Addressing the Intergenerational Transmission of Gender-Based Violence: Focus on Educational Settings

REPORT

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Authors: Stephanie Perlson and Margaret E. Greene June 2014

Purpose and Origins of this Paper

Gender-based violence (GBV) is increasingly recognized as a hindrance to economic and social development, in addition to violating the human rights of those experiencing it. Therefore, preventing the perpetration of GBV has ramifications beyond simply ending violence. Gender-based violence is violence perpetrated based on a person's gender, and reflective of gender inequalities. Patriarchal social norms exist to varying degrees in almost every part of the world, often placing men and boys in dominant positions over women and girls. Their gendered control can take the form of GBV,[1] whether physical, sexual or psychological.[2] Preventing GBV allows everyone – including survivors – a chance to lead autonomous, fulfilling and productive lives free of fear and intimidation.

This paper focuses on existing knowledge to prevent the transmission of GBV from one generation to the next—the intergenerational transmission of GBV. Research demonstrates a strong link between the violence young people are exposed to at home, either as witnesses or survivors, and their resulting negative behavior later in life, such as dating violence during adolescence or intimate partner violence as adults.[3] This "cycle of violence" has grave consequences, particularly for women and girls, since it is usually gender-based, resulting in severe injuries,[4] unintended pregnancy, HIV, sexually-transmitted infections (STIs), other health risk behaviors and permanent physical and emotional scars,[5] in addition to negatively affecting girls' education.[6] To ensure a future where children's lives are not overshadowed with violence where women and girls are safe to make decisions for themselves and continue their education, and men and boys do not adhere to violence and misuse of power associated to stereotypical masculine roles, GBV must end.

What We Know about the Intergenerational Transmission of Gender-Based Violence

Parent and family dynamics strongly influence young people's development and lives. Children and adolescents look to their parents, family and other adult role models – consciously or unconsciously – for guidance on how to behave. Turning to others for cues on appropriate behavior reflects the social norms to which we are all subject. Children absorb what they are taught and what they observe their role models doing as guides for social behavior.[7] When young people witness and experience violence at home – a place that could provide nurturing, safety and a sense of belonging—they may learn that home is a place of fear, pain and instability, and may also replicate this aggressive, violent behavior in other aspects of their lives: for instance, at school in the form of bullying, or later in life as dating and intimate partner violence.[8] Young people exposed to violence during their formative years – from childhood through young adulthood—learn the powerful lesson that violence can be an effective tool of control in relationships.[9] These realities reflect the "cycle of violence" in which children imitate and replicate their parents' behavior, contributing to the transmission of violence from one generation to the next.[10] Interventions that interrupt this cycle are critical.

The reinforcement of gendered power imbalances also takes place among children witnessing intimate partner violence since men are typically in positions of power over women; this idea ingrains in children a sense that it is normal for men to exert control over women.[11] This is illustrated by data collected via the IMAGES study, the first global survey of men conducted in six low- and middle-income countries to assess men's experiences and perpetration of violence during the life cycle. Among participating men, findings indicated a high prevalence of having experienced physical violence during childhood (26% to 67%), of witnessing their mother being beaten (16% to 44%), and experiencing bullying and physical punishment by teachers (34% to 79%). In all six countries surveyed, the association between witnessing or experiencing violence during childhood and perpetrating intimate partner violence as an adult was statistically significant.[12] Similarly, a CARE Sri Lanka/Partners for Prevention study in Sri Lanka found that men who had experienced childhood physical, sexual or emotional abuse were 1.7 to 2 times more likely to perpetrate intimate partner violence against a female partner than men who did not experience abuse.[13] The study also revealed that 28% of male respondents reported having experienced sexual abuse during childhood, 38% experienced physical abuse and 44% were emotionally abused.

Childhood experiences play out across the life cycle, and young men witnessing violence against women and seeing "being a man" defined as being aggressive and using violence for conflict resolution internalize these lessons, replicating them in later relationships.[14] In fact, the CARE Sri Lanka/Partners for Prevention study found that the majority of perpetrators of sexual violence (60%) were between 20 and 29 years of age the first time they committed sexual violence; 28% of the perpetrators were 15-19 years of age when they first committed such violence; and men in the 25-34 age bracket have the highest rate of current partner violence, compared to other age groups.[15] GBV reinforces to boys and girls the positions of power of each sex in addition to conveying that violence can be used as a control mechanism,[16] which partially explains why women are significantly more likely than men to experience intimate partner violence.[17] These findings suggest that interventions to prevent GBV must target male children and adolescents in order to "un-teach" the gender inequalities and acceptance of violence that leads to perpetrating GBV in adolescence and young adulthood. Working in schools represents an opportunity to reach a large number of children, creating spaces where different norms can be experienced, particularly when male and female children and adolescents have safe spaces in classrooms to engage in non-traditional gender roles and relationships based on dialogue rather than ruled by violence.

Research indicates a strong connection between experiencing maltreatment as a child and either perpetrating or experiencing intimate partner violence as an adult.[18] Children witnessing intimate partner violence in the household

between parents/caregivers are also at increased risk for perpetrating or experiencing intimate partner violence as adolescents and adults, among other psychosocial problems.[19] (Psychosocial problems include depression, anxiety, and the internalization or externalization of problems. School-aged children may experience these as problems of attention, conduct and behavior, anxiety, affect and mood or social and interpersonal challenges (Center for Mental Health in Schools at UCLA).

A recent research review by Herrenkohl et al (2008) on the co-occurrence of child abuse and domestic violence indicated that these two forms of violence often occur together, with several studies showing that children exposed to both forms of violence experience worse psychosocial outcomes, particularly later in life, than those exposed to only one form of violence.[20] The effects of exposure to intimate partner violence and aggression between parents and child maltreatment reach beyond childhood, affecting relationships in adolescence and adulthood. Intimate partner violence and child maltreatment are linked to depression and fear, and later forms of anti-social behavior, including bullying, re-victimization for girls, use of aggression and dating violence in relationships for boys, and adult perpetration/experiences of intimate partner violence.[21] In addition, children in households where intimate partner violence occurs have emotional and behavioral problems which affect their education, leading to general delinquency, school dropout and teen pregnancy—and later intimate partner violence perpetration or victimization.[22]

Experiencing violence in the home, whether child maltreatment or witnessing intimate partner violence, is also linked to experiencing or perpetrating violence in school.[23] Research suggests a strong connection between children who bully their peers at school and the dysfunction in the homes of the bullies, such as physical punishment by parents, aggressive relations between parents, or lack of discipline altogether.[24] Bullying can be used to reinforce strict gender norms and to sanction students who depart from these norms, and can be expressed in homophobia, another form of GBV.[25] A study of North American men ages 18-35 at community health centers who had perpetrated violence against their female partners found that two-fifths of them to have also perpetrated school bullying, and the more frequently these men had acted as bullies during their

Note on Concepts/Terminology:

GBV takes many forms, and in this paper, we focus on GBV occurring at the household level. Sexual violence is a type of GBV, but since we are focusing on violence in the home, our emphasis is on intimate partner violence. Varied terminology is used to refer to violence in the home, including domestic violence,[i] which includes violence and abuse between intimate partners and family members.

In this paper we distinguish violence occurring in the home by the stage of life in which it occurs. We use the World Health Organization's (WHO) terminology for Intimate Partner Violence, defined as physical, sexual and/or psychological violence between partners or ex-partners, whether adolescents or adults.[ii] This paper also uses the WHO's definition for Child Maltreatment to refer to the physical and emotional mistreatment, which includes harsh discipline by parents or teachers (corporal punishment), sexual abuse and neglect of children.[iii] Child maltreatment may or may not be gender-based.

i Early Intervention Foundation. 2014. Early Intervention in Domestic Violence and Abuse. London: Early Intervention Foundation. Accessed at http://www.eif.org.uk/wp-content/uploads/2014/03/Early-Intervention-in-Domestic-Violence-and-Abuse-Full-Report.pdf.

ii WHO Factsheet 239. 2013. Violence against women: Intimate partner and sexual violence against women. Accessed at http://www.who.int/mediacentre/factsheets/fs239/en/.

iii WHO. 2006. Preventing child maltreatment: a guide to taking action and generating evidence.

Geneva: World Health Organization and International Society for Prevention of Child Abuse and Neglect. Accessed at http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf?ua=1.

adolescence, the more likely they were to perpetrate intimate partner violence as adults.[26] Most of the men in the study perpetrating intimate partner violence had also experienced violence as children, whether childhood sexual (42%) and physical abuse (70%) or intimate partner violence between their parents (52%). The flow of violence from parents to children and the resulting expressions of violence by the next generation continue, negatively impacting all involved.

Effects of Gender-Based Violence on Girls' Educational Outcomes

GBV is a pervasive problem that has many negative consequences and deserves more attention. Like the intimate partner violence or child maltreatment that children and young people experience or witness, the impact reaches far beyond the incident itself. Global evidence emphasizes the link between an educated population—of women and men—and countries' economic and social development. Much progress has been made in the past decade toward achieving the Millennium Development Goals of gender equality and universal primary education. However, global secondary school enrollment shows that more boys are enrolled than girls in most regions.[27] Boys' greater access to education and life opportunities than girls' serves to reinforce existing gender inequalities throughout society by decreasing economic options for girls and fuelling inequality and poverty in future generations. Gender inequalities are often more entrenched in low-income communities with low levels of education than in communities where education is more widespread, paving the way for GBV to continue from one generation to the next.[28]

School is a common setting in which GBV is perpetrated.[29] Girls may be physically and sexually harassed by male students and teachers, making them fear school. A study in Senegal found direct links between rape and decreased school performance and grade repetition.[30] In a 2009 study from Ghana on sexual abuse in schools, all girls who had been violated said they did not like school anymore, 73% said they were afraid of the perpetrator (57% for boys), and 58% could not concentrate in class.[31] They may also face taunting by their peers and teachers, since sexually assaulted girls and women are often thought to have brought the incidents upon themselves.[32] Lesbian, gay, bisexual and transgender students may also face violence for their lack of adherence to gender-based societal norms.[33] It is a tragedy when schools are environments in which gender inequalities are reinforced and children are kept from learning as they might. School attendance naturally drops and students'

academic performance suffer when they experience emotional and physical pain. The threat of such negative outcomes can cause parents to withdraw their daughters from school, or marry them very young, often believing these avenues to be safer alternatives.[34] In sum, gender inequality and violence including gender-based violence are commonplace in many school settings, teaching impressionable young people that violence and gender-based inequalities and exploitation are acceptable, and naturalizing the perpetration of GBV in school and elsewhere.

While more research is needed on the relationships between violence and poor educational outcomes, dropping out, and school completion in developing countries,[35] there are many pieces of the puzzle we know something about. Children who suffer from family violence, for example, are more likely to be bullies or to be bullied.[36] Adult men who experienced or witnessed violence as children are more likely to justify violence as a means of resolving conflict.[37] Women who witness or experience violence are more likely to justify acts of violence perpetrated against them by male partners or adult males they know.[38] Girls and boys who witness or experience GBV in school are less likely to do well in school.[39] Experiencing and fearing violence, or feeling disempowered to condemn it can prevent girls and boys from attending school and receiving an education.[40] At the same time, school can be a safe haven for students who experience violence at home or as a result of their life experiences (for instance, children living in refugee camps). School is also the most common place for children to build peer support networks. Therefore, schools represent a potential space for discussions about traditional gender norms, violence and GBV, and to work with a large number of children and adolescents to break cycles of violence.

Current Strategies and Promising Practices for Preventing GBV throughout the Life Cycle

The intergenerational transmission of violence affects women and girls, men and boys, and serves to reinforce harmful gender norms throughout society at large. While more research is constantly emerging, though mostly from developed countries, we still have a great deal to learn about the complexity of the violence young people and adults face, its causes, long-term effects, and how to prevent it.

Following the public health approach of the WHO and other organizations working to prevent all forms of violence, this paper identifies effective intervention strategies and "promising practices" to prevent and mitigate violence throughout the life cycle with a focus on early prevention. This includes targeting intimate partner violence and child maltreatment in children's homes, in order to decrease the negative impact of exposure to violence and to reduce the likelihood that exposed children will perpetrate violence throughout their life. "The public health approach is interdisciplinary… [and] considers that violence, rather than being the result of any single factor, is the outcome of multiple risk factors and causes."[41] In addition to gender inequalities, low-income and low-education, a variety of "complicating" factors interplay and may co-occur with violence at home, such as health and mental health problems, drug and alcohol misuse, housing issues and a lack of family and community support structures.[42]

Violence prevention interventions seek to address one or several of these factors with multi-component approaches, and while strong evidence is lacking for some interventions, others have demonstrated success. The WHO, among others, organizes the risk factors for experiencing violence according to the level of influence at which they occur, the "ecological model," beginning with the individual, to their personal relationships, their community, and societal factors. As they put it, "Viewing the ways in which these risk factors come together and influence patterns of behaviour throughout the life-course provides insights into the key points at which interventions to break the cycle should be implemented."[43] Protective factors against intimate partner violence have also been identified, including women and men having secondary or higher education and experiencing healthy parenting as a child, though require further research.[44] Violence risk and protective factors and their influence differ for each setting, which is why prevention efforts for all forms of violence and abuse must be tailored to address the specific factors within each context.[45]

GBV and Child Maltreatment in the Home: Risk and Protective Factors

Risk factors include:

- **Low education levels**
- **Parental exposure to maltreatment as a child**
- **Acceptance of violence**
- **Traditional gender and social norms that support the use of violence[iv]**

Protective factors include:

- **Experience of healthy parenting as a child**
- **Having a supportive family[v]**

iv WHO. 2010. Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence. Accessed at http://apps.who.int/iris/bitstream/10665/44350/1/97892/41564007_eng.pdf?ua=1 (p 21)

v WHO 2010, as above (p 31); Administration on Children, Youth and Families. DATE. "Promoting Protective Factors for In-Risk Families and Youth: A Brief for Researchers. Accessed at http://www.dsgonline.com/acyf/PF_Research_Brief.pdf

The Early Intervention Foundation has classified public health violence prevention approaches into three categories based on the stage at which actions are taken to address violence:[46]

- **Primary Prevention** (Universal Services): this "upstream" strategy is designed to address violence before it starts, often by focusing on young people with school-based or educational campaigns that question norms and offer skills for dealing with violence;

- **Secondary Prevention** (Early Intervention): this approach identifies and works with those at risk for domestic violence and abuse, such as nurse home visits with young pregnant women, who face a high risk of violence;

- **Tertiary or Remedial Prevention** (Late Prevention): this type of intervention takes place after violence has been identified and provides treatment services for survivors and perpetrators.

Existing violence prevention strategies and programs target each life stage, but outcome evidence is lacking for many violence prevention strategies and of those evaluated, not all are effective.[47] Here we focus on evaluated program interventions shown to be effective, those with emerging evidence of effectiveness or those that are promising.[vi] Effective and promising primary and secondary prevention strategies are highlighted here in relation to which stage of the life cycle they occur. Most work with young people and take more of an "upstream" approach to prevent violence from occurring, rather than focusing

[vi] The WHO (2010, p. 39; 2006, p. 32) evaluated interventions for which evidence is available and classified them based on their measured effectiveness. Changes in knowledge, attitudes and beliefs toward intimate partner violence is the weakest outcome since it does not necessarily lead to behavior change. A more effective intervention outcome is a reduction in perpetration of intimate partner violence and the most effective is a reduction in experiencing intimate partner violence. We use the WHO's classifications for effective and promising strategies: "An effective prevention programme is one that reduces the incidence of child maltreatment in the intervention population, or at least lowers the rate at which incidence is increasing… "effective" is used for programmes evaluated with a strong research design that show evidence of a preventive effect… A prevention programme is said to be promising, if it has been evaluated with a strong design, showing some evidence of a preventive effect, but requiring more testing".

on treatment services once violence has occurred. Successful strategies for preventing violence by encouraging gender norm change with adults exist and are discussed below. Additional reasons to focus strategies on young people include lack of strong evidence of success among later prevention strategies, such as working with perpetrators to reduce recidivism rates;[48] and the challenges of violence prevention everywhere, and all the more so in low- and middle-income countries which lack the resources and systems for documenting, referring and addressing violence.[49]

KEY CHARACTERISTICS OF EFFECTIVE AND PROMISING STRATEGIES: WORKING WITH CHILDREN AND YOUTH

According to the literature, one factor commonly cited as contributing to both experiencing and perpetrating intimate partner violence is child maltreatment. Taking an "upstream approach" by targeting child maltreatment may be one of the most effective ways to reduce intimate partner violence later in life since it targets all four levels of the ecological model.

Youth need psychosocial support[51] and behavioral interventions[52] to help ensure that during their development from adolescence into adulthood they do not replicate the violence they may have experienced or witnessed in their families of origin, whether it manifests as bullying at school or as intimate partner violence. Psychological treatments for children and adolescents experiencing child maltreatment and/or exposed to intimate partner violence have shown improvements in their cognitive, emotional and behavioral outcomes.[53] A systematic review and meta-analysis of the effectiveness of school-based programs around the world to reduce bullying and victimization revealed that promising programs took measures to prevent the violence at school, such as with peer mediation and improved supervision of students both in and out of the classroom, and also worked with parents and caregivers on parenting skills.[54] Intensity and duration of a program for children and teachers is connected to its effectiveness. Intensity for children was classified as 20 hours or more and for teachers it was 10 hours or more; duration for children was 270 days or more and for teachers was 4 days or more.[55] A longitudinal study of North American adolescent students maltreated as children found that positive academic performance (Grade Point Average) mitigated their perpetration of intimate partner violence as young adults, thus acting as a protective factor.[56]

Second Step, developed in 1986 by the Committee for Children, is an example of a classroom-based, primary prevention program implemented in several European countries, "to reduce impulsive, high-risk, and aggressive behaviors and increase children's social competence and other protective factors."[57] This was accomplished through a curriculum promoting empathy, impulse control and anger management, teaching children to recognize the emotions of others and understand their perspectives, practicing problem-solving skills through role plays, and learning social skills. A positive school experience can be a protective factor to prevent and reduce violence,[58] and can encourage young women and men "to challenge the limitations of stereotypical roles and the perpetuation of expected gender-based behaviors."[59]

RENACER is a community-owned, sustainable program from CARE Honduras, led by out-of-school youth, to address barriers to education. It is comprised of non-formal education for out-of-school youth, early childhood care and children's community centers, emphasizing safety and security, young people's civic action and activities encouraging economic independence. The youth groups used home visits, counseling and outreach activities to mobilize other young people and out-of-school youth to join the RENACER non-formal education groups. A significant result of the civic and community action projects was allowing adolescent girls and boys to challenge traditional gender roles in a safe space. The program's outreach made it possible for youth in gangs and teenage mothers to receive support from the RENACER groups; by mobilizing the community, the program also increased the safety of students, particularly women and girls, travelling at night. Community perceptions of the program were positive and supportive, which helped to change ideas about girls' capabilities.[60]

CARE Malawi's Advancement of the Girl Child Right to Education (ACRE) initiative for girls in school was based on CARE's Power Within framework for girls' leadership, which consists of three domains of change: (1) provision of

quality primary education; (2) development of girls' leadership skills and (3) building an enabling environment for girls' development. This "enabling environment" was achieved by training School Management Committees (SMCs), Mothers' Groups, Parent Teacher Associations (PTAs) and chiefs to increase their leadership skills and their awareness of education policies and to teach them of their responsibility to provide school oversight. They were also provided with information on the Teacher Code of Conduct in order to monitor teachers' adherence to it and to prevent them from committing child abuse, especially sexual relationships with students. The project resulted in changes in community perceptions of appropriate gender roles for girls, and especially improved support for girls' education. Girls who benefitted from the program acted as role models for other girls. Specific improvements included:

- More equitable classroom environments;
- Development of girls' self-esteem, confidence, assertiveness and participation in schools and community forums;
- Community members championing a "tolerance zero" environment for forms of gender-based violence, including forced marriages, exclusion from school, sexual abuse and harassment;
- Widespread support for the active participation and leadership of women in initiatives addressing and preventing gender-based violence;
- Community members working actively to reintegrate survivors and seek punishment for perpetrators of gender-based violence.[61]

In 2010, the WHO and the Early Intervention Foundation assessed multiple primary prevention approaches to prevent intimate partner violence and only one—a school-based program to prevent dating violence—was found to be effective at preventing violence. Preventing dating violence is critical since research suggests it is a risk factor for intimate partner violence later in life, and is associated with injuries and risky health behavior.[62] Safe Dates is a curriculum-based program developed by the Hazelden Foundation and implemented in the US that addresses attitudes and behaviors associated

with dating abuse and violence, by giving adolescents the knowledge and skills to identify healthy relationships and deal with unhealthy ones.[63] It significantly reduced psychological, moderate physical and sexual dating violence perpetrated, primarily due to changes in dating violence norms, gender role norms and awareness of community services. Other school-based programs to reduce dating violence emphasized non-abusive conflict resolution and communication skills. Despite these successes, further evaluation of these programs is needed to assess their value and effectiveness in the long term and when adapted to and delivered in resource-poor settings.[64] Though a program such as Safe Dates may appear so far to be "culture-bound" to North America, there are examples of similar work in other settings, including CARE's assertiveness training for girls (carried out in Malawi), and Sissy Aminata (an HIV/AIDS radio counseling program associated with a school curriculum, piloted in Sierra Leone by Save the Children and CARE) contain similar elements.

KEY CHARACTERISTICS OF EFFECTIVE AND PROMISING STRATEGIES: WORKING WITH PARENTS TO ADDRESS VIOLENCE IN THE HOME

As discussed, multiple factors contribute to intimate partner violence and child maltreatment in the home, and giving parents the skills to address it before or after it starts holds benefits for children and couples to end the cycle of violence. Effective training programs for parents contain the following components of good parenting and child management skills:[65]

- Identify and record problematic behaviors at home;
- Use positive reinforcement techniques, such as praise and points systems;
- Apply non-violent discipline methods, such as the removal of privileges and time out;
- Supervise and monitor child behavior;
- Use negotiating and problem-solving strategies.

Two effective approaches targeting the underlying risk factors for family violence are The Incredible Years developed by Dr. Carolyn Webster-Stratton, and the "Triple P" Positive Parenting Program , developed at the University of Queensland.. Both programs successfully reduced risk factors for child maltreatment, especially harsh parenting, and improved parenting skills.[66] While The Incredible Years program has been tested in multiple settings and countries over the past 30 years, Triple P has only been evaluated in high-income countries.[67] The Incredible Years consists of videos, discussion and role play to help parents develop strategies for building their parental self-esteem and to practice the skills to manage their children's behavior, while also working with children and teachers. Evidence shows that the approach treats children's aggressive behavior problems, promotes their problem-solving and emotional regulation and also improves parent-child interactions and builds positive parent-child relationships. The Incredible Years does not currently address domestic violence, but there is a proposed intervention component that would empower women in their relationships and address children's experience of violence.[68] Triple P works at multiple levels, providing media messages on positive parenting, informative resources such as videos, brief targeted interventions by primary care practitioners for specific behavioral problems, intensive training for parents and addressing broader family issues, such as relationship conflict, anger and stress.[69] Adaptations of parental skills-building programs from other countries have been implemented in some low- and middle-income countries, but do not show clear results.[70]

Home visitation programs to prevent child maltreatment hold promise for ending the intergenerational transmission of violence, but have not been evaluated for this.[vii] Current research indicates that more successful programs contain elements such as focusing on families in greater need of services, for instance those with children with disabilities, or low-income, unmarried teenage mothers; interventions beginning during pregnancy and continuing for at least the first few years of the child's life; flexibility to the family's need; promotion of positive physical and mental health-related behavior and

[vii] According to the WHO (2010, p. 41) "In general however, reducing the risk of the different forms of child maltreatment reviewed in Preventing child maltreatment: a guide to taking action and generating evidence (WHO-ISPCAN, 2006) can contribute to reducing the intergenerational transmission of violence and abuse… However, neither [home-visitation and parent-education programmes to prevent child maltreatment have] been evaluated for its long-term effects on the prevention of intimate partner and sexual violence among the grown-up children of parents who were involved in such programmes."

covering the broad range of issues to address each family's specific needs.[71] Home visitation programs to prevent intimate partner violence, such as the Nurse Family Partnership in the U.S. (Family Nurse Partnership in the United Kingdom) have demonstrated some positive effects, such as on maternal and child health and child maltreatment,[72] but otherwise have unclear results regarding violence prevention.[73] Currently, the program is being adapted to address domestic violence and abuse in the U.S. since with proper delivery, nurses' home visitation offers an effective way to assess the quality of relationships in the home and to identify violence before it starts.[74] Home visitation may work even better and be less costly in low- and middle-income countries where community health workers or mothers' groups are present in the community and may have significant knowledge of cases of violence of which formal health workers would not be aware.[75]

KEY CHARACTERISTICS OF EFFECTIVE AND PROMISING STRATEGIES: CHANGING NORMS ACROSS THE LIFE CYCLE

Gender inequality is consistently cited as a factor contributing to GBV among adolescents and adults, yet we lack strong evidence to demonstrate the impact on violence reduction of dismantling harmful gender norms. Programs that focus on changing gender norms, to support men and boys in finding non-violent ways of relating and to empower women and girls, also show promise for addressing the factors contributing to GBV and can take place throughout the life cycle. Indicators that measure change in non-traditional power for the sexes are associated with reductions in violence: Women's education and men's contributions to domestic work both seem to contribute to decreased violence at home.[76] Strategies that empower individuals and communities to identify and address their own problems have been effective at reducing gender inequalities since they emphasize community members' roles as agents of change and give them ownership of the process. Some exemplary programs are the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) and Stepping Stones.

IMAGE targets women in rural South Africa living in the poorest households, combining microfinance with training and skills-building on HIV prevention, gender norms, cultural beliefs, communication and intimate partner violence, while also encouraging the participation of men and boys. IMAGE was jointly administered by the Small Enterprise Foundation (SEF) and the Rural AIDS and Development Action Research Programme (RADAR). A randomized-controlled

trial revealed that two years after completing the program, participants reported a 55% decrease in the number of acts of intimate partner violence in the past 12 months.[77] Stepping Stones, developed by Alice Welbourn and implemented in 40 low- and middle-income countries, promotes communication and relationship skills within communities by running parallel training sessions separated by sex. The 50-hour program was held mostly at schools after school hours and used participatory learning approaches, role play and drama to increase knowledge, risk awareness and to stimulate critical reflection on one's own behavior, what shapes our actions, sex and love, contraception, taking risks, gender-based violence and motivations for sexual behavior.[78] Initially designed for preventing HIV prevention, some communities have integrated violence prevention (since GBV can lead to HIV infection). An evaluation of the program in South Africa suggested that among the participants aged 15-26, a lower proportion committed physical or sexual intimate partner violence in the two years after the program compared to those who had not participated.[79]

Other promising strategies to prevent gender inequalities leading to GBV are Raising Voices' SASA! and Save the Children's Choices curriculum. SASA! is a kit containing tools to support local activism, media and advocacy activities, and communication and training materials to address the power imbalance between men and women upheld by community norms and traditional gender roles in the Horn of Africa and Southern Africa. It holds great potential for reducing intimate partner violence, and the results of its evaluation will be released imminently.

Save the Children's Choices curriculum works with youth aged 10-14 to "explore alternative views" of masculinity and femininity. This period is a crucial opportunity to intervene since young people are more likely to be influenced by acquiring new knowledge and skills, allowing them to challenge harmful gender and social norms.[80] The curriculum was piloted in child clubs in a district in Nepal using trained facilitators to implement developmentally-appropriate participatory activities, such as taking photos to show gender inequalities, to explore and discuss the gender inequalities in their community—and feelings associated with them. Statistically significant results showed that the program was effective at encouraging more gender-equitable attitudes and behaviors among participating boys and girls. For example, fewer participants agreed that it was acceptable for a man to beat his wife if she disagreed with him, and more participants felt that daughters should have the same opportunities as boys to go to school or work outside the home. Parents of participants reported their sons discussing equality for their sisters.[81]

The *Empowering Men to Engage and Redefine Gender Equality (EMERGE)* Project in Sri Lanka was initiated by CARE, and targets young and adult males in various communities to promote gender equality and GBV prevention by transforming their attitudes and behaviors. This focus on men came from the realization that their meaningful participation was key for women's empowerment to progress and to be sustainable. Happy Families, part of EMERGE, is a program providing training to married couples to enhance their communication skills around family matters, such as money management, decision making, positive parenting and support for household work. They also learn about gender, domestic violence, sexual and gender based violence, family hygiene, sexual and reproductive health and money management. Additional trainings on men and masculinities, positive parenting, and fatherhood are also provided. Happy Families will be expanded to include working with the children of these couples on such matters as norms of masculinity, using forum theatre and campaigns to raise awareness on positive parenting and the changes they have noticed in their own families. CARE Sri Lanka will also expand its work with existing Male Change Agents, who will conduct activities to influence stakeholders within the patriarchal system, such as political and religious leaders, and to recruit and train additional promising change agents, so as to create a space for dialogue on GBV and alternative definitions of masculinity.[82] The project is ongoing and will be evaluated at the end of 2014.

The Young Men Initiative by CARE in the Balkans linked with youth-serving civil society organizations with experience in youth SRH and HIV prevention to build their capacity to develop programs to engage young men, using "Gender Conscious Practice." They use group education and a social marketing campaign called Budi Musko ("Be a Man") to engage young men aged 14-18 on gender, masculinities and health, with an emphasis on violence prevention. So far, the program has resulted in increased gender awareness, more gender-equitable attitudes and a self-reported reduction in violence.[83]

Gaps

As the research shows, data on the intergenerational transmission of GBV, its prevalence, its causes, its consequences, and the most effective ways to prevent it, are sparse, particularly from low- and middle-income countries. Global evidence supports the notion of a "cycle of violence" in which children experiencing and/or witnessing violence at home learn violent behavior and perpetrate it throughout their lives, at school, in dating during adolescence, and later as intimate partner violence, where the next generation witnesses it. Multiple programs, mostly in high-income countries, have been effective at addressing the factors that lead to violence at home, whether GBV or child maltreatment and preventing further violence. However, the dearth of global evidence, especially from low- and middle-income countries, and of longitudinal data measuring the effectiveness of existing strategies to prevent violence over time makes understanding the intergenerational transmission of violence and developing new interventions to prevent it much more challenging.[84] Not all interventions have been evaluated for effectiveness, and of those that have, some had weak methodology.[85] Adapting violence prevention interventions for low- and middle-income countries requires more rigorous evaluation to ensure they are implemented with evidence-based efforts.[86] More data disaggregated by age and sex is also important since some research suggests variations in the exposure to and impact of violence based on developmental stage for boys and girls.[87]

Measuring changes in gender-based violence throughout the life cycle

CARE is interested in measuring changes in the residual experience and use of violence from childhood to adulthood. What would it take to measure these changes? To be able to measure these changes, we must know something about the exposure to violence (whether the child is a survivor or a witness, their age and sex, the severity of the violence, and so on). We need also to collect data on how this exposure translates into the child's relationships and educational outcomes at school, and how it affects the child's intimate relationships in adolescence and later. We need to be careful about collecting detailed case data on such a sensitive subject. It is difficult and risky to ask

about child abuse, IPV and other types of violence, and it is exceptionally challenging to do this in resource-poor settings with weak public health services. However, an example of detailed data collection on experiences of violence from Honduras used participatory data collection methodologies (as used by RENACER) with young people serving as not only respondents, but also as interviewers and owners of databases about violence. They were empowered to use this information to better understand the effects of violence and to self-evaluate progress in a longitudinal manner. Thus what we are most interested in is how to measure whether our interventions are having an effect on preventing violence at all stages of the life cycle.

At a conceptual level, we need to think about the different changes we might hope to see as a result of our interventions:

- There could be changes in **gender-based violence between and by parents,** which we are identifying as the original source of the violence in the lives of these children.
- We can measure changes in behaviors that reject traditional gender norms, i.e. men taking on more household responsibilities, women expecting men to help with domestic work
- We could also measure changes "between generations," i.e., **changes in the chances that a child will replicate that violence** as an adult.
- We can measure changes in **levels and manifestations of violence at school** that relate to children's earlier experiences of GBV.
- We might measure changes in children's resilience to that violence. Such measures could include:
  - Changes in educational outcomes related to earlier experiences of GBV
  - Changes in the way these children conduct their intimate relationships in adolescence and beyond related to earlier experiences of GBV
- We might focus on the **impact of programs meant to interrupt the transmission of violence** in the lives of children.

The reason that change is the focus here is that we want to be able to measure whether and how programs are effective in preventing the intergenerational transmission of violence. To measure that change, however, we need to be clear about the dimensions we'd like to focus on, and the mechanism through which we believe a program might work.

MEASUREMENT APPROACHES AND TOOLS FOR DESCRIBING THE PROBLEM

Holt et al (2008) provide an excellent review of some of the measurement challenges regarding the impact of children's exposure to domestic violence.[88] The points they raise include:

- Exposure to domestic violence is not simple, uni-dimensional or homogeneous (e.g., overlaps of types of abuse), and children experience it differently
- There are few reports of domestic violence that include the perspectives from multiple family members or professionals, and when these are sought, agreement can be low
- Inconsistent use of a common criterion use for defining child abuse, dramatically different types of exposure
- There is an over-reliance on the child behavior checklist and limited usefulness of measures across culturally and socio-economically diverse populations
- Many basic variables such as mother's age, family size, child's health are not controlled for

As we have seen from the literature describing the problem, children's witness of violence between their parents, and their own experience of violence often translate into other expressions of aggression and violence in school and other

settings. The International Men and Gender Equality Surveys (IMAGES) corroborate this finding and provide measures that stand up to cross-national comparison. IMAGES has interviewed men in over 10 countries, including Brazil, Chile, Croatia*, India, Mexico and Rwanda* in phase 1. Later surveys were conducted in Eastern DRC, S. Africa, Mali* and Bosnia.* Starred countries are those where CARE participated in the research, and CARE was also involved in the Sri Lanka application of a Partners for Prevention Asia regional study that used the IMAGES survey.

From 2009 to 2010, IMAGES administered household surveys to more than 8,000 men and 3,500 women (sampled separately) ages 18-59 on gender-based violence; health and health related practices; household division of labor; men's participation in caregiving and as fathers; men's and women's attitudes about gender and gender related policies; transactional sex; men's reports of criminal behavior; and quality of life. Childhood experiences of violence associated with later adoption of inequitable gender attitudes (around decision-making, VAW, and notions of masculinity). The single strongest factor in men's use of intimate partner violence was having witnessed violence against their mother during childhood. Most important for this discussion of measurement is that this survey **retrospectively measured** men's experiences of having witnessed their mothers being beaten by their fathers, and the self-reported use of violence now and over the past twelve months. These variables are the only ones that present statistically significant associations in all 6 countries.

MEASUREMENT APPROACHES AND TOOLS FOR LOOKING AT CHILD MALTREATMENT

Comprehensive evidence on changes in child maltreatment is weak due to underreporting, lack of resources in some settings, and a variety of responses from child protection agencies, leading to assessments of a program making it appear to be less effective than it really is.[89] For this reason, it is important that an outcome evaluation use multiple measures in order to provide a more accurate assessment of the program's true outcomes in case another measure used is weak.[90] **Three types of measures exist: direct measures, proxy measures and changes in risk factors.**[91] Direct measures, such as child protection services reports, allow for the most accurate conclusion, but may not always be available, either due to underreporting, or in low-resource settings where such services do not exist or are weak. In this case, other, less direct measures, such as proxy (hospital visits or child being placed in care outside of home) and risk factors (parent-child attachment behavior, use of positive discipline) can be used to assess a program's impact. Changes in risk factors are often used to assess changes in child maltreatment, and should use standardized measurement instruments to ensure validity of the evaluation. Some tools rely on parents' self-reports and others observe parent-child interactions. The outcomes chosen to measure changes in child maltreatment rates should also include measures for the intermediate and the ultimate goal to ensure evaluators did not miss any changes in outcomes. In choosing outcomes, take into consideration its relevance, the type and frequency of the outcome (such as injuries, depression, beliefs and practices), and the availability of data for that outcome.[92] Some examples from the WHO include:

- **Parental child rearing attitudes** could be measured using scales for assessing attitudes to parenting and confidence in parenting ability – for example, the Parenting Sense of Competence Scale.
- **Interactions between parent and child** could be measured by scales assessing violent behavior towards children – for example, the Parent-Child Conflict Tactics Scale.
- **The impact of increased surveillance on early detection and on the discouragement of maltreatment** could be measured by comparing reported maltreatment rates in families receiving the intervention with reported rates from control families not receiving the intervention.

Many measurement tools exist to yield information on child maltreatment rates, but one that may be more relevant for CARE is the ISPCAN Child Abuse Screening Tools (ICAST) since experts from over 40 countries—including low-income countries—participated in its development to ensure it was internationally applicable. It contains three survey instruments, one for parents with children under 18, one for young people aged 18-24, and one to use with youth aged 12-17. (See Table 2 for a list of resources for child maltreatment measurement tools and possible outcome evaluation indicators.)

MEASUREMENT APPROACHES AND TOOLS FOR LOOKING AT GENDER

A longitudinal study in the United States oversampled adolescent males in order to obtain a sufficient number of youth at high risk for serious delinquency and drug use; this is the only nod to gender aside from including whether the adolescent was male or female, however. As a consequence, the analysis misses an important potential intervention, i.e., addressing gender norms as a way of reducing violence. The challenge is that,

> **"While programmes to alter cultural and social norms are among the most visible and ubiquitous of all strategies for preventing intimate partner and sexual violence, they remain one of the least evaluated. Even where evaluations have been undertaken, these have typically measured changes in attitudes and beliefs rather than in the occurrence of the violent behaviours themselves, making it difficult to draw firm conclusions on their effectiveness in actually preventing intimate partner and sexual violence."[96]**

Promundo and its partners have worked on improving – and measuring those improvements – in health and violence reduction through interventions that address gender norms.[97] As part of this effort, researchers on their team have developed the Gender Equitable Men, or GEM, Scale, the purpose of which is to measure prevailing norms and progress toward gender equitable norms. Such a scale is essential for measuring the impact of any program that wishes to influence gender norms in the service of rights and health-related outcomes.

The GEM scale reflects a number of important elements of interest to this discussion. It:

- Reflects multiple domains in the construction of gender norms;
- Addresses program goals related to sexual and intimate relationships, and sexual and reproductive health and disease prevention;
- Is broadly applicable yet is possible to adapt to specific cultural settings, so indicators can be applied in and compared across varied settings and be sufficiently relevant for specific cultural contexts; and
- Can easily be administered so that diverse organizations implementing interventions can conduct this type of evaluation.

Through its collaborative work with young men in low income settings in Rio de Janeiro, Promundo and its partners conducted analyses and chose 24 items to constitute the GEM Scale, of which 17 items form an 'inequitable' subscale and seven items form an 'equitable' subscale. This scale was validated through extensive use and testing and it has now been adapted for use in many culturally divergent settings.[98] Most importantly, the measures of "gender traditionalism" have been shown in varied interventions to be associated with lower self-reported condom use, greater self-reported perpetration of IPV, and greater incidence of self-reported STI symptoms. CARE also developed a Gender Equitable Index, which was born out of the GEM scale.

MEASUREMENT APPROACHES AND TOOLS FOR LOOKING AT GENDER-BASED VIOLENCE

A longitudinal study on the intergenerational transfer of mother to daughter risk of gender-based abuse in the United States also provides relevant and interesting guidance.[99] The author notes the importance of including multiple forms of gender-based abuse in research and practice to track family dynamics and describes six key areas of measurement (with reference to exposure at different stages of life):

1) Intimate Partner Violence. How often an intimate partner slapped; hit many times; or threatened them with a weapon. They were also asked about their exposure to the same items of domestic violence during their childhood, reporting on their own mother's victimization (see below).
2) Dating Violence. The same tactics administered to the mothers were given to the daughters about their recent (past year) dating violence experiences (e.g., slapped; hit many times; or threatened them with a weapon).
3) Witnessing Intimate Partner Violence. Children's exposure to domestic violence was assessed through the mother's report,

i.e., the mothers reported about their own experience of partner violence and this measure represents both her experience and her child's exposure. Women also responded as to whether they had witnessed the abuse of their mothers. The specific question was: "When you were growing up do you remember whether or how often [your father/stepfather/mother's partner] did any of the following to your mother: slapped; hit many times; threatened with a weapon."

4) Child Sexual Abuse. Sexual abuse was measured with open-ended questions coded qualitatively and several questions from the standardized instrument on childhood memories. Mothers' sexual abuse history was measured by a question on whether "any of the following things happened in your childhood, before you were 11," and rated on a 5-point scale from never true to very often true the following statements: "I believe that I was sexually abused in the family" and "Someone molested me in the family." Mothers were asked "Do you have any reason to believe, or have any of your children ever complained that [mother's current partner/or any adult outside the family] had sexual contact with them. Children responded to "How often has an older person touched you in ways that you didn't like, or hugged you too hard in private, or tried to touch you under your clothes?" and "Before you were 13, did anyone try to make you touch a sexual part of their body or touch you in a private part of your body when you didn't want them to?" Children were considered sexually abused if either the mother or the child provided affirmative answers to two questions during either wave.
5) Adolescent Romantic Attachment. The attachment style for adolescent girls was measured using a standard Experiences in Close Relationships (ECR) questionnaire on romantic partners in general, which asks respondents to describe whether they are essentially anxious, avoidant, or secure with their partners (ECR; Brennan, Clark, & Shaver, 1998).
6) Adolescent Daughter's Sexual Risk-Taking. Daughters answered, "How many different people have you had sex with in the last year?"; "How many different people have you had sex with during your life?"; "Have you ever been pregnant?"; "Have you ever gone to the doctor for a sexually transmitted disease or problem?"; and "Have you ever had sex with someone at least five years older than you?" Responses were coded into a five-point score.

Since most survivors of gender-based violence do not seek help or report their experiences,[100] it will be necessary to draw data from other sources, such as hospital emergency departments or police, in order to measure changes in the occurrence of violence. For the settings lacking the infrastructure and resources to gather such information, another approach carried out is to conduct an in-country survey or study, usually carried out by international non-government organizations and/or academic institutions, but there are limitations to this, as well.[101] Some options for collecting data in countries without easy access to information on intimate partner violence include dedicated surveys since they include information on prevalence and frequency, contextual factors, and risk and protective factors; data from registers; and rapid-appraisal techniques, which includes interviews with stakeholders, focus groups, and collection and analysis of available data from health facilities, non-government organizations and local authorities.[102] To properly monitor the effects of prevention programs, useful information to collect on intimate partner violence includes: prevalence and incidence; distribution (i.e. by age, sex, socio-economic status, etc.); health consequences (i.e. mortality, morbidity/health outcomes); risk factors; protective factors; crime data; economic data and policies and legislation.[103] Many prevention programs seek to change risk factors contributing to violence since measuring reductions in the perpetration of violence or injuries caused by it require data to be collected over long periods of time.[104]

EXAMPLES OF MEASUREMENT APPROACHES TAKEN BY INTERVENTIONS TO CHANGE GENDER-BASED VIOLENCE AND CHILD MALTREATMENT

This brief section looks at well-evaluated interventions that work through a number of important approaches. Details of their measurement and indications of how they might serve as resources for future program evaluations appear in Table 1.

Parenting Programs

A UK-based organization tested the impact of a parenting intervention on the behavior of children who referred for problems.[105] The evaluation of the Incredible Years intervention used a randomized controlled trial, conducting all assessments with standardized instruments at the homes of participants. Parent-child interaction was observed and recorded along with measures of child behavior and measures of parenting skill, confidence and mood.

Dating Interventions

The Safe Dates Program recognizes the public health problem posed by adolescent dating violence.[106] Among ten schools in rural North Carolina USA, five were assigned to a control group, while five of comparable size received the Safe Dates intervention. The intervention was comprised of a theater production performed by students, a curriculum taught by health and physical education teachers over 10 45-minute sessions, and a poster contest based on the content of the curriculum to which the students had been exposed. Data were collected at the time of the intervention, one month later, one year later, two years later, three years later, and four years later. (The study managers requested parental consent again for the adolescents' ongoing involvement in the study. After year 1, half of the intervention group was randomly assigned to receive the booster, which consisted of a newsletter and personal visit by a public health trainer.)

The study found that although prior victimization limited some of the effects of the intervention, the program still had significant effects at all levels of previous experiences of violence. Remarkably, even four years later, they were able to measure significantly less dating violence – physical, serious physical, and sexual – among the adolescents who received the intervention than among the control group. They also tested the impact of a refresher or "booster", which was conducted over a year after the first intervention; the booster had no positive effect, and thus was not recommended. Note: Adolescents receiving the booster reported more psychological abuse perpetration and serious physical and sexual victimization than those exposed only to the initial intervention when prior experience of these forms of dating violence was high. The authors suggest that the booster encouraged young people to leave abusive relationships, which exposed them to escalated levels of violence. They conclude, therefore, that, "Boosters, because of their low intensity, may be inappropriate for the secondary prevention of dating violence (p. 623)."

Community Conversations

The Stepping Stones community curriculum steadily builds the skills of groups of young women, young men, adult women, and adult men who systematically participate in sequenced activities apart and together as they diagnose and respond to the community practices that contribute to HIV, and to gender-based violence.[107] It has now been implemented in over 40 countries, suggesting its adaptability to divergent cultural settings. A cluster randomized control trial evaluation of the program in South Africa found that among younger participants, fewer committed physical or sexual intimate partner violence in the two years after the program than among non-participants. While the primary outcome measured was HIV incidence, the evaluation also measured other outcomes associated with HIV infection, which included incident of physical or sexual intimate partner violence.

Programs Addressing School-Related GBV

The approach used by ACRE in Malawi is largely based on CARE's Power Within framework for girls' empowerment, which is based on providing quality primary education, developing girls' leadership skills and building an enabling environment for girls' development.[108] Most important for this discussion of methodology, however, is that the program works through five strands of action:

1) Building students' assertiveness and self-esteem through reflective discussions on sexuality and children's rights;
2) Developing leadership skills among students and a peer support network, promoting civic action towards quality education for all;
3) Raising awareness for GBV and building community skills for whole school management among community-based organizations;
4) Raising awareness among teachers for gender issues and working towards joint management and increased accountability in schools; and
5) Building solid reporting mechanisms in schools, involving student clubs, community matrons, teachers, traditional leaders, the police, DEN and health clinics to create Zonal Task Forces able to tackle GBV cases and provide integrated support to survivors.

These five strands reflect a holistic approach that builds capacity among students and the adults at school, in their community and in government; and that contributes to shifting norms by developing a sense of entitlement and accountability. While CARE has assessed the effects of ACRE with qualitative case studies, and the program looks promising, each of these areas of activity requires quantitative data to be measured to show whether the program is having an effect and should be replicated.

Microfinance with a Gender and Health Component

A group in South Africa integrated a gender and HIV training component to a microfinance initiative to test whether the combination might lead to synergistic health and social benefits. The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) was implemented with a cluster randomized trial among 1409 women. IMAGE combined group-based micro-finance with a 12-month gender and HIV training curriculum. After two years, the participants' economic well-being and empowerment were enhanced, and their levels of physical and sexual intimate partner violence were 55% lower than among women in the control group.

What did we learn that has implications for this discussion of methodology? First, that the combination of an economic and a social intervention both attracted the poor women the program wished to reach, and had a lasting impact on the health and social outcomes of interest. Second, by virtue of the way the intervention was set up and the data were collected, the study permitted comparisons of the microfinance component and control group, the combined intervention and control group, and the microfinance-only and combined intervention. The study discussion gives much importance to both components of the intervention – with the microfinance component empowering women who had had their awareness raised to avoid violence and practice safer sex and communication with their partners.

Recommendations for CARE's Programming to Prevent Intergenerational Transmission of GBV

Among the programs explored, and after speaking with several staff, CARE is already addressing many of the factors that lead to GBV, such as gender inequality and low levels of education, especially among young people, which will help to deter its transmission to the next generation. CARE's programs such as ACRE in Malawi, RENACER in Honduras and the Young Men's Initiative in the Western Balkans put youth at the center of programming, which empowers them through awareness-raising and capacity building. These programs, and CARE's EMERGE in Sri Lanka, address

participants' support for harmful gender and social norms, such as a man's right to beat his wife as "discipline" or that girls do not need to attend school, resulting in participants changing their previously held notions. Placing youth at the center of programming has allowed CARE to learn directly from them about issues they face in their daily lives and to equip them with the tools and skills to address these issues on their own.

Also, CARE recognizes that there is opportunity to change young people's assumptions and beliefs about gender before inequitable views become cemented. Involving the community and families, for example with ACRE and RENACER, created an enabling environment for youth to fully engage in questioning harmful social and gender norms, as well as pass some of the knowledge along to their families and the community. Examining the literature on violence prevention tells us that unraveling unequal and patriarchal social norms is a key strategy among several, and CARE might be able to further prevent the transmission of violence by integrating other promising practices in its current work.

Effective Strategies and Promising Practices for CARE's Programming with Children and Adolescents

What happens in society is mirrored by youth in school and community programs to address gender inequalities, and GBV could have effects that filter into schools; to reinforce these messages, youth programs should be expanded to have a community engagement component, as RENACER and ACRE.

Since early prevention is the most effective way to avoid the intergenerational transmission of violence, CARE's programs for youth should **add psycho social support and behavioral interventions** to address the consequences of violence that youth may have already experienced at home or school. These strategies include non-violent conflict resolution, problem-solving, self-regulation and peer mediation. Since RENACER already has a counseling component, training on psycho social support and learning positive problem-solving strategies could be added to it. If feasible for CARE, the SMCs, Mothers' Groups and PTAs of ACRE could also receive training on violence identification, providing psycho social support and positive problem-solving techniques; training on psycho social support is especially important for the Mothers' Groups if they will already be tapped in to home visitation.

Another recommendation to scale-up CARE's programming with youth is to **integrate a tutoring/mentoring component** to help girls and boys achieve academic success and to have older youth or adults act as positive role models, as in ACRE and the Young Men's Initiative. Also, since young people are more open to questioning their beliefs than adults, working with very young adolescents (aged 10-14), as Save the Children's Choices curriculum did, could be an effective way to challenge their perceptions of gender norms before they are cemented. ACRE and the Young Men's Initiative should be expanded to more countries for their success at disrupting harmful gender norms, both among youth and in the community. For programs such as RENACER working with out of school youth, a micro-finance component combined with discussions on GBV and gender equality, such as with IMAGE, could be integrated to give these youth skills for economic independence so they are less vulnerable to intimate partner violence. CARE's youth-focused programs should also incorporate elements of contextually-appropriate "dating" (or early romantic relationship) violence interventions, such as providing the skills and knowledge to identify a healthy relationship, to deal with an unhealthy one and to use non-abusive conflict resolution and communication.

Effective Strategies and Promising Practices for CARE's Programming with Parents, Couples and Communities

CARE Sri Lanka works with couples in Happy Families on communication skills and positive parenting, and in the future, may include the children of these couples. Programs working with parents, such as Happy Families and RENACER, could be enhanced by **integrating components such as positive reinforcement, non-violent discipline methods, problem-solving and non-**

[viii] Evidence suggests that the Incredible Years program has been implemented successfully across countries and cultures (Knerr et al. 2011, p. 34).

violent conflict resolution to prevent child maltreatment, as in **The Incredible Years.**[viii] ACRE in Malawi worked with mothers' groups to break not only the practice of violence but also the acceptance of violence (so they do not pass it on to their children).[110] Positive reinforcement and non-violent discipline methods should also be incorporated into gender equality and GBV work with teachers so they abandon corporal punishment and learn how to manage student behavior that does not perpetuate the cycle of violence. Programs working with young and adult men to promote gender equality and discourage GBV, such as EMERGE and the Young Men's Initiative should also contain training on non-violent conflict resolution and problem-solving. Adult- and youth-focused programs may need to incorporate psychosocial and behavioral support for those who already experienced violence in order to protect their overall health and prevent the transmission of violence.

Engaging the community to raise awareness and generate support for youth-focused programs discussing harmful gender norms, as with RENACER in Honduras and ACRE in Malawi, partially accounts for their success. "[School-related GBV, (SRGBV)] can be linked to the unequal balance of power that stems from traditional gender roles in Malawian society. The same gender roles are replicated in classrooms… *There is evidence that strong, active community groups may lead to higher accountability for SRGBV, and therefore higher access to and retention in the education system* [author emphasis]."[111] Involving parents and the community encourages them to accept youth programs, as well as to possibly learn from them. Youth-focused interventions, both in formal and non-formal education settings could be expanded to include training for parents and other community members since schools are often community-gathering spots. Creating a safe space for youth and the community to discuss gender inequalities/GBV is also key so that there is recognition of what is causing poor attendance, poor performance and dropping out; this helps people call things what they are rather than people hiding behind excuses for dropping out. Parents do not say that GBV or domestic violence is affecting girls' attendance, however, girls are definitely saying that school is a bad or unsafe place.[112]

Closing Observations

Violence prevention is a delicate issue requiring careful evaluation of the interventions to reduce or prevent it so as not to incur further harm. As the research, or lack of it shows, developing and carrying out effective violence prevention among children and adults is challenging under the favorable circumstances of high-resource settings. Therefore, in settings without the resources to allocate to high-impact violence prevention, this task is much more difficult. Knerr et al. (2011) warns against implementing in new settings interventions that have not been rigorously (scientifically) evaluated in their country of origin since, as discussed above, the context in which violence takes place is crucial in order to attempt to stop it.[113] They suggest that "The decision to adapt an existing, evidence-based intervention to a culture, context or setting for which it was not originally designed should be based on whether adaptation will increase the efficacy and effectiveness of the intervention in the new context or culture compared to the original, non-adapted version."[114] For example, parenting and dating norms vary depending on the setting, as does feasibility; some settings may lack electricity or the target population may not be literate, creating a need for further modifications to the program.[115] Conducting pilot tests, using well-designed measurement and evaluation processes and additional measures for reliability are some of the procedures suggested to help ensure the intervention is effectively adapted. The WHO adds to this list measures taking into account the country's readiness for implementing the program, such as expertise among program staff, adequate resources and the health and social services infrastructure.[116]

Evidence from low- and middle-income countries demonstrating the effectiveness of some parenting programs to prevent violence may be lacking but there is evidence that they improve parenting skills, which can lead to preventing child maltreatment.[117] The rigorously evaluated research available to us does not provide all of the answers for preventing the transmission of GBV from one generation to the next, but we do have promising evidence to point us in the right direction.

TABLE 1: DATA COLLECTION EXAMPLES FROM INTERVENTIONS

Name of Intervention	Selection Criteria	Periods for Data Collection	Socioeconomic Data Collected	Impact Data Collected – Indicators	Comparison Established
Incredible Years	76 children referred for conduct problems, aged 2–9, from socially disadvantaged communities in the UK	Baseline: Follow-up at 6 & 18 months Tool used: Eyberg Child Behaviour Inventory	Single parent household Educational attainment Recipient of welfare benefits Type of employment	**Child behavior measures:** > Observed child negative behavior > Observed child independent play > Sibling behavior problem **Parenting measures:** > Observed positive & negative parenting > Parenting Scale > Parent sense of competence > Beck Depression Inventory	> Baseline > Post-intervention > 18-month follow-up, maintenance of change-Intervention group only
ACRE	Seven primary schools (out of 124 receiving ACRE) in Kasungu District, Malawi	Baseline: 2 years after initiation of intervention		> More equitable environment in classrooms; > Development of girls' self-esteem, confidence, assertiveness and participation in school and community forums; > Community members championing a "tolerance zero" environment for all forms of GBV > Widespread support for the active participation and leadership of women in initiatives addressing and preventing gender-based violence; > Community members working actively to reintegrate survivors and seek punishment for perpetrators of GBV	> Post-intervention changes
Safe Dates	Adolescents enrolled in 8th grade in one of 10 schools in rural county of North Carolina, USA	Baseline: 1 month 1 year 2 years 3 years 4 years 5 years	> Race > Gender > Previous experience of violence, including in previous wave	Measures for Perpetration & Victimization > Psychological > Physical > Serious physical > Sexual	> Baseline-endline > Intervention vs. control > Intervention+ booster vs. control
IMAGE	Women randomly selected from 12 villages in rural Limpopo, South Africa 4 to each intervention arm	Baseline: 24 months following introduction of IMAGE Tool used: WHO Violence Against Women Instrument.	> Age > Income > Employment status > Educational attainment > Household size	Economic well-being, empowerment and IPV **Quantitative indicators of empowerment:** self-confidence, financial confidence, challenging of gender norms, relationship with partner, autonomy in decision-making, perceived contribution to household, social group membership. **Measures of IPV:** assessed participants' attitudes toward and experiences of physical and sexual violence, IPV, and controlling behavior by a partner	> Baseline-endline > Micro-finance vs. Control > IMAGE vs. control > IMAGE vs. Micro-finance
Stepping Stones	Women and men aged 16-23 from rural South Africa (Eastern Cape)	Baseline: 12 months 24 months	> Age > Education > Sexual history > Experience of physical or sexual IPV > Mental health	> No of partners in past year > Any transactional sex with a casual partner > Incident of physical or sexual IPV > Pregnancy > Any casual partner > Correct condom use at last sex > Depression > Problem drinking; misuse of drugs	Women and men in intervention vs. women and men in control-baseline to endline

TABLE 2: SUGGESTIONS FOR TYPES OF OUTCOME EVALUATION INDICATORS AND TOOLS TO MEASURE CHANGES IN INTIMATE PARTNER VIOLENCE AND CHILD MALTREATMENT

	Outcome Evaluation Indicators	Measurement	Resource(s)
Preventing intimate partner violence	Risk factors for intimate partner violence: Table 3, p. 27; Protective Factors: section 2.6 p. 31	Possible data sources: Box 7, p. 62; Table 7, p. 64-65	WHO. 2010. Preventing intimate partner and sexual violence against women: Taking action and generating evidence. (For primary prevention strategies for intimate partner violence and sexual violence for which some evidence is available, see Table 5, p. 40; for those with potential, see Table 6, p. 41)
Child maltreatment	Outcome Evaluation Indicators by ecological level: Table 3.2, p. 45	> Parent–Child Conflict Tactics Scale; > Adverse Childhood Experiences questionnaires; > Lifetime Victimization Screening questionnaire; > ISPCAN Child Abuse Screening Tools, p. 20-24 Adverse Childhood Experiences Study Questionnaires, Appendix 1: p. 69; Examples of validated measurement tools for outcome evaluation, Appendix 2, p. 89	WHO. 2006. Preventing child maltreatment: a guide to taking action and generating evidence. (For effective prevention strategies at each developmental stage, see Table 3.1, p. 35)
		Common standardized instruments: Table 2, p. 18 Two observational instruments: Home Observation for Measurement of the Environment (HOME) Inventory; Dyadic Parent-Child Interaction Coding System (DPCIS)	WHO. 2013. Preventing violence: Evaluating outcomes of parenting programmes

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www.care.org

Headquarters

CARE USA
151 Ellis Street, NE
Atlanta, GA 30303-2440
USA
T) 404-681-2552
F) 404-589-2650
education@care.org

CARE Washington DC
1825 I Street, NW, Suite 301
Washington, DC 20006
USA
T) 202-595-2800
F) 202-296-8695
education@care.org

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