EDC's Health and Human Development Division

Preventing Violence *in* Schools:

An international perspective and the role of Health and Family Life Education (HFLE) in the Caribbean

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I. Introduction

Distinguished Ladies and Gentlemen,

I am very happy to be here with you today in Barbados—a culture, land, and people I truly love. My talk today addresses four key issues:

- We as educators must address violence in our own lives first, enabling us to deal with violence in our schools, with our students, and with their families.
- What does research tell us about international and regional trends?
- What does research tell us about effective strategies for schools?
- What is the role of Health and Family Life Education (HFLE) in violence prevention? What can we learn from the recent Caribbean study?

The perspectives I share today come from my early years as a teacher in Montreal and my many ongoing years at Education Development Center (EDC). EDC is an international, nonprofit organization that conducts research and develops innovative programs to address issues in health, education, and economic development worldwide. We have 1,300 staff in over 30 countries. I am very happy to say that Arlene Husbands from Barbados leads our office here for the Caribbean.

I direct the division of EDC dedicated to healthy human development. Since 1985, violence prevention has been one of the major public health issues we have tackled—especially violence prevention in and through schools—working with the World Health Organization (WHO) and other partners. Our work began with Dr. Deborah Prothrow-Stith, a physician. When doing her medical residency at Harvard, she stitched up a young man in the emergency room one night. He warned her not to go to bed because he was going to go back out on the street to "get the guy who did it." She would then have to tend to that man. Dr. Prothrow-Stith marveled that for a patient planning suicide, protocol would have required her to admit him to the hospital, but not so for a person planning violence.

Moved by homicide rates in the United States seven times higher among young Black men than among young Caucasian men, she worked with us for more than a decade to create and evaluate innovative violence prevention programs for schools. Today, EDC is involved in many different violence prevention efforts and has many resources to share with educators (see Resources at the end of this paper). For example, in the United States, we provide training and technical assistance to hundreds of schools that have received funding after the Columbine incident, to address issues of mental health, violence, and substance abuse in countries worldwide.

EDC works with Education International (global teachers' union) to design and deliver a curriculum to prevent gender-based violence.

Let us begin by asking about our personal experience with violence, as it inevitably affects what we will do with students. Through EDC projects, I have seen firsthand how educators and health care providers need an opportunity to address what has happened in their own lives and to process any remaining trauma. Workers without that opportunity often find it difficult to address violence with their students or patients. I would estimate that at least one-third of you in this audience have had some personal experience with one or another form of violence: physical, sexual, verbal, or emotional. The United Nations World Report on Violence Against Children adopted the definition of violence introduced in Article 19 of the Convention of the Rights of the Child: "all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" (quoted in Pinheiro, 2006).

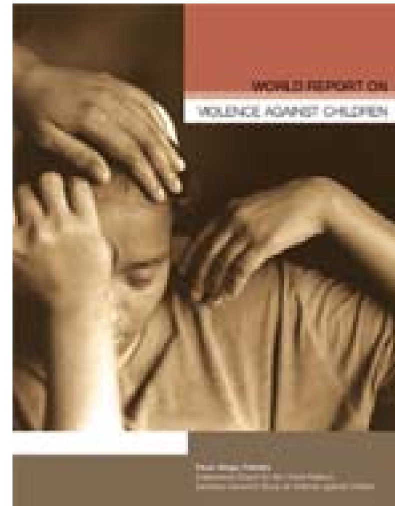
Personally, I have been very lucky. Yes, I have experienced discrimination as a girl and as an adult woman, and I have occasionally been sexually harassed. However, my mother would tell me stories of how my alcoholic grandfather was abusive to her and to my grandmother. She explained and somewhat forgave his behavior, attributing it to his experiences in the British army on the battlefield in Germany during World War I. We know now the effects of post-traumatic stress, but few people understood it and its longer-term effects at that time.

Fortunately for my brothers and me, my mother did not repeat the cycle as so many women do. Instead, she sought refuge with my father, a gentle and caring person. However, the effects of the domestic violence she had experienced in her early years persisted through her adult years, plaguing her with depression.

In the mental health field, we know much more about the follow-on to these events than we ever did before. Early violence can lead to mental health issues and substance abuse; bullying can lead to suicide; and sexual abuse can lead to depression, substance abuse, and continued victimization through prostitution or other abusive partners.

The potential for these lifelong consequences makes it very **important** that we stop the cycle in the early years. Stopping violence is necessary for its own sake. In addition, violence and unsafe learning environments have a negative effect on academic achievement. We also know the opposite is true. When schools provide curricula and opportunities for young people to engage in gaining social and emotional skills, academic performance benefits as well. A meta analysis of social-emotional learning programs has shown that such programs can contribute as much as a 10 percent increase in student academic achievement (Durlak & Weissberg, 2007).

I would like to ask *you* some questions about violence. Given all the attention today to corporal punishment, I would really love to see a show of hands of how many of you still support it, but publicly that might be unfair. Let us concentrate on the behaviors of violence you see in your schools. Is there...

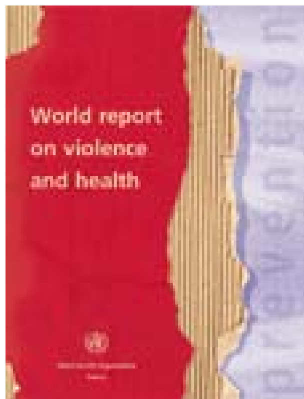


- Corporal or physical punishment of students for misbehavior?
- Teacher verbal abuse, humiliation, or ridicule of students?
- Physical fights among students?
- Verbal bullying, teasing of any kind, from student to student?
- Sexual abuse of any kind?

Thank you for sharing. Judging from your show of hands, there is some fighting, but I certainly do not see all hands in the air, not even half. There are many more for verbal abuse by teachers, which is not uncommon. A few of you acknowledge seeing sexual abuse in your schools.

It may or may not comfort you to know that these situations are typical worldwide. The international and regional data confirm such patterns and set the stage for why it is so important to deepen the teaching of HFLE in the Caribbean.

II. International Data on Trends



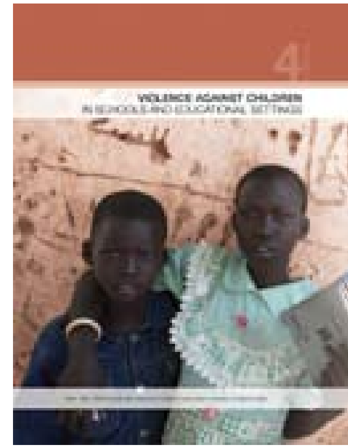
Over the past decade, there have been several important studies on violence prevention. Three valuable sources are the WHO *World Report on Violence and Health*, the *UN World Report on Violence Against Children*, with a companion study on schools, and the *Global School Health Survey (GSHS)*.

The *WHO World Report on Violence and Health*, published in 2002, set the stage for children's rights (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). This report put the UN Convention on the Rights of the Child at the forefront, charging that every country must protect its children from "all forms of physical or mental violence." Specifically, the UN Committee on the Rights of the Child has emphasized that "corporal punishment of children is incompatible with the convention" (quoted in Krug, et al., 2002). Though Barbados has signed on to that Convention, very high rates of corporal punishment continue in its schools. Moreover, as we have heard from Mr. Peter Wickham, many people in Barbados continue to condone and support it. Eliminating corporal punishment in schools is a critical first step toward changing social norms, by providing positive adult role models that respect and nurture children and that make schools physically and emotionally safe for children.

Following on the WHO report, the *UN World Report on Violence Against Children* (Pinheiro, 2006) was prepared between 2003 and 2006. This report noted that 106 of the 223 nations and dependent territories—only half—have laws banning corporal punishment in all schools. Yet, even the countries that have such policies report that the policy is very difficult to enforce.

A companion document to the full study is *Violence Against Children in Schools and Educational Settings* (Pinheiro, 2006, 108-169). In creating these reports, UNICEF held nine regional consultations, including the Caribbean. Youth were involved extensively. The Caribbean Community (CARICOM) was involved actively.

These reports elaborate worldwide patterns of violence and effective prevention strategies. Some statements in the report about schools, for example, say that:



- In Barbados, 95 percent of interviewed boys and 92 percent of interviewed girls said they had experienced corporal punishment by caning or flogging in school (p. 118).
- Worldwide, sexual harassment of school girls is so common that teachers see it as normal and thus typically ignore it (p. 119). (For additional resources on gender-based violence and sexual harassment, see Resources at the end of this paper.)
- Worldwide, one-third of students experience bullying. In more than half the cases, bullying stopped when a bystander intervened. This data underscores the critical and positive role that bystanders can play (pp. 122-123). (For additional resources on bullying, see Resources.)

The third source is both international and regional for the Caribbean: the Global School-based Student Health Survey (GSHS). The GSHS was created by the WHO and the U.S. Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (CDC & WHO, 2008). Countries in the Caribbean are now implementing the survey extensively across the Caribbean. The GSHS survey is administered in schools to students ages 9–14. GSHS provides important information on student risk behaviors, information that can be most useful to inform the design and selection of school-based programs.

Looking at the survey results across just four of the many Caribbean countries involved (Grenada, St. Lucia, Trinidad and Tobago, and St. Vincent and the Grenadines), we see the prevalence of reported violence. For example:

- More than one-half of the boys and close to one-third of the girls report that they were in a physical fight one or more times during the past 12 months.
- One-quarter of both boys and girls report that they were bullied on one or more days during the past 30 days (CDC & WHO, 2008).

(For complete results see: http://www.cdc.gov/gshs/results/index.htm)

Clearly, physical fights and bullying affect a large number of Caribbean students—both boys and girls. What strategies, then, are effective to address violence in schools, and what role is Health and Family Life Education (HFLE) playing in the Caribbean?

III. Effective Strategies for Schools

The research evidence points to the benefits of a whole-school approach for violence prevention (Cowie & Jennifer, 2007). What is a whole-school approach? It is one that draws on every facet of school life and uses multiple strategies in a coordinated way to address health issues with a public health approach (WHO, 1998). Curriculum is important, but insufficient alone. The coordination of multiple strategies is much more likely to bring about positive change (Stewart-Brown, 2006).

This whole-school approach to any health or human development challenge is represented in the petals of the flower or the concept of the Health-Promoting School in Figure I below. I know that many of you in the Caribbean are familiar with this model and are using it. This approach combines policies with curricula and instruction, such as HFLE, and addresses the psychosocial and physical environment and safety of the school. A whole-school approach has systems to screen for and detect mental health and potential violence problems early on, and it refers students, families, and staff to appropriate services. This approach must be carried out with the full participation of teachers, students, parents, and the community. Having the agency and the opportunity to affect one's circumstances are very important factors that have mental health and other benefits for all (Sen, 1999).

Figure I. Components of a Whole-School Approach in a Health-Promoting School
(Vince Whitman, 2005)

The research points to several areas critical to success.

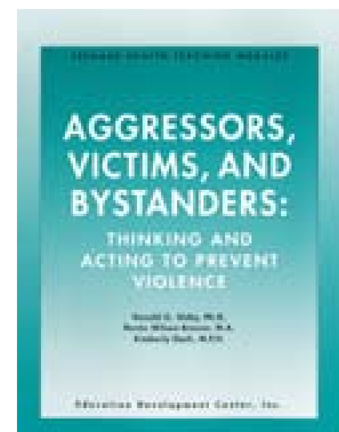
Policy: For effective learning and social development, learning environments must be safe and free from violence. Policies create norms for all to know what is acceptable behavior. These norms must be promulgated, discussed, and come alive in everyday school life. School policies must state clearly that no form of violence will be tolerated; they can drive and support behavior toward that norm. Policies must go beyond banning violence, to foster positive and respectful standards throughout the school and its grounds.

Schools must not use corporal punishment. They also need to ban any weapons in school. Sanctions must be clear, but should not further isolate and reject students at high risk (National Center, 2004). Too often bans on weapons or fighting and other violence prevention policies rely on punitive responses when students do not adhere to them. Results from the CDC's School Health Policies and Programs Study strongly suggest that bans and other efforts to reduce school violence should also promote a positive school climate that gives priority to offering services to students or others who break the rules (Jones, Fisher, Greene, Hertz, & Pritzl, 2008).

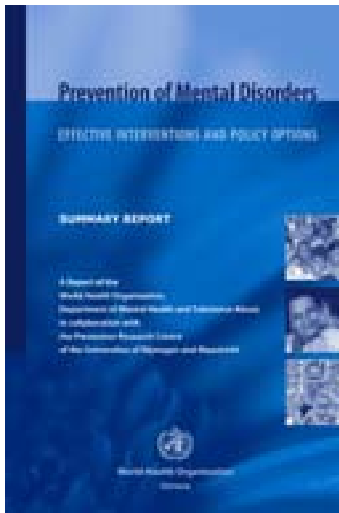
Psychosocial and Physical Environment: Along with policy, I would argue that school ethos is probably the most important and effective component in violence prevention. Extensive research has shown how important it is for students to feel connected to caring adults at school. Blum, McNeeley, & Rinehart (2002) studied thousands of students in the United States and found that they engage in fewer risk behaviors when they feel attached to their school and to caring teachers, coaches, or counselors. One simple strategy invented by teachers with whom we have worked was to identify those students whose names no one knew. As teachers became aware of these lost students, they made extra efforts to connect with them and their families (EDC, 2002).

Preventing violence also requires attention to the physical environment. Practical strategies to make schools safer include identifying and improving areas that are difficult for school staff to monitor, such as courtyards or hallways not centrally located. Research also supports the importance of ensuring sufficient lighting (CDC, 2001). A recent study of schools in Kentucky concluded that a school's immediate context—such as reduced congestion in bus-loading areas and improved surveillance—was more important for addressing violence among students than broader community-level factors, such as nearby vacant lots, etc. (Wilcox, Augustine, & Clayton, 2006).

Curricula: Skills-based health curricula that provide students with many opportunities and hours to practice skills before they encounter risks can change behavior (WHO, 2003). Skills in conflict resolution and anger management and ways for girls and boys to overcome entrenched role differences are essential. Enabling students to understand the roles of aggressors, witnesses, and bystanders and to enhance the role of bystanders in de-escalating bullying and fighting can make a difference (Stueve, et al., 2006). Teaching media literacy skills to young people can go beyond simply attempting to censor or reduce their exposure to negative messaging. Media literacy can enable young people to assess media



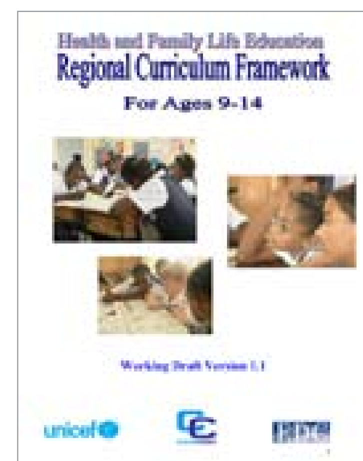
information thoughtfully and make responsible decisions about appropriate behaviors. Such skills can counter violence in the media and reduce levels of violence among children (Bergsma & Carney, 2008). All these life skills in social and emotional learning have benefits not only for violence prevention but also for academic performance.



Services: Early recognition and counseling or mental health services are critical. Unfortunately, the mental disorders of many adults were not recognized or treated when they began in childhood or adolescence. Research has shown that early intervention can save years of later suffering and harm (WHO, 2004). By the time that these individuals make contact with a mental health professional, they often present with co-morbid conditions and other complications that would have been much easier to treat earlier on in their childhood or adolescence (Kessler, et al., 2007).

This whole-school approach is essential for change. Combining policies that do not tolerate any form of violence or weapons in school with other strategies of life skills, a healthy school climate, and access to services is the cornerstone of change. Such a non-violence policy can also foster positive social norms in a caring school community, one where the staff truly connect with students. For some students, such caring does not exist in any other sphere of their lives. In this context, curricula that equip students with a range of skills and services that identify and refer students and families who need support early on, can prevent all forms of violence and serious mental health problems later in life. What then is the experience of HFLE in the Caribbean, and what can we learn from a recent four-country study?

IV. Important Role of Health and Family Life Education



HFLE has a twenty-year tradition in the Caribbean. Originally, most of the attention was on teacher training colleges. In the last five years, with the vision, leadership, and financial support of UNICEF and CARICOM, the program has taken a giant leap forward to experiment with and evaluate the implementation of HFLE among students aged 9–14. Barbados has been a leader in its HFLE activities, and I am sure many of you here today have been involved in different ways.

In 2005, working with a team of Caribbean educators, EDC facilitated the process to create the first Caribbean Regional Curriculum Framework for HFLE (UNICEF, EDC, & CARICOM, 2008 Draft). The Framework sets forth standards, learning objectives, and outcomes for four themes: *Sexuality and Sexual Health*, *Self and Interpersonal Relationships* (which addresses violence), *Eating and Fitness*, and *Environment*. To accompany the Framework, educators created lessons to be part of a core curriculum for Forms I, II, and III.

In the last three years, CARICOM and UNICEF have supported and guided a four-country study of the core curriculum for the first two modules (*Sexuality and Sexual Health* and *Self and Interpersonal Relationships*). The study took place in four countries: Barbados, St. Lucia, Grenada, and Antigua and Barbuda.

Approximately 2,000 students were involved from Forms I–III. Three matched pairs of schools participated in each country. I will refer to schools that participated in the core curriculum as 'intervention schools' or 'intervention sites' and schools that did not as 'comparison schools' or 'comparison sites'.
Students in Form I at the beginning of the study were on average 12 years old. By the end of the study in Form III, students were on average 14.7 years old. Surveys captured students' knowledge, attitudes, and self-reported behaviors at the beginning and end of the study in both the intervention and comparison sites. Reseachers also collected many other forms of data from classroom teachers and students throughout the study to help them understand participants' experiences with the implementation process and their reactions to and use of the core lessons.

A weeklong training for country coordinators took place in the first year. Coordinators then trained intervention teachers in their countries.

The study aimed to answer:

- To what degree did teachers use the ten lessons of each module? How comfortable were they? What activities and methods did they use?
- Did the knowledge, attitudes, and behaviors of students who participated in this core curriculum differ significantly from the students of the same age in matched schools? Teachers in the matched schools taught health education using traditional lessons.

It is important to emphasize that the intervention sites were using the core curriculum lessons, aligned with the Framework. Comparison sites used traditional HFLE activities and lessons that had been in place.

Following are some results from the full HFLE study that examine the above questions for the module on *Self and Interpersonal Relationships*, including lessons on violence prevention. The ten lessons for each Form examine such issues as self-concept, pressures on youth, domestic violence, substance use, refusal skills, and anger management.

The following results come from the four-country evaluation of HFLE (EDC, 2008).

What did teachers teach? Of the ten lessons in a module, about half of the teachers report they were able to complete seven to nine lessons averaging 45 minutes each. Only one-third of teachers said they did all ten. Research (National Professional School Health Education Organization, 1984) tells us that it takes approximately 30 hours of instruction to reach a point of behavior change—so students have not had anywhere near the depth of exposure that is possibly needed to create change.

Teachers reported that it was always a challenge to have enough time to implement the lessons. Only 20%–35% of teachers said the lessons fit the teaching time allocated to HFLE throughout the study. It often took teachers longer to teach an individual lesson than was estimated. Knowing what and how much was taught clearly sets the stage for understanding the student outcome results.

How did teachers react to the core curriculum lessons? Overall, teachers were very enthusiastic about the core curriculum. Most were comfortable with lesson content. Teachers reported students were engaged in activities and learned new things. The teachers reported that they found the lessons to be developmentally and culturally appropriate and covered important topics. The majority of teachers said they would be "very likely" to recommend the lessons to their peers. Over half of the students reported that they used the skills outside the classroom.

Teachers in the intervention schools, using the core curriculum, reported:

- Receiving more training on the core HFLE training than did comparison school teachers.
- Reaching higher levels of preparedness to teach HFLE and greater comfort teaching HFLE topics than the comparison teachers. Comparison teachers began the study with many more years of HFLE teaching experience, but perhaps had less formal health education training.

By follow-up time, three years after the study began, nearly 60% of teachers in the intervention sites, using the common core curriculum, but less than 20% of comparison site teachers, said HFLE is more important than other subjects. In addition, fewer of the intervention teachers reported administrative barriers to teaching HFLE.

It is interesting to compare how teachers in the intervention sites, using the common core curriculum, perceived barriers to implementation in contrast to the comparison site. Over the three years, as shown in Table I below, intervention teachers experienced increasing administrative support; the lack of administrative support as a barrier dropped from 23% to 8%. In comparison sites, teachers reporting lack of administrative support as a barrier increased from 15% to 25%.

Table I. Teachers Reporting Barrier "Moderate" or "Large"

	Baseline		Follow-up	
	Comparison	Intervention	Comparison	Intervention
Lack of administrative support/encouragement	15%	23%	25%	8%

At the end of the study, it is very encouraging to note that teachers in the intervention site, using the common core curriculum (67%), were more likely than comparison school teachers (20%) to report their level of preparation as "very good" or "excellent."

This level of confidence in preparation may be one explanation for the many different teaching methods that core curriculum teachers used. Research has reported that participatory engagement of students in learning is much more likely than lectures to lead to skill development and behavior change (Mangrulkar, Vince Whitman, & Posner, 2001). Table II reports that teachers trained in the core curriculum were much more likely to use these participatory methods. None of the comparison teachers used role-play while 54% of the intervention site teachers did. Similarly, a much higher percentage of intervention site teachers used brainstorming (62% vs. 38%) and case studies (54% vs. 38%). The full report includes additional examples.

Table II. Participatory Teaching Methods
Teachers Reporting Use of a Technique "Very Often" or "Always"

	Follow-up	
	Comparison	**Intervention**
Role-plays	0%	54%
Brainstorming	38%	62%
Case studies/real-life scenarios	38%	54%

Most significantly, training was an important factor in implementation. No matter which condition, intervention or comparison, at follow-up, over 90% of teachers wanted additional training on HFLE.

Let us now turn to the second major question of the four-country study: What was the effect of the core curriculum lessons for *Self and Interpersonal Relationships* on students' knowledge, attitudes, and self-reported behaviors, compared to the traditional teaching of HFLE. Across all questions, findings show no major statistically significant differences between students exposed to the common core curriculum and those, in the comparison sites, exposed to more traditional HFLE lessons. Table III shows a statistical difference in the fighting behaviors that girls report seeing among peers at their school. The percentage of girls who report that all or most girls fight weekly is 22% in the intervention sites and 28% in the comparison sites. There is no statistically significant difference in the fighting that boys report. On average, 55% of males in both conditions report that all or most males at their school fight weekly. This high number is consistent with worldwide patterns in the global reports cited earlier.

Table III. Reported Fighting Behavior in HFLE Study

Item	Total	Comparison	Intervention	P value
Most/all males the same age: In physical fight weekly	56%	55%	56%	ns
Most/all females the same age: In physical fight weekly	25%	28%	22%	<.01

Table IV shows students' answers to questions about acquiring skills to refuse fighting. When students were asked about how much they agreed (1=strongly disagree; 4=strongly agree) with statements regarding their refusal skills, boys in the intervention group agreed more strongly with the statement "I can say no to fight if someone pushes me around" than the comparison group (3.25 versus 2.29). Girls in the intervention group reported only slightly higher average scores (2.60) versus the comparison group (2.48). However, these differences were not statistically significant.

Table IV. Refusal Skills for Fighting

	Males		Females	
	Comparison	**Intervention**	**Comparison**	**Intervention**
I can say no to fight if someone pushes me around	2.29	3.25	2.48	2.60

Students' feelings about their school environment and school attachment remained relatively positive as they moved from Form I to Form III.

At Form I, almost all boys and girls (90%) reported liking school and being happy there. By Form III, students continued to report positive school experiences, with 80%–85% of youth reporting they feel they are a part of their school and happy there. There was no significant change.

At Form I, the majority of students (79%) felt there was an adult at school they could go to if they needed help with a problem. By Form III, a smaller proportion of students (59%) reported there was a teacher they could go to for help with a personal problem.

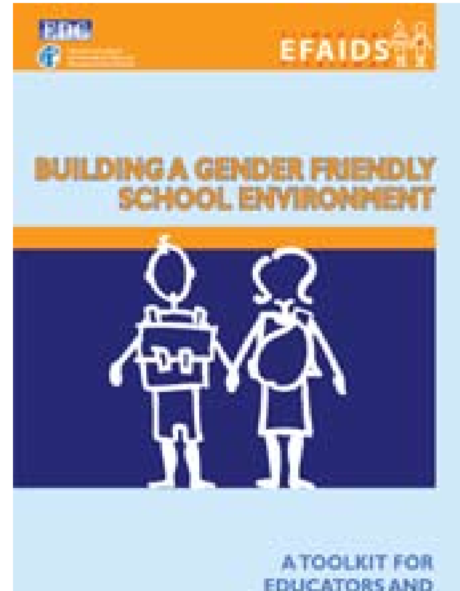
In summary, the study in itself has pushed forward the boundaries of implementation of HFLE in schools and our learning about what is required. Clearly, it shows the value and importance of:

- Providing extensive training
- Dedicating adequate teaching time to HFLE—at least 10 periods for each module across forms—and ensuring teachers can cover the material in each lesson in the allocated time
- Offering steady and consistent administrator support
- Providing curricular and training materials

Teachers in the intervention sites reported that they are growing in their confidence and skills to teach the subject, that they see its value and importance, and that they are using a variety of participatory methods. Students say they are using the skills outside the classroom. In addition, while the student findings do not scream with statistical significance, they are showing some positive direction, and the interventions are perhaps retarding escalation of risk behaviors as youngsters enter years of greater experimentation.

V. Conclusion

As I end this presentation, I ask myself what difference it will make in your work. What new actions, if any, will you take when you return to schools next week? I suggest a few. I sincerely hope you will select even one or two. Also, please review the many resources listed at the end of this paper to assist you. Talk to a trusted colleague or form a discussion group about violence in your own lives. Support one another. To help your students, you must help yourselves and each other too.



1. Talk with your administrator if your school does not have a policy to ban corporal punishment. Ban it.
2. If you cannot set a school policy, stop using corporal punishment yourself. Move beyond a policy against corporal punishment to one that encourages all in the school not to tolerate any form of physical, verbal, emotional, or sexual abuse. Make it explicit, talk about it. Create positive norms of a caring, safe, respectful community.
3. Consider your own teaching practices. Are they authoritarian and didactic or democratic, respectful and participatory? Connect to your students. Know them as people. Know and use their names. Let them know they can come to you.
4. Consider if there are any physical spaces that are particularly unsafe. At times, there are places that girls must frequent that are isolated and risky. Bathrooms can be particularly unsafe. How can you identify physically unsafe places for students in your school and do something about them?
5. Take the pulse of the psychosocial environment of your school. There are many tools for staff and students to do this, especially the WHO Psycho Social Environment Profile listed in the Resources.
6. Deepen your implementation of HFLE. Get the richest materials you can. Spend time using skills dedicated to violence prevention and related behaviors. Train, train, and train your teachers. They will grow in their confidence with the content and methods. Assure them they can take enough time in the week to teach the lessons. It will make a difference and academic performance should improve.
7. Last, consider creating coalitions that connect the school with the health and mental health services and with the police in your community. Together, perhaps, you will be able to identify those young people and families at most risk. Instead of punitive actions, perhaps you can direct them to much needed services, and engage then in prevention and early intervention activities that might save delinquency, gang involvement and school dropout.

You can make a difference in one life, in ten lives, or in hundreds of lives. You must. If, in your role of educators, you do not act, who will? You will find great rewards in doing so.

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Resources

Classroom Curricula and Evidence Base

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Some Evidence-Based Programs

Olweus Bullying Prevention Program
www.clemson.edu/olweus

The Child Development Project
www.devstu.org/cdp

Steps to Respect
www.cfchildren.org

Don't Laugh at Me
www.operationrespect.org

The High/Scope Perry Preschool Project
www.highscope.org

The Incredible Years
www.incredibleyears.com

Linking the Interests of Families & Teachers (LIFT)
www.oslc.org

Eyes on Bullying
www.eyesonbullying.org

Stop Bullying Now!
www.stopbullyingnow.org

Online course: Bullying Prevention
http://www.ed.gov/admins/lead/safety/training/bullying/bullying.html

Other Online Resources

Harvard University's Center on Media and Child Health:
Database on Research
www.cmch.tv/research/searchCitations.asp

International Alliance for Child and Adolescent Mental Health and Schools (INTERCAMHS)
www.intercamhs.org

Center for Effective Collaboration and Practice: School Safety and Violence Prevention Links
cecp.air.org/guide/websites.asp

Search Institute
www.search-institute.org

Resourceful Adolescent Manual: A Program for Teachers to Promote School Connectedness
www.rap.qut.edu.au