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Asking and telling in humanitarian contexts: A feasibility assessment of para-social worker-led screening for sexual violence against children in Uganda

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THE REPUBLIC OF UGANDA

Asking and Telling in Humanitarian Contexts:

A Feasibility Assessment of Para-Social Worker-Led Screening for Sexual Violence Against Children in Uganda

Baobab

Generating Evidence to Enhance Sexual and Reproductive Health and Rights in Refugee Settings

THE REPUBLIC OF UGANDA

Baobab

Generating Evidence to Enhance
Sexual and Reproductive Health and Rights
in Refugee Settings

Together
for girls

STRENGTH IN NUMBERS

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Generating Evidence to Enhance Sexual and Reproductive Health and Rights in Refugee Settings

The Population Council leads the Baobab Research Program Consortium in close partnership with the Population Council Kenya and the African Population and Health Research Centre. Situated in the East and Horn of Africa, this Africa based and African lead consortium is filling critical evidence gaps to reduce inequities in sexual reproductive health and rights among vulnerable populations in humanitarian settings.

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Acknowledgements

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Acronyms

CMR	Clinical Management of Rape
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HVACS	Humanitarian Violence Against Children and Youth Survey
IRC	International Rescue Committee
LWF	Lutheran World Federation
MGLSD	Ministry of Gender, Labour and Social Development
MoES	Ministry of Education and Sports
MoH	Ministry of Health
OPM	Office of the Prime Minister - Department of Refugees
PSW	Para-Social Worker
REPSSI	Regional Psychosocial Support Initiative
RPC	Research Programme Consortium
STI	Sexually Transmitted Infection
SV	Sexual Violence
SVAC	Sexual Violence Against Children
TfG	Together for Girls
UNHCR	United Nations High Commissioner for Refugees
VAC	Violence Against Children
VACS	Violence Against Children and Youth Surveys
WHO	World Health Organization
WIU	Windle International Uganda

Executive Summary

Sexual violence against children (SVAC) is an acknowledged concern in humanitarian contexts. In Uganda's refugee settings, preventing and responding to SVAC is also a key priority among humanitarian stakeholders. Of particular interest to the latter is establishing mechanisms to promote the disclosure of SVAC among young survivors, and to spur the uptake of available care by such survivors in these settings.

While studies conducted in development settings demonstrate the feasibility and positive effects of proactively identifying child/adolescent survivors, promoting disclosure, and increasing the uptake of care through screening protocols, tested interventions for doing so in humanitarian contexts have hitherto been non-existent.

Employing a mixed-methods concurrent triangulation study design, this study assessed the feasibility of implementing SVAC screening, referral protocols, and service provision within two primary schools in Kiryandongo Refugee Settlement within Kiryandongo District, Northwestern Uganda. Para-Social Workers (PSWs) under the Ministry of Gender, Labour and Social Development were trained to screen pupils in Primary 6 to 7 for exposure to SVAC. Survivors identified through this process received school-based counseling, and were referred for further care, where necessary or desired. The 7-month intervention occurred from April to October 2024, with data collection to assess the screening model occurring alongside intervention implementation.

Screening for SVAC in schools was found to be feasible, in accordance with the following feasibility outcomes related to the demand for, and acceptability of, the intervention:

Demand for the Intervention

Parents' Expressed Interest or Intention to Use the Intervention

- Of 894 eligible parents of children enrolled in P6 and P7 at the two participating schools, the vast majority (93%) submitted permission slips. Of these, 100% gave permission for their children to be privately screened by school-based PSWs for SVAC.
- Parents advocated for the intervention to be offered to all pupils, and to be delivered in wider community contexts beyond schools alone. Parents also took advantage of the psychosocial support offered as part of the intervention to address their own personal needs for such support.

Pupils' Expressed Interest and Actual Use of the Intervention

- All pupils who were eligible to enroll in the screening intervention (100%; n=831) were independently willing to be screened and provided their assent. Of these, most (96%; n=794) were screened.
- The vast majority of screened pupils (82%; n=653) disclosed ever having experienced some form of sexual violence (SV).
- All pupils who disclosed ever having experienced SV (100%; n=653) obtained care as a result of the screening intervention.

Perceived Demand for the Intervention in the Wider Community

- Based on the positive effects of the intervention, humanitarian actors called for the expansion of the intervention to other schools, categories of pupils (i.e., grades beyond Primary 6 and 7), and refugee settlements.
- Teachers in participating schools advocated for their own capacity-strengthening to support the intervention in appropriate ways, while local government representatives had already begun using emerging evidence from the study to influence policy and programming at local and regional levels.
- Narratives from a wide range of humanitarian actors pointed to a demand for the intervention due to perceptions that the screening model fostered a wider sense of responsibility for reporting sexual violence in the community; spurred reporting of sexual violence by community members; enhanced service delivery by health providers; and sparked personal activism by community members.

Acceptability of the Intervention

Intent to Continue Use of the Intervention

- Narratives of government stakeholders in the humanitarian sector demonstrated commitment to expanding the screening intervention beyond the intervention schools, and to integrating the model into routine health and education systems.
- Non-governmental organization actors emphasized the need for scale-up in order to reach a larger proportion of young survivors. Narratives from both categories of stakeholders were shaped by emerging results on the positive effects of the intervention during the implementation period.

Satisfaction with the Intervention among Pupils

- Pupils expressed high levels of satisfaction with the screening intervention – particularly, the model's ability to enhance communication (child-parent, parent-child, provider-child, child-provider, etc.) around sensitive subjects, which in turn helped promote disclosure, and ultimately resulted in robust service uptake.

Additionally, records from the two primary schools indicate that only 16 pupils were passively identified and connected to care through established, conventional referral mechanisms in the 12-month period prior to the intervention, compared to 653 pupils proactively identified during a 5-month period dedicated to screening under the current study's intervention.

Selected Recommendations for Programming

- Introduce SV prevention and response programs early on in the lives of children. Couple these interventions with community-wide prevention programs targeting a wide variety of community members for effective prevention and response.

- Strengthen parenting and children's empowerment programming by enhancing bi-directional communication between parents and children (i.e., both parent-child and child-parent communication).
- Introduce SV screening interventions in schools carefully and cautiously, with attention to: 1) establishing functioning, post-screening service provision and strong, 'warm' referral systems before the commencement of screening, and 2) close monitoring, supervision, and mentoring of PSWs carrying out screening.
- Incorporate the tested screening model into Uganda's National Training Manual for Para-Social Workers. Develop an accompanying, user-friendly screening handbook for trained PSWs to refer to during their daily work. The handbook in question should be attentive to PSW literacy levels.

Introduction

This study evaluates the feasibility of an intervention that proactively identifies child and adolescent sexual violence (SV) survivors and connects them to care, while also changing norms that help sustain violence, and strengthening child-parent and parent-child communication and relationships. The study is an initiative under the Baobab Research Programme Consortium (RPC), which focuses on filling gaps in evidence to enhance sexual and reproductive health and rights among vulnerable populations in refugee settings in the East and Horn of Africa. Baobab does this by transposing adapted study tools and intervention approaches from development settings (where they were initially tested and validated) to refugee contexts for the first time. Accordingly, the study is an adaptation (for refugee contexts) of a previous intervention developed and tested under the Population Council-led 'Africa Regional Sexual and Gender-Based Violence Network' in development settings in Nairobi, Kenya in 2017.

The Violence Against Children and Youth Surveys (VACS), conducted in at least 23 countries so far across the globe, have arguably generated much of the definitive evidence on experiences of violence in childhood and adolescence in the field. These surveys were designed for implementation in development settings. In 2022, however, in collaboration with the Government of Uganda's Office of the Prime Minister-Department of Refugees (OPM), UNHCR, and a range of other humanitarian partners, Baobab carried out the first-ever Humanitarian Violence Against Children and Youth Survey (HVACS) situated exclusively in refugee settings. Conducted in all refugee settlements in Uganda, findings from this HVACS highlighted the high prevalence of violence against children (VAC), including sexual violence, in these contexts (OPM, UNHCR, Baobab, & TfG, 2024).

Through a subsequent Data-to-Action workshop co-convened by OPM and Baobab with support from the Ministry of Gender, Labour and Social Development (MGLSD); humanitarian stakeholders in Uganda identified priorities for action in responding to VAC in refugee settings. Among these priorities were need to: address SV in particular; attend to the low rates of disclosure and service-seeking among child and adolescent SV survivors; address high rates of mental distress among SV survivors; shift negative gender norms in communities; foster parental engagement with children; and capitalize on high school enrollment rates in refugee settings to help mitigate violence (Undie, Muthuri, Odwe, Kisaakye et al., 2023). The focal intervention – screening primary school pupils for SV through a standardized assessment, and linking identified survivors to care – was designed to collectively attend to all of these concerns.

Screening for SV has been shown to promote child/adolescent survivor disclosure/detection and uptake of SV services in development contexts in the East African region (Undie & Mak'anyengo, 2020, 2022). Little is known, however, about how to effectively screen this population for SV in humanitarian contexts, and the extent to which violence screening models successfully used in development settings can be transposed to humanitarian

settings. Yet, sexual violence against children (SVAC) is a pervasive issue in humanitarian settings in the region. The Uganda HVACS found the prevalence of SV in childhood (before the age of 18) among young people aged 18–24 years to be at 19% and 10% for females and males, respectively. Among 13-17-year-olds, 11% and 12% of girls and boys, respectively, had ever experienced SV (Obare, Odwe, Wado, Kisaakye et al., 2024).

Disclosure of SV in childhood was low for both girls and boys – at 6% among 13-17-year-olds who experienced SV in the past 12 months, and – among 18-24-year-olds reporting on their childhood experiences – at 17% and 31% for females and males, respectively. Help-seeking among these populations was even lower – at 2% for girls ages 13-17, while none of their male peers sought help. Among those in the 18-24 age range, 5% of females and 17% of males sought help for SV experienced in childhood (ibid.).

SV places children and adolescents at risk for pregnancy and sexually-transmitted infections (STIs), including HIV. Males aged 18-24 who experienced SV in childhood were more likely to have ever had symptoms or been diagnosed with an STI (52%) compared to those who did not experience SV in childhood (31%) (ibid.), providing evidence of the long-term impacts of SV in the absence of early intervention. Survivors of SV in childhood were found to be twice as likely to experience psychological distress as non-survivors, with 48% exhibiting signs of post-traumatic stress disorder and 31% reporting severe depression. Furthermore, in Uganda's refugee settlements, child and adolescent survivors of SV were significantly more likely to report feelings of anxiety, depression, suicidal thoughts, and suicide attempts than their peers who have not experienced SV (ibid.).

Despite the problems that sexual violence poses for children and adolescents in Uganda's refugee contexts, and the role that screening can play in the early detection of survivors, promoting disclosure, and increasing SV service uptake, evidence-based, systematic screening interventions for this population are currently non-existent in this setting. This study therefore contributes to building the evidence base in humanitarian settings by assessing the feasibility of adapting and conducting a screening intervention for children/adolescents in school settings.

Evaluation findings from the original iteration of the intervention (Undie & Mak'anyengo 2020, 2022, 2023) demonstrate that this intervention effectively: fosters parent-child and child-parent communication to promote SV disclosure and child/adolescent survivor support; promotes disclosure; expands survivors' access to care; responds to mental health needs; and provokes an organic shift in gender/social norms within survivors' communities. Given the alignment between these outcomes and the priorities identified by humanitarian actors during the Data-to-Action Workshop co-convened by OPM and Baobab, the piloting and testing of this multi-faceted screening intervention was therefore deemed by the MGLSD (as lead government agency in the country for child protection) an appropriate initial response to the 2022 Uganda HVACS findings.

Study Aim, Design, and Context

Aim

The aim of this study was to determine the feasibility of screening children/adolescents for SV in school settings, and of enhancing child/adolescent survivor disclosure and service uptake through this process. The study focused on two dimensions of feasibility, as outlined by Bowen et al. (2009), namely: 'demand' and 'acceptability.' Informed by Bowen et al., these dimensions have been operationally defined as follows for the purposes of this study:

- *Demand*: The extent to which the screening intervention is likely to be used by children/adolescents, their parents/guardians, and other humanitarian stakeholders.
- *Acceptability*: The extent to which the screening intervention is judged as suitable, satisfying, or attractive to providers, child/adolescent survivors, parents/guardians, and other humanitarian actors.

The dimensions of demand and acceptability are broken down further into the specific feasibility outcomes that the study explored (Table 1):

Table 1: Evaluation Focal Areas and Outcomes

Areas of focus	***Feasibility studies ask …:***	***Outcomes of interest***
Demand	To what extent is the new intervention/program likely to be used (i.e., how much demand likely exists)?	▪ Expressed interest or intention to use the intervention ▪ Actual use of the intervention ▪ Perceived demand for the intervention
Acceptability	To what extent is the new intervention/program judged as suitable, satisfying, or attractive to program deliverers? to program recipients?	▪ Intent to continue use of the intervention ▪ Satisfaction with the intervention

Adapted from Bowen et al. (2009)

Design

The study replicated the design and methodology of the original, Kenya-based evaluation, described elsewhere (Undie & Mak'anyengo, 2020, 2021). A mixed-methods design was employed, drawing on a concurrent triangulation strategy (Creswell et al., 2003). This approach involved collecting quantitative and qualitative data simultaneously and then integrating both data sets into a single, unified analysis. Both kinds of data lent evidence toward the feasibility assessment, and the qualitative insights were essential for capturing the stories, experiences, perspectives, and realities behind the numbers of screened

children/adolescents, their parents, and other stakeholders. The qualitative data were also particularly important for bringing children's voices to the fore of this assessment, as their personal perspectives are often excluded from research on sensitive topics.

Context

Located in Northwestern Uganda's Kiryandongo District, Kiryandongo Refugee Settlement was first established in 1990, followed by a period of closure. Propelled by the South Sudanese emergency, it was re-opened in 2014 (REACH, 2019). As of January 2025, Kiryandongo Settlement hosts a total of 139,815 refugees, the majority (60%) of whom are from South Sudan (OPM & UNHCR, 2025). Armed conflict in Sudan since 2023 has also led to a more recent influx of Sudanese refugees, which 95% of registered refugees from this country residing in Kiryandongo (IFRC, 2024). Recent conflict escalation in eastern DRC has also resulted in an additional influx of refugees and asylum-seekers.

Kiryandongo District has had a history of registering the highest number of cases of domestic violence and child neglect (Uganda Police Force, 2022) and the second highest number of cases of defilement (Uganda Police Force, 2022, 2023) and child-related offences (Uganda Police Force, 2022) at police stations in the country.

Kiryandongo Refugee Settlement is regarded as being a diverse location in terms of demographic groups, ethnicities, countries of origin, time spent in Uganda, and socio-economic status (SCC, 2018).

Two primary schools within this settlement were selected as the study sites, due to their relatively high reporting of sexual violence cases, compared to other schools in this setting.

Intervention Description

Partnership

The screening intervention implementation was enabled through a collaborative effort between the MGLSD, OPM, the Ministry of Education and Sports (MoES), the Ministry of Health (MoH), UNHCR, Windle International Uganda (WIU), and Baobab. The MGLSD is the lead government agency for the Social Development Sector, which promotes empowerment for marginalized groups, including children, and promotes issues of social protection, gender equality, equity, and human rights. In the humanitarian sector, the MGLSD is the lead agency for child protection, with support from OPM, UNICEF, UNHCR, and other agencies. Given the location of the intervention in schools, and the referral of survivors from schools to health facilities for care, the MoES and the MoH provided critical guidance and oversight, in collaboration with other government partners.

In Kiryandongo Refugee Settlement, WIU is UNHCR's lead implementing partner within the education sector, providing leadership for the implementation of service delivery programs

offered within education contexts. WIU's role during the intervention period entailed convening parent dialogues in collaboration with the schools, collating survivor reporting information across all schools in the settlement to support the feasibility assessment, and providing guidance to ensure the intervention functioned within school sites without disrupting normal school operations. During the intervention implementation period, Baobab provided technical support for the intervention implementation, monitoring, and evaluation.

Together, all of these institutions formed a multi-functional team which paid periodic visits to the intervention sites during the implementation period to provide an extra layer of joint supervision, oversight, and learning.

Adaptation

In their role as the government's lead agency for child protection, a noted model of the MGLSD involves the identification, training, and supervision of para-social workers (PSWs)– the first-line cadre of child protection and welfare response that reaches households with services through home visits, referral provision, and a community case management approach. As 'first responders,' PSWs provide preventative, responsive, and promotive services, including for violence prevention and response at the household and community levels (MGLSD, 2023). The original, Kenya-based version of the screening intervention was adapted for refugee settings in Uganda by task-shifting – that is, replacing trained psychologists with trained PSWs.

Other adaptations included refining the screening tool (*see* Appendix 1), which was originally developed for use in primary schools and health facilities within development settings. For the present study, the original tool focused solely on primary schools and was adjusted to incorporate pupils' displacement status and enable disaggregation between refugee and host community pupils. It was also further enhanced by including a new section on disability status based on indicators developed by the Washington Group on Disability Statistics. This enabled pupils to report any difficulty in performing basic universal activities related to movement, sight, hearing, communication, self-care, and cognition.

Similar to the original screening tool, the adapted version was designed to gather information on lifetime and current experiences of sexual violence, including the form(s) of violence experienced, the timing of these incidents, the perpetrator types, interest in care-seeking, and interest in having parental/caregiver presence as part of the care-seeking process.

Some questions, particularly regarding the types of SV experienced, were designed to be open-ended, allowing pupils to describe their experiences in their own words. This approach was essential, as pupils were not expected to have acquired the technical vocabulary necessary for articulating their experiences. To be classified as SV, the reported incidents had to align with the World Health Organization (WHO) definition of the term: 'non-consensual completed or attempted sexual contact and acts of a sexual nature not involving contact (such as voyeurism or sexual harassment)' (WHO, 2019).

Intervention Components

The intervention was carried out from April to October 2024 and comprised five components, namely: Parent Dialogues, Student Sensitization, Provider Training, Screening for SVAC, and SVAC Service Provision. While these components are described in detail elsewhere (Undie & Mak'anyengo, 2020, 2021), they are outlined again here to capture the slight modifications that were made to suit the humanitarian context.

Parent Dialogues (April – October 2024)

The two participating primary schools, in collaboration with the MGLSD, the OPM, UNHCR, WIU, and Baobab, convened three parent dialogues in each school (*total* = 6) with parents of all students in Primary 6 and 7 invited to participate. Those dialogues were critical for introducing the screening exercise to parents/caregivers and ensuring their support and buy-in for the intervention. The dialogues (*see* Appendix 2) involved guided, interactive exercises (e.g., skits performed by pupils, scenario-building, discussion prompts, question-and-answer sessions) to foster conversations about SVAC in the refugee settlement and other relevant topics such as the negative consequences of such abuse, the barriers to children/adolescents seeking care for it, parental barriers to seeking care for their children, and school-based screening as a possible solution. The dialogues also served as an efficient platform for obtaining written consent from willing parents for their children to participate in each aspect of the screening exercise – including, confidential, child-friendly screening; school-based counseling and accompanied referrals, as needed; and anonymized documentation of notes and service statistics based on the screening processes. Particular emphasis was laid on the fact that participation was completely voluntary for both parents and pupils; parents and pupils could change their minds at any time; pupils would only be invited to participate if their parents had opted in; and that there were no repercussions for whichever decision parents and pupils made. Parent dialogues were also used as a forum for disseminating emerging findings to parents and schools.

Student Sensitization (April – October 2024)

Student sensitization involved integrating information about the impending intervention into existing student school assemblies. These assembly sessions were coupled with classroom sensitization sessions conducted by Gender-Based Violence (GBV) specialists (1 per school) who monitored the day-to-day implementation of the intervention, supervised the screening and service provision, and supported the PSWs and school personnel throughout the intervention period. During the assembly and classroom sensitization sessions, PSWs and GBV specialists collaboratively shared information on the planned intervention, as well as on SVAC, and informed pupils that their schools were taking measures to make it easier for pupils to receive care for SV if it ever occurred. The specific measures being taken (that is, the availability of school-based psychosocial support for any reason during the school day) were also elaborated upon.

Para-Social Worker Training (April – May 2024)

The intervention included 11 PSWs assigned to the schools on a full-time basis during the study period. Female PSWs solely screened female pupils, while male pupils were only screened by male PSWs. Due to the disparity in school sizes (with School A having a larger population of pupils in general than School B), a different number of PSWs was assigned to each school, as outlined in the Table below:

Table 2: School Population and PSW Distribution

	School A		***School B***	
	Girls	Boys	Girls	Boys
Attendance during intervention period	246	403	67	109
Total number of pupils attending school during intervention period	649		176	
Number of **female** PSWs assigned to school	2		3	
Number of **male** PSWs assigned to school - males	5		1	
Total number of PSWs assigned to school	*7*		*4*	

To minimize language barriers in the course of their duties, PSWs are identified by the MGLSD from within the communities concerned in collaboration Sub-County Child Wellbeing Committees. As part of this process, they are vetted on issues of moral behavior (for example, the absence of a history of violence perpetration or other criminal behavior) by this community structure. PSWs in Uganda have a minimum of complete primary school education (i.e., up to the equivalent of Primary 7 in Uganda), and are of any gender.

PSWs supporting the screening intervention underwent a 21-day training session, led by the MGLSD with support from OPM, and drawing on the national training manual for PSWs (MGLSD, 2023). The training session focused on a variety of subject areas, including childcare and protection, GBV and school-related GBV, mental health/psychosocial support, positive parenting, counseling, self-care, and case management skills, including the case management cycle, assessment and interview skills, and data collection management and usage. Following this, the PSWs received an additional training session, which focused on understanding, administering, and filling out the screening tool effectively; sensitively screening children/adolescents appropriately for SV experiences; offering first-line counseling to children/adolescents; managing referrals emanating from schools; engaging with parents of child survivors; rigorous notetaking to document field notes; and serving as a child survivor advocate to enhance the screening, referral, and service provision process. This additional training session was carried out by Baobab, with support from the multi-functional team. Five out of the 11 PSWs were refugees, while 6 were host community members.

Screening, Referrals, and Service Provision (May – September 2024)

The screening exercise was conducted using a designated screening tool in both participating schools (*see* Appendix 1). PSWs facilitated the screening exercise during recess and free periods. All students in Primary 6 and 7 whose parents had given permission (*see* Appendix 3) and who gave their own personal assent (*see* Appendix 4) were invited to participate in the screening exercise. PSWs maintained a register of eligible students and, with the help of teachers and GBV specialists, systematically invited those listed for screening one after the other and carried out screening in private tents designated for this purpose at each school. Each eligible child/adolescent was screened twice during the intervention period if SV was not disclosed the first time. If a child/adolescent reported having experienced SV, the PSW offered school-based counseling for as long as the child/adolescent survivor needed it over the life of the intervention and inquired if the child/adolescent wanted to discuss their experience further and receive additional support. Those who requested or required further assistance received an accompanied referral to the nearest health facility, managed by the International Rescue Committee (IRC). Accompanied referrals were executed by PSWs and/or the Senior Women Teacher or Senior Men Teacher in each school, depending on the sex of the survivor. Within the health facilities, IRC additionally provided support for the Clinical Management of Rape (CMR), along with psychosocial support services.

Ethical Considerations

Ethical approval and research clearance for the study were provided by the Population Council's Institutional Review Board, the Mildmay Uganda Research Ethics Committee (Approval No. REC REF 0611-2023), and the Uganda National Council for Science and Technology (Approval No. SS2265ES). Pupils were only eligible for participation in the intervention if they had parental permission. Pupil participation remained voluntary, despite parental permission.

The screening tool and process were attentive to ethics in the following ways: Child/adolescent survivors were deliberately not interviewed under this study; rather, their voices were captured via the fieldnotes documented by PSWs as part of the screening encounter.

To ensure pupils were as comfortable as possible during the screening process, female PSWs solely screened female pupils, while male pupils were only screened by male PSWs. Screening also occurred in locations offering audiovisual privacy. Furthermore, the screening tool contained measures designed to be child survivor-friendly: The tool contained prompts for PSWs to remind pupils that there were multiple ways to respond to the questions, such as by doing so verbally, by writing down their response, by holding up a card with a pre-recorded 'yes/no' response, or by using dolls to demonstrate what occurred, rather than verbalize the incident. The screening tool also included prompts to remind the

pupil that they did not have to respond to any questions that they did not want to, and that there would be no repercussions for choosing not to respond.

The intervention was situated in primary schools that were located in very close proximity (walking distance) to external response services offered by health facilities. Furthermore, sensitization sessions were held with humanitarian partners providing child protection and health services to alert them to the fact that an increase in their child/adolescent client load was likely to occur due to the intervention, and to have them prepare to efficiently manage these emerging cases.

Lastly, given the task-shifting involved in adapting the intervention (from trained psychologists to trained PSWs), GBV specialists were incorporated into the piloting process to provide daily supportive supervision and mentoring, ensuring PSWs grew to become comfortable in their new screening role.

Study Sample

The study sample comprised three different sub-populations, namely: parents, pupils, and stakeholders across a range of humanitarian sectors, including child protection, education, and health.

All parents who had a child in Primary 6 or 7 at the school sites (*n* = 894) were invited to attend the first parent dialogue in each school, and formed the parent sample. Children of the parents described, who gave their assent to participate in the study (*n* = 831), formed the overall pupil sample. The majority of such pupils (90%, n=748) were refugees, with 6% of pupils (n=46) being from the host community. The remaining 4% (n=37) were pupils who happened to be absent from school during the intervention period. The age range of pupils who assented and who were also available to participate in the intervention (n=794) was 11 to 35 years old, with 83% (n=656; 232 females and 424 males) being aged 15 or older at the time of the screening. In addition, the sample included a total of 80 sectoral stakeholders who participated in group interviews.

Data Collection

Data collection activities occurred alongside the intervention implementation.

Quantitative Data

The study's quantitative data set drew on the following sources of data: school enrollment records (which clarified the universe of parents and students for each school); completed parent permission slips (which pinpointed the proportion of parents that consented versus the proportion that declined); completed pupil assent slips (which highlighted the proportion

of pupils that were not willing to participate compared to the proportion of parents that were), and screening tool statistics, which provided information on the proportion of pupils disclosing lifetime and current experience of SV, specific types of SV disclosed, perpetrator type, interest in service-seeking, and actual care-seeking following screening.

Qualitative Data

The study's qualitative data set drew on fieldnotes documented by PSWs with support from GBV specialists, parent dialogue reports documented by GBV specialists, and group interviews.

Fieldnotes

The fieldnotes were generated through participant-observations conducted by trained PSWs during the screening process. During screening sessions, PSWs manually documented detailed fieldnotes for each child who disclosed having experienced sexual violence, capturing direct quotes, descriptions of non-verbal cues, and other relevant observations. The fieldnotes therefore provided in-depth descriptions of both the observed interactions and the broader contextual factors. These detailed records played a crucial role in capturing nuanced insights throughout the study. GBV specialists held daily debriefings with PSWs to collaboratively review the fieldnotes and screening tool and ensure rigorous documentation. Fieldnotes were only documented for pupils disclosing SV. In total, 653 fieldnotes were compiled.

The documentation of fieldnotes adhered to a structured methodology, beginning with brief, informal notes taken during and immediately after each screening session or parent dialogue. These initial jottings served as memory aids, capturing key observations that could later be expanded into detailed narratives (Bernard, 2011; Lofland & Lofland, 2006). To ensure depth and analytical rigor, fieldnotes were elaborated by PSWs with support from GBV specialists into comprehensive written records on the same day, incorporating reflective commentary to interpret and contextualize observed interactions (Spradley, 2016). Such analytic reflections, often referred to as "observer comments" or "memos," serve to clarify interpretations, highlight emerging themes, and pose critical questions for further analysis (Saldaña, 2015; Wolfinger, 2002). Parent dialogue reports also served as a form of fieldnotes, documenting insights gathered from the 6 parent dialogues (3 per school) and other interactions with parents/caregivers.

Group Interviews

Sixteen group interviews were conducted with a total of 8 different stakeholder categories across both schools, including: school personnel; parents/caregivers of pupils; PSWs conducting screening; local government/District leadership; medical response partners who managed survivors identified through the screening intervention; child protection response partners who managed survivors identified through the screening intervention; screening and service provision supervisors at the settlement level; and key agencies overseeing the protection, health, and/or education of refugees, nationally.

Group interviews, defined as “interviews where two or more participants engage in a discussion led by one or more interviewers” (Guest et al., 2017, p. 113), generated collective insights and shared perspectives among participants. Each session fostered interactive discussions that encouraged reflection on experiences, challenges, best practices, and a view of the future with regard to the intervention.

Data Analysis

Quantitative Data

Each eligible pupil was screened twice during the intervention period if SV was not disclosed the first time. The results presented in this report are based on the second round of screening. The screening tool was designed to have pupils describe their experiences of SV in their own words, which were subsequently categorized under corresponding technical classifications before being quantified for statistical analysis. Other sections of the screening tool consisted of structured, numerical responses, facilitating direct quantitative measurement.

To analyze the screening tool data, responses from both study sites were systematically entered into an Excel database, organized by screening questions. Descriptive statistics were then generated for each variable around all indicators captured by the screening tool.

Data collected via parent permission and pupil assent slips were manually analyzed and integrated into the assessment. Data emerging from the use of the screening tool and consent/assent slips were categorized according to the feasibility dimensions of ‘acceptability’ and ‘demand,’ as conceptualized by Bowen *et al*. (2009).

For analytical consistency, denominators included the total number of eligible parents invited to participate in the dialogues (that is, those with pupils in Primary 6 and 7) and the total number of parents who returned their permission slips, irrespective of their decision to consent to, or decline, participation. This approach ensured that response rates and participation trends were systematically assessed within the overall study framework (Bryman, 2016). In some cases, more than one parent per child/adolescent attended the dialogues; however, only one permission slip was signed per child/adolescent.

Qualitative Data

Qualitative data played a crucial role in triangulating and contextualizing the quantitative findings. Content analysis techniques were employed to identify patterns, themes, and emerging narratives within the dataset (Braun & Clarke, 2006). For fieldnotes, the primary screening tool topics were initially used as thematic codes, ensuring alignment with the study’s key research questions. Multiple readings of the transcripts facilitated systematic

coding and categorization of key themes related to pupils' experiences, disclosure dynamics, and service accessibility (Denzin & Lincoln, 2018).

The subsequent phase of analysis encompassed all qualitative data sources and involved coding them based on their relevance to 'demand' and 'acceptability' indicators, following the feasibility framework proposed by Bowen *et al.* (2009). These feasibility indicators were established as *a priori* codes, which were then examined in relation to any parallel patterns identified within the quantitative dataset.

Finally, an iterative analysis process occurred during the result-writing phase, where continuous engagement with the data helped refine and strengthen analytical interpretations (Smith, Flowers, & Larkin, 2009). This reflexive approach enabled a more nuanced understanding of feasibility dimensions, ensuring that both numerical trends and experiential narratives were comprehensively integrated into the study's findings.

Results

Evidence of Demand

Parents' Expressed Interest or Intention to Use the Intervention

Parents expressed strong interest in having their children participate in the SV screening intervention, and they supported having PSWs accompany their children for further referrals – such as to health facilities and psychosocial support services – in their absence, if needed. Of 894 eligible parents of children enrolled in P6 and P7 at the two participating schools, 831 (93%) submitted their permission slips during the first or second parent dialogue, or shortly after that. Remarkably, all parents who submitted these slips (100%, n=831) granted permission for their children to be screened and referred by a PSW to appropriate care services, as necessary.

Parental demand for the screening intervention and their intention to use it was apparent ever before the actual screening intervention began. Fieldnotes from the parent dialogues highlight parents' eagerness for solutions to SVAC and willingness to support the process. During the dialogues, for instance, many parents questioned why the target group was limited to students in Primary 6 and 7, arguing that the intervention should include children from all grades. Additionally, during subsequent dialogues, many parents suggested extending the program to children in other schools within the settlement. Several parents also requested personal counseling to help them cope with their own experience of SV, or that of their children. The following quotes illustrate several of these points:

> *'[After the dialogue], three [female] parents approached the GBV specialist separately and expressed a personal need for counseling, and during the counseling sessions, they disclosed that their children were defiled and got pregnant while studying in this school, and had dropped out of school. [The] parents asked if these children could still come to be screened and supported through counseling and referrals.'* (Excerpt from parent dialogue report, School A)

> *'During the parent dialogue, a female parent shared her testimony of how she got married at 14 due to relatives who used to mistreat her by not providing for her basic needs like food and school requirements. This parent was 31 years old with a firstborn boy aged 17. She appreciated that, in Uganda, it is a practice to speak against sexual violence and awareness creation is encouraged, unlike in South Sudan, where children grow up without being informed about sexual violence. She said that she is very happy to learn about sexual violence while in Uganda and she promised that she will continue being an ambassador against sexual violence, and when she returns to South Sudan she will continue discouraging sexual violence. She emphasized that she does not want her children to go through what she went through.'* (Excerpt from parent dialogue report, School B)

> *'In our community, once girls clock 9 years old, they are booked by men immediately, the man will even fulfill the bride price obligation of paying her parent with 100 cows and money. This pains me a lot because these girls have no choice, and the booking is arranged by us parents. This is the reason why I want the screening to be conducted for all the girls in the school.'* (Excerpt from female parent - parent dialogue report, School A)

Parents' intention to use the intervention was also evidenced by their desire to have the dialogues extend beyond schools alone in order to reach more of their peers and benefit the wider community:

> *'We can extend the dialogues to the community [...]. So [...] [all] parents, if they listen to this dialogue very carefully, they will also improve on their [parenting] work, on their behavior with others, [and] maybe the well-being in the community.'* (Group interview, Female parents – School A)

> *'Now that we, as parents, have been called in schools to come and attend the dialogues [...] we request they can come to the community, whereby [intervention implementers] can organize a community dialogue. [...] It can help disseminate the information, and the cases of sexual harassment may be eliminated completely in our communities.'* (Group interview, Male parents – School B)

Pupils' Expressed Interest and Actual Use of the Intervention

Expressed Interest in being Screened

All pupils (100%, n=831, of whom 748 were refugees) whose parents gave permission were willing to be screened and provided their assent. Among the 831 pupils who provided written assent to be screened for SV, 96% (n=794) were eventually screened. The remaining 4% who were not screened were absent from school during the intervention period (the majority had returned to their home country of South Sudan during this time). Of the 794 pupils who participated in the screening intervention, 62 percent were male, and 38 percent were female. The gender disparity is explained by the enrollment and, by extension, attendance statistics in both primary schools. Male pupils represent the striking majority (68%) of attending pupils. Among the pupils screened, 178 (22%) were living with disabilities (42% female and 56% male).

Actual Use of the Intervention

Disclosure of Sexual Violence

As further evidence of demand for the intervention, pupils were not only willing to sign up to participate in the screening exercise, but were also willing to disclose their experiences of SV. Of the 794 pupils who were screened for SV, the vast majority (82%, n=653) indicated that they had ever experienced some form of SV. Broken down by gender, results show that

a total of 249 (82%) out of 305 females, and 404 (83%) out of 489 males, had experienced some form of SV in their lifetime. Of these, 17% (n=53) of females and 21% (n=102) of males disclosed that they were currently experiencing SV (i.e., at the time of screening). Among the 178 pupils living with disabilities, an even greater proportion (92%, n=164) reported having ever experienced SV, and 22% (n=39) were currently experiencing this form of violence.

Table 3 presents the various types of SV that screened pupils disclosed experiencing in their lifetime. While females were more likely overall to disclose sexual harassment,[1] sexual touching,[2] and attempted defilement/rape, males were more likely to disclose other forms of violence, including forced viewing of pornographic material, completed defilement/rape, and child marriage or attempted child marriage.

Table 3. Proportion of pupils disclosing lifetime experience of sexual violence by type of sexual violence and gender

Type of sexual violence disclosed*	Girls N= 305	Boys N= 489
Any type of sexual violence	82% (n=249)	83% (n=404)
Sexual harassment	49% (n=149)	18% (n=90)
Sexual touching	31% (n=95)	29% (n=140)
Forced viewing of pornography	8% (n=23)	32% (n=158)
Child marriage/Attempted child marriage	8% (n=23)	20% (n=96)
Completed defilement/rape	6% (n=18)	20% (n=99)
Child sexual exploitation/abuse[3]	0	15% (n=72)
Attempted defilement/rape	11% (n=33)	1% (n=6)
Forced sexual touching/sexual viewing of others	1% (n=3)	9% (n=43)
Other (including inappropriate [non-genital] touching, oral sex, attempted genital touching)	2% (n=5)	4% (n=15)

* Multiple responses allowed

In addition to 'giving voice' to pupils' lived experiences of SV, the qualitative data offer compelling evidence of their active engagement with the screening intervention, highlighting their readiness to respond to the screening questions. The detailed insights from the pupils' accounts indicate a strong sense of comfort with both the screening tool and the overall process.

[1] For the purposes of this study, defined as unwelcome and inappropriate behavior of sexual nature – pressure for sexual favors; letters of a sexual nature; sexual gestures; etc.

[2] Referred to in this report as the touching of the genitals, breasts, and other sexual areas.

[3] For the purposes of this study, child sexual exploitation/abuse is defined as a form of sexual abuse in which a child/young person is coerced, manipulated, or deceived into sexual activity with another child/young person, typically in the context of initiation rites, child marriage, or war, for example.

'After getting circumcised, I was at home and a village member called me and asked to have sex with me, [saying], since I had been circumcised, I was ready to have sex. I refused and told him no. Then he grabbed me, pushing me down but I managed to scream, and other children came, then the man ran away.' (Fieldnotes: 14-year-old girl, attempted defilement by a neighbor)

'In 2022, I was taken back to South Sudan by my uncle. When we reached the village, he said he decided to bring me back home to continue growing my late father's lineage. He said he had got a 15-year-old girl, agreed with her parents, and paid her dowry for her to be my wife, and that if I had any problem with my manhood, I should tell him [...]. He locked [me] in a room with this girl and we were forced to have sex. But the next morning, I escaped and came back to Uganda to continue with my studies. Still, my uncle kept the girl, saying he had already married her for me, so she would wait for me until I go back home, but I am not interested in those cultural practices of forcing a girl on us.' (Fieldnotes: 18-year-old boy, child marriage, and child sexual exploitation/abuse by a relative)

'There is a boy who invited me over to his house and told me he loves me and forced me to have sex. I reported him to my parents, but the boy ran away. (...) Secondly, there is a boy who wrote me a love letter. He said that he will love me until Lake Victoria dries up and he will give me sweet sex if I accept. But I said no and never replied.' (Fieldnotes: 14-year-old girl living with disabilities, defilement, sexual harassment)

'During the first [round of] screening, I feared to talk about my experience, but after participating in so many of your sensitization sessions, I have learned and built the courage to share my experience. Last year, my uncle forced me to watch pornographic movies. I felt bad, but he kept saying he wanted me to learn how to have sex. I have never reported it to anyone but now I have learned through the sensitization and the counseling sessions that it is an act of violence against children. And I will one day explain all the things you taught us to my uncle because you have given me a lot of courage to speak about what bothers me.' (Fieldnotes: 15-year-old boy, forced viewing or pornography by a relative)

Disclosure of Polyvictimization

A total of 305 pupils (47%) who disclosed ever experiencing SV also disclosed experiencing more than one type of SV concurrently. These experiences of multiple sexual victimizations of different kinds are captured in Table 4 below. As the Table indicates, sexual touching is a frequently-experienced form of SV that occurs in practically every instance of polyvictimization described by children.

Table 4. Proportion of pupils disclosing lifetime experience of sexual violence who had experienced more than one type of sexual violence concurrently

Types of sexual violence disclosed	Pupils disclosing SV (N=305[4])
Sexual touching (ST) + sexual harassment	24% (n=74)
ST + forced viewing of pornographic material	18% (n=56)
ST + defilement/rape	14% (n=43)
ST + attempted defilement/rape	6% (n=19)
ST + forced sexual touching/sexual viewing of others	7% (n=21)
ST + child marriage (or attempt)	6% (n=18)
ST + child sexual exploitation/abuse	5% (n=16)
Defilement/rape + sexual harassment	7% (n=21)
ST + forced porn viewing + sexual harassment	4% (n=11)

Disclosure of Perpetrator Types

Pupils were also willing to disclose the perpetrators of the SV that they had experienced. Among those disclosing ever having experienced SV, the most commonly reported perpetrators identified were fellow pupils (34%), closely followed by neighbors (32%), as shown in Table 5. The perpetrator types most cited by pupils disclosing lifetime experience of SV slightly differ by gender, as girls mostly reported neighbors, while boys mostly cited relatives. Pupils living with disabilities who had ever experienced SV (*n*=164) primarily mentioned fellow pupils (n=26) and neighbors (*n* = 24) as perpetrators.

Table 5. Proportion of perpetrator types cited by pupils disclosing lifetime experience of sexual violence by gender

Type of perpetrator cited*	Girls N= 249	Boys N= 404
Fellow pupil	36% (n=89)	33% (n=134)
Neighbor	38% (n=94)	28% (n=112)
Relative	10% (n=26)	41% (n=165)
Friend	4% (n=9)	18% (n=71)
Stranger	28% (n=70)	18% (n=71)
Other (including teacher, community leader)	3% (n=7)	3% (n=14)

*Multiple responses allowed.

[4] Only the most reported 'combinations' of types of sexual violence disclosed concurrently are included, representing 91% of all pupils who disclosed experiencing more than one type of SV concurrently (n=279). The remaining 9% reported a wide range of less common combinations, each with very few cases (typically, fewer than five).

Uptake of Services

All pupils who disclosed ever experiencing SV (100%, n=653) accessed a sexual violence health service to attend to the issue. As part of the intervention, school-based counseling provided by trained PSWs was readily available and easily accessible. A lower proportion of pupils (25%, n=162) required referral outside the school setting for higher-level or comprehensive care. Of these, 57% (n=92) were accompanied to psychosocial support services provided by child protection response partners, including the Lutheran World Federation (LWF) and the Regional Psychosocial Support Initiative (REPSSI), and 39% (n=63) were accompanied to the nearest health facility, managed by IRC. Eighteen percent of pupils (n=117) who disclosed experiencing some form of SV had experienced completed defilement/rape; of these, over a third (36%, n= 42) were accompanied to the nearest health facility, where IRC provided CMR services. For various reasons, not all 117 defilement/rape survivors were referred for (CMR) services, including the timing of the defilement/rape incident (for some, it was as long ago as several years), or the fact that the pupil concerned had already received care before the screening intervention. However, all pupils who had experienced defilement/rape were willing to receive ongoing school-based counseling from PSWs, and did so.

Pupils who needed to receive further care outside the school context widely requested to do so alone (i.e., without a female parent/caregiver), or in the company of the screening PSW. Only 21% of pupils (n=34) wanted to receive care in the company of their female caregiver, as most pupils reported fearing parental involvement in this process:

> *'I was coming from school, and a man touched my private parts – my vagina and breast. When he wanted to touch me again, I grabbed his hand and warned him to not touch me again. He continued to beg me to have sex with him, but I said no, that I was not interested in him and not interested in sex. He walked away shamefully, and when I reached home, I kept quiet. I didn't tell anyone at home because I was afraid to get beaten.'* (Fieldnotes: 15-year-old girl, sexual touching by a neighbor)

> *'I did not tell my mother because if you try to disclose anything to her, she will say you are responsible for this.'* (Fieldnotes: 15-year-old girl, sexual harassment by a stranger)

Perceived Demand for the Intervention in the Wider Community

The child-focused screening intervention entailed the direct or indirect involvement of a range of humanitarian stakeholders representing the wider community, including parents/guardians, and the humanitarian workforce from the child protection, education, and health sectors. Narratives from a wide range of humanitarian actors highlighted a demand for the intervention due to perceptions that the screening model fostered a wider sense of responsibility for reporting sexual violence in the community; spurred reporting of sexual violence by community members; enhanced service delivery by health providers; and

sparked personal activism by community members. These perceived ripple effects of the intervention were described in the following terms by interviewees:

> *'Even the parents, they are now reporting to us. When they see something happening there, even with the neighbor's child, they [...] report to the school. Because they know now, from the [parent] dialogues that they had here. Thank you.'* (Group interview, School Personnel – School B)

> *'When you look at the data [...] we have right now [...], I think around May, you see the number of children and adolescents who are coming in the clinics [increase]. Now we have reached up to nine hundred plus, and it used not to be like that. So, it has also created some impact here within the facility.'* (Group interview, Medical Response Partners)

> *'One thing that I got from this [...] intervention: There are many ways that I learnt how to deal with children. Actually, [since] that day [parents dialogue day] I've been taking some notes, which I'm going to apply [.] But the knowledge I got from here, I will use it to help children in my area, in any community that I will be a part of.'* (Group interview, Female parent – School A)

Other ripple effects included the perception of improved school attendance by pupils as a result of the intervention through enhancing students' motivation and emotional well-being. Group interviews highlight students' increased sense of purpose in their education, and emotional support also led to behavioral and academic improvements, with previously struggling pupils showing better performance and stability at home.

> *'And apart from improving on attendance, the intervention has also made the learners to improve on their studies. They are now scoring higher grades compared to the time before the intervention began.'* (Group interview, School Personnel – School A)

> *'Lastly, this project has improved the education of our children. My child is now able to attend school every day, and she is now happy and has an interest in studying.'* (Group interview, Male parent – School B)

In general, there were multiple calls by the wider community for the expansion of the intervention, not only to additional schools but also to additional categories of pupils (i.e., more grades), and additional refugee settlements:

> *'I wish it could be scaled up to the entire country. I wish it could go everywhere, in all regions of the country, because violence is not just in one refugee settlement [...]. So I wish other partners could come on board, government could come on board and take it up and scale it up.'* (Group interview, Government officials [OPM, MGLSD, MoE, MoH] – National level)

> *'You should think of scaling up to other schools, bringing on board more para-social workers, more parental engagement, so that in all areas there is a chance of helping out. You can also think of training of trainers.'* (Group interview, District leadership)

As further evidence of perceived demand for the intervention, teachers within the participating schools – despite their acknowledgment of not being best-placed to handle screening (due to their role as disciplinarians, which conflicts with the kind of persona required for effective screening), expressed their interest in enhancing their skills to support screening processes. Pointing to psychological first-line counseling and referrals, and the sustainability that could be fostered if teachers possessed these skills, teachers advocated for such capacity-strengthening:

> *'My main take is for the teachers to be trained because we are the ones who are with the learners most of the time. During the screening exercise, we had seven para-social workers in the school. […] And look what they were able to do within that short period. You can imagine what the teachers can do if they are trained.'* (Group interview, School Personnel – School A)

> *'There was a child […] whom we have been referring to as a child having mental problems, but little did we know that the child had been going through several underlying challenges. And he had even lost hope in life and was even thinking of hanging himself. Thus, when screening was done, really, the challenges were identified, and referrals were made. Right now, the child is okay and doing very well in his studies and very interactive with his peers and other people […]. The intervention […] has made me very happy and made me to learn that, these children, we don't have to be handling them in a rough manner when they come to us. We need to listen to them because they have many challenges, hence, we need to give them a listening ear.'* (Group interview, School Personnel – School A)

Furthermore, Kiryandongo District representatives reported using emerging evidence from the screening intervention to inform their child protection and legal work, and to influence policy and programming at the local and regional levels.

> *'The data that was given to us is a working document for us. […] For the local leadership, […] it gives us handy data which informs our advocacy, our lobbying. Because at the regional meeting in Hoima, I used the same data to rally support from the different partners to support us on child protection.'* (Group interview, Local government leadership)

Evidence of Acceptability

Intent to Continue Use of the Intervention

Group interviews shed light on humanitarian and government stakeholders' strong commitment to continuing the screening intervention in pilot schools and expanding it further. In recognition of the intervention's positive effects on disclosure promotion and SV service uptake, government stakeholders expressed their interest in finding ways to integrate the model into routine health and education systems. Government stakeholders also highlighted the need to train more personnel, secure long-term funding, and embed the intervention into existing policies to ensure sustainability.

> *'We may not need to always place para-social workers in schools. We could use community/village health teams (VHTs), too. They are not only handling health issues, but they are also trained to address other issues, including VAC and GBV. They are trained to refer cases and provide psychosocial support. [...] We should integrate PSWs and VHTs for sustainability.'* (Group interview, Government officials – National level)

> *'The government has been informed, and now, we need to lobby for more resources, we need to act by educating, by sensitizing and doing that [screening]. (...) We need the teachers fully trained (...), because you will not keep on coming as a sustainable way, they must remain with the knowledge, they have to be equipped with the skills of screening because that skill can help them to [screen children] every term.'* (Group interview, Local government leadership)

In a similar vein, non-governmental organization stakeholders' narratives touched on the need for scale-up to ensure a larger proportion of survivors could be reached:

> *'I think [the intervention] should be carried out in more schools. (...) We had around 18 [children] being referred daily, they come with their para-social workers (...) so if we see that big number [for two schools] how about when we tackle more schools? I think (...) it should be extended to those other schools, it would solve a lot.'* (Group interview, Health response partners)

> *'[We request] stretching out [this intervention] to the other [pupils] and other schools, which will benefit the other communities who are not able to receive those services from those locations.'* (Group interview, Child Protection response partners)

> *'Now, we are looking at other schools within the settlement. These are the only two schools that got the services, but we also looking at other schools – how are we going to do it, how are [children] supposed to be supported (...) we hope for those children to get services too.'* (Group interview, Health response partners)

> *'The [screening intervention] approach being holistic, it has really covered all issues when it comes to [...] providing protection services because the cases that [were]*

identified were referred for immediate support and […] even families were supported overall. We appreciate such a holistic approach. You should continue doing this and strengthen it and roll out even at the national level.' (Group interview, Child Protection response partners)

Satisfaction with the Intervention among Pupils

Pupils intimated that the screening intervention was particularly valuable to them. Given the child-parent and parent-child communication challenges mentioned above, their satisfaction stemmed largely from the newfound ability to discuss their experiences of SV with their parents/caregivers. The screening helped reveal these experiences, and, over time, the series of student sensitization sessions and parent dialogues equipped children and parents alike to handle such sensitive topics. Some children who struggled to disclose their experiences directly to their parents asked the PSWs to facilitate communication, further enhancing the connection between parents and children.

'In March 2022, some girl wrote me a love letter thrice, asking me to be her sex partner [.] She was a friend to my cousin, so I told my cousin to tell her friend to stop forcing me to be her boyfriend because I didn't want it. But they all kept insisting[.] This year again, my sisters brought a letter from that same girl. This happened after your first sensitization, so I decided to report them to my aunt, who is like my mother[.] She called all of them and warned them never to disturb me again. I felt relieved because since that day, my sisters stopped forcing me to love their friend[.] I even feel that my level of concentration in class has improved because those girls were stressing me so much.' (Fieldnotes: 17-year-old boy, sexual harassment by a relative)

'There were children who could be going through something, and they feared talking to their parents. Some would come to me and tell me, 'Madam, please go talk to my parents because I cannot do it.' But nowadays, they are no longer coming, so I think they are talking to their parents whenever they are faced with any challenges. They are now able to communicate, and parents can listen to them.' (Group interview, School Personnel – School A)

Children who initially struggled with disclosure nevertheless expressed satisfaction with the sense of empowerment and confidence that the intervention provided:

'When I was 12 years old, we were playing hide and seek with my neighbor's kids, and one of the girls who was 15 years old […] had sex with me. I never reported to anyone because she said she would beat me if I reported her. When you were sensitizing us in class about sexual violence, I remembered how that girl used to sexually abuse me and my other brother. […] At first, I feared disclosing it because no one had ever come to our school to ask us about such sensitive and private matters as sexual violence. Thank you for what your organization is doing for children in our school.' (Fieldnotes: 16-year-old boy, completed defilement by a neighbor)

'During the first screening, I was scared to tell you, I felt guilty and thought you would blame me for this [attempted defilement incident]. I thought my teachers, parents, and fellow pupils would be informed and I would be embarrassed.' [After counseling], the PSW and the girl agreed [that the girl would] tell [her] mother. [The girl] said 'I am

happy. Thank you for counselling me, and as agreed with you, I will let my mother know. Thank you so much!' (Fieldnotes: 17-year-old girl, attempted defilement by a neighbor)

'And also, another thing that impressed me so much is, [the intervention] has given our girls that ability to know that they have to raise their self-esteem; they have their voice to speak, no matter what happens to them. At least they now know that […] they have the voice to speak out their minds.' (Group interview, School Personnel – School B)

Group interviews with GBV specialists, sector partners, and parents also confirm children's satisfaction with the intervention – particularly, the student sensitization sessions component of the intervention.

'Children were very excited about the intervention. Usually, sensitization programs target adults. For once, children were at the center of an intervention which allowed them to ask questions about sexual violence, care services available in their community, referral pathways, and so forth. We noticed a very high engagement of children during these sensitization sessions in class. We also conducted gender-segregated sessions and touched upon other topics, including sexual and reproductive health and rights. […] Children who were not eligible to be screened still came to PSWs to receive on-site counseling.' (Group interview, GBV specialist)

'My boy [son] tells me that 'This organization really is there for us as children, and they don't want bad people to harm us'. This made me very happy as a parent and I knew that our children are being helped with their wounds and hopelessness.' (Group interview, Male parent – School A)

Furthermore, positive perceptions among GBV specialists and school personnel of children's increased confidence were a recurring theme in group interviews. They believe that children's participation in the screening intervention, which emphasizes promoting openness, communication, and disclosure, appears to increase their confidence that their school cares about them, which translates into proactive communications with their teachers.

'This intervention is truly exciting as it helps build more trust between children and teachers. Children are now making their teachers their first contact for support, especially for those who have suffered child marriage or are at risk of it.' (Group interview, GBV specialists)

Discussion and Conclusion

The feasibility of systematic screening for promoting disclosure by child survivors of sexual violence and for expanding their access to care has been established and documented by previous studies (Undie & Mak'anyengo, 2020, 2022, 2023). What has been less clear is the extent to which similar interventions can be successfully applied in humanitarian contexts with robust results. Findings from the present study demonstrate similar patterns when compared to the original, development setting-based screening intervention (Undie & Mak'anyengo, 2020): Ultimately, the intervention in both contexts resulted in high survivor disclosure and service uptake rates.

This finding is important, given that, in the present study, trained PSWs took on a function originally designed for trained psychologists. It underscores that, in low-resource contexts, PSWs are able to play a critical role in the response to SVAC – one that supports children and adolescents in opening up and in getting the care that they need. It also highlights the cruciality of instituting the close supervision and mentoring of PSWs by a higher cadre of providers (as carried out under the current intervention) to ensure that PSWs become comfortable, confident, and proficient in their screening role over time, and that careful attention to ethical issues remains foregrounded.

Building on lessons learned from the original model, which relied solely on female psychologists for screening, the current version of the intervention included male providers (PSWs) to promote disclosure among boys, particularly given the much higher proportion of boys enrolled in the school sites. While not directly attributable to this approach, it is noteworthy that a remarkably high proportion of male survivors disclosed experiencing sexual violence under this intervention. Of these, 72 male refugees specifically disclosed experiencing child sexual exploitation/abuse – a violence form that did not arise in the course of the development setting study. As one such male survivor in Kiryandongo Settlement described it:

> *'In 2017, while I was still in South Sudan, I was arrested by the rebels and while in captivity they forced me to have sex with women. If you refuse or fail, you would be killed. I was forced to have sexual intercourse with several women, both young and old. […] Today I have opened up about something that I have never told anyone, I am so worried about my HIV status but because I have been hearing a lot of teachings from your team, I now have the courage to check my status if you can support me through it all.'* (Fieldnotes: 18-year-old boy)

This finding underscores the fact that certain forms of sexual violence are unique to humanitarian settings, and are gender-specific, with the need for appropriate responses are needed to attend to them. Notably, no girls disclosed this violence form. On the other hand, about half of the girls disclosing sexual violence referred to experiencing sexual harassment – the form of sexual violence disclosed the most out of all other kinds of sexual violence. Programming for sexual violence against children must therefore take gender specificity into account.

Additionally, the original screening tool was enhanced in this humanitarian setting study to include questions on disability. Doing so helped not only to reaffirm the increased vulnerability of children with disabilities in these settings, given their higher levels of sexual violence disclosure (Odwe, Muthuri, Obare, Kisaakye et al., 2024), but also to confirm the utility of the intervention for some of the most marginalized children.

Children's experience of polyvictimization almost always included sexual touching by the perpetrator concerned. This signals the need for awareness programs that educate children about appropriate and inappropriate physical contact right from early childhood. This is critical, given that inappropriate touching can be a strong indicator of the likelihood of subsequent and more severe forms of sexual violence.

With regard to perpetration, a high proportion of those identified as inflicting sexual violence on pupil survivors happened to be fellow pupils, in addition to neighbors, strangers, and (for boys) relatives. This range of offenders requires a community-wide prevention approach to stemming sexual violence. Furthermore, a thoughtful, tailored, early onset approach is required for addressing perpetration by children and adolescents – one that involves age-appropriate education centered on issues such as consent, healthy relationships, healthy sexuality, and gender issues (Undie, Chrichton, & Zulu, 2007; Undie & Mak'anyengo, 2020).

Parent-child communication for the enhancement and safeguarding of children's sexual and reproductive health and rights is well-discussed in the literature (Crichton, Ibisomi, & Gyimah, 2011; Kamangu, Magata, & Nyakoki, 2017; Isaken, Musonda, & Sandøy, 2020; Grey, Atkinson, Chater, Gahagan et al., 2022). However, this study adds to the sparse evidence base on the importance of *child-parent* communication for preventing and responding to sexual violence. It is as critical for children to be empowered to communicate with their parents about sexual violence as it is for their parents to be equipped for such conversations. Interventions geared toward fostering bi-directional communication between children and parents must be developed as a means of mitigating sexual violence (Undie & Mak'anyengo, 2023). Without them, child/adolescent survivors are unlikely to have the tools to be proactive in disclosing sexual violence incidents early on before they escalate.

A unique aspect of the intervention in the humanitarian context involves the age range of pupil beneficiaries. In Uganda's development context, pupils in Primary 6-7 are typically 11- to 13-years-old. With the disruptions to education faced by refugees in their home countries, a considerable proportion understandably fall outside this age range. In the present study, 65% of pupils who participated in the screening intervention were ages 16 and above, with the oldest pupil being age 35. This reality points to two issues: The fact that school-based interventions in humanitarian settings must take older pupil populations into account, and the evidence (from the present study) that screening interventions designed to promote disclosure and health service uptake among children and adolescents might also be useful for older students schooling within the same context.

While this study was designed to assess feasibility, evidence from school records demonstrates what happens when screening does <u>not</u> occur, shedding light on the effectiveness of the screening intervention, as well. Specifically, school records collated by Windle International Uganda, UNHCR's lead implementing partner for education, indicate that in the absence of screening in the two primary schools for a full 12-month period before the

intervention began (February 2023 to March 2024), a total of 16 pupils were passively identified and supported as sexual violence survivors. During this same 12-month period, a total of 40 survivors of sexual violence were passively identified across all 5 public primary schools in Kiryandongo combined. In contrast, during the 5-month period devoted specifically to screening in the two primary school sites (May to September 2024), a total of 653 pupils were identified as having experienced some form of sexual violence, and as having received care.

Nevertheless, screening for sexual violence within schools is only recommended with an abundance of caution. As indicated elsewhere (Undie, Maternowska, Mak'anyengo, & Askew, 2016; Undie, Birungi, Namwebya, Taye et al., 2016; Undie & Mak'anyengo, 2020), screening interventions should only be established in settings where a comprehensive response and strong referral linkages exist, and are ascertained in advance to be functioning to minimize risks to identified survivors. Capacity-strengthening for providers to conduct screening properly and ethically is also needed. In the intervention under assessment, the training of PSWs was coupled with close, day-to-day supervision, monitoring, capacity-building, and mentoring of PSWs by GBV specialists throughout the 5-month screening period to ensure a robust and ethical response to survivors. Intermittent monitoring was also conducted by the MGLSD. PSW monitoring and oversight will continue to be key under this task-shifting model. To render this even more feasible, screening can be scheduled to occur once a term, or twice overall during the school year.

The limitations of this study are acknowledged. Despite the high school enrollment rates in the study context, which make schools an efficient platform for reaching children/adolescents, it is plausible that pupils who were absent from school during the intervention were experiencing worse forms of SV that hindered their school attendance. For example, a small proportion of pupils who signed up to participate in the intervention ended up being absent from school throughout the intervention period. Furthermore, although a small proportion of parents declined participation in the intervention, the study still focused on a sample of parents (and pupils) that consented to participate. While this sample was the vast majority and therefore cannot necessarily be said to be a select group, it is noteworthy that parents who chose not to participate may have had different characteristics that the study is unable to capture.

These limitations notwithstanding, findings from the study demonstrate that school-based, PSW-led screening for sexual violence against children is feasible to conduct in humanitarian settings. Screening of this kind is also effective for promoting disclosure and enhancing the uptake of available sexual violence services.

Programming Recommendations

Findings from the study lead to the following programming recommendations for humanitarian contexts in Uganda:

- Introduce sexual violence prevention and response programs early on in the lives of children, ensuring the inclusion of the most rudimentary of prevention approaches (such as 'good touch-bad touch' awareness programs) to help mitigate the tide of more

severe forms of sexual violence over time. These interventions should be coupled with community-wide prevention programs targeting a wide variety of community members for effective prevention and response.

- Develop effective, evidence-based approaches to preventing child-on-child perpetration of sexual abuse, including appropriate psychosocial (and other) responses for both child survivors and child perpetrators.
- Strengthen parenting and children's empowerment programming by enhancing bi-directional communication between parents and children (i.e., both parent-child and child-parent communication).
- Consider offering screening interventions to other populations (particularly, in service delivery contexts where under-reporting is a concern), given that the current, child/adolescent-focused model was effective in promoting disclosure among youth and adult survivors, and in linking them to care.
- Introduce school-based sexual violence screening protocols carefully and cautiously, with attention to: 1) establishing functioning, post-screening service provision and strong, 'warm' referral systems before the commencement of screening, and 2) close monitoring, supervision, and mentoring of PSWs carrying out screening.
- Incorporate the tested screening model into Uganda's National Training Manual for Para-Social Workers. Develop an accompanying, user-friendly screening handbook for trained PSWs to refer to during their daily work. The handbook in question should be attentive to average PSW literacy levels.
- To avoid the exclusion of the most marginalized survivors, expect and prepare to respond to emerging, gender-specific forms of sexual violence, and to children/adolescents living with disabilities.

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Appendices

Appendix 1: Screening Tool for Sexual Violence Against Children

NOTES FOR PARA-SOCIAL WORKER (PSW):

1. This tool is to be used during school recess and any free periods in Primary 6-7.
2. This tool is to be used **only** with pupils meeting **all** of the following criteria at **[Name of School]**:

Those in Primary 6-7
Those who have a record of parental permission on file
Those who have a record of personal assent on file

Please consult your register for the list of pupils meeting these criteria.

3. Using this screening tool could pose psychological risks for pupils who have experienced sexual violence. Be alert to signs of distress during the screening process. Be prepared to offer immediate counseling, if deemed necessary and

NAME OF PUPIL: _____ CLASS: _____AGE_____

Introduction

Hello, [Name of Pupil]. How are you today? My name is [Name of PSW].

Please have a seat. Thank you for stopping by to see me today. I'm not going to take too much of your time.

Now, remember how we've been having assemblies where we talk about 'good touches' and 'bad touches,' and 'sexual violence,' and about how pupils should let someone know if this is happening to them so they can get help? And you may also remember that we always mention that we want to do something about 'sexual violence' to help any pupils in school who may be going through this. Do you remember hearing about this? [If not, provide an overview.]

Okay, great. Now, we are asking pupils at this school a few questions just to see if there is anyone that needs help. Please know that whatever we say in this room is between you and me. No one else will know what you have said, okay? Also, if I ask you a question that you do not want to answer, I want you to just hold up this red card, okay? If you do that, I will just move on to the next question.

Do I have your permission to continue? YES ___ NO ___ (if 'NO,' end the screening exercise)

Now, let me start with some questions to find out whether you have any difficulty doing every-day things (NOTE TO PSW: THESE QUESTIONS ARE TO BE ASKED DURING THE FIRST ROUND OF SCREENING ONLY.):

1.	Are you blind, or do you have serious difficulty seeing, even when wearing glasses?	YES, CANNOT DO AT ALL..... YES, A LOT OF DIFFICULTY..... YES, SOME DIFFICULTY..... NO, NO DIFFICULTY..... DON'T KNOW..... DECLINED.....	1 2 3 4 98 99
2.	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	YES, CANNOT DO AT ALL..... YES, A LOT OF DIFFICULTY..... YES, SOME DIFFICULTY..... NO, NO DIFFICULTY..... DON'T KNOW..... DECLINED.....	1 2 3 4 98 99
3.	Do you have serious difficulty walking or climbing stairs?	YES, CANNOT DO AT ALL..... YES, A LOT OF DIFFICULTY..... YES, SOME DIFFICULTY..... NO, NO DIFFICULTY..... DON'T KNOW..... DECLINED.....	1 2 3 4 98 99
4.	Do you have serious difficulty hearing?	YES, CANNOT DO AT ALL..... YES, A LOT OF DIFFICULTY..... YES, SOME DIFFICULTY..... NO, NO DIFFICULTY..... DON'T KNOW..... DECLINED.....	1 2 3 4 98 99
5.	Do you have difficulty dressing or bathing?	YES, CANNOT DO AT ALL..... YES, A LOT OF DIFFICULTY..... YES, SOME DIFFICULTY..... NO, NO DIFFICULTY..... DON'T KNOW.....	1 2 3 4 98

		DECLINED.....	99
6.	Because of a physical, mental, or emotional condition, do you have difficulty doing errands/chores alone such as collecting firewood, collecting water or shopping?	YES, CANNOT DO AT ALL..... YES, A LOT OF DIFFICULTY..... YES, SOME DIFFICULTY..... NO, NO DIFFICULTY..... DON'T KNOW..... DECLINED.....	1 2 3 4 98 99
7.	Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	YES, CANNOT DO AT ALL..... YES, A LOT OF DIFFICULTY..... YES, SOME DIFFICULTY..... NO, NO DIFFICULTY..... DON'T KNOW..... DECLINED.....	1 2 3 4 98 99

Now, we've talked a lot about 'sexual violence' during school assemblies. Can you tell me what 'sexual violence' means? [Offer praise for the pupil's understanding of the term. Fill in any gaps, if necessary.]

Now, if you don't feel comfortable answering 'yes' or 'no' to this next question, you can write down your answer for me instead, or hold up the green card for 'yes,' or the red card for 'no,' okay?
I'm so sorry to hear that. We talked about what 'sexual violence' means, and the different kinds of sexual violence. If you don't feel comfortable answering this question out loud, you can write down

Question 1: Have you ever experienced sexual violence?

YES ___ NO ___ (if 'NO,' skip to Closing 1)

Question 2: What kind of sexual violence has happened to you?

Insert description here. Probe to determine type of sexual abuse, e.g.: rape, attempted rape, touching of private parts, attempted touching of private parts, being forced to touch the private parts of someone else, or to perform any kind of sexual act, being forced to watch pornographic movies, etc.

your answer for me, or show me what you mean using these two dolls.

If you don't feel comfortable answering this question out loud, you can write down your answer for me.

Question 3: Who were you sexually violated by?

Stranger __ Relative (specify) ___ Neighbor ___ Fellow Pupil ___ Other (specify) __

If you don't feel comfortable answering 'yes' or 'no' to this next question, you can write down your answer for me instead, or hold up the green card for 'yes,' or the red card for 'no,' okay?

Question 4: When did the incident of sexual violence happen?

YEAR ___ MONTH___ DON'T REMEMBER _____

Question 5: Are you experiencing sexual violence right now?

YES ___ NO___ (if 'NO,' skip to Question 8)

Question 6: What kind of sexual violence are you experiencing g right now?

Insert description here. Probe to determine type of sexual violence, e.g.: completed rape, attempted rape, touching of private parts, attempted touching of private parts, being forced to touch the private parts of someone else, or to perform any kind of sexual act, etc.

If you don't feel comfortable answering this question out loud, you can write down your answer for me, or show me what you mean using these two dolls.

If you don't feel comfortable answering this question out loud, you can write down your answer for me.

Question 7: Whom are you being sexually abused by?

Stranger __ Relative (specify) ___ Neighbor ___ Fellow Pupil ___ Other (specify) __

I'm sorry to hear about what you've gone through. I want you to know that there are different kinds of help we can offer. We can start by having you talk to someone about what is going on so that we can find out the kinds of help that you need.

Question 8: It would be good to get some help to make sure you are healthy. Would you like to get

Question 9: Would you like your parent to be with you when you get help, or would you like to be alone?

ALONE ___ WITH MOTHER___ WITH FATHER___ WITH BOTH___

(When done with this question, skip to Closing 2)

Closing 1 (for those who have not experienced sexual violence)

I want you to know that it was brave of you to come in and talk about sexual violence. I'm happy that you are not going through this. I will call you in again over the next few months just to make sure everything is going well with you. If any kind of sexual violence ever happens to you, please do not keep quiet about it. Feel free to stop by and see me to talk about it, or make sure you tell someone that you trust. Many pupils experiencing sexual violence do not know who to tell or that help is available. I just want you to know that there is help, in case you ever need it. Also, if any other pupil at

this school tells you that they are experiencing sexual violence, I would like to ask you to tell them not to be afraid, but to come talk to me. *Do you have any questions for me before you leave?*

Closing 2 (for those who have experienced sexual violence)

I want you to know that you've done a very brave thing today by telling someone about what you're going through. You have not done anything wrong or 'bad', and you are not to blame for what has happened/is happening. Now that we know you need some help, we are going to do everything we can to make sure that you get it.

There are many other pupils who are going through the same thing, but they don't know who to tell and they don't know that help is available. If any other pupil at this school tells you that they are experiencing sexual violence, I would like to ask you to tell them not to be afraid, but to come talk to me. *Do you have any questions for me?*

NOTES FOR PSW:
Pupils disclosing sexual violence have already been asked if they would like to talk further and get help along with their parent(s). For those that have experienced forms of sexual violence **other than completed rape/defilement**, offer first-line counseling, and schedule (school-based) follow-up counseling sessions and, as needed. Pupils who would like to get extra support outside the school should be taken through the referral process outlined below.

Instructions for those that have experienced completed rape:

For those preferring to get help along WITH their parent: Initiate the referral process: contact the parent via phone (asking that they pay a visit to the school) or home visit (provided the parent was not named as the perpetrator). Confidentially advise the parent of the situation and of available services. Schedule an appointment with the one-stop center and inform the parent of the date and time. Ensure that the parent and pupil are accompanied on this appointment by a PSW trained under this intervention.

For those preferring to get help WITHOUT their parent: Provide an initial, school-based counseling session. Based on this session, devise a counseling plan for the pupil which will take place at school. It is important to take the pupils' opinions about their home situation seriously. If a pupil is of the opinion that involving their parent in this situation would be risky or undesirable, **do not** try to convince them otherwise. Rather, proceed to contact the one-stop center and ensure the pupil is accompanied there for comprehensive care.

Appendix 2: Parent Dialogue (Adaptable Agenda)

Name of Primary School _____
Date _____

Time Slot	Activity	Responsible
9:00-9:05	Opening Prayer	Parent
9:05-9:10	Welcome Remarks	Head Teacher Deputy Head Teacher
9:10-9:40	Brief Remarks	Multi-Functional Team Representatives
9:40-9:50	Overview of Sexual Violence Against Children in [NAME OF COMMUNITY]	TBD
9:50-9:55	Introduction to the Skit	TBD
9:55-10:10	Skit by Pupils	TBD
10:10-10:40	Reactions from the Floor Facilitated Discussion (Part 1)	TBD
	Distribution of bottled water	ALL
10:40-11:00	Facilitated Discussion (Part 2)	TBD
11:00-11:20	Facilitated Discussion (Part 3)	TBD
11:20-11:30	What we plan to do: Screening, referral, and access to health services	TBD
11:30-11:50	Facilitated Discussion (Part 4)	TBD
11:50-12:00	Final Word	Head Teacher
12:00-12:10	Pass out parent permission slips	TBD
12:10-12:15	Closing Prayer	Parent
12:15-1:00	Collection of parent permission slips	TBD
1:00-2:00	LUNCH	
2:00	Dismissal	

Preparation for the Skit/Drama by Students

In each school, with permission from the school head, work with drama teachers (or any teachers with an interest in drama) to have school children prepare to perform a 15-minute skit on the day of the parent dialogue. The skit should focus on the devastation of sexual violence against children – how it affects the child, the family, and the community.

Possible Scenes to Include:

a. Mother urging child to keep quiet about the violence
b. Perpetrator visiting to compensate for the crime by giving the parents a chicken
c. Trauma of the child survivor (crying, not concentrating in school, HIV infection)
d. The help of the trauma counselor, taking the survivor to the hospital
e. The survivor in the skit could be either a boy or a girl.

Facilitated Discussion (Part 1)

Give parents time to react to the skit independently and then begin facilitating the discussion. The questions below are a guide. Although they have been used successfully in previous parent dialogues, facilitators should feel free to include new questions based on the context, the flow of the discussion, and the amount of time available.

a. What are your initial reactions to this play/skit?

b. What did you like/not like?
c. What did you agree/disagree with?

Facilitated Discussion (Part 2)

a. What are some of the things you saw in the play that are actually happening in your community?
   Probes (if necessary)
   - Mother encouraging silence
   - Perpetrator trying to pay off the parents

b. When it comes to sexual violence against children in your community, what have you observed?
c. [Anything else that comes up]

Facilitated Discussion (Part 3)

a. When sexual violence happens, are there any support mechanisms for affected children in the community? What about for the parents of affected children?
b. As a parent, if this happened to your child, would you want to know? Would you know where to get help?
c. [Anything else that comes up]
d. In this school, we would like to begin asking pupils (privately) whether they are experiencing any kind of sexual abuse so that we can make sure they get help. What do you think of this approach [**bear in mind that some parents/caregivers may be the actual perpetrators**]?

Facilitated Discussion (Part 4)

You've heard about the new plan in this school to be proactive by asking children if they have experienced sexual violence, rather than assuming that they have not, or waiting for sexually abused children to open up on their own.

a. What's good about this approach?
b. What are your concerns about this sort of approach?
c. What do you recommend?

Appendix 3: Parent Permission Slip

(For pupil participation in screening intervention)

[DATE]

Dear Parents and Guardians of Pupils in Primary 6-7 at [NAME OF SCHOOL]:

Sexual violence against children has become a big problem in our schools and communities. Children who have experienced sexual violence need health care and other kinds of support to help them overcome the trauma that it causes. In [MONTH, YEAR], [NAME OF SCHOOL] is taking action to ensure that its pupils are able to get the help they need if they do experience this kind of violence. Parents/guardians also need support when their child experiences sexual violence, and we want to make sure that parents/guardians are included in this process.

We are spending the day with parents/guardians of pupils at [NAME OF SCHOOL] to provide more information about how the school will help pupils who have experienced sexual violence. Please feel free to ask any questions you may have during today's meeting.

Sincerely,

Head Teacher, [NAME OF SCHOOL]

Please cut off and return the permission slip below, today, [DATE].

✂ --

Pupil's Name ____________________________ Pupil's Class ______ Date _____________________

____ **No**, my child does not have permission to participate in the sexual violence against children screening exercise at [NAME OF SCHOOL] from [MONTH to MONTH, YEAR]

____ **Yes**, my child has permission to participate in the sexual violence against children screening exercise at [NAME OF SCHOOL] from [MONTH to MONTH, YEAR]. **I understand that my child may opt out of participating, despite my permission.** I also understand that my child's screening information will be combined with that of other children, their names will be removed from this information to protect their privacy, and the information will be studied by researchers to better understand the problem of sexual violence in schools in this community.

____ **Yes**, I authorize [NAME OF SCHOOL] to take the necessary steps to get care for my child at the nearest one-stop center in Kiryandongo Settlement in the event that my child has experienced sexual violence and I am not available to accompany my child from [MONTH to MONTH, YEAR].

Parent's name _________________ Parent's signature_________ Parent's phone number _________

Appendix 4: Pupil Assent Slip (only for pupils with parental permission)

(to take part in being asked some questions about sexual violence in private)

[DATE]

Dear Pupil in Primary 6-7 at [NAME OF SCHOOL]:

Sexual violence against children has become a big problem in our schools and communities. Children who have experienced sexual violence need health care and other kinds of help for them to feel better and live a better life. In 2024, [NAME OF SCHOOL] is doing something about this problem so that its pupils can get the help they need if they do experience this kind of violence.

We spent a day with parents/guardians of pupils at [NAME OF SCHOOL] to share information about how the school will help pupils who have experienced sexual violence. Your parent/guardian attended the event and has given permission for you to be a part of what the school will be doing: Asking pupils questions in private to see if they are facing sexual violence and need help. **You do not have to take part in this if you do not want to – even if your parent/guardian has given you permission to do so.**

Please fill out the form below, letting us know what you decide. You can change your mind about your decision at any time.

Sincerely,

Head Teacher, [NAME OF SCHOOL]

Please cut off and return the form below by [DATE].

-- --

Pupil's Name ____________________________ Pupil's Class ______ Date __________________

____ **No**, I would not like to take part in my school's activity on asking pupils questions in private to see if they are facing sexual violence and need help from [MONTH to MONTH, YEAR]. **I understand that I am allowed to change my mind about this whenever I want to.**

____ **Yes**, I would like to take part in my school's activity on asking pupils questions in private to see if they are facing sexual violence and need help from [MONTH to MONTH, YEAR]. **I understand that I am allowed to change my mind about this whenever I want to.** I also understand that the information I share will be combined with other pupils' information, our names will be removed from this information so no one will ever know what we have shared, and this combined information will be studied by researchers to better understand the problem of sexual violence in schools in this community, and how to deal with it.

Pupil's name ________________________________