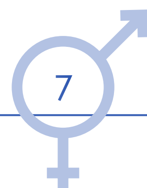
According to the United Nations Educational, Scientific and Cultural Organization (2016), the adult literacy rate for South Sudan is one of the lowest in the world (overall 26.8% in 2016); however, the gender gap for literacy is 15.6 per cent with adult women's literacy reported to be only 19.2 per cent compared to men at 34.8 per cent.[19] Furthermore, there is an exceptionally high early pregnancy rate of 65.9 per cent (births per 1,000 women ages 15–19). According to the UNFPA, this is attributable to the high rate of child, early and forced marriage.[20] Furthermore, there is a well-defined link between human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and GBV, as the report of UNAIDS indicates, women who have experienced intimate partner violence (IPV) are up to 50 per cent more likely to be infected with HIV than those who have not.[21] Forms of GBV such as rape results in lacerations and injuries that increase

18 D. Dziewanski, E. LeBrun and M. Racovita, "In war and peace: Violence against women and girls", in: *Small Arms Survey 2014: Women and Guns* (Small Arms Survey, Graduate Institute of International and Development Studies, Geneva, 2014) pp. 8–33.

19 United Nations Educational, Scientific and Cultural Organization Institute for Statistics, Country-level data for South Sudan, 2016. Available at http://data.uis.unesco.org/Index.aspx?DataSetCode=EDULIT_DS&popupcustomise=true&lang=en (accessed November 2017).

20 UNFPA, Country programme document for South Sudan (DP/FPA/CPD/SSD/2), Annual Session 2016, 6–10 June 2016, New York.

21 UNAIDS, *When Women Lead, Change Happens: Women advancing the end of AIDS* (UNAIDS, Geneva, 2017), p. 14. Available at www.unaids.org/en/resources/documents/2017/when-women-lead-change-happens.



the risk of HIV, and women and girl's lower social status denies them the opportunity to protect themselves such as failing to negotiate for condom use due to fear. HIV infection also predisposes women and girls to violence, such as fear or abandonment by their partners or disinheritance of widows who are accused of infecting their husbands.

Social norms perpetuating GBV are deeply ingrained in the behaviours of both men and women across the country. For instance, research in Upper Nile state found that there is an inescapable, profound, deeply rooted and internalized individual acceptance by women and girls of sexual violence as part of their life as a cultural practice.[22] One prominent example of the interaction between cultural norms and violence is the issue of child marriage. This remains a common practice in South Sudan, with studies on the topic suggesting that 52 per cent of girls are married before the age of 18.[23] Traditional beliefs about gender roles and sexuality and women and girls' subordination also reinforce many customary practices, like the payment of bride price or dowry, which perpetuate child marriage.[24] The African Charter on the Rights and Welfare of the Child prohibits the marriage of any child under the age of 18 years,[25] as does the South Sudan Child Act (2008).[26] Yet, South Sudanese communities see child marriage as being in the best interests of girls and their families, and an important way to access much-needed resources, such as cattle, money and other gifts via the traditional practice of transferring wealth through the payment of dowries.[27] Child marriage is also related to social structures that

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22 F. Rivelli, *South Sudan/Gender-Based Violence Research on Sexual Assault: Maban County, South Sudan.* Research Study, August 2015 (Danish Research Council, Juba, 2015), p. 4.

23 UNICEF, *The State of the World's Children 2016: A fair chance for every child* (UNICEF, New York, 2016), p. 152.

24 Human Rights Watch, *Ending Child Marriage in Africa: Opening the Door for Girls' Education, Health, and Freedom from Violence* (Human Rights Watch, New York, 2015), p. 7.

25 African Union, *African Charter on the Rights and Welfare of the Child.* Organization of African Unity document, CAB/LEG/24.9/49 (1990), entered into force 29 November 1999.

26 South Sudan, *The Child Act, 2008* (Southern Sudan) (Sudan), 13 October 2008, Articles 23(1) and 26 (1). Available at www.refworld.org/docid/49ed840c2.html.

27 Human Rights Watch, *"This Old Man Can Feed Us, You Will Marry Him,": Child and Forced Marriage in South Sudan* (HRW, United States, 2013) p. 4. Available at www.hrw.org/sites/default/files/reports/southSudan0313_forinsertWebVersion_0.pdf.

ensure power, wealth and family lineage is passed through the male descendants.

The situation has been exacerbated by fighting in many areas of South Sudan. Conflict in the country, continuously accompanied by violations and abuses of international human rights and humanitarian law by parties to the conflict, comes with pervasive sexual violence.[28] A recent report published by the Office of the United Nations High Commissioner for Human Rights describes a multitude of horrendous human rights violations, including a government-operated "scorched earth policy", and deliberate targeting of civilians for killing, rape and pillage.[29] During armed conflict and in other humanitarian contexts, social norms are redrawn and acts that may not have been acceptable previously may become commonplace, especially in contexts where one social group is dehumanized by another.[30] Sexual violence, including rape, gang rape, sexual slavery, sexual mutilation, torture, castration or forced nudity, has been used by the warring parties as a weapon of war. Amnesty International's recent report documents thousands of such cases that are described as "shocking in their scale and level of brutality, and will leave physical, psychological, and social impacts for decades to come".[31] Furthermore, GBV further fuels wider conflict as families seek justice for the victims.[32]

Even in the United Nations PoC sites – where many women and girls seek refuge – risks are abundant. The high density of people, merging of disparate communities, presence of societal divisions and lack of adequate security all contribute to a heightened risk of GBV. The intentional targeting of women and girls by armed actors has led to alarming levels of GBV in areas surrounding PoCs. Furthermore, the

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28 Amnesty International, *Amnesty International Report 2016/17: The State of the World's Human Rights* (Amnesty International, London, 2017), p. 334.

29 United Nations, "UN report highlights 'searing' account of killings, rapes by South Sudanese forces", United Nations News Centre, 11 March 2016. Available at www.un.org/apps/news/story.asp?NewsID=53420#.VuQg8JN95E4.

30 CARE International, 2014:3.

31 Amnesty International, *"Do Not Remain Silent": Survivors of Sexual Violence in South Sudan Call for Justice and Reparations* (Amnesty International, London, 2017).

32 Security Research and Information Centre, 2017:41.

current crisis has exacerbated GBV risks related to food insecurity, fuel and resource needs. For women in South Sudan, "the food crisis means more than just hunger; it means risking the most brutal, personal violence while struggling to keep their families alive across the country;"[33] for example, women and girls must travel outside of the relative safety of PoCs in order to access water, food, firewood or shelter materials, significantly increasing their vulnerability to GBV.[34]

Sexual and gender-based violence against men and boys is happening in South Sudan, and as a result of the conflict, it has been getting increasing coverage in the context of conflict-related sexual violence (CRSV).[35] There is significant social stigma attached to sexual violence against men and boys, as often this violence may be used as a way of undermining "masculine power", which is equated with heterosexuality, and therefore call into question the intended victim's masculinity and sexual orientation. Furthermore, current legislation criminalizes lesbian, gay and bisexual relationships. The *South Sudan Penal Code*[36] states that "any acts against the law of nature" are subject to potential imprisonment of 14 years. High levels of stigma and the possibility that reporting a case may bring about criminal proceedings against the survivor means that these forms of violence are less likely to be reported than those against women and girls.[37] In response, a UN Report of the Secretary-General on sexual violence in conflict states that, though "women and girls are predominantly affected by sexual violence […] more monitoring and information regarding male victims and the types of sexual violence

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33 South Sudan GBV sub-cluster, "Between a Rock and a Hard Place: Why we need to invest in GBV in food crisis? The Link between Food Security and Conflict Related Sexual Violence in South Sudan" (2014).

34 A. Giffin et al., *"Will They Protect Us for the Next 10 Years?" Challenges Faced by the UN Peacekeeping Mission in South Sudan* (Stimson Center and Sudd Institute, 2014), p. 22.

35 An Amnesty International report, for instance, indicated that some civilian men "have been raped, others castrated or had their testicles pierced with needles. In one particularly gruesome case, four government soldiers inserted grass in a young man's anal passage, set it on fire and watched him burn to death". See: Amnesty International, "South Sudan: Sexual violence 'on a massive scale' leaves thousands in mental distress amid raging conflict", 24 July 2017. Available at www.amnesty.org/en/latest/news/2017/07/south-sudan-sexual-violence-on-a-massive-scale-leaves-thousands-in-mental-distress-amid-raging-conflict/.

36 Government of South Sudan, *The Penal Code Act, 2008*, Chapter XVIII, Article 248, p. 130.

37 E.J. Wood, "Armed groups and sexual violence: When is wartime rape rare?" *Politics & Society,* 37(1):131–161 (2009).

perpetrated against them is required to tailor prevention initiatives, sensitization campaigns, treatment protocols and services for survivors".[38]

Many of these normative forces exist in opposition to formal endeavours and statutory commitments made by the Government of South Sudan to ensure the rights of men and women to full equality. In order to advance the rights of women and girls in the country, the Government of South Sudan ratified the Convention on Elimination of Discrimination Against Women in September 2017, and most recently the Maputo Protocol in October 2017. The transitional constitution also sets out clear equality and protections to protect the rights of women and children.[39] Legislation dealing specifically with GBV has enshrined the prohibition of rape and other sexual violence in the national legislation in the 2008 Penal Code Act[40] and of GBV including early and forced marriage and harmful traditional practices in the Child Act (2008).[41] However, there is a need for harmonization, as some elements of the Penal Code conflict with the Child Act and 2011 Transitional Constitution and undermine child and women's rights.[42] Furthermore, in 2017, the MGCSW, in collaboration with UNFPA, launched a task force to end child marriage that will be developing a road map to end child marriage under the leadership of the Government of South Sudan.[43]

To tackle the issue of CRSV, the Government of South Sudan has ratified the United Nations Security Council resolution (UNSCR) 1325[44] and developed an associated South Sudan National Action Plan 2015-

38 United Nations, Sexual violence in conflict: Report of the Secretary-General (A/67/792–S/2013/149), General Assembly, Sixty-seventh session, p. 3. Available at www.un.org/en/ga/search/view_doc.asp?symbol=S/2013/149.

39 Government of South Sudan, *The Transitional Constitution of the Republic of South Sudan, 2011* (2011): Articles 16 and 14.

40 Government of South Sudan, 2008: Chapter XVIII, Article 247, p. 129.

41 South Sudan, 2008, Articles 23(1) and 26 (1).

42 See analysis of legislative protections in: *Human Rights Initiative, Legal Provisions Relating to Gender Equality & Sexual and Gender Based Violence in South Sudan.* August 2017 (Human Rights Initiative, 2017). Available at www.ss.undp.org/content/south_sudan/en/home/library/Gender_Equality_Women_Empowerment/legal-provisions-gender-equality-sgbv-south-sudan.html.

43 Girls Not Brides, "Child marriage around the world: South Sudan. Available at www.girlsnotbrides.org/child-marriage/south-sudan/ (accessed October 2017).

44 United Nations Security Council, Resolution 1325, S/RES/1325 (2000), 31 October.

2020 on UNSCR 1325 on Women, Peace and Security and Related Resolutions.[45] Through the resolution, the Government of South Sudan reaffirms "the need to implement fully international humanitarian and human rights law that protects the rights of women and girls during and after conflicts."[46] The 2014 Joint Communiqué of the Republic of South Sudan and the United Nations on the Prevention of Conflict-Related Sexual Violence also outlines the following steps to reduce CRSV: (a) holding armed forces accountable for such crimes; (b) providing adequate training for all security sector personnel; (c) encouraging the inclusion of more women in the security sector; (d) strengthening legislation and bolstering access to justice for survivors; and (e) ensuring the provision of appropriate services for survivors of sexual violence.[47]

The pledges made by the Government of South Sudan are important first steps in confronting the problem of GBV. However, these political and legislative commitments are undercut by the practical realities facing the country. Despite these high-level political and legislative commitments by the Government of South Sudan to gender equality, issues of legislative harmonization, cultural pluralism enshrined in the Transitional Constitution, strong patriarchal social norms and lack of socialization of these laws, means that there is ambiguity and the continued implementation of customary law is at odds with these formal rights and protections afforded in South Sudan statutory law.

The application of customary law at the local level is conflicting with upholding the rights of women and girls. South Sudan's legal system gives precedence to formal law in adjudicating criminal cases, which include cases of rape. Unfortunately, given the poor state of the statutory courts, customary courts hear the vast majority – up to 90 per cent – of

45 Government of *South Sudan, South Sudan National Action Plan 2015-2020 on UNSCR 1325 on Women, Peace and Security and Related Resolutions* (Government of South Sudan, Juba, 2015).

46 United Nations Security Council, 2000:1.

47 United Nations Office of the Special Representative of the Secretary-General for Sexual Violence in Conflict, "Joint Communiqué of the Republic of South Sudan and the United Nations on the Prevention of Conflict-Related Sexual Violence" (n.d.). Available at www.un.org/sexualviolenceinconflict/joint-communique/joint-communique-of-the-republic-of-south-sudan-and-the-united-nations-on-the-prevention-of-conflict-related-sexual-violence/ (accessed 22 October 2017).

cases.[48] The traditional authorities that preside over customary courts are generally older men, many with deeply ingrained patriarchal views. Within the justice system – whether formal or traditional – different types of GBV, particularly IPV and child marriage, is seen as a social issue to be solved by family or community, rather than a violation of the fundamental human right to security held by all women and girls. Moreover, research indicates that traditional authorities are more easily swayed by males' interests and perspectives, so that their judgments are often favour men.[49]

There are appeals provisions from the customary to the statutory courts, the widespread absence of local courts prevents many South Sudanese from accessing the formal legal system. The challenges women face in accessing courts in the face of abuse were poignantly described by a woman from Bahr el Ghazal:

> When your husband abuses you at home, […] you complain to the civil court. The judge will mostly refer you back to the customary male chiefs in your tribe. You complain to the male customary chiefs, and they will ask you to obey your husband and follow our community culture. […] Actually, we don't know where to find justice.[50]

Other areas of criminal justice are lacking as well. Throughout the country, law enforcement services are implemented by police that are both under-trained and under-resourced. The South Sudan National Police Service faces many challenges, including: (a) low salaries and delayed payments; (b) high levels of illiteracy; (c) inadequate training on human rights; and (d) a culture of impunity.[51] In particular, police are given

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48 Small Arms Survey, "Women's Security and the Law in South Sudan", Document for the Human Security Baseline Assessment (HSBA) for Sudan and South Sudan (Small Arms Survey, Geneva, 2012), p. 2. Available at www.smallarmssurveysudan.org/fileadmin/docs/facts-figures/south-sudan/womens-security/HSBA-women-security-law.pdf.

49 T. Mennen, *Adapting Restorative Justice Principles to Reform Customary Courts in Dealing with Gender-Based Violence in Southern Sudan* (UNFPA and DPK Consulting, San Francisco, California, 2008), p. 17.

50 A. Aldehaib, "Sudan's Comprehensive Peace Agreement Viewed through the Eyes of Women of South Sudan", Fellows Programme Occasional Paper No. 3 (Institute for Justice and Reconciliation, Cape Town, 2010), p. 2.

51 Small Arms Survey, *Policing in South Sudan: Transformation Challenges and Priorities*. HSBA Issue Brief no. 26, March 2017, p. 1.

little training on how to handle cases of GBV and, for the most part, have little knowledge of the concept of women's rights; in some cases, arresting rape survivors for adultery or incarcerating them for their own "protection" until a perpetrator is caught.[52] Newly developed special protection units seek to address this shortfall. Situated at police stations, these specialized units are staffed by police who are specially trained to assist women and children offering legal aid, protection, medical care and psychosocial support to improve response to cases involving GBV.[53] But even with these improvements to service provision, when survivors do come forward, they continue to face systemic barriers to justice, including lack of resources, infrastructure and personnel.

Family and community reactions reflect the pervasive culture of shame and blame that exists around GBV in South Sudan, which further prevents survivors from coming forward to seek support. Unfortunately, social norms on GBV are so enrooted that women will offer little peer support, and some will judge and blame those that have been affected.[54] Depending on the form of GBV, the identity of the perpetrator and the survivor, there are different types of shame and stigma that result in many GBV survivors suffering in silence; for example, sexual violence against an unmarried girl impacts both the family's social status within the community and fear that seeking support outside the family will harm a girl's chances of "winning a husband."[55] A girl's prospects in marriage are often seen as an important economic asset by her family, particularly in rural areas. These barriers to support-seeking behaviour are reflected in research on the topic. For example, according to CARE International, an overwhelming majority of GBV cases were never reported to authorities, and in most cases, those that are reported did not result in convictions.[56] Only 7 per cent of those who said they experienced GBV immediately reported it to the police, 54 per cent said they first reported the incident only to other

52 Small Arms Survey, 2012:2.

53 United Nations Mission in South Sudan, "SSNPS launches Special Protection Unit", 6 July 2015. Available at https://unmiss.unmissions.org/ssnps-launches-special-protection-unit.

54 Rivelli, 2015:4.

55 CARE International, 2014:8.

56 Ibid.

family members, and 12 per cent said they reported to the local tribal chief. Of the respondents, 27 per cent who had experienced GBV said they eventually did go to a medical facility, but only 37 per cent of the respondents who said they reported to hospitals or police received any psychological support via counselling.

In general, response services for GBV is lacking throughout the country. Experiences from other fragile settings has found that increasing demand for services requires ensuring that the supply end functions to meet such demand.[57] Furthermore, some SRH indicators reveal extremely low service utilization, supporting the assertion that there are entrenched political, economic and social structures that systematically deny reproductive health rights to females across the country.[58] For instance, last estimates of maternal mortality survey positioned South Sudan as having one of the highest maternal mortality ratios in the world.[59] It is estimated that 46.7 per cent of all pregnant women had at least one visit with a skilled health provider, and 14.7 per cent of deliveries were attended by skilled health professionals.[60] In addition, the contraceptive prevalence rate is just 4.7 per cent, with only 1.7 per cent of women reporting using modern methods of contraception.[61] Not surprisingly, the health status of the population is marked by high health needs, limited health service provision and significant urban–rural and regional disparities.[62]

Despite the worrying situation of VAWGs in South Sudan, it is also important to recognize the important role and contribution of women

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57 Irish Consortium on Gender Based Violence, *Effective Responses for Gender Based Violence. Addressing GBV in Post-Conflict & Fragile States: A Case Study of Sierra Leone*. Learning Brief No. 7 (2011), p. 6.

58 It is to be noted that studies on SRH in South Sudan are limited, and many cases of women and adolescents' denial of access to reproductive health services have not been formally documented.

59 In 2015, the estimated maternal mortality ratio in South Sudan was 789 per 100,000 live births (See https://data.worldbank.org/indicator/SH.STA.MMRTWorld Bank).

60 Government of South Sudan, *Health Sector Development Plan 2012-2016* (Ministry of Health, Juba, 2012), p. 5.

61 S. Kane et al., "Social norms and family planning decisions in South Sudan", *BMC Public Health*, 16:1183 (2016).

62 N. Mugo et al., "Maternal and child health in South Sudan: Priorities for the Post-2015 Agenda", *SAGE Open*, 5(2) (2015), p. 3.

and girls in the current conflict situation. For instance, women managed to keep a semblance of community life as they went about taking care of their children and doing the majority of work typically done by men gone to war.[63]

63 Global Network of Women Peacebuilders, *Women Count, Security Council Resolution 1325: Civil Society Monitoring Report 2012* (n.p.), p. 5.

Research methodology

The study methodology utilized both primary and secondary data sources. This methodology was designed to ensure validation of data through triangulation and provide for a holistic assessment of both descriptive and casual aspects of GBV and its linkages with SRH. The assessment tools were developed based on existing documents such as the Global AIDS Response Progress Reporting 2016,[64] and including classifications of GBV were adapted from the GBV Data Management System for comparability.[65] When testing for justifications and incidences of IPV, the vignette-style questions are based on those included in the *Demographic and Health Survey*.[66] Design of research and tools, data cleaning and analysis, and reporting of findings was led by IOM South Sudan. Data collection was managed by Ipsos Limited, in partnership with Tango research firm, and subject to the supervision of and input from IOM South Sudan.

The research began with a comprehensive desk review of existing South Sudan GBV data gathered through discussions with key stakeholders to provide context for the study's findings and inform aspects of the research design; all secondary materials used for this study are listed in the endnotes of this report. However, the research focused on primary sources that relied on both quantitative and qualitative data. For primary data collection, a research protocol was developed, shared with stakeholders and approved before commencing data collection.[67] Quantitative data consisted of surveys among IDPs in PoCs, host communities, and FSWs, which were used to measure

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64 For survey questions specifically on FSWs, see: Global AIDS Response Progress Reporting 2016: Construction of core indicators for monitoring the 2011 United Nations Political Declaration on HIV and AIDS (January 2016, Geneva), pp. 51–57. Available at https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf

65 See: GBV Information Management System, *Gender-Based Violence Classification Tool*, p. 1. Originally, other forms of violence against women and girls – such as robbery and murder – were also included in the study. Ultimately, these were excluded from consideration during analysis for the sake of consistency and clarity.

66 Demographic and Health Surveys, Demographic and Health Survey Domestic Violence Module: Model Household Questionnaire (2017), pp. W-4–W-7.

67 IOM, *Gender-based Violence Knowledge, Attitude and Practices Survey in South Sudan: Research Protocol*, 13 February 2017 (Unpublished).

knowledge about GBV and SRH, gauge attitudes about gender norms, understand perceptions of safety, and map and profile incidences of and responses to GBV. Quantitative data was used to deepen understanding of ways of thinking and behaving that are contributing to GBV and inhibiting response to it. Qualitative research included key informant interviews (KIIs) and focus group discussion (FGDs) that gave context to quantitative findings and were used to help determine the underlying causal and explanatory factors related to GBV incidence and response, and to profile the linkages between GBV and SRH. Qualitative methods were also used to recognize structural factors affecting prevention and response efforts, and to help identify appropriate policy and programming options.

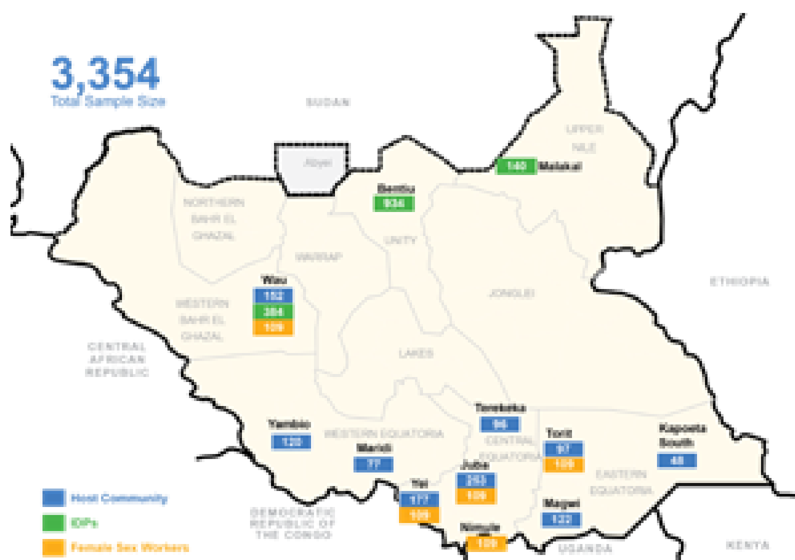
Primary data collection

The target groups of IDPs in PoCs, host communities and FSWs were chosen because these are populations of concern for the Global Fund HIV prevention programming. The research sites were selected based on direct vulnerability of populations due to displacement – such as IDPs in PoCs – and indirect effects of displacement through proximity to vulnerable populations, for instance, persons living in host communities. However, research locations were also selected based on IOM areas of operation and areas of high HIV prevalence.[68] A two-stage sampling process was utilized to first identify enumeration areas within research sites that were selected by IOM and the second stage of sampling involved selection of participants for research. This stage of sampling was randomized in host communities and PoCs, while surveys administered to FSWs were based on snowball sampling. Participants in all quantitative research were women and girls aged 16 years and above. Rather than interviewing men directly, perceptions of men's knowledge, attitudes and behaviours were solicited through interviews with women. Such an approach best balances sampling constraints related to time and finances. Choosing research participants for qualitative research was purposeful and based on convenience sampling. The second stage of sampling for KIIs and FGDs was also done purposefully. This aspect of the research included both females and males aged 16 years and above. Fieldwork

68 Research sites were identified by IOM in the study's research protocol (IOM, 2017:25).

was undertaken on 4 April–20 July 2017. Prior to the fieldwork, four separate trainings were held in Juba and in the PoC research sites of Bentiu, Malakal and Wau.[69]

Figure 1: Map showing the research sites of the primary data collection of the study



Note: This map is for illustration purposes only. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by IOM.

Household surveys for protection of civilian sites and host communities

The household survey sample was designed to produce representative statistics for host communities and IDPs in PoCs in the targeted locations. Sampling calculations were conducted using the following formula:

$$n = \frac{Z^2 P(1-P)}{d^2}$$

69 During the initial training in Juba, held on 20–25 March 2017, supervisors and enumerators were trained to understand the study methodology, tools and handheld devices on which data was collected. Importantly, there was a training-of-trainers session through which supervisors were capacitated and deployed to conduct separate trainings with locally recruited data collection teams in PoCs in Bentiu, Malakal and Wau. The follow-up trainings were conducted on 6–10 April 2017 in Malakal, on 7–11 April 2017 in Wau and on 8–12 June 2017 in Bentiu.

Calculations were made using an unknown population and prevalence rate (as the survey is descriptive and does not focus on any single parameter of the study population), using a confidence interval of +/- 5 and a 95 per cent level of confidence. Further adjustments were made to account for the cluster sampling methodology using a design effect of two, as is typical for surveys using this type of methodology. This required a minimum sample of 768 surveys for each target group. The survey used a two-stage sampling design that is similar to that used in many health surveys including the *Demographic and Health Surveys*.[70] While this method is less precise than a typical random sample and cannot be used for calculations of estimates of individual clusters, it is more cost effective, while still providing an acceptable level of accuracy. However, the sample sizes were later adjusted upwards to account for modification in research design, as will be described below. Final samples were also weighted to reflect population distribution for each target group. Weighting was also undertaken to adjust for under-sampling of Juba and Bentiu due to the changes in research design described below. Table 1 and Table 2 show that final sample sizes were 1,142 for host community respondents and 1,458 for IDPs in PoCs.

Table 1: Distribution of host communities survey sample

State	Location	Sample
Western Bahr el Ghazal	Wau	152
Western Equatoria	Yambio	120
Western Equatoria	Maridi	77
Central Equatoria	Terekeka	96
Central Equatoria	Yei	177
Central Equatoria	Juba	253
Eastern Equatoria	Torit	97
Eastern Equatoria	Kapoeta South	48
Eastern Equatoria	Magwi	122
Total		**1,142**

70 Adapted from, for example: Government of South Sudan, *Republic of South Sudan: The Sudan Household Health Survey 2010* (n.p.). Available at https://reliefweb.int/sites/reliefweb.int/files/resources/SHHS%20II%20Report%20Final.pdf.

Sampling of enumeration areas within host communities was done by South Sudan's National Bureau of Statistics (NBS), using demarcations used for the Population and Housing Census 2008. Sampling for IDPs in PoCs was done using PoC blocks to demarcate enumeration areas. Enumeration areas in host communities and PoCs were selected based on probability proportional to size.

Table 2: Distribution of protection of civilian sites survey sample

State	Location	Sample
Upper Nile	Malakal	140
Unity	Bentiu	934
Western Bahr el Ghazal	Wau	384
Total		**1,458**

In the second stage of sampling, 24 households were allocated to each enumeration area. Sampling required that each household within the enumeration area had equal probability of being selected. Households were selected by computing a sampling interval based on the number of households in the enumeration area, divided by 24, and then selecting a "random start" by drawing a random number between 1 and the sampling interval. Research teams started at a central point in their enumeration areas and moved in separate directions until they completed the allotted number of surveys. Once a household was identified for surveying, one randomly selected 16-and-over female from each household was chosen to complete the survey. Household randomization was conducted electronically according to all eligible females in the household. Quantitative data was collected using a standardized questionnaire collected on an electronic handheld device. Surveys were conducted in a location of the respondent's choosing, based on the respondent's assessment of that location's convenience, privacy and security.

Surveys for female sex workers

Snowball sampling was chosen as an appropriate sampling strategy. Though it does not generate representative data, as suggested by MacGaffey and Bazenguissa-Ganga,[71] snowball sampling is an effective

71 J. MacGaffey and R. Bazenguissa-Ganga, *Congo-Paris: Transnational Traders on the Margins of the Law* (Indiana University Press, Bloomington, 2000).

method for research on activities outside the law.[72] FSWs were only sampled from host community research areas where there was known HIV prevention programming, not from in or around PoCs.[73] Inclusion criteria included female respondents at least 16 years of age who self-reported performing a sexual act for money, food, shelter or any other benefit in the last year. The total sample size of 654 is consistent with similar studies.[74] Final samples were also weighted to create equal distribution across research sites – as shown in Table 3. It should be noted that because FSWs were drawn from networks connected to the activities of IOM and its partners, research is likely to oversample those respondents who are familiar with GBV and the services available to respond to it.

Table 3: Distribution of female sex workers survey sample

State	Location	Sample
Western Bahr el Ghazal	Wau	109
Western Equatoria	Yambio	109
Western Equatoria	Nimule	109
Eastern Equatoria	Torit	109
Central Equatoria	Yei	109
Central Equatoria	Juba	109
Total		**654**

FSWs participated in the standardized portions of the survey that were also applied to host communities and IDPs in PoCs. However, FSW-specific questions gauged: (a) frequency of sex work; (b) risk of GBV due to sex work; (c) condom usage; and (d) HIV prevalence and treatment rates. Questions targeted to this group were meant to inform programming initiatives directed at the specific GBV risk factors and SRH problems related to sex work in South Sudan. As with all other surveys, FSW surveys were carried out by female enumerators. Due to the particularly sensitive nature of sex work, interviews were carried

72 Ibid., 24–25.

73 FSW interviews were included in Wau because research activities were included both in Wau Town and Wau PoC.

74 Snowballed and respondent-driven sampling sample sizes of other hidden populations range from 70 to 2,500.

out during the day in a central and private location within research locations, and all measures to ensure confidentiality were observed to avoid stigma. Eligible respondents were asked for informed consent before they were interviewed, in line with the study's overall adherence to principles of voluntariness, with the physical and emotional well-being of all participating in the research taking precedence over data collection.

Key informant interviews

The study utilized KIIs with national stakeholders to capture high-level dynamics of GBV and SRH and with those working in the health and protection sectors in communities and with IDPs in PoCs, in order to understand local GBV and SRH issues. National-level interviews were undertaken with representatives from the following organizations: MGCSW, UNFPA, UNICEF, CARE International, International Rescue Committee, Nile Hope, United Nations Mission in South Sudan, World Vision and International Medical Corps (IMC)S. As shown in Table 4, there were 17 interviews done at the local level with stakeholders operating within the locations of the three PoCs and host communities.

Table 4: Distribution of local-level key informant interview sample

State	Location	Sample
Western Equatoria	Yambio	1
Western Equatoria	Maridi	1
Central Equatoria	Terekeka	1
Central Equatoria	Yei	1
Central Equatoria	Kajo-Keji	0
Eastern Equatoria	Torit	1
Eastern Equatoria	Kapoeta South	1
Eastern Equatoria	Magwi	1
Central Equatoria	Juba	0
Western Bahr el Ghazal	Wau	4
Upper Nile	Malakal	3
Unity	Bentiu	3
Total		**17**

Qualitative data was collected through a dialogical format, allowing for follow-up and probing. KIIs were semi-structured, using standardized open-ended questions. Semi-structured interviews allow for non-standardized follow-up questions that may vary between key informants in order to conduct an in-depth analysis of key points as they arise. In general, qualitative data collection focused on developing an interconnected and cascading understanding of the following: (a) problems of GBV and its causes; (b) actual GBV prevention and response services and activities and obstacles to these; and (c) required GBV prevention and response activities and services. Interviews with national stakeholders were intended to establish the high-level contextual frame in which GBV exists in South Sudan, as well as its links to SRH. At the local level, the goal of KIIs and FGDs was to develop a broad, descriptive analysis of the IDPs in PoCs and host communities, exploring the issues specific to the context of each research location and not about GBV issues in South Sudan in general. Discussion guides provided general questions that were used to inform discussion, but researchers were given discretion in asking probing questions that related to the broader topics. Data was audio recorded and notes were taken. All interviews were done at location that was considered convenient, private and secure by respondents, which was mainly at their offices or place of work.

Focus group discussions

As with KIIs, FGDs were used to gather qualitative data regarding GBV and SRH. FGDs were distributed throughout PoC research sites.[75] A total of six 6 FGDs were conducted, as shown in Table 5. Individual FGDs consisted of 7–8 persons. Using 6–12 persons per discussion is standard practice when conducting FGDs. The mid-range of this spectrum was chosen to allow for a deeper analysis of the project through discussion with few participants.

75 This form of qualitative research was limited to IDPs in PoCs due to the sampling focus on direct vulnerability of populations due to displacement.

Table 5: Distribution of focus group discussion sample

State	Location	FGD	Participants
Upper Nile	Malakal	Females	8
		Males	8
Western Bahr el Ghazal	Wau	Females	8
		Males	7
Unity	Bentiu	Females	8
		Males	8
Total			**47**

As shown in Table 5, a total of 47 IDPs in PoCs participated in the FGDs. Participants were recruited from the selected PoC sites. Discussions were held within PoC sites in secure locations. Groups were separated by gender, and discussions were held on different dates for males and females. The approach and format of FGDs mirrored that, which was used for KIIs, in that they were semi-structured, cascading and contextualized. As with interviews, discussions were guided by a moderator, and discussions were recorded on audio, as well as by a note taker. For the most part, female facilitators were used to conduct FGDs and take notes. However, this was not always possible because of a lack of human resources with requisite research and language skills. FGDs were conducted in a preselected space that was considered to be private and safe for all participants.

Training, supervision, data cleaning, analysis and reporting

A training for the field data collection teams were conducted, which included a one-day pilot session in which the teams conducted interviews applying the study methodology. Pilot sessions were followed by debriefing sessions in which the team's experiences during pilot were shared and potential solutions were discussed in a participatory manner. During data collection, all survey areas were monitored by supervisors through spot checks and observation. Furthermore, regular debriefings were required after data collection in order to troubleshoot challenges in field data collection. Data collection was also directly accessible and checked via a mobile platform for further quality checks. Regular updates and communication were kept between researchers, Tango, Ipsos Limited and IOM throughout fieldwork. Concerns and

issues arising were shared and clarified in real time to ascertain proper administration and application of the questionnaire in subsequent days. After data collection, data was cleaned for skimming, outlying variables, high-response errors and improperly screened FSWs. Data did not have logical inconsistencies as skip instructions, filters, single and multiple responses recording were programmed in the script, according to the logic of the questions as indicated in the questionnaire. Conclusions from all research were drawn from the identification of generalizable patterns and trends through the analysis of data. For quantitative data, analysis was conducted using Statistical Package for Social Sciences 20. For qualitative data, this was specifically undertaken through content analysis using NVivo 10. Following analysis and initial reporting, preliminary results were presented to the South Sudan GBV sub-cluster. Feedback from this presentation was then incorporated into a draft report circulated among relevant stakeholders for further feedback and revision. A participatory approach was used to address conflicting views, focusing on the points at which opinions diverged. A final report was then compiled, the result of which were presented to and validated by the GBV sub-cluster and relevant stakeholders upon completion.

Ethical, safety and security considerations

The World Health Organization (WHO) acknowledges that the highly sensitive nature of GBV poses a unique set of challenges for any data gathering activity that touches on this issue. Therefore, a range of ethical and safety issues must be considered and addressed prior to the commencement of any research project related to GBV. Failure to do so can result in harm to the physical, psychological and social wellbeing of those who participate and can even put lives at risk. Taking this as the starting point, best practices related to researching GBV – in particular, those outlined in the *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* – guided the design and implementation of the research methodology.[76]

76 WHO, 2007:9.

Though the study is premised on the necessity of a data-driven approach to policy and programming, it also acknowledges that research must, at all times, consider the benefits and risks to respondents and the communities. In those cases where such risks outweigh potential benefits, data collection should be stopped or amended in a way that such risks are addressed. Indeed, the safety and security of all those involved in information gathering about GBV was of paramount concern throughout the project, and it was up to those leading the design and supervision of the project to consider security as the overarching determination when determining research sites, sampling strategy, tools and questions, training, movement and logistics in-field and interviewing practices. Moreover, as much as possible, efforts were made to recruit and train female researchers, including female supervisors. While enumerators were indeed female, meaning that those undertaking surveys were female, it was not possible to include only female supervisors. Therefore, as mentioned above, there were instances where KIIs and FGDs were conducted by males. All enumerators and supervisors were given extensive training to ensure that all principles and guidelines – including those outlining safety, respect, confidentiality and non-discrimination[77] – were understood and adhered to throughout the research project. To this end, the study guidelines were employed to ensure that responses would not be revealed to anybody other than the enumerator administering the interview and the research supervisors.

Additionally, during the training, supervisors and enumerators were made aware of the potential types of physical and emotional harm that respondents could face by participating in the research. Researchers were also trained on appropriate research techniques, including how to ask questions about sensitive topics. Separate sessions on conducting GBV research were undertaken for supervisors and enumerators to ensure the physical and emotional well-being of the respondents and researchers. Importantly, it is deemed the role of enumerators not only to promote a secure and comforting environment, but to proactively appraise situations for potential sources of insecurity. If the security of any person was threatened as a result of research, supervisors and

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77 Gender-based Violence Area of Responsibility Working Group, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings* (2010), p. 19.

enumerators were instructed to terminate research activities and report situations of insecurity. Because research deals directly with questions around situations of violence, a protocol was developed and implemented to manage with cases of GBV. Use of this protocol was an important focus of training activities. Details of existing referral services for each site were provided to interviewers, who were then supposed to provide the information to respondents who were in need of such services. Only respondents who provided informed consent were interviewed. Those who did not grant consent were excluded from the study. Table 6 shows the number and reasons for unsuccessful contacts per respondent category. These surveys were terminated, and the household was replaced. There was a total of 147 refusals throughout the surveys.

Table 6: Unsuccessful contacts during surveys

State	IDPs in PoCs	Host communities	FSWs	Total
Refusal by selected respondent	22	31	20	73
Refusal by head of household	4	3	0	7
Refusal by parent or guardian for under	1	3	0	4
Respondent below	27	19	2	48
Partial interviews	4	9	2	15
Total	**58**	**65**	**24**	**147**

Where selected respondents were under 18 years of age, the interviewer sought permission from that respondent's guardian before starting the interview. However, where an individual was aged 16–17 years and also the head of household, the person was considered to be capable of providing his/her own informed assent. If informed consent or assent was not granted, the interviewer terminated the process and moved to the next household.

A delicate balance between safety, assent and choice was built into the research design to engage adolescents. Because children are often simply told what to do, extra efforts were taken to clarify that nothing bad would happen if they refuse to participate in the research or stop the interview at any point, without giving a reason for doing so. There were

also a number of best practices that were followed when interviewing adolescents, such as: (a) keep the wording simple; (b) questions and instructions should consist of several short sentences; (c) give the respondent adequate time to recall so that he or she can answer the question; (d) avoid interruptions in the interview unless requested by the respondent to do so; and (e) make practical arrangements to ensure that the space is comfortable, pleasant and secure from the perspective of the respondent. These precautions were taken based on the understanding that the involvement of children in research demands more rigorous consideration of ethical and safety issues than working with adults, as children are among the most vulnerable population subgroups.[78] Nevertheless, involving children and young people in the gathering of GBV data is necessary to understand better their unique needs and strengths, and thereby create programmes and services that can meet the needs of all South Sudanese, regardless of age and other characteristics.

Key challenges and limitations

The key challenges and limitations affecting the survey are outlined below. Only those challenges and limitations that affected the overall research design and data outputs are considered below, omitting commentary on delays, transportation issues, administrative problems and others.

Insecurity

This study was subject to a number of challenges and limitations, and insecurity in study locations was the most significant challenge. As much as possible, risks from insecurity were mitigated by planning research activities in advance in accordance to security protocols and adjusting these with the most relevant security updates. At the field level, security was monitored closely through local contacts, in which chiefs briefed and alerted the researchers on the security situation in the sites and provided intelligence information on areas that were too insecure to conduct research or where population movements meant that research could not be conducted. However, even with considerable preparation

78 WHO, 2007:27–29.

and risk mitigation, research activities were affected by violence. Research could not take place in Kajo-Keji, Kaya and the town of Malakal that were selected for host community and FSW interviews. There was a breakout of fighting in Wau during data collection that caused a one-day suspension of fieldwork and training. The population in some selected enumeration areas in Nimule, Wau and Yei had migrated to the PoCs, other areas of South Sudan and neighbouring Uganda. Moreover, one researcher was arrested and questioned by the military in Nimule, while another was arrested in one of the enumeration areas in Wau. Insecurity resulted in a dynamic approach to the research design, with sampling adjustments made in reaction to the evolving security situation in the country. Because research could not be carried out in Kajo-Keji, surveys from that site were distributed to Maridi, Nimule, Wau, Torit, Yambio and Yei. Other sampled enumeration areas – in Nimule, Wau and Yambio – were replaced because residents had migrated to other areas due to security issues. Replacement enumeration areas were provided by NBS based on a probability proportional to size randomization. The distribution of FSW surveys was also revised because of security-related population movements in Malakal and Kaya. These surveys were distributed to Nimule, Torit, Wau, Yambio and Yei. Further, the insecurity situation in Yei and Wau significantly reduced the number of FSWs in the two areas, as most FSWs had migrated to Juba, Uganda, nearby PoCs and other towns due to insecurity. Consequently, Maridi and Kuajok were identified as replacement sites for remaining interviews.

Access to populations

The initial research design called for the study to be conducted in a number of refugee camps throughout the country: Ajoung Thok, Maban and Pamir. Unfortunately, IOM was not successful in getting approval from the United Nations High Commission for Refugees to carry out the study in the camps. Therefore, after consultation with stakeholders, the refugee component was dropped from the study, and the sample was redistributed. Sample size was increased in Juba and Bentiu, in a way that was consistent with the study methodology. Juba was added as an additional host community site and Bentiu as a PoC research area, according to the estimated share each would have of the minimum 768 surveys each target group required for an overall representative sample. Based on this estimate, there were 264 surveys conducted in Juba and

528 in Bentiu. Because Juba and Bentiu were not originally included in sampling consideration and fieldwork, all other host communities and IDPs in PoCs were oversampled. As previously mentioned, adjustments for oversampling were made during analysis through weighting. Other quantitative and qualitative research activities were also redistributed to both research sites. There were 120 FSW interviews conducted in Juba, but none in Bentiu because it is a PoC site. Three KIIs and two FGDs were conducted in Bentiu, but no qualitative research took place in Juba, apart from national-level KIIs.

Differences in sampling methods

It should be noted that there are differences in sampling strategies used between research conducted with IDPs in PoCs and host communities on one hand, and FSWs on the other. Such differences inhibit direct statistical comparability. However, it was decided that in order to facilitate the presentation of analysis, aggregated figures should be provided across all target groups to gauge respondents' overall experiences with and in response to GBV. To mitigate differences that exist in terms of comparability, disaggregated figures are provided wherever possible to indicate the specific KAP of each target group. As previously mentioned, an additional sampling-related limitation stems from the likely oversampling of FSWs that are familiar with GBV and the services available to respond to it, due to their proximity networks and activities of IOM and its partners. By extension then, the least accessible – and likely the most vulnerable – cohort of the FSW population was underrepresented. Sampling only women and girls for the quantitative portion of the research as discussed is attributed to limitations related to time and finances. The respondents were asked about their perceptions of men's knowledge, attitudes and behaviours on GBV.

Underreporting

Underreporting limits the accuracy of research related to GBV. Indeed, it is generally accepted that the prevalence of sexual violence is underreported almost everywhere in the world.[79] This risk of underreporting also affects surveys, although generally to a lesser degree than through other forms of data capture, such as government

79 WHO, 2007:1.

surveillance mechanisms.[80] The term GBV itself is a contested term and often understood differently by different persons, even in the humanitarian community. The relationships between norms, gender relations and violence were explored and discussed with researchers, but it is often the case that understanding and translations of complex terms like this can be limited. Thus, it is important to understand that actual levels of all forms of GBV are likely to be higher than those reported through this study. Despite the attention paid to minimizing underreporting through appropriate training and methods design, "the possibility of some underreporting of violence cannot be entirely ruled out in any survey".[81]

80 E. Krug et al. (eds.), *World Report on Violence and Health* (WHO, Geneva, 2002), p. 150.

81 Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health and Social Welfare, National AIDS Control Program and Macro International, *Liberia Demographic and Health Survey 2007* (LISGIS and Macro International, Monrovia, 2007), p. 227.

Respondents' profiles

This section profiles the women and girls who participated in the quantitative research portion of this study; it summarizes respondents according to age, religion, education level, relationship status and income. Table 7 indicates that the most sampled age group among all respondents was those aged 25–34 years old.

Table 7: Age groupings of respondents

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/Average (%)
16–17 years	7.8	8.2	6.3	7.6
18–24 years	33.3	24.7	28.8	29.3
25–34 years	34.6	30.6	47.4	35.9
35–44 years	14.8	20.9	13.0	16.8
45 years and over	9.5	15.6	4.5	10.4

Note: For PoC IDPs, host communities, FSWs and all respondents, n = 1,299; n = 1,093; n = 636; and n = 3,028 respectively.

In terms of religious composition of the sample, the vast majority of all respondents (93.9%, n = 3,130) self-identified as Christian, with the remainder classifying themselves as either Muslim, animist or another religion. Further, Table 8 shows that almost half of the respondents had not completed primary education at the time of the study. There were no significant differences in terms of religious self-identification across respondent groups.

Table 8: Highest level of education completed by respondents

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/Average (%)
None	63.3	37.8	22.8	45.7
Primary	26.2	35.8	41.7	32.9
Secondary	8.2	19.8	31.4	17.2
Higher	2.3	6.5	4.2	4.2

Note: For IDPs in PoCs, host communities, FSWs and all respondents, n = 1,333; n = 1,116; n = 641; and n = 3,090 respectively.

Many respondents reported not attaining a primary level of education. That IDPs in PoCs were considerably more likely to say that they had not even completed primary school likely points to the effects that displacement can have on interrupting education, or perhaps preventing children from going to school altogether. This profiling of IDPs in PoCs also indicates that once education is interrupted, it is difficult to restart, despite education efforts focused on this population of humanitarian concern. It has been noted that the interruption of education has consequences in the short-, medium- and long-term, as children who are not in school will lack the structure and stimulation required for healthy cognitive and psychosocial development.[82] If not addressed, this form of underdevelopment among South Sudanese children has important knock-on effects that can undermine the future stability and development of the country.

Table 9: Relationship status of respondents

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/Average (%)
Married	84.3	81.4	40.7	84.3
Cohabitating	1.0	1.2	10.5	1.0
Boyfriend	2.0	3.0	13.9	2.0
Single	12.7	14.4	34.9	12.7

Note: For IDPs in PoCs, host communities, FSWs and all respondents, n = 1,233; n = 930; n = 361; and n = 2,524 respectively.

Just over half (54.6%, n = 2,081) of the respondents stated that their partner has a way to earn income. Disaggregated by target group, FSWs (67.8%, n = 227) were most likely to state that their partner earns an income, followed by respondents from host communities (59.7%, n = 780) and IDPs in PoCs (48%, n = 1,074). However, as shown in Table 9, FSWs were far less likely to report being in married relationships, and therefore this group is also more likely to rely on just a single source of income.

82 South Sudan Education Cluster, *Education Cluster Assessment South Sudan*, November 2016 (n.p.), p. 10.

Table 10: Household income of respondents in the last month

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/ Average (%)
Less than SSP 2,500	74.6	68.7	48.8	67.3
SSP 2,501 to SSP 5,000	16.4	17.2	29.4	19.4
SSP 5,001 to SSP 10,000	5.5	8.0	13.5	8.0
SSP 10,001 to SSP 15,000	1.7	3.9	4.8	3.0

Note: For IDPs in PoCs, host communities, FSWs and all respondents, n = 1,262; n = 867, n = 562; and n = 2,691 respectively.

Despite being more likely to be limited to one source of income, Table 10 indicates that FSWs were most likely to report having earned SSP 2,500 or more in the month preceding the survey. Looking at the socioeconomic profile of all respondents, more than two thirds said their household income was less than SSP 2,500 in the month preceding the survey. The group that was most likely to say this were IDPs in PoCs, underlining the precarious socioeconomic status of this target group.

Table 11: Households being short on money for basic expenses in the last month

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/Average (%)
Not at all	26.1	32.3	29	28.9
Sometimes	61.4	48.6	59.8	56.4
Often	12.5	19.2	11.1	14.6

Note: For IDPs in PoCs, host communities, FSWs and all respondents, n = 1,332; n = 1,110; n = 637; and n = 3,079 respectively.

As shown in Table 11, IDPs in PoCs were also the most likely to say that in the last month, they had sometimes been short on money for basic living expenses, such as food, water and medicine.[83] The overall reality is that respondents across all target groups reported being short on money for basic necessities; this underlines the current levels of economic precariousness defining life throughout South Sudan.

83 Of IDPs in PoCs, host community respondents, FSWs and all respondents, 73.9 per cent, 67.8 per cent, 70.9 per cent and 71 per cent respectively, said that in the last month, they had – at some point – been short on money for basic living expenses, such as food, water and medicine.

1. Experience and perceptions of safety and violence

Local understanding of a globally contested term

A starting point to changing behaviours around GBV is increasing knowledge and raising awareness about the issue. However, the definition being used needs to be clear, and gender-based violence is a term that even among the humanitarian community is often confused and contested.[84] For the purpose of this study, the definition of GBV being used is outlined in the Inter-Agency Standing Committee (IASC) GBV Guidelines:

> Gender-based violence (GBV) is defined as "[a]n umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. The term 'gender-based violence' is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence… The term is also used by some actors to describe some forms of sexual violence against males and/or targeted violence against LGBTI populations, in these cases when referencing violence related to gender-inequitable norms of masculinity and/or norms of gender identity."[85]

Therefore, initial questions were asked of respondents to understand whether they were aware of the term itself and to triangulate, further questions were about what types of act/violence were understood

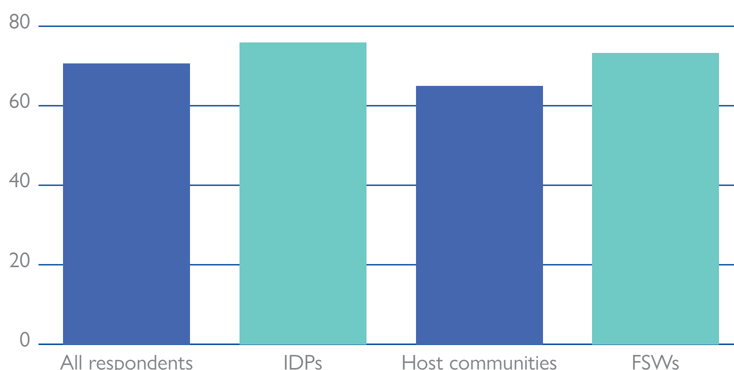
84 For further reading: S. Read-Hamilton, "Gender-based violence: A confused and contested term", Overseas Development Institute, Humanitarian Practice Network, February 2014. Available at https://odihpn.org/magazine/gender-based-violence-a-confused-and-contested-term/.
C. Dolan, "Letting go of the gender binary: Charting new pathways for humanitarian interventions on gender-based violence", *International Review of the Red Cross*, 96(894):485–501 (2014). Available at www.icrc.org/en/international-review/article/letting-go-gender-binary-charting-new-pathways-humanitarian.

85 IASC, 2015:322.

by respondents to be GBV. The aim is to ensure that GBV, in all its manifestations, is more commonly understood by all members of society in a way that supports other efforts aimed at GBV prevention and response.

In this regard, the majority of people interviewed had heard of the term GBV; as illustrated in Figure 2, IDPs in PoCs were most likely to say they are familiar with GBV, perhaps due to the concentration of organizations in PoCs carrying out GBV-related programming. However, it cannot be assumed that the ability to identify GBV terminology yields a deep understanding of GBV as a concept. For some, awareness of GBV may also speak to a familiarity with humanitarian language, more than the ability to conceptualize an understanding of what gendered violence is. When probed in focus groups to elaborate on the concept of GBV, research participants most often identified types of GBV, or suggested definitions that focus on perpetration of violent acts by males against females, without linking violent behaviour to patriarchal structures of power or discriminatory gender relations. However, it is important to note that national discussion has given the issue of rape prominence that may be creating awareness among the general population but conflating it only with sexual violence. Therefore, knowledge of the problem of GBV at the level of the community are likely connected to an appreciation that certain behaviours have harmful consequences, but not necessarily to the factors that underlie those behaviours. If this is the case, more needs to be done to leverage awareness about GBV to an understanding of GBV as a concept, challenging persistent myths and misunderstandings that perpetuate normalcy of violence perpetrated by men towards women, about GBV and addressing the rigid notions of masculinity and femininity that are key contributing factors to violent behaviour.

Figure 2: Awareness of the term gender-based violence

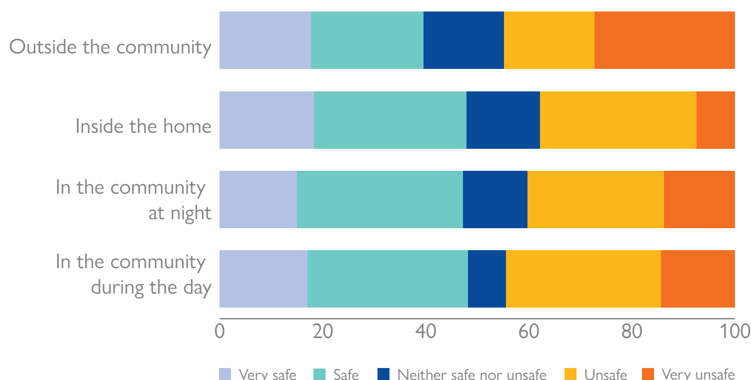


Note: All respondents: n = 3,098; IDPs in PoCs: n = 1,333; host communities: n = 1,118; and FSWs: n = 647.

Women and girls' perceptions of security and risks of violence

Because females have a different social status in society, they are subjected to situations of violence that are different from those experienced by males. The omnipresence of risks of GBV, particularly affecting women and girls, can contribute to perceptions of insecurity and fear of victimization. Looking at situational perceptions of security, the female respondents of the survey indicated that they are most likely to feel unsafe or very unsafe both outside the community (45.9%) and inside the community (44.5%) during the day. Interestingly, fewer respondents expressed feelings of insecurity in the community at night (40.3%) than in the day, perhaps because movements during the night are restricted.

Figure 3: Perceptions on security at home and in the community



Note: Respondents, in the community during the day: n = 3,126; in the community at night: n = 3,121; inside the home: n = 3,126; and outside the community: n = 3,108; men, in the community during the day: n = 3,104; in the community at night: n = 3,102; inside the home: n = 3,103; and outside the community: n = 3,104; and boys, in the community during the day: n = 3,099, in the community at night: n = 3,100, inside the home: n = 3,105; and outside the community: n = 3,084.

Cumulative experiences of violence create perceptions of insecurity that can also have very important ramifications on groups of people. If a community is perceived to be no longer safe, young women and girls will forego social activities,[86] or restrict their movements around a community,[87] further exacerbating their social isolation.[88] Coping strategies like these are symptomatic of how GBV comes to shape the everyday life of those affected by it. Those affected by violence deal with it the best they can, adapting to it to be able to carry on with their daily lives. Figure 4 illustrates female respondents' worries about the security of household members, both male and female, to any form of violence (not just gender-based). To a significant extent, such worries appear to be gendered. Respondents are generally more worried that a woman or a girl in their household will experience violence than a man or boy will. Of all women and girls participating in the survey, 60 per cent were

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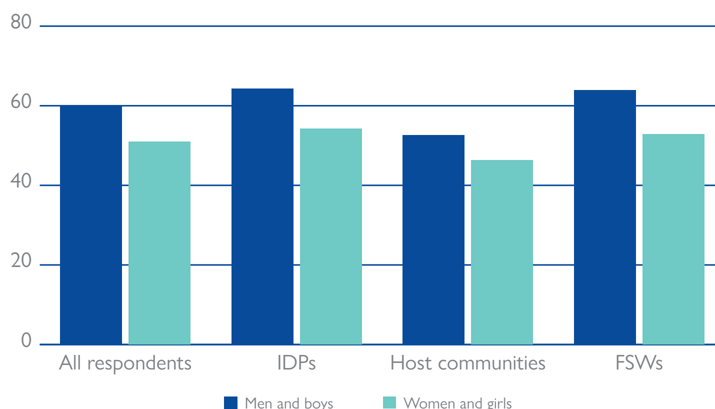
86 C. Moser, "Urban violence and insecurity: An introductory roadmap", *Environment & Urbanization*, 16(2):3–16 (2004).

87 T. Emmett et al., "Community responses to crime", in: *Behind the Mask: Getting to Grips with Crime and Violence in South Africa* (T. Emmett and A. Butchart, eds.) (HRSC Press, Cape Town, 2000), pp. 229–255.

88 Moser, 2004:3.

concerned about females in their households, while 51 per cent were concerned about males, as shown in Figure 4. This was true across all target groups. It is important to note that there is a potential for significant bias in relating to the experiences of others, particularly of a different sex and social status.

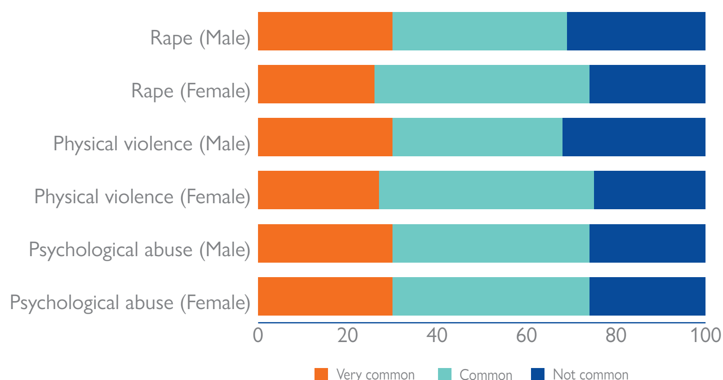
Figure 4: Worries that a household member will experience any form of violence



Note: In response to the questions: (a) Do you worry about a woman/girl, all respondents: n = 3,065; IDPs in PoCs: n = 1,327; host communities: n = 1,109; and FSWs: n = 629; and (b) Do you worry about a man/boy: n = 3,037; IDPs in PoCs: n = 1,327; host communities: n = 1,091; and FSWs: n = 619.

Respondents were also much more likely to think that women and girls will be affected by different types of GBV, as shown in Figure 5. Respondents are more likely to say that psychological abuse, physical abuse and rape (74.6%, 74.6% and 73.8% respectively) targeting females are common or very common, as compared to those targeting males (68.3%, 68.3% and 69.7% respectively). However, it is again important to note that respondents' understanding of different forms of GBV affects the reliability of the data.

Figure 5: Perceptions on frequency of different types of gender-based violence



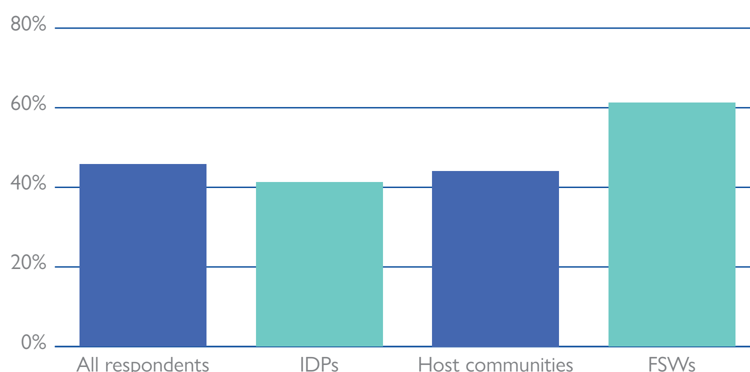
Note: Against women and girls psychological abuse: n = 3,108, physical abuse: n = 3,098, and rape: n = 3,035; against men and boys, psychological abuse: n = 3,086, physical abuse: n = 3,066, and rape: n = 2,904.

Gender-based violence experienced by women and girls

In addition to gauging perceptions of security, this study also examined actual experiences of GBV in the household. Women and girl respondents were asked about incidents of GBV that had occurred to females living in the household in the previous year. In total, 45.8 per cent of households had experience such an incident, as shown in Figure 6. The findings are comparable to those from other studies on VAWGs in South Sudan, which have noted high levels of such violence – with the vast majority of those affected being female. Although the findings suggest a high rate of GBV, it is important to remember that due to high levels of stigma, risks of retaliation from perpetrators and normalization of GBV, actual prevalence of all types of GBV are likely to be higher than those reported.[89]

89 WHO, 2007:1.

Figure 6: Rates of gender-based violence against females in respondents' households in the last year



Note: All respondents: n = 3,084; IDPs in POCs: n = 1,330; host communities: n = 1,110; and FSWs: n = 644.

Disaggregated by target group, FSWs were much more likely to report an incidence of GBV affecting a female member of their household than IDPs in PoCs and respondents from host communities. Surveys did not clarify whether the reported acts of GBV were committed against the respondents themselves or their household members. If it is a case of the former, there is anecdotal evidence that this group is at higher risk of violence, though little research has been conducted on the experiences of FSWs with violence in South Sudan.[90] Indeed, such findings echo international reports on sex work, which indicate that FSWs often find themselves in situations that put them at increased risk of violence.[91] In addition to being a violation of rights, GBV also increases vulnerability to HIV and other health concerns.[92] Mainly, violence or even the fear of violence has a negative influence on the ability of women and

90 S. See: Barbarani and S. Glinski, "In South Sudan's war, shelter protects girls from selling sex", Thomson Reuters Foundation, 7 June 2017and Bierrenbach Feder 2016. Available at https://reliefweb.int/report/south-sudan/south-sudans-war-shelter-protects-girls-selling-sex.

91 See: International HIV/AIDS Alliance, *Sex Work, Violence and HIV: A guide for programmes with sex workers* (International HIV/AIDS Alliance, 2008), p.2; and WHO, *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions* (WHO, Geneva, 2013), p. 22.

92 WHO and The Global Coalition on Women and AIDS, *Violence against Sex Workers and HIV Prevention*. Information Bulletin Series, Number 3, p. 1.

girls to protect themselves against HIV.[93] Sexual violence that results to lacerations or injuries increases risk of HIV, but HIV vulnerability also extends to failure to negotiate condom use. Studies suggest that women who have experienced IPV were 50 per cent more likely to have acquired HIV than women who had not experienced violence.[94] The fear of violence predisposes women to more risks oftentimes being an important barrier to the uptake of HIV testing and counselling, to the disclosure of HIV-positive status, and to treatment uptake and adherence, including among women living with HIV.[95]

When asked about the type of GBV experienced, over one quarter of the respondents reported that a female in their household had experienced a rape in the previous year – see Table 12. The high self-reporting of rape among study households may have to do with the fact that these types of incidents are more likely to be acknowledged within the household as a form of GBV. It is important to note that national discussion has given the issue of rape prominence that may be creating awareness among the general population above other forms of GBV. Disaggregation by target group shows that IDPs in PoCs are more likely to report psychological abuse, while respondents in host communities reported more incidents of physical abuse and forced early marriage, but less incidents of rape than the other two groups (Table 12). By comparison, FSWs reported the highest rates of rape and the largest percentage of physical abuse. Again, these findings underscore the particular risk that sex work presents in terms of victimization by sexual, emotional and physical violence.

93 UNAIDS, 2017:14.

94 UNAIDS, *The Gap Report* (UNAIDS, Geneva, 2014), p. 136.

95 UNAIDS, 2017:14.

Table 12: Type of gender-based violence reported for most recent incident

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/Average (%)
Psychological abuse	33.3	12.7	16.5	22.5
Physical abuse	17.1	33.5	29.4	25.4
Rape	37.7	37	44.7	39.6
Sexual assault	2.8	3.5	3.2	3.1
Forced early marriage	8.8	12	5.8	8.8
Denial of resources	0.2	1.4	0.3	0.6

Note: For IDPs in PoCs, host communities, FSWs and all respondents, n = 432, n = 284, n = 309 and n = 1,025 respectively.

The study also examined reporting of incidents according to place in which each was said to have occurred – depending on whether incidents happened in communities or PoCs. As shown in Figure 7, those incidents that happened in a PoC setting were most likely to occur near water points, within the household and outside of the PoC during collection of firewood. When looking at the types of violence for IDPs in PoCs, the home was most commonly reported for physical violence (50.7%), whereas water points and firewood collection are reported as areas for rape (27.1% and 23.5%) and psychological violence (40.3% and 18.1%).[96]

Water collection for household consumption is seen as the role of women and girls in South Sudan. A recent gender and conflict analysis lead by Oxfam[97] that documents women and girls' risks of GBV at sanitation facilities is well documented in the context in both PoCs and wider communities, and an IMC study in Malakal PoC showed that women and girls felt "humiliated and undignified" and reported significant safety concerns when using latrine and bathing facilities.[98]

96 Disaggregation by type of GBV only included the types of GBV with enough statistical power for disaggregation, which excluded sexual assault.

97 Oxfam International, 2017.

98 Assessment of Improved Safety and Security from GBV for Women and Girls at WASH Facilities in Malakal PoC. International Medical Corps (June 2017).

The concentration of violent events at water points and firewood collection areas indicates the need for increased risk-mitigation strategies for humanitarian and security actors in these areas.

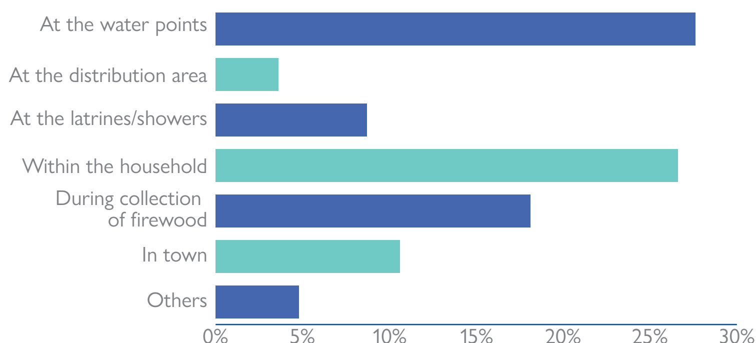
Insecurity resulting from firewood collection was a key discussion point throughout qualitative research in and around PoCs. As explained by one key informant: "[Women] move out to collect firewood; they really think there is a big risk moving out. But still, because they need all things in order to survive, they move out even when they know the risk."[99] These comments are supported by other studies that have also found firewood collection to be the factor that contributes to GBV in the PoC setting. One such study commissioned by the Danish Refugee Council, for example, stated that: "the risk of murder, disappearance and torture for men leaving the PoC causes women to engage in more and more precarious livelihoods strategies, leaving the camp to collect firewood where they are in danger of rape."[100] The quote highlights the gravity of the situation facing people across South Sudan, and the desperate measures that South Sudanese women and girls are often forced to take to survive. Sadly, their desperation puts them in greater harm of becoming victims of violence.

In addition, a high frequency of incidents was also said to have occurred at home, despite the fact that Figure 3 also showed that respondents reported the highest feelings of safety at home. One explanation for this may be that respondents do not consider those acts of violence that occur within their home with the same gravity as those that occur outside – if they consider these to be violence at all, which they often do not.

99 KII, Juba, 31 March 2017.

100 Danish Refugee Council, Congestion in the Malakal Protection of Civilian (PoC) Site, South Sudan (2017), p. 25.

Figure 7: Where the most recent gender-based violence incident occurred (PoC) (n = 437)

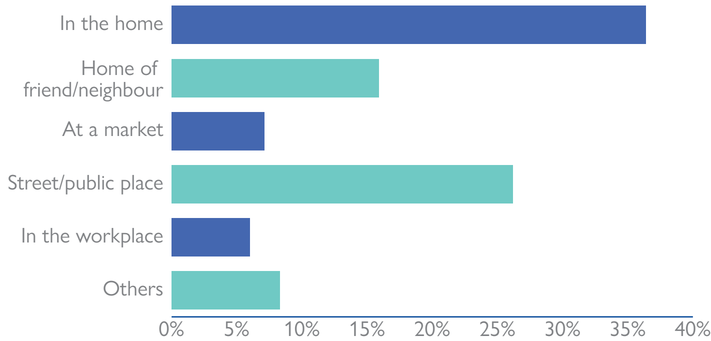


Those incidents that occurred in communities outside the PoCs were most likely to take place in the home, on the street or in a public place, or in the home of a friend or neighbour – as shown in Figure 8. While this study did not collect data on perpetrators of GBV, it is probable that the high rates of GBV reported in the home and in the home of a friend or neighbour indicate that survivors know perpetrators. When disaggregating data between types of GBV, there is slightly more reported psychological and physical violence perpetrated at home (38.3% and 38.3% respectively) rather than rape (26.8%), whereas more physiological violence and rape occur in the street or public place (31.4% and 31.1% respectively) rather than physical violence (26.7%).[101] This would be consistent with findings of international research that suggests that the perpetrator is, more often than not, someone known to the survivor; they may, for instance, be an acquaintance, a friend, a family member or former or current partner.[102] Indeed, as shown on Figure 8, there is a considerable risk of violence in the home that is perpetrated by intimate partners.

101 Disaggregation by type of GBV only included the types of GBV with enough statistical power for disaggregation, which excluded sexual assault.

102 UNFPA and Women against Violence Europe (WAVE), *Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia: A Resource Package* (UNFPA Regional Office for Eastern Europe and Central Asia and WAVE Network and European Info Centre Against Violence, Istanbul and Vienna, 2014). Available at www.health-genderviolence.org/sites/default/files/download/WAVE-UNFPA%20English.pdf.

Figure 8: Where the most recent gender-based violence incident occurred (non-PoC) (n = 588)

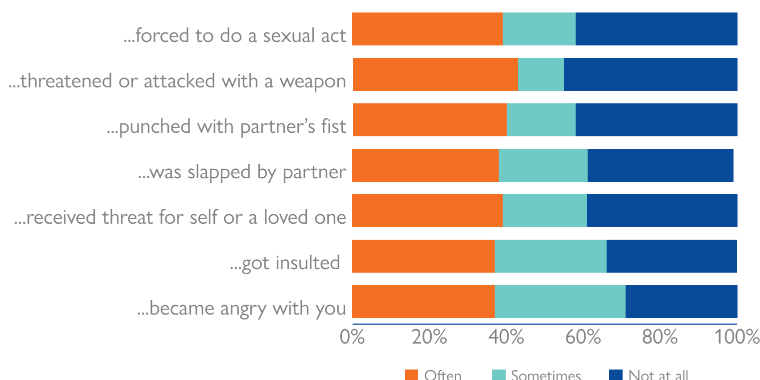


Experience of intimate partner violence

The South Sudan GBV sub-cluster reports that across the country, 40 per cent of reported cases are IPV.[103] This section examines experiences with IPV as reported by women and girl survey respondents. Of the respondents, 75 per cent (n = 2,105) had experienced any kind of IPV – ranging from threats to forced sexual acts, as listed in Figure 9. Disaggregated data by target groups indicates that IDPs in PoCs were much less likely to experience any type of IPV – 62.1 per cent (n = 668) compared to 87.5 per cent (n = 694) of host community respondents and 93.6 per cent (n = 220) of FSWs. Figure 9 then breaks down IPV according to type. It shows that 71.3 per cent of the respondents reported that their partner had become angry with them at some point in the month preceding the survey. Another 65.4 per cent and 61.3 per cent were exposed to insults and threats, respectively, while 54.9 per cent, 58.6 per cent and 61.7 per cent were threatened or attacked with a weapon, punched or slapped, respectively. Troublingly, 57.6 per cent of all respondents said that they had been forced by a partner to do a sexual act when they did not want to, with 38.5 per cent saying this had happened often. However, rape within marriage is not recognized as a criminal offence in the *South Sudan Penal Code* (Article 247).

103 GBV sub-cluster meeting, Thursday, 7 December 2017.

Figure 9: Rates of intimate partner violence reported by respondents



Note: Became angry: n = 2,100; insulted: n = 2,088; threatened: n = 2,098; slapped: n = 2,090; punched: n = 2,082; threatened or attacked with a weapon: n = 2,072; and forced sexual act: n = 2,054.

Interestingly, when respondents were asked specifically about types of IPV occurring in their household, their responses indicated a higher prevalence of violence than when just asked about violence committed against females in their household. Questions about specific acts – such as those asked here about types of IPV – are likely to elicit a more accurate response than those asking about violence in general. Part of the reason is that notions of what is and what is not violence are themselves subjective; a woman may not perceive herself to be a victim of violence for culture-specific expected gender norms in South Sudan, even if she concedes that she has been threatened, hit or forced into a sexual act.[104] Cultural factors contribute to a situation where violence against intimate partners may go unaddressed – "people will not report it, [if] people don't look at it as a crime".[105]

104 It should be pointed out that research also examined violence by females committed against their partners. Though the vast majority of those affected by GBV, and IPV in particular, are women and girls, men and boys can also be affected. Research showed that 17 per cent (n = 2,079) reported that, in a month preceding the survey, they had hit their partner when he was not already beating them; 6.1 per cent said this had happened often. Looking at specific target groups indicates that FSWs (33.5%, n = 233) are more likely to report hitting their male partners than IDPs in PoCs (13.5%, n = 1,057) and host community respondents (16.9%, n = 788).

105 KII, Juba, 20 April 2017.

The study also showed a strong link between payment of bride price and the likelihood and frequency of GBV in a relationship. There has been much debate in South Sudan about this issue and the effects that bride price has on relations between men and women in the home. Opponents of the practice blame it for the subjugation of females, with wives being considered as a family resource and a husband's property.[106] Literature on the topic finds that systems of marriage payments[107] have been connected to IPV, abuse of women's rights, marital rape, poverty among newly married couples and murder.[108] This study found that, of all married respondents, 69.4 per cent (n = 2,048) said that a bride price was used to formalize their primary marriage. In all instances of violence noted above – from threats to sexual violence – the payment of bride price showed a higher reporting of IPV overall, as well as a greater likelihood that it was reported often; this can be seen in Table 13.[109] Research findings suggest that bride price can increase the risk of IPV. The effects may even be more pronounced than data suggests; bride price can contribute to underreporting, with economic transfers giving extended families a large stake in marriages and can lead to the encouragement of women to ignore or not report abuse.[110] This social regulation presents a barrier to formally reporting interpersonal violence. Women in marriages characterized by marriage payment are cast as property, with men holding the power to disown them as "damaged goods".[111]

106 I. Kircher, *Challenges to Security, Livelihoods, and Gender Justice in South Sudan: The situation of Dinka agro-pastoralist communities in Lakes and Warrap States*. Oxfam Research Report, March 2013 (Oxfam International, Oxford), p. 26.

107 The two types of marriage payments are: (a) bride price, where the groom's family transfers wealth to the bride's family (most prominent in sub-Saharan Africa); and (b) dowry, where the bride's family transfers wealth to the groom.

108 G. Krantz and C. Garcia-Moreno, "Violence against women", *Journal of Epidemiology & Community Health*, 59(10):820–821 (2005).

109 Though they are not presented in Figure 9: Rates of intimate partner violence reported by respondents, similar – and sometimes more severe – rates of bride-price-disaggregated IPV were found for threats, slapping and threats and attacks with a weapon.

110 O. Stern, "This Is how marriage happens sometimes': Women and marriage in South Sudan", in: *Hope, Pain and Patience: The Lives of Women in South Sudan* (F. Bubenzer and O. Stern, eds.) (Jacana Media, Johannesburg, 2011), pp. 1–24.

111 T. Sideris, "War, gender and culture: Mozambican women refugees", *Social Science & Medicine*, 56(4):713–724 (2003).

Table 13: Rates of selected types of intimate partner violence when bride price is paid

... Punched with the partner's fist		
	Bride price (%)	No bride price (%)
Often	46.0	29.2
Sometimes	24.5	21.3
Not at all	34.7	55.1
... Forced to do a sexual act		
	Bride price (%)	No bride price (%)
Often	42.8	30.7
Sometimes	20.5	16.4
Not at all	36.7	52.9

Note: With bride price, punched: n = 1,410; and forced sexual act: n = 1,383; no bride price, punched: n = 617 and forced sexual act: n = 616.

2. Prevention and mitigation of gender-based violence

No single factor alone causes GBV. GBV is "structural violence",[112] and because structural violence is part of the social, political and economic organization, it is not easily observed.[113] Furthermore, it is caused by a combination of drivers operating at different levels of the social ecology, including the following: (a) a person's genetic predisposition; (b) developmental history and attitudes or beliefs; (c) their relationships and household dynamics; (d) community factors such as social norms and levels of poverty and macrolevel factors such as religious ideologies; (e) and market forces that affect realities at all the other levels.[114] At the societal level, attitudes about gender norms[115] are an important factor driving GBV.[116]

Social norms are shared beliefs about what is typical and appropriate behaviour, above and beyond individual attitudes, beliefs and behaviours. Social norms determine, for instance, gender relations in the home and community. Normative factors also influence widely held attitudes about the lesser value of females in the home, community and to wider society, expected behaviours of men and women, the acceptability of punishing those who deviate from expected behaviour, and norms surrounding the use of violence as a means of resolving conflict are among the many factors that influence GBV.[117] Violent behaviour may

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112 Farmer et al., "Structural violence and clinical medicine", *PLOS Medicine*, 3(10):e449 (2006).

113 P. Bourgois and J. Schonberg, *Righteous Dopefiend* (University of California Press, Berkeley, 2009), p. 16.

114 M. Alexander-Scott, E. Bell and J. Holden, 2016, *Shifting social norms to tackle violence against women and girls*. DFID Guidance Note (VAWG Helpdesk, London, 2016), p. 6.

115 Social norms have been described as "expectations about action – one's own action, that of others, or both – which express what action is right or wrong' within a particular social group". See: J. Coleman, "Norms as social capital", in: *Economic Imperialism: The Economic Approach Applied Outside the Field of Economics* (G. Radnitzky and P. Bernholz, eds.) (Paragon House Publishers, St. Paul, Minnesota, 1987), p. 133–155.

116 Krug et al., 2002:12–13.

117 WHO, "Changing cultural and social norms that support violence", in: *Violence Prevention: The Evidence, Series of Briefings on Violence Prevention* (WHO, Geneva, 2010), pp. 95–110.

be incentivized through social approval or left undeterred through stigmatization, intersecting with a type of manhood that looks to gain the males that use it as access to power and privilege, while reinforcing structural relations of domination over females.[118]

Thus, to fully address the risks of VAWGs – whether targeting FSWs or others in communities and PoCs – prevention efforts need to target risk factors across all levels, spanning from the individual, to the relational, to the community level, all the way through to overarching societal structures that drive VAWGs.[119] This section outlines gender norms that perpetuate different forms and GBV and identifies strategies and opportunities to prevent and mitigate GBV.

Gender norms

Within the household, gender norms and dynamics shape attitudes about male and female responsibilities. Typically, women and girls in South Sudan are expected to manage farming, collecting water and firewood, cooking, cleaning and childcare, whereas men and boys have responsibilities as decision makers for the communities and their families, herding cattle, hunting, fishing and charcoal making.[120] This study aimed to assess current gender norms relating to SRH and GBV.

As shown in Figure 10, most respondents either agreed or strongly agreed that responsibilities related to avoiding pregnancy (51.8%) and taking care of children (51.8%) are female responsibilities. Fewer (45.9%) felt that household finances are a man's responsibility, with a relatively small group (9.6%) strongly agreeing with this statement. Thus, it can be said that certain responsibilities in the household exist around prescribed gender norms and roles. Such gender relations often mean that men hold decision-making power around the nature of sexual relationships, but although they lack decision-making power in

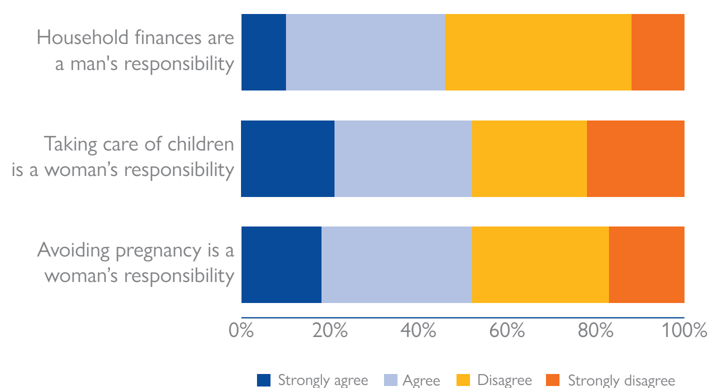
118 R. Luyt and D. Foster, "Hegemonic masculine conceptualisation in gang culture", *South African Journal of Psychology*, 31(3):1–11 (2001).

119 E. Fulu and S. Miedema, "Violence against women: Globalizing the integrated ecological model", *Violence Against Women*, 21 (12):1444–1448 (2015).

120 CARE International, *Inequality and Injustice: The Deteriorating Situation for Women and Girls in South Sudan's War. A Progressive Gender Analysis: 2013-2016* (2016), p. 6.

relationships, the burden of child spacing and family planning rests on women.[121] Thus, addressing norms that reinforce gendered household relations and decision-making could have important positive effects for promoting the SRH of women and girls in South Sudan, as well as preventing GBV in the country.

Figure 10: Statements testing attitudes about gender roles in the household



Note: Avoiding pregnancy is a woman's responsibility: n = 3,051; taking care of children is a woman's responsibility: n = 3,105; and household finances are a man's responsibility: n = 3,093

Social norms of rape and sexual violence

The power imbalance between men and women that support traditional gender roles in the household also justify male authority over women, and can mean that GBV is both the result of the power imbalance and used as a means to assert authority. Figure 11 shows that many respondents hold attitudes about rape that justify rape. More than half of the respondents agreed or strongly agreed that women cause rape by being alone with men (51.6%) and women cause rape by wearing revealing clothes (52.6%). These views are endorsed by opinions such as the one expressed by a male focus group participant: "The man is like a lion. When you see [a woman] here you will decide to do something [have sexual relations] though the girl is young – still young. But you will

121 J. Scott et al., "An assessment of attitudes toward gender inequitable sexual and reproductive health norms in South Sudan: A community-based participatory research approach," *Conflict and Health*, 7(1):24 (2013).

take some steps to reach the girl. It's normal."[122] It is an understanding of being a man that can see males as natural sexual aggressors, which excuses violent behaviour or puts the emphasis on females to avoid it.[123]

Attitudes like these are key to understanding the norms that underlie harassment, violence and coercion. Findings inform discussions about the links between norms and sexual subjectivities in ways that can be applied to behavioural change programming. Such attitudes about rape also speak to the subordinate position of females in marriage. For example, the majority question a wife's power to negotiate her sexual relationship with her partner by refusing sex, with 52.8 per cent disagreeing or strongly disagreeing that a wife can say no to sex. By extension, 52 per cent do not believe that rape can take place marriage; 49.4 per cent disagreed that a wife can ask her husband to wear a condom. Such opinions should perhaps not be surprising, as marital rape is not criminalized under South Sudan's 2008 Penal Code Act, which excludes such acts that occur in the context of a marital union, saying that "[s]exual intercourse by a married couple is not rape",[124] nor is it outlawed under many customary laws.[125] Though legislative changes are not sufficient to change norms, they are an important symbolic and practical step in determining the standards that govern relations in any given society, and can be an antecedent to broader social change.

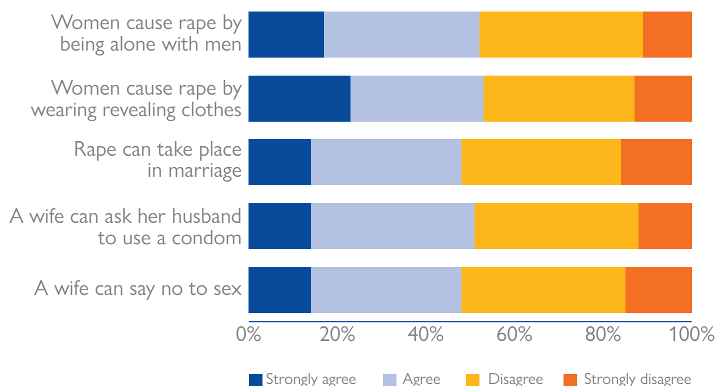
122 FGD, male, Wau, 15 April 2017.

123 H. Hlavka, "Normalizing sexual violence: Young women account for harassment and abuse", *Gender & Society*, 28(3):337–358 (2014).

124 Government of South Sudan, 2008: Chapter XVIII, Article 247, p. 129.

125 Amnesty International, 2017:19.

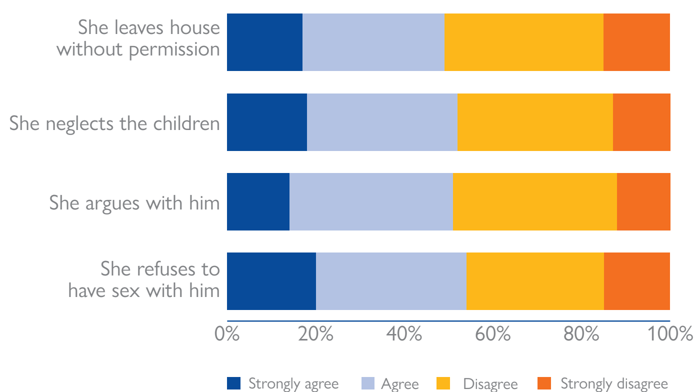
Figure 11: Statements testing attitudes about rape



Note: A wife can say no to sex: n = 3,063; it is possible for a boy to be raped: n = 2,920; it is possible for man to be raped: n = 2,930; women cause rape by being alone with men: n = 3,097; women cause rape by wearing revealing clothes: n = 3,110; rape can take place in marriage: n = 3,054; and a wife can ask her husband to use a condom: n = 3,032.

Social norms of physical violence

Figure 12: Statements testing attitudes about intimate partner violence



Note: She refuses to have sex with him: n = 3,084; she neglects the children: n = 3,105; she argues with him: n = 3,114; and she leaves house without permission: n = 3,110.

The findings presented in Figure 12 show that most women believe that male dominance in marital sexual relations is justifiably enforceable through physical violence.[126] The majority (52.1%) of the respondents said that a husband is justified in beating his wife if she refuses to have sex with him. Most also justified rape if a wife argues with her husband (51%) and neglects the children (53.2%), providing further evidence of the entrenchment of patriarchal norms in marital relationships in South Sudan. Less than half (48.8%) – but still a considerable number – said it is justified that the husband beats his wife if she leaves the house without first asking his permission. Though this study did not interview males, it did test female perceptions of male attitudes on issues related to GBV. Results show that most women believe that men hold attitudes that in different ways justify GBV.

All societies distinguish between so-called acceptable and unacceptable types of violence.[127] These social norms around the normalcy of physical and emotional violence in intimate relationships are explained by key informants: "[W]hen explained in local terms, it can be a form of love and an acceptable behaviour by a husband or spouse or family member."[128] In this way, certain individuals – often husbands – are given the right to punish females physically for perceived social transgressions. Women and girls can also justify domestic abuse as a result of guilt or self-blame, which can be common reactions to such violence. As explained by a female FGD participant: "Some wives, they can also argue with their husband, and cause too many problems, and that's why [their husbands] beat them."[129] These kinds of reactions frequently come about as a result of patriarchal social attitudes that hold women responsible for GBV.[130]

126 IPV refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, and may include acts of physical violence, sexual violence, emotional or psychological abuse and controlling behaviours. See: WHO and Pan American Health Organization, Intimate partner violence. Infosheet, WHO/RHR/12.36 (2012).

127 WHO, 2002:95.

128 KII, Juba, 20 April 2017.

129 FGD, female, Wau, 14 April 2017.

130 WHO, 2002:109–112.

While the relationship between attitudes and violence is complex, attitudes are significant in shaping violent behaviours against women and girls in three key areas: men's perpetration of violence against women, women's responses to victimization, and community and institutional responses to VAWGs.[131] This dynamic is illustrated when women try to escape abusive relationships; social pressures may impede them from doing so:

> [Husbands] beat their wife when they become frustrated with them. But if that woman tries to rise and run… the other people will prevent her… Because your husband may not trust you, and violence may become often so they convince her like this; they may say you can solve it at the level of your house.[132]

There are other risk factors that are associated with increased risk of IPV. The re-emergence of conflict in South Sudan contributes to GBV not only through those acts of violence committed as a direct result of fighting, but also through the other repercussions of war. The worsening economic situation of the country is of particular concern. Though there exists a complex relationship between poverty and violence,[133] there is a common perception among survey respondents that poverty and other types of deprivation are important drivers of violence between romantic partners. Increasing economic pressures are exacerbating stresses in the households. Rising food prices, in particular, were identified as an aggravating factor: "[A]t the moment is the issue of food [prices]… Somebody comes home, but there is no food – or not enough. When the woman fails to explain, they don't understand that and they end up beating the women."[134] Furthermore, the situation means men are under

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131 Victorian Health Promotion Foundation, *National Survey on Community Attitudes to Violence against Women 2009, Changing cultures, changing attitudes – preventing violence against women: A summary of findings* (Victorian Health Promotion Foundation, Carlton, 2010), p. 16.

132 FGD, male, Malakal, 13 April 2017.

133 The WHO (2002:12) adopted an "ecological model" to help understand the multilevel, multifaceted nature of violence. As an analytical tool, the model recognizes that a wide and complex range of factors increases the risk of violence and helps to perpetuate it – or, alternatively may protect against it. The ecological model identifies personal history and characteristics of the victim or perpetrator, his or her family, community factors and the characteristics of the larger society.

134 KII, Torit, 12 April 2017.

pressure to fulfil their social role as household provider and protector, which is increasingly difficult in the current economic and security context. As male focus group participants said:

> As for us men, we do have challenges. Our challenge is the issue of work. As you see, we have no jobs. So they face very big problems for their families because if a man is the head of the family and you do not have something to get the wife, then it is a problem. So it brings also fighting in the family. Even though your wife will insult you, abuse you because you have nothing to do.[135]

Another factor frequently mentioned as a contributing factor to IPV was alcohol. Though not an excuse for violent behaviour, alcohol abuse is an escape mechanism that can also decrease male inhibitions towards acting violently. It is important to note that these negative coping strategies are exacerbated by increasing difficulties of men to fulfil their traditional gender roles:

> I am not able now, while I'm the man, to provide meal for my children. So it's better I end up drinking alcohol so that I cannot think of this... When I come back home and I find that all things are [still] negative... I'm drunk, then I will start quarrelling with [my wife] and start beating her.[136]

Indeed, international research suggests that alcohol consumption by an intimate partner may increase the risk of a woman or girl being subject to violence.[137] In some cases, alcohol consumption may also serve as a means of eschewing guilt and responsibility of perpetrators. Thus, as with other factors that contribute to GBV, the effects of alcohol consumption on violent behaviour are not straightforward, but are affected by a broad set of interacting factors that contribute to high rates of IPV among respondents.

135 FGD, male, Bentiu, 19 June 2017.

136 FGD, men, Malakal, 13 April 2017.

137 LISGIS, Ministry of Health and Social Welfare, National AIDS Control Program and Macro International, 2007:236.

Social norms of child marriage

One especially egregious example of the interaction between norms and GBV is the issue of child marriage. It is a practice that is supported by the application of customary laws in South Sudan, although it violates the South Sudan Transitional Constitution (2011) and the Child Act (2008).[138] This study found that 42.7 per cent (n = 3,116) agreed that child marriage is acceptable to solve the financial problems of the family. Almost one fifth (19.7%) of the respondents strongly agreed with this statement. Thus, many people are generally supportive of attitudes related to child marriage, with a smaller group that strongly believes in the practice. The latter group, especially, must be considered in the design of behavioural change campaigns as potential spoilers to change. Indeed, child marriage was mentioned as a problem across the majority of interviews and focus groups. It should be noted that structural drivers intertwine with culture in a way that makes child marriage more likely. Poverty, in particular, was cited as a contributing factor to norms that see young girls as a form of property and source of income. As indicated by an FGD participant: "[parents] see their children are the source of income. They see their daughters to be married early so that they get resources."[139] Thus, efforts to address this issue should be embedded in a larger framework of policy and programming that addresses structural drivers of child marriage, as well as other types of violence.

Looking at people's attitudes about the effects of child marriage, 43.3 per cent (n = 3,115) disagreed that the practice can negatively affect the health of a girl, with 13.7 per cent strongly disagreeing. In the context of such marriages, power imbalances that already favour men are likely to be exacerbated by age imbalances in relationships. One reason this may be is that older men are often the only ones who have sufficient resources to pay a bride price.[140] Societal structures – including those where authority is attributed to age and gender – may, for example,

138 See analysis of legislative protections in Human Rights Initiative, 2017.

139 FGD, female, Bentiu, 21 June 2017.

140 J. Ward, "Because now men are really sitting on our heads and pressing us down…" Report of a Preliminary Assessment of Gender-based Violence in Rumbek, Aweil (East and West), and Rashad County, Nuba Mountains (USAID and University of Missouri, 2005), p. 30.

limit space for genuine sexual negotiation in relationships.[141] Above all, the power imbalances in these relationships can make it very difficult for young women to insist on condom use, further disempowering girls and women and exposing them to the risks of sexually transmitted diseases.[142] Qualitative research suggests that as girls are pushed into motherhood through child marriage, increases in maternal and domestic responsibilities are likely to come at the cost of female education. Not only is girls' education critical for their empowerment and development, studies on child mortality shows that maternal education have had a significant impact in reducing child deaths.[143] Moreover, focusing on girls' education and women's economic and political empowerment can have important pay-offs with regard to health care-seeking practices.[144]

Perceptions of gender-based violence against men and boys

Because GBV is typically seen as an issue that affects women and girls and due to the significant and different forms of stigma and shame particularly associated with GBV against men and boys, reporting of incidents by male survivors is said to be rare. As summarized by a key informant: "It's just so taboo. I mean rape is taboo. But it's a different level of taboo. Sexual contact between males is just seen as completely unacceptable… that adds a kind of [internal and external] shame in that."[145] KIIs suggest that this stigma is structural, both at the organizational and service provider level: "There is still not a clear understanding [among local organizations], for example, that men and boys could be survivors of sexual violence. But of course, we do know that it happens."[146] This reflects findings from the survey on perceptions of the community-level female respondents, with 47.2 per cent

141 K. Wood and R. Jewkes, 'Love is a dangerous thing': Micro-dynamics of violence in sexual relationships of young people in Umtata (Medical Research Council, Pretoria, 1998), p. 33.

142 UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa* (UNAIDS Regional Support Team for Eastern and Southern Johannesburg, 2013), p. 20.

143 H. Wang et al., "Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013", *Lancet*, 384 (9947):957–979.

144 UNICEF, *Committing to Child Survival: A Promise Renewed – Progress Report 2014* (UNICEF, New York, 2014), p. 81.

145 KII, Juba, 17 March 2017.

146 KII, Juba, 25 March 2017.

(n = 2,930) either having disagreed or strongly disagreed that a man can be raped, and 45.7 per cent (n = 2,920) disagreed or strongly disagreed with the same statement being made about a boy.

Qualitative research revealed that conflict, especially, is influencing GBV committed against men and boys. Though reporting on the subject is limited, there are indications that males are being raped and sexually abused in other horrendous ways.[147] Such violence is perpetrated as a tactic of war, or in the context of detention or interrogation, and can have acute consequences. When it comes to male-directed sexual violence, there may be a lack of empathy for survivors among service providers stemming from homophobia and perceived loss of masculinity, as well as a lack of knowledge, legal frameworks and acknowledgement for the situation.[148]

However, conflict may present both opportunities and constraints when dealing with issues around male experiences with sexual and gender-based violence. On one hand, it was indicated by key informants that discussions of sexual violence in conflict might create space for discussion of male experiences with GBV; on the other hand, it was also said that all issues related to GBV in conflict in South Sudan are incredibly sensitive:

> This idea of GBV as a weapon of war ... I feel like this is the only space within which men would even be willing [to discuss GBV targeted at males]. Because the power dynamics are such that they allow you to at least open up this dialogue.

Thus, the compounded sensitivities of the issue mean that direct policy and programmatic action in this area will be a challenge. Nonetheless, steps must still be taken to engage in societal shifts in awareness,

147 An Amnesty International report (2017), for instance, indicated that some civilian men "have been raped, others castrated or had their testicles pierced with needles. In one particularly gruesome case, four government soldiers inserted grass in a young man's anal passage, set it on fire and watched him burn to death;" see: Amnesty International, "South Sudan: Sexual violence 'on a massive scale'".

148 C. Dolan and A. Hilton, Defining the scope & challenges, Presentation on "Male-Directed Sexual Violence: Increasing Understanding for a Better Response", New York, 25 and 26 July 2013.

attitudes and behaviours in which the Government of South Sudan must play a central role.

Mitigating gender-based violence

Strategies to mitigate GBV are primarily outlined for the humanitarian community in the IASC GBV Guideline.[149] Key risk areas for GBV for PoC populations, as demonstrated in Figures 7 and 8, are water points and collecting firewood. A number of programming suggestions were made to mitigate the risks posed by firewood collection. Though these were all cited in conversations regarding the PoC context, these may be conceivably extended beyond PoCs in relevant situations. Firstly, the provision of firewood or charcoal was noted a potential action that could be taken: "organisations wishing to stop violence, they should at least try to bring firewood or charcoal to the community."[150] Another suggestion was "the provision of cooking stoves to the women… in order to minimize the cases of women being raped outside the PoC during the collection of firewood".[151] In particular, solar cooking could be encouraged and instruction can be provided on how to use these as a way of reducing the need for women to go to the bush to collect firewood.[152] Finally, key informants mentioned patrols as a potentially effective method for providing protection for women and girls collecting firewood.[153] Patrolling and other interventions could either be pursued individually or simultaneously with the security outcomes of each noted to gauge which strategy is most useful for the purposes of scaling up.

Changing harmful gender norms

The prevention of GBV depends on changing discriminatory social norms.[154] Gender dynamics roles and expected behaviours can and do change, across societies, time and locations, and are often disrupted in

149 IASC, 2015.

150 FGD, male, Bentiu, 19 June 2017.

151 KII, Bentiu, 20 June 2017.

152 CARE International, 2016:18.

153 KII, Juba, 25 March 2017.

154 Population Council, *Sexual and Gender Based Violence in Africa: Literature Review* (Population Council, Nairobi, 2008), p. 36.

times of conflict and crisis. The importance of changing harmful gender norms has become increasingly important in accepted strategies for preventing GBV. [155] Around the world, activists are challenging the social norms that support GBV; and normatively focused interventions can be integrated into other approaches, such as improved data collection, legal reform, economic empowerment and increased provision of response services. In order to tackle harmful social norms, interventions need to create new and shared beliefs within an individual's reference group, which in turn change expectations around behaviour.[156] GBV interventions that aim to transform social norms at social and community level that embody gender inequality and unequal power relations have been proven more effective in reducing violence than those that only address individual attitudes and behaviours.[157]

Due to the emergency in South Sudan, the focus of prevention activities is short term, and characterized by actors' populations in flux and with high humanitarian needs, and many humanitarian actors with low capacity. Therefore, awareness-raising has been primarily used. It must be mentioned that promoting normative change in any context is a long and difficult process. Conflict makes it even more difficult. Population movements resulting from the current fighting make behavioural change extremely challenging. Social learning and social sanctions are both embedded in community and occur over time. Thus, programmes focused on normative change may be most effective when targeted to communities that are more stable.

Awareness-raising is an important component of behavioural change around social norms but does not systematically address the structural nature of entrenched means of attaining control and power by males against females. Because of this, breaking the dynamics that drive gendered violence requires more than increasing knowledge about GBV, or merely convincing a person that violent behaviour is wrong. Behavioural change strategies must work holistically to target the social

155 WHO, 2010:100–102.

156 Academic Council on the United Nations System (ACUNS) Vienna Liaison Office, *Femicide: A Global Issue that Demands Action* (ACUNS Vienna Liaison Office, Vienna, 2013), p. 181.

157 Alexander-Scott, Bell and Holden, 2016:6.

ecology of violence that reinforces GBV as an acceptable or appropriate behaviour.[158] An example of programming model from South Sudan that represents this sort of thinking is Communities Care: Transforming Lives and Preventing Violence Programme piloted by UNICEF.[159] The model is premised on the idea that individual thinking and behaviour is embedded in larger social contexts, within which harmful social norms must be transformed in a way that restrains GBV and upholds women and girls' equality, safety and dignity. Preliminary evaluations of the pilot suggest promising trends, with the intervention communities promoting community actions against violence and showing improvement on some of the dimensions of social norms measured.[160] However, this programme had several reported disruptions, as their targets groups were displaced during the implementing period. Start, Awareness, Support, and Action (SASA!) was one such model that was mentioned during research. Other internationally recognized primary prevention programme models such as SASA!,[161] which has been extensively used in Uganda is the Engaging Men in Accountable Practice.[162] If applied in the South Sudanese context, adaptations would also be necessary, "because Uganda is a more stable and the population is static [compared to South Sudan]".

As indicated by one key informant: "[M]en and boys should be targeted to attend trainings on GBV issues, causes and its effects, because they are the main perpetrators [of GBV] in all circumstances."[163] Indeed, there is a growing acceptance that men and boys must be included in interventions aimed at GBV, especially given the role of males in the perpetration of violence, and recognition that masculinity and gender-

158 L. Heise, *What Works to Prevent Partner Violence? An evidence overview* (STRIVE, 2011), p. vi.

159 UNICEF, *Communities Care: Transforming Lives and Preventing Violence* (2017) (n.p.).

160 S. Read-Hamilton and M. Marsh, "The Communities Care Programme: Changing social norms to end violence against women and girls in conflict-affected communities", *Gender & Development*, 24 (2):261–276 (2016).

161 Raising Voices, n.d.

162 International Rescue Committee, *Part 1: Introductory Guide – Preventing Violence Against Women and Girls: Engaging Men Through Accountable Practice* (International Rescue Committee, New York, 2013), pp. 6–7.

163 KII, Juba, 27 March 2017.

related social norms are implicated in GBV.[164] Given the inter-gender dynamics of how norms function, evidence suggests that interventions working with males, as well as females, are more effective at reducing violence than single-sex interventions.[165] Doing so can encourage men to speak and act against GBV in a society where they hold most of the power and control over resources and decision-making at household, community and national levels.[166] Behavioural change programming that works with male stakeholders – such as influential traditional chiefs and religious leaders – can establish male "champions" in their respective areas of influence.

Women continue to have limited access to education, health care, security, and legal and judicial services, which further inhibits their equal participation in the society. However, interventions that shift harmful gender norms and increase gender equality are likely to generate multiple outcomes, as gender equality has been shown to be correlated with wider indirect benefits, such as economic, health and educational outcomes.[167] Therefore, the empowerment of women and girls is an important strategy for improving women's rights and changing social norms. However, females that challenge male authority, accept non-traditional jobs or break other social taboos can be perceived to be "going against the grain" and may experience an increased risk of violence. Studies throughout the world have documented how rising relationship tensions and violence can accompany male humiliation and frustration when gender roles shift, and men's ability to provide economically for their families decreases or is lost altogether. As one key informant said: "[T]he issues of our gender and women empowerment, it's always well-received in some parts of Southern Sudan. We empower the woman, but at the same time it causes harm, because men don't receive it

164 C. Ricardo, M. Eads and G. Barker, *Engaging Boys and Men in the Prevention of Sexual Violence: A systematic and global review of evaluated interventions* (Sexual Violence Research Initiative and Promundo, Pretoria, 2011), p. 2.

165 R. Jewkes, M. Flood and J. Lang, "From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls", *The Lancet*, 385(9977):1580–1589 (2015).

166 Oxfam, 2017:57.

167 M. Remme, C. Michaels-Igbokwe and C. Watts, "What works to prevent violence against women and girls? Evidence review of approaches to scale up VAWG programming and assess intervention cost-effectiveness and value for money" (2014) (n.p.).

well." Proper safeguards must be taken to prevent such reactions. For example, work that includes males could aim to show them the benefits of women's empowerment and make them aware of the detrimental effects that rigid notions of masculinity can have.[168]

Given the widespread factors that lead to GBV, normative change undertaken at the community level can be used to link local action to broader macrolevel processes. Government action and legislative efforts, for instance, represent important symbolic and practical endeavours to embed actions taken against GBV within the State. An example was given of successful partnership with government that was associated with deep-rooted cultural practices that support child marriage:

> As Ministry of Gender, what we do is we try to reach out to the communities through our State ministries, so that they understand child marriage is impacting negatively on young girls. It stops them from furthering their education, and it impacts on them on their health. Our main work is to work with the communities, and to educate them, and to disseminate issues related to policies, and this of course we don't do it alone. We do it with the States' Ministry of Gender branches.[169]

To be effective, programmatic models must be conscious of the interplay between gender norms, alcohol and the economy, as well as with cultural considerations, such as child marriage and payment of bride price. Interventions focused on increasing knowledge about the harmful effects of alcohol can support initiatives aimed at changing attitudes and behaviours within which alcohol can be used to legitimize behaviour that is based on patriarchal beliefs, as well as reinforce a sense of self-righteousness and self-justification. Such efforts should be supported more broadly by concurrent work to change cultural practices around child marriage and bride price, as well as creating economic opportunities for South Sudanese men and women. It is a strategy that is analogous to the multipronged efforts that are required to address GBV more generally by addressing the individual, relationship, community and societal factors that bring it about.

168 These may include the following: (a) increased likelihood of aggression and risk-taking behaviour; (b) denial of weakness or vulnerability; (c) emotional and physical control; (d) the appearance of being strong and robust; and (e) dismissal of any need for help.

169 KII, Juba, 21 April 2017.

3. Support-seeking behaviour and response to gender-based violence

The lack of awareness of the physical and mental health, social and economic consequences of GBV, knowledge of types of services available, as well as limited availability and competency of services are often major barriers to the effective recovery of GBV survivors and their families. These challenges are compounded by pervasive stigma associated with various forms of GBV, and in many cases widespread social acceptance of different forms of violence that prevent GBV survivors from seeking support. This section aims to provide information on barriers and facilitators affecting access to services to better address the needs of GBV survivors.

Awareness of available health services for gender-based violence survivors

Looking at awareness of physical and mental health services, 88.4 per cent (n = 2,324) of all respondents indicated some knowledge about the availability of services that support GBV survivors in their community. Both IDPs in PoCs and FSWs were considerably more likely to know of the availability of such services, as seen in Table 14. It is important to note likely that the high levels of awareness among FSWs is due to the fact that this target group was sampled through its existing relationships with IOM and its partners who provide these services. Similarly, it is probable that relatively high levels of knowledge among IDPs in PoCs regarding GBV services is due to the concentration of actors running GBV-related programmes in PoCs. This indicates a relationship between the presence of service provision and increased awareness, which in turn indicates a need for, firstly, an expansion of services provided in host communities, and secondly, an expansion of the awareness of those services in host communities.

Table 14: Awareness of types of gender-based violence service providers in the community (n = 2,044)

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/ Average (%)
Pharmacy	15.3	25.8	16.6	18.5
Traditional healer[170]	1.9	7.1	5.8	4.2
Religious healer	1.6	4.8	5.9	3.4
Community health worker (CHW)	6.3	12.0	9.8	8.7
Mobile clinic	14.5	9.5	7.8	11.7
Private facility	12.1	7.8	12.3	10.9
Primary health-care centres/ Primary health-care units	49.0	11.9	15.3	31.3
Hospital	58.2	82.3	91.2	72.0
Other	6.3	16.9	21.6	12.5

Note: For IDPs in PoCs, host communities, FSWs and all respondents: n = 1,031; n = 579; n = 434; and 2,044 respectively. Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

Looking at the types of services mentioned, most people associated GBV services with the formal health system, and in particular with hospitals. Almost 7 in 10 of all respondents cited hospitals as a place that women and girls could seek GBV services; the next popular category was primary health-care units (PHCU)s and primary health-care centres (PHCCs). Less than 1 in 10 linked traditional healers or religious healers to GBV response. Disaggregating awareness of GBV service providers by target group shows that host communities and FSWs are much more likely to associate hospitals with GBV services than IDPs in PoCs, though over half of IDPs in PoCs still cited hospitals as a place that GBV services are provided.[171] IDPs in PoCs are more likely to look to PHCUs

170 For all tables and figures, traditional healer category also includes traditional birth attendants.

171 Looking at GBV service providers that respondents are aware of, 49 per cent of IDPs in PoCs, 11.9 per cent of host communities and 15.3 per cent of FSWs were aware of PHCUs/PHCCs, and 58.2 per cent of IDPs in PoCs, 82.3 per cent of host communities and 91.2 per cent of FSWs were aware of hospitals. For IDPs in PoCs, host communities and FSWs, n = 1,031, n = 579 and n = 434, respectively. Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

and PHCCs as GBV service responders, which again is likely due to the higher proportion-to-population of PHCU and PHCC services in PoCs.

Awareness of sexual and reproductive health

Health services were identified by the female respondents as the main entry points after a GBV incident. Therefore, the study also looked at SRH to understand more about awareness of SRH services as an entry point and address the wide range of health needs associated with different forms of GBV. Of all female respondents, 67.3 per cent (n = 3,089) said they had heard of SRH (see Figure 13). Probing further, people generally related definitions of SRH only to the provision of contraception and notions of safe sex. However, efforts in the areas of sexual health and reproductive health have more expansive objectives, aiming to support pregnancy and childbirth, reduce adverse outcomes of sexual activity and reproduction, and enable people of all ages to have safe and satisfying sexual relationships.[172,173] In 1994, during the International Conference on Population and Development, the international community agreed to provide universal access to reproductive health, acknowledging it as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and a recognition that reproductive rights embrace certain human rights.[174] Thus, as with understandings of GBV, more must be done to increase awareness and understanding related to the breadth and depth of SRH. Doing so will help ensure that South Sudanese women and girls have the comprehensive health information to make free and informed choices in a way that allows them to be better at exercising their right to SRH.

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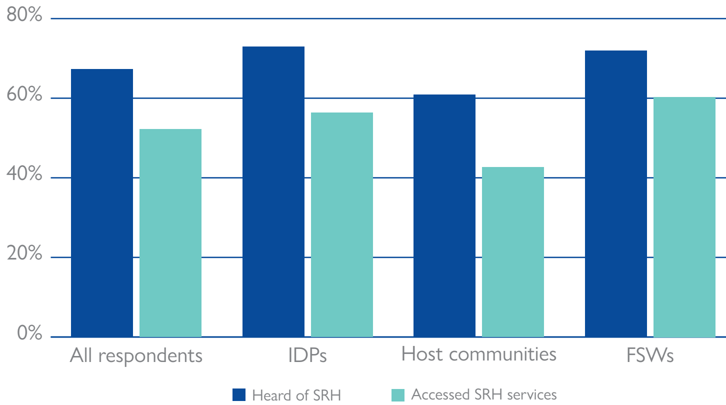
172 A. Glasier et al., "Sexual and reproductive health: A matter of life and death", *Sexual and Reproductive Health 1*, Journal paper. Pre-print copy of a paper published in *The Lancet Sexual and Reproductive Health Series*, October 2006 (WHO, Geneva, 2006), p. 2.

173 The core aspects of reproductive and sexual health are as follows: (a) improving antenatal, perinatal, postpartum and newborn care; (b) providing high-quality services for family planning; (c) eliminating unsafe abortion; (d) combating STIs, reproductive tract infections, cervical cancer and other gynaecological morbidities; and (e) promoting sexual health. See: WHO, *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets* (WHO, Geneva, 2004), p. 21.

174 UN, Report of the International Conference on Population and Development, A/CONF.171/13, 18 October 1994. Available at www.un.org/popin/icpd/conference/offeng/poa.html (accessed October 2017), Articles 7.2 and 7.3.

Figure 13: Awareness of the term sexual and reproductive health and use of sexual and reproductive health services



Note: Heard of SRH, all respondents: n = 3,088; IDPs in POCs: n = 1,323; host communities: n = 1,118; and FSWs: n = 647; used SRH services, all respondents: n = 1,924; IDPs in POCs: n = 916; host communities: n = 579; and FSWs: n = 429.

Especially important will be the need to grow the recognition of the linkages between SRH and GBV.[175] GBV, for instance, has been linked to increased risk of miscarriages and abortions, premature labour and foetal distress,[176] while women exposed to unwanted and highly traumatic pregnancies may risk unsafe abortions.[177] Providing comprehensive, high-quality SRH that intersects with GBV programming requires a multisectoral, integrated approach that incorporates the

175 Importantly, this includes the relationship that GBV has as a cause and consequence of HIV. For example, men who perpetrate violence are more likely to engage in risk behaviours, have higher numbers of sexual partners, report higher levels of alcohol use, lower condom use, and are also more vulnerable to HIV acquisition; whereas women and girls with unequal status and power within the relationship, and with potentially violent partners are less able to negotiate risks, and are also likely to suffer from mental health issues, which also reduce their ability to address violence, and/or may cause them to also engage in risk behaviours. The experience of physical, sexual or emotional abuse as children also presents as a causal factor for HIV acquisition. See: ATHENA Network, *Integrating Strategies to Address Gender-based Violence and Engage Men and Boys to Advance Gender Equality through National Strategic Plans on HIV and AIDS*, Regional Eastern and Southern Africa consultation to strengthen attention to gender-based violence in National HIV and AIDS Plans and other critical policies. Meeting summary (Johannesburg, South Africa, 2013), pp. 7–8.

176 L. Heise, M. Ellsberg and M. Gottmoeller, "A global overview of gender-based violence", *International Journal of Gynaecology and Obstetrics*, 78 Supplement 1, S5–S14 (2002).

177 B. Byrne, "Towards a gendered understanding of conflict", *Ids Bulletin* 27(3):31–40 (1996).

full engagement of affected communities, interdisciplinary and inter-organizational cooperation and collaboration and coordination among health, psychological, legal and security services when responding to the needs of survivors of GBV.[178] Without adequate SRH, South Sudanese women and girls have their health further undermined in a way that is then exacerbated by other factors of GBV, including child marriage, resultant early pregnancy and frequent pregnancy.[179]

Availability of gender-based violence and sexual and reproductive health services

At present, the provision of GBV and SRH response services in South Sudan is incomplete and inconsistent. Shortages in funding mean that resources are often concentrated in urban centres or in PoCs. But even in larger cities, services may also be lacking or may not be of adequate quality. The most glaring deficiencies in service provision persist in providing access to those populations outside of cities. Qualitative research suggested that there are still many places in the country with no services at all. As explained by one key informant: "[I]n terms of medical [services], there is still a big gap in many locations… there are areas where we don't have trained medical health practitioners who are able to provide clinical management of rape."[180] Therefore, in terms of health priorities, the immediate point of intervention would be to expand coverage, with KIIs suggesting a prioritization of basic health components, psychosocial support and exploring possibilities for community-based support for areas in highest need.

Conflict was cited as the most pressing impediment to the provision of services, as well as their expansion, even at the most basic level. For those seeking services, fighting creates problems in terms of access and referral. Even when services are available, their provision can be very unstable. Displacement of international actors that results from conflict, for instance, can badly affect the management of rape cases. In

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178 Inter-agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2010 Revision for Field Review (2010) (n.p.), p. 159.

179 CARE International, 2014:9.

180 KII, Juba, 31 March 2017.

response to these challenges, national-level key informants indicated that working with local partners should be a key area of focus in providing more expansive and stable services to hard-to-reach populations. Local organizations frequently maintain important activities during times of crisis and turmoil, when many international actors have pulled back. In this sense, building local capacities can be an effective hedge against possible instability due to the onset of fighting. However, working with local partners comes with notable challenges. Key informants, for instance, also suggested that increases in the quantity of local groups working in GBV have led to inadequacies in the quality of programming. Not all have the capacity to undertake GBV interventions according to proper guidelines: "[M]any national organizations have erupted because of this conflict, and they claim to do GBV… But then they don't have the capacity, and can [potentially] do a lot of harm to the population."[181] While it was generally thought by those interviewed that national organizations can provide important value-added to SRH and GBV programming, more needs to be done to build their capacities. Working to mitigate the potential challenges of local partnerships can strengthen provision and continuity of programming in periods of conflict-related instability, as well as create a foundation of endogenous capacity that can be leveraged post-conflict.

Utilization of sexual and reproductive health services

The vast majority of female respondents who indicated that they had knowledge of SRH said that they knew of some SRH services in their community,[182] and that they had ever used those SRH services.[183] FSWs were most likely to have accessed services, but as previously mentioned, the sampling strategy used for this study is likely to have over-represented those FSWs familiar with SRH and other health services. Interestingly, however, despite the concentration of programming on SRH present

181 KII, Juba, 25 March 2017.

182 Of those that said they had knowledge of SRH, 92.2 per cent (n = 2,095) indicated that they knew of some SRH services in their community.

183 Of those respondents who were both aware of SRH and knew of SRH in their community, 83.8 per cent (n = 1,924) indicated that they had ever used SRH services in their community. Disaggregated by target group, 81.3 per cent (n = 916) of IDPs in PoCs, 82.2 per cent (n = 579) of the respondents in host communities and 90.9 per cent (n = 429) of FSWs indicated that they had used SRH services at some point.

in PoCs, IDPs in PoCs are least likely to have accessed SRH services. Indeed, FGDs with IDPs in PoCs revealed that even those who are aware of SRH might not be putting this into practice. As said by one FGD participant: "culturally, if I stay in PoC you don't use condoms. So how can you change culture? Because in PoC here people tell us about condoms, but people still don't use [them]."[184] Indeed, there were multiple occasions when IDPs in PoCs focus group participants cited cultural factors as working against the uptake of safe sexual practices – and of condom use, in particular. This is evidence that it is necessary to move beyond awareness-raising on issues related to SRH – as well as, on those related to GBV – in a way that alters attitudes and leads to positive changes in behaviour.

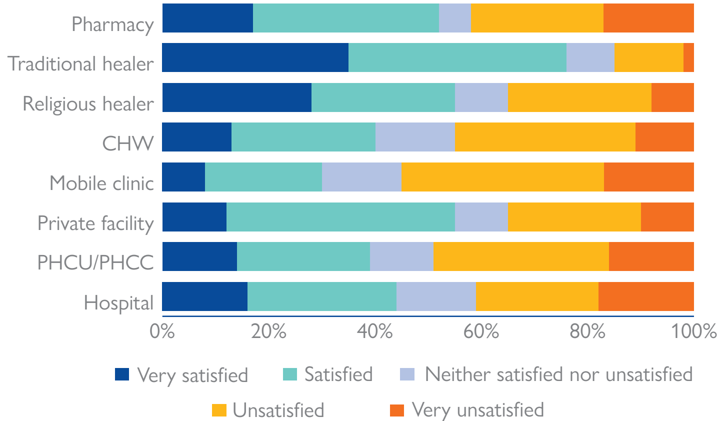
Table 15: Types of sexual and reproductive health services ever accessed by respondents (n = 1,607)

	IDPs	Host communities (%)	FSWs (%)	Total/Average (%)
Pharmacy	23.1	32.0	27.0	26.7
Traditional healer	1.7	8.0	5.9	4.6
Religious healer	2.7	3.4	5.7	3.6
CHW	3.9	8.8	9.3	6.6
Mobile clinic	16.5	11.8	9.5	13.4
Private facility	15.6	13.7	16.0	15.1
PHCU/PHCC	48.8	16.0	18.1	31.7
Hospital	49.6	75.8	93.4	67.9
Other	2.4	6.1	3.3	3.7

Note: For IDPs in PoCs, host communities, FSWs and all respondents: n = 745; n = 474; n = 434; and n = 389 respectively. Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

184 FGD, female, Malakal, 13 April 2017.

Figure 14: Levels of satisfaction with sexual and reproductive health services ever accessed by respondents



Note: Pharmacy: n = 429; traditional healer: n = 74; religious healer: n = 58; CHW: n = 107; mobile clinic: n = 215; private facility n = 243; PHCU/PHCC: n = 509; and hospital: n = 1,092.

Although Table 15 shows that hospitals and PHCUs and PHCCs are the services that were most likely to be accessed, Figure 14 shows that people's perceptions of experiences with traditional healers were most positive. The respondents were also least satisfied with visits to mobile clinics, CHWs, PHCUs and PHCCs and hospitals. Though the study did not probe reasons for dissatisfaction with service use, improving client experiences with the health system should be considered a priority. Despite being less likely to seek SRH services through the informal health system, respondents were most likely to be satisfied or very satisfied with visits to traditional healers, with 75.8 per cent saying this (see Figure 14). Findings from other African contexts indicate that dissatisfaction with the formal health system may be associated with the fact that perceived quality of health care is not solely biomedical, but figures in other social, material and even spiritual factors.[185] These may include experiences with rude or unhelpful medical staff, in a clinical setting that can be intimidating and unfamiliar, and a lack of congruency between care and social and spiritual beliefs. Taking such factors into account is important when considering how health services are provided. This also speaks more broadly to the prominence that

185 L. Denney and R. Mallet, *Mapping Sierra Leone's Plural Health System and How People Navigate It*. Briefing Paper 6 (Secure Livelihoods Research Consortium, September 2014).

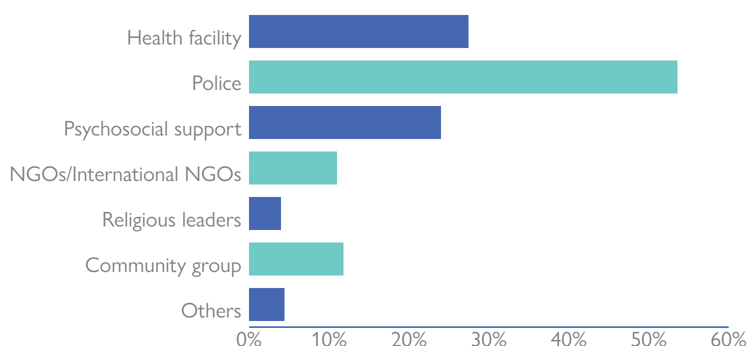
traditional leaders – and religious structures – have in all facets of community life.

Gender-based violence reporting and support-seeking behaviour

Incidents of GBV experienced by female-respondent households in the last year were reported to a service provider by the vast majority (82.7%, n = 1,037). Among the targeted groups surveyed, there was little variation in overall reporting rates. High rates of GBV reporting may be partly explained by the fact that each target group that participated in the research was well positioned to access GBV services.[186] In all likelihood, one can expect rates of GBV reporting by more marginal populations to be significantly lower as this statistic is not borne by qualitative interviews with GBV service providers, which indicate that high levels of stigma, potential for retaliations by perpetrators and lack of confidentiality among service providers are significant barriers to seeking support from formal services.

Actors first disclosed to

Figure 15: Initial place where most recent gender-based violence incident is reported



Note: n = 840.

186 The sampled respondents have a high concentration of GBV services accessible to IDPs living in PoCs and to people living in the urban areas from which host communities were sampled, while FSWs were accessed through IOM networks linked to GBV-related programming.

More than half of the respondents first disclosed GBV incidents to police, as Figure 15 indicates, while approximately a quarter went to a health facility first, followed by psychosocial actors. The survey also examined SRH-seeking behaviours of the respondents. As shown in Table 15, hospitals and PHCUs and PHCCs are the services that were most likely to be accessed. According to disaggregated data, IDPs in PoCs received most SRH services from hospitals and PHCUs and PHCCs, while host community respondents, and especially FSWs, were more likely to go to a hospital.[187] Those in host communities and FSWs are also more likely to access SRH through a pharmacy or through traditional and religious healers.

It is likely that high levels of reporting of GBV incidents to police is linked to local enforcement by both health providers and police to complete Form 8 by the police before receiving services. The Ministry of Interior issued a circular on 1 November 2012 to say that Form 8[188] is not required before providing health services. However, the application at the local level by both health services and police is creating a significant barrier to effective care and recovery of GBV survivors. The following is an extreme example of how this dynamic affects GBV survivors: "I have seen a girl come in [to a health facility] actively bleeding and she is brought to the police to fill in a form before she is taken to the doctor."[189]

Timing of reporting

Looking at the timing of reporting, as shown in Table 16, a significant number of respondents stated that incidents have been reported within

187 Looking at SRH services accessed by target group, 49.6 per cent of IDPs in PoCs, 75.8 per cent of host communities and 93.4 per cent of FSWs went to a hospital; 48.8 per cent of IDPs in PoCs, 16 per cent of host communities and 18.1 per cent of FSWs went to a PHCU/PHCC; 23.1 per cent of IDPs in PoCs, 32 per cent of host communities and 27 per cent of FSWs went to a pharmacy; 1.7 per cent of IDPs in PoCs, 8 per cent of host communities and 5.9 per cent of FSWs went to a traditional healer; and 2.7 per cent of IDPs in PoCs, 3.4 per cent of host communities and 5.7 per cent of FSWs went to a religious healer. For IDPs in PoCs, host communities and FSWs, n = 747, n = 474 and n = 389 respectively. Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

188 Ministry of Interior, Statement Memorandum Circular, Office of the Commissioner of Police, Guidelines for Using Form 8 for Survivors of SGBV: Form 8 is not mandatory for survivors of gender-based violence seeking health services, 1 November 2012.

189 KII, Juba, 17 March 2017.

a few hours, while many people still did not report incidents until some weeks or months later. IDPs in PoCs were the least likely to report an experience of GBV immediately, with 16.3 per cent waiting some weeks or months. Generally, the table indicates that most people reported speaking to somebody immediately, while just over one quarter did so after some days, and 1 in 10 waited some weeks or months.

Table 16: Time to report most recent gender-based violence incident

	IDPs in PoCs (%)	Host communities (%)	FSWs (%)	Total/Average (%)
Immediately, in the course of the next few hours	52.8	73.8	70.1	63.7
After some days	29.1	23.1	21.2	25.1
After some weeks or some months	18.1	3.1	8.7	11.2

Note: For IDPs in PoCs, host communities, FSWs and all respondents, n = 354; n = 229; n = 241; and n = 824 respectively.

The type of violence also affected the timing of reporting, with those who experienced rape less likely to seek services immediately (57.6%) than those who experienced physical or psychological violence (74.6% and 64.4%).[190]

Timely reporting of GBV cases to service providers is a key challenge to responding to GBV. Lack of timely reporting was deemed to be particularly problematic in cases of rape, as the most effective clinical treatment for rape is within 72 hours of an incident.[191] Non-reporting has obvious health consequences for survivors of sexual violence. Those who do not come forward impede their access to psychosocial and reproductive health services to prevent unintended pregnancies and the transmission of communicable diseases such as HIV/AIDS.[192] In response, qualitative research indicated the need for more awareness-raising to be conducted about the risks of waiting to report rape cases:

190 Disaggregation by type of GBV only included the types of GBV with enough statistical power for disaggregation, which excluded sexual assault.

191 Health Cluster South Sudan, Health Cluster Bulletin #40, 6 September 2014, p. 4.

192 S.E. Casey et al., "Care-seeking behavior by survivors of sexual assault in the Democratic Republic of the Congo", *American Journal of Public Health*, 101(6):1054–1055 (2011).

"People are not aware that if you come within 72 hours, it will help you prevent unwanted pregnancies or [help] prevent them from getting [sexually transmitted infections] STIs. [If this knowledge is provided], I think people will come forward."[193]

Barriers to support seeking after gender-based violence incidents

Female respondents reported that the main reasons they do not report if they experience a GBV incident are primarily being afraid of further violence from perpetrators, did not trust anyone or they thought that nothing could be done (see Figure 16). Studies conducted on GBV in South Sudan also reinforced the findings of this survey, indicating that the key reasons that survivors do not bring cases forward are as follows: (a) potential retaliation from perpetrators; (b) social stigma; (c) and fear of rejection from family and community members.[194] For those survivors who do not come forward to report an incident, physical trauma is compounded by feelings of extreme isolation, hopelessness and powerlessness.[195]

Potential for violence from perpetrators, lack of trust in those providing services and the risk of stigma – whether from a partner or community – indicates that women and girls are very concerned about confidentiality when accessing services. Health, psychosocial, security and legal service providers must be able to handle cases, and the associated personal information, with appropriate levels of non-judgemental attention and confidential case management. Breaking confidentiality puts GBV survivors at risk of retaliation, hinders their emotional and social recovery due to stigma and therefore deters them from reporting and seeking support. The fear of further violence was articulated by one key informant:

> There is also a fear to report the perpetrators. […] They think once they come forward, there would be a need for the protection actors to know who the perpetrator is. For example, in cases of domestic

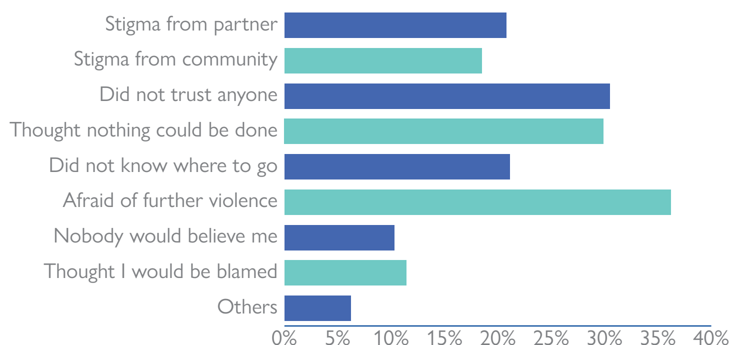
193 KII, Bentiu, 21 June 2017.

194 GBV sub-cluster, *Assessment of Barriers to Services for GBV Survivors – August 2016 UN House Protection of Civilians Site, Juba Compiled Data and Recommendations* (2016) (n.p.).

195 C. Garcia-Moreno H. Jansen, M. Ellsberg, L. Heise and C. Watts, *Multi-country Study on Women's Health and Domestic Violence against Women: Initial results on prevalence, health outcomes and women's responses* (WHO, Geneva, 2005), p. 79.

violence, if a husband beats or harms the wife, on coming for help, she will fear that her husband will get to know that she is exposing him; therefore, she fears the occurrence of more beatings and so keeps silent about the incident.[196]

Figure 16: Reasons for not reporting most recent gender-based violence incident (n = 166)



Note: Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

High levels of stigma are particularly the case with incidents of rape and sexual violence. Survivors who are not yet married see their chances of marriage seriously jeopardized, while those already in marital unions risk divorce by coming forward. As a result, survivors may not seek services, or if they do, it may only be in those cases where there is apparent physical injury; for example, two key informants explained:

Most of them they would be coming if [there is] physical damage ... physical injuries to the body. The other people [without physical injuries] do not come [forward to report cases].[197]

Health services were also not exempt from serious challenges related to confidentiality, and therefore underreporting of cases. Key informants cited cases in which the confidentiality of survivors was violated by health staff. Inability of the health staff to handle cases respectfully and confidentially will compound the reluctance of survivors to bring cases forward.

196 KII, Bentiu, 21 June 2017.

197 KII, Nimule, 10 April 2017.

Both key informants and FGD respondents raised serious concerns about police effectiveness particularly when handling cases of GBV. Although Figure 15 shows many respondents first reported cases to police, it should be reiterated that high levels of initial reporting to police were likely driven by the requirement to report cases in order to receive medical attention (the issue of local implementation of Form 8 procedures before accessing medical care). Thus, these high rates of reporting to the police do not negate the serious problems that exist in the way that police handle cases of GBV. As one key informant put it:

> [Survivors] come only for medical service but will not go to the police. They give you reasons like: I don't want other community members to know about it, my husband will divorce me, my daughter will not get married, or my boyfriend will leave me.[198]

Qualitative research suggested overall structural deficiencies within the criminal justice system, particularly among the police, are a key impediment to seeking justice. Even if police were better informed and more aware of how to handle cases of GBV, there is still little willingness or capacity to prosecute cases:

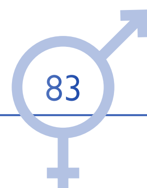
> Police may arrest any perpetrator who is found guilty, put in the cell for a couple of days, or weeks, and can be released and set free. This… puts the survivor in danger and [a state of] fear.[199]

A further concerning figure is that 30 per cent of the respondents thought that nothing could be done, and one fifth of the respondents did not report cases because they did not know where to go (see Figure 16). The first relates to lack of awareness among respondents about the consequences of GBV, and the second concerns inconsistencies in service availability that can result in considerable confusion about service availability. As said by one key informant: "The hospital is in the town, which is about two-hour drive. But then I don't know the next nearest health facility, where it is in that location and what services are provided where."[200] Key informants report that there exists a patchwork of actors

198 KII, Torit, 11 April 2017.

199 KII, Bentiu, 20 June 2017.

200 KII, Juba, 25 March 2017.



that support different health services: "You might go to one location where the service is free, and another location where it's not. That can be very confusing to a community – not knowing if they are going to be charged and not knowing their rights."[201] Consequently, survivors seeking health care may not have adequate information to determine where to access free service or even what service is available.

Issues related to accessibility of health services were not widely mentioned by survey respondents as an impediment to reporting, probably because research was conducted around urban areas and in PoCs where services are concentrated. But it was often cited throughout the qualitative research as an obstacle for remote populations. Those living remotely have less access to services because of the long distances they must travel to get to the health facilities. Research on the economic costs of violence experienced by women and girls indicates that survivors can spend a great deal in direct out-of-pocket costs on transportation to health facilities.[202] These expenditures compound the effects of violence and greatly affect household consumption, skewing it away from the goods and services that would be chosen in the absence of violence.[203] Survivors in remote areas also have less information about what services are potentially available to them.

Other barriers not reported by respondents but by key informants is the normalization of different forms of GBV. Beliefs related to the subordination of women in intimate relationships were also mentioned throughout the qualitative research as a key reason for non-reporting of IPV. One health-care worker said: "In the case of domestic violence... [women] will not go and report … because they are seeing it like it's a normal thing."[204]

201 KII, Juba, 17 March 2017.

202 T. Day, K. McKenna and A. Bowlus, "The economic costs of violence against women: An evaluation of the literature", Expert brief compiled in preparation for the Secretary-General's in-depth study on all forms of violence against women (United Nations, 2005), p. 10.

203 Ibid.

204 KII, Maridi, 25 April 2017.

Improving access to services for gender-based violence survivors

Increasing knowledge about different forms of GBV and available services is important for GBV prevention and response. Awareness-raising campaigns are appealing, for instance, because these can reduce feelings of isolation among survivors.[205] It may also help to combat the stigma around the reporting of GBV, which is a key factor for underreporting.[206] As mentioned in an interview with a health-care provider: "The obstacle is stigma […] [survivors] are hiding. They don't want to come out in the open, to the police or maybe to the hospital for help. It's like a taboo in the community for you to say that you are raped."[207] As a result, awareness-raising initiatives should be seen as one important element of a broad range of interventions that can contribute to GBV prevention and response. They can improve knowledge, for instance, about availability of referral services and can be connected to endeavours aimed at changing attitudes and behaviours through educational measures and deeper, long-term programmatic engagements.

There is an important opportunity to leverage influential community stakeholders in activities aimed at creating awareness and promote attitudinal shifts and behavioural change around GBV and SRH issues. As indicated by one key informant:

> Working with religious leaders, I don't think we have really done enough of that… [In] evaluations of the 16 days [of activism against GBV] this year, and also in other discussions in sub-clusters, several times people have said we have to do more with religious leaders, because the messages during Sunday sermon is one of the most important places to [pass messages to communities].[208]

In the current South Sudanese context – defined by conflict-driven community dislocation caused by significant movements of population and the divisions brought about by ethnic fragmentation –

205 Heise, 2011:19.

206 Oxfam International, 2017:45.

207 KII, Maridi, 26 April 2017.

208 KII, Juba, 25 March 2017.

religious structures, in particular, may offer a common point of collective education.[209]

Programming challenges related to raising awareness among hard-to-reach populations were also discussed broadly throughout qualitative research: "[A] lot of organisations use radio programmes. It's definitely something we support and we consider a key component, but … you [must be careful about] what actually is being said." If not implemented appropriately, awareness-raising campaigns can be a double-edged sword. Such campaigns can, for instance, reinforce the idea that a particular behaviour is going on everywhere, having precisely the opposite effect as intended. In this case, awareness-raising could communicate that GBV is prevalent, rather than support messages targeting violent behaviour as inappropriate.[210] Therefore, there is a necessity for accountability and monitoring of messaging that adhere to do-no-harm principles.[211]

Health priorities include the expansion of coverage of clinical management of rape services, including remote locations and improving the quality of care, stemming from lack of confidentiality. KIIs suggested a prioritization of the following: (a) basic health components; (b) psychosocial support; and (c) community-based support for areas in highest need and with current gaps. Options suggested for reaching faraway survivors were mobile health teams, community health volunteers and improving access at PHCC level. However, to be effective, these would have to engage with communities with sufficient frequency to allow survivors of rape to receive support within 72 hours, as well as address the satisfaction challenges identified for access to SRH services.

Given the traumatic nature of GBV, addressing the gap in comprehensive, empathetic and confidential health care is a crucial element of building capacities in formal health care to address issues of adherence to

209 KII, Terekeka, 8 April 2017.

210 E. L. Paluck and L. Ball, *Social Norms Marketing Aimed at Gender based Violence: A Literature Review and Critical Assessment* (International Rescue Committee, New York, 2010), p. 19.

211 For example, in fragile and conflict-affected areas, shifting social norms around reporting violence may channel individuals into poorly resourced or dysfunctional services. See: Paluck and Ball, 2010:7.

GBV guiding principles[212] among health service providers and increase people's trust in and satisfaction with formal health facilities. Addressing the broader issue of dissatisfaction with formal health system for SRH services, particularly among mobile clinics, is required so that both GBV and SRH are more effective and accessible, and as a way of increasing demand by improving supply of services. Non-reporting and reporting delays were said to be especially challenging in remote communities.

Another increasingly popular strategy for addressing GBV is through the establishment of one-stop centres, which provide integrated, multidisciplinary services in a single physical location, including health care, psychosocial support and police and justice sector responses.[213] A comparative case study in Kenya and Zambia shows that a health facility-based, hospital-owned one-stop centre model is well suited for achieving the broadest range of health and legal outcomes to survivors.[214] If implemented properly, however, the one-stop centre model can create a safe and supportive environment for women and girls to seek services, such as medical treatment, protection from further violence and legal advice. Importantly, the centres are designed to reduce the number of institutions that a survivor must visit to receive basic support following an incident of violence, by coordinating the assistance and referral process through one location. In this way, one-stop centres counteract incomplete and inconsistent information that exists regarding service provision. They can also provide the confidential, safe and respectful atmosphere that is often missing – especially in police station – as well as private treatment rooms and the facilities to conduct the specialized examinations and analysis needed to provide the medical evidence that assists in prosecution of a legal case.[215]

212 IASC, 2015.

213 Government of Liberia, *Standard Operating Procedures for GBV Services at 'One Stop Centre'* (2013) (n.p.), pp. 3–6.

214 J. Keesbury, W. Onyango-Ouma, C. Undie, C. Maternowska, F. Mugisha, E. Kahega and I. Askew, *A Review and Evaluation of Multi-Sectoral Response Services ("One-Stop Centers") for Gender-Based Violence in Kenya and Zambia* (Population Council, Nairobi, 2012), p. 28.

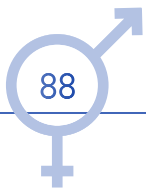
215 UN Women, "Consider investment in 'one-stops' to meet the multiple needs of survivors" (n.d.). Available at www.endvawnow.org/en/articles/1094-consider-investment-in-one-stops-to-meet-the-multiple-needs-of-survivors.html (accessed December 2017).

Safe-house services were not mentioned by respondents, and are important temporary protection mechanisms; however, where such initiatives are pursued, they must be done so according to appropriate guidelines, given the security risks involved. Key informants reported instances where this was not the case:

> You see a lot of initiatives, which they may have good intentions, but then they don't follow [appropriate] guidelines… [The Government] now is setting up a safe house. It should be a last resort, because in this context, we know what can happen. If it is not situated in a hospital, or near a police station, it should be really disguised. There should be 24-hour surveillance and services. But, at the end of the day, they will put the women into [the safe house], and they will be unsafe [if it is not implemented well].[216]

Working with the criminal justice system is important to protect survivors and hold perpetrators accountable. The provision of legal aid services and community paralegals to educate and advocate for the rights of GBV survivors, especially in areas where customary law is predominately applied. Furthermore, to increase reporting rates for investigations, further training of police officers on duty and before active duty is necessary to develop their capacities to handle GBV cases in ways that meet appropriate guidelines and are survivor-centred. In particular, there is a requirement to address harmful social norms among the police and provide further training and support to implement privacy and confidentiality requirements. Putting these in place can strengthen legal response to GBV. However, deep structural changes are required within the criminal justice to ensure that justice is truly accessible to GBV survivors. This will require a strong commitment by the Government working with international and local stakeholders to build capacities of actors across the range of security, legal and judicial services. Providing justice to GBV survivors requires that appropriate procedures are in place that enable investigations, prosecutions and access to appropriate resolutions and reparations. The South Sudanese state must work to socialize and implement current statutory laws at local level, where traditional courts are implementing customary

216 KII, Juba, 25 March 2017.



law for criminal cases. However, there are also several laws that do not protect women and girls, such as rape within marriage or require harmonization, as in child marriage. If prosecutions of perpetrators are more probable, support-seeking behaviour is also likely to increase.

4. The situation of female sex workers

Little research exists on sex work in South Sudan.[217] By specifically focusing on FSWs as a target group of interest, this study attempted to fill this gap in knowledge. It found that the vast majority of all interviewed FSWs (92.9%, n = 652) stated that, in a month before the survey, they had performed at least one sexual act for money, food, shelter or any other benefit. This means that those using sex work to survive are doing so actively – inclusion criteria for the study required only one act of sex work in the year preceding the survey. Indeed, Table 17 indicates that most FSWs had performed transactional sexual acts 5–10 times in the month before the survey, and another one third (34.7%) performed 11 or more such acts. A mapping of sex workers in Juba and Yambio similarly found high frequency of sex work.[218] The worsening socioeconomic situation in South Sudan is poignantly captured in the realities of those who "practise the world's oldest profession in the world's newest country".[219] High rates of sex work are undoubtedly indicative of the vulnerability facing women and girls in South Sudan, many of whom may be from livelihoods, or who have lost income and possessions through conflict and displacement: "apart from the fighting, now we have the famine issue that also puts women and girls at risk with GBV especially exploitation and abuse".[220] Qualitative research also reveals that the spectrum of what may qualify as sex work is broad. Such work might involve the direct exchange

217 The most comprehensive effort is the *Mapping Report of Female Sex Workers in South Sudan, Phase 1* (2012). The report indicates that the average age of FSWs is between 23 and 26 years of age and that less than 10 per cent of FSWs in Juba were South Sudanese, with the majority coming from Uganda and Kenya, while about 45 per cent of those from Yambio were from South Sudan. See: WHO and South Sudan HIV/AIDS Commission, *Mapping Report of Female Sex Workers in South Sudan, Phase 1* (2012) (n.p.).

218 FSWs in Juba generally entertain between 7 and 8 clients per day and those in Yambio see between 2 and 4 clients, and most FSWs in these two locations tend to be hotel-based, venue-based and street-based. See: ibid.

219 IRIN, "Sex workers risk violence, HIV in Juba's brothels", 28 November 2011. Available at www.irinnews.org/report/94320/south-sudan-sex-workers-risk-violence-hiv-jubas-brothels.

220 KII, Juba, 27 March 2017.

of money for sexual acts, but it may be more subtle: "where men, just sometimes come into the house sometimes, and bring food or something. The women they probably don't even see it as commercial sex work."[221] This gives further evidence to the survival mechanisms many South Sudanese females are forced to employ.

Table 17: Frequency of sex work in the last month (n = 579)

	Per cent
Once	11.7
2–4 times	25.4
5–10 times	28.3
11–20 times	16.1
More than 20 times	18.6

The *South Sudan Penal Code* criminalizes prostitution,[222] therefore, sex work is typically pushed underground and puts those who engage in this activity at greater risk of human rights violations, including GBV.[223] As mentioned above, FSWs are the target group that is more likely to report that an incident of GBV was committed against a female in their household. This study also gauged violence directly committed against FSWs because of their work. Figure 17 indicates that sex work comes with a significant cost to physical safety, with 57.5 per cent (n = 650) of FSW respondents saying they had ever been beaten up or physically hurt because of the work they do. Further, 57.7 per cent (n = 651) said they had ever been forced to have sex because of sex work. In addition to the physical and emotional effects of such violence, which are considerable, FSWs who experience violence are also much more likely to experience condom failure, putting them and others at greater risk of STIs like HIV.[224]

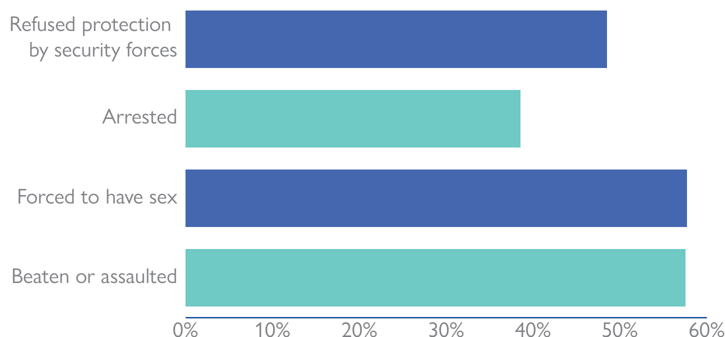
221 KII, Juba, 27 March 2017.

222 Government of South Sudan, 2008: Chapter XVIII, Article 252, p. 132.

223 International HIV/AIDS Alliance, 2008:8.

224 ATHENA Network, 2013:8.

Figure 17: Types of gender-based violence and insecurity experienced due to sex work

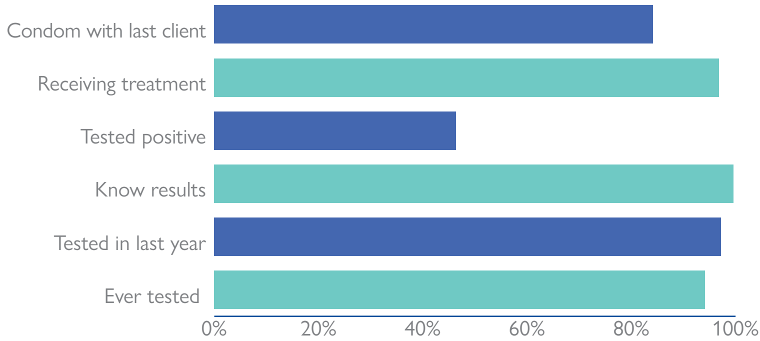


Note: Beaten or assaulted: n = 650; forced sex: n = 651; arrested: n = 643; and refused protection: n = 650.

Another 38.5 per cent said they had ever been arrested because of sex work. Of those that had been arrested, most (57.7%) said that this had happened once or twice. That 22.2 per cent indicated that it happened more than five times indicates that there is a group of FSWs particularly vulnerable to predatory interactions with security forces. Almost half of the FSWs reported that they had at some point been refused protection by the police, United Nations Police or other security actors because of sex work. Violence by representatives of the State compromises sex workers' access to justice and police protection, and sends a message that such violence is acceptable, and the criminalization of sex work can provide a cover for violence.[225] For this reason, prevention messages and trainings should be targeted to personnel within the security system. Particular sensitivities exist in terms of GBV and conflict, meaning that programming with armed forces is unlikely. Thus, working with the police would be a priority. But even with the police, a transfer of staff away from the GBV issues to a different department might mean that turnover undermines training efforts. Similar challenges are not faced with service providers such as health personnel, who will continue to provide health care even if transferred. Such limitations must be taken into account when designing and implementing programmes.

225 WHO, 2013:24.

Figure 18: Key indicators of sexual and reproductive health among female sex workers



Note: Ever tested: n = 653; tested in last year: n = 614; know results: n = 596; tested positive: n = 581; receiving treatment: n = 270, and condom with last client: n = 649.

Figure 18 shows key indicators of SRH among FSWs. It shows that in terms of HIV testing, the vast majority of FSWs interviewed said they have been tested at some point in their lives, almost all who had been tested had a test in the last year, and almost all knew the results of the test. Of the 46.4 per cent that tested positive, the overwhelming majority were receiving some form of treatment. High levels of treatment among FSWs are likely explained by snowball sampling techniques that were used to access this group. Respondents in this group were connected to the IOM networks and that of its partners, which work with FSWs to – among other things – access and use contraception and HIV testing and treatment. It is likely then that more hidden populations of FSWs would express significantly lower levels of awareness of, and access to, testing, treatment and contraception. That being said, the most popular treatment being received was anti-retroviral treatment (89.1%, n = 256) and counselling (55.5%, n = 256).[226] Of the respondents, 96.4 per cent (n = 252) said that a hospital is the main place they received treatment, with the remaining 3.5 per cent going to pharmacies, mobile clinics, PHCU or PHCCs. Of the 7 respondents who had tested positive but were not receiving treatment, 5 said that they were afraid of violence and that they did not trust anybody, and 3 said that they thought nothing would be done and that they were afraid of stigma, shame or rejection.[227]

226 Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

227 Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

Table 18: Reasons for not using a condom among female sex workers (n = 98)

	Per cent
Client did not want to but did not pay more	29.2
Client paid more	45.0
Client threated me	42.3
Afraid of rejection	37.9
I did not want to	32.0
Other	5.2

Note: Respondents were allowed to select multiple responses. Aggregated responses add up to more than 100 per cent.

When it comes to condom use, most FSWs (84.2%, n=649) indicated that they had used a condom with their most recent paying client. Again, FSWs in IOM's networks are likely to display higher usage of condoms than those outside of these. For those who did not use a condom, higher pay, fear of threat and fear of rejection were the most important reasons for not doing so, as shown in Table 18. The findings of this study indicate that particular attention should be paid in GBV prevention and response to FSWs, who appear to be a group that is particularly vulnerable to different types of gendered violence. But because of the clandestine nature of the sex industry, little information exists about FSWs in South Sudan. The findings outlined in this section, along with those in other parts of this study, have helped profile frequency of sex work, experiences with violence, arrest and detention, HIV prevalence and treatment and condom usage. This is a key first step in developing effective GBV and HIV prevention and response strategies targeted at FSWs throughout South Sudan. Still, more work is required to add research that produces policy-related and programmatic knowledge that furthers understanding of the situation of FSWs in South Sudan.

Key recommendations

The Government of South Sudan including Ministries of Health, Ministry of Justice, Ministry of Defence and Ministry of Gender, Child and Social Welfare, with the Health Cluster, GBV sub-cluster and other international partners need to collaborate on the following efforts:

- This research confirms there is a high level of experienced incidents of GBV by women and girl respondents – from rape, to child marriage and different forms of IPV – as well as high level of perceived risk of different forms of physical, psychological and sexual violence both inside and outside the PoCs. Therefore, GBV programming should be broadened beyond the PoCs to expand and provide more sustainable services to more inaccessible populations. Health partners are recommended to ensure resources for increasing the scope of access to clinical management of rape services in hospitals, PHCCs and PHCUs at the same time addressing quality of service provided.

- Although there is a good level of knowledge about GBV service availability within the formal health-care system, there is still limited understanding of consequences, the importance of seeking services early and there are significant concerns around safety and confidentiality of services. Therefore, there is a need for investment in continued awareness-raising efforts on GBV and capacity-building for multisectoral service providers to enable them to provide safe, confidential and survivor-centred services. Furthermore, there is need to develop, disseminate and monitor the implementation of the referral pathway and standard operating procedures.

- There is limited understanding of the different types of GBV, conflating it with sexual violence, yet other types of GBV including different forms of IPV and child marriage are common and culturally condoned. There is a critical need for more awareness raising on what GBV is, its forms and consequences

among communities, local authorities and traditional leaders, as well as service provider staff and outreach workers.

- Sociocultural beliefs in bride wealth and child marriage predispose women and girls to GBV. Therefore, there is the need to strengthen work with traditional institutions, leaders and government actors to systematically address these issues.

- There are high levels of risk of violence in PoCs in water, sanitation and hygiene (WASH) facilities and when IDPs go in search of firewood. There is a need for GBV, WASH and shelter/non-food item actors in particular to work together to reduce risks of GBV at WASH facilities. The Humanitarian Coordinator and Cluster coordinators need to reinforce practical efforts to make accountable and tangible mainstreaming of GBV risk mitigation both inside and outside of the PoCs, to ensure that services and humanitarian assistance are safe and accessible for women and girls.

- High reported rates of GBV are compounded and perpetuated by a high level of acceptance of harmful gender norms and normalization of violence. Investment in primary prevention of GBV is crucial, utilizing and adapting evidence-based approaches:

  — The GBV sub-cluster and the MGCSW should improve the quality of awareness messages and socialize these among organizations utilizing these messages and ensure that those engaging on awareness raising are adequately trained to do so. Messages must seek to address the culture of victim-blaming, gender stereotypes and harmful notions masculinity and femininity, and raise awareness of consequences of different forms of GBV in emergency contexts.

  — Donors should seek to fund support well-researched adaptions of globally recognized long-term behaviour change strategies, which can be scaled up as integral to peace process and reconciliation at the community level. These approaches

need to holistically target the social ecology,[228] engage men and boys as agents of change,[229] and invest in broader women's empowerment and initiatives.

- GBV survivors should report particular concerns about retaliation from perpetrators. Investment in initiatives to address the culture of impunity and survivors' safety concerns are paramount. This includes the systematic training of police officers to develop capacities in handling GBV cases, which are survivor-centred and strengthen safety measures, procedures and provision of legal aid.

- FSWs are consistently more at risk of GBV than other groups. FSWs should be integrated into broader GBV programming, utilizing the understanding of their specific vulnerabilities and capacities. Working with the clients and the police will also be a key element of efforts to reduce GBV and other forms of violence against sex workers.

- There is a high level of social denial that GBV, particularly sexual violence against men and boys, is committed in South Sudan. While further research is called for in this area, GBV programming should also invest in addressing attitudes among service providers and the community that contribute to lack of reporting among male survivors of GBV.

This study examined some of the key characteristics and trends related to the KAP that affect GBV in South Sudan. Understanding the problem through reliable and accurate data is not only a precursor for effective prevention and response interventions, but also the basis for tracking the effectiveness of such interventions across time and space. This is a necessary step towards preventing and responding to GBV; a step to be taken along the path towards the consolidation of both peace and security for all women, men and children living in South Sudan.

228 Heise, 2011:vi.

229 Jewkes, Flood and Lang, 2015.

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