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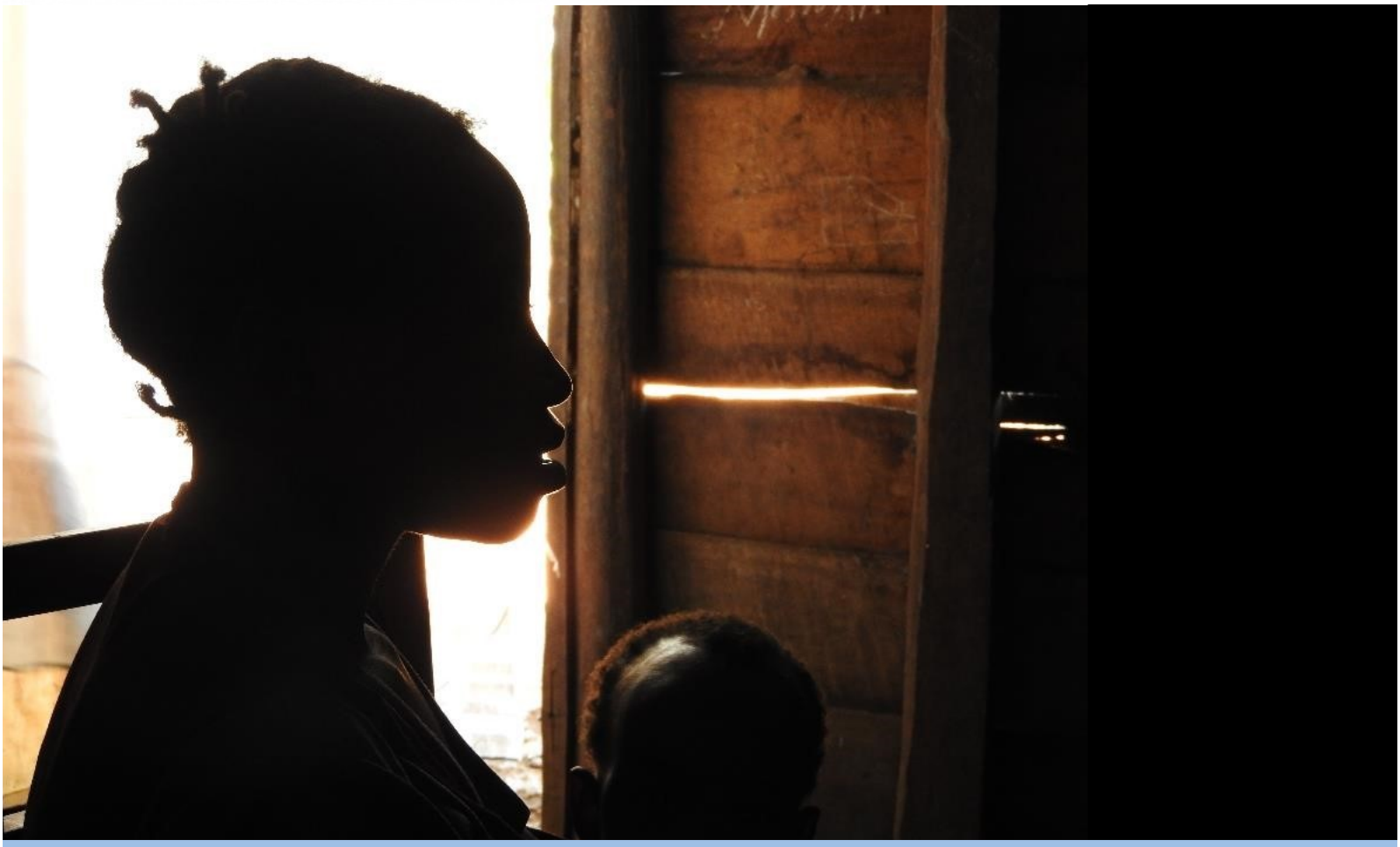

IMPACT EVALUATION

Overcoming sexual and gender-based violence in Eastern Democratic Republic of Congo

October 2016

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OVERCOMING SEXUAL AND GENDER-BASED VIOLENCE IN EASTERN DEMOCRATIC REPUBLIC OF CONGO

October 31, 2016

Cooperative Agreement No. # AID-623-A-10-00012-00

Prepared by IMA World Health

Cover Photo Credit: "Abducted" Lynn Lawry

Acronyms

ABA	American Bar Association
BCC	Behavior Change Communications
CBO	Community Based Organization
CDF	Congolese Franc
CoP	Chief of Party
CPT	Cognitive processing therapy
DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
FAT	Famille d'Accueil Transitoire (Temporary Foster Family)
FDLR	Democratic Force for the Liberation of Rwanda
FY	Fiscal Year
GBV	Gender Based Violence
HA	Health Area
Heal Africa	Health, Education, Community Action, Leadership Development
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HIV+	Human Immunodeficiency Virus Positive Status
HZ	Health Zone
IGA	Income Generation Activities
IMA	Interchurch Medical Assistance
IP	Implementing Partner
IR	Intermediate Result
KIIs	Key Informant Interviews
LQAS	Lot Quality Assurance Sampling
MNCH	Maternal Newborn Child Health
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
OFDA	Office of U.S. Foreign Disaster Assistance
OSC	Overseas Strategic Consulting Ltd.
PEP	Post Exposure Prophylaxis
PF	Panzi Foundation
PMTCT	Prevention of Mother to Child Transmission (HIV)
PPR	Performance Plan Result
PPSSP	Programme de Promotion des Soins de Santé Primaires
PTSD	Post-Traumatic Stress Disorder
RECOP	Réseau Communautaire de Protection de l'Enfance (Community Network for Child Protection)
SBCC	Strategic Behavior Change Communication
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infection
SV	Sexual Violence
UPC	Union of Patriotic Congolese
USAID	United States Agency for International Development
USD	United States Dollar
Ushindi	We Will Overcome (Swahili)
VSLA	Village Savings and Loans Associations

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Executive Summary

Evaluation Objectives

IMA World Health contracted Overseas Strategic Consulting, Ltd. (OSC) in May 2016 to conduct an impact evaluation of Ushindi. IMA requested a quasi-experimental impact evaluation of the project to include analysis of the projects quantitative data collected by IMA and its partners over the five-year course of the project. The impact evaluation evaluates measurable impact from its projects and whether Ushindi had achieved its planned results at the conclusion of its five-year implementation. The results of this evaluation will also inform lessons learned from the previous five years and determine cost effective and impact-focused interventions to pilot in three new health zones in USAID priority areas. At the conclusion of the 12-month implementation period in the three new health zones USAID will be provided with an evidence-based model or package of assistance which could be expanded, scaled up, or added on to other USAID supported interventions in other geographic areas.

The evaluation was guided by the following questions:

- What is the impact the Ushindi Program has had on survivors of sexual and gender based violence (SGBV) and what impact has it had on local communities in terms of awareness and prevention of SGBV and promotion of gender rights?
- For survivors, what is their knowledge of a support structure (*Noyaux Communautaire*, safe houses, counselors, legal assistance) and who they would go to for help?
- For survivors who require medical assistance, their knowledge of the importance of seeking medical services, the availability of post-exposure prophylaxis (PEP) kits to prevent HIV/AIDS, and the fact that such care is free of charge?
- For survivors requiring or having received psychosocial services, what is their knowledge of the presence of psychosocial services; a village counselor (lay) at the village level and advanced counselor at the safe house level? Have they had such services, the impact of such services, were they able to be functional again in their community, the need for further (higher level) counseling for victims of post-traumatic stress disorder (PTSD) for survivors who have not been able to regain their past level of functionality?
- For survivors requiring or having received legal services, what is their knowledge of the presence of legal services; a jurist at the safe house to offer counsel, enter mitigation or reconciliation between parties, or pursue criminal proceedings? Have they had such services, the impact of such services, and their satisfaction? Has this had any impact (positive or negative) in the incidence of SGBV? Has pursuing justice put them at risk?
- For survivors having received socio-economic assistance what was their inclusion in any of the socio-economic services in the Ushindi health zones (Village Savings and Loans Associations (VSLA), social fund, and literacy program)? Have they experienced a socio-economic hardship as a survivor? Are there other needs we have not met? How can we prevent/avoid stigmatization? Having been included back in the community are they more or less vulnerable to SGVB?
- For communities that have benefited from Ushindi services, has there been any impact on the prevalence of SGVB?
- What is the impact of literacy clubs, youth clubs, foster families, campaigns and VLSAs?

Project Background

From July 2010 through July 2015, IMA implemented a USAID Cooperative Agreement, Ushindi: Overcoming Sexual & Gender-Based Violence (SGBV) in Eastern Congo.[1] The Ushindi program implemented a holistic approach integrating psychosocial, medical, legal and economic activities to support survivors of SBGV. The scope of work intended to 1) increase access to timely and quality comprehensive services for individuals affected by SGBV (psychosocial, medical, legal, and socio-economic assistance); 2) improve the quality of services and interventions for individuals and communities affected by SGBV; and 3) reduce the vulnerability of individuals to future acts of abuse and violence. This five-year program was implemented in four provinces among 10 health zones with 1.1 million beneficiaries. In these health zones, the program was included in 106 health areas and 106 health centers (Table 1). The three implementing local partner organizations were:

- **Heath, Education, Community Action, Leadership Development (Heal Africa)** (based in Goma): works in North Kivu and Maniema provinces
- **Fondation Panzi** (PF; based in Bukavu): works in South Kivu province
- **Programme de Promotion des Soins de Santé Primaires** (PPSSP; based in Beni): works in North Kivu and Orientale provinces

The Ushindi project covered 10 health zones (HZ), 108 health areas (HA) and 1,118 villages with a total beneficiary population of 1,083,071 people for the first four years (Table 2).[2] In 2013, USAID decreased funding levels and the geographic scope of Ushindi which led the program to decrease its geographic scope to seven health zones with a total beneficiary population of 858,733 people. On January 30, 2016, IMA received additional funding to complete an amended scope of work, which would be used to continue 'scaled down' assistance to the current seven health zones, consolidate data from five years of intervention for focused analysis and research, measure the impact of the previous five years of treatment and prevention activities on survivors of victims of SGBV as well as on the prevalence of SGVB in the communities served. This additional 4.5 million USD for February 2016 through July 2017 also included focused research, the addition of cognitive processing therapy (CPT) and the expansion of services into three new health zones: Karisimbi, Katana, and Walikale.

Methods

This program evaluation research was conducted in accord with the Declaration of Helsinki, as revised in 2000.[3] Every effort was made to ensure protection and confidentiality and to reduce any potential adverse consequence to the participants. Participants, ≥18 years of age or emancipated minors, did not receive any material compensation and were informed of this in the consenting process. Children interviewed in the youth clubs were interviewed in the presence of parents or teachers. All participants were informed that participation or lack thereof would not affect their access to or the quality of the care they receive, and were explicitly given the right to refuse participation. Respect for the right of all respondents, especially survivors, to confidentiality was a central principle guiding the design and implementation of the study. Particular care was taken to ensure that survivors only participated in the

[1] Ushindi means to overcome or victory in Swahili.
[2] 2 HZs (Lolwa and Komanda) were treated as single project area with one base and one set of staff thus creating nine project areas; 12 HAs per project area.
[3] Declaration of Helsinki. http://www.wma.net/en/30publications/10policies/b3/. Program evaluation, especially with unidentifiable data and questions that relate to programming is exempt from IRB review as per DHHS 45 CFR 46.101(4),(5). See: https://www.hhs.gov/ohrp/sites/default/files/ohrp/policy/ohrpregulations.pdf.

field research after having first given their informed consent and that their best interests were safeguarded. At no time during the research was the name of a respondent recorded; individuals are identifiable only to the study team by a transcript code number. All information provided by survivors and other key informants during the interviews was confidential to the study team. Findings and interview statements cannot be directly attributed to any individual.

This mixed methods quasi-experimental impact evaluation included the following methodologies:

- An extensive desk review
- Semi-directed (qualitative) interviews with survivors, key informants, healthcare personnel, and special programs (literacy, youth club and VSLA)
- Quantitative analysis of programmatic data collected over five years
- Lot Quality Assurance Sampling (LQAS) of opinions and attitudes

The desk review included the quarterly and the final program reports, external evaluation reports, national gender statistics, national protocols, and peer-reviewed literature and grey literature with regard to SGBV in Eastern DRC.

The qualitative method was designed to provide an in-depth, contextualized understanding of the dynamics of change from the perspectives of program beneficiaries, communities, program implementers, and providers, among others. The qualitative methods included key informant interviews (KIIs) with 251 respondents. All consenting and eligible survivors (chosen by Ushindi partners) at each safe house or clinic were included in the study. A total of 251 semi-structured in-depth interviews were conducted in all three health zones: survivors, healthcare personnel, police, lawyers, program staff (national and international staff), local and traditional leaders, and community members.

Program data were collected over the five years of the project. These data were entered into databases by local contractors from DRC. Approximately 79,000 paper-based data sheets required on-line entry. Quantitative analysis of programmatic data collected over five years was used to examine impact for the various arms of the program.

The LQAS methodology was used to examine temporal changes in key outcome indicators between the baseline and endline for rape attitudes and myths.[4] To ensure comparability of findings, the quantitative methodology used the same survey instrument and sampling frame during the baseline and endline data collection but limited the questions to relevant attitudes and myths. The LQAS method was used to select community members for a community survey of a select set of attitudes and myths. For the selection of the sample, the LQAS sampling framework originally included a random selection of approximately 19 community members for interviews in three health zones (Komanda, Lolwa and Lubero) across each health area where Ushindi is implemented. These data were collected to compare to the 2011 baseline.

All of these methodologies used in concert were to aid in understanding the nuances of programmatic impact in addition to triangulation of data across methodologies.

[4] *USHINDI* Baseline Evaluation: Report of LQAS Survey Findings Assessing Rape Myth Acceptance, Attitudes and Practices Towards Rape Victims, and Beliefs about Gender Equality. October 2011 and Final Report: Ushindi Baseline Analysis 2011. Note: Although entitled as a baseline, the 2011 "baseline" survey was carried out after project start up and therefore cannot be considered a true baseline, and was not envisioned as so in the USAID cooperative agreement.

Limitations

The impact evaluation could only employ a non-experimental design. Cause and effect cannot be determined in this methodology. The non-experimental pre/post intervention evaluation LQAS design does not account for non-program influences on outcomes such as other SGBV programming in the same health zones. Baseline/endline comparisons can be influenced by confounders, although these were minimized by using the same survey instruments, survey teams, and sampling frames. To improve the comparability and reliability of endline survey data, the same instrument designed by IMA was utilized, however only a subset of the rape myths and attitudes assessed in 2011 were analyzed for comparison.[5] The time period between baseline and endline, especially for behavior change was only five years and could decrease any behavioral differences observed. Individual semi-structured qualitative interviews represent individual experiences of those most willing to speak, and cannot be generalized beyond those interviewed.

Information on practices, attitudes and behaviors among respondents may be subject to social desirability bias. Halo bias may be a factor since respondents might have reported what they should do/think instead of what they actually do/think.

Local data collectors familiar with local language and culture were utilized to minimize respondent bias. Data collectors were supervised throughout the study with supervisors in the field at all times. Although data collectors were careful to explain that there will be no material or other gain by participation in the assessment, respondents might have exaggerated or underestimated responses if they believed it would be in their interest to do so.

In some instances (e.g., when interviewing beneficiaries), responses might have been constrained due to fear of reporting or stigma such as with questions around SGBV, however, based on our qualitative study, it was noted that SGBV was normalized and responses were less likely to be constrained. Although it is possible that differences within the interviewer due to ethnicity, sex, or overall comfort level during the interview could bias the results, this was mitigated largely through the use of local data collectors, properly trained in interviewing techniques who did not interview in areas with which they were familiar.

Finally, this study was limited by the security within each health zone, time, and funding to complete the study. Of the seven project health zones, only Komanda, Lolwa and Lubero were deemed safe to work in at the time of the survey. In addition, curfews in each area limited the number of respondents who could be interviewed on any given day.

Findings

Ushindi has been successful and cost-effective for ensuring medical, psychosocial, socioeconomic services and justice are available should survivors seek and request such services. The documented impacts of Ushindi include increasing community knowledge about SGBV, increasing the number of survivors that present to care within the 72 hour window to receive PEP, the constant, cost-effective and reliable supply of PEP kits to the health centers in Ushindi implementation areas, the improvement in the knowledge of health care personnel at the health center level to identify and treat survivors of sexual violence, a context specific and accepted method for psychosocial care, the implementation of

[5] The 2011 Rape Myths LQAS also had added questions that were not from the standardized Rape Myth assessment.

higher level, evidence-based treatment for PTSD and severe depression (CPT), and significant and important effort to bring cases of sexual violence to court and push for a judgment. Improvements to the program are minor and include things such as increasing the capacity of local partners to adapt their traditional communication programs to Social and Behavior Change Communications (SBCC) that focuses on behavior change, packaging PEP kits to decrease the temptation to use parts of the kits for other diagnoses, considering other socioeconomic approaches for education and/or documenting the increase in financial independence. In the next phase of Ushindi, the intake data forms should have indicators added that might help with proving impact such as adding in periodic symptom monitoring of mental health disorders associated with SGBV and better data to evaluate if survivors are indeed coming to care within 72 hours. Each evaluation question is presented below with a succinct summary and recommendations specific to each question.

Conclusions and Recommendations

Evaluation Question 1:

> What is the impact the Program has had on survivors of Gender and Sexual Based Violence and what impact has it had on local communities in terms of awareness and prevention of SGVB and promotion of gender rights?

Summary

- Anecdotally, among survivors, Ushindi's programs (specifically the medical services, safe houses and psychological care) were the most commonly mentioned services that helped them "recover"
- Ushindi had a significant impact on survivor's ability to seek care and access services that were not previously available to address the known sequelae of sexual violence.
- Anecdotally, the establishment of 108 youth clubs (30,000 participants), 108 *Noyaux*, 415 VSLAs, 9 child protection networks (RECOPE), over 100,000 mass community awareness-raising sessions in villages and 26 women-led income generation activities (IGAs)/CBOs all added to community knowledge and awareness of sexual violence and information for the community to help survivors reach out to seek necessary care
- Anecdotally, there was a belief by survivors and key informants that men are less likely to force sex on their spouses due to Ushindi sensitization activities, although there is no baseline data to compare this belief change
- Victim blaming persists since baseline, although these issues were not specifically addressed in SBCC campaigns[6]
- With the exception of Lolwa, gender attitudes and or rights based on the LQAS myths study[7] which was limited with regard to the assessment of a range of attitudes and gender rights, improved with some regression in Lubero and Komada

Recommendations

- Continued integration of lay counselors and mental health services for survivors CPT and other psychological services with periodic symptom assessment of survivors to determine impact of CPT, psychological services on survivors
- Improved SBCC to address the community-based violence and the prevalent rape myths and

[6] For example, how women dress and behave.
[7] Gender rights were limited to the right to refuse sex.

negative gender roles in order to adjust negative norms into positive behavior change
- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change
- To determine impact of Ushindi on survivors requires periodic surveys developed to address variables of interest such as satisfaction and improvement in symptoms post sexual violence
- To determine the impact of Ushindi on community awareness would also require at least baseline/midline/endline of specific gender rights and community awareness addressed through SBCC campaigns
- Determination of programmatic impact on SGBV (sexual violence) requires population-based assessment at baseline/midline/endline of yearly rates in each health zone or across the entire program

Evaluation Question 2:

For survivors, what is their knowledge of a support structure (*Noyaux Communautaire*, Safe Houses, Counselors, legal assistance[8]) and who they would go to for help?

Summary

- Community awareness of support structures of survivors were well known largely due to the activities of the *Noyaux Communautaire* who pointed survivors in the direction of all arms of the services in cooperation and support by its local partners, PPSSP and Heal Africa within the health zones of Komanda, Lolwa and Lubero
- The most common entry points for support include medical services (not necessarily at Safe Houses) and the *Noyaux Communautaire*
- According to the vast majority of survivors interviewed, more than three-quarters were aware of Ushindi and its support services such as the *Noyaux*, counselors, legal assistance and the safe houses
- Survivors rely heavily on the lay counselors associated with the safe houses and communities and credit them with their comfort and recovery
- It was not clear if the *Noyaux* identified survivors, or were referred survivors, through community networks
- Not all survivors accessed care through the Safe Houses but when they presented to any arm of the program (including legal), they were referred to all arms of the program, especially medical as a first step of the process of care
- Among the survivors interviewed, there was less knowledge of the legal services available to survivors which was mainly due to strongly-held beliefs that justice could not be served without a known perpetrator, and the belief that few if any perpetrators actually served time, especially for conflict-associated rapes. Other reasons for avoiding legal services were somewhat due to a fear of humiliation and the perceived need for bribery during the process and/or lack of funding for participation in court proceedings

Recommendations

- Increase community outreach through the *Noyaux* to ensure survivors are identified within the community as opposed to waiting for survivors to present to services

[8] Legal Services: See Evaluation Question 5.

- Improve the communication to the community regarding the legal services available and or the successes due to community beliefs about the limits of the legal system

Evaluation Question 3:

> For survivors who require medical assistance, their knowledge of the importance of seeking medical services, the availability of PEP kits to prevent HIV/AIDS, and the fact that such care is free of charge?

Summary

- Despite data limitations on the actual presentation time to services, there appears to be an increase in the number of survivors coming to care within 72 hours which suggests the communication campaigns by the *Noyaux* have been successful
- PEP kits are used appropriately by providers who feel more confident about the use of National Treatment Guidelines for the identification and treatment of survivors since the start of Ushindi
- PEP kits used during the five years of Ushindi increased also suggesting that survivors were coming to care earlier (within 72 hours)
- Ushindi was able to consistently supply PEP kits to health centers and even with a limited stock out period, providers and clinics had enough kits to share until replacements were supplied
- The outside sourcing model for PEP kits by IMA was cost-effective and efficient and should be replicated by others to ensure important treatments are available
- PEP kits tended to have differing expiration dates but they did not impact treatment or expire prior to use
- PEP kits which were not packaged were, at times, taken apart in some clinics if a need for a specific drug contained in the kit arose
- There was a higher than expected rate of pregnant survivors that presented to Ushindi based on the know rate of sexual violence related pregnancies
- Prevention of Mother to Child Transmission (HIV) (PMTCT) services are not a provision through Ushindi and could be incorporated through a larger reproductive health package for survivors given the risk for violence among pregnant women and the 2.5% of pregnant survivors that need PMTCT
- Among survivors interviewed, it was common knowledge that medical services were free
- The sustainability of payments to the health zone and health clinics for the care of survivors is questionable if Ushindi does not exist

Recommendations

- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change
- Increase community outreach through the *Noyaux* to ensure survivors are identified within the community as opposed to waiting for survivors to present to services
- PEP kits should be packaged to avoid the temptation to use specific drugs in the kit for other medical uses
- IMA's model for procurement should be replicated in other projects for cost-effective and efficient drug procurement
- The concern of health care providers regarding pregnant survivors using Ushindi as a way to avoid admitting sexual activity needs to be addressed and researched
- Identification and follow up with pregnant women to evaluate SGBV/IPV risk in the community
- Consider integration of Ushindi services into Maternal Newborn Child Health (MNCH) services to provide early intervention services to at-risk-families, and identification of those at risk for

SGBV
- Integration of PMTCT services for pregnant HIV positive survivors
- Sustainability of payments for survivor care needs to be evaluated and a different model used to ensure the community and health zone/Ministry of Health can sustain care for survivors
- Consider survivor care payments through and from the Safe House to eliminate the payments directly to the local health zone and providers at the health centers
- Income generation and sustainability plans among *Noyaux* is a must to ensure their programs persist

Evaluation Question 4:

For survivors requiring or having received Psychosocial Service, their knowledge of the presence of psychosocial services; a village counselor (lay) at the village level and advanced counselor at the Safe House Level? Have they had such services, the impact of such services, were they able to be functional again in their community, the need for further (higher level) counseling for victims of PTDS for survivors who have not been able to regain their past level of functionality?

Summary
- Survivors were very aware of the *Noyaux* and the psychosocial services available to them
- Psychosocial services were heavily used by survivors who "feel better" with services
- Safe Houses are important for combined service access, and represent a safe/calm/welcoming place for survivors
- Lay counselors in particular are used heavily by survivors and are liked, well-trained and a mainstay of the program
- Psychologists are present for cases that cannot be handled at the lay counselor level and treat a smaller proportion of survivors
- Recovery is anecdotal and not clinically assessed[9]

Recommendations
- More training for lay counselors to avoid dispensing advice such as "just forget the issue"[10]
- CPT for more difficult cases
- Should consider periodic mental health symptom tools and/or functional status tools to quantify recovery and "feeling better" and to prove impact of these treatments on survivors[11]

[9] Since the evaluation, a check list on symptom improvement has been adapted for the program in cooperation with JHU and is being utilized in current phase of Ushindi.
[10] Clinically this can devolve into later PTSD as the trauma is not dealt with and is instead compartmentalized. See: Van der Kolk, B. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma (1st ed.). New York, NY: Viking.
[11] Judith Bass (Hopkins) has a number of these tools validated in DRC and in local languages

Evaluation Question 5:

> For survivors requiring or having received legal services, their knowledge of the presence of legal services; a jurist at the safe house to offer counsel, enter mitigation or reconciliation between parties, or pursue criminal proceedings? Have they had such services, the impact of such services, and their satisfaction? Has this had any impact (positive or negative) in the incidence of SGBV? Has pursuing justice put them at risk?

Summary

- Survivors interviewed were not as aware of legal services compared with other arms of Ushindi
- Few of the survivors interviewed had pursued cases largely due to held beliefs that justice was not possible
- More than half (56%) of cases brought to the legal clinics were pursued
- Given the difficulties of the judicial system in DRC, the fact that 21% of cases reach a judgement heralds a significant effort by the American Bar Assiociation (ABA) to pursue justice for victims
- Anecdotally, the fact that sexual violence is prosecuted and sentences have been given, fear about being held accountable is instilled in communities
- Local Chiefs are still mediating cases as a first intervention, especially those involving minors and/or IPV cases, which when that fails, they then go to legal clinics
- Local Chiefs are primarily mediating child cases to save the family embarrasment
- Families are making the decisions for young girls (14-21) and using community mediation to protect the family name and to obtain the financial incentive imposed by the Chief on the perpetrator. The compensation is paid to the family and not the survivor
- Corruption is present at all levels from the police to courts
- Weekend liberty from prison results in perpetrators disappearing
- The need for survivors to seek medical attention prior to seeking support from the justice sector is understood among Ushindi's various arms
- Rebel cases cannot be prosecuted, which is frustrating to many women
- Military cases are, in some cases, brought to military justice

Recommendations

- Satisfaction of survivors in the process will require a much larger mixed methods study where the risk put on survivors who pursue justice can also be determined[12]
- Many survivors interviewed were not aware of services for justice. Better outreach and information about cases may help to bring more case to this arm of Ushindi
- Local Chiefs, although they state they understand it is illegal to mediate SGBV cases, they are doing so. Chiefs need sensitization to understand the harm such mediation can do for survivors and the legal system
- Corruption, an ongoing issue in DRC justice, must be addressed at the highest level
- A few rebel cases are being prosecuted at the level of the International Criminal Court. Information at the community level regarding these cases might be helpful to survivors who suffered/suffer conflict-related SGBV
- ABA to complete a more indepth analysis of the database

[12] There were more than 5200 cases pursued. Follow up of these survivors would help to answer impact and would require a mixed methods study to determine impact, risk, and outcome.

Evaluation Question 6:

> For survivors having received socio-economic assistance what was their inclusion in any of the socio-economic services in the Ushindi health zones (VLSA, social fund, and literacy program)? Have they experienced a socio-economic hardship as a survivor? Are there other needs we have not met? How can we prevent/avoid stigmatization? Having been included back in the community are they more or less vulnerable to SGVB?

Summary

- Quantitative data was not available to assess VSLA and literacy club use
- Anecdotally the survivors report economic hardship due to the inability to complete activities of daily living due to psychological distress or simply fear of walking to the fields or by the bush
- Abandonment by families was particularly hard for young survivors
- Other needs not met, according to survivors interviewed included schooling, and trades so they do not have to work in other people's fields
- Stigmatization was mentioned by survivors but it should be kept in mind that in population-based surveys this was not as prevalent as perceived in DRC[13]
- Prevention of stigma needs more research. The *Noyaux* have decided that a way to minimize this is for women not to talk about their experiences with the community, especially when joining VSLA and to "forget about the incident"
- Many survivors state they are accepted by the community but it comes with a cost of ridicule and marginalization
- Survivors who cannot find work or continue with the same small businesses after the incident, have to start businesses that put them at risk for further sexual violence including working in other people's fields and working longer hours (especially after dark) and selling beer or alcohol

Recommendations

- Consider a tutoring project for survivors especially given the number of pregnant teens that drop out of school and do not return because they fall behind in their studies[14]
- Consider teaching survivors trades/skills such as sewing, which was mentioned the most, baking, or business development skills to decrease the likelihood that survivors will need to participate in risky small businesses that may put them at risk for further violence (selling alcohol, working in other people's fields, prostitution, survival sex, etc.)
- Ensure there is access to VSLAs for survivors and consider a "Survivor VSLA" to limit the stigma and worry that survivors expressed in joining community VSLAs

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[13] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562

[14] The most recent DHS in DRC showed that a woman with a secondary education has on average 2.9 children, while a woman with no education has 7.4, a gap that highlights the key role education plays in positive health outcomes. Furthermore, with more schooling, women tend to have fewer children and space births more widely, therefore, education is a message that is important for the health of communities and vitally important for the health of women and girls. Education is a primary indicator for health especially among women. See: Demographic Health Survey. DRC 2013. http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf; Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. Gakidou, Emmanuela et al. The Lancet , 2010. 376 (9745): 959 – 974 and Reldmmi J, Makiir [), Kleinman J, Crjmoni-Htmtly J. National trends in educational differentials in mortality. *AmJEpidetnioL* 1989;129:919-933.

- Document the successes of the VSLAs, especially for survivors financially or tangibly
- Consider a more nuanced assessment of stigma and how it ultimately affects survivors with the understanding that this is for a minority of survivors
- Special attention to young survivors, and especially pregnant young survivors, who were (anecdotally) more likely to be abandoned by family, drop out of school and had a hard time coming with ways to make money for survival

Evaluation Question 7:

For communities that have benefited from Ushindi Services has there been any impact on the prevalence of SGVB?

Summary

- The prevalence of SGBV in the implementation areas was not assessed at baseline, therefore it is not possible to say what impact Ushindi had on the prevalence of SGBV in the health areas/zones where Ushindi was implemented; however, the Demographic Health Survey (DHS) data might be considered a baseline for yearly prevalence rates whereby Ushindi could conduct a population-based assessment at midline/endline to determine impact of Ushindi on prevalence rates assuming correlations and associations were also surveyed to tie decreases to specific arms of the program
- Anecdotally, more than 67% of survivors interviewed stated that the perceived decrease in sexual violence in their communities was due to Ushindi, justice, and a change in behavior and attitudes related to Ushindi's programs

Recommendations

- Even though the prevalence of SGBV in the implementation areas was not assessed at baseline it is possible to determine if Ushindi's impact on the prevalence on SGBV using DHS data as a baseline for yearly prevalence rates. Such a study would require cluster sampling to keep the costs of the study reasonable but could be limited to the entire implementation area versus data that can be sub-grouped by health zone to reduce costs
- Correlations and associations must accompany a prevalence survey to tie decreases in SGBV to specific arms of the program
- A midline and endline assessment of the prevalence of sexual violence will be possible for the newly implemented health zones due to the extensive baseline completed in August 2016; however, and as stated, it is possible to design a population-based survey to cover all implementation areas of Ushindi

Evaluation Question 8:

What is the impact of literacy clubs, youth clubs, foster families, campaigns and VLSAs?

Summary

- Determination of impact and literacy from the participation of literacy clubs could not be determined or measured and few if any survivors could verbalize any type of true impact on their recovery or lives such as improved financial gain and/or social re-integration due to being able to write their name or read
- Youth clubs have had anecdotal impact on awareness of children's rights and sexual violence among youth including early marriage
- Foster families had little to no measurable impact on child SGBV survivors and could only house

a minimum of survivors at a significant cost to the program
- Campaigns, based on the LQAS, made some improvement in attitudes and myths among the communities evaluated especially in Lolwa
- Several survivors bought land, were able to support their children and/or pay their school fees, or start a small business
- VSLAs were culturally accepted in that there were twice as many spontaneous VSLAs that developed during the life of the project
- VSLA was anecdotally helpful to survivors and the community for microloans
- The impact and financial improvement from participation in VSLA among households of survivors could not be determined

Recommendations

- Consider a tutoring program for survivors especially given the number of pregnant teens that drop out of school and do not return because they fall behind in their studies[15]
- If literacy clubs are continued, measurable periodic impact questionnaires will need to be developed and analyzed
- Youth clubs should have an assessment of a child development specialist to ensure the clubs are not putting the children at risk[16] and they are addressing difficult topics such as rape for all ages involved in the youth clubs
- Periodic assessment will need to be implemented to assess the anecdotal successes in child rights, early marriage and child violence reported by youth
- Consider dropping the Foster Family model from Ushindi and instead, further develop child friendly services and guidelines that meet the developmental needs of child survivors that are in consultation with a child development specialist
- Consider school based programs to reach children concerning SGBV, child violence, protection and child rights
- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior changes in the community to address gender rights, myths, prevention of SGBV and attitudes
- To determine impact of VSLAs, periodic assessment of household and/or survivor financial improvement will need to be implemented
- Ensure there is access to VSLAs for survivors and consider a "Survivor VSLA" to limit the stigma and worry that survivors expressed in joining community VSLAs
- Document the successes of the VSLAs, especially for survivors financially or tangibly

[15] The most recent DHS in DRC showed that a woman with a secondary education has on average 2.9 children, while a woman with no education has 7.4, a gap that highlights the key role education plays in positive health outcomes. Furthermore, with more schooling, women tend to have fewer children and space births more widely, therefore, education is a message that is important for the health of communities and vitally important for the health of women and girls. Education is a primary indicator for health especially among women. See: Demographic Health Survey. DRC 2013. http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf; Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. Gakidou, Emmanuela et al. The Lancet, 2010. 376 (9745): 959 – 974 and Reldmmi J, Makiir [), Kleinman J, Crjmoni-Htmtly J. National trends in educational differentials in mortality. *AmJEpidetnioL* 1989;129:919-933.

[16] Some youth clubs were asking children to report parents and other adults to the police. Anecdotally, some children have been beaten after doing so.

Project Background

DRC has experienced continued violence and civil conflict for more than two decades and is routinely listed as the site of one of the world's worst humanitarian crises. The crises have resulted in millions of women and men being subjected to human rights abuses and SGBV.[17] Academics, human rights organizations, non-governmental organizations (NGOs), the United Nations, journalists, and politicians have spoken out about this violence consistently. Of the studies that evaluate sexual violence in the DRC, the majority do not include all forms of sexual violence[18] and are largely qualitative, or evaluate patients presenting to medical care, which comprise a biased, nonrandomized sample.[19] Of the few population-based studies assessing violence in Eastern DRC, estimates of reported sexual violence were between 16% and 35%.[20] Both studies limited inquiries about sexual violence to very narrow definitions and/or age groups and did not ask about perpetrators, circumstances, mental and physical health consequences of the violence, or establish if the violence was community based, conflict-related, or

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[17] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562; Lawry L, Rosa JC, Kisielewski M, Johnson K, Scott J, Wieczorek J. The Use of Population-Based Surveys for Prosecutions at the International Criminal Court: A Case Study of Democratic Republic of Congo. International Criminal Justice Review. 2014; 24:1 doi:10.1177/1057567714523982; and Lawry L, Johnson K, Asher J. Evidence-Based Documentation of Gender-Based Violence. In: Stephan Parmentier, Jeremy Sarkin and Elmar Weitekamp (Eds), New Series on Transitional Justice, Prosecuting Sexual Violence as an International Crime: Interdisciplinary Approaches. Antwerp, Belgium: Intersentia Publishers 2013.

[18] Vinck P, Pham P, Baldo S, Shigekane R. Living With Fear: A Population-Based Survey on Attitudes about Peace, Justice, and Social Reconstruction in Eastern Democratic Republic of the Congo. http://hrc.berkeley.edu/pdfs/LivingWithFear-Exec-Summ.pdf. August 2008 and Peterman A, Palermor T, and Brendenkamp C. Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo. Am J Public Health. 2011 June; 101(6): 1060–1067.
doi: 10.2105/AJPH.2010.300070

[19] Murray L, Bass J, Bolton P. *Qualitative Study to Identify Indicators of Psychological Problems and Functional Impairment Among Residents of Sange District, South Kivu, Eastern DRC. A Report to the Victims of Torture Fund.* USAID Development Experience Clearinghouse. http://pdf.usaid.gov/pdf_docs /PNADI610.pdf. October 2006; The War Within the War: Sexual Violence Against Women and Girls in Eastern Congo. Human Rights Watch Web site. http://www.hrw.org/en/reports /2002/06/20/war-within-war-0. July 31, 2002. Harvard Humanitarian Initiative and Open Society Institute. Characterizing Sexual Violence in the Democratic Republic of the Congo: Profiles of Violence, Community Responses, and Implications for the Protection of Women. http://www.hhi.harvard.edu /images/resources/reports/final%20report%20for%20the%20open%20society%20institute%20-%201.pdf. August 2009; Bartels S, VanRooyen M, Leaning J, Scott J, Kelly J. "Now, The World Is Without Me": An Investigation of Sexual Violence in Eastern Democratic Republic of Congo. Harvard Humanitarian Initiative and Oxfam International. http://www.iansa-women.org/sites /default/files/newsviews/HHI-Oxfam%20DRC%20GBV%20report.pdf. April 2010.

[20] Vinck P, Pham P, Baldo S, Shigekane R. Living With Fear: A Population-Based Survey on Attitudes about Peace, Justice, and Social Reconstruction in Eastern Democratic Republic of the Congo. http://hrc.berkeley.edu/pdfs/LivingWithFear-Exec-Summ.pdf. August 2008 and Peterman A, Palermor T, and Brendenkamp C. Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo. Am J Public Health. 2011 June; 101(6): 1060–1067 and Peterman A, Palermor T, and Brendenkamp C. Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo. Am J Public Health. 2011 June; 101(6): 1060–1067.
doi: 10.2105/AJPH.2010.300070

violence against men.[21] To date, there is only one evidence based study that is able to estimate the prevalence of sexual violence in Eastern territories of DRC. The 2010 DRC Study[22] was conducted in the territories[23] of North and South Kivu provinces and Ituri district in March 2010. This study included 67 villages (10-15 households per village) and 998 households, representing 5.2 million adults living in 19 territories in North and South Kivu provinces and Ituri district.[24] This study revealed that among the household-based population in the survey area, 39.7% of women and 23.6% of men were reported to have been exposed to sexual violence during their lifetime. Thirty-one percent of women were reported to have been exposed to intimate partner violence compared with 16.6% of men. Of those who were exposed to sexual violence, 74.3% of women and 64.5% of men were exposed to conflict-associated sexual violence. Perpetrators of conflict-associated sexual violence were reported to include 41.1% women as perpetrators among female survivors vs. 10.0% among male survivors. The most common type of sexual violence reported by both women and men was rape. Using population data from that time, this study estimated 1.31 million women and 0.76 million men were survivors of sexual violence in North and South Kivu and Ituri district and might need health services specific to sexual violence–related care.[25]

From July 2010 through July 2015, IMA was awarded a USAID grant program entitled Ushindi[26]: Overcoming Sexual & Gender-Based Violence (SGBV) in Eastern Congo." The project's focus was (1) to increase access to timely and quality comprehensive services for individuals affected by SGBV (specifically psychosocial, medical, legal, and socio-economic assistance); 2) improve the quality of services and interventions for individuals and communities affected by SGBV; and 3) reduce the vulnerability of individuals to future acts of abuse and violence. The project implements a holistic approach integrating psychosocial, medical, legal and economic activities to support survivors of SBGV. While the term SGBV is an umbrella term for all forms of gender based violence (GBV), the Ushindi project specifically supports survivors of sexual violence. This five-year program was implemented in four provinces among 10 health zones with 1.1 million beneficiaries (2010-2013). In these health zones, the project was included in 106 health areas and 106 health centers (Table 1). The project worked with three local implementing partner (IP) organizations included:

- **Heal Africa** (based in Goma): works in North Kivu and Maniema provinces
- **PF** (based in Bukavu): works in South Kivu province
- **PPSSP** (based in Beni): works in North Kivu and Orientale provinces

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[21] Reis C and Lawry L. Challenges for Justice in Democratic Republic of Congo for Human Rights Violations. JURIST - Hotline, Mar. 7, 2013, http://jurist.org/hotline/2013/03/reis-lawry-icc-sexual-violence.php and Lawry L, Reis C, Kisielewski M, Asher J. Problems in Reporting Sexual Violence Prevalence. Am J Public Health. 22 September 2011, 10.2105/AJPH.2011.300347. Available at <http://ajph.aphapublications.org/cgi/reprint/AJPH.2011.300347v1>.

[22] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562.

[23] 26 provinces were subdivided into 192 territories. See eMethods at http://www.jama.com.

[24] Details of the sampling frame, including the selection of clusters/villages, selection of households, and selection of participants within households, are described in the online supplemental eMethods at http://www.jama.com.

[25] Scott J, Polak S, Kisielewski M, McGraw Gross M, Johnson K, Hendrickson M, and Lawry L. A Mixed-Methods Assessment of Sexual and Gender-based Violence in Eastern Democratic Republic of Congo to Inform National and International Strategy Implementation. International J of Health Planning and Management. 2012; DOI: 10.1002/hpm.2144.

[26] Ushindi means "overcome" or "victory" in Swahili.

Table 1: Geographic scope of implementing partners 2010-2013

Project Assisted Health Zones			
Province	**Health Zone**	**Population**	**IP**
Orientale	Lolwa	42,138	PPSSP
	Komanda	78,501	
Nord Kivu	Mutwanga	183,973	
	Lubero	213,548	HEAL
	Alimbongo	184,739	
Maniema	Obokote	73,874	
	Ferekeni	60,444	
Sud Kivu	Shabunda	90,020	PF
	Kitutu	75,233	
	Mwenga	80,601	
TOTAL		**1,083,071**	

In addition to IMA's cadre of local partner organizations, a number of technical partners were contracted to provide focused support including: CARE (socio-economic interventions), Save the Children (prevention and services to child victims of SGVB), Children's Voices and the ABA (legal representation and advocacy).

During project implementation, supplemental funding was awarded which included an Office of U.S. Foreign Disaster Assistance (OFDA) grant of approximately 1.2 million USD to rehabilitate and augment the capacity of health facilities and in 2013, a supplementary Women's Leadership Grant to promote family planning and women's leadership. In 2013 USAID decreased funding levels and the geographic scope of Ushindi, forcing the program to decrease its geographic scope to seven health zones with the population and health area descriptions described in Figure 1. At this time, all technical assistance contracts were discontinued with the exception of the ABA. The project covered ten health zones[27] (HZ), 108 health areas[28] (HA) and 1,118 villages with a total beneficiary population of 1,083,071 people for the first four years. For year five and due to a decrease in funding, Ushindi covered 7 health zones (Table 2) with 72 health areas and a total beneficiary population of 858,733 people (Figure 1).

[27] 2 HZs (Lolwa and Komanda) were treated as single project area with one base and one set of staff thus creating 9 project areas.
[28] 12 HAs per project area.

Table 2: Geographic scope and population figures of Ushindi implementing partners 2013-2015

Health Zone	Health Areas in Zone	Total Zone Population	Health Areas Assisted	Total Population Assisted
Lolwa	5	42,138	5	42,138
Komanda	14	170,063	7	78,501
Mutwanga	20	254,582	12	183,973
Lubero	16	242,912	12	213,548
Alimbongo	17	201,209	12	184,739
Kitutu	22	132,155	12	75,233
Mwenga	17	121,524	12	80,601
Total	111	1,164,583	72	858,733

Despite funding cutbacks, the large majority of indicators were met or surpassed and the project was completed as planned at the end of fiscal year (FY) 2015. IMA was asked to continue services for several months with residual funding with the aim of obtaining an 18-month cost extension for continuing services. On Jan 30, 2016, IMA received additional funding to complete an amended scope of work, which would continue 'scaled down' assistance to current health zones, consolidate data from five years of intervention for focused analysis and research, measure the impact of the previous five years of treatment and prevention activities on survivors of victims of SGVB as well as on the prevalence of SGVB in the communities served. This additional 4.5 million USD for February 2016 through July 2017 also includes focused research, the addition of CPT and the expansion of services into three new health zones; Karisimbe, Katana, and Walikale.

In order to capture the scale and effects of the project, a host of indicators were used to track project progress. Table 3 demonstrates the results framework for the Ushindi Project.

Figure 1: Map of Ushindi Implementation Health Zones 2013-2015

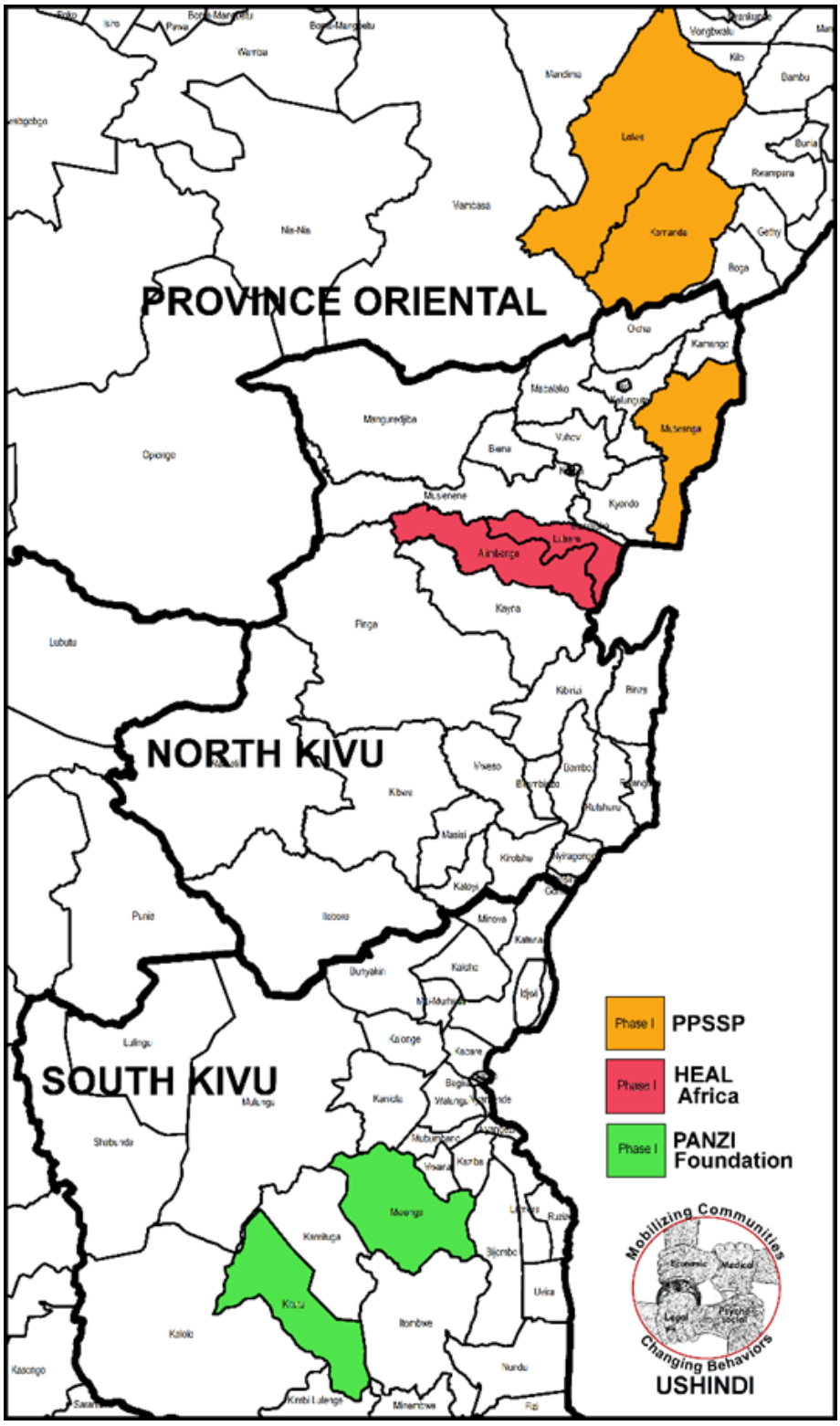


Table 3: Results Framework

Performance Plan Result (PPR)	Intermediate Result (IR)	Strategies by Sub-IR
PPR I. Number of people benefiting from USG-supported social services	IR1 Increased Access to Quality and Timely Care and Treatment Services	Number of survivors counseled for psychosocial support Number of survivors receiving medical support (including PEP, sexually transmitted infection (STI), and Fistula Care) Number of survivors receiving legal support (for GBV and sexual violence (SV)) Number of cases referred to jurist for prosecution (and number of judgments) Number of mediation cases achieved
	IR 2 Increased organizational and community capacity to respond to SGBV (BCC) and reintegration of survivors	Number of survivors enrolled in VSLA groups (and total number of persons enrolled & cycles) Number of people assisted by social fund Number of persons benefiting from youth-led environmental services Number of community leaders engaged in BCC activities (*Noyaux Communautaires*) Community members reached by BCC activities (including school children and people in uniform)
PPR 2. Number of service providers trained who serve vulnerable populations	IR 2.1 Increased organizational and community capacity to respond to SGBV and reintegration of the survivors	Health service providers Psychological counselors CPT counselors Number of police (OPJ) trained in procedures and evidence related to SGBV *Noyaux Communautaires* Community leaders on customary laws Teachers, school directors Leaders of women's associations Youth club leaders Community mobilizer for VLSA and GBV prevention
	IR3.0 Improved ability of communities and individuals to lead and participate in community-based social integration and economic recovery activities	Economic empowerment by socio–economic activities: VSLA, IGA
PPR 3. Number of organizations or services deliveries strengthened	IR4.0 Number of organizations' delivery systems strengthened	Number of health facilities supplied with appropriate medicine and supplies CBO and associations created (VSLA) Youth clubs engaged in environment and peace building

Evaluation Methodology

The OSC evaluation was guided by the following questions:

1. What is the impact the Ushindi Program has had on survivors of SGBV and what impact has it had on local communities in terms of awareness and prevention of SGVB and promotion of gender rights?
2. For survivors, what is their knowledge of a support structure (*Noyaux Communautaire*, safe houses, counselors, legal assistance) and who they would go to for help?
3. For survivors who require medical assistance, their knowledge of the importance of seeking medical services, the availability of PEP kits to prevent HIV/AIDS, and the fact that such care is free of charge?
4. For survivors requiring or having received psychosocial services, their knowledge of the presence of psychosocial services; a village counselor (lay) at the village level and advanced counselor at the safe house Level? Have they had such services, the impact of such services, were they able to be functional again in their community, the need for further (higher level) counseling for victims of PTSD for survivors who have not been able to regain their past level of functionality?
5. For survivors requiring or having received legal services, their knowledge of the presence of legal services; a jurist at the safe house to offer counsel, enter mitigation or reconciliation between parties, or pursue criminal proceedings? Have they had such services, the impact of such services, and their satisfaction? Has this had any impact (positive or negative) in the incidence of SGBV? Has pursuing justice put them at risk?
6. For survivors having received socio-economic assistance, what was their inclusion in any of the socio-economic services in the Ushindi health zones (VLSA, social fund, and literacy program)? Have they experienced a socio-economic hardship as a survivor? Are there other needs we have not met? How can we prevent/avoid stigmatization? Having been included back in the community are they more or less vulnerable to SGVB?
7. For communities that have benefited from Ushindi Services has there been any impact on the prevalence of SGVB?
8. What is the impact of literacy clubs, youth clubs, foster families, campaigns and VLSAs?

Evaluation Geographic Area

Due to security concerns, the evaluation covered three of the current seven health zones. The design was closely coordinated with IMA and its partners. The health zones that were included in this evaluation can be seen in Table 4.

Table 4: Impact Evaluation Health Zones and Health Areas

Province	Health Zone	Health Area
Ituri	Lolwa	Bahaha
		Lolwa
	Komanda	Mangiva
		Komanda
		Bamande
Nord Kivu	Lubero	Baraka
		Kasima
		Mulo
		Kasalala
		Lubero

Design

This impact evaluation employed a mixed methods quasi-experimental design, which included the following methodologies:

- An extensive desk review
- Semi-directed (qualitative) interviews with key informants such as sexual violence survivors, healthcare personnel, and members of literacy clubs, youth clubs and VSLA)
- Quantitative analysis of programmatic data collected over five years
- LQAS assessment of opinions and attitudes around SGBV

The desk review included the quarterly and the final program reports, external evaluation reports, national gender statistics, national protocols, and peer-reviewed literature and grey literature with regard to SGBV in Eastern DRC.

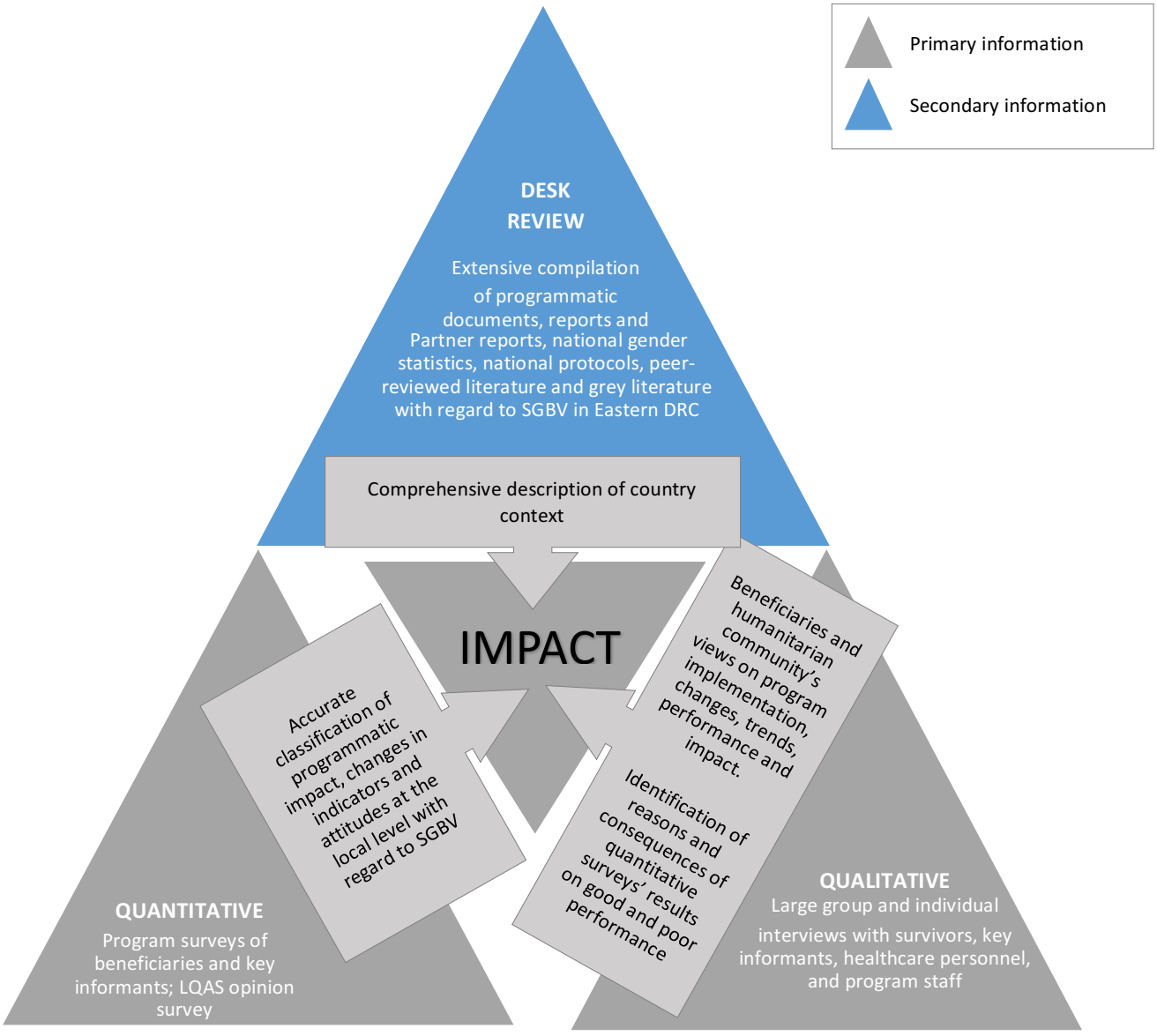
The qualitative method was designed to provide an in-depth, contextualized understanding of the dynamics of change from the perspectives of program beneficiaries, communities, program implementers, and providers, among others. The qualitative methods included KIIs with 251 respondents (Annex I) The survey questionnaires and semi-directed KII instrument used during the evaluation can be found in Annexes II-IV.

Program data was collected over the five years of the project. These data were entered into databases by local contractors from DRC. Approximately 79,000 data sheets were handwritten over the course of the project and required on-line entry. Quantitative analysis of programmatic data collected over five years was used to examine impact for the various arms of the program.

The LQAS methodology was used to examine temporal changes in key outcome indicators between the baseline and endline for rape attitudes and myths. To ensure comparability of findings, the quantitative methodology used the same survey instrument and sampling frame during the baseline and endline data collection but limited the questions to relevant attitudes and myths.

All of these methodologies used in concert were to aid in understanding the nuances of programmatic impact in addition to triangulation of data across methodologies (Figure 2).

Figure 2: Methodologies utilized for the quasi-experimental impact evaluation of Ushindi



Evaluation Team

The team included Lynn Lawry MD, MSPH, MSc, Team Leader; Joseph Ciza, IMA NGO Program Coordinator; and Milka Kavera, Director of Programs /PPSSP. Dr. Lawry and Mr. Ciza carried out the KIIs in addition to four data collectors hired to focus on survivor interviews. The LQAS survey was carried out by Mr. Ciza. Logistical and administrative support was provided by IMA staff based in Goma, the home office for IMA, and with the local partners in each health zone. The team selected the interviewers and data collectors on the basis of their skills, experience in conducting surveys, and knowledge of the local language/dialect of the survey sites. Once in the health zones, the survey team divided into three sub-teams (survivor interviews, KIIs and LQAS interviews) in order to maximize the geographic reach of the evaluation study. All questionnaires were conducted in French or local languages. In each health zone, a new team of data collectors and interviewers was selected to ensure that the data collection team had local citizens who knew the local languages and cultures. The data collection period was from May 15-31, 2016. This report was written by Lynn Lawry MD, MSPH, MSc, OSC.

Sampling Strategy and Data Collection

Document Review

The evaluation team reviewed various documents from IMA and its partners, including the LQAS baseline survey conducted by a consultant in 2012, quarterly/annual reports from 2010-2015, external evaluation reports, national gender statistics, national protocols, and peer-reviewed literature and grey literature with regard to SGBV in Eastern DRC. The document review provided a foundation for understanding for the evaluation. The key informant interview instruments were designed based on evaluation questions. The documents were used to assess the coverage and the extent of project interventions and implementation during data analysis and triangulation.

Attitudes and Myths Survey

The LQAS method was used to select community members for a community survey of a select set of attitudes and myths. Selective and modified Rape Myth Acceptance Scale[29] questions were used to assess the change in attitudes at the community level for comparison of these data to baseline. The survey was administered across three "lots" or health zones, which reflect three implementation areas of Ushindi. For the selection of the sample, the LQAS sampling framework originally included a random selection of approximately 19 community members for interviews in each health zone (Komanda, Lolwa and Lubero) across each health area where the project is implemented. These data were collected to compare to the 2011 baseline. All questionnaires were conducted in French or local languages.

Key Informant Interviews

All consenting and eligible survivors at each safe house or clinic were included in the study. A total of 251 semi-structured in-depth interviews were conducted in all three health zones with: survivors, healthcare personnel, police, lawyers, program staff (national and international staff), local and traditional leaders, and community members (Table 5). A list of interviewees is found in Annex I. The key informant interviews were conducted in Kiswahili, Nande and French and translated into English and transcribed for subsequent analysis. Interviewees were selected via convenience and snowball sampling.

[29] See: Payne, Lonsway, & Fitzgerald, 1999; McMahon & Farmer, 2011 and Ushindi Baseline Evaluation 2011.

Table 5: Number of Key Informant Interviews by Type

Type[30]	Total No.
Survivors	74
LQAS Community	57
Community Members	23
Key Informants	12
Legal	6
Counselors and Psychologists	6
Healthcare Workers	11
Foster parents	6
***Noyaux Communautaire* members**	28
VSLA members	19
Literacy beneficiaries	6
Youth club members	22
TOTAL	251

Beneficiary Quantitative Data

Partner organizations collected data on paper-based forms for each part of their project. Over the course of three months, data was entered by a consultant group which included data entry of more than 79,000 data sheets, data cleaning and submission of data files in Excel format. Data included demographic information, incidents, program resources used, and outcomes. Each arm of the program had separate forms for data collection. Specific variables were used to triangulate qualitative data collected for this impact evaluation.

Human Subjects Protection

The program evaluation research was conducted in accord with the Declaration of Helsinki, as revised in 2000.[31] Every effort was made to ensure protection and confidentiality and to reduce any potential adverse consequence to the participants. Participants, ≥18 years of age or emancipated minors, did not receive any material compensation and were informed of this in the consenting process. Children interviewed in the youth clubs were interviewed in the presence of parents or teachers. All participants were informed that participation or lack thereof would not affect their access to or the quality of the care they receive, and were explicitly given the right to refuse participation. Respect for the right of all respondents, especially survivors', to confidentiality was a central principle guiding the design and implementation of the study. Particular care was taken to ensure that survivors only participated in the field research having first given their informed consent and that their best interests were safeguarded. At no time during the research was the name of a respondent recorded; individuals are identifiable only to the study team by the transcript code number. All information provided by survivors and other key informants during the interviews was confidential to the study team. Findings and interview statements cannot be directly attributed to any individual.

[30] For gender breakdowns of each category, see Annex I.

[31] Declaration of Helsinki. http://www.wma.net/en/30publications/10policies/b3/. Program evaluation, especially with unidentifiable data and questions that relate to programming is exempt from IRB review as per DHHS 45 CFR 46.101(4),(5). See: https://www.hhs.gov/ohrp/sites/default/files/ohrp/policy/ohrpregulations.pdf.

Training of the Data Collection Team

For the quantitative and qualitative components of this evaluation, the training goals included the following: appropriate and accurate introduction and explanation of purpose through a consent statement, complete and accurate questioning and corresponding accurate documentation, ability to illicit information about private, shameful and/or traumatic events in a warm and respectful manner, correct and simple explanation of terms and probing for more complete answers, and the ability to accomplish the above in a rapid fashion while maintaining warmth and respect. Training for the four data collectors were held in Komanda (n=2) and in Lubero (n=2). Due to the previous research/evaluation experience and the number of the selected data collectors as well as the simplicity of the qualitative instrument, training included a 2 hour training for presentation of key terms, concepts, and procedures, item-by-item review of interview questions. Data collectors were supervised at each site and questionnaires were reviewed for completeness at the end of each interviewing session at safe houses and/or clinics. Feedback was given to eliminate systematic errors. The data from the paper questionnaires were computerized using Access by the lead researcher experienced in data entry. Data cleaning and post-data entry coding were also part of the data quality assurance procedures.

Data Entry

Data were collected from March to July 2016. Twenty-one data clerks were recruited from a pool of ~30 tested and were trained by the Kinshasa-based team who designed the original collection tool in 2011. All data collectors underwent an extensive period of training in data collection and methodology. A team of four supervisors oversaw the data collection process. Data from the field was collected using the government data entry protocol for SGBV (Système de gestion des informations sur la violence sexuelle basée sur le Genre GBVIMS) http://gbvims.org/contacts/ .

Figure 3: Manuel des Procedures de Collecte des Donnees sur les Violences Sexuelles et Basees sur le Genre

The protocol was updated in 2013 Manuel des procédures de collecte des données sur la violence sexuelle et base sur le Genre version finale; Kinshasa 2013; Ministère du Genre, de la famille et de l'enfant.
Data were entered by two teams, one in Goma and one in the city of Bukavu. They entered the data on pre-printed data entry forms on laptops via a Java-based entry system. At the end of the day the data entered was collected from each laptop and exported into a central data bank. Supervisors did regular proofing to review the data and check for mistakes. Any mistakes found were corrected and clerks were instructed on how to correct the error.

The Java System used to input data was developed by a team of national software consultants at the start of the Ushindi Project. The software is proprietary and labeled Ushindi 2.0. Once entered, data was exported from the Java Platform into Microsoft Excel.

A total of 79,000 data questionnaires were entered by the data clerks (1.5% were reentered by

supervisors). The continued improvement of the DRC/GBV national protocol during the project life effected the variables (the number of variables increased from 2010-2013). Data entry sheets were modified to accommodate those changes; and in some cases data for certain variables were only available for the latter half of the program.

Ushindi used a data coding system (identic unique codification) which also had to be adjusted as variables were added. The solution was to create a list of additional digits related to supported health zones. Some data sheets did not have unique code, and we created a conventional code following some survivor's information and his/ or her zone of origin.

Data Analysis

LQAS Assessment of Attitudes and Rape Myths

All quantitative data analysis was performed using the survey module within the statistical software package R.[32] Baseline and endline survey data for attitudes and myths (LQAS) were appended to create a combined Excel database for pre/post attitude comparison analysis. To make comparisons between baseline and endline on attitudes and rape myths, the minimal number of correct responses required for a lot[33] (n=19) to pass was established based on the average proportion of those (all lots from all three health zones) who responded correctly to each statement at baseline. The proportion of correct responses was calculated and compared to that threshold. (Annex VI). A lot was considered to have failed if the proportion of favorable responses fell below the threshold, barely passed if the proportion was within 2% above the threshold and passed if the proportion was at least 2% above the threshold.

Survivor Data

Analysis of the programmatic survivor data indicators focused on descriptive statistics and impact outcomes, for example, the number of survivors by year receiving care before 72 hours. All data for this analysis came from intake forms filled out by service providers from the different Ushindi components.

For each survivor encounter, a series of intake forms were filled out - a general information form, a sector-specific form and when necessary, referral and follow-up forms. The general information form was the same across all sectors. For each new encounter, the java system was designed to collect information from the general information form and the sector specific form only. When downloading the data, there were five different datasets one could download:

1. **Incidents**– A compilation of all the general information forms, but nothing from the sector-specific forms
2. **Medical** – Information from medical-specific form and some information from the general information form
3. **Legal** – Information from legal-specific form and some information from the general information form

[32] Lumley T. Survey Analysis in R. http://faculty.washington.edu/tlumley/survey.

[33] A "lot" included 19 surveys within a health zone across all of the accessible health areas. For example, for a particular statement, the average correct response was 60%, then for each lot of 19, the threshold was set to at least [(60%x19) - 2] of those favorable responses. In this case that number was 9 which becomes the decision rule; 9/19 is 47.3%, therefore if the average coverage for a particular lot fell below 47.3% then it was said that the lot failed. If the average coverage for a particular lot was between 47.3 and 49.3% then it was said that the lot "Barely Passed".

4. **Psychosocial** – Information from psychosocial-specific form and some information from the general information form
5. **Socio-Economic** – Information from reintegration-specific form and some information from the general information form

Analysis involved the calculation of population proportions and Wald confidence intervals for the entire period of the project and broken down by year. For results broken down by year, a regression of the characteristic of interest on year was performed and p-values for the trend were calculated using Wald test of association: $p<0.05$ was considered significant.

Qualitative

Qualitative information collected through semi structured interview guides (KIIs) were recorded onto a word document whereby themes were coded, analyzed and used to add nuance to the quantitative data. *A priori* themes were not developed prior to the study. When data saturation occurred within one area, further interviews within a key informant group were ended. In analyzing the qualitative information, the aim was to identify common themes and convergent and divergent ideas in the transcribed documents. The qualitative analysis processes included summarizing, categorizing, and constantly triangulating the various sources of information. A thematic analysis of these qualitative data was conducted by examining frequencies of specific responses to the various evaluation questions, and dominant themes were then calculated and/or used as quotes to supplement the quantitative data findings. A list of interviewees is found in Annex I.

Limitations

The impact evaluation could only employ a non-experimental design. A causal relationship cannot be determined using this methodology. The non-experimental pre/post intervention evaluation LQAS design does not account for non-project influences on outcomes such as other SGBV project in the same health zones. Baseline/endline comparisons can be influenced by confounders, although these were minimized by using the same survey instruments, survey teams, and sampling frames. To improve the comparability and reliability of endline survey data, the same instrument designed by IMA was utilized, however a select and more relevant set of variables were assessed for comparison (attitudes and rape myths). The time period between baseline and endline, especially for behavior change, was only five years and could decrease any behavioral differences observed although many of the rape myths and attitudes identified at baseline were not part of SBCC campaigns.

Information on practices, attitudes and behaviors among respondents may be subject to social desirability bias. Halo bias may be a factor since respondents might have reported what they should do/think instead of what they actually do/think. The approach that would introduce the least amount of interviewer (and respondent) bias was to employ local field personnel; thus local data collectors familiar with local language and culture were utilized. Data collectors were supervised throughout the study with supervisors in the field at all times. Although data collectors were careful to explain that there will be no material or other gain by participation in the assessment, respondents might have exaggerated or underestimated responses if they believed it would be in their interest to do so.

In some instances (e.g., when interviewing beneficiaries), responses might have been constrained due to fear of reporting or stigma such as with questions around SGBV. However, based on our qualitative study, it was noted that SGBV was normalized and responses were less likely to be constrained. Although it is possible that differences within the interviewer due to ethnicity, sex, or overall comfort level during the interview could bias the results, this was mitigated largely through the use of local data collectors, properly trained in interviewing techniques who did not interview in areas they are familiar with. Individual semi-structured qualitative interviews represent individual experiences of those most willing to speak, and cannot be generalized beyond those interviewed.

During data cleaning and analysis, some of the survivors appearing in the sector-specific datasets were not in the incidents dataset indicating that the Incidents dataset was not a complete compilation of all those who had accessed Ushindi services. Between 2010 and 2015, the intake forms used to collect the data were revised twice and the java system updated accordingly. Each time the system was updated, data entered up until that moment was downloaded and archived. The final dataset used for analysis was a compilation of all the datasets. Missing data was due to an error in compiling the different datasets. To update the Incidents dataset, we successively added to the Incidents dataset survivor information from each sector-specific dataset for those survivors who appeared in the sector-specific dataset but not in the Incident dataset.

Some of the analysis that needed to be performed required merging all of the datasets. For instance, to look at the proportion of people presenting for medical services within 72 hours of the incident, the medical visit date and incident date were needed, however, the medical dataset included the visit date but not the incident date. Furthermore, the incident dataset provided a visit date and incident date. Because this dataset did not distinguish between medical, legal, psychosocial and socio-economic services, it was not clear what Ushindi service the visit date referred to.

When merging the sector-specific datasets to the Incidents dataset based on information, there were matches for less than half of the survivors in the Incidents dataset. The difficulty with merging the datasets in this way revealed that for the same survivor, the general information part filled out by all service providers was not always identical. This required merging datasets by survivor code only. Merging the datasets this way led to the creation of duplicate data. For instance, a survivor who appeared in the Incidents dataset twice (reporting two different incidents of sexual violence) but in the medical dataset only once (the survivor only sought medical assistance on one of those occasions) would end up with information from the medical dataset being assigned to both observations from the Incidents dataset. To remove the duplicate data, all observations with duplicate survivor codes were compared visually to make sure that the observations were indeed different incidents being reported and that information from the sector-specific forms was applied to the right observation.

Finally, this study was limited by the security within each health zone, time, and funding to complete the study. Of the seven project health zones, only Komanda, Lolwa and Lubero were deemed safe to work in at the time of the survey. In addition, curfews in each area limited the number of respondents who could be interviewed on any given day.

Findings

Evaluation Question 1

> What is the impact the Program has had on survivors of Gender and Sexual Based Violence and what impact has it had on local communities in terms of awareness and prevention of SGVB and promotion of gender rights?

Overview

During the first five years of the Ushindi project, partners provided assistance to 24,793 survivors amongst whom 89% were women and girls. To address awareness and prevention, over 20,000 group meetings were held in the first five years with the active participation of over 400,000 civilian and uniformed participants to discuss the impact of SGBV on communities.

Community structures supported by the Ushindi Project included 108 youth clubs (with 30,000 participants), 108 *Noyaux*, 415 VSLAs, 9 child protection networks (RECOPE) and 26 women-led Income Generating Activities/Community Based Organizations (IGA/CBOs). These groups collectively organized over 100,000 mass community awareness-raising sessions in villages over the first five years, including during international commemorative days. According to data taken from the Ushindi Five Year Report, essentially all people in the catchment area were reached by one session or another, including the participation of nearly 50,000 community leaders and over 200,000 students.[34]

Qualitative Findings

Impact on Survivors

One of the biggest achievements for the project was in its ability to facilitate recovery from sexual violence under extremely trying circumstances. Of the 74 survivors interviewed, only 5% did not use any of the services and 16% (n=12) did not know what services were used, the remainder interviewed (95%) used one or more of Ushindi services. These included 10/12 survivors under the age of 17 years and the remaining two of age 30 years. One survivor stated she used "all" of the services.

Survivors were asked how the Ushindi programs directly helped them in general and in recovery. Of the 74 survivors interviewed, the majority stated that medical and psychological services (58%) were the most commonly used services.[35] Three percent mentioned that only VSLA helped them and another 3% stated literacy was what directly helped them.

Ushindi services were well regarded by survivors who felt comfortable when presenting to care and felt there were attitude changes in the community and how survivors were perceived:

> *"…I received treatment from them and when I presented myself there, I was really*

[34] Ushindi: Overcoming sexual and gender-based violence in Eastern D R Congo – Cumulative Report First Five Years (Ushindi Five-Year Report), 23.

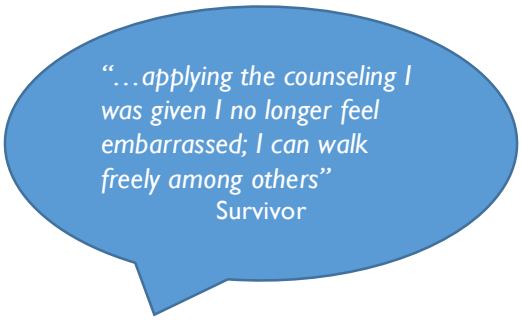
[35] Medical alone 12%, medical and psychological services combined 19%, psychological alone 20%. Another 3% stated that medical/psychological and VSLA were helpful, whereas 4% included medical/psychological/VSLA as helpful.

welcomed"

"Before whenever a person was raped, people would laugh at her. We didn't know that these people could work together and could build something together. But now we are unified thanks to Ushindi"

"It helped me in a way I could feel good in the community, at church and with friends"

Survivors were also asked how the services helped them to recover. For the majority (98%), the psychological services (primarily from lay counselors) were mentioned directly as one of the most important services that helped them recover:



"I needed treatment…I got pregnant from the rape and then when I had the baby, it died five days later. The counseling helped"

"…the project has helped me begin new activities because I was overwhelmed by my problems"

"The counseling given through was and is still helping me. I really appreciate this project and I encourage them to continue helping because there are a lot of sexual violence cases"

"I used to think a lot. The incident kept coming through my brain and I had no peace but helped me through…"

"…counseling, because I was tormented. The counselor took enough time to counsel me"

"…through their counseling and mostly through their follow up because without them I wouldn't be where I am today"

Awareness Impact on Communities

During the first five years, members of different supported community groups (local SGBV committees/*Noyaux*, youth clubs, Réseau Communautaire de Protection de l'Enfance (RECOPE), VSLAs and other local organizations), with the support of the community mobilization advisors and the lawyers attached to the legal clinics, led many participatory communication sessions for Strategic Behavior Change Communication (SBCC), via forums and focus groups. These sessions analyzed the root causes of SGBV, the needs of survivors and the path to solutions, each according to the local context in the HZs. Themes were debated regarding myths surrounding sex, gender equity and GBV and practical theories of change were discussed. Some of the theories of change discussed included defining positive roles of both men and women in facing social norms that perpetuate violence within clans as well as at household and work place levels. These are themes that have been known to be associated with

positive change that increases women's and men's engagement in solid partnership for lasting peace and development.[36]

Key informants were asked about changes in attitudes in the community regarding SGBV and how the Ushindi Project facilitated these changes. A *Noyaux Communautaire* member in Baraka HA – Lubero HZ stated:

> *"…even soldiers are punished now; husbands don't force their wives to have sex and women can negotiate sex"*

Another member in Kasima HA – Lubero HZ stated the following:

> *"As men have come through sensitization, it has brought changes to us; first, we don't force our wives to have sex, and second, we have better family planning as a result. Women do not have babies every year"*

Youth Club members told researchers that:

> *"We believe attitudes of parents have changed because our parents are not beating us anymore and child rights are no longer violated. Parents no longer mock us"*

Finally, the following is an indicator that sensitization has had a positive effect on communities:

> *"Ushindi has helped change community behavior, early marriages have decreased and no longer does the community accept that violence is normal"*

LQAS Attitude and Myth Explanations

During the LQAS survey, participants (n=80) were also asked to expand on the reasons for agreeing or disagreeing with statements that reflect rape myths.

When asked why respondents agreed that raped women do not deserve to be raped, respondents (91%) stated the vast majority of rape survivors have been forced and subjected to death threats by attackers carrying weapons which reflects the context of numerous armed groups in all three health zones.

Regarding the myth that women entice men to rape, nearly two-thirds (63%) of respondents did not agree with this statement. However, it should be noted that a third (31%) stated that women and girls are raped because they "exposed their private parts to men." Some explained that this may happen with alcohol and drug use but they stood fast in their belief that women can, in some circumstances, entice men to rape.

Ninety percent of respondents stated that armed groups were not the only perpetrators. They concurred with survivors that armed groups who do use rape generally hide in the forests and commit rape against women and girls during the nights they raid villages, when women are walking back from the fields, and while they are searching for wood in the bush. They also stated that they are aware that there are perpetrators in the community (not associated with armed groups) in addition to these armed groups.

Seventy-four percent of respondents agreed that if a woman really didn't want to be raped she could fight off the attacker. This was more common in urban areas in Lubero, Kipese and Komanda where

[36] Ushindi Five-Year Report, 19, 23-24.

prostitution was a prominent feature of the areas.

When respondents were asked if a spouse owes the other partner sex no matter what the circumstance, 67% of men and women disagreed. Some of the respondents shared that if a woman was tired, breastfeeding or just post-partum, then she would not be expected to have sex with her partner. However, 23% agreed and stated that a woman "must obey and love husband" and therefore does not have the right to refuse sex regardless of the circumstances. They did caveat this buy saying that if she is gravely ill then perhaps she would be forgiven. These respondents stated they had not participated in any awareness training.

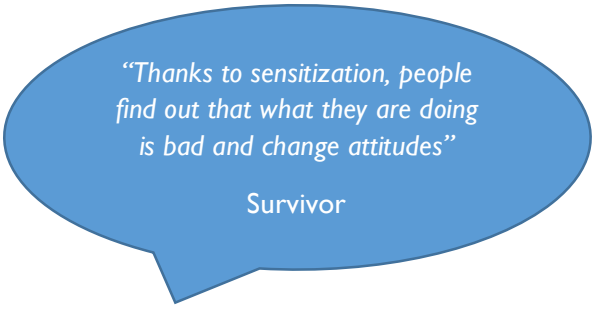
Two-thirds of respondents agreed that survivors of rape are innocent victims, however, 23% believed otherwise. These respondents stated that women tend to put themselves in risky situations such as "drinking alcohol with strange men" or "exposing themselves" such as wearing tight clothing.

In all health areas and especially among respondent women, 41% stated that women should not report rape in order to protect their dignity and their reputation especially to their neighbors and colleagues. The culture of silence is strong in communities. Lawyers and police interviewed stated that they feel the silence is due to a fear of humiliation and rejection of relatives but impunity and lack of compensation for survivors may also play a role in the need to stay silent.

What women wear provoked opposite responses based on gender. More than half (53%) of women and girls agreed that rape is not provoked by their appearance or what they wear. Whereas 40% of men and boys argued that rape is most definitely dependent on physical appearance and the woman's behavior. Close to half of respondents (47%) agreed that women put themselves at undue risk by wearing short skirts or tight clothing. An even larger proportion of respondents (56%) also believed that if a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her. Some of the respondents stated this may be linked to cultures and myths about "love gestures between men and women" which are socially misinterpreted and the belief that a woman does not have a right to refuse sex.

Quantitative Findings

Attitudes and Myths



Nearly a third of survivors (29%) stated that a change in behavior and a change in attitudes had happened as a result of Ushindi. However, only 3% of survivors felt that Ushindi had decreased the number of cases of sexual violence. (See: Evaluation Question 7; Figure 15: Reasons given by survivors for a perceived decrease in sexual violence). Given the effort on changing behaviors, we assessed the impact of Ushindi on local community's awareness and prevention of SGVB and promotion of gender

rights through changes in a select set of attitudes and myths since the baseline (2012).[37] During the LQAS survey, participants were also asked to explain their responses to attitudes and myths for which they were to reply "agree" or "disagree" to as a means to triangulate data and better understand the context. Relevant comments based on further qualitative research are imbedded in this section to help put the quantitative data in context. Participants of the LQAS data included 56% women and 44% men (Table 6). The age distribution of respondents is presented in Table 7.

Table 6: Demographic Data of LQAS Participants by Health Area

Health Area	No. of Women	No. of Men	Sub total
Bahaha	6	6	12
Lolwa	4	2	6
Mangiva	3	3	6
Komanda	11	7	18
Bamande	4	4	8
Baraka	4	4	8
Kasima	7	7	14
Mulo	4	2	6
Kasalala	4	2	6
Lubero	3	3	6
	50	40	**Total 90**
	56%	**44%**	

Overall, 14% of respondents were emancipated minors. The vast majority of respondents were adults represented by the age groups of 18 to 25 years (39%); 28% aged 26 to 35 years, 10% ages 46 to 55 years and 9% for those in the group between 36-45 years.

Table 7: Age distribution among LQAS respondents

Age distribution, years	n	%
15 -17	13	14%
18 -25	35	39%
26 -35	25	28%
36 - 45	8	9%
46 -55	9	10%
n/Percent	90	100%

Among the beliefs regarding rape myths, the respondents, both during baseline and follow-up and in three health zones, understood that rape is not deserved, women are victims, more than just soldiers can rape, a spouse does not "owe" her partner sex, and when women say no they mean it (Table 8).

In Lolwa, compared to Komanda and Lubero and from baseline, attitudes improved whereby more respondents now understood that no means no, that rapes do not happen because women entice men, women do not claim rape to protect their reputations and prior sex has no bearing on claiming rape.

[37] See Methodology for a review of the LQAS methods used to assess these changes.

There were, however, some regression in attitudes and myths from the baseline assessment. Respondents in Komanda and Lubero believe that if a woman didn't want to be raped, she could fight off her attacker. In Lolwa, respondents believe that a woman can enjoy sex even if it is forced and in all three health zones, it is believed that a woman can provoke rape by what she chooses to wear and that women were also responsible for rape.[38] In Lubero, respondents, since baseline, agree that revealing clothing can provoke rape.

Overall, Lolwa, of all the health zones, had significant improvements in attitudes regarding rape and minimal regression, whereas Komanda and Lubero had more regression in attitudes from baseline. Myths associated with victim blaming were commonly agreed to by both men and women.

Table 8: Changes from baseline in attitudes and myths regarding rape in Komanda, Lolwa and Lubero

Statement	Health Zone	Pass/Fail 2016	Pass/Fail 2011	Compared to Baseline
In most cases when a woman is raped she deserved it[a]	Komanda	P	NA	-
	Lolwa	P	P	U
	Lubero	P	P	U
Women who say no to sexual intercourse often mean yes	Komanda	P	NA	-
	Lolwa	P	BP	I
	Lubero	P	P	U
Most rapes happen because women entice men	Komanda	P	NA	-
	Lolwa	P	F	I
	Lubero	P	P	U
If a woman really didn't want to be raped she could fight off the attacker	Komanda	F	NA	-
	Lolwa	P	P	U
	Lubero	F	P	R
Only soldiers can rape	Komanda	P	NA	-
	Lolwa	P	P	U
	Lubero	P	P	U
A spouse owes the other partner sex no matter what the circumstance	Komanda	P	NA	-
	Lolwa	P	P	U
	Lubero	P	P	U
A woman can enjoy sex even when it is forced upon her	Komanda	P	NA	-
	Lolwa	F	P	R
	Lubero	P	P	U
A raped woman is	Komanda	P	NA	-

[38] It is important to note that in DRC, women and men are survivors as well as perpetrators (See: Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562.). The answers represented here may reflect the known use of rape among various rebel groups in the area which have been documented to use women as perpetrators (See: Lawry L, Rosa JC, Kisielewski M, Johnson K, Scott J, Wieczorek J. The Use of Population-Based Surveys for Prosecutions at the International Criminal Court: A Case Study of Democratic Republic of Congo. International Criminal Justice Review. 2014; 24:1 doi:10.1177/1057567714523982.

usually an innocent victim	Lolwa	P	P	U
	Lubero	P	P	U
Women often claim rape to protect their reputations	Komanda	P	NA	-
	Lolwa	P	BP	I
	Lubero	P	P	U
Women who have had prior sexual relationships should not complain about rape	Komanda	P	NA	-
	Lolwa	P	BP	I
	Lubero	P	P	U
Women do not provoke rape by their appearance or behavior	Komanda	F	NA	-
	Lolwa	F	F	U
	Lubero	F	P	R
Men, not women, are responsible for rape	Komanda	F	NA	-
	Lolwa	F	P	R
	Lubero	F	P	R
Women who wear short skirts or tight shirts are not inviting rape	Komanda	P	NA	-
	Lolwa	P	P	U
	Lubero	F	BP	R
If a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her	Komanda	P	NA	-
	Lolwa	P	P	U
	Lubero	P	P	U

[a] For data and decision rules, see Annex VI

P = pass; F = fail; BP = barely passed; U = unchanged, I = improved, R = regressed; NA = not applicable

Evaluation Question 2

For survivors, what is their knowledge of a support structure (*Noyaux Communautaire*, Safe Houses, Counselors, legal assistance[39]) and who they would go to for help?

Noyaux Communautaire

Overview

The 108 *Noyaux Communautaires* are the driving force behind success and cost effectiveness where voluntary community leaders have played a significant role in "owning" activities. They are crucial to community ownership and sustainability. They function to educate the community through SBCC messaging to raise awareness about the fight against SGBV, family planning services, and the search for peace, social cohesion, and development in their communities. A primary role is the identification and referral of potential victims. They also hold meetings committed to parenting skills to benefit over 20,000 community members in sharing their experiences and responsibilities as parents, as well as those

[39] Legal Services: See Evaluation Question 5.

of their children, in order to reduce violence within the family and with neighbors.

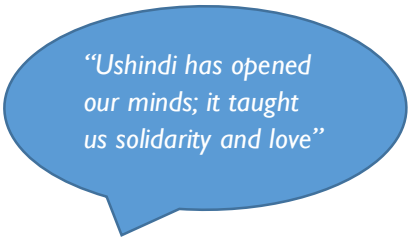
Each health area has a *Noyaux* in all villages within the health area and are constituted of approximately 25 local leaders from all layers of local society, including schools, churches, women's groups, traditional leaders, local authorities and any other local community organization. In general, 10,000 to 15,000 people are covered by each *Noyaux*.

Qualitative Findings

Survivors

Seventy-seven percent of survivors know of and utilized the Noyaux in their health area. The remaining 23% stated they were not aware of the *Noyaux*. On average, these survivors were younger than those who were aware of the *Noyaux* (average age 22.6 years vs 24.4 years). Overall, survivors relied on them for referral to medical or psychological care, VSLA and for finding the funding for medical care. Many mentioned that they knew of the sensitization that was done in the community by these groups. One survivor stated:

> *"I know that once a girl has experienced the case of sexual violence the Noyaux Communautaire is ready to receive her"*



Members of the Noyaux

In interviews with *Noyaux* members, they were consistently able to describe the sensitization (SBCC) projects they were doing and how they helped survivors. The groups interviewed were a mix of male and female members including survivors, traditional leaders and healthcare personnel. Noyaux shared some of their feelings on the SBCC efforts such as:

> *" …[Since Ushindi] now women come to care and do not hide themselves"*[40]

> *"As men have come through sensitization, it has brought changes to us; first, we don't force our wives to have sex, and second, we have better family planning as a result. Women do not have babies every year."*[41]

> *"This issue [SGBV] was taboo and hidden but now with Ushindi, they [survivors] come on their own"*[42]

All of the groups stated they needed SBCC materials, money to get to further health areas, goods such as machetes to get through the bush, motorcycles, and new uniforms.[43] After considerable time with the members, funding for themselves was brought up. Although they assured researchers they would

[40] Baraka HA member.
[41] Baraka HA member.
[42] Senior nurse and *Noyaux* member, Baraka HA.
[43] All the *Noyaux* stated the t-shirts had "worn out" over time.

continue with the programs, they also verbalized:

> *"My wife asks me why this job is not paid"*[44]

> *"I have to support my family and taking time to do this job does not get fields planted or money in my house"*[45]

When the members were asked about sustainability the most common responses were:

> *"…we were working on a plan, we don't need to worry about that now because Ushindi will continue"*

> *"We have discussed this but to this time, it is not realized"*

None of the members and or groups interviewed could present a sustainability plan of action.[46] Most were resistant to questions of such, claiming that "USAID [would] continue to support them for another six years so there was no rush to come up with a plan for sustainability."

Safe Houses

Overview

Over the course of the project, nine safe houses were established, stocked with food, supplies and fuel in order to provide care for SGBV survivors and to facilitate program supervision and reporting. At these sites, legal and psychological resources were readily available for survivors. Safe Houses were marked from the road, leaving those who wanted to remain more anonymous hindered in their ability to access this resource.

Qualitative Findings

The vast majority of respondents knew about safe houses. For example, 85% of survivors stated they had heard about or knew about the safe house in their area. Four percent had no response and of those who stated they were unaware of the safe house (11%), half of those stated the lay counselor in the community told them about the safe house and urged them to go to receive care. Those who were unaware of the safe house, on average, were younger (average 17.6 years) versus those who knew about safe house (25.6 years) and used the safe house for medical and psychological care as well as for receiving non-food items such as clothes, blankets and money for food and medical care. One of the survivors stated:

> *"When I was raped, I came directly to the safe house that helped me with medicine to remove germs [infection] that I received from the person who raped me and I benefited from the alphabetization programs"*

Among the interviews, and of those referred from the community, most of the survivors were referred from the community lay counselors who were part of the *Noyaux Communautaire*.

---

[44] *Noyaux* member Bahaha HA.
[45] *Noyaux* member, Mangiva HA.
[46] The Bahaha health area *Noyaux* claimed to have had a sustainability plan, however, Mado (the elephant that is in the bush) "ate our plan".

Counselors

Overview

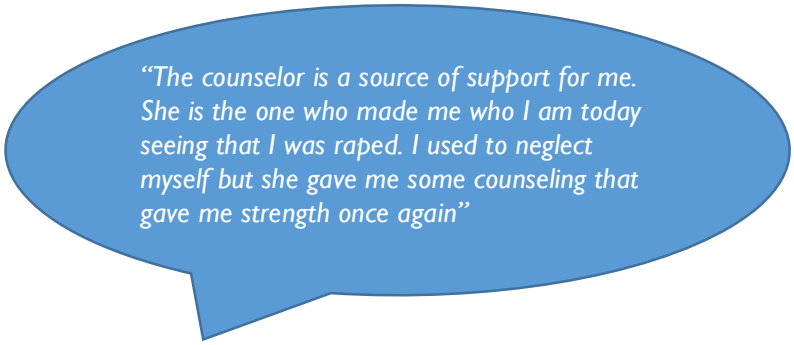
Lay (community) counselors have been a critical factor behind Ushindi's cost effectiveness and ability to reach such a large number of survivors. Locally respected women (and in a few cases, men) who are mostly volunteers[47] and are not dependent on other structures[48] have served communities to provide a local, safe source that survivors felt comfortable interacting with.

A total of 24,526 survivors received psycho-social support out of 24,793 survivors for a coverage of 99%. The psycho-social case reports indicate that 96% of these cases received active listening and counseling, 80% had home visits and 9% were supported with family mediation for more effective reintegration. Others received donations of food and non-food item to resolve social issues.

There are currently 76 psycho-social agents[49], supervised by three clinical psychologists. The majority of assisted people presented different signs of stress and trauma due to sexual violence and other forms of GBV.

The therapy includes a combination of various therapeutic methods such as active listening and counseling, relaxation exercises, occupational therapy, home visits, and family mediations. These therapeutic methods have resulted in an average of two thirds of the survivors declaring (and as witnessed by the psycho-social counselors) that they had recovered psychologically and had reintegrated socially. Psychological assistance was considered to be brought to a conclusion when the signs of stress or trauma had largely disappeared and the survivor was able to return to the normal activities that they had engaged in prior to the incident.

Frequent behavioral problems that the survivors experienced, and sought help for, included feelings of shame, fear or rejection, disturbed sleep, loss of self-esteem, sadness and suicidal feelings, among others. Recovery was indicated by the re-establishment of a feeling of comfort, self-confidence, peaceful sleep, the hope for a better future and especially the personal motivation to return to the everyday activities that were followed before the traumatic incident.



[47] They do receive some money for transport and other costs related to monthly meetings and documentation of their work. Efforts should be made in any future iteration of the project to reduce this further to become even closer to pure volunteerism.
[48] As opposed to community based counselors who are part of a CBO, these women are doing this on their own – usually for personal reasons to help their community – making them more independent.
[49] Previously 108 during first 4 years.

Qualitative Findings

Virtually all (77 of 78) survivors interviewed accessed psychological services. Survivors were positive about their experiences with the lay counselors, with many stating they had been following up with them

long term (more than 6 months). It was clear from the interviews that the counselors are supportive, warm, caring and helpful.

The following transcript excerpts are some of the statements made about the counselors when asked how they were helped by the psychological services available:

> *"Since I was counseled, bad thoughts that I had have changed and my health [which] is good because I was so worried, then I had peace of mind"*
>
> *"…I was traumatized by the situation of the rape, the psychosocial counselor helped me more with some advice and I was morally healed and I was able to forget what happened to me"*
>
> *"The psychosocial counselor comes very often to counsel me through her counseling she tries to make us understand the situation of rape but also she makes us forget [the rape] through the counseling"*
>
> *"She helped me a lot with advice. I wished to run away but I no longer did because of her. I live a life without too much thinking and stress because of her"*
>
> *"I live a life without too much thinking and stress because of her"*

For the one person who did not access care from counselors, her reason was as followed:

> *"I did not ask for counseling because of shame. I knew there was a group that could help me pay the bills"*

Quantitative Findings

Analysis of the database revealed the following. The 23,384 survivors who presented to care were largely women (91.3%). It was more common for single persons to present to care although the next largest category was those who were legally (as opposed to traditionally) married. Survivors were more likely to state they were Christian or animist and were farmers and/or students. The largest majority of survivors were native residents of the areas where they presented to care and the following is the order (most to least) of services accessed: psychosocial, medical, legal and socioeconomic. Full data tables with all the demographics and by health zone are available in Annex VII; Tables 1-8.

Evaluation Question 3

For survivors who require medical assistance, their knowledge of the importance of seeking medical services, the availability of PEP kits to prevent HIV/Aids, and the fact that such care is free of charge?

Overview

Ushindi's activities under intermediate result (IR1) were to increase access to quality and timely care and treatment services. Between 2010 and 2015, Ushindi partners provided assistance to 24,793

survivors amongst whom 89% were women and girls. By age group, children represented 35% compared to 65% for adults. Children between 12 and 17 years old comprised 30% of the total of all assisted survivors and 84% of all children. The findings for this question are derived from the relevant qualitative data from the KIIs and from an analysis of the quantitative data from survivor data collected throughout the life of the project.

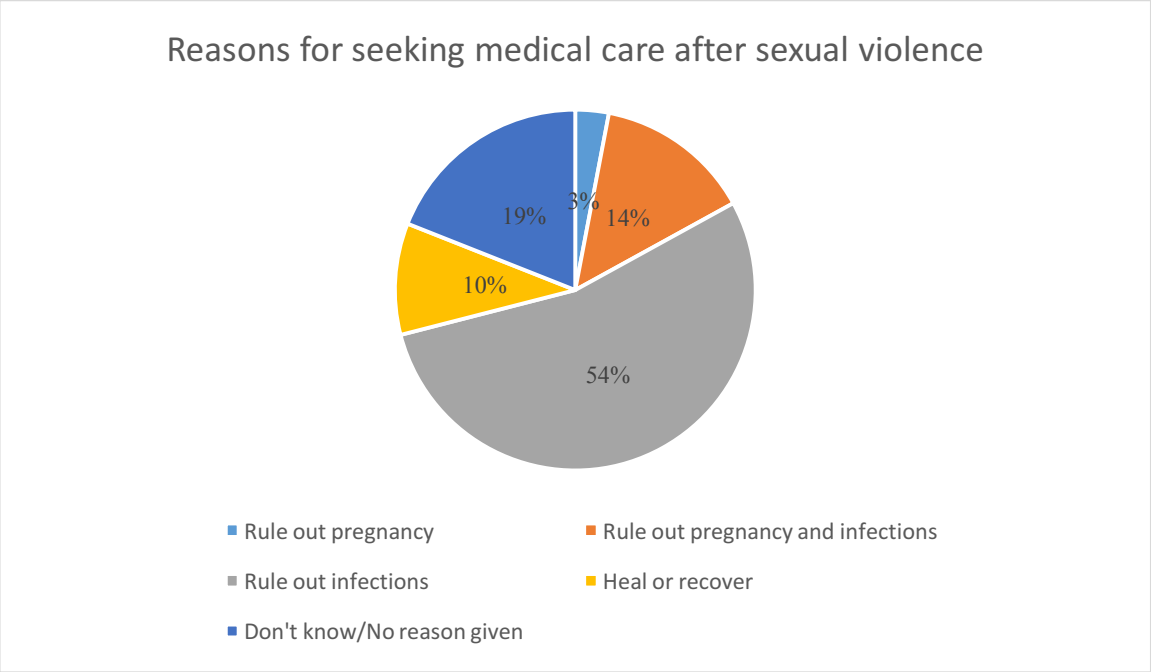
Qualitative Findings

Survivors

Survivors (n=74) were asked to comment on what to do after an incident of SGBV, asked to comment on the importance of seeking medical care, the timing of seeking medical services and the costs related to such services.

Overall, 81% of survivors interviewed sought medical care and 19% did not seek medical care. Regarding their knowledge and understanding of the importance of seeking medical services, Figure 4 shows the breakdown of responses. "Checking for pregnancy and/or infections/diseases" was the most common answer.

Figure 4: Survivors (n=74) knowledge and Importance of Seeking Medical Services after Sexual Violence



With regard to costs of medical services, 72% of respondents stated they did not have to pay anything for the services, with 11% stating they had to pay. However, these survivors initially were not seen at Ushindi supported facilities. In other facilities, costs for treatment after an incident of SGBV can cost up to 20 USD. The remaining respondents (17%) were unsure if they paid anything for their medical services. These respondents were younger than the overall age of survivors interviewed (20 years vs 25 years).

Finally, survivors were asked how soon after an incident of sexual violence someone should seek care. Just over three-quarters (76%) of survivors stated that care should be sought within 72 hours. Seven percent stated more than 72 hours, 4% within hours of an incident and the remainder (13%) did not know or had no response to the best timing of presentation to medical care after sexual violence.

Medical Providers

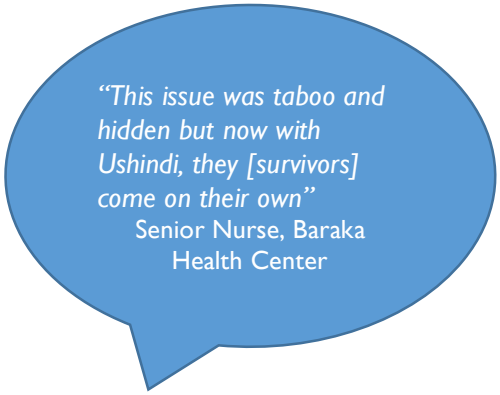
Medical providers (n=11) also commented on the positive changes in their communities regarding presentation to care after sexual violence. One provider stated:

> *"At the start of Ushindi, cases did not come to the health center in less than 72 hours. Now, 90% of survivors come to medical up to 72 hours because of the sensitization in the community by the Noyaux Communautaire"*[50]

Overall, medical providers felt that Ushindi had a positive impact on their community's knowledge and understanding of the importance of timely medical care.

> *"The population is informed [about sexual violence], medications are provided and on time for survivors and the beneficiaries are enthusiastic."*[51]

> *"Due to Ushindi, the community knows what to do if there is rape. Women even come to the health center at night if it happens at night."*[52]



Post Exposure Prophylaxis (PEP) Kits

Throughout the project, PEP kits have been supplied by IMA to participating health centers. Providers, using the National Guidelines for the treatment of survivors, dispense them to survivors if they come within 72 hours of the incident.[53] Upon talking with providers, there was some anxiety about the supply of these kits if Ushindi were to no longer support the supply.

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[50] Senior Nurse, Mangiva Health Center.
[51] Chief Doctor, Lubero.
[52] Senior Nurse, Kasima Health Center.
[53] Ushindi Five-Year Report, 14. Amongst all SGBV cases receiving medical care, 86% were rape incidents amongst which 47% arrived in less than 72 hours from the incident. Nearly 100% of cases reporting in less than 72 hours received PEP kits. Note that the 53% who reported their incident after 72 hours received Voluntary Counseling and Testing services (VCT) for STIs and HIV as well as STI treatment.

"If Ushindi did not bring PEP, I do not know how the population would be"[54]

In the five years of the project, there was a national stock-out of PEP kits from December 2013 – April 2014 due to supplier issues. During this short-period of time, only a few health centers ran out of PEP kits and several of the healthcare providers were able to send patients to other near-by health centers where kits were available. IMA was able to supply kits in May and in some cases doubled shipments in that month where needed.

Program staff[55] expressed concern that some of the PEP kits were being taken apart and pieces of the kit (such as the antibiotics) were being used when Ministry of Health supply of medications was slow or non-existent. In addition, through observation and inspection, the kits were in fact, not packaged (Figure 5) but in several health clinics were kept in a locked cabinet.

Figure 5: Unpackaged PEP Kits in a locked cabinet (Bamande Health Center; Komanda)

Another concern raised by the Chief of the Health Zone in Lubero was the expiration dates on the different drugs within the kits. No other healthcare providers raised this concern.

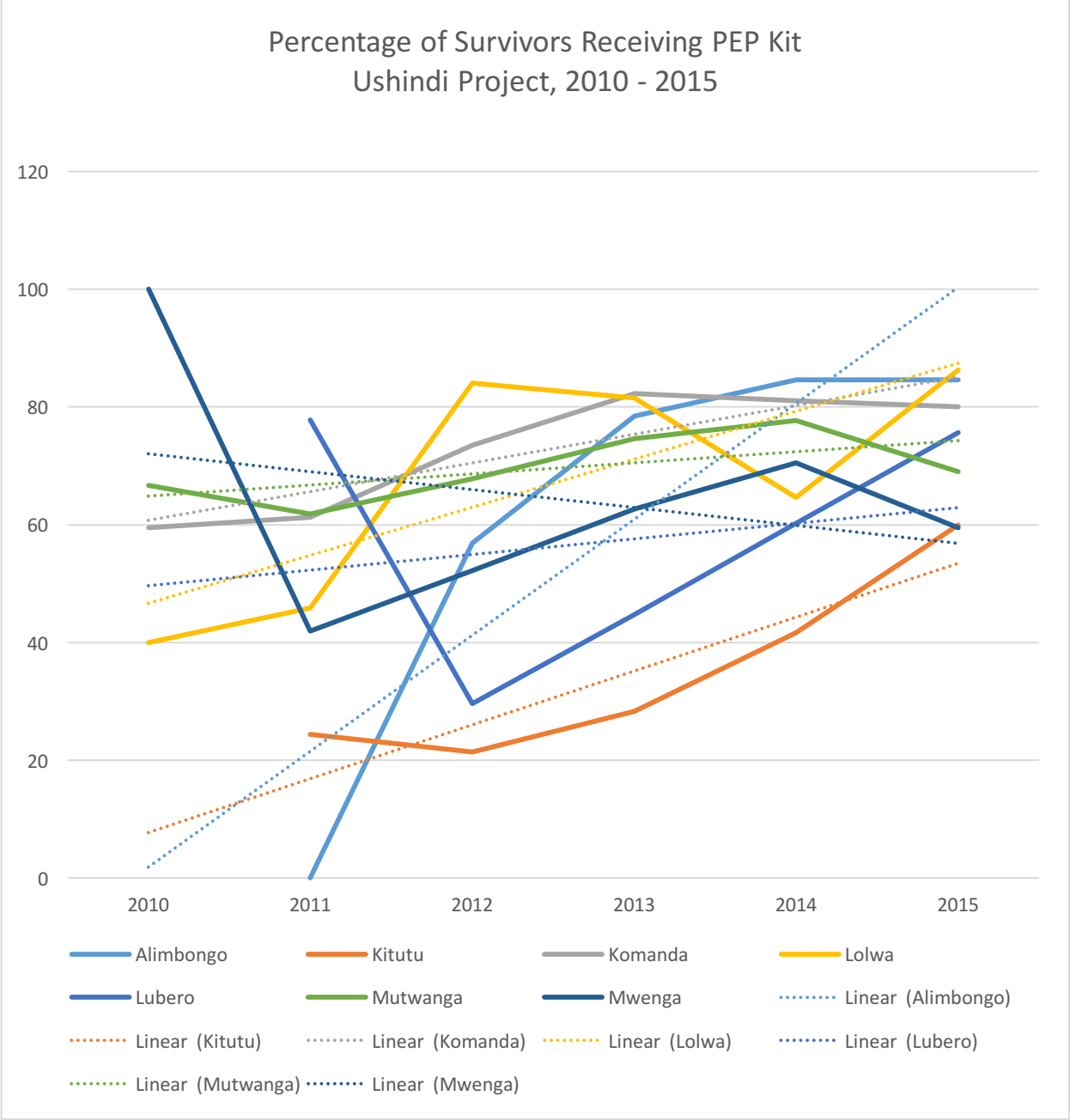
In the Kasima health center, the head nurse raised two issues. The first issue was that patients who were given the PEP kit were frequently lost to follow up. Even though they were given follow up appointments, survivors did not return. The second issue raised was a concern about perpetrators rights to health care. She felt that perpetrators were not given the same medical care as survivors and that once they were arrested, they went to prison where testing for infections such as HIV or sexually transmitted infections (STIs) was not given to them as an option.

Quantitative Findings

PEP Kit usage was assessed among survivors who presented to care within 72 hours (Figure 6). All of the health zones had an overall increase in the use of PEP kits with the exception of Mwenga (Annex VII, Table 9).

[54] Senior Nurse, Bahaha Health Center, Lolwa HZ.
[55] Dr. William Clemmer (COP) and Joseph Ciza.

Figure 6: Percentage of Survivors Receiving PEP Kits by Year

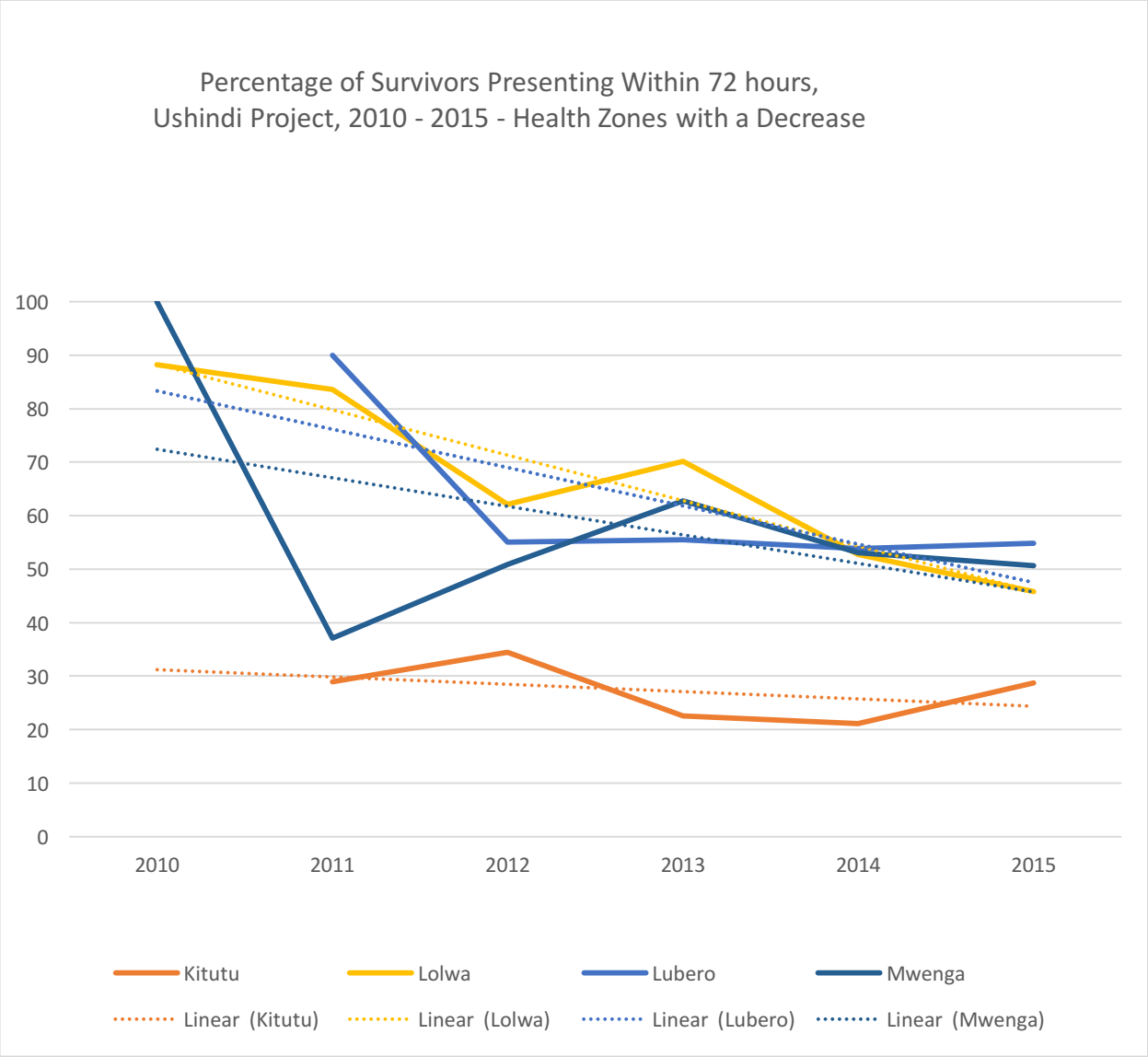


Despite the stock out period (December 2013 – April 2014), PEP kits were available and the use was unchanged for all of the health zones except Lolwa. (Annex VII; Table 10) In other words, there were no statistical differences in the use of PEP kits during or after the brief stock-out period.

The data entry forms did not have a specific question to address whether survivors presented to care within 72 hours of the sexual violence incident. Data had to be present on the date of presentation and the date of the incident to calculate if presentation was within 72 hours. It should also be noted that there is missing data due to data form problems and data entry, therefore, care should be given to any

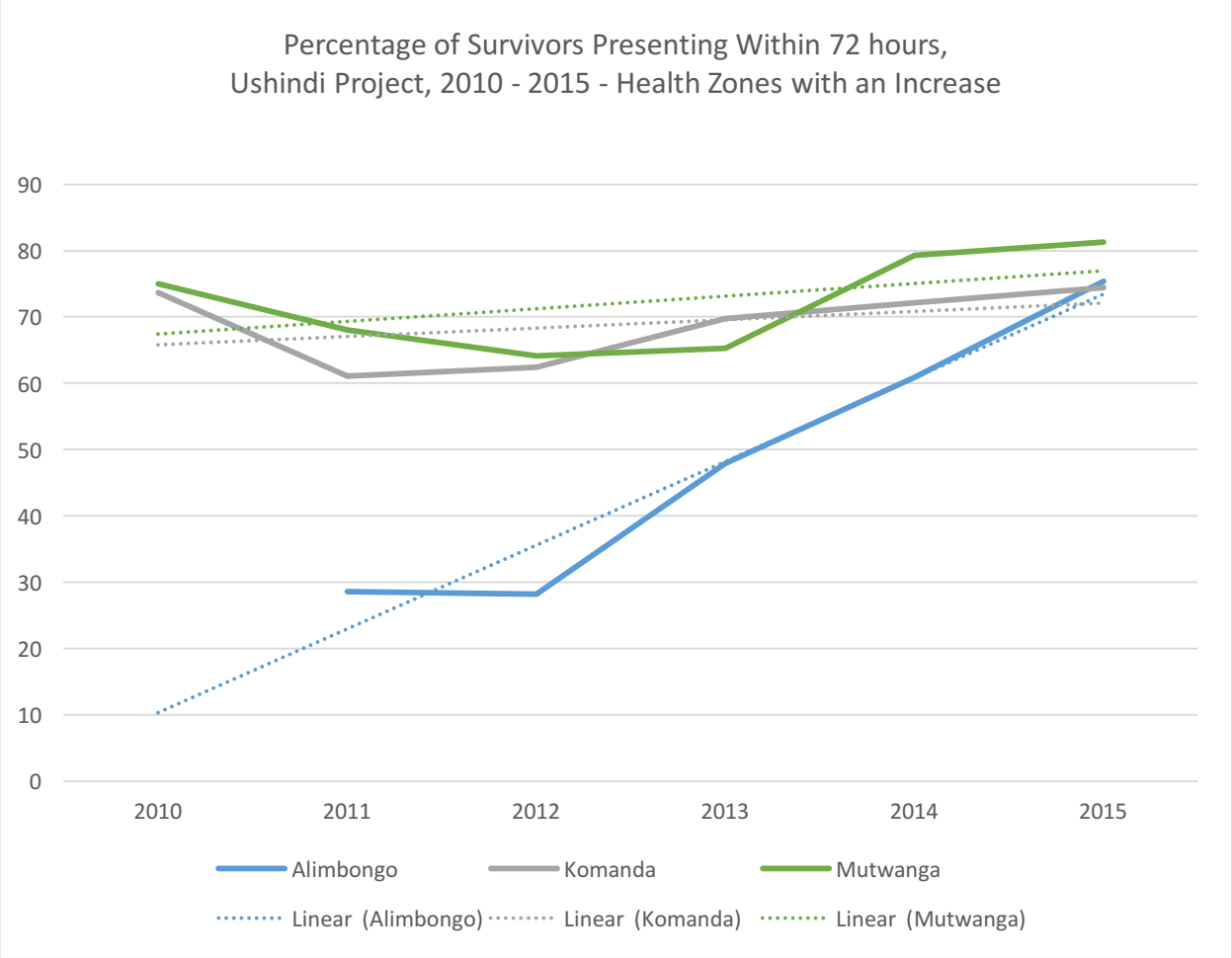
overarching statements regarding the impact of Ushindi on getting survivors to care within 72 hours (Annex VII, Table 11). Understanding these limitations, Kitutu, Lolwa, Lubero and Mwenga had a decrease in the number of survivors coming within 72 hours (Figure 7).

Figure 7: Health Zones with an Overall Decrease in the Number of Survivors Coming to Care within 72 hours



In comparison, Alimbongo, Komanda and Mutwanga had increases in the number of survivors presenting to care within 72 hours (Figure 8).

Figure 8: Health Zones with an Overall Increase in the Number of Survivors Coming to Care within 72 hours



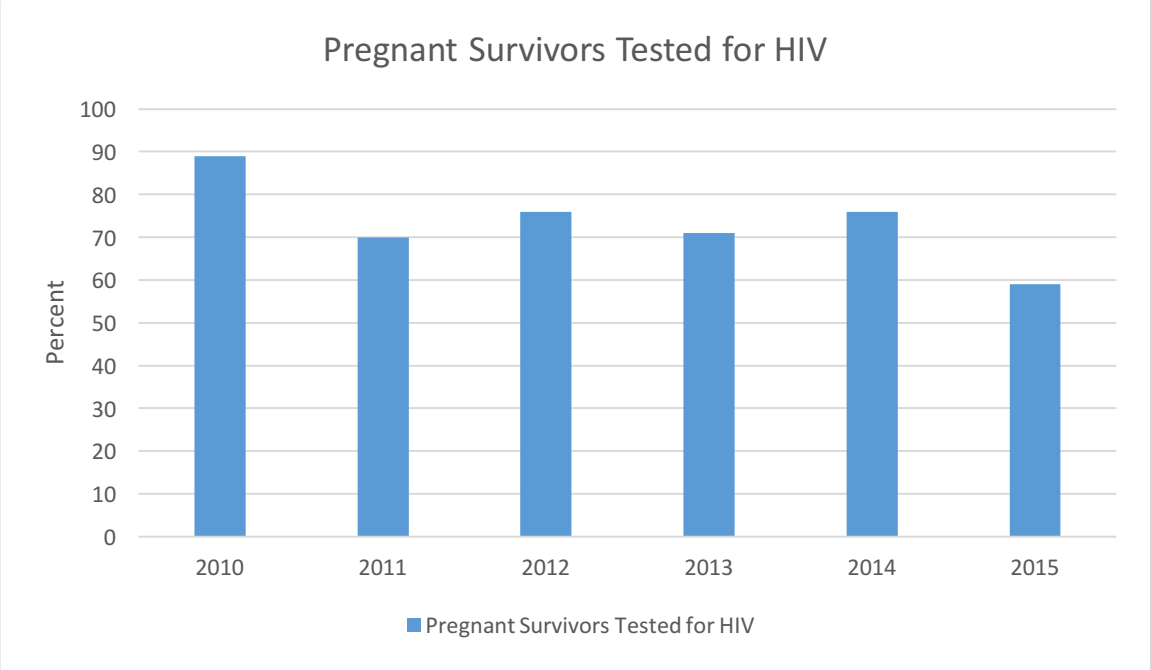
Finally, anecdotally there appeared to be a large number of survivors who were presenting pregnant. In addition, health care providers expressed concerns that many of the pregnancies among young girls (< 18 years of age) might not be rape related but instead were a way to not having to admit they were sexually active. In general, the rate of sexual violence associated pregnancy is 4-5% among women, ages 12-45.[56] According to the quantitative survivor data, 14.5% (957/6581, 95% CI - 13.2 - 14.8) of all the survivors who presented to care presented pregnant with the largest percentage among ages 13-17 (26.4%, 95% CI: 24.5 - 28.4). Lolwa, Lubero and Mutwanga were less likely to have young women presenting pregnant compared with other health zones. (Annex VII) It is not possible qualitatively or quantitatively to determine the concern raised by the health care providers however, the largest group of pregnant survivors suggests this may need more research.

Among pregnant survivors and overall, 73% were tested for HIV (Figure 9). Health zone sub-grouped data can be found in Annex VII; Table 13 as to the yearly percentages of pregnant survivors tested for HIV/AIDS at entrance into Ushindi services. Of the 916 pregnant survivors tested, 2.5% (n=23) tested

[56] Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. Am J Obstet Gynecol. 1996 Aug;175(2):320-4; discussion 324-5.

positive and were referred to clinics that could supply PMTCT treatment services during the prenatal, intra-partum, and postnatal periods. A further 3.5% (23/664; 95%CI (2.1%, 4.9%) of survivors who presented pregnant had known HIV/AIDS positive status and also needed referral to PMTCT services (Annex VII, Tables 13-14).

Figure 9: Percentage of Pregnant Survivors Tested for HIV by Year



Evaluation Question 4

For survivors requiring or having received Psychosocial Service, their knowledge of the presence of psychosocial services; a village counselor (lay) at the village level and advanced counselor at the Safe House Level? Have they had such services, the impact of such services, were they able to be functional again in their community, the need for further (higher level) counseling for victims of PTDS for survivors who have not been able to regain their past level of functionality?

Overview

As stated regarding Evaluation Question 1, lay counselors have been a critical factor behind Ushindi's cost effectiveness and ability to reach large numbers of survivors. Locally trained and respected women (and in a few cases men) who are mostly volunteers[57] and are not dependent on other structures[58] have served communities to provide a local, safe source of psychological support that survivors felt comfortable interacting with.

[57] They do receive some money for transport and other costs related to monthly meetings and documentation of their work. Efforts should be made in any future iteration of the project to reduce this further to become even closer to pure volunteerism.

[58] As opposed to community based counselors who are part of a CBO, these women are doing this on their own – usually for personal reasons to help their community – making them more independent.

Based on the 5-year Ushindi report, a total of 24,526 survivors received psycho-social support out 24,793 survivors for a coverage of 99%. The psycho-social case reports indicate that 96% of these cases received active listening and counseling, 80% had home visits and 9% were supported with family mediation for more effective reintegration. Others received donations of food and non-food item to resolve social issues.

There are currently 76 psycho-social agents, supervised by three clinical psychologists.[59] The majority of assisted people presented different signs of stress and trauma due to sexual violence and other forms of GBV.

The therapy includes a combination of various therapeutic methods such as active listening and counseling, relaxation exercises, occupational therapy, home visits and family mediations. These therapeutic methods have resulted in an average of two thirds of the survivors anecdotally declaring (and as witnessed by the psycho-social counselors) that they had recovered psychologically and had reintegrated socially. Psychological assistance was considered to be brought to a conclusion when the signs of stress or trauma had largely disappeared and the survivor was able to return to the normal activities that they had engaged in prior to the incident.[60]

Frequent behavioral problems that the survivors experienced, and sought help for, included feelings of shame, fear or rejection; disturbed sleep; loss of self-esteem; sadness and suicidal feelings; amongst others. Recovery was indicated by the re-establishment of a feeling of comfort, self-confidence, peaceful sleep, the hope for a better future and especially the personal motivation to return to the everyday activities that were followed before the traumatic incident.

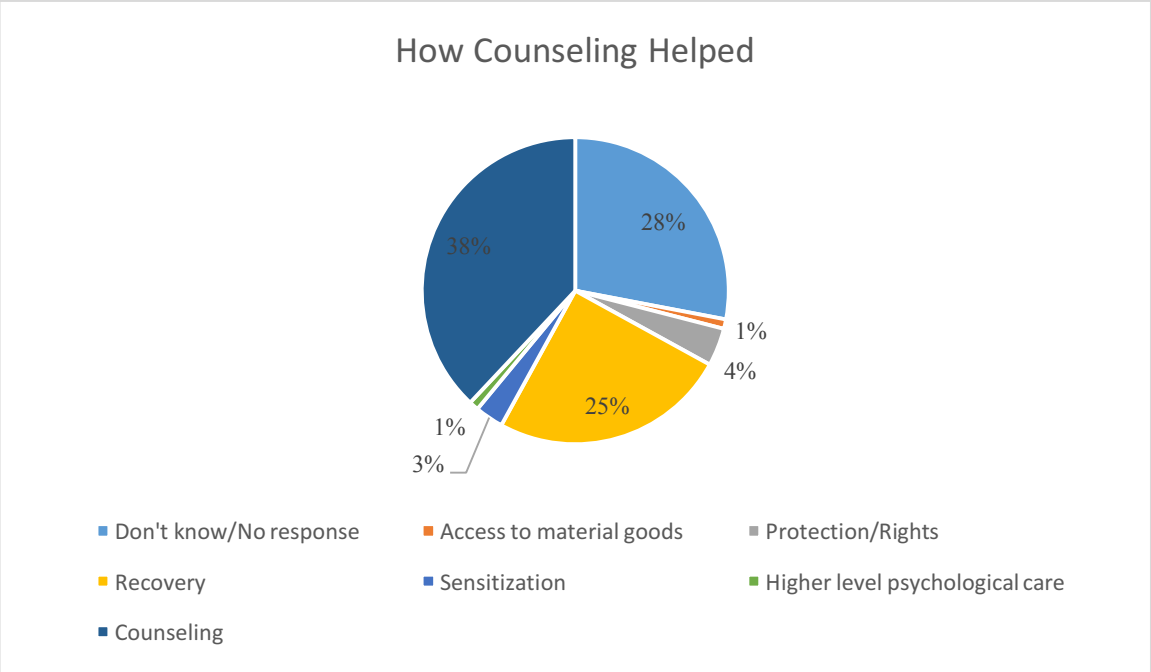
Qualitative Findings

These findings refer to the 74 qualitative interviews of survivors in the three health zones visited. Ninety-nine percent of survivors accessed psychological services. Survivors were positive about their experiences with the lay counselors, with many stating they had been following up with them long term (more than 6 months). It was clear from the interviews that the counselors are supportive, warm, caring and helpful and improved survivors function significantly (See quotes in Evaluation Question 1).

When survivors were asked to expand on how the services helped them or the impact of the services, more than a third (28%) could not express how the services psychologically helped them. However, the vast majority gave useful answers as to how the counseling helped them (Figure 10).

[59] Ushindi Five-Year Report, 13. Previously 108 during first 4 years.
[60] Ibid.

Figure 10: Survivors responses as to how counseling helped them



Many of the survivors specifically mentioned "recovery" such as:

> *"These services helped my health recover and made me feel at ease among others and remove the embarrassment I had"*
>
> *"When I was counseled, I was helped a lot because I saw myself of no value. But since the help of these services I have recovered"*
>
> *"Since these services have helped me, I have felt better and relieved from the heavy load that morally troubled me"*
>
> *"Thanks to counseling I was able to recover and I got back my joy that I lost when I got raped"*

Three of the survivors discussed how the counseling helped them overcome perceived shame:

> *"They helped me feel confident because before that I could feel ashamed walking on the road thinking that everybody was looking and talking about me…"*
>
> *"I felt comfortable because anytime I walked in the village I thought people were talking badly about me"*
>
> *"These services helped me a lot showing me how I can continue living in the society"*

Four percent of survivors stated that the counseling protected them from further rape and better understood their rights:

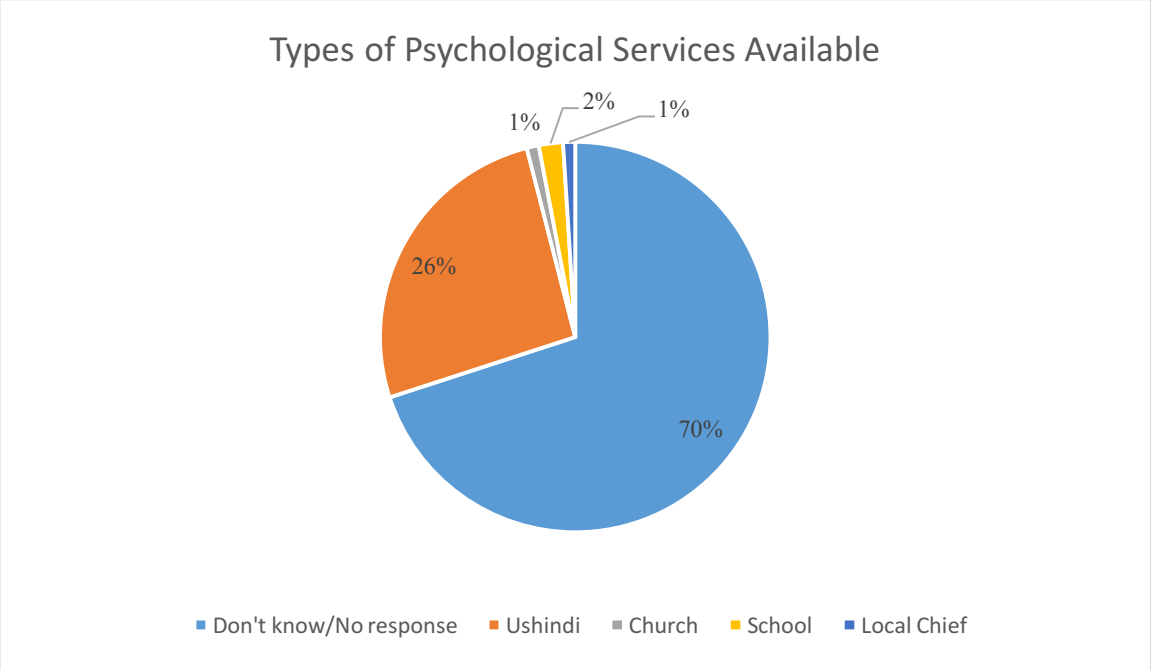
> *"It helped me protect myself against violence"*

"The psychosocial service has helped me understand women's rights and see how the women must not be raped like that. And the women should enjoy her rights"

With regard to availability for higher level counselling, only two survivors were aware of higher level counselling services; one because she was getting care at the hospital and the other because the Lay Counselor referred her to the psychologist at the safe house.

Survivors were also asked what kinds of psychological services were available in their area. Figure 11 represents the answers given. The vast majority of the survivors stated they did not know what services were available or they gave no response.

Figure 11: Knowledge of survivors with regard to psychological services available



Quantitative Findings

From the survivor database (2010-2015) data was retrieved and analyzed for 23,384 survivors. Among these, 71% (n=16,633) of survivors accessed psychological services. Men, those in forced marriages, were living with a partner who did not pay a bride price (not legally or traditionally married) and those who stated their abuse was "denied resources" and had less education were less likely to access these services. Those who did access services, overall, were largely single and higher educated women. In addition, students were more likely to access these services and those who claimed to be native residents (Annex VII, Table 14).

Only 1% of survivors were referred to higher level mental health services. Those referred were more likely to have a university level education and claimed to have no religious preferences and represented those with more severe mental health symptoms. However, there is no symptom inventory baseline or periodically throughout the treatment.

Although the database had fields for "discharged from services", this field was not updated. There were no fields to determine if these survivors felt recovered which Ushindi defined as re-establishment of a

feeling of comfort, self-confidence, peaceful sleep, and a hope for a better future subjectively and as stated previously, nothing to clinically document improvement in mental health symptoms.

Evaluation Question 5

> For survivors requiring or having received Legal Services, their knowledge of the presence of legal services; a jurist at the safe house to offer counsel, enter mitigation or reconciliation between partiers, or pursue criminal proceedings? Have they had such services, the impact of such services, and their satisfaction? Has this had any impact (positive or negative) in the incidence of SGVB? Has pursuing justice put them at risk?

Figure 12: Lubero Tribunal (Photo credit: Lynn Lawry)

Overview

From 2010-2015, among the 24,793 cases assisted by USG-funded social services, 48% (11,890) received legal aid of which 83% were women.[61] Of all cases receiving legal aid, 60% had suffered some other form of SGBV and 40% of which were survivors of sexual violence. Women were somewhat more likely than men to seek aid for other forms of SGBV (e.g. domestic violence) where 80% of all female survivors received legal aid compared to 71% of men who also suffered some other form of SGBV; however**,** women were much less likely to get legal help if they were survivors of sexual violence **–** only 28% of all female survivors of SV sought legal help compared to 70% of male survivors. Nearly one fourth of all cases of other forms of SGBV seeking legal assistance were men.

Nine legal clinics, hosted in different supported safe houses, initiated complaints with police stations, followed them through the courts and facilitated mediation for domestic disputes as well as denial of rights. Among 14,418 cases requesting legal aid from the nine -supported legal aid clinics, 19% consented to have their cases taken to court or trial with the lawyers. Judgments were obtained for 16% of the cases taken to court. The low level of judgment is due, in part, to the slowness and complexity of the Congolese judicial system.[62]

[61] Ushindi Five-Year Report, 16.
[62] Ibid.

Mediation was facilitated by lawyers for 2,244 cases of other SGBV issues, representing 31% of those cases. These included denial of access to household resources, opportunities or emotional support; refusal of heritage or abandonment of children by parents and siblings; and children in conflict with their parents or neighbors. These were resolved with generally satisfactory results with mutual agreement to put an end to their differences and promote a lasting reconciliation between the two parties.

Besides legal assistance for survivors of SGBV, the lawyers based in the 9 legal clinics, in close collaboration with the citizen legal activists and local staff, received over 6,000 people (with slightly more than half women and girls) who came for legal advice on other problems of human rights. Most of these related to public infractions such as theft, land tenure, calumny, public insults, etc. These legal counseling sessions were highly appreciated because they reinforced the community's level of basic knowledge and understanding of what constitutes a public infraction and of the penal code, increased the confidence and use of the Congolese judicial system and reduced the number of cases resolved privately in the case of sexual violence.

SBCC activities by *Noyaux* members which included campaigns to raise awareness regarding national and international laws related to SGBV, anecdotally helped to halt ignorance about human rights, child rights, roles of women and men, and matrimonial rights.

During the course of Ushindi, several health zones showed a positive trend related to the registration of births and marriages. This improved the recognition of rights associated with marriage and nationality. This was true in Lubero, Mwenga, and Beni. In addition, in Orientale province dozens of pygmy couples defied their ancestral practices and entered into civil marriages.

Less than 1% of court files that ended in a guilty verdict for perpetrators of rape included reparations to the survivor. Many of the survivors and community members testified that the judgments were not satisfactory because the women and girls who appeared in court without obtaining compensation lost time and will be subjected to social mockery and rejection.[63]

Moreover, several cases of temporary release of alleged perpetrators of child rape have been documented. This practice is surrounded by corruption and the use of influence by perpetrators' families and discourages the reporting of sexual violence to courts. This also perpetuates customs of early and forced marriage.

Qualitative Findings

Survivor knowledge of availability of legal services

Among the 74 survivors interviewed, 64% of survivors stated they did not utilize legal services, whereas only 18% used the legal services available. Another 18% did not know or gave no response. During discussions with survivors and key informants, the reasons for non-use included a perception that perpetrators were simply let go due to police and/or judges being bribed for the perpetrators freedom, and inability to pay travel costs to appear in court or pay for perceived bribes that would be needed for their cases to be heard, and a fear of humiliation by making their issue public.

Impact for those who utilized legal services

[63] Ushindi Five-Year Report, 36.

For those who used the legal services, 2 of 13 (15%) stated that the case was in process. The other 11 stated that either the perpetrator had fled, had fled after being given weekend liberty, or the perpetrator was unknown. This was true for the cases where the rape was by an armed group member. Another issue found during interviewing was a mistaken belief that adjudication by a Chief is considered legal assistance. One survivor stated:

> *"The service helped me because his family payed three goats and they brought me a cloth because I went to see the village Chief"*
>
> *"…my parents wanted my case to go to the Chief"*

Survivors were not the only ones to raise the issue of community based justice. Despite this type of mediation or justice being illegal[64] police and lawyers stated this type of justice is still happening:

> *"Cases where the chief mediates SGBV cases are isolated. But when the chief mediates a solution (ten goats) and it is not paid, the victim returns to justice…the Noyaux have taught them the law but it still happens"*[65]
>
> *"In some cases the Chief is making deals between the families for the case. I don't know how it happens and I know I have done my part and obligation but if I discover this, I will have to fulfill my obligation and arrest him"*[66]

Impact on the incidence of SGBV

As discussed in Evaluation Question 7, the impact of legal services on the prevalence of SGBV is not possible due to lack of a prevalence baseline study in the health zones where the Ushindi Project has been working. However, qualitatively there is anecdotal evidence (from survivors) to support the idea that there is a decrease in the number of new cases (incidence) and/or even a less likelihood that others would consider sexual violence due to the imprisonment and punishment of alleged perpetrators:

> *"Once the perpetrator is caught and taken to justice other will fear punishment"*
>
> *"…because those who are caught and punished puts fear in others"*
>
> *"When a case if followed up and the legal assistants brings punishment, that makes people fear"*

Other survivors credited the police with the decrease in sexual violence:

> *"…because the police do their best to catch the perpetrators"*
>
> *"The state agents [police have] contribute [to the decrease in sexual violence in the community] because once you are caught as a rapist, you are killed or put in jail…"*

When healthcare providers and lawyers were asked about their perceptions of the rates of sexual violence in communities where Ushindi has implemented, they too thought the rates had decreased:

> *"…many have been arrested and prosecuted…with changes in attitudes and in the*

[64] Penal Code Procedures 1982. Chiefs can mediate or adjudicate any offense under one month penalty. Given that SGBV carries a term of 10-20 years, the Chiefs are not allowed to mediate such cases and must refer them to the police.
[65] Lawyer, Lubero health zone.
[66] Commander of Police in Lubero.

community and among police, it [rate of sexual violence] is decreasing…people are afraid because of the prosecutions"[67]

One of the lawyers interviewed also felt similarly to the survivors and community members:

"Cases have incited fear in communities, they know they cannot get away with rape"[68]

There were however others who felt arrests and prosecutions did not make any impact in the incidence of SGBV. For survivors who thought sexual violence had increased in communities, the reasons given included alcohol, boys and men want sex, a loss of religious morals, insecurity, lack of justice, areas are remote and therefore women must walk alone, and continued tribal and armed conflicts:

Survivors stated the following:

"It seems to decrease but after a while they get into groups and restart the sexual violence"

"I think legal justice does not help. Because the perpetrator pay and set free without any proceedings"

One lawyer also commented on her skepticism regarding any decrease in the incidence of SGBV based on prosecutions:

"[Mobile Courts] once we leave, then they forget and continue"[69]

Risk to survivors due to legal cases

There were not enough survivors who could answer this question to assess any risk associated to them from participating in legal cases.[70] In discussions with lawyers, the risks were more so related to perpetrators disappearing, being given weekend liberty and then disappearing, and pay offs from perpetrator's families to police and judges. In isolated cases, the perpetrator or his family would threaten the survivor but these have not (in their knowledge) resulted in any injuries or "real threat".

Quantitative Findings

From the survivor database (2010-2015) data was retrieved and analyzed for 18,735 survivors. Among these, only 27% (n=5136) of survivors accessed legal services. Of the male survivors, more men accessed legal assistance than those who did not but the vast majority of those who accessed legal services were women. Those who were single, or those who were living with a partner and no bride price had been paid (not legally or traditionally married) were more likely to access legal services. Those who were less educated, did not work and were denied resources were more likely to use the legal services than those who chose not to use legal services (Annex VII, Table 15).

The number of cases pursued remained steady 2010-2015 (Annex VII, Table 16). Over the five years, there were 5,213 cases brought to the legal arm of Ushindi. Those pursued included 56% (2926 cases) of which 21% had a judgment, 8% went to mediation and the remaining 71% did not have any judgment (Annex VII, Table 16).

[67] Samuel Mukubwa, Lawyer ABA.
[68] Me Aline Mbambli, Lawyer, Lubero health zone.
[69] Fatuma Kahindo, Lawyer ABA.
[70] Only 2/74 survivors stated they used legal services.

Evaluation Question 6

For survivors having received socio-economic assistance what was their inclusion in any of the socio-economic services in the zones (VLSA, Social Fund, and Literacy program)? Have they experienced a socio-economic hardship as a survivor? Are there other needs we have not met? How can we prevent/avoid stigmatization? Having been included back in the community are they more or less vulnerable to SGVB?

Overview

In general, a VSLA is an initiative of a self-managing group of 25 members living in the same area, all motivated to save small amounts weekly, and to grant themselves credit from the fund of which each member has bought a share (or shares). At the end of the annual cycle for each VSLA, the members divide up the dividends according to the shares that each has purchased and can then go on to the next cycle.

According to the Ushindi Five-Year Report, VSLAs have been an enormous success and, although designed for socio-economic reintegration of survivors, proved to be so popular that the communities spontaneously created their own VSLAs (besides those created by the project) more than doubling the original target. Among the 415 VSLAs aided by Ushindi, an additional 481 spontaneous VSLAs were created during the project. Eighty percent of members are women. An estimated 3,800 survivors of sexual violence have actively participated in supported VSLAs and received financial assistance from VSLA members after the annual sharing of dividends.[71] However, due to confidentiality, there is under-reporting of the numbers of survivors involved in the VSLAs. The high numbers of women involved in VSLA activities contributes to improving women's social condition leading to socio economic empowerment and safety at the household level as well as decreasing their vulnerability to intimate partner's violence, denial of resources and opportunities.[72]

Lolwa and Komanda have 79 VSLA (48 project supported, 31 spontaneously developed VSLAs) and Lubero has 168 VSLAs (48 project supported and 120 spontaneous). During the five-year project, 27,752 VSLAs developed across ten health zones. Financial impact is apparent for most who participate in these programs.

Among survivors interviewed, less than10% mentioned participation in the literacy programs or clubs.

Qualitative Findings

Participation in socio-economic activities

Forty percent of survivors stated they were not participating in socio-economic activities. Many stated they lacked money to give a contribution. Of the 44% of survivors interviewed who were participating in socio-economic activities the following reports their successes and satisfaction with the programs:

> *"It has really helped me because when I take money there after a year it has doubled and we also need money to supply needs or do a small business it really helps to borrow money"*

[71] Ushindi Five-Year Report, 20-22.
[72] Ibid., 20.

"VSLA really helped me a lot though I have to pay too. But when I need money I get it and it helps me in many matters"

"Thought the amount we get is not that much, it has helped me have the willingness to work. Because if I need to get I have to put [money in]. So with VSLA we work to earn especially when we are waiting to bring in the harvest from the fields"

Survivors also stated what the VSLA funds helped them achieve:

"I can supply my own needs"

"VSLA has helped me find soap, feed my children and get clothes"

"I bought land"

"I have a small business. With the money I make cakes and I sell fish"

"I can write my name and now I know when someone takes advantage of me with money"

"The literacy club helped me a lot because before I didn't know how to write; today I can write"

In some cases, and among younger survivors, the mothers were members of VSLA. For a 20 and 21 year old survivor, they reported the following:

"My mother is a member VSLA and she receives money"

"My mother is in the program on my behalf. With VSLA you can buy soap, pay for school fees"

Hardships as a survivor

Hardships discussed by survivors included having children due to the rape, dropping out of school due to pregnancy and then no means to support herself or her baby in addition (especially among the younger women) experience with small businesses.

Most of the survivors mentioned financial hardships after the incident. Many of these were related to the psychological trauma of the event and not feeling well enough, or having mental health issues or fear to resume normal activities that prevented work:

"Since I had nothing, I worked in field after the violence but I have no strength and I don't know what to do"

"Sickness prevents us from economic activities"

"I could not even get soap to wash my clothes. After the war, everything was looted and I was not stable and could not work"

"It is very difficult for us to get money because we are afraid of going to the bush. I live on agriculture but now there is no strength and I am afraid of going to the bush"

One of the factors adding to the hardship was abandonment by family:

"I was only 16 years old when I was raped, my parents rejected me and I did not have a job"

"I find it impossible to feed my children because my husband has abandoned me"

Thirteen percent of survivors reported they had to work in the fields to support themselves. Generally, this required working for someone else which included low pay and many hours, sometime late hours, in other people's fields:

"I have a lot of difficulties. To survive I work for someone in his field and he pays me 100OCDF (~1USD) per day. I have no other work"

"I had to work in someone's field. He paid me very little and I had to work long hours. Sometimes he did not pay me"

Unmet Needs

Schooling was mentioned by most of the interviewed survivors as the one need not met. And among younger survivors who became pregnant after the sexual violence (~20%), all dropped out of school because "the other girls would laugh at us and made us feel ashamed". Most of these young girls thus resorted to trying to operate small businesses. However they were emphatic that revenue from these activities would now go to the care of their child and could not be saved for school fees. It appears, with the exception of a few, most of these girls did not return to school.

Older women also stated they did not have the opportunity for schooling. Some of this was due to cultural beliefs that women should not be in school and other reasons such as poverty or inability to pay for school fees, displacement, or the need to care for family due to looting during conflicts.

Overall, financial wellbeing was a preoccupation of survivors. As stated above, many had to work in other people's fields which left them vulnerable to being taken advantage of financially and in some cases, sexually. And although survivors (32/74) were able to use VSLA as a means to borrow money, several other survivors (5/74) specifically mentioned they were unable to participate due to the lack of money to invest.

Although VSLA helped women start small businesses, much of these were selling fish, cakes, vegetables, sodas, and beer. Women stated they would prefer to learn a trade such as sewing whereby they could earn much better money and have a trade. They stated they would need a sewing machine in addition to learning the trade.

Finally, the jobs open to survivors were limited. These included working in someone else's fields and or selling alcohol. Both of these put women at further risk for SGBV (see below).

Inclusion into the community and stigma

Stigma is one of the main reasons women did not want to pursue justice. Counselors tell survivors they should "forget" the incident instead of accept and recover and they insist on confidentiality for inclusion in VSLAs and other Ushindi projects which may enable stigma. Most of the survivors told researchers they were told by counselors and nurses not to tell anyone they were survivors for fear of stigmatization. Several of the survivors felt they did not need to hide their status and were open with researchers about being survivors.

According to survivors, in some cases communities have included women who have suffered sexual violence however, they express frequently that their "status" or ability to have work, and most importantly respect, within the community suffers despite community mediation and campaigns.

Vulnerability to SGBV as a survivor

Most of the survivors stated they were more vulnerable to SGBV based on their limited choices for working. Many of the women stated the only jobs they could find were working in other people's fields. Two women stated they were raped by the field owners or they had to agree to sex with these owners in lieu of the one USD they are paid. In addition, owners would require long hours in the fields necessitating walking home alone and late in the evening. In many cases, women reported that they have been raped coming from fields.

Another job available to survivors is selling beer. Many of the customers (primarily but not solely men) will get drunk and assault these women. Forty-three percent of the survivors interviewed who stated they were selling beer reported they were raped by customers while selling alcohol.

Evaluation Question 7

For communities that have benefited from services has there been any impact on the prevalence of SGVB?

Overview

To date, there is only one evidence based study that is able to estimate the prevalence of sexual violence in eastern territories of DRC which included women, men and all forms of SGBV. The 2010 DRC Study[73] was conducted in the territories[74] of North and South Kivu provinces and Ituri district in March 2010. Eighty-eight percent of respondents reported perpetrators to be combatants with the most common perpetrators belonging to the Mai Mai, Democratic Force for the Liberation of Rwanda (FDLR), Union of Patriotic Congolese (UPC) and Interhamwe. These data are summarized in Table 9.

Table 9: SGBV data from the 2010 DRC Study

Sex	SGBV-Ever	Conflict related SGBV-Ever	IPV-Ever	IPV sexual violence-ever	IPV committed by a partner or spouse Male/female
Female	39.7	41.1[75]	30.5	8.5	31.1/12
Male	23.6	10.0	16.6	7.7	24.7/1.5

The most recent DHS 2013-201476 which only reports data on women ages 15-49 collected also collected limited data on SGBV. It is important to keep in mind that the DHS only studies reproductive age women, does not collect data on SGBV among men or assess all perpetrators (e.g. conflict-related) or all forms of sexual violence. Table 10 shows prevalence data from the DHS relevant to the provinces covered by Ushindi.

[73] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562.
[74] 26 provinces are subdivided into 192 territories. See eMethods at http://www.jama.com.
[75] 41.1/39.7% of the sexual violence reported "ever" was described as perpetrators related to rebel groups.
[76] Demographic Health Survey. DRC 2013. http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf.

Table 10: SGBV data from the DHS 2013-2014

Province	Sexual-Ever	Sexual - 12 mos	Physical-Ever	Physical-12 mos	Physical during pregnancy	Among married women Emotional/physical/sexual	Physical committed by a partner or spouse Male/female
Orientale	24	13	48.3	26	9.5	29.4/39.7/19.2	31.1/12
South Kivu	27.6	14.6	25.6	11.4	8.8	33.6/20.3/25.8	24.7/1.5
North Kivu	34.5	18.3	47.5	31.1	10.9	47.3/41.7/26.1	36.2/7.2

The baseline for Ushindi did not include a household prevalence study in health zones where Ushindi was implemented therefore true prevalence data and the impact of Ushindi on the prevalence of SGBV is not possible to estimate.

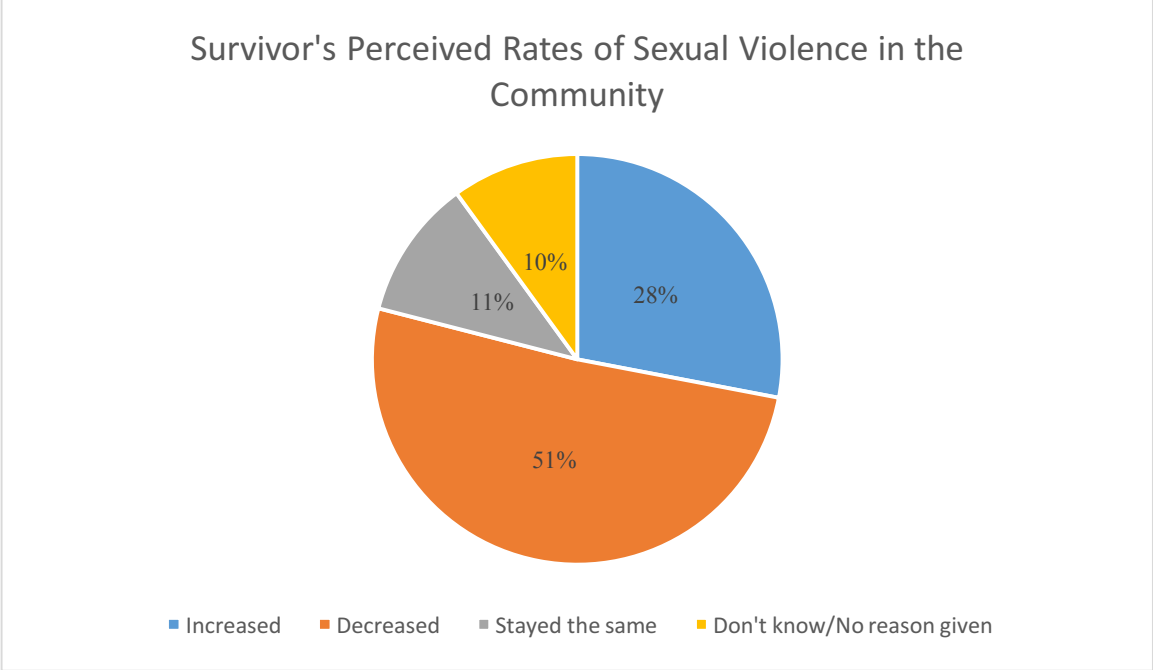
One of the easiest ways to collect data is to do so in a healthcare facility where patients with abuses including SGBV present for care. Care should be given to the interpretation of these data as this is a highly biased population due to under-reporting of sexual assault and the ability of patients to get to clinics which for the vast majority in war-torn areas or areas where there are large rural populations is not possible. While the *prevalence* of sexual violence can be underestimated by relying on clinical data, the *severity* of sexual violence might be highly overestimated as only those with severe complications from SV will, if possible, present to care.[77] That being said, in some instances, clinical data may help to provide clues to patterns of sexual violence. Clinical/medical data can be useful especially for assessing surges in violence. An increase in presentations to the clinic for rape or other human rights abuses may be an indicator of a larger problem in the community; however, caution and restraint should be used when using the statistics to describe that problem. These data are representative *only of those able and willing to come to care* and cannot be extrapolated to calculate or present a prevalence at the health zone or provincial level. Therefore, this study had only the ability to assess perception of changes in sexual violence qualitatively.

Qualitative Findings

Survivors were asked, in their opinion, if the frequency of sexual violence in their communities was increasing, decreasing, or staying the same. Among the survivors interviewed, more than half (51%) felt it was decreasing, 28% thought it was increasing and 11% thought it has stayed the same (Figure 13). Ten percent were unsure or had no response. Women who stated the violence had stayed the same were, on average, younger (17.4 years) compared with women who stated the violence had increased (21.5 years) or women who believed it had decreased (22.7 years).

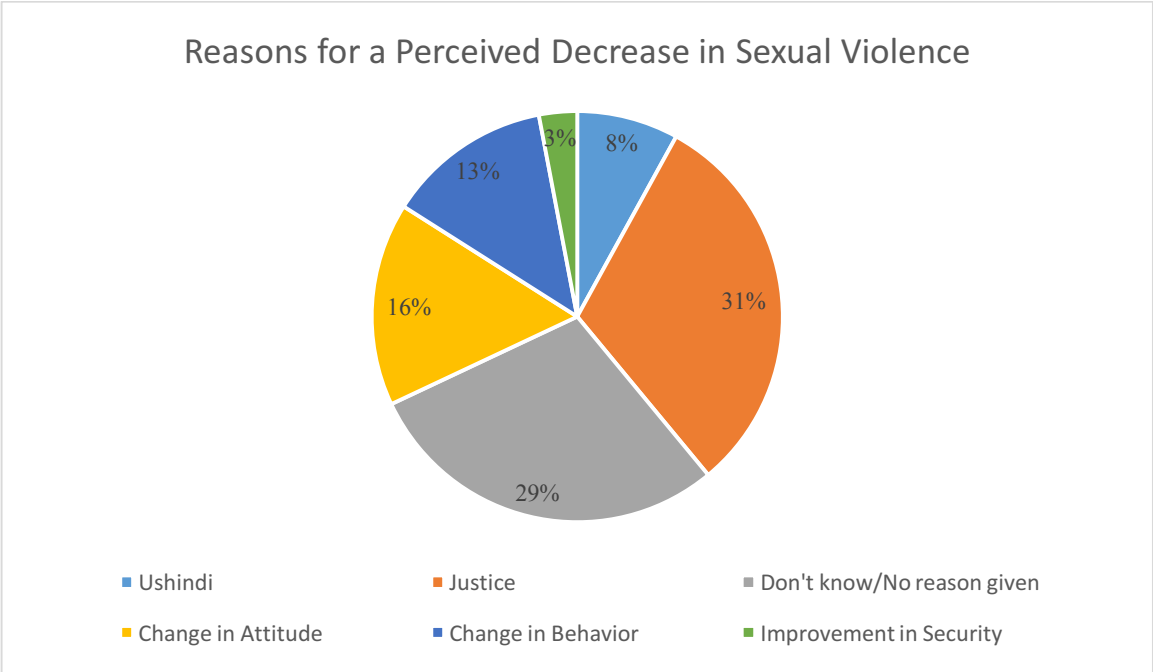
[77] As an example, women or men who have suffered a fistula as a consequence of rape may be more likely to obtain care at a health facility. By recording the consequences of rape from a clinical setting, one may assume that all rapes result in fistula which is not the case.

Figure 13: Survivor's perception of sexual violence rates in their community since the start of Ushindi



Survivors were also asked what the reasons were for their perception of the change in sexual violence. For those who thought sexual violence had decreased in their communities, Ushindi, changes in behavior or attitudes, justice, and a change in security were reasons given (Figure 14).

Figure 14: Reasons given by survivors for a perceived decrease in sexual violence since the start of Ushindi



With regard to a decrease due to justice, survivors stated:

> *"Once the perpetrator is caught and taken to justice others will fear punishment"*
>
> *"…because those who are caught and punished puts fear in others"*
>
> *"When a case if followed up and the legal assistants bring punishment, that makes people fear"*

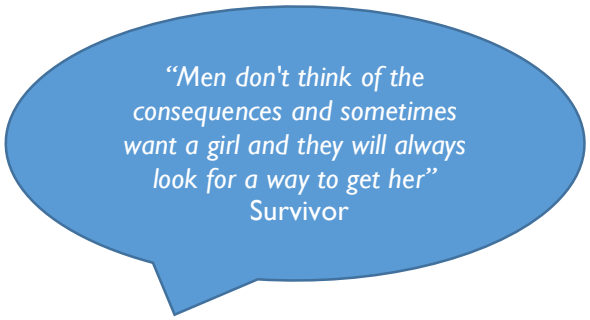
Others credited the police with the decrease in sexual violence:

> *"…because the police do their best to catch the perpetrators"*
>
> *"The state agents [police have] contribute [to the decrease in sexual violence in the community] because once you are caught as a rapist, you are killed or put in jail…"*

When healthcare providers and lawyers were asked about their perceptions of the rates of sexual violence in communities where Ushindi has implemented, they too thought the rates had decreased:

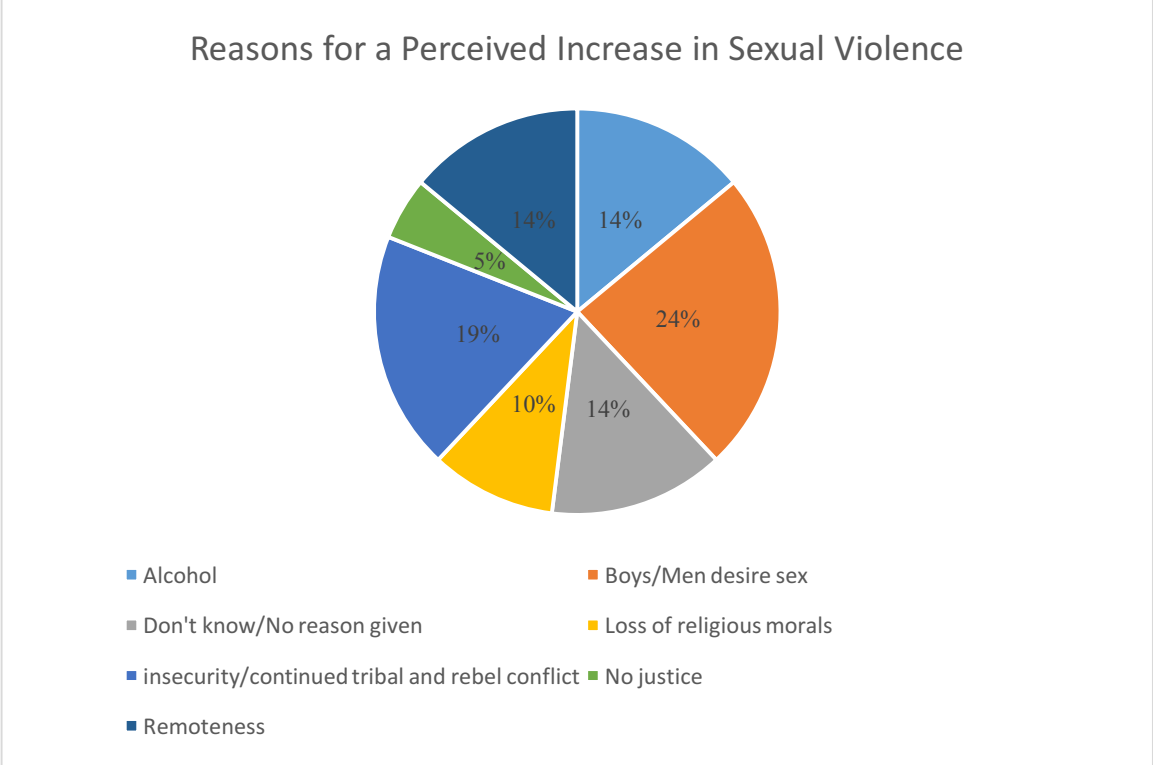
> *"Rape consultations are down and this is because most of the rape in the area was due to armed groups and with better security, the numbers have decreased"*[78]
>
> *"…many have been arrested and prosecuted…with changes in attitudes and in the community and among police, it [rate of sexual violence] is decreasing…people are afraid because of the prosecutions"*[79]

For those who thought sexual violence had increased in communities the reasons given included alcohol, boys and men want sex, a loss of religious morals, insecurity, lack of justice, areas are remote and therefore women must walk alone, and continued tribal and armed conflicts (Figure 15).



[78] Senior Nurse, Kasima Health Center, Lubero HZ.
[79] Samuel Mukubwa, Lawyer ABA.

Figure 15: Reasons given by survivors for a perceived increase in sexual violence



For some survivors, alcohol seemed to be a risk factor, not simply alcohol use by perpetrators, as women also drink and/or they are forced to sell alcohol to make money:

> *"Many of us [survivors] delivered children at an early age due to drunkenness which pushed the person to do things they would not normally do…"*

> *"Alcohol makes it increase. They can tell me to go sell alcohol now those who buy and get drunk and that's how raping increases and they can rape me"*

For those who stated the rates of sexual violence had remained the same (n=8), 38% had no response, 25% stated that the area was remote and required women to walk alone, another 25% stated the continued tribal/rebel conflict was the reason it was not changing and 12% thought that men and boys "just want sex and will take it."

Evaluation Question 8

What is the impact of literacy clubs, youth clubs, foster families, campaigns and VLSAs?

Literacy Clubs

Overview

Although started as paid positions, throughout the lifecycle of the program, teachers were volunteers which affected the quality and quantity of this activity. Little is known regarding the number of participants over the course of the project, or the curriculum used or the impact of this program.

Qualitative Findings

All five survivors who discussed the literacy classes stated the classes were an important opportunity for them as they did not have schooling. Literacy classes have been taught by volunteers two times a week for the last two years. Of the five women interviewed who had participated in the literacy training for more than two years, only two of the five were able to write their name when asked to demonstrate (Figure 16).

Figure 16: A survivor illustrating that she is able to write her name since attending literacy classes

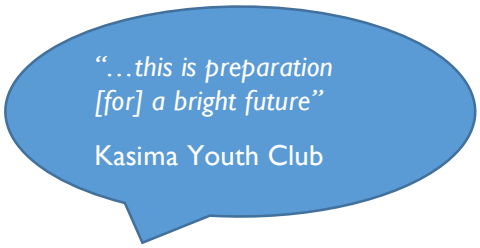
When they were asked how writing their name helps them, they could only say it will help them get a job (work for someone) and help them have a better life. None of the women stated that knowing how to write their name had helped financially. All of these women were small business owners (selling bananas and agriculture) but none could equate being able to read or write their name to an overall improvement in their businesses or financial situation.

There is no impact data for women who participate in the literacy classes. Financial data such as household increases in income after literacy classes was not available. Anecdotally, local partners stated women who have learned to write their name and mastered basic numeracy have now benefited from VSLA. However, these benefits were not elucidated nor separated from VSLA impact.

Youth Clubs

Overview

The youth clubs worked to spread messages of gender equity and violence prevention in their communities. It is assumed the most effective mechanism for long term behavior change is through the youth and should be reinforced in the future**.** During the project, 108 youth clubs received material, recreational space and training to help provide safe environments for children and to implicate them in community outreach for SGBV and children's rights, especially amongst their peers.



Qualitative Findings

Twenty-two youth club participants (ages 10-15) were interviewed with parents and or youth club adult chaperones present. The children stated they create messages to sensitize the community about sexual violence, child rights and child abuse. They use plays and games such as soccer at schools to sensitize peers and they perform at churches in the area to pass messages to the community about child rights.

One of the youth clubs told researchers that "when we see a friend is being abused by the parents, we confront the parents and call the police if needed."

Other youth clubs such as those in Komanda HZ have focused on food hygiene, the environment (planting trees), HIV/AIDS, and WASH. In this health zone, there is a Bantu practice known as Kumbi Kanji (circumcision ceremony done in the bush). Anecdotally, the Youth Club reports that this practice has been abolished due to messaging by the youth club.

The Youth Club in Baraka HA (Lubero HZ) has been focusing on livestock breeding, agriculture, and small businesses in order to pay school fees for those in the club who cannot otherwise afford to go to school. This club also sensitizes communities using plays and radio. The topics include sexual violence, physical violence and child rights. When asked what they think the impact of their programs have been on the community, they stated:

> *"…attitudes of parents have changed because our parents are not beating us anymore and child rights are no longer violated…parents no longer mock us"*
>
> *"…and we don't see early marriages anymore"*

According to the local partner interviews, there are no survey assessments of child rights or changes in attitudes based on sensitization by the youth clubs.

Foster Families

Overview

Over the course of the project, 45 Temporary Foster Families (*Famille d'Accueil Transitoire or FATs*) were provided with food and supplies to provide transitional care for child survivors of SGBV. These families were to take in children who had suffered sexual violence for no more than two weeks or until the parents were found or family mediation occurred in order to return the child back to their home and family. According to local partners, families qualified if there were other children in the home and if the home was deemed to be a "loving household."

Qualitative Findings

Six foster families were interviewed. On average, each family took in 4-6 children/year. If extrapolated to the 45 families, only 180-270 children per year of the 8,798 children identified as survivors were housed with FATs.

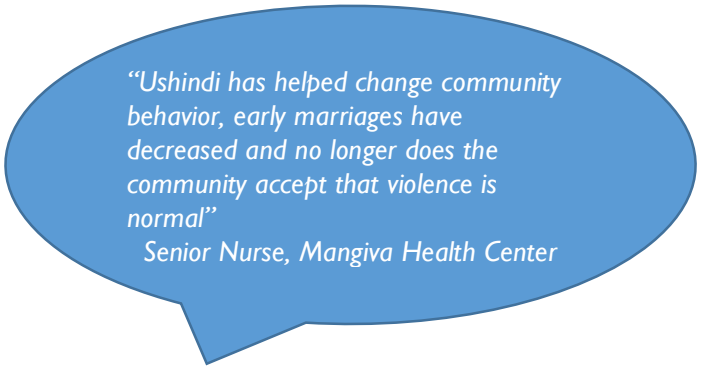
The families all stated their position was rewarding. In general they put the foster child with their children. Some sent survivors to school, others did not. It was apparent from both the FATs and the interview with RECOUPE, a local child organization that places these children, that the vast majority of

placements were not necessarily child survivors but included a mix of "street children", children in conflict with the law, and children who were lost in internally displaced camps (IDP) or children who fled conflict areas.

The families insisted that the money given to support these children was not enough and there were other needs "to better care for these children" such as solar lighting, beds, bedding, more money for food, money for medical care and compensation when these children stole from the families housing them.

According to RECOUPE[80], there is no data to assess how these children have fared after being placed in FATs. Many of the children placed in homes temporarily, once sent back to their family, do not have follow up.

Social Behavior Change Communication Campaigns (SBCC)



Overview

SBCC activities were integrated across activities, including (but not limited to) mass campaigns, local radio spots, discussion groups and coordinated messaging across legal clinics, legal (among police, lawyers and judges), *Noyaux*, youth clubs VSLAs, schools and churches, forums and focus groups. This permitted a near total saturation of the population and was key to broad scale prevention activities. Collectively, over 100,000 mass community awareness-raising sessions in villages over the first five years, including during international commemorative days. A large number of people in the catchment area were reached by one session or another, including the participation of nearly 50,000 community leaders and over 200,000 students. Most of the campaigns were to educate on women's rights, child rights, rape myths, medico-legal processes for survivors of sexual violence, positive norms (contraception rights and information, schooling for all children, etc.).[81]

Qualitative Findings

Across all of the interviews completed, many if not all of them mentioned the sensitization efforts were successful in changing attitudes. Data to support behavior change specific to the SBCC done during the program was not assessed at baseline and therefore this impact evaluation can only assess community changes in attitudes (See Evaluation Question 1).

The Senior Nurse at Mangiva Health Center stated:

> *"…with sensitization done in the communities, the cases of community or household rape have decreased significantly…cases where girls marry early are also less"*

[80] Mme Dorcas, Founder of RECOUPE.
[81] Ushindi Five-Year Report, 24.

However, using clinical data, he was also able to say the following:

> *"Now, because of the sensitization of the Noyaux Communautaire, 90% of survivors come to medical before 72 hours [after sexual assault]"*

In the Bahaha health area of Lolwa , another Senior Nurse was able to quote the following based on clinic records:

> *"In the last month there was a 35% decrease in the number of cases of SV and early marriage has decreased significantly"*

The Lay Counselor, also from Bahaha, who is part of the *Noyaux* made the following statement:

> *"…at the highest time, I was seeing 6/month [survivors] but now I see only 2/month. The numbers have decreased significantly since 2014 due to the sensitization the Noyaux do in the community"*

Youth clubs claimed the following in addition to eliminating harmful practices[82]:

> *"…attitudes of parents have changed because our parents are not beating us anymore and child rights are no longer violated…parents no longer mock us"*

> *"…and we don't see early marriages anymore"*

In Lubero, the Commander of the Police is also doing sensitization of communities on SGBV law:

> *"…myself and my deputies have been doing community sensitization by going to communities and talking at schools, to teachers, churches where for 15-20 minutes where we discuss laws…transportation is difficult, if I had a car I could go to other places"*

The *Noyaux* and the youth clubs all ask for sensitization materials and capacity building. They do not have materials they can learn from and they would like them in both French and local languages.

Finally, researchers found that there are broader more contextualized messages that are missing from campaigns including contraception, alcohol, drugs, walking alone, law, mining, trafficking, and survival sex. Certain negative norms in different areas are also not being addressed. For example, the harmful practice of circumcision (Kumbi Kanji) among Bantu boys, girls not being allowed in school, dowry (goats) as found to be an issue in Lubero among others.

Impact of VSLAs

See Evaluation Question 6.

[82] Anecdotal data only.

Summary and Recommendations

Ushindi has been cost-effective and had a host of successes as outlined below:

- Ensuring medical, psychosocial, socioeconomic, and justice services are available should survivors want and need such services
- Increasing community knowledge about SGBV
- Increasing the number of survivors that present to care within the 72-hour window to receive PEP
- The constant, cost-effective and reliable supply of PEP kits to the health centers in Ushindi implementation areas
- The improvement in the knowledge of health care personnel at the health center level to identify and treat survivors of sexual violence
- A context specific and accepted method for psychosocial care
- The implementation of higher level, evidence-based treatment for PTSD and severe depression (CPT)
- Significant and important effort to bring cases of sexual violence to court and push for a judgment

Improvements to the program are minor and include things such as increasing the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change, packaging PEP kits to decrease the temptation to use parts of the kits for other diagnoses, considering other socioeconomic approaches for education and/or documenting the increase in financial independence. In the next phase of Ushindi, the intake data forms should have indicators added that might help with proving impact such as adding in periodic symptom monitoring of mental health disorders associated with SGBV and better data to evaluate if survivors are indeed coming to care within 72 hours. Each evaluation question is presented below with a succinct summary and recommendations specific to each question.

Evaluation Question 1:

> What is the impact the Program has had on survivors of Gender and Sexual Based Violence and what impact has it had on local communities in terms of awareness and prevention of SGVB and promotion of gender rights?

Summary

- Anecdotally, among survivors, Ushindi's programs (specifically the medical services, safe houses and psychological care) were the most commonly mentioned services that helped them "recover"
- Ushindi had a significant impact on survivor's ability to seek care and access services that were not previously available to address the known sequelae of sexual violence
- Anecdotally, the establishment of 108 youth clubs (30,000 participants), 108 *Noyaux*, 415 VSLAs, 9 child protection networks (RECOPE), over 100,000 mass community awareness-raising sessions in villages and 26 women-led IGA/CBOs all added to community knowledge and awareness of sexual violence and information for the community to help survivors reach out to seek necessary care
- Anecdotally, there was a belief by survivors and key informants that men are less likely to force sex on their spouses due to Ushindi sensitization activities, although there is no baseline data to compare this belief change

- Victim blaming persists since baseline, although these issues were not specifically addressed in SBCC campaigns[83]
- With the exception of Lolwa, gender attitudes and or rights based on the LQAS myths study[84] which was limited with regard to the assessment of a range of attitudes and gender rights, improved with some regression in Lubero and Komada

Recommendations

- Continued integration of lay counselors and mental health services for survivors with CPT and other psychological services with periodic symptom assessment of survivors to determine impact of CPT, psychological services on survivors
- Improved SBCC to address the community-based violence the prevalent rape myths and negative gender roles in order to adjust negative norms into positive behavior change
- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change
- To determine impact of Ushindi on survivors requires periodic surveys developed to address variables of interest such as satisfaction and improvement in symptoms post sexual violence
- To determine the impact of Ushindi on community awareness would also require at least baseline/midline/endline of specific gender rights and community awareness addressed through SBCC campaigns
- Determination of programmatic impact on SGBV (sexual violence) requires population-based assessment at baseline/midline/endline of yearly rates in each health zone or across the entire program

Evaluation Question 2:

For survivors, what is their knowledge of a support structure (*Noyaux Communautaire*, Safe Houses, Counselors, legal assistance[85]) and who they would go to for help?

Summary

- Community awareness of support structures of survivors were well known largely due to the activities of the *Noyaux Communautaire* who pointed survivors in the direction of all arms of the services in cooperation and support by its local partners, PPSSP and Heal Africa within the health zones of Komanda, Lolwa and Lubero
- The most common entry points for support include medical services (not necessarily at Safe Houses) and the *Noyaux Communautaire*
- According to the vast majority of survivors interviewed, more than three-quarters were aware of Ushindi and its support services such as the *Noyaux*, counselors, legal assistance and the safe houses
- Survivors rely heavily on the lay counselors associated with the safe houses and communities and credit them with their comfort and recovery
- It was not clear if the *Noyaux* identified survivors, or were referred survivors, through community networks
- Not all survivors accessed care through the Safe Houses but when they presented to any arm of

[83] For example, how women dress and behave.
[84] Gender rights were limited to the right to refuse sex.
[85] Legal Services: See Evaluation Question 5.

the program (including legal), they were referred to all arms of the program, especially medical, as a first step of the process of care
- Among the survivors interviewed, there was less knowledge of the legal services available to survivors, which was mainly due to strongly-held beliefs that justice could not be served without a known perpetrator, and the belief that few, if any, perpetrators actually served time, especially for conflict associated rapes. Other reasons for avoiding legal services were somewhat due to a fear of humiliation and the perceived need for bribery during the process and/or lack of funding for participation in court proceedings

Recommendations

- Increase community outreach through the *Noyaux* to ensure survivors are identified within the community as opposed to waiting for survivors to present to services
- Improve the communication to the community regarding the legal services available and or the successes due to community beliefs about the limits of the legal system

Evaluation Question 3:

> For survivors who require medical assistance, their knowledge of the importance of seeking medical services, the availability of PEP kits to prevent HIV/AIDS, and the fact that such care is free of charge?

Summary

- Despite data limitations on the actual presentation time to services, there appears to be an increase in the number of survivors coming to care within 72 hours which suggests the communication campaigns by the *Noyaux* have been successful
- PEP kits are used appropriately by providers who feel more confident about the use of National Treatment Guidelines for the identification and treatment of survivors since the start of Ushindi
- PEP kits used during the five years of Ushindi increased also suggesting that survivors were coming to care earlier (within 72 hours)
- Ushindi was able to consistently supply PEP kits to health centers and even with a limited stock out period, providers and clinics had enough kits to share until replacements were supplied
- The outside sourcing model for PEP kits by IMA was cost-effective and efficient and should be replicated by others to ensure important treatments are available
- PEP kits tended to have differing expiration dates but they did not impact treatment or expire prior to use
- PEP kits which were not packaged were, at times, taken apart in some clinics if a need for a specific drug contained in the kit arose
- There was a higher than expected rate of pregnant survivors that presented to Ushindi based on the known rate of sexual violence related pregnancies
- PMTCT services are not a provision through Ushindi and could be incorporated through a larger reproductive health package for survivors given the risk for violence among pregnant women and the 2.5% of pregnant survivors that need PMTCT
- Among survivors interviewed, it was common knowledge that medical services were free
- The sustainability of payments to the health zone and health clinics for the care of survivors is questionable if Ushindi does not exist

Recommendations

- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change

- Increase community outreach through the *Noyaux* to ensure survivors are identified within the community as opposed to waiting for survivors to present to services
- PEP kits should be packaged to avoid the temptation to use specific drugs in the kit for other medical uses
- IMA's model for procurement should be replicated in other projects for cost-effective and efficient drug procurement
- The concern of health care providers regarding pregnant survivors using Ushindi as a way to avoid admitting sexual activity needs to be addressed and researched
- Identification and follow up with pregnant women to evaluate SGBV/IPV risk in the community
- Consider integration of Ushindi services into MNCH services to provide early intervention services to at-risk-families, and identification of those at risk for SGBV
- Integration of PMTCT services for pregnant HIV positive survivors
- Sustainability of payments for survivor care needs to be evaluated and a different model used to ensure the community and health zone/Ministry of Health can sustain care for survivors
- Consider survivor care payments through and from the Safe House to eliminate the payments directly to the local health zone and providers at the health centers
- Income generation and sustainability plans among *Noyaux* is a must to ensure their programs persist

Evaluation Question 4:

For survivors requiring or having received Psychosocial Service, their knowledge of the presence of psychosocial services; a village counselor (lay) at the village level and advanced counselor at the Safe House Level? Have they had such services, the impact of such services, were they able to be functional again in their community, the need for further (higher level) counseling for victims of PTDS for survivors who have not been able to regain their past level of functionality?

Summary

- Survivors were very aware of the *Noyaux* and the psychosocial services available to them
- Psychosocial services were heavily used by survivors who "feel better" with services
- Safe Houses are important for combined service access, and represent a safe/calm/welcoming place for survivors
- Lay counselors in particular are used heavily by survivors and are liked, well-trained and a mainstay of the program
- Psychologists are present for cases that cannot be handled at the lay counselor level and treat a smaller proportion of survivors
- Recovery is anecdotal and not clinically assessed[86]

Recommendations

- More training for lay counselors to avoid dispensing advice such as "just forget the issue"[87]
- CPT for more difficult cases

[86] Since the evaluation, a check list on symptom improvement has been adapted for the program in cooperation with JHU and is being utilized in current phase of Ushindi.

[87] Clinically this can devolve into later PTSD as the trauma is not dealt with and is instead compartmentalized. See: Van der Kolk, B. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma (1st ed.). New York, NY: Viking.

- Should consider periodic mental health symptom tools and/or functional status tools to quantify recovery and "feeling better" and to prove impact of these treatments on survivors[88]

Evaluation Question 5:

> For survivors requiring or having received legal services, their knowledge of the presence of legal services; a jurist at the safe house to offer counsel, enter mitigation or reconciliation between parties, or pursue criminal proceedings? Have they had such services, the impact of such services, and their satisfaction? Has this had any impact (positive or negative) in the incidence of SGBV? Has pursuing justice put them at risk?

Summary

- Survivors interviewed were not as aware of legal services compared with other arms of Ushindi
- Few of the survivors interviewed had pursued cases largely due to held beliefs that justice was not possible
- More than half (56%) of cases brought to the legal clinics were pursued
- Given the difficulties of the judicial system in DRC, the fact that 21% of cases reach a judgement heralds a significant effort by the ABA to pursue justice for victims

- Anecdotally, the fact that sexual violence is prosecuted and sentences have been given, fear about being held accountable is instilled in communities
- Local Chiefs are still mediating cases certain cases as a first intervention, especially those involving minors and/or IPV cases which when that fails they then go to legal clinics
- Local Chiefs are primarily mediating child cases to save the family embarrasment
- Families are making the decisions for young girls (14-21) and using community mediation to protect the family name and to obtain the financial incentive imposed by the Chief on the perpetrator. The compensation is paid to the family and not the survivor
- Corruption is present at all levels from the police to courts
- Weekend liberty from prison results in perpetrators disappearing
- The need for survivors to seek medical attention prior to seeking support from the justice sector is understood among Ushindi's various arms
- Rebel cases cannot be prosecuted, which is frustrating to many women
- Military cases are, in some cases, brought to military justice

Recommendations

- Satisfaction of survivors in the process will require a much larger mixed methods study where the risk put on survivors who pursue justice can also be determined[89]
- Many survivors interviewed were not aware of services for justice. Better outreach and information about cases may help to bring more case to this arm of Ushindi
- Local Chiefs, although they state they understand it is illegal to mediate SGBV cases, they are doing so. Chiefs need sensitization to understand the harm such mediation can do for survivors and the legal system
- Corruption, an ongoing issue in DRC justice, must be addressed at the highest level

[88] Judith Bass (Hopkins) has a number of these tools validated in DRC and in local languages

[89] There were more than 5200 cases pursued. Follow up of these survivors would help to answer impact and would require a mixed methods study to determine impact, risk, and outcome.

- A few rebel cases are being prosecuted at the level of the International Criminal Court. Information at the community level regarding these cases might be helpful to survivors who suffered/suffer conflict-related SGBV
  ABA will complete a more indepth analysis of the database

Evaluation Question 6:

For survivors having received socio-economic assistance what was their inclusion in any of the socio-economic services in the Ushindi health zones (VLSA, social fund, and literacy program)? Have they experienced a socio-economic hardship as a survivor? Are there other needs we have not met? How can we prevent/avoid stigmatization? Having been included back in the community are they more or less vulnerable to SGVB?

Summary

- Quantitative data was not available to assess VSLA and literacy club use
- Anecdotally the survivors report economic hardship due to the inability to complete activities of daily living due to psychological distress or simply fear of walking to the fields or by the bush
- Abandonment by families was particularly hard for young survivors
- Other needs not met, according to survivors interviewed included schooling, and trades so they do not have to work in other people's fields
- Stigmatization was mentioned by survivors but it should be kept in mind that in population-based surveys this was not as prevalent as perceived in the 2010 study[90]
- Prevention of stigma needs more research. The *Noyaux* have decided that a way to minimize this is for women not to talk about their experiences with the community, especially when joining VSLA and to "forget about the incident"
- Many survivors state they are accepted by the community but it comes with a cost of ridicule and marginalization
- Survivors who cannot find work or continue with the same small businesses after the incident, have to start businesses that put them at risk for further sexual violence including working in other people's fields and working longer hours (especially after dark) and selling beer or alcohol

Recommendations

- Consider a tutoring project for survivors especially given the number of pregnant teens that drop out of school and do not return because they fall behind in their studies[91]
- Consider teaching survivors trades/skills such as sewing, which was mentioned the most, baking,

[90] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562

[91] The most recent DHS in DRC showed that a woman with a secondary education has on average 2.9 children, while a woman with no education has 7.4, a gap that highlights the key role education plays in positive health outcomes. Furthermore, with more schooling, women tend to have fewer children and space births more widely, therefore, education is a message that is important for the health of communities and vitally important for the health of women and girls. Education is a primary indicator for health especially among women. See: Demographic Health Survey. DRC 2013. http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf; Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. Gakidou, Emmanuela et al. The Lancet , 2010. 376 (9745): 959 – 974 and Reldmmi J, Makiir [), Kleinman J, Crjmoni-Htmtly J. National trends in educational differentials in mortality. *AmJEpidetnioL* 1989;129:919-933.

or business development skills to decrease the likelihood that survivors will need to participate in risky small businesses that may put them at risk for further violence (selling alcohol, working in other people's fields, prostitution, survival sex, etc.)
- Ensure there is access to VSLAs for survivors and consider a "Survivor VSLA" to limit the stigma and worry that survivors expressed in joining community VSLAs
- Document the successes of the VSLAs, especially for survivors financially or tangibly
- Consider a more nuanced assessment of stigma and how it ultimately affects survivors with the understanding that this is for a minority of survivors
- Special attention to young survivors, and especially pregnant young survivors, who were (anecdotally) more likely to be abandoned by family, drop out of school and had a hard time coming with ways to make money for survival

Evaluation Question 7:

For communities that have benefited from Ushindi Services has there been any impact on the prevalence of SGVB?

Summary

- The prevalence of SGBV in the implementation areas was not assessed at baseline, therefore it is not possible to say what impact Ushindi had on the prevalence of SGBV in the health areas/zones where Ushindi was implemented; however, the DHS data might be considered a baseline for yearly prevalence rates whereby Ushindi could conduct a population-based assessment at midline/endline to determine impact of Ushindi on prevalence rates assuming correlations and associations were also surveyed to tie decreases to specific arms of the program
- Anecdotally, more than 67% of survivors interviewed (n=74) stated that the perceived decrease in sexual violence in their communities was due to Ushindi, justice, and a change in behavior and attitudes related to Ushindi's programs

Recommendations

- Even though the prevalence of SGBV in the implementation areas was not assessed at baseline it is possible to determine if Ushindi's impact on the prevalence on SGBV using DHS data as a baseline for yearly prevalence rates. Such a study would require cluster sampling to keep the costs of the study reasonable but could be limited to the entire implementation area versus data that can be sub-grouped by health zone to reduce costs
- Correlations and associations must accompany a prevalence survey to tie decreases in SGBV to specific arms of the program
- A midline and endline assessment of the prevalence of sexual violence will be possible for the newly implemented health zones due to the extensive baseline completed in August 2016; however, and as stated, it is possible to design a population-based survey to cover all implementation areas of Ushindi

Evaluation Question 8:

What is the impact of literacy clubs, youth clubs, foster families, campaigns and VLSAs?

Summary

- Determination of impact and literacy from the participation of literacy clubs could not be determined or measured and few if any survivors could verbalize any type of true impact on

their recovery or lives such as improved financial gain and/or social re-integration due to being able to write their name or read
- Youth clubs have had anecdotal impact on awareness of children's rights and sexual violence among youth including early marriage
- Foster families had little to no measurable impact on child SGBV survivors and could only house a minimum of survivors at a significant cost to the program
- Campaigns, based on the LQAS, made some improvement in attitudes and myths among the communities evaluated especially in Lolwa
- Several survivors bought land, were able to support their children and/or pay their school fees, or start a small business
- VSLAs were culturally accepted in that there were twice as many spontaneous VSLAs that developed during the life of the project
- VSLA was anecdotally helpful to survivors and the community for microloans
- The impact and financial improvement from participation in VSLA among households of survivors could not be determined

Recommendations

- Consider a tutoring program for survivors especially given the number of pregnant teens that drop out of school and do not return because they fall behind in their studies[92]
- If literacy is continued, measurable periodic impact questionnaires will need to be developed and analyzed
- Youth clubs should have an assessment of a child development specialist to ensure the clubs are not putting the children at risk[93] and they are addressing difficult topics such as rape for all ages involved in the youth clubs
- Periodic assessment will need to be implemented to assess the anecdotal successes in child rights, early marriage and child violence reported by youth
- Consider dropping the Foster Family model from Ushindi and instead, further develop child friendly services and guidelines that meet the developmental needs of child survivors that are in consultation with a child development specialist
- Consider school based programs to reach children concerning SGBV, child violence, protection and child rights
- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior changes in the community to address gender rights, myths, prevention of SGBV and attitudes
- To determine impact of VSLAs, periodic assessment of household and/or survivor financial improvement will need to be implemented
- Ensure there is access to VSLAs for survivors and consider a "Survivor VSLA" to limit the

[92] The most recent DHS in DRC showed that a woman with a secondary education has on average 2.9 children, while a woman with no education has 7.4, a gap that highlights the key role education plays in positive health outcomes. Furthermore, with more schooling, women tend to have fewer children and space births more widely, therefore, education is a message that is important for the health of communities and vitally important for the health of women and girls. Education is a primary indicator for health especially among women. See: Demographic Health Survey. DRC 2013. http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf; Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. Gakidou, Emmanuela et al. The Lancet, 2010. 376 (9745): 959 – 974 and Reldmmi J, Makiir [), Kleinman J, Crjmoni-Htmtly J. National trends in educational differentials in mortality. *AmJEpidetnioL* 1989;129:919-933.

[93] Some youth clubs were asking children to report parents and other adults to the police. Anecdotally, some children have been beaten after doing so.

stigma and worry that survivors expressed in joining community VSLAs

- Document the successes of the VSLAs, especially for survivors financially or tangibly

Annex I: Key Informants Interview Respondents

Number	Name	Contact info	Title/Home organization
	Key Informants		
1	Milka Kavera	0997715408	Director /PPSSP
2	Joseph Ciza Nakamina	0997715408	IMA; NGO Program Coordinator
3	Dr. William Clemmer	73 Avenue Lyn Lusi, Quartier les Volcans Goma - DR. Congo. Mobile DRC: +243813873978 Mobile USA: +14105966672 Skype: congokin6	Chief of Party, Ushindi Project /USAID
4	Dr. Jonathan Lusi		Founder/President Heal Africa
7	Neema Kamuswekere	Lubero HZ	Chief, Bureau of Social Affairs – Lubero Letter received with needs and thoughts about
6	Community member; Male	Komanda HZ; Mangiva HA	
7	Asumani Nicolas	Komanda HZ; Mangiva HA	Local Chief Mangiva – Member of *Noyau Communautaire*
8	Ambo Kunanga	Komanda HZ; Mangiva HA	Pastor, Mobilizer – *Noyaux Communautaire*
9	Lamber Ausse Mboko	0813524880	Chief of Babila Bakwanza (collective)
10	Jean Pierre Bulaw Angsandi	0829523719	Secretary to the Chief of Babila Bakwanza
11	Mme. Dorcas	Komanda City	President of Recoupe (Community Network for Child Protection)
12	Daniel Mbungu	Lubero HZ	Project Director , Heal Africa
	Legal Sector		
1	Mr. Aline Mbambli	Lubero HZ; Mulo HA	Lawyer
2	Samuel Muhindo Mukubwa	0971387800	Paralegal
3	Fatuma Kahindo	0999981472	Lawyer; Project Director
4	Bernard Mulumba	0995430150	Lawyer
5	Major Jaques	Lubero Center	Police Commander; Lubero HZ

	Ciragaga Ntwali		
6	Roger Waywaywa	Komanda HZ	Captain of the Police Unit in Komanda
	Survivors		
1-9	Names withheld	Komanda HZ; Komanda HA	
10-12	Names withheld	Komanda HZ; Bamanda HA	
13-21	Names withheld	Komanda HZ; Mangiva HA	
22-29	Names withheld	Lolwa HZ; Lolwa HA	
30-33	Names withheld	Lolwa HZ; Bahaha HA	
34-38	Names withheld	Lubero HZ; Kasalala HA	
39-46	Names withheld	Lubero HZ; Baraka HA	
47-59	Names withheld	Lubero HZ; Mulo HA	
60-64	Names withheld	Lubero HZ; Kasima HA	
65-74	Names withheld	Lubero HZ; General Hospital	
	Counselors		
1	Nathaniel Mbwirwa	Komanda HZ; Komanda HA – Safe House	Psychologist (adults)
2	Shomama Uchayi	Komanda HZ; Mangiva HA	Lay Counselor and *Noyaux Communautaire* member
3	Mugasia Irene	Lolwa HZ, Bahaha HA	Lay Counselor
4	Asero Furaha	Komanda HZ; Bamanda HA	Lay Counselor
5	Nguru Bislere Beldis	Lubero HZ; Baraka HA 0993491993	Lay Counselor
6	Jeannine Kavugho Zamadi	Lubero HA; Mulo HA 0813226254	Psychologist, Mulo Health Center
	Healthcare Personnel		
1	Denis Baseme	0815627476	Senior Nurse, Mangiva Health Center
2	Fuastin Singo	Komanda HZ; 08174808802	Chief,
3	Dr Buenisnu Mbaute	Lolwa HZ; 0823570778	Director Hospital Lolwa
4	Dr Patrick Mbaricale	Lolwa HZ;0811087491	Chief of
5	Atwandi Bemengwa	Lolwa HZ; 0823129760	Nurse Supervisor
6	Mbokani Nzawro	Lolwa HZ; 0827919569	Nurse Supervisor
7	Jean Faustin Pelemisbiso	Komanda HZ; Bamande HA No phone due to no signal	Nurse
8	Dr Cyril Mumbere	Lubero HZ	Chief,
9	Kasereka Kavinywa	Lubero HZ, Baraka HA	Senior Nurse, Baraka Health Center
10	Kabuo Ngvomoja	Lubero HZ; Kasima HA	Senior Nurse, Kasima Health Center (only female head nurse interviewed)
11	Jean De Dicu Kakule Kibwana	Lubero HZ; Mulo HA 0874631499	Senior Nurse, Mulo Health Center
	Foster Parents		
1-4	Names Withheld	Komanda HZ; Komanda HA	
5-6	Names Withheld	Lubero HZ	
	Noyaux Communautaire	(In other categories/dual hatted = 5	

1	Kahindo Siriwayo	Komanda HZ; Mangiva HA	Member
2	Fidele Bambisi	Lolwa HZ; Bahaha	Sensitization;
3	Binzolo Bulahimo	Lolwa HZ; Bahaha	Member
4	Hamadi Haji	Lolwa HZ; Bahaha	Secretary
5	Charlotte Ndalumi	Lolwa HZ; Bahaha	Member
6	Meaio Kitoko	Lolwa HZ; Bahaha	Member
7	Ketsu Bakebionga	Lolwa HZ; Bahaha	Lay counselor
8	Zakiniki Kwekinay	Lolwa HZ; Bahaha	Member
9	Desire Amsini	Lolwa HZ; Bahaha	Member
10	Amsini Temudu	Lolwa HZ; Bahaha	Lay counselor
11	Jean Tumbuazi	Lolwa HZ; Bahaha	Member
12	Lumzambi Pita	Lolwa HZ; Bahaha	Member
13	Solomono Alimasi	Lolwa HZ; Bahaha	Member
14	Moaeste Apalay	Lolwa HZ; Bahaha	Member
15	Muhindo Paluku	Lolwa HZ; Bahaha	Member
16	Henry Aumyu	Lolwa HZ; Bahaha	Member
17	Safina Ochuoka	Lolwa HZ; Bahaha	Member
18	Jeanot Aboli	Lolwa HZ; Bahaha	Member
19	Kakule Kykwyirewe	Lumbero HZ; Baraka HA	Member
20	Paluku Mbayambki	Lumbero HZ; Baraka HA	Member
21	Kangere Kipura	Lumbero HZ; Baraka HA	Member
22	Kavugho Kyamabale	Lumbero HZ; Baraka HA	Member
23	Kavira Matumaini	Lumbero HZ; Baraka HA	Member
24	Kakale Tavahola	Lubero HZ; Kasima HA	Member
25	Paluke Givasima	Lubero HZ; Kasima HA	Member
26	Denise Minbayakeka	Lubero HZ; Kasima HA	Member
27	Kavira Kasayi	Lubero HZ; Kasima HA	Member
28	Kahindo Pascaline	Lubero HZ; Kasima HA	Member
	VSLA		
1	Mumbere Mutsuvamula	Lumbero HZ; Baraka HA	Member
2	Paleskis Limindo	Lumbero HZ; Baraka HA	Member
3	Katungu Matabishi	Lumbero HZ; Baraka HA	Member
4	Kyakimwa Kahamba	Lumbero HZ; Baraka HA	Member
5	Kyakinwa Musumba	Lumbero HZ; Baraka HA	Member
6	Mbusa Kapisa	Lubero HZ; Kasima HA	Member
7	Jean Pierre Kambale	Lubero HZ; Kasima HA	Member
8	Kahindo Kazimoto	Lubero HZ; Kasima HA	Member
9	Nziavake Kasay	Lubero HZ; Kasima HA	Member
10	Kanyere Muke	Lubero HZ; Kasima HA	Member
11-13	Names withheld	Lubero HZ; Mulo HA	Survivors and members
14-15	Names withheld	Lubero HZ; Kasalala HA	Survivors and members
16-19	Names withheld	Lubero HZ	Survivors and members
	Literacy Program		
1	Kalume Blaise	Komanda HZ; Mangiva HA	*Noyaux Communautaire* member, Literacy teacher

2-6	Names Withheld	Komanda HZ; Bamande HA	Beneficiaries
	Youth Group		
1-12	Names withheld	Lolwa HZ; Bamande HA	Ages 10-15 accompanied by a teacher and parent
13-17	Names withheld	Lubero HZ; Baraka HA	Ages 10-16 accompanied by Heal Africa Staff
18-22	Names withheld	Lubero HZ; Kasima HA	Ages 14-16, accompanied by Heal Africa Staff

Annex II: LQAS Attitudes and Myth Survey

Opinion Survey

Hello and thank you very much for talking with me. We are interested in learning about the opinions of the community on sexual violence. You will not receive any money for being here and your participation will in no way affect your position or affect the services anyone receives in the community or be shared with anyone. Everything you say here is completely confidential. We will not use your name or tell anyone you talked with us. You are free to leave at any time or skip questions. You will not be asked to share your personal information or history. Instead, we are interested in your opinions about sexual violence. We will be interviewing others; please do not discuss what was said here once you leave. This discussion should take about 10 minutes. Thank you again for your time. You are free not to participate or withdraw at any time during the survey without fear of any repercussions.

1. Consent to Interview: Yes No
2. Date: (MM/DD/YY)
3. Data collector name:
4. Heath Zone:
5. Health Area:
6. Age of respondent: Years
7. Sex:

Question	Agree	Disagree	Don't know	Skipped/ Refused
In most cases when a woman is raped, she deserved it				
Women who say no to sexual intercourse often mean yes				
Most rapes happen because women entice men				
If a woman really didn't want to be raped she could fight off the attacker				
Only soldiers can rape				
A spouse owes the other partner sex no matter what the circumstance				
A woman can enjoy sex even when it is forced upon her				
A raped woman is usually an innocent victim				
Women often claim rape to protect their reputations				
"Good" girls are less likely to be raped as "bad" girls				
Women who have had prior sexual relationships should not complain about rape				
Women do not provoke rape by their appearance or behavior				
Men, not women, are responsible for rape				
Women who wear short skirts or tight shirts are not inviting rape				
If a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her				

Annex III: Qualitative Key Informant Interview: Survivors

Notes for the Interviewer:

- At all times you must remain non-judgmental
- Do not offer any of your own opinions
- Do not agree or disagree with statements in the discussion. There are no right or wrong answers
- Do not put words in participants' mouths
- No names should be used
- When speaking to the respondent, we are talking about his or her experiences and opinions and what they believe is the prevailing community opinion
- Be sure to write everything down just as the person says it. Do not edit or interpret what they are saying

Introduction:

Hello and thank you very much for talking with me. We are interested in learning more about how women who suffered sexual violence over the last five years have been doing and what they thought of the resources available to them. In addition, we are interested in barriers that might make this care difficult. We hope that your answers to these questions will inform and help improve the programmatic interventions for survivors. You will not receive any money for being here and your participation will in no way affect your position or affect the services anyone receives in the community.

Everything you say here is completely confidential. We will not use your name or tell anyone you talked with us. You are free to leave at any time or skip questions. You will not be asked to share your personal information or history. Instead, we are interested in your opinions, experiences and views about the services for women who have survived sexual violence. We will be interviewing others; please do not discuss what was said here once you leave. This discussion should take about 30 minutes. Thank you again for your time. You are free not to participate or withdraw at any time during the survey without fear of any repercussions.

1. Consent to Interview: Yes No
2. Date: (MM/DD/YY)
3. Data collector name:
4. Health Zone:
5. Health Area:
6. Village:
7. Age of respondent: Years
8. Sex:
9. Education (highest level finished):
10. Ethnic Group:

11. Did you seek help from Safe Houses? Yes No

    11a. Why or why not? (Probe how they may have been helpful)

12. Did you seek help from counselors? Yes No

    12a. Why or why not? (Probe how they may have been helpful, lay versus professional)

13. Do you believe legal assistance is helpful for survivors? Yes No

    13a. Why or why not? (Probe how this may have been helpful)

14. Did you access legal assistance? Yes No

    14a. Why or why not?

15. Have you heard of *Noyaux Communautaire*? Yes No

    15a. Please explain your experience with the *Noyaux Communautaire*?

16. How has and/or its programs directly helped you? (Probe examples, specifics)

17. Has the services of helped you recover (how? why? Examples)

18. What has happened to the frequency of women that suffer sexual violence in your community? (increased, decreased, stayed the same)

    18a. What do you think contributed to this increase/decrease/unchanged number of women suffering sexual violence?

<u>Since the start of (2010) did you participate as a survivor in any of the following programs:</u>

19. Medical: Yes No (GO TO 21)

20. Were you required to pay anything for the services? Yes No

21. Is it important for someone who suffers sexual violence to seek medical care and why?

22. How soon after violence should someone seek medical care?

23. Psychosocial Services: Yes No **(GO TO #33)**

24. How or how not did these services help you?

25. What kind of other psychosocial services that are needed?

26. What type of psychosocial care is available in your area?

27. Legal Services: Yes No **(GO TO #37)**

28. What part of the legal services did you use and what course of action did you take?

29. What did you think of your experience with the legal services? (Probe: what would you have done differently? Did they feel at risk in anyway?)

30. Have legal proceedings for sexual violence had any impact on the number of cases of sexual violence in your community? (explain)

31. Socio-economic (VLSA, Social funds, literacy programs) Yes No (**GO TO #33)**

32. How did these programs help you?

33. As a survivor, did you suffer economic hardship as a survivor? (explain, examples)

34. Of all of the programs you had experience with or participated in, which ones do you think were the most important services for your recovery?

Annex IV: Qualitative Community Interviews on Attitudes and Rape Myths

Hello and thank you very much for talking with me. We are interested in learning about the opinions of the community on sexual violence. You will not receive any money for being here and your participation will in no way affect your position or affect the services anyone receives in the community or be shared with anyone. Everything you say here is completely confidential. We will not use your name or tell anyone you talked with us. You are free to leave at any time or skip questions. You will not be asked to share your personal information or history. Instead, we are interested in your opinions about sexual violence. We will be interviewing others; please do not discuss what was said here once you leave. This discussion should take about 20 minutes. Thank you again for your time. You are free not to participate or withdraw at any time during the survey without fear of any repercussions.

1. Consent to Interview: Yes No
2. Date: (MM/DD/YY)
3. Data collector name:
4. Health Zone:
5. Health Area:
6. Age of respondent: Years
7. Sex:

8. Do you agree or disagree with the following statement:
In most cases when a woman is raped, she deserved it; Please explain your answer

9. Do you agree or disagree with the following statement:
Most rapes happen because women entice men; Please explain your answer

10. Do you agree or disagree with the following statement:
Only soldiers can rape; Please explain your answer

11. Do you agree or disagree with the following statement:
A raped woman is usually an innocent victim; Please explain your answer

12. Do you agree or disagree with the following statement:
Women who have had prior sexual relationships should not complain about rape; Please explain your answer

13. Do you agree or disagree with the following statement:
Women do not provoke rape by their appearance or behavior; Please explain your answer

14. Do you agree or disagree with the following statement:
Women who wear short skirts or tight shirts are not inviting rape; Please explain your answer

15. Do you agree or disagree with the following statement:
If a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her; Please explain your answer

16. Do you agree or disagree with the following statement:
If a woman really didn't want to be raped she could fight off the attacker; Please explain your answer

17. Do you agree or disagree with the following statement:
A woman can enjoy sex even when it is forced upon her; Please explain your answer

18. Do you agree or disagree with the following statement:
A spouse owes the other partner sex no matter what the circumstance; Please explain your answer

Annex V: Qualitative Key Informant Interview

Introduction:

Hello and thank you very much for talking with me. We are interested in learning more about how women who suffered sexual violence over the last five years have been doing and what they thought of the resources available to them. In addition, we are interested in barriers that might make this care difficult. We hope that your answers to these questions will inform and help improve the programmatic interventions for survivors. You will not receive any money for being here and your participation will in no way affect your position or affect the services anyone receives in the community.
Everything you say here is completely confidential. We will not use your name or tell anyone you talked with us. You are free to leave at any time or skip questions. You will not be asked to share your personal information or history. Instead, we are interested in your opinions, experiences and views about the services for women who have survived sexual violence. We will be interviewing others; please do not discuss what was said here once you leave. This discussion should take about 30 minutes. Thank you again for your time. You are free not to participate or withdraw at any time during the survey without fear of any repercussions.

1. Consent to Interview: Yes No
2. Date: (MM/DD/YY)
3. Data collector name:
4. Health Zone:
5. Health Area:
6. Age of respondent: (Years)
7. Sex:

8. Please tell me what you think about how has made an impact for survivors and the community
9. What do you think were the programs best qualities and why?
10. Can you think of any problems that may have developed as a result of the implementation of ?
11. Do you think that community attitudes towards survivors and about sexual violence have changed over the course of ? Why?
12. In your opinion, has the prevalence of sexual violence increased, decreased or stayed the same? Can you give examples?
13. What changes would you like to see to in the future?

Annex VI: LQAS Data Analysis

S1. In most cases when a woman is raped she deserved it

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	5%	89%	0%	5%	P
Lolwa	17%	83%	0%	0%	P
Lubero	5%	95%	0%	0%	P

(P if Disagree > 60%, BP if Disagree between 58 % and 60% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S2. Women who say no to sexual intercourse often mean yes

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	26%	74%	0%	0%	P
Lolwa	11%	83%	6%	0%	P
Lubero	47%	53%	0%	0%	P

(P if Disagree > 18%, BP if Disagree between 16% and 18% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S3. Most rapes happen because women entice men

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	47%	53%	0%	0%	P
Lolwa	17%	78%	6%	0%	P
Lubero	37%	63%	0%	0%	P

(P if Disagree > 18%, BP if Disagree between 16% and 18% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S4. If a woman really didn't want to be raped she could fight off the attacker

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	79%	11%	11%	0%	F
Lolwa	72%	28%	0%	0%	P
Lubero	79%	5%	16%	0%	F

(P if Disagree > 13%, BP if Disagree between 11% and 13% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S5. Only soldiers can rape

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	0%	100%	0%	0%	P
Lolwa	0%	100%	0%	0%	P
Lubero	0%	100%	0%	0%	P

(P if Disagree > 81%, BP if Disagree between 79% and 81% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S6. A spouse owes the other partner sex no matter what the circumstance

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	16%	84%	0%	0%	P
Lolwa	11%	78%	11%	0%	P
Lubero	11%	74%	16%	0%	P

(P if Disagree > 45%, BP if Disagree between 43% and 45% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S7. A woman can enjoy sex even when it is forced upon her

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	0%	100%	0%	0%	P
Lolwa	22%	72%	0%	6%	F
Lubero	0%	95%	5%	0%	P

(P if Disagree > 81%, BP if Disagree between 79% and 81% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S8. A raped woman is usually an innocent victim

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	84%	11%	0%	5%	P
Lolwa	89%	11%	0%	0%	P
Lubero	74%	26%	0%	0%	P

(P if Agree > 65%, BP if Agree between 63% and 65% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S9. Women often claim rape to protect their reputations

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	58%	37%	5%	0%	P
Lolwa	22%	72%	6%	0%	P
Lubero	37%	47%	16%	0%	P

(P if Disagree > 23%, BP if Disagree between 21% and 23% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S10. Women who have had prior sexual relationships should not complain about rape

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	11%	84%	5%	0%	P
Lolwa	22%	72%	6%	0%	P
Lubero	21%	79%	0%	0%	P

(P if Disagree > 45%, BP if Disagree between 43% and 45% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S11. Women do not provoke rape by their appearance or behavior

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	47%	47%	0%	5%	F
Lolwa	44%	56%	0%	0%	F
Lubero	42%	53%	5%	0%	F

(P if Agree > 55%, BP if Agree between 53% and 55% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S12. Men, not women, are responsible for rape

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	5%	95%	0%	0%	F
Lolwa	11%	67%	22%	0%	F
Lubero	5%	68%	26%	0%	F

(P if Agree > 55%, BP if Agree btween 53% and 55% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S13. Women who wear short skirts or tight shirts are not inviting rape

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	58%	42%	0%	0%	P
Lolwa	50%	44%	6%	0%	P
Lubero	42%	553%	5%	0%	F

(P if Agree > 50%, BP if Agree between 48% and 50%, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

S14. If a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her

HEALTH ZONE	AGREE	DISAGREE	DON'T KNOW	REFUSED	PASS/FAIL
Komanda	47%	53%	0%	0%	P
Lolwa	61%	39%	0%	0%	P
Lubero	68%	32%	0%	0%	P

(P if Disagree > 8%, BP if Disagree between 6% and 8% inclusive, F otherwise; P- Pass; F-Fail; BP-Barely Passed; I-improved; R-regressed; U-unchanged; NA - not available)

Annex VII: Full Data Tables

Table 1. Characteristics of SGBV Survivors supported by the Ushindi Project by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value[b]
Characteristic	**n[a]**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**244**		**3306**		**4666**		**4335**		**3609**		**2575**	
Sex													
Female	235	96.3 (93.9 – 98.7)	2992	90.5 (89.5 – 91.5)	4130	88.5 (87.6 – 91.5)	3858	89.0 (88.1 – 89.9)	3354	92.9 (92.1 – 93.8)	2329	90.4 (89.3 – 91.6)	**0.0213**
Male	9	3.7 (1.3 – 6.1)	314	9.5 (8.5 – 10.5)	536	11.5 (10.5 – 12.4)	477	11.0 (10.1 – 11.9)	255	7.1 (6.2 – 7.9)	246	9.6 (8.4 – 10.7)	**0.0213**
Age (years)	230	19.0 (17.8 – 20.2)	2803	25.5 (24.9 – 26.0)	4097	24.5 (24.1 – 24.9)	3873	25.6 (25.2 – 26.0)	3243	25.1 (25.7 – 25.6)	2340	25.1 (24.6 – 25.6)	**0.0354**
Marital Status													
Single	202	82.8 (78.1 – 87.5)	1758	53.2 (51.5 – 54.9)	2605	55.8 (54.4 – 57.3)	2418	55.8 (54.3 – 57.3)	2007	55.6 (54.0 – 57.2.)	1413	54.9 (53.0 – 56.8)	0.3283
Married with certificate	34	13.9 (9.6 – 18.3)	958	29.0 (27.4 – 30.5)	802	17.2 (16.1 – 18.3)	751	17.3 (16.2 – 18.5)	591	16.4 (15.2 – 17.6)	429	16.7 (15.2 – 18.1)	**<0.0001**
With partner/bride price	4	1.6 (0.0 – 3.2)	131	4.0 (3.3 – 4.6)	623	13.4 (12.4 – 14.3)	621	14.3 (13.3 – 15.4)	533	14.8 (13.6 – 15.9)	389	15.1 (13.7 – 16.5)	**<0.0001**
With partner/no bride price	2	0.8 (0.0 – 2.0)	111	3.4 (2.7 – 4.0)	329	7.1 (6.3 – 7.8)	234	5.4 (4.7 – 6.1)	214	5.9 (5.2 – 6.7)	175	6.8 (5.8 – 7.8)	**<0.0001**
Other[b]	2	0.8 (0.0 – 2.0)	348	10.5 (9.5 – 11.6)	303	6.5 (5.8 – 7.2)	302	7.0 (6.2 – 7.7)	264	7.3 (6.5 – 8.2)	169	6.6 (5.6 – 7.5)	**<0.0001**
Religion													
Christian	206/240	85.8 (81.4 – 90.2)	1971/3159	62.4 (60.7 – 64.1)	4259/4650	91.6 (90.8 – 92.4)	4031/4321	93.3 (92.5 -94.0)	3418/3586	95.3 (94.6 – 96.0)	2445/2568	95.2 (94.4 – 96.0)	**<0.0001**
Muslim	2/240	0.8 (0.0 – 2.0)	26/3159	0.8 (0.5 – 1.1)	45/4650	1.0 (0.7 – 1.2)	49/4321	1.1 (0.8 – 1.4)	23/3586	0.6 (0.4 – 0.9)	23/2568	0.9 (0.5 – 1.3)	0.6794
Other	2/240	0.8 (0.0 – 2.0)	87/3159	2.8 (2.2 – 3.3)	59/4650	1.3 (0.9 – 1.6)	42/4321	1.0 (0.7 – 1.3)	32/3586	0.9 (0.6 – 1.2)	16/2568	0.6 (0.3 – 0.9)	**<0.0001**
None	30/240	12.5 (8.3 – 16.7)	1074/3159	34.0 (32.3 – 35.7)	287/4650	6.2 (5.5 – 6.9)	197/4321	4.6 (3.9 – 5.2)	113/3586	3.2 (2.6 – 3.7)	84/2568	3.3 (2.6 – 4.0)	**<0.0001**
Highest Level of Education													
Primary	162	66.4 (60.5 – 72.3)	1571/3287	47.8 (46.1 – 49.5)	2363/4652	50.8 (49.4 – 52.2)	2146/4330	49.6 (48.1 – 51.1)	1786/3590	49.7 (48.1 – 51.4)	1231/2569	47.9 (46.0 – 49.8)	0.1214
Secondary	30	12.3 (8.2 – 16.4)	565/3287	17.2 (15.9 – 18.5)	930/4652	20.0 (18.8 – 21.1)	909/4330	21.0 (19.8 – 22.2)	851/3590	23.7 (22.3 – 25.1)	712/2569	27.7 (26.0 – 29.4)	**<0.0001**
University/Higher Education	0	-	9/3287	0.3 (0.1 – 0.5)	21/4652	0.5 (0.3 – 0.6)	8/4330	0.2 (0.1 – 0.3)	9/3590	0.3 (0.1 – 0.4)	11/2569	0.4 (0.2 – 0.7)	0.8413
Other	0	-	41/3287	1.2 (0.9 – 1.6)	25/4652	0.5 (0.3 – 0.7)	15/4330	0.3 (0.2 – 0.5)	7/3590	0.2 (0.1 – 0.3)	6/2569	0.2 (0.0 – 0.4)	**<0.0001**
None	52	21.3 (16.2 – 26.4)	1101/3287	33.5 (31.9 – 35.1)	1313/4652	28.2 (26.9 – 29.5)	1252/4330	28.9 (27.6 – 30.3)	937/3590	26.1 (24.7 – 27.5)	609/2569	23.7 (22.1 – 25.4)	**<0.0001**
Occupation													
Farmer	137	56.1 (49.9 – 62.4)	2023	61.2 (59.5 – 62.9)	3038	65.1 (63.7 – 66.5)	2880	66.4 (65.0 – 67.8)	2351	65.1 (63.6 – 66.7)	1685	65.4 (63.6 – 67.3)	**0.0002**
Student/Pupil	70	28.7 (23.0 – 34.4)	629	19.0 (17.7 – 20.4)	991	21.2 (20.1 – 22.4)	915	21.1 (19.9 – 22.3)	820	22.7 (21.4 – 24.1)	643	25.0 (23.3 – 26.6)	**<0.0001**
Businessman/woman	11	4.5 (1.9 – 7.1)	107	3.2 (2.6 – 3.8)	69	1.5 (1.1 – 1.8)	58	1.3 (1.0 – 1.7)	50	1.4 (1.0 – 1.8)	25	1.0 (0.6 – 1.3)	**<0.0001**
Professional	0	-	17	0.5 (0.3 – 0.8)	45	1.0 (0.7 – 1.2)	50	1.2 (0.8 – 1.5)	51	1.4 (1.0 – 1.8)	27	10.0 (0.7 – 1.4)	**0.0014**
Other[c]	0	-	71	2.1 (1.7 – 2.6)	119	2.6 (2.1 – 3.0)	110	2.5 (2.1 – 3.0)	99	2.7 (2.2 – 3.3)	61	2.4 (1.8 – 3.0)	0.1595
No occupation	26	10.7 (6.8 -14.5)	459	13.9 (12.7 – 15.1)	404	8.7 (7.9 – 9.5)	322	7.4 (6.6 – 8.2)	238	6.6 (5.8 – 7.4)	134	5.2 (4.3 – 6.1)	**<0.0001**
Residency Status													
Native	95	38.9 (32.8 – 45.1)	868	26.3 (24.8 – 27.8)	1726	37.0 (35.6 – 38.4)	1749	40.4 (38.9 – 41.8)	1300	36.0 (34.5 – 37.6)	1003	39.0 (37.1 – 40.8)	**<0.0001**
Resident	129	52.(946.6 – 59.1)	1776	53.7 (52.0 – 55.4)	2573	55.1 (53.7 – 56.6)	2249	51.9 (50.4 – 53.4)	1997	55.3 (53.7 – 57.0)	1384	53.7 (51.8 – 55.7)	0.9380
IDP/Refugee	4	1.6 (0.0 – 3.2)	425	12.9 (11.7 – 14.0)	225	4.8 (4.2 – 5.4)	219	5.1 (4.4 – 5.7)	262	7.3 (6.4 – 8.1)	160	6.2 (5.3 – 7.1)	**<0.0001**
Other[d]	16	6.6 (3.5 – 9.7)	237	7.2 (6.3 – 8.0)	142	3.0 (2.6 – 3.5)	117	2.7 (2.2 – 3.2)	50	1.4 (1.0 – 1.8)	28	1.1 (0.7 – 1.5)	**<0.0001**

[a]n – number of survivors with characteristic, where represented as n/N, n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]Breakdown of "Other" marital status responses: Separated (321), Divorced (134), Unspecified "other" response (934). [c]Breakdown of "Other" occupation response: Other Community Leader (44), Religious Leader (26), Police/Military (20), Humanitarian (9), Government Worker (8), Unspecified "other" response (353). [d]Breakdown of "Other" residency status responses: Stateless(38), Repatriated (18), Foreigner (16), Demobilized (14), Asylum Seeker (9), Unspecified "other" response (495).

[b]Wald test of association

Table 1 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in by year, 2010 - 2015

Characteristic	2010 n	2010 % (95% CI)	2011 n	2011 % (95% CI)	2012 n	2012 % (95% CI)	2013 n	2013 % (95% CI)	2014 n	2014 % (95% CI)	2015 n	2015 % (95% CI)	p-value, Wald test of association
Number of Survivors		**244**		**3306**		**4666**		**4335**		**3609**		**2575**	
Type de Violence													
Rape	215	88.1 (84.1 – 92.2)	1930	58.4 (56.7 – 60.1)	2556	54.8 (53.4 – 56.2)	2286	52.7 (51.2 – 54.2)	2042	56.6 (55.0 – 58.2)	1370	53.2 (51.3 – 55.1)	**<0.0001**
Sexual Harassment	9	3.7 (1.3 – 6.1)	102	3.1 (2.5 – 3.7)	181	3.9 (3.3 – 4.4)	182	4.2 (3.6 – 4.8)	144	4.0 (3.4 – 4.6)	147	5.7 (4.8 – 6.6)	**<0.0001**
Physical Harassment	3	1.2 (0.0 – 2.6)	451	13.6 (12.5 – 14.8)	639	13.7 (12.7 – 14.7)	595	13.7 (12.7 – 14.7)	396	11.0 (10.0 – 12.0)	284	11.0 (9.8 – 12.2)	**0.0040**
Forced Marriage	0	-	12	0.4 (0.2 – 0.6)	36	0.8 (0.5 – 1.0)	26	0.6 (0.4 – 0.8)	24	0.7 (0.4 – 0.9)	20	0.8 (0.4 – 1.1)	0.0913
Emotional/Psychological Violence	5	2.0 (0.3 – 3.8)	276	8.3 (7.4 – 9.3)	732	15.7 (14.6 – 16.7)	848	19.6 (18.4 – 20.7)	665	18.4 (17.2 – 19.7)	497	19.3 (17.8 – 20.8)	**<0.0001**
Denied Resources/Opportunities	3	1.2 (0.0 – 2.6)	103	3.1 (2.5 – 3.7)	143	3.1 (2.6 – 3.6)	141	3.3 (2.7 – 3.8)	176	4.9 (4.2 – 5.6)	132	5.1 (4.3 – 6.0)	**<0.0001**
Other	8	3.3 (1.0 – 5.5)	349	10.6 (9.5 – 11.6)	300	6.4 (5.7 – 7.1)	156	3.6 (3.0 – 4.2)	122	3.4 (2.8 – 4.0)	83	3.2 (2.5 – 3.9)	**<0.0001**
None	1	0.4 (0.0 – 1.2)	83	2.5 (2.0 – 3.0)	79	1.7 (1.3 – 2.1)	101	2.3 (1.9 – 2.8)	40	1.1 (0.8 – 1.4)	42	1.6 (1.1 – 2.1)	**0.0095**
Services Accessed													
Medical Services	115	47.1 (40.9 – 53.4)	1085	32.8 (31.2 – 34.4)	1408	30.2 (28.9 – 31.5)	1785	41.2 (39.7 – 42.6)	1506	41.7 (40.1 – 43.3)	953	37.0 (35.1 – 38.9)	**<0.0001**
Psychosocial Services	211	86.5 (82.2 – 90.8)	2160	65.3 (63.7 – 67.0)	3028	64.9 (63.5 – 66.3)	3263	75.3 (74.0 – 76.6)	2803	77.7 (76.3 – 79.0)	1929	74.9 (73.2 – 76.6)	**<0.0001**
Socio-economic Services	1	0.4 (0.0 – 1.2)	61	1.8 (1.4 – 2.3)	57	1.2 (0.9 – 1.5)	30	0.7 (0.4 – 0.9)	42	1.2 (0.8 – 1.5)	65	2.5 (1.9 – 3.1)	0.1052
Legal Services	6	2.5 (0.5 – 4.4)	713	21.6 (20.2 – 23.0)	1778	38.1 (36.7 – 39.5)	1287	29.7 (28.3 – 31.0)	869	24.1 (22.7 – 25.5)	560	21.7 (20.2 – 23.3)	**<0.0001**

Table 2. Characteristics of SGBV Survivors supported by the Ushindi Project in Alimbongo Health Zone by year, 2010 - 2015

Characteristic	2010 n[a]	2010 % (95% CI)	2011 n	2011 % (95% CI)	2012 n	2012 % (95% CI)	2013 n	2013 % (95% CI)	2014 n	2014 % (95% CI)	2015 n	2015 % (95% CI)	p-value, Wald test of association[b]
Number of Survivors		**1**		**160**		**1106**		**930**		**798**		**620**	
Sex													
Female	1	100.0	141	88.1 (83.1 - 93.1)	924	83.5 (81.4 - 85.7)	785	84.4 (82.1 - 86.7)	729	91.4 (89.4 - 93.3)	551	88.9 (86.4 - 91.3)	**<0.0001**
Male	0	-	19	11.9 (6.9 - 16.9)	182	16.5 (14.3 - 18.6)	145	15.6 (13.3 - 17.9)	69	8.6 (6.7 - 10.6)	69	11.1 (8.6 - 13.6)	**<0.0001**
Age (years)	1	20.4	142	22.8 (21.1 - 24.4)	1023	23.9 (23.2 - 24.6)	793	25.0 (24.2 - 25.8)	715	24.3 (24.5 - 26.1)	740	25.9 (25.0 - 26.8)	**<0.0001**
Marital Status											276		
Single	1	100.0	111	69.4 (62.2 - 76.5)	663	59.9 (57.1 - 62.8)	603	64.8 (61.8 - 67.9)	476	59.6 (56.2 - 63.1)	344	55.5 (51.6 - 59.4)	**0.0066**
Married with certificate	0	-	37	23.1 (16.6 - 29.7)	246	22.2 (19.8 - 24.7)	210	22.6 (19.9 - 25.3)	180	22.6 (19.7 - 25.5)	145	23.4 (20.1 - 26.7)	0.6958
With partner/bride price	0	-	2	1.3 (0.0 - 3.0)	59	5.3 (4.0 - 6.7)	40	4.3 (3.0 - 5.6)	45	5.6 (4.0 - 7.2)	33	5.3 (3.6 - 7.1)	0.2455
With partner/no bride price	0	-	3	1.9 (0.0 - 4.0)	84	7.6 (6.0 - 9.2)	36	3.9 (2.6 - 5.1)	42	5.3 (3.7 - 6.8)	61	9.8 (7.5 - 12.2)	**0.0357**
Other[c]	0	-	7	4.4 (1.2 - 7.5)	54	4.9 (3.6 - 6.2)	41	4.4 (3.1 - 5.7)	55	6.9 (5.1 - 8.7)	37	6.0 (4.1 - 7.8)	0.0754
Religion													
Christian	1	100.0	155/158	98.1 (96.0 - 100.0)	1078/1098	98.2 (97.4 - 99.0)	910/925	98.4 (97.6 - 99.2)	784/796	98.5 (97.6 - 99.3)	601	96.9 (95.6 - 98.3)	0.2096
Muslim	0	-	0/158		1/1098	0.1 (0.0 - 0.3)	8/925	0.9 (0.3 - 1.5)	2/796	0.3 (0.0 - 0.6)	3	0.5 (00 - 1.0)	0.2970
Other	0	-	1/158	0.6 (0.0 - 1.9)	3/1098	0.3 (0.0 - 0.6)	2/925	0.2 (0.0 - 0.5)	3/796	0.4 (0.0 - 0.8)	3	0.5 (0.0 - 1.0)	0.6340
None	0	-	2/158	1.3 (0.0 - 3.0)	16/1098	1.5 (0.7 - 2.2)	5/925	0.5 (0.1 - 1.0)	7/796	0.9 (0.2 - 1.5)	13	2.1 (1.0 - 3.2)	0.4650
Highest Level of Education													
Primary	1	100.0	59/159	37.1 (29.6 - 44.6)	525/1105	47.5 (44.6 - 50.5)	403/927	43.5 (40.3 - 46.7)	321/785	40.9 (37.5 - 44.3)	280/618	45.3 (41.4 - 49.2)	0.4506
Secondary	0	-	38/159	23.9 (17.3 - 30.5)	222/1105	20.1 (17.7 - 22.5)	179/927	19.3 (16.8 - 21.9)	197/785	25.1 (22.1 - 28.1)	150/618	24.3 (20.9 - 17.7)	**0.0185**
University/Higher Education	0	-	1/159	0.6 (0.0 - 1.9)	3/1105	0.3 (0.0 - 0.6)	2/927	0.2 (0.0 - 0.5)	4/785	0.5 (0.0 - 1.0)	4/618	0.6 (0.0 - 1.3)	0.2878
Other	0	-	1/159	0.6 (0.0 - 1.9)	5/1105	0.5 (0.0 - 0.8)	4/927	0.4 (0.0 - 0.9)	3/785	0.4 (0.0 - 0.8)	1/618	0.2 (0.0 - 0.5)	0.3238
None	0	-	60/159	37.7 (30.2 - 45.3)	350/1105	31.7 (28.9 - 34.4)	339/927	36.6 (33.5 - 39.7)	260/785	33.1 (29.8 - 36.4)	183/618	29.6 (26.0 - 33.2)	0.1990
Occupation													
Farmer	1	100.0	124	77.5 (71.0 - 84.0)	807	73.0 (70.3 - 75.6)	695	74.7 (71.9 - 77.5)	587	73.6 (70.5 - 76.6)	460	74.2 (70.7 - 77.6)	0.9832
Student/Pupil	0	-	18	11.3 (63.4 - 16.1)	220	19.9 (17.5 - 22.2)	162	17.4 (15.0 - 19.9)	110	13.8 (11.4 - 16.2)	114	18.4 (15.3 - 21.4)	0.3720
Businessman/woman	0	-	5	3.1 (0.4 - 5.8)	6	0.5 (0.1 - 1.0)	13	1.4 (0.6 - 2.2)	13	1.6 (0.8 - 2.5)	5	0.8 (0.01 - 1.5)	0.9881
Professional	0	-	1	0.6 (0.0 - 1.8)	12	1.1 (0.5 - 1.7)	10	1.1 (0.4 - 1.7)	19	2.4 (1.3 - 3.4)	7	2.1 (0.3 - 2.0)	0.1885
Other[d]	0	-	6	3.8 (0.8 - 6.7)	27	2.4 (1.5 - 3.4)	25	2.7 (1.6 - 3.7)	42	5.3 (3.7 - 6.8)	23	3.7 (2.2 - 5.2)	**0.0273**
No occupation	0	-	6	3.8 (0.8 - 6.7)	34	3.1 (2.1 - 4.1)	25	2.7 (1.6 - 3.7)	27	3.4 (2.1 - 4.6)	11	1.8 (0.7 - 2.8)	0.2166
Residency Status		-											
Native	0		58	36.3 (28.8 - 43.7)	529	47.8 (44.9 - 50.8)	533	57.3 (54.1 - 60.5)	434	54.4 (50.9 - 57.8)	401	64.7 (60.9 - 68.4)	**<0.0001**
Resident	1	100.0	95	59.4 (51.8 - 67.0)	508	45.9 (43.0 - 48.9)	342	36.8 (33.7 - 39.9)	324	40.6 (37.2 - 44.0)	182	29.4 (25.8 - 32.9)	**<0.0001**
Internally Displaced Person/Refugee	0	-	6	3.8 (0.8 - 6.7)	37	3.3 (2.3 - 4.4)	33	3.5 (2.4 - 4.7)	26	3.3 (2.0 - 4.5)	27	4.4 (2.7 - 6.0)	0.4819
Other[e]	0	-	1	0.6 (0.0 -1.8)	32	2.9 (1.9 - 3.9)	22	2.4 (1.4 - 3.3)	14	1.8 (0.8 - 2.7)	10	1.6 (0.6 - 2.6)	0.1930

[a]n – number of survivors with characteristic, where represented as n/N , n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]p-value calculated for trend from 2011 to 2015. [c]Breakdown of "Other" marital status responses: Separated (35), Divorced (24), Unspecified "other" response (135). [d]Breakdown of "Other" occupation response: Other community leader (14), Religious Leader (7), Humanitarian (3), Police/Military (2), Unspecified "other" response (97). [e]Breakdown of "Other" residency status responses: Foreigner (6), Demobilised (3), Repatriated (3), Asylum Seeker (2), Stateless (2), Unspecified "other" response (63).

Table 2 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in Alimbongo Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association[a]
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**1**		**160**		**1106**		**930**		**798**		**620**	
Type de Violence													
Rape	1	100.0	78	48.8 (41.0 - 56.5)	625	56.5 (53.6 - 59.4)	536	57.6 (54.5 - 60.8)	496	62.2 (58.8 - 65.5)	363	58.5 (54.7 - 62.4)	**0.0133**
Sexual Harassment	0	-	5	3.2 (0.4 - 5.8)	41	3.7 (2.6 - 4.8)	37	4.0 (2.7 - 5.2)	29	3.6 (2.3 - 4.9)	15	2.4 (1.2 - 3.6)	0.2961
Physical Harassment	0	-	10	6.3 (2.5 - 10.0)	130	11.8 (9.9 - 13.7)	105	11.3 (9.3 - 13.3)	77	9.6 (7.6 - 11.7)	58	9.4 (7.1 - 11.6)	0.3212
Forced Marriage	0	-	0	-	5	0.5 (0.1 - 0.8)	5	0.5 (0.1 - 1.0)	1	0.1 (0.0 - 0.4)	3	0.5 (0.0 - 1.0)	0.9322
Emotional/Psychological Violence	0	-	17	10.6 (5.8 - 15.4)	165	14.9 (12.8 - 17.0)	169	18.2 (15.7 - 20.7)	107	13.4 (11.0 - 15.8)	87	14.0 (11.3 - 16.8)	0.6818
Denied Resources/Opportunities	0	-	2	1.3 (0.0 - 3.0)	47	4.2 (3.1 - 5.4)	25	2.7 (1.6 - 3.7)	40	5.0 (3.5 - 6.5)	43	6.9 (4.9 - 8.9)	**0.0008**
Other	0	-	47	29.4 (22.3 - 36.4)	85	7.7 (6.1 - 9.3)	37	4.0 (2.7 - 5.2)	32	4.0 (2.6 - 5.4)	27	4.4 (2.7 - 6.0)	**<0.0001**
None	0	-	1	0.6 (0.0 - 1.8)	8	0.7 (0.2 - 1.2)	16	1.7 (0.9 - 2.6)	16	2.0 (1.0 - 3.0)	24	3.9 (2.4 - 5.4)	**<0.0001**
Services Accessed													
Medical Services	0	-	23	14.4(8.9 - 19.8)	253	22.9 (20.4 - 25.4)	480	51.6 (48.4 - 54.8)	441	55.3 (51.8 - 58.7)	223	37.6 (33.8 - 41.4)	**<0.0001**
Psychosocial Services	1	100	150	93.8 (90.0 - 97.50	692	62.6 (59.7 - 65.4)	624	67.1 (64.1 - 70.1)	633	79.3 (76.5 - 82.1)	462	74.5 (71.1 - 77.9)	**<0.0001**
Socio-economic Services	1	100	5	3.1 (0.4 - 5.8)	12	1.1 (0.5 - 1.7)	7	0.8 (0.2 - 1.3)	11	1.4 (0.6 - 2.2)	19	3.1 (1.7 - 4.4)	**0.0373**
Legal Services	0	-	3	1.9 (0.0 - 4.0)	450	40.7 (37.8 - 43.6)	276	29.7 (26.7 - 32.6)	149	18.7 (16.0 - 21.4)	133	21.5 (18.2 - 24.7)	**<0.0001**

[a] p-value calculated for trend from 2011 to 2015.

Table 3. Characteristics of SGBV Survivors supported by the Ushindi Project in Kitutu Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association[b]
Characteristic	**n[a]**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**1**		**875**		**814**		**629**		**508**		**378**	
Sex													
Female	1	100.0	785	89.7 (87.7 - 91.7)	753	92.5 (90.7 - 94.3)	565	89.8 (87.5 - 92.2)	457	90.0 (87.3 - 92.6)	316	83.6 (79.9 - 87.3)	**0.0038**
Male	0	-	90	10.3 (8.3 - 12.3)	61	7.5 (5.7 - 9.3)	64	10.2 (7.8 - 12.5)	51	10.0 (7.4 - 12.7)	62	16.4 (12.7 - 20.1)	**0.0038**
Age (years)	1	38.8	778	31.3 (30.2 - 32.4)	724	27.0 (26.0 - 28.1)	560	29.4 (28.0 - 30.7)	459	26.4 (25.0 - 27.8)	362	29.0 (27.3 - 30.6)	**0.0012**
Marital Status													
Single	0	-	292	33.4 (30.2 - 36.5)	325	39.9 (36.6 - 43.3)	235	37.4 (33.6 - 41.1)	220	43.3 (39.0 - 47.6)	157	41.5 (36.6 - 46.5)	**0.0009**
Married with certificate	1	100.0	303	34.6 (31.5 - 37.8)	88	10.8 (8.7 - 12.9)	67	10.7 (8.2 - 13.1)	44	8.7 (6.2 - 11.1)	34	9.0 (6.1 - 11.9)	**<0.0001**
With partner/bride price	0	-	48	5.5 (4.0 - 7.0)	203	24.9 (22.0 - 27.9)	171	27.2 (23.7 - 30.7)	134	26.4 (22.5 - 30.2)	104	27.5 (23.0 - 32.0)	**<0.0001**
With partner/no bride price	0	-	60	6.9 (5.2 - 8.5)	82	10.1 (8.0 - 12.1)	44	7.0 (5.0 - 9.0)	30	5.9 (3.9 - 8.0)	25	6.6 (4.1 - 9.1)	0.2285
Other[c]	0	-	172	19.7 (17.0 - 22.3)	112	13.8 (11.4 - 16.1)	112	17.8 (14.8 - 20.8)	80	15.7 (12.6 - 18.9)	58	15.3 (11.7 - 19.0)	0.1272
Religion													
Christian	1	100.0	297/804	36.9 (33.6 - 40.3)	664/810	82.0 (79.3 - 84.6)	555/628	88.4 (85.9 - 90.9)	432/492	87.8 (84.9 - 90.7)	332/377	88.1 (84.8 - 91.3)	**<0.0001**
Muslim	0	-	1/804	0.1 (0.0 - 0.4)	4/810	0.5 (0.0 - 1.0)	3/628	0.5 (0.0 - 1.0)	5/492	1.0 (0.1 - 1.9)	7/377	1.9 (0.5 - 3.2)	**0.0012**
Other	0	-	69/804	8.6 (6.6 - 10.5)	45/810	5.6 (4.0 - 7.1)	29/628	4.6 (3.0 - 6.3)	19/492	3.9 (2.2 - 5.6)	6/377	1.6 (0.3 - 2.9)	**<0.0001**
None	0	-	437/804	54.4 (50.9 - 57.8)	97/810	12.0 (9.7 - 14.2)	41/628	6.5 (4.6 - 8.5)	36/492	7.3 (5.0 - 9.6)	32/377	8.5 (5.7 - 11.3)	**<0.0001**
Highest Level of Education													
Primary	1	100.0	367/870	42.2 (38.8 - 45.5)	438	53.8 (50.4 - 57.2)	340	54.1 (50.2 - 57.9)	276	54.3 (50.0 - 58.7)	194	51.3 (46.3 - 56.4)	**0.0002**
Secondary	0	-	137/870	15.7 (13.3 - 18.2)	155	19.0 (16.3 - 21.7)	127	20.2 (17.1 - 23.3)	126	24.8 (21.0 - 28.6)	110	29.1 (24.5 - 33.7)	**<0.0001**
University/Higher Education	0	-	1/870	0.1 (0.0 - 0.3)	7	0.9 (0.2 - 1.5)	1	0.2 (0.0 - 0.5)	1	0.2 (0.0 - 0.6)	1	0.03 (0.0 - 0.8)	0.7259
Other	0	-	36/870	4.1 (2.8 - 5.5)	11	1.4 (0.6 - 2.1)	2	0.3 (0.0 - 0.8)	0	-	2	0.5 (0.0 - 1.3)	**<0.0001**
None	0	-	329/870	37.8 (34.6 - 41.0)	203	24.9 (22.0 - 27.9)	159	25.3 (21.9 - 28.7)	105	20.7 (17;1 - 24.2)	71	18.8 (14.8 - 22.7)	**<0.0001**
Occupation													
Farmer	1	100.0	537	61.4 (58.1 - 64.6)	479	58.8 (55.5 - 62.2)	421	66.9 (63.3 - 70.6)	291	57.3 (53.0 - 61.6)	235	62.2 (57.3 - 67.1)	0.9041
Student/Pupil	0	-	119	13.6 (11.3 - 15.9)	208	25.4 (22.4 - 28.4)	141	22.4 (19.2 - 25.7)	148	29.1 (25.2 - 33.1)	98	25.9 (21.5 - 30.3)	**<0.0001**
Businessman/woman	0	-	34	3.9 (2.6 - 5.2)	12	1.5 (0.6 - 2.3)	6	1.0 (0.2 - 1.7)	3	0.6 (0.0 - 1.3)	3	0.8 (0.0 - 1.7)	**<0.0001**
Professional	0	-	0	-	9	1.1 (0.4 - 1.8)	4	0.6 (0.0 - 1.3)	5	1.0 (0.1 - 1.8)	5	1.3 (0.2 - 2.5)	**0.0201**
Other[d]	0	-	32	3.7 (2.4 - 4.9)	34	4.2 (2.8 - 5.6)	9	1.4 (0.5 - 2.4)	13	2.6 (1.2 - 3.9)	10	2.6 (1.0 - 4.3)	0.0555
No occupation	0	-	153	17.5 (15.0 - 20.0)	72	8.8 (6.9 - 10.8)	48	7.6 (5.6 - 9.7)	48	9.4 (6.9 - 12.0)	27	7.1 (4.5 - 9.7)	**<0.0001**
Residency Status													
Native	0	-	219	25.0 (22.2 - 27.9)	376	46.2 (42.8 - 49.6)	187	29.7 (26.2 - 33.3)	151	29.7 (25.7 - 33.7)	67	17.7 (13.9 - 21.6)	**0.0005**
Resident	1	100.0	313	35.8 (32.6 - 38.9)	289	35.5 (32.2 - 38.8)	351	55.8 (51.9 - 59.7)	329	64.8 (60.6 - 68.9)	299	79.1 (75.0 - 83.2)	**<0.0001**
Internally Displaced Person/Refugee	0	-	228	26.1 (23.1 - 29.0)	119	14.6 (12.2 - 17.0)	76	12.1 (9.5 - 14.6)	24	4.7 (2.9 - 6.6)	10	2.6 (1.0 - 4.3)	**<0.0001**
Other[e]	0	-	115	13.1 (10.9 - 15.4)	30	3.7 (2.4 - 5.0)	15	2.4 (1.2 - 3.6)	4	0.8 (0.0 - 1.6)	2	0.5 (0.0 - 1.3)	**<0.0001**

[a]n – number of survivors with characteristic, where represented as n/N , n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]p-value calculated for trend from 2011 to 2015. [c]Breakdown of "Other" marital status responses: Separated (164), Divorced (22), Unspecified "other" response (348). [d]Breakdown of "Other" occupation response: Religious Leader (6), Other community leader (6), Government Worker (2), Humanitarian (2), Police/Military (2), Unspecified "other" response (80). [e]Breakdown of "Other" residency status responses: Foreigner (4), Demobilised (2), Repatriated (2), Stateless (2), Asylum Seeker (1), Unspecified "other" response (155).

Table 3 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in Kitutu Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association[a]
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**1**		**875**		**814**		**629**		**508**		**378**	
Type de Violence													
Rape	0	-	463	52.9 (49.6 - 56.2)	476	58.5 (55.1 - 61.9)	326	51.8 (47.9 - 55.7)	256	50.4 (46.0 - 54.7)	125	33.1 (28.3 - 37.8)	**<0.0001**
Sexual Harassment	0	-	28	3.2 (2.0 - 4.4)	39	4.8 (3.3 - 6.3)	25	4.0 (2.4 - 5.5)	7	1.4 (0.4 - 2.4)	16	4.2 (2.2 - 6.3)	0.5102
Physical Harassment	0	-	222	25.4 (22.5 - 28.3)	129	15.8 (13.3 - 18.4)	73	11.6 (9.1 - 15.1)	52	10.2 (7.6 - 12.9)	50	13.2 (9.8 - 16.6)	**<0.0001**
Forced Marriage	0	-	5	0.6 (0.1 - 1.1)	8	1.0 (0.3 - 1.7)	5	0.8 (0.1 - 1.5)	3	0.6 (0.0 - 1.3)	1	0.3 (0.0 - 0.8)	0.5183
Emotional/Psychological Violence	1	100.0	23	2.6 (1.6 - 3.7)	83	10.2 (8.1 - 12.3)	145	23.1 (19.8 - 26.3)	153	30.1 (26.1 - 34.1)	156	41.3 (36.3 - 46.2)	**<0.0001**
Denied Resources/Opportunities	0	-	29	3.3 (2.1 - 4.5)	7	0.9 (0.2 - 1.5)	16	2.5 (1.3 - 3.8)	17	3.3 (1.8 - 4.9)	19	5.0 (2.8 - 7.2)	**0.0400**
Other	0	-	60	6.9 (5.2 - 8.5)	61	7.5 (5.7 - 9.3)	28	4.5 (2.8 - 6.1)	16	3.1 (1.6 - 4.7)	9	2.4 (0.8 - 3.9)	**<0.0001**
None	0	-	45	5.1 (3.7 - 6.6)	11	1.4 (0.6 - 2.1)	11	1.7 (0.7 - 2.8)	4	0.8 (0.0 - 1.6)	2	0.5 (0.0 - 1.3)	**<0.0001**
Services Accessed													
Medical Services	0	-	214	24.5 (21.6 - 27.3)	308	37.9 (34.5 - 41.2)	235	27.4 (33.6 - 41.1)	172	33.9 (29.7 - 38.0)	87	23.0 (18.8 - 27.3)	0.5307
Psychosocial Services	1	100.0	498	56.9 (53.6 - 60.2)	530	65.1 (61.8 - 68.4)	386	61.4 (57.6 - 65.2)	313	61.6 (57.4 - 65.8)	246	65.1 (60.3 - 69.9)	**0.0320**
Socio-economic Services	0	-	13	1.5 (0.7 - 2.3)	17	2.1 (1.1 - 3.1)	23	3.7 (2.2 - 5.1)	25	4.9 (3.0 - 6.8)	21	5.6 (3.2 - 7.9)	**<0.0001**
Legal Services	0	-	99	11.3 (9.2 - 13.4)	104	12.8 (10.5 - 15.1)	105	16.7 (13.8 - 19.6)	88	17.3 (14.0 - 20.6)	92	24.3 (20.0 - 28.7)	**<0.0001**

[a]p-value calculated for trend from 2011 to 2015.

Table 4. Characteristics of SGBV Survivors supported by the Ushindi Project in Komanda Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n[a]**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**106**		**310**		**434**		**473**		**416**		**225**	
Sex													
Female	103	97.2 (94.0 - 100.0)	287	92.6 (89.7 - 95.5)	403	92.8 (90.4 - 95.3)	423	89.4 (86.7 - 92.2)	398	95.7 (93.7 - 97.6)	209	92.9 (89.5 - 96.2)	0.9836
Male	3	2.8 (0.0 - 6.0)	23	7.4 (4.5 - 10.3)	31	7.1 (4.7 - 9.6)	50	10.6 (7.8 - 13.3)	18	4.3 (2.4 - 6.3)	16	7.1 (3.8 - 10.5)	0.9836
Age (years)	101	18.9 (17.0 - 20.7)	283	19.6 (18.5 - 20.6)	402	21.8 (20.7 - 22.8)	430	23.0 (21.9 - 24.1)	410	23.0 (21.8 - 24.1)	219	21.7 (20.3 - 23.1)	**<0.0001**
Marital Status													
Single	91	85.8 (79.2 - 92.5)	197	63.5 (58.2 - 68.9)	285	65.7 (61.2 - 70.1)	293	61.9 (57.6 - 66.3)	262	63.0 (58.33 - 67.6)	140	62.2 (55.9 - 68.6)	**0.0049**
Married with certificate	13	12.3 (6.0 - 18.5)	88	28.4 (23.4 - 33.4)	62	14.3 (11.0 - 17.6)	65	13.7 (10.6- 16.8)	44	10.6 (7.6 - 13.5)	42	18.7 (13.6 - 23.8)	**0.0027**
With partner/bride price	0	-	8	2.6 (0.8 - 4.3)	28	6.5 (4.1 - 8.8)	70	14.8 (11.6 - 18.0)	59	14.2 (10.8 - 17.5)	27	12.0 (7.8 - 16.2)	**<0.0001**
With partner/no bride price	0	-	5	1.6 (0.2 - 3.0)	40	9.2 (6.5 - 11.9)	28	5.9 (3.8 - 8.0)	33	7.9 (5.3 - 10.5)	11	4.9 (2.1 - 7.7)	**0.0166**
Other[b]	2	1.9 (0.0 - 4.5)	12	3.9 (1.7 - 6.0)	19	4.4 (2.5 - 6.3)	17	3.6 (1.9 - 5.3)	18	4.3 (2.4 - 6.3)	5	2.2 (0.3 - 4.1)	0.8511
Religion													
Christian	88/102	86.3 (79.6 - 93.0)	257/307	83.7 (79.6 - 87.8)	384/433	88.7 (85.7 - 91.7)	440/471	93.4 (91.2 - 96.7)	399/412	96.8 (95.2 - 98.5)	220	97.8 (95.9 - 99.7)	**<0.0001**
Muslim	2/102	2.0 (0.0 - 4.7)	6/307	2.0 (0.4 - 3.5)	9/443	2.1 (0.7 - 3.4)	15/471	3.2 (1.6 - 4.8)	3/412	0.7 (0.0 - 1.5)	2	0.9 (0.0 - 2.1)	0.2014
Other	0/102	-	3/307	1.0 (0.0 - 2.1)	2/433	0.5 (0.0 - 1.1)	0/471	-	5/412	1.2 (0.2 - 2.3)	1	0.4 (0.0 - 1.3)	0.7005
None	12/102	11.8 (5.5 - 18.0)	41/307	13.4 (9.5 - 17.2)	38/433	8.8 (6.1 - 11.4)	16/471	3.4 (1.8 - 5.0)	5/412	1.2 (0.2 - 2.3)	2/225	0.9 (0.0 - 2.1)	**<0.0001**
Highest Level of Education													
Primary	73	68.9 (60.1 - 77.7)	153/300	51.0 (45.3 - 56.7)	211/431	49.0 (44.2 - 53.7)	249/472	42.8 (48.2 - 57.3)	221/415	53.3 (48.5 - 58.1)	108/224	48.2 (41.7 - 54.8)	0.1360
Secondary	16	15.1 (8.3 - 21.9)	64/300	21.3 (16.7 - 26.0)	101/431	23.4 (19.4 - 27.4)	99/472	21.0 (17.3 - 24.6)	78/415	18.8 (15.0 - 22.6)	46/224	20.5 (15.2 - 25.8)	**0.8032**
University/Higher Education	0	-	0/300	-	2/431	0.5 (0.0 - 1.1)	1/472	0.2 (0.0 - 0.6)	0/415	-	0/224		0.6057
Other	0	-	2/300	0.7 (0.0 -1.6)	1/431	0.2 (0.0 - 0.7)	1/472	0.2 (0.0 - 0.6)	1/415	0.2 (0.0 - 0.7)	0/224	-	0.3813
None	17	16.0 (9.1 - 23.0)	81/300	27.0 (22.0 - 32.0)	116/431	26.9 (22.7 - 31.1)	122/472	25.8 (21.9 - 29.8)	115/415	27.7 (23.4 - 32.0)	70/224	31.3 (25.2 - 37.3)	**0.0397**
Occupation													
Farmer	47	44.3 (34.9 - 53.8)	179	57.7 (52.2 - 63.2)	221	50.9 (46.2 - 55.6)	284	60.0 (55.6 - 64.5)	263	63.2 (58.6 - 67.9)	141	62.7 (56.3 - 69.0)	**0.0001**
Student/Pupil	40	37.7 (28.5 - 57.0)	75	24.2 (19.4 - 29.0)	129	29.7 (25.4 - 34.0)	119	24.2 (21.2 - 29.1)	113	27.2 (22.9 - 31.4)	60	26.7 (20.9 - 32.4)	0.3105
Businessman/woman	9	8.5 (3.2 - 13.8)	14	4.5 (2.2 - 6.8)	14	3.2 (1.6 - 4.9)	9	1.9 (0.7 - 3.1)	2	0.5 (0.0 - 1.1)	3	1.3 (0.0 - 2.8)	**<0.0001**
Professional	0	-	0	-	4	0.9 (0.0 - 1.8)	4	0.8 (0.0 - 1.7)	2	0.5 (0.0 - 1.1)	1	0.4 (0.0 - 1.3)	0.5397
Other[c]	0	-	3	1.0 (0.0 - 2.1)	10	2.3 (0.9 - 3.7)	14	3.0 (1.4 - 4.5)	8	1.9 (0.6 - 3.2)	6	2.7 (0.6 - 4.8)	0.1008
No occupation	10	9.4 (3.9 - 15.0)	39	12.6 (8.9 - 16.3)	56	12.9 (9.7 - 16.1)	43	9.1 (6.5 - 11.7)	28	6.7 (4.3 - 9.1)	14	6.2 (3.1 - 9.4)	**0.0013**
Residency Status													
Native	38	35.8 (26.7 - 45.0)	113	36.5 (31.1 - 41.8)	145	33.4 (29.0 - 37.8)	244	51.6 (47.1 - 56.1))	182	43.8 (39.0 - 48.5)	82	36.4 (30.2 - 42.7)	**0.0250**
Resident	58	54.7 (45.2 - 64.2)	170	54.8 (49.3 - 60.4)	257	59.2 (54.6 - 63.8)	212	44.8 (40.3 - 49.3)	203	48.8 (44.0 - 53.6)	106	47.1 (40.6 - 53.6)	**0.0017**
Internally Displaced Person/Refugee	1	0.9 (0.0 - 2.8)	15	4.8 (2.4 - 7.2)	10	2.3 (0.9 - 3.7)	5	1.1 (0.1 - 2.0)	23	5.5 (3.3 - 7.7)	32	14.2 (9.7 - 18.8)	**<0.0001**
Other[d]	9	8.5 (3.2 - 13.8)	12	3.9 (1.7 - 6.0)	22	5.1 (3.0 - 7.1)	12	2.5 (1.1 - 4.0)	8	1.9 (0.6 - 3.2)	5	2.2 (0.3 - 4.1)	**0.0010**

[a]n – number of survivors with characteristic, where represented as n/N, n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]Breakdown of "Other" marital status responses: Separated (21), Divorced (10), Unspecified "other" response (42). [c]Breakdown of "Other" occupation response: Police/Military (3), Religious Leader (2), Other community leader (2), Humanitarian (1), Unspecified "other" response (33). [d]Breakdown of "Other" residency status responses: Stateless (15), Foreigner (3), Demobilised (2), Asylum Seeker (1), Repatriated (1), Unspecified "other" response (46).

Table 4 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in Komanda Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**106**		**310**		**434**		**473**		**416**		**225**	
Type de Violence													
Rape	102	96.2 (92.6 - 99.9)	248	80.0 (75.5 - 84.5)	266	61.3 (56.7 - 65.9)	286	60.5 (56.1 - 64.9)	266	63.9 (59.3 - 68.6)	161	71.6 (65.7 - 77.6)	**<0.0001**
Sexual Harassment	3	2.8 (0.0 - 6.0)	6	1.9 (0.4 - 3.5)	14	3.2 (1.6 - 4.9)	15	3.2 (1.6 - 4.8)	17	4.1 (2.2 - 6.0)	17	7.6 (4.1 - 11.0)	**0.0032**
Physical Harassment	0	-	9	2.9 (1.0 - 4.8)	31	7.1 (4.7 - 9.6)	70	14.8 (11.6 - 18.0)	33	7.9 (5.3 - 10.5)	15	6.7 (3.4 - 9.9)	**0.0012**
Forced Marriage	0	-	0	-	2	0.5 (0.0 - 1.1)	1	0.2 (0.0 - 0.6)	6	1.4 (0.3 - 2.6)	1	0.4 (0.0 - 1.3)	0.0586
Emotional/Psychological Violence	0	-	35	11.3 (7.8 - 14.8)	89	20.5 (16.7 - 24.3)	85	18.0 (14.5 - 21.4)	70	16.8 (13.2 - 20.4)	14	6.2 (3.1 - 9.4)	0.5103
Denied Resources/Opportunities	0	-	1	0.3 (0.0 - 1.0)	7	1.6 (0.4 - 2.8)	12	2.5 (1.1 - 4.0)	10	2.4 (1.0 - 3.9)	3	1.3 (0.0 - 2.8)	0.0529
Other	0	-	9	2.9 (1.0 - 4.8)	16	3.7 (1.9 - 5.5)	3	0.6 (0.0 - 1.3)	10	2.4 (0.9 - 3.9)	13	5.8 (2.7 - 8.8)	0.1246
None	1	0.9 (0.0 - 2.8)	2	0.6 (0.0 - 1.5)	9	2.1 (0.7 - 3.4)	1	0.2 (0.0 - 0.6)	4	1.0 (0.0 - 1.9)	1	0.4 (0.0 - 1.3)	0.3638
Services Accessed													
Medical Services	58	54.7 (45.2 - 64.2)	150	48.4 (42.8 - 54.0)	162	37.4 (32.8 - 41.9)	202	42.7 (38.2 - 47.2)	170	40.9 (36.1 - 45.6)	142	63.1 (56.8 - 69.4)	0.1366
Psychosocial Services	85	80.2 (72.6 - 87.8)	218	70.3 (65.2 - 75.4)	309	71.2 (66.9 - 75.5)	368	77.8 (74.1 - 81.5)	317	76.2 (72.1 - 80.3)	178	79.1 (73.8 - 84.4)	**0.0473**
Socio-economic Services	0	-	0	-	0	-	0	-	0	-	0	-	-
Legal Services	0	-	57	18.4 (14.1 - 22.7)	218	50.2 (45.5 - 54.9)	193	40.8 (36.4 - 45.2)	172	41.3 (36.6 - 46.1)	64	28.4 (22.65 - 34.3)	**<0.0001**

Table 5. Characteristics of SGBV Survivors supported by the Ushindi Project in Lolwa Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**67**		**361**		**339**		**309**		**211**		**116**	
Sex													
Female	64	95.5 (90.6 - 100.0)	344	95.3 (93.1 - 97.5)	308	90.9 (87.8 - 93.9)	283	91.6 (88.5 - 94.7)	198	93.8 (90.6 - 97.1)	113	97.4 (94.5 - 100.0)	0.95513
Male	3	4.5 (0.0 - 9.4)	17	4.7 (2.5 - 6.9)	31	9.1. (6.1 - 12.2)	26	8.4 (5.3 - 11.5)	13	6.2 (2.9 - 9.4)	3	2.6 (0.0 - 5.5)	0.95513
Age (years)	65	19.8 (17.7 - 21.9)	300	20.3 (19.2 - 21.4)	319	23.1 (21.8 - 24.4)	304	25.0 (23.6 - 26.4)	207	23.0 (21.5 - 24.5)	113	24.7 (22.5 - 26.8)	**<0.0001**
Marital Status													
Single	55	82.1 (72.9 - 91.3)	261	72.3 (67.7 - 76.9)	229	67.6 (62.6 - 72.5)	192	2.1 (56.7 - 67.5)	138	65.4 (59.0 - 71.8)	80	69.0 (60.5 - 77.4)	**0.0108**
Married with certificate	12	17.9 (8.7 - 27.1)	67	18.6 (14.5 - 22.6)	34	10.0 (6.8 - 13.2)	43	13.9 (10.1 - 17.8)	20	9.5 (5.5 - 13.4)	11	9.5 (4.1 - 14.8)	**0.0023**
With partner/bride price	0	-	10	2.8 (1.1 - 4.5)	47	13.9 (10.2 - 17.5)	28	9.1 (5.9 - 12.3)	25	11.8 (7.5 - 16.2)	14	12.1 (6.1 - 18.0)	**<0.0001**
With partner/no bride price	0	-	8	2.2 (0.7 - 3.7)	16	2.7 (2.5 - 7.0)	33	10.7 (7.2 - 14.1)	21	10.0 (5.9 - 14.0)	4	3.4 (0.1 - 6.8)	**0.0002**
Other	0	-	15	4.2 (2.1 - 6.2)	13	3.8 (1.8 - 5.9)	13	4.2 (2.0 - 6.4)	7	3.3 (0.9 - 5.7)	7	6.0 (1.7 - 10.4)	0.3063
Religion													
Christian	56	83.6 (74.7 - 92.5)	303	83.9 (80.1 - 87.7)	321	94.7 (92.3 - 97.1)	289	93.5 (90.8 - 96.3)	193	91.5 (87.7 - 95.2)	108	93.1 (88.5 - 97.7)	**0.0002**
Muslim	0	-	1	0.3 (0.0 - 0.8)	1	0.3 (0.0 - 0.9)	0	-	3	1.4 (0.0 - 3.0)	3	2.6 (0.0 - 5.5)	**0.0105**
Other	2	3.0 (0.0 - 7.1)	4	1.1 (0.0 - 2.2)	0	-	1	0.3 (0.0 - 1.0)	0	-	1	0.9 (0.0 - 2.5)	0.0650
None	9	13.4 (5.3 - 21.6)	52	14.4 (10.8 - 18.0)	17	5.0 (2.7 - 7.3)	19	6.1 (3.5 - 8.8)	15	7.1 (3.6 - 10.6)	4	3.4 (0.1 - 6.8)	**<0.0001**
Highest Level of Education													
Primary	47	70.1 (59.2 - 81.1)	200	55.4 (50.3 - 60.5)	194	57.2 (52.0 - 62.5)	166	53.7 (48.2 - 59.3)	121	57.3 (50.7 - 64.0)	64	55.2 (46.1 - 64.2)	0.3477
Secondary	3	4.5 (0.0 - 9.4)	42	11.6 (8.3 - 14.9)	40	11.8 (8.4 - 15.2)	39	12.6 (8.9 - 16.3)	21	10.0 (5.9 - 14.0)	22	19.0 (11.8 - 26.1)	0.0737
University/Higher Education	0	-	1	0.3 (0.0 - 0.8)	0	0	1	0.3 (0.0 - 1.0)	0	-	0	-	0.6665
Other	0	-	0	-	0	-	0	-	1	0.5 (0.0 - 1.4)	1	0.8 (0.0 - 2.5)	0.0989
None	17	25.4 (14.9 - 35.8)	118	32.7 (27.8 - 37.5)	105	31.0 (26.0 - 35.9)	103	33.3 (28.1 - 38.6)	68	32.2 (25.9 - 38.5)	29	25.0 (17.1 - 32.9)	0.6980
Occupation													
Farmer	46	68.7 (57.5 - 79.8)	214	59.3 (54.2 - 64.3)	235	69.3 (64.4 - 74.2)	230	74.4 (69.6 - 79.3)	142	67.3 (61.0 - 73.6)	80	69.0 (60.5 - 77.4)	**0.0240**
Student/Pupil	14	20.9 (11.2 - 30.6)	74	20.5 (16.3 - 24.7)	53	15.6 (11.8 - 19.5)	39	12.6 (8.9 - 16.3)	34	16.1 (11.2 - 21.1)	19	16.4 (9.6 - 23.1)	0.0647
Businessman/woman	0	-	8	2.2 (0.7 - 3.7)	1	0.3 (0.0 - 0.9)	3	1.0 (0.0 - 2.1)	2	0.9 (0.0 - 2.3)	4	3.4 (0.1 - 6.8)	0.5404
Professional	0	-	5	1.4 (0.2 - 2.6)	1	0.3 (0.0 - 0.9)	3	1.0 (0.0 - 2.1)	1	0.5 (0.0 - 1.4)	3	2.6 (0.0 - 5.5)	0.4626
Other	0	-	1	0.3 (0.0 - 0.8)	6	1.8 (0.4 - 3.2)	2	0.6 (0.0 - 1.5)	4	1.9 (0.1 - 3.7)	2	1.7 (0.0 - 4.1)	0.0989
No occupation	7	10.4 (3.1 - 17.8)	59	16.3 (12.5 - 20.2)	43	12.7 (9.1 - 16.2)	32	10.4 (7.0 - 13.8)	28	13.3 (8.7 - 17.8)	8	6.9 (2.3 - 11.5)	**0.0403**
Residency Status													
Native	40	59.7 (48.0 - 71.5)	135	37.4 (32.4 - 42.4)	76	22.4 (18.0 - 26.9)	73	23.6 (18.9 - 28.4)	100	47.4 (40.7 - 54.1)	59	50.9 (41.8 - 60.0)	0.1600
Resident	24	35.8 (24.3 - 47.3)	183	50.7 (45.5 - 55.9)	253	74.6 (70.0 - 79.3)	220	71.2 (66.1 - 76.2)	103	48.8 (42.1 - 55.6)	53	45.7 (36.6 - 54.8)	0.8094
Internally Displaced Person/Refugee	2	3.0 (0.0 - 7.1)	13	3.6 (1.7 - 5.5)	4	1.2 (0.0 - 2.3)	13	4.2 (2.0 - 6.4)	1	0.5 (0.0 - 1.4)	2	1.7 (0.0 - 4.1)	0.1842
Other	1	1.5 (0.0 - 4.4)	30	8.3 (5.5 - 11.2)	6	1.8 (0.4 - 3.2)	3	1.0 (0.0 - 2.1)	7	3.3 (0.9 - 5.7)	2	1.7 (0.0 - 4.1)	**0.0020**

[a] n – number of survivors with characteristic, where represented as n/N, n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b] Breakdown of "Other" marital status responses: Divorced (14), Separated (4), Unspecified "other" response (37). [c] Breakdown of "Other" occupation response: Other community leader (4), Religious Leader (2), Unspecified "other" response (9). [d] Breakdown of "Other" residency status responses: Stateless (5), Demobilised (2), Asylum Seeker (1), Unspecified "other" response (41).

Table 5 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in Lolwa Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Type de Violence													
Rape	52	77.6 (67.6 - 87.6)	249	69.0 (64.2 - 73.7)	201	59.3 (54.1 - 64.5)	194	62.8 (57.4 - 68.2)	135	64.0 (57.5 - 70.5)	77	66.4 (57.8 - 75.0)	0.1390
Sexual Harassment	3	4.5 (0.0 - 9.4)	12	3.3 (1.5 - 5.2)	8	2.4 (0.7 - 4.0)	8	2.6 (0.8 - 4.4)	7	3.3 (0.9 - 5.7)	2	1.7 (0.0 - 4.1)	0.4323
Physical Harassment	3	4.5 (0.0 - 9.4)	20	5.5 (3.2 - 7.9)	32	9.4 (6.3 - 12.6)	27	8.7 (5.6 - 11.9)	13	6.2 (2.9 - 9.4)	13	11.2 (5.5 - 16.9)	0.1210
Forced Marriage	0	-	4	1.1 (0.0 - 2.2)	1	0.3 (0.0 - 0.9)	0	-	1	0.5 (0.0 - 1.4)	0	-	0.1859
Emotional/Psychological Violence	3	4.5 (0.0 - 9.4)	39	10.8 (7.6 - 14.0)	86	25.4 (20.7 - 30.0)	68	22.0 (17.4 - 26.6)	41	19.4 (14.1 - 24.8)	18	15.5 (8.9 - 22.1)	**0.0072**
Denied Resources/Opportunities	1	1.5 (0.0 - 4.4)	19	5.3 (3.0 - 7.6)	0	-	7	2.3 (0.6 - 3.9)	1	0.5 (0.0 - 1.4)	3	2.5 (0.0 - 5.5)	**0.0355**
Other	5	7.5 (1.2 - 13.8)	11	3.0 (1.3 - 4.8)	6	1.8 (0.4 - 3.2)	4	1.3 (0.0 - 2.6)	11	5.2 (2.2 - 8.2)	1	0.9 (0.0 - 2.5)	0.3443
None	0	-	7	1.9 (0.5 - 3.4)	5	1.5 (0.2 - 2.8)	1	0.3 (0.0 - 1.0)	2	0.9 (0.0 - 2.3)	2	1.7 (0.0 - 4.1)	0.5806
Services Accessed													
Medical Services	42	62.7 (51.1 - 74.3)	193	53.5 (48.3 - 58.6)	36	40.1 (34.9 - 45.3)	179	57.9 (52.4 - 63.4)	109	51.7 (44.9 - 58.4)	56	48.3 (39.2 - 57.4)	0.7050
Psychosocial Services	65	97.0 (92.9 - 100.0)	299	82.8 (78.9 - 86.7)	279	82.3 (78.2 - 86.4)	309	100	208	98.6 (97.0 - 100.0)	111	95.7 (92.0 - 99.4)	**<0.0001**
Socio-economic Services													
Legal Services	0	62.7 (51.1 - 74.3)	70	53.5 (48.3 - 58.6)	114	20.1 (34.9 - 45.3)	83	57.9 (52.4 - 63.4)	38	41.7 (44.9 - 58.4)	8	48.3 (39.2 - 57.4)	0.4140

Table 6. Characteristics of SGBV Survivors supported by the Ushindi Project in Lubero Health Zone by year, 2010 - 2015

	2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**50**		**386**		**689**		**625**		**529**	
Sex											
Female	47	94.0 (87.4 - 100.0)	331	85.8 (82.3 - 89.2)	628	91.1 (89.0 -93.3)	583	93.3 (91.3 - 95.2)	486	91.9 (89.5 - 94.2)	**0.0070**
Male	3	6.0 (0.0 - 12.6)	55	14.2 (10.8 - 17.7)	61	8.9 (6.7 - 11.0)	42	6.7 (4.8 - 8.7)	43	8.1 (5.8 - 10.5)	**0.0070**
Age (years)	48	20.5 (18.1 - 22.9)	375	25.0 (23.7 - 26.2)	669	25.5 (24.5 - 26.4)	579	25.5 (24.5 - 26.5)	502	24.5 (23.4 - 25.6)	0.8044
Marital Status											
Single	38	76.0 (64.2 - 87.8)	210	54.4 (49.4 - 59.4)	384	55.7 (52.0 - 59.4)	348	55.7 (51.8 - 59.6)	327	61.8 (57.7 - 66.0)	0.2506
Married with certificate	10	20.0 (8.9 - 31.1)	83	21.5 (17.4 - 25.6)	192	27.9 (24.5 - 31.2)	179	28.6 (25.1 - 32.2)	103	19.5 (16.1 - 22.8)	0.4816
With partner/bride price	1	2.0 (0.0 - 5.9)	40	10.4 (7.3 - 13.4)	61	8.9 (6.7 - 11.0)	43	6.9 (4.9 - 8.9)	49	9.3 (6.8 - 11.7)	0.8417
With partner/no bride price	1	2.0 (0.0 - 5.9)	31	8.0 (5.3 - 10.7)	30	4.4 (2.8 - 5.9)	24	3.8 (2.3 - 5.3)	27	5.1 (3.2 - 7.0)	0.2036
Other	0	-	22	5.7 (3.4 - 8.0)	22	3.2 (1.9 - 4.5)	31	5.0 (3.3 - 6.7)	23	4.3 (2.6 - 6.1)	0.7378
Religion											
Christian	50	100	369	95.6 (93.5 - 97.6)	671/685	98.0 (96.9 - 99.0)	617	98.7 (97.8 - 99.6)	516/524	98.5 (97.4 - 99.5)	**0.0183**
Muslim	0	-	0	-	2/685	0.3 (0.0 - 0.7)	0	-	0/524	-	0.5034
Other	0	-	1	0.3 (0.0 - 0.8)	0/685	-	3	0.5 (0.0 - 1.0)	0/524	-	0.9664
None	0	-	16	4.1 (2.2 - 6.1)	12/685	1.8 (0.8 - 2.7)	5	0.8 (0.1 - 1.5)	8/524	1.5 (0.5 - 2.6)	**0.0184**
Highest Level of Education											
Primary	24	48.0 (34.1 - 61.9)	178	46.1 (41.1 - 51.1)	322/688	46.8 (43.1 - 50.5)	270/623	43.3 (39.4 - 47.2)	235	44.4 (40.2 - 48.7)	0.3096
Secondary	8	16.0 (5.8 - 26.2)	63	16.3 (12.6 - 20.0)	157/688	22.8 (19.7 - 26.0)	167/623	26.8 (23.3 - 30.3)	172	32.5 (28.5 - 36.5)	**<0.0001**
University/Higher Education	0	-	2	0.5 (0.0 - 1.2)	2/688	0.3 (0.0 - 0.7)	4/623	0.6 (0.0 - 1.3)	4	0.8 (0.0 - 1.5)	0.3288
Other	0	-	1	0.3 (0.0 - 0.8)	1/688	0.1 (0.0 - 0.4)	1/623	0.2 (0.0 - 0.5)	1	0.2 (0.0 - 0.6)	0.9633
None	18	36.0 (22.7 - 49.3)	142	36.8 (32.0 - 41.6)	206/688	29.9 (26.5 - 33.4)	181/623	29.1 (25.5 - 32.6)	117	22.1 (18.6 - 25.7)	**<0.0001**
Occupation											
Farmer	38	76.0 (64.2 - 87.8)	273	70.7 (66.2 - 75.3)	460	66.8 (63.2 - 70.3)	403	64.5 (60.7 - 68.2)	341	64.5 (60.4 - 68.5)	**0.0150**
Student/Pupil	6	12.0 (3.0 - 21.0)	49	12.7 (9.4 - 16.0)	125	18.1 (15.3 - 21.0)	130	20.8 (17.6 - 24.0)	128	24.2 (20.5 - 27.8)	**<0.0001**
Businessman/woman	2	4.0 (0.0 - 9.4)	8	2.1 (0.7 - 3.5)	12	1.7 (0.8 - 2.7)	16	2.6 (1.3 - 3.8)	7	1.3 (0.3 - 2.3)	0.4360
Professional	2	4.0 (0.0 - 9.4)	9	2.3 (0.8 - 3.8)	22	3.2 (1.9 - 4.5)	14	2.2 (1.1 - 3.4)	6	1.1 (0.2 - 2.0)	0.0594
Other	0	-	15	3.9 (2.0 - 5.8)	23	3.3 (2.0 - 4.7)	11	1.8 (0.7 - 2.8)	10	1.9 (0.7 - 3.1)	0.0704
No occupation	2	4.0 (0.0 - 9.4)	32	8.3 (5.5 - 11.0)	47	6.8 (4.9 - 8.7)	51	8.2 (6.0 - 10.3)	37	7.0 (4.8 - 9.2)	0.9862
Residency Status											
Native	13	26.0 (13.8 - 38.2)	129	33.4 (28.7 - 38.1)	240	34.8 (31.3 - 38.4)	163	26.1 (22.6 - 29.5)	206	38.9 (34.8 - 43.1)	0.2954
Resident	35	70.0 (57.3. - 82.7)	235	60.9 (56.0 - 65.8)	391	56.7 (53.0 - 60.4)	388	62.1 (58.3 - 65.9)	283	53.5 (49.2 - 57.7)	**0.0482**
Internally Displaced Person/Refugee	2	4.0 (0.0 - 9.4)	17	4.4 (2.4 - 6.5)	52	7.5 (5.6 - 9.5)	71	11.4 (8.9 - 13.8)	38	7.2 (5.0 - 9.4)	**0.0251**
Other	0	-	5	1.3 (0.2 - 2.4)	6	0.9 (0.2 - 1.6)	3	0.5 (0.0 - 1.0)	2	0.4 (0.0 - 0.9)	0.1438

[a]n – number of survivors with characteristic, where represented as n/N, n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]Breakdown of "Other" marital status responses: Separated (24), Divorced (15), Unspecified "other" response (59). [c]Breakdown of "Other" occupation response: Police/Military (8), Other community leader (5), Religious Leader (3), Unspecified "other" response (43). [d]Breakdown of "Other" residency status responses: Asylum Seeker (3), Repatriated (3), Unspecified "other" response (10).

Table 6 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in Lubero Health Zone by year, 2010 - 2015

	2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Type de Violence											
Rape	33	66.0 (52.9 - 79.1)	165	42.7 (37.8 - 47.7)	251	36.4 (32.8 - 40.0)	228	36.5 (32.7 - 40.3)	234	44.2 (40.0 - 48.5)	0.5962
Sexual Harassment	2	4.0 (0.0 - 9.4)	16	4.1 (2.2 - 6.1)	37	5.4 (3.7 - 7.1)	49	7.8 (5.7 - 9.9)	59	11.2 (8.5 - 13.8)	**<0.0001**
Physical Harassment	1	2.0 (0.0 - 5.9)	62	16.1 (12.4 - 19.7)	118	17.1 (14.3 - 19.9)	64	10.2 (7.9 - 12.6)	40	7.6 (5.3 - 9.8)	**<0.0001**
Forced Marriage	0	-	1	0.3 (0.0 - 0.8)	5	0.7 (0.1 - 1.4)	7	1.1 (0.3 - 1.9)	2	0.4 (0.0 - 0.9)	0.6140
Emotional/Psychological Violence	6	12.0 (3.0 - 21.0)	93	24.1 (29.8 - 28.4)	197	28.6 (25.2 - 32.0)	169	27.0 (23.6 - 30.5)	139	26.3 (22.5 - 30.0)	0.2802
Denied Resources/Opportunities	8	16.0 (5.8 - 26.2)	24	6.2 (3.8 - 8.6)	49	7.1 (5.2 - 9.0)	74	11.8 (9.3 - 14.4)	33	6.2 (4.2 - 8.3)	0.9299
Other	0	-	17	44.0 (23.6 - 64.5)	23	33.4 (2.0 - 4.7)	28	4.5 (2.9 - 6.1)	14	2.6 (1.3 - 4.0)	0.6741
None	0	-	8	2.1 (0.7 - 3.5)	9	1.3 (0.5 - 2.2)	6	1.0 (0.2 - 1.7)	8	1.5 (0.5 - 2.6)	0.7046
Services Accessed											
Medical Services	23	46.0 (32.2 - 59.8)	60	15.5 (11.9 - 19.2)	190	27.6 (24.2 - 30.9)	153	24.5 (21.1 - 27.9)	139	26.3 (22.5 - 30.0)	0.2081
Psychosocial Services	7	14.0 (4.4 - 23.6)	169	43.8 (38.8 - 48.7)	540	78.4 (75.3 - 81.4)	549	87.8 (85.3 - 90.4)	461	87.1 (84.3 - 90.0)	**<0.0001**
Socio-economic Services	13	26.0 (13.8 - 38.2)	27	7.0 (4.4 - 9.5)	0	-	1	0.2 (0.0 - 0.5)	0	-	**<0.0001**
Legal Services	8	16.0 (5.8 - 26.2.)	199	51.6 (46.6 - 56.5)	167	24.2 (21.0 - 27.4)	99	15.8 (13.0 - 18.7)	70	13.2 (10.3 - 16.1)	**<0.0001**

Table 7. Characteristics of SGBV Survivors supported by the Ushindi Project in Mutwanga Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**68**		**684**		**973**		**616**		**519**		**353**	
Sex													
Female	65	95.6 (90.7 - 100.0)	625	91.4 (89.3 - 93.5)	852	87.6 (85.5 - 89.6)	561	91.1 (88.8 - 93.3)	495	95.4 (93.6 - 97.2)	328	92.9 (90.2 - 95.6)	**0.0094**
Male	3	4.4 (0.0 - 9.3)	59	9.6 (6.5 - 10.7)	121	12.4 (10.4 - 14.5)	55	8.9 (6.7 - 11.2)	24	4.6 (2.8 - 6.4)	25	7.1 (4.4 - 9.8)	**0.0094**
Age (years)	61	17.8 (15.4 - 20.1)	646	22.6 (21.7 - 23.5)	927	23.5 (22.7 - 24.3)	599	23.3 (22.3 - 24.4)	505	23.9 (22.8 - 24.9)	335	22.0 (21.0 - 23.1)	0.3121
Marital Status													
Single	55	80.9 (71.5 - 90.2)	493	72.1 (68.7 - 75.4)	660	67.8 (64.9 - 70.8)	391	63.5 (59.7 - 67.3)	353	68.0 (64.0 - 72.0)	226	64.0 (59.0 - 69.0)	**0.0017**
Married with certificate	7	10.3 (3.1 - 17.5)	110	16.1 (13.3 - 18.8)	121	12.4 (10.4 - 14.5)	76	12.3 (9.7 14.9)	47	9.1 (6.6 - 11.5)	53	15.0 (11.3 - 18.7)	0.1245
With partner/bride price	4	5.9 (0.3 - 11.5)	28	4.1 (2.6 - 5.6)	101	10.4 (8.5 - 12.3)	82	13.3 (10.6 - 16.0)	67	12.9 (10.0 - 15.8)	49	13.9 (10.3 - 17.5)	**<0.0001**
With partner/no bride price	2	2.9 (0.0 - 7.0)	27	3.9 (2.5 - 5.4)	58	6.0 (4.5 - 7.4)	34	5.5 (3.7 - 7.3)	36	6.9 (4.8 - 9.1)	19	5.4 (3.0 - 7.7)	0.1002
Other	0	-	26	3.8 (2.4 - 5.2)	33	3.4 (2.3 - 4.5)	33	5.4 (3.6 - 7.1)	16	3.1 (1.6 - 4.6)	6	1.7 (0.4 - 3.0)	0.4673
Religion													
Christian	60	88.2 (80.6 - 95.9)	568/683	83.2 (80.4 - 86.0)	916/971	94.3 (92.9 - 95.8)	574/615	93.3 (91.4 - 95.3)	503	96.9 (95.4 - 98.4)	342	96.9 (95.1 - 98.7)	**<0.0001**
Muslim	0	-	18/683	2.6 (1.4 - 3.8)	30/971	3.1 (2.0 - 4.2)	20/615	3.3 (1.8 - 4.7)	9	1.7 (0.6 - 2.9)	6	1.7 (0.4 - 3.0)	0.3610
Other	0	-	0/683	-	0/971	-	3/615	0.5 (0.0 - 1.0)	0	-	3	0.8 (0.0 - 1.8)	**0.0208**
None	8	11.8 (4.1 - 19.4)	97/683	14.2 (11.6 - 16.8)	25/971	2.6 (1.6 - 3.6)	18/615	2.9 (1.6 - 4.3)	7	1.3 (0.4 - 2.3)	2	0.6 (0.0 - 1.3)	**<0.0001**
Highest Level of Education													
Primary	40	58.8 (47.1 - 70.5)	401/681	58.9 (55.2 - 62.6)	504/963	52.3 (49.2 - 55.5)	323	52.4 (48.4 - 56.4)	311/516	60.3 (56.0 - 64.5)	184/350	52.6 (47.4 - 57.8)	0.5524
Secondary	11	16.2 (7.4 - 24.9)	118/681	17.3 (14.5 - 20.2)	203/963	21.1 (18.5 - 23.7)	140	22.7 (19.4 - 26.0)	103/516	20.0 (16.5 - 23.4)	94/350	26.9 (22.2 - 31.5)	**0.0022**
University/Higher Education	0	-	3/681	0.4 (0.0 - 0.9)	7/963	0.7 (0.2 - 1.3)	1	0.2 (0.0 - 4.8)	0/516	-	2/350	0.6 (0.0 - 1.4)	0.4476
Other	0	-	2/681	0.3 (0.0 - 0.7)	7/963	0.7 (0.2 - 1.3)	6	1.0 (0.2 - 1.7)	1/516	0.2 (0.0 - 0.6)	0/350	-	0.5208
None	17	25.0 (14.7 - 35.3)	157/681	23.1 (19.9 - 26.2)	242/963	25.1 (22.4 - 27.9)	146	23.7 (20.3 - 27.1)	101/516	19.6 (16.1 - 23.0)	70/350	20.0 (15.8 - 24.2)	**0.0413**
Occupation													
Farmer	41	60.3 (48.7 - 71.9)	407	59.5 (55.8 - 63.2)	590	60.6 (57.6 - 63.7)	340	55.2 (51.3 - 59.1)	317	61.1 (56.9 - 65.3)	197	55.8 (50.6 - 61.0)	0.2979
Student/Pupil	16	23.5 (13.4 - 33.6)	157	23.0 (19.8 - 26.1)	195	20.0 (17.5 - 22.6)	143	23.2 (19.9 - 26.5)	136	26.2 (22.4 - 30.0)	117	33.1 (28.2 - 38.1)	**<0.0001**
Businessman/woman	2	2.9 (0.0 - 7.0)	20	2.9 (1.7 - 4.2)	26	2.7 (1.7 - 3.7)	12	1.9 (0.9 - 3.0)	10	1.9 (0.7 - 3.1)	1	0.3 (0.0 - 0.8)	**0.0060**
Professional	0	-	4	0.6 (0.0 - 1.2)	8	0.8 (0.3 - 1.4)	2	0.3 (0.0 - 0.8)	4	0.7 (0.0 - 1.5)	4	1.1 (0.0 - 2.2)	0.4200
Other	0	-	8	1.2 (0.4 - 2.0)	23	2.4 (1.4 - 3.3)	33	5.4 (3.6 - 7.1)	11	2.1 (0.9 - 3.4)	7	2.0 (0.5 - 3.4)	0.0995
No occupation	9	13.2 (5.2 - 21.3)	88	12.9 (10.4 - 15.4)	131	13.5 (11.3 - 15.6)	86	14.0 (11.2 - 16.7)	41	7.9 (5.6 - 10.2)	27	7.6 (4.9 - 10.4)	**0.0008**
Residency Status													
Native	16	23.5 (13.4 - 33.6)	178	26.0 (22.7 - 29.3)	325	33.4 (30.4 - 36.4)	208	33.8 (30.1 - 37.6)	158	30.4 (26.5 - 34.4)	124	35.1 (30.1 - 40.1)	**0.0090**
Resident	45	66.2 (54.9 - 77.4)	431	63.0 (59.4 - 66.6)	602	61.9 (58.8 - 64.9)	373	60.7 (56.8 - 64.5)	339	65.3 (61.2 - 69.4)	218	61.8 (56.7 - 66.8)	0.9737
Internally Displaced Person/Refugee	1	1.5 (0.0 - 4.3)	36	5.3 (3.6 - 6.9)	21	2.2 (1.2 - 3.1)	14	2.3 (1.1 - 3.5)	12	2.3 (1.0 - 3.6)	5	1.4 (0.2 - 2.6)	**0.0028**
Other	6	8.8 (2.1 - 15.6)	39	5.7 (4.0 - 7.4)	25	2.6 (1.6 - 3.6)	20	3.3 (1.8 - 4.7)	10	1.9 (0.7 - 3.1)	6	1.7 (0.4 - 3.0)	**<0.0001**

[a]n – number of survivors with characteristic, where represented as n/N, n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]Breakdown of "Other" marital status responses: Separated (20), Divorced (16), Unspecified "other" response (78). [c]Breakdown of "Other" occupation response: Other community leader (10), Government Worker (4), Religious Leader (4), Police/Military (3), Humanitarian (1), Unspecified "other" response (60). [d]Breakdown of "Other" residency status responses: Stateless (9), Repatriated (6), Foreigner (3), Demobilised (2), Asylum Seeker (1), Unspecified "other" response (85).

Table 7 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in Mutwanga Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**68**		**684**		**973**		**616**		**519**		**353**	
Type de Violence													
Rape	59	86.8 (78.7 - 94.8)	456	66.7 (63.1 - 70.2)	481	49.4 (46.3 - 52.6)	337	54.7 (50.8 - 58.6)	314	60.5 (56.3 - 64.7)	217	61.5 (56.4 - 66.6)	0.1318
Sexual Harassment	3	4.4 (0.0 - 9.3)	9	1.3 (0.5 - 2.2)	37	3.8 (2.6 - 5.0)	31	5.0 (3.3 - 6.8)	25	4.8 (3.0 - 6.7)	24	6.8 (4.2 - 9.4)	**<0.0001**
Physical Harassment	0	-	51	7.5 (5.5 - 9.4)	125	12.8 (10.7 - 14.9)	85	13.8 (11.1 - 16.5)	78	15.0 (12.0 - 18.1)	57	16.1 (12.3 - 20.0)	**<0.0001**
Forced Marriage	0	-	1	0.1 (0.0 - 0.4)	11	1.1 (0.5 - 1.8)	4	0.6 (0.0 - 1.3)	2	0.4 (0.0 - 0.9)	1	0.3 (0.0 - 0.8)	0.8367
Emotional/Psychological Violence	1	1.5 (0.0 - 4.3)	90	13.2 (10.6 - 15.7)	182	18.7 (16.3 - 21.2)	105	17.0 (14.1 - 20.0)	65	12.5 (9.7 - 15.4)	33	9.3 (6.3 - 12.4)	0.1523
Denied Resources/Opportunities	2	2.9 (0.0 - 7.0)	28	4.1 (2.6 - 5.6)	50	5.1 (3.8 - 6.5)	17	2.8 (1.5 - 4.1)	16	3.1 (1.6 - 4.6)	11	3.1 (1.3 - 4.9)	0.1138
Other	3	4.4 (0.0 - 9.3)	37	5.4 (3.7 - 7.1)	62	6.4 (4.8 - 7.9)	16	2.6 (1.3 - 3.9)	12	2.3 (1.0 - 3.6)	9	2.5 (0.9 - 4.2)	**0.0002**
None	0	-	12	1.8 (0.8 - 2.7)	25	2.6 (1.6 - 3.6)	21	3.4 (2.0 - 4.8)	7	1.3 (0.4 - 2.3)	1	0.3 (0.0 - 0.8)	0.2301
Services Accessed													
Medical Services	14	20.6 (11.0 - 30.2)	150	21.9 (18.8 - 25.0)	222	22.8 (20.2 - 25.5)	200	32.5 (28.8 - 36.2)	196	37.8 (33.6 - 41.9)	139	39.4 (34.3 - 44.5)	**<0.0001**
Psychosocial Services	55	80.9 (72.5 - 90.2)	459	67.1 (63.6 - 70.6)	646	66.4 (63.4 - 69.4)	469	76.1 (72.8 - 79.5)	368	70.9 (67.0 - 74.8)	203	57.5 (52.3 - 62.7)	0.1451
Socio-economic Services	0		0		0		0		0		0		
Legal Services	6	8.8 (2.1 - 15.6)	184	26.9 (23.6 - 30.2)	396	40.7 (376 - 43.8)	255	41.4 (37.5 - 45.3)	207	39.9 (35.7 - 44.1)	125	35.4 (30.4 - 40.4)	**<0.0001**

Table 8. Characteristics of SGBV Survivors supported by the Ushindi Project in Mwenga Health Zone by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**1**		**866**		**614**		**689**		**532**		**354**	
Sex													
Female	1	100	763	88.1 (85.9 - 90.3)	559	91.0 (88.8 - 93.3)	613	89.0 (86.6 - 91.3)	494	92.9 (90.7 - 95.0)	326	92.1 (89.3 - 94.9)	**0.0091**
Male	0	-	103	11.9 (9.7 - 14.1)	55	9.0 (6.7 - 11.2)	76	11.0 (8.7 - 13.4)	38	7.1 (5.0 - 9.3)	28	7.9 (5.1 - 10.7)	**0.0091**
Age (years)	1	26	565	27.9 (26.6 - 29.1)	327	28.1 (26.6 - 29.7)	518	27.9 (26.7 - 29.2)	368	28.0 (26.6 - 29.5)	269	26.3 (24.7 - 28.0)	0.3109
Marital Status													
Single	0	-	366	42.3 (39.0 - 45.6)	233	37.9 (34.1 - 45.6)	320	46.4 (42.7 - 50.2)	210	39.5 (35.3 - 43.6)	139	39.3 (34.2 - 44.4)	0.6273
Married with certificate	1	100	343	39.6 (36.3 - 42.9)	168	27.4 (23.8 - 30.9)	98	14.2 (11.6 - 16.8)	77	14.5 (11.5 - 17.5)	41	11.6 (8.2 - 14.9)	**<0.0001**
With partner/bride price	0	-	34	3.9 (2.6 - 5.2)	145	23.6 (20.3 - 27.0)	169	24.5 (21.3 - 27.7)	160	30.1 (26.2 - 34.0)	113	31.9 (27.1 - 36.8)	**<0.0001**
With partner/no bride price	0	-	7	0.8 (0.2 - 1.4)	18	2.9 (1.6 - 4.3)	29	4.2 (2.7 - 5.7)	28	5.3 (3.4 - 7.2)	28	7.9 (5.1 - 10.7)	**<0.0001**
Other	0	-	116	13. (11.1 - 15.7)	50	8.1 (6.0 - 10.3)	64	9.3 (7.1 - 11.5)	57	10.7 (8.1 - 13.3)	33	9.3 (6.3 - 12.4)	0.0606
Religion													
Christian	0	-	341/796	42.8 (39.4 - 46.3)	527/613	86.0 (83.2 - 88.7)	592/688	86.0 (83.5 - 88.6)	490/531	92.3 (90.0 - 94.5)	326/353	92.4 (89.6 - 95.1)	**<0.0001**
Muslim	0	-	0/796	-	0/613	-	1/688	0.1 (0.0 - 0.4)	1/531	0.2 (0.0 - 0.6)	2/353	0.6 (0.0 - 1.3)	**0.0470**
Other	0	-	10/796	1.3 (0.5 - 2.0)	8/613	1.3 (0.4 - 2.2)	7/688	1.0 (0.3 - 1.8)	2/531	0.4 (0.0 - 0.9)	2/353	0.6 (0.0 - 1.3)	0.0854
None	1	100	445/796	55.9 (52.5 - 59.4)	78/613	12.7 (10.1 - 15.4)	86/688	12.5 (10.0 - 15.0)	38/531	7.2 (5.0 - 9.3)	23/353	6.5 (3.9 - 9.1)	**<0.0001**
Highest Level of Education													
Primary	0	-	367	42.4 (39.1 - 45.7)	313	51.0 (47.0 - 54.9)	343	49.8 (46.0 - 53.5)	266	50.0 (45.8 - 54.2)	166	46.9 (41.7 - 52.1)	**0.0380**
Secondary	0	-	158	18.2 (15.7 - 20.8)	146	23.8 (20.4 - 27.1)	168	24.4 (21.2 - 27.6)	159	29.9 (26.0 - 33.8)	118	33.3 (28.4 - 38.2)	**<0.0001**
University/Higher Education	0	-	3	0.3 (0.0 - 0.7)	0	-	0	-	0	-	0	-	-
Other	0	-	0	-	0	-	1	0.1 (0.0 - 0.4)	0	-	1	0.3 (0.0 - 0.8)	0.2040
None	1	100	338	39.0 (35.8 - 42.3)	155	25.2 (21.8 - 28.7)	177	25.7 (22.4 - 29.0)	107	20.1 (16.7 - 23.5)	69	19.5 (15.4 - 23.6)	**<0.0001**
Occupation													
Farmer	1	100	524	60.5 (57.3 - 63.8)	433	70.5 (66.9 - 74.1)	450	65.3 (61.8 - 68.9)	348	65.4 (61.4 - 69.5)	231	65.3 (60.3 - 70.2)	0.1798
Student/Pupil	0	-	180	20.8 (18.1 - 23.5)	137	22.3 (19.0 - 25.6)	186	27.0 (23.7 - 30.3)	149	28.0 (24.2 - 31.8)	107	30.2 (25.4 - 35.0)	**<0.0001**
Businessman/woman	0	-	24	2.8 (1.7 - 3.9)	2	0.3 (0.0 - 0.8)	3	0.4 (0.0 - 0.9)	4	0.8 (0.0 - 1.5)	2	0.6 (0.0 - 1.3)	**0.0005**
Professional	0	-	5	0.6 (0.1 - 1.1)	2	0.3 (0.0 - 0.8)	5	0.7 (0.1 - 1.4)	6	1.1 (0.2 - 2.0)	1	0.3 (0.0 - 0.8)	0.6259
Other	0	-	21	2.4 (1.4 - 3.4)	4	0.7 (0.0 - 1.3)	4	0.6 (0.0 - 1.1)	10	1.9 (0.7 - 3.0)	3	0.8 (0.0 - 1.8)	0.0928
No occupation	0	-	112	12.9 (10.7 - 15.2)	36	5.9 (4.0 - 7.7)	41	6.0 (4.2 - 7.7)	15	2.8 (1.4 - 4.2)	10	2.8 (1.1 - 4.6)	**<0.0001**
Residency Status													
Native	1	100	152	17.6 (15.0 - 20.1)	146	23.8 (20.4 - 27.1)	264	38.3 (34.7 - 41.9)	112	21.1 (17.6 - 24.5)	64	18.1 (14.1 - 22.1)	0.0751
Resident	0	-	549	63.4 (60.2 - 66.6)	429	69.9 (66.2 - 73.5)	360	52.2 (48.5 - 56.0)	311	58.5 (54.3 - 62.6)	243	68.6 (63.8 - 73.5)	0.2163
Internally Displaced Person/Refugee	0	-	125	14.4 (12.1 - 16.8)	17	2.8 (1.5 - 4.1)	26	3.8 (2.4 - 5.2)	105	19.7 (16.4 - 23.1)	46	13.0 (9.5 - 16.5)	**0.0476**
Other	0	-	40	4.6 (3.2 - 6.0)	22	3.6 (2.1 - 5.1)	39	5.7 (3.9 - 7.4)	4	0.8 (0.0 - 1.5)	1	0.3 (0.0 - 0.8)	**<0.0001**

[a]n – number of survivors with characteristic, where represented as n/N , n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]p-value calculated for trend from 2011 to 2015. [c]Breakdown of "Other" marital status responses: Separated (53), Divorced (33), Unspecified "other" response (235). [d]Breakdown of "Other" occupation response: Other community leader (3), Government Worker (2), Humanitarian (2), Police/Military (2), Religious Leader (2), Unspecified "other" response (31). [e]Breakdown of "Other" residency status responses: Stateless (5), Demobilised (3), Repatriated (3), Unspecified "other" response (95).

Table 8 Cont. Characteristics of SGBV Survivors supported by the Ushindi Project in Mwenga Health Zone by year, 2010 - 2015

Characteristic	2010 (N = 1) n	2010 (N = 1) % (95% CI)	2011 (N = 843) n	2011 (N = 843) % (95% CI)	2012 (N = 605) n	2012 (N = 605) % (95% CI)	2013 (N = 647) n	2013 (N = 647) % (95% CI)	2014 (N = 520) n	2014 (N = 520) % (95% CI)	2015 (N = 351) n	2015 (N = 351) % (95% CI)	p-value, Wald test of association
Number of Survivors		**1**		**866**		**614**		**689**		**532**		**354**	
Type de Violence													
Rape	1	100	403	46.5 (43.2 - 49.9)	342	55.7 (51.8 - 59.6)	356	51.7 (47.9 - 55.4)	347	65.2 (61.2 - 69.3)	193	54.5 (49.3 - 59.7)	**<0.0001**
Sexual Harassment	0	-	40	4.6 (3.2 - 6.0)	26	4.2 (2.6 - 5.8)	29	4.2 (2.7 - 5.7)	10	1.9 (0.7 - 3.0)	14	4.0 (1.9 - 6.0)	0.0868
Physical Harassment	0	-	138	15.9 (13.5 - 18.4)	130	21.2 (17.09 - 24.4)	117	17.0 (14.2 - 19.8)	79	14.8 (11.8 - 17.9)	51	14.4 (10.7 - 18.1)	0.1699
Forced Marriage	0	-	2	0.2 (0.0 - 0.6)	8	1.3 (0.4 - 2.2)	6	0.9 (0.2 - 1.6)	4	0.8 (0.0 - 1.5)	12	3.4 (1.5 - 5.3)	**0.0005**
Emotional/Psychological Violence	0	-	66	7.6 (5.9 - 9.4)	34	5.5 (3.7 - 7.3)	79	11.5 (9.1 - 13.8)	60	11.3 (8.6 - 14.0)	50	14.1 (10.5 - 17.8)	**<0.0001**
Denied Resources/Opportunities	0	-	16	1.8 (1.0 - 2.7)	8	1.3 (0.4 - 2.2)	15	2.2 (1.1 - 3.3)	18	3.4 (1.8 - 4.9)	20	5.6 (3.2 - 8.1)	**0.0001**
Other	0	-	185	21.4 (18.6 - 24.1)	53	8.6 (6.4 - 10.9)	45	6.5 (4.7 - 8.4)	13	2.4 (1.1 - 3.8)	10	2.8 (1.1 - 4.6)	**<0.0001**
None	0	-	16	1.8 (1.0 - 2.7)	13	2.1 (1.0 - 3.3)	42	6.1 (4.3 - 7.9)	1	0.2 (0.0 - 0.6)	4	1.1 (0.0 - 2.2)	0.4679
Services Accessed													
Medical Services	1		331	39.2 (35.0 - 41.6)	267	43.5 (39.6 - 47.4)	299	43.4 (39.7 - 47.1)	265	49.8 (45.6 - 54.1)	157	44.4 (39.2 - 49.5)	**0.0006**
Psychosocial Services	1		529	61.1 (57.8 - 64.3)	403	65.6 (61.9 - 69.4)	565	82.0 (79.1 - 84.9)	415	78.0 (24.5 - 81.5)	268	75.7 (71.2 - 80.2)	**<0.0001**
Socio-economic Services	0		30	3.5 (2.2 - 4.7)	1	0.2 (0.0 - 0.5)	0	-	5	0.9 (0.1 - 1.8)	25	7.1 (4.4 - 9.7)	0.1267
Legal Services	0		292	33.7 (30.6 - 36.9)	297	48.4 (44.4 - 52.3)	208	30.2 (26.8 - 33.6)	116	21.8 (19.3 - 25.3)	68	19.2 (15.1 - 23.3)	**<0.0001**

[a]p-value calculated for trend from 2011 to 2015.

Table 9. Number of PEP Kits used among SGBV Survivors supported by the Ushindi Project by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Health Zone	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	
Alimbongo	0/0	-	0/4	-	33/58	56.9 (44.1 – 69.7)	146/186	78.5 (72.6 – 84.4)	187/221	84.6 (79.9 – 89.4)	132/156	84.6 (78.9 – 90.3)	**<0.0001**
Kitutu	0/0	-	20/62	24.4 (15.1 – 33.7)	21/98	21.4 (13.3 – 29.6)	15/53	28.3 (16.2 – 40.5)	15/36	41.7 (25.5 – 57.8)	15/25	60.0 (40.8 – 79.2)	**0.0004**
Komanda	25/42	59.5 (44.7 – 74.4)	49/80	61.3 (50.6 – 71.9)	72/98	73.5 (64.7 – 82.2)	116/141	82.3 (76.0 – 88.6)	90/111	81.1 (73.8 – 88.4)	72/90	80.0 (71.7 – 88.3)	**0.0001**
Lolwa	12/30	40.0 (22.4 – 57.6)	61/133	45.9 (37.4 – 54.3)	69/82	84.1 (76.2 – 92.1)	101/124	81.5 (74.6 – 88.3)	31/48	64.6 (51.0 – 78.1)	19/22	86.3 (72.0 – 100.0)	**<0.0001**
Lubero	0/0	-	14/18	77.8 (58.5 – 97.0)	8/27	29.6 (12.4 – 46.9)	43/96	44.8 (34.8 – 54.8)	47/78	60.3 (49.4 – 71.1)	56/74	75.7 (65.9 – 85.5)	**0.0026**
Mutwanga	6/9	66.7 (34.8 – 97.4)	63/102	61.8 (52.3 – 71.2)	97/143	67.8 (60.2 – 75.5)	94/126	74.6 (67.0 – 82.2)	122/157	77.7 (71.2 – 84.2)	78/113	69.0 (60.5 – 77.6)	**0.0564**
Mwenga[b]	1/1	100.0	50/119	42.0 (33.1 – 50.9)	72/138	52.2 (43.8 – 60.5)	106/169	62.7 (55.4 – 70.0)	98/139	70.5 (62.9 – 78.1)	47/79	59.5 (48.7 – 70.3)	**<0.0001**

[a]n/N – Number of survivors who received a PEP kit/Number of survivors presenting within 72 hours. [b]p-value calculated for trend from 2011 to 2015.

Table 10. Number of PEP Kits used among SGBV Survivors during and after stock-out period in 2014

	Jan-April 2014		May – Dec 2014		p-value, Wald test of association
Health Zone	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	
Alimbongo	52/64	81.3 (71.7 – 90.8)	135/157	86.0 (80.5 – 91.4)	0.3775
Kitutu	6/15	40.0 (14.9 – 65.1)	9/21	42.9 (21.4 – 64.3)	0.8639
Komanda	34/40	85.0 (73.9 – 96.1)	56/71	78.9 (69.3 – 88.4)	0.4308
Lolwa	17/20	85.0 (69.1 – 100.)	14/28	50.0 (31.3 -68.7)	**0.0177**
Lubero	17/26	65.4 (47.0 – 83.8)	30/52	57.7 (44.2 – 71.2)	0.5135
Mutwanga	42/50	84.0 (73.8 – 94.2)	80/107	74.8 (66.5 – 83.0)	0.1990
Mwenga	28/38	73.7 (59.6 – 87.7)	70/101	69.3 (60.3 – 78.3)	0.6144

[a]n/N – Number of survivors who received a PEP kit/Number of survivors presenting within 72 hours

Table 11. Number of Survivors presenting within 72 hours, Ushindi Project, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Health Zone	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	
Alimbongo	0	-	4/14	28.6 (4.9 – 52.2)	58/206	28.2 (22.0 – 34.3)	186/388	47.9 (43.0 – 52.9)	221/363	60.9 (55.9 – 65.9)	156/207	75.4 (69.5 – 81.2)	**<0.0001**
Kitutu	0	-	82/211	28.9 (32.3 – 45.4)	98/285	34.4 (28.9 – 39.9)	53/236	22.5 (17.1 – 27.8)	36/171	21.1 (14.9 – 27.2)	25/87	28.7 (19.2 – 38.2)	**0.0001**
Komanda	42/57	73.7 (62.2 – 85.1)	80/131	61.1 (52.7 – 69.4)	98/157	62.4 (54.8 – 70.0)	141/202	69.8 (63.5 – 76.1)	111/154	72.1 (65.0 – 79.2)	90/121	74.4 (66.6 – 82.2)	**0.0441**
Lolwa	30/34	88.2 (77.4 – 99.1)	133/159	83.6 (77.9 – 89.4)	82/132	62.1 (53.8 – 70.4)	124/177	70.1 (63.3 – 76.8)	48/91	52.7 (42.5 – 63.0)	22/48	45.8 (31.7 – 59.9)	**<0.0001**
Lubero	0/0	-	18/20	90.0 (76.8 – 100.0)	27/49	55.1 (41.1 – 69.0)	96/173	55.5 (48.1 – 62.9)	78/145	53.8 (45.7 – 61.9)	74/135	54.8 (46.4 – 63.2)	0.1038
Mutwanga	9/12	75.0 (50.5 – 99.5)	102/150	68.0 (60.5 – 75.5)	143/223	64.1 (57.8 – 70.4)	126/193	65.3 (58.6 – 72.0)	157/198	79.3 (73.6 – 84.9)	113/139	81.3 (74.8 – 87.8)	**0.0003**
Mwenga	1/1	100.0	119/321	37.1 (31.8 – 42.4)	138/271	50.9 (45.0 – 56.9)	169/269	62.8 (57.0 – 68.6)	139/262	53.1 (47.0 – 59.1)	79/156	50.6 (42.8 – 58.5)	**0.0002**

[a]n/N – Number of survivors presenting within 72 hours/Number of survivors presenting for care

Table 12. Number of survivors presenting pregnant by year, 2010 - 2015

Health Zone	Age (years)	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
		n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	n/N[a]	% (95% CI)	
All Zones	All ages	9/115	7.8 (2.9 – 12.7)	161/1084	10.4 (8.6 – 12.2)	244/1408	17.3 (15.4 – 19.3)	269/1785	15.1 (15.4 – 19.3)	211/1506	15.0 (12.3 – 15.8)	111/953	11.6 (9.6 – 13.7)	0.8520
All Zones	13 - 17	1/42	2.4 (0.0 – 7.0)	54/224	24.1 (18.5 – 29.7)	141/384	36.7 (31.9 – 41.5)	146/556	26.3 (22.6 – 29.9)	121/484	25.0 (21.1 – 28.9)	78/358	21.8 (17.5 – 26.1)	0.1380
	18 - 24	2/21	9.5 (0.0 – 2.2)	14/129	10.9 (5.5 – 16.2)	24/142	16.9 (10.7 – 23.1)	30/206	14.6 (9.7 – 19.4)	27/192	14.1 (9.1 – 19.0)	9/134	6.7 (2.5 – 11.0)	0.3430
	> 25	0/16	-	18/2113	8.0 (4.3 – 11.6)	22/220	10.0 (6.0 – 14.0)	28/335	8.4 (5.4 – 11.3)	21/306	6.9 (4.0 – 9.7)	11/179	6.1 (2.6 – 9.7)	0.4010
Alimbongo	13 - 17	0/0	-	7/9	77.8 (50.6 - 100.0)	66/83	79.5 (70.8 - 88.2)	75/156	48.0 (40.2 - 55.9)	44/122	36.1 (27.5 - 44.6)	11/62	17.7 (8.2 - 27.3)	**<0.0001**
	18 - 24	0/0	-	0/0	-	13/45	28.9 (15.6 - 42.2)	10/73	13.7 (5.8 - 21.6)	14/93	15.0 (7.8 - 22.3)	3/44	6.8 (0.0 - 14.2)	**0.0125**
	> 25	0/0	-	0/1	-	6/35	17.1 (4.6 - 29.6)	13/101	12.9 (6.3 - 19.4)	10/125	8.0 (3.2 - 12.8)	5/67	7.5 (1.2 - 13.8)	0.0827
Kitutu	13 - 17	0/0	-	18/31	58.1 (40.7 - 75.5)	35/64	54.7 (42.5 - 66.9)	25/50	50.0 (36.1 - 63.9)	19/63	30.2 (18.8 - 41.5)	31/54	57.4 (44.2 - 70.6)	0.2639
	18 - 24	0/0	-	1/12	8.3 (0.0 - 24.1)	2/20	10.0 (0.0 - 23.3)	5/14	35.7 (10.4 - 61.0)	0/7	-	0/5	-	0.9298
	> 25	0/0	-	4/83	4.8 (0.2 - 9.4)	9/80	11.3 (4.3 - 18.2)	0/60	-	2/39	5.1 (0.0 - 12.1)	1/8	12.5 (0.0 - 35.5)	0.7029
Komanda	13 - 17	1/22	4.5 (0.0 - 13.3)	9/44	20.5 (8.5 - 32.4)	11/75	14.7 (6.6 - 22.7)	4/93	4.3 (0.2 - 8.4)	11/86	12.8 (5.7 - 19.9)	4/62	6.5 (0.3 - 12.6)	0.2002
	18 - 24	1/13	7.7 (0.0 - 22.2)	2/38	5.3 (0.0 - 12.4)	1/21	4.8 (0.0 - 13.9)	1/18	5.6 (0.0 - 16.2)	2/9	22.2 (0.0 - 49.5)	0/22	-	0.7778
	> 25	0/6	-	2/20	10.0 (0.0 - 23.2)	0/15	-	0/19	-	3/22	13.6 (0.0 - 28.0)	1/31	3.2 (0.0 - 9.5)	0.9139
Lolwa	13 - 17	0/18	-	3/72	4.2 (0.0 - 8.8)	5/53	9.4 (1.6 - 17.3)	3/80	3.8 (0.0 - 7.9)	3/41	7.3 (0.0 - 15.3)	2/23	8.7 (0.0 - 20.2)	0.3380
	18 - 24	1/6	16.7 (0.0 - 46.6)	5/24	20.8 (4.5 - 37.1)	0/26	-	3/33	9.1 (0.0 - 18.9)	2/21	9.5 (0.0 - 22.1)	2/16	12.5 (0.0 - 28.8)	0.5362
	> 25	0/7	-	2/22	9.1 (0.0 - 21.1)	1/25	4.0 (0.0 - 11.7)	3/48	6.3 (0.0 - 13.1)	1/22	4.5 (0.0 - 13.3)	1/10	10.0 (0.0 - 28.7)	0.8059
Lubero	13 - 17	0/0	-	2/10	20.0 (0.0 - 44.9)	1/14	7.1 (0.0 - 20.7)	21/54	38.9 (25.9 - 51.9)	8/54	14.8 (5.3 - 24.3)	11/67	16.4 (7.5 - 25.3)	0.2117
	18 - 24	0/0	-	0/4	-	3/7	42.9 (5.9 - 79.8)	7/28	25.0 (8.9 - 41.1)	6/21	28.6 (9.1 - 48.0)	1/14	7.1 (0.0 - 20.7)	0.4687
	> 25	0/0	-	0/2	-	1/7	14.3 (0.0 - 40.4)	7/31	22.6 (7.8 - 37.4)	3/32	9.4 (0.0 - 19.5)	0/18	-	0.1037
Mutwanga	13 - 17	0/2	-	7/32	21.9 (7.5 - 36.2)	17/64	26.6 (15.7 - 37.4)	7/59	11.9 (3.6 - 20.1)	6/45	13.3 (3.4 - 23.3)	3/40	7.5 (0.0 -15.7)	**0.0225**
	18 - 24	0/2	-	3/21	14.3 (0.0 - 29.3)	5/19	26.3 (6.4 -- 46.2)	2/16	12.5 (0.0 - 28.8)	2/27	7.4 (0.0 - 17.3)	3/19	15.8 (0.0 - 32.3)	0.6067
	> 25	0/2	-	1/22	4.3 (0.0 - 12.7)	4/26	15.4 (1.4 - 29.3)	2/21	9.5 (0.0 - 22.1)	1/15	6.7 (0.0 - 19.4)	1/17	5.9 (0.0 - 17.1)	0.9044
Mwenga	13 - 17	0/0	-	8/26	30.8 (13.0 - 48.6)	6/31	19.4 (5.4 - 33.3)	11/64	17.2 (7.9 - 26.4)	30/73	41.1 (29.8 - 52.4)	16/50	32.0 (19.0 - 45.0)	0.1180
	18 - 24	0/0	-	3/30	10.0 (0.0 - 20.8)	0/4	-	2/24	8.3 (0.0 - 19.5)	1/14	7.1 (0.0 - 20.7)	0/14	-	0.3313
	> 25	0/1	-	8/62	12.9 (4.5 - 21.3)	1/32	3.1 (0.0 - 9.2)	3/55	5.5 (0.0 - 11.5)	1/51	2.0 (0.0 - 5.8)	2/28	7.1 (0.0 - 16.7)	0.1047

[a]n/N – Number of survivors presenting pregnant for medical care/Number of survivors reporting having been raped

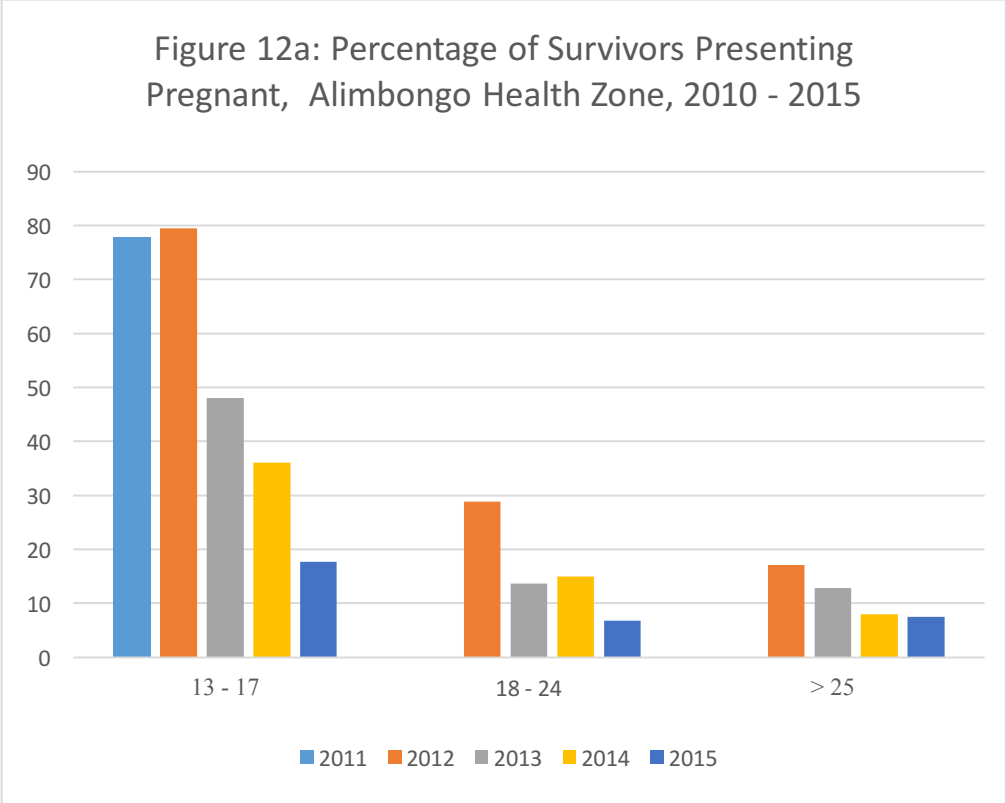


Figure 12a: Percentage of Survivors Presenting Pregnant, Alimbongo Health Zone, 2010 - 2015
90
80
70
60
50
40
30
20
10
0
13 - 17
18 - 24
> 25
2011
2012
2013
2014
2015

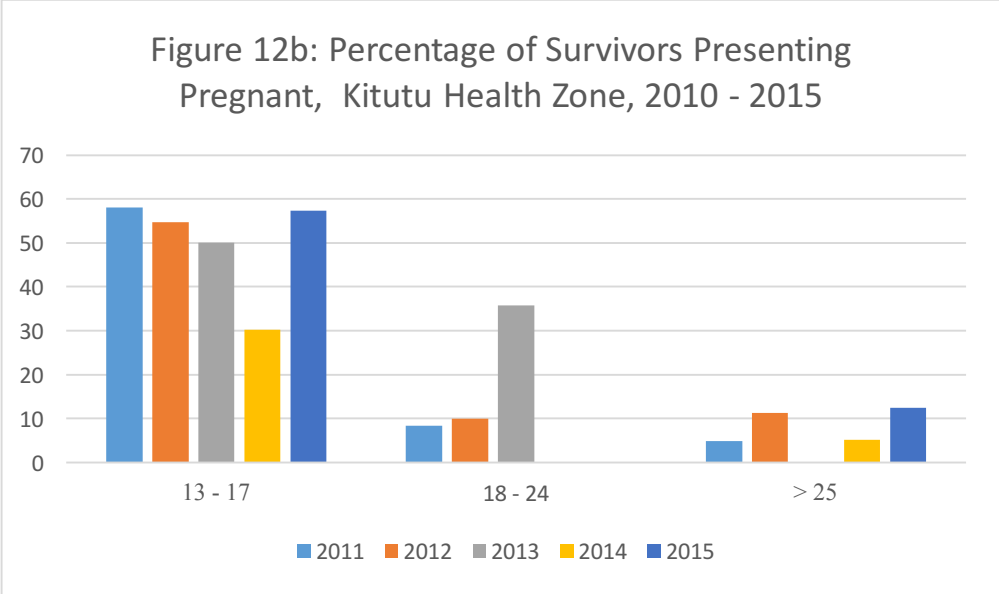


Figure 12b: Percentage of Survivors Presenting Pregnant, Kitutu Health Zone, 2010 - 2015
70
60
50
40
30
20
10
0
13 - 17
18 - 24
> 25
2011
2012
2013
2014
2015

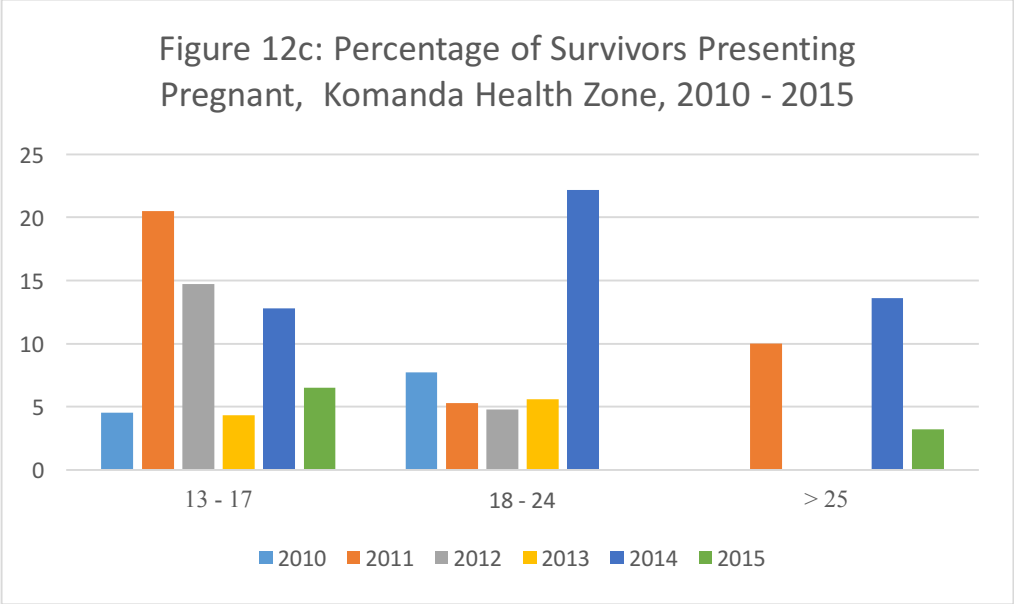


Figure 12c: Percentage of Survivors Presenting Pregnant, Komanda Health Zone, 2010 - 2015
25
20
15
10
5
0
13 - 17
18 - 24
> 25
2010
2011
2012
2013
2014
2015

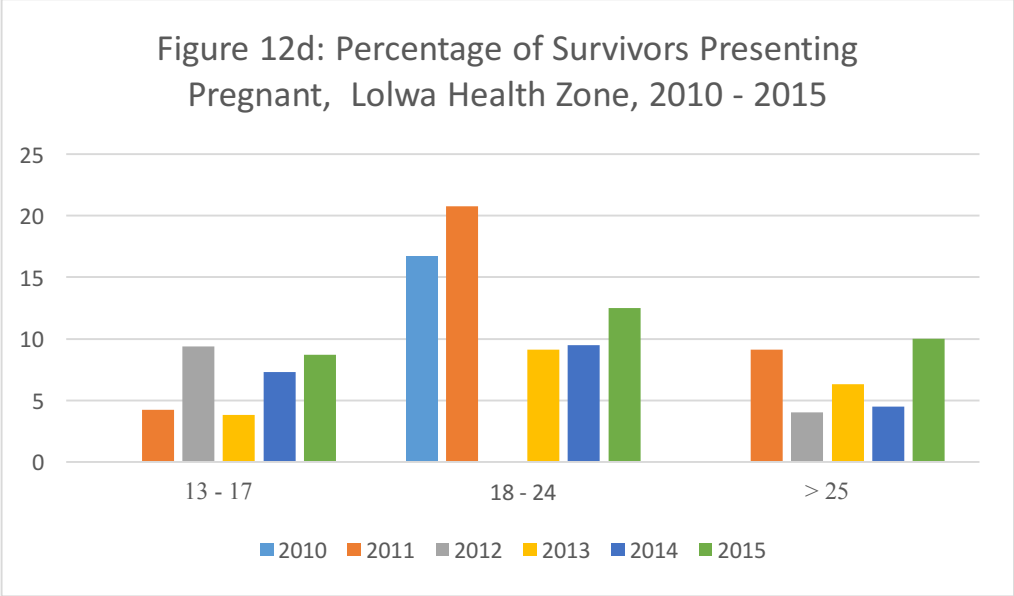


Figure 12d: Percentage of Survivors Presenting Pregnant, Lolwa Health Zone, 2010 - 2015
25
20
15
10
5
0
13 - 17
18 - 24
> 25
2010
2011
2012
2013
2014
2015

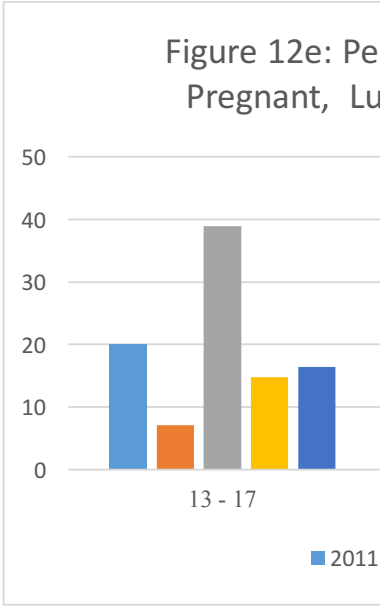


Figure 12e: Pe
Pregnant, Lu
50
40
30
20
10
0
13 - 17
2011

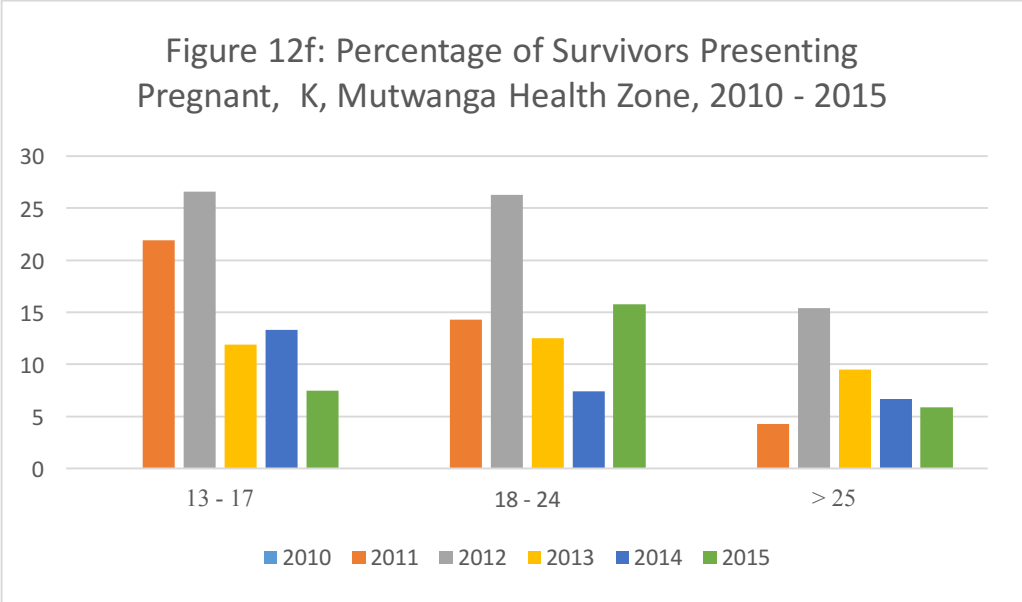


Figure 12f: Percentage of Survivors Presenting Pregnant, K, Mutwanga Health Zone, 2010 - 2015
30
25
20
15
10
5
0
13 - 17
18 - 24
> 25
2010
2011
2012
2013
2014
2015

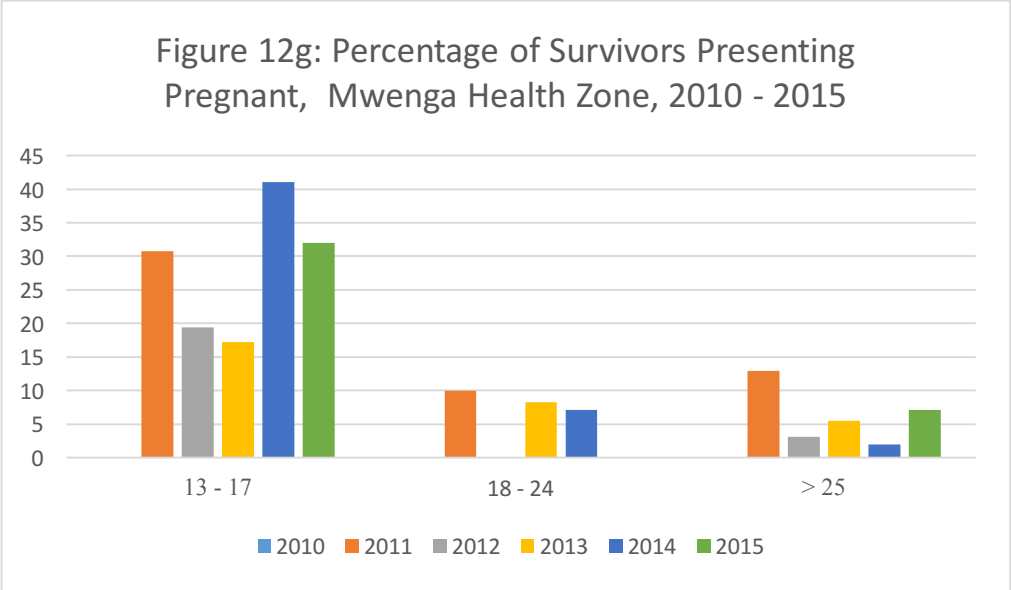


Figure 12g: Percentage of Survivors Presenting Pregnant, Mwenga Health Zone, 2010 - 2015
45
40
35
30
25
20
15
10
5
0
13 - 17
18 - 24
> 25
2010
2011
2012
2013
2014
2015

Table 13a. Number of Survivors Presenting Pregnant and tested for HIV at entrance, Ushindi Project by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Health Zone	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	
Alimbongo	0/0	-	7/7	100.0	76/86	88.4 (81.6 – 95.2)	87/113	77.0 (69.2 – 84.8)	69/79	87.3 (80.0 – 94.7)	18/20	90.0 (76.8 – 100.0)	**0.8664**
Kitutu	0/0	-	15/25	60.0 (40.7 – 79.3)	27/62	43.5 (31.1 – 55.9)	10/39	25.6 (11.9 – 39.4)	3/24	12.5 (0.0 – 25.8)	5/33	15.2 (2.9 – 27.4)	**<0.0001**
Komanda	6/6	100.0	12/17	70.6 (48.8 – 92.4)	11/13	84.6 (64.9 – 100.0)	3/6	50.0 (9.7 – 90.3)	15/21	71.4 (52.0 – 90.9)	3/5	60.0 (16.7 – 100.0)	**0.2127**
Lolwa	1/1	100.0	3/13	23.1 (0.0 – 46.2)	3/4	75.0 (32.1 – 100.0)	8/9	88.9 (68.1 – 100.0)	9/10	90.0 (71.2 – 100.0)	6/6	100.0	**0.0016**
Lubero	0/0	-	1/3	33.3 (0.0 – 87.0)	4/4	100.0	31/39	79.5 (66.7 – 92.2)	18/19	94.7 (84.6 – 100.0)	10/10	100.0	0.0165
Mutwanga	1/2	50.0 (0.0 – 100.0)	19/23	82.6 (67.1 – 98.2)	41/47	87.2 (77.7 – 96.8)	20/23	87.0 (73.1 – 100.0)	12/15	80.0 (59.7 – 100.0)	8/9	88.9 (68.3 – 100.0)	**0.6676**
Mwenga	0/0		20/22	90.9 (78.9 – 100.0)	14/14	100.0	25/29	86.2 (73.6 – 98.8)	31/39	79.5 (66.8 – 92.1)	10/19	52.6 (30.1 – 75.2)	0.0025

[a]n/N – Number of survivors whose HIV status was tested /Number of survivors presenting pregnant

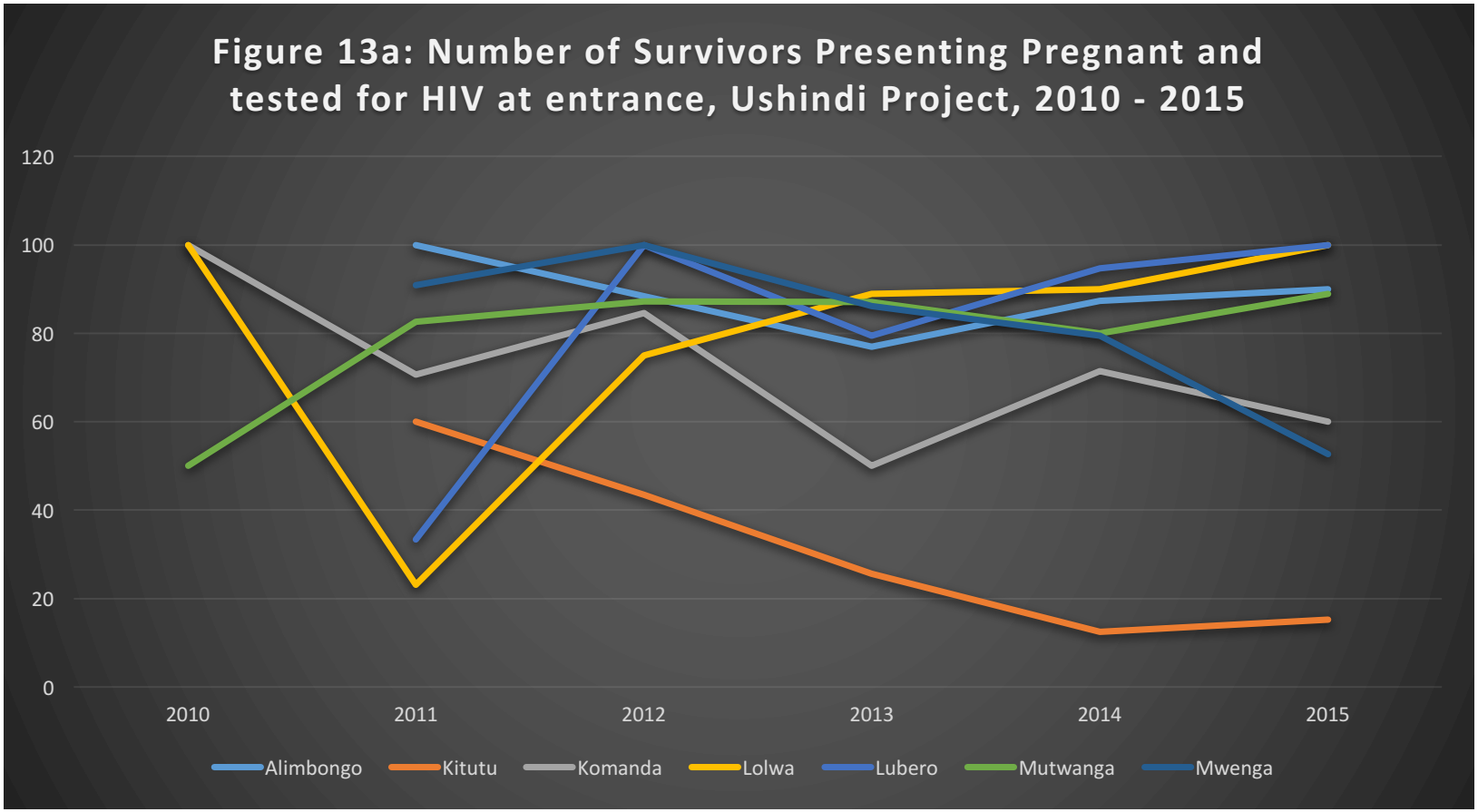


Figure 13a: Number of Survivors Presenting Pregnant and tested for HIV at entrance, Ushindi Project, 2010 - 2015
120
100
80
60
40
20
0
2010
2011
2012
2013
2014
2015
Alimbongo
Kitutu
Komanda
Lolwa
Lubero
Mutwanga
Mwenga

Table 13b. Number of Survivors Presenting Pregnant with positive HIV status, Ushindi Project by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Health Zone	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	**n/N[a]**	**% (95% CI)**	
Alimbongo	0/0	-	0/7	-	1/76	1.3 (0.0 – 3.9)	3/87	3.4 (0.0 – 7.3)	4/70	5.7 (0.3 – 11.2)	0/18	-	**0.3596**
Kitutu	0/0		1/15	6.7 (0.0 – 19.4)	0/27	-	0/10	-	0/3	-	0/5	-	**-**
Komanda	4/6	66.7 (28.6 – 100.0)	0/12	-	1/11	9.1 (0.0 – 26.3)	0/3	-	0/15	-	0/3	-	**0.0216**
Lolwa	1/1	100.0	1/3	33.3 (0.0 – 87.6)	0/3	-	0/8	-	0/9	-	0/6	-	**-**
Lubero	0/0	-	0/1	-	0/4	-	0/31	-	0/18	-	0/10	-	-
Mutwanga	0/1	-	3/19	15.8 (0.0 – 32.3)	2/42	4.8 (0.0 – 11.2)	0/20	-	0/12	-	1/8	12.5 (0.0 – 35.5)	**0.3293**
Mwenga	0/0	-	1/20	5.0 (0.0 – 14.6)	0/14	-	0/25	-	0/31	-	0/10	-	-

[a]n/N – Number of survivors with who tested positive for HIV or indicated that they were HIV positive at entrance/Number of survivors presenting pregnant who were tested for HIV at entrance or who indicated that they were HIV positive at entrance

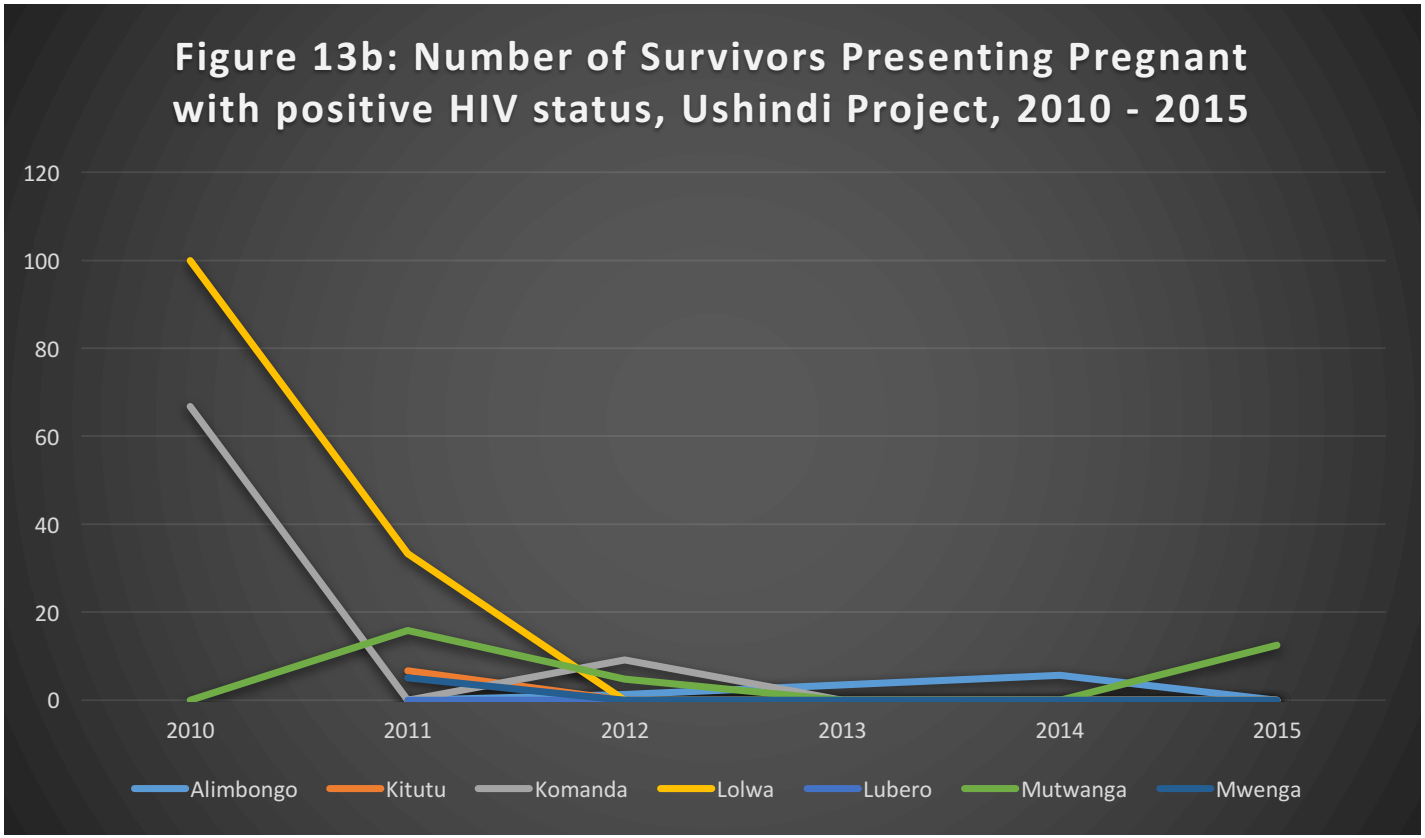


Figure 13b: Number of Survivors Presenting Pregnant with positive HIV status, Ushindi Project, 2010 - 2015
120
100
80
60
40
20
0
2010
2011
2012
2013
2014
2015
Alimbongo
Kitutu
Komanda
Lolwa
Lubero
Mutwanga
Mwenga

Table 14. Characteristics of SGBV survivors who accessed psychosocial services compared to those who did not, Ushindi Project, 2010 - 2015

	Accessed Psychosocial Services		Did not access psychosocial servies		p-value, Wald test of association
Characteristic	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Number of Survivors		**16633**		**6751**	
Sex	15104	90.8 (90.4 – 91.2)	5902	87.4 (86.6 – 88.2)	**<0.0001**
Female	1529	9.2 (8.8 – 9.6)	849	12.6 (11.8 – 13.4)	**<0.0001**
Male	15008	26.1 (25.9 – 26.4)	6045	25.2 (24.9 – 25.5)	**<0.0001**
Age (years)					
Marital Status					
Single	8661	52.1 (51.3 – 52.8)	3383	50.1 (48.9 – 51.3)	0.0066
Married with certificate	3424	20.6 (20.0 – 21.2)	1410	20.9 (19.9 – 21.9)	0.6075
With partner/bride price	2281	13.7 (13.2 – 14.2)	967	14.3 (13.5 – 15.2)	0.2216
With partner/no bride price	1024	6.2 (5.8 – 6.5)	497	7.4 (6.7 – 8.0)	0.0007
Other	1216	7.3 (6.9 – 7.7)	494	7.3 (6.7 – 7.9)	0.9858
Religion					
Christian	14656/16446	89.1 (88.6 – 89.6)	5730/6721	85.3 (84.4 – 86.1)	**<0.0001**
Muslim	170/16446	1.0 (0.9 – 1.2)	95/6721	1.4 (1.1 – 1.7)	0.0140
Other	174/16446	1.1 (0.9 – 1.2)	116/6721	1.7 (1.4 – 2.0)	<0.0001
None	1443/16446	8.8 (8.3 – 9.2)	779/6721	11.6 (10.8 – 12.4)	**<0.0001**
Highest Level of Education					
Primary	8274/16569	49.9 (49.2 – 50.7)	3623/6748	53.7 (52.5 – 54.9)	**<0.0001**
Secondary	3646/16569	22.0 (21.4 – 22.6)	1263/6748	18.7 (17.8 – 19.6)	**<0.0001**
University/Higher Education	56/16569	0.3 (0.2 – 0.4)	23/6748	0.3 (0.2 – 0.5)	0.9728
Other	49/16569	0.3 (0.2 – 0.4)	55/6748	0.8 (0.6 – 1.0)	**<0.0001**
None	4544/16569	27.4 (26.7 – 28.1)	1784/6748	26.4 (25.4 – 27.5)	0.1242
Occupation					
Farmer	10814	65.0 (64.3 – 65.7)	4532	67.1 (66.0 – 68.3)	**0.0020**
Student/Pupil	3767	22.6 (22.0 – 23.3)	1275	18.9 (18.0 – 19.8)	**<0.0001**
Businessman/woman	282	1.7 (1.5 – 1.9)	136	2.0 (1.7 – 2.3)	0.0956
Professional	189	1.1 (1.0 – 1.3)	65	1.0 (0.7 – 1.2)	0.2467
Other	430	2.6 (2.3 – 2.8)	151	2.2 (1.9 – 2.6)	0.1211
No occupation	1151	6.9 (6.5 – 7.3)	592	8.8 (8.1 – 9.4)	**<0.0001**
Residency Status					
Native	6208	37.3 (36.6 – 38.1)	2743	40.6 (39.5 – 41.8)	**<0.0001**
Resident	8651	52.0 (51.3 – 52.8)	3175	47.0 (45.8 – 48.2)	**<0.0001**
Internally Displaced Person/Refugee	1397	8.4 (8.0 – 8.8)	546	8.1 (7.4 – 8.7)	0.4364
Other	377	2.3 (2.0 – 2.5)	286	4.2 (3.8 – 4.7)	**<0.0001**
Type of Violence					
Rape	3992	59.1 (58.0 – 60.3)	8910	53.6 (52.8 – 54.3)	**<0.0001**
Sexual Harassment	343	5.1 (4.6 – 5.6)	678	4.1 (3.8 – 4.4)	**0.0007**
Physical Harassment	1001	14.8 (14.0 – 15.7)	2217	13.3 (12.8 – 13.8)	**0.0026**
Forced Marriage	38	0.6 (0.4 – 0.7)	174	1.0 (0.9 – 1.2)	**0.0005**
Emotional/Psychological Violence	690	10.2 (9.5 – 10.9)	2866	17.2 (16.7 – 17.8)	**<0.0001**
Denied Resources/Opportunities	303	4.5 (4.0 – 5.0)	564	3.4 (3.1 – 3.7)	**<0.0001**
Other	262	3.9 (3.4 – 4.3)	937	5.6 (5.3 – 6.0)	**<0.0001**
None	123	1.8 (1.5 – 2.1)	290	1.7 (1.5 – 1.9)	0.6799

[a] n – number of survivors with characteristic, where represented as n/N, n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b] Breakdown of "Other" marital status responses: Separated (357), Divorced (205), Unspecified "other" response (1151). [c] Breakdown of "Other" occupation response: Other Community Leader (54), Religious Leader (48), Police/Military (31), Government Worker (16), Humanitarian (10), Unspecified "other" response (422). [d] Breakdown of "Other" residency status responses: Stateless(45), Demobilized (18), Repatriated (18), Foreigner (17) Asylum Seeker (14), Unspecified "other" response (551).

Table 15. Characteristics of SGBV survivors who accessed legal services compared to those who did not, Ushindi Project, 2010 - 2015

Characteristic	Did not access legal services n[a]	Did not access legal services % (95% CI)	Accessed legal services n	Accessed legal services % (95% CI)	p-value, Wald test of association
Number of Survivors		**13599**		**5136**	
Sex					
Female	12435	91.4 (91.0 – 91.9)	4463	86.9 (86.0 – 87.8)	**<0.0001**
Male	1164	8.6 (8.1 – 9.0)	673	13.1 (12.2 – 14.0)	**<0.0001**
Age (years)	11973	25.5 (25.2 – 25.7)	4613	24.0 (23.6 – 24.4)	**<0.0001**
Marital Status					
Single	7467	54.9 (54.1 – 55.7)	2936	57.2 (55.8 – 58.5)	**0.0056**
Married with certificate	2761	20.3 (19.6 – 21.0)	804	15.7 (14.7 – 16.6)	**<0.0001**
With partner/bride price	1633	12.0 (11.5 – 12.6)	668	13.0 (12.1 – 13.9)	0.0635
With partner/no bride price	665	4.9 (4.5 – 5.3)	400	7.8 (7.1 – 8.5)	**<0.0001**
Other[b]	1061	7.8 (7.4 – 8.3)	327	6.4 (5.7 – 7.0)	**0.0008**
Religion					
Christian	11799/13416	87.9 (87.4 – 88.5)	4531/5108	88.7 (87.8 – 89.6)	0.1544
Muslim	89/13416	0.7 (0.5 – 0.8)	79/5108	1.5 (1.2 – 1.9)	**<0.0001**
Other	203/13416	1.5 (1.3 – 1.7)	35/5108	0.7 (0.5 – 0.9)	**<0.0001**
None	1322/13416	9.9 (9.3 – 10.4)	463/5108	9.1 (8.3 – 9.9)	0.1037
Highest Level of Education					
Primary	6515/13545	48.1 (47.3 – 38.9)	2744/5127	53.5 (52.2 – 54.9)	**<0.0001**
Secondary	2983/13545	22.0 (21.3 – 22.7)	1014/5127	19.8 (18.7 – 20.9)	**0.0008**
University/Higher Education	45/13545	0.3 (0.2 – 0.4)	13/5127	0.3 (0.1 – 0.4)	0.3900
Other	80/13545	0.6 (0.5 – 0.7)	14/5127	0.3 (0.1 – 0.4)	**0.0076**
None	3922/13545	29.0 (28.2 – 29.7)	1342/5127	26.2 (25.0 – 27.4)	**0.0002**
Occupation					
Farmer	8840	65.0 (64.2 – 65.8)	3274	63.7 (62.4 – 65.1)	0.1079
Student/Pupil	2958	21.8 (21.1 – 22.4)	1110	21.6 (20.5 – 22.7)	0.8364
Businessman/woman	234	1.7 (1.5 – 1.9)	86	1.7 (1.3 – 2.0)	0.8274
Professional	153	1.1 (0.9 – 1.3)	37	0.7 (0.5 – 1.0)	**0.0144**
Other[c]	369	2.7 (2.4 – 3.0)	91	1.8 (1.4 – 2.1)	**0.0002**
No occupation	1045	7.7 (7.2 – 8.1)	538	10.5 (9.6 – 11.3)	**<0.0001**
Residency Status					
Native	4623	34.0 (33.2 – 34.8)	2118	41.2 (39.9 – 42.6)	**<0.0001**
Resident	7427	54.6 (53.8 – 55.5)	2681	52.2 (50.8 – 53.6)	**0.0032**
Internally Displaced Person/Refugee	1146	8.4 (8.0 – 8.9)	149	2.9 (2.4 – 3.4)	**<0.0001**
Other[d]	403	3.0 (2.7 – 3.2)	187	3.6 (3.1 – 4.2)	**0.0179**
Type of Violence					
Rape	7751	57.0 (56.2 – 57.8)	2648	51.6 (50.2 – 52.9)	**<0.0001**
Sexual Harassment	538	4.0 (3.6 – 4.3)	227	4.4 (3.9 – 5.0)	0.1528
Physical Harassment	1622	11.9 (11.4 – 12.5)	746	14.5 (13.6 – 15.5)	**<0.0001**
Forced Marriage	95	0.7 (0.6 – 0.8)	23	0.4 (0.3 – 0.6)	0.0549
Emotional/Psychological Violence	2243	16.5 (15.9 – 17.1)	780	15.2 (14.2 – 16.2)	**0.0301**
Denied Resources/Opportunities	394	2.9 (2.6 – 3.2)	304	5.9 (5.3 – 6.6)	**<0.0001**
Other	731	5.4 (5.0 – 5.8)	287	5.6 (5.0 – 6.2)	0.5669
None	225	1.7 (1.4 – 1.9)	121	2.4 (1.9 – 2.8)	**0.0016**

[a]n – number of survivors with characteristic, where represented as n/N, n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]Breakdown of "Other" marital status responses: Separated (321), Divorced (134), Unspecified "other" response (934). [c]Breakdown of "Other" occupation response: Other Community Leader (44), Religious Leader (26), Police/Military (20), Humanitarian (9), Government Worker (8), Unspecified "other" response (353). [d]Breakdown of "Other" residency status responses: Stateless(38), Repatriated (18), Foreigner (16), Demobilized (14), Asylum Seeker (9), Unspecified "other" response (495).

Table 16. Outcomes of legal aid provided by Ushindi Project by year, 2010 - 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association[b]
Characteristic	**n/N[a]**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	**n**	**% (95% CI)**	
Case Pursued in Court	4/6	66.7 (28.9 – 100.0)	399/713	56.0 (52.3 – 59.6)	978/1778	55.0 (52.7 – 57.3)	746/1287	58.0 (55.3 – 60.7)	516/869	59.4 (56.1 – 62.6)	283/560	50.5 (46.4 – 54.7)	0.7762
Court case reached judgement													
Yes	2/6	33.3 (0.0 – 71.1)	149/713	20.9 (17.9 – 23.9)	317/1777	17.8 (16.1 – 19.6)	353/1287	27.4 (25.0 – 29.9)	166/868	19.1 (16.5 – 21.7)	100/560	17.9 (14.7 – 21.0)	0.9031
No	4/6	66.7 (28.9 – 100.0)	503/713	70.5 (67.2 – 73.9)	1332/1777	75.0 (72.9 – 77.0)	824/1287	64.0 (61.4 – 66.6)	635/868	73.2 (70.2 – 76.1)	405/560	72.3 (68.6 – 76.0)	0.4505
No, Mediation Used	0/6	-	61/713	8.6 (6.5 – 10.6)	128/1777	7.2 (6.0 – 8.4)	110/1287	8.5 (7.0 – 10.1)	67/868	7.7 (5.9 – 9.5)	55/560	9.8 (7.4 – 12.3)	0.2831

[a]n/N - number of survivors with characteristic/number of survivors with available data on characteristic. [b]p-value calculated for trend from 2011 to 2015.

Table 17. Number of SGBV survivors who participated in VSLA, Ushindi Project by year, 2010 – 2015

	2010		2011		2012		2013		2014		2015		p-value, Wald test of association
Characteristic	**n/N[a]**	**% (95% CI)**	**n/N**	**% (95% CI)**	**n/N**	**% (95% CI)**	**n/N**	**% (95% CI)**	**n/N**	**% (95% CI)**	**n/N**	**% (95% CI)**	
Participated in VSLA	1/244	0.4 (0.0 – 1.2)	26/3306	0.8 (0.5 – 1.1)	40/4666	0.9 (0.6 – 1.1)	23/4335	0.5 (0.3 – 0.7)	34/3609	0.9 (0.6 – 1.3)	63/2575	2.4 (1.8 – 3.0)	**<0.0001**

[a]n – n/N - number of survivors with characteristic/number of survivors with available data on characteristic