# RESPONSIBLE, ENGAGED AND LOVING (REAL) FATHERS: SCALE-UP AND INTEGRATION WITH EARLY CHILDHOOD DEVELOPMENT



## REAL FATHERS PROGRAM COHORT 1 EXTERNAL OUTCOME EVALUATION FINAL ENDLINE REPORT, NOVEMBER 2025

UNIVERSITY OF CALIFORNIA SANDIEGO
NaNa DEVELOPMENT CONSULTANTS LIMITED

UC San Diego
CENTER ON GENDER EQUITY AND HEALTH

NaNa Development Consultants

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## List of Acronyms:

| SN | Acronym | Full Expansion |
|---|---|---|
| 1 | A-level | Advanced Level |
| 2 | ANCDC | All Nations Children Development Center |
| 3 | ARUWE | Action for Rural Women Empowerment |
| 4 | ATE | Average Treatment Effect |
| 5 | BIU | Bantwana Initiative Uganda |
| 6 | CCI | Children's Chance International |
| 7 | CI | Confidence Interval |
| 8 | C-RCT | Phased Rollout Cluster Randomized Controlled Trial |
| 9 | CREDI | Care Givers Reported Development Index |
| 10 | DiD | Difference in Difference Estimation |
| 11 | ECD | Early Childhood Development |
| 12 | FAWE | Forum for Women Empowerment |
| 13 | FP | Family Planning |
| 14 | GPS | Global Positioning System |
| 15 | HOLD-UG | Holistic Community Development -Uganda |
| 16 | IIDC | Impact and Innovations Development Center |
| 17 | IO | Intermediate Outcome |
| 18 | IPV | Intimate Partner Violence |
| 19 | IRB | Institutional Review Board |
| 20 | IRC | Institutional Review Committee |
| 21 | ITT | Intent to Treat |
| 22 | LO | Long-Term Outcome |
| 23 | MEAL | Monitoring Evaluation, Accountability and Learning |
| 24 | NaNa DCLTD | NaNa Development Consultants Limited |
| 25 | NDP | National Development Plan |
| 26 | O-Level | Ordinary Level |
| 27 | RA | Research Assistant (s) |
| 28 | REAL | Responsible Engaging and Loving Fathers |
| 29 | UCSD | University of California and San Diego |
| 30 | UNCST | Uganda National Council of Science and Technology |
| 31 | USA | United States of America |
| 32 | VAC | Violence Against Children |
| 33 | VISION-TERUDO | Teso Rural Development Organization |
| 34 | WACSOF | Western Ankole Civil Society Organizations Forum |
| 35 | WOS | Windows Operating System |
| 36 | YF | Young Father(s) |

# EXECUTIVE SUMMARY

## *Introduction:*

This report presents findings of the Responsible, Engaged and Loving (REAL) Fathers outcome evaluation for program Cohort 1. Results come from a sample of 1,187 husband-wife/ Young Father- spouse couple dyads in two study arms: intervention and control. The findings presented here describe the differences between the intervention and control groups from baseline to endline (one-month before intervention and one-month following intervention) on key outcome measures of the REAL Fathers program Primary outcomes include: positive parenting practices, Intimate Partner Violence (IPV), violent physical punishment of children, and early child development (ECD) indicators.

## *Methodology:*

The outcome evaluation employed a Longitudinal, Phased Rollout Cluster Randomized Controlled Trial (C-RCT) design. Data was collected using a questionnaire adopted and updated from the earlier pilot evaluation of REAL Fathers and spouse survey questionnaires covering the following domains.

| *SN* | *Sections covered by each questionnaire* |
|---|---|
| *Fathers Questionnaire* | *1) Respondent's Background (age, education, work, religion)*<br>*2) Partner and Child Background*<br>*3) Relationship With Partner, Communication, and Attitudes Toward Intimate Partner Violence*<br>*4) Parenting Attitudes and Experience*<br>*5) Contraception and Family Planning*<br>*6) Early Childhood Development (CREDI)*<br>*7) Exposure to the Intervention* |
| *Spouse (Wife's) questionnaire* | *1) Respondent's Background*<br>*2) Relationship With Partner, Communication, and Attitudes Toward Intimate Partner Violence*<br>*3) Contraception and Family Planning*<br>*4) Early Childhood Development (CREDI)*<br>*5) Child Immunizations and Play*<br>*6) Child Health and Breastfeeding*<br>*7) Exposure to the intervention* |

*Table 1: Summary sections covered by the survey questionnaires*

The survey questionnaires used validated questions to measure a total of five (5) primary and then (10) intermediary outcome indicators (see table-3).

In addition, four (4) inter-related domains of ECD including motor, language, cognition, social emotions and mental health indicators were collected using the Caregivers Reported Early Development Instruments (CREDI) for children between the ages of 0-36+ months.

The survey questionnaires also captured basic demographic characteristics including: age of fathers, wives, and children, educational attainment, employment, religion, and tribe/ethnicity of the fathers and wives, and the child's sex. A total of 1,258 young father-spouse couple dyads participated in the data collection at baseline, and 1,187 dyads at endline, representing a response rate of 93.6%. At baseline, young fathers were between the ages of 16 and 25 years, had a child or children under the age of 3 years, and were living with their significant others (wives or girlfriends or spouses).

Interviews occurred across six (6) regions of Uganda, with one to two districts within each region including:), Ankole (Isingiro), Buganda (Kayunga and Luwero), Bunyoro (Kiryandongo and Masindi), Busoga (Bugiri), Lango (Dokolo) and Teso (Katakwi). Buganda. All young fathers and their spouses/ wives who participated the in the baseline survey were invited for the endline survey. In instances where a household had more than one child under the age of three, the respondents were asked to focus on the

eldest child (this child of focus is called the 'index child'). In instances where the father's significant other had changed from baseline to endline, the current significant other was interviewed.

The questionnaires were translated from English to the six local languages spoken in each of the above regions including Runyankole, Luganda, Runyoro, Lusoga, Langi and Ateso respectively. The questionnaires went through both ethical review and Institutional Review Committee (IRC) at College of Humanities and Social Science at Makerere University and Uganda National Council of Science and Technology (UNCST) respectively. A team of twelve (12) Research Assistants (RAs), about two (2) from each region, were trained in the local language versions of the questionnaires and subsequently administered the data collection tools. All selected RAs were graduates aged between 20-35 years both males and females. Data was collected using handheld devices (tablets) with validated question items with automatic skips using XML file format programmed using KoboCollect software.

Collected data was downloaded from the handheld devices (tablets) daily and checked for errors relating to illogical and inconsistent entries, merged and transferred to R software for analysis using frequencies, percentages, means, medians and scores. The Average Treatment Effect (ATE) on primary and secondary outcomes was estimated using difference-in-differences (DiD) mixed-effects logistic and linear regression models to account for the clustered study design. Primary analysis followed an intention-to-treat (ITT) approach, whereby all participants were analyzed according to their original randomization at baseline. A Bonferroni correction was applied to adjust for multiple comparisons in the primary outcomes while maintaining an overall 5% level of statistical significance for the trial. Analyses were performed at the individual level, rather than using cluster-averaged data. Finally, predicted margins derived from the mixed-effects logistic regression models were used to compute the average causal effect, equivalent to the ATE estimates. Findings are summarized in Table 2 and described in more depth below.

**Interpretation of findings.**
Table 2 provides: 1) Descriptive statistics—unadjusted baseline and endline values of the outcome measures for the intervention and control groups; and 2) Difference-in-Differences (DiD) regression results—results from the mixed effects models assessing the differences between the control and intervention groups from baseline to endline.

## *Results*

### Demographics

The average ages of young fathers, spouses, and children increased slightly from baseline to endline with no statistical variation between control and intervention. The age increased from 23.2 years to 24.2 years at endline for the young fathers, while spouses' average age increased from 20.7 to 21.6 years and the average age of the index child rose from 18.8 months to 28.6 months.

The education level of respondents, both young fathers (YFs) and their spouses, remained largely stable between control and intervention at baseline and endline, with minimal shifts observed across control and intervention groups. Among YFs, the majority had completed upper primary education in both control (55.7% baseline; 55.6% endline) and intervention groups (48.9% baseline; 49.2% endline), followed by O-level completion (28.2%; 33.2%- control/ intervention), and a small proportion had A-level or higher (control: 5.9%; intervention: 5.3%). Those with no or only lower primary education remained fairly consistent (10.2%;12.5%-- control/ intervention). Similarly, spouses' education levels showed stability: the largest proportion had completed upper primary (49.2%;47.6%- control/ intervention), O-level was next (23.6%;29.6%-- control/ intervention), while A-level and above remained minimal (~3%), and never/low primary ranged from 20–24.5%.

Overall, across all districts, 61.3% of respondents were married at baseline, increasing slightly to 62.1%

at endline, while cohabiting fathers decreased from 38.7% to 37.9%. The average duration of marriage increased from 2.7 years at baseline to 3.7 years at endline, reflecting both natural progression over time and possibly greater stability in unions. only 37 couples change their partners by endline time.

Farming is still the predominant source of livelihood for both young fathers and their spouses across all districts, with 71.2% of young fathers and 85.5% of spouses engaged in farming. Self-employment is the next most common source of income for fathers (31.5%) and spouses (23.1%), while formal employment (working for an employer) is relatively low among both groups (8.6% of fathers and 5.6% of spouses). Notably, a small proportion of fathers and spouses work for family members or in other categories, and 9.5% of spouses reported having no work.

Most districts are dominated by one or two major ethnic groups, but with notable diversity in some regions. In Ankole, respondents are almost evenly split between Banyankore (50.0%) and Bakiga (47.3%), while in Bunyoro, Banyoro (36.5%) and Alur (25.9%) are the largest groups, but there is also a significant proportion of Acholi (16.6%) and other tribes (20.9%), indicating higher diversity. Busoga displays multiple smaller groups with Banyole (33.1%) and Basoga (25.3%) leading, alongside Jopadhola, Itesot, and others. Lango and Buganda are largely homogenous, with Lango comprising 81.3% Lango respondents and Baganda making up 75.3% in Buganda. Teso is entirely Itesot (100%).

Roman Catholic was the most prevalent religion among respondents, representing 46.7% overall, followed by Anglican/Protestant at 27.2%, Muslims at 14.2%, Pentecostals at 8.4%, and other religions at 3.5%.

### *Long-term and intermediate outcome indictors*

| | |
|---|---|
|  | **Intimate Partner Violence (IPV)**<br>**Decrease from 54% to 32%** victimization among wives<br>**Decrease from 41% to 16%** victimization among husbands |
|  | **Family Planning**<br>**Increase from 37.1% to 41.8%** in fathers' knowledge of and support for family planning<br>**Unmet need for Family Planning declined from 26.4% to 20.5%** among spouses |
|  | **Immunization**<br>Fathers taking their children for immunization **increased from 45.2% to 64.3%**<br>Number of children with complete vaccination coverage **increased from 47.5% to 54.0%** |
|  | **Early Child Development**<br>Caregivers Reported Early Development Index (**CREDI) score increased from 46.0 at baseline to 47.5 as reported by fathers** |
|  | **Positive parenting and child disciplining**<br>Positive parenting knowledge and self-efficacy **increased from 61.0% to 94.2%** |
|  | **Gender-equitable decision-making and planning and joint household decision-making increased from 79.0% to 93.4%** |
|  | **Couple communication and conflict resolution**<br>Fathers reporting an **increase in positive communication from 61.6% to 72.8%** |
|  | **Young fathers' engagement in stimulation and play**<br>Fathers engaging in early learning and play with their children **increased from 37.0% at baseline to 51.3%** |

### Intimate Partner Violence (IPV).

IPV victimization among wives declined significantly in the intervention arm, with experiencing at least one form of IPV decreasing from 54.0% to 32.3% - control/ intervention (ATE = −15.4%; 95% CI: −23.7, −7.1; p<0.001). Reductions were also observed in verbal (from 44.5% to 26.6%; ATE = −14.9; p<0.001), physical IPV reduced from 28.5% to 14.1% (ATE =−17.3; p<0.001), and sexual IPV reduced from 22.1% to 12.2%; (ATE = −20.6; p<0.001)

IPV victimization among fathers declined between baseline and endline: any IPV from 41.4% to 16.7% (ATE = −12.1; p<0.002), verbal IPV from 34.9% to 11.5% (ATE= −14.1; p<0.001), and sexual IPV from 13.0% to 10.4% (ATE = −7.3; p<0.012), while physical IPV reductions were smaller and not statistically significant (14.7% to 7.8%; p<0.081). Perpetration of IPV by fathers decreased markedly between baseline and endline: any IPV from 54.1% to 20.7% (ATE = −19.9; p<0.001), verbal IPV from (43.9% to 17.0% (ATE = −19.2; p<0.001), physical IPV from 25.7% to 7.9% (ATE = −12.6; p<0.001), and sexual IPV from 20.8% to 9.6% (ATE = −21.1; p<0.001). These results indicate strong program impact on both IPV reduction and couple dynamics.

### Family Planning.

Unmet need for Family Planning (FP) among spouses slightly declined in the intervention arm between baseline and endline from 26.4% to 20.5% (ATE = −6.6; p<0.085) while fathers' knowledge of and support for family planning improved, with escorting spouses for FP increasing from 37.1% to 41.8% (ATE = 8.5; p<0.032).

### Immunization.

The proportion of fathers taking their children for any immunization round increased in the intervention group from 45.2% at baseline to 64.3% at endline (ATE=−2.0; p<0.325). Relatedly the number of children with complete vaccination coverage across both the control and intervention groups between baseline and endline, though not statistically significant slightly increased from 47.5% to 54.0% (ATE=1.9; p<0.628).

### Early Child Development: Caregivers Reported Early Development Index (CREDI).

The overall mean raw CREDI scores remained constant in the control group (57.9 at both baseline and endline), while a modest improvement was observed in the intervention group from 46.0 at baseline to 47.5 at endline with age-standardized Average Treatment Effect (ATE) of 0.47 (95% CI: 0.12–0.90, p<0.008) indicates a statistically significant positive effect of the intervention on fathers reported CREDI scores. In contract for mothers in the control group, scores rose slightly from 52.5 to 52.6, while in the intervention group remained virtually unchanged (52.5 to 52.6). The calculated ATE of 0.29 (95% CI: -0.22, 0.81, p<0.667) indicates that the observed difference was not statistically significant.

***Intermediate outcome indicators.***

### Positive parenting and child disciplining.

Positive parenting knowledge and self-efficacy improved markedly between baseline and endline: knowledge increased from 61.0% to 94.2% (ATE = 6.7; p<0.016), attitudes from 27.4% to 36.0% (ATE = 16.4; p<0.000), and self-efficacy from 62.7% to 80.1% (ATE = 22.6; p<0.000). Household communication and conflict resolution was strengthened including positive couple communication among fathers increased from 61.6% to 84.7% (ATE = 28.8; p<0.000), and positive conflict resolution improved from 14.3% to 36.5% (ATE = 24.2; p<0.000).

**Gender-equitable decision-making and planning** also improved between baseline and endline including joint household decision-making which rose from 79.0% to 93.4% (ATE = 23.1; p<0.000), and joint child discipline discussions from 25.9% to 61.6% (ATE = 16.1; p<0.000), Fathers' use of positive,

non-violent child discipline increased from 6.3% to 32.9% (ATE = 21.9; p<0.000), while harsh discipline decreased slightly (p<0.087).

### Couple communication and conflict resolution:

Survey data indicate that 72.8% of fathers in the intervention group reported positive communication with their spouses at endline, up from 61.6% at baseline (ATE = 28.8; 95% CI: 21.2–36.5; p< 0.000). This demonstrates a substantial improvement compared to the control group, which remained relatively stable (68.4% at baseline to 65.5% at endline).

### Social support for father engagement and positive parenting:

Father engagement and positive parenting indicate a substantial improvement in the intervention group compared to control. At baseline, the proportion of fathers who agreed or strongly agreed that their social networks approved of engaging with children and using positive parenting skills was slightly higher in the control group (55.7%) than in the intervention group (45.2%). By endline, this proportion increased significantly in the intervention arm to 64.3%, whereas it remained largely unchanged in the control group (56.4%)-ATE=29.4%, CI:21.1 to 37.7; p<0.000).

### Gender-equitable couple planning and decision-making:

The proportion of fathers reporting joint decision-making about household matters increased from 79.0% at baseline to 93.4% at endline in the intervention group (ATE = 23.1; 95% CI: 16.8–29.4; p<0.000), compared to a slight decline in the control group (80.6% to 76.1%).

### Young fathers' engagement in stimulation and play:

The proportion of fathers engaging in early learning and play with their children rose form 37.0% at baseline to 51.3% by endline (ATE = 35.8; 95% CI: 28.2–43.4; p<0.000) in the intervention group. Relatedly emotional engagement with children increased from 80.7% to 85.1% (ATE = 21.6; 95% CI: 15.1–28.1; p<0.001), and the proportion of fathers with a dedicated play space at home rose from 41.8% to 88.8% (ATE = 17.9; 95% CI: 11.0–24.8; p<0.000).

## *CONCLUSIONS AND RECOMMENDATIONS*

**Conclusions:**

1) Overall, the intervention was effective, consistent and statistically significant in improving all primary outcome indicators across the intervention group between baseline and endline, particularly reduction on Intimate Partner Violence (IPV, positive parenting, rejection of harsh discipline approaches, involvement of fathers in caregiving and parenting.
2) The intervention also achieved statistically significant improvements on intermediate outcomes related to parenting knowledge, attitudes, and gender dynamics further demonstrating improved knowledge about positive parenting.
3) There was a notable significant shift toward positive and non-violent discipline practices, fathers' support towards family planning including escorting wives/ spouses for FP and immunization. These changes underscore the holistic effect of the intervention, promoting gender-equitable roles, shared caregiving, and more nurturing fatherhood.
4) The fact that most of these outcomes improved significantly in the intervention arm but remained static or only modestly changed in the control group highlights the program's added value in transforming harmful norms, improving couple relationships and promoting positive father engagement. This provides strong empirical evidence for scaling and sustaining the REAL Fathers model.

**Recommendations:**

1) Undertake a follow-up/ tracer study at both one (1) and two (2) years' time points to assess the sustained impact of the intervention across all regions on all outcome indicators.
2) Roll-out the intervention to the control sub-counties participants to equally benefit from the positive impact of the intervention and for ethical reasons.
3) Undertake a fidelity of implementation assessment study of the intervention to assess if the intervention was delivered according to the protocol.
4) Undertake a cost effectiveness study to guide additional and wider scale-up of the intervention for policy and practice recommendations.
5) Explore cultural and contextual factors that affect the intervention effectiveness on IPV and perpetration, family planning, child discipline strategies, child immunization, couple communication and decision making across regions through a qualitative study.
6) Explore additional analysis on programme monitoring (adaptive management on monitoring, evaluation and learning) data to validate the consistence, reliability and comparability of the survey data against the achieved programme impact.

***Table 2: Indicator summary table***

| Indicators | Control | | Intervention | | ATE | 95% CI | p-value |
|---|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | Baseline (n=797) | Endline (n=747) | | | |
| | % | % | % | % | | | |
| [LO1.1] % of young father's wives reporting having experienced any physical/sexual/or psychological abuse by their husbands in the last 3 months | | | | | | | |
| % YF whose wives reported experiencing at least one form of IPV | 53.8 | 47.5 | 54.0 | 32.3 | -15.4 | (-23.7, -7.1) | 0.000 |
| % YF whose wives reported experiencing verbal IPV | 42.1 | 39.1 | 44.5 | 26.6 | -14.9 | (-23.0, -6.8) | 0.000 |
| % YF whose wives reported experiencing physical IPV | 26.7 | 29.5 | 28.5 | 14.1 | -17.3 | (-24.4, -10.2) | 0.000 |
| % YFs whose spouse reported Sexual IPV | 19.3 | 30.0 | 22.1 | 12.2 | -20.6 | (-27.5, -13.7) | 0.000 |
| [LO1.2] % of fathers reporting having experienced any physical/sexual/or psychological abuse by their wives in the last 3 months | | | | | | | |
| % of YF experienced at least one form of IPV | 41.3 | 29.1 | 41.4 | 16.7 | -12.1 | (-19.9, -4.3) | 0.002 |
| % of YF experienced verbal IPV | 33.6 | 24.3 | 34.9 | 11.5 | -14.1 | (-21.3, -6.9) | 0.000 |
| % of YF experienced physical IPV | 16.7 | 15.0 | 14.7 | 7.8 | -5.2 | (-11.1, 0.6) | 0.081 |
| % of YF experienced sexual IPV | 12.4 | 17.0 | 13.0 | 10.4 | -7.3 | (-13.0, -1.6) | 0.012 |
| [LO1.3] % of young father's wives reported perpetrating physical/sexual/or psychological abuse against their husbands in the last 3 months | | | | | | | |
| % YF whose wives reported perpetrating IPV | 8.5 | 8.4 | 8.3 | 4.3 | -3.9 | (-8.2, 0.3) | 0.068 |
| [LO1.3] % of young fathers who reported perpetrating physical/sexual/or psychological abuse against their wives in the last 3 months | | | | | | | |
| % of YF reported perpetrating at least one form of IPV | 48.2 | 34.8 | 54.1 | 20.7 | -19.9 | (-27.9, -12.0) | 0.000 |
| % of YF reported perpetrating verbal IPV | 39.0 | 31.4 | 43.9 | 17.0 | -19.2 | (-26.9, -11.5) | 0.000 |
| % of YF reported perpetrating physical IPV | 23.4 | 18.2 | 25.7 | 7.9 | -12.6 | (-18.9, -6.2) | 0.000 |
| % of YF reported perpetrating sexual IPV | 11.9 | 21.8 | 20.8 | 9.6 | -21.1 | (-27.2, -14.9) | 0.000 |
| [LO2.1] % of fathers and their wives with unmet need for family planning | | | | | | | |
| Spouse reported unmet need for FP | 25.5 | 21.1 | 26.4 | 20.5 | -6.6 | (-14.0, 0.9) | 0.085 |
| [LO3.1] Average CREDI score | | | | | | | |
| CREDI Tool total raw scores by the mother (0-100 scale) | 52.5 | 52.6 | 52.5 | 52.6 | 0.29 | (-0.22, 0.81) | 0.667 |
| CREDI Tool total raw scores by the father (0-100 scale) | 57.9 | 57.9 | 46.0 | 47.5 | 0.47 | (0.12–0.90) | 0.008 |
| [LO4.1] % of fathers who escorted or took their children for immunization | 56.5 | 85.2 | 43.6 | 88.9 | 6.5 | (2.1, 10.9) | 0.004 |
| [IO1.1] % of fathers demonstrating improved knowledge about positive parenting and discipline | 75.1 | 90.7 | 61.0 | 94.2 | 6.7 | (1.3, 12.1) | 0.016 |
| [IO1.2] % of fathers demonstrating positive attitudes towards positive | 36.8 | 31.1 | 27.4 | 36.0 | 16.4 | (8.1, 24.6) | 0.000 |

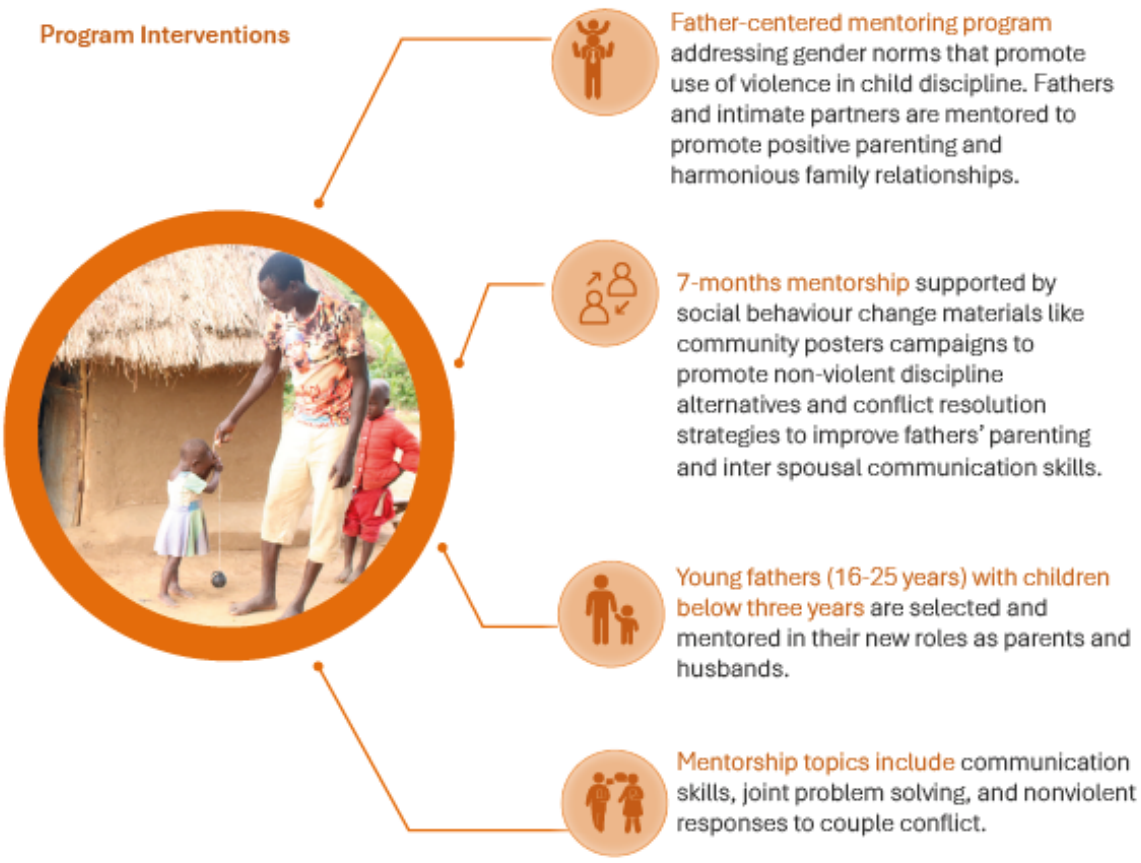
| Indicators | Control | | Intervention | | ATE | 95% CI | p-value |
|---|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | Baseline (n=797) | Endline (n=747) | | | |
| | % | % | % | % | | | |
| discipline | | | | | | | |
| [IO1.3] % of fathers who self-reporting self-efficacy (confidence) in positive parenting skills | 63.3 | 60.0 | 62.7 | 80.1 | 22.6 | (14.7, 30.5) | 0.000 |
| [IO2.1] % of wives and fathers reporting positive couple communication at household level | 71.1 | 65.5 | 61.6 | 84.7 | 28.8 | (21.2, 36.5) | 0.000 |
| % Young fathers whose wives reported Positive couple communication | 65.1 | 63.0 | 65.4 | 79.1 | 15.9 | (8.0, 23.7) | 0.000 |
| [IO2.2] % of wives and fathers reporting positive conflict resolution at household level | | | | | | | |
| % YF who reported Positive conflict resolution | 19.5 | 17.5 | 14.3 | 36.5 | 24.2 | (18.1, 30.7) | 0.000 |
| %YFs whose spouses reported Positive conflict resolution | 12.8 | 12.5 | 10.4 | 14.8 | 1.7 | (-1.2, 2.9) | 0.360 |
| [IO3.1] % young fathers who know where to obtain modern FP methods | 43.6 | 67.5 | 50.7 | 64.3 | 1.6 | (-2.0, 5.2) | 0.374 |
| [IO3.2] % young fathers who support (escorted) their wives to use FP | 37.3 | 33.4 | 37.1 | 41.8 | 8.5 | (0.7, 16.3) | 0.032 |
| [IO4.1] A proportion of fathers that agree or strongly agree that their social networks approve of engaging with children and using positive parenting skills | 43.7 | 51.4 | 38.2 | 70.1 | 29.4 | (21.1, 37.7) | 0.000 |
| [IO5.1] % of fathers reporting planning or discussing child rearing strategies with their wives | 31.5 | 44.1 | 38.6 | 50.2 | 3 | (-5.9, 9.8) | 0.625 |
| [IO5.2] % of fathers reporting planning/discussing child discipline strategies with their wives | 35.0 | 53.6 | 25.9 | 61.6 | 16.1 | (7.8, 24.4) | 0.000 |
| [IO5.3] % of fathers and wives reporting joint (gender-equitable) decision-making about household matters | | | | | | | |
| % of fathers who reported joint (gender-equitable) decision-making about household matters | 84.8 | 76.1 | 79.0 | 93.4 | 23.1 | (16.8, 29.4) | 0.000 |
| % of fathers whose wives reported joint (gender-equitable) decision-making about household matters | 80.0 | 70.7 | 81.8 | 88.4 | 15.9 | (9.3, 22.6) | 0.000 |
| [IO5.4] % of father's reporting gender-equitable decision-making about child-oriented activities (i.e., discipline and childrearing) | 10.7 | 40.0 | 15.2 | 45.3 | 0.8 | (-7.5, 7.1) | 0.959 |
| [IO6.1] % of young fathers reporting use of early learning activities and play with child (stimulation activities) | 48.4 | 26.8 | 37.0 | 51.3 | 35.8 | (28.2, 43.4) | 0.000 |
| [IO6.2] % of young fathers reporting increased emotional engagement and affection towards child | 86.7 | 71.6 | 78.7 | 85.1 | 21.6 | (15.1, 28.1) | 0.000 |
| [IO6.3] % of young fathers reporting having a dedicated play space at home for their children | 42.3 | 71.4 | 41.8 | 88.8 | 17.9 | (11.0, 24.8) | 0.000 |
| [IO7.1] % of fathers' reporting use of positive non-violent disciplining of | 14.8 | 19.5 | 6.3 | 32.9 | 21.9 | (15.5, 28.2) | 0.000 |

| Indicators | Control | | Intervention | | ATE | 95% CI | p-value |
|---|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | Baseline (n=797) | Endline (n=747) | | | |
| | % | % | % | % | | | |
| children in past 3 months | | | | | | | |
| [IO7.2] % of fathers' self-reporting harsh/violent discipline of children in past 3 months | 46.4 | 58.6 | 38.3 | 43.0 | -7.5 | (-16.1, 1.1) | 0.087 |

# 1. INTRODUCTION AND BACKGROUND

The Responsible, Engaged and Loving (REAL) Fathers program is an evidence-based father-centered mentoring program designed to address gender norms that promote use of violence in child discipline and with intimate partners through promotion of positive parenting and partnership skills building. The REAL Fathers Initiative uses a 7-month mentoring program and a community poster campaign to model alternative strategies for nonviolent discipline and conflict resolution to improve fathers' parenting and communication skills and confidence in adapting nonviolent strategies.

The project works with young fathers (ages 16-25) whose eldest child is below the age of three years (under-3Yrs) who are learning new roles as parents and husbands. This stage in a man's life is an ideal time to promote nonviolence in parenting and partner relationships as there is still ambiguity in the normative expectations about these roles and behaviors. Targeting couple communication skills, joint problem solving, and nonviolent responses to couple conflict reduces perpetration of intimate partner violence (IPV) in the long term. Self-reflection on gender roles, by husbands and wives, and at the community level through exposure to posters, leads to improvement in acceptance of an expanded role for the father over time.




The project was piloted in Atiak, Northern Uganda between 2013 and 2015 laying the groundwork for transformative impact. Between *2014 and 2018 was* Expanded into Northern Uganda and Karamoja, broadening reach and refining approaches. Between *2020 and 2022 it was integrated with* Early Childhood Development (ECD) programs, strengthening program effectiveness. In January 2022, the Government

of Uganda officially endorsed REAL Fathers as a strategic model aligned with the third National Development Plan (NDP III 2021–2025) and relevant early childhood development (ECD) policies. This endorsement paved the way for a LEGO Foundation grant to scale the program nationally from 2023 to 2027.

The REAL Fathers Program adoption, scale-up and integration is led, implemented, and evaluated by a consortium of organizations that reflect the principles guiding the programmatic approach: continuous quality improvement; learning and adaptation; effectiveness and efficiency; and sustainable impact. The REAL Fathers Initiative Scale-up Consortium covers three (3) program arms:

a) **Learning & Results/Management Arm.** Led by Impact and Innovations Development Centre (IIDC), a learning partner and Technical Assistance organization supporting violence prevention partners in 3 East African Countries. IIDC and its partners led REAL Fathers integration into ECD systems, resulting into Government buy-in and scale-up endorsement. Building on this experience as lead partner for the REAL Fathers Program integration, IIDC provides leadership and overall implementation oversight, infusing evidence-based learning/adaptation in implementation, managing sub-grants and results management.

b) **Implementation Arm.** Ten (10) organizations are implementing REAL Fathers Program across Uganda: Somero Uganda (Busoga and Buganda regions), Action for Rural Women Empowerment (ARUWE)- Buganda, All Nations Child Development Centre (ANCDC) and Children Chance International (CCI)-Lango Region, Bantwana Initiative Uganda (Teso and Bunyoro region). LACWADO- Bunyoro, Western Ankole Civil Society Organization (WACSOF)-Ankole, VISION TERUDO, Teso region, HOLD Uganda- Busoga region and Forum for African Women Educationalists (Ankole Region).

c) **Evidence Generation/Research Arm.** University of California San Diego (UCSD) together with NaNa Development Consultants Limited (Local Contractor) lead research activities, including M&E study design, indicator selection, and protocol development.

## 1.1 Objectives of the survey

Recent funding to Impact and Innovations Development Centre (IIDC) allows for the scale-up of REAL Fathers to six (06) new regions in Uganda. As an initial research aim of this work is to compare evidence between baseline and endline on current prevalence of positive parenting practices, intimate partner violence (IPV), violent physical punishment of children and early child development indicators, an endline survey was conducted to address the following research questions:

| | | | |
|---|---|---|---|
| i) Assess endline levels of **positive parenting practices** and father-child interaction. | ii) Assess endline levels of **harsh physical punishment** of young children and IPV. | iii) Compare evidence between baseline and endline on **fathers' gender attitudes and households' decision-making** around caregiving and childcare. | iv) Establish endline levels **of early childhood development** outcomes. |

## 1.2 Deliverables of the assignment

In performance of the task the following deliverables were expected:

i) Preparation of an inception report detailing project work plan and timelines
ii) Drafting, refining and pretesting of final data collection instruments as generated in coordination with UCSD and IIDC
iii) Preparation of documentation for UCSD & Local IRB approvals in coordination with UCSD and National Council for Science & Technology (NCST) approval.
iv) Develop an outline of the endline report.
v) Undertake survey programming in online software (such as Kobocollect)
vi) Hiring, create a training plan and train survey enumerators.
vii) Undertake endline survey data collection activities.
viii) Preparation and formation the final clean dataset.
ix) Undertake basic descriptive analyses and
x) Contribute to the final endline survey report in collaboration with UCSD.

# 2. METHODOLOGY

## 2.1 Methodology overview

The survey adopted a Longitudinal, Phased-Rollout Cluster Randomized Controlled Trial (C-RCT) design using an extended REAL father's endline survey questionnaire adopted and updated from the baseline evaluation of REAL Fathers with the same primary outcome indicators. The survey used validated questions to measure a total of five (5) primary and ten (10) intermediary outcome indicators, as summarized in Table 3.

*Table 3: Summary of primary and secondary outcome measures. *=Long-term (impact indicators)*

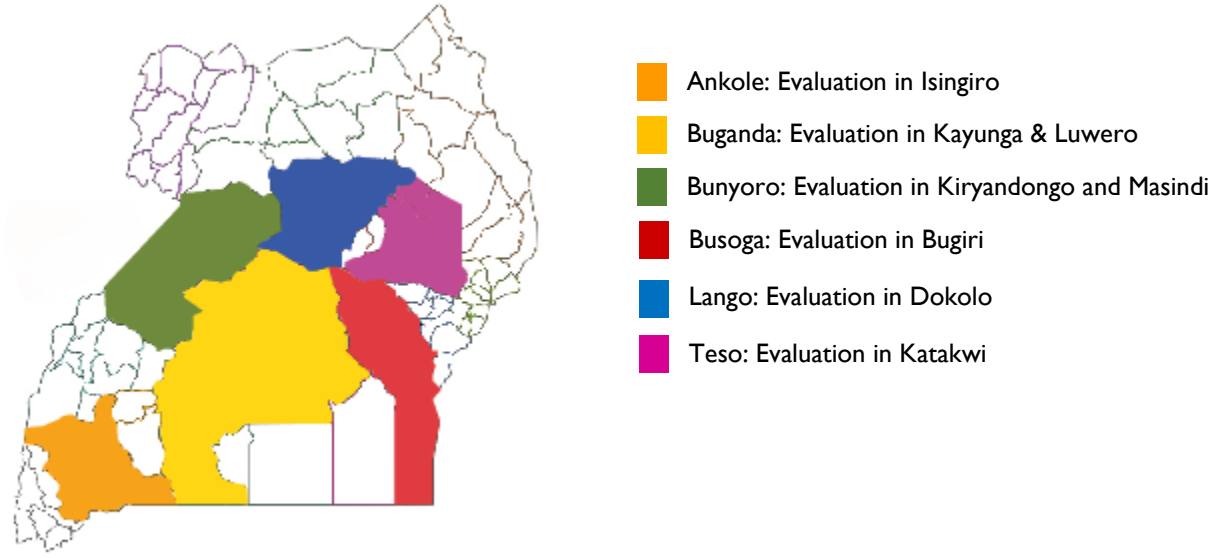
| *Primary Outcome Measures* | | |
|---|---|---|
| *Outcome* | *Measure Description* | *Questionnaire* |
| *Intimate partner violence (IPV): Perpetration and Victimization** | *Proportion of young fathers and their wives reporting perpetrating or being a victim of physical, sexual, and/or emotional IPV in the past three months.* | *Male and Female caregiver* |
| *Harsh violent discipline of children* | *Proportion of fathers reporting they used a form of harsh/violent discipline with their child in the past month.* | *Male* |
| *Fathers' positive parenting and discipline behaviors* | *Proportion of fathers reporting use of positive parenting and discipline practices in the past three months.* | *Male* |
| *Fathers' increased use of child engagement (early stimulation) activities** | *Proportion of fathers reporting use of early learning and play activities with child (i.e., stimulation activities).* | *Male* |
| *Early childhood development* | *Scores on the short-form version of the Caregiver Reported Early Development Instruments (CREDI)* | *Male and Female* |
| *Secondary Outcome Measures* | | |
| *Couple communication and conflict resolution* | *Proportion of fathers and mothers reporting increased and improved communication with the other.* | *Male and Female* |
| *Father engagement in household duties* | *Proportion of fathers who engage with household chores and caretaking activities in past three months.* | *Male* |
| *Father alcohol and drug use* | *Reduction in proportion of fathers' heavy alcohol use (i.e., three or more drinks in a single day).* | *Male* |
| *Fathers' use of emotional engagement towards child* | *Proportion of fathers reporting increased emotional engagement and affection towards children.* | *Male* |
| *Fathers' knowledge of positive parenting and discipline skills* | *Proportion of fathers who can correctly distinguish between positive and harsh discipline.* | *Male* |
| *Fathers' attitudes towards positive parenting and discipline* | *Proportion of fathers who hold positive attitudes for the use of non-violent parenting practices.* | *Male* |
| *Supportive environments for father engagement and positive parenting* | *Proportion of fathers agreeing or strongly agreeing that their social networks approve of engaging with children and using positive parenting skills.* | *Male* |
| *Father engagement in child health-promoting activities** | *Proportion of fathers and mothers reporting that the father took their child(ren) for rounds of immunization(s)* | *Male and Female* |
| *Knowledge of where to access family planning method(s)* | *Proportion of fathers and mothers who know where to obtain a method of family planning.* | *Male and Female* |
| *Reduced unmet need for family planning** | *Proportion of fathers and mothers with unmet need for healthy timing and spacing of children.* | *Male and Female* |

In addition, four (4) inter-related domains of ECD including motor, language, cognition, social emotions indicators were added using the Caregivers Reported Early Development Instruments (CREDI) for children between 0-36+ months. The survey questionnaires were extended to capture basic demographic characteristics including both the fathers and spouse's age; children(s') age; educational attainment; employment to mention (see annex for data collection tools).

Data was collected from a maximum of 1,187 (young father- spouse dyads) out of 1,258 dyads which participated at baseline. This translated to a total of 2,374 questionnaires (1,187 father questionnaires and 1,187 spouse questionnaires) across the six (6) regions of Uganda i.e., one district within each region (with exception of Buganda and Bunyoro which provided two districts each).

## 2.2 Study Location

The study was conducted in six (6) regions of Uganda across eight (8) Districts of **Ankole** (Isingiro), **Buganda** (Kayunga and Luwero), **Bunyoro** (Kiryandongo and Masindi), **Busoga** (Bugiri), **Lango** (Dokolo) and **Teso** (Katakwi).




## 2.3 Study Population

The study was conducted with young fathers, their spouses and children who participated in the baseline survey. The table below summarizes the inclusion and exclusion criteria for participation into the study at baseline:

i) Being male aged between aged 16-25 years.
ii) Being a biological father to a first-born biological child (ren) under the age of 3 years and no other older biological child/ren.
iii) Living in union with the mother/stepmother of the child
iv) Living in one of the six (6) selected regions and districts
v) Being a spouse of and living with a selected young father (women only)
vi) Consented to participate in the study

## 2.4 Sampling

### 2.4.1 Sample size determination

The sample size at baseline study was based on the proportion of young fathers who apply positive parenting skills. Based on the pilot studies on REAL Fathers intervention in Uganda, and also to obtain the largest sample size possible (for statistical power of sub-group analyses), only 40% of the young fathers apply positive parenting skills at the baseline[Error! Bookmark not defined.]. From pilot studies, the REAL Fathers intervention improved this proportion by at least 10% (effect size on absolute scale) by the endline. The sample size computation was based on the formula:

$$n = \frac{[2*(Z_{\alpha}+Z_{1-\beta})^2 * \bar{P}(1-\bar{P})]}{(P_1-P_0)^2} \times Deff$$

Where:

n = minimum sample size of individuals required per arm of study
$Z_{\alpha}$ = the critical value of the standard normal variate at one-sided significance level of α (assumed 0.05 or 95% certainty for improvement in the indicator)
$Z_{\beta}$ = the critical value of the standard normal distribution at a power of 1-β (assumed to be 0.84 or 80% power)
$P_0$ = the value of positive parenting indicator at the baseline; assumed 40%
$P_1$ = the value of positive parenting indicator at the endline; assumed to improve by 15% based on pilot studies on REAL Fathers Interventions in Uganda)
$\bar{P} = \frac{P_1 + P_0}{2}$
Deff = clustering effect, assumed to be 2.3

The computation of the design effect was based on the following arguments: Based on the Uganda Bureau of Statistics (UBOS) 2019 population projections and Uganda Demographic and Health Survey (UDHS 2016 data, only 4% of the male population (16-26 years) are young fathers who are married or cohabiting. Thus, in a village of 100 households (average village size is about 100 households according to Uganda National Population and Housing Census, 2014), no more than 10 young men (16-25 years) are young fathers with children 0-3 years. To be on the conservative side, the study assumed that, on average, only 8 young fathers were eligible for the study from any given village. Let $\bar{m}$ denote this average, and suppose *cv* is the coefficient of variation in the number of fathers across the different villages, and $\rho$ is intra-cluster correlation (ICC). Pilot studies on REAL Fathers intervention approximated ICC of 0.20-0.24 at the village level.

Thus:

$$Deff = \left(1 + \left((cv^2 + 1)\bar{m} - 1\right)\rho\right) = \left(1 + \left((0.063 + 1) \times 7 - 1\right)\right) \times 0.20 = 2.3$$

Based on the above parameters and an attrition rate of 10% between the baseline and endline, a total of 1,872 young fathers are required per study arm (3,744 in total). This translates to 156 per district; 78 in each study arm from 7-12 villages. Following the same procedures, the same number (3,744) of spouses commonly known as dyads were interviewed to validate the fathers' information on IPV, family planning, child immunization indicators.

### 2.4.2 Sampling weights:

The complex sample survey design features were accounted for at analysis. Micro data was collected to enable selection of sub-counties, parishes and villages. These were used as base sampling weights where relevant, non-response weights or attrition were computed and used at baseline

### 2.4.3 Sample selection

All 1,187 out of the1,258 (husband and wife dyads) at baseline across eight (8) Cohort I selected districts who participated in the baseline survey were invited for endline survey. All 1,187 young fathers and their spouses who responded to the endline were informed about the endline study and invited for an interview. All young fathers and their spouses willing to follow the study protocol were taken through an informed consent process. The consenting process started with the father, if accepted to participate in the study, the wife was also invited for consenting. In case the wife refused, the young father was also rejected without replacement. A written informed consent was obtained from a young father and the spouse who agreed to take part in the study.

If the young father or the spouse was not available on the day of the interview, up to three (3) additional attempts were made to contact a young father on varying days of the week including providing transport refund to those who had moved very faraway for work and other reasons to improve on the response rate and reduce on lost to follow-up for endline survey. If the young father or his spouse declined to participate or couldn't be located, the reasons for their lost to follow-up were documented. (See annex 5 for documented reasons for YFs who were lost to follow-up).

## 2.5 Data collection

Survey data was collected using a REAL Father's and Spouse endline survey questionnaires to ascertain self-reported current prevalence of positive parenting practices, Intimate Partner Violence (IPV), Violent physical punishment of children and early childhood development indicators measured from interviews administered face-to-face to young fathers (ages 16-25) who have toddler-aged children under the age of 3 years. A module on IPV, family planning and immunization of children were answered by spouses of young fathers to validate and triangulate the young fathers' information. The questionnaires were extended to capture the respondents' social demographic characteristics including age, sex, religion, location, marital status, education and level of income to mention. Interviews lasted approximately 50 minutes for the spouse (wife) and about 60 minutes for the fathers' questionnaire.

All data collection tools were administered to the survey respondents in local languages spoken by the participants in each region including Runyankole, Luganda, Runyoro, Lusoga, Langi and Ateso. The research team worked with Vision Group who are publishers of local dailies in the selected languages to translate the tools. Two (2) translators were assigned to each language. One translated and another back translated. A harmonization conference was held to handle inconsistencies and harmonize the translations. Additional translations and context matching were done by RAs during the training and pre-testing of the study tools.

Besides translation, the tools were pretested and went through ethical review at both an Institutional Review Committee (IRC) at College of Humanities and Social Science at Makerere University before they were submitted to the Uganda National Council of Science and Technology (UNCST) and UCSD Institutional Review Board (IRB). The study is also registered on ClinicalTrials.gov (Identification Number: NCT06100679), an online database by the U.S. National Library of Medicine of randomized trials.

All developed data collection tools data capture screens were programmed into the hand-held computers devices (tablets) with validated question items, automatic skips using XML file format in Kobocollect software. Kobocollect operates on phones and computers with Android operating systems and allows for data export into the Windows Operating System (WOS). The tools were programmed with internal skip logic partners and validated to improve consistence and accuracy of entries. All questions were programmed to be close ended with pre-determined responses to ensure accurate and consistent meaning in the responses. The tablets were also programed with GPS devices and it was a MUST field for all RAs to take the GPS reading for the for the respondents' interview location. The data capture forms were programmed not be completed and accept to save unless the GPS readings were taken.

A team of twelve (12) trained Research Assistant (RAs), two (2) from each region administered all the data collection tools. All selected RAs were graduates aged between 25-35 years both males and females. Each RA completed about five (5) questionnaires per day. Mobile (wireless) internet was activated on all data collection devices (tablets) during the data collection period and data was hosted on a cloud server account whose URL address was fixed on each tablet for real time data uploads. Completed forms (questionnaires) were checked for errors at the end of the field day directly sent (uploaded from each tablet) onto the cloud server.

## 2.6 Data handling, management and quality control

A series of data handling and quality control approaches were undertaken including the following:

a) Daily data downloads and checks: Data was downloaded from the handheld devices (tablets) on a daily basis by the consultant and the Field Supervisors. Data was checked for error relating to illogical and inconsistent entries. Any flagged query was shared with the responsible interviewer/research assistant (RA) for action (that includes consulting with the interviewer, and possibly re-contacting the respondent). In addition, the data capture forms were designed with inbuilt skips and validation keys to reduce on inconsistent entries and also to enforce that all questions are answered.

b) *Data processing:* editing, cleaning and storage: All raw data was downloaded and transferred to R/STATA. Data summaries, tabulations and cross-tabulations were undertaken to resolve the flagged errors. These actions as noted above included re-coding of some responses and taking data as missing. Only the consultants had access rights and permission to change any entry to the database during the final data cleaning or process.

c) *Data collection process and questionnaire administration*: All selected RAs were local people and natural speakers of the local languages. These administered the data collection tools in their local languages to ensure consistency of the meaning and to elicit accurate responses. An equal number of men and women were recruited for the survey to take care of the gender issues during data collection. The data collection teams were also segmented into six (6) sub-teams based on the region, each sub-team comprised of two (2) people including a Field Supervisor (FS), one consultant. Data collection was initiated in at least one sub-county at a time in each district to ensure close supervision.

d) *Field supervision*: The Field Supervisors (FS) led field data collection supervision. One FS was allocated for each sub-team of data collectors in the regions. Each FS led one to two RAs and all FS were under the leadership of a consultant in the region and under the overall supervision of the Team Leader. The field supervisors received additional field supervision training on data quality control and troubleshooting of field related challenges. The consultant and the field supervisors carried out random check on a range of forms captured by different RAs and on-spot checks to ensure consistency, completeness of questionnaires. The supervisors also undertook troubleshooting for challenging cases and scenarios in the field. Any issues identified that needed retraining were immediately dealt with. A field supervision meeting with all RAs in the region was undertaken daily and once a week a general field supervision meeting was conducted with all sub-teams with the Team Leader.

e) *Data quality control sample:* A quality control sample of approx. 01% (25 respondents) was input and these were re- interviewed by different sets of RAs for quality control purposes. If the error margin was > 5%, data collection was stopped immediately and posed for additional data quality

control measures to be implemented such as retraining, re- interviewing the respondents, contacting the RAs for explanations and change of the RAs to mention. If the data collection errors were <5%, data collection continued as planned.

## 2.7 Data cleaning, analysis, validation and reporting:

### 2.7.1 Data cleaning

All raw data downloaded from the tablets and the server was merged and transferred to STATA V16. Data summaries, tabulations and cross-tabulations were done and appropriate actions to resolve flagged errors using a data cleaning log written in STATA before being transferred to R for analysis. (See Annex 1 for cohort1 raw database and cleaning do- file).

### 2.7.2 Data analysis

Descriptive analyses were conducted in R software using frequencies, percentages, means, and medians. The average treatment effect (ATE) on primary and secondary outcomes were estimated using difference-in-differences (DiD) mixed-effects logistic and linear regression models to account for the clustered study design. The primary analysis followed an intention-to-treat (ITT) approach, whereby all participants were analyzed according to their original randomization at baseline.

A Bonferroni correction was applied to adjust for multiple comparisons in the primary outcomes while maintaining an overall 5% level of statistical significance for the trial. Analyses were performed at the individual level, rather than using cluster-averaged data. Finally, predicted margins derived from the mixed-effects logistic regression models were used to compute the average causal effect, equivalent to the ATE estimates.

# 3. ENDLINE STUDY ACTIVITIES

## 3.1 Research Assistants selection and training

Two (2) regional trainings were undertaken with a total of twelve (12) locally selected Research Assistants (RAs) to participate in the REAL Fathers' endline survey. The overall objective of the trainings was to introduce the participants to REAL fathers' endline survey instruments and prepare them for the subsequent endline data collection.

### 3.1.1 Objectives of the training:

i) To introduce the participants to the REAL Fathers endline study including all the necessary data collection tools.
ii) To introduce the participants to research ethics and data collection principles.
iii) To familiarize the participants with the endline data collection tools.
iv) To refine and update endline data collection translation and customize the data collection tools to local context.
v) To participate in pilot test and finalization of REAL Fathers endline data collection tools.
vi) To prepare and plan for REAL father endline data collection in the respective regions and districts.

### 3.1.2 Training Methodology:

The training adopted a workshop setting using PowerPoint, lectures, role-plays and brainstorming sessions to deliver the content. The trainings were conducted over a period of two (2) days. Key materials used in the trainings included, a projector, tablet computers, laptops and manila papers and notebooks.

### 3.1.3 Content Delivery:

Day one focused on self-introductions which were conducted by the participants sharing their names and the districts where they came from. Sessions of the workshop focused on a brief overview of the project including, the project development journey from pilot phases, initial implementation in Karamoja and integration of ECD outcomes and nationwide scale-up which is currently taking place. The facilitators shared the objectives of the research, the adopted methodology, data collection process, analysis, theory of change, outcome indicators of interest, participants' observation and measurement periods and an overview of the data collection tools. The day ended with review and navigation of the REAL Fathers and spouse questionnaires and role-plays between RAs to build speed of interviewing, clarity of the questions and review and improvement of the translation in line with the local context. The sessions also focused reviewing the translations by going through both questionnaires using the English version and the local languages versions to test for clarity of the questions to the participants, review of the translations to ensure consistence of meaning and cultural appropriateness of the language used. Mismatching translations were corrected, and revised versions were adopted.

The review of the questionnaires also assessed the functionality of the automated skips and clarification of the intended meaning of the questions and how to handle different questions with unique measuring scales (Likert scale questions). The review also shared ways of ensuring confidentiality of some sections, how to handle emotions brought about by some questions and how to handle sensitive questions. At the end of each questionnaire review, role-plays were conducted to further build speed, clarity and familiarization with the questions. Table 4 below lists changes that were identified and made to the final data collection tools during the training and pilot testing. (See annex 3 for the final data collection tools.) The participants were also taken through an abridged Human Research Ethics training critical for conducting research with human subjects. The content focused on the key principles of conducting

human research ( including beneficence, Justice and respect for persons), the informed consent process including the seven key elements of the consent form such as description of the research and study design, risk, benefits, confidentiality, alternatives, voluntary participation, contacts and compensation), researchers and sponsors' of research responsibilities, the process of documenting an informed consent and research approval processes in Uganda (See respective presentations attached as annex 2).

Day two (2) focused on planning for field pilot testing of the data collection tools and field logistics for the endline study, pilot testing the questionnaires with young fathers and spouses (face-to-face interviews) and field Visit debrief.

*Table 4: List of comments identified and addressed during the training and programming data collection tools:*

| SN | Comments/ changes implemented on data collection tools |
|---|---|
| | **Feedback and comments addressed on Cohort 1 Endline – Women's Questionnaire:**<br>Study Plan<br>- Need to update with the women's version of the study plan. It currently is for fathers. For example, it says, "You are being asked to take part in this study because you live in this community, you are a father with a child under the age of three years old, living with your wife or girlfriend, and you are between the ages of 16 and 25." "In these activities, the group will talk about topics like parenting, communicating with your wife, and solving arguments without violence."<br>- I am able to enter a date in the future – possible to add validation?<br>Section 1<br>- Q106: please update the response option of "live with a woman" to "live with a man"<br>- When age and marital status that are not valid are entered (for example, age 3 and not in union), after clicking validate, the message says, "OK – Form is valid" (see screenshot below) – is it possible to put an age validation such that if age of less than, say, 13 is entered, it is not possible to continue?<br>- Q110: English version says "Some Difficult" and "A lot of Difficult" – should use difficulty<br>Section 2<br>- Q211b – just noticed we have two response options related to leaving – leave the house and leave. Please delete the second option of "leave"<br>- Q212 – the stem currently says: "In the past three months, how often have you: a) shouted or yelled at you?" Please update to read: "In the past three months, how often has your current husband/ partner / spouse/ boyfriend: …"<br>- Q212a, b, e, f … Ideally these would all end in question marks, but not a huge issue.<br>- Q213 instructions currently read: ""FOR THESE KIND OF QUESTIONS (LIKERT), FIRST READ THE RESPONSE OPTIONS TO THE FATHER. THEN READ THE QUESTION. THEN REPEAT THE RESPONSE OPTIONS. THEN PAUSE WHILE THE FATHER THINKS AND RESPONDS." Needs to be updated to "mother"<br>- Q213a, b, c, d … Ideally these would all end in question marks, but not a huge issue.<br>- Q214 step – instructions currently read: ""FOR THESE KIND OF QUESTIONS (LIKERT), FIRST READ THE RESPONSE OPTIONS TO THE FATHER. THEN READ THE QUESTION. THEN REPEAT THE RESPONSE OPTIONS. THEN PAUSE WHILE THE FATHER THINKS AND RESPONDS."<br>  o Let's also add: "Please remember that you don't have to answer any questions that you do not wish to."<br>- Q214a, b … Ideally these would all end in question marks, but not a huge issue. |

- Is it possible to add more validate instructions or something saying "this response is required"? As it stands, you can get quite away through section 2 with not answering some questions. For example, I didn't answer Q222c and was able to continue on through Section 3 and into Section 4. Maybe we should have validation requirements after each section?
- Q223 – update instructions to read "the mother" instead of "to the father"
- Q224 - update instructions to read, "to the mother" instead of "to the father"
- Q225 - update instructions to read, "to the mother" instead of "to the father"

Section 3

- Q304 – we should add a response option of "Not Applicable" for women who don't go to clinics for FP. For example, I select in 302 "no" – not currently doing something to avoid getting pregnant and then I am asked 304 "Does your partner go to the clinic with you for FP services."
- Q307 – if you select "no more child/ren" the box months pops up.
- Q309b – I'm getting this option (you said you do not want another child) even when I select the response in 302 (yes – currently doing something or using a method to delay) –
- I also got 309c (you said you do not want another child SOON) – even though I selected in 307 no more child/ren

Section 4

- 402b - Possible to add a validation to the age in case birth date is entered incorrectly? For example, I was able to select a birth date that was in 2020 (with child then being older than age 3).
    - For the enumerator instructions in 402b, please update to mother in this sentence: "IF THE FATHER DOES NOT KNOW THE EXACT DAY, THEN INPUT THE 1ST DAY OF THAT MONTH"
- 405. I'm also able to enter dates in the future for the immunization records. Possible to add validation to dates here, too?
- 408. Will there be pictures associated with this question? It's a bit confusing as currently written when it says "like (this/any of these)?"
- 412. The survey is making me upload a picture before I can validate the survey (at the end). Remove this validation note of "This field is required." Here.
- 413. I'm able to select None along with toy options (for example, I did 1, 3, 6, 7).
    - I'm also able to continue on to the very end of the survey with having selected "other" but not writing anything in the "others specify" text box. Would be useful to have this validation before the end of the survey.
- 414. When I choose a child age that is less than one year old, I still get the disability questions. This needs to be fixed.
    - I'm sharing here our decisions on the disability questions for easy reference: the following 7 disability items are asked to mothers of children aged 13-24 months: CF3, CF6, CF10, CF11, CF14, CF15, CF16. Mothers with children aged 25-35 months should receive all 16 of the CFM questions (PDF attached to email).
- I selected 'NO CARD' in 402, but was asked in 413 for the immunization card to validate age of child. I'd suggest we move 413 up to be 401 (also – there are 2 items numbered as 413)
- The text after the validation says, "Ask the father" – update to "ask the mother"

CREDI

- The images are not displaying for me in C1, C4, C8, C11-, C18. I'm viewing on my computer, so perhaps the images display on the tablet. But figured I'd mention this so it can be confirmed that it's ok on the tablet.
- I am able to continue to Section 5 with having not answered all of the CREDI questions. Possible to add a validation here so that enumerators cannot proceed to Section 5 without answering all of the CREDI questions?

Section 5

- When I select "Much less" the survey displays item 505, but it skips to Item 507 if any other response in 505 is selected.
- 517 – would it make sense to add years and months to this item? Could also update to say, "How long ago did your household get the mosquito net?" if there is only 1 net – and "How long ago did your household get your newest mosquito net?" if there is more than one mosquito net
- Section 6
- 602a asks, "From where did you get information?" – this is potentially something that the wife may not know. Is it necessary to ask this question? I'm not sure what information is useful by asking this if the response options are just the IPs. If we do want to keep this, we should also update to the new Implementing Partners that will be working during Cohort 2.
    - If we're trying to understand whether there are other partners working on father programs in the community, there might be other ways to ask this question.
- 603. Since this is endline, we should rephrase. Perhaps, "Has your spouse/husband/partner/boyfriend been visited by a mentor to discuss parenting in the past 6 months?" Though I'm not sure that's necessary if we're sure that none of the individuals being interviewed were in implementation sites previously.
- 604-606. Suggest removing these items.
- 607. Keep, but remove "(OTHER THAN THE MENTOR)"
- 608. Keep, but remove "(OTHER THAN THE MENTOR)"
- 609. I'd suggest adding here [Note to enumerator – please add any of your observations noted during the interview that you want the data team to understand when reviewing this interview's information.]
    - Note: I would also suggest that we make this field optional, rather than requiring a response in this field.

**ADDITIONAL COMMENTS AFTER PILOT TESTING THE TOOLS: WOMEN'S QUESTIONNAIRE**

- Update the consent information (see attached – first page).
- Q106B – Update the item per attached document.
- Q115.
    - Add enumerator note: **[NOTE TO ENUMERATOR: IF THE TRIBE IS NOT LISTED, SELECT "OTHER UGANDAN" AT END OF LIST.]**
    - Move the option "Other Ugandan" to the end of the list of response options
- Q301. Add "/ vasectomy" to the male sterilization option
- Q303.
    - Add "or your partner" to the item so that it reads: "Which method are you or your partner using?"
    - Add "/ vasectomy" to the male sterilization option
    - Add/update enumerator note: [NOTE TO ENUMERATOR: CIRCLE ALL MENTIONED. DO NOT READ OPTIONS ALOUD. IF MORE THAN ONE

| | |
|---|---|
| | METHOD MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD IN LIST.]<br>○ Update logic such that if female or male sterilization is selected, the respondent skips to 401 (see attached)<br>• Qs 229-231 – please newly add this series of three questions to the women's questionnaire<br>• Q601 – please update the item based on the attached<br>• Q602 – please update the item based on the attached<br>• Q602B – please update the item based on the attached<br>• Q603 – please update the item based on the attached<br>• Q605a AND b – please update the item based on the attached<br>• Q606A AND B – please update the item based on the attached<br>• Q607 – please update the item based on the attached<br>• Q608A through D – please update the item based on the attached<br>• Q103: Please update response options to mirror what is in the men's questionnaire (see attached) |
| | **FEEDBACK AND COMMENTS ADDRESSED ON COHORT 1 ENDLINE – MALE QUESTIONNAIRE**<br>Study Plan<br>- I'd suggest updating the duration of the interview noted in the study plan to be 55 to 60 minutes. Or even "around an hour." It's very likely the interview will last longer than 60 minutes.<br>- I am able to enter a date in the future when signing – possible to add validation?<br>Section 1<br>- When age that is not valid is entered (for example, age 6), after clicking validate, the message says, "OK – Form is valid"<br>- Q103: Possible to add an error message to the other specify text entry box if Other is checked – but the text is not then subsequently filled-in?<br>- Q104: Possible to add an error message to the other specify text entry box if Other is checked – but the text is not then subsequently filled-in?<br>- Q106: English version says "Some Difficult" and "A lot of Difficult" – should instead say "Some difficulty"<br>Section 2<br>- Q201 – When "not married" is selected, after clicking validate, the message says, "OK – Form is valid"<br>- Q203 – We should likely add Don't Know/Don't Remember & Refused to Answer as response options (perhaps also on female questionnaire if they're not there)<br>- Q203 – add error message if Other is selected but text box not filled-in<br>- Q206 – add error message if Other is selected but text box not filled-in<br>Section 3<br>- Let's consider adding validation messages at the end of each section so that the enumerators cannot advance to the next section if there are any incomplete items.<br>- Q301: Please update the question to read: "please tell me whether you agree or disagree that the word describes your relationship. [remove marriage (SPOUSE)].<br>- Q311a - add error message if Other is selected but text box not filled-in<br>- Q311b - add error message if Other is selected but text box not filled-in<br>- Q311b - just noticed we have two response options related to leaving – leave the house and leave. Suggest that we please delete the second option of "leave"<br>- Q311c - add error message if Other is selected but text box not filled-in<br>- Q313a, b, c, d … Ideally these would all end in question marks, but not a huge issue. |

- Q314a, b … Ideally these would all end in question marks, but not a huge issue.
- Q314a – a, b - Ideally these would end in question marks, but not a huge issue.
- Q314b – b, d - Ideally these would end in question marks, but not a huge issue.
- Q320c – could you please bold or ALL CAPS the word believe – just to further distinguish this series of questions from the previous one? [Now I'd like you to think about what other families in your community **BELIEVE**.]
- Q322. This sentence should be revised: "322. I am now going to read statements ~~and opinions about your opinions~~ about how husbands should discipline their wives. After I read each statement, please tell me if you Strongly agree, agree, neither agree or disagree, disagree or strongly disagree with the statement ~~it.~~"
- Q325B – This is displayed if I select "10 days or more" – but should only be displayed if "did not have any drinks in last month" is selected in Q324
- Q325B – possible to add error message if Other is selected but text box not filled-in?
- Q326 - possible to add error message if Other is selected but text box not filled-in?
- Q326B – This is displayed if I select "10 days or more" – but should only be displayed if "did not have any drinks in last month" is selected in Q324
- Q326b - possible to add error message if Other is selected but text box not filled-in?
- Q328 – if "did not have any drugs in the last month" is selected, it does not ask subsequent questions about drugs
- Q329 - possible to add error message if Other is selected but text box not filled-in?
- Q330 - possible to add error message if Other is selected but text box not filled-in?
- Q330B – this item displays even if I have selected 0-4 days in Q328

Section 4

- Q401 – update to read do NOT read options (t is missing). Please also add to the enumerator instructions – "Please think about which situation **best** describes who took care of you when you were a child – and only select one option."
- Q401 – remove the "or" in "mostly my other or stepmother or" and in "mostly my father or stepfather or"
- Q401 - possible to add error message if Other is selected but text box not filled-in?
- Q405 – it is possible to select DK/DR and Refused along with all of the other options. Also – is it possible to add an error message if Other is selected but text box not filled-in?
- Q407 – Dennis, just out of curiosity, is it common that a young father would be home all afternoon? If not, perhaps we remove that part of the sentence and just say, "**Imagine a situation where you ~~have been home all afternoon and~~ find yourself very annoyed with Aguti alpha."**
- Q407 – Should we add DK/DR and Refused options to this item? Also add an error message for the other response (if not filled-in?)
- Q408: I think we should revise the instructions here to include the true/false nature of the responses. The current version is: "Please tell me which of the following are positive ways parents can discipline their children" – perhaps we instead say, "Please tell me either true or false to whether the following actions are examples of positive discipline. For example, if you think it is a type of positive discipline, say true. If it is not a type of positive discipline, say false."
- Q408G – Please update to say "Shouting at the child" – this will help make clear that we're not talking about the wife (since the wife is referenced in the item before)
- Q410 – This is past THREE MONTHS – but the next set of items about family members is past THREE DAYS. It should be three days in both spots.
- Q411C – if I select "Yes – reported" to 411C, 411D pops up to enter a picture of the play space

- Q411e – None can be selected along with options 1-5 – should be updated such that if none is selected none of the other options can be selected
- Q411f – it would be useful to include some sort of transition statement before starting this series. For example, we could say, "Now I'd like you to think about what you have done around your home in the past three months. In the past three months, did you participate in the following household activities: please answer with yes, no, or don't remember. Remember that you do not need to answer any questions that you do not wish to answer.

Section 5

- Q501 – Here I am able to select DK/DR and Refused along with all of the other response options. Also – possible to add an error message if Other is selected but the text box is not filled-in?
- Q503 – I think we should add DK/DR and Refused options to this item
- Q504 – Update to remove "your use" **[Does your partner support ~~your~~ use of family planning method(s)?]**
- Q505 – if I select No more child/ren, the entry box for Months pops up – this also pops-up when Refused to Answer is selected.
- Q507B – please add DK/DR and Refused as options. Please also add "select all that apply" to the question wording. (**You said you do not want another child. Can you tell me why you are not using a method to prevent pregnancy? [Note: please wait for the father to respond and select all that apply.]**
- Q509 – There are 2 outreach options and 2 fieldworker/VHT options – one of each should be removed. Also – add the error message if Other is selected but the text box is not filled-in

Section 6 - CREDI

- There are a number of places where the child's age is listed/accessed. For example, at the start of the survey, it lists the child's age. Is that considered the accurate age? Is there some way to cross-reference/validate against the various ages that are listed and entered?
- Relatedly, is it possible to add a validation to the age in case birth date is entered incorrectly? For example, I was able to select a birth date that was in 2020 (with child then being older than age 3).
- The images are not displaying for me in B1, B5, B7-9, B11, B12, B15, B17, B19, B20, C18. I'm viewing on my computer, so perhaps the images display on the tablet. But figured I'd mention this so it can be confirmed that it's ok on the tablet.

Section 7

- 602a asks, "From where did you get information?" – this is potentially something that the wife may not know. Is it necessary to ask this question? I'm not sure what information is useful by asking this if the response options are just the IPs. If we do want to keep this, we should also update to the new Implementing Partners that will be working during Cohort 2.
    - If we're trying to understand whether there are other partners working on father programs in the community, there might be other ways to ask this question.
- 706. I'm not 100% convinced that this question is necessary if we're sure that none of the individuals being interviewed were in implementation sites previously. But I suppose this could assess exposure to other programs, too? Note that Q705 references past three months – if we keep Q706, we should modify so that it references last three months – rather than last SIX months as currently stated.

**ADDITIONAL COMMENTS AFTER PILOT TESTING THE TOOLS:**

## MEN'S QUESTIONNAIRE

1. Update the consent information (see attached – first page).
2. Q104 – Update response option #11 ("Mammon") to be Latter Day Saints (Mormon) – the correct option (#11) is also in the attached questionnaire.
3. *Q112 – Update to read ONE pair of shoes (not a pair) – also add the following enumerator note: [NOTE TO ENUMERATOR: HOUSEHOLD MEMBERS WHO SHOULD BE CONSIDERED HERE FOR HAVING ONE PAIR OF SHOES INCLUDE MAIDS / HOUSEHOLD HELP AND SMALL BABIES. SHOES ARE ACTUAL SHOES – NOT SLIPPERS OR "NIGINA."]*
4. *Q114 – Add the following enumerator note: [NOTE TO ENUMERATOR: IDEALLY, YOU WILL VERIFY THE TOILET FACILITIES VIA VISUAL OBSERVATION]*
5. *Q115 – Add the following enumerator note: [NOTE TO ENUMERATOR: IF 'NO' IS SELECTED, IT MEANS THAT THERE ARE HOUSEHOLD MEMBERS AGED 6 TO 12 YEARS, BUT THEY ARE NOT ENROLLED IN SCHOOL.]*
6. *Q117 – Add the following enumerator note: [NOTE TO ENUMERATOR: THIS IS TEA LEAVES AND NOT FOR EXAMPLE, MUJAJA, MUDARASINI, OR KISUBI]*
7. *Q118 – Add the following enumerator note: [NOTE TO ENUMERATOR: THIS IS TOOTHPASTE IN A TUBE – NOT ASH OR STICKS OR SALT]*
8. Q119 – Add to the enumerator note: [ENUMERATOR: DO NOT READ ALOUD. Please observe and tick the appropriate material. The house being referred to should be the main house that the father sleeps in.]
9. Q121 – add enumerator note: *[NOTE TO ENUMERATOR: IF THE TRIBE IS NOT LISTED, SELECT "OTHER UGANDAN" AT END OF LIST.]*
10. *Q201B*
    a) Change prompt: "before the start of the project or the past one and a half years" (see attached)
    b) please also update the response options to include 'Refused to answer=99'
11. Q501
    a) Add "what are they?" to the question (see attached)
    *b)* Update the enumerator note to read: *(ENUMERATOR NOTE: DO NOT READ OPTIONS ALOUD. SELECT ALL METHODS MENTIONED BY THE FATHER)*
    c) Add "/ vasectomy" to the male sterilization option
12. Q503 (see attached)
    a) Include in the prompt "you or your partner" so it's clear that it's not just the man using the contraception
    b) add "/ vasectomy" to the option of male sterilization
    c) Program such that if 'female sterilization' is selected, they skip to 600

One final quick change requested – for Q111 in the male questionnaire: Please add as an enumerator note:

*[NOTE TO ENUMERATOR: WE ARE ONLY COUNTING FULLY FUNCTIONING MOBILE PHONES, OR THOSE SUBSCRIBING TO A PUBLIC MOBILE TELEPHONE SERVICE PROVIDER USING CELLULAR TECHNOLOGY, OWNED INDIVIDUALLY OR JOINTLY BY ANY MEMBER OF THE HOUSEHOLD.]*

- For the index child's age – is it possible to pull-in the child's birth date instead of age? We'd like the interviewers to compare the date of birth of the index child recorded at baseline against the immunization card that is presented for the 'index child' at endline.
    - If it is not the same date of birth, we need to have a space where enumerators can provide a new date of birth.

| | |
|---|---|
| | • Q103: please update response options to newly include (DOESN'T WORK FOR MONEY=6) (as specified in the attached using track changes)<br>• Q708 a,b & Q709a,b. I've updated these questions (see attached). This will allow the logic to be more accurate. |

*Figure 1: Images of Regional trainings taking place:*




RA training Covering RAs from Buganda, Busoga and Ankole Region (Jinja City).




RA training Covering RAs from Teso, Lango and Bunyoro Region (Lira City).

## 3.2 Pilot testing of data collection tools.

### 3.2.1 Introduction

Pilot testing of the endline survey tools took place at Buwaguma Village, Nawanyago subcounty, Kamuli district. A total of six (06) participants were interviewed including six (6) fathers and their spouses. Special attention during the pre-test exercise was given to, clarity of the questions and responses, tracing the participants, time taken to complete the survey, accuracy of the translations, data quality and possible logistics to undertake the actual study.

After the pre-test exercise, a debriefing meeting was organized to share the feedback and a standard operating guideline for the study were developed detailing all the steps and the likely actions for scenario cases. This task delivered final study tools, standard operating guidelines, final group of Research Assistants and pre-test report.

### 3.2.2 Feedback from the pilot testing exercise.

**Average time spent completing the questionnaire (s)**

| SN | Research Assistants | Fathers' questionnaire completion time in minutes | Research Assistants | Spouse questionnaire completion time in minutes |
|---|---|---|---|---|
| 1 | RA1 | 60 | RA1 | 56 |
| 2 | RA2 | 61 | RA2 | 54 |
| 3 | RA3 | 62 | RA3 | 55 |
| 4 | RA4 | 58 | RA4 | 56 |
| 5 | RA5 | 64 | RA5 | 57 |
| 6 | RA6 | 55 | RA6 | 54 |
| **Average time** | | **60** | **Average time** | **55** |

**Reasons for the time spent on the questionnaire.**

| Long time on Fathers' questionnaire | Shorter time on the Spouse questionnaire |
|---|---|
| Clarity needs to be made on questions under section 4 to the respondent before he can respond. Also, the way Likert questions are phrased and supposed to be asked to take a lot of time because you have to start with the responses, then the question, then the responses again and pause.<br><br>The questionnaire had more questions compared to the spouse questionnaire. | This questionnaire was very short compared to the fathers |
| Some fathers did not know most of the questions under section 6 (CREDI) since they were about children, and they had less information about children. | Mothers would answer all questions fast without asking anyone about their own children. |
| The timing was quite bad because some fathers go fishing during afternoon time. | Emotions made the conversations longer since some mothers would be asked questions that reminded them of a bad experience. |

### 3.2.3 Final agreed standard operating guidelines for the endline survey

RESPONSIBLE, ENGAGED AND LOVING (REAL) FATHERS
ENDLINE AND FOLLOW–UP SURVEY DATA COLLECTION STANDARD OPERATING GUIDELINES FOR FIELD RESEARCH ASSISTANTS.

1) Set a time convenient for the father: When setting the time, tell father that he will need to have the immunization card at the time of the interview.
2) Ask the father to think about a location to meet where you will have some privacy (cannot be overheard easily)
3) Arrive on time
4) Be well-rested so you can have energy and listen carefully
5) Leave judgment at home – be aware of your own biases (cultural, social, economic, ethic, religious, and/or gender)
6) Telling participants in advance that the questionnaire might take a bit longer than 60 minutes. This will prepare their minds in case they had other dues to do so that they can reschedule them.
7) Getting familiar with the questions to know what one needs to ask exactly rather than reading directly from the tablet/questionnaire. This can save time during the interviews.
8) Warning the participants in advance about the possibility of emotions and bad experiences. For example, some children take long to do some things, babies are considered at 0-5 months all questions must be asked even if the child doesn't do what you are asking them.
9) Ask for immunization cards before the interview because it is a **MUST** in the questionnaire and a photo must be taken
10) Personal biases may affect the data collection process and be careful not to use body language that appears judgmental or exposes any negative feelings (what are your examples of this?)
11) When you arrive, make sure you are in a location where people will not hear the questions and responses
12) Fathers and spouses should NOT be in the same room/place during the interview (except for CREDI if the father needs help)
13) Do not tell the father/spouse what questions were asked on the other's interview (esp. important for violence questions)
14) Create good rapport and be comfortable with someone and trusting them for the interview and work to put the respondent at ease by:
15) Being an active/engaged listener
16) Using the father's, the child and the spouse's name is key to winning them to the interview.
17) Watching and responding in kind to the respondent's body language and physiology, including facial expressions, gestures, and the quality and type of movements

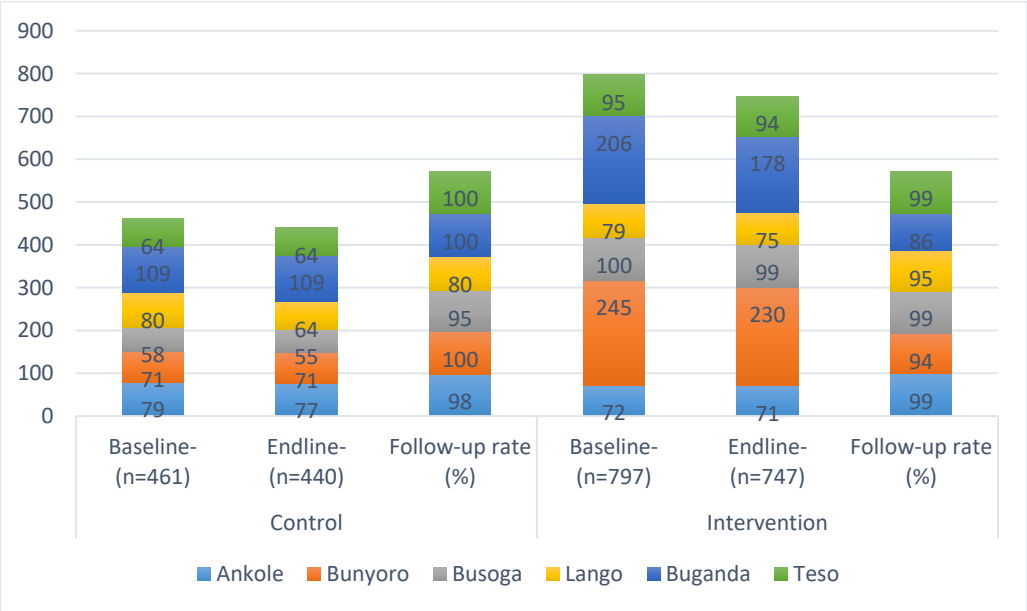
# 4. SURVEY RESULTS AND FINDINGS: PARTICIPANTS' SOCIAL DEMOGRAPHIC CHARACTERISTICS

This section presents the endline survey response rate across cohort-1 endline districts alongside the social demographic characteristics of the respondents including, age, sex of the children, marital status, education level and main income sources.

## 4.1 Response rate

A total of 1,187 couple dyads out of 1,258 dyads at baseline were reached at endline representing a 93.6% response rate. Overall, both control and intervention groups maintained high follow-up rates across regions, with total follow-up of 95.4% in the control and 93.7% in the intervention group. Participant numbers were largely stable from baseline to endline, with slight decreases in Lango and Buganda. The intervention group was also larger than the control at baseline and endline, but both groups were well represented across regions.

*Figure 2 Regional sample distribution and follow-up rate.*




## 4.2 Age of the respondents:

Figure-3 show age distribution of the young fathers, spouse and the children. Overall, the average ages of young fathers, spouses, and children increased slightly from baseline to endline across all districts, reflecting the passage of time over the study period. At baseline, the average age of young fathers was 23.2 years, increasing to 24.2 years at endline, while spouses' average age increased from 20.7 to 21.6 years. Similarly, the average age of the index child rose from 18.8 to 28.6 months, consistent with the longitudinal design tracking the same cohort. District-level data indicate that these increases were relatively uniform; for instance, in Isingiro, fathers' ages rose from 22.6 to 23.6 years and spouses from 19.8 to 20.9 years, while the index child aged from 18.7 to 29.9 months. Other districts such as Masindi, Dokolo, and Katakwi showed similar patterns, with both fathers and spouses aging by approximately 1 year and children aging by around 10–12 months.

These changes are expected and natural within a longitudinal study, reflecting the cohort's growth rather than any intervention effect, and no statistical significance testing is reported for these demographic

changes. Overall, the demographics confirm that the baseline and endline populations are comparable, providing confidence that observed differences in key outcome indicators are not confounded by large demographic shifts.

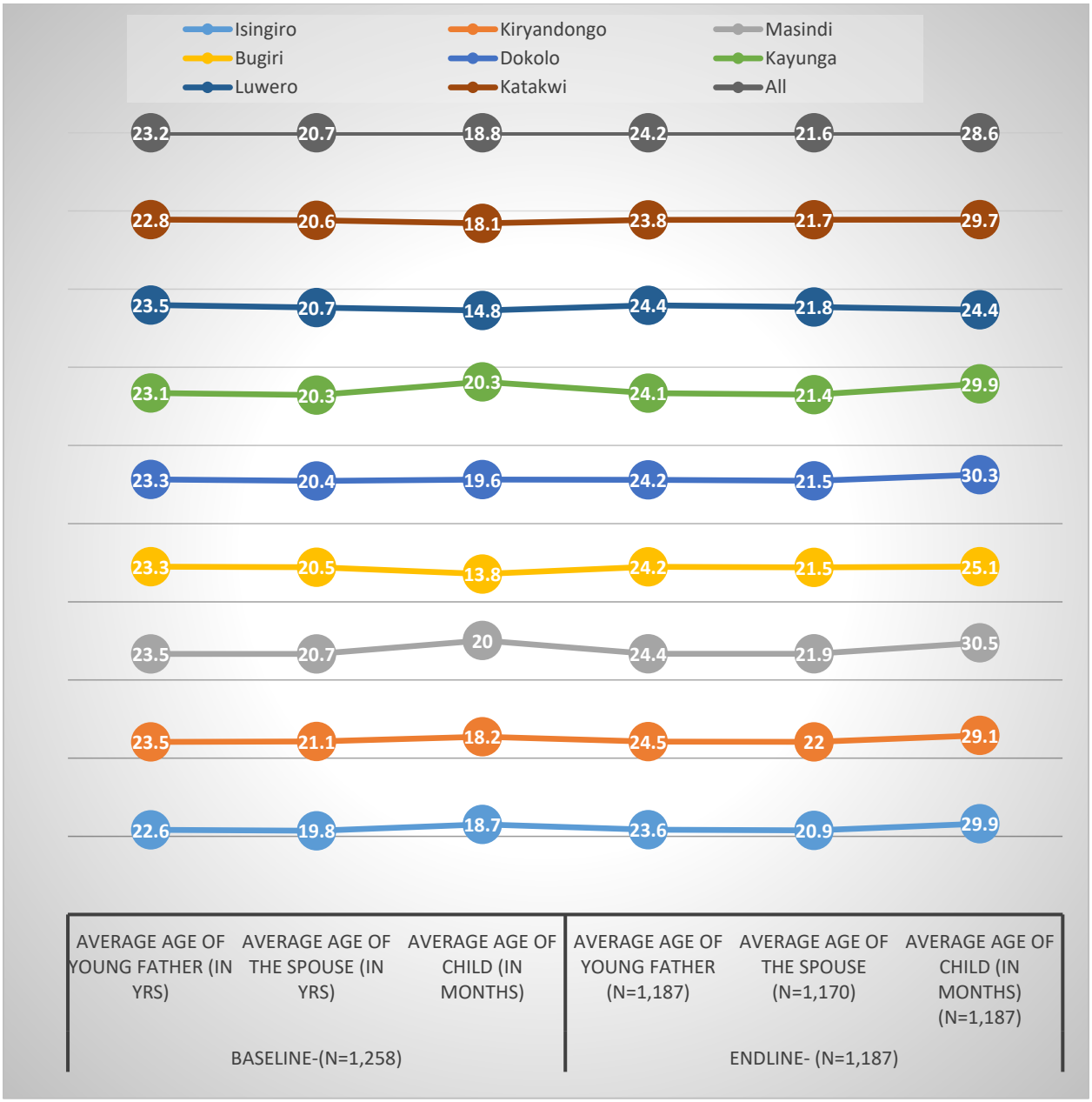



*Figure 3: Average age of the respondents between baseline and endline surveys.*

## 4.3 Education level of the participants

The education level of respondents, both young fathers (YFs) and their spouses, remained largely stable between baseline and endline, with minimal shifts observed across control and intervention groups. Among YFs, the majority had completed upper primary education in both control (55.7% baseline; 55.6% endline) and intervention groups (48.9% baseline; 49.2% endline), followed by O-level completion (control: 28.2%; intervention: 33.2%), and a small proportion had A-level or higher (control: 5.9%; intervention: 5.3%). Those with no or only lower primary education remained fairly consistent (control: 10.2%; intervention: 12.5%).

Similarly, spouses' education levels showed stability: the largest proportion had completed upper primary (control: 49.2%; intervention: 47.6%), O-level was next (control: 23.6%; intervention: 29.6%), while A-level and above remained minimal (~3%), and never/low primary ranged from 20–24.5%. Overall, the table suggests that there were no substantial changes in formal education levels over time, and baseline differences between control and intervention groups were small, indicating that education is unlikely to confound comparisons of program outcomes between arms. This stability provides confidence that observed intervention effects in the REAL Fathers study are attributable to program activities rather than shifts in educational attainment over the study period.

*Table 5: Education level of the respondents*

| | Baseline (n=1,258) | | | | Endline (n=1.187) | | | |
|---|---|---|---|---|---|---|---|---|
| | Control | | Intervention | | Control | | Intervention | |
| **Education level of YF** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** |
| Never/Lower primary | 47 | 10.2 | 100 | 12.5 | 45 | 10.2 | 91 | 12.2 |
| Upper primary | 257 | 55.7 | 390 | 48.9 | 245 | 55.6 | 368 | 49.2 |
| O-level | 130 | 28.2 | 265 | 33.2 | 124 | 28.2 | 248 | 33.2 |
| A-level and above | 27 | 5.9 | 42 | 5.3 | 26 | 5.9 | 40 | 5.4 |
| **Education of spouse** | | | | | | | | |
| Never/Lower primary | 112 | 24.3 | 159 | 19.9 | 105 | 24.5 | 148 | 20.0 |
| Upper primary | 227 | 49.2 | 379 | 47.6 | 211 | 49.2 | 356 | 48.0 |
| Ordinary level (O-level) | 109 | 23.6 | 236 | 29.6 | 103 | 24.0 | 215 | 29.0 |
| A-level and above | 13 | 2.8 | 23 | 2.9 | 10 | 2.3 | 22 | 3.0 |

## 4.4 Marital status

The marital status data across the eight districts indicate that the majority of young fathers were married at both baseline and endline, though the proportion varied by district. Overall, across all districts, 61.3% of respondents were married at baseline, increasing slightly to 62.1% at endline, while cohabiting fathers decreased from 38.7% to 37.9%. Relatedly only 37 couples changed their partners between baseline and endline. The average duration of marriage increased from 2.7 years at baseline to 3.7 years at endline, reflecting both natural progression over time and possibly greater stability in unions.

District-level variations were notable: for instance, Kiryandongo saw married fathers increase from 63.4% to 72.9%, while Masindi, which initially had a high proportion of cohabiting fathers (94.2%), experienced a substantial shift with married fathers rising to 41.3% by endline. Other districts such as Bugiri and Kayunga maintained very high proportions of married fathers (>95% and >83% respectively) with only minor changes. The increases in average duration of marriage were consistent across all districts, ranging from 2.4–2.9 years at baseline to 3.3–3.8 years at endline. Overall, these results suggest a modest but meaningful shift toward formalized marital status over the study period, alongside natural increases in marital duration, which may influence family stability, father engagement, and implementation of parenting interventions as noted in the REAL Fathers baseline data.

*Table 6: Marital status of the respondents:*

| | **Baseline** | | | **Endline** | | | | **Reasons for getting married**** | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Marital status | | Average duration in marriage (years) | Marital status | | Average duration in marriage (years) | | ***Respondents could select more than one option, so the total across categories can sum to more than 100%* | | | | | | |
| **District** | Married | Cohabiting | | Married | Cohabiting | | % With same partner [only 37 changed] | She was pregnant | She pressured you | Love | Companion ship | Economic advantage | Family pressure | Other reasons |
| Isingiro | 61.1 | 38.9 | 2.4 | 60.1 | 39.9 | 3.3 | 98.0 | 8.6 | 5.6 | 84.6 | 44.4 | 4.9 | 3.7 | 9.3 |
| Kiryandongo | 63.4 | 36.6 | 2.7 | 72.9 | 27.1 | 3.7 | 94.0 | 43.1 | 9.2 | 75.2 | 59.5 | 3.3 | 17.0 | 0.0 |
| Masindi | 5.8 | 94.2 | 2.7 | 41.3 | 58.7 | 3.5 | 96.4 | 9.6 | 13.5 | 28.2 | 30.8 | 3.8 | 0.0 | 0.6 |
| Bugiri | 98.6 | 1.4 | 2.7 | 96.8 | 3.3 | 3.6 | 94.6 | 45.9 | 6.1 | 91.9 | 8.1 | 0.0 | 8.1 | 0.0 |
| Dokolo | 64.8 | 35.2 | 2.6 | 72.8 | 27.2 | 3.6 | 97.9 | 24.5 | 1.9 | 77.4 | 45.9 | 1.3 | 4.4 | 1.3 |
| Kayunga | 83.3 | 16.7 | 2.8 | 84.4 | 15.6 | 3.8 | 98.1 | 16.7 | 3.2 | 85.3 | 71.8 | 1.3 | 2.6 | 0.0 |
| Luwero | 60.0 | 40.0 | 2.9 | 60.0 | 40.0 | 3.5 | 89.5 | 56.0 | 4.7 | 57.3 | 8.0 | 3.3 | 2.7 | 2.0 |
| Katakwi | 55.8 | 44.2 | 2.6 | 61.2 | 38.8 | 3.5 | 95.2 | 55.2 | 41.7 | 85.9 | 33.1 | 0.6 | 2.5 | 0.0 |
| **All** | **61.3** | **38.7** | **2.7** | **62.1** | **37.9** | **3.7** | **96.9** | **32.2** | **10.9** | **73.3** | **38.0** | **2.3** | **5.1** | **1.7** |

## 4.5 Employment status

The employment and income decision data show that farming is the predominant source of livelihood for both young fathers and their spouses across all districts, with 71.2% of young fathers and 85.5% of spouses engaged in farming. Self-employment is the next most common source of

income for fathers (31.5%) and spouses (23.1%), while formal employment (working for an employer) is relatively low among both groups (8.6% of fathers and 5.6% of spouses). Notably, a small proportion of fathers and spouses work for family members or in other categories, and 9.5% of spouses reported having no work. There is substantial variation across districts: for instance, Bugiri and Dokolo report the highest engagement in farming for both fathers (96.8% and 90.6%) and spouses (37.6% and 62.9%—possibly reflecting multiple responses), while Luwero has the lowest proportion of fathers in farming (47.1%) and a relatively high proportion of spouses without work (28.6%).

Income decision-making appears to be heavily influenced by gender roles: the majority of fathers are engaged in income-generating activities and likely control financial resources, while spouses' participation in formal employment is low, reflecting both the cultural context of young couples in rural Uganda and the subsistence-based livelihoods noted in the REAL Fathers baseline report. These findings highlight economic constraints and gendered patterns in employment, which have implications for designing interventions that aim to improve fathers' engagement in child-rearing and joint decision-making, as financial dependence and workload may affect participation in parenting programs.

*Table 7: Respondents' employment status and income decisions*

| | Young fathers' employment status** Multiple response | | | | | Spouse employment status ** multiple response | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| District | Farming | Work for an employer | Work for family member | Self-employed | Other | Farming | Work for an employer | Work for family member | Self-employed | Other | No work |
| ISINGIRO | 62.9 | 12.5 | 1.6 | 37.0 | 8.5 | 78.0 | 6.6 | 1.7 | 17.7 | 1.5 | 8.3 |
| KIRYANDONGO | 62.4 | 12.3 | 0.0 | 29.3 | 31.5 | 59.6 | 4.2 | 0.6 | 11.5 | 10.7 | 19.8 |
| MASINDI | 82.2 | 9.9 | 0.0 | 39.3 | 3.9 | 85.0 | 0.6 | 0.5 | 37.7 | 2.2 | 10.5 |
| BUGIRI | 96.8 | 6.1 | 1.4 | 70.7 | 2.5 | 137.6 | 1.5 | 0.0 | 10.0 | 5.1 | 1.3 |
| DOKOLO | 90.6 | 3.3 | 0.6 | 12.6 | 10.9 | 62.9 | 0.9 | 2.2 | 37.5 | 0.5 | 0.0 |
| KAYUNGA | 87.0 | 4.3 | 0.0 | 38.3 | 0.5 | 88.3 | 2.8 | 0.6 | 11.0 | 1.6 | 4.5 |
| LUWERO | 47.1 | 9.7 | 0.0 | 45.8 | 4.6 | 26.1 | 6.1 | 0.8 | 25.2 | 1.5 | 28.6 |
| KATAKWI | 80.0 | 20.3 | 16.5 | 21.3 | 19.2 | 104.3 | 23.4 | 18.9 | 15.2 | 0.5 | 0.6 |
| **All** | **71.2** | **8.6** | **2.4** | **31.5** | **11.0** | **85.5** | **5.6** | **3.7** | **23.1** | **3.3** | **9.5** |

## 4.6 Religious affiliation

The religious affiliation data show that Roman Catholic is the most prevalent religion among respondents, representing 46.7% overall, followed by Anglican/Protestant at 27.2%, Muslims at 14.2%, Pentecostals at 8.4%, and other religions at 3.5%. There is notable regional variation: Katakwi has the highest proportion of Catholics (82.9%), while Isingiro and Dokolo also show a strong Catholic presence (24.3% and 51.8%, respectively). Anglican/Protestant affiliation is particularly high in Isingiro (47.3%) and Luwero (32.1%), whereas Muslim respondents are concentrated in Kayunga (32.7%), Masindi (31.4%), and Bugiri (31.8%). Pentecostal representation is highest in Dokolo (20.1%) and Isingiro (16.2%). These patterns indicate that religion is an important contextual factor in these districts, which may influence social norms, parenting practices, and acceptance of interventions like REAL Fathers, as religious institutions and beliefs could be leveraged to promote positive father engagement and gender-equitable practices.

*Table 8:Participants religious affiliation*

| District/ Religion | Roman Catholic | Anglican/ Protestant | Muslim | Pentecostal | Other |
|---|---|---|---|---|---|
| | **554** | **323** | **168** | **100** | **42** |
| Isingiro | 24.3 | 47.3 | 4.7 | 16.2 | 7.4 |
| Kiryandongo | 55.9 | 28.3 | 11.0 | 2.8 | 2.1 |
| Masindi | 24.4 | 26.9 | 31.4 | 13.5 | 2.6 |
| Bugiri | 24.7 | 27.3 | 31.8 | 13.6 | 2.6 |
| Dokolo | 51.8 | 21.6 | 0.7 | 20.1 | 5.8 |
| Kayunga | 48.7 | 15.4 | 32.7 | 1.3 | 1.9 |
| Luwero | 35.9 | 32.1 | 22.1 | 0.8 | 9.2 |
| Katakwi | 82.9 | 10.8 | 1.3 | 4.4 | 0.6 |
| **Total** | **46.7** | **27.2** | **14.2** | **8.4** | **3.5** |

## 4.7 Tribal affiliation:

| Region | Tribe | n | % |
|---|---|---|---|
| Ankole | Banyankore | 74 | 50.0 |
| | Bakiga | 70 | 47.3 |
| | Other | 4 | 2.7 |
| Bunyoro | Banyoro | 110 | 36.5 |
| | Acholi | 50 | 16.6 |
| | Aur | 78 | 25.9 |
| | Other | 63 | 20.9 |
| Busoga | Banyole | 51 | 33.1 |
| | Basoga | 39 | 25.3 |
| | Jopadhola | 27 | 17.5 |
| | Itesot | 18 | 11.7 |
| | Other | 19 | 12.3 |
| Lango | Lango | 113 | 81.3 |
| | Other | 26 | 18.7 |
| Buganda | Baganda | 216 | 75.3 |
| | Basoga | 23 | 8.0 |
| | Other | 48 | 16.7 |
| Teso | Itesot | 158 | 100.0 |

The tribal distribution of respondents shows that most districts are dominated by one or two major ethnic groups, but with notable diversity in some regions. In Ankole, respondents are almost evenly split between Banyankore (50.0%) and Bakiga (47.3%), while in Bunyoro, Banyoro (36.5%) and Aur (25.9%) are the largest groups, but there is also a significant proportion of Acholi (16.6%) and other tribes (20.9%), indicating higher diversity. Busoga displays multiple smaller groups with Banyole (33.1%) and Basoga (25.3%) leading, alongside Jopadhola, Itesot, and others. Lango and Buganda are largely homogenous, with Lango comprising 81.3% Lango respondents and Baganda making up 75.3% in Buganda, though some minority tribes are present. Teso is entirely Itesot (100%). Overall, these results highlight that while some regions are ethnically homogenous, others show considerable tribal diversity, which has implications for cultural tailoring of interventions and messaging in programs like REAL Fathers, ensuring they resonate across different cultural contexts.

# 5. RESULTS AGAINST LONG TERM OUTCOME INDICTORS:

## 5.1 Intimate partner violence (IPV)

Intimate partner violence (IPV) includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)[1] The Problem of Intimate partner violence (IPV) is a significant public health problem. Data from the Rakai Community Cohort Study annual surveys between 2000 and 2009, indicated that Women who had ever experienced IPV had an adjusted IRR of incident HIV infection of 1.55 (95% CI 1.25–1.94, $p$<0.000), compared with women who had never experienced IPV[2]. The most recent data from Uganda Police Force (2016-2021) crime reports document 272,737 GBV cases between 2016 and 2021, including 2,278 homicides attributed to intimate partners.

## 5.2 Spouse reported intimate partner violence (IPV)

### *5.2.1 Spouses reported experiencing at least one form of IPV in the past 3 months*

Table-9 shows caparison of data from the REAL Fathers baseline and endline survey (fathers' data). Overall, results show a notable reduction in spouse-reported experiences of at least one form of intimate partner violence (IPV) from baseline to endline, particularly in the intervention group. At baseline, the proportion of spouses reporting IPV was very similar between the control (53.8%) and intervention (54.0%) groups, reflecting a balanced starting point across study arms, consistent with the REAL Fathers baseline report which indicated evenly distributed indicators.

By endline, the proportion reporting IPV decreased to 47.5% in the control group and 32.3% in the intervention group, suggesting a larger improvement in the intervention arm. Regionally, reductions were especially pronounced in Lango (from 60.8% to 44.0%) and Teso (from 48.4% to 43.6%) within the intervention group, while some regions like Busoga and Buganda showed less consistent changes, reflecting context-specific variations in the impact of the program.

*Table 9: Spouse reported experiencing at least one form of IPV in the past 3 months*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 62.0 | 53.2 | 57.7 | 69.4 | 1.4 | 35.7 |
| Bunyoro | 64.8 | 39.4 | 52.1 | 59.6 | 39.6 | 49.9 |
| Busoga | 34.5 | 69.1 | 51.3 | 46.0 | 68.7 | 57.3 |
| Lango | 41.2 | 23.4 | 33.3 | 60.8 | 44.0 | 52.6 |
| Buganda | 44.0 | 58.7 | 51.4 | 45.6 | 3.9 | 26.3 |
| Teso | 81.3 | 35.9 | 58.6 | 48.4 | 43.6 | 46.0 |
| All | 53.8 | 47.5 | 50.7 | 54.0 | 32.3 | 43.5 |
| ATE (95%CI) | | | | | | -15.4 (-23.7, -7.1) |
| P-value | | | | | | 0.000 |

Statistical analysis confirms that this reduction in IPV in the intervention group compared to control is significant, with an average treatment effect (ATE) of -15.4% and a 95% confidence interval ranging from -23.7% to -7.1% (p<0.001). This indicates that the REAL Fathers program had a meaningful effect in reducing

[1] Breiding MJ, Basile KC, Smith SG, Black MC, Mahendra RR. Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2015.

[2] Kouyoumdjian, Fiona G.a; Calzavara, Liviana M.a; Bondy, Susan J.a; O'Campo, Patriciaa; Serwadda, Davidb; Nalugoda, Fredc; Kagaayi, Josephc; Kigozi, Godfreyc; Wawer, Mariad; Gray, Rond. Intimate partner violence is associated with incident HIV infection in women in Uganda. AIDS 27(8):p 1331-1338, May 15, 2013. | DOI: 10.1097/QAD.0b013e32835fd851.

spouse-reported IPV over the study period. The endline results also suggest that targeted interventions focusing on young fathers' attitudes and behaviours can significantly reduce IPV, aligning with the baseline report's conclusion that high levels of IPV among young fathers present a critical area for improvement.

### 5.2.2 Spouse-reported verbal IPV in the past 3 months

The results on spouse-reported verbal IPV in the past 3 months indicate an overall level decreased substantially in the intervention group compared to the control group. At baseline, the proportion of spouses reporting verbal IPV was similar across groups (44.5% in intervention vs. 42.1% in control), reflecting a comparable starting point. By endline, however, the intervention group experienced a significant reduction to 26.6%, whereas the control group only slightly decreased to 39.1%, highlighting the effectiveness of the REAL Fathers intervention in reducing verbal IPV.

Regionally, declines were particularly notable in Bunyoro (from 51.8% to 29.6%) and Lango (44.3% to 36.0%), while some regions such as Busoga and Teso showed more moderate changes, suggesting some regional variation in impact. The estimated average treatment effect (ATE) of −14.9% with a 95% confidence interval of −23.0 to −6.8 and a p<0.000 confirms that this reduction is statistically significant, indicating that the intervention meaningfully improved communication and reduced verbal abuse by fathers across the study regions. Overall, these findings demonstrate that the program successfully promoted safer and more respectful relationships between young fathers and their spouses, aligning with the broader objectives of the REAL Fathers program.

*Table 10: Spouse reported experiencing verbal IPV in the past 3 months*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 55.7 | 50.6 | 53.2 | 56.9 | 1.0 | 28.7 |
| Bunyoro | 54.9 | 26.8 | 40.8 | 51.8 | 29.6 | 41.1 |
| Busoga | 22.4 | 60.0 | 40.7 | 37.0 | 63.6 | 50.3 |
| Lango | 32.5 | 18.8 | 26.4 | 44.3 | 36.0 | 40.3 |
| Buganda | 27.5 | 46.8 | 37.2 | 40.8 | 2.8 | 23.2 |
| Teso | 65.6 | 28.1 | 46.9 | 32.6 | 38.3 | 35.4 |
| All | 42.1 | 39.1 | 40.6 | 44.5 | 26.6 | 35.9 |
| ATE (95%CI) | | | | | | -14.9 (-23.0, -6.8) |
| P-value | | | | | | 0.000 |

### 5.2.3 Spouse-reported physical IPV in the past 3 months

The table 11 shows spouse-reported physical IPV in the past 3 months. Overall, there is a reduction in the intervention group compared to control across the study regions, reflecting a significant impact of the REAL Fathers program. At baseline, the prevalence of physical IPV was comparable between control (26.7%) and intervention (28.5%) groups, indicating a similar starting point. By endline, the intervention group experienced a substantial reduction to 14.1%, whereas the control group slightly increased to 29.5%. This corresponds to an average treatment effect (ATE) of −17.3% with a 95% confidence interval of −24.4 to −10.2 and a p<0.000, confirming that the decrease in physical IPV among intervention participants was statistically significant.

Across the regions, the declines were particularly notable in Bunyoro (29.4% to 20.0%), Busoga (32.0% to 22.2%), and Buganda (27.2% to 15.4%), while some regions, such as Lango and Teso, showed smaller reductions, reflecting local variability. Overall, these results demonstrate that the intervention was effective in significantly reducing the prevalence of physical IPV reported by spouses, aligning with the program's aim of promoting non-violent parenting, improving couple communication, and shifting harmful norms around gender and intimate partner interactions.

*Table 11: Spouse reported experiencing physical IPV in the past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 32.9 | 42.9 | 37.8 | 41.7 | 1.0 | 21.0 |
| Bunyoro | 23.9 | 14.1 | 19.0 | 29.4 | 20.0 | 24.8 |
| Busoga | 10.3 | 54.5 | 31.9 | 32.0 | 22.2 | 27.1 |
| Lango | 18.8 | 9.4 | 14.6 | 19.0 | 18.7 | 18.8 |
| Buganda | 20.2 | 33.9 | 27.1 | 27.2 | 1.7 | 15.4 |
| Teso | 57.8 | 21.9 | 39.8 | 23.2 | 21.3 | 22.2 |
| All | 26.7 | 29.5 | 28.1 | 28.5 | 14.1 | 21.5 |
| ATE (95%CI) | | | | | | -17.3 (-24.4, -10.2) |
| P-value | | | | | | 0.000 |

### *5.2.4 Spouse reported experiencing sexual IPV in the past 3 months*

Overall, the data show that sexual intimate partner violence (IPV) was prevalent across all regions at baseline, with slightly higher levels in the intervention group (22.1%) compared to control (19.3%). By endline, there was a marked reduction in the intervention arm to 12.2%, while the control arm remained relatively high at 30.0%. The differences between baseline and endline in the intervention group indicate a substantial improvement, suggesting that the REAL Fathers program was effective in reducing sexual IPV as reported by spouses. The adjusted treatment effect (ATE) of −20.6% with a 95% confidence interval of −27.5 to −13.7 and a p<0.000 shows that this reduction is statistically significant.

*Table 12: Spouse reported experiencing sexual IPV in the past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 17.7 | 45.5 | 31.4 | 25.0 | 1.4 | 13.3 |
| Bunyoro | 14.1 | 25.4 | 19.7 | 11.0 | 22.6 | 16.6 |
| Busoga | 19.0 | 41.8 | 30.1 | 27.0 | 9.1 | 18.1 |
| Lango | 16.3 | 9.4 | 13.2 | 26.6 | 14.7 | 20.8 |
| Buganda | 11.0 | 32.1 | 21.6 | 32.0 | 7.3 | 19.7 |
| Teso | 45.3 | 12.5 | 28.9 | 17.9 | 18.1 | 18.0 |
| All | 19.3 | 30.0 | 24.5 | 22.1 | 12.2 | 17.3 |
| ATE (95%CI) | | | | | | -20.6 (-27.5, -13.7) |
| P-value | | | | | | 0.000 |

Regionally, the impact of the intervention varied. For example, Ankole and Busoga showed large reductions from baseline to endline (Ankole: 25.0% to 1.4%; Busoga: 27.0% to 9.1%), while some regions, such as Lango, showed more modest reductions (26.6% to 14.7%). In contrast, the control group generally experienced increases or smaller decreases in sexual IPV across most regions, highlighting the added effect of the intervention. These results demonstrate that targeted father-focused interventions can meaningfully reduce sexual IPV, with consistent improvements across multiple regions, aligning with the broader findings from the REAL Fathers program on IPV reduction.

## 5.3 Young father reported intimate partner violence (IPV)

### *5.3.1 YFs that reported experiencing at least one form of IPV in the past 3 months*

Overall, the results show a notable reduction in IPV experiences among young fathers in the intervention group compared to control across the study regions. At baseline, similar proportions of young fathers

reported experiencing at least one form of IPV (42.0% in intervention vs. 42.3% in control). By endline, this proportion dropped sharply to 26.4% in the intervention group, while it decreased modestly to 40% in the control group. The adjusted treatment effect (ATE) of −12.1% with a 95% confidence interval of (−19.9, −4.3) and a p<0.002 indicates statistically significant reduction highlighting the impact of the REAL Fathers program in reducing IPV experiences.

Regionally, reductions in IPV were observed across most areas, with the intervention showing particularly strong improvements in Teso (from 28.4% to 4.3%), Lango (from 34.2% to 10.7%), and Buganda (from 44.7% to 0.6%). Some regions, like Busoga and Ankole, displayed smaller reductions or increases at endline in control, reflecting local variations in IPV trends. Overall, the data suggest that the intervention effectively mitigated the risk of IPV among young fathers, consistent with the program's focus on positive parenting, improved couple communication, and behaviour change, as highlighted in the REAL Fathers baseline report.

*Table 13: Percentage of YF that reported experiencing at least one form of IPV in the past 3 months*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 43.0 | 50.6 | 46.8 | 55.6 | 1.4 | 28.7 |
| Bunyoro | 50.7 | 36.6 | 43.7 | 48.6 | 37.0 | 42.9 |
| Busoga | 29.3 | 87.3 | 57.5 | 30.0 | 26.3 | 28.1 |
| Lango | 28.7 | 6.3 | 18.8 | 34.2 | 10.7 | 22.7 |
| Buganda | 25.2 | 25.2 | 25.2 | 44.7 | 0.6 | 31.1 |
| Teso | 66.5 | 66.5 | 66.5 | 28.4 | 4.3 | 22.7 |
| All | 42.3 | 40.0 | 35.8 | 42.0 | 26.4 | 29.8 |
| ATE (95%CI) | | | | | | -12.1 (-19.9, -4.3) |
| P-value | | | | | | 0.002 |

### *5.3.2 YFs that reported experiencing verbal IPV in the past 3 months*

Overall, the findings in table 13 indicate a significant reduction in the proportion of young fathers reporting experiences of verbal intimate partner violence (IPV) over the study period, with stronger declines observed in the intervention group compared to the control.

At baseline, the prevalence of verbal IPV was comparable between the control (33.6%) and intervention (34.9%) groups. However, by endline, reports of verbal IPV had dropped more sharply in the intervention group to 11.5%, compared to a modest reduction to 24.3% in the control group. The estimated average treatment effect (ATE) of -14.1 percentage points (95% CI: -21.3, -6.9) and a p<0.000 indicate that the observed reduction is statistically significant, suggesting that the intervention meaningfully contributed to reducing verbal IPV among young fathers.

Across regions, this positive trend was consistent throughout with varying magnitudes. For instance, regions such as Bunyoro, Teso, and Lango registered substantial declines in the intervention arm, while in Ankole and Buganda, the intervention almost eliminated verbal IPV cases by endline (0.0%). Conversely, some control regions, including Busoga and Ankole, experienced increases or smaller declines, implying that without the intervention, verbal IPV remained persistent or worsened. These results collectively suggest that the Real Fathers intervention effectively reduced verbal IPV among young fathers, highlighting its potential for promoting non-violent communication and conflict resolution within households.

*Table 14: Percentage of YFs that reported experiencing verbal IPV in the past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 35.4 | 42.9 | 39.2 | 50 | 16.9 | 33.5 |
| Bunyoro | 49.3 | 29.6 | 39.4 | 42.0 | 25.7 | 34.1 |
| Busoga | 25.9 | 63.6 | 44.2 | 17.0 | 19.2 | 18.1 |
| Lango | 22.5 | 3.1 | 13.9 | 25.3 | 6.7 | 16.2 |
| Buganda | 18.3 | 7.3 | 12.8 | 37.4 | 12.9 | 25.2 |
| Teso | 60.9 | 14.1 | 37.5 | 26.3 | 3.2 | 14.8 |
| All | 33.6 | 24.3 | 29.1 | 34.9 | 11.5 | 23.6 |
| ATE (95%CI) | | | | | | -14.1 (-21.3, -6.9) |
| P-value | | | | | | 0.000 |

### *5.3.3 YFs that reported experiencing physical IPV in the past 3 months.*

Overall, table 15 shows a decline in the proportion of young fathers (YFs) who reported experiencing physical intimate partner violence (IPV) in the intervention group compared to the control group between baseline and endline. At baseline, 14.7% of YFs in the intervention group reported experiencing physical IPV, which declined to 8% at endline, while the control group showed a smaller increment from 16.7% to 18.6% over the same period.

*Table 15: Percentage of YFs that reported experiencing physical IPV in the past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 15.2 | 37.7 | 26.3 | 18.1 | 1.4 | 9.8 |
| Bunyoro | 4.2 | 9.9 | 7.0 | 14.7 | 18.3 | 16.4 |
| Busoga | 13.8 | 41.8 | 27.4 | 12.0 | 8.1 | 10.1 |
| Lango | 8.7 | 6.3 | 7.6 | 15.2 | 5.3 | 10.4 |
| Buganda | 15.6 | 10.1 | 12.9 | 18.4 | 5.1 | 11.8 |
| Teso | 46.9 | 38.1 | 42.5 | 6.3 | 2.1 | 4.2 |
| All | 16.7 | 18.6 | 17.7 | 14.7 | 8 | 11.4 |
| ATE (95%CI) | | | | | | -5.2 (-11.1, 0.6) |
| P-value | | | | | | 0.081 |

This pattern suggests that the Real Fathers intervention may have contributed to reducing fathers' experiences of physical IPV in the intervention than the control group. Regional variations were observed, with the largest declines in Ankole (18.1% to 1.4%) and Teso (6.3% to 2.1%), while other regions such as Bunyoro showed a slight increase from 14.7% to 18.3%. The overall average treatment effect (ATE) was -5.2, with a 95% confidence interval ranging from -11.1 to 0.6, and a $p<0.081$, indicating that the reduction was not statistically significant at the 5% level but suggests a promising downward trend in physical IPV among young fathers exposed to the intervention.

### *5.3.4 YFs that reported experiencing sexual IPV in the past 3 months*

Overall table-16 shows a notable decline in reported sexual intimate partner violence (IPV) among young fathers in the intervention group compared to the control group between baseline and endline. At baseline, the proportion of young fathers who reported experiencing sexual IPV was similar across groups (13.0% in the intervention and 12.4% in the control). However, by endline, the intervention group showed a reduction to 10.4%, while the control group increased to 17.0%. The overall average treatment effect (ATE) was –7.3 (95% CI: –13.0, –1.6), and the $p<0.012$ indicates that this reduction was statistically significant. This finding suggests that the Real Fathers intervention effectively reduced the experience of sexual IPV among young fathers over the project period.

Regional analysis of the results reveals varying trends. In Ankole, Buganda, and Teso, reports of sexual IPV among young fathers in the intervention arm dropped to 0% at endline, indicating a substantial reduction compared to their control counterparts. Other regions, including Bunyoro and Busoga, recorded higher rates of sexual IPV in both study arms, but the intervention arm consistently had lower rates at endline than the control. These regional variations may reflect differences in local social norms, program implementation intensity, and community engagement. Nonetheless, the consistent decline in the intervention group across most regions highlights the positive influence of the Real Fathers program in promoting respectful and non-violent relationships among young couples.

*Table 16: Percentage of YF that reported experiencing sexual IPV in the past 3 months*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 5.1 | 16.9 | 10.9 | 13.9 | 0.0 | 7.0 |
| Bunyoro | 9.9 | 21.1 | 15.5 | 10.2 | 23.0 | 16.4 |
| Busoga | 10.3 | 83.6 | 46.0 | 11.0 | 22.2 | 16.6 |
| Lango | 12.5 | 0.0 | 6.9 | 19.0 | 4.0 | 11.7 |
| Buganda | 5.5 | 0.9 | 3.2 | 18.9 | 0.0 | 10.2 |
| Teso | 37.5 | 22.5 | 30.0 | 4.2 | 0.0 | 2.1 |
| All | 12.4 | 17.0 | 14.7 | 13.0 | 10.4 | 11.8 |
| ATE (95%CI) | | | | | | -7.3 (-13.0, -1.6) |
| P-value | | | | | | 0.012 |

## 5.4 Reported intimate partner violence (IPV) perpetrating in the last 3 months

### *5.4.1 Spouse reporting perpetrating at least one form of IPV in the last 3 months.*

Overall, reports of spouses perpetrating intimate partner violence (IPV) among young fathers remained relatively low across both intervention and control groups. In the control group, the proportion of wives who reported perpetrating IPV showed little change between baseline (8.5%) and endline (8.4%). In contrast, the intervention group recorded a notable decline from 8.3% at baseline to 4.3% at endline, suggesting a reduction in women's perpetration of IPV over time. The average treatment effect (ATE) was -3.9, with a 95% confidence interval of (-8.2, 0.3) and a $p<0.068$, indicating that the observed reduction was not statistically significant but showed a meaningful downward trend favouring the intervention arm.

Regional variations were also evident. At baseline, some control regions such as Teso (32.8%) and Buganda (11.0%) had relatively high reports of IPV perpetration compared to regions like Bunyoro (0.5%) and Ankole (1.3%). By endline, the intervention regions generally recorded lower levels of perpetration, with some like Ankole reporting zero cases both at baseline and endline. The most notable reduction was in Teso, where the rate dropped sharply from 32.8% to 0% in the control and remained consistently low in the intervention arm. Although the overall effect was not statistically significant ($p<0.068$), the consistent decline across intervention regions suggests potential positive influence of the Real Fathers program in reducing wives' perpetration of IPV within young couples.

*Table 17: Percentage of YF whose wives reporting perpetrating at least one form of IPV in the last 3 months*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 1.3 | 3.9 | 2.6 | 0.0 | 0.0 | 0.0 |
| Bunyoro | 0.5 | 1.4 | 0.7 | 14.3 | 2.6 | 8.6 |
| Busoga | 3.4 | 21.8 | 12.4 | 20.0 | 5.1 | 12.6 |
| Lango | 3.7 | 1.6 | 2.8 | 3.8 | 22.7 | 13.0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Buganda | 11.0 | 18.3 | 14.7 | 2.4 | 1.7 | 2.1 |
| Teso | 32.8 | 0.0 | 16.4 | 3.2 | 1.1 | 2.1 |
| All | 8.5 | 8.4 | 8.4 | 8.3 | 4.3 | 6.3 |
| ATE (95%CI) | | | | | | -3.9 (-8.2, 0.3) |
| P-value | | | | | | 0.068 |

### *5.4.2 YFs reported perpetrating at least one form of IPV in the past 3 months*

Findings reveal a notable reduction in young fathers' self-reported perpetration of intimate partner violence (IPV) in the intervention areas compared to the control regions over time. At baseline, the proportions were relatively similar across study arms 48.2% in the control and 54.1% in the intervention but by endline, the rate dropped sharply to 20.7% in the intervention group compared to 34.8% in the control.

*Table 18: Percentage of YFs reported perpetrating at least one form of IPV in the past 3 months*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 45.6 | 55.8 | 50.6 | 84.7 | 7.0 | 46.2 |
| Bunyoro | 66.2 | 38.0 | 52.1 | 60.4 | 38.7 | 49.9 |
| Busoga | 29.3 | 87.3 | 57.5 | 34.0 | 24.2 | 29.1 |
| Lango | 45.0 | 32.8 | 39.6 | 48.1 | 36.0 | 42.2 |
| Buganda | 33.0 | 2.8 | 17.9 | 45.1 | 1.7 | 25.0 |
| Teso | 78.1 | 17.2 | 47.7 | 60.0 | 7.4 | 33.9 |
| All | 48.2 | 34.8 | 41.6 | 54.1 | 20.7 | 38.0 |
| ATE (95%CI) | | | | | | -19.9 (-27.9, -12.0) |
| P-value | | | | | | 0.000 |

This decline indicates that exposure to the Real Fathers intervention likely contributed to meaningful behavioural change in reducing IPV perpetration among young fathers. When examined by region, the pattern of improvement is consistent, with the largest declines observed in areas such as Ankole, Teso, and Buganda, where endline IPV perpetration rates dropped to 7.0%, 7.4%, and 1.7% respectively among intervention participants. The average treatment effect (ATE) of –19.9 (95% CI: –27.9, –12.0; p<0.000) confirms a statistically significant reduction in IPV perpetration associated with the intervention. These results suggest that the Real Fathers programme had a substantial and positive influence in curbing violent behaviours among young fathers across multiple regions.

### *5.4.3 YFs that reported perpetrating verbal IPV in the past 3 months*

The overall results show a substantial reduction in verbal IPV perpetration among young fathers in the intervention group compared to the control. At baseline, 43.9% of fathers in the intervention group reported perpetrating verbal IPV, slightly higher than 39.0% in control. By endline, this proportion dropped sharply to 17.0% in the intervention group, while control fathers declined modestly to 31.4%. Regionally, the intervention saw marked declines, particularly in Buganda (35.4% to 0.0%) and Teso (49.5% to 6.4%), illustrating consistent impact across diverse contexts. The average treatment effect (ATE) of −19.2% with a 95% CI of (−26.9, −11.5) and a p<0.000 indicates this change is highly statistically significant.

These findings suggest that the REAL Fathers program effectively reduced verbal IPV over the 12-month period, outperforming natural reductions observed in the control group. The magnitude of change across most regions highlights the intervention's ability to influence attitudes and behaviours related to couple communication and conflict resolution, aligning with the program's broader aim to promote positive, non-violent parenting and gender-equitable relationships.

*Table 19: Percentage of YFs that reported perpetrating verbal IPV in the past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 38.0 | 54.5 | 46.2 | 72.2 | 4.2 | 38.5 |
| Bunyoro | 60.6 | 31.0 | 45.8 | 50.6 | 31.3 | 41.3 |
| Busoga | 25.9 | 72.7 | 48.7 | 23.0 | 19.2 | 21.1 |
| Lango | 33.8 | 31.3 | 32.6 | 39.2 | 36.0 | 37.7 |
| Buganda | 21.1 | 2.8 | 11.9 | 35.4 | 0.0 | 19.0 |
| Teso | 65.6 | 17.2 | 41.4 | 49.5 | 6.4 | 28.0 |
| All | 39.0 | 31.4 | 35.3 | 43.9 | 17.0 | 30.9 |
| ATE (95%CI) | | | | | | -19.2 (-26.9, -11.5) |
| P-value | | | | | | 0.000 |

### *5.4.4 YFs that reported perpetrating physical IPV in the past 3 months*

The study's overall results demonstrate that the intervention was highly effective in encouraging young fathers to stop perpetrating physical intimate partner violence (IPV). Across all study regions, the group that did not receive the program (the control group) showed a small, spontaneous reduction in reported violence, dropping from 23.4% at the start of the study to 18.2% at the end. The group that received the program (the intervention group) reported a much larger and more significant change, falling dramatically from 25.7% at baseline to just 7.9% at endline. This massive difference confirms the program's success. The intervention caused a statistically significant 12.6 percentage point reduction in physical IPV perpetration compared to the control group. This is backed up by a $p<0.000$ and a 95% confidence interval of (-18.9, -6.2), meaning we can be extremely confident that this positive result was due to the program and not chance.

Looking at the regional data highlights both the program's maximum impact and some surprising variations in the control groups. The intervention was overwhelmingly successful in regions like Ankole and Buganda, where high baseline rates of 43.1% and 29.6%, respectively, were nearly eliminated, falling to 2.8% and 1.1%. This shows the program's ability to drive dramatic behavioural change. However, some control groups experienced large, unexpected changes on their own: the control group in Ankole saw reported violence more than double from 21.5% to 45.5%, while the control group in Teso saw an enormous, unexplained drop from 62.5% to 7.8%. Despite these regional variations, the intervention consistently outperformed the control group, successfully driving down overall perpetration rates.

*Table 20: Percentage of YFs that reported perpetrating physical IPV in the past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 21.5 | 45.5 | 33.3 | 43.1 | 2.8 | 23.1 |
| Bunyoro | 23.9 | 9.9 | 16.9 | 25.7 | 17.8 | 21.9 |
| Busoga | 17.2 | 50.9 | 33.6 | 14.0 | 10.1 | 12.1 |
| Lango | 8.7 | 7.8 | 8.3 | 19.0 | 1.3 | 10.4 |
| Buganda | 15.6 | 0.0 | 7.8 | 29.6 | 1.1 | 16.4 |
| Teso | 62.5 | 7.8 | 35.2 | 22.1 | 3.2 | 12.7 |
| All | 23.4 | 18.2 | 20.9 | 25.7 | 7.9 | 17.1 |
| ATE (95%CI) | | | | | | -12.6 (-18.9, -6.2) |
| P-value | | | | | | 0.000 |

### *5.4.5 YFs that reported perpetrating sexual IPV in the past 3 months*

The results indicate a substantial reduction in young fathers' self-reported perpetration of sexual IPV in the

intervention group compared to control, with notable variation across regions. At baseline, 20.8% of fathers in the intervention group reported perpetrating sexual IPV, which decreased dramatically to 9.6% at endline, whereas in the control group, the prevalence increased slightly from 11.9% to 21.8%.

Regionally, the intervention achieved strong reductions in sexual IPV in areas like Ankole (25.0% to 0.0%), Lango (19.0% to 1.3%), Buganda (32.0% to 0.6%), and Teso (24.2% to 1.1%), while some regions, such as Bunyoro and Busoga, showed smaller or mixed changes. The adjusted treatment effect (ATE) of −21.1% with a 95% CI of (−27.2, −14.9) and a p<0.000 confirms that this decline is statistically significant, highlighting the effectiveness of the REAL Fathers intervention in reducing sexual IPV.

Overall, the findings suggest that the intervention had a strong protective effect, substantially lowering fathers' sexual IPV perpetration across most regions, contrasting with the control group, where rates remained high or increased, emphasizing the program's potential to transform harmful gender norms and improve couple relationships.

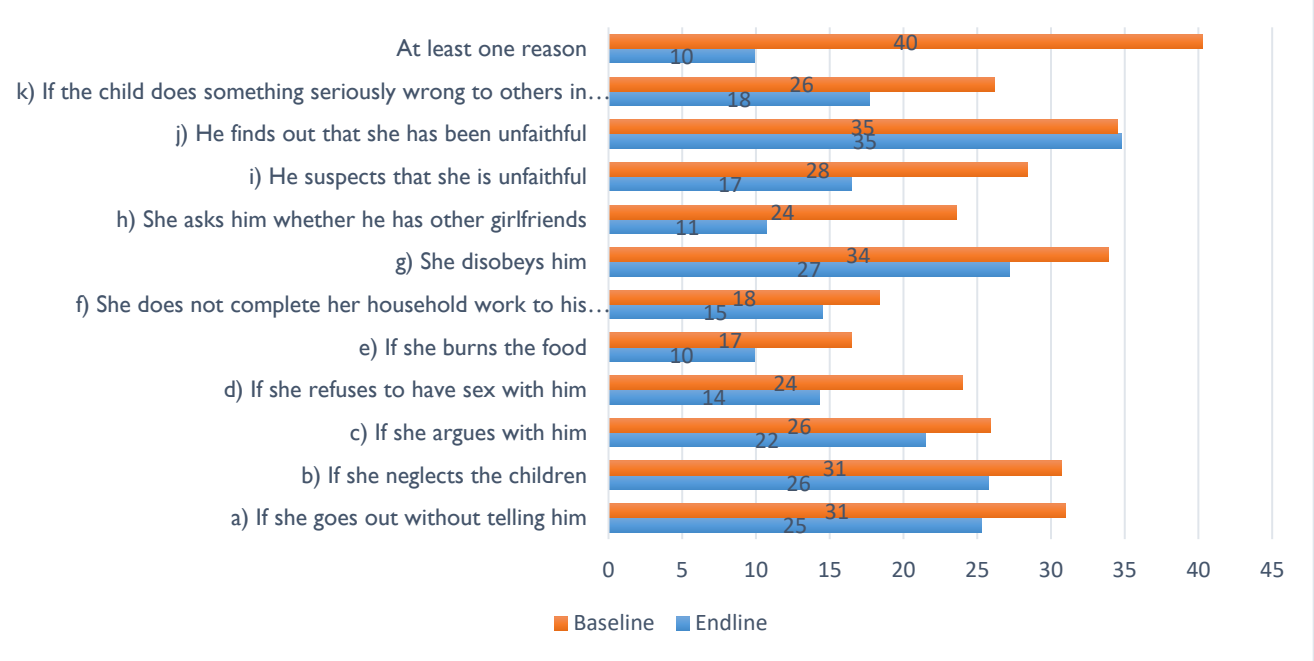
*Table 21: Percentage of YFs that reported perpetrating sexual IPV in the past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 6.3 | 48.1 | 26.9 | 25.0 | 0.0 | 12.6 |
| Bunyoro | 7.0 | 23.9 | 15.5 | 13.9 | 21.3 | 17.5 |
| Busoga | 8.6 | 72.7 | 39.8 | 10.0 | 20.2 | 15.1 |
| Lango | 18.8 | 1.6 | 11.1 | 19.0 | 1.3 | 10.4 |
| Buganda | 4.6 | 0.0 | 2.3 | 32.0 | 0.6 | 17.4 |
| Teso | 31.3 | 1.6 | 16.4 | 24.2 | 1.1 | 12.7 |
| All | 11.9 | 21.8 | 16.8 | 20.8 | 9.6 | 15.4 |
| ATE (95%CI) | | | | | | -21.1 (-27.2, -14.9) |
| P-value | | | | | | 0.000 |

### *5.4.6 Main reasons cited by men for perpetrating physical IPV against women:*

The main reasons cited by men for perpetrating physical IPV against women between baseline and endline improved in proportions showing a positive trend in reduction of physical IPV against women. At baseline, the number of YFs perpetrating physical IPV at least for one reason improved from 40% to only 10%, those perpetrating physical IPV for the wife's disobedience improved from 34% to 27% at endline, neglect of children improved from 31% to 26% at endline, refusing to have sex with him improved from 24% to 14% while arguing with him improved from 26% to 21% at endline.

*Figure 4: Reasons for perpetrating IPV by fathers against spouses (wives):*




All other reasons for perpetrating physical IPV against women also reduced from baseline to endline as indicated in figure 4.

## 5.5 Family planning needs.

Couples can use contraceptive methods to limit or space the number of children they have. This section presents data on knowledge of contraceptive methods, use and sources of contraceptive methods, unmet family planning need and support in form of the decision to use family planning including escorting to get the methods.

### 5.5.1 YFs whose spouses that reported unmet need for modern contraceptives.

Table 22- shows results on family planning needs. Overall, a substantial proportion of young fathers' spouses reported unmet need for modern contraceptives across both control and intervention groups, with some regional variation. At baseline, unmet need was relatively similar between control (31.5%) and intervention (33.4%) groups. By endline, the proportion declined slightly in the intervention group to 29.5%, while it increased slightly in the control group to 34.1%, leading to an overall slight reduction of 6.6 percentage points in the intervention group compared to control (ATE = −6.6; 95% CI: −14.0, 0.9), though this difference did not reach conventional statistical significance ($p<0.085$).

*Table 22: Percentage of YFs whose spouses that reported unmet need for modern contraceptives*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 29.1 | 20.8 | 25.0 | 23.6 | 19.7 | 21.7 |
| Bunyoro | 46.5 | 49.3 | 47.9 | 39.2 | 39.6 | 39.4 |
| Busoga | 36.2 | 40.0 | 38.1 | 47.0 | 27.3 | 37.2 |
| Lango | 42.5 | 20.3 | 32.6 | 36.7 | 22.7 | 29.9 |
| Buganda | 16.5 | 7.3 | 11.9 | 16.5 | 0.6 | 9.1 |
| Teso | 25.0 | 87.5 | 56.3 | 45.3 | 74.5 | 59.8 |
| All | 31.5 | 34.1 | 32.7 | 33.4 | 29.5 | 31.5 |
| ATE (95%CI) | | | | | | -6.6 (-14.0, 0.9) |
| P-value | | | | | | 0.085 |

Regionally, there were notable fluctuations: for instance, in Lango and Buganda, unmet need decreased considerably in the intervention group (from 36.7% to 22.7% and 16.5% to 0.6%, respectively), while in Teso and Busoga, unmet need increased or remained high. These findings suggest that while the REAL Fathers intervention may have had some positive impact in reducing unmet need for modern contraceptives in certain regions, the overall change across all regions was modest and not statistically significant, highlighting the ongoing challenges in addressing family planning gaps among young fathers' households and the need for more targeted or region-specific strategies.

### 5.5.2 Young fathers who supported (escorted) their wives to use FP

Table 23- shows that overall, the intervention was effective in increasing the proportion of young fathers who supported or escorted their wives to use family planning (FP). At baseline, the overall support was similar between the control group (37.3%) and the intervention group (37.1%), showing comparable starting points.

By endline, support in the control group slightly decreased to 33.4%, while the intervention group increased to 41.8%, suggesting a positive impact of the program. The average treatment effect (ATE) confirms this improvement, showing an 8.5 percentage point increase (95% CI: 0.7, 16.3; p<0.032), indicating that the change is statistically significant and unlikely due to chance.

Regionally, there were notable variations: in Ankole, the intervention group increased from 23.6% to 43.7%, whereas the control decreased from 35.4% to 19.5%; in Bunyoro, the intervention group improved modestly from 34.3% to 37.8%, while the control increased slightly from 14.1% to 18.3%; in Busoga, the intervention group decreased from 46.0% to 25.3%, whereas the control also decreased from 29.3% to 16.4%; Lango showed strong gains in both groups, but the intervention increased more markedly from 22.8% to 48.0%; Buganda had high baseline support in both groups, with the intervention maintaining a similar high level (50.5% to 70.8%), and Teso showed very low endline support in both groups but slightly higher in the intervention (28.4% to 7.4%).

*Table 23: Percentage of young fathers who supported (escorted) their wives to use FP*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 35.4 | 19.5 | 27.6 | 23.6 | 43.7 | 33.6 |
| Bunyoro | 14.1 | 18.3 | 16.2 | 34.3 | 37.8 | 36.0 |
| Busoga | 29.3 | 16.4 | 23.0 | 46.0 | 25.3 | 35.7 |
| Lango | 33.8 | 46.9 | 39.6 | 22.8 | 48.0 | 35.1 |
| Buganda | 54.1 | 72.5 | 63.3 | 50.5 | 70.8 | 59.9 |
| Teso | 48.4 | 1.6 | 25.0 | 28.4 | 7.4 | 18.0 |
| All | 37.3 | 33.4 | 35.4 | 37.1 | 41.8 | 39.4 |
| ATE (95%CI) | | | | | | 8.5 (0.7, 16.3) |
| P-value | | | | | | 0.032 |

The results further suggest that the intervention was successful in increasing active participation of young fathers in FP, particularly in regions where baseline support was lower, highlighting the program's potential for targeted regional impact.

### 5.5.3 YFs who know where to obtain modern FP methods

Overall, there was an improvement in the proportion of young fathers who know where to obtain modern family planning (FP) methods across both the control and intervention groups, but the change due to the

intervention was small and not statistically significant.

At baseline, knowledge levels were slightly higher in the control group (58.6%) compared to the intervention group (53.7%), indicating somewhat comparable starting points. By endline, knowledge in the control group increased to 67.5%, while in the intervention group it rose to 64.3%, reflecting modest gains in both groups. The average treatment effect (ATE) was 1.6 percentage points (95% CI: -2.0, 5.2; p<0.374), showing that the difference between the intervention and control groups is not statistically significant, suggesting that the observed changes could be due to chance rather than the program.

Regionally, there were variations: in Ankole, the intervention group increased from 72.2% to 78.9%, outperforming the control group, which moved only slightly from 63.3% to 64.9%; in Bunyoro, the intervention group showed a substantial increase from 55.9% to 78.7%, while the control group improved from 42.3% to 52.1%; Busoga saw the control group maintain very high knowledge (87.9% to 89.1%), while the intervention group remained lower and stable (51.0% to 51.5%), indicating regional baseline differences; Lango and Buganda experienced moderate increases in both groups, with Lango showing slightly higher gains in the intervention group; Teso showed improvements in both groups, but overall knowledge remained higher in the control group at endline. By and large, while young fathers' awareness of where to access modern FP methods improved modestly in some regions, the intervention did not produce a statistically significant effect compared to the control group, suggesting that additional targeted strategies may be needed to further enhance knowledge in regions with lower baseline awareness.

*Table 24: Percentage of YFs who know where to obtain modern FP methods.*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 63.3 | 64.9 | 64.1 | 72.2 | 78.9 | 75.5 |
| Bunyoro | 42.3 | 52.1 | 47.2 | 55.9 | 78.7 | 66.9 |
| Busoga | 87.9 | 89.1 | 88.5 | 51.0 | 51.5 | 51.3 |
| Lango | 50.0 | 70.3 | 59.0 | 58.2 | 72.0 | 64.9 |
| Buganda | 45.9 | 57.8 | 51.8 | 50.0 | 51.7 | 50.8 |
| Teso | 76.6 | 82.8 | 79.7 | 41.1 | 48.9 | 45.0 |
| All | 58.6 | 67.5 | 62.9 | 53.7 | 64.3 | 58.8 |
| ATE (95%CI) | | | | | | 1.6 (-2.0, 5.2) |
| P-value | | | | | | 0.374 |

## 5.6 Immunization

Immunizing children against vaccine-preventable diseases can greatly reduce childhood morbidity and mortality[3]. Information on vaccination coverage was collected from the child's health card or the mother's/ young father's direct report.

### 5.6.1 Fathers who escort or take their children for any immunization round/episode

The immunization data show that across regions, the proportion of fathers escorting or taking their children for any immunization round increased in the intervention group from 45.2% at baseline to 64.3% at endline, while the control group showed a smaller change from 55.7% to 51.4%.

Regionally, the intervention arm saw notable improvements in Ankole (27.8% to 73.0%), Buganda (43.2% to 78.8%), and Teso (30.5% to 63.4%), whereas changes in the control regions were more modest and in-some

[3] Uganda Bureau of Statistics (UBOS) and ICF. 2018. *Uganda Demographic and Health Survey 2016.* Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF

cases declined, such as in Ankole (54.4% to 36.4%) and Busoga (93.1% to 85.5%). Despite these improvements in the intervention group, the overall average treatment effect (ATE) was 11.4% with a 95% confidence interval of −2.0 to 24.8 and a p<0.325, indicating that the difference between intervention and control groups is not statistically significant. This suggests that while the REAL Fathers intervention may have contributed to increased paternal involvement in child immunization in certain regions, the change was not large enough across all regions to reach statistical significance, highlighting potential regional variation in uptake and engagement.

*Table 25: Percentage of fathers who escort or take their children for any immunization round/episode*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 54.4 | 36.4 | 45.4 | 27.8 | 73.0 | 50.4 |
| Bunyoro | 49.3 | 53.5 | 51.4 | 55.9 | 60.4 | 58.2 |
| Busoga | 93.1 | 85.5 | 89.3 | 40.0 | 54.5 | 47.3 |
| Lango | 41.2 | 40.6 | 40.9 | 57.0 | 50.7 | 53.9 |
| Buganda | 45.9 | 59.0 | 52.5 | 43.2 | 78.8 | 61.0 |
| Teso | 65.6 | 53.1 | 59.4 | 30.5 | 63.4 | 47.0 |
| All | 55.7 | 51.4 | 53.6 | 45.2 | 64.3 | 54.8 |
| ATE (95%CI) | | | | | | 11.4 (-2.0, 24.8) |
| P-value | | | | | | 0.325 |

### 5.6.2 Children with complete vaccination:

Results in table-26, show modest improvements in the proportion of children with complete vaccination coverage across both the control and intervention groups between baseline and endline, though the change was not statistically significant.

In the control group, full vaccination increased slightly from 47.5% at baseline to 54.0% at endline, indicating some natural improvement over time. In the intervention areas, coverage rose from 39.9% to 56.0%, suggesting a relatively larger improvement compared to the control group. At the region level, the greatest increases within intervention districts were observed in Ankole (from 43.6% to 67.5%) and Busoga (from a notably low 6.3% to 73.3%), reflecting substantial program impact in these areas. However, in regions such as Bunyoro, Lango, Teso and Buganda, vaccination coverage remained largely unchanged, implying regional variation in program effectiveness. The Average Treatment Effect (ATE) was 1.9 percent points (95% CI: -2.6, 6.5) with a p<0.628, indicating that the observed improvements were not statistically significant. While the intervention appears to have supported gains in some regions, particularly Ankole and Busoga, the lack of statistical significance suggests that broader effects across all regions were limited or uneven, possibly due to variations in health service access, implementation intensity, or contextual factors influencing vaccination uptake.

*Table 26: Percentage of children with complete vaccination*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 49.2 | 59.6 | 54.4 | 43.6 | 67.5 | 55.6 |
| Bunyoro | 40.7 | 42.1 | 41.4 | 34.5 | 38.8 | 36.7 |
| Busoga | 77.1 | 77.1 | 77.1 | 6.3 | 73.3 | 39.8 |
| Lango | 51.6 | 53.2 | 52.4 | 46.7 | 46.7 | 46.7 |
| Buganda | 37.2 | 40.9 | 39.1 | 37.1 | 37.1 | 37.1 |
| Teso | 43.1 | 61.9 | 52.5 | 87.9 | 87.9 | 87.9 |

| | | | | | | |
|---|---|---|---|---|---|---|
| All | 47.5 | 54.0 | 50.8 | 39.9 | 56.0 | 48.0 |
| ATE (95%CI) | | | | | | 1.9 (-2.6, 6.5) |
| P-value | | | | | | 0.628 |

## 5.7 Caregivers Reported Early Development Index (CREDI).

Assessments of Early Child Development (ECD) can be used for population monitoring, program evaluation, or exploratory research[4]. Screening tools can also be used to identify children who may need further testing, diagnosis, and treatment[4]. The Caregiver Reported Early Development Instrument/ Index (CREDI) was designed to serve as a population-level measure of early childhood development (ECD) for children from birth to age three[5]. CREDI exclusively relies on caregiver reports, and thus primarily focuses on milestones and behaviors that are easy for caregivers to understand, observe, and describe[5].

Data for the REAL fathers' baseline survey was collected using exactly 20 questions (CREDI short form) for each index child on four (4) inter-related domains of ECD including motor, language, cognition, social emotions and mental health indicators. Data was reported by both the young fathers and their spouses separately or with support from each other if needed on each index child between 0-36 months. The results presented here show a summary score for children's overall developmental status both from the fathers and spouse survey data using a scale of 0-20. The analysis is based on raw scores and only age groups that are common to both baseline and endline are presented i.e., children aged below 12 months and above 36 months were excluded from the analysis. The ATE is age standardized.

Overall, the findings from the CREDI raw scores show that both fathers and mothers in the intervention and control regions demonstrated generally similar developmental scores for their children at baseline, with small but meaningful changes observed at endline. For fathers, the overall mean raw scores remained constant in the control group (57.9 at both baseline and endline), while a modest improvement was observed in the intervention group from 46.0 at baseline to 47.5 at endline. The age-standardized Average Treatment Effect (ATE) of 0.47 (95% CI: 0.12–0.90, p<0.008) indicates a statistically significant positive effect of the intervention on fathers reported CREDI scores. This suggests that children whose fathers participated in the Real Fathers intervention showed improved early childhood development outcomes compared to those in the control group.

*Table 27: Fathers and mothers raw CREDI scores*

| | Fathers raw scores | | | | | Mothers raw scores | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Control | | Intervention | | | Control | | Intervention | | |
| Region | Baseline (n=461) | Endline (n=440) | Baseline (n=461) | Endline (n=440) | ATE (95%CI) | Baseline (n=461) | Endline (n=440) | Baseline (n=461) | Endline (n=440) | ATE (95%CI) |
| Ankole | 56.9 | 59.0 | 45.9 | 47.9 | - | 51.9 | 53.5 | 52.4 | 53.8 | |
| Bunyoro | 57.7 | 57.5 | 46.1 | 46.1 | - | 52.5 | 52.5 | 52.5 | 52.4 | |
| Busoga | 58.7 | 58.0 | 46.6 | 46.8 | - | 52.3 | 53.1 | 53.1 | 53.3 | |
| Lango | 57.8 | 59.0 | 46.2 | 46.7 | - | 52.7 | 54.0 | 52.6 | 53.1 | |
| Buganda | 57.8 | 57.4 | 46.0 | 47.0 | - | 52.4 | 52.1 | 52.1 | 52.9 | |
| Teso | 59.1 | 57.1 | 45.5 | 46.5 | - | 52.9 | 51.3 | 52.3 | 51.2 | |
| All | 57.9 | 57.9 | 46.0 | 47.5 | | 52.5 | 52.6 | 52.5 | 52.6 | |
| ATE (95%CI) | | | | | 0.47 (0.12, 0.90) | | | | | 0.29 (-0.22, 0.81) |
| **P-value** | | | | | **0.008** | | | | | **0.667** |

The improvement, though modest in numerical terms, is meaningful in the context of community-based interventions, demonstrating that father engagement activities likely contributed to enhanced stimulation

[4] Boggs D, Milner KM, Chandna J, et al. Arch Dis Child 2019;**104**:S22–S33.
[5] Dana Charles McCoy and Günther Fink; Caregiver-Reported Early Development Index (CREDI), User's Guide, 14, April 2017.

and developmental interactions between fathers and their young children.

In contrast, mothers' CREDI raw scores showed very minimal changes between intervention and control groups. For mothers in the control group, scores rose slightly from 52.5 to 52.6, while in the intervention group they remained virtually unchanged (52.5 to 52.6). The calculated ATE of 0.29 (95% CI: -0.22, 0.81, $p<0.667$) indicates that the observed difference was not statistically significant. This implies that while the intervention may have enhanced fathers' engagement with children, these effects did not translate into substantial or measurable differences in mothers' reports of child development outcomes within the same period. Taken together, these results suggest that the Real Fathers intervention was more effective in influencing father-child interactions and fathers' perceptions of their children's development than it was in shifting maternal assessments, reflecting the program's focus on strengthening paternal involvement in early caregiving and stimulation practices.

# 6. RESULTS AGAINST INTERMEDIATE OUTCOMES

## 6.1 Positive parenting and child disciplining strategies.

Positive parenting is the continual relationship of a parent(s) and a child or children that includes caring, teaching, leading, communicating, and providing for the needs of a child consistently and unconditionally (Seay et al., 2014, p. 207). The Committee of Ministers of the Council of Europe (2006) similarly defined positive parenting as "… *nurturing, empowering, nonviolent…*" and which "*provides recognition and guidance which involves setting of boundaries to enable the full development of the child*" (Rodrigo et al., 2012, p. 4). Godfrey (2019) further adds that the objective of positive parenting is to teach discipline in a way that builds a child's self-esteem and supports a mutually respectful parent-child relationship without breaking the child's spirit.[6]

### 6.1.1 Fathers demonstrating improved knowledge about positive parenting and discipline

Endline survey results generally indicate that the intervention was effective in improving young fathers' knowledge about positive parenting and child disciplining. At baseline, the overall knowledge levels were similar between the control group (73.4%) and the intervention group (76.8%), suggesting comparable starting points. By endline, both groups showed improvements, with the control group increasing to 92.2% and the intervention group reaching 91.5%. Although the control group also improved substantially, the intervention group's gains, as indicated by the average treatment effect, were statistically significant, with a 6.7 percentage point increase (95% CI: 1.3, 12.1; $p<0.05$), showing that the program positively influenced fathers' knowledge beyond any general improvement in the control group. This demonstrates that the intervention successfully enhanced fathers' understanding of positive parenting practices and child disciplining, a key objective of the program.

Looking at the results by region, there is notable variation. In Bunyoro, the intervention group increased from 51.4% at baseline to 93.0% at endline, while the control improved from 58.2% to 87.0%, reflecting strong program effects. Busoga showed a similar pattern, with the intervention group increasing from 56.7% to 92.6% and the control from 62.0% to 95.8%. Lango and Buganda achieved near-universal knowledge at endline for the intervention group (100%), even though the control group also showed high levels. Teso similarly demonstrated strong gains in both groups.

*Table 28: Percentage of fathers demonstrating improved knowledge about positive parenting and discipline*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 58.2 | 87.0 | | 51.4 | 93.0 | 58.2 |
| Bunyoro | 58.2 | 87.0 | 72.4 | 51.4 | 93.0 | 72.0 |
| Busoga | 62.0 | 95.8 | 78.9 | 56.7 | 92.6 | 74.1 |
| Lango | 98.3 | 95.0 | 99.1 | 36.0 | 100.0 | 67.8 |
| Buganda | 68.8 | 94.4 | 81.9 | 64.6 | 100.0 | 81.8 |
| Teso | 46.8 | 95.0 | 73.4 | 57.3 | 92.7 | 73.7 |
| All | 73.4 | 92.2 | 82.8 | 76.8 | 91.5 | 84.1 |
| ATE (95%CI) | 65.1 | 90.7 | 80.0 | 57.0 | 94.2 | 75.0 |
| P-value | | | | | | 6.7 (1.3, 12.1) |

[6] Godfrey, D. (2019). Retrieved from https://positiveparenting.com.

These regional variations suggest that while all areas benefited from improved knowledge, the intervention was particularly effective in regions where baseline knowledge was lower, confirming the program's capacity to drive meaningful improvements in positive parenting practices among young fathers.

### 6.1.2 Young fathers demonstrating positive attitudes towards positive discipline

Overall, the intervention had a positive effect on young fathers demonstrating positive attitudes towards positive discipline, although there were notable regional variations. At baseline, overall support was slightly higher in the control group (38.8%) compared to the intervention group (27.4%), indicating some initial differences between the groups. By endline, support increased in the intervention group to 36.0%, while the control group decreased slightly to 31.1%. The average treatment effect (ATE) was 16.4 percentage points (95% CI: 8.1, 24.6; p<0.000), demonstrating that the intervention led to a statistically significant improvement in fathers' attitudes towards positive discipline compared to the control, confirming the program's effectiveness across the study population.

*Table 29: Percentage of fathers demonstrating positive attitudes towards positive discipline*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 34.2 | 3.9 | 19.2 | 26.4 | 57.7 | 42.0 |
| Bunyoro | 22.5 | 46.5 | 34.5 | 35.5 | 53.5 | 44.2 |
| Busoga | 67.2 | 0.0 | 34.5 | 30.0 | 19.2 | 24.6 |
| Lango | 22.5 | 12.5 | 18.1 | 26.6 | 10.7 | 18.8 |
| Buganda | 40.4 | 52.6 | 55.5 | 51.0 | 71.9 | 32.3 |
| Teso | 45.3 | 45.3 | 39.8 | 44.2 | 59.6 | 45.3 |
| All | 38.8 | 31.1 | 35.1 | 27.4 | 36.0 | 31.5 |
| ATE (95%CI) | | | | | | 16.4 (8.1, 24.6) |
| P-value | | | | | | 0.000 |

Looking at regional patterns highlights both strong program effects and some unexpected fluctuations. In Ankole, the intervention group increased markedly from 26.4% at baseline to 57.7% at endline, while the control dropped from 34.2% to 3.9%, showing a dramatic positive shift due to the program. Bunyoro also showed strong gains in the intervention group (35.5% to 53.5%), whereas the control increased moderately (22.5% to 46.5%). Some regions, such as Busoga and Teso, showed declines in both groups, with Busoga's control dropping from 67.2% to 0.0% and Teso's intervention decreasing from 44.2% to 59.6%, suggesting contextual factors may have affected implementation or measurement. Buganda showed substantial improvement in the control group (40.4% to 52.6%), with a moderate increase in the intervention group (51% to 71.9%). Overall, despite regional variations, the intervention consistently improved positive disciplinary attitudes among young fathers, supporting the program's value for policy and targeted behavioral interventions

### 6.1.3 Fathers who self-reporting self-efficacy (confidence) in positive parenting skills

The intervention was highly effective in improving fathers' self-reported self-efficacy and confidence in positive parenting skills. Overall, at baseline, self-efficacy was similar between the control group (65.3%) and the intervention group (62.7%), indicating comparable starting points. By endline, the control group decreased slightly to 60.0%, while the intervention group increased substantially to 80.1%, resulting in a statistically significant average treatment effect (ATE) of 22.6 percentage points (95% CI: 14.7, 30.5; p<0.000), confirming that the observed improvement was due to the program and not chance.

Looking at regional patterns, the intervention had its strongest impact in Ankole, where fathers' self-efficacy

rose from 81.9% at baseline to 91.5% at endline, while the control group fell from 73.4% to 29.9%, demonstrating a dramatic improvement in the intervention group and a decline in the absence of the program. In Bunyoro, the intervention group improved from 54.7% to 85.7%, outperforming the control group, which increased modestly from 36.6% to 91.5%. Busoga also showed marked gains in the intervention group (54.0% to 78.8%) compared with a decline in the control group (58.6% to 32.7%). Lango and Buganda demonstrated smaller but consistent improvements in the intervention groups compared with the controls. Teso presented a unique pattern, with the intervention group slightly decreasing from 52.6% to 47.9%, while the control group dropped sharply from 82.8% to 18.8%, indicating regional variations but an overall net positive effect for the intervention.

*Table 30: Percentage of fathers who self-reporting self-efficacy (confidence) in positive parenting skills*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 73.4 | 29.9 | 51.9 | 81.9 | 91.5 | 86.7 |
| Bunyoro | 36.6 | 91.5 | 64.1 | 54.7 | 85.7 | 69.7 |
| Busoga | 58.6 | 32.7 | 46.0 | 54.0 | 78.8 | 66.3 |
| Lango | 66.2 | 78.1 | 71.5 | 58.2 | 82.7 | 70.1 |
| Buganda | 70.6 | 88.1 | 79.4 | 76.2 | 84.8 | 80.2 |
| Teso | 82.8 | 18.8 | 50.8 | 52.6 | 47.9 | 50.3 |
| All | 65.3 | 60.0 | 62.7 | 62.7 | 80.1 | 71.1 |
| ATE (95%CI) | | | | | | 22.6 (14.7, 30.5) |
| P-value | | | | | | 0.000 |

These results highlight that the program effectively boosted fathers' confidence in positive parenting, especially in regions where baseline self-efficacy was moderate or low, emphasizing the importance of targeted interventions to enhance parenting skills among young fathers

### 6.1.4 Fathers' reporting use of positive non-violent disciplining of children in past 3 months

Table-31 shows that the intervention substantially increased the proportion of fathers reporting the use of positive, non-violent disciplining of children in the past three months. Overall, baseline levels were similar or slightly lower in the intervention group (6.3%) compared to the control group (14.8%), indicating comparable starting points across study arms. By endline, the intervention group rose dramatically to 32.9%, while the control group increased only slightly to 19.5%, demonstrating a clear positive effect of the program. The average treatment effect (ATE) was 21.9 percentage points (95% CI: 15.5, 28.2; $p<0.001$), showing a statistically significant impact of the intervention on promoting non-violent disciplining practices.

Regionally, the intervention had its strongest impact in Lango, where fathers reporting positive discipline increased from 6.3% at baseline to 81.3% at endline, compared to a rise from 10.0% to 54.7% in the control group. In Ankole, the intervention increased from 5.6% to 45.1%, while the control rose modestly from 3.8% to 10.4%. Busoga showed a similar trend, with the intervention increasing from 2.0% to 37.4%, versus a smaller rise in the control from 0.5% to 5.5%. Buganda also experienced gains in the intervention group (9.2% to 32.0%), compared to a smaller increase in the control (9.2% to 21.1%).

Relatedly, in Teso, showed a similar trend, with the intervention increasing from 8.4% to 12.4%, versus a smaller rise in the control from 8.4% to 12.1%. Overall, the intervention consistently outperformed the control across most regions, confirming the program's effectiveness in promoting positive, non-violent parenting practices among fathers and highlighting the potential for substantial behavioural change in targeted communities.

*Table 31: Percentage of fathers' reporting use of positive non-violent disciplining of children in past 3 months.*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 3.8 | 10.4 | 7.1 | 5.6 | 45.1 | 25.2 |
| Bunyoro | 7.0 | 21.1 | 14.1 | 4.9 | 24.8 | 14.5 |
| Busoga | 0.5 | 5.5 | 2.7 | 2.0 | 37.4 | 19.6 |
| Lango | 10.0 | 54.7 | 29.9 | 6.3 | 81.3 | 42.9 |
| Buganda | 9.2 | 21.1 | 15.1 | 9.2 | 32.0 | 19.8 |
| Teso | 8.4 | 12.1 | 8.4 | 8.4 | 12.1 | 5.3 |
| All | 14.8 | 19.5 | 17.1 | 6.3 | 32.9 | 19.2 |
| ATE (95%CI) | | | | | | 21.9 (15.5, 28.2) |
| P-value | | | | | | 0.001 |

### 6.1.5 Fathers' self-reporting harsh/violent discipline of children in past 3 months

The overall prevalence of fathers self-reporting harsh or violent discipline of children in the past three months was generally high and varied across regions, with some notable differences between the intervention and control groups. At baseline, the overall proportion of fathers reporting harsh discipline was slightly higher in the control group (46.4%) than in the intervention group (38.3%), suggesting slightly more initial exposure to violent discipline in the control.

By endline, the control group showed an increase to 58.6%, while the intervention group also increased, but to a smaller extent, reaching 43.0%, suggesting that the program may have had a modest protective effect. The average treatment effect (ATE) was a reduction of 7.5 percentage points (95% CI: -16.1, 1.1; $p<0.087$), indicating that the decrease in harsh discipline in the intervention group compared to the control was not statistically significant at the conventional 0.05 level, though the trend suggests a possible positive program impact.

Regionally, there were substantial variations: in Ankole, the control group's reported harsh discipline increased sharply from 12.7% to 54.5%, whereas the intervention group remained relatively stable (45.8% to 42.3%); in Bunyoro, both groups had similar prevalence at endline with a slight increase in the intervention (40.4% to 56.5%); Busoga saw dramatic changes, with the control group increasing from 3.4% to 85.5% while the intervention decreased from 43.0% to 26.3%; Lango had decreases in both groups, but the intervention group slightly outperformed the control (63.3% to 56.0% vs 66.2% to 57.8%); in Buganda, the control increased dramatically (45.9% to 90.8%) while the intervention increased moderately (28.2% to 47.8%); and in Teso, the control decreased sharply from 96.9% to 1.6%, while the intervention decreased from 23.2% to 8.5%.

Overall, the results suggest that while the intervention did not lead to a statistically significant reduction in harsh discipline overall, it may have contributed to smaller increases or larger decreases in several regions, highlighting the potential of targeted interventions to reduce violent parenting practices among young fathers.

*Table 32: Percentage of fathers' self-reporting harsh/violent discipline of children in past 3 months*

| Region | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 12.7 | 54.5 | 33.3 | 45.8 | 42.3 | 44.1 |
| Bunyoro | 52.1 | 45.1 | 48.6 | 40.4 | 56.5 | 48.2 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Busoga | 3.4 | 85.5 | 43.4 | 43.0 | 26.3 | 34.7 |
| Lango | 66.2 | 57.8 | 62.5 | 63.3 | 56.0 | 59.7 |
| Buganda | 45.9 | 90.8 | 68.3 | 28.2 | 47.8 | 37.2 |
| Teso | 96.9 | 1.6 | 49.2 | 23.2 | 8.5 | 15.9 |
| All | 46.4 | 58.6 | 52.4 | 38.3 | 43.0 | 40.5 |
| ATE (95%CI) | | | | | | -7.5 (-16.1, 1.1) |
| P-value | | | | | | 0.087 |

## 6.2 Couple communication and conflict resolution:

All couples have conflicts at some time[7]. Conflicts are not bad if the couple works through the problem and are respectful of one another in communication and action. Understanding that men and women in general have different styles of communication can help men and women better understand one another. Understanding gender differences in communication can also help in having a more meaningful communication and satisfying resolutions when conflict occur.

### 6.2.1 Young fathers reporting positive communication at household level

Endline survey results on couple communication and conflict resolution indicate that the intervention was highly effective in improving positive communication among young fathers at the household level. Overall, baseline levels of positive communication were somewhat similar between the control group (71.1%) and the intervention group (61.6%), suggesting comparable starting points.

By endline, the control group experienced a slight decline to 65.5%, whereas the intervention group increased substantially to 84.7%, demonstrating a clear program impact. The average treatment effect (ATE) was 28.8 percentage points (95% CI: 21.2, 36.5; p<0.000), indicating that this improvement is statistically significant and very likely attributable to the intervention rather than chance.

Regionally, the intervention achieved remarkable gains. In Ankole, positive communication increased dramatically from 68.1% at baseline to 95.8% at endline, compared to a sharp decline in the control group from 65.8% to 31.2%. Bunyoro also showed strong improvements in the intervention group, rising from 54.3% to 83.0%, while the control increased moderately from 46.5% to 85.9%. Busoga and Lango demonstrated steady improvements in the intervention group, with endline values of 80.8% and 86.7%, respectively, outperforming the control groups, which saw declines or smaller increases. Buganda maintained high levels in both groups but still showed an advantage for the intervention group (89.9% vs 96.3%). Teso, which had a very low baseline in the intervention group (52.6%), increased to 73.4% by endline, outperforming the control group, which dropped sharply from 92.2% to 25.0%. Generally, these findings highlight that the program substantially strengthened couple communication across regions, especially in areas where baseline levels were lower.

This suggests that targeted interventions can effectively foster healthier household communication and conflict resolution, with significant implications for promoting stronger family relationships and reducing domestic conflicts.

*Table 33: Percentage of fathers reporting positive communication at household level*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 65.8 | 31.2 | 48.7 | 68.1 | 95.8 | 81.8 |
| Bunyoro | 46.5 | 85.9 | 66.2 | 54.3 | 83.0 | 68.2 |
| Busoga | 79.3 | 54.5 | 67.3 | 57.0 | 80.8 | 68.8 |

[7] Sandra J. Bailey; Couple Relationships: Communication and Conflict Resolution; MT200917HR New 11/09.

| | | | | | | |
|---|---|---|---|---|---|---|
| Lango | 70.0 | 81.3 | 75.0 | 59.5 | 86.7 | 72.7 |
| Buganda | 75.2 | 96.3 | 85.8 | 75.2 | 89.9 | 82.0 |
| Teso | 92.2 | 25.0 | 58.6 | 52.6 | 73.4 | 63.0 |
| All | 71.1 | 65.5 | 68.4 | 61.6 | 84.7 | 72.8 |
| ATE (95%CI) | | | | | | 28.8 (21.2, 36.5) |
| P-value | | | | | | 0.000 |

### 6.2.2 Young fathers whose wives reported positive couple communication

Overall, the intervention had a strong positive effect on promoting positive couple communication among young fathers and their wives. At baseline, levels of reported positive communication were similar between the control group (65.1%) and the intervention group (65.4%), indicating comparable starting points.

By endline, the control group showed a slight decrease to 63.0%, while the intervention group increased substantially to 79.1%, suggesting a clear impact of the program. The average treatment effect confirms this improvement, showing a 15.9 percentage point increase (95% CI: 8.0, 23.7; p<0.000), demonstrating that the increase is statistically significant and highly likely attributable to the intervention rather than chance. Regionally, the intervention produced large gains: in Ankole, reported positive communication increased from 72.2% to 90.1% in the intervention group while the control group declined from 75.9% to 31.2%; in Bunyoro, the intervention group improved from 54.7% to 82.2% compared to the control's increase from 47.9% to 93.0%; Busoga showed moderate gains in the intervention group (56.0% to 71.7%) while the control declined (51.7% to 34.5%); Lango's intervention group increased from 51.9% to 80.0% compared to the control's increase from 65.0% to 82.8%; Buganda maintained high levels in both groups, with the intervention rising slightly from 77.2% to 88.2%; and in Teso, the intervention group increased from 83.2% to 53.2%, while the control dropped sharply from 76.6% to 37.5%.

Overall, these results indicate that the program was highly effective in fostering positive couple communication, particularly in regions where baseline communication was lower, demonstrating the intervention's potential to strengthen relationship dynamics and support joint decision-making among young fathers and their partners.

*Table 34: Percentage of young fathers whose wives reported positive couple communication*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 75.9 | 31.2 | 53.8 | 72.2 | 90.1 | 81.1 |
| Bunyoro | 47.9 | 93.0 | 70.4 | 54.7 | 82.2 | 68.0 |
| Busoga | 51.7 | 34.5 | 43.4 | 56.0 | 71.7 | 63.8 |
| Lango | 65.0 | 82.8 | 72.9 | 51.9 | 80.0 | 65.6 |
| Buganda | 68.8 | 83.5 | 76.1 | 77.2 | 88.2 | 82.3 |
| Teso | 76.6 | 37.5 | 57.0 | 83.2 | 53.2 | 68.3 |
| All | 65.1 | 63.0 | 64.0 | 65.4 | 79.1 | 72.0 |
| ATE (95%CI) | | | | | | 15.9 (8.0, 23.7) |
| P-value | | | | | | 0.000 |

### 6.2.3 Fathers reporting positive conflict resolution

Overall, the intervention had a strong positive effect on promoting positive cconflict resolution among young fathers and their wives. At baseline, levels of reported positive conflict resolution at in the intervention group was twice the control group (6%) and the intervention group (13%). By endline, the control group showed a slight increase from 6% to 13%, while the intervention group increased substantially to 23%, suggesting a clear impact of the program. The average treatment effect confirms this improvement, showing

a 17.9 percentage point increase (95% CI: 15.5, 28.2; p<0.001), demonstrating that the increase is statistically significant and highly likely attributable to the intervention rather than chance.

Regionally, the intervention produced large gains: in Ankole, reported positive conflict resolution increased from 12.7% to 19.2% in the control group while the intervention group increased from 4.2% to 8.3%; in Bunyoro, the intervention group improved from 2.8% to 11.3% compared to the control's increase from 10.6% to 23.8%; Busoga showed moderate gains in the intervention group (31.0% to 43.0%) while the control increased (3.4% to 7.1%); Lango's intervention group increased from 3.8% to 12.9% compared to the control's group which remained at 2.5% ; Buganda maintained high levels in both groups, with the intervention rising slightly from 5.8% to 12.8% compared to control of 11.9% to 12.9%; and in Teso, the intervention group increased from 21.1% to 40.0%, while the control sharply increased from 3.1% to 15.6%.

Overall, these results indicate that the program was highly effective in fostering positive conflict resolution, particularly in regions where couple baseline conflict resolution was lower, demonstrating the intervention's potential to strengthen relationship dynamics and support couple conflict resolution among young fathers and their partners.

*Table 35: Percentage of fathers reporting positive conflict resolution*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 12.7 | 19.2 | 16.0 | 4.2 | 8.3 | 6.3 |
| Bunyoro | 2.8 | 11.3 | 7.1 | 10.6 | 23.8 | 17.2 |
| Busoga | 3.4 | 7.1 | 5.3 | 31.0 | 43.0 | 37.0 |
| Lango | 2.5 | 2.5 | 2.5 | 3.8 | 12.9 | 8.4 |
| Buganda | 11.9 | 12.8 | 12.4 | 5.8 | 12.8 | 9.3 |
| Teso | 3.1 | 15.6 | 9.4 | 21.1 | 40.0 | 30.6 |
| All | 6 | 11 | 9 | 13 | 23 | 18 |
| ATE (95%CI) | | | | | | 17.9 (15.5, 28.2) |
| P-value | | | | | | 0.001 |

### 6.2.4 Young fathers whose spouses reported positive conflict resolution

Overall, there was little change in positive conflict resolution reported by spouses of young fathers between baseline and endline, and the intervention did not appear to have a meaningful effect compared to the control. At baseline, reported positive conflict resolution was slightly higher in the control group (12.8%) than in the intervention group (10.4%). By endline, the control group slightly improved to 17%, whereas the intervention group decreased to 18.7%, indicating a decline rather than improvement.

*Table 36: Percentage of young fathers whose spouses reported positive conflict resolution*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 15.2 | 11.7 | 13.5 | 2.8 | 5.6 | 4.2 |
| Bunyoro | 8.5 | 1.4 | 4.9 | 8.2 | 0.4 | 4.4 |
| Busoga | 25.9 | 18.2 | 22.1 | 22.0 | 12.1 | 17.1 |
| Lango | 7.5 | 14.1 | 10.4 | 19.0 | 4.0 | 11.7 |
| Buganda | 9.2 | 11.9 | 10.6 | 6.3 | 12.6 | 9.5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Teso | 15.6 | 35.9 | 25.8 | 11.6 | 17.0 | 14.3 |
| All | 12.8 | 17.0 | 14.9 | 10.4 | 27.0 | 18.7 |
| ATE (95%CI) | | | | | | 1.7 (-1.2, 2.9) |
| P-value | | | | | | 0.360 |

Regionally, variations were inconsistent: for example, in Ankole, both groups showed minimal changes (control 15.2% to 11.7%; intervention 2.8% to 5.6%), while in Teso, the control group increased substantially from 15.6% to 35.9%, but the intervention only increased modestly from 11.6% to 17.0%. The average treatment effect was 1.7 percentage points (95% CI: -1.2, 2.9; p<0.360), which is not statistically significant, confirming that the program did not have a detectable impact on positive conflict resolution. These findings indicate that, unlike other outcomes such as couple communication or parental involvement, additional strategies may be needed to improve conflict resolution skills among young fathers, as the intervention alone was insufficient to produce measurable change.

### 6.3 Social support for father engagement and positive parenting.

The transition to parenthood is accompanied with many new challenges and can be an overwhelming experience[8]. Many parents have questions or concerns regarding their child's health, behavior, development, or their own parenting skills[9]. Strengthening social support has been recognized as a potentially effective strategy to enhance parenting self-efficacy, but empirical evidence is limited especially in resource limited countries[10]. Improving and including social support in parenting interventions may improve parenting self-efficacy[10] and may foster a parent's ability to self-regulate[11].

*Table 37: A proportion of fathers that agree or strongly agree that their social networks approve of engaging with children and using positive parenting skills*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 54.4 | 46.4 | 50.4 | 27.8 | 73.0 | 50.4 |
| Bunyoro | 49.3 | 53.5 | 51.4 | 55.9 | 60.4 | 58.2 |
| Busoga | 93.1 | 85.5 | 89.3 | 40.0 | 54.5 | 47.3 |
| Lango | 41.2 | 40.6 | 40.9 | 57.0 | 60.7 | 58.9 |
| Buganda | 45.9 | 49.0 | 47.5 | 43.2 | 78.8 | 61.0 |
| Teso | 65.6 | 63.1 | 64.4 | 30.5 | 63.4 | 47.0 |
| All | 55.7 | 56.4 | 56.1 | 45.2 | 64.3 | 54.8 |
| ATE (95%CI) | | | | | | 29.4 (21.1, 37.7) |
| P-value | | | | | | 0.000 |

The results on social support for father engagement and positive parenting indicate a substantial improvement in the intervention group compared to control. At baseline, the proportion of fathers who agreed or strongly agreed that their social networks approved of engaging with children and using positive parenting skills was slightly higher in the control group (55.7%) than in the intervention group (45.2%). By endline, this proportion increased significantly in the intervention arm to 64.3%, whereas it remained largely

[8] Nyström K, Öhrling K. Parenthood experiences during the child's first year: literature review. J Adv Nurs. 2004;46(3):319–30
[9] Reijneveld SA, de Meer G, Wiefferink CH, Crone MR. Parents' concerns about children are highly prevalent but often not confirmed by child doctors and nurses. BMC Public Health. 2008;8(1):124
[10] Fierloos, I.N., Windhorst, D.A., Fang, Y. *et al.* The association between perceived social support and parenting self-efficacy among parents of children aged 0–8 years. *BMC Public Health* **23**, 1888 (2023). https://doi.org/10.1186/s12889-023-16710-8
[11] Dadds MR, McHugh TA. Social support and treatment outcome in behavioral family therapy for child conduct problems. J Consult Clin Psychol. 1992;60(2):252

unchanged in the control group (56.4%). The overall adjusted treatment effect (ATE) of 29.4%, with a 95% confidence interval of 21.1 to 37.7 and a p<0.000, indicates that the change is statistically significant. Regionally, the intervention produced pronounced gains, with the largest improvements observed in Ankole (27.8% to 73.0%) and Buganda (43.2% to 78.8%), demonstrating strong regional variation in impact. This suggests that the REAL Fathers intervention successfully enhanced social approval for father engagement, providing fathers with stronger perceived social support to adopt positive parenting practices, which aligns with the program's emphasis on leveraging social networks and community norms to promote nurturing fatherhood.

## 6.4 Gender-equitable couple planning and decision-making

Influencing how decisions are made, and by whom can have a profound effect on health, household and child rearing status[12]. In many societies, men are the primary decision makers controlling both the communication and decisions around household matters, sex and the health of their wives and children[12]. Fathers can also exert significant control over child rearing, the health and health-seeking behaviors of their children and their spouses[12]. Their influence is especially evident in the areas of healthy timing, spacing of pregnancy, sexual and reproductive health and household decisions including child rearing. Interventions that promote equitable relationships and decision making facilitate positive shifts in attitudes, engendering healthy behaviors across a range of household, health and child rearing areas.

### 6.4.1 YFs reporting joint (gender-equitable) decision-making about household matters

Endline results demonstrate that the intervention had a substantial positive impact on promoting improved and gender-equitable couple decision-making among young fathers. Overall, at baseline, the proportion of young fathers reporting joint decision-making was fairly similar between the control group (84.8%) and the intervention group (79.0%), indicating comparable starting points.

*Table 38: YFs reporting joint (gender-equitable) decision-making about household matters*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 87.3 | 41.6 | 64.7 | 83.3 | 98.6 | 90.9 |
| Bunyoro | 81.7 | 94.4 | 88.0 | 80.0 | 91.7 | 85.7 |
| Busoga | 93.1 | 70.9 | 82.3 | 69.0 | 92.9 | 80.9 |
| Lango | 71.3 | 93.8 | 81.3 | 68.4 | 93.3 | 80.5 |
| Buganda | 82.6 | 96.3 | 89.4 | 87.9 | 97.2 | 92.2 |
| Teso | 98.4 | 50.0 | 74.2 | 73.7 | 87.2 | 80.4 |
| All | 84.8 | 76.1 | 80.6 | 79.0 | 93.4 | 86.0 |
| ATE (95%CI) | | | | | | 23.1 (16.8, 29.4) |
| P-value | | | | | | 0.000 |

By endline, joint decision-making decreased in the control group to 76.1%, whereas it increased markedly in the intervention group to 93.4%, suggesting that the program effectively enhanced gender-equitable decision-making. The average treatment effect confirms this positive change, showing a statistically significant increase of 23.1 percentage points (95% CI: 16.8, 29.4; p<0.000), indicating that the improvement is highly unlikely to be due to chance.

Regionally, the intervention produced striking effects: in Ankole, joint decision-making rose from 83.3% to 98.6%, compared to a drop in the control group from 87.3% to 41.6%; in Bunyoro, the intervention group

[12] Public Health Foundation of India, Health Policy Project, MEASURE Evaluation, and International Center, for Research on Women. 2014. Promoting Equitable Relationships and Decision Making. Washington, DC: Futures Group, Health Policy Project.

increased from 80.0% to 91.7%, while the control increased more modestly from 81.7% to 94.4%; Busoga saw a large intervention gain from 69.0% to 92.9%, while the control declined from 93.1% to 70.9%; Lango improved strongly in both groups, with the intervention rising from 68.4% to 93.3% and control from 71.3% to 93.8%; Buganda had high baseline joint decision-making, with intervention reaching 97.2% and control 96.3%; Teso showed the most dramatic improvement in the intervention group from 73.7% to 87.2%, whereas the control dropped sharply from 98.4% to 50.0%. These results indicate that the intervention was highly effective in strengthening joint decision-making across households, particularly in regions where baseline practices were weaker, demonstrating the program's capacity to foster gender-equitable behaviours and inform targeted policy and programmatic strategies.

### 6.4.2 YFs whose wives reported joint (gender-equitable) decision-making about household matters.

The intervention effectively increased wives' reports of joint, gender-equitable decision-making about household matters among young fathers. Overall, baseline levels were similar between the control group (80.0%) and the intervention group (81.8%). By endline, reports in the control group decreased to 70.7%, while the intervention group increased to 88.4%, indicating a clear program effect. The average treatment effect was 15.9 percentage points (95% CI: 9.3, 22.6; p<0.000), confirming that the improvement is statistically significant.

Regionally, the intervention achieved strong gains: in Ankole, it rose from 95.8% to 93.0%; in Bunyoro, from 77.6% to 90.9%; in Busoga, from 70.0% to 83.8%; in Lango, from 65.8% to 88.0%; in Buganda, from 90.8% to 99.4%; and in Teso, from 88.4% to 62.8%. These findings indicate that the program substantially strengthened gender-equitable decision-making in households, particularly in regions where baseline practices were lower, highlighting its potential for promoting equitable couple dynamics.

*Table 39: Percentage of YFs whose wives reported joint (gender-equitable) decision-making about household matters.*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 82.3 | 40.3 | 61.5 | 95.8 | 93.0 | 94.4 |
| Bunyoro | 83.1 | 94.4 | 88.7 | 77.6 | 90.9 | 84.0 |
| Busoga | 84.5 | 56.4 | 70.8 | 70.0 | 83.8 | 76.9 |
| Lango | 77.5 | 87.5 | 81.9 | 65.8 | 88.0 | 76.6 |
| Buganda | 76.1 | 87.2 | 81.7 | 90.8 | 99.4 | 94.8 |
| Teso | 79.7 | 48.4 | 64.1 | 88.4 | 62.8 | 75.7 |
| All | 80.0 | 70.7 | 75.5 | 81.8 | 88.4 | 85.0 |
| ATE (95%CI) | | | | | | 15.9 (9.3, 22.6) |
| P-value | | | | | | 0.000 |

## 6.5 Young fathers' engagement in stimulation and play.

Prenatal sensory experiences significantly impact the child's brain and nervous system development[13]. Brain development in children accelerates rapidly between birth and three years of age. Positive interactions with parents, caregivers and a stimulating learning environment (play space) contributes to this process[14]. Research indicates that positive children early experiences such as play and routine with adults strengthen brain connections and helps them to be eager and engaged for a lifetime of learning[14]. Play-based learning can be used to stimulate child brain development to counteract toxic stress in the environment. This learning style is important for the development of confident and capable learners.

[13] *The Importance of Early Childhood Learning & Development: Kids Club Early Childhood Learning Centres (2023).*
[14] Australian Early Development Census, 2013

When paly based learning is employed, children can construct their own understanding and learn collaboratively with their peers. In addition, children are given the opportunity to make connections between new learning and prior experiences, further developing concepts and relationships[14].

### 6.5.1 YFs reporting use of early learning activities and play with child (stimulation activities).

The results show that the intervention substantially increased young fathers' engagement in early learning and play activities with their children. Overall, table 38 shows at baseline, the levels of reported stimulation activities were similar between the control group (48.4%) and the intervention group (37.0%). By endline, engagement in the intervention group rose to 51.3%, while the control group decreased to 26.8%, indicating a clear positive impact of the program. The average treatment effect confirms this improvement, with a statistically significant increase of 35.8 percentage points (95% CI: 28.2, 43.4; p<0.000).

Relatedly across regions, the intervention showed dramatic gains, particularly in Ankole (47.2% to 91.5%), Bunyoro (40.0% to 73.5%), and Busoga (80.0% to 97.0%), whereas some regions such as Lango, Buganda, and Teso showed smaller improvements or low engagement at endline. These findings suggest that the program effectively promotes active father-child interaction and stimulation, highlighting its potential to enhance early childhood development, especially in areas with initially low engagement.

*Table 40: Percentage of YFs reporting use of early learning activities and play with child (stimulation activities)*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 49.4 | 23.4 | 36.5 | 47.2 | 91.5 | 69.2 |
| Bunyoro | 33.8 | 70.4 | 52.1 | 40.0 | 73.5 | 56.2 |
| Busoga | 69.0 | 60.0 | 64.6 | 80.0 | 97.0 | 88.4 |
| Lango | 47.5 | 9.4 | 30.6 | 46.8 | 22.7 | 35.1 |
| Buganda | 30.3 | 10.1 | 20.2 | 14.6 | 17.4 | 15.9 |
| Teso | 76.6 | 0.0 | 38.3 | 16.8 | 5.3 | 11.1 |
| All | 48.4 | 26.8 | 37.8 | 37.0 | 51.3 | 43.9 |
| ATE (95%CI) | | | | | | 35.8 (28.2, 43.4) |
| P-value | | | | | | 0.000 |

### 6.5.2 YFs reporting increased emotional engagement and affection towards child

Further, table 41 shows that the intervention was effective in increasing young fathers' emotional engagement and affection towards their children. Overall, at baseline, similar proportions of fathers reported high emotional engagement in the control (88.7%) and intervention groups (80.7%). By endline, engagement declined in the control group to 71.6% but increased in the intervention group to 85.1%, demonstrating a positive program impact. The average treatment effect confirms this, showing a statistically significant 21.6 percentage point increase (95% CI: 15.1, 28.1; p<0.001).

*Table 41: Percentage of YFs reporting increased emotional engagement and affection towards child*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 82.3 | 46.8 | 64.7 | 68.1 | 91.5 | 79.7 |
| Bunyoro | 73.2 | 97.2 | 85.2 | 77.1 | 94.3 | 85.5 |
| Busoga | 93.1 | 81.8 | 87.6 | 82.0 | 98.0 | 89.9 |
| Lango | 96.3 | 82.8 | 90.3 | 91.1 | 97.3 | 94.2 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Buganda | 90.8 | 96.3 | 93.6 | 86.4 | 84.3 | 85.4 |
| Teso | 96.9 | 10.9 | 53.9 | 76.8 | 36.2 | 56.6 |
| All | 88.7 | 71.6 | 80.4 | 80.7 | 85.1 | 82.8 |
| ATE (95%CI) | | | | | | 21.6 (15.1, 28.1) |
| P-value | | | | | | 0.001 |

Across the regions, the intervention led to strong improvements in Ankole (68.1% to 91.5%), Bunyoro (77.1% to 94.3%), Busoga (82.0% to 98.0%), and Lango (91.1% to 97.3%), while Buganda remained stable and Teso showed modest gains despite a sharp drop in the control group. These findings suggest that the program successfully enhanced fathers' emotional involvement, highlighting the importance of targeted interventions to foster positive father–child relationships.



*Figure 5: A young father engaging and playing with his children in Iganga district: Busoga region*

### 6.5.3 YFs reporting having a dedicated play space at home for their children

Overall, the results indicate that the intervention had a substantial positive effect on young fathers providing a dedicated play space at home for their children. At baseline, the proportion of fathers reporting a dedicated play space was similar between the control (42.3%) and intervention groups (41.8%), suggesting comparable starting conditions.

*Table 42:Percentage of YFs reporting having a dedicated play space at home for their children*

| | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| Region | Baseline (n=461) | Endline (n=440) | All (n=901) | Baseline (n=797) | Endline (n=747) | All (n=1,544) |
| Ankole | 3.8 | 57.1 | 30.1 | 23.6 | 98.6 | 60.8 |
| Bunyoro | 97.2 | 70.4 | 83.8 | 69.4 | 72.6 | 70.9 |
| Busoga | 5.2 | 76.4 | 39.8 | 15.0 | 92.9 | 53.8 |
| Lango | 8.7 | 12.5 | 10.4 | 20.3 | 86.7 | 52.6 |
| Buganda | 47.7 | 99.1 | 73.4 | 42.7 | 100.0 | 69.3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Teso | 95.3 | 96.9 | 96.1 | 28.4 | 96.8 | 62.4 |
| All | 42.3 | 71.4 | 56.5 | 41.8 | 88.8 | 64.5 |
| ATE (95%CI) | | | | | | 17.9 (11.0, 24.8) |
| P-value | 3.8 | 57.1 | 30.1 | 23.6 | 98.6 | 60.8 |

By endline, the intervention group showed a dramatic increase to 88.8%, whereas the control group increased more modestly to 71.4%. The average treatment effect (ATE) of the intervention was 17.9 percentage points, with a 95% confidence interval of 11.0 to 24.8 and a p-value indicating statistical significance ($p<0.001$). This demonstrates that the program was highly effective in encouraging fathers to provide play spaces, beyond what was observed in the control group, confirming that the observed improvements are unlikely due to chance.



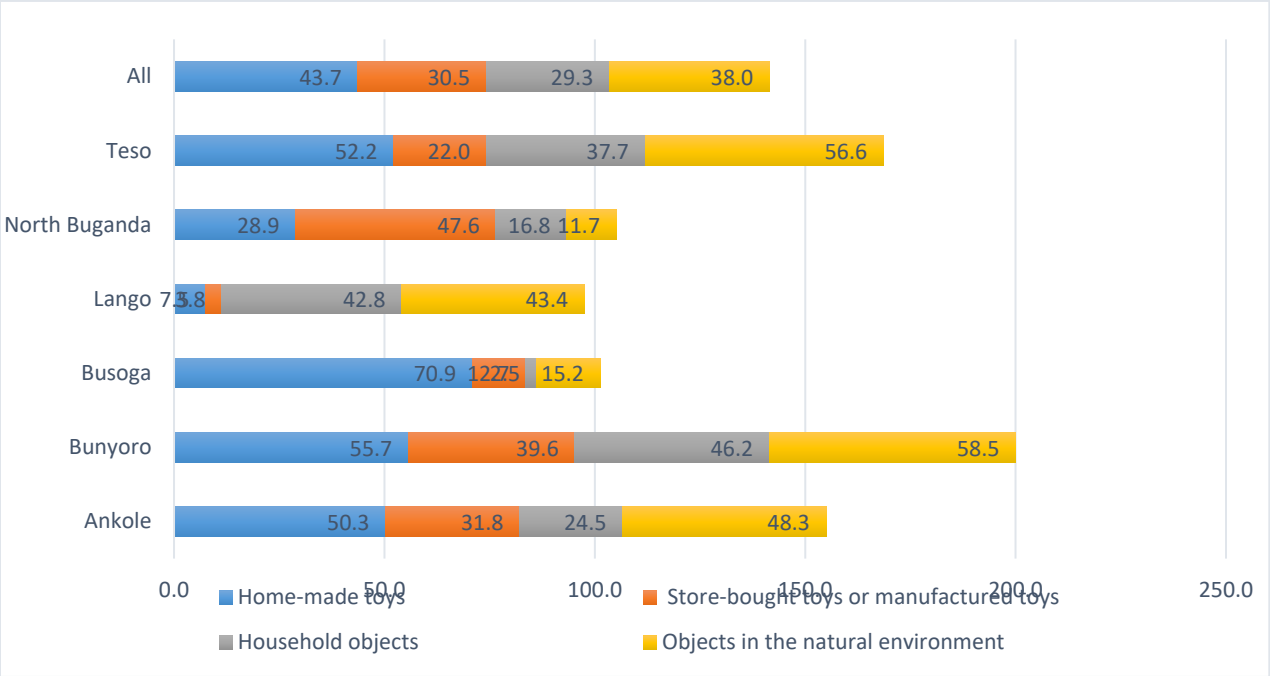

*Figure 6: A Young father with his child at a dedicated play corner in Kole District: Lango region.*

Looking at regional variations provides additional insights into the program's impact. In Ankole, the intervention group increased from 23.6% at baseline to an impressive 98.6% at endline, compared to a control increase from 3.8% to 57.1%, highlighting a particularly strong effect of the program. Similar trends were observed in Busoga (15.0% to 92.9%) and Lango (20.3% to 86.7%), demonstrating large, consistent gains across multiple regions. In contrast, regions with already high baseline values, such as Bunyoro (69.4%) and Teso (28.4%), saw smaller relative increases but still showed the intervention outperformed the control group. These findings suggest that while regional context and starting conditions influence the magnitude of change, the intervention consistently promoted child-focused home environments, emphasizing its potential for scalable impact in improving parenting practices across diverse settings.

### 6.5.4 Most common types of play materials across regions:

Data from the survey indicate that the most common types of play materials were homemade toys (43.7%), objectives in the natural environment (38.0%), store bought toys (30.5%) and household objects (29.3%) across the regions.

*Figure 7: Most common types of play materials across regions:*



# 7. CONCLUSIONS AND RECOMMENDATIONS

## 7.1 Conclusions:

1) Overall, the intervention was effective, consistent and statistically significant in improving all primary outcome indicators across the intervention group between baseline and endline, particularly reduction on intimate partner violence (IPV), positive parenting, rejection of harsh discipline approaches, involvement of fathers in caregiving and parenting.
2) The intervention also achieved statistically significant improvements on intermediate outcomes related to parenting knowledge, attitudes, and gender dynamics further demonstrating improved knowledge about positive parenting.
3) There was a notable significant shift toward positive and non-violent discipline practices, fathers' support towards family planning including escorting wives/ spouses for FP and immunization. These changes underscore the holistic effect of the intervention, promoting gender-equitable roles, shared caregiving, and more nurturing fatherhood.
4) The fact that most of these outcomes improved significantly in the intervention arm but remained static or only modestly changed in the control group highlights the program's added value in transforming harmful norms, improving couple relationships and promoting positive father engagement. This provides strong empirical evidence for scaling and sustaining the REAL Fathers model.

## 7.2 Recommendations:

1) Undertake a follow-up/ tracer study at both one (1) and two (2) years' time points to assess the sustained impact of the intervention across all regions on all outcome indicators.
2) Roll-out the intervention to the control sub-counties participants to equally benefit from the positive impact of the intervention and for ethical reasons.
3) Undertake a fidelity of implementation assessment study of the intervention to assess if the intervention was delivered according to the protocol.
4) Undertake a cost effectiveness study to guide additional and wider scale-up of the intervention for policy and practice recommendations.
5) Explore cultural and contextual factors that affect the intervention effectiveness on IPV and perpetration, family planning, child discipline strategies, child immunization, couple communication and decision making across regions through a qualitative study.
6) Explore additional analysis on programme monitoring (adaptive management on Monitoring, Evaluation and Learning) data to validate the consistence, reliability and comparability of the survey data against the achieved programme impact.

# 8. ANNEXES:

| SN | Item name | Items | SN | Name of Item (s) | Items |
|---|---|---|---|---|---|
| 1 | Data collection tools | | 2 | Research Assistants training materials. | RA-Training SlideDecks |
| a) | Spouse questionnaire. | Spouse-Endline Questionniare | 3 | Cohort-1 Endline Clean Dataset. | |
| b) | Fathers' questionnaire. | Fathers-Endline Questionnaire | 4 | List of Young fathers/ spouses lost to follow-up-accounted for with reasons for missing. | List of Lost to follow-up YFs-Spouse |