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Sexual violence stigma experiences among refugee adolescents and youth in Bidi Bidi refugee settlement, Uganda: Qualitative insights informed by the stigma power process framework

Carmen H. Logie [a,b,c,d,*], Moses Okumu [e], Madelaine Coelho [f], Miranda G. Loutet [g], Isha Berry [g], Simon Odong Lukone [h], Nelson Kisubi [h], Daniel Kibuuka Musoke [h], Peter Kyambadde [i,j]

[a] Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, ON, M5S 1V4, Canada
[b] United Nations University Institute for Water, Environment, and Health, Hamilton, ON, L8P 0A1, Canada
[c] Centre for Gender & Sexual Health Equity, Vancouver, BC, V6Z 2K5, Canada
[d] Women's College Research Institute, Women's College Hospital, Toronto, ON, M5G 1N8, Canada
[e] School of Social Work, University of Illinois at Urbana Champaign, Urbana, IL, 61801, USA
[f] Department of Sociology, University of Toronto, Toronto, ON, M5S 2J4, Canada
[g] Dalla Lana School of Public Health, University of Toronto, Toronto, ON, M5T 3M7, Canada
[h] Uganda Refugee and Disaster Management Council, Yumbe, Uganda
[i] National AIDS Coordinating Program, Ugandan Ministry of Health, Kampala, Uganda
[j] Most at Risk Population Initiative (MARPI), Kampala, Uganda

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ABSTRACT

There are over 100 million forcibly displaced persons who experience elevated risks for sexual violence. Sexual violence stigma can have immediate and long-lasting effects on social and health outcomes among survivors. There is a dearth of information on the experiences of sexual violence stigma among refugee adolescents and youth, particularly in low and middle-income contexts where most forcibly displaced persons are hosted. Our study focuses on understanding the lived experiences of sexual violence stigma among refugee adolescents and youth in Bidi Bidi Refugee Settlement, Uganda. This qualitative study involved twelve individual in-depth interviews and six focus groups in Bidi Bidi with refugee youth aged 16–24, refugee elder interviews (n = 8), and service provider interviews (n = 10). We explored experiences and impacts of sexual violence stigma, including accessing supportive resources. We conducted thematic analysis informed by the Stigma Power Process framework. This framework examines how social processes of stigma serve to keep people 'in', 'down', and 'away'. Participant narratives highlighted negative cultural conceptions of sexual violence survivors and of women and girls, as well as daily indignities targeting survivors that reinforced their lower status. Shaming sexual violence survivors as 'immoral' operated to keep people 'in' the social order where it was expected that 'moral' persons would not experience sexual violence. Fear of such judgment, and wanting to stay 'in', produced barriers for survivors to access healthcare and legal support. Participants reported community-level blame and punishment kept them 'down', and community isolation and rejection kept them 'away'. At the individual level, survivors were kept 'down' through internalizing shame, low self-esteem, self-isolation, and hiding. Findings signal the need to address the far-ranging impacts of sexual violence stigma on refugee youth health, wellbeing, and rights. Meaningfully engaging refugee youth and communities in reducing sexual violence stigma must concomitantly transform inequitable gender norms and power relations.

1. Introduction

Refugee and other forcibly displaced women and girls are at elevated risk for experiencing sexual violence—during conflict, in transit, and after resettlement (Hourani et al., 2021). An estimated 21% of refugee women spanning fourteen countries reported sexual violence victimization (World Health Organization, 2013; Stark and Landis, 2016; Vu et al., 2014). With more than 100 million forcibly displaced persons at

* Corresponding author. University of Toronto, Factor-Inwentash Faculty of Social Work, 246 Bloor St W, Toronto, ON, M5S 1V4, Canada.
E-mail address: carmen.logie@utoronto.ca (C.H. Logie).

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the end of 2022, addressing the health and wellbeing of refugee sexual violence survivors requires urgent attention (UNHCR & Government of Uganda, 2022). Uganda is the largest refugee hosting nation in Africa—and the third largest refugee hosting nation globally—with over 1.5 million refugees, of whom 81% are women and children and 24% are youth aged 16–24 years (UNHCR & Government of Uganda, 2022). Refugees living in the Western, Midwestern, and Northern regions of Uganda have reported experiencing multiple forms of sexual and gender-based violence, including rape, forced and early marriage, intimate partner violence, and sexual violence during and following forced migration (UNHCR & Government of Uganda, 2022; 2023). For instance, a 2018 Women's Refugee Commission report found that sexual violence and exploitation were identified as major protection risks for women and girls in Bidi Bidi refugee settlement in Northwestern Uganda. These incidents of sexual violence are often unreported due to fear of stigma and retaliation. Despite being disproportionately affected by sexual violence, there is limited knowledge of lived experiences of sexual violence stigma and its impacts among refugee adolescents and youth (Albutt et al., 2017; Kelly et al., 2017; Murray et al., 2018; Robbers and Morgan, 2017; Singh et al., 2018a,b). This is a notable gap, as adolescence and early adulthood are periods of extensive neurobiological, social, emotional, and psychological changes, hence this developmental life phase may increase vulnerability to long-term health consequences of toxic environments such as sexual violence and harsh social relationships, including those characterized by stigma (Bonnie and Backers, 2019).

Sexual violence stigma refers to the ways in which sexual violence survivors experience devaluing, blame, social rejection, mistreatment, and constrained access to opportunities and resources (Albutt et al., 2017; Kelly et al., 2017; Murray et al., 2018). Sexual violence can have wide ranging impacts that are both immediate and long-term, including mental (e.g., depression, anxiety, and PTSD), physical (e.g., unplanned pregnancy), and sexual (e.g., sexually transmitted infections) health challenges in addition to poorer social (e.g., social isolation) and economic outcomes (e.g., disrupted education) (Logie et al., 2019b, 2020; Murray et al., 2018, 2021; Robbers and Morgan, 2017). These health issues can be exacerbated by stigma, as fear of experiencing sexual violence stigma is linked with reduced uptake of post-rape clinical care services (e.g., post exposure prophylaxis, emergency contraception) that could prevent HIV infection and unplanned pregnancy (Abrahams and Jewkes, 2010; Muuo et al., 2020). Additionally, sexual violence stigma presents barriers to disclosing experiences of sexual violence, in turn reducing access to social support (Schmitt et al., 2021). Systematic review findings regarding sexual violence outcomes among civilians in conflict zones reported social outcomes including family and community rejection as well as spousal abandonment (Ba and Bhopal, 2017). This reflects manifestations of enacted stigma—acts of mistreatment, exclusion, and discrimination. Stigma can also be internalized, resulting in feelings of shame that can lead to further withdrawal from social networks and reduced likelihood of engaging in healthcare or accessing social support (Kelly et al., 2017; Overstreet and Quinn, 2013; Shuman et al., 2016; Verelst et al., 2014). In this way, mistreatment and rejection (enacted stigma), awareness of harmful social norms and fear of mistreatment (perceived or felt normative stigma), and feelings of shame (internalized stigma) are manifestations of stigma (Stangl et al., 2019) that can reduce the likelihood of sexual violence survivors engaging with social and healthcare resources, services, and supports.

Research with conflict-affected persons in varied contexts reports that sexual violence stigma presents barriers to accessing care and support. For instance, in a quantitative study in Northern Uganda, youth survivors of sexual violence during war were more likely to report stigma and barriers to seeking care than counterparts who did not report sexual abuse (Amone-P'Olak et al., 2018). This study also reported that stigma and poor community relations mediated the pathway from sexual violence to poor general functioning (Amone-P'Olak et al., 2016). In a qualitative study of service providers working with Rohingya refugee adults in Bangladesh, providers described stigma as a barrier to sexual violence disclosure that could exacerbate trauma and prevent survivors from accessing healthcare (Green et al., 2022). A qualitative study with male sexual violence survivors in three refugee settings (Kenya, Italy, Bangladesh) reported that social stigma (family and community level rejection and blame), self-stigma (guilt, self-blame), and negative provider attitudes (attributed to racism, homophobia, transphobia, xenophobia) presented barriers to engaging with post-rape healthcare (Chynoweth et al., 2020). Among women and girls in South Sudan who experienced sexual violence in conflict, agreement with a survey item indicative of internalized stigma ("If a woman is raped, she has usually done something careless to put herself in that position") was associated with 40% lower odds of disclosing experiences of violence to anyone (Murphy et al., 2020). In this study adolescent girls aged 15–19 years were less likely to disclose sexual violence experiences than older women aged 30 years and above (Murphy et al., 2020). Together, these studies signal the need for better understanding what drives sexual violence stigma among conflict-affected adolescents and youth to reduce stigma and its impacts.

Stigma frameworks propose archetypes of stigma that are relevant to understanding sexual violence stigma, including the social construction of the 'immoral' other (Goffman, 1963). Following sexual violence experiences, conflict-affected sexual violence survivors in eastern Democratic Republic of Congo (DRC) reported worsened family relationships, household insults, a loss of respect from their children, reduced status in their household and communities, and not attending church due to fear of stigma (Albutt et al., 2017). Sexual violence stigma, as described by men in the DRC, is also rooted in beliefs that sexual violence violates the fidelity of marriage (Kelly et al., 2017). Another dimension of this 'immoral' stigma archetype is the concept of controllability, how much the person is perceived as responsible for their condition (Crocker et al., 1998). This shapes how sexual violence stigma is produced, whereby a women could be perceived as 'at fault' if they did not have evidence of resisting rape, and could be blamed for 'deceit' if they did not disclose their sexual violence right away (Kelly et al., 2017). Victim blaming was also associated with increased sexual violence stigma in the DRC (Koos and Lindsey, 2022), as have acceptance of rape myths which include beliefs that women are responsible for rape (reflecting the notion of controllability) (Schmitt et al., 2021). In another example, girls who reported sexual violence in the DRC were more likely to be accused of witchcraft and to report perceived discrimination and social exclusion in familial and community contexts (e.g., mistreatment, isolation) than those not reporting sexual violence (Verelst et al., 2014). These findings signal the ways in which sexual violence survivors are stigmatized and lose status and social capital through being viewed as 'immoral'.

Another stigma archetype is the 'unhealthy' or 'physically damaged' other (Goffman, 1963). This is relevant to understanding sexual violence stigma in conflict-affected settings in two ways. First, sexual violence stigma may be exacerbated through the acquisition—and fear of acquisition—of HIV or other sexually transmitted infections through sexual violence (Kelly et al., 2017; Koos and Lindsey, 2022; Logie et al., 2021a; Mootz et al., 2017). This reflects the ways in which stigma toward HIV and STIs can interact with stigma towards sexual violence. Second, the convergence of the 'immoral' and 'unhealthy/physically damaged' archetypes in sexual violence stigma are evident in customs and cultural understandings of virginity and sexuality that frame survivors as unfaithful (reflecting the 'immoral other') *and* damaged (indicative of the 'unhealthy/physically damaged' other), which in turn often result in isolation, further stigmatization, and even re-victimization (Green et al., 2022; Koos and Lindsey, 2022). Forced marriage among refugee adolescent girls and young women sexual violence survivors, in part due to this devaluation of survivors and beliefs that survivors are less 'marriageable', is a notable human rights concern (Bartels et al., 2018; Gottschalk, 2007; Roupetz et al., 2020).

There has been limited attention to the ways in which stigma theoretical frameworks at large may be applied to understand the root causes

and lived experiences of stigma among conflict-affected sexual violence survivors in low and middle-income countries (LMIC) (Murray et al., 2018), particularly among adolescents and youth. Murray et al. (2018) described that most sexual violence stigma literature examines harmful community attitudes toward survivors rather than the lived experiences of survivors spanning a range of stigma manifestations, while quantitative sexual violence stigma measures often focus on high-income settings rather than LMICs. When validating a sexual violence stigma measure, they found different factor structures in the DRC (Murray et al., 2018), Kenya, and Jordan (Murray et al., 2021), which suggests the importance of understanding nuanced and contextually specific experiences and impacts of sexual violence stigma to inform healthcare and stigma reduction programming. They specifically call for further attention to the experiences of sexual violence stigma among adolescent girls (Murray et al., 2021). Age may elevate young people's sexual violence stigma exposure. For instance, negative societal attitudes, judgment, and mistreatment of young people who engage with sexual and reproductive health (SRH) services and adolescent parents is also known as adolescent SRH stigma; among urban refugee youth in Uganda, adolescent SRH stigma was associated with lower testing for HIV (Logie et al., 2019a) and STIs (Logie et al., 2020)

As refugee youth in LMICs already experience constrained access to sexual and mental health services due to geographic isolation, language barriers, HIV-related stigma, limited health services, and poverty (Logie et al., 2021b; O'Laughlin et al., 2014, 2016, 2017; Robbers and Morgan, 2017), the impacts of sexual violence stigma could be particularly profound and warrant further attention. This knowledge could inform age-tailored stigma reduction and health promotion strategies. Our study aims to address knowledge gaps regarding lived experiences of sexual violence stigma among refugee adolescents and youth in Bidi Bidi refugee settlement, Uganda.

2. Methods

2.1. Overview

This community-based research study was conducted between February 2020–February 2021 in Bidi Bidi refugee settlement in collaboration with Uganda Refugee and Disaster Management Council, Ugandan Ministry of Health and academics based in Canada and the United States. The qualitative data for this manuscript was collected during Phase 1 of larger research project on sexual and gender-based violence (SGBV) prevention. Phase 1 included eliciting experiences and perspectives on sexual violence drivers and facilitators, stigma, protective factors, and recommendations for SGBV prevention and post-rape clinical care. This qualitative data informed the development of a SGBV prevention intervention that was piloted tested in Phase 2, the study protocol (Logie et al., 2022b and intervention results (Logie et al., 2022c) are published elsewhere.

2.2. Study site

The study was conducted in Bidi Bidi refugee settlement, one of the largest settlements in the world located within Yumbe district in Northwestern Uganda. This settlement was established in September 2016, and hosts approximately 190,000 refugees as of February 2023 of which 25% are aged 15–24 years, and the overwhelming majority (>99%) are from South Sudan (UNHCR & Government of Uganda, 2023). Our study was conducted in Zone 3, the most populated zone with over 45,000 residents, a location where the community partners including study coauthors (SOL, NK) provide services. The UNHCR and Government of Uganda report that 50.3% of people living in Bidi Bidi were reached with SGBV awareness raising messages or sessions in 2022, yet no further information is provided on this SGBV messaging or SGBV needs or lived experiences (UNHCR & Government of Uganda, 2023). Previous literature with refugee youth Bidi Bidi has illustrated contextual factors that shape everyday experiences, such as inadequate access to food, water, and firewood which increase SGBV exposure among for women and girls (Logie et al., 2021c, 2022a), risk factors for child, early, and forced marriage among adolescent girls and young women in Bidi Bidi (Loutet et al., 2022), and linkages between water insecurity and depression (Logie et al., 2023).

2.3. Study design & participants

This qualitative study is based on data from in-depth individual interviews (IDI) and focus groups that involved refugee youth, community elders, and service providers who provide health care or police services in Bidi Bidi, Uganda. IDI and focus groups were conducted by eight peer navigators [PNs] (ages 18–24 years; women, n = 4 and men, n = 4) who are young refugees living in Bidi Bidi with lived experiences of SGBV. These PNs identified and recruited by the community partner working with youth programs in Bidi Bidi, self-identified as refugees fluent in English and Juba Arabic and/or Bari, and received training for this research project on study design, research ethics, and psychological first aid. Participants were recruited through word-of-mouth with peer navigators and purposive sampling with community partners.

Refugee adolescents and youth were assigned to participate in either an IDI or a focus group. We conducted 12 IDI with refugee youth, 6 among young women and 6 among young men. We conducted 6 focus groups with refugee youth, 3 groups with young women and 3 with young men. Inclusion criterion included being able to provide informed consent, residing in Zone 3, and being between the ages of 16–24 years. For refugee youth partaking in IDIs, an additional inclusion criterion was reporting lived experiences of SGBV. Community elders were refugees aged 50 years or older, or who were identified as an elder by a peer navigator. Service providers were either police officers or health care practitioners who resided in Bidi Bidi or worked in and provided services to refugee youth in Bidi Bidi. All participants must have been able to speak Bari, Juba Arabic, or English and provide informed consent.

2.4. Data collection and analysis

Both IDI and focus groups were semi-structured and lasted approximately one hour in duration. All interviews and focus groups were recorded, transcribed, and translated from Bari or Juba Arabic to English. Translation and quality checks were completed by a team of trained refugee translators who were former teachers in South Sudan. Focus group and IDI questions explored SGBV within Bidi Bidi refugee settlement, survivor experiences within the community and family settings, healthcare treatment and support options, HIV prevention engagement, and social contexts surrounding instances of SGBV (See Appendix in the Online Supplemental Files for the interview guides). Both modalities (i.e., focus groups and IDI) allowed for a larger and more diverse sample of participants and the ability to capture individual and group sentiments, and IDI allowed confidential discussion of more stigmatized topics among SGBV survivors.

Dedoose, a platform for analyzing qualitative and mixed methods research (Dedoose, 2016), was used to code all relevant transcripts. Thematic analysis, a theoretically flexible approach that integrates both deductive and inductive analyses, was used to identify, analyze, and interpret patterns of meaning related to themes and subthemes associated with sexual violence, stigma, healthcare access, and other experiences of social marginalization (Braun and Clark, 2006). We followed the thematic analysis steps, including having three investigators/coders familiar with the study context, read transcripts to generate initial ideas of codes, identifying and refining potential themes, naming and defining themes, developing a thematic map, and producing the final analysis with illustrative data extracts (Braun and Clark, 2006). Inter-coder reliability was ensured by consistent meetings between the research team that included researchers from Uganda and Canada. Data analysis was informed by overarching theoretical perspectives from the Stigma

Power Process framework (Link and Phelan, 2014), described below.

2.5. Conceptual approach to sexual violence stigma

While SGBV itself is conceptualized as harm inflicted on others due to gender and power inequities (García-Moreno et al., 2015; World Health Organization, 2013), there has been less discussion of how power drives and shapes sexual violence stigma experiences with refugee youth who may experience intersecting forms of social marginalization based on gender, age, refugee status, and poverty (Logie et al., 2021b). Centering power in experiences of sexual violence *stigma* may be particularly important and warrants further exploration among refugee adolescents and youth. However, limited sexual violence stigma conceptual frameworks have focused on youth experiences in humanitarian settings. The Health Stigma and Discrimination Framework provides a means to conceptualize intersecting stigma (e.g., inclusive of sexual violence stigma) as produced in social processes that occur across multiple *social ecological levels* (e.g., individual, community, structural domains of life), and *stigma types*, including enacted (acts of mistreatment and discrimination), anticipated (fear and concern over mistreatment), perceived or felt-normative (awareness of negative social norms), and internalized (acceptance of negative social values towards one's own identity/experiences) stigma (Stangl et al., 2019).

To better understand the lived experiences of refugee youth, we applied the Stigma Power Process framework conceptualized by Link and Phelan (2014) which was developed to enhance understanding of how stigma can serve to (re)produce social hierarchies through domination and exploitation. This framework examines the ways that social processes of stigma serve to keep people *'in'*, *'down'*, and *'away'*, and how stigma can be enacted in both direct and indirect ways and through social actors, sociocultural norms, and institutional practices and policies (Link and Phelan, 2014). The stigma power framework begins with a cultural assessment of value whereby individuals consider who is (and is not) valued in society, and in turn this raises awareness of how they themselves may be socially perceived—including if they anticipate negative societal evaluation and in turn discrimination. Socially devalued persons experience a lower status and related everyday mistreatment, referred to as 'daily indignities'. For instance, stigma can keep people *'down'* through domination and exploitation that results in unequal social hierarchies and constrains access to power, resources, and status (e.g., racism, sexism) (Phelan et al., 2008). Stigma in this example works in ways that keep people *'down'* to maintain inequitable power dynamics and social advantage (Phelan et al., 2008).

Stigma can keep people *'in'* via enforcing social norms through punishing violators; this includes promoting ideologies of (im)morality and shaming persons who violate norms or 'acceptable' behaviour through adopting identities or engaging in practices considered to be 'voluntary' (e.g., sexual practices that do not align with dominant heteronormative and cisnormative roles and expectations, such as sexually and gender diverse identities and same-gender sexual practices, sex outside of marriage, etc.) (Phelan et al., 2008). Keeping people *'in'* via shame, blame, and social rejection is premised on the perception that the identities, practices, and/or experiences are voluntary (whether or not that aligns with the lived experience of the stigmatized person) and that stigma can set an example of what boundaries are acceptable/unacceptable for the larger social group (Phelan et al., 2008). This form of stigma to keep people *'in'* functions to enforce the current social order (Phelan et al., 2008).

Finally, stigma that operates to keep people *'away'* and *'down'* is rooted in conceptualizations of who is considered to be 'healthy' or 'diseased' (Link and Phelan, 2014). Avoiding and shunning persons who deviate from how 'normal' people are expected to look and act can encapsulate a range of health conditions and behaviours, including physical, sexual, and mental health challenges. This concept of 'disease avoidance' could therefore be applied to persons who have visible mental health challenges, or physical illness or harm (e.g., scars), and other non-normative or 'deviant' behaviour and practices. Experiences of rejection among stigmatized persons could result in their choosing to withdraw from future social situations and interactions to avoid potential rejection—in this way, the stigmatized person can reproduce the goal of the stigmatizer/dominant social order to keep the 'unhealthy other' *'away'* from the 'healthy, normal' person (Link and Phelan, 2014). Being kept *'down'* and *'away'* may be achieved through lowering social status that in turn lowers self-esteem. Individuals with a lower perceived worth are more easily able to be controlled and less likely to "make or be able to demand broader inclusion" (p. 30).

2.6. Ethics

Ethical oversight and approval was provided through Mildmay Uganda (Ref: 0212–2019), Uganda National Council for Science and Technology (SS 5273), and the University of Toronto Research Ethics Board (Ref: 37981).

3. Results

A total of 12 refugee youth, 8 refugee elders, and 10 service providers (health care providers, n = 8; police officers, n = 2) engaged with individual interviews and 48 refugee youth participated in a total of 6 focus groups. Refugee youth and elder participants were primarily from South Sudan, with a minority from the DRC. Further participant demographics are presented in Table 1.

Themes that emerged on stigma, including its manifestations, drivers, and impacts, were organized in alignment with the Stigma Power Framework (Link and Phelan, 2014) as shown in Fig. 1 below. This figure illustrates a cascade of issues that emphasize the role of power in shaping the experiences and impacts of stigma. It begins with societal devaluation, that in turn leads to persons being concerned about staying within what is socially acceptable, then those who are not socially acceptable are kept away, and in turn they feel down. As illustrated in Fig. 1, the first box, *cultural assessment of value*, reflects how people who hold a stigmatized condition—in this case, sexual violence survivors—are aware that society negatively evaluates and judges sexual violence survivors. This negative cultural evaluation results in sexual violence survivors experiencing negative treatment, including: "being taken less seriously, being treated unfairly, or being taken advantage of" (Link and Phelan, 2014, p. 6). This awareness of negative cultural evaluation and accompanying mistreatment of survivors (Box 1) leads to *concerns with staying 'in' the social order* (Box 2). This dimension includes community-level shaming of sexual violence survivors as 'immoral' to keep people *'in'* the social order—this framing thus imagines that 'moral' persons who stay *'in'* the social order would not experience sexual violence. Concerns of experiencing this judgment, and wanting to stay *'in'* the social order, produced barriers for survivors to access structural supports such as healthcare and legal resources. When people are not able to stay *'in'* the social order and experience and/or fear rejection, they may withdraw from or be banished from social contacts and interactions, in essence being kept *'away'* (Box 3a). As depicted in Fig. 1, participants in our study described community-level isolation and rejection kept them *'away'*. Finally, as depicted in Box 3, concerns about 'staying in' reinforce the negative cultural assessments of value, in turn lowering self-worth and self-esteem, in turn reflecting how the stigmatized person is being kept *'down'*. This is exacerbated by community-level blame and punishment, and is manifested at the individual level in low self-esteem and hiding.

3.1. Cultural assessment of value: community level experiences of sexual violence survivors

At the community level, participant narratives revealed that sexual violence survivors were kept *'in'*, *'down'*, and *'away'* through a combination of norms and practices that shamed and devalued survivors

Table 1
Sociodemographic characteristics in-depth individual interview and focus group participants in Bidi Bidi Refugee Settlement, Uganda (n = 78).

	Focus groups with refugee youth (n = 6 focus groups; total n = 48 youth) (%)	Individual interviews with refugee youth (n = 12) *n*(%)	Individual interviews with refugee elders (n = 8) *n*(%)	Individual interviews with service Providers (n = 10) *n*(%)
Age (mean)	20.9	19.9	58.2	31.5
Range	16–24	15–24	50–62	24–40
Gender				
Men	24 (50)	6 (50)	4 (50)	5 (50)
Women	24 (50)	6 (50)	4 (50)	5 (50)
Country of Birth				
South Sudan	41 (85.4)	9 (75)	7 (87.5)	–
DRC	7 (14.6)	3 (25)	1 (12.5)	–
Duration of Years in Uganda				
Mean	2.05	2.4	2	–
Range	0.5–4	1–4	1–5	–
Immigration Status				
Refugee	91 (91.7)	12 (100)	8 (100)	–
Undocumented	4 (8.3)	–	–	–
Level of Education				
Less than Primary	15 (31.2)	3 (25)	2 (25)	–
Less than Secondary	21 (43.7)	8 (67)	3 (37.5)	–
Completed Secondary	8 (16.7)	–	2 (25)	–
Attended Technical College	2 (4.2)	–	–	–
Some University	2 (4.2)	–	1 (12.5)	–
University Degree	–	1 (8)	–	–
Current Employment Status				
Unemployed	19 (39.6)	2 (20)	–	–
Looking for work	17 (35.4)	8 (80)	6 (75)	–
Employed	3 (6.2)	–	2 (25)	–
Student (not employed)	1 (2.1)	–	–	–
Self-employed	8 (16.7)	–	–	–
Designation				
Midwife	–	–	–	4 (40)
Clinical Officer	–	–	–	2 (20)
Nurse	–	–	–	1 (10)
Laboratory technologist	–	–	–	1 (10)
Police officer	–	–	–	2 (20)
Years Worked				
Mean	–	–	–	4.2
Range	–	–	–	1–7

which ultimately resulted in less access to power, agency, and resources. Persons who experience sexual violence were described across participant narratives as being judged and blamed in their community, reflecting Link and Phelan's (2014) discussion of *cultural assessment of value*. Specifically, sexual violence survivors were judged as deserving of punishment for 'immoral' behaviour that resulted in violence victimization. This converged with the lower cultural assessment of value towards girls and women in comparison with boys and men. For instance, participant narratives reflected a negative cultural assessment of value toward refugee girls and women whereby they had less access to power and decision-making regarding bodily autonomy. A way to enforce cultural devaluing of refugee girls and women within the community was the 'daily indignities' that refer to negative treatment such as being taken less seriously, treated unfairly, or being taken advantage of. In an example of the devaluation of sexual violence survivors, a young refugee man (ID 4) described: "survivors are considered inferior. Worse enough, their opinions in any community matters are not taken into consideration. In other words, they become voiceless in matters of the community". In a similar vein, a young refugee man (ID 1) described the cultural devaluation of women and girls: "Our culture elevates men than women, thus many rules are against women and girls."

3.1.1. Keeping people 'in' (community level): sexual violence survivors constructed as the 'immoral' other

As a young man (ID 6) explained when discussing young refugee women and girls who experienced sexual violence: "the community does not support girls, instead they refer to them as 'prostitutes' and feel good it happened to these 'prostitutes' that deserved it". Individuals are aware of how the community perceives sexual violence survivors, which feeds into the concern regarding 'keeping in' what is considered socially acceptance practices. Concepts of (im)morality were not only associated with perceptions of survivors as 'prostitutes', but refugee girls and women were also blamed for sexual violence for not wearing what was considered proper clothing. For example, a young women described: "if it's a young girl who is poorly dressed, the people will say the girl looked for it because she dresses to tempt the men" (FG 3, young woman).

Respondents recounted how a community's blame towards sexual assault survivors could result in a lack of external help-seeking practices, as individuals may respond to anticipated community backlash by enacting a strategy of secrecy and concealment. A young woman described: "When issues are reported, they do not take proper action. Even those that come to the scene, instead of helping, they just utter words like 'you wanted it, you suffer'" (ID 8, young woman). These examples of blaming survivors as immoral ('prostitutes', 'poorly' dressed) and subsequently deserving of punishment and suffering may reinforce social rules regarding 'acceptable' behaviour to keep young refugees *'in'* these norms. Survivors may concern themselves with staying 'in' to avoid being blamed for their assault by the greater community.

3.1.2. Keeping people 'down' (community level): women and girls blamed and punished for sexual violence

First, participants described the ways in which boys and men are valued over girls and women in their community. For example, as a young woman (ID 2) notes, "the culture, our tribe, puts men over women. Most complaints against boys and men are not taken seriously" and men are not held responsible for violence, as "the female usually gets the blame". In a similar way, another young woman described: "our society favors boys. Boys are generally shielded from punishment when they commit some of these offenses" (FG 1, young woman). As women are considered inferior, there are more social rules and norms dictating expectations of women's behaviour. A young man (ID 1) explained that these social rules contribute to violence targeting women and girls, providing the example of dowry rules:

> *A man cannot for any reason be denied sex when he paid dowry. This can cause a serious fight even when it comes after assault for something else and can cause reporting to elders. In most cases when it comes to sex related matters in wedded families, the women are on the losing end.* (ID 1, young man)

Forced marriage to rapists could occur due to a combination of negative perceptions of sexual violence survivors as well as family poverty, as described by a young woman (ID 4): "Sometimes parents cause the abuses such as early marriages by pushing their girls to get married to the people who rape them. This is probably due to sometimes culture and other times poverty of the parents." An elder (ID 4, woman) further described how this could lead to family silence regarding sexual violence: "Some parents encourage the daughter to keep silent to avoid shame or even the man may decide to keep quiet when abused by a woman". Women and girls are seen as lower worth or value and are

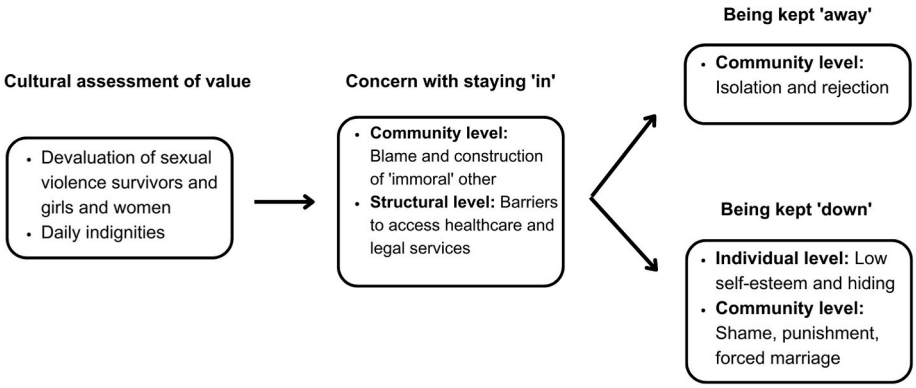

Fig. 1. Applying the Stigma Power Process Framework to sexual violence stigma experiences among refugee youth in Bidi Bidi refugee settlement, Uganda.

downwardly placed in relation to social placement. This makes it difficult to demand broader inclusion or respect and contributes to the blaming of girls and women who experience sexual violence.

3.1.3. Keeping people 'away' (community level): community isolation and rejection of sexual violence survivors

Keeping people *'away'* can be a strategy as described in the Stigma Power Process framework for community members to avoid people who exhibit what is perceived as non-normative practices. In the case of participant narratives, sexual violence survivors were socially distanced due to their perceived deviation from social norms. Indeed, a young man (ID 6) described the fear-inducing nature of sexual violence survivors that motivated people to keep *'away'* from survivors, explaining that when someone is assaulted the "community members refuse to associate with such a person, calling her a curse of the community." Others corroborated that: "the victim is usually isolated, and community members refuse to associate with such a person." (ID 6, young woman). A health care provider (ID 7, woman) explained this stigma and blame can even be enacted by friends and family:

> *One of the challenges that survivors of SGBV face is stigma. When the girl is raped, people will start talking ill about her and also blaming her for what happened more, especially the friends and some family members. This leads to her isolation from people.*

Often families reinforced isolation and rejection of survivors. For example, "one girl who suffered sexual violence was rejected by her grandmother. She threatened to walk away from home if the survivor returned to where they used to live." (FG 1, young man). A healthcare provider (ID 2, woman) noted that there is "no support from family and colleagues," and at times survivors were afraid that their parents could force them "to live with either HIV or getting pregnant." Anticipated community mistreatment and isolation could result in survivors self-isolating, where they: "will run away from home because of the fear that the community will not accept them again and they think this is the best way." (FG 2, young woman). The expectation of potential rejection by the community can result in survivors feeling forced to stay away.

3.2. Concern with staying in: structural level

Awareness and experiences of mistreatment of sexual violence survivors at family and community social-ecological levels produced concerns with staying *'in'* socially accepted norms. This could at times result in secrecy, concealment, and avoiding structural level supports and services offered in healthcare and legal systems. In this way, the various types of stigma experienced at interpersonal and community levels could present barriers to engagement in structural level support services.

3.2.1. Keeping people in (structural level): barriers for sexual violence survivors to access post-rape healthcare

In addition to enacted stigma that manifested as mistreatment at the community level, at the structural level stigmatizing healthcare practices reduced the quality of healthcare received by survivors while also presenting barriers to healthcare engagement. One of the main concerns described by sexual violence survivors was confidentiality breaches within healthcare services. An elder (ID 6, man) explained this as underlying survivors' hesitancy to receive formal support:

> *There is no confidentiality among the community, counsellors or even the police. There are no women centers in some of these villages to report such cases freely. Others are injured and have to live with the scars which are clearly seen and embarrassing. Socially, they have stigma in accessing health care because there is no confidentiality among some healthcare providers.*

This narrative underlines the structural barriers to accessing health and legal services, including confidentiality breaches, that reflect anticipated stigma. Moreover, increased visibility of sexual violence victimization via scars and physical injuries can exacerbate stigma. Practitioners fail to meaningfully respond to survivors and at times mistreat survivors, reflecting enacted stigma. For example, some healthcare providers may lack empathy and compassion towards sexual assault survivors; "Some survivors also have fear for other health providers as most of them can be harsh to them." (ID 7, healthcare provider, woman). Some healthcare providers can also blame survivors, underscoring the structural barriers in health systems which lead to concealment of abuse history.

To avoid confidentiality breaches and mistreatment, participants described that sexual violence survivors often avoided going to healthcare centers to access or complete post-rape care services. A young man described the importance of secrecy among sexual violence survivors: "They [survivors] say going to the health center will just expose them to a scorning community. So, they rather keep quiet and everything disappears in thin air. At least no one will ever know she was raped" (ID 6, young man). This avoidance of healthcare engagement due to fears of being scorned is another example of anticipated stigma (fear of mistreatment) and also reflects perceived stigma (awareness of community devaluation of sexual violence survivors). Healthcare providers noted that after being given post-exposure prophylaxis (PEP) to prevent HIV acquisition post-rape, "they [survivors] are supposed to come back after 3 months for a follow-on HIV test but normally they don't" (ID 3, healthcare provider, woman). Clinical post-rape care includes PEP alongside emergency contraception to prevent unplanned and unwanted pregnancy; however, the fear of accessing post-rape healthcare can lead to scenarios where the survivors "report late and get either infected with HIV or get pregnant" (ID 7, healthcare provider, woman). In other cases, survivors may utilize traditional practices in lieu of, or before accessing, formal healthcare: "Some survivors opt for witchcraft and when their

health becomes worse, is when they look for a hospital which endangers their lives" (ID 9, police, man). These avoidance techniques are a response to healthcare practices which can result in enacted and anticipated stigma for sexual assault survivors.

3.2.2. Keeping people in (structural level): constrained access to legal services

Participant narratives described that survivors often intentionally avoided exposing themselves to places where they could experience sexual violence stigma, such as legal systems. This avoidance of legal systems is indicative of anticipated stigma at the structural level. As a police officer (ID 9, man) explained:

> *Survivors develop stigma and self-isolate themselves from the rest of the community. They hide and kill the evidence and can't get proper legal and health support. The young girls who get raped delay to go for emergency pills, hence get pregnant.*

This narrative also described the social and health consequences, such as unplanned pregnancy, resulting from not accessing formal support. Participants noted challenges experienced with the integration of legal and healthcare support: "There is a slow process of support at the health facilities, police delay to follow-up, nurses keep giving excuses" (FG 1, young woman). Others describe a lack of access to justice after reporting sexual violence to the legal system:

> *Apart from reporting the case to police, nothing much is being done to help survivors. And when the perpetrator is not caught in action and disappears it is very difficult for the survivor to open up a case because they will not [have] enough evidence. So many raped girls whose perpetrators disappear don't even bother reporting to police let along go to the health facility* (ID 6, young man).

This narrative suggests that the perceived limited support services for survivors, alongside potential challenges accessing sufficient evidence, can result in a lack of engagement with law enforcement to access justice.

3.3. Being kept down: individual level

As a result of the negative cultural evaluations of sexual violence survivors, participants described that survivors often experienced shame, low self-esteem, and in turn may self-isolate or hide. As a young woman (ID 2) explained: "the community, as a community, has not helped us enough, we battle out the post rape shame ourselves by keeping quiet and suffering". This shame and mistreatment could keep survivors down by cultivating feelings of low worth as: "stigmatization affects their social life in the community. This can make them feel outcasts, rejected, and worthless" (FG 1, young man). Others linked negative social attitudes with survivors' poor self-worth, describing that survivors often experience low self-esteem "due to public criticism and mockery in some cases." (ID 5, elder man). This internalizing behaviour, reflective of internalized stigma, is a response to the downward placement of both women and girls and sexual violence survivors as the community level.

Feelings of shame and fear of exposure can keep survivors down through resulting in survivors isolating and concealing experiences of sexual violence: "Some community members stop survivors to report issues because they fear being exposed. Others do not report due to stigma. They feel being isolated, hiding is the best" (ID 3, elder woman). In response to internalized stigma and specifically shame, some survivors may leave the refugee settlement. A desire to withdraw is exacerbated for women and girls, as explained by a young man (ID 3) "many [survivors] feel victimized and withdrawn to themselves, especially women. This is basically because of shame. Some survivors even escape and leave the camp."

3.4. Recommended solutions to support sexual violence survivors

Participant narratives also reflected suggestions for supportive actions. One young man (ID 3) described needing to improve care and love at the community-level for survivors, suggesting this could improve access for healthcare, legal services, and could reduce isolation:

> *The community should receive and love these people instead of isolating or chasing them away. This would help stop instances where girls hide information or escape from home. They should advise the person to go for medical checkup and also report the case to police.*

Others described community-based solutions led by survivors themselves. For instance, an elder (ID 4, woman) described the benefits of a local survivor-led women's organization:

> *In my village one of the survivors is a businesswoman after the counselling and is helping many other to learn from her. There are women who visit the survivors in their homes, advising them to join organized women groups who engage in many activities like handicrafts, farming and even learn how to do business.*

This quotation also raises the issue of economic opportunities and business training for survivors. Another suggestion raised by participants is supporting survivors to continue their education, as focusing on one's studies can help the survivor "cope with the whole situation since she hopes to go ahead with her studies" (ID 5, young man). Together, activities that supported survivors to look toward the future and have hope in increased life opportunities, could support survivors' coping with sexual violence related challenges.

4. Discussion

Taken together, participants discussed that sexual violence stigma was experienced in Bidi Bidi in ways that reduced the value and dignity of young survivors. This was interconnected with the lower social status and power afforded to girls and women compared with boys and men. Sexual violence survivors were shamed as 'immoral' and 'deserving' of the violence they experienced, reflecting concepts from the Stigma Power Process framework (Link and Phelan, 2014) regarding how stigmatizing persons as 'immoral' operates to keep people *'in'* the dominant social order, reinforce norms, and set examples for others in the community of what is deemed socially acceptable. Fear of being shamed, blamed, and wanting to keep 'in' socially accepted norms, in turn presented barriers for sexual violence survivors to access healthcare and legal services. Blame and punishment from communities, including forced marriage, further kept sexual violence survivors who were largely girls and women in social positions with lower access to power and resources—keeping them 'down' and maintaining perpetrators (mostly boys and men) in positions of power and advantage. Participants discussed the ways that familial and community rejection and isolation of survivors kept them *'away'* from the community. Our findings can inform sexual violence programming and stigma reduction that addresses the wide-ranging effects of sexual violence with refugee adolescents and youth in LMIC.

Findings align with past research on how sexual violence survivors in conflict-settings experience *felt stigma*, including being treated badly by family, community members, and feelings of shame and wanting to hide; and *enacted stigma*, including being abandoned and rejected by families (Ba and Bhopal, 2017; Murray et al., 2018). This lack of family support for young sexual violence survivors detailed in our study presented barriers to accessing post-rape healthcare and often resulted in silencing and banishing survivors. Other healthcare barriers discussed by participants included confidentiality concerns in healthcare settings and feeling blamed or treated harshly by providers. These findings corroborate research with both conflict-affected youth (Amone-P'Olak et al., 2018) and adults (Chynoweth et al., 2020) and youth in non-conflict setting such as Kenya (Wangamati et al., 2020) who reported barriers

to post-rape care, including a perceived lack of empathy, stigma, and a lack of confidentiality.

Participants also detailed how hiding and destroying evidence of sexual violence to avoid being stigmatized produced barriers to engaging with legal support; this fear of stigma converged with a perceived lack of efficacy in the legal system to reduce refugee youth's access to justice. This reflects findings on IPV in three refugee settlements (Kenya, Iraq, South Sudan) with adult women, who viewed formal services as a last resort due to the stigma and social consequences of disclosing violence (Horn et al., 2021). Together these findings indicate the need for healthcare provider and police training and skills development for trauma-informed care and sexual violence stigma reduction with young refugee sexual violence survivors; acquiring resources and time for such comprehensive training may be particularly challenging in resource-constrained humanitarian settings (Kwiringira et al., 2018). This training could also integrate youth-friendly service delivery (James et al., 2018) and adolescent SRH stigma reduction (Logie et al., 2019a) to ensure refugee youth can access competent care.

While aligning with the Stigma Power Process framework, our findings also build on various conceptual approaches to sexual violence stigma. First, Barnett et al.'s study on intimate partner violence (IPV) stigma experienced by adult women in Kenya found that stigma processes operated to exert social control of the 'moral order' (Barnett et al., 2016). Stigma from this perspective is conceptualized as a relational social process that operates to maintain current power dynamics and enact social functions, particularly serving to 'get things done' and show what matters and who/what is valued in the social order (Barnett et al., 2016). They discuss that "violence and stigma work together in a context of inequitable, gendered power arrangements as mechanisms of social control that maintain that inequitable distribution of power" (p. 14) (Barnett et al., 2016). This was reflected in our study findings, whereby sexual violence stigma blames women survivors (not men perpetrators) thereby reflecting and reinforcing social devaluation of girls and women, as illustrated in the quotation we shared earlier by a young man (ID1): "Our culture elevates men than women, thus many rules are against women and girls."

Our findings also builds on Overstreet and Quinn's (2013) model of intimate partner violence (IPV) stigma among adults that posits cultural stigma (negative societal beliefs and ideologies regarding IPV survivors) can lead to anticipated stigma and internalized stigma, and all three manifestations of stigma can reduce help-seeking practices. Participants in our study, as illustrated in the results section, internalized shame and even went so far as to leave the settlement due to anticipated stigma. We also found stigma from various actors—families, community members, health providers—reduced engagement with healthcare and legal support systems. This model also discusses the importance of considering how concealability of IPV shapes stigma experiences (Overstreet and Quinn, 2013). Concealing sexual violence victimization also emerged in our findings, ranging from a lack of disclosure, to avoiding engaging in health or legal support services, to destroying evidence of sexual violence.

Participant narratives reflected how sexual violence stigma was linked with notions of *controllability* (Crocker et al., 1998), whereby survivors were blamed for their own victimization attributed to their behaviour (e.g., "people will say the girl looked for it because she dresses to tempt the men"). Narratives also align with stigma archetypes of the *'unhealthy other'* (Goffman, 1963) where survivors were perceived as physically damaged (e.g., "a girl who already had sex is 'deformed'"), and the *visibility* of the stigmatized condition exacerbated stigma experiences ("Others are injured and have to live with the scars which are clearly seen and embarrassing"). Together, these varied conceptual approaches hold potential for exploring how sexual violence stigma reducing interventions and programming need to center power and the multiple dimensions and levels of stigma that span structural, community, and individual dimensions. Thus, sexual violence healthcare and police provider trainings and police, and community-level stigma reduction initiatives in Bidi Bidi, could directly address these underlying biases regarding control, damage, and visibility. For example, training relating to addressing stigmatizing practices in a healthcare setting could address some of the structural barriers (such as reducing blaming attitudes, setting up youth-friendly services, confidentiality training) to improve survivors' post-rape care access. Moreover, programs could engage with community leaders such as traditional healers to connect with survivors and provide culturally tailored support, community stigma reduction, and linking survivors with formal and informal support across a range of actors (e.g., healthcare, legal, educational, religious, community leaders, traditional healers).

Participants reported several suggestions regarding reducing sexual violence stigma. These spanned structural approaches (i.e., supporting refugee youth survivors to continue their education, access healthcare, and access livelihood support), community norms (e.g., improving community attitudes toward survivors), and social cohesion (i.e., connecting survivors with grassroots survivor support groups). Some of these participant suggestions align with prior work with adult women survivors in Northern Uganda, including support and engagement with survivor-led grassroots organizations and increasing access to economic opportunities for survivors to enhance self-sufficiency (Woldetsadik et al., 2022). Studies with conflict-affected survivors provide recommendations that could also be applicable to refugee youth in Bidi Bidi, including: integrating mental health care for survivors into general healthcare and community support systems; building capacity of community health workers—including survivors—in providing psychosocial support; engaging elders, community leaders, and faith leaders in reducing stigma; family mediation and counselling; engaging boys and men; and implementing group psychotherapy approaches with established efficacy in conflict-affected settings (Amone-P'Olak et al., 2018; Kelly et al., 2017; Koos and Lindsey, 2022; Woldetsadik et al., 2022).

Our application of the Stigma Power Process framework (Link and Phelan, 2014) can advance understanding of sexual violence stigma as experienced by refugee youth (as illustrated in Fig. 1). By examining motivations for stigma where stigma is understood as "the power mechanism of choice" (p., 2) (Link and Phelan, 2014), we can see in participant narratives how this power operates across multiple social ecological levels. At the *community* level, survivors are shamed as deserving of violence to keep people *'in'* line with social norms regarding (im)morality; girls and women who experience sexual violence victimization are blamed and punished (including through forced marriage) and this further keeps them *'down'* below boys and men in the social hierarchy; and survivors are rejected and isolated as deviant to keep them *'away'* from families and communities. Survivors may be afraid of community devaluation and rejection and in turn want to keep *'in'* socially accepted norms, and this can manifest at the *structural* level through avoidance of accessing formal support from healthcare and legal systems. These experiences can be internalized and ultimately result at the *individual* level in self-isolation, hiding, and lower self-esteem—all preventing survivors from realizing their full potential. This concern with staying *'in'*, felt so strongly to the extent where young refugee survivors may destroy evidence of their sexual assault, reflects a stigma consciousness that extends beyond concepts of internalized stigma (Link and Phelan, 2014) to signal larger ideas of how people may enact agency in contexts of constrained power (Logie and Daniel, 2016; Mannell et al., 2016 Mannell et al., 2016) and warrants further exploration.

This Stigma Power Process framework integrates Bourdieu's concept of *symbolic power* (Link and Phelan, 2014) which is also reflected in our findings. Symbolic power conceptualizes how: power is enacted through cultural notions of value and worth (participants described devaluing and lower worth ascribed to survivors and women/girls); cultural notions of value influence socially disadvantaged persons to accept their devaluation and lower social status (participants discussed self-isolation and low self-esteem); power mechanisms that operate through stigma practices are often hidden within larger notions of cultural norms

(participants situated sexual violence stigma within larger social contexts where girls/women were punished and less favoured than boys/-men) (Bourdieu, 1986, 1987, 1990). This highlights the need to expose and address how power relations are central to (re)producing sexual violence stigma with refugee youth. Conceptualizing sexual violence stigma as a mechanism to keep people 'down', 'in', 'away' can be applied to develop stigma reduction strategies targeting various actors (e.g., family, community members, police, healthcare providers), stigma manifestations (e.g., enacted, internalized, felt), and structural stigma (policy, laws, social contexts, institutional practices) (Link and Phelan, 2014; Stangl et al., 2019). This framework opens up multiple intervention possibilities, including gender transformative approaches to work with people in positions of power (e.g., men, community leaders) as agents of positive change through raising awareness and reflection on stigma as a harmful power mechanism and to shift social hierarchies, rape myths, and underlying harmful attitudes (Foster et al., 2017; Gibbs et al., 2017; *What works to prevent violence against women and girls in conflict and humanitarian crisis, 2016*). This work requires long-term investment in efforts spanning community, healthcare, education, legal, and family systems.

5. Study limitations and strengths

There are study limitations. First, questions on sexual violence stigma were embedded within a larger SGBV prevention study, so we did not explore the intersection of sexual violence stigma with other forms of stigma (e.g., HIV, sexual orientation). Second, most narratives focused on the lived experiences of refugee adolescent girls and young women, resulting in limited understanding of the ways through which sexual violence stigma affects refugee adolescent boys and young men. Third, our sample of service providers included 8 health care practitioners and 2 police officers; insights could be enriched through including a greater range of police officers and humanitarian actors. We did not include traditional healers, or spiritual/religious leaders, and future studies can include these stakeholders to increase perspectives on culturally relevant local solutions to sexual violence stigma. Finally, there was not a focus within the interview guide on solutions for reducing sexual violence stigma or stigma resistance; this could be further examined in future research.

Despite these limitations, our findings address knowledge gaps regarding adolescent and youth post-rape clinical care in humanitarian settings (Singh et al., 2018a, 2018b). We highlight that without addressing contexts of gender inequity and the devaluing of survivors as 'immoral' and 'damaged' in community and family norms, it is unlikely that most refugee adolescents and youth would choose to engage with healthcare and legal systems for fear of further stigmatization and negative social ramifications. Post-rape clinical care hence can be one component of a multi-level strategy to advance health and human rights of young sexual violence survivors in LMIC humanitarian settings.

6. Conclusions

This study presents perspectives on sexual violence stigma among refugee adolescents and youth in Bidi Bidi, Uganda. Findings suggest the need for an intersectional stigma approach (Berger, 2010; Turan et al., 2019) with young refugee survivors that considers how gender inequity, refugee status, and younger age converge with community norms that frame sexual violence survivors as 'immoral' and 'damaged' to reduce access to power and resources. This study signals the importance of understanding how sexual violence stigma works as a mechanism of power to keep survivors *'in'*, *'down'*, and *'away'* to maintain social hierarchies while preventing survivors from realizing their full health, life potential, or human rights. Sexual violence stigma operates at community levels (norms and values regarding sexual violence and gender relations), structural levels (healthcare, legal systems), and is internalized by individuals, so responses similarly need a multi-level approach (Michau et al., 2015). Moreover, findings call for further sexual violence stigma research and interventions with and for refugee adolescents and youth where they are meaningfully engaged in program design, delivery, and evaluation.

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CRediT authorship contribution statement

Carmen H. Logie: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Moses Okumu:** Conceptualization, Methodology, Investigation, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Madelaine Coelho:** Formal analysis, Writing – original draft, Writing – review & editing. **Miranda G. Loutet:** Formal analysis, Investigation, Writing – review & editing, Project administration. **Isha Berry:** Investigation, Writing – review & editing, Project administration. **Simon Odong Lukone:** Conceptualization, Methodology, Investigation, Writing – review & editing, Supervision, Project administration. **Nelson Kisubi:** Investigation, Writing – review & editing, Project administration. **Daniel Kibuuka Musoke:** Conceptualization, Methodology, Investigation, Writing – review & editing, Supervision, Project administration. **Peter Kyambadde:** Conceptualization, Methodology, Investigation, Writing – review & editing, Project administration.

Declaration of competing interest

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Appendix A. Supplementary data

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