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Prevention of Violence Against Children: A Systems Readiness Assessment in CÔTE D'IVOIRE

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PREVENTION OF VIOLENCE AGAINST CHILDREN: A SYSTEMS READINESS ASSESSMENT IN CÔTE D'IVOIRE

by

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(Under the Direction of Ashley Walker)

ABSTRACT

Violence against children (VAC) is a global problem with significant consequences. Recognizing the need to better understand the problem of VAC in Côte d'Ivoire (CI), the government of CI recently completed a survey on violence against children. The recent data will support an evidence-based national action plan for the prevention of VAC. Research shows that initiatives tackling specific problems will only be as successful as the community's readiness to take action. This study applied the community readiness model to assess the readiness of the multisectoral task force (MSTF) to implement the national action plan in CI. Eight MSTF participants' interview scores determined the overall and dimension-specific level of readiness. The findings suggest that the MSTF's overall stage of readiness is in the "preplanning stage," indicating that a clear recognition exists that something must be done to address the issue of VAC in CI, and there are even mechanisms to address it. Nevertheless, the present efforts are neither sufficiently focused nor comprehensive. The study also evaluated six specific dimensions of the system, revealing varying stages of readiness across dimensions. The dimension of *efforts* had the highest stage of readiness, whereas the dimension *knowledge of efforts* had the lowest stage. Based on these findings, the recommendation is to strengthen the dimensions with the lowest readiness level. The system's immediate strategy must be to increase awareness and knowledge of all

policies and programs addressing violence against children and to intensify political engagement to support existing and new programs addressing the problem.

INDEX WORDS: Violence against children, Community Readiness Model, National action plan, Children, INSPIRE technical package

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DEDICATION

To God, my life

To Papa, my inspiration

To Mom, my support

To my siblings, my fan club

To the Church, my family

To my husband Robert, my love

To my daughter Daisy, my source of pride

Everyone should be so lucky!

Thank you all with all my heart!

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ACRONYMS:

CDC: Centers for Disease Control and Prevention

CI: Côte d'Ivoire

CRA: Community Readiness Assessment

CRM: Community Readiness Model

D2A: data-to-action

MFFE : Ministère de la Femme, de la Famille, et de l'Enfant–Ministry of Gender, Family and Children

MSTF: Multisectoral task force

VAC: Violence against children

VACS: Violence Against Children Surveys

CHAPTER 1

INTRODUCTION

The United Nations Convention on the Rights of the Child of 1989 defines the term "child" as "any human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier" (United Nations General Assembly, 1989, article 1). Children account for approximately one-third of the world's population—2.2 billion—and they constitute some of the most vulnerable populations in our societies. Children and young people suffer an array of issues, including the consequences of poverty (Meinck, Cluver, & Boyes, 2015), illnesses (Sumner, Mercy, & Saul, 2015), wars, and violence (Krug, Mercy, Dahlberg, & Zwi, 2002). Children do not receive equal treatment across the world, nor do they enjoy the same rights from one corner of the world to the other. Children living in poorer countries or communities suffer more infringements to their rights than those living in wealthier contexts; for example, a study in eSwatini (previously known as Swaziland) in Southern Africa identified poverty as a driver of physical and emotional violence against children (Clacherty, Donald, & Clacherty, 2005).

Violence against children (VAC) is a worldwide problem that affects close to half of the children in the world. More than one billion children aged 2 to 17 years have experienced at least one form of violence, irrespective of race, socio-economic status, gender, culture, or living location (Hillis, Mercy, Amobi, & Kress, 2016). In many regions of the world, the problem of violence against children is often compounded with several other issues, such as poverty, social unrest, and HIV (Hillis, Mercy, & Saul, 2017). A body of literature has demonstrated the multiple ill effects, over both the short and the long term, on children who have been victims of

physical, emotional, and sexual violence (Mercy et al., 2013). Children affected by violence suffer disastrous consequences, including multiple adverse health events, up into adulthood (Hillberg, Hamilton-Glachritsis, & Dixon, 2011; Norman et al., 2012). Several studies have come close to establishing a causal relationship between exposure to violence in childhood and an increased risk for HIV infection (Anda, Butchart, Felitti, & Brown, 2010; Anderson et al., 2008; Chiang et al., 2015; Jewkes et al., 2010; Machtinger et al., 2012). Furthermore, VAC not only damages the children who are victims of the incidents but also affects entire communities and populations (Sumner et al., 2015). For example, numerous studies have revealed the enormous costs of VAC to national economies (Buvinic, Morsson, & Shifter, 1999; Fang, Brown, Florence, & Mercy, 2012; Fang et al., 2015; Hsiao, Ward, Ganz, Zheng, & Fang, 2018).

Although pervasive (Lansford & Dealer-Deckard, 2012; Stoltenborgh, 2011; Finkelhor, Hamby, Ormord, & Turner, 2009) and destructive (Mercy et al., 2013; Hillis et al., 2017), the problem of violence against children is both predictable and preventable (Hillis et al., 2017). World leaders and leading institutions have recently recognized and highlighted this problem as an issue of universal priority. Many have decided to combine their efforts to not only define the problem but also to establish scientific methodologies to understand its magnitude, scope, and contour. For instance, under the leadership of the United Nations, the Sustainable Development Goals (SDG) for 2030 were adopted in 2015 (Kusuma & Babu, 2017; United Nations General Assembly, 2015); in contrast to the previous set of SDGs, the newer plan outlines several targets and SDGs related to the elimination of violence in general and, more specifically, violence against women and girls (VAWG) (Kusuma & Babu, 2017). Recognizing that violence against children is a preventable problem, the international community has also identified and/or has developed strategies to prevent violence against children (UNICEF, 2014).

One of the main obstacles to tackling the public health crisis of VAC is the lack of accurate, consistent, and timely data on the issue. More research to understand the breadth and depth of the problem, further investigation into enabling and protective factors, and uncovering the resultant consequences of VAC is necessary. Comprehensive and relevant data will effectively inform VAC prevention and response policy and programming. Data sources pertaining to VAC are multiplying, one of which is the Violence Against Children Surveys project (VACS). The VACS are nationally representative studies that investigate the scale and nature of violence against children. The VACS have been implemented in over 20 countries since 2007 under government-led implementation strategies, with the technical support of the Centers for Disease Control and Prevention (CDC), the United Nations Children's Fund (UNICEF), the International Organization for Migration (IOM), and other partners (Chiang et al., 2016).

As part of the VACS planning process, governments in each country establish a multisectoral task force (MSTF), which is tasked with leading, guiding, and supporting the national survey and ensuing activities. Subsequent to VACS data collection and data analysis, country experts and policy makers from all sectors are assembled during a data-to-action (D2A) workshop to interpret results contextually and translate the findings into actionable policies and strategies that best fit VAC prevention for the country. The main objective of the D2A workshop is to develop a multisector national action plan (Gray, Pesevska, Sethi, González, & Yon, 2016) for the prevention of VAC or to adapt, in a coordinated way, violence prevention strategies within existing national programs.

Over the years, the execution of national action plans to address VAC has varied greatly, producing different outcomes. Plan execution has varied from one country to another in

prioritization, resource allocation, leadership commitment, and overall success. In some countries, the plan has been fully and faithfully executed and has generated expected outcomes to reduce incidences of violence perpetuated against children and increase response to VAC cases. In contrast, in many other countries, very little traction and action have stemmed from the action plan document. Recognizing that each country's performance will vary greatly depending on the strategies prioritized in the plans and that the execution of those plans will result in different outcomes, a group of organizations collaborated to develop the INSPIRE (**I**mplementation and enforcement of laws, **N**orms and values, **S**afe environments, **P**arent and caregiver support, **I**ncome and economic strengthening, **R**esponse and support services, **E**ducation and life skills) technical package (Butchart & Hillis, 2016). INSPIRE (see Appendix A) uses a multisectoral approach and a framework for action and contains seven evidence-based strategies to address violence against children. Each strategy fits within a sector, and the implementation of multiple, if not all, the strategies combined is recommended to magnify their impact. This technical package is one step towards ensuring that national action plans include evidence-based strategies (Sethi, et al., 2013) that match appropriately and efficiently with the national data obtained through the VACS, thereby leading to impactful prevention outcomes.

Since 2016, the official launch year for the INSPIRE technical package, the approach has become a reference point for country-level policy makers and experts on prevention strategies to address violence against children. Nevertheless, to apply INSPIRE effectively, a certain set of conditions should exist in the countries or communities adopting INSPIRE. Furthermore, to promote success, the strategies for VAC prevention (VACP) must match the appropriate level of readiness of the entire system (and of each part within) put in place to implement them. Without appropriate resource availability, knowledge of the issue, political and leadership will, and other

environmental contexts, the implementation of INSPIRE strategies may, at best, be problematic and have limited impact or may even fail to reduce or prevent VAC.

This research project endeavors to evaluate whether the conditions needed for the successful implementation of a national action plan, including INSPIRE strategies, are met within the MSTF in CI. This research will fill an important gap in the VACS data-to-action process by conducting a readiness assessment for the implementation of violence against children prevention strategies in Côte d'Ivoire (CI) before a national action plan is developed. CI has recently completed a Violence Against Children Survey. A readiness assessment associated with a D2A process will identify what key capacities already exist in the country and what additional capacities may be needed to implement VACP programs utilizing evidence-based strategies from the INSPIRE package. The D2A would then result in an action plan for the prevention and response to VAC in CI, where the VACS was recently completed in September 2018. This study will conduct a readiness assessment of the MSTF for VACP based on the community readiness model described later in this chapter. This study is innovative because it is designed to conduct a systems capacity assessment using a community assessment model. Furthermore, this readiness assessment would be the first to be conducted in countries that have implemented the VACS. This study could further improve D2A and INSPIRE outcomes by ensuring a good match between INSPIRE strategies and a country's initial readiness level and offering more robust follow-up in future countries.

Statement of the Problem

VAC is preventable (Krug et al., 2002). From a public health standpoint, VAC must be tackled before it begins. The goal of preventive measures is to avoid the manifold negative life

consequences and health risks in the lives of children who are susceptible to violence. Quality data is the foundational key to scoping the problem and identifying prevention strategies.

The VACS is a national-level survey that measures the prevalence, nature, and consequences of physical, emotional, and sexual violence against children. VACS systematically collects population-level and comprehensive data on children and youth aged 13-24 years old in countries, often for the first time (Chiang et al., 2016). Ensuing findings then form the basis for a set of recommendations for targeted areas/strategies most appropriately designed to reduce or prevent VAC. As part of the VACS implementation partnership, host governments commit to several process requirements, including government leadership, a multisectoral involvement and response plan, and dissemination of VACS findings. A D2A workshop is organized after the data have been analyzed. During this workshop, country experts along with CDC scientists and other partners identify and prioritize context specific strategies that will eventually be included in a national action plan to prevent violence against children in their country.

The development of a national action plan to address VAC, even when soundly drafted, does not guarantee its execution, nor does it assure successful outcomes after implementation. Varying resources and degrees of readiness affect the successful execution of a national action plan. Given the scarce resources in some settings, the need for efficient processes is perhaps more acute to ensure impactful implementation of an action plan. An action plan, no matter how well it has been crafted, is not failsafe unless an analysis of desired versus required resources necessary for implementation has been completed, and a clear breakdown of existing capacities has been compiled to determine assets versus needs. A poorly executed action plan will lead to limited success and could, potentially, even worsen the situation. Key agencies and agents may become demoralized by limited to no success (Slater et al., 2005), and decision makers may see

lack of success as an excuse not to prioritize and invest in VAC prevention, particularly in a resource-constrained setting.

To ensure the proper and successful execution of any evidence-based intervention, the planned intervention must be suitably matched to the community's level of readiness to implement programs and strategies addressing a specific issue (Paltzer, Black, & Moberg, 2013). Birkby's study (as quoted in Paltzer, Black, & Moberg, 2013, p. 28) defines readiness as "the extent to which a community is adequately prepared to implement a strategic planning effort that achieves long-term results that benefit a target community." The definition of community is equally important. Here, community will be considered in the sense of the group of government institutions that could or should be implementing or materializing a plan or, at least, enabling it. The word community is thus used in this study as a proxy for the multisectoral task force for the prevention of VAC in CI.

A readiness assessment would allow fast and accurate insight into the level of readiness of the system to address violence against children and then serve as a pathway to devise a strategic and actionable plan to move forward based on the identified readiness level. The readiness assessment would also establish a baseline for a monitoring and evaluation plan. It is especially important to put forth efforts to determine the level of readiness to implement strategies for violence against children prevention in low-resource countries such as CI.

Rationale and Purpose Statement

Once the government of CI acknowledged the scarcity of data regarding VAC and recognized that this lack of data hindered effective and sufficient policy and interventions designed to address this problem, decision makers welcomed the proposal to implement a national Violence Against Children Survey. The project's goal was to obtain a national estimate

of violence against children, which will support future interventions to reduce and prevent VAC in CI. Currently, all VACS efforts in CI are guided by a MSTF, which is coordinated by the Ministry of Women, Family, and Children (Ministère de la Femme, de la Famille, et de l'Enfant, MFFE) as the lead agency representing the government regarding VACP efforts in CI.

The present study sought to conduct a readiness assessment of the MSTF to lead violence against children prevention (VACP) efforts in CI. As the lead governmental agency, the MFFE sits as the secretary within the MSTF. This MSTF was tasked with coordinating the Violence Against Children Survey in CI, which would lead to a national action plan addressing violence against children in CI. A readiness assessment will serve to understand the overall readiness of the MSTF to then implement VACP strategies in CI.

Country Profile: Côte d'Ivoire

Côte d'Ivoire, also known as the Ivory Coast, is a French-speaking country located on the western coast of the African continent (see Figure 1). Surrounded by several countries, it has a large coast on the North Atlantic Ocean (between Liberia and Ghana; see Figure 1). Comparatively, the area occupied by CI is slightly larger than the state of New Mexico in the US (The World Factbook, 2018). By July 2017, CI had an estimated population size of more than 24 million; this estimate vacillates due to AIDS-related excess mortality. In 2017, almost 60% of the population were younger than 20, and approximately 8,940,520 of the population were 0 to 14 years old (37%). In 2017, the sex ratio is estimated at 1.02 male/female, and the fertility rate is estimated at 3.38 children born to each woman (The World Factbook, 2019).

Figure 1. Map of Côte d'Ivoire surrounded by country borders. (From: United Nations Geospatial Information Section)

Côte d'Ivoire is a low-income country, with an economy that is highly dependent on agriculture. The distribution of wealth is highly unequal (demonstrated by a Gini coefficient of 0.48 in 2008), and almost half of the population lives below the poverty line (International Monetary Fund, 2009). With such poverty, the risk of diseases and death is increased multifold. Moreover, since 2000, CI has known many difficult years, filled with political conflicts, civil wars, and a volatile economy. In 2011, the political situation declined, leading to a civil war.

Consequently, social instability increased, healthcare and education decreased, and protection laws and programs were stunted (International Monetary Fund, 2009; UNICEF Côte d'Ivoire, 2018). The most vulnerable subpopulations are residents of the poorest communities (mainly rural areas), women (who have higher illiteracy and unemployment rates than men do and suffer widespread violence), and children (child and infant mortality is the highest of all other subpopulations, and violence against children is rampant), many of whom do not make it to the age of five (UNICEF Côte d'Ivoire, 2018).

The situation of children in CI, albeit slowly improving in recent years, remains alarming. The child mortality rate declined from 125 per 1,000 in 2005 to 96 per 1,000 in 2016; however, half of all child deaths occur within their first year of life. Children's vulnerability to adverse factors is increased by environmental and socioeconomic factors. Geographical location is also an influential element: children living in the northern and western areas of the country have poorer health outcomes than their counterparts in other regions, just as children in urban areas have better health outcomes than those living in rural areas. HIV and violence against children are pervasive throughout the nation, and according to the 2017 UNICEF report, the national capacity to prevent and/or reduce violence against children is deficient (UNICEF Côte d'Ivoire, 2018).

The government has collaborated with organizations such as the World Health Organization (WHO) and the United Nations Infant and Children Funds (UNICEF) to implement educational, nutritional, and child protection interventions for children in homes and in schools. In September 2014, the CI government adopted a national strategy against sexual violence, which led to some positive steps to address the issue (Human Rights Watch, 2016). However, limited funding, staff turnaround, and revolving leadership, among other challenges, often

threaten these programs. The composition of the government in CI has changed several times over the past several years, which has impacted the stability and continuation of policies and programs in general and, more specifically, of the ministry mandated to lead child protection efforts and other family programs.

In July 2018, a new CI government was constituted that is composed of a Prime Ministry and 34 technical ministries, including the new Ministry of Women, Family and Child Protection (MFFE). Up until July 2018, this ministry was known as the Ministry of Gender, Solidarity, and Child Protection. The Ministry of Women, Family, and Children is mandated by the government to lead welfare policy reform and programmatic efforts to ensure the wellbeing of women, children, and families. Furthermore, in 2017, the First Lady held a meeting on child protection in West Africa and the Sahel, where a declaration committing to ending violence against children was approved (UNICEF-Côte d'Ivoire, 2018). Finally, in 2018, the CI government, through the MSTF, led a nationwide VACS with the goal of obtaining baseline data first to better frame the problem of VAC in CI and then to better address it.

Despite the noticeable political will and government leadership initiatives devoted to solving this major problem, the country lacks the overall human and financial resources to manage social welfare services programs effectively (UNICEF-CI, 2018). CI also previously lacked real data on VAC, making the recent completion of a VACS a significant step.

Purpose Statement

This exploratory study seeks to assess and define the degree of readiness of the MSTF, a governmental system, to implement evidence-based VACP strategies in CI. Determining the violence against children prevention readiness in CI will serve to identify areas of strengths and

gaps in the system, and to develop a readiness-appropriate plan, thereby targeting sound resources allocation to build greater systemic capacity.

National action plans are proven and effective policy instruments used to tackle major issues at all levels and over a specific period (Amling & O'Reilly, 2016). Action plans support VACP by focusing actions on integrative, multisectoral, and evidence-based strategies that hold promise for reducing VAC. The impetus for this study is thus to assess the current readiness of the MSTF to carry through and coordinate national efforts in collaboration with other ministries and nongovernmental organizations to prevent violence against children. This study will mainly target the VACP MSTF, which involves various sectors (including ministries, departments, and nongovernmental organizations), as the coordination mechanism. Members of the MSTF for VACP in CI were interviewed using the community readiness model (Plested, Edwards, & Jumper-Thurman, 2006), and readiness was assessed to determine the level of violence against children prevention readiness in CI.

The central question driving this research is: Is the system established to support VACP in Côte d'Ivoire ready to implement evidence-based strategies to prevent violence against children?

Research Questions

1. What level of MSTF readiness do MSTF members perceive to support VACP strategies?
    a. Climate:
        i. What is the degree to which the current climate of the country facilitates positive change?
    b. Current attitudes and efforts toward prevention:

i. To what extent do members of the MSTF know about the causes of the problem, its consequences, and how it impacts the nation?

ii. What efforts currently exist that deal with prevention of violence against children?

c. Leadership and commitment to change:

i. To what extent do members perceive their leadership as committed to and supportive of implementation of a prospective change effort in violence against children prevention?

ii. To what extent are leaders and influential stakeholders supportive of the issue, or to what extent is leadership effective (policy, coordination, sustainability efforts)?

iii. What is the perceived worth or importance placed on VACP in CI?

d. Resources:

i. To what extent are local resources (people, time, money, and space) available to support VACP efforts?

ii. To what extent do relational attributes for change exist (including community attachment, stakeholder involvement, and collaboration/teamwork)?

e. Skills and knowledge necessary to implement INSPIRE strategies, including:

i. Is the staff and volunteer base needed to implement INSPIRE available?

ii. Is training and expertise to implement INSPIRE available?

2. How much does readiness level vary across dimensions? (Dimensions are key factors from the CRM that influence the issue)
    a. Which dimension reveals the greatest level of readiness?
        i. In which specific sector is this strong dimension noticeable?
        ii. What strength factors can be gleaned from this information?
    b. Which dimension reveals the lowest level of readiness?
        i. Which specific sector demonstrated limitations in the dimension?
        ii. What are some possible causes?

Relevance and Innovation

Violence against children is a critical problem globally, with disastrous consequences for children and the communities to which they belong (Anda, et al., 2006; Bellis, et al., 2014; Sethi, et al., 2013). Although of pandemic proportions, this problem is preventable (Gray, Pesevska, Sethi, González & Yon, 2018). Significant headway has been made in understanding this global issue, and evidence-based strategies have demonstrated that violence can be avoided through thoughtful policies and strategic programs. The VACS has become an important source of data and information for governments seeking to comprehend the contour of the problem of violence against children in their country (Chiang et al., 2016). Nevertheless, better comprehension of this problem through data alone does not constitute the solution to this problem. Even when countries obtain good data to develop a national action plan in response to the problem of VACS in their country, this undertaking will often encounter obstacles at some point due to lack of readiness (proper resources, political leadership, and public engagement) (Plested, Edwards, & Jumper-Thurman, 2006).

This proposed study is relevant because it addresses a current need. This readiness assessment study will fill a gap within the process toward developing a solid, realistic, actionable plan to prevent the VAC problem in CI (Thurman, Plested, Edwards, Foley, & Burnside, 2003). This study will contribute to bridging the gap between VAC research data and the successful implementation of evidence-based strategies for VAC prevention by evaluating the readiness of the country's response system to implement such strategies and subsequently developing an appropriate national action plan against VAC in CI (Silwa et al., 2011).

To the researcher's knowledge, this study represents the first application of the CRM to conduct a formal readiness assessment of the system leading the prevention efforts following the implementation a VACS; this innovative study will help guide the adoption of appropriate strategies and interventions based on the country's degree of preparedness to implement INSPIRE strategies. As such, this study will demonstrate innovation in the violence prevention field, as this approach has not been taken before and could further improve INSPIRE and D2A outcomes by ensuring appropriate preparedness levels and adequate interventions in future countries (Miller & Shinn, 2005).

This study will use the Community Readiness Model (CRM) (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000) supported by the Appreciative Inquiry (AI) model (Cooperrider, Barrett, Srivastva, 1995; Cooperrider & Whitney, 2005). The CRM assesses the readiness level of communities to address a specific issue, thereby ensuring that any program developed within a community is matched to the resources at hand to tackle any issues successfully. The AI model provides a positive undertone during the evaluative process.

Assumptions

1. The interview questions from the CRM instrument were adapted according to its developers' guidelines. The French translation of the interview instrument were valid.
2. The interviews were conducted according to the CRM guide. The investigator followed a consistent protocol with each interview, from introduction to conclusion, and limited discussions and interjections to avoid injecting any personal biases or values.
3. The participants were in leadership (management or senior) positions the ministries or agencies that are members of the multisectoral task force and have worked in one of the following sectors for at least one year: social welfare, education, health, justice, labor, or finance.
4. The informants provided honest answers to the instrument questions.

Delimitation of the Study

1. The survey instrument has been piloted and the questions validated in previous studies,
2. Two interviewers/scorers scored individually and then combined their scores to increase inter-rater reliability.
3. This study used key informants who have been employed in the field for at least one year.
4. This study used senior workers in the ministry or members of the MSTF who are familiar with government systems and resources.
5. The study was qualitative to explore the topic in depth.

Limitations of the Study

1. The study was limited to the participation of key informants, members of the MSTF.
2. The study used self-reported demographics, such as age, residence, location of work, etc.

3. The sample of participants was small and targeted and thus nonrepresentative of all ministries or sectors throughout the government.
4. The study findings are not generalizable.

Definitions of Terms

Systems Thinking

According to Leischow et al. (2008) and Leischow and Milstein (2006), "systems-thinking perspectives and approaches" are "shared across fields" and share the following characteristics: (1) increased attention to how new knowledge is gained, managed, exchanged, interpreted, integrated, and disseminated; (2) emphasis on a network-centric approach that encourages relationship-building among and between individuals and organizations across traditional disciplines and fields in order to achieve relevant goals and objectives; (3) the development of models and projections, using a variety of analytic approaches (e.g., differential equations, agent-based modeling, system-dynamics modeling) in order to improve strategic decision making; and (4) systems organizing in order to foster improvements in organizational structures and functions. (Leischow et al., 2008, p. S196)

Readiness

Readiness (Edwards et al., 2000) is defined as the degree to which a community is prepared to take action to address a specific issue. A prepared community would demonstrate the set of criteria below:

- Key players' attitudes are supportive of violence against children prevention;
- The will in society to address the problem is present;
- The necessary resources in terms of personnel, infrastructure, and funding are available;
- Adequate legislation and policies for preventing violence against children are in place.

Violence

The World Health Organization offers the following definition of violence: "The intentional use of physical force or power threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (as cited in Krug, Mercy, Dahlberg, Zwi, & Lozano, Eds., 2002, p. 5).

Violence against Children (VAC)

VAC includes all forms of physical and sexual violence and emotional abuse, neglect, and exploitation that is perpetrated against minors aged 18 years and under (UNICEF, 2014).

Evidence-based (Puddy & Wilkins, 2011)

Evidence-based programs have demonstrated effectiveness through rigorous scientific evaluation or in large studies with diverse populations or through multiple replications and demonstrate significant and sustained effects.

Dimensions

Dimensions of readiness are key factors that influence a community's preparedness to take action (Edwards et al., 2000). These dimensions are qualitative indicators used to assess the community's readiness to address an issue in specific areas or overall. According to the CRM, dimensions include:

Efforts. Efforts include policies established, programs implemented, and services offered (Plested, Edwards, & Jumper-Thurman, 2006). The study assesses what already exists, what the community knows about current efforts, and the gaps identified.

Climate. Climates indicates here the beliefs, priorities and disposition of the community. This dimension assesses the pool of the environment regarding the issue researched.

Leadership. Leadership notes routes of action to government officials, policy and decision makers, and external stakeholders to CI who have influence over decisions in the country.

Resources. Resources consist of funds, properties and other material items. Resources also include staffing, volunteers, and training.

Chapter Summary

This chapter discussed the need for addressing VAC in CI by determining the readiness level of the MSTF to lead VACP strategies. The study will be supported by two theoretical frameworks: the appreciative inquiry model and the community readiness model. The statement of the problem, the purpose of the study, relevance, assumptions, and definitions of terms were included. The next chapter will discuss the literature on violence against children, with a narrowed focus on VAC in CI.

CHAPTER 2

REVIEW OF LITERATURE

The impetus for this study is to determine the level of readiness or preparation of Côte d'Ivoire's system to lead violence against children (VAC) prevention programs. This literature review will highlight VAC as a preventable issue; describe the global impact of VAC and, more specifically, its impact in Côte d'Ivoire (CI); and discuss how data emphasizes the issues and strategies to transform data into actions.

Preventable Consequences

Violence against children (VAC) encompasses all forms of violence against individuals 18 years old and younger, irrespective of the nature, the extent, the frequency or the severity of the violent behavior (Krug et al., 2002; UNICEF, 2014). According to the World Health Organization's (WHO) typology, the four types of violence are physical, sexual, psychological, and neglect or negligent treatment; these types of violence can be perpetrated by parents, family or other caregivers, peers, romantic partners, acquaintances, and strangers (WHO, 2002). Despite the scarcity of data describing the extent and impact of violence against children, there is consensus that this problem is global (Chiang et al., 2016). According to the WHO, VAC is a universal problem affecting over a billion children annually. Recently, the Centers for Disease Control and Prevention (CDC) estimated that one billion children experience violence annually (Hillis et al., 2016). The CDC also reported in 2015 that over half of the world's children are victims of some type of violence (physical, sexual, and emotional) every year (Centers for Disease Control and Prevention, 2015).

The consequences of VAC, although preventable, are disastrous, not only for the children experiencing violence but also for communities and societies at large (Mercy et al., 2013). A robust body of literature can attest that the negative effects of even one violent event can be long lasting (Norman et al., 2012; Policy, Genuis, & Violato, 2001). The impact of violence in the life of children is devastating, often leading to an unending cycle of violence in their lives with multiple victimization and perpetration (Morojele & Brooks, 2006). Studies have also demonstrated that exposure to violence leads to children's increased vulnerability to a host of health issues (Felitti et al., 1998). VAC also impacts entire nations. Several studies on the economic burden of violence against children conducted in Asian countries have demonstrated that entire populations bear the cost of this preventable problem (Fang, 2015; Fang et al., 2015; Pollett & Gurr, 2009).

A deeper understanding of the magnitude and nature of violence against children has become critical to developing effective prevention strategies. Over the last three decades, the international community has been sounding the alarm over this insidious yet predictable problem (WHO, 2014; United Nations General Assembly, 2015). Although still under-researched, this issue has become a primary focus of many multilateral organizations, such as the World Health Organization, the World Bank, and the United Nations system. The United Nations, for example, led the development of 17 Sustainable Development Goals (SDG) in 2015, which will remain the underlying guiding principles of any humanitarian work around the world (in at least 190 countries) until the member nations have reached their target in 2030 (United Nations General Assembly, 2015). Several of these SDGs are relevant to the problem of violence, including SDG 16.2, which is the most relevant as it aims to "end abuse, exploitation, trafficking and all forms of violence against, and torture of, children" (United Nations General Assembly, 2015, para. 59).

The United Nations Post-2015 Sustainable Development Goals also proposed as a priority a new agenda, "The Elimination of Violence Against Children" (UNICEF, 2014).

The prevention of violence against children occupies the juncture of the human rights and public health fields. The UN has clearly condemned violence against children in any form of acceptable standards, whether legal, cultural, or social (UN Committee in the Rights of Children, 2011). VAC is also a major global public health concern because children who experience violence also experience magnified vulnerability and elevated risks for other health issues (both behavioral and environmental) (Sumner et al., 2015).

Forms of Violence

Violence is a complex concept with many nuances, variations and distinctions. Various institutions have offered definitions of violence against children. In 2011, The United Nations Committee on the Rights of the Child provided a set of definitions of four different forms of violence against children: physical violence, sexual violence, mental violence, and neglect (UN, 2011). Child maltreatment applies mostly to parents and caregivers and is narrower in scope than VAC, which considers all perpetrators in all settings. Child maltreatment has been divided into two categories by the CDC: acts of commission, which include physical abuse, sexual abuse, and psychological abuse; and acts of omission, also referred to as neglect or negligent maltreatment (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008), which involve failing to meet children's physical and psychological needs, to protect them from danger, or to obtain medical or other social services as needed.

In the World Report on Violence and Health, child abuse or maltreatment "constitute all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health,

survival, development or dignity in the context of a relationship of responsibility, trust or power" (Krug et al., 2002, p. 77). A typology chart (see Appendix B) of violence helps elucidate some of the nuances in the definition of terms that often seem synonymous (Krug et al., 2002).

Violence against children has multiple levels. Although universal agreement on defining these notions is lacking, some experts in the field research violence according to intentionality and across the four levels of the socio-ecological framework: individual, interpersonal, community, and societal. These scholars also focus on the different natures/forms of violence: physical, sexual, and psychological/emotional. Other social scientists research structural violence (Galtung, 1969) and symbolic violence (Bourdieu, 1987). These are much more subtle factors of violence but include poverty, racism, misogyny, and more, and exert enormous effects on the health and wellbeing of children everywhere. Structural violence, which is linked to social and institutional injustices, is an indirect form of violence (Farmer, 2004). This indirectness is an important component to understand, especially as it relates to interpersonal violence (Parkes, 2015; Pells, Morrow, Maternowska, & Potts, 2018; UNICEF, 2018). Symbolic violence is another type of invisible violence that manifests in the power differential between social groups, beyond institutions (Morgan & Bjorkert, 2006). This type of violence is relevant to violence against children as it refers to the advantage that persons or groups exert over children because of their higher social position.

Physical violence against children includes all corporal punishment and all other forms of torture, cruel, inhuman, or degrading treatment or punishment as well as physical bullying and hazing by adults and other children. One of the most pervasive forms of physical violence against children is child abuse. The Centers for Diseases Control and Prevention has defined childhood physical abuse as the "intentional use of physical force against a child that results in or

has the potential to result in physical injury" (Leeb et al., 2008); it is often perpetrated by "someone who is in a temporary or permanent custodial role." Some Violence Against Children Surveys have revealed a very high prevalence of physical violence. In a large study of 24 developing countries, approximately 63% of caregivers reported that their child(ren) had been victims of physical violence in their household within the last four months (Lansford & Deater-Deckard, 2012).

Sexual violence encompasses any sexual activities or attempt to obtain sexual acts imposed on a child (Jewkes, Sen, & Garcia-Moreno, 2002), including unwanted sexual comments, coerced sex or sexual behavior, and commercial sexual exploitation. The health-related outcomes of sexual violence include sexually transmitted diseases and HIV, infectious diseases, chronic diseases, reproductive consequences, unintended pregnancies, and mental health problems (Hillis et al., 2017; Williams, Clear, & Coker, 2013; Reza et al., 2009; Felliti et al., 1998).

Mental and emotional violence against children comprises psychological maltreatment, mental abuse, verbal abuse, and emotional abuse or neglect. The range of behaviors to include in this definition is broad, but bullying and hazing (both by adults and by other children) are notable, as is the use of new communication technologies as bullying means (text phones, social media and internet). Many studies have demonstrated that violence victimization increases the risk of many negative mental health consequences, ranging from depression to suicide attempts and completing suicide (Benjet, 2010; Hillberg, Hamilton-Giachritsis, & Dixon, 2011; Dube et al., 2001). One study on the mental health consequences to children exposed to intimate partner violence (IPV) showed that IPV is associated with a greater risk of mental health problems (Sonego, Pichiule, Gandarillas, Polo, & Ordobas, 2018).

VAC in Africa

Low-income countries in Africa are plagued with numerous public health problems but often have limited information and resources to address them successfully. In 2014, it was estimated that over 200 million children aged 2 to 17 had been exposed to violence in Africa (Hillis et al., 2017). The problem of VAC in Africa is particularly high (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011) and is amplified by multiple and multidimensional risk factors including poverty, gender and social inequalities, wars and civil unrest, inexistent or ineffective VAC prevention policies and/or inadequate governance or law enforcement, and more (Cluver, Orkin, Boyes, Gardner, & Meinck, 2015). The problem of violence perpetrated against African children must also be considered and addressed within a broader social and cultural context (African Child Policy Forum, 2016; Miller & Shinn, 2005). Competing public health and other social priorities added to harmful social norms and the paucity of data about the problem of violence against children hinder appropriate and effective prevention and response options.

The very first Violence Against Children Survey was conducted in Swaziland (now known as eSwatini). Although this study was conducted only with females, it revealed that nearly 1 in 5 females in Swaziland had experienced childhood physical abuse (Breiding, Mercy, Gulaid, Reza, & Hleta-Nkambule, 2013). The research on risk factors associated with violence against children has been limited to individual and interpersonal risk factors. For instance, in Swaziland, more females in Swaziland who were abused in their childhood had lost their mother before they were 13. Furthermore, childhood physical abuse was significantly associated with several adverse health events among these girls, including sexually transmitted infections (Breiding et al., 2013).

Research led by the African Child Policy Forum (ACPF) has indicated that a large percentage of children are victims of physical violence in the home setting. Violent forms of discipline, including beating, are perpetrated towards children on a regular basis as discipline or punishment. For example, 60% of children in Zambia, Morocco, and Uganda and approximately half of children in Mali and Ethiopia experienced physical punishment in the home setting from family members, mainly mothers, fathers, and older siblings. In the school setting, an estimated 92% of pupils in Togo, 86% in Sierra Leone, 73% in Egypt, 71% in Ghana, 60% in Kenya, and 55% in Senegal and Benin reported having experienced physical violence by teachers or classmates (African Child Policy Forum-ACPF, 2014). In four African countries, the prevalence of physical violence ranged from 64% to 74% for girls and 72% to 76% for boys (Reza et al., 2009; UNICEF, CDC, & Kenya National Bureau of Statistics [KNBS], 2012; UNICEF, CDC, & the Muhimbili University of Health & Allied Sciences, 2012; Zimbabwe National Statistics Agency [ZIMSTAT], UNICEF, & Collaborating Centre for Operational Research and Evaluation (COORE), 2013).

Sexual violence against children has been a lasting and uncomfortable subject in Africa. Although the sexual abuse of children is a global problem, it is of large magnitude in Africa (Lalor, 2004; Stoltenborgh, 2011). In Africa, the African Child Policy Forum has reported incidents of sexual violence in the home ranging from 2% to 9% and in the community from 10% to 30% (ACPF, 201). The dearth of data on sexual violence against children creates an obstacle to addressing this underreported problem. Where data have been accessed, the rates of sexual violence against children are high in many countries, with, in general, more than 25% of girls and more than 10% of boys reporting having experienced childhood sexual violence (Sumner et al., 2015). Previous VACS have revealed that more than one-fourth of girls had

experienced sexual violence (forced or pressured) during her first sexual intercourse (Fielding, Teutsch, & Breslow, 2010).

Both sexes experience sexual violence; however, the problem is more prominent with girls. Studies indicate that girls are at greater risk, whether it be in the school setting, in the community (e.g., on the street, from school to their homes), or at home. In four countries, VACS findings revealed that the prevalence of sexual abuse for girls was between 27% to 38%, and for boys, the prevalence ranged from 9% to 18% (Reza et al., 2009; UNICEF, CDC, & KNBS, 2012; UNICEF, CDC, & the Muhimbili University of Health & Allied Sciences, 2012; ZIMSTAT, UNICEF, & Collaborating Centre for Operational Research and Evaluation (COORE), 2013). Globalization and the internet, with the advent of social media, have increased other forms of sexual violence targeting girls. Furthermore, the aforementioned studies show that many young women and girls who suffer sexual violence in sub-Saharan Africa also suffer significant, debilitating obstetric issues and increased STD and HIV transmission in both the short and long terms (Chiang et al., 2015).

Although mental and emotional violence are not always recognized as a problem in most African communities, several VACS studies have revealed that such violence is pervasive and normalized. Prior Violence Against Children Surveys in Kenya, Tanzania, and Zimbabwe have shown that although all children suffer emotional violence from various perpetrators, more boys are victims of emotional violence than are girls (with prevalence as high as 39% and 29%, for the respective countries) (Reza et al., 2009; UNICEF, CDC, & KNBS, 2012; UNICEF, CDC, & the Muhimbili University of Health & Allied Sciences, 2012; ZIMSTAT, UNICEF, & Collaborating Centre for Operational Research and Evaluation (COORE), 2013). Various forms of emotional violence are used as disciplinary methods. Very little is known on the topic, and more research

will provide more visibility and clarity for this little-understood area (Africa Child Policy Forum, 2014).

VAC in Côte d'Ivoire

Although it is suspected that the situation in Côte d'Ivoire pertaining to VAC is exacerbated by the accumulation of multiple factors, there is currently little to no data to determine the magnitude of this problem. The scope of violence against children in the country raises concerns considering the intergenerational transmission of violence in a context already worsened by the ten-year political/military crisis and related violence (Human Rights Watch, 2018).

Factors Associated with VAC in CI

Factors supporting violence against children in CI include, among others, harmful social norms and beliefs supporting gender-based violence and other attitudes that are accepting of violence in general, such as impunity (Amnesty International, 2007). VAC in CI is widespread and socially tolerated. Political and social instability engendered by conflict (Amnesty International, 2007; Blay-Tofey & Lee, 2015) and war (Human Rights Watch, 2018) have also fueled, or at the very least sustained, the problem. Other factors include poverty and lower literacy and educational levels. According to the African Child Policy Forum, war-torn countries see a spike of the worst kind of sexual violence as it is weaponized (ACPF, 2016). Existing data, albeit limited, reveal high levels of violence against children in CI. UNICEF's study on disciplinary practices at home in low- and middle-income households revealed that 92% of children interviewed in CI aged 2-14 experienced physical punishment in the home (UNICEF, 2010). The Multiple Indicator Cluster Surveys (MICS) conducted by UNICEF in 2006 revealed that social norms justify violence against women and children within the family, as evidenced by

the acceptability of wife beating and corporal punishment of children (UNICEF, 2006). Very little changed from 2006 to 2015. The Demographic and Health Surveys (DHS) final report in 2012 (ICF International, Ministry of the Fight Against AIDS (Côte d'Ivoire), National Institute of Statistics (Côte d'Ivoire), 2012) and a 2015 national study on violence against child students in primary and secondary schools revealed a high percentage of VAC in both schools and homes (MENET & UNICEF, 2015). The DHS study (2012) also provided sobering information on physical and sexual violence against girls and women after the age of 15. Among children, 40% of both boys and girls had been physically punished by their teachers, and 3.5% of students stated that they had sexual intercourse with a teacher. In the face of these dismaying findings, the government of CI has recognized the lack of comprehensive data on violence against children as an important challenge to the development of a sound action plan addressing violence.

Status of Child Protection Systems in CI

In 2012, the government of Côte d'Ivoire adopted and launched a national child protection policy to prevent and protect children from all forms of violence and abuse. The policy, called the "Politique Nationale de Protection de l'Enfant (PNPE)" (Ministère de la Famille, de la Femme et de l'Enfant, 2012), outlines the child protection system plan for the next 10 years and the interventions, strategic directions, and responsibilities of each sector to improve prevention, detection, and victim assistance and to fight against impunity. This policy also requires more systematic efforts to assess and monitor trends in violence against children.

In a 2012 working paper, the Interagency Group on Strengthening Child Protection Systems (Interagency Group on Strengthening Child Protection, 2012) provided the status of the child protection system in CI and described the efforts that have been deployed as presented below:

- A coordination body was put in place in 2012, which is led and facilitated by a government-mandated governmental agency.
- A mapping of child protection services was completed in 2010 that identified all child protection services and other associated services in all regions of the nation (government report by Child Frontiers). A more recent review of the mapping was conducted by UNICEF in 2018.
- A strategy document to address the issue was in progress in 2012. In 2014, a national child protection policy was finalized and was supported by a national action plan (2014-2018) for its implementation. The aim of the plan was to combat violence, abuse, and exploitation against children. Consultations are currently underway for the plan to be actualized.
- A costing activity was later completed, providing an estimated budget of over $7 billion; the government of CI had committed to advancing a little less than half of the funding.

Table 1 lists five priority areas for action from government to improve the life of children recommended in the 2013 African Child Policy Forum Report (African Child Policy Forum-ACPF, 2013). The recommendations proposed in the following section align with these priority areas. Overall, addressing political support or devising political strategies is key for enabling all dimensions to progress.

Table 1

Five Priority Areas for Action

1. Strengthening systems and capacities to enhance accountability to children.
2. Further improving the survival of children and their access to basic needs and services.
3. Increasing budgetary allocations to programs benefiting children and enhancing

commitment to address growing inequality.

4. Providing full legal protection for children and strengthening enforcement.

5. Putting in place mechanisms to ensure children's participation in decisions that affect them.

Note. Source: African Child Policy Forum, 2013.

Nonetheless, the very first step towards tackling the problem of VAC is for each country to fully understand the issue, each in their specific context.

Using Data to Make Violence against Children Visible

Although data on violence against children remain scarce, there are useful data sources to describe the magnitude and impact of violence, elucidate the risk and protective factors, and determine the effectiveness of violence prevention initiatives. Those data sources gather various information types such as individuals, agency records, local programs, community and government records, special studies, and population-based and other surveys, including the Multiple Indicative Surveys, WorldSAFE, the Health Behavior in School-Aged Children Survey, and the Global School Health Surveys. These surveys mostly focus on a single type of perpetrator or location of the violence event, such as parents/caregivers and school, respectively. The Violence Against Children Surveys (VACS) administered by the UN, however, capture information about multiple perpetrators, locations, etc. (Chiang et al., 2016; Hillis et al., 2016).

Violence Against Children Surveys (VACS)

Evidence from a longitudinal study on adverse childhood experiences (ACEs) in the US suggests a dose-response relationship between adverse experiences (including emotional, physical, or sexual violence; witnessing intimate partner violence (IPV) or an attack in the community; or the death of one or both parents) and the negative impact on a range of health

outcomes in adulthood (Brown et al., 2009; Felitti et al., 1998; Hillis, Anda, Felitti, & Marchbanks, 2001; Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000). Evidence from ACE studies suggests that as the number of ACEs increases, so does the risk of poor health outcomes. The Violence Against Children Surveys project (Chiang et al., 2016; Hillis et al., 2016), or VACS, builds upon ACE studies by researching violence against children in other countries. The VACS are nationally representative, cross-sectional household surveys about childhood experiences of violence. The participants are females and males, 13 to 24 years old, who are asked about their experiences of violence before age 18.

VACS started in 2006 and has expanded since then to 24 surveys in 22 countries around the world. This rapid expansion has substantially increased the availability of critical data on the burden of violence against children and youth. This data constitutes part of the resources leveraged to drive public health action. The VACS are implemented as part of the Together for Girls partnership, which brings together 22 national governments, six UN entities, and private-sector organizations. UN partners of Together for Girls include UNICEF, UNAIDS, WHO/PAHO (Pan American Health Organization), UN Women, United Nations Population Fund (UNFPA), and the UN Special Representative of the Secretary-General on Violence Against Children, as well as the Global Partnership to End Violence Against Children. The United States and Canada are represented by their respective agencies: CDC, the US President's Emergency Plan for AIDS Relief (PEPFAR), the United States Agency for International Development (USAID), and Global Affairs Canada. Private-sector partners include BD (Becton, Dickinson and Company), Cummins & Partners, and the CDC Foundation.

VACS systematically estimate the national prevalence of physical, emotional, and sexual violence against children through multiple measures, in addition to identifying risk and

protective factors, health consequences, and service availability and utilization for violence-related events. VACS ask a series of questions about different forms of violence, demographics, health outcomes, sexual risk-taking, HIV/AIDS testing behaviors in countries with high HIV prevalence, migration and internal displacement in conflict-affected countries, and about gender attitudes in all countries.

VACS data provide a baseline for understanding the burden of violence against children in the countries in which the survey is taking place. Country governments can then use this data to delineate the problem of violence against children according to the realities of their country and to develop prevention programming and response as well as policy reform. This data is also comparative across countries, allowing for easier and more accurate interpretations of the data, south-to-south collaborations, and the potential to identify regional trends. VACS maintain their fundamental methodology (such as participant criteria and recruitment, the definition of each form of violence, etc.) across all the surveys while adapting the survey to each country's specific realities.

The translation of the data into actionable and measurable outcomes starts during a data-to-action (D2A) workshop that is tailored to the country-specific context and data but grounded in the INSPIRE framework of identifying evidence-based interventions for adaptation (the data-to-action framework will be discussed in greater detail later). The VACS is the lynchpin of a broader initiative to use data collection to engage country governments in policy changes and effective programming. Not only is there a dearth of data on violence against children everywhere, there is also a need to strengthen policy and programming for VAC prevention using evidence. As such, VACS are the first step in a multistep process to better inform policy and programming. The strategy to accomplish this goal includes the engagement of local

institutions early in the process, leadership and government participation, and the involvement of all sectors from planning throughout data collection; the process culminates with a data-to-action workshop.

The VACS utilize a multisectoral approach and follow a six-step process (Appendix C) from country engagement to the development of a multisectoral national response plan (via the data-to-action workshop). From the start of the process until its end, when a national action plan has been laid out, close communication, continual engagement, and strong collaboration are priority principles.

Multisectoral System Approach to the VACS

Findings from a roundtable discussion held at the 2014 Centre for Global Health and Health Equity's Forum identified four main priorities when addressing violence: 1) support and adopt policies to prevent or reduce structural violence; 2) adopt multipronged strategies to transform dominant social norms associated with violence; 3) establish standards and ensure adequate funding for violence prevention programs and services; and 4) fund higher-level ecological research on violence prevention and mitigation (Hyman et al., 2016). To align with these recommendations, the VACS was designed to be multisectoral by scientists at the Centers for Disease Control and Prevention (CDC), who collaborate with and assist governments and local partners with the planning and implementation of the survey. The idea is to strengthen multisector prevention and response by developing evidence-based approaches (Wirtz et al., 2016). In South Africa, for instance, the prevalence of VAC is high (Artz et al., 2016). To address sexual violence against children, the South African government, international agencies such as UNICEF, and other local nongovernmental agencies understand the need to integrate

health, social, police, and criminal justice services to adequately serve abused children (UNICEF South Africa, 2013).

The VACS operate under the paradigm of collective impact (Kania & Kramer, 2011), which supports a multisectoral representation with governmental leadership and guidance of the VACS process. The principles to achieve collective impact are:

- Understanding that social problems—and their solutions—arise from the interaction of many organizations within a larger system;
- Cross-sector alignment with government, civil society, nonprofit, philanthropic and corporate sectors as partners;
- Organizations actively coordinating their action and sharing lessons learned;
- Organizations working toward the same goal and tracking the same measures of progress.

The key for both the VACS and the data-to-action workshop is the composition of a VACS multisectoral task force led by a governmental agency and consisting of the sectors of social protection, health, justice, education, and finance, plus civil-society organizations. In the beginning of the partnership, country governments are encouraged to form a multisectoral task force to advise survey implementation throughout every step of the process. This element is essential from policy and methodological viewpoints. Representation from multiple governmental and nongovernmental organizations fosters buy-in from country stakeholders not only for the smooth execution of the survey itself but also for subsequent response actions.

The process of VACS implementation has six steps (Appendix C) that include both the political and technical elements necessary for successful implementation of the survey and the adoption of policy and programmatic improvements based on the INSPIRE framework. The steps are as follows: 1) country engagement; 2) mobilization; 3) ethical review; 4) field work

training and preparation; 5) data collection, analysis, and report writing; and 6) dissemination and data-to-action. Steps 1 and 2 have a heavy policy component aimed at establishing the survey in the country and identifying its organizational structure and lead agencies. Steps 1 to 5 serve to mobilize local stakeholders around the issues and survey project, prepare and plan the project, and implement the survey. In each step (1 to 6), strong policy and governance elements are highlighted.

During Step 6, dissemination and data-to-action, the data-to-action workshop implements a structure and process aimed at identifying country goals and creating a draft national action plan or VAC-related recommendations for the country. Activities are intended to help institutions transition from data and data interpretation into policy goals and objectives supplemented by activities.

Country Engagement via Bilateral Meetings and Data-to-Action Workshop

The VACS data and INSPIRE form the twin cornerstones of the CDC and Together for Girls strategy to help countries improve efforts to prevent and respond to violence against children and youth. Following data collection and data analysis, the final report will highlight recommendations for an effective and strategic national action plan to prevent VAC in Côte d'Ivoire. A critical step towards the development of the national action plan is country leadership engagement in the steps following the VACS. A series of bilateral meetings serve to socialize key government departments and nongovernmental agencies with the analyzed results of the survey priority indicators. Then, a data-to-action workshop is conducted in the country, during which country leaders and other stakeholders meet to discuss VAC prevention strategies and prioritize strategies for adaptation, implementation, evaluation and, eventually, for scale up. The first part of this workshop aims to make the data accessible by translating it into clear and simply

stated findings; the second part emphasizes the importance of evidence-based strategies, particularly those assembled in the INSPIRE technical package.

The agenda for the three (or sometimes four) day workshop is as follows: the first module comprises a review of the VACS data, supplemented by additional data from other sources. Then, in module two, each sector group, as well as CSOs, works in small groups to discuss how a specific problem relates to that sector; they also discuss the INSPIRE strategies to determine which of the strategies and approaches to adopt. Finally, in module three, all the participants come together to decide which of the proposed options will be retained in the final plan. This process paves the way for the national action plan.

The VACS in Côte d'Ivoire

Since the first political coup in 1999, the government of Côte d'Ivoire has been unstable, and the country has witnessed a spiral of violent events. These events have gravely affected the entire population, but more specifically, women and children. In 2013, the African Child Policy Forum reported that Côte d'Ivoire ranked 44 on the Child-Friendliness Index (CFI), in the "least child-friendly" category (ACPF, 2013). In 2014, the Dialogue, Truth and Reconciliation Commission of CI submitted a report describing serious violations committed between 1990 and 2011 (as cited in Wormington, 2015). Amid everything else, this report documented horrible cases of sexual violence against women and girls. In 2014, the government of CI determined that the time had come to combat this problem by strategically targeting gender-based violence. The government called for the support of multilateral organizations to address this issue. Recognizing the dearth of data nationwide, it was decided to conduct a VACS. The results of this survey would serve as a baseline national estimate of violence against children and youth for future response interventions and prevention strategies.

The main objectives of the VACS-CI are to determine the magnitude of the VAC problem in CI and to define the context surrounding the problem, thereby providing the government and other local stakeholders with comprehensive data to develop sound and efficient policies and programs. In a series of visits during the engagement phase, decisions were made to determine the roles and responsibilities of the government and other partners, including the ministry representing the government, and parties were charged with leading the survey. The VACS use a multisectoral framework, which encourages deliberate and sustained collaboration between multiple stakeholders and across sectors, departments, and organizations. Salunke and Lal (2017) posited that "[b]y engaging multiple sectors, partners can leverage knowledge, expertise, reach, and resources, benefiting from their combined and varied strengths as they work toward the shared goal of producing better health outcomes" (p. 163).

The next phase allowed the mobilization of the appropriate leaders around the issue of violence against children, to identify funding sources for the nationwide survey, and to support the implementation of the survey and ensuing programs. The lead ministry assembled a multisectoral task force (MSTF) composed of additional key line ministries and other key stakeholders to provide input and foster broad ownership. The idea was to integrate various sectors and strategies to ensure the development of a final, comprehensive national action plan and its implementation. The National Program for Orphans and Vulnerable Children (Programme National de prise en charge des Orphelins et autres Enfants rendus Vulnérables du fait du VIH/SIDA, or PNOEV) was the coordinating agency and the National Statistics Institute implemented the survey.

During the third phase, which consisted of ethics review, CDC collaborated with the MSTF to finalize the research protocol and survey tools, which ensure the protection of survey

participants and the integrity of the research procedures during field work. The fourth and fifth phases consisted of implementation planning and training of interviewers for data collection and the subsequent analysis of the data collected, respectively. Data collection was recently completed (September 2018), and the data analysis is currently underway.

The final, sixth phase is the dissemination of and response to the survey findings through a VACS-CI final report and the development of a national action plan to reduce and prevent VAC in CI. The final report will provide a set of recommendations to the government and partners to address the problem of VAC. In efforts to ensure that data is followed by concrete actions, a series of bilateral meetings took place in December 2018. During these meetings with key ministries and other organizations, VACS leadership shared results of the primary indicators of the study.

Country leaders and experts were then gathered for a data-to-action workshop. Throughout every step, communication, engagement, and collaboration with the country remains important from both a policy and methodological standpoint. The data-to-action process in CI recently took place, in June of 2019.

Strategies to End Violence against Children

The importance of evidence is uncontested by researchers, practitioners, and decision makers; nonetheless, there is little consensus on the definition and criteria for evidence. According to Rycroft-Malone et al. (2004), "a unifying theme in all definitions of evidence is that, however evidence is construed, it needs to be independently observed and verified" (p. 82). The continuum of evidence of effectiveness (Puddy & Wilkins, 2011) is a tool (see Appendix D) that clarifies and defines standards of the best available evidence for research. Although best-available research evidence (Puddy & Wilkins, 2011) is the evidence type most commonly used

in many fields, it is not the only standard of evidence that has been proposed by the CDC's Evidence Project (CDC, 2013). Other forms of evidence are also very important when making decisions based on evidence (Puddy & Wilkins, 2011). Experiential evidence is based on professional experience, otherwise known as intuitive or tacit knowledge, and contextual evidence focuses on applicable, achievable, and putative strategies for communities (Puddy & Wilkins, 2011). The INSPIRE technical package is composed of seven strategies based on best available evidence (Butchart & Hillis, 2016).

In recent years, WHO has collaborated with 10 other agencies, including the CDC and UNICEF, to develop and launch a technical package describing seven evidence-based strategies to prevent VAC (WHO, 2016), entitled INSPIRE: Seven Strategies for Ending Violence Against Children. Countries that have implemented or are planning to implement a VACS for their nation are encouraged to familiarize themselves with the package and consider adopting these strategies. These strategies form the acronym for INSPIRE and are as follows: **I**mplementation and enforcement of laws, **N**orms and values, **S**afe environments, **P**arent and caregiver support, **I**ncome and economic strengthening, **R**esponse and support services, **E**ducation and life skills (Butchart & Hillis, 2016; World Health Organization, 2016).

The INSPIRE technical package (see Appendix A) is an evolving, unified package that has compiled several of the best available evidence-based strategies and programs from different sectors to date for preventing and responding to violence using an actionable framework. Although these seven evidence-based strategies are not exhaustive, they were selected because they demonstrated criteria for being effective, promising, and prudent. More importantly, these strategies needed to incorporate at least two cross-cutting components: multisectoral actions and coordination, and/or monitoring and evaluation (Frieden, 2014). INSPIRE interventions require

and support multisectoral collaborations for prevention and response efforts. Moreover, the VACS incorporate INSPIRE indicators, which directly measure key indicators of each INSPIRE strategy to monitor and evaluate over time.

Recognizing the complex factors and their interplay that enable or prevent violence against children, the developers of this technical package evaluated the strategies included in the package through the ecological framework lens. The INSPIRE package thus provides an ecological perspective to address violence against children at the individual, interpersonal, community, and societal levels (Fielding et al., 2010; WHO, 2016). The strategies described in the package intervene on one or several levels of the ecological model, separately or together, sequentially or concomitantly. INSPIRE is a technical tool that can help policy makers frame actions within an evidence-based set of possible strategies. Those strategies also stem from multiple sectors and can be combined to form an integrative and comprehensive approach. This approach has proven effective and efficient (Frieden, 2014). The INSPIRE strategies have also been linked to the SDG targets that they will be supporting. Finally, monitoring and evaluation tools have also been created that can help governments implement and follow-up their implementation over time. The seven evidence-based strategies in the INSPIRE package strategies are described in Table 2 below and aligned with sustainable development goals.

Table 2

Description of INSPIRE Strategies Aligned with Relevant Sustainable Development Goals

Strategies	Strategy Description	Sustainable Development Goals

Implementation and enforcement of laws through the justice sector	This strategy stresses the importance of implementing two sets of laws in the prevention of VAC: laws that prevent violence against children and enforce retribution for that behavior and laws that reduce or prevent risky behaviors.	SDG: 3.5, 5.c and 16.3
Norms and values, usually through gender and social protection	Norms and values impact not only the individual's beliefs and way of thinking but also entire communities and societies. Norms and values are deeply engrained, making them difficult, albeit not impossible, to uproot. This strategy seeks to strengthen norms and values that support nonviolent, positive, and gender-equitable relationships.	SDG: 4.7 and 5.1.

Table 2 (CONTINUED)

Description of INSPIRE Strategies Aligned with Relevant Sustainable Development Goals

Strategies	Strategy Description	Sustainable Development Goals
Safe environments	This strategy focuses on community environments, i.e., those other than homes and schools. The idea is that safe communities (physically and structurally) foster positive behaviors while dissuading destructive ones. This strategy benefits both children and adults.	SDG: 11.1 and 11.7
Parent and caregiver support	Violent discipline is one of the most recurrent forms of physical violence against children. In many cultures and communities, this mode of discipline is the main method used for parenting. This strategy seeks to reduce harsh parenting practices and replace them with gentler, more effective methods.	SDG: 1.3, 3.2 and 4.2

Table 2 (CONTINUED)

Description of INSPIRE Strategies Aligned with Relevant Sustainable Development Goals

Strategies	Strategy Description	Sustainable Development Goals
Income and economic strengthening through the finance sector	The foundation for this strategy is the assumption that improved economic security and stable income will reduce child maltreatment and intimate partner violence. This strategy focuses more specifically on women's access to more and better resources.	SDG: 1.3, 1.4, 5.2, 5.3 and 10.2
Response and support services through the health services sector	This important strategy highlights the need to increase access to good basic health and social services, including response to violence. An entire mechanism should be established that encourages disclosure to the appropriate person/service, seeking help post-violence as needed, and easy access to child protection services.	SDG: 3.8 and 16.3
Education and life skills through the educational sector	The rationale for this strategy is that education protects from victimization and perpetration of violence; furthermore, schools are an essential space where children learn life skills, and even teachers can learn and adopt positive behavior to prevent violence against children.	SDG: 4.4, 4.7, 4.a and 5.1

Given its multisectoral underpinning, implementing INSPIRE necessitates the leadership and involvement of several sectors. Ideally, at least one intervention from each INSPIRE strategy should be implemented by their respective lead sectors, either progressively or simultaneously. Typically, the VACS multisector task force consists mainly of specific sectors and is coordinated and presided over by a governmental organization. The MSTF forms a system within which INSPIRE strategies can be implemented to address the VAC problem.

To guarantee collective impact, which occurs when organizations across different sectors agree to solve a specific social problem using a common agenda to align their efforts, with common measures of success and ongoing communication in a coordinated way (Kania & Kramer, 2011), it is safe to conclude that a successful implementation of INSPIRE in CI will require:

1. Strong governmental engagement and political commitment to solve the problem of violence against children;
2. Common objectives and a clear implementation agenda across all partners and stakeholders;
3. Appropriate resources from each sector involved;
4. Effective governmental coordination of agencies and partners and cross-cutting interventions.

Theoretical Framework

This study will be supported by the appreciative inquiry (AI) model, which focuses on strengths rather than weaknesses during the evaluative process, and by the community readiness model.

Appreciative Inquiry

Prior to the 1980s, the research field's approach to needs assessment and evaluative efforts was problem based. The research study typically began with the identification of the

problem and sought to find causes and the solutions to this problem by investigating several alternative (external) avenues.

Appreciative inquiry was created in the 1980s by David Cooperrider and colleagues. Their objective was to offer a paradigm shift to existing change management theories, which are problem focused (Cooperrider, Barrett, Srivastva, 1995; Cooperrider & Whitney, 2005). As Stavors, Godwin, and Cooperrrider (2015) explain,

> [At] its heart, AI is about the search for the best in people, their organizations, and the strengths-filled, opportunity-rich world around them. AI is not so much a shift in the methods and models of organizational change, but AI is a fundamental shift in the overall perspective taken throughout the entire change process to 'see' the wholeness of the human system and to 'inquire' into that system's strengths, possibilities, and successes. (p. 97)

Cooperrider and colleagues sought to encourage researchers and community developers to forego the deficit-based perspective and adopt a strengths-based perspective (Stavors, Godwin, & Cooperrrider, 2015). The guiding idea for such a shift was that the entities (organizations, or communities) under research should not be diagnosed to be fixed; rather, they should be assessed to bring to light their existing assets and other positive qualities. AI "deliberately seeks to discover people's exceptionality—their unique gifts, strengths, and qualities. It actively searches and recognizes people for their specialties—their essential contributions and achievements" (Hammond & Royal, 2001, p. 12).

The core processes of AI form a cycle and are referred to as the 5 Ds, which stand for: 1) Definition, when a positive focus of inquiry is selected; 2) Discovery (what is), which probes into currently through open conversation; 3) Dream (what could be), which creates a positive

image of what could be based on the positive Discovery; 4) Design (what should be), which determines a present plan based on past successes; and 5) Delivery (what will be), which develops programs to realize the dreamed-of future (Mohr & Watkins, 2002).

The first and main premise that underlies appreciative inquiry is the idea of strengths-based assessment and change. Instead of examining what does not work within the unit of study, AI concentrates on what is already good and right and what has the potential to work. The readiness assessment, albeit realistic, should not be imprinted with negativity, difficulties, and problems. Once the focus is on weaknesses, the assessment takes on negative undertones. The AI model seeks to shift the assessment and change planning from a SWOT analysis (strengths, weaknesses, opportunities, and threats) to a SOAR analysis (strengths, opportunities, aspirations, and results).

The second premise of the AI model proposes that the change process should involve the entire system in any organization from beginning to end. AI also posits not only that every compartment of the organization should be represented in the process but also that, strategically, many individuals should participate for a broader impact. All focus thus remains on the endless possibilities of desired outcomes based on existing strengths (Hammond, 1998).

In a context of limited resources, the intent behind conducting a readiness assessment under the premises of the appreciative inquiry model is to highlight assets during the survey, rather than needs, and to secure the trust and openness of leadership and other stakeholders by validating the positive elements of their system. In other words, instead of criticizing and highlighting what does not work, the study uses positive questioning techniques to lead to desired outcomes and solutions. Regardless of the level of readiness assessed during the study, the analysis will steer away from a problem-based approach and draw attention to the existing

strengths and other supportive features instead. By emphasizing the positive, the government and its partners will likely be empowered to own whatever plan emanates from this process and will be motivated to continue to build upon it (Delgadillo, Palmer, & Goetz, 2016).

The scope of use of the AI model will be limited during this study. The topic of study has already been identified. This study will not focus on the Design and Delivery phases of the process, as the Discovery and Dream phases are more relevant for this project. The Discovery phase will be appropriate during the inquiry phase of the study. The Dream phase will also be embedded into the inquiry phase of the study and, based on the readiness stage found by the study, will influence the vision for the future.

Community Readiness

This study will adopt the community readiness model (CRM), which was developed at the Tri-Ethnic Center for Prevention Research (Oetting et al., 1995; Plested et al., 2006; Oetting et al., 2014). Edwards and her colleagues (2000) at the University of Colorado first developed the model to understand which kind of program would best suit alcohol and drug use prevention in small communities in the US (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). The basis for this model is to ensure that any program developed within a community should match the resources at hand to tackle any issues successfully. The community readiness model stems from the stages of change (Prochaska & Velicer, 1997) and community development (innovative decision-making model and social action process) models (Oetting et al., 1995; Jumper-Thurman, 2000).

As described in *Community Readiness: A Handbook for Successful Change*, the CRM process assesses the preparedness to "take action" on a specific issue (Plested, Edwards, & Jumper-Thurman, 2006) by measuring the attitude, knowledge of issue, efforts and activities, and

resources of the community and of the leadership. The goal is to assess the community's readiness in the six following key dimensions: Efforts, knowledge of efforts, leadership, community climate, knowledge of issue, and resources (Thurman, Plested, Edwards, Foley, & Burnside, 2003) (Appendix E).

Recognizing that communities behave very similarly to individuals when it comes to change, one of the foundations of the community readiness model is the transtheoretical model of behavior change, also called the stages of change model (Diclemente & Prochaska, 1997). The stages of change model posits that there are essentially five stages of change that any individual (or, in our case, the governmental system of response to VAC) may occupy: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance.

The authors of the community readiness model (Oetting et al., 1995) defined community readiness as the "degree to which a community is willing and prepared to take action on a particular issue" (p.660). To the stages of change, they added other constructs from Warren (1978) as cited in CDC's "Handbook of Injury and Violence Prevention" (Doll, Bonzo, Sleet, & Mercy, Eds., 2007). The community readiness model (CRM) thus has nine stages of readiness: No awareness, denial/resistance, vague awareness, preplanning, preparation, initiation, stabilization, confirmation/expansion, and high level of community ownership (Appendix F). The higher the state of readiness is, the more ready the community is to take action.

Some of the issues addressed by the community readiness model include drug use (Oetting & Edwards, 1999; Plested, Smitham, & Jumper-Thurman, 1999) and alcohol abuse (Paltzer, Black, & Moberg, 2013), HIV/AIDS (Plested, Edwards, & Thurman, 2009), obesity (Findholt, 2007); nutrition (Hildebrand, Blevins, Carl, Brown, Betts, & Poe, 2018), and child abuse (Ottumwa, Wapello County, 2015). One of the many benefits of this model is that

communities can work within their culture to establish effective and sustainable actions that fit within their specific context.

A qualitative approach will be more effective to study the contextual background and all other relevant aspects to consider when assessing readiness to address any health and social problem using specific evidence-based strategies. This exploratory study will be a one-time endeavor that will provide information pertinent to the realities of the country at the time of data collection. This research method was selected because it suits the purpose of the study, which is to explore the level of readiness of the VAC response system of CI to lead VAC prevention efforts. This method is also appropriate because it will allow a relatively short timeframe for data collection, using a relatively easy and inexpensive instrument.

This methodology is appropriate considering the limited financial and human resources available for this research endeavor. Nonetheless, the validity and reliability of this qualitative research will be warranted using the community readiness assessment instrument, which has been used in multiple previous studies as aforementioned.

Chapter Summary

In this chapter, the literature review focused on VAC and efforts to prevent this problem. The need for data on VAC to serve as the basis for national action plans was also discussed. In CI, a recent completion of a VACS (2018), followed by a data-to-action workshop (2019), is providing an opportunity for the implementation of a national action plan to prevent VAC. Finally, the two-pronged model theoretical framework supporting the study was introduced. The methodology is presented in the next chapter.

CHAPTER 3

METHODOLOGY

This qualitative exploratory study examined several measures to evaluate the systems readiness of Côte d'Ivoire to implement evidence-based strategies to prevent violence against children. The study was supported by two main models: the appreciative inquiry (AI) model, which focuses on strengths rather than weaknesses during the evaluative process, and the community readiness model (CRM), which measures a community's level of readiness to address any identified issue. Figure 2 depicts how these two models relate and where they meet to form the basis for the study.

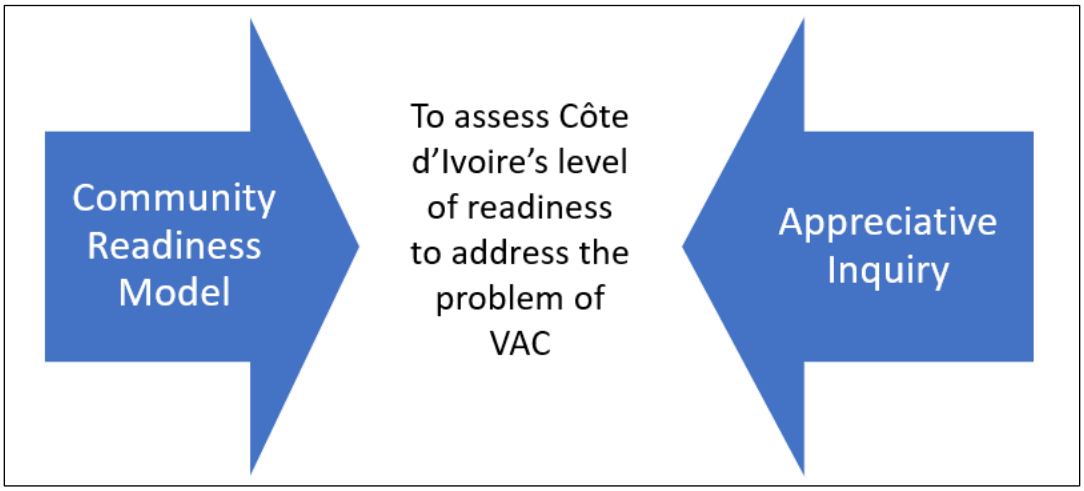

Figure 2. Study Supported by Two Models.

This qualitative research study, semi-structured in design, was supported by a primary data collection process using a paper-based questionnaire. During the community readiness assessment, participants from five main sectors of the MSTF were interviewed using a questionnaire modified from an existing instrument developed by the Tri-Ethnic Center for

Prevention Research (Oetting et al., 1995). The interview instrument was modified to focus on the topic of violence against children and explore key dimensions such as existing efforts to deal with the problem of VAC, knowledge of these efforts, political will and community climate to address this problem, knowledge of issues, and resources.

The research sought to answer the following two overarching questions:

1. What level of MSTF readiness do MSTF members perceive to support violence against children prevention strategies?

2. How much does readiness level vary across dimensions and across sectors?

Study Sample

The study recruited participants representing the sectors composing the MSTF: social welfare services, health, education, justice, interior planning, finance, and labor (see sampling frame in Table 3). The inclusion criteria for participants was as follows: 1) individuals with national knowledge about the issue, 2) individuals working in one of the sectors of the INSPIRE package cited above, 3) mid-level management representative of departments and ministries, and representatives of civil society organizations from the MSTF. To ensure a more representative sample, at least two representatives from each sector were invited to participate. More than 20 MSTF members were invited from the list of representatives in the MSTF.

Table 3

Sampling Frame

Sector	Number Anticipated	Actual Participation
Social welfare services	2	2
Health	2	1
Education	2	2
Justice	2	1
Interior planning	2	0
Finance	2	0
Labor	2	2

The researcher was supported by an institutional review board (IRB)-approved research assistant to recruit the study participants. Participants were identified from the MSTF membership list and invited via telephone or email. All recruitment materials were in French. The invitation letter (see Appendix G) stated the purpose of the study and described how individuals had been identified to participate in the study. When participants showed interest, individuals agreed to an appointment to complete the interview. A calendar of interviews was developed for the first two weeks in December 2018. The research assistant then followed up with each participant a few days before the interview with a reminder of the interview date and location.

A total of eight participants were interviewed. Table 4 presents informants' characteristics. All the participants were CI nationals who resided and worked in Abidjan, the

economic capital of CI. Among the informants, there was one (1) female and seven (7) males. This ratio is reflective of the gender mix ratio within the CI government in general (i.e., the current May 2019 government comprises a prime minister and 29 ministers, of which six are women ministers). Typically, government departments are more often headed by a man than by a woman.

Table 4

Study Respondents' Demographics and Sector of Employment

Demographic Variables	Number of Participants
Gender	
Male	7
Female	1
Age	
35-44	2
45-54	2
55-64	4
Sectors	
Social welfare	2
Justice	1
Education	2
Labor	2
Health	1
Overall participation	8

Regarding sectors of intervention represented in the MTSF, two (2) participants were from the education sector, one (1) from the justice sector, two (2) from the social welfare sector, two (2) from the labor sector, and one (1) from the health sector. Although no participant was recruited from the Department of Justice, a lawyer who works for an agency member of the MSTF was interviewed and serves as an appropriate proxy to represent the justice sector. All respondents were mid-level management employees within their agencies of employment. Each

participant stated that his or her agency's mission was (more or less) associated with children's wellbeing and safe development. The sectors of finance and interior planning were not represented due to lack of availability for an interview during the study period.

Data Collection and Procedures

Data collection used a modified version of the interviewer guide, the *Community Readiness Model Questionnaire,* from the community readiness model (CRM). This instrument was developed by the Tri-Ethnic Center for Prevention Research at Colorado State University after much research and testing in communities. This instrument incorporates six key dimensions and consists of 35 items. As mentioned above (section on theoretical models), the validity and reliability of the CRM interview tool have been demonstrated in multiple communities and for many different issues, including child abuse (Plested, Edwards, & Jumper-Thurman, 2006).

This questionnaire has been used to assess the readiness to address many issues in multiple communities. The questions and measures of the instruments described below have been piloted in many past studies (Findholt, 2007; Hildebrand, Blevins, Carl, Brown, Betts, & Poe, 2018; Oetting & Edwards, 1999; Ottumwa, Wapello County, 2015; Paltzer, Black, & Moberg, 2013; Plested, Edwards, & Thurman, 2009; Plested, Smitham, & Jumper-Thurman, 2006).

Instrumentation

This research study used an adaptation of the existing interview guide. The authors of the CRM developed the questions to be applied to each dimension, and they are all closely tied to the scoring process. Therefore, it was critical to ensure fidelity in adapting the questionnaire to the issue of VAC in CI. The questionnaire used in this study substituted the term "issue" in the questions with the phrase "violence against children." Additional questions were added to the

existing community readiness assessment original questionnaire to 1) obtain general institutional context 2) and assess perceived power to effect change. These additional questions served to illuminate the relevancy of the agencies represented in current efforts tackling VAC. Two questions pertaining to perception of power and six organization-specific questions were added to the instrument. Although these latter questions have not been scientifically validated, they have been used in previous country-level assessment and provided a deeper level of information useful for this kind of assessment. These questions were also piloted for this study as part of the questionnaire pilot phase. The following questions were added to investigate variations of readiness levels and factors of variation between dimensions and sectors:

- How confident are you that your agency can impact change on the topic?
- Do you feel that the multisectoral task force (MSTF) has the power to initiate, support, and sustain the change necessary to implement INSPIRE?
- What is the stated mission of this institution?
- What role does this institution have in preventing and controlling violence against children, adolescents, and youth?
- Does this institution have formal collaborations on the issue of violence against children, adolescents, and youth with other government institutions?
- Does this institution have formal collaborations on the issue of violence against children, adolescents, and youth with other international institutions?
- Do you systematically collect data or have administrative datasets with information on violence against children, adolescents, and youth?
- What are the most important programs or interventions within this institution (if any) that address violence against children, adolescents, and youth?

The modified questionnaire guide was validated through a pilot in French, which was completed via a purposeful selection of two employees of the Ministry of Women, Families and Child Protection, to ensure understanding and appropriateness of the questions. French-speaking locals who are professional translators and familiar with the culture translated the instrument from English to French. The French-speaking investigator also verified the translation to ensure fidelity to the original content and meaning of the questions. The answers to the questions on the piloted questionnaire were analyzed for content to ensure that the intention of the questions was satisfactorily captured and adequately conveyed.

Furthermore, although the questions were all important, some were skipped during an interview when time was limited. The authors of the CRM made clear that some questions could be skipped, while others (in bold) were essential questions to scoring and thus should never be skipped. The adapted CRM questionnaire served to answer both research questions, which sought to assess the MSTF's level of readiness to guide violence prevention strategies, and the readiness level variation across dimensions and sectors.

Procedures

Data collection took place in Abidjan, CI, via informal, semi-structured face-to-face interviews and paper-and-pen questionnaires. Both before and on the day of the interview, the researcher used a script (see Appendix H) to explain the purpose of the research and potential risks of participation in the survey and guarantee confidentiality of participants' answers; this information was also fully outlined in the consent form (see Appendix I). After participants were provided with a document explaining voluntary consent, they completed and submitted a consent form. Participants were also verbally informed that their participation in the study was both confidential and voluntary and that there were no direct benefits or compensation for their

participation. Last, the participants were informed that the interview might last up to 90 minutes and would be audio recorded. Before the interview, participants were reassured that if they were uncomfortable answering any question, they could skip those questions, and that they could stop the interview at any time without penalty. Participants were reminded that their responses would remain confidential and that survey information would solely be used for research purposes. Informed consent occurred by participants checking "Yes" on the informed consent form and signing the document. A copy of the consent form was the shared with each participant for their records. Any risk of participating in the study was minimized by efforts to ensure that the interview was conducted in a safe, private place. To minimize the risk of releasing sensitive information, all interviews took place in a private setting, selected by the participant, and information was collected confidentially. All study investigators were asked to protect confidentiality as stipulated in a confidentiality agreement form (see Appendix J) and to keep the study information private.

To help elucidate the observations, select sociodemographic information was collected from all eight participants, including demographic background, educational level, professional positions, institutions of work, and other characteristics. All interviews except one were conducted face to face. One interview was conducted via telephone, as the participant was not available for a face-to-face interview. Participants were interviewed using the CRM semi-structured questionnaire (see Appendix K), which was translated into French. Each interview took approximately 40 to 90 minutes. Unique identifiers were assigned to each selected interviewee, composed of the first initial of the sector they represented and the numeral 1 or 2, to ensure that no one would be able to connect the participant's unique identifier to a name.

The interviews were conducted by the primary researcher, who is bilingual English-French speaking, with assistance by the research assistant. To ensure congruence with the appreciative inquiry model, positive questioning was used to reframe positively all answers as needed. The objective was to generate positive ideas from the participants, which would help generate positive recommendations from the study (Mohr & Watkins, 2002).

The interviews were audio recorded, and the interviewers also took copious notes during the interviews, focusing on the details that could not be captured by the instrument. At the end of the interview, participants were invited to ask questions and add anything else they felt like discussing as it pertained to the topic.

The completed interviews were transcribed verbatim by a professional transcription service and translated back into English as needed by the researcher for the purposes of this report.

Data Analysis

The data analysis plan was based on the methods described by the CRM to identify the level of readiness on the nine-stage readiness scale for each dimension. Concomitantly with the CRM data analysis, the researcher used In Vivo coding (Charmaz, 2014; Saldaña, 2016) to conduct a thematic analysis across interview transcripts in sequence to detect themes, up to the point of saturation, meaning when there are no more apparent new ideas (Glaser & Strauss, 1967).

Through the CRM analysis, a deductive coding system was developed based on the six CRM dimensions (see Appendix E). This coding system was used to describe, sort, and analyze each participant's quotes. The inductive coding (In Vivo) was also used to analyze the quotes that did not appear to fit into the deductive coding list. Major themes were extracted from similar

statements across the transcripts. As themes appeared, they were collapsed and categorized into a coding frame using the CRM dimensions. Thematic analysis can be approached in many ways (Alhojailan, 2012; Javadi & Zarea, 2016; Maguire & Delahunt, 2017). The thematic analysis took place at the latent level (Braun & Clarke, 2006), and the process allowed an in-depth knowledge of the transcripts because each interviewer spent time reviewing each interview transcript and highlighting key comments, repeating a method from a previous study that assessed community readiness to implement environmental and policy-based alcohol evaluation (Paltzer, et al., 2013). The information under each theme was summarized into a readiness profile and scored by the interviewers according to the nine stages of change (Plested, Edwards, & Jumper-Thurman, 2006).

The analyses were conducted in three stages:

1. Using In Vivo coding to identify key constructs from the interviews. These constructs were compared for convergence and divergence to the findings from the CRA. These constructs formed the basis for key themes within and across interviews.
2. Using the dimension scoring method recommended by CRA authors to score dimensions and determine the stages of readiness.
3. Integrating analysis steps 1 and 2 to present the summary findings for each research question.

In Vivo coding. The researcher used In Vivo coding (Saldaña, 2016), also known as "literal", "inductive" or "verbatim" coding for three main reasons: 1) it is a straightforward and suitable approach for a beginning qualitative researcher (Saldaña, 2016); 2) it prioritizes study participants' voices and message (Strauss, 1987). In Vivo, was used during the qualitative data analysis of this study to lift and highlight short phrases directly from the interview transcription,

thereby coding using "terms used by [participants] themselves" (Strauss, 1987, p. 33); and 3) it has demonstrated applicability to action and practitioner research by linking the community's voice to recommendations for action (Stringer, 2014).

During the analysis, In Vivo coding served two purposes: 1) To support scoring for each dimension (see tables in sections for each dimension); 2) to stress additional recurrent themes discussed by study participants, including any topic related to each of the seven strategies of INSPIRE (see the recommendations regarding INSPIRE). Codes lifted during the In Vivo process were helpful to identify all possible themes from the interviews until coding saturation was attained. Table 5 provides a list of some strengths and aspects to improve in the overall system. These strengths and opportunities for improvements will be developed further in the recommendations section of Chapter 5.

Table 5

Strengths and Other Aspects to Improve in the System

Strengths	Aspects to Improve
Collaborative system	Communication/sharing of information
Technical knowledge and resources	Coordination of efforts
Dedicated professionals	Professional training for staff
	Financial and human resources
	Monitoring and evaluation

Community Readiness Assessment Scoring

The interviews were transcribed verbatim in French by the research assistant, who was also present during each interview. The research assistant submitted each interview transcription to the researcher for analysis. The research assistant also subsequently analyzed those same transcriptions and served as the second scorer. Both the primary researcher and assistant scored the interviews to comply with the CRM guidelines for scoring (Appendices L, M and N). The scores offer a quantitative approximation of readiness stage. Specifically, in the case of this study, I used the scores to estimate the country's systems readiness to implement a violence against children prevention national action plan. We separately scored each interview, using the nine anchored rating statements for each dimension (see Table 6). We each and separately read the transcripts methodically and compared interview transcripts contents against anchored statements within each dimension; we attempted to find statements similar or reminiscent of the anchored rating statements detailed in Table 6. We identified the anchored statement that best aligned with the highest rating level possible between 1, representing "No awareness" of the issue, and 9, establishing the level of "Professionalization," with actions already undertaken to address the problem. The following steps taken were to review our separate scores and come to a consensus on each dimension score for each interview.

Table 6

Rating Statements per Dimension

Rating	Community Efforts	Community Knowledge of Efforts	Community Leadership/ Political Will	Community Climate	Community Knowledge About Issue	Community Resources
1 = No awareness	No awareness of the need for efforts to address this issue	Community has no knowledge of need for efforts to address this issue	Leadership has no recognition of this issue	Prevailing attitude is "there is not a problem related to this issue"	Not viewed as an issue	There is no awareness of the need for resources to deal with this issue
2 = Denial	No efforts addressing this issue	Community has no knowledge about efforts addressing this issue	Leadership believes that this is not an issue in their community	The prevailing attitude is "there is nothing we can do" or "only 'those' people do that"	No knowledge about this issue	No resources available for dealing with this issue
3 = Vague awareness	A few individuals in the community recognize need for some type of effort, but there is no immediate motivation	Some members of the community have heard about efforts, but the extent of their knowledge is limited	Leaders recognize the need to do something regarding this issue; offer only verbal support	Community climate is neutral, disinterested, or believes that this issue does not affect the community as a whole	A few in the community recognize that some people here may be affected by this issue	Community is not sure what it would take or where the resources would come from to initiate efforts
4 = Preplanning	Some community members have met and have begun a discussion of developing community efforts	Some members of the community are beginning to seek knowledge about efforts in their own or similar communities	Leaders are trying to get something started; a meeting has been held to discuss this issue	The attitude in the community is now beginning to reflect interest in this issue	Some community members recognize that this issue occurs locally, but information about this issue is lacking	Some in the community know what resources are available to deal with this issue
5 = Buy-in direct impact planning	Efforts (programs/activities) are being planned by the community	Some members of the community have basic knowledge about local efforts (i.e. purpose)	Leaders are part of committee(s) and are meeting regularly to consider alternatives and make plans	The attitude in the community is "this is our problem," with modest support for efforts	Community members know that this issue occurs locally, and general information about this issue is available	Some in the community are aware of available resources and a proposal has been prepared or submitted
6 = Initiation of work	Efforts (programs/activities)	An increasing number of community members have	Leaders support implementation efforts and may be	The attitude in the community is "this is our responsibility," with	A majority of community members know that this issue	Resources have been obtained from grant funds or outside funds;

	have been implemented by the local community	knowledge of local efforts and are trying to increase the knowledge of the general community	enthusiastic because they are not yet aware of the limitations or problems	modest involvement in the efforts	occurs locally, and there is enough information about this issue to do something	programs or activities are time limited
7 = Stabilization, positive outcomes	Local efforts have been running for several years and are expected to run indefinitely, no specific planning for other efforts	There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.	Leaders support continuing basic efforts and are considering resources available for self-sufficiency	The majority of the community generally supports programs, activities, or policies: "We have taken responsibility"	Community members have knowledge of, and access to, detailed information about local prevalence	A considerable part of support of on-going efforts are from local sources that will provide continuous support; additional resources are being sought
8 = Confirmation & expansion	Several different local efforts are in place, reaching a wide range of people; new efforts are being developed based on feedback	There is considerable community knowledge about different community efforts, as well as the level of program effectiveness	Leaders support expanding/improving efforts through active participation in the expansion or improvement	The general community is strongly supporting of the need for efforts; participation level is high	Community members have knowledge about prevalence, causes, risk factors, and consequences	Diversified resources and funds are secured, and efforts are expected to be permanent; there is additional support for further efforts
9 = Professionalization	Evaluation plans are routinely used to test effectiveness of local efforts, wide range of people. New efforts are being developed	Community has knowledge of program evaluation data on how well the different local efforts are working, and their benefits and limitations	Leaders from all sectors of the community are directly involved in sustaining and improving the efforts	All of the community is highly supportive, and community members are actively involved in improving efforts and demand accountability	Community members have detailed information about this issue as well as information about the effectiveness of local programs	There is continuous and secure support for programs; evaluation is routinely completed; substantial resources for trying new efforts

Citation: Community Readiness Assessment Guidance; adapted from the Tri-Ethnic Center Community Readiness Handbook, 2nd edition, 2014. Model originally developed by E. R. Oetting, B. A. Plested, R. W. Edwards, P. J. Thurman, K. J. Kelly, and F. Beauvais. Modified and expanded by Linda R. Stanley.

Note. Dimension G was not part of the Tri-Ethnic Center's Community Readiness Model and was added specifically for Colorado's Strategic Prevention Framework State Incentive Grant. This dimension was not used during this study.

Research has demonstrated that the dynamics of power relations should invite careful consideration of power and ethics within the research process, and, in this case more specifically, in terms of the interpretation of data (Das, 2010). Steps were applied during the scoring process to alleviate concerns regarding a potential power differential and undue influence during the consensus discussion with the research assistant. To attain more rigorous interrater reliability, an attitude of reflexivity was adopted (Koch & Harrington, 1998; Maxey, 1999). The research assistant submitted his scores ahead of discussion to mitigate and limit any power differential bias that might exist during the consensus process. After de-identifying and shuffling the interview scores, discussions first highlighted all major score differences; each scorer provided his/her rational for each score, supported by appropriate interview "quotes" to evidence for each score. The process allowed the research assistant to defend his scores first 1) to ensure a high level of analytical transparency and 2) to avoid obtaining analyses that would mainly be representative of only one person's thinking. This process valued each scorer's opinions and ensured that neither party would (even unknowingly) influence the other's argument.

Divergences in scoring were reconciled through discussion between the two scorers (the researcher and the research assistant) to obtain final scores for each dimension of each interview, the average dimension scores across all interviews, and, finally, the overall readiness score. Once all the interviews and their dimensions had been assigned combined scores, the mean for each dimension was calculated by totaling each dimension's scores across all interviews (8) and by dividing the total by eight. Finally, the dimensions' means were added up and divided by six (the number of dimensions) to produce the overall score for the MSTF in CI. Table 7 shows that each score from 1 to 9 is attributed to a stage of readiness. Using the rating statements described in

Table 6, the scorers determined scores for each of the six dimensions as described in Table 7. Those scores are a quantitative approximation of the concept of stage of readiness.

Table 7

Scores and Attributed Readiness Stages

Scores	**Nine Stages of Readiness**
1	No awareness
2	Denial / resistance
3	Vague awareness
4	Preplanning
5	Preparation
6	Initiation of work
7	Stabilization
8	Confirmation / expansion
9	High level of community ownership

The scores indicated which level the MSTF reached out of the nine stages of readiness (see Appendix F) for VAC prevention, both overall and for each dimension. Because each score matched a specific readiness stage, dimensions with varying scores revealed different readiness stages.

Chapter Summary

This chapter described the methodology used in this study, including the study sample, data collection procedures, and analysis. The overarching research questions were also recapped, and findings from the study are presented in the following chapter.

CHAPTER 4

RESULTS

The results for each dimension are discussed in subsequent sections of this chapter. Interviews were transcribed and analyzed, and each dimension was scored using a nine-point anchored rating scale by two scorers for each interview (see Table 6). The scores help to pinpoint the readiness stage for each dimension and the overall readiness.

Research Question 1

What Level of MSTF Readiness do MSTF Members Perceive for VAC Prevention in CI?

Table 8 provides the combined scores from both scorers for each dimension and the overall readiness score for the MSTF.

Table 8

Combined Scores for Each Dimension Across all Interviews

Combined Scores									**Average Scores**
Dimension names	#1	#2	#3	#4	#5	#6	#7	#8	
Community efforts	7	6	6	6	3	7	7	6	6

Table 8 (continued)

Combined Scores for Each Dimension Across all Interviews

Community knowledge of efforts	3	5	3	3	3	6	5	3	3.87
Community leadership / political will	4	5	5	3	3	5	5	3	4.12
Community climate	6	6	5	6	5	5	6	4	5.37
Community knowledge about VAC	4	5	3	4	4	5	5	2	4
Community resources	4	6	6	3	3	4	6	3	4.37
Average of the entire system									4.62

The frequency and percentages of each stage are reported in Table 9 for all dimensions. Overall readiness scores ranged from 2 to 7 on the nine-point scale. None of the dimensions received a score of 1 (no awareness), 8 (confirmation/expansion), or 9 (high level of community ownership) on the readiness scale. Only 2% reported stage 2 (denial/resistance), followed by 6% for stage 7 (stabilization), 15% for stage 4 (preplanning), 21% for stage 5 (buy-in/preparation), and 25% for stage 6 (initiation of work). The highest percentage of scores (31%) were received for stage 3 (vague awareness). Table 9 presents the mean readiness score of 4.62, which corresponds with a preplanning level of readiness. It also shows the range of scores for each dimension. Of the six dimensions, community leadership and community resources varied the

least (mean score, 4.12 and 4.37, respectively); community climate varied the most (mean score, 5.37).

Table 9

Frequency and Percentages for Stages Reported by Sample for Each Dimension

Stages	**Frequency of Scores**	**Percentage of Scores**
1 No awareness	0	0%
2 Denial/resistance	1	2%
3 Vague awareness	15	31%
4 Preplanning	7	15%
5 Preparation	10	21%
6 Initiation of work	12	25%
7 Stabilization	3	6%
8 Confirmation/expansion	0	0%
9 High level of community ownership	0	0%
Total	48	100%

Overall Readiness Score

The study reveals an overall readiness score of 4.62 for the MSTF, as shown in Table 10. The CRM authors recommend rounding scores down rather than rounding up (Plested, Edwards, & Jumper-Thurman, 2006); therefore, this score indicates stage-4 readiness (preplanning).

According to the CRA, the level of preplanning shows "a clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed" (Plested, Edwards, & Jumper-Thurman, 2006, p. 9). The preplanning phase suggests that most members of the MSTF view VAC as an important issue and are contemplating what actions can be taken or what more should be done to combat VAC.

Table 10

Final Scores and Stage Level for Each Dimension and Overall

Dimension	**Average Score**	Stage	Range of Scores
Community efforts	**6**	Initiation	3-7
Community knowledge of efforts	**3.87**	Vague awareness	2-6
Community leadership / political will	**4.12**	Preplanning	3-6
Community climate	**5.37**	Preparation	1-6
Community knowledge about VAC	**4**	Preplanning	1-5
Community resources	**4.37**	Preplanning	3-6
Overall score:	**4.62**	**Stage: Preplanning**	

Table 10 also provides the score for each dimension assessed during this study. This summary addresses the main highlights from the findings for each dimension, including their scores and the themes identified during the In Vivo coding analysis (see Table 11). The dimension of efforts received a score of 6, the highest score at the initiation stage, suggesting that one or more efforts are being implemented. The knowledge of efforts dimension received the lowest score, at 3.87, indicating stage 3, or vague awareness. These findings suggest that knowledge about local efforts addressing the issue is limited. The dimension for knowledge of VAC was scored as 4, locating it in the preplanning readiness stage. This finding demonstrates that some community members have knowledge that this issue occurs in their community, but information about the issue remains insufficient. The leadership dimension received a score of 4.12, indicating a stage-4 (preplanning) readiness level, which indicates that leadership acknowledges that this issue is a concern in the community and that something must be done to address it. The dimension for climate received a score of 5.37, giving it a readiness level of preparation; at this level, the community believes that this issue is their problem and supports modest efforts. The final dimension, resources, received a score of 4.37, placing it in the preplanning readiness stage, where there are available resources (funding), and some community members know what and where these resources are.

Table 11

Major Themes Extracted for Each Dimension During In Vivo Coding

Dimensions	In Vivo Codes/Themes
Climate	- Perception of violence - Violence normalized - Consciousness awareness
Knowledge about VAC	- Informed leadership - Underestimation of VAC
Efforts	- Efforts at the institutional level - National policy - Community programs - No evaluation
Knowledge of efforts	- Few people know - Minimal information
Leadership/political will	- Mitigated government engagement - Limited action
Resources	- No government funding - Financial support from key partners - Nonexistent volunteer force - VAC training - Good teamwork and collaboration

Climate

What is the degree to which the current climate of the country facilitates positive change? The climate dimension received a score of 5, revealing a stage of readiness of buy-in and preparation. This finding suggests that most MSTF members are concerned about the problem of VAC and want to take action. Participants generally agreed that there was ownership of the problem of VAC in Côte d'Ivoire and that support for efforts to address this problem, albeit modest, were headed in a positive direction.

Perception of violence, normalization of violence, and consciousness awareness stood out as the main themes for this dimension among all eight participants during the study (see Table 11). The perception of violence was inconsistent. Participant 1 acknowledged that violence is not tolerated within the government of CI: "The government of Côte d'Ivoire as far as I know does not tolerate these [violence against children] practices."[1] Based on interview responses such as the aforementioned, it is acknowledged that violence is not tolerated (as all of the MSTF participants stated that VAC is not tolerated); however, the attitude of the local communities is often opposite that of the MSTF or the government. This discrepancy is reiterated by participant 7: "The government or the committee, etc., the leaders, their conscience sees the problem, but not necessarily the community."

All eight participants felt that harmful norms and values have normalized violence against children as acceptable child-rearing practices in the population. Violence in all its forms is often used as punishment to correct children when they are perceived to be misbehaving (UNICEF,

[1] In this paper, I have translated all quotations from French into English.

2010). During a discussion about the community's perception of VAC, participant 8 stated: "Here people do not agree [that violence against children is a problem]; it hurts their sensitivity a lot because they say that in African culture, when you want to punish a child, you do it."

Not only is the government of CI, including the MSTF, conscious and concerned about the problem of VAC; they also have taken action to address this serious issue. One participant said that the Government of CI has made its position clear. For example, recent legal codes have been created to prevent VAC. As participant 8 stated, "There is the decree that the ministry, for example, has made that prohibits, for example, corporal punishment of children under penalty of fine, of course."

Knowledge of the Problem of Violence against Children

To what extent do members of the MSTF know about the causes of the problem, its consequences, and how it impacts the nation? The dimension evaluating MTSF members' knowledge of violence against children in CI received a score of 4 (see Table 10). This result indicates that this dimension is in the preplanning stage of readiness and that some MSTF members have limited knowledge about VAC. Some informants recognize that this problem occurs in CI, but information about VAC is insufficient. Conversations about this issue remains taboo in many communities, and information about it is largely anecdotal.

Analysis of this dimension exposed the following main themes: informed leadership and underestimation of violence. There is a sense that leaders are more informed about the problem than the rest of the population are, although some leaders are more informed than others, and some forms of violence attract more attention than others. According to participant 5, "They [leaders] have the right information, since they are sufficiently well informed [and] well-educated on the issue to be able to react." However, it was also clear that both leaders and

community members underestimate the problem, thereby revealing a stark need for education on the impact and consequences of violence on individuals and the community. Participant 4 made that point:

> There is some violence, they know, but there are some [issues] that are understated; so, as it is, they [the leaders] need to be enlightened, the community needs to be enlightened to be able to identify the types of violence. They need to be enlightened.

Three of the informants thought that the VACS in CI, which had recently been conducted, would provide needed information on the issue to guide policy and programming decision making at the leadership level to prevent VAC. Participant 5 explained: "I think that the VACS that has been conducted will provide clear enough results to prompt the decision makers and to test the ability of our leaders to respond to the problems of violence against children."

Community Efforts

What efforts currently exist that deal with prevention of violence against children?

The MTSF received a score of 6 for the efforts dimension (see Table 10), indicating the "initiation of work" stage of readiness. This result indicates that most members of the MSTF view the issue of VAC as their responsibility, and they are now beginning to take action to address this issue. At the level of initiation of work, some programs and other efforts have already been implemented.

"Efforts" implies any endeavors initiated by any agency or government at the policy, structural, and programmatic levels (Plested, Edwards, & Jumper-Thurman, 2006). For example, informants mentioned the following efforts: a code of conduct for schools; regulatory texts; international conventions; watch committees; social-center–facilitated programs and services;

national and international workshops on the subject; psychological, medical and legal support; gender-based-violence platforms; a helpline; and a sensitization campaign.

Four major themes emerged regarding this dimension: institution-level efforts, national policy, community programs, and lack of evaluation. Participants discussed positive institution-level efforts as well as perceived challenges of the system. The government of Côte d'Ivoire has put in place violence prevention mechanisms to deal with topics related to children's wellbeing. Institutionally, a ministry has been mandated to support women, families, and children. At least one department has been delegated within the ministry to lead child protection initiatives. Participant 1 describes the benefit of such institutional efforts:

> The existence of the Ministry of Family, Women and Child Protection is evocative, and it means that the State, the Ivorian government is concerned with children's issues ... the Department of Child Protection addresses particularly the issues related to violence against children.

All eight participants also identified challenges associated with institutional efforts. Civil unrest, war and other political-military upheavals steered the government's focus away from social services for a full decade (2000 to 2010); moreover, the population swell during that same period dwarfed existing services. The participants agreed that lack of funding and training impedes the capacity of social workers to support violence victims in communities (see resources dimension below). One participant described the reduction in adequate services: "Schools, hospitals, and other classical structures are not enough anymore. The need is great, so we must perform activities specific to the protection of children" (Participant 3). In response to a question about the need to scale up current efforts, participant 4 stated, "Yes, it is more than necessary to scale up existing efforts, and this study is welcome!"

The second theme, existence of a national policy, was also identified in all eight interviews. In CI, a national child protection policy has been drafted and supports a national child protection plan, which is renewed every three years. A set of new laws prohibiting violence, including corporal punishment in schools, has been written. This last was especially important after recent studies showed a high percentage of violence in schools by teachers. Almost half of child students (46%) are victims of physical violence by a teacher. Children are hit daily by the teacher as a punishment, with no significant gender disparities (ICF International, Ministry of the Fight Against AIDS (Côte d'Ivoire), National Institute of Statistics (Côte d'Ivoire), 2012). Participant 3 supported the notion of institutional engagement: "Yes, there are efforts. The efforts are initially institutional by the establishment of structures dedicated to the protection of children ... it even has a policy, which is the national policy for child protection."

In addition to the existence of policy, accessible community programs also support the community efforts dimension. Child protection committees have been established in various communities. These committees also implement VAC community mobilization and prevention programs in communities. For example, these committees facilitate conversations on the topic of child protection in target communities, where an upsurge of violence has been observed. As stated by participant 2, the MTSF does conduct outreach efforts: "We do outreach efforts on the ground and then we go into communities, we actually work in communities." In addition to these resources, social centers, hospitals and police stations are main entry points for post-violence service delivery. Most victims of violence usually seek help first from one of these locations. In most instances, social workers are trained to ensure referrals for additional or follow-up services as needed.

Seven out of eight participants agreed that the government has made efforts to tackle the problem of violence against children, mostly at the institutional level (as supported by quotes above). Participants mentioned several programs and activities linked to VAC and cited several national policies and governmental agencies and other infrastructures that are currently involved in child protection or have the potential to be involved in VAC response and prevention initiatives (see Table 11). The establishment of a department of child protection and a national child protection policy form the basis for current programs and services, which are offered mostly at the social centers, through the Ministry of Education in schools, and by nongovernmental organizations.

Despite evidence of efforts put in place to address VAC, one participant's statements suggested that these efforts were insufficient. Participant 5 stated:

> I do not accuse anyone directly, but I'm telling myself that I do not think we do enough ... there are not a lot of structures and there are not a lot of trained staff ... the children are left to fend for themselves.

Efforts are insufficient; therefore, coverage is not uniform throughout the territory, and access is limited in rural areas, as stated by participant 2: "Access to rural people is a bit difficult. Otherwise, in some areas, they do not have ***[2] like in San Pedro, for example. There are large communities in isolated areas where access is really, really, very difficult." Finally, lack of monitoring and evaluation (M&E) for existing programs was a recurrent theme across all interviews. Participant 3 summarized the situation:

[2] The audio recording was inaudible.

> There is no evaluation. Because in order to evaluate an activity or the progress of a project, you first have to collect preliminary data. So, most of the time, we cannot assess the impact of an activity because we simply do not take the measures to evaluate them.

Knowledge of Efforts

Participants were also asked to discuss the degree to which they felt existing efforts for VAC prevention were known. The knowledge of efforts dimension received a score of 3.87 (see Table 10), indicating a level of readiness of vague awareness. This score suggests that although some members of the MSTF know of the existence of efforts to address VAC, their knowledge remains limited; there seems to be vague awareness about what is currently being done to address VAC. A few members of the MSTF have at least heard about existing efforts but know little about them. Specifically, MSTF participants may have some knowledge about efforts stemming from their department, but there seems to be limited sharing of information across departments within the MSTF.

All the participants except one agreed that information about current policies, plans, and programs that address this issue was minimal and only accessible by a few people (see Table 11). For instance, few MSTF members know about the implementation of the national child policy or other programs. For example, at least two informants were unaware of the existence of a helpline for victims of violence. Participant 1 attributed the limited information about current efforts to a lack of ineffective dissemination:

> The points to improve, the points to improve [repeated during the interview], me, what I think it is necessary to popularize, it is necessary to popularize the existence of the mechanisms of prevention of violence. We must popularize these mechanisms.

Nevertheless, these efforts seem insufficient and remain unfamiliar to the population. For example, regarding recently enacted laws that forbid corporal punishment in schools, participant 1 stated that these laws are inadequate and not well disseminated within the population:

> I say the inadequacy of the [legal] texts, but when [legal codes] do exist, the lack of disclosure of these [legal] texts. It is necessary to make campaigns of awareness, it is necessary to inform the populations about [legal codes] that prohibit this violence and existing mechanisms that are available to take care of these children.

Leadership and Political Will

a) To what extent do members perceive their leadership as committed to and supportive of implementation of a prospective change effort in violence against children prevention? The dimension of leadership and political will received a score of 4, indicating at this stage of readiness (preplanning) that leadership acknowledges that this issue is a concern in the community and that something must be done to address it.

All participants, representing five sectors, were adamant that their leadership was preoccupied with this issue. The participants could attest to the political will and leadership support for actions targeting VAC based on actual policies and programs. Participant 1 said:

> The government is also concerned about this situation because the government has created a program the *PPEAV*, program for the care of children in situations of vulnerability. The children we are talking about. This program implements a number of mechanisms to find a solution to reduce these forms of violence. We can say that the government, when I look at this, I think that the government is concerned about the violence that exist, the violence that affects children.

Two principal themes emerged for this dimension (see Table 11) of leadership and political will: mitigated government engagement and limited action. Although most ministries in various sectors (health, education, justice, social work, and labor) have an action plan to support child protection, some leaders have been more involved than others. When asked about leadership involvement and support for VACP, participant 4 replied:

> You saw earlier with the office of the minister's advisor, they are not informed so much of these aspects that are done on the ground. Therefore, there is work to be done at this level, to raise awareness at the cabinet level.

b) To what extent are leaders and influential stakeholders supportive of the issue, or to what extent is leadership effective (policy, coordination, sustainability efforts)? The MSTF coordination requires further strengthening to rally key players in the field and to harmonize the programs and policies targeting the VAC issue. Participant 2 asserted that "Coordination is needed for effective action." A question was added to the CRA tool to assess the MSTF's perceived volition. The question aimed to gauge the participant's perception of the role, capability, and overall control of the MSTF to drive VAC response initiatives. All participants felt strongly that the MSTF was the appropriate structure to guide VAC prevention initiatives in CI because of its members' experience and knowledge about the issue and their familiarity with the social and cultural territory. Participant 2 also mentioned that they need to be motivated to accomplish this task:

> The MSTF is really a committee of experts. I saw people who work well. They really know a lot of information. The MSTF can do this work. With a little more motivation, I think they will really do this job. If they are motivated, they will.

Five participants reported that coordination of action towards violence prevention was failing because of divergent objectives across ministries and nongovernmental partners. Participant 3 explained that agencies are focused on their objective and do not always communicate what actions are being taken:

> But I think that there is a failure at the coordination level ... that means that often we do not see the impact of what is done, we cannot communicate what is done, while it is communication that can actually make a difference, as efforts are scattered.

Participant 5 also suggested that more formal government recognition would cement the MSTF leadership and coordination role: "It is, as we say, to formalize the mandate of the technical committee to give them the [authoritative] weight, if only at the legal level, at the administrative level."

c) What is the perceived worth or importance placed on VACP in CI? The overall feeling from the participants was that although the government has shown concern for this problem, limited action has been undertaken, and the problem of violence against children is not yet paramount at the political level. Participant 8 relayed in succinct words the shared feeling that political will may exist, but real actions are limited: "They react, but they do not take real actions." One participant provided insight into the perceived priority the government gives to social work and acknowledged funding to support these programs is scarce. One major issue is the limited budget, as participant 3 claims:

> Budgets are very limited, especially for the structures that are in the social field, while the social field for Ivory Coast, which is the field that I know better, is what comes after the others. Because it is when they are done covering everything else that they say, "What's

with your social work needs? What do you say about it?" So, it [social work] will always come in last place, and we see the importance of something in view of the budget allocated.

Resources

a) To what extent are local resources (people, time, money and space) available to support VACP efforts? The score for the resources dimension is 4.1, which demonstrates a readiness level of preplanning. This result suggests that resources to support further efforts to address VAC in CI are limited. All the participants mentioned funding limitations, among other resource restrictions. This consistent trend may also suggest that only a limited number of members know what resources are available and where to find them. One of the main themes for this dimension was the lack of government funding. The participants were unanimous about a lack of funding from the CI government. Participant 8 commented that financial support from the government was reported to be insufficient, almost nonexistent: "The government finances these kinds of things as little as possible… The government does not finance [things] like that, when you ask the government, it says we cannot afford it, so you have to look for [funding] yourself."

According to all the participants, governmental support was lacking not only in terms of money but also in terms of logistical resources, human resources and adequate training for existing staff (e.g., social workers and police). Furthermore, just two participants demonstrated in their responses that they had knowledge of other funding sources. This result indicates that only a limited number of MSTF members know what resources are needed, what are available, and where to find them. Those with greater knowledge of resources and funding opportunities mentioned funding partners from the UN system and other country partners (e.g., the US government). However, overall, they had no real knowledge of any upcoming open grants or funding proposals to support efforts to address VAC. Participant 8 mentioned receiving support

from “traditional” funding partners: “I think it's funded by the NGOs, huh. The government finances as little as possible in these kinds of things.”

b) To what extent do relational attributes for change exist (including community attachment, stakeholder involvement, and collaboration/teamwork)? When participants were asked about collaboration, a fifth theme emerged: good teamwork and collaboration. All the participants agreed that there is solid groundwork for effective teamwork within the MSTF and integrative collaboration with outside agencies. The interviews revealed that many of the agencies hosting members of the MSTF are already working together on other subjects and causes. For example, Participant 4 felt that the agencies were set up well for cooperation: “I know that ... there is a letter that has been written to accept this collaboration: from the Minister of the Family to the Minister of Education, etc. for us to work together.”

Some basic blueprints appear to exist for extensive collaboration and teamwork. Stronger leadership, however, is needed to keep all stakeholders engaged and focused on a common objective. Participant 2 discussed the need for stronger coordination, which was the seventh theme: “Now, what’s the problem? The problem is a coordination problem. This problem arises. There is a problem of coordination, a problem of leadership.”

Regarding the skills and knowledge necessary to implement INSPIRE strategies, the study answered the following questions:

a) Is the staff and volunteer base needed to implement INSPIRE available? All eight participants reported that there is staff to perform this work. Human resources usually come from three main institutional structures: the police, hospitals and clinics, and social workers from the social centers. However, as Participant 2 explained, existing staff is willing to support victims, but they do not always have the necessary means to reach the communities:

> All the staff exists, the policy is there, in any case the will is there. But how to access the community? That's the problem because people are isolated in villages and access is difficult. It's a problem of means, that's it.

Although half of the participants mentioned the use of a volunteer force for community initiatives, the other half thought that the volunteer force was practically nonexistent in CI. Participant 3 revealed that the volunteers were de facto paid workers, given that they were usually compensated by nongovernmental organizations: "There are volunteers, in the communities there are volunteers, but who are helped a little by NGOs." Other participants, such as participant 7, denied the existence of a strong volunteer base within communities everywhere: "I think that in some localities volunteers exist but in others… It cannot be said that volunteering is spread everywhere."

b) Is training and expertise to implement INSPIRE available? Study participants did not feel that the staff received appropriate training to address VAC issues. Although dedicated staff is currently available, the training and expertise to implement programs based on INSPIRE strategies is limited and insufficient. Participant 3 also mentioned a strong need for additional staff and training: "Social workers are well trained. They are relatively well trained. Now, as there are emerging themes, new vulnerabilities that appear, they [social workers] need to have additional training and capacity building."

The issue of lack of training appeared several times throughout the interviews, suggesting a glaring need for more VAC-appropriate training for the workforce directly serving the population. Three-quarters of the participants felt that more training is needed. For example, although most social workers and some members of the police workforce have received basic training, participant 2 stated that current training is insufficient to provide the appropriate

services to victims of violence: “There is a need for more training; there is a need to build the capacity of the actors.” However, other participants, such as participant 1, strongly disagreed, feeling instead that training has been more than adequate:

> I think, nowadays, the police receive a lot of training. All those who intervene [police, doctors, actors of psychosocial care], both in the after-care or the prevention regarding the gender-based violence, they received a lot of training in the matter: prevention of violence and support of victims. This only in the gender-based violence thematic, they are included. There has been a lot of training.

As participants’ interviews reflected, while the workforce does receive basic training, there is room for improvement and further VAC specific training.

Research Question 2

How Much Does Readiness Level Vary across Dimensions?

The efforts dimension received the highest scores among all six dimensions, whereas knowledge of community efforts scored the lowest. Scores for each dimension across all interviews also ranged between 2 and 7 between both scorers. The lowest score of 2 indicated the stage of denial, and the maximum score of 7 indicated the stage of stabilization of positive outcomes. After combining (scores from both scorers) and averaging (across all interviews) the scores of each dimension, scores for each dimension ranged between 3 and 6, meaning that readiness levels for dimensions fluctuated between the stages of vague awareness and initiation of work. The most recurrent level of readiness is pre-planning, which also represents the MSTF’s overall stage of readiness to implement VAC evidence-based strategies.

Dimension with the Greatest Level of Readiness

Community efforts	Score: 6	Initiation	**Range: 3-7**

The readiness level for community efforts received the highest score of all the dimensions, at 6, which is indicative of a level of initiation of work. This finding signifies that efforts (programs/activities) are being made to address the issue of violence against children.

The sectors of justice, health, and labor demonstrated the strongest levels of readiness in community efforts. These sectors received a score of 7, indicating the level of "stabilization" after having experienced certain positive outcomes. The participant's responses suggested that in the abovementioned sectors, local efforts have been operating for several years. Participants 6 and 7 reported that "programs have been running for approximately 10 years." For example, participants described programs such as sensitization campaigns on the topic of violence in the community and through social centers in the social welfare sector; watch committees in the sector of education; and prevention of mother-to-child transmission of HIV (PMTCT) programs in the health sector. These programs are expected to run indefinitely; however, the participants mentioned no specific planning for other or new efforts.

Not surprisingly, the health sector appeared to have implemented multiple programs that are linked to violence prevention or post violence care, followed immediately by the social work sector. This rapidity of action can be attributed mainly to these institutions' original mandate and mission, as well as the funding they have received from governmental and nongovernmental sources over the years.

For example, the Ministry of Health implements HIV prevention and care and treatment programs such as the National Maternal and Child Health program (PNME), the youth and adolescent HIV testing program, and the mental health program. The social work sector leads

multiple programs and activities in the communities and through social centers, including psychosocial services and community education programs. Participant 6 cited a list of current programs, including the following: "Sensitization of community leaders to denounce violence (protection). Maternal health and violence prevention programs through the Ministry of Health, and other programs with the Ministry of Justice."

Dimension with the Lowest Level of Readiness

Community knowledge of efforts	Score: 3.87	Vague awareness	**Range: 2-6**

The dimension of knowledge of community efforts received the lowest of all readiness scores, with just 3.87, suggesting that the most MSTF members are not aware of current efforts to prevent violence against children. Most participants scored at the readiness level of vague awareness for the dimension of knowledge of community efforts against VAC. The three participants who received scores higher than 3 were from the health (score of 6), social work (score of 5) and labor (score of 5) sectors. This finding may suggest that knowledge is not equally shared across and among sectors.

The limited knowledge of existing efforts can be attributed to several factors, including two mentioned during the interviews: lack of communication and lack of coordination. First, during the interviews with participants, the notion that agencies and departments fail to work in synergy was recurrent. According to the participants, there is limited cross-communication about programs and activities between ministries (and across sectors), despite regular interagency leadership meetings. There is also limited information sharing between government agencies and nongovernmental organizations. Experts represent the trustworthy source of knowledge for communities. The main concern is that when experts do not know about services and programs

that would benefit the community, it is not surprising that community members, in turn, will be ignorant of these services and fail to utilize them.

Chapter Summary

The study revealed that the MSTF for the prevention of VAC in CI is currently at the preplanning readiness stage, suggesting that the topic of VAC is considered important and that there is some focus around developing a plan to address VAC. The study's assessment also revealed some variation in readiness stages across dimensions. The knowledge of existing efforts dimension is at the readiness stage of vague awareness, indicating that only a few community members are aware of local efforts and that knowledge about those efforts is scarce. The four following dimensions were reported at the stages of either preplanning (the dimensions of knowledge of the problem, leadership, and resources) or buy-in/ownership (climate), indicating that although knowledge about VAC and current resources are limited, leadership and community nonetheless demonstrate concern about this issue. The following section provides more detail for the four stages of readiness that received the highest score percentages reflected across all six dimensions. The dimension scores ranged from 3 to 6 as follows: stages three (vague awareness), four (preplanning), five (preparation) and six (initiation of work).

The efforts dimension displayed the highest level of readiness, i.e., initiation of work, meaning that there are current policies and programs targeting the issue at hand. The knowledge of efforts dimension demonstrated the lowest stage of readiness, reflecting vague awareness of existing policy and laws as well as programs and services for the prevention of violence.

CHAPTER 5

DISCUSSION

Violence against children is a global issue at the intersection of human rights and public health. Côte d'Ivoire (CI) established a multisectoral task force (MSTF) to support and guide the prevention of violence against children (VAC). The MSTF provided leadership and guidance for the implementation of the VACS in CI and is now tasked with leading the development of a national action plan to prevent and reduce VAC in CI. This action plan will consist of concrete actions and draw on existing relevant legislation, policies, and strategies across all sectors (WHO, 2016). One of the requirements that the WHO proposed during the planning phase of the national action plan is to "identify enabling factors for the plan and barriers to change, developing and maintaining a risk-mitigation plan" (WHO, 2016, p. 15).

This study's assessment of the MSTF's level of readiness to implement a national action plan reveals that the MSTF is currently in the pre-planning stage. Furthermore, this study also offers a deeper view of the system's overall level of readiness by assessing several specific aspects (dimensions) (see Figure 3). Stages of readiness for dimensions varied between vague awareness to initiation of work. This chapter discusses the study's findings and offers some recommendations to move the MSTF from the pre-planning stage of readiness to the next stages of preparation, implementation, stabilization, scale up and evaluation (Plested, Edwards, & Jumper-Thurman, 2006). The goal is to reinforce the system's readiness to implement the national action plan for the prevention of VAC. The results of this study are similar to at least one previous report that indicates that although CI has mandated structures, dedicated human

resources, and drafted policies supporting child protection and violence prevention, the current system is still facing challenges and more remains to be done (UNICEF, 2015). During implementation of the national action plan to prevent VAC, the MSTF will build upon existing efforts.

Figure 3. Dimensions Stages of Readiness in Relations to the Overall Stage of Readiness.

Research Question 1

What Level of MSTF Readiness do MSTF Members Perceive for VAC Prevention in CI?

The MSTF received an overall readiness score of 4.62, indicating a preplanning stage of readiness. As suggested by the CRA authors (Oetting, et al., 2014), the preplanning stage implies that within the MSTF:

a. Some members of the MSTF have at least heard about local efforts but know little about them;

b. Leadership and members representing various sectors acknowledge that this issue is a concern in the country and that something must be done to address it;

c. Members of MSTF have limited knowledge about the issue;

d. There are limited resources that could be used for further efforts to address VAC.

Multiple factors impact the issue of VAC in CI, many of which have already been mentioned. Factors linked to VAC in CI include poverty, harmful values and norms, wars and civil strife (UNICEF Côte d'Ivoire, 2018), limited awareness and action at the political level, limited collaboration between ministries and lack of vertical collaboration between the national and local governing bodies for policy making and regulation, and programming (UNICEF Côte d'Ivoire, 2018). Despite a recent decline in the poverty level, CI is still considered a poor country, with 46% of the population living below the poverty threshold (Quinn, 2017). Furthermore, an armed conflict that lasted approximately a decade in CI has likely exacerbated the problem of VAC in the country (International Monetary Fund, 2009). Evidence suggests that children are affected by armed conflicts both directly and immediately as well as indirectly and in the long term (Kadir, Shenoda, Goldhagen, & Pitterman, 2018). During times of armed conflict, both boys and girls are at increased risk for multiple types of violence, including rape. These findings are compounded by poverty and patriarchal norms (Murphy, Bingenhiemer, Ovince, Elsberg, & Contreras-Urbina, 2019).

The MSTF's overall readiness remains in the preplanning stage, at which the system has recognized that violence against children is an important issue in CI. The dimensions of leadership, knowledge of the problem of VAC, and resources also received scores placing them at the preplanning level. The dimension of knowledge of efforts was placed in the preceding stage of vague awareness, whereas the dimensions of climate and efforts were placed in following stages of buy-in/ownership and initiation, respectively.

Climate

According to UNICEF, violence against children is widespread and tolerated overall in CI, whether in households or institutions (UNICEF Côte d'Ivoire, 2016). The readiness stage for the dimension of climate is buy-in and preparation. Government and sector leaders recognize that VAC is a real problem in Côte d'Ivoire. To move towards the next stage—initiation and application of solutions—requires a national action plan, and country leadership needs to shift from recognizing the problem to owning the problem of VAC in CI. Ownership of the problem entails moving this issue higher on the priority ladder, and actively supporting effective strategies to prevent and reduce VAC. A progress report on the implementation of priority actions to end violence against children in Nigeria described activities undertaken within a year (2015-2016) of campaign. The goal of the campaign was to escalate the problem of VAC to a highest priority on the government agenda (Federal Republic of Nigeria, End Violence, Together for Girls, U.S. Centers for Disease Control and Prevention, PEPFAR, USAID, EU, UNICEF, 2016).

Unlike government representatives, community members in general do not acknowledge VAC as an issue affecting their communities. Similarly, to violence against women, VAC is normalized among populations because communities adhere to harmful beliefs and attitudes that justify behavior of violence towards women and children (Ellsberg, Madrid, Quintanilla, Zelaya & Stöckl, 2017; Laisser, Nyström, Lugina & Emmelin, 2011; World Health Organization, 2009). This characteristic is consistent with studies on violence in Sub-Saharan Africa. In Nigeria and Tanzania, decision makers developed an action plan that included activities to raise awareness about VAC (Federal Republic of Nigeria, End Violence, Together for Girls, U.S. Centers for

Disease Control and Prevention, PEPFAR, USAID, EU, UNICEF, 2016; United Republic of Tanzania, 2012).

Despite this general recognition, the attitude of leaders is, fortunately, different than that of the community at large. Leaders are more educated on the issue and seem more concerned about resolving this problem. The CRM authors suggest that an environment where more information is made available, helps to reduce community resistance regarding the issue (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). Therefore, leaders should support awareness raising and educational programs about VAC in CI.

Knowledge of the Problem of Violence against Children

Knowledge about VAC is in the preplanning readiness stage, signifying that although members of the MSTF recognize that VAC is a serious concern in Côte d'Ivoire, information on the issue is lacking. A recent report from UNICEF supported this study's findings by noting that duty bearers have limited understanding of the impact of violence and abuse on children and society (UNICEF, 2015). Several studies have investigated this important topic in CI, including work by UNICEF (the Demographic and Health Surveys (DHS) (ICF International, Ministry of the Fight Against AIDS (Côte d'Ivoire), 2012), and the Ministry of National Education and Technical Education (Ministère de l'Éducation Nationale et de l'Enseignement Technique, MENET) (MENET & UNICEF, 2015); however, they have been limited in scope and reach. For example, the UNICEF Multiple Indicators Cluster Surveys (MICS), which primarily covers early childhood and parenting, and violence in schools, presented one of the latest studies on the topic (National Institute of Statistics (Côte d'Ivoire) & UNICEF, 2018). Nevertheless, findings and other information obtained from these studies have not been properly disseminated.

To move the readiness stage of the dimension of knowledge of VAC from preplanning to the next stage, i.e., preparation for action, more information and education about the issue is key to support attitude change about VAC in CI and to increase political and community will to reduce and prevent VAC (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). More strategic efforts must be made to ensure that duty bearers and service providers who are involved in child well-being and violence prevention efforts receive a copy of violence related survey reports and understand their findings and recommendations. The pending VACS-CI final report (no date) will include newly obtained data, as a timely additional source of information to increase everyone's understanding the impact of VAC on children and communities. In Tanzania, the Government of Tanzania developed a set of priority actions following a VACS. The document was then disseminated, and the priority actions were included in their national action plan (United Republic of Tanzania, 2012). Furthermore, national and comprehensive data from the recently implemented VACS is under analysis and will shed more light on the issue upon release of the VACS-CI report.

Community Efforts

Community efforts were found to be at the "initiation of work" readiness level. This result is evidence that Côte d'Ivoire has made substantial steps in the right direction. Numerous and earnest efforts have begun to address various forms of violence against children, but these efforts must be strengthened. Several official documents have been developed by the government subsequent to the political and civil unrest that the country experienced, including the 2012 National Policy on Child Protection (Politique Nationale de Protection de l'Enfant, PNPE), and the 2015 National Child Justice Strategy. Several programs and services are supported and mainly funded by non-governmental organizations such as UNICEF (UNICEF Côte d'Ivoire,

2017) and the US Department of Labor, which oversees child labor issues (US Department of Labor, 2017).

Several policies, structures, programs, and services exist in CI to protect children and support victims of violence (UNICEF Côte d'Ivoire, 2017). The existence of these structures suggests not only that the government of CI is alarmed about this serious issue but also that they want to take action to address it. CI appears to be actively supportive both of continuing and improving current efforts and of developing new efforts. Although some efforts have been implemented, much work remains to be done, including improving existing regulatory systems, adding new legal codes, and increasing protection structures and trained staff pertaining to the protection of children. Furthermore, the response to violence should turn more to effective prevention strategies rather than the existing protection efforts noted during this study (Gray, Pesevska, Sethi, González & Yon, 2018).

Knowledge of Efforts

Knowledge of efforts was scored at the stage of vague awareness, indicating that a limited number of MSTF members had limited knowledge of current actions underway to respond to VAC. Simply put, information is lacking about programs and services that are directly or indirectly linked to child protection and well-being. This finding falls in line with other surveys that report that victims of violence often do not access services because they are not aware of their existence (Ellsberg, Madrid, Quintanilla, Zelaya & Stöckl, 2017; Sumner et al., 2015). Information about this issue and about current programs and services addressing VAC is, at best, not appropriately divulged and, at worst, nonexistent. For example, communities are unaware of the existence of a helpline for survivors of violence.

There are multiple levels of barriers to accessing violence services; limited knowledge or lack thereof constitute a programmatic barrier. Although the assessment of the dimension of community efforts revealed that efforts have been initiated to address VAC, the target population cannot access them if they are uninformed of their existence. Strategies to raise the readiness level of the knowledge of efforts dimension from vague awareness to the preplanning stage include implementing effective dissemination methods, such as outreach activities (Cowper-Smith, 2015; Fong, 2004) to increase the knowledge of existing laws, programs, and services across agencies. More efforts will need to be made to bring the information about existing policies, programs, and activities related to child protection within everyone's reach. Another strategy is to enhance a multi-sectoral referral system for post-violence services to ensure that victims of violence are fully supported and do not fall through the cracks. The Government of Malawi included activities supporting the above strategies in their national action plan (Government of Republic of Malawi, PEPFAR, USAID, UNICEF, 2015).

Leadership and Political Will

With a readiness level assessed at stage 5 (preparation), leaders are not only conscious of the problems that VAC causes in Côte d'Ivoire, they are ready to effectively deal with them. System-wide and institutional structures have been established to frame a more solid and integrated national action plan to prevent VAC in Côte d'Ivoire. Leadership will need to demonstrate greater engagement by holding high-level, cross-sectoral meetings regularly and by allocating more resources to support efforts addressing the problem (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000).

Political support and strategies are key for enabling all dimensions to progress. Although established through an official decree signed by the government, the MSTF, according to the

participants, does not yet have enough influence to guide and regulate efforts to suppress VAC. Notwithstanding governmental infrastructure and institutions officially mandated to serve and protect children, the problem of VAC has lacked tangible and lasting momentum and resources for any sustainable effort. Moreover, the lack of information or limited knowledge of current efforts suggest a need to improve communication and coordination across agencies and sectors.

Table 12 lists agencies involved in VAC prevention activities, based on the number of times a department was mentioned during the interviews. From a frequency table, the listed agencies were ranked in order of importance using the rule of primacy. The primacy effect (Lavrakas, 2008) served to provide an idea of which department is seen as the most involved in child protection. Both the Department of Child Protection (DPE) and the national OVC program (PNOEV) were the most frequently cited departments across all the interviews. The DPE and the PNOEV offices were tied as the most relevant organizations in VAC prevention efforts.

The mission of the Programme de Protection des Enfants et Adolescents Vulnérables (PPEAV) formerly known as the Department of Child Protection (DPE) derives mainly from the Ministry of Women, the Family and Children (Ministère de la Femme, de la Famille et de l'Enfant-PPEAV, 2019). This department created in 2005, coordinates and monitors the country's policy on family promotion and child protection. The National Program for the Care of Orphans and Other Children made Vulnerable by HIV/AIDS (PNOEV) is also a sub-agency to the Ministry of Women, the Family and Children (Ministère de la Femme, de la Famille et de l'Enfant-PN-OEV, 2019). The PNOEV was created in 2003 in response to the HIV/AIDS pandemic in Côte d'Ivoire to implement the national policy on this theme and ensure the coordination of all interventions on the national territory through the decentralized units that are the social centers.

Table 12

Governmental Institutions Involved in VAC Prevention

Agency Acronym	**Official Agency Name (French)**	**English Translation**
DPE*	Direction de la Protection de l'Enfant	Department of Child Protection
PNOEV	Programme National des Orphelins et autres Enfants Vulnérables du fait du VIH	National Program for Orphans and Vulnerable Children
DLC	Direction des Lycées et Collèges	Department of High Schools and Colleges
DLTE	Direction de la Lutte contre le Travail de l'Enfant	Department of Child Labor Prevention
DSPS	Direction de la Planification de la Sante	Department of Health Planning
DPJEJ	Direction de la Protection Judiciaire de l'Enfant et de la Jeunesse	Department of Judicial Protection of Children and Youth
DMOS	Direction Mutualité et des œuvres sociales	Mutuality and Social Services Department
DEPS	La Direction des Études, de la Planification des Statistiques	Office of Studies, Planning and Statistics
GELC	Gestion des Écoles, Lycées et Collèges	Management of Schools, High Schools and Colleges
EPR	Établissement de Protection de Remplacement	Institution of Replacement Protection
CPPE	Centre de Protection de la Petite Enfance	Early Childhood Protection Centers

Note: Government agencies involved in child protection are ranked and listed by order of importance based on the number of times mentioned during the study.
*DPE has recently been renamed to PPEAV

Resources

The stage of readiness for the *resources* dimension is preplanning. At this stage, some members of the MSTF are informed about what resources exist to support efforts addressing this problem. Despite the existence of such resources, however, they are not supported by sustainable funds. Most programs are funded by international organizations and time stamped. The government of CI must elevate the issue of VAC to a key priority and create more room in its budget to support programs and policies through the national action plan for the long haul (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000).

Research Question 2

How Much Does Readiness Level Vary Across Dimensions?

According to the CRM authors, efforts for change will only be successful when 1) all dimensions are at approximately the same readiness level and 2) the strategies for change align with the level of readiness (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). This study revealed a variety of readiness levels for the MSTF across all dimensions, as shown in Figure 3. The highest-scoring dimension was **community efforts** (6), which suggests that efforts in the form of policies, programs, and organizational arrangements have been initiated. The lowest-scoring dimension was **knowledge of community efforts** (3.87), which resonated with the anchored rating statement: “Some members of the community have heard about efforts, but the extent of their knowledge is limited.” Examining the score combined with the qualitative analysis of the transcripts clearly reveals that most members of the MSTF are not fully aware of

the violence against children prevention and child protection initiatives currently being undertaken in Côte d'Ivoire.

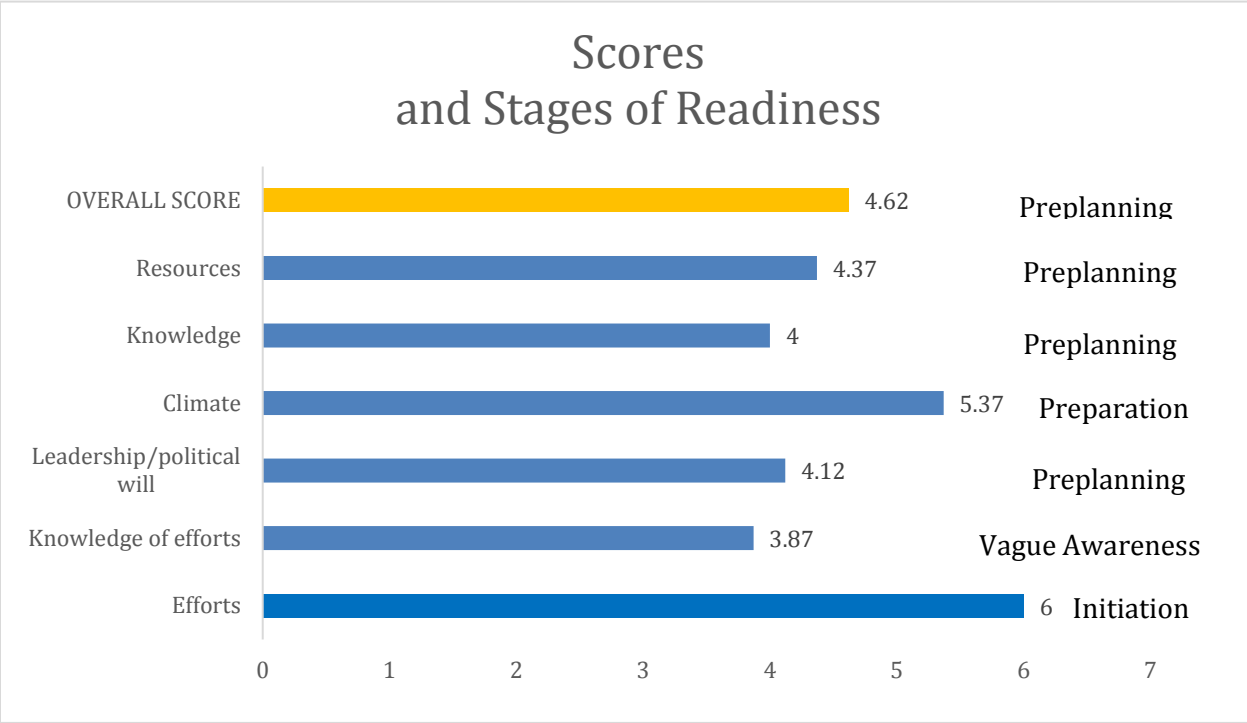

Figure 4. Dimension Scores and Stages of Readiness.

The variance in stages of readiness across dimensions demonstrates the areas of need and provides some insights into designing a strategic plan based on the stages of readiness for each area. The CRA authors recommend that the focus should first be directed to the dimensions that reflect the lowest readiness stage, which is, in this case, the dimension of knowledge of efforts to prevent VAC, which was assessed at the level of vague awareness. The dimension of knowledge of efforts received lower scores than the overall readiness stage. This dimension is thus the primary target of intervention to increase the MSTF's level of readiness. The main objectives of the plan would be to raise awareness about what actions have been taken and what plans and resources currently exist, thereby increasing the MSTF's overall readiness level. Although most

of the MSTF participants were somewhat cognizant about the efforts being made within their specific department or agency, few could describe efforts undertaken in other sectors.

The limited knowledge of existing efforts can be attributed to several factors, including two mentioned during interviews: Lack of interagency communication and coordination of efforts. The history of instability in CI government is reflected in the comments made during interviews. During the interviews, the notion that agencies and departments were working in silos was recurrent. According to the participants, there is limited cross-communication about programs and activities between ministries (and sectors), despite interagency leadership meetings. There is also limited information sharing between government agencies and nongovernmental organizations about current activities. Furthermore, MSTF coordination must be strengthened to rally key players in the field and to harmonize the programs and policies targeting the VAC issue.

Overall Recommendations

Edwards and colleagues posit that any given initiative to resolve a problem will only be as successful as the readiness to implement the initiative (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). The more prepared a community is to execute a plan to address an issue, the better the outcome will be. Plested, Edwards, and Jumper-Thurman (2006) make the case that matching a community's (or, in this case, a government systems) intervention to its level of readiness is key to achieving success (Plested, Edwards, & Jumper-Thurman, 2006). Past studies have found that a positive change in the problem addressed within a community is associated with a higher community readiness level of at least five (preparation) or six (initiation) (Miller & Shinn, 2005; Slater, et al., 2005). The MSTF's overall readiness to support an evidence-based national action plan is in the preplanning stage. The goal may thus be to

increase the MSTF's overall readiness stage from preplanning to preparation. In a resource-limited context, it is unrealistic to presume that all dimensions can be tackled simultaneously. All the dimensions, except one, also scored at this level of readiness or higher. The critical question, then, is: Which dimensions must be addressed for the others to progress? The CRM authors pointed out that a first step towards increasing the overall readiness stage is to improve the dimensions with the lowest stage of readiness (Plested, Edwards, & Jumper-Thurman, 2006). The dimension of knowledge of current efforts received a readiness score of 3, at the stage of vague awareness. The dimensions of knowledge of the problem, resources and community leadership each scored a 4, placing them at the preplanning readiness stage. Based on these findings, focus should be placed on increasing knowledge of the problem and of current efforts among the population and leaders as a strategy to drive a surge of readiness. Emphasis should also be placed on leadership engagement and resource acquisition because the support of community decision makers is key, and activities cannot be sustained without appropriate resources (Silwa, et al., 2011).

System Organization

The key to a successful child protection and VAC prevention mechanism is an integrative approach of all parts of the system (ACPF, 2016); any other approach would otherwise lead to efforts that are limited in scope and time and have limited impact on the problem, especially one of such magnitude and ramifications as VAC. This study has revealed that the MSTF must strengthen its communication and coordination system.

Managing system knowledge: Communication. The limited awareness of efforts suggests a communication gap between the community and the leadership. Data use for action is dependent on the dissemination and comprehension of violence research findings; similarly,

effective coordination is dependent on the communication of existing efforts to avoid duplication of efforts and saturation of services in certain regions. Enhancing communication within the system will improve information sharing across sectors and agencies and with communities. For instance, efforts could be made to strengthen a database managed by the Office of Studies, Planning and Statistics (Table 10), which collects information on the different types of violence committed against children, disaggregated by age and sex. Databases such as those mentioned above, and studies such as the VACS, MICS and other studies, should be made accessible for professional use. Professionals need training in how to interpret and match survey findings to interventions and policies. Dissemination approaches must include multiple strategies based on the who (government, policy makers, communities, parents, and children); the how, when, and where (the medium used for communication, meeting the target audience where they are); and the what (products and documents).

Coordination. The response to the problem of violence against children is grounded in a powerful governance and coordination mechanism that integrates all the actors in the system. This coordination can be achieved by developing comprehensive, multisectoral child protection strategies that emphasize enhancing the implementation of policies and reinforcing laws by involving governmental and nongovernmental agencies and by forming realistic and time-bound objectives.

An appropriate response to VAC in CI will require the efforts of the entire nation. Sectors, agencies, and departments will need to come together at one table to lay out what they each currently do and what they have done in the past. These stakeholders will then be able to devise a comprehensive, multisectoral national action plan, with SMART (smart, measurable,

achievable, realistic, and timely) goals integrating various strategies from the INSPIRE package and scaling up to the national level. To this end, the following recommendations are beneficial:

a. Strengthen the coordination efforts of the lead government agency with the capacity to involve multiple sectors (including governmental and nongovernmental stakeholders) in a broad-based implementation strategy.
b. Cultivate partnerships (internally and externally to the government) to multiply and/or scale up efforts towards the resolution of this problem, thereby reducing duplicated efforts and ensuring proper resource management.
c. Leverage existing albeit minimal resources: Increase funds and human resources from the government, primarily from grants and contracts with international organizations (such as UNICEF, UNFPA, the World Bank and the African Development Bank) and other partner countries.
d. Monitoring and evaluation (M&E): Incorporate M&E activities into all programs and services during the planning phase, and budget them accordingly.
e. Utilize INSPIRE evidence-based strategies for programming and other response efforts to abide by another of the ACFP recommendations, which is to encourage evidence-based and cultural and context appropriate community child protection activities (ACFP, 2014).

Raising Awareness of VAC and Efforts

This study's findings revealed that one of the main challenges facing the MSTF is the lack of congruence in the knowledge of VAC between leadership and the communities and the vague awareness of current efforts. Therefore, the first goal of any action plan or intervention should be to raise awareness of all efforts and programs that currently exist in the community.

Given that a Violence Against Children Survey has recently been completed in CI, the MSTF should seize the opportunity of recent, nationwide data to raise more awareness of this problem at multiple levels, from the government to civil society organizations and other partners, to local communities. The data-to-action workshop gathered country experts around the table to discuss the recent data through Ivorian lenses. This situation was the appropriate setting and time to expand and encourage multisectoral collaborations at a higher decision-making level and create momentum and synergy to tackle the problem of VAC in CI. Examples of communication strategies include:

- Use targeted and audience-appropriate messaging; share the evidence and information, translate the data, disseminate the data (final report) via multiple varied and creative channels to reach all populations and communities in CI. Benefit from every avenue to ensure local communities have access to the correct information irrespective of socioeconomic situation, level of education, or location of residence.
- For stronger community buy-in and culturally relevant messaging, engage local communities in the contextualization of the following messages: "Violence against children is a problem in our communities; the consequences are disastrous for all; VAC can be prevented; we can do something about VAC."
- Use all existing communication media to get these messages across, from traditional messaging methods (flyers, posters, and billboards) to social media to more novel communication forms.
- Engage local communities in brainstorming sessions and create platforms of discussions on the topic; create planning activities of dissemination events.

- Increase local ownership and capacity to research VAC through partnerships with USG and other international partners. Publish articles in partnership with USG and local researchers that highlight local implications targeting the local scientific community and other international partners who recognize the importance of this topic and support national efforts to prevent violence against children. The interest of local researchers to continue surveying this issue is key to continuing to elucidate the factors associated with or causing this problem, as well as how to prevent its continuance.

Public Health Implications

The main objective of public health is to prevent disease and to promote the health and wellbeing of the greatest number of people. Violence is a health issue because of the many direct and indirect effects it can have on the victims (Krug, Mercy, Dahlberg, & Zwi, 2002). Exposure to violence and abuse has been associated with severe physical and mental health outcomes, such as chronic disease (heart disease, asthma, stroke, cancer, and more) and mental health problems (PTSD, stress, anxiety, depression, and more) and death. Additionally, violence disproportionately affects vulnerable populations such as women, children, LGBTQ individuals, and those living in poverty, among others. For all these reasons, VAC has been recognized as a growing public health problem.

Public health draws upon a multidisciplinary scientific foundation. Preventing any public health issue requires strong collaboration across a wide array of sectors and disciplines. The violence prevention field has moved from a narrower focus towards a more systemic approach in tackling the problem of violence against children. As described by Leischow et al. (2008),

> "[E]ach separate activity [or program] to address [violence against children] is necessary but insufficient. However, when viewed together, the structures and functions to prevent

> and contain [VAC] represent an ever-changing complex adaptive system whose sum is greater than the parts." (p. 1)

The findings of this study reflect a need for more, improved and better-coordinated efforts. Furthermore, increased dissemination of these efforts will increase access to services.

More remains to be done to ensure that evidence-based strategies are implemented as part of the VAC national prevention action plan. The INSPIRE package (described in Chapter 2) proposes seven broad evidence-based strategies across seven sectors and recommends the simultaneous implementation of multiple of these strategies' programs and policies, galvanizing multisectoral and cross-agency efforts through a governmental leadership system to ensure successful violence prevention and response outcomes.

Recommendations for the Implementation of INSPIRE Strategies

The strategies assembled in the INSPIRE package are based on strict scientific criteria, represent best practices for preventing and responding to violence against children and youth, and reflect best evidence about what works to prevent violence. The INSPIRE strategies listed below were discussed by participants and ranked in order of relevance to the issue of VAC, based on the number of times they were discussed by participants during the interviews:

1. Norms and values: During the study, cultural norms and values adhering to violence against children formed a recurrent theme. All participants mentioned the impact of harmful social norms on the beliefs and perspective that the communities hold regarding violence perpetrated towards children. Many forms of violence are used as disciplinary methods, and very little is done to challenge these norms. Programs and other initiatives supported by strategies that target norms and values are key to changing and/or eliminating harmful practices.

2. Parents and caregiver support: Another crucial and recurrent theme is the adherence of parents and caregivers to harmful norms supporting violence as a method of discipline. Parent educational programs supported by parent and caregiver support strategies will be key to breaking generational cycles of violence and prompting a mentality shift towards a more positive form of discipline (both in the home, community, and in the school setting).
3. Response and support services: Several participants discussed not only the paucity of services and service providers for post-violence care but also communities' ignorance of services currently available, despite their limitations. This lack of knowledge is linked to the limited funding received by the government for sustained programs and the lack of widely disseminated information on what services and programs are currently offered. Despite government efforts to implement violence prevention programs and offer post violence care services, the population remains vulnerable. More remains to be accomplished, not only to inform the population of services such as helplines but also to devise other response and support services strategies to increase service uptake.
4. Implementation and enforcement of laws: A few participants brought up the topic of policies and laws tackling VAC in Côte d'Ivoire. The government of CI has ratified the key international and regional human rights instruments, which all provide safety and child protection decrees. Côte d'Ivoire has also drafted a National Child Protection Policy (Programme National de la Protection de l'Enfant, PNPE). Furthermore, a few sector-specific policies all linked to child protection. For instance, a law was recently passed prohibiting physical violence as a disciplinary means in school. Such actions are indicative of the goodwill of the governing institutions in dealing with the problem of VAC in CI. Nevertheless, more remains to be done to encourage the application of these laws and the

implementation of such policies. Strategies focusing on the implementation and enforcement of laws are unavoidable to ensure that legal codes are translated into actions and that communities buy into them.

5. Monitoring and evaluation (M&E) programs: A lack of M&E programs was cited as one of the weaknesses of the system. Development in this area is vital to improving monitoring and evaluation mechanisms (within and across agencies) to ensure proper use of limited resources. Indicators of INSPIRE exist for each strategy, making M&E a viable activity. Data from the VACS would serve as baseline information to be tracked for improvements, depending on the INSPIRE strategies implemented. These indicators can be used to evaluate and monitor efforts using short- and long-term measures, as it may take decades or generations to reduce the prevalence of VAC.

Summary, Limitations, and Conclusion

Summary

In response to concerns regarding violence against children and youth, especially sexual violence, the government of Côte d'Ivoire implemented a violence against children survey. Findings from that survey (and past studies) will support new and ongoing efforts to prevent VAC. Kostadinov et al., found that a community readiness assessment has a primary part in the planning process for any plan or program (Kostadinov et al., 2015). Assessing readiness for preventing violence against children serves to identify gaps in readiness to implement a national action plan compared to the actual level of efforts needed to carry out prevention interventions or programs. The objective of such an assessment is to ensure appropriate policies and intervention strategies are devised and included in the national action plan, based on the readiness (Kostadinov, Daniel, Stanley, Gancia & Cargo, 2015). Arguably, national action plans that focus

their interventions on evidence-based strategies within an integrative and multisectoral context hold the most promise for reducing VAC (Hillis et al., 2016). In this study, eight participants were interviewed about the MSTF's knowledge, beliefs, leadership, and resources regarding violence against children and current efforts to prevent this problem.

Strengths and Limitations

The results of this study are qualitative in nature and reflect findings from key informant interviews with members of the Côte d'Ivoire MSTF for the prevention of VAC. Although qualitative results are not representative, they provide rich, contextual information that is key to understanding how ready the government is to move forward with developing and supporting a response plan based on the recent Violence Against Children Survey results.

Limitations of this study include the restricted number of participants. Although the study met the recommended number of participants per the CRM authors' recommendations (between four and six), this study aimed at interviewing 14 participants to allow two participants for each of the seven sectors covered by INSPIRE. Given that the MSTF is a system composed of multiple networks, two interviews per sector was deemed appropriate to assess each sector in more depth. As shown in Table 4, however, only three of seven sectors completed the two interviews, and information was collected from only five of the seven sectors that the study endeavored to explore. No data was collected from the sectors of interior planning and finance. This study was thus not able to investigate in further detail the specific strengths and needs of the MSTF by each sector. The interior planning sector has often taken the lead on INSPIRE's safety environments strategies, and the finance sector usually supports the income and economic strengthening strategies. An opportunity to interview members from both sectors would have provided crucial information regarding current policies and services in favor of victims of

violence. Specifically, given the link between income level and violence, income-strengthening strategies have contributed to the reduction of violence against women and children. It is unfortunate that this study will not be able to discuss efforts from these sectors.

Another disadvantage is a variability in the definition of "community" from one respondent to the other. Although for the purposes of this study, "community" referred to the MSTF system for the prevention of VAC, some informants of the MSTF felt the need to redefine their community as they perceived. This amalgam of the definition created some difficulty during the scoring and analysis of the interviews.

The strengths of the study include a strong theoretical/conceptual framework, a survey instrument that has been validated in numerous previous studies, and the use of local key informants, which supported strong contextual findings. This study adds to the body of knowledge in the scientific literature in general and, more specifically, in the African context.

Conclusion

Violence against children is a worldwide problem. Its effects are global, profound, and long-lasting on children and societies at large. Many worldwide organizations and governments, including the government of CI, have recognized this issue as a preventable public health and humanitarian issue. The Violence Against Children Surveys (VACS) (Chiang et al., 2016) seek to assess the magnitude of this problem and understand it in context in multiple countries, thereby offering an opportunity to address VAC appropriately. In CI, a VACS was completed in September 2018, and data analysis will translate the findings into a national action plan for the prevention of VAC using seven evidence-based strategies compiled within the INSPIRE package.

Most researchers, practitioners, and decision makers agree on the importance of strong violence data and evidence to guide effective violence prevention and response (MacGregor, Wathlen, Kothari, Hundal, & Naimi, 2014). Furthermore, while engaging multisector stakeholders in supporting violence prevention strategies is key (Boykes, Wathen, & Kothari, 2017), success is more likely when promoting factors and challenges to implementation have been identified at the outset (Black, 2001).

A readiness assessment is vital to match INSPIRE strategies to the readiness level assessed in each country. Such an approach helps to reduce waste of resources and time and to avoid leadership and developer discouragement and community fatigue. Developing a readiness plan and appropriately matching the strategies to the level of preparedness, by contrast, strengthens ownership and sustainability. Given the scarce national resources in Côte d'Ivoire, the best option is to use evidence-based interventions. Conducting a readiness assessment after the data-to-action workshop is likely to better inform the recommendations for the country's national action plan. As Leischow et al. (2008) state,

> There is a critical need for government agencies to take a leadership role in fostering increased transdisciplinary and translational collaboration and to employ an approach that recognizes that public health is the culmination of a complex, adaptive federation of systems. (p. 8)

Taking such a leadership role, a multisectoral task force was established in CI to guide the implementation of a Violence Against Children Survey and a subsequent response plan. This analysis of existing versus required resources was crucial to determine what can be done to ensure that a soon-to-be-developed action plan addressing VAC in CI does not become just another hollow paper document. The findings of this research study will be used to inform the CI

government in creating a strategic plan to ensure the successful implementation of the national action plan for VAC prevention. The overall level of readiness was assessed at the preplanning stage. This result indicates that there is a clear recognition that action must be taken, and there is even a system in place to address the issue. However, efforts are not yet focused or detailed.

Furthermore, the level of readiness is uneven across dimensions. The weakest dimension (or dimensions) must be strengthened to ensure the successful implementation of the national action plan. In this case, the dimension *knowledge of efforts* (with a score of 3) had the lowest stage of readiness, even lower than the overall readiness score (score of 4); thus, the system's immediate next step should be to increase both internal and external awareness and knowledge of all current efforts to deal with this issue by using dissemination strategies (proximity and larger range) for better and wider exploitation of the services already available.

The dimension of community efforts revealed the highest level of readiness (stage six), which indicated that programs and other efforts have been initiated and implemented to address violence against children. On the other hand, the dimension with the lowest level of readiness was knowledge of community efforts, at stage three, indicating limited awareness and understanding of current efforts implemented to respond to VAC in CI.

The central question driving this research was: Is the system established to support VACP in Côte d'Ivoire ready to implement evidence-based strategies to prevent violence against children? The answer offered by this study is that the MSTF is in the preplanning phase for developing a solid and effective plan to address the issue of VAC in CI. Overall, the MSTF demonstrates full engagement with this issue and a desire to continue guiding the response to the problem of VAC. The MSTF has been set up to lead this process and is fully capable to do so,

provided the authority of this body is officially and administratively recognized and that resources are appropriately allocated to support its function.

This readiness assessment revealed that, although the MSTF in Côte d'Ivoire has some positive and encouraging features, such as existing policies, programs, and resources for programming and a government agency with coordinating responsibilities, much more remains to be accomplished in all six dimensions to ensure that the MSTF is fully ready to effectively guide the implementation of an INSPIRE-supported national action plan for the prevention of VAC. At different levels, engaging the government and the population will be slightly different and require slightly different strategies. It will thus be important, moving forward, to link these strategies vertically to more local expressions of the MSTF.

Future research should focus on evaluative research to identify the most effective evidence-based interventions from INSPIRE in CI and assess the effectiveness of the MSTF coordination of efforts. Furthermore, region-specific and context-specific risk factors surrounding VAC are important to research and understand to implement insightful response programs and policies. Finally, research about causal and dosage relationships between risk factors and VAC will be beneficial to prioritize interventions preventing or reducing VAC.

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APPENDIX A

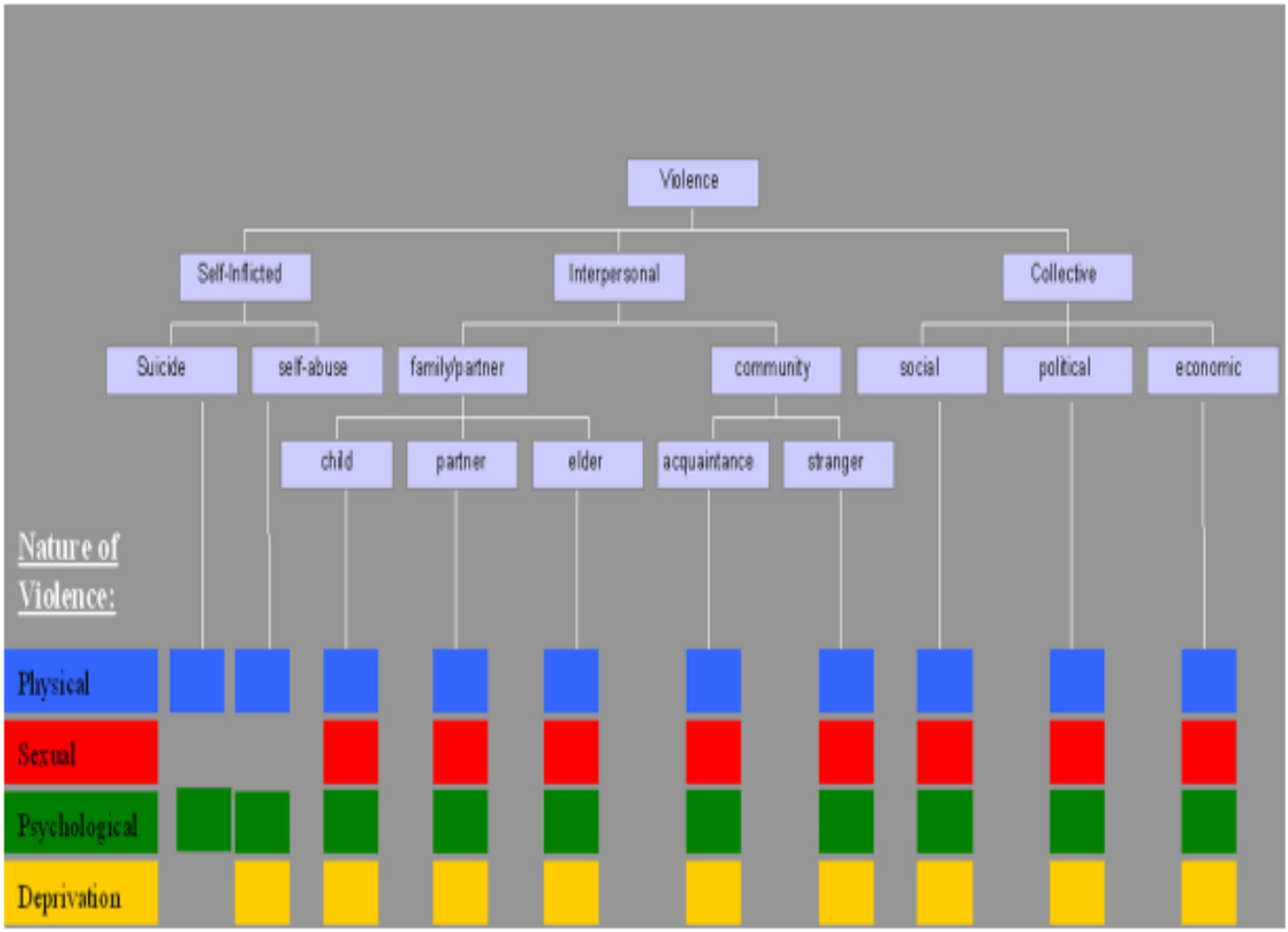
OVERVIEW OF INSPIRE PACKAGE FOR PREVENTING AND RESPONDING TO VIOLENCE AGAINST CHILDREN AGED 0-18 YEARS

Strategy	Approach	Sectors	Cross-cutting Activities
Implementation and enforcement of laws	• Laws banning violent punishment of children by parents, teachers or other caregivers • Laws criminalizing sexual abuse and exploitation of children • Laws that prevent alcohol misuse • Laws limiting youth access to firearms and other weapons	Justice	Multisectoral action and coordination
Norms and values	• Changing adherence to restrictive and harmful gender and social norms • Community mobilization programmes • Bystander interventions	Health education, Social welfare	
Safe environment	Reducing violence by addressing "hotspots" • Interrupting the spread of violence • Improving the built environment	Interior planning	
Parent and caregiver support	Delivered through home visits • Delivered in groups in community settings • Delivered through comprehensive Programs	Social welfare, Health	
Income and economic strengthening	• Cash transfers • Group saving and loans combined with gender equity training • Microfinance combined with gender norm Training	Finance, Labor	Monitoring and evaluation
Response and support services	Counselling and therapeutic approaches • Screening combined with interventions • Treatment programs for juvenile offenders in the criminal justice system • Foster care interventions involving social welfare services	Health, Justice, Social welfare	
Education and life skills	• Increase enrolment in pre-school, primary and secondary schools • Establish a safe and enabling school	Education	

environment • Improve children's knowledge about sexual abuse and how to protect themselves against it • Life and social skills training • Adolescent intimate partner violence prevention programmes		

APPENDIX B

WORLD HEALTH ORGANIZATION TYPOLOGY OF VIOLENCE



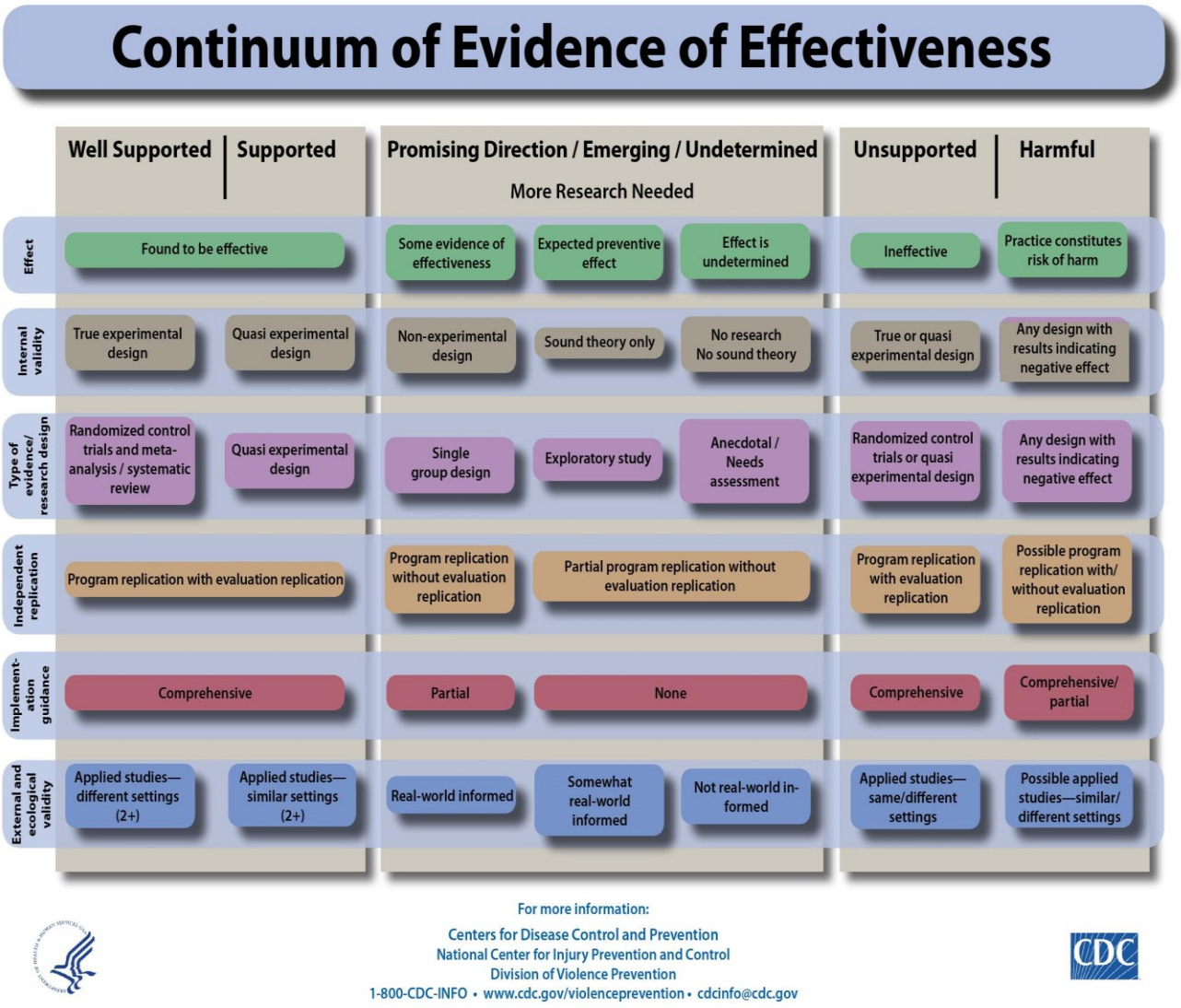
APPENDIX C

VACS SIX-STEP PROCESS

Process step	Activities
Step 1 Country engagement:	Activities in this step focus mainly on determining the local needs and interest for conducting VACS in a country. This activity is complemented by visits aimed at assessing feasibility of the study and meeting potential partners, organizing timelines and addressing budgetary and administrative issues.
Step 2 Mobilization:	Activities in this component focus on setting up the organizational structure of the VACS collaboration in the country. In addition, the first formal interactions with the multisectoral task force are initiated in this stage. An important component is the contextualization and adaptation of the questionnaires to the country language, administrative structure, and selected priority themes. Other key elements associated to the whole implementation process include the drafting and signing of a Memorandum of Understanding and the drafting and signing of a data sharing agreement.
Step 3 Ethical review:	This step focuses more on addressing and adapting the protocol to the international and national ethical standards required to conduct human subjects research in vulnerable populations. The process is reviewed by local partners to ensure that local laws and norms are also consistent with the core protocol.
Step 4 [Field work training and Preparation	The actual training for the implementation of the survey is the main activity here. Policy and governance elements at this stage are secondary to the technical and implementation components but with direct participation of key government institutions.
Step 5 Data collection, analysis & report writing:	Operational issues are typically addressed to ensure quality of the data collection process and safety of teams and the human subjects who agree to participate in the survey. Once data collection is completed, a more structured and involved process of political engagement is proposed and aimed mostly at socializing the findings and obtaining feedback from key institutions with a systematic strategy under the tutelage of the lead government agency. Typically, an iterative process linked to a preliminary report has been shared with countries and feedback obtained. The VACS reports provide recommendations towards national policies and programs to prevent VAC.
Step 6 Data-to-action and dissemination:	The Data-to-Action workshop has a structure and process aimed at identifying country goals, creating a draft national response plan or VAC-related recommendations for the country. Activities are aimed at helping institutions transition from data and data interpretation into policy goals and objectives supplemented by activities. During this step, a final report is published, and results disseminated to the world.

APPENDIX D

CONTINUUM OF EVIDENCE OF EFFECTIVENESS (CDC)



APPENDIX E

SIX DIMENSIONS OF COMMUNITY READINESS

Community Efforts (10 items)

What efforts exist to address the issues?

Community Knowledge of Efforts (4 items)

How much does the community know about the current programs and activities?

Leadership (4 items)

What is leadership's attitude toward addressing the issue?

Community Climate (5 items)

What is the community's attitude toward addressing the issue?

Community Knowledge of Issue (4 items)

How much does the community know about the issue?

Resources (8 items)

What are the resources that are being used or could be used to address the issue?

APPENDIX F

COMMUNITY READINESS MODEL'S 9 STAGES OF CHANGE

Stage of change	Description	Example for VAC
Stage 1: No Awareness	• Community has no knowledge about local efforts addressing the issue. • Leadership believes that the issue is not much of a concern. • The community believes that the issue is not a concern. • Community members have no knowledge about the issue. • There are no resources available for dealing with the issue.	Children are victim of all forms of violence
Stage 2: Denial/Resistance	• Leadership and community members believe that this issue is not a concern in their community, or they think it can't or shouldn't be addressed. • Community members have misconceptions or incorrect knowledge about current efforts. • Only a few community members have knowledge about the issue, and there may be many misconceptions among community members about the issue. • Community members and/or leaders do not support using available resources to address this issue.	"We can't do anything about this problem"
Stage 3: Vague Awareness	• A few community members have at least heard about local efforts but know little about them. • Leadership and community members believe that this issue may be a concern in the community. They show no immediate motivation to act. • Community members have only vague knowledge about the issue (e.g. they have some awareness that the issue can be problem and why it may occur). • There are limited resources (such as a community room) identified that could be used for further efforts to address the issue.	"Something should probably be done, but what? Maybe someone else will work on this."
Stage 4: Pre-planning	• Some community members have at least heard about local efforts but know little about them. • Leadership and community members acknowledge that this issue is a concern in the community and that something must be done to address it. • Community members have limited knowledge about the issue. • There are limited resources that could be used for further efforts to address the issue.	"This is important. What can we do?"

Stage 5: Preparation	• Most community members have at least heard about local efforts. • Leadership is actively supportive of continuing or improving current efforts or in developing new efforts • The attitude in the community is ―We are concerned about this and we want to do something about it‖. • Community members have basic knowledge about causes, consequences, signs and symptoms. • There are some resources identified that could be used for further efforts to address the issue; community members or leaders are actively working to secure these resources.	"we will develop and National Action Plan"
Stage 6: Initiation	• Most community members have at least basic knowledge of local efforts. • Leadership plays a key role in planning, developing and/or implementing new, modified, or increased efforts. • The attitude in the community is ―This is our responsibility‖, and some community members are involved in addressing the issue. • Community members have basic knowledge about the issue and are aware that the issue occurs locally. • Resources have been obtained and/or allocated to support further efforts to address this issue.	"This is our responsibility; we are now beginning to do something to address this issue."
Stage 7: Stabilization	• Most community members have more than basic knowledge of local efforts, including names and purposes of specific efforts, target audiences, and other specific information. • Leadership is actively involved in ensuring or improving the long-term viability of the efforts to address this issue. • The attitude in the community is ―We have taken responsibility‖. There is ongoing community involvement in addressing the issue. • Community members have more than basic knowledge about the issue. • A considerable part of allocated resources for efforts are from sources that are expected to provide continuous support.	"We have taken responsibility"
Stage 8: Confirmation/Expansion	• Most community members have considerable knowledge of local efforts, including the level of program effectiveness. • Leadership plays a key role in expanding and improving efforts. • The majority of the community strongly supports efforts or the need for efforts. Participation level is high. • Community members have more than basic knowledge about the issue and have significant knowledge about local prevalence and local consequences.	"How well are our current programs working and how can we make

	• A considerable part of allocated resources is expected to provide continuous support. Community members are looking into additional support to implement new efforts.	them better?"
Stage 9: High Level of Community Ownership	• Most community members have considerable and detailed knowledge of local efforts, • Leadership is continually reviewing evaluation results of the efforts and is modifying financial support accordingly. • Most major segments of the community are highly supportive and actively involved. • Community members have detailed knowledge about the issue and have significant knowledge about local prevalence and local consequences. • Diversified resources and funds are secured, and efforts are expected to be ongoing.	"These efforts are an important part of the fabric of our communit y."

APPENDIX G

LETTER OF INVITATION FOR STUDY PARTICIPATION

Date 5, 2018

Key Informant's name

XYZ Organization

1234 Street Road

Wherever, OH 40404

Dear Name of potential study participant,

We are trying to gather the insights of those with relevant experience in any area supporting the prevention of violence against children in Côte d'Ivoire. We hope to develop a set of strong recommendations that will contribute to the implementation of evidence-based strategies for violence against children prevention. Because of your experience with the topics that we are exploring, we would like to invite you to participate in an interview which would last 60 to 90 minutes.

In the near future, you will be contacted via phone or email to set up an appointment for an interview. We encourage you to indicate a time and location for the interview that is more convenient for you.

The interview will include questions regarding your experience or knowledge of violence against children prevention. We hope to briefly explore topics such as community knowledge of efforts to prevent violence against children, resources, training, political environment, and more. The results will help in the design of important recommendations for a more effective strategic

National Action Plan to respond to violence against children in Côte d'Ivoire and will identify areas for further research in this field.

If you have any questions, please email me at ms10193@georgiasouthern.edu. We appreciate the time that you will take out of your busy schedule to speak with us. We see this project as an important contribution to the field of child protection and to the development of efficient programs for violence against children prevention response and action.

Sincerely,

Marie-Kaye Soletchi Seya

APPENDIX H

PRE-INTERVIEW INTRODUCTION SCRIPT

Hello, my name is _____ from (Georgia Southern University).

Thank you so much for agreeing to be interviewed for this project. We have contacted key people to ask about Violence Against Children prevention (VACP) in Côte d'Ivoire. The entire process, including individual names and other personal information, will be kept confidential. Just to be clear, when I refer to VACP, I specifically mean:

Existing strategies and programs to prevent violence against children, knowledge by the community of such efforts, current climate, political environment, resources, etc.

In addition, I would like you to answer specifically about the multisectoral task force (MSTF), and your agency. This MSTF supports VACP in Côte d'Ivoire.

I would like to go over the consent form with you and answer any questions you may have.

I would like to record our interview, so that we can get an accurate representation of what you've said. The recording will be erased once it has been transcribed.

Would that be okay with you?

APPENDIX I

CONSENT FORM FOR PARTICIPATION IN STUDY

INTRODUCTION: Hello, my name is _____. I am the Principal Investigator and one of the interviewers for a research study supported by Georgia Southern University. We are conducting a study in Côte d'Ivoire to assess the readiness of the multi sectoral system supporting violence against children prevention in Côte d'Ivoire to implement violence against children prevention strategies.

As part of the study, I would like to ask you some questions about your knowledge, experience, and expertise regarding violence against children prevention. The interview will last anywhere between 60 and 90 minutes and would take place at your preferred location, in a private setting. There is little or no risk to you answering these questions. Some of the questions during the interview ask about knowledge of existing efforts, climate, will, resources, etc. for the prevention of violence against children. There are no consequences for not participating in this study, nor are there any direct benefits to you for participating in this study. You will not get anything, such as money or gifts, for being in this survey. You have the right to stop the interview at any time, or to skip any questions that you do not want to answer. There are no 'Right' or 'Wrong' answers. Data already provided will be retained in case of interview interruption.

You have been invited to participate as one of 14 key informants in this study because you are 18 years of age or older, work for an agency member of the multisectoral task force and have at least one-year experience in the field of child protection. I want to assure you that all of your answers will be kept strictly confidential. You are free to give your name or not, it is

voluntary. Only the investigators will have access to the raw data which will be stored on an encrypted key and in a locked file cabinet for 3 years, at which point it will be destroyed.

Your participation is completely voluntary, but your experiences could be very helpful to understand how prepared the multisectoral task force supporting violence against children prevention in Côte d'Ivoire is to implement violence against children prevention evidence-based strategies. A better understanding of the system's readiness would allow for a more effective strategic National Action Plan to respond to violence against children in Côte d'Ivoire.

Deidentified or coded data from this study may be placed in a publicly available repository for study validation and further research. You will not be identified by name in the data set or any reports using information obtained from this study, and your confidentiality as a participant in this study will remain secure. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions

Would it be alright for me to ask you some questions? Remember the questions should take only about 60 to 90 minutes to answer.

Response of individual:

☐ **DOES NOT AGREE TO ANSWER QUESTIONS.**

☐ **AGREES TO ANSWER THE QUESTIONNAIRE. DATE: _____**

NAME OF PARTICIPANT: _____

SIGNATURE OF PARTICIPANT: _____

NAME OF INTERVIEWER: _____

SIGNATURE OF INTERVIEWER: _____

You will be given a copy of this consent form to keep for your records. This project has been reviewed and approved by the GSU Institutional Review Board under tracking # H_____.

Title of Project: Violence Against Children Prevention: A Systems' Readiness Assessment in Côte d 'Ivoire: A systems thinking approach

Principal Investigator: Marie-Kaye Soletchi Seya, tel: 0012675153201, email: ms10193@georgiasouthern.edu

Faculty Advisor: Dr. Walker, email awalker@georgiasouthern.edu/ GSU-IRB irb@georgiasouthern.edu

and the local Ethics Committee at email cner_ci@gmail.com

APPENDIX J

INTERVIEW CONFIDENTIALITY AGREEMENT

I agree to keep all information I may receive regarding participants of the violence against children prevention readiness assessment completely confidential on a permanent basis**.**

Information to be kept confidential includes**:**

- names
- age/birthdates
- location of work
- location of homes
- all personal information reported by participants

_____ _____

Interviewer Signature Date

_____

Interviewer Printed Name

APPENDIX K

COMMUNITY READINESS MODEL QUESTIONNAIRE FOR VACP IN CI

COMMUNITY EFFORTS (Programs, Activities, Policies, etc.)

COMMUNITY KNOWLEDGE OF EFFORTS

Using a scale from 1-10, how much of a concern is violence against children in your community, with one being not at all and ten being a very large concern? Please explain.	-1 -2 -3 -4 -5 -6 -7 -8 -9 -10
Please describe the efforts that are available in your community to address violence against children?	
How long have these efforts been going on in your community?	-1 -2 -3 -4 -5 -6 -7 -8 -9 -10
Using a scale from 1 to 10, how aware are people in the community of these efforts, with one being no awareness and ten being very aware? Please explain. **What does the community know about these efforts or activities?** **What are the strengths of these efforts?**	-1 -2 -3 -4 -5 -6 -7 -8 -9 -10

What are the weaknesses of these efforts? Who do these programs serve? (For example: individuals of a certain age group, ethnicity, etc.) Would there be any segments of the community for which these efforts/services may appear inaccessible? (For example: individuals of a certain age group, ethnicity, income level, geographic region, etc.) Is there a need to expand these efforts/services? Why? Is there any planning for additional efforts/services going on in your community surrounding violence against children? If yes, please explain. What formal or informal policies, practices and laws related to violence against children in place in your community, and for how long? (Prompt: An example of formal would be school, police, or courts and an example of informal would	

be like the police not responding to a particular part of town, etc.) Are there segments of the community for which these policies, practices and laws may not apply? (Prompt: for example, due to socioeconomic status, ethnicity, age, etc.) Is there a need to expand these policies, practices and laws? If yes, are there plans to expand? Please explain. How does the community view these policies, practices and laws?	

LEADERSHIP

Who are the leaders specific to violence against children in your community?	
Using a scale from 1 to 10, how much of a concern is violence against children to the leadership in your community, with one being not at all and ten being a very large concern? Please explain.	-1 -2 -3 -4 -5 -6 -7 -8 -9 -10

How are the "leaders" in your community involved in efforts regarding violence against children? Please explain. (For example: Are they involved in a committee, task force, etc.? What is their role? How often do they meet? Etc.)	
Would the leadership support additional efforts? Please explain.	

COMMUNITY CLIMATE

Describe your community.	
Is there ever a time or circumstance in which members of your community might think that violence against children should be tolerated?	
How does the MSTF support the efforts to address VAC?	

What are the primary obstacles to efforts in your community?	
What is the community's attitude about violence against children?	

KNOWLEDGE ABOUT THE ISSUE

How knowledgeable are community members about violence against children? Please explain. (Such as: dynamics, signs, symptoms, statistics, effects on family and friends, etc.)	
What type of information is available in your community regarding violence against children?	
What local data on violence against children is available in your community?	
How do people obtain this information in your community?	

RESOURCES FOR PREVENTION EFFORTS

To whom would an individual affected by violence against children turn to first for help and why?	
On a scale from 1-10, what is the level of expertise and training among those working on this issue? Please explain.	-1 -2 -3 -4 -5 -6 -7 -8 -9 -10
Do efforts that address violence against children have a broad base of volunteers?	
What is the community's and/or local business' attitude about supporting efforts with people volunteering time, making financial donations, and/or providing space?	
How are the current efforts funded? Please explain.	
Are you aware of any proposals or action plans that have been submitted for funding to address violence against children in your community? If yes, please explain.	-1 -2 -3 -4 -5 -6 -7 -8 -9 -10

Do you know if there is any evaluation of these efforts? If yes, using a scale from 1 to 10, how sophisticated is the evaluation effort, with one being not at all and ten being very sophisticated? **Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?**	

DEMOGRAPHIC INFORMATION

The following questions are optional but help us to know the types of people we have interviewed.	OPTIONAL
Would you be willing to answer questions such as your profession, ethnicity, age, etc.? If "yes": What is your work title?	YES NO
What is your gender?	

What is your ethnicity? Anglo Hispanic African American Asian American Native American Native Alaskan Other	Anglo Hispanic African American Asian American Native American Native Alaskan Other
What is your age range? 19-24 25-34 35-44 45-54 55-64 65 and above	19-24 25-34 35-44 45-54 55-64 65 and above
Do you live in Abidjan?	____ Yes ___ NO
Perception of Power questions: 1. How confident are you that your agency can impact change on the topic?	1) very confident, 2) confident, 3) neutral, 4) not so confident, 5) not confident at all
	____ YES ____ NO

2. Do you feel that the Multi Sectoral Task Force (MSTF) has the power to initiate, support, and sustain change necessary to implement INSPIRE?	
Questions for general institutional context:	
1. What is the stated mission of this institution?	
2. What role do you see this institution has in preventing and controlling violence against children, adolescents, and youth?	
3. Does this institution have formal collaborations on the issue of violence against children, adolescents and youth with other government institutions?	
4. Does this institution have formal collaborations on the issue of violence against children, adolescents and youth with other international institutions?	
5. Do you systematically collect data or have administrative datasets with information on violence against children, adolescents and youth?	

6. What are the most important programs or interventions within this institution (if any) that address violence against children, adolescents and youth?	

APPENDIX L

SCORING INSTRUCTIONS FOR COMMUNITY READINESS QUESTIONS

(from Tri-Ethnic Center for Prevention Research)

Move through the interviews one at a time [using the "Community Readiness Questions"], scoring each interview individually [using the "Scoring Sheets"]. Read through each interview before you begin to score to get a general feeling and impression from the interview.

Begin picking out statements and references that refer to specific dimensions, and then create a score for each of the six dimensions according to the anchored grading scales [detailed in the Scoring Sheets]. Each interview will encompass six different dimensions scores. Interviews are scored by dimensions and not by individual questions.

Under the section titled "Individual Score" [on the "Community Readiness Scoring" page], you are to fill in *your* scores for each dimension of each of the interviews. Please note: There may be more than four key informant interviews in a community. If this is the case simply add #5 and #6, handwritten to this form.

The section under the subheading "Combined Score" [on the "Community Readiness Scoring" page] represents the section where you and one other scorer that scored this same community will come together and agree on the scores for each interview on each of the dimensions. It is important that there be consensus on the scores by both scorers. Remember different people can have slightly different impressions and it is important to explain how you arrived at your decision. Enter your agreed upon score on one of the scoring sheets for each dimension and each interview.

After both scorers have agreed upon the scores in the above section, the mean will be calculated for the "Calculated Score." For some (actually many) this can be confusing so let me give you an example. Let's say that under the "Final Score" section, myself and the other scorer have under Dimension A the following:

Dimension A:	# 1	#2	#3	#4
3.5	5.0	4.25	4.75	

I would then add the scores **across** for all interviews under Dimension A and divide by four (calculate the mean). So, I would get a calculated score for Dimension A of 4.37. This will then be entered under Dimension A, "Calculated Score", and so forth by Dimension.

For the "Average" at the bottom of the page, below Dimension F, you will take the Calculated Score for each dimension, add them together and divide by six (the mean for all of the dimensions combined). For example, if we had:

Dimension A: 3.28; Dimension B: 5.67; Dimension C: 2.54; Dimension D: 3.29; Dimension E: 6.43; Dimension F: 4.07; Total average 25.28/6 = 4.21. A score of 4.21 would be entered under "Average."

For "Stage", you will enter the stage that is represented by your final average. In the above example, the "Calculated Average" represents the 4th stage or Preplanning. Please Note: The scores correspond with the numbered stage, so a score between a 1.0 and a 1.99 would be the first stage, a score of 2.0 to 2.99 would be the second and so forth. [For a list of the stages, visit http://www.open.org/~westcapt/crstages.htm]

Finally, under comments, write any impressions about this community, any unique outcomes, and qualifying statements that you wish to make regarding the score of the community.

APPENDIX M

SCORING SHEETS

Dimension A: Community Efforts (Programs, Activities, Policies, etc.)

0

1 No awareness of the need for efforts to address the issue.

2 No efforts addressing the issue.

3 A few individuals in the community recognize the need to initiate some type of effort, no immediate motivation to do anything.

4 Some community members have met and have begun a discussion of developing community efforts.

5 Efforts (programs/activities) are being planned.

6 Efforts (programs/activities) have been implemented.

7 Efforts (programs/activities) have been running for several years and are fully expected to run indefinitely, no specific planning for anything else.

8 Several different efforts (programs/activities) are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.

9 Evaluation plans are routinely used to test effectiveness of many different efforts, wide range of people. New efforts are being developed based on evaluation data.

10

Dimension B: Community Knowledge of the Efforts

0

1 Community has no knowledge of the need for efforts addressing the issue.

2 Community has no knowledge about efforts addressing the issue.

3 Some members of the community have heard about efforts, but the extent of their knowledge is limited.

4 Some members of the community are beginning to seek knowledge about efforts in their own, or in similar communities.

5 Some members of the community have basic knowledge about local efforts (i.e. purpose).

6 An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.

7 There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.

8 There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.

9 Community has knowledge of program evaluation data on how well the different local efforts are working, and their benefits and limitations.

10

Dimension C: Leadership (Includes appointed leaders and influential community members.)

0

1 Leadership has no recognition of the issue.

2 Leadership believes that this is not an issue in their community.

3 Leader(s) recognize the need to do something regarding the issue.

4 Leader(s) are trying to get something started. A meeting has been held to discuss the issue.

5 Leaders are part of a committee or committees and are meeting regularly to consider alternatives and make plans.

6 Leaders are supportive of the implementation efforts and may be enthusiastic because they are not yet aware of the limitations or problems.

7 Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.

8 Leaders are supportive of expanding/improving efforts through active participation in the expansion/improvement.

9 Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.

10

Dimension D: Community Climate

0

1 The prevailing attitude is that it's an accepted part of community life. "It's just the way things are."

2 The prevailing attitude is "there's nothing we can do" or "only 'those' people do that."

3 Community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole.

4 The attitude in the community is now beginning to reflect interest in the issue. "We have to do something, but we don't know what to do."

5 The attitude in the community is “this is our problem” and they are beginning to reflect modest support for efforts.

6 The attitude in the community is “this is our responsibility” and is now beginning to reflect modest involvement in the efforts.

7 The majority of the community generally supports programs, activities, or policies. “We have taken responsibility.”

8 Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high. “We need to keep up on the issue and make sure what we are doing is effective.”

9 All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

10

Dimension E: Community Knowledge About the Issue

0

1 Not viewed as an issue.

2 No knowledge about the issue.

3 A few in the community recognize that some people here may be affected by the issue.

4 Some community members recognize that this issue occurs locally, but information about the issue is lacking.

5 Community members know that this issue occurs locally and general information about the issue is available.

6 A majority of community members know that the issue occurs locally and there is enough information about the issue to justify doing something.

7 Community members have knowledge of, and access to, detailed information about local prevalence.

8 Community members have knowledge about prevalence, causes, risk factors, and consequences.

9 Community members have detailed information about the issue as well as information about the effectiveness of local programs.

10

Dimension F: Resources Related to the Issue (People, money, time, space, etc.)

0

1 There is no awareness of the need for resources to deal with this issue.

2 No resources available for dealing with the issue.

3 The community is not sure what it would take, or where the resources would come from to initiate efforts.

4 Some in the community know what resources are available to deal with this issue.

5 Some in the community are aware of available resources for this issue and a proposal has been prepared, submitted, and may have been approved.

6 Resources have been obtained from grant funds or outside funds. Programs or activities are time limited.

7 A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community member and leaders are beginning to look at continuing efforts by accessing additional resources.

8 Diversified resources and funds are secured, and efforts are expected to be permanent. There is additional support for further efforts.

9 There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

10

APPENDIX N

SCORING SHEET CALCULATIONS

Staff: _____ **Date**:_____

Individual Score				
	Interview			
Dimension	#1	#2	#3	#4
A				
B				
C				
D				
E				
F				

Combined Score				
	Interview			
Dimension	#1	#2	#3	#4
A				
B				
C				
D				
E				
F				

Calculated Score		Community State	
Dimension			
A		Comments about Calculated Score (if any):	
B			
C			
D			
E			
F			
Average			