Improving the Prevention of, and Response to SEXUAL VIOLENCE AGAINST CHILDREN (SVAC) in Zanzibar, Tanzania

Endline Evaluation Report of the KUWAZA III Project

2024

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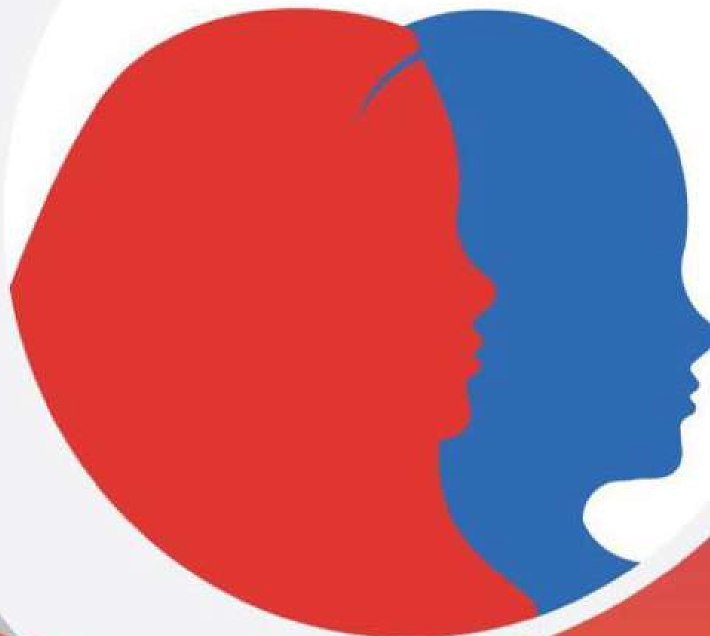

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Children celebrating the graduation of the 12 SVAC prevention sessions at Mahonda Shehia. © Pathfinder Intl Tanzania

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LIST OF ABBREVIATIONS

AIPW	Adjusted Inverse Probability Weighting
ATE	Average Treatment Effect
ATET	Average Treatment Effect on the Treated
CHV	Community Health Volunteer
CSA	Child Sexual Abuse
DHS	Demographic and Health Survey
FGD	Focus Group Discussion
GBV	Gender-based Violence
KII	Key Informant Interview
KUWAZA	Kuzuia Uzalilishaji wa Watoto Zanzibar
NPA-VAWC	National Plan of Action to end Violence Against Women and Children
SVAC	Sexual Violence Against Children

EXECUTIVE SUMMARY

Tanzania's National Plan of Action to End Violence Against Women and Children (NPA-VAWC 2017/18–2021/22) envisions a society where children enjoy an environment free from all forms of violence. Yet, recent evidence indicates that in many parts of the country, including Zanzibar, boys and girls of all ages are at risk of abuse and exploitation, and that sexual violence against children (SVAC) remains prevalent across different settings: at home, at school, and in communities. Currently, more than 1 in 20 females and about 1 in 10 males aged 13 to 24 from Zanzibar experience at least one form of sexual violence before the age of 18.

The KUWAZA III program was a three-year multi-component SVAC primary prevention and response intervention, funded by the OAK Foundation. The program, implemented by Pathfinder International Tanzania, Action Aid Tanzania, C-Sema, and the International Center for Research on Women, aimed to improve primary prevention of SVAC and strengthen secondary prevention services in Unguja North, Zanzibar. KUWAZA Phase III has three main pillars: 1) develop a synchronized SVAC prevention training toolkit and deploy it to a cohort of children aged 7-10 and 11-14, parents/teachers, religious leaders, and local leaders; 2) provide services to establish a surveillance system, strengthen case management, and implement a child help hotline, and 3) develop an advocacy strategy to ensure critical changes at all levels of society, along with the social-ecological model, which will help prevent SVAC.

This report presents findings of an endline evaluation study that focused on the first pillar, assessing the effectiveness and impacts of the SVAC prevention toolkit after the implementation of synchronized SVAC prevention training to a cohort of children aged 7-10 and 11-14, parents/teachers, religious leaders, and local leaders. The study aimed to document changes in knowledge, attitudes, perceptions, and behaviors related to SVAC, including child sexual abuse and exploitation in Zanzibar. A quasi-experimental study design involving mixed-method research was used to collect quantitative and qualitative data. The study was conducted in the North A and North B districts of the North Unguja region of Zanzibar, Tanzania, in 39 *shehias* (27 intervention *shehias* and 12 control *shehias*). At baseline, 1,221 children and 701 parents/caregivers were interviewed, and at for the endline study, 739 children and 421 parents/caregivers were interviewed.

The endline evaluation showed significant improvements in children's knowledge of SVAC-related harmful practices (p=.000) and legal protections for children (p=.000). However, in all findings, there were observable differences among children with different social demographic characteristics, including age groups and sex. For instance, girls showed notably higher knowledge levels than boys on SVAC-related harmful practices and legal protection (p=.000), while boys had significantly higher knowledge

of reporting points than girls (p=.000). The younger children (7-10 years) had significantly higher knowledge of SVAC-related harmful practices than the older ones (11-14 years) (p=.000). On the other hand, older children (11-14 years) and children residing with biological parents had significantly more knowledge about legal protection and reporting than their respective counterparts (p=.004). The intervention increased children's self-reported willingness, agency, and confidence to report SVAC (p=.000), including an increase in their self-reported confidence in disclosing instances of abuse. By endline, children in the intervention group were three times more likely to have asked a question about SVAC than their counterparts (p=.000). Overall, data showed positive shifts in children's attitudes toward SVAC, for instance, a reduction in sexual abuse survivor-blaming. Additionally, the intervention had a positive influence on parental attitudes toward believing children who report abuse, indicating success in dispelling myths and misconceptions surrounding SVAC survivor disclosure. Findings show that the intervention facilitated open communication and dialogue on sensitive topics like SVAC within families and communities. Parents also showed increased awareness of informal reporting avenues and positive attitude changes, though formal reporting channels remained underutilized. Despite these gains, behavior changes were slow, highlighting the need for sustained efforts. Recommendations include the following:

- **Consider further robust randomized controlled trial studies before scaling up the SVAC toolkit.**
- **Increase emphasis and strengthen the implementation of culturally sensitive toolkit sessions that address specific misconceptions around SVAC.**
- **Ensure continuous awareness and education of stakeholders on SVAC to reinforce positive messages and sustain positive beliefs and behavior change while addressing harmful cultural norms.**
- **Strengthen formal reporting mechanisms and build trust among parents and children to use these channels.**

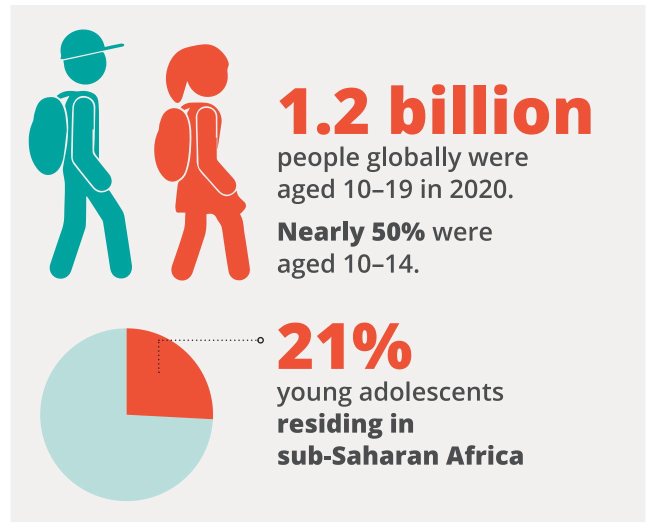
Overall, the KUWAZA SVAC toolkit made substantial progress in raising awareness, changing attitudes, and improving behaviors related to SVAC, but ongoing support is essential for a lasting impact.

INTRODUCTION

1.1 Background

In pursuance of Agenda 2030, Sustainable Development Goals (SDGs), and the African Union Commission's Agenda 2063 – The Africa We Want, many African countries have developed strategies to reduce poverty and protect the most vulnerable members of their populations. Building on its key strategy document, The Tanzania Vision 2025, Poverty Reduction Strategy II, Tanzania has consolidated its strategy for the prevention of Violence Against Children (VAC) agenda into one document: the National Plan of Action to End Violence Against Women and Children (NPA-VAWC 2017/18 – 2021/22). The NPA-VAWC recognizes that violence occurs on a continuum—violence in childhood has an impact on a person's health and well-being well into adulthood, and that violence is cyclical. It further acknowledges that addressing violence in childhood will also reduce violence against women and that violence is interpersonal as well as inter-generational and impacts individual, family, and community health and well-being. The document also envisions a Tanzania where women and children enjoy their right to an environment free from all forms of violence.

Development community actors increasingly are acknowledging that adolescence (10 to 19 years) represents an important and unique opportunity to reap a triple dividend for adolescents: in the present, for their adult trajectories, and for the trajectories of their children. Globally, in 2020, young adolescents aged 10 to 14 accounted for approximately half of the 1.2 billion people between the ages of 10 and 19, representing about 8 percent of the total global population. Nearly 9 out of 10 of these young adolescents lived in developing countries, with sub-Saharan Africa alone accounting for 21 percent. The young adolescent population in the developing world is projected to grow by over 30 million between 2020 and 2030, with most of this increase expected to occur in sub-Saharan Africa [1]



Indeed, the years between 10 and 19 are critical in accelerating progress against the effects of poverty, inequity, and discrimination, and to foster positive development in adolescents [2]. Although the period of adolescence spans 10 years, early or young adolescence is a time of particularly dynamic and rapid transitions [3]. Girls are especially vulnerable to sexual coercion during early adolescence [4]. Gathering evidence about the timing, nature, and consequences of the key transitions that young adolescents undergo is critical for the development of appropriate policies and programs for this population.

While data are available in the Demographic Health Surveys (DHS) for 21 countries on the percentage of adolescent girls (aged 15-19) who experienced sexual violence and the age at which they first experienced it, similar data for very young adolescents remains scarce. The violence against children surveys are the most recent and detailed data sources for this type of information. Existing nationally representative surveys, such as the DHS, restrict questions to the most extreme forms of sexual violence, offering mostly data on forced intercourse/unwanted sex in the past year for ages 15-19 years [2]. Child sexual exploitation (defined as sex given for money, food, or other favors), though widespread and a severe form of abuse, is rarely available in national statistics. This

is because such acts, by their very nature, are hidden, making it extremely difficult to grasp the true magnitude of the problem.

According to the findings of the violence against children national survey in Zanzibar, boys and girls of all ages are at risk of abuse and exploitation [5]. Sexual exploitation and abuse are prevalent across different settings: at home, at school, and in communities. More than 1 in 20 females and about 1 in 10 males aged 13-24 years from Zanzibar reported experiencing at least one incident of sexual violence before the age of 18. The most common form of childhood sexual violence reported by females was unwanted attempted sex, followed by unwanted sexual touching. The most common form of childhood sexual violence reported by males was unwanted sexual touching, followed by unwanted forced sex and unwanted attempted sex. Among youth aged 13-17 years, 2.3 percent of females and 3.7 percent of males reported that they had experienced at least one form of sexual violence in the past year. Of those who had their sexual debut before age 18, nearly 9.6 percent of females and 13.3 percent of males reported that their first sexual intercourse was unwilling, meaning that they were coerced into sexual intercourse.

A survey of adults and children in Unguja North, conducted by ICRW in 2019 for KUWAZA Phase II, assessed perceptions, attitudes, and knowledge of sexual violence against children (SVAC) among 10–17-year-olds and parents of children in 20 *shehias.*[1] Furthermore, it identified persistent social norms that value intra-family confidentiality in cases of SVAC and reinforce survivor blame based on children's choice of dress, activity, or behavior.

While reliable Unguja-specific SVAC data are not available and difficult to collect because the issue of child sexual abuse (CSA) is sensitive and challenging to study [6], the KUWAZA III intervention draws on global patterns of SVAC to build on the following evidence:

- **The first experience of sexual violence occurs early.** Estimates vary widely by country and are not available for Tanzania, but more than 50 percent of children who report SVAC by age 18 became survivors before the age of 15. In some countries, a majority of SVAC survivors first experience violence by the age of 12 [7].
- **More than 90 percent of abusers** are people children know, love, and trust [8].
- **At least 30-50 percent of SVAC incidents take place within children's homes.** In-home perpetrators are most commonly intimate partners (older adolescents) or other family members (very young adolescents or pre-pubescent children). Schools are settings of vulnerability for boys.[2]
- **Economic vulnerability, physical or cognitive disability, and substance use/abuse** all increase the risk and incidence of SVAC [9].

[1] Shehia is the lowest level government administrative unit in the Revolutionary Government of Zanzibar. A similar level is known as Ward in Tanzania's Mainland.

[2] Stakeholder Interviews and focus groups (2020). Conducted in Kuwaza II program communities.

1.2 The KUWAZA Program

1.2.1 A glimpse of KUWAZA Phase I and II interventions

The KUWAZA program has had 3 phases to date. Phases I and II were implemented by the KUWAZA partners, Pathfinder International in Tanzania, C-Sema, and Action Aid Tanzania from 2014 to 2020. The partners promoted systemic approaches to primary prevention of violence and supported select interventions for secondary prevention, focusing specifically on sexual and gender-based violence prevention among 7–18-year-olds. Phase I and II interventions focused on the household and broader community levels to promote positive masculinity and more gender-equitable relationships, parent-child communication around sexuality and violence, and public acknowledgment and condemnation of violence against children and sexual and gender-based violence. The program used an ecological model to drive normative change through three main approaches: 1) facilitating changes in the household through direct parenting interventions using a modified Families Matter! program curriculum; 2) reinforcing changes in community norms and actions through interventions using Male Engage methodology for community exploration; and 3) supporting household and community changes through a media campaign and reinforcing dialogue and addressing sexual risk through action with children and teachers in schools.

1.2.2 KUWAZA III

The KUWAZA III program, funded by the Oak Foundation, was a three-year, multi-component intervention aimed at preventing and responding to SVAC. The program was implemented by a consortium comprising Pathfinder International Tanzania, Action Aid Tanzania, C-Sema, and ICRW. The program's goal was to reduce SVAC in Unguja North, Zanzibar, through a three-pronged strategy involving:

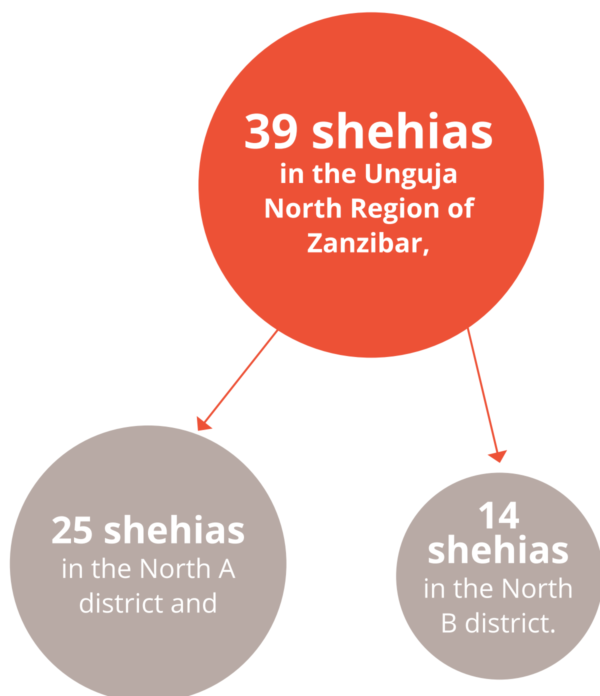
i. Development and delivery of a synchronized SVAC prevention training toolkit among a cohort of children aged 7-10 and 11-14, parents/teachers, religious leaders, and local leaders
ii. Advocacy
iii. Implementation of a child abuse surveillance system, case management strategy, and child help hotline.

The KUWAZA III program has norms-targeting interventions aimed at various segments of the community, including children, parents, teachers, religious leaders, and community leaders. The norms were identified during a collaborative norm-mapping exercise in Zanzibar. Based on the mapping exercise, the most prevalent norms that perpetuate CSA in the communities were: the belief that a girl who has reached puberty or is out of school is ready for adult responsibilities (including sex, marriage, etc.); the fear that disclosing/reporting CSA will compromise a survivor's future marriage due to the belief that men are entitled to marry a virgin bride, and sexually exposed brides (unless known to be widowed or a mother) can be returned to their families; and the widely held norm that boys/men are entitled to sex without consequences, which creates an expectation for girls not to reject a boy/man's sexual advances.

To ensure that children are always safe from SVAC in all places, including their homes and communities, KUWAZA III sought to enhance SVAC prevention skills among adults (parents, caregivers, teachers, and religious and local leaders) and children using the SVAC prevention toolkit, which the project developed. The program also advocated for increased allocation and disbursement of funds for violence against children and enforcement of the Children Act No. 6, 2011.

Situating the SVAC toolkit intervention

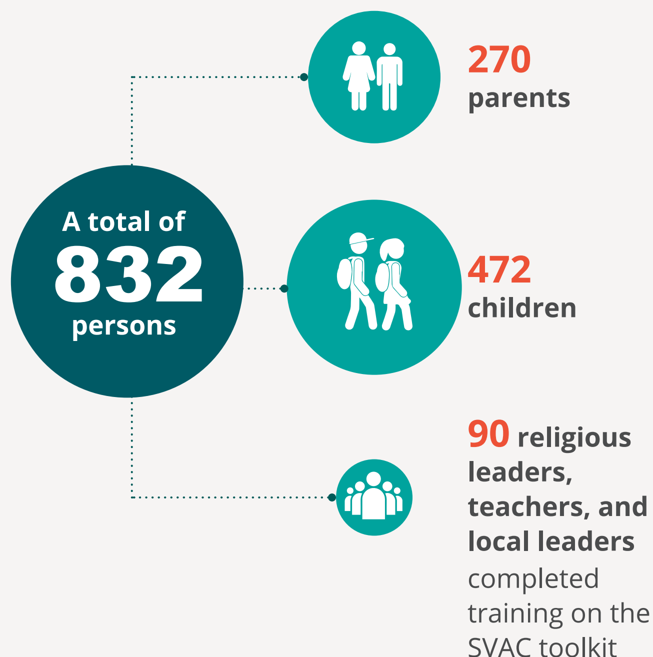
The toolkit intervention was implemented in



At pre-intervention, the study area of North A and North B districts of the North Unguja region was divided into two groups: intervention (also known as treatment) and control groups. All these *shehias* are approximately 1.5 to 2 kilometers apart, with some sharing direct boundaries. Both study groups/communities were selected in consultation with relevant stakeholders, with consideration that they have as many similarities as possible with respect to socio-demographic characteristics.

- *The control group:* Out of the 39 *shehias* involved in the study, 12 were in the control group. The control communities were neither exposed to any of the earlier interventions of KUWAZA (I and II) nor any activities of the KUWAZA III intervention.
- *The intervention group:* Of the 39 *shehias*, 27 were in the intervention group.

Participants for the SVAC toolkit



Training participants were selected based on the following criteria:

- Households with children who are not in school clubs or children who do not go to school or madrassa classes regularly, or out-of-school children
- Households with children aged 7-14
- Households with vulnerable children facing economic hardship, parents/caregivers who suffered from chronic diseases rendering them unable to attend to their children, and households headed by a widow with no reliable source of income, or headed by children. Additionally, households with a history of any kind of violence against children or women were prioritized.

How the SVAC toolkit was delivered

The SVAC toolkit training sessions spanned 12 weeks (three months). Nine sessions were held with children aged 7-10 and 10 sessions with children 11-14. The SVAC toolkit content for children was mostly tailored to be age-sensitive and age-specific. In this case, children of the two age groups attended eight separate training sessions, except for two general sessions where children from both age groups attended together.

Parents/caregivers had 10 sessions and religious leaders, teachers, and local leaders had nine. Each session lasted two hours on a single day of the week. Nine school hubs conducted their sessions on Sundays while one school hub held theirs on Saturdays.

Participant attendance was documented at every session to facilitate regular monitoring and follow-up. The team attempted to follow up with participants who missed a training session. To ensure participation, facilitators maintained direct contact with participants to provide them with regular updates; parents were allowed to substitute for each other in cases of pressing circumstances that required absence. Additionally, facilitators endeavored to ensure that participants did not miss more than three sessions consecutively to avoid excessive learning loss and disqualification. By the end of the intervention, almost 100 percent of the participants in the intervention group had completed the training and had access to the SVAC toolkit. For the effectiveness of the implementation, the team provided supportive supervision for quality assurance.

Following the SVAC toolkit training, participating community members and their leaders developed and implemented a community action plan.

The findings of the KUWAZA III endline evaluation could lead to more robust and more sustained program impacts envisioned in the Theory of Change for the program, presented in Figure 1 below.

Sichana Othman Ali and Kazija Ali facilitating a session to children (10-14 years) at Kidoti school hub.
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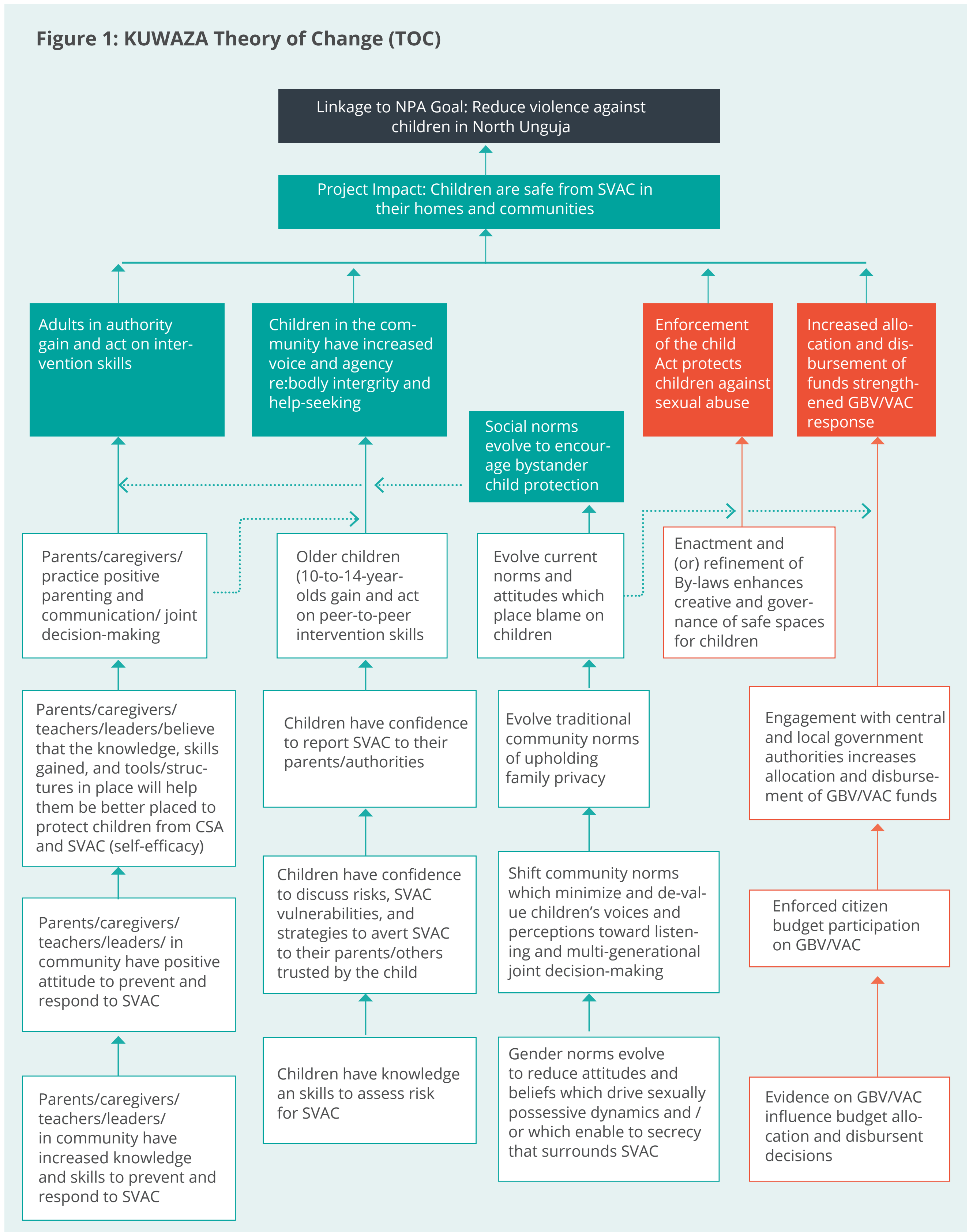
Figure 1: KUWAZA Theory of Change (TOC)



METHODOLOGY

2.1 Objective

The primary objective of this endline assessment was to assess the impact of the KUWAZA III SVAC toolkit on reducing sexual violence against children in Zanzibar, Tanzania. Specifically, this study assessed the impact of the KUWAZA III SVAC toolkit on knowledge, perceptions, attitudes, agency, and intentions/behaviors related to mitigating children's risk of exposure to child sexual abuse and exploitation, including through their reporting and help-seeking.

2.2 Research design

The study adopted a quasi-experimental design. To measure and attribute impact, we used a difference in differences approach to estimate the causal effect. We evaluate the following equation:

$$\Delta Y_{igt} = y_g + y_t + D_{gt}\beta + \varepsilon_{igt}$$

Where ΔY_{igt} is the change in outcome (knowledge, perceptions, attitudes, agency, and intentions/behaviors related to mitigating risks of exposure of children to child sexual abuse and exploitation, including their reporting and help-seeking) across different groups (g), individuals (i) and two time periods (t). **β** is the total effects coefficient, and **ε** is the error term with a parallel trend assumption.

2.3 Scope

The endline study was conducted in the same areas as the baseline study. Initially, the North A and North B districts of the North Unguja region were divided into intervention (treatment) and control groups to estimate changes that could be attributed to the KUWAZA III SVAC toolkit intervention. Specifically, 27 *shehias* were in the intervention group and 12 *shehias* were in the control group. Baseline data were collected from households with children aged 7-14 years and their parents/guardians through cross-sectional quantitative surveys. Qualitative data were gathered through focus group discussions (FGDs) with children and parents/guardians, and key informant interviews (KIIs) with district social welfare officers, teachers/facilitators, community health volunteers (CHVs), women and child welfare coordinators at the *shehia* level, and religious leaders. Data from these sources were triangulated to meet the endline evaluation objectives. The same districts, *shehias*, households, and respondents were revisited during the endline study.

2.4 Sampling design and sampling frame

Sampling procedure: structured survey

The communities (intervention and control) consisted of 39 *shehias*, which were considered a domain of the study. During the baseline study, systematic household sampling frames were used in the 39 *shehias*. Households with children ages 7-14 were the ultimate unit of sampling, with the parents/guardians and respective child/children as the main respondents. The inclusion criterion was to have a child aged 7-14 years in the household.

During the baseline study, the sample size was computed based on the total number of households by using Yamane's (1967) formula with level of confidence of 5 percent as follows:
Whereby:

$$n = \frac{N}{1 + N(e)^2}$$

- **N** is the household population for Unguja North as per the 2012 Population and Housing Census
- **n** is the total household sample size for intervention group
- **e** is the level of significance

Based on the 2012 population and housing census, Unguja North had a total of 36,736 households (20,522 from North A district and 16,214 households from North B district). The final sample size was estimated to be:

$$= \frac{36{,}736}{\mathbf{1} + 36{,}736(\mathbf{0.05})^2}$$
$$= \mathbf{395}$$

Considering the attrition rate of 20 percent and non-response rate of 10 percent, the final sample size for intervention group was estimated at 514 households (parent/guardian). Due to the nature of the study, it implied that at least one child would be included from every sampled household, yielding a total sample to be estimated at 514*2 =1,028.

The same respondents from the baseline study were followed up at the endline. For the intervention group, the inclusion criteria were:

1. **Participation in the baseline assessment study.**
2. **Completion of the training conducted by KUWAZA III partners.**

The second criterion did not apply to the control group. The baseline sampling frame was updated based on these criteria, and the listed children and parents/guardians were revisited for data collection. Essentially, the same respondents from the baseline study were followed up for the endline study.

Qualitative study
Focus group discussions (FGDs) with parents of 7–14-year-olds, in sex-disaggregated groups of 8-12 participants, were conducted to gather community perceptions on SVAC and evaluate the KUWAZA III SVAC toolkit. Participatory sessions with children (7-14 years) were held in age- and sex-disaggregated groups (7-10 years and 11-14 years), with 12-16 children per session. Persons with disabilities were included to understand the project's impact on the most vulnerable.

Key informant interviews with subject matter experts on SVAC focused on external topics and professional opinions. Selected based on their roles in the KUWAZA III program and community SVAC prevention and response structures, KIIs provided feedback on the program's progress, areas for improvement, and strategy effectiveness. Participants included facilitators/trainers, social service providers, community leaders, and police gender desk officers or focal persons.

2.5 Ethical considerations

The Zanzibar Health Review Board and the Office of the Chief Government Statistician reviewed and approved the study protocol. Additionally, permission to conduct the study was obtained from the Office of the Second Vice President of the Revolutionary Government of Zanzibar. Participation was voluntary, with all participants signing two copies of the consent form before responding to questions. Parents/guardians signed on behalf of minors. To ensure the confidentiality of responses, participants' identifying information has been thoroughly expunged from the datasets and reports.

2.6 Measures

The structured survey measured recognition of child sexual abuse and exploitation, as well as relevant perceptions, attitudes, agency, and intentions/behaviors. The tools were compiled and adapted from several existing validated tools.

The study tools assessed perceptions about CSA using the CSA Myth Scale. This is a standardized 10-item tool with responses on a 3-point Likert scale ("agree," "disagree," "unsure"). This scale demonstrated good internal consistency and construct validity in previous studies [10]. Recognition of CSA was assessed using the Assessment of Sexual Abuse in Children tool. The assessment tool demonstrated good discriminant validity, effectively distinguishing between cases of sexual abuse and non-abuse. The internal consistency and reliability measures were also strong, indicating the tool's robustness for assessing CSA [11]. Parent-child communication practices were evaluated using the CSA Prevention Education Scale [12] developed based on a series of published studies. The Children's Knowledge of Abuse Questionnaire was used to measure what was learned regarding important beliefs and facts about child abuse. Recent applications show strong internal consistency ($\alpha = 0.86$) and responsiveness to intervention effects [13]. Understanding of appropriate and inappropriate touch was assessed through the Touch Continuum [14], which continues to demonstrate high content validity and sensitivity in differentiating children's understanding of "good," "bad," and "confusing" touch [15]. Skills that could potentially prevent abuse were also assessed.

According to social cognitive theory, self-efficacy refers to one's perceived ability to deal with a

task or situation [16], while agency is one's actual ability to deal with a task or situation. For this study, perceived agency or self-efficacy for children was measured on a Likert scale assessing respondents' confidence in their ability to enact preferences over life choices and exert control over their own motivation, behavior, and social environment. Initial research using the Children's Knowledge of Abuse Questionnaire as an outcome measure utilized a design where a group of 400 elementary school-aged children were tested at three time points: before participating in a prevention program, two weeks after, and at a five-month follow-up [17]. In their program, participants scored significantly better than children in the control group at post-test, and all children maintained their knowledge gains at follow-up.

For the parents' survey, we used the Parental Knowledge Questionnaire to gauge their knowledge regarding the nature of CSA. The tool consists of nine validated items on commonly misunderstood or underestimated factors. The behaviors captured in the survey included the amount of communication parents/caregivers engage in with their children about CSA Following their participation in the parental/caregiver sessions, the survey measured behavioral outcomes using a 5-item validated self-report scale [18]. Each of the instruments were translated to Swahili, the local language, and translated back to English to ensure consistency in meaning before data collection. Qualitative data helped in unpacking knowledge, attitudes, and behaviors related to SVAC that surfaced in the quantitative surveys.

2.6 Data collection

Before pretesting, all study tools were prepared in English and professionally translated into Swahili. Quantitative data were collected from children and parents/caregivers using computer-assisted personal interviews with the Open Data Kit interface. Qualitative interviews were conducted in Swahili and audio-recorded. These included single-sex FGDs with six to eight participants for boys and girls aged 11-14 years and three single-sex FGDs for caregivers (one for men and two for women). Fourteen KIIs were conducted with religious leaders, CHVs, teachers, social welfare officers, gender desk police officers, district budget officers, and health workers.

2.7 Data analysis

This evaluation assessed changes in knowledge, attitudes, behaviors, decision-making, and intentions to prevent risks of sexual abuse and exploitation among children and parents by comparing baseline and endline data.
Quantitative data were analyzed using descriptive and inferential methods, following a data analysis plan. For descriptive analysis, percentages and counts assessed changes across four groups: control baseline, intervention baseline, control endline, and intervention endline. Inferential analysis used the difference in differences method to compare these groups over time using composite variables and odds ratios. The internal reliability of these variables was checked using Cronbach's alpha, with 0.70 considered acceptable, 0.80 better, and 0.90 excellent [19], [20]. For added accuracy, Adjusted Inverse Probability Weighting (AIPW) was used to control for participant dropouts and measure the Average Treatment Effect on the Treated (ATET) (the intervention group), focusing on intervention group changes from baseline to endline using coefficients.

Qualitative data from interviews (translated from Swahili to English) were coded and analyzed. Both a deductive strategy that drew on the topic guide and an inductive one that enabled themes to develop from transcribed material facilitated the identification of key and common themes. Ongoing and iterative investigation of the research responses and narratives allowed categories, relationships, and features to emerge in the data. Where applicable, verbatim quotes from the respondents are used to illustrate topical issues and expound on the quantitative findings.

2.8 Study limitations

Despite efforts to minimize contamination of the control group, such as by registering participants of the intervention group to ensure they are the only ones attending the SVAC toolkit sessions, it was not possible to eliminate potential spillover of the intervention to the control group. This was due to the geographical proximity of the intervention and control groups—approximately 1.5 to 2 kilometers apart, with some sharing direct boundaries. Some KUWAZA III activities were community-based, such as the development and implementation of a community action plan against SVAC, and it is possible that some elements of the intervention inadvertently influenced the control group, potentially affecting the study's outcomes.

The quasi-experimental study design had some limitations, such as lack of randomization, which could introduce selection bias and affect internal validity. As researchers, we often have limited control over extraneous variables, making it harder to isolate the effects of the intervention. Additionally, our study did not account for other interventions or external factors that might have been occurring simultaneously in the control group.

The relatively short time-frame of the endline study raises the need for caution on some of the conclusion of the study. Beyond the endline study, there is need for a follow-up study to assess the persistence of the effects of the intervention . Finally, the study uses self-reported data, which can be affected by social desirability bias, recall bias, and inaccuracies in reporting sensitive information.

FINDINGS

3.1 Introduction

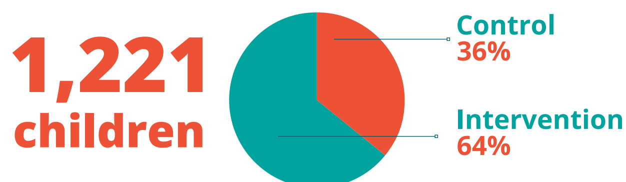
This chapter presents the findings from the baseline and endline studies, which assessed the contribution of the KUWAZA III SVAC intervention to reducing SVAC in the implementation communities in Zanzibar, Tanzania. The data are disaggregated by study phase (baseline vs. endline) and study group (intervention vs. control). The socio-demographics of study participants are detailed, followed by descriptive and regression statistics. Qualitative data are also included to provide context to the findings.

3.2 Children/minors and the prevention of SVAC

3.2.1 Socio-demographic characteristics of children

Table 1 shows the distribution of children across study phases and groups. The baseline survey included 1,221 children, with 36 percent from the control group and 64 percent from the intervention group. The endline survey included 739 children, with 49.5 percent from the control group and 50.5 percent from the intervention group. The studies (baseline and endline) had about the same number of boys and girls (see Appendix A, Table A 1). There were slightly higher numbers of older children (ages 11-14) than younger children (ages 7-10) in both studies. However, the proportions of older children increased at endline, likely due to the passage of time between the studies. Both studies (baseline and endline) predominantly consisted of children in grades 5-7, with a smaller proportion in lower secondary level.

BASELINE



ENDLINE

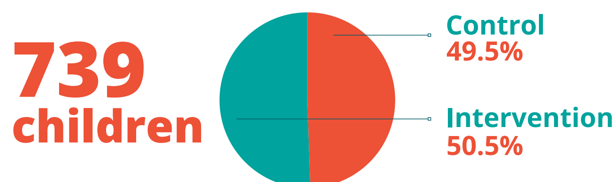


Table 1: Distribution of the children across study phases and study groups

Phase	Group	n (%)
BASELINE	Intervention	781(64.0)
	Control	440(36.0)
ENDLINE	Intervention	373(50.5)
	Control	366(49.5)

3.2.2 Children's knowledge and awareness of SVAC

This section presents data on children's knowledge of sexual violence and harmful practices. The analysis aims to elucidate shifts from the baseline to endline in children's awareness and understanding of sexual violence and associated harmful practices, including reporting channels.

Children's knowledge and awareness of harmful practices that constitute SVAC were assessed in the study (see Appendix B, Table B 1). There was a 21-percentage point increase in knowledge of sexual abuse as a harmful practice among children in the intervention group from baseline to endline, compared to a 27- percentage point increase in the control group. Knowledge of child marriage as a harmful practice increased by 4 percentage points in the intervention group by endline, while the control group saw an 8 percentage point increase. Regarding awareness of rape as a crime, there was no improvement in the intervention group (-2 percentage points), whereas the control group showed a 2-percentage point increase at endline.

A composite variable for knowledge on SVAC harmful practices (knw1) was created by combining three variables: sexual abuse, child marriage, and rape. A score greater than 1 was considered high knowledge, while a score of 1 or less was considered low knowledge. The reliability of the composite variable, tested by Cronbach's alpha, was 0.84, indicating better reliability. At baseline, children in the intervention group had slightly higher knowledge of harmful practices (42.6 percent) compared to those in the control group (41.6 percent). However, by endline, the control group exhibited a greater increase in knowledge, with a 21-percentage point rise, compared to a 15-percentage point increase in the intervention group.

Similarly, qualitative findings showed children's improved knowledge of several harmful practices and the importance of avoiding these practices to protect their rights and well-being. During the FGDs, children discussed the importance of avoiding illegal activities and staying away from "bad company" to protect their well-being. They discussed various forms of sexual abuse and how to avoid them, including inappropriate touching. Children showed awareness of the risks and consequences of SVAC including rape, early pregnancy, and being expelled from school if they became pregnant. They noted:

… we need to put more effort into education, prayer, following instructions on what we are asked to do, and avoiding bad company." (Boy, 11-14 years, **FGD participant)**

… there is a risk of being expelled from school if … pregnant, as well as being subjected to humiliation" (Girl, 11-14 years, **FGD participant)**

Children's knowledge of legal protection against SVAC was assessed in the baseline and endline studies, as shown in Table B 2 (see Appendix B). There was a 20-percentage point increase in knowledge of rape as a crime among children in the intervention group from baseline to endline, compared to a 10-percentage point increase in the control group. Similarly, the knowledge that sexual intercourse with a minor is a crime increased by 7 percentage points in the intervention group by endline, while the control group saw only a 0.2-percentage point increase. Also, the knowledge that 18 years and above was the legal age of marriage improved by 4 percentage points among children in the intervention group and by 3 percentage points in the control group by endline. The slight improvement in knowledge about the age of consent could be attributed to their baseline knowledge being rooted in the predominantly Islamic social structure in Zanzibar, where religious laws stipulate an age of consent different from the national laws. In Tanzania, the legal age of consent is 18 years old [21]. However, under Islamic law, which is influential in Zanzibar, the age of consent can be lower if the individual is married [22].

A composite variable for knowledge of legal protection against SVAC (knw2) was created by combining three variables: the knowledge that rape is a crime, sexual intercourse with a minor is a crime, and the age of consent (see Annex B, Table B 2). A score greater than 1 was considered high knowledge, while a score of 1 or less was considered low knowledge. The reliability of the composite tested by Cronbach's alpha, was 0.75, indicating acceptable reliability. At baseline, children in the control group had slightly higher knowledge (88.3 percent) than their intervention group counterparts (74.4 percent). However, by endline, the proportion of children with high knowledge in the control group increased by only 0.3 percentage points, while the intervention group saw an 11-percentage point increase. This underscores the impact of the KUWAZA III intervention on improving knowledge of legal protection against SVAC among children in the intervention group.

Children's knowledge of where to report SVAC was assessed at baseline and endline by asking them, "Where would you go to report sexual abuse, or who would you speak to?" Overall, children most often identified parents as the most likely to report to, with 90 percent in the intervention group and 86 percent in the control group saying this at endline. (See Appendix B, Table B 3 for all findings on this question.)

Notably, there was a positive shift in children's knowledge of being able to report SVAC to authority figures outside their immediate

"Children were taught (in KUWAZA training sessions) to report their cases to the person they trust most and feel comfortable with, since some parents are too strict and harsh. Some of them report to the coordinator, some to psychology teachers, and from there, escalate the case to higher authorities." **(KII, Social Welfare Officer, North B).**

A 20-percentage point increase in knowledge of rape as a crime was observed among children in the intervention group from baseline to endline, compared to a **10-percentage point increase in the control group.**

family by endline. For example, the intervention group's awareness that they could report SVAC incidents to the police increased by 7 percentage points, and the control group saw a 12-percentage point increase. Similar awareness improvements were observed for reporting SVAC to village elders, area advisory councils, and child protection officers. Awareness of reporting to village elders increased by 8 percentage points in the intervention group and by 15 percentage points in the control group. The observed increase in awareness of reporting SVAC to authorities such as the police and village elders indicates a positive shift toward addressing the social norms around non-disclosure of SVAC and improving the protection of children against SVAC.

A composite variable for knowledge and awareness of reporting points (knw3) was created by combining 10 reporting points, as seen in Table B 3. A score greater than 6 was considered high knowledge, and 6 or less was considered low knowledge. The reliability of the composite variable, tested by Cronbach's alpha, was 0.74, indicating good reliability. Children in the intervention group had slightly higher knowledge (17.5 percent) compared to the control group (7.3 percent) at baseline. However, by endline, the proportion of children with high knowledge in the control group increased by 8 percentage points, while the intervention group saw a 0.5 percentage point increase.

In the FGDs with children, they identified key individuals who can recognize existing risks and take timely action. These trusted individuals included community police, teachers, the sheha[3], and the coordinator (Mratibu). During the discussions, most children highlighted the teacher or head teacher as the primary person to report to in case of an incident at school. Parents were also mentioned as important figures in this context, as shown below.

"Students report the matter to the head teacher. The head teacher takes it up to the sheha, and parents will report to the police"
(FGD boys 11-14 years).

"The abused child's mother may take her to the hospital to confirm evidence of sexual violence. Once confirmed, then the police can be called for further investigation."
(FGD boys 11-14 years).

"If the abused child tells her parent, it would be better because her parents would go to the police station, and they would start investigating the reports." **(FGD girls 11-14 years).**

[3] A sheha is a local administrative officer who is part of the shehia, the lowest level of local government.

Table 2: Difference in differences analysis of changes in knowledge of harmful practices, legal protection, and where to report among children.

Knowledge	Categories	Odds ratios: *Knowledge of harmful practices*	Odds ratios: *Knowledge of legal protection*	Odds ratios: *Knowledge of reporting points -*
Study phase	Baseline	1	1	1
	Endline	**2.398*** [2.253, 2.552] p=0.000**	**1.538*** [1.245, 1.901] p=0.000**	2.356 [0.925, 6.004] p=0.073
Study group	Control	1	1	1
	Intervention	1.060 [0.927, 1.212] p=0.393	**0.582*** [0.531, 0.639] p=0.000**	**2.673*** [1.568, 4.556] p=0.000**
Sex	Boy	1	1	1
	Girl	**1.111*** [1.103, 1.119] p=0.000**	**1.131*** [1.130, 1.133] p=0.000**	**0.915*** [0.905, 0.925] p=0.000**
Age group	7-10 years	1	1	1
	11-14 years	**0.763*** [0.691, 0.844] p=0.000**	**2.044*** [2.038, 2.050] p=0.000**	**1.386*** [1.109, 1.732] p=0.004**
Primary caregiver	Biological parent			1
	Adopted parent			**0.471* [0.229, 0.967] p=0.004**
	Others family			0.990 [0.664, 1.477] p=0.962
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	**0.771*** [0.696, 0.853], p=0.000**	1.243 [0.856, 1.804] p=0.252	**0.423*** [0.275, 0.652] p=0.000**
Adjusted inverse probability weighting				
Knowledge	**Categories**	**Coefficient**	**Coefficient**	**Coefficient**
Average treatment effect on the treated	Baseline#Intervention	1	1	1
	Endline#Intervention	**0.150*** [0.079, 0.221] p=0.000**	**0.100*** [0.044, 0.153] p=0.000**	-0.002 [-0.044, 0.153] p=0.958

**0.05 **0.01 and ***0.001 significance level*

Generally, children's knowledge about SVAC-related harmful practices and legal protection significantly increased among children in the endline intervention group compared to the baseline intervention group (p=.000), while knowledge about reporting points did not show a similar increase. Overall, girls showed notably higher knowledge levels than boys on harmful practices and legal protection (p=.000), and boys had significantly higher knowledge on reporting points than girls (p=.000). The younger children (7-10 years) had significantly higher knowledge of harmful practices than the older ones (p=.000). On the other hand, children aged 11-14 and children residing with biological parents had significantly (p=.000) more knowledge about legal protection and reporting than their respective counterparts.
The significant increase in knowledge of harmful practices and legal protection among children in the intervention group underscores the positive impact of the KUWAZA III SVAC toolkit.

3.2.3 Beliefs, perceptions, and attitudes of children on SVAC

This section presents the findings on children's beliefs, perceptions, and attitudes toward SVAC, which were measured using several statements with which they could agree, disagree, or remain neutral. By examining the complex panorama of children's viewpoints, this section offers useful insights into how KUWAZA III impacted their viewpoints over time.
Table C 1 (Appendix C) shows shifts in children's beliefs, perceptions, and attitudes toward SVAC at endline compared to baseline, comparing the intervention and control groups. For the statement that "if someone walks in while they are having a bath and you feel uncomfortable, children should keep quiet," the proportion of children who agreed with this statement increased by 15 percent in both the intervention and control groups. Conversely, those who disagreed reduced in proportion by 16 and 14 percent in the intervention and control group, respectively.

On the belief that "even hugs and tickles can turn into bad touches if they go on too long," the proportion of children who agreed decreased slightly in the intervention group (by 4 percentage points) and marginally in the control group (by 0.1 percentage points). The proportion of those who disagree increased in the intervention group (by 4 percentage points) and in the control group (by 0.6 percentage points).

Regarding children's beliefs that they have to let grown-ups touch them whether they like it or not, the proportion of children who agree decreased in the intervention group (by 8 percentage points) but increased in the control group (by 5 percentage points). There was also an increase in the proportion of those who disagree in the intervention group (by 9 percentage points) and a decrease in the control group (by 5 percentage points).

15 percent

of children in both the intervention and control groups agreed with the statement *"if someone walks in while they are having a bath and you feel uncomfortable, children should keep quiet,"*

When asked whether it is sometimes okay to say "no" to a grown-up, the proportion of children who agree decreased in the intervention group (by 1 percentage point) but increased in the control group (by 2 percentage points). The proportion of those who disagree increased in the intervention group (by 1.2 percentage points) but decreased in the control group (by 1 percentage points).

When asked if they must comply with a babysitter who tells them to get undressed even when it's not time to get ready for bed, the proportion of children who agreed decreased more in the intervention group (by 14 percentage points) than in the control group (by 5 percentage points). The proportion of those who disagreed increased in the intervention group (by 14 percentage points) and in the control group (by 5 percentage points).

Regarding the belief that it is their fault if someone touches them in a way they don't like, the percentage of children who agree decreased in both the intervention group (by 3 percentage points) and the control group (by 4 percentage points). Those who disagree increased by 4 percentage points in both the intervention and control groups.

For the statement that sometimes someone in their family might touch them in a way they don't like, the percentage of children who agree this is acceptable remained almost unchanged in the intervention group (an increase of 0.1 percentage points) but decreased in the control group (by 1 percentage points). Those who disagreed increased slightly in the intervention group (by 0.2 percentage points) and in the control group (by 1 percentage points).

A composite variable for beliefs was created by combining seven selected parameters (see Table C 1 in Appendix C). A score greater than 3 was considered indicative of positive beliefs, while a score of 3 or less indicated negative beliefs. The reliability of the composite variable, tested by Cronbach's alpha, was 0.78, indicating acceptable reliability. By endline, the proportion of children with positive beliefs in the control group had reduced by 1 percent, whereas their counterparts in the intervention group with positive beliefs had increased by 6 percentage points.

Emerging findings on children's attitudes toward SVAC are presented in Appendix C, Table C 2. For the statement about keeping silent if a relative or teacher engages in sexual contact with a minor, more children in the intervention group disagreed with this statement (increased by 4 percent). Conversely, in the control group, there was a 2 percent reduction among children who disagreed with this statement at the time of the endline.

Qualitative findings in the intervention group support this positive shift in attitudes toward speaking up and reporting SVAC. In FGDs, children were presented with a scenario (Rema's story—a young school girl who is sexually violated). The responses indicated a positive attitude toward speaking up against SVAC, as shown below:

"If Rema tells her parent, it would be better because her parents would go to the police station, and they would start investigating the reports" **(FGD girls 11-14 years).**

The proportion of children who agreed that they must comply with a babysitter's request to undress—even when it's not bedtime—decreased by **14 percentage points in the intervention group, compared to a 5-point decrease in the control group.**

Regarding the statement that a girl is at fault if she is sexually abused due to her style of dress, children in the intervention group who disagreed with this statement increased by 9 percent from baseline to endline, while in the control group, children who disagreed with this statement only increased by 4 percent.

There was a similar increase in both groups among children who agreed with the statement that forcing a girl under 18 to marry is abusive, with a 21 percent increase in the intervention group and a 22 percent increase in the control group.

For the idea that girls should choose when to marry, children in agreement increased by 12 percent in the intervention group and by 16 percent in the control group.

The proportion of children who disagreed with the statement that a woman deserves to be beaten increased by 11 percent in the intervention group and by 9 percent in the control group by the endline.

Regarding the notion that a woman should tolerate violence to keep the family intact, the proportion of children who disagreed in the intervention group increased by 13 percent from baseline to endline compared to only a 5-percent increase in the control group. Lastly, at the endline, there was a 4-percent increase among children in the intervention group who disagreed with the statement that a boy/man is entitled to sex when he demands it, while the proportion of children disagreeing with this statement in the control group decreased by 2 percent.

A composite variable for attitudes was created by combining seven selected parameters, as shown in Table C 2. A score greater than 3 was considered indicative of positive beliefs, while a score of 3 or less indicated negative beliefs. The reliability of the composite variable, tested by Cronbach's alpha, was 0.77, indicating acceptable reliability. In the intervention group, the proportion of children with positive attitudes in the intervention group increased by 11 percent, from 79.0 percent to 89.8 percent, whereas in the control group, they increased by 7 percent, from 82.0 to 89.3 percent. These figures indicate that the children's attitudes with respect to dealing with SVAC saw a substantially greater improvement in the intervention group compared to the control group.

"They [parents] should take action and take him to the police station because if they let him go, he will become accustomed to it"
(FGD girls 11-14 years).

"Rema can as well report the perpetrator to her mother, and the mother will tell the father"
(FGD boys 11-14 years).

"Female teachers or her mother may take Rema to the hospital to confirm if she has experienced sexual violence. Once they have confirmed, they can call the police for further investigation"
(FGD boys 11-14 years).

Table 3: Difference in differences analysis of changes in beliefs and attitudes on SVAC among children

Beliefs (positive)	Categories	Odds ratios: *Beliefs*	Odds ratios: *Attitudes*
Study phase	Baseline	1	1
	Endline	**0.960*** [0.945, 0.975] p=0.000**	**1.810*** [1.598, 2.050] p=0.000**
Study group	Control	1	1
	Intervention	1.104 [0.852, 1.429] p=0.455	**0.820*** [0.758, 0.888] p=0.000**
Sex	Boy	1	1
	Girl	**1.077*** [1.065, 1.090] p=0.000**	1.000 [0.999, 1.000] p=0.773
Age group	7-10 years	1	1
	11-14 years	1.012 [0.902, 1.136] p=0.834	0.963 [0.641, 1.445] p=0.854
Primary caregiver	Biological parent	1	1
	Adopted parent	**1.133*** [1.075, 1.195] p=0.000**	**0.607*** [0.467, 0.788] p=0.000**
	Others family	1.105 [0.977, 1.250] p=0.111	**0.889*** [0.863, 0.913] p=0.000**
Average treatment effect	Endline#Intervention	1.336 [0.921, 1.937] p=0.127	1.276 [0.626, 2.605] p=0.502
Beliefs	**Categories**	**Coefficient: Beliefs**	**Coefficient: Attitudes**
Average treatment effect on the treated	Baseline#Intervention	1	1
	Endline#Intervention	0.061 [-0.009, 0.132] p=0.090	**0.107*** [0.057, 0.157] p=0.000**

*0.05 **0.01 and ***0.001 significance level

Children in the endline intervention group showed significantly more positive attitudes toward dealing with SVAC. However, beliefs did not change at the same scale within this group. Generally, girls and children with adoptive parents had higher odds of having positive beliefs than their counterparts. Notably, ATET provides a coefficient of 0.107, indicating a significant increase in positive attitudes in the intervention group at endline compared to baseline. This result is statistically significant (p=.000).

3.2.4 Child agency and self-efficacy

This section explores various aspects related to children's confidence in navigating sensitive topics, including their willingness to disclose experiences of SVAC, their ability to resist peer pressure, and their confidence in making informed sexual choices. The analysis will highlight patterns, trends, and relationships that can inform KUWAZA on how to support and empower children in their interactions with peers, caregivers, and broader social actors.

Table D 1 in Appendix D highlights children's self-reported confidence on a number of SVAC-related parameters. Regarding confidence in disclosing sexual abuse to a parent or caregiver, the proportion of children who were not confident reduced by 15 percent in the intervention group and by only 2 percent in the control group. On the other hand, the proportion of children who were confident increased by 31 percent in the intervention group and by only 9 percent in the control group.

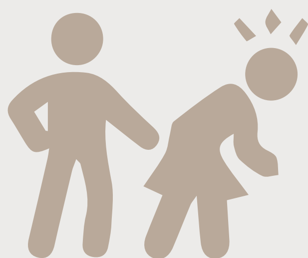
Further, the percentage of children indicating that they are not confident that they would report sexual abuse if they experienced it decreased by 12 percent in the intervention group and by only 2 percent in the control group. On the other hand, the proportion of those expressing confidence increased by 28 percent in the intervention group and by only 9 percent in the control group.

Regarding confidence in disclosing the perpetrator in a case of sexual abuse, the percentage of children expressing a lack of confidence decreased by 13 percent in the intervention group and by only 2 percent (from 6.4 percent to 4.1 percent) in the control group. Conversely, the percentage of children expressing confidence increased by 32 percent in the intervention group and by only 6 percent in the control group.

A composite variable for confidence was created by combining three selected parameters, as shown in Table D 1. A score greater than 1 was considered indicative of confidence, and 1 or less was not confident. The reliability of the composite variable, tested by Cronbach's alpha, was 0.91, indicating excellent reliability. The proportion of children who expressed confidence increased by 13 percent in the intervention group and by only 3 percent in the control group. These results indicate major improvements in children's confidence to disclose and report SVAC in the intervention group, with substantial increases in the "confident" category compared to the control group.

Qualitative data indicate that the children learned about strategies for preventing SVAC, and this has improved their agency. Children in the FGDs generally expressed feeling confident in their ability to report SVAC incidents to trusted adults and authorities. One child provided an example of a case that she reported:

"Some young people were following me and giving me money" **(FGD girls 11-14).**
She went on to say that she reported this to the teachers, who instructed her to provide information to them and her parents.



The proportion of children who expressed confidence disclosing the perpetrator in a case of sexual abuse increased by 13 percent in the intervention group and by only 3 percent in the control group.

Key informants in the study also spoke about how the intervention has enhanced children's agency about what to do in situations of SVAC. As one key informant noted:

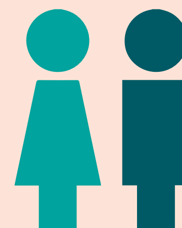
"... also, there are children who are brave enough to go directly to the police station and from there, the police will make an effort to consult the child's parent" "I loved the way the program has equipped children on different ways to resist sexual abuse, since they are the direct victims then they are now capable of identifying and resisting sexual abuse" **(KII CHV MAHONDA)**

Children's confidence in enacting preferences over life choices was assessed in the study (see Appendix D, Table D 2). Findings indicate a decline in the proportion of children in the intervention group expressing uncertainty about their ability to follow their convictions when under peer pressure. Specifically, by the endline, a higher percentage of children in the intervention group indicated confidence to do what is right amidst peer pressure (marking a 10 percent increase). In contrast, the control group showed a slight decline in the proportion of children reporting confidence on the same issue, from 84.5 percent at baseline to 82 percent at endline.

The children were asked about their confidence in refusing sex with a person who has power over them. The intervention group did not show any improvement at the endline; instead, the proportion of children who felt confident to refuse sex decreased by 2 percent. Conversely, the control group exhibited a slight improvement in their confidence to refuse sex with a person who has power over them (2 percent).

A composite variable of confidence to enact preferences over life choices was created by combining two selected parameters, as shown in Table D 2. A score greater than 1 was considered indicative of confidence. The reliability of the composite variable, tested by Cronbach's alpha, was 0.84, indicating better reliability. In the "Confident" category, children in the intervention group increased from 61.1 percent at baseline to 70 percent at endline, and the control group increased from 70.2 percent to 74.0 percent. These results indicate an overall improvement in children's confidence to make life choices in both groups, with children in the intervention group showing a more pronounced increase.

The proportion of children with confidence to enact preferences over life choices In intervention group increased from 61.1 percent at baseline to 70 percent at endline, and the control group increased from 70.2 percent to 74.0 percent.



Children's reporting of SVAC

The study assessed where children would feel most comfortable reporting SVAC. Emerging evidence shows shifts in the proportion of children who feel comfortable reporting SVAC at various entities by the endline (see Table D 3, Appendix D). In the intervention group, the proportion of children who are comfortable reporting SVAC to an adult family member decreased by 4 percent. Conversely, the proportion in the same group who indicated they could report to a local leader/sheha increased by 4 percent. Children who reported feeling comfortable reporting to a child helpline in the intervention group increased by 2 percent at endline. In the control group, the proportion of children who are comfortable reporting to a friend decreased by 2 percent, while those saying they felt comfortable reporting to a local leader/sheha increased by 8 percent. These changes reflect shifts in children's preferences and trust in different reporting channels over the study period.

Children's preferred channels of reporting CSA were classified into formal and informal channels (see Table D 4, Appendix D). The formal channels included local leaders, head teacher, police/court, health facility, child helpline, and the one-stop center, while the others were considered informal. Data indicated a critical shift in how children preferred to report SVAC over the course of the study. Initially, most children felt more comfortable using informal reporting points. However, by the endline, there was a noticeable increase in preference for formal reporting points. In the intervention group, the preference for formal reporting points increased by 6 percent, while in the control group, it increased by 13 percent.

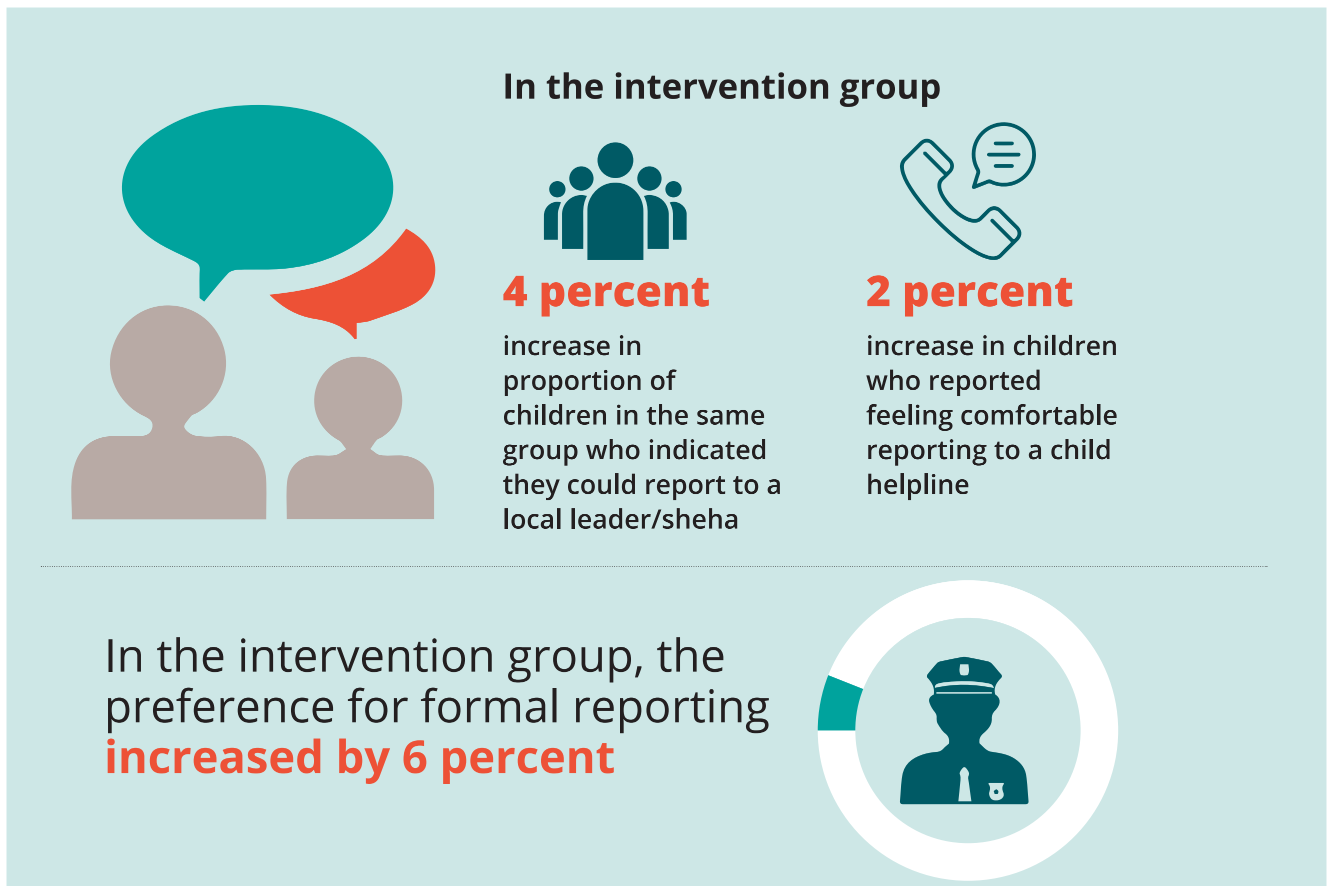


Table 4: Difference in differences analysis of changes in agency and self-efficacy

Change in agency and self-efficacy	Categories	Odds Ratios: *Confidence to report SVAC*	Odds Ratios: *Confidence to enact preferences*	Odds Ratios: *Preference of formal reporting points for SVAC*
Study phase	Baseline	1	1	1
	Endline	**1.512*** [1.355, 1.688] p=0.000**	1.206 [0.999, 1.456] p=0.051	**2.736*** [2.453, 3.053] p=0.000**
Study group	Control	1	1	1
	Intervention	**0.424** [0.247, 0.729] p=0.002**	**0.656** [0.497, 0.866] p=0.003**	**1.740*** [1.633,1.959] p=0.009**
Sex	Boy	1	1	1
	Girl	**0.807* [0.768, 0.848] p=0.049**	**0.981*** [0.976, 0.985] p=0.000**	**0.946*** [0.933,0.959 p=0.000**
Age group	7-10 years	1	1	1
	11-14 years	**3.598** [2.577, 5.025] p=0.003**	**1.462*** [1.295, 1.651] p=0.000**	**1.632*** [1.615, 1.649] p=0.000**
Primary caregiver	Biological parent	1	1	1
	Adopted parent	1.211 [0.729, 2.011] p=0.460	1.123 [0.501, 2.516] p=0.460	1.189 [0.466, 3.030] p=0.717
	Others family	1.284 [0.836, 1.972] p=0.253	1.808 [0.900, 1.550] p=0.253	1.015 [0.685, 1.505] p=0.941
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	**3.039*** [1.945, 4.750] p=0.000**	**1.213*** [1.211, 1.216] p=0.000**	**0.529*** [0.516, 0.543] p=0.000**
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient:**	**Coefficient:**	**Coefficient:**
Average treatment effect on the treated	Baseline#Intervention	1	1	1
	Endline#Intervention	**0.121*** [0.082, 0.160] p=0.000**	**0.086** [0.018, 0.153] p=0.013**	**0.060* [0.001, 0.118] p=0.045**

*0.05 **0.01 and ***0.001 significance level

Overall, there was a significantly positive shift in reporting SVAC (p=.000), confidence in enacting preferences (p=.045), and preference for the formal reporting points for SVAC (p=.013) in the endline intervention group compared to the baseline intervention group. Children in the intervention group were three times more likely to express confidence to report SVAC than those in the control group (p=.000). However, these children demonstrated a lesser preference for formal reporting points for SVAC (p=.000) compared to the control group. Older children (11-14 years) and boys in general showed higher odds in all aspects (confidence to report SVAC, confidence to enact preferences, preference of formal reporting points for SVAC*)* than their counterparts.

3.2.5 Intentions/behavior related to mitigating risk exposure to sexual abuse and exploitation

This section presents findings on children's intentions and behavior related to mitigating the risk exposure to SVAC. The analysis sheds light on the proactive measures children take to reduce the risks of sexual abuse, and whether and how the intervention impacts the measures.

Protective behaviors for children against SVAC

As shown in Table E 1 in Appendix 5, children expressed their views on selected strategies for protecting themselves from sexual abuse. Most children were familiar with these strategies throughout the study phases. The proportion of children who mentioned reporting perpetrators as a strategy to protect themselves from sexual abuse increased by 3 percentage points in the intervention group. However, the proportion of children in the control group who mentioned utilizing the same strategy reduced by 0.9 percentage points. An inverse trend was seen regarding children mentioning distancing themselves from bad people: the proportion of children in the intervention group decreased by 4 percentage points, and by 1.5 percentage points in the control group.

At endline, the proportion of children reporting "avoiding walking alone" as a prevention strategy increased marginally in both groups (1.3 percent in the intervention group and 2 percent in the control). Regarding wearing clothing that will be considered provocative, children in the intervention group who mentioned using this strategy reduced by 15 percent while those in the control group reduced by 8 percent at the endline. When responses on the utilization of this strategy were disaggregated by sex, boys in the intervention group had reduced by 7 percent while in the control group, they had reduced by 3 percent. Girls who mentioned using this strategy in the intervention group had reduced by 8 percent and those in the control group had reduced by 5 percent.

A composite variable of protective measures from SVAC exposure was created by combining four selected parameters, as shown in Table E 1. A score greater than 1 was considered indicative of having adequate protective measures from SVAC exposure. The reliability of the composite variable, tested by Cronbach's alpha, was 0.82, indicating better reliability. The proportion of children in the intervention and control groups who mentioned the use of selected protective measures against SVAC reduced by 11 percent at the endline.

Child-parent communication and sexuality education

Table E 2 (Appendix E) shows children's levels of comfort toward discussing SVAC with their parents or guardians. At the baseline and endline, most children across all groups reported feeling comfortable discussing SVAC with their parents or guardians (66.5 percent and 60.5 percent of the children in the intervention group and control group, respectively). At endline, these proportions increased to 86.3 percent in both groups. Notable, among children in the intervention group is that by the endline, none of them reported being uncomfortable asking their parent or guardian a question about SVAC or gender-based violence (GBV). Likewise, the proportion of children who had initially disagreed with asking a parent a question about SVAC or GBV decreased by 18 percent in the intervention group and by 20 percent in the control group.

In the survey, children were asked, "Have you gone to your parents/guardian or an adult person to talk to or ask them about issues, including how to protect yourself from sexual abuse?" Findings in Table E 3

(Appendix E) show an improvement across both the intervention and control groups. At baseline in the intervention group, 31.5 percent of children reported having initiated these conversations. However, this number increased to about 42.1 percent of children at the endline. Similarly, in the control group, the percentages for the same increased from 12.5 percent to 43.7 percent at the endline.

Table E 4 in Appendix E shows responses to questions related to parental communication on sexuality by intervention and control group at baseline and endline. Across all groups and study phases, most children reported that their parent or guardian have not talked to them about forming healthy relationships with the opposite sex or about puberty. However, there were slight but important variations between intervention and control groups. At the endline, there was a slight decrease in the intervention group in the proportion of children reporting that their parents have never talked to them about forming healthy relationships with the opposite sex (from 61.7 percent to 60.6 percent). The control group had a more dramatic decrease in children reporting the same, from 71.6 percent to 57.1 percent. Similarly, there was a slight decrease at the endline in the proportion of children in the intervention reporting that their parents have never talked to them about puberty (from 76.4 percent to 63 percent). Interestingly, again, the control group saw a more dramatic decrease in the same, from 85 percent to 62 percent.

Regarding child-parent discussions on avoiding sexual risks, most children reported having been talked to by their parents or guardians at least once or more, with an increase from baseline to endline. In the intervention group, children reporting this increased by 14 percent while those in the control group increased by only 3 percent. A similar trend is observed among children who mentioned that their parents or guardians discuss with them ways to seek help when they feel unsafe. In the intervention group, the proportion of these children increased by 21 percent while those in the control group increased by 7 percent, suggesting the positive impact of the KUWAZA SVAC toolkit on parent-child communication on sexual risks.

A sexuality education composite variable was created by combining four parameters, as shown in Table E 4. A score greater than 1 was considered indicative of a child receiving sexuality education from parents. The reliability of the composite variable, tested using Cronbach's alpha, was 0=.77, indicating acceptable reliability. The proportion of children in the intervention group reporting sexuality education by the endline had increased by 7 percent, while those in the control group increased by 13 percent.

The proportion of children in the intervention group who reported receiving sexuality education from parents by the endline had increased by 7 percent

Table 5: Difference in differences analysis of changes in the intentions/behavior related to mitigating risk exposure to sexual abuse and exploitation

Intentions/behavior related to mitigating risk exposure to sexual abuse and exploitation	Categories	**Odds Ratios:** *Protective behaviors for children against SVAC*	**Odds ratios:** *Children's level of comfort to ask about SVAC*	**Odds ratios:** *Ever asked a question on SVAC*	**Odds ratios:** *Sexuality Education practices*
Study phase	Baseline	1	1	1	1
	Endline	**0.471*** [0.326, 0.681] p=0.000**	**4.199*** [3.856,4.573] p=0.000**	**5.685*** [4.745, 6.810] p=0.000**	**2.770*** [2.509, 3.057] p=0.000**
Study group	Control	1	1	1	1
	Intervention	0.937 [0.412, 2.127] p=0.876	**1.298*** [1.196, 1.409] p=0.000**	**3.273*** [2.245, 4.773] p=0.000**	1.233 [0.950, 1.601] p=0.115
Sex	Boy	1	1	1	1
	Girl	**1.084*** [0.779, 1.297] p=0.000**	**1.221*** [1.213, 1.228] p=0.000**	**1.234*** [1.226, 1.242] p=0.000**	**1.136*** [1.118, 1.154] p=0.000**
Age group	7-10 years	1	1	1	1
	11-14 years	1.005 [1.615, 1.649] p=0.968	**1.630** [1.106, 2.403] p=0.014**	**2.112*** [1.824, 2.445] p=0.000**	**2.158*** [1.870, 2.491] p=0.000**
Primary caregiver	Biological parent	1	1	1	1
	Adopted parent	1.180 [0.643, 2.164] p=0.593	1.187 [0.842, 1.673] p=0.328	**1.305*** [1.186, 1.436] p=0.000**	1.411 [0.886, 2.245] p=0.147
	Others family	1.139 [0.685, 1.771] p=0.563	**1.113* [1.026, 1.208] p=0.010**	**0.935*** [0.918, 0.952] p=0.000**	0.984 [0.753, 1.286] p=0.908
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention				1
	Endline#Intervention	0.995 [0.768, 1.289] p=0.970	0.748 [0.410, 1.364] p=0.970	**0.268*** [0.156, 0.461] p=0.000**	**0.629** [0473, 0.838] p=0.002**
Adjusted inverse probability weighting					
Beliefs	**Categories**	**Coefficient**	**Coefficient**	**Coefficient**	**Coefficient**
Average treatment effect on the treated	Baseline#Intervention	1		1	1
	Endline#Intervention	**-0.112*** [-0.171, -0.054] p=0.000**	**0.195*** [0.139, 0.252] p=0.000**	**0.101** [0.032, 0.171] p=0.004**	**0.623* [0.014, 0.111] p=0.002**

*0.05 **0.01 and ***0.001 significance level

The AIPW shows that in the endline intervention group, children showed a significant positive change in their comfort level with asking about SVAC (p=.000), a higher likelihood to have ever asked an SVAC-related question (p=.004), and positive sexuality education practices (p=.002). However, protective behaviors against SVAC decreased significantly (p=.000).
Children living with other family members had significantly higher odds of being comfortable asking questions around SVAC than their counterparts (p=.010). Girls demonstrated higher odds of positive shifts in all these aspects than boys (p=.000). Similarly, older children showed positive shifts with significantly higher odds than younger children in all aspects, except protective behaviors against SVAC.

3.3 Parents/Caregivers and the prevention of SVAC

This section presents findings on parental/caregiver responses related to the prevention of SVAC. It seeks to assess the impact of the KUWAZA III SVAC toolkit in strengthening their capacity to prevent and respond to SVAC. The section begins with an analysis of the socio-demographic characteristics of the responding parents and caregivers.

3.3.1 Socio-demographic characteristics of parents

Table A 2 in Appendix A shows the distribution of parents/caregivers in the study. The baseline reached a total of 701, and the endline study reached a total of 421. In both study phases and groups, the majority of the respondents were female (Table A 3, Appendix A). Many of the parents were aged 34 years and above, with a fair distribution of approximately 70 percent across the two study phases and groups. Most of the parents/caregivers were working (97 percent and above) at the time of the studies. The majority of parents had only a primary level of education, and more than 65 percent of the parents/caregivers were married at the time of the studies.

3.3.2 Knowledge and Awareness of SVAC

Knowledge of the existing avenues in the community where parents express concerns about SVAC

Parents/ caregivers were asked about avenue/s available in their community to express their concerns on SVAC/CSA issues. Table B 4 in Appendix B highlights existing informal avenues to express concerns about SVAC. At the end of the KUWAZA III intervention, 14 percent more parents in the intervention group indicated more than one informal avenue of expressing their concerns about SVAC in schools and communities, while only 7 percent more parents in the control group indicated the same by the endline. Table B 5 outlines the formal channels available for parents to voice concerns about SVAC in schools and communities (Appendix B). The findings indicate that the proportion of parents in the intervention group who are aware of more than one formal channel for expressing concerns about SVAC increased by 4 percent, compared to a 1 percent increase in the control group.

Table 6: Difference in differences analysis of changes in the knowledge of existing avenues in the community where parents express concerns about SVAC

Knowledge of the existing avenues in the community where parents express concerns about SVAC	**Categories**	**Odds Ratios:** *Use of informal reporting channels*	**Odds Ratios:** *Use of formal reporting channels*
Study phase	Baseline	1	1
	Endline	**1.812*** [1.735, 1.893] p=0.000**	1.064 [0.932, 1.215] p=0.361
Study group	Control	1	1
	Intervention	**2.620*** [2.6008, 2.631] p=0.000**	**0.940** [0.902, 0.979] p=0.003**
Sex	Male	1	1
	Female	**1.051*** [1.048, 1.054] p=0.000**	**1.043*** [1.029, 1.057] p=0.000**
Age group	18-24 years	1	1
	25-34 years	1.041 [0.909, 1.193] p=0.559	0.923 [0.785, 1.086] p=0.334
	>34 years	1.152 [0.730, 1.817] 0.544	0.901 [0.768,1.057] p=0.201
Education level	Primary	1	1
	Post primary	**1.236** [1.060, 1.441] p=0.007**	1.010 [0.965, 1.056] p=0.667
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention		
	Endline#Intervention	**0.735* [0.567, 0.951] p=0.019**	1.138 [0.675, 1.917] p=0.627
Adjusted inverse probability weighting			
Beliefs	**Categories**	**Coefficient**	**Coefficient**
Average treatment effect on the treated	Baseline#Intervention	1	1
	Endline#Intervention	**0.093*** [0.045, 0.141 p=0.000**	0.036 [-0.011, 0.083] p=0.136

**0.05 **0.01 and ***0.001 significance level*

At endline, parents in the intervention group showed a significantly higher preference for informal reporting channels (p=.000). However, there was no significant change in the preference for formal reporting channels.

Parents with post-primary education showed preference for informal reporting channels more than those with less education (p=.007). Female parents had a significantly greater shift in knowing more informal and formal reporting channels than male parents. Overall, parents at endline displayed a significantly higher preference for informal reporting channels.

3.3.3 Beliefs, perceptions, and attitudes of parents on SVAC

The evaluation assessed parents' beliefs, perceptions, and attitudes regarding SVAC. By examining parents' knowledge, attitudes, and practices related to SVAC, this assessment seeks to uncover underlying factors that may contribute to the perpetuation or prevention of sexual violence within families and communities. These aspects were evaluated at both baseline and endline, highlighting changes in the control and intervention groups.

Table 7: Children who report sexual abuse can be believed

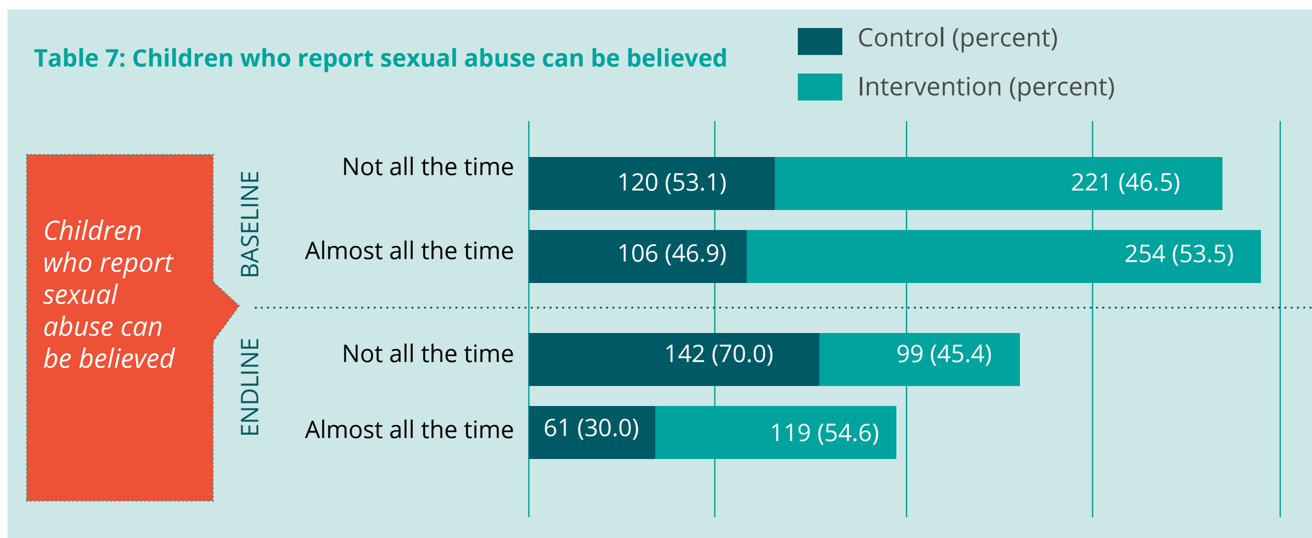


Table 7 shows changes in parents' beliefs about whether children who report sexual abuse can be believed. By endline, in the control group, the percentage of parents who said that children who report sexual abuse can be believed almost all the time decreased by 17 percent. Conversely, in the intervention group, the percentage of parents agreeing with the statement increased slightly, by 1 percent. This indicates a notable decline in trust within the control group, while the intervention group saw a marginal improvement in the belief that children who report sexual abuse can be trusted almost all the time.

Table 8: A person who has sexually abused a child will repeat

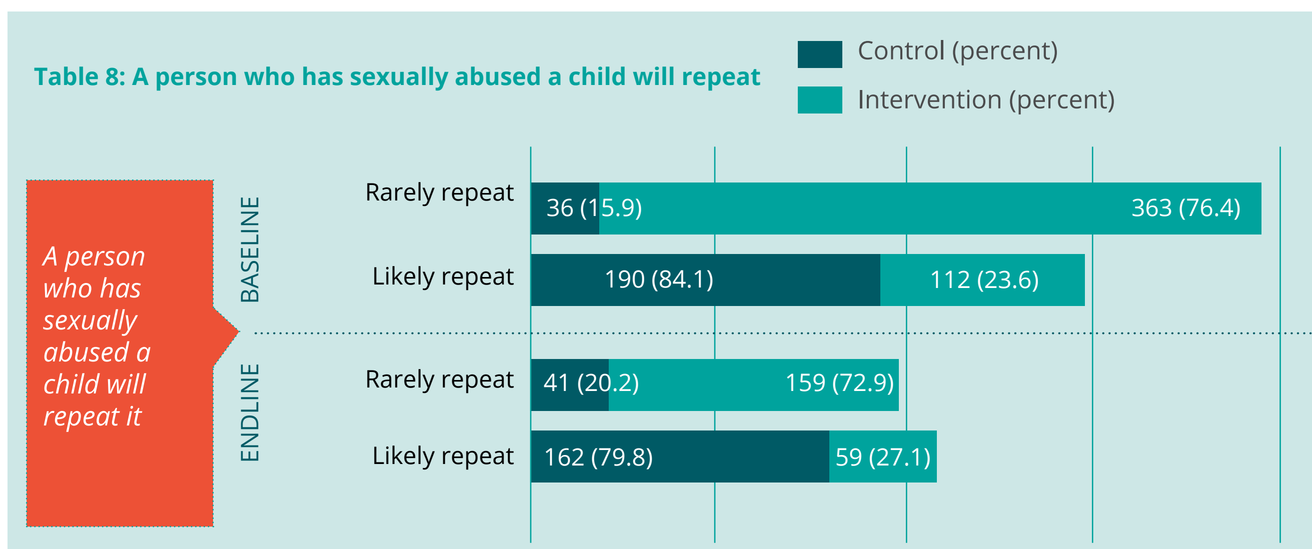


Table 8 shows changes in parents' beliefs about whether a person who has sexually abused a child is likely to repeat the offense. In the control group, the percentage of parents who believed that a person who has sexually abused a child is likely to repeat the offense decreased by 4 percent at endline. Conversely, in the intervention group, the percentage of parents who believed that a person who has sexually abused a child is likely to repeat the offense increased by 4 percent at endline. This indicates a shift in beliefs within both groups, with a decrease in the control group and an increase in the intervention group regarding the likelihood of repeat offenses.

Parents' beliefs on dress and sexual abuse

Table C 3 shows changes in parents' beliefs regarding whether it is a girl's fault if she is sexually abused due to her immodest attire (see Appendix C). In the control group, the proportion of parents who disagreed with this statement decreased slightly by 1 percent at endline. In the intervention group, there was a more substantial decrease (24 percent) of parents disagreeing at endline. This indicates that more parents now agree with the notion that if a girl does not wear modest clothes and is sexually abused, it is her fault. As several parents insisted in the FGDS, dressing children modestly can help prevent sexual abuse. For many of them, immodest dressing can provoke abusers to target a child. As some of them noted:

"… secondly, the dressing code, some dressing styles expose the child to sexual abuse, such as short dresses and tight clothes, the dressing style may attract an individual to harm a child" **(FGD women).**

"Sometimes parents are the cause of sexual abuse, some of them allow their children to dress inappropriately, and later this parent will call a bodaboda guy for transportation, when the guy sees the body being exposed, he becomes attracted to the girl and may want to do something different … ..I once made a follow-up and one guy told me, "You can't blame us, instead blame yourself as a parent for allowing your children to dress inappropriately…" **(FGD women).**

"There should be improvement in culture by dressing children modestly during different occasions and ceremonies" **(FGD men).**

Parental attitudes toward sexuality education

Table C 4 in Appendix C shows changes in parents' perspectives on various aspects of sexuality education. In the control group, the proportion of parents who disagreed with the statement "I think my child is still too young to learn about sex issues" increased by 7 percent at endline. For the intervention group, this proportion increased by 3 percent. Regarding the statement, "I think that if I talk to my child about sex issues, I will encourage him or her to have sex," the proportion of parents in the control group who disagreed with the statement increased by 24 percent, while those in the intervention group increased by 12 percent at endline.

When asked, "If my child talked to me about sex issues, I would assume that he or she is sexually active," the parents in the control group who disagreed with the statement increased by 3 percent, whereas those in the intervention group slightly reduced by 0.9 percent at endline. A similar positive trend was evident with the statement, "It is my duty to make sure my child knows about sex." The proportion of parents in both the control and intervention group who agreed increased by 12 percent at endline.

A composite variable for perceptions of sexuality education was created during the analysis by combining four selected parameters, as shown in Table C 4. A score greater than 2 was considered indicative of positive perceptions. The reliability of the composite variable, tested by Cronbach's alpha, was 0.84, indicating better reliability. The proportion of parents with positive perceptions in the control group decreased by 3 percent (from 56.6 percent to 53.7 percent), and those with positive perceptions in the intervention group decreased by 0.9 percent (from 51.8 percent to 50.9 percent).

"It is my duty to make sure my child knows about sex." At the endline, the proportion of parents in both the control and intervention group who agreed increased by

12 percent

Table 9: Difference in differences analysis of changes in beliefs on SVAC among parents

Beliefs and perceptions *(Negative vs. positive)*	**Categories**	**Odds Ratios:** *Children who report sexual abuse can be believed*	**Odds Ratios:** *A person who has sexually abused a child will repeat it*	**Odds Ratios:** *Beliefs on dressing and sexual abuse*	**Odds Ratios:** *Perceptions on sexuality education*
Study phase	Baseline	1	1	1	1
	Endline	**0.489*** [0.437, 0.547] p=0.000**	**0.729*** [0.654, 0.812] p=0.000**	0.995 [0.615, 1.607] p=0.980	0.887 [0.739, 1.065] p=0.198
Study group	Control	1	1	1	1
	Intervention	**1.276*** [1.187, 1.373] p=0.000**	**0.056*** [0.040, 0.078] p=0.000**	**0.525*** [0.516, 0.535] p=0.000**	**0.818*** [0.740, 0.905] p=0.000**
Sex	Male	1	1	1	1
	Female	**0.948*** [0.938, 0.959] p=0.000**	**1.193*** [1.191, 1.195] p=0.000**	**1.079*** [1.293, 1.464] p=0.000**	**1.423*** [1.397, 1.450] p=0.000**
Age group	18-24 years	1	1	1	1
	25-34 years	**1.261*** [1.151, 1.381] p=0.000**	**1.305** [1.083, 1.572] p=0.005**	**1.376*** [1.293, 1.464] p=0.000**	**1.491** [1.181, 1.882] p=0.001**
	>34 years	**1.029* [1.002, 1.056] p=0.035**	1.066 [0.814, 1.397] p=0.642	**1.254*** [1.287, 1.404] p=0.000**	1.010 [0.906, 1.336] p=0.337
Education level	Primary	1	1	1	1
	Post-primary	**0.843*** [0.839, 0.848] p=0.000**	0.955 [0.699,1.306] p=0.775	**1.355*** [1.192, 1.540] p=0.000**	**1.072** [1.021, 1.125] p=0.005**
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention				
	Endline#Intervention	**2.100*** [1.521, 2.901] p=0.000**	**1.648*** [1.494, 1.818] p=0.000**	**3.134*** [2.198, 4.469] p=0.000**	1.104 [0.924, 1.317] p=0.124
Adjusted inverse probability weighting					
Beliefs	**Categories**	**Coefficients**	**Coefficients**	**Coefficients**	**Coefficient**
Average treatment effect on the treated	Baseline#Intervention	1	1	1	1
	Endline#Intervention	0.012 [-0.084, 0.109] p=0.800	0.029 **[-0.556, 0.114] p=0.504**	**0.242*** [0.150, 0.333] p=0.000**	-0.006 [-0.103, 0.090] p=0.898

**0.05 **0.01 and ***0.001 significance level*

Among the four aspects presented in Table 9, the AIPW shows that parents in the endline intervention group only had significantly more positive beliefs and perceptions about not faulting an SVAC survivor due to her dress code compared to those in the baseline intervention group (p=.000), while the other aspects showed no significant changes. The ATE indicates that parents in the endline intervention group also had significantly more positive beliefs on all aspects (p=.000) except the perceptions on sexuality education, which were improved but not statistically significant.

Parents showed mixed results by social demographic characteristics. For instance, parents with higher education had significantly more positive beliefs about not faulting an SVAC survivor due to her dress code and positive perceptions of sexuality education, while those with less education had significantly more positive beliefs with respect to believing children who report SVAC. Parents aged 25-34 years showed significantly more positive beliefs across all four aspects than younger parents, whereas parents over 34 years had significantly more positive beliefs that children who report SVAC could be believed plus not faulting an SVAC survivor due to her dress code. Male parents had significantly more positive beliefs about believing children who report SVAC, while female parents had significantly more positive beliefs and perceptions on the other three aspects.

3.3.4 Parents' self-efficacy

Parent's self-efficacy on a range of parameters related to SVAC was assessed during the study as shown in Table D 5 in Appendix D. The majority of the parents in both study groups indicated feeling confident to report sexual abuse if their child confided in them, even if their partner may be against it. There were minimal shifts in the intervention and control groups, with an increase in the proportion of parents agreeing with this of 0.6 and 0.9 percent, respectively.

Similarly, while the majority of parents felt confident they could reject marrying off their child, there were minimal shifts during the study period. In the intervention group, the proportion of parents agreeing with this increased by 2 while in the control group, the proportion increased by 1 percent.

A composite variable for parent's self-efficacy was created during the analysis by combining two selected parameters, as shown in Table D 5 . A score of greater than 1 was considered indicative of self-efficacy to handle SVAC issues. The reliability of the composite variable, tested by Cronbach's alpha, was 0.79, indicating acceptable reliability. The proportion of parents with high self-efficacy in the control group increased by 1 percent, while the proportion of parents in the intervention group increased by 2 percent, underscoring the positive impact of the KUWAZA III's SVAC toolkit intervention.

During the study, parents were asked, "With whom do you feel confident or not confident to talk to about risks of sexual violence against children in your community?" Findings in Table D 6 show changes in the proportion of parents who felt confident talking about the risks of SVAC in their community with different entities from baseline to endline. In the intervention group, there were notable increases in parents reporting confidence on different aspects of this measure. The proportion of parents agreeing that they felt confident talking to their child increased by 8 percent, talking to other relatives increased by 4 percent, and using the Toll-Free Child Helpline (116) increased by 14 percent. Conversely, the proportion of parents in the control group exhibited a substantial decrease in confidence levels: those reporting that they felt confident talking to their child decreased by 4 percent, talking to an adult family member decreased by 13 percent, and talking to other relatives decreased by 19 percent. These findings highlight the positive impact of KUWAZA III's SVAC toolkit on parents' confidence in discussing SVAC risks.

The proportion of parents in intervention group agreeing that **they felt confident talking to their child increased by**

8 percent

Table 10: Difference in differences analysis of changes in parents' self-efficacy on SVAC issues

Parents' self-efficacy on SVAC	**Categories**	**Odds Ratios:** *Parents Self-Efficacy on SVAC issues*
Study phase	Baseline	1
	Endline	1.162** **[1.065, 1.266] p=0.001**
Study group	Control	1
	Intervention	**0.398*** [0.341, 0.465] p=0.000**
Sex	Male	1
	Female	**0.949*** [0.946, 0.952] p=0.000**
Age group	18-24 years	1
	25-34 years	0.902 [0.622, 1.309] p=0.589
	>34 years	1.216 [0.953, 1.551] p=0.116
Education level	Primary	1
	Post primary	1.341 [1.272, 1.414] p=0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention	
	Endline#Intervention	1.038 [0.809, 1.329] p=0.771
Adjusted inverse probability weighting		
Beliefs	**Categories**	
Average treatment effect on the treated	Baseline#Intervention	1
	Endline#Intervention	-0.012 [-0.050, 0.025] p=0.514

**0.05 **0.01 and ***0.001 significance level*

AIPW shows that between baseline and endline intervention groups, there was no significant change in self-efficacy on handling SVAC issues. Similarly, the ATE indicates no significant change in the endline intervention group. However, in general, male parents demonstrated significantly higher odds of self-efficacy on handling SVAC issues than female parents.

3.3.5 Intentions/behavior related to mitigating risk exposure to sexual abuse and exploitation

Parents' willingness to discuss SVAC

Parents' willingness to discuss SVAC or CSA issues was assessed at baseline and endline, as shown in Appendix E, Table E 5. In the control group, the proportion of parents who expressed willingness to discuss these issues in school or community settings increased by only 0.3 percent, while in the intervention group, the proportion decreased by 2 percent.

The proportion of parents willing to discuss SVAC or CSA issues within the family increased by 2 percent in the control group, while in the intervention group, it slightly increased by 0.1 percent. Similarly, findings from the stakeholders that were interviewed show that some parents are now willing to discuss SVAC with their children.

> ***"Previously, if a child experienced sexual abuse and reported it to the parents, she would be warned quickly not to narrate the scenario; besides, she would be perceived as immoral and engaging in affairs. Currently, parents give attention to their children and discuss matters together"*** **(KII, Social Welfare Officer, North A).**

The parents willing to discuss these issues with the school management committee parent representatives increased by 5 percent in the control group, whereas in the intervention group, it decreased by 5 percent. The proportion of parents willing to discuss SVAC or CSA with community members increased by 4 percent in the control group but reduced by 4 percent in the intervention group.

A composite variable of willingness to discuss SVAC or CSA issues was created by combining four selected parameters, as shown in Table E 5. A score greater than 1 was considered indicative of a willingness to discuss SVAC. The reliability of the composite variable, tested by Cronbach's alpha, was 0.85, indicating better reliability. The proportion of parents expressing willingness to discuss SVAC in the control group increased by 1 percent (baseline: 96.5 percent, endline: 97.5 percent), while in the intervention group, it reduced by 1 percent (baseline: 96.0 percent, endline: 95.0 percent).

Table E 6 presents changes between baseline and endline in parents' communication about sexual risk reduction with their children (see Appendix E). The proportion of parents in the control group who report not holding discussions with their children on how to avoid peer pressure to engage in sex prematurely decreased by 1 percent and increased in the intervention group by 3 percent. The proportion of parents who once discussed with their child how to avoid peer pressure to engage in sex prematurely decreased by 1 percent in the control group but increased by 5 percent in the intervention group. The proportion of parents who discussed it more than once increased by 2 percent in the control group but decreased by 8 percent in the intervention group.

Qualitative findings show that some parents see the value in sexuality education and are capable of describing how it can proceed. As one of them noted:

> ***"After creating a friendly environment, then parents should educate their children on sexual abuse and educate them on the procedures to be followed once they experience any form of sexual abuse, educating our children to stay away from bad friends and how to protect their bodies from strangers, etc."*** **(FGD female parent).**

By endline, the proportion of parents who never discussed ways to seek help their child feels at risk of sexual abuse in any situation in the control group slightly increased by 1 percent and increased by 7 percent in the intervention group. The proportion of parents who once talked to their children about body changes decreased by 1 percent in the control group but increased by 3 percent in the intervention group. The proportion of parents discussing body changes with their children more than once increased slightly by 0.3 percent in the control group but decreased by 10 percent in the intervention group.

A composite variable for communication on sexual risk reduction was created by combining two selected parameters, as shown in Table E 6. A score greater or equal to 1 was considered indicative of communication on sexual risk reduction. The reliability of the composite variable, tested by Cronbach's alpha, was 0.84, indicating better reliability. The proportion of parents who indicated that they communicated about sexual risk decreased by 0.1 percent in the control group (from 91.1 percent to 91 percent) while in the intervention group, this proportion decreased by 5 percent (from 91 percent to 86 percent).

Children celebrating the graduation of the 12 SVAC prevention sessions at Mahonda Shehia. © Pathfinder Intl Tanzania

Parents' sexuality education practices

Table E 7 presents baseline and endline results on parents' sexuality education practices for control and intervention groups. Regarding parents talking to their children about healthy relationships, by endline, the proportion of parents in the control group who never talked to their children increased by 7 percent. The proportion of parents who talked to their children once reduced by 4 percent, and those who talked to their children more than once reduced by 4 percent. For the same measure in the intervention group, there was no change from baseline to endline in the proportion of parents who never talked to their children about healthy relationships; a 2-percent increase in the proportion of parents who talked once to their children about healthy relationships; and a 2-percent reduction in the proportion of those who discussed the topic more than once.

Further, in the control group, the proportion of parents who never talked to their children about this aspect reduced by 2 percent at the endline. Those who talked once reduced by 1 percent, while the proportion of parents who talked more than once increased by 3 percent. In the intervention group, the proportion of parents who never talked to their children about body changes reduced by 1 percent by endline, the proportion of those who talked once increased by 3 percent, while the proportion of parents who talked more than once reduced by 2 percent.

On the issue of parent-child discussions on sexual violence risk, by endline in the control group, the proportion of parents who never discussed this with their children reduced by 2 percent, and those who discussed it once reduced by 1 percent. However, there was an increase of 3 percent in the proportion of parents who discussed this issue more than once. In the intervention group, the proportion of parents who never discussed risks of sexual violence with their children increased by 4 percent, while the proportion of those who discussed this issue once increased by 3 percent. However, there was a 7-percent reduction at endline in the proportion of parents who discussed this issue more than once.

A composite variable for "sexuality education practices" was created by combining three selected parameters, as shown in Table E 7 . A score greater than 1 was considered indicative of parents having sexual education practices (discussions) with their children. The reliability of the composite variable, tested by Cronbach's alpha, was 0.74, indicating acceptable reliability. Overall, for sexuality education practices, the control group had an increase of 2 percent in parents who reported having engaged in sexuality education conversations (baseline: 88.9 percent, endline: 91.1 percent), while the intervention recorded a decrease of 3 percent (baseline: 90.3 percent, endline: 87.2 percent). Results for the intervention group were mixed, indicating areas for improvement.

Overall, proportion of parents in the intervention group who reported engaging in sexuality education conversations with children reduced by 3 percent.

Table 11: Difference in differences analysis of changes in parents' willingness to discuss SVAC, communication on risk reduction, and sexuality education practices

Variable	Categories	**Odds Ratios:** Parents' willingness to discuss SVAC	**Odds Ratios:** Communication on sexual risk reduction	**Odds Ratios:** Sexuality Education practices
Study phase	Baseline	1	1	1
	Endline	1.277 [0.785, 2.076] p=0.325	0.910 [0.752, 1.101] p=0.330	**1.225** [1.080, 1.390] p=0.002**
Study group	Control	1	1	1
	Intervention	**0.783*** [0.703, 0.873] p=0.000**	1.006 [0.898,1.127] p=0.917	1.214 [0.835,1.766] p=0.310
Sex	Male	1	1	1
	Female	**0.718*** [0.686, 0.750] p=0.000**	**0.835*** [0.797,0.874] p=0.000**	**1.117*** [1.094, 1.141] p=0.000**
Age group	18-24 years	1	1	1
	25-34 years	**0.346*** [0.304, 0.393] p=0.000**	1.001 [0.806, 1.245] p=0.990	**1.052*** [1.034, 1.070] p=0.000**
	>34 years	**0.493*** [0.360,0.676] p=0.000**	**3.194*** [2.459, 4.150] p=0.000**	**2.205*** [1.680, 2.896] p=0.000**
Education level	Primary	1	1	1
	Post-primary	1.035 [0.629, 1.704] p=0.000	1.011 [0.576, 1.776] p=0.968	1.285 [0.868, 1.902] p=0.211
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			
	Endline#Intervention	**0.611*** [0.570, 0.655] p=0.000**	**0.655** [0.470, 0.913] p=0.013**	**0.606** [0.452, 0.815] p=0.001**
Adjusted inverse probability weighting				
Willingness to discuss SVAC	**Categories**	**Coefficient**	**Coefficient**	**Coefficient**
Average treatment effect on the treated	Baseline#Intervention	1	1	1
	Endline#Intervention	-0.010 [-0.051, 0.031] p=0.806	-0.047 [-0.109, 0.158] p=0.143	-0.028 [-0.094,0.034] p=0.380

*0.05 **0.01 and ***0.001 significance level

In analyzing the three key aspects of parents' willingness to discuss SVAC, their communication on sexual risk reduction, and their communication on sexuality education practices, AIPW shows no significant changes between the parents in the baseline and endline intervention groups. The ATE confirms that the endline intervention group showed a significant reduction in all three aspects of parents' behavior around this measure.

However, among parents of different social demographics, there were mixed results. In general, parents over 34 years had significantly higher odds of having positive shifts in communication on sexual risk reduction and sexuality education practices (p=.000), while the younger parents (18–24) showed a greater willingness to discuss SVAC than older parents. Meanwhile, parents aged 25–34 were more willing to engage in sexuality education practices than their younger counterparts (p=.000). Finally, while female parents showed higher odds of engaging in sexuality education practices (p=.000), male parents demonstrated a higher willingness to discuss SVAC and hold conversations on sexual risk reduction.

Othman Juma (Left), facilitates a tug of war game during a joint session with children and parents at Bandamaji school hub. © Pathfinder Intl Tanzania

DISCUSSION

The endline evaluation of the KUWAZA III SVAC toolkit provides critical insights into the effectiveness of the intervention in reducing sexual violence against children in Zanzibar. Specifically, the assessment examined the impact of the KUWAZA III SVAC toolkit on knowledge, perceptions, attitudes, agency, and intentions/behaviors related to mitigating risks of children being exposed to child sexual abuse and exploitation, including through reporting and help-seeking. This discussion synthesizes the key findings, highlighting the KUWAZA III SVAC toolkit's impact.

The findings indicate that the SVAC prevention toolkit had a statistically significant (p=.000) impact on increasing children's knowledge of SVAC harmful practices, including sexual abuse, child marriage, and rape, with notable improvements in their understanding of legal protections against SVAC compared to children in the control group. However, within these findings, there were notable differences among children with different social demographic characteristics, including age groups and sex. For instance, girls showed notably significant (p=.000) knowledge levels than boys on SVAC harmful practices and legal protection, while boys had significantly (p=.000) higher knowledge on reporting points than girls. The younger children (7-10 years) had significantly (p=.000) higher knowledge of SVAC harmful practices than the older ones. On the other hand, children aged 11-14 and children residing with biological parents had significantly (p=.000) more knowledge about legal protection and reporting points than their respective counterparts.

Qualitative findings corroborate children's improved knowledge on several harmful practices and the importance of avoiding them to protect their rights and well-being. These findings suggest that the toolkit effectively conveyed critical information to children, enhancing their ability to recognize and respond to SVAC. These results align with previous research indicating that educational interventions can effectively enhance children's understanding of SVAC [21], [23].

Additionally, the intervention improved children's knowledge of where to report SVAC, as seen in the qualitative and qualitative findings. Children were able to identify key individuals who can recognize existing SVAC risks and take timely action. Their increased awareness that they can report to established authorities such as the police and village elders is a critical step toward ensuring that cases are treated seriously and that appropriate actions are taken to prevent further abuse. Reporting to persons outside of immediate family provides an alternative route for children to seek help, especially when family members may be perpetrators or may discourage reporting due to fear of stigma [24]. Regression analysis showed that boys and generally older children were significantly (p=.000) more likely to know where to report SVAC compared to girls and younger children.

The intervention positively influenced children's attitudes and beliefs around SVAC. By endline, the proportion of children in the intervention group who disagreed with harmful norms, such as the belief that it is a girl's fault if she is sexually abused due to her style of dress, increased substantially. This shift indicates a reduction in victim-blaming attitudes and an increased understanding of the rights and protections afforded to children. Additionally, significant (p=.000) results were noted among children staying with biological parents, suggesting that despite the efforts of the intervention, the type of primary caregiver plays a crucial role in shaping children's attitudes towards SVAC, with biological parents being more effective in fostering positive attitude changes.

Despite these positive changes, some areas showed less improvement. For instance, there was an increase in the proportion of children who agreed that children should keep quiet if someone walks in while they are bathing, even if that makes them uncomfortable. This finding highlights the need for continuous reinforcement of messages that empower children to speak out against inappropriate behavior.

The findings demonstrate statistically significant (p=.000) improvements in children's confidence to disclose and report sexual violence. The proportion of children in the intervention group who felt confident reporting sexual abuse and disclosing the perpetrators substantially increased by endline, and in FGDs, children provided scenarios of how they have report-

ed SVAC and perpetrators. Also, key stakeholders attested that they have observed increased agency in children who now know what to do in situations of sexual violence. These findings indicate that KUWAZA III successfully empowered children to take action against sexual violence, which is crucial for early intervention and support. The KUWAZA III intervention was also highly effective in empowering children to make confident life choices, such as the confidence to do what is right amidst peer pressure and the confidence to refuse sex with a person who has power over the child. Another positive impact of KUWAZA III was on child-parent communication regarding SVAC and sexuality education. **The proportion of children who felt comfortable discussing SVAC with their parents or guardians substantially increased by endline, and this was statistically significant.** Literature shows that child-parent communication improvement is critical, as open communication is a key factor in preventing and responding to SVAC [25], [26]socio-cultural influences can inhibit meaningful SRH communication. Restrictive gender norms threaten the SRH of adolescents, as they make adolescent boys more likely to engage in risky sexual behavior and make girls more vulnerable to negative SRH outcomes. This study intended to critically understand the impact of gender norms and expectations on parent–child SRH communication in rural south-western Uganda. Methods: The study adopted a community-based participatory approach using community stakeholder engagement meetings (n = 2.

However, the assessment also identified areas for improvement. While there was an increase in children's willingness to in discuss sexual risks and body changes with their parents, the overall frequency of these conversations remained low, suggesting that while the intervention inspired the initiation of important dialogue, sustained efforts are needed to normalize these discussions within families.

The assessment found that the intervention did not lead to a significant increase in the use of protective strategies against SVAC exposure. This slow change in behavior can be attributed to the complex and gradual nature of behavior change, which often requires sustained effort and time [27], [28]; in other words, the intervention's effect on behavior may take a while to become evident. The findings underscore the need for ongoing support and reinforcement to sustain initial gains from the intervention. Additionally, follow-up surveys should be conducted to assess long-term after-effects of the intervention on behavior change.

The evaluation revealed mixed results of the intervention's impact regarding parental knowledge, attitudes, and practices related to SVAC. While parents' awareness of informal avenues for expressing concerns about SVAC increased, the use of formal channels remained low. However, by endline, among children there was a noticeable increase in the preference for formal reporting points such as police and *sheha*. These findings indicate a need for further efforts to build trust in formal reporting mechanisms and ensure parents are aware of and comfortable using these resources.

The KUWAZA III SVAC toolkit also had a positive influence on parents' attitudes toward believing children who report SVAC. For instance, findings show that parents in the endline intervention group were more than twice as likely to believe children who report SVAC almost all the time. Although not statistically significant, the intervention made positive shifts in parents' attitudes. Qualitative results indicate a strong commitment of parents to safeguard children from harm. Parents felt more empowered and informed about SVAC, which contributed to these positive shifts.

The study results suggest that there was a noticeable rise in the children's self-reported comfort in discussing SVAC. Although the intervention's impact was not statistically significant on parents' willingness to discuss SVAC, nor on their communication on sexual risk reduction and sexuality education practices, the qualitative findings revealed discussions indicating their willingness to engage in these conversations. Notable was a decline among parents in the intervention group in discussing the risks with their children of sexual violence more than once; this finding indicates a need for strategies to encourage consistent communication. Younger parents, in particular, may need more targeted support and resources to feel comfortable and confident in discussing these topics with their children [16] .

CONCLUSION AND RECOMMENDATIONS

Overall, the KUWAZA III SVAC toolkit has made significant progress in improving the prevention and response to SVAC in Zanzibar. The findings highlight the effectiveness of the toolkit in raising awareness, changing attitudes, and improving behaviors related to SVAC. The study evidence shows a more significant impact on children's knowledge, beliefs, attitudes, and agency in response and prevention of SVAC than the parents' attitudes and behavior. We acknowledge there were improvements observed among the control groups which might be influenced by broader societal changes, other concurrent interventions, or increased media attention on SVAC issues.

The slow changes observed in behavior and practice can be attributed to the complex and gradual nature of behavior change. For example, little improvement was found with respect to children's utilization of protective measures against SVAC exposure and parents' sexuality education practices. This is explained by behavior change theory. Behavior change, especially regarding sensitive issues like SVAC, often requires sustained effort and time. The Stages of Change Model suggests that behavior change occurs in stages, and the lack of significant change could indicate that many individuals are still in the early stages, such as pre-contemplation or contemplation. The Social Cognitive Theory highlights that behavior change is influenced by personal, behavioral, and environmental factors, which could explain the gender differences observed in some of the results. Additionally, the Diffusion of Innovations Theory explains how new behaviors spread within a community, suggesting that the slow uptake of protective measures might be due to the time it takes for these innovations to be widely adopted.

While KUWAZA III successfully challenged some harmful norms, others persisted. The intervention should focus on reinforcing positive beliefs and addressing deeply ingrained cultural attitudes that perpetuate SVAC through the use of culturally sensitive, tailored interventions.

The findings of this evaluation align with Tanzania's National Plan of Action to End Violence Against Women and Children. Integrating the KUWAZA III SVAC toolkit into national policy frameworks can enhance its reach and impact, providing a model for SVAC prevention that can be scaled up and replicated in other regions. Policy actors and practitioners should support and expand such programs to ensure wider reach and sustainability, fostering a culture of awareness and prevention from an early age.

Recommendations

Based on the findings from the KUWAZA III SVAC toolkit's endline evaluation, the following recommendations are proposed to enhance the effectiveness of the intervention aimed at preventing and responding to SVAC in Zanzibar:

1 Further studies could consider a more robust randomized controlled trial before scaling up of the SVAC toolkit

- A comprehensive randomized controlled trial for the SVAC toolkit intervention addressing the challenges and limitations identified during the KUWAZA Phase III pilot is required before scaling up. Considerations could include:
    - Areas/communities that have not been previously exposed to any KUWAZA activities should be included in the study to ensure a "true control," limited spillover effects, and unbiased results.
    - Provide the control group with a placebo that does not compromise the intervention results but still offers some benefit to the participants.

2 Strengthen toolkit sessions that focus on culturally sensitive topics

- Increase emphasis and strengthen the implementation of culturally sensitive toolkit sessions that address specific misconceptions, such as the belief that a girl's clothing can be blamed for sexual abuse. These sessions could involve key stakeholders such as community leaders, religious leaders, and local influencers to ensure acceptance and impact.
- Continue to provide education and training for parents, teachers, and community members to reinforce positive beliefs and attitudes such as on the importance of believing children who report sexual abuse and the potential for repeat offenses by perpetrators.

3 Enhance parental involvement and support

- Expand and enhance training programs for parents to improve their knowledge and communication skills regarding SVAC and sexuality education. These programs should focus on building parents' confidence to discuss sensitive topics with their children and to report abuse.
- Provide additional support and resources for younger parents to help them feel more comfortable and confident in discussing SVAC and sexuality education with their children. This could include peer support groups, mentoring programs, and access to educational materials.

4 Improve and build trust in reporting mechanisms and support services

- Strengthen and promote accessible reporting mechanisms for children and parents. Build trust among parents and children to use these formal channels by ensuring they are reliable and supportive. The use of formal channels for reporting SVAC remained low, indicating a need to build trust and ensure parents and children are comfortable using these resources.
- Enhance support services for survivors of SVAC, including counseling, medical care, and legal assistance. Ensure these services are child-friendly, confidential, and easily accessible.

5 Address and foster positive attitudes and beliefs

- Focus on reinforcing positive beliefs and addressing deeply ingrained cultural attitudes that perpetuate SVAC through culturally sensitive and tailored interventions. Implement behavior change interventions that target harmful attitudes and beliefs about SVAC using evidence-based approaches, such as social norms theory and behavior change communication, to shift community attitudes and promote protective behaviors.
- Integrate SVAC prevention and response education into school curricula to foster positive attitudes and beliefs from an early age. This should include age-appropriate lessons on consent, healthy relationships, and reporting mechanisms.

6 Consider intersectionality

- Intersectionality is essential in addressing SVAC and CSA, as certain groups may be disproportionately affected. Future interventions could explore the specific needs and vulnerabilities of different populations, including children with disabilities, refugees, and marginalized communities, to ensure that interventions are inclusive and equitable. This requires a comprehensive understanding of intersecting factors such as disability, ethnicity, and socioeconomic status when designing and implementing interventions.

7 Enhance child-parent communication

- Continue to promote and support open communication between children and parents regarding SVAC and sexuality education. Existing evidence emphasizes the importance of child-parent communication in preventing and responding to SVAC. While the intervention has made positive shifts in this area, the frequency of these conversations remained low. We need to normalize conversations about SVAC, reduce stigma, and improve prevention and response to SVAC.

8 Ensure continuous reinforcement and follow-up

- Strengthen and promote accessible reporting mechanisms for children and parents. Build trust among parents and children to use these formal channels by ensuring they are reliable and supportive. The use of formal channels for reporting SVAC remained low, indicating a need to build trust and ensure parents and children are comfortable using these resources.
- Enhance support services for survivors of SVAC, including counseling, medical care, and legal assistance. Ensure these services are child-friendly, confidential, and easily accessible.

9 Address and foster positive attitudes and beliefs

- We recommend implementing ongoing support and follow-up sessions to sustain behavior change and reinforce positive messages. Literature shows that behavior change, especially regarding sensitive issues like SVAC, requires sustained effort and time. Continuous reinforcement can help maintain the gains achieved through the program thus far.
- Continuous reinforcement could be done by:
    - Scheduling regular follow-up sessions with participants to reinforce key messages and provide additional support.
    - Offering refresher training to participants periodically.
    - Establishing a support network for participants to share experiences and seek guidance.

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Appendix

Appendix A: Social Demographics

Table A 1: Socio-demographic characteristics of children across study groups and study phases

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Intervention	Control	Intervention	Control
Sex	Boy	395(50.6)	197(44.8)	184(49.3)	166(45.4)
	Girl	386(49.4)	243(55.2)	189(50.7)	200(54.6)
Age group 10.8±2.4	7-10 years	356(45.6)	215(48.9)	144(38.6)	173(47.3)
	11-14 years	425(54.4)	225(51.1)	229(61.4)	193(52.7)
Primary caregivers	Biological parent	605(77.5)	336(76.4)	313(83.9)	271(74.0)
	Adopted parent	32(4.1)	21(4.8)	7(1.9)	95(26.0)
	Other family	144(18.4)	83(83)	53(14.2)	92(58.6)
Parent status	No parent	7(0.9)	1(0.2)	3(0.8)	2(0.5)
	One parent	102(13.1)	25(5.7)	39(10.5)	34(9.3)
	Both parents	672(86.0)	414(94.1)	331(88.7)	330(90.2)
Level of education	Grades 5-7	733(93.9)	430(97.7)	354(94.9)	355(97.0)
	Lower level of secondary school (O-level)	48(6.1)	10(2.3)	19(5.1)	11(3.0)
Participation in school or community activities	No	417(53.4)	278(63.2)	148(39.7)	271(74.0)
	Yes	417(46.6)	162(36.8)	225(60.3)	95(26.0)

Table A 2: Distribution of parents/caregivers in the study

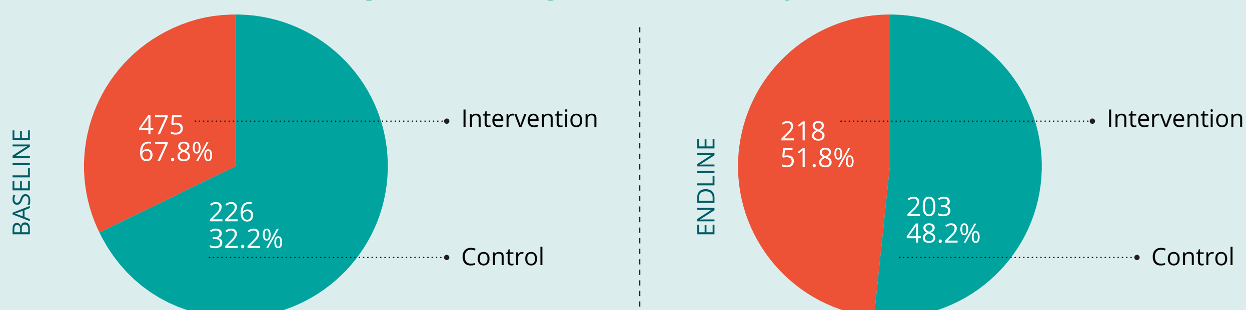


Table A 3: Parents'/caregivers' socio-demographics

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Control	Intervention	Control	Intervention
Sex	Male	22(9.7)	43(9.1)	16(7.9)	23(10.6)
	Female	204(90.3)	432(90.9)	187(92.1)	195(89.4)
Age group	18-24 years	12(5.3)	25(5.3)	7(3.4)	12(5.5)
	25-34 years	48(21.3)	119(25.1)	40(19.7)	54(24.8)
	>34 years	165(73.3)	331(69.7)	156(76.8)	152(69.7)
Employment status	Not Employed	0(0.0)	13(2.7)	5(2.5)	1(0.5)
	Employed	226(100.0)	462(97.3)	198(97.5)	217(99.5)
Education level	Primary	136 (60.2)	297(62.5)	108(53.2)	160(73.4)
	Post Primary	90(39.8)	178(37.5)	95(46.8)	58(26.6)
Marital status	Unmarried	78(34.5)	112(23.6)	59(29.1)	55(25.2)
	Married	148(65.5)	363(76.4)	144(70.9)	163(74.8)

Appendix B: Knowledge and Awareness of SVAC

Table B 1: Children's Knowledge and awareness of harmful practices that constitute SVAC

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Intervention	Control	Intervention	Control
Sexual abuse	No	473 (60.6)	275(62.5)	149(39.9)	131(35.8)
	Yes	308(39.4)	165(37.5)	224(60.1)	235(64.2)
Child marriage	No	571(73.1)	325(73.9)	259(69.4)	240(65.6)
	Yes	210(26.9)	115(26.1)	114(30.6)	126(34.4)
Rape	No	250(32.0)	139(31.6)	127(34.0)	107(29.2)
	Yes	531(68.0)	301(68.4)	246(66.0)	259(70.8)
Knowledge on harmful practice	Low	448(57.8)	257(58.4)	159(42.6)	136(37.2)
	High	333(42.6)	183(41.6)	214(57.4)	230(62.8)

*Cronbach's alpha coefficient: 0.8442.

Table B 2: Change in Children's knowledge of legal protection against SVAC

Knowledge of legal protection against SVAC					
Variable	**Categories**	**Baseline n (percent)**		**Endline n (percent)**	
		Intervention	**Control**	**Intervention**	**Control**
Rape is a Crime	True	587(75.4)	377(85.7)	354(94.9)	350(95.6)
	False	131(16.8)	35(8.0)	12(3.2)	13(3.6)
	Don't know	61(7.8)	28(6.4)	7(1.9)	3(0.8)
Sexual intercourse with a minor/ defilement is a crime	TRUE	594(76.2)	374(85.0)	312(83.6)	312(85.2)
	FALSE	130(16.7)	37(8.4)	52(13.9)	50(13.7)
	Don't know	56(7.2)	29(6.6)	9(2.4)	4(1.1)
Age of consent is ≥18 years	TRUE	477(61.2)	293(66.6)	243(65.1)	254(69.4)
	FALSE	152(19.5)	57(13.0)	62(16.6)	56(15.3)
	Don't know	150(19.3)	90(20.5)	68(18.2)	56(15.3)
Knowledge of legal protection against SVAC	Low	199(25.6)	75(17.0)	55(14.7)	43(11.7)
	High	579(74.4)	365(83.0)	318(85.3)	323(88.3)

*Cronbach's alpha coefficient: 0.7500.

Table B 3: Children's knowledge and awareness on where to report SVAC

Where to report	Categories	Baseline n (percent)		Endline n (percent)	
		Interventionw	Control	Intervention	Control
Police	No	542(69.4)	320(72.7)	233(62.5)	221(60.4)
	Yes	239(30.6)	120(27.3)	140(37.5)	145(39.6)
Teachers	No	341(43.7)	223(50.7)	191(51.2)	181(49.5)
	Yes	440(56.3)	217(49.3)	182(48.8)	185(50.5)
Parents	No	79(10.1)	60(13.6)	37(9.9)	50(13.7)
	Yes	702(89.9)	380(86.4)	336(90.1)	316(86.3)
Neighbor/friends	No	600(76.8)	376(85.5)	307(82.3)	313(85.5)
	Yes	181(23.2)	64(14.5)	66(17.7)	53(14.5)
Village Elder	No	475(60.8)	307(69.8)	194(52.0)	202(55.2)
	Yes	306(39.2)	133(30.2)	179(48.0)	164(44.8)
Relatives	No	588(75.3)	382(86.8)	315(84.5)	326(89.1)
	Yes	193(24.7)	58(13.2)	58(15.5)	40(10.9)
Pastor	No	664(85.0)	435(98.9	331(88.7	328(89.6)
	Yes	117(15.0)	5(1.1)	42(11.3)	38(10.4)
Child helpline	No	733(93.9)	435(98.9)	353(94.6)	338(92.3)
	Yes	48(6.1)	5(1.1)	20(5.4)	28(7.7)
Area advisory	No	757(96.9)	438(99.5)	354(94.9)	343(93.7)
	Yes	24(3.1)	2(0.5)	19(5.1)	23(3.1)
Child protection officers	No	748(95.8)	436(99.1)	356(95.7)	350(95.6)
	Yes	33(4.2)	4(0.9)	16(4.3)	16(4.4)
Knowledge and awareness on reporting points	Low	644(82.5)	408(92.7)	305(82.0)	308(84.2)
	High	137(17.5)	32(7.3)	67(18.0)	58(15.8)

*Cronbach's alpha coefficient: 0.7426

Table B 4: Existing informal avenues to express concerns about SVAC

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Control	**Intervention**	**Control**	**Intervention**
My child	No	30(13.3)	152(32.0)	44(21.7)	57(26.1)
	Yes	196(86.7)	323(68.0))	159(78.3))	161(73.9)
Tell an adult family member	No	110(48.7)	187(39.4)	89(43.8)	80(36.7)
	Yes	116(51.3)	288(60.6)	114(56.2)	138(63.3)
Other relative	No	131(58.0)	291(61.3)	99(48.8)	105(48.2)
	Yes	95(42.0)	184(38.7)	104(51.2)	113(51.8)
Neighbor	No	134(59.3)	279(58.7)	104(51.2)	119(54.6)
	Yes	92(40.7)	196(41.3)	99(48.8)	99(45.6)
A friend	No	198(87.6)	366(77.1)	148(72.9)	146(67.0)
	Yes	28(12.4)	109(22.9)	55(27.1)	72(33.0)
Informal Avenues	≤1avenue	160(70.8)	229(48.2)	115(56.7)	91(41.7)
	>1 avenue	66(29.2)	246(51.8)	88(43.3)	127(58.3)

**Cronbach's alpha coefficient: 0.8486*

Table B 5: Existing formal avenues to express concerns about SVAC

Variable	Categories	Baseline n (percent)		Endline n(percent)	
		Control	**Intervention**	**Control**	**Intervention**
Community leaders	No	87(38.5)	152(32.0)	71(35.0)	50(22.9)
	Yes	139(61.5)	323(68.0)	132(65.0)	168(77.1)
School teachers	No	179(79.2)	315(66.3)	144(70.9)	136(62.4)
	Yes	47(20.8)	160(33.7)	59(29.1)	82(37.6)
Advisor of a school club	No	212(93.8)	387(81.5)	168(82.8)	169(77.5)
	Yes	14(6.2)	88(18.5)	35(17.2)	49(22.5)
Secretary for Women and Children Affairs	No	208(92.0)	315(66.3)	142(70.0)	154(70.6)
	Yes	18(8.0)	160(33.7)	61(30.0)	64(29.4)
Community dialogue	No	219(96.9)	405(85.3)	177(87.2)	169(77.5)
	Yes	7(3.1)	70(14.7)	26(12.8)	49(22.5)
Toll-Free Child Helpline	No	225(96.9)	423(85.3)	187(87.2)	182(77.5)
	Yes	1(3.1)	52(14.7)	16(12.8)	36(22.5)
Religious leaders	No	220(97.3)	374(78.7)	183(90.1)	158(72.5)
	Yes	6(2.7)	101(21.3)	20(9.9)	60(27.5)
Police	No	197(87.2)	342(72.0)	177(87.2)	179(82.1)
	Yes	29(12.8)	133(28.0)	26(12.8)	39(17.9)
Formal avenues	≤1avenue	83(36.7)	182(38.3)	72(35.5)	74(33.9)
	>1 avenue	143(63.3)	293(61.7)	131(64.5)	144(66.1)

**Cronbach's alpha coefficient: 0.8416*

Appendix C: Beliefs, perceptions, and attitudes on SVAC

Table C 1: Changes in children's beliefs, perceptions, and attitudes towards SVAC

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Intervention	Control	Intervention	Control
If someone walks in while you are having a bath and you feel uncomfortable, you should just keep quiet	Agree	442(56.7)	251(57.0)	267(71.8)	265(72.4)
	Disagree	321(41.2)	175(39.8)	95(25.5)	94(25.7)
	Neither agree or Disagree	17(2.2)	14(3.2)	10(2.7)	7(1.9)
Even hugs and tickles can turn into bad touches if they go on too long.	Agree	700(89.6)	383(87.0)	320(86.0)	318(86.9)
	Disagree	75(9.6)	50(11.4)	50(13.4)	44(12.0)
	Neither agree or Disagree	6(0.8)	7(1.6)	2(0.5)	4(1.1)
You have to let grown-ups touch you whether you like it or not.	Agree	320(41.0)	172(39.1)	123(33.1)	160(43.7)
	Disagree	448(57.4)	260(59.1)	246(66.1)	198(54.1)
	Neither agree or Disagree	13(1.7)	8(1.8)	3(0.8)	8(2.2)
Sometimes it's OK to say "no" to a grown-up	Agree	54(6.9)	24(5.5)	22(5.9)	26(7.1)
	Disagree	723(92.6)	413(93.9)	349(93.8)	339(92.6
	Neither agree or Disagree	4(0.5)	3(0.7)	1(0.3)	1(0.3)
If your babysitter tells you to take off all your clothes, but it's not time to get undressed for bed, you have to do it.	Agree	236(30.2)	108(24.5)	60(16.1)	71(19.4)
	Disagree	538(68.9)	325(73.9)	309(83.1)	287(78.4)
	Neither agree or Disagree	7(0.9)	7(1.6)	3(0.8)	8(2.2)

If someone touches you in a way that you don't like, it's your own fault.	Agree	61(7.8)	31(7.0)	17(4.6)	12(3.3)
	Disagree	713(91.5)	407(92.5)	354(95.2)	354(96.7)
	Neither agree or Disagree	5(0.6)	2(0.5)	1(0.3)	0(0.0)
Sometimes someone in your family might touch you in a way you don't like.	Agree	642(82.2)	373(84.8)	306(82.3)	306(83.6)
	Disagree	133(17.0)	66(15.0)	64(17.2)	60(16.4)
	Neither agree or Disagree	6(0.8)	1(0.2)	2(0.5)	0(0.0)
Beliefs (Composite)	Negative	330(42.3)	196(44.5)	136(36.5)	167(45.6)
	Positive	451(57.7)	244(55.5)	237(63.5)	199(54.4)

*Cronbach's alpha coefficient: 0.7834

Table C 2: Changes in children's attitudes towards SVAC

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Intervention	Control	Intervention	Control
If a relative or teacher engages in sexual contact with a minor, the family should keep silent about the issue to keep the respect of the family or of the teacher.	Agree	63(8.1)	15(3.4)	18(4.8)	19(5.2)
	Disagree	714(91.4)	423(96.4)	353(94.9)	347(94.8)
	Neither agree or Disagree	4(0.5)	1(0.2)	1(0.3)	0(0.0)
If a girl does not wear modest clothes and is sexually abused, it is her fault for not dressing properly.	Agree	193(24.7)	96(21.8)	56(15.1)	68(18.6)
	Disagree	583(74.6)	340(77.3)	309(83.1)	296(80.9)
	Neither agree or Disagree	5(0.6)	4(0.9)	7(1.9)	2(0.5)
Forcing a girl aged below 18 years to get married if she does not want to is a form of abuse.	Strongly Disagree	22(2.8)	8(1.8)	4(1.1)	3(0.8)
	Disagree	202(25.9)	109(24.9)	53(14.2)	45(12.3)
	Neutral	9(1.2)	5(1.1)	10(2.7)	8(2.2)
	Agree	369(47.2)	204(46.6)	255(68.5)	251(68.6)
	Strongly Agree	179(22.9)	112(25.6)	50(13.4)	59(16.1)

Girls should be able to choose when to get married.	Strongly Disagree	37(4.7)	26(5.9)	7(1.9)	7(1.9)
	Disagree	190(24.3)	115(26.2)	67(18.0)	65(17.8)
	Neutral	9(1.2)	3(0.7)	19(5.1)	10(2.7)
	Agree	404(51.7)	210(47.8)	238(64.0)	232(63.4)
	Strongly Agree	141(18.1)	85(19.4)	41(11.0)	52(14.2)
There are times when a woman deserves to be beaten	Strongly Disagree	139(17.8)	92(21.0)	54(14.5)	70(19.1)
	Disagree	430(55.1)	229(52.2)	244(65.6)	223(60.9)
	Neutral	7(0.9)	7(1.6)	11(3.0)	10(2.7)
	Agree	178(22.8)	100(22.8)	60(16.1)	56(15.3)
	Strongly Agree	27(3.5)	11(2.5)	3(0.8)	7(1.9)
A woman should tolerate violence to keep the family together.	Strongly Disagree	162(20.7)	99(22.6)	15.3)	76(20.8)
	Disagree	439(56.2)	252(57.4)	256(68.8)	230(62.8)
	Neutral	12(1.5)	1(0.2)	9(2.4)	6(1.6)
	Agree	161(20.6)	80(18.2)	46(12.4)	52(14.2)
	Strongly Agree	7(0.9)	7(1.6)	4(1.1)	2(0.5)
A boy/man is entitled sex when he demands it.	Strongly Disagree	232(29.9)	100(22.7)	85(22.8)	82(22.4)
	Disagree	458(59.1)	316(71.8)	271(72.8)	255(69.7)
	Neutral	12(1.5)	11(2.5)	9(2.4)	9(2.5)
	Agree	68(8.8)	11(2.5)	6(1.6)	17(4.6)
	Strongly Agree	5(0.6)	2(0.5)	1(0.3)	3(0.8)
Attitudes (Composite)	Negative	164(21.0)	79(18.0)	38(10.2)	39(10.7)
	Positive	617(79.0)	361(82.0)	335(89.8)	327(89.3)

*Cronbach's alpha coefficient: 0.7799

Table C 3: Beliefs in modest dressing and sexual abuse

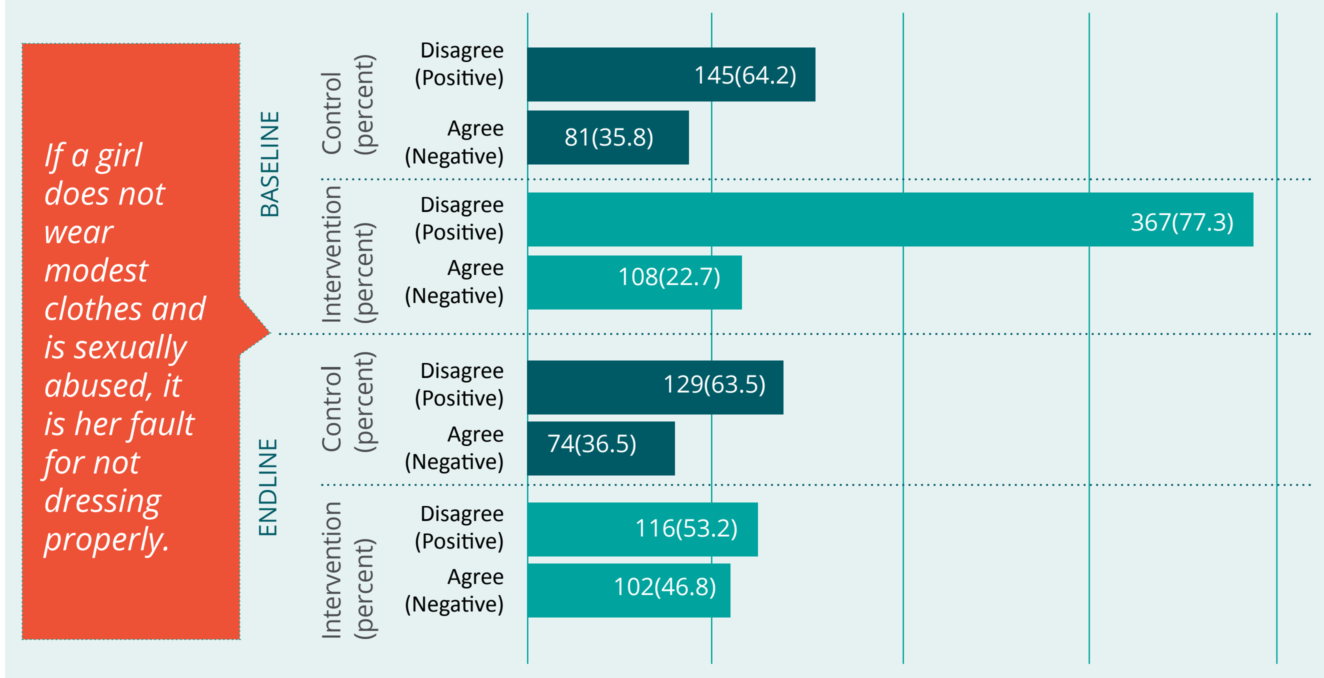


Table C 4: Parents' perspectives on sexuality education

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Control	Intervention	Control	Intervention
I think my child is still too young to learn about sex issues.	Yes	30(27.8)	122(43.4)	21(20.8)	51(40.8)
	No	78(72.2)	158(56.2)	80(79.2)	74(59.2)
	I don't know	0(0.0)	1(0.4)	0(0.0)	0(0.0)
I think that if I talk to my child about sex issues, I will encourage him or her to have sex.	Yes	45(49.5)	82(25.6)	5(27.8)	24(12.9)
	No	44(48.4)	238(74.4)	13(72.2)	161(86.6)
	I don't know	2(2.2)	0(0.0)	0(0.0)	1(0.5)
If my child talked to me about sex issues, I would assume that he or she is sexually active.	Yes	18(16.7)	101(35.9)	14(13.9)	46(36.8)
	No	90(83.3)	171(60.9)	87(86.1)	75(60.0)
	I don't know	0(0.0)	9(3.2)	0(0.0)	4(3.2)
It is my duty to make sure my child knows about sex.	Yes	55(60.4)	254(79.4)	13(72.2)	169(90.9)
	No	32(35.2)	60(18.8)	5(27.8)	15(8.1)
	I don't know	4(4.4)	6(1.9)	0(0.0)	2(1.1)
Perceptions on Sexuality Education (Composite)	Wrong	98(43.4)	229(48.2)	94(46.3)	107(49.1)
	Right	128(56.6)	246(51.8)	109(53.7)	111(50.9)

*Cronbach's alpha coefficient: 0.8461

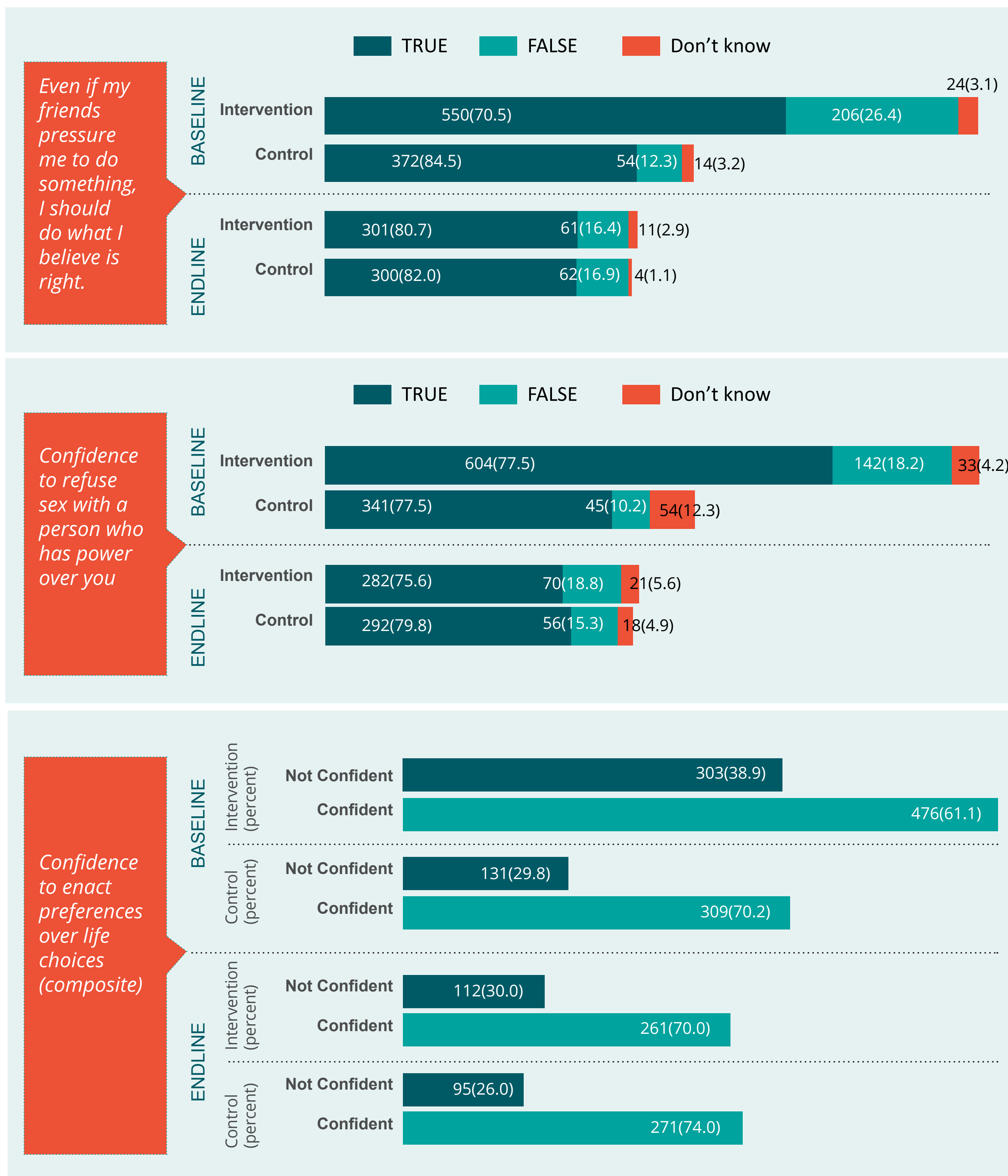
Appendix D: Agency and self-efficacy

Table D 1 : Confidence to disclose and report SVAC

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Intervention	Control	Intervention	Control
How confident are you that you can disclose sexual abuse to your parent/s or caregiver if faced with such a situation?	Not confident	134(17.2)	28(6.4)	9(2.4)	18(4.9)
	Somewhat not confident	29(3.7)	13(3.0)	8(2.1)	6(1.6)
	Confident	392(50.3)	308(70.0)	302(81.0)	289(79.0)
	Very confident	225(28.8)	91(20.7)	54(14.5)	53(14.5)
How confident are you that if you experienced adverse circumstances of sexual abuse, you would report it somehow?	Not confident	110(14.1)	26(5.9)	8(2.1)	13(3.6)
	Somewhat not confident	22(2.8)	14(3.2)	6(1.6)	9(2.5)
	Confident	414(53.1)	312(70.9)	303(81.2)	294(80.3)
	Very confident	234(30.0)	88(20.0)	56(15.0)	50(13.7)
How confident are you that if you experienced sexual abuse, you would disclose the perpetrator?	Not confident	117(15.0)	28(6.4)	6(1.6)	15(4.1)
	Somewhat not confident	21(2.7)	13(3.0)	9(2.4)	12(3.3)
	Confident	388(49.8)	310(70.5)	303(81.5)	279(76.5)
	Very confident	253(32.5)	89(20.2)	54(14.5)	60(16.4)
Confidence to report SVAC	Not confident	136(17.4)	39(8.9)	16(4.3)	22(6.0)
	Confident	645(82.6)	401(91.1)	357(95.7)	344(94.0)

*Cronbach's alpha coefficient: 0.9195

Table D 2 : Confidence to enact preferences over life choices



Cronbach's alpha coefficient: 0.8493

Table D 3 : Children were asked about where they would be comfortable to report SVAC

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Intervention	Control	Intervention	Control
Where would you feel comfortable to report SVAC?	A friend	11(1.4)	15(3.4)	6(1.6)	6(1.6)
	An adult family member	606(77.6)	361(82.0)	275(73.5)	262(71.8)
	Local leader/*sheha*	71(9.1)	27(6.1)	48(12.8)	53(14.5)
	A teacher	27(3.5)	20(4.5)	7(1.9)	10(2.7)
	A head teacher	3(0.4)	0(0.0)	1(0.3)	2(0.5)
	The advisor of a school club	0(0.0)	0(0.0)	1(0.3)	0(0.0)
	Police/court	52(6.7)	17(3.9)	12(3.2)	15(4.1)
	Health facility or hospital	2(0.3)	0(0.0)	0(0.0)	0(0.0)
	One stop center	0(0.0)	0(0.0)	1(0.3)	0(0.0)
	Child helpline	0(0.0)	0(0.0)	8(2.1)	2(0.5)
	Other organization/ person	9(1.2)	0(0.0)	15(4.0)	15(4.1)

Table D 4 : Where would a child feel most comfortable reporting SVAC?

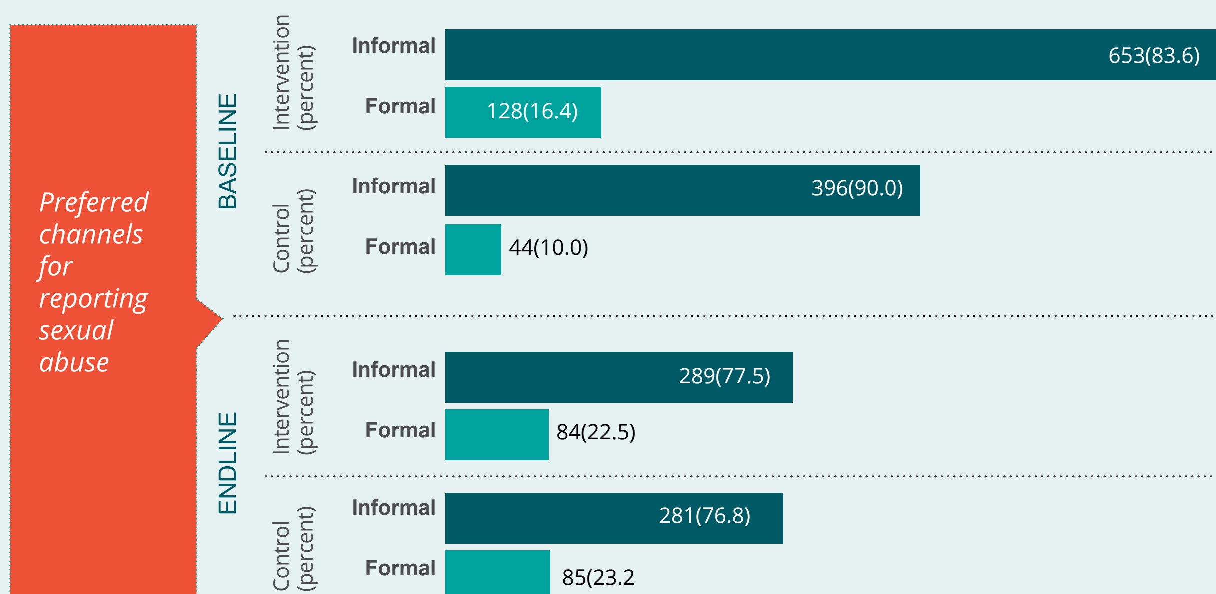


Table D 5: Parental Self-Efficacy on SVAC issues

		BASELINE		ENDLINE	
		Control (percent)	Intervention (percent)	Control (percent)	Intervention (percent)
I can report child sexual abuse if my child confides in me even if my partner may be against it.	Yes	213(94.7)	457(96.2)	194(95.6)	211(96.8)
	NO	10(4.4)	15(3.2)	9(4.4)	5(2.3)
	I don't know	2(0.9)	3(0.6)	0(0.0)	2(2.3)
I can reject marrying off my child.	Yes	215(95.6)	403(84.8)	197(97.0)	189(86.7)
	NO	8(3.6)	61(12.8)	5(2.5)	22(10.1)
	I don't know	2(0.9)	11(2.3)	1(0.5)	7(3.2)
Parents' self-efficacy **Composite)**	LOW	17(7.5)	82(17.3)	13(6.4)	33(15.1)
	HIGH	209(92.5)	393(82.7)	190(93.6)	185(84.9)

*Cronbach's alpha coefficient: 0.795

Table D 6: Persons that parents are confident to talk to about the risks of SVAC in the community

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Control	Intervention	Control	Intervention
With whom do you feel confident or not confident to talk to about risks of sexual violence against children in your community?	My child	223(98.7)	413(86.9)	192(94.6)	207(95.0)
	Tell an adult family member	187(82.7)	394(82.9)	141(69.5)	181(83.0)
	Other relative	196(86.7)	369(77.7)	138(68.0)	177(81.2)
	Community leader/ *sheha*	181(80.1)	418(88.0)	154(75.9)	192(88.1)
	Neighbor	178(78.8)	372(78.3)	125(61.6)	178(81.7)
	School teacher	162(71.7)	386(81.3)	121(59.6)	166(76.1)
	The advisor of a school club	141(62.4)	324(68.2)	96(47.3)	159(72.9)
	A friend	159(70.4)	352(74.1)	116(57.1)	163(74.8)
	Secretary for Women and Children Affairs	156(69.0)	379(79.8)	120(59.1)	160(73.4)
	Community dialogue/talk show	126(55.8)	265(55.8)	85(41.9)	141(64.7)
	Toll Free Child Helpline (116)	93(41.2)	251(52.8)	69(34.0)	146(67.0)
	Religious leader	139(61.5)	344(72.4)	99(48.8)	151(69.3)
	Police	132(58.4)	338(71.2)	99(48.8)	139(63.8)

Appendix E: Intentions/behavior related to mitigating risk exposure to sexual abuse and exploitation

Table E 1 : Children's Views on the use of selected protective measures against SVAC exposure

	BASELINE		ENDLINE	
	Control (percent)	Intervention (percent)	Control (percent)	Intervention (percent)
Report bad people (perpetrators)	No 98(12.5); YES 683(87.5)	No 42(9.5); YES 398(90.5)	No 36(9.7); YES 337(90.3)	No 38(10.4); YES 328(89.6)
Keep away from bad people	No 71(9.1); YES 710(90.9)	No 36(8.2); YES 404(91.8)	No 50(13.4); YES 323(86.6)	No 35(9.6); YES 331(90.4)
I avoid walking alone	No 107(13.7); YES 674(86.3)	No 56(12.7); YES 384(87.3)	No 46(12.4); YES 324(87.6)	No 39(10.7); YES 327(89.3)
I don't wear provocative dresses	No 145(18.6); YES 636(81.4)	No 84(19.1); YES 356(80.9)	No 126(33.8); YES 247(66.2)	No 99(27.0); YES 267(73.0)
Protective strategies from SVAC exposure (composite)	No 102(13.1); YES 679(86.9)	No 54(12.3); YES 386(87.7)	No 91(24.4); YES 282(75.6)	No 84(23.0); YES 282(77.0)

*Cronbach's alpha coefficient: 0.8219

Table E 2 : Child – parent communication on SVAC issues

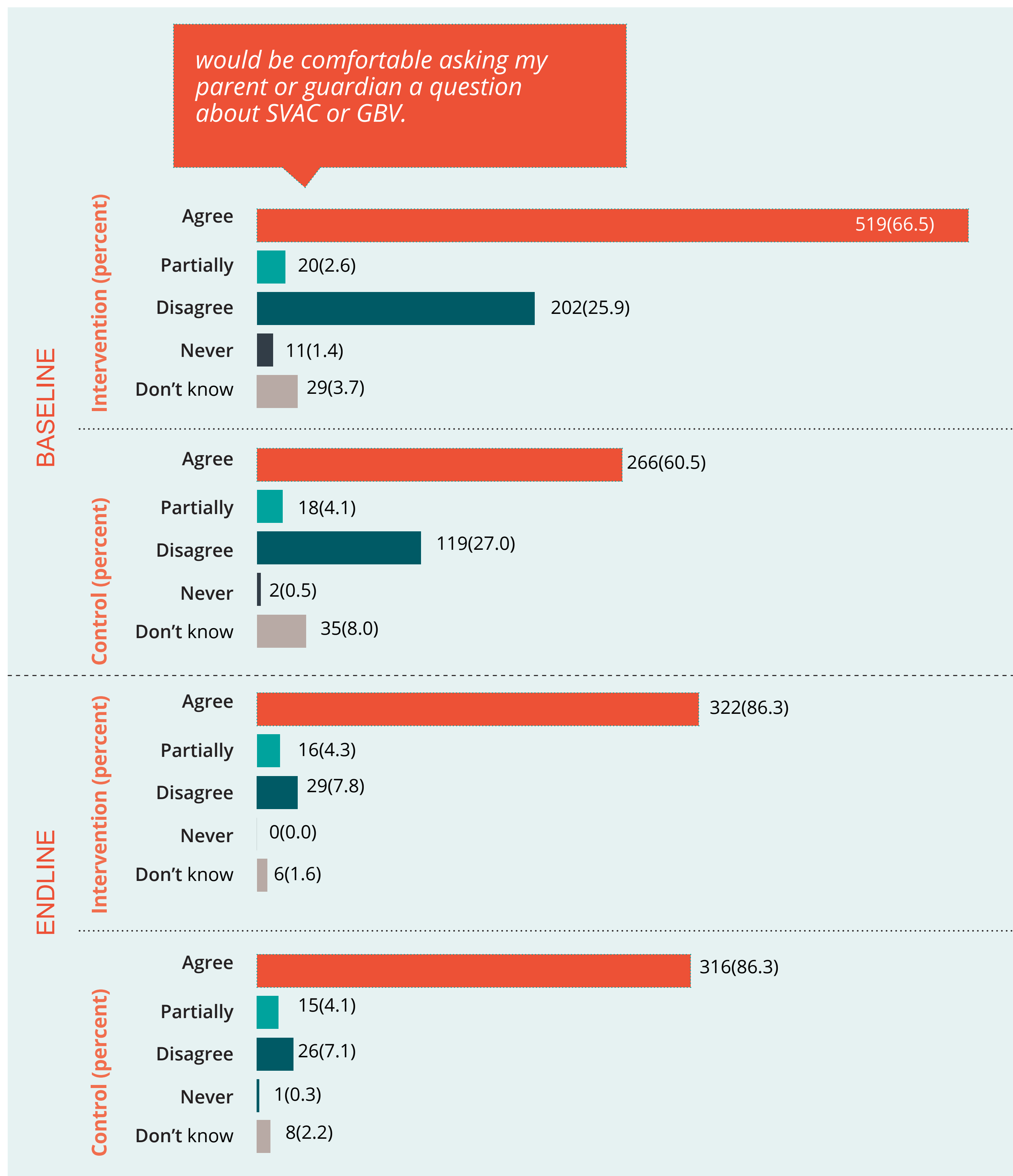


Table E 3 : Children asking questions about how to protect themselves from sexual abuse

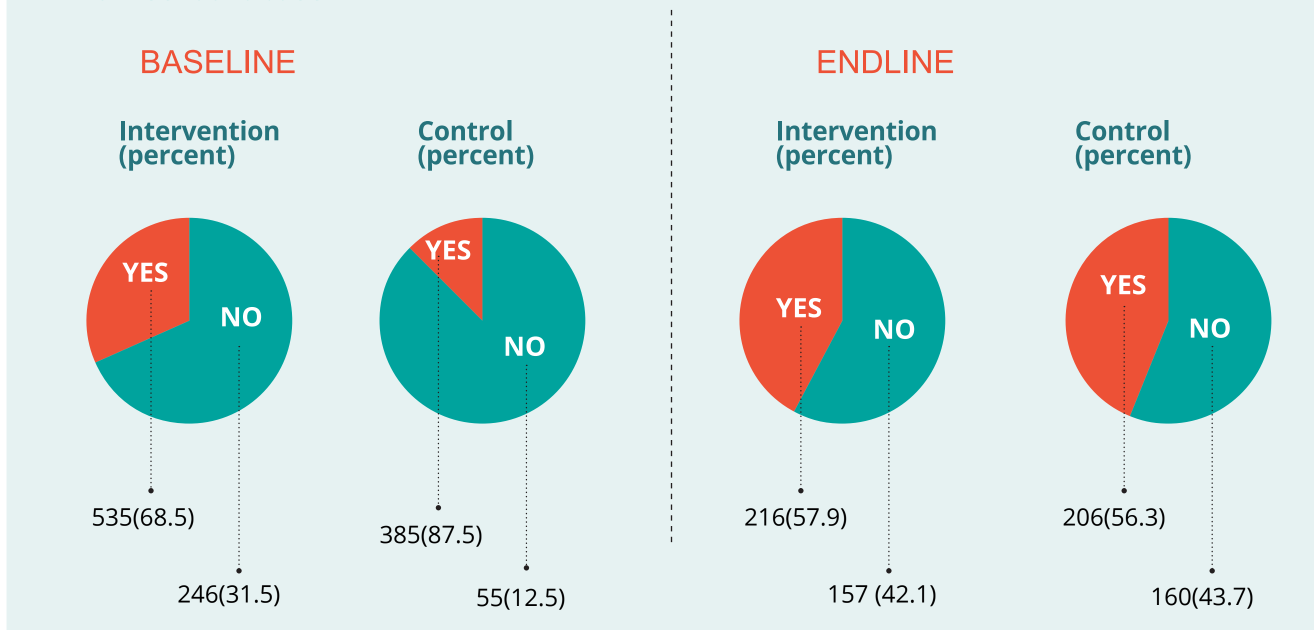


Table E 4 : Parent communication on sexuality education

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Intervention	Control	Intervention	Control
Does your parent or guardian talk to you about how boys and girls form healthy relationships?	No	482(61.7)	315(71.6)	226(60.6)	209(57.1)
	Yes, once	161(20.6)	56(12.7)	81(21.7)	89(24.3)
	Yes, >once	138(17.7)	69(15.7)	66(17.7)	68(18.6)
Does your parent or guardian talk to you about how your body changes as you grow up? This is called puberty.	No	597(76.4)	374(85.0)	235(63.0)	227(62.0)
	Yes, once	99(12.7)	24(5.5)	76(20.4)	77(21.0)
	Yes, >once	85(10.9)	42(9.5)	62(16.6)	62(16.9)
My parent or guardian has discussed with me about topics related to avoiding sexual risks.	No	335(42.9)	207(47.0)	117(31.4)	114(31.1)
	Yes, once	207(26.5)	60(13.6)	88(23.6)	99(27.0)
	Yes, >once	239(30.6)	173(39.3)	168(45.0)	153(41.8)
My parent or guardian discusses with me about ways to seek help when I feel unsafe in any situation.	No	215(27.5)	126(28.6)	48(12.9)	41(11.2)
	Yes, once	260(33.3)	80(18.2)	99(26.5)	104(28.4)
	Yes, >once	306(39.2)	234(53.2)	226(60.6)	221(60.4)
Sexuality Education (composite)	No	143(18.3)	96(21.8	41(11.0)	34(9.3)
	Yes	638(81.7)	344(78.2)	332(89.0)	332(90.7)

*Cronbach alpha coefficient : 0.7755

Table E 5 : Parents' perceptions regarding discussing SVAC

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Control	Intervention	Control	Intervention
Are you willing to discuss SVAC or CSA issues in your school or community?	No	25(11.1)	75(15.8)	22(10.8)	38(17.4)
	Yes	201(88.9)	400(84.2)	181(89.2)	180(82.6)
Are you willing to discuss SVAC or CSA issues in your family?	No	10(4.4)	29(6.1)	5(2.5)	13(6.0)
	Yes	216(95.6)	446(93.9)	198(97.5)	205(94.0)
Are you willing to discuss SVAC or CSA issues with the school management committee parent representative in your community?	No	36(15.9)	100(21.1)	23(11.3)	57(26.1)
	Yes	190(84.1)	375(78.9)	180(88.7)	161(73.9)
Are you willing to discuss SVAC or CSA issues with your community (community members)?	No	27(11.9)	82(17.3)	17(8.4)	47(21.6)
	Yes	199(88.1)	393(82.7)	186(91.6)	171(78.4)
Willingness to discuss SVAC	Low	8(3.5)	19(4.0)	5(2.5)	-5
	High	218(96.5)	456(96.0)	198(97.5)	207(95.0)

*Cronbach's alpha coefficient: 0.8576

Table E 6: Parents' communication on sexual risk reduction

Variable	Categories	Baseline n(percent)		Endline n(percent)	
		Control	Intervention	Control	Intervention
Have you ever discussed with your child how to avoid peer pressure to engage in sex prematurely?	No	35(15.6)	76(16.0)	29(14.3)	41(18.8)
	Yes, once	48(21.3)	118(24.8)	41(20.2)	65(29.8)
	Yes, more than once	142(63.1)	281(59.2)	133(65.5)	112(51.4)
Have you ever discussed with your child about ways to seek help when he/she feels at risk of sexual abuse in any situation	No	23(10.2)	82(17.3)	23(11.3)	53(24.3)
	Yes, once	53(23.6)	115(24.2)	45(22.2)	59(27.1)
	Yes, more than once	149(66.2)	278(58.5)	135(66.5)	106(48.6)
Communication on sexual risk reduction	No	20(8.8)	42(8.8)	18(8.9)	30(13.8)
	Yes	206(91.2)	433(91.2)	185(91.1)	188(86.2)

*Cronbach's alpha coefficient: 0.8487

Table E 7 : Parents' sexuality education practices

Variable	Categories	Baseline n (percent)		Endline n (percent)	
		Control	Intervention	Control	Intervention
Have you ever talked to your child about how boys and girls form healthy relationships?	No	86(38.2)	220(46.3)	92(45.3)	101(46.3)
	Yes, once	62(27.6)	98(20.6)	49(24.1)	49(22.5)
	Yes, more than once	77(34.2)	157(33.1)	62(30.5)	68(31.2)
Have you ever talked to your child about how his or her body changes as he or she grows up?	No	90(40.0)	265(55.8)	78(38.4)	120(55.0)
	Yes, once	49(21.8)	81(17.1)	42(20.7)	44(20.2)
	Yes, more than once	86(38.2)	129(27.2)	83(40.9)	54(24.8)
Do you discuss with your child about risks that may expose him or her to sexual violence either at home, school or anywhere else in your community?	No	30(13.3)	52(10.9)	23(11.3)	32(14.7)
	Yes, once	61(27.1)	122(25.7)	53(26.1)	63(28.9)
	Yes, more than once	59.6)	301(63.4)	127(62.6)	123(56.4)
Sexuality Education Practices	No	25(11.1)	46(9.7)	18(8.9)	28(12.8)
	Yes	201(88.9)	429(90.3)	185(91.1)	190(87.2)

*Cronbach's alpha coefficient: 0.7418

Appendix F: Regression tables

Table F 1: Difference in difference: Change in knowledge of harmful practices

Knowledge of harmful practices	Categories	Odds ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	2.398	[2.253, 2.552]	0.000
StudygGroup	Control	1		1
	Intervention	1.060	[0.927, 1.212]	0.393
Sex	Boy	1		1
	Girl	1.111	[1.103, 1.119]	0.000
Age group	7-10 years	1		1
	11-14 years	0.763	[0.691, 0.844]	0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.771	[0.696, 0.853]	0.000
Adjusted inverse probability weighting				
Knowledge of harmful practices	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.150	[0.079, 0.221]	0.000

Table F 2: Difference in differences: Change in knowledge on legal protection

Knowledge on legal protection	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.538	[1.245, 1.901]	0.000
Study group	Control	1		1
	Intervention	0.582	[0.531, 0.639]	0.000
Sex	Boy	1		1
	Girl	1.131	[1.130, 1.133]	0.000
Age group	7-10 years	1		1
	11-14 years	2.044	[2.038, 2.050]	0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	1.243	[0.856, 1.804]	0.252
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.100	[0.044, 0.153]	0.000

Table F 3 : Difference in difference: Change in knowledge on where to report SVAC

Knowledge of reporting points	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	2.356	[0.925, 6.004]	0.073
Study group	Control	1		1
	Intervention	2.673	[1.568, 4.556]	0.000
Sex	Boy	1		1
	Girl	0.915	[0.905, 0.925]	0.000
Age group	7-10 years	1		1
	11-14 years	1.386	[1.109, 1.732]	0.004
Primary caregiver	Biological parent	1		1
	Adopted parent	0.471	[0.229, 0.967]	0.040
	Others family	0.990	[0.664, 1.477]	0.962
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.423	[0.275, 0.652]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	-0.002	[0.044, 0.153]	0.958

Table F 4 : Difference in differences: Change in beliefs on SVAC

Beliefs (positive)	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	0.960	[0.945, 0.975]	0.000
Study group	Control	1		1
	Intervention	1.104	[0.852, 1.429]	0.455
Sex	Boy	1		1
	Girl	1.077	[1.065, 1.090]	0.000
Age group	7-10 years	1		1
	11-14 years	1.012	[0.902, 1.136]	0.834
Primary caregiver	Biological parent	1		1
	Adopted parent	1.133	[1.075, 1.195]	0.000
	Others family	1.105	[0.977, 1.250]	0.111
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	1.336	[0.921, 1.937]	0.127
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.061	[-0.009, 0.132]	0.090

Table F 5 : Difference in Differences: Change in attitudes on SVAC

Attitudes (positive)	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.810	[1.598, 2.050]	0.000
Study group	Control	1		1
	Intervention	0.820	[0.758, 0.888]	0.000
Sex	Boy	1		1
	Girl	1.000	[0.999, 1.000]	0.773
Age group	7-10 years	1		1
	11-14 years	0.963	[0.641, 1.445]	0.854
Primary caregiver	Biological parent	1		1
	Adopted parent	0.607	[0.467, 0.788]	0.000
	Others family	0.889	[0.863, 0.913]	0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	1.276	[0.626, 2.605]	0.502
Adjusted inverse probability weighting				
Attitudes	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.107	[0.057, 0.157]	0.000

Table F 6: Difference in difference: Change in confidence in reporting of SVAC

Reporting SVAC	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.512	[1.355, 1.688]	0.000
Study group	Control	1		1
	Intervention	0.424	[0.247, 0.729]	0.002
Sex	Boy	1		1
	Girl	0.807	[0.768, 0.848]	0.049
Age group	7-10 years	1		1
	11-14 years	3.598	[2.577, 5.025]	0.003
Primary caregiver	Biological parent	1		1
	Adopted parent	1.211	[0.729, 2.011]	0.460
	Others family	1.284	[0.836, 1.972]	0.253
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	3.039	[1.945, 4.750]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.121	[0.082, 0.160]	0.000

Table F 7: Difference in difference: Change in confidence to enact preferences over life choices

Confidence to enact preferences	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.206	[0.999, 1.456]	0.051
Study group	Control	1		1
	Intervention	0.656	[0.497, 0.866]	0.003
Sex	Boy	1		1
	Girl	0.981	[0.976, 0.985]	0.000
Age group	7-10 years	1		1
	11-14 years	1.462	[1.295, 1.651]	0.000
Primary caregiver	Biological parent	1		1
	Adopted parent	1.123	[0.501, 2.516]	0.460
	Others family	1.808	[0.900, 1.550]	0.253
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	1.213	[1.211, 1.216]	0.000
Adjusted inverse probability weighting (AIPW)				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.086	[0.018, 0.153]	0.013

Table F 8: Difference in difference: Change in Preferred point for reporting sexual abuse

Preference of formal reporting points for SVAC	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	2.736	[2.453, 3.053]	0.000
Study group	Control	1		1
	Intervention	0.946	[0.933,0.959	0.009
Sex	Boy	1		1
	Girl	0.981	[0.976, 0.985]	0.000
Age group	7-10 years	1		1
	11-14 years	1.632	[1.615, 1.649]	0.000
Primary caregiver	Biological parent	1		1
	Adopted parent	1.189	[0.466, 3.030]	0.717
	Others family	1.015	[0.685, 1.505]	0.941
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.529	[0.516, 0.543]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.060	[0.001, 0.118]	0.045

Table F 9: Difference in difference: Change in protective measures from SVAC exposure

Protective measures from SVAC exposure	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	0.471	[0.326, 0.681]	0.000
Study group	Control	1		1
	Intervention	0.937	[0.412, 2.127]	0.876
Sex	Boy	1		1
	Girl	1.084	[0.779, 1.297]	0.000
Age group	7-10 years	1		1
	11-14 years	1.005	[1.615, 1.649]	0.968
Primary caregiver	Biological parent	1		1
	Adopted parent	1.180	[0.643, 2.164]	0.593
	Others family	1.139	[0.685, 1.771]	0.563
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.995	[0.768, 1.289]	0.970
Adjusted inverse probability weigthing				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	-0.112	[-0.171, -0.054]	0.000

Table F 10: Difference in difference: Comfort to ask parent/guardian a question about SVAC

Children's level of comfort to ask about SVAC	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	4.199	[3.856,4.573]	0.000
Study group	Control	1		1
	Intervention	1.298	[1.196, 1.409]	0.000
Sex	Boy	1		1
	Girl	1.221	[1.213, 1.228]	0.000
Age group	7-10 years	1		1
	11-14 years	1.630	[1.106, 2.403]	0.014
Primary caregiver	Biological parent	1		1
	Adopted parent	1.187	[0.842, 1.673]	0.328
	Others family	1.113	[1.026, 1.208]	0.010
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.748	[0.410, 1.364]	0.970
Adjusted inverse probability weigthing				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.195	[0.139, 0.252]	0.000

Table F 11: Difference in differences: Ever asked a question on SVAC

Variable	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	5.685	[4.745, 6.810]	0.000
Study group	Control	1		1
	Intervention	3.273	[2.245, 4.773]	0.000
Sex	Boy	1		1
	Girl	1.234	[1.226, 1.242]	0.000
Age group	7-10 years	1		1
	11-14 years	2.112	[1.824, 2.445]	0.000
Primary Caregiver	Biological parent	1		1
	Adopted parent	1.305	[1.186, 1.436]	0.000
	Others family	0.935	[0.918, 0.952]	0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.268	[0.156, 0.461]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.101	[0.032, 0.171]	0.004

Table F 12: Difference in difference: Sexuality education

Sexuality education	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	2.770	[2.509, 3.057]	0.000
Study group	Control	1		1
	Intervention	1.233	[0.950, 1.601]	0.115
Sex	Boy	1		1
	Girl	1.136	[1.118, 1.154]	0.000
Age group	7-10 years	1		1
	11-14 years	2.158	[1.870, 2.491]	0.000
Primary caregiver	Biological parent	1		1
	Adopted parent	1.411	[0.886, 2.245]	0.147
	Others family	0.984	[0.753, 1.286]	0.908
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.629	[0473, 0.838]	0.002
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.623	[0.014, 0.111]	0.012

Table F 13: Difference in difference: Informal avenues for reporting SVAC

Informal Avenues	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.812	[1.735, 1.893]	0.000
Study group	Control	1		1
	Intervention	2.620	[2.6008, 2.631]	0.000
Sex	Male	1		1
	Female	1.051	[1.048, 1.054]	0.000
Age group	18-24 years	1		1
	25-34 years	1.041	[0.909, 1.193]	0.559
	>34 years	1.152	[0.730, 1.817]	0.544
Education level	Primary	1		1
	Post primary	1.236	[1.060, 1.441]	0.007
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.735	[0.567, 0.951]	0.019
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.093	[0.045, 0.141]	0.000

Table F 14: Difference in difference: Formal avenues for reporting SVAC

Difference in difference: Comfort on using formal channels to report SVAC				
Preference for use of formal reporting channels	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	2.737	[2.453, 3.053]	0.000
Study group	Control	1		1
	Intervention	1.740	[1.689, 1.792]	0.000
Sex	Boy	1		1
	Girl	0.946	[0.933, 0.959]	0.000
Age group	7-10 years	1		1
	11-14 years	1.632	[1.614, 1.649]	0.000
Primary caregiver	Biological parent	1		1
	Adopted parent	1.889	[0.466, 3.030]	0.717
	Others family	1.015	[0.685, 1.505]	0.941
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.529	[0.516, 0.543]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.060	[0.001, 0.118]	0.045

Table F 15: Difference in difference: Children who report sexual abuse can be believed

Almost all the time (not all the time)	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	0.489	[0.437, 0.547]	0.000
Study group	Control	1		1
	Intervention	1.276	[1.187, 1.373]	0.000
Sex	Male	1		1
	Female	0.948	[0.938, 0.959]	0.000
Age group	18-24 years	1		1
	25-34 years	1.261	[1.151, 1.381]	0.000
	>34 years	1.029	[1.002, 1.056]	0.035
Education level	Primary	1		1
	Post-primary	0.843	[0.839, 0.848]	0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	2.100	[1.521, 2.901]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.012	[-0.084, 0.109]	0.800

Table F 16: Difference in differences: Belief 3 - A person who has sexually abused a child will repeat it

Belief One	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	0.729	[0.654, 0.812]	0.000
Study group	Control	1		1
	Intervention	0.056	[0.040, 0.078]	0.000
Sex	Male	1		1
	Female	1.193	[1.191, 1.195]	0.000
Age group	18-24 years	1		1
	25-34 years	1.305	[1.083, 1.572]	0.005
	>34 years	1.066	[0.814, 1.397]	0.642
Education level	Primary	1		1
	Post primary	0.955	[0.699,1.306]	0.775
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	1.648	[1.494, 1.818]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.029	[-0.556, 0.114]	0.504

Table F 17: Difference in differences: Beliefs in modest dressing and sexual abuse

Beliefs in modest dressing and sexual abuse	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	0.995	[0.615, 1.607]	0.980
Study group	Control	1		1
	Intervention	0.525	[0.516, 0.535]	0.000
Sex	Male	1		1
	Female	1.079	[1.293, 1.464]	0.000
Age group	18-24 years	1		1
	25-34 years	1.376	[1.293, 1.464]	0.000
	>34 years	1.254	[1.287, 1.404]	0.000
Education level	Primary	1		1
	Post primary	1.355	[1.192, 1.540]	0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	3.134	[2.198, 4.469]	0.000
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	0.242	[0.150, 0.333]	0.000

Table F 18: Difference in difference: perceptions on sexuality education

Perception on SE (wrong/right)	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	0.887	[0.739, 1.065]	0.198
Study group	Control	1		1
	Intervention	0.818	[0.740, 0.905]	0.000
Sex	Male	1		1
	Female	1.423	[1.397, 1.450]	0.000
Age group	18-24 years	1		1
	25-34 years	1.491	[1.181, 1.882]	0.001
	>34 years	1.010	[0.906, 1.336]	0.337
Education level	Primary	1		1
	Post primary	1.072	[1.021, 1.125]	0.005
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	1.104	[0.924, 1.317]	0.124
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	-0.006	[-0.103, 0.090]	0.898

Table F 19: Difference in Differences on self-efficacy on sexuality education among parents

Self-efficacy on SVAC	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.162	[1.065, 1.266	0.001
Study group	Control	1		1
	Intervention	0.398	[0.341, 0.465]	0.000
Sex	Male	1		1
	Female	0.949	[0.946, 0.952]	0.000
Age group	18-24 years	1		1
	25-34 years	0.902	[0.622, 1.309]	0.589
	>34 years	1.216	[0.953, 1.551]	0.116
Education level	Primary	1		1
	Post primary	1.341	[1.272, 1.414]	0.000
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	1.341	[0.809, 1.329]	0.771
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	-0.012	[-0.050, 0.025]	0.514

Table F 20: Difference in difference: Willingness to discuss SVAC

Variable	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.277	[0.785, 2.076]	0.325
Study group	Control	1		1
	Intervention	0.783	[0.703, 0.873]	0.000
Sex	Male	1		1
	Female	0.718	[0.686, 0.750]	0.000
Age group	18-24 years	1		1
	25-34 years	0.346	[0.304, 0.393]	0.000
	>34 years	0.493	[0.360,0.676]	0.000
Education level	Primary	1		1
	Post primary	1.035	[0.629, 1.704]	0.275
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.611	[0.570, 0.655]	0.000
Adjusted inverse probability weighting				
Willingness to discuss SVAC	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	-0.010	[-0.051, 0.031]	0.627

Table F 21: Difference in difference: Communication on sexual risk reduction

Sexual risk reduction	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	0.910	[0.752, 1.101]	0.330
Study group	Control	1		1
	Intervention	1.006	[0.898,1.127]	0.917
Sex	Male	1		1
	Female	0.835	[0.797,0.874]	0.000
Age group	18-24 years	1		1
	25-34 years	1.001	[0.806, 1.245]	0.990
	>34 years	3.194	[2.459, 4.150]	0.000
Education level	Primary	1		1
	Post primary	1.011	[0.576, 1.776]	0.968
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.655	[0.470, 0.913]	0.013
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	-0.047	[-0.109, 0.158]	0.143

Table F 22: Difference in difference: Sexuality education practices

Sexuality education practices	Categories	Odds Ratios	Confidence Interval	p-value
Study phase	Baseline	1		1
	Endline	1.225	[1.080, 1.390]	0.002
Study group	Control	1		1
	Intervention	1.214	[0.835,1.766]	0.310
Sex	Male	1		1
	Female	1.117	[1.094, 1.141]	0.000
Age group	18-24 years	1		1
	25-34 years	1.052	[1.034, 1.070]	0.000
	>34 years	2.205	[1.680, 2.896]	0.000
Education level	Primary	1		1
	Post primary	1.285	[0.868, 1.902]	0.211
Average treatment effect	Baseline#Control, Endline#Control, Baseline#intervention			1
	Endline#Intervention	0.606	[0.452, 0.815]	0.001
Adjusted inverse probability weighting				
Beliefs	**Categories**	**Coefficient**	**Confidence Interval**	**p-value**
Average treatment effect on the treated	Baseline#Intervention	1		1
	Endline#Intervention	-0.028	[-0.094,0.034]	0.380

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