ICRW
INTERNATIONAL CENTER FOR RESEARCH ON WOMEN

Bantwana INITIATIVE UGANDA

PREVENTING AND RESPONDING TO CHILD SEXUAL ABUSE AND EXPLOITATION IN WESTERN UGANDA

ENDLINE EVALUATION REPORT OF THE SAFE IN OUR HANDS (SAFE) PROGRAM'S CHILD SEXUAL ABUSE PREVENTION CURRICULUM

2024

SAPRT Session 3. Photo credit: Bantwana Initiative Uganda

ACKNOWLEDGMENT:

The International Center for Research on Women (ICRW) Africa is grateful to Bantwana Initiative Uganda, whose dedication and hard work were instrumental in the project's success. We thank the ICRW operations and technical project team for their work. We also appreciate Naome Wandera for her earlier efforts toward the study and the various participants interviewed throughout the study.

This project was made possible through support from the Oak Foundation.

The opinions expressed herein and the language used are those of the implementing partners and do not necessarily reflect the views of the donor.

CITATION:

Kirabo Suubi, Venantius Bbaale Kirwana, Linet Arisa, Marion Ouma, Maureen Kangere, and Chimaraoke Izugbara. (2024). *The Prevention of and Response to Child Sexual Abuse(CSA) in Western Uganda: Endline evaluation report of the Safe in our hands (SAFE) Curriculum*. International Center for Research on Women.

DISCLAIMER

Table of Contents

List of Tables

List of Figures

Acronyms

AIPW	Adjusted Inverse Probability Weighting
ATET	Average Treatment Effect in the Treated
BIU	Bantwana Initiative Uganda
CDO	Community Development Officer
CSA	Child Sexual Abuse
CSAE	Child Sexual Abuse and Exploitation
DCDO	District Community Development Officer
DCWC	District Child Well-being Committee
DiD	Difference-in-Differences
FGD	Focus Group Discussion
GRS	Grassroots Soccer
ICRW	International Center for Research on Women
SAFE	Safe in Our Hands (Program)
SVAC	Sexual Violence Against Children
VAC	Violence Against Children
VACiSC	Violence Against Children in Schools and Communities

EXECUTIVE SUMMARY

Background

Child sexual abuse (CSA) is a problem in Uganda. According to the National Survey on Violence, 59 percent of females under the age of 15 experience sexual violence. The Government of Uganda thus specifies the roles of key stakeholders in ending CSA in national directives like the National Strategy to End Child Marriages and Teenage Pregnancy.

For its part, Uganda's National Child Policy 2020 recommends establishing a National Child Well-being Steering Committee and corresponding District Child Well-being Committees to build a system that delivers, maintains, and protects the four cardinal rights of all children: survival, development, protection, and participation.

The SAFE Program CSA Prevention Curriculum

In partnership with the International Center for Research on Women and with funding from the OAK Foundation, the Bantwana Initiative Uganda revised its 12-year-old Safe in Our Hands (SAFE) Program model in 2023. The resulting SAFE Program CSA Prevention Curriculum were pilot-tested as an intervention aimed at shifting gender norms and preventing CSA in 10 schools in Western Uganda's Bunyangabu, Kyenjojo, and Kabarole districts. The intervention targeted teachers, parents, and caregivers.

Study Design

To assess the effectiveness of the SAFE Program CSA Prevention Curriculum in improving child sexual abuse and exploitation response and prevention, we used a quasi-experimental study design involving mixed-method research to collect quantitative and qualitative data at baseline and at endline in the 10 intervention schools and

Child sexual abuse (CSA) is a problem in Uganda. According to the National Survey on Violence, **59 percent** of females under the age of 15 experience sexual violence.

in 4 control group schools. In addition to targeting teachers, caregivers, and children who were enrolled in the curriculum, we also conducted key informant interviews. The retention rate of respondents from baseline to endline was 76 percent for teachers, 61 percent for parents and caregivers, and 68 percent for children.

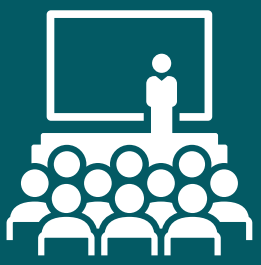
The study assessed changes in knowledge, perceptions, attitudes, agency, intentions, and behaviors with respect to mitigating children's risk exposure to sexual abuse and exploitation, including reporting and help-seeking behaviors.

Findings

The SAFE Program CSA Prevention Curriculum made significant progress in raising awareness, changing attitudes, and improving behaviors related to child sexual abuse in Western Uganda. At the same time, the findings reveal complex outcomes among different groups:

Teachers

- Teachers in the endline intervention group were significantly more likely than those in the control group to know that safeguarding policies existed in their schools (p=0.019) and to be aware of the enforcement of these policies (p=0.000).
- Female teachers were particularly more knowledgeable than their male counterparts about existing safeguarding policies (p=0.000) and their enforcement.
- The intervention did not significantly impact teachers' overall willingness to report suspected CSA. That is, although there was a slight increase in the proportion of teachers who were willing to report CSA, even if their school administration disagreed or if they feared family or community retaliation, these findings were not statistically significant.

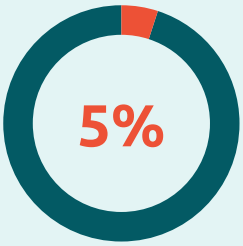


Teachers in the endline intervention group were significantly more likely than those in the control group to know that safeguarding policies existed in their schools

Parents and Caregivers

- At endline, parents and caregivers in the intervention group were nearly nine times more likely than parents and caregivers in the control group to have discussed community CSA risks, and also significantly more likely to have had discussions on CSA with their children.
- Although the proportion of caregivers who indicated they would believe children who report sexual abuse increased by 5 percent, this finding was not statistically significant.
- The intervention did not impact caregivers' willingness to report CSA if their partner was against it.
- The intervention did not significantly impact caregivers' attitudes toward CSA-related norms and practices by endline.
- The intervention did not impact parents and caregivers' self-efficacy to provide sexuality education to their children.

The proportion of caregivers who indicated they would believe children who report sexual abuse increased by **5 percent**



In general, female parents and caregivers were significantly less likely than males to have taken part in discussions about CSA risks in their community, to believe children who report sexual abuse, and to report CSA if their partner was against it. By contrast, female parents and caregivers were significantly more likely than males to have positive attitudes toward CSA-related norms and practices, to have discussions about CSA with their children, and to have self-efficacy to provide sexuality education.

Children

- Children in the intervention group were twice more likely than children in the control group to know at least three of their rights.
- Although qualitative findings showed that children recognize CSA-related harmful practices in their communities, the intervention did not significantly impact children's awareness of these harmful practices.
- Although there was a 3 percent increase in the proportion of children with positive CSA-related beliefs in the intervention group, this shift was not statistically significant. Still, the study registered a significant positive shift in children's attitudes towards CSA in the intervention group by endline.
- The intervention increased children's self-reported willingness, agency, and confidence to report sexual violence and their increased ability to enact preferences over life choices.

As was the case with parents and caregivers, gender differences also arose between boys and girls. At endline, boys experienced significantly greater increases than girls in their willingness and confidence to report sexual violence, their agency against CSA, and their ability to enact preferences over life choices. On the other hand, girls were significantly more likely to have knowledge of children's rights.

There was a 3 percent increase in the proportion of children with positive CSA-related beliefs in the intervention group, this shift was not statistically significant.

> Overall, our findings highlight the effectiveness of the SAFE Program CSA Prevention Curriculum in raising awareness and changing attitudes towards CSA.

CONCLUSIONS AND RECOMMENDATIONS

Overall, our findings highlight the effectiveness of the SAFE Program CSA Prevention Curriculum in raising awareness and changing attitudes towards CSA, while also indicating areas where further support and targeted interventions are needed to sustain positive changes and address deeply ingrained cultural attitudes. We recommend that the program team:

- Conduct a more rigorous randomized controlled trial before scaling up the program to address observed limitations and unintended outcomes in this study.
- Reassess how norms around respect for adults are framed to avoid reinforcing harmful obedience that may discourage children from resisting abuse.
- Review training and sensitization content to ensure it does not place the burden of prevention on children, which can contribute to self-blame. Instead, the emphasis should be on adult and institutional accountability.
- Translate the curriculum into local languages to ensure consistency in delivery and understanding.
- Conduct follow-up studies to assess the long-term sustainability of behavior change among curriculum beneficiaries.

1.0 INTRODUCTION

Among 13-to-17-year-olds, **44 percent** of girls and **59 percent** of boys report experiencing some violence in the previous year, whereas 25 percent of girls and 10 percent of boys explicitly report experiencing sexual violence.

1.1 Introduction

In partnership with the International Center for Research on Women (ICRW) and with funding from the OAK Foundation, the Bantwana Initiative in Uganda (BIU) developed the Safe in Our Hands (SAFE) Program Child Sexual Abuse (CSA) Prevention Curriculum (also known as the toolkit) to shift gender norms and prevent CSA in Western Uganda.

In 2023, we designed a quasi-experimental study to assess the effectiveness of the CSA Prevention Curriculum in improving CSA prevention and response. We then conducted the study in 10 intervention schools and four control schools in Western Uganda's Bunyangabu, Kyenjojo, and Kabarole districts. Our research measured pre- and post-intervention knowledge, attitudes, perceptions, agency, and intentions or behaviors among enrolled children, teachers, and parents and caregivers with respect to mitigating child sexual abuse and exploitation, including by reporting and seeking help.

This report presents our key findings.

1.2 Background

Efforts in Uganda to protect children from violence, abuse, exploitation, and neglect are undermined by inadequate implementation and enforcement of existing policies and laws; poverty; the limited capacity of a proactive and responsive statutory workforce; and weakening family structures.[1] Whereas young males are more prone to experiencing violence overall, young females have a much higher risk of specifically suffering sexual violence. Among 13-to-17-year-olds, 44 percent of

Caregiver Parenting session 2. Photo credit: Bantwana Initiative Uganda

girls and 59 percent of boys report experiencing some violence in the previous year, whereas 25 percent of girls and 10 percent of boys explicitly report experiencing sexual violence. Similarly, in the 18-to-24 age group, 35 percent of females and 17 percent of males report that they experienced sexual violence before the age of 18.[2]

The COVID-19 pandemic aggravated adultism and deeply entrenched social and gender norms, which reinforce unequal power structures between adults and children, and between men and women; and are ultimately a root cause of violence against children in schools and communities (VACiSC). In addition to unequal social and gender norms, harsh parenting approaches and household poverty contribute to fractured relationships between caregivers and their children and are proven drivers of gender-based violence and CSA

35%

of females and 17 percent of males report that they experienced sexual violence before the age of 18.

at the family level. Violence in schools is exacerbated by normalized corporal punishment, bullying, and violence; all coupled with limited adherence to teacher codes of conduct, harmful gender stereotypes, and weak knowledge in the school setting about the impact of school-related gender-based violence.

In 2023, ICRW undertook a cross-sectional study of norms and practices related to CSA in Western Uganda's Kyenjojo, Bunyangabu, and Kabarole districts. Among respondents, 28 percent of girls and 14 percent of boys reported that they experienced at least one form of sexual abuse in the 12 months preceding the survey, and 27 percent of parents and caregivers reported having a child in their household who experienced sexual abuse during the same period. We found that victims and their parents or caregivers rarely disclose CSA, undertake negotiations with perpetrators outside the judicial system, fear community or family retaliation if they report CSA, view the police as being corrupt, and lack faith in the justice system.

Uganda's National Child Policy of 2020[1] defines system strengthening as an essential part of providing services that deliver, maintain, and protect the four cardinal rights of children: survival, development, protection, and participation. Systems strengthening will achieve a well-built and coordinated protection system for providing critical services to children. With this in mind, Uganda's policy framework outlines establishment of a National Child Wellbeing Steering Committee, as well as District Child Well-being Committees, Sub-County Child Wellbeing Committees, and Village Child Case Management Committees to convene regular meetings with service providers to identify and address violence against children and CSA.

27%

of parents and caregivers reported having a child in their household who experienced sexual abuse.

Photo credit: A. Warner / ICRW

1.3 The Bantwana Initiative in Uganda

Since 2008, BIU has been implementing a socio-ecological program in Western Uganda with the long-term goal of preventing and reducing sexual violence and other forms of violence against pre-adolescent and adolescent girls and boys.

1.4 The SAFE Program Intervention

The SAFE Program is a multi-component primary intervention aimed at preventing and responding to sexual violence against children (SVAC). It is funded by the Oak Foundation and a private donor. The program's model features a whole community approach to reducing SVAC (including child sexual abuse and exploitation [CSAE]) in targeted Western Ugandan communities. BIU implemented the CSA Prevention Curriculum within a larger approach that included economic and system-strengthening activities.

Theory of Change

The SAFE Program's theory of change posits that *if* schools and other community structures receive continuous sensitization to children's rights and are empowered to support these rights; *then* negative norms that contribute to child sexual abuse will be broken, adults will be enabled to act against child sexual abuse, and children will experience greater voice and agency, including bodily integrity and help-seeking behavior; *resulting* in significantly increased prevention and reduction of sexual violence and other forms of violence against pre-adolescent and adolescent girls and boys.

By implementing a revised school community engagement model that comprises Sexual Abuse Prevention and Response Training, School Leadership Training (SAPRT), and school-based CSA campaigns, SAFE will create an enabling environment in which improved knowledge, attitudes, practices, and self-efficacy translate into lower CSA risk exposure and higher rates of CSA reporting.

Moreover, SAFE will enhance enforcement of the Children's Act to protect children against sexual abuse by building the capacity of school leaders, communities (via Village Child Case Management Committees (VCCMCs)), child rights organizations, and local government authorities to prevent and respond to VACiSCs and to advance gender equality.

“The SAFE Program's theory of change posits that if schools and other community structures receive continuous sensitization to children's rights and are empowered to support these rights; then negative norms that contribute to child sexual abuse will be broken”

Outcome Areas

The SAFE Program aims to achieve four short-term outcomes, as detailed in our Monitoring and Evaluation Framework (see Appendix E):

1. Educators actively prevent and respond to VACiSC (including CSA); create safer environments that protect children from violence; and treat girls and boys equally through non-violent means
2. Caregivers actively prevent and respond to VACiSC (including CSA) and adopt positive parenting, providing for and treating girls and boys equally through non-violent means
3. Boys and girls have improved agency to prevent and respond to VACiSC (including CSA) and internalize and promote new positive gender norms.
4. Local government authorities have the capacity to deliver programs that mitigate, prevent, and respond to VACiSC in communities and schools across their respective sub-counties.

Implementation Design

In September 2022, ICRW and BIU mapped child sexual abuse social norms in selected communities in Western Uganda. Results showed that the four most prevalent social norms underpinning CSA disclosure, reporting, and help-seeking behaviors are beliefs that: 1) a girl who has reached puberty or is out of school is ready for adult responsibilities, including sex and marriage; 2) people disclosing CSA are alarmists; 3) boys and men are entitled to sex without consequences or reprimand; and 4) a child who is not in school is no longer considered to be a child (i.e., non-provision of basic needs, and they are prone to marriage and CSAE). The rigorous mapping process provided information on the social, cultural, and geographical context of prioritized gender-discriminatory CSA norms. BIU thus revised, refined, and

The top four identified social norms underpinning child sexual abuse (CSA) disclosure, reporting, and help-seeking behaviors, include a girl who has reached puberty or is out of school is ready for adult responsibilities (including sex and marriage.

SAPRT Parenting Session. Photo credit: Bantwana Initiative Uganda

adapted its 12-year-old SAFE Curriculum with new content drawn from existing evidence-based source material, and mapped identified norms against the curriculum. The result was the SAFE Program CSA Prevention Curriculum, which is aligned with course guidelines provided in the National Sexuality Education Framework (2018) for children aged 9-to-14. The curriculum consists of three modules that target parents, children, and teachers:

1. **The FRESH START (School Leaders and Teachers Able to Retain and Protect Children) Package** enables school leaders, teachers, and pupils to protect children from all forms of abuse.
2. **The Norms Diffusion, Skills, Economic Strengthening, and Parenting Training (NEST) Package** is a synchronized training package for primary caregivers and children. Its layered toolkit of curriculum interventions is designed to be delivered to the same individuals over a four-to-six-month period.
3. **The Formal and Informal Safe Systems Strengthening (Triple S) Package** involves strengthening and supporting national and local government structures to address CSA.

BIU implemented FRESH START and NEST elements of the intervention in Bunyangabu, Kyenjojo, and Kabarole districts. At pre-intervention, 14 schools and their communities were selected to be part of the study. BIU had never implemented interventions in these schools and communities. Of the sample, 10 schools and their communities were selected to be in the intervention group and 4 were selected to be in the control group.

Control group communities were selected in consultation with relevant stakeholders and had similar socio-demographic characteristics to intervention group communities. In light of variations in local governance, the study team selected control schools that were located in intervention districts, but in sub-counties where BIU had no past or ongoing similar interventions. Furthermore, control schools were situated within no more than of 25 kilometers (about 15.5 miles) of from the nearest intervention schools.

In 2023, ICRW undertook a cross-sectional study to establish a baseline status for assessing the effectiveness the SAFE Program CSA Prevention Curriculum. Implemented in 10 SAFE Model pilot intervention schools and four control schools, the baseline study assessed pre-intervention knowledge, attitudes, perceptions, agency, intentions, and behaviors related to mitigating risk exposure to child sexual abuse and exploitation, including reporting and help-seeking, in.

We then piloted the CSA Prevention Curriculum in 10 schools in Bunyangabu, Kyenjojo, and Kabarole. Participants met the following criteria:

- **Parents and caretakers:** men and women over the age of 18 who have children aged 9-to-14.
- **Children** aged 9-to-14.

At pre-intervention, 14 schools and their communities were selected to be part of the study. BIU had never implemented interventions in these schools and communities. Of the sample, 10 schools and their communities were selected to be in the intervention group and 4 were selected to be in the control group.

Although most baseline participants were enrolled in the intervention curriculum, others who met the inclusion criteria were also included. Only participants who completed both the baseline survey and the curriculum were included in the endline study analysis.

A total of 111 teachers (54 males, 57 females) and 565 children (272 males, 293 females) were enrolled in the curriculum. Additionally, 782 caregivers (202 males, 579 females) participated in Positive Parenting sessions (see below).

The implementation design of the curriculum during the research period involved multiple targeted components across key stakeholder groups, including:

- A three-day workshop for school leadership in each intervention school
- Positive Parenting sessions for parents and caregivers, consisting of 10 weekly sessions lasting up to two hours, and delivered by BIU staff
- Ten Grassroots Soccer skills program sessions for children, comprising two-hour play-based sessions that were delivered twice a week by coaches
- Sexual Abuse Prevention and Response Training for teachers comprising 10 weekly "Lunch and Learn" sessions.

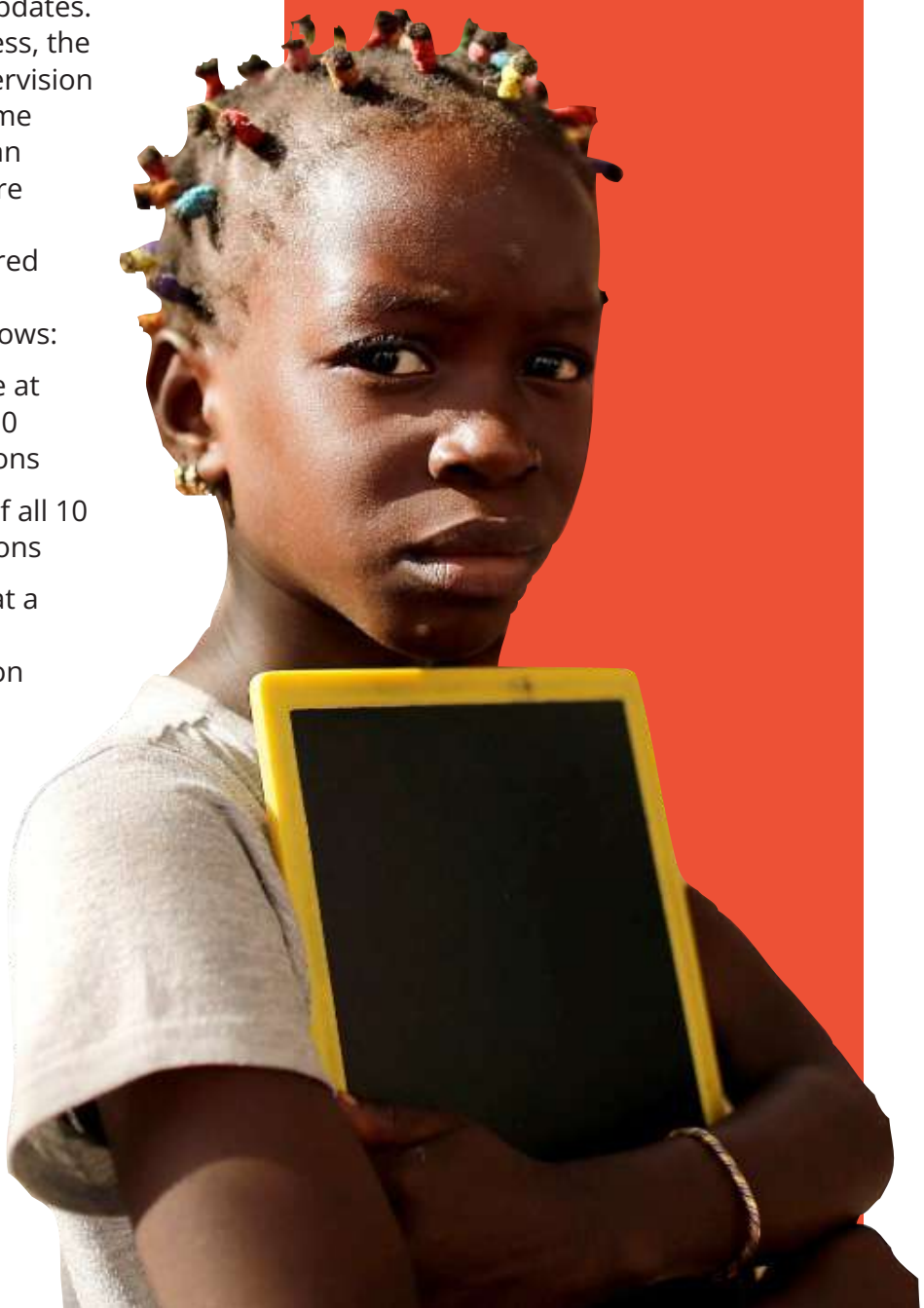
The implementation design included ten Grassroots Soccer skills program sessions, comprising two-hour play-based sessions that were delivered twice a week by coaches

The full curriculum training was implemented over a period of four-to-six months in 2023.

Participant attendance was documented at every session to facilitate regular monitoring and follow-up. The team followed up with participants who missed training sessions. Such efforts to ensure participation involved facilitators maintaining direct contact with participants to provide them with regular updates. For implementation effectiveness, the team provided supportive supervision for quality assurance. By the time of the endline survey, more than half of the participants that were enrolled in the curriculum had completed the minimum required sessions. Minimum attendance thresholds were defined as follows:

- **Caregivers:** Attendance at a minimum of 7 out of 10 Positive Parenting sessions
- **Children:** Completion of all 10 Grassroots Soccer sessions
- **Teachers:** Attendance at a minimum of 8 out of 10 Sexual Assault Prevention and Response Training sessions

By the time of the endline survey, more than half of the participants that were enrolled in the curriculum had completed the minimum required sessions.



2.0 METHODOLOGY

2.1 Objective of the Study

The overall objective of the study was to assess the effectiveness of the SAFE Program CSA Prevention Curriculum in improving the prevention of and response to child sexual abuse and exploitation.

Specific objectives were to:

1. Assess post-intervention knowledge, attitudes, perceptions, agency, intentions, and behaviors related to mitigating risk exposure to CSAE, including reporting and help-seeking
2. Assess the extent to which the CSA Prevention Curriculum is relevant to addressing CSA

2.2 Research Questions

1. How does participation in the SAFE Program CSA Prevention Curriculum affect the knowledge, attitudes, perceptions, intentions, and behaviors of children and parents or caregivers with respect to mitigating child sexual abuse, including through reporting and help-seeking?
2. To what extent do educators who participate in the SAFE Program CSA Prevention Curriculum create an enabling environment that mitigates CSA risk exposure and promotes reporting?
3. Is the SAFE Program CSA Prevention Curriculum relevant to addressing CSA in target communities?

2.3 Research Design

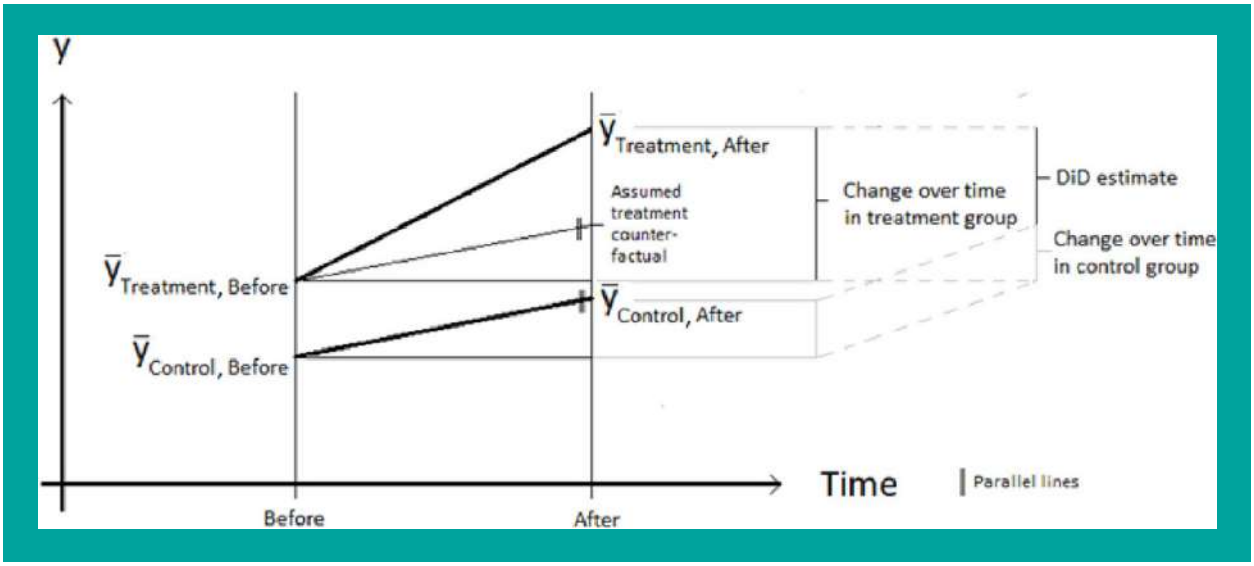
The study adopted a quasi-experimental design. To measure and attribute impact, we used a Difference-in-Differences (DiD) approach to estimate the causal effect. DiD provides opportunities for a combination of before-after and treatment-control group comparisons.

With two groups and two periods, and with a sample of data from the population of interest, the DID estimate is expressed as follows:

$$DID = (\bar{y}_{Treatment,t=After} - \bar{y}_{Treatment,t=Before}) - (\bar{y}_{Control,t=After} - \bar{y}_{Control,t=before})$$

Where is the outcome variable, the bar () represents the average value (averaged over individuals, typically indexed by), and t is time. The assumed treatment group counterfactual equals the treatment group pre-reform value plus the after-before difference from the control group (see Figure 1).

Figure 1: Illustration of the Two-group, Two-period DiD Estimate



2.4 Study Scope

The endline study targeted research participants from the 10 intervention and four control school communities who were interviewed during the baseline study, including teachers, parents or caregivers, and children.

2.5 Sampling design and procedure

Quantitative studies were conducted at baseline and endline. At endline, the primary sampling frame included only teachers, parents or caregivers, and children who participated in the baseline survey.

During the baseline study, the sample size determination for intervention communities was calculated based on assumptions for randomized controlled trials involving a fixed number of clusters. [3] The formula was:

$$n = \frac{D[(Z_a + Z_b)^2 \times (p_1\{1 - p_1\} + p_2\{1 - p_2\})/(p_2 - p_1)^2]}{R}$$

Where:

n = required minimum sample size per survey round or comparison group

D = design effect (assumed here to be 1)

p_1= the estimated level of an indicator measured as a proportion at the time of the first survey or for the control area $(p = 50\%)$

p_2 =the expected level of the indicator either at some future date or for the project area such that the quantity $(p_2 - Pp_1)$ is the size of the magnitude of change desired to detect

$(p = 60\%)$

Z_a =**1.96** is the Z- score corresponding to the desired degree of confidence to be able to conclude that the observed change of size $(P_2 - P_1)$ would not have occurred by chance (the level of statistical significance in this case 95)

$Z_b = 0.84$ is the z-score corresponding to the desired degree of confidence to be certain of that change of size $(P_2 - P_1)$ occurred (statistical power in this case is taken to be 80)

R the attrition rate (attributed to 80 response rate)

The research study relied on a pre-post-test longitudinal cohort study design

The above equation gives a sample size of 480 participants for each category, including children aged 9-to-14 and parents or caregivers; equally distributed across the 10 SAFE intervention schools, and rounded to 50 children and 50 caregivers per school.

The sample size determination for control communities was: The proportional sample size for control should lie between 0.4 and 0.45 of the total intervention sample size. The study targeted 200 parents or caregivers and 200 children from control communities or schools.

Eligibility criteria (inclusion and exclusion criteria) at baseline:

- A household was eligible for inclusion in the sampling frame if it had a child aged 9-to-14 attending an intervention or control school. Parents in the sampled households had to give consent for their children to participate in the study.
- The register of children was generated at the school level, but all recruitment of children began with obtaining their parents' consent. Children were only approached for assent after their parents consented. Without parental consent, the children were ineligible to participate.

At endline in 2024, the curriculum training registers were used as the sampling frame to select teachers, children, and parents or caregivers who were enrolled in the CSA Prevention Curriculum and who completed or participated in the minimum number of curriculum sessions. In addition, all participants consented to participate in the survey. Table 1 shows the primary sampling criteria for the endline study eligibility.

Table 1: Enrollment criteria in the endline study

Category of respondents	Intervention	Control
Parents or caregivers	- Participated in the baseline study - Completed or participated in the minimum required number of CSA Prevention Curriculum sessions - Provided consent to participate in the endline study	- Participated in the baseline study - Provided consent to participate in the endline study
Children	- Participated in the baseline study - Completed all required CSA Prevention Curriculum sessions - Parent or caregiver provided consent for them to participate in the endline study - Assented to participate in the endline study	- Participated in the baseline study - Parent or caregiver provided consent for them to participate in the endline study - Assented to participate in the endline study
Teachers	- Participated in the baseline study - Completed or participated in the minimum required number of CSA Prevention Curriculum sessions - Provided consent to participate in the endline study	- Participated in the baseline study - Provided consent to participate in the endline study
Key informants	- Provided consent to participate in the study - Played a critical role in implementing the CSA Prevention Curriculum or addressing sexual violence against children	

Table 2: Distribution of sample sizes

	Baseline	Endline	Success/Attrition rate
Teachers	129 (Control=43, Intervention=86)	98 (Control=31, Intervention=67)	76 percent (Control=72 percent, Intervention=78 percent
Parents and Caregivers	674 (Control=188, Intervention=486)	412 (Control=165, Intervention=247)	61 percent (Control=88 percent, Intervention=51 percent)
Children	707 (Control=207, Intervention=500)	483 (Control=157, Intervention=326)	68 percent (Control=76 percent, Intervention=65 percent)

Qualitative data

At endline, participatory sessions with parents and caregivers in gender-specific groups of 10-to-16 participants were conducted to gather community perceptions on CSA and evaluate the CSA Prevention Curriculum. Other participatory sessions with children were held in age- and gender-specific groups (9-to-10 years of age and 11-to-14 years of age; separate for boys and girls), with 10-to-16 children participating in each session. Key informant interviews were conducted with such respondents as BIU project technical staff, CSA Prevention Curriculum facilitators, para-social workers, and Grassroots Soccer coaches (some of whom were school teachers or community members). Other key informants were representatives of Child Wellbeing Committees at the parish (Parish Chiefs), sub-county (sub-county chiefs), and district levels (Community Development Officers, Chief Administrative Officer - CAO, probation officers), as well as program focal persons and project partners who provided thematic services such as professional psychosocial support and legal services.

2.6 Ethical Considerations

Participation in the study was voluntary. All study participants provided verbal and written consent. Children provided assent after we received consent from their parents or caregivers. If a parent declined to consent to their child's participation, the child was not enrolled in the study. Likewise, if a child was unwilling to participate (i.e., they withheld assent)—even despite consent from their parent or caregiver—they were not enrolled, but the consenting adult was. This was considered in the study design to safeguard the child from potential backlash.

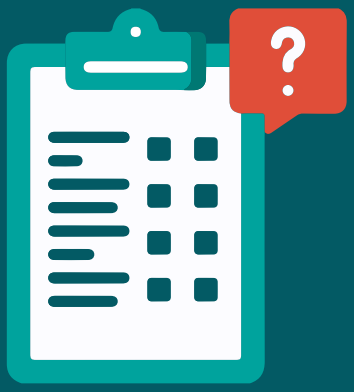
The research team was trained on ICRW and BIU's Safeguarding Principles and Child Protection Policies, and signed commitments to these policies. They committed to adhering to Child and Adult Safeguarding. The team maintained the ethical principles of confidentiality, informed consent, and do no harm.

Interviews were conducted in secure environments, away from interference from onlookers. Moderators maintained discipline and ensured that participants respected each other. All data collected was treated with confidentiality. No identifying information was shared in collected datasets or compiled reports.

Ethical approval for this study was obtained from the Makerere University School of Health Sciences Research and Ethics Committee (Protocol No. MAK-SHSREC-2023-549). The Uganda National Council for Science and Technology (UNCST) also approved the study (SS2506ES).

The research team signed the Safeguarding Principles and Child Protection Policies of ICRW and BIU. They committed to adhering to Child and Adult Safeguarding.

2.7 Assessment of Knowledge, Attitudes, Perceptions, Agency, and Intentions or Behaviors on Child Sexual Abuse



The evaluation used an adapted Parental Knowledge Questionnaire to gauge parent's knowledge regarding the nature of CSA.

The structured surveys measured knowledge, perceptions, attitudes, agency, practices with respect to child sexual abuse and exploitation.

The study assessed perceptions about CSA using a culturally adapted CSA Myth Scale.[4] This consists of 15 items with response choices on a 3-point Likert scale of *agree, disagree,* and *don't know.*

Parents' knowledge about the seriousness of child sexual abuse is likely to affect what they convey to their children about sexual abuse. There are many myths about sexual abuse that the SAFE intervention aimed to challenge. The evaluation used an adapted Parental Knowledge Questionnaire to gauge parent's knowledge regarding the nature of CSA. The tool consists of culturally adapted items on commonly misunderstood or underestimated factors such as the most likely perpetrators, age of victims, location of abuse, availability of medical evidence after disclosures, and believability of disclosures. Recognition of CSA was assessed using a dichotomous scale, the Assessment of Sexual Abuse in Children.[5] Ten questions were compiled to assess parent–child communication practices using the CSA Prevention Education Scale.[6]

The pre-post-test used a culturally adapted Children's Knowledge of Abuse Questionnaire (CKAQ)[7] tool to measure the amount of information learned regarding important beliefs and facts about child abuse (e.g., "strangers look like ordinary people" and "even someone

Photo credit ICRW.

you know might try to touch you in ways you don't like"). The study examined pre- and post-intervention whether children understood the distinction between *good, bad*, and *confusing* touch using the Touch Continuum.[8] We also measured knowledge of skills that could potentially prevent abuse such as saying 'no,' moving away if someone touches you in a way you don't like, and telling a grown-up you trust if someone touches you in a way you don't like. The CKAQ was constructed so that children with no previous exposure to prevention materials could understand the questions. It was designed to cover a set of issues, ranging from simple information that the children may have already known (e.g., the need for cautiousness with strangers) to common misconceptions (e.g. children are more at risk of being sexually abused by strangers). Questions on areas that were expected to be familiar to children were asked first and were intended to establish a sense of comfort in responding to the questionnaire as a whole. These included questions about assertiveness, coercion by peers, non-sexual touch, and attitudes regarding strangers. Items related to sexual abuse and to the possibility that familiar people may touch children in confusing or uncomfortable ways were situated toward the end of the survey. According to social cognitive theory, self-efficacy refers to one's perceived ability to deal with a task or situation[9], whereas agency is one's actual ability to deal with a task or situation. For this study, we measured self-efficacy for children using a Likert scale that assessed respondents' confidence in their own ability to enact preferences over life choices and exert control over their own motivation, behavior, and social environment. Based on this theory, the following items were explored:

- Confidence they can seek out support services if they are sexually victimized
- Confidence that, if they witnessed or experienced child sexual abuse, they would report it

Based on the tenets of the SAFE intervention, it was expected that parents and caregivers who were exposed to interventions would perceive greater competence and effectiveness in communicating with their children about CSAE. Given this increase in efficacy, parents and caregivers would be more likely to perform the behavior of talking to and educating their children about CSAE. Based on this theory, the following expected intermediate behavioral outcomes were explored:

a. Parents enrolled in the parental intervention were expected to have higher self-efficacy, response efficacy, severity, and vulnerability scores than parents enrolled in the control group.

b. Parents enrolled in SAFE group sessions were expected to have significantly greater intentions of informing their children about CSAE and intervening than parents enrolled in the control group.

c. In turn, intentions would predict parents' actual behavior of talking to their children about CSAE.

d. Parents enrolled in SAFE group sessions would report a significantly higher frequency of parent-child discussions about CSA than parents in the control group.

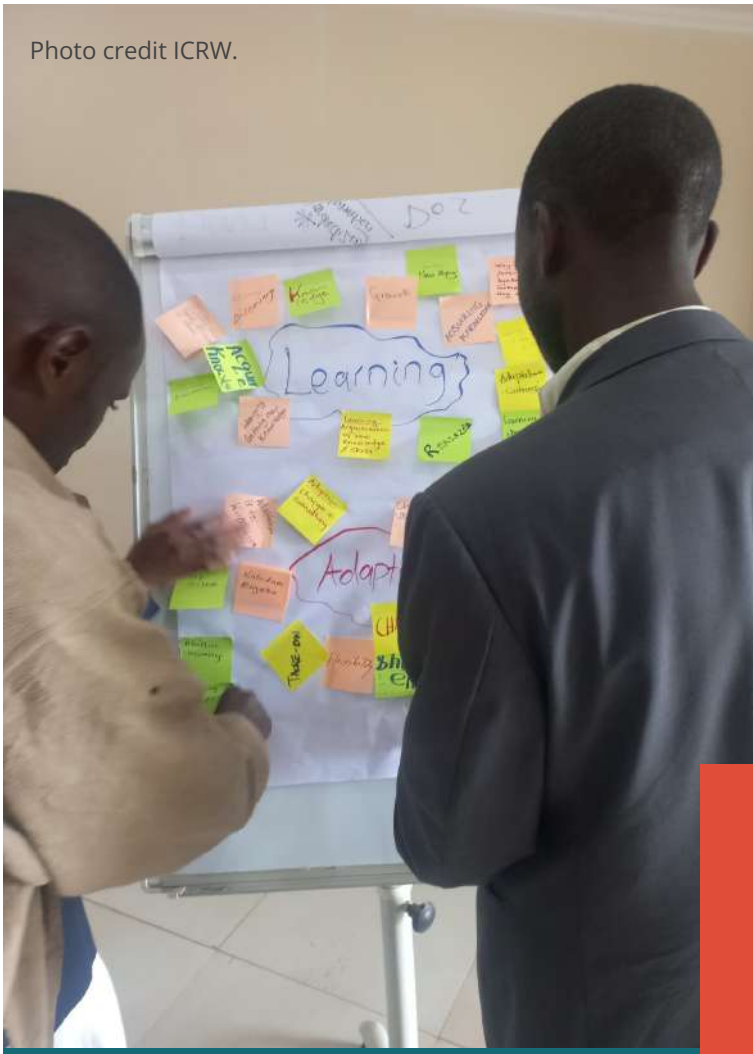
Behaviors captured in the survey included the amount of communication parents and caregivers engage in with their children about CSAE. Following the parent and caregiver sessions, the survey measured behavioral outcomes using the followed validated five-item self-report scale developed by Campis et al (1989):

Based on the tenets of the SAFE intervention, it was expected that parents and caregivers who were exposed to interventions would perceive greater competence and effectiveness in communicating with their children about CSAE.

1. Parents' self-efficacy or perceived ability to talk to and educate their child about sexual abuse (e.g., "I can talk to my child about sexual abuse as a safety issue.")
2. Parents' response-efficacy beliefs that educating children about sexual abuse is an effective intervention (e.g., "Educating children about sexual abuse is a good way to prevent their victimization.")
3. Parent's view of the severity of child sexual abuse (e.g., "Most sexually abused children are not harmed from the experience.")
4. Parents' perceived vulnerability of their children to sexual abuse (e.g., "My child is safe from sexual abuse at this point in time.")
5. Parents' intentions to talk to their children about sexual abuse (e.g., "I will have my child repeat back our family touching rules the next time they go out to play.")

Each of the instruments was translated into Rutooro, the primary local language in the target districts, and translated back to English to ensure consistency in meaning before data collection. Qualitative data helped us analyze the knowledge, attitudes, and behaviors related to CSA that we identified in our quantitative surveys.

Photo credit ICRW.



Following the parent and caregiver sessions, the survey measured behavioral outcomes using the followed validated five-item self-report scale developed by Campis et al (1989):

2.8 Data collection

Before pretesting, all study tools were prepared in English and professionally translated into local languages. Quantitative data were collected using Computer Assisted Personal Interviews with the Open Data Kit interface from teachers, children, and parents or caregivers. Qualitative interviews were conducted in local languages and audio recorded. Ten participatory sessions with caregivers of 9-to-14-year-olds in gender-specific groups of 10-to-16 participants were conducted. Ten participatory sessions with children were held in age- and gender-specific groups (9-to-10 years of age and 11-to-14 years of age, separated for boys and girls), with between 10 and 16 children attending each session. Twenty-four key informant interviews were conducted with the respondents listed in section 2.5.

Quantitative data were collected using Computer Assisted Personal Interviews with the Open Data Kit interface from teachers, children, and parents or caregivers.

2.9 Data Analysis

This evaluation assessed baseline-to-endline changes in the knowledge, attitudes, perceptions, agency, and intentions or behaviors of children, teachers, and parents with respect to preventing child sexual abuse and exploitation.

Quantitative data was analyzed using descriptive and inferential methods, as detailed in our data analysis plan. For descriptive analysis, percentages and counts showed changes across four groups: control baseline, intervention baseline, control endline, and intervention endline. Inferential analysis used the DiD method to compare these groups over time, mostly using composite variables with 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.[10,11] For added accuracy, Adjusted Inverse Probability Weighting (AIPW) was used to control for participant dropouts and measure the

Average Treatment Effect in the Treated (ATET), focusing on intervention group changes from baseline to endline using coefficients.

Qualitative data from interviews (translated from local languages to English) was 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 made it easier to find 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.

For added accuracy, Adjusted Inverse Probability Weighting (AIPW) was used to control for participant dropouts and measure

2.10 Study limitations

CSA Prevention Curriculum training sessions were implemented over a period of four-to-six months. Apart from the endline study, we were not able to do a follow-up survey to see whether the effects of the intervention were sustained in the long term. Additionally, the attrition rate faced at the endline may have influenced the study findings to some extent. We assessed whether there were statistically significant differences between control and intervention groups at baseline and endline (see Table A1, Appendix A). The results showed no statistically significant differences in group distribution for teachers ($\chi^2 = 0.073$, df = 1, $p = 0.787$) and children ($\chi^2 = 1.407$, df = 1, $p = 0.236$). However, a statistically significant difference was observed in the parents/caregivers group ($\chi^2 = 17.221$, df = 1, $p < 0.001$), suggesting that changes in sample composition for this group should be considered when interpreting the results.

The quasi-experimental study design has 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.

Efforts were made to minimize contamination of the control group, such as registering participants in the intervention group to ensure they were the only ones attending the curriculum sessions. One of the main limitations of this study is the potential spillover of the intervention to the control group due to the geographical proximity of the intervention groups and control groups, which were no more than 25 kilometers apart. Some SAFE program activities were community-based such as community awareness sessions and radio programs. It is possible that some elements of the larger intervention might have inadvertently influenced the control group, potentially affecting the study's outcomes.

Finally, the study relied on self-reported data from participants, which can be subject to biases such as social desirability bias, recall bias, and inaccuracies in reporting sensitive information.

“One of the main limitations of this study is the potential spillover of the intervention to the control group due to the geographical proximity of the intervention groups and control groups, which were no more than 25 kilometers apart.”

> The overall objective of the study was to assess the effectiveness of the SAFE Program CSA Prevention Curriculum in improving the prevention of and response to child sexual abuse and exploitation in Western Uganda.

3.0 FINDINGS

3.1 Introduction

This chapter presents our findings on the extent to which the SAFE Program CSA Prevention Curriculum improved CSAE prevention and response in Western Uganda. Data are disaggregated by study phase (baseline versus endline) and study group (intervention versus control). The findings are presented based on our research objectives and the outcomes in the SAFE Model Monitoring and Evaluation Framework (see Appendix E). Socio-demographics of study participants are detailed, followed by descriptive and regression statistics. Qualitative data are also included to provide context to the findings.

By endline, the percentage of teachers in the intervention group who agreed that it is their responsibility to safeguard children from sexual abuse while they are at school increased by **1.2 percent,** reaching 100 percent.

Outcome 1

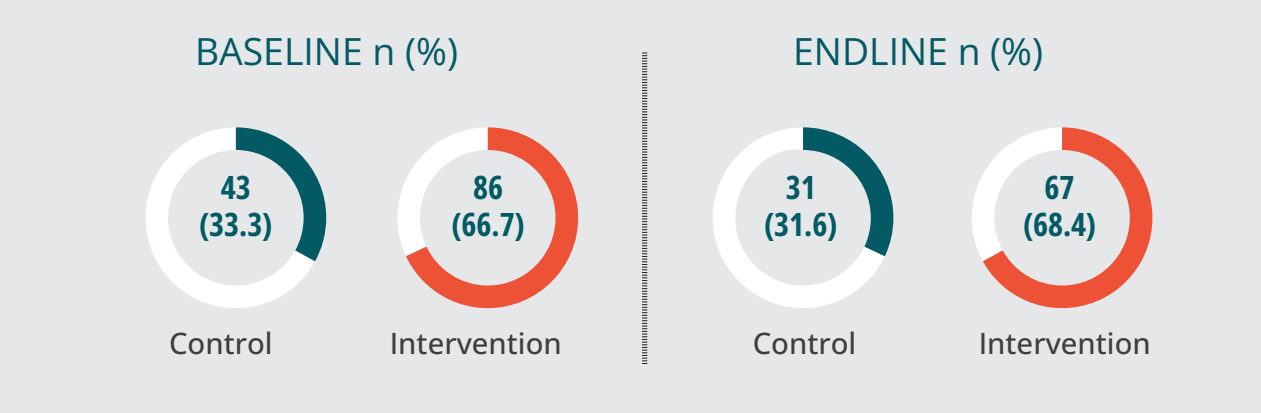
Educators actively prevent and respond to VACiSC (including CSA), create safer environments that protect children from violence, and treat girls and boys equally through non-violent means

The pathway to achieving Outcome 1 was implementation of the FRESH START intervention. In this section we present the socio-demographic characteristics of teachers who participated in the study, findings for each indicator associated with Outcome 1, and analysis of shifts from the baseline to endline.

Socio-demographic characteristics of teachers

The sociodemographic characteristics of teachers who participated in the baseline and endline studies are discussed in this sub-section.

Table 3: Distribution of the teachers across study phases and study groups



As seen in Table 3, 129 teachers were interviewed at baseline. At endline, we successfully followed up with 98 of the 129 teachers who participated in the baseline, thus achieving 76 percent retention in the study. The attrition rate of teachers at endline was primarily due to transfers to other schools.

As shown in Table A2 (Appendix A), there was a low variation in the gender composition of teachers at the endline compared with the baseline in both intervention and control schools. Additionally, teachers had an average age of 40.5 across the two study phases and study groups, with a standard deviation of ± 9.1 at both baseline and endline.

Indicator 1A

Teachers' awareness of children's rights and understanding of how to protect children from CSA

Findings under indicator 1A show teachers' knowledge and awareness of child safeguarding policies. As shown in Table B1 (Appendix B), intervention and control schools recorded high increases (14 percent and 12 percent, respectively) in the proportion of teachers who were aware of child safeguarding policies in their schools. Similarly, the proportion of teachers who reported that their schools actively enforced the child safeguarding policies rose in both study groups (16 percent in the intervention group and 21 percent in the control group).

By endline, the percentage of teachers in the intervention group who agreed that it is their responsibility to safeguard children from sexual abuse while they are at school increased by 1.2 percent, reaching 100 percent. Findings show that all teachers who participated in the study (in both the intervention and control groups) shared this belief. As one teacher who also serves as a Grassroots Soccer coach shared during a key informant interview:

Photo credit: ICRW.

> ***"... another thing is that the Lunch and Learn activity enlightened us as teachers. There were things we didn't know, some of us were doing things without realizing they were against children's rights. But after that, we learned and became more aware, we learned some new approaches about how we can handle children."***

Further driving this point home, another Grassroots Soccer coach highlighted one of the available safeguarding procedures as follows:

> ***"... we have a senior man and woman, in case, it (abuse) has happened to a boy, he reports to a man, a girl reports to a senior woman. If the case is severe, it is reported to the CDO."***

Table 4: Difference in Differences analysis on change in knowledge of child safeguarding policies

Variable	Categories	Odds ratios: *Knowledge of Safeguarding policies (knw1)*	Odds ratios: *Aware of the role to safeguard children (knw2)*	Odds ratios: *Awareness of the enforcement of the safeguarding policy at school (knw3)*
Study Phase	Baseline	1		1
	Endline	**11.718**** ***[1.493, 92.013] p=0.019***	Omitted	7.380 [0.802, 67.906] p=0.078
Study Group	Control	1		1
	Intervention	0.742 [0.488,1.130] p=0.165	Omitted	1.178[0.949,1.463] p=0.137
Sex	Male	1		1
	Female	**1.111***** ***[1.089, 1.133] p=0.000***	Omitted	**1.421***** ***[1.394, 1.448] p=0.000***
Average treatment effect	Baseline#Intervention Baseline#Control Endline#Control	1	1	1
	Endline#Intervention	Omitted	Omitted	Omitted
Adjusted inverse probability Weighting (AIPW)				
Awareness and knowledge	**Categories**	**Coefficient:**	**Coefficient:**	**Coefficient:**
Average treatment effect on the treated (ATET)	Baseline# Intervention	1	1	1
	Endline#Intervention	**0.135**** ***[0.129, 0.148] p=0.001***	Omitted	**0.171***** ***[0.097, 0.245] p=0.000***

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

Teachers in the endline intervention group were significantly more likely than teachers in the baseline intervention group to know that safeguarding policies existed in their schools. That is, teachers at endline were eleven times more likely to know that safeguarding policies existed in their schools than teachers at baseline. Moreover, female teachers were significantly more likely than their male counterparts to know that safeguarding policies existed in their schools.

Furthermore, teachers in the endline intervention group were significantly more likely to be aware of enforcement of their school's safeguarding policy. Female teachers were also significantly more aware of safeguarding policy enforcement than male teachers.

The significant increase in teachers' knowledge and awareness of child safeguarding policies in the endline intervention group underscores the positive impact of the SAFE Program CSA Prevention Curriculum.

Indicator 1B

Teachers show a positive shift in attitudes toward recognizing, reporting, and protecting children from CSA

Findings in table C1 (Appendix C) show a shift in teachers' attitudes toward reporting CSA. From baseline to endline, 2 percent more teachers in the intervention group stated they would report CSA, even if their school administration disagreed. Conversely, willingness to report decreased by 12 percent among teachers in the control group. Additionally, the proportion of teachers in the intervention group willing to report CSA despite fear of family or community retaliation increased by 3 percent, whereas the proportion of teachers in the control group who made the same commitment decreased by 5 percent. Increases in the intervention group highlight a positive shift that could be associated with participation in the SAFE program's CSA prevention curriculum.

From baseline to endline, 2 percent more teachers in the intervention group stated they would report CSA, even if their school administration disagreed.

Table 5: Difference-in-Differences analysis on change in teacher's attitudes toward reporting CSA

Variable	**Categories**	**Odds ratios:** *Willingness to report CSA even if the school administration disagreed*	**Odds ratios:** *I would be apprehensive to report child sexual abuse for fear of family/community retaliation*
Study Phase	Baseline	1	1
	Endline	0.465 [0.205, 1.054] p=0.067	0.684 [0.117, 4.003] p=0.674
Study Group	Control	1	1
	Intervention	0.923 [0.313, 2.726] p=0.885	0.740 [0.058, 9.506] p=0.817
Sex	Male	1	1
	Female	**1.344*** *[1.314, 1.373] p=0.000**	1.047 [0.992, 1.105] p=0.096
Average treatment effect	Baseline#Intervention Baseline#Control Endline#Control	1	1
	Endline#Intervention	2.445 [0.568, 10.522] p=0.230	1.917 [0.220, 16.663] p=0.555
Awareness and knowledge	**Categories**	**Coefficient**	**Coefficient**
Average treatment effect on the treated (ATET)	Baseline#Intervention	1	1
	Endline#Intervention	0.852 [0.778, 0.926] p=0.803	0.029 [-0.077, 0.135] p=0.594

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

We found no significant difference between baseline and endline in the teacher's willingness to report CSA if the school administration disagreed, nor between the endline intervention and other study groups. However, female teachers were significantly more willing than male teachers to report CSA, even if their school administration disagreed. Findings show no significant difference in teachers' lack of willingness to report CSA between baseline and endline in the different groups due to fear of family or community retaliation.

Indicator 1C

Active participation by teachers in mitigating risks to child safety in and around the school

Findings in Table D1 (Appendix D) reveal that, from baseline to endline, only 1 percent more teachers in the intervention group indicated they would report suspected CSA, with this proportion decreasing by 6 percent in the control group. During an interview, one senior probation officer noted:

> ***"... in schools, most teachers don't like disclosing (abuse cases) but there are some teachers who report ..."***

These findings underscore the deeply ingrained negative social views within the community regarding disclosure and reporting of CSA. Factors such as fear of retaliation from the community or family members and a lack of trust in authorities to handle CSA cases appropriately can deter teachers from reporting CSA.

> **We found no significant difference between baseline and endline in the teacher's willingness to report CSA if the school administration disagreed, nor between the endline intervention and other study groups.**

Table 6: Difference in Differences analysis on change in teachers reporting suspected CSA

Variable	Categories	**Odds ratios:** *I would report CSA when I suspect it*
Study Phase	Baseline	1
	Endline	0.506 [0.060, 4.252] p=0.530
Study Group	Control	1
	Intervention	1.206 [0.117, 12.429] p=0.875
Sex	Male	1
	Female	***0.847*** *[0.809, 0.887]* ***p=0.000***
Average treatment effect	Baseline#Intervention Baseline#-Control Endline#Control	1
	Endline#Intervention	2.617 [0.118, 58.262] p=0.543
Awareness and knowledge	**Categories**	**Coefficient**
Average treatment effect on the treated (ATET)	Baseline#Intervention	1
	Endline#Intervention	0.012 [-0.056, 0.081] p=0.724

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

There was no significant difference in the reporting of suspected CSA between teachers in the baseline intervention and endline intervention groups. Additionally, female teachers were significantly less likely to report suspected CSA than male teachers.

Outcome 2

Caregivers actively prevent and respond to VACiSC (including CSA), adopt positive parenting, and provide for and treat girls and boys equally through non-violent means

The SAFE Program CSA Prevention Curriculum contributed to Outcome 2 through the NEST Package's parent-focused curriculum on norms diffusion, skills, economic strengthening, and parenting. These sessions were central to raising awareness about violations against children and how to identify, prevent, and respond to violence against children within schools and surrounding communities, as well as to empower stakeholders to identify unsafe places and understand appropriate actions to improve child safety. In this section, we present the socio-demographic characteristics of caregivers who participated in the study, findings on each indicator associated with Outcome 2, and analysis of shifts from the baseline to endline.

Socio-demographic characteristics of caregivers

The socio-demographic characteristics of parents and caregivers who participated in the baseline and endline studies are discussed in this sub-section.

Table 7: Distribution of parents and caregivers across study phases and study groups

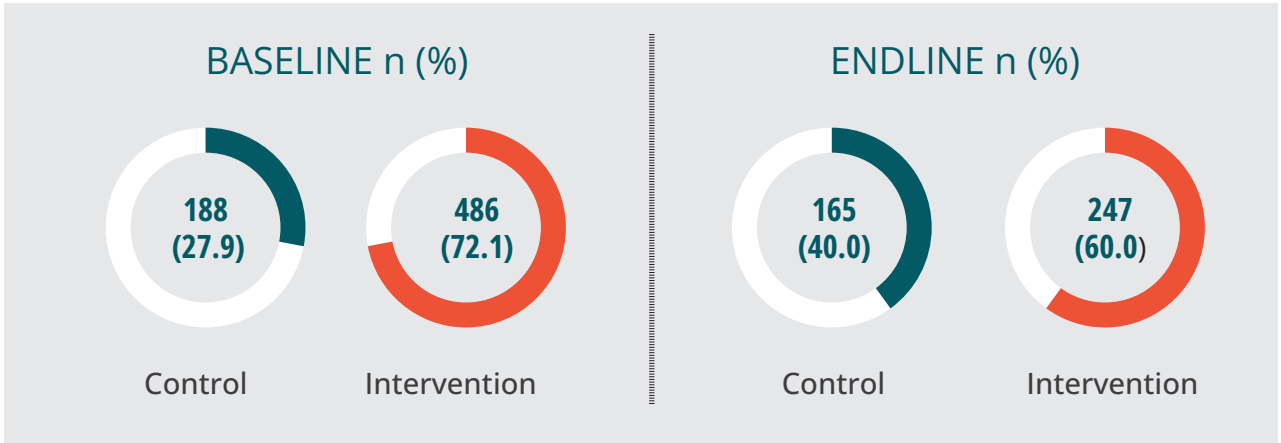


Table 7 shows the distribution of parents and caregivers across study phases and groups. The baseline survey included 674 parents or caregivers, with 28 percent from the control group and 72 percent from the intervention group. The endline survey included 412 parents or caregivers, with 40 percent from the control group and 60 percent from the intervention group. The others were either lost to follow-up or did not complete the minimum number of required parenting curriculum sessions. At baseline, males accounted for 34 percent in both study groups and females made up 66 percent. At endline, males comprised 29 percent of both study groups and females comprised 71 percent (see details in Table A3, Appendix A).

Many of the parents (79 percent) were aged 35 and above; parents in both studies had an average age of 45, with a standard deviation of 12 between the two study periods. Regarding occupations and main sources of income, study communities majorly relied on agriculture and farming.[12,13] More than 68 percent of the parents and caregivers were married or cohabiting at both study phases.

Indicator 2A

Parents and caregivers' awareness of children's rights and risks to abuse and understanding of how to protect them from CSA.

Table B2, (Appendix B) shows that parents and caregivers who reported awareness of harmful practices against children in their communities decreased by 5 percent in both the intervention and control groups. This finding could result from some caregivers not viewing certain practices as harmful or not comprehending the magnitude of harm that could come from some practices in the community. The findings are reaffirmed by the qualitative data. During participatory sessions, some caregivers were noted to be perpetrators of harmful practices like marrying off their children, which may have affected their view of such practices as being harmful.

At endline, males comprised 29 percent of both study groups and females comprised 71 percent

"Our children have been abused due to poverty in our homes. For example, some parents set up their young girls to engage in sexual activities with a boy so that they can extort money or other material items from the boys' parents."

—Female focus group discussion (FGD) participant

"I have also seen in the community that some parents ask their children to work with them in bars. When customers touch the mother, the children are watching. Such behaviors have a negative impact on children because they tend to imitate what they see the mother or father doing in the bar."

—Female FGD participant

"We still have cases of rape and defilement in the community, which parents sometimes promote. As a parent, you cannot allow a child to be out of the home beyond 7:00pm."

—Female FGD participant

"I will blame parents because sometimes a child engages in bad behavior due to a parent's failure to understand their responsibilities. In the training, they taught us about unsafe places where we are not supposed to allow children to go, but you find some parents going to such places with children."

—Female FGD participant

Although efforts are being made to address harmful practices against children, several policy stakeholders and community members noted that child abuse still exists, including early marriages and pregnancies, rape, and defilement. However, they also noted that efforts have been made to identify hot spots of harmful practices against children in communities as a result of community dialogues, and that appropriate duty-bearers have been mandated to act as illustrated below:

"There is another girl of 14 years who was impregnated. When we went to arrest the man, he ran away. All these events are happening in our community."
—Female FGD participant

"There are minor issues where parents still send children out at night, but we are collaborating with the local leadership to address these behaviors."
—Male FGD participant

"There are harmful practices in the community, such as children leaving school to marry at a young age. However, we now know how to manage such cases if they happen. I would approach the local leadership and the Community Development Officer if I learned of such a situation. We would then locate the child and take her to the hospital for pregnancy and disease check-ups. If all medical examinations yielded negative results, we would speak to the child's parents and involve the authorities regarding the man involved."
—Female FGD participant

"We have been monitoring a case involving a child from Nsongya school who eloped to the neighboring village of Kahondo. She was in Primary Six and had been promoted to Primary Seven. Together with the girl's parents, we tracked them down. However, when the man learned that the case had been reported to the police, he fled, leaving the girl at the house. We retrieved her and took her to the health center, where, fortunately, we confirmed that she was not pregnant and had not contracted any diseases. At the beginning of this term, I visited the girl at her home and encouraged her to return to school. Currently, the girl is stable and back in school."
—Female FGD participant

Several policy stakeholders and community members noted that child abuse still exists, including early marriages and pregnancies, rape, and defilement.

"Another concerning behavior in the community is when foster parents engage in sexual activities with children brought by their wives from previous marriages. For instance, in Lwamabya village, there was a case where a 28-year-old man abused a 13-year-old child. When this misconduct persisted, the child confided in a neighbor who informed me (the para-social worker). I engaged the local leadership, the CDO, and the Police. Together, we apprehended the man and took him to Kisomoro Prison. Unfortunately, the child became fearful because her mother blamed her for disclosing the situation to the neighbor and held her responsible for her husband's imprisonment. When I heard about this, I went to the Police, got a letter, and took the child to the hospital to confirm if, indeed, there was any penetration, which was true. The woman threatened the child to change the statement to say it was not the foster father who had been having sex with her and that she should say other boys had been using her. We informed Bantwana and the man was transferred to another prison in Fort Portal. All this is happening in our community,"
—Female key informant

Findings show that there was a 48 percent increase in the proportion of parents and caregivers in the intervention group who participated in sessions to discuss the risks of child sexual abuse in their communities during the six months preceding the endline. In the control group, this proportion increased by a marginal 0.1 percent. The finding underscores the positive impact of the intervention on encouraging parents to engage in these critical discussions.

There was a
48 percent
increase in the proportion of parents and caregivers in the intervention group who participated in sessions to discuss the risks of child sexual abuse

Table 8: Difference in Differences analysis on the change in parents and caregivers' knowledge of CSA

Variable	Categories	Odds ratios: *Aware of harmful practices against children*	Odds ratios: *In the last 6 months, participated in sessions to discuss sexual abuse risks that children face in our communities*
Study Phase	Baseline	1	1
	Endline	**0.822*** *[0.768, 0.880] p=0.000***	1.010 [0.733, 1.391] p=0.953
Study Group	Control	1	1
	Intervention	**1.432*** *[1.423, 1.441] p=0.000***	1.687 [0.738, 3.857] p=0.215
Sex	Male	1	1
	Female	**0.920*** *[0.910, 0.930] p=0.000***	**0.906*** *[0.900, 0.912] p=0.000***
Average treatment effect	Baseline#Intervention Baseline#Control Endline#Control	1	1
	Endline#Intervention	0.976 [0.860, 1.107] p=703	**8.725*** *[4.131, 18.430] p=0.000***
Awareness and knowledge	**Categories**	**Coefficient**	**Coefficient**
Average treatment effect on the treated (ATET)	Baseline#Intervention	1	1
	Endline#Intervention	-0.047 [-0.129, 0.034] p=0.254	**0.290*** *[0.233, 0.346] p=0.000***

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

Although caregivers in the intervention group were generally more likely to report being aware of harmful practices against children than those in the control group, there was no significant difference in caregiver awareness of harmful practices against children between the endline intervention group and the baseline intervention group, baseline control group, and endline control group. Caregivers at endline were significantly less likely to report being aware of harmful practices against children than they were at baseline.

Caregivers in the endline intervention groups were significantly more likely than those in the baseline intervention group to have discussed community CSA risks in the six months prior to the survey. They were also eight times more likely to have had these discussions in the same period compared with those in the baseline intervention, baseline control, and endline control groups.

Additionally, there were gender differences in the findings. That is, female parents and caregivers were less likely than their male counterparts to report being aware of harmful practices against children and discussing community CSA risks in the six months preceding the survey.

Indicator 2B

Caregivers who show a positive shift in attitudes towards reporting and protecting children from CSA

The SAFE Program CSA Prevention Curriculum's NEST component targets a shift toward positive norms such as parents believing their children when they report cases of sexual abuse (see Table C2, Appendix C).

The study assessed parents and caregivers' attitudes toward believing children's reports of sexual abuse. Findings show that, from baseline to endline, the number of parents and caregivers indicating that children who report sexual abuse can be believed (either most of the time or always) increased by 12 percent in the control group and by 5 percent in the intervention group.

Although the majority (over 90 percent) of parents and caregivers indicated at endline that they would be willing to report cases of sexual abuse perpetrated against their children even if their partner were unwilling, the proportion of such parents still decreased by 3 percent in the intervention group and by 1 percent in the control group. Qualitative data corroborates these findings, showing hesitation by some parents to disclose or report sexual abuse when their partners are against it. There were many potential reasons for concealment, especially when such abuse came at the hand of a parent. These included fear of bringing shame on the family and concern that the offending parent would be imprisoned, thus leaving the family without livelihood support if they were the breadwinner. During an FGD, a female caregiver noted,

> ***"... some parents are concealing cases of defilement, and some parents are having sex with their daughters. Female parents do not report such cases for fear of humiliating their husbands in the community. Such cases are not heard of because some parents choose to keep quiet."*** —Female FGD participant

90%
of parents and caregivers indicated at endline that they would be willing to report cases of sexual abuse perpetrated against their children even if their partner were unwilling.

Photo credit: ICRW.

The SAFE CSA Prevention Curriculum aimed to address the norms that contribute to CSA, which we measured through a set of statements (see Table C3, Appendix C).

Findings show that a majority of parents and caregivers (over 90 percent) had the appropriate attitude that reaching puberty or leaving school did not mean a child was automatically ready for sex. However, by the endline, the proportion of caregivers who held negative attitudes in this regard slightly increased. That is, those believing that reaching puberty or leaving school indicated that a child was ready for sex rose by nearly 5 percent (from 2.7 to 7.3 percent) in control communities and by slightly more than 1 percent (from 5.3 to 6.5 percent) in intervention communities.

Parents and caregivers who agreed that people should disclose sexual abuse increased by only 1 percent in the intervention group by endline, but by 3 percent in the control group.

Findings show a slight increase in the proportion of caregivers who agreed that

boys and men should not be entitled to have sex with girls and forced sex with women without consequences. The proportion increased by only 1 percent in the control group and by 2 percent in the intervention group.

Furthermore, the majority of parents and caregivers (over 60 percent) disagreed with the statement that children bring sexual abuse upon themselves. Disagreement with this negative attitude increased from baseline to endline at a higher rate among parents and caregivers in the control group (13 percent) than those in the intervention group (5 percent).

At endline, the proportion of parents and caregivers who believed that relatives and teachers should not be reported for sexually abusing children decreased by 2 percent in the intervention group and by 1 percent in the control group.

A composite variable for attitudes towards CSA-related-norms was created by combining five selected parameters, as shown in Table C3 (Appendix C). A score greater than 3 was considered indicative of positive attitudes in relation to norms otherwise not. The reliability of the composite variable (tested by Cronbach's alpha) was 0.72, indicating good reliability. By endline, the proportion of caregivers with positive attitudes in relation to the selected CSA-related-norms in the control group decreased by 4 percent, whereas the proportion decreased by 1 percent in the intervention group. Although strides were achieved on positive attitude change regarding social norms, the overall reduction in the proportion of caregivers with positive attitudes toward selected norms points to the persistence of negative social norms that pose risks for CSA. During the key informant interviews, a Community Development Officer highlighted persistent negative attitudes around reporting CSA, stating:

> ***"The main challenge is with the community—they don't want to comply. For example, when a child has been raped and we go to arrest the perpetrator, they say, 'Don't arrest our member, people will hate me.' Sometimes the trial fails because the community is unwilling to do what is necessary."***

60%
of parents and caregivers (over 60 percent) disagreed with the statement that children bring sexual abuse upon themselves.

Table 9: Difference in Differences analysis on change in parents and caregivers' attitudes toward believing children, reporting CSA, and on selected community norms and practices that pose risks for CSA.

Variable	Categories	Odds ratios: *Children who report CSA can be believed*	Odds ratios: *I can report CSA even if my partner is against it*	Odds ratios: Attitudes in relation to selected community CSA-related-norms and practices
Study Phase	Baseline	1	1	1
	Endline	1.817 [0.319, 10.341] p=0.501	0.289 [0.076, 1.104] p=0.070	**0.557*** *[0.438, 0.710] p=0.000**
Study Group	Control	1	1	1
	Intervention	0.977 [0.641, 1.488] p=0.913	**0.132** *[0.037, 0.464] p=0.002**	**0.640** *[0.475, 0.862] p=0.003**
Sex	Male	1	1	1
	Female	**0.921*** *[0.915, 0.926] p=0.000**	**0.887*** *[0.882, 0.891] p=0.000**	**1.800*** *[1.715, 1.888] p=0.000**
Average treatment effect	Baseline#Inter-ventionBase-line#Control Endline#Control	1	1	1
	Endline#Intervention	0.580 [0.092, 3.648] p=0.562	2.050 [0.542, 7.745] p=0.290	1.527 [0.697, 3.348] p=0.290
Awareness and knowledge	**Categories**	**Coefficient**	**Coefficient**	**Coefficient**
Average treatment effect on the treated (ATET)	Baseline#Intervention	1	1	1
	Endline#Intervention	0.004 [-0.042, 0.049] p=0.879	-0.025 [-0.065, 0.014] p=0.210	-0.012 [-0.060, 0.036] p=0.619

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

Findings in table 9 reveal that there was no significant change among parents or caregivers with respect to believing children who report sexual abuse between the endline intervention group and the baseline intervention group, baseline control group, and endline control group. However, findings reveal that female caregivers were significantly less likely to believe children who reported sexual abuse than male caregivers.

Regarding caregivers' willingness to report CSA if a partner were against it, findings show no significant change between the endline intervention group and the baseline intervention group, baseline control group, and endline control group. However, caregivers in the intervention groups were significantly less likely than those in control groups to express willingness to report CSA if a partner were against it. Additionally, female parents and caregivers were significantly less likely than their male counterparts to report CSA if a partner were against it.

Also, results show no significant change in positive attitudes about norms and practices on CSA in the endline intervention group and the baseline intervention group. Parents and caregivers were significantly more likely at baseline than at endline to have exhibited positive attitudes about norms and practices on CSA. Likewise, parents and caregivers in the intervention group were significantly less likely than those in the control group to have positive attitudes concerning norms and practices on CSA. Overall, female parents and caregivers were significantly more likely to have positive attitudes concerning norms and practices on CSA than male parents and caregivers.

Female parents and caregivers were significantly less likely than their male counterparts to report CSA if a partner were against it.

Indicator 2C

Caregivers demonstrate increased accountability and responsibility toward their children

The SAFE CSA Prevention Curriculum aims to empower caregivers to openly and confidently talk to their children about how to prevent and respond to CSA and other risky behaviors that can threaten child safety.

Table D2 (Appendix D) shows that, from baseline to endline, the proportion of parents and caregivers that had spoken to their children about:

- *menstruation* rose by 6 percent (from 65 percent to 71 percent) in the control group and by 4 percent (from 66 percent to 70 percent) in the intervention group;
- *peer pressure to engage in sex* increased by 12 percent in the control group and by 9 percent in the intervention group;
- *seeking help when they feel at risk of sexual abuse* increased by 10 percent in both study groups; and
- *strategies to avoid early marriage and under-age marriage* increased by 13 percent in the control group and by 14 percent in the intervention group.

A composite variable on discussions with parents and caregivers on sexuality education and CSA was created by combining four selected variables, as shown in Table D2 (Appendix D). A score greater than 3 was considered indicative of a positive attitude toward discussing CSA with children otherwise not. The reliability of the composite variable (tested by

The proportion of parents and caregivers that had spoken to their children about: menstruation rose by 4 percent (from 66 percent to 70 percent) in the intervention group;

Cronbach's alpha) was 0.86, indicating very good reliability. By endline, the proportion of parents and caregivers that had discussed CSA with their children increased by 10 percent in the control group by 16 percent in the intervention group. The high increase in the intervention group underscores the positive influence of the SAFE CSA Prevention Curriculum on influencing parents to have discussions on sexuality education and CSA with their children.

During participatory sessions, parents in the intervention group reaffirmed the benefits of the curriculum. They highlighted how it provided them with valuable information to understand their adolescent children and how to discuss CSA issues with them and how to maintain open and friendly communication. Caregivers shared their experience, noting:

"I understood the challenges children face when they experience body changes between nine and 18 years. As parents, we have been taught that you have to move along with your child so that you are in a position to understand and guide where necessary. This has helped me a lot because when a child makes a mistake, I quickly analyze the age bracket and advise accordingly."

—Female FGD participant

"I talk to my children about peer pressure and how to avoid early marriage. It's important to educate them."

—Male FGD participant

IN **NUMBERS**

2.89 times

Caregivers in the intervention communities were 2.89 times more likely to have talked to their children about risks that exposed them to CSA than their counterparts in the control communities

2.929 times

Female parents were 2.929 times more likely to have talked to their children than males

2 times

At the endline, caregivers in the intervention communities were twice more likely to have talked to their children (9-14 years) about healthy relationships between boys and girls than their counterparts in the control communities

1.8 times

Caregivers in the intervention communities were 1.8 times more likely to participate in or attend activities their children engaged in (such as sports, boy/girl scouts, or church youth groups) than those in the control communities

- At the endline, caregivers in the intervention communities were twice more likely to have discussed body changes with their children
- Female caregivers were thrice more likely to have discussed body changes with their children than their male counterparts
- At the endline, female caregivers were more likely to have discussed issues related to female menstruation than their male counterparts

1.6 times

Caregivers in the intervention communities were 1.6 times more likely to attend PTA meetings than control communities

1.5 times

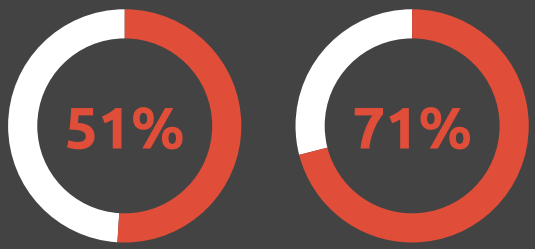
Caregivers in the intervention communities were 1.5 times more likely to compliment their children when they do something well than those in the control communities

2.3 times

Caregivers in the intervention communities were 2.3 times more likely to have frequent talks with their children (9-14 years) than their counterparts in the control communities

2 times

Children in intervention communities were at least twice more likely to tell at least three of the children's rights than their counterparts in the control schools



BASELINE **ENDLINE**

Children in the intervention schools able to tell at least three ways of protecting themselves against CSA increased from 51 percent at baseline to 71 percent at the endline compared to an increase from 53 percent at baseline to 61 percent at endline in control schools

1.663 times

Children in the intervention schools were 1.663 times more likely to tell at least three ways of protecting themselves from CSA

- The three most common ways of preventing CSA mentioned by children included: not moving at night, not moving alone, and avoiding bad peer groups

- Defilement and rape, battering/beating, use of abusive/insulting words, child labor, child neglect, kidnapping and ritual killing.

1 in 4

About one in every four children (26 percent) at the endline reported having encountered a situation that gave them fear or made them worry about being sexually abused

- The leading career aspirations of girls at the endline were: nurse/midwife (60 percent), doctor (12 percent), and teaching (13 percent). On the other hand, career aspirations mentioned by boys were mainly doctor (41 percent) and teaching (12 percent)

Children who were confident to; a) seek out support services in case of abuse (DID= 0.107, p<0.05), b) resist pressure to engage in sex from their teacher or relative (DID= 0.100, p= 0.002), c) report CSA (DID= 0.048, p= 0.125), d) seek medical attention if someone forced or lured them into sex (DID= 0.134, p= 0.002), report the person to authorities and tell all that happened without fear if someone forced or lured them into sex (DID= 0.116, p= 0.001), and disclose the identity of the perpetrator (DID= 0.075, p= 0.004).

Parent and caregiver self-efficacy on a range of parameters related to providing sexuality education was assessed, as shown in Table D3 (Appendix D). Findings show an increase in the proportion of parents who would be comfortable answering and providing information to sex-related questions that their children ask. The proportion of such parents in the control group increased by 6 percent and by 4 percent in the intervention group.

Parents and caregivers who reported being able to adequately explain sexual violence against children (including sexual abuse and exploitation) to their children and answer their children's questions on the matter increased by 3 percent in the control group and by 4 percent in the intervention group.

Findings at endline showed a drop in the proportion of caregivers would be willing to reject marrying off their child if a partner wanted to. This proportion decreased by 1 percent in the control group and by 3 percent in the intervention group.

A composite variable on caregivers' self-efficacy to provide sexuality education was created by combining three selected variables, as shown in Table D3 (Appendix D). A score greater than 1 was considered indicative of self-efficacy to provide sexuality education otherwise not. The reliability of the composite variable (tested by Cronbach's alpha) was 0.79, indicating good reliability. By endline, the proportion of caregivers who had self-efficacy to provide sexuality education increased by 5 percent in the control group but by only 1 percent in the intervention group.

The proportion of parents who would be comfortable answering and providing information to sex-related questions that their children ask in the control group increased by 6 percent and by 4 percent in the intervention group.

Table 10: Difference in Differences analysis of change in parents and caregivers' attitudes and practices toward sexuality education and CSA

Variable	Categories	Odds ratios: *Discussion on CSA*	Odds ratios: *Self-Efficacy to provide sexuality education*
Study Phase	Baseline	1	1
	Endline	1.661 [0.759, 3.634] p=0.204	**2.205** [1.252, 3.881] p=0.006**
Study Group	Control	1	1
	Intervention	**1.085*** *[0.233, 0.346] p=0.000***	**1.404*** *[0.233, 0.346] p=0.000***
Sex	Male	1	1
	Female	**2.512*** [2.470, 2.555] p=0.000**	**1.172*** [1.165, 1.179] p=0.000**
Average treatment effect	Baseline#Intervention Baseline#Control Endline#Control	1	1
	Endline#Intervention	1.580 [0.552, 4.523] p=0.394	**0.518*** [0.371, 0.722] p=0.000**
Awareness and knowledge	**Categories**	**Coefficient**	**Coefficient**
Average treatment effect on the treated (ATET)	Baseline#Intervention	1	1
	Endline#Intervention	**0.150*** [0.084, 0.215] p=0.000**	0.009 [-0.034, 0.053] p=0.674

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

Caregivers in the endline intervention were significantly more likely to have had discussions on CSA with children than those in the baseline intervention group. Caregivers in the intervention groups were also significantly more likely to have had these discussions on CSA than those in the control groups. Additionally, female parents and caregivers were approximately 2.5 times more likely than their male counterparts to discuss CSA issues with their children.

There was no significant difference in the self-efficacy of caregivers to provide sexuality education between the endline intervention group and the baseline intervention group. However, caregivers were significantly more likely to have self-efficacy to provide sexuality education to their children at endline than at baseline. Also, findings show that caregivers in the intervention groups were significantly more likely to have self-efficacy to provide sexuality education compared with those in the control groups. Further, female parents and caregivers were significantly more likely to have self-efficacy to provide sexuality than males.

Outcome 3

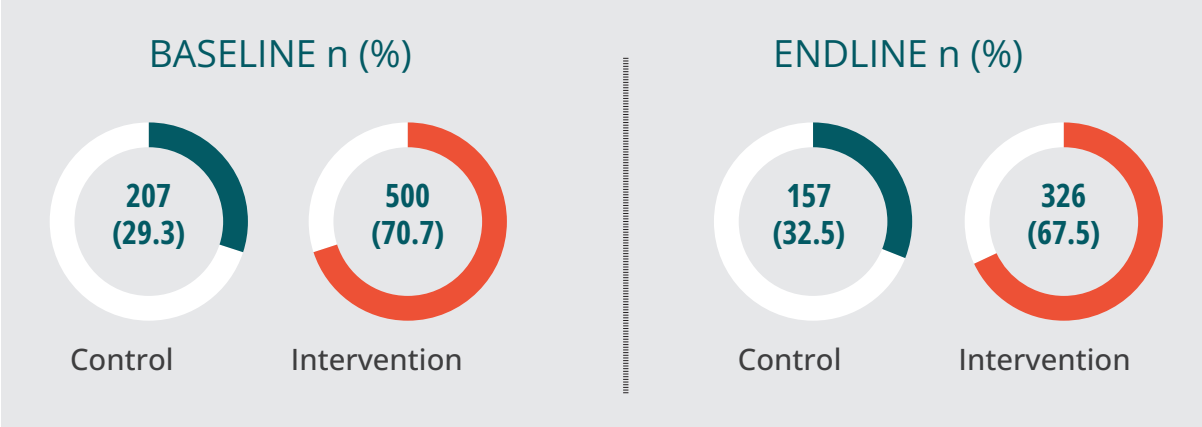
Improved agency of boys and girls to prevent and respond to VACiSC (including CSA) and internalize and promote new, positive gender norms

In this section, we present the socio-demographic characteristics of children who participated in the study, findings on indicators associated with Outcome 3, and an analysis of shifts in the agency of boys and girls to prevent and respond to VACiSC from baseline to endline.

Socio-demographic characteristics of children

The socio-demographic characteristics of the children who participated in the baseline and endline studies are discussed in this sub-section.

Table 11: Distribution of the children across study phases and study groups



Of the 707 children interviewed at baseline, 483 were re-interviewed at endline, signifying a 68 percent retention rate in the study (control = 76 percent and intervention = 65 percent, as shown in Table 11). The decrease in the number of children at the endline was mainly due to absenteeism, change of schools (studying in schools outside the study area), and school discontinuation.

At both baseline and endline, girls slightly outnumbered boys. That is, girls represented 53 percent of participants at baseline and 55 percent at endline (see Table A4, Appendix A). There were slightly higher numbers of older children (ages 11-14) than younger children (ages 9-10) in both studies. At endline, the mean age of child participants was 13.2 , with a standard deviation of ±1.0 between the two study periods. The proportion of older children increased at endline, likely due to the passage of time between the studies. The study predominantly

consisted of children between primary four (P4) and seven (P7). At baseline, the larger proportion of children were in primary five (P5). By endline, children had transitioned from one class to the next; therefore, most of the children were in primary six (P6) at endline. For a majority of the children (more than 80%), both parents were alive at the time of the two study groups and phases.

Indicator 3A

Children have increased knowledge and awareness of their rights, responsibilities, and VACiSC (including CSA)

This section presents data on shifts from the baseline to endline in children's awareness and understanding of their rights and associated harmful practices.

Children's rights are fundamental entitlements that every child should be aware of and enjoy. These rights are outlined in the United Nations Convention on the Rights of the Child, which is the most widely ratified human rights treaty in history. The Government of Uganda recognizes the importance of ensuring children's four cardinal rights (survival, development, protection, and participation) through a well-built and coordinated protection system.1 The baseline and endline study phases explored children's knowledge of their rights.

Table B3 (appendix B) presents findings on the change in children's knowledge of their rights and on CSA-related harmful practices. There was a 20 percent increase in knowledge of children's rights among children in the control group from baseline to endline, and a 16 percent increase in the intervention group. The proportion of children who could mention three or more rights increased by only 1 percent in

There was a 20 percent increase in knowledge of children's rights among children in the control group from baseline to endline, and a 16 percent increase in the intervention group.

Photo credit: BIU.

the control group, whereas the proportion of such children increased by 20 percent in the intervention group. One of the teachers who doubles as a Grassroots Soccer coach also explained:

> ***"... learners are now enlightened about their rights and safe spaces. They now recognize places and situations that may put their lives at risk. We've also helped them understand that they shouldn't automatically trust everyone, not even teachers, pastors, or some of their relatives. At least now, they know."***

The proportion of children who indicated awareness of CSA-related harmful practices in their communities decreased by 7 percent in the control group, whereas this proportion increased by only 1 percent in the intervention group. It is noteworthy that there was little shift in children's awareness of CSA-related harmful practices in their communities. This could be because some of these practices have been normalized. Children see them as part of daily life, and critical assessment of these practices as being harmful may thus not come naturally. However, during participatory sessions, when children were probed on what constitutes CSA-related harmful practices, they cited these practices and confirmed that they see them happening in their communities; sometimes perpetuated by their parents. Testimony from children in the 11-to-14-year-old age group included:

ICRW
INTERNATIONAL CENTER FOR RESEARCH ON WOMEN

bantwana
INITIATIVE UGANDA

"Male parents marry off their children."
—Girl FGD participant

"Parents make their daughters stop school when money is not enough, and they take boys to school and not girls."
—Boy FGD participant

"Parents no longer care for their children; the children who provide financial help to parents are the ones who are cared for. There is discrimination by the parents." *—Boy FGD participant*

"The men chase the children and wife out of the house to sleep out when they come back drunk."
—Boy FGD participant

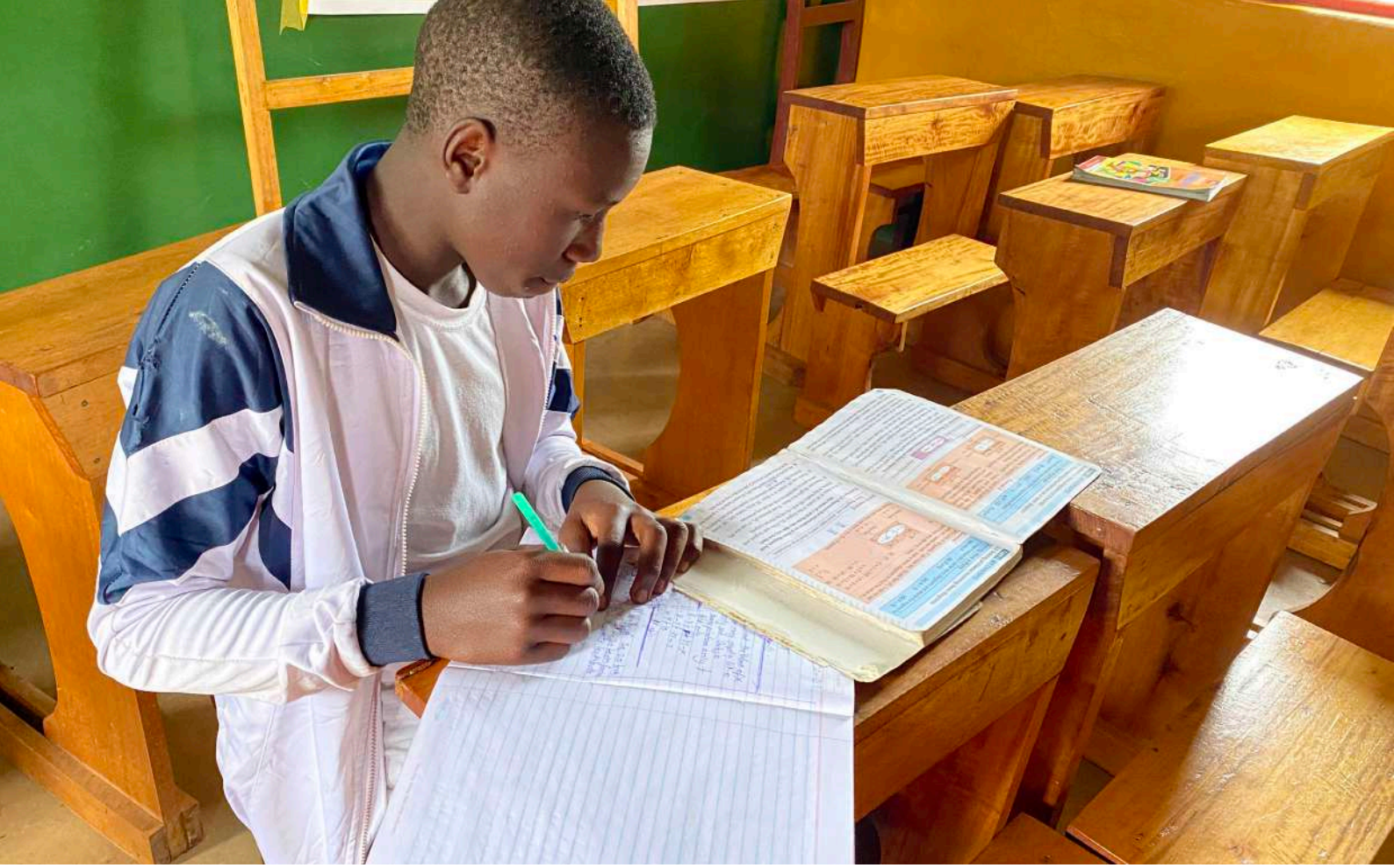
"The man comes back drunk, and he begins to mistreat the children;
he beats and chases them from home."
—Boy FGD participant

"Parents marry off children when they are still young because they want money. A girl in the village was married off while she was in Primary Seven."
—Boy FGD participant

"Parents sell maize and use the money to take alcohol and don't pay school fees for their children, hence, staying home."
—Boy FGD participant

"Parents no longer discipline their children; the children go out and come back late at 11:00 pm, and they say nothing to them."
—Boy FGD participant

"When adults have misunderstandings, they transfer the anger towards the children; for example, neighbors quarreled, and one of them drowned the other's child."
—Boy FGD participant



Student during GRS Session. Photo credit: Bantwana Initiative Uganda

The study also assessed if children could identify ways of protecting themselves against CSA. During the participatory sessions, the most common ways of preventing CSA that children mentioned included not moving at night, not moving alone, avoiding bad peer groups, and resisting sexual advances. Some girls in the 11-to-14-year-old age group were quoted as saying:

> ***"We should go home early after school. We should stop moving unnecessarily and be obedient to our elders. We should avoid going to places where children aren't entertained."***
>
> ***"If you have a parent who disturbs you (sexually), try to change location; maybe go and stay with your grandparents."***
>
> ***"You refuse when a boy wants to engage you in sex."***
>
> ***"Don't allow boys to touch your private parts; run away in case of abuse."***

It should also be noted that self-reported CSA prevention approaches mentioned by children place too much responsibility on children to protect themselves, potentially leading to victim-blaming if abuse occurs.

Table 12: Difference-in-Differences analysis of change in children's knowledge of their rights and of harmful CSA-related practices

Variable	Categories	Odds ratios: *Knowledge of rights (knw)*	Odds ratios: *Awareness of ≥ 3 rights (awr1)*	Odds ratios: *Awareness of harmful practices*
Study Phase	Baseline	1		1
	Endline	**3.018*** [2.658, 3.428] p=0.000**	1.053 [0.837, 1.325] p=0.659	0.734 [0.447, 1.205] p=0.221
Study Group	Control	1		1
	Intervention	**2.127*** [1.535, 2.946] p=0.000**	1.170 [0.862, 1.586] p=0.312	**0.895* [0.812, 0.986] p=0.025**
Sex	Boy	1	1	1
	Girl	**1.014* [1.000, 1.027] p=0.045**	**1.054*** [1.049, 1.057] p=0.000**	**1.372*** [1.361, 1.384] p=0.000**
Average treatment effect	Baseline#Intervention Baseline#Control Endline#Control	1	1	1
	Endline#Intervention	**1.645* [1.128, 2.399] p=0.010**	**2.199*** [1.617, 2.991] p=0.000**	1.441[0.877,2.366] p=0.149
Adjusted inverse probability Weighting (AIPW)				
Awareness and knowledge	**Categories**	**Coefficient:**	**Coefficient:**	**Coefficient:**
Average treatment effect on the treated (ATET)	Baseline#Intervention	1	1	1
	Endline#Intervention	**0.155*** [0.112, 0.199] p=0.000**	**0.202*** [0.132, 0.272] p=0.000**	0.012 [-0.054, 0.0772] p=0.728

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

Children in the endline intervention group were significantly more likely than those in the baseline intervention group to know their rights. In fact, children in the intervention endline group were significantly more likely to know about their rights than the combination of those in the intervention baseline group, the baseline control group, and the endline control group. All children in the intervention group were twice as likely as those in the control group to have knowledge of their rights, and girls were significantly more likely boys to have such knowledge.

Children in the endline intervention group were significantly more likely than those in the baseline intervention group to know at least three rights. Importantly, children in the endline intervention group were twice as likely to know at least three rights than the combination of those in the baseline intervention group, baseline control group, and endline control group. Additionally, girls were much more likely to know at least three rights than boys.

By endline, there was no significant change in the awareness of harmful CSA-related practices between the endline intervention group and the baseline intervention group, or the baseline intervention group, baseline control group, and the endline control groups combined. Children in the control groups were significantly more likely than those in the intervention groups to be aware of harmful practices. Also, girls were significantly more likely than boys to be aware of harmful practices.

Girls were much more likely to know at least three rights than boys.

Indicator 3B

Children who believe in their ability to resist abuse and who possess a sense of self-efficacy in reporting CSA.

The SAFE Program CSA Prevention Curriculum aims to empower children to have self-efficacy, and positive beliefs and attitudes in relation to preventing and responding to CSA. We assessed these traits during the baseline and endline studies.

Table C4 (see Appendix C) provides insights into shifts in children's efficacy to resist abuse and report CSA.

Children were asked whether they agreed with the statement that it is sometimes acceptable to say 'no' to an adult. The proportion of children who agreed with this statement decreased at endline by 15 percent in the control group and by 6 percent in the intervention group. This could be due to strong social norms emphasizing that children should respect and listen to elders. However, a majority agreed that they should report a teacher who engages in sexual behavior with a school friend, with a greater positive shift among children in the control group (6 percent) than in the intervention group (0.5 percent).

For the remainder of sub-indicators under Indicator 3B, we assessed whether children had positive or negative beliefs, attitudes, or perceptions about CSA-related issues, and how the CSA Prevention Curriculum influenced such viewpoints over time.

Table C5 (Appendix C) provides insights into shifts in children's beliefs, perceptions, and attitudes towards SVAC. The percentage of children who agreed that it is acceptable to say 'no' if someone touches you in a way you don't like and to move away from them decreased by 5 percent in the control group and by 4 percent in the intervention group.

The percentage of children who agreed that it is acceptable to say 'no' if someone touches you in a way you don't like and to move away from them decreased by 5 percent in the control group and by 4 percent in the intervention group.

The proportion of children who held the positive perception that they did not have to let grown-ups touch them regardless of whether they liked it or not increased more in the intervention group (by 8 percent) than in the control group (by 5 percent).

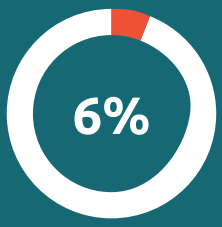
Children's attitude towards keeping secrets was assessed in the study. At endline, the proportion of children who believed they had to keep secrets increased more in the control group (by 9 percent) than in the intervention group (by 3 percent). During participatory sessions, some children mentioned that they recognized the danger of keeping secrets. One boy in the 9-to-10-year-old age group said:

> ***"If someone tells me something I don't understand as a child, I should always tell my parents and teachers."***

During the survey, children were asked if they should keep it secret when someone touched them in a way they didn't like. Although a majority of interviewed children had a positive belief about reporting inappropriate touching, the proportion of children in the control group with this belief increased by only 0.3 percent from baseline to endline. However, this proportion increased by 7 percent in the intervention group.

It should also be noted that self-reported CSA prevention approaches mentioned by children place too much responsibility on children to protect themselves, potentially leading to victim-blaming if abuse occurs.

90 percent of children had a positive belief about reporting instances of feeling uncomfortable when someone walked in on them during bathtime.



By endline, **6 percent** more children in the intervention group (9 percent) than in the control group (3 percent) agreed that boys and men cannot just have sex with a girl or coerced sex with a woman without consequences or reprimand.

Children were also asked if it is the child's fault when someone touches them in a way they don't like. The proportion of children who held a negative belief in this regard (i.e., the child is at fault) increased by 3 percent in the control group and by 2 percent in the intervention group by endline. Children were also asked whether boys need to worry about someone touching their private parts. The proportion of children in the intervention group who were cognizant of this type of sexual abuse increased by 6 percent and by 5 percent in the control group.

The majority (about 90 percent) of children had a positive belief about reporting instances of feeling uncomfortable when someone walked in on them during bathtime. The proportion of children with this positive belief increased by 6 percent in the control group and by 5 percent in the intervention group.

We assessed children's perception of the statement: "Even hugs and tickles can turn into bad touches if they go on too long." Whereas the proportion of children who agreed with this statement increased in both study groups between baseline and endline, the increase in the control group was only 1 percent and the increase in the intervention group was 4 percent.

By endline, 6 percent more children in the intervention group (9 percent) than in the control group (3 percent) agreed that boys and men cannot just have sex with a girl or coerced sex with a woman without consequences or reprimand.

A composite variable for beliefs was created by combining nine selected parameters, as shown in Table C5 (Appendix C). A score greater than 6 was considered indicative of positive beliefs, while a score of 5 or less indicated negative beliefs. The reliability of the composite variable (tested by Cronbach's alpha) was 0.72, indicating good reliability. By endline, the proportion of children with positive beliefs in the control group increased by 1 percent and by 3 percent in the intervention group, underscoring the positive impact of the CSA Prevention Curriculum on children's beliefs.

Children's attitudes toward CSA were assessed by seeking their opinion on several statements (see Table C6, Appendix C). By endline, the proportion of children who indicated that a teacher who engages in sexual contact with a child should be reported increased by 8 percent in the control group and by 5 percent in the intervention group. During participatory sessions, children expressed their understanding of the importance of reporting CSA; with one girl in the 11-to-14-year-old age group noting:

> ***"If a teacher engages in sexual behavior with a friend, we should report it to another teacher or the headmaster."***

At endline, the proportion of children who reported a positive attitude toward reporting a relative who engages in sexual contact with a child increased by 19 percent in the control group and by 16 percent in the intervention group.

On the other hand, the proportion of children who held a negative belief that children who do not report sexual abuse against them want the abuse to continue increased more in the control group (by 7 percent) than in the intervention group (by 3 percent).

A composite variable for attitudes was created by combining three selected parameters, as shown in Table C6 (Appendix C). A score greater than 2 was considered indicative of positive attitudes otherwise not. The reliability of the composite variable (tested by Cronbach's alpha), was 0.87, indicating good reliability. By endline, the proportion of children with positive attitudes in the control group increased by 20 percent and by 16 percent in the intervention group. The improvements in the intervention group show the positive impact of the curriculum on children's attitudes regarding CSA.

19%

The proportion of children at endline, who reported a positive attitude toward reporting a relative who engages in sexual contact with a child increased by 19 percent in the control group and by 16 percent in the intervention group.

Table 13: Difference in Differences analysis on change in beliefs and attitudes on CSA.

Variable	Categories	Odds ratios: *Beliefs (bel)*	Odds ratios: *Attitudes (att)*
Study Phase	Baseline	1	1
	Endline	1.194 [0.261, 5.450] p=0.819	**20.326*** [3.663, 112.673] p=0.001**
Study Group	Control	1	1
	Intervention	0.690 [0.395, 1.206] p=0.193	0.985 [0.699, 1.387] p=0.930
Sex	Boy	1	1
	Girl	**1.542*** [1.537, 1.547] p=0.000**	**1.423*** [1.411, 1.435] p=0.000**
Average treatment effect	Baseline#Intervention Baseline#Control Endline#Control	1	1
	Endline#Intervention	1.424 [0.759,2.670] p=0.271	0.241 [0.046, 1.270] p=0.093
Adjusted inverse probability Weighting (AIPW)			
Knowledge, beliefs, and Attitudes	**Categories**	**Coefficient:**	**Coefficient:**
Average treatment effect on the treated (ATET)	Baseline#Intervention	1	1
	Endline#Intervention	0.030 [-0.003, 0.631] p=0.080	**0.160*** [0.115, 0.203] p=0.000**

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

Findings in table 13 show that children in the intervention group did not experience significant changes in positive beliefs regarding CSA by endline but did experience significant increases in positive attitudes. Girls were likelier to have more positive beliefs and attitudes than boys.

Indicator 3C

Percentage of children taking on a more active role in preventing and reporting child sexual abuse within schools and communities. (Behavior/Practice)

At home, parents are caregivers are the closest adults to children and teachers are the closest adults at school. Children need to openly and freely discuss or disclose any worrying issues they have with their parents or caregivers.

Table D4 (Appendix D) shows that the proportion of children who felt willing to report worrying concerns at home to their parents increased by 4 percent in both study groups from baseline to endline.

Children were also asked if they had a teacher to whom they could easily speak about or report worrying issues at school. By endline, the proportion of children identifying such a teacher increased by 16 percent in the intervention group and by 6 percent in the control group. Two children in the 11-to-14-year-old age group said:

> ***"There is a teacher at school who we can talk to if we have any problems. She is very understanding."***
> —Girl FGD participant

> ***"I feel confident to report any issues to my class teacher. He always listens and takes action."***
> —Boy FGD participant

It is important for children to have the confidence to speak out on issues or violations against them, no matter who the perpetrator is and what position they hold in the family or in society. By endline, the proportion of children in who reported that they would speak up if they saw a peer being hurt rose by 5 percent in the control group but only by 3 percent in the intervention group. A teacher who also serves as a grassroots soccer coach noted:

> ***"These learners are now the ones reporting cases; for example, when a classmate drops out, has been defiled, or is facing another issue. When they bring such concerns to us, we take them to the headteacher, who … involves a parasocial worker."***

A composite variable for children speaking up and reporting worrying concerns was created by combining three selected parameters, as shown in Table D4 (Appendix D). A score greater than 2 was considered indicative of increased confidence in the ability to speak up and report worrying concerns, otherwise low confidence in the ability to speak up and report worrying concerns. The reliability of the composite variable (tested by Cronbach's alpha) was 0.74, indicating good reliability. By endline, 5 percent more children in the intervention group than in the control group expressed increased confidence in the ability to speak up and report worrying concerns. This underscores the positive impact of the CSA Prevention Curriculum in building children's confidence to speak up and report worrying concerns.

During participatory sessions, children shared their experiences and confidence in reporting CSA and speaking up about violations, with several saying,

> ***"I can talk to my parents about anything that worries me. They always listen and help me."***
> —Girl FGD participant (9-to-10-year-old age group)

> ***"When I feel scared or uncomfortable, I tell my mother, and she helps me." —Boy FGD participant (9-to-10-year-old age group) "If I see someone being hurt, I will speak up and tell an adult. It's important to protect each other."***
> —Girl FGD participant (11-to-14-year-old age group)

> ***"We should always speak up when we see something wrong happening to our friends."***
> —Boy FGD participant (9-to-10-year-old age group)

These qualitative findings support the quantitative data, indicating that children in the intervention group have increased confidence in reporting CSA and in speaking up about violations.

The research continued to explore the various aspects related to children's confidence in their ability to navigate sensitive topics, including their willingness to disclose experiences of sexual violence, their ability to resist peer pressure, and confidence in their ability to make informed sexual choices. This analysis provides patterns, trends, and relationships that can inform the SAFE Program on supporting and empowering children in their interactions with peers, caregivers, and broader social actors.

Table D5 (Appendix D) highlights children's self-reported confidence in their ability on a number of SVAC-related parameters. Findings show that there was a 5 percent increase in the proportion of children in the control group who indicated that a child should report cases in which a teacher engages in sexual behavior with a fellow student. Although the proportion of such children in the intervention group remained high (92 percent), there was only a 0.5 percent increase by endline.

Similarly, although over 90 percent of children expressed confidence in their ability to report sexual abuse perpetrated against them, this proportion increased by 4 percent at endline in the intervention group and by merely 0.4 percent in the control group. One key informant highlighted increased confidence among children who participated in the curriculum, stating:

> ***"...the learners have grown more confident and are now able to report these issues (cases of abuse) themselves."***

Over 90 percent of children expressed confidence in their ability to report sexual abuse perpetrated against them.

The majority of children (over 90 percent) expressed confidence in their ability to report a sexual abuse perpetrator in cases where they were sexually abused. While the proportion of the children in the intervention group increased by 6 percent by endline, their counterparts in the control schools decreased by 1 percent.

Findings still show that over 90 percent of child respondents expressed confidence in their ability to seek support services following sexual abuse. While the proportion of such children increased by 6 percent in intervention schools, it decreased by 4 percent in control schools.

Over 90 percent of children across both study groups expressed confidence in being able to resist pressure from a teacher or relative to engage in sex, including a 6 percent increase from baseline to endline in the intervention group and a 4 percent increase in the control group.

A composite variable for agency (confidence in children's ability) was created by combining five selected parameters, as shown in Table D5 (Appendix D). A score greater than 3 was considered indicative of high agency otherwise not. The reliability of the composite variable (tested by Cronbach's alpha) was 0.73, indicating good reliability. By endline, the proportion of children with high agency in the intervention group had increased by 10 percent and decreased by 1 percent in the control group. The increase in agency among children in the intervention school underscores the role of the SAFE Program's CSA Prevention Curriculum in building children's agency.

Children's confidence in their ability to enact preferences over life choices was assessed in the study, as shown in Table D6 (Appendix D). There was a significant increase of 13 percent in the proportion of children in intervention schools who would resist peer pressure from friends to do what they believe is right, whereas the proportion of such children increased by only 0.3 percent in control schools. Additionally, 5 percent more children in the intervention schools than in the control group said that they would not have sex with a person even if that person held power over them (e.g., a relative, local leader, or teacher).

90%

of children expressed confidence in their ability to report a sexual abuse perpetrator in cases where they were sexually abused.

Table 14: Difference in Differences analysis on change in agency, reporting, and enacting preferences over life choices.

Variable	Categories	Odds ratios: *Reporting (rep)*	Odds ratios: *Agency (agc)*	Odds ratios: *Life Choices (lc)*
Study Phase	Baseline	1	1	1
	Endline	**1.579*** [1,239, 2.013] p=0.000**	0.952 [0.755, 1.201] p=0.678	0.552 [0.251, 1.212] p=0.139
Study Group	Control	1	1	1
	Intervention	**1.196** [1.042, 1.374] p=0.011**	**0.524** [0.318, 0.863] p=0.011**	**0.291* [0.112, 0.755] p=0.011**
Sex	Boy	1	1	1
	Girl	**0.843*** [0.843, 0.843] p=0.000**	**0.690*** [0.672, 0.709] p=0.000**	**0.977*** [0.966, 0.988] p=0.000**
Average treatment effect	Baseline#Intervention Baseline#Control Endline#Control	1	1	1
	Endline#Intervention	1.230 [0.805, 1.880] p=0.338	**1.971*** [1.451, 2.678] p=0.000**	**4.978** [1.527, 16.220]**
Adjusted inverse probability Weighting (AIPW)				
Reporting SVAC	**Categories**	**Coefficient** *Reporting (rep)*	**Coefficient** *Agency (agc)*	**Coefficient** *Life Choices (lc)*
Average treatment effect on the treated (ATET)	Baseline#Intervention	1	1	1
	Endline#Intervention	**0.160*** [0.090,0.229] p=0.000**	**0.105*** [0.047, 0.162] p=0.000**	**0.166*** [0.109, 0.222] p=0.000**

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

Children in the intervention group were significantly more likely to self-report confidence in their ability to report CSA at endline than at baseline. Similarly, children were significantly more likely at endline to self-report increased confidence in their ability to report CSA. Moreover, children in the intervention group were significantly more likely to self-report increased confidence in their ability to report CSA than those in the control group. Finally, girls expressed less confidence than boys in their ability to report CSA.

Children in the intervention group were significantly more likely to report increased agency in their ability to resist CSA at endline than children in the combined baseline intervention, baseline control, and endline control groups. Girls expressed significantly less agency in their ability to resist CSA than the boys.

Children in the intervention group were 4.5 times more likely to self-report increased ability to enact preferences over life choices than the combination of children in the baseline intervention, baseline control, and endline control groups. Children in the intervention group indicated a significantly lesser likelihood of making better life choices than those in the control group. Additionally, girls had a significantly lesser likelihood than boys of self-reporting an ability to enact preferences over life choices.

Children in the intervention group were 4.5 times more likely to self-report increased ability to enact preferences over life choices

4.0 DISCUSSION

The SAFE Program CSA Prevention Curriculum aimed to address child sexual abuse in Western Uganda by engaging teachers, caregivers, and children in raising awareness, changing attitudes, and improving behaviors. Literature shows that CSA prevention programs can reduce the incidence of abuse and or play a critical role in enabling earlier detection and response.

The initial step in preventing CSA is enhancing the knowledge of children and adults to identify CSA.[14] Our study revealed significant improvements in teachers' awareness of child safeguarding policies and their attitudes towards reporting CSA. By endline, teachers in the intervention group were significantly more likely to know that safeguarding policies existed in their schools (p=0.019) and were more aware of the enforcement of these policies (p=0.000). Female teachers were significantly more likely than male teachers to know about safeguarding policies (p=0.000) and be aware of their enforcement. Qualitative data also confirmed these findings, SAFE Program Grassroots Soccer coaches, many of whom were teachers in the intervention schools, frequently expressed strong commitment to safeguarding children.

Still, the intervention did not significantly impact teachers' willingness to report CSA if their school administration disagreed or if they feared family or community retaliation. Key informant interview data indicates that, in addition to fear of retaliation, barriers to teachers' willingness to report CSA include a lack of trust in authorities to handle CSA cases.

Qualitative data revealed that parents and caregivers who participated in the SAFE Program toolkit training were more likely to discuss CSA and sexuality education with their children. The SAFE model considers caregiver–child conversations on peer pressure a critical strategy that contributes to the prevention of CSA. Quantitative analysis corroborates these findings, showing that parents and caregivers in the intervention group were nearly nine times more likely than their control group counterparts to have participated in discussions on CSA risks in their community. However, female parents and caregivers were significantly less likely to have discussed community CSA risks than their male counterparts. One possible explanation of

Parents and caregivers in the intervention group were nearly nine times more likely than their control group counterparts to have participated in discussions on CSA risks in their community.

this result is the link between gender roles and access to information. In many communities, men often have more opportunities to engage in public spaces where educational messages are disseminated, such as community meetings, workplaces, and social gatherings.[15] Cultural norms and responsibilities might also play a role. That is, because women are often the primary caregivers in their families, they may have less time to engage with media or attend informational sessions .[16]

Despite positive changes among parents and caregivers, we found that the intervention did not significantly impact their willingness to report CSA if their partner was against it, especially among women. Studies have shown an association between disclosure of CSA and stressful experiences for parents and caregivers. The events that follow disclosure (e.g., police investigations, testifying in court, seeking medical services, and family conflict in cases of familial abuse) can be unexpected and traumatizing. [17,18] Additionally, the intervention made no significant impact on caregivers' CSA-related norms and practices by endline; though female caregivers were significantly more likely than men to have positive attitudes about CSA-related norms and practices. These findings can be attributed to several cultural, societal, and gender-specific factors prevalent in Western Uganda and similar communities, in many communities, family reputation and community standing are highly valued, and reporting CSA can be seen as disgracing the family. This may especially deter caregivers from speaking up if their partner is against it or if the perpetrator is the family provider.[19] Traditional gender roles also play a significant role, as discussions about sexuality are often considered taboo and thus prevent female caregivers from disclosing abuse. As Turyomurugyendo's study on parents' reactions to the disclosure of CSA shows, mothers may be

“Despite positive changes among parents and caregivers, we found that the intervention did not significantly impact their willingness to report CSA if their partner was against it, especially among women.”

more interested in protecting their child, while male parents or caregivers may feel a stronger sense of responsibility in ensuring the offender is punished, and may therefore be more willing to report CSA despite opposition from their partner. [17] Additionally, the collectivist nature of some societies, where the needs of the group may take precedence over those of the individual, may further discourage caregivers from reporting CSA due to concerns about community reputation and harmony.[20] The stigma and shame surrounding CSA contribute to a culture of silence and secrecy. In Rutoroo, this deeply ingrained norm of non-disclosure is referred to as *kitadungaho* (I will not let secrets out). Studies have found that such cultural expectations of silence create major barriers to CSA disclosure.[17,19,20] Existing literature emphasizes the importance of addressing cultural norms and societal attitudes to enhance parental involvement in CSA prevention and promote a supportive environment for reporting abuse. [21,22]

The intervention and its positive impact on children are supported by existing literature, which underscores the importance of empowering children with knowledge and skills to protect themselves from CSA. According to Finkelhor et al (2014), educational programs that focus on children's rights and self-protection can significantly reduce the risk of CSA.[23]

Our study showed significant improvements in children's knowledge of their rights and increased confidence in their ability to report CSA. By endline, children in the intervention group were twice as likely as children in the control group to know at least three of their rights, with girls significantly more likely than boys to have such knowledge. Children in the intervention group were significantly more likely to self-report an increased ability to report CSA, increased agency in their ability to resist CSA, and an increased ability to enact preferences over life choices. Boys significantly outpaced girls in these three aspects. Qualitative findings show that children recognize CSA-related harmful practices in their communities, although the

intervention did not significantly impact children's awareness of these practices.

The study registered a significant positive shift in children's attitudes towards CSA in the intervention group. However, there was no statistical significance in the positive shift in children's beliefs in the intervention group. Worryingly, the analysis revealed a decrease in the proportion of children who felt that it was not acceptable to say 'no' to an adult at any time or to resist and move away when an adult touched them inappropriately. Additionally, there was an increase in the number of children endorsing victim-blaming attitudes toward peers who experienced unwanted touches. Research suggests that societal norms and values can influence children to reinforce practices that compromise their dignity, as seen in these examples. To uphold children's rights, it is crucial to address and challenge such harmful beliefs and practices. Such transformation requires culturally sensitive strategies that actively involve children and their communities. Participatory approaches, including the dissemination of informational materials that are child-friendly and age-appropriate, can empower children by enhancing their self-esteem and confidence, ultimately equipping them to navigate and respond effectively to CSA and other risky situations.[24]

It is noteworthy that children's awareness of harmful practices in their communities did not shift appreciably. This finding could be due to the normalization of some harmful practices in the community. Additionally, the CSA prevention approaches self-reported by children place too much responsibility on children to protect themselves, potentially leading to victim-blaming if abuse occurs. Additionally, while children may gain knowledge and confidence, their actual ability to prevent abuse may be limited by factors beyond their control, such as power dynamics with adults and societal norms; and these challenges should be precisely targeted to be diffused by CSA prevention interventions.

Despite efforts to prevent CSA, stakeholders noted that there were still cases of child abuse in the communities, which were at times perpetrated by family members and the result of children being exposed to activities that put them at risk of abuse.

“Children's awareness of harmful practices in their communities did not shift appreciably. This finding could be due to the normalization of some harmful practices in the community.”

5.0 CONCLUSION AND RECOMMENDATIONS

The findings from this study provide valuable insights for future interventions aimed at preventing and responding to CSA in similar settings. The significant improvements in teachers, caregivers, and children's knowledge, attitudes, and behaviors underscore the effectiveness of the SAFE Program CSA Prevention Curriculum. However, the study also highlights the need for continuous support, targeted interventions, and longer implementation periods to sustain positive changes and address deeply ingrained cultural attitudes.

We recommend the following with respect to the SAFE Program's CSA Prevention Curriculum:

1. **Future studies should consider a more robust randomized control trial before scaling up the SAFE Program's CSA Prevention Curriculum.** Although the curriculum aimed to reduce harmful norms, build children's agency, and increase willingness to report CSA, the findings revealed some unintended negative outcomes. These included a decline in caregivers' willingness to report CSA and a decrease in the proportion of children who felt it was acceptable to say 'no' to adults, even in instances when they were touched inappropriately. These undermine the program's intended protective effects. In response, there is an urgent need for future randomized control trials to test mechanisms for increasing people's willingness to report CSA in communities where cultural norms may discourage disclosure, and to explore culturally-sensitive approaches for building agency among in contexts where unquestioned respect for adult authority is expected.

2. Program implementers should critically **reassess how social norms regarding respect for adults and authority figures are framed within training content** to avoid reinforcing the idea that children must always comply with adults, even in harmful situations. This recommendation is driven by findings from the study that revealed a decline in the proportion of children who felt it was acceptable to say 'no' to adults, even when touched inappropriately. Emphasizing absolute obedience can leave children vulnerable to abuse and discourage them from resisting or reporting inappropriate behavior this will. Therefore, future curriculum content should strike a careful balance, promoting respect for adults while also empowering children to recognize and respond appropriately to abuse.

3. **Training and sensitization efforts should avoid emphasizing children's involvement in CSA prevention, since this may unintentionally create victim-blaming or self-blame when abuse happens** . Our study findings showed an increase in the proportion of children believing that it is a child's fault if someone

“Program implementers should critically reassess how social norms regarding respect for adults and authority figures are framed within training content to avoid reinforcing the idea that children must always comply with adults, even in harmful situations.”

touches them in a way they do not like. These unintended outcomes suggest that framing children as primarily responsible for preventing abuse may contribute to victim-blaming or self-blame when abuse occurs. Programs should thus focus on fostering children's confidence to seek help, reinforcing that abuse is never the child's fault, and strengthening the accountability of adults and institutions to protect children.

4. The implementing team should utilize **evidence-based practices** derived from the research findings and implementation experience to inform adaptation and improvement of the SAFE Program CSA Prevention Curriculum and its implementation.
5. **Follow-up research studies** (post-intervention studies) could be undertaken to understand changes in the curriculum participants' behavior over time. Understanding long-term behavior change will provide additional valuable insights into the sustained effectiveness of the SAFE Program CSA Prevention Curriculum and help identify areas where program adjustments or reinforcement strategies may be necessary.
6. The **curriculum should be formally translated into local languages** for consistency in message delivery during training and implementation. Currently, the curriculum is documented in English and facilitators are responsible for real-time translation during sessions. This approach risks inconsistencies in how key concepts are conveyed and interpreted across different facilitators, trainee groups, and cohorts. Providing standardized translations will help ensure that facilitators deliver content accurately and consistently, while enabling participants, particularly caregivers and children, to engage more fully with the material in a language they understand.

“The curriculum should be formally translated into local languages for consistency in message delivery during training and implementation.”

References

1. Government of Uganda. *National Child Policy*.; 2020. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.unicef.org/uganda/media/8166/file/Final-Uganda-National%20Child%20Policy-October-2020-lores.pdf
2. Ministry of Gender, Labour and Social Development. *Violence against Children in Uganda: Findings from a National Survey*. UNICEF; 2015. Accessed March 18, 2025. https://www.unicef.org/uganda/reports/uganda-violence-against-children-survey
3. Hemming K, Girling AJ, Sitch AJ, Marsh J, Lilford RJ. Sample size calculations for cluster randomised controlled trials with a fixed number of clusters. *BMC Med Res Methodol*. 2011;11:102. doi:10.1186/1471-2288-11-102
4. COLLINGS SJ. Development, Reliability, and Validity of the Child Sexual Abuse Myth Scale. *J Interpers Violence*. 1997;12(5):665-674. doi:10.1177/088626097012005004
5. Salvagni EP, Wagner MB. Development of a questionnaire for the assessment of sexual abuse in children and estimation of its discriminant validity: a case-control study. *J Pediatr (Rio J)*. 2006;82(6):431-436. doi:10.2223/JPED.1523
6. Chen JQ, Chen DG. Awareness of child sexual abuse prevention education among parents of Grade 3 elementary school pupils in Fuxin City, China. *Health Education Research*. 2005;20(5):540-547.
7. Tutty LM. The revised Children's Knowledge of Abuse Questionnaire: Development of a measure of children's understanding of sexual abuse prevention concepts. *Social Work Research*. 1995;19(2):112-120.
8. Anderson. History of the Touch Continuum (From Educator's Guide to Preventing Child Sexual Abuse, P 15-25, 1986, Mary Nelson and Kay Clark, eds. - See NCJ-104251) | Office of Justice Programs. 1986. Accessed February 12, 2025. https://www.ojp.gov/ncjrs/virtual-library/abstracts/history-touch-continuum-educators-guide-preventing-child-sexual
9. Bandura A. On the Functional Properties of Perceived Self-Efficacy Revisited. *Journal of Management*. 2012;38(1):9-44. doi:10.1177/0149206311410606
10. Taber KS. The Use of Cronbach's Alpha When Developing and Reporting Research Instruments in Science Education. *Res Sci Educ*. 2018;48(6):1273-1296. doi:10.1007/s11165-016-9602-2
11. Jack Barbera, Nicole NaibertRegis KomperdaThomas C. Pentecost. Clarity on Cronbach's Alpha Use | Journal of Chemical Education. 2020. Accessed November 8, 2024. https://pubs.acs.org/doi/10.1021/acs.jchemed.0c00183
12. Noel K, Heil B. Land-use land cover changes and their relationship with population and climate in Western Uganda. *Journal of Degraded and Mining Lands Management*. 2024;11:6201-6212. doi:10.15243/jdmlm.2024.114.6201

13. UBOS. *Annual Agricultural Survey 2019 Report.* Uganda Bureau of Statistics (UBOS); 2022. https://www.ubos.org/wp-content/uploads/publications/04_2022AAS2019_Report.pdf

14. Ferragut M, Cerezo MV, Ortiz-Tallo M, Rodríguez-Fernandez R. Effectiveness of child sexual abuse prevention programs on knowledge acquisition: A meta-analytical study. *Child Abuse & Neglect*. 2023;146:106489. doi:10.1016/j.chiabu.2023.106489

15. Lee M. Breaking Down Barriers: Navigating the Cultural Impact on Child Abuse Cases. NCACIA Protection. July 31, 2023. Accessed March 18, 2025. https://www.ncacia.org/post/breaking-down-barriers-navigating-the-cultural-impact-on-child-abuse-cases

16. UN Women. *LANDSCAPE OF CARE WORK IN UGANDA*. UN Women office publishing: East and Southern Africa Regional Office; 2024. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://africa.unwomen.org/sites/default/files/2024-06/landscape_of_care_-_uganda.pdf

17. Turyomurugyendo F, Twikirize JM, Walakira EJ, Revheim C. Negative reactions of Uganda's parents towards the disclosure of child sexual abuse and perceived psychosocial consequences on survivors. *Journal of Social Work in Developing Societies*. 2024;6(3):1-19. doi:10.4314/jswds.v6i3.1

18. Cyr M, Hébert M, Frappier JY, Tourigny M, McDuff P, Turcotte ME. Parental Support Provided by Nonoffending Caregivers to Sexually Abused Children: A Comparison Between Mothers and Fathers. *Journal of Child Custody*. 2014;11:216-236. doi:10.1080/15379418.2014.954688

19. Waiswa EK, Kiconco M, Namara S& NL. Socio-cultural barriers to child sexual abuse investigation in Uganda: Experiences of police officers at Kamuli District central police station. IIARI. 2025. https://iiari.org/journal_article/socio-cultural-barriers-to-child-sexual-abuse-investigation-in-uganda-experiences-of-police-officers-at-kamuli-district-central-police-station/

20. NDHLOVU N G, Mfoafo-M'carthy M. Exploring the culture of silence on child sexual abuse within the family in Zimbabwe: A review of the literature. IJSSASS Repository. 2022. https://ijssass.com/journal/exploring-the-culture-of-silence-on-child-sexual-abuse-within-the-family-in-zimbabwe-a-review-of-the-literature/

21. Kamukama A, Luwaga R, Tugume R, et al. Exploring parental understanding of child sexual abuse and prevention as a measure for HIV prevention in Rwampara district. *PLoS One*. 2022;17(6):e0269786. doi:10.1371/journal.pone.0269786

22. Meinck F, Cluver LD, Boyes ME, Loening-Voysey H. Physical, emotional and sexual adolescent abuse victimisation in South Africa: prevalence, incidence, perpetrators and locations. *J Epidemiol Community Health*. 2016;70(9):910-916. doi:10.1136/jech-2015-205860

23. Finkelhor D, Shattuck A, Turner HA, Hamby SL. The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *J Adolesc Health*. 2014;55(3):329-333. doi:10.1016/j.jadohealth.2013.12.026

24. Blanchet-Cohen N. Children, agency and violence: in and beyond the United Nations study on violence against children. *UNICEF Innocenti Research Centre, Innocenti Working Papers*. Published online January 1, 2009.

Appendices

Appendix A: Social Demographics

Table A1: Differences between study group sample sizes at baseline and endline

Respondent Categories	Study group	Study phase		Chi square	df	p-value
		Baseline	*Endline*			
Children	Control	207 (29.3)	157 (32.5)	1.407	1	0.236
	Intervention	500 (70.7)	326 (67.5)			
Caregivers	Control	188 (53.3)	165 (46.7)	**17.221*** **	1	**0.000**
	Intervention	486 (66.3)	247 (33.7)			
Teachers	Control	43 (58.1)	31 (41.9)	0.073	1	0.787
	Intervention	86 (56.2)	67 (43.8)			

***0.001 significance level

Table A2: Socio-demographic characteristics of teachers across study groups and study phases

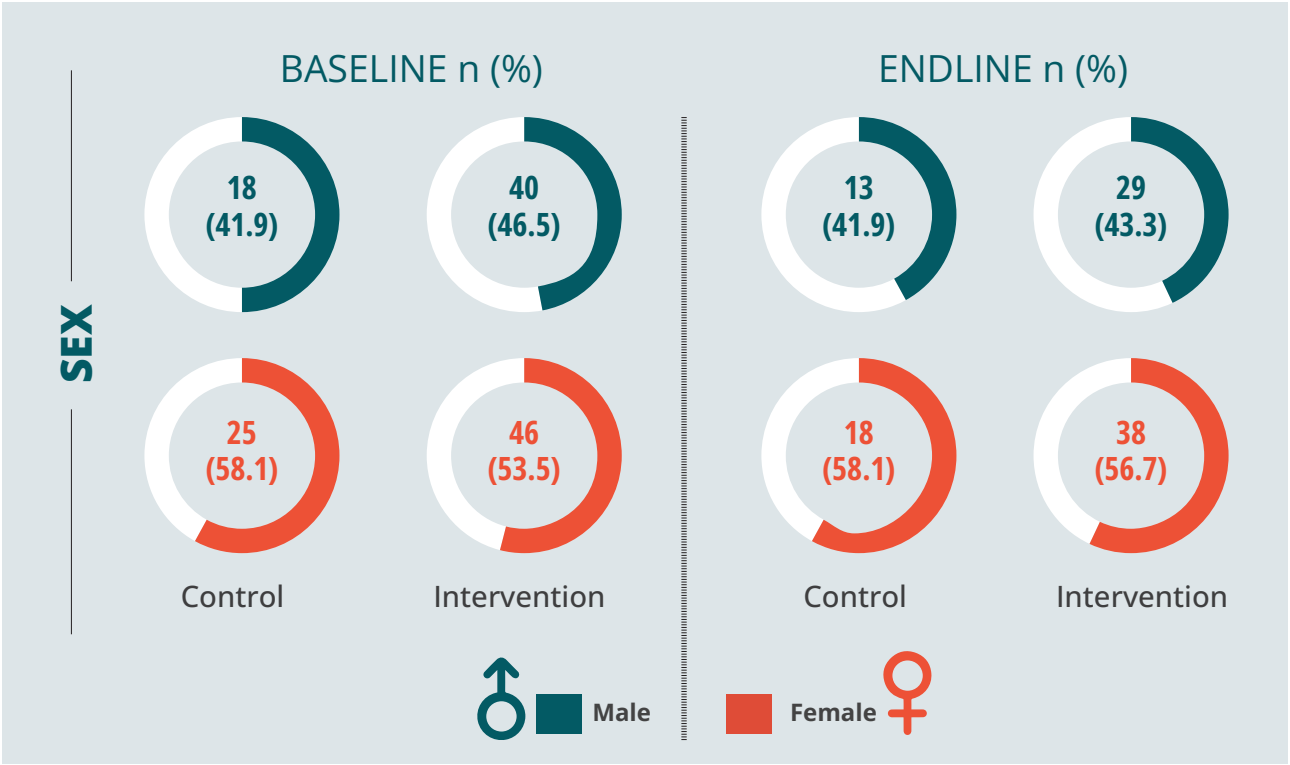


Table A2: Socio-demographic characteristics of teachers across study groups and study phases

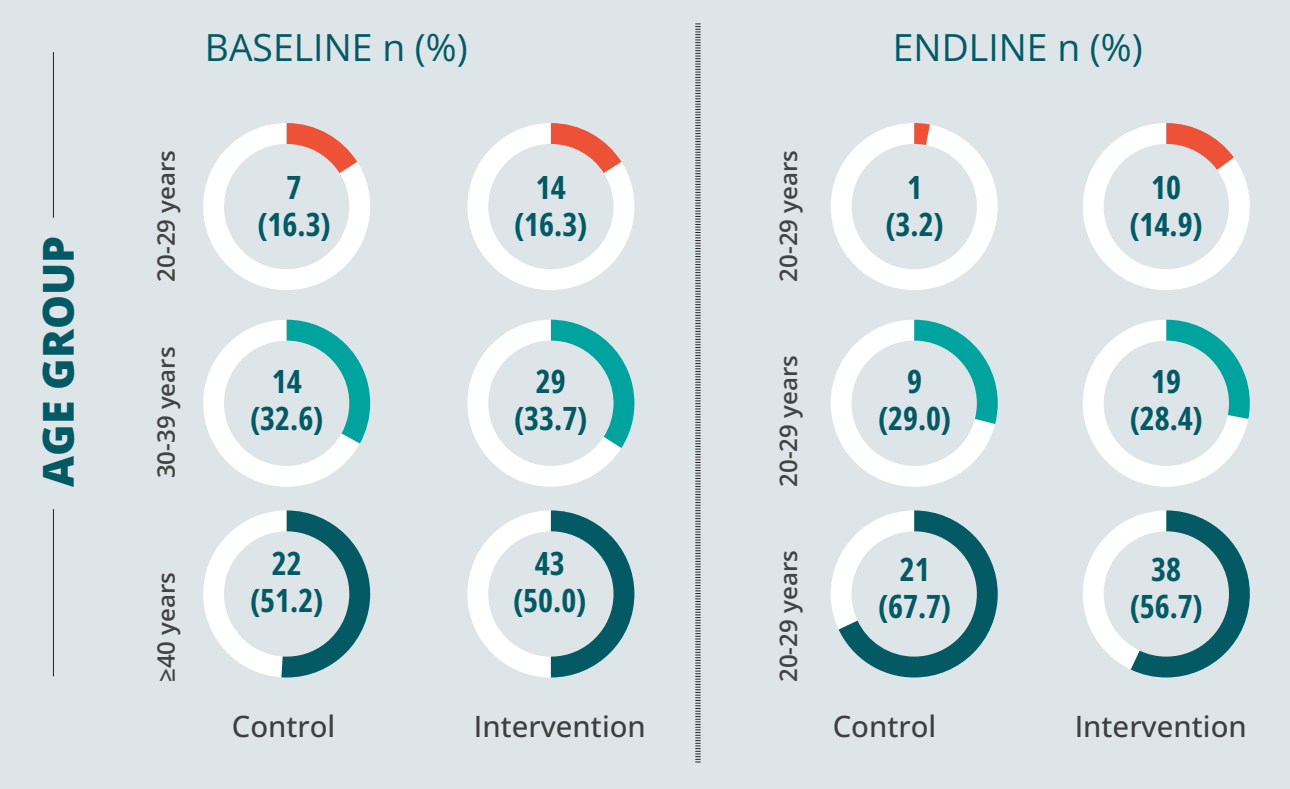


Table A3: Socio-demographic characteristics of parents and caregivers across study groups and study phases

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
Age group	18-24 years	4 (2.1)	7 (1.4)	2 (1.2)	1 (0.4)
44.6 ± 12.1	25-34 years	36 (19.1)	81 (16.7)	24 (14.5)	38 (15.4)
	≥35 years	148 (78.7)	398 (81.9)	139 (84.2)	208 (84.2)
Sex	Male	64 (34.0)	163 (33.5)	55 (33.3)	65 (26.3)
	Female	124 (66.0)	323 (66.5)	110 (66.7)	182 (73.7)
Level of education	Primary	101 (53.7)	298 (61.3)	41 (24.8)	53 (21.5)
	Post Primary	44 (23.4)	87 (17.9)	21 (12.7)	21 (8.5)
Marital Status	Single	15 (8.0)	52 (10.7)	10 (6.1)	17 (6.9)
	Married/Cohabiting	129 (68.6)	346 (71.2)	114 (69.1)	173 (70.0)
	Widowed	20 (10.6)	49 (10.1)	24 (14.5)	25 (10.1)
	Separated/Divorced	24 (12.8)	39 (8.0)	17 (10.3)	32 (13.0)

Table A4: Socio-demographic characteristics of children across study groups and study phases

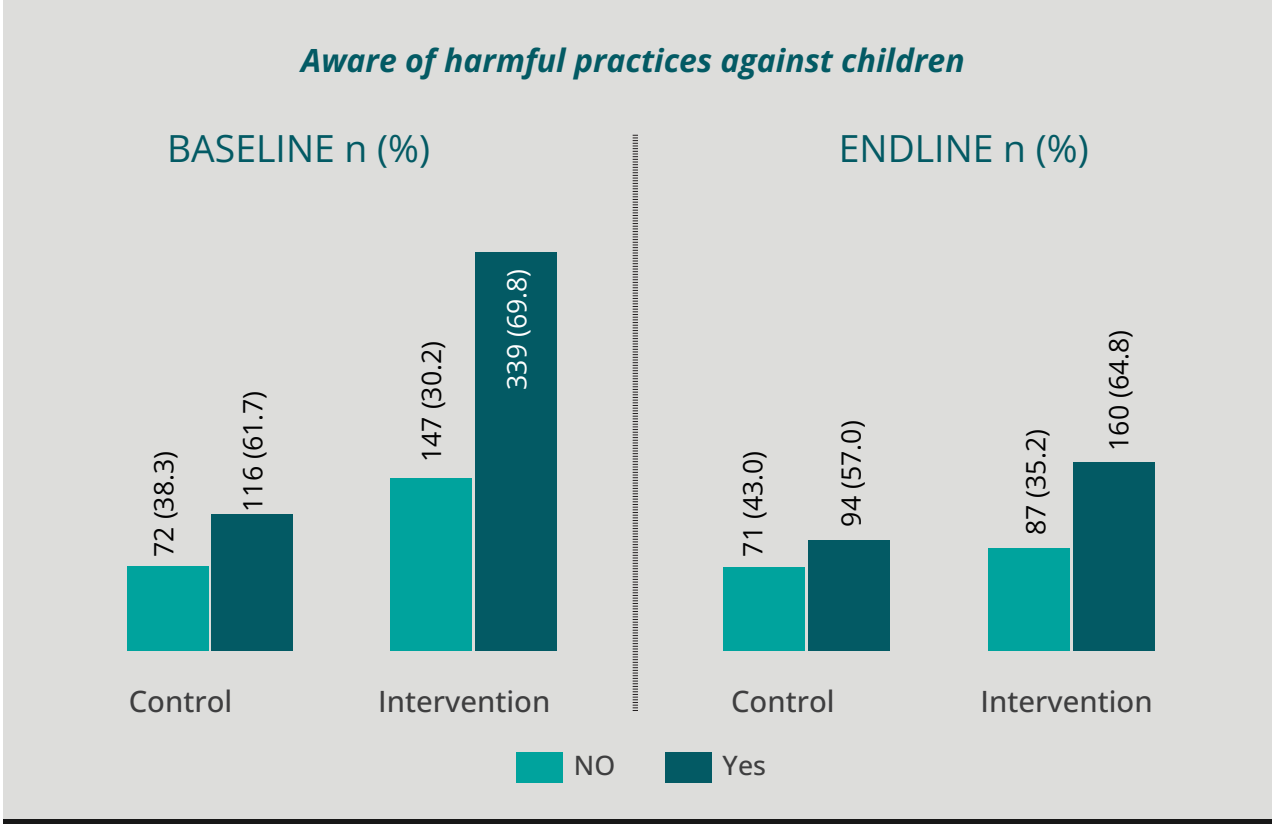
Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Interven-tion	Control	Interven-tion
Sex	Boy	92 (44.4)	237 (47.4)	67 (42.7)	151 (46.3)
	Girl	115 (55.6)	263 (52.6)	90 (57.3)	175 (53.7)
Age group 13.2 ± 1.0	7-10years	4 (1.9)	11 (2.2)	0 (0.0)	0 (0.0)
	11-14years	203 (98.1)	489 (97.8)	139 (88.5)	271 (83.1)
	≥15years	0 (0.0)	0 (0.0)	18 (11.5)	55 (16.9)
Class	P4	20 (9.7)	25 (5.0)	0 (0.0)	3 (0.9)
	P5	92 (44.4)	273 (54.6)	19 (12.1)	32 (9.8)
	P6	95 (45.9)	202 (40.4)	70 (44.6)	178 (54.6)
	P7	0 (0.0)	0 (0.0)	68 (43.3)	113 (34.7)
Parental status	No Parents	1 (0.5)	5 (1.0)	0 (0.0)	3 (0.9)
	One Parent	33 (15.9)	69 (13.8)	23 (14.6)	38 (11.7)
	Both Parents	173 (83.6)	426 (85.2)	134 (85.4)	285 (87.4)

Appendix B: Knowledge and Awareness of SVAC

Table B1: Teacher's knowledge and awareness of child safeguarding policies

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
I am aware of my school's child safeguarding policies.	No	5 (11.6)	13 (15.1)	0 (0.0)	1 (1.5)
	Yes	38 (88.4)	73 (84.9)	31 (100.0)	66 (98.5)
It is my job to safeguard children from child sexual abuse while they are at school.	No	0(0.0)	1(1.2)	0(0.0)	0(0.0)
	Yes	43 (100.0)	85 (98.8)	31 (100.0)	67 (100.0)
The school where I teach actively enforces the child safeguarding policy.	No	9(20.9)	16(18.6)	0(0.0)	2(3.0)
	Yes	34 (79.1)	70 (81.4)	31 (100.0)	65 (97.0)

Table B2: Parents and caregivers' knowledge and awareness of CSA



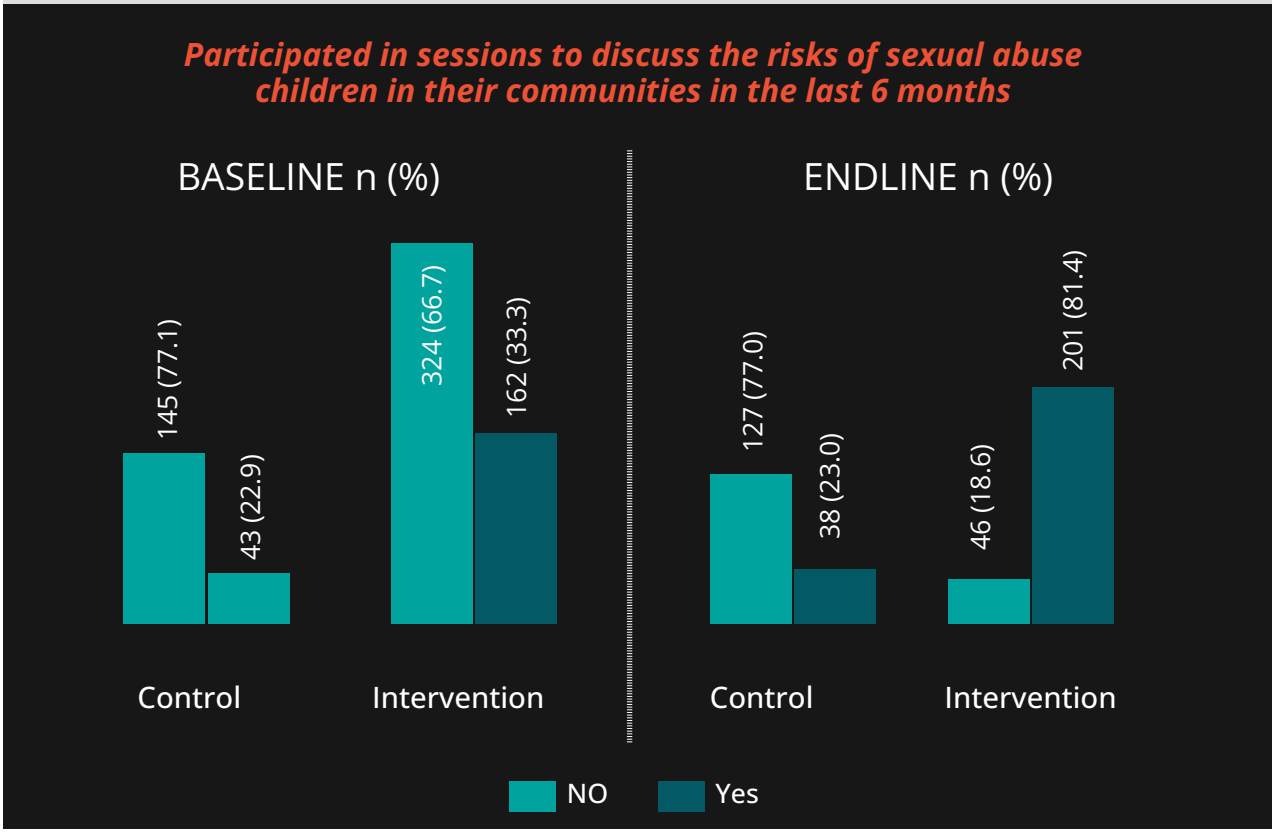


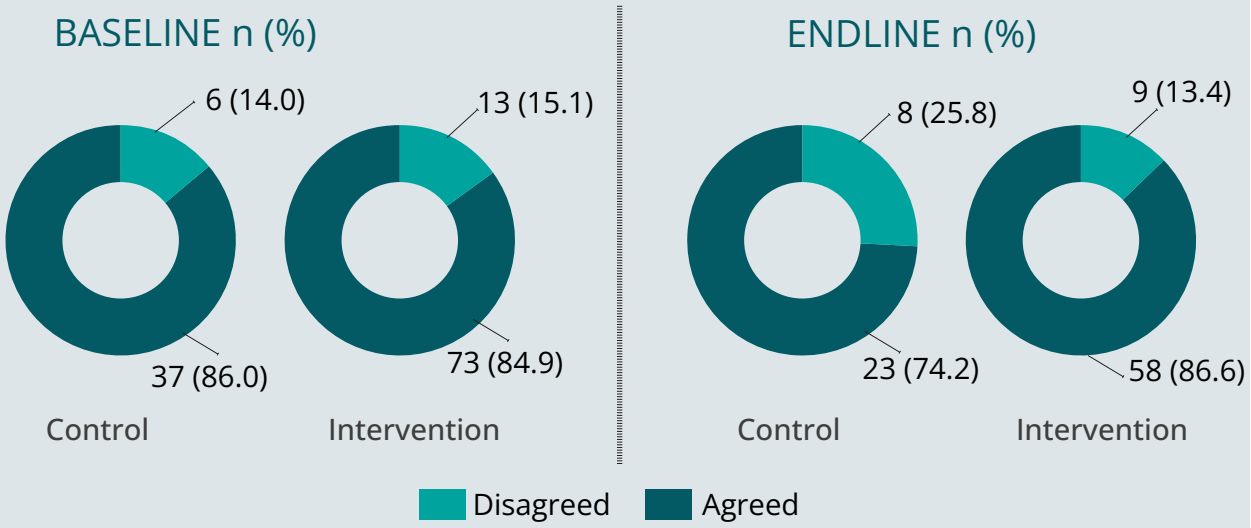
Table B 3: Change in knowledge of children's rights and harmful practices

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
Knowledge on rights	No	73 (35.3)	102 (20.4)	24 (15.3)	16 (4.9)
	Yes	134 (64.7)	398 (79.6)	133 (84.7)	310 (95.1)
Awareness of at least 3 Rights	<3 rights	146 (70.5)	336 (67.2)	109 (69.4)	153 (46.9)
	≥ 3rights	61 (29.5)	164 (32.8)	48 (30.6)	173 (53.1)
Awareness of harmful practices	No	59 (28.5)	155 (31.0)	55 (35.0)	97 (29.8)
	Yes	148 (71.5)	345 (69.0)	102 (65.0)	229 (70.2)

Appendix C: Beliefs, perceptions, and attitudes on SVAC

Table C1: Teachers' attitudes toward reporting CSA

I would report CSA even if my school administration disagreed with me.



I would be apprehensive to report CSA for fear of family or community retaliation.

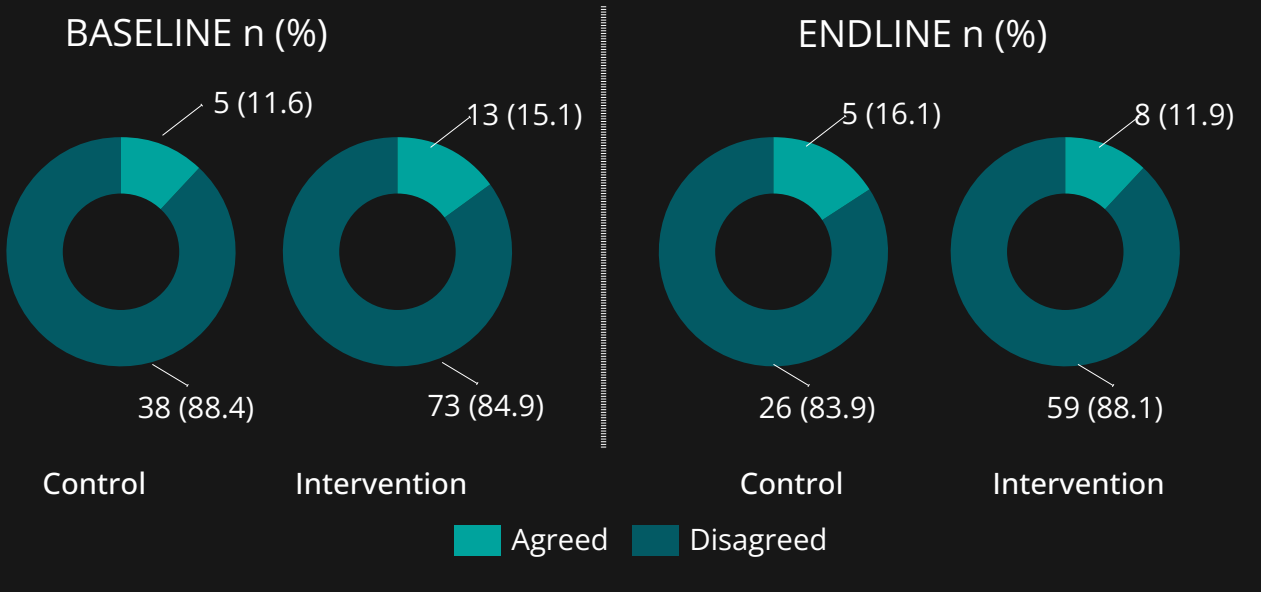


Table C2: Parents and caregivers' belief in children who report CSA and willingness to refer such reports

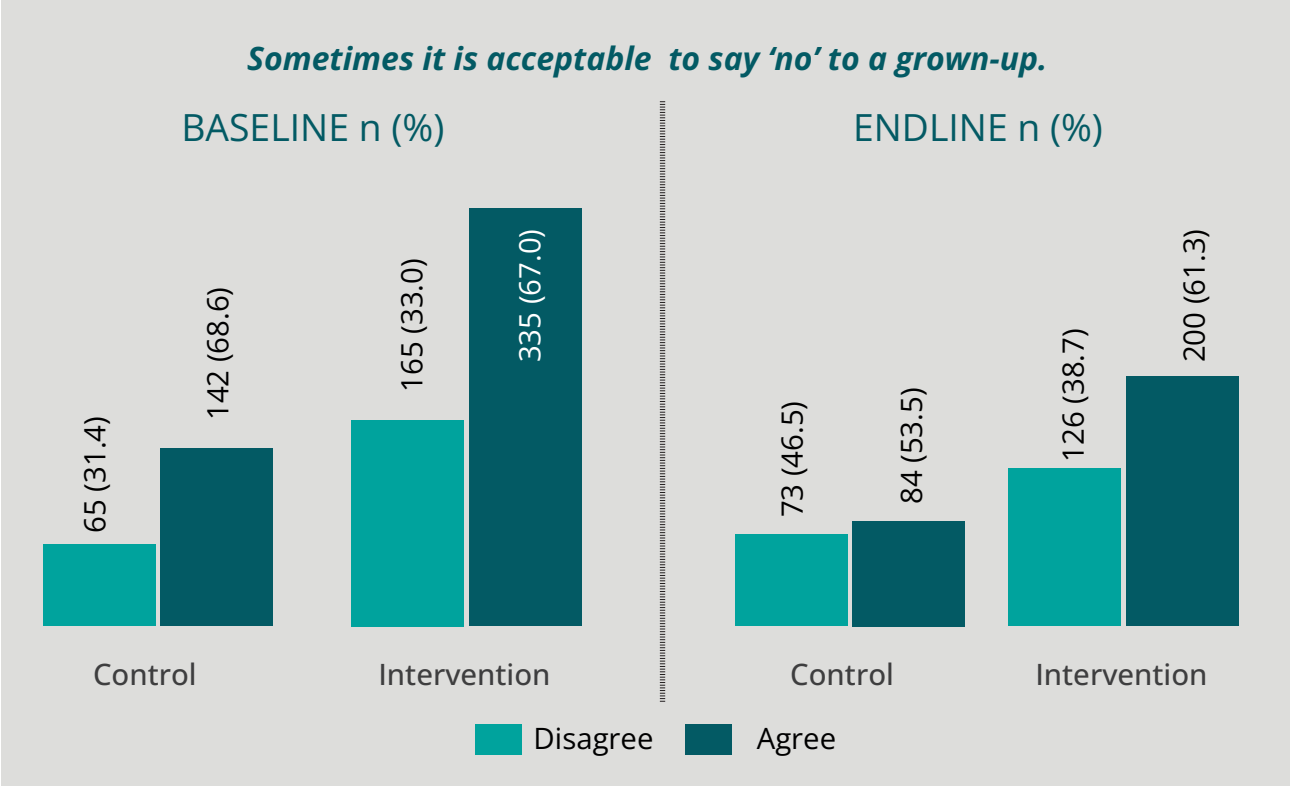
Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
I think children who report sexual abuse can be believed easily.	Not at all	6 (3.2)	25 (5.1)	2 (1.2)	9 (3.6)
	Sometimes	70 (37.2)	174 (35.8)	47 (28.5)	73 (29.6)
	Most of the time	56 (29.8)	181 (37.2)	64 (38.8)	106 (42.9)
	Always	48 (25.5)	94 (19.3)	47 (28.5)	50 (20.2)
	Not Sure	8 (4.3)	12 (2.5)	5 (3.0)	9 (3.6)
I can report child sexual abuse if my child confides in me, even if my partner may be against it.	No, never	4 (2.1)	21 (4.3)	5 (3.0)	18 (7.3)
	Yes, once	42 (22.3)	82 (16.9)	31 (18.8)	45 (18.2)
	Yes, often	142 (75.5)	383 (78.8)	129 (78.2)	184 (74.5)
	Yes (combining yes-once and yes often)	184 (98)	465 (96)	160 (97)	229 (93)

Table C3: Parents and caregivers' attitudes toward selected community norms and practices that pose CSA risks

Variable	Categories	Baseline n(%)		Endline n(%)	
		Control	Intervention	Control	Intervention
A girl who has reached puberty or is out of school is ready for sex.	Negative	5 (2.7)	26 (5.3)	12 (7.3)	16 (6.5)
	Positive	183 (97.3)	460 (94.7)	153 (92.7)	231 (93.5)
People should not disclose child sexual abuse.	Negative	4 (2.1)	18 (3.7)	8 (4.8)	7 (2.8)
	Positive	184 (97.9)	468 (96.3)	157 (95.2)	240 (97.2)
Boys and men should be entitled to having sex with girls and women without consequences.	Negative	11 (5.9)	25 (5.1)	8 (4.8)	9 (3.6)
	Positive	177 (94.1)	461 (94.9)	157 (95.2)	238 (96.4)
Children cause their perpetrators to sexually abuse them.	Negative	65 (34.6)	132 (27.2)	35 (21.2)	54 (21.9)
	Positive	123 (65.4)	354 (72.8)	130 (78.8)	193 (78.1)
If a relative or teacher engages in sexual contact with a child, the family should keep silent to maintain respect.	Negative	7 (3.7)	25 (5.1)	5 (3.0)	9 (3.6)
	Positive	181 (96.3)	461 (94.9)	160 (97.0)	238 (96.4)
Norms (Composite)	Negative	10 (5.3)	39 (8.0)	15 (9.1)	22 (8.9)
alpha 0.725	Positive	178 (94.7)	447 (92.0)	150 (90.9)	225 (91.1)

*Cronbach's alpha coefficient: 0.725

Table C4: Children's efficacy in resisting abuse and reporting CSA



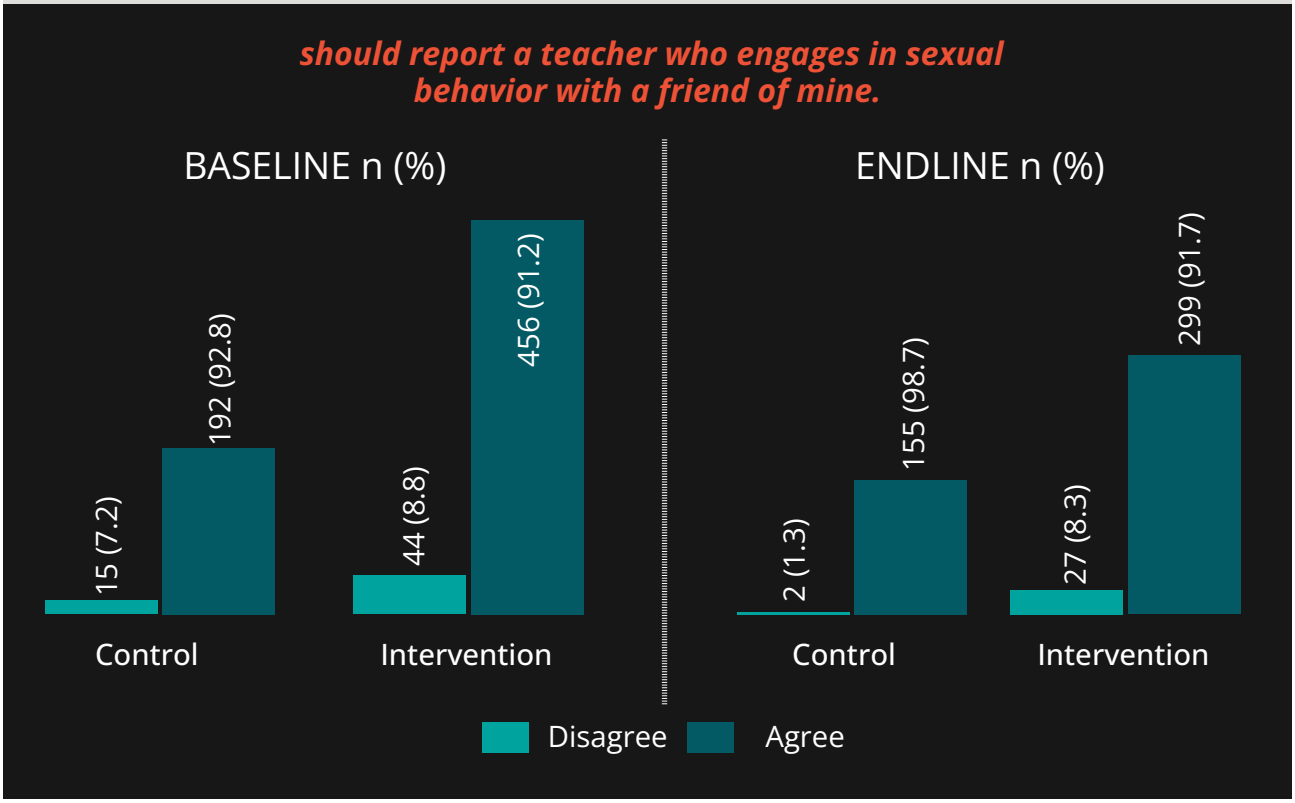


Table C5: Changes in children's beliefs, perceptions, and attitudes towards CSA

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
It is acceptable to say 'no' and move away if someone touches you in a way you do not like.	Negative	9 (4.3)	26 (5.2)	15 (9.6)	29 (8.9)
	Positive	198 (95.7)	474 (94.8)	142 (90.4)	297 (91.1)
You must let grown-ups touch you whether you like it or not.	Negative	20 (9.7)	70 (14.0)	7 (4.5)	19 (5.8)
	Positive	187 (90.3)	430 (86.0)	150 (95.5)	307 (94.2)
You always have to keep secrets.	Negative	57 (27.5)	179 (35.8)	58 (36.9)	125 (38.3)
	Positive	150 (72.5)	321 (64.2)	99 (63.1)	201 (61.7)
If someone touches you in a way you do not like, you should not tell anyone.	Negative	39 (18.8)	117 (23.4)	29 (18.5)	53 (16.3)
	Positive	168 (81.2)	383 (76.6)	128 (81.5)	273 (83.7)
If someone touches you in a way you do not like, it is your own fault.	Negative	55 (26.6)	112 (22.4)	46 (29.3)	79 (24.2)
	Positive	152 (73.4)	388 (77.6)	111 (70.7)	247 (75.8)
Boys do not have to worry about someone touching their private parts.	Negative	36 (17.4)	112 (22.4)	19 (12.1)	52 (16.0)
	Positive	171 (82.6)	388 (77.6)	138 (87.9)	274 (84.0)
If someone walks in while you are having a bath and you feel uncomfortable, you should just keep quiet.	Negative	14 (6.8)	45 (9.0)	1 (0.6)	12 (3.7)
	Positive	193 (93.2)	455 (91.0)	156 (99.4)	314 (96.3)
Even hugs and tickles can turn into bad touches if they go on too long.	Negative	34 (16.4)	96 (19.2)	24 (15.3)	75 (23.0)
	Positive	173 (83.6)	404 (80.8)	133 (84.7)	251 (77.0)
Boys and men can have sex with girls and forced sex with women without consequences or reprimand.	Negative	14 (6.8)	57 (11.4)	6 (3.8)	8 (2.5)
	Positive	193 (93.2)	443 (88.6)	151 (96.2)	318 (97.5)
Beliefs (composite)	Negative	11 (5.3)	38 (7.6)	7 (4.5)	15 (4.6)
	Positive	196 (94.7)	462 (92.4)	150 (95.5)	311 (95.4)

*Cronbach's alpha coefficient: 0.7208

Appendix D: Behavior/Practice related to SVAC

Table D1: Teachers' attitudes towards reporting suspected CSA

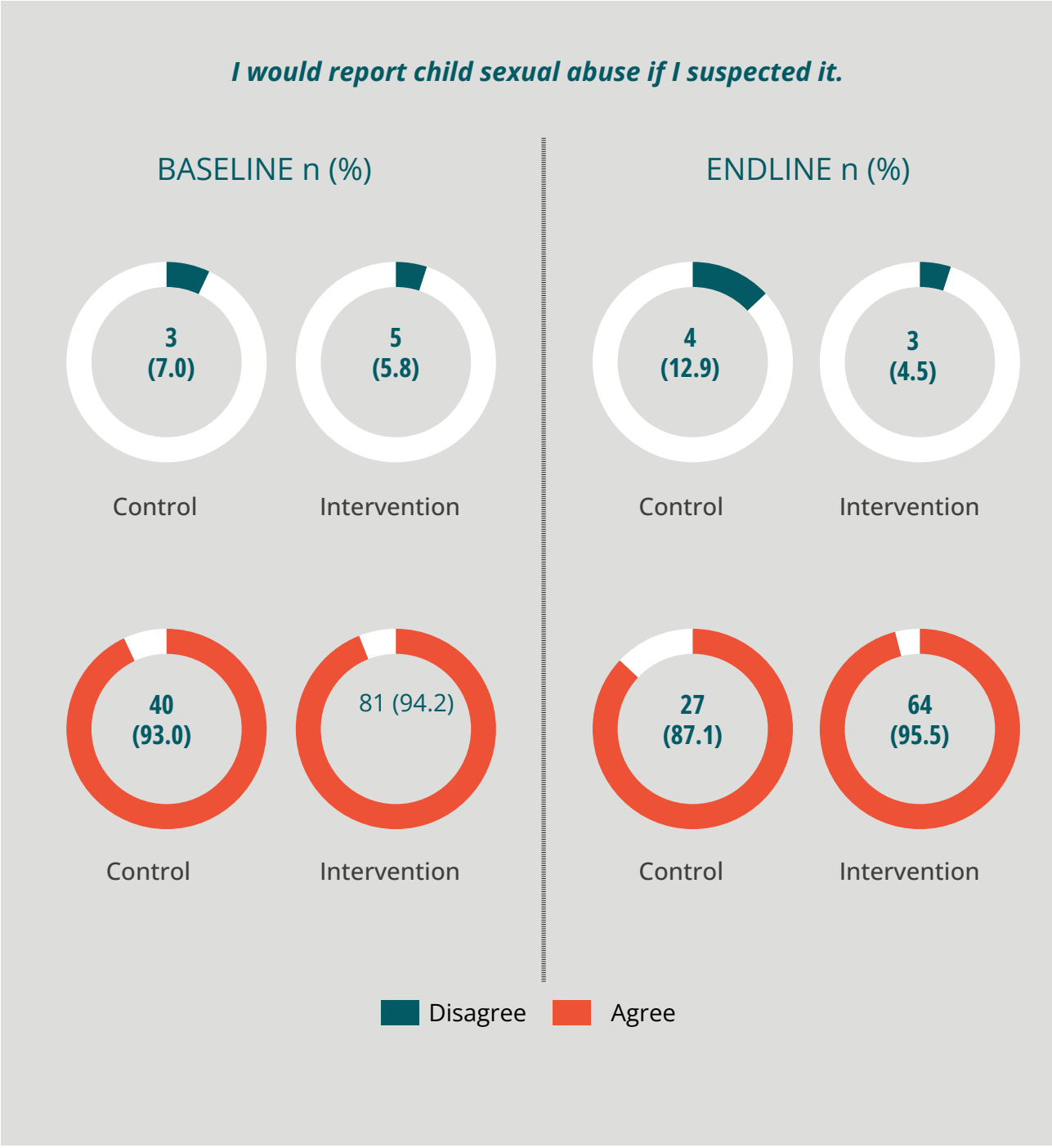


Table D2: Parent and caregivers' discussions with their children on sexuality education and CSA

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
Have you ever talked to your child about menstruation?	No	66 (35.1)	166 (34.2)	48 (29.1)	75 (30.4)
	Yes	122 (64.9)	320 (65.8)	117 (70.9)	172 (69.6)
Have you ever talked to your child about peer pressure to engage in sex?	No	37(19.7)	75(15.4)	12(7.3)	15(6.1)
	Yes	151 (80.3)	411 (84.6)	153 (92.7)	232 (93.9)
Have you ever spoken with your child about ways to seek help when they feel at risk of sexual abuse in any situation?	No	36 (19.1)	89 (18.3)	15 (9.1)	20 (8.1)
	Yes	152 (80.9)	397 (81.7)	150 (90.9)	227 (91.9)
Have you ever had discussions with your child about strategies to avoid early and under-age marriage?	No	42 (22.3)	103 (21.2)	15 (9.1)	17 (6.9)
	Yes	146 (77.7)	383 (78.8)	150 (90.9)	230 (93.1)
Discussion on CSA (Composite)	No	59 (31.4)	144 (29.6)	36 (21.8)	33 (13.4)
	Yes	129 (68.6)	342 (70.4)	129 (78.2)	214 (86.6)

*Cronbach's alpha coefficient: 0.869

Table D3: Parents and caregivers' self-efficacy to provide sexuality education

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
Report being comfortable answering questions from their children about sex	No	28 (14.9)	57 (11.7)	14 (8.5)	18 (7.3)
	Yes	160 (85.1)	429 (88.3)	151 (91.5)	229 (92.7)
Report being able to adequately explain sexual violence against children (including sexual abuse and exploitation) to their children	No	22 (11.7)	57 (11.7)	14 (8.5)	19 (7.7)
	Yes	166 (88.3)	429 (88.3)	151 (91.5)	228 (92.3)
Report the ability to reject marrying off their children, even if their partner wants to	No	4 (2.1)	21 (4.3)	5 (3.0)	18 (7.3)
	Yes	184 (97.9)	465 (95.7)	160 (97.0)	229 (92.7)
Reports self-efficacy to provide sexuality education (Composite)	No	19 (10.1)	36 (7.4)	8 (4.8)	16 (6.5)
	Yes	169 (89.9)	450 (92.6)	157 (95.2)	231 (93.5)

*Cronbach's alpha coefficient: 0.796

Table D4: Children's attitudes towards speaking up and reporting worrying concerns

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
Reporting worrying concerns at home to a parent	No	56(27.1)	129(25.8)	36(22.9)	71(21.8)
	Yes	151(72.9)	371(74.2)	121(77.1)	255(78.2)
Reporting worrying concerns at school to a teacher	No	58(28.0)	145(29.0)	34(21.7)	44(13.5)
	Yes	149(72.0)	355(71.0)	123(78.3)	282(86.5)
Speaking up when witnessing someone else being hurt	No	20(9.7)	39(7.8)	8(5.1)	16(4.9)
	Yes	187(90.3)	461(92.2)	149(94.9)	310(95.1)
Reporting worrying concerns (composite)	No	113(54.6)	250(50.0)	68(43.3)	111(34.0)
	Yes	94(45.4)	250(50.0)	89(56.7)	215(66.0)

*Cronbach's alpha coefficient: 0.741

Table D5: Confidence in children's ability to resist, disclose, and report CSA

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
I should report a teacher who engages in sexual behavior with a friend of mine.	No	15 (7.2)	44 (8.8)	2 (1.3)	27 (8.3)
	Yes	192 (92.8)	456 (91.2)	155 (98.7)	299 (91.7)
I would report instances of CSA perpetrated against me.	No	7 (3.4)	48 (9.6)	6 (3.8)	17 (5.2)
	Yes	200 (96.6)	452 (90.4)	151 (96.2)	309 (94.8)
If someone forced or lured me into sex, I would disclose their identity.	No	4 (1.9)	39 (7.8)	5 (3.2)	5 (1.5)
	Yes	203 (98.1)	461 (92.2)	152 (96.8)	321 (98.5)
I would seek out sexual abuse support services if I needed them.	No	6 (2.9)	45 (9.0)	11 (7.0)	8 (2.5)
	Yes	201 (97.1)	455 (91.0)	146 (93.0)	318 (97.5)
I can resist pressure from a teacher or relative to engage in sex.	No	12 (5.8)	45 (9.0)	15 (9.6)	9 (2.8)
	Yes	195 (94.2)	455 (91.0)	142 (90.4)	317 (97.2)
Agency (composite)	Low agency	34 (16.4)	135 (27.0)	27 (17.2)	54 (16.6)
	High agency	173 (83.6)	365 (73.0)	130 (82.8)	272 (83.4)

*Cronbach's alpha coefficient: 0.734

Table D6: Confidence in the ability to enact preferences over life choices

Variable	Categories	Baseline n (%)		Endline n (%)	
		Control	Intervention	Control	Intervention
Children who do what they believe is right, even when friends pressure them to do something wrong	Wrong	10 (4.8)	92 (18.4)	7 (4.5)	17 (5.2)
	Right	197 (95.2)	408 (81.6)	150 (95.5)	309 (94.8)
Children who would not have sex with a person, even if that person had power over them (e.g., a relative, local leader, or teacher)	Wrong	18 (8.7)	101 (20.2)	23 (14.6)	29 (8.9)
	Right	189 (91.3)	399 (79.8)	134 (85.4)	297 (91.1)
Life Choices (composite)	Wrong	23 (11.1)	150 (30.0)	29 (18.5)	44 (13.5)
	Right	184 (88.9)	350 (70.0)	128 (81.5)	282 (86.5)

*Cronbach's alpha coefficient: 0.813

Appendix E: SAFE Monitoring and Evaluation Framework

Curriculum Pillars	Outcome	Performance Indicator	Measurement Variable	Statistical Significance of Change (baseline to endline in intervention group)
SAFE's FRESH START package School leaders and Teachers Able to Retain and Protect Children (**START)**	Outcome 1: Educators actively prevent and respond to VACiSC (including CSA), create safer environments that protect children from violence, and treat girls and boys equally through non-violent means	**Indicator 1A:** Demonstrated awareness of children's rights and an understanding of how to protect them from CSA. **KNOWLEDGE**	Percentage of teachers who possessed knowledge of relevant legal frameworks (child safe-guarding policy, teachers' code of conduct)	Change is significant at $p < 0.01$
			Percentage of teachers who indicated it was their responsibility to protect children and safeguard their rights	Change significant at $P<0.001$
		Indicator 1B: Percentage of teachers who show a positive shift in attitudes towards recognizing, reporting, and protecting children from CSA. **ATTITUDES**	Percentage of teachers who would report child sexual abuse to authorities, even if the school administration disagreed	No significant change
			Percentage of teachers who indicated willingness to report child sexual abuse despite fear of family or community retaliation	No significant change
		Indicator 1C: Active participation by teachers in mitigating risks to children's safety in and around school. **BEHAVIORS/ PRACTICES**	Percentage of teachers who engaged in mitigation measures (i.e., teachers who would report child sexual abuse if they suspected it)	No significant change

Curriculum Pillars	Outcome	Performance Indicator	Measurement Variable	Statistical Significance of Change (baseline to endline in intervention group)
NEST PACKAGE: Norms Diffusion, Skills, Economic Strengthening and Parenting Training **(NEST)**	Outcome 2: Parents and caregivers actively prevent and respond to VACiSC (including CSA), adopt positive parenting, and provide for and treat girls and boys equally through non-violent means	**Indicator 2A:** Demonstrated awareness of children's rights, risks of abuse, and an understanding of how to protect children from CSA. **KNOWLEDGE**	Percentage of parents and caregivers who reported awareness of harmful practices against children in their communities	No significant change
		Indicator 2B: Percentage of parents and caregivers who show a positive shift in attitudes towards reporting CSA and protecting children from CSA. **ATTITUDES**	Percentage of parents and caregivers who would believe their children if they reported CSA to them (most of the time or always)	No significant change
			Percentage of parents and caregivers who indicated willingness to report child sexual abuse if their child confided in them, even if their partner was against it	No significant change
		Indicator 2C: Percentage of parents and caregivers who demonstrate increased accountability and responsibility towards their children. **BEHAVIOR**	Percentage of caregivers who reported to spoken with their children (9-14 years) about risks that may expose them to sexual violence, either at home, school, or anywhere else in the community	No significant change

Curriculum Pillars	Outcome	Performance Indicator	Measurement Variable	Statistical Significance of Change (baseline to endline in intervention group)
GET PROUD CURRICULUM	Outcome 3: Improved agency of boys and girls to prevent and respond to VACiSC (including CSA), and internalize and promote new positive gender norms	**Indicator 3A:** Children have increased knowledge and awareness of their rights and responsibilities, and of VACiSC (including CSA). **KNOWLEDGE**	Percentage of children who were able to name at least three of their rights	Change significant at P<0.001
			Percentage of children who could identify at least three ways of protecting themselves against CSA	Change significant at P<0.05
		Indicator 3B: Percentage of children who believe in their ability to resist abuse and possess a sense of self-efficacy in reporting CSA. **ATTITUDES**	Percentage of children who noted that, at times, it is acceptable to say 'no' to an adult	No significant change
			Percentage of children who said they would report sexual abuse perpetrated against a peer	Change significant at P<0.001
		Indicator 3C: Percentage of children taking a more active role in preventing and reporting child sexual abuse in schools and communities **BEHAVIOR/PRACTICE**	Percentage of children who reported they can easily talk to their mother, father or teachers	Change significant at P<0.001
			Percentage of children who can speak up when they see someone else being hurt	Change significant at P<0.001

Curriculum Pillars	Outcome	Performance Indicator	Measurement Variable	Statistical Significance of Change (baseline to endline in intervention group)
SAFE COMMUNITIES	Outcome 4: Local government authorities have the capacity to deliver VACiSC mitigation, prevention, and response programming in communities and schools across their sub-counties	**Indicator 4A:** Percentage increase in the number of child abuse cases (including CSA) reported to the committee, non-statutory cases resolved at Parish child wellbeing committees (PCWCs), and cases referred to the next level	Percentage increase in the number of child abuse cases (including CSA) (a) reported to PCWCs, (b) resolved (when non-statutory), and (c) referred to the next level	Not assessed
		Indicator 4B: Percentage decrease in time taken for authorities to respond to reported cases of CSA, and for victims to receive the minimum service package within 72 hours	Percentage of CSA cases that receive the minimum service package within 72 hours (The minimum service package includes medical service, psychosocial support, and case referral to the appropriate local government authorities.)	Not assessed
		Indicator 4C: Local government authorities and structures using the capacity provided to them and evidence to make decisions to mitigate, prevent, and respond to VACiSC.	Percentage of government structures that integrate monitoring data on CSA into decision-making processes	Not assessed

ICRW Africa Regional Office (Kenya)
Vienna Court, Fourth Floor, State House Crescent,
Nairobi, Kenya
P.O. Box 44168 – 00100 Nairobi, Kenya
Phone numbers: +254) 769 060 463 / 785 048 377
Email: info.kenya@icrw.org

ICRW Africa Office (Uganda)
1st Floor, S&L Chambers, Plot 14 Mackinnon Road,
Nakasero – Kampala, Uganda
P.O. Box 131136, Kampala, Uganda
Phone Number: +256) 760 004 478
Email: info.uganda@icrw.org
website: www.icrw.org