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Dedicated to the memory of Peter Bell, who advanced the rights of the world's poor through exceptional work at CARE, Clark Foundation, Ford Foundation, and Harvard University

Guest Editors: A. K. Shiva Kumar, Lorraine Sherr, Vivien Stern and Ramya Subrahmanian

(*Continued on inside back cover*)

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Psychology, Health & Medicine is a multidisciplinary journal highlighting human factors in health. The journal provides a peer reviewed forum to report on issues of psychology and health in practice. This key publication reaches an international audience, highlighting the variation and similarities within different settings and exploring multiple health and illness issues from theoretical, practical and management perspectives. It provides a critical forum to examine the wide range of applied health and illness issues and how they incorporate psychological knowledge, understanding, theory and intervention. The journal reflects the growing recognition of psychosocial issues as they affect health planning, medical care, disease reaction, intervention, quality of life, adjustment adaptation and management.

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EDITORIAL

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Ending violence in childhood: a global imperative

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Introduction

The time has come to end violence in childhood. The best and only way we can build peaceful societies is by preventing victimization of children and perpetration of violence by children. This can and must be done – with the aspiration to achieve this within a single generation. Collective action and concerted efforts succeeded in ending great evils such as the slave trade and apartheid. Violence in childhood is also a great evil affecting at least 1.6 billion child victims every year (Hillis, Mercy, Amobi, & Kress, 2016). It has long-lasting consequences through childhood, into adulthood, inter-generationally and for society. It is universal – in every country of the world – and its most common forms are usually perpetrated by people with whom children interact every day in their homes, schools and communities.

Violence victimisation is an adverse childhood experience, defined as potentially traumatic events that can have negative lasting impacts on health and wellbeing (Felitti et al., 1998). As per the United Nations Convention on the Rights of the Child (CRC), the definition of violence victimisation spans *neglect* – failure of responsible caregivers to provide needed food, clothing, shelter, medical care, supervision that guards child safety and well-being; *abuse* – actions, or threatened actions that cause, or have the potential to cause significant harm to a child, including emotional, physical and sexual actions; and extends to *exploitation* – the use of a child for profit, power, status, sexual gratification or other purpose. Children are also exposed to *harm* because of traditional practices that are sanctioned by cultures (e.g. female genital mutilation (FGM) or early marriage). These forms of violence are also termed as *child maltreatment* in the public health domain (World Health Organisation, 2006). Ending victimization of children not only protects the human rights

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of the child but reduces the likelihood that they will grow up and continue the cycle of violence against others.

According to UNICEF (2014), children's experience of violence includes:

- *Homicide* – In 2012 alone, homicide took the lives of about 95,000 children and adolescents under the age of 20 – almost one in five of all homicide victims that year.
- *Physical punishment* – Around six in ten children between the ages of two and 14 worldwide are regularly subjected to physical punishment by their caregivers.
- *Bullying* – More than one in three students between the ages of 13 and 15 worldwide regularly experience bullying (cyberbullying not included).
- *Forced sex* – Around 120 million girls under the age of 20 (about one in ten) have been subjected to forced sexual intercourse or other sexual acts at some point in their lives. Boys are also at risk, although a global estimate is unavailable.
- *Intimate partner violence (IPV)* – One in three adolescent girls aged 15–19 worldwide have been the victims of any emotional, physical or sexual violence committed by their husbands or partners at some point in their lives (UNICEF, 2014). Globally, 20% of adolescent girls are either married or in a union. Early marriage puts young girls at risk of IPV and in a vulnerable position as they are cut off from their families and support networks. Adolescent girls in informal unions are also vulnerable to IPV (UNICEF, 2014).
- *Witnessing domestic violence and co-occurrence with IPV* – Country level studies establish that children are affected by the violence they witness between parents (Iles-Caven, Ellis, & Golding, 2017; Indermaur, 2001; Kyu & Kanai, 2005). Children also have an increased risk of directly experiencing violence if their mothers are victims of domestic violence.

In addition, children experience grave violations in contexts of conflict and war: either drafted to support armed forces or groups or forced to leave home without adult care. They are exposed to forms of modern slavery including economic and sexual exploitation and trafficking. Newer risks in the form of exposure to online forms of bullying and exploitation can negatively impact their safety and development if not addressed through adequate safeguards.

The scale and range of violence holds up a disturbing mirror to society. However, while episodic reporting may trigger a momentary sense of outrage and sadness it rarely leads to sustained comprehensive action. Indeed, too much focus on numbers means the scale and enormity of the issue can seem overwhelming. Numbers need to be supplemented by effective descriptions or narratives in order to get a proper understanding of the human condition – and what to do about it.

About Know Violence in Childhood

This special issue is one of the outputs of the *Know Violence in Childhood*: *A Global Learning Initiative*. The Initiative was established as a collective response by individuals from multilateral institutions, non-governmental organisations and funding agencies concerned about the global impact of violence in childhood and the lack of investment in effective violence prevention strategies. The importance of credible global evidence was seen as central to increasing advocacy and investment in effective strategies to end violence in childhood.

A central message of the initiative is that violence is preventable. Strategies for prevention can help build better lives for boys and girls – optimising their well-being and their development to adulthood. Both established systems of child protection as well as innovative field-based programmes across countries have generated insights and lessons about the strategies that can yield effective results to end violence. These innovations and strategies address both the structural roots as well as the individual behaviours that give rise to aggression and violence. Countries can also learn from each other, adapting effective strategies to their contexts and realities.

Launched in November 2014 after nearly two years of international consultations and preparatory work, the Initiative's learning effort has been organised as follows:

- *Three learning groups* – Under the leadership of eminent academic experts based in institutions in Brazil, Jamaica, South Africa, the United Kingdom and the United States, the learning groups specifically addressed interpersonal violence in homes, schools and communities. The groups comprised experts from multiple disciplines – including psychology, crime prevention, epidemiology, paediatrics and security and development – from around the world. Additional papers were commissioned to cover related topics that cut across or were outside of the frameworks of these groups.
- *Commissioned papers* – The learning groups commissioned 41 papers (see Table 1) from 100 authors from universities and institutions around the world. These in turn drew on over 3000 articles, books and reviews, including 192 systematic reviews of evidence.
- *Regional outreach* – A series of meetings has been held in Central Asia, East Asia and the Pacific, Latin America and South Asia bringing together researchers, practitioners and policy makers addressing different issues of violence salient to these regions.

The work of the Initiative is focused on providing a narrative that can

(i) unify and strengthen this diverse field by putting prevention of violence in childhood in a context that will resonate with a broad range of actors;
(ii) Provide a convincing and unifying ethical framework which essentially enshrines a human development vision of social policy;
(iii) Offer a range of arguments, derived from research as to why violence in childhood must be tackled; and
(iv) Propose guidance on the actions that can be taken to prevent violence in childhood.

This special issue contains a selection of 15 papers that have contributed to the Initiative's evidence base. In this editorial, we refer both to the synthesis of evidence from the full range of commissioned work as well as the specific papers included in this volume.

Unpacking violence in childhood

A significant transition is underway in our collective understanding of what transpires in childhood and the consequences for human development. Interpersonal violence is fast emerging as the missing piece in child well-being policies, with children's safety and protection increasingly being understood to be the centrepiece of achievement of their full potential. The consequences of exposure to 'toxic stress' at a young age are beginning to be well understood (Shonkoff et al., 2012).

Table 1. Know Violence in Childhood Commissioned Papers.

	Author, year, title
1.	Abt (2017) Towards a Comprehensive Framework for Community Violence Reduction*
2.	Bacchus et al. (2017) Exploring Opportunities for Coordinated Responses to Intimate Partner Violence and Child Maltreatment in Low and Middle Income Countries: A Scoping Review*
3.	Brodie and Pearce (2017) Violence and Alternative Care: A Rapid Review of the Evidence*
4.	Brown, de Graaff, Annan, and Betancourt (2017) Breaking Cycles of Violence: Common Elements of Interventions for Children, Adolescents and Youth Affected by War
5.	Bulger and Burton (2017) Online Violence in Schools: Cyberbullying and Other Adverse Online Experiences*
6.	Burton (2017) The Role of ICT and Social Media in Preventing Violence in Schools and Institutions
7.	Carbonari and Alys (2017) Learning from Latin America: Policy Trends of Crime Decline in 10 Cities Across the Region
8.	Cid (2017) Interventions using Regular Activities to Engage High-risk School-age Youth: A Review of After-school Programmes in Latin America and the Caribbean
9.	Clarke et al. (2017) Patterns and Predictors of Violence against Children in Uganda: A Latent Class Analysis
10.	Coore-Desai et al. (2017) The Prevention of Violence in Childhood through Early Childhood Parenting Programmes: A Global Review
11.	Deanne and Fox (2017) The Role of the Health Sector in Violence Prevention and Management
12.	Devries et al. (2017) Who Perpetrates Violence against Children? A Global Systematic Analysis of Age and Sex-specific Data
13.	Ellsberg et al. (2017) Violence against Adolescent Girls: Falling through the Cracks?
14.	Embleton (2017) Twice Victims of Violence: The Plight of Street-connected Children and Youth
15.	Esquivel and Kaufmann (2017) Gender Dimensions of Violent Urban Contexts: Bridging the Gaps in Theory and Policy
16.	Gershoff (2017) School Corporal Punishment in Global Perspective: Prevalence, Outcomes and Efforts at Intervention*
17.	Guerra et al. (2017) Community Readiness for Youth Violence Prevention: The Youth Violence Prevention Readiness and Needs Scale (YVP-RNS)
18.	Iles-Caven et al. (2017) Polyvictimisation in the UK: Some Findings from the ALSPAC Study
19.	Kidwai (2017) School-based Violence in South Asia: State of the Evidence Report
20.	Le et al. (2017) Prevalence and Determinants of Bullying Victimisation and Perpetration among Adolescents in Vietnam*
21.	Leoschut and Kafaar (2017) The Frequency and Predictors of Polyvictimisation and the Role of Schools in its Prevention*
22.	Lester et al. (2017) Systematic Review on the State of Knowledge on Violence within Schools: A Systematic Review of Reviews*
23.	Lilleston et al. (2017) Social Norms and Violence in Childhood*
24.	Maternowska (2017) The Politics of the Age-gender Divide in Responding to Sexual, Physical and Emotional Violence
25.	McTavish et al. (2017) Mandatory Reporting: An Evidence-based Overview and Meta-synthesis of Qualitative Studies
26.	Meinck and Cluver (2017) Disclosure of Physical, Emotional and Sexual Child Abuse, Help-seeking and Access to Abuse Response Services in Three South African Provinces*
27.	Menesini and Salmivalli (2017) Bullying in Schools: The State of Knowledge and Effective Interventions*
28.	Muggah (2017) Measuring Fragility in Cities
29.	Naker (2017) Operational Culture at Schools: An Overarching Entry Point for Preventing Violence against Children at School
30.	Peterman, Neijhoft, Cook, and Palermo (2017) Understanding the Linkages between Social Protection and Childhood Violence: A Review of the Evidence
31.	Ranford and Slutkin (2017) Seeing and Treating Violence as a Health Issue
32.	Ravi and Ahluwalia (2017) What Explains Childhood Violence? Micro Correlates from VACS Surveys*
33.	Rubenstein and Stark (2017) The Impact of Humanitarian Emergencies on the Prevalence of Violence against Children: An Evidence-based Ecological Framework*
34.	Samms-Vaughan & Lambert (2017) The Impact of Polyvictimisation on Children in LMIC: The Case of Jamaica*
35.	Samms-Vaughan (2017) Violence and Early Childhood Development: What Do We Know?
36.	Schmidt (2017) Institutional Violence against Children: How to Cope with the Inevitable and the Unconquerable
37.	Sherr et al. (2017) Child Violence Experiences in Institutionalised/Orphanage Care*
38.	Stöckl, Dekel, Morris, Watts, and Abrahams (2017) Child Homicide Perpetrators Worldwide: A Systematic Review
39.	Vergara (2017) Children Trapped in Fragile Cities: Communities, Organised Crime and the Rule of Law
40.	Villaveces (2017) Access to Means such as Alcohol, Drugs and Firearms and Built Environment Characteristics: Implications for Cities with High Rates of Violence
41.	Williams and Davies (2017) Early Childhood Teachers and Children's Curricula and Violence Prevention and Management

*Denotes the selection of commissioned papers appearing in this issue. All other papers are to be made available on the Know Violence in Childhood website: http://www.knowviolenceinchildhood.org/. Versions of some of these are also under submission for broader publication.

The need for an integrated approach to understanding violence is based on increasing recognition that interpersonal violence spills from one setting to another – say from the home to the school, or the school to the community – resulting in what is commonly known as 'poly-victimization' (Leoschut & Kafaar, 2017). Children who witness violence as means to resolve conflicts at home, are more likely to use it in schools and other settings. Similarly, being abused within the home or at school increases children's risk to being victims of violence within the community. Thus, girls who are victims of sexual abuse in the school are also likely to face such abuse in the streets. The rapid uptake of internet use and mobile telephony has added another, virtual, environment in which violence occurs, and emerging evidence points to the overlap between both victimization and perpetration of violence between the online and offline (Bulger & Burton, 2017). While globally the evidence base does not yet allow us to identify the overlap in the experience of the different forms of violence, Clarke et al. (2017) find overlapping experiences of physical, emotional and sexual violence from a study in Uganda, and suggest that about 1 in 4 children experience multiple forms of violence. Studies from South Africa and Jamaica (Leoschut & Kafaar, 2017; Samms-Vaughan & Lambert, 2017) point to the inter-connected nature of types of victimisation and the aggregation of negative effects that can severely impair child development.

Unpacking the age and gender dimensions of violence (Learning Group 1)

Children's experiences of violence vary by age. The exposure to violence in early childhood – both direct (such as child sexual abuse) and indirect (such as growing up in a violent household) – can have longer term impacts on the child, including a later risk of using and/or experiencing violence in adulthood. These associations point to the value of intervening early in violence prevention. This later violence is not inevitable, however. Children's resilience is important, and needs to better understood and nurtured.

The experience of violence can set in as early as pregnancy, with children born of victims facing a higher risk of disability and problems in the child's nervous system and brain. Domestic violence against pregnant women by their partners, spouses and other members of the family is the most prescient risk for the unborn child.

In their systematic review Devries et al. (2017) find that globally, emotional violence from caregivers is the most common form of violence experienced by children across age groups.

Available data for 2–4 year olds across 58 countries show that children within this age group who experienced any violent discipline in the surveyed month ranged from almost 90% in countries such as Algeria, Morocco, Swaziland, Yemen, Cameroon, The Central African Republic and Tunisia to 45% as the minimum level in Panama and Mongolia. Ravi and Ahluwalia (2017) review data for 10,000 children from four countries in Africa that have implemented Violence against Children surveys which corroborate early exposure to violence, often as early as age six.

The age at which children enter late childhood and adolescence varies between societies. As children begin to become more independent and interact with peer groups, they become more susceptible to interpersonal violence. Generally, children in the age groups 10–18 become vulnerable to all forms of violence but the most prevalent form of violence is physical violence for boys and girls by a member of their peer group. Along with physical attacks, this age group sees an increase in fighting between children and sometimes with violent means such as a firearm (UNICEF, 2014).

As children grow older, they are at greater risk of sexual violence, but to a much larger extent for girls. Boys are under-represented in data collection on sexual violence, but available data suggests that they are less vulnerable to sexual violence than girls (Devries et al., 2017), though there is evidence from South Africa, Switzerland and China that this is changing (Optimus Study, 2012, 2013, 2016). As Ellsberg et al. (2017) establish, girls aged 15–18 become vulnerable to physical violence by an intimate partner or spouse and sexual violence in the home. Seventy percentage of girls name their current or former partners or husband as the perpetrator of physical violence against them (UNICEF, 2014).

Gender-based violence (GBV) is a manifestation of patriarchal systems of organising society whereby girls and boys are socialised into differentiated gender roles that place them within unequal structures of power. For certain forms of violence girls are worse off; these include domestic violence, sexual violence, feticide and early marriage. Cultural manifestations of GBV can be seen in society with respect to specific forms of childhood violence such as honour killings, acid attacks, dowry and FGM.

Boys, on the other hand, are at higher risk of experiencing physical violence from their peers, as well as corporal punishment. The normalisation of violence against boys renders invisible the threats they face. For instance, two countries legally permit corporal punishment in schools for boys alone (Gershoff, 2017). Boys entering adolescence are vulnerable to peer group pressure to join gangs and engage in criminal activity. Adolescent boys between 15 and 19 years witness a dramatic increase in their risk of dying by homicide compared to boys aged 10–14 and regional differences are pronounced with adolescents in Latin America and the Caribbean accounting for 4% of all global homicides likely in part due to activities of organised criminal groups, street gangs and access to firearms (UNICEF, 2014).

The widespread abuse children experience is not matched by adequate disclosure and response services. Meinck and Cluver (2017) find that a small proportion of affected children are able to report violence. From a study in South Africa, they find that disclosure when it takes place, is usually to family, teachers and other members of the community, and not to formal services. Where formal services exist, they may not be able to respond in a timely and appropriate way. The lack of adequate and effective response is a further deterrent to reporting, justice and support.

Recognising the synergies between violence experienced by children and women within the home

Violence experienced by children has direct connections with violence against women. Women and girls have shared risk factors. Guedes, Bott, Garcia-Moreno, and Colombini (2016) highlight that children are more likely to be physically abused in homes in which women are victims of IPV, with estimates of the co-occurrence of the two ranging from 18 to 67%. They also find that girls exposed to violence, either as victims or witnesses, are at greater risk of experiencing physical or sexual violence in adulthood and that men abused or neglected as children are significantly more likely to report perpetrating physical or sexual violence against women. The clustering of these two types of violence within families, in part reflects shared risk factors, such as social norms supporting the unequal status of women and children, a tolerance of male dominance and violence as a means to resolve conflict, heavy alcohol use, notions of privacy and stigma, and weak legal sanctions against violence.

Maternowska (2017) analyse the historical evolution of the fields of violence against women and violence against children, and argue that they have developed in parallel, resulting in fundamental differences in approaches which inhibit realisation of the potential for accelerating progress towards ending both. For example, there is uncertainty whether children's witnessing of IPV should be reported as part of a mandatory reporting system. As McTavish et al. (2017) highlight, while mandatory reporting can result in positive experiences and outcomes, many negative experiences are also documented, such as harmed therapeutic relationships and child death following removal from their family of origin. Despite such tensions, the synergies between programmes that can end violence against women and children within the home are strong, and many programmes that aim to address one group can have collateral positive impacts on the other, especially where they are designed to take advantage of the common ground.

Violence in schools (Learning Group 2)

School violence can severely hamper a child's ability to learn and adversely affect their development. The negative outcomes associated with school violence can extend well after an actual experience of violence at school (Lester et al., 2017). School children around the world are subject to different forms of violence, at the hands of teachers and authority figures. School teachers often use a variety of methods to inflict punishment for a very diverse, and often innocuous range of student behaviours (Gershoff, 2017). These methods of punishment cause emotional humiliation, physical injury and in rare cases, even death. Evidence further shows that rather than resulting in benefits such as increased learning, corporal punishment negatively impacts intellectual learning. As Gershoff (2017) notes 'if an adult were to be hit with an object such as children are [in schools], it would be considered assault'.

The case for a 'whole school approach' to address all forms of interpersonal violence has never been stronger (Naker, 2017). Violence is facilitated by bystanders, not just the individual perpetrator(s). Menesini and Salmivalli (2017) show how members of a classroom contribute to the dynamics of a violent act, say bullying. They find that the likelihood that vulnerable children become targets of bullying is exacerbated in classrooms characterised by high levels of reinforcing the bully and low levels of defending the victim. Teachers' beliefs and attitudes towards violence are strong determinants of violence in their classrooms. Teachers are powerful culture creators within schools and classrooms, and have a disproportionate influence over what constitutes 'normal' or appropriate behaviour. Teachers' beliefs, as far as they result in inaction, may thus increase the prevalence and frequency of bullying behaviour in the classroom (Menesini & Salmivalli, 2017).

Social and cultural contexts matter too. Just as girls are often more likely to be the victims of sexual assault, Gershoff (2017) documents how in the USA racially black children are more likely to the victims of corporal punishment in schools. The various forms of violence that different children experience is not a coincidence, but rather a result of identity stereotypes that make normal and acceptable certain types of violence against certain types of people. Interventions should be cognizant of, and draw attention to the cultural stereotypes (e.g. race, gender, sexual orientation) that often underpin assumptions relating to the normalisation of violence. This suggests that schools must address inequities in the external environment and address them through fostering greater inclusiveness.

Violence in communities (Learning Group 3)

Most people in the world today live in urban and peri-urban agglomerations with significant variations in resource availability. And while a thin bandwidth of city residents lives in relative prosperity, the vast majority of urban living will be in poorer, informal and fast-growing settlements of the Global South. As more people migrate to cities, their capacity to govern and deliver services, including security, is pushed to the breaking point. The most fragile of these communities can concentrate risks of violence against children. By contrast, more healthy, nurturing and resilient neighbourhoods are essential to preventing and reducing violence over the medium- to long-term. Interventions focused narrowly on at-risk children, on parents or schools cannot be sustained without a wider engagement with the communities where children and families live. They are necessary, but insufficient.

Although gang violence and homicides are largely an urban phenomenon, violence by and against children is by no means inevitable in urban settings. Presenting an overall macro picture of how violence against children has panned out across so-called 'high burden' cities, Muggah (2017) shows that a number of cities worldwide have managed to bring down violence and crime dramatically in relatively short time periods, although he emphasises that this does not happen overnight. Guerra, Shadowen, Reyes, and Serrano-Berthet (2017) reiterate that it is possible to change conditions to make violence less adaptive, but this emphasis on prevention is not universally shared; it needs to be aggressively socialized.

Culture and context matter. Not all communities are equally susceptible to the risks of violence against children. Indeed, as Vergara (2017) suggests, the highest rates of violence in childhood tend to be concentrated in the poorest neighbourhoods, where social cohesion tends to be in lower supply, and alcohol, drugs and firearms are easily accessible. The specific dynamics of violence must be carefully documented before prevention efforts are rolled out.

The gendered dimension of violence must also be understood and addressed. Esquivel and Kaufmann (2017) find that although boys and men are more likely to be involved in lethal violence than girls and women, the highest violence rates against women are observed in settings with the highest violence rates by men.

Other settings of violence

There are many other dimensions of violence that fall outside of the everyday settings where children experience violence, but which are less well studied. For instance, children placed in formal institutions of care, are vulnerable to multiple forms of violence, which are hidden from view. While violence is not inevitable in institutions (Brodie & Pearce, 2017; Sherr, Roberts, & Gandhi, 2017) – the paucity of data monitoring this formally is lamentable and systematic review evidence suggests clear patterns of elevated abuse experience in Institutional care. In some cases, institutions and alternative care environments are sets up to provide an alternative safe space for children who are exposed to a wide range of forms of violence ranging from neglect to abuse and maltreatment (Brodie & Pearce, 2017). Yet reviews show that there are elevated levels of violence experience within institutions as well as negative cognitive effects associated with institutionalisation, especially for younger children, and those who spend long periods in institutions (Sherr et al., 2017). Such cognitive delay can be seen as a form of neglect – especially when it is redressed upon placement outside of the institution. Given the startling finding that the majority of institutionalised

children have at least one parent usually alive, the root causes of institutionalisation need to be better understood and addressed.

Similarly, little is known about children in humanitarian emergencies, and the pathways of impact between larger scale social and political breakdown, and violence in the community and home. Rubinstein and Stark (2017) make a strong plea for attention to better research and evidence to ensure that children's rights are protected in contexts of civil and political emergencies. Embleton (2017) points to the neglect of research on street-connected youth for whom violence victimisation is both a driver of leaving home as well as a feature of their street experiences.

Prevention strategies

Violence is often thought of as a series of events categorised according to severity or type. It is tempting therefore to invest in solving the problem sequentially, such as beginning with issuing prohibitions on corporal punishment or investing in anti-bullying campaigns. But violence emerges from a culture or an ecosystem that either nourishes children's wellbeing, or undermines it. Thus it is important to view different forms of violence in an integrated way, identifying those that need to be addressed through universal programmes, and those that are best targeted in high risk communities or at highly vulnerable groups in the population.

Violence is generally misrepresented as a problem only between individuals. This has led to fragmented approaches, which in turn have tended to:

Individualize the problem: There is often a tendency to treat an act of violence such as a rape as a stray occurrence committed by an 'abnormal individual'. This could lead us to ignore serious underlying social factors that condition such unacceptable human behaviours.

Stigmatize the survivor: This is a way of wishing away the problem as the stigma attached to the experience of violence discourages children from reporting incidents of violence, placing emphasis on the individual, yet again, rather than on the social and structural drivers of the violence. Stigma can also be attached to the parents or families of survivors. For example, there is a tendency to blame parents for not being able to bring up their children properly – the idea of 'good' and 'bad' parents – without fully understanding the context and circumstances under which parents find themselves helpless to prevent aggressive or violent behaviour.

Criminalize the response: while laws against violence must be strictly implemented, the challenges particularly arise when young children are themselves perpetrators of violence, especially serious violence. Responses tend to be punitive, wrongly encouraging authorities to punish or arrest children, or place them in reform homes and similar institutions in the hope that such acts will deter these children as well as others from misbehaving.

Medicalize the response to the perpetrator: While this might be necessary in some cases, treating deviant or aggressive behaviour as a mental disorder that can be treated medically and clinically might mean looking at only the tip of the iceberg, ignoring the deeper societal factors that give rise to violent behaviour.

Commercialize the solution: There is the danger of profit-making commercial enterprises beginning to market training modules and other packages for 'teaching' parents, children and caregivers how best to deal with issues of violence – without recognising that such

band-aid solutions do little to address serious underlying factors and guidance on effective interventions should be freely available.

The limitations of punishment

Punitive measures may mean little when the perpetrator is within the circle of care-givers that a child is required to implicitly trust. When the perpetrator of violence against a child is a parent or close relative or friend; or when the perpetrator is a mother battling post-natal depression or experiencing violence herself within an intimate relationship, punitive measures alone are unlikely to be effective in stopping violence.

Towards enabling and effective prevention strategies

Papers in this volume recommend a range of strategies that have been proven to positively impact violence. These reflect some of the lessons generated within the Initiative, which will be documented at length in the Initiative's flagship report (Know Violence, in press).

Start with the home

Coore-Desai, Reece, and Pellington (2017) review the existing evidence on the efficacy of parenting programmes to address violence within the home and find that parenting programmes have the potential to both prevent and reduce the risk of child maltreatment. The importance of parenting programmes as an entry-point to address vulnerabilities and risks within home environments is well-emphasised in global studies. However, there is lack of good evidence from LMICs where the risk of child maltreatment is greatest. Bacchus et al. (2017) argue that there are opportunities for greater synergies between IPV and child maltreatment programmes, which include parenting programmes. Their review identifies six programmes that reported outcomes for both IPV and child maltreatment in low-and middle-income countries. However, the evidence at this stage does not allow us to determine which programme components are responsible for producing the promising outcomes in relation to IPV and child maltreatment. In order to ensure the effectiveness of interventions that may impact on multiple forms of violence, further research is strongly recommended.

Children are less likely to be separated from their families and placed in alternative care (where they can face an increased risk of abuse, abandonment and neglect) when there are coordinated and multi-sectoral responses that ensure children are being raised in protective, stable and healthy families. Programs and strategies to strengthen and support families to prevent unnecessary family separation are being rolled out globally with the aim of protecting children from all forms of risk, including the need to enter into an alternative care arrangement. And, if children are in need of alternative care, the imperative is to ensure that the care they receive is appropriate to their particular needs, and focused on reintegrating them safely into a protective, nurturing environment within their own families of family-based alternative setting.

Overall, for violence prevention to take place at scale, investment in changing social norms that enable the assertion of power over women and children, as well as those that endorse violence as a socially acceptable behaviour, is a necessary strategy. Lilleston, Goldmann, Verma, and McCleary-Sills (2017) provide an overview of the ways in which social norms

change can be brought about. Opportunities for linking ending violence against women with child victimization should be explored and used to maximise results and accelerate the end to violence.

Reform within schools

Given that the operational culture of a school has a significant impact on the normalisation (or disruption) of violent behaviours and practices, a key strategy is to reform the operational culture of schools. The Good Schools Toolkit implemented in Uganda has demonstrated significant positive results in addressing the dynamics of violence, at multiple levels, across multiple stakeholder groups including staff and students, parents and administrators, with the potential to succeed at scale (Naker, 2017). Whole school approaches can help disrupt a culture wherein violent acts are seen as normal by both children and adults. However, and as Lester et al. (2017) find in their systematic review on school violence interventions, for specific forms of violence such as peer aggression, implementing discrete interventions may be more suitable. There are many positive examples of discrete interventions that can address peer aggression, especially working with the perpetrators. Lessons from anti bullying programmes are reviewed by Menesini and Salmivalli (2017). Le et al. (2017) draw attention to the need to link anti-bullying programmes to mental health promotion, and to focus on peer social relationships more broadly, including with the engagement of family members, as relevant. Sherr et al. (2017) show that effective changes in institutions can alleviate violence either by structural and code of conduct interventions or policy changes that avert such placements or expedite onward movement to family type environments.

Build resilient communities

There are many strategies which are proving to explain how cities and urban communities are reducing violence, particularly in Latin America, Central America and the Caribbean, where high levels of homicide and gang violence are concentrated:

(a) The rule of law must be strengthened to prevent violence. In separate papers, Muggah (2017) and Vergara (2017) emphasise that a major factor in violence in urban settings is the inability of governments at all levels to respond appropriately, creating mistrust, opportunities for youth gangs and organised crime, and vigilante justice.
(b) A national prevention agenda with local institutionalization. In their papers, Carbonari and Willman (2017) and Muggah (2017) show that while a national agenda sets the stage, effective policies and programs must be implemented locally. The most successful violence prevention efforts are those that benefit from a continuum of strategy across actors and agencies and locally coordinated efforts. To complement this, sustained, committed and coordinated municipal leadership is key.

(c) Comprehensive approaches work best. Abt (2017) suggests that the most successful interventions are those that combine multiple levels of prevention, suppression, and rehabilitation focused on the specific dynamics of risk within settings and develop an integrated set of services for places where violence is most likely to occur, for people most involved in violence, and for behaviours most associated with violence.

(d) Community-based interventions to engage at-risk youth in skill building, vocational training, music, and art during the day and after school show results. Cid (2017) shows how such everyday activities hold significant promise for preventing violence in childhood.

For change to take place, governments should invest in strategies that show promising results. According to Villaveces (2017), interventions that emphasise deterrence (say from alcohol) and targeted community development in high-risk areas with high-risk individuals can show positive returns. But in a separate paper assessing communities' 'readiness' to implement prevention programs, Guerra et al. (2017) emphasise how such interventions can be successful only if backed by adequate resources and implemented with fidelity. Finally, the appropriate sequencing of interventions is critical to their success. Attention is required to the process of design, implementation and monitoring and evaluation. For example, in urban environments with diffused and disorganised crime, focused deterrence, cognitive behavioural therapy, and environmental design measures may be most appropriate. Meanwhile, where the urban environment is associated with organised crime, community building, citizen participation and routine criminal investigation and persecution may be more useful.

Recording, measuring and researching violence in childhood

Collecting information on violence in childhood is not easy. To begin with, very small children may simply not have the capacity to report an incident of violence or abuse. Many may not be able to talk, and even when they can talk, they may not speak up in front of adults. Violence against children tends to go unrecorded – for three main reasons.

- *Fear* – Many children are very scared to report violence. They are afraid that if they complain, they themselves may be blamed or punished. Many children are just too scared to report or are fearful of the consequences especially when the complaint is against an adult or a person in a position of authority. Parents too prefer to remain silent particularly if the offender happens to be a family member (as in the case of incest) or an important official (a police officer) as the harassment that could follow might make the situation even more traumatic for the child and the family.
- *Stigma* – Many families are afraid of the 'loss of face' or humiliation that the child is likely to experience particularly in societies that do not offer the necessary protection to children. Girls in particular can find sexual violence difficult to talk about in contexts where they are likely to encounter shame and blame for their 'behaviour'. As a result, official statistics on violence in the home tend to be grossly under-reported.
- *Societal acceptance* – Many societies consider violence as normal and inevitable. They do not regard certain acts as being violent or abusive causing harm to the child. Corporal punishment, bullying, sexual harassment and violent forms of disciplining may be perceived as being normal, especially when such acts do not result in visible physical injury.
- *Inadequate institutional procedures for reporting or recording violence against children* – The problem of under-reporting is compounded by weaknesses in formal systems for gathering and reporting information on incidents of violence in many countries. Many institutions such as jails and detention centres, schools, or even institutions of

alternate care may not maintain or be even required to maintain records of violence. There may be no officials or persons of authority with whom a child can register a complaint. Even when there are, lack of trust in the designated officials may discourage children and families from reporting cases of violence. Many schools, for instance, may not have trusted mechanisms in place for a child to confidentially and safely report any incident of abuse.

- *Inadequate death registration systems* – In the case of fatal deaths due to violence against children, only if death registration is universal and post-mortem and other systems of investigation and reporting are in place can statistics be termed reliable. However, this is often not the case in many countries. Sexual abuse and extreme forms of bullying, for instance, could drive a child to commit suicide, but the real reasons behind suicide are seldom recorded. Similarly, it is difficult to find out the proportion of homicide deaths among children that could be attributed to violence.

Data on prevalence of violence does not cover all forms of violence. Information is rarely disaggregated by characteristics of perpetrator and victim, such as class, race, ethnicity and religion. While some surveys undertake a gendered analysis, specialised data is often missing on socioeconomic categories of boys or girls who are exploited, or become perpetrators of violence. This includes data on children with disabilities, and intersex and transgender children, amongst others.

The efficacy of data is often questioned because there is no globally accepted definition of violence. And reporting based on recall by a young person is influenced by both perceptions and ambiguity. For instance, the notions of 'good' touch vs. 'bad' touch may vary across societies and might be equally difficult for children to discern objectively.

In addition to completeness and efficacy of information, we need to be cautious about generalising and drawing conclusions using the available data. We need to be careful about drawing conclusions that have a universal applicability. Many risk factors may be similar in different western societies; but evidence is thin for the rest of the world. As has been pointed out, more than 95 per cent of all program evaluations relate to about 12% of the global population (Eisner & Nivette, 2012).

A line in the sand

The Know Violence initiative has set out to draw a line in the sand, marking a moment in global development and research where strides in both knowledge and action culminate in a do-able agenda. Such an agenda must resonate in the corridors of homes, schools communities and governments. Overall the work of the Initiative has highlighted both the wealth of knowledge that is available as well as some of the challenges that need to be addressed by the research and funding communities. These challenges include significant geographical gaps in the knowledge base. Several challenges stem from the lack of use of standardised definitions and methodologies, as well as limitations linked to evaluation research in particular. The most pressing challenge, however, is to move from knowledge to action.

Much work remains ahead, but the series of papers commissioned in the Know Violence initiative indicate that there is very encouraging evidence that can initiate action and investment by governments and the donor community for violence prevention.

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What explains childhood violence? Micro correlates from VACS surveys

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ABSTRACT

Violence in childhood is a serious health, social and human rights concern globally, there is, however, little understanding about the factors that explain the various forms of violence in childhood. This paper uses data on childhood violence for 10,042 individuals from four countries. We report Odds Ratios from pooled logit regression analysis with country fixed effects model. There is no gender difference in the overall incidence of childhood violence. The data shows that 78% of girls and 79% of boys have suffered some form of violence before the age of 18 years. Odds of violence are higher among richer households, among individuals who have attended school and among individuals who have been married or in marriage-like arrangements. Individuals who justify wife beating have significantly higher likelihood of having faced violence themselves. Most perpetrators of violence against children – physical, emotional and sexual – are people known to them in their homes and community, and not strangers. There is limited understanding of the factors that explain violence in childhood. This study highlights some key factors that can explain this phenomenon.

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Introduction

Violence in childhood is a serious health, social and human rights concern globally. Recognising the significance of this problem, the United Nation's Sustainable Development Goals include an agenda to end all forms of violence against children. Recent literature has documented the magnitude of violence against children at country levels by synthesising available evidence across countries. A recent study finds that over 1 billion children in the age group of 2–17 years have experienced violence in the past year.[1] There is, however, little understanding about the factors that explain the various forms of violence in childhood. This paper uses individual level data from four countries on childhood violence to highlight some of the key factors that can explain these disturbing phenomena globally.

Experience of violence in childhood is widespread, as highlighted by the recent literature. A statistical analysis carried out by the United Nations Children's Fund, (UNICEF, 2014),

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reports that 60% of children experience physical punishment on a regular basis, and worldwide, nearly one in three adolescents face bullying on a regular basis. Using self-reported data, the prevalence, incidence, perpetrators and locations of physical, emotional and sexual adolescent abuse victimisation was documented for South Africa (Meinck, Cluver, Boyes, & Loening-Voysey, 2016). Research has also established risk and protective factors for severe physical and emotional abuse among South African youth (Meinck, Cluver, Boyes, & Ndhlovu, 2015). In a survey in the U.S. (Finkelhor, Ormrod, Turner, & Hamby, 2005) report that nearly one half of American children were assaulted at least once in the previous year. Finkelhor et al. (2005) also reported that more than 1 in 4 (273 per 1000) of the children and youth had experienced a property offense in the study year, more than 1 in 8 (136 per 1000) a form of child maltreatment, 1 in 12 (82 per 1000) a sexual victimization, and more than 1 in 3 (357 per 1000) had been a witness to violence or experienced another form of indirect victimization. A recent study has shown that children and youth are exposed to violence, abuse and crime in varied and extensive ways, which justifies continued monitoring and prevention efforts (Finkelhor, Turner, Shattuck, & Hamby, 2015). There is effort to identify the location of abuse, such that policy interventions can be appropriately designed. Assessment of at-school victimization and violence exposure was done through a national household survey of children and youth (Finkelhor, Vanderminden, Turner, Shattuck, & Hamby, 2016). As a widespread problem with enduring impact on the lives of people, this is a topic that requires more attention from public agencies.

There is extensive literature which highlights that childhood violence has negative effects on an individual's well-being and can persist into adulthood. Research has also shown that exposure to violence predicts poor educational outcomes in young children using data from South Africa and Malawai (Sherr et al., 2015). Using data from East Asia and Pacific region, research has established the consequences of maltreatment on children's lives. Children in the region experiencing maltreatment are at increased risk of experiencing mental health consequences, physical health sequelae, high-risk sexual behaviours, and increased exposure to future violence including intimate partner violence as an adult (Fry, McCoy, & Swales, 2012). Gilbert et al. (2009) report that child maltreatment has long lasting effects on mental health, drug and alcohol abuse, risky sexual behaviour, obesity and criminal behaviour. Anda et al. (2006) show through an epidemiological study that adverse childhood experiences are related with poor outcomes in a broad spectrum of areas. DuRant, Getts, Cadenhead, Emans, and Woods (1995) examined the relationships between exposure to violence and depression, hopelessness and purpose in life among black adolescents living in or around public housing developments. The World report on violence and health (Krug, Mercy, Dahlberg, & Zwi, 2002) shows that the victims of child abuse have an above average chance of becoming involved in aggressive and violent behaviour as adolescents and adults and sexual abuse during childhood or adolescence has been linked to suicidal behaviour.

In an early estimate of the economic costs of violence against children, Fromme (2001) reviewed a variety of sources and calculated a total of $94 billion in annual costs to the US economy from child abuse which is a significant 1.0% of the gross domestic product. Fang, Brown, Florence, and Mercy (2012) did a similar analysis and placed this number at $124 billion in 2008. In another study, Fang et al. (2015) scrutinise the effects of child maltreatment in the East Asia and Pacific region and conclude that the estimated economic value of Disability Adjusted Life Years lost due to child maltreatment is equivalent to nearly 2% of the region's GDP. The literature and show that there are linkages between different

forms of violence. It is therefore not surprising that in some instances different forms of violence share the same risk factors (Dartnall and Gevers (2015).

Research has also tested the effectiveness of child abuse prevention programmes for adolescents in low-or middle-income countries using pre-and post methodology (Cluver et al., 2016). The study highlights the need for more rigorous testing using randomized controlled trials. Longitudinal study has also tested the effectiveness of Community-Based Organisation Support for children, showing that these are associated with behavioural and mental health benefits for children over time (Sherr et al., 2016). Recent study has identified the pathways from family disadvantages in the form of abusive parenting and mental health of caregiver to health risks for adolescents in South Africa (Meinck et al., 2017). Some researchers have proposed a call for action using public health approach to preventing child abuse in low- and middle-income countries by Skeen and Tomlinson (2013); while others have proposed a new research agenda to address violence in childhood (Ward et al., 2012).

We aim to extend the literature on childhood violence by highlighting the factors that significantly explain these different forms of childhood violence. This study looks to contribute through an empirical analysis using individual level data from four countries collected through the Violence Against Children Surveys (VACS). We have more than 10,000 observations from four countries – Tanzania, Cambodia, Kenya and Swaziland. The data covers details of physical, emotional and sexual violence faced by individuals in the age group of 13–24 years of age in these four countries.

Methods

Our paper studies micro correlates of violence in childhood, where we use individual level data from VACS carried out by the Centers for Disease Control and Prevention in VACS Cambodia (2014), VACS Kenya (2012), VACS Tanzania (2011) and VACS Swaziland (2007). In Cambodia 1121 females and 1255 males completed the questionnaire (2376 in total), giving individual response rates for females of 93.7% and for males of 92.1%. In Kenya a total of 1227 females and 1456 males completed the individual survey. The individual response rates were 94.0% for females and 89.8% for males. In Tanzania 3739 interviews were conducted and were divided in the following manner: 1968 females, and 1771 males with individual response rates of 93.5% and 92.6% respectively. In Swaziland information was collected from 1244 of the 1292 eligible females, for a response rate of 96.3%. In all countries, the sampling frame was the one used for the national population census, and sample sizes were selected to be nationally representative.

The surveys measure physical, emotional and sexual violence against girls and boys among respondents aged 13–24 years. The basic structure of the questionnaires is similar, but there are differences from country to country so we pool the similar elements of data from these countries and construct measures of experience of physical, emotional and sexual violence. Details of each of the variables has been explained in Appendix 1 and 2. Emotional violence includes, when the respondent was a child, the threat of abandonment, name calling or being made to feel unwanted. Sexual violence includes unwanted sexual touching, unwanted attempted sex, pressured/coerced sex, or forced sex. Physical violence includes slapping, beating with object, kicking, threatening and attacking with weapons and violent disciplining.

Table 1. Prevalence of violence against children.

Experience of violence	Percentage of girls	Percentage of boys
Any violence	77.9	78.8
Physical violence	72.1	73.2
Sexual violence	20.3	11.1
Emotional violence	27.8	32.0
More than one form (physical/sexual/emotional) of violence	34.3	33.3
Total observations	5560	4482

Note: Author's calculations from VACS data.

We estimate the Odds Ratio (OR) from logit regressions using individual country level data as well as the pooled data for all the 10,042 individuals in the age group of 13–24 years from four countries. The analysis is done using country fixed effects, so the ORs picks up statistically significant relationship over and above the country level variations. As a critical explanatory factor, we also construct an asset index using multiple correspondence analysis on assets common to the four countries. So we combine availability of a toilet, bicycle, car, radio, TV, phone, fridge and availability of electricity. For any form of violence, the VACs questionnaires ask the respondent their age and when they first experienced it. We use this question to create a common variable across countries on the age of first experience of violence – whether physical, emotional or sexual. Because of response coding in Cambodia and Kenya, we are limited to age groups instead of actual ages for the pooled data. For our main analysis we pool the country data to account for the variations in the availability of data for all four countries. These are reported as different specifications in the results tables.

Results

We begin the analysis by first looking at the prevalence of violence. Table 1 shows that 78% of girls and 79% of boys have suffered some form of violence before the age of 18. Further disaggregated data shows that physical violence is the predominant form of abuse and it includes being slapped, punched, pushed, kicked, beaten with object and attacked with a weapon. The other two forms of violence reported in the data are emotional violence which includes humiliation and threatened with abandonment; and sexual violence which includes unwanted sexual touching, unwanted attempted sex, pressured sex and physically forced sex.

Sexual violence is twice as likely for girls than boys. Nearly 20.3% of girls have reported some form of sexual violence while for boys this figure is 11%. Emotional violence, however, is higher among boys (32%) than girls (27.8%). More than one third of all individuals surveyed have reported poly-victimization. Here poly-victimization is defined as abuse from many different levels of the ecological framework. This means that they have suffered more than one form of violence including physical, emotional and sexual in their childhood. Poly-victimization seems to be equally prevalent among girls and boys in the population.

We have further disaggregated the data by age groups in Table 2, and find that childhood violence is distributed across all age groups of children. The distribution of violence across age groups is also quite symmetric for both boys and girls. So while approximately 12% of both boys and girls in the age group of 0–5 years report abuse, it is significantly higher in the age group of 6–11 years for both boys and girls. More than 40% of boys and girls in the age group of 6–11 years have faced some form of childhood abuse. There is a decline in reported violence from age 12–17 but it still remains significant at approximately 20% for

Table 2. Prevalence of violence against children by age groups.

Age group(years) at first experience of any violence (physical/ sexual/emotional)	Percentage of girls	Percentage of boys
0–5	11.9	12.4
6–11	40.8	43.7
12–17	19.9	16.6
18 or older	3.2	2.8
Total	75.9	75.6
Did not experience violence/reveal age	24.1	24.4
Total observations	5560	4482

Note: Author's calculations from VACS data.

Table 3. Perpetrators of violence against children.

Perpetrators	Percentage of girls	Percentage of boys
Sexual violence		
Boyfriend/girlfriend/partner	32.8	32.6
Neighbour	27.9	21.8
Family member	9.6	20.8
Friend/classmate	15.6	14.2
Stranger	19.0	20.1
Authority	11.3	2.3
Other	11.5	4.4
Physical violence		
Parent or adult relative	53.1	57.1
Authority	14.5	19.6
Teacher	52.6	50.8
Partner	14.5	2.2
Other	27.6	
Emotional violence		
Relative	68.9	65.4
Authority	9.0	8.9
Neighbour	19.1	34.0
Partner	12.4	7.3
Total observations	5560	4482

Notes: Author's calculations from VACS data; Percentages can total more than 100 because one person can report multiple perpetrators.

girls and 17% for boys. After 18 years, there is a tremendous decline where approximately 3% of boys and girls report any abuse. The data, thus, shows that prevalence of childhood violence is very high in the population and 3 out of 4 children, both boys and girls, face some form of violence.

Another cut of the data is by perpetrators of violence against children. The results are presented in Table 3. An overall look at the disaggregated data reveals that most forms of violence against children – physical, emotional and sexual – are perpetrated by people known to them in their homes and community, and not strangers. Perpetrators of violence vary by the nature of violence and this is reflected by the distribution for each of the three types of violence – sexual, physical and emotional.

Sexual violence is often perpetrated by partners (boyfriend/girlfriend) for both boys and girls. But while the data shows that partners are the largest single perpetrator category reported for sexual violence, approximately 40% of boys and girls report that neighbours and family members have been their sexual offenders. The likelihood of strangers sexually assaulting children is lower than that, and equal for both boys and girls at approximately 20%. But where the distinctions become stark is the role of family members in sexually

Table 4. What explains violence against children? Country level analysis.

	(1)	(2)	(3)	(4)
	Tanzania	Cambodia	Kenya	Swaziland
Justifiable to beat wife	1.91***	.94	1.60***	
	(.29)	(.10)	(.22)	
Asset index	1.03	1.05	1.20	.91
	(.09)	(.06)	(.15)	(.06)
Lives with mother	1.20	.67***	.71*	.54***
	(.20)	(.10)	(.13)	(.08)
Ever attended school	5.56***	1.84**	5.85***	1.03
	(2.66)	(.50)	(1.83)	(.38)
Female	1.00	.91	.71	1.00
	(.16)	(.09)	(.29)	(.)
Ever married or lived with someone as if married	1.74**	1.00	.95	1.25
	(.41)	(.17)	(.22)	(.34)
Age	.91***	1.02	.99	1.00
	(.02)	(.02)	(.03)	(.)
Muslim	.73		.25***	1.00
	(.24)		(.11)	(.)
Traditional	1.26		6.23	
	(.91)		(7.06)	
Catholic	.81		.77	.98
	(.27)		(.34)	(.32)
Protestant	.56*		.75	.88
	(.19)		(.32)	(.14)
No religion	.66		.57	1.28
	(.27)		(.46)	(1.07)
Primary education	.55	1.01	1.20	.00
	(.24)	(.14)	(.21)	(.00)
Secondary education	.71	.76		.00
	(.32)	(.15)		(.00)
University education	.28	.73		.00
	(.37)	(.27)		(.00)
Observations	3739	2376	2683	1242
Pseudo R^2	.057	.008	.059	.043

Notes: Dependent variable is 'Experienced Violence'. This equals 1 if individual reported some form of violence, 0 otherwise. Exponentiated coefficients; Standard errors in parentheses.
*$p < .10$; **$p < .05$; ***$p < .01$.

assaulting boys and the role of 'authority' in sexually assaulting girls. Authority could be teachers, employers, religious leaders, community leaders, police and soldiers. Physical violence is perpetrated largely by parents and teachers – for both boys and girls. It is interesting that the summary statistics from the individual level micro data is consistent with cross country data collected from UNICEF's Hidden in Plain Sight report where violent discipline at home was faced by a significant 78% of children globally. It is important to remember the differences in the data here. UNICEF's data from 62 countries on discipline at home indicates that 78% of children face violence and parents are likely to be the most common perpetrators. Yet, it is useful to understand that this data on prevalence was based on sample surveys of parents who actually report on parental practices, that is, parents are asked how frequently they had hit their children in the past month if they had committed a particular offence. Thus, they need to be read as parental reports of accounts of violence.

In the micro data, individuals aged 13–24 years were surveyed and asked for accounts of violence they faced in the past. They report parents (followed by teachers) as the main perpetrators of violence. So parents (surveyed for macro data) and children (surveyed for micro data) reveal consistent accounts of violence at home. The data also reveals that girls

Table 5. What explains violence against children? Pooled regression analysis.

	(1)	(2)	(3)	(4)
	Without Swaziland	Without Cambodia	All countries	All countries
Justifiable to beat wife	1.44***	1.90***		
	(.15)	(.29)		
Asset index	1.05*	1.03*	1.05*	1.11*
	(.03)	(.02)	(.04)	(.06)
Lives with mother	1.05	1.20	1.17	.89
	(.14)	(.20)	(.19)	(.09)
Ever attended school	2.80***	5.55***	5.28***	4.12***
	(.59)	(2.66)	(2.53)	(.68)
Female	.97	1.00	1.03	1.00
	(.10)	(.16)	(.16)	(.09)
Ever married or lived with someone as if married	1.40**	1.75**	1.79**	1.20**
	(.22)	(.41)	(.41)	(.05)
Age	.96**	.91***	.91***	.98
	(.02)	(.03)	(.02)	(.01)
Primary education	1.06	.55	.60	
	(.13)	(.24)	(.26)	
Secondary education	1.14	.71	.74	
	(.18)	(.32)	(.33)	
University education	.76	.28	.25	
	(.33)	(.37)	(.30)	
Muslim		.71	.72	
		(.23)	(.21)	
Catholic		.78	.79	
		(.26)	(.23)	
Protestant		.55**	.56**	
		(.15)	(.16)	
No religion		.64	.68	
		(.25)	(.26)	
Country FE	Yes	Yes	Yes	Yes
Observations	6115	3739	4983	10,042
Pseudo R^2	.044	.057	.041	.037

Notes: Dependent variable is 'Experienced Violence'. This equals 1 if individual reported some form of violence, 0 otherwise. Exponentiated coefficients; Standard errors in parentheses.
*$p < .10$; **$p < .05$; ***$p < .01$.

are facing physical violence from their partners which is rare for boys. Emotional violence is largely inflicted by relatives for both boys and girls. Boys also report facing emotional violence from neighbours while girls are less likely to report this. Once again, partners are more likely to inflict emotional violence on girls than on boys.

The next step is to do regression analysis using the VACS data to understand what micro factors can potentially explain childhood violence at the individual level. For this analysis, we have combined all forms of violence together, so the dependent variable in our regression is whether the individual experienced any form of violence or not. The regressions are logit regressions and we report the OR against each explanatory variable in the Tables 4 and 5. For this analysis, we also construct an asset index using multiple correspondence analysis on assets common to the four countries – availability of a toilet, bicycle, car, radio, TV, phone, fridge and availability of electricity.

Table 4 reports the results for each country in the VACS data – Tanzania, Cambodia, Kenya and Swaziland. The sample sizes are large but the pseudo R^2 are low as would be expected for individual level analysis. This means that there are many other unobservable and observable variables that can potentially explain whether an individual has experienced

any childhood violence. We look at explanations in people's attitudes, asset ownership, age, gender, living arrangements, religion and education among several other observable factors. The different explanatory variables in the regression analysis therefore include measures of attitude (whether justifiable to beat wife), asset ownership which is a good proxy for wealth of the individual, age, gender, religion and level of education. Besides the explanatory variables described above, we have included three more interesting variables in our regression analysis. These include (i) whether the individual lives with her/his own biological mother, (ii) if the individual has ever attended school and (iii) if the individual has ever been married or lived with someone as if married. The hypothesis for the first is that children who live with their biological mothers are less likely to face violence. The hypothesis for the second variable is that children who attend school are more prone to peer violence and physical violence from teachers and figures of authority, as the summary statistics highlighted in Table 3. The hypothesis for the third variable is that children who are either married or living in a marriage –like arrangement are more prone to sexual, emotional and physical violence from their partners, as highlighted by Table 3.

The results show that there is no significant relationship between likelihood of facing violence and gender. Boys and girls are both equally likely to have faced violence, as per the VACS data. In two out of the four countries, we see that when individuals support and justify wife beating, they are more likely to have faced violence themselves. Once again, actual incidence of violence reinforces and in turn is reinforced by individual's attitude and values. The OR tell us that individuals who justify wife beating have 1.9 and 1.6 times higher likelihood of having faced violence themselves, compared to their peers in Tanzania and Kenya respectively. The results show that individuals who live with their biological mothers are less likely to have faced some form of violence, and it is consistently a strong result in three out of the four countries we analysed. The OR show that individuals who live with their mothers are .67, .71 and .54 times less likely to have faced violence than their peers who do not live with their mothers, in Cambodia, Kenya and Swaziland respectively. Similarly individuals who reported to have 'ever attended school' are significantly more at 5.56, 1.84 and 5.85 times more likely to have faced some form of violence than their peers who have never attended school in Tanzania, Cambodia and Kenya respectively. This can be understood by the fact that teachers and 'authority figures' are common perpetrators of different forms of childhood violence as reported in Table 3. Peer violence from classmates and 'friends' is also common and likely to arise more when children attend school, compared with when they do not. Here the individual level data is analysed at the country level, so the results must be understood in that context. So while Muslim children in Kenya have 25% higher odds of facing violence compared to their peers from other religions, Protestants in Tanzania report 56% higher odds of facing violence compared to their peers from other religious groups.

We sharpen the analysis by incorporating country fixed effects into our regression methodology. The results from this are reported in Table 5. These are the OR from logit regressions using the pooled data for all the 10,042 individuals in the age group of 13–24 years from four countries. The analysis is done using country fixed effects, so the ORs must pick up a statistically significant relationship over and above the country level variations. Since all the countries do not have all the explanatory variables that we are interested in analysing, we report results from pooled regressions using four specifications, as reported in the four columns in Table 5.

The first regression is without Swaziland because it only has women respondents in the survey and the survey does not have attitudinal information. The second regression is

without Cambodia because there is no information on religion for Cambodia. The third regression specification involves all the four countries and adds all relevant explanatory variables including education and religion as controls in the analysis. The last column reports the results from a pooled regression using a sparse specification such that no observations are dropped, we therefore have all 10,042 individuals in the final specification. In this sparse specification, however, we have to drop controls such as attitude, religion and education. As one can see, the main results, however are consistent across most specifications.

People's attitude to wife-beating is a strong predictor for whether they have faced violence themselves. As our main results show, individuals who justify wife-beating have 1.44 (and 1.9) times the odds of facing violence than those who do not support wife beating. This is statistically and economically a strong result. It is also consistent with the country level analysis using VACS data in Table 4. Contrary to popular belief, wealth seems to be positively correlated with incidence of childhood violence. As the results on the asset index show, consistency, for all specifications, people from richer households report higher incidence of childhood violence. This is a consistent result across all four columns. Though statistically these results are significant only at the 90 confidence interval, the economic significance as shown by the magnitude of the OR is worth noting. Individuals with higher asset ownership are more likely to have faced violence of some form in their childhood.

Once again, and not surprisingly, gender doesn't seem to affect odds of facing violence in childhood. Both boys and girls report high incidence of childhood violence and there is no statistically significant difference between the two genders in likelihood of abuse. The results on 'age' show that older the individual, the higher the odds of him/her having faced some form of violence. The two factors, beside individual attitude and asset ownership, which significantly explain childhood violence in this data are 'ever attended school' and 'ever been married or lived as if married'. Once again, these are consistent with previous findings from country level analysis for each of the four countries in Table 4. Every specification in the pooled regressions of Table 5 shows a significant OR for 'ever attended school'. Column 4 results show that individuals who have ever attended school have more than 4 times the odds of facing some violence than those who have not attended school. This is consistent with teachers and authority figures being significant perpetrators of physical violence and classmates being involved in peer violence.

In terms of married youth being at higher risk of facing violence, the pooled regressions are once again consistent with the country level results. Each of the four specifications show that being married or in a marriage like arrangement significantly increases the odds of facing violence. Column 4 specifically shows that individuals who are married have a 1.2 times higher odds of facing violence than those who are not married. Since partners are the main perpetrators of sexual violence and also significant afflicters of physical and emotional violence, this result is in line with our summary statistics in Table 3. The pooled regressions also show that Protestants in the population have .5 times lower odds of facing violence than people from other religions. This is a consistent result across specifications.

Discussion

We conduct econometric analysis using data from four countries collected through the VACS. We have more than 10,000 observations from four countries – Tanzania, Cambodia, Kenya and Swaziland. The data covers details of physical, emotional and sexual violence faced by individuals in the age group of 13–24 years of age. The data reveals evidence on

violence faced by children worldwide, and our findings are broadly consistent with the existing literature. There is no gender difference in the overall incidence of childhood violence. Boys and girls are equally likely to face violence. The data shows that 78% of girls and 79% of boys have suffered some form of violence before the age of 18 years.

The analysis reveals that the odds of childhood violence are higher among richer households, among individuals who have attended school and among individuals who have been married or in marriage-like arrangements. The data also reveals that most forms of violence against children – physical, emotional and sexual – are perpetrated by people known to them in their homes and community, and not strangers. Teachers and parents are the highest perpetrators of physical violence while relatives are the most common inflictors of emotional violence. Data on sexual violence shows that while partners are the most commonly reported perpetrators of sexual violence, approximately 40% of boys and girls report that neighbours and family members have been their sexual offenders. Authority figures in the community, who could be employers, religious leaders, community leaders, police and soldiers, have also been reported to be perpetrators of all three forms of violence against children.

We find that there is no gender difference in the overall incidence of childhood violence, which is faced by approximately three-fourths of all children. Boys and girls are equally likely to face violence. There are, however, variations in the nature of violence between girls and boys where girls face more sexual violence while boys report higher emotional violence, and both are equally likely to report physical violence. The age distributions of childhood violence for boys and girls also look very similar, with the highest likelihood of violence in the age group of 6–11 years of age. Our results reveal another consistent finding regarding people's attitude to violence. Attitudes are correlated with actual incidence of childhood violence faced by individuals. We find that individuals who justify wife beating are significantly more likely to have faced childhood violence themselves. Given the nature of the data, it is difficult to establish the direction of the causality in the relationship between actual violence and attitude towards violence. However, these results indicate the potential significance of changing mind-sets as a policy priority to tackle violence against children across the world. The individual level data analysis reveals that possibility of childhood violence is higher among richer households, among individuals who have ever attended school, who don't live with their biological mother, and among individuals who have been married or in marriage-like arrangements.

The data also reveals a disturbing fact that most forms of violence against children – physical, emotional and sexual – are perpetrated by people known to them in their homes and community. Strangers account for a much smaller proportion of childhood violence. Teachers and parents are the most common perpetrators of physical violence while relatives are the most common inflictors of emotional violence. Data on sexual violence shows that while partners are the most commonly reported perpetrators of sexual violence, approximately 40% of boys and girls report that neighbours and family members have been their sexual offenders. Authority figures in the community, who could be employers, religious leaders, community leaders, police and soldiers, have also been reported to be perpetrators of all three forms of violence against children.

Limitations

The main concern with empirical estimates like this paper, is the lack of complete and consistent data availability. Our estimates, similar to the remaining literature, relies on data

for few forms of violence across select countries. Given this broad limitation, our main results are consistent internally, across various data and specifications.

Conclusion

Recognizing the seriousness of childhood violence as a health, social and human rights concern globally, the United Nation's Sustainable Development Goals expanded its scope to include an agenda to end all forms of violence against children globally. Recent literature has documented the magnitude of violence against children and the results are overwhelming. A statistical analysis carried out by the United Nations Children's Fund, (UNICEF 2014), reports that 60% of children experience physical punishment on a regular basis, and worldwide, nearly one in three adolescents face bullying on a regular basis. There is, however, little understanding about the factors that explains the various forms of violence in childhood. This paper uses individual level data for four countries and our analysis highlights some of the key factors that can explain the phenomenon of childhood violence globally.

Note

1. Hillis, Mercy et al. (2016).

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Appendix 1. Definitions of variables used in analysis

Justifiable to beat wife	If the respondent thinks that a man has the right to beat his wife
Lives with mother	Whether the biological mother of the respondent stays in the house with the respondent
Ever attended school	If the respondent has ever attended any form of schooling
Female	If the respondent is female
Ever married or lived with someone as if married	If the respondent has ever been married or has ever lived with a partner as if married
Age	Age of the respondent
Muslim	If the respondent follows the religion of Islam
Traditional	If the respondent follows traditional beliefs and practices of African people
Catholic	If the respondent is a Catholic Christian
Protestant	If the respondent is a Protestant Christian
No religion	If the respondent does not practice any religion
Primary education	Standard 1–7 (Tanzania) Grade 1–7 (Swaziland) Grade 1–6 (Cambodia) Standard 1–8 (Kenya)
Secondary education	Form 1–6 (Tanzania) Grade 8–12 (Swaziland) Grade 7–12 (Cambodia) Standard 9–12 (Kenya)
University education	Education for 3 years or more after advanced secondary education (Tanzania) Post – secondary level of education from age 19 (Swaziland) Education after upper secondary (Cambodia) 4 years of post-secondary education (Kenya)
Emotional violence	If the respondent has ever experienced being called bad names, made to feel unwanted or threatened with abandonment
Physical violence	If ever any parent, current or previous partner or any other person has kicked, punched, whipped, slapped, pushed, threatened to use knife or any other weapon to harm the respondent
Sexual violence	If ever anyone tried to touch the respondent sexually without consent, attempted forced sex with or without success or pressured the respondent to have sex
Any violence	If the respondent has suffered any emotional, physical or sexual violence

Note: All variables except age are dummy variables where Yes = 1 and No = 0.

Appendix 2. Definitions in VACS

Attempted unwanted intercourse	Act in which perpetrator tried to make the respondent have sexual intercourse when he or she did not want to, but the assailant did not succeed in doing so
Child	Any person under the age of 18
Child sexual exploitation	Children receiving money or goods in exchange for sex: any person under 18 who received money or goods in exchange for sex
Coerced intercourse (Tanzania)	Act when a perpetrator pressured or non-physically forced the respondent to have sexual intercourse against his or her will
Coerced intercourse (Swaziland)	Act in which a man or boy persuaded or pressured the respondent to have sexual intercourse against her will
Female genital mutilation/cutting	Procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons
Physically forced intercourse (Cambodia)	If anyone ever physically forced the respondent to have sexual intercourse of any kind regardless of whether the respondent did or did not fight back
Physically Forced Intercourse (Tanzania/Swaziland)	Act in which a perpetrator physically forced the respondent to have sexual intercourse against his or her will

(continued)

Appendix 2. (*Continued*).

Pressured Intercourse (Cambodia)	If anyone ever pressured the respondent in a non-physical way, to have sexual intercourse of any kind when they did not want to and sex happened
Sexual intercourse	Sexual Intercourse refers to anytime a male's penis enters someone else's vagina or anus, however slight
Sexual intercourse for females	Includes someone penetrating a female's vagina or anus with their penis, hands, fingers, mouth, or other objects, or penetrating her mouth with their penis
Sexual intercourse for males	Includes someone penetrating a male's anus with their penis, hands, fingers, mouth, or other objects, or penetrating his mouth with their penis; this can also include someone forcing the male's penis into their mouth, vagina, or anus
Unwanted completed sex (Cambodia/Kenya)	A combination of physically forced and pressured sex as defined above
Unwanted touching (Cambodia)	If anyone, male or female, ever touched the respondent in a sexual way without their permission, but did not try and force the respondent to have sex of any kind
Unwanted touching (Swaziland)	Act of perpetrator in which a man or boy forced the respondent to touch his private parts against her will, but he did not force her to have sexual intercourse
Unwanted touching (Tanzania)	Act when a perpetrator touched the respondent against his or her will in a sexual way, such as unwanted touching, kissing, grabbing, or fondling, but did not try to force him or her to have sexual intercourse
Unwilling first sex	First sexual intercourse was pressured, lured, tricked, or physically forced

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Child violence experiences in institutionalised/orphanage care

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ABSTRACT

Institutions are not necessarily good environments for children. In the face of challenges such as HIV, Ebola, poverty, conflict and disaster the numbers have grown rather than reduced. Some countries have closed institutions down –driven by findings that cognitive developmental delay is associated with institutional care. Yet insight into abuse and violence within institutionalised settings is neglected. Maltreatment -violence and abuse -may be an issue. This systematic review series addresses violence and abuse experiences in institutionalised care, exploring firstly the frequency of abuse/violence in institutions, secondly any interventions to reduce such violence or abuse and thirdly the perpetrators of such violence or abuse. The final systematic review updates the findings on cognitive delay associated with institutionalised care. With a violence lens, cognitive delay may well be considered under the umbrella of neglect. Maltreatment and abuse may be a driver of cognitive delay. The keyword search covered several electronic databases and studies were included for data abstraction if they met adequacy criteria. Eight studies were identified on the prevalence of abuse in institutions and a further three studies reported on interventions. Only one study was identified documenting peer on peer violence in institutions. Sixty-six studies were identified examining cognitive development for institutionalised children. All but two of these record cognitive deficits associated with institutionalisation. Only two asked about violence or abuse which was found to be higher in institutionalised children. Overall the abuse experiences of children in institutions are poorly recorded, and in one study violence was associated with high suicidal attempts. The major intervention pathway for ameliorating cognitive challenge seems to be placement out of the institutions which shows benefits and redresses some cognitive outcomes – yet not a total panacea. The single study providing training and monitoring of harsh punishment and maltreatment showed immediate and decided reductions. This data suggest, despite the paucity of studies, violence and abuse, by commission or omission is prevalent in institutions, has an effect on child well-being and is amenable to intervention. Simple training or more complex structures to place children within conducive alternative environments (or to avoid institutionalised placements in the first place) seem to be the main pathway of intervention.

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Background

The way in which children are cared for has a profound effect on their development (Engle et al., 2007) with lifelong implications (Campbell, Conti, Heckman, et al., 2014; Walker, Chang, Powell, Simonoff, & Grantham-McGregor, 2006; Walker, Chang, Vera-Hernández, & Grantham-McGregor, 2011). For most children care takes place within the family which is seen as protective (Fluke et al., 2012) – with initiatives set up to explore ways of ensuring the wellbeing of children outside of family care (Maholmes, Fluke, Rinehart, & Huebner, 2012). Yet there are multiple forms of alternative care arrangements for children, either as a result of interruptions in normative patterns or variations of culture and background. Such flexibility of approach includes single, dual or multiple parenting, nuclear or extended families, child headed households, adoption or foster caring. In the absence of families or designated adults, orphanages or institutionalised care arrangements have also evolved – either formally or informally. The drivers of such institutions have ostensibly been orphanhood, but on closer scrutiny there are often other drivers including illness, poverty, culture, politics or societal challenges such as war, conflict, disaster and displacement/migration (Williamson & Greenberg, 2010). Both push and pull factors have been identified, with the funding flows and commercial factors being issues not to be overlooked in the establishment and sustaining of institutions (Rotabi et al. 2016).

Both child survival (in the Millennium Development Goals) and thriving (now captured in the Sustainable Development Goals) are acknowledged as important global aims. In recent times the importance of early child experience has been consolidated in the evidence base both in terms of short and long term outcomes (Black & Hurley, 2016; Dua et al., 2016). Such outcomes cross a wide spectrum of achievement including education, employment, wellbeing, mental health and intergenerational parenting to mention a few. The advent of brain sciences has also highlighted the importance of the early years as brain cells proliferate, and early childhood is seen as an extremely important phase of development (Phillips & Shonkoff, 2000). The global community has begun to question institutionalised care arrangements – often triggered by the fact that children in such environments have been observed as neglected in some form. A series of systematic reviews and insights into cognitive development has shown that institutionalised care is invariably associated with poor cognitive development (Berens & Nelson, 2015; Johnson, Browne, & Hamilton-Giachritsis, 2006; Van IJzendoorn, Luijk, & Juffer, 2008). The picture, however, is complex. The literature also shows that disability in its own right is a predictor of institutionalisation and the cause and effect mechanisms are hard to disentangle. In this era of evidence based understanding it is also a challenge to ever understand true causal pathways, as random allocation to institutions could never be ethically defended. Indeed the current advice is the closure and non-utilisation of institutions in the first place. However, the astute studies can provide some rigour in interventions where random allocation to subsequent care environments has been possible and these have shown a number of key findings. Of note from these studies is the fact that the subsequent progress of children can be examined more scientifically in randomised controlled trials. For example, children randomly allocated to family care versus remaining in the institution fare better, those with cognitive delays show evidence of catch up and a detailed examination of the findings also show that age of placement and duration of stay in the institution are key predictors of subsequent achievement.

At this point in time there are a number of factors at play that should be considered. A series of systematic reviews have shown negative cognitive outcomes associated with

institutionalised care (Berens & Nelson, 2015; Johnson et al., 2006; Van IJzendoorn et al., 2008). Growth has been shown to be dramatically effected (Van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2007). Enabling attachment has been questioned (Vorria et al., 2003; Zeanah, Smyke, Koga, Carlson, & the Bucharest Early Intervention Project Care Group, 2005). Some countries have dismantled such forms of care (e.g. UK, USA) while some are in the process of so doing (e.g. Ethiopia, Malawi, Rwanda, Georgia; Greenberg & Partskhaladze, 2014). A review in 2006 (Johnson et al., 2006) demonstrated that optimal child development was not facilitated by institutional care. Van IJzendoorn et al. (2011) propose that children exposed to institutional care can suffer from what they call 'structural neglect' which combines environmental challenges such as minimum physical resources, challenging staffing patterns and inadequacy in caregiver-child interactions all of which can impact child development. They note that the evidence is still unclear on the inevitability of irreversible scars and explore different institutional and child factors that may contribute to averting or compounding difficulties. Furthermore they suggested that lengthier periods of residence in such care were related to risk of harm to developmental trajectories – both physical and psychological. Such policy change needs to consider the mechanisms for dismantling such institutions, the handling of current residents in such environments, and the transition phases to new provision. At all times the primary consideration needs to be the needs and rights of the child.

At the very time when there is sound knowledge on the hazards of institutionalised care, there are clear warnings and cautions around diversion of funds and there is concern around problems such as orphan tourism (Richter & Norman, 2010). It is important to note that rather than declining in numbers there is a growth of institutions and orphanages to care for children globally. This has been driven by a number of factors. HIV infection and AIDS as an epidemic directly affected a number of countries, causing premature death among young adults and thus affecting child care provision and the level of orphaning among young children (Belsey & Sherr, 2011). The advent of HIV treatment and its global roll out has played a part in averting this situation, but full coverage and historical death rates have not removed the crisis resulting in a sudden and perhaps urgent need for alternative care provision where traditional safety nets were stretched to breaking point (Dawson, 2013; Foster, 2007; Heymann & Kidman, 2009; Seeley et al., 1993; Zagheni, 2011). This is not confined to HIV infection, and was seen as an issue in the recent Ebola outbreaks and high death tolls in Western Africa (Evans & Popova, 2015). Many forms of institutions proliferated to accommodate or care for such orphans. Conflict and poverty have also fed into the cycle of family breakdown and alternative care provision. Other drivers include disaster either natural or man-made, which has resulted in the abrupt breakdown of family care. Some children experience maltreatment prior to institutionalisation (Morantz, Cole, Ayaya, Ayuku, & Braitstein, 2013) and poverty and the strains of family life may have driven the placement of children in institutions.

The link between orphaning and orphanage placement of children is not direct. Many children in orphanages have surviving parents – i.e. they are not orphans; and many children who are orphaned are not in orphanages (Sherr et al., 2008). The care needs of older children or those with temporary requirements may differ from the traditional view of long term early orphanage placement and a variety of alternative provisions have emerged which may cloud the picture and affect the evaluation when different forms of care are being compared. Funding flows are often targeted on orphanage care which makes unfunded community

comparisons difficult methodologically as economic security may not be equal among groups. This can particularly cloud outcomes which are economically dependent – such as school enrolment. Transitional care may also not be equated with long term care. For example many infants move through transitional care en-route to international adoption. It is unclear how these infants compare to those who are cared for long term in institutions – even if eventually they are moved to adoptive families – national or international. Early studies differentiated between group homes and large impersonal institutions – showing the former to provide a more acceptable care environment. Subsequent evaluations need to differentiate between these for accurate insight.

From the standpoint of the violence literature, one can commence to examine institutionalisation as a form of neglect. Such child neglect is itself a neglected type of maltreatment considered in scientific research (Stoltenborgh, Bakermans-Kranenburg, & van Ijzendoorn, 2013). Violence in childhood – together with interventions for its prevention, have begun to provide a series of definitions for violence experiences as well as formulations to explore violence contexts. It seems that definitions provide a detailed continuum marked by severity of violence acts – both in terms of objective perpetration and subjective experience – as well as frequency or chronicity of exposure. Violence against children can be seen as both commission and omission. Commission refers to abuse, harsh punishments, physical psychological and sexual violence, whereas omission encompasses neglect and absence of positive experiences. Many researchers have tried to divide violence experiences according to home, school and community. Within this it is important to locate the effects of institutionalisation on children (Johnson et al., 2006). One could argue that neglect – or the failure to thrive and develop in the context of cognitive development – would be one ramification to explore. Secondly there are a number of anecdotal accounts of severity of experience within institutionalised care which would fall under the harsh punishment and abuse umbrella. These accounts – often in the popular press or within legal court proceedings – examine factors such as sexual and physical violence experience. Yet many of these are retrospective recollections and recall.

It seems timely to provide some definitive systematic review evidence on violence experiences for children in institutionalised/orphanage care. This review was thus set up to provide an up to date synthesis in the area. It was set up to examine a series of interlinked questions

(1) What is the prevalence of abuse or violence in institutionalised care? Can this be disaggregated and explored as staff/adult to child violence and peer on peer violence?
(2) What interventions have been utilised to reduce violence in institutionalised care?
(3) If cognitive delay is construed as neglect, what is the up to date evidence on cognitive delay within institutionalised care. This question has previously been addressed in a series of reviews, and this review will summarise these and update the findings.

Method

Search strategy

A series of systematic searches were undertaken in March 2016 to provide data for this review. The review was conducted according to guidance from the PRISMA 2009 checklist

(Moher, Liberati, Tetzlaff, & Altman, 2009), flow diagram and informed by the Assessment of Multiple Systematic Reviews to guide methodological quality (Shea et al., 2009). The papers yielded by the search strategies are reported using the PRISMA flow chart in the figures for each section.

Abuse prevalence in institutionalised care

The first was a search to identify studies reporting on the maltreatment of children within institutional care, in order to establish the rate and nature of abuse experienced by children within institutional care. The search strategy involved a key word search of the following electronic databases: PsycINFO (1872–2015), Medline (1950–2015), Web of Science (1900–2015) and Embase (1980–2015) and hand searching. Keyword search terms covering topics such as children, institutional care, development and maltreatment were used to identify relevant studies within databases (see Supplementary material for keyword search terms and number of results for each step within the electronic databases above).

Interventions to reduce abuse in institutionalised care settings

A sub-search was conducted as part of the above search to identify those studies that reported on the use of an intervention to reduce abuse/maltreatment within institutional care. These studies were drawn from the same search that identified articles reporting on prevalence where by a second set of data extraction was carried out to identify studies reporting on any interventions (see Figure 1 for the number of studies included in each set).

Peer violence in institutions

As a follow-up to the first search, a second search was conducted to identify studies reporting on peer violence within institutional care. This search involved a key word search of the databases outlined above and repeated the keyword search term topics with the addition of 'peer violence' (see Supplementary material for the keyword search terms used and the number of studies identified from each electronic database).

Abuse as neglect – updated review of cognitive development in institutions

A final search was conducted to identify studies that reported on the cognitive and social development of children within institutional care. The study involved a keyword search of the PsycINFO (1872–2016) and Medline (1950–2016) in March 2016, electronic databases as well as hand searching. Keyword search terms used topics including children, institutional care, cognitive development and social development to identify relevant studies (See Supplementary material for the keyword search terms used and the number of studies identified from each electronic database). A number of previous reviews on this topic have been conducted and these are summarised, included, and provide a source of references for this up to date data abstraction. This analysis goes beyond the previous reviews in that it explores whether any of the cognitive studies take measures on abuse and subsequently summarises the studies reporting on interventions to reduce the cognitive effects.

Criteria for inclusion

All studies identified with relevant keywords were then read and sorted for inclusion.

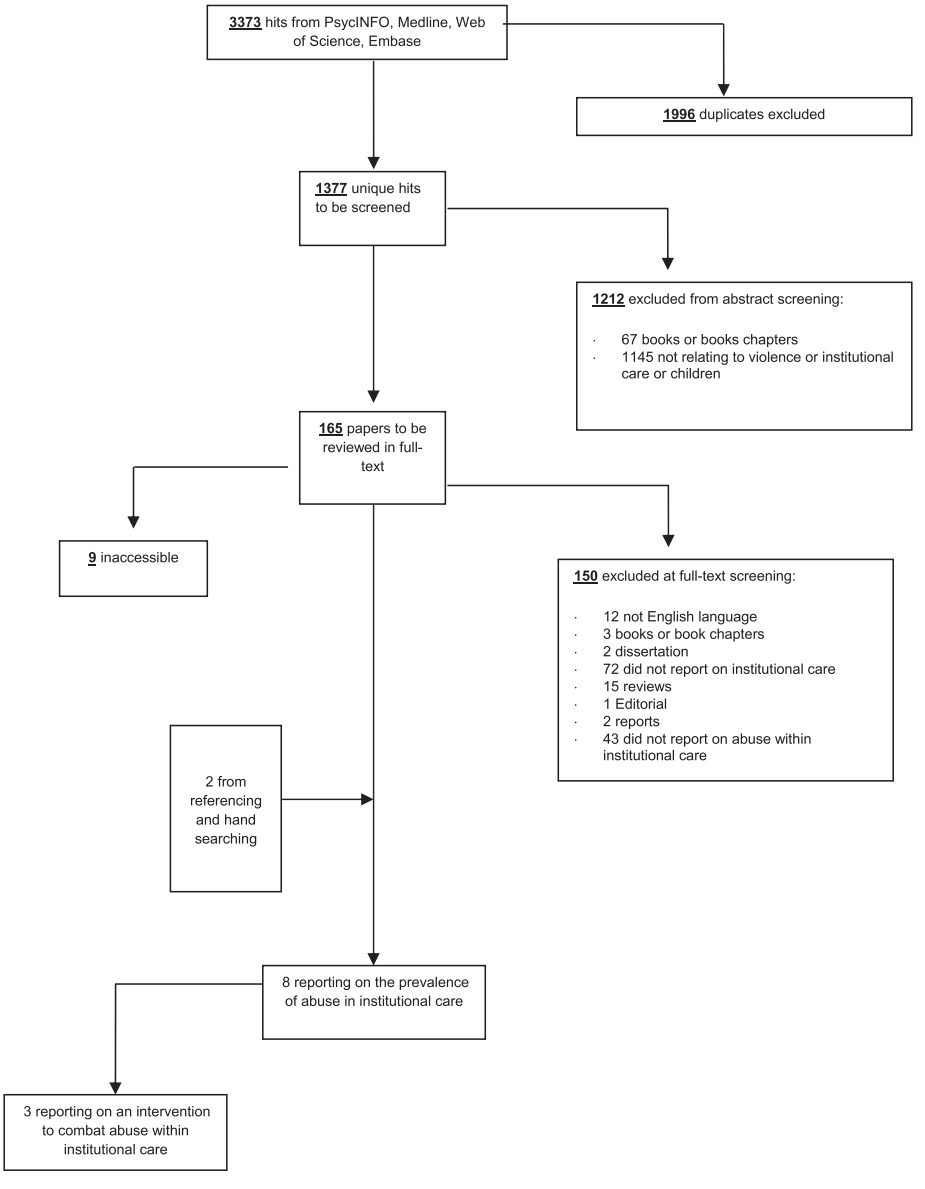

Figure 1. Flow chart: prevalence of abuse within institutional care systematic review – paper inclusion.

Abuse prevalence in institutionalised care

The criteria for inclusion of studies investigating maltreatment were original empirical research papers in English language, the inclusion of children within institutional care and the inclusion of a measure (self-report or observation) of maltreatment (violence or abuse) within institutional care. From this search, studies assessing the prevalence of abuse within institutional care were identified. Children in formal institutional care settings such as prisons, young offender or court ordered care placements or hospitalisation were not included.

Abuse interventions in institutionalised care

From this group, a sub-group of studies were identified from those that included an intervention to reduce maltreatment. These studies were required to meet the above criteria and include a comparison group not exposed to institutional care, a comparison group of some other form, or use a repeated measures design (see Figure 1 for an overview of how studies were excluded at each step).

The initial search generated 3373 hits of which 1996 were immediately excluded as duplicates leaving 1377 unique abstracts for screening. This first screen excluded 1212 abstracts based on 67 not fitting the type of publication criteria (i.e. books) and 1445 not relating to violence or abuse as set out. The remaining 165 papers were reviewed in full text. From the full screen 150 were excluded for not being in English language (12), book, book chapters or dissertations (5), 72 did not report on institutionalised care, 18 were reviews, editorials or reports, 9 were inaccessible and finally 43 had no measure of abuse within institutional care. Remaining papers were then used to track any references which may be applicable. This tracking generated 2 additional papers. The final papers for inclusion allowed for 8 reporting the prevalence of abuse in institutions and 3 reporting on interventions to combat such abuse (see Figure 1).

Peer on peer violence in institutional care

The criteria for inclusion for studies identifying peer violence were the same criteria used to identify the prevalence of abuse. Additionally, measures of maltreatment must have assessed peer on peer violence (see Figure 2 for an overview of how studies were excluded at each step). For the depth exploration of peer violence within institutional care – the paper inclusion flow chart is set out below. Key word searches generated 1391 hits of which 67 were excluded as duplicates and 1324 were screened on abstract resulting in 1267 exclusions and 57 remaining for full text review. On review, 54 were excluded (22 did not report on institutional care, 2 were reviews, 2 were inaccessible, 1 was a qualitative study, 24 had no measure of peer violence and finally 5 were non-academic reports). There was thus only one single paper on peer on peer violence in institutional care which met the systematic review inclusion criteria (see Figure 2).

Effect of institutions on cognitive development – abuse by neglect?

For studies assessing the impact of institutional care on child development (shown in Supplementary material) the criteria for inclusion were original empirical research papers in English language, the inclusion of children within institutional care and the inclusion of a measure (self-report or observation) of cognition or socialisation. The issue of cognitive development and institutionalised care has been the subject of previous systematic and comprehensive reviews (Berens & Nelson, 2015; Johnson et al., 2006). For the purpose of this review, search terms are set out in Supplementary material. All studies meeting eligibility criteria were included and subjected to data extraction. References of existing studies were followed through to add to the database of studies.

Cognitive/social development and institutional care – paper inclusion

As a result 356 hits were made with 29 papers excluded as duplicates leaving 327 unique hits to be screened in full. From these 258 were excluded – 60 as the incorrect type of

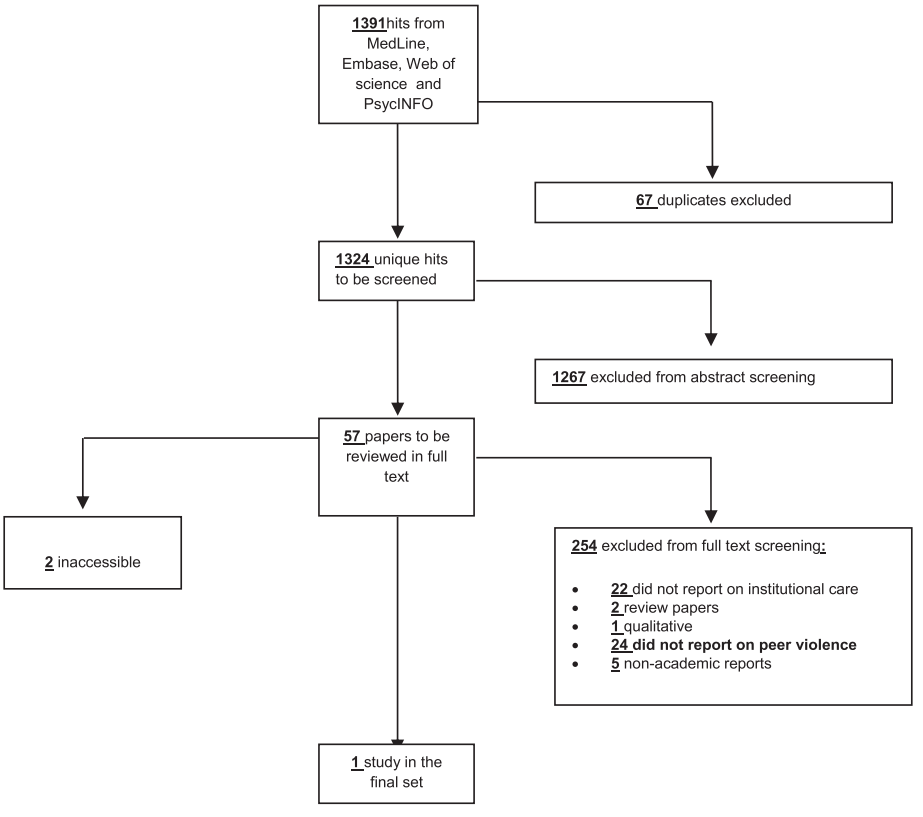

Figure 2. Peer violence within institutional care – paper inclusion.

publication (34 books, 2 non English, 3 case studies, 2 dissertations, and 19 reviews). 175 papers were excluded on sampling or design factors and 23 were inaccessible. Hand searching and comparisons with references from existing short listed papers or earlier reviews generated an additional 20 papers for inclusion. The final set for inclusion comprised 66 studies (see Figure 3).

Institutionalised care definition

The concept of institutional care used within this review includes large institutions dedicated to care for children with employed staff. Thus other institutions such as schools and hospitals were not considered. Our definition was not inclusive of rehabilitative or therapeutic care settings where children with specific identified emotional or behavioural problems may be placed or rehabilitation settings or youth detention settings. Thus studies reporting on violence and abuse within these settings (such as Attar-Schwartz, 2013, 2014; Attar-Schwartz & Khoury-Kassabri, 2015; Khoury-Kassabri & Attar-Schwartz, 2013) were excluded. Additionally, the findings of this review are not inclusive of non-academic surveys reporting on violence and abuse completed by organisations (Harr, 2011; Stavita, 2002) nor thesis or dissertation projects (Rus, 2012).

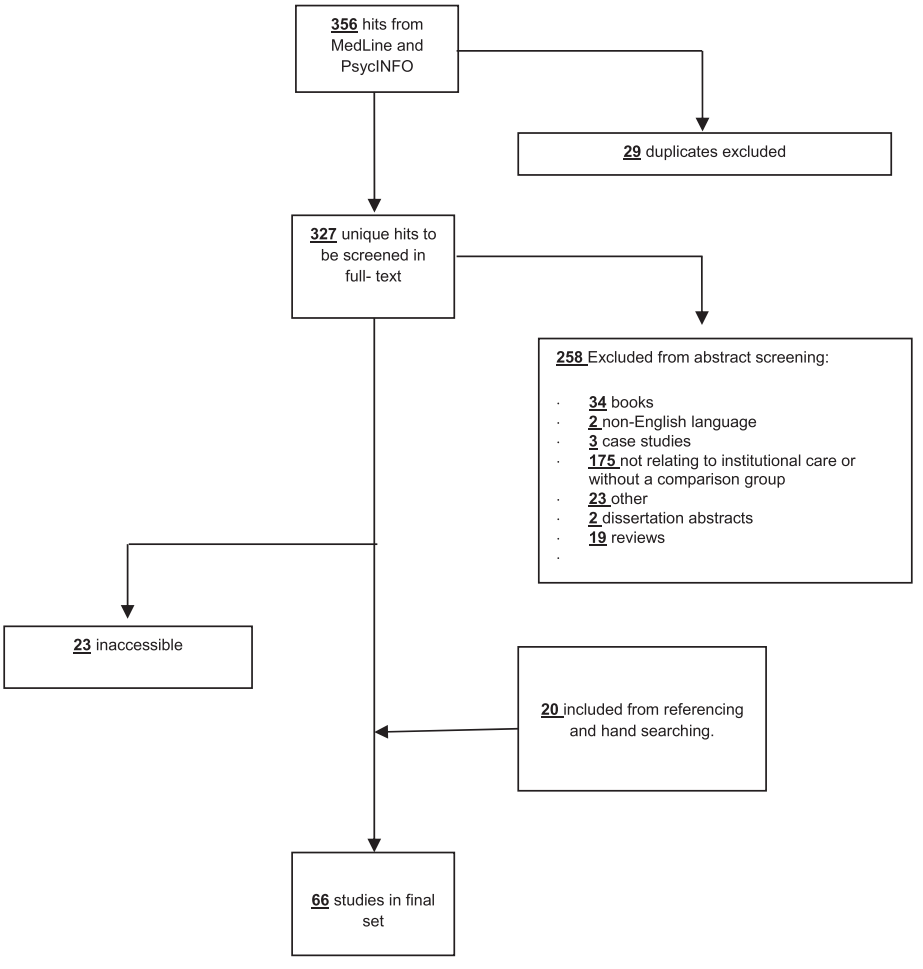

Figure 3. Flow chart: cognitive/social development and institutional care – paper inclusion.

Data extraction

For all four investigations, data extraction was carried out by the creation of a data abstraction database in excel and subsequent detailed interrogation of each full paper. Data from each study was extracted to a common table which had a set of key headings to ensure systematic and compatible insight. This included study, authors, place, date, sample, measures, detail and findings. Extraction was carried out by two psychologists and confirmation/checking and arbitration for final inclusion was carried out by a third psychologist in the team. For the cognitive systematic review, all studies were examined to list location, authors, included sample, cognitive measures, cognitive outcomes and a further interrogation of the studies to specifically add to the data abstraction whether abuse in any form was measured, and what the findings on abuse were (see Figure 3 for an overview of how studies were excluded at each step of the cognitive review).

Results

Prevalence of abuse

Nine studies were identified examining prevalence of abuse in institutionalised settings. This included 2995 children. Despite the long history of abuse with multiple press and media reports, and the searches not being limited by date, such studies are all reported from 2011 to 2015. The studies cover a wide geographical range. Three emanated from Tanzania, two from Romania, 1 each from Kazakhstan, Netherlands and Israel and one multicounty study covered Cambodia, Ethiopia, India, Kenya and Tanzania. The age ranges varied from 7 years to 20 years. Thus there is no data at all on abuse for children under the age of 7 in institutionalised settings. The methodologies of the studies varied in terms of the recall period of abuse and the definitions of abuse. Not a single study used the same measure as another. Measures were either specific measures, derivatives from other measures or study specific questions. These are set out in the box below.

- Self reported if spanked, beaten, screamed or yelled at over three time periods.
- Life Events Checklist (Self reported measure by National Centre of PTSD).
- Maltreatment and Abuse Chronology of Exposure interview.
- Self report on physical abuse, psychological abuse and harsh verbal abuse.
- Survey questions:

(1) Have you been severely punished (beaten) by the staff – and how many times.
(2) Have you happened to be severely punished, inclusively beaten, by the staff.
(3) An adult in the residential care facility or foster family where I lived (1) hit me on the bottom with a hard object; (2) hit me with a fist or kicked me; (3) grabbed me around the neck and choked me; (4) beat me up; (5) burned or scalded me on purpose; (6) hit me on some other part of the body apart from the bottom with a hard object; (7) threatened me with a knife or gun; (8) threw or knocked me down).

Overall the prevalence was high (Table 1). Hermenau, Kaltenbach, Mkinga, and Hecker (2015; Tanzania) noted 93% reporting physical maltreatment at baseline. Gray et al. (2015a, 2015b) noted that 50.3% of 1053 children in institutional care across 5 countries reported physical or sexual abuse with no differences by gender, but more abuse among the younger age groups. Hermenau, Hecker, Elbert, and Ruf-Leuschner (2014) in Tanzania compared reports for children who were institutionalised from 0 to 4 years of age with those 5–14 years of age, and noted that 89% reported at least one experience of abuse, more so among those institutionalised at birth. In a comprehensive country wide study in the Netherlands, Euser, Alink, Tharner, van IJzendoorn, and Bakermans-Kranenburg (2014) found that adolescents exposed to institutional care were significantly more at risk of physical abuse than those in foster care or the general population. Rates for males were 31% and females were 18%. Rus et al. (2013) in a large sample of 1391 children aged 7–20 years, 39.5% recorded severe punishment or beatings by staff – 80% of whom record that this occurred many times and with greater odds for males. In a large (n = 1053) 5 country study, Gray et al. (2015a) predicted 50.3% [95% CI: 42.5, 58.0] of those children within institutional care experienced physical or sexual abuse. In a second study (Gray et al., 2015b) from the same group predicted prevalence of physical and sexual abuse for institutionalised children at age 13 was 49.4% of males and 51.3% of females and 13.6% for males and 12% for females when confined to the last 12 months. Pinto and Maia (2013) reported on 86 children in institutional care and noted emotional abuse for 36%, physical abuse for 34.9%, emotional neglect 57%, physical neglect 45.3% and sexual abuse 21%.

This limited data suggest a pervasive abuse problem for children in institutions, however abuse was defined. When comparisons are available (4 studies) the levels were higher than other forms of care or general population rates.

Peer on peer violence

During the course of the review, the concept of peer on peer abuse or violence within institutionalised settings was discussed and it was felt that a separate review and scan of the literature would be helpful to explore this specific form of abuse to understand if peer on peer violence was exacerbated within institutionalised settings. A thorough systematic review of peer on peer violence was undertaken and papers were sifted for those which provided information on residents in institutional care and orphanage environments. However, with the inclusion criteria and quality needs, the review revealed only a single study reporting on levels of peer on peer violence. This single study (Euser et al., 2014; Table 1) showed 9% of the victims from residential care reported youths of 18 years or older from the residential care facility as perpetrator.

Interventions to ameliorate abuse in institutions

The review identified 3 specific studies aimed at reducing such abuse and relevant to only 152 children (Table 2). Clearly the removal of children from such care environments may be another form of intervention, but these are rarely stated as being an abuse reduction intervention. The three studies include two from Tanzania by the same author (Hermenau et al., 2011, 2015), but seemingly on different groups of children in 2011 and again in 2015. It is unclear whether these are the same children, but in any event the numbers are very small (38 in one study and 28 in another). Both interventions involved caregiver training and as a result child report of maltreatment was reduced at follow up. This went down dramatically from 93% to 50% to 18% from baseline to two post-intervention follow up periods. In this study emotional maltreatment went down and reported depression also decreased significantly. In the Portuguese study, Pinto and Maia (2013) compared 80 children in institutions with 50 in home based care and found abuse higher in institutions. This was the only study in the review that provided specific information on suicidal behaviour, with institutional children reporting the astonishingly high rate of 52.3% suicidal attempts. This was significantly lower for the home based care group (32% $X = 5.28$, $p < .05$), but still notably high.

Abuse and cognitive/social development

A number of previous reviews have been conducted to explore the effects of institutionalised care on cognitive development. These will be briefly summarised prior to the results of this review.

(1) Johnson et al. (2006) searched for studies from 1944 to 2006 and identified 27 studies (involving 1663 children) to examine 3 domains of enquiry – attachment; social and behavioural development and cognitive development. No measures of abuse or violence were reported. From the 12 studies on attachment 11 reported disordered attachment of some form. Of the 17 studies on social and behavioural

Table 1. Prevalence of abuse.

Study	Location	Sample	Measure of abuse	Prevalence
Abuse by staff				
1. Rus et al. (2013)	Romania	1391 (648 female) children within institutional care. Age 7–20 years (*M* 12.86 [SD = 2.8])	Survey question: 'Have you happened to be severely punished (beaten) by the staff?' including both physical and emotional abuse. For 'yes', they were asked: how many times have you been severely punished by the staff? (*Once/ many times*)	39.5% had been severely punished or beaten by the staff - 7.7% once and 31.8% reported many times. Males > severe punishment (OR = 1.79) than females ($p < .001$)
2. Euser et al. (2014)	The Netherlands	*N* = 329: 168 adolescents (38% female) in institutional care (age: 16.1 [SD = 1.43]) vs. 115 adolescents (53% female) in foster care (age: 15.1 [SD = 1.86])	Self- report questionnaire of 24 questions. Eight physical abuse where included (i.e. An adult in the residential care facility or foster family where I lived (1) hit me on the bottom with a hard object; (2) hit me with a fist or kicked me; (3) grabbed me around the neck and choked me; (4) beat me up; (5) burned or scalded me on purpose; (6) hit me on some other part of the body apart from the bottom with a hard object; (7) threatened me with a knife or gun; (8) threw or knocked me down)	Adolescents exposed to institutional care significantly higher risk of physical abuse than foster care (Risk Ratio – 1.9; 95% CI:1.2–3.0) Physical abuse not related to age for any out of home care settings. Males > physical abuse than females (31% vs. 18%) 42% of those physically abused chose not to disclose the perpetrator. Of those who did disclose, (71%) abused by an employee- their perpetrators were other adults (e.g. teachers, security personnel, strangers; 26% in residential care). Two reported more than one type of perpetrator
Abuse by peers				
3. Euser et al. (2014)	The Netherlands	*N* = 329: 168 adolescents (38% female) in institutional care (age: 16.1 [SD = 1.43]) vs. 115 adolescents (53% female) in foster care (age: 15.1 [SD = 1.86])	Same as 2 above	Institutional care significantly higher risk of exposure to physical abuse than foster care (Risk Ratio – 1.9; 95% CI:1.2–3.0) 9% of the victims from residential care reported youths of 18 years or older from the residential care facility as perpetrator
Abuse, perpetrator not specified/measured				
4. Hermenau et al. (2015)	Tanzania	28 (14 female) children within institutional care. Age 7–12 years (*M* 9.79y [SD = 1.45])	Physical maltreatment defined as being spanked or beaten. Emotional maltreatment as being screamed or yelled at. Maltreatment and abuse Chronology of Exposure was used to assess adverse childhood experience over 3 time periods	Physical Maltreatment: 93% reported physical maltreatment at baseline, 50% at time 1 and 18% at time 2. Emotional Maltreatment: 61% at baseline, 32% at time 1, and 79% at time 2. N analysed by age or gender
5. Gray et al. (2015a)	Cambodia Ethiopia India Kenya Tanzania	1053 (551 female) children in institutional care. Age 10–12 years	Potentially traumatic experiences were assessed using the Life Events Checklist (LEC), a self-report measure developed by the National Centre of Post-Traumatic Stress Disorder (PTSD)	50.3% [95% CI: 42.5, 58.0] of children within institutional care experienced physical or sexual abuse. Did not differ by gender however, incidence of abuse higher within younger adolescents (10–13 years) vs. (14–15 years). 6.6% of children within institutional care reported violence within the family or care setting within the previous 12 months compared to 9.1% of children within family based care

6. Gray et al. (2015b)	Cambodia Ethiopia India Kenya Tanzania	1053 (551 female) children in institutional care. Age 10–12 years	Potentially traumatic experiences were assessed using the Life Events Checklist (LEC), a self-report measure developed by the National Centre of Post-Traumatic Stress Disorder (PTSD). This study focused on gender comparisons	Gender specific estimates of abuse within groups were comparable. 50.3% [95% CI: 42.5, 58.0] of those children within institutional care reported physical or sexual abuse. Within the institutional care group the predicted prevalence of physical and sexual abuse at age 13 was 49.4% of males and 51.3% of females. Incidence of physical and sexual abuse within the last 12 months (age 13) was found to be 13.6% males and 12% of females
7. Hermenau et al. (2014)	Tanzania	$N = 70$–35 children who were institutionalised at birth-4 years of age (16 female) vs. 35 children institutionalised at 5–14 years of age (16 female). Interview age mean 10.5 years range 8–15 years)	Structured interview. Adverse childhood experiences were assessed using the Maltreatment And Abuse Chronology Of Exposure Paediatric Interview. This reflected the number of experienced and witnessed types of physical, emotional, and sexual maltreatment by caregivers toward children	62 (89%) children reported that they had least experienced one ACE type in institutional care. Children who were institutionalised at birth-4 years were more likely to experience abuse than those children aged 5–14 years
8. Hermenau et al. (2011)	Tanzania	38 children within institutional care (IC; 47% female, age: $M = 8.56$ years [R: 3–16 years])	Children were asked 41 questions about violence (http://www.vivo.org). At t1 children were asked about the violence they had experienced at home, school, in the neighbourhood and within the orphanage over their life time. At time 2, children were asked about the violence they had experiences in these settings over the past 6 months	At t1 children reported that they had experienced and average of $M = 4.03$ [SD = 3.99], different violent events within the orphanage over their lifetime. At t2 children reported that they had experienced an average of $M = 1.93$ [SD = 2.40], different violence event within the orphanage within the last 6 months. Findings aggregated by age and gender were not presented in this study
9. Pinto and Maia (2013)	Portugal	86 children in institutional care (IC) vs. 50 children in home based care (HBC) vs. 80 in the comparison group. 111 females, age: range 14–23 years ($M = 17.05$ years, SD = 1.8 years)	Children completed ACE study questionnaire - evaluates 10 categories of adverse childhood experiences including Emotional abuse: two items (e.g. 'How often did a parent, stepparent, or adult living in your home swear at you, insult you, or put you down'). A response of often or very often to at least one of the items. Physical abuse: four items (e.g. 'While you were growing up, that is, during your first 18 years of life, how often did a parent, stepparent, or adult living in your home push, grab, slap, or throw something at you?'). A response of often or very often to the first item or sometimes, often, or very often to the second item. Sexual abuse: four items (e.g. 'During the first 18 years of your life, did an adult, relative, family friend or stranger ever touch or fondle your body in a sexual way?'). A response of yes to any of the four items. Emotional neglect: five reverse-scored items (e.g. there was someone in my family who helped me feel important or special). A response of never or once in response to one of the five items. Physical neglect: five items (two reverse-scored items) (e.g. 'I didn't have enough to eat'; 'I knew there was someone there to take care of me and protect me'.)	Children exposed to IC overall reported higher levels of abuse compared to those children in the HBC intervention on self-report measures (emotional abuse: IC [36%] vs. HBC [18%]; $X = 11.36$, $p < .01$; physical abuse: IC [34.9%] vs. HBC [14%]; $X = 14.50$, $p < .01$; emotional neglect: IC [57%] vs. HBC [42%]; $X = 10.21$, $p < .01$; physical neglect: IC [45.3%] vs. HBC [20%]; $X = 22.59$, $p < .01$; sexual abuse: IC [21%] vs. HBC [12.2%]; $X = 2.16$, n.s.). Based on documented abuse reported in official records children in IC greater amount of physical neglect, emotional neglect and sexual abuse when compared to the HBC intervention group (physical neglect: IC [94.1%] vs. HBC [76%], $X = 9.39$, $p < .01$; emotional neglect: IC [38.8%] vs. HBC [32%], $X = .634$, n.s.; sexual abuse: IC [9.4%] vs. HBC [6%], $X = .49$, n.s.)

Table 2. Interventions for violence/abuse in institutions.

Study	Location	Sample	Description of intervention	Measures	Findings	Comment
1. Hermenau et al. (2015)	Tanzania	28 children within institutional care (IC; 14 female; age: *M* 9.79 [SD 1.45])	Training for caregivers of children in IC. Aimed to prevent abuse and improve care quality. Mental health and exposure to abuse within IC assessed at 3 time points; 20 m prior, 1 m prior and 3 m following caregiver training	Structured interview. Maltreatment and Abuse Chronology of Exposure was used. Children's Depression Inventory (CDI), The Strengths and Difficulties Questionnaire (SDQ) and the Reactive-Proactive Questionnaire (RPQ completed	A reduction in reported exposure to maltreatment over time. 93% reported physical maltreatment at t0, 50% at t1 and 18% at t3. Significantly less physical maltreatment at t3 compared to t1, $\chi^2(1) = 4.27$, $p = .018$, and t0, $\chi^2(1) = 17.39$, $p < .001$. Emotional maltreatment for 61% at baseline, 32% at t1, and 79% at t3. Depressive symptomology changed over time, $F(252) = 15.00$, $p < .001$ as did internalising and externalising problems, $F(254) = 12.58$, $p < .001$. RPQ scores reduced over time; t3 to t0, $t(23) = 6.27$, $p < .001$. Findings not aggregated by age or gender	Following the caregiver training intervention, children reported improved caregiving, less physical maltreatment by caregivers, improved mental health and reduced aggressive behaviour. The authors do not comment on the prevalence of violence in terms of gender or age
2. Pinto and Maia (2013)	Portugal	86 children in institutional care (IC) vs. 50 children in home based care (HBC) vs. 80 in the comparison group. 86 children in institutional care (IC) vs. 50 children in home based care (HBC) vs. 80 in the comparison group. 111 females, age: range 14–23 years ($M = 17.05$ years, SD = 1.8 years)	This study assessed psychopathology, childhood adversity, physical health and health risk behaviours among youths who received one of two different protective interventions which comprised movement from family into residential or foster care (HBC vs. IC). Comparisons were made between groups and with a comparison group	Social-demographic questionnaire, brief symptom inventory (evaluating psychological distress), Rotterdam symptom checklist (measure of physical and psychological symptoms), health risk behaviour checklist, ACE study questionnaire (evaluation of adverse childhood experience). Official records grid.	Children exposed to IC overall reported higher levels of abuse compared to those children in the HBC intervention on self-report measures (emotional abuse: IC [36%] vs. HBC [18%]; $X = 11.36$, $p < .01$; physical abuse: IC [34.9%] vs. HBC [14%]; $X = 14.50$, $p < .01$; emotional neglect: IC [57%] vs. HBC [42%]; $X = 10.21$, $p < .01$; physical neglect: IC [45.3%] vs. HBC [20%]; $X = 22.59$, $p < .01$; sexual abuse: IC [21%] vs. HBC [12.2%]; $X = 2.16$, n.s.). Documented abuse in official records IC > physical neglect, emotional neglect and sexual abuse than HBC (physical neglect: IC [94.1%] vs. HBC [76%], $X = 9.39$, $p < .01$; emotional neglect: IC [38.8%] vs. HBC [32%], $X = .634$, n.s.; sexual abuse: IC [9.4%] vs. HBC [6%], $X = .49$, n.s.). No significant differences on risk behaviours. IC group significantly > attempt suicide (IC [52.3%] vs. HBC [32%], $X = 5.28$, $p < .05$)	Significantly higher levels of abuse were identified in the IC group compared to the HBC group. While only one significant difference was found between groups with regard to risk behaviours, attempted suicide was found to be greater in the IC group

3. Hermenau et al. (2011)	Tanzania	38 children within institutional care (IC; 47% female, age: $M = 8.56$ years [R: 3–16 years])	The intervention consisted of a new instructional system which included training for caregivers. Following an initial workshop, the implementation of the system was supervised for 6 months. Additionally, physical punishment was banned and any maltreatment would lead to dismissal. Children over 12 years were informed of ban and received sex education	Children were asked 41 violence questions (http://www.vivo.org). At t1 violence at home, school, neighbourhood and orphanage over their lifetime. At time 2, over the past 6 months. Plus socio-demographic information, physical health, mental health (SDQ), Post-traumatic stress disorder (UCLA PTSD Index for Children), depression and suicidality (Mini-International Neuropsychotic Interview kid for children and adolescence; section A and C) and aggression (reactive–proactive questionnaire).	Violence within the orphanage was found to reduce between t1 and t2 (t1: M 4.48[SD 4.14]; t2: M 1.93[2.40]; t[28] = 3.42, $p < .01$), with Cohen's d indicating a large effect ($d = .86$)	Experiences of violence within institutional care were found to reduce dramatically after the implementation of a training intervention for staff and the introduction of a zero-tolerance policy concerning maltreatment

development all recorded some evidence of negative social or behavioural consequences. Of the 13 studies on cognitive development, 12 reported poor cognitive performance. They noted that the degree of delay varied according to the standard of care provided.

(2) Van IJzendoorn, Juffer, and Klein Poelhuis (2005) carried out a meta-analysis of 62 studies including 17.767 adopted children to compare their cognitive development with those who remained in institutional care or in the family of birth and non-adopted siblings. Van IJzendoorn et al. (2008) provided a meta-analysis of 75 studies covering just under 4000 children from 19 countries to explore cognitive development of children in institutions comparing them with foster family children. They found substantially lowered IQ levels for institutionalised children.

Our review identified 66 studies with developmental outcomes within institutionalised settings for 5640 children (including early adopted children $n = 306$). The detailed data abstract table is set out in Supplementary material. Of the 66 studies identified in this review, measuring cognitive and/or social development within institutional care 45 included specific measures of cognitive development. Of these 45, 42 reported that children exposed to institutional care experienced cognitive deficit and three studies reported no cognitive deficit. These three studies (Whetten et al., 2009; Wolff & Fesseha, 1999; Wolff, Tesfai, Egasso, & Aradomt, 1995 [2 studies – baseline and follow up from the same group]) are all notable. The Wolff et al. study (1995) and Wolff and Fesseha (1999) compared institutionalised children to refugee children – and it is probably important to reflect that both groups suffer hardships and challenge. The Whetten et al. study (2009) which is a large multi-country study compared all children in institutions (defined as group homes with 5 or more children) to community residing peers. The inclusion age was on 6–12 years so does not include younger children) and the observational study did not control for resources allocated to either group. An additional four studies highlighted the detrimental effects of institutional care on cognition indirectly, reporting on social measures and the association between poor social development and cognitive deficit. 16 studies reporting on cognitive and social development randomised children to receive a specific intervention; either movement to a non-institutionalised setting ($n = 15$) or to receive care from staff who had received specific training ($n = 1$). Of the 15 studies reporting on the movement of children to a non-institutionalised setting, 7 studies record cognitive improvements in the children who received the intervention, 4 studies recorded social improvements and 2 studies recorded both cognitive and social improvements within these children. 2 studies (Levin, Zeanah, Fox, & Nelson, 2014; Sheridan, Fox, Zeanah, McLaughlin, & Nelson, 2012) reported on cognitive outcomes and recorded no significant difference between those children within institutional care and those who had received the foster care intervention. The 1 study reporting on a training intervention (Berument, 2013) recorded cognitive improvement although the intervention was found to have no effect on the social development gap (Table 3).

Within the 66 studies identified, 43 studies report on the social and behavioural development of children within institutional care. 41 of these studies found institutional care to have detrimental effects on the development of children. Only one study reported that children within institutional care fair better on social measure compared to children within a control group (Whetten et al., 2009) (Table 4).

Table 3. Summary of studies noting cognitive effects (present, absent or indirect).

Cognitive deficit	No cognitive deficit	No cog. measure but yes social measure	Indirect association – cog. deficit
Sonuga-Barke et al. (2008)	Whetten et al. (2009)	Román et al. (2012)	Rutter et al. (2007)
Rutter + English/Romanian Adoptee Team (1998)	Wolff et al. (1995) – no cog. but social deficit	Fisher et al. (1997)	O'Connor et al. (2000)
Beckett et al. (2006)	Wolff and Fesseha (1999)	McLaughlin et al. (2012)	Croft et al. (2001)
Smyke et al. (2007)		Drury, Gleason, et al. (2012)	Smyke et al. (2010)
Nelson et al. (2007)		Lawler et al. (2014)	
Pollak et al. (2010)		Kang et al. (2014)	
McDermott et al. (2012)		Gabrielli et al. (2015)	
Bos et al. (2009)		Simsek et al. (2008)	
Güler et al. (2012)		Rus et al. (2014)	
Loman et al. (2013)		Erol et al. (2010)	
Govindan et al. (2010)		Simsek et al. (2007)	
Bauer et al. (2009)		Davidson-Arad et al. (2003)	
Tottenham et al. (2010)		Zeanah et al. (2009)	
Mehta et al. (2009)		Lee et al. (2010)	
Sheridan et al. (2012)		Daunhauer et al. (2005)	
Hanson et al. (2015)		Andersson (2005)	
Tottenham et al. (2011)		McGoron et al. (2012)	
Vanderwert et al. (2010)			
Vorria et al. (2003)			
Dobrova-Krol et al. (2010)			
Marcovitch et al. (1997)			
Drury, Theall, et al. (2012)			
Fox et al. (2011)			
Ahmad et al. (2005)			
Beckett et al. (2007)			
Bos et al. (2010)			
Ghera et al. (2009)			
Miller et al. (2005)			
Roy and Rutter (2006)			
Vorria et al. (2006)			
Cermak and Daunhauer (1997)			
Chisholm (1998)			
Johnson et al. (2010)			
Kreppner et al. (2007)			
Lin et al. (2005)			
McLaughlin et al. (2010)			
Stevens et al. (2008)			
Slopen et al. (2012)			
Merz et al. (2013)			
Levin et al. (2014)			
Cardona et al. (2012)			
Berument (2013)			

Within the 66 studies only two measured any form of maltreatment such as abuse, violence or any other harsh punishment or experience. The first showed a relation to amygdalae formation as the outcome (Hanson et al., 2015) and the second showed that children in institutional settings were significantly more likely to experience forms of abuse/violence measured (Whetten et al., 2009 reported in Gray et al., 2015a, 2015b). The latter were drawn from the same five country study of 6–12 year olds where no differences in cognitive outcomes had been identified – yet more abuse was recorded.

It is a stark finding that despite the fact that so many research groups, obviously concerned about the wellbeing and development of children in institutions carried out detailed and depth evaluation of children in institutions and only two included violence measures in their design.

Table 4. Summary of studies showing presence or absence of social development issues linked with institutional care.

Social development issues	No social development issues
Ahemd et al. (2005)	Whetten et al. (2009)
Andersson (2005)	
Beckett et al. (2007)	
Cermak and Daunhauer (1997)	
Chishom (1998)	
Croft et al. (2001)	
Daunhauer et al. (2005)	
Davidson-Arad et al. (2003)	
Dobrova-Krol et al. (2010)	
Drury, Gleason, et al. (2012)	
Erol et al. (2010)	
Fisher et al. (1997)	
Gabrielli et al. (2015)	
Ghera et al. (2009)	
Hanson et al. (2015)	
Kang et al. (2014)	
Lawler et al. (2014)	
Lee et al. (2010)	
Marcovitch et al.(1997)	
McGoron et al. (2012)	
McLaughlin et al. (2010)	
McLaughlin et al. (2012)	
O'Connor et al. (2000)	
Román et al. (2012)	
Rus et al. (2014)	
Rutter et al. (2007)	
Simsek et al. (2008)	
Simsek et al. (2007)	
Slopen et al. (2012)	
Smyke et al. (2010)	
Smyke et al. (2007)	
Sonuga-Barke et al. (2008)	
Tottenham et al. (2010)	
Tottenham et al. (2011)	
Vorria et al. (2003)	
Vorria et al. (2006)	
Wolff et al. (1995)	
Zeanah et al. (2009)	
Wolff and Fesseha (1999)	
Kreppner et al. (2007)	
Stevens et al. (2008)	
Berument (2013)	

Discussion

Abuse and institutionalised care is a subject that merits close and careful examination. Some children are removed from family care into alternative care environments as a result of abuse – yet a clear and full understanding of the abuse experienced in such environments is needed. The strategy of removal may perpetuate rather than avert such abuse. Institutionalised care seems to contribute to the cycles of abuse. What is surprising is the fact that there is so much more to child development and thriving than cognitive development, yet there is an abundance of studies on the effects of institutionalised care on cognitive outcomes, but a dearth on abuse experiences and the consequences. The literature on abuse and violence also suggests that such exposure may directly or indirectly affect cognitive development, and as such there needs to be a more complex lens with which to

view these children. The existing and this updated systematic review clearly demonstrate cognitive delay in children reared in institutionalised settings. Violence in childhood is a topic of current focus (see Violence against children studies [Centres for Disease Control & Prevention (CDC), 2015], UNICEF, WHO and various initiatives), but exploration within institutions is lacking. Prevalence and intervention studies have only reached the published literature in the last 5 years.

High levels of abuse within institutional care have been identified by the reports of organisations such as UNICEF. Children report being physically hurt, beaten and abused by staff and report witnessing the abuse of other children by staff within institutions (Harr, 2011; Stavita, 2002). Rus (2012) also identified high levels of physical punishment by staff within institutions, with the majority of children affected reporting multiple occasions for such punishment. Such experiences may cultivate more generalised abuse, and peer on peer abuse was identified in one study – clearly a topic in need of more detailed examination. The perpetrators of abuse in institutions includes staff, other adults and peers, but is poorly studied. Peer violence has been described in both qualitative and in depth studies (Barter, Renold, Berridge, & Cawson, 2004; Sekol, 2013) and although these studies did nto meet the inclusion criteria for the systematic review, preliminary data suggests that peer violence may be enhanced in residential environments and exacerbated by the subcultures within such environments. It is also important to differentiate studies which include residential care for reasons linked with juvenile correction and legal placement/removal from more traditional institutionalised orphanage type care.

Studies of children within institutions are fraught with difficulties in understanding, comparisons and conclusions. Institutionalised care brings a lot of challenges. All studies need to understand the trigger reasons for the child being placed in the institution in the first place. These may have profound effects on any variables under measurement. The review shows that when randomised controlled methodology is utilised for subsequent placement of children, cognitive delay can be averted and ameliorated. Thus cognitive stimulation neglect, however it is represented, seems to be present in institutions and amenable to change. The broader literature suggests that such catch up is not inevitable or comprehensive (The Leiden Conference, 2012) with indices such as head circumference, social, behavioural, cognitive and attachment measures being explored (Judge, 2003; Van Londen, Juffer, & van IJzendoorn, 2007).

The review concludes that comparison groups matter. For example one study compared institutionalised children to refugee children and found no differences. However, it can surely be concluded that both are negative environments for children. Other studies use comparison groups where one is resourced and the other is not – thus providing inadequate comparisons and as they are not comparing like with like, where poverty is a driver of institutionalised care, conclusions need to be taken with caution. The studies clearly suggest that in terms of cognitive development, age of placement in the institution, age of removal from the institution and duration of stay matter. The younger the placement the worse the outcome. The longer the stay the worse the outcome. The earlier the change and the quicker the change the better the outcome. However, studies also suggest that other environments, such as foster care, are not guarantees of protection for children.

The process of reintegration and children into family has been documented as a potential intervention in the literature, yet no evaluations are to hand (Rotabi, Pennell, & Roby, 2012).

The review also suggests that definitions matter. For example one study included large institutions with any that had 5 plus children. The latter may be better described as a group home. Data that conflates these may be misleading as it is established that a group home is preferable to a large institution. The drivers of institutional placement must be understood and their role in child development disentangled. Such drivers include free food, access to school and school equipment and shelter. Such poverty drivers themselves may be linked with neglect and abuse.

There is a dearth of insights into interventions that work. In the few studies that attempted interventions, mostly from training and monitoring types of programmes, sudden and clear reductions in violence and abuse was recorded. This may reflect social and normative changes and signify a ground shift of opinion on child discipline that reaches these environments. For the most part interventions were seen to be around removal from the institution. The considerable body of studies on such removal show consistent gains for children on many variables. However, it seems that while many children are still cared for in institutions, interventions to address violence are somewhat unpalatable and are not considered, implemented or studied.

Rehabilitative and therapeutic care has also been found to the setting of peer and caregiver violence. A group of large scale studies identified children to be exposed to physical maltreatment by staff (Attar-Schwartz, 2013; Khoury-Kassabri & Attar-Schwartz, 2013), both physical and verbal victimisation by peers (Attar-Schwartz & Khoury-Kassabri, 2015) as well as sexual victimisation by peers (Attar-Schwartz, 2014). Younger children and particularly children with greater levels of adjustment difficulties were found to be particularly vulnerable within these settings (Attar-Schwartz, 2013; Attar-Schwartz & Khoury-Kassabri, 2015; Khoury-Kassabri & Attar-Schwartz, 2013). However this review was confined to specific institutions. A broader look at different types of institutions may be needed. Children in prison or youth detention centres, those in therapeutic residential environments and those in rehabilitative residential settings were beyond the scope of this review. Studies clustering numerous care settings as well as institutional care under the umbrella term of 'residential care' report on both peer and caregiver violence (Attar-Schwartz, 2008, 2009), however, this aggregation leads to a lack of clarity within the data and regrettably does not allow for a specific focus on the prevalence of abuse within institutional settings. For such children pre-existing factors associated with the reasons for their institutionalised care in the first place may be pertinent, but there is potential for harsh treatment, abuse and violence in all types of such settings and our findings cannot easily generalise to these.

Abuse in institutions is confirmed, yet the paucity of studies looking at this, monitoring this or even asking the children is lamentable. Even where large funded studies enter institutions for the sake of detailed cognitive measurement, few consider including abuse measures or bother to examine abuse experiences – a clear driver of cognitive development and attainment.

There are too few studies on interventions to provide a clear picture. Those that exist show that reductions in abuse experience is possible with intervention. Indirect interpretation can also show that removal from institutions can result in cognitive catch up and as such the reversal of neglect is possible. The data suggests that younger children are more at risk of abuse and boys are more at risk of harsh punishments.

The abuse itself breeds subsequent problems. Intergenerational abuse is one potential outcome. Peer on peer violence may be enhanced within institutionalised environments.

The causal factors for this are unclear. Either there is a lack of supervision, peers learn from observation of staff that violence is acceptable, or that the hot house of emotions erupts in elevated peer on peer violence. This may be enhanced by the fact that troubled and difficult to control children may be disproportionately represented among those who are placed in institutions in the first place.

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The impact of humanitarian emergencies on the prevalence of violence against children: an evidence-based ecological framework

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ABSTRACT

Little is known about the patterns and mechanisms by which humanitarian emergencies may exacerbate violence against children. In this article, we propose using the ecological framework to examine the impact of humanitarian emergencies on interpersonal violence against children. We consider the literature that supports this framework and suggest future directions for research to fill identified gaps in the framework. The relationship between humanitarian emergencies and violence against children depends on risk factors at multiple levels, including a breakdown of child protection systems, displacement, threats to livelihoods, changing gender roles, changing household composition, overcrowded living conditions, early marriage, exposure to conflict or other emergency events, and alcohol abuse. The empirical evidence supporting the proposed emergency/violence framework is limited by cross-sectional study designs and a propensity to predominantly examine individual-level determinants of violence, especially exposure to conflict or emergency events. Thus, there is a pressing need to contextualize the relationship between conflict or emergency events and violence against children within the wider ecological and household dynamics that occur during humanitarian emergencies. Ultimately, this will require longitudinal observations of children, families and communities from before the emergency through recovery and improvements to ongoing global surveillance systems. More complete data will enable the humanitarian community to design effective, appropriate and well-targeted interventions.

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Introduction

Violence against children is widely recognized as a critical child protection and health concern during humanitarian emergencies, including armed conflict, political unrest and natural disasters (Apfel & Simon, 1996; Machel, 1996; Silverman & La Greca, 2002). Due

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to a combination of factors (e.g. lack of standardized definitions and tools for measuring violence, a culture of stigma, limited resources and capacity to conduct population-based surveys), it is difficult to quantify the precise magnitude of violence against children in humanitarian emergencies. Still, according to a recent systematic review, numerous studies have documented alarming prevalence rates in settings as diverse as eastern Democratic Republic of the Congo, Afghanistan and Sri Lanka. Both girls and boys are victimized by violence in humanitarian emergencies, albeit in different ways (girls are more likely to be sexually abused and boys are more likely to experience physical violence). Further, in most cases, prevalence rates from the studies in the review did not include infants and young children, suggesting the true prevalence of violence against children is likely even higher than reported (Stark & Landis, 2016). Given the scale of the exposure and the harmful effects of violence against children on individuals' physical, emotional and social development throughout the life-course, as well as its associated impact on national development potential, preventing and responding to violence against children represents a global public health priority (Felitti et al., 1998; Krug, Mercy, Dahlberg, & Zwi, 2002; Pinheiro, 2006).

Yet, while the importance of addressing violence against children in humanitarian emergencies has become increasingly accepted by programmers and policymakers, most prevention and response work is informed by evidence from outside the humanitarian sphere. The recent systematic review found that there has been a spike in research on violence against children in humanitarian settings in the past five years, but overall, these studies still fail to measure and evaluate variables that adequately capture the rapidly changing contextual dynamics caused by conflict, migration and/or natural disasters. As a result, very little is known about the specific patterns and mechanisms by which humanitarian emergencies may exacerbate violence against children or interact with risk factors for violence against children that precede the emergency. The dearth of information available from the existing literature leaves the humanitarian community unable to identify or to mitigate these risks, or to identify protective factors that may contribute to children's resilience. In fact, the basic assumption that humanitarian emergencies necessarily increase violence against children is itself unproven and merits critical evaluation (Catani, 2010; Stark & Landis, 2016). The purpose of this article is therefore to propose a framework for thinking about the impact of humanitarian emergencies on interpersonal violence against children, to consider the literature that supports this framework and finally, to suggest future directions for research to fill identified gaps in the framework.

Framework

Definitions

For our purposes, humanitarian emergencies are defined as circumstances brought about by armed conflict, natural disasters or political unrest that cause 'widespread human, material or environmental losses' and impair the ability of a society 'to cope using its own resources' (Red Cross & Red Crescent, 2012). In keeping with the Sphere Standards, this definition also allows for both slow and rapid onset events, as well as protracted emergencies (Red Cross & Red Crescent, 2011). In addition, a setting is considered an emergency if it occurs within any phase of the humanitarian response cycle, ranging from acute response to early recovery and development (Inter-Agency Standing Committee, 2011).

Violence is defined in terms of four forms of intentional, interpersonal harm: physical violence, sexual violence, mental violence and neglect. Definitions of these forms of violence are drawn from the 2014 UNICEF report on violence against children (UNICEF, 2014). Physical violence is defined as 'all corporal punishment and all other forms of torture, cruel, inhuman or degrading treatment or punishment as well as physical bullying and hazing by adults or by other children.' Sexual violence is defined as 'any sexual activities imposed by an adult on a child against which the child is entitled to protection by criminal law' or 'committed against a child by another child if the offender is significantly older than the victim or uses power, threat or other means of pressure.' Mental violence is defined as 'psychological maltreatment, mental abuse, verbal abuse and emotional abuse or neglect.' Neglect is defined as 'the failure to meet children's physical and psychological needs, protect them from danger or obtain medical, birth registration or other services when those responsible for their care have the means, knowledge and access to services to do so.' Finally, in accordance with the United Nations Convention on the Rights of the Child, children are defined as those under the age of 18 years (UNICEF, 1989).

Relationship between humanitarian emergencies and violence against children

The relationship between humanitarian emergencies and violence against children depends on ecological, household and individual risk factors and this relationship may fluctuate at different stages of the humanitarian response cycle (e.g. conflict and post-conflict). Further, any theoretical model must recognize that the relationship between humanitarian emergencies and violence against children will differ across contexts due to variability in the underlying population characteristics, gender roles and features of the emergency itself (e.g. scale, duration, involvement of civilians, levels of morbidity and mortality, levels of displacement). Brofenbrenner's ecological framework has been influential in drawing attention to the interplay between environmental and social forces and individual behaviors and traits (Bronfenbrenner, 1979). The framework has previously been applied to understanding issues ranging from early childhood education to public health promotion and may also be usefully applied to understand how emergencies affect violence against children.

At the ecological level, humanitarian emergencies are associated with a breakdown of systems, including legal, medical and social services, compared to prior to the emergency (Haj-Yahia & Abdo-Kaloti, 2003; Wexler, Branski, & Kerem, 2006). Informal community groups such as religious associations, school clubs and women's groups and networks of extended family also tend to be disrupted by emergencies and related displacement (Wessells & Monteiro, 2004). These factors lead to weakened community coherence, impaired social support and isolation, all of which make it more difficult for violence against children to be recognized, reported and prevented. In addition, displacement creates situations where populations may resettle to locations where they are perceived as a stigmatized minority, resulting in repeated exposure to discrimination (Stark, Plosky, Horn, & Canavera, 2015). Subsequent 'minority stress' is a risk factor for poor mental health, which is known to exacerbate violence (Charles & Denman, 2013; Pascoe & Smart Richman, 2009). To some extent, the arrival of UN agencies and NGOs may introduce new services and structures to reduce violence against children and 'build back better,' especially in the post-conflict period. However, truly embedding these programs within the social fabric of a destabilized

community is a tremendous challenge (Canavera, Lanning, Polin, & Stark, in press; Training Resources Group & Play Therapy Africa, 2012).

Humanitarian emergencies also have profound economic consequences which originate at the ecological level, but ultimately manifest in households and individuals. Emergencies threaten basic livelihoods and increase poverty and food insecurity (Cliffe, 1994; Drapcho & Mock, 2000). Often these extra financial pressures generate anxiety and tensions amongst parents and caregivers struggling to provide for their children and such feelings can fuel violence. Further, changing economies frequently lead to changing gender roles. For example, men may be unable to maintain their traditional role as 'breadwinner,' and women may take up income-generating activities that would otherwise not have been within their domain. More women and girls may engage in transactional sex or be forced into early marriage, making them vulnerable to violence. In some cases, men may resent these changes to social norms and attempt to reassert their power through violence against their families and others. Men may also be prone to drink alcohol to cope with their shame and boredom, which in turn may contribute to further violence. Alternately, women may become empowered by their new economic roles and be more able to assert their independence from men (Biswas, Rahman, Mashreky, Rahman, & Dalal, 2010; Boutron, 2012; Charles & Denman, 2013; Horn, 2010; Horn, Puffer, Roesch, & Lehmann, 2014; Payne, 1998).

Finally, households and individuals are directly impacted by humanitarian emergencies in a myriad of ways that affect violence. Household composition is regularly altered, especially as able-bodied men join the armed forces, migrate or die, leaving behind disproportionate numbers of women, children and elderly (Brück & Schindler, 2009; Ezeoha, 2015; Hill, 2004). Households may also absorb extended relatives or neighbors, including children who have been separated from their primary caregiver as a result of the emergency (Stark et al., 2016). These changes increase the household dependency ratio and may cause further emotional and financial stress and violence, especially for single parents or caregivers and unaccompanied children (Ezeoha, 2015; Hadley, Belachew, Lindstrom, & Tessema, 2011). At the same time, people are often living in overcrowded housing conditions and may have limited freedom of movement outside the home due to security concerns and/or curfews (Charles & Denman, 2013; Haj-Yahia & Abdo-Kaloti, 2003). Again, these conditions likely increase stress and violence, though it has also been posited that close, multi-family living arrangements may also be protective of violence against children because perpetrators are embarrassed to display violence in the presence of strangers (Usta & Masterson, 2012).

In terms of the direct effects of humanitarian emergencies on individuals, it is important to recognize that the emergency shapes the experiences and behaviors of both adults and children. Both age groups should be considered in tandem to fully understand the dynamics of violence. Adults and children are more likely to witness traumatic events during humanitarian emergencies, including shelling, gunfire, abduction, torture, destruction of property, death of loved ones and domestic abuse between adults in their own household (Haj-Yahia & Abdo-Kaloti, 2003; Qouta, Punamäki, Miller, & El-Sarraj, 2008). Children who witness conflict or other emergency events are also more likely to show signs of post-traumatic stress and displays of anger and aggressiveness, which may provoke violent reactions from parents, caregivers and peers (Qouta et al., 2008). Adults and older children with post-traumatic stress are prone to perpetrate interpersonal violence themselves (Catani, 2010; Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Catani et al., 2009). The effects of post-traumatic stress on violence perpetration have been

documented to persist over the lifecourse and across generations (Devakumar, Birch, Osrin, Sondorp, & Wells, 2014; Saile, Ertl, Neuner, & Catani, 2014). These long-term effects are often compounded by lack of educational opportunities for children growing up in emergencies and permanent disabilities caused by military victimization or other injuries (Charles & Denman, 2013; Qouta et al., 2008).

Evidence

The empirical evidence supporting the proposed emergency/violence framework is limited by cross-sectional study designs and a propensity to predominantly examine individual-level determinants of violence. Despite these limitations, a growing body of quantitative research has consistently found that parental exposure to conflict or other emergency events predicts the perpetration of violence against children, and that this association is highly correlated with children's exposure to conflict or emergency events, post-traumatic stress in parents and children, paternal alcohol use, children's aggressive behavior and parental socio-demographics characteristics like low income and low education (Catani et al., 2008, 2009; Haj-Yahia & Abdo-Kaloti, 2003; Qouta et al., 2008; Saile et al., 2014; Sriskandarajah, Neuner, & Catani, 2015). The directionality between parental exposure to conflict or emergency events and the correlated variables cannot be established due to the cross-sectional nature of the data. This means, for example, it is unknown whether parental low income increases the risk of parental exposure to conflict or emergency events, or parental exposure to conflict or emergency events increases the risk of parental low income. However, the relationship between exposure to conflict or emergency events and violence against children does appear to exhibit a dose-response pattern, with more frequent and severe exposure predicting greater risk of violence against children (Catani et al., 2008, 2009; Haj-Yahia & Abdo-Kaloti, 2003). Further, correlations between exposure to conflict or emergency events and violence against children have been detected decades after the emergency has ended, though measurement of conflict or emergency events may be particularly subject to recall bias in studies with long time lags (Devakumar et al., 2014; Gupta et al., 2009; Saile et al., 2014).

Of note, the literature on the trauma and violence effects associated with acute natural disasters is much more limited than the literature from protracted conflict settings. One study from Bangladesh did find a significant association between exposure to floods and violence against children (Biswas et al., 2010). However, a study from Sri Lanka that measured both Tsunami exposure and war exposure, only war exposure predicted violence against children and in fact, Tsunami exposure was protective. The author hypothesized that the short duration of the Tsunami might have led to a period of family cohesion and that the longer duration of the war hindered similar household dynamics, but this theory is purely speculative (Catani et al., 2008).

In contrast to the relatively robust research agenda to identify individual-level determinants of violence against children in emergencies, knowledge about ecological and household-level determinants of violence against children in emergencies is based on a combination of indirect quantitative evidence and non-representative qualitative narratives. For instance, there are studies that show that emergencies cause changes to household employment status, and there are studies that show changes in employment status increase the risk of violence, but there are no studies that have evaluated the full causal pathway from emergency to change in employment status to violence against children

(Brück & Schindler, 2009; Krishnan et al., 2010). Without this type of longitudinal follow-up in two exchangeable populations with varying levels of emergency exposure, it is impossible to estimate the isolated effects of the humanitarian emergency, rather than the general effects of other economic fluctuations in society. Simplistic comparisons between rates of violence in conflict-affected areas versus stable areas or between rates of violence during times of conflict and times of peace are deeply flawed because such comparisons are obscured by a plethora of residual confounders (e.g. governance, culture) (Catani, 2010; Peterman, Palermo, & Bredenkamp, 2011; Usta & Farver, 2010). Also, without accounting for the ecological and household-level determinants of violence against children in study designs, the aggregate effects of humanitarian emergencies on violence remain unknown. In other words, while exposure to conflict or emergency events seems to increase violence against children, if multi-family living arrangements or greater economic independence for women simultaneously decrease violence against children, capturing the interaction between these variables is crucial to measuring the cumulative impact of emergencies on violence against children.

It is worth noting that qualitative narratives can and have introduced useful insights regarding the complex dynamics driving violence against children in humanitarian emergencies. Qualitative methods have revealed potential mechanisms and depths of understanding about violence that would otherwise not have been evident to researchers, such as awareness of local gender norms, details about living conditions and ideas about how both of these elements have changed as a result of the emergency (Charles & Denman, 2013; Horn, 2010; Usta & Masterson, 2012). Because this type of data is not representative by nature, qualitative studies are not appropriate for definitively describing population-wide trends. Still, qualitative approaches are an essential formative tool in generating hypotheses, developing surveys, explaining perceptions and beliefs and triangulating findings (Bolton, Tol, & Bass, 2009).

Future directions

In synthesizing the theories and evidence on the impact of humanitarian emergencies on violence against children, several research gaps have emerged. First, there is a pressing need to contextualize the relationship between conflict or emergency events and violence against children within the wider ecological and household dynamics that occur during humanitarian emergencies. In what ways do various features of emergencies predict the degree and type of violence against children? Which features are most significant? Do protracted conflicts have fundamentally different effects than natural disasters, and why might this be the case? Does violence against children increase and decrease at different stages of the humanitarian response cycle? If so, how and why do these changes happen and what are the optimal periods in which to intervene to prevent violence? Are there any factors that tend to emerge during emergencies which may be protective of violence against children and can these factors be harnessed as part of interventions?

Ultimately, the answers to these questions depend on causal inference, which will require longitudinal observations of children, families and communities from before the emergency through recovery. Improvements to ongoing global surveillance systems at multiple levels will also facilitate the availability of baseline data when emergencies inevitably, though unexpectedly, arise. The national Violence Against Children Surveys (VACS) that have

been conducted in 11 countries so far are an excellent example of the movement towards better surveillance (Chiang et al., 2016). VAC-type studies should continue to be supported and expanded, with consideration of creating specialized modules for emergency-prone locations and inclusion of community-level data.

For many years, the humanitarian community mistakenly operated under the assumption that HIV prevalence was heightened during conflict. Comprehensive surveillance data from seven countries allowed a rigorous appraisal of this assumption and eventually led to a paradigm shift in understanding and mitigating HIV risk amongst displaced populations (Spiegel et al., 2007). Once again, the humanitarian community must carefully examine its basic assumptions, this time with regards to violence against children. More complete data on violence against children will enable the humanitarian community to design effective, appropriate and well-targeted interventions. Children in emergencies deserve an evidence-based approach to their protection and well-being.

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The impact of polyvictimisation on children in LMICs: the case of Jamaica

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ABSTRACT

Children who experience polyvictimization in high-income countries (HICs) are at higher risk for mental health-related trauma symptoms. There is limited information on the impact of polyvictimisation on children with high levels of exposure, as occurs in some low- and middle-income countries (LMICs). This study investigates the impact of poyvictimization on Jamaican children's intellectual functioning, achievement, and disruptive behaviors. Data from a geographical subgroup (n = 1171) of a 1986 population based birth cohort study were utilised. At age 11–12 years, the sub-group completed questionnaires on exposure to violence at school, at home and in their communities, and tests of academic and intellectual functioning. Their parents completed questionnaires on family resources (socioeconomic status) and children's behaviour. Findings from Structural Equational Modelling indicated that for both genders, exposure to polyvictimisation had a direct negative effect on intellectual functioning, and an indirect negative effect on achievement mediated through intellectual functioning. For boys, polyvictimisation had a direct negative effect on behavioural risk. Family resources was negatively associated with exposure to polyvictimisation. In Jamaica, a LMIC country with high levels of polyvictimisation, there is a significant negative effect of polyvictimisation on children. The secondary- and tertiary-level interventions to address these effects are costly to LMICs with limited financial resources. Prevention of exposure to violence in all its forms is therefore the recommended approach to reduce violence-related morbidity.

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Violence; childhood; LMIC; Polyvictimisation; Jamaica

Background

In the last two decades, there has been the recognition that children are exposed to many different forms of violence. Property victimization (e.g. robbery, theft), personal experiences of physical and sexual assault, maltreatment by caregivers in the home setting and indirect victimization (e.g. witnessing robbery, physical assault, physical domestic violence,

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shooting, war and losing a close friend or family member to violence) have all been included in early instruments designed to measure children's exposure to multiple forms of violence, such as the Juvenile Victimisation Questionnaire and the Child's Exposure to Violence Checklist (Amaya-Jackson, 1998; Hamby & Finkelhor, 2004). A more expanded concept of polyvictimisation has considered current relevant exposures such as internet or cell phone harassment and sexual assault, and peer and sibling assault (Finkelhor, Turner, Shattuck, & Hamby, 2015). Other country-specific questionnaires have considered additional and culturally relevant aspects of violence, such as verbal aggression and corporal punishment perpetrated by teachers or other school personnel and the use of chemically disfiguring substances such as acid (Samms-Vaughan, Jackson, & Ashley, 2005; Samms-Vaughan, in press).

Prevalence studies indicate that in high income countries (HICs), children's exposure to polyvictimisation is high. In the USA, Canada and the United Kingdom, some 70–80% of children have experienced at least one form of violence in their lifetime (Cyr et al., 2013; Finkelhor, Ormrod, & Turner, 2009; Radford, Corral, Bradley, & Fisher, 2013). In low and middle income countries (LMICs) such as South Africa and Jamaica, lifetime exposure to at least one form of violence is considerably higher and experienced by almost every child in the samples in these countries (Kaminer, du Plessis, Hardy & Benjamin, 2013; Samms-Vaughan, Jackson & Ashley, 2005; Samms-Vaughan, in press). However, in some LMICs such as China, the prevalence of exposure to violence is relatively low (Dong, Cao, Cheng, Cui, & Li, 2013). Lifetime polyvictims are defined as the top 10% of those who had multiple experiences of violence, and past year polyvcitims as those who had more than four different exposures (Finkelhor et al., 2009). Similar to lifetime victimization, the prevalence of past year polyvictimisation is also high.

The importance of polyvictimisation lies in its association with a higher likelihood of trauma symptoms, when compared with individual exposures. Finkelhor and Turner reported that experiencing many different forms of victimization is more highly related to trauma symptoms than experiencing repeated victimizations of a single type, and that lifetime exposure to multiple victimizations substantially accounts for the effects of individual victimization types (Finkelhor, Ormrod, Turner, & Hamby, 2005; Turner, Finkelhor, & Ormrod, 2010). In the UK, polyvictims had higher total scores on the Trauma Symptom Checklist (TSCC) than their peers (Radford et al., 2013). In China, an LMIC with a relatively low rate of polyvictimisation, past year polyvictims were more likely to suffer PTSD, depression, suicidal and self-harm ideation than non-victims and victims of one to three forms of violence (Chan, 2013). There are no studies of which the authors are aware in which the impact of poyvictimisation on child outcomes was investigated in LMICs, such as South Africa and Jamaica, with the highest published rates of exposure to polyvictimisation (Kaminer, du Plessis, Hardy & Benjamin, 2013; Samms-Vaughan, Jackson & Ashley, 2005; Samms-Vaughan, in press).

This study uses data from one of the few comprehensive birth cohort studies in a LMIC, the Jamaican Perinatal Morbidity and Mortality Survey (JPMMS) (Ashley, McCaw-Binns, & Foster-Williams, 1988), to investigate the associations of polyvictimisation, including indirect (witnessing) and direct (victimization) community violence, corporal punishment at home and at school and indirect (witnessing) domestic violence with cognitive, behavioural and academic outcomes in 11–12 year old children. The impact of family resources was also investigated.

This study contributes to the literature documenting the potential impact of polyvictimisation on children worldwide, and specifically, on children with exposure to very high levels of polvictimisation, as occurs in some LMICs. It is anticipated that the information provided will be used to assist policy formulation to prevent violence against children in Jamaica, other LMICs, and HICs.

Method

Participants

The participants represent a geographical sub-group of a national birth cohort of 10 500 children identified during the JPMMS of 1986–1987. The birth cohort comprised all children born September and October 1986; the methodology of the birth cohort study is described in detail elsewhere (Ashley et al., 1988). The geographical subgroup included all cohort children resident or attending school in the two most urban parishes in Jamaica, Kingston and St Andrew, from November 1997 to February 1999. Some 25% of Jamaicans lived in these parishes at this time (Population Census, 2001). These 11–12 year old children and their parents had detailed assessments completed as part of a larger study of child development and behaviour in Jamaica (Samms-Vaughan, 2001).

Procedure

As school enrolment in Jamaica was between 97.8 and 100.0% in this age group (Jamaica Survey of Living Conditions, 1996), children were identified by their date of birth from school and Ministry of Education records. Parents were preferentially seen first each morning to facilitate attendance at work. Children were released from regular classroom activities during the school day to allow completion of the full set of questionnaires and evaluations for the larger study.

Measures

This paper confines itself to parent-reported family resources, child reported experiences of violence and child outcome measures of intellectual functioning, academic achievement and behaviour.

Family resources

Family Resources was measured by three separate but related variables: occupation of the head of the household, maternal education and crowding. The occupation of the head of the household is a recognised measure of socio-economic status and is reflective of family income. Occupation was classified into five categories: unskilled, semi-skilled, skilled, technical and clerical, and professional, using a modified version of the Revised Classification of Occupations of the Statistical Institute of Jamaica. Parental education is another recognised measure of socio-economic status; it reflects the likely educational environment in children's homes. As 99.7% of 11–12- year-olds reported the presence of a mother figure, with this being the biological mother for 86.4%, while only 89% reported a father figure, with this being the biological father in only 65.4% (Samms-Vaughan, 2001), maternal/mother figure education was used in preference to paternal/father figure education. Education was classified into four categories, based on completed level of education: primary, secondary,

vocational and tertiary. Crowding, or availability of space in the home, is another common measure of socio-economic status. Primarily a measure of the physical conditions in which children live, crowding is calculated by dividing the number of rooms used for sleeping by the number of persons in the home.

Exposure to violence and poly-victimization

Exposure to violence and polyvictimisation were measured by a child completed Exposure to Violence questionnaire, which contained questions on exposure to community violence, as well as modifications of the original Conflict Tactics Scales (CTS) (Straus & Hamby, 1995) which captured data on verbal aggression and physical forms of violence experienced by children at home and at school, and witnessed among adults in their homes.

Questions on children's exposure to community violence enquired of their lifetime experience as witnesses and victims to fighting, robbery, stoning, stabbing, shooting, gang wars, rape, threats of serious harm, police arrest/detention, use of chemicals (acid), as well as loss of a close family friend or family member to murder and witnessing a dead body following a violent event. As with the CTS all exposures that did and did not use an implement were considered major and minor events, respectively.

The CTS, originally designed to measure disciplinary measures used for children in the home setting has 18 scored items, divided into three scales: reasoning, verbal aggression and violence. The reasoning scale was not administered in this study. Verbal aggression includes threatening, insulting/swearing, spiting, sulking/refusing to talk, stomping out of room/house, and throwing or smashing objects. The violence scale is further sub-divided into minor and severe violence categories. Minor violence includes throwing an object at a child or pushing, grabbing or slapping them. Severe violence includes kicking, biting, throwing objects at children, beating with an object and threating with or actually using a gun or a knife. The CTS was modified for use in Jamaica to account for language and cultural differences; the modified CTS had 11 items. The language was also modified to allow for collection of data on verbal aggression and physical violence experienced by children in the school setting and observed in the home among adults. The details of the modification of the CTS for this study are documented elsewhere (Samms-Vaughan, in press). Many investigators have modified the CTS in different ways (Straus & Hamby, 1997).

Using the modified CTS, 97.2% of Jamaican children reported a lifetime experience of some form of verbal aggression or maltreatment (minor or major violence) from adults within their homes, with any form of verbal aggression at 82.3%, and any form of minor and major violence at 87.4 and 84.8%, respectively. A total of 86.2% of children reported a lifetime experience of some form of verbal aggression or physical violence at school. Any form of verbal aggression at school was at 49.5%, while any form of minor and major violence at school was at 74.0% and 75.4%, respectively. Some 67.5% of children reported observation of verbal aggression or violence among adults at home, with verbal aggression at 67.3%, and minor and major physical violence at 30.8 and 22.0%, respectively. In terms of community violence, children witnessed 4.1 ± 2.2 of eleven possible exposures, and experienced 1.2 ± 1.3 of eight possible violent acts.

Further details of the prevalence of children's witnessing and personal experiences of community violence, and exposure to violence at home, at school and among adults in their homes are documented elsewhere (Samms-Vaughan, in press; Samms-Vaughan et al., 2005).

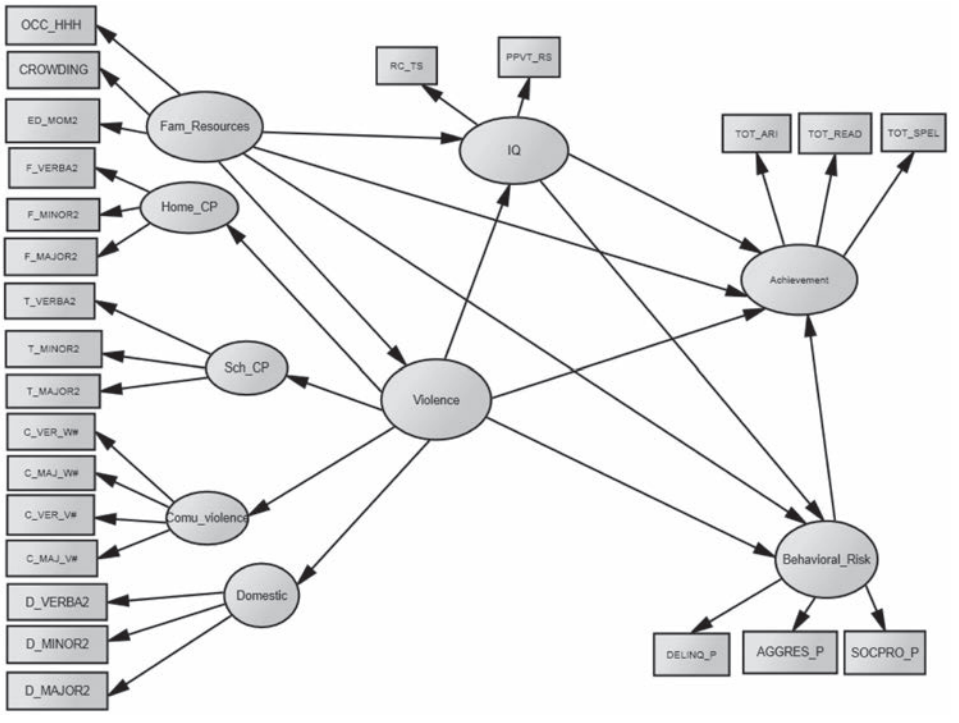

Figure 1. Theoretical structural equation model of violence on variables of IQ, achievement and behavioural risk.

Three first order latent variables were created from the CTS indicators of number of verbal aggression, minor and major violent experiences inflicted by parents/caregivers in the home (Home_CP), caregivers at school (Sch_CP), and observed as family violence in the home (Domestic), as in Figure 1. A fourth (Comu_violence) was created from numbers of experiences of witnessing and being a victim of verbal and physical violence in the community.

Cognitive function

Two measures of cognitive function were administered, the Peabody Picture Vocabulary Test (PPVT) (Dunn & Dunn, 1997), which measures verbal comprehension, and the Ravens Coloured and Standard Progressive Matrices (Raven, Raven, & Court, 1996), which measure deductive reasoning.

These tests were selected for a number of reasons. First, they can be administered in a relatively short time, as compared to more detailed cognitive tests. Second their administration did not require the use of oral language, and would encourage participation by very shy children. For the PPVT, children were asked to point to one picture of four shown which best represented each word called by the examiner. For the Raven's test, children were asked to select from six patterns, the best fit to complete a fourth missing pattern given three existing patterns. Finally the tests had been used previously in studies conducted with Jamaican school children (Grantham-McGregor, Powell, Walker, Chang, & Fletcher, 1994; Walker, Grantham-McGregor, Himes, & Williams, 1994), with high test-retest reliability of .90 to .99 and inter-observer reliability agreement of .96.

A single cognitive latent variable, IQ was created from the raw scores of the cognitive function tests (RC_TS & PPVT_RS) (Figure 1). Both indicators loaded on the latent variable.

Achievement

Academic achievement was measured using the Wide Range Achievement Test (WRAT3) (Wilkinson, 1993). The WRAT3 has three separate academic assessments: reading, spelling and arithmetic. Reading was administered individually, but spelling and arithmetic were administered in groups. Similar to the cognitive function tests, the WRAT has been used in Jamaica previously with acceptable psychometric indices (Grantham-McGregor et al., 1994; Walker et al., 1994). WRAT scores were used to create three indicators which loaded on the latent variable Achievement.

Behavioural risk factors

The Achenbach System of Empirically Based Assessments (ASEBA) questionnaires are widely used measures of child behavioural and emotional functioning internationally. Behaviour reports for children 6–17 years have been extensively studied and psychometric properties have been documented for measuring child and adolescent functioning in Jamaica (Lambert, Essau, Schmitt, & Samms-Vaughan, 2007; Lambert, Samms-Vaughan, & Achenbach, 2006; Lambert et al., 2003). The Child Behaviour Checklist (CBCL) Parent Report, with over 100 questions, identifies eight individual syndromes: withdrawn, somatic complaints, anxious/depressed, social problems, thought disorder, attention problems, delinquent behaviour and aggressive behaviour. The syndromes most likely to be influenced by exposure to violence were those selected for study: social problems, delinquent behaviour and aggressive behaviour. Scores on these dimensions were used as indicators for a Behavioural Risk Factor latent variable (Behavioural_Risk). The CBCL has previously been used in Jamaica and has shown acceptable psychometric indices (e.g. test-retest reliability = .89 and inter-observer agreement .79, see Lambert et al., 1994). More recently, the parent report has been extensively studied and its psychometric properties documented for measuring child and adolescent functioning in Jamaica. (Lambert et al., 2003, 2006).

Data analyses

Simple frequencies were used to report descriptive statistics for categorical variables; means and standard deviations were used to report descriptive statistics for continuous variables.

Analyses were conducted to test the model in Figure 1, using Structural Equational Modelling (SEM). That is, to test the associations among polyvictimisation, cognition, academic achievement, behaviour and family resources among 11–12 year old Jamaican children. We further tested whether the pathways in the model were identical for boys and girls. Prior to testing such models we tested whether the models possessed configural and metric invariance across males and females. Invariance is important, as its absence makes it difficult to approximate true differences or similarities across genders.

Configural invariance

Configural invariance addresses whether the factor structure of measures used are the same as those established when the measures were developed in the USA, including whether the number of factors extracted from one group is the same for another and whether the same

items load on the factors for each group studied (Campbell, Barry, Joe, & Finny, 2008; Lavoie & Douglas, 2012). Confirmatory factor analyses (CFAs) were used to test for configural invariance on boys and girls separately.

Metric invariance

Metric invariance measures the degree to which items load on a given factor and whether such loadings are identical across groups. Campbell et al. (2008) argued that the presence of metric invariance means that the groups studied are likely to be interpreting the items in a similar fashion.

Model fit

CFA and structural equation modelling (SEM) require that the model is appropriately specified and that the covariance structure of the data fit the hypothesized model. That is, there is no significant difference between the covariance structure of the data and that of the hypothesized model (Iacobucci, 2010). Stable SEM parameter estimates require large sample sizes such as that used in the present study. Yet, the chi square which is the only true statistical test for data to model fit in SEM is highly sensitive to large sample sizes. This phenomenon can result in rejection of a well-fitting model if used exclusively. Hence, additional fit indices that are less sensitive to sample size were utilized. If fit indices meet a priori established criteria for model fit, one can more confidently infer that data fits the hypothesized model (Chen, 2007). Indices of absolute fit, such as the Root Mean Square Error of Approximation (RMSEA), measure how poorly fitting a model is; lower values are considered as proxies of better fit. On the other hand, fit indices such as the Tucker Lewis Index (TLI) and Comparative Fit Index (CFI) are incremental fit indices, since higher values are considered to be indicators of better fit. Although Hu and Bentler (1999) have argued that CFI and TLI ≥.95 as well as RMSEA <.08 should be considered as indicators of good data to model fit, others (e.g. Vandenberg & Lance, 2000) have argued that their criteria might be too stringent and that ≥.90 in these incremental fit indices are acceptable cutoffs for good fit, especially if sample sizes are large (e.g., $n > 50$) (see Iacobucci, 2010). Because our sample size is large, we deemed good data to model fit if CFI and TLI are ≥.90 and RMSEA ≤.08

The typical test of invariance has been the chi square difference test ($\Delta\chi^2$). It has been argued that while the chi square test is inappropriate for model testing, $\Delta\chi^2$ test is considered appropriate for comparing nested models. More recently, researchers (e.g. Chen, 2007) have conducted Monte Carlo studies on the use of $\Delta\chi^2$ test in model comparison. Such studies have shown that the standards held for the χ^2 (i.e. where caution underscores that a large sample size such as ours can result in significance and rejection of a good model fit) are not typically held for the $\Delta\chi^2$. Yet, these studies have shown that the $\Delta\chi^2$ is just as susceptible to the impact of sample size as the χ^2. Hence, Chen has shown the use of ΔCFI and ΔRMSEA that are not as sensitive to sample size as an appropriate alternative to the $\Delta\chi^2$. In our case where our sample size is unequal Chen has shown that a change of ≥−.005 in the CFI and ≥.01 in the RMSEA would indicate lack of invariance. These criteria were used for model comparisons in our study.

Table 1. Fit indices for confirmatory factor analysis tests of configural invariance and alternative models.

	Males					Females				
Model	χ^2	df	TLI	CFI	RMSEA	χ^2	df	TLI	CFI	RMSEA
Nonhierarchical	883.61	224	.90	.92	.06	933.50	224	.90	.92	.06
Hierarchical	958.12	238	.90	.91	.06	984.38	238	.90	.91	.06

Results

Descriptive statistics

Of an estimated 2048 children of 11–12 years living in the study areas, 1784 (87.1%) were able to be contacted. Of these, 1720 children participated in the study. This paper is confined to the 1171 (68.0%), whose parents also participated and provided family resource data, obtained from a comprehensive socio-economic questionnaire. The mean age of children in this study was 11.7 ± .3; that of children without parental participation was 11.9 ± .3 ($p < .001$). The difference, though statistically significant, has a small effect size and is reflective of the high power the large sample size afforded. Thus it is of no practical significance. Males formed 48% and females 52% in both groups.

Preliminary test of assumptions

Data assumption

Because our data did not meet criteria for normality (i.e. skewness and kurtosis), a bootstrapping procedure was conducted prior to each set of analyses, where multiple (i.e. 200 bootstrap) samples were extracted from the data and used in the estimate of the populations' sampling distributions.

Testing for measurement invariance

Table 1 shows that CFAs conducted on males and females considered separately yielded good data to model fit for both hierarchical and nonhierarchical models. Intriguingly, the ΔCFI calculated from the results presented in Table 1 shows that the nonhierarchical model might fit the data best for both groups considered separately but the RMSEA values for both boys and girls were identical for both hierarchical and nonhierarchical models. With a χ^2 (476) = 1942.56, TLI = .90, CFI = .91, and RMSEA = .04, the multigroup unconstrained hierarchical measurement model, where pathways for boys and girls were estimated freely showed good data to model fit. Similar incremental and absolute fit indices were evident for the constrained model. Metric invariance was evident for both hierarchical and nonhierarchical models Δ TLI = .00, and RMSEA = .0)

Structural equation modelling

Proposed model vs. alternate model

As indicated above, the evidence for a better fitting hierarchical measurement model (i.e. for violence) than nonhierarchical model, is equivocal. Hence, we treated the hierarchical model as the model of focus and the nonhierarchical as a competing model. With all paths between endogenous and exogenous variables unconstrained, we tested the model in Figure 1

and compared it with the nonhierarchical model. The fit indices for the hierarchical model are χ^2 (476) = 1942.56, TLI = .90, CFI = .92, and RMSEA = .04. Since the nonhierarchical model's indices were χ^2 (464) = 2364.25, TLI = .87, CFI = .92, and RMSEA = .05, there was evidence that the data fit the hierarchical model best. All further analyses were conducted on the hierarchical model.

Final model

We took the subtractive approach recommended by Shoemaker and Lomax (2016), where we included all possible paths in a non-recursive model. Next we tested the unconstrained model across boys and girls. We removed all paths that were nonsignificant for boys and girls. If paths were significant for only one of the two groups or across both groups, they were retained. The path between violence and achievement was nonsignificant for both males and females. Indeed, for males the path had a standardised regression weight of 0 and for females it was .01. This path was thus removed from the model. Fit indices with this path left in the model and removed were identical and thus showed no evidence of model deterioration emerging from its removal.

Invariance of pathways for boys vs. girls

To test for invariance of pathways from endogenous to exogenous, variables were constrained across boys vs. girls. Testing of this model revealed the following four fit indices: χ^2 (487) = 1953.66, TLI = .90, CFI = .91 and RMSEA = .04. There was a .01-point difference in the constrained CFI, findings that might suggest the lack of invariance in one or more paths. Hence each pathway was constrained iteratively. No differences in the CFI and RMSEA were found for each iteratively constrained path when we compared them with such indices from the unconstrained model.

Direct effects

Figures 2 and 3 show that for both genders, although the first order latent variables domestic violence and school related violence had respectable loadings on the second order Violence latent variable, community based violence and violence inflicted on children in the home had the highest loadings on the second order Violence. These two first order factors accounted for the highest amount of variance in the second order factor.

For the trimmed model, the paths from Violence to IQ were significant for both girls and boys, and the paths from Violence to Achievement were nonsignificant for both. The path from Violence to Behavioural Risk was significant for boys, but not for girls.

Additionally, all paths from the exogenous Family Resources variable to Achievement ($p < .01$), IQ ($p < .001$) and Violence ($p < .001$) were significant for boys ($p < .001$).Similar findings were evident for each of the respective paths for girls ($p = .007$ and $< .001$). The path from Family Resources to Behavioural Risk factors was significant for boys ($p < .001$) it was not significant for girls. Moreover, all other paths, but that from Behavioural Risk Factors to Achievement in the trimmed model, were significant for boys.

Indirect, and mediated effects for boys and girls

Family Resources had a significant negative direct association with Achievement for both genders. This negative effect on achievement was mediated by a significant indirect and relatively large positive effect through IQ for both boys and girls (i.e. .72 for boys and .65 for

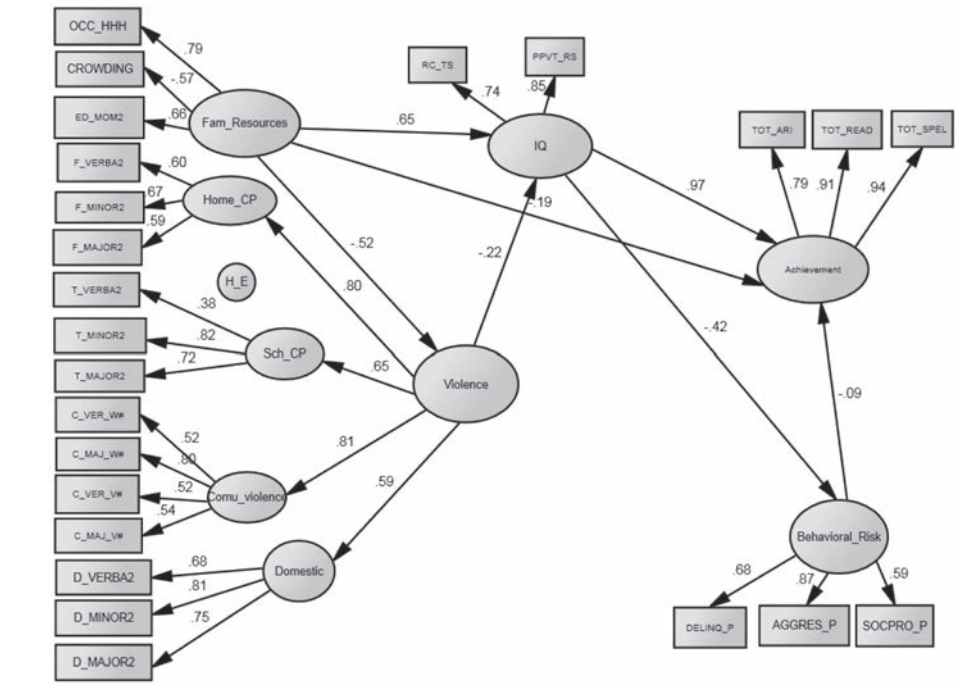

Figure 2. Final model for girls.

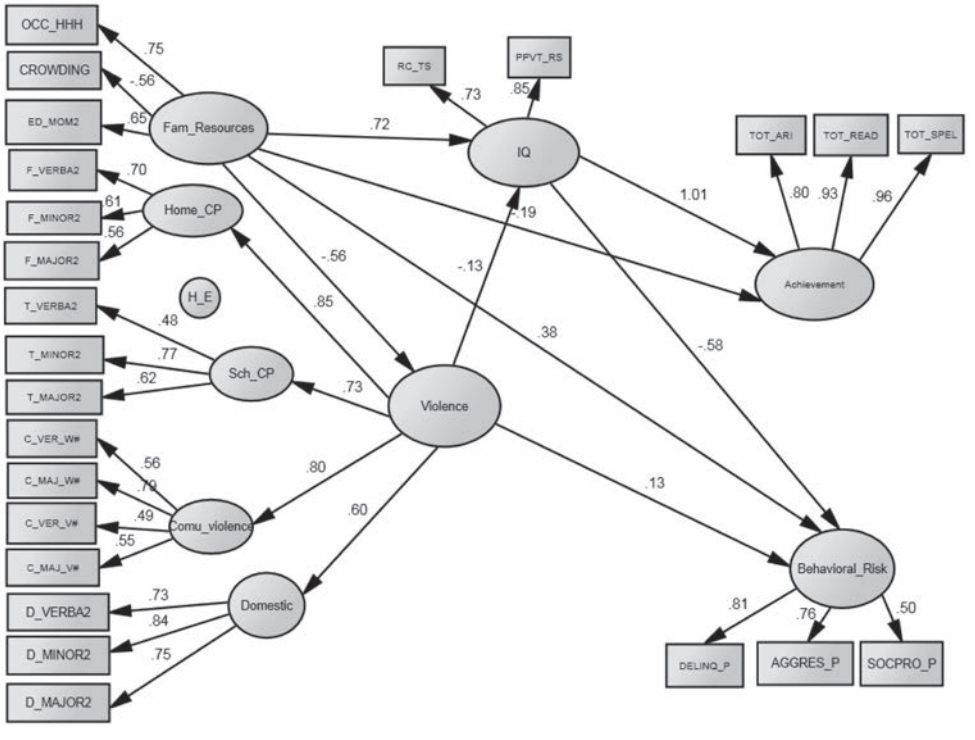

Figure 3. Final model for boys.

girls). The highly significant association between Family Resources and IQ was mediated by a positive significant indirect pathway though Violence. The direct path from Violence to Behavioral Risk is significant for boys only, but part of the variance is mediated by a negative indirect pathway through IQ. Only the indirect pathway is significant for girls.

Discussion

Using a hierarchical model for polyvicitimization, as measured by the latent variable Violence, this study revealed a set of complex pathways to child adjustment following exposure to violence, as measured by Behavioural Risk, IQ and Academic Achievement latent variables.

The direct negative impact of violence on IQ shows that Jamaican boys and girls who have suffered such victimization are at increased risk for compromised intellectual functioning as measured by the Ravens and PPVT. Exposure to violence does not directly impact children's school achievement, but it indirectly impacts achievement through suppressing intellectual functioning. This suggests that children exposed to violence are unlikely to develop their full intellectual potential, and this in turn suppresses academic achievement.

In high income countries, impairment in intellectual functioning and academic achievement has been associated with exposure to violence (Gilbert et al., 2009; Jonson-Reid et al., 2004; Lansford et al., 2002). Impairment in academic functioning has been so marked, that almost a quarter of maltreated children (24%) in the USA received special education, compared with 14% who had not experienced maltreatment.

The significant negative association between family resources and violence suggest that children from the lowest socio-economic (SES) groups are more likely to be exposed to polyvictimization, and therefore its effects, than their higher SES peers. This more complex model supports earlier findings of a greater likelihood of Jamaican children of lower SES being at risk of individual exposures of witnessing community violence, and experiencing violence at home and school (Samms-Vaughan et al., 2005; Samms-Vaughan, in press). This finding is concerning as children who are at socio-economic disadvantage are those for whom intellectual functioning and educational advancement present the greatest opportunity for improving their own socio-economic status.

Exposure to violence has a direct association with disruptive behaviour for boys only. For girls, there is no direct effect, but there is an indirect effect mediated by IQ. The direct effect of violence on behavioural risk factors for boys but not for girls is worthy of note. This suggests that in terms of behaviour, boys are more susceptible to the effects of polyvictimisation than girls. Boys are documented to be more susceptible to the effects of the development of severe behavioural and emotional problems, such as conduct disorder, oppositional defiant disorder and ADHD (DSM5, 2013).

The negative association between family resources and achievement is intriguing. At first blush this finding seems counterintuitive. Yet it might be true that children from higher SES families might feel less motivated to invest as much energy into academic achievement as their lower SES peers who might view academic achievement as the primary step toward upward mobility.

For LMICs like Jamaica, where there are high levels of exposure to violence, the intellectual, academic and behavioural associations with childhood exposure to violence have significant implications. Suppression of intellectual functioning in large numbers of children

may require the development of extensive educational support systems, at great additional cost to education systems. Additionally, large numbers of children, and particularly boys in our study, with behaviour related to violence exposure, may require intervention such as trauma focused cognitive behaviour therapy (TF-CBT). TF-CBT has been shown to be useful in reducing the impact of violence on some children (Cohen, Deblinger, & Mannarino, 2016). While effective, this is an expensive form of therapy, typically delivered individually by highly trained mental health professionals, which is often not available in LMICs. If available, it is often not accessible or affordable to large numbers of children living in LMICs.

In the absence of intervention, impaired academic functioning and higher levels of disruptive behaviours in large numbers of children may translate in the future to an under-educated society with high proportions of persons with antisocial behaviour. Together these will necessarily impede developmental advancement of a country. The interventions to address the consequences of exposure to violence, including remedial education and specialist mental health therapy for large numbers of persons, are costly, and are often not affordable within the limited financial resources of LMICs.

Prevention of childhood exposure to violence is therefore the most feasible option for LMICs and probably also for HICs. This research provides evidence that could be used to inform policy and practice decisions to reduce exposure to polyvictimisation and possibly reduce, if not remove, most of its effects on young adolescent adjustment. For example, reduction of exposure to violence at school and at home could be addressed by legislation to ban corporal punishment, supported by public education on non-violent forms of discipline. Addressing exposure to community violence is more complex given the social contributors. However, public education in communities on the impact of community violence on children may be useful.

Ethical Approval

Ethical approval was received from the University of the West Indies, Faculty of Medical Sciences Ethics Committee.

Disclosure statement

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The frequency and predictors of poly-victimisation of South African children and the role of schools in its prevention

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ABSTRACT

Violence has become a characteristic feature of South African society, with women and children often bearing the brunt of this. Contemporary research suggests that the key to stemming the tide of child victimisation is understanding the complete inventory of victimisations that may co-occur during childhood. There is growing recognition that children in South Africa typically experience abuse in the context of other forms of maltreatment and victimisation. This article draws on the empirical data collected for a national prevalence and incidence study on child sexual abuse and maltreatment in South Africa and draws attention to the frequency of poly-victimisation amongst South African children and highlights why some children experience multiple co-occurring forms of victimisations while others do not. Understanding the complete victim profile of young children, and how the different forms of victimisation they experience intersect, is critical to ensuring that the most vulnerable South Africans are provided with the extensive and targeted interventions required to break free from their heightened vulnerability to victimisation.

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KEYWORDS
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Introduction

Violence has become a characteristic feature of South African society, with women and children often bearing the brunt of this. Contemporary research suggests that the key to stemming the tide of child victimisation is not focusing on individual types of child victimisation, but rather considering the complete inventory of victimisations that may co-occur during childhood. In so doing, the multiple underlying causes of child victimisation will be addressed, rather than merely the symptoms, and more appropriate interventions can be developed.

Nature and extent of child and youth victimisation

South Africa's first national youth victimisation study found that for a large proportion of 12–22 year olds (41.4%), violence and crime was a common occurrence; with much of this

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violence occurring within their homes (21.8%) (Leoschut & Burton, 2006). Loeber and Stouthamer-Loeber (1986) state that 'family factors never operate in a vacuum but take place against a backdrop of other influences' which serves to amplify the effects of family variables on child victimisation. The frequency with which children are exposed to violence in their communities became apparent when 50.1% of participants in a national study reported having witnessed someone in their community using threat or force to physically harm another person (Leoschut, 2009).

Child abuse is also widespread in South Africa. According to a recent study, 35.4% of children are sexually victimised before the age of 17 (Artz et al., 2016). These figures were consistent with an earlier study that showed that 38% of women and 17% of men had been sexually victimised before the age of 18 (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010). Although underreported, the official police statistics also attest to the widespread occurrence of child sexual victimisation; with between 18,000 and 20,000 child sexual abuse cases reported each year (Artz et al., 2016).

Physical abuse is pervasive, with 20.8% of children reporting physical abuse by a parent or caregiver (Artz et al., 2016). Similarly, Dawes, Kafaar, Richter, and De Sas Kropiwnicki (2005) found that 58% of parents reported having ever smacked their children, at times, using an object to do so (33%). Neglect (15%) (Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009) and emotional abuse (16.1%) are also endemic (Artz et al., 2016).

The identification of violence as one of the leading causes of child mortality in South Africa clearly demonstrates the vulnerability of children. A study analysing data from mortuaries in South Africa, found that in 2009, there were 1018 child murders (Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013). A total of 44.5% of these murders occurred in the context of child abuse, and in 10% of these cases sexual abuse was suspected (Mathews et al., 2013).

Research studies also point toward the school environment as a common site for victimisation (Stevens, Wyngaard, & Van Niekerk, 2001) with school violence rates ranging from 15.1 to 22.2% nationally (Burton & Leoschut, 2013).

The child victimisation literature in South Africa have largely been concerned with documenting the magnitude of individual forms of victimisation (Ellonen & Salmi, 2011; Holt, Finkelhor, & Kantor, 2007) exploring the risk factors, as well as, identifying the deleterious outcomes associated with these specific forms of victimisation (Finkelhor, Ormrod, Turner, & Hamby, 2005a; Finkelhor, Shattuck, Turner, Ormrod, & Hamby, 2011; Ford, Wasser, & Connor, 2011; Voith, Gromoske, & Holmes, 2014). While these efforts have been lorded as useful for providing practitioners with an in-depth understanding of individual types of victimisation, many authors have argued that it ignores the greater spectrum of adversities that children are susceptible to during childhood (Hamby & Finkelhor cited in Finkelhor et al., 2005b; Price-Robertson, Higgins, & Vassallo, 2013) and underestimates the full burden of child victimisation (Holt et al., 2007).

Poly-victimisation in South Africa

There is growing recognition that children in South Africa often experience abuse in the context of other forms of victimisation. According to Finkelhor, Ormrod, Turner, and Holt (2009), victimisation types are often interconnected, and any one type of victimisation, breeds not only susceptibility to other forms of victimisation (Cole, Maxwell, & Chipaca,

2014), but also vulnerability across contexts. Thus, victimisation is rarely a one-off event, but instead a condition in which children may become ensnared (Finkelhor, Ormrod, & Turner, 2007) for years on end (Widom, Czaja, & Dutton, 2008).

In the South African context, risk factors for victimisation include, family and household composition, frequent exposure to violence in the home, living in a disorganised community, harsh and inconsistent parenting, poor parental supervision and monitoring, parental absence due to prolonged illness or hospitalisation, parental substance misuse, and child disability (Artz et al., 2016; Hawkins et al., 2000).

There is evidence to suggest that experiences of victimisation tend to cumulate for certain high-risk individuals or certain high-risk environments (Finkelhor et al., 2011). Finkelhor and colleagues use the term *poly-victim* to refer to those children who experience high levels of multiple forms of victimisation (Finkelhor et al., 2011). Not only do poly-victims experience high numbers of victimisations, but they also experience victimisation in different contexts (Finkelhor et al., 2009; Simmons, Wijma, & Swahnberg, 2015). For this reason, poly-victims have a higher likelihood of maladjustment given the more severe symptomatology associated with the co-occurrence of victimisation (Cyr, Clement, & Chamberland, 2014; Voith et al., 2014). Ellonen and Salmi (2011) found that poly-victimisation is associated with an increased level of psycho-social problems compared to children with no victimisation experience, as well as, those with fewer experiences.

Holt et al. (2007) found that poly-victims often behave aggressively towards others. Schools in South Africa already face a myriad of challenges including poor infrastructure, a lack of resources, and various safety-related concerns (Burton & Leoschut, 2013; Stevens et al., 2001). In addition, schools are tasked with having to teach large numbers of learners who experience a range of emotional and behavioural difficulties as a result of their extensive victimisation experiences (Burton & Leoschut, 2013; Holt et al., 2007). For this reason, schools, have an important preventative role to play.

Method

Aims and objectives

This article is based on the empirical data collected for a national prevalence and incidence study on child sexual abuse and maltreatment (Artz et al., 2016). The overall goal of this retrospective study was to provide an accurate estimation of the annual incidence and lifetime prevalence of child sexual abuse and to locate this abuse within the context of other forms of victimisation.

Participants

Data for this study was collected using a population-based survey that was targeted at households as well as schools. The sample frame for the population survey was based on the 2001 Census data of South Africa, adjusted according to the Statistics South Africa's 2011 census population numbers and other district council estimates. A multi-stage stratified sample was used to achieve a nationally representative sample of 15–17 year olds at a household level. A school survey was also conducted at high schools that were clustered around the

enumerator areas identified in the household survey; the analysis for this article draws on the household survey data only.

In the household survey, 5635 participants were recruited nationally, who described themselves as Black (80.4%), Coloured (9.5%), White (8.0%) and Indian (2.0%). Young people from KwaZulu-Natal (21.6%), Gauteng (18.6%), the Eastern Cape (14%) and Limpopo (12.5%) provinces comprised the greater part of the sample, followed by those from the Western Cape (10.0%), Mpumalanga (8.5%), North West (6.9%), Free State (5.3%) and Northern Cape (2.6%). There were more male (55.4%) than female participants (44.6%). Most of the participants were 16 years of age (36.5%), followed by those who were 15 (34.2%) and 17 (29.4%) years old.

Measures

The study used a combination of an interviewer-administered and self-administered questionnaire to collect the survey data. The questionnaires were designed to examine; the prevalence and incidence of child sexual abuse and maltreatment, the consequences of abuse, as well as the risk and protective factors associated with abuse.

In designing the questionnaires, the study drew on two instruments, namely the Juvenile Victimization Questionnaire (Finkelhor, Ormrod, Turner, & Hamby, 2005a) and the Trauma Symptom Checklist for Children (Briere et al., 2001). Minor revisions and additions were made to these instruments so that it was more appropriate to the South African context.

The result was a 38-item screener measure that explored a broad range of victimisations across several modules – conventional crime, cyber-bullying and online victimisation, child maltreatment, sexual victimisation, and witnessing and indirect victimisation. The questionnaires were comprehensively pilot-tested using cognitive interview techniques (Carbone, Campbell, & Honess-Morreale, 2002; Miller, Mont, Maitland, Altman, & Madans, 2011).

Procedure

The main questionnaire was administered by a trained enumerator, where after the participant was invited to also self-complete a short one-page version of the questionnaire; the analysis for this article was done using the data generated from the interviewer-administered questionnaire only. Interviews were conducted after informed parental consent and child assent was obtained. A number of measures were put in place to protect the privacy and confidentiality of the participants given the sensitive nature of the study. All questionnaires were stored in locked filing cabinets until it was captured electronically, all identifying information recorded on the first sheet of the questionnaire was removed and stored separately – ensuring that no information about child maltreatment and abuse could be traced back to any participant by name, and access to the password-protected data file was limited to core members of the research team only.

Participants were provided with the details for counselling services in their area in the event that they required any support following their interview. The research team was also legally obligated to report any cases of abuse that were disclosed during the course of the interviews, that had not previously been reported to a child protection agency. Prior to the interviews, the participants were informed of this in a manner they could understand. Enumerators were trained to flag reportable cases of sexual abuse, physical abuse and child

neglect that were later reported to a child protection agency servicing the geographic location in which the participants lived. This reporting procedure as well as the research study more broadly was approved by both the Human Research Ethics Committee of the Faculty of Health Sciences, and the Research Ethics Committee of the Faculty of Humanities, of the University of Cape Town.

Limitations

The data for this article stems from a cross-sectional study. Since information on the different variables were all collected at the same point in time, it does not allow for the exploration of cause-and-effect relationships between poly-victimisation and the risk factors explored in this article. Instead, it merely points toward an association between the two.

Data analysis

This article follows the analysis of Finkelhor and his colleagues, to a large degree, by examining the clustering of different types of victimisation among a sample of 15–17 year olds. While this article does not explore the traumatic effects of poly-victimisation on children, it includes an examination of the factors associated with an increased risk for poly-victimisation.

Here, the term *poly-victimisation* referred to a situation where a participant had experienced several victimisations across different contexts *ever* in their lives. Calculating poly-victimisation using lifetime prevalence rather than last-year prevalence, provides a more holistic picture of the victimisation profile of young children (Finkelhor, Ormrod, & Turner, 2009) rather than focusing only on victimisation occurring in a one-year time period.

Descriptive analysis

Poly-victimisation was measured by items that asked participants whether they had experienced any of a number of victimisations. Items were scored 1 for Yes and 0 for No. A composite variable was created by summing all 38 items to create a Lifetime Poly-victimisation variable. The potential range of scores for poly-victimisation was thus from 0 to 38. Scores for the Lifetime Poly-victimisation variable ranged from 0 to 28, with a median of 3, a mean of 4.16 and a standard deviation of 4.0 events.

Inferential analysis

Predictor variables were created for the following constructs: sleeping density (i.e. the number of people with whom the participant shares a bedroom), accessing a social grant, which parent/s resided with the participant, parental absence due to physical ill-health, parental mental health, parental substance misuse, child substance misuse, parental incarceration, participant disability, child sexual risk behaviours, and whether the child lived in an urban or rural area.

Five binary logistic regression analyses were run with the same set of independent variables. The first regression compared no poly-victimisation to low poly-victimisation, the

second compared low poly-victimisation to high poly-victimisation, the third compared high poly-victimisation to very high poly-victimisation, the fourth compared no poly-victimisation to any form of poly-victimisation and the final binary logistic regression compared no poly-victimisation to very high poly-victimisation.

Results

In order to run a binary logistic regression, the lifetime poly-victimisation variable was changed from an interval scale to an ordinal scale. Four categories were created using the mean and SD: (1) No or 1 victimisation, i.e. no poly-victimisation; (2) Low poly-victimisation (below the mean, i.e. 2–4 events); (3) High poly-victimisation (between the mean and 1 SD above the mean, i.e. 5–8 events); and (4) Very high poly-victimisation (more than 1 SD above the mean, i.e. 9–28 events). The frequencies for these categories are listed in Table 1.

Table 2, lists the frequency of the different forms of victimisation. The forms of victimisation are arranged from the most frequently to the least frequently occurring. The most frequent form of victimisation was theft, with 2133 participants (37.9%) reporting that they had had an item stolen from them at least once in their lifetime. While it is comforting to note that only 37 participants (.7%) reported that they had been sexually abused by an adult known to them, it is concerning to note that 357 participants (6.3%) report having had a sexual experience with an adult.

Binary logistic regression analyses predict membership of one of the categories of the binary dependent variable. Table 3 below lists the number of cases per analysis, the Wald statistic, statistical significance, β and Exp β as well as model significance values. The category of membership being predicted is denoted by an asterisk.

Table 4 lists the significant predictors of poly-victimisation for all five regression analyses, followed by detailed explanations of the predictors of poly-victimisation.

Of the 5635 young people interviewed, 2033 had experienced no or only one type of victimisation ever in their lives, while 3602 – the majority of the sample – had experienced two or more different forms of victimisations ever in their lives. Furthermore, 35.4% had experienced five or more types of different victimisations by the time they turned 17 years of age.

Parental substance misuse

Parental substance misuse consistently significantly predicted higher poly-victimisation in all five regression analyses. Participants whose parents abused substances were 11.852 (95% CI; 1.325–106.010) times more likely to have experienced low poly-victimisation (between one and four victimisation events) compared to no poly-victimisation ($p < .05$), 3.454 (95%

Table 1. Frequency of poly-victimisation.

Poly-victimisation category	Frequency	Per cent
No (0–1 events)	2033	36.1
Low (2–4 events)	1605	28.5
High (5–8 events)	1288	22.9
Very high (>8 events)	709	12.6
Total	5635	100.0

Table 2. Frequency of types of victimisation.

Type of victimisation (total sample size $N = 5635$)	Poly-victimisation category			
	No	Low	High	Very high
Had something stolen ($N = 2133$, 37.85%)	96	691	818	528
Seen anyone attacked without a weapon ($N = 1859$, 32.99%)	43	504	750	562
Seen anyone attacked with a weapon ($N = 1774$, 31.48%)	28	495	712	539
Had something forcefully removed ($N = 1318$, 23.39%)	46	375	511	386
Item stolen from home ($N = 1109$, 19.68%)	53	286	446	324
Threaten to hurt ($N = 1072$, 19.02%)	26	240	406	400
Bullied ($N = 965$, 17.13%)	10	179	396	380
Physical victimisation ($N = 962$, 17.07%)	43	228	356	335
Attacked without an object ($N = 939$, 16.67%)	9	146	404	380
Attacked with an object ($N = 831$, 14.75%)	17	174	336	304
Heard shots, bombs or riots ($N = 818$, 14.52%)	14	146	349	309
Malicious damage to property ($N = 698$, 12.39%)	6	158	255	279
Emotional abuse ($N = 688$, 12.21%)	16	130	253	289
Seen parent hurt siblings ($N = 633$, 11.23%)	17	123	211	282
Escape attack ($N = 537$, 9.53%)	2	68	197	270
Parent threatened to hurt other parent ($N = 524$, 9.30%)	9	76	170	269
Murder of friend/neighbour/family member ($N = 436$, 7.74%)	16	65	177	178
Member of household assaulted other member ($N = 416$, 7.38%)	24	112	127	153
Parent pushed other parent ($N = 383$, 6.80%)	1	25	108	249
Sexual experience with an adult ($N = 357$, 6.34%)	33	89	122	113
Neglect due to physical living conditions ($N = 351$, 6.23%)	12	76	133	130
Parent hit or slapped other parent ($N = 350$, 6.21%)	4	23	99	224
Hit or attacked by an adult ($N = 332$, 5.89%)	3	46	98	185
Hit on purpose other than mentioned ($N = 266$, 4.72%)	7	28	69	162
Parent damaged other parent's property ($N = 262$, 4.65%)	1	13	62	186
Neglect due to fear of parents' visitors ($N = 259$, 4.60%)	5	51	77	126
Parent kicked, choked or beat other parent ($N = 217$, 3.85%)	1	9	43	164
Sexual exposure abuse ($N = 192$, 3.41%)	4	29	51	108
Attacked due to prejudice ($N = 131$, 2.33%)	2	13	45	71
Forced sexual intercourse (actual or attempted) ($N = 128$, 2.27%)	7	23	27	71
Written or verbal sexual harassment ($N = 121$, 2.15%)	2	15	39	65
Sexual abuse by child or teen ($N = 114$, 2.02%)	2	22	27	63
Sexual abuse by known adult ($N = 110$, 1.95%)	1	24	30	55
Neglect due to alcohol or drugs ($N = 100$, 1.78%)	3	14	22	61
Attempted kidnapping ($N = 86$, 1.53%)	2	8	37	39
Neglect due to abandonment ($N = 80$, 1.42%)	1	8	15	56
Neglect of physical cleanliness ($N = 75$, 1.33%)	3	9	17	46
Sexual abuse by unknown adult ($N = 37$, .66%)	1	9	8	19

Table 3. Binary logistic regression analyses.

Lifetime poly-victimisation	*N*	Wald	Sig	*B*	Exp (*B*)	Model sig
No vs. Low poly-victimisation*	347	20.393	.000006	.5	1.649	.000004
Low vs. High poly-victimisation*	524	15.984	.000064	.355	1.426	.001
High vs. Very high poly-victimisation*	532	13.152	.000287	−.138	.727	.000157
No vs. Any poly-victimisation*	879	338.363	<.000001	1.742	5.71	<.000001
No vs. Very high poly-victimisation*	355	23.787	.000001	.536	1.71	<.000001

*Category of membership being predicted.

CI; 1.790–6.665) times more likely to experience high poly-victimisation (between five and eight victimisation events) compared to low poly-victimisation ($p < .001$), and 1.796 (95% CI; 1.128–2.861) times more likely to experience very high poly-victimisation (more than eight victimisation events) compared to high poly-victimisation ($p < .05$) when compared to participants whose parents did not misuse substances.

Table 4. Significant predictors for poly-victimisation.

	No poly-victimisation vs. Low poly-victimisation			Low poly-victimisation vs. High poly-victimisation			High poly-victimisation vs. Very high poly-victimisation			No poly-victimisation vs. Any poly-victimisation			No poly-victimisation vs. Very high poly-victimisation		
	Odds ratio	95% CI for odds ratio		Odds ratio	95% CI for odds ratio		Odds ratio	95% CI for odds ratio		Odds ratio	95% CI for odds ratio		Odds ratio	95% CI for odds ratio	
Predictors		Lower	Upper		Lower	Upper		Lower	Upper		Lower	Upper		Lower	Upper
Parental substance misuse	11.852*	1.325	106.01	3.454***	1.790	6.665	1.796*	1.128	2.861	24.392***	3.109	191.345	47.611***	4.729	479.374
Parental absence due to physical ill-health				2.303***	1.548	3.428	1.527*	1.050	2.220	2.987***	1.830	4.876	4.393***	2.311	8.354
Child substance misuse	2.008**	1.222	3.298				1.739**	1.170	2.586	2.823***	1.844	4.323	4.845***	2.646	8.871
Child sexual risk behaviour	1.98*	1.176	3.322							2.074**	1.323	3.253	2.393**	1.3	4.405
Parents residing with child										2.260*	1.231	4.148			
Urban/rural residence													2.545*	1.144	5.65

*$p < .05$; **$p < .01$; ***$p < .001$.

When we compare no poly-victimisation to any poly-victimisation and very high poly-victimisation, the odds ratios increase substantially. Participants whose parents abused substances were 24.392 (95% CI; 3.109–191.345) times more likely to be members of the poly-victims category than the no poly-victims category ($p > .001$), and 47.611 (95% CI; 4.729–479.374) times more likely to be very high poly-victims than participants whose parents did not misuse substances ($p < .001$).

Parental absence due to illness

Parental absence due to illness significantly predicted poly-victimisation in all the regression analysis excluding the regression analysis that compared no poly-victimisation to low poly-victimisation. Children whose parents were absent for prolonged periods due to physical health problems were 2.303 (95% CI; 1.548–3.428) times more likely to experience high poly-victimisation compared to low poly-victimisation ($p < .001$), and 1.527 (95% CI; 1.050–2.220) times more likely to experience very high poly-victimisation compared to high poly-victimisation, than children whose parents had not been absent ($p < .05$).

When we compare no poly-victimisation to any and very high poly-victimisation, we see that children whose parents were absent due to ill-health were 2.987 (95% CI; 1.830–4.876) times more likely to experience any poly-victimisation compared to none ($p < .001$), and 4.394 (95% CI; 2.311–8.354) times more likely to experience very high poly-victimisation compared to none, than children whose parents had not been absent ($p < .001$).

Child substance misuse

Child substance misuse significantly predicted poly-victimisation in all the regression analyses except the regression analysis that compared low to high poly-victimisation. Children who abused substances were 2.008 times (95% CI; 1.222–3.298) more likely to experience low poly-victimisation ($p < .01$), and 1.739 (95% CI; 1.170–2.586) times more likely to experience very high poly-victimisation (>8 events) than children who did not misuse substances ($p < .01$).

When we compare no poly-victimisation to any poly-victimisation and very high poly-victimisation, we see that children who misuse substances are 2.823 (95% CI; 1.844–4.323) times more likely to experience any poly-victimisation ($p < .001$) and 4.845 (95% CI; 2.646–8.871) times more likely to experience very high poly-victimisation (>8 events) than children who do not abuse substances ($p < .001$).

Child sexual risk behaviour

Children who engaged in sexual risk behaviour significantly predicted poly-victimisation in three of the five regression analyses. When predicting membership of the low poly-victimisation category, children who engaged in risky sexual behaviour were 1.98 (CI 95%; 1.176–3.322) times more likely to experience low poly-victimisation than children who did not engage in sexual risk behaviour ($p < .05$). Similarly, when predicting membership of the any poly-victimisation category, children who engaged in risky sexual behaviour were 2.074 (95% CI; 1.323–3.253) times more likely to experience poly-victimisation than children who did not engage in risky sexual behaviour ($p < .01$). Finally, when predicting membership

of the very high poly-victimisation category (>8 events), children who engaged in risky sexual behaviour were 2.392 (95% CI; 1.3–4.405) times more likely to experience very high poly-victimisation than children who did not engage in risky sexual behaviour ($p < .01$).

Stays with parents

Which parent/s resided with the child was only significant when predicting membership of any poly-victimisation. Children who lived with one parent were 2.260 (95% CI; 1.231–4.148) times more likely to experience any poly-victimisation than children who lived with both parents ($p < .05$).

Urban/rural

Whether the children resided in an urban or rural area was only significant when predicting membership of the very high poly-victimisation category (>8 events) compared to no poly-victimisation. Children in urban areas were 2.545 (95% CI; 1.144–5.65) times more likely to experience very high poly-victimisation than children from rural areas.

Discussion and conclusion

Eaton, Flisher, and Aarø (2003) argue that there are three levels at which risk behaviours are influenced: the personal; the proximal (the physical environment and interpersonal relationships); and the distal level (cultural and structural factors). It would seem that experiencing poly-victimisation is influenced by factors at all levels. At the personal level (sexual risk behaviour and substance misuse), in the proximal context (parental substance misuse, parental absence due to physical health reasons, and the number of parents the child resides with) as well as in the distal context (urban vs. rural).

This article draws attention to the frequency of poly-victimisation amongst South African children and highlights why some children experience multiple co-occurring forms of victimisations while others do not. Understanding the complete victim profile of young children, and how the different forms of victimisation they experience intersect, is critical to ensuring that the most vulnerable South Africans are provided with the extensive and targeted interventions required to break free from their heightened vulnerability to victimisation. This is essential, given that poly-victims are likely to remain highly victimised as they get older (Finkelhor et al., 2007; Finkelhor et al., 2011).

Poly-victims are significantly more likely to be urban children, living with one rather than both their biological parents, whose parents abuse substances, and are absent from the home due to prolonged illness and are children who themselves use substances and engage in risky sexual behaviours. For each of the victimisation types, participants were asked whether they had been under the influence of alcohol and/or drugs at the time of the incident. In the vast majority of cases, the participants were found to have been sober at the time of the incident. Although, this research can merely point toward an association between these descriptors and poly-victimisation and cannot make any causal claims about these variables, it may suggest that participant substance abuse specifically, may have been a consequence of the poly-victimisation.

Given the persistent nature of poly-victimisation across the life-span of children, early intervention is key. Identifying children most at risk of poly-victimisation and intervening early on may buffer children from experiencing continued victimisation later on in life (Finkelhor, Ormrod, & Turner, 2009). Schools are in an ideal position to do this, given that children spend a large amount of time there.

The identification of schools as an important site for violence prevention is further underscored by Ozer and Weinstein (2004) cited in Ozer (2005) who argue that there are generally two types of protective factors for adolescents. The first, are supportive relationships with significant others, while the second, is growing up in physically safe social environments; of which the home and the school are most important (Ozer & Weinstein, 2004 cited in Ozer, 2005).

There are also other reasons why schools are ideal sites for preventing child victimisation. *Firstly*, schools provide a social context that comes along with established infrastructure and resources that could support violence prevention initiatives (Stevens et al., 2001). When school personnel can effectively identify high risk learners, they can ensure that the available resources are targeted at those children who are most prone to multiple victimisations. *Secondly*, schools have a captive audience and can implement carefully targeted interventions for a sustained period of time. This will ensure that poly-victims who are attending schools, can access continued support services during the years that they'll be attending school. *Thirdly*, schools are attended by children and youth who are at critical developmental stages in their lives. Carefully targeted interventions can positively influence their developmental trajectories (Ozer, 2005).

Although schools provide an important entry-point for prevention (Holt et al., 2007), other interventions that fall outside the ambit of schools are required to address poly-victimisation including substance abuse treatment and prevention initiatives, and parenting support programmes (Finkelhor et al., 2011).

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Disclosure of physical, emotional and sexual child abuse, help-seeking and access to abuse response services in two South African Provinces

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ABSTRACT

Physical, emotional and sexual child abuse are major problems in South Africa. This study investigates whether children know about post-abuse services, if they disclose and seek services, and what the outcomes of help-seeking behaviour are. It examines factors associated with request and receipt of services. Confidential self-report questionnaires were completed by adolescents aged 10–17 (n = 3515) in South Africa. Prevalence of frequent (>weekly) physical abuse was 7.4%, frequent emotional abuse 12.4%, and lifetime contact sexual abuse 9.0%. 98.6% could name one suitable confidante or formal service for abuse disclosure, but only 20.0% of abuse victims disclosed. Of those, 72% received help. Most common confidantes were caregivers and teachers. Of all abuse victims, 85.6% did not receive help due to non-disclosure or inactivity of services, and 14.4% received help: 4.9% from formal health or social services and 7.1% through community vigilante action. Emotional abuse, sexual abuse and female gender were associated with higher odds of help-seeking. While children in South Africa showed high knowledge of available services, access to and receipt of formal services among abused children was low. Notably fewer children received help from formal services than through community vigilante action. Urgent action is needed to improve service access for child abuse victims.

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"I went to the police to tell them that that boy who had raped me was harassing me. They laughed and said I should not bother them. So now, every time he rapes me I won't go to the police because they won't believe I am telling the truth." (Girl, 17, Mpumalanga)

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Background

South Africa has a high prevalence of physical, emotional and sexual child abuse (Artz et al., 2016), and this abuse is associated with negative long-term and short-term health outcomes (Norman et al., 2012; Paolucci, Genuis, & Violato, 2001). While national policy frameworks and legislation for child protection is rigorous, problems have been identified with the implementation of services. The national government, international agencies such as UNICEF, and non-governmental services have identified the urgent need for integrated health, social, police and criminal justice services to support victims of child abuse (UNICEF South Africa, 2013). However, limited studies about access to services for abused children exist globally and within South Africa, and those that do focus mostly on victims of sexual abuse.

It is essential that victims disclose their abuse in order to access support services. Research on sexual abuse disclosure suggests that it is a multi-stage process that may include stages of reluctance, denial and re-affirmation (Bradley & Wood, 1996). Globally, research indicates that disclosure of sexual abuse is often delayed: the younger the victim, the longer the delay between onset and disclosure (London, Bruck, Ceci, & Shuman, 2005). In the majority of cases, initial disclosures are made to informal confidantes such as parents, teachers or friends, rather than professionals (Allnock & Miller, 2013; McElvaney, 2015). Where children do disclose to professionals, swift action is usually experienced as helpful (Allnock & Miller, 2013), while matter-of-fact responses, not being told about the plan of action and not being listened to further exacerbated the trauma (Mudaly & Goddard, 2006).

Reasons for non-disclosure have been identified as lacking vocabulary to describe the abuse, feeling threatened by the perpetrator, and experiencing shame, embarrassment and fear of not being believed (Allnock & Miller, 2013; McElvaney, Greene, & Hogan, 2014). Factors promoting disclosure are being asked about it, growing more mature and being able to vocalise the abuse, feeling unable to cope anymore, protecting others from similar abuse and enduring an escalation of abusive acts (Allnock & Miller, 2013). Evidence is thus far unclear about whether severity of the assault increases disclosure rates (London et al., 2005). Throughout the disclosure process, many children describe not being believed, lack of support and inadequate protective action (Allnock & Miller, 2013; Hershkowitz, Lanes, & Lamb, 2007; Mudaly & Goddard, 2006).

A recent qualitative study from South Africa suggests similar findings. The multi-stage process of disclosure is often delayed due to the child fearing that they would be blamed or punished by the caregiver or not believed. Most initial disclosures are made to close confidantes such as parents. However, some of these disclosures are elicited through threats or beatings where caregivers realise something is wrong with the child. Responses following disclosure range from being supportive to blaming and punishing the child (Mathews, Hendricks, & Abrahams, 2016).

A small number of quantitative studies examine abuse response services in South Africa with a focus on initial disclosure of rape, service delivery following disclosure and progression of court cases. Almost all those investigating service delivery have used official records. They are therefore limited to sexual abuse cases reported and responded to by available services. As children were selected from services records, these data give little insight into the views and experiences of those who do not have access to services.

In a study in KwaZulu-Natal, one in four children who disclosed rape (25.9%) reported non-supportive reactions by confidantes such as disbelieving or blaming the child when they inititally disclosed sexual abuse victimisation. Non-supportive disclosure was higher where children chose community members as confidantes compared to guardians, other relatives or professionals (Collings, 2007).

There is, however, an important distinction between supportive disclosure and receipt of actual help. In another study amongst children referred to socio-medical services following sexual assault, only 49% received counselling and social work services. These services were delayed anywhere between two days and six months (61% seen within the first week), and in all but one case, the support was limited to a single appointment. Children living in informal settings or those who sought help after hours were much less likely to receive any counselling or social services (Collings, 2009). In Gauteng, a suspect was arrested in only 57.2% of child rape cases. Of those, 18.1% went to trial, 7.4% were convicted and 4% sentenced to imprisonment. Documented injuries were predictive of cases going to trial but not of a conviction. The presence of obtainable DNA, which was only available in 1.4% of all reported cases was not a predictor either (Jewkes et al., 2009). These rates are much lower than in the United States, where a meta-analysis found that between 28% and 95% of alleged child abusers were charged. A mean of 79% of these cases were carried forward, 82% pleaded guilty and 94% were convicted (Cross, Walsh, Simone, & Jones, 2003).

In a recent, nationally representative sample of South African adolescents, the majority of children disclosed sexual abuse to their parents, although boys reported much lower levels of initial disclosure (15.2% for rape) than girls (36.2%). Of those who disclosed, 72.5% experienced a supportive disclosure when the perpetrator was a known adult. When the perpetrator was an unknown adult, 59.1% experienced a supportive disclosure. Much lower rates of supportive disclosure were recorded for those who experienced rape. Social services investigations were carried out in only 28.6% of rape cases (Artz et al., 2016).

Trends are similar across the sub-Saharan region as investigated by the nationally representative Violence Against Children Studies. In Malawi and Kenya, less than 10% of child sexual abuse victims sought formal services, while in Tanzania, less than 20% surveyed disclosed their abuse experience to formal service providers or family members. The percentage of children receiving services following sexual violence exposure varied from 2.7% in Zimbabwe to 25% in Swaziland (Sumner et al., 2015).

These existing studies provide valuable evidence of rates of disclosure, disclosure responses, access to services and receipt of services for sexual abuse victims who have reported their experiences to official services. However, evidence is urgently needed from community-based studies of all child abuse victims, including those who experience physical and emotional abuse and sexual abuse victims who have not sought services. Such studies would investigate the different stages in the process, from knowledge of services via disclosure to help-seeking behaviours to receipt of services. This information is essential to identifying whether there are gaps in knowledge of services, barriers to access and help-seeking, or difficulties with service delivery. Increased information can support plans for an adequate national implementation of child protection policies (DSD, DWCPD, & UNICEF, 2012).

Objective

This paper aims to establish (1) whether South African children know where to seek help in case of abuse (physical, emotional or sexual); (2) what proportions of abused children disclose and seek help; (3) the outcomes reported by children who accessed post-abuse services; and (4) the sociodemographic factors associated with requesting and receiving help.

Methods

This paper reports on a longitudinal, community-based household survey carried out in two different provinces of South Africa. In each province, two health districts with high deprivation were selected and census enumeration areas were chosen randomly. Within these census enumeration areas, every household was visited to recruit children aged 10–17 (n = 3514) for participation. The majority of children (n = 3401, 96.8%) were followed up a year later and this analysis reports on the follow-up sample.

Procedure

Children completed confidential 60–80-min study-specific self-report questionnaires with the help of trained local interviewers. Questionnaires were translated into five local languages and checked with back translation. Children participated in the language of their choice. All survey items were pre-piloted with vulnerable youth to investigate age-appropriateness and cultural sensitivity. Data were collected using paper questionnaires with the help of experienced research assistants. Stringent quality checks were in place so that missing data were <.05%.

Ethics statement

Ethical approval was granted by the University of Oxford (SSD/CUREC2/09–52).

Informed consent for child participation was sought from children and their caregivers. Due to low literacy in the sampled population groups, information and consent sheets were read aloud to children and caregivers, and clarification questions were answered until participants were satisfied and gave written consent. Participation was voluntary and children were able to stop the interview at any time. All participants received a certificate and a participant pack irrespective of completion of the questionnaire.

Confidentiality was maintained throughout the study unless participants were considered at risk of significant harm or requested help from the research team. In this case, the project manager and interviewer discussed options for referrals with the child, and immediate referrals were made to local child protection or health services as necessary. A total of 664 referrals were made throughout the duration of the research.

Measures

Physical and emotional abuse was measured with the UNICEF Measures for National-level monitoring of orphans and other vulnerable children (Snider & Dawes, 2006), and seven additional items devised with the help of local social workers and children. All items were

modified to fit the cultural context in consultation with service providers and children. The measure was previously used in the Western Cape and showed good reliability of $\alpha = .70$ (Meinck, Cluver, Boyes, & Ndhlovu, 2015). Items measured hitting or slapping with a hard item or so that the child had marks, standing/kneeling in an uncomfortable position for a long period of time, being singled out to do household chores, being insulted, threatened to be hurt or abandoned, told one is a burden, felt unwelcome in the home and having a meal withheld. For the full measure see (Meinck, Cluver, & Boyes, 2015a). *Frequent physical and emotional abuse* was defined as occurring weekly or more frequently. *Contact child sexual abuse and rape* were measured using the Juvenile Victimisation Questionnaire (Finkelhor, Hamby, Ormrod, & Turner, 2005). Items included unwanted touching or kissing, touching of private parts and forced sex. Contact sexual abuse was defined as lifetime exposure to contact sexual abuse or rape. For individual items please see (Meinck, Cluver, & Boyes, 2015b).

Access to services was measured using four items developed with local social workers examining knowledge of services, help-seeking behaviours and the outcomes if reporting occurred. One dichotomous item measured whether the child sought help. Three items were free-text responses without prescribed answer categories: 'Where would you tell victims of violence to get help? Who did you ask for help? What actions were taken?' The answers were then re-coded into categorical variables for this analysis.

Potential demographic covariates such as gender, age, and urban or rural location were measured. *Poverty* was measured using an index of the eight highest socially-perceived necessities for children in South Africa (Barnes & Wright, 2012) and was defined as lacking three or more necessities.

Analyses

Descriptive analyses were conducted using SPSS 22. Knowledge of post-abuse services, prevalence rates of help-seeking behaviour and receipt of services were examined. Multivariate logistic regression analyses were employed to investigate factors associated with help-seeking behaviour and receipt of services, as sample size allowed for subgroup analyses. Interactions between gender and the different abuse types were examined for each model.

Results

Prevalence of abuse

Socio-demographic characteristics of the sample are displayed in Table 1. Prevalence of frequent (weekly or more) physical abuse was 7.4%, frequent emotional abuse was 12.4% and lifetime contact sexual abuse was 9%. Overall, 22.0% of children were exposed to at least one form of violence (Table 1).

Knowledge of where to report abuse

98.6% of children could name at least one suitable formal service or confidante for abuse disclosure. 48.6% recommended that abuse victims seek help from the police while trusted adults, social workers, and the clinic or hospital were mentioned less often. Only 1.6% of children were not able to name a service or person that could provide help (Figure 1).

Table 1. Socio-demographic characteristics of the samples.

	(*N* = 3401)
Age	14.67 SD 2.22 SE .04
Female	57.0% (1937)
Province	Mpumalanga 48.5% (1648)
	Western Cape 51.5% (1753)
Poverty (missing 3 or more necessities)	45.4% (1543)
Rural location	49.8% (1692)
Weekly physical	7.4% (250)
Weekly emotional	12.4% (427)
Contact sexual abuse and rape	9.0% (306)
Multi-victims	6% (203)
Any type of victimisation	22.0% (749)
Knowledge of available services	98.6% (3353)
Of those abused: disclosed and asked for help	20.0% (150)
Of those abused: child received help	14.4% (108)

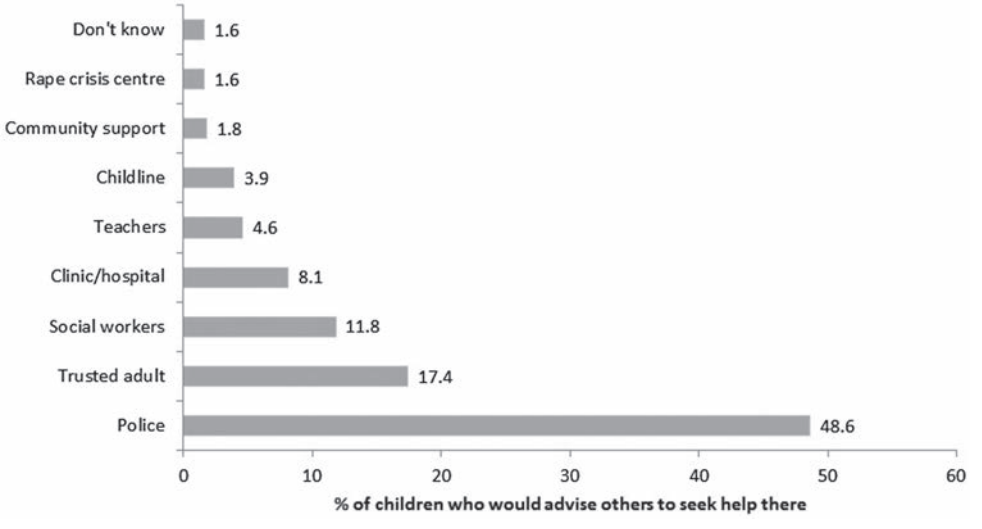

Figure 1. Children's knowledge of services where child abuse victims could seek help.

Disclosure and help-seeking

20.0% of abused children had disclosed and asked for help while 80.0% did not (Table 1). Confidantes were the caregiver (27%), teachers (22%), other family members (12.2%), friends (9.6%), siblings (6.8%), social workers (6.8%), police (6.8%), community organisations (4%), health care professionals (2.7%) and neighbours (2.7%).

Outcomes of help-seeking and disclosure

Overall, 85.6% of abused children received no help due to a combination of non-disclosure and inactivity of services. Figure 2 demonstrates differences in knowledge about service, requests for help by abused children and help received through formal services. 28.0% (n = 42) of children who had been abused and requested help from a confidante or service were denied it. In 89.1% (n = 37) of these cases, no further action was taken while 11.9%

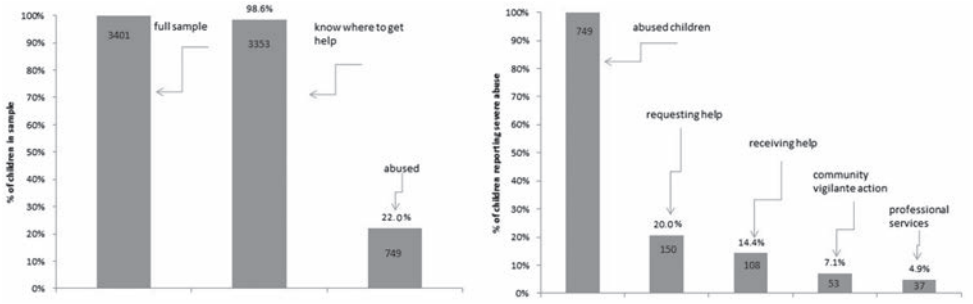

Figure 2. Child abuse victim's access to services: attrition in the process from knowledge of services to outcomes of help-seeking.

Table 2. Multivariate regression analyses of factors associated with help-seeking behaviour among abused children.

	Help seeking (n = 749)	Receiving help (n = 749)
Physical abuse	1.22 (.69–2.14)	1.58 (.49–5.11)
Emotional abuse	1.71* (1.15–2.89)	.37 (.12–1.11)
Sexual abuse	10.08*** (5.53–18.37)	.41 (.11–1.51)
Female gender	2.42*** (1.45–4.04)	.73 (.22–2.33)
Age	.95 (.85–1.03)	.82 (.65–1.04)
Poverty	1.01 (.64–1.58)	.62 (.23–1.68)
Rural location	.67 (.42–.1.03)	1.64 (.64–4.22)

***$p < .001$; *$p < .05$.

(n = 5) were re-victimised by being subjected to harassment by the perpetrators or punished by their parents.

Of those who were abused, 2.8% (n = 21) reported being assisted by the police, 2.1% (n = 16) by medical or social services, and 2.2% (n = 18) in other, not specified ways. However, a large proportion of those who were abused and received services, 7.1% (n = 53), received assistance in the form of community vigilante retribution and not from government or NGO services. Community vigilante retribution is defined as actions that are carried out by members within the community who chase the perpetrator away, beat the perpetrator or arrange some form of financial recompense to the family of the victim. This was the outcome of a free-text answer option and not anticipated by the researchers.

Is type of abuse associated with help-seeking and receipt of help?

Girls and victims of emotional and contact sexual abuse were more likely to seek help. Type of abuse was not significantly associated with receipt of help (Table 2). No significant interactions between type of abuse and gender with respect to help-seeking were found.

Discussion

This study identified high rates of frequent child abuse victimisation in two provinces of South Africa. Severe disparities between children's knowledge of services and children's reluctance to disclose and seek help from formalised services were found.

Knowledge of services and disclosure

The vast majority of children knew about services that can help victims of abuse. It may be that education in schools and communities about formal services is successful in generating knowledge about their availability. However, in this large sample, only 20% of children who experienced contact sexual abuse or frequent physical or emotional abuse disclosed their abuse or requested help.

Similar low rates of disclosure of sexual abuse in child samples have been reported in studies from high-income countries (London et al., 2005; Mcgee, Garavan, & Byrne, 2002) and South Africa (Artz et al., 2016) and may be due to fear of the perpetrator, not being believed, or being shamed or blamed (Allnock & Miller, 2013; Mathews et al., 2016). International research is limited on disclosure rates of physical and emotional abuse. Where it is available, disclosure rates are much higher (40–80%), but studies use retrospective self-report in adult samples and thus recall memory of when disclosure happened may be affected (Bottoms et al., 2016; Foynes, Freyd, & DePrince, 2009).

Choice of confidante

In this sample, the majority of children disclosed to a caregiver, teacher or other family member rather than professionals. Research from high-income countries corroborates this finding and adds friends to the list of close confidantes (Bottoms et al., 2016). In Sweden, the majority of adolescents disclosed to their peers (Priebe & Svedin, 2008), while in Ireland, confidantes were parents and friends (Mcgee et al., 2002). Confidante's response to the disclosure of abuse was not directly measured in this study. Although the confidante was a trusted adult in most cases, 11.9% of children who disclosed abuse reported re-victimisation as an outcome while 28% reported that no further action was taken. This tallies with evidence from Israel where 20% of children reported unsupported disclosure (Hershkowitz et al., 2007). It is thus important to distinguish non-supportive disclosure, supportive disclosure and receipt of service provision as these can be mutually exclusive (Mudaly & Goddard, 2006).

Service provision

Notably, the number of cases in which community vigilante action took place was greater than the combined number of cases where responses were provided by social, health and police services. The perception that formal services are inaccessible or ineffective may be the reason that crimes are reported to community leaders instead of professional services. This finding is in line with a decrease of reported cases of maltreatment to the police since 2003 (South African Police Service, 2010), even though surveys suggest continuing high past-year prevalence rates of abuse (Artz et al., 2016; Meinck, Cluver, Boyes, & Loening-Voysey, 2016). Similar findings are also reported in Kenya, where village elders are perceived to be most effective in responding to child abuse reports (UNICEF, 2011); Sierra Leone, where structural barriers and poor training of child protection committees are reported (Wessells et al., 2012); and Tanzania, where distances, slow responses, and corruption of police and other service providers prevent victims from seeking help (Abeid et al., 2014). Within South Africa, qualitative research suggests that professional services are not designed

to facilitate abuse disclosure and service access for children (Bray, Gooskens, Kahn, Moses, & Seekings, 2010). Some of the perceived barriers are logistical and practical obstacles, such as transport or money (Lankowski, Siedner, Bangsberg, & Tsai, 2014); inadequate and badly designed services and poor service delivery (Roehrs, 2011); lack of faith in a timely and positive outcome (Smith, Bryant-Davis, Tillman, & Marks, 2010); fear of repercussions such as re-victimisation (Akal, 2005); and stigma and coercion within the family (Akal, 2005; Bray et al., 2010). The low numbers of children disclosing directly to professionals and receiving services in our present study support these qualitative findings.

Even in high-income countries, the number of sexual abuse cases reported to formal services is strikingly low with 4.6%. Half of respondents stated that they were not given satisfactory information about further support services or procedures, and a significant minority reported insensitivity to their feelings (Mcgee et al., 2002).

Factors associated with help-seeking

In this study, factors associated with increased odds of requesting help were gender, sexual abuse and emotional abuse, whereas poverty, location and age were not associated with help-seeking. In contrast, a similar Canadian study with a much larger sample size (N = 23,000) found associations between contact with child protection organisations and younger age, poverty and gender, as well as exposure to physical, emotional and sexual abuse using adult self-report (Afifi et al., 2015). Differences in the findings may be due to differences in sample size and methodology as well as vastly different social welfare systems and resourcing.

Notably, girls were more likely to seek help for abuse than boys. Although girls reported higher rates of sexual abuse in this sample, interactions between abuse types and gender were not significant. This may demonstrate an increased vulnerability for male victims of sexual abuse who are not disclosing and accessing services (Artz et al., 2016). Several qualitative studies similarly find that male childhood sexual abuse victims experience similar barriers to disclosures as females and, in addition, face negative stereotypes and lack of acceptance of male sexual victimisation (Gagnier & Collin-Vézina, 2016; Sorsoli, Kia-Keating, & Grossman, 2008). Future qualitative research in South Africa should examine this further.

Cultural factors that were not measured in this study may also play a role: lower rates of disclosure in physical abuse cases may reflect high levels of societal acceptance of corporal punishment (Dawes, De Sas Kropiwnicki, Kafaar, & Richter, 2005). Lower rates in sexual abuse disclosure by males may be influenced by patriarchal societies and traditional values of strong males who are not victimised (Bridgewater, 2016).

Implications for future research

In addition to identifying a need for urgent action to improve services in South Africa, these findings also suggest a number of further research needs. (1) Examine service bottlenecks: although South Africa has a robust and well-considered legal framework for child protection, it would be valuable to explore how the application of this framework is failing abused children in these two provinces. (2) Investigate ways in which services can be made more accessible to children. (3) Explore the ways that services can be made more appealing and accessible to adult confidantes following child disclosure. (4) Examine how services can be

more gender- and child-sensitive. (5) Explore knowledge, attitudes and practices of mandated service providers to identify potential for changes in service delivery. (6) Investigate outcomes of community vigilante actions and why this approach is a preferred response of victims and their families, taking power dynamics among victims, confidantes and formal services into account. In addition, research should evaluate whether and in which ways use of each respective post-abuse service type impacts on the psychosocial well-being of victims.

Limitations

This study is subject to a number of limitations. First, data are not representative of the South African population as the study took place in low-income, black African communities only. However, the study benefitted from in-sample variation such as the inclusion of five African language groups from rural and urban areas. Second, the research used child-self report, which may be subject to social-desirability bias. However, self-report is preferable to social services data, considering the scope of the study and the variation across provinces in the provision of social services. Third, the study did not measure response to first disclosure and this makes it difficult to separate disclosure from help-seeking. Fourth, the authors had not anticipated vigilante action as a major source of help. Further research is needed to elucidate why families use vigilante action as a preferred response to child abuse. Finally, low numbers of children who had disclosed to a confidante did not allow for sub-group analyses due to a lack of statistical power on those who had received particular services or were re-victimised.

Implications for policy and programming

This study identifies a number of key implications for policy and programming in response to child abuse in South Africa. First, while children know where help is theoretically available when they experience abuse, few disclose and request help. Urgent action at national, provincial and municipal levels is needed to establish why this is the case and to determine how access to services and confidence in disclosure of abuse can be improved. In particular, stigmatisation of male sexual abuse victims needs to be addressed to increase levels of disclosure in boys. Second, the low number of abused children who receive formal services is concerning and has the potential to increase risk of re-victimisation as perpetrators are not prosecuted. Furthermore, there are increased health risks, particularly for sexually-abused children, as post-exposure prophylaxis for HIV-prevention and emergency contraception are not administered. These shortcomings need to be addressed urgently as they have the potential to lead to further severe traumatisation and poor health outcomes. Policy makers and child protection professionals who deliver services could enlist community support expressed by the vigilante movement to create safe and protective environments, thereby increasing our chances of circumventing the perpetuation of violence.

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Temporal patterns and predictors of bullying roles among adolescents in Vietnam: a school-based cohort study

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ABSTRACT

Although many cross-sectional studies have examined bullying experiences and correlated factors among adolescents in schools, relatively little is known about the extent to which bullying roles are stable or fluid over time. This short-term quantitative longitudinal study in Vietnam examined temporal patterns and predictors of bullying roles over an academic year. A total of 1424 middle and high school students aged 12–17 years completed two anonymous, self-administered questionnaires six months apart in 2014 and 2015. Young people were classified into different bullying roles as follow: not-involved (38.9%), victims only (24%), bullies only (6.6%), and bully-victims (40.4%) across the two times. About 60% of all surveyed students experienced bullying either as victim, bully, or bully-victim during the year. Of these students, nearly three in four indicated unstable bullying roles over time. Multivariate multinomial logistic regressions indicated factors ranging from individual (age, gender, and mental health) to family (social support, parental supervision and monitoring, witnessing parental violence, and conflict with siblings), school (perceived social support, teachers' attempt to stop bullying at school), and peers (social support, students' attempt to stop bullying at school) have significant associations with levels of bullying involvement. Implications for bullying prevention programs nationally and internationally are discussed.

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Introduction

Bullying is intentional and repeated aggression via physical, verbal, relational or cyber forms in which the targets cannot defend themselves (Olweus, 1994; Smith, Mahdavi, Carvalho, Fisher, Russell, & Tippett, 2008). This type of interpersonal aggression has been studied for over thirty years in Western countries (Smith, 2016) and more recently in North Asian

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countries, such as Japan (Toda, 2016; Yoneyama & Naito, 2003), Korea (Yang et al., 2006, 2013) and China (Chan & Wong, 2015).

The Southeast Asian region has a population of more than 600 million people, but to date there has been relatively limited standardised survey research into bullying, and no relevant cohort studies in schools in this region (Sittichai & Smith, 2015). In Vietnam, some research in schools has addressed various forms of violence among young people (Nguyen, 2012; Nguyen & Tran, 2013) and child maltreatment experiences (Le, Holton, Nguyen, Wolfe, & Fisher, 2015; Nguyen, Dunne, & Le, 2010). The studies that focus specifically on school bullying in Vietnam have used in-depth qualitative methods to explore the characteristics and contexts of bullying (Horton, 2011; Horton, Lindholm, & Nguyen, 2015; UNESCO, 2015).

Globally, scholars have identified four main bullying roles that to classify children's involvement as bully, victim, bully-victim (Gumpel, 2008; Gumpel, Zioni-Koren, & Bekerman, 2014; Salmivalli, Lagerspetz, Björkqvist, Österman, & Kaukiainen, 1996; Thornberg, 2007). International estimates suggest that from 10% to 30% of children and adolescents are victims only (Gumpel, 2008; Gumpel et al., 2014; Lereya et al., 2015; Solberg, Olweus, & Endresen, 2007; Vlachou, Andreou, Botsoglou, & Didaskalou, 2011). The proportions of those who bully others range from 3 to 15 % of adolescents (Gumpel et al., 2014; Lereya et al., 2015; Solberg et al., 2007). Further, bully-victims or 'provocative victims' (Gumpel, 2008) who are both victimised and bully others comprise between 15 and 20% of populations of young people (Lereya, Copeland, Zammit, & Wolke, 2015; Salmivalli, 2010).

Bullying is a very complex phenomenon that is related to multiple causal factors ranging from individual characteristics to school, family and social environments (Swearer Napolitano & Espelage, 2011). At the individual level, numerous factors have been linked with bullying roles, such as younger age (Chan & Wong, 2015; Hong & Espelage, 2012) and male gender. Risk of exposure may vary in different geographic regions. Boys are more likely to be engaged in bullying both as victims or perpetrators than are girls in some Asian countries (Chan & Wong, 2015; Yang et al., 2013); while females are more likely than males to report being bullied in some Western countries (Rigby & Johnson, 2016). Researchers have found significant associations between social media use and online or cyber victimisation or cyber perpetration (Mishna, Khoury-Kassabri, Gadalla, & Daciuk, 2012; Zhou et al., 2013). Notably, previous studies have reported the relationships between mental health problems and various types of victimisation in both online and offline spaces (Lereya et al., 2015; Yang et al., 2013).

Features of parent–child relationships can be either protective or risk factors for engagement in bullying. For instance, parental monitoring of Internet usage may prevent adolescents from bullying others online (Zhou et al., 2013). High parental social support can protect adolescents from being victimised by their peers (Holt & Espelage, 2007) or bullying others online and in traditional ways (Fanti, Demetriou, & Hawa, 2012; Wang, Iannotti, & Nansel, 2009). There are also many converse family influences. Adolescents who witness parental violence may be more likely to be involved in bullying others in school and online (Hemphill et al., 2012). Adolescents who are bullied by siblings are more likely to be victimised by their peers (Tucker, Finkelhor, Turner, & Shattuck, 2014) or to experience bully-victim roles in offline and online settings (Tanrikulu & Campbell, 2014).

School environment appears to strongly affect bullying involvement. Students who lack teacher's restrictions on their mobile phone usage (Zhou et al., 2013) have higher risk of being victims or perpetrators online. Also, those who experience less teacher social support

are more likely to be victims (Furlong & Maynard, 1995). Interestingly, there is a positive correlation between cyberbullying perpetration and students' perception about teachers' abilities in stopping bullying at school (Elledge et al., 2013). The majority of students who are bullied do not disclose this to their teachers (Mishna et al., 2012). It may be because students assume that school staff would not help them (Li, 2007).

Young people who have antisocial friends in early adolescence are more likely to engage in both traditional and cyberbullying perpetration (Hemphill et al., 2012). Also, students who lack peer social support are more likely to be cyber victims (Fanti et al., 2012) and traditional victims (Furlong & Maynard, 1995). Peers can be protective as well; victimisation at school may be less likely when peers do not agree with bullying (Denny et al., 2015).

To date, little is known about the extent to which the bullying roles are stable or fluid over time (Gumpel et al., 2014; Ryoo, Wang, & Swearer, 2015). There is some emerging evidence that the majority of youth who report involvement have infrequent experiences (Ryoo et al., 2015). Even for youth who bully others, there seems to be unstable involvement over one or a few years at middle or high school (Lereya et al., 2015). Findings of an ethnographic study conducted with 10th grade adolescents revealed that 'many roles are fluid' (Gumpel et al., 2014) in specific situational context. Unfortunately, most evidence regarding factors associated with bullying roles has been derived from cross-sectional studies (Cook, Williams, Guerra, Kim, & Sadek, 2010; Hong & Espelage, 2012). The present study builds upon prior research by Lereya et al. (2015) to examine the extent to which students have stable or unstable in bullying roles over time. We analyse associations between individual characteristics and family, peer and school relationships and the different levels of patterns in bullying roles among adolescents in schools in Vietnam.

Method

Data for this study were derived from two waves of school-based surveys, six months apart at four public middle and high schools in urban areas of Vietnam during the academic year 2014–2015. Details of the study are described elsewhere (Le, Holton, Nguyen, Wolfe, & Fisher, 2016a). Briefly, an invitation to participate in the study was sent to 1668 students, of whom 1539 (92.3%) consented to and completed the questionnaire at the baseline survey (Time 1). Of them, 1460 students were followed up at Time 2. The final sample for analyses included 1424 students, accounting for 92.5% of the initial sample. Of the remainder, 115 students were lost to follow-up or could not be matched at Time 2 due to absence on the survey days, change in school, or inability to visually match questionnaire identification across the two surveys. Male students comprised 45.1% of the sample. Age ranged from 12 to 17 ($M = 14.7$, $SD = 1.87$). The majority of students lived with both biological parents (87.6%) and had at least one sibling (89.0%). Most students (90%) said they can access the Internet and spent at least one hour daily online.

Ethical clearance was obtained from the Human Research Ethics Committees of the Queensland University of Technology (No. 1400000713) and Hanoi University of Public Health (No. 279/2014/YTCC-HD3). All respondents in the study provided informed consent prior to survey administration.

Measures

Bullying victimisation and perpetration

Traditional and cyber bullying victimisation and perpetration were measured in relation to six behaviours including hitting/kicking/shoving around, robbing/stealing/damaging properties, threatening/forcing someone to do things they do not want to do, calling mean names/teasing in rude ways, excluding, and spreading rumours. These behaviours were identified from literature review and through 16 in-depth interviews during the pilot phase with and were validated among Vietnamese students (Le et al., 2016a). A definition adapted from Ybarra, Boyd, Korchmaros, and Oppenheim (2012) and Langos (2012) was given to students prior to the completing the questionnaires in order to standardise understanding of bullying. For the victimisation scale, students were prompted with the question 'How often have you been bullied in any way during the last six months?' then six items were presented. The bullying perpetration measurement was similar, with prompts to ask the students how often they bullied others. We distinguished traditional bullying from cyber-bullying via different modes of communication (in-person or cyber) by which students experienced bullying behaviours. A five-point Likert scale, ranging from 0 = 'never', 1 = 'a few times during the last six months', 2 = 'once or twice a month'; 3 = 'once or twice a week', to 4 = 'almost every day', was used to measure frequency of behaviour, for each mode of communication. The study employed a cut-off point to classify victimisation or perpetration behaviours from '1 = a few times' to more often.

Risk and protective factors

Demographic characteristics of the respondents included age (year of birth), gender (0 = female, 1 = male), family structure (0 = living with both parents, 1 = living with single parent/stepparent/others).

Reaction when seeing bullying events was assessed with an item from the Olweus Bully/Victim Questionnaire (Olweus, 1996). The respondents were asked 'How do you usually react if you see or understand that a student at your age is being bullied by other students?' with possible responses: 0 = I have never noticed; 1 = I take part in; 2 = I don't do anything, but I think the bullying is OK; 3 = I just watch goes on; 4 = I don't do anything, but I think I ought to help; 5 = I try to help the bullied student in one way or another.

Online activities were measured with 4 items asking respondents about time spent on online activities including communication, social networking and entertainment in the past week. The five-point Likert scale response options were '1 = never use', '2 = several times a week', '3 = several times a day', '4 = several times an hour', '5 = all the time'. Summed scores ranged from 4 to 20, with higher score indicating more time spent online.

Parents' and teachers' supervision of online activities were assessed by two questions: How often do your (i) 'parents supervise your online activities?' and (ii) 'teachers supervise your online activities?'; using a 5-point Likert scale (1 = none of the time to 5 = all of the time). *Parents' and teachers' control of Internet and mobile phone usage* was measured with these questions: How often do your parents (i) 'control your access to the Internet?', (ii) 'control your use of the mobile phone?' and how often do your teachers (iii) 'control your access to the Internet?', (iv) 'control your use of the mobile phone?'. Response options were on a 5-point Likert scale ranging from '1 = none of the time' to '5 = all of the time'.

Family, friend, and school social support was measured by the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS comprises 12 items that are equally distributed to measure family support (e.g. 'My family really tries to help me'), friend support (e.g. 'My friends really try to help me'), and school support (e.g. 'There is a school staff member who is around when I am in need'); using a 4-point Likert scale ranging from '1 = strongly disagree' to '4 = strongly agree'. These were summed with higher score values indicating higher levels of support. In this study, alpha coefficients for the three subscales respectively were .88 (family support), .91 (friend support), and .90 (school support) at Time 1.

Witnessing parents serious arguing or fighting was assessed by asking students 'How often have you witnessed your parents having (i) a serious argument with each other? and (ii) physically fighting with each other?; using a 4-point Likert scale ranging from 1 = never to 4 = often. In this study, alpha coefficients were .71 at Time 1.

Conflict with siblings was assessed with the question 'How often have you had serious conflict (argument, fighting etc.) with your siblings?' using 4-point Likert scale ranging from 1 = never to 4 = often.

Perceptions of students and teachers trying to stop bullying at school were assessed by asking students 'How often do (i) teachers/other adults try to stop to it when a student is being bullied at school? and (ii) students at school try to stop to it when a student is being bullied at school?; using a 5-point Likert scale ranging from 1 = almost never to 5 = almost always.

Depressive symptoms were measured with The Centre for Epidemiological Studies-Depression Scale (CESD) (Radloff, 1977). The scale comprises 20 items (e.g. 'I felt lonely'). Respondents were asked to indicate the frequency with each item that they experienced during the previous week. Response options on the four-point scale were 0 = 'less than 1 day', 1 = '1–2 days', 2 = '3–4 days', and 3 = '5–7 days'. These were summed with scores ranging from zero to 45, the higher scores indicating the higher level of depressive symptom. In this study, the alpha coefficient for this scale was .86 for Time 1.

Psychological distress was assessed by using The Kessler Psychological Distress Scale (K10) (Kessler et al., 2002) . The scale includes 10 items (e.g. 'during the last 30 days, about how often did you be tired out for no good reason?' to measure emotional feelings experienced in the last month with a five-point Likert scale ranging from '1 = none of the time' to '5 = all of the time'. A composite score was created so that a higher score indicated higher levels of psychological distress. In this study, the alpha coefficient was .87 at Time 1.

Self-esteem was assessed by The Rosenberg Self-esteem scale (RSES) (Rosenberg, 1965). The scale includes 10 items (e.g. 'On the whole, I am satisfied with myself') using a 4-point Likert scale ranging from '1 = strongly agree' to '4 = strongly disagree'. Higher score values higher levels of self-esteem. Cronbach's alpha was .70 at Time 1.

Suicidal ideation was measured with three items adapted from the American School Health Association (Kent, 1989). Respondents were asked 'During past 6 months, have you ever (i) seriously thought about attempting suicide? (ii) made a specific plan about how you would attempt suicide? and (iii) attempted suicide?'. The responses were categorised as 0 = no, 1 = yes if respondents admitted at least one of these thoughts or behaviours.

Data analyses

Data analyses were performed using Stata (version 11.2). Descriptive analyses explored the prevalence and stability in bullying experiences as well as the characteristics and distribution of other variables. Multinomial logistic regressions were utilised in bivariate and multivariate association analyses. Bivariate analyses examining the associations between each predictor at Time 1 and temporal patterns of bullying roles as victims, bullies, and bully-victims were conducted. All predictors with p value ≤.2 (Bursac, Gauss, Williams, & Hosmer, 2008) were entered in the multivariate models, controlling for other significant variables. Multinomial logistic regressions were utilised in bivariate and multivariate association analyses.

Results

Prevalence of bullying victimisation and perpetration

Table 1 presents prevalence estimates for specific forms of traditional bullying and cyberbullying victimisation and perpetration at Times 1 and 2. Cyberbullying victimisation and perpetration were reported much less often than traditional bullying experiences at both times. A high correlation between traditional and cyberbullying was observed, with very few students experiencing only cyberbullying victimisation or perpetration.

Temporal pattern in bullying roles

The responses from students were divided into four bullying roles at Times 1 and 2. The baseline survey yielded prevalence estimates for each role: not involved at all (48.3%); victims only (22.7%); bullies only (6.9%); and bully-victims (22%). At follow-up six months later, the estimates were: not involved (62.1%); victims only (17.6%); bullies only (4.7%); and bully-victims (15.5%). Subsequently, we measured temporal patterns of each bullying

Table 1. Specific forms of traditional and cyberbullying victimisation and perpetration among school adolescents at Times 1 and 2.

	Victimisation *N* (%)		Perpetration *N* (%)	
Behaviours	Traditional	Cyber	Traditional	Cyber
TIME 1				
Hitting	373 (26.2)	NA	247 (17.3)	NA
Robbing	170 (11.9)	NA	43 (3.0)	NA
Threatening	140 (9.8)	78 (5.5)	85 (6.0)	31 (2.2)
Teasing	392 (27.5)	112 (7.9)	202 (14.2)	57 (4.0)
Excluding	97 (6.8)	36 (2.5)	105 (7.4)	35 (2.5)
Spreading rumours	166 (11.7)	83 (5.8)	58 (4.1)	33 (2.3)
Specific form	620 (43.5)	170 (11.9)	400 (28.1)	87 (19.8)
Any or both forms	637 (44.7)	412 (28.9)		
TIME 2				
Hitting	290 (20.4)	NA	185 (13.0)	NA
Robbing	127 (8.9)	NA	39 (2.7)	NA
Threatening	105 (7.4)	57 (4.0)	64 (4.5)	37 (2.6)
Teasing	308 (21.6)	86 (6.0)	149 (10.5)	41 (2.9)
Excluding	75 (5.3)	24 (1.7)	80 (5.6)	28 (2.0)
Spreading rumours	140 (9.8)	69 (4.8)	53 (3.7)	28 (2.0)
Specific form	461 (32.4)	134 (9.4)	282 (19.8)	66 (4.6)
Any or both forms	472 (33.1)	288 (20.2)		

Note: NA = not applicable.

role by following Turner and his colleague's classification (Turner, Shattuck, Finkelhor, & Hamby, 2015) to categorise the respondents into four levels of bullying involvement: stable-low, declining, increasing, and stable-high. Further details of generating the patterns of bullying roles over Times 1 and 2 have been provided elsewhere (Le et al., 2016b).

The levels of stability in bullying roles across two times were: (i) not involved in any bullying at either time, accounting for 38.9% of the sample, (ii) victims only, accounting for 24% (of these students, 58.2% were stable-low, 17.0% declining at time 2, 14.3% increasing at time 2, 10.5% were stable-high), (iii) bullies only, accounting for 6.6% (of them, 23.4%

Table 2. Multivariate multinomial logistic regression of predictors for intensity of stability in victimisation across Times 1 and 2.

	Intensity of stability in Victimisation (the ref. group: 'Not-involved')			
Predictors measured at Time 1	Stable low OR (95% CI)	Declining OR (95% CI)	Increasing OR (95% CI)	Stable high OR (95% CI)
Gender				
Female	1.0	1.0	1.0	1.0
Male	1.3 (.9–1.9)	1.8 (.9–3.7)	.6 (.3–1.4)	3.5 (1.4–8.4)**
Age (years)	.8 (.7–.9)***	.7 (.6–.9)**	.8 (.6–.9)**	.8 (.6–1.0)†
Depressive symptoms	1.0 (.9–1.0)	1.04 (1.0–1.1)†	1.0 (.9–1.0)	1.05 (1.0–1.1)†
Psychological distress	1.1 (1.0–1.1)**	1.1 (1.0–1.1)*	1.0 (.9–1.1)	1.08 (1.0–1.1)*
Reaction when seeing bullying events				
Never noticed	1.0	1.0	1.0	1.0
Take part in/think bullying is acceptable	.8 (.4–1.7)	1.0 (.2–3.9)	1.6 (.4–5.9)	.8 (.1–4.9)
Think they ought to help	1.1 (.6–1.9)	.8 (.2–2.8)	1.3 (.4–3.9)	1.1 (.3–4.5)
Try to help stop bullying	.9 (.6–1.5)	2.2 (.9–5.5)	1.7 (.7–4.4)	2.4 (.8–7.3)
Time spent online	1.0 (.9–1.1)	1.1 (.9–1.2)	1.1 (.9–1.2)	.9 (.8–1.1)
Parents' supervise online				
Frequent	1.0	1.0	1.0	1.0
Infrequent	1.6 (1.0–2.4)**	1.0 (.5–2.2)	.7 (.3–1.4)	1.7 (.7–4.4)
Parents' control Internet access and mobile phone				
Infrequent	1.0	1.0	1.0	1.0
Frequent	1.4 (.9–2.0)	1.1 (.5–2.3)	.8 (.4–1.7)	1.8 (.8–4.3)
Family social support				
High	1.0	1.0	1.0	1.0
Low	1.5 (.9–2.3)†	.8 (.4–1.7)	1.0 (.4–2.2)	1.4 (.5–3.7)
Witness parental violence				
No/rarely	1.0	1.0	1.0	1.0
Often	1.2 (.8–1.8)	1.6 (.8–3.3)	1.3 (.6–2.7)	1.0 (.4–2.4)
Conflict with siblings				
No/rarely	1.0	1.0	1.0	1.0
Often	1.3 (.9–1.9)	1.3 (.6–2.6)	1.2 (.5–2.4)	1.2 (.5–2.9)
Perception of teachers trying to stop bullying				
Frequent	1.0	1.0	1.0	1.0
Infrequent	.8 (.5–1.2)	.6 (.3–1.3)	.7 (.3–1.5)	.6 (.3–1.5)
School social support				
High	1.0	1.0	1.0	1.0
Low	1.0 (.6–1.5)	1.7 (.7–3.8)	.9 (.4–2.1)	1.3 (.5–3.5)
Friend social support				
High	1.0	1.0	1.0	1.0
Low	.9 (.6–1.5)	1.3 (.6–2.8)	1.5 (.7–3.2)	1.3 (.5–3.1)
Perception of students trying to stop bullying				
Frequent	1.0	1.0	1.0	1.0
Infrequent	1.8 (1.2–2.9)**	3.0 (1.3–6.7)**	2.0 (.9–4.6)†	1.5 (.6–4.1)

$^{\dagger}p < .10$ $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Table 3. Multivariate multinomial logistic regression of predictors for intensity of stability in perpetration across Times 1 and 2.

	Intensity in stability in perpetration (ref group: Not-involved)		
Predictors measured at Time 1	Stable low OR (95% CI)	Declining OR (95% CI)	Increasing OR (95% CI)
Gender			
Female	1.0	1.0	1.0
Male	.9 (.3–2.6)	1.7 (.7–4.0)	1.6 (.7–3.6)
Age (years)	1.3 (.9–1.8)	.8 (.6–1.1)	1.0 (.7–1.2)
Depressive symptoms	1.0 (.9–1.0)	1.0 (.9–1.0)	.9 (.9–1.0)
Psychological distress	.9 (.8–1.0)	1.1 (.9–1.1)	1.0 (.9–1.1)
Time spending online	1.1 (.9–1.3)	1.1 (1.0–1.3)†	1.1 (.9–1.2)
Family structure			
Living with biological parents	1.0	1.0	1.0
Living with single parent/stepparent/ others	4.8 (1.6–14.6)*	.6 (.1–2.9)	1.6 (.5–5.0)
Family social support			
High	1.0	1.0	1.0
Low	2.1 (.7–6.1)	1.3 (.5–3.3)	.8 (.3–2.1)
Witnessed parental violence			
No/rarely	1.0	1.0	1.0
Often	.2 (.1–.8)*	2.6 (1.0–6.7)*	1.6 (.7–3.6)
Conflict with siblings			
No/rarely	1.0	1.0	1.0
Often	2.2 (.8–6.3)	2.0 (.8–4.6)	2.9 (1.3–6.5)*
Teachers' supervise online			
Frequent	1.0	1.0	1.0
Infrequent	.8 (.3–2.3)	1.4 (.6–3.2)	1.7 (.7–3.8)
School social support			
High	1.0	1.0	1.0
Low	2.0 (.6–5.9)	1.4 (.5–3.4)	.9 (.4–2.2)

$^{\dagger}p < .10$ $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

were stable-low, 36.2% were declining, 40.4% were increasing which included just 4 students who were involved at stable-high level), and (iv) bully-victims, accounting for 40.4% (of these students, 52.8% were stable-low, 19.3% declining, 14.5% increasing, and 13.4% were stable-high).

Determinants of bullying roles

Associations between individual, family, peer and school related factors at Time 1 and levels of stability in bullying roles over Times 1 and 2 were examined. Table 2 presents the results of multivariate multinomial logistic regression of predictors of temporal patterns of victim role. Older students significantly decreased the odds of being in the stable-low, declining, or increasing victimisation groups, compared to the not involved group. Those students who reported higher level of psychological distress, low parental supervision of online activities, and those who perceived that other students infrequently try to stop bullying at school increased the odds of being in the stable-low victimisation group. Students who reported higher psychological distress and perceived that students infrequently try to stop bullying at school were more likely to be in the declining group (e.g. involved high at Time 1 but low at Time 2). These factors were not associated with the likelihood of students being in the group with increasing victimisation, with the exception of younger students. Male students who reported higher psychological distress had increased odds of being frequent victims over time (e.g. stable high victimisation).

Table 4. Multivariate multinomial logistic regression of associated predictors for changes in Bully-victim status across Times 1 and 2.

	Bully-victim group (Ref. group: not-involved)			
Predictors measured at Time 1	Stable low OR (95% CI)	Declining OR (95% CI)	Increasing OR (95% CI)	Stable high OR (95% CI)
Gender				
Female	1.0	1.0	1.0	1.0
Male	1.9 (1.2–2.8)***	1.7 (.9–3.1)	2.2 (1.1–4.2)*	2.3 (1.1–4.6)*
Age (years)	.6 (.5–.7)***	.7 (.6–.9)**	.7 (.5–.9) **	.5 (.4–.7)***
Depressive symptoms	1.01 (1.0–1.0)	1.07 (1.0–1.1)**	1.01 (.9–1.1)	1.0 (.9–1.0)
Psychological distress	1.04 (1.0–1.1)	1.04 (.9–1.1)	1.07 (1.0–1.1)*	1.07 (1.0–1.1)*
Self-esteem	1.04 (1.0–1.1)	1.1 (1.0–1.2)	1.03 (.9–1.1)	1.1 (1.0–1.2)**
Suicidal ideation				
No	1.0	1.0	1.0	1.0
Yes	1.2 (.7–2.2)	1.1 (.5–2.4)	1.9 (.8–4.3)	1.6 (.7–3.9)
Reaction when seeing bullying events				
Never noticed	1.0	1.0	1.0	1.0
Take part in bullying events	.4 (.04–4.4)	8.6 (1.8–40.5)**	4.3 (.6–28.9)	4.2 (.6–30.5)
Passively watch and think bullying is acceptable	1.8 (.9–3.7)	1.6 (.5–5.1)	2.3 (.8–7.1)	3.4 (1.0–11.2)*
Think they ought to help	1.7 (1.0–3.1)	1.2 (.5–3.4)	1.2 (.4–3.5)	2.4 (.8–7.4)
Help stopping bullying	1.2 (.7–2.0)	2.2 (.9–4.5)	1.1 (.4–2.8)	1.4 (.5–4.2)
Time spending on online	1.0 (.7–1.5)	.9 (.5–1.7)	.8 (.4–1.6)	1.1 (.5–2.3)
Family structure				
Living with biological parents	1.0	1.0	1.0	1.0
Living with single parent/stepparent/others	2.3 (1.4–4.1)**	.9 (.3–2.3)	.3 (.1–1.6)	1.5 (.5–4.1)
Parents' supervise online				
Frequent	1.0	1.0	1.0	1.0
Infrequent	1.2 (.8–1.8)	1.4 (.7–2.6)	1.9 (.9–3.8)†	1.3 (.6–2.7)
Parents' control Internet access and mobile phone				
Infrequent	1.0	1.0	1.0	1.0
Frequent	.9 (.6–1.3)	.5 (.3–.9)*	.8 (.4–1.6)	.9 (.4–1.8)
Family social support				
High	1.0	1.0	1.0	1.0
Low	1.1 (.7–1.7)	1.8 (.9–3.6)	.8 (.4–1.8)	1.4 (.6–3.1)
Witness parental violence				
No/rarely	1.0	1.0	1.0	1.0
Often	2.9 (1.9–4.4)***	1.8 (1.0–3.4)	2.0 (1.0–4.2)*	3.1 (1.4–6.8)**
Conflict with siblings				
No/rarely	1.0	1.0	1.0	1.0
Often	.9 (.6–1.3)	1.3 (.7–2.4)	1.1 (.6–2.2)	1.6 (.8–3.3)
Teacher's control mobile phone/Internet frequently				
Frequent	1.0	1.0	1.0	1.0
Infrequent	1.2 (.8–1.8)	.8 (.4–1.4)	1.6 (.8–3.3)	.6 (.3–1.3)
Perceive that teachers trying to stop bullying				
Frequent	1.0	1.0	1.0	1.0
Infrequent	1.1 (.7–1.7)	1.1 (.6–1.9)	1.3 (.6–2.5)	2.2 (1.1–4.6)*
School social support				
High	1.0	1.0	1.0	1.0
Low	1.6 (1.0–2.6)*	.9 (.4–1.8)	1.8 (.8–3.8)	1.3 (.6–3.0)
Friend's social support				
High	1.0	1.0	1.0	1.0
Low	1.1 (.7–1.7)	.8 (.4–1.5)	.6 (.3–1.3)	1.0 (.5–2.1)
Perceived that students try to stop bullying				
Frequent	1.0	1.0	1.0	1.0
Infrequent	1.4 (.9–2.2)	1.3 (.7–2.5)	1.2 (.6–2.3)	1.3 (.6–2.8)

†$p < .1$ *$p < .05$; **$p < .01$; ***$p < .001$.

Predictors of temporal patterns of the 'bully only' role are presented in Table 3. Only a few factors were significantly associated with perpetration. Students who were not living

with both biological parents had higher odds of being in the stable-low perpetration group. Students who witnessed parental violence had higher odds of being in perpetration at Time 1 than at Time 2 (i.e. the declining group), and those who had serious conflict with siblings had higher odds of being involved in the increasing perpetration, compared to students not involved in bullying.

Table 4 summarises findings for factors associated with temporal patterns of bully-victim role over time. The adjusted models show that the odds of being in any bully-victim group significantly decreased with age, and were higher among males. Adolescents who were not living with both biological parents, or who witnessed parental violence often, and experienced low school social support had higher odds of being in the low level but chronic bully-victim group. Students who reported more depressive symptoms and those who showed their support to perpetrators were more likely to have been involved in the bully-victim group at a higher level at Time 1 than at Time 2 (i.e. the declining group). Interestingly, frequently reported parental control of children's mobile phone and Internet access was associated with lower odds of being in the declining bully-victim group. Experiencing higher psychological distress increased the odds of being in the increasing or stable-high bully-victim groups. Adolescents who reported higher self-esteem, and those who passively watched and thought bullying was acceptable, and who perceived that teachers infrequently try to stop bullying at school, had higher odds of being high involvement as both victims and bullies over time.

Discussion

This is the first short-term quantitative longitudinal study of bullying in Vietnam and any Southeast Asian country (Sittichai & Smith, 2015) and one of few international studies examining predictors for different levels of temporal stability in bullying roles among school adolescents. It is clear that traditional bullying victimisation and perpetration are much more common than cyberbullying victimisation and perpetration among Vietnamese school students. This pattern is unlikely to be due to limited online activity, as over 90% of students reported using mobile phones and other devices that connect to the Internet and most spend at least one hour daily online. The dominance of traditional bullying victimisation and perpetration and high correlations between traditional bullying and cyberbullying are consistent with previous studies in both Western and Asian countries (Chan & Wong, 2015; Modecki, Minchin, Harbaugh, Guerra, & Runions, 2014; Olweus, 2013). There is growing evidence worldwide that cyberbullying rarely occurs in isolation from traditional forms. Preventive intervention should address all forms of bullying rather than focus heavily on the online environment (Modecki et al., 2014). Anti-bullying programs should include components on cyberbullying within the context of broader efforts to prevent interpersonal conflict and violence.

In relation to stability or change in bullying roles, our findings show that about 60% of students engaged in bullying roles as victim, bully, or bully-victim at some point during the year. Of these students, nearly three in four indicated unstable bullying roles over time. The findings are consistent with other studies indicating that bullying experiences are fluid (Gumpel et al., 2014; Lereya et al., 2015). Among the students who experiences remained stable, the two largest groups were those with stable-low victimisation or stable-low bully-victim status. The largest group of perpetrators also had low level and stable involvement.

In contrast, stable high involvement over time was relatively rare for victims, bullies and bully-victims. These patterns are similar to a North American study (Ryoo et al., 2015) that showed victimisation and bully-victim status were more stable at low level involvement. In contrast to the relatively few stable-high victims or perpetrators, students were more likely to change their role over the six-month period (i.e. declining or increasing groups).

Consistent with international trends, age differences were observed among the victimisation and bully-victim groups in Vietnam. Students were more likely to be victimised in early secondary school (sixth and seventh grade) while transitioning from primary school to a new environment (Cook et al., 2010; Olthof, Goossens, Vermande, Aleva, & van der Meulen, 2011). At this time, some children seek social dominance over their peers in a new environment; for many, this places them at risk of being in the victimisation or bully-victim group. This underscores the need to start prevention of bullying early when students are in primary school and especially for students in transition years (Olthof et al., 2011).

The present study found that adolescents who experience poor mental health might be most at risk of becoming victimised, or being bully-victims, over time (Cappadocia, Craig, & Pepler, 2013; Goldbaum, Craig, Pepler, & Connolly, 2003). Analyses of these data indicated that those with the worst mental health had more persistent and frequent involvement as victims or bully-victims. To be effective, anti-bullying efforts should be a core element of mental health promotion in schools rather than addressed in programs that stand alone from mental health promotion efforts (Carta, Fiandra, Rampazzo, Contu, & Preti, 2015).

As in other societies, it is clear that social normalisation of bullying has negative effects among Vietnamese adolescents. Perceptions that peers typically react against bullying are significantly associated with declining victimisation (Denny et al., 2015). This is also consistent with findings from previous research indicating that school students are more likely to be victimised when there are social rewards to the perpetrators (like cheering) and less support to the victims (Denny et al., 2015; Salmivalli, 2014). It is possible that if students are aware of their teachers trying to stop bullying in school, they change their strategy to bully their peers in covert forms, including cyberbullying, where the teachers are less able to monitor the behaviour (Elledge et al., 2013).

There was no significant association between family support and bullying experiences. It is possible that students think parents are unable to help them to solve the problem or it is not discussed if there are wide gaps in communication between children and their parents (Trinh, Steckler, Ngo, & Ratliff, 2009). The situation is further complicated because children's experience at violence at home influence their bullying experiences outside. Similar to previous studies, Vietnamese students who witness parental conflict or are bullied by siblings are more prone to perpetrate bullying (Hemphill et al., 2012; Hong & Espelage, 2012). It seems that students involved in bullying as perpetrators or as bully-victims are exposed to complex risk environments with many relationship problems with family, school, and peers. Indeed, while bullying events mostly happen in school settings, the majority of predictors of perpetration in this study were related to the family environment. Violence and disharmony at home predict perpetration and bully-victim status. It is recommended that future protective interventions and broader prevention programs need to address family conflict (Hemphill et al., 2012). Parents should be engaged in anti-bullying programs and be educated to recognise the impact of their own behaviours and home environment. In addition, the link between inter-sibling aggression and peer bullying (Wolke, Tippett, & Dantchev, 2015) suggests interventions need to involve other family members.

In conclusion, these novel findings from a Southeast Asian country strongly suggest that anti-bullying programs should incorporate action across a wide range of settings and social relationships, rather than focus primarily on classmate relationships or social skills training (Mitchell, Finkelhor, Jones, & Wolak, 2012). This study has highlighted the need for comprehensive prevention and intervention programs against bullying in schools throughout Vietnam.

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Understanding social norms and violence in childhood: theoretical underpinnings and strategies for intervention

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ABSTRACT

Violence in childhood is a widespread human rights violation that crosses cultural, social and economic lines. Social norms, the shared perceptions about others that exist within social groups, are a critical driver that can either prevent or perpetuate violence in childhood. This review defines injunctive and descriptive social norms and lays out a conceptual framework for the relationship between social norms and violence in childhood, including the forces shaping social norms, the mechanisms through which these norms influence violence in childhood (e.g. fear of social sanctions, internalization of normative behavior), and the drivers and maintainers of norms related to violence in childhood. It further provides a review of theory and evidence-based practices for shifting these social norms including strategic approaches (targeting social norms directly, changing attitudes to shift social norms, and changing behavior to shift social norms), core principles (e.g. using public health frameworks), and intervention strategies (e.g. engaging bystanders, involving stakeholders, using combination prevention). As a key driver of violence in childhood, social norms should be an integral component of any comprehensive effort to mitigate this threat to human rights. Understanding how people's perceptions are shaped, propagated, and, ultimately, altered is crucial to preventing violence in childhood.

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Introduction

Violence in childhood is a widespread human rights violation that crosses cultural, social and economic lines (UNICEF, 2014). Worldwide, at least 23% of adults report experiencing physical abuse as a child, 36% report experiencing emotional abuse, and 16.3% report experiencing physical neglect (Hillis, Mercy, Amobi, & Kress, 2016). Violence in childhood occurs in a variety of contexts – from the home and family to schools and communities – and manifests in various ways within different types of relationships. Both boys and girls experience violence in childhood but differ in the nature of the violence experienced (Landers, 2013; UNICEF, 2014). Violence experienced in childhood can be direct – when a child experiences aggression – or indirect, when she or he witnesses the aggression (Fleckman,

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Drury, Taylor, & Theall, 2016). Direct violence includes both interpersonal violence and self-directed violence (Krug, Mercy, Dahlberg, & Zwi, 2002).

The repercussions of violence in childhood are powerful and enduring. Early abuse can hinder brain development, leading to long term problems with learning and cognitive ability (Landers, 2013). Childhood violence additionally increases survivors' likelihood of depression, anxiety, aggression, criminal behavior, and self-abuse (Landers, 2013). The effects may be particularly pronounced among female survivors, who experience more severe economic repercussions, complete fewer years of education, and have lower IQ levels as a result of childhood violence than their male counterparts (Currie & Widom, 2010). Children who live in homes and neighborhoods with high levels of intimate partner violence (IPV) or other forms of physical and emotional violence are more likely to experience clinical disorders, aggression, irritability, and interpersonal difficulties, and may be more likely to perpetrate IPV as adults (Edleson, 1999; Klugman et al., 2014; Schwab-Stone et al., 1995; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Additionally, the economic costs of childhood violence are high; it increases health, welfare, and criminal justice expenditures while decreasing rates of productivity and property values (WHO, 2016; Zielinski, 2009).

Regardless of its type or context, violence in childhood is a social problem embedded within a broader social ecology, with risk factors existing at the individual, interpersonal, household, community, and societal levels (Craig et al., 2009; Dunne & Salvi, 2014; Feldman-Jacobs & Clifton, 2014; UNICEF, 2014; Young & Hassan, 2016). Social norms are a key aspect of this social ecology that can either prevent or perpetuate violence in childhood (Bhatla, Achyut, Khan, & Walia, 2015; Boyce, Zeledón, Tellez, & Barrington, 2016; Carlson et al., 2015). This paper describes the relationship between social norms and violence in childhood. It defines social norms, conceptualizes them with respect to their influence on violence in childhood, and provides key mechanisms and strategies for effective social norms change processes.

Methods

From June through August, 2016, the authors conducted a review and synthesis of the peer-reviewed and grey literature based on experts' knowledge of the literature and a search of scholarly databases. To capture the multidisciplinary swath of research on the subject, the investigators used PubMed, Google Scholar, and Web of Science. The references in priority citations were also reviewed for additional relevant sources. Only articles published in English were considered for this review. While not systematic, this review was intended to provide an overview of the literature as well as practical and theoretical linkages between social norms and violence in childhood.

Defining social norms

Social norms are shared perceptions about others that exist within social groups and are maintained through group approval and disapproval (Mackie, Moneti, Denny, & Shakya, 2012). There are two broad types of social norms: 1. descriptive norms: perceptions about what members of social groups do and, 2. injunctive norms: perceptions about what members of a social group think others ought and ought not to do (Cialdini, Reno, & Kallgren, 1990; Rimal & Real, 2005).

While descriptive norms characterize perceptions about the prevalence of a certain behavior, injunctive norms describe the extent to which individuals feel pressured- through either perceived social benefits or sanctions- to engage in a certain behavior. What is commonly referred to as social norms can reflect behaviors, attitudes, beliefs, and moral judgements about what behaviors are "right". In order for a social norm to be perpetuated, the majority of people do not need to believe it is right or true, but rather perceive that others in their social group believe it to be right or true (Berkowitz, 2003). And, social norms do not necessarily reflect reality; members of a social group may think that a belief or behavior is prevalent within their social group when, in actuality, it is not (Borsari & Carey, 2003).

Social norms are linked to, but distinct from, both personal attitudes and individual behavior. Individual behavior is what one does, whereas norms reflect what one think or believes others do. Personal attitudes are the extent to which a person evaluates something with favor or disfavor (Eagly & Chaiken, 2007). Social norms, personal attitudes, and individual behavior all influence each other. However, research suggests that in cases when social norms and personal attitudes are incongruous, social norms may, in fact, exert a more powerful influence on individuals' behavior (Asch, 1951; Mackie et al., 2012; Nolan, Schultz, Cialdini, Goldstein, & Griskevicius, 2008). This can mean that an individual behaves in a way that adheres to what she or he believes others deem acceptable, even if this behavior is inconsistent with her or his own beliefs.

Conceptual framework: social norms and violence in childhood

Forces shaping social norms

Social norms are not formed within a vacuum. Rather, they are shaped by larger environmental forces including culture, religion, policy and regulation, and economics. In Peru, for example, daughters have less economic potential compared to sons, which drives social norms permissive of parental neglect (Larme, 1997). In countries such as Sierra Leone and Guinea, with high prevalence of female genital mutilation, social norms related to the practice are strongly rooted in cultural and religious beliefs suggesting it enhances fertility and promotes female purity (Gruenbaum, 2005; Sipsma et al., 2012). Additionally, in South Asia, social norms related to child marriage are perpetuated by an entrenched system of patriarchy which denies women and girls rights to their own body and sexuality (Malhotra et al., 2011).

Mechanisms through which social norms influence violence in childhood

Social norms are one way that violence "transmits" within groups (Ransford & Slutkin, 2016). Through the fear of social sanctions, desire to win approval, and internalization of normative behavior, perceived social norms can influence people to perpetrate, condone, or challenge violence (Bandura, 2004; Fishbein & Ajzen, 1977; Marcus & Harper, 2014). The motivation to avoid sanctions and win approval from one's social group is a powerful force grounded in human physiology. The brain experiences social and physical pain in similar ways, sometimes driving people to conform with social norms, even if they personally disagree with the dominant attitude or behavior (Bandura, 1986; Marcus & Harper, 2014). Additionally, people are socialized into specific norms starting at a young age, allowing

certain ideas and behaviors to be taken for granted as the only way to think or act. Fear of stigma, guilt, and shame all contribute to the maintenance of common practices by discouraging individuals from challenging prevailing norms (Marcus & Harper, 2014; Posner & Rasmusen, 1999).

Drivers and maintainers of social norms related to violence in childhood

Figure 1, adapted from Marcus and Harper's (2014) framework, highlights many of the forces that can be harnessed or targeted in order to shift the social norms that influence violence in childhood. The framework illustrates the broad factors that shape social norms (e.g. economics, culture, law), the bidirectional relationships between social norms, individual attitudes, and perpetration of violence, as well as the influence of social norms on childhood violence in different contexts. It further identifies points for intervention, including those factors that serve to maintain or change social norms related to violence in childhood. Forces that maintain violence in childhood include existing power dynamics (e.g. gender inequality, perceived lack of agency in children) (Blanchet-Cohen & UNICEF, 2009; Paluck, Ball, Poynton, & Sieloff, 2010), prevalent violent behaviors (e.g. domestic violence, community violence), social and psychological processes (e.g. the rewards of complying with social norms) (Ransford & Slutkin, 2016; Rimal & Real, 2005), and insufficient structural intervention (e.g. lack of legal protections for children) (Landers, 2013). Forces that drive change around violence in childhood, on the other hand, include shifting power structures (e.g. giving children a voice) (Blanchet-Cohen & UNICEF, 2009), social movements that condemn violent practices (e.g. coalition-led efforts by children's rights NGOs, media campaigns) (Grugel & Peruzzotti, 2010; Paluck et al., 2010), and policy change (e.g. implementation of laws that punish violent behavior) (UNICEF, 2014).

The framework also provides some insight into why some social norms are more resistant to change than others. For example, a Conditional Cash Transfer program in India provided

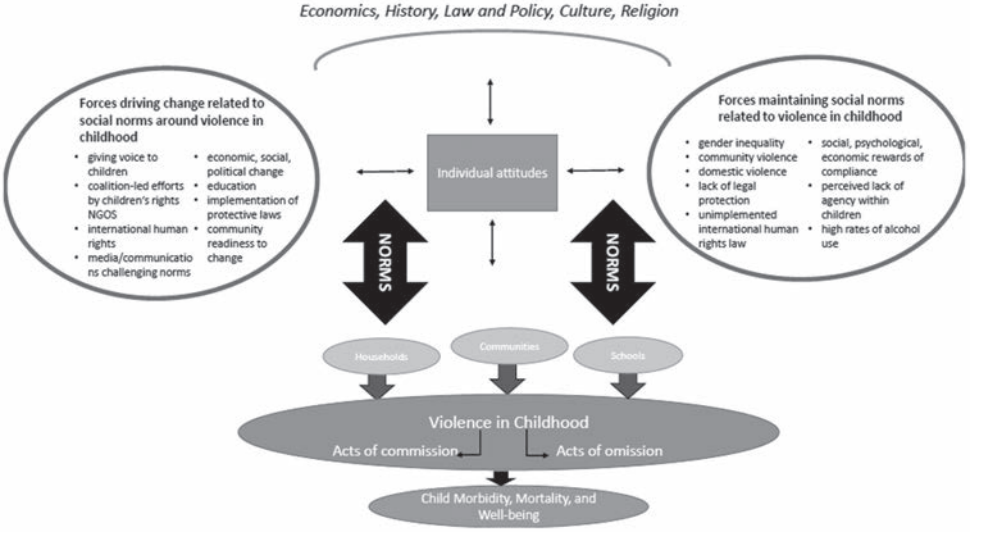

Figure 1. Conceptual framework for the relationship between and forces shaping social norms and violence in childhood.

a financial incentive for families to keep their daughters from marrying in childhood with the additional aims of improving girls' education and increasing their perceived value. While the program changed norms and practices surrounding education for girls and reduced child marriage, it had very little impact on the deeply and culturally entrenched gender norms that drive early marriage in India (e.g. undervaluing girls compared to boys) and may have even reinforced these norms by providing additional income to offset the costs of getting girls married (Nanda, Datta, Pradhan, Das, & Lamba, 2016).

Intervening to shift social norms

Both theory and practice provide useful insight into how interventions can shift the social norms that promote violence in childhood. Human actions are interdependent; the choices of one individual inevitably affect the choices of others (Mackie, 1996, 2000; Schelling, 1980). Therefore, interventions aimed at shifting social norms address the interconnected nature of social groups, while focusing on changing individuals' perceptions. Effective social norm change interventions tend to accomplish this in one of three ways: (1) by targeting social norms directly; (2) by changing attitudes and beliefs to shift social norms or; (3) by changing behaviors to shift social norms.

Target social norms directly

Some interventions directly target descriptive norms by informing their audience of what their peers do or do not do (e.g. 88% of men in your neighborhood do not spank their children) and/or injunctive norms by informing their audience of what their peers do or do not think (e.g. 90% of men in your neighborhood think it is wrong to spank a child) (Burchell, Rettie, & Patel, 2013). These interventions tend to be informed by a schema change approach in which countering evidence is provided in order to alter socially shared beliefs about a given issue (Rousseau, 2001).

One way that interventions provide countering evidence is through the use of opinion leaders within social groups to openly demonstrate desired behaviors and opinions, thus shifting people's perceptions of what others in their social group do and think through the presentation of alternative social norms (Carter, 2000). These interventions tend to be informed by "Diffusion of Innovations" theory which posits that ideas are propagated by influential and open-minded protagonists who facilitate the introduction of new ideas into a social group. A late majority then adopts the ideas after a tipping point is reached and social norm change quickly proliferates (Rogers & Shoemaker, 1971).

Some research suggests that interventions targeting both descriptive and injunctive social norms may be most effective in ultimately changing behaviors as opposed to interventions that target descriptive norms alone (Schultz, Nolan, Cialdini, Goldstein, & Griskevicius, 2007). Table 1 provides examples of programmatic approaches that directly target social norms in order to reduce violence in childhood.

Change attitudes and beliefs to shift social norms

Other interventions target social norms indirectly by changing people's attitudes and beliefs. These interventions are often informed by health behavior change theories and models,

Table 1. Programmatic approaches that directly target social norms related to violence in childhood.

Community Mobilization

The **Green Dot Campaign**, first implemented in high schools in Kentucky, USA, utilizes a diffusion of innovations approach by training "popular opinion leaders" to motivate others in their social groups to be active bystanders should they witness sexual assault in schools, communities, and military bases. It utilizes peer-influence to shift social norms and, eventually behavior, around identification of and intervention in sexual assault. A 5 year randomized control trial of the campaign on university campuses indicates that the intervention significantly reduced interpersonal violence victimization rates and interpersonal violence perpetration rates including stalking, sexual harassment, and psychological violence (Coker et al., 2016; Cook-Craig et al., 2014).

The **Good School Toolkit** is a multisector intervention that recruits school employees, students, and parents to create a nurturing, safe school environment for children. The Toolkit recruits student and staff "protagonists" to facilitate activities (e.g. hanging codes of conduct in visible places, painting murals, facilitating conversations) that aim to shift corporal punishment practices perpetrated by teachers in schools. By engaging these opinion leaders to introduce new ideas around corporal punishment, the intervention encourages teachers to question their perceived social norms, eventually changing their own attitudes and behaviors. At baseline, more than 60% of Ugandan students reported experiencing daily violence at school. However, after the 18-month intervention, the risk of physical violence against children by school staff reduced by 42% and self-reported rates of violence by teachers reduced by 50% (Devries et al., 2015).

Tostan's Community Empowerment Program uses a diffusion of innovations approach to impact violent traditional practices including female genital cutting (FGC). By training program participants about the harms of FGC and encouraging them to voice their new knowledge and opinions to their social networks through social mobilization teams, radio programs, and inter-village meetings, the program uses peer influence to shift social norms and behaviors around these practices. In Senegal, communities that participated in the program showed a significant decrease in the prevalence of FGC among girls age 10 and younger compared to the comparison communities (Diop & Askew, 2009).

Mass Media/ Social Marketing

Program H in Brazil utilized a variety of approaches, including social marketing through billboards and radio, to target young men and adolescent boys aged 15–24 to reduce dating violence perpetrated against adolescent girls. The program directly targeted injunctive and descriptive norms with messages, often conveyed by male celebrities, that indicated men in the community support gender-equitable behaviors. An evaluation of the program found that, following 6 months of program exposure, males in the intervention sites showed significant increases in gender equitable attitudes compared to males in the comparison sites (Pulerwitz, Barker, Segundo, & Nascimento, 2006).

An anti-bullying intervention targeting adolescents, aged 11 to 14, in New Jersey, USA used posters hung in middle schools to disseminate social norms messages about the actual prevalence of positive attitudes and behaviors among peers (e.g., "94% of _____ Middle School students believe students should NOT shove, kick, hit, trip, or hair pull another student."). There were significant decreases in students' perceptions of peer-bullying and pro-bullying attitudes as well as personal bullying perpetration and victimization in schools exposed to these messages (Perkins, Craig, & Perkins, 2011).

Social Movement

Bachpan Bachao Andolan, the save the child movement, is a grassroots social movement which seeks to eradicate child labor and trafficking in India. Through its leadership of a large, grassroots civil society campaign, the Global March Against Child Labor, the movement works with a coalition of unions, teachers' organizations, and child rights organizations to shift perceptions around the acceptability of child labor and has contributed to numerous policy interventions including the adoption of the Right of Children to Free and Compulsory Education (RTE) Act in 2010 (Association for Voluntary Action).

such as the Health Belief Model, which seeks to shift attitudes by introducing people to the harmful effects of a given behavior and the benefits of avoiding that behavior (Rosenstock, 1974). Such interventions posit that if enough people within a social group shift their attitudes towards a given behavior, eventually, the injunctive norms related to that behavior will also change. The Gender Equity Movement in Schools (GEMS), for example, worked with boys and girls ages 12–14 in Mumbai, India to shift students' attitudes and beliefs related to gender-roles, violence, and health. Through group discussion, engagement with teachers, and a school-based campaign, the intervention improved students' attitudes towards equitable gender roles, physical violence, and sexual and reproductive health, in turn, shifting social norms among the school children in these areas as well (Achyut, Bhatla, & Verma, 2015). For example, the proportion of male and female program participants reporting gender-equitable attitudes more than doubled after six months (Achyut et al., 2015). Table 2 provides additional examples of programmatic approaches that target attitudes to shift social norms related to violence in childhood.

Table 2. Programmatic approaches that target attitudes to shift social norms related to violence in childhood.

Small Group Training
Sikhula Ndawonye, a parenting program currently being tested in South Africa, conducts group sessions with mothers of infants on child development, reading a baby's signals, and calming babies. The program hopes to promote positive parent-child interactions by increasing parents' understanding of and attitudes towards their babies' behavior. By creating support groups of women who all engage in positive, healthy parenting practices, the program aims to shift mothers perceptions of how others believe babies ought to be treated (SVRI, 2016).
Mass Media/Social Marketing
Soul City in South Africa was a comprehensive "edutainment" program aimed at reducing gender-based violence among adults and adolescents. It included a prime-time television series, radio drama episode, booklets, and an advertising and public campaign that encouraged audiences to think critically about social norms that encourage gender-based violence. Evaluation results indicate the campaign was effective in shifting attitudes towards more positive perceptions of gendered-equitable social norms. For example, exposure to the intervention was associated with a 10% increase in respondents disagreeing that domestic violence should be kept private (Usdin, Scheepers, Goldstein, & Japhet, 2005).
MTV's A Thin Line campaign aims to end digital abuse among youth through online, television, and in-person initiatives. It includes PSAs, MTV news specials, and an original movie called (Dis)connected, that aim to change youths' attitudes around the safe use of digital technology, ultimately shifting injunctive and descriptive norms. (Dis)connected, for example, aimed to create new social norms around intervening in online abuse and perpetrating violence online by convincing youth that they should personally practice safer behavior online and confront those who perpetrate online abuse. After watching the movie, the majority of youth viewers reported they would be more likely to confront someone who abuses them or a friend digitally, would be less likely to forward inappropriate messages, and believed spreading sexually explicit images of a person was an inappropriate activity (Harmony Institute, 2012).

Change behaviors to shift social norms

Additional interventions target social norms by focusing on behaviors. Structural interventions, for example, seek to alter the structural context in order to make certain behaviors more or less easy to perform (Blankenship, Friedman, Dworkin, & Mantell, 2006). They may shift costs, policies, or the built environment. Formal laws, for example, impose sanctions which are less desirable than the informal, social sanctions imposed by violating social norms (Posner & Rasmusen, 1999). Conditional Cash Transfer interventions provide economic incentives to change behavior which may be stronger than the social sanctions imposed for violating a social norm (Diepeveen & Stolk, 2012). Eventually, the goal of a law or conditional cash transfer intervention is to change the prevalence of a behavior, in turn, shifting related descriptive and injunctive norms. However, in some cases, structural interventions may shift behavior without ever changing the targeted social norms. For example, the Apni Beta Apna Dhan (ABAD) Conditional Cash Transfer Program in India aimed to keep girls in school and unmarried until the age of 18 and also change community perceptions of girls' value and ability to contribute to society. An evaluation showed that program participants were more likely to delay marriage until after age 18 and to have completed 8th grade than non-participants. However, the results suggest that there was no change in perceptions of the value of girls and that, in fact, the cash received was often used as dowry to marry girls to a more desirable suitor at the age of 18 or 19 (Nanda et al., 2016).

Although limited theory illuminates the pathways through which behavior change can shift social norms (Blankenship et al., 2006), Nudge Theory provides one hypothesized mechanism. Nudge Theory suggests that making small changes to the built environment can "nudge" people towards more desirable behaviors without restricting their choices (Leonard, 2008). In theory, if enough people are "nudged" into a certain practice, it will eventually become a descriptive social norm. Table 3 provides several examples of programmatic approaches that target behaviors to shift social norms related to violence in childhood.

Table 3. Programmatic and policy approaches that target behaviors to shift social norms related to violence in childhood.

Law and Policy
In Pakistan's Khyber Pakhtunkhwa province, the **Child Protection and Welfare Act of 2010** criminalized violence against children and abolished corporal punishment (Know Violence in Childhood, 2016). By changing the policy environment around violence in childhood, the law seeks to prevent violent behavior and, in turn, shift perceived social norms related to corporal punishment, sexual violence, and other forms of violence.
In India, the **1994 Hindu succession act** reformed inheritance laws so that boys and girls were granted equal inheritances by their families. The law helped to change inheritance practices which altered social norms and shared beliefs about the value of boys and girls, resulting in increases in both educational achievement and marital age of children (Deininger, Goyal, & Nagarajan, 2013).
Community Mobilization
Cure Violence, which has been implemented in a variety of settings from the United States to South Africa, shifts social norms around violence in communities, in part, by "interrupting" (i.e. identifying and mediating) potentially fatal conflicts within communities. Trained outreach workers help to prevent retaliations after shootings and mediate disputes, thus reducing violent behavior which, in turn, changes the perceptions among community members that others in their social groups resolve conflict through violence (Butts, Roman, Bostwick, & Porter, 2015). An evaluation of the program in Baltimore, Maryland, USA found a 56% drop in homicides and a 34% decrease in non-fatal shootings after implementation of the program (Webster, Whitehill, Vernick, & Parker, 2012).

Core principles and strategies for social norm change interventions

There are a number of core principles and strategies related to programmatic perspective, or motivation, and design that should be taken into account when planning interventions that target social norms related to violence in childhood.

The perspective that programs take to address violence in childhood is central to effective social norm change. Successful interventions often use public health frameworks that conceptualize violence as an issue that can be systematically studied and prevented (Ransford & Slutkin, 2016). Cure Violence, for example, treats violence as a public health problem, transmitted between individuals and social groups through, in part, social norms. Their model suggests that preventing violence requires: interrupting violent conflict, identifying and treating people who are at highest risk for perpetrating violence, and mobilizing social groups to change the social norms that drive violence (Cure Violence, 2016). Engaging girls and boys to critically examine gender norms and stereotypes has been effective in addressing the gender dynamics that perpetuate violence against children. For example, the GEMS project works with students to evaluate attitudes and beliefs, such as perceptions around "masculine" behavior, that perpetuate gender-based violence in childhood (Achyut et al., 2015). Last, a rights-based perspective acknowledges existing power dynamics between victims and perpetrators while empowering individuals with resources and opportunities to make their own decisions (Blanchet-Cohen & UNICEF, 2009; UNFPA, 2016).

Table 4 details specific evidence-based strategies that have proven effective in operationalizing these perspectives and approaches.

Limitations

The authors used a traditional, as opposed to systematic, review process in order to research and write this manuscript. As such, the theoretical and practice cases presented in the text should be considered illustrative examples rather than a comprehensive review of the theory and practice related to social norms and violence in childhood.

Table 4. Strategies for social norm change interventions aimed at preventing violence in childhood.

(1) *Incorporating bystander training:* Social norm campaigns directed at the family and community levels should incorporate bystander intervention training. In the case of childhood violence, individuals cannot assume that others will intervene. Instead, potential bystanders should be trained in tested and safe strategies for intervention (Cismaru, 2013).

(2) *Mobilizing community values:* Incorporate core values that are already shared in the community in intervention messaging instead of employing top-down, negative messaging (Alexander-Scott, Bell, & Holden, 2016). For example, a campaign to prevent spanking might highlight the fact that, globally, 70% of adults do not believe corporal punishment is necessary for raising a child properly (UNICEF, 2014).

(3) *Delivering combination prevention strategies*: Interventions that target multiple levels of engagement tend to be more effective than those that target one level only (Sallis, Owen, & Fisher, 2008). Laws alone, for example, are rarely enough to change social norms. However, interventions that engage families and communities, in addition to altering the legal environment, may be effective in shifting social norms around violence in childhood. Voices for Change in Nigeria prevents violence against women and girls by supporting the passage of bills aimed at increasing gender equality while simultaneously engaging opinion leaders to spread ideas condemning violence against girls at the community level (V4C Nigeria, 2014).

(4) *Involving stakeholders:* Collaborating with stakeholders who will take ownership over and support the social norm change intervention can help to ensure community buy-in and sustainability over time. Partners can range from traditional leaders, to the private sector, to children themselves (Blanchet-Cohen & UNICEF, 2009). The Good School Toolkit, for example, engages teachers and administrators in schools as well as a team of community members to champion the program (Devries et al., 2015).

(5) *Planning for long-term engagement*: Although there is no required timeframe for social norm change to occur, evaluations of successful interventions suggest that at least eighteen months to two years is required for sustained social norm change.

(6) *Avoiding the boomerang effect:* Research suggests that social norms interventions can inadvertently increase undesirable behaviors by highlighting their high prevalence in communities. In communities where perpetration of violence is practiced by the majority, interventions should instead use reward-focused messaging which celebrates individuals who practice the desired behavior (Burchell et al., 2013). The MenCare Campaign, for example, celebrates engaged, non-violent fathers (José Santos, 2015).

(7) *Collecting sex-disaggregated data on violence in childhood:* Data on violence in childhood is very limited. To further understand what strategies are effective in shifting the social norms that drive violence in childhood, it is necessary to collect data on violence, particularly through community and population-based surveys (Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002; UNICEF, 2014). The U.S. Centers for Disease Control and Prevention's Violence Against Children Surveys, implemented in at least 11 countries across Asia, the Caribbean and East and Southern Africa have been instrumental in awareness-raising around violence in childhood, in some cases contributing to policy change (Chiang et al., 2016).

(8) *Making context-specific prescriptions for change:* Violence in childhood is context-specific. Interventions aimed at preventing violence in childhood should adapt best practices and theory-driven programming to fit the context in which they will be implemented (Alexander-Scott et al., 2016). This includes understanding the culture around violence in childhood, the nature of the system of message delivery, and the culture of the target social group (Berkowitz, 2003) and can be achieved through formative research and local experience.

Conclusion

The 2030 Sustainable Development Goals call on the international community to promote well-being and equality for all (UNDP, 2015). Violence in childhood is a public health problem that poses a threat to the health, well-being, and human rights of children and adults worldwide. Preventing violence in childhood requires a multi-sectoral response that unites the research, program, and advocacy communities to better understand, implement, and advocate for evidence-based responses to this urgent threat.[1]

Social norms are a critical driver of violence in childhood that should be an integral component of any comprehensive effort to mitigate this threat to human rights. People's perceptions, particularly with regard to their own social groups, are a powerful force in

shaping human behavior. Understanding how these perceptions are shaped, propagated, and can ultimately be altered through evidence and theory driven programming is crucial to preventing violence in childhood.

Note

1. Know Violence in Childhood is one such effort to unite the international community around childhood violence prevention through mapping, consultations, thematic papers, and advocacy.

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Exploring opportunities for coordinated responses to intimate partner violence and child maltreatment in low and middle income countries: a scoping review

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ABSTRACT

Intimate partner violence (IPV) and child maltreatment (CM) by a parent or caregiver are prevalent and overlapping issues with damaging consequences for those affected. This scoping review aimed to identify opportunities for greater coordination between IPV and CM programmes in low- and middle-income countries (LMIC). Nine bibliographic databases were searched and grey literature was identified through the scoping review team. Eligible studies were published in English; described primary prevention programmes in LMIC that addressed IPV and CM, or addressed one form of violence, but reported outcomes for the other; reported IPV and CM outcomes; and evaluated with any study design. Six studies were identified published between 2013 and 2016 (four randomised controlled trials, one pre-post non-randomised study and one qualitative study). Programmes were based in South Africa (2), Uganda, (2), Liberia (1) and Thailand (1). All except one were delivered within parenting programmes. The emphasis on gender norms varied between programmes. Some parenting programmes addressed gender inequity indirectly by promoting joint decision-making and open communication between caregivers. Conclusions are tentative due to the small evidence base and methodological weaknesses. More robust evaluations are needed. Improved coherence between IPV and CM programmes requires equal attention to the needs of women and children, and the involvement of fathers when it is safe to do so.

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Introduction

Violence against women (VAW) and violence against children (VAC) are recognised as a serious global health concern and a violation of human rights (World Health Organization, 2000). Yet historical developments in the VAW and VAC fields have led to these phenomena being considered distinct from one another. Whilst this has been essential for the development of adequate laws, advocacy and programmes, there have been calls for prevention strategies that address both forms of violence. This review aimed to scope the current evidence to identify synergistic intervention opportunities for a more coordinated approach.

Intimate partner violence (IPV) is one of the most common forms of VAW and includes acts of physical, sexual, and emotional abuse and controlling behaviours by an intimate partner (World Health Organization, 2000). Global estimates show that 30% of women aged 15 and over have ever experienced physical and/or sexual violence by an intimate partner (Devries et al., 2013) and 38.6% of all female homicides are perpetrated by intimate partners (Stöckl et al., 2013). Women who are physically or sexually abused by their partners are more likely to have an abortion, suffer from depression, and in some regions are more likely to acquire HIV compared with women who have not experienced IPV (World Health Organization, 2013).

Child maltreatment (CM) is a common form of violence against children (VAC) perpetrated by a parent or caregiver and includes acts of commission, such as physical, sexual and psychological abuse, as well as acts of omission such as neglect or exposure to violent environments (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). However, in the context of this review which focuses on CM that occurs in the family context (i.e. by a parent or caregiver), we limit our definition of 'acts of omission' solely to children's exposure to IPV in the home, which is associated with impairment similar to other types of maltreatment (MacMillan & Wathen, 2014). The United Nations Children's Fund (UNICEF) reports that around 6 in 10 children worldwide aged 2–14 experience regular physical punishment and 7 in 10 experienced psychological aggression by caregivers (United Nations, 2014). The immediate consequences of CM include physical injury, cognitive impairment, impaired attachment, and symptoms consistent with depression and post-traumatic stress disorder (Norman, Byambaa, Butchart, Scott, & Vos, 2012) although the damage to health and social functioning can last into adolescence and adulthood (Felitti et al., 1998; Oladeji, Makanjuola, & Gureje, 2010; Ramiro, Madrid, & Brown, 2010; Releva, Peshevska, & Sethi, 2013; Tran, Dunne, Van Vo, & Luu, 2015).

The rationale for this review stems from increasing evidence that IPV and CM intersect on a number of levels. Guedes, Bott, Garcia-Moreno, and Colombini (2016) define four aspects of this intersection: (i) overlapping risk factors (e.g. unemployment, poverty and social isolation); (ii) the presence of social norms that condone violence; (iii) co-occurrence of IPV and CM in the same family, which has implications for the intergenerational transmission of violence; and (iv) similar health outcomes. IPV and CM share a number of commonly associated underlying risk factors, which include unemployment, poverty, high levels of community violence and social isolation, as well as individual level factors such as poor mental health and substance abuse (Alhusen, Ho, Smith, & Campbell, 2014). IPV and CM are also associated with some of the same social norms that condone violence and reinforce gender inequality. These norms include victim blaming attitudes that reinforce male sexual entitlement and support men's right to control women, as well as norms that

prioritise family privacy and the belief that corporal punishment of children is necessary (Alhusen et al., 2014; Guedes et al., 2016).

The presence of IPV in the home is a risk factor for CM (Hamby, Finkelhor, Turner, & Ormrod, 2010) and the high co-occurrence of IPV and CM has been reported in LMIC (Dalal, Lawoko, & Jansson, 2010; Gage & Silvestre, 2010; Rada, 2014). Childhood exposure to IPV is associated with multiple health problems including internalising behaviour problems (e.g. anxiety and depression), externalising behaviour problems (e.g. aggression, delinquency) and trauma symptoms (Evans, Davies, & DiLillo, 2008). Exposure to certain forms of IPV and CM, for example sexual abuse, have been shown to have similar consequences with regards to mental health outcomes and social functioning (Wilkins, Tsao, Hertz, Davis, & Klevens, 2014). Furthermore, the risk of adult victimisation and/or perpetration of IPV is greater amongst children who have been abused, highlighting the intergenerational transmission of violence (Abramsky et al., 2011; Fry, McCoy, & Swales, 2012; Spatz Widom, Czaja, & Dutton, 2014). These intersections are important to consider as this paper examines promising interventions to prevent and respond to IPV and CM.

The dominant programmatic efforts for addressing IPV in high income countries have been response-driven and focused on providing services to survivors (Ellsberg et al., 2014). In comparison, research and programmes in LMIC have prioritized primary prevention. These use multiple approaches such as media campaigns and community mobilisation, economic empowerment and group education which aim to change attitudes and norms that reinforce violence against women and girls and promote gender-equitable behaviours (Abramsky et al., 2014; Jewkes, Nduna, Levin, et al., 2008; Kim, Watts, Hargreaves, et al., 2007; Wagman, Gray, Campbell, et al., 2015). According to recent reviews, the most effective programs in reducing IPV in LMIC are those that involve community mobilisation and/or economic empowerment paired with gender equality training (Ellsberg et al., 2014; Heise, 2011). Some of these programmes also seek to address issues that are concomitant with violence against women and girls, such as HIV, poverty, low education and women's economic dependence on men.

Prevention strategies to reduce violence against children outside of the family have predominantly been implemented in schools in high-income countries, mainly in the form of group education and training to address either teen dating violence or childhood sexual abuse (De La Rue, Polanin, Espelage, & Pigott, 2014; MacMillan et al., 2009; Walsh, Zwi, Woolfenden, & Shlonsky, 2015). Prevention programmes for violence in the family have generally been embedded within home visiting programmes, group or individual based parenting programmes, and paediatric care. Some perinatal home visiting programmes, such as the Nurse Family Partnership, and early childhood parenting programmes have been shown to prevent or reduce certain forms of CM such as physical abuse and neglect, whilst others have been found to prevent reoccurrence of CM (Barlow, Simkiss, & Stewart-Brown, 2006; MacMillan et al., 2009). However, the evidence base is relatively modest and sometimes of poor quality. With regards to children exposed to IPV, a systematic review found that parent skills training, delivered in combination with practical support for non-abusing mothers and group based psycho-education delivered to mothers and children may be effective for improving children's behavioural outcomes, although this is a tentative conclusion based on a small number of studies (Howarth et al., 2016). The evidence for CM prevention programs in LMIC is scant (Mikton & Butchart, 2009). A systematic review of parenting programmes in LMIC to reduce harsh and abusive parenting identified 12 randomised trials, of which

two high quality trials reported positive effects of the intervention in reducing dysfunctional or harsh parenting (Knerr, Gardner, & Cluver, 2013).

The pervasive link between IPV and CM has resulted in calls for the provision of comprehensive and complementary services to families affected by these forms of violence (Guedes & Mikton, 2013; Herrenkohl, Higgins, Merrick, & Leeb, 2015; Lessard & Alvarez-Lizotte, 2015). Amongst the various intervention approaches in high-income countries, only the health care sector has recognised the potential for addressing IPV and CM as co-occurring issues, for example in home visiting and paediatrics (Dubowitz, Feigelman, Lane, & Kim, 2009; Dubowitz, Lane, Semiatin, & Magder, 2012; Prossman, Lo Fo Wong, van der Vouden, & Lagro-Janssen, 2015). In the United States, where there has been a substantial investment in perinatal home visiting programmes, guidelines for joint IPV and CM interventions have been developed for policymakers (Family Violence Prevention Fund, 2010). In LMIC where resources are low, there is a need to maximise prevention efforts particularly in view of the shared risk factors and health consequences.

Despite growing evidence of the intersection between IPV and CM, there is a paucity of research regarding effective strategies for addressing both forms of violence. The goal of this scoping review was to identify interventions that have measured outcomes for both IPV and CM and programme components that may have contributed to positive outcomes. Due to the fact that current evidence focuses largely on high-income countries, this paper focuses on interventions in LMIC to build the knowledge base in less developed settings.

Methods

Our scoping approach was informed by Arksey and O'Malley's (2005) methodological framework which comprises six phases that do not necessarily occur in a linear manner: (i) identifying the research question; (ii) searching for relevant studies; (iii) selecting relevant studies; (iv) charting the data; (v) collating, summarising and reporting the results; (vi) and consulting with stakeholders. The research question for this paper was developed through stakeholder consensus at the Know Violence in Childhood Learning Initiative meeting on intersections between violence against children and violence and women (22–24 April 2015). The workshop brought together leading experts in the fields of VAW and VAC to explore the potential for core principles and key skills involved in developing a shared approach to preventing these forms of violence, as well as identify where priorities differ. A scoping study team, comprised of the co-authors of this paper, was formed to contribute expertise (i.e. programmatic, policy, research and advocacy) at various stages of the scoping review (Levac, Colquhoun, and O'Brien (2010).

Search procedure

The scoping team agreed on the inclusion and exclusion criteria for the review (Figure 1).

Nine bibliographic databases (MEDLINE, EMBASE, Global Health, Health Management Information Consortium, Cumulative Index to Nursing and Allied Health Literature [CINAHL], Africa Wide, Latin American and Caribbean Health Sciences [LILACS], Index Medicus for South-East Asia [IMSEAR], Index Medicus for the Eastern Mediterranean Region [IMEMR] were searched from 2010 to 2015 using controlled vocabularies for each database and text words (Appendix 1). To identify studies prior to 2010, we drew upon

Inclusion Criteria

(i) Published in English
(ii) Primary prevention programmes in LMIC designed to address IPV and CM, or addressed one form of violence, but reported outcomes for the other form of violence
(iii) Reported IPV outcomes (physical, emotional, verbal and/or sexual)
(iv) Reported changes in attitudes and/or knowledge regarding IPV
(v) Reported CM carried out by a parent or caregiver (neglect, physical abuse, sexual abuse, harsh or abusive parenting or discipline
(vi) Reported changes in attitudes and/or knowledge regarding harsh and abusive discipline
(vii) Any study design

Exclusion criteria

(i) Studies that report on other forms of CM such as child marriage, female genital mutilation of sexual abuse by someone outside of the family

Figure 1. Inclusion and exclusion criteria.

systematic reviews of interventions to prevent or reduce violence against women and girls (Arango, Morton, Gennari, Kiplesund, & Ellsberg, 2014; Ellsberg et al., 2014) and of interventions to prevent child maltreatment (Knerr et al., 2013; MacMillan et al., 2009; McCloskey, 2011; Mikton & Butchart, 2009). Study selection was an iterative process. First, a list of potentially relevant studies resulting from this search was sent to the scoping team requesting that they check for missing studies, particularly unpublished data and grey literature. Bacchus contacted implementers of three parenting programmes in process that address IPV and CM in order to enquire about interim findings. One team member who was involved in a large review of interventions for violence against women and girls checked the list against their own database (Contreras Urbina). Another team member (Gardner) with expertise in parenting programmes provided a list of 20 contacts for parenting programmes in LMIC, to whom an email and one follow-up was sent to request unpublished findings regarding IPV related outcomes. Following this, an amended list of studies was sent to the scoping team for review.

Screening and data extraction

One author (Bacchus) screened all abstracts and full texts of potentially eligible studies and extracted the data. The scoping team agreed on what information should be extracted which included: country; programme name; programme aims; key components (i.e. topics in the curriculum); setting in which the intervention was delivered; target groups; evaluation methods (study design, measures used to assess IPV and CM, data collection activities, sample size, follow-up period); and IPV/CM findings. Key components were extracted directly from the training manuals where these were available, from publications and by contacting authors and programme implementers. We looked specifically for programme content which engaged participants in exploring gender norms and values in the context of parenting, decision-making and violence against women and children. This stems from our feminist epistemological position which seeks to understand violence against women within the interaction of gender norms, power and patriarchy which create inequalities and disadvantage women in many spheres of life (Yllo, 2005). Furthermore, programmes

that address gender inequitable norms have been shown to reduce violence and improve health outcomes (Dworkin, Treves-Kagan, & Lippman, 2013; Jewkes, Flood & Lang, 2015).

The data was tabularised in Word and reviewed by the scoping team to determine whether additional data needed to be extracted and agree on information to be presented in the synthesis. The findings and abridged tables were also presented to leading experts at the second Know Violence in Childhood Learning Initiative meeting on intersections between VAW and VAC (10–11 March 2016). This provided another opportunity to discuss the findings and key recommendations arising from the review.

Synthesis

A narrative approach was used which provides descriptive information about the overall number of studies included, years of publication, the countries in which they were based, and whether they addressed IPV only, CM only or both. A formal quality appraisal was not undertaken due to the variation in the study designs used to evaluate programmes. Therefore, the findings from individual programmes are presented by levels of evidence starting with randomised controlled trials. With regards to mixed methods studies (i.e. trials with a nested qualitative study) the trial evidence is presented first. Findings from the individual programmes include a brief description of the content (including whether or not it addressed gender norms and values) and the target groups. Statistical tests from pre and post measures are reported for quantitative studies and key themes are presented from qualitative data, supported by quotes. The limitations of the study designs are elaborated in the discussion.

Results

The search strategies retrieved 1387 studies published between 2013 and 2016, of which 6 were directly relevant to the aims of the review. Two of the studies were based in South Africa, two in Uganda, one in Liberia and one in Thailand. Of the six studies, two described programmes that were designed to address IPV and CM jointly (Ashburn, Kerner, Ojamuge, & Lundgren, 2016; Hatcher, Colvin, Ndlovu, & Dworkin, 2014; Van den Berg et al., 2013); one was designed to address IPV, but reported unintended outcomes for CM (Abramsky et al., 2014, 2016; Kyegombe et al., 2015); and three were designed to address CM, but reported unintended outcomes for IPV (Cluver, Lachman et al., 2016; Cluver, Meinck et al., 2016; Sim, Puffer et al., 2014; Sim, Annan, Puffer, Salhi, & Betancourt, 2014).

Randomised controlled trials

Table 1 presents four studies which used a randomised controlled trial with a nested qualitative component: REAL Fathers in Uganda (Ashburn et al., 2015); SASA! in Uganda (Abramsky et al., 2014, 2016); Parents Make the Difference in Liberia (Sim, Puffer et al., 2014); and Building Happy Families in Thailand (Sim, Annan, et al., 2014).

REAL Fathers, a father-centred mentoring programme in Uganda which targets young fathers aged 16–25, is designed to address IPV and CM. The programme aims to improve knowledge and skills in positive parenting, communication and conflict resolution, encourage reflection on the gender roles of parents in childcare, and improve acceptance

Table 1. Evidence from randomised controlled trials.

Author/year	Country	Intervention name	Programme aims/key components	Setting and target group	Methods	IPV and CM outcomes/themes
Ashburn et al. (2016)	Uganda	Responsible, Engaged and Loving (REAL) Fathers	Programme aims: A 6-month father-centred mentoring programme plus a community awareness campaign to improve knowledge and skills in positive parenting and conflict resolution, and reflection on gender roles or parents in childcare	Setting: delivered in community settings. Amuru district, Northern region of Uganda	Randomised controlled trial with a nested qualitative study. $N = 250$ men assigned to the mentoring programme and community poster series and $N = 250$ men assigned to the community poster series only in two cohorts. Fathers interviewed at baseline, end line (4 months post intervention) and follow-up (12 months for cohort 1 and 8 months for cohort 2, after completing the intervention).	CM quantitative findings: significant reduction in physical punishment in the exposed versus the unexposed group at follow-up, but not at end line (62.0 vs. 42.1; $p < .000$). Parents attitudes rejecting use of physical punishment were significantly higher at end line (53.6 vs. 64.5; $p = .023$) and follow-up (42.2 vs. 65.7; $p < .000$). Parents confidence in dealing with a child without using threats, shouting or beating significantly increased at end line (15.1 vs. 28.9; $p < .001$) and follow-up (22.9 vs. 45.1; $p < .000$)
			Key components: Six large scale posters were sequenced over time in central meeting locations to spark community dialogue and reinforce mentoring sessions. 64 mentors, chosen by the young men from within their community, were trained and supported up to 4 fathers each. Mentoring included 6 individual (2 of which included wives) and 6 group (1 of which included wives) mentoring sessions. Topic areas: understanding gender values and norms; parenting (respecting the child and the child's mother, spending time with children, disciplining with love, being a role model and teacher, talking and listening to children, showing love); effective communication in the home, stronger couples through communication (including how to resolve differences within couples without violence); dealing with stress and managing emotions	Target group: young fathers aged 16–25 years of age who have a child aged 1 to 3 years and are cohabiting with an intimate partner	CM outcomes taken from parent-child Conflict Tactics Scale: six items measuring types of violence during child discipline in the past month; attitudes toward the use of physical punishment. IPV perpetration in the past three month measured with an adapted Conflict Tactics Scale including verbal, psychological, physical; justification of IPV. Qualitative interviews with 20 men and 10 women in the intervention group.	CM qualitative themes: some men reported spending more time with children in play and positive interaction; that their children were less afraid of them and that they had greater awareness that the use of physical punishment made their children more aggressive

(Continued)

Table 1. (*Continued*).

Author/year	Country	Intervention name	Programme aims/key components	Setting and target group	Methods	IPV and CM outcomes/themes
Ashburn et al. (2016)						IPV quantitative findings: IPV scores (any form) were significantly lower in the exposed versus unexposed group at end line (68.7 vs. 53.1; $p < .001$) and follow-up (47.6 vs. 28.8; $p < .000$). Significant reduction in verbal IPV at end line (58.1 vs. 42.6; $p < .001$) and follow-up (38.6 vs. 23.6; $p < .001$) IPV qualitative themes: some men reported a reduction or cessation of alcohol use which they linked to less use of violence towards their wives and being more cooperative. Some women still felt a strain in the relationship with reports of men resuming their use of violence after alcohol use. Significant reduction in psychological IPV at end line (36.9 vs. 25.0; $p = .008$) and follow-up 25.3 vs. 12.0; $p < .001$). The reduction in physical IPV was significant at endline (36.8 vs 27.7; p=0.043), but not at long term follow up Significant reduction in attitudes related to justification of IPV at end line (39.1 vs. 28.2; $p = .019$) and follow-up (35.4 vs. 21.2; $p = .002$)
Kyegombe et al. (2015)	Uganda	SASA!	Programme aims: Community mobilisation approach that seeks to prevent violence against women and HIV. SASA! is unique in its focus on power (positive and negative uses) and shifts away from a traditional focus on gender norms. Includes a range of activities that focuses on changing attitudes, norms and behaviours that underpin power imbalances between men and women and reinforce HIV risk behaviours	Setting: delivered in community settings. Eight communities in Kampala (Rubaga and Makindye Divisions)	Mixed methods design using baseline and follow-up survey data from the SASA! randomised controlled trial and interview data from a nested qualitative study. Quantitative outcomes based on women with at least one biological/step child living in the household	IPV quantitative findings: women in the intervention communities were less likely to report past year physical or sexual IPV than controls (aRR = .68; 95% CI .16, 1.39)
				Target group: community members	1538 baseline and 2532 4 year follow-up surveys completed	CM quantitative findings: of women who did report past year IPV, fewer reported that a child was present or overhead physical or sexual IPV (aRR = .58; 95% CI .19, 1.74). Authors estimate that reductions in IPV combined with reduced witnessing by children when IPV did occur, led to a 64% reduction in the prevalence of children witnessing IPV in their home (aRR = .36; 95% CI .06, 2.20)

Kyegombe et al. (2015)			Key components: The programme includes four phases: (i) START: staff from implementing organisation learn about the community (ii) AWARENESS: building activists' confidence as they conduct activities in the community (iii) SUPPORT: skills and connections between community members are strengthened to encourage people who are trying to foster change and (iv) ACTION: individuals try out new behaviours and celebrate change within their community. Intervention staff work with four groups: community activists selected from progressive men and women in the community; community leaders (i.e. religious, cultural); professionals (i.e. police, health etc. who provide direct services); and institutional leaders who have power to implement policy change. Strategies used included: local activism, media and advocacy, communication materials and training. One-on-one and group based activities are used		Past year experience IPV and attitudes towards IPV measured with the WHO Multi-Country study on Women's Health and Domestic Violence Survey For the qualitative evaluation, 82 men and women who participated in SASA! activities were interviewed including community members, community activists and community leaders	CM qualitative themes: being a positive role model for children (i.e. showing that violence is not normal or acceptable); men spending more time with their children, change in attitude about being solely a provider of money; improved communication with children; improved anger management strategies; less use or rejection of harsh discipline and violence towards children. In reducing IPV, children's exposure to IPV is also reduced
Abramsky et al. (2014, 2016)	Uganda	SASA!	Same as Kyegombe et al. (2015)	Same as Kyegombe et al. (2015)	Pair matched cluster randomised controlled trial in eight communities	IPV quantitative findings: the intervention was associated with significantly lower social acceptance of IPV among women (aRR = .54; 95% CI .38, .79) and men (aRR = .13; 95% CI .01, 1.15); significantly greater acceptance that a woman can refuse sex among women (aRR = 1.28; 95% CI 1.07, 1.52) and men (aRR = 1.31; 95% CI 1.00, 1.70)
					Past year experience IPV and attitudes towards IPV measured with the WHO Multi-Country study on Women's Health and Domestic Violence Survey	52% lower past year experience of physical IPV among women (aRR = .48; 95% CI .16, 1.39); and lower levels of past year sexual IPV (aRR = .76; 95% CI .433, 1.72) although not statistically significant

(Continued)

Table 1. (*Continued*).

Author/year	Country	Intervention name	Programme aims/key components	Setting and target group	Methods	IPV and CM outcomes/themes
Abramsky et al. (2014, 2016)					Baseline survey: (Intervention communities: $n = 374$ women and $n = 419$ men; 97%) and (Control communities: $n = 343$ women and $n = 447$ men; 98%). At four year follow up: (Intervention communities: $n = 600$ women and $n = 768$ men, 99%) and (Control communities: $n = 530$ women and $n = 634$ men; 98%)	Intervention was also associated with lower continuation of prior abuse. Statistically significant effects were observed for continued physical IPV (aRR = .42; 95% CI .18 to .96); continued sexual IPV (aRR = .68; 95% CI .53 to .87); continued emotional aggression (aRR = .68; 95% CI .52 to .89); continued fear of partner (aRR = .67; 95% CI .51 to .89); and new onset of controlling behaviours (aRR = .38; 95% CI .23 to .62)
Sim, Puffer et al. (2014)	Liberia	Parents make the difference	Programme aims: To decrease the use of physical and psychological punishment; increase the use of positive parenting strategies; and increase malaria prevention	Setting: delivered in community settings plus one home visit. Rural Liberia not specified further	Randomised waitlist controlled design with a nested qualitative study and observations of caregiver and child in an unstructured play activity	CM quantitative findings: average decrease of 56% in the use of physical and psychological punishment (effect size −.61; $p < .001$). Percentage of caregivers who reported beating, whipping and spanking their child in the last month decreased by 64% (effect size −.67; $p < .001$); 62% (effect size −.62; $p < .001$) and 56% (effect size −.42; $p < .001$) respectively. The use of psychological punishment (e.g. yelling at child) decreased by 29% (effect size −.65; $p < .001$). 9% of caregivers in the treatment group reported beating their child the last time they misbehaved compared to 45% in the control group
				Target group: caregivers and children aged 3 to 7 years. 57% of caregiver participants were women	135 families in the intervention and 135 in the control group, randomised by lottery and stratified by community	CM qualitative themes: some caregivers reported using non-violent discipline techniques, increased awareness that beating was not effective and would harm their child's development and adopting a more nurturing parenting approach. Some respondents reported that learning about the negative effects of domestic violence on children was motivation for reducing family conflict and being a positive role model
			Key components: 10 weekly group sessions facilitated by two trained Liberian staff from IRC, plus one individual home visit. The home visit was used for individualised support and to discuss previous sessions. Parent support groups provided a forum for sharing		Baseline and one month follow-up surveys measured parenting attitudes, beliefs and practices including use of violent and non-violent discipline using validated measures: Discipline Module of Multiple Indicator Cluster Survey (MICS); Parental Acceptance and Rejection Questionnaire (PARQ); Adult-Adolescent Parenting Inventory (AAPI-2); Dyadic Parent-Child Interaction Coding System (DPICS)	

Sim, Puffer et al. (2014)			Underpinned by behavioural theory, highly skills-based, provides opportunities for discussion and skills practice. Content includes: negative effects of physical and psychological punishment; use of non-violent discipline; positive parenting interaction and communication; strategies for stimulating children's cognitive development including communication and activity to promote children's numeracy, vocabulary and critical thinking skills; basics of child development and importance of active involvement in children's education. The programme also included one session on malaria prevention		Purposive sample of 30 caregivers participated in a semi-structured interview	IPV qualitative themes: the intervention had a positive effect on some caregiver's relationship with their partner. More open communication, collaborative problem solving and understanding of one another appeared to reduce conflict and violence in the home. Some men and women reported less anger towards each other. Some men also reported decreased use of drugs and alcohol and spending more time at home, which may also have helped to reduce conflict and violence in their relationships with their spouses
Sim, Annan et al. (2014)	Thailand	Building Happy Families	Programme aims: Increase the use of positive parenting skills; decrease harsh punishment; improve family functioning and child psychosocial wellbeing	Setting: delivered in community settings. 479 households from 20 urban and rural communities in the Tak province	Waitlist randomised controlled design	CM quantitative findings: caregivers reported an average decrease of 13% in the use of harsh discipline overall as measured by Discipline Interview (effect size −.40; $p < .001$). 90% decrease in scaring their child into behaving well, 18% decrease in beating their child and 17% decrease in swearing at their child
				Target group: caregivers and children aged 8 to 12 years. Burmese migrant and displaced families living on Thai-Burmese border. 83% of parent/caregiver participants were women	Intervention group: $n = 256$ caregivers and $n = 240$ children. Control group: $n = 257$ caregivers and $n = 239$ children	Children reported a small, non-significant decrease in their caregivers' use of harsh punishment overall on the Discipline Interview (effect size −.12) and a 15% reduction in spanking and slapping (effect size −.33; $p < .001$). Using the second measure (MICS), caregiver reports found a small and non-significant decrease in harsh discipline overall (effect size −.10). Analysing individual items on MICS, only using a hard object to beat significantly decreased by 16% (effect size −.22; $p < .01$). Reductions in harsh parenting overall were maintained at 6 months follow-up in the intervention group

(Continued)

Table 1. (*Continued*).

Author/year	Country	Intervention name	Programme aims/key components	Setting and target group	Methods	IPV and CM outcomes/themes
Sim, Annan et al. (2014)			Key components: Delivered by IRC programme staff and community based facilitators. Adapted from the Strengthening Families Programme. A 12 week group-based parenting family skills intervention for children aged 8–12 years and their caregivers. Caregivers and children participate in parallel group sessions each week followed by joint activities in which skills can be practice under supervision. The programme also included structured opportunities for positive interactions (e.g. family meal ending with games)		Baseline, 1 month end line, and six-month follow-up. measures included: Discipline module of Multiple Indicator Cluster Survey, MICS); Parental Acceptance and Rejection Questionnaire, Burmese Family Functioning Scale; Child Behaviour Checklist/Youth self-report; Burmese Child Resilience Scale; and Alcohol Use Disorders Identification Test (AUDIT) administered to caregivers. End line survey was conducted with all participants at 1 month after the intervention. Only participants in intervention group completed a 6-momth follow-up	CM qualitative themes: some caregivers described decreased use of or cessation of harsh physical punishment and were no longer swearing or shouting at their children, or using hurtful language towards them. They also reported increased empathy for children in relation to how harsh punishment can negatively affect their development IPV qualitative themes: some caregivers reported improvements in their relationships with their partners. For example, reduced conflict, fewer fights, improved communication, more discussion regarding household finances and problem solving. The relaxation techniques they were taught to reduce stress (e.g. breathing and relaxation exercises) may have contributed to improved relationships and interactions with children, partners and community members. Some caregivers reported reducing their use of alcohol
			Caregiver content included: setting appropriate developmental expectations; understanding negative consequences of harsh punishment; non-violent discipline strategies; positive communication and problem solving skills; behaviour management; effects of alcohol and drugs on families; managing stress; and maintaining change. Children's content included: speaking and listening to others; rewarding good behaviour; peer resistance; communication skills; coping and resilience skills; problems solving; recognising feelings; dealing with criticism and anger management		Semi-structured interviews conducted with a purposive sample of 25 families in the intervention group	

of non-traditional gender roles. Mentors are recruited from the study communities and chosen by the young men as people whom they respect and can take advice from.

In the REAL Fathers trial, young fathers aged 16–25 who were cohabiting with their partner were eligible to participate, with 250 assigned to the intervention group and 250 to the control group. Men who received the intervention engaged in mentor facilitated discussion groups with other fathers, and individual and couple mentoring. Topics include: understanding gender values and norms; parenting (including talking and listening to children and showing love); effective communication in the home and between couples (including resolving conflict without violence); and dealing with stress and managing emotions. In the final group session on parenting, wives are invited to participate. In addition, a poster series representing topics from the curriculum is implemented in locations frequented by young fathers in order to stimulate discussion. Fathers in the control group were only exposed to the posters series. Men completed outcomes measures at end line (4 months post intervention) and at longer term follow-up (12 and 8 months respectively for cohorts 1 and 2). Women were not followed-up so as not to compromise their safety and due to the lack of local IPV resources (Ashburn et al., 2015). Analysis compared men exposed to the intervention (defined as at least one individual and one group mentoring session) versus men not exposed at endline and longer term follow up. Unique identification codes were not used during data collection because of concerns about confidentiality. Therefore the survey data were analysed as two cross sectional surveys post intervention rather than panel data. According to men's reports, there was a significant reduction in the use of physical punishment to discipline children at longer term follow up (aOR = .52, 95% CI: 32 to .82, $p < .001$) and in IPV at end line (aOR .48, 95% CI: .31 to .76, $p < .01$) and at longer term follow up (aOR = .48, 95% CI: .31 to .77, $p < .01$). Men also reported significantly higher levels of confidence in dealing with their child's behaviour without resorting to violence or verbal threats at end line (aOR = 2.5, 95% CI: 1.50 to 4.28; $p < .001$) and over the longer term (aOR = 2.4; 95% CI: 1.55 to 3.98, $p < .001$).

The qualitative component of REAL Fathers involved interviews with 20 men and 10 women in the intervention group Ashburn et al., (2015). Some men reported an increased awareness that using physical punishment to discipline only made children more aggressive. In addition, some of the wives and partners of the young fathers commented that children appeared to be less afraid of their fathers. The positive impact of the programme on men's relationships with their partners may, in part, be related to a reduction in their use of alcohol which some of them linked to less use of violence and being more cooperative in the home regarding household chores and child care.

> Before this mentorship, I was a drunkard and violent [fought] my wife a lot. I had the wrong peer company who only know drinking alcohol as a way of life, but after the REAL Fathers mentorship, I could see and understand clearly. I had to dump my friends and become a real friend to my family. I stopped drinking alcohol, my violence vanished, we started communicating and working well … [Young Father]

According to the interviews with women, this behaviour change was not always sustained and some reported that their partner had reverted to using violence, often accompanied by alcohol use.

> At the beginning of the program things were working well, he would understand me and I also understand him. Later came a time when we went to attend the training, upon my returning home my husband started a terrible quarrel, accusing me that I took long there [at the training]

> … he threatened to slap me if I answered him … Adding to that he could return home very late … he resorted to too much drinking. [Wife of a REAL participant]

SASA! in Uganda was designed to address IPV, but reported unintended outcomes for CM. Drawing on the ecological model in its programme design, SASA! challenges social norms and beliefs about gender that contribute to violence using a community mobilisation approach which actively engages stakeholders within the community including activists, local government, cultural leaders, religious leaders, and professionals such as the police and health care providers. The language used in the programme focuses on how power can produce positive and negative outcomes, and encourages participants to consider this in the context of relationships between men and women in different spheres of life. The programme has four phases described further in Table 1 and engages men and women of all ages in a range of one-to-one and group activities to discuss and engage on issues of gender inequality, violence and HIV. SASA! encourages critical reflection on violence against women and the development of communication and relationship skills. It also encourages activism against violence at the community level. Trained community activists conduct informal activities within their own social networks, among their families, friends, colleagues and neighbours. Consequently, community members are exposed to SASA! ideas repeatedly and in diverse ways within the course of their daily lives, from people they know and trust as well as from more formal sources within their communities (Abramsky et al., 2014).

The IPV outcomes and children's exposure to IPV are derived from a pair-matched cluster randomised controlled trial in eight communities in Kampala, with 1538 men and women (aged 18–49 years) completing a baseline survey and 2532 completing the four-year follow-up. The evaluation also included a qualitative component from which the CM outcomes are derived. The intervention was associated with significantly lower social acceptance of IPV among women (aRR = .54, 95% CI .38, .79) and men (aRR = .13, 95% CI .01, 1.15); and significantly greater acceptance that a woman can refuse unwanted sex among women (aRR = 1.28, 95% CI 1.07, 1.52) and men (aRR = 1.31, 95% CI 1.00, 1.70). There was a 52% lower past year experience of physical IPV among women and lower levels of past year sexual IPV, although this was not statistically significant (Abramsky et al., 2014). However, SASA! did have a significant impact on stopping violence from continuing, where it occurred previously (Abramsky et al. 2016). Statistically significant effects were observed for continued physical IPV (aRR = .42; 95% CI .18 to .96); continued sexual IPV (aRR = .68; 95% CI .53 to .87); continued emotional aggression (aRR = .68; 95% CI .52 to .89); continued fear of partner (aRR = .67; 95% CI .51 to .89); and new onset of controlling behaviours (aRR = .38; 95% CI .23 to .62).

In order to examine changes in children's exposure to IPV, Kyegombe et al. (2015) used baseline and follow-up survey data from a subset of women in the trial who also reported past year IPV at baseline, and qualitative interviews with a sub-sample of men and women who participated in the intervention. Women in the intervention communities were less likely to report past year physical or sexual IPV than those in the control communities (aRR = .68; 95% CI .16, 1.39). Amongst the women who experienced past year IPV, fewer reported that a child was present or overhead physical or sexual IPV. The reduction in past year IPV combined with reduced witnessing by children when IPV did occur, led to a 64% reduction in the prevalence of children witnessing IPV in their home (aRR = .36; 95% CI .06, 2.20). Amongst couples that experienced a reduction in IPV, qualitative data suggested that this had a positive effect on parent-child relationships through improved parenting and

discipline practices. Some participants also reported being less tolerant of violence against children in their community and more willing to intervene when necessary.

> Before I joined SASA! I used to think that as a man I used to have all the power in the home so whenever a child made a mistake I would, without understanding, punish the child badly. But from when I joined SASA! whenever a child makes a mistake, I have to first understand the cause of the mistake. [Male Community Member 18]

> For us who have been to those sessions [SASA! activities] we are like attorneys for such children or we are like watchmen for abused people in the community. On many occasions I have confronted parents and rebuked their actions. [Male Community Member 10]

Parents Make the Difference in Liberia (Sim, Puffer, et al., 2014) and Building Happy Families in Thailand (Sim, Annan, et al., 2014) were designed to address CM, but reported unintended outcomes for IPV. In both studies, the CM outcomes were assessed quantitatively within the trial, whilst the IPV outcomes were reported in the qualitative component. Parents Make the Difference in rural Liberia is adapted from existing evidence-based parenting programmes and targets parents and caregivers with children aged 3–7 years of age. It uses behavioural theory and is highly skills-based, providing caregivers with specific techniques to promote positive caregiver-child interactions and positive discipline strategies. Group sessions are designed to be interactive, with a focus on discussion, modelling and practicing of skills. This is supplemented with a single home visit for individualised feedback and ongoing support is provided via parenting groups. The programme does not explore parenting within the context of traditional gender norms and values, or how these perpetuate violence in the home. In a randomised controlled waitlist trial with a one month follow-up, 135 families were randomly assigned to the intervention group and 135 families to the control group. An observational assessment was conducted of each caregiver and child pair comprising a brief unstructured play activity that was audio-recorded. Additionally, semi-structured interviews were conducted with 30 caregivers who participated in the intervention. In relation to the quantitatively measured CM outcomes, the study reported a statistically significant decrease of 56% (effect size −.61; $p < .001$) in caregiver's use of physical and psychological punishment. Qualitative interviews also revealed reports of some parents no longer beating their children or using harsh discipline such as shouting or denying their children food, and having an increased recognition of the harmful effects of aggressive discipline on children.

> First I used to beat on them because they were not understanding me at all, but right after this training the people taught me how to counsel your children, how to talk to them so that they can change and be somebody better, which I did. My children now don't hestitate to do things I ask them which is the change I saw in them. It's beause the way I used to treat them, I'm not treating them like that again. [31 year old father]

With regards to the IPV findings, in the qualitative interviews some caregivers reported that the intervention had an unintended positive impact on their relationship with their partner in terms of improved communication, problem solving and understanding of each other. Some men also reported decreased use of drugs and alcohol and spending more time with their families, which they perceived to contribute to reduced conflict in the home and less use of violence with spouses (Sim, Puffer et al., 2014).

> One of the main changes in my woman and I are not making confusion again like the way we used to make palaver [arguments] every time, and the people [facilitators] are even telling us

> not to be making palaver and abusing our woman because if we have confusion, our children will practice that from us. [47 year old father]

> I used to drink and smoke, but thank God I'm dropping all those things now, because the money I'm taking to buy cigarettes and liquor I can use that as recess for my children. Since the people came and started advising us how to take care of our children I looked into it and I left all of things. [39 year old father]

Happy Families is a parenting and family skills intervention for Burmese migrant and displaced families living on the Thai-Burmese border, and is adapted from the evidence-based US programme Strengthening Families (Kumpfer, Pinyuchon, Teixeira de Melo, & Whiteside, 2008). Sim, Annan, et al. (2014) contend that many of the stressors associated with forced migration, such as economic hardship, psychological distress, discrimination, abuse and weakening of social support structures, are known to have a negative impact on parenting. These factors can also compromise the protective capabilities of parents and may increase the risk of child maltreatment and abuse. The 12-week course provides parallel group sessions for caregivers and their children, in addition to joint sessions in which they can practice the skills learned. The programme content focuses on helping caregivers to understand their children's development and teaches caregivers and children communication and problem solving skills. For example, parents are taught how to reward good behaviour, set goals and objectives with children, problem solve, manage behaviour and maintain changes. Child sessions focus on speaking and listening to others, problem solving, recognising feelings, and dealing with criticism and anger. Both parents and child sessions include content on the effects of alcohol and drugs. The curriculum does not include content which encourages participants to explore traditional social norms and beliefs about gender in the context of parenting or in relation to gender based violence.

A waitlist randomised controlled design with a one month follow-up was used to measure the impact of the intervention on CM outcomes. The programme was implemented in 20 urban and rural communities in the Tak province. Parents or caregivers of Burmese origin with children aged 8–12 years of age were eligible to participate in the programme. A further 6-month follow-up was undertaken with the intervention, but not the control group. A purposive sample of 25 families from the intervention group participated in a semi-structured interview in which themes relating to IPV were identified. With regards to CM, the intervention had a significant medium effect on reducing harsh discipline overall as measured by the Discipline Interview (effect size −.40, $p < .001$). Children reported a small, but non-significant decrease in their caregiver's use of harsh discipline overall on the child report version of the Discipline Interview and a 15% reduction specifically in spanking and slapping which was significant (effect size −.33; $p < .01$). Using the second measure, the discipline module of the Multiple Indicator Cluster Survey, there was a small, non-significant decrease in harsh discipline practices overall as reported by caregivers only (effect size -0.10). When looking at individual items on harsh discipline, the only significant result was a 16% decrease in using a hard object to beat their child (-0.22, $p<0.01$). Reductions in harsh or negative parenting overall were maintained at six-month follow up with the intervention group.

In the semi-structured interviews, some caregivers reported using less harsh physical punishment to discipline their children and described an increased awareness of the negative impact that harsh discipline had on their child's development.

> If my children don't listen to me, I do meditation. I don't let myself have a hot temper. [Before] I threw everything, cooking pots and plates. My children didn't dare to stay with me when I was angry. Now I try to control my temper … They told us to calm down by using breathing exercises, controlling our mind. [56 year old mother]

Although IPV was not assessed quantitatively within the trial, the author reports that the qualitative interview data highlighted that the communication and problem solving skills component had a positive impact on some caregiver's relationships, evidenced through fewer fights with spouses. Furthermore, that the intervention may have had an unintended and positive impact on parents' wellbeing, for example, through the relaxation and breathing techniques that they were taught which helped them to regulate negative emotions. More open communication and shared decision-making between caregivers was perceived to reduce the levels of conflict in the home. Men's reduced alcohol use may also have contributed to the improved relationships with children and reduced conflict with spouses. However, no illustrative quotes were provided for these latter findings (Sim, Annan, et al., 2014).

Pre and post non-randomised pilot evaluation

Table 2 presents one study which used a pre-post non-randomised design. Sinovuyo Caring Families in South Africa is distinct from other parenting programmes described, as it targets older children who have been identified as having behavioural problems or a suspected history of abuse (Cluver, Lachman et al. 2016; Cluver, Meinck et al. 2016). Designed specifically to address CM, it also reported outcomes for IPV, both measured quantitatively. The programme uses group-based parent workshops, adolescent and joint parent-adolescent sessions so that skills can be practiced together. A buddy system consisting of peer support provides help to participants between sessions. The curriculum draws on evidence-based parenting programmes and includes collaborative problem solving, home practice and discussion (Cluver, Lachman et al. 2016). Session content includes trust building, talking about emotions, dealing with stress and anger, joint problem solving, non-violent discipline techniques, rules and routines, responding to a crisis, and keeping adolescents safe in the community. The curriculum does not explore parenting within the context of traditional gender norms and values, or how gender norms reinforce violence in the home.

In the first pre-post pilot study 30 adolescents and their caregivers were referred to the programme by a local NGOs. At the two week follow-up there were significant reductions in the use of violent and abusive discipline on parent (pre-test $\bar{x} = 7.94$, SD = 7.72; post-test $\bar{x} = 1.63$, SD = 2.83; $t = 4.18$, df = 15, $p = .001$) and adolescent measures (pre-test $\bar{x} = 25.53$, SD = 4.52; post-test $\bar{x} = 21.87$, SD = 2.11; $t = 2.39$, df = 29, p = .024). Positive parenting also significantly improved according to parent (pre-test $\bar{x} = 117.75$, SD = 14.27; post-test $\bar{x} = 132.13$, SD = 13.20; $t = -4.49$, df = 23, $p = .000$) and adolescent reports (pre-test $\bar{x} = 118.24$, SD = 12.99; post-test $\bar{x} = 127.38$, SD = 13.98; $t = -3.85$, df = 23, $p = .001$).

IPV amongst caregivers was measured using the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugerman, 1996) and children were also asked two separate questions regarding how many days there were arguments with adults shouting at each other and hitting each other in the home. There were no significant differences between the pre and post test scores in relation to the parent or children measures. Attitudes towards gender based and sexual violence was assessed using the Gender Equitable Men Scale (Pulerwitz

& Barker, 2008). The pre-post pilot found significant reductions amongst parents (pre-test $\bar{x}$ = 24.23, SD = 3.72; post-test $\bar{x}$ = 22.37, SD = 3.88; t = 3.39, df = 29, p = .002) and adolescents (t = 2.18, df = 29, p = .38) in their acceptance of gender and sexual violence post intervention (Cluver – personal communication).

A second, larger pre-post study of Sinovuyo was conducted with 115 adolescents and their caregivers (Cluver, Meinck et al., 2016). At the two to six week follow-up physical, emotional abuse and neglect of adolescents within the home significantly decreased according to adolescent and caregiver reports (p < .001) dropping from an average score of 4.33 (SE.57) to 1.33 (SE.27) for adolescents and 11.32 (SE.84) to 1.68 (SE.36) for caregivers. Positive and involved parenting showed significant improvement following the intervention, as reported by both adolescents (pre-test $\bar{x}$ = 48.71, SE 1.07; post-test $\bar{x}$ = 51.62, SE .91; p = .01) and caregivers (pre-test $\bar{x}$ = 49.23, SE .98; post-test $\bar{x}$ = 53.83, SE .81; p < .001). There was also a reduction in physical abuse, emotional abuse and neglect following the intervention according to adolescent (pre-test $\bar{x}$ = 4.33, SE = .57; post-test $\bar{x}$ = 1.33, SE = .27; p = .001) and caregiver reports (pre-test $\bar{x}$ = 11.22, SE = .84; post-test $\bar{x}$ = 1.68, SE = .36; p = .001). A large cluster randomised trial is currently underway.

Qualitative evaluation

One Man Can (OMC) Fatherhood Programme in South Africa was evaluated qualitatively and presented in Table 3 (Hatcher et al., 2014; Van den Berg et al., 2013). OMC is a gender-transformative, masculinities and rights-based programme that aims to reduce violence against women, decrease levels of unsafe sex and promote more gender equitable relations. It is underpinned by the notion that fatherhood is an opportune time for challenging harmful masculine norms and explores with men the disadvantages that accompany male privilege such as reduced intimacy with partners and children. The curriculum includes specific sessions that address gender violence, gender, sex and HIV/AIDS, developing healthy relationships, and content on fatherhood that explores non-traditional gender roles in caregiving, non-violence and the needs and rights of children.

The programme targets black South African men aged 18 years and over living in communities with high AIDS morality where children are left vulnerable by the deaths of one or both parents. Since one of the aims is to increase men's involvement in the lives of their own children and children in general, it is not restricted to men who are fathers. The programme is delivered as a series of workshops in community settings. Van den Berg et al. (2013) conducted interviews with 90 men within six months of completing the programme. One of the key themes identified focused on a shift in parenting style from disciplinary and authoritarian, to a more caring and nurturing role, with men reporting less use of violence and corporal punishment and improved communication with their children. Hatcher et al. (2014) also conducted interviews with 53 men within six months of completing the programme. Three key themes were identified which included reduced alcohol intake which was linked to shifting ideals of manhood; improved communication with more equal and shared decision-making between men and their partners; and shifting views around sexual entitlement and more shared sexual decision-making. It appeared that the programme helped some men to learn new ways of communicating respectfully with their partners and children in order to avoid escalation of emotions and the use of violence. Within the

Table 2. Evidence from pre-post non-randomised studies.

Author/ year	Country	Intervention name	Programme aims and key components	Setting and target group	Methods	IPV and CM outcomes/themes
Cluver, Lachman et al., (2016)	South Africa	Sinovuyo Caring Families Teen Programme	Programme aims: Increase parenting skills and confidence; decrease harsh discipline; help teenagers manage their behaviour; improve mental health and social support; improve problem solving skills; help families respond better to crisis situations; improve knowledge of services for violence, illness and arrest; reduce stress that families feel about money Key components: Comprised 12 weekly sessions, each lasting 2–2.5 h. For eight sessions caregivers and adolescents attended jointly, and in four sessions they attended in separate caregiver and adolescent groups. The programme followed core principles of evidence-based parenting programmes, including collaborative problem-solving, home practice and discussion, and skills-based active participation. Content included: building trust and spending time; praising each other; identifying and talking about emotions; dealing with stress, fear, shame and anger; joint problem-solving; non-violent discipline; rules and routines; keeping adolescents safe in the community; and responding to crisis. A peer-support system of 'Sinovuyo buddies' was introduced to help participants between sessions, as low literacy levels limited the use of written materials. Also included mindfulness-based physical exercises for stress reduction	Setting: delivered in community settings Target group: families were identified by the NGO as having expressed challenges with their adolescents, or with adolescent behavior, or families where the NGO or community suspected violence. There were no exclusions for severity of circumstances nor for mental or physical health problems or any other cause. Adolescents were aged 10 to 17 years. 97% of parents/caregivers participants were women	Pre-post non-randomised pilot test of the programme. 60 participants (30 caregiver-adolescent dyads) from two high-poverty, rural communities of South Africa's Eastern Cape province. Interviews at baseline and two weeks post-intervention. Violent and abusive discipline measured using the International Society for Prevention of Child Abuse and Neglect (IPSCAN) child and parent version of the International Child Abuse Screening Tool (ICAST-C and ICAST-P). Positive parenting assessed using relevant child and parent subscales of the Alabama Parenting Questionnaire (APQ). Attitudes to gender and sexual violence (parents and adolescents) were measured using the Gender Equitable Men scale (GEM).	CM quantitative findings: significant reductions in the use of violent and abusive discipline following the intervention, as reported by caregivers (pre-test $\bar{x} = 7.94$, SD = 7.72; post-test $\bar{x} = 1.63$, SD = 2.83; $t = 4.18$, df = 15, $p = .001$; effect size −1.09; 95% CI −1.80, −.32) and adolescents (pre-test $\bar{x} = 25.53$, SD = 4.52; post-test $\bar{x} = 21.87$, SD = 2.11; $t = 2.39$, df = 29, $p = .024$; effect size −.47; 95% CI −.99, .06). Improvements in positive parenting following the intervention as reported by caregivers (pre-test $\bar{x} = 117.75$, SD = 14.27; post-test $\bar{x} = 132.13$, SD = 13.20; $t = -4.49$, df = 23, $p = .000$; effect size 1.05; 95% CI .43, 1.63) and adolescent (pre-test $\bar{x} = 118.24$, SD = 12.99; post-test $\bar{x} = 127.38$, SD = 13.98; $t = -3.85$, df = 23, $p = .001$; effect size .68; 95% CI .08, 1.25) IPV quantitative findings: significant reduction in acceptance of gender and sexual violence on the GEM scale following the intervention as reported by amongst caregivers (pre-test $\bar{x} = 24.23$, SD = 3.72; post-test $\bar{x} = 22.37$, SD = 3.88; $t = 3.39$, df = 29 $p = .002$) and adolescents (pre-test $\bar{x} = 27.90$, SD = 5.16; post-test $\bar{x} = 25.62$, SD = 3.88; $t = 2.18$, df = 29, $p = .038$) - personal communication.

(Continued)

Table 2. (*Continued*).

Author/ year	Country	Intervention name	Programme aims and key components	Setting and target group	Methods	IPV and CM outcomes/themes
Cluver, Meinck et al. (2016)	South Africa	Sinovuyo Caring Families Programmes	Same as Cluver, Lachman et al. (2016)	Setting: delivered in community settings	Larger pre-post study. 230 participants (115 adolescent-caregiver dyads), living in six deprived rural and peri-urban communities	CM quantitative findings: abuse of adolescents within the home (physical, emotional, neglect) significantly decreased following the intervention ($p < .001$ adolescent and caregiver reports), dropping from an average score of 4.33 (SE.57) to 1.33 (SE.27) for adolescents and an average score of 11.32 (SE.84) to 1.68 (SE.36) for caregivers. Proportions of adolescents reporting within-home abuse were 63.0% at pre-test, and 29.5% at post-test, and proportions of caregivers reporting within-home abuse were 75.5% at pre-test and 36.5% at post-test
				Target group: Two thirds of families were referred by NGOs, schools, clinics, chieftains, and social workers, based on family conflict or challenges in dealing with adolescents. The remainder of families were approached door-to-door. No eligibility criteria exclusions were mde regarding factors such as parental or adolescent literacy, mental or physical health, or domestic violence. Adolescents were aged 10 to 17 years. 94% of parents/caregivers participants were women	Interviews at baseline and two to six weeks post-intervention. Violent and abusive discipline measured using the International Society for Prevention of Child Abuse and Neglect (IPSCAN) child and parent version of the International Child Abuse Screening Tool (ICAST-C and ICAST-P). Positive parenting assessed using relevant child and parent subscales of the Alabama Parenting Questionnaire (APQ). Attitudes to gender and sexual violence (parents and adolescents) were measured using the Gender Equitable Men scale (GEM)	Positive and involved parenting showed improvements following the intervention as reported by adolescents (pre-test $\bar{x} = 48.71$, SE = 1.07; post-test $\bar{x} = 51.62$, SE = .91; $p = .01$) and caregivers (pre-test $\bar{x} = 49.23$, SE = .98; post-test $\bar{x} = 53.83$, SE = .81; $p = .01$) df = 23, $p < .001$). Poor monitoring and inconsistent discipline decreased following the intervention, as reported by adolescents (pre-test $\bar{x} = 19.64$, SE = 1.01; post-test $\bar{x} = 15.52$, SE = .90; $p < .001$) and caregivers (pre-test $\bar{x} = 24.36$, SE = 1.21; post-test $\bar{x} = 16.87$, SE = 1.06; $p < .001$)

specific sub-theme of 'reduced violence', a few men also attributed this to their reduced alcohol and marijuana use.

> In one of my frequent drunken states, I would go and look for my girlfriend and when I wanted her to come along with me there would be no compromise. My word was the final word and I would not take any input from her. Attending the OMC workshops, I got to understand the wrongs of my past behaviour and I started understanding that men should listen to women's inputs. [Khuzani, 33 years, 9 sessions]

> … I used to drink every day and go home drunk and shouting to my children. I really have changed, I have completely stopped drinking. [Sizwe, 62 years, 1 session]

> It was one of my fascinations to hear men defining power that people have within the communities that included sexual power carried by men over women. When I looked at the topic deeply, I then had to search inside me and compare what I do to women as well to influence their decision … But things have changed. Even women can protect and provide for the family. [Makondelela, 42 years, 2 sessions]

Discussion

This review identified six programmes in LMIC that demonstrate promise for developing a coordinated response to IPV and CM. It also identified key programme components that may have contributed to positive outcomes for both forms of violence. With the exception of SASA!, all were parenting education programmes targeting caregivers and children. Only two (One Man Can Fatherhood Programme in South Africa and Real Fathers in Uganda) were specifically designed to address both forms of violence. All programmes were delivered in community settings and engaged participants in group education and discussion sessions, although REAL Fathers in Uganda supplemented this with individual and couple mentoring sessions and Parents Make the Difference in Liberia included a home visit.

The interventions were complex and it was difficult to determine precisely which components were directly responsible for producing the promising outcomes for IPV and CM. The emphasis on gender and gender norms varied between programmes. Parenting programmes focussed primarily on improving parent-child relationships and reducing harsh and abusive parenting. However, they also enabled couples to develop better communication skills with each other, which encouraged joint decision-making in relation to caregiving, household and financial issues and collaborative problem solving. This indirect mechanism for addressing gender equity appeared to reduce conflict in caregiver relationships, and improve overall family functioning and cohesion. Caregivers appeared better equipped to resolve emotionally heightened situations with each other before they escalated to violence. This highlights the potential for caregivers to be positive role models for their children and prevent future IPV perpetration and victimisation.

There were other unintended positive outcomes in some programmes. Building Happy Families and Parents Make the Difference documented reports of reduced alcohol use by male partners in the qualitative interviews, although this was only a specific programme component in Building Happy Families. Reduced alcohol use by male partners appeared to contribute to improved relationships and some men reported spending more time at home with their families as opposed to drinking with peers, which helped to reduce partner conflict. Whilst some lower level forms of aggression may be borne out of family stress, there

Table 3. Evidence from qualitative studies.

Author/year	Country	Intervention name	Programme aims and key components	Setting and target group	Methods	IPV and CM outcomes/themes
Van den Berg et al. (2013)	South Africa	One Man Can Fatherhood Project	Programme aims: Gender transformative programme to: (i) increase men's involvement in the lives of their own children, and ensure that children in general have access to essential social services and have their psychosocial and educational needs met (ii) develop men's capacity to be activists in efforts to eliminate violence against women and children and prevent the spread of HIV/AIDS (iii) give voice to vulnerable children and raise awareness of their needs within the community Key components: Workshops of 15–20 men are facilitated by men. Activities focus on the costs of masculinity and encourages men to reflect on how masculinities is practiced in relationships with women, men and the broader community. Workshop content: gender power and health; gender and violence; gender, sex and HIV/AIDS; and healthy relationships. Fatherhood content: father's impact; pregnancy; birth; family planning; caregiving; gender roles; non-violence; needs and rights of children; division of caregiving	Setting: delivered in community settings Target group: Black South African men aged 18 and over in communities affected by high AIDS mortality and where children are left vulnerable by the deaths of one or both parents	Qualitative evaluation consisting of 90 in-depth interviews with men during the 6 months after they completed the programme	CM qualitative themes: shifts in parenting style from disciplinary and authoritarian to a more caring, nurturing and protective role; men's recognition that their role extended beyond that of being a financial provider for the family; less use of violence and corporal punishment; and improved communication with children and spending more time with them.
Hatcher et al. (2014)	South Africa	One Man Can Fatherhood Project	Same as Van den Berg et al. (2013)	Same as Van den Berg et al. (2013)	Qualitative evaluation. In-depth interviews with 53 men during the 6 months after they completed the programme	IPV and CM qualitative themes: Reduced alcohol use by men potentially linked to less risky sexual behaviour and reduced relationship conflict. More open and emotional communication with partners and children. Communication changes including shifts towards more gender equality in decision-making, including sexual decision-making and more respectful handling of volatile emotional states to prevent escalation to violence

is a danger in conveying to programme participants that IPV is solely a communication issue or due to family stress and programmes must ensure that men take responsibility for their use of violence.

The focus on female caregivers is a noted commonality in the general literature on parenting programmes and the subject of considerable discussion. Three parenting programmes targeted male and female caregivers (Sinovuyo, Parents Make the Difference and Building Happy Families). However, with the exception of Parents Make the Difference in Liberia (in which 57% of attendees were female), the majority of caregiver participants were female (94–97% in Sinovuyo and 92% in Happy Families). There are concerns that interventions that target or are primarily attended by female caregivers fail to address structural and other contextual factors that impact children, families and communities. Therefore, such programmes may inadvertently reinforce traditional gender roles and ideologies that can increase women's risk of gender based violence (Daly et al., 2015). However, SASA! demonstrated that it is possible to address gender based violence without focussing explicitly on traditional gender norms that can sometimes discourage community participation. Discussions about the positive and negative aspects of power can be an indirect way of addressing the imbalances between men and women and how this manifests in different spheres of life (Abramsky et al., 2014; Kyegombe et al., 2015).

In recent years, fatherhood programmes have been identified as a key environment in which to transform harmful masculine norms that underpin gender based violence (Levtov, van der Gaag, Greene, Kaufman, & Barker, 2015; McAllister, Burgess, Kato, & Barker, 2012). Although the two fatherhood programmes in this review included components that address traditional gender norms in relation to caregiving, female caregiver involvement was minimal or absent (Ashburn et al., 2015; Hatcher et al., 2014; Van den Berg et al., 2013). There is growing recognition that fatherhood programmes need to work alongside efforts to support and protect women and children exposed to family violence. Another gap within parenting programmes is the lack of provision for adolescents as many are designed for young children (Daly et al., 2015). Although interventions for parents of adolescents are rare in LMIC countries, our review identified two which targeted older children (Building Happy Families in Thailand and Sinovuyo Caring Families in South Africa). Future programmes and services need to be tailored to the needs of both younger children and adolescents, where the latter are at higher risk of exposure to and perpetration of IPV.

Although the evidence in this review was concentrated in parenting programmes, there are other settings in which greater coherence between CM and IPV programming can be achieved. The SASA! community mobilisation programme in Uganda did not include a specific parenting component, yet the study found that after the intervention fewer children witnessed IPV and that men were spending more time with their children, using less or rejecting harsh discipline and violence towards their children. The mechanisms through which the intervention may have impacted on children witnessing and experiencing violence are multiple. The programme encouraged participants to reflect on the consequences of violence for their relationships with partners, children and other community members. It taught communication, joint decision-making and conflict resolution skills between couples, which parents may have adopted in their parenting practices. It also encouraged more connected and intimate relationships, which may have impacted on parents spending more time with children and listening to them. Beyond the relationship level, SASA! also played a role in reducing the acceptability of violence and fostering a sense of responsibility to

act to prevent violence and communities had more supportive structures (e.g. community activists) to do this. Both SASA! and REAL Fathers, which identified and trained local men to act as mentors to deliver the programme, illustrate the importance of broader social networks, influential people and community engagement in supporting and sustaining positive changes in behaviour.

The push towards more coordinated responses to IPV and CM has given rise to discussions about the potential risks of a combined agenda. Advocates in the fields of VAW and VAC have highlighted that integration may not always be the best approach, or in the best interests of women and children, and that separate interventions are sometimes necessary (Guedes et al., 2016). Specific concerns relate to the historical protection of children being prioritised over the safety of women, if it is determined that their children are being exposed to IPV. Typically, mothers are held solely responsible for the health, safety and wellbeing of their children, regardless of whether or not they are responsible for their abuse. Failing to address the needs of maltreating fathers creates problems for all family members and increases the risk of violence to women and children. As the fields of IPV and CM start to converge there has been growing awareness that both parents play an important role in ensuring child safety and wellbeing and that interventions are needed for fathers that address both CM and IPV. However, interventions must be underpinned by accountability principles that prioritise the safety and wellbeing needs of children and mothers (Peled, 2000; Scott & Crooks, 2007). Furthermore, research and discussion is needed regarding how to support the parenting practices of men who are known to be abusive to their partner and in which circumstances this should be promoted or restricted. McMahon and Pence (1995) maintain that a considered and critical perspective is needed to ensure that the policies and procedures of such programmes do not perpetuate gender inequality and the damaging consequences for women and children.

Conflicting priorities, policies and the differential allocation of resources across sectors and organisations may impede a coordinated response. More work is needed to encourage collaborative working across the VAW and VAC sectors without either feeling undermined. This includes agreed safety measures to reduce possible increased risk of violence to women and children when IPV and CM are identified as occurring within the same household, with equal attention to women and children. There must also be consideration of the level of resources available in countries to develop such programmes and the scarcity of qualified professionals in some settings. Three of the programmes (SASA!, REAL Fathers and Building Happy Families) used trained community members to help deliver the intervention, an approach which may provide a solution to the lack of professional staff. With the exception of SASA! which was community based, the interventions were all targeted, focussing on young children within a specific age group (Parents Make the Difference, Building Happy Families), older children with identified behavioural problems (Sinovuyo), young fathers of toddler aged children (REAL Fathers) or men living in communities affected by high AIDS mortality (One Man Can). Whilst targeted approaches are lower cost than universal programmes, there are disadvantages that should be considered. Not all eligible families will want to enrol in targetted programmes because of stigma (e.g. children with behavioural problems or where there is a known history of abuse or alcohol problems in the home), or due to negative attitudes from the community which result in segregation. Furthermore, strict eligibility criteria may exclude families that could benefit from the programme. Women and

children affected by violence in the home, may move in and out of the eligibility criteria for targeted programmes as their family circumstances change. Participation may be higher and with greater community integration in universal programmes, for examples in schools or health care settings. Due to scarcity of resources in some LMIC, a hybrid approach might be preferable. This would ensure that all families receive some services, with more intensive services provided if additional needs are identified.

Limitations

Caution is warranted when interpreting the findings. The evidence is limited due to the small number of studies identified, limitations in the study designs and the exclusion of articles written in languages other than English. With regards to the strength of the evidence, not all outcomes were measured quantitatively in the studies that used a trial design, but relied on qualitative data from interviews (Kyegombe et al., 2015; Sim, Puffer et al., 2014). The IPV finding for Sinovuyo Caring Families was partially based on a quantitative measure of caregiver and adolescent attitudes towards sexual and gender based violence and traditional gender roles (Cluver, Lachman et al. 2016). However, the use of scales that measure attitudes and knowledge are not reliable indicators of behaviour change and direct measures of IPV are needed. One of the studies that included a qualitative component presented the author's interpretation of the data without including illustrative quotes to support the findings. In comparison, the quantitative data was presented in detail (Sim, Annan, et al., 2014). In the case of REAL Fathers, ethical concerns regarding use of unique identifier codes during data collection limited the ability to maintain group assignment in the RCT design.

Some evaluations relied on men's reports of IPV with no corroborating evidence from women (Ashburn et al., 2015; Hatcher et al., 2014; Van den Berg et al., 2013). Similarly, reports of changes in relation to harsh and abusive parenting practices were based on caregiver accounts (Ashburn et al., 2015; Kyegombe et al., 2015; Sim, Puffer et al., 2014) and only two studies included follow-up interviews with children (Cluver, Lachman et al., 2016; Cluver, Meinck et al., 2016; Sim, Annan, et al., 2014). Two of the trials and the pre-post pilot study had short follow-up periods (Cluver, Lachman et al., 2016; Cluver, Meinck et al., 2016; Sim, Puffer et al., 2014; Sim, Annan, et al., 2014). Longitudinal research using mixed methods designs is needed to strengthen the evidence in LMIC regarding sustainability of programme outcomes. Our findings and recommendations are partially informed by studies that used qualitative interviews with participants to explore their perceptions of how the programmes changed their behaviour in regard to IPV and CM. Given the highly sensitive and stigmatised nature of these issues, consideration must be given to the presence of social desirability bias which may have influenced participant disclosures of change following their involvement in the programmes.

Future evaluations of programmes that are likely to impact on IPV and CM should include the use of validated measures with men and women which can be triangulated with data from qualitative data sources. Furthermore, this should be corroborated with children's reports of the nature, frequency and severity of IPV and CM whenever possible. Evidence suggests there are low to moderate associations between parent and child reports of the child's exposure to IPV (Kolko, Kazdin, & Day, 1996; Litrownik, Newton, Hunter, English, & Everson, 2003). Children may be aware of abuse which parents believe they are shielded from, and parents and children may be aware of, attend to and remember different aspects

of hostile interactions leading to differences in their accounts (Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Jouriles et al., 2001). Ethical dilemmas involving children in research relate to conflicting constructions of children as both competent and vulnerable. This necessitates further discussion of the methods that may be used to capture children's exposure to and descriptions of violence (Cater & Overlien, 2013).

Although the scoping team and other experts were involved at various stages of the review process, an important limitation is that screening of abstracts and data extraction was conducted by one reviewer. It is recommended that at least two reviewers independently review abstracts and extract data to temper biases related to interpretation of the findings (Levac et al., 2010). However, we aimed to limit potential bias by ensuring input from the scoping review team during drafting of the paper, in addition to an independent review of the paper by four international experts, and presentation of the findings at the Know Violence in Childhood expert meeting.

Conclusion

Our review has highlighted that opportunities do exist for greater coherence between IPV and CM programmes, especially in community-based programmes targeting parents. Researchers and programmers should be mindful of these opportunities whilst working towards shared goals, so that violence against women and violence against children are not addressed in isolation.

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Appendix 1. Example search strategy from medline

(1) Domestic violence/or battered woman/or family violence/or partner violence/
(2) gender based violence/
(3) (spous* abuse or wife abuse or abuse of wives or abuse of women or wife battering or battering of wives or partner abuse or partner violence or family violence or battered wom*n or dating violence or violence against women or gender based violence). mp. [mp = title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
(4) dating violence/
(5) child neglect/or child abuse/or child sexual abuse/
(6) (child* maltreatment or child* neglect or child* sex* abuse or violence against children or violence against girls). mp. [mp = title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
(7) child health care/or prenatal care/or community health nursing/
(8) postnatal care/
(9) secondary prevention/or prevention study/or primary prevention/
(10) early childhood intervention/or intervention study/or early intervention/
(11) ((gender adj 3 education) or gender power or prevention or primary prevention or secondary prevention or intervention* or program* or what works or response or approach or approaches or advocacy or perinatal home visit* or parenting program* or home visit* or health visiting or nurse family partnership or family nurse partnership or health sector intervention* or health service intervention or school program* or community mobilisation). mp. [mp = title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
(12) 1 or 2 or 3 or 4
(13) 5 or 6
(14) 7 or 8 or 9 or 10 or 11
(15) 12 and 14
(16) 13 and 14
(17) 12 and 13 and 14

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The prevention of violence in childhood through parenting programmes: a global review

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ABSTRACT

Child maltreatment is a global problem affecting both high income (HICs) and low and middle income countries (LMICs). However research has shown that children who live in the world's poorest countries and communities are more likely to suffer from abuse and neglect. There is some evidence that parenting interventions can assist in the prevention of child maltreatment, but most of this research has been conducted in HICs. The main aim of this review was to examine the evidence from previous systematic reviews on the role of parenting programmes in the prevention of violence against children in both HICs and LMICs. A comprehensive internet search was conducted for published and unpublished reviews. After reviewing abstracts and full texts against established criteria for inclusion in the study, 28 reviews (20 systematic reviews/meta-analyses and 8 comprehensive reviews) were used in the analyses. The findings suggest that parenting programmes have the potential to both prevent and reduce the risk of child maltreatment. However, there is lack of good evidence from LMICs where the risk of child maltreatment is greatest. Implications for policy and future research are discussed, especially for the LMIC context.

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Parenting programmes; violence prevention; child maltreatment; early childhood; systematic review; low and middle income countries (LMICs)

Violence is a major public health and human rights issue with serious consequences for individuals, families and societies (Wessels et al., 2013). Young children are particularly at risk for exposure to violence due to their dependence on caregivers, lack of mobility and limited social interactions outside of the home (UNICEF, 2014b). Child maltreatment encompasses all forms of physical and/or emotional ill-treatment. It also incorporates sexual abuse, neglect or negligent treatment and commercial or other exploitation of children (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Children can also be exposed to violence by witnessing the violence suffered by others in their families and communities.

Violence against children (VAC) is a global problem affecting both high income countries (HICs) and low- to middle- income countries (LMICs). However, research has shown that the burden of child injury and violence is heaviest in LMICs (Skeen & Tomlinson, 2013). Children who live in the world's poorest countries are more likely to suffer from violence.

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Two-thirds of child murders take place in either low income or lower middle income countries (UNICEF, 2014a). Exposure to violence is also more prevalent in neighbourhoods and communities that are impoverished or isolated (UNICEF, 2014a).

Regardless of socio-economic status, parenting has been identified as an important factor in the aetiology of child maltreatment. Maltreatment is more likely when parents have a poor understanding of child development, are less nurturing, have an authoritarian parenting style or were abused themselves (McCloskey, 2011). There are also psychosocial risks for poor parenting that have been linked to child maltreatment including drug or alcohol dependency, depression, anxiety, low self-esteem and parenting stress (McCloskey, 2011).

It is therefore not surprising that the first of UNICEF's six strategies for ending VAC relates to supporting parents, caregivers and families (UNICEF, 2014a). Parenting interventions have been shown to be effective both in improving parenting and children's cognitive and behavioural outcomes (Knerr, Gardner, & Cluver, 2013; Mejia, Calam, & Sanders, 2012). However, most of the evidence for the prevention of child maltreatment through parenting interventions relates to physical abuse and neglect (MacMillan et al., 2009). There is less evidence for the prevention of sexual and emotional abuse because these forms of maltreatment are often the focus of different types of interventions or, as in the case of emotional abuse, are less well studied (Barlow, Simkiss, & Stewart-Brown, 2006).

Parenting interventions can use a range of delivery mechanisms (e.g. group-based or individual; home visiting; multicomponent interventions; media) and can be offered in many different settings (e.g. primary health-care, hospitals, early childhood centres, schools, homes, community centres). They may target specific groups of parents (e.g. teenage parents or parents with substance abuse issues) and have content that is tailored to the needs of particular populations. Parenting interventions can also be classified as – universal, selective or indicated – using a public health prevention framework. Universal programmes are aimed at the general public and do not discriminate on the basis of risk. Selective programmes on the other hand, are directed to at-risk groups (e.g. families living in poverty; teen mothers). Finally, indicated programmes are aimed at groups or individuals where there are already signs of problematic behaviours and may include treatment.

Evaluations of parenting programmes suggest that they can positively impact risk factors such as parental attitudes and relationships with partners, as well as help in the prevention of child maltreatment (WHO, 2013). Despite this evidence, there are several issues that currently make it difficult to be conclusive about the effectiveness of parenting programmes in the prevention of VAC. For example, there is often no consistent definition or measurement of child maltreatment across evaluations. Some evaluations use objective measures of child maltreatment such as reports from child protection services or number of injuries, while others use risk factors as a proxy for child maltreatment like parental stress and attitudes toward discipline. Systematic reviews of parenting evaluations have also highlighted several methodological weaknesses in evaluations (Euser et al., 2015) and overall, there are few randomised controlled trials on whether interventions prevent maltreatment (WHO, 2013). Programmes also differ in terms of target group, type of professional delivering the programme, number and length of sessions/visits, outcome measures and follow-up period. As a result, overall effects are often difficult to separate and quantify.

There is even less evidence regarding the role of parenting interventions in the prevention of child maltreatment in LMICs. However, there is evidence from low-resource settings in

HICs that suggest that parenting programmes can have an impact in different cultural and economic contexts (WHO, 2013). A recent review of research from LMICs suggests that parenting programmes do improve parenting in these contexts (Knerr et al., 2013). However, very few of these studies actually measured violence as an outcome and therefore can offer less support for the role of these interventions in preventing violence.

Given the pervasive nature and profound effects of VAC, it is important that we use the best available evidence to guide our decisions regarding the implementation of interventions to prevent its occurrence. There is some evidence that strengthening families through parenting programmes can prevent child maltreatment and children's exposure to other forms of violence such as intimate partner violence (IPV). However, this literature has serious gaps especially regarding the quality of evaluations and the efficacy of these types of programmes in LMICs. Consequently, the main aim of this review is to examine the evidence from previous systematic reviews on the role of universal and targeted parenting programmes in the prevention of VAC in both HICs and LMICs.

Method

A comprehensive internet search was conducted for published and unpublished reviews. The following electronic databases were searched: Academic Search Complete (EBSCO), PubMed, Medline, Psych Info and Cochrane Library. The initial search was restricted to titles, abstracts and keywords and included search terms such as 'home visiting', 'child maltreatment', 'parent program', and 'systematic reviews'. A different search term was used in Cochrane Library (see Appendix A for the complete search terms). Unpublished reports and reviews such as workshop summaries, dissertations and conference reviews were located via Google Scholar and other websites such as World Health Organization (WHO) and United Nations Children's Fund (UNICEF).

The inclusion criteria for the review were the following:

(1) Systematic reviews, meta analyses or comprehensive reviews that included evaluations that measured child maltreatment outcomes.
(2) Interventions had to target child maltreatment preventions, general parenting skills and the early childhood years.
(3) Reviews written in English and published between 2000 and March 2016 (week 4).

During the identification process, reviews were excluded if they were related to disorders, diseases, obesity, the elderly, immunization and/or dental problems. During screening, reviews were excluded if they were editorials, letters, commentaries, solely for practitioners, tertiary intervention programmes, school interventions and interventions targeted at the child only. They were also excluded if the main outcome measures were birth outcomes or bullying. Finally, at the eligibility level, reviews with low Assessing the Methodological Quality of Systematic Reviews (AMSTAR) scores (0–4) were dropped from the analysis. AMSTAR is a measurement tool for the assessment of multiple systematic reviews that has good reliability and validity (Shea et al., 2007).

The search identified 4304 sources with nine being from grey literature. An initial screening of the titles and abstracts was used to exclude reviews not meeting the inclusion criteria. Articles that were duplicated were removed and selected reviews retrieved for detailed appraisal. A total of 154 articles were selected for detailed review. During this process 24

articles were excluded based on inclusion criteria. We attempted to contact authors to obtain articles we could not retrieve online, however, of the 22 authors contacted we received eight full text reviews. Overall, the research team reviewed 130 full text articles using the eligibility criteria and a standard data extraction form. Twenty-three systematic reviews and meta-analyses were scored for methodological quality using AMSTAR and three were eliminated based on low scores.

The flowchart of the entire selection process is detailed in Figure 1.

Results

The findings of the systematic reviews are presented by child maltreatment outcome variables or by proxies such as parental mental health and attitudes to parenting or parenting stress, which have been associated with maltreatment. Included in the analysis are 28 reviews

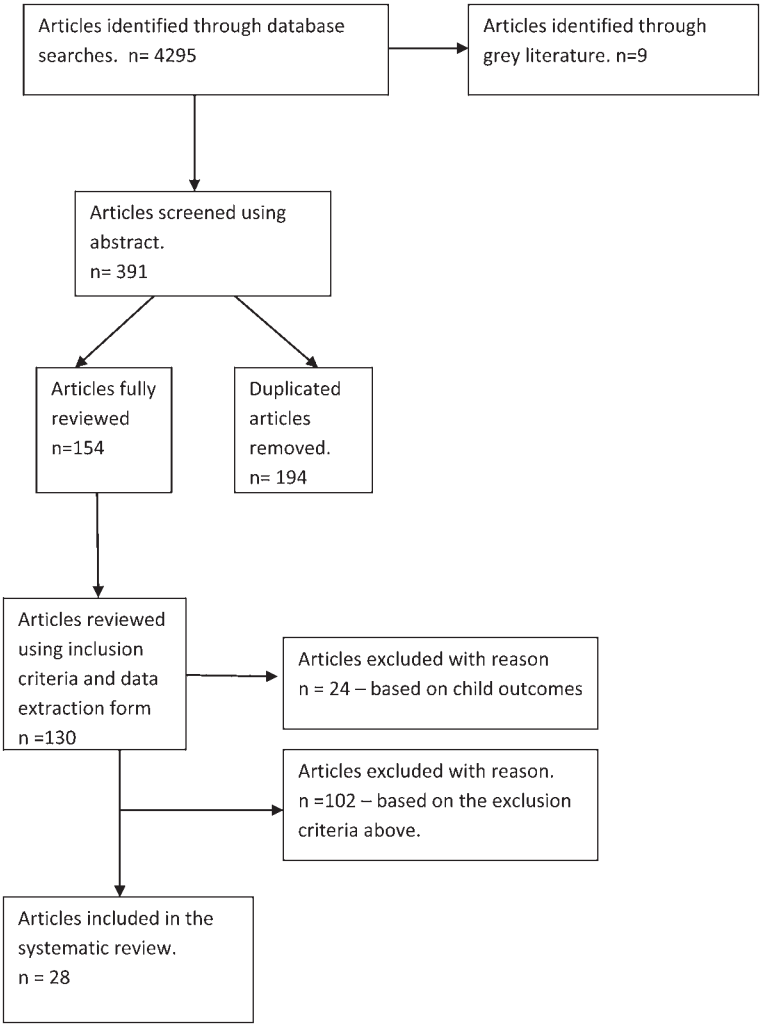

Figure 1. PRISMA flowchart of the search strategy.

Table 1. Summary of findings.

Article	Programme type	Papers reviewed	Outcomes assessed	Summary of main findings	AMSTAR
Alderdice et al. (2013)	Multi modal	32	Maternal mental health and well being	• Postnatal nursing home visits (at risk mothers) was protective in first 6 weeks postpartum • Group parenting participants had less depression, anxiety/stress, self-esteem and relationship adjustment	6
Avellar and Supplee (2013)	Home Visitation	207	Child maltreatment	• Five programmes showed reduction in child maltreatment in parent and official reports	7
Barlow et al. (2014)	Group parenting programmes	48	Parental mental health	• Improved psychosocial health post intervention for mothers • Reduced parental stress for fathers in the short term • Effects were non significant at one year	9
Barlow et al. (2002)	Group Parenting Programmes	15	Maternal mental health	• Improved the mental health of parents from high and lower SES groups in the short term	6
Barlow et al. (2006)	Multi modal	15	Documented or reported abuse or neglect, parenting attitudes and practices, anger and stress levels.	• Limited evidence about improving objective measures of physical abuse or neglect • Modest benefits in improving parental and family functioning • Media intervention and perinatal coaching were ineffective for high risk groups	7
Barlow et al. (2011)	Individual and Group	9	Parental Psychosocial health, Child health and development, parent–child relationship	• No evidence regarding parental attitudes to child rearing • Positive effect on parent interactions with infants • 19/47 individual studies had statistically significant effect sizes for the intervention group	9
Bennett, Barlow, Huband, Smailagic, and Roloff (2013)	Group Parenting Programmes	48	Parental psychosocial health	• Small short-term reduction in depression, anxiety, stress, anger and guilt and improvement in confidence and satisfaction with the partner relationship • Effects became non – significant one year post intervention	8
Bilukha et al. (2005)	Home Visiting	20	Parental violence, Intimate partner violence, child maltreatment, child violence	• Some evidence of effectiveness that home visitation prevents of child maltreatment • Insufficient evidence for all other outcomes	7
Chen and Chan (2016)	Multi modal	37	Child maltreatment, parental risk factors, parental protective factors	• A small but positive effect in reducing the number of substantiated child maltreatment reports, psychological aggression, harsh discipline, corporal punishment, neglect • Reduction of inappropriate parenting attitudes regarding corporal punishment • Small positive effect re: reduction of parental depression • Effect size was larger for developing countries (.627 vs. .200)	8

(*Continued*)

Table 1. (*Continued*)

Article	Programme type	Papers reviewed	Outcomes assessed	Summary of main findings	AMSTAR
Euser et al. (2015)	Multi modal	23	Child maltreatment, parent–child attachment	• 5/20 programmes were effective in reducing or preventing child maltreatment • Programmes more effective at reducing maltreatment than preventing it	6
Filene et al. (2013)	Home visitation	51	Child maltreatment	• In general, home visiting programs had no significant effects on child maltreatment	5
Geeraert et al. (2004)	Multi modal	40	Child Maltreatment, parent child interaction	• Significant reduction in abusive and neglectful acts • Reduced risk of negative family functioning and parent child interaction	7
Kendrick et al. (2008)	Multi modal	15	Unintentional injuries, maternal psychosocial functioning	• Programmes effective in preventing unintentional injuries in young children by increasing parental knowledge	8
Kendrick et al. (2000)	Home visits	34	Unintentional injuries, maternal health, postnatal depression	• Home visiting was found to significantly increase the quality of the home environment	9
Kendrick et al. (2013)	Multi modal	22	Maternal psychosocial health, unintentional injuries	• Home visiting reduced unintentional injuries and improved home safety practices for at risk parents	10
Knerr et al. (2013)	Multi modal	12	Parent–child interaction, parental attitudes and knowledge	• Two studies assessed harsh punishment and both studies showed significant reduction in harsh or dysfunctional parenting from two months to six years • Two of the three studies showed an increase in parental attitude and knowledge	7
Howard and Brooks-Gunn (2009)	Home visiting	9	Child abuse and neglect, maternal mental health	• Little evidence that home visiting programmes decreased child abuse and neglect and some evidence that home visiting positively affects parenting practices	N/A
MacMillan et al. (2009)	Parent interventions	N/A	Child maltreatment, Exposure to IPV	• Nurse Family Partnership and Triple P were shown to reduce child maltreatment	N/A
Mikton and Butchart (2009)	Multi modal	26	Child maltreatment, child abuse, hospitalization, parental stress	• 4/7 studies showed evidence of reducing child maltreatment; 3/7 reduced risk factors associated with child maltreatment • One study showed improvement in abusive head trauma • Inadequate evidence regarding media interventions	8

Olds et al. (2007)	Home visiting	31	Punishment, child abuse, neglect	• Lower rates of emergency room visits, injuries, and verified rates of child abuse 2 years post intervention • Lower rates of official child abuse and neglect for participating mothers 15 years post • Healthy Families America – greater use of non-violent methods of discipline	N/A
Olds (2008)	Home visiting	N/A	Maternal mental health (depression, stress, anxiety) and well being. Child maltreatment Unintentional injuries.	• Lower rates of emergency room visits and verified rates of child abuse up to 15 years post intervention • Fewer injuries from partner violence	N/A
Olds et al. (2000)	Home visiting	9	Child maltreatment, injuries	• Lower rates of emergency room visits and verified rates of child abuse up to 15 years post intervention	N/A
Peacock, Konrad, Watson, Nickel, and Muhajarine (2013)	Home visiting	15	Child abuse and neglect	• Paraprofessional home visiting was associated with decreases in harsh parenting	6
Persily (2003)	Home visiting	14	Child abuse and neglect	• No difference in rates of child abuse. Argued that paraprofessional services may not be best for working with families at risk	N/A
Poole et al. (2014)	Media	17	Child maltreatment rates	• Two studies found reductions in injuries and child maltreatment cases • Reduced parental anger and stress, improvements in the use of positive discipline	5
Reynolds et al. (2009)	Multi modal	15	Parental stress, parental care giving abilities. Child maltreatment	• 6/ 12 found no preventive effects on maltreatment while 4/ 12 studies found significantly lower rates of substantiated child maltreatment	N/A
Sandler et al. (2011)	Multi modal	13	Parent behaviour and skills.	• 3/4 of studies reported improvement in parenting skills and reductions in child abuse and neglect • Reduced reports of IPV • Reductions in child injuries and ingestion of toxic substances • Lower rates of abuse and neglect at 4 years (Nurse Family Partnership), stronger effects for at risk mothers	N/A
Sweet and Appelbaum (2004)	Home visitation	60	Child abuse, parent stress, child outcomes	• Studies targeting low-income parents were more successful • Para- professional home visitors were more effective than professionals or non-professionals • Studies targeting low-income parents were more successful in preventing potential child abuse • Targeted programmes more effective than universal programmes • Overall, home visiting is not effective in reducing child abuse or parent stress as an indicator of potential child abuse	6

of which 20 were systematic reviews or meta-analyses and eight comprehensive reviews (see Table 1). The average AMSTAR of included systematic reviews and meta-analyses was 7.2, indicating that the reviews were of moderate quality. One of these 28 reviews was focused on findings from LMICs while another included studies from LMICs. Many studies (13) focused on the effects of a combination of parenting interventions (home visiting, group based etc.) while 11 focused on home visiting, and four reported on group programmes, and one study assessed media-based parent training.

Maternal psychosocial well being and mental health

Six reviews reported on the effects of parenting programmes on parental (primarily maternal) mental health. Alderdice, McNeill, and Lynn (2013) reviewed the impact of postnatal home visiting and found that programme participants had lower rates of depression, anxiety/stress and self-esteem than non participants. Meta-analyses (Barlow, Coren, & Stewart-Brown, 2002; Barlow, Smailagic, Huband, Roloff, & Bennett, 2014) have found that intervention groups had significant immediate post intervention effects for rates of depression, anxiety, anger, guilt and partner relationships. These results were maintained at six months post intervention but disappeared at one year. A review of parenting programmes delivered using media-based materials (Poole, Seal, & Taylor, 2014) identified two studies that reported on reduced parental anger and stress post intervention.

IPV and family violence

Six reviews focused on how home visiting interventions addressed IPV during the antenatal period. A review by Sharps, Campbell, Baty, Walker, and Bair-Merritt (2008) stated that home visiting was not as effective in reducing rates of maltreatment when delivered in homes with IPV. Bilukha et al. (2005) found that there was some evidence to support using home visiting as a means to reduce levels of child maltreatment in homes with IPV, but no evidence of a reduction in the rate of IPV itself. On the contrary, studies have reported that the Nurse–Family Partnership (NFP) was associated with a reduction in IPV in homes that were experiencing IPV (Olds, 2008; Olds, Sadler, & Kitzman, 2007).

Child maltreatment

The majority of the studies reviewed attempted to assess the specific outcome of child maltreatment. The analysis of this outcome was limited by variations in the way the construct was measured, with some studies relying on parent reports and others collecting data from official sources. Both methods have inherent biases that limit the ability to make definitive statements about the relationship between parenting programmes and child maltreatment.

Positive evidence

Avellar and Supplee (2013) in a review of home visiting programmes found that five of six programmes that assessed child maltreatment as an outcome had positive results. Reviews of the evidence related to the NFP (Olds, 2008; Olds, Hill, Robinson, Song, & Little, 2000; Olds et al., 2007) have found that for one study site, there were significant differences in maltreatment rates (as measured by substantiated reports) between the intervention and

control group. Using parent reports, Olds et al. (2007) found that home-visited mothers engaged in fewer neglectful behaviours at follow up. These differences were significant for two years post intervention but waned by four years. The long term follow up 15 years post intervention also found significantly lower maltreatment rates for the intervention group.

Meta-analyses of various types of parenting programmes have found that the intervention groups had reduced levels of child maltreatment, and harsh and dysfunctional parenting practices (Chen & Chan, 2016; Geeraert, Van Den Noortgate, Grietens, & Onghena, 2004). Sandler, Schoenfelder, Wolchik, and MacKinnon (2011) reviewed four studies, three of which reported a reduction in corporal punishment, child abuse, and neglect. Unintentional injuries serve as a measure of the safety of the home environment, which is often used as a proxy indicator of child maltreatment. Several reviews (Kendrick, Barlow, Hampshire, Stewart-Brown, & Polnay, 2008; Kendrick et al., 2000, 2013; Olds et al., 2000, 2007, 2009; Roberts, Kramer, & Suissa, 1996) found that parenting programmes/interventions were effective in reducing the rates of child injuries and hospital visits.

Mixed or no evidence

Several reviews have argued that there is mixed or insufficient evidence to conclude that parenting programmes are an effective means to prevent maltreatment (Euser et al., 2015; Howard & Brooks-Gunn, 2009; Mikton & Butchart, 2009; Reynolds, Mathieson, & Topitzes, 2009). One issue raised in these reviews was the fact that there were few long term follow up studies. MacMillan et al. (2009) stated that the NFP is the only home visiting programme with proven effects while the Triple P programme was found to be effective in a single population. Meta-analyses of home visiting programmes (Filene, Kaminski, Valle, & Cachat, 2013; Sweet & Appelbaum, 2004) found that programmes targeted towards low income mothers had a significant effect on child abuse rates. On the other hand, Roberts et al. (1996) noted that for five of nine home visiting programmes reviewed the intervention group had higher rates of maltreatment; it is theorized that these findings may be as a result of surveillance bias.

Evidence from LMICs

Of the 28 reviews, there was only one (Knerr et al., 2013) that specifically focused on data from LMICs. In this review, one study reported on abusive parenting but this outcome could not be assessed because of insufficient data. Two other studies assessed harsh parenting and found that the intervention groups used harsh punishments less often than the comparison groups. One other paper (Chen & Chan, 2016) included two studies from LMICs in their review. They found that there was significantly greater reduction in child maltreatment rates in LMICs than for HICs, even though both saw benefits.

Discussion

This systematic review of reviews has identified evidence about the relationship between parenting programmes and child maltreatment from predominantly HICs. Our review has determined that parenting programmes appear to have a positive effect on risk factors or proxy measures associated with child maltreatment such as maternal psychosocial health and parental perceptions about harsh parenting practices. This is also true for the rates of

unintentional injuries, which showed consistent significant differences between intervention and non-intervention groups.

Measuring the effect of parenting programmes on reported or actual cases of child maltreatment was more difficult because of methodological issues. Firstly, there were no standard outcomes measured as some studies relied on parent reports and others on official reports. The use of different sources makes synthesis of the data difficult, and there are biases associated with each method, which can compromise data validity. Secondly, child maltreatment was often excluded from many programme evaluations, and when it was measured there were few long-term follow up studies. Thirdly, some studies were of low quality and did not include a comparable control group. Despite these measurement challenges the data presented do trend toward the potential of parenting programmes to prevent or reduce child maltreatment. Additionally, significant effects for at-risk groups are often found even in meta-analyses that conclude that there is no generalized effect (Reynolds et al., 2009; Sweet & Appelbaum, 2004).

There was limited data on whether parenting programmes could prevent maltreatment in homes with IPV. There also did not appear to be any data on children witnessing IPV. Another gap in the literature is the role of parenting programmes in preventing sexual abuse, as most sexual abuse programmes are offered to children through schools (MacMillan et al., 2009; Mikton & Butchart, 2009). There were no reports on sexual abuse prevention and parenting programmes.

Application to LMICs

Proportionally, there were very limited data regarding child maltreatment outcomes originating from LMICs. In the review by Knerr et al. (2013) only 3 of the 12 included studies addressed child maltreatment. Most studies assessed the quality of the parent–child relationship, which was significantly improved by the parenting intervention. Outcomes for parenting programmes in LMICs are often more focused on nutrition or cognitive factors that are known to have a direct impact on human capital development.

The challenge for LMICs is that the need for child maltreatment prevention programmes is great (as a means to break the cycle of violence) but the evidence base within LMICs is weak (Ward, Sanders, Gardner, Mikton, & Dawes, 2015). In both LMICs and HICs there has been a traditional focus on child protection services for children who have experienced abuse and trauma (Mikton et al., 2013). Child protection services are, therefore, often established in law and receive consistent (if inadequate) resource allocations from the state. As such, a shift in resource allocation in LMICs to child maltreatment prevention services will require strong evidence that can sway policy makers, especially the since the payoff is over the long term.

In the research community, the highest quality evidence comes from randomized controlled trials. In resource-poor LMICs however, RCTs are not common due to high cost and the lack of technical experts to run such complicated studies (Ward et al., 2015). The parenting programme evaluations that are conducted in LMICs are often methodologically weak due to factors such as a lack of pre- and post-tests, comparison groups or conducting a follow up assessment only. As a result, LMICs tend to be caught in a catch-22, investing in programmes that have no real evidentiary base yet needing strong evidence to make proper decisions about what to invest in. At the political level, there is also often pressure in LMICs to prove effectiveness rapidly but funds directed towards research can be interpreted as a

waste of resources, especially when there are urgent matters that need to be addressed. Ward et al. (2015) proposes that other methods such as propensity score matching or regression continuity designs that are commonly used to evaluate social development projects be used when RCTs are not possible.

Universal vs. targeted programmes

In LMICs, limited resources mean that serious thought has to be given to whether programmes should be offered to those in greatest need (targeted) or to all the eligible members (universal) of the population. Some studies recommended the implementation of a universal approach because of difficulty associated with identifying maltreatment within families and it avoids the stigma of labels (Pisani Altafim & Martins Linhares, 2016). In the context of LMICs there is no evidence found as to whether programmes should be universal or targeted. The data in the review from HICs was mixed on the effectiveness of universal vs. targeted programmes with both the NFP (targeted to low income mothers) and Triple P Level one (Universal) significantly reducing child maltreatment. It is likely that a multifaceted approach similar to the structure of the Triple P needs to be designed to ensure a minimum level of service provision for all families while ensuring that the necessary services are available for families at risk.

Cost effectiveness

While this review did not focus on the economic costs associated with parenting programmes, the cost benefit of the service provision has to be critically assessed in LMICs. This is because well-established programmes with strong evidence from HICs have very prohibitive affiliation and training costs. Development of local programmes and materials is also an option but can also prove costly, time consuming and may not, in the end, prove effective. Ward et al. (2015) notes that the cost of implementing some parenting programmes in LMICs is much greater than the per capita budgetary health allocation. Additionally some parenting services are most effective when delivered by highly qualified professionals and may require extensive physical resources resulting in increased costs. There is evidence that preventative services are cheaper than child protection based services, but this needs to be firmly established within the context of LMICs.

Limitations

There are some limitations that may impact the interpretation of the findings of this review. Firstly, some systematic reviews may have been missed because particular databases were not searched. Additionally, resources only allowed for the inclusion of English language sources. Although there was a search of grey literature, this was not comprehensive and none of the identified reports or dissertations met inclusion criteria. Given the similarity of included sources with previous review of reviews, we do not believe that these limitations have a major impact on our findings.

Secondly, many of the reviews included data from the same studies, so there may be an overrepresentation of findings from some programmes and studies. This was a similar limitation identified by Barlow et al. (2006) in their systematic review of reviews of

interventions to prevent or ameliorate child physical abuse and neglect. Finally, the reviews included in this work varied in terms of their scope and quality. This imposes limitations on the interpretation of key findings. Also there were very few studies and programmes from LMICs. Together these issues make interpretation of the findings challenging and limits conclusions about the effectiveness of these programmes, especially in different contexts.

Recommendations: research and policy

The evidence base on the effectiveness of parenting interventions for the prevention of VAC (especially in LMICs) needs to be strengthened through more high quality evaluations with different populations and in different countries. Countries should also invest in research on the magnitude, causes and consequences of child maltreatment, as well as their capacity to develop and/or adapt prevention interventions. Research in LMICs can be expanded and enhanced through the provision of increased funding and technical assistance.

Researchers in this area must also address issues related to consensus on the definition of VAC and the most appropriate outcomes and outcomes measures. This will allow for more consistent measurement of the effectiveness of interventions. In addition, programme monitoring and evaluation frameworks need to explicitly measure child maltreatment and exposure to IPV as outcomes and evaluations need to have longer follow-ups. Research is also needed to address the gaps in the literature such as the effectiveness of parenting programmes for fathers and for preventing exposure to IPV.

At the policy level, every country should place the prevention of all forms of violence against children on their policy agendas. This will guide the development of national action plans which are critical for good planning, intersectoral coordination and implementation of effective strategies for the prevention of VAC, including interventions with parents. Policymakers must also consider offering different types of interventions for the prevention of VAC in different settings. There is a place for universal, selective and indicated programmes in a comprehensive strategy for the prevention and treatment of child maltreatment.

Countries should take steps to strengthen national capacity for collecting, linking and disseminating relevant administrative data that can be used in the evaluation of violence prevention interventions (e.g. injuries and hospitalizations) and wherever possible parenting interventions should be integrated into existing services and systems. This is especially important in LMICs where scarce resources have to be used wisely. Integration into existing structures and systems will also contribute to the sustainability of programmes.

Ultimately, countries should develop a comprehensive prevention strategy based on their level of burden, evidence base of what works in their contexts, existing programmes and services and capacity to offer high quality programmes. Consideration must also be given to entry points for programmes and the most cost effective setting to offer particular programmes depending on level of risk, age of parents and/or children and other key factors. This will ensure the best use of scarce resources so as to maximize prevention efforts.

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Appendix A. Search Term

Academic search complete (Ebsco), PubMed, Medline, PsycInfo
(parent* program* or home visiting) AND (child maltreatment or intimate partner violence or ipv or harsh punishment or corporal punishment or systematic review or review or meta-analysis or meta analysis or LMIC or Developing countries) NOT (autism or ASD or elderly or ADHD or caries or dental or obesity or overweight or immunization or renal or cancer)
Cochrane Library
Parenting program

Appendix B. Excluded References

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What do we know about preventing school violence? A systematic review of systematic reviews

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ABSTRACT

Many children across the world are exposed to school violence, which undermines their right to education and adversely affects their development. Studies of interventions for school violence suggest that it can be prevented. However, this evidence base is challenging to navigate. We completed a systematic review of interventions to reduce four types of school violence: (a) peer violence; (b) corporal punishment; (c) student-on-teacher violence and (d) teacher-on-student violence. Reviewers independently searched databases and journals. Included studies were published between 2005 and 2015; in English; considered school-based interventions for children and measured violence as an outcome. Many systematic reviews were found, thus we completed a systematic review of systematic reviews. Only systematic reviews on interventions for intimate partner violence (IPV) and peer aggression were found. These reviews were generally of moderate quality. Research on both types of violence was largely completed in North America. Only a handful of programmes demonstrate promise in preventing IPV. Cognitive behavioral, social-emotional and peer mentoring/mediation programmes showed promise in reducing the levels of perpetration of peer aggression. Further research needs to determine the long-term effects of interventions, potential moderators and mediators of program effects, program effects across different contexts and key intervention components.

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Introduction

School violence undermines children's right to education and adversely affects their development. The long term consequences are also costly for broader society (Burton & Leoschut, 2013). Worryingly, children across the world report exposure to violence at school (Due, Holstein, & Soc, 2008).

Although bullying is a major focus of school violence research, violence in schools encompasses much more. Bullying is defined as repeated aggressive episodes where there is a power

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imbalance between the bully and his/her victim (Menesini & Salmivalli, in press). Bullying is thus a subset of peer violence, a broader group of behaviors that include 'the intentional use of physical force or power, threatened or actual, …. that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation' (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 4). School violence thus includes any violence between students, corporal punishment of students by teachers (Burton & Leoschut, 2013), other forms of violence directed at students by teachers such as verbal aggression or rape (Lee, 2015), and violence directed by students at teachers (Dzuka & Dalbert, 2007; Wilson, Douglas, & Lyon, 2011). Furthermore, school violence is specifically defined as violence occurring on school premises, while traveling to or from school, or during a school-sponsored event (http://www.cdc.gov/violenceprevention/youthviolence/schoolviolence/).

A number of interventions have been tested for their potential to prevent school violence. These may be *universal* (all students participate; Mrazek & Haggerty, 1994). Others may target students at increased risk for violence or those already demonstrating violent behaviors, known respectively as *selected* and *indicated* interventions (Mrazek & Haggerty, 1994). Additionally, interventions using a *whole-school* approach intervene at multiple levels within a school (Gevers & Flisher, 2012), whereas *discrete* interventions work only with a particular aspect of the school, for example just the students (Gevers & Flisher, 2012). *Comprehensive* programmes address a range of risk behaviors, whereas *specific* programmes address a particular problem (Gevers & Flisher, 2012). Such complexity can make it challenging to determine exactly which interventions are the most effective for different types of school violence.

A number of reviews of school violence interventions have synthesized the literature and so addressed a variety of these issues; thus, following Mikton and Butchart's (2009) approach to understanding interventions to prevent child maltreatment, we aimed to complete a systematic review of systematic reviews that addressed the question: What do we know about preventing school violence?

Methods

Search strategy

Pairs of research assistants each independently searched 49 electronic databases, 3 clinical trial registries and 10 online journals for articles on school violence (see Appendix A). Searches were limited to papers in English and in publication years 2005–2015, except for those addressing corporal punishment. Two searches of abstracts were conducted. The first used search terms: *school AND (violen* OR aggress* OR bully* OR bulli*)*, while the second used the search terms *school* AND *'corporal punishment'*. Literature on corporal punishment was sought from 1980 to 2015, because of the small body of work completed on this type of violence in schools (there is a large body of work on parental corporal punishment; Gershoff & Grogan-Kaylor, 2016). Experts in the field who were part of the kNOw Violence in Childhood Project School's Learning Group were also consulted about relevant studies.

Studies were considered relevant if they:

(1) Were in English;

(2) Included change in violent behavior or one of its synonyms (such as aggression, externalizing behavior/problems, conduct behavior/problems or intimate partner violence [IPV]) as an outcome;
(3) Addressed an intervention for violent behavior that was implemented at, or recruited participants from, school; and
(4) Included pre-primary, primary or secondary school students.

We focused on change in behavior because changes in knowledge and attitudes alone are not sufficient to change behavior (De La Rue, Polanin, Espelage, & Pigott, 2014; Whitaker, Murphy, Eckhardt, Hodges, & Cowart, 2013). In addition, articles with (a) suicide, (b) school shootings and (c) teacher-on-teacher violence as an outcome were excluded. Information and communication technology interventions (which relate more to cyberbullying), psychopharmacological interventions, and interventions which extended across multiple domains like multisystemic therapy (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997), were also excluded.

The initial search identified a large number of relevant systematic reviews, and we therefore decided to do *a systematic review of systematic reviews,* rather than a systematic review of primary studies (Mikton & Butchart, 2009). Research assistants then screened the full text of reviews to determine whether they met an additional inclusion criterion: the review included at least three primary studies about interventions which were implemented at school or recruited participants from school (see Appendix B and C respectively, for included and excluded reviews).

Data extraction

The quality of the relevant reviews was assessed, and descriptive information captured (see Appendix D for extraction document).

We used the AMSTAR tool to assess methodological quality of each review (Shea et al., 2009). AMSTAR scores between 0 and 4 indicate that a review is of poor quality, scores between 5 and 8 indicate moderate quality, and scores of 9–11 indicate high quality (Mikton & Butchart, 2009). A second reviewer checked 42% of the AMSTAR scores. An intra-class correlation coefficient of above .80 was achieved, indicating a good level of coding consistency (Aspland & Gardner, 2003).

Results

Our initial screening identified over 400 systematic reviews. A second round of screening found 36 that were eligible for inclusion (see Figure 1). These only addressed interventions for IPV and peer aggression.

A small number of narrative reviews and primary studies (which were excluded) were identified on student-on-teacher violence, teacher-on-student violence and corporal punishment in schools.

IPV

Five reviews of interventions for IPV were identified. On average, these were of moderate quality (see Table 1).

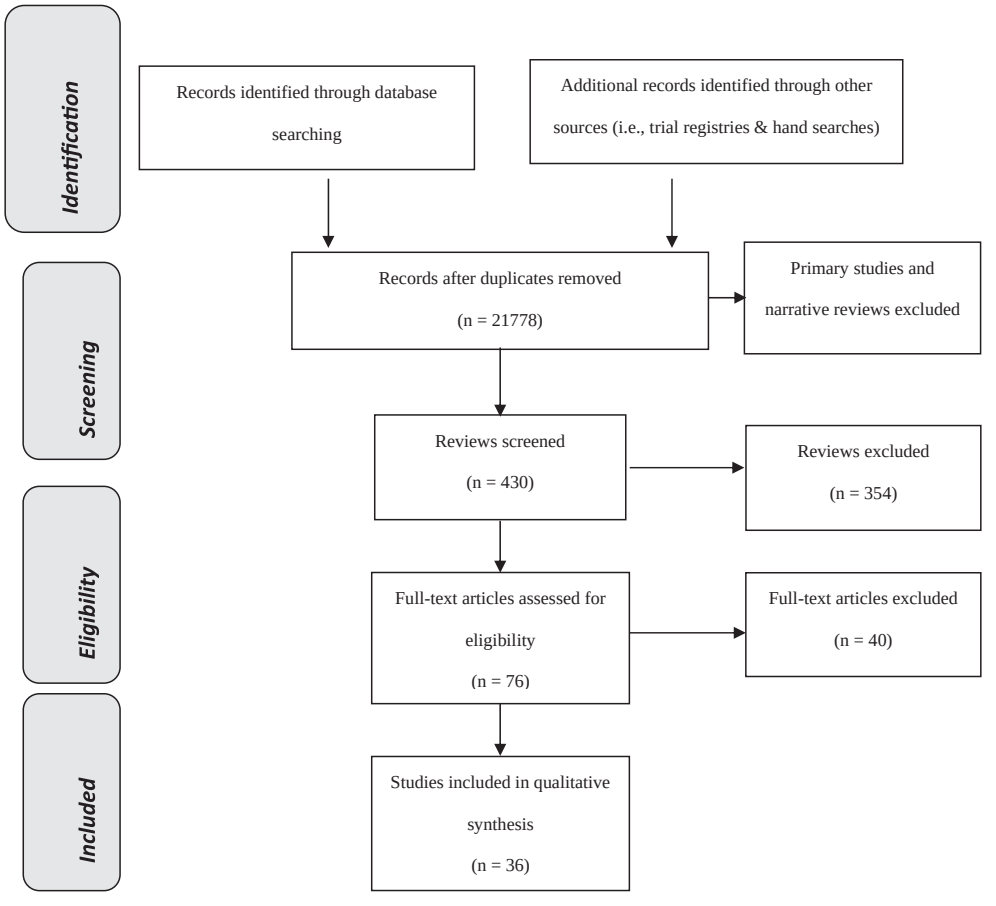

Figure 1. PRISMA flowchart.

Descriptions of programmes to prevent IPV

Since a number of school-based IPV prevention programmes have been studied using randomised controlled trials (RCTs) – the strongest evaluation design – we report only on these 11 programmes (see Table 2).

All programmes were universal and largely specific to IPV, and barring two (the building-based version of Shifting Boundaries, which targeted the whole school; Taylor, Stein, Mumford, & Woods, 2013; and the Safe Dates poster and theatre elements; Foshee et al., 2005) were discrete. Interventions were aimed at high school students of both genders, with the lone exception of Coaching Boys into Men, which focused only on boys (Miller et al., 2013).

All but one of the primary studies included in the reviews were completed on the North American continent (10 studies), and largely in the USA. One study by Jewkes et al. (2008) was conducted in the African region (South Africa), and none in any other region. Yet rates of IPV are highest in Africa, the Eastern Mediterranean and South East Asia, followed by the Americas (Stöckl, Devries, & Watts, 2015). Most programmes have thus been tested in contexts that need them least.

Table 1. Quality of reviews on intimate partner violence.

Review	AMSTAR score	No. of studies included in review	No. of school-based interventions included	No. of school-based interventions studied in RCTs
DeGue et al. (2014)	4	35	6	6
De Koker et al. (2014)	6	8	8	8
De La Rue et al. (2014)	10	23	23	10
Whitaker et al. (2006)	6	11	10	4
Whitaker et al. (2013)	4	9	4	4

Table 2. Intimate partner violence programmes assessed in RCTs with behavioral outcomes.

Programme	Target population, type of program and country of study	Implementer	No. of sessions and duration	Delivery mechanism
1. Dating Violence Prevention Program (Avery-leaf, Cascardi, O'Leary, & Cano, 1997)	11th and 12th grade students Universal, discrete, specific Study conducted in New York	Teachers	1 week	Psychoeducation on 'courtship' aggression
2. Safe Dates (Foshee et al., 1998, 2005, 2000, 1996)	8th and 9th grade students Universal, whole school, specific Study conducted in North Carolina	Teachers	10 45-min sessions	Lecture, poster contest, peer theatre production; Also includes a community component (crisis line, support groups, material for parents, training of service providers)
3. Safe Dates with booster (Foshee et al., 2004)	This is a trial within the original trial, provided to randomly selected participants after the 2-year follow-up Universal, whole school, specific	Health educator	–	Newsletter containing information drawing on the Safe Dates curriculum; personal telephone call
4. Ending Violence (Jaycox et al., 2006)	9th grade students Universal, discrete, specific Study conducted in California	Attorneys	3 days	Lecture and discussion of legal issues
5. Stepping Stones (Jewkes et al., 2008)	Secondary school students Universal, discrete, comprehensive Study conducted in rural South Africa	Project staff	50 for 6–8 weeks outside of school hours	Discussion, role-plays, drama
6. Fourth R: Skills for Youth Relationships (Wolfe et al., 2009)	9th grade students Universal, discrete, comprehensive Study conducted in Canada	Teacher	21 sessions over 7 weeks	Videos, handouts, role-play
7. Law and Justice Curriculum (Taylor et al., 2010a, 2010b)	6th and 7th grade students Universal, discrete, specific Study conducted in Ohio	–	5 sessions	Knowledge-based curriculum
8. Interaction-based Treatment (Taylor et al., 2010a, 2010b)	6th and 7th grade students Universal, discrete, specific Study conducted in Ohio	–	5 sessions	Identifying unwanted behavior, setting boundaries, bystander intervention
9. Shifting Boundaries classroom-level (Taylor, Stein, Woods, & Mumford, 2011; Taylor et al., 2013)	6th and 7th grade students Universal, discrete, specific Study conducted in New York	Teachers	8 weeks	Lecture and discussion about identifying unwanted behavior and setting boundaries
10. Shifting Boundaries school-level (Taylor et al., 2011, 2013)	6th and 7th grade students Universal, whole-school, comprehensive Study conducted in New York	–	8 weeks	'Building-based restraining orders'; school violence protocols with emphasis on reporting to teachers; awareness posters; student-created 'hotspot' map
11. Coaching Boys Into Men (Miller et al., 2013, 2012)	Male middle-school students in sports teams Universal, discrete, specific Study conducted in the USA	Sports coaches	11 brief discussions (10–15 min) during sports season	Discussion

Evidence for programmes to prevent IPV

Safe Dates (Foshee et al., 2005), the Fourth R (Wolfe et al., 2009), Stepping Stones (Jewkes et al., 2008) and the building-level version of Shifting Boundaries (Taylor et al., 2013) stand out as the only programmes that achieved positive effects (see Table 3). Teachers, project staff and health educators implemented these programmes. The duration of the latter three programmes seemed to average around 7 weeks. However, number of sessions ranged from 10 to 21. Safe Dates (Foshee et al., 2005), the Fourth R (Wolfe et al., 2009) and Stepping Stones (Jewkes et al., 2008) are also conspicuous as having been studied in trials with the strongest methods for determining evidence of effect in that they have the longest follow-up periods (3, 2.5 and 2 years, respectively). The Safe Dates trial was also strong in that it measured the widest range of forms of dating violence, and was able to show that effects for several forms of violence persisted over time (Foshee et al., 1998, 2004, 2005, 2000, 1996). Two programmes – the Law and Justice Curriculum (Taylor, Stein, & Burden, 2010a) and Interaction-Based Treatment (Taylor et al., 2010a) – were identified as possibly doing harm, in that they led to increased reporting of perpetration.

No program had been studied in more than one RCT, and so the evidence for any program can at best only be considered promising by two of the current standards for prevention science: Blueprints for Healthy Youth Development (http://www.blueprintsprograms.com), and those of the Society for Prevention Research (Gottfredson et al., 2015). Many of the trials reviewed also had some risk of bias (De Koker, Mathews, Zuch, Bastien, & Mason-Jones, 2014; Whitaker et al., 2006).

Moderation effects are also key in understanding programmes (Gottfredson et al., 2015): Safe Dates has produced evidence that there is no difference in effectiveness by gender, by white vs. other ethnicity, or by whether students had previous experience of dating violence; but the trial of the Fourth R showed that the effect was present only for boys (Whitaker et al., 2013).

Safe Dates thus appears to be the most effective school-based program for preventing dating violence, but the evidence base in general needs much more development.

Peer aggression

We identified a total of 31 reviews addressing effectiveness of interventions to prevent peer aggression. AMSTAR scores (see Table 4) had a mean of 6, indicating that on average the reviews were of moderate quality. Nearly 40% (387) of the primary studies on school-based interventions evaluated the interventions in RCTs, and 213 (22%) utilized quasi-experimental designs. However, many reviews did not provide information on study design.

Descriptions of programmes to prevent peer aggression

Universal interventions were much more commonly included in the reviews than selected and indicated interventions, as were discrete rather than multi-level or whole-school interventions (see Table 5). There were also more specific than comprehensive programmes. Nearly half of all the interventions targeted children of primary school age. Interventions were also generally delivered to both genders.

Most of the interventions were studied in North America, specifically within the USA (see Table 6 and Figure 2). This is exceptionally problematic as countries outside the USA

Table 3. Effectiveness of intimate partner violence prevention programmes.

Programme	Follow-up period[a]	Types of perpetration assessed	Types of victimisation assessed	Perpetration prevention	Victimisation prevention
1. Dating Violence Prevention Program (Avery-leaf et al., 1997)	Immediate post-test	Moderate physical aggression	–	No effect	–
2. Safe Dates (Foshee et al., 1998, 2005, 2000, 1996)	3 years	Moderate & severe physical; sexual; psychological violence	Moderate & severe physical; sexual; psychological violence	Effective at 2 years for all outcomes; at 3 years only for psychological and severe physical perpetration	Effective at 2 years for moderate physical and sexual victimisation; no effect at 3 years
3. Safe Dates with booster (tested against Safe Dates; Foshee et al., 2004)	3 years	Moderate & severe physical; sexual; psychological violence	Moderate & severe physical; sexual; psychological violence	Significant effect only for psychological perpetration	No effect
4. Ending Violence (Jaycox et al., 2006)	6 months	IPV	IPV	No effect	No effect
5. Stepping Stones (Jewkes et al., 2008)	1 year	Physical and sexual IPV, males	Physical and sexual IPV, females	Effective for perpetration by men at 2-year follow-up	No effect
6. Fourth R: Skills for Youth Relationships (Wolfe et al., 2009)	2.5 years	Moderate physical perpetration	–	Effective	–
7. Law and Justice Curriculum (Taylor et al., 2010a, 2010b)	6 months	Sexual violence	–	Increased reporting (possibly because of increased awareness)	–
8. Interaction-based Treatment (Taylor et al., 2010a, 2010b)	6 months	Sexual violence with dating partner	Sexual violence with dating partner	Increased reporting (possibly because of increased awareness)	No effect
9. Shifting Boundaries classroom-level (Taylor et al., 2011, 2013)	6 months	Prevalence and frequency of IPV	Prevalence and frequency of IPV	No effect	No effect
10. Shifting Boundaries school-level (Taylor et al., 2011, 2013)	6 months	Prevalence and frequency of IPV	Prevalence and frequency of IPV	No effect	Reductions in prevalence and frequency
11. Coaching Boys Into Men (Miller et al., 2013, 2012)	1 year	IPV perpetration	–	No effect	–

[a]We report only the results from the longest possible follow-up period.

Table 4. Quality of reviews on peer aggression.

Review	AMSTAR score	No. of studies included in review	No. of studies with school-based intervention and effects for violence[a]	No. of school-based studies using randomised controlled trials	No. of school-based studies using quasi-experimental designs
Allen-Meares, Montgomery, and Kim (2013)	3	18	3	1	2
Barnes, Smith, and Miller (2014)	4	25	20	13	7
Blank et al. (2010)	3	37	6	4	–
Bond, Woods, Humphrey, Symes, and Green (2013)	6	38	5	0	5
Bonell, Wells, et al. (2013)	7	10	4	3	1
Durlak, Weissberg, Dymnicki, Taylor, and Schellinger (2011)	5	213	112	–	–
Dymnicki, Weissberg, and Henry (2011)	4	26	26	–	–
Fagan and Catalano (2013)	4	18	9	7	2
Farahmand, Grant, Polo, Duffy, and DuBois (2011)	8	21	5	5	0
Gansle (2005)[b]	4	27	22	–	–
Gavine, Donnelly, and Williams (2016)	7	16	12	7	5
Hahn et al. (2007)	7	65	65	–	14
Hale, Fitzgerald-Yau, and Mark Viner (2014)	6	50	8	8	–
Leff, Waasdorp, and Crick (2010)	4	10	9	7	2
Limbos et al. (2007)	5	41	22	–	–
Moestue, Moestue, and Muggah (2013)	5	18	4	3	1
Mytton, DiGuiseppi, Gough, Taylor, and Logan (2006)	8	51	34	34	0
Oliver, Reschly, and Wehby (2011)	4	12	4	4	0
Park-Higgerson, Perumean-Chaney, Bartolucci, Grimley, and Singh (2008)	5	26	26	26	0
Reddy, Newman, De Thomas, and Chun (2009)	9	29	22	4	18
Reese, Prout, Zirkelback, and Anderson (2010)[c]	4	188	59	–	–
Sancassiani et al. (2015)	8	22	3	3	0
Schindler et al. (2015)	6	31	31	–	–
Sklad et al. (2012)	6	75	35	–	–
Stoltz et al. (2012)	6	24	24	18	6
Tolan et al. (2013)	9	46	3	–	–
Vidrine (n.d.)	6	10	10	8	2
Vreeman and Carroll (2007)	4	26	11	2	9
Wilson and Lipsey (2006a)	9	47	47	40	7
Wilson and Lipsey (2006b)	9	73	73	32	41
Wilson and Lipsey (2007)	9	399	249	158	91
Total	-	1692	963	387	213
Mean	5.93				
Percentage[d]				39.77%	21.89%

[a]If the number of studies utilizing a randomised controlled trial design and quasi-experimental design do not equal the number of studies on school-based interventions for the same reviews, this study design information was not specified.
[b]Figures based on the number of comparisons instead of the number of studies.
[c]Figures based on the number of outcome measures instead of studies.
[d]Total of column/total number of studies with school-based interventions.

Table 5. Characteristics of school-based programmes with effects on peer aggression.

Review	Prevention target (*n*; %)[a–c]	Intervention approach (*n*; %)[a,b,d]	Intervention content (*n*; %)[a,b,e]	School level (*n*; %)[a,b,f]	Participant gender (*n*; %)[a,b,g]
Allen-Meares et al. (2013)	U (2; 67%) S (1; 33%) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M(0) D (0) NS (3; 100%)	C (0) S (0) NS (3; 100%)	PP (0) P (2; 67%) H (0) C – PP & P (0) C – P & H (1; 33%) NS (0)	M (0) F (0) B (3; 100%) NS (0)
Barnes et al. (2014)	U (14; 70%) S (5; 25%) I (1; 5%) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (20; 100%) NS (0)	C (0) S (11; 55%) NS (9; 45%)	PP (0) P (19; 95%) H (0) C – PP & P (0) C – P & H (1; 5%) C – (0) NS (0)	M (1; 5%) F (0) B (19; 95%) NS (0)
Blank et al. (2010)	U (6; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (6; 100%) M (0) D (0) NS (0)	C (0) S (1; 17%) NS (5; 83%)	PP (0) P (0) H (1; 17%) C – PP & P (0) C – P & H (2; 33%) C – (0) NS (3; 50%)	M (0) F (0) B (5; 83%) NS (1; 17%)
Bond et al. (2013)	U (0) S (0) I (5; 100%) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (3; 60%) D (2; 40%) NS (0)	C (3; 60%) S (2; 40%) NS (0)	PP (0) P (3; 60%) H (0) C – PP & P (0) C – P & H (1; 20%) C – (0) NS (1; 20%)	M (0) F (0) B (5; 100%) NS (0)
Bonell, Wells, et al. (2013)	U (4; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (1; 25%) M (0) D (3; 75%) NS (0)	C (0) S (3; 89%) NS (1; 11%)	PP (0) P (2; 50%) H (0) C – PP & P (1; 25%) C – P & H (1; 25%) C – (0) NS (0)	M (0) F (0) B (4; 100%) NS (0)
Durlak et al. (2011)	U (112; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (0) NS (112; 100%)	C (0) S (0) NS (112; 100%)	PP (0) P (0) H (0) C – PP & P (0) C – P & H (0) C – (0) NS (112; 100%)	M (0) F (0) B (0) NS (112; 100%)
Dymnicki et al. (2011)	U (26; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (0) NS (26; 100%)	C (0) S (0) NS (26; 100%)	PP (0) P (0) H (0) C – PP & P (26; 100%) C – P & H (0) C – (0) NS (0)	M (0) F (0) B (0) NS (26; 100%)
Fagan and Catalano (2013)	U (2; 22%) S (3; 33%) I (1; 12%) U & S (3; 33%) U & I (0) S & I (0) NS (0)	W (0) M (7; 78%) D (2; 22%) NS (0)	C (0) S (2; 22%) NS (7; 78%)	PP (2; 22%) P (6; 67%) H (0) C – PP & P (0) C – P & H (1; 11%) C –(0) NS (0)	M (1; 11%) F (0) B (8; 89%) NS (0)

(*Continued*)

Table 5. (*Continued*).

Review	Prevention target (*n*; %)[a–c]	Intervention approach (*n*; %)[a,b,d]	Intervention content (*n*; %)[a,b,e]	School level (*n*; %)[a,b,f]	Participant gender (*n*; %)[a,b,g]
Farahmand et al. (2011)	U (2; 40%) S (3; 60%) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (0) NS (5; 100%)	C (0) S (5; 100%) NS (0)	PP (0) P (4; 80%) H (1; 20%) C – PP & P (0) C – P & H (0) C – (0) NS (0)	M (0) F (0) B (5; 100%) NS (0)
Gansle (2005)	U (0) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (22; 100%)	W (0) M (0) D (0) NS (22; 100%)	C (0) S (0) NS (22; 100%)	PP (0) P (0) H (3; 15%) C – PP & P (7; 35%) C – P & H (10; 50%) C – (0) NS (0)	M (0) F (0) B (0) NS (20; 100%)
Gavine et al. (2016)	U (12; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (5; 42%) D (7; 58%) NS (0)	C (0) S (0) NS (12; 100%)	PP (0) P (5; 42%) H (2; 36%) C – PP & P (0) C – P & H (5; 42%) C – (0) NS (0)	M (0) F (0) B (0) NS (21; 100%)
Hale et al. (2014)	U (7; 78%) S (1; 12%) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (2; 43%) M (3;37) D (3; 37%) NS (0)	C (8; 100%) S (0) NS (0)	PP (0) P (7; 87%) H (0) C – PP & P (0) C – P & H (1; 13%) C – (0) NS (0)	M (0) F (0) B (8; 100%) NS (0)
Hahn et al. (2007)	U (65; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (1; 2%) M (0) D (0) NS (64; 98%)	C (0) S (0) NS (65; 100%)	PP (0) P (34; 52%) H (4; 6%) C – PP & P (6; 9%) C – P & H (21; 33%) C – (0) NS (53; 100%)	M (0) F (0) B (0) NS (65; 100%)
Leff et al. (2010)	U (6; 67%) S (0) I (3; 33%) U & S (0) U & I (0) S & I (0) NS (0)	W (1; 11%) M (2; 22%) D (6; 67%) NS (0)	C (0) S (9; 100%) NS (0)	PP (1; 11%) P (5; 56%) H (0) C – PP & P (2; 22%) C – P & H (1; 11%) C – (0) NS (0)	M (6; 67%) F (3; 33%) B (0) NS (0)
Limbos et al. (2007)	U (17; 77%) S (5; 23%) I (0) U & S (0) U & I(0) S & I (0) NS (0)	W (0) M (0) D (0) NS (22; 100%)	C (0) S (0) NS (22; 100%)	PP (0) P (0) H (2; 9%) C – PP & P (3; 14%) C – P & H (16; 73%) C – (1; 4%) NS (0)	M (0) F (0) B (0) NS (22; 100%)
Moestue et al. (2013)	U (3; 75%) S (0) I (1; 25%) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (1; 25%) D (3; 75%) NS (0)	C (0) S (3; 75%) NS (1; 25%)	PP (0) P (1; 25%) H (0) C – PP & P (1; 25%) C – P & H (0) C – (0) NS (2; 50%)	M (0) F (0) B (4; 100%) NS (0)

Table 5. (*Continued*).

Review	Prevention target (*n*; %)[a–c]	Intervention approach (*n*; %)[a,b,d]	Intervention content (*n*; %)[a,b,e]	School level (*n*; %)[a,b,f]	Participant gender (*n*; %)[a,b,g]
Mytton et al. (2006)[h]	U (0) S (0) I (0) U & S (0) U & I (0) S & I (34; 100%) NS (0)	W (0) M (0) D (0) NS (34; 100%)	C (0) S (0) NS (34; 100%)	PP (0) P (22; 65%) H (0) C – PP & P (0) C – P & H (12; 35%) C – (0) NS (0)	M (12; 35%) F (0) B (22; 65%) NS (0)
Oliver et al. (2011)	U (4; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (1; 25%) D (3; 75%) NS (0)	C (0) S (4; 100%) NS (0)	PP (0) P (4; 100%) H (0) C – PP & P (0) C – P & H (0) C – (0) NS (0)	M (0) F (0) B (3; 75%) NS (1; 25%)
Park-Higgerson et al. (2008)	U (7; 27%) S (17; 65%) I (1; 4%) U & S (1; 4%) U & I (0) S & I (0) NS (0)	W (0) M (10; 39%) D (16; 61%) NS (0)	C (7; 27%) S (19; 73%) NS (0)	PP (0) P (19; 73%) H (3; 11%) C – PP & P (2; 8%) C – P & H (2; 8%) C – (0) NS (0)	M (3; 11%) F (0) B (23; 89%) NS (0)
Reese et al. (2010)	U (0) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (59; 100%)	W (0) M (0) D (0) NS (59; 100%)	C (0) S (0) NS (59; 100%)	PP (0) P (0) H (0) C – PP & P (0) C – P & H (0) C – (0) NS (59; 100%)	M (0) F (0) B (0) NS (59; 100%)
Reddy et al. (2009)	U (0) S (8; 36%) I (14; 64%) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (0) NS (22; 100%)	C (0) S (0) NS (22; 100%)	PP (0) P (0) H (0) C – PP & P (0) C – P & H (0) C – (0) NS (22; 100%)	M (0) F (0) B (0) NS (22; 100%)
Sancassiani et al. (2015)	U (3; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (3; 100%) M (0) D (0) NS (0)	C (2; 67%) S (1; 33%) NS (0)	PP (0) P (2; 67%) H (1; 33%) C – PP & P (0) C – P & H (0) C – (0) NS (0)	M (3; 100%) F (0) B (0) NS (0)
Schindler et al. (2015)	U (0) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (31; 100%)	W (0) M (0) D (0) NS (31; 100%)	C (0) S (0) NS (31; 100%)	PP (31; 100%) P (0) H (0) C – PP & P (0) C – P & H (0) C – (0) NS (0)	M (0) F (0) B (0) NS (31; 100%)
Sklad et al. (2012)	U (35; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (0) NS (35; 100%)	C (0) S (0) NS (35; 100%)	PP (0) P (0) H (0) C – PP & P (0) C – P & H (0) C – (0) NS (35; 100%)	M (0) F (0) B (0) NS (35; 100%)

(*Continued*)

Table 5. (*Continued*).

Review	Prevention target (*n*; %)[a–c]	Intervention approach (*n*; %)[a,b,d]	Intervention content (*n*; %)[a,b,e]	School level (*n*; %)[a,b,f]	Participant gender (*n*; %)[a,b,g]
Stoltz et al. (2012)	U (0) S (0) I (24; 100%) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (13; 54%) D (11; 46%) NS (0)	C (0) S (0) NS (24; 100%)	PP (2; 8%) P (15; 63%) H (0) C – PP & P (5; 21%) C – P & H (0) C – (0) NS (2; 8%)	M (6; 25%) F (0) B (18; 25%) NS (0)
Tolan et al. (2013)	U (0) S (2; 67%) I (1; 33%) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (2; 67%) D (1; 33%) NS (0)	C (0) S (0) NS (3; 100%)	PP (0) P (1; 33.33%) H (1; 33.33%) C – PP & P (0) C – P & H (1; 33.33%) C – (0) NS (0)	M (0) F (0) B (2; 67%) NS (1; 33%)
Vidrine (n.d.)	U (0) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (10; 100%)	W (0) M (0) D (0) NS (10; 100%)	C (0) S (10; 100%) NS (0)	PP (6; 60%) P (4; 40%) H (0) C – PP & P (0) C – P & H (0) C – (0) NS (0)	M (0) F (0) B (10; 100%) NS (0)
Vreeman and Carroll (2007)	U (5; 46%) S (3; 27%) I (1; 9%) U & S (0) U & I (1; 9%) S & I (0) NS (1; 9%)	W (3; 27%) M (2; 18%) D (6; 55%) NS (0)	C (2; 18%) S (9; 82%) NS (0)	PP (0) P (6; 55%) H (1; 9%) C – PP & P (0) C – P & H (4; 36%) C – (0) NS (0)	M (0) F (1; 9%) B (10; 91%) NS (0)
Wilson and Lipsey (2006b)	U (73; 100%) S (0) I (0) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (0) NS (73; 100%)	C (0) S (0) NS (73; 100%)	PP (14; 19%) P (47; 64%) H (12; 16%) C – PP & P (0) C – P & H (0) C – (0) NS (0)	M (8; 11%) F (6; 8%) B (59; 81%) NS (0)
Wilson and Lipsey (2006a)	U (0) S (17; 36%) I (30; 64%) U & S (0) U & I (0) S & I (0) NS (0)	W (0) M (0) D (0) NS (47; 100%)	C (0) S (0) NS (47; 100%)	PP (0) P (31; 66%) H (16; 34%) C – PP & P (0) C – P & H (0) C – (0) NS (0)	M (14; 30%) F (1; 2%) B (32; 68%) NS (0)
Wilson and Lipsey (2007)	U (89; 36%) S (0) I (0) U & S (0) U & I (0) S & I (117; 47%) NS (43; 17%)	W (0) M (21; 8%) D (228; 92%) NS (0)	C (0) S (0) NS (249; 100%)	PP (0) P (178; 72%) H (50; 20%) C – PP & P (21; 8%) C – P & H (0) C – (0) NS (0)	M (43; 17%) F (17; 7%) B (179; 72%) NS (10; 4%)

(Continued)

Table 5. (*Continued*).

Review	Prevention target (*n*; %)[a–c]	Intervention approach (*n*; %)[a,b,d]	Intervention content (*n*; %)[a,b,e]	School level (*n*; %)[a,b,f]	Participant gender (*n*; %)[a,b,g]
Total across reviews	U (494; 51.30%) S (65; 6.75%) I (81; 8.41%) U & S (5; 0.52%) U & I (1; 0.10%) S & I (151; 15.68%) NS (166; 17.24%)	W (17; 1.77%) M (70; 7.27%) D (311; 32.29%) NS (565; 58.67%)	C (22; 2.28%) S (79; 8.20%) NS (862; 89.51%)	PP (56; 5.82%) P (417; 43.30%) H (94; 9.76%) C – PP & P (68; 7.06%) C – P & H (69; 7.17%) C – (1; 0.10%) NS (258; 26.79%)	M (88; 9.14%) F (28; 2.91%) B (440; 45.69%) NS (407; 42.26%)

[a]% = number of studies on school-based interventions with effects for peer aggression with characteristic/total number of studies on school-based interventions with effects for peer aggression.
[b]NS = not specified.
[c]U = universal, S = selected, I = indicated.
[d]W = whole-school, M = multilevel, D = discrete.
[e]C = comprehensive, S = specific.
[f]PP = pre-primary school, P = primary school, H = high school.
[g]F = female-only participants, M = male-only participants, B = participants of both genders.
[h]All descriptives and effects reflect studies using measures of the level or extent of actual aggressive behavior or physical acts of aggression, either observed or reported only.

show comparable, if not higher; levels of peer aggression (for instance, see; Chen & Avi Astor, 2010).

Evidence for programmes to prevent peer aggression

We analyzed effectiveness in reducing peer victimization (see Table 7) and perpetration of peer aggression (see Table 8) separately. Less than half the studies used RCTs to examine program effects, thus some caution is required when interpreting findings relating to effectiveness of interventions.

Prevention of victimization. Only eight reviews considered program effectiveness for reducing peer *victimisation*. The specific type of victimization explored in evaluations was not often specified, but when it was, the focus was on physical and relational victimization. The vast majority of programmes were universal in terms of target, and the majority of these scored poorly in terms of effectiveness. The single selective intervention was found to be ineffective. Most were discrete interventions and of these, only cognitive behavioral programmes showed promise for preventing victimization. Violence prevention programmes showed some promise in preventing victimization only when implemented as a whole-school intervention. No harmful effects were noted in this area overall. These findings tentatively suggest that discrete, cognitive-behavioral programmes that specifically target the prevention of victimisation show promise, and that consideration should be given to ways they can be included in whole-school interventions.

Programmes to prevent perpetration. All 31 reviews considered the capacity of school-based interventions to reduce *perpetration* of peer aggression. Intervention effects on the perpetration of aggression or violence (verbal or physical) in particular were considered in

Table 6. No. of studies by country, by WHO regions.

WHO regions	No. of studies
North America (total)[a]	562
USA	527
Canada	35
Europe (total)	14
UK	6
Italy	2
Norway	2
Israel	1
Netherlands	1
Finland	1
Spain	1
South America (total)	7
Argentina	2
Columbia	2
Brazil	1
Jamaica	1
Mexico	1
Western Pacific (total)	7
Australia	6
China	1
South East Asia (total)	1
India	1
Africa (total)	0
Eastern Mediterranean (total)	0
Not Specified	372
Total Relevant Studies	963

[a]We decided to split the Americas region into two: North (USA and Canada) and South (all other countries in the Americas), because of the vastly disproportionate amount of research typically conducted in North America.

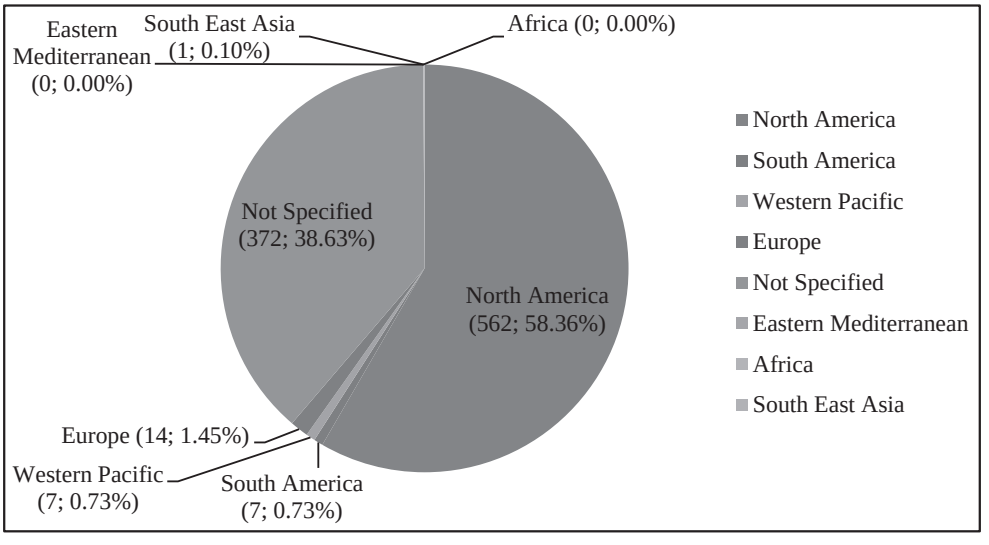

Figure 2. WHO regions covered by peer aggression programmes.

nearly every review, followed by studies that assessed broader outcomes that may include aggression, such as externalizing behavior.

Universal interventions seem to have undergone the most testing, followed by selected interventions, interventions where this information was not specified, and then indicated

Table 7. Effectiveness of peer aggression programmes to prevent victimisation.

	Prevention target				Intervention approach				Harmful effects	Outcome behavior[a]	Significant moderators
Review	Universal: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g]	Selected: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g]	Indicated: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g]	Not specified: PT[b]/ FU[c]/NS[d]: E[e] (n)[f/g]	Whole-school: PT[b]/ FU[c]/NS[d]: E[e] (n)[f/g] – IT[h]	Multi-level: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g] – IT[h]	Discrete: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g] – IT[h]	Not specified: PT[b]/ FU[c]/NS[d]: E[e] (n)[f/g] – IT[h]			
Barnes et al. (2014)	NS:1 (1)[f]						NS:1 (1)[f] – 5		No	4	Prevention target (universal vs selected)
Blank et al. (2010)[i]	NS: 7 (1)[f]				NS: 7 (1)[f] – 10				No	1	Not considered
Bonell, Wells, et al.(2013)	PT: 5 (2)[f] FU: 7 (1)[f]						PT: 5 (2)[f] – 9 FU: 7 (1)[f] – 9		No	1; 2; 3; 4	Not considered
Gavine et al. (2016)[j]	FU: 7 (1)[f] NS: 5 (3)[f]					FU: 7 (1)[f] – 1 NS: 4 (1)[f] – 1	NS: 6 (2)[f] – 1		No	1; 2; 3; 4	Not considered
Hale et al. (2014)	FU: 4 (1)[f]						FU: 4 (1)[f] – 9		No	2	Not considered
Leff et al. (2010)	NS: 1 (2)[f]				NS: 1 (1)[f] – 1		NS: 1 (1)[f] – 1		No	2; 4	Not considered
Sancassiani et al. (2015)	PT: 7 (1)[f]				PT: 7 (1)[f] – 4				No	1	Not considered
Vreeman and Carroll (2007)[k]		PT: 7 (1)[f]					PT: 7 (1)[f] – 4		No	1	Not considered

[a]1 – Victimisation (specific type not specified); 2 – Physical victimsation; 3 – Verbal victimisation; 4 – Relational victimization.
[b]Post-test effects.
[c]Follow-up effects.
[d]Post-test or follow-up measurement was not specified in review.
[e]Effectiveness rating based on rubric. We rated the effectiveness of interventions reviewed according to the following rubric: (1) Found overall to be effective (i.e. peer aggression reduced in 100% of the effects, or as reported by a meta-analysis); (2) Found to be mostly effective (i.e. peer aggression reduced in 75% or more of the reviewed studies' effects as a result of the intervention); (3) Found to be slightly effective (i.e. peer aggression reduced in 56–74% of the reviewed studies' effects as a result of the intervention); (4) Overall mixed effects (i.e. peer aggression reduced in 45–55% of the reviewed studies' effects as a result of the intervention); (5) A minority of studies found an effect (i.e. peer aggression reduced in 26–44% of the reviewed studies' effects as a result of the intervention); (6) Found to be mostly ineffective (i.e. peer aggression reduced in 25% or less of the reviewed studies' effects as a result of the intervention); (7) Found overall to be ineffective (i.e. no effects/change on peer aggression overall, or as reported by a meta-analysis).
[f]Number of primary studies used in calculating effect.
[g]Based on effect derived from meta-analysis.
[h]Intervention type: 1 – Violence prevention programmes (also includes conflict training, modified discipline, anger management); 2 – Classroom management programmes; 3 – Life skills programmes (also includes problem solving skills training, perspective taking skills training and coping skills training); 4 – Social-emotional programmes (also includes social skills programmes); 5 – Cognitive behavioral interventions (also includes cognitive interventions and interventions for behavior modification) or social cognitive interventions; 6 – Peer mediators or mentoring; 7 – ECD/ECE; 8 – Combined; 9 – Other; 10 – Not specified.
[i]Many study outcomes were not clear. Only the studies that explicitly discussed school-based interventions for the outcomes of interest were considered.
[j]Conservatively coded as multilevel instead of whole-school because they did not indicate at which levels they intervened.
[k]Effects for victimization were only extracted for studies which did not also have effects on bullying as it was assumed the victimization would relate to bullying instead of peer aggression.

Table 8. Effectiveness of peer aggression programmes to prevent perpetration.

	Prevention target				Intervention approach						
Review	Universal: PT[b]/FU[c]/NS[d]: E[e] (n)[f/g]	Selected: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g]	Indicated: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g]	Not specified: PT[b]/ FU[c]/NS[d]: E[e] (n)[f/g]	Whole-school: PT[b]/FU[c]/NS[d]: E[e] (n)[f/g] – IT[h]	Multi-level: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g] – IT[h]	Discrete: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g] – IT[h]	Not specified: PT[b]/ FU[c]/NS[d]: E[e] (n)[f/g] – IT[h]	Harmful effects	Outcome behavior[a]	Significant moderators
Allen-Meares et al. (2013)	NS:1 (2)[f]	PT: 1 (1)[f]						NS: 1 (2)[f] –5 PT: 1 (1)[f] – 9	No	1; 4	Not considered
Barnes et al. (2014)	NS:3 (15)[f]	NS: 3 (6)[f]					NS: 3 (20)[f] – 5		Yes	1; 2; 4	Prevention target (universal vs selected)
Blank et al. (2010)[i]	NS: 3 (6)[f]				NS: 1 (2)[f] – 3 NS: 3 (4)[f] – 10				No	1	Not considered
Bond et al. (2013)[i]			PT: 2 (5)[f] FU: 1 (3)[f]			PT: 2 (3)[f] – 9 FU: 1 (2)[f] – 9	PT: 1 (2)[f] – 9 FU: 1 (1)[f] – 9		No	1; 4	Not considered
Bonell, Wells, et al. (2013)	PT: 5 (2)[f] FU: 6 (3)[f]				FU: 7 (1)[f] – 9		PT: 5 (2)[f] – 9 FU: 5 (2)[f] – 9		No	1; 2	Not considered
Durlak et al. (2011)	PT: 1 (112)[g] FU: 1 (21)[g]							PT: 1 (112)[g] – 4 FU: 1 (21)[g] – 4	No	3 (including 1)	None
Dymnicki et al. (2011)	PT: 1 (26)[g]							PT: 1 (26)[g] – 1	Yes	1	Not considered
Fagan and Catalano (2013)[j]	PT: 4 (3)[f]	FU: 3 (4)[f]	PT: 4 (1)[f]	PT: 1 (1)[f] FU: 4 (1)[f]		FU: 3 (2)[f] – 7 PT: 4 (3)[f] – 8 FU: 3 (3)[f] – 8	PT: 4 (1)[f] – 1 PT: 1 (1)[f] – 4		Yes	1	Not considered
Farahmand et al. (2011)[i]	PT: 4 (2)[f] FU: 7 (1)[f]	PT: 6 (3)[f] FU: 7 (1)[f]						PT: 5 (5)[f] – 9 FU: 7 (2)[f] – 9	Yes	4	Not considered
Gansle (2005)[k]				PT: 1 (22)[g] FU: 1 (9)[g]				PT: 1 (22)[g] – 1; 4; 5 FU: 1 (9)[g] – 1; 4; 5	No	4 (including 1 and 3)	Random assignment and treatment duration[l]
Gavine et al. (2016)[m]	PT: 5 (2)[f] FU: 5 (4)[f] NS: 5 (7)[f]					PT: 7 (1)[f] – 1 FU: 6 (2)[f] – 1 NS: 5 (3)[f] – 1	PT: 1 (1)[f] – 1 NS: 4 (3)[f] – 1 FU: 3 (1)[f] – 3 FU: 6 (1)[f] – 9 NS: 1 (1)[f] – 9		Yes	1	Not considered
Hahn et al. (2007)[n]	NS: 1 (65)[g]							NS: 1 (30)[g] – 4 NS: 1 (6)[g] – 5 NS: 1 (2)[g] – 6 NS: 1 (25)[g] – 9	No	1; 2; 3; 4	Not considered

Hale et al. (2014)	PT: 1 (2)[f] FU: 1 (4)[f]	PT: 1 (1)[f]			PT: 1 (1)[f] – 4 FU: 1 (1)[f] – 9	PT: 1 (1)[f] – 5 FU: 1 (1)[f] – 8 FU: 1 (1)[f] – 9	PT: 1 (1)[f] – 4 FU: 1 (1)[f] – 9		No	1	Not considered
Leff et al. (2010)	PT: 5 (4)[f] NS: 1 (1)[f]		NS: 1 (3)[f]			NS: 1 (2)[f] – 5	PT: 4 (2)[f] – 1 NS: 1 (1)[f] – 1 PT: 7 (1)[f] – 2 PT: 1 (1)[f] – 4 NS: 1 (1)[f] – 5		No	1; 2	Not considered
Limbos et al. (2007)[o]	NS: 5 (17)[f]	NS: 5 (5)[f]						NS: 5 (22)[f] – 1	No	1	Not considered
Moestue et al. (2013)	PT: 1 (3)[f]		NS: 1 (1)[f]			PT: 1 (1)[f] – 1	NS: 1 (1)[f] – 2 PT: 1 (1)[f] – 4 PT: 1 (1)[f] – 9		No	1; 3	Not considered
Mytton et al. (2006)[p]		PT: 1 (34)[g] FU: 1 (7)[g]						PT: 1 (18)[g] – 1 FU: 1 (2)[g] – 1 PT: 1 (7)[g] – 4/6 FU: 7 (2)[g] – 4/6 PT: 1 (7)[g] – 8 FU: 7 (3)[g] – 8	No	1	School level
Oliver et al. (2011)[q]	PT: 6 (4)[f]					PT: 7 (1)[f] – 2	PT: 5 (3)[f] – 2		No	1; 3; 4	Not analyzed
Park-Higgerson et al. (2008)[r]	PT: 2 (4)[f] FU: 5 (4)[f]	PT: 4 (16)[f] FU: 5 (4)[f]	PT: 4 (1)[f] FU: 4 (1)[f]			PT: 5 (4)[f] – 5 FU: 5 (2)[f] – 5 PT: 7 (1)[f] – 8 FU: 7 (1)[f] – 8 PT: 1 (2)[f] – 9 PT: 7 (1)[f] – 10	PT: 1 (1)[f] – 1 PT: 1 (1)[f] – 2 FU: 7 (1)[f] – 3 PT: 4 (4)[f] – 5 FU: 5 (3)[f] – 5 PT: 2 (3)[f] – 8 FU: 5 (1)[f] – 8 PT: 1 (5)[f] – 9		No	1; 2; 4	Not considered
Reddy et al. (2009)		PT: 1 (8)[g] FU: 1 (3)[g]	PT: 1 (12)[g] FU: 1 (3)[g]					PT: 1 (22)[g]–10 FU: 1 (22)[g]–10	No	4	No analysis completed
Reese et al. (2010)[s]				PT: 1 (59)[g]				PT: 1 (59)[g] – 9	No	4	No analysis completed
Sancassiani et al. (2015)	PT: 3 (2)[f]				PT: 7 (1)[f] – 3 PT: 1 (1)[f] – 4				No	1; 3	Not considered
Schindler et al. (2015)				PT: 7 (31)[g]				PT: 7 (31)[g] – 7	No	4 (including 1)	Extent of focus on socio-emotional development

(*Continued*)

Table 8. (*Continued*)

	Prevention target				Intervention approach						
Review	Universal: PT[b]/FU[c]/NS[d]: E[e] (n)[f/g]	Selected: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g]	Indicated: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g]	Not specified: PT[b]/ FU[c]/NS[d]: E[e] (n)[f/g]	Whole-school: PT[b]/FU[c]/NS[d]: E[e] (n)[f/g] – IT[h]	Multi-level: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g] – IT[h]	Discrete: PT[b]/FU[c]/ NS[d]: E[e] (n)[f/g] – IT[h]	Not specified: PT[b]/ FU[c]/NS[d]: E[e] (n)[f/g] – IT[h]	Harmful effects	Outcome behavior[a]	Significant moderators
Sklad et al. (2012)[t]	PT: 1 (35)[g] FU: 1 (35)[g]							PT: 1 (35)[g] – 4/5 FU: 1 (35)[g] – 4/5	No	1; 4	Duration of program, school level.
Stoltz et al. (2012)[u]			PT: 1 (24)[g]			PT: 1 (13)[g] – 5	PT: 1 (11)[g] – 5		Yes	4 (including 1, 2 and 3)	Age of participants
Tolan et al. (2013)		NS: 4 (2)[f]	NS: 7 (1)[f]			NS: 4 (2)[f] – 6	NS: 7 (1)[f] – 6		No	1	Not considered
Vidrine (n.d.)[v]				FU: 1 (10)[g]				FU: 1 (10)[g] – 3	No	4 (including 1 and 2)	Age of participants
Vreeman and Carroll (2007)[w]	PT: 3 (4)[f] NS: 7 (1)[f]	PT: 1 (2)[f]	NS: 7 (1)[f] Combination U&I PT: 5 (1)[f]	PT: 1 (1)[f]	PT: 2 (2)[f] – 6 NS: 7 (1)[f] – 10	PT: 7 (1)[f] – 5 PT: 1 (1)[f] – 9	PT: 1 (1)[f] – 3 PT: 4 (2)[f] – 4 PT: 1 (1)[f] – 6 NS: 7 (1)[f] – 6		Yes	1; 2; 4	Not considered
Wilson and Lipsey (2006b)[x]	PT: 1 (73)[g]							PT: 1 (73)[g] – 5	No	1; 3; 4	Socioeconomic status, routine practice, frequency of sessions, implementation quality
Wilson and Lipsey (2006a)[y]			PT: 1 (47)[g]					PT: 1 (47)[g] – 5	No	1; 3; 4	Attrition, special education
S. J. Wilson and Lipsey (2007)[z]	PT: 1 (77)[g]	PT: 1 (108)[g]		PT: 7 (43)[g]		PT: 7 (21)[g] – 4/5/6/9	PT: 3 (228)[g] – 4/5/6/9		No	1; 3	Student socio-economic status, attrition, student risk level, implementation quality

[a]1 – Aggression and/or violence (physical aggression/violence, physical fights or attacks, verbal aggression); 2 – Relational aggression; 3 – Conduct problems/disorder; 4 – Externalizing behaviors.
[b]Post-test effects.
[c]Follow-up effects.
[d]Post-test or follow-up measurement was not specified in review.
[e]Effectiveness rating based on rubric. We rated the effectiveness of interventions reviewed according to the following rubric: (1) Found overall to be effective (i.e. peer aggression reduced in 100% of the effects, or as reported by a meta-analysis); (2) Found to be mostly effective (i.e. peer aggression reduced in 75% or more of the reviewed studies' effects as a result of the intervention); (3) Found to be slightly effective (i.e. peer aggression reduced in 56–74% of the reviewed studies' effects as a result of the intervention); (4) Overall mixed effects (i.e. peer aggression reduced in 45–55% of the reviewed studies' effects as a result of the intervention); (5) A minority of studies found an effect (i.e. peer aggression reduced in 26–44% of the reviewed studies' effects as a result of the intervention); (6) Found to be mostly ineffective (i.e. peer aggression reduced in 25% or less of the reviewed studies' effects as a result of the intervention); (7) Found overall to be ineffective (i.e. no effects/change on peer aggression overall, or as reported by a meta-analysis).
[f]Number of primary studies used in calculating effect.
[g]Based on effect derived from meta-analysis.
[h]Intervention type: 1 – Violence prevention programmes (also includes conflict training, modified discipline, anger management); 2 – Classroom management programmes; 3 – Life skills programmes (also includes problem solving skills training, perspective taking skills training and coping skills training); 4 – Social-emotional programmes (also includes social skills programmes); 5 – Cognitive behavioral interventions (also includes cognitive interventions and interventions for behavior modification) or social cognitive interventions; 6 – Peer mediators or mentoring; 7 – ECD/ECE; 8 – Combined; 9 – Other; 10 – Not specified.
[i]Many study outcomes were not clear. Only the studies that explicitly discussed school-based interventions for the outcomes of interest were considered.
[j]Effects in not specified column represent combined universal and selective programmes.
[k]Figures based on the number of comparisons instead of the number of studies.
[l]Not strictly moderators, but considered their correlation with effect size.
[m]Conservatively coded as multilevel instead of whole-school because they did not indicate at which levels they intervened.
[n]In this review, violence refers to both victimization and perpetration. Placed effects in perpetration table only as these seemed to be more common, and their studies likely followed this trend.
[o]Review provides unconservative estimates of a study's effectiveness. Each study only needed one positive effect to be considered effective overall.
[p]All descriptives and effects reflect studies using measures of the level or extent of actual aggressive behavior or physical acts of aggression, either observed or reported only.
[q]Utilized the effects of the ICC.10 analysis only in determining effectiveness.
[r]Selected interventions seemed to included indicated samples at times, we relied on their classification.
[s]Figures based on the number of outcome measures instead of studies.
[t]Post-test considered effects up to and including 6 months after completion of the intervention. Follow-up included outcomes measured at least 7 months after completion of an intervention.
[u]The multilevel number might be inflated due to this review not separating whole-school interventions.
[v]Effects based on most distal results.
[w]Coded post-test and follow-up information according to their study design information.
[x]Only 74% of the included studies had effects at immediate post-test, thus our results are coded as post-test overall.
[y]Results thought to be most reflective of post-test findings, and selected and indicated intervention effects were combined. There were more indicated than selected interventions, so effects were placed under the former column.
[z]Could not isolate all effects for universal programmes and selected/indicated programmes. As subject risk was selected (42%) and indicated (19%), effects for selected/indicated interventions were thought to be more reflective of selective interventions, thus they were placed under this category. Effects with $p < .10$ were not considered effective in our analysis.

interventions. The majority of these were scored as effective, with 58% of the unspecified interventions scoring a 1 and 89% of the indicated interventions scoring 1. There is some evidence that the effects of universal interventions endure beyond the immediate post-test. For selected and indicated interventions, these effects were largely only found at post-test. Interventions which did not specify their prevention target demonstrated more mixed effects for reducing peer aggression immediately after program completion; however longer-term follow-up effects were largely positive.

With regards to intervention approaches, discrete programmes had the most evidence for effectiveness, followed by multi-level and whole-school programmes – although it should be noted that approach was specified in less than half of the reviews. Socio-emotional programmes have been found to be one of the most promising approaches, while cognitive behavioral and peer mentoring/mediation interventions have also fairly consistently demonstrated positive results. There was a broad range in the duration of these programmes. Socio-emotional programmes generally seemed to offer around 16 sessions. Unfortunately, session number information was often not specified. Program sessions were also implemented at a varying rate; once or twice a week seemed fairly common. Various school (mostly teachers) and research personnel were often involved in their implementation as well. Other types of intervention were effective in some studies but ineffective or harmful in others. Very few studies considered the effectiveness of whole-school programmes, suggesting the need for further research on these types of interventions. Promisingly, across all reviews, harmful effects (i.e. increased reports of perpetration) were reported in very few studies.

Only a handful of the reviews considered moderators of program effects. Well implemented cognitive behavioral interventions and those with more sessions each week were found to be beneficial (Wilson & Lipsey, 2006b). Considering socio-emotional and cognitive behavioral programmes together there was mixed evidence for short program duration to be associated with positive effects (Gansle, 2005; Sklad, Diekstra, De Ritter, Ben, & Gravesteijn, 2012), however a trend towards younger students benefiting more from these types of interventions was found in two reviews (Sklad et al., 2012; Stoltz, van Londen, Dekovic, de Castro, & Prinzie, 2012).

Discussion

There is very little literature on prevention of teacher-on-student violence (including corporal punishment) and student-on-teacher violence, even though these forms of violence seem quite common (see, for instance; Burton & Leoschut, 2013; Chen & Wei, 2011; Lee, 2015). More promisingly, there is a great deal of literature addressing prevention of IPV and even more dealing with peer aggression at school, although there are substantial gaps even here.

One key gap in the field is that studies often only measure one outcome, even where a program is theoretically likely to reduce more than one form of violence. For instance, peer aggression and dating violence share common risk factors (Smallbone & McKillop, 2015), and reductions in dating violence are thus highly likely to follow from interventions to reduce peer violence. Similarly, victimisation is seldom measured as an outcome. Importantly, the field of violence prevention will only be advanced if specific effects on aggressive behavior are reported separately from other forms of externalizing behaviors.

More high quality studies are also needed: RCTs with longer follow-up periods, lower risk of bias, and which explore mediation and moderation effects, will allow us to understand

which programmes have sustained effects, what theoretical perspectives drive effective programmes (and so to understand not only what programmes work, but also why they work), and which programmes are generalizable to which groups (Gottfredson et al., 2015; Whitaker et al., 2006, 2013).

Another bias in the literature is that research on the effectiveness of interventions was almost exclusively completed in wealthier regions, particularly in the USA. This is exceptionally problematic, as school violence is a global problem (see, for instance; Burton & Leoschut, 2013; Chen & Avi Astor, 2010; Due et al., 2008; Fernandez-Fuertes & Fuertes, 2010; Wubs et al., 2009). More studies in high-violence, low-resource contexts are urgently needed.

Some interventions were identified as harmful, in that they led to increasing reports of aggression. This may be because programmes increased awareness and thus increased reporting (Taylor et al., 2010a; Taylor, Stein, & Burden, 2010b), but it may also have been because of adverse reactions to the intervention (DeGue et al., 2014). It may also be an artefact of study design: studies with short follow-up periods will be unable to differentiate an increase in response to heightened awareness from those that actually cause increased aggression, as it takes time for reporting to stabilize in response to awareness and then to decline in response to an effective program.

Another important focus for new studies should be components of effective interventions (Whitaker et al., 2013). This could be done either through developing and testing new programmes that build on what has been learned about effective interventions (Whitaker et al., 2006), or through meta-analytic studies of successful programmes (see, for instance; Kaminski, Valle, Filene, and Boyle, 2008). Studies of this nature assist in identifying the 'active ingredients' in programmes (Embry & Biglan, 2008).

This review does have some limitations. Firstly, we included only systematic reviews, and the information we were able to extract from each review was dependent on what was reported. This strategy means that promising interventions that had not yet been included in a review would have been missed. Secondly, we were unable to determine the extent of primary study duplication across the reviews on peer aggression. Therefore, the true size of the evidence base on school-based violence prevention interventions remains somewhat unclear. Thirdly, we only included studies published in English. Thus, our results do not reflect the findings of any possible reviews on school violence interventions published in other languages.

Despite these limitations, it is clear that a number of violence prevention initiatives have been successfully delivered at school. Several promising interventions to prevent IPV could be identified. Cognitive behavioral, social-emotional and peer mentoring/mediation programmes were effective for preventing perpetration of peer violence, and cognitive behavioral and whole-school violence prevention programmes show promise for preventing peer victimisation. While the field needs considerable development in order to be regarded as having a strong evidence base, the existing literature does provide us with a good foundation for tackling this serious problem.

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Appendix A. List of searched databases, trial registries and online journals

EBSCOHost databases
Academic Search Premier
Business Source Premier
Africa-Wide Information
AHFS Consumer Medication Information
ATLA Religion Database with ATLASerials
CINAHL
Communication & Mass Media Complete
ERIC
Health Source: Nursing/Academic Edition
Humanities International Complete
International Bibliography of Theatre & Dance with Full Text
Library, Information Science & Technology Abstracts
MasterFILE Premier
MEDLINE
Philosopher's Index
PsycARTICLES
PsycCRITIQUES
PsycINFO
PsycTESTS
SocINDEX with Full Text
Teacher Reference Center
ProQuest databases
Environment Abstracts
ERIC
International Bibliography of the Social Sciences (IBSS)
International Index to Performing Arts Full Text
Library and information Science Abstracts (LISA)
PAIS International and PAIS archive
PILOTS: Published International Literature On Traumatic Stress
ProQuest Education Journals
Social Services Abstracts
Sociological Abstracts
OCLC FirstSearch
Medline
ERIC
PubMed
Medline
Wiley Online Library
Sage Journals Online – 2014 Premier Package
Web of Science
Africa Bibliography
British Education Index- the free collections
ERIC (directly at eric.ed.gov)
Cochrane Library
Campbell Collaboration Libraries
Open Grey
BDENF
Global Health
HISA
LILACS
MedCarib
WPRIM

Trial registries
Clinical Trials Registry: www.clinicaltrials.gov
The Pan-African Clinical Trials Registry: http://www.pactr.org/
The WHO violence prevention trials registry: http://www.preventviolence.info/Trials
Aggression and Violent Behavior

Hand search journals
Aggression and Violent Behavior
International Journal of Violence and schools
Journal of School Violence
Journal of Injury and Violence Research
Youth Violence and Juvenile Justice
Violence and Victims
Journal of Aggression, Maltreatment and Trauma
The School Community Journal
Journal of School Health
Journal of Interpersonal Violence
Journal of School Psychology
Journal of Educational Psychology
School Psychology Quarterly
Journal of Applied School Psychology
Contemporary School Psychology
Psychology in the Schools
British Journal of Educational Psychology
School Psychology International
School Psychology Review
Educational Psychology

Appendix B. References of included reviews

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Appendix C. Excluded reviews' reasons for exclusion and references

Review	Reason for exclusion
Barlow, Smailagic, Ferriter, Bennett, and Jones (2010)	Too few school-based studies on outcomes of interest included
Baskin et al. (2010)	Unclear if outcomes of interest were included in review, and if they were to what extent
Beelmann and Raabe (2009)	Review of reviews
Bonell et al. (2013)	Protocol of a review, not an actual review
Bowman-Perrott, Burke, Nan, and Zaini (2014)	Too few school-based studies on outcomes of interest included
Candelaria, Fedewa, and Ahn (2012)	Could not clearly determine all of the studies which were school-based and which considered outcomes of interest
Cobb, Sample, Morgen, and Johns (2006)	Could not clearly determine all of the studies which were school-based and which considered outcomes of interest
Edwards and Hinsz (2014)	Too few school-based studies on outcomes of interest included
Ehiri, Hitchcock, Ejere, and Mytton (2007)	Protocol of a review, not an actual review
Fellmeth, Heffernan, Nurse, Habibula, and Sethi (2013)	Could not clearly determine which studies that were included in analysis were school-based
Ferguson, Miguel, Kilburn, and Sanchez (2007)	Effects for bullying and other types of violence were not reported separately. Could not determine extent to which violence outside of bullying was represented in statistics
Grove, Evans, Pastor, and Mack (2008)	Could not clearly determine how many school-based interventions were included, and thus how represented they were in the statistics
R. Hahn et al. (2007)	A published version of this report was also found in our searches and thus used instead.
R. A. Hahn et al. (2005)	Too few school-based studies on outcomes of interest included
Hankin, Hertz, and Simon (2011)	Too few school-based studies on outcomes of interest included
January, Casey, and Paulson (2011)	No clear effects on outcome behaviors of interest i.e., there was no way to determine to what extent aggression was an outcome which was considered in included studies and thus how represented it was in the analysis
Klasen and Crombag (2013)	Too few school-based studies on outcomes of interest included
Kristjansson et al. (2006)	Too few school-based studies on outcomes of interest included
D. M. Maggin, Chafouleas, Goddard, and Johnson (2011)	Did not consider outcomes of interest
Daniel M. Maggin, Johnson, Chafouleas, Ruberto, and Berggren (2012)	Outcome behaviors of interest comprised less than 5% of outcome behaviors considered in review. No way of determining the effects specific to outcome behaviors of interest either

Appendix C. *(Continued)*

Review	Reason for exclusion
Matjasko et al. (2012)	Review of reviews
McCart, Priester, Davies, and Azen (2006)	School-based intervention effects could not be separated from the effects for interventions implemented elsewhere. No way of knowing how many school-based interventions were included either
Meirelles dos Santos and Giglio (2012)	Too few school-based studies on outcomes of interest included
Montgomery and Maunders (2015)	Too few school-based studies on outcomes of interest included
Ozabaci (2011)	Too few school-based studies on outcomes of interest included
Parker and Turner (2013)	Too few school-based studies on outcomes of interest included
Piquero et al. (2008)	Too few school-based studies on outcomes of interest included
Piquero, Jennings, Farrington, and Jennings (2010)	Unclear to what extent outcomes of interest were included and separating school-based effects was impossible to do
Polanin and Espelage (2015)	Primary study
Reichow, Barton, Boyd, and Hume (2014)	Did not consider outcomes of interest
Sentenac et al. (2012)	Too few school-based studies on outcomes of interest included
Silverman et al. (2008)	Too few school-based studies on outcomes of interest included
Singh et al. (2011)	Too few school-based studies on outcomes of interest included
Solomon, Klein, Hintze, Cressey, and Peller (2012)	Unclear to what extent outcomes of interest are included and represented in statistics
Sugimoto-Matsuda and Braun (2014)	Did not consider outcomes of interest.
Ting (2009)	Did not consider outcomes of interest
Vannest, Davis, Davis, Mason, and Burke (2010)	No distinct separation of the effects for the outcome behaviors of interest and other behaviors
Walsh, Zwi, Woolfenden, and Shlonsky (2015)	Too few school-based studies on outcomes of interest included
Weisburd, Telep, Hinkle, and Eck (2008)	Too few school-based studies on outcomes of interest included
Wilson and Institute for Public Policy Studies (2005)	Showed significant similarity to Wilson and Lipsey (2007) article. Later article was chosen to be included in review as it included a greater number of studies and was published more recently

Barlow, J., Smailagic, N., Ferriter, M., Bennett, C., & Jones, H. (2010). Group-based parent-training programmes for improving emotional and behavioural adjustment in children from birth to three years old. *Cochrane Database of Systematic Reviews*(3). doi:10.1002/14651858.CD003680.pub2

Baskin, T. W., Slaten, C. D., Crosby, N. R., Pufahl, T., Schneller, C. L., & Ladell, M. (2010). Efficacy of Counseling and Psychotherapy in Schools: A Meta-Analytic Review of Treatment Outcome Studies 1Ψ7. *The Counseling Psychologist, 38*(7), 878–903. doi:10.1177/0011000010369497

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Cobb, B., Sample, P. L., Morgen, A., & Johns, N. R. (2006). Cognitive-Behavioral Interventions, Dropout, and Youth With Disabilities: A Systematic Review. *Remedial and Special Education, 27*(5), 259–275.

Edwards, S. R., & Hinsz, V. B. (2014). A Meta-Analysis of Empirically Tested School-Based Dating Violence Prevention Programs. *SAGE Open, 4*(2). doi:10.1177/2158244014535787

Ehiri, J. E., Hitchcock, L. I., Ejere, H. O. D., & Mytton, J. A. (2007). Primary prevention interventions for reducing school violence. *Cochrane Database of Systematic Reviews*(1). doi:10.1002/14651858.CD006347

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Grove, A. B., Evans, S. W., Pastor, D. A., & Mack, S. D. (2008). A meta-analytic examination of follow-up studies of programs designed to prevent the primary symptoms of oppositional defiant and conduct disorders. *Aggression and Violent Behavior, 13*(3), 169–184. doi:10.1016/j.avb.2008.03.001

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Polanin, J., & Espelage, D. (2015). Using a Meta-analytic Technique to Assess the Relationship between Treatment Intensity and Program Effects in a Cluster-Randomized Trial. *Journal of Behavioral Education, 24*(1), 133–151. doi:10.1007/s10864-014-9205-9

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Appendix D. Data extraction document

kNOw Violence Stage 2 Extraction – Meta-analyses and Systematic Reviews

Reviewer	Date of Extraction
Choose an item.	//2016

Citation:	

PART A: SCREENING

			Exclude if:
1)	**Is the publication available in English:**	Choose an item.	**No**
2)	**Review Type:**	Choose an item.	**Review of Reviews**
3)	**Type of violence considered in review**		
a)	**Is violent behaviour (aggression, externalising behaviour/problems, conduct disorder/problems) an outcome which is considered in the review?**	Choose an item.	**No**
4)	**Intervention Type:**		
	a) Does the review include at least three studies which provide the results for an intervention implemented at school/which recruited students from school?	Choose an item.	**No**
	b) If yes, do at least of three of the school-based studies in the review consider intervention effectiveness on the outcome violent behaviour (as described above)?	Choose an item.	**No**
5)	**Relevant:**	Choose an item.	

Part B: AMSTAR

			Yes	No	Can't answer	Comments
1.	Question:	**Was an 'a priori' design provided?**				
	Explanation:	The research question and inclusion criteria should be established before the conduct of the review				
	Note:	Need to refer to a protocol, ethics approval, or pre-determined/a priori published research objectives to score a 'yes'				
2.	Question:	**Was there duplicate study selection and data extraction?**				
	Explanation:	There should be at least two independent data extractors and a consensus procedure for disagreements should be in place				
	Note:	Two people do study selection, two people do data extraction, consensus process or one person checks the other's work				
3.	Question:	**Was a comprehensive literature search performed?**				
	Explanation:	At least two electronic sources should be searched. The report must include years and databases used (e.g. Central, EMBASE, and MEDLINE). Key words and/or MESH terms must be stated and where feasible the search strategy should be provided. All searches should be supplemented by consulting current contents, reviews, textbooks, specialized registers, or experts in the particular field of study, and by reviewing the references in the studies found				
	Note:	If at least two sources + one supplementary strategy used, select 'yes' (Cochrane register/central counts as two sources; a grey literature search counts as supplementary)				
4.	Question:	**Was the status of publication (i.e. grey literature) used as an inclusion criterion?**				
	Explanation:	The authors should state that they searched for reports regardless of their publication type. The authors should state whether or not they excluded any reports (from the systematic review), based on their publication status, language etc.				
	Note:	If review indicates that there was a search for 'grey literature' or 'unpublished literature', indicate 'yes'. SIGLE database, dissertations, conference proceedings, and trial registries are all considered grey for this purpose. If searching a source that contains both grey and non-grey, must specify that they were searching for grey/unpublished lit				
5.	Question:	**Was a list of studies (included and excluded) provided?**				
	Explanation:	A list of included and excluded studies should be provided.				
	Note:	Acceptable if the excluded studies are referenced. If there is an electronic link to the list but the link is dead, select 'no'				
6.	Question:	**Were the characteristics of the included studies provided?**				
	Explanation:	In an aggregated form such as a table, data from the original studies should be provided on the participants, interventions and outcomes. The ranges of characteristics in all the studies analyzed e.g., age, race, sex, relevant socioeconomic data, disease status, duration, severity, or other diseases should be reported				
	Note:	Acceptable if not in table format as long as they are described as above				

7.	Question:	**Was the scientific quality of the included studies assessed and documented?**
	Explanation:	'A priori' methods of assessment should be provided (e.g. for effectiveness studies if the author(s) chose to include only randomized, double-blind, placebo controlled studies, or allocation concealment as inclusion criteria); for other types of studies alternative items will be relevant
	Note:	Can include use of a quality scoring tool or checklist, e.g., Jadad scale, risk of bias, sensitivity analysis, etc., or a description of quality items, with some kind of result for EACH study ('low' or 'high' is fine, as long as it is clear which studies scored 'low' and which scored 'high'; a summary score/range for all studies is not acceptable)
8.	Question:	**Was the scientific quality of the included studies used appropriately in formulating conclusions?**
	Explanation:	The results of the methodological rigor and scientific quality should be considered in the analysis and the conclusions of the review, and explicitly stated in formulating recommendations
	Note:	Might say something such as 'the results should be interpreted with caution due to poor quality of included studies'. Cannot score 'yes' for this question if scored 'no' for question 7
9.	Question:	**Were the methods used to combine the findings of studies appropriate?**
	Explanation:	For the pooled results, a test should be done to ensure the studies were combinable, to assess their homogeneity (i.e. Chi-squared test for homogeneity, I^2). If heterogeneity exists a random effects model should be used and/or the clinical appropriateness of combining should be taken into consideration (i.e. is it sensible to combine?)
10.	Note:	Indicate 'yes' if they mention or describe heterogeneity, i.e., if they explain that they cannot pool because of heterogeneity/variability between interventions
	Question:	**Was the likelihood of publication bias assessed?**
11.	Explanation:	An assessment of publication bias should include a combination of graphical aids (e.g. funnel plot, other available tests) and/or statistical tests (e.g. Egger regression test, Hedges-Olken)
	Note:	If no test values or funnel plot included, score 'no'. Score 'yes' if mentions that publication bias could not be assessed because there were fewer than 10 included studies.
	Question:	**Was the conflict of interest included?**
	Explanation:	Potential sources of support should be clearly acknowledged in both the systematic review and the included studies
	Note:	To get a 'yes', must indicate source of funding or support for the systematic review AND for each of the included studies
		Total AMSTAR Score:

Part C: Extraction

Please extract the descriptive information from each study first. Information relating to each field needs to be marked with an 'X' if relevant to the review. If a field is relevant, please also specify the number of primary studies in the review this information pertains to. If the information in a particular field is not specified please specify this using the NS (not specified) option.

Descriptive information

1.	No. of studies in review	Not specified
2.	No. of studies on school-based interventions with violent behavior as an outcome	Not specified
3.	No. of studies on school-based interventions with ONLY attitudes towards violence as an outcome	Not specified

Prevention target	Characteristic relevant	No. of primary studies
1 Universal only		
2 Selected only		
3 Indicated only		
4 Combination		
5 Not specified		
Approach		
1 Whole-school only		
2 Discrete only		
3 Combination		
4 Not specified		
Content		
1 Comprehensive only		
2 Specific only		
3 Combination		
4 Not specified		
School level		
1 Pre-primary only		
2 Primary only		
3 High only		
4 Combination PP + P		
5 Combination P + H		
6 Combination all		
7 Not specified		
Participant gender		
1 Female-only		
2 Male-only		
3 Mixed		
4 Not specified		
Study design		
1 Randomised controlled trial		
2 Quasi-experimental		
3 Not specified		
WHO regions	*Characteristic relevant*	*No. of primary studies for each country in region*
1 North America		
2 South America		
3 Western Pacific		
4 Europe		
5 Eastern Mediterranean		
6 Africa		
7 South East Asia		
8 Not specified		

Effects information

1. For meta-analyses with school-based interventions which have effects on violence overall please mark the appropriate column in the table below with an 'X'.

Reduction in violence (effective)	No effect on violence (ineffective)	Increase in violence (harmful)

2. For reviews where primary studies' effects need to be individually extracted, please add the name of each primary study which needs to have their effects extracted first. Then, for each of these relevant primary studies mark the appropriate column in the table below with an 'X'.

No.	Primary study name	Reduction in violence (effective)	No effect on violence (ineffective)	Increase in violence (harmful)
1				
2				
3				
4				
5				
6				
7				
	Sub-totals:			
	Grand total number of effects:			

3. Were harmful effects reported or found?
   Yes/No
4. Did the reviews include individual primary studies with effect sizes on relevant outcomes?
   Yes/No
5. Specific type of outcome behavior considered in review (e.g. physical aggression): _____
   _____
6. Specific type of intervention considered in review (e.g. social-emotional program): ___
   _____

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School corporal punishment in global perspective: prevalence, outcomes, and efforts at intervention

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ABSTRACT

School corporal punishment continues to be a legal means of disciplining children in a third of the world's countries. Although much is known about parents' use of corporal punishment, there is less research about school corporal punishment. This article summarizes what is known about the legality and prevalence of school corporal punishment, about the outcomes linked to it, and about interventions to reduce and eliminate school corporal punishment around the world.

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Corporal punishment of children has been the focus of increasing concern from researchers and policymakers around the world. The U.N. Committee on the Rights of the Child has defined corporal punishment as 'any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light' (2007, ¶11) and has called it a form of violence against children. Much of the global concern about corporal punishment has focused on parents' use of it (Gershoff, 2013; Gershoff & Grogan-Kaylor, 2016), yet it is also the case that corporal punishment in schools remains widespread. This article summarizes what is known to date about school corporal punishment around the world.

Definition and forms of school corporal punishment

Schoolchildren of all ages are subject to corporal punishment, although is it more often used in primary school (Clacherty, Donald, & Clacherty, 2005b; Human Rights Watch & the ACLU, 2008; Youssef, Attia, & Kamel, 1998). In practice, school corporal punishment often involves the use of objects (Gershoff, Purtell, & Holas, 2015). Children around the world report that they are hit by their teachers with a variety of objects, including sticks (Egypt: Youssef et al., 1998), straps (Jamaica: Baker-Henningham, Meeks-Gardner, Chang, & Walker, 2009), and wooden boards (U.S.: Pickens County [Alabama] Board of Education, 2015). Children have reported being hit with hands or objects on virtually every part of their bodies, although the hands, arms, head, and buttocks are common targets (Ba-Saddik & Hattab, 2013; Beazley, Bessell, Ennew, & Waterson, 2006; Human Rights

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Watch & ACLU, 2008; Youssef et al., 1998). Other forms of assault administered as corporal punishment include pinching, pulling ears, pulling hair, slapping the face, and throwing objects (Ba-Saddik & Hattab, 2013; Beazley et al., 2006). Teachers and school personnel also punish children by forcing them to stand in painful positions, to stand in the sun for long periods, to sit in an 'invisible chair' for long periods, to hold or carry heavy objects, to dig holes, to kneel on small objects such as stones or rice, to exercise excessively without rest or water, and to ingest noxious substances (e.g. cigarettes) (Ba-Saddik & Hattab, 2013; Beazley et al., 2006; Feinstein & Mwahombela, 2010; Hyman, 1995).

School administrators report that they reserve corporal punishment for serious student infractions, such as fighting with fellow students (Medway & Smircic, 1992), yet interviews with students make clear that corporal punishment is used more widely. Children in India, Republic of Korea, South Africa, Sudan, Swaziland, the United States, and Zambia have reported being subject to corporal punishment for a range of behaviors, including not doing their homework, coming late to class, bringing cell phones to school, running in the hallway, sleeping in class, answering questions incorrectly, having an unacceptable appearance, using bad language, writing in a text book, failing to pay school fees, making noise in class, and being absent (Beazley et al., 2006; Breen, Daniels, & Tomlinson, 2015; Clacherty, Donald, & Clacherty, 2005a; Clacherty et al., 2005b; Elbla, 2012; Human Rights Watch & ACLU, 2008; Mitchell, 2010; Morrow & Singh, 2014). Students also report that an entire class may be subject to corporal punishment for the misbehavior of a single student or because an entire class or school performs poorly on examinations (Beazley et al., 2006; Pinheiro, 2006).

Legal status of school corporal punishment around the world

Corporal punishment is legally prohibited in schools in 128 countries and allowed in 69 (35%) (Global Initiative to End All Corporal Punishment of Children [Global Initiative], 2016g). Table 1 lists each of the countries that allow school corporal punishment. It is banned in all of Europe and most of South America and East Asia. Three industrialized countries are outliers that continue to allow school corporal punishment: Australia, the Republic of South Korea, and the United States. In Australia, school corporal punishment is banned in 5 of its 8 states and territories, while in the United States it is banned from public schools in 31 of 50 states (Global Initiative, 2016g). A sampling of the laws that allow corporal punishment is presented in Table 2.

The United Nations has clearly stated that corporal punishment violates the Convention on the Rights of the Child (the CRC) (United Nations, Committee on the Rights of the Child, 2007), specifically Article 19's guarantee of protection from all physical and mental violence, Article 37's protection from cruel, inhuman, or degrading punishment, and Article 28's provision that school discipline should be consistent with children's 'human dignity' (United Nations, 1989).

It is worth noting that if an adult were to be hit with an object such as schoolchildren are, it would be considered assault in any of these countries. The 69 countries that legally permit school corporal punishment, to say nothing of the 149 countries that allow corporal punishment in homes, are not providing children with equal protection under the law, despite their more vulnerable status.

Table 1. The 69 countries in which school corporal punishment is legally permitted in 2016.

Angola	Mozambique
Antigua and Barbuda	Myanmar
Australia	Nepal
Bahamas	Niger
Barbados	Nigeria
Bhutan	Pakistan
Botswana	Palau
Brunei Darussalam	Panama
Burkina Faso	Papua New Guinea
Central African Republic	Qatar
Comoros	Republic of Korea
Côte d'Ivoire	Samoa
Dominica	Saudi Arabia
DPR Korea	Senegal
Egypt	Seychelles
Equatorial Guinea	Sierra Leone
Eritrea	Singapore
Gambia	Solomon Islands
Ghana	Somalia
Grenada	Sri Lanka
Guatemala	St Kitts and Nevis
Guinea	St Lucia
Guyana	St Vincent and the Grenadines
India	State of Palestine
Indonesia	Sudan
Iran	Suriname
Iraq	Swaziland
Jamaica	Syrian Arab Republic
Lebanon	Timor-Leste
Lesotho	Tuvalu
Liberia	UR Tanzania
Malaysia	United States of America
Maldives	Western Sahara
Mauritania	Zimbabwe
Morocco	

Source: Global Initiative (2016g).

Global prevalence of school corporal punishment

Corporal punishment continues to occur in schools throughout the world, both in countries where it is legal and countries where it is banned, leading to estimates that millions of children are subject to legalized assault at their schools (Covell & Becker, 2011). Table 3 provides estimates of the prevalence of school corporal punishment in 63 countries. Twenty-nine of these countries have legally banned corporal punishment from schools, yet they have rates of corporal punishment ranging from 13% of students in Kazakhstan to fully 97% of students in Cameroon. South Africa banned school corporal punishment when it transitioned to a new government and a new Constitution that valued the rights of children in 1996. However, students have reported that corporal punishment continues to be a regular part of education in South Africa (Payet & Franchi, 2008).

Nine countries in this table have been found to have corporal punishment rates of over 90% of students (Botswana, Cameroon, Jamaica, St. Kitts & Nevis, Republic of Korea, Trinidad & Tobago, Uganda, United Republic of Tanzania, and Yemen) and 11 have rates of between 70 and 89% (Benin, Dominica, Egypt, Ghana, Grenada, India, Morocco, Myanmar, St. Vincent & the Grenadines, State of Palestine, and Togo). It is extremely troubling that virtually all children in these 20 countries are subject to corporal punishment in schools.

Table 2. Examples of laws permitting school corporal punishment.

Botswana, Children's Act 2009, article 61[a]
(1) No person shall subject a child to torture or other cruel, inhuman or degrading treatment or punishment
(2) No person shall subject a child to correction which is unreasonable in kind or in degree relative to the age, physical and mental condition of the child and which, if the child by reason of tender age or otherwise is incapable of understanding the purpose and fairness thereof
(3) The provisions of this section shall not be construed as prohibiting the corporal punishment of children in such circumstances or manner as may be set out in this Act or any other law.…
Dominica, Education Act 1997, article 49[a]
(1) In the enforcement of discipline in public schools, assisted private schools and private schools degrading or injurious punishment shall not be administered
(2) Corporal punishment may be administered where no other punishment is considered suitable or effective, and only by the principal, deputy principal or any teacher appointed in writing by the principal for that purpose, in a manner which is in conformity with the guidelines issued in writing by the Chief Education Officer
(3) Whenever corporal punishment is administered an entry shall be made in a punishment book that shall be kept in each school for such purpose with a statement of the nature and extent of the punishment and the reasons for administering it
(4) A person other than those mentioned in subsection (2) who administers corporal punishment to a child on the school premises is guilty of an offence and liable on summary conviction to a fine of one thousand dollars
Papua New Guinea, Criminal Code 1974, article 278[a]
It is lawful for a parent or a person in the place of a parent, or for a schoolmaster, or master, to use, by way of correction, towards a child, pupil or apprentice under his care such force as is reasonable under the circumstances
Singapore, Education (School) Regulations 1958, article 88(2)[a]
The corporal punishment of boy pupils shall be administered with a light cane on the palms of the hands or on the buttocks over the clothing. No other form of corporal punishment shall be administered to boy pupils
St Kitts and Nevis, Education Act 2005, article 49(2)[a]
Corporal punishment may be administered where no other punishment is considered suitable or effective, and only by the principal, deputy principal or any teacher appointed by the principal for that purpose, in a manner which is in conformity with the guidelines issued, in writing, by the Chief Education Officer
United States, Mississippi, 37-11-57. (2)[b]
Corporal punishment administered in a reasonable manner, or any reasonable action to maintain control and discipline of students taken by a teacher, assistant teacher, principal or assistant principal acting within the scope of his employment or function and in accordance with any state or federal laws or rules or regulations of the State Board of Education or the local school board, does not constitute negligence or child abuse
United States, Tennessee[c]
49-6-4103. Corporal punishment. Any teacher or school principal may use corporal punishment in a reasonable manner against any pupil for good cause in order to maintain discipline and order within the public schools.
49-6-4104. Rules and regulations. Each local board of education shall adopt rules and regulations it deems necessary to implement and control any form of corporal punishment in the schools in its district.
Zimbabwe, Criminal Law (Codification and Reform) Act 2004, article 241(2)[a]
… a school-teacher shall have authority to administer moderate corporal punishment for disciplinary purposes upon any minor male pupil or student; and, where moderate corporal punishment is administered upon a minor person by a parent, guardian or school-teacher within the scope of that authority, the authority shall be a complete defence to a criminal charge alleging the commission of a crime of which the administration of the punishment is an essential element.

[a]Global Initiative (2015b). [b]Bezinque, Meldrum, Darling-Churchill, and Stuart-Cassel (2015); Mississippi Code (2013). [c]Bezinque et al. (2015); Tennessee Statutes and Codes (2016).

In light of the fact that children are likely to under-report corporal punishment because they are afraid of the repercussions (Morrow & Singh, 2014; Parkes & Heslop, 2013), the corporal punishment rates in Table 1 may be an underestimate of the actual rate in any of these countries. There is also considerable within-country variation that is masked by these statistics. For example, in the United States, corporal punishment is only allowed in 19 states, and thus when the rate for the entire country is calculated it is quite small at 1% of all schoolchildren, although the size of the child population in that country means that this represents a total of 163,333 children subject to corporal punishment in the 2011–2012 school year alone (Gershoff & Font, 2016). However, in the state of Mississippi, 7% of all

Table 3. Prevalence of school corporal punishment in selected countries, regardless of legality.

			Prevalence	
Country	Legal status	Year	% of students reporting they were subject to corporal punishment	% of students or teachers reporting others were subject to corporal punishment
Benin	Banned	2009	88% of girls beaten in schools	
Botswana	Legal	2007	92% of students	
Cameroon[b]	Banned	2000	97% of students	
Central African Republic	Legal	2013	51% of males and 45% of females	
Djibouti	Banned	2006	28% hit with object, 14% had been pinched or had hair or ears pulled	
Egypt[c]	Legal	1998	80% of boys, 62% of girls	
Equatorial Guinea	Legal	2011	54%	
Ethiopia[d]	Banned	2009	38% of 8 year olds in past week; 12% of 15 year olds in past week	76% of 8 year olds observed in past week; 49% of 15 year olds observed in past week
Ghana	Legal	2010	71% of students	
Kenya[e]	Banned	2010	41% of females, 46% of males were punched, kicked, whipped, or beaten with an object in previous 12 months	
Malawi	Banned	2007	48% of students	
Mali	Banned	2009		83% of students report that it occurs
Morocco[f]	Legal	2005	87% of students	
Mozambique	Legal	2009	40% hit with an object in past two weeks	
Nigeria	Legal	2011		80% of respondents had seen students hit with a cane, 46% with a horsewhip, 30% with hand
South Africa	Banned	2013	50% of students	
Swaziland[g]	Legal	2005	59% of students beat with object in previous 2 weeks; 20% of students hit with hand in previous 2 weeks	
Togo	Banned	2005	88% of girls and 87% of boys	
Uganda[h]	Banned	2015	90% of students in primary school (88% reported caning)	
United Republic of Tanzania[i]	Legal	2014	98% of boys, 91% of girls	98% of boys, 99% of girls
Zambia[j]	Legal	2005	32% of students in previous 2 weeks	
Zimbabwe	Legal	2009		67% of students report teachers use corporal punishment
Europe and Central Asia[k]				

(*Continued*)

Country	Legal status	Year	Prevalence	
			% of students reporting they were subject to corporal punishment	% of students or teachers reporting others were subject to corporal punishment
Belgium	Banned	2011	23% of students had ear pulled, 18% had hair pulled, 20% were hit with a hand on their hand or fingers, 14% forced to stand or kneel in painful position	
Czech Republic	Banned	2011		30% of teachers had slapped a student
Kazakhstan	Banned	2013	13% in past year	
Serbia	Banned	2006	43% in past three months	
TFYR Macedonia	Banned	2009		57% knew a child who had been beaten by a teacher
Middle East and South Asia[l]				
Afghanistan	Banned	2008		Observed in 100% of boys' schools and 20% of girls' schools
Bangladesh	Banned	2015	53% of students	
India[d]	Legal	2009	78% of 8 year olds in past week; 34% of 15 year olds in past week	93% of 8 year olds observed in past week; 68% of 15 year olds observed in past week
Iraq	Legal	2008		48% of teachers used
Jordan	Banned	2007	57% of students had been subject to severe violence (hitting with object, biting burning); 50% had been subject to mild violence (slapping, pulling hair, pinching, pushing, twisting arms or legs)	
Lebanon[f]	Legal	2005	46% of students in previous month	
Pakistan	Legal	2014	44% of students in previous 6 months	
State of Palestine	Legal	2010	80% of students	
Yemen[f]	Banned	2010	90% of students	
East Asia And The Pacific[m]				
Cambodia	Banned	2013	15% of boys and 9% of girls in previous 6 months	
China	Banned	2004	58% of students (10% beat with an object)	
Fiji	Banned	2008	31% in past month	
Hong Kong[n]	Banned	2006		54% of discipline involves physical punishment
Indonesia	Legal	2014	27% of boys and 9% of girls in previous 6 months	
Myanmar	Legal	2012	82% of students beaten	
Philippines	Banned	2009	18% of students pinched, 16% spanked with hand or object	
Republic of Korea[n]	Legal	2011	98% of students	94% of discipline involves physical punishment
Samoa	Legal	2013	41% in past year	
Taiwan	Banned	2012		95% of students have seen school corporal punishment

Vietnam[d,n]	Banned	2009	20% of 8 year olds in past week; 1% of 15 year olds in past week	59% of 8 year olds in past week; 13% of 15 year olds in past week; 69% of discipline involves physical punishment
North, Central, and South America[o]				
Barbados	Legal	2009	56% of students flogged at school	
Dominica	Legal	2009	86% of students	
Grenada[p]	Legal	2014	85% of students	86% of teachers report using
Jamaica[q]	Legal	2009	96% of boys and 89% of girls	
Peru[d]	Banned	2009	30% of 8 year olds in past week; 7% of 15 year olds in past week	51% of 8 year olds observed in past week 19% of 15 year olds observed in past week
St. Kitts & Nevis[p]	Legal	2014	92% of students	88% of teachers report using
St. Lucia	Legal	2011		86% of students report corporal punishment at their school
St. Vincent & the Grenadines[p]	Legal	2014	82% of students	83% of teachers report using
Trinidad & Tobago[p]	Banned	2014	92% of students	71% of teachers report using
United States of America[r]	Legal	2012	1% of all public school students nationally (7% in Mississippi, 4% in Alabama, 4% in Arkansas, 2% in Oklahoma; all other states 1% or less)	

Note: Dates refer to year of survey if available or to year of report if not. Source for prevalence data is report cited in section heading, unless otherwise indicated.

[a]Global Initiative (2016a); [b]Pinheiro (2006); [c]Youssef et al. (1998); [d]Ogando Portela and Pells (2015); [e]United Nation's Children's Fund Kenya County Office et al. (2012); [f]Save the Children Sweden (2011); [g]Clacherty et al. (2005b); [h]DeVries et al. (2015); [i]Hecker et al. (2014); [j]Clacherty et al. (2005a); [k]Global Initiative (2016d); [l]Global Initiative (2016e, 2016f); [m]Global Initiative (2016c); [n]Beazley et al. (2006); [o]Global Initiative (2016b); [p]Bailey, Robinson, and Coore-Desai (2014); [q]Baker-Henningham et al. (2009); [r]Gershoff and Font (2016).

public school children, or one in every 14, were subject to corporal punishment in that single year (Gershoff & Font, 2016).

Concerns about school corporal punishment

Although the majority of research to date on corporal punishment has been focused on parents' use of it (Gershoff & Grogan-Kaylor, 2016), there is sufficient data on several potential outcomes of school corporal punishment to engender concern about its continued use around the world. Given the conclusion stated above that school corporal punishment is a form of violence that violates children's human rights (Committee on the Rights of the Child, 2007), arguments about its effects on children are, or at least should be, moot. After all, we have not needed research to decide that violence against women should be unlawful. That said, because some policymakers and citizens are more convinced by data on outcomes then by human rights arguments, this brief summary is provided.

School corporal punishment can interfere with learning

No children in any country behave well all of the time, and any child's misbehavior can be a detriment to their own learning and a distraction to the learning of his or her peers. It is thus necessary the world over for school personnel to institute some form of guidance and discipline. If it was effective at maintaining appropriate student behavior, school corporal punishment would be expected to predict better learning and achievement among students.

Yet there is in fact no evidence that school corporal punishment enhances or promotes children's learning in the classroom. In a cross-sectional study in Jamaica, school children who received one or two types of school corporal punishment scored lower on mathematics, and children who received 3 more types of corporal punishment at school scored lower on spelling, reading, and mathematics (Baker-Henningham et al., 2009). In a study in Nigeria, children who attended a school that allowed corporal punishment (slapping, pinching, hitting with a stick) had lower receptive vocabulary, lower executive functioning, and lower intrinsic motivation than children who attended a school that did not allow corporal punishment (Talwar, Carlson, & Lee, 2011).

The strongest demonstration of the links between school corporal punishment and children's learning to date has come from UNICEF's Young Lives study of children in four developing countries, namely Ethiopia, India, Peru, and Vietnam (Ogando Portela & Pells, 2015). The study followed children over time and linked corporal punishment at age 8 to school performance at age 12, thus eliminating the possibility that children's later school performance could predict their corporal punishment earlier in time. The study also controlled for a range of factors that might predict both whether a child receives corporal punishment and their school performance, namely age of the child, gender of the child, height-for-age, birth order, caregiver's education level, household expenditures, household size, and whether the child lived in an urban locale. Children from each country reported high rates of school corporal punishment (from 20 to 80% of children) when they were 8 years of age, and the more corporal punishment they received at age 8, the lower their math scores were in two samples (Peru and Vietnam) and the lower their vocabulary scores in Peru (Ogando Portela & Pells, 2015). Importantly, in none of the countries did school corporal punishment at age 8 predict better school performance at age 12.

One reason that corporal punishment may interfere with children's learning is that children avoid or dislike school because it is a place where they are in constant fear of being physically harmed by their teachers. In the Young Lives study, 5% of students in Peru, 7% in Vietnam, 9% in Ethiopia, and 25% in India reported that being beaten by teachers was their most important reason for not liking school (Ogando Portela & Pells, 2015). Interviews with students in Barbados, Egypt, India, Pakistan, Sudan, Tanzania, and Zimbabwe have revealed that school corporal punishment was painful, and that it made the adolescents hate their teachers, have difficulty concentrating and learning, perform less well in school, and avoid or even drop out of school for fear of being beaten (Anderson & Payne, 1994; Elbla, 2012; Feinstein & Mwahombela, 2010; Gwirayi, 2011; Morrow & Singh, 2014; Naz, Khan, Daraz, Hussain, & Khan, 2011; Youssef et al., 1998).

School corporal punishment poses a significant risk for physical injury

Studies in a range of countries have documented high rates of injury related to school corporal punishment. School children in Zambia reported pain, physical discomfort, nausea, and embarrassment as well as feeling vengeful (Clacherty et al., 2005a). In Egypt, 26% of boys and 18% of girls reported that they had been injured by school corporal punishment, including bumps, contusions, wounds, and fractures (Youssef et al., 1998). A remarkably similar rate of injury was found in the United Republic of Tanzania, where nearly a quarter of the 408 primary school children surveyed said they experienced corporal punishment so severe that they were injured (Hecker, Hermenau, Isele, & Elbert, 2014). In the United States, schoolchildren have suffered a range of physical injuries that often require medical treatment, including bruises, hematomas, nerve and muscle damage, cuts, and broken bones (e.g. Block, 2013; *C. A. ex rel G.A. v. Morgan Co. Bd. of Educ.*, 2008; *Garcia ex rel. Garcia v. Miera*, 1987; Hardy, 2013; *Ingraham v. Wright,* 1971). Over ten years ago, the Society for Adolescent Medicine (2003) estimated that between 10,000 and 20,000 students required medical attention as a result of school corporal punishment each year in the U.S. alone.

Although rare, the U.N. has identified numerous cases of children who have died as a result of corporal punishment at school, including a 7-year old boy in Malaysia, a 9-year old boy in South Africa, an 11-year old girl in India, a 13-year-old girl in Sri Lanka, and a 14-year-old boy in the Philippines (Covell & Becker, 2011). Additional cases of children dying as a result of school corporal punishment have been documented in India (Morrow & Singh, 2014) and Nigeria (Chianu, 2000). Any injury to a child from corporal punishment is regrettable and a death at the hands of teachers is particularly tragic, especially given that it was preventable.

School corporal punishment is linked with mental health and behavioral problems

In addition to being physically painful and potentially injurious, school corporal punishment is also often emotionally humiliating for children (Feinstein & Mwahombela, 2010). Feelings of humiliation can be heightened when children are punished in front of the class or when the child's reaction to the punishment is broadcast over the school's public address system in administrators' attempts to 'teach a lesson' to all of the children in the school (Feinstein & Mwahombela, 2010; Human Rights Watch & the ACLU, 2008).

It is thus not surprising that school corporal punishment has been linked with mental and behavioral problems in children. School corporal punishment was the strongest predictor of depression among school children in a study in Hungary, more so than corporal punishment by parents (Csorba et al., 2001). Among a sample of Tanzanian children, school corporal punishment was linked with decreased empathic behavior (Hecker et al., 2014). In Pakistan, school corporal punishment was linked with greater hostility, pessimism, and depression (Naz et al., 2011). In a cross-sectional study in Egypt, children who were corporally punished reported that they were also more disobedient, stubborn, verbally aggressive, and likely to lie than children not corporally punished (Youssef et al., 1998). The Young Lives study found that more frequent school corporal punishment at age 8 predicted less self-efficacy 4 years later in Ethiopia and Peru and lower self-esteem 4 years later in Ethiopia and Vietnam (Ogando Portela & Pells, 2015). These findings support the conclusion that corporal punishment may cause children to experience mental health and behavioral problems.

Although the research on school corporal punishment and children's mental health and behavior is limited, it should be noted that these findings are consistent with those from research on parents' use of corporal punishment, namely that it is linked with more mental health problems and more problematic behavior (Gershoff & Grogan-Kaylor, 2016). These links have been confirmed across race and ethnic groups in the United States (Gershoff, Lansford, Sexton, Davis-Kean, & Sameroff, 2012) and across six different countries (China, India, Italy, Kenya, Philippines, and Thailand: Gershoff et al., 2010).

Disparities in school corporal punishment by race, gender, ethnic group, or disability status

Another source for concern is that certain groups are targeted for more corporal punishment than other groups. Boys, children from ethnic minorities, and children with disabilities are more likely to experience corporal punishment than their peers (Alyahri & Goodman, 2008; Covell & Becker, 2011; Dunne, Humphreys, & Leach, 2006; Lee, 2015). In the Young lives study, boys were more likely than girls to experience school corporal punishment in each country: Ethiopia: 44% (boys) vs. 31% (girls); India: 83% vs. 73%; Peru: 35% vs. 26%; Vietnam: 28% vs. 11% (Ogando Portela & Pells, 2015). In both Singapore and Zimbabwe, gender discrimination is written into law – only boys can be subject to school corporal punishment in these countries (see Table 2; Makwanya, Moyo, & Nyenya, 2012).

Disparities in school corporal punishment by gender, race, and disability status have been documented in the United States. Using data from all 95,088 public schools in the U.S., Gershoff and Font (2016) found that boys, racially Black children, and children with disabilities were more likely to be corporally punished in school than their peers. These disparities are in contravention of several U.S. federal laws that protect schoolchildren from discrimination on the basis of race, gender, and disability status (United States Department of Education, Office for Civil Rights, 2015). Disparities in the use of school corporal punishment are concerning because students who perceive they are being treated in a discriminatory fashion are more likely to engage in negative school behaviors, to have low academic achievement, and to have mental health problems (Schmitt, Branscombe, Postmes, & Garcia, 2014; Smalls, White, Chavous, & Sellers, 2007).

Costs to society

If countries are not motivated to eliminate school corporal punishment out of respect for children's human rights or concern for their welfare, they may be motivated by potential benefits to their bottom line. Researchers with Plan International estimated the economic costs to society from the continued use of school corporal punishment in India, focusing on costs that accrue from lower achievement, lower earnings, higher physical and mental health needs, and higher reliance on social services (Pereznieto, Harper, Clench, & Coarasa, 2010). They calculated that the costs to society of children dropping out of school as a result of school corporal punishment were between $1.5 billion and $7.4 billion in lost benefits to society each year, which is the equivalent to between .13% and .64% of GDP in India alone (Pereznieto et al., 2010). Multiplied by the 69 countries that still allow school corporal punishment, and the large number of countries that turn a blind eye to the continued use of corporal punishment despite legal bans, the costs of school corporal punishment to global society is staggering.

They way forward: ending school corporal punishment

The data summarized above makes clear that school corporal punishment is consistently linked with harm to children's learning, physical safety, and mental health, and that it is not effective at maintaining discipline and facilitating academic achievement. Ending school corporal punishment will require educating the public about harms of corporal punishment, instituting appropriate sanctions for continued use of corporal punishment by school personnel, monitoring compliance with bans, creating procedures for students, parents, or staff to report use of corporal punishment, and instructing teachers in alternative methods of discipline (Global Initiative, 2016b). Advocacy and public education campaigns that combine the efforts of governmental and non-governmental agencies are needed to raise awareness about the harms of corporal punishment among teachers, parents, and children (Save the Children Sweden, 2011).

The United Nations has called on countries to ban corporal punishment in all settings, including schools, in order to ensure the safety of children and to be in compliance with the CRC (Pinheiro, 2006; United Nations Committee on the Rights of the Child, 2007). According to the Global Initiative (2016a), 30 states were advised to end all corporal punishment by United Nations treaty bodies, and 26 countries were so advised during their Universal Periodic Reviews (Global Initiative, 2016a). Legal bans on school corporal punishment, and ideally on all corporal punishment of children in any setting, would be welcome steps toward ensuring children's safety and well-being in school settings. Yet as demonstrated above and in Table 3, legal bans are not sufficient to completely eliminate school corporal punishment. True behavior change by teachers and school administrators will require education about the harms of corporal punishment and about alternative, positive forms of discipline (Pinheiro, 2006).

There are a limited number of school- and community-level interventions to reduce school corporal punishment, but their results to date are very promising. The most rigorous test of a corporal punishment reduction intervention was the randomized controlled trial evaluation of the Good Schools Toolkit in Uganda (DeVries et al., 2015). The intervention, developed by a Ugandan non-profit organization called Raising Voices, involved

extensive staff training on non-violent disciplinary methods as well as staff coaching from program staff. The Toolkit also involves classroom activities linked to a sequence of 6 steps aimed at reducing teachers' use of corporal punishment and increasing their use of positive disciplinary methods (see: raisingvoices.org/good-school). Schools that implemented the Good Schools Toolkit saw a 42% reduction in the number of students who reported they had been victims of violence from school staff. There were no effects of the intervention on students' behavior problems or on their educational performance (DeVries et al., 2015), which importantly refutes arguments that removing corporal punishment will lead to an increase in students' problem behaviors and decrease their learning at school.

Another promising intervention is ActionAid's Stop Violence Against Girls in School multilevel intervention designed to reduce violence across multiple settings, including schools, through a combination of advocacy and education about topics such as the importance of gender equity and about the harms of corporal punishment (Parkes & Heslop, 2013). The program was implemented simultaneously in Ghana, Kenya, and Mozambique from 2007 to 2013 and yielded significant results. In all three countries, the percentage of students and teachers who thought teachers should not whip students increased, and the percent of girls who reported experiencing corporal punishment in schools also decreased. For example, in Mozambique, the percentage of girls saying they had been caned in the previous year dropped from 52% to 29%. Additional impacts were found in school participation and achievement. The intervention schools saw increases in girls' enrollment increase by 14% in Ghana, 17% in Kenya, and 10% in Mozambique over the five years of the evaluation and an accompanying decrease in dropouts among both boys and girls in Ghana and Kenya (Parkes & Heslop, 2013). In qualitative interviews, teachers reported that caning had reduced drastically, but also reported that they had not been instructed in alternative forms of discipline and so were left not clear how to manage students' behavior (Parkes & Heslop, 2013). Clearly, interventions to reduce corporal punishment will only be effective if they provide teachers instruction in alternative, effective methods.

Similar interventions have been tried elsewhere in the world, although many have yet to be rigorously evaluated. For example, the organization Plan International initiated its Learn Without Fear campaign in 2008 to promote legal bans on corporal punishment in schools and protect children from all forms of violence in school. It trained over 50,000 teachers in non-violent disciplinary methods and worked with teachers' unions in 20 countries; it also engaged in awareness raising activities through a variety of media that reached over 110 million people (Global Advocacy Team, Plan International, 2012). The organization touts as success the fact that several countries they worked with passed legislation or regulations banning school corporal punishment (Global Advocacy Team, Plan International, 2012), but the impacts on individual children were not assessed.

Conclusion

School corporal punishment is a fact of life for millions of children around the world, despite no evidence that it promotes learning and substantial evidence that it instead is linked with physical harm, mental and behavioral health problems, and impaired achievement. It is encouraging that 128 countries have banned corporal punishment, but there is still much work to be done to educate teachers about alternatives to corporal punishment so that they completely abandon its use in schools. Legislative reform, advocacy, and education are

each needed to ensure that school corporal punishment is abandoned once and for all and that children can attend school without fear of violence at the hands of school personnel.

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Bullying in schools: the state of knowledge and effective interventions

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ABSTRACT

During the school years, bullying is one of the most common expressions of violence in the peer context. Research on bullying started more than forty years ago, when the phenomenon was defined as 'aggressive, intentional acts carried out by a group or an individual repeatedly and over time against a victim who cannot easily defend him- or herself'. Three criteria are relevant in order to define aggressive behaviour as bullying: (1) repetition, (2) intentionality and (3) an imbalance of power. Given these characteristics, bullying is often defined as systematic abuse of power by peers. It is recognised globally as a complex and serious problem. In the present paper, we discuss the prevalence, age and gender differences, and various types of bullying, as well as why it happens and how long it lasts, starting from the large surveys carried out in western countries and to a lower extent in low- and middle-income countries. The prevalence rates vary widely across studies; therefore, specific attention will be devoted to the definition, time reference period and frequency criterion. We will also focus on risk factors as well as short- and long-term outcomes of bullying and victimisation. Finally, a section will be dedicated to review what is known about effective prevention of bullying.

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Bullying; violence in school; children; adolescents; antibullying intervention

Violence has been recognised as a relevant and serious problem by several international agencies. In 1996, the World Health Assembly adopted a resolution declaring violence a leading worldwide public health problem (WHA 49.25) and called upon Member States to give urgent consideration to the problem of violence. In the school context, peer bullying is the most common form of violence among children and youths. Bullying compromises children's rights, including the right to education as requested by the Convention on the Rights of the Child (The United Nations 1989). It presents special risks for vulnerable children, such as children with disabilities; refugees, or children affected by migration; children who are excluded; children who belong to a minority group, or simply children that differ from the peer group.

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What is bullying?

Research on bullying started more than 40 years ago (Olweus, 1973, 1978) and defined this behaviour as 'aggressive, intentional acts carried out by a group or an individual repeatedly and over time against a victim who cannot easily defend him or herself' (Olweus, 1993, p. 48). Despite some debate over the definition, most researchers agree that bullying involves the intent to harm and an imbalance of power between the aggressor and the victim, and it takes place repeatedly (Farrington, 1993; Olweus, 1993). Bullying involves a dynamic interaction between the perpetrator and the victim. The bully increases in power, and the victim loses power. As a result, it is difficult for the victim to respond or to cope with the problem (Menesini et al. 2012; Swearer & Hymel, 2015). Imbalance of power can be derived from physical strength, social status in the group, or from group size (e.g. a group targeting a single person). Power may also be achieved through knowing a person's vulnerabilities (e.g. appearance, learning problem, family situation, personal characteristics) and using this knowledge to harm him or her.

Bullying comprises verbal attacks (e.g. name calling, threats), physical behaviours (e.g. hitting, kicking, damaging victim's property), and relational/social aggression (e.g. social exclusion, rumour spreading) (Monks & Smith, 2006; Olweus, 1993; Smith, 2014) up to the most recent forms of attacks through Internet and new technologies (also referred to as cyberbullying).

Prevalence

There is a wide variation in prevalence rates of bullying across studies, partially due to differences in measurement and/or operationalisation of the bullying construct. Such inconsistencies have strongly influenced rate estimation, and scholars have called for greater consensus in definition and measurement (Menesini & Nocentini, 2009).

In a recent review, Juvonen and Graham (2014) report that approximately 20–25% of youth are directly involved in bullying as perpetrators, victims, or both. Large-scale studies conducted in Western countries suggest that 4–9% of youths frequently engage in bullying behaviours and that 9–25% of school-age children are bullied. A smaller subgroup of youth who both bully and are bullied (bully/victims) has also been identified. In a recent meta-analysis on bullying and cyberbullying prevalence across contexts (Modecki et al., 2014) with an overall sample of 335,519 youth (12–18 years), the authors estimated a mean prevalence of 35% for traditional bullying (both perpetration and victimisation roles) and 15% for cyberbullying involvement.

Contextual and cultural factors on prevalence estimation

Besides scientific research done in numerous countries, data on prevalence can be derived from large cross-national surveys carried out by NGOs, state governments, or other organisations. Smith, Robinson, and Marchi (2016) used four surveys for a global comparison on bullying and victimisation: EU Kids Online Survey (www.eukidsonline.net), Global School Health Survey (GSHS) (www.who.int/chp/gshs/factsheets/en/index.html), Trends in International Mathematics and Science Study (TIMSS) (http://timssandpirls.bc.edu/timss2011/international-results-mathematics.html) and Health Behaviour in School-aged

Children (HBSC), (http://www.hbsc.org/). They found a very low agreement (from small to zero) in terms of correlations across surveys, raising concerns about using cross-national datasets to make judgements on the rates of bullying and victimisation in different countries. In another contribution, Sittichai and Smith (2015) reviewed studies from 10 ASEAN countries, making use of two sets of comparative data: (1) large-scale surveys (GSHS and TIMSS), and (2) papers reported by research scholars. They came to the conclusion that there are important cultural and linguistic differences between eastern and western countries in terms of who does the bullying (friends in the same class or strangers), where it happens (classroom, playground), and types of bullying (social exclusion, extortion). In addition, definitions of bullying-like phenomena show linguistic variation and may be influenced by what is viewed as legitimate from a cultural point of view. Despite these differences, they concluded that bullying-like behaviours are fairly frequent in the 10 countries, showing comparable prevalence rates to those found in western countries (around 10%).

Whereas extensive research has been conducted on bullying and victimisation in Western and Eastern high-income countries, far less research has been done in low- and middle-income countries (Zych, Ortega, & Del Rey, 2015).

Results from Latin America show a high prevalence of bullying, with 40–50% of teens in Peru and Colombia reporting that they bully others (Oliveros, Figueroa, & Mayorga, 2009). A recent study from Lister et al. (2015) on victimisation among Peruvian adolescents provided data from an ongoing prospective study involving a cohort of 12,000 children (the Young Lives – YL). Being bullied showed figures of 47.3% at the age of 8; of 30.4% at the age of 12, and of 21.9% at the age of 15. Two studies from Nicaragua showed the involvement of 35% of secondary school students, 124% as victims, 109% as bullies and 117% as bully-victims (Del Rey & Ortega, 2008).

As for Africa, Greeff and Grobler (2008) found a percentage of 564% of South African students reporting to be bullied. Another recent study was carried out in Algeria involving a sample of 1452 school children aged 8, 10 and 12 years (Tiliouine, 2015). The findings showed a level of involvement of approximately 25–35%, including direct and indirect forms of bullying.

Age and gender differences

Several studies suggest that the prevalence and forms of bullying are different across age groups, even though the findings are not straightforward. In a meta-analysis of 153 studies, Cook, Williams, Guerra, Kim and Sadek (2010) found that the effect size of age was 0.09 on bully role, 0.01 on bully/victim role; and –0.01 on victim role, indicating an overall stability of victim and bully-victim roles over time and a slight increase of bullying behaviour with age. Bullying peaks during middle school years (i.e. 12–15 years), and tends to decrease by the end of high school (Hymel & Swearer, 2015). With respect to the forms of bullying, with increasing age there appears to be a shift from physical bullying to indirect and relational bullying (Rivers & Smith, 1994).

It is commonly reported that boys are more likely to be involved in bullying others than are girls (HBSC survey; Pepler, Jiang, Craig, & Connolly, 2008), although some studies have found little difference. In their meta-analysis of 153 studies, Cook et al. (2010) found a correlation of gender (boys) with the bully role of .18, with the bully/victim role of .10, and with the victim role of .06, indicating a higher prevalence of boys for all three roles (although the gender difference for the victim role is not large). Most studies found that

boys are more likely to be involved in physical forms of victimisation, while bullying among girls is more likely to be either relational or verbal (Besag, 2006; Crick & Grotpeter, 1995).

Prejudice-related bullying

Recent reviews have called for more studies on discriminative, or so-called prejudice-related bullying (Juvonen & Graham, 2014). The risk for bullying and victimization is not equal across student groups; a number of studies indicate that students with disabilities or suffering from obesity, or the ones belonging to ethnic or sexual minorities, are at greater risk for being victimised than their peers. Farmer et al. (2012) found that female students who received special education services were 3.9 times more likely to be victims and 4.8 times more likely to be bully-victims than their peers without disabilities. Similar results were also found in USA by Blake, Lund, Zhou, and Benz (2012).

To address the role of ethnicity in different contexts, one study examined sixth-grade students' experiences of vulnerability at school, defined as perceived victimisation, feeling unsafe and feeling lonely. The students were from 99 classrooms in 10 middle schools that varied with respect to ethnic diversity (Juvonen, Nishina, & Graham, 2006). Greater ethnic diversity was related to a lower sense of vulnerability among different ethnic groups. The authors argued that power relations may be more balanced in ethnically diverse schools with multiple ethnic groups. A recent meta-analysis of Vitoroulis and Vaillancourt (2015) focused on ethnic group differences in peer victimisation and suggested that ethnic minority status alone was not strongly associated with a higher level of peer victimisation. Thus, although ethnic minority status poses a risk for victimisation, its effect seems to depend on the context.

Many studies on the incidence of homophobic bullying are limited to single-item measures of sexual minority status, and do not measure dimensions of sexual orientation (i.e. identity as well as behaviour). In addition, even in large population-based samples, the prevalence of sexual minorities is quite low, and often different types of sexual identities and preferences are combined into a single category for statistical analyses. Despite these limitations, some data are impressive; for example, a survey run by LGBT associations involving more than 7000 students, aged 13 to 21 years, showed that nearly 9 out of 10 LGBT students experience harassment at school (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). In addition, homophobic teasing or name-calling is a commonly reported experience, particularly by students who identify themselves as gay, lesbian, bisexual, or transgender, among these students 50–80% have experienced it (Espelage, Hong, Rao, & Thornberg, 2015; Russell, Toomey, Ryan, & Diaz, 2014). In conclusion, the problem of prejudice-related bullying appears highly relevant, affecting minority groups seriously.

Risk factors

Individual-level risk factors for bullying and victimisation

Bullies

In his seminal work, Olweus (1978, p. 136) described the 'aggressive personality pattern' of bullies as a driving force behind their mean behaviour. As bullying is a form of aggressive behaviour, it is not surprising that an individual's general tendency to aggress (trait

aggression) is associated with bullying. Having attitudes and cognitions that favour aggression and low levels of empathy towards other people are associated with both general aggression and bullying (e.g. Van Noorden, Bukowski, Haselager, & Cillessen, 2016).

Some theoretical accounts view bullies as individuals who lack social skills, have a low self-esteem, deficiencies in social information processing, low social standing in the peer group, and other adjustment problems. Others view bullying as functional, adaptive behaviour associated with benefits. Empirical studies have not always succeeded in clarifying this issue, partly due to the failure to acknowledge the heterogeneity of children and adolescents engaging in bullying. Some of them are victimised themselves (so-called bully-victims) whereas others can be considered 'pure' (non-victimised) bullies. Bully-victims are typically highly maladjusted in comparison to pure bullies. To keep this distinction clear, we discuss bullies, victims and bully-victims separately.

There used to be a rather common belief that low self-esteem leads to aggression, including bullying. Although negative self-related cognitions are (weakly) related to bullying, they do not predict a greater likelihood of being a pure, non-victimised bully (Cook et al., 2010). There is little support for the aggression – low self-esteem hypothesis in general (Baumeister, Bushman, & Campbell, 2000). Instead, recent evidence suggests that narcissism, or a sense of grandiosity and entitlement, as well as callous-emotional traits (characterised by lack of empathy and shame) are associated with bullying (Fanti & Kimonis, 2012; Reijntjes et al., 2016).

The belief that bullies are socially incompetent was challenged by Sutton, Smith, and Swettenham (1999), who found that 7–10-year-old bullies scored relatively high in tasks designed to assess understanding of others' cognitions and emotions. Accordingly, Peeters, Cillessen, and Scholte (2010) identified three subtypes of bullies, a popular-socially intelligent group, a popular moderate group, and an unpopular-less socially intelligent group; the study underlines the heterogeneity of children and adolescents involved in bullying. Overall, there is a need to understand better the heterogeneity of students bullying their peers and their differing motivations to do so (Rodkin, Espelage, & Hanish, 2015).

Research guided by the social cognitive framework has found that bullies are characterised by thought processes that support the use of aggression. Bullies feel confident about using aggression, expect positive outcomes for aggression (e.g. peer approval), view aggression as an accepted way of behaving, and have an overall positive view on the use of aggression (Toblin, Schwartz, Gorman, & Abou-ezzeddine, 2005). A recent meta-analysis (Gini, Pozzoli, & Hymel, 2014) provides empirical evidence of bullies using several moral disengagement mechanisms to self-justify their negative behaviour.

Whether such tendencies should be regarded as deficiencies or merely as differences in social-cognitive processing styles, has been debated in the literature. Traditionally, social competence has been seen as a behaviour that is socially accepted and associated with being liked by others. However, it can be also defined as an ability to be successful at achieving one's goals. According to the latter view, children who successfully achieve their goals, either by using prosocial or coercive strategies, could be seen as socially competent. Some studies suggest that many (pure) bullies are so-called bistrategic controllers, who use both prosocial and coercive strategies to get what they want (Olthof & Goossens, 2008; Olthof, Goossens, Vermande, Aleva, & Van der Meulen, 2011; Rodkin et al., 2015).

Bullies value dominance (Olthof et al., 2011; Sijtsema, Veenstra, Lindenberg, & Salmivalli, 2009) and they often acquire it (Olthof et al., 2011; Pellegrini & Long, 2002). Even if they are

not necessarily personally liked by many classmates, bullies may be perceived as popular, powerful, and 'cool' among their peers (Caravita, DiBlasio, & Salmivalli, 2009; Reijntjes et al., 2016). Moreover, bullies are often central members of their peer networks and have friends. Adolescent bullies like others who engage in similar behaviours (Sentse, Kiuru, Veenstra, & Salmivalli, 2014), and affiliate with them and can thereby provide reinforcement for each other's coercive behaviour.

Regarding family influence, bullies tend to perceive their parents as authoritarian, punitive and unsupportive (Baldry & Farrington, 2000), and they report less family cohesiveness than other children (Smith, 2014). In a meta-analysis by Cook et al. (2010) family factors were, on average, only weakly related to bullying; however, several family factors such as parental conflict, monitoring and family SES were examined together rather than separately.

Victims of bullying

Victimisation is associated with a number of internalising problems such as depression, anxiety and low self-esteem (Cook et al., 2010; Hawker & Boulton, 2000). Victimisation is also related to numerous interpersonal difficulties such as peer rejection, low peer acceptance, having few or no friends, and negative friendship quality (Cook et al., 2010; Hawker & Boulton, 2000). Also, children with externalising problems and low levels of prosocial behaviour are more likely to be victimised (Card, 2003; see the section on bully-victims). Children with internalising (or externalising) problems are more likely to become victimised if they also face interpersonal difficulties (Hodges, Boivin, Vitaro, & Bukowski, 1999; Hodges & Perry, 1999).

Many risk factors for being bullied can be understood in the light of the bullies' characteristics and goals: children who are unassertive and insecure can elicit aggression-encouraging cognitions in potential bullies. Such characteristics may also make a child a suitable target for someone aiming at status enhancement. By choosing victims who are submissive, insecure about themselves (Salmivalli & Isaacs, 2005), physically weak (Hodges & Perry, 1999), and rejected by the peer group (Hodges & Perry, 1999), bullies can signal their power to the rest of the group without having to be afraid of confrontation or losing affection of other peers (Veenstra, Lindenberg, Munniksma, & Dijkstra, 2010).

Having protective friends moderates the association between risk factors and victimisation. Thus, children who are shy and anxious have a higher probability of being victimised if they have friends who are physically weak and/or disliked by other peers, as compared to the children who have friends and who are strong and/or liked by others (Hodges, Malone, & Perry, 1997). Yet, although victimised children can benefit from having friends who are strong and who can protect them from bullies, in reality, victimised children tend to hang out with other victimised peers (Sentse, Dijkstra, Salmivalli, & Cillessen, 2013).

Many children who are victimised by peers are also victimised in other contexts, including their home (poly-victimisation, see Finkelhor, Ormrod, & Turner, 2007). In contrast, some studies have found that victims view their home environment as rather positive, but also overprotective. A meta-analysis by Lereya, Samara, and Wolke (2013) found support for both overprotection and abuse/neglect in the family: the former was more strongly related to being a pure victim, whereas the latter was more strongly associated with the bully-victim status.

Bully-victims: a distinct group

Bully-victims are a distinct, albeit a rather small group of children and adolescents. They are highly rejected by their peers and show both externalising and internalising problems. They often come from the most adverse home environments, characterised by maltreatment and neglectful parenting (Cook et al., 2010; Lereya et al., 2013). Bully-victims score high on reactive aggression (besides scoring high on proactive aggression). They also show a different socio-cognitive profile compared to pure bullies (e.g. Toblin et al., 2005).

Classroom-level risk factors

Classrooms of students, as well as whole schools, vary in rates of bullying. As variation between different classrooms is much larger than variation between schools, we focus on the former. Classroom-level risk factors may be sought from demographic factors (such as class size), peer group dynamics, or teacher characteristics.

Demographic factors do not seem to explain classroom-level differences in bullying well. For instance, there is no clear evidence of class size being related to the prevalence of bullies or victims in the class. When an association has been found, it has often been contrary to the common expectation: more bullying has been found in smaller rather than in bigger classrooms. Several other demographic candidates have failed to explain differences between classrooms as well (e.g. the proportion of boys in a classroom, the proportion of immigrants in a classroom), or the findings have been controversial. Classroom differences can be better explained by factors related to peer group dynamics or teacher characteristics (for a review, see Saarento, Boulton, & Salmivalli, 2015).

Classroom hierarchy is associated with bullying behaviour: there is more bullying in highly hierarchical classrooms, where peer status (such as popularity) or power (who typically decides about things) are centred upon few individuals rather than being evenly distributed. In a recent study (Garandeau, Lee, & Salmivalli, 2014), it was found that classroom hierarchy leads to an increase in bullying over time, rather than bullying leading to increased hierarchy. A non-hierarchical classroom, on the other hand, is not a favourable environment for bullying to flourish.

Furthermore, classroom norms explain why students in some classrooms are more likely to be involved in bullying. Probullying norms can be reflected in low levels of antibullying attitudes, in positive expectations regarding the social outcomes of probullying actions and negative expectations of the social outcomes of provictim actions – each of these factors is associated with students' higher risk of bullying involvement in a classroom (Nocentini, Menesini, & Salmivalli, 2013). Classroom norms can also be reflected in the behaviours of students when witnessing the acts of bullying. As the reactions of peers in bullying situations provide direct feedback to the bullies, they have important implications for the emergence and maintenance of bullying. The frequency of bullying perpetration is indeed higher in classrooms where reinforcing the bullies' behaviour is common and defending the victimised classmates is rare, implying that bullying is socially rewarded (Salmivalli, Voeten, & Poskiparta, 2011).

From the point of view of students at risk for becoming the targets of bullying, recent research has shown that the association between individual risk factors (such as social anxiety and peer rejection) and victimisation varies across classrooms, suggesting that individual vulnerabilities are more likely to lead to victimisation when the classroom context allows that to happen. The likelihood that vulnerable children become the targets of bullying is

exacerbated in classrooms characterised by high levels of reinforcement of the bully and low levels of defence of the victim (Kärnä, Voeten, Poskiparta, & Salmivalli, 2010) by the peer bystanders.

Finally, students' perceptions regarding teacher attitudes towards bullying are associated with the level of bullying problems in a classroom. A study examining the mediators of the KiVa antibullying programme (Saarento et al., 2015) found that changes in student perceptions of their teachers' bullying-related attitudes mediated the effects of the programme on bullying. During the year when the KiVa programme was implemented, students started to perceive their teachers' attitudes as more disapproving of bullying, and consequently, their bullying behaviour was reduced. This is strong evidence for the importance of teachers communicating their disapproval of bullying to students.

Health consequences for bullying

Bullying brings negative health consequences for both bullies and victims, and it can have a negative impact on the bystanders as well (Wolke & Lereya, 2015). Several longitudinal studies from different countries, along with systematic reviews and meta-analyses, have demonstrated the relationship between school bullying or the experience of being victimised and later health outcomes. These associations hold even when controlling for other childhood risk factors (Arseneault, Bowes, & Shakoor, 2010).

In the past three decades, a significant effort has been put forth by researchers analysing the effects of bullying and victimization on physical, psychological, relational and general wellbeing. The main results show that adolescents who are bullied miss more school and show signs of poor school achievement (Nakamoto & Schwartz, 2009), report higher loneliness and poorer health (Fekkes, Pijpers, Fredriks, Vogels, & Verloove-Vanhorick, 2006), and greater levels of anxiety and depression than their non-victimised peers (Juvonen & Graham, 2014). These negative outcomes are also related to the severity of the victimisation experience. Van der Plog, Steglich, Salmivalli, and Veenstra (2015) found that victims of frequent and multiple victimisation, and victims who were victimised by several bullies, suffered more than those whose experiences were less frequent or perpetrated by fewer peers. Reijntjes, Kamphuis, Prinzie, and Telch (2010) analysed the role of internalising problems and their relationship to bullying. They concluded that such problems appear to be both antecedents and consequences of peer victimisation, constituting a 'vicious cycle' that contributes to the elevated stability of peer victimisation. Studies have also linked victimisation to suicidal ideation (Holt et al., 2015; Klomek, Sourander, & Elonheimo, 2015). As Arseneault et al. (2010) underscored in their review, being bullied is associated, in the short-term, with severe symptoms of mental health problems and, furthermore, has long-lasting effects that can persist until late adolescence. McDougall and Vaillancourt (2015) in recent systematic review underscored the necessity to use a complex and multifactorial model to understand direct and indirect links connecting peer victimisation experiences and later adult outcomes. Finally, Wolke and Lereya (2015), reviewing studies of genetically identical monozygotic twins who lived in the same households but were discordant for experiences of bullying, confirmed the dramatic consequences of being a victim of bullying over and above other personal and contextual factors.

Active bullying has also relevant impact on individual life. In a meta-analysis of 28 longitudinal studies, Ttofi, Farrington, Lösel, and Loeber (2011b) concluded that bullying

perpetration is a strong and a specific risk factor for later criminal offending and psychotic symptoms. Klomek et al. (2015) confirmed this pattern and proposed a dose effect, in which more frequent bullying involvement in childhood is more strongly associated with adult adversities. The same authors concluded that bullying perpetration is followed by an increased risk of delinquency whereas victimisation is followed by an increased risk of depression.

Bully-victims, victims and bullies had a significantly higher risk for psychosomatic problems than non-involved age-mates (Gini & Pozzoli, 2015), and victimisation is a major childhood risk factor that uniquely contributes to later depression, even controlling for many other major childhood risks (Ttofi, Farrington, Lösel, & Loeber, 2011a).

The authors of the studies cited above brought up the importance of carrying out effective anti-bullying programmes that would have a high benefit-cost ratio in terms of preventing early crime, suicide, internalising symptoms and other psychological problems. Many authors proposed that such interventions should be viewed as a form of early intervention for public health.

Effective interventions

The amount of research on antibullying interventions is significant, with numerous scientifically evaluated school-based programmes. In their meta-analysis, Farrington and Ttofi (2009) concluded that such programmes are often effective, reaching an average decrease of 20–23% for bullying others and of 17–20% for being bullied. However, the effects vary considerably across programmes; they are also weaker when programmes are evaluated with more stringent designs, such as randomised controlled trials (Langford et al., 2015; Ttofi & Farrington, 2011). It should be noted that some programmes do *not* lead to positive outcomes, some have never been evaluated, and some have been evaluated so poorly that no conclusions can be drawn regarding their effects. Evans and colleagues (Evans, Fraser, & Cotter, 2014) reported that up to 45% of the studies showed no programme effects on bullying perpetration and about 30% showed no programme effects on victimisation. Which programmes work best, or what are the effective ingredients of these programmes, are urgent questions.

Whole-school programmes are often complex, consisting of various components targeted at different levels of influence (individual students, parents, classrooms, whole schools) and including a variety of methods. The different components are typically evaluated in combination, rather than separately. Consequently, the contribution of each individual component to the overall effects of a given programme is unknown. It is possible that a programme reaches the best effects when all components are used together, but it is also conceivable that some components are responsible for the good outcomes whereas some others contribute little, or nothing to the effects. From the public health perspective, it is necessary to assess interventions in terms of their cost-effectiveness.

The effective ingredients of bullying prevention programmes were investigated by Ttofi and Farrington (2011). Their conclusion, based on between-programmes evaluation, was that the intensity (such as number of hours) and duration (number of days/months) of programmes is related to their effectiveness. This suggests that programmes need to be long-lasting and intensive in order to have the desired effects. The authors identified two additional

elements that were related to programme effectiveness, namely parent training/parent meetings, and disciplinary methods (referring to sanctions within a warm framework).

The mobilisation of bystanders, or the silence of the majority witnessing bullying, are key to success. Research has demonstrated that peer witnesses' responses are crucial to inhibit or fuel bullying. Further, some of the highly effective programmes, such as the KiVa antibullying programme developed in Finland, rely on enhancing bystanders' awareness, empathy and self-efficacy to support victimised peers, instead of reinforcing the bullies' behaviour (Kärnä et al., 2011). Although the inclusion of the element 'work with peers' was not found to strengthen the effects of antibullying programmes in the analysis by Ttofi and Farrington (2011), in their coding work with peers it was defined as 'formal engagement of peers in tackling bullying' (including the utilisation of formally assigned peer mediators, or peer supporters), rather than awareness-raising about the role of *all* peers and formulation of rules for bystander intervention in classrooms. On a theoretical as well as empirical basis, the latter type of approach is highly recommended (Salmivalli, 2010). Formal peer helpers intervening in bullying has, based on current evidence, little effect on ongoing bullying. It should be noted, however, that assigning peers as *educators* (involving them in awareness-raising) has been found effective in reducing bullying among adolescents (NoTrap! intervention, see Palladino, Nocentini, & Menesini, 2015).

There is variation between schools and between individual teachers in how they implement prevention programmes. Even programmes that were designed to be intensive can be implemented more or less intensively, depending on the resources and commitment in the schools. Also, teachers might adapt the programmes and change some critical parts; in other words, they can decide not to implement the programme as it was designed to be implemented. There is evidence that better implementation fidelity is associated with better outcomes (such as greater reductions in students' experiences of being bullied, see Haataja, Boulton, Voeten, & Salmivalli, 2014).

In summary, whole-school programmes to prevent bullying are often successful. Their effects vary, however; some programmes show consistent positive effects whereas others have little or no evidence of effectiveness. What explains the divergent effects? Programmes should be intensive and long-lasting, and they should be implemented with fidelity. Involving parents seems to strengthen the effects, as well as the use of disciplinary practices with bullies. Raising awareness among students about the role of the whole group has an impact on maintaining bullying, and enhancing antibullying norms and responses within classrooms is crucial. It is also highly important that teachers clearly communicate their antibullying attitudes to students.

In several countries, it is legally required that schools have an anti-bullying policy. This obligation is desirable, but it should be remembered that having *any kind of policy* in place might not be enough; interventions that have been found to be effective through rigorous evaluations should be utilised. Schools should be provided with guidance regarding most effective practices and programmes. We agree with the suggestion by Farrington and Ttofi (2009) that a system of accrediting effective anti-bullying programmes should be developed in order to ensure that programmes adopted by schools contain elements that have been proved to be effective in high-quality evaluations.

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Violence and alternative care: a rapid review of the evidence

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ABSTRACT

This paper focuses on the mechanisms through which international policy and practice relating to the safeguarding of children and young people living in alternative care is being implemented in national policy and practice. It is based on a rapid review of the evidence regarding the violence experienced by children and young people living in different forms of alternative care internationally. The evidence base indicates that children living in alternative care are especially vulnerable to violence and abuse, prior to and during their care experience and also in the longer term. The introduction of the UN Guidelines for the Alternative Care of Children has encouraged greater attention to this issue. The paper concludes that progress is variable according to a range of political, economic and social factors, and that greater attention to practice at national and community levels is required if more effective safeguarding practice is required. A more sophisticated evidence base is required to support this.

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Introduction

The numbers of children and young people living in different forms of alternative care throughout the world are impossible to estimate with accuracy; between two and eight million children live in some form of institutional or residential care, and as many or more again will live in family based care (Pinheiro, 2006; United Nations, 2014; United States Government, 2012). It has been widely recognised in international legislation and policy that different forms of violence are experienced disproportionately by children and young people living in alternative care, and that strong measures are required to ensure their protection and welfare.

This paper has emerged from a rapid review of the evidence relating to violence experienced by children and young people living in different types of alternative care internationally. It is based on a rapid review of the literature undertaken as part of the *Know Violence in Childhood* initiative, in partnership with the Better Care Network (www.bettercarenetwork.org). The review aimed to examine seven questions relating to children and young people's experience of violence. These covered three areas: progress in implementing the United Nations Guidelines for the Alternative Care of Children in terms of the provision of safe

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and high quality alternative care; evidence relating to the relationship between experience of alternative care and experience of violence, both pre-entry and during the experience of alternative care; and evidence relating to the rebalancing of alternative care, including the development of more family-based options.

This paper will focus on the first of these areas, namely the distance travelled in the implementation of the UN Guidelines for the Alternative Care of Children, and the challenges and opportunities associated with this. Conceptually, this is linked to questions about the drivers for policy and practice change in relation to alternative care, and the conditions and resources necessary to trigger such change. Methodologically it raises questions regarding the value of addressing these questions in an international context, and the implications for further development of the evidence base.

It begins with a brief description of the methodology that informed the overall review. It then considers the broad research findings relating to violence experienced by children and young people living in different types of alternative care, and the international policy framework. The discussion then focuses on the question of how this international framework can be translated into action at the level of individual nation states.

Review methods

Rapid reviews of the literature can be distinguished from systematic and scoping reviews by dint of their policy or practice focus, and their emphasis on provide an overview of the topic, often within a short timescale (see, for example, Academy Health, 2015; Gannan, Gliska and Thomas, 2010; National Foundation for Educational Research, 2011; Polisena et al., 2015). The questions that inform rapid reviews can take many different forms, and tend to relate to problems, options or issues relating to implementation, rather than the impact of a single intervention, and can involve a range of different types of evidence.

The flexible nature of rapid reviews also makes them methodologically problematic, in that they can suffer from problems of definition and the diversity of methodologies applied (Academy Health, 2015; Gannan, Gliska and Thomas, 2010). Unlike systematic reviews, they tend not to involve the weighting of different forms of evidence, which can generate bias. These advantages and disadvantages are significant in the context of alternative care, where information generated by NGOs and governments are often as relevant as peer-reviewed research, but where more emphasis may be given to the policy relevance of findings, rather than methodological transparency. Rapid reviews may therefore be best seen as an interim measure, providing 'best available' evidence but by no means replacing more comprehensive and robust review methodologies.

Inclusion and exclusion criteria were applied in relation to date of publication, type of publication, language and scope. Conceptually, the research questions for this review are wide-ranging, and search terms were therefore identified according to individual questions, rather than for the review overall. There has been some disciplinary bias towards social care and social work sources. This is notable in that other disciplinary perspectives – for example, in economics, development studies and anthropology –are equally important in understanding the landscape of alternative care internationally, and this has not been fully exploited. The search process took account of the wide range of language used to describe different forms of alternative care. Violence was provisionally defined for the purposes of searching in accordance with the UN Guidelines on Alternative Care and the United

Nation's Committee on the Rights of the Child General Comment No. 13 (2011; see also United Nations, 2014).

Peer reviewed literature was searched using bibliographic databases including the University of Bedfordshire's Discover; SocIndex; ASSIA; Google; Googlescholar and key research repositories. The search also benefited from two existing databases previously undertaken by the International Centre and with relevant content, though both required updating (Shaw et al., 2010 regarding private foster care; SOS International & the University of Bedfordshire, 2014 regarding violence alternative care). Additionally, reference harvesting provided further material and a small number of key journals were hand searched.

Violence and alternative care

There are well-established methodological difficulties associated with understanding the nature and scale of violence experienced by children and young people living in alternative care. These include a lack of official data collected by states; the associated dependence on data provided by NG0s, which may be of variable quality or methodological transparency; and significant problems of definition (Bronsard et al., 2011; Mann, Lang, Delap, & Cornell, 2012; Meinck, Cluver, Boyes, & Ndhluvu, 2013; Ohara & Matsuura, 2016; Thoburn, 2007). These problems make it difficult to establish how many children live in alternative care, and in which kind of settings, quite apart from exploration of the quality of their care or outcomes from this.

In the present review there are definitional problems associated with both alternative care and violence. The literature demonstrates clearly the multitude of definitions that have been and are attached to different forms of alternative care (McLean, Price-Robertson, & Robinson, 2011) andto what constitutes a child living in alternative care, especially in relation to extended family or kinship care. The definitional issues are equally problematic in relation to violence (Haarr, 2011), Further work is needed to develop to develop tools for measuring the nature and prevalence of different forms of abuse (Stoltenborg, van IJzendoorn, Euser, & Bakermans-Kronenberg, 2011) and there is a lack of replication across research studies. There are a number of issues that help explain this: not all types of violence are recognised in all countries; some definitions of violence may subsume violence against children within other categories, such as domestic violence; some measures may concentrate on referred cases of maltreatment while others on substantiated cases; in some countries reporting of maltreatment is mandatory while in others this is not the case. Violence is also a matter of intrinsic shame and fear, with the result that it may be difficult or impossible to research aspects of the problem, and sophisticated methods are used by care providers to hide the extent of violence, particularly sexual violence against children (Gilbert, Parton and Skivenes, 2011).

The evidence is strong that large numbers of children throughout the world, whether or not living in alternative care, experience high levels of all types of violence (Pinheiro, 2006; UN, 2014). In turn these experiences of violence have been linked to a range of negative outcomes for children and young people. Equally, many of these outcomes are associated with experience of alternative care, and include child mortality and morbidity, physical, emotional and mental health problems, low educational achievement, involvement with the criminal justice system and difficult transitions to adulthood (Gilbert et al., 2009). The overlap between vulnerability and violence is also reflected in studies of other groups – for

example, children living on the street (for example, Meinck et al., 2013; Walakira, Nyanzi, Lisham, & BAizerman, 2014; Wlodarczyk & Makaruk, 2013), children living with HIV/AIDS (Thurman & Kidman, 2011) and children experiencing domestic violence (Haarr, 2011). Children who are disabled are also more likely to experience harsh discipline and violence at home (Hendricks et al., 2014).

The literature also emphasises the need to recognise 'polyvictimisation', or multiple experiences of violence in different contexts, including the home, peer group, and school as well as different forms of alternative care (Finkelhor et al., 2013). For example, a Polish survey of children and young people's experience of violence found that 71% of children and teenagers had experienced one form of violence, while one in ten had experienced six or more forms of victimisation (Wlodarczyk and Makamuk, 2013). Awareness and recognition of overlapping and multiple experiences of violence is important in identifying risk and intervening to prevent violence. For example, experience of domestic abuse carries with it many of the same risk factors as other forms of childhood abuse, will often take place within the same household, and is often legitimated by the same social norms (see, for example, Guedes and Colombini, 2016; Haarr, 2011). The pattern of violence will vary according to geographic and cultural context, but overall the striking feature of the evidence is the range and levels of different forms of violence reported by children (see, for example, Pinheiro, 2006; Ruiz-Casares et al., 2013).

An important question has been the extent to which different placement types affect the extent to which different types of violence are likely to be known to be present. There is extensive evidence of abuse in large-scale institutions, usually defined as establishments caring for more than 10 children (Canadian Law Commission, 2000; Colton, 2002; Government of Ireland, 2009; Mathews, Rosenthal, Ahern, & Kurylo, 2015; Senate Community Affairs References Committee, 2004). This evidence has emerged both through historical enquiries illustrating the abuse of power by institutions such as the Roman Catholic Church (Death, 2015) and a significant body of evidence emerging from regions such as Eastern Europe where large institutions continue to play a significant role. A Romanian study found that 38% of 7 to 18-year-olds in residential care reported severe punishments or beatings (see also Popescu, 2016). A report for the Committee on the Rights of the Child in Kyrgyzstan found that children living in institutional settings were beaten, forced to do physical exercise and deprived of sleep (Utesheva, Votslava, & Medetov, 2013). Violence is not confined to institutional care. Violence in formal family foster care is under-researched, but where information exists it is clear that there is also evidence of different types of violence and abuse (Euser et al., 2013). Research relating to extended-family care indicates significant levels of violence and abuse (see, for example, Kulyuni, Alhassan, Tollend, Weld, & Hanna, 2009; Shibuya & Taylor, 2013).

However, the evidence does not suggest that violence is inevitable in alternative care settings, and indeed, there is considerable evidence – albeit not from a sufficiently wide range of cultural and national contexts – that care can be provided in a way that protects children and promotes their welfare (Connolly et al., 2013; Forrester, 2008; Morgan, 2010; Rahilly & Hendry, 2014). Studies asking older children and adolescents for their views have also found that while children continue to miss their birth families and struggle with the impact of separation, they value the safety of the foster care environment (Ahmed, Windsor, & Scott, 2015; Johnson, Yoken and Voss, 1995; McSherry, Malet, & Weatherall, 2013). Rather, the specific vulnerabilities associated with alternative care settings should

be considered, firstly, in terms of the wider socio-political and cultural context, including war and conflict and disease, and cultural beliefs regarding different forms of violence. Secondly, there is the question of the alternative care economy, which includes the history of alternative care, the relative role of the state in providing and regulating alternative care, and the mix of placements available.

The international framework

The Guidelines for the Alternative Care of Children were introduced in 2009 in response to this kind of evidence. The Guidelines are underpinned by the United Nations Convention on the Rights of the Child (1989). This asserts a view of children as individuals bearing rights regardless of context, including their right to safety, welfare and to be listened to. More specifically, Article 20 states that a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State. States should ensure that alternative care for children in these situations should be provided, and this could include any of a range of options, including foster placement, kafala in accordance with Islamic law, adoption or placement in an institution suitable for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

States therefore have a fundamental role in implementing children's rights in all aspects of legislation, policy and practice, and this should be reflected in support and services to all children who require alternative care (CELCIS, 2012). This should include the establishment of independent bodies such as children's ombudsmen or commissioners to monitor children's rights; the promotion of children's rights through the media and other awareness campaigns; consideration that the rights of all children are upheld regardless of status or circumstances, including poverty, ethnicity, religion, sex, mental and physical disability, HIV/AIDS or other serious illnesses whether physical or mental, birth outside of marriage and socioeconomic stigma. For children in alternative care, this will mean allowing participation in activities that reflect wider social practices.

The development of the guidelines, even before their implementation, served to highlight the evidential gaps associated with the experiences of children living in alternative care. More generally, it takes place in a context where there has been growing interest in the nature of social work and care internationally, and in the challenges and opportunities presented by comparative data.

Attitudes towards what is meant by 'violence' towards children changes over time and at a different rate according to cultural and social context. Thus, the use of corporal punishment may be viewed as a matter of normal 'discipline', or children with disabilities may be subject to treatment that is violent, including different forms of incarceration (Mathews et al., 2015). In some countries certain groups will be discriminated against, with the result that violence against children in these groups is not recognised or is legitimated, for example in regard to Roma children and young people in Bulgaria (D'Arcy & Brodie, 2015; Petrova-Dimitrova, 2005). Equally, there may be powerful social assumptions about who is most vulnerable to violence – girls rather than boys, younger children rather than older, children living in

residential care rather than foster care. This can mean that the violence experienced by some groups – for example, boys' experience of child sexual exploitation – is underestimated.

Distance travelled in the implementation of the guidelines

The search process demonstrated that the Guidelines provided an important backdrop to descriptions of developments and in providing a common international framework for what states were trying to achieve (Milligan, 2012; Muhamedrahimov & Grigorenko, 2015). In a review of progress and guide to future directions, CELCIS (2012) suggests there have been 'big steps' evidenced by a more coherent international policy framework. Arguably the Guidelines have also provided the basis for an international dialogue on the nature of alternative care, and for examination of the extent to which messages regarding good practice are transferable (Berridge, 2016; Kornbeck, 2013).

Regionally and nationally, it is important to note that ratification of international frameworks will co-exist, sometimes uneasily, with other legal systems. The Guidelines are intended to enhance children's rights, and are complementary to the UNCRC. The extent to which states demonstrate a commitment to the UNCRC, for example through the embedding of children's rights in domestic law, is therefore important in evaluating progress in respect to implementation of the Guidelines. This is regularly monitored by the UN. Studies reveal that progress has been made in the development of legal provisions, data collection, and the embedding of the UNCRC in domestic law (Lundy, Kilkelly, Byrne, & Kang, 2012). Some examples of promising developments have been identified within the literature. For example, in relation to the development of legal frameworks, Namibia's Child Care and Protection Act explicitly recognises the role and status of kinship care as an alternative care form (Assim & Sloth-Nielson, 2014). The work undertaken by NGOs in individual countries is important in monitoring progress in these areas.

The UN Guidelines are clear that family based interventions which can help avoid the child's removal from their family should be a priority in state intervention and there is support internationally for family based alternatives to care. At the same time, it is clear that there are counter-drivers, in the form of disease, war, displacement and migration, and poverty. An extensive body of research attests to the way in which HIV/AIDS epidemic has placed existing systems of support via the extended family under stress in Africa (see, for example, Miller, 2007; Wallis, Dukay, & Mellins, 2010; Sherr, 2008).

Gale (2015), in a comparative study of deinstitutionalisation in Bulgaria and Ukraine, argues that differing socio-political contexts have helped – in the case of Bulgaria – or hindered – in the case of Ukraine – progress in implementing successful policy aimed at reducing the number of institutions. She also notes that political change takes time, and the impact of the shadow of history should not be underestimated. In the case of Eastern Europe, the legacy of state paternalism and autocracy continues to exercise considerable influence. The relationship with other institutions is likely to be important – for example, Jurgena and Mikainis (2005; see also Ivanova and Bugdanov, 2013) note the significance of accession to the European Union in generating discussion about family based care in Latvia. In Armenia, and evaluation of the developing family support (VistAAPlus & Mathematica Policy Research, 2015) found that the development of capacity in the child protection system, including professional training and increasing the number of personnel,

were important issues. Relationships between state governments and NGOs will also be important (Rosenbery, Hartwig, & Merson, 2008).

Drivers of change

So, the evidence on violence is discouraging, and it is clear that progress is patchy at best in taking forward policy and practice that support children better with their families, and seek to prevent violence. There are important indicators of the drivers that support change and which indicate that, notwithstanding the methodological difficulties, there is value associated with examining alternative care through a comparative or international lens (see, for example, Kendrick, Steckley, & McPheat, 2008; Thoburn, 2007).

The recognition and awareness of violence as is fundamental to driving change in alternative care and should be prioritised. Underlying this principle is recognition of the relationship between different forms of violence in different social settings, and for all groups of children (Bosnjak, 2009; Pinheiro, 2006; see also Cloward, 2016). This will include an appreciation of levels of violence in the society more generally. There are a number of fora and mechanisms through which such awareness can be generated, including international policy actors (for example, the UN, international NGOs), regional political organisations, historical abuse enquiries, police investigations, parliamentary enquiries, academic reports, national fora in highlighting the issues and the scale of the problem (see, for example, Kendrick, 2014). Wider social interventions will include awareness raising about the nature of abuse, parenting and corporal punishment.

Nevertheless, it will prove difficult to assess children's experiences of violence when living in alternative care without the generation of more general data concerning the child population and their experiences of violence for comparison. Understanding of the characteristics of the population living in alternative care and the levels of abuse and maltreatment experienced prior to care is important in the design of interventions and identification of areas of policy and practice that need to change. This will include information about subgroups of children who are especially vulnerable and those who are marginalised, including children who are disabled, minority ethnic groups, and others who may be discriminated against or stigmatised.

This will require developing a better understanding of the context of children's lives at home, school and in the community. As children have become recognised as individuals who actively create and contribute to their environment, so the richness and complexity of their lives has become apparent. This includes aspects of their lives that are positive and protective, but also those that may be associated with violence or danger for the young person. Some factors, such as the significance of friendships and peers, may involve both benefits and risks (Barter, Renold, Berridge, & Cawson, 2004; Thakkar, Mepukari, Henschel, & Tran, 2015). Research that explores the everyday lives of children and young people can help develop understanding of these issues – for example, a study by young people in Bangladesh which identified interactions with visitors to family homes as something that exposed them to risk of sexual abuse (Aparajeyo Bangladesh & ECPAT International, 2010).

These conceptual issues should not imply a downplaying of the importance of structural developments, specifically the development of systems for the protection of children. This may be linked to the development of other welfare services, including services for pregnant women, ante- and postnatal care, early years care and education, and other health and

education services. Stevens, Connelly, and Milligan (2013) found that even where resources, policy and legislation sympathetic to the development of family based care existed, there may be problems of lack of capacity in the system to establish alternative forms of are.

Adapting the analytical framework for understanding violence in alternative care

The complexity of the issues involved in understanding the scale and nature of violence in alternative care can appear overwhelming. In this context, it is important to consider the different levels at which change occurs, and the significance of more informal processes. A key element of this will be less a focus on an 'international' picture, and greater emphasis on the regional and local. An appreciation of the extent of difference and of alternative care in cultural and historical context is also needed (Kendrick, 2014; Tobis, 2000), such as the legacy of colonialism or communism (Gale, 2015).

This question of the relationship between local cultures and changes to alternative care runs through debates on measures to reduce violence. Cultural barriers, for example in terms of attitudes to discipline and corporal punishment, have also been highlighted (Frankenberg et al., 2010; Hendricks et al., 2014; Lardhi, 2016). Cloward (2016) discusses the question of the tension between international policy and local norms, and the factors that lead to local practices being abandoned. A number of strategies are available to achieve this, including coercion, material incentives and efforts to influence 'community leaders', whose changed behaviour may encourage emulation by the rest of the community. Overall, she suggests, much greater attention needs to be given to the dynamics of local relationships and the mechanisms by which non-state actors absorb international policy messages (p. 10), and the extent to which state bureaucracies have the capacity to communicate new messages. This is highly relevant to the question of violence in the context of alternative care, which also reflects beliefs regarding appropriate discipline and attitudes towards violence. It may also help explain variation in practice within countries. The policy implications of this are not easily deduced in relation to alternative care, but there is little evidence that progress can be made in preventing violence without an appreciation of beliefs about children, family, parenting practices and violence itself. This reflects much thinking in international development more generally; a greater challenge is to translate such thinking into funding and the practice of state governments, international and regional NGOs, and academic research.

Conclusion

This review has both positive and challenging implications in terms of the state of current knowledge regarding the experience of children and young people living in alternative care, though its conclusions should also be viewed as tentative in the light of the limitations of the methodological approach. There is much greater academic interest in this area and this has revealed more about the relationship between history, culture and the political and socio-economic context in shaping children's lives and experiences of violence. This greater visibility of children living in alternative care, and the trajectories of violence that have characterised many of their lives, is positive. There is also evidence of progress in the development of legal and policy structures within nation states that have the potential to protect children and enhance their welfare. There continue to be major barriers resulting

from high levels of child poverty, conflict, displacement and the political relationships between the providers of child care and state governments.

The gaps in evidence have also become apparent within this review. There is a need to identify the mechanisms through which states and NGOs can work together to improve basic data gathering and analysis, both in terms of the population of children living in alternative care and their experiences of violence. This will require the development of research capacity and expertise in different national and regional contexts to meet the needs of policy makers, child welfare services and individual professionals. This should include evaluation of individual programmes or interventions which aim to prevent or mitigate the effects of different types of violence.

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Towards a framework for preventing community violence among youth

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ABSTRACT

This article, in an effort to assist the selection and deployment of evidence-informed strategies, proposes a new conceptual framework for responding to community violence among youth. First, the phenomenon of community violence is understood in context using a new violence typology organized along a continuum. Second, the need for a new anti-community violence framework is established. Third, a framework is developed, blending concepts from the fields of public safety and public health. Fourth, evidence from systematic reviews and meta-analyses concerning community violence is summarized and categorized. Finally, an anti-violence framework populated with evidence-informed strategies is presented and discussed.

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Introduction

In 2012 alone, 95,000 children and young people under the age of 20 were murdered, constituting almost 20% of all homicides (UNICEF, 2014). 90% of these young victims lived in low- and middle-income countries, and especially in Latin America and the Caribbean where the highest homicide rates for children and adolescents are found. Boys are at particular risk for homicide, accounting for 70% of victims less than 20 years of age, particularly during late adolescence (ages 15–19), when 57% of all violent deaths among young victims occur. Violent death at any age is brutal and tragic, but particularly so for children, as their innocence and powerlessness belies personal culpability and heightens our sense of unfulfilled potential and lost opportunity.

This article primarily concerns the violence, particularly lethal violence, which occurs among youth under the age of 20 and in community settings. While young people are the main focus, this content is also relevant for those in young adulthood and beyond. This article draws heavily from a comprehensive study of community violence reduction strategies recently completed by the author and Christopher Winship, the Diker-Tishman Professor of Sociology at Harvard University, "What Works in Reducing Community Violence: A Meta-Review and Field Study for the Northern Triangle" (Abt & Winship, 2016). That study's meta-review synthesized the results of 43 systematic reviews and meta-analyses of

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violence reduction programs, aggregating over 1400 individual programmatic evaluations in order to identify 'what works' in reducing community violence.

Systematic reviews use predetermined methods to identify, select, appraise, and combine the results from individual studies in a clear, unbiased, and systematic manner. Meta-analyses combine quantitative data from individual studies using established statistical techniques. Both are designed to overcome limits to the external validity of individual studies (Killias & Villetaz, 2008). These techniques have grown popular as scholars recognize their usefulness for identifying themes and patterns across large numbers of empirical studies (Makarios & Pratt, 2012), and are being employed with increasing frequency in medicine, education, criminal justice, and other fields (Aos, Miller, & Drake, 2006).

Only causal evidence, i.e. evidence identifying a causal relationship between an intervention and its intended effect, was considered in the underlying report. The same is true here. While an emphasis on rigorous evidence, i.e. causal evidence drawn from high quality experimental or quasi-experimental designs, has advantages in terms of accuracy, reliability, and transparency, there are at least three significant limitations associated with such an approach. First, it is important to remain mindful that public policy cannot be based exclusively on science. Evidence and data should be used to improve public policy decisions, not replace them entirely (Robinson & Abt, 2016), which is why the phrase 'evidence-informed' will be used here instead of the more recognized term 'evidence-based'. Second, the vast majority of rigorous research has been conducted in high-income settings, so conclusions drawn from such studies may be of limited external validity when applied in low- or middle-income settings. Third, focusing on causal evidence creates a bias in favor of the programmatic interventions capable of generating such evidence. Evaluating institutions or systems is a much more complicated exercise where establishing causality may be difficult or even impossible. Nevertheless, a sound understanding of the causal evidence, albeit mostly from high-income counties and programmatic evaluations, can enhance understanding and improve decision-making with regard to community violence prevention.

Community violence, defined and described

The term 'community violence' is best understood in context alongside other forms of violence. While the World Health Organization (WHO) (Krug, Mercy, Dahlberg, & Zwi, 2002), United Nations (UNODC, 2013), and others divide violence into discrete categories, these schemas generally fail to conform to actual violence as witnessed or experienced on the ground. In reality, violence comes in many forms, all containing similarities and dissimilarities, each independent from and dependent on the others. To better capture this complexity and provide meaningful guidance to practitioners in field, violence may be better understood according to a set of six attributes described along an admittedly imperfect continuum.

First, violence varies in its lethality or capacity to cause serious physical injury – a shove versus a fatal shooting. Second, it occurs in different settings – in the privacy of one's home or on a public street. Third, the number of individuals involved may be few, as with a dispute between neighbors, or many, as with conflicts among gangs. Fourth, violence may be as spontaneous as a bar brawl or as methodically planned as an assassination. Fifth, it may be expressive of emotions, including anger, or instrumental in its aim of achieving a particular goal. Sixth and finally, incidents of violence may occur as frequently as domestic disputes or as rarely as formally declared wars between states.

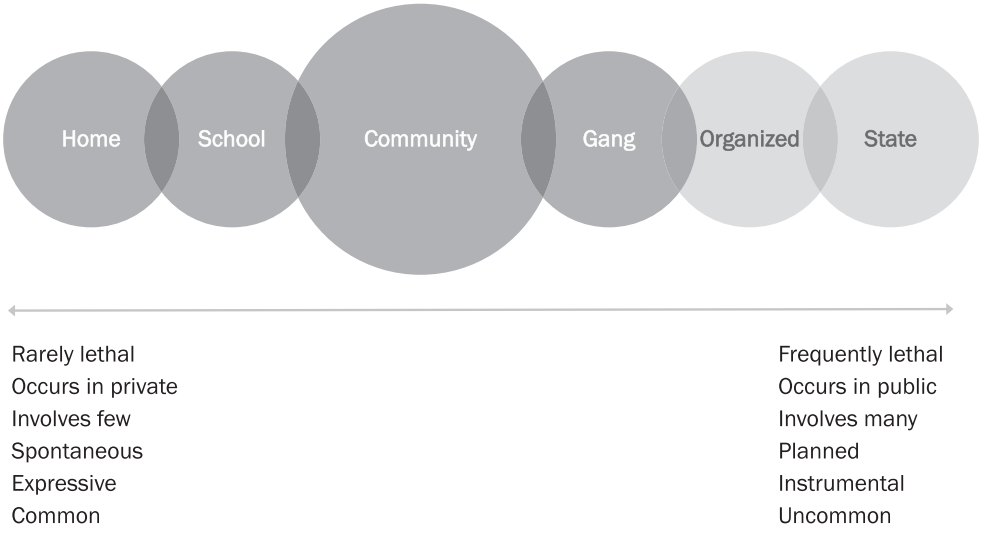

Figure 1. Typology of violence continuum.

These six attributes are strongly, but not perfectly, associated with each other. To capture these associations we collapse them into a single dimension along a continuum (Figure 1). Obviously, this continuum is neither entirely complete nor perfectly accurate, but viewing violence along a continuum is a helpful means of understanding the relationships between different forms of violence while avoiding overly simplistic categories.

The typology in Figure 1 describes six forms of violence: violence between family members and/or intimate partners in the home; violence involving students at school; violence between and among community members; violence committed by gang members; violence committed by organized criminal groups; and violence between nation states, i.e. war. These categories are intended to be illustrative, not exhaustive, and do not single out specific populations, i.e. men, women, children, or the elderly. Community violence is emphasized because it is the focus of this paper. Organized and state violence are de-emphasized here because they are less likely to involve children or young people directly, although there are notable exceptions, e.g. child assassins and soldiers.

At one end of the continuum, violence is interpersonal, i.e. generally occurring between individuals known to one other. Individual incidents occur frequently but are rarely lethal or cause permanent physical injury. It is unplanned, disorganized, emotional, and impulsive in nature. This violence is traditionally viewed a private matter, occurring between family members, intimate partners, schoolmates, or friends. If addressed by public institutions, it will likely involve a wide array of public health stakeholders with limited law enforcement participation, if any. Bullying is one example of violence at this end of the continuum.

At the opposite end, violence occurs between groups, often large in size, where individuals are generally not known to one another. Unlike bullying, this violence occurs infrequently but is highly lethal, often resulting in significant numbers of casualties. It is planned, organized, and instrumental. This violence is a generally state matter and traditionally the province of law enforcement and military institutions. Formally declared conflicts between states exemplify the violence at this end of the continuum.

In the middle of this continuum lies community violence, the focus of this article. Community violence, particularly homicide, occurs primarily in public settings. It is interpersonal, i.e. taking place between individuals and small groups that may or may not know one another. It is loosely planned at best and generally impulsive in nature. That said, the impact of community violence is nevertheless severe, often resulting in death or disabling injury. Its perpetrators and victims are usually, but not exclusively, young men and boys from disadvantaged backgrounds and communities. Community violence may result from disputes or from conventional forms of street crime, e.g. robberies, and implicates both the public health and public safety fields as well as multi-disciplinary, multi-sector responses.

As noted previously, all forms of violence are interconnected. The contagion between different forms of violence is an important subject worthy of serious exploration but lies beyond the scope of this article.

Establishing the need for a community violence framework

While it is clear that all violence is interrelated, it is equally clear that the differing characteristics of various forms of violence necessitate differing approaches – there is no universal strategy for violence prevention, nor should there be. For instance, a key component of any strategy is deciding the number and type of partners to be mobilized. In this regard, responses to violence will vary greatly – a response to bullying may involve coalitions of educators and parents, while addressing organized criminal violence typically demands the coordination of law enforcement groups. Community violence is perhaps unique in the breadth of stakeholders who may contribute to an effective response, including children and parents; community, business, and faith-based leaders; social service and health providers; along with law enforcement and criminal justice agencies.

This broad range of partners is appropriate given that community violence is a pervasive, persistent, and complex socioeconomic phenomenon. Understanding it requires a multi-disciplinary approach. Addressing it demands a multi-sector response. In order to properly organize any collective response, a framework is necessary to coordinate the activities of individual components so that they help rather than hinder one another in pursuit of a common goal: diminished community violence. According to the National Academy of Sciences, 'As the global community recognizes the connection between violence and failure to achieve health and development goals, a resource such as an evidence-based framework could more effectively inform policies and funding priorities locally, nationally, and globally' (Carroll, Perez, & Taylor, 2014).

In order to be useful, a framework must be theoretically sound but also grounded in the empirical reality of the problem it seeks to address. It must also have practical utility for implementation in the field. As criminologist Lawrence Sherman has noted, 'Crime should be classified in whatever way supports crime prevention' (Sherman, 2012). In short, an effective framework for responding to community violence must clearly articulate a reasonably complete, accurate, and useful description of both the problem and its solution.

Blending public safety and public health: a proposed framework

While many fields have made contributions to the study and practice of community violence prevention, public safety and public health outpace the others by a significant margin.

A framework for preventing community violence should therefore look to these disciplines first for organizing insights and principles. There are many differences between them, and the two fields occasionally compete for attention and resources, but fortunately public safety and public health professionals have become increasingly collaborative, drawn together by their shared interest in promoting peace and reducing violence. In fact, the future success of violence prevention depends in part on the continued strength of this critical partnership.

In describing the challenge posed by community violence, a framework can begin by drawing from a number of complementary criminological perspectives, most fundamentally rational choice and routine activities theory. Rational choice theory posits that criminals are self-interested rational decision-makers who weigh the costs and benefits of their conduct, albeit imperfectly, before acting (Cornish & Clarke, 2008). Routine activities theory holds that crime occurs when likely offenders meet suitable targets in the absence of capable guardians (Figure 2) (Cohen & Felson, 1979), and where the likelihood of such convergence is considered a function of the routine activity patterns of all concerned.

Next, the routine activities framework is amended to reflect that community violence occurs at the confluence of many factors, perhaps best summarized using the well-known journalistic and investigative trope of the five Ws and one H, i.e. who, what, when, where, why, and how. If community violence is 'what happened', then such violence is a function of place ('where it happened'), time ('when it happened'), people ('who was involved'), the motivations of those involved ('why it happened'), and behavior ('how it happened'), all of which can be crudely formulized as follows and as visualized in Figure 3:

$$cv = f\left(p_l, t, p_e, m, b\right)$$

With the additional elements in place, this expanded formula can account for any number of criminological theories concerning the causes of crime and violence. Biological, psychological, and developmental theories influence people, or p_e. Social, cultural, and environmental theories impact either the social or physical environment, i.e. place or p_l. All of these theories affect motivations and behavior, i.e. m and b. Lastly, this framework can be

Figure 2. Routine activities theory.

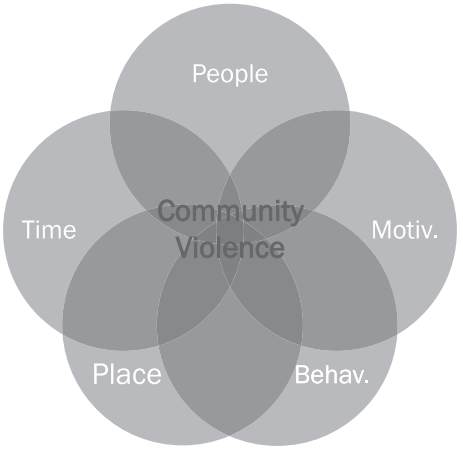

Figure 3. Community violence theory, full version.

Figure 4. Community violence theory, simplified version.

consolidated by merging time into place and motivation into people (Figure 4). Community violence, in this simplified equation, becomes a function of places, people, and behaviors:

$$cv = f\left(p_l, p_e, b\right)$$

Critically, understanding community violence in this manner reflects how such violence actually behaves in the real world. One of the most powerful criminological findings from the past two decades is that community violence is sticky, clustering tightly in specific places, among specific people, and around specific behaviors. In Boston, 1% of youth aged 15–24 were responsible for over 50% of city-wide shootings, and 70% of total shootings over a three decade period were concentrated in 'hot spots' covering approximately 5% of the city's geography (Braga & Winship, 2015). In five Latin American cities, 50% of homicides occur in 1.59% of blocks (CAF, 2014). In most metropolitan areas, .5% of the population is responsible for 75% of the homicides (Muggah, 2015). Given that all the 'available empirical

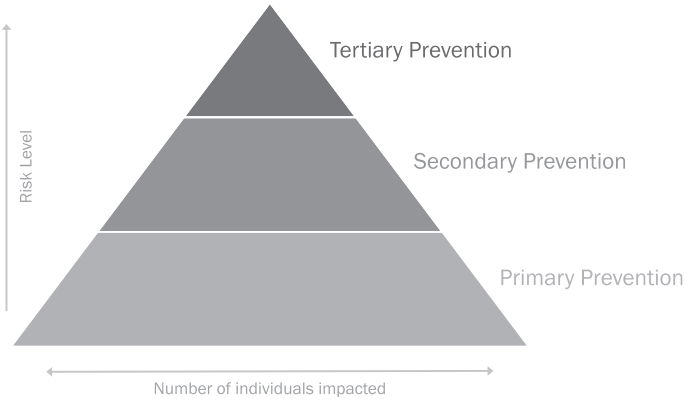

Figure 5. Public health model, original version.

and theoretical evidence suggests that crime is concentrated at a small number of high-risk places during high-risk times and generated by a small number of very risky people' (Braga, 2015), the evidentiary foundation for this conclusion is strong enough to warrant organizing policies around it. In addition to places and people, community violence also concentrates around high-risk behaviors, including (1) carrying a firearm (typically illegally) (Koper & Mayo-Wilson, 2006), (2) being under the influence of alcohol (WHO, 2010), and (3) belonging to a gang or otherwise violent group of individuals (Decker, 1996).

In addition, understanding community violence in terms of places, people, and behaviors is more easily grasped and readily implemented by practitioners than other conceptual frameworks. Hot spot and problem-oriented policing strategies, for instance, have been disseminated around the globe, familiarizing many law enforcement agencies with at the least a rudimentary understanding of place, people, and behavior-based strategies.

To capture potential responses to the challenges posed by community violence, a framework can look to the public health field, which generally organizes anti-violence efforts into primary, secondary, and tertiary prevention as shown in Figure 5. Primary prevention addresses risk factors associated with violence in the general population. Secondary prevention focuses on sub-populations with risk factors for future violence either as victims or perpetrators. Tertiary prevention attempts to intervene with those already engaged in violent behavior.

This model has many advantages. First, it classifies efforts by risk level with the understanding that as risk levels increase, fewer individuals are implicated. Second, it emphasizes prevention, a crucial component of a collective anti-violence response that has been traditionally underappreciated and underutilized. Third, the model is familiar to most public health practitioners and many others in the field, making it accessible and easy to use.

The public health model also has a number of disadvantages. First and foremost, it ignores law enforcement, the traditional institution charged with responding to crime and violence. This alone renders the model incomplete. Law enforcement is an essential partner in any community violence prevention strategy, and violence prevention efforts will be inhibited if police and prosecutors view their role as purely reactive. Violence prevention should be viewed and defined broadly in order to include law enforcement efforts to stop violence before it begins. Secondly, the public health model has yet to provide a clear explanation to practitioners of how tertiary prevention operates in the context of violence prevention.

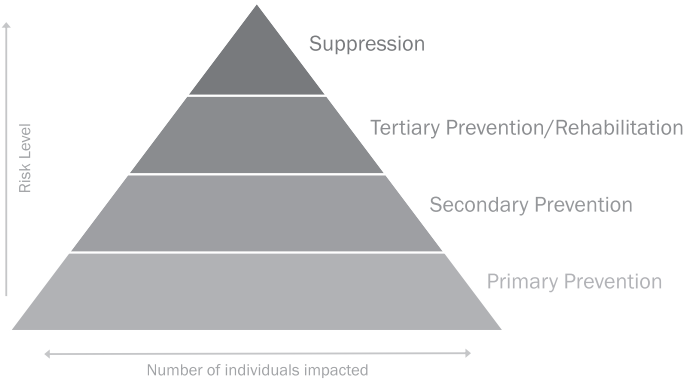

Figure 6. Public health model, revised version.

Table 1. Anti-community violence framework, empty.

	Primary prevention	Secondary prevention	Tertiary prevention	Suppression	Rehabilitation
Places					
People					
Behaviors					

Under tertiary prevention, the model tends to conflate prevention and rehabilitation – two practices that are generally conducted separately in the field. Third, in practice the model has generally placed an exaggerated emphasis on primary prevention, an important but not necessarily dominant element of an evidence-informed, multi-sector response for preventing community violence.

For these reasons, the public health model should be modified when used in relation to community violence (Figure 6). First, suppression should be added to account for the role of law enforcement. Suppression prevents violence via deterrence and incapacitation, generally but not exclusively through threats of arrest and incarceration. Second, tertiary prevention and rehabilitation should be separated into discrete categories. While they both concern those engaged in violence, tertiary prevention focuses on those currently in residing the community, whereas rehabilitation generally assists former offenders reentering society after they have been adjudicated and/or imprisoned.

Having provided a conceptual framework for understanding both the problem of and solutions to community violence, we now combine our criminology-based theory of community violence with our modified public health model, mapping places, people, and behaviors against prevention (primary, secondary, and tertiary), suppression, and rehabilitation, creating a grid with a total of fifteen sections (Table 1). This framework is theoretically sound, reasonably complete, informed by the evidence, and implementable in practice.

As noted previously, different forms of violence require different strategies. This framework is carefully constructed in order to address community violence among youth, especially lethal violence. Addressing other forms of violence will require different strategies, partners, and frameworks. As discussed further below, an approach carefully constructed to address one form of violence cannot be casually transferred to other forms of violence, such as family violence or violence perpetrated by organized crime, without significant modification.

Understanding 'what works' in community violence prevention

An effective anti-community violence framework should be populated with strategies informed by the best and most rigorously generated evidence, data, and information available. In addition, selected programmatic strategies should be suitable for and tailored to the local context in which it will operate. Finally, in order to be effective, programming must be soundly implemented. In some analyses, well-implemented interventions outperform poorly implemented ones, even if the latter have stronger, more evidence-informed designs (Lipsey, 2009). Tension between these principles is unavoidable, and mitigating such tension is a complex matter of professional judgment. This section explores the first of these principles; the latter two are examined in the discussion.

Since its introduction in the late 1990s, the term 'what works' has been understood in criminology to mean programming that has been demonstrated to be effective according to causal evidence generated from well-designed quasi-experimental or preferably experimental evaluations (Sherman et al., 1997). As noted previously, this paper draws significantly from a recent report (Abt & Winship, 2016) that analyzed 43 separate systematic reviews and meta-analyses synthesizing such evidence concerning community violence. Conclusions from that report are summarized and elaborated upon below in order to provide initial guidance on how best to populate the proposed framework.

Place-based primary prevention

Urban renewal strategies are associated with reduced crime and violence as well as improvements in police legitimacy and collective efficacy, but the number and quality of studies supporting these findings are limited (Cassidy et al., 2014). CPTED, or Crime Prevention Through Environmental Design, seeks to prevent crime through manipulation of the physical environment. Multiple reviews found only modest impacts on crime and especially violence for such strategies (Cassidy et al., 2014; Farrington & Welsh, 2002; Farrington et al., 2007; Welsh & Farrington, 2009). Neighborhood watch programs yielded similarly modest effects (Bennett et al., 2006).

In order to strengthen these programmatic strategies, particularly for urban renewal and CPTED, the focus of these efforts could be narrowed to the specific locations where most violence occurs, i.e. hot spots, in effect elevating them in focus from primary to secondary or tertiary prevention. Urban revitalization and environmental crime prevention efforts are worthwhile for a multitude of reasons, but if the intended purpose is violence prevention specifically, their focus should be restricted to those micro-locations that generate the greatest amounts of such conduct.

People-based primary prevention

Researchers disagree as to the impacts of vocational training on criminal behavior, reflecting a broader uncertainty in the field as to the effectiveness of stand-alone employment, vocational, and training programs (Aos et al., 2006; Visher, Winterfield, & Coggeshall, 2005) for violence reduction. Youth mentoring receives a similarly mixed assessment (Fagan & Catalano, 2013; Jolliffe & Farrington, 2007). As with place-based primary prevention, such programs could improve performance with additional focus on youth at the greatest risk

for violence. In addition, pairing such programming with proven strategies like cognitive behavioral therapy (CBT) (examined further below) could also enhance effectiveness.

More promising were school and especially family-based interventions, particularly when such efforts employed CBT. Early childhood programs such as the Perry Preschool program and the Nurse Family Partnership have especially strong and well-established effects (Fagan & Catalano, 2013). Making sure these programs serve the schools and families most impacted by violence will further strengthen anti-violence outcomes.

Behavior-based primary prevention

Juvenile curfews, gang prevention, and gun buyback strategies all demonstrated no impacts on crime or violence (Adams, 2003; Gravel, Bouchard, Morselli, & Descormiers, 2012; Makarios & Pratt, 2012).

Place-based secondary prevention

No systemic reviews examining place-based secondary prevention interventions were identified. An exploration of why systematic causal evidence is available for certain framework categories but not others would be worthwhile but is beyond the scope of this article.

People- and behavior-based secondary prevention

CBT uses clinical psychological techniques to alter the distorted thinking and behavior of criminal and juvenile offenders. A Campbell Collaboration review strongly reinforced, with 58 studies, 19 of which were randomized controlled trials, what numerous others had previously found: CBT works (Lipsey, Landenberger, & Wilson, 2007). CBT has been effective in reducing recidivism among juvenile and adult offenders, in institutional or community settings, as part of a broader program or as a stand-alone intervention. Few interventions can match its reliability and versatility. CBT was associated with a relatively large 25% average decrease in recidivism, but when the most effective types of CBT were used, recidivism declined 52%. These most positive results were not an outlier – approximately 1 in 5 of the interventions studied produced such effects or better.

Several family-based secondary prevention programs, including the well known Family Functional Therapy, Multi-Systemic Therapy, and Multidimensional Treatment Foster Care interventions, have strong records of demonstrated of effectiveness in reducing aggressive behavior, delinquency, and contact with the criminal and juvenile justice systems (Fagan & Catalano, 2013). These programs often prominently feature CBT, among other techniques. It should be noted, however, that one systematic review has questioned the effectiveness of Multi-Systemic Therapy (Littell, Campbell, Green, & Toews, 2005).

While no systematic reviews have been conducted, numerous studies indicate that violence can be reduced substantially by regulating the availability and use of alcohol (WHO, 2010), either by managing the hours, prices, and locations at which it is sold, providing treatment for alcohol abusers, or by improving the management of environments where it is served.

Place-based tertiary prevention

No systemic reviews examining place-based tertiary prevention interventions were identified.

People- and behavior-based tertiary prevention

A common prominent feature of strategies in this area is an intense focus on those at the highest risk for violence, paired with an equally intense focus on a narrow range of behavior, usually firearm-related shootings and homicides. Focused deterrence had the largest direct impact on crime and violence, by far, of any intervention examined in the meta-review. Focused deterrence involves the identification of specific offenders and offending groups, the mobilization of a diverse group of law enforcement, social services, and community stakeholders, the framing of a response using both sanctions and rewards, and direct, repeated communication with the individuals and groups in order to stop their violent behavior. In another Campbell Collaboration review, 9 of 10 focused deterrence interventions substantially reduced crime and violence, with homicide reductions ranging from 34% to 63% (Braga & Weisburd, 2012). Since publication of that review, additional studies have documented more examples of focused deterrence success (Corsaro & Engel, 2015).

The use of street, gang, or youth workers to quell violence has a mixed record of effectiveness and the strategy's results appear quite sensitive to implementation. No systematic review has been performed, but the best-known application of the strategy, CureViolence, has been evaluated numerous times, earning uneven results (Whitehill, Webster, & Vernick, 2012; Wilson & Chermak, 2011) while drawing support from some quarters (Butts, Roman, Bostwick, & Porter, 2015) and criticism from others (Kennedy, 2011; Papachristos, 2011). 'Street mediation' strategies offer significant promise but also some risk. Further systematizing and professionalizing the approach, clarifying streetworkers' relationship to formal institutions such as law enforcement, and evaluating additional streetworker models (Los Angeles' Urban Peace Institute and Providence's Institute for the Study and Practice of Nonviolence are both noteworthy, longstanding efforts) could strengthen the understanding and performance of these efforts.

Place-based suppression

Hot spots policing, which focuses police attention on the small geographic areas where crime frequently concentrates, has consistently demonstrated modest to moderate impacts on crime and violence (Braga, Papachristos, & Hureau, 2014). Disorder policing, also known as broken windows policing, addresses physical and social disorder in neighborhoods in order to prevent crime and violence. While this strategy has moderate crime benefits, problem- and community-oriented applications demonstrated stronger results, without triggering community resistance, than aggressive 'zero tolerance' versions (Braga, Welsh, & Schnell, 2015). Community policing leverages partnerships with residents and the community in order to reduce crime and disorder, but surprisingly has little discernable impact on crime and violence, although it did positively affect citizen satisfaction, perceptions of disorder, and police legitimacy (Gill, Weisburd, Telep, Vitter, & Bennett, 2014).

People-based suppression

Problem-oriented policing uses analysis to tailor law enforcement responses to specific public safety problems, yielding a modest to moderate reductions in crime and violence (Weisburd, Telep, Hinkle, & Eck, 2010). Interestingly, problem-oriented policing appears to improve the performance of other policing strategies, such as hot spots, disorder, and community-oriented policing, and may have greater impact in a supporting rather than leading role. It should be noted that problem-oriented strategies span the spectrum of place-, people-, and behavior-based approaches.

Behavior-based suppression

Targeted firearms enforcement has demonstrated moderate effects in reducing gun crime and violence (Koper & Mayo-Wilson, 2006; Makarios & Pratt, 2012). Conversely, aggressive drug enforcement appears to have minimal impacts (Mazerolle, Soole, & Rombouts, 2006) and may actually increase violence by destabilizing drug markets thereby increasing competition and violence among drug sellers (Werb et al., 2011).

Place-based rehabilitation

No systemic reviews examining place-based rehabilitation interventions were identified.

People-based rehabilitation

There is a substantial body of evidence demonstrating that well-designed, well-implemented recidivism reduction programs employing a risk/needs/responsivity framework are effective (Lipsey, 2009; Smith, Gendreau, & Swartz, 2009). The evidence is equally clear that surveillance, deterrence, and discipline strategies are ineffective at best in reducing recidivism among youth (Petrosino, Turpin-Petrosino, Hollis-Peel, & Lavenberg, 2013; Wilson, MacKenzie, & Mitchell, 2005). While boots camps have no impact, Scared Straight programs actually cause harm in that they are associated with modest increases in juvenile recidivism. Restorative justice programs appear to have modest impacts on offender recidivism, when both the victim and offender affirmatively consent to participate in the intervention (Latimer, Dowden, & Muise, 2005; Sherman, Strang, Mayo-Wilson, Woods, & Ariel, 2015).

Behavior-based rehabilitation

Multiple systematic reviews indicate that drug treatment and drug courts can significantly and positively impact recidivism (Holloway, Bennett, & Farrington, 2006; Mitchell, Wilson, Eggers, & MacKenzie, 2012; Mitchell, Wilson, & MacKenzie, 2007).

Populating the framework with 'what works'

A framework populated with the strategies described above is provided in Table 2. When interventions with minimal, mixed, null, or negative effects on community violence are removed from the framework as in Table 3, a clearer picture of 'what works' begins to

Table 2. Anti-community violence framework, populated.

	Primary Prevention	Secondary Prevention	Tertiary Prevention	Suppression	Rehabilitation
Place	*Urban renewal* *CPTED* *Neighborhood watch*			Hot spots policing Disorder policing Problem-oriented policing *Community policing*	
People	Family-based therapy School-based programs *Vocational training* *Mentoring*	CBT Family-based therapy	Focused deterrence *Streetworker programs*	Problem-oriented policing	Recidivism reduction *Restorative justice* *Boot camps* *Scared straight*
Behavior	Family-based therapy School-based programs *Juvenile curfews* *Gun buybacks* *Gang prevention*	CBT Family-based therapy Alcohol regulation	Focused deterrence *Streetworker programs*	Problem-oriented policing *Firearms enforcement* *Drug enforcement*	Drug courts and treatment

Note: Interventions with modest, mixed, null, or negative effects on community violence are indicated in italics.

Table 3. Anti-community violence framework, populated with 'what works' only.

	Primary Prevention	Secondary Prevention	Tertiary Prevention	Suppression	Rehabilitation
Place			(Urban renewal) (CPTED)	Hot spots policing Disorder policing Problem-oriented policing	
People	Family-based therapy School-based programs	CBT Family-based therapy	Focused deterrence (Streetworker programs)	Problem-oriented policing	Recidivism reduction
Behavior	Family-based therapy School-based programs	CBT Family-based therapy Alcohol regulation	Focused deterrence (Streetworker programs)	Firearms enforcement Problem-oriented policing	Drug courts and treatment

Note: Interventions that, if revised, could have significantly improved effects are indicated in parentheses.

emerge. Once the places, people, and behaviors responsible for generating most community violence in a given jurisdiction have been identified, this framework can provide a helpful roadmap for identifying, selecting, and coordinating programmatic responses.

For instance, with micro-locations where violence generally concentrates, place-based suppression strategies such as hot spots policing can make an immediate difference, while hot spot urban renewal and CPTED prevention strategies can improve transportation, housing, lighting, and vegetation in the immediate area so that reductions in violence are more likely to be sustained over time.

For those most likely to perpetrate or be victimized by violence in and around hot spots, focused deterrence initiatives supported by street or youth workers could send a

clear message that violence will not be tolerated. CBT can train young men to control their anger and solve their disputes peaceably. Weak programming can be strengthened rather than eliminated by incorporating CBT elements. Family-based therapy can assist parents in keeping their children on the right path.

For the most dangerous behaviors, targeted police patrols can engage repeat offenders and take guns off the street. Regulations on alcohol can change when, where, and how liquor is sold, making it harder for violent people in hot-spot areas to drink to excess. Finally, as to gangs, focused deterrence and streetworker programs have proven capable of influencing gang behavior.

Making the case for accumulation, concentration, and coordination

Examining anti-violence efforts across all categories, it becomes clear that only a few demonstrate clear and substantial positive effects on crime and violence, and even the most powerful interventions are incapable of reversing high rates of community violence by themselves. Given this, success requires the accumulation of individually modest but collectively robust programmatic effects. Risk and protective factors for violence are cumulative by nature (Office of the U.S. Surgeon General, 2001), so a strategy that builds impact over multiple programs makes similarly good sense.

As noted previously, crime and violence generally concentrate in and around a small number high-risk places, people, and behaviors. It follows that programmatic interventions targeting these concentrations are more likely to be effective than those that do not. Across the spectrum of anti-violence programming, it is well established that interventions focusing on the highest risk places, people, and behaviors generate the strongest effects. This is true of interventions relating to policing (Braga, 2015), gang reduction (Gravel et al., 2012), youth firearm violence reduction (Petrosino et al., 2015), youth violence prevention (Matjasko et al., 2012); and adult and juvenile recidivism reduction (Hollin, 1999; Lipsey & Cullen, 2007).

Similarly, in public health terminology, interventions targeting indicated and selected populations tend to outperform those addressing universal ones. In a systematic review of 41 youth violence interventions, researchers found that effectiveness increased as the interventions moved from primary through secondary to tertiary prevention (Limbos et al., 2007). Of the 15 studies that were randomized controlled trials, two of six (33%) primary, three of seven (43%) of secondary, and both (100%) of the tertiary prevention interventions were effective in reducing violent behavior among youth.

Accumulating and concentrating effects will fail if crime simply 'moves around the corner'. Fortunately, a robust body of rigorous evidence clearly establishes that when crime and violence are targeted, displacement to surrounding areas is minimal.

> [O]ver 30 years of research evidence on this topic … suggests that crime relocates in only a minority of instances. More commonly, it has been found that the opposite, a diffusion of crime reduction benefits in nearby areas not targeted by interventions, occurs at a rate that is about equal to observations of displacement. (Johnson et al., 2014)

A corollary to the case for concentration is the need for coordination among selected programs. Unfortunately, there is little practical guidance for policymakers on how to identify the right mix of interventions and how to coordinate them effectively (Abt, 2014). For instance, the case for 'comprehensive' approaches to community violence prevention is

decidedly mixed. Some reviews have found comprehensive or holistic approaches to be ineffective due to the inherent implementation challenges associated with getting numerous participants and organizations 'on the same page' (Gravel et al., 2012; Matjasko et al., 2012). Others claim such approaches work because they capitalize on the strength and diversity of multiple stakeholders (Makarios & Pratt, 2012; Petrosino et al., 2015). Complete comprehensiveness, while laudable in theory, is unlikely to be achievable in practice. The best case for multi-disciplinary collaboration recognizes that the capacity to coordinate is a finite resource like any other, and one to be used judiciously.

In order to achieve significant reductions in community violence, resources should be amassed and aligned where they will be most effective. Accumulating, concentrating, and coordinating efforts is intuitive, backed by strong evidence, and perhaps most importantly, economically and administratively feasible. Public and private institutions responding to violence lack the capacity to act everywhere, but they can collaborate where it matters most.

Discussion

The conceptual framework proposed here has several advantages over previous models. First, community violence – the challenge to be addressed – is contextualized in relation to other forms of violence. Second, the framework integrates theories and models from criminal justice and public health, the two most dominant fields in violence prevention. In doing so, the framework accounts for both the problem of community violence as well as potential policy solutions – an advancement over models that describe only one or the other. Third, the framework is informed by the most rigorous evidence currently available, in that the model reflects the concentrated nature of the phenomenon and synthesizes programmatic evidence of effectiveness. Fourth, by consolidating and adapting previous well-recognized theories and models, the framework is relatively readily understood and applied. In short, the proposed framework satisfies the previously-stated criteria of completeness, accuracy, and usability.

This conceptual framework also has a number of limitations. First, the proffered violence continuum is admittedly and necessarily imperfect. This can and should be improved upon as scholars and practitioners focused on other forms of violence contribute their insights and expertise.

Second, the framework itself is intended for community violence only. Violence in homes and schools operates differently than in the community, as does organized violence between gangs, criminal organizations, or states. For example, while the evidence is clear with regard to the limited displacement of community violence, the same cannot be said for sophisticated criminal organizations such as transnational drug cartels, which have repeatedly demonstrated the capacity to relocate or otherwise respond to targeted interventions. Relatedly, the framework does not speak to crime generally, but instead focuses squarely on violence, particularly lethal violence. Finally, the framework primarily addresses youth, but with adaptation the framework could have value in addressing community violence more generally, as its concentrated nature tends not vary with age.

Third, while the populated framework represents a summary of the best evidence currently available concerning anti-community violence programming, the limits of this evidence and of evidence-informed policy generally must be kept in mind. Within the field of community violence prevention, significant evidentiary gaps remain, and the scientific

process is an iterative one, meaning that our understanding of community violence and how best to prevent it must be continually updated and refined. In addition, the evidence relied upon here was drawn overwhelmingly from high-income settings, raising important questions concerning its generalizability or external validity. While emerging evidence indicates that while crime and violence appears to concentrate similarly across contexts (Jaitman & Ajzenman, 2016), low and middle-income nations often face capacity challenges when attempting to implement evidence-informed programming.

Fourth, the framework speaks primarily to the identification, selection, and organization of evidence-informed programs, but understanding the evidence is only one of several components of success in reducing violence. Programs must be carefully selected, adapted, and implemented according to local circumstances. Doing this effectively requires a sound understanding of the local context along with an intervention's essential elements of effectiveness. If the context allows for adoption of the essential elements, implementation can proceed with nonessential components altered as necessary. If the context requires compromising of one or more essential elements, a more contextually appropriate choice should be selected. Additionally, the programmatic focus of the framework offers little in terms of institutional strengthening, which is another important component of any long-term anti-violence strategy.

Fifth, the framework does not address program implementation, a critical component of intervention success (Hollin, 1999; Lipsey & Cullen, 2007). When implementing, careful attention should be paid to the quantity, intensity, and/or dosage of a given treatment. The U.S. National Research Council (2013) has concluded that with regard to youth at risk for violence and criminality, 'Whatever the specific mechanism, the appropriate focusing of more intense (and costly) interventions on higher risk adolescents produces a greater reduction in subsequent offending and limits the negative effects of unwarranted intensive intervention on less serious offenders'. This finding reinforces the previously made case for the accumulation and concentration of programmatic effects.

With these advantages and disadvantages in mind, how might be the theoretical framework advanced in this article be adopted? First, every effort – whether at the local, state, or national level – should begin with analysis, the goal of which is to identify the places, people, and behavior among which violence concentrates. Next, a common understanding of the concentrated nature of violence must be built by transparently sharing this information with civic, community, and criminal justice stakeholders. Procedural justice principles (Tyler, 2006), increasingly used in the United States and elsewhere to improve the legitimacy of criminal justice institutions, can offer helpful guidance in this area.

Once a common understanding of the problem has been achieved, the effort may turn to solutions. Using the framework, stakeholders would identify a balanced set of contextually appropriate programmatic interventions, including both suppression and some form of prevention (preferably secondary or tertiary), in each of the categories of place, people, and behaviors. Especially initially, care must be taken to avoid 'policy sprawl', e.g. including extraneous partners who contribute little but drain coordination capacity. Ideally, the selected interventions will bring together a small set of like-minded multi-disciplinary partners who can focus exclusively on preventing community violence where it concentrates most. In terms of measuring performance, it makes sense to begin with homicide, as it is the most costly, comparable, and reliably measured form of violence.

Once selected, the implementation of interventions must maintain fidelity to the essential elements of effectiveness while adapting said interventions to the local context. Care must be taken to ensure the delivery of high-dosage treatments to high-risk places and people. Efforts should be monitored and evaluated on an ongoing basis, using the best data and most rigorous methodologies available under the circumstances.

Finally, an ongoing effort should be conducted to coordinate with other anti-violence efforts represented along the violence continuum. Regions plagued by high rates of violence generally suffer from numerous forms of violence, necessitating a set of separate but loosely connected strategies. While emphases may vary, given the diversity of and contagion between different forms of violence, policymakers cannot afford to focus on only one type of violence to the exclusion of all others. Community violence prevention practitioners should therefore meet semi-regularly with their colleagues working to prevent other forms of violence, maintaining situational awareness and seizing opportunities to collaborate when possible. For instance, in El Salvador, efforts to prevent community violence should be aligned with efforts to limit the violence perpetrated by gangs, cartels, and other criminal organizations. Similarly, community violence practitioners should be aware of the linkages between early exposure to family and intimate partner violence and violence perpetrated later in life.

Conclusion

Community violence among youth is a complex and persistent social phenomenon. Responding to such a challenge requires a sophisticated and nuanced understanding of the problem as well as the collective capacity for solutions. Such an understanding is necessarily imperfect and constantly evolving, but can nevertheless be advanced via the development and adoption of theoretically sound, evidence-informed, and practically implementable frameworks such as the one proposed in this article.

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