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# CHILD PROTECTION PROTOCOL FOR DATA COLLECTION: USAID/UGANDA PERFORMANCE AND IMPACT EVALUATION FOR LITERACY ACHIEVEMENT AND RETENTION ACTIVITY (LARA)

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## NORC at the University of Chicago and Panagora Group

### Performance and Impact Evaluation (P&IE) of the Literacy Achievement and Retention Activity (LARA)

## Child Protection Protocol for SRGBV Data Collection

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## Glossary of terms and definitions

**Child:** Any person below the age of 18 years. The LARA P&IE adopts the definition of a child, consistent with Article 1 of the United Nations Convention on the Rights of the Child, as “every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier”. The term youth is not defined in international law; however, working definitions from the United Nations use the term youth for a young person aged 15 through to 24 years. We are aware that the age-based definition of a child incorporates a wide range of children and young people/youth, who have very different life experiences. See also, “**minor.**”

**Child abuse:** All forms of physical abuse, emotional ill treatment, sexual abuse and exploitation, neglect or negligent treatment, commercial or other exploitation of a child, including any actions that result in actual or potential harm to a child. Child abuse may be a deliberate act or it may be failing to act to prevent harm. Child abuse consists of anything that individuals, institutions, or processes do or fail to do, intentionally or unintentionally, which harms a child or damages his or her prospect of safe and healthy development into adulthood.

**Child protection:** The responsibilities, measures, and activities that the external evaluation team, the LARA implementing organization, and referral service providers (e.g., mental and physical health care, legal aid, safe house, hotline) undertake to safeguard children from intentional and unintentional harm.

**Child sexual exploitation:** A form of sexual abuse that involves children being engaged in any sexual activity in exchange for money, gifts, food, accommodation, affection, status, or anything else that they or their family needs. It usually involves a child being manipulated or coerced, which may involve befriending children, gaining their trust, and subjecting them to drugs and alcohol. The abusive relationship between victim and perpetrator involves an imbalance of power where the victim’s options are limited. It is a form of abuse that can be misunderstood by children and adults as consensual. Child sexual exploitation manifests in different ways. It can involve an older perpetrator exercising financial, emotional or physical control over a young person. It can involve peers manipulating or forcing victims into sexual activity, sometimes within gangs and in gang-affected neighborhoods. It may also involve opportunistic or organized networks of perpetrators who profit financially from trafficking young victims between different locations to engage in sexual activity with multiple men.

**Commercial exploitation:** Exploiting a child in work or other activities for the benefit of others and to the detriment of the child’s physical or mental health, education, moral or social-emotional development. It includes, but is not limited to, child labor.

**Emotional abuse:** Persistent emotional maltreatment that impacts on a child’s emotional development. Emotionally abusive acts include restriction of movement, degrading, humiliating, bullying (including cyber bullying), and threatening, scaring, discriminating,

ridiculing or other non-physical forms of hostile or rejecting treatment. See also **“psychological violence.”**

**Gender:** Refers to socially ascribed identities, roles and responsibilities between men and women, boys and girls that are learned, and though deeply rooted in every culture, are changeable over time, and have wide variations both within and between cultures.

**Gender-based Violence:** Gender-based violence is an umbrella term for any harm that is perpetrated against a person’s will, and that results from power inequities that are based on gender roles. Around the world, gender-based violence almost always has a greater negative impact on women and girls. For this reason the term "gender-based violence" is often used interchangeably with the term "violence against women." One reason the term "gender-based violence" is often considered preferable to other terms that describe violence against women is that it highlights the relationship between women’s subordinate status in society and their increased vulnerability to violence. However, it is important to remember that in some cases men and boys may also be victims of gender-based violence. Violence may be **physical, sexual, psychological**, economic, or socio-cultural. Categories of perpetrators may include family members, community members, and/or those acting on behalf of cultural, religious, or state institutions.

**Minor:** Person under the age of 18 (according to the United Nations Convention on the Rights of the Child). See also, **“child.”**

**Neglect and negligent treatment:** Allowing for context, resources and circumstances, neglect and negligent treatment refers to a persistent failure to meet a child’s basic physical and/or psychological needs, which is likely to result in serious impairment of a child’s healthy physical, spiritual, moral and mental development. It includes the failure to properly supervise and protect children from harm and provide for nutrition, shelter and safe living/working conditions. It may also involve maternal neglect during pregnancy as a result of drug or alcohol misuse and the neglect and ill treatment of a disabled child.

**Perpetrator:** Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her/his will.

**Physical violence in and around school:** Girls and boys experience physical violence or abuse by an adult or another child through corporal punishment, forced labor, fighting and bullying. Corporal punishment is any punishment in which physical force is used to cause some degree of pain or discomfort, however minimal. This type of violence involves hitting children with the hand or an implement (e.g., whip, stick, belt, shoe, wooden spoon). It can also involve kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion (e.g., washing children’s mouths out with soap or forcing them to swallow hot spices). In general, teachers apply corporal punishment differently to girls than they do to boys. In many cases, boys experience more frequent and severe physical punishment at

school than girls as a way to “make them men.” Corporal punishment has negative physical and psychological effects on students, which include pain, injury, humiliation, guilt, helplessness, anxiety and low self-esteem. Teachers can physically abuse children through forced labor during and outside school hours. Teachers may force students either to fetch water or work in their fields, with children running the risk of physical injury from heavy manual labor and educational failure from missing class time. Physical violence and abuse among students takes the form of bullying, beating and fighting. Physical violence can have devastating, long-lasting effects on students, including increased risk of social, emotional and psychological damage, increased risk of substance abuse, physical, mental health and social problems, memory disturbances and aggressive behavior, and can negatively affect educational attainment.

**Psychological violence in and around school:** Girls and boys experience psychological violence and abuse from both peers and teachers through verbal harassment, bullying, teasing or degrading and cruel punishment. Teachers may use nonphysical punishment that belittles, humiliates, denigrates, scapegoats, threatens, scares or ridicules children. Constant criticisms of an unjustified nature, refusal to praise, unclear boundaries and unpredictable behavior eventually take their toll on young people. Psychological violence and abuse among students takes the form of verbal taunting used toward boys and girls whose behavior does not fit into society’s image of what is “masculine” or “feminine” as a way to make them conform. Bullying can range from teasing to physical violence perpetrated by both students and teachers. Other forms of bullying include threats, name-calling, sarcasm, spreading rumors, exclusion from a group, humiliation and abusive remarks. Bullying is also a pattern of behavior rather than an isolated incident. Psychological abuse can have devastating, long-lasting effects on students, including increased risk of social, emotional and psychological damage and mental health and social problems such as anxiety and depression, and can negatively affect educational attainment.

**School-related gender-based violence:** The first ever United Nations resolution on SRGBV signed by 58 countries in April 2015 defined SRGBV in that it:

- (a) is an expression of gender stereotyping and gender inequality at work in all of our societies, the reproduction of which is sustained through that violence;
- (b) includes all forms of violence and threats of violence directed specifically against a pupil because of gender and/or that affects girls and boys disproportionately, as the case may be;
- (c) can be of physical, sexual or psychological nature and take the form of intimidation, punishment, ostracism, corporal punishment, bullying, humiliation and degrading treatments, harassment, sexual abuses and exploitation;
- (d) can be inflicted by pupils, teachers or members of the educational community;
- (e) can occur: within the school; in its outbuildings; on the way to or from school; during extracurricular activities or through the increasingly widespread use of information and communication technology (ICT) (cyberbullying, sexual harassment through mobile phones);



- (f) can have serious and long-term consequences such as: loss of confidence and self-esteem, impaired physical and psychological health, early and unintended pregnancies, depressions, reduced learning achievement, absenteeism and drop-out, aggressive behaviors, etc.

**Secondary Survivor:** Person impacted by the experience of gender-based violence inflicted upon the survivor. May include family members or others close to the survivor.

**Sexual violence in and around school:** Girls and boys experience sexual violence or abuse by an adult or another child through any form of forced or unwanted sexual activity where there is no consent, consent is not possible or power or intimidation is used to coerce a sexual act. Sexual violence and abuse include direct physical contact, such as unwanted touching of any kind, or rape, which is also known as "defilement" for young people under the legal age of consent. Regardless of the legal age of consent, sexual activity between a teacher and a student is considered abuse because of the age and power differentials between the two. Activities such as making a child watch sexual acts or pornography, using a child to make pornography, or making a child look at an adult's genitals is also abuse. Sexual violence can be perpetrated verbally. For example, sexually explicit language aimed at children or any repetitive, unwanted and uninvited sexual attention through teasing or taunting about dress or personal appearance is also sexual abuse. Sexual violence or abuse can have devastating, long-lasting effects on students, including increased risk of social, emotional and psychological damage, increased risk of substance abuse, health and social problems such as unwanted pregnancy, sexually transmitted infections including HIV/AIDS, depressive disorders, memory disturbances, and aggressive behavior, and can negatively affect educational attainment.

**Survivor:** Any person who has experienced violence, abuse or exploitation.

**Violent episode:** An act or series of acts of violence or abuse by one perpetrator or group of perpetrators. May involve multiple types of violence (physical, sexual, emotional, economic, socio-cultural); and may involve repetition of violence over a period of minutes, hours, or days.

## Purpose and Overview

The purpose of this Child Protection Protocol (hereafter “the Protocol”) is to define procedures, roles and responsibilities of NORC at the University of Chicago, Panagora Group, the survey firm CSR, agents of the Ugandan Child Protection system, counselors, health and legal aid service providers, and RTI in working together to protect children from harm during and up to a two months immediately following each School-related Gender-based Violence (SRGBV) data collection period for the external Performance and Impact Evaluation (P&IE) of the Literacy Achievement and Retention Activity (LARA) program from 2017 through 2020. The Protocol will help to minimize potential risks of harm resulting from SRGBV data collection to child respondents, evaluation professionals and others, as well as ensure that any remaining risks are mitigated and outweighed by the potential benefits. This Protocol provides information for LARA P&IE staff and consultants; partners; and child protective services to take appropriate action when it is believed that a child has suffered harm recently, or is likely to suffer harm during or following participation in a SRGBV interview for the LARA P&IE. Responsibility for implementation of child protection standards and procedures set forth in the Protocol beyond two months immediately following SRGBV data collection are the responsibility of the LARA implementing organization RTI International, during LARA program implementation, and RTI monitoring and evaluation activities. At two months following SRGBV data collection, the LARA P&IE external team will transition responsibility to the implementing organization RTI for any ongoing need for follow-up on child protection cases reported during P&IE SRGBV data collection in “Cluster Two” schools.

Relevant international ethics frameworks, as well as national research ethics guidelines in Uganda, inform the Protocol on good practice for involving children in research on violence. Because we will be asking children questions about experiences of violence which may be severe, and in some cases, pose immediate risk of further violence and/or acute health difficulties (for example, physical injuries or feeling suicidal), interviewers and facilitators will be equipped with practical guidance on psychosocial “first aid” for children who participate, and a more serious child protection protocol for those who disclose severe abuse requiring urgent follow-up action, as well as less-urgent, but serious abuse disclosures that require nonetheless timely referrals and support. All of these procedures have been previously developed, piloted and adopted in Uganda as part of the Good Schools Study, led by one of the LARA P&IE SRGBV experts. NORC at the University of Chicago and Panagora Group have adapted these procedures keeping in mind the LARA project and the reality that Ugandan child protection referral and support structures may be weak or under-resourced in some school districts.

The Protocol was developed in consultation with local child protection professionals to ensure its integration with local legal, service provider and practical environments of the LARA intervention. The Protocol is the result of the following steps taken to develop referral pathways, and a reporting and tracking procedures for two months after LARA P&IE data collection:

- Coordinated with Ugandan government District Probation and Social Welfare Officers and Community Development Officers (who are officially responsible for Child Protection) to engage with and map local referral networks consisting of counselors, health centers, local NGOs, safe houses, police and legal aid services, assessed for their capacities to respond in a child-friendly, non-discriminatory manner to children who disclose SRGBV and require follow-up within the same day or other time period specified according to the severity of each child protection case and services needed.
- Reviewed child protection ethics guidance resources, as well as documentation of child protection follow-up in Uganda, including on research with children to explore their experiences of support following violence disclosures during SRGBV data collection within Ugandan primary schools during the Good Schools Toolkit program.
- Prepared information sheets and referral contingencies for areas where available child protection services under the formal government system may be insufficient to support a child who disclosed severe violence. In all cases, LARA P&IE will provide respondents with information to support access to psychosocial and health services if local child protection services are found to be untimely or unresponsive.
- Identified a cadre of psychosocial counselor professionals to be trained by the LARA SRGBV specialists who will accompany all data collection teams in all districts. Study counselors will be prepared to provide psychological first aid, child protection reporting, referral support and monitoring of local child protective services response to each case up to two months following data collection, and to transition these responsibilities to RTI International after the two month period.
- Coordination with RTI International to take over responsibility for following up on child protection cases with district-level child protective services after two months following P&IE SRGBV data collection periods.

The LARA P&IE Child Protection Protocol includes precise definitions and concrete, detailed reporting and referral pathways (see Figures 5 and 6); and has been developed taking into consideration local Ugandan government child protection system and service provider capacities. This comprehensive Protocol to handle child violence disclosures builds on past experience and expertise, and was developed with child protection and gender-based violence prevention and response expertise. The Protocol specifies pathways of action depending on the severity and time frame of what a child disclosed into three main categories:

1. Referral Level 1: Urgent action needed for severe sexual violence or obvious physical injuries
  2. Referral Level 2: Less urgent, but serious notification
  3. Referral Level 3: Non-urgent, but serious notification (past month)
  4. Referral Level 4: Non-urgent, but serious notification (before past year)
0. Voluntary notification

Decisions on child violence disclosures that would necessitate referral and to where they would be referred have been specified in accordance with Ugandan child protection systems in the LARA Cluster Two school districts in the P&IE sample. Documentation of reporting and referral follow-up will help inform and contribute to strengthening child protective systems following the LARA program.

It is every child's right to be heard, counted and their needs addressed on risks and experiences of School-related Gender-based Violence (SRGBV). Few studies have found evidence of psychological trauma from child participation in research on violence against children<sup>1</sup>. The UN Secretary General's study on Violence against Children specifically calls for more investigation to provide accurate and up-to-date prevalence, prevention and intervention evaluation data. This Child Protection Protocol builds on research on how to minimize underreporting to ensure that results benefit children through providing accurate prevalence, incidence, prevention and intervention evaluation information on SRGBV in context of the external P&IE of the LARA 5-year program in Ugandan primary schools. It articulates clear coordination with local child protection professionals, engaging directly with District Probation and Social Welfare Officers, who are officially responsible for child protection, and Community Development Officers, for referrals to a local counselors, health centers, relevant NGOs, safehouses, and legal support services, assessed for their capacities to respond in a child-friendly, non-discriminatory manner to children who report SRGBV.

The P&IE SRGBV survey instruments and focus group discussion guides<sup>2</sup> to be implemented with children in Primary Levels 2, 4 and 6 (aged about 6 – 15 years) will provide multiple opportunities for child disclosures of experiences of violence at school in order to ensure accurate prevalence and incidence estimates in and around school as a site of gender-based violence against children. This Protocol lays out a proactive plan for referrals and response to child disclosures during and following baseline, midline and endline data collection.

The Protocol is underpinned by both human subjects research ethics general principles of respect for persons, beneficence, and justice, as well as the Convention on the Rights of the Child, outlining children's rights to be heard and their needs for safety addressed. Institutional Review Board (IRB) approval is to be sought through NORC at the University of Chicago (IRB) and the Uganda National Council for Science and Technology Research Ethics Committee. The Council for International Organizations of Medical Sciences (CIOMS) 2002 also provides guidance on ethical biomedical research involving human subjects, with particular aim on conditions and needs of low-resource countries, and with guidelines (Guideline 14) on research involving children stipulating that the primary investigator must ensure that:

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<sup>1</sup> DePrince AP, Freyd JJ. Costs and Benefits of Being Asked About Trauma History. *Journal of Trauma Practice*. 2004;3(4):23–35.

<sup>2</sup> Please note that while SRGBV surveys will be implemented with children ages 6 to 10, and ages 11+, focus group discussions will only be held with children ages 11+.

- Research with children will only address questions that cannot be carried out with adults
- The purpose of the research is to obtain knowledge relevant to health needs of children
- A parent or guardian of each child has given permission (informed consent)
- The agreement (assent) of each child has been obtained to the extent of the children's capabilities
- A child's refusal to participate or continue in the research will be respected.

The overall consent process for interviewing primary school children will secure permissions from the:

- Chief Administrative Officer of the Uganda Ministry of Education and Sports, providing a signed, stamped letter for survey teams to carry into the districts and schools;
- Town clerks in districts of P&IE Cluster Two SRGBV data collection who will receive forms informing them about the data collection;
- Primary caregivers for each child who participates in a survey; and
- Child respondents who assent to participate in a survey.

Informed primary caregiver consent form and child assent language have been adapted from the World Health Organization templates for research involving children:

[http://www.who.int/ethics/review-committee/informed\\_consent/en/](http://www.who.int/ethics/review-committee/informed_consent/en/) Survey and focus group participation will be voluntary at all times.

This Protocol further sets out strategies to uphold privacy and confidentiality in school settings. It clearly sets expectations for reporting criteria, with specific decision-making protocol for reporting and referrals following child protection disclosures. All decisions concerning reporting and referral will be made with the "best interests of the child" as the top priority. Rare cases may emerge where a child does not wish to report, and yet it may be necessary to report formally to the District Probation and Social Welfare Office. Mandatory reporting of child protection cases to local services are to be considered following criteria and referral decision-making pathways articulated in Figures 5 and 6 of this Protocol.

LARA P&IE psychosocial counselor(s) trained by NORC at the University of Chicago and Panagora Group will report child disclosures to and follow-up with District Probation and Social Welfare Officers and Community Development Officers on child protection cases within agreed criteria and response time frames (per Figures 5 and 6) to ensure study compliance on child protection referral, tracking and response, and fulfill ethical obligations to child respondents. Using a Child Protection Safety Information and Referral Form, P&IE survey team supervisors and counselors will document child protection reports with a unique case number. The P&IE Evaluation Manager and local SRGBV Specialist will carry out monitoring checks during and up to two month following SRGBV data collection to ensure compliance with the Child Protection Protocol and to make adjustments to the protocol

itself if needed to prevent harm to children. The P&IE Evaluation Manager and local SRGBV Specialist will further work to ensure a smooth handover of responsibilities from the external evaluation team and its counselors to RTI, the LARA program implementing organization.

Throughout all data collection on SRGBV, the LARA P&IE team will document steps taken to mitigate risks to children and respond with their confidentiality, safety and best interests prioritized as to uphold children’s rights to both protection and participation, and as a contribution to the field of SRGBV intervention evaluation.

### Guiding ethical frameworks and principles

While the UN Convention on the Rights of the Child first and foremost informs the ethical principles underpinning the LARA P&IE Child Protection Protocol, the Protocol is further shaped by frameworks for research involving children generally, and specifically by ethics for researching sexual and gender-based violence against children. As no single ethic guidance framework to date addresses all of the issues concerning sexual and gender-based violence against children in and around schools, this Protocol draws upon and synthesizes several relevant and intersecting guidance frameworks.

The 2007 “Uganda National Council for Science and Technology National Guidelines for Research Involving Humans as Research Participants”<sup>3</sup> state that if there is greater than minimal risk and the study entails no prospect of direct benefit to the individual child participant, it may not be conducted unless:

- the risk is only a minor increase over minimal risk;
- the intervention or procedure presents experiences that are commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
- the intervention or procedure is likely to yield generalizable knowledge about the child’s disorder or condition that is of vital importance for the understanding or amelioration of that disorder or condition; and
- adequate provisions have been made for the solicitation of the child’s assent and their parents’/guardians’ permission.

The Ugandan guidelines are supported by and reflected in current international norms for ethics in research involving children set out across multiple countries. These include:

### Figure 1 Norms for child research from across multiple national ethics guidelines

The participation of children is indispensable for the research
The research problem is of relevance to children

<sup>3</sup> Uganda National Council for Science and Technology (2007) National guidelines for research involving humans as research participants. Kampala, Uganda: UNCST.



Taking part would not be contrary to the best interests of the child [new]
The research presents acceptable standards of risk for child participants
The research will take into account children's privacy interests [new]
The research will ensure abuse and neglect are reported [new]
The research will ensure thoughtful reporting of underage sex [new]
The research will seek appropriate permission for the research (consent from parent or guardian, or from a substitute; or from children themselves are possible approaches depending on various factors)
The research will be reviewed by a research ethics review board with appropriate child expertise

Source: Strode AE, and Slack CM (2015) *Child research in South Africa: How do the new regulations help?* SAMJ: South African Medical Journal 105(11): 899-900.

Seven ethical principles articulated by the International Charter for Ethical Research Involving Children<sup>4</sup> further guide all aspects of LARA P&IE work on SRGBV. These are:

### Figure 2 International Charter for Ethical Research Involving Children

#### International Charter for Ethical Research Involving Children

"As a research community working with children, we are committed to undertaking and supporting high quality ethical research that is respectful of children's human dignity, rights and wellbeing. The following seven commitments guide our work:

**1. Ethics in research involving children is everyone's responsibility**

We, the research community, including all who participate in undertaking, commissioning, funding and reviewing research, are responsible for ensuring that the highest ethical standards are met in all research involving children, regardless of research approach, focus or context.

**2. Respecting the dignity of children is core to ethical research**

Ethical research is conducted with integrity and is respectful of children, their views and their cultures. Involving children respectfully requires that researchers recognize children's status and evolving capacities and value their diverse contributions.

**3. Research involving children must be just and equitable**

Children involved in research are entitled to justice. This requires that all children are treated equally, the benefits and burdens of participating are distributed fairly, children are not unfairly excluded and that barriers to involvement based on discrimination are challenged.

**4. Ethical research benefits children**

Researchers must ensure that research maximizes benefits to children, individually and/or as a social group. The researcher bears primary responsibility for considering whether the research should be undertaken and for assessing whether research will benefit children,

<sup>4</sup> See the full International Charter for Ethical Research Involving Children at: <http://childethics.com/charter/>

during and as a consequence of the research process.

**5. Children should never be harmed by their participation in research**

Researchers must work to prevent any potential risks of harm and assess whether the need to involve the individual child is justified.

**6. Research must always obtain children’s informed and ongoing consent**

Children’s consent must always be sought, alongside parental consent and any other requirements that are necessary for the research to proceed ethically. Consent needs to be based on a balanced and fair understanding of what is involved throughout and after the research process. Indications of children’s dissent or withdrawal must always be respected.

**7. Ethical research requires ongoing reflection**

Undertaking research involving children is important. Ethical research demands that researchers continually reflect on their practice, well beyond any formal ethical review requirements. It requires ongoing attention to the assumptions, values, beliefs and practices that influence the research process and impact on children.”

The WHO Ethical and safety recommendations for interviewing trafficked women<sup>5</sup> further holds relevance and may be adapted for research with children, particularly concerning adolescent girls, who are disproportionately affected by all form of sexual and gender-based violence in schools, homes and communities. The recommendations discuss ten guiding principles for research on sexual and gender-based violence. These are:

- Do no harm;
- Know your subject and assess the risks;
- Prepare referral information;
- Adequately select and prepare interpreters and co-workers;
- Ensure anonymity and confidentiality;
- Get informed consent;
- Respect each respondent’s assessment of their situation and risks to their safety;
- Do not re-traumatize a respondent;
- Be prepared for emergency intervention; and
- Put information collected to good use.

The most comprehensive ethics guidance for research on violence comes from recommendations of the World Health Organization ethical and safety recommendations for domestic violence research. This Protocol adapts those ethical and safety recommendations for LARA P&IE SRGBV evaluation with children:

**Figure 3 Ethical and Safety Recommendations for SRGBV Evaluation with Children**

- The safety of all respondents, especially children, and of the external evaluation team is paramount, and should guide all LARA P&IE decisions.

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<sup>5</sup> Zimmerman, C., and C. Watts (2003) WHO Ethical and Safety Recommendations for Interviewing Trafficked Women. London: London School of Hygiene and Tropical Medicine (LSHTM). Geneva: World Health Organization.

- Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the under-reporting of SRGBV against children.
- Protecting confidentiality is essential to ensure both respondents' safety and data quality.
- All external evaluation team members should be carefully selected and receive specialized training and on-going support.
- The evaluation design must include actions aimed at reducing any possible distress caused to the participants by the research.
- Fieldworkers should be trained to refer respondents, especially children, requesting assistance to available local services and sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
- Evaluators and donors have an ethical obligation to help ensure that evaluation findings are properly interpreted and used to advance policy and intervention development.
- Violence questions should only be incorporated into surveys designed for other purposes when ethical and methodological requirements can be met.

*Source: Adapted from Moreno, C., L. Heise, M. Ellsberg and C. Watts (2001) Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women. World Health Organization, Geneva*

### **Protecting children is everyone's business**

In short, protecting children is everyone's responsibility: Civil society organizations, parents and caregivers, teachers, communities and governments all have a role to play. This The Protocol provides a foundation for improving children's rights to both protection and participation in research on violence in and around schools that can bring beneficial results for preventing and responding to SRGBV and improving learner retention and educational attainment.

### **Best interests of the child principle**

The "best interests of the child" promotes the right of every child participating in P&IE SRGBV data collection to live a full and productive life in an environment that builds confidence, friendships, security and happiness irrespective of their family circumstances, background or school they attend. The UN Convention on the Rights of the Child provides key building blocks to promote children's safety, wellbeing and development during and following SRGBV data collection. This Protocol forwards a unifying set of "best interests" principles that require the P&IE staff, consultants and associates, as well as child protection professionals and service providers to protect children's rights to both protection and participation in evaluating issues of violence that affect their health and well-being, and to promote their longer-term development in gender, age and culturally equitable ways.

For the purposes of this protocol, acting in the best interests of the child includes:

- Reporting a child protection case for all disclosures of serious physical, sexual or psychological abuse requiring urgent assistance and follow up per the referral and response criteria of this Protocol;
- Reporting a child protection case when a concern is formed that a child has been harmed or is at risk of being harmed;
- Making the child's ongoing safety and wellbeing the primary focus of decision-making;
- Sharing appropriate information with child protection service providers supporting the child through referral forms;
- Protecting and promoting the cultural and spiritual identity of a child and maintaining their connection to their family or community of origin where possible; and
- Enabling the child and the child's family to access appropriate services in order to reduce the long-term effects of violence against children.

### Duty of care

From a child rights-based perspective, external evaluators have a duty of care to ensure that no harm is done to individual children participating in data collection, as well as attend to the intermediate-term in ways that contribute to the greater good for diverse children as social groups over the long term. External evaluators are responsible for protecting child SRGBV data collection participants from any physical, emotional or social harm that might result from evaluation activities, and must do everything possible to anticipate strategies to respond to any potential adverse consequences. Potential harm, distress or discomfort must be minimized or eliminated where possible through ensuring that ethical issues are reflected on from the outset of the project and throughout implementation of the external evaluation, as well as through practical measures underpinned by the ethical guidance provided in this Protocol.

Staff, consultants or other associates working on the LARA P&IE have an ethical obligation to protect the children and young people with whom they professionally interact. When P&IE staff, consultants or other associates form a reasonable concern that a child or young person has been harmed per referral and response criteria in this Protocol, or is at imminent risk of harm, they are ethically bound to take action following procedures laid out in this Protocol to protect the safety and wellbeing of that child. For some staff members, consultants or other associates this obligation may be legally mandated under Ugandan law.

Duty of care is breached if a person:

- Does something that a reasonable person in that person's position would not do in a particular situation;
- Fails to do something that a reasonable person in that person's position would do in the circumstances; or
- Acts or fails to act in a way that causes harm to a child to whom the person owes a duty of care.

A critical question for LARA P&IE staff and contractors is where does the obligation of the external evaluation team end following SRGBV data collection activities. This is especially important to consider in school districts where SRGBV data will be collected yet health and social service infrastructure may have weak capacity for receiving referrals and responding to child protection cases. Typically, the duty of care in research and evaluation with children would obligate evaluator staff and consultants to refer children to, or directly provide any services or health care required for participating safely in evaluation activities *during data collection*. However, given recent experience implementing the child protection protocol of the Good Schools Toolkit<sup>6</sup> in Uganda, and based on the most up-to-date ethical guidance for research and evaluation with children on violence issues, the duty of care can place obligations on external evaluators to refer to or provide directly services beyond those immediately required for the LARA P&IE when the evaluation team possesses “expertise sufficient to meet the need safely and effectively, ability to apply that expertise without incurring inordinate costs, absence of other individuals or organizations able to meet the need, and freedom from competing obligations that preclude taking the action otherwise called for.”<sup>7</sup>

Although the fundamental obligation will be to refer children to existing child protection services, when these prove inadequate, the external evaluation team must be prepared to take it upon itself to ensure appropriate psychosocial support to children who disclose violence and require assistance by deploying immediately a dedicated SRGBV/child protection counselor for this purpose. Working to address a child survivor’s health and emotional needs arising from SRGBV, rather than from participating in SRGBV data collection, may be considered care that is “ancillary” or outside of the obligations of the external evaluation team. However, given foreseeable contexts where the team finds an absence of individuals or institutions to meet this need to at least a minimum acceptable standard, then the duty of care will obligate the external evaluation team to attend to the immediate psychosocial and if urgent, the physical health needs of children who make serious and urgent SRGBV disclosures during data collection and require assistance.

This Protocol seeks to respect the sovereignty of and integrate with local child protection services where they exist, and to operate in a way that does no harm to and strengthens local systems. The external evaluators will seek to work with local agencies. However, where these agencies are weak or unresponsive, the team will provide information to facilitate contacting local para-social workers and NGOs providing relevant services when the well being of a child survivor may be seriously at stake. To this end, the team has identified SRGBV child protection counselors and will train them in this Protocol, and its related Child Safety Information and Referral Form. Additionally, counselors will be trained in the

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<sup>6</sup> Devries, K et al (2015) I never expected that it would happen, coming to ask me such questions”: Ethical aspects of asking children about violence in resource poor settings. *Trials* 16:516.

<sup>7</sup> Merritt MW, Taylor H, Mullany LC. (2010) Ancillary care in community-based public health intervention research. *American Journal of Public Health*. 100(2):211—6, cited in Devries, K et al (2015) I never expected that it would happen, coming to ask me such questions”: Ethical aspects of asking children about violence in resource poor settings. *Trials* 16:516. p. 10.

fundamentals of gender and gender-based violence, in child rights and in psychological first aid.

The external evaluation team and associates have carefully mapped and considered the balance between existing, on-the-ground availability and capacity of local SRGBV child protection services—and—the team’s duty of care. The P&IE team’s duty of care will be focused on data collection periods and for a period of two months thereafter. It is essential therefore, that SRGBV/child protection counselors and RTI, the LARA program implementing organization, prepare necessary resources (human and technical resources, time, budget) to transition over responsibility for child protection case monitoring with the District Probation and Social Welfare Officers in LARA Cluster 2.

### Consent procedures

To give their consent, potential caregivers and child participants must know and understand the purpose of the research. The quality of the explanation given either enables or disables caregivers and children to give informed consent and informed child assent. In planning for the LARA P&IE SRGBV data collection, survey supervisors will conduct advance trips to schools in the SRGBV Cluster Two evaluation sample. Over two-day advance trips to each school, the supervisors will on the first day meet with the head teacher and LARA coordinators to explain the study, and give selected students letters of invitations for parents to come to the school the next day. On the second day, the supervisors will meet with approximately 75 parents to explain the study and obtain signed **Informed Primary Caregiver Informed Consent (See Annex B)** forms. A subset of parents, approximately 15 from each school, will be asked to return to school on the day of the SRGBV survey with learners to complete the caregiver survey. On the day of the survey, all children will be lead by an interviewer through an **Informed Child Assent (See Annex C)** process and will provide verbal assent if they agree to participate in the survey or focus group discussion. Both the informed caregiver consent and the informed child assent processes provide information covering seven basic elements in research consent documents with application in research on violence against children. These elements include:

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| 1. An explanation of the purpose of the research, the expected duration and a description of the process.  |
| 2. A description of any foreseeable risk or discomfort. In research on violence against children this may include distress, anxiety, embarrassment and loss of self-esteem, and the risk of revealing information that could lead to child abuse being suspected and subsequently reported.  |
| 3. A description of any benefits to the subject that can be expected. Alongside the risks, the opportunity to discuss the abuse or neglect that has occurred in one’s life can have helpful or useful consequences, including being referred to services that may help. <i>Note: Children will be informed before an interview begins that writing their name or marking an X on an envelope provided to them would be understood by researchers as a request to access follow-up support.</i> |
| 4. A description of how confidentiality and anonymity will be assured and any limits   |



to such assurances. This could include those imposed by mandatory reporting procedures in this Protocol on disclosed child maltreatment or abuse.
5. For research involving more than minimal risk, a statement of whether treatment for emotional harm or injury is available. Harm such as emotional upset and disturbance is possible in social research on VAC, and immediate counseling or provision of contact with appropriate services should be available. <b><i>Note: Children will be given contact information for the sub-district Community Development Officer or Para-Social Worker, a health clinic, etc. to report any retaliation after being seen speaking to a counselor on the school grounds.</i></b>
6. Contact information for answers to questions about the research, the rights of the subject, and research related injury to the subject.
7. Indication that (a) participation is voluntary, (b) refusal to participate will involve no penalty or loss of benefits to which the subject would otherwise be entitled, and (c) the subject may discontinue participation at any time.

### How much information to provide primary caregivers and children

Parents and children will be told before they agree to or decline the interview that the survey will be about child safety. A card listing the topics covered in local language, including sensitive issues such as physical abuse, may be shown to participants when negotiating informed child assent. Child participants will also be told that their answers will be anonymous unless they give information that suggests they are in immediate danger. Children and young people will be reminded that they can choose not to answer and skip questions if they choose. This reminder may appear on screen during tablet-administered surveys with children. Also, parents and children will be informed about the potential limits of confidentiality if the need for a child safety referral to a counselor, health or other services becomes apparent during an interview.

Some researchers in child maltreatment studies have decided to avoid the use of terms such as 'child abuse', 'child maltreatment' and 'child neglect' in the information provided to potential participants, on the grounds that their use would decrease the likelihood of people participating in the study, or allowing their children to do so.<sup>8</sup> However, lack of full disclosure challenges the ethical principles of honesty and autonomy, which underpin the requirements for informed caregiver consent and informed child assent. Individual children may be best placed to assess any risks to themselves, which is why informed child assent becomes very important. Child abuse and maltreatment tend to occur in secret and the argument can be made that being explicit about it helps to expose harmful practices and advocate for children.

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<sup>8</sup> Kotch, J. (2000) Ethical Issues in Longitudinal Child Maltreatment Research. *Journal of Interpersonal Violence* 15(7): 696-709. July 2000.

## Privacy and Confidentiality

Protecting confidentiality is essential to ensuring both children's and adults' safety and data quality, as revealing violent details can provoke further violent episodes for survivors. Confidentiality must be upheld throughout and following data collection, and selectively throughout reporting and referral processes. Multiple mechanisms will be required to protect confidentiality of information collected and reported, such as:

- No names written on surveys, only unique codes to distinguish questionnaires, which should be destroyed after data entry;
- No questionnaires will be linked to a child's assent and caregiver consent forms;
- Participants will be informed of confidentiality procedures during informed consent and assent;
- Interviewers must be pre-selected and trained well on steps to ensure privacy and confidentiality of respondent identities and information;
- Child Safety Information and Referral Forms will not state the child's name, but instead a unique case number. A separate code list with children's names will be made available exclusively to the relevant Community Development Officer and District Probation and Social Welfare Officer.

There are **limits of confidentiality** in the light of a child participant's disclosure of abuse or risk of harm. The confidentiality of children must be protected except where there is risk of significant harm to the participant or others. SRGBV survey interviewers must specify clearly before the interview that they may breach confidentiality to report and refer the child to protective services if necessary per criteria for reporting and referral in this Protocol. Choosing to breach confidentiality without discussing the potential for doing so in advance with child respondents and their caregivers during the informed consent process could damage the trust between children and evaluation staff and consultants with impacts on the situation of trust for other children.

Privacy is a key ethical issue closely related to confidentiality with direct relevance to research on SRGBV. Privacy considerations in the LARA P&IE include both the need to have a safe, private physical location at school where interviews can take place, and ensuring child participants' privacy through confidentiality. Privacy and confidentiality can be compromised in school locations through difficulties in finding a private space, peer and staff curiosity, adult concerns over children's well-being, or a perpetrator's awareness and anxiety that a child seen to be participating in a survey may disclose violence. Enumerators must be vigilant about ensuring privacy and confidentiality as an ethical imperative in data collection with children on SRGBV in order to protect them from potential stigma, retaliation and reprisals from an abusive peer or older child, teacher, parent or other school or community member.

SRGBV interviewers must consider multiple requests, pressures and potential lapses that might breach confidentiality across a range of primary school contexts. These may include: teachers or parents wanting to know what the child has said; evaluation professionals feeling the need to discuss data as a result of the emotional impact; shared datasets in the

project, which increase the risk of privacy violations; individuals involved in legal proceedings who want to access information for their legal cases; and evaluators feeling legally or ethically obligated to report information disclosed in the study related to suspected child maltreatment.

It is important, therefore, that practical measures are taken to ensure that privacy and confidentiality are maintained during and after research participation. Care should be taken that research activities take place in private spaces where participants will not be overheard and that their identity is protected. The protection of their identity includes consideration of data storage. It also includes ensuring anonymity in the dissemination of research findings, such as research reports and presentations, so that participants, families and communities cannot be identified.

### **Risks and Benefits**

Best practice to minimize harm and optimize benefits requires that the LARA P&IE team:

- Be able to justify why data collection is being done and why children or a specific group of children are being included in or excluded from the research.
- Work to ensure that children are not harmed as a consequence of their participation in data collection from the outset of the project through to its completion.
- Consider, as widely as possible, any potential harms and/or benefits for child participants, their families or wider community groups.
- Employ strategies to minimize distress for children participating in data collection.
- Have a child protection protocol in place to safeguard children from abusive or incompetent staff, consultants, associates or other persons.
- Have an agreed-upon plan for responding to child safety concerns.
- Consult locally when planning the research and developing protocols, without jeopardizing children's safety or well-being.
- Ensure that support for children, if needed during and after data collection processes, has been planned for.

*Source: Graham, A., Powell, M., Taylor, N., Anderson, D. & Fitzgerald, R. (2013). Ethical Research Involving Children. Florence: UNICEF Office of Research - Innocenti.*

### **Forms of potential risks**

Actions aimed at reducing or alleviating possible risks of distress, discomfort or reprisals caused to child participants by LARA P&IE SRGBV data collection include:<sup>9</sup>

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<sup>9</sup> Adapted from Graham, A., Powell, M., Taylor, N., Anderson, D. & Fitzgerald, R. (2013). Ethical Research Involving Children. Florence: UNICEF Office of Research - Innocenti. pp. 125-127.

- Limited disclosure of the P&IE SRGBV external evaluation purpose to reduce possibility of retaliation by teachers or caregivers who may be abusing a respondent;
- A non-judgmental environment created for conducting interviews, supported through interviewer training, role play practice, and cognitive testing during piloting of the survey instruments;
- Interviewers will be matched with respondents by the same sex;
- Girl and boy respondents are to be interviewed simultaneously in separate enumeration areas to reduce the possibility that a perpetrator in the same school as a respondent would learn of the nature of the survey;
- Lists of services on a small, laminated card in local language are to be provided to all respondents so that they are aware of where they can call or go to seek help if needed;
- A response plan is to be established that links service agencies and/or counselors with respondents who may become upset or expressed a desire to get help;
- A simple and easy to understand informed child assent process is to be provided after informed caregiver consent is obtained;
- Respondents will be allowed every opportunity to decline to answer questions or stop the interview process;
- All survey instruments are to be translated into local language and tested to for age- and cultural appropriateness for younger versus older children in the SRGBV data collection sample;
- Cognitive testing of the survey instruments will be carried out to investigate how well questions perform when asked of younger and of older child respondents. This is to ensure respondents understand each question correctly and that they can provide accurate answers. Cognitive testing will further help ensure that each survey question successfully captures the scientific intent of the question, and makes sense to respondents. Questions that respondents do not understand, or that are difficult to answer can be improved prior to fielding the survey, thereby increasing the overall quality of SRGBV survey data.

“From a public health perspective, the question is not whether to ask but how to ask about participants’ experience with violence and abuse.”<sup>10</sup> All told, a further question should be asked of what are the risks of NOT collecting data with children on SRGBV and inaction on violence in schools. Girls and boys might suffer worse mental and physical poor health because of not being asked their views or provided with avenues of assistance if needed.

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<sup>10</sup> Black, M. & Black, R. (2007). A public health perspective on ‘The ethics of asking and not asking about abuse. *American Psychologist*, 328-329. Cited in Child Protection Monitoring and Evaluation Reference Group (2012). *Ethical principles, dilemmas and risks in collecting data on violence against children: A review of available literature*. Statistics and Monitoring Section/Division of Policy and Strategy. New York: UNICEF.

## Potential risks, management strategies and responsibilities

The following is a table of the potential child protection risks and management strategies to mitigate those risks. It cites who is responsible for follow up of each risk and risk management strategy. The strategies are to be put in place and coordinated by the LARA P&IE implementing organizations before, during and after data collection. The strategies will be:

- 1) Planned in advance by NORC at the University of Chicago and Panagora Group in consultation with local child protection professionals;
- 2) Carried out by CSR, the survey implementing partner, and P&IE psychosocial counselors during data collection in coordination with NORC at the University of Chicago and Panagora Group; and
- 3) Transitioned over to RTI after two month following SRGBV data collection to monitor child protection cases between P&IE data collection periods.

**Figure 4 Potential risks, management strategies and responsibilities**

Risk	Risk Management Strategy	Responsibility
Child respondent has grave and obvious health concerns	<p>Child Protection Protocol criteria and referral decision pathways determine when and what action needs to be taken, and in what time frame</p> <p>Interviewers / Moderators to provide information sheet with details of relevant local health facilities provided to participants evidencing acute conditions</p>	<ul style="list-style-type: none"> <li>• Interviewers or Moderators,</li> <li>• Supervisors/Survey Manager</li> <li>• CDO/DPSWO</li> <li>• P&amp;IE Psychosocial Counselor</li> </ul>
Communities, or adult or child respondents, have complaints or concerns about the survey	<p>Establish complaints focal point from survey implementing partner for addressing issue</p> <p>In the first instance, concerns will, if possible be addressed by interviewers / moderators and supervisors,</p>	<ul style="list-style-type: none"> <li>• Interviewers or Moderators</li> <li>• Supervisors/Survey manager</li> </ul>

	<p>then the survey manager</p> <p>Information to be provided to participants and communities regarding contact details of concerns or complaints focal point</p>	
<p>Respondent becomes visibly distressed by certain questions</p>	<p>If necessary, interviewer / moderator asks participant if they want to stop for a few minutes and return to the question afterward. A second option may be to ask the respondent if he/she wants to skip the particular question.</p> <p>If respondent continues to be distressed, interviewer / moderator may stop the interview and offer that the respondent can speak with a counselor on-site. Ask the child where they would feel safest speaking with a counselor. The child may not feel safe being seen speaking with a counselor on school grounds. In this case, an alternate arrangement should be made with the child for follow up.</p>	<ul style="list-style-type: none"> <li>• Interviewers / Moderators</li> <li>• Supervisors/Survey manager</li> <li>• P&amp;IE Psychosocial Counselors</li> </ul>
<p>Presence or sight of school or other authority figure(s) are potentially intimidating for respondents</p>	<p>Survey supervisor negotiates presence with authority figure(s) in such a way that will minimize any potential intimidation. These figures should be best kept out of sight and listening range during the survey.</p>	<p>Survey supervisor</p>
<p>Limited or no privacy (e.g. an adult or peer in direct proximity)</p>	<p>Interviewer / moderator can ask for a place in or around the school where they and the respondents will not be in hearing distance of any adults</p> <p>If privacy is limited before certain parts of the questionnaire (e.g. violence</p>	<p>Interviewer / Moderator</p>



	experiences questions), interviewer / moderator may explain the sensitive nature of questions about learners' health, and again ask for privacy. dx	
Data on respondents are shared breaching confidentiality  Any hard copies of informed consent or assent forms, or questionnaires are not in a secure, confidential location  Identified data not anonymized and secured by unique codes and a file passphrase	Survey manager discusses individual cases with the field teams only privately to ensure the Child Protection Protocol is applied correctly. Re-training on confidentiality may be necessary.  Any and all paper informed consent, assent forms, tablets with the questionnaires are provided to supervisor at end of day and kept in a secure, confidential location.  Identified data (data identifying location and names of respondents are kept in a passphrase protected file). Data are de-identified before sharing of data (as per usual procedures)	Survey manager
Interviewer / moderator know respondents	The supervisor assigns a different interviewer to the respondent	Survey Manager
Interviewer's / moderators beliefs in conflict with that of the community	Interviewers and moderators are trained not to provide any information regarding their gender attitudes, religious or political affiliations or other beliefs	Supervisor/Survey manager
Disclosure of events that are in conflict with local laws	Clear articulation to participants before individual surveys and focus group discussion that the interviewer / moderator	<ul style="list-style-type: none"> <li>• Interviewer / Moderator</li> <li>• Supervisors</li> <li>• P&amp;IE Psychosocial Counselors</li> </ul>

<p>Where no legislation exists</p>	<p>cannot report information disclosed to law enforcement, only the victim or their primary caregiver can report a crime allegedly committed against them to law enforcement. However, evidence of a child at risk of harm will be referred for consultation with a Counselor to discuss child protection services follow up.</p> <p>No measures will be taken unless the respondent asks for legal help. Interviewer / moderator will provide information to all respondents on relevant legal health and psychosocial support services and help lines (determined in advance and provided to interviewers as a list in local language of local or relevant health and social support services that are available and willing to provide support as necessary).</p>	<ul style="list-style-type: none"> <li>• Relevant government and service providers</li>   <li>• Interviewers / Moderators</li> <li>• P&amp;IE Psychosocial Counselors</li> </ul>
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**Risks in the Field**

In instances where risks actually occur, it is important that they be noted and collected by supervisors at the end of fieldwork discussions. These should be documented by supervisors and submitted to the survey manager.

**Benefits to asking children about violence**

Rather than a barrier, being asked about violence, if done with a functioning Child Protection Protocol in place, can enhance children’s rights and provide opportunities to be heard and even possibly bring healing to children. This table below describes reasons for encouraging greater participation by children in researching violence against them: Benefits to children themselves, to the research, and to society. Supporting children without discrimination to talk about difficult topics can be empowering for them.

<p>Assertion of children’s right to participate to participate in research:</p> <ul style="list-style-type: none"> <li>• Perhaps the principal argument for children being more actively involved research concerning them is that it is their right. Boys and girls have the right to decide if they</li> </ul>
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wish to get involved, to what degree and how. They will be able to identify the most important concerns related to violence against children.

- Active participation by children will also help to challenge the silence surrounding much violence against children, and the stigma that can attach to those who have experienced it.

Participation can help protect children:

- Children are most vulnerable to abuse in situations where they have little opportunity to voice their views. A participative approach helps overcome fear and build skills to resist exploitation.
- Through developing their critical thinking abilities, children are helped to discern and discriminate what information is important.
- Participation in research teaches children how to access information—and this can be of crucial importance to their very survival. Increased self-confidence is also protective.

Children's participation can help to heal the past:

- In relation to traumatic events, the process of involvement, if undertaken in a supportive and understanding environment, can help children to explore past experiences and regain confidence for the future. At its best, participation can be an important tool out of victimization, passivity, and silence.

*Source: Save the Children (2004) So you want to involve children in research? A toolkit supporting children's meaningful and ethical participation in research relating to violence against children. Stockholm: Sweden.*

### **Risks/Benefits ratio**

There is a consensus evident in documentation of research ethics with children on the need to include children directly in research and evaluation on issues that affect them, such as SRGBV, while offering them appropriate protection. The analysis of risks and benefits are therefore assessed in accordance with varying levels of risk and against benefits to individual children, their longer-term development and the wider society.

Therefore, P&IE responsibilities stress balancing the risks and benefits of children's participation in SRGBV evaluation data collection. It is essential that children are not left feeling exposed or vulnerable without follow-up support, and that the evaluation team is able to deal appropriately with any distress that is expressed. To this end, interviewers, supervisors and managers must be trained to refer children per this Protocol requesting assistance to available local services and sources of support. Where few resources exist, the evaluation team will provide short-term support mechanisms. It is important that the interviewers, supervisors, and managers anticipate and prepare to respond appropriately to children who may need additional assistance during or following an interview. Prior to conducting the SRGBV data collection, evaluation managers are required to have spoken with and ideally met in person with potential providers of support, which may include existing health, legal and social services resources in the community, and less formal providers of support (including community representatives, traditional healers and women's

organizations). Discussions must be held to obtain providers' agreement to assist and to identify the forms of support that each is able to provide.

A list of resources was then be developed to be offered to all respondents, irrespective of whether they have disclosed experiencing SRGBV or not. The resource list should either be small enough to be hidden or include a range of other services so as not to alert a potential perpetrator to the nature of the information supplied. **An example of an information sheet** provided to a child respondent during LARA P&IE SRGBV baseline data collection is located in **Annex E**.

Where few resources exist, it is necessary to have a trained counselor paired with each interview team to provide support on an "as needed" basis at out of earshot location on the school grounds. At the start of each interview after the informed child assent process, each respondent can be instructed by each interviewer to either write their name on a sheet of paper provided separately from the survey or mark that paper with an X to signify that they are requesting psychosocial assistance and possible referral to medical or other services during or after the interview. The interview may be interrupted to clarify the child's request and then resume if the child wishes, or stopped altogether if the child requires an immediate response to a serious and urgent child protection issue. Interviews should proceed at the child's pace and under the child's control.

SRGBV interviewers should have sufficient training, skills, knowledge and supervisory support to be able to recognize and respond per procedures laid out in this Protocol to children's distress. SRGBV interviewers should invest time ensuring that children are informed about, and understand, the concept of dissent and their right to withdraw from participation in the research and they can also actively encourage children to practice stopping the interview. They should also be vigilant in attending to children's visual, verbal and non-verbal cues to monitor unspoken expressions of unease or dissent, and be prepared to make reports and referrals following the criteria provided by this Protocol.

### **SRGBV interviewer and counselor recruitment and training**

Given the need for data collection supervisors and interviewers to make on-the-spot decisions in the field, awareness raising and training on SRGBV and this Child Protection Protocol will be of the utmost importance.

Drawing on past experience, our SRGBV specialists will train survey enumerators and focus group moderators on how to handle ethical and child protection issues that may emerge during data collection. They will discuss with enumerators/moderators complex ethical considerations such as the developmental and legal ability of children to provide informed consent, their ability to understand questions, this Protocol to be followed in case of abuse disclosure, the tradeoff between children's confidentiality and obligations to report cases of disclosed abuse. The NORC at the University of Chicago and Panagora Group team may additionally hire child protection counselors who will be further trained prior to data collection. All enumerators, moderators and counselors will be trained on this

comprehensive Protocol to handle, report and refer child violence disclosures.

All research team members will be carefully selected and receive specialized training and on-going support over and above that normally provided to enumerators on the fundamentals of survey administration. This will include a basic introduction to SRGBV issues, child protection, and an overall orientation to the concepts of gender, gender-discrimination and inequality, and how this affects younger and older girls and boys. The training will provide mechanisms for fieldworkers to confront and overcome their own biases, fears and stereotypes regarding sexual and gender-based violence against children in all settings, including in and around school. Some fieldworkers will have internalized the “victim-blaming” attitudes that permeate the culture at large—a reality that is likely to undermine their ability to get full and honest disclosure from the girls, boys, women and men they interview. Rates of reported violence have been shown to be very sensitive to intimation of judgment or blame on the part of interviewers.

All members of the P&IE evaluation team working on SRGBV data collection will be further trained in strategies to prevent and respond to vicarious trauma and burnout, with guidance on how to facilitate regular debriefings and on self-care during and after SRGBV data collection. Training will include opportunities for research staff to come to terms with their own experiences of abuse. The high prevalence of sexual and gender-based violence against children worldwide means that it is very likely that one or more research staff will have been a direct target, or have familial experiences of sexual and gender-based violence. While this may improve interviewers’ skills and empathy, the process of being involved in a study (either as an interviewer, supervisor, data processor, statistician, counselor, manager or other role related to data collection on SGBV) may awaken images, emotions, confusion and conflict. These reactions may affect their ability to work, may have a negative impact on their health, and may create tension in the home. Even where a researcher or fieldworker her or himself has not experienced violence, listening to stories of violence and abuse, not unlike research in the fields of death and dying, may be draining and even overwhelming. Experience has shown that unless this reality is confronted directly, research projects can experience high rates of attrition among staff.

Further, interviewers will be trained on a range of practical steps they can take to help uphold the ethical principle of confidentiality. This will include:

**Interviewer practical strategies to uphold confidentiality and minimize risk of harm to respondents:**

- All interviewers should receive strict instructions about the importance of maintaining confidentiality. This must also be addressed in their training. No interviewers should conduct interviews in their own community.
- No names should be written on questionnaires. Instead, unique codes should be used to distinguish questionnaires. Where identifiers are needed to link a questionnaire with the household location or respondent, they should be kept separately from the questionnaires, and upon completion of the research, destroyed. In all further analysis,

the codes should be used to distinguish questionnaires. Participants should be informed of confidentiality procedures as part of the consent process.

- Where tapes are made of in-depth interviews with all respondents, including survivors of SRGBV, these should be kept in a locked cabinet with limited access, and erased following transcription. The permission of the respondents should be sought before taping. Again, no record of the name of the person interviewed should be kept and respondents should be informed of who will have access to the tapes and for how long they will be kept.
- Particular care should be taken during the presentation of the research findings that the information presented is sufficiently aggregated to ensure that no one community or individual can be identified. Where case-study findings are presented, sufficient detail should be changed to ensure that it is not possible to identify the source of this information.
- Although photographs of abused children may seem to some people to be a powerful and emotive way of communicating about SRGBV, extreme care and confidentiality should be used. Photographic documentation must only be undertaken with the informed consent of a survivor of violence as part of collecting forensic evidence for a potential legal proceeding.
- **Strictly no other types of photographs, video, or voice recordings may be taken of child respondents in the P&IE data collection.**

*Source: Adapted from Moreno, C., L. Heise, M. Ellsberg and C. Watts (2001) Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women. World Health Organization, Geneva*

Recruitment of enumerators, as well as SRGBV counselors, will be carried out in a semi-structured manner with a Screening Tool and interview question guide to assess levels of knowledge, competence, comfort and prior experience on SRGBV and child protection. Training of interviewers will include techniques for building rapport and making children feel comfortable, identifying and managing emotional or physical distress, respondent dissent against questions or desire to end the interview, and sensitive ways of speaking with children while determining whether a disclosure of violence should result in a report, referral and response services. An excess of interviewers will be trained with a view toward only and only hiring the best. The entire data collection team will be trained on and required to sign NORC's Supplemental Confidentiality Agreement which explains NORC's statement of professional ethics and requires signing NORC professional ethics agreement.

Interviewer training will include the following topics:

- Gender-based violence against children and child rights with clear definitions
- Strategies to maintain privacy and confidentiality in a school setting
- Informed consent and informed child assent, and role plays to practice
- Techniques for building rapport and making children feel comfortable
- Role playing of interviewing techniques
- Strategies for and the importance of remaining non-judgmental



- Role plays to practice protocol steps consulting child protection officers or medical/psychosocial/legal services for child GBV survivors
- Focused practice sessions for how to handle disclosures of sexual violence against children in a non-discriminatory manner
- Practice and role playing on a scripted interview finish for children who disclosed severe violence
- External evaluation's Child Protection Protocol including:
  - Violence definitions to set response criteria for making referrals for child access to psychosocial, medical, legal or other follow-up services.
  - Referral decision tree (detailed)
- Forms related to implementation of the Child Protection Protocol:
  - Child Safety Information and Referral Form (Annex D)

To summarize the necessary procedures to carry out the Child Protection Protocol, checklists of important information and reminders was developed for each role on the LARA P&IE SRGBV baseline data collection team: Enumerators, Focus group discussion moderators, and Counselors. **The In-Field Child Protection checklists** are included in **Annex F**.

### Managing vicarious trauma

Despite these measures, some SRGBV survey interviewers may need to be given less emotionally taxing tasks to be given a break from data collection, or may have to withdraw from data collection altogether. Interviewers must also be helped to understand their role in relation to a girl or boy who reports experiencing violence. They should be open to assisting each child if asked, but they should not tell a child what to do or take on the personal burden of trying to "save" her or him. Interviewers should not take on a role as counselor and any counseling activity that may be offered in the context of the study should be entirely separate from the data collection. Interviewers will be trained on the Sexual Violence Research Initiative's guidelines for prevention and management of vicarious trauma,<sup>11</sup> including risk and protective factors and practical strategies for responding to and preventing vicarious trauma among anyone involved in research or evaluation on sexual and gender-based violence issues.

## Guidance on child protection case reporting and referral

### Mandatory reporting of child protection cases

P&IE evaluation staff, contractors and counselors **must** make a Child Protection report as soon as practicable after forming a concern on reasonable grounds per the Child Protection

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<sup>11</sup> Sexual Violence Research Initiative (2015) Guidelines for the prevention and management of vicarious trauma among researchers of sexual and intimate partner violence. Pretoria: South Africa. <http://www.svri.org/sites/default/files/attachments/2016-06-02/SVRIVTguidelines.pdf>

Protocol criteria and referral decision pathways that a child is in need of protection from significant harm as a result of physical injury or sexual abuse, and if they become aware that the child's parents are unable or unwilling to protect the child.

### **Forming a concern on reasonable grounds per Child Protection Protocol criteria**

There may be reasonable grounds for forming such a belief if:

- A child or young person states that they have been physically or sexually abused
- A child or young person states that they know someone who has been physically or sexually abused (sometimes the child may be talking about themselves)
- Someone who knows the child or young person states that the child or young person has been physically or sexually abused
- A child shows signs of being physically or sexually abused
- An evaluation team member or counselor is aware of persistent family violence or parental substance misuse, psychiatric illness or intellectual disability that is impacting on the child or young person's safety, stability or development
- An evaluation team member or counselor observes signs or indicators of abuse, including non-accidental or unexplained injury, persistent neglect, poor care or lack of appropriate supervision
- A child's actions or behavior may place them at risk of significant harm and the child's parents are unwilling or unable to protect the child.

### **Reporting child protection disclosures**

P&IE evaluation team members need to report child protection disclosures adhering to the Protocol criteria for referral and response in the course of undertaking data collection. Accordingly, a verbal report must be made and a **Child Safety Information and Referral Form** (See **Annex D**) completed as soon as practicable after determining a case qualifies based on set criteria and any further reasonable grounds for concern for the child's safety. Specific referral and response criteria, and reasonable grounds are articulated in **Figure 5: Physical and sexual violence definitions used in LARA SRGBV surveys to set response criteria for referring children who make disclosures; and Figure 6: SRGBV Referral Decision Tree for Child Protection Protocol (Time period: During and two months following end of LARA P&IE SRGBV data collection)**

If one P&IE survey supervisor has a different view from another supervisor or counselor about making a report and the supervisor continues to hold the concern that a child is in need of protection, that person is still obliged to make a verbal report and provide a written Child Safety Information and Referral Form completed by themselves or a counselor.

### **Professional liability protection for reporting child protection cases**

If a child protection report is made in good faith:

- It does not constitute unprofessional conduct or a breach of professional ethics on the part of the reporter; and
- The reporter cannot be held legally liable in respect of the report.

This means that a person who makes a report in accordance with this Child Protection

Protocol will not be held liable for the eventual outcome of any investigation of the report.

### Failure to report

A failure by evaluation staff, consultants or counselors to report a reasonable concern based on established criteria that a child is in need of protection from significant harm as a result of physical or sexual abuse will result in a breach of this Protocol and disciplinary actions up to dismissal.

## Reporting and Referral Decision-Making Criteria

The thresholds for raising a red flag for a “Referral Level 1” or yellow flag for “Referral Level 2” response have been developed with input from child protection professionals within LARA Cluster Two implementation districts. Some key types of information considered in developing reporting and referrals pathways include:

- the severity and nature of the abuse, and how recent it was;
- whether or not the child had suffered life threatening injury or rape;
- whether the perpetrator was likely to be abusing other children;
- any self-harming or suicidal intent;
- whether the child or young person already had access to help and support;
- the child or young person’s wishes and feelings;
- potential for a referral against the child’s wishes to help or to pose a further threat to the child’s safety

**Figure 5 Physical and sexual violence definitions used in LARA SRGBV surveys to set response criteria for referring children who make disclosures<sup>12</sup>**

Child discloses	Referral level (All Mandatory)	Indicated by positive answer to any of below discrete violent acts or injuries by any person	Response <sup>1</sup>
Sexual intercourse within the past month  --Or--  Obvious untreated physical injuries	1 Level defined as “recent abuse requires immediate action”	<u>In past month</u> : Threatened or pressured into sex; physically forced sexual intercourse or doing sexual things; suffered cuts, loss of consciousness; dislocated, sprained, fractured or broken bones; untreated injuries or severe injuries (requiring medical attention) reported as a result of physical or sexual violence	Interviewer alerts Supervisor/Survey Manager who urgently phones Community Development Officer (CDO) who is to lead the referral. Phone also the District Probation and Social Welfare Officer (DPSWO) District CDO to ensure notification. If unable to reach CDO, DCDO, DPSWO (after calling each twice), LC III, or the Cub-County Chief.

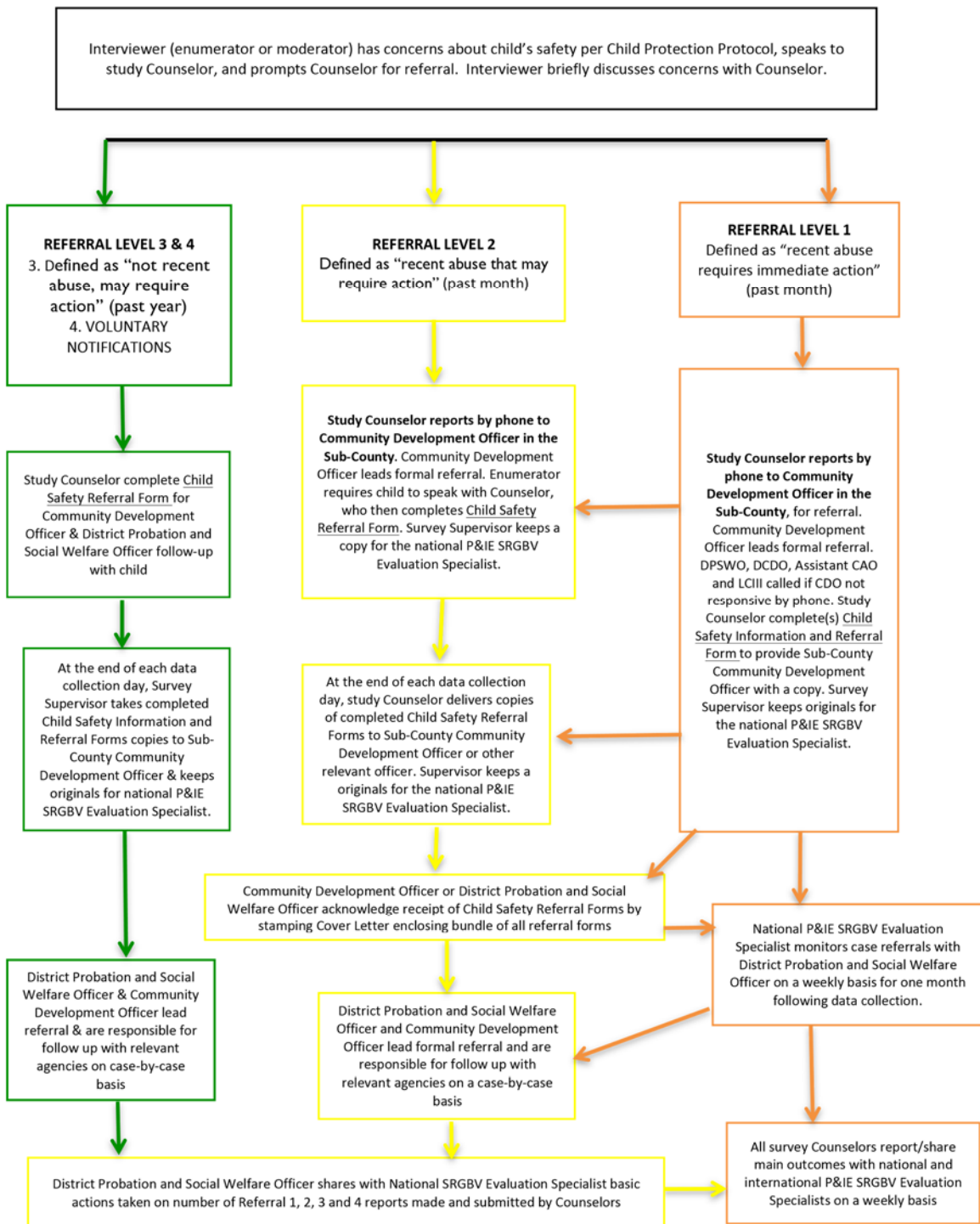
<sup>12</sup> Adapted from Devries, K. et al, "I never expected that it would happen, coming to ask me such questions": Ethical aspects of asking children about violence in resource poor settings. *Trials*, 2015; 16:516; pp. 5-6.

Child discloses	Referral level (All Mandatory)	Indicated by positive answer to any of below discrete violent acts or injuries by any person	Response <sup>1</sup>
			<p>Each district Information Sheet will have phone numbers for the above individuals</p> <p>Study counselor offered.</p>
<p>Severe physical violence <u>within the past month</u>, or less severe sexual violence within the <u>past month</u>, or minor injuries observed</p>	<p>2 Level defined as "recent abuse that may require action"</p>	<p><u>In past month</u>: burnt; choked; cut with a sharp object; severely beaten; had genitals, breasts, or buttocks touched; exposed to pornographic imagery; forced undressing; exposed to nudity; forced to touch someone else's genitals, breasts, or buttocks; involved in making of sexual photos or videos; forced kissing; suffered bruising; swelling; bleeding; difficulty sitting or walking; had to seek medical attention; and disclosures do not meet same urgency or severity criteria as for Referral Level 1 (e.g. forced sex or in need of urgent medical attention)</p>	<p>As for Referral Level 1 above</p>
<p>Severe physical violence <u>within the</u></p>	<p>3 Level defined as "not recent abuse, may</p>	<p>As for Referral Level 2, but <u>past year</u>; and disclosures do not meet same criteria as for Referral Level 2</p>	<p>No phone calls; submit all child safety and referral sheets to the CDO, LC III or Sub-county Chief.</p>

Child discloses	Referral level (All Mandatory)	Indicated by positive answer to any of below discrete violent acts or injuries by any person	Response <sup>1</sup>
<u>past year</u> or sexual violence <u>within the past year</u> , but no violence within the past month	require action"		Study Counselor offered.
Severe physical violence, or any sexual violence <u>before the past year</u>	4 Level defined as "Not recent, may require action"	As for Referral Level 2, but before past year; and disclosures do not meet same criteria as for level 2	As for referral 3. Study Counselor offered.
No disclosure of specific violent acts in baseline survey, but child indicates they wish to receive further help	0 Level defined as "voluntary notification"		As for referral 3. Study Counselor offered.
Any child offered counseling	N/A	Child requests counseling	Study Counselor offered.

**Figure 6 SRGBV Referral Decision Tree for Child Protection Protocol (Time period: During and two months following end of LARA P&IE SRGBV data collection)<sup>13</sup>**

**Figure 6 Child Protection Referral Decision Tree**



<sup>13</sup> Adapted from Devries, K. et al, "I never expected that it would happen, coming to ask me such questions": Ethical aspects of asking children about violence in resource poor settings. *Trials*, 2015; 16:516; pp. 5-6.

## Submission of all child safety and referral sheets to the CDO, LC III or Sub-county Chief

Given the large number of children to be interviewed during the LARA P&IE baseline data collection and the experience of past SRGBV survey data collectors, the SRGBV specialists expected to need to manage a large number of child safety and referral forms. Therefore, systems were developed prior to training and data collection to assure that bundling and handing over the referral forms to the appropriate local authorities would be organized and respect the privacy of the child to the extent possible.

The child safety and referral sheet were submitted to the local child welfare authority with two additional documents. The first document is the **Referral form cover sheet**—an example is located in **Annex G**—and the second document is **the Child ID and Child Name Crosswalk**—a template is located in **Annex H**. The crosswalk is an essential part of the submission as it is the only sheet that identifies the children by name. The child safety and referral forms only have the Child ID included. For more instruction on the use of the documents, see Annex X with the In-field Child Protection Checklists.

## Tracking and follow up

Once all Child Safety Information and Referral Form have been completed from P&IE SRGBV data collection for Cluster Two, responsibility for monitoring compliance on an acceptable standard of child protection response is the responsibility of the P&IE team up to two month following data collection. This monitoring becomes the responsibility of the LARA implementing partner, RTI, from week eight following P&IE data collection. Key to continuity of this Protocol and handover of child protection case follow-up will be RTI's and their community-based partners' strengthening and use of the Uganda Reporting, Tracking, Referral and Response (RTRR) Guidelines on Violence Against Children in Schools (2014) and National Strategic Plan on Violence Against Children in Schools (2015-2020) of the Ministry of Education, Science, Technology and Sports (MoESTS).

An example of the **Referral Follow-up Tracking Sheet** is included in **Annex I**. One local SRGBV specialist was responsible for completing and updating this form as the referral forms were submitted to the local authorities and as the specialist called to follow-up on the progress of the local authorities in responding to the cases.

## Selected further reading

World Vision (2015) Protecting Girls and Boys in USAID Literacy Achievement and Retention Activity. Draft, December 11, 2015.

Child Protection Monitoring and Evaluation Reference Group (2012), Ethical principles, dilemmas and risks in collecting data on violence against children: A review of available literature, Statistics and Monitoring Section/Division of Policy and Strategy, UNICEF, New York.

Devries et al. (2015) "I never expected that it would happen, coming to ask me such questions": Ethical aspects of asking children about violence in resource poor settings. *Trials* 16:516

Devries, K. et al. (2016) Collecting data on violence against children and young people: need for a universal standard. *Int Health* 2016; 8: 159-161 doi: 10.1093/inthealth/ihw009. Advance Access publication, 1 April 2016.

Graham, A., Powell, M., Taylor, N., Anderson, D. & Fitzgerald, R. (2013) *Ethical Research Involving Children*. Florence: UNICEF Office of Research - Innocenti.

Greene, M., Robles, O., Stout, K. and Suvilaakso, T. (2013) *A girl's right to learn without fear: working to end gender-based violence at school*. Plan International, Woking.

Moreno, C., L. Heise, M. Ellsberg and C. Watts (2001) *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*. World Health Organization, Geneva.

Reproductive Health Response in Conflict Consortium (2004) *Gender-based Violence Tools Manual: For Assessment & Program Design, Monitoring & Evaluation in conflict-affected settings*. RHRC Consortium, New York.

Uganda National Council for Science and Technology – *National guidelines for research involving humans as research participants* (2007)



## ANNEX A: Important Contact Details

CSR Survey Manager: Wilson Asimwe, [direcsr@gmail.com](mailto:direcsr@gmail.com)

P&IE Evaluation team members:

Ritu Nayar-Stone, [nayyarstone-ritu@norc.org](mailto:nayyarstone-ritu@norc.org)

Alicia Menendez, [menendez@uchicago.edu](mailto:menendez@uchicago.edu)

Jennifer Schulte, [jenniferschulte@panagoragroup.net](mailto:jenniferschulte@panagoragroup.net)

## ANNEX B: Informed Primary Caregiver Consent Form

### LARA P&IE

#### Informed Consent Form for Caregivers, for Learner Participation in SRGBV Survey

##### Part I: Information Sheet

Hello, my name is [say name], and I work with the Centre for Social Research, a research organization based in Kampala. We are working with NORC at the University of Chicago on an evaluation of the Literacy Achievement and Retention Activity (LARA) program in collaboration with the Ministry of Education and Sports. The LARA program aims to improve the reading skills of primary-grade learners in government schools through early grade reading and creating a safe school environment to improve retention and attendance. The program and the evaluation are funded by USAID.

I am here with a team to assess if classrooms and schools are safe places for learners. We will talk with many learners, in many schools that we have selected for this evaluation. Your child has been selected to be interviewed for a survey, and as the primary caregiver we are seeking your permission first before we interview your child. You can refuse to give us permission to interview your child. This is your right and we will respect it. We will also ask your child for permission or assent separately, before we carry out the survey.

If there is anything you do not understand, please let me know. I will take time to clarify and explain.

##### **Purpose of the assessment**

In this assessment we will talk to learners 6 years and older to determine how safe boys and girls feel in their schools and classrooms. The information provide by your child will be used to improve this and future programs that seek to make schools a safe place to learn.

##### **Voluntary Participation**

Participation is voluntary. You do not have to agree to have your child take part in the survey. You can choose to say no and there will be no positive or negative consequences for your or your child.

### **Survey Procedure**

*Your child will be interviewed one on one by an interviewer who will ask him or her questions. The survey will be conducted in school on [insert date or date range].*

### **Duration of the Survey**

*The survey will be completed during the school day and will take about 20-30 minutes for learners age 6-10, and 30-40 minutes for learners age 11+.*

### **Risks and Discomforts and stopping the Survey**

*The survey will include questions about your child's experience of safety in and around school. Since we will be asking about some personal and confidential information your child may feel uncomfortable talking about some of the topics. If your child does not wish to answer some of the questions included in the questionnaire, she/he may skip them and move on to the next question, or stop the survey at any time without providing any reason. We will let your child know about this before we get assent and start the survey.*

### **Benefits of participating in the Survey**

*There will be no immediate and direct benefit to your child or to you for participating in the survey, but your child's participation will give us more information about the safety of the school in which your child studies, and we hope this information will help this school and other schools in Uganda to become safer for learners.*

### **Reimbursements and Referrals**

*Your child will not be provided any payment to take part in the survey. However, s/he may be referred to a child protection professional counselor and/or contacted by the district community development officer if we identify a need for help based on the information s/he shares with us.*

### **Confidentiality:**

*Responses from your child will be kept anonymous and nothing that he/she says will be linked to his or her name. Your child's identity will always be kept confidential and not shared with anyone outside the evaluation team.*

### **Who to Contact**

*If you have any questions you may ask them now or later, even after the survey has started. If you wish to ask questions later, you may contact any of the following: [name, address/telephone number/e-mail]*

*This proposal has been reviewed and approved by TASO Research Ethics Committee, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the REC, contact Mr. Bakanda Celestin, P.O. Box 10443 Mulago, 0752 774178  
Do you have any questions about the information I just shared?*

**PART II: Certificate of Consent**

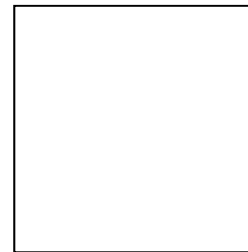
**Certificate of Consent**

I have been asked to give consent for my child to participate in this research study which will involve him/her completing one questionnaire. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for my child to participate as a participant in this study.

Print Name of Parent or Caregiver \_\_\_\_\_

Signature of Parent or Caregiver \_\_\_\_\_ or Thumb print of  
Caregiver

Date \_\_\_\_\_  
Day/month/year



## ANNEX C: Informed Child Assent Form

- Let me tell you why I am here today. I work with the Centre for Social Research, and we and the Ministry of Education, & Sports are trying to understand more about how safe learners feel in school. You were picked by chance, like in a raffle or lottery. [TRANSLATION HERE]
- We would like your help in this. But you do not have to take part if you do not want to. [TRANSLATION HERE]
- We are going to ask you a series of questions about yourself, your thoughts about your school; your experiences with safety at school; and your thoughts about your safety at school. [TRANSLATION HERE]
- I will also ask you other questions about your family and your home. [TRANSLATION HERE]
- This is NOT a test and it will not affect your grade at school, or your participation in school. [TRANSLATION HERE]
- This assessment will take between 25 to 30 minutes. [TRANSLATION HERE]
- I will NOT write down your name so no one will know these are your answers. [TRANSLATION HERE]
- Once again, you do not have to participate if you do not wish to. Once we begin, if you would rather not answer a question, that's all right. You are also free to stop the interview and leave if you wish at any time. [TRANSLATION HERE]
- Do you have any questions? Do you want to participate? [TRANSLATION HERE]

*Check box if verbal agreement is obtained:*             YES



Incident ID:

Survivor Code:

**ANNEX D: Draft Referral Form: Child Safety Information and Referral Form<sup>14</sup>**

**CONFIDENTIAL:**

**Child Safety Information and Referral Form**

**A. CHILD SAFETY ASSESSMENT**

Main Assessment Point: The child's current safety status.

- Referral Level 1: Urgent action needed
- Referral Level 2: Less urgent, but serious notification
- Referral Level 3: Non-urgent, but serious notification (past month)
- Referral Level 4: Non-urgent, but serious notification (before past year)
- Voluntary notification

Yes, the child is safe.

Please explain in the box.

No, the child is not safe.

The following safety risks have been identified:

- The child is fearful of someone at school and does not want to remain at/return to school.
- Child's caregivers cannot or will not protect the child from further abuse.
- The perpetrator lives with the child/can easily access the child at home.
- The child is fearful of family members and does not want to return home.
- Other reason (please identify) \_\_\_\_\_

**CHILD SAFETY REFERRAL**

**Child Safety Referral** Describe referral plan here.

<sup>14</sup> Adapted from International Rescue Committee, Gender-based Violence Responders' Network (2014). Child Needs Assessment and Action Planning Form. Caring for Child Survivors Guidelines. [http://gbvresponders.org/wp-content/uploads/2014/07/4\\_Child-Needs-Assessment-and-Action-Planning-Tool.pdf](http://gbvresponders.org/wp-content/uploads/2014/07/4_Child-Needs-Assessment-and-Action-Planning-Tool.pdf)



Safety Referral Made?  Yes  No

If YES

Child client is referred to:

Child will be accompanied by (describe by relationship e.g., Mother)

IF NO

Why not?

### B. CHILD PHYSICAL HEALTH NEEDS ASSESSMENT

Main Assessment Point: Does the child require a physical health referral?

Yes, a health referral is needed because:

- Last incident was within the past week
- Child complains of physical pain and injury
- Other reason indicated (e.g. bleeding or discharge, or is requested by survivor)

No, a referral is not needed because:

- Services already received from another agency
- Service not applicable (e.g. abuse did not involve physical contact)
- Other reason: \_\_\_\_\_

### PHYSICAL HEALTH REFERRAL

Health Referral Made?

Yes  No

If YES

Child client is referred to:

Child will be accompanied by:

HEALTH REFERRAL NEEDED, BUT NOT MADE BECAUSE:

- Referral declined by survivor
- Referral refused by caregiver
- Service Unavailable
- Non-urgent referral made

Explain:

**Note:** In cases of medical emergency, it is in the child's best interest to receive life-saving care. If a caregiver or child refuses the referral, the District Community Development Officer must be contacted immediately and/or a referral to a health center made directly if the child's life is at risk.

### C. CHILD PSYCHOSOCIAL NEEDS ASSESSMENT

Main Assessment Point: The child's current emotional state and level of functioning.

The child's behavior has changed significantly since the abuse in the following ways:

Describe the child's emotional state (describe expressed or observed emotional state of the child)

<input type="checkbox"/> Stopped going to school <input type="checkbox"/> Stopped going home after school <input type="checkbox"/> Stopped playing with friends <input type="checkbox"/> Cannot concentrate on school work <input type="checkbox"/> Feels sad most of the time <input type="checkbox"/> Exhibits sleeping or eating changes <input type="checkbox"/> Became physically violent toward self or others <input type="checkbox"/> Other major changes or difficulties reported:	
--	--

**PSYCHOSOCIAL REFERRAL**

<input type="checkbox"/> Provide emotional support. <input type="checkbox"/> Provide education and counseling about psychological and physical abuse to help children understand and manage emotional reactions. <input type="checkbox"/> Provide education and counseling about sexual abuse to help children understand and manage emotional reactions. <input type="checkbox"/> Assist the child with any problems identified in the assessment above (going back to school, etc.)	<input type="checkbox"/> Provide counseling with caregiver and/or other family members.
	Describe why this is needed and how it will be done here:

**E. CASE REFERRAL REVIEW AND FOLLOW- UP MEETING**

This Child Protection Needs Assessment and Case Referral Information Form has been developed and agreed by:

<input type="checkbox"/> Child Client	<input type="checkbox"/> Counselor Code: _____	<input type="checkbox"/> CSR Supervisor Code: _____
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## ANNEX E: Information Sheet on Local Child Protection Services (district-specific)

**Whom may I contact for further information?** If you have further questions about the research, please contact us using the following contact details:

Name: Asiimwe Wilson  
Address: Centre for Social Research  
Nkumba University Building, 1st Floor  
Mengo, Kabakanjala Road  
P.O Box 35573 Kampala Uganda  
Email: [direcsr@gmail.com](mailto:direcsr@gmail.com)  
Tel/mobile: [Tel:+256 392-845881](tel:+256392845881)

**What if a child urgently needs medical care or a counsellor to speak with?** You can use the contact details below for information, advice and referrals. Please select the appropriate contact based on your Sub County:

**1. Community Development Officer**

Name: Mutabazi Perez  
Bitsya Sub County  
Tel/mobile: 0776-509920

**2. Community Development Officer**

Name: Babwetera Innocent  
Bihanga Sub County  
Tel/Mobile: 0776-300512

**Important Note:**

If your Sub-County CDO is not responding or is out of station, please call the District Probation and Social welfare Officer:

**3. District Probation and Social Welfare Officer**

Name: Kamaranzi Pereskah

Buhweju District Local Government  
Email: [pkamaranzi@yahoo.com](mailto:pkamaranzi@yahoo.com)  
Tel/mobile: +256772325564

**What if the Community Development Officer and District Probation and Social Welfare Officer are not available and I or a child in my care needs urgent medical attention right now?** You can go to your nearest Health Centre at:

1. Butogota Sub-County Health Centre III
2. Mpungu Sub-County Health Centre III
3. Kayonza Sub-County Health Centre III

**What if the CDO and DPSWO are not available and I or a child needs to speak with a counsellor right now?** CDOs are trained in psychological counselling. If they are not available, you can call or go to speak with:

**1. District Community Development Officer**

Buhweju District Local Government  
Tel/Mobile: [0779803257](tel:0779803257)

**2. Child Protection Point of Contact**

Name: Kamaranga Margaret  
Buhweju District Local Government  
Tel/Mobile: [0772556240](tel:0772556240)

**3. Sub County Chief**

Bitsya Sub County  
Tel/Mobile: [0773129065](tel:0773129065)

**4. Chief Administrative Officer**

Buhweju District Local Government  
Tel/Mobile: [0392174837](tel:0392174837)

## ANNEX F: In-Field Child Protection Protocol Checklists

### Enumerator child protection checklist for learner surveys and FGDs:

- Ensure that you have enough of the following materials for learner surveys:
  - Paper and pen for the envelope method
  - Happy and sad face cards for the envelope method
  - District-specific **Information Sheet**
- Offer a District-specific **Information Sheet** at the end of each learner interview, and also each primary caregiver interview. Explain the information sheet.
- Ensure you refer children who make spontaneous disclosures or made “red flag” referrals during their survey to the study counselor. Ensure girls speak with women counselors. Boys can speak with either a woman or man counselor.
- ENSURE THAT ALL CHILD PROTECTION REFERRALS ARE KEPT IN THE STRICTEST OF CONFIDENTIALITY. DATA COLLECTION TEAM MEMBERS, INCLUDING ENUMERATORS, ARE NOT PERMITTED TO DISCUSS CASES EVEN WITHIN THE TEAM.
- ENSURE THAT NO SCHOOL STAFF PERSON OVERHEARS OR IS TOLD INFORMATION ABOUT THE LEARNER SURVEY IF THEY ASK QUESTIONS OR TRY TO OBTAIN INFORMATION BY OTHER MEANS.
- UNDER NO CIRCUMSTANCES ARE ENUMERATORS PERMITTED TO SHARE OR DISCUSS INFORMATION ABOUT INDIVIDUAL CHILD PROTECTION CASES WITH THE HEAD TEACHER, TEACHERS OR OTHER SCHOOL STAFF OR LEARNERS. THIS IS TO PREVENT STIGMA AND RETALIATION AGAINST A CHILD SURVIVOR OF SRGBV AND TO AVOID DAMAGING INTERFERENCE WITH ANY POTENTIAL FOLLOW-UP INVESTIGATION THAT THE CDO OR OTHER GOVERNMENT OFFICER MAY INITIATE.

### Moderator child protection checklist for learner surveys and FGDs:

- Ensure that you have enough of the following materials for the learner FGDs:
  - Flipchart paper
  - Colored markers for drawing on flipchart paper (red, blue, green markers)
    - Ensure each focus group has at least two red markers
  - Emotion cards on different colored paper per card
  - District-specific **Information Sheet**
- Offer a District-specific **Information Sheet** to each learner in an FGD, and also each primary caregiver interviewed. Explain the information sheet.
- Ensure you refer children who make spontaneous disclosures of personal SRGBV experiences the FGD to the study counselor. Ensure girls speak with women counselors. Boys can speak with either a woman or man counselor.
- Ensure that you take the drawings (maps) that children draw in the focus groups and submit them to CSR. Do not leave child-drawn maps with the children or at school as

they can put children at risk of retaliation. [CSR supervisors should photograph those drawings and submit the photographs to NORC along with the qualitative transcripts.]

- ENSURE THAT ALL CHILD PROTECTION REFERRALS ARE KEPT IN THE STRICTEST OF CONFIDENTIALITY. DATA COLLECTION TEAM MEMBERS, INCLUDING MODERATORS, ARE NOT PERMITTED TO DISCUSS CASES EVEN WITHIN THE TEAM.
- ENSURE THAT NO SCHOOL STAFF PERSON OVERHEARS OR IS TOLD INFORMATION ABOUT THE LEARNER SURVEY IF THEY ASK QUESTIONS OR TRY TO OBTAIN INFORMATION BY OTHER MEANS.
- UNDER NO CIRCUMSTANCES ARE MODERATORS OR NOTETAKERS PERMITTED TO SHARE OR DISCUSS INFORMATION ABOUT INDIVIDUAL CHILD PROTECTION CASES WITH THE HEAD TEACHER, TEACHERS OR OTHER SCHOOL STAFF OR LEARNERS. THIS IS TO PREVENT STIGMA AND RETALIATION AGAINST A CHILD SURVIVOR OF SRGBV AND TO AVOID DAMAGING INTERFERENCE WITH ANY POTENTIAL FOLLOW-UP INVESTIGATION THAT THE CDO OR OTHER GOVERNMENT OFFICER MAY INITIATE.

#### Counselor Checklist for Child Protection Referrals

- PLEASE PRIORITIZE COUNSELING CHILDREN BEFORE ANY OTHER ACTIVITY. Ensure that you make yourself available when a child is referred to you. Children who have been referred to a counselor take priority over any adult that a counselor may be interviewing at the moment that an enumerator or moderator refers a child to a counselor.
- Ensure you speak with each child in a private space without anyone else present, listening in nearby or standing or sitting within earshot.
- Record information for each child referred to you as a Counselor in the **Supervisor Cross-Walk Form**.
  - Fill in the unique EMIS school code, assign a Unique ID number for the learner, the learner's name and the referral level (1, 2, 3, 4, or 0)
- Ensure that you complete one **Child Safety Information and Referral Forms** per child referred to them.
- Ensure that all **Child Safety Information and Referral Forms** have a readable duplicate.
- Ensure that all **Child Safety Information and Referral Forms** are collected once completed and packaged into one bundle PER SUB-COUNTY for submission to the local child protection authority (CDO, DPWSO, DCDO, Assistant CAO, LCIII)
- Make calls to the appropriate authority listed in **Figure 5** and **Figure 6** of the Child Protection Protocol for all Referral Level 1 and Referral Level 2, and in the **Information Sheet**
- Complete one **Cover Sheet** per Sub-County tallying all totals for Referral Level 1, Referral Level 2, Referral Level 3, Referral Level 4, and Referral Level 0
- Confirm completion of all **Supervisor Cross-Walk Forms**, including double-checking that all Unique ID, Learner name and Referral Levels listed reflect exactly what is in the referral forms
- Submit the bundle of **Child Safety Information and Referral Form** copies, a copy of a completed **Supervisor Cross-Walk Form** and a **Cover Sheet** to the local child protection authority (CDO, DPWSO, DCDO, Assistant CAO, LCIII) in the Sub-County before leaving the Sub-County.

- Ensure that the recipient of the bundle (**Child Safety Information and Referral Form** copies, a copy of a completed **Supervisor Cross-Walk Form** and a **Cover Sheet**). NOTE: THE ONLY APPROVED RECIPIENTS OF THE CHILD PROTECTION REFERRAL BUNDLES ARE THE:
  - CDO
  - DPSWO
  - DCDO
  - ASSISTANT CAO
  - LCIII
- ENSURE THAT ALL CHILD PROTECTION REFERRALS ARE KEPT IN THE STRICTEST OF CONFIDENTIALITY. DATA COLLECTION TEAM MEMBERS, INCLUDING COUNSELORS ARE NOT PERMITTED TO DISCUSS CASES EVEN WITHIN THE TEAM.
- ENSURE THAT NO SCHOOL STAFF PERSON OVERHEARS OR IS TOLD INFORMATION ABOUT THE LEARNER SURVEY IF THEY ASK QUESTIONS OR TRY TO OBTAIN INFORMATION BY OTHER MEANS.
- UNDER NO CIRCUMSTANCES ARE COUNSELORS PERMITTED TO SHARE OR DISCUSS INFORMATION ABOUT INDIVIDUAL CHILD PROTECTION CASES WITH THE HEAD TEACHER, TEACHERS OR OTHER SCHOOL STAFF OR LEARNERS. THIS IS TO PREVENT STIGMA AND RETALIATION AGAINST A CHILD SURVIVOR OF SRGBV AND TO AVOID DAMAGING INTERFERENCE WITH ANY POTENTIAL FOLLOW-UP INVESTIGATION THAT THE CDO OR OTHER GOVERNMENT OFFICER MAY INITIATE.
- HOWEVER—DO SAY THIS AND ONLY THIS TO THE HEAD TEACHER AT THE END OF A DAY OF DATA COLLECTION:
  - “We did find some child protection cases and we will be referring them to the CDO of the Sub-County. It’s possible that some of these may not have been reported to you.”

Supervisor child protection checklist for learner surveys and FGDs:

- Please help reinforce the rule that all child protection disclosures and referrals are to be kept in the strictest terms of confidentiality and privacy. Data collection teams are not permitted to discuss child protection cases even within the team.
- Under no circumstances are Supervisors or data collection team members permitted to share or discuss information about individual child protection cases with the head teacher, teachers or other school staff or learners. This is to prevent stigma and retaliation against a child survivor of SRGBV and to avoid damaging interference with any potential follow-up investigation that the CDO or other government officer may initiate.

**ANNEX G: Cover Sheet for Submission of Child Safety and Referral Sheets**

Date: [dd/mm/yyyy]

To: \_\_\_\_\_

**RE: LARA evaluation data collection**

The Ministry of Education and Sports (MoES) with support from the USAID/Uganda Literacy Achievement and Retention Activity is working in 28 districts to improve early grade reading, and create positive and supportive school climate to enhance the quality of education.

NORC at the University of Chicago, in collaboration with the Center for Social Research, is implementing a baseline study in schools in April, 2017.

The purpose of this letter is to inform you of child protection referrals made during data collection.

For further information, contact the Resident Evaluation Manager, Literacy Achievement and Retention Activity, Martin John Opolot Tel No: 0772-624667.

With this letter, the Center for Social research hereby submits the following total numbers and enclosed child protection referral reports:

Referral Level 1 forms: \_\_\_\_\_

Referral Level 2 forms: \_\_\_\_\_

Referral Level 3 forms: \_\_\_\_\_

Referral Level 4 forms: \_\_\_\_\_

Referral Level 0 forms: \_\_\_\_\_

Acknowledgement of receipt of child protection referral forms:

I received today these forms from the Center for Social Research:

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Stamp:

**ANNEX H: Crosswalk for Child ID and Child Locating Information**

EMIS Codes	Unique ID	Name of learner	Referral level
School 1			
School 2			
School 3			



**and Referral Form Follow-up Tracking Sheet**

Child Protection Referral Level 1	# of Child Protection Referral Level 2	# of Child Protection Referral Level 3	# of Child Protection Referral Level 4	# of Child Protection Referral Level 0	Sub-County Name	School District Name
Contacted by Child Protection Officer to complete referral bundle	Date and time of follow-up call #1 (MM/DD/YYYY; 00:00 AM or PM)	Actions taken by Child Protection Officer: ("No action reported"; "# children accessed medical services"; "# children accessed psychosocial counseling"; "# children accessed justice response"; Other, please describe)	Notes on discussion with child protection officer	Date and time of follow-up call #2	Actions taken by Child Protection Officer: ("No action reported"; "# children accessed medical services"; "# children accessed psychosocial counseling"; "# children accessed justice response"; Other, please describe)	Notes on discussion with child protection officer
Completed by Child Protection Officer: ("No action reported"; "# children accessed medical services"; "# children accessed psychosocial counseling"; "# children accessed justice response"; Other, please describe)	Notes on discussion with child protection officer	Date and time of follow-up call #4	Actions taken by Child Protection Officer: ("No action reported"; "# children accessed medical services"; "# children accessed psychosocial counseling"; "# children accessed justice response"; Other, please describe)	Notes on discussion with child protection officer	# Cases completely resolved according to child protection officer	

