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Addressing
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Care and support for survivors of human trafficking in Uganda

A survey of key stakeholders

October 2022

This report presents analysis of responses to a survey of government and civil society representatives in Uganda assessing the care and support needs of survivors of human trafficking. The survey was conducted as part of the Standards of Care work package in the GFEMS-funded Addressing Child Trafficking and Slavery (ACTS) in Uganda project, delivered by Hope for Justice, PLA, and the Rights Lab, in conjunction with the Rehabilitation and Reintegration for Survivors of Trafficking & At-Risk Populations project, delivered by Willow International.

The survey is intended to inform the development of new Standards of Care for survivors of human trafficking in Uganda, informing care and support provision by organisations providing services to survivors. Survey responses will be combined with a wide range of consultation activities with government and CSO stakeholders in Uganda, as well as with survivors.

Data availability statement: Aggregated, anonymised, and redacted survey data will be made available in an open access repository after all project findings have been published.

Authorship and acknowledgements

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The Standards of Care (SOC) work package is informed by consultation with the SOC Technical Group, including representatives from each of the partner organisations.

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Contents

1. Executive summary

Experiences of human trafficking are complex—with both immediate and long-term impacts on survivors' health and wellbeing. Experiences of trauma are common amongst those with lived experience of trafficking, with implications for their interactions with service providers and officials, as well as their recovery and reintegration. The care and support needs of survivors of human trafficking are likewise complex and multi-faceted, entailing a range of different support needs tailored to the individual survivors based on a range of different factors.

This survey sought to understand key stakeholders' perspectives on survivors' support needs in Uganda, and the extent to which current provision fulfilled these needs. Respondents from civil society organisations providing support services to survivors of trafficking, as well as government representatives in relevant roles, shared perspectives on both the generalised support needs of all survivors, and the specialised needs of survivors in different groups. The different needs of survivors of different ages, genders, exploitation types, and migration statuses were examined.

1.1. Key findings

› Survivors require a range of different forms of support

Respondents emphasised the multiple support needs of survivors of human trafficking, highlighting the importance of a wide range of different forms of support in facilitating survivors' recovery.

› Survivors require both immediate and long-term support

Both immediate and long-term support were viewed as crucial, yet respondents noted that long-term support in particular was often insufficiently considered.

› Many survivors cannot access the support they require in Uganda

Current limitations in support provision—including critical issues in resourcing—were considered as significantly constraining, with implications for survivors' recovery and reintegration. Overall, this was considered to create a context in which survivors received the support they needed, at the level required to facilitate recovery, only some of the time.

› Significant barriers to accessing support in Uganda exist

Significant barriers to survivors accessing support were outlined, with implications for the overall level of support survivors could obtain within Uganda. In addition to limited resourcing, key barriers emphasised by respondents included a range of structural, community, family, and individual factors, as well as a lack of provision in relation to various forms of support required.

› Support should be responsive to survivors' age, gender, exploitation type, and migration status

Respondents generally considered survivors' support needs to be highly specialised on the basis of age, gender, exploitation type, and migration status. While some groups within these categories were considered to have more specialised needs than others, all groups were considered to have needs more specialised than not.

› Core forms of support were considered common for all survivors

While some forms of support were considered more relevant to particular groups of survivors, many forms of support were considered to be common across all. These included, in particular, provision for psychosocial support, healthcare, shelter and material needs, and reintegration.

› Recognition of specialised needs often related more to approach than forms of support

In many cases, it was not the specific forms of support that dictated respondents' recognition of the specialisation of support needs for different groups of survivors. Support needs identified were often common across different groups, yet respondents nonetheless emphasised specialised needs. This indicates that an approach responsive to the survivors' age, gender, exploitation experiences and migration status is required, rather than different forms of support.

› Specific forms of support were more heavily associated with some groups of survivors than others

While in general all forms of support were considered relevant for all survivors, some specificity in forms of support for different survivors groups was recognised. Support needs were considered to progress through the life journey, transforming through the different age groups. Some specific needs for female survivors were also noted, in particular the need for menstrual hygiene kits. Addressing stigma was particularly emphasised for survivors of sexual exploitation, and rehabilitation for survivors of forced criminal activity. Immediate support needs were of greater concern to respondents in relation to third country nationals, while support needs identified for Ugandan nationals and citizens were more likely to include a long-term focus.

› Centralised standards of care for survivors in Uganda would increase access to core resources across the sector

Limitations in existing coordination and information sharing around survivor care and support were noted by respondents. While some respondents indicated access to high quality existing resources within their organisations, those without internal resources reported little access to high quality guidance and toolkits. This suggests a need for accessible, centralised standards and frameworks that reflect joint learning, knowledge, and expertise across the sector.

1.2. New Standards of Care for trafficking survivors in Uganda

New standards of care should be developed in collaboration with civil society, government, survivors, and communities. They should be trauma-informed, evidence-based, and human rights based, emphasising non-discrimination. They should include sections for different exploitation types, genders, migration statuses, and age groups, but adopt a holistic, needs-based approach focused on the individual survivor's experiences, identity, and needs. Standards of care should be comprehensive and accessible, covering all relevant topics using jargon-free language.

2. Methodology

A survey on care and support for survivors of human trafficking in Uganda was conducted between May 2021 and May 2022. The survey sought to understand key stakeholder perspectives on survivors' support needs, as well as the current state of provision in Uganda.

2.1. Survey structure

The survey was broken into seven substantive parts, addressing general support needs and access in Uganda, the support needs of different groups of survivors, and the requirements and value of establishing new, centralised standards of care for survivors of human trafficking in Uganda.

Part 1. Respondent details gathered basic information about the nature of the respondents work, including the nature of the organisation, the main activities and functions involved in the work, the geographic focus of activities, and the forms of survivor support provided.

Part 2. General support needs of survivors collected information the importance of different forms of support, levels of access, barriers to survivor recovery, and barriers to accessing support. It also collected respondents' perspectives on the importance of centralised referral mechanisms and community reintegration.

Part 3. Survivor support needs based on age collected perspectives on the degree to which survivor support needs were specialised between different age groups, and the specific support needs of these different groups.

Part 4. Survivor support needs based on gender collected perspectives on the degree to which survivor support needs were specialised between different gender groups, and the specific support needs of these different groups.

Part 5. Survivor support needs based on exploitation type collected perspectives on the degree to which survivor support needs were specialised between those having experienced different forms of exploitation, and the specific support needs of these different groups.

Part 6. Survivor support needs based on migration status collected perspectives on the degree to which survivor support needs were specialised between different migration status groups, and the specific support needs of these different groups, as well as the primary countries of origin for non-Ugandan nationals supported in Uganda.

Part 7. Standards of care collected perspectives on the existence and quality of existing standards, policies, manuals, guidelines and operating procedures for supporting survivors as well as the priorities for new Standards of Care.

The survey combined multiple answer multiple choice questions, rating scales, Likert scales, and open-ended free text entry questions. Respondents were permitted to respond to any/all questions, or to skip questions freely.

2.2. Sampling and dissemination

The research used purposive sampling, focused on key stakeholders involved in service provision for survivors of trafficking in Uganda or working in relevant government roles. The survey was distributed through two mechanisms:

(1) An online survey hosted on Qualtrics was disseminated via email to members of the Uganda Coalition Against Trafficking in Persons (UCATIP)—a network of civil society organisations working to combat trafficking in persons. Responses were collected between May and August 2021.

(2) An abridged survey was disseminated at a Standards of Care workshop hosted in Kampala, Uganda, in May 2022. Invited participants included representatives from relevant government departments, as well as representatives of each UCATIP member.

In total, 33 distinct engagements with the online survey instrument were recorded, and 24 respondents completed the initial sections confirming consent and outlining the role and remit of their organisation. However, only seven respondents went on to respond to substantive survey questions about care and support needs for survivors of human trafficking in Uganda. These seven responses are included in the analysis. Nineteen survey responses were collected at the in-person event, for a total of 26 responses. Respondents who had previously completed the online survey did not complete the in-person survey at the workshop.

Note on language: victims or survivors?

The terms used to describe those individuals who have experienced human trafficking vary, not only between organizations but also between individuals. There is no single settled term used to describe those who have been subjected to trafficking.

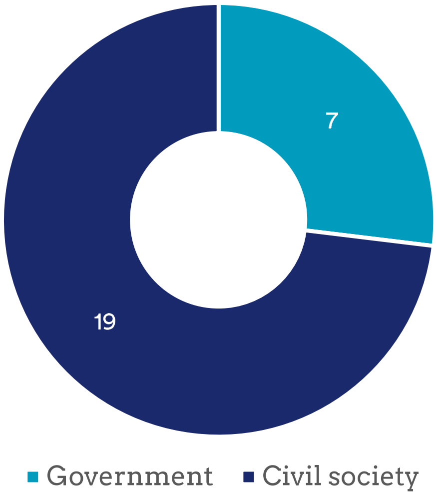
While the law tends to identify those who have been subjected to a crime as ‘victims’, this language has been criticised as disempowering of those individuals. The term ‘survivor’ is preferred by many in describing those who have experienced situations of trafficking. However, not all those that have lived experience of human trafficking identify as survivors and it may not apply to those who remain in exploitative situations.

The Standards of Care work package—of which this survey is a component—predominantly relates to individuals who have experienced and exited situations of human trafficking. The term ‘survivor’ is therefore employed throughout this report as the dominant language. The term ‘victim’ is used only when discussing particular legal obligations and frameworks that relate specifically to victims in the relevant legal sense.

3. Profile of respondents

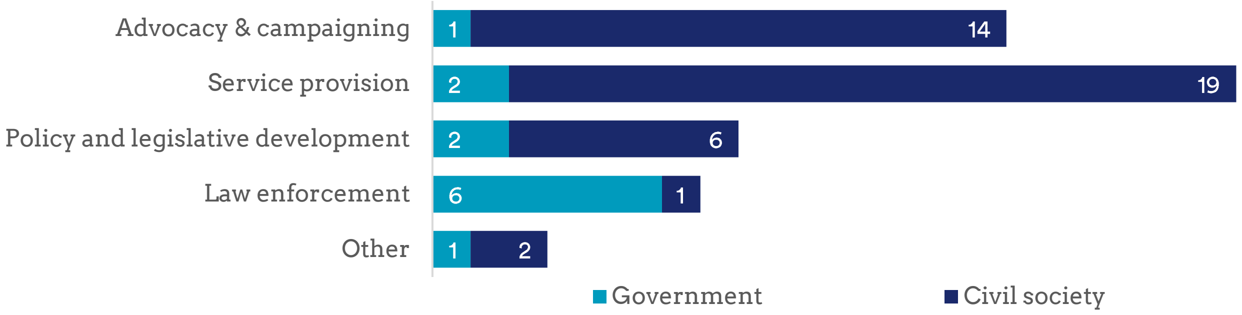
All respondents were representatives of key government departments relevant to the issue of human trafficking in Uganda, or civil society organisations providing support services to survivors. The majority of respondents were civil society representatives, making up 73% of total respondents, while government representatives made up the remaining 27%. All respondents to the online survey were civil society representatives—reflecting dissemination through the CATIPU network—while respondents at the workshop were mixed.

Figure 1. Respondent sector



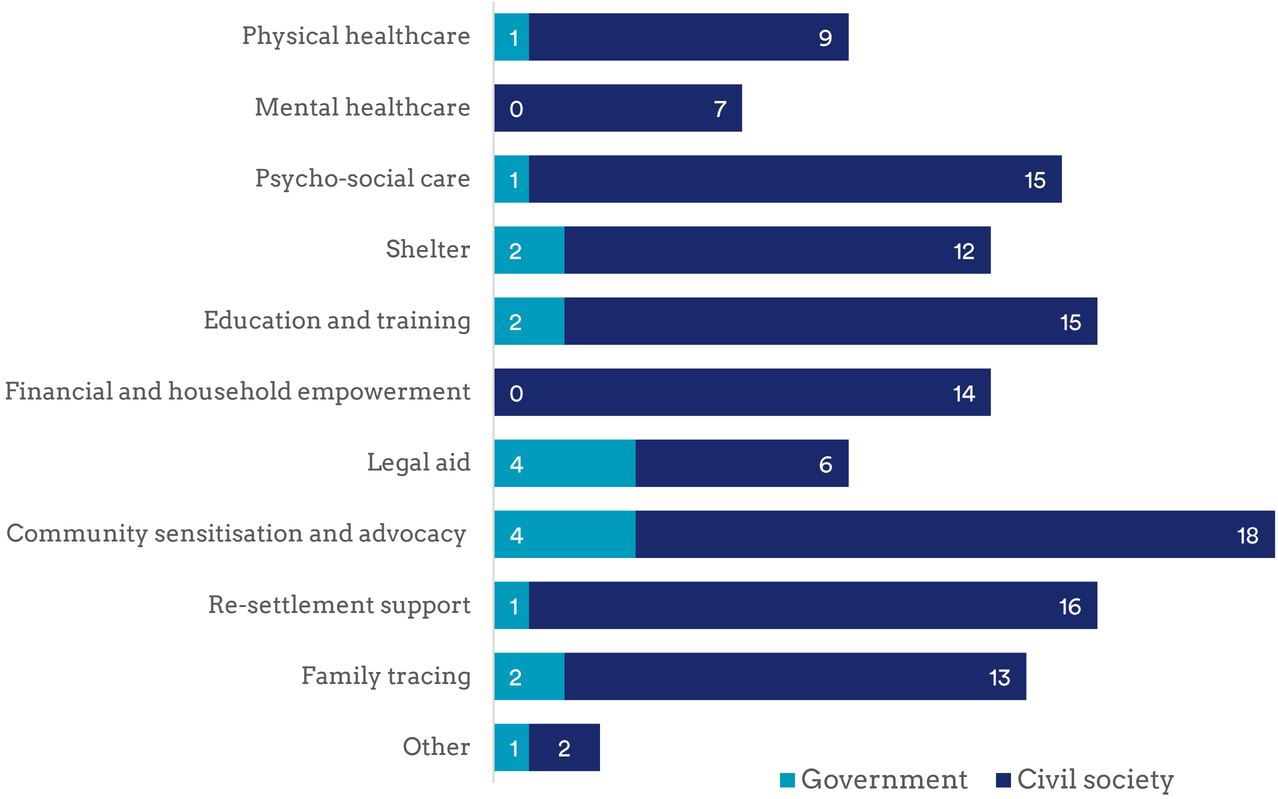
The majority of respondents (n=21) reported the main activities and functions involved in their work to include service provision for survivors of human trafficking, predominantly representing civil society organisations. Many civil society respondents (n=14) also reported their work to involve advocacy and campaigning. The most common function for government representatives was law enforcement (n=6). Three respondents reported 'other' functions, including coordinating activities, prevention and development work, and withdrawal rehabilitation and reintegration.

Figure 2. Main activities and functions involved in respondents' work



Respondents' organisations were generally reported to be involved in a range of care and support activities, with community sensitisation and advocacy the most common (n=22). A high proportion of respondents also reported involvement in education and training (n=17), resettlement support and reintegration (n=17), psycho-social care (n=16), and family tracing (n=15). Relatively few organisations (n=10) reported providing legal aid—identified as a particularly specialised form of support provision. Other forms of support reported included coordinating functions across different forms of support provision, monitoring and overseeing provision, and referrals through established partnerships.

Figure 3. Forms of care and support provided to survivors by respondents' organisations



All 26 respondents reported operating in Central Uganda, with many respondents based in Kampala and primarily operating within the city. Other areas of the country were less strongly represented, with nine respondents working in Eastern Uganda, five in Northern Uganda, and only four in Western Uganda. This reflects qualitative observations reported within the survey—that service provision often concentrated in Central and urban areas, leaving a scarcity of services in other regions and rural areas. The limited number of service providers in rural and non-Central areas is of concern both for the ability of survivors identified outside Kampala to access services, but also in access to services post-reintegration for those returning to communities outside the central region.

Figure 4. Areas of operation

4. General support needs

4.1. Key barriers to survivors’ recovery in Uganda

Respondents were invited to list the five main barriers to survivors’ recovery in Uganda from their perspectives. Almost all respondents (n=25) listed barriers to recovery, entering barriers in free text entry fields without prompts or examples to influence responses. This makes consensus around barriers more significant, as responses were entirely dictated by respondents’ rather than being directed by survey options.

Respondents highlighted a range of different barriers to recovery operating in the country, from issues in support provision to structural, family, and individual factors.

Shortcomings in service provision

- Insufficient shelters, including specifically for males
- Lacking long-term support
- Lacking reintegration support and follow-ups
- Insufficient psychosocial and mental healthcare
- Lacking (free) medical support
- Insufficient legal support
- Insufficient material support
- Insufficient employment support
- Insufficient information, education, and training
- Lacking coordination and effective referral infrastructure

Structural factors

- Limited resourcing
- Lack of political will
- Structural and institutional issues
- Poverty
- Corruption
- Justice system delays
- Inadequate protection laws
- Lacking social support systems
- Hidden nature of trafficking

Family and community factors

- Negligent leaders
- Stigma and shaming
- Cultural values
- Family involved or complicit in trafficking
- Lack of family and community support
- Family dependency on survivor
- Lack of awareness
- Role of the media

Individual factors

- Survivors’ mindset, motivations, and compliance
- Survivor expectations
- Fear and threats from perpetrators
- Stress, trauma, and risks of re-traumatisation
- High levels of individual vulnerability
- Low self-esteem

4.1.1. Resourcing limitations

Limitations in resourcing for survivor support services was the most often cited and most strongly rated barrier to recovery in Uganda across responses. Of the 25 respondents, 11 (44%) emphasised the lack of resourcing for support provision as a key barrier to recovery. Respondents typically rated this constraint highly, with nine positioning it in their top three barriers to recovery. Respondents noted that insufficient resourcing translated to insufficient support for survivors, thereby inhibiting recovery. One respondent also highlighted the insufficiency of government resourcing for survivor support services specifically, indicating the perceived responsibility of the government in this regard.

4.1.2. Lack of training for service providers

The absence of training for service providers, including in relation to specialised forms of support, was noted to be a barrier to survivors' recovery by almost a third of respondents (28%). These respondents noted limitations in the existing knowledge, expertise, and skills of staff within service provision organisations—not necessarily in relation to dedicated areas of support that particular members of staff might be specialised in, but more in relation to general and comprehensive support provision.

Areas in which training needs were specifically identified included trauma, health support, comprehensive service provision, and recovery. In addition to support service providers, one respondent highlighted training and capacity building needs for law enforcement, particularly in relation to handling survivors in a trauma-informed manner.

4.1.3. Lack of coordination

Limitations in existing coordination efforts and infrastructure were also highlighted by 28% of respondents. Connections between overall coordination and referral were made by several respondents, suggesting a strong relationship between collaboration and capacity to effectively refer survivors. The need for greater coordination between civil society organisations and government actors was highlighted, as was the need for an increase in networking generally.

Coordination infrastructure within Uganda has been strengthened in recent years. In 2013, the Coordination Office for Prevention of Trafficking in Persons (COPTIP) was established, at the Ministry of Internal Affairs Headquarters.[1] As outlined in the National Action Plan, 'The Coordination Office is responsible for coordination, monitoring and overseeing the implementation of counter human trafficking activities carried out by several operational government agencies and civil society organizations.'[2] The Uganda Coalition Against

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[1] National Action Plan for Prevention of Trafficking in Persons in Uganda, available here, p 4.
[2] Ibid, p 5.

Trafficking in Persons (UCATIP) has also undertaken significant efforts to improve coordination across the sector,[3] and the ACTS Uganda project has included a network strengthening component. However, survey responses indicate that there is still important work to do to ensure effective cross-sectoral coordination.

4.1.4. Family factors

A range of family-level factors operating as barriers to survivors' recovery were identified in responses, with 40% of respondents noting a key barrier related to survivors' family dynamics. The specific issues engaged in the family dynamic varied. Three respondents noted negligent or neglectful family units to be a barrier to survivors' recovery, while another considered the lack of strong family support to be a key inhibiting factor in recovery. Family units are therefore presented as an important element of long-term recovery.

Respondents also highlighted push factors driving trafficking in the family unit, including family dependency on the survivor for income. This relationship of dependency can make returning 'with nothing' a particular challenge for survivors. Economic strain within the family was also noted to fuel re-trafficking.

Family involvement in the original trafficking experience was also raised as a significant concern complicating survivors' recovery. Where family members are direct perpetrators this may make return to a survivors' family and community entirely inappropriate, entailing displacement impacts where they are reintegrated into unfamiliar environments with no existing social networks. Where involvement is more complex, this creates difficult dynamics for survivors and support providers to navigate.

4.1.5. Stigma and shame

Barriers associated with stigma and shame were highlighted by a quarter of respondents (24%) and was listed by each of these respondents as either the first or second identified barrier to recovery. Concern over stigma and shame experienced by respondents in general terms was noted by three respondents, while three provided some clarification on the source of stigma. One respondent noted that 'other members of society' were often a source of stigma for respondents, one specifically noted stigma from communities, while another considered stigma of both communities and families.

The frequency and level of stigma experienced by survivors on reintegration is further considered in section 4.5.

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[3] UCATIP, 'Ending Human Trafficking: Coalition Against Trafficking in Persons Uganda Five Year Status Report' (2020), available here.

4.1.6. Limitations in existing service provision

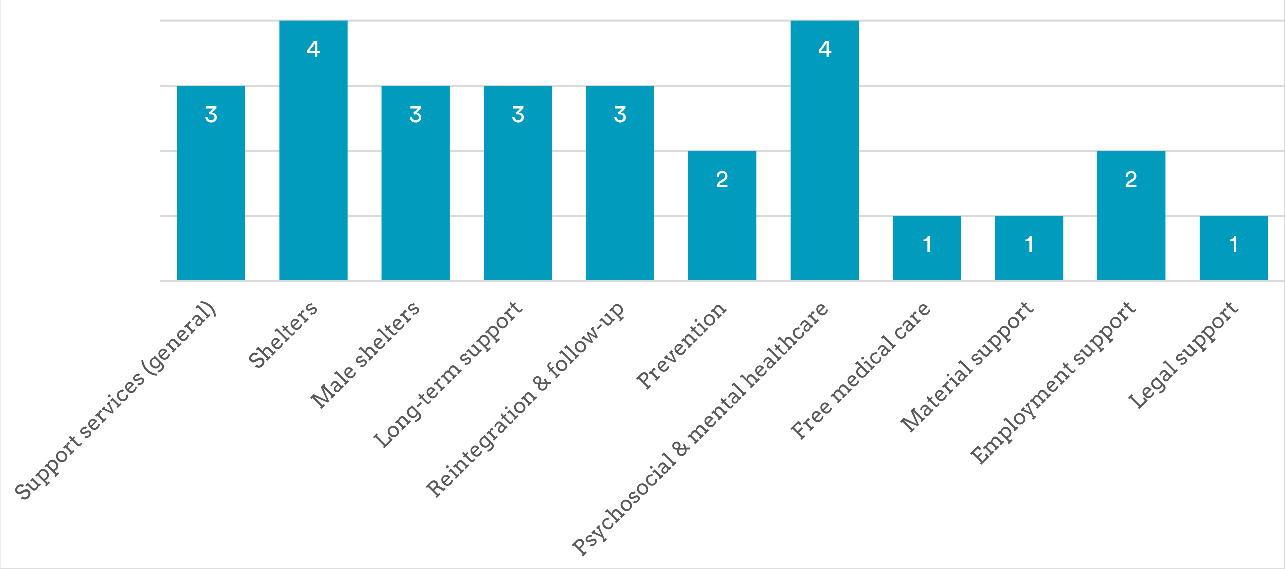
Shortages or limitations in existing service provision were highlighted by most respondents (72%) as barriers to survivors' recovery, covering a range of different forms of support where limitations were noted.

Seven respondents highlighted an insufficient number of shelters and shelter capacity as key barriers—four of which referred to shelter provision generally, and three to provision for male survivors specifically. Respondents noted the need for a greater number of shelters, as well as improved resourcing and provision for comprehensive services within shelters.

Four respondents noted limitations in provision of psychosocial support and mental healthcare as key barriers to survivors' recovery, highlighting both the absence of such support and the inadequacy of provision where it is provided.

Concern for long-term support was also evident, with three respondents noting the need for longer support periods for survivors, and three emphasising gaps in reintegration support and follow-ups post-reintegration.

Figure 5. Limitations in service provision identified as key barriers to recovery



4.2. The importance of different forms of support

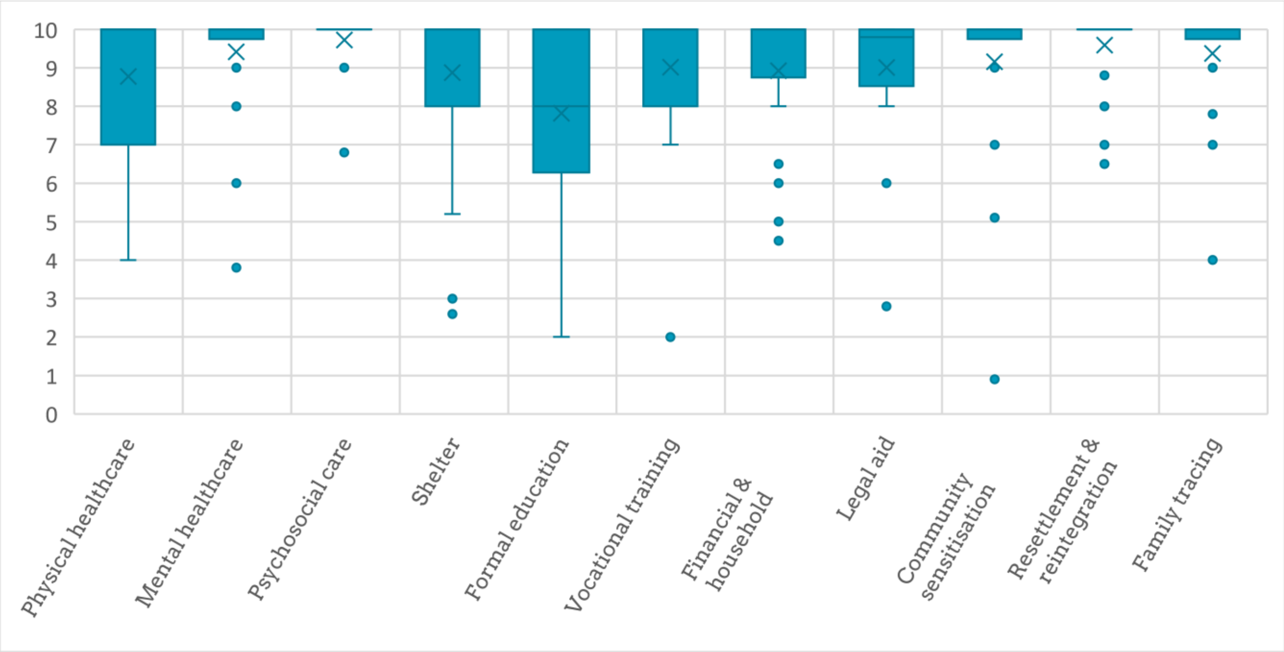
Eleven general areas of support for survivors of human trafficking were identified and examined in the survey. Respondents rated the importance of each form of support to survivors' recovery on a scale from zero (unimportant) to ten (vital). Overall, each form of support was reported to be vital to survivors' recovery—68% of all responses across support types were reported at the highest level of significance (rated ten). A further 10% of all responses rated at nine, and 8% at eight.

Six respondents rated all forms of support as equally vital to survivors' recovery, rating all forms at ten. Given the general emphasis on holistic care, this was an expected result within responses. However, the majority of respondents did provide insights on the relative importance of different forms of support, that differentiated importance at least to a degree.

For each form of support except one, the majority of respondents rated importance at the highest level (ten). The proportion of respondents rating each form of support at this level was highest for psychosocial care—which 88% of respondents rated at ten and with an average (mean) score of 9.73. No respondent rated psychosocial support at less than seven.

Although still rated as important with an average score of 7.85, formal education was considered the least important to survivors' recovery of the listed options. 35% of respondents rated formal education at ten, 12% at nine, and 23% at eight, while 4% rated it at two and three respectively and 15% at five (the mid-point of the scale).

Figure 6. The importance of different forms of support for survivors' recovery



4.3. Access to support in Uganda

In addition to outlining the importance of different forms of support in survivors' recovery, respondents also rated how often survivors in Uganda are currently able to access the different forms of support at the level they need to support recovery. Respondents in the online survey rated access on a five-point scale while in-person survey respondents rated on a scale from zero to ten.[4]

No respondent considered access levels to be standard across different forms of support. Rather, all respondents provided a diverging picture of access to different forms of support. Responses on the level of access were also more diverse between respondents than in relation to needs—where one respondent reported that survivors could always access a particular form of support, another might report that they could never access such support.

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[4] The in-person survey question was amended to increase standardisation of response formats in the less responsive hard copy format.

Overall access to support across exploitation types was most commonly assessed towards the middle of the scale, indicating that survivors' ability to access the support they need was less than they were considered to require. In person respondents painted a slightly more positive overall picture of access to support, with 49% of respondent ratings above the midpoint (ratings higher than five). This compared to 21% of online respondent ratings above the midpoint of the scale. The overall average rating for in-person respondents sat just above the midpoint, with an overall average score of 5.7 (midpoint=5). Online respondents averaged lower than the midpoint, averaging 2.6 on the five-point scale (midpoint=3).

Forms of support reported by in-person respondents to have the highest current levels of access compared to needs included community sensitisation and advocacy (average rating 6.6/10), family tracing (average rating 6.6/10), and vocational training (average rating 6.2/10). Online respondents likewise indicated family tracing, community sensitisation and advocacy programmes, and vocational training to demonstrate higher levels of existing access (average ratings 3.1/5, 3.0/5, and 3.0/5 respectively), alongside psychosocial care (3.1/5). However, it is notable that these scores indicate that survivors have access to these forms of support at the levels required only 'about half the time'. A significant provision gap therefore remains evident across both respondent groups, even in the forms of support considered most accessible.

The lowest current levels of access compared to needs were reported in relation to mental healthcare (average rating 4.7/10), financial and household empowerment (4.8/10) and legal aid (4.9/10) by in-person respondents. Online respondents reported the lowest levels of access to financial and household empowerment (average rating 1.9/5), physical healthcare (2.0/5), and formal education (2.2/5).

Although still rated as important with an average score of 7.85, formal education was considered the least important to survivors' recovery of the listed options. 35% of respondents rated formal education at ten, 12% at nine, and 23% at eight, while 4% rated it at two and three respectively and 15% at five (the mid-point of the scale).

Figure 7. Survivors' ability to access different forms of support (in-person respondents)

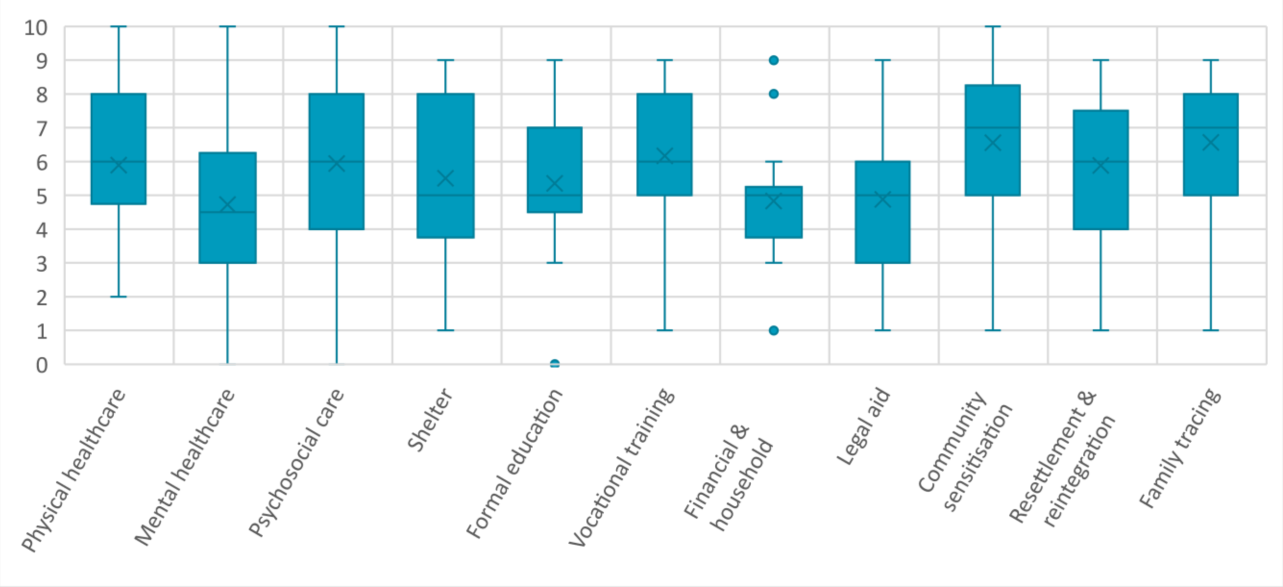
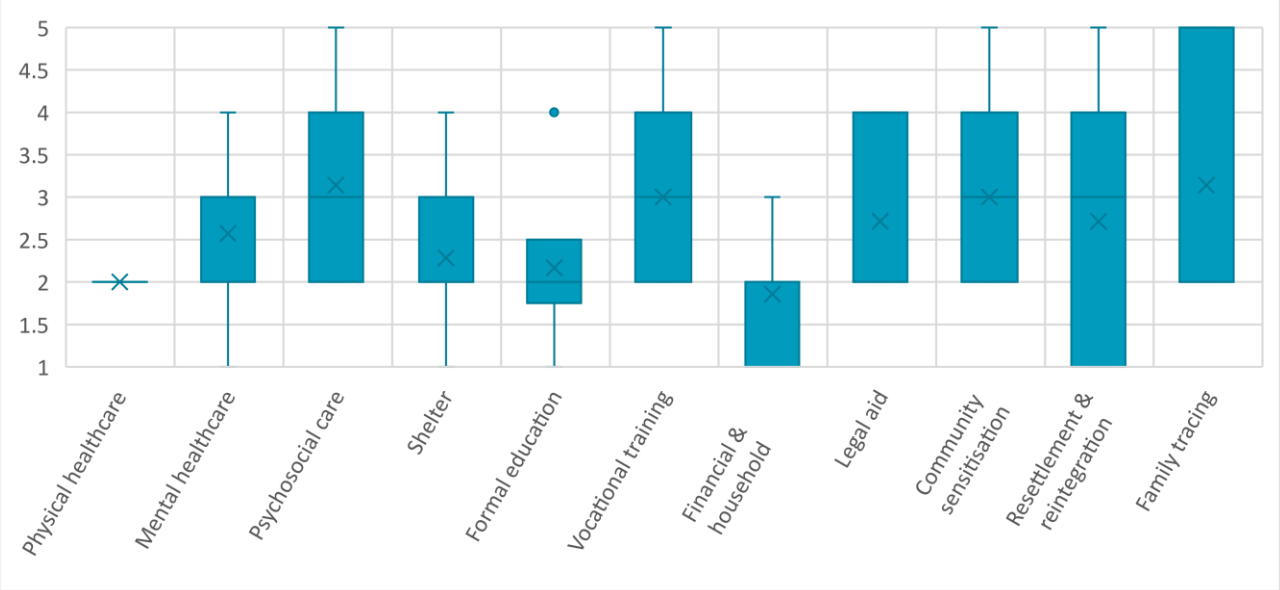


Figure 8. Survivors' ability to access different forms of support (online respondents)



4.4. The value of a centralised National Referral Mechanism

The 2015 National Action Plan for Prevention of Trafficking in Persons in Uganda confirmed the government's intention to establish a 'national Coordination and Referral mechanism on prevention of TIP', to be led by the Coordination Office for Prevention of Trafficking in Persons (COPTIP).[5] In July 2020, the government adopted the National Referral Guidelines for Management of Victims of Trafficking in Uganda, providing victim referral guidelines for stakeholders and describing social services resources and recommendations for victim protection.[6]

Respondents demonstrated consensus over the importance of establishing a centralised National Referral Mechanism (NRM) for survivors of human trafficking in Uganda in facilitating access to support and care. On a scale from zero to ten, 50% of in-person respondents rated the establishment at the highest level of importance (ten), and an additional 6 rated it at nine. Likewise, on a scale from one to five, 43% of online respondents rated an NRM at the highest level of importance. However, where no in-person respondent rated the importance of an NRM below the scale midpoint of five, one online respondent reported importance below the midpoint of three.

Figure 9. Importance of a centralised NRM in Uganda (in-person respondents)

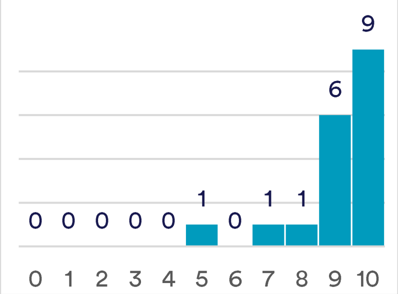
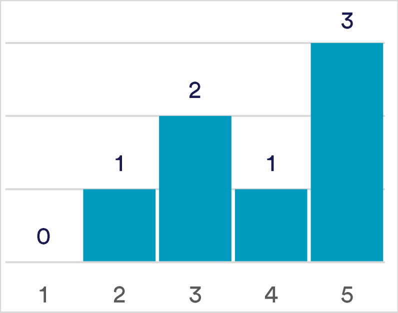


Figure 10. Importance of a centralised NRM in Uganda (online respondents)



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[5] National Action Plan for Prevention of Trafficking in Persons in Uganda, available here, p 11.
[6] US Department of State, 'Trafficking in Persons Report: Uganda', available here.

Issues with referrals were also highlighted as a key barrier to survivors accessing the support and care they require. Several respondents noted issues with referrals and coordination as key barriers to survivors' recovery in Uganda, emphasising the need for progress in this regard.

4.5. Survivors' return and reintegration

Respondents reported survivors often wanting to return to their families and communities, creating key concerns for return and reintegration in source contexts. In-person respondents reported survivors' desire to return at a slightly higher level than online respondents, with 11% of respondents reporting below the midpoint of the scale (five), 11% reporting at the midpoint, and the remaining 79% reporting above the midpoint. However, no respondent rated desire to return at a ten (always).

Figure 11. Return and reintegration: survivors' desires, difficulties, and stigma (in-person respondents)

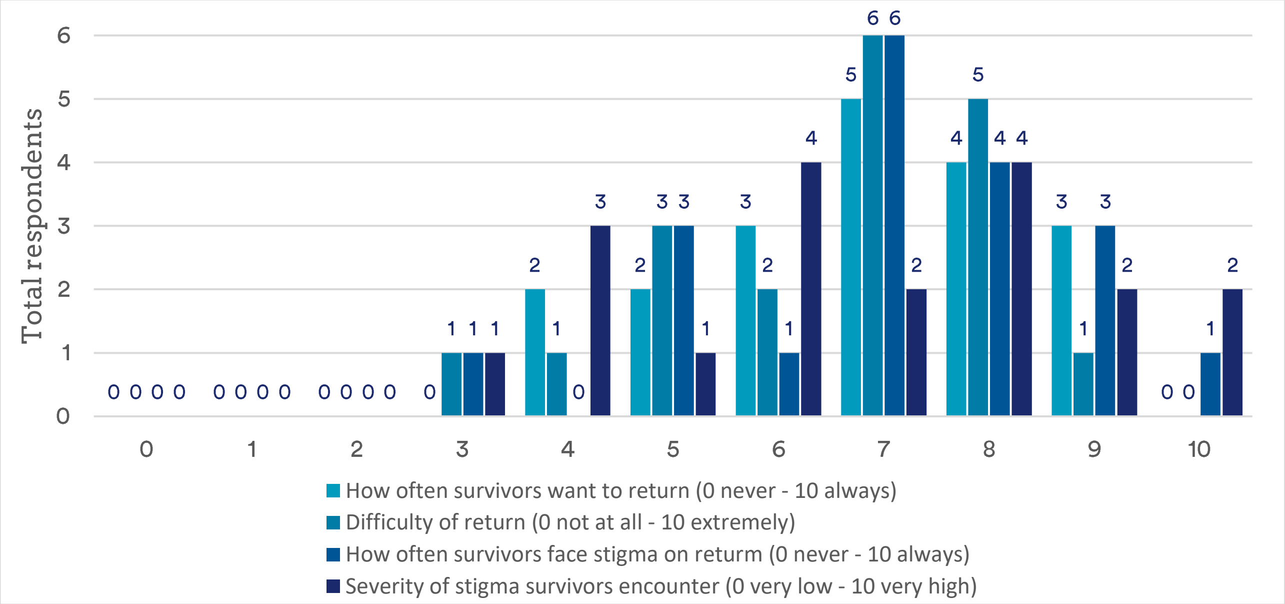
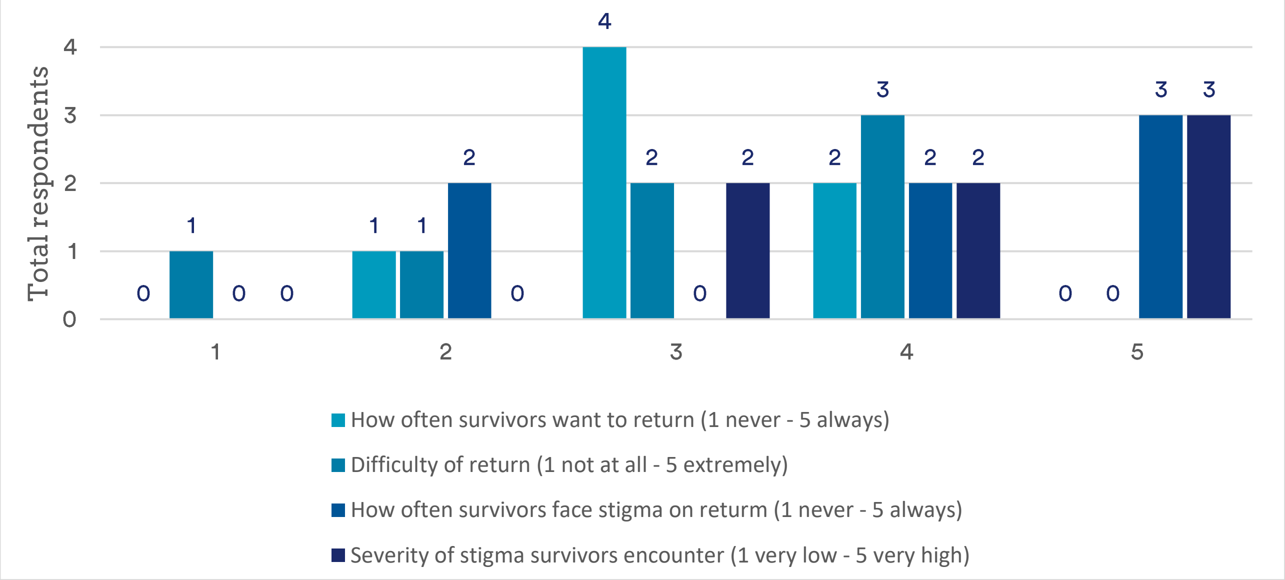


Figure 12. Return and reintegration: survivors desires, difficulties, and stigma (online respondents)



In person respondents were more likely to report survivors wanting to return to their families or communities at the midpoint (three)—'about half the time'—with 57% of respondents reporting this rating. Only one respondent reported below this midpoint, while two reported above. Like in-person respondents, no online respondent reported that survivors 'always' wanted to return.

While respondents reported a substantial proportion of survivors wanting to return to their families or communities, they also highlighted the difficulty survivors faced in doing so. On a scale from zero (not at all difficult) to ten (extremely difficult), 74% of in-person respondents reported difficulty above the midpoint (five), with 32% rating difficulty at a seven, and 26% rating at eight. No in-person respondent rated difficulty at the highest level (ten). Online respondents likewise reported difficulty at significant levels, with 43% reporting difficulty level above the midpoint (three), although like in-person respondents none reported difficulty at the highest level (five).

Frequency of stigma faced was likewise reported to be high, with 79% of in-person respondents reporting stigma to be frequent (above the midpoint of five) and 71% of online respondents reporting above the midpoint (three – about half the time). Reporting on the levels of stigma faced in these contexts was mixed. While online respondents clearly all indicated moderate to very high levels of stigma—29% at moderate, 29% at high, and 43% at very high—in-person respondents' ratings varied from three (low) to ten (very high). Despite this, 74% of in-person respondents rated stigma levels above the midpoint, in line with the 71% of online respondents reporting above the midpoint.

4.5.1. The best ways to support and facilitate reintegration

Online respondents were invited to provide additional information (free text entry) on the 'best ways that service providers can support and facilitate survivors' recovery'. Considerations and approaches highlighted included:

- Coordinating responses to address the needs of all survivors without re-traumatising
- Providing economic empowerment to survivors' families
- Ensuring sufficient resources to address the needs of survivors
- Offering counselling and continuing such post-reintegration
- Contacting family members in advance of reintegration
- Ensuring uniformity and no favouritism in provision
- Equipping survivors with a range of support mechanisms, including economic empowerment services, such as small grants with training and support to manage such, vocational training, and employment opportunities
- Providing spiritual support and guidance during the recovery period
- Always acting in the best interests of survivors

4.6. Other considerations about general care and support for survivors

In addition to specific questions on different aspects of care and support identified in this section of the survey, respondents were invited to share any additional considerations about general care and support for survivors they wished. Nine in-person respondents provided additional information.

The need for continued, long-term support was further emphasised in response to this question. One respondent noted that survivors 'need continued support'. Another noted that long term care has proven to be more effective for survivors, yet government guidelines 'stipulate a shorter time than some survivors may require'. This was reported to result in some shelter providers reintegrating survivors prematurely to align with guidance.

One respondent highlighted that the lack of resources resulted in survivors not receiving holistic support and missing out on different forms of support considered vital to survivors' recovery by respondents in section 4.2. Another likewise emphasised that survivors' needs should be prioritised, with funding to build more shelters needed.

Collaboration, coordination, training, and information sharing were also considered in this section. One respondent suggested collaboration with regional and international organisations and experts be strengthened, to share lessons in managing care and support for survivors. Relatedly, training and empowerment for staff was prioritised by another respondent, noting that survivors are heavily dependent on staff.

The value of spiritual support and guidance were noted by one respondent, recognising that survivors have been 'spiritually and emotionally wounded', and advocating that these wounds be addressed.

Security issues were also raised by respondents in this section, noting that perpetrators pose significant threats to survivors, and that protection laws and mechanisms are insufficient. This results in survivors being intimidated into withdrawing cases against perpetrators. The gendered implications of security were also noted by another respondent, suggesting that female survivors should have female security personnel whenever possible, to prevent against abuse. This also tied into a larger point raised by a respondent, that safeguarding needs to be reemphasised in survivor care.

5. Survivor support needs based on age

Respondents were invited to consider the level of specialisation of survivor care and support needs in relation to seven different age groups, rating on a scale from zero (not specialised) to ten (extremely specialised). This is intended to identify the extent to which care and support must be tailored to the age group of respondents, rather than assuming that the same needs and approaches are common across ages.

Respondents generally considered the needs of survivors in different age groups to be highly specialised, with over 70% of respondents reporting level of specialisation above the midpoint for all age groups. In general, respondents considered the younger age groups to entail more specialised needs than the older age groups, with average ratings for children higher than those for adults in each of the relevant age groups.

The strongest consensus over a very high level of specialisation was recorded in relation to children aged five to twelve years—all respondents rated the level of specialisation at seven or higher, with 13% rating at seven, 38% rating at eight, 19% rating at nine, and 31% rating at ten. The average (mean) rating for the five to twelve group was 8.7.

Figure 13. Level of specialisation of support needs by age group (in-person respondents)

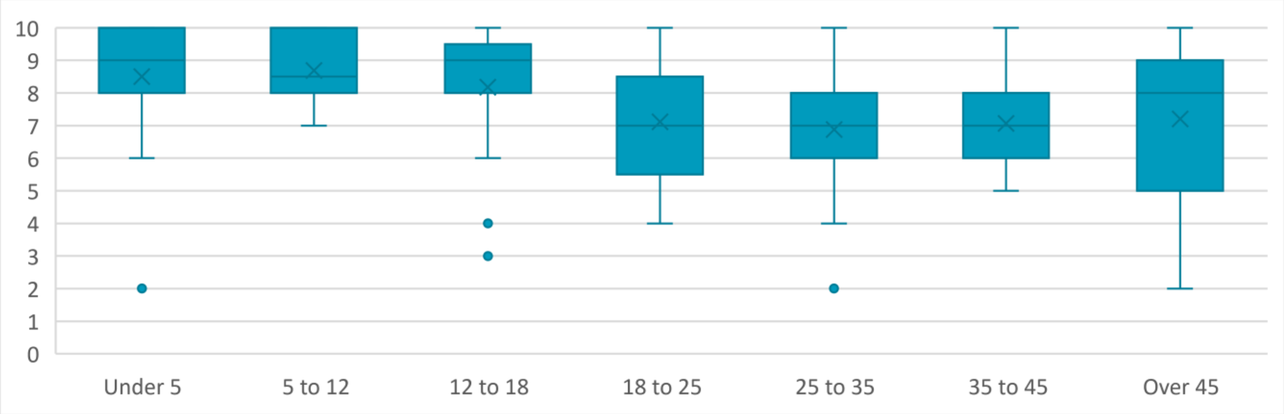
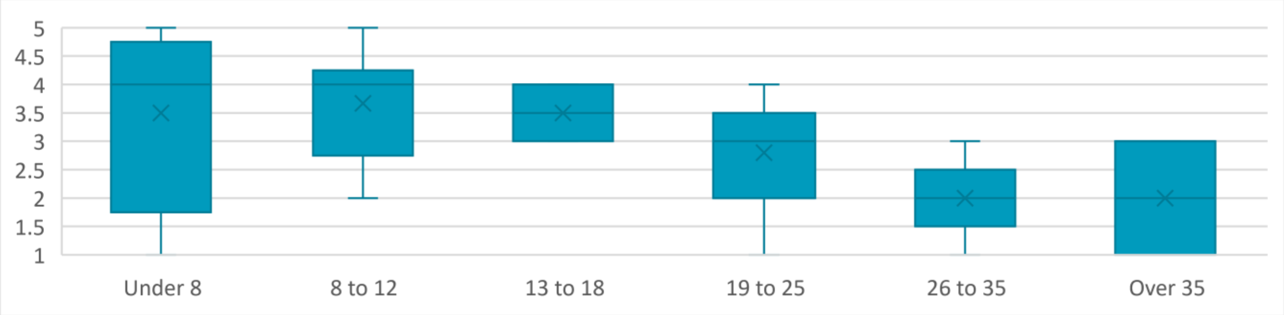


Figure 14. Level of specialisation of support needs by age group (online respondents)



The highest number of respondents rated specialisation at ten for the lowest age group—children under five years—with 44% of respondents rating specialisation at ten. However, one respondent rated specialisation for children under five at a two, bringing the average rating down to 8.5. Online respondents likewise rated the support needs of children as the more specialised, although age groups were divided into fewer groupings for online than in-person respondents. The highest overall level of specialisation was recorded for children aged from eight to twelve, with an average rating of 3.7 on the five-point scale. Both the under eight group and the thirteen to eighteen group received an average rating of 3.5—making children's needs notably more specialised in the views of respondents than those of adults.

The lowest overall level of specialisation was reported by in-person respondents in relation to those aged 25 to 35, with an average rating of 6.9. Ratings for this group ranged from two to ten, demonstrating mixed opinions amongst respondents. However, 81% of in-person respondents nonetheless rated specialisation for 25 to 35 year olds above the midpoint (five). Online respondents rated both those aged 26 to 35 and those over 35 as the least specialised, with an average rating of two for each group.

The least consensus amongst in-person respondents was demonstrated in relation to over 45 year olds, whom some respondents considered to have highly specialised needs while others considered their needs to be less specialised than other age groups. Ratings ranged from two to ten, with an average rating of 7.2. For this group, 20% rated specialisation at the midpoint (five), only 7% rated below the midpoint, and 73% rated above the midpoint. Ratings were relatively evenly distributed between ratings from six to ten.

5.1.1. Specific needs of survivors in different age groups

In considering the specific support needs of different age groups, respondents collectively painted a picture of shifting support needs throughout the life journey. While generally recognising that survivors of all age groups required multi-faceted support across the different support types addressed in the survey, some forms of support were considered to relate more strongly to particular age groups.

Notably, the focus of education and training evolved through the different age groups. For children under five, four respondents highlighted the need for formal education and school programmes. In the next age group (five to twelve), the number of respondents highlighting education needs doubled, in each case focused on formal education and schooling. While the need for education was noted by a similar number of respondents for survivors aged twelve to eighteen (nine respondents), the emphasis for this group also diversified. Not only was formal education and schooling highlighted for this group, but the need to begin vocational and life skills training, as well as sexual and reproductive health education were also noted.

For those in age groups over eighteen, the emphasis shifted significantly from education towards vocational and life skills training and economic empowerment support. While education was more heavily represented for eighteen to 25 year olds, the balance for this group already shifted towards economic empowerment, shifting further for the later age groups. Economic empowerment needs highlighted for adult age groups included vocational training, entrepreneurship and business skills, and provision of start-up capital. Job placement and employment were also emphasised.

For survivors under the age of five, basic needs—including healthcare, welfare, food, and shelter—were considered particularly important. In addition, several respondents highlighted a unique need amongst this group to be 'love and care'. The need for building trust was also noted here, as well as a need for 'play materials'—recognising that survivors in this bracket are young children. The intensity of care for this age group was also noted to be high, given that 'they can't take care of themselves'.

The five to twelve age group shared many characteristics with the age groups below and above, particularly in relation to basic needs. The need for 'care and love' was also noted by one respondent for this group (as well as for the twelve to eighteen group). However, this was also considered to transform by others suggesting that building self-esteem and confidence, as well as a sense of belonging, entered into the picture at this age group. Art therapy, play therapy, and other non-verbal techniques were also noted in relation to this group.

Approval, acceptance, a sense of belonging, and care and love were emphasised for survivors in the twelve to eighteen age group. Several respondents also highlighted support for this age group as importantly focused on maximising survivors' potential, identifying their goals and aspirations and providing them with the necessary tools to fulfil these. Psychosocial support (emphasised across all age groups) remained a focus for this group, but without the emphasis on non-verbal approaches that appeared in the younger age groups. This also carried through the older age groups.

Economic empowerment was emphasised most strongly for survivors in the adult age groups. Legal support and legal aid were also more strongly represented for these groups than for children. Where family tracing, placement, and foster arrangements were noted for children, this transitioned to an emphasis on housing and independent living for adults. Family support also appeared in the adult age groups, and for over 45 year olds, consideration of care homes for the elderly was also introduced.

Responses on the different support needs for survivors in different age groups demonstrated a high level of commonality in the core requirements of survivor care and support—covering basic material needs, healthcare, psychosocial support, and shelter. However, the transforming emphasis from education through vocational skills training to economic empowerment showed a clear life trajectory in perceptions of support needs. The emotional needs of survivors were also seen to change across the life journey, shifting from an emphasis on love and care, through belonging, to self-actualisation.

6. Survivor support needs based on gender

Respondents were invited to consider the level of specialisation of survivor care and support needs based on gender, on a scale from zero (not specialised) to ten (extremely specialised). This is intended to identify the extent to which care and support must be tailored to the gender of respondents, rather than assuming that the same needs and approaches are common between them.

Respondents generally considered the needs of both male and female survivors to be highly specialised, with over 81% and 100% of in-person respondents respectively reporting level of specialisation above the midpoint. Online respondents considered support needs slightly less specialised based on gender, with 25% of respondents reporting specialisation above the midpoint for males, and 50% above the midpoint for females.

In general, respondents considered the support needs of female survivors to be more specialised than the needs of males, with an average rating of 9.5 for females and 7.5 for males by in-person respondents. Online respondents likewise rated female needs as more specialised, with an average rating of 3.75 compared to 2.25 for males.

Ratings on the specialisation of support needs for female survivors were strongly concentrated in the highest ratings, with 73% of in-person respondents rating specialisation at a ten. No in-person respondent rated the level of specialisation for female survivors below a seven, and no online respondent rated below the midpoint (three).

Figure 15. Level of specialisation of support needs by gender (in-person respondents)

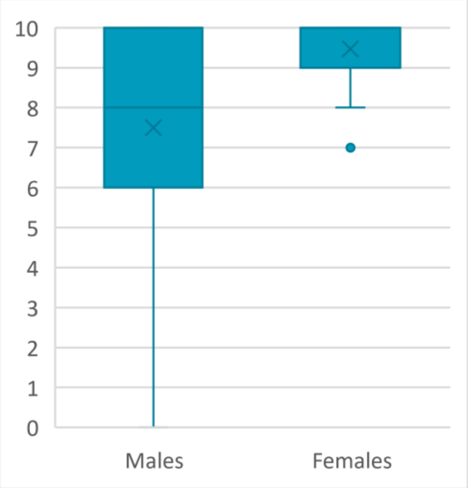
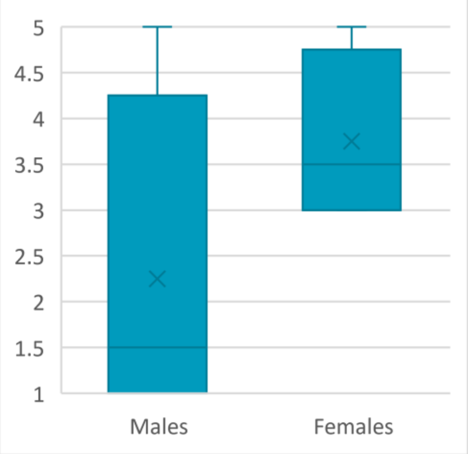


Figure 16. Level of specialisation of support needs by gender (online respondents)



Ratings on the specialisation of support needs for male survivors were more varied, ranging from zero (not specialised) to ten (extremely specialised) for in-person respondents, and one (not specialised) to five (extremely specialised) for online respondents. Nonetheless, the majority of respondents did consider male survivors' needs to be specialised. Online respondents considered male needs as less specialised compared to the larger group of in-person respondents. Where 81% of in-person respondents rated male needs specialisation above the midpoint of five, 75% of online respondents rated below the midpoint of three.

6.1.1. Specific needs of survivors of different genders

As with children, certain support needs were considered common across gender, including in particular psychosocial support, healthcare, shelter, and basic needs. Respondents also often considered skills training needs to be shared by both male and female survivors.

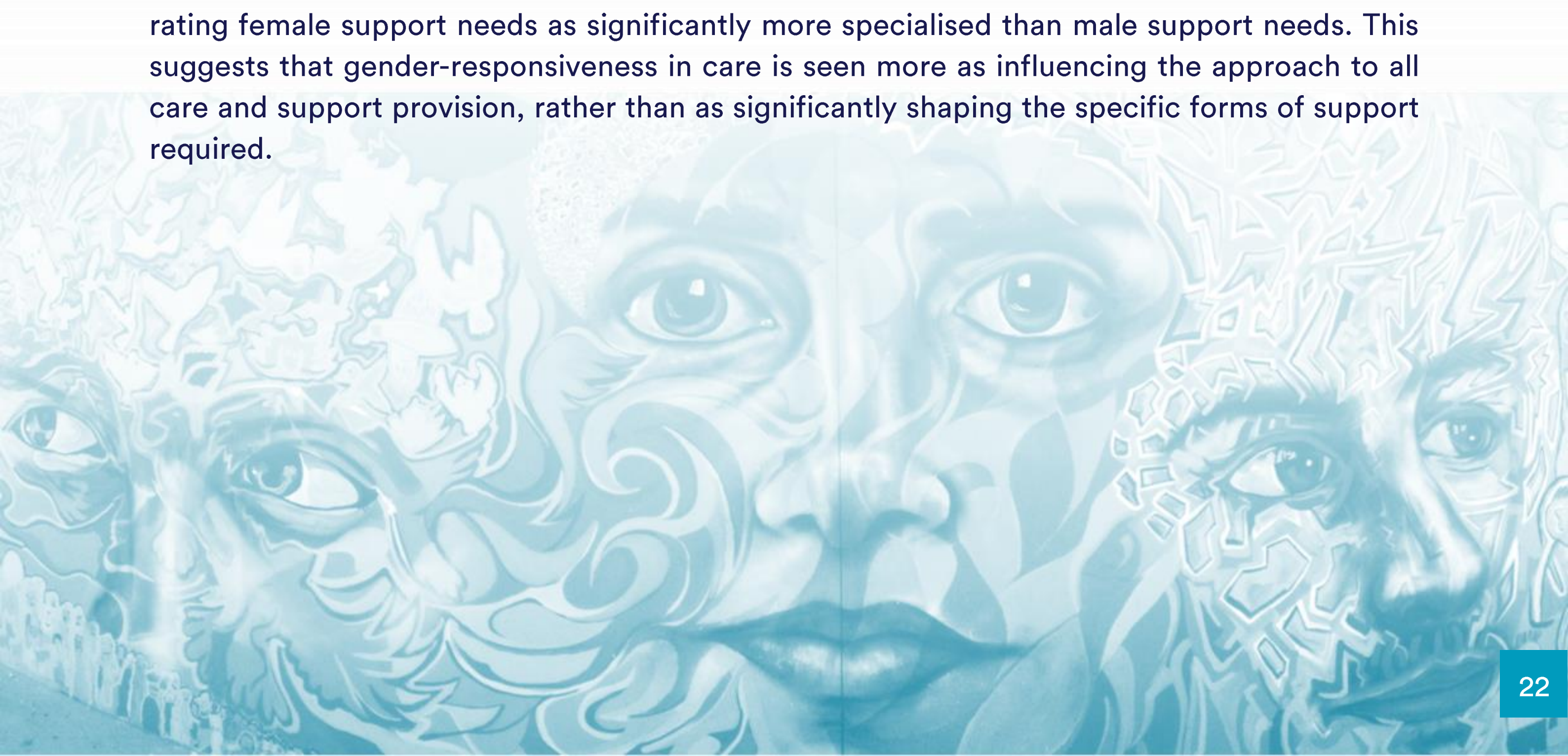
The provision of sanitary products and menstrual hygiene was specific to female survivors, with several respondents reporting this as a specific need. Hygiene kits for both males and females were identified to require soap, underwear, and a bucket, while female kits were also considered to require sanitary products and a small bag in which to keep these. The language of 'dignity kits' was also used by one respondent to refer to hygiene products provided to females, while the equivalent for males were simply described as 'hygiene kits' This implies an association between female hygiene and dignity that is not held in relation to men and boys.

Several respondents emphasised the economic empowerment element of support more strongly for male survivors than for females. One highlighted that 'most male survivors above 18 years of age are more interested in support areas that will help them to get money to support their families', while suggesting that for female survivors 'psychosocial needs around marriage and family survival' were of greater concern. Another respondent likewise emphasised economic empowerment to provide for families as more important for male than female survivors.

Two respondents identified gender-specific needs related to parenting skills. However, in one case this was identified as required specifically for male survivors (positive parenting skills) while the other called for parenting and nutrition training for females. Another respondent also noted a need for male survivors for 'sensitisation on roles and responsibilities for strong family networks'.

A difference in emotional needs was also identified by one respondent, emphasising the need for male survivors for 'confidence building' and 'being trusted', and for females the need for 'acceptance' and 'valued'.

Overall, respondents did not articulate strong distinctions in many specific needs, despite rating female support needs as significantly more specialised than male support needs. This suggests that gender-responsiveness in care is seen more as influencing the approach to all care and support provision, rather than as significantly shaping the specific forms of support required.



7. Survivor support needs based on exploitation type

Respondents were invited to consider the level of specialisation of survivor care and support needs in relation to survivors that had experienced different forms of exploitation, rating on a scale from zero (not specialised) to ten (extremely specialised). This is intended to identify the extent to which care and support must be tailored to the exploitation experiences of survivors, rather than assuming that the same needs and approaches are common across exploitation types.

Respondents generally considered the needs of survivors of different forms of exploitation to be highly specialised, with over 75% of in-person respondents reporting level of specialisation above the midpoint for all exploitation types. Online respondents reported slightly more variation between exploitation types, with 80% of respondents reporting above the midpoint for sexual exploitation (commercial and non-commercial), 60% above the midpoint for forced labour, servitude, and forced criminal activity, and 50% for slavery. Only 25% of online respondents reported the level of specialisation above the midpoint for forced marriage, and 40% for practices similar to slavery.

The form of exploitation considered to entail the highest level of specialised needs overall was commercial sexual exploitation, with an average rating of 8.8 by in-person respondents (on a ten-point scale) and 4.2 for online respondents (on a five-point scale). All in-person respondents except two rated specialisation of needs for those having experienced this form of exploitation at an eight (17% of respondents), nine (28%), or ten (44%).

Figure 17. Level of specialisation of support needs by exploitation type (in-person respondents)

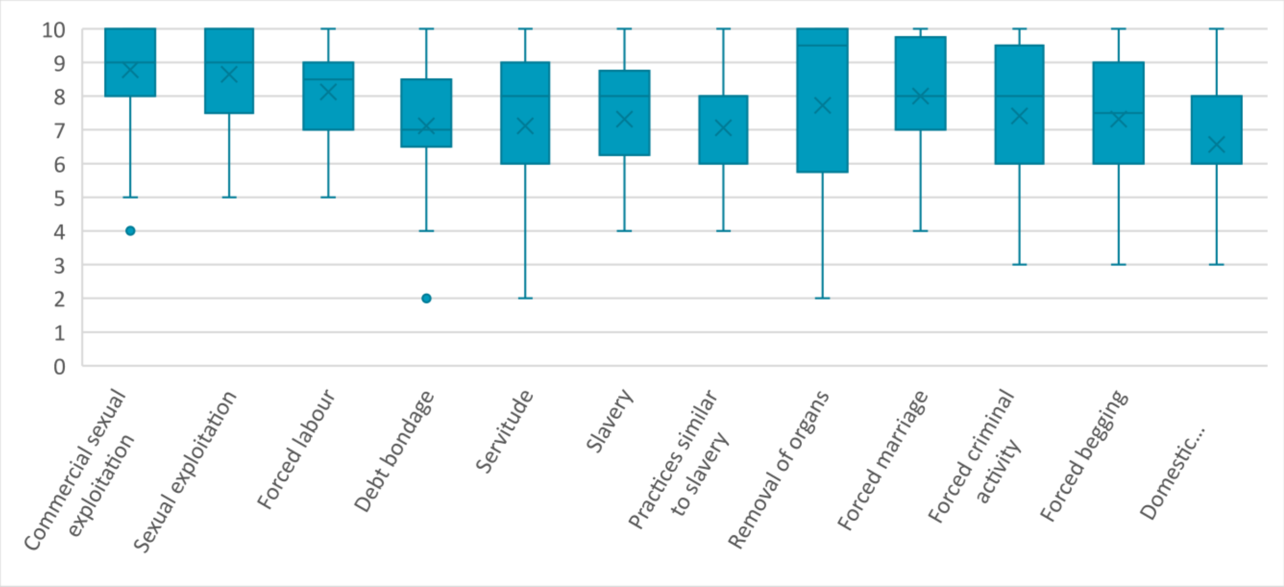


Figure 18. Level of specialisation of support needs by exploitation type (online respondents)

The lowest overall level of specialisation was reported by in-person respondents in relation to survivors of domestic servitude, with an average rating of 6.6—only slightly above the midpoint of the scale. Ratings for this group ranged from two to ten, demonstrating mixed opinions amongst respondents. However, 81% of respondents nonetheless rated specialisation for survivors of domestic servitude above the midpoint (five). Online respondents rated forced marriage and practices similar to slavery as entailing the least specialised needs, with an average rating of three (the midpoint) for each.

7.1.1. Specific needs of survivors of different exploitation types

Respondents generally did not strongly identify particular forms of support as associated with different forms of exploitation, nor did they present particular approaches necessary for support for the different groups. Rather, they highlighted a range of different forms of support relevant across exploitation types, with some deviation in which forms were emphasised. As one respondent noted, ‘services must be comprehensive to address multiple needs’.

Restoring dignity and dealing with stigma were particularly noted in relation to experiences of sexual exploitation, whether commercial or otherwise. Respondents recognised that the level of stigma associated with sexual exploitation was often stronger than in relation to other forms of exploitation, as communities may regard this behaviour as ‘immoral/unacceptable’.

For survivors of debt bondage, several respondents highlighted the specific need for financial literacy, particularly in relation to debt. One indicated that it may be necessary in some cases to arrange repayment of the debt, although suggested it would be preferable to have the perpetrator arrested. Specialised needs were also highlighted in relation to survivors of forced criminal activity. Respondents noted the need ‘to break through from a criminal mindset’, to understand ‘acceptable behaviour in society’. Rehabilitation was more heavily emphasised for survivors in this group than for other forms of exploitation.

Emphasis on meeting basic needs was more strongly emphasised for survivors of forced begging than for other exploitation types. Economic factors were particularly evident in responses for this group, highlighting the role of economic deprivation in driving forced begging in particular. Rehabilitation was also more highly represented for survivors in this group than for other groups.

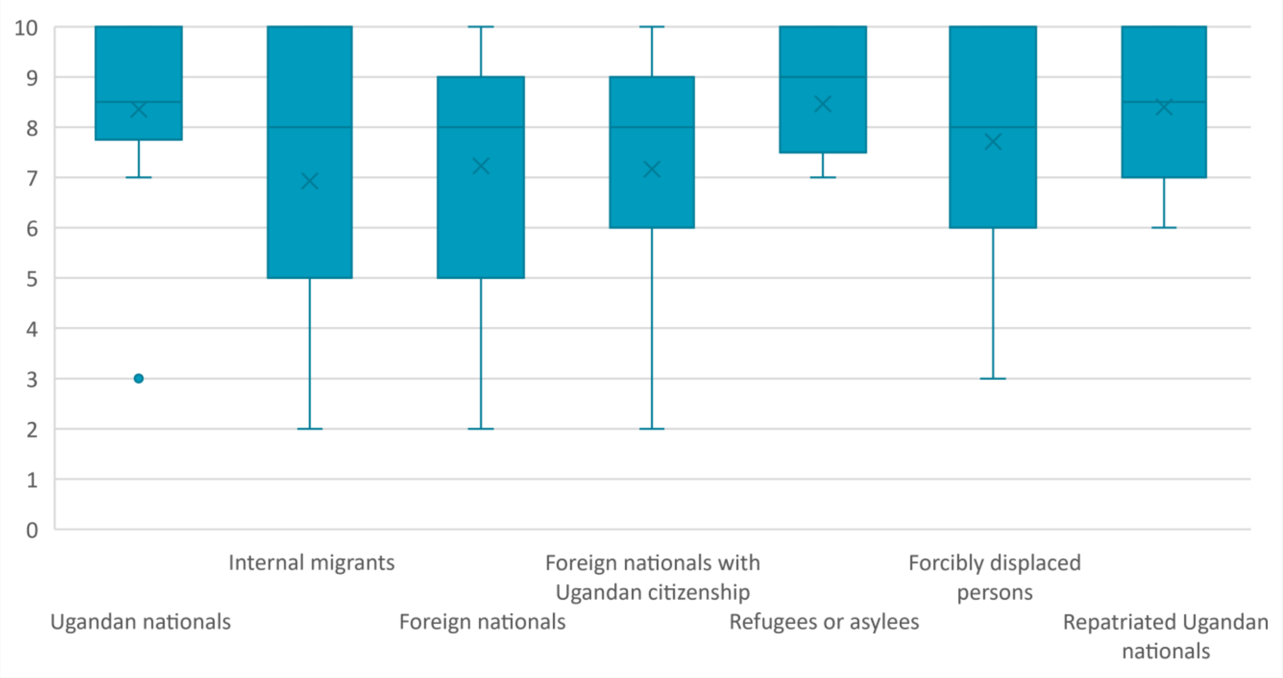
8. Survivor support needs based on migration status

Respondents were invited to consider the level of specialisation of survivor care and support needs in relation to survivors with different migration statuses and experiences, rating on a scale from zero (not specialised) to ten (extremely specialised). This is intended to identify the extent to which care and support must be tailored to the migration status of respondents, rather than assuming that the same needs and approaches are common across different migration experiences.

In-person respondents generally considered the needs of survivors with different migration statuses to be specialised, with the majority of respondents (over 65%) reporting the level of specialisation above the midpoint for all groups. An insufficient number of online respondents considered the specialisation of support needs for survivors with different migration statuses to include in the analysis. However, it was notable that a higher number of respondents felt they had the necessary expertise to report on the specialisation of needs of Ugandan nationals specifically, compared against other migration status groups.

The migration status considered to entail the highest level of specialised needs overall was refugees or asylees from third countries in Uganda, with an average rating of 8.5. All respondents except one rated specialisation of needs for refugees or asylees between seven and ten, with 38% of respondents reporting specialisation at the highest level (ten).

Figure 19. Level of specialisation of support needs by migration status (in-person respondents)



The lowest overall level of specialisation was reported in relation to internal migrants—Ugandan nationals that have migrated within Uganda—with an average rating of 6.9. Ratings for this group ranged from two to ten, demonstrating mixed opinions amongst respondents. However, 67% of respondents nonetheless rated specialisation for internal migrants above the midpoint (five).

8.1.1. Specific needs of survivors with different migration statuses

Respondents did not strongly articulate specialised forms of support associated with particular migration statuses. Needs identified in responses were generally common across the different groups. Slightly greater emphasis was placed on reintegration for people repatriated back to Uganda from third countries and for Ugandan nationals. For foreign national migrants, slightly greater emphasis was placed on meeting basic needs and shelter. In some instances, repatriation was also a significant focus for non-Ugandan national groups, including consideration of associated support. Two respondents notably included repatriation in the needs of this group—an issue of concern in this group in particular.

Responses evidenced a more long-term focus in thinking about care and support needs for Ugandan nationals and citizens, and a more immediate, short-term focus when considering the needs of foreign nationals. Even in relation to refugees and asylees from third countries in Uganda, greater emphasis was placed on immediate needs than considered for Ugandan national groups. Neither reintegration or integration were significantly represented in responses on any non-Ugandan national or citizen group.

9. Standards of care

9.1. Existing materials

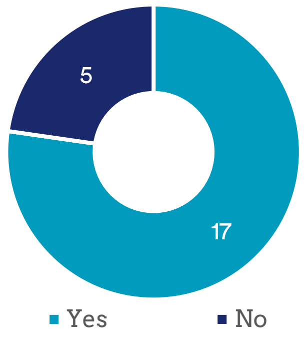
All respondents were asked whether their organisations already had a standard policy, set of guidelines, manual, or standard operating procedures for supporting survivors in place. The majority of respondents (77%) reported that their organisation did have some form of existing materials guiding survivor support provision, while 23% reported no such materials being in place.

Respondents' evaluation of the quality of existing materials was closely related to the existence of materials within their own organisation. Those that did not have internal frameworks in place were more likely to report existing materials to be inadequate across the six measures assessed, while those with internal frameworks in their organisations were more positive in their evaluation of these. This suggests that although internal materials may provide a solid foundation for survivor support, there is relatively little coordination and centralisation in standards. Information sharing around standards is limited, meaning that organisations are not benefitting from the work of others in this area. Duplication of effort is also more likely in this context.

Overall, existing materials were considered by respondents to be user-friendly and accessible, to address all topics relevant to respondents' work (comprehensive), and to be based on solid evidence. While in-person respondents considered existing materials to be current and up to date, online respondents presented a more mixed picture of this measure. Survivor involvement in the development of existing materials was also less strongly rated than other measures, with only 65% of in-person respondents rating above the midpoint (notably lower than other measures), and 50% of online respondents.

The majority of in-person respondents rated above the midpoint (five) for each measure assessed. All measures were rated above the midpoint (three) by every online respondent with two exceptions—only 50% of respondents rated survivor-informed above the midpoint;

Figure 20. Existence of a standard policy, guidelines, or standard operating procedures for supporting survivors within respondents' organisation



Respondents' opinions on the strengths of existing materials were closely tied to whether their organisation had internal frameworks in place. Respondents without such generally considered guiding materials to be inaccessible, out of date, insufficient, and not user-friendly.

Although materials that do exist were generally viewed favourably by the organisations that developed them, this suggests that materials are not being shared across the sector. The development of shared standards of care is intended to help address these gaps.

and only 33% of respondents rated above the midpoint on materials being current and up to date.

The characteristic most strongly rated by in-person and online respondents was existing materials being based on solid evidence, with an average rating of 7.5 and 3.8 respectively. Although two in-person respondents rated this characteristic at two, and one online respondent rated at one (not at all), all remaining respondents (rated at the midpoint or above). Further, 39% of in-person respondents and 40% of online respondents rated this measure at the highest point in the scale (ten and five respectively), evidencing a high degree of confidence in the evidence underpinning existing materials.

The characteristic least strongly rated by in-person respondents was that survivors were involved in developing existing materials. Responses were widely distributed in relation to this measure, reflecting the diversity of materials referenced by respondents (mostly focused on their own organisations' internal frameworks rather than a shared framework). The average score for this measure was 6.5, with 24% of respondents rating below the midpoint, 12% rating at the midpoint, and 65% rating above the midpoint. Responses above the midpoint were almost evenly distributed between ratings from seven to ten.

Figure 21. Evaluation of existing materials (in-person respondents)

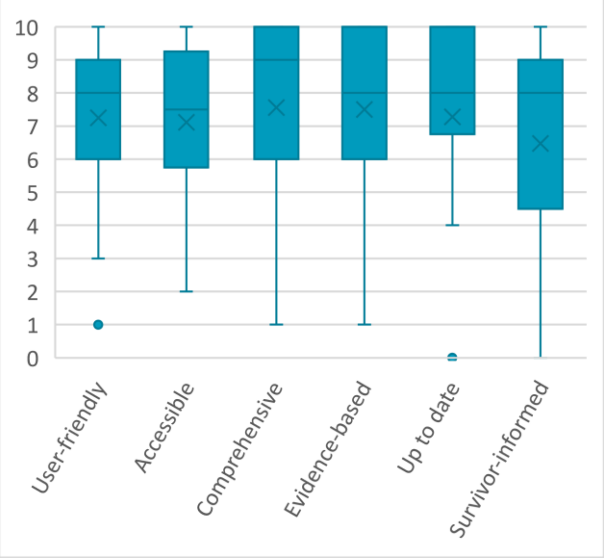
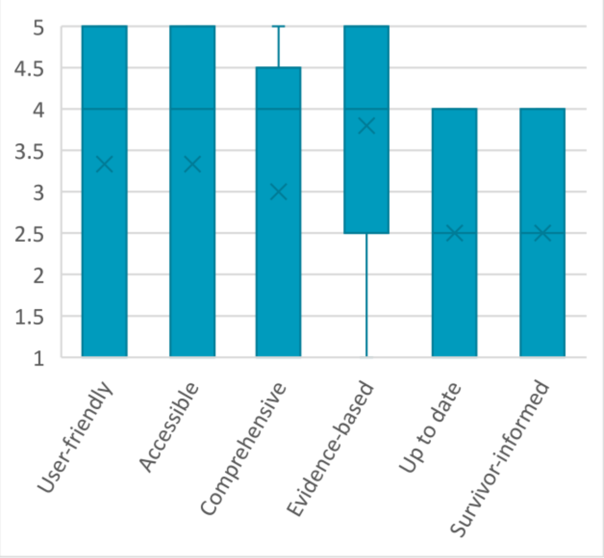


Figure 22. Evaluation of existing materials (online respondents)



While online respondents also reported lower confidence in existing materials having involved survivors in their development—with 50% of respondents rating below the midpoint (three) and an average rating of 2.5—the measure least strongly rated was that materials were current and up to date. Online respondents demonstrated notable less confidence in this measure than in-person respondents, with 50% rating below the midpoint, 17% at the midpoint, and 33% above. No online respondent rated this measure at the highest score.

9.2. Priorities for new standards of care

Respondents were invited to reflect on the features and qualities of new standards of care being developed, indicating the extent to which they valued different features and approaches. The importance of fourteen different features was assessed on a scale—from zero (not at all important) to ten (extremely important) for in-person respondents and one (not at all important) to five (extremely important) for online respondents.

Overall, the listed feature rated most highly by in-person respondents was collaboration with civil society in the development of new standards of care. This was followed by SOCs being trauma-informed, evidence-based, and including specialised sections for different exploitation types. Online respondents also rated SOCs being trauma-informed most highly, alongside basing standards on human rights principles, emphasising non-discrimination, and including specialised sections for different genders and age groups.

Table 1. Features of new standards of care in order of importance to in-person respondents

Ranking		Features of new standards of care (SOCs)	Average rating	
In-person	Online		In-person	Online
1	8 =	SOCs are developed in collaboration with civil society	9.67	4.67
2 =	1 =	SOCs are trauma-informed	9.61	4.83
2 =	1 =	SOCs are based on human rights principles	9.61	4.83
2 =	8 =	SOCs include sections for different exploitation types	9.61	4.67
5 =	1 =	SOCs emphasise non-discrimination	9.56	4.83
5 =	1 =	SOCs include sections for different genders	9.56	4.83
5 =	6 =	SOCs are developed in collaboration with Government	9.56	4.80
5 =	10	SOCs are evidence-based	9.56	4.60
9	12	SOCs include sections for different migration statuses	9.47	4.40
10 =	11	SOCs are comprehensive/ address all aspects of support	9.44	4.50
10 =	13	SOCs use accessible, jargon-free language	9.44	4.33
12	1 =	SOCs include sections for different age groups	8.94	4.83
13	14	SOCs are developed in collaboration with communities	8.59	3.83
14	6 =	SOCs are developed in collaboration with survivors	8.50	4.80

Both in-person and online respondents rated collaboration with communities in the development of new standards of care relatively low—with in-person respondents assessing this as the second least important feature and online respondents rating it the least important.

In-person and online respondents differed, however, on the overall importance of collaborating with survivors in the development of new standards of care, with in-person respondents rating it the least important overall while online respondents considered it relatively important.

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