World Vision

It takes a world
to end violence against children

It Takes Community Health Workers to End Violence Against Children

Summary of new research findings by World Vision[1]

Introduction

Violence against children affects an estimated 1.7 billion children every year,[2] and roughly half of all children have experienced some form of emotional, physical or sexual abuse during their childhood.[3] Violence against children in all its forms (physical, sexual and emotional abuse, as well as neglect and exploitation) robs children of their human rights, dignity and future - the opportunity to fulfil their potential. Violence has a negative impact on childhood health and development, and can severely impair a child in adult life, as well.[4,5,6]

Recently, there has been increased global interest in strengthening the health sector's role in ending violence against children and evidence-based strategies have been recommended.[7,8,9] These strategies describe approaches in which community health workers (CHWs, defined in Box 1) can play a key role through educating parents, promoting caregiver skills, identifying children and families at risk, and providing community-level referrals for child protection interventions.

BOX 1: DEFINITION OF A COMMUNITY HEALTH WORKER (CHW)

CHWs are health workers based in communities (i.e. conducting outreach beyond primary health care facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours.

Source: World Health Organisation (2018). "WHO guideline on health policy and system support to optimize community health worker programmes".

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[2] "Know Violence in Childhood, Global report 2017." http://globalreport.knowviolenceinchildhood.org/global-report-2017/

[3] Hillis S, Mercy J, Amobi A, et al. "Global prevalence of past-year violence against children: a systematic review and minimum estimates." Paediatrics. 2016;137(3):e20154079. 3.

[4] World Health Organization (2016). "INSPIRE: Seven strategies to end violence against children."

[5] Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, Koss M, Marks J. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults – the adverse childhood experiences (ACE) study." American Journal of Preventive Medicine, 1998; 14(4): 245-58.

[6] Lozano R, Naghavi M, Foreman K, Lim S, Shibuya K. Aboyans V., et al. "Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study." Lancet. 2010;2012380 (9859): 2095–128.

[7] World Health Organization (2016). "Global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children."

[8] World Health Organization, United Nations Children's Fund, World Bank Group (2018). "Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential."

[9] World Health Organization (2016). INSPIRE, ibidem.

Given CHWs' proximity to communities and families, and their widespread distribution in underserved communities, they offer a promising opportunity to scale up interventions to end violence against children globally. The contributions of CHWs have been widely recognised in prior studies for their role within community-based interventions in improving social behaviour for health and nutrition. Yet, of the vast literature on CHWs' practices, there is scant global research on perceptions and practices of CHWs in preventing violence against children, and in their potential role in reducing it. Furthermore, the voices of CHWs themselves in such policy debates are rarely put forth and heard.

In the 2019 study "Understanding community health workers' perceptions and practices in preventing, detecting and responding to violence against children", World Vision interviewed 412 CHWs[10] in four countries – Bangladesh, Myanmar, Kenya and Tanzania – regarding their roles in preventing and detecting, as well as responding to all forms of violence including existing support and training, plus barriers and enablers they perceive; 55% of survey participants were female CHWs, 94% literate, with a mean age of 37 years, and an average of 9.5 years of schooling.

Key findings

1. Community health workers' perceptions of the prevalence of violence against children

In the four countries surveyed, CHWs witness violence against children at a very high rate in their work, confirming official data about the prevalence of varied forms of violence in each country (Figures 1 and 2). Overall, **76% of CHWs reported observing any form of violence against children during the course of their work,** with neglect[11] (54%), child marriage (40%), harsh physical punishment (40%), and verbal abuse (36%), as most commonly observed. Other forms of violence against children include child labour (31%), sexual violence[12] (16%), non-disciplinary physical abuse (6%), child trafficking (5%) and female circumcision[13] (5%). Abuses more frequently witnessed against girls than boys include child marriage, trafficking, and sexual violence, whilst dangerous or full-time work, physical abuse, harsh punishment and neglect were more common in boys than girls.

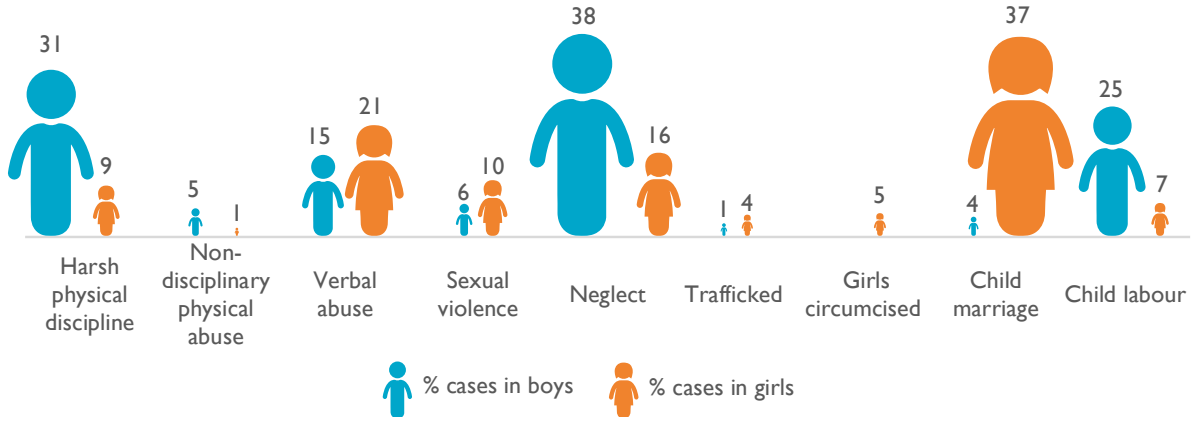
Over 74% of CHWs in the four countries studied perceived all forms of violence against children to be a "serious" or "very serious" problem for children. A generational effect was observed in the perception of severity, with younger age CHWs significantly more likely than older generation (>35 years) CHWs to consider violence against children to be serious or very serious.

2. Community health workers' responses to violence against children

Most CHWs believed their role encompasses preventing and responding to violence against children, and over 60% reported taking action after witnessing abuse. Overall, Kenyan CHWs were most likely to respond to abuse, with CHWs from Bangladesh and Myanmar less likely to respond. No differences in gender were observed.

> In our village, most parents conventionally do slapping and spanking to children as punishment. Whenever I saw such kind of parents, I explain [to] them the bad effects of it on children and usually give awareness and encourage them [in] positive parenting.
>
> **Female CHW, Baliadangi, Myanmar**

Figure 1: Frequency with which CHWs witnessed violence against children in the course of their duties in the last three months, by abuse-type and gender of the child



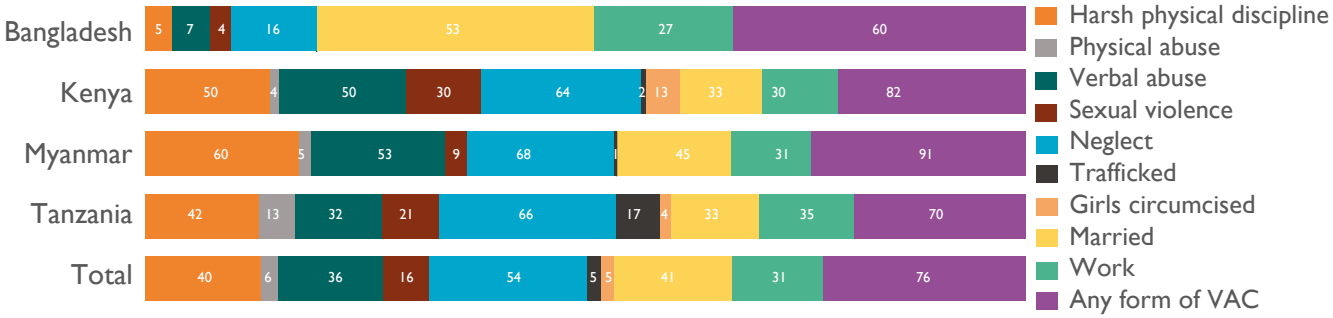
[10] This study collected quantitative data using a semi-structured questionnaire that was deployed using stratified sampling procedures in each country. The countries were purposely selected due to the presence of World Vision field offices implementing a multi-country health and nutrition programme involving CHWs.

[11] Includes not attending school, receiving insufficient food, inadequate health care, having inadequate clothing and left unattended.

[12] Includes touching, exposure, sexual assault, molestation and receiving explicit messages.

[13] CHWs' role may not formally include identifying female circumcision; thus observations are likely lower than prevalence of female circumcision.

Figure 2: Frequency with which CHWs witnessed violence against children in the course of their duties in the last three months, by country, (%)



Over 72% of CHWs reported that preventing, identifying and responding to violence against children are currently within their role as CHW, including female genital mutilation. CHWs perceived their most common role as counselling families (>85%), with less of a role treating child injuries. Similarly, CHWs consistently reported they felt capable of carrying out these roles. **CHWs reported providing violence against children-related services frequently in the last three months** (Figure 3)**, most commonly as counselling caregivers for positive parenting** (87%). Making a referral for cases of child protection, sexual or gender-based violence, and disability and treatment of child injuries were consistently low, at approximately 31%. Kenya and Tanzania had significantly higher rates of referral for child protection at 47% and 48%, respectively. Provision of services was not significantly different between male and female CHWs, or by age of CHWs.

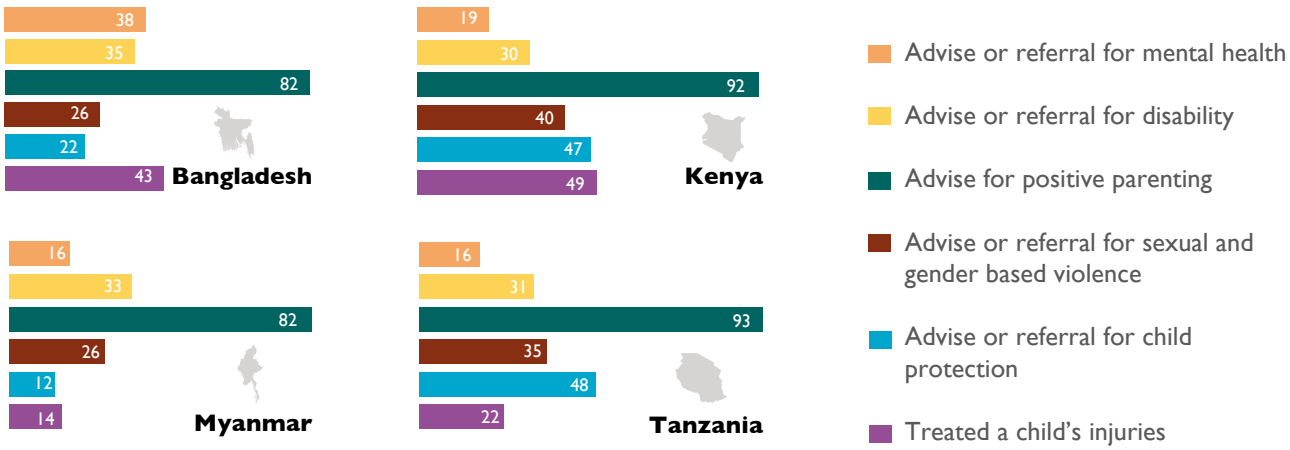
3. Support systems for community health workers dealing with violence against children

CHWs were highly motivated to receive training on violence against children-related issues, with over 54% listing violence against children topics in their top three training needs, and 58% reporting the desire to be trained on violence against children. Of the 81% of CHWs that reported receiving any training in the last 12 months, only **23% reported having any violence against children-related training in the last 12 months.**[14]

> As a community health worker, I wish I could be trained on issues regarding violence against children and gender-based violence at large, so I can be in a position to act against and prevent any violence that may arise in my community, whenever necessary.
>
> **CHW, Nshishinuru, Tanzania**

92% of CHWs reported having a supervisor, and 79% reported three or more supervisions in the last three months, but only 45% of CHWs reported having discussed a violence against children-related case with their supervisor. This suggests supervisors are under-utilised as support for violence against children issues in communities.

Figure 3: Percentage of CHWs who reported providing violence against children-related services within the last three months



[14] Relevant training topics included: child protection, early childhood development, mental health, sexual and gender-based violence.

Only 16% of CHWs identified existing child protection groups (CPGs) in their communities, of which 85% had community and civil society representatives, and only 47% of CHWs reported they are members of CPGs.

In terms of social norms and beliefs, CHWs perceived strong support for their work to end violence against children in their community, and by parents, with over 96% reporting that – within their own belief system – they felt that "God"[15] would approve of this work, and 30% listed religious leaders among those who would approve.

4. Barriers and enablers encountered by community health workers dealing with violence against children

The top three barriers reported when partaking in violence against children interventions were lack of training (56%), lack of community support (38%) and inadequate transportation (30%). By contrast, commonly reported barriers in CHW functioning[16,17] were notably low; they included lack of time or high workload (9%), lack of supervision (5%) and low motivation (3%). CHWs experienced high workloads with 73% reporting more than 10 routine tasks. CHWs mentioned insufficient training, lack of community support, and their own lack of motivation as top barriers to partaking in violence against children interventions, as well as potential non-cooperation of victims or families (22%). Personal security was a more frequently perceived barrier for violence against children work (13%) compared with other types of work, with no variation observed between male and female CHWs. Three stakeholder-types were consistently more commonly cited as most likely and least likely to approve and disapprove of CHWs' prevention and response work on violence against children. CHWs most frequently reported that community leaders (77%), government workers (59%), and parents (57%) would approve of their work to prevent violence against children. These three stakeholder-types were also most frequently identified for their disapproval of prevention work: parents (16%), community leaders (9%), and government workers (9%).

Conclusions and recommendations

> "I believe that CHWs should be involved in child protection issues in the community, as we are the ones who visit households from time to time. We are able to interact and witness any issues affecting children."
>
> **CHW, Koisungur Community Unit, Kenya**

This study by World Vision demonstrates that CHWs frequently encounter violence against children in households and throughout the course of their work. CHWs detect typically hidden forms of violence against children, potentially offering a new venue for data-collection in this arena. Whilst policy-makers may voice concerns about the burden of added tasks on CHWs with interventions to end violence against children, the study finds that most CHWs already believe that intervening on violence against children is within their role. Plus, it is a position they are capable of assuming. Moreover, when assessing service provision, in many cases, CHWs already are providing services related to violence against children. These services include educating and counselling parents, treating injured children, and making referrals, when appropriate. However, the study also showed that only a minority of CHWs received training to conduct this work on violence against children and few CHWs participated in community-based child protection structures.

The research results have implications for developing strategies to end violence against children that leverage the role of CHWs. Policy changes to strengthen their role in ending violence against children should ensure adequate support for CHWs, such as training, supervision, and safety mechanisms. Any future interventions aiming to strengthen the role of CHWs in ending violence against children must carefully consider how to lower barriers reported by workers in this survey. In particular, interventions of this kind should be complemented by efforts to increase community participation and support, plus incorporate social norms changes. There is also need to assess how CHWs might implement interventions to end violence against children with quality, considering cultural dimensions and task-shifting effects, while maintaining community trust and CHW safety. Within World Vision's work with CHWs, field testing of educational materials against child marriage received positive responses from CHWs, but only when prefaced by strong community and faith actors' engagement.[18] To expand their role to address child development and child violence, CHWs should be embedded within community-based programmes for child protection. These can improve community-led and culturally-acceptable responses to violence against children in the absence of social services. All violence against girls and boys is preventable and, as this study shows, well-designed and integrated multi-sectoral solutions involving CHWs can support its eradication.

[15] Locally translated to culturally appropriate term: God, Allah, other.
[16] Kok MC, Dieleman M, Taegtmeyer M, et al. "Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review." Health Policy Plan. 2014;30(9):1207–1227. doi:10.1093/heapol/czu126.
[17] Perry HB, Sacks E, Schleiff M, et al. "Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 6. strategies used by effective projects." *J Glob Health*. 2017;7(1):010906. doi:10.7189/jogh.07.010906.
[18] Examples included World Vision's partnership with Ministry of Health of Mauritania, and contractual accord with the Council of Imams to end child marriage; field testing in Sudan proved more problematic as Imams had not reached an accord on child marriage, so World Vision continues to work at that level rather than introduce messages in households.