

Communities Care: An Integrated Community-Based Sexual and Gender-Based Violence Intervention in Uribia, Colombia

Endline Evaluation Report

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Acknowledgments

The research team comprised co-principal investigators Dr. María Cecilia Dedios Sanguinetti and Dr. Ángela María Guarín Aristizábal, research assistants Ariana Catalina Torres García, Isabella Yacelly Acosta, and Santiago Nicolás Rojas Valencia (at endline) of Universidad de los Andes, Colombia, and Principal Investigators Katherine Gambir and Dr. Julianne Deitch of the Women's Refugee Commission, USA. The field team at endline was composed of two male and nine female enumerators.

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This study is part of a multi-country research initiative under WRC's Communities Care Project, a multi-country sexual and gender-based violence (SGBV) innovation project aimed at expanding access to quality and timely sexual violence medical and psychosocial care in humanitarian settings.

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Introduction

Profamilia, in partnership with the Women's Refugee Commission (WRC), implemented the Communities Care program, seeking to facilitate care-seeking behavior and timely uptake of care by survivors of sexual and gender-based violence (SGBV) in Uribia, La Guajira, Colombia. The project entailed a monitoring and evaluation (M&E) component carried out by Universidad de los Andes School of Government (UniAndes), consisting of a mixed-methods, quasi-experimental design to assess the effect of the Communities Care intervention. The evaluation aimed to determine the efficacy, feasibility, and safety aspects of the Communities Care model in a humanitarian context. This report documents the endline research process and evaluation findings of the Communities Care intervention in Uribia, comparing the baseline (Dedios et al., 2024) and endline findings.

Methodology

The Communities Care Intervention

The *Communities Care program model* is a two-component intervention in which community health workers (CHWs) are trained to deliver (a) community-based referrals to facility-based care for survivors of SGBV and (b) community sensitization activities using gender-transformative approaches. In Colombia, Profamilia's community sensitization programming included both medium- and large-scale group activities and home visits to deliver information about SGBV, its consequences, the benefits of seeking help, and information on where to find care and support. The *Communities Care* project was implemented in an informal settlement located in Uribia over nine months (July 2023 to February 2024), through household and medium- and large-scale activities. Additional information about the project can be found in the Lessons Learned Report.

Community Advisory Board (CAB). A CAB was convened for this project. CAB members were community leaders with intimate knowledge of gender norms and community knowledge, attitudes, and practices about gender and gender-based violence (GBV). Their role in the evaluation was to provide feedback and suggestions to evaluation instruments, ensuring that all tools were culturally and contextually appropriate. The CAB comprised 21 community stakeholders from Uribia.

Study Design

We used a mixed-methods, quasi-experimental longitudinal design to (a) assess the effect of the *Communities Care* intervention and (b) determine the efficacy, feasibility, and safety aspects of the *Communities Care* model in this humanitarian setting. Pre- and post-intervention data collection was conducted before program implementation (baseline) and immediately after (endline) and included surveys and participatory focus group discussions (FGDs) with program participants in the intervention site and community members in the comparison site. Qualitative data was also collected at the intervention site through key informant interviews (KIs) with project staff, CHWs, and community leaders. Monitoring data was collected throughout the implementation period. The question answered by this design is not only whether the site that received the intervention had an improvement or change, but also whether the intervention site improved or changed more than the comparison site. Baseline data collection allowed the identification of systematic differences between the intervention and comparison sites. This information helped inform the analysis to estimate the effect of the intervention, controlling for systematic baseline differences between sites.

Setting and Population

Both study sites were informal settlements located in the periphery of the city of Uribia, in the department of La Guajira, Colombia. The actual names of the communities are confidential to protect the privacy and safety of study participants. Uribia has the highest incidence rate of municipal multidimensional poverty in La Guajira: 92.2 percent of its population lives in multidimensional poverty (DANE, 2020). These sites were intentionally selected based on their similarities regarding the population's sociodemographic composition (including Indigenous Wayuú communities and Venezuelan refugees and migrants), the low availability of health facilities, and no availability of community-level provision of medical and psychosocial care for survivors of sexual violence (SV).

Sampling Procedure

Quantitative sample. The selection of participants followed a different strategy at each site. In the intervention site, we conducted nine community assemblies to collect basic demographic and contact information for people who intended to participate in the intervention. The list of potential participants included 554 people. The anonymized list of community members who indicated interest in participating in the intervention and research activities included each person's sex, marital status, and age, and was shared with the data collection team, managed by the Centro Nacional de Consultoría (CNC). The CNC randomly selected research participants from the list, following quotas per subgroups established by the research team. This yielded the study sample in the intervention site (n=337). The sample in the comparison site was obtained using the National Geostatistical Framework of the National Administrative Department of Statistics (n=352).

The following quotas were implemented for the selection of participants in both sites:

- a. a minimum of 50 percent of Venezuelan refugees and migrants
- b. at least 26 percent of participants between 13 and 19 years old, 61 percent of participants between 20 and 49 years old, and 13 percent of participants 50 and older
- c. at least 32 percent men and 58 percent women.

The inclusion criteria for participants were 13 and older, living in the sites, and providing informed consent or informed assent to participate. The exclusion criteria were being under 13 years of age, not living in the selected sites, and not providing informed consent or assent to participate.

At endline, we aimed to survey individuals who participated in both the baseline evaluation and, for those in the intervention site, in program activities. Acknowledging that there is significant in- and out-migration across the border with Venezuela, once baseline evaluation participants had been exhausted at the intervention site, individuals who had been a part of the intervention and had the same demographic characteristics required to reach the quotas were contacted. In the intervention site, the endline sample consisted of 319 participants. In the comparison site, once baseline evaluation participants had been exhausted, the CNC performed household visits in the community to survey individuals with the same demographic characteristics to reach the quotas, reaching a final sample of 311 participants.

Qualitative Sample. The qualitative sample was selected through an intentional sampling strategy. Homogenous purposive sampling was used to identify key informants (KIs) from Profamilia program staff, participating CHWs, and members of the CAB, given their crucial role in the intervention implementation or their role in the community. KIs were conducted at baseline and endline.

Participatory FGDs were conducted with community members. FGD participants were selected using a purposive maximum variation sampling strategy across age, gender, and ethnic group. Refer to annex Tables 1 to 3 for more information on the qualitative sample. (Tables can be found in the annex at https://www.womensrefugeecommission.org/wp-content/uploads/2025/04/UTF-8Communities-Cares-GBV-Colombia_TABLES_FINAL-1.pdf).

Study Instruments

WRC and UniAndes co-developed the data collection instruments, which were validated by the CAB. The quantitative data was collected through a knowledge, attitudes, and practices (KAP) survey. This survey was designed to understand community members' KAP about SGBV, including health-seeking behaviors, service availability, and service uptake. The KAP survey also included a demographic section.

Two interview guides and one FGD guide were developed for the evaluation, as described below:

1. KII guide (program staff, including CHWs): The semi-structured interview guide was designed to understand project staff and CHWs' experience delivering the intervention and the staff's understandings of and attitudes about SGBV. These interviews were implemented in the intervention community only with CHWs, project supervisors of CHWs, and program staff.
2. KII guide (community leaders): The semi-structured interview guide sought to explore the community leaders' knowledge and attitudes about SGBV, their knowledge of SGBV services and programs, and CHWs' capacity to prevent and respond to SGBV. These interviews were implemented in the intervention and the comparison sites.
3. FGD guide (community members). The semi-structured FGD guide comprised participatory group activities and was designed to explore the communities' understanding of gender and SGBV; knowledge and attitudes about SGBV referral services; and the *Communities Care* participants' perception of the changes propelled by the program, also known as *Stories of Change*.

Procedure

Both the quantitative and qualitative data were collected at baseline in the intervention site and the comparison site between August and September 2022, and at endline between March and April 2024. The CNC led and oversaw data collection in both sites. Following IRB approval, the CNC team was trained by UniAndes and WRC on the objectives of the study, research ethics, and data collection instruments. Field teams included interpreters to support data collection in Spanish and Wayuunaiki, the language of the Wayuú communities. Male enumerators interviewed boys and men while female enumerators interviewed girls and women.

Participants received incentives to offset the time and costs for participating in research activities. Survey respondents received 15,000 Colombian pesos (COP) (US\$3.5), while FGD participants received 30,000 COP (US\$7), as this activity was lengthier. Profamilia program staff, CAB members, and CHWs did not receive any incentives to participate in the study.

Data Management and Analysis

Quantitative data

Quantitative data was collected on smartphones using electronic questionnaires programmed with

Open Data Kit (ODK) software. Back-to-back encryption was implemented to protect respondents' data. The finalized datasets were stored in a secure, password-protected cloud-based software available only to the research team. At baseline, descriptive statistics and tests of differences were conducted to understand whether there were statistically significant differences between the intervention and the comparison site.¹ At endline, we assessed differences in key project outcomes between intervention and comparison sites at both baseline and endline, calculated the difference between the two sites, and analyzed the intensity of change in key outcomes over time. All the analyses were conducted in Stata 17.

In addition to the descriptive analysis, we conducted a robust analysis of the direct association between outcomes and the two main variables of interest: the time (baseline versus endline) and the community (intervention versus comparison). The analyses were performed using multiple linear regression with control variables, in which we analyzed changes between communities and over time. Descriptive statistics showed the difference in outcomes between and within sites but did not account for the potential influence of the program. Therefore, multiple linear regression assessed the potential influence of the program on key outcomes, as it allowed us to control for baseline differences and evaluate the condition of both sites after the intervention. We included two main variables ("InterventionSite" and "Endline"), as well as the interaction term "InterventionSite x Endline." We also used demographic and socioeconomic characteristics variables. Furthermore, we conducted subgroup analyses by sex, age, marital status, and migration status to better understand the differential results within these categories (See Table 3 to Table 10). For further information on the variables and subgroups included in this analysis, refer to the methodology annex (MA1).

The key results were interpreted from the coefficients of three variables: i) "InterventionSite x Endline" was the main variable we considered as it captured the combined effect of being in the intervention site at the endline and assessed changes in pre-existing differences between communities. The interaction term indicates the relative change in the intervention community compared to the comparison community. ii) "Intervention Site" representing baseline differences between the intervention site and the comparison site. iii) "Endline" indicating changes from baseline to endline in the comparison site. The interaction term's coefficient indicates an increase or decrease in the number of participants responding positively to the outcomes (e.g., feeling safe) over time, controlling for key characteristics. A statistically significant change is noted when $p\text{-value} \leq 0.1$.

Qualitative data

Qualitative data from KIs and FGDs was audio-recorded and transcribed verbatim and translated from Wayuunaiki to Spanish, as needed. The research team developed, piloted, and implemented a codebook using an iterative process. Any discrepancies between coding were resolved through discussion-based consensus and adaptations to the codebook. Each transcript was uploaded to NVivo 14 Plus for thematic analysis. Thematic network analysis was used to generate relevant themes associated with community understanding of SGBV and gender equality (Braun and Clarke, 2021). Key themes were further explored across study sites and KI affiliation or community subgroup to explore linkages and discordances in the data. Differences between baseline and endline were evaluated by comparing the appearance of new themes, codes, and categories of the core analysis concepts of "gender," "GBV," and "help seeking behavior."

1 Significant differences are indicated in the text in parentheses (Table 2) by showing the statistical significance of tests for differences as follows: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.10$. We use 0.05 as the most commonly used threshold for statistical significance but also included a more stringent (0.01) and a more relaxed threshold (0.10).

Analysis limitations

Results should be interpreted with caution due to several limitations described in detail in the Discussion (p. 14), namely, a similar intervention was implemented by another organization in the comparison site, limiting the validity of our findings.

Ethics

Ethical approval was obtained from the Universidad de los Andes Research Ethics Committee (certificate no. 1506) prior to conducting the study. The research team obtained informed consent and assent prior to all data collection activities. Names and other identifying information used for recruitment were recorded in a separate document from the study data, and this document was shredded immediately following data collection. The study team provided an information sheet for each respondent with the research team's contact information and directions for anonymous reporting channels as per safeguarding policies. Activities were audio-recorded with the respondents' consent. Any names mentioned during the research activities were deleted during transcription. A psychological first-aid protocol was developed and implemented during data collection. Additionally, a referral pathway was available for participants who reported cases of SGBV and for those who required referral to emergency mental health services.

Key Findings

Overall survey participants

Table 1 presents the demographic characteristics of the KAP survey participants in each site at baseline. Overall, we found significant differences between the intervention site and the comparison site in several demographic and socioeconomic categories. These include language spoken, marital status, reported disabilities, main activities during the last week, food security, highest education level, and literacy rates. Additionally, we found differences in time spent in Colombia, nationality, and types of identity documents held (identity card, temporary protection permit, and migration card). These baseline differences underscore each community's distinct characteristics, most of which were controlled for in the model and are essential for interpreting the intervention's outcomes.

Interview and FGD participants

We conducted 30 FGDs at baseline (N=216) and 30 FGDs at endline (N=207). The complete breakdown by subgroup and site is presented at Table A1 in the Appendix.

We conducted 31 KIIs at baseline (N=22 in the intervention site and N=9 in the comparison site). At endline, we conducted 22 KIIs (N=15 at intervention site and N= 7 at comparison site). These KIIs included community leaders and CHWs. Tables A2 and A3 in the Appendix present the number of interviews by type of interviewee and site (at baseline and endline), as well as the participants' leadership classification.

Comparative analysis of changes in key outcomes

Table 2 shows the percentage of participants who responded affirmatively to the outcome-related question (the description of each outcome and score is explained below). This percentage is shown by time of the survey (baseline or endline), site (intervention site or comparison site) and allows a

preliminary descriptive visualization of the differences between communities and over time. The last two columns contain the coefficients of the multivariate regressions, establishing whether there is a robust relationship between the outcomes and the variable “InterventionSite x Endline.” Results are shown for two regressions: one excluding and the other including the control variables that account for differences in the two sites at baseline. The outcome variables used in the analysis are shown in Table 11, and the scales used are presented in the methodology annex (MA2).

Additionally, Tables 3 to 10 present the subgroup analysis, which follows a similar structure to Table 2 but includes only the regression results with control variables and reports the interaction term “InterventionSite x Endline.” The subgroup analysis stratifies the data by sex (men vs. women), age (young, 13–19-year-olds vs. adults 20+), marital status (living together or married vs. single), and migration status (Venezuelan migrants vs. non-Venezuelan participants) to better understand the differential results within these categories. The interaction term reflects whether the intervention had a statistically significant influence within each subgroup, such as “InterventionSite x Endline” for men or women, for example. For men, the analysis compares men in the intervention site with men in the comparison site, assessing the specific impact of the intervention on men by comparing those who received the intervention with those who did not.

Community members’ sense of safety and well-being (KAP Survey).

A greater proportion of survey participants reported feeling safe than unsafe in both sites at baseline and endline. However, more participants reported feeling safe before the intervention than after in both sites, although these differences were not statistically significant at the intervention site (Table 2). Additionally, several participants from the intervention site expressed throughout the FGDs feeling disappointed that SGBV are still prevalent in their community despite the *Communities Care* program.

“[I would have liked that after the program] the streets would have been safer, but everything remains the same. I would have liked for people to change regarding respecting others for their gender, whether they are lesbian or anything else, and for people to change their way of thinking. But a woman does not feel safe alone because men harass her.” (FGD with young non-Wayuú women)

Regression results indicate that participants in the comparison site reported feeling significantly less safe over time when controlling for key characteristics at baseline (Appendix Table A6). In contrast, the intervention led to a relative increase in the feeling of safety compared to the control site. While the general trend showed a decrease in safety over time, the intervention mitigated this decline in the intervention site, resulting in a relatively higher feeling of safety in the intervention site compared to the control site.

Finally, women in the intervention site had a significant increase in their sense of safety (Table 3), while this feeling decreased to a lesser extent in the intervention site compared to the comparison site (at a significance level of 10 percent) for those aged 20 years or older and those who are married or living with a couple (Tables 6-7).

Community members knowledge and attitudes towards GBV.

Awareness of GBV (KAP Survey)

Awareness of GBV significantly increased from baseline to endline at both sites, with nearly twice as many participants reporting having heard the term GBV at each location (Table 2). Controlling for key differences at baseline, the comparison site experienced a significant increase in awareness of GBV over time (Endline indicator, Appendix Table A6). However, the intervention was not associated

with a significant change in awareness of GBV compared to the comparison site. The analysis for subgroups only showed statistically significant differences after controlling for key differences among Venezuelan refugees and migrants, the increase in the proportion of people who knew the GBV term was lower in the intervention group than in the comparison group (Table 9).

Community members' knowledge and attitudes towards SV.

Knowledge of SV (FGDs and KAP Survey)

At baseline, participants in several FGDs in both the intervention and the comparison site expressed that they did not know what SV meant. At endline, all participants were familiar with the definition of SV, indicating that the concept had become more widely known in both locations. Two key changes in how SV was defined between sites were observed at endline. First, at baseline, adult Wayuú women and young Wayuú men in both sites believed that SV was a result of sexual desire. At endline, this belief persisted in the same subgroups in the comparison site. In contrast, only one participant at the intervention site hinted at this belief at endline. Second, participants in two FGDs in the intervention site described SV as a phenomenon rooted in control and power. Whilst this was an understanding also found at baseline, at endline participants who defined SV in this way directly attributed it to the influence of the patriarchy and patriarchal culture ("*machismo*"). This was a new theme found in the endline data set, which suggests that there has been a shift in the way participants in the intervention site understand and explain SV.

P1: "For me [sexual violence] is one of those situations, for example, when we don't want to have sex, and the man says, yes, take off your panties because I'm coming. Take off your panties because I'm coming. So, you're left... Even if you say no, no, you feel... It's like having to go to class when you feel tired, for example. But sometimes they are so *machistas* that they don't understand that." (FGD with adult Wayuú women)

Regarding the knowledge about the consequences of SV, over 90 percent of participants in both sites reported at least one consequence of SV before and after the intervention, with statistically significant increases in both sites after the intervention. After controlling for key differences at baseline (Table 2), the interaction term indicates that there is no significant difference in the change in reporting knowledge of the consequences of SV between the intervention site and the comparison site over time. Although the interaction term is positive, we cannot conclusively state that knowledge about the consequences of SV in the intervention site increased more or less than the comparison site.

In the subgroup regression analysis, the increase in the proportion of people who knew about the consequences of SV was significantly higher in the intervention than in the comparison site for the group of participants aged 13 to 19 (Table 5).

Benefits of seeking help

More than half of the participants at each site reported knowing at least one benefit of seeking help for survivors of SV; at baseline, more participants reported having this knowledge in the intervention site as compared to participants in the comparison site with more participants having this knowledge at baseline in the intervention site. After the intervention, there were statistically significant increases in this knowledge, with the number of participants knowing the benefits reaching nearly 100 percent at each site (Table 2). The interaction term in the regression results indicates that, after controlling for key baseline characteristics, there was a significantly smaller increase in the proportion of participants in the intervention site knowing at least one benefit of seeking help compared to the comparison site (Table 2).

All the subgroups of participants that maintained statistically significant changes followed the same pattern described above. The groups with statistically significant changes include women, those over 19 years of age, both married and single, and non-Venezuelan participants (Table 3, Tables 6-8, and Table 10).

Community member knowledge and access to SGBV services after *Communities Care*.

Community member knowledge of available GBV services (KAP survey and FGDs)

Before the intervention, about 40 percent of participants in the intervention site and about 30 percent in the comparison site reported knowledge about the available services that can provide support to someone who had experienced GBV. In both sites, there was a statistically significant increase in the proportion of participants who reported this knowledge at endline (Table 2). The regression results also indicate that there was a significant increase in this outcome over time in the intervention site when controlling for key differences between sites at baseline (Appendix Table A6). However, there was no significant difference in the changes in this outcome between the intervention and comparison site over time (Table 2). This implies that the intervention did not result in a significantly different change compared to the comparison site.

During baseline FGDs, participants in the intervention site discussed seeking GBV information or help mostly with family members or from community leaders. At endline, participants still mentioned community leaders, but looking for help at home was not mentioned as frequently. At baseline and endline, some FGD participants in the intervention site stated that there are no places in the community specifically designed to provide GBV-related information or help. However, at endline, some participants did identify CHWs as able to provide information or help after GBV in the intervention site. In the comparison site, participants also mentioned a lack of GBV services in the community at baseline and endline. There, at baseline, participants more often identified NGOs as sources of information or services for GBV, whereas at endline, more participants identified community leaders.

Access to GBV services

Before the intervention, less than 20 percent of participants reported having ever accessed GBV services at each site, with more participants in the intervention site having accessed services compared to the comparison site (Table 2). After the intervention, there were significant increases in the percentage of participants who had ever accessed GBV services at both sites (Table 2). Regression analysis controlling for key differences at baseline indicates that there is no significant difference in the change in accessing GBV services between the intervention and comparison sites (Appendix Table A6). Due to the small number of respondents who had accessed GBV services, there were no significant post-intervention differences between intervention and comparison sites among any subgroups (Tables 3-10).

Community member knowledge of available SV services (KAP Survey and FGDs)

Regarding knowledge of available SV services, 42 percent of participants in the intervention site and 27 percent of participants in the comparison site knew of available services at baseline. At endline, there were significant increases in the proportion of participants who reported this knowledge at both the intervention and comparison sites (55 and 41 percent, respectively) (Table 2). The interaction term in the regression analysis shows a positive but not statistically significant coefficient, suggesting that there is no significant difference in the change in reporting this outcome between the intervention and comparison site over time, controlling for key differences at baseline (Table 2 and Appendix Table A6). This finding is maintained in all regression analyses by subgroups (Tables 3-10).

FGD analysis at the intervention site suggests an increase in community members' knowledge of available SV services. At baseline, most participants in the intervention site stated that they did not have any knowledge of available services in their community and that they mainly sought help at home with their families. At endline, most participants mentioned that they would find the CHWs if they required these services, or that they would reach out to community leaders for help. Participants in several FGDs from the intervention site also identified sites to receive support for survivors of SV that were not mentioned at baseline. These findings suggest that participants not only identify where to seek help but also were willing to talk about SV more openly and outside the family group. However, most participants emphasized how inaccessible services are since they are located in Uribia, where the nearest hospital is half an hour away from the intervention site on foot. Traveling to the city was described as difficult, requiring money and time. Travel becomes impossible when the road gets blocked due to heavy rain, a common occurrence in the area.

Baseline FGDs in the comparison site showed that participants mainly mentioned receiving SV-related services through NGOs and seeking help with leaders. Discussions also focused on how participants did not know where to access SV-related services. At endline more participants in the comparison site seemed to look for help with leaders and were less likely to discuss the absence of SV services in the community.

When describing the perceived impact of the intervention, participants in all FGDs emphasized that the most significant change prompted by it was them acquiring information about SV, especially where to seek help as a survivor. Some participants emphasized that before the intervention, they or others in their community did not know where to look for help after abuse. They also mentioned sharing these learnings with family members who were not able to attend the activities. For the non-Wayuú women, participating in *Communities Care* cleared up past misunderstandings they had about the availability of SV services for survivors, learning that the hospital can provide these services to foreigners, including Venezuelans.

A key change described by participants was the perception that SV survivors would be more likely to value institutional and peer support due to the fact that they had learned about existing programs and services for survivors. Young non-Wayuú women consider that learning about referral services and their benefits is beneficial to survivors, as they do not have to disclose their abuse to people they don't trust and can go directly to the services they need. This is a clear change from baseline, where we found a major lack of trust towards institutions in the intervention site and a big social stigma regarding being an SV "victim."

Attitudes towards GBV and accessing services

The only subscale with an acceptable Cronbach's alpha was attitudes toward accessing services; accordingly, we have excluded the other subscales from this report. At baseline, both sites had a similar score (1.86 for the intervention site and 1.88 for the comparison site) on a range between one and two, where a higher score means more positive attitudes towards survivors of GBV accessing services. After the intervention, there was a slight increase in the score for both sites, but statistically significant differences were observed only for the intervention site (Table 2). The regression results suggest that the increase in support for survivors accessing services was significantly greater in the intervention site compared to the comparison site over time (Table 2 and Appendix Table A6). This positive increase was concentrated among the groups of women participants, those 20 years of age or older, living with a couple or married, and among non-Venezuelan participants (Table 3, Table 6, Table 7, and Table 10).

Safety of the *Communities Care* model

Additional risks to CHWs or survivors

Several CHWs reported risks associated with household visits and medium scale activities. Firstly, a hostile environment informed by *machismo* prevents people from talking openly about SGBV. CHWs' experienced mocking and questioning from men about the intervention activities. Some CHWs felt constant fear of male offenders and were accused to be "homewreckers" by some men in the community. On one occasion, a CHW received direct threats from a male perpetrator after a home visit with him and his wife:

"I had to talk less about, like, not go into details about violence with the guy, he is a perpetrator, because I always see him abusing a woman a lot, his wife and his daughter, he sometimes hits them, to the point of drawing blood. ... One day, we went to do a household visit to the woman's house, but he wasn't there and then he arrived. ... I gave advice to the woman and in that moment I felt threatened, because he said [to his wife] 'I don't want her to come anymore, because she's, she's polluting your mind, so if I ever see her around, I'll mess her up (*yo la jodo*)', so I did feel threatened at that time." – Community Health Worker

Secondly, some CHWs and community leaders reported that the medium- and large-scale activities had created tension between CHWs and participants, as some community members called out possible "favoritisms" because they could not invite all members of the community to the activities:

"Well, a man I don't know, he was rude with me a while ago, the day of the event of the threads, because he had already participated in the shopping activity and I explained we needed to give opportunities to another person, so he said that if he saw other people there, why couldn't he be there. ... I hope it doesn't go further than that, because men like that are a little bit problematic." - Community Health Worker

Ability of CHWs to carry out prevention and response programming (e.g., community awareness activities, household visits, identification) (KIs and FGDs)

By the end of the intervention, CHWs reported feeling confident carrying out SV prevention and response actions in their community. CHWs who felt the most confident, mentioned that *Communities Care* provided them with valuable information on SGBV care routes. They reported that this knowledge allowed them to talk to and better support survivors. CHWs who felt the least confident indicated they felt they needed to learn more tools that would allow them to respond to violence in the community. For example, they described wanting to learn more about how to provide emotional support, as talking about SV could cause emotional distress in some individuals.

Some of the CHWs were themselves domestic abuse survivors. They described how the *Communities Care* training process helped them develop positive skills to prevent and respond to violence in their communities:

"Well, yes, it did help me be better, I'll explain. I, I mentioned before, I was a victim of violence, and it affected me at the beginning of the training events they gave us, so from there they sent me to the psychologist. ... I used to think in a way, like, with rage, and the training with the psychologist helped me understand we can't act with rage. I used to say 'No, if I ever see a man mistreating someone, I'll go up to him (*'le caigo*)', I'll hit him.' ... Now I have a different way to act in case I, that's why I say it did help me a lot." - Community Health Worker

Some CHWs identify the survivors' reluctance to seek services as a main limitation of their prevention and response activities, stating they can't cross the fine line between providing information about GBV and trying to convince someone who seems to be undergoing violence to speak out:

"Well, we were welcomed, but in some cases, in some households, I felt like there was violence and, as we gave the information, one of the persons, one of the neighbors' eyes got teary, like they wanted to cry. And I thought, there's violence here, but we couldn't say anything, because in the training they told us we couldn't go deeper with people, simply give them information. But if they ever ask for help, then we can get involved. ... I felt in her eyes she needed help. She didn't want to talk. And we can't force people." - Community Health Worker

Feasibility of the *Communities Care* model

Acceptance by CHWs and community members of the community-level model as a response to SV

Throughout FGDs and KIs in the intervention site, most community participants, leaders, and CHWs expressed satisfaction with the intervention, stating a desire to continue participating and recommending implementing the intervention in nearby communities. Community members highly valued the SV information they received, especially knowing more about where to seek help. CHWs expressed satisfaction about *Communities Care*, as it provided them with an employment opportunity in a resource-scarce context and allowed them to contribute to their community.

"Mainly because I want to overcome this, because it is a way in which I can have a job, to get out, like, talking like this, from all this poverty, because we go through a lot of troubles. So, this is a way to move forward, to support my children and have new abilities and knowledge." - Community Health Worker

Participants identified five aspects of the intervention as motivating and increasing participant involvement. First, community members and CHWs perceived that the intervention worked because the activities had a hands-on approach that involved games, with participants seeing them as opportunities to get out of their daily routines and have fun. Some participants contrasted the *Communities Care* activities with other NGO interventions in which games were not involved, stating that activities were boring and felt like "attending school."

Second, Wayuú community members discussed the value and importance of having Wayuúnaiki interpreters in all activities. It facilitated their engagement in program activities, with some saying this was the first time an intervention had included Wayuúnaiki-only speakers in the community.

Third, the cultural relevance of the activities in the large- and medium-scale meetings made them enjoyable for community members. Participants particularly cited activities that included traditional Wayuú practices (weaving, Yonna dance), which enhanced interest and made Wayuú participants feel included. The intervention also appeared to successfully address some cultural barriers to service access identified in our baseline evaluation, such as lack of trust in institutional help and social stigma around being an SV "victim."

"There was also a dance within the activity, an activity where the 'Yonna' was also danced. ... The 'Yonna' is a traditional Wayuú dance, yes, it's what they used to call the 'Chichamaya,' the 'Yonna.' It's where the women dances. ... So there was something that we who were there, people who attended, they danced and explained during the process, how we could reflect on and demonstrate when there can be sexual violence within the dance and also within our community." (Community leader)

"[I liked that] they do activities related to us, like the *Chichamaya* dance, they give out something. ... Something like, for example, the activities that women do, like crafts, so that they can do that." (FGD with Wayuú men)

Fourth, visual aids like brochures and other materials given to the participants helped them remember key points and share them with other people in the community who did not attend the program activities. However, some CHWs noticed that Wayuú participants struggled with brochures written in Spanish.

Finally, the gift raffles done in the medium-scale activities were major motivation incentives for activity attendance. Participants from FGDs and CHWs remembered the activities by the incentives instead of the content presented in them. However, the gift raffles appeared to trigger conflict between community members, as well as between community members and CHWs, explaining that they resented neighbors who won raffles or being upset when the CHW didn't invite them to activities. Some FGD participants, community leaders, and CHWs believed people were not legitimately interested in the topics and just attended the activities for the incentives, recognizing this as a major barrier for the intervention's impact in the community.

P1: "There's a CHW who lives at the end of the street, and she's in charge of giving the talk or inviting those people because it's close to her. But the first thing people ask is, 'What are they going to give? What are they going to give?' "

P2: "And if you don't tell them there's going to be a benefit, they won't go. And if you give them words, 'yes, yes, we'll go,' you wait for them, and later they say, 'I got busy with this.' So it's like you end up taking care of it, but if you don't tell people they're going to get something, they won't go. It's like people don't make an effort, just as they can get a benefit from a gift or something, receiving the information is also important." (FGD with young non-Wayuú women)

Participants identified three main aspects of the intervention that hampered its success. The most prevalent problem was related to some participants reporting they didn't receive information about the scheduled activities or were not allowed to attend events due to the venue being overcrowded. The second problem identified was scheduling: activities and household visits interfered with some men's and young women's work and school schedules, impeding their participation. The third aspect that hindered the intervention's acceptance was related to their perceptions of CHWs' availability. Some FGD participants (notably non-Wayuú adult women) expressed discomfort and a lack of trust in approaching CHWs for assistance, perceiving that they were only willing to help during the activities, but not in their day-to-day lives; these participants said that they therefore preferred to seek help on their own.

P6: "The truth is that to be a CHW they should be more sociable, friendly with the community, know the community, not just on the day they are assigned to give a talk... and they don't see the person anymore."

P4: "You don't see the person anymore."

P6: "And that's what's happening in the neighborhood, that happens in the neighborhood, you see the person when you need them, otherwise, no. And how do you approach that person if you don't know where they are? On the other hand, if they visit, with kindness: 'Oh no, I'll go to María because she is trustworthy and has given me many talks, I'd rather go to her.' See? That's the idea." (FGD with adult non-Wayuú women)

Participants' recommendations for improving the intervention mainly targeted these identified problems. The most frequent suggestion was to establish a specific, consistent service delivery point where people can access SV care services in the community. Several CHWs and FGD participants stated concerns about the inefficiency of ambulances and police patrols to provide timely care for SV survivors, as traveling to Uribia, the nearest town, to seek help poses financial and time constraints and is nearly impossible in extreme (but common) weather conditions such as droughts and heavy rain.

Ability of survivors to access support services within the critical period of care

Community members reported having more knowledge on where to receive immediate care after an SV incident and expressed greater willingness to seek services at endline. At endline, participants in 11 out of the 18 FGDs stated that they would approach the CHWs if they needed information about SV and/or available services.

"I feel good when [CHWs] give a talk or provide us with knowledge, and it's like they tell us where we can seek help or what systems we can rely on or where we can go. For me ... I feel good when they give me information so I can access certain places."
(FGD with young Wayuú women)

Some participants said that they would not seek help from a CHW because they did not know them or trust them, or stated they lived very far away.

Enumerator: "And have you sought out community workers for help regarding gender violence?"

P1: "I don't know them, and I don't know where they live."

P4: "I haven't because I don't trust them."

(FGD with adult non-Wayuú women)

Among community members, difficulties accessing CHWs were perceived to be the main impediment to accessing timely services for SV. However, CHWs considered the lack of healthcare services available within the community as the main limitation to survivors' ability to access clinical care during the critical window.

For their part, CHWs expressed that they had the knowledge and desire to support survivors who approached them to access care, but that resource constraints made it challenging for them to support them throughout the entire process. CHWs would have liked to have been able to accompany survivors to the health facility, but this would have required time and monetary resources that were not necessarily available. Accompanying survivors to the healthcare services in Uribia requires time and monetary resources, which cannot always be afforded by the CHW. Furthermore, some CHWs noted a lack of emergency transportation, highlighting that available transport in the community may not be safe or adequate for SV survivors:

"Something happens here in (intervention site), the survivor has to look for a bike-taxi ('ciclo') even though they are hurt, because there's no ambulance here, there's nothing, they need to look for a bike-taxi to get to the hospital, so that's the deal, because really, how am I going to send someone abused and torn. ... The first thing we need to do is call an ambulance, activate the route ... so they can look for a bike-taxi and take them, or a motorcycle or something, because there aren't ambulances here." - Community Health Worker

Ability of CHWs to facilitate confidential referrals

Several CHWs reported that the intervention strengthened their knowledge about the importance of maintaining confidentiality, as well as looking for safe and private spaces to speak with a community member who approached them to disclose SV. To keep themselves and survivors safe, CHWs learned how to protect confidentiality and maintain privacy when working with survivors. Some FGD participants, notably young Wayuú women, emphasized feeling encouraged to reach out to CHWs about prior experiences with SV as they knew they would keep all their information confidential.

“[I would reach out to a CHW] because she explains things to us, and whatever we tell her is completely confidential. Also, her personality is super cool, friendly, and caring. And like not only with everyone at Profamilia, but also because they all explain to us, like if we don’t feel safe in this situation or if something happens to us, we have somewhere to go.” (FGD with Young Wayuú Women)

Despite the comfort of CHWs to facilitate referrals, monitoring data revealed that no one presented to a CHW for a referral to health services during the project period.

Discussion

Statistically significant findings

Overall, the intervention site demonstrated mixed but notable results on key outcomes compared to the comparison site. While general improvements in key outcomes were observed from baseline to endline in both sites, the intervention effectively mitigated declines in the sense of safety in the intervention site, resulting in a relatively higher feeling of safety compared to the comparison site. Awareness of GBV and knowledge of the benefits of seeking help for SV survivors increased significantly in both sites; however, the intervention did not produce a statistically significant differential result on these outcomes as compared to the comparison site. As noted, our analysis is limited by the implementation of a similar intervention in the comparison site during the project period.

Additionally, knowledge of available SGBV services significantly increased in both sites, but there was no significant difference in these changes between the intervention site and the comparison site over time. One key area where the intervention drove changes in community members’ KAP was in the attitudes towards accessing services: the intervention site experienced a significantly greater improvement compared to the comparison site. Importantly, the qualitative results indicate that access to the now-known services is still extremely difficult, pointing to the need to engage local health services and other institutions to meet this increased demand for care and work collaboratively with CHWs.

The subgroup analysis indicated that, in general, the same statistically significant results by site were also true for women, adults, and married individuals. For the other subgroups, results were not statistically significant due to the absence of differential results or due to small sample sizes.

Safety of the Communities Care model

Communities Care’s community sensitization activities were generally perceived as safe for CHWs and community members. Yet, the evaluation identified some important safety considerations. First, there is a general sense of insecurity and an absence of institutions that can provide safety in the community. Then, SGBV are sensitive issues that can generate a hostile environment towards CHWs,

with threats and intimidation acted out mostly by male perpetrators. This risk was particularly salient during home visits. Although the activities and information delivered during house-to-house visits was not specific to an individual household, there was still the risk that it could be perceived as such by an abuser, or that community members who opposed the program or disagreed with the information could pose a risk to the safety of family members and/or CHWs. CHWs affirmed that there were a number of circumstances in which they felt unsafe, underscoring the importance of safety planning and risk mitigation in community-based programming addressing gender norms and GBV.

Acceptability and feasibility of the Communities Care model

The *Communities Care* program model was highly acceptable to community members. Participants highly valued both the content and delivery of the intervention. The experience in Colombia shows the success of adapting the intervention to the socio-cultural context where it is to be implemented. Participatory and culturally relevant activities were key to maintain motivation among participants and for the adequate delivery of the intervention content.

The feasibility of *Communities Care* varied across components. Community sensitization activities were largely feasible. Moreover, CHWs developed strategies to protect confidentiality, making it possible to discuss highly sensitive topics with participants during community sensitization activities. However, no survivors presented to CHWs for a referral to health services during the project period. This may be due to the distance to health services and the cost of transport. In fact, CHWs didn't consider it feasible to accompany survivors to seek care services within the critical period of care. This is largely due to the lack of medical and other services in the community, and challenges of accessing services despite an increased knowledge and awareness of the importance of timely care.

Limitations

The results of the evaluation from the quantitative component should be interpreted in the light of the following limitations. First, the change in the sample composition over time, due to the inability to survey the same participants at both time points and the high mobility of individuals, limits the analysis. There is an attrition bias resulting from losing participants between the baseline and endline surveys. The number of individuals surveyed at both points was very low.

The evaluation revealed that a similar intervention was implemented in the comparison site between baseline and endline data collection. While there is no way to assess the percentage of study participants who received relevant information or services in the comparison site, qualitative activities did indicate that there was significant contamination. Community leaders from the comparison site mentioned participating in SGBV learning activities conducted by national and international institutions during the intervention's implementation period. Participants in these sessions learned about the definition of SGBV-related terms, as well as how to identify survivors in their community. Several leaders from the comparison community indicated that some community members attended *Communities Care* activities during the intervention site's implementation process. This was facilitated by the proximity between the two communities, enabling leaders to participate in the learning activities, return to their community, and use the knowledge to plan SGBV response and prevention activities. This potential contamination and ongoing programming in the comparison site limits our analysis and could explain why there was more significant change in key outcomes in the comparison site.

Conclusion and Recommendations

The evaluation of the *Communities Care* model highlights its mixed but significant impacts on key outcomes related to SGBV awareness, knowledge of available services, and attitudes toward accessing services. While both the intervention and comparison sites showed general improvements from baseline to endline, the intervention notably mitigated declines in the sense of safety, resulting in a higher feeling of safety among participants in the intervention site as compared to the comparison site. Although awareness and knowledge about SGBV services increased significantly in both sites, no significant differential impact was observed between the sites. The intervention site did show a significant improvement in attitudes towards accessing services, a key area where the intervention made a difference.

The qualitative data suggested increased knowledge and awareness of SV care services among community members, although geographical and logistical constraints limited access. The evaluation also highlighted safety risks for CHWs, particularly from male perpetrators when conducting community sensitization programming at the household level, underscoring the need for additional protective strategies. The program model was found to be highly acceptable, yet feasibility varied across program components. Notably, CHWs were perceived as trustworthy sources of information, but were not utilized as part of the referral pathway. This limitation, along with the contamination of comparison group data due to similar interventions, posed significant challenges to the evaluation.

Our findings also underscore the importance of tailoring programming for diverse linguistic and cultural backgrounds. Accessibility, effectiveness, and sustainability of the *Communities Care* model requires the presence of local support through CHWs while also ensuring their safety through robust protective measures. Fostering community engagement and trust-building activities can further improve attitudes towards accessing services. Strengthening partnerships with Indigenous leaders and organizations will also enhance the sustainability and impact of interventions.

Further research should evaluate the sustainability of observed changes over time and assess whether changes in gender and social norms related to SGBV extend beyond intervention participants to the broader community. Additionally, research should focus on addressing attrition, ensuring culturally sensitive survey terms, and evaluating the impact of interventions in the presence of other similar programs. Any future research should also consider what success looks like to the community and to survivors.

In conclusion, while the *Communities Care* model has demonstrated promise, especially in improving attitudes towards accessing services, real world challenges limit our ability to fully implement the package of care and meaningfully measure the impact of the intervention. Continued evaluations and iterative program adjustments will be crucial for achieving sustainable, long-term positive outcomes in diverse and challenging environments.

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Methodology Annex

MA1

Subgroup analysis: In addition to analysis by site, we conducted subgroup analysis by age group (young people 13-19 years old) vs. adults (20 and older), by sex (women vs. men), by civil/relationship status (living with their couple or married vs. single—including separated or widowed), by migration status (Venezuelan migrants vs. non-Venezuelan migrants—including Colombians, those with double nationality, and Colombians who have returned).

Variables included in the regression models: The multiple linear regression analysis with control variable included three key variables. Firstly, we included two variables ("Intervention Site" and "Endline") that take values of 0 or 1 depending on the individual's site and the time at which their information was being collected (e.g., whether the person was surveyed at baseline, endline, or both). Then, an interaction term (InterventionSite x Endline) was created between the two previously mentioned variables. Furthermore, we included variables that allowed us to control differences at baseline between both sites by demographic and socioeconomic characteristics.

MA2

The "Attitudes Towards GBV and Accessing Services Scale" addressed 11 questions:

- A. *It is acceptable to marry a woman under the age of 18*
- B. *The husband and wife should make decisions together about how money will be spent in the household*
- C. *Violence against women is acceptable under certain circumstances*
- D. *Violence against girls is acceptable under certain circumstances*
- E. *Violence against men is acceptable under certain circumstances*
- F. *Violence against boys is acceptable under certain circumstances*
- G. *Violence against LGBTIQ+ persons, i.e., gay/lesbian persons, persons who do not identify with the sex they were assigned at birth or who are attracted to the opposite sex, is acceptable under certain circumstances*
- H. *If a woman is exposed to violence, she will seek help from a person she trusts*
- I. *If a girl is exposed to violence, she will seek help from a person she trusts*
- J. *If a woman is exposed to violence, she will seek help from individuals, companies or groups specialized in providing services*
- K. *If a girl is exposed to violence, she will seek help from individuals, companies or groups specialized in the provision of services.*

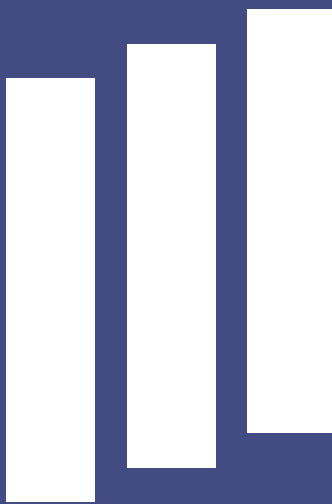
The "Attitudes Towards GBV and Accessing Services Scale" was created by dividing these questions into two sub-scales. The first one (attitudes towards GBV) includes five items (questions C-G). Each item had three possible answers: no response (99 –recoded to missing), agree (01), and disagree (02). To score the scale we added the participants' answers (maximum possible score

of 10 if they answered all the questions) and divided this into the number of questions answered (excluding missing or no response). Following this, the scale score had a minimum score of one and a maximum of two. The higher the score, the higher the disagreement with GBV. This means, for example, that a participant with a score of 1 agrees more with GBV attitudes (e.g., believes that violence against others is acceptable), while a participant with 2 points disagrees more with GBV attitudes. The second sub-scale (attitudes towards accessing services) had four items (questions H-K), each of them with three possible answers: no response (99 –recoded to missing), disagree (01), and agree (02). To score the scale we added the participants' answers (maximum possible score of 8 if they answered all four questions) and divided this into the number of items answered. The scale score had a minimum score of one and a maximum score of two, where a higher score means higher support for survivors of GBV accessing services.

The 11-question scale was divided into two sub-scales (attitudes towards GBV and attitudes towards accessing services). For further information about the scale used, refer to the methodology annex (MA2). The complete scale (including the 11 items) and the first sub-scale (attitudes towards GBV) yielded a poor Cronbach's alpha across all subgroups, meaning poor internal consistency, or reliability, of the scale. However, the second sub-scale (attitudes towards accessing services) yielded an acceptable Cronbach's alpha in all sub-groups, as it exceeded a Cronbach's alpha of 0.70 at baseline (Revicki, 2014).

Acronyms and Abbreviations

| | |
|----------|---|
| CAB | Community advisory board |
| CNC | Centro Nacional de Consultoría |
| CHW | Community health worker |
| FGD | Focus group discussion |
| GBV | Gender-based violence |
| KAP | Knowledge, attitudes and practices (survey) |
| KI | Key informant |
| KII | Key informant interview |
| M&E | Monitoring and evaluation |
| NGO | Nongovernmental organization |
| ODK | Open Data Kit |
| SGBV | Sexual and gender-based violence |
| SV | Sexual violence |
| WRC | Women's Refugee Commission |
| UniAndes | Universidad de los Andes |



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