Shifting attitudes and behaviours underpinning physical punishment of children

Briefing Paper

Written by:
Stefanie Röhrs
Children's Institute
University of Cape Town
May 2017

planning, monitoring & evaluation
Department: Planning, Monitoring and Evaluation
REPUBLIC OF SOUTH AFRICA

2030 NDP

PSPPD
PROGRAMME TO SUPPORT PRO-POOR POLICY DEVELOPMENT

1 Executive Summary

Physical punishment is the most widespread form of violence against children globally.[1] While up-to-date national prevalence data is lacking in South Africa, 89% of young women and 94% of young men in a large community-sample reported physical punishment by their parents or caregivers before the age of 18 years.[2] 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.[3] Physical punishment also continues at high rates in South African schools despite it being legally prohibited. Between 22% (Western Cape) and 74% (KwaZulu-Natal) of learners experience physical punishment at school.[4]

The high levels of physical punishment, particularly harsh forms of punishment, are concerning because this form of punishment can have detrimental effects on children's health and psycho-social development. Evidence shows that even 'mild' forms of physical punishment such as spanking can increase aggression and anxiety in childhood and adulthood.[5] Moreover, physical punishment is strongly associated with physical child abuse which may result in injury or even death.[6] Given that violent behaviour is likely learnt during childhood, experiences of physical punishment also play a role in the development of violent masculinities and the perpetration of intimate partner violence later in life.[7]

Due to the magnitude of the problem, small-scale interventions such as parenting programmes alone seem insufficient to curb physical punishment. What is needed are large-scale interventions that will result in a radical shift in people's attitudes and behaviours. Such interventions should be based on a sound theoretical framework and should be multi-pronged, thus targeting prevention at the individual, relationship, community and societal levels.

The purpose of this briefing paper is to assist policy makers and practitioners to make informed decisions about interventions that could support the development and implementation of policies and programmes targeting physical punishment. This briefing paper presents evidence on large-scale interventions that have been used to shift attitudes and behaviours underpinning physical punishment. In light of the paucity of evidence in relation to physical punishment, the briefing paper also presents evidence on the effectiveness of large-scale interventions targeting other forms of violence against children and intimate partner violence.

A small number of large-scale interventions have shown to be effective or are promising in reducing physical punishment.[8] One example is the *Good School Toolkit*, a

school-based intervention that was implemented in primary schools in Uganda. Over the course of 18 months the intervention succeeded in reducing physical punishment of learners by 42%.[9] Another case in point is the work by the non-governmental organisation *TOSTAN* in Senegal which did not deal with physical punishment, but with the deeply entrenched practice of female genital mutilation/cutting (FGM/C). A two-year community intervention successfully shifted attitudes in relation to FGM/C and resulted in reductions of the practice.[10] Other community programmes, such as the *SASA*! intervention to reduce intimate partner violence, have also shown promising results, but require further testing.

Early-childhood home visitation programmes also show promising results in relation to parenting and child development. The *Thula Sana* home visitation programme in South Africa was effective in promoting sensitive parenting and secure attachment, thus contributing to a positive mother-infant relationship.[11] A home visitation programme in the Caribbean, which draws on 'roving caregivers' to assist socially and economically deprived families, showed significant effects on the cognitive development of children.[12] While the evidence suggests that certain school-, community- and home-based interventions can prevent or reduce violence against children, the effectiveness of mass media communication campaigns in this regard is less clear. Mass media campaigns, such as entertainment-education, are appealing because they have the potential to reach very large populations. However, to date, these campaigns have largely focused on health behaviours and the evidence of their impact on violent behaviours is insufficient.

Research in other countries suggest that social norms play an important role in both physical punishment and intimate partner violence.[13] Comparative research in South Africa does not exist. We therefore recommend that the role of social norms on physical punishment and intimate partner violence be explored in the South African setting.

In terms of interventions, **the intersections of physical punishment and intimate partner violence should inform the design of interventions** so that shared risk factors and social norms can be addressed. Given the promising evidence on school-based interventions in other settings, **school-based programmes** should be adapted and tested in the South African setting to address the high levels of physical punishment and other forms of violence in schools. It should furthermore be explored whether **community interventions** that have effectively targeted other forms of violence can inform the development of similar interventions in South Africa to address physical punishment and intimate partner violence. Further research should also explore promising interventions such as **early-childhood home visitation programmes**. While these programmes can have positive effects, it remains unclear whether they can effectively shift attitudes and practices relating to physical punishment and to what extent home visitation programmes can be scaled. Lastly, any intervention research should, firstly, rigorously evaluate the impact of the intervention on attitude and behaviour change, including its impact on 'intermediate' or 'facilitating' factors such as knowledge, attitudes and social norms; and, secondly, undertake a cost-effectiveness assessment.

2 Background

Definition of physical punishment

According to the UN Committee on the Rights of the Child, physical punishment refers to "any punishment in which physical force is used and intended to cause some degree of pain or discomfort, *however light*"(our emphasis). Most physical punishment involves hitting (smacking, slapping, spanking) children, with the hand or with an implement – a whip, stick, belt, shoe, wooden spoon, etc. But it can also involve, for example, 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 (for example, washing children's mouths out with soap or forcing them to swallow hot spices). In the view of the UN Committee, physical punishment is invariably degrading and violates children's right to dignity and physical integrity, amongst other rights.[14]

The UN Committee on the Rights of the Child recognises that, in addition to physical punishment, there are non-physical forms of punishment that are also cruel and degrading and therefore incompatible with children's rights. These include, for example, punishment which "belittles, humiliates, denigrates, scapegoats, threatens, scares or ridicules the child".[15]

Harsh discipline vs physical punishment

In practice, 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 UN Committee on the Rights of the Child.

In South Africa, children experience many forms of violence and many children experience multiple forms of violence.[16] These multiple forms of violence often co-occur and intersect.[17] Physical punishment 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.[18] In a 2005 study, 57% of parents reported smacking their child/children and 30% reported having done so in the past month.[19] Children were most likely to be smacked at ages three and four.[20] 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.[21] 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.[22] Physical punishment also continues at high rates in South African schools despite it being legally prohibited. Nationally, approximately 50% of learners experience physical punishment

Physical punishment is the most widespread form of violence against children globally.

by teachers.[23] The prevalence of physical punishment in schools varies considerably between provinces. In the Western Cape, 22% of learners experience physical punishment at school, while the proportion rises to 74% in KwaZulu-Natal.[24]

The links between physical punishment and physical abuse

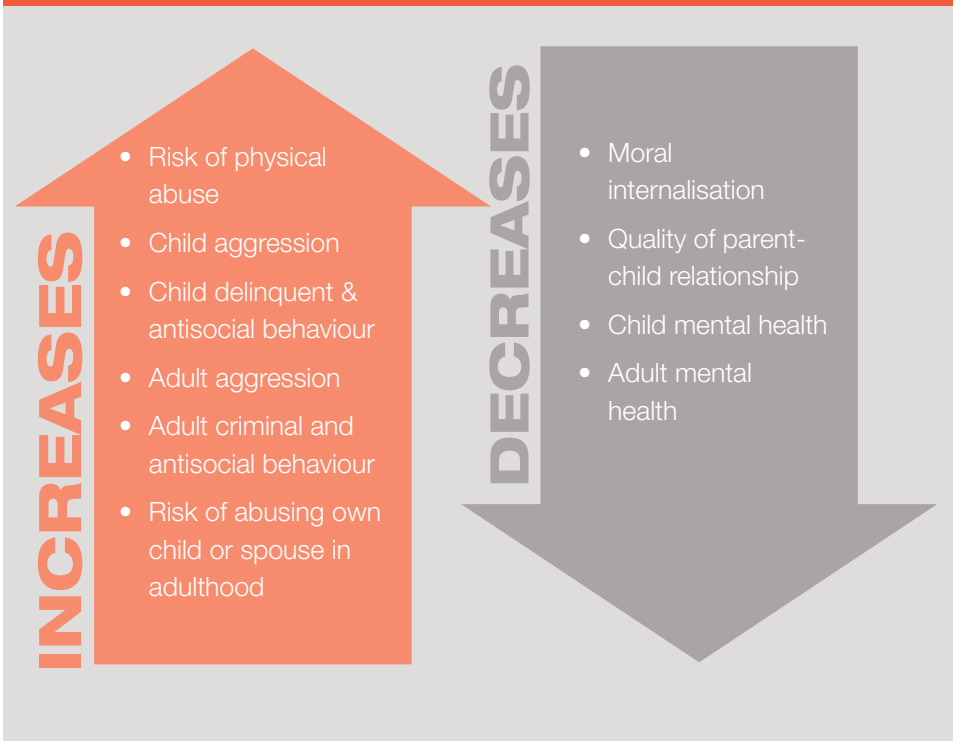
The divide between physical punishment and physical abuse is blurry. Many researchers regard physical punishment and potentially abusive forms of punishment as "points on a continuum of physical acts toward children".[25] In fact, there is considerable overlap between less severe forms of physical punishment (e.g. spanking with open hand) and more severe forms of physical punishment which bear a risk for injury and would be considered physical child abuse. Studies from the U.S. and Canada have shown that most physical child abuse takes place in the context of discipline: 75% of physical abuse of children occurs during episodes of discipline using physical punishment, and children who are spanked by their parents are seven times more likely to also be severely assaulted by their parents.[26] The links between 'mild' forms of physical punishment and child abuse have also been confirmed in a study across nine countries.[27]

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.[28] 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 parents and other primary caregivers, followed by teachers and relatives.[29] Younger children were more likely to experience physical abuse than older children.[30]

In the most extreme cases physical abuse can be fatal. Child homicide rates in South Africa are double the global average and research indicates that just under half (44.6%) of these homicides happen in the context of child abuse and neglect.[31] Young children up to the age of four years are most at risk, and most of these deaths occur in the home.[32] The links between 'mild' forms of physical punishment, physical child abuse and fatal child abuse highlight the importance of primary prevention. Preventing physical punishment is critical for the prevention of more severe forms of child abuse and death.

If we can prevent physical punishment, we will in all likelihood lower the incidence of physical abuse.

FIGURE 1: ASSOCIATIONS BETWEEN PHYSICAL PUNISHMENT AND UNWANTED OUTCOMES



Consequences of physical punishment

Physical punishment requires urgent attention from a public health perspective. The evidence suggests that physical punishment may have detrimental effects, particularly if experienced during early childhood, because early childhood experiences have a strong influence on the development of cognitive, behavioural and social skills, as well as on brain architecture and neurochemistry.[33] Even 'mild' forms of physical punishment such as spanking and slapping are associated with a number of unwanted outcomes (see Figure 1).[34]

Preventing physical punishment is thus critical to prevent more severe forms of child abuse, but also to protect children from developing aggressive, delinquent and antisocial behaviours, to promote the parent-child relationship, and to protect child and adult mental health.

The links between intimate partner violence and physical punishment of children

Research has also investigated the links between physical punishment and intimate partner violence (IPV). Evidence suggests that IPV in the home increases the risk of physical punishment.[35] The social context that permits the use of IPV also fosters the use of physical punishment leading to the co-occurrence of IPV and physical punishment.[36] Women anticipate and tolerate the use of violence under certain conditions, and men's use of violence is associated with searching for respect and power which is often translated into controlling behaviour of a man towards his partner and children.[37] Both forms of violence are associated with norms that reinforce male dominance and accept violence as a reasonable means to resolve conflict.[38] **Research in South Africa demonstrates the**

increased risk for both emotional and physical abuse for children living in households where there is domestic conflict.[39]

Both direct experiences of violence and indirect experiences such as witnessing IPV can lead to negative long-term consequences. A study in six countries in Asia and the Pacific found that males who experienced physical violence during childhood were more likely to perpetrate violence later in life.[40] Furthermore, male children who witnessed IPV had an increased risk of developing violent masculinities and abusing their partners in adulthood; whereas female children were at an increased risk of becoming victims of IPV in adulthood.[41]

In light of the links between IPV and physical punishment, interventions should ideally integrate the prevention of IPV and violence against children for greater impact.

Physical punishment and human rights

In addition to the negative public health consequences, physical punishment is highly problematic from a human rights perspective because the practice violates children's rights under international and domestic law. 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 children's right to be free from physical and mental violence, injury and abuse, and maltreatment while in the care of parent(s), legal guardian(s) or any other caregiver.[42] The state has a duty to protect children from these forms of maltreatment and abuse through legislative, administrative, social and educational measures.[43] As noted above, the UN Committee on the Rights of the Child considers all forms of physical punishment, however light, a violation of children's right to dignity and physical integrity.[44] The South African Constitution also protects children's right to be free from all forms of violence, their right to bodily and psychological integrity, and their right to be protected from maltreatment and abuse.[45]

In light of the public health and human rights concerns, the prevention of physical punishment must be a priority. This briefing paper presents evidence on large-scale interventions that aim to shift attitudes and behaviours underpinning physical punishment. The analysis of the current evidence base is meant to 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.

States shall take all appropriate measures to protect the child from all forms of physical or mental violence.

3 Behaviour Change Theories

For the design and evaluation of interventions, it is helpful to consider theoretical frameworks that examine human behaviour and behaviour change. Given that many complex theories examine behaviour and behaviour change, we will only present key elements of some of the most relevant theories.

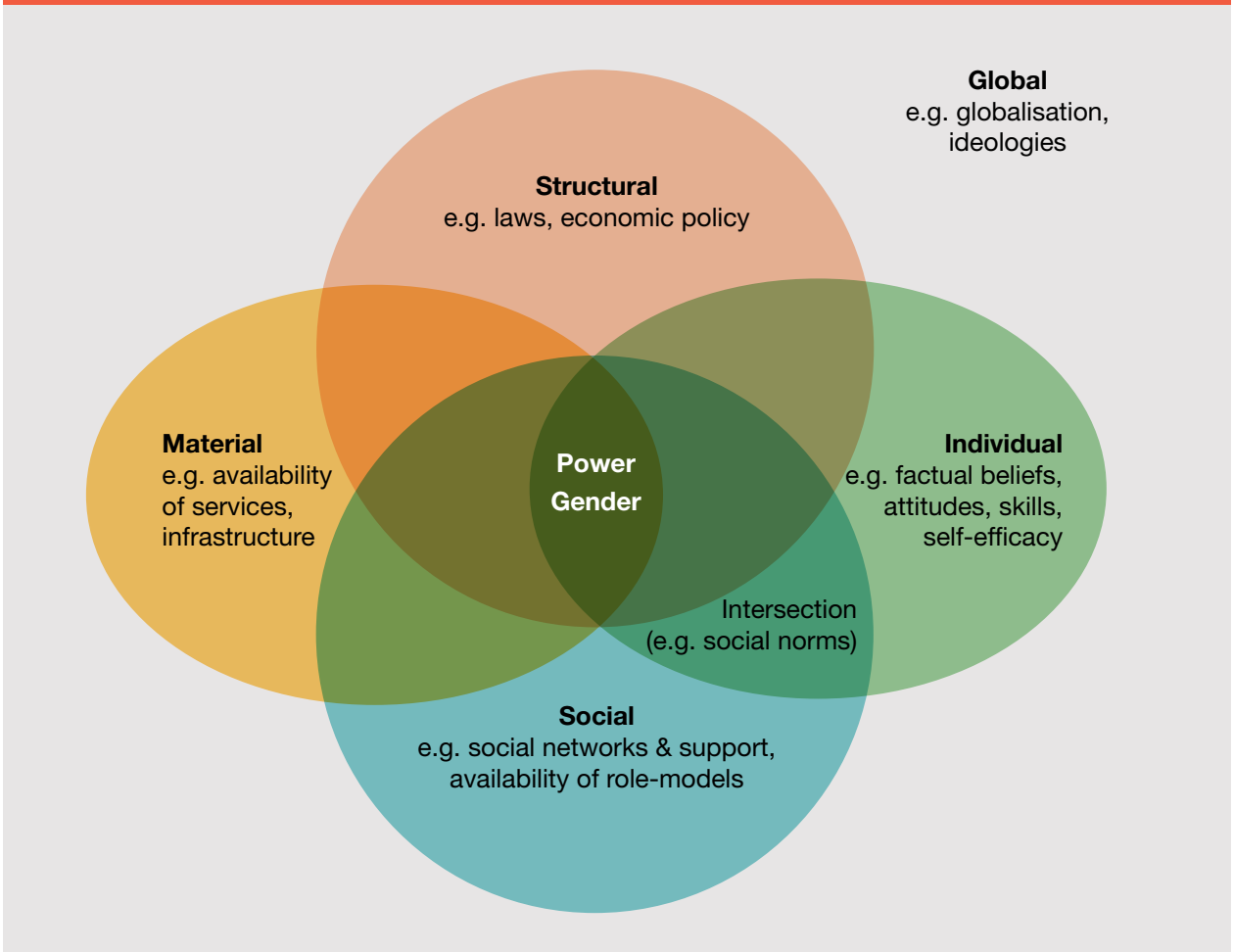
Bandura's Social Learning Theory, which was developed in the 1970s, views behaviour as something that can be learned through observation, modelling and imitation.[46] His theory emphasises cognition, motivation and self-efficacy, which refers to the individual's belief that he or she can perform a certain behaviour.[47] Lewin's Theory of Change from the 1940s describes how psychological components such as an individual's emotion, abilities and internal resources can influence behavioural change.[48] Other examples of behaviour change theories are provided in Table 1.

While these theories differ in the emphasis they place on particular elements, certain key concepts are common across several theories, such as cognition, self-efficacy, attitudes, intention and motivation to change, as well as the influence of social identity and social norms.

TABLE 1: BEHAVIOUR CHANGE THEORIES

Social Learning Theory	• Behaviour learnt through observation, modelling and imitation • Importance of motivation • Importance of self-efficacy
Lewin's Theory of Change	• Behaviour influenced by emotion, abilities and internal resources • Importance of societal norms
Theory of Planned Behaviour	• Behaviour shaped by intention • Intention influenced by attitude, subjective norms and perceived behavioural control
Theory of Social Identity	• Behaviour influenced by social categorisation, self-esteem, social comparison and social identity
Information-Motivation-Behaviour Skills Model	• Behaviour change requires information, motivation and skills • Motivation influenced by social support
Transtheoretical Model	• Behaviour change is influenced by decision-making abilities • Behaviour change occurs over time in six stages

FIGURE 2: 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

A newer theory called Social Norms Theory draws particular attention to social norms to explain why certain behaviours are common in a group and may be difficult to change.[49] Social norms refer to what people think others expect of them or the unwritten rules about what is acceptable in a particular society or group of people.[50] As illustrated in Figure 2, Cislaghi & Heise place the development of social norms at the intersection of individual attitudes and social factors. Their model for behaviour change further illustrates the relevance and interaction of various factors in determining behaviour.

The influence of social norms can prevent or accelerate changes in behaviour.[51] Changing social norms, however, is not a guarantee for behaviour change because other determinants may sustain a particular behaviour.[52] 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.[53] 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.

Locally, there is limited conceptual work examining behaviour change in relation to physical punishment. One large multi-country study investigated *inter alia* the links between attitudes towards physical punishment, and how these attitudes are linked to violent behaviours towards children.[54] In all 25 countries, individuals' belief that physical punishment is a necessary form of child discipline predicted the actual use of physical punishment and psychologically aggressive behaviour towards children.[55] Interestingly, the study furthermore found that women who believe that husbands are justified in hitting their wives *and* that physical 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.[56]

Social norms played an important role in the prevalence of physical punishment. Firstly, children living in countries where social norms supported domestic violence and corporal punishment were more likely to experience harsh discipline.[57] Secondly, the strength of the association between individual attitudes and the use of harsh discipline was weaker in countries where social norms supported domestic violence and corporal punishment, compared to countries where these types of violence were not supported.[58] Lansford et al. explain, "[I]n countries where domestic violence and corporal punishment are widely accepted, harsh behaviors [sic] toward children may be parents' default responses, less guided by individual choices regarding discipline strategies than by adoption of common social practices".[59] 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.[60] The study highlights that interventions aimed at shifting attitudes and behaviour in relation to physical punishment should target both individual attitudes and social norms.[61] Furthermore, the findings underline the potential of integrating interventions to address domestic violence and harsh discipline.

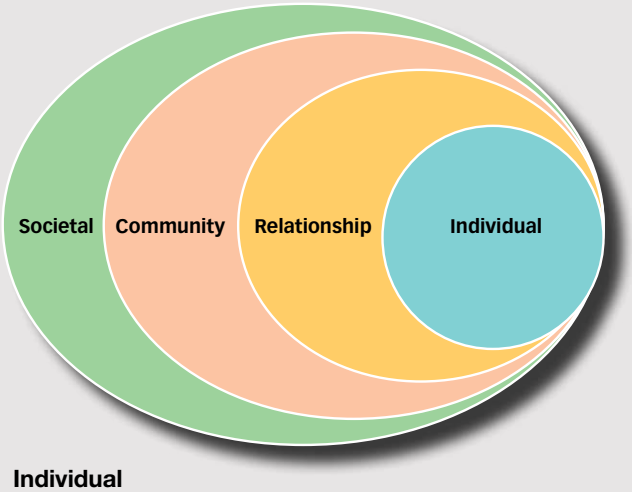
A first step in developing an intervention that aims to shift attitudes and behaviours underpinning physical punishment should therefore be to explore the role of individual attitudes, social norms and other factors in supporting physical punishment in South Africa.

4 Large-scale interventions

Physical punishment, like other forms of violence, can best be understood as a complex interaction of different factors that operate at different levels. The social-ecological model is a useful framework to examine risk and protective factors of physical punishment at the individual, relationship, community and societal levels (see Figure 3). Due to the multi-dimensional nature of physical punishment, interventions aimed at preventing or reducing physical punishment should be multi-pronged to address risk factors at different levels. While interventions may not be able to address all levels at the same time, it is important to bear these different levels in mind to create a continuum of activities that address multiple levels of the model over time.[62]

The review of the literature highlights that the evidence on large-scale interventions addressing physical punishment specifically is very limited. In light of the paucity of evidence, the case studies presented here include examples of large-scale interventions targeting risk factors underpinning physical punishment and interventions on other forms of violence against girls and women. We also present interventions that are 'medium scale', but have the potential of scale-up.

FIGURE 3: THE SOCIAL-ECOLOGICAL MODEL



Individual
Identifies biological and personal history factors; such as age, education, income, substance use, or history of abuse, that increase the likelihood of becoming a victim or perpetrator of violence.

Relationship
Examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle – peers, partners and family members – influences their behaviour and contributes to their range of experience.

Community
Explores the settings, such as schools, workplaces and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence.

Societal
Looks at the broad societal factors, such as health, economic, educational and social policies, that help create a climate in which violence is encouraged or inhibited and help to maintain economic or social inequalities between groups in society.

Source: Centres for Disease Control and Prevention (undated) *The Social-Ecological Model: A Framework for Violence Prevention*. Atlanta, GA: CDC

1. Early-childhood home visitation programmes

Home visitation programmes involve visits by professionals or paraprofessionals to provide support and/or education to the household. They have been implemented in many countries with different focus areas such as early-childhood development, prevention of maltreatment, infant attachment, child health, and maternal depression. Home visitation programmes generally target the mother/primary caregiver of the child and thus work at the individual and relationship level.

Promising practice: *Thula Sana* (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.[63] 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 determine how children form relationships with peers, partners and their own children later in life.[64] Poor attachment can lead to an inability to form healthy relationships and increases the risk of perpetrating violence later in life.[65] 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 each of the 220 women in the intervention group 16 times.[66] The home visits started in the last trimester of pregnancy and continue until six months after birth.[67] During the home visits, community workers engaged mothers in different activities to increase their awareness of their infants' individual capacities and needs.[68] *Thula Sana* was evaluated in a randomised controlled trial 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.[69]

Thula Sana increased sensitive parenting and promoted secure infant attachment.

Furthermore, infant attachment security at 18 months was significantly higher in the intervention group.[70]

Overall, the effect of the intervention was moderate. Follow-up research showed that genetic differences in children influenced the effectiveness of the intervention, with certain children benefitting much more from the intervention than others. Children with a short form of a particular gene and whose mothers received the intervention were 3.86 times more likely to be securely attached at 18 months than children with the same gene whose mothers did not receive the intervention.[71]

Promising practice: *Roving Caregivers* (Caribbean)

Similar to the *Thula Sana* programme, the *Roving Caregivers* programme draws on trained members of the community to make weekly home visits to families with infants and toddlers up to the age of three years who live in socially and economically disadvantaged communities.[72] The roving caregivers show parents how to stimulate children's cognitive, social and physical development, and give advice on parenting and child-rearing practices.[73] In addition to the home visits, the intervention includes monthly parent meetings where participants can share their knowledge and experiences.[74] The programme was initially started in Jamaica, but subsequently rolled out to other Caribbean countries (Belize, Saint Lucia, Saint Vincent and the Grenadines, Grenada and Dominica).[75]

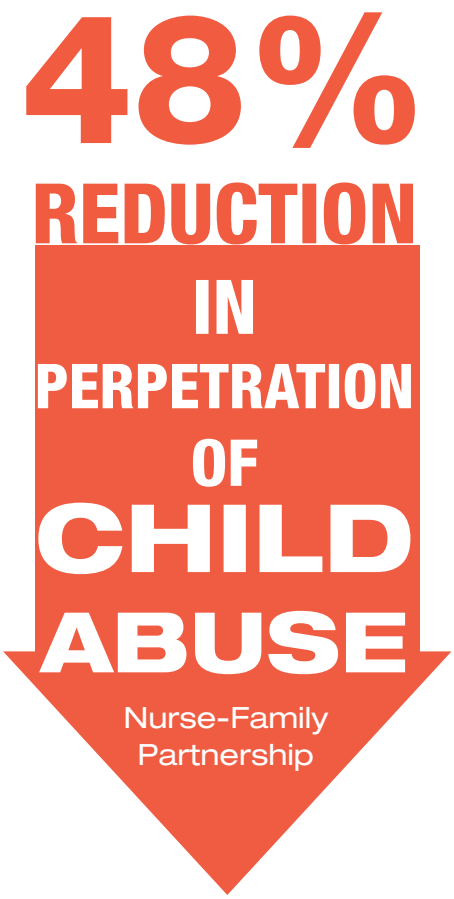
In 2008, the impact of the programme was evaluated qualitatively and quantitatively in Saint Lucia. The findings of the evaluation are reported in an impact report (i.e. not peer reviewed).[76]

The evaluation showed significant effects on the cognitive development of children, particularly for younger children between six and 18 months.[77] 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.[78]

The intervention's effect on parental discipline is not comprehensively documented. The impact report highlights that the visits from the roving caregivers sparked the desire of parents in the intervention group to use less physical punishment.[79] According to the impact report, parents who participated in the intervention addressed discipline with more talking rather than physical punishment.[80] A cost-benefit analysis found the programme to be cost-effective.[81]

Further evidence on early-childhood home visitation programmes

In the U.S., the *Nurse-Family Partnership*, a home visiting programme by nurses, has been evaluated through randomised controlled trials over the course of 15 years.[82] The programme, which includes nine home visits during pregnancy and 23 home visits from the child's birth through to the second birthday, had numerous positive impacts on women and children.[83] Compared to women in the control group, women who were enrolled in the home visitation programme were 48% less likely to be a perpetrator of child abuse in cases that had been reported to child protection agencies.[84] It is noteworthy that the impact of the intervention decreased as the level of domestic violence increased.[85] Child abuse was significantly lower in families receiving home visits where women



had experienced up to 28 domestic violence incidents over the 15 years follow-up period.[86] Where women reported more than 28 incidents of domestic violence, the intervention did not reduce child maltreatment.[87]

In South Africa, home visitation programmes using paraprofessionals have also been successfully used to address child and maternal health such as health seeking behaviours, reducing maternal depression, lowering levels of child stunting and reducing the child's risk of hospitalisation.[88]

Lessons learnt

Early-childhood home visitation programmes have been successful in promoting maternal and child health, and individual studies suggests that these programmes can reduce risk factors for child abuse and promote protective factors such as sensitive parenting and secure infant attachment. However, the evidence is limited due to the small number of studies in resource-poor settings. Systematic reviews of home visitation programmes in high-income countries have mixed results. While some systematic reviews suggest that home visitation programmes, including those by paraprofessionals, can improve child development and prevent child abuse,[89] others caution that the evidence may not be robust due to methodological challenges including surveillance bias (i.e., an increased likelihood that the outcome will be identified and reported due to the home visits).[90]

South African studies show 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 which includes home visits by trained community members to provide practical assistance 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 that families find these interventions acceptable. Similar to the *Roving Caregivers* programme, *Isibindi* has demonstrated the cost-effectiveness of home visitation programmes led by paraprofessionals.

Further research is needed to investigate whether a controversial topic such as physical punishment, which is 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.

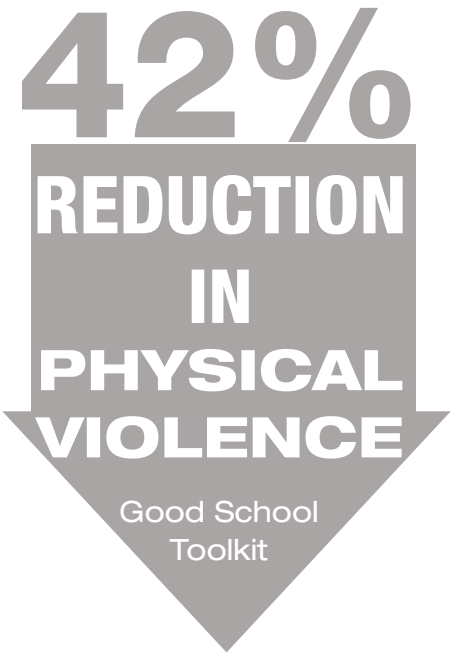
2. School-based interventions

School-based interventions focus on reducing physical punishment by school staff. The target group for behaviour change are teachers and other school staff, learners and, in some instances, parents and communities. School-based interventions operate at the individual and relationship level and can, depending on the design, also target the community level. Even where parents are not directly involved, the approaches used to change school staff's behaviour may be useful for the development of behaviour change programmes targeting parents.

✓✓✓ Best practice: *Good School Toolkit* (Uganda)

In Uganda, the non-governmental organisation Raising Voices developed the *Good School Toolkit,* a complex, multi-component intervention which aims to change school staff's behaviour.[91] The intervention 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.[92] The techniques include the setting of school-wide goals, development of action plans, and the provision of information on non-violent discipline.[93] Learners are required to actively participate in the intervention through committees and groups.[94] The intervention furthermore includes activities with learners' parents and community members.[95]

The intervention was rigorously evaluated through a cluster randomised controlled trial. Baseline and follow-up interviews were conducted with over 3,700 students from 42 primary schools; 21 one these schools were intervention schools.[96] At 18-month follow-up, the likelihood of experiencing physical violence from school staff was significantly lower at the intervention schools.[97] While 49% of learners at control schools reported past-week physical violence from school staff, only 31% of learners at the intervention schools did.[98] This means that learners at the intervention school had a 42% lower risk of experiencing past-week physical violence.[99]



Further analysis of the data suggests that when physical punishment was used at the intervention schools, it was less severe than before the intervention.[100] The intervention also had a positive effect on learners' feelings of safety and wellbeing.[101] Furthermore, the intervention was

The *Good School Toolkit* reduced the risk of past-week physical punishment by 42%.

successful in changing school culture by reducing physical and emotional violence perpetrated by school staff and peer learners.[102]

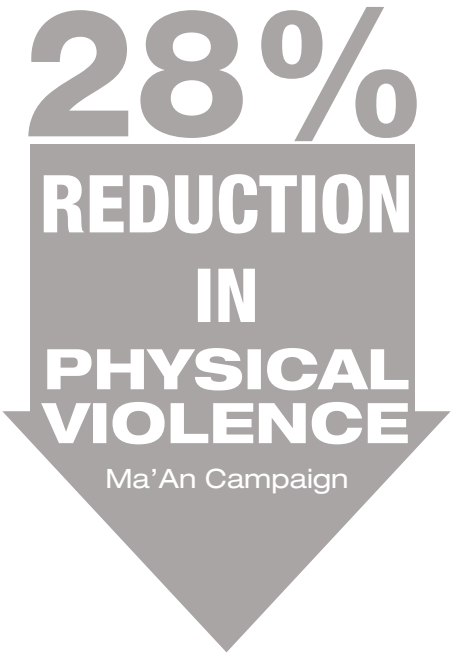
The success of the intervention is attributed to four pathways of change. One, the intervention meaningfully improved the relationship between learners and teachers.[103] At the intervention schools, learners described their teachers as approachable and concerned about learners. Two, the intervention encouraged good learner behaviour through rewards and praise, thereby reducing the need for discipline.[104] Three, the intervention led to increased knowledge of alternative discipline methods among teachers who had been unaware of alternative forms of discipline.[105] With this new knowledge, teachers had the tools to instil discipline among learners without reverting to physical punishment.[106] Four, the intervention changed some teachers' attitudes towards physical punishment. Some teachers started viewing physical punishment as ineffective.[107]

The *Good Schools Toolkit* is currently being rolled out to schools across Uganda and its long-term impact is being assessed.

Further evidence on school interventions

Interventions to reduce physical punishment in schools are currently explored in a number of other countries. In Jordan the national, multi-pronged *Ma'An (Towards a Safe School)* campaign is currently underway. This campaign includes school-based activities to promote behavioural changes among teachers.[108] In addition, the intervention uses community-based activities and a media campaign to shift social norms.[109] The campaign is still ongoing and a final evaluation of the intervention is not yet available. A survey after the first year of the campaign reports an average decline of 28% in physical violence and a 15% decline in verbal violence in schools.[110] Yet, it remains unclear whether these reductions refer to violence perpetrated by teachers specifically, or whether they include learner-on-learner violence.

In Jamaica, an intervention based on the *Incredible Years Teacher Training* programme and modules from the *Incredible Years Dina Dinosaur Classroom Curriculum* has been piloted in a small number of Jamaican pre-schools.[111] The intervention does not specifically address physical punishment, but aims to strengthen



positive relationships between teachers and learners and reduce 'inappropriate' teacher behaviour.[112] The intervention combines professional development for teachers and a curriculum unit on social and emotional skills.[113] An evaluation using a rigorous study design showed that the intervention significantly reduced negative teacher behaviours at the three intervention schools and increased positive teacher behaviours at the three intervention schools.[114] However, the evaluation does not provide information on what kind of negative behaviours were reduced. It is therefore unclear whether the reduction in negative behaviours refers to a reduction in the use of physical punishment. A larger study using a different intervention methodology is currently underway at Jamaican pre-schools.[115] Given that one of the outcome measures of this study will include teacher's use of violence against learners, this study might provide stronger evidence, particularly in relation to physical punishment.[116]

Lessons learnt

While only a small number of school programmes addressing physical punishment in low-resource settings have thus far been rigorously evaluated, these studies suggest that school interventions can be very successful in changing teachers' attitudes and behaviours. The evidence on the *Good School Toolkit* is strong and shows that a short (18-month) intervention can have a substantial impact on children's experience of violence at school. The intervention had a large effect on reducing teacher on learner violence (42%) and many other positive outcomes. Although the goal of school interventions is changing behaviours of teachers and other school staff (e.g. principles), the methods used in these programmes could be adapted for interventions targeting parents. For instance, the *Good School Toolkit* in Uganda provides teachers with information on alternative forms of discipline – information that would be valuable for parents and caregivers, many of whom are unaware of non-violent forms of discipline.

School interventions also provide an opportunity to teach learners about their rights and non-violent forms of conflict resolution, which may shift attitudes among learners as the next generation of parents. School interventions may furthermore provide an opportunity to engage parents and caregivers on the issue of physical punishment. Exposure to a 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 and other caregivers to challenge their norms and practices regarding physical punishment in the home.

3. Community interventions

Community interventions try to change behaviours at the population level by shifting norms, practices, and public discourse.[117] Community interventions, which are particularly useful to address behaviour that is influenced by social norms, either target a whole community or rely on a 'diffusion effect'. Diffusion effect means that the intervention does not only have an effect on those exposed to the intervention, but also on those who have not been exposed. To date, most of the evidence on community interventions evaluates interventions addressing IPV and female genital mutilation/cutting (FGM/C). Community interventions target the individual, relationship and community level.

Best practice: *TOSTAN* (Senegal)

The non-governmental organisation *TOSTAN* tackled a specific form of child maltreatment in Senegal. Their community intervention aimed to challenge attitudes and behaviours around FGM/C.[118] *TOSTAN's* approach is to empower communities by combining educational skills (e.g. reading, writing, arithmetic), life skills, and human rights education.[119] In 2001, *TOSTAN* established and trained community management committees in 90 villages.[120] The training included classes on human rights, particularly women's and girls' right to bodily integrity, problem-solving, basic hygiene and women's health.[121] 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.[122]

The intervention was rigorously evaluated by interviewing community members in 20 intervention villages with 20 control villages before and two years after the intervention.[123] In the intervention villages, surveys were administered to participants and non-participants to measure whether the intervention had a diffusion effect on community members who had not participated in the intervention.[124]

The intervention had significant effects on attitudes towards and practices relating to FGM/C. Attitudes in support

TOSTAN shifted attitudes and practices in relation to FGM/C.

of FGM/C decreased significantly among participants and non-participants in the intervention villages after the intervention.[125] 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 (see Table 2).[126] The drop in supportive attitudes among non-participants in the intervention villages clearly illustrates a diffusion effect of the intervention. Although attitudes supportive of FGM/C also decreased significantly among community members in the control villages, which did not receive the intervention, overall support for FGM/C remained much higher in these villages (60%).[127]

In addition to changes in attitudes, the intervention was successful in changing behaviours. The practice of FGM/C decreased significantly for daughters of participants and non-participants in the intervention villages.[128] In the control villages, the prevalence of FGM/C on young girls did not change between baseline and endline.[129]

Promising practice: *SASA!* (Uganda)

One promising practice in relation to reducing IPV is *SASA*! (*Now!*).[130] *SASA!* is a multipronged community mobilisation intervention that is implemented through members of a community who become community activists.[131] Community activists and public sector officials (e.g. health workers, police officers) receive training on violence, power and rights.[132] After the training, community activists conduct activities focusing on these issues in their community.[133]

Compared to community members in the control villages, attitudes supporting IPV were lower among female participants of the intervention.[134] While the intervention led to substantial changes in attitudes and behaviour in the intervention communities, not all of these changes were statistically significant.[135] For instance, the intervention led to a 50% reduction in physical IPV experience and perpetration, but some of the reduction may have been due to chance rather than the intervention.[136] Interestingly, it was also noted that **changes in community norms were the most influential facilitator for the reduction of physical IPV experience and perpetration**.[137]

TABLE 2: SUPPORTIVE ATTITUDES TOWARDS FGM/C BEFORE AND AFTER INTERVENTION

	Approval of FGM/C	
Group	**Before intervention**	**After intervention**
Participants in intervention village	72%	16%
Non-participants in intervention village	72%	28%
Non-participants in control village	89%	60%

Changes in community attitudes regarding the acceptability of violence were responsible for most of the intervention effect seen in women and men.[138] This underlines the importance of targeting social norms in violence prevention interventions.

Another remarkable finding is that ***SASA!*** **had a diffusion effect** on community members who had not been exposed to the intervention.[139] Furthermore, despite the intervention's focus on IPV, participants of the intervention reported behavioural changes affecting children, such as changing parenting practices or trying to protect their children from witnessing domestic violence.[140] While these behavioural changes require further investigation, they illustrate the interconnectedness of IPV and violence against children.

Further evidence on community interventions

In Uganda, another community intervention called *SHARE* (*Safe Homes and Respect for Everyone*) challenged attitudes, social norms and behaviours related to IPV. Similar to *SASA!*, *SHARE* included capacity building, advocacy and special community events, and targeted the individual, relationship and community level.[141] *SHARE* was successful in reducing women's experiences of different forms of IPV.[142] Females in the intervention group were significantly less likely to report past-year physical IPV, sexual IPV and forced sex.[143] However, perpetration of IPV reported by males was not significantly reduced by the intervention.[144] The evaluation of *SHARE* does not discuss changes in individual attitudes versus changes of social norms. It is therefore unclear how the intervention achieved the reductions of IPV.

Lessons learnt

The evidence base for community interventions aimed at violence prevention is small. Although community programmes have been able to reduce IPV, the reductions were only reported for the experience, but not the perpetration of violence (*SHARE*), or it is unclear whether the reductions were due to chance or the intervention (*SASA!*). The work by *TOSTAN*, however, shows that it is possible to change deeply engrained behaviours such as FGM/C through carefully designed, multi-pronged community interventions.

Community interventions have the potential to impact at the community level. Both *SASA!* and *TOSTAN* were able to demonstrate a diffusion effect whereby attitudes had changed even among community members who had not participated in the intervention. This effect is most likely achieved through multipronged programmes that target different stakeholders.[145]

Although most of the community interventions targeted IPV, they provide important insights for the development of interventions to prevent physical punishment. One, both types of interventions need to address social norms around male dominance and entitlement. Because of the links between IPV and violence against children, it is not surprising that *SASA!* shifted norms and practices relating to violence against children even though the intervention had targeted IPV. Two, the methodologies used in community interventions could be used in interventions targeting physical punishment of children. Given the success of *TOSTAN* and *SASA*! in changing community attitudes and norms, further research should explore what types of activities could shift deeply engrained social norms.

4. Entertainment-education

Entertainment-education, which is also referred to as 'edutainment', refers to the use of popular entertainment formats to tackle serious social and health issues.[146] The purpose of edutainment is to increase the knowledge about a health or social issue and to create favourable attitudes in order to change people's behaviour to a desired behaviour.[147] Edutainment can use a wide variety of formats, including radio and television soap operas, feature films, animation films, short video clips, public service announcements, talk shows and game shows. Edutainment generally targets the individual and relationship level. Edutainment is sometimes paired with other activities, such as community mobilisation and advocacy, to also target the community level.

Emerging evidence: *Soul City* (South Africa)

Soul City is a television drama series developed by the Soul City Institute for Social Justice (hereafter: Soul City Institute)[148] that aims to initiate behaviour change among viewers in response to health or social issues. Since its launch in 1994, the series has covered many different issues, including maternal and child health, HIV/AIDS and substance abuse, to name but a few.[149] The television series is part of a multi-pronged campaign which usually includes additional media elements (radio, print), social mobilisation and advocacy activities.[150]

In 1999, the campaign focused on the topic of violence against women, including domestic violence and the Domestic Violence Act. The campaign also included community mobilisation activities, ongoing media coverage and engagement with political stakeholders.[151]

The appeal of edutainment is that it can reach vast number of people. The 1999 television series, for instance, is estimated to have reached 16.2 million viewers.[152] However, the effectiveness of this intervention is unclear. The evaluation reports increases in knowledge and awareness on women's rights and shifts in relation to some gender equitable attitudes, but not in relation to deeply engrained beliefs.[153] For instance, the intervention did not reduce agreement with the statement, "As head of the household, a man has the right to beat a woman".[154] Those exposed to multiple formats of the campaign reported changes in self-seeking behaviour (i.e. calling a helpline) and in offering support to women who had been abused.[155] However, the evaluation was unable to determine whether the intervention had resulted in behaviour changes pertaining to the perpetration or experience of domestic violence.[156]

Further evidence on entertainment-education

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.[157] Little evidence is available on edutainment focusing on IPV prevention because initiatives other than *Soul City*, such as *Brothers for Life* in South Africa and *Bell Bajao!* in India, were not rigorously evaluated in terms of large-scale effects.[158]

Lessons learnt

Edutainment has been predominantly used to address health issues and has, in some instances, been found to be effective in changing behaviours. For instance, Naugle & Hornik, evaluating mass media interventions on child survival in low- and middle-income countries, report that such interventions can be effective in changing behaviours linked to child survival.[159] Edutainment paired with community-based social mobilisation activities has also been effective in changing HIV-risk behaviours. The multi-pronged edutainment campaign *OneLove*, for instance, which was implemented across Southern Africa, was able to significantly increase HIV testing and condom use.[160] Similarly, *Somos Diferentes, Somos Iguales* (*We are different, we are the same*), an edutainment campaign in Nicaragua, improved self-efficacy in relation to condom use and gender-equitable attitudes, and increased condom use for casual sex.[161] However, the effectiveness of edutainment appears to depend on the type of behaviour that is targeted for change. Although partner reduction was the main message in the *OneLove* campaign, multiple concurrent sexual partnerships were only reduced in two out of eight countries.[162] Equally, the *Soul City* campaign was unable to determine whether the intervention had reduced the perpetration or experience of domestic violence. Both locally and internationally, there is insufficient evidence on the effectiveness of edutainment to shift attitudes and behaviour related to violence.[163] 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 they are designed to address social norms.

There is insufficient evidence on the effectiveness of edutainment to shift attitudes and behaviour related to violence.

5 Recommendations

South Africa has extraordinary high levels of physical punishment of children and IPV, both of which have long-lasting detrimental effects on children and enormous social and economic costs to the country. Most notably, physical punishment is associated with more severe forms of child abuse, including fatal child abuse. Furthermore, physical punishment and witnessing IPV play a role in the intergenerational transmission of violence; male children who experience physical violence or witnesses IPV against their mother are more likely to perpetrate violence against their partner and children later in life; female children are at an increased risk of becoming victims of IPV in adulthood. It is therefore paramount that South Africa invests in large-scale interventions that prevent physical punishment of children and its consequences. In light of the existing evidence, we make the following recommendations:

- **Research should explore the role of individual attitudes and social norms on physical punishment.** Research from other settings suggests that the use of physical punishment is supported by social norms. The role of social norms in relation to physical punishment has not yet been examined in South Africa. In order to target interventions effectively, research should investigate to what extent physical punishment is driven by individual attitudes and by social norms in South Africa.
- School-based interventions have shown efficacy to reduce teacher-on-learner violence and foster positive teacher behaviour towards learners. The evidence base is limited but promising. The ***Good School Toolkit*** **has undergone a rigorous evaluation** and has been shown to reduce the use of physical punishment and other forms of violence in Ugandan primary schools over the course of 18 months. **Using the lessons learnt from this programme and adapting this school-based model for testing in the South African setting is imperative to make schools a safer space for children.**
- **Develop a home visitation programme led by para-professionals to specifically shift attitudes and practices in relation to physical discipline.** The programme design should draw on available evidence such as *Thula Sana* and *Roving Caregivers*. Before a larger campaign is adopted, implement and rigorously test effectiveness of the programme, assess whether outcomes differ if home visits start before or after birth and investigate scalability.

- **Develop a community-based intervention that aims to shift attitudes and practices in relation to physical discipline.** The programme design should draw on successful community interventions such as *TOSTAN* and *SASA!* but needs to take into account the South African context. Before a larger campaign is adopted, implement and rigorously test effectiveness of the programme and investigate cost-effectiveness. Liaise with implementing organisations of comparable programmes to discuss how to maximise diffusion effect.
- **Due to the co-occurrence and intersections between IPV and physical punishment, it is important to develop interventions that address mutual risk factors and social norms that support IPV and physical punishment.** Where possible, integrate IPV prevention and prevention of physical punishment of children in interventions.
- **Rigorously evaluate the effectiveness of interventions in addressing physical punishment.** Drawing on behaviour change theories, evaluations should assess effects on individual attitudes and behaviours as well as social norms. Evaluations should also examine changes in relation to 'intermediate' or 'facilitating' factors of behaviour change, such as knowledge, intention, motivation to change and self-efficacy. Outcomes and cost-effectiveness of different types of interventions need to be compared.

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.

References

1 UNICEF (2014) *Hidden in Plain Sight: A Statistical Analysis of Violence Against Children*. New York: UNICEF.

2 Jewkes RK, Dunkle K, Ndunad M, Jamaa PN, Purene A (2010) Associations between childhood adversity and depression, substance abuse and HIV & HSV2 incident infections in rural South African youth. C*hild Abuse & Neglect*, 34(11): 833–841.

3 See Jewkes et al (n 2) above.

4 Burton P & Leoschut L (2012) *School Violence in South Africa: Results of the 2012 National School Violence Study.* Cape Town: Centre for Justice & Crime Prevention.

5 Gershoff ET (2002) Corporal punishment by parents and associated child behaviours and experiences: A meta-analytic and theoretical review. *Psychological Bulletin*, 128(4): 539-579.

6 Lansford JE, Godwin J, Uribe Tirado LM, Zelli A, Al-Hassan SM, Bacchini D, Bombi AS, Bornstein MH, Chang L, Deater-Deckard K, Di Giunta L, Dodge KA, Malone PS, Oburu P, Pastorelli C, Skinner AT, Sorbring E, Tapanya S, Peña Alampay L (2015) Individual, Family, and Culture Level Contributions to Child Physical Abuse and Neglect: A Longitudinal Study in Nine Countries, *Development & Psychopathology* 27(4):1417-28; Mathews S & Martin L (2016) Developing an understanding of fatal child abuse and neglect: Results from the South African child death review pilot study. SAMJ, 106(12):1160-1163.

7 Fulu E, Miedema S, Roselli T, McCook S, Chan KL, Haardörfer R & Jewkes R (2017) Pathways between childhood trauma, intimate partner violence, and harsh parenting: findings from the UN Multi-country Study on Men and Violence in Asia and the Pacific. *Lancet Global Health*, 5:e512-522.

8 The briefing paper focuses on successful and promising interventions. A more detailed review of the evidence is available in the literature review. See Röhrs S (2017) *Shifting attitudes and practices underpinning physical punishment of children: A literature review*. Cape Town: Children's Institute, UCT.

9 Devries KM, Knight L, Child JC, Mirembe A, Janet Nakuti, Jones R, Sturgess J, Allen E, Kyegombe N, Parkes J, Walakira E, Elbourne D, Watts C & Naker D (2015) The Good School Toolkit for reducing physical violence from school staff to primary school students: A cluster-randomised controlled trial in Uganda. *The Lancet Global Health*, 385:e378-386.

10 Diop NJ & Askew I (2009) The effectiveness of a community-based education program on abandoning female genital mutilation/cutting in Senegal. *Studies in Family Planning*, 40(4):307-318.

11 Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, McPherson K & Murray L (2009) Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: Randomised controlled trial. *BMJ*, 338:b974.

12 Wint E & Jannsens W (2008) I*mpact Study of the Roving Caregivers Programme: Research Findings 2008*. Barbados: Caribbean Child Support Initiative Bridgetown.

13 Lansford JE, Deater-Deckard K, Bornstein MH, Putnick DL, Bradley RH (2014) Attitudes Justifying Domestic Violence Predict Endorsement of Corporal Punishment and Physical and Psychological Aggression towards Children: A Study in 25 Low- and Middle-Income Countries *The Journal of Pediatrics*, 164(5):1208-13.

14 UN Committee on the Rights of the Child (2007) General comment No. 8 (2006): *The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (Arts. 19; 28, Para. 2; and 37, inter alia) CRC/C/GC/8.

15 UN Committee on the Rights of the Child (n 14) above.

16 Meinck F, Cluver LD, Boyes ME & Loening-Voysey H (2016) Physical, emotional and sexual adolescent abuse victimisation in South Africa: Prevalence, incidence, perpetrators and locations. *Journal of Epidemiology and Community Health*, 70(9):910-916.

17 Meinck et al (n 16) above.

18 UNICEF (n 1) above.

19 Dawes A, De Sas Kropiwnicki Z, Kafaar Z & Richter L (2005) Corporal Punishment of Children: A South African National Survey. (Commissioned by Save the Children Sweden, July).

20 Dawes et al (n 19) above.

21 Jewkes et al (n 2) above.

22 Jewkes et al (n 2) above.

23 Burton & Leoschut (n 4) above.

24 Burton & Leoschut (n 4) above.

25 Gershoff (n 5) above.

26 Durrant J & Ensom R (2012) Physical punishment of children: lessons from 20 years of research. *Canadian Medical Association Journal*, 184(12): 1373–1377.

27 Lansford et al (n 6) above.

28 Burton P, Ward CL, Artz L & Leoschut L (2016) *The Optimus Study on Child abuse, Violence and Neglect in South Africa (Research Report)*. Cape Town, South Africa: Centre for Justice and Crime Prevention, University of Cape Town.

29 Meinck et al (n 16) above.
30 Meinck et al (n 16) above.
31 Mathews & Martin (n 6) above.
32 Mathews & Martin (n 6) above.
33 Knudsen EI, Heckman JJ, Cameron JL & Shonkoff JP (2006) Economic, neurobiological, and behavioral perspectives on building America's future workforce. *PNAS*, 103(27): 10155–10162.; Anda RF, Felitti VJ, Bremner JD, Walker JK, Whitfield C, Perry BD, Dube SR & Giles WH (2006) The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3):174-86.
34 Gershoff (n 5) above.
35 Bacchus LJ, Colombini M, Contreras Urbina M, Howarth E, Gardner F, Annan J, Ashburn K, Madrid B, Levtov R & Watts C (2017) Exploring opportunities for coordinated responses to intimate partner violence and child maltreatment in low and middle income countries: a scoping review. *Psychology, Health & Medicine*, 22(sup1): 135-165.
36 Mathews S, Jewkes R, Abrahams N (2015) "So now I'm the man": Intimate partner femicide and its interconnections with expressions of masculinities in South Africa, *British Journal of Criminology* 55(1):107-124.
37 Dawes et al (n 19) above.
38 Bacchus et al (n 35) above.
39 Mathews & Martin (n 6) above.
40 Fulu et al (n 7) above.
41 Machisa M, Christofides N & Jewkes R (2016) Structural pathways between child abuse, poor mental health outcomes and male-perpetrated intimate partner violence (IPV). *PLoS ONE*, 11(3):e0150986 Abrahams N & Jewkes R (2005) What is the impact of witnessing mother abuse during childhood on South African men's violence as adults? *American Journal of Public Health*, 95:1811-1816; Fonseka RW, Minnis AM & Gomez AM (2015) Impact of adverse childhood experiences on intimate partner violence perpetration among Sri Lankan men. *PLoS ONE*, 10(8): e0136321; Stith SM, Rosen KH, Middleton KA, Busch AL, Lundeberg K & Carlton RP (2000) The intergenerational transmission of spouse abuse: A meta-analysis. *Journal of Marriage and Family*, 62(3):640-654.
42 Article 19(1) of the UNCRC; Article 16(1) of the ACRWC.
43 Article 19(1) of the UNCRC; Article 16(1) of the ACRWC.
44 UN Committee on the Rights of the Child (n 14) above.
45 Sections 12, 28(1)(d) of the Constitution.
46 Bandura A (1971) *Social Learning Theory*. Englewood Cliffs, NJ: Prentice Hall.
47 Bandura (n 46) above.
48 Lewin KL (2012) Frontiers in group dynamics: Concept, method and reality in social science; Social equilibria and social change. *Human Relations*, 1 (5):5-41.
49 Mackie G, Moneti F, Shakya H & Denny E (2015) *What Are Social Norms? How Are They Measured?* UNICEF/University of California.
50 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.
51 Cislaghi & Heise (n 50) above.
52 Cislaghi & Heise (n 50) above.
53 Cislaghi & Heise (n 50) above.
54 Lansford et al (n 13) above.
55 Lansford et al (n 13) above.
56 Lansford et al (n 13) above.
57 Lansford et al (n 13) above.
58 Lansford et al (n 13) above.
59 Lansford et al (n 13) above.
60 Lansford et al (n 13) above.
61 Lansford et al (n 13) above.
62 Mathews S & Benvenuti P (2014) Violence against children in South Africa: Developing a prevention agenda. In: Mathews S, Jamieson, Lake L & Smith C (eds) *South African Child Gauge 2014*. Cape Town: Children's Institute, UCT.
63 Cooper et al (n 11) above.
64 Belsky, J (1993) Etiology of child maltreatment: a developmental-ecological analysis, *Psychological Bulletin* 114(3):413-34; Norton WE, McCannon CJ, Schall MW & Mittman BS (2012) A stakeholder-driven agenda for advancing the science and practice of scale-up and spread in health, *Implementation Science* DOI: 10.1186/1748-5908-7-118.
65 Belsky (n 64) above; Norton et al (n 64) above.
66 Cooper et al (n 11) above.
67 Cooper et al (n 11) above.
68 Morgan B, Kumsta R, Fearon P, Moser D, Skeen S, Cooper P, Murray L, Moran G & Tomlinson M (2017) Serotonin transporter gene (SLC6A4) polymorphism and susceptibility to a home-

visiting maternal-infant attachment intervention delivered by community health workers in South Africa: Reanalysis of a randomized controlled trial. *PLoS Med*, 14(2): e1002237.

69 Cooper et al (n 11) above.
70 Cooper et al (n 11) above.
71 Morgan et al (n 68) above.
72 UNICEF (2014) *Ending Violence Against Children: Six Strategies for Action*. New York: UNICEF.
73 UNICEF (n 72) above.
74 UNICEF (n 72) above.
75 UNICEF (n 72) above.
76 Wint & Jannsens (n 12) above.
77 Wint & Jannsens (n 12) above.
78 Wint & Jannsens (n 12) above.
79 Wint & Jannsens (n 12) above.
80 Wint & Jannsens (n 12) above.
81 Janssens W & Rosemberg C (2012) *The impact of a Caribbean home-visiting child development program on cognitive skills.* Available at http://www.comminit.com/files/com_init_july2012.pdf.
82 World Health Organisation (2016) INSPIRE: *Seven strategies for ending violence against children.* Geneva: World Health Organisation.
83 Olds DL, Eckenrode J, Henderson CR Jr, Kitzman H, Powers J, Cole R, Sidora K, Morris P, Pettitt LM & Luckey D (1997) Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. *JAMA*, 278(8):637-643.
84 Olds et al (n 83) above.
85 Eckenrode J, Ganzel B, Henderson CR Jr, Smith E, Olds DL, Powers J, Cole R, Kitzman H & Sidora K (2000) Preventing child abuse and neglect with a program of nurse home visitation: The limiting effects of domestic violence. *JAMA*, 284(11):1385-91.
86 Eckenrode et al (n 85) above.
87 Eckenrode et al (n 85) above.
88 Nsibande D, Doherty T, Ijumba P, Tomlinson M, Jackson D, Sanders D & Lawn J (2013) Assessment of the uptake of neonatal and young infant referrals by community health workers to public health facilities in an urban informal settlement, KwaZulu-Natal, South Africa. *BMC Health Services Research*, 13:47 DOI: 10.1186/1472-6963-13-47; Tomlinson M, Rotheram-Borus MJ, Le Roux IM, Youssef M, Nelson SH, Scheffler A, Weiss RE, O'Connor M & Worthman CM (2016) Thirty-six-month outcomes of a generalist paraprofessional perinatal home visiting intervention in South Africa on maternal health and child health and development. *Prevention Science*, 17:937–948.
89 Peakock S, Konrad S, Watson E, Nickel D & Muhajarine N (2013) Effectiveness of home visiting programs on child outcomes: a systematic review. *BMC Public Health*, DOI: 10.1186/1471-2458-13-17; Bilukha O, Hahn RA, Crosby A, Fullilove MT, Liberman A, Moscicki E, Snyder S, Tuma F, Corso P, Schofield A & Briss PA (2005) The effectiveness of early childhood home visitation in preventing violence: a systematic review. *American Journal of Preventive Medicine*, 28(2):11-39.
90 Mikton C & Butchart A (2009) Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organisation*, 87:353–361 with further references.
91 Devries et al (n 9) above.
92 Devries et al (n 9) above.
93 Devries et al (n 9) above.
94 Devries et al (n 9) above.
95 Amisi M (2017) *Uganda Study Tour Report*. Pretoria: Department of Planning, Monitoring & Evaluation. Unpublished report.
96 Devries et al (n 9) above.
97 Devries et al (n 9) above.
98 Devries et al (n 9) above.
99 Devries et al (n 9) above.
100 Devries KM, Knight L, Allen E, Parkes J, Kyegombe N & Naker D (2017) Does the Good Schools Toolkit Reduce Physical, Sexual and Emotional Violence, and Injuries, in Girls and Boys equally? A Cluster-Randomised Controlled Trial. *Prevention Science*, DOI: 10.1007/s11121-017-0775-3.
101 Devries et al (n 9) above.
102 Devries et al (n 100) above.
103 Kyegombe N, Namakula S, Mulindwa J, Lwanyaaga J, Naker D, Namy S, Nakuti J, Parkes J, Knight L, Walakira E & Devries KM (2017) How did the Good School Toolkit reduce the risk of past week physical violence from teachers to students? Qualitative findings on pathways of change in schools in Luwero, Uganda. *Social Science & Medicine*, 180:10-19.
104 Kyegombe et al (n 103) above.
105 Kyegombe et al (n 103) above.
106 Kyegombe et al (n 103) above.
107 Kyegombe et al (n 103) above.
108 UNICEF (2007) Violence against children study in Jordan: Summary. Retrieved 4 May 2017, at

https://www.unicef.org/jordan/protection_6079.html.

109 UNICEF (n 108) above.

110 UNICEF (n 72) above.

111 Baker-Henningham H, Walker S, Powell C & Meeks Gardner J (2009) A pilot study of the Incredible Years Teacher Training programme and a curriculum unit on social and emotional skills in community pre-schools in Jamaica. *Child: Care, Health and Development*, 35(5):624–631.

112 Baker-Henningham et al (n 111) above.

113 Baker-Henningham et al (n 111) above.

114 Baker-Henningham et al (n 111) above.

115 Baker-Henningham H, Vera-Hernández M, Alderman H & Walker S (2016) Irie Classroom Toolbox: A study protocol for a cluster-randomised trial of a universal violence prevention programme in Jamaican preschools. *BMJ Open*, 6:e012166.

116 Baker-Henningham (n 115) above.

117 Ellsberg M, Arango DJ, Morton M, Gennari F, Kiplesund S, Contreras M & N Watts (2015) Prevention of violence against women and girls: What does the evidence say? The Lancet, 385(9977): 1555–1566.

118 Diop & Askew (n 10) above.

119 Diop & Askew (n 10) above.

120 Diop & Askew (n 10) above.

121 Diop & Askew (n 10) above.

122 Diop & Askew (n 10) above.

123 Diop & Askew (n 10) above.

124 Diop & Askew (n 10) above.

125 Diop & Askew (n 10) above.

126 Diop & Askew (n 10) above.

127 Diop & Askew (n 10) above.

128 Diop & Askew (n 10) above.

129 Diop & Askew (n 10) above.

130 Raising Voices (2013) 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.

131 Diop & Askew (n 10) above.

132 Raising Voices (n 130) above.

133 Abramsky T, Devries K, Kiss L, Nakuti J, Kyegombe J, Starmann E, Cundill B, Francisco L, Kaye D, Musuya T, Michau L & Watts C (2014) Findings from the SASA! Study: A cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC Medicine*, 12:122-138.

134 Abramsky et al (n133) above.

135 Abramsky et al (n 133) above.

136 Abramsky et al (n 133) above.

137 Abramsky T, Devries K, Michau L Nakuti J, Musuya T, Kiss L, Kyegombe N & Watts C (2016) Ecological pathways to prevention: How does the SASA! community mobilisation model work to prevent physical intimate partner violence against women? *BMC Public Health*, DOI 10.1186/s12889-016-3018-9.

138 Abramsky et al (n 137) above.

139 Abramsky et al (n 133) above.

140 Kyegombe N, Namakula S, Mulindwa J, Lwanyaaga J, Naker D, Namy S, Nakuti J, Parkes J, Knight L, Walakira E & Devries KM (2017) How did the Good School Toolkit reduce the risk of past week physical violence from teachers to students? Qualitative findings on pathways of change in schools in Luwero, Uganda. *Social Science & Medicine*, 180:10-19.

141 Wagman JA, Gray RH, Campbell JC, Thoma M, Ndyanabo A, Ssekasanvu J, Nalugoda F, Kagaayi J, Nakigozi G, Serwadda D & Brahmbhatt H (2015) Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort. *The Lancet Global Health*, 3:e23–33.

142 Wagman (n 141) above.

143 Wagman (n 141) above.

144 Wagman (n 141) above.

145 Abramsky et al (n 145) above; Ellsberg et al (n 117) above.

146 Perlman H (2013) *Edutainment Using stories and Media for Social Action and Behaviour Change.* Johannesburg: Soul City Institute for Health & Development Communication.

147 Vaughan P, Rogers E, Singhal A & Swalehe R (2000) Entertainment-education and HIV/AIDS prevention: A field experiment in Tanzania. *Journal of Health Communication*, 5 (Supplement): 81–100.

148 The Soul City Institute for Social Justice was formerly called the Soul City Institute for Health and Development Communication.

149 Soul City Institute for Social Justice (Unknown) Soul City television series. Retrieved 4 May 2017, at http://www.soulcity.org.za/projects/soul-city-series.

150 Soul City (n 149) above.
151 Usdin S, Scheepers E, Goldstein S & Japhet G (2005) Achieving social change on gender-based violence: A report on the impact evaluation of Soul City's fourth series, *Social Science & Medicine*, 61 2434–2445.
152 Perlman (n 146) above.
153 Usdin et al (n 151) above.
154 Ibid.
155 Perlman (n 146) above.
156 Usdin et al (n 151) above. The authors argue that the number of responses was too small to determine behaviour change in relation to domestic violence perpetration/experience.
157 Scheepers, E (2013) *OneLove Regional HIV Prevention Campaign: Evaluation Summary 2013*. Johannesburg: Soul City Institute for Health & Development Communication; Jana M, Letsela L, Scheepers E & Weinerb R (2014) Understanding the role of the *OneLove* campaign in facilitating drivers of social and behavioural change in Southern Africa: A qualitative evaluation. *Journal of Health Communication*, 20(3):1-7; Sebert-Kuhlmann AK, Kraft JM, Galavotti C, Creek TL, Mooki M & Ntumy R (2008) Radio role models for the prevention of mother-to-child transmission of HIV and HIV testing among pregnant women in Botswana. *Health Promotion International,* 23(3):260-268; Solórzano I, Bank A, Peña R, Espinoza H, Ellsberg M & Pulerwitz J (2008) Catalyzing Personal and Social Change around Gender, Sexuality, and HIV: Impact evaluation of Puntos de Encuentro's communication strategy in Nicaragua. Horizons Final Report. Washington, DC: Population Council; Vaughan et al (n 147) above; Vaughan P, Regis A & St. Catherine E (2000) Effects of an entertainment-education radio soap opera on family planning and HIV prevention in St. Lucia. *International Perspectives on Sexual and Reproductive Health,* 26(4):148–157.
158 Myers L, Hajiyiannis H, Clarfelt A & Motuba-Matekane T (2014) *Evaluation of season two of the television drama series, Intersexions.* Cape Town and Johannesburg: CADRE; Chakraborty S (2010) *Bell Bajao: Endline Survey on Domestic Violence and HIV/AIDS*. Retrieved 10 May 2017 at: http://www.bellbajao.org/wp-content/uploads/2012/08/Bell-Bajao-Endline-Report.pdf.
159 Naugle DA & Hornik RC (2014) Systematic review of the effectiveness of mass media interventions for child survival in low- and middle-income countries. *Journal of Health Communication*, 19(1):190-215.
160 Scheepers (n 157) above.
161 Solórzano et al (n 157) above.
162 Scheepers (n 157) above.
163 Ellsberg et al (n 117) above.