Shifting attitudes and behaviours underpinning physical punishment of children

A literature review on large-scale interventions

May 2017

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Acknowledgements

This research was funded by the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership programme of the Presidency, Republic of South Africa, and the Delegation of the European Union (EU). The contents of the paper are the sole responsibility of the author and can in no way be taken to reflect the views of the Presidency (RSA) and the European Union. Funding by the PSPPD and the EU is gratefully acknowledged.

Contents

I. Background

Corporal punishment of children, also referred to as physical punishment or harsh discipline,[1] is a global phenomenon that affects children in both high- and low-income settings.[2] The United Nations Committee on the Rights of the Child defines corporal punishment as "any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light".[3] This definition clarifies that corporal punishment includes 'less severe' acts such as spanking or smacking and 'more severe' acts such as hitting children with a tool (e.g. whip, stick, belt, shoe, wooden spoon, etc.), kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion.[4]

Harsh discipline vs physical punishment

Physical punishment and non-physical aggression such as yelling, threatening or scaring children often co-occur when parents discipline children. The term 'harsh discipline' is commonly used to refer to either or both of these types of discipline. Although non-physical aggression can also have negative effects on children, the focus of this briefing paper is physical punishment, as defined by the United Nations Committee on the Rights of the Child.

In South Africa, children experience many forms of violence and many children experience multiple forms of violence.[5] These multiple forms of violence often co-occur and intersect.[6] Physical punishment, however, is the most widespread form of violence against children globally and, while national prevalence data is lacking, available data suggest that it is highly prevalent in South Africa.[7] In a 2005 national study, 57% of parents reported smacking their child/children and 30% reported having done so in the past month.[8] Children were most likely

[1] The terms corporal punishment and physical punishment are used interchangeably in this paper.
[2] Unicef 2014.
[3] United Nations Committee on the Rights of the Child 2007.
[4] United Nations Committee on the Rights of the Child 2007.
[5] Meinck et al. 2016.
[6] Meinck et al. 2016.
[7] Unicef 2014.
[8] Dawes et al. 2005.

smacked at age three and four.[9] However, large community studies report much higher levels of physical discipline. A population-based survey, using a large sample of young men and women in the Eastern Cape province, found that 89% of young women and 94% of young men reported physical punishment by their caregivers before the age of 18 years.[10] In this study, a large proportion of young people (85% of young men and 69% of young women) report having been beaten as a child with a belt, stick or other hard object.[11] Corporal punishment also continues in South African schools despite it being legally prohibited. Nationally, approximately 50% of learners experience corporal punishment by teachers.[12]

The divide between physical punishment and physical abuse is blurry. Many researchers regard physical punishment and potentially abusive techniques as "points on a continuum of physical acts toward children".[13] In fact, there is a lot of overlap between less severe forms of physical punishment and more severe forms of child maltreatment which would be considered physical child abuse.[14] Studies from the U.S.A. and Canada have shown that most physical child abuse takes place in the context of punishment: 75% of physical abuse of children occurs during episodes of discipline using corporal punishment, and children who are spanked by their parents are seven times more likely to also be severely assaulted by their parents.[15] Physical child abuse is highly prevalent in South Africa. The first national study on violence against children found that 34% of children between 15 and 17 years report lifetime experiences of physical abuse by an adult.[16] Community-based studies report even higher levels of physical child abuse. For instance, in a study in the Western Cape and Mpumalanga, 56% of children aged 10–17 years reported lifetime physical abuse which was mostly perpetrated by primary caregivers, followed by teachers and relatives.[17] Younger children were more likely to experience physical abuse than older children.[18]

[9] Dawes et al. 2005.
[10] Jewkes et al. 2010.
[11] Jewkes et al. 2010.
[12] Burton & Leoschut 2012.
[13] Gershoff 2002.
[14] The majority of child abuse researchers see corporal punishment and physical abuse as points on a continuum of abusive acts towards children. Gershoff 2012.
[15] Durrant & Ensom 2012.
[16] Burton et al. 2016.
[17] Meinck et al. 2016.
[18] Meinck et al. 2016.

The links between physical punishment and physical abuse are significant because in the most extreme cases physical abuse can be fatal. Child homicide rates are double the global average in South Africa, and research indicates that just under half (44.6%) of these homicides happen in the context of child abuse and neglect.[19] Young children between birth to four years are most at risk, and most of their deaths occur in the home.[20]

As a widespread form of violence against children, physical punishment requires urgent attention both from a public health perspective and from a human rights perspective.

1. Public health considerations

Physical punishment is often not regarded as harmful but rather as a normal and necessary part of disciplining children. Yet, the evidence suggests that physical punishment may have deleterious effects, including externalising and internalising behavioural problems and reduced cognitive performance. If experienced during early childhood, the risk of negative immediate, medium- and long-term effects is higher because early childhood experiences have been shown to have a strong influence on the development of cognitive and social skills, behavioural outcomes, as well as on brain architecture and neurochemistry.[21]

A meta-analysis of 88 studies showed that 'mild' forms of parental physical punishment such as spanking and slapping are associated with 10 unwanted outcomes:

- Decreased –
    - moral internalisation;
    - quality of relationship between parent and child;
    - child mental health; and
    - adult mental health.

[19] Mathews et al. 2016.
[20] Mathews et al. 2016.
[21] Knudsen et al. 2006; Anda et al. 2006.

- Increased –
    - child aggression;
    - child delinquent and antisocial behaviour;
    - adult aggression;
    - adult criminal and antisocial behaviour;
    - risk of abusing own child or spouse in adulthood.[22]

Harsher forms of physical punishment are more strongly associated with these outcomes than 'mild' forms of physical punishment such as spanking.[23] The strongest association was observed for physical punishment and the increased risk of parental physical abuse (i.e. behaviours that risk injury) of the same children.[24] This highlights the link between physical discipline and physical abuse. As noted earlier, 75% of physical abuse of children occurs during episodes of physical discipline.[25]

Yet, some researchers contest the associations between corporal punishment and negative outcomes arguing that existing studies have inflated effect sizes, in other words exaggerate the effects of physical punishment.[26] Ferguson, for instance, purports that the impact of corporal punishment on negative behaviours and low cognitive performance is actually minimal.[27] Gershoff & Grogan-Kaylor, however, underline that even though 'the magnitude of the observed associations may be small, when extrapolated to the population in which 80% of children are being spanked, such small effects can translate into large societal impacts'.[28] In other words, even though the proportion of children who experience negative outcomes from mild forms of physical punishment may be small, this small proportion translates into large absolute numbers because of the high overall prevalence of such punishment.

[22] To research the effects of 'less severe' forms of corporal punishment such as spanking, researchers need to distinguish it from abusive behaviours that would be regarded as child abuse. Gershoff, 2002.
[23] Ferguson 2013; Gershoff & Grogan-Kaylor 2016.
[24] Gershoff 2002.
[25] Durrant & Ensom 2012.
[26] Ferguson 2013.
[27] Ferguson 2013.
[28] Gershoff & Grogan-Kaylor 2016.

Addressing physical punishment is also critical to reduce the inter-generational transmission of violence. Physical punishment conveys the message that violence is an acceptable way of conflict resolution. Evidence suggests that violent behaviour is likely learnt during childhood. For boys, physical punishment increases the risk of adopting violent masculinities and perpetrating violence in adulthood; for girls, it increases the risk of becoming victims of violence in adulthood.[29] Corporal punishment thus plays a strong role in fuelling violence across the life-course, including intimate partner violence (IPV). Curbing physical punishment is therefore necessary to break the cycle of violence.

2. Human rights considerations

In addition to the adverse public health consequences, physical punishment is highly problematic from a human rights perspective. South Africa has ratified the United Nations Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). Both of these legal instruments protect a comprehensive set of children's rights, including their right to be free from physical and mental violence, injury and abuse, negligent treatment, maltreatment and exploitation while in the care of parent(s), legal guardian(s) or any other caregiver.[30] The state has a duty to protect children from these forms of maltreatment and abuse through legislative, administrative, social and educational measures.[31]

In addition, the UNCRC prohibits torture and other cruel, inhuman or degrading treatment and punishment of children,[32] and the ACRWC stipulates that parents and caregivers of children have the duty to ensure that domestic discipline is administered with humanity and in a manner consistent with the inherent dignity of the child.[33] The UN Committee on the

[29] Machisa 2016; Abrahams & Jewkes 2005; Fonseka et al. 2015; Stith et al. 2000.
[30] Article 19(1) of the UNCRC; Article 16(1) of the ACRWC.
[31] Article 19(1) of the UNCRC; Article 16(1) of the ACRWC.
[32] Article 37 UNCRC.
[33] Article 20 ACRWC.

Rights of the Child furthermore released a General Comment which deals specifically with physical punishment.[34] This General Comment provides a definition for corporal punishment and calls on governments to enact laws that ban all forms of physical punishment, including corporal punishment in the home.[35] International law thus clearly protects children from physical discipline by their caregivers.

South African constitutional law also protects children from physical discipline by caregivers. South Africa's Constitution protects children's right to be free from all forms of violence, the right to bodily and psychological integrity and their right to be protected from maltreatment and abuse.[36] However, the Children's Act, which is meant to give effect to children's constitutional rights, does presently not explicitly prohibit corporal or physical punishment by parents or caregivers. Corporal punishment is only prohibited in schools, detention centres and for children in alternative care.[37] However, the legal landscape could change in the near future. A legal ban of corporal punishment in the home is expected to be included in the Child Care & Protection Policy, which is currently being finalised by the Department of Social Development. A legal ban is a necessary first step that will send a clear message that the physical punishment of children is a human rights violation. However, as evidenced by the legal prohibition of corporal punishment in schools, a legal ban will in and by itself not reduce the use of physical punishment. It is therefore critical to develop and roll out evidence-based interventions that will shift attitudes and practices.

This literature review summarises and highlights evidence on large-scale interventions that aim to shift attitudes and behaviours underpinning physical punishment. The analysis of the current evidence base will assist policy makers and practitioners in making informed decisions about interventions that could support the development and implementation of policies and programmes targeting physical punishment.

[34] United Nations Committee on the Rights of the Child 2007.
[35] United Nations Committee on the Rights of the Child 2007.
[36] Sections 12, 28(1)(d) of the Constitution.
[37] South African Schools Act 84 of 1996; Correctional Services Second Amendment Act 79 of 1996; General Regulations Regarding Children 2010.

II. Methodology

This desktop review includes peer reviewed literature (journal articles) and grey literature (e.g. UNICEF reports; research reports; project evaluations). Searches were conducted in the online database PubMed using various search terms (e.g. 'harsh discipline', 'community intervention', 'physical discipline', 'edutainment', 'behaviour change'), and different combinations of search terms. Searches prioritised studies conducted in low- and middle-income countries that reported on large-scale or scalable interventions. Reference lists of journal articles were perused for further relevant literature. In addition, online searches in search engines were conducted to identify grey literature. Where appropriate, references provided in the grey literature were reviewed. Due to the focus on large-scale interventions, parenting programmes are not reported in this paper.

III. Behaviour change theories

When evaluating the effectiveness of interventions, it is helpful to consider the theoretical framework that examines and explains human behaviour and behaviour change. The following are examples of theories that can guide the design and/or evaluation of behaviour change interventions.

1. Social Learning Theory

Social Learning Theory views behaviour as something that can be learned through observation, modelling and imitation. Bandura stipulates that learning behaviour through observation is straightforward because this process does not require the efforts of building certain patterns by trial and error.[38] This theory combines the dynamics of socialisation with the internal processes of cognition. The theory also describes how motivation directs behaviour and how this can influence the retention of a certain behaviour.[39] Additionally, behaviour can be learned by processes of reinforcement wherein people observe and assess

[38] Bandura 1971.
[39] Bandura 1971.

the consequences of the actions they may take or consider taking.[40] Bandura also argues that it is important that an individual believes that they can perform a certain behaviour (self-efficacy) as this will help them persevere during difficulties which are associated with performing that behaviour.[41]

2. Lewin's Theory of Change

Lewin's Theory of Change describes how psychological components such as an individual's emotion, abilities and internal resources can influence behavioural change.[42] This theory explains that external forces such as societal norms or group membership can have an influence on certain aspects of behaviour and thus lead to a restraint or a production of new behaviour.[43] Behaviour change is explained using a three-step process which includes unfreezing, moving and freezing, whereby a certain disturbance or, what Lewin terms an 'emotional stir-up', is initiated.[44] Lewin explains that the first step in this three-step process is the unfreezing of a nearly 'stationary equilibrium of social forces' that either restrain or drive behaviour.[45] The second step necessitates the movement of individuals into more favourable behaviours, and the third stage seeks to stabilise a new equilibrium wherein the new behaviours are less likely to regress.[46] Applying this theory with hopes to elicit behaviour change would require contact sessions of dialogue, engagement with different views, and a disputation that should occur amongst those who are due for change.[47]

3. Theory of Planned Behaviour

The Theory of Planned Behaviour is an extension of the Theory of Reasoned Action.[48] The central factor in this model is intention, which is also referred to as the primary determinant of behaviour.[49] The Theory of Planned Behaviour explains three main psychological constructs which influence intention: attitude, subjective norm and perceived behavioural control.[50]

[40] Bandura 1971(a).
[41] Bandura 2009.
[42] Lewin 2012.
[43] Zand & Sorensen 1975.
[44] Lewin 2012.
[45] Lewin 2012.
[46] Burnes 2004.
[47] Schein 1996.
[48] Beck & Azjen 1991.
[49] Whitaker et al. 2016.
[50] Beck & Azjen 1991.

Attitude refers to an individual's approval or disapproval of the behaviour of interest. [51] Subjective norm can be explained as the personal evaluation of the existence of social pressure to execute or not execute a behaviour. Perceived behavioural control deals with the individual's perception of ease or difficulty associated with performing a certain behaviour.[52] Furthermore, what this theory attempts to describe is that the more positive an attitude and subjective norm is towards a certain behaviour, the greater the perceived behavioural control and the intention to act out that behaviour.[53]

4. Social Identity Theory

Social Identity Theory deals with the characteristics of a group that manifest in the individual. In other words, it deals with a person's identity which develops from their group's culture and norms.[54] The basis of this theory is that people have a desire and therefore make efforts to ensure that they have a positive social identity which is consistent with the norms of that group.[55] The groups which they belong comprises of negative and positive notions which may be determined within or outside the group. An evaluation of the group's social identity is determined by a comparison of the individual's group with other groups. Brown further indicates how efforts to maintain this positive identity would influence an individual to depart from their current group or encourage them to make certain changes if that identity is unsatisfactory.[56] Social Identity Theory has four underlying principles, namely social categorisation, self-esteem, social comparison and social identity.[57]

5. Information-Motivation-Behaviour Skills Model

The Information-Motivation-Behaviour Skills Model focuses on the individual's ability to use information and learn certain skills that thus propel them to behaviour change. Fisher and Fisher proposed this model with the purposes of applying it to HIV-related behaviours , but it can be applied to a range of contexts that could eventually lead to a change in behaviour.[58] This model has been constructed with the use of three concepts: information, motivation and behaviour. Firstly, information is regarded as the basis for behaviour given that being informed will allow one to make and act upon decisions.[59] Secondly, motivation deals with the individual's personal motivation or willingness to engage in a given behaviour. Motivation

[51] Beck & Azjen 1991.
[52] Beck & Azjen 1991.
[53] Beck & Azjen 1991.
[54] Tajfel & Turner 1986.
[55] Tajfel & Turner 1986.
[56] Brown 2000.
[57] Tajfel & Turner 1986.
[58] Fisher & Fisher 1992.
[59] Chang et al. 2014.

is also linked to social support, which is needed to influence a person to participate or change their mindset.[60] Thirdly, individuals must have the behavioural skills to carry out the behavioural change. Thus one's objective skills may need to be modified so as to enable the individual to direct their behaviour.[61]

6. Transtheoretical Model

The Transtheoretical Model of change or Stages of Change is explained as a theory that has a primary focus on decision-making abilities that individuals possess as compared to biological and social determinants of behaviour.[62] The theory has been identified as distinctive because it states the value of time and acknowledges that change occurs over time.[63] According to this theory change occurs in a course of six stages.[64] The precontemplation stage is one where the individual does not intend on changing their behaviour.[65] This has been attributed to either lack of information about the consequences of that behaviour or an individual's opposition to change behaviour[66] The second stage is contemplation wherein the individual has a certain level of awareness of the behaviour they have to change.[67] In this stage, individuals may develop an intention to change and, as a result of this, weigh the negatives and positives of making this change.[68] There are also instances where the individual may continue to engage in the problem behaviour, yet the cornerstone of this stage is that the individual seriously considers changing their behaviour.[69]

The third stage is the preparation stage and it deals with the individual devising to take action in the near future.[70] In some instances, during this stage a person has taken some form of action yet still continues with behaviour that is detrimental.[71] Furthermore individuals in this stage may be uncertain about their ability to change.[72] The fourth stage is the action stage and this stage is associated with the modification of behaviour.[73] It is in this stage that the

[60] Fisher et al. 2003.
[61] Fisher et al. 2003.
[62] Lenio 2006.
[63] Prochaska and Velicer 1997.
[64] Prochaska and Velicer 1997.
[65] Prochaska and Velicer 1997.
[66] Prochaska and Velicer 1997.
[67] Morris et al. 2012.
[68] Lenio 2006.
[69] Prochaska et al. 1992 as cited in Lenio 2006.
[70] Prochaska and Velicer 1997.
[71] Prochaska et al. 1992 as cited in Lenio 2006.
[72] Scholl 2002 as cited in Lenio 2006.
[73] Prochaska and Velicer 1997.

individual's efforts to change is visible to others.[74] Yet, the *effort* to change cannot be directly translated as change.[75] According to Prochaska and Velicer, the maintenance stage involves the individual's efforts to prevent relapse of the problem behaviour and also the confidence that they will continue with change.[76] The sixth stage is termination and it yields full self-efficacy of the individual and 'zero temptation' to revert to the previous problem behaviour.[77] Theorists acknowledge that it may be difficult for people not to relapse as a way to cope when adversity arises.[78]

7. Social Norms Theory

The social context, including social norms and beliefs, can strongly influence behaviour and behaviour change. Social Norms Theory therefore draws attention to the social norms and beliefs to explain why certain behaviours are common in a group.[79] The theory emphasises the importance of social norms while acknowledging that non-social factors also play a role in determining behaviour.[80] Social norms refer to the rules of a particular group that set out what the group considers as normal behaviour.[81] Bicchieri proposes that social norms are determined by:

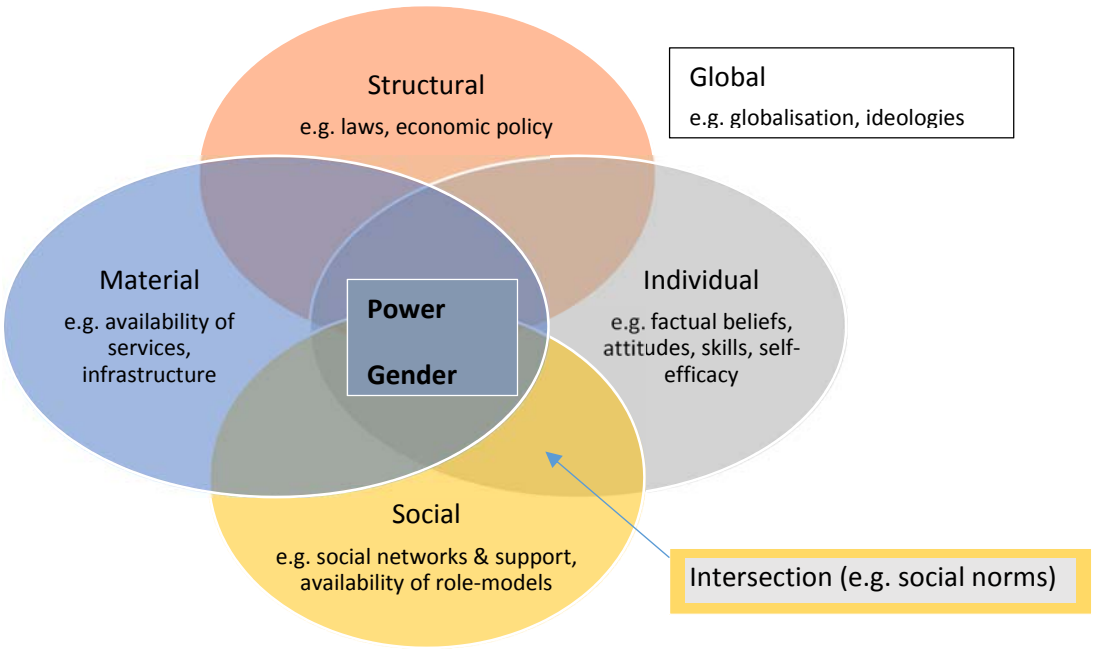
- Empirical expectations, i.e. the belief that members of their group would act in a certain way.
- Normative expectations, i.e. the belief that others think that they themselves should also act in that particular way.
- Sanctions, i.e. seeking of positive sanctions (approval) and fear of negative sanctions from the group.[82]

Cislaghi & Heise summarise that, 'When individuals act under the influence of what they think others expect of them, they are operating in the realm of social norms.'[83] As illustrated in Figure 2, their framework for behaviour change illustrates how social norms are just one

[74] Lenio 2006.
[75] Prochaska and Velicer 1997.
[76] Prochaska and Velicer 1997.
[77] Prochaska and Velicer 1997.
[78] Prochaska and Velicer 1997.
[79] Mackie et al. 2015.
[80] Mackie et al. 2015.
[81] Cislaghi & Heise, 2016.
[82] Bicchieri 2006 as quoted in Cislaghi & Heise 2016.
[83] Cislaghi & Heise 2016.

aspect that influences behaviour. Social factors interact with individual factors such as individual beliefs, self-efficacy and attitudes, and social norms are created through the interaction of individual and social factors. The theory also acknowledges the role of structural factors and access to materials in behaviour.

Figure 1: Framework for behaviour change



Source: Cislaghi B & Heise L (2016) *Measuring Gender-related Social Norms: Report of a Meeting, Baltimore Maryland, June 14-15, 2016.* Learning Group on Social Norms and Gender-based Violence of the London School of Hygiene and Tropical Medicine

The influence of social norms can prevent or accelerate changes in behaviour.[84] Changing social norms, however, is not a guarantee for behaviour change because other determinants may sustain a particular behaviour.[85] Interventions that aim to shift behaviour should therefore explore whether social norms support a particular practice or whether changes in other domains are more critical to enable behaviour change.[86]

[84] Cislaghi & Heise 2016.
[85] Cislaghi & Heise 2016.
[86] Cislaghi & Heise 2016.

Furthermore, Social Norms Theory suggests that interventions targeting individual attitudes and behaviours can lead to behaviour change, but material and structural factors (e.g. poverty, inequality, unemployment) may also have to be addressed to create an enabling environment that supports sustainable behaviour change.

8. Summary

Although behaviour change theories focus on individual's cognitive decisions, some theories also acknowledge the influence of social norms or group membership on behaviour and behaviour change. While the theories differ in terms of the emphasis they place on particular elements, certain key concepts are common, such as cognition, self-efficacy, intention and/or motivation, as well as social identity and social norms.

Conceptual work examining behaviour change in relation to physical punishment is scarce. However, there is one large multi-country study that reports on the interaction between individual attitudes, social norms and the use of physical punishment. Drawing on data from 85,999 female caregivers in 25 low- and middle-income countries, the study investigated *inter alia* the links between attitudes towards corporal punishment, and how these attitudes are linked to violent behaviours towards children.[87] In all 25 countries, individuals' belief that corporal punishment is a necessary form of child discipline predicted the actual use of physical punishment and psychologically aggressive behaviour towards children.[88] Interestingly, the study furthermore found that women who believe that husbands are justified in hitting their wives *and* that corporal punishment is a necessary form of discipline were up to eight times more likely to report that their children had experienced psychological aggression, physical violence, and severe physical violence in the last month, compared with women who did not hold these beliefs.[89] This suggests that women who hold gender inequitable beliefs are more likely to use physical punishment.

[87] Lansford et al. 2014.
[88] Lansford et al. 2014.
[89] Lansford et al. 2014.

Social norms also played an important role in the prevalence of physical punishment. Firstly, children living in countries where social norms support domestic violence and corporal punishment were more likely to experience physical punishment.[90] Secondly, the strength of the association between individual attitudes and the use of physical punishment was weaker in countries where social norms supported domestic violence and corporal punishment, compared to countries where these types of violence were not supported.[91] Lansford et al. explain 'that in countries where domestic violence and corporal punishment are widely accepted, harsh behaviours toward children may be parents' default responses, less guided by individual choices regarding discipline strategies than by adoption of common social practices'.[92] In countries where norms around gender equality and physical punishment are less normative, individual attitudes may play a larger role in determining the use of physical and emotional violence towards children.[93] The study highlights that interventions aimed at shifting attitudes and behaviour in relation to physical punishment should target both individual attitudes and social norms.[94] Furthermore, the findings underline the potential of integrating interventions to address domestic violence and physical punishment.[95]

IV. Large-scale interventions with potential for behaviour change

In light of behaviour change theories, interventions aimed at changing attitudes and behaviour should aim to:

- Educate participants on child development, positive effects of a nurturing parent-child relationship, negative effects of physical punishment, alternative forms of discipline and children's rights;
- Change participants' individual attitudes towards physical discipline of children (e.g. by increasing self-efficacy and motivation to change);

[90] Lansford et al. 2014.
[91] Lansford et al. 2014.
[92] Lansford et al. 2014.
[93] Lansford et al. 2014.
[94] Lansford et al. 2014.
[95] This will also be discussed below. See IV.3.

- Change social norms around the acceptance of physical discipline of children (e.g. by working with communities to interrogate norms); and, as a result of these,
- Change behaviour to non-violent forms of discipline.

When evaluating interventions, it is useful to bear in mind that behaviour change is a process and involves several intermediate steps. Thus, even interventions that have been unsuccessful in changing behaviour may still be valuable if they have changed intermediate outcomes such as beliefs and self-efficacy, or if they have created motivation to change.

The review of the literature highlights that the evidence on large-scale interventions addressing physical punishment specifically is very limited. Programmes aimed at preventing physical punishment in the home are mostly small-scale interventions, such as parenting programmes and support groups. Violence prevention interventions in schools often focus on the prevention of *other forms of violence* such as sexual violence and bullying. In light of the paucity of evidence, the literature presented here includes examples of large-scale interventions targeting other forms of violence and health behaviours. We also present evidence on interventions that were 'medium scale', but have the potential of being scalable, such as home visitation programmes.

1. Early-childhood home visitation programmes

Home visitation programmes involve visits by professionals or paraprofessionals to provide some form of support or education to the household. They have been implemented in many countries with different focus areas.

a) Nurse-Family Partnership (U.S.A.)

The *Nurse-Family Partnership* is a home visiting programme by nurses that was initiated in New York State, U.S.A., in 1977.[96] It includes nine home visits during pregnancy and 23 home

[96] World Health Organisation 2016.

visits from the child's birth through to the second birthday.[97] The programme has been evaluated at various intervals through randomised control trials (RCT). The last evaluation was conducted with 324 women at the 15-year follow-up interval (i.e. 15 years after the birth of the first child). This evaluation shows that the home visiting programme has had numerous positive impacts on women and children.[98] Compared to women in the control group, women who were enrolled in the home visitation program were 48% less likely to be a perpetrator of child abuse in child abuse cases that had been reported to child protection agencies.[99] Women who received home visits also had fewer subsequent births, had longer periods of time between having children ('child spacing'), and were less likely to have behavioural problems caused by alcohol or drugs, compared to women in the control group.[100]

Further research examined whether the existence of domestic violence in the home undermined the effects of the intervention. Almost half (48%) of the women participating in the study had experienced domestic violence since the birth of the first child.[101] The impact of the intervention decreased as the level of domestic violence increased.[102] Child abuse was significantly lower in families receiving home visits where women had experienced up to 28 incidents over the 15-year follow-up period.[103] Where women reported more than 28 incidents of domestic violence, the intervention did not reduce child maltreatment.[104] The Nurse-Family Partnership has been scaled-up in the USA and has been replicated in several other countries, including Australia, Canada, the Netherlands and the United Kingdom.[105]

b) Roving Caregivers programme (Caribbean – multi-country)

The *Roving Caregivers* programme is a home visitation programme that was initially started in Jamaica, but subsequently rolled-out to several other Caribbean countries (Belize, Saint

[97] Olds et al. 1997.
[98] Olds et al. 1997.
[99] Olds et al. 1997.
[100] Olds et al. 1997.
[101] Eckenrode et al. 2000.
[102] Eckenrode et al. 2000.
[103] Eckenrode et al. 2000.
[104] Eckenrode et al. 2000.
[105] World Health Organisation 2016.

Lucia, Saint Vincent and the Grenadines, Grenada and Dominica).[106] Trained members of the community ('roving caregivers') make weekly home visits to families with infants and toddlers up to the age of three years and live in socially and economically disadvantaged communities.[107] The roving caregivers show parents how to stimulate children's cognitive, social and physical development, and give advice on parenting and child-rearing practices.[108] In addition to the home visits, the intervention includes monthly parent meetings where participants can share their knowledge and experiences.[109]

In 2008, the impact of the programme was evaluated qualitatively and quantitatively in Saint Lucia.[110] The quantitative evaluation used a quasi-experimental longitudinal design.[111] Four hundred children and their families, half of them living in intervention communities, half in control communities, participated in the quantitative evaluation.[112] Children's development was assessed at baseline, 12-month and 24-month follow-ups at health centres.[113] Additionally, repeat surveys were conducted with parents to assess parenting behaviour, including disciplining methods.[114] The impact evaluation compares results between baseline and 24-month follow-up. The evaluation showed significant effects on the cognitive development of children, particularly for younger children between six and 18 months.[115] Compared to participants of the control group, parents who participated in the intervention were significantly more likely to engage in stimulating parent-child interactions such as singing and story-telling.[116]

Changes in parental discipline were only reported on in the qualitative evaluation, and the information provided is not very detailed. The report highlights that both parents in the

[106] Unicef 2014.
[107] Unicef 2014.
[108] Unicef 2014.
[109] Unicef 2014.
[110] The evaluation is published as an impact report. It is not peer-reviewed.
[111] Wint & Janssens 2008.
[112] Wint & Janssens 2008.
[113] Wint & Janssens 2008.
[114] Wint & Janssens 2008.
[115] Wint & Janssens 2008.
[116] Wint & Janssens 2008.

intervention and in the control group wished to use less corporal punishment.[117] In the intervention group, this desire had been sparked by the roving caregivers' visits and the newly learned parenting skills.[118] In terms of parenting practices, the only information provided is that "the largest impact" of the intervention in relation to corporal punishment was observed for first time mothers.[119] Furthermore, parents who participated in the intervention addressed discipline "with a much higher degree of talking and words rather than corporal punishment".[120] The effectiveness of the intervention in relation to changing attitudes and practices related to harsh parenting is therefore unclear. A cost-benefit analysis found the programme to be cost-effective.[121]

c) Mother-infant programmes (South Africa)

Thula Sana (*Hush Baby*) is a home visitation programme that was implemented in Khayelitsha. The aim of the programme is to improve the quality of the mother-infant relationship and to promote security of infant attachment.[122] Both of these goals are linked to the prevention of physical punishment. Firstly, strengthening the mother-infant relationship by promoting sensitive parenting can reduce negative forms of parenting, such as violent discipline. Secondly, improving infant attachment refers to improving the bond between the primary caregiver, usually the mother, and the infant. Secure attachment is one of the factors that determines how children form relationships with peers, partners and their own children later in life.[123] Poor attachment can lead to an inability to form healthy relationships and increases the risk of perpetrating violence later in life.[124] Interventions strengthening the mother-infant relationship and promoting infant attachment can therefore reduce risk factors for violence perpetration later in life.

Thula Sana was adapted from a British intervention. Four lay community workers, who were trained in basic parenting and counselling, visited 220 women in the intervention group 16

[117] Wint & Janssens 2008.
[118] Wint & Janssens 2008.
[119] Wint & Janssens 2008.
[120] Wint & Janssens 2008.
[121] Janssens & Rosemberg 2012.
[122] Cooper et al. 2009.
[123] Belsky 1993.
[124] Belsky 1993.

times.[125] The home visits start in the last trimester of pregnancy and continue until six months after birth.[126] During the home visits, community workers engage mothers in different activities to increase their awareness of their infants' individual capacities and needs.[127] *Thula Sana* was evaluated in a randomised control trial (RCT) which found that, compared to the control group, mothers in the intervention group were significantly more sensitive and less intrusive at six and 12 months postpartum. Infant attachment security at 18 months was also significantly higher in the intervention group.[128] The study illustrated that home visitation programmes can be adapted to low-resource settings and can achieve similar results as home visitation programmes in developed countries.[129] Though the study did not report on cost-effectiveness, it is remarkable that four lay counsellors with no specialist qualification were able to deliver the intervention.[130]

Home visitation programmes have also been used to address other health issues in South Africa. The *Good Start Saving Newborn Lives* programme, which involved home visits during pregnancy and after delivery, focused on the uptake of Prevention of Mother-to-Child Transmission (PMTCT) interventions and appropriate infant care practices.[131] The intervention was successful in ensuring that mothers followed community health workers' advice to take their sick baby to a clinic.[132] Home visitation programmes by trained community health care workers have also been successful in reducing maternal depression, lowering levels of child stunting, and reducing the child's risk of hospitalisation.[133]

d) Summary

The evidence base for home visitation programmes focusing on the prevention of child maltreatment is scarce. However, the *Nurse-Family Partnership* suggests that home visitation programmes can reduce risk factors for child abuse, and other home visitation programmes

[125] Cooper et al. 2009.
[126] Cooper et al. 2009.
[127] Morgan et al. 2017.
[128] Cooper et al. 2009.
[129] Cooper et al. 2009.
[130] Cooper et al. 2009.
[131] Nsibande et al. 2013.
[132] Nsibande et al. 2013.
[133] Tomlinson et al. 2016.

showed effects on improving children's cognitive development, improving infant attachment, and promoting mother and child health. Despite these promising results, systematic reviews evaluating home visitation programmes, which largely focus on the global north, have showed mixed results. While some systematic reviews suggests that home visitation programmes, including those by paraprofessionals, can significantly improve child development and prevent child abuse,[134] others caution that the evidence may not be robust due to methodological challenges including 'surveillance' or 'detection' bias.[135]

South African evidence illustrates that home visitation programmes can be implemented successfully by lay counsellors and community health workers who are adequately trained and supervised. The *Isibindi* model is another South African intervention that includes home visits by trained community members to provide practical assistance and, where necessary, referrals to children and their families. The fact that this model has been rolled out to all South African provinces suggests that home visitation programmes are scalable and acceptable. Similar to the *Roving Caregivers* programme, *Isibindi* has demonstrated the cost-effectiveness of home visitation programmes led by paraprofessionals.

The success of home visitation programs focusing on developmental and child health outcomes may not be transferable to other thematic areas. Further research is needed to investigate whether a controversial topic such as physical punishment, which appears to be shaped by both individual attitudes and social norms, can be addressed in a home visitation programme. The research should be mindful of potential methodological challenges.

2. School-based interventions

A number of low-and middle-income countries have implemented programmes to reduce the use of physical punishment in schools or to improve classroom atmosphere. Some

[134] Peakock et al. 2013; Bilukha et al. 2005.
[135] Mikton & Butchart 2009 with further references. Surveillance bias refers to an increased likelihood that child abuse will be identified and reported due to the home visits.

programmes have a wider focus on violence prevention and have also engaged parents. The approaches used to change teachers' behaviour may be useful for the development of behaviour-change programmes targeting parents.

a) Good School Toolkit (Uganda)

In Uganda, researchers tested whether an intervention could reduce corporal punishment by primary school staff.[136] The *Good School Toolkit* developed by the non-governmental organisation Raising Voices is a complex, multi-component intervention which aims to change teachers' behaviours.[137] The intervention, which is based on the Transtheoretical Model of Behaviour Change, draws on different techniques and offers 60 activities that school staff can select from to proceed from one step to the next in a six-stage programme.[138] The techniques include the setting of school-wide goals, development of action plans and the provision of information on non-violent discipline.[139] Learners participate actively in the intervention through different committees and groups. The intervention addresses not only teachers, but also engages administrative staff and parents to support a more widespread shift of attitudes.[140] The intervention goes beyond the school setting and also engages the communities where the learners come from.

The intervention was evaluated through a cluster RCT. The intervention was implemented in 21 primary schools; a further 21 primary schools were selected as a waitlisted control group.[141] Baseline interviews were conducted with 3,706 students from all 42 primary schools.[142] After 18 months of programme implementation, post-intervention interviews were conducted with 3,814 students (approximately half at the control and intervention schools, respectively).[143] The success of the intervention was assessed by comparing baseline

[136] Devries et al. 2015.
[137] Devries et al. 2015.
[138] Devries et al. 2015.
[139] Devries et al. 2015.
[140] Devries et al. 2015.
[141] Although the intervention was conducted at primary schools, most of the learners who participated in the baseline and follow-up survey were between 11 and 14 years old. Devries et al. 2015.
[142] Devries et al. 2015.
[143] Devries et al. 2015.

and follow-up outcomes which were similar across the control and intervention schools at baseline. At baseline, 54% of learners reported past-week physical violence from school staff at intervention and control schools.[144] At follow-up, the odds of experiencing physical violence from school staff were significantly lower at the intervention schools. While 49% of students at control schools reported past-week physical violence from school staff, only 31% of students at the intervention schools did.[145] This amounts to a 42% reduction in risk of past-week physical violence for students at intervention schools.[146] The intervention also had a positive effect on students' feelings of safety and wellbeing, but it did not improve students' mental health status and educational test scores.[147]

In addition to reductions in past-week physical violence from school staff, the intervention reduced other types of violence by both school staff and peers. For instance, the prevalence of emotional and severe physical violence (i.e. 'being severely beaten up') from school staff over the past school term were significantly lower at the intervention schools.[148] Learners at intervention schools also reported lower levels of emotional violence from peers over the past week and past term.[149] For certain types of violence, the extent of the reduction was higher among boys than girls.[150] The intervention was thus successful in changing school culture by reducing both physical and emotional violence perpetrated by school staff and peer learners.[151]

The intervention was also evaluated using qualitative methods to explore how the intervention managed to change school staff's behaviour. The qualitative analysis identifies several pathways of change. Firstly, the intervention meaningfully improved the relationship between students and teachers.[152] At the intervention schools, pupils described their

[144] Devries et al. 2015.
[145] Devries et al. 2015.
[146] Devries et al. 2015.
[147] Devries et al. 2015.
[148] Devries et al. 2017.
[149] Devries et al. 2017.
[150] Devries et al. 2017.
[151] Devries et al. 2017.
[152] Kyegombe et al. 2017.

teachers as approachable and concerned about learners. Secondly, the intervention encouraged good student behaviour through rewards and praise.[153] Thirdly, the intervention led to increased knowledge of alternative discipline methods.[154] With this new knowledge, teachers had the tools to instil discipline among learners without reverting to corporal punishment.[155] They had not been aware of these alternatives before the intervention. Fourthly, the intervention changed some teachers' attitudes towards corporal punishment, with some teachers reporting that they believed corporal punishment to be ineffective.[156] In addition, the qualitative analysis of the intervention suggests that the intensity of corporal punishment changed at the intervention schools.[157] For instance, students and teachers reported that the number and severity of the strokes were reduced.[158]

In light of its success in reducing various forms of violence against learners, including physical punishment by teachers, the *Good Schools Toolkit* is currently being rolled out to schools across Uganda, and its long-term impact is being assessed.

b) Ma'An (Jordan)

Interventions to reduce violence against children in schools have also been undertaken in Jordan. In 2009, UNICEF and the Jordanian Ministry of Education started a national campaign to reduce violence against children in schools.[159] The *Ma'An* (*Towards a Safe School*) campaign is multi-pronged; it includes school-based activities to promote behavioural changes among teachers; community-based activities; and a media-campaign.[160] At the institutional level, the intervention includes capacity building for teachers (e.g. non-violent forms of discipline; classroom management) and the establishment of teacher 'advocacy

[153] Kyegombe et al. 2017.
[154] Kyegombe et al. 2017.
[155] Kyegombe et al. 2017.
[156] Kyegombe et al. 2017.
[157] Devries et al. 2017.
[158] Devries et al. 2017.
[159] Unicef 2014.
[160] Unicef, Violence against children study in Jordan: Summary. Retrieved 4 May 2017 at: https://www.unicef.org/jordan/protection_6079.html

teams' that promote non-violent discipline among colleagues.[161] At community level, the goals and activities of the campaign are disseminated and activities such as meetings and community drama are used to shift social norms.[162] The campaign also draws on traditional communication channels such as religious leaders.[163] The media campaign takes place three times a year for three weeks each cycle. It uses different media (television, radio, newspaper) for persistent 'messaging' on zero tolerance of violence against children and advertising the 'New Way of Discipline'.[164]

The campaign is still ongoing and an evaluation of the intervention is not yet available. UNICEF reports that after the first year of the campaign, a survey showed an average decline of 28% in physical violence (58% for girls) and a 15% decline in verbal violence in schools.[165] These are very promising results. It remains unclear at this stage whether the reduction in violence refers to violence perpetrated by teachers, specifically, or whether it includes learner-on-learner violence.

c) Incredible Years Teacher Training (Jamaica)

In 2009, the *Incredible Years Teacher Training* and the *Incredible Years Dina Dinosaur Classroom Curriculum* were tested in a small sample of preschools in Jamaica. The intervention consisted of professional development for teachers paired with a curriculum unit on social and emotional skills.[166] The intervention, which is based on materials from the U.S.A., involved seven days of training for teachers.[167] The intervention was evaluated using a cluster RCT design including three intervention and two control schools.[168] The impact of

[161] Unicef, Violence against children study in Jordan: Summary. Retrieved 4 May 2017 at: https://www.unicef.org/jordan/protection_6079.html.
[162] Unicef, Violence against children study in Jordan: Summary. Retrieved 4 May 2017 at at: https://www.unicef.org/jordan/protection_6079.html.
[163] Unicef, Violence against children study in Jordan: Summary. Retrieved 4 May 2017 at: https://www.unicef.org/jordan/protection_6079.html.
[164] Unicef, Violence against children study in Jordan: Summary. Retrieved 4 May 2017 at: https://www.unicef.org/jordan/protection_6079.html.
[165] Unicef 2014.
[166] Baker-Henningham et al. 2009.
[167] Baker-Henningham et al. 2009.
[168] Baker-Henningham et al. 2009.

the intervention was assessed through structured observations of teacher behaviour.[169] The evaluation showed that the intervention significantly reduced negative teacher behaviours, and increased positive teacher behaviours and the extent to which teachers promoted children's social and emotional skills.[170] It is unclear what kind of behaviours constituted 'negative' or 'positive' teacher behaviours. This intervention did not measure a reduction in the use of physical discipline, but focused on outcomes like positive classroom atmosphere. Its suitability for reducing corporal punishment by teachers is therefore unclear. It also needs to be highlighted that the study was relatively small.

A further intervention, the *Irie Classroom Toolbox*, is currently being tested in a larger cluster of 76 Jamaican preschools.[171] The intervention includes teacher training on classroom management.[172] Given that one of the outcome measures of this study will be observed levels of violence against children by teachers, this study may contribute to the evidence base on interventions that reduce corporal punishment by teachers.[173]

d) Stop Violence Against Girls in School (Southern Africa – multi-country)

ActionAid International's *Stop Violence Against Girls in School* campaign is somewhat different from the other school interventions discussed in this section because its focus is not to protect all learners from corporal punishment, but to protect *girls* from *all forms of violence* in schools. The multi-level intervention was implemented in Ghana, Kenya, and Mozambique.[174] The focus of the project was to protect girls' right to education by reducing violence against girls in schools. The project had three main components: (1) advocacy, (2) community initiatives, and (3) research at baseline and endline.[175] While many of the project's activities were conducted at community level, the activities differed from country to country. For instance, in Ghana, volunteers were trained as 'Peer Parent Educators' who organised

[169] Baker-Henningham et al. 2009.
[170] Baker-Henningham et al. 2009.
[171] Baker-Henningham et al. 2016.
[172] Baker-Henningham et al. 2016.
[173] Baker-Henningham et al. 2016.
[174] ActionAid International 2013.
[175] ActionAid International 2013.

activities to raise awareness on girls' right to education.[176] In Mozambique, 'REFLECT circles' were established to provide a forum for adults to acquire literacy and numeracy skills whilst also discussing key problems in the community.[177] In Kenya, 'Zonal Education Committees' were set up, bringing together representatives from local education authorities, members from parent-teacher organisations and school governing bodies.[178] In each country, girls' clubs were established to ensure active participation of girls in the programme, to support girls in challenging the culture of violence in and around schools, to report incidents of violence and to create peer support networks.[179]

The programme was evaluated in a mixed-methods study after five years at four schools per country.[180] The evaluation did not include a control group and the research report does not provide sufficient information to fully analyse the results. The overall number of participants participating in the quantitative survey is 1,067 female learners, 526 male learners and 220 teachers. However, it is unclear whether this number combines baseline and follow-up participants or whether these numbers refer to the follow-up interviews only. While pupils participating in the survey were selected randomly, it is unclear whether the sample of teachers was randomised. The research report also lacks information on participants' country of residence.[181] The results from this evaluation therefore need to be interpreted with caution.

The evaluation showed positive effects for certain outcomes, but the results were inconsistent across countries. After the intervention, teachers in all countries reported changes in attitudes towards corporal punishment. In Mozambique, the proportion of girls who had been caned in the previous 12 months decreased from 52% in 2009 to 29% in 2013.[182] The report fails to specify whether this reduction was statistically significant.

[176] ActionAid International 2013.
[177] ActionAid International 2013.
[178] ActionAid International 2013.
[179] ActionAid International 2013.
[180] The evaluation is published as an impact report. It is not peer-reviewed. Parkes & Heslop 2013.
[181] Parkes & Heslop 2013.
[182] Parkes & Heslop 2013.

However, in Ghana the use of corporal punishment by teachers only decreased "slightly", according to the report, and in Kenya corporal punishment of girls *in*creased over the study period.[183] Researchers believed that the lack of an intervention effect may be due to inappropriate survey design. Instead of asking pupils whether they had experienced any corporal punishment in the previous 12 months, the survey should have included questions around the frequency of the practice.[184]

Some teachers raised concerns that they had not been informed about alternative forms of discipline, and some suggested that they had stopped beating learners for fear of being taken to court by ActionAid.[185] This suggests that some of the changes in attitude reported by teachers might also have been due to social desirability bias (i.e. participants giving answers perceived to be favourable to researchers). Outside the school setting, some positive effects were related to family dynamics and corporal punishment in the home.[186] It appears, for instance, that the message of corporal punishment being unacceptable at school filtered through to girls' homes, with girls in all three countries reporting reduced corporal punishment in the home.[187]

As noted above, the study design of this evaluation is not as strong as other school interventions (e.g. *Good School Toolkit*). It is further noteworthy, that Parkes & Heslop, who evaluated the programme, suggest that more reflection on norms and values as well as more collective processes and dialogue with communities are necessary to change deeply entrenched beliefs and attitudes.[188] They believe that the strong focus of the intervention on a rights framework may have limited the effects of the programme.[189] In addition, the responses by teachers (fear of being prosecuted; lack of knowledge on alternative forms of

[183] Parkes & Heslop 2013.
[184] Parkes & Heslop 2013.
[185] Parkes & Heslop 2013.
[186] Parkes & Heslop 2013.
[187] Parkes & Heslop 2013.
[188] Parkes et al. 2017.
[189] Parkes et al. 2017; Parkes & Heslop 2013.

discipline) underlines the importance of providing individuals with the necessary skills to enable them to perform a desired behaviour.

e) Summary

Only a small number of school programmes addressing physical punishment in low-resource settings have thus far been rigorously evaluated. However, the evidence provided by the evaluation of the *Good School Toolkit* is strong and shows that an 18-month intervention can have a significant impact on children's experience of violence at school. The intervention managed to reduce the use of physical violence by 42%. Although the goal of school interventions is to change behaviours of teachers and other school staff (e.g. principles), the methods used in these programmes could be adapted for community interventions. For instance, the *Good School Toolkit* provides teachers with information on alternative forms of discipline – information that would be valuable for caregivers, many of whom are unaware of non-violent forms of discipline. Given that the materials for the *Good School Toolkit* were developed and tested in Uganda, these materials may be more appropriate for adaptation in South Africa than materials from the U.S.A.

School interventions also provide an opportunity to teach learners about their rights and non-violent forms of conflict resolution, which may contribute to shifting attitudes towards violence among learners as the next generation of parents. School interventions may furthermore provide an opportunity to engage parents/caregivers on the issue of physical punishment. Exposure to the school intervention may initiate reflection on their own attitudes and behaviours without confronting them directly. This may pave the way for subsequent interventions targeting parents/caregivers to challenge their norms and practices regarding physical punishment in the home.

Despite the overall potential of school interventions, the evidence base is currently very small due to the limited number of studies. The further roll-out of the *Good School Toolkit* in Uganda as well as the finalisation of the *Ma'An* campaign in Jordan and the *Irie Classroom* intervention

in Jamaica will provide additional insights, but the evidence base will still remain small. The cost-effectiveness of school interventions have not yet been established.

3. Community interventions

Community interventions for violence prevention try to change behaviours at the population level by shifting norms, practices, and public discourse.[190] So far, most of these programmes have focused on violence against women. Violence against women intersects with violence against children at a number of levels. For instance, violence against children and intimate partner violence (IPV) share certain risk factors and are both associated with social norms that reinforce male dominance and accept violence as a reasonable means to resolve conflict.[191] Violence against children and IPV can also have similar health outcomes for the victims of the abuse.[192] The most obvious intersection, however, is the co-occurrence of violence against children and IPV. IPV in the home increases the risk of child abuse because men who are violent towards women are often also violent towards their children.[193] As noted earlier, the use of physical punishment is also linked to attitudes supportive of domestic violence.[194]

In addition to the direct effects of violence, children may suffer long-term consequences from witnessing violence. Male children who witness domestic violence have an increased risk of developing violent masculinities and abusing their partners in adulthood; female children are at an increased risk of becoming victims of violence in adulthood.[195]

Interventions that aim to reduce IPV are therefore not only critical to reduce violence against women, but also to reduce violence against children. Furthermore, the methods used in IPV

[190] Ellsberg et al. 2015.
[191] Bacchus et al. 2017.
[192] Bacchus et al. 2017.
[193] Bacchus et al. 2017.
[194] See III.7. above.
[195] Abrahams & Jewkes 2005; Fonseka et al. 2015; Stith et al. 2000.

interventions may inform the development of interventions to address physical punishment of children.

a) Strong Communities for Children (U.S.A.)

Strong Communities for Children is one of the few community interventions that aims to prevent child maltreatment. According to McDonell et al., 'It is one of the largest community-wide initiatives ever undertaken for the purpose of improvement of children's safety in the United States'.[196] The multi-year initiative is not tied to a set of techniques, but rather draws on six principles to strengthen communities. These principles include:

- integrating support into existing settings where children and families are naturally to be found;
- strengthening community norms that protect children;
- mobilising members of the community residents and community leaders to become involved in the issue;
- strengthening organisational capacity in primary community institutions;
- helping children by assisting their parents; and
- providing universal, non-stigmatising support to families and children.[197]

The goals of the intervention are, *inter alia*, to change social norms and values over time, and to make actions to protect children from harm a part of everyday life.[198]

Strong Communities for Children has been evaluated in numerous studies.[199] The most recent study reports findings from a baseline and follow-up survey of random samples of parents of

[196] McDonell et al. 2015.
[197] McDonell et al. 2015.
[198] McDonell et al. 2015.
[199] McDonell et al. 2015 with further references.

young children in the Strong Communities service area and in a control area.[200] The baseline survey was conducted with 232 participants in the intervention communities and 238 participants from control communities. The follow-up survey involved similar numbers of participants. Furthermore, the study evaluated data on cases of physical abuse, sexual abuse, and neglect reported to child protection services and hospital records on injuries to children that suggest child abuse.[201]

The intervention was successful in relation to some of the outcomes measured, but the size of the intervention effect was often small and in some instances not statistically significant. For instance, in the intervention communities, child injuries suggesting child abuse and neglect decreased, as did substantiated reports of child abuse for children under the age of 10, the target age for the intervention.[202] However, for certain age groups, the intervention effect was not statistically significant, making it unclear whether these reductions were achieved through the intervention or other factors.[203] Similarly, the reduction in physical punishment and psychological aggression observed in the intervention group was not statistically significant.[204] A key challenge in this evaluation is the study design, which used a small sample that only accounted for approximately 1% of the intervention population.[205] The evidence on this intervention is thus not reliable.

b) TOSTAN (Senegal)

TOSTAN, a non-governmental organisation, tackled a specific form of child maltreatment in Senegal. Their community intervention aimed to challenge attitudes and behaviours around female genital mutilation/cutting (FGM/C).[206] *TOSTAN*'s approach is to empower communities by combining educational skills (e.g. reading, writing, arithmetic), life skills, and

[200] McDonell et al. 2015.
[201] McDonell et al. 2015.
[202] McDonell et al. 2015.
[203] McDonell et al. 2015.
[204] McDonell et al. 2015.
[205] McDonell et al. 2015.
[206] Diop & Askew 2009.

human rights education.[207] In 2001, *TOSTAN* established and trained community management committees in 90 villages.[208] The training included classes on human rights, particularly women's and girls' right to bodily integrity; problem-solving, basic hygiene and women's health.[209] After the training, *TOSTAN* organised discussions and social mobilisation activities regarding the abandonment of FGM/C and encouraged the community management committees to arrange meetings with other villages to exchange experiences and discuss collective actions.[210]

The intervention was evaluated using a quasi-experimental design. Twenty villages were randomly selected from the intervention clusters and 20 control villages were purposively selected to match these villages.[211] A baseline survey, an immediate post-intervention survey and an endline survey two years after the intervention were conducted in the intervention villages, while baseline and endline surveys were undertaken in the control villages.[212] In the intervention villages, surveys were administered to 333 participants and 200 non-participants to measure the extent of diffusion of information from participants to others living in the same community.[213] The control group included 200 women living in control villages.[214]

The intervention had significant effects on attitudes towards and practices relating to FGM/C. Attitudes in support of FGM/C decreased significantly among participants and non-participants in the intervention villages between baseline and endline survey.[215] For instance, the proportion of women who approved of FGM/C dropped from 72% to 16% among participants in the intervention village, from 72% to 28% among non-participants in the intervention village, but only from 89% to 60% among participants from the control villages.[216] This clearly illustrates a diffusion effect of the intervention. Although attitudes

[207] Diop & Askew 2009.
[208] Diop & Askew 2009.
[209] Diop & Askew 2009.
[210] Diop & Askew 2009.
[211] Diop & Askew 2009.
[212] Diop & Askew 2009.
[213] Diop & Askew 2009.
[214] Diop & Askew 2009.
[215] Diop & Askew 2009.
[216] Diop & Askew 2009.

supportive of FGM/C also decreased significantly among participants in the comparison villages – possibly due to 'contamination' – overall support for FGM/C remained much higher in the comparison villages.[217] The practice of FGM/C also decreased significantly for daughters of participants and non-participants in the intervention villages.[218] In the control villages, the prevalence of FGM/C on young girls did not change between baseline and endline.[219]

Although the findings suggest that this intervention was very effective in changing attitudes and behaviours, researchers highlight that some of the observed differences may have been caused by selectivity bias. Participants in the intervention villages had somewhat different characteristics to those in the comparison villages and, given that they volunteered to participate in the intervention, their attitudes towards FGM/C may have been more open to change from the start.[220] However, the prevalence of FGM/C was similar in the intervention and control communities at baseline.[221]

c) SASA! (Uganda)

SASA! (*Now!*) is an intervention that aims to reduce IPV and HIV at community level. It was launched by the civil society organisation Centre for Domestic Violence Prevention. Based on the Stages of Change Theory, the intervention aims to shift community attitudes, norms and behaviours underpinning gender inequality, violence and HIV.[222] *SASA!* is a community mobilisation intervention that trains 'community activists' (i.e. ordinary members of a particular community) and public sector officials (e.g. health workers, police officers) on violence, power and rights.[223] After the training, community activists conduct activities of their choice within their community.[224] The intention is to increase the number of individuals

[217] Diop & Askew 2009.
[218] Diop & Askew 2009.
[219] Diop & Askew 2009.
[220] Diop & Askew 2009.
[221] Diop & Askew 2009.
[222] Abramsky et al. 2014.
[223] Raising Voices, SASA! Mobilizing communities to inspire social change. Retrieved 4 May 2017, at: http://raisingvoices.org/wp-content/uploads/2013/03/downloads/resources/Unpacking_*SASA!*.pdf.
[224] Abramsky et al. 2014.

and groups involved in these activities over time to create a 'critical mass' of people who participate in the social norm change.[225]

SASA! has been evaluated quantitatively and qualitatively. The quantitative intervention used a cluster RCT. Before the intervention, baseline data was collected from 793 respondents in four communities designated to receive the intervention, and from 790 respondents waitlisted to receive the full intervention upon study completion.[226] The effect of the intervention was assessed through post-intervention surveys with 1,368 participants in the intervention and 1,164 participants in the control communities four years later.[227] Government stakeholders in both the intervention and control communities received the intervention. The evaluation, therefore, does not assess the intervention per se, but only the 'added value' of training community activists.[228]

Compared to the control group, acceptance of IPV was substantially lower among women and men in the intervention group, but among male participants the results did not reach statistical significance.[229] Furthermore, female participants in the intervention arm were more likely to support women's right to refuse sex, and male participants in the intervention communities were less likely to report having had extra-marital sexual partners in the past year.[230] These intervention effects were demonstrated at the community level. This means that the effects of the intervention did not only have a positive effect on individuals who had high levels of exposure to the intervention, but also on other community members who had not been exposed to the intervention ('community diffusion process').[231]

[225] Abramsky et al. 2014.
[226] Abramsky et al. 2014.
[227] However, the duration of the intervention was approximately 2.8 years. The programme was delayed at several points in time due to political disturbances and elections.
[228] Abramsky et al. 2014.
[229] Abramsky et al. 2014.
[230] Abramsky et al. 2014.
[231] Abramsky et al. 2014.

The evaluation showed that many attitudes and behaviour changed among participants in the intervention communities, but often the changes were not statistically significant.[232] For instance, the intervention resulted in substantial reductions of IPV experience by women and perpetration by men, but these reductions were not statistically significant, which may be due to the small number of communities included in the study.[233] Another explanation for the lack of statistical significance may be inter-cluster variation for certain outcomes in control communities.[234]

Given that the reduction in IPV experience and perpetration was large (50%), further analysis explored the pathways that reduced the experience and perpetration of physical IPV against women.[235] While community-, relationship- and individual-level factors were all relevant, changes in community norms were the most influential facilitator for the reduction of IPV.[236] Changes in attitudes regarding the acceptability of violence and gender relations were responsible for most of the intervention effect seen in women and almost all of the effect seen in men.[237] This highlights the importance of targeting social norms in violence prevention interventions.

Interestingly, a qualitative evaluation of *SASA!* suggests that the intervention can have positive effects on children. Interviews with parents from the intervention communities demonstrated that some parents had changed their attitudes and practices.[238] Parents highlighted, for instance, that they tried to protect their children from witnessing domestic violence or to intervene when they saw other parents beating their children.[239] Furthermore,

[232] Abramsky et al. 2014.
[233] Abramsky et al. 2014.
[234] For instance, the prevalence of IPV also decreased in several control communities. This makes it difficult to show a significant impact of the intervention in the intervention communities. Abramsky et al. 2014.
[235] Abramsky et al. 2016.
[236] Abramsky et al. 2016.
[237] Abramsky et al. 2016.
[238] Kyegombe et al. 2015.
[239] Kyegombe et al. 2015.

some parents in the intervention group reported changes in parenting practices such as improved parent-child communication and a reduction in the use of corporal punishment.[240]

A study evaluating the cost-effectiveness of *SASA!* has recently been published using a full costing approach, including administrative and overhead costs of the intervention.[241] In 2011 values, the intervention cost US$389 per activist and the average cost per person reached in intervention communities was US$5 annually.[242] The costs per averted IPV incident are estimated, but this estimate uses a 90% (rather than 95%) confidence interval with a very wide range (90 % CI: 97–2307 cases averted).[243] The cost per averted incident may therefore be unreliable.

d) SHARE (Uganda)

Another example of a community-level intervention focusing on violence prevention is the programme Safe Homes and Respect for Everyone (*SHARE*). This violence reduction intervention aims to change attitudes, social norms and behaviours related to IPV.[244] *SHARE* includes five strategies:

- Community assessment;
- Raising awareness on the intervention and stimulating dialogue on IPV and its consequences;
- Building networks;
- Integrating action/Full intervention implementation which includes making actions against IPC part of everyday life; and
- Phasing out of intervention by winding down involvement of *SHARE* staff.[245]

[240] Kyegombe et al. 2015.
[241] Michaels-Igbokwe et al. 2016.
[242] Michaels-Igbokwe et al. 2016.
[243] The study uses a 90% confidence interval, rather than a 95% confidence interval. The range of the 90% confidence interval is very wide (90 % CI: 97–2307 cases averted). The number of actually averted incident is therefore unclear.
[244] Wagman et al. 2015.
[245] Wagman et al. 2015.

Intervention activities such as capacity building, advocacy and special events take place at least nine days per month.[246] The interventions target the individual, relationship and societal level.[247] Between 2005 and 2009, *SHARE* was combined with an intervention to reduce IPV related to HIV disclosure and risk behaviours among women seeking HIV counselling and testing services.[248]

The intervention was evaluated in Uganda using a cluster RCT in which 5,337 individuals in four intervention clusters received the *SHARE* plus HIV intervention, while 6,111 individuals in seven control communities received the standard HIV care.[249] Researchers conducted a baseline and two follow-up surveys. At the second follow-up, females in the intervention group were significantly less likely to report past-year physical IPV, sexual IPV and forced sex.[250] Although past-year experience of violence decreased significantly among females in the intervention group, male reported perpetration of IPV was not significantly reduced by the intervention.[251] Participants in the intervention group were furthermore significantly less likely to test HIV positive at the second follow-up of the intervention.[252] Although past-year incidence of violence decreased among females in the intervention group, perpetration of IPV reported by males was not significantly reduced by the intervention.[253] The paper does not discuss changes in individual attitudes and social norms. It is therefore unclear whether the intervention had an effect on attitudes and social norms. This information would be useful to determine why the intervention did not significantly reduce IPV perpetration by men.

[246] Ellsberg et al. 2015.
[247] Wagman et al. 2015.
[248] Wagman et al. 2015.
[249] Wagman et al. 2015.
[250] Wagman et al. 2015.
[251] Wagman et al. 2015.
[252] Wagman et al. 2015.
[253] Wagman et al. 2015.

In light of these promising results reported by female participants, *SHARE* is currently adapted for other settings and will be tested in other Southern African countries as well as in Haiti.[254]

e) Program H (Ethiopia)

Program H ('H' for *homem* or 'man' in Portuguese and *hombre* in Spanish) is an intervention that aims to change gender-inequitable norms related to masculinity to promote sexual health, prevent violence against women and increase men's participation in child care. The intervention was originally developed in 2002 by NGOs in Brazil and Mexico, but has subsequently been adapted for and implemented in different settings around the world.[255] The programme provides a curriculum for group training and other activities to engage young men (aged 15 – 24 years) in critical reflection and dialogue about gender equality.[256]

Program H was evaluated in Ethiopia using a quasi-experimental design involving three groups of young men who regularly met in youth clubs.[257] Over the course of four months, 244 participants received eight interactive group training sessions *and* community education (newsletters, leaflets, drama, etc.), 287 participants received only community education activities, and 198 participants were assigned to a waitlisted control group.[258] Interviews were conducted at baseline and six month after the intervention.[259]

Participants in the group who received both group training and community education were the only ones who reported more support for gender-equitable norms in the follow-up interviews.[260] While reductions in the perpetration of violence were reported for both intervention groups compared to the control group, these effects did not sustain statistical significance in the multivariate analysis.[261] The lack of statistical significance, however, does not necessarily mean that the intervention was not successful, but may be due to the small

[254] Ellsberg et al. 2015.
[255] Promundo et al. 2013.
[256] Promundo et al. 2013.
[257] *Program H* has been evaluated in several countries, but many of the evaluations are published as impact reports only.
[258] Pulerwitz et al. 2015.
[259] Pulerwitz et al. 2015.
[260] Pulerwitz et al. 2015.
[261] The intervention was marginally significant for the group that received community education only.

number of participants, paired with a small proportion of participants with sexual partners who could report behaviour change.[262]

f) Stepping Stones (South Africa)

Stepping Stones is an HIV intervention which includes gender equity elements, which was originally developed for use in Uganda.[263] Since then, the programme has been adapted for different settings and implemented in more than 40 countries.[264] In South Africa, the programme was implemented in the Eastern Cape in 2003.[265] *Stepping Stones* is a participatory 50-hour group training programme that aims to prevent HIV by promoting strong, gender equitable relationships.[266] The intervention uses single-sex group sessions which involve critical reflection, roleplay and drama, three meetings of peer groups and a final community meeting.[267]

The programme was tested through a cluster RCT, with 1,409 participants from 35 villages/townships receiving the intervention and 1,367 participants from 35 control villages/townships receiving a three-hour intervention on HIV and safer sex.[268] The impact of the intervention was tested quantitatively through interviews and blood testing for HIV and herpes simplex type 2 (HSV-2) at baseline, and follow-ups at 12 months and 24 months.[269]

The intervention had mixed results. While it did not reduce the number of new HIV infections among participants, it did lower the incidence of herpes simplex type 2 in the intervention group.[270] In terms of behaviour change, the impact of the intervention was different for males and females. Males in the intervention group reported significant positive behaviour changes

[262] Pulerwitz et al. 2015.
[263] Jewkes et al. 2008.
[264] Jewkes et al. 2008.
[265] Jewkes et al. 2008.
[266] Jewkes et al. 2008.
[267] Jewkes et al. 2008.
[268] Jewkes et al. 2008.
[269] Jewkes et al. 2008.
[270] Jewkes et al. 2008.

such as a reduction in transactional sex, perpetration of IPV and problem drinking at either 12 or 24 months follow-up or both.[271] While some behavioural changes had disappeared at 24 months follow-up, the reduction in male perpetration of IPV was strengthened over the time period.[272] Females who participated in the intervention, however, reported an increase in undesired behaviours such as transactional sex.[273] Researchers believe that undesired behaviours only *appear* to have increased due to reporting bias (i.e. in women underreporting these behaviours at baseline).

g) Summary

The evidence base for community interventions aimed at violence prevention is small. Only few studies exist and these report mixed results. The community interventions reviewed here report both successes and failures in preventing violence and suggest that certain attitudes and behaviours are more difficult to change than others. Changing harsh parenting practices (*Strong Communities for Children*) as well as reducing the perpetration of IPV (*SASA!*; *Stepping Stones*) seem to be particularly challenging. However, the lack of statistically significant differences between intervention and control groups does not necessarily mean that the intervention did not have an effect. A small sample size – either because of a small number of participants or because only a small proportion of participants report a particular outcome – makes it very difficult to show an intervention effect. Despite methodological challenges, one intervention was able to show a significant reduction in IPV (*SHARE*) and the *TOSTAN* intervention illustrates that even deeply engrained behaviours such as FGM/C can be shifted through carefully designed, multi-pronged community interventions.

Community interventions have the potential to achieve community level effects. Both *SASA!* and *TOSTAN* were able to demonstrate a community or 'diffusion' effect whereby attitudes had changed even among individuals who had not participated in the intervention but lived

[271] Jewkes et al. 2008.
[272] Jewkes et al. 2008.
[273] Jewkes et al. 2008.

in the intervention villages. This effect is most likely achieved through multi-pronged programmes that target different stakeholders.[274]

Although most of the community interventions targeted IPV, they provide important insight for the development of interventions to prevent physical punishment. First, both types of interventions need to address social norms around male dominance and entitlement that underpin IPV and violence against children. Because of the links between IPV and violence against children, it is not surprising that *SASA!* had shifted norms and practices relating to violence against children even though the intervention targeted IPV. Second, the methodologies used in the community IPV interventions could be used in interventions targeting physical punishment of children. However, it is possible that the practice of physical punishment is as resistant to change as the perpetration of IPV. Further research should be conducted to assess what types of activities have the potential to shift social norms. Due to the variations in timeframes, the minimum or optimal duration of community interventions also remains unclear.

4. Entertainment-education ('edutainment')

Another form of large-scale intervention to shift behaviour are campaigns using entertainment-education, also referred to as 'edutainment'. Entertainment-education refers to the use of popular entertainment formats to tackle serious social and health issues.[275] The purpose of entertainment-education is threefold: (1) to increase the audience's knowledge about a health or social issue; (2) to create more favourable attitudes towards the desired behaviour; and (3) to change behaviours related to the health or social issue.[276] Entertainment-education uses a wide variety of formats, including radio and television soap operas, feature films and animation films, short video clips, public service announcements, talk shows and game shows.

[274] Abramsky et al. 2014; Ellsberg et al. 2015.
[275] Perlman 2013.
[276] Vaughan et al. 2000.

Edutainment has been most widely used and evaluated in the area of public health. In the global north, public health campaigns using edutainment have addressed the prevention of various diseases and risk behaviours, including cancer,[277] HIV/AIDS,[278] and alcohol abuse.[279] Many of the interventions in the global north focused on communities that are difficult to reach via regular health communication programmes, such as immigrants. In the global south, the focus of entertainment-education has been on HIV/AIDS prevention, but, as will be shown, there are also examples where it has been used for violence prevention, or for other health-related behaviours.

The appeal of edutainment is that it can reach vast number of people. For instance, the multi-media campaign *Shuga*, which was launched in Kenya in 2009 to promote sexual and reproductive health, now reaches 719 million households worldwide.[280] Yet the campaign's impact on changing attitudes and behaviours has not been evaluated. Given that only a few edutainment campaigns to date have dealt with violence, the following section will also review evidence pertaining to campaigns focusing on health behaviours.

a) Violence prevention

i. Soul City (South Africa)

Soul City is a television drama series developed by the Soul City Institute for Health and Development Communication (Soul City Institute)[281] that addresses health and social issues in order to raise awareness and initiate behaviour change among viewers. The series has covered many different topics since its launch in 1994, including maternal and child health, HIV/AIDS and substance abuse, to name but a few.[282] The television series, however, is only one component of a multi-pronged campaign. For each theme, the Soul City Institute

[277] Lamb et al. 2017.
[278] Willis et al. 2016.
[279] Kim et al. 2014.
[280] MTV http://www.mtvstayingalive.org/campaign/shuga/.
[281] The Soul City Institute for Health and Development Communication is now called the Soul City Institute for Social Justice.
[282] http://www.soulcity.org.za/projects/soul-city-series

develops additional forms of media elements (radio, print) and conducts social mobilisation and advocacy activities.[283]

In 1999, the campaign focused on the topic of violence against women, including domestic violence and the Domestic Violence Act. The Soul City Institute partnered with the National Network on Violence against Women, which participated in the campaign by providing a platform for community mobilisation activities, including ongoing media coverage and engagement with political stakeholders.[284] Using an ecological model, the campaign aimed to change individual knowledge, attitudes and practices while at the same time creating an enabling community to facilitate behaviour change, and promoting implementation of the law.[285]

The campaign was evaluated in several ways using quantitative and qualitative methods. Evaluations included a before-and-after survey using a multi-stage stratified national random sampling design; a community-based study of two sentinel sites; focus groups and in-depth interviews; local and national media monitoring and document reviews.[286] Overall, people exposed to the campaign had increased knowledge and awareness on women's rights and were more likely to have a 'progressive' attitude towards domestic violence.[287] For instance, people who were exposed to several formats of the multimedia campaign were 4.5 times more likely to have 'progressive' attitudes towards domestic violence than those who were not exposed to the campaign.[288] There were also differences regarding community norms. For instance, 63% of respondents with high exposure to the radio component agreed with the statement, 'My community feels that violence between a man and a woman is not a private affair', compared to 53% of people who had not been exposed to the campaign.[289] However, certain attitudes were resistant to change. For instance, agreement with the statement 'As

[283] http://www.soulcity.org.za/projects/soul-city-series.
[284] Usdin et al. 2005.
[285] Usdin et al. 2005.
[286] Perlman 2013; Usdin et al. 2005.
[287] Perlman 2013.
[288] Perlman 2013.
[289] Usdin et al. 2005.

head of the household, a man has the right to beat a woman' was not significantly reduced through the intervention.[290]

Changes in behaviour were reported for individuals who were exposed to multiple formats of the campaign. These respondents were more likely to support survivors of domestic violence by –

- informing an abused person about a telephone helpline; and
- standing outside the house of an abuser and making noise to let the abuser know that they were aware of what was going on.[291]

Some of the positive shifts in attitude and behaviour change showed a dose-response relationship, i.e. the higher the exposure to the campaign, the higher the attitudinal/behavioural shift.[292] The evaluation was unable to determine whether the intervention had resulted in reducing levels of domestic violence.[293]

ii. Brothers for Life (South Africa)

Another South African social and behaviour change communication campaign was *Brothers for Life*. This national campaign specifically targeted men aged 30 years and older as the primary audience.[294] The campaign covered a number of topics related to masculinity and HIV/AIDS, including:

- positive male norms and values;
- fatherhood;
- HIV risks associated with having multiple and concurrent partnerships;
- HIV testing and disclosure; and

[290] Usdin et al. 2005.
[291] Perlman 2013.
[292] Usdin et al. 2005; Perlman 2013.
[293] Usdin et al. 2005.
[294] Myers et al. 2012.

- gender-based violence.[295]

The campaign used a multi-pronged approach including mass media, social mobilisation activities, advocacy activities, partnerships and referrals.[296] In terms of mass media, the campaign used different types of television and radio formats (e.g. public service announcements, a 'manifesto', talk shows), print media, and outdoor media (e.g, billboards, building wraparounds, street-pole posters, taxi and bus advertising).[297] The campaign was linked to community-level organisations through social mobilisation activities such as community dialogues and peer educators.[298] In addition, the campaign used other types of advocacy activities (e.g. summits, consultative meetings) to reach government stakeholders, traditional leaders and other opinion leaders in communities.[299]

The campaign was evaluated using qualitative methods, which limits the generalisability of the results. Study results are reported in an evaluation report. Focus groups were conducted with 101 men and 31 women from urban, peri-urban and rural areas in each province.[300] The messages around the gender-based violence theme were the most effective, as participants had internalised these the most and some believed that gender-based violence was the main subject of the campaign.[301] According to the evaluation, the campaign led to 'in-depth reflection and dialogue over normative masculinities', particularly attitudes that underpin and encourage violence against women.[302] Respondents described the campaign as opening up spaces for communication about gender-based violence, motivating viewers to change and giving direction for such change.[303] However, the evaluation reports little actual behaviour change but rather intention to change. While intention to change is a precursor to behaviour change, it is unclear whether the campaign did significantly spark intention to change because the campaign was not evaluated quantitatively. The report campaign also saw a substantial

[295] Myers et al. 2012.
[296] Myers et al. 2012.
[297] Myers et al. 2012.
[298] Myers et al. 2012.
[299] Myers et al. 2012.
[300] Myers et al. 2012.
[301] Myers et al. 2012.
[302] Myers et al. 2012.
[303] Myers et al. 2012.

increase in the proportion of males accessing the promoted Stop Gender Based Violence Helpline.[304] The evidence on the efficacy of the campaign is thus limited.

iii. Bell Bajao! (India)

Bell Bajao! (*Ring the Bell!*) was a national campaign in India that aimed to end violence against women and promote women's rights.[305] The multi-pronged campaign was developed by the organisation Breakthrough. It combined a multimedia component (public service announcements on television, print, radio, internet and a 'video van') with community mobilisation (e.g. workshops, training, street theatre) to initiate change in attitudes and behaviours.[306] The goal of the campaign was for people to stop seeing domestic violence as a private matter and to take action by 'interrupting' domestic violence when it occurs.[307] The public service announcements often centred around the 'message' that people should stop ignoring violent domestic disputes of neighbours and rather ring the doorbell to interrupt the violence.[308] The community mobilisation activities focused on issues relating to gender equality, for instance women's right to negotiate safer sex, India's domestic violence legislation, and where women can access support after an incident of domestic violence.[309] Both the multi-media campaign and the community activities encouraged men to play an active role in ending violence against women.

The campaign was evaluated using quantitative methods to measure changes in knowledge and attitudes among respondents of the campaign.[310] The evaluation uses a baseline and endline survey, but fails to report whether differences in attitudes reached statistical significance.[311] Where statistical significance is reported, it is set at an inappropriate level. It is also unclear why certain findings are reported as a case-control study, whereas other

[304] Myers et al. 2012.
[305] Chakraborty 2010.
[306] Chakraborty 2010.
[307] Chakraborty 2010.
[308] See video clips on http://www.bellbajao.org/.
[309] Chakraborty 2010.
[310] Chakraborty 2010.
[311] Chakraborty 2010.

findings are reported for the total study population.[312] The success of the campaign is therefore unclear.

b) Health

i. Child mortality (Burkina Faso)

In Burkina Faso, a 35-month-long radio campaign was launched to reduce child mortality for children under the age of five. This communication campaign used short spots (60 seconds), which were aired 10 times per day, and interactive long-format dramas (two hours) which were aired five days per week.[313] The campaign was broadcast on seven radio stations, in six local languages.[314] The campaign covered 19 target behaviours linked to antenatal care, newborn health, child nutrition, childhood illnesses, home treatment for diarrhoea, the use of bed nets, and sanitation.[315]

The campaign used a cluster randomised control trial design to measure behaviour changes related to child survival. Researchers performed three surveys: (1) a baseline survey to estimate a) under-five child mortality prior to the intervention, b) radio ownership, and c) listenership; (2) a survey after 20 months of campaigning (midline evaluation); and (3) a survey after the completion of the campaign (endline evaluation).[316] In addition to the surveys, routine health facility data was used to assess changes in health facility utilisation.[317] While no similar radio interventions were conducted at the same time, some nutrition and sanitation programmes were conducted in one of the intervention communities and one of the control communities.[318]

[312] Chakraborty 2010.
[313] Sarrassat et al. 2015; Murray et al. 2015.
[314] Sarrassat et al. 2015.
[315] Sarrassat et al. 2015.
[316] Sarrassat et al. 2015.
[317] Sarrassat et al. 2015.
[318] Sarrassat et al. 2015.

At the time of writing, the midline evaluation has been published and preliminary findings from the endline evaluation have been made available. For the midline evaluation, researchers interviewed 2,586 women in the control group and 2,596 women in the intervention group.[319] The findings of the midline evaluation were mixed. The intervention was unsuccessful in changing many of the targeted behaviours. There was, however, evidence that the intervention led to behaviour change in terms of the family's response to the child having diarrhoea and fast or difficult breathing.[320] Women in the intervention group were also more likely to save money during pregnancy.[321]

The preliminary findings from the endline evaluation show that in the first year the intervention led to a 35% increase in health facility visits for children with fast or difficult breathing as well as for children with symptoms of malaria and diarrhoea in the intervention communities, compared to the control zones.[322] In addition, the intervention increased antenatal care visits and facility deliveries by 6% and 7%, respectively.[323]

One of the reasons why the intervention managed to change certain behaviours but not others may be the airtime assigned to certain topics in the campaign.[324] Even though the campaign had a lot of airtime – approximately 70 hours in total per week[325] – it was ambitious to attempt to target 19 different behaviours with one campaign. Another reason for the mixed results is that certain behaviours are easier to change than others. There may, for instance, be cultural norms that prevent a specific behaviour change or structural barriers such as poverty that make it difficult to change a behaviour (e.g. behaviours linked to child nutrition).[326] Another limitation of the campaign was that it was not based on a sound behavioural change theory. Instead, the intervention was based on the 'Saturation Plus' theory, which overemphasises the need to have sufficient exposure (saturation) to relevant

[319] Sarrassat et al. 2015.
[320] Sarrassat et al. 2015.
[321] Sarrassat et al. 2015.
[322] http://www.developmentmedia.net/news/dmi-publishes-child-survival-rct-endline-results.
[323] http://www.developmentmedia.net/news/dmi-publishes-child-survival-rct-endline-results.
[324] Sarrassat et al. 2015.
[325] Sarrassat et al. 2015.
[326] Sarrassat et al. 2015.

information. The assumption, under this model, is that a high volume of 'messages' in the form of entertainment-education will lead to increased awareness and knowledge among the audience that will lead to behaviour change. The theory fails to take into account other determinants of behaviour change and disregards the complex nature of behaviour change.

ii. Prevention of Mother-to-Child-Transmission of HIV (Botswana)

An edutainment campaign in Botswana with considerably less exposure was also successful in changing behaviour. The radio soap opera *Makgabaneng* (*Rocky Road*) encouraged women to access Prevention of Mother To Child Transmission (PMTCT) services.[327] The soap opera was first broadcast in 2001 and consists of two 15-minute episodes per week broadcast in Setswana.[328] The drama includes good characters, bad characters and transitional characters.[329] The transitional characters, who adopt new behaviours by changing their attitudes and overcoming obstacles, aim to motivate listeners to follow suit.[330]

The impact of the radio programme was measured in a cross-sectional study which compared rates of HIV testing among listeners (at least once per week) and non-listeners. The evaluation took place after approximately 250 episodes had broadcast.[331] Researchers conducted interviews with 504 women and reviewed logbooks recording HIV testing at health facilities.[332] The evaluation found that being a regular listener or recalling a character of the programme not did not increase HIV testing.[333] However, women who named one of the PMTCT characters of the drama as their favourite character were nearly twice as likely to have had an HIV test during pregnancy compared to women whose favourite character was not a PMTCT character.[334] Accordingly, what mattered was not exposure to or recalling the programme, but *identification* with one of the characters who performs the desired

[327] Sebert Kuhlmann et al. 2008.
[328] Sebert Kuhlmann et al. 2008.
[329] Sebert Kuhlmann et al. 2008.
[330] Sebert Kuhlmann et al. 2008.
[331] Sebert Kuhlmann et al. 2008.
[332] Sebert Kuhlmann et al. 2008.
[333] Sebert Kuhlmann et al. 2008.
[334] Sebert Kuhlmann et al. 2008.

behaviour.[335] Identification with one of the PMTCT characters was higher among regular listeners, underlining the importance of high exposure to the intervention.[336]

iii. HIV/AIDS (Southern Africa – multi-country)

Edutainment focusing on general HIV/AIDS prevention has been used in a number of African countries, including South Africa, Zambia, Tanzania, Saint Lucia, Malawi, and Botswana.[337] *OneLove* was the largest multi-country HIV-prevention communication campaign in Southern Africa. Coordinated by the Soul City Institute for Social Justice[338] and implemented by local partners in nine Southern African countries, the programme reached almost 27 million people.[339] The campaign used a multi-pronged approach. One component of the intervention was the use of national multimedia platforms (radio, television and print). The television component focused on edutainment and included a series of nine films called *Love Stories*.[340] Another component of the campaign was the use of advocacy and community-based social mobilisation activities such as community dialogues.[341] The key message of the campaign was that having concurrent partners increases the risk for contracting HIV.[342] The need for improving relationships through open communication between couples and in families was one of the 'sub-messages'.[343]

OneLove was evaluated both qualitatively and quantitatively. The qualitative evaluation of the campaign highlighted that individuals who had watched the television series had rich emotional responses and could relate to the characters and challenges identified in the

[335] Sebert Kuhlmann et al. 2008.
[336] Sebert Kuhlmann et al. 2008.
[337] Vaughan et al. 2000; Vaughan et al. 2000(a); Sebert Kuhlmann et al. 2008; Meekers et al. 2007; Myers et al. 2012.
[338] The Soul City Institute for Social Justice was previously called Soul City Institute for Health and Development Communication.
[339] Scheepers 2013 at 7. Jana et al. report that the campaign was implemented in nine countries. Scheepers reports that it was implemented in 10 countries, but her quantitative evaluation only reviews the impact of the campaign in eight countries. See Jana et al. 2014 at 2; Scheepers at 3 and 7.
[340] Jana et al. 2014 at 2.
[341] Jana et al. 2014 at 2.
[342] Jana et al. 2014 at 2.
[343] Jana et al. 2014

programme.[344] Individuals reflected on their lives, circumstances and behaviours; some contemplated changing their behaviours and others reported having changed behaviours.[345] Exposure to the materials also led to open dialogue about sex and HIV/AIDS in one-to-one contexts (e.g. with sexual partners, children, grandparents), in families and at community level.[346]

The quantitative evaluation of *OneLove* included more than 52,000 individuals and was conducted in eight countries.[347] The evaluation used a post-intervention cross-sectional design and included people who had and had not been exposed to the campaign.[348] Like *Intersexions*, the South African evaluation was conducted through the 2012 National Communication Survey.[349] Overall, the campaign showed statistically significant results in relation to several HIV prevention behaviours:

- Increase in HIV testing;
- Increase in condom use;
- Reduction in inter-generational sex;
- Reduction in transactional sex.[350]

The campaign was also successful in addressing 'intermediate' factors such as knowledge and attitudes. For instance, the campaign raised awareness around the increased risk of HIV infection in the context of having multiple partners and shifted certain attitudes around ideas of masculinity.[351] The campaign also contributed to discussions on HIV with partners, friends and with children.[352] However, the goal of changing behaviour in relation to having multiple concurrent sexual partners was only achieved in Namibia and Zambia.[353]

[344] Jana et al. 2014 at 4.
[345] Jana et al. 2014 at 4, 5.
[346] Jana et al. 2014 at 4.
[347] The evaluation took place in 2011 and 2012 in Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. Scheepers 2013 at 4.
[348] Scheepers 2013 at 5.
[349] Scheepers 2013 at 5.
[350] Scheepers 2013 at 13; 14.
[351] Scheepers 2013 at 15.
[352] Scheepers 2013 at 16
[353] Scheepers 2013 at 12.

The impact of the campaign differed by outcome, communication medium/method and country. While the campaign improved communication between sexual partners around sexual satisfaction in Zimbabwe and Malawi, the opposite was true for Namibia; and other countries had inconsistent results.[354] In some countries (Lesotho, Malawi, Namibia and Swaziland), the *OneLove* print materials increased HIV testing; in other countries, it was the *radio campaign*.[355] Certain interventions were successful for particular groups of respondents (e.g. young women; mobile populations, etc.), but not, or to a lesser extent, for others.[356] Thus what works in a particular setting is not necessarily transferable to another settings or to a different audience.

For many outcomes, researchers observed a dose-response relationship. The higher the exposure to the *OneLove* campaign, the more attitudes or behaviour would change. For instance, in South Africa, 48% of respondents who were not exposed to the campaign practiced safer sex.[357] Fifty percent of respondents who had low exposure to the campaign practiced safer sex.[358] Among those who had medium and high exposure to the campaign, the proportion of respondents practicing safer sex rose to 58% and 60%, respectively.[359] Similarly, in Lesotho, 46.4% of respondents who were not exposed to the campaign tested for HIV in the preceding 12 months, compared to 52.8% for those who were exposed to *one* medium of the campaign, and 59% for those who were exposed to *two* media of the campaign.[360] This suggests that higher saturation with the campaign messages resulted in higher rates of behaviour change. However, the evaluation report does not specify whether the observed dose-response relationships were statistically significant.

[354] Scheepers 2013 at 15.
[355] Scheepers 2013 at 11.
[356] Scheepers 2013.
[357] Scheepers 2013 at 14.
[358] Scheepers 2013 at 14.
[359] Scheepers 2013 at 14.
[360] Scheepers 2013 at 11.

iv. HIV/AIDS (South Africa)

Another example of edutainment to reduce HIV transmission is *Intersexions*, a multi-award-winning South African television drama series, which consisted of two seasons (*Intersexions I* and *Intersexions II*) of 25 interlinked television drama episodes. The purpose of the drama series was to prevent HIV transmission by highlighting the risks of having multiple and concurrent sexual partners.[361] *Intersexions I* focused on the sexual network and *Intersexions II* looked at how secrets in personal relationships place people at risk for HIV infection.[362] After the 25 episodes, the series closed with a 'docudrama' that explained the HI-virus in more detail, as well as risk and protective behaviours.[363] In addition to the television series, *Intersexions I* and II used social media platforms (Facebook, Twitter, MXit and WhatsApp) to engage viewers in discussions on the episodes and how the content of the episodes relates to their lives.[364]

Intersexions I and II were evaluated qualitatively through focus group discussions and interviews. Furthermore, researchers evaluated viewers' posts and comments on social media. In the qualitative evaluations, viewers reported a number of behaviours which they attributed to having watched the television series:

- Testing for HIV;
- Increase in consistent condom use;
- Increased communication between intimate partners;
- Choosing not to have sex while under the influence of alcohol; and
- Reducing their number of concurrent sexual partners.[365]

Intersexions I was evaluated quantitatively as part of the 2012 National HIV Communication Survey which was carried out approximately one year after the broadcast.[366] Results are

[361] Myers et al. 2014 at 7.
[362] Myers et al. 2014 at 7.
[363] Myers et al. 2014 at 7.
[364] Myers et al 2014 at 9; Myers et al. 2016.
[365] Myers et al 2014 at 10; Hajiyiannis et al. 2011 at 5.
[366] Collinge et al. at 32.

reported for different numbers of participants, including 3,658 viewers of the series. The quantitative evaluation shows some impact on attitudes and self-efficacy, i.e. factors that influence behaviour, but the research was unable to demonstrate behaviour change. For instance, watching *Intersexions I* had a significant yet 'modest' effect on positive attitudes towards condom use and self-efficacy in the use of condoms.[367] The effect showed a dose-response relationship, i.e. the more episodes people watched, the larger the effect on positive attitudes and self-efficacy.[368] Positive attitudes and a strong sense of efficacy influence the actual use of condoms: 48% of viewers with a 'low' positive attitude to condoms used a condom at last sex compared to 57% of viewers who had a 'high' positive attitude to condom use.[369] But the statistic fails to distinguish viewers and non-viewers. It is therefore unclear whether viewers had higher levels of positive attitudes *and* higher levels of condom use. Caution also needs to be applied when interpreting the impact of *Intersexions I* reported for HIV testing. It is disappointing that the quantitative evaluation was unable to demonstrate changes in viewers' attitudes or behaviours regarding multiple sexual partners even though this was the focus of the television series.

v. HIV/AIDS (Nicaragua)

Edutainment campaigns have also been used in Latin America to address HIV/AIDS. *Somos Diferentes, Somos Iguales* (*We are different, we are the same*) was a multi-pronged intervention to prevent the spread of HIV in Nicaragua.[370] Gender equity was an important theme of the intervention. The intervention used capacity building, partnership building and edutainment (a weekly television soap opera), which was the largest component of the intervention.[371] Furthermore, the intervention included a nightly youth call-in radio show, distribution of materials for use by local groups, community-based activities such as training workshops, and coordination with local non-governmental organisations and public service providers. The intervention was implemented from 2002 until 2005, focusing on social and cultural barriers to HIV prevention.

[367] Collinge et al. at 37.
[368] Collinge et al. at 37, 38.
[369] Collinge et al. at 38.
[370] Solórzano et al. 2008.
[371] Solórzano et al. 2008.

The intervention was evaluated using quantitative and qualitative methods. A longitudinal study with over 3,000 participants (aged 13 – 24 years) was conducted in 2003, 2004 and 2005 in three Nicaraguan cities.[372] Outcomes were measured between participants with high exposure to the intervention (participants who watched 'almost always' or 'occasionally') and those with low exposure to the intervention. Interviews and focus groups were conducted at the same intervals.[373] Compared to participants with low exposure to the intervention, participants with high exposure had:

- more gender-equitable attitudes;
- less stigmatising attitudes towards people living with HIV;
- greater probability of knowing a centre that provides attention for cases of domestic violence; and
- higher perceptions of self-efficacy to negotiate condom use despite an overall reduction in self-efficacy.[374]

The effect sizes for the outcomes varied and some outcomes did not reach statistical significance.[375] The intervention was not successful in increasing condom use in long-term relationships, but a significant increase in condom use was reported for sex with a casual partner, both for last sex and consistently in the previous six months.[376]

vi. HIV/AIDS (Tanzania)

An early example of edutainment focusing on HIV/AIDS is *Twende na Wakati* (*Let's go with the times*), a Swahili radio soap opera which was broadcast in Tanzania twice per week for 30 minutes each from 1993 until 1999.[377] In addition to four HIV/AIDS prevention messages, the

[372] Solórzano et al. 2008.
[373] Solórzano et al. 2008.
[374] Solórzano et al. 2008.
[375] Solórzano et al. 2008.
[376] Solórzano et al. 2008.
[377] Vaughan et al. 2000(a).

soap opera provided information on family planning and other health issues and aimed to promote gender equity.[378]

The intervention was evaluated through a non-randomised quantitative study at baseline and repeat studies over the next four years.[379] The first two years evaluated the effect of the intervention on listeners compared to non-listeners.[380] Regular listeners were defined as people who listened to the soap opera at least once per week.[381] In the subsequent two years, the evaluation assessed replicability because the radio show was then also broadcast in the control areas.[382] The evaluation showed that the intervention was effective in changing certain attitudes and behaviours among listeners.[383] For example, the perception of being at risk for HIV when having multiple sexual partners increased significantly among listeners compared to non-listeners. Furthermore, the number of sexual partners declined significantly more among both male and female listeners, and condom use increased significantly among sexually active listeners with multiple sexual partners.[384] These changes were replicated in the comparison areas when the radio show was broadcast in these areas. Other attitudes and behaviours did not change significantly.[385]

vii. HIV/AIDS (Saint Lucia)

Another early example of entertainment education is the radio soap opera *Apwe Plezi*, which was broadcast from 1996 to 1998 and in 2000 in Saint Lucia.[386] The soap opera addressed issues on family planning, HIV prevention, gender equity, relationship fidelity and domestic violence.[387] The radio drama was broadcast three to four times per week.[388] A total of 260 15-

[378] Vaughan et al. 2000(a).
[379] Vaughan et al. 2000(a).
[380] Vaughan et al. 2000(a).
[381] Vaughan et al. 2000(a).
[382] From 1995 the soap opera was also broadcast in the control areas where non-listeners lived. The survey was repeated annually over five years to measure replicability of the effects. Vaughan et al. 2000(a).
[383] Vaughan et al. 2000(a).
[384] Vaughan et al. 2000(a).
[385] Vaughan et al. 2000(a).
[386] Vaughan et al. 2000.
[387] Vaughan et al. 2000.
[388] Vaughan et al. 2000.

minute episodes were broadcast between 1996 and 1997, and a further 105 episodes were broadcast between 1997 and 1998. As in other entertainment-education programs, *Apwe Plezi* included positive, negative and transitional role models who demonstrated the effects of alternative behaviours.[389]

The impact of the 1997 and 1998 programme was evaluated by conducting pre- and post-intervention interviews among listeners and non-listeners, and through focus group discussions with listeners.[390] In addition, researchers assessed the use of family planning services (patient visits) and collected data on contraceptive imports.[391] However, methodological challenges hampered the evaluation because the number of regular listeners among the 1,238 study participants was low.

The results of the study were mixed. Certain desired outcomes (knowledge, attitude, behaviour change) were reported by casual and regular listeners, while other desired outcomes were more prevalent among non-listeners.[392] Even where listeners reported higher levels of a particular behaviour change, the differences between listeners and non-listeners were often not statistically significant, which could be due to the small numbers of listeners.[393]

c) Summary

A review of the literature shows that edutainment campaigns use diverse methodologies. For instance, some edutainment interventions are paired with community mobilisation activities, while other initiatives rely on radio or television components only. The interventions also vary considerably in terms of their timeframes, levels of exposure, and definitions of what constitutes high/low exposure. Furthermore, evaluations of edutainment interventions

[389] Vaughan et al. 2000.
[390] Vaughan et al. 2000.
[391] Vaughan et al. 2000.
[392] Vaughan et al. 2000.
[393] Vaughan et al. 2000.

report a wide range of outcome measurements. These factors make it very difficult to compare and evaluate the effectiveness of edutainment interventions.

Most of the evidence on edutainment stems from studies assessing its impact on HIV prevention behaviours, such as condom use and multiple sexual partners, and other health behaviours. Little evidence is available on edutainment focusing on violence prevention, let alone physical punishment. *Soul City* is the only edutainment campaign that has been rigorously evaluated in relation to its impact on attitudes and behaviours in relation to violence. However, the evaluation was unable to show an effect on reducing domestic violence perpetration, despite its large sample size. The other edutainment initiatives focusing on violence prevention were not evaluated quantitatively and/or rigorously. Ellsberg et al. rightly point out that at present there is insufficient evidence on the effectiveness of edutainment programmes to shift attitudes and behaviour related to violence.[394]

The evidence on health-related edutainment suggests that, in addition to the levels of exposure and duration of the campaign, the effectiveness of edutainment depends on the type of behaviour that is targeted for change. Certain health behaviours, for instance those relating to child health, may be susceptible to change. Naugle & Hornik, evaluating mass media interventions in low- and middle-income countries, found that mass media can be effective in changing different behaviours linked to child survival.[395] In contrast, the evaluation of the *OneLove* campaign showed that it is difficult to change behaviours that are deeply entrenched in social norms, such as multiple concurrent sexual partnerships. This finding suggests that edutainment may not be suitable to challenge behaviours such as IPV and physical punishment.

Where edutainment was shown to be successful in changing attitudes or behaviours, researchers regularly report that higher exposure leads to higher rates of attitude/behaviour

[394] Ellsberg et al. 2015.
[395] Naugle & Hornik 2014.

change. Sufficient exposure to the campaign materials is therefore crucial. This underlines the importance of creating relevant and engaging outputs and/or characters to bind the audience to the programme.[396] Duration and timing of programmes are also important. However, the interventions in Burkina Faso and Botswana show that high exposure in and by itself is not a guarantee for success. In the Botswanan programme, viewers' identification with one of the characters who performs the desired behaviour determined whether viewers were likely to change behaviours.

Several studies highlighted methodological challenges in evaluating edutainment interventions such as cross-contamination, confounding and other uncertainties, which are difficult to control for. Where edutainment is paired with community mobilisation activities, it is questionable whether the edutainment component provides additional benefit or whether community mobilisation alone would have had the same impact. Furthermore, as with other types of interventions, it remains unclear whether the attitude/behaviour change is sustainable and leads to long-term change. Despite these difficulties, edutainment may have the potential to change attitudes and norms relating to violence if the content of the programme addresses both individual and social norms.

V. Conclusion

The literature review provides examples of large-scale interventions that have been used or could be adapted for the prevention of physical punishment. First and foremost, the literature review highlights that there is little empirical research to guide the development of policies and programmes targeting physical punishment. This shortage of evidence is particularly concerning given the high prevalence of physical punishment of children and other forms of violence against children in South Africa and elsewhere. Further research is thus urgently needed to establish whether early-childhood home visitation programmes, school-based interventions, community interventions and entertainment-education can effectively shift attitudes and behaviours underpinning physical punishment.

[396] Parkes et al. 2017.

There are, however, large-scale interventions that have been effective in preventing or reducing harmful behaviour. The *Nurse-Family Partnership* was able to reduce the risk of physical child abuse and *Thula Sana* strengthened the mother-infant relationship and secure infant attachment. Early-childhood home visitation programmes with other focus areas (child health; cognitive development) have also been successful in changing behaviours. Home visitation programmes with a violence prevention focus should therefore be developed and tested in the South African setting.

Another setting for interventions are schools. The *Good School Toolkit* led to a 42% reduction of violence against learners over a relatively short period of time (18 months). While the primary target of school-based interventions are teachers rather than caregivers, school-based interventions have the potential to have a diffusion effect by also engaging learners and their parents. Community interventions have the potential to reach large groups of people through a community diffusion effect. *TOSTAN* managed to shift deeply entrenched attitudes and practices relating to FGM/C over the course of two years. It is noteworthy that *TOSTAN* reduced the practice of FGM/C among participants and non-participants in the intervention villages. The evidence on health-related edutainment is mixed and there is currently insufficient evidence on the effectiveness of edutainment to shift attitudes and behaviour related to violence. However, given that edutainment has been able to shift health behaviours, this type of intervention may have the potential to change attitudes and norms relating to violence if it is designed to address social norms.

Promising interventions such as home visitation programmes, school-based interventions and community interventions should be adapted and tested in South Africa to explore whether any or all of them are able to effectively shift attitudes and practices relating to physical punishment in the local context. The research should rigorously evaluate the impact of interventions on behaviour change, including their impact on 'intermediate' or 'facilitating' factors such as knowledge, attitudes and social norms. Furthermore, interventions need to be assessed for scalability and cost-effectiveness.

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