Interagency Rapid Gender Analysis – COVID-19

Uganda Refugee Response

November 2020

ACKNOWLEDGEMENTS

This report is the result of a collaboration between the Government of Uganda, UNHCR, UN Women, DRC, IRC, ALIGHT and CARE International. The process was initiated and co-ordinated by UNHCR and UN Women. Appreciation goes out to OXFAM, TPO and Over-comers Women's Group for their support with data collection.

We wish to extend our gratitude to the Government of Uganda for their continued gener-osity to refugees and asylum seekers in Uganda and their support with carrying out this assessment. In particular, we thank the Office of the Prime Minister, the Ministry of Gen-der, Labour and Social Development, the Comprehensive Refugee Response Framework Secretariat and the Uganda Bureau of Statistics for availing their time and expertise dur-ing this process.

We would like to also acknowledge the refugee women, men, girls and boys of diverse backgrounds whose participation in this assessment demonstrates their willingness to contribute to their wellbeing and the wellbeing of their communities.

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Abbreviations

CFRM	Complaints, Feedback and Referral Mechanism
CoP	Category of Person
COVID-19	Novel Corona Virus Disease 2019
CRRF	Comprehensive Refugee Response Framework
DLG	District Local Government
DRC	Democratic Republic of Congo
FP	Family Planning
IMS	Information Management System
GoU	Government of Uganda
HoH	Head of Household
HIV	Human Immunodeficiency Virus
KII	Key Informant Interview
MGLSD	Ministry of Gender, Labour and Social Development
MHPSS	Mental Health and Psychosocial Support
MNCH	Maternal, New-born, and Child Health
NGO	Non-Governmental Organization
OPM	Office of the Prime Minister
PLW	Pregnant or Lactating Woman
PLWD	Persons Living with Disabilities
PPE	Personal Protective Equipment
PSEA	Protection from Sexual Exploitation and Abuse
RGA	Rapid Gender Analysis
RWC	Refugee Welfare Committee
SGBV	Sexual and Gender-based Violence
SRH	Sexual and Reproductive Health
TPO	Transcultural Psychosocial Organisation
UBOS	Uganda Bureau of Statistics
UNHCR	United Nations High Commissioner for Refugees
VHT	Village Health Team
VSLA	Village Savings and Loans Associations
WASH	Water, Sanitation and Hygiene
YUGNET	Yumbe Gender-Based Violence Network

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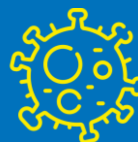

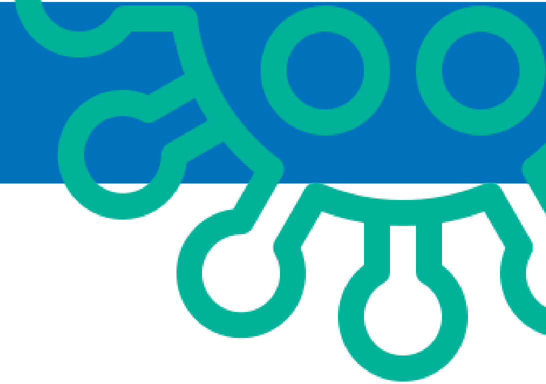

Executive Summary

Introduction

While the Government of Uganda (GoU) responded rapidly to implement measures for the Novel Corona Virus Disease 2019 (COVID-19) prevention and response, restrictions on movement and other necessary lockdown measures taken to prevent further spread of the virus have also had an immense impact on the lives of both Ugandans and refugees and led to a rise in protection risks and challenges.

The number of COVID-19 cases also continues to rise in Uganda, presenting a growing risk to refugees and asylum seekers. There have been fears that risks of a widespread outbreak could be magnified in settlements where water and sanitation facilities are scarce, and many people live hand to mouth.

To allow for a proper understanding of the extent of the impact of COVID-19 on refugees in Uganda, the need was identified to carry out a Rapid Gender Assessment (RGA) to assess the impact of the pandemic on women, men, girls, and boys of diverse backgrounds, including persons with disabilities, older persons and those with serious medical conditions. This assessment was conducted jointly by UNHCR, UN Women, International Rescue Committee (IRC), CARE International, ALIGHT, the Danish Refugee Council (DRC), with support from the Ministry of Gender, Labour, and Social Development (MGLSD), the Office of the Prime Minister (OPM), the Comprehensive Refugee Response Framework (CRRF) Secretariat, Uganda Bureau of Statistics (UBOS), OXFAM, TPO, Over Comers Women Group and YUGNET. The assessment was carried out both in Kampala and across refugee settlements.

Methodology

A mixed methods approach was used to address the central objectives of the study, including a review of secondary sources, a household survey, and key informant interviews. The household survey targeted 1,535 individuals, including vulnerable groups such as child heads of household (HoH), persons living with disabilities (PLWD), and persons with a serious medical condition. Key informant interviews (KII) were conducted with 185 individuals, including representatives from the COVID-19 District Task Force, interagency coordination sector leads, settlement commandants, sub-county and village task teams, Refugee Welfare Committee (RWC) representatives, and other resource persons. The

final locations included within the sample were Kampala, Kyaka II, Nakivale, Oruchinga, Adjumani, Bidibidi, Imvepi, Kiryandongo, Lobule, and Rhino Camp. These locations were selected to ensure that all regions and population groups were represented in the final sample of respondents.

Selected Key Findings

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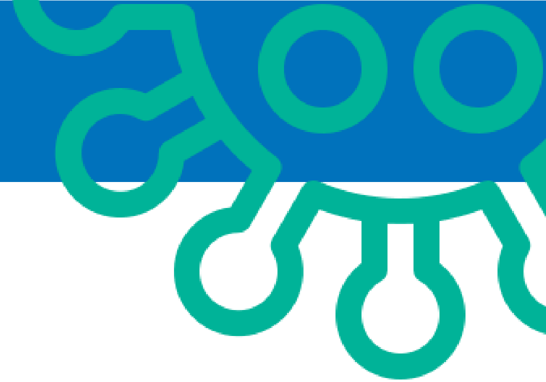
Household Economic Activities & Livelihoods

58.0% of respondents reported a decrease in income since the onset of the pandemic, a value which rises to 69.6% among those who reported paid work as their main income activity pre-pandemic. A higher percentage of men reported a negative impact when compared to women, which may be due to more men having been employed in paid work prior to the pandemic, however, it is clear that both groups have been impacted significantly. Adding to the impact on incomes, the findings show that women have been less able to continue saving through VSLAS when compared to men (43.7% of women compared to 53.5% of men).

The groups most often reporting additional unpaid work are girls, women aged 18-24, and female child HoH. While male respondents more often reported spending additional time on farming (30.0%) and leisure (19.1%), female respondents reported cooking (43.4%), doing housework (38.3%), collecting fuel (23.5%), and collecting water (22.5%), the latter two of which exposes them to greater risks of SGBV as will be discussed below.

The most common negative coping mechanisms reported by survey respondents were buying food on credit (53.1%), spending savings (36.9%), and reducing essential non-food expenditures (26.3%), and were found to depend greatly on location. Key informants further highlighted that men and boys engaged in theft (8%), while women and girls engaged in survival sex work (10%). Child marriage (18%) was also frequently raised relating to girls. Key informants descriptions also highlighted the gendered nature of the negative coping mechanisms, as well as the sheer number of strategies employed by women and girls. From their replies, it appears that theft, selling drugs, and borrowing money were most often employed by men and boys, while women and girls engaged in survival sex work, burning charcoal, brewing alcohol,



selling food rations, reducing the number of meals, and selling off personal items.

The impact of lost livelihoods also underlines the disproportionate impact on women and girls. Key informants explained how men suffered from stress and a lack of confidence due to the loss of their livelihoods and an inability to provide for their families (23%), increasing “idleness” (16%), alcohol and drug abuse (14%), and engaging in criminality (8%). Simultaneously their deteriorating mental health, substance abuse, social isolation, lack of food, and crowding in the home were seen to increase the likelihood of domestic violence (10%).

The impact on women and girls following the key informants was therefore clear: increased incidents of SGBV (23%) and domestic violence (17%), a greater burden of the unpaid care work (7%), and a simultaneous inability to meet the basic needs of the household - including food (15%), menstrual hygiene products (9%), and family planning essentials (5%). They were also seen to be at risk of having their resources confiscated by their partners (5%).

Access to Information

Women and girls less frequently reported access to a mobile phone when compared to men and boys and were also less frequently able to access the internet through the phone with 11.4% of women and girls being able to do so compared to 19.1% of men and boys. In general, mobile phone use and internet access are very dependent on location, with little to no issues in Kampala (only 0.6% of respondents did not have a phone), and greater issues in the settlements in the South West (overall 44.8% did not have a phone in the settlements of the South West compared to 25.8% in West Nile and 0.6% in Kampala).

The two most common access issues to information were a lack of equipment (37.7%) and an inability to read (32.2%). Given the challenges women and girls have to accessing a mobile phone, it is not surprising that a lack of equipment was their greatest cited barrier. What was more surprising was the higher percentage of girls compared to boys who cited an inability to read with 31.1% of girls citing this issue compared to only 15.8% of boys. These two issues were also frequently raised by older persons and PLWD and reconfirmed by key informants.

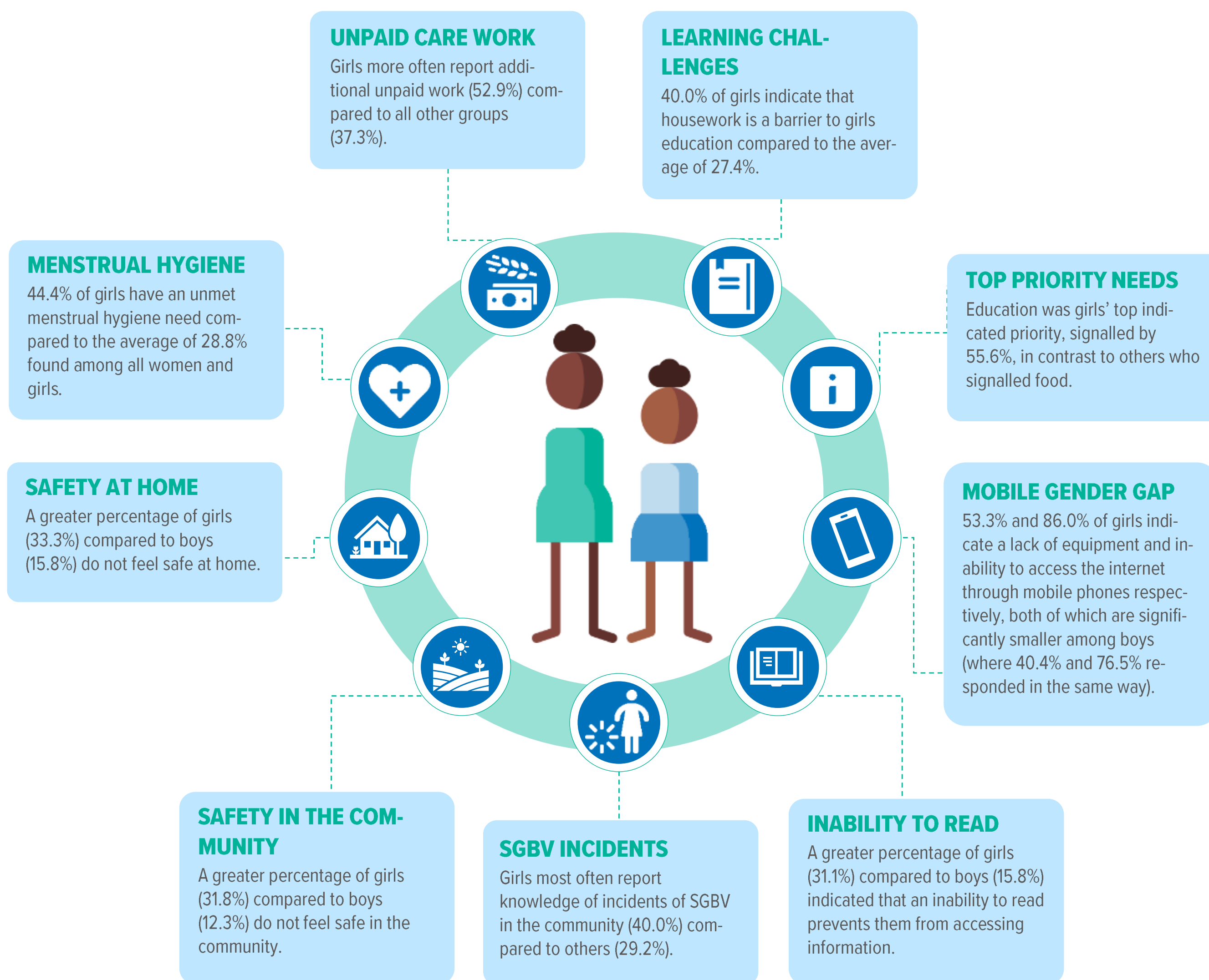
These findings confirm the presence of a mobile gender gap, both in terms of mobile phone ownership and access to internet. This has many implications, from the level of access to information and services to women and men’s sense of security.

Healthcare

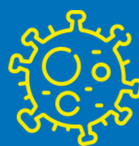
74.2% of respondents indicated needing to access healthcare after the onset of the pandemic, and most frequently women aged 18-24 (84.9%). 90.9% of the respondents who reported needing healthcare indicating having no challenge to access. Nevertheless, key informants did indicate that the pandemic has impacted on the accessibility of healthcare and especially to Maternal New-born and Child Health (MNCH) (20.2%) and HIV chronic services (13.3%). Some of the most frequent barriers they mentioned were a lack of adequate transportation for pregnant women, as

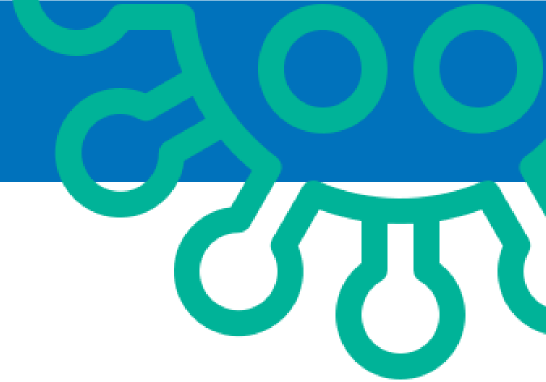
Girls are heavily impacted by the pandemic on a variety of fronts including: livelihoods, healthcare, education, access to information, and exposure to protection and security risks.

Figure 1: An examination of the impact of the pandemic on girls.



well as a decrease in community outreach for women and girls which had been an important point of care for family planning and menstrual hygiene, in addition to many other barriers to health care provision





(supply-side) and to seeking care (demand-side). One serious consequence raised by key informants resulting from this assembly of barriers facing women and girls was the possibility that they may seek traditional treatments for abortion and home births, exposing them to even greater health risks.

Education

The results indicate that close to 40% of boys and girls either have no materials to study or have stopped learning. Two settlements had a particularly high percentage of respondents indicating that children have no materials, Kyaka II and Nakivale, with 38.2% and 46.7% reporting so respectively, while Kampala had an especially high percentage of respondents indicating that children have stopped learning (42.9%). Other challenges to learning highlighted by respondents were the same for boys and girls, with the two most important being a lack of skilled instruction and an inability for parents to help, both signalled by close to half of the participants. Respondents did indicate the challenge to learning of household chores more frequently for girls when compared to boys, with 27.4% reporting this challenge for girls compared to 13.3% for boys. This was confirmed by the key informants.

Key informants further outline some of the worst challenges to girls' and boys' education. With respect to girls, key informants made a clear link between the closure of schools and an increase in teenage pregnancy (21%) and child marriage (18%), two conditions which have been shown in Uganda and elsewhere to lead to higher dropout rates. With respect to boys, school closures were seen to increase "idleness" which consisted of alcohol and drug abuse (14%), involvement in theft and other crimes (8%), and an increase in committing SGBV.

While the likelihood of school-aged children not returning to school was only signalled by 3.9% of the respondents, that percentage was curiously higher among boys 12-17 with 10.0% indicating that school-aged children would not be returning to school. It may be interesting to see whether boys are less inclined to return to school. In addition, the percentage of respondents indicating no return to school was much higher in Kampala, with 19.5% indicating so. This is not surprising given that the pandemic has had a big impact on refugee families in this location.

Menstrual Hygiene

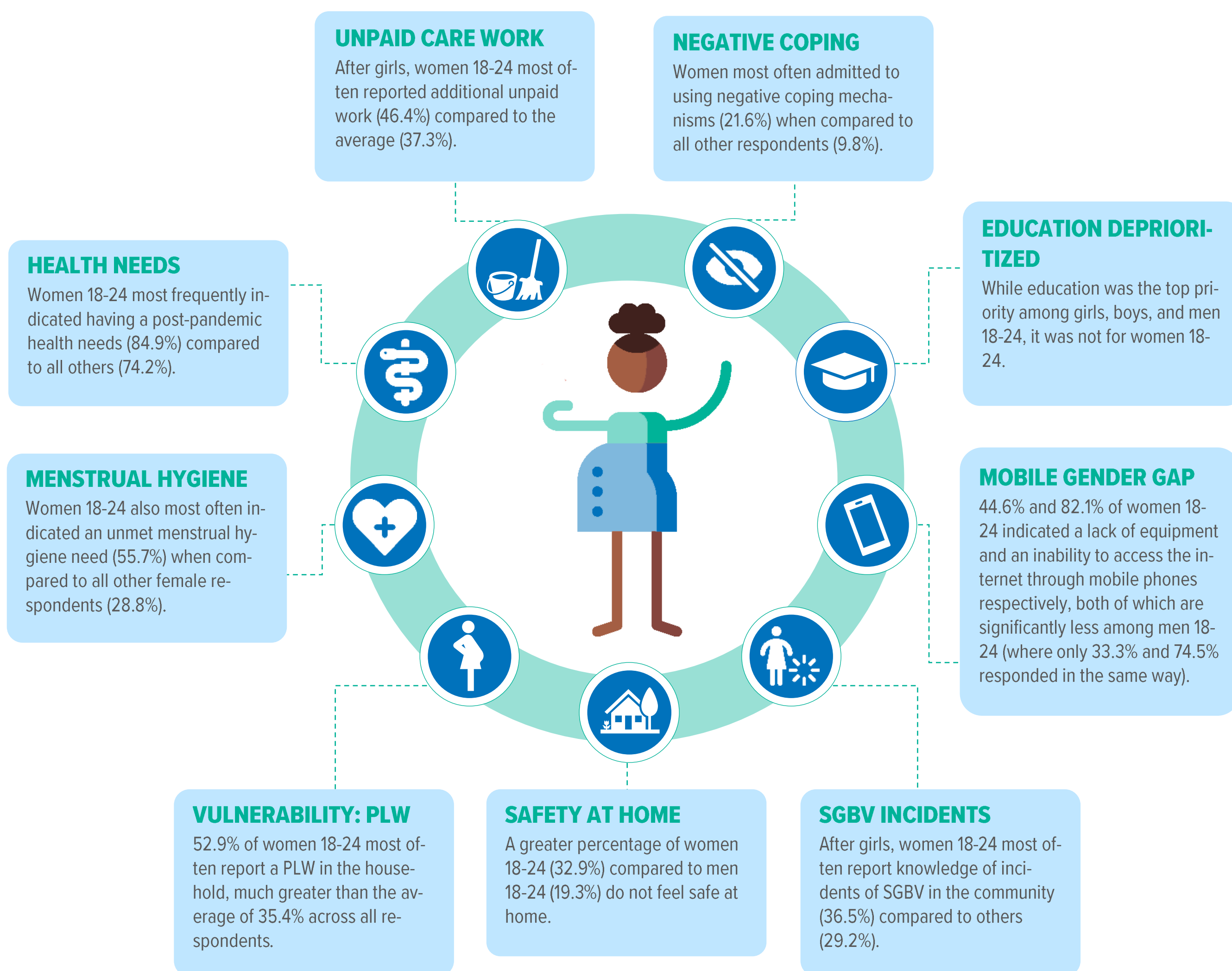
Many women and girls have unmet menstrual hygiene needs, as reported by 44.4% of girls, 55.7% of women aged 18-24, 31.2% of women aged 25-59, and 10.2% of women above 60. These needs were the greatest in Adjumani, Bidibidi and Kampala, (55.5%, 47.3%, and 41.6% respectively). The products to which women and girls most often reported a decrease in access were sanitary pads, soap, and underwear.

Protection & Security

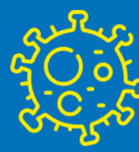
While the majority of respondents, including women and girls, indicated feeling safe at home and in the community, a couple of key pieces of data point to the problem of SGBV and domestic violence. First, as reported above, when asked about the impact of the loss of livelihoods on women and girls, the most frequently mentioned risks were SGBV,

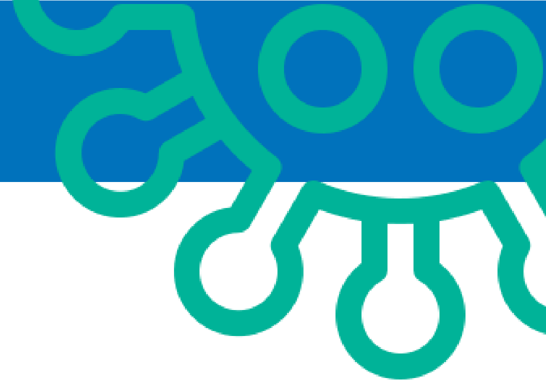
Women 18-24 are also heavily impacted by the pandemic in some of the same ways as girls: livelihoods, healthcare, access to information, and exposure to protection and security risks.

Figure 2: An examination of the impact of the pandemic on women 18-24.



domestic violence, teenage pregnancy, and child marriage, with the latter two closely linked to school closures. Second, girls were the group most likely to report knowledge of an incident of SGBV in the community. Whereas on average 29.2% affirm knowledge





of an incident, that percentage rises to 40.0% among girls. While this data cannot be conflated with direct experience to SGBV, it at least provides an indication of girls' exposure to SGBV through information network and social circles.

Priority Needs

Food was by far the most frequent need mentioned regardless of respondent sex, age group, or location, perhaps indicating a rise in the number of food insecure households. Though food was mentioned overall by 76.7% of respondents, it was mentioned by 91.0% of respondents in Kampala, which is significant given that urban refugees are normally not eligible for food assistance.

Not surprisingly, healthcare was the second most frequently reported need by respondents (60.0%), especially in Kampala (73.1%) which has been the most impacted by pandemic-related prevention measures and restrictions. This concern was expressed less by girls, boys and child HoHs when compared to the adult groups.

In contrast with the indicated need for healthcare, girls and boys more often signalled support for education when compared to other groups. While education was mentioned by 39.2% of all respondents, it was mentioned by 55.6% of girls and 68.4% of boys. Education was also their greatest information need. While signalled by 41.4% of all respondents, 75.6% of girls and 63.2% of boys reported this information need.

Many other needs were identified by respondents in the following order: food (76.7%), healthcare (60.0%), livelihoods (51.3%), education (39.2%), NFIs (34.5%), cash assistance (25.8%), water (18.4%), PSN support (17.7%), shelter (16.0%), physical protection (8.7%), sanitation/hygiene (7.5%), and resettlement (7.1%).

Key Recommendations

1 General

1.1 Increase the equal and meaningful participation of women and girls in decision-making, community management and leadership structures, through leadership trainings, mentorship programmes for women and girls and sensitization campaigns on the importance of sharing power.

1.2 Increase the capacity of humanitarian actors to integrate age, gender and diversity considerations throughout the operations management cycle in all sectors and train all staff on gender equality, SGBV and PSEA.

1.3 Empower and equip community leaders to promote gender equality and facilitate awareness and sensitization sessions in the community around the importance of sharing power at the household and community level and supporting women and girls to claim their rights.

2 Household Economic Activities & Livelihoods

2.1 Support and prioritise social economic empowerment of women, child headed households, PLWDs and older persons including use of

multipurpose cash interventions to mitigate the negative coping mechanisms as a result of disrupted livelihoods. This may include partnering with private sector entities to promote livelihood and economic opportunities and working with strategic partners targeting social protection mechanisms and economic stimulus packages for vulnerable groups.

2.2 Consideration of household dynamics in design and implementation, including the division of labour within the household and unpaid care burden.

2.3 Provide vulnerable groups such as female-headed households, women with disabilities and women survivors of GBV with cash assistance and cash for work which will build their resilience and strengthen their coping mechanisms.

2.4 Heighten social mobilization measures to promote messaging on redistribution and recognition of unpaid care and domestic work. This includes working at community level to support and alleviate the burden of care on women, including through work with male gender equality advocates on a ‘share the care’ campaign to encourage men’s equal participation in social reproduction.

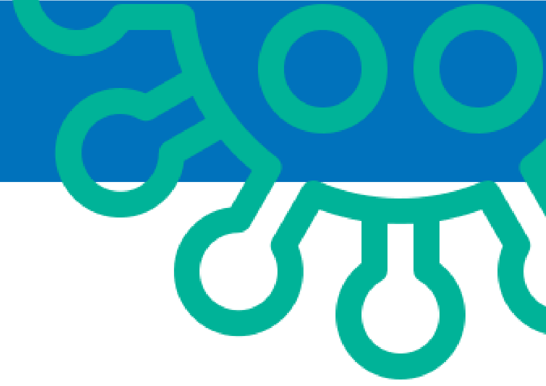
3 Access to Information

3.1 Advocate for information to be shared in formats that are user friendly for especially women and girls who do not have access to communication equipment and have low literacy levels. This may include empowering the Community Development Officers at subcounty level, community structures including VHTs, RWC, and women’s leaders at the lowest levels of the community to provide needed information on COVID-19 and other key services. Information dissemination can take the form of providing PPEs to enable door to door dissemination to households and to esp. reach the most vulnerable and excluded from information, translating the information into the local languages spoken by refuges, use of mega phones, utilising community radios among others.

4 Education

4.1 Monitor the rates of return to school among girls and boys in different locations, particularly in Kampala.

4.2 Provide second chance education (e.g. accelerated learning and vocational skills training) for girls who have become child mothers and those that have been married off early during this lockdown. Funds should specifically be earmarked to support such girls to access education when schools reopen. There should be continuous awareness raising and community dialogues involving the different elders, cultural and religious leaders in the settlement who apparently are custodians of these negative cultural practices to mitigate the challenge off early marriages among the refugee communities. In addition, advocacy should target the school board of governors and district officials to ensure pregnant girls can return to school, stay in



school for as long as is safe, and that the girls' personal circumstances allow for after giving birth.

4.3 Establish family friendly interventions that will enable parents / guardians to meaningfully engage their children during this period of extended lockdown since it is uncertain when schools will open. This should include availing information to parents on the dangers of child marriage, sexual exploitation and abuse, protection and safety measures, among others.

4.4 Organize awareness campaigns focusing on the importance of education. The campaigns should also include messages that emphasize gender equality concepts in the households to leverage study time for both girls and boys within a household. It is also important to provide remote-learning tools to households alleviating burdens on caregivers ensuring children do not fall behind.

5 Health

5.1 Improve the accessibility of maternal, newborn and child healthcare and HIV chronic services through improvement of existing infrastructure, procurement of more maternity beds, hiring of more maternal health staff and conducting sensitization campaigns.

5.2 Explore the provision of menstrual hygiene materials at accessible points in the community.

5.3 Intensify reach to families in need of emotional and psychosocial support. This may entail provision of Mental Health Psychosocial Support services (MHPSS) to combat the stress and a lack of confidence amongst both men and women due to the loss of their livelihoods and inability to provide for their families; training more social workers/counsellors online for virtual counselling and protection services. Other efforts should be about raising awareness about mental wellbeing and invoking the concept of recognition. This means that humanitarian actors use different communication channels to recognize the collective tragedy being experienced and to normalize the anxiety, stress, and concerns that community members may be feeling. This should be followed up by suggestions for community members in supporting one another, and in defining for communities' concepts of safe spaces free of GBV and domestic violence.

6 Assistance

6.1 Provide tailored support for PLWD, older persons, and other vulnerable persons such as adapted transportation and mobile clinics.

6.2 Conduct more research to understand the assistance modalities preferred by different groups of people and how they may differ by location.

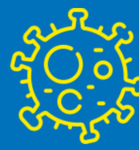
6.3 Humanitarian actors must coordinate advocacy efforts and provide technical expertise to ensure that the COVID-19 refugee response interventions are gender responsive and

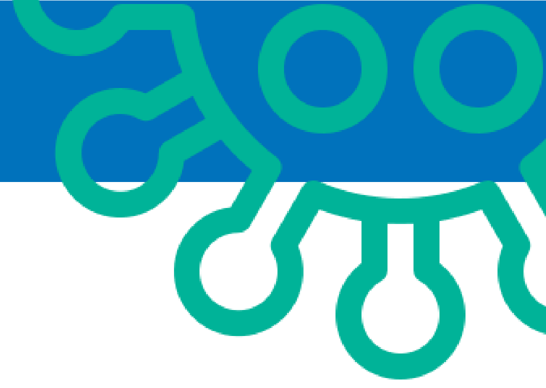
ensure that refugees are not left behind.

7 Protection & Security

7.1 Support and facilitate District Local Governments to form sector response teams and maintain referral pathways to respond to protection issues, sensitise on referral pathways to report GBV cases sensitize on referral pathways to report GBV cases and keep referral pathways functional. Services to address violence against women and GBV need to be increased and expanded to the communities, including through shelters, hotlines and counselling, advocacy and media campaigns and reach the widest possible audience to prevent SGBV including through targeting men.

7.2 Advocacy and awareness raising on socio-cultural factors that promote sexual abuse and child marriages. This includes working with cultural, religious and opinion leaders at community level to raise their voices against such practices. Involving religious and cultural leaders in awareness raising and engaging men and boys could deter would-be perpetrators.





Introduction

COVID-19 in Uganda

The number of COVID-19 cases continues to rise in Uganda, presenting a growing risk to refugees and asylum seekers. There have been fears that risks of a widespread outbreak could be magnified in settlements where water and sanitation facilities are scarce, and many people live hand to mouth.

Despite many challenges, Uganda continues to host more than 1.4 million refugees, 23% of whom are women and 60% are children. South Sudanese make up the largest refugee population in Uganda (885,171) as of November 2020, followed by refugees from the Democratic Republic of Congo (DRC; 418,396) and Burundi (49,082). Approximately 78,000 refugees from Somalia, Rwanda, Eritrea, Sudan and Ethiopia have also lived in protracted exile in Uganda for the past three decades. Thirteen of Uganda's 134 districts host the majority of refugees. The vast majority (94%) live in settlements alongside the local communities, including 62% in northern Uganda or West Nile (Adjumani, Palabek, Bidibidi, Imvepi, Rhino Camp, Lobule, and Palorinya), 21% in southwestern Uganda or South West (Nakivale, Oruchinga, Rwamwanja and Kyaka II) and 12% in central Uganda or Mid-West (Kiryandongo and Kyangwali). Urban centres are home to five per cent of the refugee population, mainly Kampala. With expected refugee influxes in the remainder of 2020 and in 2021, Uganda is likely to host more than 1.56 million refugees by the end of 2021.

While the Government of Uganda responded rapidly to implement measures for COVID-19 prevention and response, restrictions on movement and other necessary lockdown measures taken to prevent further spread of the virus have also had an immense impact on the lives of both Ugandans and refugees and led to a rise in protection risks and challenges. These include restricted access to asylum, increased tensions between refugees and host community members, discrimination and social stigma, lack of access to services, increased SGBV, child and family separation and increased physical and emotional distress. Women and children have been the most susceptible to violence within the home, with no shelter or alternative place to run to distance themselves from abusers. Many do not have support structures within the community to assist as cultural norms relegate SGBV as a private matter to be dealt with by the affected parties. The closure of schools has meant that children and young adults that were attending institutionalized

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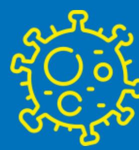
education have been at home, with limited access to education, increasing the burden at home.

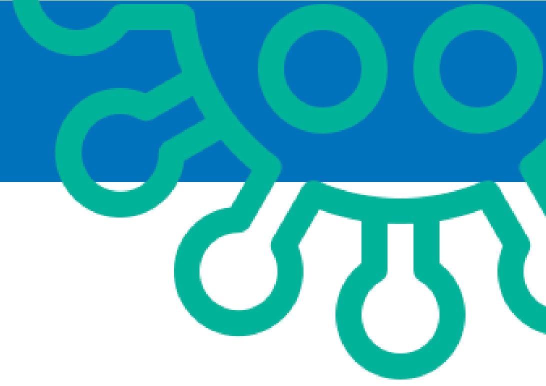
To allow for a proper understanding of the extent of the impact of COVID-19 on refugees in Uganda, it was decided to carry out an RGA to assess the impact of the pandemic on women, men, girls, and boys of diverse backgrounds, including persons with disabilities, older persons and those with serious medical conditions. This assessment was conducted jointly by UNHCR, UN Women, IRC, CARE International, ALIGHT, DRC, with support from the MGLSD, OPM, the CRRF Secretariat, UBOS, OXFAM, TPO, Over Comers Women Group and YUGNET. The assessment was carried out both in Kampala and across refugee settlements.

Literature Review

Several studies examining the impact of COVID-19 in Uganda, and on refugee populations in specific, have been conducted, including an RGA by Care and another by DRC which have provided a solid base of information and recommendations which bare mentioning here. With respect to SGBV, the World Bank recently released a report, while UNHCR has also generated new data with respect to this same sector[1]. Relating to Uganda more broadly, the UN Social Economic Impacts of COVID-19 report[2] was also launched in June 2020 and can be consulted for a more detailed examination of the economic impacts on multiple sectors, service delivery and human development, as well as poverty and vulnerability. It is not, however, confined to the refugee population.

The first study was conducted by Care International in May 2020[3] to gather information on how the pandemic has affected refugees' lives using key informant interviews, individual stories, and desk review in the districts of Arua, Moyo, Lamwo, and Gulu. Some of the key findings of this study included: an increase in GBV along with a decrease in the accessibility of GBV services to survivors. SRH services were also found to be inaccessible to women and girls. In addition, the study found that the pandemic considerably increased women and girls' unpaid care burden due to family members being at home, as





well as an increased demand for water. They also signal that the number of food insecure households has likely increased, particularly given that World Food Programme (WFP) rations had been cut. The report further found that the pandemic has had a devastating impact on livelihoods, and particularly on people working in the informal sector, who often happen to be women and girls. The suspension of VSLA groups further exacerbated the financial situation of women and girls who constituted the majority of its members, additionally cutting them off from the peer support and access to information to which they usually received through these groups. Finally, the study outlined that women and girls have not been adequately involved in the COVID-19 decision-making platforms and response.

Another study, also conducted in May 2020, was carried out by the Danish Refugee Council[4] using a Lot Quality Assessment methodology in the settlements of Kyaka II, Kiryandongo, Rhino Camp, Imvepi, and Lobule, covering the areas of protection, livelihoods, WASH, conflict/security, and information/coordination. Some of their key findings were that 96% of the interviewed refugees reported difficulties in accessing basic needs, while negative coping strategies had increased, particularly in food insecure households. In addition, all the targeted settlements, with the exception of Rhino Camp, reported losses in income, which was found to be higher among men than women, as well as being unable to continue to save since the onset of the pandemic. The study also found evidence of women and girls' vulnerability to domestic violence, while boys were believed to face risks of child labour. With respect to water, respondents in this study reported an increase in use, and challenges with access due to long distances and queues at the water sources. Furthermore, soap availability was a concern in some settlements.

RGA Objectives

The main objective of this RGA is to assess the impact of COVID-19 on refugee women, men, girls and boys of diverse backgrounds in Uganda. This will further complement the earlier assessments outlined above, in order to get updated information, and generate targeted recommendations for the response to COVID-19 and its consequences.

Specifically, the analysis will:

1. Assess the impact of COVID-19 on refugees' social and economic well-being including the impact of gender-based violence
2. Examine the impact of COVID-19 on refugee communities on access to services across sectors including household economic activities and livelihoods, access to information, healthcare, education, WASH, menstrual hygiene, assistance, protection and security, and priority needs.
3. Generate sector specific targeted recommendations to inform the response during and after COVID-19

Age, Gender and Diversity and Accountability to Affected People

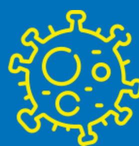
This RGA was carried out using the Age, Gender and Diversity (AGD) approach which is central to the Ugandan refugee response. It requires that all actors in the response consider the distinct needs and views of women, men, girls and boys of diverse backgrounds, including persons with disabilities, persons with diverse sexual orientations and gender identities and ethnic, religious and linguistic minorities or indigenous groups, in assessment, planning, implementation and monitoring processes.

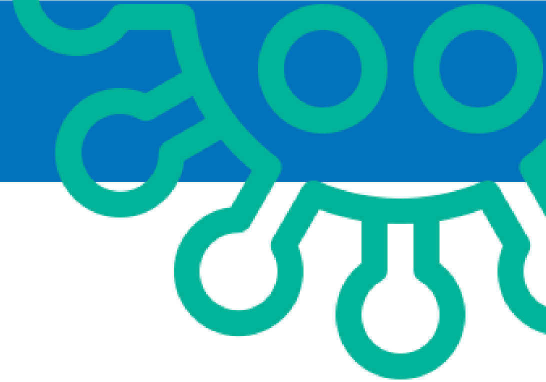
This approach is important due to the recognition that forced displacement affects people differently, depending on age, gender, and diversity. This is equally true of the COVID-19 pandemic. Understanding and analyzing the impact of intersecting personal characteristics on people's experiences of the pandemic are necessary for an effective response to it. An effective and accountable humanitarian response therefore requires: (i) continuous and meaningful engagement with persons of concern; (ii) understanding their needs and protection risks; (iii) building on their capacities; and (iv) pursuing protection, assistance, and solutions that take into account their perspectives and priorities.

The AGD approach further requires that actors in the refugee response mainstream gender equality in all their activities, to ensure equal access to services for all. This goes beyond non-discrimination and requires targeted actions to advance the rights of women and girls for the advancement of gender equality.

The AGD approach is also key to ensuring accountability to affected people. It entails that women, men, girls, and boys of diverse backgrounds are meaningfully and continuously involved in decisions that directly impact their lives. It also requires that the information that is received through diverse communication channels and feedback mechanisms is used to adapt and improve services.

Through the application of the AGD approach, partners can ensure that all persons of concern can enjoy their rights on an equal footing and participate meaningfully in the decisions that affect their lives, families and communities, without discrimination and with respect to their rights





Methodology

General Approach

A mixed methods approach was used to address the central objectives of the study, including a secondary data review, a household survey, and key informant interviews.

1. The **secondary data review** was conducted first to help identify the study's priority areas and its methodology, as well as to triangulate the study's findings after the analysis phase.

2. The **household survey** applied quantitative techniques to gather information on all the key study topics from a representative sample of refugees in selected locations. This enabled for the collection of baseline data on all thematic areas and to conduct comparative analyses to highlight the specific needs, issues, and vulnerabilities of different groups of people.

3. Finally, the **key informant interviews** were conducted with key stakeholders in refugee and host communities to solicit more detailed information on the thematic areas of the study to produce a more fulsome picture of the impact of COVID-19.

The household surveys and key informant interviews were conducted following the COVID-19 prevention guidelines.

Sampling Strategy

HOUSEHOLD SURVEY

The household survey targeted women, men, girls, and boys residing in refugee settlements. The targeting of certain vulnerable groups was also conducted such as PLWD, older persons, persons with serious medical conditions, persons living with HIV, and pregnant and lactating women (PLW).

The sample size was calculated using ProGres V4 data. The refugees were stratified into the following categories: female HoH, female HoH with no adult male family member, male HoH with female adult family members, male child HoH (child registered as focal point and no adult family members in the household), female child HoH (child registered as focal point and no adult family members in the household), households having at least one PLWD, households having at least one older person (65+ years), and households having at least one youth between the age of 15-18 years old.

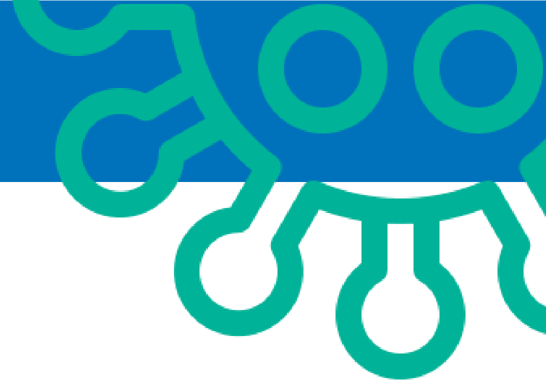
A confidence level of 95% and two different confidence intervals of 3 and 3.2 were used resulting in a sample size of 1791. The sample size was equally distributed across the locations, meaning that the target number of interviews for each location was 190. The final sample used in the quantitative analysis can be found in the Demographics section below.

KEY INFORMANT INTERVIEW

Key informants were purposively selected from stakeholders in the COVID-19 response and in the refugee response. They comprise of members of the District COVID-19 Task Force teams, interagency coordination sector leads, assistant settlement commandants, sub-county and village leaderships structures, refugee leaders, community support structures, and representatives of local women's groups. An effort was made to balance the sex, age and diversity representativeness of key informants.

16 key informants were selected from each location, making a total of 176 with a suggested breakdown as shown in the table above. The final achieved sample can be found in the demographics section below.

Proposed Respondents		Proposed Sample Size
District COVID-19 Task Force Teams:	RDC District Health Officer Woman Council representative	3 per district*9 = **27**
Interagency Coordination Sector leads:	DCDO DPC SGBV, Livelihoods, Education, WASH, Health, Food and Nutrition, Environment	5 per district*9 = **45**
Settlement Commandants/Ass. Settlement Commandants		1 per settlement*9 = **9**
Sub County and Village task teams:	Sub-county Chief PLWD representative	2 per sub county* 9 = **18**
RWC leaders/ community structures:	Chairperson (M), Vice (F), Youth representative, Paralegals / Psychosocial volunteers	3 per settlement*9 = **27**
Resource Persons:	Cultural leaders Religious leaders	2 per settlement*9 = **18**
Total		**144**



Data Management

HOUSEHOLD SURVEY QUESTIONNAIRE

The household survey questionnaire covered thematic areas highlighted as fruitful avenues of explorations with respect to the most significant impacts of COVID-19 on the lives of refugees in Uganda through the secondary data review. These topics include:

- **Demographic data**, as well as household composition, and vulnerability identifiers.
- **Household economic activities and livelihoods**: income sources, changes to income since the onset of the pandemic, household decision-making, household division of labour, engagement in savings schemes, and negative coping mechanisms.
- **Information**: Access, especially to a mobile phone and the ability to use the internet through it, as well as any challenges to accessing information.
- **Healthcare**: Access and any obstacles to doing so.
- **Education**: Mechanisms of learning for boys and girls, challenges to learning, and plans to return to school.
- **Menstrual hygiene**: Changes in access to menstrual products and any unmet menstrual hygiene needs.
- **Assistance**: Benefitting from assistance since onset of the pandemic.
- **Protection and security**: At home and in the community, as well as knowledge of incidents of SGBV.
- **Priority needs**.

KEY INFORMANT INTERVIEW QUESTIONNAIRE

Many of the same thematic areas were covered in the key informant interview questionnaire including household economic activities and livelihoods, healthcare, education, WASH, assistance, protection and security, and priority needs. However a series of questions were also added to address mental health impacts and response and access to water. In addition, respondents were asked to opine on the specific impacts to PLWD, older persons, and other minority groups.

DATA COLLECTION TEAM

The data collection team was trained on the questionnaires, the use of tablets and ethical issues related to the research. The data collectors comprised of staff of women-led organisations, refugee women leaders, staff of partner organizations and community-based volunteers. The criteria for their selection were that they should be able to speak English, and any relevant local language, as well as having experience with digital data collection.

Data for both the household surveys and the key informant interviews were entered into KoBoToolbox with use of electronic tablets.

Data quality assurance was carried out by OPM, District Local Governments (DLG), UN agencies, and the I/NGOs who were responsible for the supervision of the data collection.

Data Analysis

QUANTITATIVE ANALYSIS

The quantitative analysis followed two steps. First, frequency tables were generated to generate measures and to examine the relative distribution of categorical variables, by sex, age group, location and category of person. Second, different statistical treatments were applied to examine trends and differences between groups to be able to highlight their unique needs and issues.

A note on language: measures and indicators have been calculated for the entire group or respondents. Values are only disaggregated by sex, age group, or location if they are significantly different from the overall value or average of the group.

QUALITATIVE ANALYSIS

Qualitative data in both the household survey and the key informant interviews were treated using thematic analysis which is comprised of three steps: (1) codification; (2) analysis; and (3) concluding.

1. **Codification** involves assigning codes that identify the key themes within a piece of text. A piece of text can be assigned one or multiple codes depending on the number of unique themes found within it.
2. **Analysis** occurs in two steps. The first is to examine the frequency of each code which helps to underline which themes may have been most important to the respondents. For example, the most frequent code arising from the negative coping mechanisms texts of the key

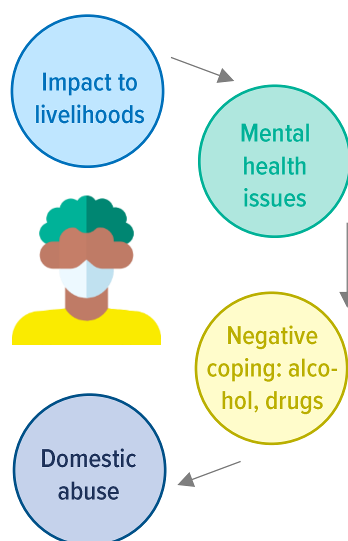
Thematic analysis consists of three steps – coding, analysis, and concluding – which helps in the identification of important themes within narrative text.

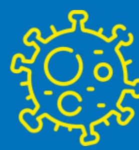
Figure 3: Illustration of the coding of one narrative text.

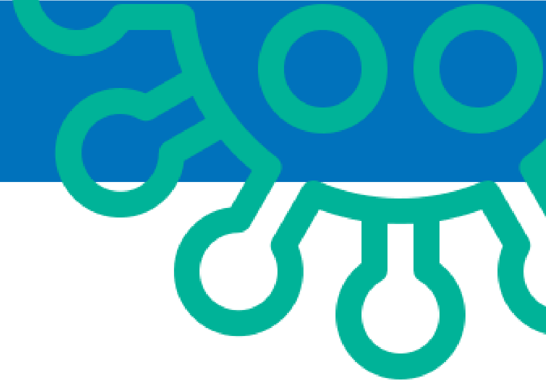
How have men been impacted by the pandemic?

Because of the pandemic, many men are experiencing stress from the pressure of providing for the family and they are having trouble coping with it, so they are resorting to drugs and alcohol, and also mistreating their wives.

-Female, aged 26, Bidibidi







informant interviews was "theft", followed by "survival sex work", perhaps indicating the importance of these negative coping mechanisms to refugees (or the belief that they are by the key informants). The second step was to read and re-read all of the text for which a particular code was assigned to see if there were any other patterns related to that particular theme. A good example illustrating the importance of this step is that the majority of texts coded as "child marriage", or "early pregnancy" also contained mentions of school closures, indicating that school closures are related to or responsible for the aforementioned phenomena.

3. **Concluding** is the final step in the thematic analysis process which provides a space to reflect upon the findings generated from the analyses steps and how they related to the central study questions.

Survey Ethics

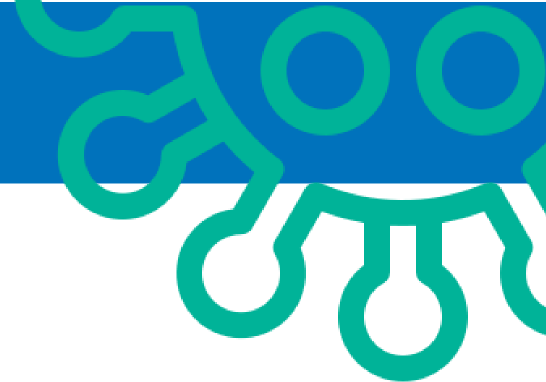
Permission to collect data was obtained from OPM and DLGS at Kampala and settlement level. Verbal consent was sought from household survey respondents and key informants prior to conducting the activity. Consent for interviews with child HoHs was sought from Probation Social Welfare Officers and partner organizations, as well as from the child HoH themselves. Attention to body language and verbal expressions was observed during interviews to ensure that interviews were stopped should respondents appear unwilling to continue. Attention was also taken to manage and minimise expectations from respondents. Cases requiring referrals were identified and referred through the appropriate referral pathways.

Data confidentiality was maintained and participant identities sufficiently concealed.

Study Limitations

This study provides valuable information on the impact that COVID-19 has had on the refugee population in Uganda, however some limitations are important to highlight. First, there was an insufficient sample of people living with HIV, PLWD, and LGBTI individuals. It was therefore impossible to include them in

any statistical analysis. Second, within the key informant interviews, it was clear that most respondents conflated LGBTI and minority categories with PLWD or did not believe that they existed within their location. The results of these questions were therefore not included in the report. Furthermore, the sampling frame did not cover all the refugee settlements due to limited time and resources, though the sampled locations do represent the diversity found in Uganda in terms of persons and location types. Finally, enumerators were required to translate answers given in local languages back into English which may have introduced errors.



Findings & Analysis

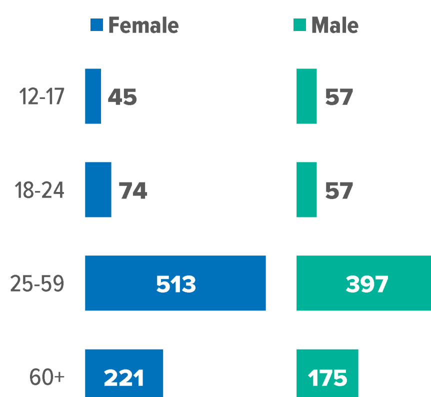
Demographics

SURVEY DEMOGRAPHICS

A total of 1,539 respondents were included in the analysis, of which 55.4% were women and girls. The majority of participants were in the 25-59 age group (59.1%), followed by the 60+ age group (25.7%), the 18-24 age group (8.5%), and the 12-17 age group (6.6%). Figure 4 illustrates the number of respondents by sex and age group. The number of respondents per settlement and the % female respondents can be seen in Figure 7 below.

Women and girls represent 55% of the respondents who were interviewed for this study.

Figure 4: Number of respondents by respondent sex and age group.



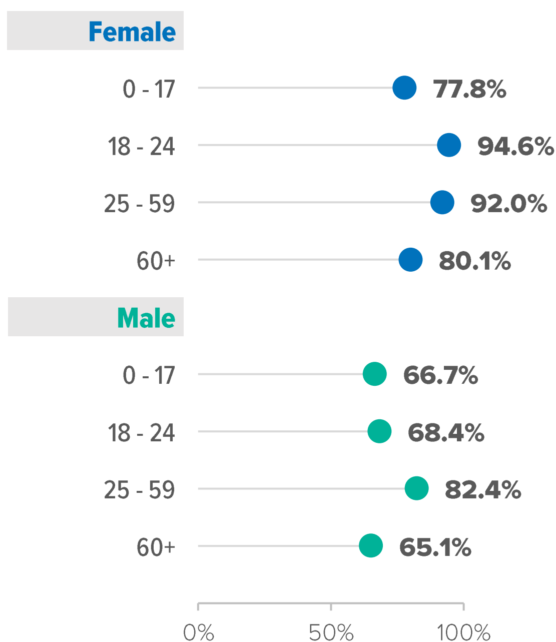
Certain categories of person (CoP) were also interviewed to identify the specific needs and issues that they may have. Groups having at least 35 respondents were included in this analysis[5]: female HoH (n=516), male HoH (n=504), older persons (n=308), PLWD (n=181), single female HoH (n=136), youth (n=113), persons with a serious medical condition (n=72), male child HoH (n=41), and female child HoH (n=35). It is important to note that a respondent may have fallen into more than one category.

With respect to household composition, 82.7% of participants indicated that they live with others. Not surprisingly, women aged 18-24 and 25-59 were more likely to live with others, with 94.6% and 92.0% respectively, and among male respondents, men aged 25-59 were similarly most likely to live with others, with 82.4% signalling so. Similarly, households headed by women and persons living with either a disability or a serious medical condition were less likely to live alone (90.3%, 85.1%, and 81.9% respectively). With respect to location, respondents in Kampala and

Nakivale were less likely to live with others in comparison to other locations, having only 71.8% and 65.0% respectively saying that they live with others.

Women and girls more frequently live with others when compared to men and boys.

Figure 5: % of respondents who live with others by respondent sex and age group.

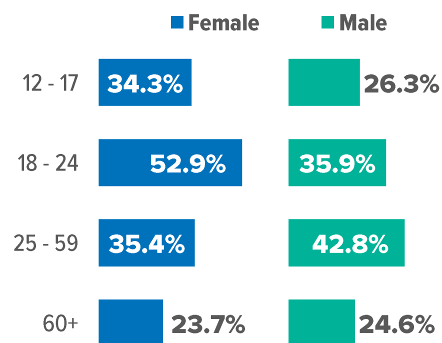


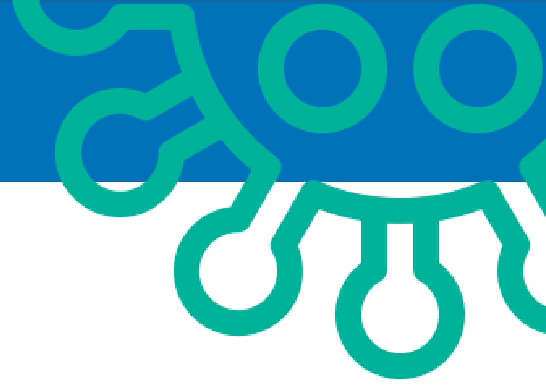
Among the respondents living with others, the average household size was found to be 5.8 persons, and the average number of children was 3.6. No real differences could be found when comparing these measures by sex, though when comparing age groups, both household size and number of children were slightly higher among respondents aged 25-59. Both figures were much lower in Kampala and Nakivale and much higher in Adjumani, Kiryandongo, and Rhino Camp when compared to the average. Youth and male child HoH also tended to report lower than average figures.

These same participants were also asked whether there was a pregnant or lactating woman (PLW) in the household, with 35% responding affirmatively. The most notable difference when disaggregating by sex and age group was that women 18-24 were much more likely to report having a PLW in the household versus other groups, with 52.9% reporting affirmatively. To put this into perspective, only 35.9% of their male counterparts reported a PLW in the household, women 25-59 with 35.4%, and men 25-59 with 52.8%. The percentage of respondents with a PLW in the household can be seen in Figure 6. In terms of location, the lowest

Women aged 18-24 are the group who most often report a PLW in the household.

Figure 6: % of respondents reporting a PLW in the household by respondent sex and age group.

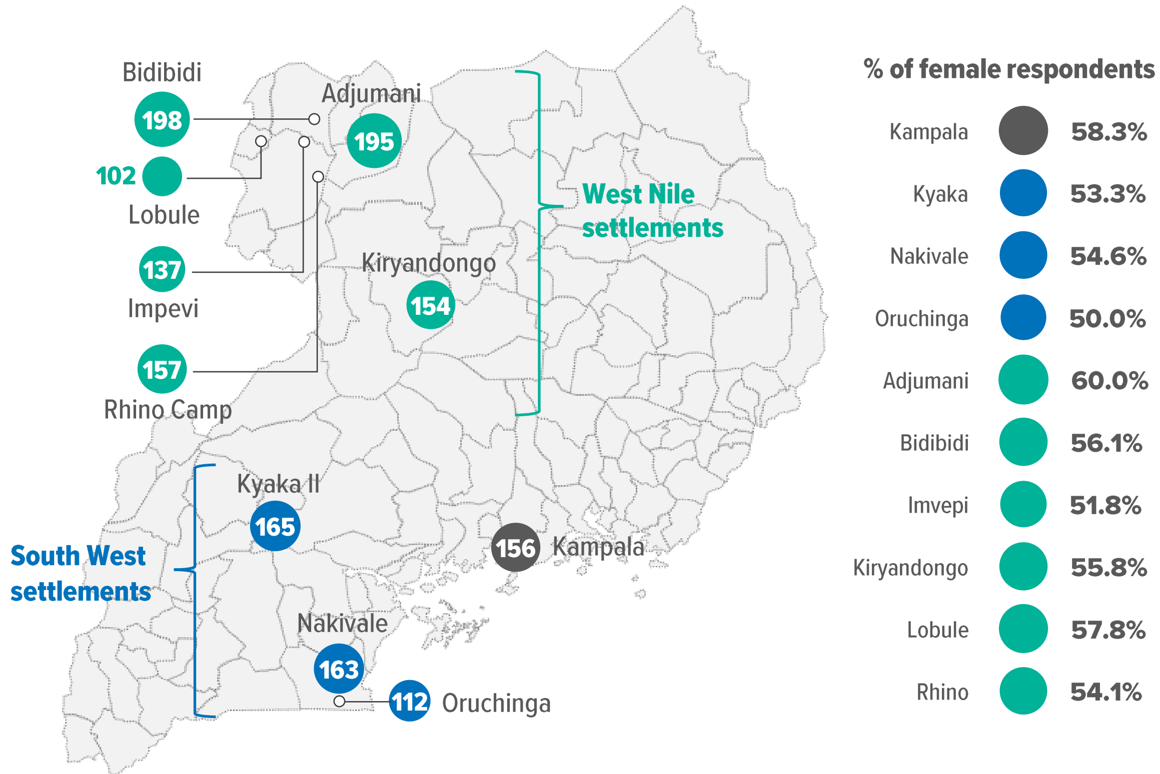




percentage of respondents with a PLW was in Kampala (11%), while Adjumani and Rhino Camp had the highest (48.6% and 46.9% respectively). Finally, when disaggregating by CoP, it is also possible to see that a higher percentage of female child HoH report having a PLW in the household (46.2%).

For the purpose of this study, Kiryandongo is being included with the West Nile settlements due to similarities in the diversity of its inhabitants.

Figure 7: Nb of respondents and percentage of female respondents per settlement.

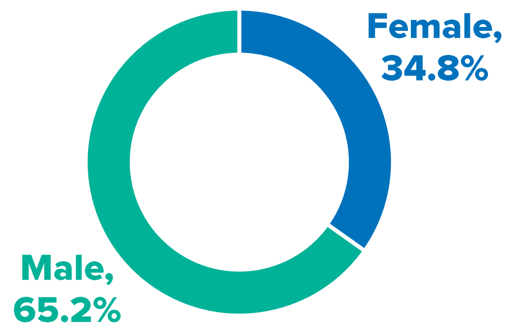


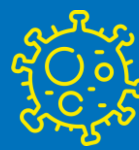
KEY INFORMANT DEMOGRAPHICS

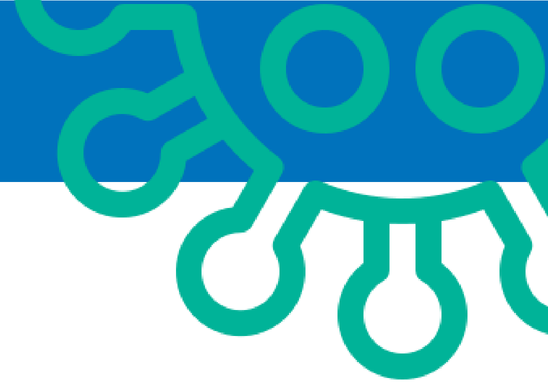
As described in the methodology section above, key informants were selected based on their expertise, or because they are leaders or influential in the COVID-19 response. They hail from the District COVID-19 Task Force Teams, settlement commandants, sub-county and village task teams, RWC leaders, and other resources persons such as religious and cultural leaders. The overall number of participants who were interviewed as key informants was 158, with 34.8% women.

Of the 158 key informants, 34.8% were women.

Figure 8: % of key informants by sex of key informant.







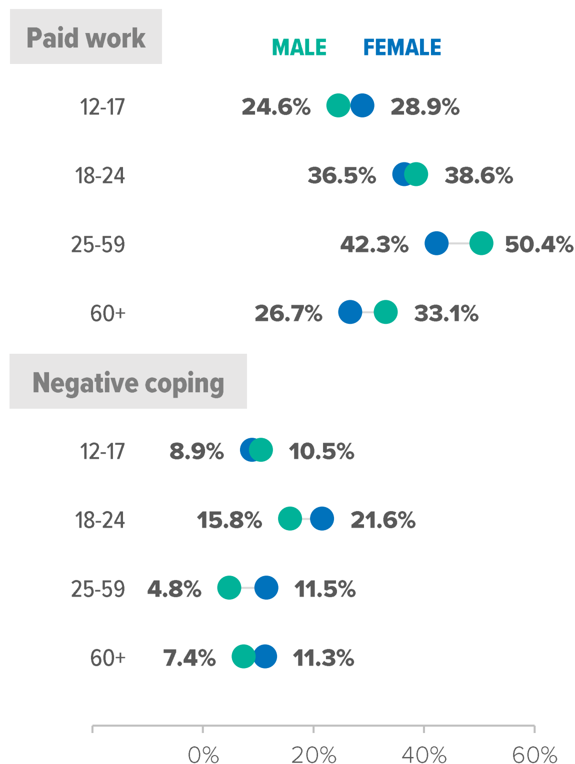
Household Economic Activities & Livelihoods

HOUSEHOLD INCOME SOURCES

Before the pandemic, the most common sources of income reported by respondents were assistance (49.4%), followed by paid work (39.6%), negative coping mechanisms (9.8%), and support from family (8.8%). With respect to the different income sources, surprisingly few differences could be seen by age or sex. A couple worth nothing are that men 25-59 more often report paid work when compared to women of the same age (42.3% and 50.4%) respectively, and the 18-24 group less frequently reported depending on assistance, while more frequently indicating the use of negative coping mechanisms when compared to the averages (39.7% of the 18-24 group reported receiving assistance and 19.1% reported using negative coping mechanisms). Finally, women aged 18-24 and 25-59 more often report the use of negative coping mechanisms when compared to men.

Women reported relying on negative coping mechanisms slightly more often when compared to men.

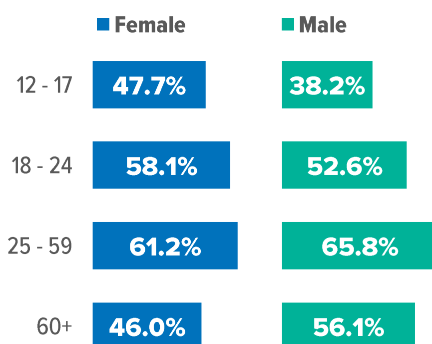
Figure 9: % of respondents who partake in paid work OR negative coping mechanisms by respondent sex and age group.



Many interesting differences in income source can be observed through the lens of location. Respondents from Oruchinga, Kiryandongo, and Lobule more often reported engaging in paid work (67.9%, 69.5%, and 70.6% respectively), whereas Rhino Camp had the lowest percentage of respondents reporting paid work (17.2%). Assistance, on the other hand, was most often reported in Nakivale and Rhino Camp (76.7% and 70.1% respectively) and less often in Bidibidi and Kampala (12.1% and 17.9% respectively). These findings are not surprising when considering the settlements that are newer or more established. Nakivale and Rhino Camp still receiving new refugees who are more likely to rely on food/cash assistance, whereas, Lobule, Oruchinga, and Kiryandongo are more established.

Girls aged 12-17 and women aged 60+ reported negative income changes slightly more often than their male counterparts.

Figure 10: % of respondents reporting a negative income change by respondent sex and age group.

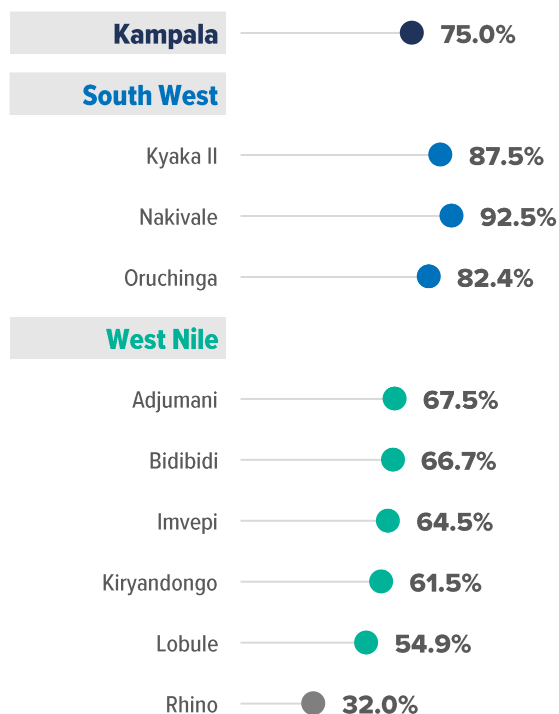


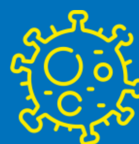
Furthermore, income from family (e.g. money received from family or friends abroad, money received from family or friends in country) was the most important income source reported by respondents in Kampala (51.3%) and was the only location in which income from family was reported more frequently than the average. Finally, negative coping mechanisms were more regularly reported in Bidibidi (46.5%) and almost not at all in Lobule, Nakivale, and Oruchinga (0.0%, 0.6%, 1.8%).

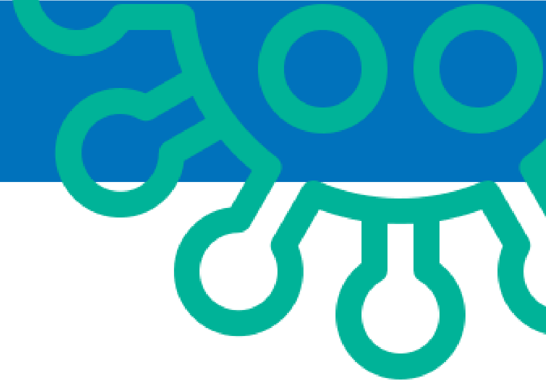
Overall, 58% of respondents reported a decrease in income. Interestingly, the only differences between men and boys and women and girls could be found among the 12-17 and 60+ age groups, where slightly more women and girls than men and boys reported negative income changes. Examining CoP also confirms that little difference exists between men and boys and women and girls, as the percentage of male and female HoH reporting a decrease in income were statistically equivalent to the overall average. Generally, the 12-17 age group less frequently reported a decrease in income when compared to the older age groups. With respect to location, respondents in Imvepi, Rhino Camp, and Bidibidi far less frequently reported a

Respondents in settlements of the South West who had been involved in paid work most frequently reported a negative income change.

Figure 11: % of respondents who had paid work reporting a negative income change by respondent location[6].







decrease in income when compared to other locations (32.4%, 33.6%, and 41.8% respectively), whereas Oruchinga and Kyaka II far more frequently reported such a change (80.0% and 78.5%).

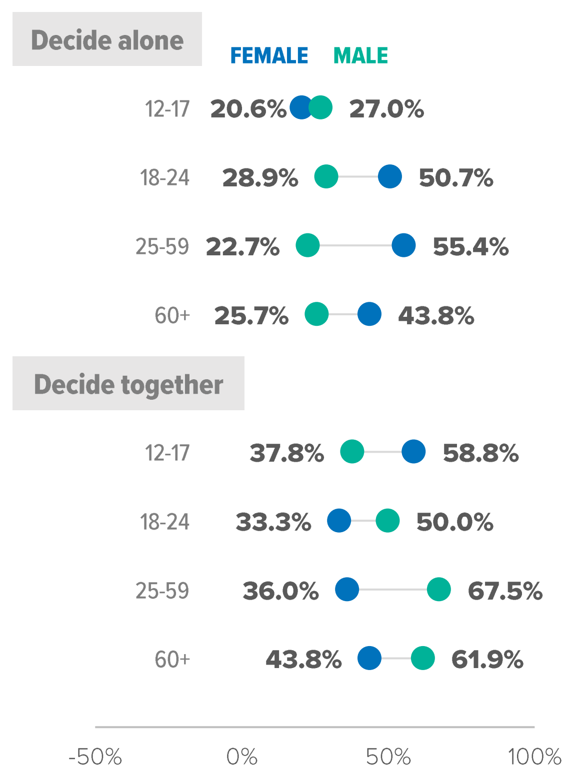
When isolating the responses of respondents who previously indicated paid work as their main income source prior to the pandemic, what is found is that an even higher percentage of respondents indicate a negative change in income, with 69.6% signalling so compared to the 58% found above. Men and boys more frequently reported a negative income change compared to women and girls, with 74.3% and 65.2% respectively, which may be the result of women and girls more frequently working in the informal sector and receiving in-kind payments for goods and services. In addition, as shown in Figure 11, respondents from the settlements in the South West more frequently reported a negative income change, while respondent from Lobule less often reported the same (54.9%).

HOUSEHOLD DECISION-MAKING

As shown in Figure 12, women and girls more often reported sole decision-making, whereas men and boys more often reported joint decision making. Furthermore, when asked whether their decision-making power had changed since the onset of the pandemic, most participants responded that no change had occurred (59.0%), and only 18.5% reported less decision-making power. No notable differences could be seen when examining change in decision-making power by sex, age group, location, or CoP.

Women reported sole decision-making more frequently, while men reported joint decision-making more frequently.

Figure 12: % of respondents reporting sole decision-making or joint decision-making by respondent sex and age group.



Participants were also asked whether they had money or resources which they alone could decide how to use, with 33.1% responding affirmatively, with no notable difference by sex. Not surprisingly, the groups most often reporting not having their own resources were girls and boys aged 12-17, with no difference between the two (12.5%). This same result can be seen by examining the responses

of child HoH, with only 7.7% of female child HoHs and 3.8% of male child HoHs indicating personal money or resources. With respect to location, respondents in Kampala and Nakivale far more frequently reported having personal money or resources (57.7% and 49.0% respectively), while the converse was true among respondents in Imvepi (only 18.6% reported affirmatively).

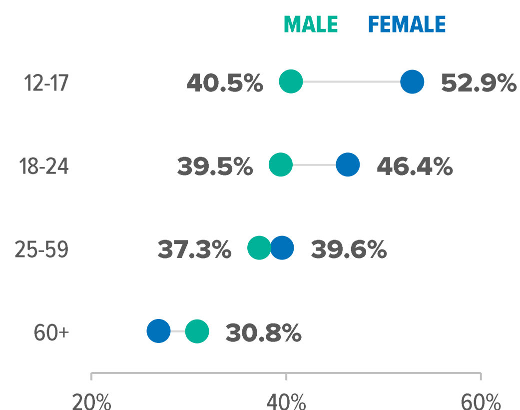
Although respondents reported joint decision-making within households, previous gender analyses carried out in the Ugandan context show that there are clear lines of decision-making within households. While women are primarily responsible for decision-making on healthcare, the children, caretaking responsibilities, food preparation, and cooking and cleaning, men were primarily found to be responsible for decision-making on how income is spent and how assets are managed. Despite some sharing of decision-making power within households, men remain the final decision-makers. The most recent UNHCR participatory assessment conducted in 2019[7] confirms this, as well as the CARE RGA (CARE, 2020). The answers to this particular question show that respondents interpreted the question to mean whether they have personal resources which no one outside of the household could access, rather than whether they have resources that neither persons within the household can decide on how to use.

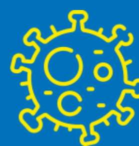
HOUSEHOLD DIVISION OF LABOUR

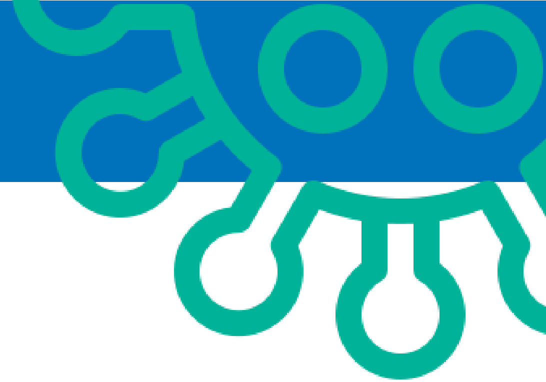
Overall, 37.3% of respondents reported additional time spent on unpaid labour since onset of the pandemic, 29.4% reported spending less time, and 33.3% reported spending the same amount of time on unpaid work. While this percentage disaggregated by sex does not yield a significant difference (38.0% of women and girls and 36.3% of men and boys indicating so), further disaggregation by age highlights that girls and women 18-24 more frequently report additional time spent on unpaid work compared all other groups. The same can be seen among female child HoH with 50.0% signalling additional unpaid work. Participants from Rhino Camp and Oruchinga also more frequently reported a greater amount of unpaid work when compared to the average (61.6% and 59.1% respectively). The finding that the burden of unpaid work most often falls to women and girls was also confirmed by CARE (2020).

The burden of unpaid work has most impacted girls and women 18-24.

Figure 13: % of respondents reporting additional time spent on unpaid work by respondent sex and age group.

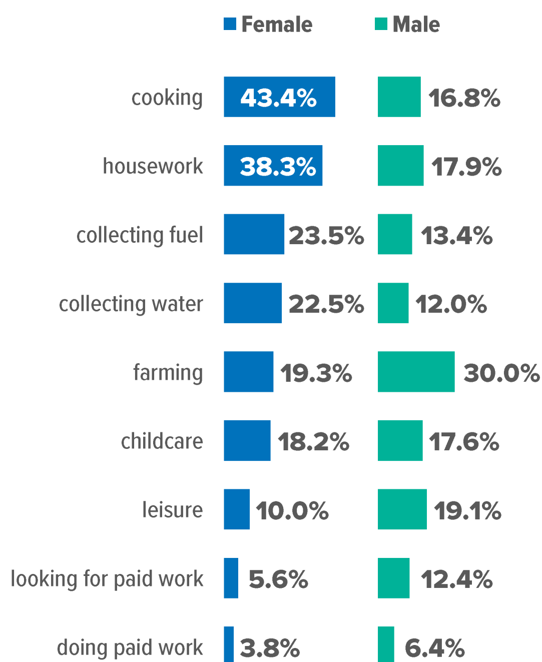






Women and girls spend more time on cooking, housework, collecting fuel, and collecting water. Men and boys spend more time on farming and leisure.

Figure 14: Main unpaid activities respondents report spending additional time on since the onset of the pandemic by respondent sex.



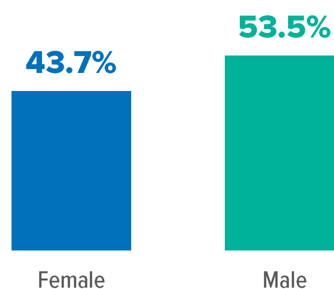
When examining which unpaid activities take up most of respondents' time, the activities depend strongly by respondent sex. By far the most common activities reported by men and boys was farming (30.0%) and leisure (19.1%), whereas for women and girls they were cooking (43.4%) and housework (38.3%). In addition, women and girls were more likely than men and boys to report to spend time cooking, doing housework, collecting fuel, caring for children, and collecting water, whereas men and boys more often indicated farming and leisure. The finding that men and boys spend more time on leisure further underlines that the majority of the burden of unpaid work falls upon women and girls.

PARTICIPATION IN VSLAs

29.6% of respondents reported participating in a Village Savings and Loan Association (VSLA), with higher participation among the 25-59 age group (36.1%), and lower participation among the 12-17 age group (12.7%). Though VSLA participation is more common among women and girls, no difference could be seen among the respondents of this survey (31.3% of women and girls report participating compared to 27.6% of men and boys).

Men more frequently reported being able to continue to save with VSLAS after onset of the pandemic.

Figure 15: % of respondents involved in VSLAs who reported being able to continue saving after onset of the pandemic by respondent sex.



What is more striking is how VSLA participation is more common in Oruchinga, Adjumani, and Lobule (with 59.1%, 50.5%, and 46.9% respectively), and less common in Kampala, Nakivale, and Imvepi (1.9%, 11.7%, and 17.5% respectively).

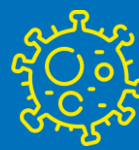
Surprisingly, the majority of those reporting participation in a VSLA also reported being able to continue saving regularly with the scheme since the onset of COVID-19 (52.2%). However, men more often indicated being able to save when compared to women (53.5% versus 43.7%).

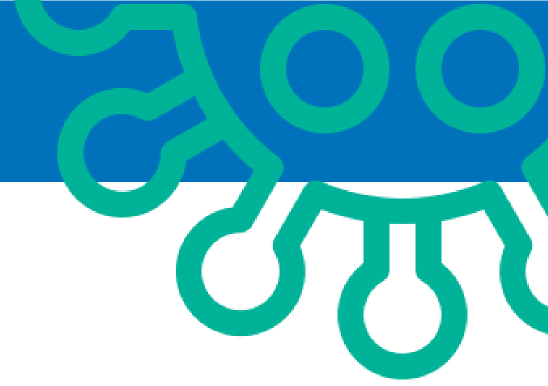
NEGATIVE COPING MECHANISMS

The most common coping mechanisms reported by respondents were buying food on credit (53.1%), spending savings (36.9%), and reducing essential non-food expenditures (26.3%). Harvesting immature crops (12.0%), consuming seed stock (9.3%), and selling household goods (6.5%) were mentioned much less frequently. Negative coping mechanisms related to children, such as working, survival sex work, and begging were extremely rare with the exception of boys and girls engaging in labour which was mentioned by 4.8% and 2.8% of the respondents, respectively. Similarly, negative coping mechanisms with adults involved in high risk jobs, begging, and survival sex work were not commonly signalled, with the most frequent being women begging mentioned by only 1.7% of respondents.

Differences along gender and age lines were not apparent. What the survey results suggest, however, is that negative coping mechanisms may be more strongly related to the location of the respondent. Buying food on credit was much more frequently reported by respondents from Lobule, Rhino, Oruchinga, and Nakivale (80.4%, 75.2%, 69.6%, and 65.6% respectively), spending savings from Kiryandongo, Kampala, and Adjumani (71.4%, 50.0%, and 46.7% respectively); reducing essential non-food expenditures also from Kampala (42.3%); and harvesting immature crops from Kiryandongo (34.4%).

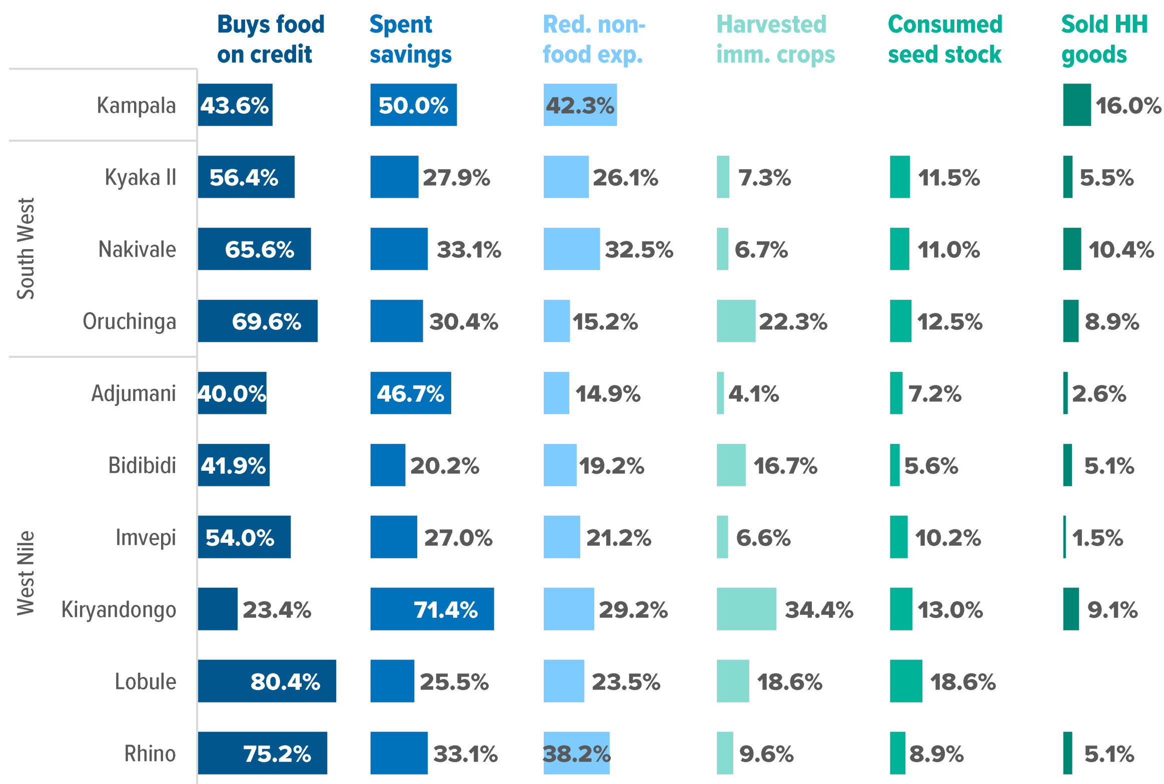
In contrast to the survey results, key informant interviews brought attention to different coping mechanisms. Spending savings was in fact the only one of the top six negative coping mechanisms showcased in the survey results that also appeared in the key informant interviews and was only mentioned by 3.8% of the key informants. Rather, key informants chose to underline the incidence of theft among boys and men and survival sex work among girls and women. On the contrary, survival sex work was mentioned by less than 1% of survey participants and theft was not mentioned at all. Child marriage was the fourth most commonly mentioned negative coping mechanism by the key informants. This difference in comparing the survey results to the key informant interviews is understandable when one considers, on the one hand, that respondents would not feel comfortable admitting to the use of sensitive types of negative coping (like theft or survival sex work), while on the other hand, that key informants may be more inclined to highlight the most egregious types of negative coping.





The use of particular mechanisms seemed to depend on respondent location. For instance, spending savings was much more frequently reported in Kiryandongo than in other locations, while selling household goods was more common in Kampala in comparison.

Figure 16: % of respondents who use particular negative coping mechanisms by respondent location.



Apparent within the key informant responses was also the gendered nature of most negative coping mechanisms. From their replies, it appears that theft, selling drugs, and borrowing money are most often employed by men and boys, while women and girls engage in survival sex work, burning charcoal, brewing alcohol, selling food rations, reducing the number of meals, and selling off personal items.

LOSS OF LIVELIHOODS IMPACTS

Key informants were also asked about the unique challenges relating to livelihoods facing women and girls, men and boys, older persons, and people with disabilities. Men's challenges were described in terms of lost

livelihoods (61%), a lack of confidence due to their inability to provide for the family (23%), and having to deal with a "lack of respect" from their wives (5%), resulting in an increase in "idleness" (16%), alcohol and drug use (14%), participation in crime (8%), and in committing domestic violence (10%). There were also reports of boys increased involvement in child labour (4%).

The most frequently mentioned challenges to women and girls by the key informants were rising incidences of SGBV (23%), teenage pregnancy (21%), child marriage (18%), and domestic violence (17%), the latter three of which were reported separately from mentions of SGBV. Other important challenges included reduced household income and an inability to meet the basic needs of the household – especially food (15%), menstrual hygiene (9%), and Sexual and Reproductive Health (SRH) needs (5%) – all while having an increase in unpaid care work such as childcare, cooking, and cleaning (7%). Here too, respondents mentioned that women and girls at times have to resort to survival sex work to meet their basic needs (10%) and may be at greater risk of having their resources confiscated by male partners (5%).

With respect to PLWD and older persons, reduced income was mentioned by 26% of the key informants, while 20% underlined the diminished financial and physical support they would likely receive from family due to impacts on their own livelihoods, and an additional 11% pointed to the decreased assistance provided to PLWD and older persons by humanitarian organizations. There was also a general recognition of the increased mobility challenges faced by this group as a result of limited or more expensive transportation. This was seen to lead to food insecurity, shelter insecurity, lack of access to healthcare, and a general inability to meet their own basic needs. A couple of respondents further highlighted the possibility that these groups may be more dependent on others and may be more vulnerable to abuse

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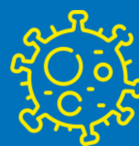
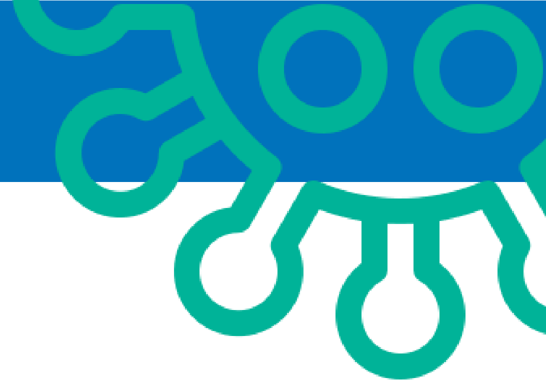




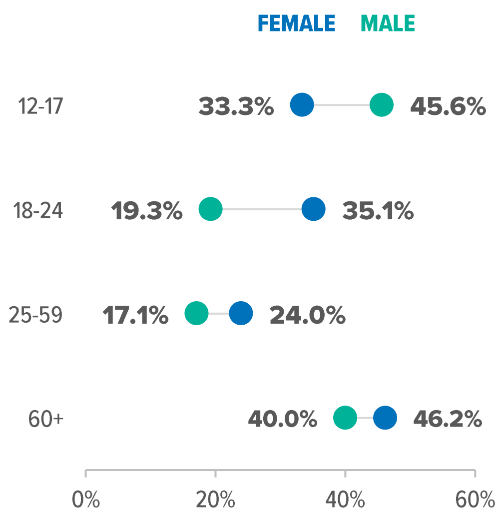
Access to Information

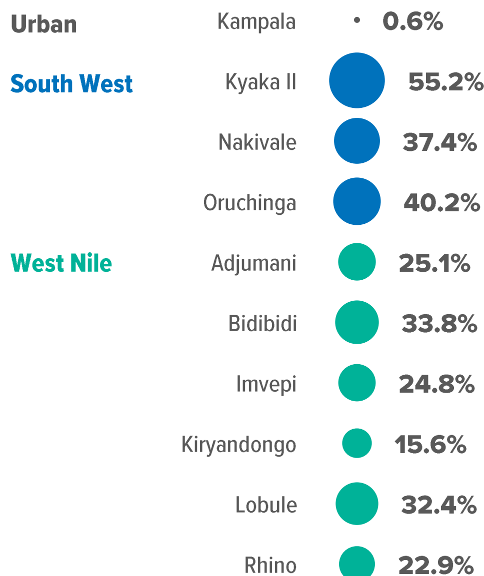
MOBILE PHONE ACCESS & USE

Irrespective of sex or age group, respondents indicated using mobile phones primarily for contacting friends and family (61.4%), followed by general information in distant second with only 4.9% indicating so. A further 28.7% of respondents signalled not having a mobile phone. Women aged 18-24 and 25-59 more frequently reported not having a mobile phone when compared to men of the same age. The converse trend can be seen among girls and boys (45.6% of boys report no phone versus 33.3% of girls). The percentage of respondents without a mobile phone varied considerably by location as well, with very few respondents without a phone in Kampala (0.6%). Generally, respondents in the West Nile settlements less frequently reported not having a mobile phone when compared to the settlements in the South West.

Not having a mobile phone seems to depend on the sex, age group, and location of the respondent. Women more often report not having a mobile phone, as do respondents in the settlements of the South West.

Figure 17: % of respondents reporting no access to a mobile phone by respondent sex and age group, as well as by location.





Respondents were also asked whether they could access internet through a mobile phone, with only 14.9% indicating that they were able to. Boys and men aged 18-24 and 25-59 more often signalled being able to access the internet through a mobile phone when compared to women and girls. No difference could be seen in the 60+ age group (5.4%), though older persons also more frequently reported not having access to a mobile phone at all (43.4%). Persons with a disability or serious medical condition also reported low levels of access to internet through a phone (8.0% and 10.9%). These findings confirm the presence of a mobile gender gap, both in terms of mobile phone ownership and access to internet. This has many implications, from the level of access to information and services to women and men's sense of security.

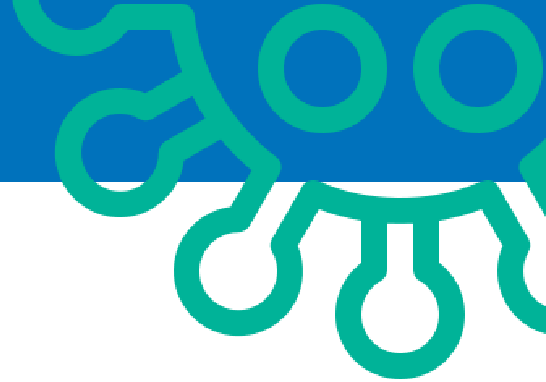
INFORMATION NEEDS

With respect to information needs, food was by far the most frequently indicated information need by 66.6% of the respondents, followed by education indicated by 41.4%. Rounding off the top five were shelter, disease, and security mentioned by 29.4%, 26.5%, and 24.2% respectively. A couple of interesting differences are worth noting. With respect to education, girls, boys, and men aged 18-24 more frequently indicated this need (with 75.6%, 63.2%, and 64.9% respectively). In comparison to women, men aged 18-24 inquired more frequently for shelter (33.3% of men versus 14.9% of women), resettlement (31.6% of men versus 9.5% of women), and employment (31.6% of men versus 18.9% of women).

It is also instructive to examine the top concerns by respondent location as considerable variation can be noted. For instance, the top three concerns in Kampala were food (70.5%), resettlement (53.8%), and employment (47.4%). Conversely, in most of the settlements in West Nile, the information priorities were food (67.2%), education (49.1%), and disease (34.7%). Oruchinga also had widely diverging information priorities. After food (83.0%), they most frequently inquired after security (42.9%). The ranking of information needs by location can be seen in Figure 18.

INFORMATION MEDIUMS

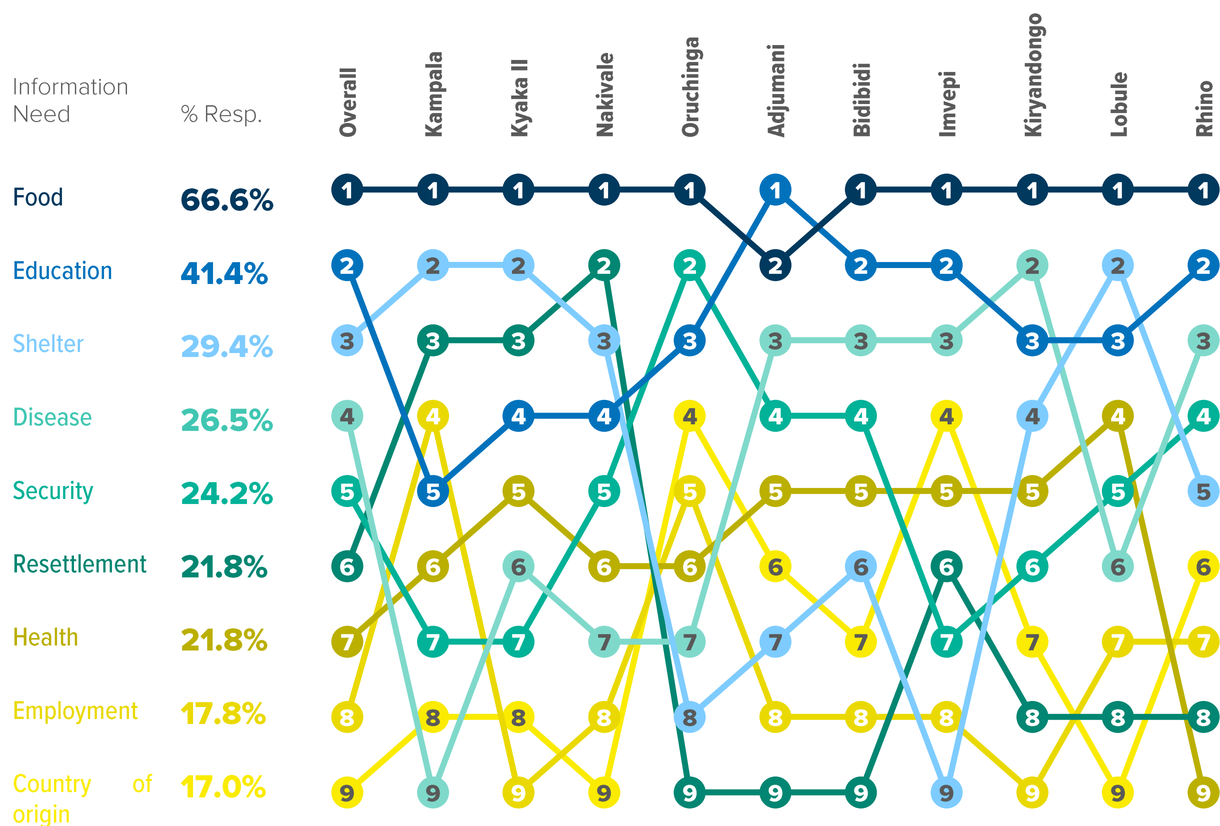
A wide array of information mediums were reported by respondents, with the top ten being community leaders (60.8%), friends/neighbours (41.1%), NGOs (39.8%), community meetings (31.5%), the radio (31.1%), religious places (27.6%), family (22.9%), local community organizations (20.4%), aid organization volunteers/staff (18.6%), and mobile phones (13.0%). Girls' preferences departed greatly from those of other groups, far more often preferring to receive information via friends/neighbours (55.6%) and family (33.3%), while showing less preference for receiving information through community leaders (37.8%) and community meetings (17.8%). These same preferences can be seen among female child HoH. With respect to other CoP, it is also important to note that persons with serious medical conditions more often prefer receiving information by phone (20.8%) when compared to others.



As was seen with information needs, preferred information mediums appear to vary significantly by respondent location. Respondents in Kampala, for instance, make much more frequent mention of phones and religious places, and much less mention of NGOs and aid organizations, community meetings, radios, and health centres. Conversely, respondents from Nakivale more often indicate a preference for NGOs compared to others (75.5%), while respondents in Rhino Camp prefer to receive information from friends and neighbours. The ranking of information mediums by location can be seen in Figure 19.

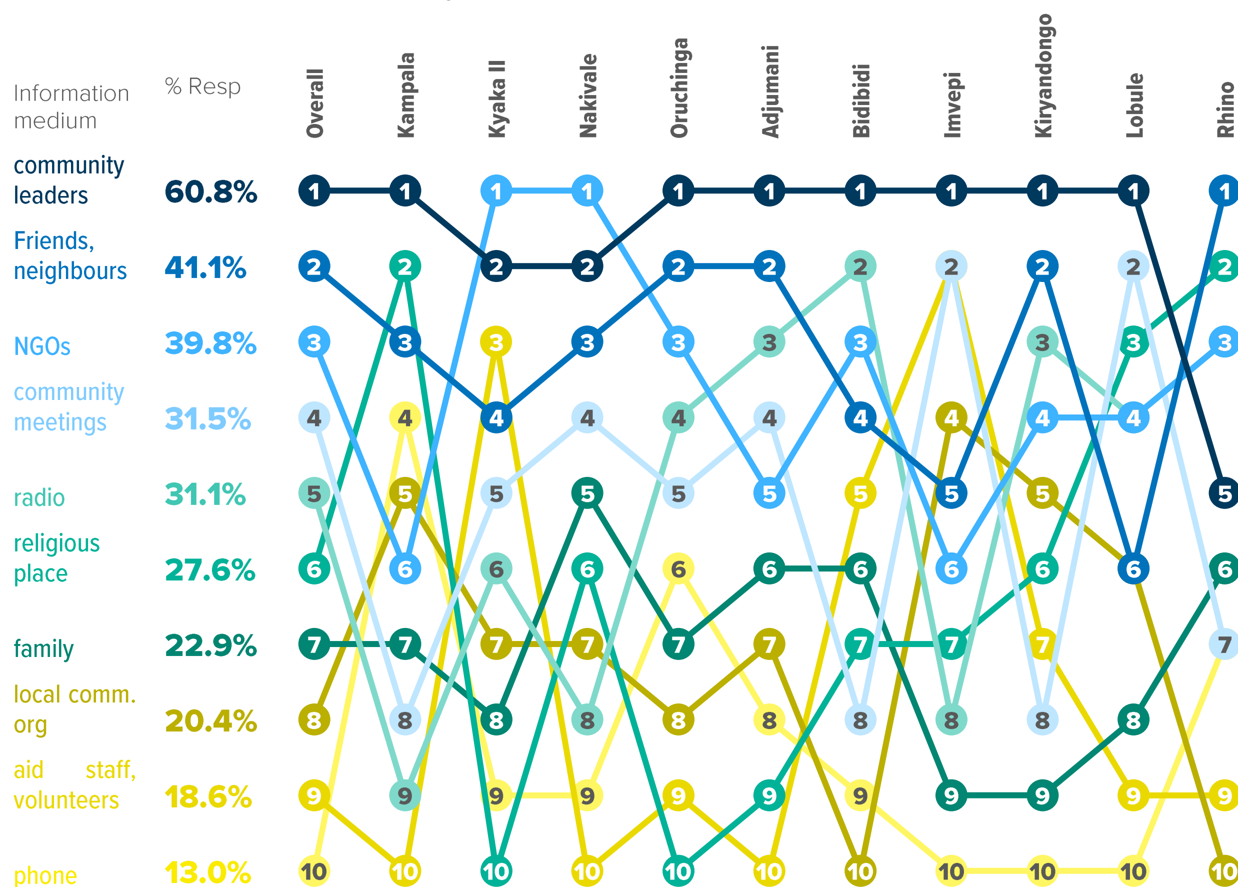
Information needs vary widely by location. For example, while food was consistently ranked first across all settlements (other than Adjumani), shelter, which ranked third overall, varied widely, ranking second in Kampala and Kyaka II, and in last place in Imvepi.

Figure 18: % of respondents mentioning a top nine information need, as well as the overall rank of each need, and their rank by location.



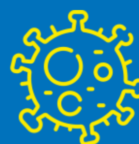
Information medium preference also varied widely by location. Take for instance community leaders, who were ranked in first or second place across all locations, other than in Rhino Camp where they fell to fifth place.

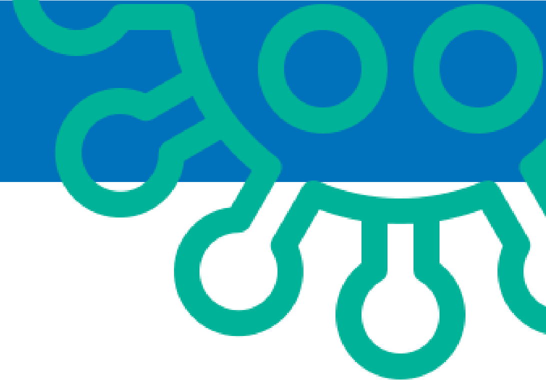
Figure 19: % of respondents mentioning a top ten information medium, as well as the overall rank of these mediums, and their rank by location.



INFORMATION ACCESS ISSUES

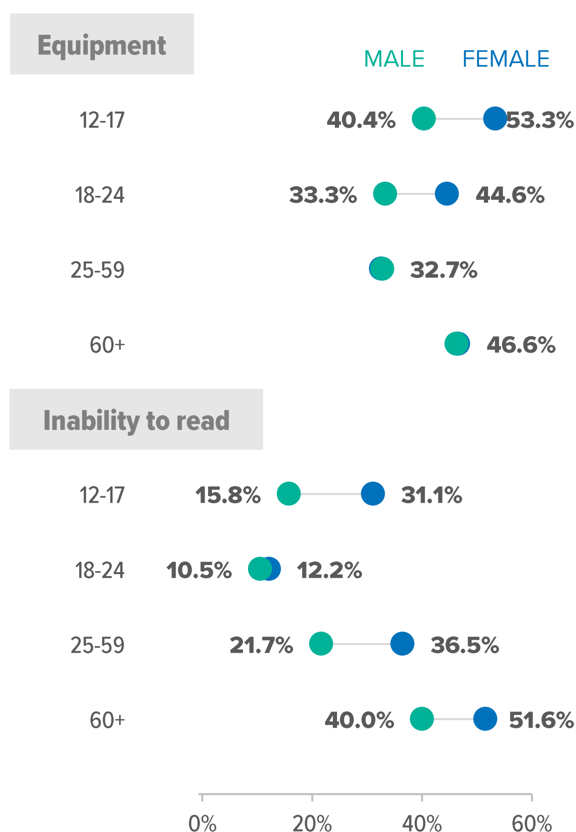
By far the most regularly mentioned access issues were a lack of equipment (37.7%) and an inability to read (32.2%). Cost of charging equipment (17.5%) and electricity (15.1%) were also mentioned by respondents, though less frequently. It should also be noted that 28.1% of respondents indicated having no difficulty accessing information. Given the higher percentage of women previously indicating no access to a mobile phone, it is not surprising





Women and girls suffer access issues to information as a result of a lack of equipment and an inability to read more often than men and boys.

Figure 20: % or respondents who cannot access information due to a lack of equipment or an inability to read by respondent sex and age group.

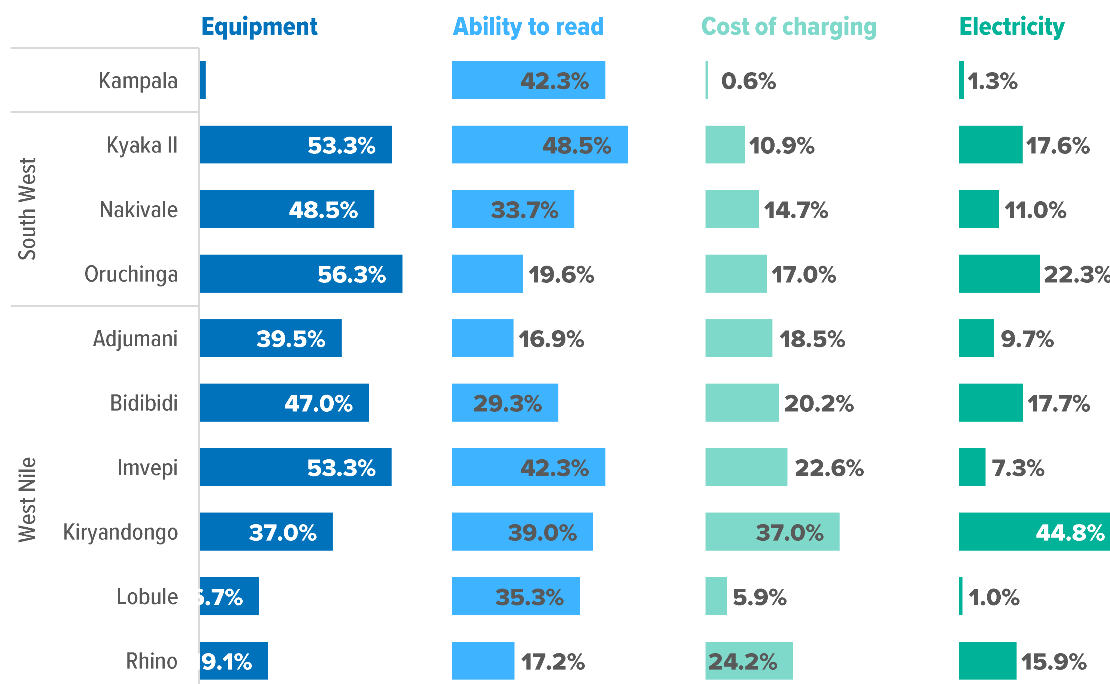


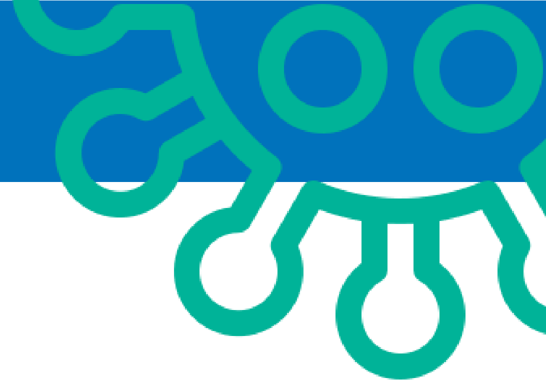
that girls and women aged 18-24 more often reported lack of equipment when compared to men of the same age. Other than the 18-24 age group, women also more frequently mentioned that an inability to read prevents them from accessing information. This is especially alarming among child respondents where 31.1% of girls cite this issue compared to 15.8% of boys. On the contrary, boys and men aged 18-24 more commonly indicated having no difficulty accessing information at all (38.6% of each age group indicated so). Lack of equipment and an inability to read were also important issues experienced by older persons and PLWD. This point was also raised frequently by key informants who noted that these groups may have difficulties accessing information related to COVID-19, which is especially troubling given that they have preconditions which put them at risk of the virus.

Access issues were not surprisingly also linked to location. Following trends seen previously, 50% of respondents in Kampala cited not having any difficulties accessing information, while another 42.3% indicated an inability to read, and only 1.6% indicated equipment. Interestingly, the majority of participants in Lobule and Rhino camp also cited having no challenges in accessing information (55.9% and 52.2% respectively). On the contrary, Kiryandongo appeared to have the most diverse set of access issues, with a lack of equipment, an inability to read, cost of charging equipment, and electricity all mentioned by at least one third of respondents in that location (37.0%, 39.0%, 37.0%, and 44.8% respectively). Differences in access issues by location are highlighted in Figure 21.

Information access issues also appear to depend on location. For instance, ability to read is the largest access issue to information in Kampala, whereas in Kiryandongo, it appears to be electricity.

Figure 21: % of respondents mentioning an information access issue by respondent location.





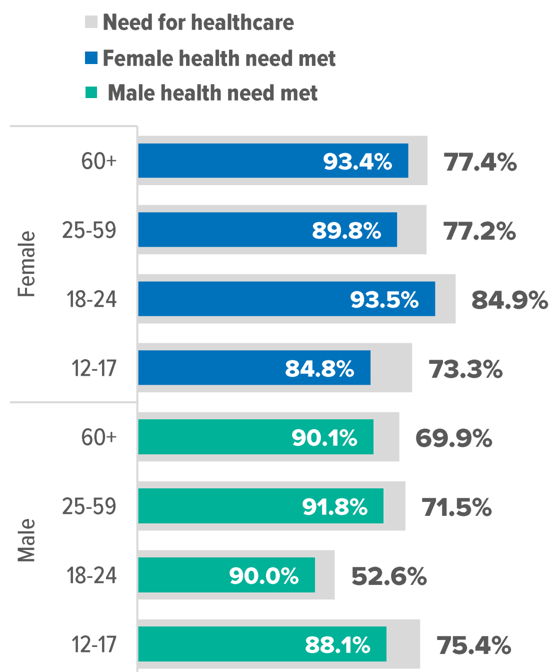
Access to Healthcare

HEALTHCARE NEED

With respect to healthcare, 74.2% of the respondents indicated needing to access healthcare after onset of the pandemic, with women aged 18-24 most often reporting this need (84.9%). The greater necessity of this group is further highlighted when compared with men of the same age where only 52.6% had needed healthcare. No other differences could be noted through the lenses of sex, age group, or CoP. With respect to location, the respondents of only two settlements Nakivale and Adjumani, less often reported requiring health services, with 60.1% and 64.4% respectively. Conversely, the percentage of respondents requiring healthcare in Rhino Camp was higher than the average (86.1%).

Women aged 18-24 most frequently required healthcare after onset of the pandemic.

Figure 22: % of respondent indicating that they required healthcare after onset of the pandemic, as well as the % that were able to access healthcare, by respondent sex and age group.

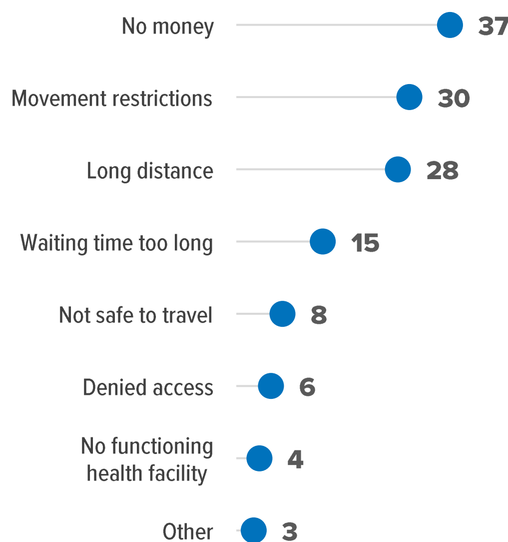


HEALTHCARE ACCESS ISSUES

Of those persons who reported needing to access healthcare, 90.9% specified that they

The most common barriers to healthcare mentioned by respondents were lack of money, movement restrictions, and long distances.

Figure 23: Main challenges reported by respondents to accessing healthcare.

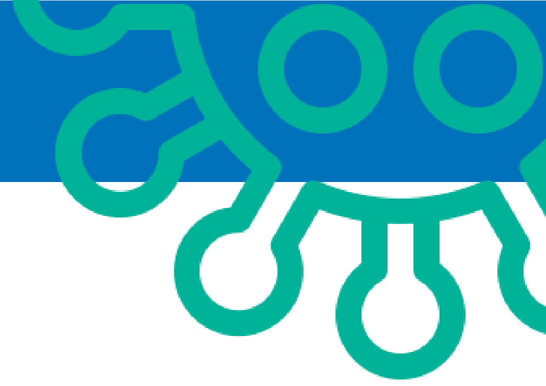


were able to do so. This percentage did not change by sex, age group, or CoP. Interestingly, Kampala was the only location where a significantly lower percentage of respondents reported being able to access healthcare, with only 67.6% claiming so. The health services that were not accessible to the selected few who indicated not being able to do so were child healthcare (n=27), radiology (n=15), HIV chronic services (n=11), Maternal Newborn and Child Health (MNCH) services (n=10), and oncology (n=2). Some of the more common barriers raised by these participants included a lack of money, movement restrictions, long distances, and longer wait times at the health facility. The frequencies of these responses are shown in Figure 23.

Survey respondents were also asked whether they must consult a family member before they can access healthcare. 66% indicated having to do so, irrespective of sex. Youth, male child HoH, and female child HoH less frequently reported needing to consult with others before seeking healthcare (48.2%, 48.0%, and 38.5%), while single female HoH more frequently indicated having to do so (78.4%). A higher percentage of respondents also reported having to consult from Rhino Camp (81.6%), Lobule (77.1%), and Nakivale (77.7%) when compared to the average.

In contrast to this data, more than half of the key informants underlined that the accessibility to some types of healthcare had been reduced after the onset of the pandemic. By far the most common types of healthcare to which they reported reduced accessibility were MNCH (20.2%), most often delivery by a skilled birth attendant, followed by HIV chronic services (13.3%). Less often were mentions of malaria, family planning, typhoid, minor surgery, general consultations, oncology, radiology, and EPI.

With respect to the access issues faced by women and girls, physical access accounted for 44.9% of the responses. Specifically, transportation and a lack of nearby health facility were seen to be central issues, and particularly for pregnant women. Key informants



indicated that transportation was an issue for several reasons including limited public transportation and the increased cost and restrictions associated with boda-boda use. Simultaneously, movement restrictions and curfews exacerbated the issue of physical access to the health facility.

Girls face stigmatization as a result of teenage pregnancy and child marriage and when they go to the health facility, no one is attending to them.

-Female, aged 46, Imvepi

Many supply (relating to the health facility) and demand-side (relating to the health seeker) issues were raised by participants. The most common supply-side issues were a prioritization of COVID-19 and a reduction of outreach services which were seen to be critical to reaching women and girls in the community, particularly for family planning (FP) and SRH. Paired with the limited focus of health facilities on treatment of the virus was the sense that health facilities were overwhelmed, understaffed, and not prepared, resulting in delays and longer wait times to receive care. Key informants also signalled to an important issue predating COVID-19, that health facilities are not adolescent friendly, discriminating against girls in particular who seek FP or MNCH services.

On the demand side were the issues of reduced money for treatments and fear of exposure to the virus at the health facility. Some respondents also mentioned that women and girls did have easy or regular access to PPE, which is a requirement to enter health facilities.

One serious consequence raised by key informants resulting from this assembly of barriers facing women and girls was the possibility that they may seek traditional treatments for abortion and home births, exposing them to even greater health risks.

Due to the difficult access to healthcare, more women are threatening to abort at home, to use traditional methods, and even to resort to witchcraft.

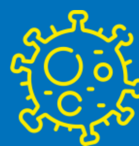
-Female, aged 33, Rhino Camp

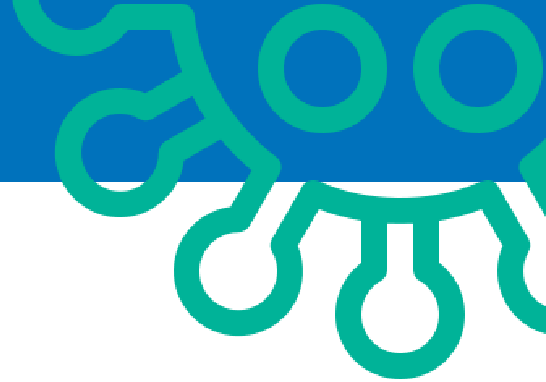
The same concerns outlined for women and girls were also raised for older persons and PLWD, though transportation was considered even more of a barrier for this group when compared to women and girls. Whereas transportation accounted for 25.0% of the challenges mentioned for women and girls, it accounted for 45.5% of the challenges mentioned for older persons and PLWD. This was explained due to their reliance on wheelchairs, as well as their physical condition. As was the case with women and girls, the closure of community outreach and mobile clinics was seen to impede access of this group to critical healthcare.

MENTAL HEALTH ISSUES AND CARE

MHPSS key informants were asked a series of questions regarding whether COVID-19 has had an impact on the mental health of people within the community, as well as how these impacts have been managed. Of the MHPSS actors interviewed, 80.6% agreed that COVID-19 has had an impact on mental health. Some of the most common mental health issues mentioned by respondents were an increase in stress, anger, anxiety, and a decrease in confidence as a result of the loss of livelihoods. Mental health was also seen to be impacted by the social isolation resulting from the lockdown, movement restrictions, and bans on community activities. In the case of men in particular, MHPSS actors explain that men's inability to fulfil their traditional role of provider has led to a decrease in their confidence, with many turning to alcohol and drugs to cope. This combination of stress, social isolation, and substance abuse has not surprisingly led to a rise in SGBV and domestic violence. Interestingly, the mental health impact of these incidences of SGBV and domestic violence on women was not explored by the interviewed MHPSS actors.

Mental health management was described to include individual or family counselling with exposure to positive coping mechanisms and tools for effective problem solving and better communication with family members. Farming, for instance, was a frequently promoted positive coping mechanism seen to keep people productive while improving family food security. More severe mental health issues, on the other hand, were typically referred for more specialized psychosocial support with a properly certified professional. MHPSS actors were also careful to note that the provision of food and cash assistance was also imperative to address the root causes of people's stress and anxiety.





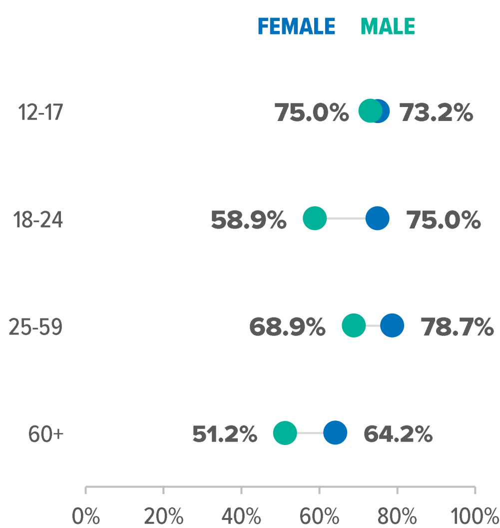
Education

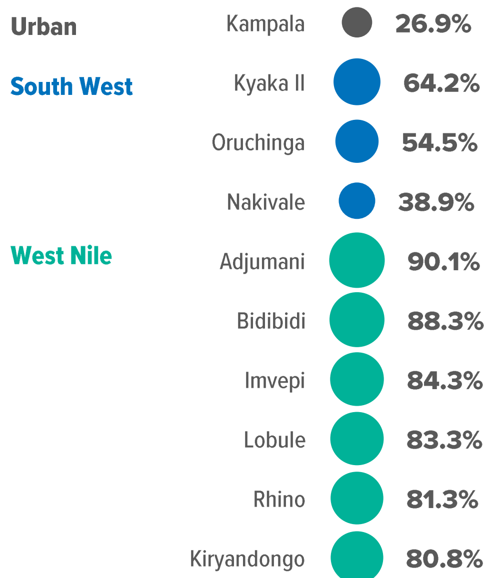
HOUSEHOLDS WITH SCHOOL-AGED CHILDREN

69.9% of respondents reported to have a school-aged child in the household, with women more often reporting so. Overall, 74.5% of women replied affirmatively to this question compared to 64.0% of men. It is interesting to note that similar percentages of girls and boys reported school-aged children in the household (75.0% and 73.2%), who are themselves school-aged, perhaps signalling the rate of scholarization of children aged 12-17. With respect to location, it appears that respondents from settlements in West Nile more frequently report having school-aged children compared to Kampala or the settlements of the South West. Respondents in Kampala and Nakivale were least likely to have school-aged children which corresponds with the demographic data highlighted in the section above regarding household composition, whereby these same two locations were also most likely to have respondents who live alone.

Women across all three age groups indicated having school-aged children in the household more often than men. In addition, the percentage of respondents responding affirmatively to this question was far greater from the settlements in West Nile.

Figure 24: % of respondents who have school-aged children by respondent sex and age group, as well as by location.



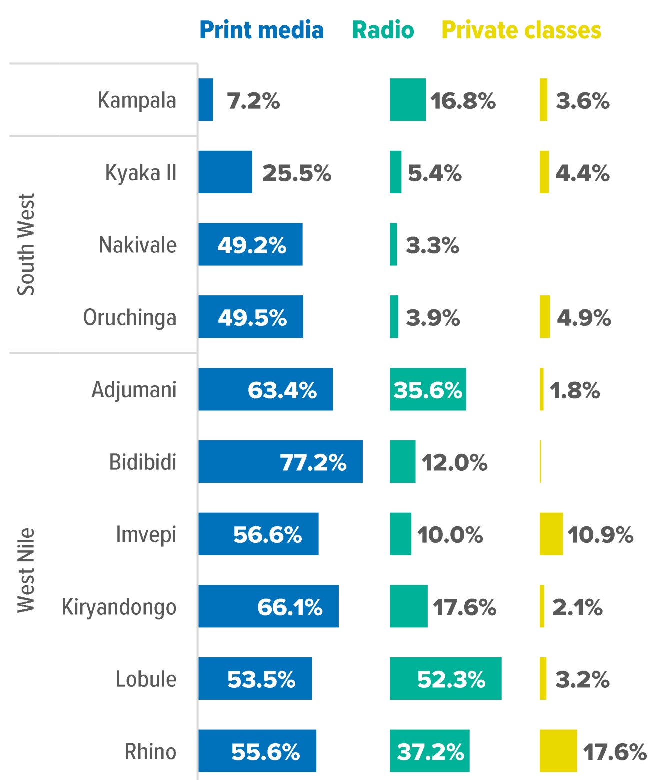


MECHANISMS FOR LEARNING

The top learning mechanisms mentioned for girls were print media (56.7%), followed by radio (20.5%). Private classes (4.9%), social media (1.5%), tv (1.1%), and online learning (0.7%) all received far fewer mentions by respondents. A further 22.0% noted that girls had no materials for learning, while 16.0% noted that girls had stopped learning.

Certain mechanisms appear more popular in certain locations, such as radios in Lobule or private classes in Rhino Camp.

Figure 25: % of respondents mentioning one of the top three learning mechanisms by respondent location.

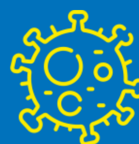


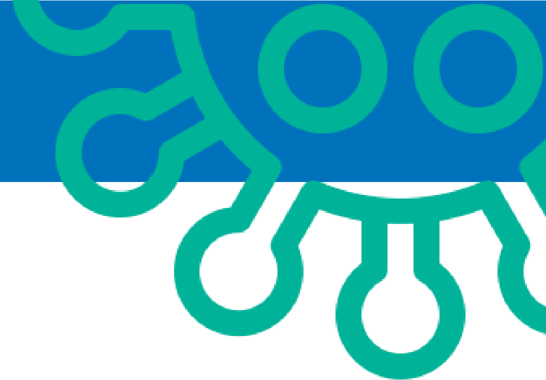
The mentions made for the learning mechanisms used by boys were the same as those indicated for girls. Print media and radio for instance were mentioned by 55.7% and 21.5% of respondents, while the percentages for girls were 56.7% and 20.5% respectively. Similarly, the percentage of respondents indicating that boys had no materials for learning or had stopped learning altogether was 19.2% and 16.9%, respectively, also with no statistical difference to the responses made regarding girls.

It is also invaluable to see how the frequency of mentions of the different learning mechanisms varied by respondent location. For instance TV was only mentioned frequently in Kampala (12.2%), with less than 2% of respondents mentioning this modality in other locations. Similarly, learning through social media was only signalled by more than 2% of respondents in Kampala and Rhino Camp (4.9% and 6.4% respectively). Furthermore, the issue of having no materials appeared to be greater in Kyaka II and Nakivale (43.1% and 45.0%), while children having stopped learning was much more frequently reported in Kampala (41.5%). The top three learning mechanisms have been depicted by location in Figure 25, whereas a separate figure examining the girls and boys having no materials or who have stopped learning can be found below.

CHALLENGES FOR LEARNING

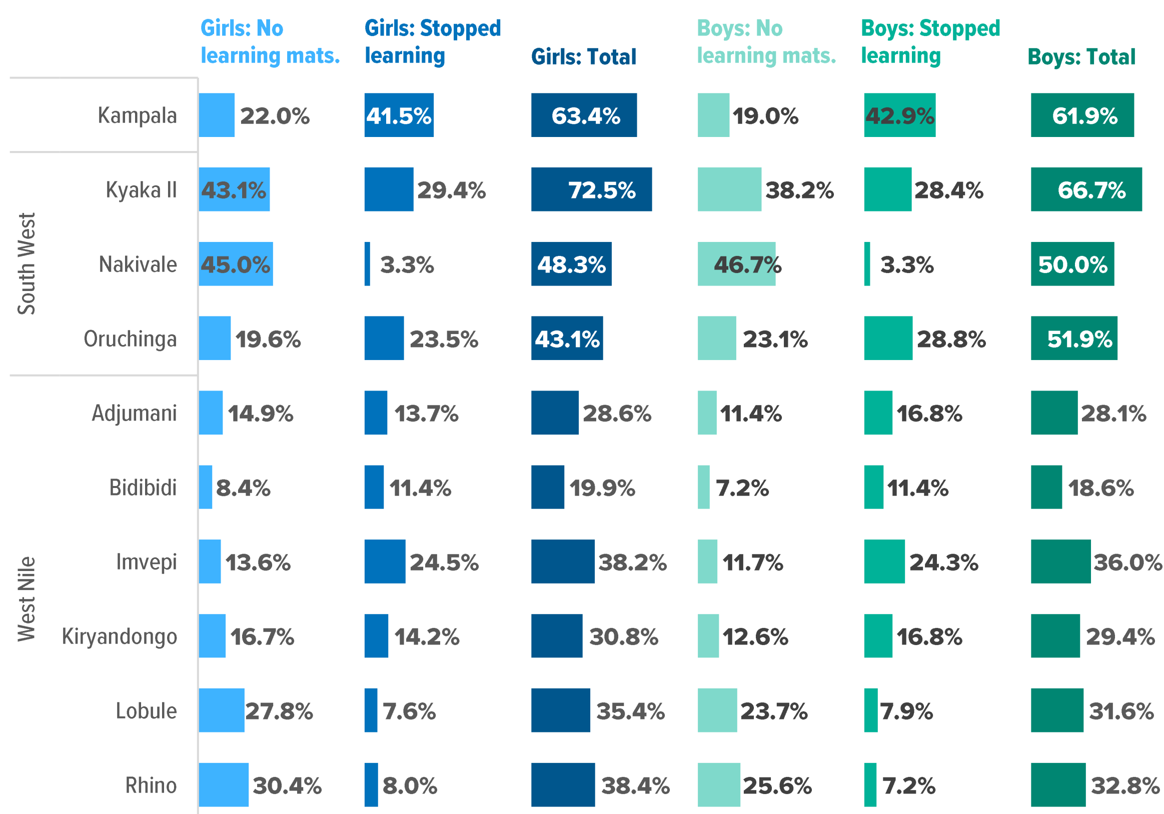
According to respondents, the main challenges for learning experienced by girls include a lack of skilled instruction (52.7%) and an inability for parents to help (43.7%). All





The issue of having no materials appeared to be greatest in Kyaka II and Nakivale, while children having stopped learning was much more frequently reported in Kampala.

Figure 26: % of respondents indicating that girls and boys have no learning materials or have stopped learning by respondent location.



Region	Location	Girls: No learning mats.	Girls: Stopped learning	Girls: Total	Boys: No learning mats.	Boys: Stopped learning	Boys: Total
	Kampala	22.0%	41.5%	63.4%	19.0%	42.9%	61.9%
South West	Kyaka II	43.1%	29.4%	72.5%	38.2%	28.4%	66.7%
South West	Nakivale	45.0%	3.3%	48.3%	46.7%	3.3%	50.0%
South West	Oruchinga	19.6%	23.5%	43.1%	23.1%	28.8%	51.9%
West Nile	Adjumani	14.9%	13.7%	28.6%	11.4%	16.8%	28.1%
West Nile	Bidibidi	8.4%	11.4%	19.9%	7.2%	11.4%	18.6%
West Nile	Imvepi	13.6%	24.5%	38.2%	11.7%	24.3%	36.0%
West Nile	Kiryandongo	16.7%	14.2%	30.8%	12.6%	16.8%	29.4%
West Nile	Lobule	27.8%	7.6%	35.4%	23.7%	7.9%	31.6%
West Nile	Rhino	30.4%	8.0%	38.4%	25.6%	7.2%	32.8%

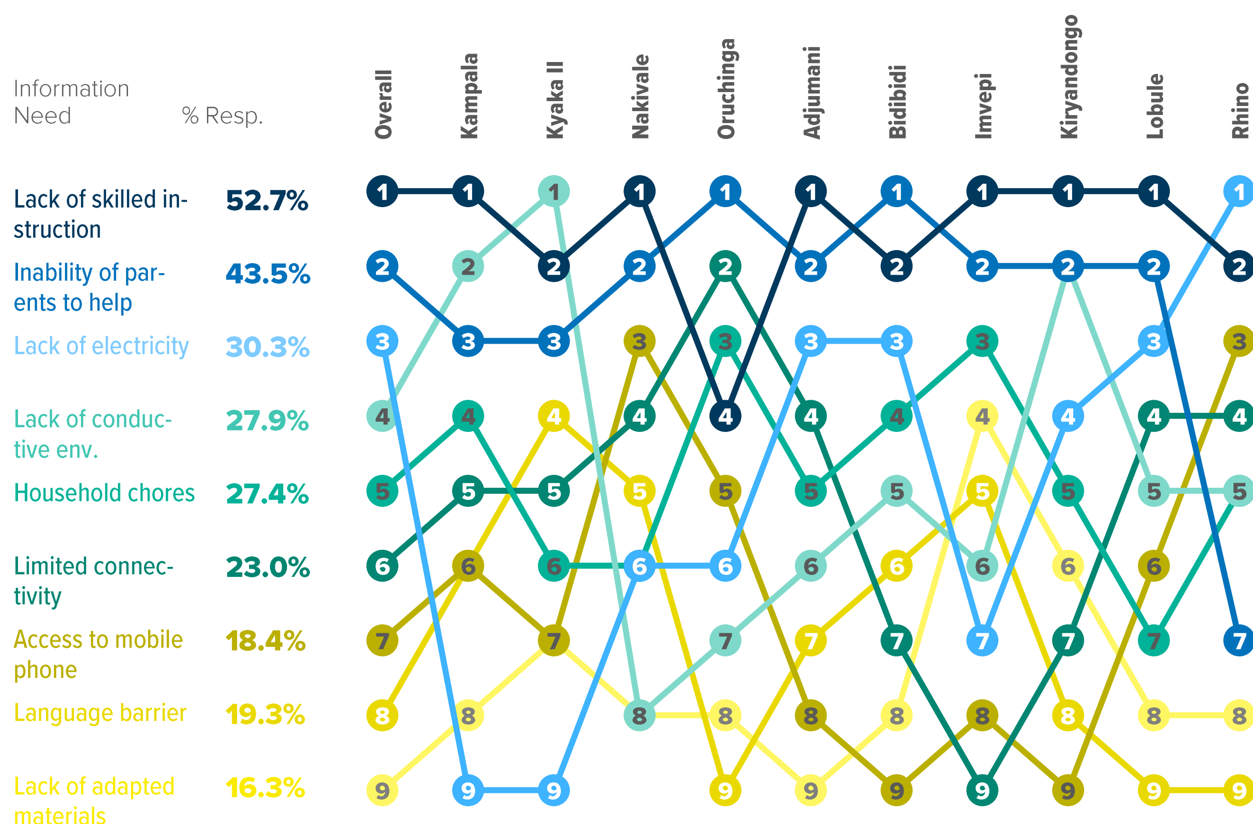
other challenges were mentioned much less frequently, including a lack of electricity (30.3%), a lack of conducive environment

(27.9%), household chores (27.4%), limited connectivity (23.0%), access to a mobile phone (18.4%), having a language barrier (19.3%), and a lack of adapted materials (16.3%).

Certain challenges appeared to be more acute in particular locations. A lack of skilled instructors was mentioned by 75.6% of the respondents in Lobule and was more frequently mentioned in the settlements of West Nile (60.9%). Also more frequently mentioned in West Nile was an inability of parents to help (47.1%, compared to 35.1% in Kampala and 33.0% in the South West), and a lack of

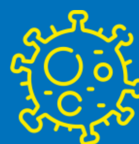
The education challenges mentioned by respondents varied widely by location. For instance, an inability for parents to help was ranked in second or third across all locations, other than in Rhino Camp where it was placed in seventh (of nine).

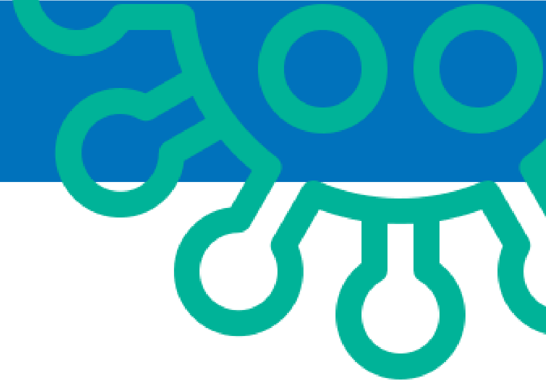
Figure 27: % of respondents mentioning an education challenge experienced by girls, as well as the overall rank of these challenges, and their rank by location.



electricity (37.8%, compared to 0.0% in Kampala and 18.4% in the South West). Connectivity and access to a mobile phone appeared to be more significant in Oruchinga, Rhino Camp, and Nakivale, while language barriers were more often highlighted by respondents in Bidibidi (32.5%) and Imvepi (34.9%). Interestingly, a lack of adapted material was much more frequently mentioned in Imvepi compared to other locations (37.6%).

The key informants corroborated all of the trends mentioned above, including the centrality of print media and radio learning materials, as well as highlighting some of the same challenges such as an inability for parents to help. Furthermore, they confirmed that

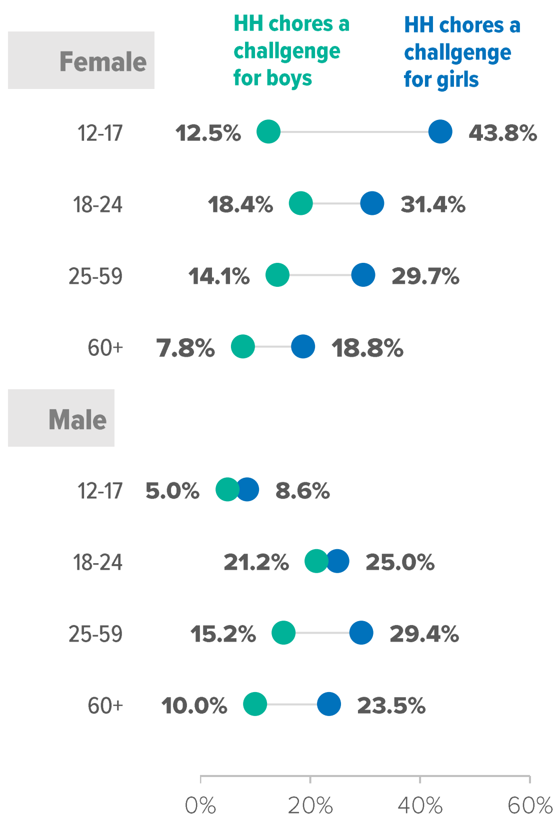




household chores were much more of a challenge for girls than for boys, with 57.9% identifying the challenge for girls compared to only 33.3% for boys.

Girls much more frequently noted the barrier of household chores to learning.

Figure 28: % or respondents who indicate that household chores are a challenge to learning for girls and for boys by respondent sex and age group.



Other than household chores, no other differences could be noted in the challenges indicated for girls versus for boys *when asked specifically about the challenges to learning*. However, additional challenges to education were apparent when key informants were asked about the overall impact of the pandemic on boys and girls. With respect to girls, the three greatest challenges identified were an increased incidence of SGBV (23%), teenage pregnancy (21%), and child marriage (18%). The latter two were seen to be specifically linked to the school closures and girls being out of school. These two conditions have also been shown in previous studies to negatively impact upon the education outcomes of girls and lead to increased dropout rates in Uganda[8]. It also bares noting that 10.8% of respondents indicated that girls were at risk of engaging in survival sex work.

With respect to boys, school closures were seen to result in a condition of idleness (11%). Respondents further linked “idleness” with an increase in alcohol and drug abuse (14%), involvement in theft and other crime (8%), and committing SGBV. 4% of respondents also indicated that boys were at risk of engaging in child labour.

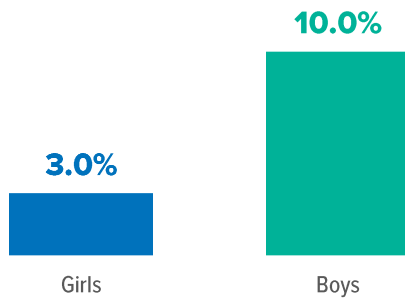
RETURN TO SCHOOL

94.9% of the respondents with school-aged children within their household indicated that they would be returning to school. Only two out of 1,000 respondents indicated a preference for sending boys to school when compared to girls.

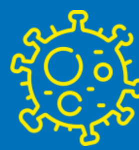
Two deviations are worth noting with respect to a return to school. The first is that boys most often indicate that school-aged children are not returning to school, with 10.0%

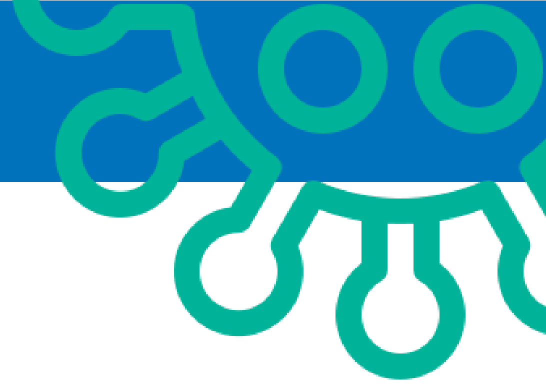
Boys appear more likely to indicate that school-aged children will not be returning to school.

Figure 29: % girls and boys who indicate that school-aged children will not return to school.



indicating so, compared to 3.0% of girls and the overall average of 3.9% across all respondents. Given that this group is school-aged, it raises the question of whether boys are less inclined to return to school. The second deviation is that respondents in Kampala were much more likely to indicate that children will not be returning to school, with 19.5% indicating so. Other locations showed no statistical difference from the average. This may be because respondents interpreted this question to mean whether they *want* to send their children back to school after COVID-19 instead of whether they will be *able* to.





WASH

ACCESS TO WATER

The key informants were asked to consider the main challenges for women and girls to accessing water. Overcrowding was the most frequently mentioned issue by 26.6% of the key informants. They linked overcrowding to increased water needs to maintain proper sanitation and hygiene and the requirement to socially distance at the waterpoints, but also to the reported return of many refugees to the settlements since onset of the pandemic. Overcrowding was also seen by some to increase the likelihood of in-fighting among women as they waited (2.5%). The return of refugees was also seen by respondents to place greater demands on the water systems, leading to frequent water shortages (20.3%), and the risk of not meeting the household water needs.

The quantity of water is not enough as the population has increased with many returning to the settlements, leading to overcrowding at the water points. Many are forced to go to the lake and dams to get water where they are at risk of being raped or defiled.

-Male, aged 61, Nakivale

Women and girls are being forced to wake up while it is still night to go and fetch water. They are also forced to reduce the rate of water consumption like for example from 5 Jerry cans to 2 or 3.

-Male, aged 57, Oruchinga

The second most frequently mentioned access barrier was the distance to the water source (25.3%). In addition, in the event of water service delays (4.4%) or water point maintenance (5.7%), women and girls faced the additional barrier of movement restrictions in trying to access other, more distant water sources (4.4%). The fetching of water across long distances was also seen by key informants to increase the likelihood of incidences of SGBV (10.8%). Furthermore, key informants signalled that a lack of nearby water sources might lead women and girls to use unclean water sources instead, increasing the risk of waterborne diseases.

Following overcrowding and distance to the water source, the third most frequent access issue raised by participants was cost to access waterpoints in “town areas” (16.5%). Some key informants even indicated that the cost of access had increased post pandemic.

Some final access issues to mention include fear of the virus which may prevent women and girls from wanting to collect water, a lack of handwashing facilities and sanitizer at the waterpoint, a lack of PPE, and limited time to collect water due to the imposed curfews. These issues were all reported by less than 2% of the respondents.

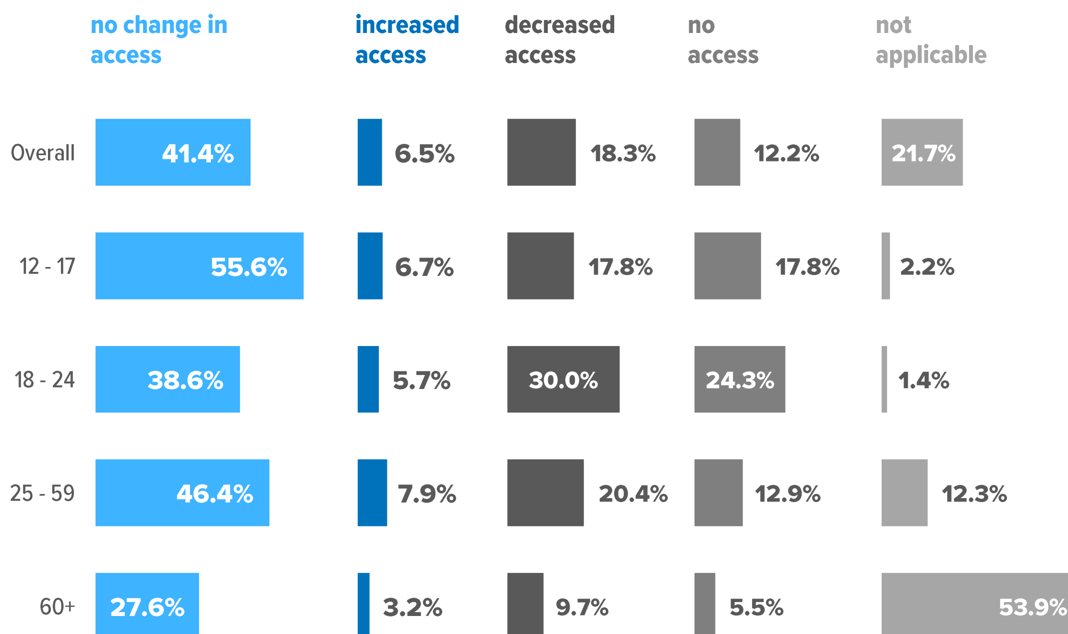
These barriers to access water correspond to the most recent UNHCR participatory assessment findings (UNHCR, 2019), conducted pre-COVID-19. However, the pandemic has made these issues more pertinent.

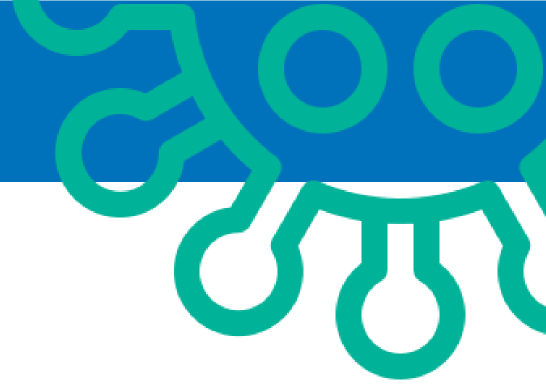
MENSTRUAL HYGIENE

With respect to access to menstrual hygiene products, 18.3% of women and girls reported a decrease in access, while a further 12.2% reported having no access at all. 41.4% indicated having no change in access while 6.5% signalled an increase in access. The decrease or lack of access to menstrual hygiene products was more often reported by women aged 18-24 while girls and women aged 25-59 most often reported no change in access. While the issue of decreased access was reported to some degree in all settlements, it

Women aged 18-24 more often reported a decrease in access or no access to menstrual hygiene products.

Figure 30: % of respondents indicating their menstrual hygiene needs by age group of respondent.





was reported by 54.9% of the women and girls in Imvepi settlement, which is significantly greater than the average of 18.3%. Furthermore, the settlements of Adjumani and Bidibidi overwhelmingly had a higher percentage of participants indicating no access to menstrual hygiene products (40.2% and 23.4% respectively). The products for which women and girls most often reported having a decreased in access to were sanitary pads (n=91), soap (n=29), and underwear (n=22).

The overall percentage of women and girls indicating an unmet need was 28.8%, while those stating to have their needs met represented 43.9% of the total. Not surprisingly, women aged 18-24 also more often indicated unmet menstrual hygiene needs, with 55.7% saying so, compared to 44.4% of girls, 31.2% of women aged 25-59, and only 10.2% of women aged 60 and over. Following the results seen above, these needs were the greatest in Adjumani, Bidibidi, as well as in Kampala (55.5%, 47.3%, and 41.6% respectively).

Protection & Security

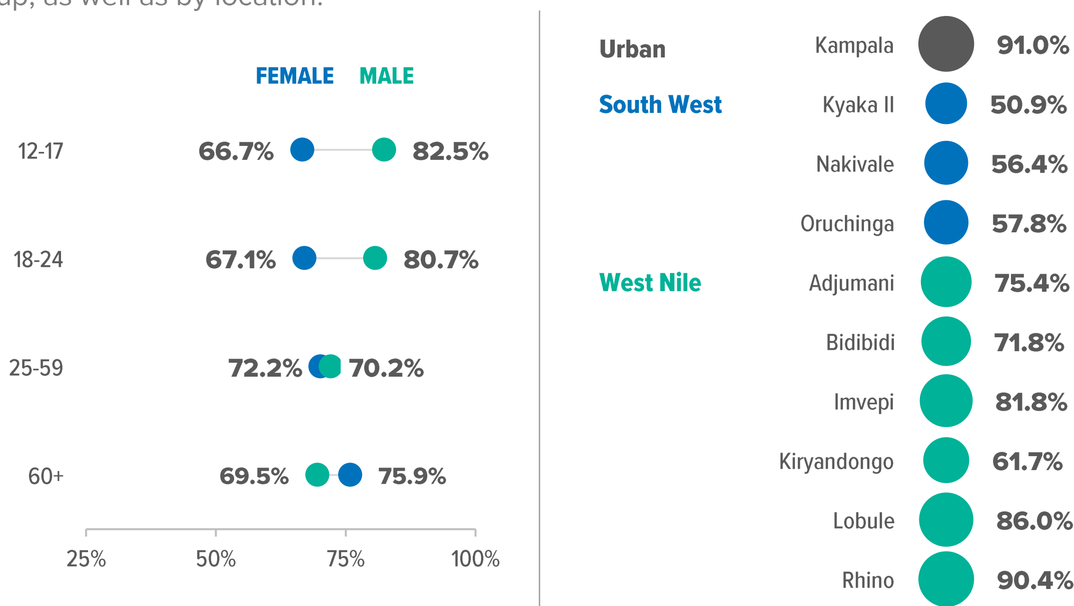
FEELING SAFE AT HOME

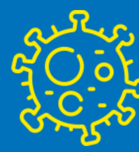
Respondents were asked whether they felt safe at home and 72.0% responded affirmatively. A higher percentage of boys, men aged 18-24, and male child HoH indicated feeling safe at home with respect to the average and compared to women and girls of the same age groups, with 82.5%, 80.7%, and 82.9%, respectively indicating so. Conversely, persons with a disability or with a serious medical condition less often reported feeling safe at home (57.8% and 61.4% respectively). No other significant differences could be found by sex or age group.

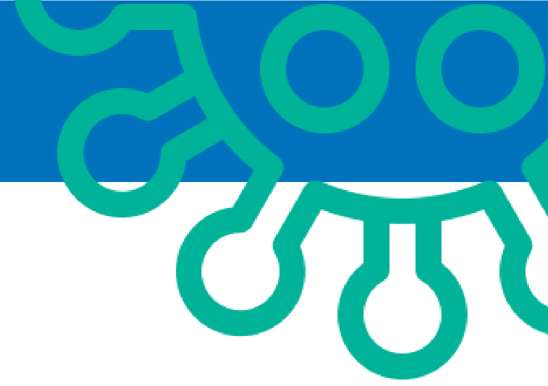
Additional differences, however, were apparent when examining the results by location. Respondents from Kampala, Rhino Camp, Lobule, and Imvepi more frequently reported feeling safe at home, with 91.0%, 90.4%, 86.0%, and 81.8% saying so respectively. Conversely, respondents from Kyaka II, Nakivale, and Oruchinga (all of the settlements in the South West included in this study) much less commonly reported feeling safe at home (50.9%, 56.4%, and 57.8%, respectively). Respondents from Kiryandongo also less often indicated feeling safe at home (60.7%).

Boys and men 18-24 most often reported feeling safe at home, as well as respondents from Kampala, Rhino Camp, Lobule, and Imvepi.

Figure 31: % of respondents who reported feeling safe at home by respondent sex and age group, as well as by location.







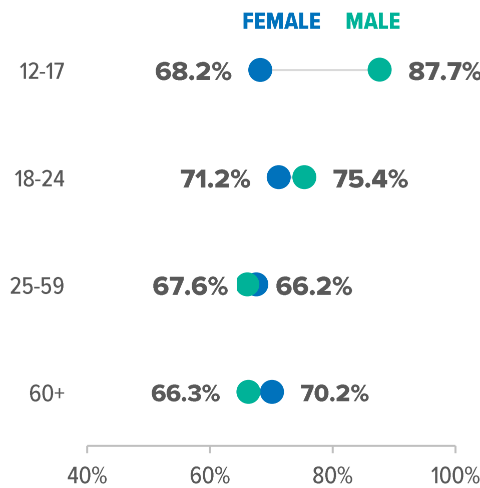
Of the respondents who indicated not feeling safe at home, the reasons they most commonly provided included having a disability or vulnerability (23.9%), having no resources (22.2%), being unable to communicate (21.8%), having a serious medical condition (15.8%), being exposed to physical violence (10.1%) or verbal violence (9.2%), and being exposed to substance abuse (9.9%). Though sample sizes were too small to draw many conclusions, it is clear that PoC aged 60+ most commonly cite having a disability or vulnerability as to why they do not feel safe.

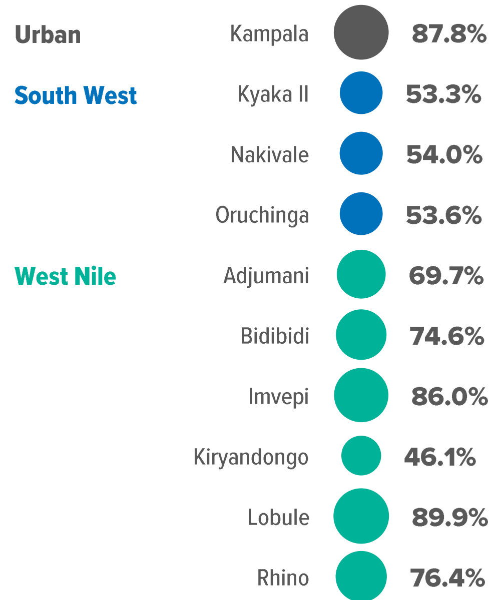
FEELING SAFE IN THE COMMUNITY

With respect to feeling safe in the community, almost the same percentage responded affirmatively as when asked about feeling safe in their homes, with 68.7% reporting so. Again, it is apparent that boys and men aged 18-24, and male child HoH feel safer in the community when compared to other groups (87.7%, 75,4%, and 87.8%, respectively). Also similar to what was found above was that more respondents from Kampala, Lobule, and Imvepi reported feeling safer in the community with 87.8%, 89.9%, and 86.0% saying so respectively. Furthermore, respondents from Kyaka II, Nakivale, Oruchinga, and Kiryandongo less often signalled feeling safe in the community (53.3%, 54.0%, 53.6%, and 46.1%), mirroring sentiments about the home. When comparing the percentage of respondents feeling safe at home versus in the

The same groups who indicated feeling safe at home also reported feeling safe in the community, notably boys and men aged 18-24.

Figure 32: % of respondents who reported feeling safe in the community by respondent sex and age group, as well as by location.





community, more people in Kiryandongo and Rhino Camp feel safer at home than in the community. Specifically, in Kiryandongo, 61.7% reported feeling safe at home versus only 46.1% indicating feeling safe in the community. Likewise in Rhino Camp, while 90.4% felt safe at home, only 76.4% signalled feeling safe in the community. In the same way, less PLWD feel safe in the community compared to the home, with only 48.1% saying so compared to 57.8% who indicated feeling safe at home (though in both cases the percentage reporting feeling safe is significantly lower than the overall average).

The most common reasons participants contributed for not feeling safe in the community included being in an unsafe area (30.3%), having an insecure shelter (27.5%) or lack of lighting (22.2%), being elderly (17.7%), having a disability (15.5%), or a serious medical condition (11.2%), and having no access to basic services (14.3%).

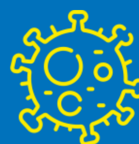
INFORMATION ABOUT SEA AND OTHER FORMS OF SGBV

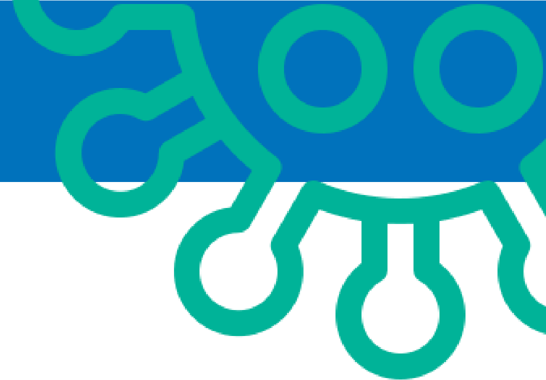
Only 10.6% of respondents reported having received information about SEA and other forms of SGBV[9]. This percentage was even lower among girls and female child HoH where only 2.2% and 0% report having received this type of information. A small percentage of respondents across most locations reported having received information about SGBV, however the percentage was much higher in Oruchinga where 60.7% of respondents responded affirmatively. Interestingly, persons with a serious medical condition also more often reported receiving information (21.1%) when compared to the overall average.

Of the 10.6% of respondents (n=162) who confirmed having received information about SGBV, the most commonly reported source of information were humanitarian actors, with 57.6% reporting so. Less often reported sources included community structures (29.4%), friends or neighbours (24.9%), health workers (19.2%), media (13.0%), government (10.2%), and the internet or social media (4.0%). Of the two groups of respondents who more often indicated having received information, respondents from Oruchinga and persons with serious medical conditions, more than 85% reported receiving their information from humanitarian actors.

SGBV INCIDENTS

Respondents were also asked if they were aware of any members in the community being exposed to SGBV since the onset of the pandemic, with 29.2% responding affirmatively. As can be seen in Figure 33, what is most impactful is how this response varies by age, with girls much more frequently reporting knowledge of an incident compared to women, and particularly women aged 60+ who had little knowledge of an event (40.0% of girls reported knowledge of an incident of SGBV compared to only 16.7% by women aged 60+). The reverse trend could be observed among men with the percentage indicating knowledge of an incident increasing with age, again with the exception of men 60+ who had a lower percentage reporting affirmatively. In the same manner, when examining this question by CoP, what is





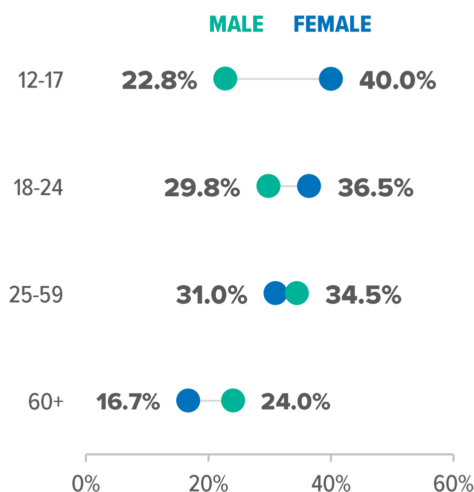
revealed is that female child HoH far more frequently report knowledge of an incident of SGBV (42.9%), while male child HoH and older persons less often reporting so (19.5% for both).

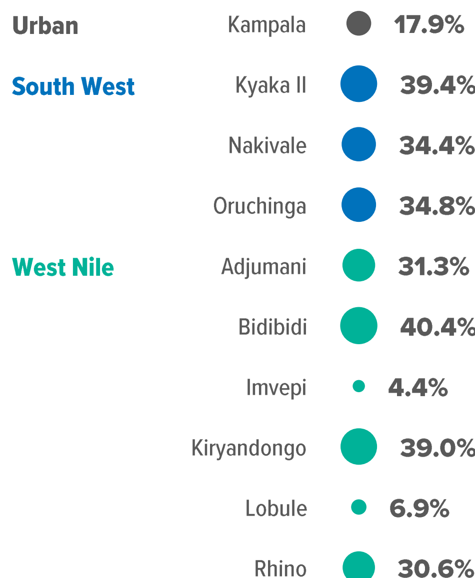
When examining knowledge of an incident by location, patterns seen above relating to feeling safe at home and in the community continue here. Specifically, persons in Kampala, Imvepi, and Lobule less frequently report knowledge of an incident of SGBV compared to the average (where a higher percentage indicated feelings of safety in both the home and the community), with 17.9%, 4.4%, and 6.9% reporting so. Also following previous trends, respondents from Kiryandongo more frequently reported knowledge of an incident (39.0%). The unique deviation from previous trends is that the respondents from Bidibidi also more frequently indicated knowledge of an SGBV incident (40.0%), despite having an average percentage of persons reporting feeling safe at home and in the community.

The most common type of SGBV reported by respondents was physical violence with 19.1%. Physical violence, however, was less often reported from Kampala (10.3%), Imvepi (2.2%), and Lobule (4.9%). On the opposite end, incidents of physical violence were more commonly reported from Kyaka II (26.7%), Bidibidi (25.8%), and Kiryandongo (27.9%). Less frequently reported were incidents of

Girls were much more likely to report knowledge of an event of SGBV when compared to other groups.

Figure 33: % of respondents who reported knowledge of an event of SGBV by respondent sex and age group, as well as by location.

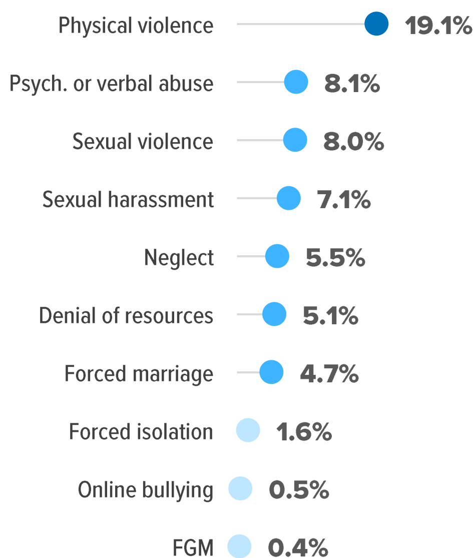




psychological or verbal abuse (8.1%), sexual violence (7.1%), sexual harassment (7.1%), neglect (5.5%), or denial of resources (5.1%). Nevertheless, some locations had higher rates of response for certain types of SGBV. Sexual violence was more commonly mentioned by respondents in Kyaka II (17.0%) and Bidibidi (16.2%), sexual harassment from Rhino Camp (18.5%), denial of resources from Kyaka II (17.0%), and psychological or verbal abuse and neglect more common from Kiryandongo.

Physical violence was the main type of SGBV to which respondents had knowledge of occurring within the community.

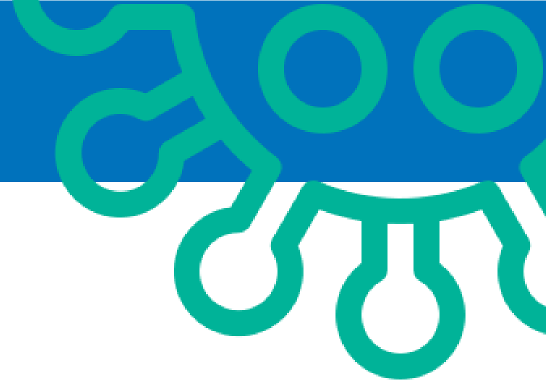
Figure 34: % of respondents who reported knowledge of a type of SGBV occurring within the community by respondent sex and age group, as well as by location.



Of the persons who reported knowledge of a GBV incident, almost half reported that the perpetrator was a neighbour or member of the community (49.5%), followed by a family member (36.7%) or a friend (26.6%). Much less frequently cited were a structure representative (5.7%), a member of the police force (4.4%), an aid worker (2.8%), a health worker (1.8%), a religious leader (1.6%), or a government worker (0.7%). Due to the small sample sizes, comparisons were difficult, however a couple of trends can be noted. Women and girls more often reported the perpetrator to be a family member compared to men and boys (40.4% versus 32.3%). It also appears that the respondents from settlements in West Nile more commonly reported the perpetrator to be a family member or a friend compared to in the settlements of the South West.

With respect to whether the incident was reported, 65.3% respondent affirmatively with no differences apparent by respondent sex or age group. This percentage, however, was much lower in Kampala and Kiryandongo with only 14.3% and 49.2% respectively reporting so. Adjumani, on the other hand, had a higher percentage of respondents confirming that the incident had been reported (84.7%).

To provide more perspective on how the pandemic has impacted upon incidences of SGBV, health workers and SGBV structures were inquired to opine on whether they have detected an increase in the occurrence of SGBV since the onset of the pandemic, with 93.8% responding affirmatively. As detailed in the section on livelihoods and mental



health, these actors linked the rising rates of SGBV to the loss of (male) livelihoods (74%), the lockdown (32%), and negative coping through alcohol and drug abuse (30%). These actors explained how lost male employment and an inability to provide for the household led to feelings of anger and frustration, an increased reliance on alcohol and drugs, and ultimately to misunderstandings and violence within the family unit. As one respondent succinctly described: “Men are distressed due to unemployment and tend to transfer their anger to wives and children and food shortage has exacerbated this situation” (man, aged 30, Kampala). Decreased household income and food shortages in particular were seen to fuel misunderstandings within the family (11%), as were conditions of overcrowding in the home due to the imposition of the lockdown (11%).

SGBV SUPPORT

The same health workers and SGBV structures were asked whether the capacity of service providers to respond to cases of SGBV in the community had changed, with almost half (48.7%) indicating no change, while 19.7% indicated decreased capacity to respond, and 31.6% an increase in capacity. Decreased capacity was explained by a reduction in the resources provided for SGBV response in the community, movement restrictions and reduced community outreach, and a refocus on COVID-19 response.

Increased capacity, on the other hand, was mainly seen to be the result of sensitization efforts of the community conducted through radio talk shows, community dialogues, and outreach to community leaders, including highlighting the importance of reporting cases to the relevant focal points (community leaders, SGBV actors, and the police). Respondents also mentioned that capacity building of health workers had occurred, some increases in police patrolling, and a general engagement of communities to address the issue.

CHALLENGES ACCESSING SGBV SUPPORT

The challenges to accessing SGBV support listed by the key informants were numerous, mostly predating COVID-19, and mirror those detailed in the most recent UNHCR participatory assessment (UNHCR, 2019).

Cultural myths are a serious barrier, such as accepting marriage at any age, or that beating a woman is normal. That prevents many from reporting.

-Male, aged 56, Lobule

From the demand-side, the most frequently mentioned access issue was fear and stigma felt by the survivor preventing them from reporting. This fear could be from their husbands finding out about the incident, reprisals from the perpetrator, fear of stigmatization from their family and the community at large, or fear of the actual process and of the police. Key informants also reported that survivors are often not aware about what SGBV is, what their rights are, what the importance of

Women and girls fear reporting to the police because of corruption, stigmatization by the community, as well as threats from perpetrators and their families. Poverty makes families compromise and hide cases like child rape, favouring child marriage instead to avoid shame and social discrimination.

-Female, aged 40, Kyaka II

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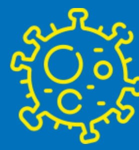
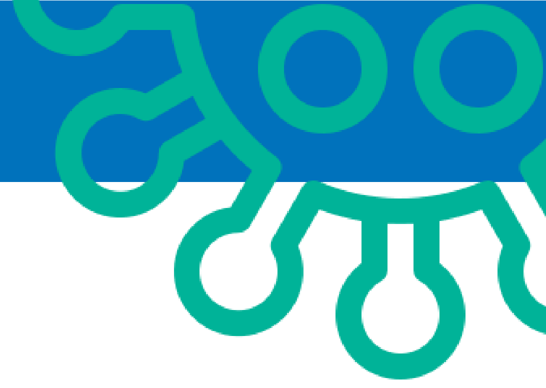
reporting an incident is, or how to go about doing so. They further suggested that cultural attitudes and gender stereotypes have normalized SGBV and silenced women and girls in the process, which has been reinforced by families and communities. Limited access to means of communication was another common barrier mentioned by respondents, confirmed by the higher percentage of girls and young women with no access to a mobile phone, as seen in the information section above.

Many supply-side factors contributed to limiting women and girls' access to essential SGBV services as well. Respondents most commonly raised the issue of physical access as a result of transportation and distance to facilities. They also, however, highlighted that women and girls are not properly supported through the entire reporting process which was described as lengthy and arduous. This included a lack of safe space at the police station to report, inadequate support from the police throughout the reporting process, delays in case follow-up which was seen to compromise evidence, and a lack of safe shelters for women and girls who were not safe to return to their homes. In addition, key informants also mentioned instances of services having been scaled down or closed and not having sufficient resources to handle the SGBV cases, including the police. In a few instances, key informants raised the issue of corruption as being an obstacle to reporting, whereby the survivor is asked for money to be attended to, whether at the hospital or the police station, or conversely, that the perpetrator can bribe the police to ignore the case.

SECURITY CONCERNS

Key informants were finally asked about the most common security concerns to which they thought women and girls, and men and boys were exposed. With respect to women and girls, SGBV and domestic violence were by far the most commonly mentioned risks mentioned by key informants, mirroring precisely what had been seen in the survey data. Their responses all further confirmed the link between school dropout and the risk of

teenage pregnancy and child/forced marriage. One additional security risk mentioned by key informants was heightened exposure to theft, due to the widespread impact to livelihoods within the community which may push people towards crime and delinquency.

With respect to the security risks against men and boys, key informants equally talked about men and boys as both victims and aggressors. For instance, key informants equally mentioned men and boys as victims and aggressors of the two most commonly mentioned security risks – theft and physical violence. Police violence followed in frequency of mention, specifically related to the breaking of curfew. Risk of arrest was next and most often attributed to the aforementioned incidences of delinquency and theft.

With respect to boys, key informants again highlighted the number of risks associated with the school closures, including an increase in “idleness” or delinquency, increased alcohol or drug abuse, teenage pregnancies, child marriages, and child labour.

Men and boys engage more often in violence, stealing, and theft, though they also get robbed and beaten as well.

-Male, aged 54, Imvepi

Assistance

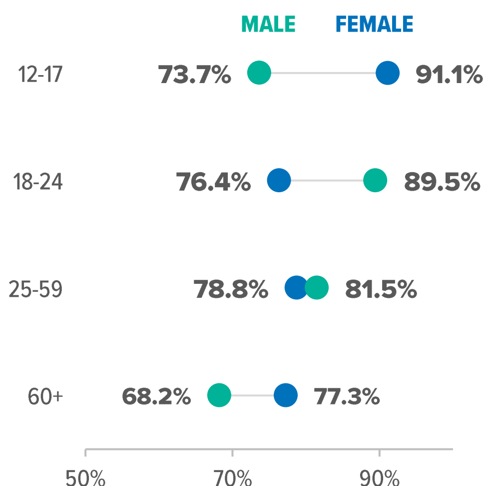
RECEIVED AND BENEFITTED FROM ASSISTANCE

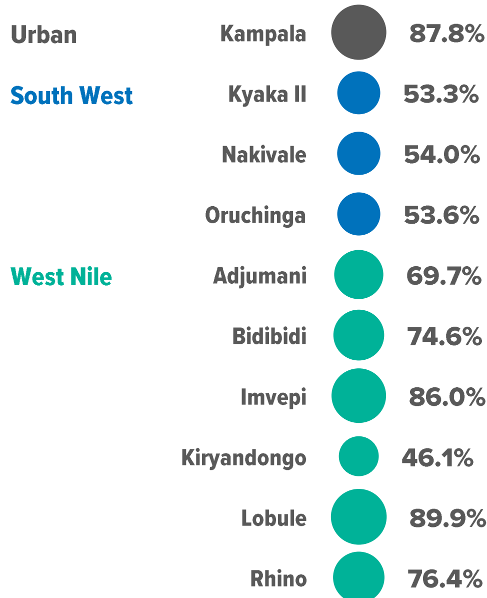
With respect to whether respondents had received additional assistance since the onset of COVID-19, 78.5% indicated that they had not received any since the onset of the pandemic. Not having received additional assistance was most often reported by girls (91.1%), and men aged 18-24 (89.5%). This percentage while high across all settlements, appeared to vary somewhat as can be seen in Figure 35.

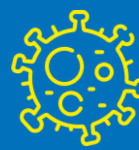
Of the 21.5% who signalled having received assistance since onset of the pandemic, 92.2% indicated that they had benefitted from the assistance. This was an important follow-up to ask given that data from the interagency Feedback, Response, and Resolution Mechanisms indicates that children and youth at times do not receive the assistance distributed to the head of household. Similar to what was seen regarding receiving assistance, there was some evidence that girls and men aged 18-24 also do not benefit from received assistance when compared to others as only 66.7% of girls and 66.7% of men aged 18-24 responded affirmatively to this question. Bidibidi also has a lower percentage of respondents confirming that they had benefitted from assistance (29.2%). These

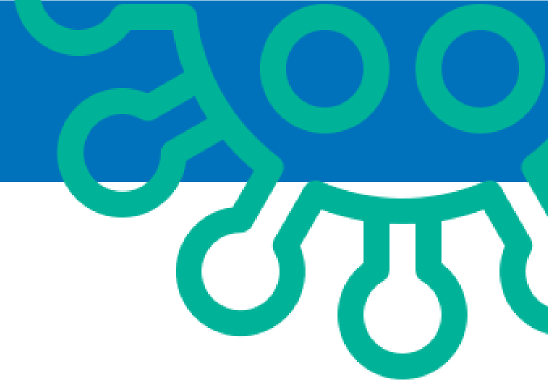
Girls and men aged 18-24 most often reported not having received any assistance after onset of the pandemic. This percentage also varied widely by location.

Figure 35: % or respondents who reported not having received assistance after onset of the pandemic by sex, age group, and location of respondent.









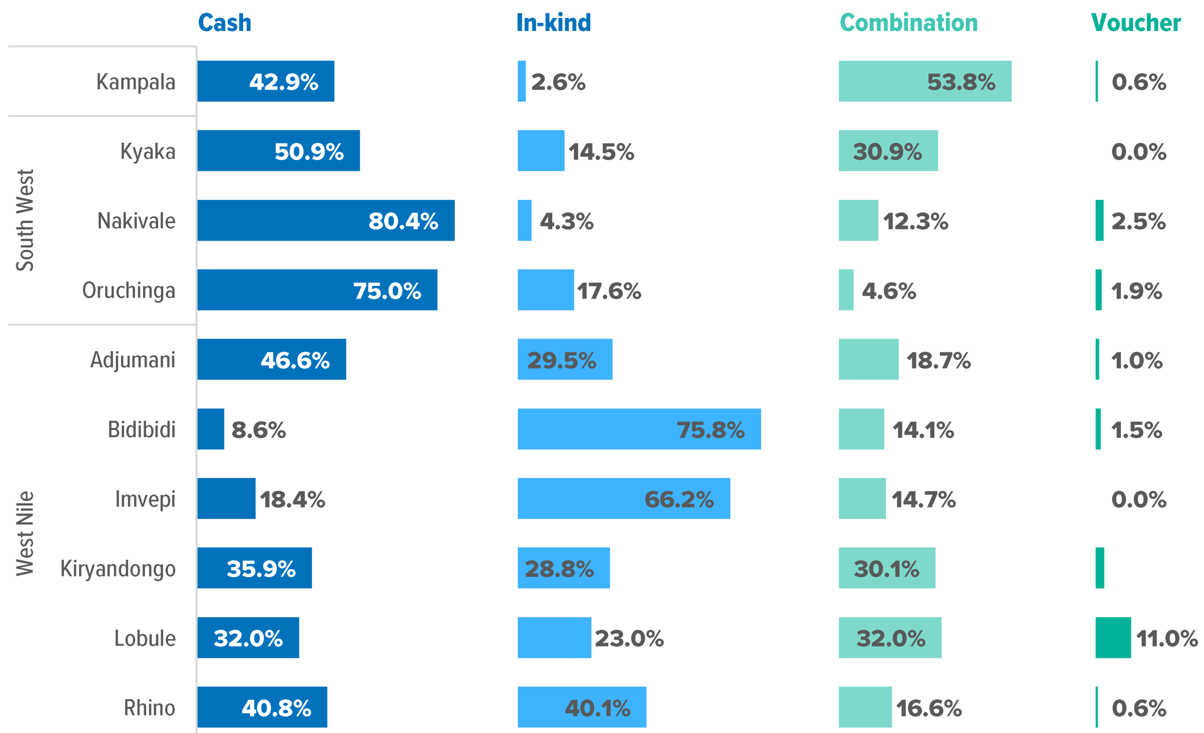
findings, however, cannot be confirmed statistically due to low sample sizes.

ASSISTANCE TYPE PREFERENCE

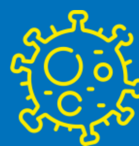
Respondents were also asked for their preference for assistance generally, without specifying the type of assistance, whether for cash, in-kind, a combination of cash and in-kind, or vouchers. Overall, 42.2% preferred cash, 31.5% preferred in-kind, 22.8% indicated wanting a combination, 1.8% wanted vouchers, and 1.7% desired another form of assistance. When examining these results by sex and age group, it does not appear that any group had a strong preference, however, a few differences can be noted. A lower percentage of boys and men aged 18-24 indicated a preference for cash when compared to the average, with only 23.2% and 26.3% respectively indicating so. These two groups, conversely, more often appeared to prefer combination assistance, with 37.5% of boys and 31.6% of men aged 18-24 reporting a preference for this type of assistance. Finally, while approximately one third of each group signalled a preference for in-kind assistance, the percentage was higher among girls (42.2%).

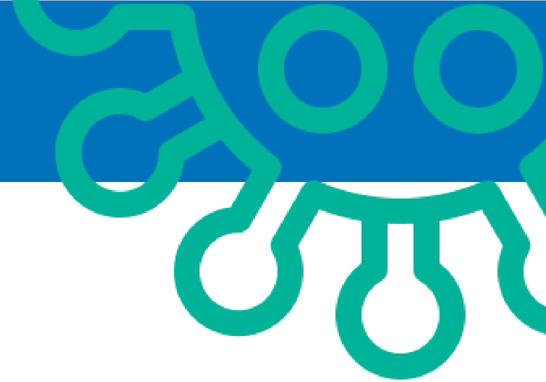
Assistance preference appeared to depend on location. For instance, while cash was preferred by 42.2% or respondents overall, and by 80.4% of respondents in Nakivale, it was only preferred by 8.6% of respondents in Bidibidi.

Figure 36: % of respondents indicating their assistance preference by respondent location.



Location may also very well play a role in the types of assistance that are preferred as shown in Figure 36. For example, when analysing the percentage of respondents who prefer vouchers, one would find no clear pattern by respondent sex or age group with 0 to 3% indicating this preference. However, when considering location, 11.0% of respondents in Lobule have a preference for vouchers. Respondents in Nakivale and Oruchinga, conversely, strongly prefer cash, whereas few respondents from Bidibidi and Imvepi feel the same way, much solidly preferring to receive in-kind assistance. Finally, preference for combination assistance is much more prominent in Kampala.



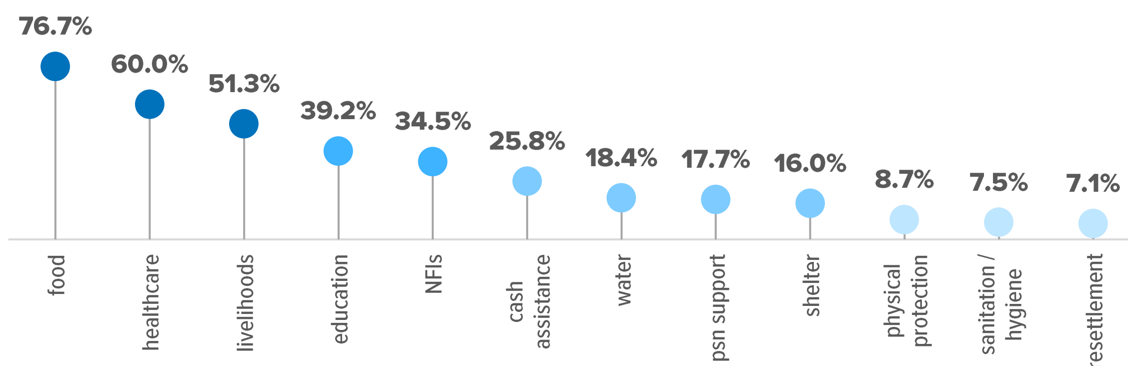


PRIORITY NEEDS

Twelve broad needs were mentioned by at least 100 respondents. They are food (76.67%), healthcare (60.0%), livelihoods (51.3%), education (39.2%), NFIs (34.5%), cash assistance (25.8%), water (18.4%), PSN support (17.7%), shelter (16.0%), physical protection (8.7%), sanitation/hygiene (7.5%), and resettlement (7.1%). The trends of each of these needs are examined below to outline the unique differences apparent by sex, age group, and location. They have been listed from most to least frequently mentioned. Figure 38 also shows the overall rank of needs and the rank of needs by sex and age group to highlight some of the most significant differences.

Food was by far the top priority need, mentioned by three quarters of the respondents.

Figure 37: % of respondents indicating a priority need.

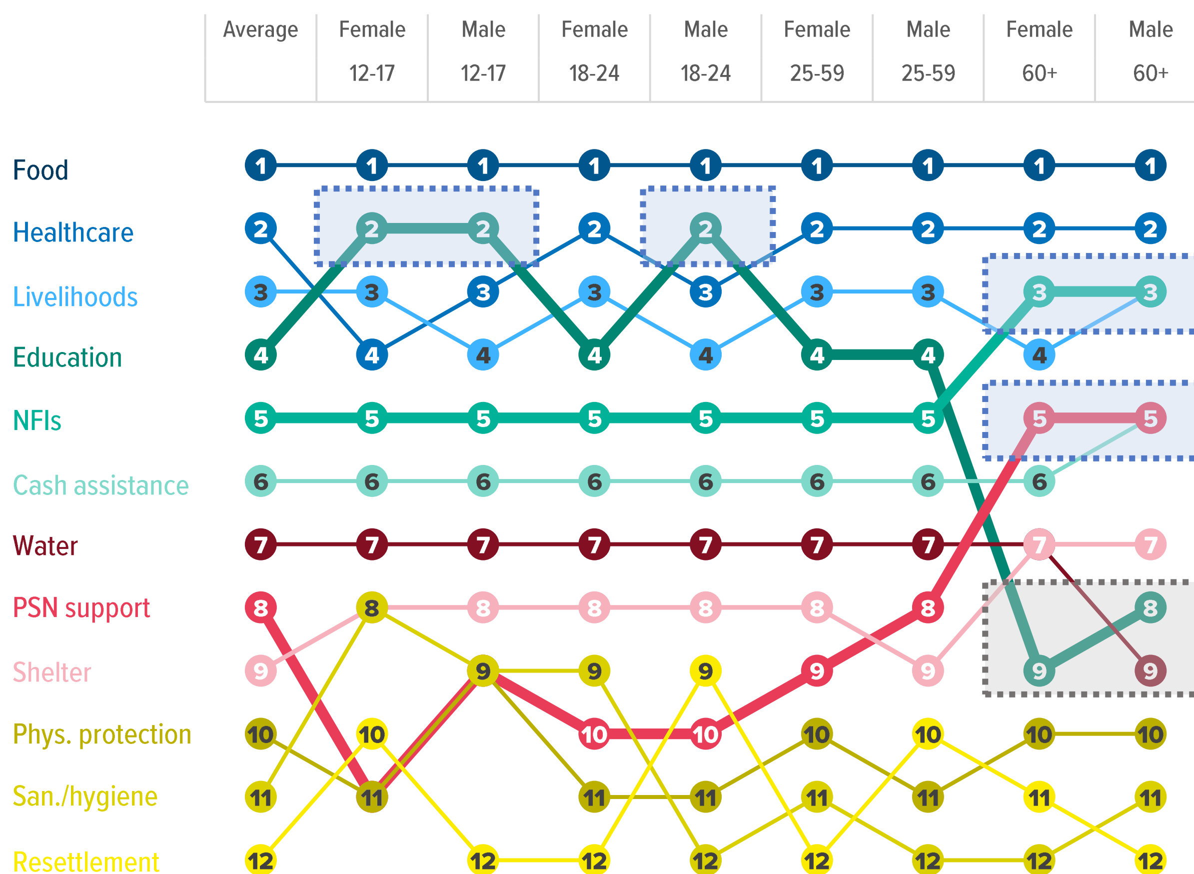


Food: Food was the most frequently identified need by 76.7% of respondents. This was equally true for women, men, girls and boys and across age groups, with the exception of girls where a lower percentage indicated this need (66.7%). The respondents in two locations more frequently mentioned food: Kampala (91.0%) and Adjumani (88.7%). The high percentage of respondents in Kampala signalling food is significant given that they are normally not eligible for this type of assistance.

Healthcare: Healthcare was the second most frequently identified need by 60.0% of the respondents. Healthcare was less frequently identified by girls (44.4%), boys (52.6%), and men aged 18-24 (50.9%), as well as by youth (46.9%) and female child HoH (45.7%). Not surprisingly, the one location where this need was mentioned by more respondents was in Kampala (73.1%), while being less often

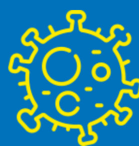
In comparison to the overall prioritization of needs by the entire set of respondents, education was much more important among children and men aged 18-24. With respect to women and men 60+, NFIs and PSN support was more highly valued. Not surprisingly, among this same group, education was not a priority.

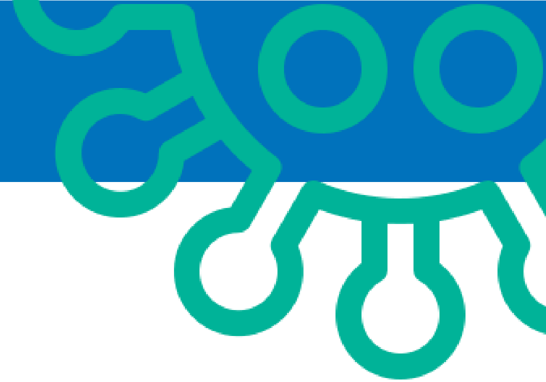
Figure 38: Overall rank of priority needs, and rank of priority needs by respondent sex and age group.



mentioned in Kyaka II (34.5%) and Oruchinga (49.1%).

Livelihoods: Livelihoods support was desired by just over half of the respondents (51.3%). The only groups which less often signalled livelihoods support were women and men aged 60 and over. Male child HoH (34.1%) and persons with serious medical conditions (33.3%) also less often asked for livelihoods. Livelihoods support was more often asked for





in Kampala (71.2%) and Kyaka II (61.2%), and less often mentioned in Bidibidi (32.8%) and Lobule (34.3%).

Education: Education was mentioned by 39.2% of respondents. Not surprisingly, the proportion of respondents mentioning education was inversely related to age, it was mentioned significantly more often by girls (55.6%) and boys (68.4%) and much less often by those aged 60 and over (18.6% by women and 23.4% by men). Likewise, education was more frequently mentioned by female child HoH (65.7%), male child HoH (65.9%), and youth (61.1%). Education was also more frequently mentioned by respondents from Adjumani (68.2%) and Kiryandongo (55.2%), and less frequently by respondents from Kampala (24.4%), Kyaka II (24.8%), Nakivale (30.7%), and Imvepi (29.9%).

NFIs: NFIs were mentioned by just over one third of the respondents (34.5%). NFIs were mentioned more by women aged 60+ (47.5%), female child HoH (54.3%), and in Bidibidi (55.1%) and Lobule (66.7%). NFIs were less frequently mentioned by respondents from Kampala (5.8%) and Nakivale (11.7%).

Cash assistance: Cash assistance was mentioned by 25.8% of the respondents with no difference by sex or age group. Cash assistance was more frequently mentioned by respondents from Kyaka II (42.4%), Bidibidi (41.9%), and Imvepi (40.9%), while being mentioned less frequently by respondents from Kampala (2.6%), Oruchinga (12.5%), and Kiryandongo (9.1%).

Water: Water was mentioned by 18.4% of the respondents with no difference by sex or age group. The issue of water was raised much more frequently by respondents in Imvepi (40.1%), Rhino Camp (36.9%), and Nakivale (29.4%), while being mentioned less frequently by respondents in Kampala (7.1%), Kyaka II (4.8%), Adjumani (8.7%), and Lobule (2.0%).

PSN support: PSN support was indicated as a need by 17.7% of respondents. Not surprisingly, PSN support was infrequently mentioned by girls (2.2%) and boys (5.3%), while being a more frequent concern for women (34.8%) and men (28.6%) aged 60 and over, and for PLWD (36.5%). PSN support was also more often mentioned in Kyaka II (32.7%), Nakivale (35.0%), and Lobule (32.4%), and less often mentioned in Kampala (5.1%), Oruchinga (6.3%), and Adjumani (5.1%).

Shelter: Shelter support was mentioned by 16.0% of respondents with no difference by sex or age group. Shelter, however, was much more frequently highlighted by respondents from Kyaka II (30.9%), and less frequently in Kampala (5.1%).

Physical protection: Physical protection was mentioned as a priority issue by 8.7% of the respondents with no apparent difference by sex and age group. The respondents of one settlement in particular more frequently mentioned physical protection – Nakivale (25.8%).

Sanitation/hygiene: Sanitation and hygiene was mentioned by 7.5% of the respondents with no difference apparent by sex or age group. Respondents from Bidibidi, however,

did make more mention of sanitation and hygiene compared to other locations (16.7%).

Resettlement: Resettlement was mentioned as a priority need by 7.1% of the respondents with no apparent difference by sex or age group. Respondents from Nakivale, however, did more frequently mention resettlement (29.4%).

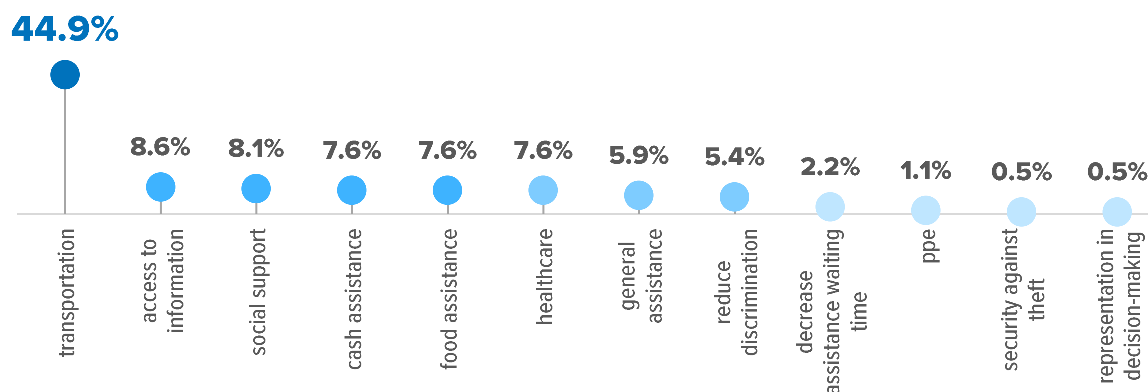
ASSISTANCE RECOMMENDATIONS FOR PLWD AND OLDER PERSONS

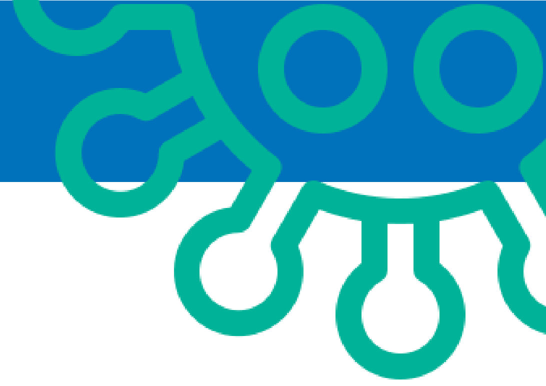
Key informants were also asked to outline some priority recommendations for PLWD and older persons specifically. By far the most frequent recommendation was to provide appropriate transportation for PLWD and older persons, mentioned by 44.9% of key informants, including those with limited mobility who rely on the use of wheelchairs or other assisted devices. Transportation was frequently linked to a PoC's ability to access food assistance and health care, to carry out daily tasks, and even to reduce social isolation.

Increasing access to information was the second most frequently mentioned assistance recommendation (8.6%) due to the belief that PLWD and older persons have less access to information or that the forms in which information is transmitted are not accessible to them. For instance, the frequent use of radios to disseminate important news would not be accessible to PLWD who are hard of hearing. Along with access to information, social support, cash assistance, food assistance, and healthcare all received the same number of mentions. Receiving far fewer mentions, but important to mention were recommendations to reduce the discrimination of PLWD and older persons when seeking assistance, decreasing the waiting time for assistance, providing PPE, increase their security against theft, and promoting their representation in decision-making.

According to key informants, increasing access to appropriate transportation was the priority need for PLWD and older persons.

Figure 39: % of key informants indicating a priority need for PLWD and older persons.





Discussion

Household Economic Activities & Livelihoods

58% of all survey respondents reported a negative change to their income and this percentage increased to 69.6% among those who earned their incomes from paid work. While the reports of negative change among men were higher than women (for instance in the 25-59 age group 79.8% of men report a negative change compared to 69.0% of women 25-59), it is clear that both groups have been impacted significantly. In addition, the findings show that women have been less able to continue to save through VSLAS when compared to men (43.7% of women compared to 53.5% of men).

Unpaid care burden appears to have fallen disproportionately to girls, women aged 18-24, and female child HoH when compared to other groups. This was further underlined by the two main activities upon which men and boys reported spending their time – farming (30.0%) and leisure (19.1%) – which are not unpaid care work. Women and girls reported spending additional time on cooking (43.4%), housework (38.3%), collecting fuel (23.5%), and collecting water (22.5%), the latter two of which expose them to greater risks of SGBV.

The most common negative coping mechanisms reported by survey respondents were buying food on credit (53.1%), spending savings (36.9%), and reducing essential non-food expenditures (26.3%), and were found to depend greatly on location. Key informants further highlighted that men and boys engaged in theft (8%), while women and girls engaged in survival sex work (10%). Child marriage (18%) was also frequently raised relating to girls. Key informants' descriptions also highlighted the gendered nature of the negative coping mechanisms, as well as the sheer number of strategies employed by women and girls. From their replies, it appeared that theft, selling drugs, and borrowing money were most often employed by men and boys, while women and girls engaged in survival sex work, burning charcoal, brewing alcohol, selling food rations, reducing the number of meals, and selling off personal items.

Though women and girls may not have suffered more economic losses than men and boys, it is clear that women and girls bear the brunt of the impact of the loss of livelihoods. On the one hand, key informants explained how men suffered from stress and a lack of confidence due to the loss of their livelihoods

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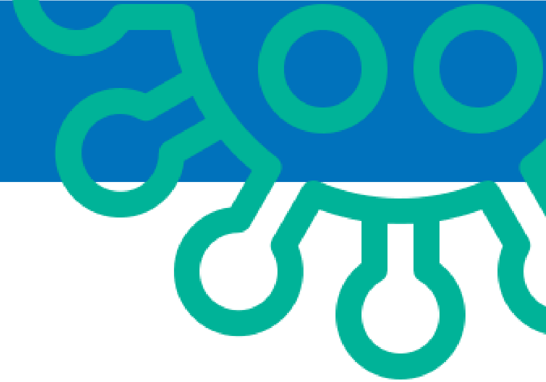
and inability to provide for their families (23%), increasing "idleness" (16%), alcohol and drug abuse (14%), and engaging in criminality (8%). Deteriorating mental health, substance abuse, social isolation, lack of food, and crowding in the home together were seen to increase the likelihoods of domestic violence (10%). And on the other hand, the impacts on women and girls were numerous: increased incidents of SGBV (23%) and domestic violence (17%), a greater burden of the unpaid care work (7%), and a simultaneous inability to meet the basic needs of the household - including food (15%), menstrual hygiene products (9%), and family planning essentials (5%) – as well as the risk of having their few resources confiscated by their partners (5%).

Access to Information

Women and girls less frequently reported access to a mobile phone when compared to men and boys, particularly in the 18-24 and 25-59 age groups. Women and girls were also less frequently able to access the internet through the phone with 11.4% claiming to be able to do so compared to 19.1% of men and boys. In general, mobile phone use and internet access were very dependent on location, with no issues in Kampala, and greater issues in the settlements of the South West.

The most regularly cited information access issues were a lack of equipment (37.7%) and an inability to read (32.2%). Given the challenges of girls and women aged 18-24 in accessing a mobile phone, it is not surprising that lack of equipment was their greatest cited barrier. What is more surprising is the higher percentage of girls compared to boys who cited an inability to read with 31.1% of girls citing this issue compared to only 15.8% of boys. These findings confirm the presence of a mobile gender gap, both in terms of mobile phone ownership and access to internet. This has many implications, from the level of access to information and services to women and men's sense of security.

The findings also underline the importance of considering who the audience will be when considering which medium to use to



disseminate information. For instance, girls show a strong preference to receive information from friends/neighbours or NGOs, while every other group prefer to receive their information from community leaders.

Location also appears to play an important factor in the mediums preferred by its respondents, as well as the access issues encountered. For instance, radios were mentioned far more frequently in the West Nile (40.4%), compared to the South West (21.4%), and Kampala (2.6%). Mobile phones, on the other hand, were only mentioned frequently in Kampala (29.5%) and Rhino Camp (29.9%) when compared to the average (13.0%). Furthermore, when considering potential access issues, while electricity as a barrier to information was only mentioned by 15.1% of respondents, that percentage rose to 44.8% in Kiryandongo. Nevertheless, community leaders (60.8%), friends/neighbours (41.1%), and NGOs (39.8%), were the three most frequently mentioned mediums that incidentally circumvent the most frequently mentioned access issues.

Healthcare

74.2% of respondents indicated needing to access healthcare after the onset of the pandemic, and most frequently women aged 18-24 (84.9%). 90.9% of those respondents who indicated needing access to healthcare did not report facing any issues to doing so. The majority of the key informants, however, believed that access to healthcare had been reduced, and specifically to maternal, newborn and child health (20.2%), and to HIV chronic services (13.3%). Some of the most frequent barriers they mentioned were a lack of adequate transportation for pregnant women, as well as a decrease in community outreach for women and girls which had been an important point of care for family planning and menstrual hygiene, in addition to many other supply and demand-side barriers. One serious consequence raised by key informants resulting from the assembly of barriers facing women and girls to healthcare was the possibility that they may seek traditional treatments for abortion and home births, exposing them to even greater health risks.

Education

The results indicate that close to 40% of boys and girls either have no materials to study or have stopped learning. Two settlements have a particularly high percentage of respondents indicating that children have no materials, Kyaka II and Nakivale, with 38.2% and 46.7% reporting so respectively, while Kampala has an especially high percentage of respondents indicating that children have stopped learning (42.9%). Challenges highlighted by respondents were the same for boys and girls, with the two most important being a lack of skilled instruction and an inability for parents to help, both signalled by close to half of the participants. It is clear that even having access to learning materials is not sufficient for learning to occur. Respondents did indicate one barrier more frequently for girls when compared to boys – household chores (27.4% for girls and 13.3% for boys). This tracks with

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the finding that unpaid care work has mostly fallen to girls to carry out.

Departing from the survey results, key informants further outline some of the most significant challenges to girls and boys education. With respect to girls, key informants made a clear link between the closure of schools and an increase in teenage pregnancy (21%) and child marriage (18%), two conditions which have been shown in Uganda and elsewhere to lead to higher dropout rates. With respect to boys, school closures were seen to increase "idleness" which consisted of alcohol and drug abuse (14%), involvement in theft and other crime (8%), and an increase in committing SGBV.

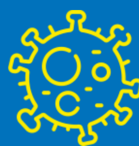
While no return to school for school-aged children was only signalled by 3.9% of the respondents, that percentage was curiously higher among boys with 10.0% indicating that school-aged children would not be returning to school. It may be interesting to see whether boys are less inclined to return to school. In addition, the percentage of respondents indicating no return to school was much higher in Kampala, with 19.5% indicating so.

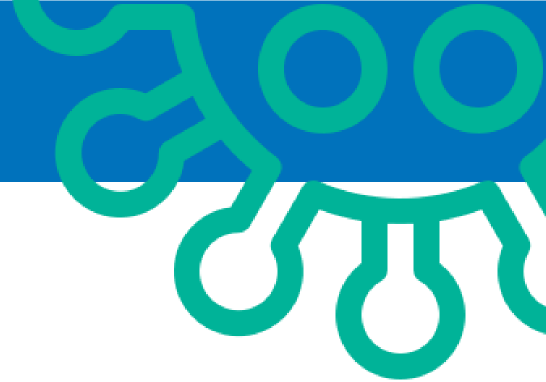
Menstrual Hygiene

Many women and girls have unmet menstrual hygiene needs, which was reported by 44.4% of girls, 55.7% of women aged 18-24, 31.2% of women aged 25-59, and by 10.2% of women above 60. These needs were the greatest in Adjumani, Bidibidi, as well as in Kampala, (55.5%, 47.3%, and 41.6% respectively). The products to which women and girls most often reported a decrease in access were sanitary pads, soap, and underwear.

Protection & Security

While the majority of participants, including women and girls, indicated feeling safe at home and in the community, a couple of key pieces of data point to the increasing rise of SGBV and domestic violence, some of which has already been discussed above.





First, when asked about the impact of the loss of livelihoods on women and girls, and when asked about the protection risks faced by the same group, key informants answers were always the same: SGBV, domestic violence, teenage pregnancy, and child/forced marriage, with the latter two closely linked to school closures. Second, girls and female child HoH curiously were the groups most likely to report knowledge of an incident of SGBV in the community. Whereas on average 29.2% affirm knowledge of an incident, that percentage rose to 40.0% among girls. While this data cannot be conflated with exposure to SGBV, it at least provides an indicator of girls' proximity to SGBV through information network and social circles. Juxtaposed with this increase in knowledge of incidents of SGBV is a troubling lack of exposure to SGBV sensitization. While 10.6% of respondents indicate having received information on SGBV, 2.2% and 0% of girls and female child HoH respectively indicate the same.

With respect to the challenges in accessing SGBV support, many were listed and mirror those detailed in the most recent UNHCR participatory assessments of 2018 and 2019, while the barriers specific to the pandemic echoed those mentioned for healthcare: limited transportation, restricted mobility, limited community outreach, and decreased human and financial resources dedicated for service provision.

Priority Needs

Food was by far the need that was most frequently mentioned across age groups, sex and locations, perhaps indicating a rise in the number of food insecure households, particularly given the recent cuts made to food rations. Though food was mentioned overall by 76.7% of respondents, it was mentioned by 91.0% of respondents in Kampala, which is significant given that urban refugees are normally not eligible for food assistance.

Not surprisingly, healthcare was the second most frequently reported need by respondents (60.0%), especially in Kampala (73.1%) which has been hit hardest by the pandemic. This concern was expressed less by girls boys and child HoHs when compared to the adult groups.

In contrast with the need for healthcare, girls and boys did more often signal wanting support for education. While education was mentioned by 39.2% of the total respondents, it was mentioned by 55.6% of girls and 68.4% of boys. Education was also their greatest information need. While signalled by 41.4% of the total respondents, 75.6% and 63.2% of girls and boys respectively reported this information need.

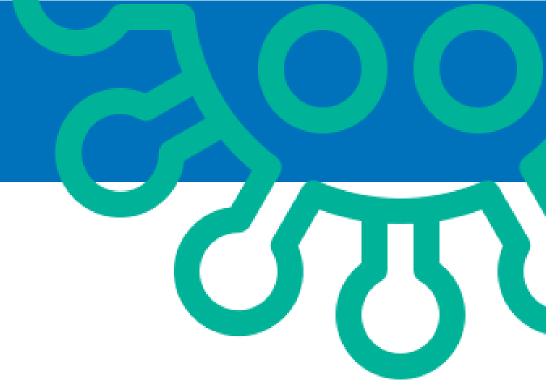
Many other needs were signalled by respondents with the following order: food (76.67%), healthcare (60.0%), livelihoods (51.3%), education (39.2%), NFIs (34.5%), cash assistance (25.8%), water (18.4%), PSN support (17.7%), shelter (16.0%), physical

protection (8.7%), sanitation/hygiene (7.5%), and resettlement (7.1%).

Priority Needs for PLWD and Older Persons

Key informants were specifically asked to expand upon the challenges and priority needs of PLWD and older persons. By far the most frequent recommendation was to provide appropriate transportation for PLWD and older persons, including those with limited mobility who rely on the use of wheelchairs or other assisted devices. Transportation was frequently linked to a PoC's ability to access food assistance and health care, to carry out daily tasks, and even to reduce social isolation. Other types of assistance were mentioned far less often by key informants.

On the contrary, the top two priority needs indicated by respondents aged 60+ followed the overall trend: food assistance and healthcare. However, NFIs (indicated by 44.6% of this group), PSN support (31.7%), and cash assistance (30.3%) received more frequent mentions by this group when compared to the average. PLWD similarly reported food (72.9%), healthcare (54.1%), livelihoods (43.6%), PSN support (36.5%), and NFIs (35.4%) as their top concerns.



Recommendations

1 General

1.1 Increase the equal and meaningful participation of women and girls in decision-making, community management and leadership structures, through leadership trainings, mentorship programmes for women and girls and sensitization campaigns on the importance of sharing power.

1.2 Increase the capacity of humanitarian actors to integrate age, gender and diversity considerations throughout the operations management cycle in all sectors and train all staff on gender equality, SGBV and PSEA.

1.3 Empower and equip community leaders to promote gender equality and facilitate awareness and sensitization sessions in the community around the importance of sharing power at the household and community level and supporting women and girls to claim their rights.

2 Household Economic Activities & Livelihoods

2.1 Support and prioritise social economic empowerment of women, child headed households, PLWDs and older persons including use of multipurpose cash interventions to mitigate the negative coping mechanisms as a result of disrupted livelihoods. This may include partnering with private sector entities to promote livelihood and economic opportunities and working with strategic partners targeting social protection mechanisms and economic stimulus packages for vulnerable groups.

2.2 Consideration of household dynamics in design and implementation, including the division of labour within the household and unpaid care burden.

2.3 Provide vulnerable groups such as female-headed households, women with disabilities and women survivors of GBV with cash assistance and cash for work which will build their resilience and strengthen their coping mechanisms.

2.4 Heighten social mobilization measures to promote messaging on redistribution and recognition of unpaid care and domestic work. This includes working at community level to support and alleviate the burden of care on women, including through work with male gender equality advocates on a 'share the care' campaign

to encourage men's equal participation in social reproduction.

3 Access to Information

3.1 Advocate for information to be shared in formats that are user friendly for especially women and girls who do not have access to communication equipment and have low literacy levels. This may include empowering the Community Development Officers at subcounty level, community structures including VHTs, RWC, and women's leaders at the lowest levels of the community to provide needed information on COVID-19 and other key services. Information dissemination can take the form of providing PPEs to enable door to door dissemination to households and to esp. reach the most vulnerable and excluded from information, translating the information into the local languages spoken by refuges, use of mega phones, utilising community radios among others.

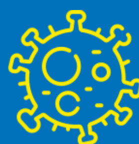
4 Education

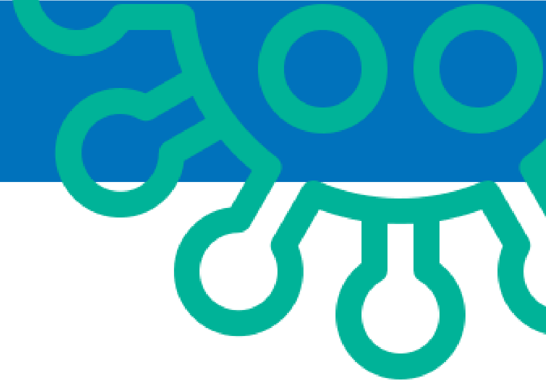
4.1 Monitor the rates of return to school among girls and boys in different locations, particularly in Kampala.

4.2 Provide second chance education (e.g. accelerated learning and vocational skills training) for girls who have become child mothers and those that have been married off early during this lockdown. Funds should specifically be earmarked to support such girls to access education when schools reopen. There should be continuous awareness raising and community dialogues involving the different elders, cultural and religious leaders in the settlement who apparently are custodians of these negative cultural practices to mitigate the challenge off early marriages among the refugee communities. In addition, advocacy should target the school board of governors and district officials to ensure pregnant girls can return to school, stay in school for as long as is safe, and that the girls' personal circumstances allow for after giving birth.

4.3 Establish family friendly interventions that will enable parents / guardians to meaningfully engage their children during this period of extended lockdown since it is uncertain when schools will open. This should include availing information to parents on the dangers of child marriage, sexual exploitation and abuse, protection and safety measures, among others.

4.4 Organize awareness campaigns focusing on the importance of education. The campaigns should also include messages that emphasize gender equality concepts in the households to leverage study time for both girls and boys within a household. It is also important to provide remote-





learning tools to households alleviating burdens on caregivers ensuring children do not fall behind.

5 Health

5.1 Improve the accessibility of maternal, newborn and child healthcare and HIV chronic services through improvement of existing infrastructure, procurement of more maternity beds, hiring of more maternal health staff and conducting sensitization campaigns.

5.2 Explore the provision of menstrual hygiene materials at accessible points in the community.

5.3 Intensify reach to families in need of emotional and psychosocial support. This may entail provision of Mental Health Psychosocial Support services (MHPSS) to combat the stress and a lack of confidence amongst both men and women due to the loss of their livelihoods and inability to provide for their families; training more social workers/counsellors online for virtual counselling and protection services. Other efforts should be about raising awareness about mental wellbeing and invoking the concept of recognition. This means that humanitarian actors use different communication channels to recognize the collective tragedy being experienced and to normalize the anxiety, stress, and concerns that community members may be feeling. This should be followed up by suggestions for community members in supporting one another, and in defining for communities' concepts of safe spaces free of GBV and domestic violence.

6 Assistance

6.1 Provide tailored support for PLWD, older persons, and other vulnerable persons such as adapted transportation and mobile clinics.

6.2 Conduct more research to understand the assistance modalities preferred by different groups of people and how they may differ by location.

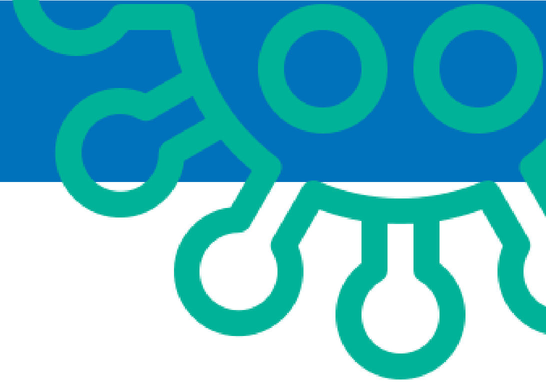
6.3 Humanitarian actors must coordinate advocacy efforts and provide technical expertise to ensure that the COVID-19 refugee response interventions are gender responsive and ensure that refugees are not left behind.

7 Protection & Security

7.1 Support and facilitate District Local Governments to form sector response teams and maintain referral pathways to respond to protection issues, sensitise on referral pathways to report GBV cases sensitize on referral pathways to report GBV cases and keep referral pathways functional. Services to address violence against women and GBV need to be increased and expanded to the

communities, including through shelters, hotlines and counselling, advocacy and media campaigns and reach the widest possible audience to prevent SGBV including through targeting men.

7.2 Advocacy and awareness raising on socio-cultural factors that promote sexual abuse and child marriages. This includes working with cultural, religious and opinion leaders at community level to raise their voices against such practices. Involving religious and cultural leaders in awareness raising and engaging men and boys could deter would-be perpetrators.



Notes

[1] These studies were not able to be included but should be consulted for more information.
[2] *Leave no one behind: From the COVID-19 response to recovery and resilience building,* United Nations Uganda, June 2020: https://www.undp.org/content/dam/uganda/docs/2020/UNCT%20Socioeconomic%20Report%20-A2020.pdf
[3] *COVID-19 Rapid Gender Analysis: Omugo Settlement, Palabek Settlement, Gulu Municipality, Arua Municipality, Moyo District, Lamwo District,* Care International Uganda, May 2020: https://www.careevaluations.org/wp-content/uploads/CARE-International-in-Uganda_Rapid-Gender-Analysis_May-2020_final.pdf
[4] *Multisector Needs Assessment: COVID-19 Situation in Uganda,* Danish Refugee Council, May 2020: https://reliefweb.int/sites/reliefweb.int/files/resources/Multisector%20needs%20assessment%20-%20COVID-19%20situation%20in%20Uganda.pdf
[5] This is due to sample size limitations of specific statistical tests.
[6] The results for Rhino Camp cannot be confirmed due to the low number of respondents (n=25).
[7] *Uganda Refugee Response – Participatory Assessment Report 2019*, UNHCR: https://data2.unhcr.org/en/documents/details/79400
[8] *A survey of re-entry of pregnant girls in primary and secondary schools in Uganda,* FAWE Uganda, 2010: http://www.education.go.ug/wp-content/uploads/2019/07/gender_Report-on-Girls-Re-ntry-in-school.pdf
[9] This lower result was likely due to the emphasis in the question placed on SEA as opposed to “SEA *and other forms of SGBV*”.