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Helpdesk Research Report

Primary and secondary prevention of child protection violations

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01.09.2016

Question

Please identify literature on how effective the primary and secondary prevention of child protection violations have been in low- and middle-income countries. Specifically, which interventions have been successes or failures (especially on violence against children), and why? Consider any interventions (other than high-level advocacy with authorities or parties to an armed conflict), whether the interventions involve domestic or foreign actors, and state or non-state actors. If possible, focus on contexts of protracted crisis or widespread social or political violence – ideally in the Levant or the Middle East and North Africa – so that findings might be applicable to the Gaza Strip.

Contents

1. Overview

A number of interventions have proven effective to prevent violations of child protection in low- or middle-income countries (LMICs), the literature shows. However, systematic, robust evidence on primary and secondary prevention of such violations has remained limited in size, scope, disaggregation by social groups, and consistency. [1] A number of authors emphasise that findings on child protection in LMICs are typically context-specific, and that child protection is part of the politics of governments, donors, and societies. All this could limit the applicability of any finding beyond their particular context (see e.g. Combaz 2013: 1-2). Nonetheless, over the past ten years, increasing research has slowly added to the evidence base (Knerr, Gardner & Cluver 2013: 353). So what does evidence show about successes and failures, and about the factors behind these?

This rapid review considered academic, practitioner and policy publications, with a focus on publications from the past five years. Where possible, it paid particular attention to protracted crises and contexts of widespread social or political violence, especially in the Levant or the Middle East and North Africa, such that findings might be applicable to the Gaza Strip, in the occupied Palestinian territory (oPt). The knowledge base is limited but does offer a number of robust, promising findings.

Section 2 presents **overarching considerations and approaches** for effective prevention.

- There remain ongoing debates about **whether and how to apply and adapt interventions** from HICs to LMICs, and from stable contexts to settings of armed conflicts and other humanitarian contexts. The majority of findings to date suggest that such translations from one setting to another are possible and effective, as long as the core elements of the interventions are preserved. For example, programmes on parenting can change materials to use local, culturally acceptable references, but should not cut down the number of planned sessions nor their essential content.
- However, **the oPt presents specific conditions that shape the success and failure of interventions** to prevent violations of child protection. Three references based on specialist knowledge of child protection in the oPt thus warn that, over the past 30 years, international aid actors' typical approaches in the oPt have failed to generate effective prevention, for example through psychosocial support or location-specific programmes such as 'safe spaces' for children. This is due to the specificities of Israeli settler colonialism – even compared to other war contexts – and to the aid politics involved. In contrast, some Palestinian-led, community-based initiatives have been successful at prevention, including for marginalised children and youth such as those with disabilities (Rabaia, Giacaman & Nguyen-Gillham 2010; Rabaia, Saleh & Giacaman 2014).

[1] In line with DFID's query, for the purpose of this report, the following understandings of prevention are used:
- Primary prevention: universal programmes directed at the general population that seek to prevent maltreatment before it occurs;
- Secondary prevention: programmes that focus on individuals, families, or populations (e.g. communities or neighbourhoods) that present one or more factors associated with a high risk of child maltreatment, such as parental substance abuse.
- Tertiary prevention: programmes focused on families where maltreatment has occurred that "seek to reduce the negative consequences of the maltreatment and to prevent its recurrence".
Source: U.S. Department of Health & Human Services (n.d.). *Framework for Prevention of Child Maltreatment*. U.S. Department of Health & Human Services.
https://www.childwelfare.gov/topics/preventing/overview/framework/

- The **most recent practice-oriented review of evidence** on the prevention of violence against children in LMICs, called 'INSPIRE', identifies seven strategies and associated interventions as having proven or promising effects (Butchard & Hillis 2016):
    - Implement and enforce laws (e.g. against the use of violence by caregivers or teachers).
    - Strengthen norms and values for positive and gender-equitable relationships for all children.
    - Create and sustain safe streets and other environments where children spend time.
    - Support parents and primary caregivers, to reduce harsh parenting and create positive parent-child relationships.
    - Strengthen the incomes and economic situation of families or women.
    - Improve access to good-quality health, social welfare, and criminal justice for all children.
    - Provide children with more effective and gender-equitable education, social-emotional learning, and training in life skills.

Multi-sectoral actions and coordination for effective prevention and rigorous **monitoring and evaluation** tailored to the prevention of child protection violations are required for the above strategies to work. Implementing these INSPIRE strategies then entails: national commitment; assessment of needs and readiness; selection and adaptation of interventions; national and local plans; costing; sustainable funding; strong staffing and staff capacities; and effectiveness in implementation, monitoring and evaluation (Butchard & Hillis 2016).

Sections 3-5 in this report present **additional evidence about the better researched types of preventive interventions.** The evidence is mixed, though mostly positive.

- **Parenting interventions**. There is limited good-quality evidence. However, emerging findings (e.g. from cases in South Africa, Pakistan, and Brazil) show that parenting interventions have been feasible and effective at preventing child protection violations even in low-resource settings (Knerr, Gardner & Cluver 2013). This early evidence from LMICs also offers pointers on programming. For example, group-based interventions have worked well, including in humanitarian contexts (Butchard & Hillis 2016), as have opportunities for parents to practise positive parenting skills (Wessels et al. 2013).[2]
- **Child-focused interventions and locations**. This includes schooling, through increasing enrolment and establishing a safe and enabling school environment (evidence of positive effects). It can also involve action to prevent violence among adolescent intimate partners (positive effects), and improving children's knowledge on protection from sexual abuse (mixed, with positive and limited effects). In short or protracted emergencies, humanitarian actors have also used child-friendly spaces (mixed, mostly little to no effect, with some positives and some negatives).
- **Larger programmes, such as social protection**. Social transfers have many direct and indirect effects on prevention, most largely positive (Barrientos et al. 2014).
    - **Cash transfers** have typically had positive effects on preventing chid protection violations when they are provided to women or families in conjunction with another intervention, such as parent training. However, specific types of cash transfers come with risks of harm that

[2] In this report, 'parent' refers to parent or primary caregiver without distinction.

need to be mitigated. For example, cash transfers without any other complementary interventions can increase girls' risks of being subjected to sexual harassment (Butchard & Hillis 2016: 56). When social protection has no explicit objective to advance child protection, it leaves protection gaps unaddressed, especially for the most disadvantaged, such as children with disabilities. This has been the case in the Palestinian National Cash Transfer Programme in Gaza (Abu-Hamad, Jones & Pereznieto 2014).

- The provision of **training on gender equality combined with savings and loans groups, or with microfinance** has generally had positive effects (Butchard & Hillis 2016).

The final section discusses the state of knowledge on the prevention of child protection violations, including the **strengths of the evidence base as well as knowledge gaps**, and their implications for primary and secondary prevention.

2. Overarching considerations and approaches for prevention

The literature relevant to this query offers three overarching considerations for assessing and using available evidence:

- Many authors note that aid actors need to consider how applicable findings from HICs are to LMICs, and how to translate any implications from this in practice. There is an ongoing debate about this in the literature.
- Applying findings to contexts such as armed conflicts and other humanitarian settings calls for careful consideration too.
- Several Palestine-specialist authors warn that even evidence-based interventions that might have worked in other contexts – be they HICs or LMICs – have not worked well in the oPt; these authors present alternative approaches.

Findings and debates on applying evidence from HICs to LMICs

There are no clear-cut findings on the applicability of interventions from HICs to LMICs. Debates are ongoing in the literature about this, with contradictory findings. [3]

The importance of differences between HICs and LIMCs

Debates and research are ongoing about how much material or immaterial **differences between and among HICs and LMICs affect** the success of interventions. For example, surveys on parenting have found wide variation among LMICs in practices and beliefs, showing that different cultures influence parenting and child outcomes (Runyan et al. cited in Knerr, Gardner & Cluver 2013: 360). Yet, in some countries where parents report high levels of child beating, a high percentage of them believe that it is unacceptable (UNICEF cited in Knerr, Gardner & Cluver 2013: 360). This suggests that parents in these countries may be open to alternative techniques for child discipline (Knerr, Gardner & Cluver 2013: 360).

In addition, materials, training and support for rigorously tested interventions may be costly to actors of child protection in low-resource settings (e.g. Triple P or Incredible Years for parenting). This too could be

[3] See summaries of debates for example in: Butchard & Hillis (2016); Gardner, Montgomery & Knerr (2015); Hughes et al. (2014); Knerr, Gardner & Cluver (2013); Wessels et al. (2013); WHO (2010 & 2015).

a barrier to the adoption of these interventions, and donors may want to consider fee waivers or reduced fees where applicable (Knerr, Gardner & Cluver 2013: 361).

The effectiveness of interventions from HICs in LMICs

Debates and research are ongoing about **whether interventions to prevent violations of child protection that are proven to be effective in HICs are also effective in LMICs**. Knerr, Gardner and Cluver (2013) note that there are indications that many interventions, such as the Strengthening Families Programme, "would be feasible, acceptable and effective if adapted to other cultures and settings" (p. 360). UNODC experience is similarly positive on the feasibility and effectiveness of implementing programmes for family skills in 16 LMICs, including ones with high levels of social or political violence (Maalouf & Campello 2014).

There is emerging evidence that parenting interventions may have an even greater positive effect in LMICs than in HICs. Parenting interventions offer a good testing ground because they have rapidly been reaching global dissemination (Gardner, Montgomery & Knerr 2015). One study explores whether interventions to reduce problems in child behaviour are effective when transported to a different country than the one in which they originated. The study examines evidence-based interventions that have shown robust effects in systematic reviews and that have been tried in a new country. It applies a systematic review or meta-analysis, followed by sub-group analyses of factors. It identifies four parenting interventions that originated in the USA or Australia that were 17 transported into trials and tested in 10 countries in five regions (n = 1,558 children). The countries include Iran and Puerto Rico, as well as HICs (Gardner, Montgomery & Knerr 2015).

The study finds that the effects of the interventions on child behaviour are substantial in the 14 randomised trials, and non-significant in the three non-randomised trials. The sub-group analyses of the randomised trials find that the interventions transported to Western countries have effects comparable to those in origin countries. However, the effects are stronger when interventions are transported to regions with greater cultural differences from the country of origin. Effects were also higher for countries where family values or child-rearing are more survival-focused than for countries that are characterised as more individualistic. The study finds no association between effect size and trial-level factors related to participants or interventions (e.g. staffing, brand of programme). It also finds no differences in effects by country-level factors related to policy or resource. The study concludes that, contrary to common belief, parenting interventions seem at least as effective when transported to countries with greater differences in culture and in service provision compared to the Western countries where the interventions were developed. In addition, extensive adaptation did not appear necessary to a successful transportation (Gardner, Montgomery & Knerr 2015).

Another study comes to a similar conclusion. It compares the pre-post changes from a standard programme for family skills called 'FAST', implemented in five Central Asian countries and in the USA. At the outset, the level of family functioning between both contexts was quite similar. After the intervention, scores showed substantially more significant improvements in the Central Asian families than in USA ones (McDonald & Doostgharin 2013 cited in Maalouf & Campello 2014: 622). Maalouf and Campello (2014) suggest that such stronger impact in LMICs might stem from the relative lack of services for parents in these settings, and the resulting demand for such programmes, as evidenced by the experience of UNODC pilot programmes (p. 622-623).

Adapting interventions between countries

Lastly, debates and research are ongoing about **what adaptations (if any) may be necessary** for interventions originating from one country to be transposed into another, especially between HICs and LMICs. Importing high-quality programmes on parenting may be more viable for LMICs than developing and testing new ones. Imported programmes must maintain important elements, but may require cultural adaptations (Wessels et al. 2013: 14). In many cases, adaptations to parenting programmes have altered the structure of existing interventions relatively superficially, addressing barriers and making programmes more relevant to communities in LMICs. For example, some interventions have introduced culturally appropriate group rituals, used role play or stories instead of videos, or altered the language level of the materials. Such adaptations are likely to be helpful and feasible without compromising fidelity to the model, as they do not involve changing the underlying theory (Knerr, Gardner & Cluver 2013: 361).

This was also the case with pilot projects that the United Nations Office on Drugs and Crime (UNODC) conducted on family skills in nine LMICs, where national governments assigned a cultural adaptation team to review the appropriateness of translated materials to local cultures. "In the vast majority of cases the adaptation was mostly cosmetic, changing only names and examples" (Maalouf & Campello 2014: 618). No changes affected the structure, content or order of programme sessions (Maalouf & Campello 2014: 618). The pre-post data indicated a high level of replicability with fidelity, as well as communities' affinity and demand for such interventions, in a context where the need for such programmes in LMICs is great (Maalouf & Campello 2014).

Knerr, Gardner and Cluver (2013) recommend including extensive qualitative and pilot testing in trials of adapted parenting interventions. This was demonstrated successfully for example in randomised trials such as that of the Incredible Years Teacher programme in Jamaica (Baker-Henningham et al. cited in Knerr, Gardner & Cluver 2013: 361), and interventions in South Africa and Pakistan (respectively Cooper et al. 2009, and Rahman et al. 2009 cited in Knerr, Gardner & Cluver 2013: 356).

It remains an open empirical question whether underlying theories need to be changed for success. Indicative findings from a systematic review on parenting and from studies showing that evidence-based programmes such as Incredible Years or Triple P have "cross-country and cross-cultural flexibility, acceptability and effectiveness" suggest that major adaptation may not be needed (Knerr, Gardner and Cluver 2013: 361).

Findings on applying evidence to armed conflicts and humanitarian contexts

A wide-ranging collection of evidence-based strategies to end violence against children, led by WHO, states that all of its seven selected **evidence-based strategies are potentially applicable** in contexts of armed conflicts, natural disasters, other humanitarian settings, and post-conflict periods. Further, several interventions recommended under the strategies have been demonstrably effective in such contexts (Butchard & Hillis 2016: 27).

However, **how feasible a successful implementation will be varies with the strategy considered and the context**. In principle, "interventions delivered through self-contained programmes can be implemented in any setting", "because they do not depend upon intact social systems and functioning governance structures" (Butchard & Hillis 2016: 27). Examples include programmes for parenting, life skills training, and services for victims of violence. In contrast, interventions that require functioning systems of police and justice to enforce laws "will be difficult to implement where conflict or natural disaster have destroyed or severely eroded these structures" (Butchard & Hillis 2016: 27).

Community-based mechanisms have been at the forefront of child protection in worldwide contexts of emergency, transition, and challenging development. A 2009 inter-agency review led by Save the Children confirms that the mobilisation of communities or grassroots groups has become common, particularly in areas of armed conflict or displacement or "where local and national government is unable or unwilling to fulfil children's rights to care and protection" (Save the Children cited in Butchard & Hillis 2016: 76). However, there is still "a lack of robust evidence about the effectiveness, cost, scalability and sustainability of these mechanisms" (Save the Children cited in Butchard & Hillis 2016: 76). The inter-agency review outlines several actions needed to maximise the contribution of community-based prevention. The primary one remains the need to strengthen the evidence base through regular, systematic, ethical evaluations. Butchard and Hillis (2016), who authored an evidence-based package of strategies and interventions to prevent violence against children, state that this package as a whole lends itself to adaptation by community-based systems of child protection (Butchard & Hillis 2016: 76).

Findings and debates on applying evidence to the oPt

There is widespread evidence that violations of child protection are systemic in the oPt. This is primarily due to violence and structural control exerted by Israel as the occupying power, and secondarily due to some violence within Palestinian society – much of which can be related back to Israeli occupation, though other factors such as structures of inequality (notably gender, age, and disability) do play a role (see e.g. Rabaia, Giacaman & Nguyen-Gillham 2010; Rabaia, Saleh & Giacaman 2014). In this context, foreign aid actors have addressed violations of child protection and engaged in both preventive and responsive interventions. However, several academic references note that these actors' approaches have typically been problematic with regard to both evidence and politics, and that evidence-based alternatives for primary and secondary prevention are available and better suited.

Overview of foreign aid actors' approaches, and alternatives

Problems with foreign aid actors' approaches, causes, and effects on prevention

Over many years, UN agencies and international NGOs **have failed to prevent systematic violations** against Palestinian children by Israeli authorities and settlers, as demonstrated in an in-depth qualitative study centred on the West Bank and East Jerusalem (Hart & Forte 2013). To explain why the numerous international interventions have still left Palestinian children chronically vulnerable to severe political violence from Israeli actors, Hart and Forte (2013) note that analysis must **look into the conceptualisation, institutions, and politics of child protection** in the oPt, beyond the merits and weaknesses of individual programmes. [4] The oPt "has witnessed an array of interventions reflecting evolving fashions within the humanitarian and development fields" (Hart & Forte 2013: 632).

International failures in child protection arise from aid institutions and aid politics (Hart & Forte 2013). Institutionally, there is abundant evidence that international actors have set **self-limitations to how they conceptualise and implement child protection** in the oPt. Conceptually, they have used the **emerging globalised language and standardised practices** on child protection, such as 'child protection in emergencies' (Save the Children) and 'child protection in crisis' (CPC Learning Network). The background

[4] The everyday nature of violations is manifest for example in settlers' recurrent attacks on Palestinian children on their way to school in areas such as the hills to the south of Hebron / al-Khalil, and in the Israeli use of its military justice system for Palestinian children. This is in addition to spikes in violence such as Israeli attacks on the Gaza strip, and other forms of structural socio-economic and political violence stemming from Israeli occupation(Hart & Forte 2013: 628-632).

frameworks for these are a mix of international human rights and humanitarian laws, centred on professional-technical expertise from mental health and social work. The resulting approach has significantly contributed to alleviating the effects of occupation-related violence, and to emotional and psychological healing. However, it has done little to stem the chronic – and worsening – threats from the occupation. In addition, mitigation has, unintentionally, deflected attention from international failures to prevent harm (Hart & Forte 2013: 632-633).

Mental health thinking has been particular influential in international actors' child protection. Psychosocial efforts are especially numerous in the oPt – a 2009 UNICEF informal assessment notes that the oPt has one of the largest number of psychosocial humanitarian emergency projects in UNICEF's operations globally. Such programming is also typically scaled up as a response to spikes in violence, as numerous organisations, including DFID, UNDP and UNRWA, did after the Israeli attack on Gaza in 2008-2009 (Hart & Forte 2013: 633-634). A central objective of international psychosocial programmes in the oPt has thus become to help children cope and live 'normal lives in abnormal conditions' – sometimes this is even the only objective of programming, for example at Save the Children US (Hart & Forte 2013: 634).

This mitigation primarily addresses response, and does not constitute prevention in the face of the stresses of occupation that contribute to interpersonal violence in the home, school, and community. To a large extent, psychosocial programming fails to address the causes of stress and trauma young people experience. However, prevention in the oPt is much harder in practical and political terms. Therefore, international aid actors may emphasise response and psychosocial programmes not only for their own sake, but also to signal concern and fend off criticism of these actors' failure to realise their mandate for protection psychosocial programming (Hart & Forte 2013: 634-635). Their programming thus serves as a cover against questions about their record of realising child protection that would be in line "with international law and the aspirations of Palestinian children and their families" (Hart & Forte 2013: 635).

Social work thinking has also been central to child protection by international actors. Since the 1980s, the 'ecological model' of child development has been the foundation of child protection conceptualisation and practice in the West, and has fundamentally influenced how experts working in emergencies think about the protection of children. In particular, spatial thinking underpins the approach of 'protective environment', which is ubiquitous in programming in the oPt, from 'child-friendly spaces' to advocacy for children as 'zones of peace' (Hart & Forte 2013: 635).

However, military occupation strongly challenges the assumption that it is possible to secure space where children can be protected in the oPt (Hart & Forte 2013: 635). This is because the Israeli occupation forces operate a 'matrix of control', whereby they can access any space at any time (Halper cited in Hart & Forte 2013: 635). The Palestinian population has no space, however intimate, where "Israeli forces cannot enter at will and with impunity" (Hart & Forte 2013: 635). If anything, some child-centred areas can be particularly dangerous, for example when playgrounds stand as hazards after Israel partially demolishes them. Lastly, spatialised 'protective environments' risk furthering Israel's agenda to appropriate land and concentrate Palestinians in cantons. A major obstacle to child protection remains the systematic constraints on freedom of movement, which prevent access to basic services, hinder familial and social interactions, create economic stagnation, and can also reinforce patriarchal power in isolated villages to the general detriment of youth (Hart & Forte 2013: 636-637).

The politics of how international aid actors operationalise their conceptualisations of child protection is also an important factor in explaining their actions and effects. These institutional dynamics relate especially to political sensitivities and the agendas that aid actors must negotiate. To them, the stakes are

not only the protection of Palestinian children, but also their own self-preservation. They navigate the national and international context politically aiming to preserve their continued presence on the ground, their international profile and their financial standing (Hart & Forte 2013: 637).

As violations of child protection in the oPt are very reliably documented, aid actors' failure in prevention is not due to gaps in knowledge at the highest level, and better documentation has no impact on prevention. In fact, UN reports from the oPt are typically subject to subsequent editing to remove points deemed too politically sensitive. More broadly, child protection activities focus largely on technical efficiency, so they are well executed technically but prevented from addressing fundamental concerns (Hart & Forte 2013: 637-638).

A lack of political will is clearly the single most important reason why child protection organisations have failed to tackle the root causes of systematic harm to Palestinian children. This affects every level of the architecture of child protection on the oPt: from donors to INGOs, "and even, to varying degrees, local NGOs" (Hart & Forte 2013: 638). All these organisations' actions deliberately contradict their – privately expressed – understanding of the causes of Palestinian youth's chronic vulnerability to political violence (Hart & Forte 2013: 638). In particular, Western leaders (especially US ones) put strong and pervasive pressure on international aid actors active in the oPt (Hart & Forte 2013: 639).

In response, aid actors typically choose to self-censor. Their own leadership can also put added pressure on staff in the oPt, especially in aid organisations that depend financially or politically on Western governments, such as UNICEF and Save the Children US. Many issues can end up being labelled as political and therefore ruled out of public discussion, even when aid staff privately acknowledge that a different approach would be needed to ensure child protection. Sensitive topics include the notion that child protection should entail prevention, not just response. Instead, in the absence of political will, a largely remedial approach centred on mental health becomes attractive. Since this fails to tackle root causes, the need for such response is potentially endless, so the failure to tackle causes ends up justifying continued presence and funding of the aid actors involved in the oPt (Hart & Forte 2013: 639-640).

Hart and Forte (2013) conclude that international aid actors have failed to protect Palestinian children from the violence perpetrated by Israeli authorities and settlers. To stave off criticism of this failure, these actors fall back on various practices, whether deliberately or not, including assumptions that young Palestinians are passive and vulnerable, and need psychological and emotional support (e.g. Save the Children US). In addition, international aid actors often document children's primary protection needs using narrow inventories that focus on immediate needs and exclude political consideration, or fail to engage children altogether (e.g. UNDP) (Hart & Forte 2013: 640-641).

Alternative approaches

The road that international aid actors have not taken on child protection includes more **preventative approaches** that would call for accountability on Israeli violations of international law, and would reflect Palestinian children's own experience and aspirations (Hart & Forte 2013: abstract). The experience so far in the oPt shows both the need and the challenges involved in having a greater integration of international human rights and humanitarian law into child protection. The challenges are partly conceptual, requiring a change from thinking centred on mental health and social work. Other challenges relate to the skills, resources, and alliances needed for sustained national and international advocacy against violations committed by a powerful government. However, the greatest challenges are political, as agencies can see their funding and standing threatened, should they address child protection as an issue of prevention based on international law (Hart & Forte 2013: 642).

International aid actors could start by **considering young Palestinians as actors with their own agency,** engaged in seriously thinking about and acting on their circumstances. This would likely lead to a different enquiry and produce a different picture of needs, and could be presented as standard practice for participation and accountability in aid. Over the years, Palestinian youth have developed a number of initiatives to draw global attention to the occupation and to express their aspiration for the upholding of international law. International aid actors could choose to engage with such dynamics and with multi-agency initiatives to challenge Israel about its violations – though they have largely failed to do so until now (Hart & Forte 2013: 641-642).[5]

Foreign actors' approach to Palestinian children's well-being and mental health

Since the First Intifada, foreign aid actors and researchers have put growing emphasis on Palestinian children's mental health and well-being in the oPt, in a context where children are exposed to chronic war-like conditions, and are part of a generations-long history of political suffering brought on by Zionist settler-colonialism. Foreign actors had thus paid growing attention to children's psychosocial health in a context of dispossession, expulsion, occupation, repression, and military attacks (Rabaia, Giacaman & Nguyen-Gillham 2010; Rabaia, Saleh & Giacaman 2014).

Problems with foreign aid actors' dominant approaches

Rabaia, Saleh and Giacaman (2014: 175) note Palestinian children have unquestionably been exposed to many violent events, that this has likely affected them, and that they may display some or all of the symptoms associated with conditions such as PTSD, anxiety, depression and mood disorders. However, the question is "whether displaying these symptoms necessarily means that children suffer a mental illness or disorder, requiring a form of specialised treatment, or alternatively, whether the fear and sadness associated with exposure to political violence are normal reactions which will diminish with time and support from family and community, and ultimately require a socio-political resolution as opposed to a medical one" (Rabaia, Saleh & Giacaman 2014: 175). Yet, foreign aid actors have turned to presuming that Palestinian children in the oPt suffer from mental disorders. In a context of collective exposure to violence, individualised, problem-focused, biomedical approaches are problematic for several reasons, and their impact questionable (Rabaia, Giacaman & Nguyen-Gillham 2010; Rabaia, Saleh & Giacaman 2014). [6]

One set of issues relates to **methodological problems** in dominant foreign approaches to children's mental health in the oPt. First, estimates of mental illness in a population that are based on the prevalence of symptoms rather than professional clinical diagnoses tend to be unrealistically high. Measures that are relevant to clinical practice should not be used to assess prevalence at the population level (Horwitz and Wakefield cited in Rabaia, Saleh & Giacaman 2014: 174). In addition, conflating sadness with depression leads to overestimates of both the severity and the prevalence components of disability ratings (Horwitz & Wakefield cited in Rabaia, Saleh & Giacaman 2014: 176). In addition, "the medicalization of collective suffering" can be a powerful tool for advocacy, which may have influenced the high percentages of PTSD or its symptoms registered (Fassin & Rechtman cited in Rabaia, Giacaman &

[5] For example, in 2012, 22 aid organisations produced a report on the negative impact of Israeli settlements on the Palestinian population that called on European nations to reconsider their policies on imports from the settlements. Not a single child protection organisation was among the 22 (Hart & Forte 2013: 643).

[6] For confirmation of some points and differences on others compared to these references, see an inter-agency evaluation, conducted in 2008-2009 with the participation of 35 organisations, about psychosocial support in the oPt: UNICEF (2011).

Nguyen-Gillham 2010: 217S). All this raises questions about frequently mentioned findings of very high levels of PTSD in the oPt, for example about Gazan children (Rabaia, Saleh & Giacaman 2014: 174-175).

Second, a critical problem arises when interventions forego clinical diagnoses and treat people on the basis of their exposure to traumatic events. A 2009 Cochrane Database of Systematic Reviews finds that such interventions have had no measurable positive effect in preventing or decreasing PTSD, anxiety or depression. In fact, they may increase the risks of PTSD and depression (Rose and others cited in Rabaia, Saleh & Giacaman 2014: 175).

For example, Doctors Without Borders has provided psychological treatment to victims of 'major life events or consequences of the conflict'. An academic study assessed the intervention using a medium-sized sample (n = 1773) of children and adults, with a 6:4 proportion. Local personnel in mental health and counselling, friends or neighbours referred participants. The patients presented with a variety of complaints, mostly fear (21%) and sadness (16%). Over half received individual therapy, over one third family therapy, and the remainder therapy for carer and child. The study finds an 80 per cent improvement rate after the therapy (Gaboulaud and others cited in Rabaia, Saleh & Giacaman 2014: 175). However, there are a variety of questions about the robustness of the study, from the validity of the diagnoses to the attribution of the improvement to the therapy (Rabaia and others 2010 cited in Rabaia, Saleh & Giacaman 2014: 175).

Third, Rabaia, Saleh and Giacaman (2014: 175) emphasise that most evaluations of such foreign aid interventions have been superficial and problematic in their methods and integrity. Many interventions, especially time-limited donor-funded projects, have only been evaluated through a log frame. Such approaches have usually been more concerned with inputs and outputs than outcome, and have tended to take place at the end of the intervention, when money is spent and little time or opportunity remains to use any lessons for amending or adapting the intervention. This has hindered the sustainability of programmes. In addition, evaluations have often involved the one-time use of outside expertise, instead of drawing upon local experts or embarking on long-term cooperation between local and international partners. Yet, only careful, rigorous evaluation can determine whether psychosocial or psychological interventions are appropriate and effective (Rabaia, Saleh & Giacaman 2014: 175).

Another set of problems is that foreign practitioners and researchers have typically **focused overwhelmingly on negatives, and paid little consideration to resilience among Palestinians** (Rabaia, Saleh & Giacaman 2014: 174). A quantitative analysis of academic articles in international journals published between 1989 and 2006 found at least 20 articles on Palestinian children's and adolescent's mental health. They provided quantitative analyses of the association between exposure to violence and mental health outcomes in Palestinian children. The vast majority of studies measured negative outcomes, with indicators such as behavioural problems, aggression and other anti-social behaviour, risk-taking, Post-Traumatic Stress Disorder (PTSD), or negative perception of parenting (Barber and Schluterman cited in Rabaia, Saleh & Giacaman 2014: 174).

Only a quarter of the articles paid some attention to positive outcomes, such as positive and active coping, personal growth, orientation towards others, social integration, or civic and religious involvement (Barber and Schluterman cited in Rabaia, Saleh & Giacaman 2014: 174). The focus on pathological symptoms has framed young Palestinians exposed to violence as mentally ill, with a need for and a right to treatment based on the UN Convention on the Rights of the Child. There has been markedly less interest in how Palestinians have maintained their mental health throughout longstanding dispossession and through violence of lower and higher intensity (Rabaia, Saleh & Giacaman 2014: 174).

Current approaches to Palestinians' mental health thus ignore Palestinians' collective strength and support in dealing with their political conditions. Palestinians have become accustomed not only to dealing with living in political, economic and human insecurity, but also to taking care of each other. "[F]amily bonds are strong and supportive, often across borders", be it in the form of financial support or providing a safe haven in emergencies (Rabaia, Saleh & Giacaman 2014: 173). In times of crises or need, neighbours and communities also help each other. Palestinians with no specific qualifications carry out "magnificent welfare projects" (Jones & Lavalette cited in Rabaia, Saleh & Giacaman 2014: 173). At this point, the protracted character of the Israeli occupation, combined with international agencies' interest in the plight of Palestinian adults and their children, have translated into a large number of psychosocial initiatives in the oPt. Palestinian psychosocial workers have therefore become experienced professionals, within a population that has become used to crises and hardship (Rabaia, Saleh & Giacaman 2014: 177).

Palestinian children too have continued to exhibit resilience. Studies in the 2000s have shown their enduring self-efficacy and their optimism that they can have a good their future by developing academically, personally, and socially (e.g. Arafat & Boothby cited in Rabaia, Saleh & Giacaman 2014: 177). In fact, a comparison of "the effects of exposure to violence between Palestinian and Bosnian adolescents found that Palestinian adolescents were protected by the fact that they understood the conflict and their place in it", in contrast to Bosnian adolescents (Barber cited in Rabaia, Saleh & Giacaman 2014: 177-178).

A final set of problems stems from foreign aid actors' **assumptions about what forms support to children's well-being and mental health in a context of political violence** should take. Cultural, and societal norms, and the individual meaning ascribed to the 'traumatic' event, ultimately shape individuals' reactions, whether or not they need, want and seek help, and their expectations of recovery (Summerfield; Young; both cited in Rabaia, Saleh & Giacaman 2014: 176; also see Rabaia, Giacaman & Nguyen-Gillham 2010: 220S).

Foreign aid actors have not sufficiently acknowledged that only some people exposed to violent events wish to have diagnosis and treatment, despite evidence that this matters. For example, a survey with a random sample, conducted immediately after the three-week Israeli assault on the Gaza Strip in 2008-2009, asked adults whom they would turn to if they wanted to talk about their worries. Only one percent mentioned a professional. 59 percent mentioned a family member, 22 percent mention a friend, and 24 percent said they would not talk to anyone (UNFPA and FAFO cited in Rabaia, Saleh & Giacaman 2014: 176).

In addition, international humanitarian actors typically turn to international mental health guidelines and practices that do not fit the Palestinian context. For example, in the wake of the 2008-2009 Israeli assault on the Gaza Strip, international trainers from the working group on mental health and psychosocial support, led by WHO and UNICEF, were flown in to explain the guidelines of the Inter-Agency Standing Committee (IASC) to the international and local relief workers of the various institutions working in psychosocial and mental health in the West Bank and the Gaza Strip (Rabaia, Saleh & Giacaman 2014: 177).

The associated workshop typified the structural problems with international approaches. First, the basis of the IASC guidelines refers to 'basic services and security' that presume that a national state is in control, whereas in the oPt it is Israel and, to some extent, international actors, that have effective control, not the Palestinian Authority. Second, Palestinian participants in the workshop repeatedly mentioned that Palestinian relief workers and the Palestinian population at large have become used to Israeli repression and aggression, and have "long-term experience in dealing with these crises" (Rabaia,

Saleh & Giacaman 2014: 177). However, the foreign trainers did not engage with this point. Third, a number of Palestinians interacting with psychosocial services supported by foreign aid actors express the demand that those actors pressure Israel into stopping its aggression, which is causing psychosocial problems in the first place (Rabaia, Saleh & Giacaman 2014: 177).

More broadly, assessments of psychosocial projects are generally **derived from Western biomedical and individualistic models with 'objective' indicators of psychosocial health** — often developed outside the context — which may not be relevant and appropriate to culture and context. Such assessments often assume that the temporality is that of a traumatic event, whereas structural factors from the historical, socio-political, and economic context are neglected (Rabaia, Saleh & Giacaman 2014: 179). Humanitarian aid agencies have adopted predominantly biomedical interventions. But in a context of collective exposure to violence, individual healing methods based on one-to-one counselling has little therapeutic effect (Rabaia, Giacaman & Nguyen-Gillham 2010).

In addition, it is often **programme frameworks and processes that come in the way of a locally relevant** approach. International NGOs typically design and implement short-term projects, and base them on questionable assumptions: (i) that children exposed to political violence must experience trauma and (ii) that these children will recover through short-term interventions. There is evidence from Palestine and other contexts to question both assumptions (Rabaia, Saleh & Giacaman 2014: 178-179).

Alternative, Palestinian-led approaches

Rather than considering social suffering an illness to be cured, foreign aid wishing to support Palestinian children needs to **address the root causes**, namely the collective and cumulative exposure to Israeli aggression and the international community's condoning of it, Rabaia, Saleh and Giacaman (2014: 178) note. They point to "the ultimate fallacy of developmental and emergency aid […] in chronic political emergencies", and the "grandiose, but seldom sustainable, interventions" (Rabaia, Saleh & Giacaman 2014: 177).

In the absence of such structural political change, Rabaia, Saleh and Giacaman (2014: 177) recommend that foreign aid actors focus on **strengthening the population's social resilience,** "with a keen eye for priorities in relation to needs, and extreme modesty" in objectives (Rabaia, Saleh & Giacaman 2014: 177; also see Rabaia, Giacaman & Nguyen-Gillham 2010: 220S). This alternative approach views Palestinian mental health in the historical and political context of loss and injustice, and understands social injustice and human insecurity as determining factors. Psychosocial interventions for mental health need to be contextually appropriate to the Palestinian situation and collective in nature (Rabaia, Giacaman & Nguyen-Gillham 2010).

To address children's exposure to violence in such a way, foreign aid actors need to pay greater attention to historical and socio-political context in social work, and to draw on qualitative research into children's own perspectives. This interdisciplinary approach challenges the portrayal of children exposed to political violence as victims, and highlights the "population's collective experience in coping with international aggression and neglect, the availability of family and community support, children's own individual and collective coping mechanisms and their resilience" (Barber and Schluterman; Nguyen-Gillham and others; both cited in Rabaia, Saleh & Giacaman 2014: 178). Interventions following this approach **focus more on psychosocial support than biomedical action or psychotherapy**. They pay more attention to identifying and strengthening community-based resources, developing creativity, and enhancing life skills (Rabaia, Saleh & Giacaman 2014: 178).

Based on research about Palestinian adolescents' coping with trauma and violence in the 2000s, researchers from the Institute of Community and Public Health at Birzeit University have articulated recommended approaches. Instead of focusing on individual behaviours and symptoms of distress which are understandable reactions to violence, the researchers have advocated **a contextualised "public health approach to dealing with the social suffering of war, violation and symptoms"** (Rabaia, Giacaman & Nguyen-Gillham 2010: 219S):

- Develop a community model for interventions, taking into consideration that young people identify themselves as groups;
- Strengthen youth centres and facilities for young people, so that youth have a space "to express themselves, share their problems, and become active in communal affairs and problem solving";
- Train youth workers in supporting and promoting youth engagement; and
- Use school resources, for example as a venue for activities involving youth or community.

One example of implementing such an approach is a youth group programme in several villages in the north of the West Bank, where there are few opportunities and services for young people' employment and leisure. [7] It focuses on 'youth as strategy' in rehabilitation and in work for community and youth development. It started in 2004 as a 'research to action' collaboration between the Institute of Community and Public Health at Birzeit University and a local Palestinian NGO focused on support for people with disabilities, called Community-Based Rehabilitation (CBR) (Giacaman et al.; Rabaia et al.; both cited in Rabaia, Saleh & Giacaman 2014: 178; and Rabaia, Giacaman & Nguyen-Gillham 2010: 219S). From the start, the design sought sustainability and minimal dependence on external funding (Rabaia, Giacaman & Nguyen-Gillham 2010: 119S).

This empowering model brings youth together, and provides a forum for them to explore and understand their own issues and challenges as well as those in their communities. At the same time, they develop their own social projects, based on their community's need and their group's capacity. In practice, the youth groups meet regularly (usually once a week) to discuss issues related to themselves and their community, to learn about disability, and to help "the CBR worker with community activities for the integration of people with disabilities" (Rabaia, Giacaman & Nguyen-Gillham 2010: 119S). These can include, for example, summer camps, communal Ramadan breakfasts, celebration of Mother's Day and the Day for people with disabilities (Rabaia, Giacaman & Nguyen-Gillham 2010: 119S). The research component has focused on the psychosocial mental health of youth, with special attention to protective factors and forms of resilience adopted by people coping with violent times (Rabaia, Giacaman & Nguyen-Gillham 2010).

The cooperation between the academic team and the local NGOs included "the sometimes painstaking task" of building confidence between both organisations, team-building within and between them, assessing needs in four pilot villages, conducting a rigorous evaluation after the first year of the pilot, and finally adapting the model (Rabaia, Giacaman & Nguyen-Gillham 2010: 119S). The commitment of both teams made it possible to overcome setbacks due to financial and human resources, and ongoing war-like conditions (Rabaia, Giacaman & Nguyen-Gillham 2010: 119S).

Taking stock of the first four years of the programme, Rabaia, Giacaman and Nguyen-Gillham (2010: 119S) noted that the project had had "still fragile but rather startling success" in some villages. An

[7] Palestinians in the north of the West Bank are also acutely exposed to violence from the Israeli State and settlers.

unexpected but important outcome was that young people with disabilities had not only become group members, but had also developed their leadership skills and contributed to the work of CBR, rather than just being recipients (Rabaia, Giacaman & Nguyen-Gillham 2010: 119S). A 2009 external evaluation noted that both the NGO workers and the participants expressed high satisfaction with the programme (Rabaia, Giacaman & Nguyen-Gillham 2010: 120S).

After ten years, the findings from this programme highlight "**the importance of doing no harm, enhancing local resources and long-term commitment**" (Rabaia, Saleh & Giacaman 2014: 179). The long-term research cooperation with the CBR programme confirms the importance of working with local resources in supporting young people to help themselves and others in a sustainable way, i.e. to strengthen their resilience. In addition, to strengthen the programme, academic partners have repeated a cycle of design, fund-raising, implementation, and reporting five times over a 10-year period. This involved researchers from Birzeit University, who themselves have been exposed to the same experiences as the youth they work with, helping to strengthen the resilience of participants and wider Palestinian society. Yet, international aid actors have lent very little financial or other support to this kind of long-term, research-based, Palestinian-led interventions (Rabaia, Saleh & Giacaman 2014: 178-179).

Further, a more sensitive and effective engagement with local professionals and researchers may improve programming for psychosocial health in the oPt. This is because psychosocial health is complex, and has intricate links to meaning, culture, and context. This calls for collaboration between local and international researchers that builds on each partner's expertise with mutual respect and joint learning. In mental health, the issue is not finding the right word in translation, or semantics. It is about a way of being, living, and reacting to stress and trauma in relation to a mindset where meaning, culture and context are essential (Rabaia, Giacaman & Nguyen-Gillham 2010: 220S; Rabaia, Saleh & Giacaman 2014: 179).

Overview of evidence-based approaches for prevention

The WHO has recently coordinated the production of a handbook that presents a **selection of strategies to end violence against children worldwide, based on the best evidence currently available** from HICs and, where possible, LMICs (Butchard & Hillis 2016).[8] This project, called 'INSPIRE', is ongoing, and further materials are under development.[9] The strategies are meant to enable governments and societies to focus their preventive programmes and services on interventions with the greatest potential to reduce violence against children (Butchard & Hillis 2016: 8). Due to the time constraints of this report, the INSPIRE handbook is the central reference used in this section and related sub-sections elsewhere in this report, because it is the most recent publication and focuses on the prevention of violence against children. The following complementary references can helpfully be consulted as well:

[8] The leading organisations were the WHO and the US Center for Disease Control and Prevention. Other core organisations were: End Violence Against Children: The Global Partnership; PEPFAR; Together for Girls; UNICEF; UNODC; USAID; WHO/PAHO; and the World Bank. In addition, the Oak Foundation facilitated a review of the document by the following civil society organisations: African Child Policy Forum; Children and Violence Evaluation Challenge Fund; Child Rights Forum; Child Protection in Crisis Network; End Child Prostitution in Asian Tourism International; End FGM EU Network; Eurochild Network; Girls Not Brides; Global Initiative to End all Corporal Punishment against Children; Promundo; Save the Children; SOS Villages; World Vision (Butchard & Hillis 2016: 2).

[9] Subsequent INSPIRE materials will detail how to implement the package. The project hopes to release indicators to monitor implementation and impact by the end of 2016. It then aims to release manuals for implementation (an overall one, and one per strategy) and for research in 2017 (Butchard & Hillis 2016: 26).

- an evaluation of UNICEF's performance in protecting children from violence (UNICEF 2015);
- an evidence brief on evaluating the outcomes of parenting programmes (Wessels et al. 2013);
- a series of briefings on rigorous evidence about violence prevention (WHO 2010); and
- an overview of the evidence on preventing youth violence: (WHO 2015).

Thematic strategies and associated interventions

The handbook recommends the following seven strategies and associated interventions (Butchard & Hillis 2016 unless otherwise indicated). Where the handbook mentions significant evidence from LMICs, the country or region concerned is indicated in brackets.

- **Implementing and enforcing laws** (p. 30-35). Relevant laws are:
  - Bans on parents, teachers and others using violent punishment against children, and laws on the use of violence by teachers or other caregivers. A 2010 systematic review concluded that, based on data from Western countries, legal bans were closely associated with decreased support for, and use of, corporal punishment for child discipline, but the decrease begins before bans are adopted into law, and continues after it (Zolotor & Puzia 2010). As of July 2016, 49 states worldwide have prohibited corporal punishment in all settings, including the home; these states are primarily in Europe and Latin America, with a few in sub-Saharan Africa, North Africa, and Central Asia. Other states, in both HICs and LMICs, prohibit corporal punishment in some settings but not all. Only 10 per cent of the world's children are protected in law from all corporal punishment. [10]
  - Laws criminalising the sexual abuse and exploitation of children. Most countries have such laws in place, though with variable scope and effect. For example, virtually all countries prohibit statutory rape, but such laws are fully enforced in less than two-thirds of countries (WHO cited p. 34).
  - Laws that limit young people's access to weapons, including firearms. Evidence, including from LMICs such as South Africa, shows that strategies are promising, although more research needs to identify the most effective ones. Laws that prevent alcohol misuse are also recommended.
- **Strengthen norms and values** "that support non-violent, respectful, nurturing, positive and gender-equitable relationships for all children and adolescents" (p. 36; see p. 36-41). This can include:
  - Changing restrictive and harmful gender and social norms. Evidence for this includes findings about the Gambia, India, Nepal, and South Africa (p. 38). There is also positive evidence on the effectiveness of such programmes against child marriage, primarily from South Asia (especially Bangladesh and India), and to a lesser extent sub-Saharan Africa and the Middle East (e.g. Ethiopia and Egypt). A 2011 review found the strongest, most consistent results against child marriage in programmes that combined empowering girls with information, skills and networks, and mobilising communities (Malhotra et al. 2011 cited p. 39).
  - Community mobilisation. There is strong evidence from Uganda and South Africa (p. 40).

[10] See: Global Initiative to End All Corporal Punishment of Children. *Countdown to Universal Prohibition*. Global Initiative to End All Corporal Punishment of Children. Last accessed on 29/08/2016. http://www.endcorporalpunishment.org/progress/countdown.html

  - Addressing potential bystanders of violence committed against dating partners and acquaintances (p. 40).
  - When combined with mass media campaigns or social mobilisation, and with supportive services, the above approaches have successfully encouraged greater reporting and the enactment of new laws and policies punishing certain forms of violence.

- **Creating and sustaining safe streets** and other environments where children and youth spend time (p. 42-47). This can entail: addressing 'hotspots' (with evidence from Argentina, Brazil, and South Africa); interrupting the spread of violence through a public health approach; or improving the built environment (with evidence from LMICs, e.g. Colombia). In addition, "institutions such as temporary and alternative care facilities, orphanages, police stations and detention centres" need to be safe for children (p. 44).
- **Supporting parents and caregivers**, to reduce harsh parenting and create positive parent-child relationships (p. 48-53). Support or training can be delivered through home visits, in groups in community settings, or as part of comprehensive programmes. There is promising evidence from LMICs – for details, see Section 3 in this report on prevention through parenting interventions.
- **Strengthening the incomes and economic situation** of families or women. This can take the form of cash transfers, and can also involve combining training on gender norms and equity with group savings, loans associations, or microfinance (p. 54-59). There is promising evidence from LMICs – for details, see Section 5 in this report on prevention through larger programmes.
- **Improving access to good-quality support services in health, social welfare, and criminal justice** for all children, including to report violence for primary or secondary prevention (p. 60-65). Interventions can entail: screening combined with interventions; treatment for juvenile offenders in the criminal justice system; and interventions in foster care, involving social welfare services. On foster care, UNICEF notes that, in many countries, placement in out-of-home care is often used for children who are victims (or at high risk) of maltreatment, and for other vulnerable children such as children with disabilities. Placements can include "alternative family care – including foster or kinship care – or institutional care such as orphanages, group homes or residential treatment centres" (UNICEF cited in Butchard & Hillis 2016: 65). Orphanages continue to be a common approach, with at least 2 million children in orphanages worldwide (UNICEF cited Butchard & Hillis 2016: 65). The interventions under this sixth strategy can also involve counselling and therapeutic approaches for children who were victims of violence, with evidence from sub-Saharan Africa including the DRC and Zambia.
- **Increasing children's access to more effective and gender-equitable education, social-emotional learning, and training in life skills** (p. 66-73). The interventions can include increasing enrolment in pre-school, primary and secondary schools, and establishing a safe and enabling school environment. They can also involve training children in life and social skills. Lastly, interventions can seek to improve children's knowledge about how to protect themselves from sexual abuse, or prevent adolescent violence among intimate partners. There is some promising evidence on LMICs on most of these interventions. For more detail, see Section 4 in this report on prevention through child-focused interventions and locations.

Cross-cutting strategies and associated interventions

Additionally, two cross-cutting approaches, combined, are essential requirements to the success of any evidence-based intervention (Butchard & Hillis 2016: 23).

Multi-sectoral actions and coordination for effective prevention

First, ensuring multi-sectoral actions and coordination is crucial (Butchard & Hillis 2016: 75-77). In many countries, efforts to eliminate violence against children are not well coordinated and supported, and few operate at a large scale (Butchard & Hillis 2016: 77). The successful implementation of evidence-based prevention depends on the strength of the **systems underlying each sector** involved, how ready they are to address violence against children, and whether there is effective coordination between sectors (Butchard & Hillis 2016: 75).

Such implementation requires the involvement of national and local government departments (e.g. education, health, justice, and social welfare), the private sector and civil society organisations, including professional associations, faith-based organisations and academia (Butchard & Hillis 2016: 75). In collaboration, these actors can reduce risk factors and enhance positive factors at the levels of individuals, families, communities, and societies. Community-based mechanisms for child protection are increasingly common, although their effectiveness for prevention remains poorly evaluated (Butchard & Hillis 2016: 76).

Coordination is essential: "no single sector can deliver the full package of interventions" and no government alone can tackle transnational violations of child protection (Butchard & Hillis 2016: 77). Implementation should encourage cooperation and learning within and between countries (Butchard & Hillis 2016: 77).

Rigorous monitoring and evaluation tailored to the prevention of child protection violations

Second, all strategies and interventions need to ensuring rigorous monitoring and evaluation (Butchard & Hillis 2016: 78-81). It is essential to collect and make available data on violence against children. This data must include information on sex, age, disability, and other characteristics that may influence vulnerability to violence. Any monitoring should use standardised, scientifically valid practices for collection and analysis. Data need to be readily available to all actors involved in violence prevention, including at the levels of national government, municipal and local authorities, and communities (Butchard & Hillis 2016: 78).

It is crucial to regularly produce and update monitoring data from **national population-based surveys and from facility-based administrative systems** (such as hospitals) (Butchard & Hillis 2016: 78). Self-reports via nationally representative surveys are the more reliable standard for measuring problems, changes, and the impact of prevention. This is because only a small proportion of violence against children is reported to official sources, and many countries have inadequate administrative systems of official data in any case (Butchard & Hillis 2016: 79).

National surveys are feasible in LMICs. A number of LMICs (e.g. Cambodia, Haiti, Kenya, Malawi, Swaziland, Tanzania, and Zimbabwe) have implemented Violence Against Children Surveys (VACS). The partnership 'Together for Girls' has then supported task forces comprising ministries and civil society groups in linking this national data to effective multi-sectoral prevention and response (Butchard & Hillis 2016: 80).

As a complement to surveys, which cannot provide in-depth information about specific policies, **administrative data** is required (Butchard & Hillis 2016: 79). Such systems routinely collect records in the management of public programmes or agencies, and are thus an inexpensive source of data (Butchard & Hillis 2016: 81). Systems for case management "that collate data from different sectors can also be helpful" (Butchard & Hillis 2016: 78). When considering violence against children that leads to death, special administrative data, collected through vital records and death certificates is relevant. Violence-related deaths among children and youth are not readily identified through population-based surveys or

service-based administrative data. They can be reliably measured only through facility-based mortality surveillance systems, including hospitals, police departments, and morgues. However, many countries still lack functioning registration for intentional injuries and death, and determining the cause of death in children may be challenging (Butchard & Hillis 2016: 81).

Given the extreme under-reporting of violence, **qualitative work** can also be critical. It helps "better understand the perspective of children, parents, caretakers and other important community influencers" and ensure that programmes meet communities' perceived needs (Butchard & Hillis 2016: 81).

As **evaluations** of the outcomes of preventive interventions in LMICs remain scarce, Butchard and Hillis (2016: 81) argue not only for a large-scale implementation of effective strategies, but also for a comparably large-scale programme of evaluation. Evaluations are needed to measure outcomes, cost-effectiveness, the scaling-up and sustaining of effective programmes, and the combined impact of the coordinated implementation of multi-sectoral approaches. This will avoid wasting scarce resources and will maximise impact (Butchard & Hillis 2016: 81).

Implementation

The INSPIRE handbook also details a number of practices for implementing its recommended strategies (Butchard & Hillis 2016: 82-91). These are not intended for implementation as a new programme, but rather as a way **to revitalise, focus, and expand current multi-sectoral efforts**. The authors argue that any implementation of INSPIRE should use "at least one intervention from each of the seven strategies (ideally at scale)", with respective sectors adopting an approach either progressively or simultaneously (Butchard & Hillis 2016: 82). This is because "the strategies are intended to work in combination and reinforce one another" (Butchard & Hillis 2016: 82). Further, each country has to adapt the package and its implementation to its specific conditions and structures, through nine actions. What follows is a summary of these actions, with highlights relevant to LMICs where possible (Butchard & Hillis 2016: 83-91 unless otherwise noted).

National commitment, needs, readiness

Actors need to build national commitment. Actors must also assess needs, including both universal coverage and, where relevant, differences and priorities among children based on various structures of inequality such as class, gender or disability.

As a complement to assessing needs, assessing readiness may be particularly useful for governments beginning to address violence against children, uncertain about their country's preparedness for implementation, or after they complete a Violence Against Children Survey (Mikton et al. cited in Butchard & Hillis 2016: 85). The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) can be used to appraise whether a country, province or community is ready to implement a large-scale preventive programme against child maltreatment or, with little adaptation, youth violence (Butchard & Hillis 2016: 85). Conducting such an assessment can itself powerful raise awareness and inform the allocation of resources (Mikton et al. 2013).

This tool has been applied in Brazil, Macedonia, Malaysia, Saudi Arabia, and South Africa. In almost all countries, the following major gaps have been identified to date (Butchard & Hillis 2016: 85, summarising Mikton et al. 2013):

- A lack of professionals with the skills, knowledge, and expertise to implement evidence-based programmes for prevention and response on child maltreatment.

- A lack of institutions to train such professionals.
- Inadequate funding, and a lack of infrastructure and equipment.
- An "extreme lack of outcome evaluations of prevention programmes", alongside a lack of national surveys on the prevalence of child maltreatment.

Selecting and adapting interventions

Actors also need to select the most appropriate interventions. Once selected, these need to be **adapted to the local context while preserving the essential features** that generate effectiveness. The authors of the INSPIRE handbook refer readers to general evidence-based guidance on how to preserve fidelity in programming (e.g. O'Connor, Small & Cooney 2007), as research has identified adaptions that are generally acceptable, and those found to be risky or unacceptable.

Acceptable adaptations include: "Changing language – Translating and/or modifying vocabulary; Replacing images to show youth and families that look like the target audience; Replacing cultural references; Modifying some aspects of activities such as physical contact; Adding relevant, evidence-based content to make the program more appealing to participants" (O'Connor, Small & Cooney 2007: 2).

Risky and generally unacceptable adaptations include: "Reducing the number or length of sessions or how long participants are involved; Lowering the level of participant engagement; Eliminating key messages or skills learned; Removing topics; Changing the theoretical approach; Using staff or volunteers who are not adequately trained or qualified; Using fewer staff members than recommended" (O'Connor, Small & Cooney 2007: 2).

Plans, costs, funding, people, action, monitoring and evaluation

Actors also need to prepare plans of action in national and local government. An INSPIRE-type programme of prevention in Saint Petersburg, Russian Federation, confirms that countries or cities with a central unit for planning and policy (within a designated ministry) and local units for implementation and enforcement can carry out successful multi-sectoral activities.

Actors also need to estimate costs and identify sustainable sources of funding. They also need to develop and manage the staff involved and their capacities. In smaller countries with limited financial resources, one person may take on more than one role. The specific skills to develop depend on existing capacities and needs, nationally and locally. They may include skills in mid-level and senior management, supervisory skills, and front line staff capacity. Lastly, actors need to ensure that they **implement, monitor and evaluate** strategies and interventions effectively. Monitoring and evaluation need to disaggregate by sex, age groups, disability, and other demographic characteristics as relevant.

3. Prevention through parenting interventions

Interventions on parenting are an important evidence-based strategy to prevent violence, both against and by children (e.g. Knerr, Gardner & Cluver 2013).

Findings from a systematic review on parenting interventions

Limited evidence base

Parenting interventions offer a striking example of the limitations of the evidence base. They are among the more implemented and researched in LMICs, compared to other types of interventions (which are even less used and evaluated in LMICs). Yet, while there have been many rigorous evaluations of parenting interventions in HICs, there are still very few in LMICs (Knerr, Gardner & Cluver 2013).

Indeed, a widely cited 2013 systematic review of randomised trials on parenting interventions in LMICs identifies only 12 relevant studies out of an initial pool of over 24,000 published and unpublished studies on parenting in LMICs. Further, just two of the 12 studies are of high quality, with larger sample sizes (over 300 individuals) and a calculation of statistical power that reduced risks of bias. The remaining ten studies suffer from substantial or unclear risks of bias which put the validity of their results in question, with problems such as a small sample size and weak study design or reporting (Knerr, Gardner & Cluver 2013).

The authors of that systematic review, in line with many other authors, note an urgent need for more rigorous studies that would focus on youth outcomes as well as parenting, and that would research interventions adapted to contexts of significant constraints on resources. The review had also not found any study about programmes with a well-established evidence base in many HICs, such as Strengthening Families Programme (Knerr, Gardner & Cluver 2013).

Findings from a systematic review about LMICs

One widely cited 2013 systematic review (Knerr, Gardner & Cluver 2013) examines the effectiveness of **randomized interventions for the parenting skills of parents or primary carers** of children aged 0-18 years in LMICs. It investigates literature published up to 2010 on whether parenting interventions have effectively reduced harsh or abusive parenting, increased positive practices in parenting, and improved parent child relationships. It also considers changes in attitudes and knowledge as secondary outcomes.

The systematic review identifies 12 eligible studies involving 1,580 parents in nine LMICs. [11] Taken as a whole, they report positive results on the outcomes investigated (Knerr, Gardner & Cluver 2013). Parenting interventions thus "hold some promise for improving parenting practices" and reducing risk factors of child maltreatment in LMICs (Knerr, Gardner & Cluver 2013: 359). However, the validity of results for ten of the studies is uncertain, due to substantial or unclear risks of bias in the studies stemming from problems such as a small sample size and weak study design or reporting (e.g. on randomisation, reliance on self-reported parenting behaviour, or treatment of missing data). The heterogeneity of the studies also precluded comparisons between studies (Knerr, Gardner & Cluver 2013).

On the other hand, the systematic review identifies two larger, high-quality trials on South Africa and Pakistan, and another good-quality one on Brazil, which together involve over 800 mothers. They present more rigorous findings showing that interventions in LMICs are feasible and can have effective results for parenting outcomes (Knerr, Gardner & Cluver 2013: 359-360). All three interventions were adaptations of programmes originating from HICs (Knerr, Gardner & Cluver 2013: 355-356).

- In South Africa, the intervention involved 449 pregnant mothers who were poor, lived in shacks, and had very high unemployment. This intervention was not part of any existing service, and was delivered by previously untrained community workers, who were trained successfully to act as lay therapists giving support and guidance in parenting. External observation confirmed that the

[11] One study each in Brazil, Chile, China, Iran, Jamaica, Pakistan, and Turkey; two in Ethiopia; three in South Africa.

intervention had a small positive effect in improving mother-child interaction during the infants' first year (Cooper et al. 2009 cited in Knerr, Gardner & Cluver 2013). More broadly, this programme, called 'Parenting for Lifelong Health' (PLH), has been testing and disseminating a suite of affordable, group-based parenting programmes for low-resource settings using evidence-based approaches such as RCTs. The interventions have centred on shared social learning for parenting, such as positive instructions and reinforcement. There is preliminary evidence of effectiveness of PHL (Butchard & Hillis 2016: 53, citing several sources including Cooper et al. 2009; Vally et al. 2015). PLH programmes are being adapted and tested in other LMICs, including the DRC, El Salvador, Kenya, Lesotho, the Philippines, South Sudan and Tanzania (Butchard & Hillis 2016: 53).

- In Pakistan, the intervention involved 334 pregnant mothers, many living on income from subsistence farming. The home visits were added to existing health services. Participants' self-reporting indicated that the intervention increased mothers' knowledge and attitude on child development during the infants' first six months (Rahman et al. 2009 cited in Knerr, Gardner & Cluver 2013).
- In Brazil, the intervention involved 38 new mothers (2-3 days after giving birth) who lived in low or median housing conditions. The home visits were implemented through health clinics and added to existing services. External observation confirmed that improved mother–infant interaction during the infant's first month (Wendland-Carro et al. 1999 cited in Knerr, Gardner & Cluver 2013).

Parenting interventions may therefore be instrumental in preventing child maltreatment in LMICs (Knerr, Gardner & Cluver 2013). This could build on the well-established, excellent evidence base for such interventions in HICs, which also includes many studies on low-income families and diverse cultural groups. Indeed, there is increasingly good evidence for the applicability of parenting interventions across cultures, income groups, and countries (Knerr, Gardner & Cluver 2013: 353).

Parenting knowledge and attitudes have at best modest effects on the development of aggressive behaviour but, in contexts where people have limited knowledge about child development, they may be necessary for behaviour change (Knerr, Gardner & Cluver 2013: 352-353).

In particular, the studies on South Africa and Pakistan demonstrate that it is **feasible in low-resource settings** to successfully use non-professional local staff, deliver interventions through home visits, and add interventions to routine services for pregnant women. Such practices "may be more cost-effective, and more familiar and acceptable to local populations" (Knerr, Gardner & Cluver 2013: 360).

Findings from an evidence review for the WHO

A 2013 evidence brief, commissioned by WHO and other agencies, highlights findings about evaluating the outcomes of parenting programmes in preventing violence, especially in LMICs (Wessels et al. 2013). It reiterates that parenting programmes can effectively prevent all forms of violence, but that further research is needed to strengthen the evidence, particularly from LMICs, and that debates remain open on adaptation (Wessels et al. 2013: 14).

Nonetheless, **some characteristics are common to effective programmes** (Wessels et al. 2013: 14). First, some general components are shared by many evidence-based programmes: a sound programme theory; a clearly defined target population; appropriate timing; acceptability to participants; sufficient sessions; well-trained and well-supervised staff; and ensuring monitoring and evaluation throughout (Wessels et al. 2013: 13). Second, some components have proven essential to effective parenting programmes to

prevent or correct behavioural problems, and they are likely to be critical too for programmes to prevent child maltreatment. They are: opportunities for parents to practise new skills; teaching parenting principles, rather than prescribed techniques; teaching positive parenting, including age-appropriate positive discipline; and considering difficulties in the relationships among adults in families (Wessels et al. 2013: 13-14).

Findings from a multi-country UNODC pilot on family skills

Type of intervention and profiles of participants

Since November 2009, the UNODC has developed a global project to advocate for evidence-based prevention in 16 LMICs, primarily against substance abuse. It consists of advocacy to encourage policy-makers to adopt evidence-based strategies and support for national technical capacity. The latter entails **helping national prevention services to adapt, pilot and evaluate evidence-based prevention programmes**, including for family skills in families with adolescents. The family skills programmes involved are Strengthening the Family 10-14 (SFP) and Family and Schools Together (FAST) (Maalouf & Campello 2014: 618-619).

As of 2014, the pilots of these programmes had reached close to 7,000 parents and adolescents (Maalouf & Campello 2014: 617-618). In the SFP pilots, preliminary indications are that the demographics of the volunteering families involved were **representative of the communities they were recruited from**. Similarly, with the FAST pilots in Central Asia, the demographic and socio-economic indicators of the volunteering families – such as income, education, family size, employment and marital statuses – were largely representative of the communities they were recruited from. The exception is that mothers volunteered to get involved in about 80% of cases, compared to low involvement from fathers (Maalouf & Campello 2014: 619).

Effects of intervention

UNODC collected pre-post data at family level from nine LMICs: data on FAST in five Central Asian countries (Kazakhstan, Kyrgyzstan, Turkmenistan, Tajikistan, Uzbekistan) from parent self-reports and teacher reports; and data on SFP in three Central American countries (Panama, Honduras, Guatemala) and one in the Balkans (Serbia), from parent and youth self-reports. These measures covered both violence and risk factors of violence, assessed before and after implementation of the pilot programmes. However, the design had a single group as reference, and post-intervention data was collected shortly after the final session – either immediately or within two weeks (Maalouf & Campello 2014: 617-619).

The pre-post data on variables associated with violence (including conduct problems, stress management, pro-social behaviours, family aggression and conflict) indicates **promising results in preventing violence**. After the interventions, there were significant changes across most of the indicators related to youth violence and child maltreatment, on a level that was at least comparable to HICs (Maalouf & Campello 2014). Both programmes also positively influenced factors that can indirectly alleviate violence, such as family cohesion, family communication, pro-social behaviour, and alleviation of child emotional problems (Maalouf & Campello 2014: 622).

In the SFP pilots, almost all groups of parents reported a statistically significant change in anger management, both on controlling and managing parents' own anger and on attempting to manage their child's anger. In the few cases where the change was not statistically significant, it remained in the appropriate direction. Similarly, children reported positive changes regarding their attitude and reaction to external influences from families, friends and teachers, and regarding violence from parents and tutors

towards them. A statistically significant change on these indicators was recorded across almost all groups in Honduras, Guatemala, Panama, and Serbia. In the few cases where the change was not statistically significant, it remained in the appropriate direction. Importantly, these changes also worked in communities where the level of violence is higher than average, such as in Honduras (Maalouf & Campello 2014: 620).

In the FAST pilots, parents reported a significant reduction of family conflict in all countries. These post-intervention results were very similar in all countries. This is despite parents in Tajikistan having reported a level of conflict higher than in other countries before the intervention. Overall, both teachers and parents a significant decrease in children's problem conducts after the intervention in all countries. The exception is Kazakhstan where teachers' reporting decreases was smaller than decreases reported by parents (Maalouf & Campello 2014: 620-622).

Further findings

Group-based interventions on parenting

As part of the strategies recommended in the INSPIRE project, led by WHO, the authors note that there is promising evidence on the effectiveness of **group training and support for parenting that is delivered in community settings**.

'Parents/Families Matter!', a parent-focused intervention, is one such promising programme. It promotes positive parenting and effective parent-child communication on issues such as sexuality, reduction of sexual risks, and physical, emotional, and sexual violence. The programme uses "community-based, group-level interventions for parents and caregivers of children aged 9–12 years" (Butchard & Hillis 2016: 52). As of 2016, it is active in eight African countries, reaching reached over 400 000 families to date (with a 90% parental participation to all sessions). Pre-post evaluations have found that parents significantly increased their knowledge, skills and confidence in communicating with their adolescent children about sex-related topics. An evaluation in Kenya showed that "parents and children both reported significant increases in parental monitoring and improved communications" on sex-related topics, and that the community received the intervention well (UNICEF, cited in Butchard & Hillis 2016: 52).

Group-based parenting programmes after armed conflicts and with displaced populations have also proven effective. The International Rescue Committee (IRC) used group-based parenting, combined with some limited home visits, with Burmese migrant and displaced families at the border between Myanmar and Thailand, and with very poor communities in rural Liberia. Its randomised control trials on this demonstrated that such programmes "can reduce harsh physical and psychological punishment, increase positive strategies to manage children's behaviour, and enhance the quality of caregiver-child interactions" (Butchard & Hillis 2016: 52, summarising two IRC studies).

Parent support and training that are part of comprehensive programmes

Comprehensive programmes provide vulnerable families (such as those with adolescent mothers or low incomes) with "family support, pre-school education, child-care and health services". They are typically delivered at health centres, schools or neighbourhood centres. Those that include a parenting component either focus on building positive social-emotional skills or specifically aim to prevent violence

by peers or partners. In HICs, these programmes were associated with significant reductions in violent behaviours (Butchard & Hillis 2016: 53). [12]

4. Prevention through child-focused interventions and locations

Interventions focused on schooling

Increasing children's enrolment

Increasing children's enrolment in pre-school, primary and secondary schools can help prevent violence against children in LMICs. For example, an intervention in Zimbabwe provided school support to orphaned girls. Its experimental evaluation showed that those receiving fees, school supplies, uniforms, and supplies for health and hygiene, saw a reduction in school dropout by 82% and a reduction in early marriage by 63% (Hallfors et al. cited in Butchard & Hillis 2016: 68).

Establishing a safe and enabling school environment

Establishing a safe and enabling school environment has been demonstrably effective in LMICs. Some interventions focus on **preventing violence by adults**. Ugandan NGO, Raising Voices, developed the 'Good School Toolkit'. It aims to reduce violence from school staff against children aged 11–14, "by building a positive school environment and positive relationships between students, their peers and authority figures" (Butchard & Hillis 2016: 68). A randomised test of the toolkit in 42 schools in a Ugandan district found it to be effective in reducing this violence. Further, 434 children could be referred to child protective services due to what they disclosed in the survey. There were no adverse effects detected from the intervention (Devries et al. cited in Butchard & Hillis 2016: 68). In Colombia, a similarly comprehensive approach was implemented as part of the programme called 'Classrooms in Peace'. A 2007 preliminary study found that it had led to significant reductions in violence and aggressive behaviours (Chaux cited in Butchard & Hillis 2016: 68).

Some interventions focus on **preventing violence by children, among peers**. In several countries, UNICEF and civil society groups have launched a large-scale programme to create safe and enabling school environments following very positive results against peer violence (e.g. bullying) in Croatia. The Violence Free School programmes have started in Bulgaria, Kazakhstan, Montenegro, Serbia and Slovenia (Butchard & Hillis 2016: 69).

Other interventions focus on **building up adults' capacities to support children**. In Zambia, schools had been poor at meeting the needs of orphaned and vulnerable children for psychosocial support. This led to the development of a teachers' diploma on psychosocial care, support and protection. This 15-month distance education programme gives teachers the knowledge and skills needed for three purposes. The first is to enhance school environments: improving relationships among teachers and between teachers and students, and enriching school environments so they are safe and equitable. The second purpose is to foster psychosocial support, both for teachers' well-being and self-care, and for students' well-being. The third is to facilitate stronger and more positive relationships between schools and their communities. A 2013–2014 medium-scale randomised controlled trial found the programme to be effective (Kaljee et al. cited in Butchard & Hillis 2016: 70). Students' perceptions regarding respect in schools, school safety, and students' "willingness to seek help for and respond to sexual abuse" improved (Butchard & Hillis

[12] In addition, for a discussion parent support to buffer the effects of poverty in LMICs, see: Ward et al. (2016).

2016: 70). Students were less involved in physical and emotional bullying. Teachers' emotional self-care increased, and their perceptions of classroom and school safety improved (Kaljee et al. cited in Butchard & Hillis 2016: 70). [13]

Preventing violence among adolescent intimate partners

The **Stepping Stones programme,** originally developed to prevent HIV infections, offers trainings in life skills. It has been implemented in a variety of LMICs worldwide, and evaluated rigorously. [14] It has successfully curbed physical and sexual violence among male and female intimate partners who are 15-26 years old. The programme "encourages participants to reflect on their attitudes and behaviour through role-play and drama", to improve sexual health through stronger, more equal relationships between partners (Butchard & Hillis 2016: 73). It addresses gender-based violence, communication about HIV, and skills and assertiveness for relationships (Butchard & Hillis 2016: 73).

Evaluations of the programme have taken place in multiple LMICs. The most thorough study is a randomised controlled trial in the mid-2000s that involved female and male participants aged 15-26 in Eastern Cape Province, South Africa. In the two years following the intervention, boys and men reduced their violent and exploitative behaviour. Compared with baseline, participants were involved in fewer incidents of intimate partner violence, rape, and transactional sex (Dunkle et al.; Jewkes et al.; cited in Butchard & Hillis 2016: 73).

Smaller-scale evaluations of Stepping Stones in South Africa and the Gambia, published in the late 1990s and 2000s, have shown a reduction in male perpetration of intimate partner violence (Jewkes et al.; Shaw; cited in Butchard & Hillis 2016: 73). One study on South Africa found that the rate of violent behaviour continued to fall among men 24 months after the intervention, suggesting that positive change strengthened over time. Attitudes shifted, particularly among young men, through educating them on reducing their risk of HIV and encouraging much greater openness in talking about HIV. In the process, the programme instilled "general life skills that made many of the men better partners, friends, family members and citizens" (Butchard & Hillis 2016: 73, summarising Jewkes et al.).

Improving children's knowledge on protection from sexual abuse

Evidence and practice have been promising but limited in the area of improving children's knowledge about how to protect themselves from sexual abuse, including in LMICs. Most of the programmes in this area that have been evaluated to date are delivered in schools. They typically teach children about body ownership, good and bad touch, and how to recognise abuse, say no, and disclose abuse to a trusted adult. Many reviews have found such interventions to strengthen protective factors (e.g. knowledge of sexual abuse and protective behaviours). However, existing research and practice have a number of gaps. It is unclear so far whether the interventions have reduced actual sexual abuse (Mikton & Butchart cited in Butchard & Hillis 2016: 70). Interventions have not recognised the important role of gender and social norms in perpetration. They also need a "whole of school" approach. This involves, for instance, having inclusive and equitable school policies and protocols, engaging school leadership, and using teaching that is sensitive to social norms and inequalities, including on gender (UNICEF cited in Butchard & Hillis 2016: 70).

In Nairobi, Kenya, a programme ('No Means No' IMpower) improves adolescent girls' self-esteem and teaches them self-defence, in order to reduce their risk of sexual violence. A review found that it

[13] For an evaluation of Evaluation of a Child-Friendly School Project conducted in 2003-2006 in 190 schools in the oPt, see: OPTIMUM (2012).
[14] See the Stepping Stones website: http://www.steppingstonesfeedback.org/

significantly increased participants' likelihood of disclosure of sexual violence (+34%), and was associated with an annual decline in sexual assault rates of 38% (Population Council; Sarnquist et al.; both cited in Butchard & Hillis 2016: 70). Butchard and Hillis recommend that using this programme in other contexts includes strong evaluation, to ensure that adaptations are both safe and effective (2016: 70).

Child-friendly spaces in short or protracted emergencies

International humanitarian actors have widely used Child-Friendly Spaces (CFS) to protect children and provide them psychosocial support in short-term and protracted emergencies. However, little evidence documents their outcomes and impacts. To address this, World Vision and Columbia University, together with Save the Children, UNICEF and others, documented the outcomes and impacts of six CFS these agencies used between 2012 and 2014 in five countries in sub-Saharan Africa and the Middle East. (Metzler et al. 2015b: 4). [15]

As part of the project, a systematic review analysed the published and grey literature from the last 15 years on CFS or equivalent interventions in emergency contexts. It examined findings about outcomes or impacts on child protection, psychosocial well-being, and community mobilisation. Just ten studies met inclusion criteria. All ten documented positive outcomes, particularly for children's social and emotional well-being. However, most studies lacked components deemed important to a rigorous evaluation: only three studies used pre-intervention baselines, and only two used comparison groups. This makes it difficult to robustly confirm change over time and to attribute any change to CFS (Ager et al. 2013).

The project then conducted a series of rigorous impact evaluations of CFS, using cluster randomised sampling and mixed methods. Overall, the impact of CFS is often small, although it has been substantial in a few cases. Two sets of factors seem to determine impact:

i. Programming quality, including the nature and intensity of the activities in CFS, the relationships between facilitators and children, and the rigorous evaluation of interventions and use of evidence. CFS failed to programme for all age groups among children. All studies found greater attendance and stronger impacts for younger children. The current curricula and approaches to engagement did not address effectively older children's needs. Additionally, planning in collaboration with education practitioners may help support CFS in successfully linking all children to formal education systems and addressing the gap in provision that often exists following the onset of crises (Metzler et al. 2015b: 20).

ii. Fit to local circumstances (general context and specific risks for children). Some approaches are suited to isolated camps with few options for children, but seem less effective in urban environments with a broader range of opportunities. In addition, the risks children face in urban refugee settings differ profoundly from those in a camp for internally displaced persons (IDPs). This has significant implications for designing CFS (Metzler et al. 2015b: 20).

What follows are more detailed findings from the consolidated trend analysis of five studies (two studies on Iraq, and one each on Ethiopia, Jordan, and Uganda).[16] On **child protection**, the impact of CFS

[15] A series of eight impact evaluations were planned, seven could be completed, six met the inclusion criteria for inclusion in the publication, and five could be incorporated into the consolidated trend analysis (Metzler et al. 2015b: 7-13). The eight studies on the Middle East: Domiz Refugee Camp, Iraq (two studies); Zarqa, Jordan; Nabatieh, Lebanon (the study did not meet inclusion criteria due to constraints in implementation); and Azraq Refugee Camp, Jordan (due to migration out of the camp, endline data collection was not feasible).
The three studies on sub-Saharan Africa: Buramino Refugee Camp, Ethiopia; Rwamwanja Resettlement Centre, Uganda; Goma IDP camps, Eastern Democratic Republic of the Congo [DRC] (for technical reasons, quantitative data could not be included in the consolidated trend analysis).

[16] On MENA, see: Lilley et al. (2015) and Metzler et al. (2014) on Iraq; and Metzler et al. (2015a) on Jordan.

attendance was positive but very small. The weighted average effect size was only 0.09 from all indicators, and 0.08 when using only the most rigorous indicators of impact. Given the confidence intervals obtained, the small differences observed could be due to chance. However, a number of measures and sites suggest that CFS had some positive impact on protection outcomes (Metzler et al. 2015b: 16).

The variation in outcomes is linked to two major factors: setting, with substantial variation across sites, and gender. In Ethiopia, the impact score was highest among the sites, and perceptions of protection risks saw a major reduction. On the other hand, in Iraq, the impact score was negative: travelling to the CFS presented protection challenges. Whether CFS can increase protection for children therefore seems highly dependent upon the setting. Overall, protection impacts were much stronger for girls (0.18 in weighted average impact) than for boys (0.04). Other factors such as participants' age and the quality of programming did not measurably affect protection scores (Metzler et al. 2015b: 16).

On **community capacities,** the impact of CFS was very small. This refers to communities' knowledge about resources, services, and reporting mechanisms to protect, support, and care for children. Again, there were substantial variations in impacts, ranging from negative to positive. One important factor associated with variations was the setting, but the trends are difficult to interpret. In any case, evaluations did not widely find strong change between baseline and endline for all children in the studies. Another important factor was age: children not attending CFS seemed to actually have greater knowledge on child protection than those attending. This suggests that the CFS generally failed to engage with older children in a way that strengthened broader capacities in the community. Lastly, factors such as the quality of programming had no clear influence on scores (Metzler et al. 2015b: 18).

On **children's psychosocial well-being**, across studies, the impact of CFS attendance was generally positive. Trends across all measures and all sites suggest that CFS typically had a small but robust impact on psychosocial well-being, even as the confidence intervals obtained mean that the impact could be due to chance. However, there was considerable variation in scores, for several probable reasons: (i) meeting established criteria for quality may be important to effectiveness: one of the strongest impacts across all studies came from those CFS in Uganda that had achieved higher scores on quality standards; (ii) there was generally a greater improvement in psychosocial well-being in younger children, with poorer attendance and engagement of older children; (iii) there was a greater impact for younger girls than younger boys (although this varies across sites, potentially due to different focuses and implementations in programmes); and (iv) those CFS programmes that focused on psychosocial activities had a more positive impact in that matter than those with a different emphasis, such as functional literacy and numeracy (Metzler et al. 2015b: 14).

5. Prevention through larger programmes

Some programmes focus on **strengthening families' economic situation and income**, to improve their economic security and stability, and to reduce child maltreatment and intimate partner violence. Promising approaches include cash transfers, and programmes that integrate training on gender equity with community groups for savings and loans, or with microfinance (Butchard & Hillis 2016: 54, 56).

Cash transfers

Evidence-based INSPIRE package

In LMICs, some cash transfers are **provided to women or families in conjunction with another intervention, such as parent training**. Several studies have shown that such combined approaches have improved parental monitoring, and reduced child maltreatment. They have also increased the pro-social behaviour of children – especially adolescent boys – so that their behaviour is positive and helpful, and promotes "social acceptance and friendship among adolescent boys" (Butchard & Hillis 2016: 56). Cash transfers in LMICs have also helped to keep girls and boys in school, and to reduce intimate partner violence witnessed by children. In turn, this can reduce children's likelihood of becoming victims or perpetrators of violence (Butchard & Hillis 2016: 56).

For example, the Transfer Project's impact evaluations show that large, government-run social transfers of cash have had a positive impact on well-being, economic situation, and child protection, in eight African countries. This is because such cash transfers have directly addressed structural factors, such as poverty and barriers to education, and have indirectly reduced gender inequality. As a result, cash transfers can "reduce the risk of sexual abuse and exploitation among children and youth" (Butchard & Hillis 2016: 57). For example, impact evaluations show that cash transfers have helped reduce child sexual abuse and exploitation in Kenya, Malawi, Tanzania, Zambia, and Zimbabwe. Emerging evidence suggests that Zimbabwe's social cash transfer reduced the likelihood of forced sex among youth, while Malawi's delayed sexual debut among youth. The work done by the Transfer Project is linked to government action, and informs how national programmes are designed (Butchard & Hillis 2016: 57).

In Mexico, the government's conditional cash transfers to families led to improvements in several factors that protect against youth violence, such as increases in school enrolment and total years of schooling, and decreases in school dropout and alcohol consumption (Bobonis & Castro cited in Butchard & Hillis 2016: 56).

However, there is also evidence that, without complementary social or behavioural interventions, cash transfers for girls **may increase these girls' risk of sexual harassment**. In Uganda, girls who had a savings account did increase their economic assets. But they were also more likely to have been sexually touched and harassed by men (Austrian & Muthengi cited in Butchard & Hillis 2016: 56). This suggests that building up girls' economic assets must be accompanied by a simultaneous strengthening of their social resources, such as social networks and knowledge about reproductive health, to protect girls from increased risk of sexual violence (Butchard & Hillis 2016: 56).

Review of impact evaluations commissioned by UNICEF

UNICEF commissioned a review in 2014 to analyse the effects of social transfers in LMICs on child protection outcomes. It examines a database with 79 impact evaluations in 28 LMICs, covering 45 medium- and large-scale programmes of social transfer to families in poverty (Barrientos et al. 2014: 105). The analysis finds **important linkages** between social transfers and risks and outcomes in child

protection. Three features suggest there are growing linkages with child protection: large-scale programmes with a significant reach; a child focus; and multi-dimensional approaches to reducing poverty. A systems approach to child protection extends such linkages, shifting the focus from individual harm (violence, abuse, child labour, trafficking) to a protective environment that addresses risks and minimises children's vulnerabilities. Three main channels can connect social transfers to risks and outcomes in child protection (Barrientos et al. 2014: 111).

Firstly, **where social transfers have explicit objectives of child protection**, direct effects are normally reported in impact evaluations. In that regard, social transfers can **generate positive, but also negative, direct effects on outcomes and risks in child protection**. There is strong evidence that children's participation in social transfers has direct positive effects on their schooling, health, and nutrition. Social transfers also have a number of other direct effects. They encourage birth registration through eligibility requirements. In child-focused programmes of social transfers, birth registration is a requirement for participation. It is also an outcome of support for, and conditions on, expectant mothers. Child-focused social transfers are also generally effective at reducing child labour. However, they can also simply lead to compensatory changes in adult labour or in children's free time, which could reduce the size of this effect. In addition, social transfers have, in some cases, facilitated parental care through an improvement in household resources which reduces family separation. However, in other cases, they have facilitated the labour migration of adults and children of secondary school age. Lastly, child-focused social transfers with schooling conditions reduce child marriage - most strongly where financial incentives maximise children's stay in school (Barrientos et al. 2014: 111).

In a number of situations, social transfers have generated direct negative effects for child protection. This can be the case with programmes transferring asset accumulation that require adult labour, such as public works and workfare. If the associated child care is inadequate, they lead to negative effects on child labour and informal care. The database of impact evaluations used for the review did not capture other negative effects on child protection, but this does not mean that no further effects exist. The evaluations focused primarily on the explicit objectives of programmes. However, many social transfers lack explicit objectives of child protection (Barrientos et al. 2014: 111).

Secondly, **some linkages between social transfers and child protection are mediated by poverty**. In particular, some changes in risks and outcomes for child protection stem from changes in poverty and exclusion that result from social transfers: "There is strong evidence that social transfers reduce poverty and exclusion" (Barrientos et al. 2014: 111). However, there is only weak research on the effects that poverty and poverty reduction may have on outcomes in child protection in LMICs. Longitudinal data from HICs on this topic suggests that poverty-mediated effects can be especially large in LMICs on child marriage, birth registration, and child labour, but less so on violence and abuse. Further research is needed to reach reliable conclusions (Barrientos et al. 2014: 111-112).

Thirdly, linkages between social transfers and child protection can stem from **significant synergies between the implementation of social transfers and the work of child protection agencies** (Barrientos et al. 2014: 111). Yet, implementation synergies remain under-researched. The introduction of social transfers in LMICs is driving innovations that have "implications for the effectiveness of child protection services" (Barrientos et al. 2014: 112). These innovations include the "unified registration of the population accessing support from public agencies, monitoring and evaluation, referral systems, and household ranking according to socio-economic status" (Barrientos et al. 2014: 112). These innovations improve the information that public agencies can have, and facilitate coordination between agencies (Barrientos et al. 2014: 112).

Research on implementation synergies is a highly promising area for knowledge and practise. The growing institutionalisation of social transfers in middle-income countries is an opportunity for common

practise in social transfers and child protection. Exploring practises of case management in social transfers and child protection is also likely to be productive (Barrientos et al. 2014: 112).

Including objectives of human development and child protection in programmes of social transfer is more important to outcomes of child protection than the design of these programmes. Pure transfers of income, transfers combined with asset accumulation, and integrated programmes against poverty all show effects on child protection. The linkages to child protection are stronger and deeper where objectives of human development and child protection are included. Public works and employment guarantees are more likely to have adverse effects on parental care, which harm child protection. This means that social transfers should be designed and implemented to prevent potentially adverse effects on child protection. It also raises the question of whether all social transfers should integrate objectives of human development (Barrientos et al. 2014: 112). [17]

Study of Palestinian National Cash Transfer Programme in Gaza

Mixed-methods primary research conducted in 2013 examined the effects of the Palestinian National Cash Transfer (PNCT) on children's right to protection from exploitation, abuse and neglect in Gaza. The PNCT provides quarterly payments to extremely poor households (Abu-Hamad, Jones & Pereznieto 2014: 121). Overall, the study found that the PNCTP **supported households in coping with economic hardship and meeting basic needs**, such as purchasing more nutritional food, paying some costs related to school and health, and contributing to debt repayment, which has been a major source of stress (Abu-Hamad, Jones & Pereznieto 2014: 133-134). Children and adult beneficiaries emphasised that they would be worse off without the transfers, and most parents were more hopeful about their children's future thanks to the transfers (Abu-Hamad, Jones & Pereznieto 2014: 134).

However, the PNCT was **not designed to address children's specific needs**. While some of these were met through the economic support to households, many other needs were not. This gap was particularly acute for problems of inadequate care, violence, or psychosocial challenges. These issues were accentuated for particularly vulnerable children, including those with disabilities (Abu-Hamad, Jones & Pereznieto 2014: 134).

Based on their findings, the research authors **recommend strengthening the PNCT as part of crafting a more comprehensive strategy for child-sensitive social protection**. This would entail access to child protection services, and referrals to other support services that strengthen children's resilience and development. Integrated social protection can reinforce children's "inclusion and positive trusting relations with key adults and peers", and offer counselling or advice for those experiencing hardships in their household, school, or community (Abu-Hamad, Jones & Pereznieto 2014: 134). Those living with disabilities require specific attention. There are contact points in the PNCT where children at risk could be identified and helped (Abu-Hamad, Jones & Pereznieto 2014: 134).

High caseloads hamper social workers, constraining their time and space. It would be helpful to increase their numbers and to provide them with more child-sensitive training. This would help them respond better to children's vulnerabilities during household visits, which includes supporting caregivers. Child protection should not be an add-on to social protection in humanitarian contexts, but rather an integral component. Child-sensitive social protection could then have an optimum impact on children and on the whole population (Abu-Hamad, Jones & Pereznieto 2014: 134). In this regard, Mitri (2011) offers a useful mapping of child protection systems for Palestinian refugee children in the Middle East. The mapping

[17] For a discussion of the benefits and harms of conditional cash transfers on child abuse and neglect, also see the discussion – based entirely on a selection of secondary literature – in: Roelen (2014).

identifies gaps in interventions, factors that have hampered effectiveness (such as fragmentation), as well as strengths and points of entry.

Training on gender equality combined with savings and loans groups

In Cote d'Ivoire, a randomised controlled trial (RCT) involved running **group savings and loans in conjunction with group discussions**, involving both men and women, on equitable gender norms. It reduced past-year physical intimate partner violence by over 50 per cent among women who had participated with their male partners in more than 75 per cent of the sessions, compared to women participating only in the group savings. Such reductions are likely to decrease children's exposure to domestic violence, an important risk factor for subsequent involvement in victimisation or perpetration. However, the programme had no effect for child brides – it significantly reduced violence only for women who had married as adults. This calls for careful consideration of the risk of violence in specific groups before proceeding with such interventions (Gupta et al. & Falb et al. cited in Butchard & Hillis 2016: 58).

Training on gender equality combined with microfinance

In rural South Africa, the IMAGE (Intervention with Microfinance for Aids and Gender Equity) programme combined microfinance with education on gender norms, domestic violence, sexuality, and HIV. Several experimental evaluations showed a 50 per cent reduction in participating women's exposure to physical or sexual violence compared to a control group (Butchard & Hillis 2016: 58).

In Afghanistan and Uganda, the Empowerment and Livelihood for Adolescents (ELA) programme has offered adolescent and young girls aged mentorship, life skills, and training in microfinance. It combines life and livelihood skills, so that social and financial empowerments reinforce each other. Peer mentors lead trainings through adolescent clubs, rather than in schools, to reach students as well as dropouts. The clubs offer spaces where girls can discuss problems in small groups and build their social networks away from family and male-centred society. Rigorous tests of ELA demonstrate its positive impact for participating girls. For example, in 2014, a World Bank evaluation of ELA in Uganda found that participants, compared to non-participants, had better situations in terms of reports of having unwanted sex (-50%), early entry into marriage or cohabitation (-58%), teen pregnancy rates (-26%), condom use (+28%), and engagement in income-generating activities (+72%), almost entirely in self-employment. Notably, participants showed no reduction in school enrolment. In fact, participants who had previously dropped out were more likely to want to re-enrol (Butchard & Hillis 2016: 59).

6. State of knowledge and knowledge gaps

Limited size of the knowledge base

There is consensus in the literature that there a limited body of rigorous knowledge on the primary and secondary prevention of violations of child protection in low- or middle-income countries (LMICs), whereas there is substantial knowledge about this on high-income countries (HICs). All the literature reviews identified for this report – whether meta-reviews or systematic reviews – come to the same conclusions about the small number of relevant studies available from academic, practitioner and policy sources. For example, a 2013 systematic search of studies published between 1995 and 2011 on the prevention of child abuse in LMICs identified only one relevant study (Skeen & Tomlinson 2013). Similarly, a 2009 meta-review on the prevention of child maltreatment identified only two studies about LMICs out of 298 studies in 26 reviews (Mikton and Butchart cited in Knerr, Gardner & Cluver 2013: 353). The

limited size of the evidence knowledge on LMICs applies not only to academic literature but also to rigorous practitioner and policy works, on both long-term and emergency action. In particular, many evaluations document the activities, outputs and outcomes of programmes to prevent violations of child protection, but very few document and demonstrate larger results and impact (see this noted e.g. in Ager et al. 2013; Butchard & Hillis 2016: 81; Metzler et al. 2015b: 4-5).

Over the past 10 years, academics and others have increasingly conducted research into the primary and secondary prevention of child protection violations in LMICs, particularly under the impetus of international agencies in the UN system, such as the WHO (for a recent state of the art, see e.g. Butchard & Hillis 2016; also see: Hughes et al. 2014). Nonetheless, there is a consensus in the literature that the number and growth in publications about LMICs on the topic have still remained limited, especially given the scale of the problem and the acute need for prioritising and using proven interventions with scarce resources (Butchard & Hillis 2016: 81).

A 2014 systematic review examined all outcome evaluations on programmes to prevent interpersonal or self-directed violence published in 2007-2013, whichever age group or other population group was targeted. The review identified 355 relevant articles globally that reported outcomes measuring violence or closely related risk factors, but only 9.3 per cent of all studies (n = 33) had been conducted in LMICs. There was no indication that numbers were increasing: between 2007 and 2013, the number of these studies was 5, 2, 7, 5, 3, 6, and 5 respectively. This is despite over 85 per cent of violent deaths occurring in LMICs and global calls for research in LMICs. This 10 per cent to 90 per cent research gap between LMICs and HICs is found on other health issues. Very few studies related to LMICs, as opposed to HICs: just 7.9 per cent of all studies on child maltreatment (three studies), 6.4 per cent of those on youth violence (13 studies), alongside 20 per cent of the studies on interpersonal violence, 21.1 per cent on sexual violence, and 9.1% on self-directed violence (Hughes et al. 2014).

Mixed findings on the rigour of knowledge

The available knowledge base, taken as a whole, presents a number of strengths. First, the methods used include quantitative, qualitative, and mixed-methods studies, with a range of individual methods used. Second, it was possible to identify and select a number of references that did meet high standards of rigour, from systematic reviews and meta-reviews to randomised control trials to well-designed single- or multi-case studies, be they quantitative or qualitative. Overall, rigorous evidence comes from a fairly balanced mix of reviews, multi-case studies, and single-case studies. Due to the time constraints of helpdesk reports, this report prioritised the selection of two sets of studies: multi-country studies that strongly consider evidence about LMICs; and single- or multi-country studies about the MENA that might be applicable to the Gaza Strip. Thirdly, the sources of rigorous knowledge available were diverse. They spanned academic, practitioner, and policy literature, and the individuals and institutions involved were diverse (though a few UN agencies, such as the WHO and UNICEF, do play an important role in commissioning research on child protection). All this strengthens the robustness of findings from individual references and triangulation between them.

However, there are also a number of problems with the rigour of available knowledge. Causality and attribution are difficult to demonstrate on child protection. In this regard, the research for this report considered evidence on both direct causalities (from intervention to the prevention of child protection violations) and indirect causalities. On the latter, the report considered evidence that interventions had had an effect on intermediate variables that are proven to significantly affect prevention, such as parenting practices or community care and support networks for girls and boys.

Regardless of what causalities were considered, this rapid review found that the rigour of available knowledge on LMICs was very variable. All the reviews of literature – whether meta-reviews or systematic reviews – come to similar conclusions: the number of relevant studies is low, and the number of rigorous studies among these is even lower. While the references used in this helpdesk report do meet high standards of methodological rigour, the studies that these references examine or build on rarely do.

Most available studies have a number of weaknesses when assessed by standards deemed important in all quantitative approaches and in some qualitative approaches. [18] In particular, many studies have small sample sizes, including a number of studies with quantitative aspects where small sample sizes actually preclude having robust statistical significance and size effect. The effects of interventions are often assessed in the very short term – immediately after the end of an intervention, or a few days, weeks, or months afterwards –, with very few longer-term longitudinal studies. Many studies also lack a baseline and/or a comparison group. In addition, the 2014 systematic review of 2007-2013 outcome evaluations on the prevention of interpersonal or self-directed violence notes that only 15.2 per cent of the 33 studies this review found on LMICs could see their quality rated as high (Hughes et al. 2014: 660). Most of the references this review identified showed positive outcomes. Among evaluations on LMICs, 78.8 per cent reported positive effects of the intervention, 91.1 per cent mixed effects, 1 per cent no effect, and no evaluation reported negative findings (Hughes et al. 2014: 660). This "suggests publication bias and conflicts somewhat with findings from various systematic reviews on violence prevention" (Hughes et al. 2014: 661).

Many studies also rely on self-reported results from primary caregivers, teachers, or children. This can be useful on some indicators and on large-scale population surveys, but also creates a number of weaknesses and biases for other studies. Few studies rely on third-party observation of behaviour, as a complement or alternative to self-reporting, even though many studies note that this can be a much better method on indicators such as parent-child interaction. For example, the systematic review of parenting interventions in LMICs found that only two of its 12 included studies had reported data from validated direct observational methods, even though these are the gold standard for measuring parenting (Gardner cited in Knerr, Gardner & Cluver 2013: 356). At the same time, some evaluations of programmes may not have involved children meaningfully (Ager et al. 2013: 143-144).

Uneven coverage with significant geographic and thematic gaps

Available knowledge offers an uneven, though generally fair, coverage of LMICs and relevant themes. Geographically, findings are available from all major world regions where LMICs are located, though some countries are the focus of noticeably more research (e.g. South Africa) and others are not covered. Further, the 2014 systematic review of 2007-2013 outcome evaluations on the prevention of interpersonal or self-directed violence found that studies from LMICs, taken all together, revealed a wide variation of thematic priorities between regions. For example, six of the eight studies in sub-Saharan Africa examined interpersonal violence or sexual violence within HIV prevention – and these studies were all in South Africa. Conversely, in LMICs in the Americas, four studies focused on youth violence, one on violence by firearms, and one on alcohol-related violence (Hughes et al. 2014).

On the oPt, the overwhelming majority of references are about 'tertiary prevention', i.e. supporting children after violations have occurred (by Israeli or Palestinian actors) and seeking to avoid their

[18] These points were observed by the report writer based on her rapid review of the literature. They are mentioned as well in a number of meta-reviews and systematic reviews, such as: Ager et al. (2013); Knerr, Gardner & Cluver (2013: 360); Maalouf & Campello (2014).

repetition. On primary and secondary prevention, a significant segment of the literature is about high-level advocacy towards Israel as the occupying power, and towards the Palestinian Authority (PA) and Hamas. The remaining body of literature on other types of primary and secondary prevention is limited. Within it, most references examine emergency humanitarian responses in the aftermath of specific spikes in direct violence by Israel, such as wars on Gaza. This leaves limited literature on sustained preventive interventions, be they community-based or part of formal government systems in Gaza, Jerusalem, or the West Bank.

Thematically, some topics or interventions have been slightly better researched, but many issues and interventions remain under-researched or not researched at all. For example, the 2014 systematic review of 2007-2013 outcome evaluations on the prevention of interpersonal or self-directed violence identified only three studies on the prevention of self-directed violence in LMICs, even though such violence accounts for over half of all violent deaths worldwide with around 80 percent in LMICs. Similarly, of the three evaluations of interventions against child maltreatment in LMICs, two were school interventions on children's self-protection from sexual abuse, and one was a parenting programme (Hughes et al. 2014). On the other hand, early-life interventions for parenting skills and parent-child bonding – which have among the strongest evidence in HICs – rarely provide outcome measurements on violence (Knerr, Gardner & Cluver 2013).

In a context where research on transferring and adapting interventions from HICs to LMICs remains needed, only 24.2 per cent of LMICs studies (n = 8) had evaluated established interventions, compared to 48.4 per cent in HICs (Hughes et al. 2014). In addition, there seem to be limited cost-effectiveness studies, evaluations on scaling up and sustaining effective programmes, and evaluations on the combined impact of coordinated implementation of multi-sectoral interventions (as hinted at in Butchard & Hillis 2016: 81).

Importantly, very few studies disaggregate findings by socio-economic groups or analyse the implications and interplay of inequalities, thus failing to address **structures of inequalities.** This problem applies to inequalities including socio-economic class, gender, and age, and even more acutely to caste, ethnicity, disability, and migration status. For example, a systematic review of parenting interventions notes that the poverty levels of study participants are often not reported, even though country-level classifications into low- or middle-income hide significant variations within countries. Interventions for children over two years old are also under-researched, thus precluding assessment of outcomes in child behaviour (Knerr, Gardner & Cluver 2013: 360).

The issue of gender shows that there are multiple problems in the way structure of inequalities are treated in the literature. In many references, gender is simply not considered, and no disaggregated data is collected. For example, a multi-site UNODC study acknowledges that the projects involved simply failed to consider gender in outcomes (Maalouf & Campello 2014). This leads to a lack of consistent analysis of, and action on, the needs and wishes of both girls and boys in the prevention of child protection violation (see e.g. Metzler et al. 2015b: 16). Further, when gender is discussed, it is often conflated with 'women and girls'. Many studies pay no attention to gendered power relations other than violence against girls, ignoring gender issues among adults and children as unpaid care labour. For example, extremely few studies consider how the gender of children, parents, and other adults affects the interventions and their effects. This is despite evidence of gender inequalities within interventions themselves (e.g. mothers' greater volunteering to interventions for parenting skills, in Maalouf & Campello 2014; strong gender dimensions in issues of child protection in Gaza, in Abu-Hamad, Jones & Pereznieto 2014).

Consistency and robustness of findings

Overall, there are many areas of agreement in the literature on the state of knowledge, its rigour, and key findings. However, there are some findings of mixed impact of certain interventions on child protection (e.g. on cash transfers). There are also some contradictory findings and ongoing debates between studies. A major example is the questions of whether and how interventions can be transposed between HICs and LMICs, among LMICs, from non-humanitarian to humanitarian contexts, and to the settler-colonial context of the oPt specifically (see section 2).

As for robustness, many, though not all, findings manage to demonstrate causalities, not just correlations, despite the methodological difficulties. Considering the overall rigour and consistency of the evidence, those findings with a strong and consistent evidence base can be deemed conclusive (e.g. on several parenting interventions). On the other hand, many findings remain indicative, though promising.

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Key websites

Academic websites:

- *Aggression and Violent Behavior* – Special issue – Violence and Health: Current Perspectives from the World Health Organization (WHO) Violence Prevention Alliance (November–December 2014, 19(6), 609-738): http://www.sciencedirect.com/science/journal/13591789/19/6
- *Child Abuse & Neglect: The International Journal* - Issues: http://www.sciencedirect.com/science/journal/01452134
- *Children & Society* (academic journal): http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1099-0860/issues
- *Children & Youth Services Review* – Special issue on Economic Dimensions of Child Protection and Well-being (December 2014, 47, Part 2): http://www.sciencedirect.com/science/journal/01907409/47/supp/P2
- Cochrane Database of Systematic Reviews – Child health: http://www.cochranelibrary.com/topic/Child%20health/
- The Campbell Collaboration [systematic reviews of the effects of interventions in crime & justice, education, international development, and social welfare] – Library – Systematic reviews: http://www.campbellcollaboration.org/the_campbell_library/
- Institute of Community and Public Health, Birzeit University (Palestine) - Publications: http://icph.birzeit.edu/research/publications

Practitioner and policy websites:

- Child Protection Monitoring and Evaluation Reference Group: http://www.cpmerg.org/
- Child Protection Working Group (CPWG): http://cpwg.net/
- Child Rights International Network (CRIN) – Library – Publications: https://www.crin.org/en/library/custom-search-publications?promo=1&search_api_language=current
- Children and Violence Evaluation Challenge Fund: http://www.evaluationchallenge.org/
- Defence for Children International – Publications: http://www.defenceforchildren.org/resources-list/publications/
- Global Initiative to End All Corporal Punishment of Children – Research: http://www.endcorporalpunishment.org/research/
- Global Protection Cluster - Child Protection Working Group (on child protection in humanitarian action): http://cpwg.net/
- International Society for Prevention of Child Abuse and Neglect (ISPCAN): http://www.ispcan.org/
- ODI - Strengthening links between poverty reduction strategies and child protection initiatives: https://www.odi.org/projects/2594-strengthening-links-between-poverty-reduction-strategies-child-protection-initiatives
- PLAN International - Research, Policy & Insight – Publications – Child protection: https://plan-international.org/publications?field_priority_areas_tid=60&field_tags_tid=All&field_publication_type_tid=All&term_node_tid_depth=All&field_publishing_office_tid_entityreference_filter=103
- Save the Children's resource centre – Child protection: http://resourcecentre.savethechildren.se/our-thematic-areas/child-protection
- Sexual Violence Research Initiative – Publications: http://www.svri.org/documents/svri-publications

- UNICEF – Evaluations - Child Protection-Violence and Abuse: http://www.unicef.org/evaldatabase/index_23758.html
- UNODC - Family skills training programmes in drug abuse prevention: https://www.unodc.org/unodc/en/prevention/familyskillstraining.html
- Violence Prevention (partnership between WHO, Center for Disease Control and Prevention [USA], and Centre for Public Health at Liverpool John Moores University) - Evidence base: http://www.preventviolence.info/EvidenceBase
- Women's Refugee Commission - Reports: https://www.womensrefugeecommission.org/resources
- WHO – Prevention of child maltreatment: http://www.who.int/violence_injury_prevention/violence/activities/child_maltreatment/en/

Suggested citation

Combaz, E. (2016). *Primary and secondary prevention of child protection violations* (GSDRC Helpdesk Research Report 1391). Birmingham, UK: GSDRC, University of Birmingham.

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