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Screening for sexual violence against children in humanitarian settings: a feasibility study of a para-social worker-led intervention in Uganda

Abir Nur[1*], Gloria Seruwagi[1], George Odwe[2], Peter Kisaakye[2], Stella Muthuri[1], Dagim Habteyesus[1], Yohannes Wado[3], Bonnie Wandera[3], Yadeta Dessie[3,4], Hilda Namakula[5], Francis Obare[2] and Chi-Chi Undie[1]

Abstract

Background Sexual violence against children (SVAC) is an acknowledged concern in humanitarian settings; yet, effective, tested interventions to support disclosure and access to care remain limited. This study assessed the feasibility of implementing SVAC screening, referral protocols, and service provision, in a bid to rectify these limitations within two primary schools in Uganda's Kiryandongo Refugee Settlement.

Methods A mixed-methods concurrent triangulation design was used to implement and assess the feasibility of a seven-month intervention (April–October 2024) in two primary schools. Para-Social Workers, trained under Uganda's Ministry of Gender, Labour and Social Development, screened Primary 6 and 7 pupils, aged 11 to 35 years old, for SVAC. Older pupils (Primary 6–7) were selected for their perceived capacity to engage on the topic. Survivors received school-based psychological first aid and were referred to additional services as needed.

Results The intervention demonstrated strong demand and acceptability among the target populations. All 831 eligible pupils assented to intervention participation, and the majority (96%, $n=794$) ended up actually participating in the screening exercise. Of these, 82% ($n=653$) disclosed experiencing SVAC, with 100% receiving care. In contrast, in the absence of screening in the 12-month period before the intervention, only 16 pupils in the same primary schools disclosed experiencing SVAC and obtained care. Stakeholders – including parents, teachers, government, and humanitarian actors – expressed strong support for expanding the model, while pupils reported high levels of satisfaction with the intervention.

Conclusions Proactive SVAC screening in schools within humanitarian settings is both feasible and holds promise for effectively identifying and supporting child and adolescent survivors of sexual violence. The intervention significantly increased disclosure and service uptake and was well received by all stakeholders. Findings support the adaptation and cautious scale-up of this model in similar, carefully selected and adequately resourced, crisis-affected contexts.

*Correspondence:
Abir Nur
anur@popcouncil.org

Full list of author information is available at the end of the article

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Keywords Uganda, Sexual violence against children, Para-Social Workers, Task-shifting, School-based intervention, Refugee settings, Disclosure and referral, Child protection, Feasibility study

Introduction

Screening for sexual violence (SV) has been shown to promote the detection of child survivors in development contexts in the East African region, as well as their uptake of relevant services (Undie & Mak'anyengo 2020, 2022). Little is known, however, about whether children/adolescents in humanitarian contexts can be screened effectively for SV, and the extent to which violence screening models successfully used in development settings can be transposed to humanitarian settings. Yet, violence against children is a pervasive issue in humanitarian settings in the region.

The 2022 Uganda Humanitarian Violence Against Children and Youth Survey (HVACS) was conducted in all refugee settlements in Uganda. Findings from this landmark survey (Office of the Prime Minister, Department of Refugees et al. 2024) indicated that half of males and close to half of females aged 18–24 in Uganda's refugee settlements experienced either sexual, physical, or emotional violence during childhood. The prevalence of such forms of violence was even higher among children aged 13–17 – at 65% for males and 49% for females. A disaggregation of these forms of violence draws attention to how the experience of SV evolves as children transition from childhood to adulthood: females in the 18–24-year-old age range experienced SV in childhood at twice the rate of their male counterparts (19% vs 10%), despite the prevalence by gender being similar at ages 13–17 (7%).

Disclosure of SV by child/adolescent survivors was low for both females and males (ranging from 6 to 31%, depending on age group and sex of participant). It was particularly low (at 6%) among 13–17-year-olds who experienced SV in the past 12 months. Help-seeking among child/adolescent survivors of SV was even lower – at 2% for girls ages 13–17, 5% for females ages 18–24, and 17% for males ages 18–24 (ibid.).

SV places children and adolescents at risk for pregnancy and sexually-transmitted infections, including HIV. Furthermore, findings from the Uganda HVACS demonstrate that, in refugee settings in Uganda, child and adolescent survivors of violence are significantly more like to report feelings of anxiety, depression, suicidal thoughts, and/or suicide attempts than their peers who have not experienced sexual violence.

In humanitarian settings, gender also shapes both exposure to and the nature of risks following SVAC: girls are more likely to face sexual exploitation, coercion, and early or forced marriage, whereas boys are at heightened risk of underreported sexual victimization linked to stigma and norms discouraging disclosure (Harrison et al. 2025). Additionally, gendered expectations can influence pathways to care, with girls more often directed toward protection or health services, while boys' experiences may be overlooked or minimized, contributing to persistent gaps in identification and support (Digidiki & Bhabha 2018).

Despite the problems that SV poses for children and adolescents in refugee contexts, and the role that routine screening can play in the early detection of survivors, evidence-based, systematic screening interventions for this population were essentially non-existent in these settings at the time of this study. However, priorities identified by humanitarian stakeholders through a 2023 Data-to-Action workshop demonstrated demand for an intervention that took into account the high school enrollment rates among 13–17 year olds in Uganda's refugee settlements; the high prevalence of SV in childhood; the low rates of disclosure and care-seeking among child/adolescent survivors; and the high rates of mental distress suffered by such survivors (Undie et al. 2023). Additionally, stakeholders emphasized the need to shift negative gender norms in humanitarian communities, and to promote parental engagement to help mitigate SV against children and adolescents.

In response to this demand, this study assesses the feasibility of adapting a previously-tested screening intervention that was designed for children/adolescents in development settings, and that addresses the demands outlined above. Evaluation findings from the original iteration of the intervention (Undie & Mak'anyengo 2020, 2022, 2023) demonstrated that this intervention: fostered child-parent communication to promote sexual violence disclosure; promoted disclosure (about 50% of children screened disclosed experiencing some form of SV); enhanced child survivors' access to care (75% of child survivors identified through the intervention received care); responded to mental health needs (primarily through school-based psychosocial support); and provoked an organic shift in gender/social norms within survivors' communities. The screening intervention was therefore deemed appropriate for adaptation and feasibility testing by humanitarian stakeholders, led by Uganda's Ministry of Gender, Labour and Social Development, and the Department of Refugees (Office of the Prime Minister).

Screening for violence has not been without controversy, however. For instance, the World Health Organization (WHO) cautions against routine, universal screening, recommending inquiry based on case-finding instead (i.e., when signs, symptoms, or risks are present),

rather than the indiscriminate questioning of all children (World Health Organization 2022). Further, routine screening for intimate partner violence against women was not found to be linked to improved health status for those screened in a systematic review of a series of randomized control trials conducted in developed countries (Jewkes 2013). However, as some authors point out (Undie et al. 2016a, b), the trials in question varied in design, with some focusing on screening alone in the absence of any other interventions to support those identified through the screening process. Several researchers have highlighted the importance of embracing a broader view of screening and its effects, including considering qualitative aspects, such as survivor satisfaction, well-being, referral rates, self-reflection, or the development of self-efficacy in coming to a decision about the place of screening in survivor support (McTavish et al. 2020; Kureshi 2012; Kulkarni 2012).

Its unequivocal stance on universal screening notwithstanding, in its *INSPIRE: Seven Strategies for Ending Violence Against Children* guidance, WHO does concede that non-universal screening 'combined with [other] interventions' (World Health Organization 2016, p. 24) is an evidence-based approach for reducing violence experienced by children. A growing body of work is in alignment with this stance, contending that SV screening should only occur in contexts where protection systems and referral mechanisms are sufficiently functional, and where trained staff, community engagement, and context-appropriate consent processes are in place (Canavera et al. 2016; Digidiki & Bhabha 2018; Ellermeijer et al. 2023; Harrison et al. 2025; Undie et al. 2016b; Undie et al. 2016; Undie & Mak'anyengo 2020).

This INSPIRE framework's evidence base, however, focuses on indirectly meeting child survivors' needs by intervening with their mothers/parents. While this approach has demonstrated evidence of reducing child protection issues (including violence), it falls short of engaging with children directly and understanding and addressing violence based on their own perspectives and positionalities.

While UNICEF (2015) proposes proactive screening as one strategy to enhance early identification and response for child survivors who have not disclosed or accessed services, such interventions remain rare and largely undocumented in humanitarian settings in the African region. This is plausibly due to sparse knowledge about the feasibility of conducting such an intervention in the first place– particularly, in contexts where factors such as disrupted schooling, stigma, limited trust in authorities, and resource constraints could influence whether children disclose and whether help-seeking leads to effective protection (Solomon 2016; Canavera et al. 2016). Disclosure of SV is also particularly challenging due to pervasive stigma, fear, and restrictive gender and social norms, underscoring the need for trauma-informed, survivor-centered approaches (Pereira et al. 2020).

These reasons, coupled with the fact that Uganda's Ministry of Gender, Labour and Social Development was interested in shifting the task of screening from psychologists (as was the case in the original, Kenya-based model) to para-social workers (PSWs), led to a need to determine the feasibility of this model in a new context (schools in refugee settings).

Methods

Study aim

This school-based study aimed to determine the feasibility of screening children/adolescents for SV. The study drew on Bowen et al.'s (2009) feasibility framework. Bowen and colleagues propose that there are up to 8 appropriate areas of focus for feasibility studies, namely: acceptability, demand, implementation, practicality, adaptation, integration, expansion, and limited-efficacy testing. For the purposes of the present study, we narrowed our exploration to the feasibility dimensions of 'demand' and 'acceptability,' viewing them as the most critical starting point for determining: 1) what the chances were for a sensitive, novel intervention to be taken up by stakeholders in the first place, and 2) what the chances were that target beneficiaries would find it appealing. Informed by Bowen et al., these dimensions have been operationally defined as follows for the purposes of this study:

- *Demand*: The extent to which the screening intervention is likely to be used by children/adolescents, their parents/guardians, and other humanitarian stakeholders. An assessment of the demand for an intervention can be facilitated by data collection on 'estimated use or by actually documenting the use of selected intervention activities in a defined intervention population or setting' (Bowen et al. 2009, p.3).
- *Acceptability*: The extent to which the screening intervention is judged as suitable, satisfying, or attractive to providers, child/adolescent survivors, parents/guardians, and other humanitarian actors. Acceptability explores 'how the intended individual recipients – both targeted individuals and those involved in implementing programs – react to the intervention' (ibid.).

These dimensions are broken down further into the specific feasibility outcomes that the study explored (Table 1).

Table 1 Evaluation Focal Areas and Outcomes

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

Study design

The study replicated the design and methodology of the original, Kenya-based evaluation, described elsewhere (Undie & Mak'anyengo 2020, 2022). In summary, a mixed-methods design was employed, drawing on a concurrent triangulation strategy (Creswell & Plano Clark 2018). This approach involved collecting quantitative and qualitative data simultaneously and then integrating both data sets into a single, unified analysis. Both kinds of data lent evidence toward the feasibility assessment, and the qualitative insights were essential for capturing the stories, experiences, perspectives, and realities behind the numbers of screened children/adolescents, their parents, and other stakeholders. The qualitative data was also particularly important for bringing children's voices to the fore of this assessment, as their personal perspectives are often excluded from research on sensitive topics.

Context

Located in Northwestern Uganda's Kiryandongo District, Kiryandongo Refugee Settlement was first established in 1990, followed by a period of closure. Propelled by the South Sudanese emergency, it was reopened in 2014 (REACH 2019). As of January 2025, Kiryandongo Settlement hosts a total of 139,815 refugees, the majority (60%) of whom are from South Sudan (Office of the Prime Minister & UNHCR 2025). Armed conflict in Sudan since 2023 has also led to a more recent influx of Sudanese refugees, with 95% of registered refugees from this country residing in Kiryandongo (IFRC 2024). Recent conflict escalation in eastern DRC has also resulted in an additional influx of refugees and asylum-seekers. Kiryandongo District has had a history of registering the highest number of cases of domestic violence and child neglect (Uganda Police Force 2022) and the second highest number of cases of defilement (Uganda Police Force 2022, 2023) and child-related offences (Uganda Police Force 2023) at police stations in the country.

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

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

Intervention description

In their role as the government's lead agency for child protection, a noted model of the MGLSD involves the identification, training, and supervision of para-social workers (PSWs) – the first-line cadre of child protection and welfare response that reaches households with services through home visits, referral provision, and a community case management approach. As 'first responders,' PSWs provide preventative, responsive, and promotive services, including violence prevention and response at the household and community levels (Ministry of Gender, Labour, and Social Development 2023). The original, Kenya-based version of the screening intervention was adapted for refugee settings in Uganda by task-shifting – that is, replacing trained psychologists with trained PSWs. This adaptation reflected the limited availability of mental health professionals in humanitarian contexts, as well as government guidance encouraging the use of the existing PSW workforce. Task-shifting also increased potential feasibility and scalability, theoretically making it possible to deliver the intervention cost-effectively and reach a larger number of pupils, while maintaining appropriate safeguarding procedures.

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

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

Some questions, particularly regarding the types of SV experienced, were designed to be open-ended, allowing pupils to describe their experiences in their own words.

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

The intervention was carried out from April to October 2024 and comprised five components, namely: Parent Dialogues, Student Sensitization, Provider Training, Screening for SVAC, and SVAC Service Provision. While these components are described in detail elsewhere (Undie & Mak'anyengo 2020, 2022), they are outlined again here to capture the slight modifications that were made to suit the humanitarian context.

Parent dialogues (April – October 2024)

The two participating primary schools, in collaboration with the MGLSD, the OPM, UNHCR, Windle International Uganda (WIU), and Baobab, convened three parent dialogues in each school (*total* = 6) with parents of all students in Primary 6 and 7 invited to participate. Those dialogues were critical for introducing the screening exercise to parents/caregivers and ensuring their support and buy-in for the intervention. The dialogues involved guided, interactive exercises (e.g., skits performed by pupils, scenario-building, discussion prompts, question-and-answer sessions) to foster conversations about SVAC in the refugee settlement, using the definition provided by the WHO (World Health Organization 2019), and other relevant topics such as the negative consequences of such abuse, the barriers to children/adolescents seeking care for it, parental barriers to seeking care for their children, and school-based screening as a possible solution. The dialogues also served as an efficient platform for obtaining written consent from willing parents for their children to participate in each aspect of the screening exercise – including confidential, child-friendly screening; school-based psychological first aid (PFA) and accompanied referrals, as needed; and anonymized documentation of notes and service statistics based on the screening processes. Particular emphasis was laid on the fact that participation was completely voluntary for both parents and pupils; parents and pupils could change their minds at any time; pupils would only be invited to participate if their parents had opted in; and that there were no repercussions for whichever decision parents and pupils made. The third parent dialogue took place after completion of the second round of screening to disseminate emerging findings to parents and schools.

Table 2 School Population and PSW Distribution

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

Student sensitization (April – October 2024)

Student sensitization involved integrating information about the impending intervention into existing student school assemblies. These assembly sessions were coupled with classroom sensitization sessions conducted by Gender-Based Violence (GBV) specialists (1 per school) who monitored the day-to-day implementation of the intervention, supervised the screening and service provision, and supported the PSWs and school personnel throughout the intervention period. The GBV specialists were both former GBV Officers with at least 5 years of experience in this role with international organizations providing child protection and GBV prevention and response interventions in refugee settlements in Uganda. Both held social science undergraduate degrees, and one held a Master's degree.

During the assembly and classroom sensitization sessions, PSWs and GBV specialists collaboratively shared information on the planned intervention, as well as on SVAC, and informed pupils that their schools were taking measures to make it easier for pupils to receive care for SV if it ever occurred. The specific measures being taken (that is, the availability of school-based psychosocial support for any reason during the school day) were also elaborated upon.

Para-social worker training (April – May 2024)

The intervention included 11 PSWs assigned to the schools on a full-time basis during the study period. Female PSWs solely screened female pupils, while male pupils were only screened by male PSWs. Due to the disparity in school sizes (with School A having a larger population of pupils in general than School B), a different number of PSWs was assigned to each school, as outlined in Table 2 below.

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

school education (i.e., up to the equivalent of Primary 7 in Uganda), and are of any gender.

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

Screening, referrals, and service provision (May – September 2024)

The screening exercise was conducted using a designated screening tool in both participating schools. PSWs facilitated the screening exercise during recess and free periods. All students in Primary 6 and 7 whose parents had given permission and who gave their own personal assent were invited to participate in the screening exercise. PSWs maintained a register of eligible students and, with the help of teachers and GBV specialists, systematically invited those listed for screening one after the other and carried out screening in private tents designated for this purpose at each school. Each eligible child/adolescent was screened twice during the intervention period if SV was not disclosed the first time. This approach allowed additional time for pupils to build trust and feel comfortable disclosing, as PSWs conducted sensitization sessions and maintained a visible presence in schools between screenings, fostering rapport and encouraging more survivors to come forward during the second round. If a child/adolescent reported having experienced SV, the PSW offered school-based PFA and inquired if the child/adolescent wanted to discuss their experience further and receive additional support. Those who requested or required further assistance received an accompanied referral to the nearest health facility, managed by the International Rescue Committee (IRC). Accompanied referrals were executed by PSWs and/or the Senior Woman Teacher or Senior Man Teacher[1] in each school, depending on the sex of the survivor. Within the health facilities, IRC additionally provided support for the Clinical Management of Rape (CMR), along with psychosocial support services.

Uganda's Children's Act (Government of Uganda 2016) includes mandatory reporting requirements for cases of SVAC, obligating practitioners to report disclosures made by children. While the PSW training incorporated guidance on these legal obligations, the application of mandatory reporting in practice was shaped by contextual realities of the humanitarian setting, including limited resources and operational constraints that can make strict adherence challenging. The legal language is somewhat vague but appears to tilt toward more acute forms of abuse; however, in practice, providers often feel obligated to mandatorily report only actual cases of rape. To ensure that survivors nonetheless had access to appropriate services, the intervention was embedded within existing referral pathways and collaborated closely with agencies positioned along the full referral cascade. Pupils who disclosed SV were linked to organizations providing medical, psychosocial, and legal support, and the toll-free child protection hotline – connected to multiple response mechanisms, including legal services – was promoted throughout the intervention. Police and legal sector implementing partners also participated in the parent dialogues, thereby facilitating access to legal avenues when survivors or their caregivers chose to pursue them. Although the intervention did not directly oversee legal case management or track legal outcomes, it supported survivor-initiated linkage to established systems operating under Uganda's mandatory reporting framework.

Sampling

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

The two primary schools were purposively selected after a multisectoral meeting in Kiryandongo, involving district leaders and representatives from OPM, MGLSD, MoE, and MoH. The meeting aimed to introduce the screening intervention and gain stakeholder buy-in. The schools were chosen based on program evidence of a relatively higher number of gender-based violence cases documenting in school records. All parents who had a child in Primary 6 or 7 at the school sites ($n = 894$) were invited to attend the first parent dialogue in each school, and formed the parent sample. Children of the parents

[1] Professional teachers responsible for addressing the day-to-day challenges learners face in pursuit of their educational aspirations. Their role is to guide and counsel learners, promote their physical and mental health, safety, security and child friendly environments.

described, who gave their assent to participate in the study ($n = 831$), formed the overall pupil sample. The majority of such pupils (90%, n = 748) were refugees, with 6% of pupils (n = 46) being from the host community. The remaining 4% (n = 37) were pupils who happened to be absent from school during the intervention period, as they had returned to South Sudan, and were therefore not screened. The age range of pupils who assented and who were also available to participate in the intervention (n = 794) was 11 to 35 years old. In Uganda, Primary 6 and 7 pupils are usually 11–13 years old. However, due to educational disruptions among refugees, many participants were older – 83% (n = 656; 232 females and 424 males) were 15 or above, with the oldest being 35.In addition, the sample included a total of 80 sectoral stakeholders who participated in group interviews.

Data collection

Data collection activities occurred alongside the intervention implementation to support the mixed-methods study design.

Quantitative data

The study's quantitative data set drew on the following sources of data: school enrollment records (which clarified the universe of parents and pupils for each school); completed parent permission slips (which pinpointed the proportion of parents that consented versus the proportion that declined); completed pupil assent slips (which highlighted the proportion of pupils that were not willing to participate compared to the proportion of parents that were), and screening tool statistics, which provided information on the proportion of pupils disclosing lifetime and current experience of SV, specific types of SV disclosed, perpetrator type, interest in service-seeking, and actual care-seeking following screening.

Table 3 Gender distribution of group interview participants

Participants in group interview	Female	Male	Total number
Parents of pupils screened in both schools	16	15	31
PSWs in both schools	5	6	11
Screening and service provision supervisors in both schools	2	1	3
Medical response partners	1	2	3
Child protection response partners	3	3	6
Government officials and partners at central level – Kampala	4	2	6
Government officials and partners at local level – Kiryandongo	1	4	5
Leadership at District Level – Kiryandongo	1	1	2
School personnel	3	5	8

Qualitative data

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

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

The documentation of fieldnotes adhered to a structured methodology, beginning with brief, informal notes taken during and immediately after each screening session or parent dialogue. These initial jottings served as memory aids, capturing key observations that could later be expanded into detailed narratives (Bernard 2011; Lofland et al. 2006). To ensure depth and analytical rigor, fieldnotes were elaborated by PSWs with support from GBV specialists into comprehensive written records on the same day, incorporating reflective commentary to interpret and contextualize observed interactions (Spradley 2016). Such analytic reflections, often referred to as "observer comments" or "memos," serve to clarify interpretations, highlight emerging themes, and pose critical questions for further analysis (Saldaña 2013; Wolfinger 2002). Parent dialogue reports also served as a form of fieldnotes, documenting insights gathered from the 6 parent dialogues (3 per school) and other interactions with parents/caregivers.

Group interviews Sixteen group interviews were conducted with a total of 8 different stakeholder categories across both schools, including: school personnel; parents/caregivers of pupils; PSWs conducting screening; local government/District leadership; medical response partners who managed survivors identified through the screening intervention; child protection response partners who managed survivors identified through the screening intervention; screening and service provision supervisors at the settlement level; and key agencies overseeing the protection, health, and/or education of refugees, nationally (Table 3).

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

Data analysis

Quantitative data

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

It should be noted that the quantitative measures used in this study were specifically the screening tool questions/indicators; other data sources – such as figures on overall sample size and participation – were obtained through additional intervention documentation (e.g., parent permission and pupil assent forms). To enhance clarity, we provide examples below of both structured and open-ended screening questions related to sexual violence:

- Have you ever experienced sexual violence?
- What kind of sexual violence has happened to you? Describe it for me.

To analyze the screening tool data, responses from both study sites were systematically entered into an Excel database, organized by screening questions. Responses to the open-ended question about children's experiences of sexual violence yielded a range of violence-related themes, which we organized into 11 categories, each defined in the table below (Table 4). Descriptive statistics were then generated for each variable around all indicators captured by the screening tool. We conducted significance tests of proportions to determine whether girls' experiences were statistically different from those of boys, assuming that the two samples (of girls and boys) were independent of each other.

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

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

Table 4 Types of sexual violence disclosed by pupils and their definitions in this paper

Types of sexual violence	Definition
Sexual harassment	Unwelcome and inappropriate behavior of sexual nature – pressure for sexual favors; letters of a sexual nature; sexual gestures; etc
Sexual touching	Touching of the genitals, breasts, and other sexual areas
Forced viewing of pornography	Exposure to sexual content without consent (videos, pictures)
Child sexual exploitation and abuse	Form of sexual abuse that occurs where an individual or group takes advantage of an imbalance in power to coerce, manipulate or deceive a child into taking part in sexual activity with another child/young person, for the financial advantage or increased status of the perpetrator or facilitator and/or through violence or the threat of violence.[a] In our cases, this form of SV happens in the context of initiation rites, child marriage, or war
Completed defilement/ rape	Physically forced or otherwise coerced penetration of the vulva, vagina, or anus with a penis, vagina, other body part, or object
Forced sexual touching or viewing of others	Being forced to touch the genitals, breasts, and other sexual areas of someone else (adult or child)

Qualitative data

Qualitative data played a crucial role in triangulating and contextualizing the quantitative findings. Content analysis techniques were employed to identify patterns, themes, and emerging narratives within the dataset (Braun & Clarke 2006). For fieldnotes, the primary screening tool topics were initially used as thematic codes, ensuring alignment with the study's key research questions. Multiple readings of the transcripts facilitated systematic coding and categorization of key themes related to pupils' experiences, disclosure dynamics, and service accessibility (Denzin & Lincoln 2018).

The subsequent phase of analysis encompassed all qualitative data sources and involved coding them based on their relevance to 'demand' and 'acceptability' indicators, following the feasibility framework proposed by Bowen

et al. (2009). Drawing on a deductive analysis approach, these feasibility indicators were established as a priori codes, which were then examined in relation to any parallel patterns identified within the quantitative dataset.

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

One researcher was involved in coding the qualitative data, while two researchers conducted the analysis. Some differences in opinion arose during the results-writing phase of the analysis. In these cases, the two researchers involved in the analysis discussed rationales for their opinions, with the strongest rationales invariably serving as the basis for eventual agreement.

Results

Evidence of demand

Parents' expressed interest or intention to use the intervention

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

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

> *'[After the dialogue], three [female] parents approached the GBV specialist separately and expressed a personal need for counseling, and during the counseling sessions, they disclosed that their children were defiled and got pregnant while studying in this school, and had dropped out of school. [The] parents asked if these children could still come to be screened and supported through counseling and referrals.' (Excerpt from parent dialogue report, School A)*
>
> *'During the parent dialogue, a female parent shared her testimony of how she got married at 14 due to relatives who used to mistreat her by not providing for her basic needs like food and school requirements. This parent was 31 years old with a firstborn boy aged 17. She appreciated that, in Uganda, it is a practice to speak against sexual violence and awareness creation is encouraged, unlike in South Sudan, where children grow up without being informed about sexual violence. She said that she is very happy to learn about sexual violence while in Uganda and she promised that she will continue being an ambassador against sexual violence, and when she returns to South Sudan she will continue discouraging sexual violence. She emphasized that she does not want her children to go through what she went through.' (Excerpt from parent dialogue report, School B)*
>
> *'In our community, once girls clock 9 years old, they are booked by men immediately, the man will even fulfill the bride price obligation of paying her parent with 100 cows and money. This pains me a lot because these girls have no choice, and the booking is arranged by us parents. This is the reason why I want the screening to be conducted for all the girls in the school.' (Excerpt from female parent - parent dialogue report, School A)*

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

> *'We can extend the dialogues to the community [...]. So [...] [all] parents, if they listen to this dialogue very carefully, they will also improve on their [parenting] work, on their behavior with others, [and] maybe the well-being in the community.' (Group interview, Female parents – School A)*
>
> *'Now that we, as parents, have been called in schools to come and attend the dialogues [...] we request they can come to the community, whereby [intervention implementers] can organize a community dialogue. [...] It can help disseminate the information, and the cases of sexual harassment may be eliminated com-*

pletely in our communities.' (Group interview, Male parents – School B)

Pupils' expressed interest and actual use of the intervention

Expressed interest in being screened

All pupils (100%, n = 831, of whom 748 were refugees) whose parents gave permission were willing to be screened and provided their assent (Table 5). Among the 831 pupils who provided written assent to be screened for SV, 96% (n = 794) were eventually screened. The remaining 4% who were not screened were absent from school during the intervention period (the majority had returned to their home country of South Sudan during this time). Of the 794 pupils who participated in the screening intervention, 62 percent were male, and 38 percent were female. The gender disparity is explained by enrollment and, by extension, attendance statistics in both primary schools. Male pupils represent the striking majority (68%) of attending pupils. Among the pupils screened, 178 (22%) were living with disabilities (42% female and 56% male).

Actual use of the intervention

Disclosure of sexual violence

As further evidence of demand for the intervention, pupils were not only willing to sign up to participate in the screening exercise, but were also willing to disclose their experiences of SV. Of the 794 pupils who were screened for SV, the vast majority (82%, $n = 653$) indicated that they had ever experienced some form of SV (461 disclosed during the first round of screening, and 192 during the second round). Broken down by gender, results show that a total of 249 (82%) out of 305 females, and 404 (83%) out of 489 males, had experienced some form of SV in their lifetime. 17% ($n = 53$) of females and 21% ($n = 102$) of males disclosed that they were currently experiencing SV (i.e., at the time of screening). Among the 178 pupils living with disabilities, an even greater proportion (92%, $n = 164$) reported having ever experienced SV (72 females and 92 males), and 22% ($n = 39$) were currently experiencing this form of violence (14 females, 25 males).

Table 6 presents the various types of SV that screened pupils disclosed experiencing in their lifetime. The statistical analysis reveals significant differences between girls and boys in the types of SV disclosed. While the overall prevalence of any SV is similar for girls (82%) and boys (83%) with no significant difference ($p = 0.718$), specific types vary notably. Girls report significantly higher rates of sexual harassment (49% vs. 18%, $p = 0.000$) and attempted defilement/rape (11% vs. 1%, $p = 0.000$). Conversely, boys report significantly higher rates of forced viewing of pornography (32% vs. 8%, $p = 0.000$), child marriage or attempted child marriage (20% vs. 8%, $p = 0.000$), completed defilement/rape (20% vs. 6%, $p = 0.000$), child sexual exploitation/abuse (15% vs. 0%, $p = 0.000$), and forced sexual touching or viewing of others (9% vs. 1%, $p = 0.000$). No significant differences were found in reports of sexual touching (31% vs. 29%, $p = 0.549$). These results highlight distinct patterns of sexual violence experiences between genders.

Table 5 Demographics of the pupils screened in both schools

Pupils screened	Female	Male	Total count
Grade 6	209	289	498
Grade 7	96	200	296
Age 11–14	73	65	138
Age 15–17	197	252	449
Age 18 and above	35	172	207
Refugee	277	471	748
Host community	28	18	46
Total pupils screened	305	489	794

Table 6 Proportion of pupils disclosing lifetime experience of sexual violence by type of sexual violence and gender, with p-values for gender differences

Type of sexual violence disclosed*	Girls $N = 305$	Boys $N = 489$	*p*-value
Any type of sexual violence	82% ($n = 249$)	83% ($n = 404$)	0.718
Sexual harassment	49% ($n = 149$)	18% ($n = 90$)	0.000
Sexual touching	31% ($n = 95$)	29% ($n = 140$)	0.549
Forced viewing of pornography	8% ($n = 23$)	32% ($n = 158$)	0.000
Child marriage/Attempted child marriage	8% ($n = 23$)	20% ($n = 96$)	0.000
Completed defilement/rape	6% ($n = 18$)	20% ($n = 99$)	0.000
Child sexual exploitation/abuse	0	15% ($n = 72$)	0.000
Attempted defilement/rape	11% ($n = 33$)	1% ($n = 6$)	0.000
Forced sexual touching/sexual viewing of others	1% ($n = 3$)	9% ($n = 43$)	0.000
Other (including inappropriate [non-genital] touching, oral sex, attempted genital touching)	2% ($n = 5$)	4% ($n = 15$)	0.121

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

'After getting circumcised, I was at home and a village member called me and asked to have sex with me, [saying], since I had been circumcised, I was ready to have sex. I refused and told him no. Then he grabbed me, pushing me down but I managed to scream, and other children came, then the man ran

away.' (Fieldnotes: 14-year-old girl, attempted defilement by a neighbor)

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

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

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

Disclosure of polyvictimization

A total of 305 pupils (47%) who disclosed ever experiencing SV also disclosed experiencing more than one type of SV concurrently. These experiences of multiple sexual victimizations of different kinds are captured in Table 7 below. As the Table indicates, sexual touching is a frequently experienced form of SV that occurs in practically every instance of polyvictimization described by children and adolescents.

Table 7 Proportion of pupils disclosing lifetime experience of sexual violence who had experienced more than one type of sexual violence concurrently

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

Table 8 Proportion of perpetrator types cited by pupils disclosing lifetime experience of sexual violence by gender, with p-values for gender differences

Type of perpetrator cited*	Girls $N=249$	Boys $N=404$	*p*-values
Fellow pupil	36% ($n=89$)	33% ($n=134$)	0.432
Neighbor	38% ($n=94$)	28% ($n=112$)	0.008
Relative	10% ($n=26$)	41% ($n=165$)	0.000
Friend	4% ($n=9$)	18% ($n=71$)	0.000
Stranger	28% ($n=70$)	18% ($n=71$)	0.003
Other (including teacher, community leader)	3% ($n=7$)	3% ($n=14$)	1.000

Disclosure of perpetrator types

Pupils were also willing to disclose the perpetrators of the SV that they had experienced. Among those disclosing ever having experienced SV, the most commonly reported perpetrators identified were fellow pupils (34%), closely followed by neighbors (32%), as shown in Table 8 below. The data shows notable differences between girls and boys regarding the type of perpetrator cited. There is no significant difference in perpetrators who are fellow pupils (36% of girls vs. 33% of boys, $p=0.432$). However, girls are significantly more likely to report neighbors (38% vs. 28%, $p=0.008$) and strangers (28% vs. 18%, $p=0.003$) as perpetrators. In contrast, boys report relatives (41% vs. 10%, $p=0.000$) and friends (18% vs. 4%, $p=0.000$) as perpetrators at significantly higher rates than girls. These findings indicate distinct gender-based patterns in the relationship to perpetrators of sexual violence. Pupils living with disabilities who had ever experienced SV ($n=164$) primarily mentioned fellow pupils ($n=26$) and neighbors ($n=24$) as perpetrators.

Uptake of services

All pupils who disclosed ever experiencing SV (100%, $n=653$) accessed a SV health service to attend to the issue. As part of the intervention, school-based PFA provided by trained PSWs was readily available and easily

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

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

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

Perceived demand for the intervention in the wider community

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

> *'Even the parents, they are now reporting to us. When they see something happening there, even with the neighbor's child, they […] report to the school. Because they know now, from the [parent] dialogues that they had here. Thank you.' (Group interview, School Personnel – School B)*
>
> *'When you look at the data […] we have right now […], I think around May, you see the number of children and adolescents who are coming in the clinics [increase]. Now we have reached up to nine hundred plus, and it used not to be like that. So, it has also created some impact here within the facility.' (Group interview, Medical Response Partners)*
>
> *'One thing that I got from this […] intervention: There are many ways that I learnt how to deal with children. Actually, [since] that day [parents dialogue day] I've been taking some notes, which I'm going to apply [.] But the knowledge I got from here, I will use it to help children in my area, in any community that I will be a part of.' (Group interview, Female parent – School A)*

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

> *'And apart from improving on attendance, the intervention has also made the learners to improve on their studies. They are now scoring higher grades compared to the time before the intervention began.' (Group interview, School Personnel – School A)*
>
> *'Lastly, this project has improved the education of our children. My child is now able to attend school every day, and she is now happy and has an interest in studying.' (Group interview, Male parent – School B)*

In general, there were multiple calls by the wider community for the expansion of the intervention, not only to additional schools but also to additional categories

of pupils (i.e., more grades), and additional refugee settlements:

> *'I wish it could be scaled up to the entire country. I wish it could go everywhere, in all regions of the country, because violence is not just in one refugee settlement […]. So I wish other partners could come on board, government could come on board and take it up and scale it up.' (Group interview, Government officials [OPM, MGLSD, MoE, MoH] – National level)*
>
> *'You should think of scaling up to other schools, bringing on board more para-social workers, more parental engagement, so that in all areas there is a chance of helping out. You can also think of training of trainers.' (Group interview, District leadership)*

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

> *'My main take is for the teachers to be trained because we are the ones who are with the learners most of the time. During the screening exercise, we had seven para-social workers in the school. [...] And look what they were able to do within that short period. You can imagine what the teachers can do if they are trained.' (Group interview, School Personnel – School A)*
>
> *'There was a child […] whom we have been referring to as a child having mental problems, but little did we know that the child had been going through several underlying challenges. And he had even lost hope in life and was even thinking of hanging himself. Thus, when screening was done, really, the challenges were identified, and referrals were made. Right now, the child is okay and doing very well in his studies and very interactive with his peers and other people […]. The intervention […] has made me very happy and made me to learn that, these children, we don't have to be handling them in a rough manner when they come to us. We need to listen to them because they have many challenges, hence, we need to give them a listening ear.' (Group interview, School Personnel – School A)*

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

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

Evidence of acceptability

Intent to continue use of the intervention

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

> *'We may not need to always place para-social workers in schools. We could use community/village health teams (VHTs), too. They are not only handling health issues, but they are also trained to address other issues, including VAC and GBV. They are trained to refer cases and provide psychosocial support. [...] We should integrate PSWs and VHTs for sustainability.' (Group interview, Government officials – National level)*
>
> *'The government has been informed, and now, we need to lobby for more resources, we need to act by educating, by sensitizing and doing that [screening]. (…) We need the teachers fully trained (…), because you will not keep on coming as a sustainable way, they must remain with the knowledge, they have to be equipped with the skills of screening because that skill can help them to [screen children] every term.' (Group interview, Local government leadership)*

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

> *'I think [the intervention] should be carried out in more schools. (…) We had around 18 [children] being referred daily, they come with their para-*

social workers (…) so if we see that big number [for two schools] how about when we tackle more schools? I think (…) it should be extended to those other schools, it would solve a lot.' (Group interview, Health response partners)

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

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

'The [screening intervention] approach being holistic, it has really covered all issues when it comes to [...] providing protection services because the cases that [were] identified were referred for immediate support and [...] even families were supported overall. We appreciate such a holistic approach. You should continue doing this and strengthen it and roll out even at the national level.' (Group interview, Child Protection response partners)

Satisfaction with the intervention among pupils

Pupils intimated that the screening intervention was particularly valuable to them. Given the child-parent and parent–child communication challenges mentioned above, their satisfaction stemmed largely from the newfound ability to discuss their experiences of SV with their parents/caregivers. An emerging organizing theme across these accounts was a strengthened feeling of being cared for – rooted not only in improved communication, but also in children seeing clear indications of adults' willingness to take action to protect them. The screening helped reveal these experiences, and, over time, the series of student sensitization sessions and parent dialogues equipped children/adolescents and parents alike to handle such sensitive topics. Some children/adolescents who struggled to disclose their experiences directly to their parents asked the PSWs to facilitate communication, further enhancing the connection between parents and children/adolescents.

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

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

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

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

'During the first screening, I was scared to tell you, I felt guilty and thought you would blame me for this [attempted defilement incident]. I thought my teachers, parents, and fellow pupils would be informed and I would be embarrassed.' [After PFA], the PSW and the girl agreed [that the girl would] tell [her] mother. [The girl] said 'I am happy. Thank you for counselling me, and as agreed with you, I will let my mother know. Thank you so much!' (Fieldnotes: 17-year-old girl, attempted defilement by a neighbor)

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

the voice to speak out their minds.' (Group interview, School Personnel – School B)

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

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

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

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

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

Discussion and conclusion

The feasibility of screening children/adolescents for SV has been established and documented by previous studies (Undie & Mak'anyengo 2020, 2022, 2023). What has been less clear is the extent to which similar interventions can be successfully applied in humanitarian contexts with robust results. Findings from the present study demonstrate similar patterns when compared to the original, development setting-based screening intervention (Undie & Mak'anyengo 2020): ultimately, the intervention in both contexts resulted in high survivor disclosure and service uptake rates. This finding is important, given that, in the present study, trained PSWs took on a function originally designed for trained psychologists. It underscores that, in low-resource contexts, PSWs are able to play a critical role in the response to SVAC – one that supports children and adolescents in opening up and in getting the care that they need. Although this was not directly evidenced by the feasibility study findings, instituting the close supervision and mentoring of PSWs by a higher cadre of providers (as carried out under the current intervention) is essential to ensure that PSWs become comfortable, confident, and proficient in their screening role over time, and that careful attention to ethical issues remains foregrounded.

This study reveals a very high prevalence of SV, with 82% of screened pupils reporting some form of SV – substantially higher than figures documented in other contexts. This suggests that SV has been significantly underreported in humanitarian settings, particularly for less acute but highly prevalent forms such as sexual harassment, forced viewing of pornography, and sexual touching. These findings highlight the need for humanitarian stakeholders to expand their focus beyond severe cases and prioritize interventions that encourage disclosure of all forms of SV among children and adolescents, while strengthening linkages to care services.

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

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

This finding echoes research showing that adolescent boys in crisis contexts face specific risks of SV (Kapila 2023; Chynoweth et al. 2022). In parallel, the predominance of sexual harassment disclosures among girls aligns with earlier studies of gendered SV in displaced settings where peer-perpetrated violence is common (Bukuluki et al. 2021). These gender-specific patterns have important programmatic implications: humanitarian interventions must offer safe disclosure pathways and trusted service providers for boys, including specialist male-focused support, and integrate prevention and response for less overt but widespread forms of SV – such as forced pornography viewing and harassment – for both genders. Moreover, community and school-based prevention should attend to cultural rites and gender norms, especially where boys may be targeted after rites of passage, by incorporating age-appropriate sexuality education, consent training, and engagement with traditional leaders to mitigate post-rite vulnerabilities.

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

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

With regard to perpetration, a high proportion of those identified as inflicting SV on pupil survivors happened to be fellow pupils, in addition to neighbors, strangers, and (for boys) relatives. This finding corroborates previous research showing that fellow children and adolescents are often the perpetrators of SVAC (Finkelhor et al. 2014). It underscores the importance of continuing prevention and response efforts in environments where children spend time – such as schools – within humanitarian settings. Given thisrange of offenders, community-wide prevention approach is essential to stem SV. Furthermore, a thoughtful, tailored, early onset approach is required for addressing perpetration by children and adolescents – one that involves age-appropriate education centered on issues such as consent, healthy relationships, healthy sexuality, and gender issues (Undie et al. 2007; Undie & Mak'anyengo 2020).

Parent–child communication for the enhancement and safeguarding of children's sexual and reproductive health and rights is well-discussed in the literature (Crichton et al. 2012; Kamangu et al. 2017; Isaksen et al. 2020; Grey et al. 2022). However, this study adds to the sparse evidence base on the importance of child-parent communication for preventing and responding to SV. It is as critical for children and adolescents to be empowered to communicate with their parents about SV as it is for their parents to be equipped for such conversations. Evidence from parenting programs in humanitarian and low-resource settings shows that strengthened parent–child interactions, increased positive parenting skills, improved caregiver-adolescent communication, and reduced harsh discipline can be achieved (Sim et al. 2014; Cluver et al. 2018). Findings from Uganda similarly show that parenting interventions can reduce child abuse and GBV, including through improved communication, greater caregiver engagement, and intentional involvement of male caregivers to prevent and reduce violence against children (Siu et al. 2017). These findings reinforce the need for interventions that foster bi-directional communication between children and parents as a means of mitigating SV (Undie & Mak'anyengo 2023). Without them, child/adolescent survivors are unlikely to have the tools to be proactive in disclosing SV incidents early on before they escalate.

A unique aspect of the intervention in the humanitarian context involves the age range of pupil beneficiaries. In Uganda's development context, pupils in Primary 6–7 are typically 11- to 13-years-old. With the disruptions to education faced by refugees in their home countries, a considerable proportion understandably falls outside this age range. In the present study, 83% of pupils who participated in the screening intervention were aged 15 and above, with the oldest pupil being aged 35. This reality points to two issues: the fact that school-based interventions in humanitarian settings must take older pupil populations into account, and the evidence (from the present study) that screening interventions designed to promote disclosure and health service uptake among children and adolescents might also be useful for older students schooling within the same context.

While this study was designed to assess feasibility, evidence from school records demonstrates what happens when screening does not occur, shedding light on the effectiveness of the screening intervention, as well. Specifically, school records collated by WIU, UNHCR's lead implementing partner for education, indicate that in the absence of screening in the two primary schools for a full 12-month period before the intervention began (February 2023 to March 2024), a total of 16 pupils were passively identified (i.e., identified without any intervention: pupils either presented themselves to school personnel, or were identified by school personnel through personal observation) and supported as SV survivors. During this same 12-month period, a total of 40 survivors of SV were

passively identified across all 5 public primary schools in Kiryandongo combined. In contrast, during the 5-month period devoted specifically to screening in the two primary school sites (May to September 2024), a total of 653 pupils were identified as having experienced some form of SV, and as having received care.

Nevertheless, screening for SV within schools is only recommended with an abundance of caution. In the intervention under assessment, the training of PSWs was coupled with close, day-to-day supervision, monitoring, capacity-building, and mentoring of PSWs by GBV specialists throughout the 5-month screening period to ensure a robust and ethical response to survivors. Intermittent monitoring was also conducted by the MGLSD. PSW monitoring and oversight will continue to be key under this task-shifting model. To render this even more feasible, screening can be scheduled to occur once a term, or twice overall during the school year.

The limitations of this study are acknowledged. Despite the high school enrollment rates in the study context, which make schools an efficient platform for reaching children/adolescents, it is plausible that pupils who were absent from school during the intervention were experiencing worse forms of SV that hindered their school attendance. For example, a small proportion of pupils who signed up to participate in the intervention ended up being absent from school throughout the intervention period. To ensure that out-of-school children, especially girls (representing only 38% of the pupils screened in this intervention), can disclose experiences of SV and access support, screening tools such as the one used here could also be implemented in other child-centered spaces, including community centers, youth groups, and health facilities, as has been done in Kenya (Undie et al. 2016b). In addition, community-based programs such as safe spaces, girls' clubs, and life-skills groups (Erulkar & Medhin 2017), as well as out-of-school comprehensive sexuality education initiatives (Malata et al. 2023), offer promising avenues to reach children who are excluded from school and to provide both prevention and response services.

Furthermore, although a small proportion of parents declined participation in the intervention, the study still focused on a sample of parents (and pupils) that consented to participate. While this sample was the vast majority and therefore cannot necessarily be said to be a select group, it is noteworthy that parents who chose not to participate may have had different characteristics that the study is unable to capture.

Additionally, although 85% of the pupils screened were aged 15 and above, acceptability of the intervention was also high among parents of younger children (ages 11–15). Parents of children in lower primary grades who participated in the parent dialogues expressed strong interest in expanding the intervention to additional classes and schools, suggesting broad parental support across age groups.

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

Abbreviations

CMR	Clinical management of rape
GBV	Gender-based violence
HIV	Human immunodeficiency virus
HVACS	Humanitarian violence against children and youth survey
IRC	International rescue committee
LWF	Lutheran world federation
MGLSD	Ministry of gender, labour and social development
MoES	Ministry of education and sports
MoH	Ministry of health
OPM	Office of the prime minister—department of refugees
PSW	Para-social worker
REPSSI	Regional psychosocial support initiative
RPC	Research programme consortium
STI	Sexually-transmitted infection
SV	Sexual violence
SVAC	Sexual violence against children
TfG	Together for girls
UNHCR	United nations high commissioner for refugees
VAC	Violence against children
VACS	Violence against children and youth surveys
WHO	World health organization
WIU	Windle international Uganda

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Authors' contributions

C.U. designed the study with support from the study team; G.S., A.N., H.N., and C.U. oversaw the implementation of the intervention and data collection; A.N. led the data analysis and preparation of the manuscript with support from C.U.; the study team reviewed the manuscript for substantial intellectual content. All authors contributed to revisions of the manuscript and read and approved the final manuscript.

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Data availability
The datasets generated and/or analysed during the current study are not publicly available but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethical approval and research clearance for the study were provided by the Population Council's Institutional Review Board (Protocol 1033), the Mildmay Uganda Research Ethics Committee (Approval No. REC REF 0611–2023), and the Uganda National Council for Science and Technology (Approval No. SS2265ES). Pupils were only eligible for participation in the intervention if they had parental permission, and if they additionally granted their own assent. Pupil participation remained voluntary, despite parental permission. All participants (and their caregivers, for minors) provided informed written consent/assent to participate.
The study was conducted in accordance with the WHO Ethical and Safety Recommendations.

Consent for publication
Consent and assent for publication were obtained from all study participants.

Competing interests
The authors declare no competing interests.

Author details
[1]Population Council, Inc., Nairobi, Kenya
[2]Population Council Kenya, Nairobi, Kenya
[3]African Population and Health Research Center, Nairobi, Kenya
[4]School of Public Health, College of Health and Medical Sciences, Haramaya University, Harar, Ethiopia
[5]Windle International Uganda, Kampala, Uganda

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