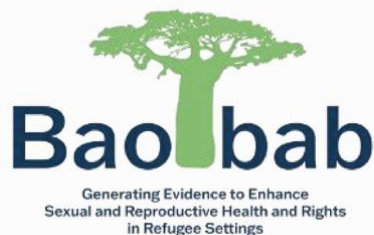




The Power of Asking: A Feasibility Assessment of Incentive Social Worker-Led Screening for Sexual Violence Against Children in Humanitarian Settings in Ethiopia

Baobab Research Programme Consortium Report

April 2026



Authors

Baobab Research Programme Consortium

Yadeta Dessie, Abir Nur, Dagim Habteyesus, Bonnie Wandera, Gloria Seruwagi, George Odwe, Peter Kisaakye, Francis Obare, Abdubasit Nuradin, Bezanesh Esubalew, Stella Muthuri, Caroline Kabiru, Yohannes Dibaba Wado and Chi-Chi Undie

RRS Ethiopia

Niway Mengistu, Misrak Mohamed, Mulualem Desta

IRC-Ethiopia

Lemlem Tsegaye

Plan International-Ethiopia

Shimelis Tadesse

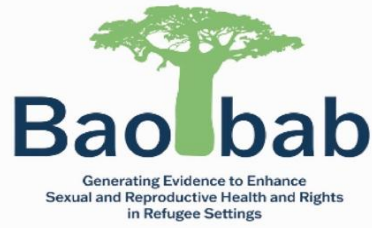
UNHCR-Ethiopia

Sidra Anwar, Sofia Esmail

Suggested citation: Dessie Y., Nur A., Habteyesus D., Wandera B. et al. (2026). "The Power of Asking: A Feasibility Assessment of Incentive Social Worker-Led Screening for Sexual Violence Against Children in Humanitarian Settings in Ethiopia," *Baobab Research Report*. Nairobi, Kenya: Population Council, Inc; Population Council Kenya, and the African Population and Health Research Center.



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Acknowledgements

We deeply value our partnership with the Federal Republic of Ethiopia's Refugees Returnees Service (RRS) at the central, regional, and camp levels for their formidable collaboration at all steps of the screening intervention. We are grateful to the non-governmental partners that contributed to the intervention implementation and/or monitoring, including the United Nations High Commissioner for Refugees (UNHCR) Ethiopia and its implementing partners in refugee settings, including the International Rescue Committee (IRC) and Plan International.

Our thanks also go to the twelve incentive-social workers who were actively involved in the screening intervention and who generated much of the study's data: Adem Kelil, Amya Abdusemed, Shahid Khami, Ekelas Kelifa, Luke Yenti, Bedriya Kelifa, Ahmed Elias, Asir Ibrahim, Gatluak Mayo, Hamid Gabash, Nidal Gemer, and Zaineb Kharasit.

We express our deep appreciation to the Bambasi Primary and Middle School in Bambasi refugee camp, which served as the study site. We thank the parents and pupils, the teachers and head teachers, and other school staff. We thank them all for bravely taking a chance on the screening intervention; for sharing their knowledge, experiences, and voices; and for sharing their ideas on how to intervene better to prevent and respond to sexual violence against children.

The intervention was also supported by child protection and medical response partners, including IRC, which offers psychosocial support services for survivors of sexual violence in Bambasi refugee camp, as well as Medical Teams International, which attended to several survivors who needed medical services.

Finally, we gratefully acknowledge the UK Government for their visionary investment in the Baobab Research Programme Consortium and for funding this study.

Acronyms

GBV	Gender-Based Violence
HVACS	Humanitarian Violence Against Children and Youth Survey
IRC	International Rescue Committee
MTI	Medical Teams International
PI	Plan International
RRS	Refugees and Returnees Service
ISW	Incentive Social Worker
RPC	Research Programme Consortium
SV	Sexual Violence
SVAC	Sexual Violence Against Children
UNHCR	United Nations High Commissioner for Refugees
VAC	Violence Against Children
VACS	Violence Against Children and Youth Survey
WHO	World Health Organisation

Executive Summary

Sexual violence against children (SVAC) is an acknowledged concern in humanitarian contexts. In response to recent findings on the prevalence of SVAC in refugee camps in Ethiopia, coupled with low levels of disclosure and service-seeking by child/adolescent survivors, the Baobab Research Programme Consortium collaborated with humanitarian stakeholders in Ethiopia to establish mechanisms for promoting sexual violence disclosure and service uptake among young survivors in refugee settings.

This study employed a mixed-methods concurrent triangulation study design (involving a combination of service statistics, group interviews, and fieldnotes) for evaluating the feasibility of the aforementioned intervention, which specifically entailed sexual violence screening (of pupils in Grades 6-8), referral protocols, and service provision within Bambasi Primary and Middle School in Bambasi refugee camp, Bambasi District, Southwestern Ethiopia. The 7-month intervention, led by incentive social workers, took place from May to November 2025.

The study focused on feasibility outcomes related to the ‘demand’ for, and ‘acceptability’ of, the intervention, and concluded that school-based screening led by incentive social workers is feasible, and results in more robust impacts when it comes to survivor identification and linkage to care than conventional approaches, as the following key findings demonstrate:

- Parents were willing for their children to be screened, with 100% of those who were sensitised to the intervention (n=1,118) granting their permission – some, for multiple children who were eligible. Parents also advocated for expanding the intervention beyond the participating grades and school context to ensure that more children, parents, and the wider community could be reached with the benefits of the intervention.
- The vast majority of pupils whose parents had given permission to participate in the intervention were also personally willing to participate, and provided their assent to do so (99.6%, n=1,123).
- The 7-month screening intervention led to the proactive identification of child/adolescent survivors: One in five screened pupils (20%; n=233) disclosed lifetime experience of SV to the incentive social workers in response to screening. This contrasts with a total of 3 child/adolescent survivors passively identified in the same school context in the 12-month period prior to the intervention.
- The screening intervention led to service uptake by survivors: All 233 pupils disclosing sexual violence received school-based psychological first aid (PFA) from the ISWs and GBV counselors. More acute forms of sexual violence received further psychosocial support from the nearest gender-based violence care and support centers and/or health facility.
- A wide range of humanitarian actors called for the expansion of the intervention to other schools, refugee camps, and beyond.

Programmatic Recommendations

- A careful, cautious approach to introducing SV screening protocols (be it in school or elsewhere) is proposed, with a focus on: 1) establishing functioning, post-screening service provision and strong, ‘warm’ referral systems before the commencement of screening, and 2) close monitoring, supervision, and mentoring of incentive social works conducting screening.
- Implement community-wide prevention and response programmes that target a wide range of community members to holistically address SV against children/adolescents.
- Experiment further with screening approaches (and other intervention components that they are combined with) to pinpoint and enhance boy-friendly approaches that can enhance SV disclosure among boys.
- Develop and implement interventions geared toward shifting gender norms that hamper sexual violence disclosure for boys.
- Mainstream inclusion and equity in screening designs to ensure the latter are gender-sensitive, disability-inclusive, and culturally adapted approaches to ensure equitable access for all children.
- Institutionalise screening through policy and guidelines, including in the next iteration of Ethiopia’s National School-Based GBV Guidelines.

1. Introduction

This study evaluates the feasibility of an intervention that is designed to proactively identify child and adolescent sexual violence (SV) survivors and connect them to care, while also changing norms that help sustain violence. The study is an initiative under the Baobab Research Programme Consortium (RPC), which focuses on filling gaps in evidence to enhance sexual and reproductive health and rights among vulnerable populations in refugee settings in the East and Horn of Africa. Baobab does this by transposing adapted study tools and intervention approaches from development settings (where they were initially tested and validated) to refugee contexts, typically, for the first time. This study is a second-time refugee context adaptation of a previous intervention developed and tested in development settings in Nairobi, Kenya in 2017 (Undie & Mak'anyengo, 2022). It was later adapted for implementation in refugee settings for the first time, in Uganda (Nur et al., 2025).

The study was developed in response to results from a nationally representative survey in refugee contexts in Ethiopia. The Violence Against Children and Youth Surveys (VACS), conducted in 26 countries to date worldwide, are considered to be one of the best sources for gathering data on violence in childhood, globally (Centers for Disease Control and Prevention, 2024). Originally developed for implementation in development settings, these surveys provide an understanding of the types, timing, and location of violence in childhood, and the results that they produce are used by countries to implement evidence-based responses for preventing such violence (ibid.). In 2024, in collaboration with the Federal Republic of Ethiopia's Refugees and Returnees Service (RRS), UNHCR, and a range of other humanitarian partners, Baobab carried out the second-ever Humanitarian Violence Against Children and Youth Survey (HVACS) to date, focusing exclusively on refugee settings (Wado et al., 2024). Conducted in 20 out of the 23 existing refugee camps in Ethiopia, findings from this HVACS highlighted that one in four (26.4%) females and one in three (31.9%) males aged 18-24 in Ethiopia's refugee camps experience either sexual, physical, or emotional violence during childhood. The prevalence of such forms of violence is even higher among children aged 13-17 – at 38% for males and 44% for females. A disaggregation of these forms of violence reveals sobering realities for girls: females in the 18-24-year-old age range experience SV in childhood at nearly six times the rate of their male counterparts (13.9% vs 2.2%).

Disclosure of SV by child/adolescent survivors is low for both females and males (ranging from 6.5%- 47.8%, depending on age group and sex of participant). Help-seeking among child/adolescent survivors of SV is also low – only 1.7% of females and no males aged 13-17 years who experienced SV in the past 12 months sought and received help, and only 5.1% of females and 17.2% of males aged 18-24 years who experienced childhood SV sought help.

In November 2024, the RRS and Baobab convened a Data-to-Action workshop with humanitarian stakeholders to discuss the HVACS findings and identify priorities for

prevention and response to violence against children and youth in the country. In line with all VAC Data-to-Action workshops globally, the discussions were guided by the World Health Organisation's INSPIRE framework, which points to seven evidence-based strategies for reducing violence against children (WHO, 2016), namely: Implementation and enforcement of laws; Norms and values; Safe environments, Parent and caregiver support; Income and economic strengthening, Response and support services, and Education and life skills. Each strategy within the INSPIRE framework is paired with specific intervention approaches.

The HVACS Data-to Action workshop in Ethiopia culminated in the selection of the following priorities by humanitarian stakeholders – the need to: address SV in particular; attend to the low rates of SV service knowledge, access, and use among child and adolescent SV survivors; shift negative gender norms in communities; foster parental engagement with children; and harness the protective environment provided by education context (Dessie et al., 2025)

Although screening can play a role in responding to the aforementioned priorities, evidence-based, systematic screening interventions for children and adolescents are currently nonexistent in Ethiopia. Nonetheless, the 'Response and support services' strategy under the INSPIRE framework recommends 4 possible, evidence-based interventions, including 'screening combined with other interventions' (WHO, 2016). This study therefore contributes to building the evidence base in humanitarian settings and on child-focused SV screening by assessing the feasibility of adapting and conducting a sexual violence screening intervention for children/adolescents in school settings, coupled with psychological first aid/first-line counseling and service uptake components to respond to identified survivors.

A similar screening intervention recently implemented in refugee settings in Uganda (Nur et al., 2025) demonstrated that the model addresses SV by proactively pinpointing child/adolescent survivors and dramatically promoting their uptake of SV services, while also strengthening communication between children and their parents as a protective measure in relation to SV, and shifting harmful norms. The present study replicates this Uganda model with slight adaptations which are described in later sections of this report.

2. Study Aim, Design, and Context

2.1. Aim

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

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

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

Table 1: Evaluation Focal Areas and Outcomes		
Areas of focus	Feasibility studies ask ...:	Outcomes of interest
Demand	To what extent is the new intervention/programme likely to be used (i.e., how much demand likely exists)?	<ul style="list-style-type: none"> ▪ 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/programme judged as suitable, satisfying, or attractive to programme deliverers? to programme recipients?	<ul style="list-style-type: none"> ▪ Intent to continue use of the intervention ▪ Satisfaction with the intervention

Adapted from Bowen et al. (2009).

2.2. Design

The study replicated the design and methodology of the original, Kenya-based evaluation, described elsewhere (Undie and Mak'anyengo, 2020) and of the Uganda refugee-based study (Nur et al., 2025). Specifically, a mixed-methods design was employed, drawing on a concurrent triangulation strategy (Creswell et al., 2003). This design integrates qualitative and quantitative data into a single, unified analysis, following an initial, separate analysis of each data set, and the subsequent merging of the two for cross-validation.

2.3. Context

Located in southwestern Ethiopia's Beninshangul-Gumuz region, Bambasi District, Womba Kebele, Bambasi refugee camp was first established in 2012 and is coordinated by the RRS Assosa branch office. The camp has an area coverage of 4.542 km² and is located 646 km from Addis Ababa, 48.6 km from Assosa (the regional capital), and 10 km away from Bambasi town. The camp mainly hosts refugees from Sudan (99.56%), while those from South Sudan (0.15%), and other countries (0.29%) form a minority of the refugee population (Refugees and Returnees Service (RRS), 2026).

The latest Ethiopia HVACS data showed that Bambasi refugee camp is among the high-violence reporting refugee camps in Ethiopia. There is only one combined primary and middle school within this camp – Bambasi Primary and Middle School – which served as the study site.

3. Intervention Description

3.1. Partnership

The screening intervention implementation was enabled through a collaborative effort between Baobab, the RRS, UNHCR, and several UNHCR implementing partners. The RRS is a governmental institution whose main role is safeguarding refugees' human rights, ensuring camp safety, and maintaining their civilian character with the mission of providing durable solutions to refugees by recognising, protecting, and helping them benefit socially and economically along with their hosts. The RRS closely works with UNHCR and other UN agencies and national and international implementing partners in Bambasi refugee camp. The roles of the RRS and UNHCR during the intervention period entailed facilitating Baobab's entry into the school site, working closely with Plan International to support the convening of parent dialogues in collaboration with the school and the collation of all necessary data that supported the feasibility assessment, and providing guidance to ensure the intervention functioned within expected protocols in the school setting. Plan International, UNHCR's main implementing partner within the education sector, provided leadership for the activities in the school. Their responsibilities included convening parent dialogues with the school, collating survivor reporting information, and working with the response partners to facilitate successful survivor referrals. Additionally, Plan International ensured that the intervention was integrated into school sites without disrupting normal operations. The International Rescue Committee provided psychosocial care and support to survivors identified during the screening process. During the intervention implementation period, Baobab RPC provided technical support for the monitoring of the intervention implementation, as well as for the generation of monitoring and evaluation data.

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

3.2. Adaptation

Refugee Incentive Social Workers (ISWs) support the work of the RRS and other partners in Ethiopia's refugee camps. Their main roles as community volunteers who receive small stipends (incentives), rather than full wages, include teaching, interpretation, community

support, and health outreach. In Bambasi refugee camp, the RRS, UNHCR, and their partners rely heavily on the contribution of refugee ISWs for child protection case management and other targeted interventions. These workers actively engage in conducting intake assessments, developing action plans, providing direct psychological first aid, making referrals to specialised care (health, legal, protection, community outreach, and psychosocial support), delivering certain services directly to refugees, and identifying vulnerable individuals in their communities. The original Kenya-based screening intervention relied on psychologists to screen children for SV. The adaptation approach for this intervention in refugee settings in both Uganda and Ethiopia involved task-shifting to community volunteers. In Uganda, para-social workers under the Ministry of Gender, Labour, and Social Development conducted the screening, while in the Ethiopian refugee context, ISWs played this role.

Lastly, while the Kenya and Uganda versions of this study focused on screening pupils in Grades 6 and 7, the present study in Ethiopia focused on those in Grades 6, 7, and 8.

3.3. Intervention Components

The intervention was carried out from May to November 2025 and comprised five components, namely: Parent Dialogues, Student Sensitisation, Provider Training, Screening for SVAC, and SVAC Service Provision. Although these components are described in detail elsewhere (Undie and Mak'anyengo, 2020, Undie and Mak'anyengo, 2022, Nur et al., 2025), in this report, we again outline the details to demonstrate the contextualisation of the model within the Ethiopian refugee context.

3.3.2. Parent Dialogues (May to October 2025)

In collaboration with the RRS and UNHCR, Baobab convened three parent dialogues in Bambasi Primary and Middle school, with parents of all learners in grades 6, 7, and 8 invited to participate. These 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 camp and other relevant topics such as the negative consequences of such abuse, the barriers to children/adolescents seeking care for it, parental barriers to seeking care for their children, and school-based screening as a possible solution. The dialogues also served as an efficient platform for obtaining written consent from willing parents for their children to participate in each aspect of the screening exercise – including confidential, child-friendly screening; school-based counseling and accompanied referrals, as needed; and anonymised documentation of notes and service statistics based on the screening

processes. Particular emphasis was laid on the fact that participation was completely voluntary for both parents and pupils; parents and pupils could change their minds at any time; pupils would only be invited to participate if their parents had opted in; and that there were no repercussions for whichever decision parents and pupils made. Parent dialogues were also used as a forum for disseminating emerging findings to parents, school staff, and the multi-sectoral supervision team.

3.3.2. Student Sensitisation (May to October 2025)

Student sensitisation involved integrating information about the impending intervention into existing student school assemblies and free classroom periods. These assembly sessions were coupled with classroom sensitisation sessions conducted by two Gender-Based Violence (GBV) specialists who monitored the day-to-day implementation of the intervention, supervised the screening, documentation, and psychological first aid provided to survivors by ISWs, and provided overall support to the ISWs and school personnel throughout the intervention period. During the assembly and classroom sensitisation sessions, ISWs and GBV specialists collaboratively shared information with pupils on the planned intervention, as well as on SVAC, and informed pupils that their school was taking measures to make it easier for pupils to receive care for SV if it ever occurred.

3.3.3. Incentive Social Worker Training (May 2025)

The intervention included 12 trained ISWs assigned to the school on a full-time basis during the study period. Female ISWs solely screened female pupils, while male pupils were only screened by male ISWs (Table 2).

Table 2: School Population and Incentive Social Worker Distribution		
	<i>Bambasi Primary and Middle School</i>	
	Girls	Boys
Attendance during the intervention period	701	677
Total number of pupils attending school during the intervention period	1378	
Number of ISWs assigned to school		
Number of female ISWs assigned to school	7	
Number of male ISWs assigned to school	5	
<i>Total number of ISWs assigned to the school</i>	12	

To minimise language barriers in the course of their duties, ISWs were identified by the RRS from within Bambasi refugee camp, in collaboration with implementing partners. ISWs in Ethiopia have a minimum of a completed Grade 10 education and are of any gender.

ISWs supporting the screening intervention underwent a 5-day training session, led by Baobab and the RRS, with the support of IRC case workers. The training session focused on values clarification around violence against children; understanding, administering, and filling out the screening tool effectively; sensitively screening children/adolescents for SV experiences; offering psychological first aid to children/adolescents; managing referrals emanating from the school; note-taking to document field notes; and serving as child survivor advocates to enhance the screening, referral, and service provision process.

3.3.4. Screening, Referrals, and Service Provision (May to November 2025)

The screening exercise was conducted using a designated screening tool at Bambasi Primary and Middle School (*see* Appendix 1). The tool was designed to gather information on lifetime and current experiences of SV, including the form(s) of violence experienced, the timing of these incidents, the perpetrator types, interest in service-seeking, interest in having parental/caregiver presence as part of the service-seeking process, and disability status (drawing on the Washington Group on Disability Statistics indicators).

Some questions, particularly regarding the types of SV experienced, were designed to be open-ended, allowing learners 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 Organisation (WHO) definition of the term: ‘non-consensual completed or attempted sexual contact and acts of a sexual nature not involving contact (such as voyeurism or sexual harassment)’ (WHO, 2019)

ISWs facilitated the screening exercise during free periods at school and during the school's summer break (July to August 2025), during which students were invited to the school for screening. All pupils in grades 6, 7, and 8 whose parents had given permission (*see* Appendix 2) and who gave their own personal assent (*see* Appendix 3) were invited to participate in the screening exercise. ISWs maintained a register of eligible pupils and, with the help of teachers and GBV specialists, systematically invited those listed for screening one after the other. Screening was carried out in private rooms designated for this purpose within the school. The majority of the eligible pupils (93.1%) were screened once during the intervention period. Students who did not report experiencing SV during the first round of screening (82.9%, n=930) were screened one more time during the second round of screening. As the second round occurred after students' summer break, sixty-nine (69) pupils were absent and thus could not be screened a second time.

If a pupil reported having experienced SV, the ISW offered school-based psychological first aid for as long as the child/adolescent survivor needed it over the life of the intervention and inquired if the child/adolescent wanted to discuss their experience further and receive additional support. Those who requested or required further care (e.g., in the case of rape/defilement) received an accompanied referral to the nearest psychosocial support center and/or health facility, respectively managed by the IRC and MTI in Bambasi refugee camp.

3.4. Ethical Considerations

Ethical approval and research clearance for the study were provided by the Population Council's Institutional Review Board and the Ethiopian Public Health Association (EPHA) (Approval No. EPHA/06/227/25).

Pupils were only eligible for participation in the intervention if they had parental permission. Pupil participation remained voluntary, despite parental permission. To ensure pupils were as comfortable as possible during the screening process, female ISWs solely screened female pupils, while male pupils were only screened by male ISWs. Screening also occurred in locations offering audiovisual privacy. Furthermore, the screening tool contained measures designed to be child survivor-friendly, including prompts for ISWs to remind pupils that there were multiple ways to respond to the questions, such as by doing so verbally, by writing down their response, or by using dolls to demonstrate what occurred, rather than verbalising the incident. The screening tool also included prompts to remind the pupil that they did not have to respond to any questions that they did not want to, and that there would be no repercussions for choosing not to respond.

The intervention site was situated in very close proximity (walking distance) to external response services. Furthermore, sensitisation sessions were held with humanitarian partners providing child protection and health services to alert them to the fact that an increase in their child/adolescent client load was likely to occur due to the intervention, and to have them prepare to efficiently manage these emerging cases. In addition, experienced case workers from the implementing partners were actively engaged from the beginning, and participated in the training of ISWs.

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

3.5. Study Sample

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

All parents who had children in grades 6, 7, and 8 at the school site ($n = 1378$) were invited to attend the first parent dialogue and served as the parent sample. A total of 1118 parents gave their permission – some, for multiple children who happened to be eligible for participation. Children of those who gave parental permission, and who additionally provided their personal assent to participate in the study ($n = 1123$), formed the overall pupil sample.

All of the pupils were refugees, as the school is dedicated to refugees alone. The age range of pupils who assented and who were also available to participate in the intervention was 10 to 41 years old, with 74.38% being aged 15 or older at the time of the screening. In addition, the sample included a total of 69 different stakeholders who participated in group interviews/discussions.

3.6. Data Collection

Data collection activities occurred alongside the intervention implementation, as outlined below.

3.6.1. Quantitative Data

The study's quantitative data set drew on the following sources of data: school enrollment records; 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.

3.6.2. Qualitative Data

The study's qualitative data set drew on three data sources: 1) Fieldnotes documented by ISWs with the support of GBV specialists, 2) Parent dialogue reports documented by GBV specialists, and 3) Group interviews with various stakeholders.

Fieldnotes

The fieldnotes were generated through participant-observations conducted by trained ISWs during the screening process. During screening sessions, ISWs manually documented fieldnotes for each child who disclosed having experienced SV, capturing direct quotes of

the description of SV incidents and other relevant observations. GBV specialists held daily debriefings with ISWs to collaboratively review the fieldnotes and screening tool and ensure rigorous documentation. Fieldnotes were only documented for pupils disclosing SV. In total, 233 fieldnotes were compiled.

The documentation of fieldnotes adhered to a structured methodology, beginning with brief, informal notes taken by ISWs during each screening session, and fleshed out after these sessions in collaboration with the GBV specialists.

Parent Dialogue Reports

Parent dialogue reports also served as qualitative data source, documenting insights gathered from the three parent dialogues conducted at Bambasi Primary School, and other interactions with parents/caregivers. GBV specialists documented the proceedings of these dialogues, taking detailed notes on discussions and captured key exchanges between the project team and parents, and provided an account of community perspectives on the intervention. These notes were subsequently synthesised into structured reports that provided a comprehensive account of engagement dynamics, emerging themes, and community perspectives.

Group Interviews

Group interviews are defined as “interviews where two or more participants engage in a discussion led by one or more interviewers (Guest, 2017). A total of 16 group interviews were conducted across 8 different stakeholder categories (Table 3), generating collective insights and shared perspectives among participants.

Table 3: List of Group Interview Participant Categories

S/n	Participant categories	Groups	Number of Participants		
			Male	Female	Total
1	School personnel	2	9	0	9
2	Parents	5	9	17	26
3	ISWs	2	4	6	10
4	GBV Counselors	1	1	2	3
5	Child protection response partner	1	2	0	2
6	Medical response partner	1	0	2	2
7	Community (women, youth, men leaders)	2	5	7	12
8	RRS	2	3	2	5
	Total	16	33	36	69

Each session fostered interactive discussions that encouraged reflection on experiences, challenges, best practices, and a view of the future with regard to the intervention. The group interviews were conducted by two multi-lingual qualitative experts.

3.7. Data Analysis

3.7.1 Quantitative Data

As mentioned previously, each eligible (and available) pupil was screened twice during the intervention period if SV was not disclosed the first time. This report presents results from pupils' final screening outcomes – i.e., the combined data from both rounds of screening.

The screening tool prompted pupils' descriptions of their SV experiences in their own words. These descriptions were then categorised according to their technical classifications prior to being quantified for statistical analysis. In addition, several sections of the screening tool consisted of structured, numerical responses, facilitating direct quantitative measurement.

To analyse the screening tool data, responses from Bambasi Primary and Middle school were systematically entered into an Excel database, organised by screening questions. Descriptive statistics were then generated for each variable around all indicators captured by the screening tool.

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

For analytical consistency, denominators included the total number of eligible parents invited to participate in the dialogues (that is, those with pupils in grades 6,7, and 8) 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.

3.7.2. Qualitative Data

Qualitative data were used to triangulate and contextualise the quantitative findings. Content analysis techniques were employed to identify patterns, themes, and emerging narratives within the dataset (Braun and 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 fieldnotes and transcripts of group interviews facilitated systematic coding and categorisation of key themes related to pupils' experiences, disclosure dynamics, service accessibility, and perceptions of the intervention by a wide range of stakeholders (Denzin and Lincoln, 2018).

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

4. Results

Results are presented according to the study's feasibility outcomes of interest – namely, for 'demand': expressed interest or intention to use the intervention; actual use of the intervention, and perceived demand for the interventions – and, for 'acceptability': intent to continue use of the intervention, and satisfaction with the intervention.

4.1. Evidence of Demand

Parents' Expressed Interest or Intention to Use the Intervention

Parents expressed a strong interest in having their children participate in the SV screening intervention. Of 1378 parents of eligible children enrolled in grades 6, 7, and 8 in Bambasi Primary and Middle school, 1118 (81%) participated in the parent dialogues and submitted their permission slips. Importantly, all parents who submitted these slips (100%, n=1118) granted permission for their children to be screened and referred by an ISW to appropriate care services, as necessary.

Parental demand for the screening intervention and their intention to use it were apparent even before the actual screening intervention began. Dialogue reports and group interviews highlighted parents' willingness to contribute to finding solutions to SVAC, and outlined parents' ask for a wider target group in the school beyond learners in grades 6, 7, and 8.

"Hopefully this programme will benefit our children and will bring change in our community regarding violence in the camp. We request you to give an opportunity for all adolescent girls who are attending school. Your intervention target should not be limited to grades 6-8; rather, it should include other students from this school and high school students too, because these groups are also vulnerable to sexual violence and they don't have anyone who supports them." (Excerpt from parent dialogue report, female parent).

"My suggestion is that all students should be included in this programme because sexual violence can happen to any student." (Group interview, Male parents)

Group interview data further demonstrated parents' interest in the intervention, with their narratives indicating that they were considering future use of the intervention for other students and community members:

"We want the screening activity to continue. When people are invited to attend the sessions, they are able to understand what is good and what is harmful." (Group interview, Female parents)

"Our children now have knowledge about sexual violence, and mothers have also received awareness, so they can teach their children at home. This awareness activity should not be limited to children and parents but should also include the wider community to ensure everyone has the same understanding." (Group interview, Female parents)

Pupils' Expressed Interest or Intention to Use the Intervention

Pupils' interest in and intention to use the intervention was demonstrated by the actions in voluntarily signing up to take part in the screening exercise. Among the 1128 pupils whose parents consented to their participation, 99.6 % (n=1123) were willing to be screened and provided their assent. Of the 1123 pupils who assented to be screened for SV, 100 percent were screened in the first round. Those who did not disclose in the first round and were available, were willing to be screened again during the second round (82.9%, n=930). Of the 1123 pupils in total who participated in the overall screening intervention, 56.54 percent were female (n=635) and 43.46 percent were male (n=488). Among the learners screened, 52 (4.64%) reported living with disabilities (38.46 % female and 61.53% male).

4.2. Actual Use of the Intervention

4.2.1. Disclosure of Sexual Violence

As further evidence of demand for the intervention, the majority of pupils were not only willing to sign up to participate in the screening exercise, but were also willing to disclose their experiences of SV, demonstrating their actual use of the intervention. Of the 1123 pupils who were screened for SV, a considerable proportion (20.8 %, n=233) indicated that they had experienced some form of SV. Broken down by gender, results show that a total of 221 (34.8%) out of 635 females, and 12 (2.5%) out of 488 males, had experienced some form of SV in their lifetime. Of these, 3.1 % (n=7) of females disclosed that they were currently experiencing SV (i.e., at the time of screening), while no males disclosed current experience of SV. Among the 52 pupils who reported living with disabilities, about one in five (21.15 %, n=11) reported having ever experienced SV.

Table 4 presents the various types of SV that screened pupils reported experiencing in their lifetime. While females primarily disclosed sexual harassment¹ and sexual touching,² males primarily reported experiencing the forced viewing of pornography.

Table 4. Proportion of pupils disclosing lifetime experience of SV by type of SV, along with their gender

Type of sexual violence disclosed*	Girls N= 635	Boys N= 488
Any type of SV	34.8. % (n=221)	2.5% (n=12)
Sexual harassment	11. 7% (n=74)	0.2% (n=1)
Sexual touching	18.9 % (n=120)	0.6% (n=3)
Forced viewing of pornography	1. 9 % (n=12)	1.2% (n= 6)
Child marriage/Attempted child marriage	0.6 % (n=4)	-----
Completed defilement/rape	6.9 % (n=44)	-----
Attempted defilement/rape	4.9 % (n=31)	0.2% (n=1)
Voyeurism	1.1% (n=7)	0.2% (n=1)
Other (including inappropriate [non-genital] touching, forced kissing, attempted sexual touching)	3.3 % (n=21)	0.2% (n=1)

* Multiple responses allowed

The fieldnotes documented by the ISWs based on the screening encounter ‘give voice’ to pupils’ lived experiences of SV, while also underscoring the fact that children were comfortable enough to disclose sensitive information, and thereby pointing to a level of demand for the intervention:

“When I was at my home, my friend came to visit me and he invited me to watch pornographic videos, which I refused. But he forced me, then I watched against my will.” (Fieldnotes: 15-year-old male, forced viewing of pornography)

“When I was going to the market by foot, crossing the bush, I met a boy who is my neighbour he was coming back from the gold-mining area. Then he greeted me and started a conversation and started touching my private parts and he said, ‘If you sleep with me, I will give you money.’ But I refused him.” (Fieldnotes: 15-year-old female, sexual touching, sexual harassment).

“When I was staying at home alone, a boy came to my home, he showed me his sexual interest, but I did not agree with him. When he saw my rejection, he caught my hand and started struggling with me to do it by force. He touched my private parts; however, when I cried loudly, he left me and ran out of my house.” (Fieldnotes: 14-year-old female, attempted defilement/rape)

“A stranger who came from Sudan one day came to my house while my family was out of the camp. He caught me and had sex with me without my consent. Following this incident, I

¹ Defined in this study as unwelcome and inappropriate behavior of a sexual nature, e.g., pressure for sexual favours; letters of a sexual nature; sexual gestures; etc.

² Defined in this study as the touching of the genitals, breasts, and other sexual areas.

got pregnant; however, the fetus aborted after 5 months.” (Fieldnotes: 10-year-old female, completed defilement/rape).

“When I was at home alone, one of my classmates came to our home and asked me to sleep with him. However, I refused. When I refused, he started touching my private parts, then he had sex with me forcefully.” (Fieldnotes:16-year-old female, completed defilement/rape)

4.2.2. Disclosure of Polyvictimisation

A total of 72 out of 233 pupils (30.9%) who disclosed ever experiencing SV also disclosed experiencing more than one type of SV simultaneously. These experiences of sexual polyvictimisation are captured in Table 5 below. Table 5 demonstrates that sexual touching is a frequently-experienced form of SV that occurs in nearly all instances of polyvictimisation described by pupils.

Table 5. Proportion of pupils disclosing lifetime experience of SV who had experienced more than one type of SV concurrently

Types of sexual violence disclosed	Pupils disclosing multiple forms of SV (N=72)
Sexual touching (ST) + sexual harassment	15.5% (n=36)
ST + forced viewing of pornography	0.9 % (n=2)
ST + completed defilement/rape	0.5 % (n=1)
ST + attempted defilement/rape	7.3 % (n=17)
ST + Inappropriate non-genital touching	0.9% (n=2)
Completed defilement/rape + sexual harassment	1.8 % (n=4)
ST + Completed defilement/rape + Attempted defilement/rape	0.9 % (n=2)
ST+ Forced viewing of pornography + Inappropriate touching	0.5%) (n=1)
ST + Sexual harassment +Voyeurism	0.9% (n=2)
ST + Sexual harassment + Inappropriate touching	0.9% (n=2)
ST+ Attempted defilement/rape + Sexual Harassment	1.3 % (n=3)

4.2.3. Disclosure of Perpetrator types

Pupils were also willing to disclose the perpetrators of the SV that they had experienced. Among those disclosing having ever experienced SV, the most commonly reported perpetrators identified were neighbours (27.9%) and strangers (27.9%), closely followed by fellow pupils (25.5%), as shown in Table 6.

Table 6. Proportion of perpetrator types cited by pupils disclosing lifetime experience of sexual violence by gender

Type of perpetrator cited*	Girls(N= 221)	Boys (N= 12)	Both(233)
Fellow pupil	24.6 % (n=54)	38.5 % (n=5)	25.5%(59)
Neighbour	27.7% (n=61)	30.8% (n=4)	27.9%(65)
Relative	12.3% (n=27)	7.7% (n=1)	12.0 %(28)
Stranger	28.6 % (n=63)	15.38% (n=2)	27.9%(65)
Boyfriend	5.5 % (n=12)	-----	5.3%(12)
Other	1.4% (n=3)	-----	1.4% (n=3)

*Multiple responses allowed.

4.2.4. Uptake of Services

One hundred percent of pupils (n=233) who disclosed ever experiencing SV received on-the-spot psychological first aid (PFA) from ISWs, as accessible school-based PFA provided by trained ISWs was a core part of the intervention. About half of the pupils (49.32%, n=110) either needed (in the case of rape/defilement) or reported wanting further services. Of these, 28.18% (n=31) received psychosocial support services available in the camp provided by the child protection response partner – IRC, and three (2.7%) visited the nearest health facility managed by Medical Teams International (MTI). The vast majority of those who reported wanting further services (n=76) were not immediately connected to such services, however, as they indicated a preference for doing so at their own time.

4.2. Perceived Demand for the Intervention in the Wider Community

The screening intervention involved various humanitarian stakeholders representing the wider community, including parents, other refugee community representatives, and the humanitarian workforce drawn from the child protection, education, and health sectors. Feedback from these actors highlighted a strong demand for the expansion of the intervention to reach additional age groups, more parents, schools, non-school settings, and development contexts, as the following quotes illustrate:

“Not all community members have received awareness, and not all students have participated in the screening. Not everyone in the community has changed yet. Therefore, the screening and awareness activities need to be expanded to reach the entire camp, because while some people have changed, others have not even received the information. Some of us parents have received awareness, but when we go back to the community and try to teach others, they do not always believe us or accept what we say. I think it is

important that they come themselves to receive the awareness, just as we did.” (Group Interview, Female parent)

“The refugee community will continue to be here, so the intervention should be ongoing and not limited by an end-line timeframe. The risk of exposure to sexual violence is always present, which means the intervention needs to be sustainable. In addition, it should be scaled up to other refugee camps, especially those in crisis settings and at entry points.” (Group Interview, Medical Response Partner).

“The intervention can be taken as a lesson for implementing similar interventions in developmental contexts. If this works effectively, we can use it in development contexts to detect sexual violence early, and the experience can serve as a lesson for national child protection interventions. So, its contribution to the Ethiopian government is positive.” (Group Interview, RRS Leader)

Demand for the intervention was also demonstrated through the perceived positive impact and "ripple effects" of the model.

Parents, for instance, consistently described improved understanding of SV and a shift from limited awareness to greater vigilance and engagement with their children as a prevention mechanism:

“To tell you frankly, since this organisation started the intervention, every parent’s knowledge and understanding of the issue has improved positively.” (Group Interview, Male parent)

“After the dialogue, parents started paying more attention to children.” (Group Interview, Female parent)

Stakeholders reported greater openness and confidence among children – particularly, girls:

“The children are no longer afraid to speak about these issues with others in the camp, including their peers, parents, and neighbours. We even hear teenage girls discussing what they learned at school when they meet at the community water points.” (Group Interview, Community leaders)

“Another positive change is how much more confident the girls have become. They now speak more freely, which was not the case before this intervention began.” (Group Interview, School Teachers)

In another vein, parents also described perceptions of improved behavior and school engagement, including greater respect for parental guidance and more consistent attendance: *“In the past, they would say they were going to school, but often didn’t attend. Now, most children are attending regularly, and this year we have seen good results in school.”* (Group Interview, Female parent)

These findings suggest a broader ripple effect of the SVAC intervention, strengthening not only violence prevention but also communication, supervision, and supportive home and educational environments.

4.4. Evidence of Acceptability

The outcomes of interest related to the acceptability of routine screening revolved around beneficiaries' intent to continue to use the intervention, and their satisfaction with the model. These outcomes are explored in this section.

4.4.1. Intent to Continue Use of the Intervention

A range of governmental and humanitarian actors, and community members stressed the prime importance of the intervention in enhancing disclosure and SV service uptake, and expressed willingness and commitment to continuing the screening intervention in other similar settings. Routinisation of the model as part of the existing protection programme with standardised operating procedures was also stressed by the stakeholders.

"[T]his intervention has only taken place in Bambasi Refugee Camp, while other camps still have children who need the same support. We would like to see the organisation continue and extend the programme to all school children and to the other camps as well." (Group Interview, Female ISWs)

"This intervention is very good because it raises awareness about sexual violence starting from childhood. Every child has the right to receive this awareness. There should also be a place outside of school where other children in the community can come to get screened and learn about sexual violence." (Group Interview, Community leaders)

4.4.2. Satisfaction with the Intervention among Stakeholders

Stakeholders' narratives of satisfaction revolved primarily around the marked difference that the intervention made in terms of the sheer number of SV cases that were identified among children/adolescents within the intervention's short timeframe. In the 12-month period prior to the intervention, a total of 3 cases were passively identified in Bambasi Primary and Middle School, compared to 233 identified through proactive screening over a 7-month period.

The fact that the intervention was built upon the valued government and humanitarian partner community-based structure of ISWs was also gratifying to government respondents, in particular, while parents were appreciative of the child-focused support provided by the intervention. The quotes below provide further insight:

"What impressed me most is that the camp has existed since 2012, and I don't think even 30 cases have ever been reported to the protection section in all those years. But the number of cases disclosed through this programme shows how much sexual violence has been happening without being reported. The method Baobab is using to identify these cases is remarkable, because such a large number has never been uncovered in the camp's history."

This assessment shows just how many cases have been hidden within the community.”
(Group Interview, School personnel)

“From what I see, all organisations working on GBV in the camp have learned from this research approach. It is unique, and it has helped reveal many cases that would have stayed hidden.” (Group Interview, Child protection response partner)

“Using incentive social workers was another exciting thing from the intervention because it was all about empowering the refugee community, and it was a platform where we made community engagement practical. Even though the incentive social workers were paid, they are part of the community, so they implemented community-based protection principles.”
(Group Interview, RRS)

“After seeing the help given to children, we understood its [the intervention’s] value.” (Group Interviews, Male Parents)

5. Discussion and conclusions

Screening combined with other interventions is a WHO-recognised INSPIRE strategy that responds effectively to violence experienced by children. The evidence to support this, however, centers on engaging with mothers or parents as a proxy for children at risk, or potentially at risk for violence exposure (WHO, 2016). Despite demonstrating a reduction in violence and other child protection issues, this approach misses an important opportunity to engage directly with children/adolescents and to inform programmes by drawing on the valuable perspectives and positionalities of this population (Nur et al., 2025).

In the African region, screening interventions that involve the direct involvement of children/adolescents have remained largely unexplored and undocumented. The potential barriers to effective, ethical screening may have hindered a deeper exploration of this area, as screening is only recommended where strong protection and referral systems can be assured, and where trained providers and robust community engagement and consent processes are available (ibid.). Establishing the feasibility and potential effects of such screening contributes to a thin, but growing, evidence base on how to identify child survivors and provide support for overcoming the barriers they face to accessing available services.

This study is the second iteration of child-focused SV screening models in refugee settings in the East and Horn of Africa region. Despite minor adaptations of the original, Uganda-based refugee setting intervention, results from the present Ethiopia version show very similar patterns. Broadly, across refugee settings in both countries, the intervention results in a much higher proportion of disclosures and service access among child/adolescent survivors over a much shorter period of time. In the seven-month period dedicated to screening, 233

pupils disclosed having experienced some form of SV to ISWs. All received PFA, and all who required and wanted more comprehensive SV care received it. In the 12 months prior to the intervention, in the absence of screening, a total of 3 pupils disclosed SV to school personnel and received services.

The pattern of strong parental, community, government, and response partner demand for, and acceptability of, the intervention also held in Ethiopia, as it did in Uganda. Stakeholders expressed their interest in the intervention, their intention to use/continue using it, and/or their satisfaction with in a variety of ways – including by signing up to be screened (or to have their children screened) in large numbers; by disclosing sensitive SV experiences and accepting immediately available care; by requesting that the screening target population and location types be expanded in order not to leave other children behind; by suggesting that screening be integrated into existing programming; and/or by expressing enthusiasm over the dramatically different survivor identification results that this proactive approach produced compared to conventional methods. The mirroring of results is observed in Ethiopia despite a different refugee population – Sudanese majority in Ethiopia versus South Sudanese majority in Uganda, with the Sudanese being mainly Muslim, Arab-influenced, and Arabic-speaking, and the South Sudanese being predominantly Christian/animist, indigenous Nilotic, and speaking a variety of local languages (Johnson, 2026).

As in Uganda, the majority of perpetrators/offenders disclosed by pupils were either neighbours, strangers, or fellow pupils, and followed by relatives. This suggests that, while school-based interventions have their place, community-wide prevention and response approaches that can reach even more community members that children interface with are necessary for tackling SV more holistically.

Noteworthy variances between the feasibility study results in Ethiopia and Uganda center on boys. Unlike in Uganda (Nur et al., 2025), where screening was particularly effective in pinpointing child sexual exploitation/abuse³ as a form of SV disclosed solely by boys (15% of those disclosing SV), this violence form did not emerge among pupils in Ethiopia.

Furthermore, in general, rates of SV disclosure among boys in Ethiopia were markedly low compared to Uganda, where boys and girls alike disclosed similarly high rates of SV overall. The low rates align with findings from the Ethiopia HVACS, which indicates that 2.2% of males in the 18-24-year-old age range reported experiencing SV in childhood, and 3.8 % of boys aged 13-17 reporting experienced the same in the past 12 months. The comparatively lower disclosure rates in Ethiopia may partly be explained by resistant sociocultural norms shaping perceptions of masculinity in Sudanese communities, which contribute to stigma, shame, and reluctance among boys to disclose experiences of SV, resulting in substantial underreporting. Moreover, boys and men who experience SV, such as rape, may fear being

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

labeled as homosexual, which is criminalised under Sudanese law, discouraging them from reporting these incidents (Centre for African Justice Peace and Human Rights, 2021), even while outside their home territory.

An additional variance between the Ethiopia and Uganda versions of the study involves pupils living with disabilities. While in Uganda, a higher proportion of pupils with disabilities disclosed experiencing some form of sexual violence (92%, compared to 82% of their peers without disabilities), in Ethiopia the disclosure levels between pupils with disabilities and those without were similar, at about 20%.

The study has limitations. First, of the 1378 parents invited to participate in the parent dialogues, 1118 attended. Those who did not attend may have distinct characteristics that could be relevant for interpreting the study's results. Second, 69 pupils who did not disclose during the first round were unavailable for screening during the second round, which may have hampered the study's ability to capture certain survivors. Third, we anticipate a potential social desirability bias (on the part of boys, in particular) in reporting SV due to the topic's sensitive nature.

Despite the limitations, the study strengthens the limited evidence base on screening children/adolescents for violence, going further to demonstrate that community-based lay providers, such as refugee ISWs or para-social workers, can attend to the task-shifted role of screening and first-line response, and can do so across different populations and age groups. Such lay providers do, however, require training and strong supportive supervision to ensure that the practice of ethical screening is properly established. The study also expands the evidence base on the feasibility of addressing sexual violence through direct engagement with child/adolescent survivors, as opposed to through doing so through intervening solely with their parents.

The study concludes that ISW-led SV screening, disclosure promotion, and enhanced service uptake are feasible in schools within refugee settings, through a combination of interventions that support these efforts. Screening combined with other intervention components is a highly proactive approach that does more for identifying child/adolescent survivors and ensuring their access to services than more conventional, passive methods.

6. Programmatic recommendations

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

- A careful, cautious approach to introducing SV screening protocols (be it in school or elsewhere) is proposed, with a focus on: 1) establishing functioning, post-screening service provision and strong, 'warm' referral systems before the commencement of

screening, and 2) close monitoring, supervision, and mentoring of incentive social works conducting screening.

- Implement community-wide prevention and response programmes that target a wide range of community members to holistically address SV against children/adolescents.
- Experiment further with screening approaches (and other intervention components that they are combined with) to pinpoint and enhance boy-friendly approaches that can enhance SV disclosure among boys.
- Develop and implement interventions geared toward shifting gender norms that hamper sexual violence disclosure for boys.
- Mainstream inclusion and equity in screening designs to ensure the latter are gender-sensitive, disability-inclusive, and culturally adapted approaches to ensure equitable access for all children.
- Institutionalise screening through policy and guidelines, including in the next iteration of Ethiopia's National School-Based GBV Guidelines.

7. Appendices

APPENDIX 1: SCREENING TOOL FOR SEXUAL VIOLENCE AGAINST CHILDREN

NOTES FOR SOCIAL WORKER:

1. This tool is to be used during school break time, lunch time, after school, and any free periods among 6-8 graders.
2. This tool is to be used **only** with students meeting **all** of the following criteria at **[Name of Primary School]**

Those in in grade 6-8.

Those who have a record of parental permission on file

Those who have a record of personal assent on file

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

3. Using this screening tool could pose psychological risks for students who have experienced sexual abuse. Be alert to signs of distress during the screening process. Be prepared to offer immediate counseling, if deemed necessary and desired by the student. Further instructions may be found at the end of this screening tool.

NAME OF SCHOOL: _____ NAME OF STUDENT: _____ CLASS:
_____ AGE: _____ SEX OF STUDENT: _____

Refugee community member

Host community member

Introduction

Hello **[Name of student]**. How are you today? My name is **[SOCIAL WORKER: _____]**.

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

Now, remember how we've been having assemblies where we talk about 'good touches' and 'bad touches,' and 'sexual violence,' and about how students should let someone know if this is happening to them so they can get help? And you may also remember that we always mention that we want to do something about 'sexual violence' to help any students in school who may be going through this. Do you remember hearing about this? Can you tell me what 'sexual violence' means? **[Offer praise for the student's understanding of the**

term. Fill in any gaps, if necessary. Sexual violence is when anyone under the age 18 is asked or made to do anything sexual. It includes rape, attempted rape, touching of private parts, attempted touching of private parts, being forced to see or touch the private parts of someone else, or to perform any kind of sexual act, being forced to watch pornographic content (movies, pictures, videos), sexual harassment, and anything else that's sexual].

Okay, great. Now, we are asking students at this school a few questions just to see if there is anyone that needs help. Please know that whatever we say in this room is between you and me. No one else will know what you have said, okay? Also, if I ask you a question that you do not want to answer, you can just write down your answer, okay? And if your answer is ever 'no,' I will just move on to the next question.

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

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

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

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

Now, if you don't feel comfortable answering 'yes' or 'no' to this question, you can write down your answer for me instead, okay?

Question 1: Have you ever experienced sexual violence?

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

I'm so sorry to hear that. We talked about what 'sexual violence' means, and the different kinds of sexual violence. If you don't feel comfortable answering this question out loud, you can write down your answer for me, or show me what you mean using these two dolls OR these cards.

Question 2: What kind of sexual violence has happened to you? Describe it for me.

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

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

Question 2: What kind of sexual violence has happened to you? Describe it for me.

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

Question 3: Who did this to you (Who were you sexually violated by)?

Stranger ___ Relative (specify) _____ Neighbor ___ Fellow Student ___ Other (specify)

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

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

YEAR _____ MONTH _____ DON'T REMEMBER _____

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

Question 5: Are you currently experiencing sexual violence? / Is it still happening to you?

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

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

Question 6: What kind of sexual violence are you experiencing currently?

Insert description here. Probe to determine type of sexual violence, e.g.: completed rape, attempted rape, touching of private parts, attempted touching of private parts, being forced to see or touch the private parts of someone else, or to perform any kind of sexual act, being forced to watch pornographic content (movies, pictures, videos), sexual harassment, etc.

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

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

Question 7: Whom are you being sexually abused by?

Stranger ___ Relative (specify) _____ Neighbor ___ Fellow Student ___ Other (specify) ___

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

YES ___ NO___ (if 'NO,' skip to Closing 2)

Question 9: Would you like your parents or guardians to be with you when you get help, or would you like to be alone? If not alone: Let me know which parents/guardians you would like to be with you:

ALONE ___ WITH MOTHER___ WITH FATHER___ WITH BOTH___

WITH GUARDIAN (Specify which) _____

OTHER _____

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

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

I want you to know that it was brave of you to come in and talk about sexual violence. I'm happy that you are **not** going through this. I will call you in again over the next few months just to make sure everything is going well with you. If any kind of sexual violence ever happens to you, please do not keep quiet about it. Feel free to stop by and see me to talk about it, or make sure you tell someone that you trust. Many children experiencing sexual violence do not know who to tell or that help is available. I just want you to know that there is help, in case you ever need it. Also, if any other student at this school tells you that they are experiencing sexual violence, I would like to ask you to tell them not to be afraid, but to come talk to me. *Do you have any questions for me before you leave?*

Closing 2 (for those who have experienced sexual violence)

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

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

NOTES FOR social workers:

Students disclosing sexual violence have already been asked if they would like to talk further and get help along with their parent(s)/guardian(s). For those that have experienced forms of sexual violence, offer first-line counseling, and schedule (school-based) follow-up counseling sessions, as needed.

Special Instructions for those that have experienced completed rape:

For those preferring to get help along WITH their parent/guardian: Initiate the referral process by contacting the school-based implementing partner, and letting them know the student's wish to get help in the company of their parent/guardian. This partner will ensure that the child obtains care in line with the existing structures and protocols.

For those preferring to get help WITHOUT their parent: Initiate the referral process by contacting the school-based implementing partner, and letting them know the student's wish **not** to get help in the company of their parent/guardian. This implementing partner will ensure that the child obtains care in line with the existing structures and protocols. It is important to take the students' opinions about their home situation seriously. If a student is of the opinion that involving their parent in this situation would be risky or undesirable, **do not** try to convince them otherwise.

APPENDIX 2: PARENT PERMISSION FORM



(for child participation in screening intervention)

DATE:

Dear Parents and Guardians of Pupils in Primary 6-8 at Bambasi Refugee Primary School

Sexual violence against children has become a big problem in our schools and communities. Children who have experienced sexual violence need health care and other kinds of support to help them overcome the trauma that it causes. In 2025, Bambasi Primary and Middle School is taking action to ensure that its pupils are able to get the help they need if they do experience this kind of violence. Parents/guardians also need support when their child experiences sexual violence, and we want to make sure that parents/guardians are included in this process.

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

Sincerely,

School Principal, Bambasi Refugee Primary School

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



Pupil's Name _____ Pupil's Class _____ Date _____

____ **No**, my child does not have permission to participate in the sexual violence against children screening exercise at Bambasi Primary and Middle School from May to October 2025

____ **Yes**: my child has permission to participate in the sexual violence against children screening exercise at Bambasi Primary and Middle School from May to October, 2025. **I understand that my child may opt out of participating, despite my permission.** I also understand that my child's screening information will be combined with that of other children, their names will be removed from this information to protect their privacy, and

the information will be studied by researchers to better understand the problem of sexual violence in schools in this community.

____ **Yes:** I authorize Bambasi Refugee Primary School to take the necessary steps to get care for my child at the nearest one-stop center in Bambasi in the event that my child has experienced sexual violence and I am not available to accompany my child from **May to October 2025.**

Parent's signature _____ Parent's phone number _____

APPENDIX 3: CHILD ASSENT FORM (ONLY FOR PUPILS WITH PARENTAL PERMISSION)



DATE:

Dear Pupil in Primary 6-8 at Bambasi Primary and Middle School:

Sexual violence against children has become a big problem in our schools and communities. Children who have experienced sexual violence need health care and other kinds of help for them to feel better and live a better life. In 2025 Bambasi Primary and Middle School is doing something about this problem so that its pupils can get the help they need if they do experience this kind of violence.

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

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

Sincerely,

School Principal, Bambasi Primary and Middle School

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



Pupil's Name _____ Pupil's Class _____ Date _____

_____ **No**, I would not like to take part in my school's activity on asking pupils questions in private to see if they are facing sexual violence and need help from May to October 2025. I **understand that I am allowed to change my mind about this whenever I want to.**

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

Pupil's signature _____

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