Evaluation of "Shaping Our Future: Developing Healthy and Happy Relationships" Primary Prevention Intervention with Young Adolescents and Caregivers in Kampong Cham, Cambodia

Adolescents participating in the 'Shaping Our Future: Developing Healthy and Happy Relationships' project © PartnersforPrevention

Empowered lives.
Resilient nations.

TABLE OF CONTENT

List of figures and tables

FOREWORD

This end-line study was commissioned by Partners for Prevention (P4P), a regional joint programme of the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and the United Nations Volunteer Programme (UNV), working for the prevention of violence against women and girls (VAWG) in Asia and the Pacific.

This study was conducted after a 12-month completion of the violence against women primary prevention project on 'Shaping our Future: Developing Healthy and Happy Relationships with adolescents and caregivers' in five communes of Prey Chhor district, Kampong Cham province. The primary prevention intervention is one of five strategic areas of the Second National Action Plan to Prevent Violence against Women 2014-2018 of the Royal Government of Cambodia (RGC). Working with young adolescents and parents is clearly emphasised under this primary prevention strategy to enhance their knowledge and skills in developing gender equitable attitudes, non-violent relationships and introducing positive practices related to social norms.

This study seeks to determine the feasibility, acceptability, accessibility, and promising impacts of the intervention as a proof to practically inform further primary prevention policy and practice in Cambodia through understanding of perception, experiences and impacts of the intervention for primary prevention of violence against women and girls.

We hope that the information presented in this report will strengthen Cambodia's efforts to effectively prevent and respond to violence against women and girls.

We appreciate the strong cooperation, partnership and commitment from the Partner for Prevention (P4) a joint regional programme of UN agencies, particularly UNFPA behind this study. The Ministry of Women's Affairs is proud to share the results of this study to other partners and relevant government ministries at both national and sub-national levels.

Phnom Penh, 05th April 2018

Secretary of State

H.E Hou Samith

Acknowledgements

The authors of this report would like to thank the women, men, girls and boys from Kampong Cham Province, who shared their experiences of the *Shaping our Future: Developing Healthy and Happy Relationships* project. We would also like to thank Mana Kheang, a national UN Volunteer, and the Cambodian Ministry of Women's Affairs who facilitated data collection. Kantar TNS collected the quantitative data in field and Srey Oeun Chem and Layhour Sao collected the qualitative data in the field. The authors also thank Partners for Prevention Joint Programme team and UNFPA Cambodia, for providing technical support for the data collection. Kathy Taylor, Sereyroth Lim and Sothea Phan trained and supported the data collection teams and Marissa Droste did the quantitative analysis. Kathy Taylor, Anik Gevers and Jennie Williams, UNFPA (Lim Saky, Aing Sokreoun and Lim Sereyroth) and MoWA team provided valuable comments to this report..

Disclaimer:
The views and opinions expressed in this report are those of the authors and the study participants and do not necessarily reflect the official policy or positions of P4P, UNFPA Cambodia or the Ministry of Women's Affairs (MoWA).

Dr. Karie L. Morgan, Independent Consultant

Acronyms

CDHS	Cambodia Demographic and Health Survey
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IPV	Intimate Partner Violence
NGO	Non-Governmental Organization
UNFPA	United Nations Population Fund
UN MCS	Partners for Prevention UN Multi-Country Study on Men and Violence
UNV	United Nations Volunteers Programme
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAWG	Violence Against Women and Girls
WHO	World Health Organization

Executive summary

Introduction

Context of violence against women and girls in Cambodia

Globally, violence against women and girls (VAWG) continues to pose a tremendous public health, human rights and social problem with extensive health consequences for women and girls in both the short- and long-term.

The 2014 Cambodia Demographic and Health Survey (CDHS) found approximately 20 percent of women (between the ages of 15 and 49 years) had experienced physical violence at least once in their lives and six percent of women had experienced sexual violence in their lives, with intimate partner violence being more prevalent.[1] The 2015 World Health Organization national survey on women's health and life experiences found that 21 percent of ever partnered women had experienced physical or sexual violence by a partner and 32 percent had experienced emotional partner violence victimization.

In Cambodia, the results of the 2013 Partners for Prevention UN Multi-Country Study on Men and Violence (UN MCS) revealed that more than one-half of men perpetrated emotional and/or economic intimate partner violence during their lifetime. More than one-third of men perpetrated physical and/or sexual violence against a partner in their lifetime. The lifetime prevalence for non-partner rape was 8 percent and 5 percent for the gang rape of a woman. More than half of all men who reported rape did so when they were teenagers.

Intervention: Shaping our Futures

UNFPA in partnership with UN Women and UNV in Cambodia together with the Ministry of Women's Affairs and supported by Partners for Prevention developed and piloted a community-based intervention that engages young adolescents and adolescent caregivers through participatory methodologies. "Shaping Our Futures" aimed to address modifiable risk factors among a critical group within an enabling environment in sustainable ways will support the changing of social norms in ways that challenge the acceptance of the problematic status quo of gender and violence. The intervention intended to both equip adolescents to foster healthy, non-violent interpersonal relationships and gender-equitable attitudes and behaviours as well as to create a more enabling environment for these changes. The overall intended outcome of the intervention was: Adolescent girls and boys aged 12–14 years have gender-equitable attitudes, low levels of violence acceptance attitudes, and are supported by their caregivers and communities.

Evaluation

Study design

This study sought to conduct a quantitative and qualitative formative evaluation to determine the feasibility, acceptability, accessibility, and promising impacts of the intervention as a proof of concept to practically inform further primary prevention policy and practice in Cambodia.

Before and after the evaluation was implemented, quantitative data were collected from all consenting adolescent and caregiver intervention participants. After the intervention, qualitative data was also collected via focus group discussions and in-depth interviews with consenting intervention participants as well as with implementation facilitators and supervisors.

1 National Institute of Statistics. 2015. Cambodia Socio-Economic Survey. Ministry of Planning: Phnom Penh, Cambodia.

Limitations

Qualitative study

Focus group discussion transcripts rarely provided any gender identifiers for participants so qualitative findings could not be reported by gender. Qualitative findings relied on reported changes as no baseline study was conducted and no control group was used. For various reasons, participants' responses may also be biased by factors such as desires to please the interviewers, to make themselves look good and to demonstrate their participation and change.

Quantitative study

Because there was no control group used, it was not possible to conclusively attribute changes to the intervention. The statistical power of the study was limited by small sample sizes (drawn from intervention participants). Due to the very small number of matched cases (59 adolescents and 53 caregivers), it was not meaningful to include findings from matched sample baseline versus endline comparisons. Similarly, analyses regarding attrition were not meaningful.

Results

Changes in Adolescents' Attitudes and Practices

Gender-equitable attitudes and practices

Data from focus group discussions demonstrated that adolescents had learned or understood that women and men have equal rights. Several adolescents also mentioned that there were no (inherent) gendered divisions of labour. However, a few adolescents qualified their comments about gendered division of labour, suggesting that this reported belief or change in attitudes is not yet fully accepted. Yet one adolescent boy spoke about having actually changed his role in the household as a result of what he had learned at the sessions.

Comparing the baseline and endline samples, boys also reported significantly increased gender-equitable attitudes (baseline M=1.63, endline M=1.77, p=0.02) endline.

Communication and conflict resolution

Participants most often mentioned changes they made related to language use and other strategies to improve communication.

Adolescent participants talked a lot about a shift to attempting to use "polite words", particularly “Khnhom" (polite for “I"), with parents, siblings and friends. Observations were mixed about whether this language change prompted any different responses from friends. Several adolescent participants believed that some change in their relationships – feeling closer to a peer – was attributable to a change in the way they addressed one another.

Adolescent participants described a shift away from both aggressive argumentation and physical violence in favour of polite language and conflict resolution strategies. They claimed to have changed ways of talking and resolving arguments with friends and younger siblings. Rather than contribute to escalating arguments, several individuals chose to practice behaviours that would help to maintain or improve relationships.

Relationships with caregivers

Several adolescents reported that their relationships with caregivers had improved as a result of participating in the sessions. Many explained that they learned from the sessions that they should improve their cooperation with their caregivers' requests. Several noted positive responses from their caregivers when participants started to take on more responsibility for household work. The change in language use was reciprocated, yielding positive results for both the caregiver and the adolescent and it led to improved relationships.

Harsh punishment

Most adolescents reported that they hit younger siblings as a form of punishment. Every respondent explained they had greatly reduced (and some stopped) violent means of resolving conflicts or addressing behaviour with younger siblings. A few respondents could identify positive outcomes, including relationship strengthening, as a result of finding non-violent means of managing their younger siblings' behaviour.

Discussion in an adolescent group ©PartnersforPrevention

In addition, both girls (M=2.04 to 1.96, p=0.03) and boys (M= 2.12 to 1.95, p=0.05) showed significant decreases in violence acceptance attitudes between the averages at base line and endline.

Avoiding or dealing with violence

During focus group discussions, adolescents could readily list a few strategies to avoid situations that might become dangerous, especially avoiding particular situations or only going places with groups of friends and not alone. In addition, adolescents learned about where to seek help when they experienced or witnessed violence. Comparing the complete baseline and endline questionnaire results showed significant increases in knowledge about support services for both girls (baseline M=1.38, endline M=2.06, p=0.00) and boys (baseline M=1.46, endline M=2.13, p=0.00) who participated in the sessions.

Volunteerism

Many adolescents reported sharing some of what they learned with others. Similarly, the questionnaire results indicated that 68 percent of girls and 58 percent of boys would definitely feel confident to share what they learned with friends and family.

At baseline, 52 percent of boys and 40 percent of girls reported being involved in volunteer activities in the past six months that focused on issues of gender equality, healthy communication, conflict resolutions, caring relationships and violence against women and girls. At endline, significantly more boys (87%, p=.01) and girls (95%, p<.01) indicated that they had been involved in such volunteer activities. In addition, 48 percent of boys and 57 percent of girls reported that they are definitely

going to help planning or organizing volunteer activities in the community on the issue of men and women and healthy communication.

Changes in Caregivers' Attitudes and Practices

Gender-equitable attitudes and practices

Several caregiver participants noted that men and women have equal rights, a concept that at least some learned via the sessions.

There were some instances where men spoke about changes they had made regarding gendered practices, usually about taking on some household tasks traditionally understood as "women's work".

A caregiver group discusses project commitments
©PartnersforPrevention

Some women participants reported that they told their husbands about some of the session content regarding gendered divisions of labour and then their husbands changed behaviours. This too, is remarkable, given that women felt empowered to have this discussion after participating in the intervention and that men, even though they were not part of the intervention, changed their behaviour based on the learning and ideas shared by their wives.

Communication and conflict resolution

Nearly everyone who participated in the caregiver focus group discussions described their attempt to practise using respectful, non-violent communication which they referred to as using "polite words". In particular, participants said they were taught to use the word *"Khnhom"* (polite form of "I"), but they also spoke more broadly about implementing the use of "sweet words" or "polite words".

Everyone who discussed the use of polite language during the focus group discussions talked as though this was a permanent change, even if they continued to work at implementing it all the time. Participants seem to have recognized benefits of this change. First, several caregivers noted that when they tried using this different language, others often responded to them in the same way. Second, several participants believed that their linguistic change resulted in closer relationships. Third, several participants also explained that they believed that using polite language prevented aggressive talk and reduced the potential for conflicts to become violent.

In addition, several participants talked about strategies to stop an argument from escalating and regulating their own emotions to stop or prevent an argument.

Relationships with children and discipline

Caregivers widely reported changes in the ways they engaged with and disciplined their children as a result of participation in the sessions. Participants talked about learning to encourage children's positive behaviour, to guide them in making good or healthy choices, and to improve communication.

Nearly every caregiver participant explained that when they shifted away from punishing children, usually by replacing threats or harsh punishment with "soft words", children were more responsive to the caregiver's request.

Several noticed that their relationships with their children had improved as a result of implementing strategies they learned through the sessions.

Harsh punishment and physical violence

All caregivers who participated in the focus group discussions talked about reducing or stopping harsh punishment of their children as a result of participating in the sessions and learning other strategies for guiding their children's behaviour.

Avoiding and dealing with violence

A few women participants reported a reduction in domestic violence because they learned from the sessions to remove themselves from an escalating conflict.

Also, the endline questionnaire showed that on average, women who participated significantly increased their knowledge of support services (baseline M=1.65, endline M=2.02, p=0.00). A few participants reported that because of the sessions, they learned and developed confidence in phoning the police when violence occurred in their communities.

Volunteerism

Participants often shared what they learned in sessions with their families, particularly husbands and children. Participants seem to have most often shared content related to child rearing and discipline, communication and conflict resolution.

Although the endline questionnaire data showed that the majority of both women (49%) and men (65%) felt confident to share their learnings with friends and family, the focus group discussions lend the impression that even more sharing was done.

Participants' reported volunteer experiences significantly increased from 67 percent of both women and men at baseline to 97 percent of women (p<.01) and 100 percent of men (p=.01) at endline.

Although participants did not plan to continue teaching on their own, 60 percent of men and 53 percent of women indicated in the endline that, in the future, they would definitely help to plan or organize volunteer activities that focused on conflict resolution, caring relationships and violence against women and girls.

Lessons learned

Participant motivations and assessments of the intervention

Most adolescent participants said they continued to attend sessions because they believed the content would benefit them in the future. Nearly all participants in the endline questionnaire indicated that they enjoyed most of the sessions and that they found the sessions quite useful or very useful.

Many caregivers who continued with sessions found them useful in their own lives, particularly for raising children. From the endline questionnaire, most found the sessions "very useful" and nearly everyone enjoyed most or a lot of the sessions.

Useful content

One facilitator noted that a session on "being a real man and women" was difficult. The perceived difficulty with this lesson may also stem from what it is trying to teach: abstract concepts that diverge from deeply entrenched understandings. If this facilitator's concern about whether they were teaching the intended lessons about "real women" and "real men" was widespread among facilitators, the lesson may have been taught differently than what was intended by the manual. This lesson should be redesigned and more time and activities should be invested in ensuring that facilitators' understandings of gender and gender equality are also transformed.

Participatory methods

A few adolescents said they felt nervous for the first two to three sessions. At least in part, such nervousness seemed to be about imagining they needed to produce "right" answers. Methods of learning that promoted active participation in group discussions were effective for helping adolescents to feel comfortable participating and all adolescent participants said they liked the various methods of learning.

Most caregivers also enjoyed the mixed pedagogical methods used in the sessions. While, the current approaches seemed to have been well received, it might be beneficial to further explain links between games and content, and increase opportunities to practice new skills to improve participants' learning.

Session logistics

Adolescents attended sessions as school and household chore schedules allowed and caregivers similarly attended based on the rhythms of work at home. Clearly, a facilitator needs to carefully consider who would be included or excluded based on the time of day during which sessions are scheduled.

Participants and recruitment

Adolescent participants wanted to see the programme continue, but did not have any particular suggestions or consensus around whether to continue training in the current locations or expand.

When talking with caregivers about ideas for improvement, one broad message is that they would like to see more people around them trained as it will make it easier to implement changes among those who have learned common values. It was, in part, for a similar reason that a number of participants suggested that more men attend. Some believed men did not have enough time to participate and others thought they may be uncomfortable participating in groups of women or older men. Targeted recruitment and mobilization efforts specifically to engage men need to be developed and implemented so more men join the sessions.

Facilitators and recruitment

According to reports by adolescents and caregivers, community facilitators generally did well in their roles.

However, recruitment of capable facilitators was reported as a challenge by some, including disagreement about whether there may have been insufficient numbers of eligible facilitators. More resources should be invested in recruiting and mobilizing facilitators. In addition, community leaders could be a useful reference for selecting facilitators, among others. Findings also suggested that it is important to recruit facilitators with strong literacy skills and those who are committed to the preparatory work necessary for each session.

Facilitator training and support

Facilitator training was personally demanding in addition to the skills and knowledge that were to be learned. First, achieving sufficient knowledge comprehension during the facilitator training proved difficult. Second, supplemental training and continuous mentoring proved useful for this intervention and should be planned in further iterations of the intervention or scale up. These supplemental trainings responded to facilitators' struggles with understanding the lesson plans well enough to teach them. Continued development of intervention materials may be useful.

Discussion

It is very encouraging that so many adolescents and caregivers wanted to and felt able to make changes in their behaviour after learning alternatives in sessions. The uptake of changes was largely incremental; there is still more transformation needed to realize the full adoption of positive social norms and practices, and the elimination of violence against women and girls. However, the findings show that participants were interested in implementing changed behaviours, felt empowered to do so with strategies learned via the intervention, and accomplished some changes in a relatively short span of time, particularly incremental changes.

The impact of this intervention is more readily visible when examined in light of the theory of change based on the social ecological model which aims to create an environment conducive to behavioural change. By engaging both boys and girls, the intervention stood to influence peer norms as well as to build complementary gender-equitable ideals and respectful relationship norms and skills among all members of a group that are likely to have ongoing social contact through school and community activities. The intervention thus aimed to create communities of shared norms and behaviours as well as to enable adolescents to act as agents of change in their social environments.

Taken together, these outcomes show promise for change in terms of the social ecological model in several ways. First, if reported reductions in harsh punishment – both caregivers punishing children and children punishing younger siblings – continue, not only has an environment been created that is less accepting of violence, but intergeneration cycles of child maltreatment within families will be interrupted. Second, most participants described some form of positive reinforcement from peers or family members for their changed behaviours. Third, participants not only reported primarily positive responses from family and peers to their behaviour changes, but sometimes found that others also changed their behaviour. Fourth, participants described feeling able to make changes in their behaviour as a result of strategies learned through the intervention. Self-efficacy is one important component of individual level change. Although there remains significant scope for continued transformation, there is evidence that self-efficacy to prevent and address violence may have increased for some women and girls as a result of participation in the sessions.

Such changes at the level of the individual, while not wholly transformed, did demonstrate positive incremental change. Although changes in gender attitudes were difficult to assess or illustrated a continued practice of traditional understandings of gender, it is hopeful that all focus group respondents were able to identify stronger gender-equitable attitudes and roles.

The reported examples of change illustrate that participants more readily changed (or attempted to) attitudes or behaviours that were presented as concrete strategies or concepts. This illustrates that while full transformations are yet to be achieved, participants recognized the value of concrete strategies and put them into practice. Hopefully these incremental changes in the process of transformation will continue, effecting changes in values in the longer term and across the social-ecological spectrum.

One particularly useful suggestion from caregivers' discussions about ideas for improvement is that they would like to see more people around them trained. This will make it easier to implement changes among those who have learned common values. Such a strategy is already incorporated in the intervention design – parallel sessions for adolescents and caregivers, but it might be developed further.

Conclusion

The *Shaping our Future: Developing Healthy and Happy Relationships* intervention aimed to sustainably promote changes in social norms among adolescents within an enabling environment to address local, modifiable risk factors for men's use of violence against women and girls. Using participatory methodology, the intervention worked with groups of adolescents and caregivers over a period of 12 months to build skills and knowledge to enable adolescents to develop healthy, non-violent interpersonal relationships and gender-equitable attitudes and behaviours with the support of influential people in their lives.

"Now when tension or verbal abuse arises in my family, I use an assertive communication strategy that I learned from the training, and it has been successful when I talk with my husband and my daughters."

-Sophea, female facilitator

The intervention showed the strongest impacts in initiating transformation with regard to boys' gender-equitable attitudes; strengthening communication and conflict resolution skills among girls, boys, men and women; and closer relationships among family members. There were also encouraging reductions reported in harsh punishment by both adolescents and caregivers towards younger siblings and those being cared for, as well as increased emotional self-regulation.

The impact on behaviour change was very encouraging in regards to breaking down gendered divisions of household labour in practice, which may also imply increased gender-equitable attitudes. A number of caregivers and one adolescent reported that men had taken on some tasks of traditional "women's work" after learning about particular lessons from the intervention. A lot of information sharing was reported by participants; this had a ripple effect with the intervention's impact. Changed approaches to communication, conflict resolution and discipline were observed in participants' family members, particularly husbands, who had only heard about the intervention's discussions, ideas, games and skills via a participant.

Challenges remain in achieving transformations in social norms across all levels of the social ecology. Most visible were remaining inequitable gender attitudes. While some part of these findings may result from an inadequate session on gender, there are indications from the qualitative results that these attitudes are so ingrained in participants' worldviews that they are very slow and difficult to change.

Due to constraints with the study design, changes could not be wholly measured or conclusively attributed to the intervention. However, there are many hopeful trends in the findings that suggest

the intervention likely had important impacts on the targeted attitudes and behaviours among direct beneficiaries as well as among their families and peers.

Lessons learned from this intervention will also prove helpful for future planning for this intervention or for its scale-up. In particular, experiences with training facilitators suggest further training and support would be useful. The limited number of participants who were men in the sessions also points to a need to more carefully plan for their inclusion to ensure a wider base of common norms are developed. Overall, this intervention was effectively implemented and generated promising results and can be used as a basis for expanding the intervention to benefit more families and communities in Cambodia for the ultimate elimination of violence against women and girls.

Introduction

Context of violence against women and girls

Globally, violence against women and girls (VAWG) continues to pose a tremendous public health, human rights and social problem. This includes intimate partner violence (IPV), non-partner sexual violence, sexual abuse of girls, female genital mutilation, sexual trafficking of women, child marriage and honour killings. Across the world, nearly one-third of women aged 15 and over experience physical or sexual intimate partner violence in their lifetimes.[2] A World Health Organization (WHO) multi-country study on women's health and domestic violence found a range between 15 percent and 71 percent of lifetime prevalence of physical or sexual violence of ever partnered women.[3]

The health consequences of violence against women and girls are multiple. Globally, 38 percent of all murders of women are committed by intimate partners.[4] Furthermore, abused women have a 16 percent greater likelihood of having a baby with low birth weight, more than twice the likelihood of having an abortion and almost twice the likelihood of having depression; in some regions, they are 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence.[5] Research indicates that rape is disproportionately common among those who use mental health services and the prevalence of substance abuse, depression, suicidality and anxiety among women who have been raped or trafficked is much higher than those who have not.[6]

Children who have been physically or sexually abused have a greater risk of depression, suicidality, post-traumatic stress disorder, unwanted pregnancy, alcohol dependency and sexually transmitted infections.[7] Exposure to abuse and neglect also increases the risk of developing anti-social and violent behaviour, including rape perpetration.[8]

2 Devries, K.M., Mak, J.Y., Garcia-Moreno, C., Petzold, M., Child, J.C., Falder, G., Lim, S., Bacchus, L.J., Engell, R.E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N. & Watts, C.H. 2013. Global health. The global prevalence of intimate partner violence against women. Science, 340: 1527–8.

3 Garcia-Moreno, C., Jansen, H.A.F.M., Ellsberg, M. & Watts, C. 2005. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial results on prevalence, health outcomes and women's responses. Geneva, Switzerland: World Health Organization.

4 Abrahams, N., Mathews, S., Martin, L.J., Lombard, C. & Jewkes, R. 2013. Intimate partner femicide in South Africa in 1999 and 2009. PLoS Med, 10, e1001412.

5 Jewkes, R., Dunkle K., Nduna M. & Shai N. 2010. Intimate partner violence, relationship gender power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet 367: 41–48.

6 Filipas, H. & Ullman S. E. 2006. Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. Journal of Interpersonal Violence, 21: 652–672. Kilpatrick, D.G., Acierno, R., Resnick, H.S., Saunders, B.E. & Best, C.L. 1997. A 2-year longitudinal analysis of the relationships between violent assault and substance abuse in women. Journal of Consulting and Clinical Psychology, 65: 834–847; Abrahams N., Jewkes R. & Mathews, S. 2013. Depressive symptomatology after a sexual assault: Understanding victim-perpetrator relationships and the role of social perceptions. African Journal of Psychiatry, 2013 Jul; 16(4): 288–93; Seedat, S., Stein, D.J. & Carey, P.D. 2005. Post-traumatic stress disorder in women: epidemiological and treatment issues. CNS Drugs, 19, 411–27; Myer, L., Smit, J., Roux, L.L., Parker, S., Stein, D.J. & Seedat, S. 2008. Common mental disorders among HIV-infected individuals in South Africa: prevalence, predictors, and validation of brief psychiatric rating scales. AIDS Patient Care STDS, 22: 147–58; Smit, J., Myer, L., Middelkoop, K., Seedat, S., Wood, R., Bekker, L.G. & Stein, D.J. 2006. Mental health and sexual risk behaviours in a South African township: a community-based cross-sectional study. Public Health, 120: 534–42.

7 Turner, H., Finkelhor D. & Ormrod R. 2006. The effect of lifetime victimization on the mental health of children and adolescents. Social Science & Medicine, 62: 13–27; Felitti, V., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M. & Edwards, V. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14: 245–258; Koss, M.P., Yuan, N.P., Dightman, D., Prince R.J., Polacca M., Sanderson B., Et Al. 2003. Adverse childhood exposures and alcohol dependency among seven native American tribes. Am J Prev Med, 25:238–244; Jewkes, R., Dunkle K., Nduna M. & Shai N. 2010.

8 Caspi, A., Mcclay, J., Moffitt, T.E., Mill, J., Martin, J., Craig, I.W., Taylor, A. & Poulton, R. 2002. Role of genotype in the cycle of violence in maltreated children. Science, 297: 851-854. Jewkes, R., Sikweyiya, Y., Morrell, R. & Dunkle, K. 2011. Gender inequitable masculinity and sexual entitlement in rape perpetration South Africa: findings of a cross-sectional study PloS One: 6.

Cambodian context: social hierarchies and status

©PartnersforPrevention

Cambodia's 15.3 million people are largely young (60 percent below 30 years old) and reside in rural areas (80 percent).[9] Culturally constructed gender inequalities are quite stark and visible in a number of social indicators. For example, women generally complete less formal education, have lower literacy rates, and earn less than men.[10] Women were traditionally expected to respect their husbands, such as by maintaining virginity prior to marriage, exhibiting quiet obedience, and not sharing problems outside the home.[11] According to a report for a 2014 stakeholder seminar on parenting in Cambodia,[12] in the past, it was widely held that fathers earned incomes, made family decisions, disciplined children, and were responsible for decisions about children's educations. Mothers stayed at home.

As a result of decades of political conflict, the genocide under the Khmer Rouge, and migration, approximately 25 percent of households are now headed by women, resulting in changed gender roles as women have to incorporate new roles.[13] More recently, the roles of mothers and fathers often differed by urban or rural residence because both parents were more likely to be educated and employed in urban areas. In urban areas, fathers were more often involved in parenting. Similarly, if mothers worked and fathers did not, fathers sometimes took on the role of caretaker of the children. [14] However, gender inequality and patriarchal gender norms persist.

Women's relatively lower position in Cambodian society relative to men is part of a broader pattern typical in societies with patriarchal gender norms. Notions of status and hierarchy are, and have long been, key features of Cambodian society.[15] Buddhism is one important contributor to this hierarchy, but one which emphasizes social mobility. The significance of social hierarchy extends into parenting values as well as into everyday language use. Pronouns, for example, reflect larger social patterns, where age confers status and authority.[16] Even within a family, a child addresses an older sibling differently from a younger sibling.

9 WHO and Cambodia Ministry of Women's Affairs 2015. National Survey on Women's Health and Life Experiences in Cambodia: 22.

10 Nationally, 55 percent of women and 40 percent of men have not completed primary school. 12 percent of women and 21 percent of men have achieved a secondary or higher level of education. Women earn 30 percent less than men on average and 49 percent of married women earn less than their husband/partner. Educational achievements are lower in Kampong Chom when contrasted with national averages. Within Kampong Chom, 19.9 percent of women and 11.1 percent of men had no education, 51.9 percent of women and 54.2 percent of men attended some primary education, 6.6 percent of women and 7.5 percent of men completed primary, 19.2 percent of women and 23.2 percent of men attended some secondary education, and 1.3 percent of women and 1.7 percent of men completed secondary education (CDHS 2014, 14–15).

11 WHO and Cambodia Ministry of Women's Affairs 2015: 23.

12 Seminar Report. Parenting in Cambodia. Friday 21 March, 2014. Phnom Penh. Available at: https://www.ics.nl/assets/Report-ParentingSeminar_March 21 Phnom Penh_ICS RUPP.pdf, accessed 10 November 2017.

13 WHO and Cambodia Ministry of Women's Affairs 2015: 22.

14 Seminar Report. Parenting in Cambodia.

15 Hinton, A.L. 2005, Why Did They Kill? Cambodia in the Shadow of Genocide. Berkeley and Los Angeles, California: University of California Press: 185–186.

16 Ibid: 184.

Violence against women and girls in Cambodia

The 2014 Cambodia Demographic and Health Survey (CDHS) includes a module on domestic violence module and the 2015 WHO survey on women's health and life experiences is a national prevalence survey on violence against women. The CDHS found approximately 20 percent of women (between the ages of 15 and 49 years) had experienced physical violence at least once in their lives and 6 percent of women had experienced sexual violence in their lives, with intimate partner violence being more prevalent than violence by others.[17] The WHO survey found that 21 percent of ever partnered women (15–64 years old) had experienced physical or sexual violence by a partner and 32 percent had experienced emotional partner violence victimization.[18] Further, most women who experienced violence in an intimate relationship experienced severe and chronic or ongoing violence.[19] Rates of both physical and sexual violence were higher in rural areas than in urban sites.[20] For non-partner violence, 14 percent of women reported experiencing physical violence victimization by a non-partner and 4 percent experience sexual violence victimization by a non-partner.

The Partners for Prevention UN Multi-Country Study on Men and Violence (UN MCS), carried out in Cambodia and other countries in the Asia-Pacific region, documented men's use of violence and identified key risk factors for perpetration of violence against women and girls with a particular focus on intimate partner violence.[21] In Cambodia, the results of this questionnaire revealed that more than one-half of men perpetrated emotional and/or economic intimate partner violence during their lifetime. More than one-third of men perpetrated physical and/or sexual violence against a partner in their lifetime, with sexual violence (21 percent perpetration prevalence) more commonly reported than physical violence (16 percent perpetration prevalence). The lifetime prevalence for non-partner rape was 8 percent and 5 percent for gang rape of a woman. Rape and gang rape of a man during their lifetime was reported by 4 percent and 3 percent of men respectively. More than half of all men who reported that they perpetrated rape did so when they were teenagers and 25 percent of men who reported first committing rape before the age of 15 years old.

An analysis comparing men who committed intimate partner violence and those who did not showed the associated specific risk factors. These risk factors included:

- Low gender-equitable attitudes.
- Poor relationship-building skills (frequent quarreling with partner).
- Mental health challenges (e.g. depression and alcohol problems).
- Childhood adversity (e.g. experiencing physical or sexual abuse during childhood; witnessing or other exposure to violence).
- Involvement in other high-risk behaviour (e.g. being involved in fights with weapons, engaging in transactional sex, and having two or more sexual partners).
- Lower levels of education (especially no secondary schooling).

For non-partner rape, risk factors included:

- Mental health challenges (depression).
- Involvement in other violence and high-risk behaviour (e.g. drug abuse, involvement in

17 National Institute of Statistics. 2015. Cambodia Socio-Economic Survey. Ministry of Planning: Phnom Penh, Cambodia.
18 For non-partner violence, the WHO report found 14 percent of women reported experiencing physical violence victimization by a non-partner and 4 percent experience sexual violence victimization by a non-partner.
19 WHO and Cambodia Ministry of Women's Affairs 2015: 50.
20 WHO and Cambodia Ministry of Women's Affairs 2015: 49.
21 Fulu, E., Warner, X. and Moussavi, S. 2013. Men, gender and violence against women in Cambodia: findings from a household study with men on perpetration of violence. Phnom Penh: UN Women Cambodia.

gangs, fighting with weapons, engaging in transactional sex, and having two or more sexual partners).

In addition, the questionnaire established the motivations for rape perpetration reported by men who had perpetrated such violence. These included, in order by rank from highest to lowest:

- Sexual entitlement.
- Anger/punishment (especially for partner rape).
- Was bored/for fun (especially for non-partner rape).
- Drinking (least frequent for all types of rape).

The majority of men reported moderate gender-equitable attitudes and women generally reported less equitable, more conservative, traditional gender attitudes in comparison. This finding notes the importance of conducting gender-transformative work with both men and women to promote gender equity and alternative constructions of masculinities and femininities that are more open and flexible than hegemonic ideas that promote the aggression and dominance of men and the passivity and compliance of women. The study findings also indicated that individuals' gender attitudes were influenced by their parents' gender attitudes and roles in the home, and how these issues were addressed in teachings at school. Overall, individuals did not accept violence against women and girls; however, men in general reported feeling that the law was too harsh on punishing perpetrators of domestic violence, suggesting some level of support for or understanding of such behaviour. Indeed, the 2014 CDHS showed that about one-half of all women in every age group and 20 to 30 percent of men agreed that some circumstances justified a husband beating his wife. Women and men respondents named "neglects the children", "goes out without telling him", and "argues with him" as the strongest justifications.

Most men (95 percent) reported high levels of trauma and adversity (e.g. emotional abuse, physical punishment and food insecurity) during their childhoods. 43 percent of men were considered clinically depressed and 25 percent were considered highly depressed.

There are different types of services needed to support survivors of violence against women and girls such as health services, mental health services, legal assistance and human rights services, shelter, and social services which support survivors of violence at the provincial level. Strengthening linkages between beneficiaries and such services is needed to increase safe access of survivors to the services.

Rationale for the intervention

The findings that emerged from this P4P UN MCS presented an opportunity to engage in the development of an evidence-driven intervention for the primary prevention of violence against women and girls. By understanding the modifiable underlying driving factors associated with the perpetration of violence against women and girls – the risk factors noted above – an intervention can be designed to address these factors and thus potentially prevent violence against women and girls before it ever begins.

Therefore, UNFPA in partnership with UN Women and UNV in Cambodia, together with the Ministry of Women's Affairs and supported by Partners for Prevention, developed and piloted a community-based intervention that engages young adolescents and adolescent caregivers (including parents, other relatives in the home, teachers, and other youth service providers in the community).

"Though investment in primary prevention takes a great deal of time and effort, I am optimistic that a changed heart and mind can have a long lasting and positive impact on society. The intervention also helped me deeper understand the issue of violence against women and girls, gender equality, and positive parenting skills which I can apply at home and share with other people around me."

-Sathaboramana Kheang,
National UN Volunteer, Partners for Prevention

Intervention: Shaping our Futures

By addressing modifiable risk factors (inequitable gender norms and constructions of gender identities; poor relationship - building skills; mental health challenges and low help-seeking skills; leisure boredom[22] and school dropout; exposure to harsh punishment in the home or school; and poor role models) among a critical group (girls and boys aged 12–14 years) within an enabling environment (engagement with adolescent caregivers including parents/guardians, teachers, youth service providers, and key community stakeholders) in sustainable ways (promoting a volunteerism component and training a cadre of local and national facilitators and programme supervisors), the intervention aimed to support the changing of social norms in ways that challenge the acceptance of problematic gender and violence status quos. Further, "Shaping our Futures" equipped adolescents to foster healthy, non-violent interpersonal relationships and gender equitable attitudes and behaviours that are supported and encouraged by influential people in their environments. By increasing access to referral information for adolescents, parents/guardians and other project beneficiaries on health, counselling, and other social welfare services, further reinforced the enabling environment for beneficiaries to seek services for violence.

The intervention employed a participatory methodology that has shown to be key to effective primary prevention in existing intervention studies (e.g. PREPARE,[23] Skhokho Supporting Success,[24] and SASA![25]) through delivery by trained and supported community facilitators.

The intervention addressed the feasible, modifiable, upstream risk factors identified in the P4P-supported UN MCS Cambodia[26] results in ways that have been demonstrated to work in multiple other settings (e.g. PREPARE and Skhokho Supporting Success). The table below summarizes the intervention aims related to each risk factor.

22 Leisure boredom is boredom during free time. Boredom is the subjective view of the adolescent in that they feel thre are no available or accessible activities that would be of interest or be satisfying to them. Wegner, L., & Flisher, A. J. (2009). Leisure boredom and adolescent risk behaviour: A systematic literature review. Journal of Child and Adolescent Mental Health, 21(1), 1-28.

23 Mathews, C., Eggers, S.M., Townsend, L., Aarø, L.E., de Vries, P.J., Mason-Jones, A.J., ... De Vries, H. (2016). Effects of PREPARE, a Multi-component, School-Based HIV and Intimate Partner Violence (IPV) Prevention Programme on Adolescent Sexual Risk Behaviour and IPV: Cluster Randomised Controlled Trial. AIDS and behavior, 20(9): 1821–1840.

24 Jama Shai, N., Mahlangu, P., Gevers, A., Shamu, S., & Jewkes, R. 2015. The effectiveness of a parent-teenager relationship strengthening programme in South Africa. SVRI Forum 2015: Stellenbosch, South Africa.

25 Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., ... Watts, C. 2014. Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. BMC medicine 12(1): 122

26 Fulu, E., Warner, X. and Moussavi, S. 2013.

Table 1: Risk factors identified for perpetration of violence against women and girls, and the intervention components that will address these factors

RISK FACTOR IDENTIFIED IN MCS CAMBODIA FINDINGS	INTERVENTION COMPONENT
Gender-inequitable attitudes and problematic constructions of masculinities	• Promote gender equity and alternative, non-violent constructions of masculinity and assertive constructions of femininity • Address issues of sexuality and sexual entitlement • Address issues of control and power and domineering attitudes, and promote respect and kindness towards everyone as an equal • Promote compassion, empathy, and social support for women/ girls, and alternative constructions of gender
Poor anger management and poor emotional regulation (e.g. depressive or anxiety symptoms or outbursts)	• Mental health promotion • Build adaptive stress management and coping skills
Not finishing secondary schooling Leisure boredom (i.e. raping for fun)	• Promote a sense of belonging and a sense of purpose, such as through volunteerism • Promote school completion (specifically through promoting a sense of purpose and belonging; and aspirational framing and decision-making using adolescents' own identified hopes and dreams for the future; and identifying factors to help them succeed in the future) • Human rights promotion including values of respect, caring/ kindness and empathic concern
Frequent quarrelling with partner or fights with peers	• Build communication skills (including polite language use) • Build conflict-resolution skills • Foster healthy relationship ideals
Harsh punishment	• Teach positive discipline skills for educators and parents • Build communication and conflict resolution skills for parents
Poor role models	• Develop gender-equitable ideals • Foster supportive, caring mentor relationships with young people • Promotie a sense of belonging and a sense of purpose among young people • Understand and support intervention goals and values (among caregivers such as parents/guardians, teachers, youth service providers, and other key community members)

The overall intended outcome of the intervention was: Adolescent girls and boys aged 12–14 years have gender-equitable attitudes,[27] low levels of violence acceptance attitudes, and are supported by their caregivers and communities.

27 Violence acceptance attitudes were measured on a 13-item scale, with statements about the acceptability of the use of violence in a range of situations. Questions were adapted from the Skhokho Supporting Success Study (Shamu, S., Gevers, A., Mahlangu, P., Jama Shai, N., Chirwa, E., & Jewkes, R. (2016). Prevalence and risk factors for intimate partner violence among Grade eight learners in urban South Africa: Baseline analysis from the Skhokho Supporting Success cluster randomised controlled trial. International Health, 8, 18-26.; Jewkes, R., Gevers, A., Shamu, S., Mahlangu, P., Shai, N., Lombard, C. & Chirwa, E. (2017). Outcome of the randomised controlled trial to evaluate the Skhokho violence prevention intervention in South African schools. Presentation at the Sexual Violence Research Initiative Forum. Rio de Janiero, Brazil.)

A local implementing partner, MOWA, was supported by partner UN agencies to implement the intervention. An intervention manual was developed through a consultative process with local stakeholders and experts. The final manual, approved by MOWA, was translated and available in Khmer and English and then used for training facilitators over the course of 10 days. Facilitators were recruited, supervised, and supported by MOWA.

Table 2: The multifaceted intervention strategy

	YOUTH COMPONENT	ADULT/COMMUNITY COMPONENT
Intervention	22 weekly or fortnightly sessions (about 2 hours each) delivered after school or over weekends over a 12-month period	12 fortnightly or monthly sessions (about 3 hours each) delivered over weekends or on weekday evenings over a 12-month period
Location and number of groups	• Kampong Cham province[28] • 1 district in Kampong Cham with 1 group each in 5 communes[29] • Total number of groups: 5	• Kampong Cham province • 1 district in Kampong Cham with 1 group each in 5 communes • Total number of groups: 5
Participants	• 12 to 14-year-old adolescents (girls and boys) in each commune • Group size 20–25 adolescents • Total participants: approximately 352 adolescents. 32 percent of adolescents attended at least 50 percent or more of the sessions.	• Caregivers of adolescents including parents/guardians, teachers, youth service providers, other key community members in each commune • Group size: 20–25 caregivers • Total participants: approximately 346 adults. 23 percent of adolescents attended at least 50 percent or more of the sessions.
Facilitators	• 3 local facilitators for each group • Total: 15 facilitators	• 3 local facilitators for each group • Total: 15 facilitators
Linking to services	Referral directories were developed and attached to the manuals for adolescents and caregivers; facilitators were to be trained to make referrals to workshop participants. In addition, service providers who were already providing services on violence against women and girls were sensitized to the project.	
Volunteerism	• Volunteer facilitators were trained and supported to implement the intervention with the manual guide. • An adolescent–adult partnership in community volunteerism was promoted.	

28 According to the CDHS, Kampong Cham had the highest reported lifetime rate of physical violence at 33.2 percent, the highest rate of physical or sexual violence by a husband/partner in the last 12 months at 20 percent, and 5.5 percent had experienced sexual violence in their lifetimes (2014).

29 Violence against women in the targeted district and communes is lower than other districts. However, the Provincial Department of Women's Affairs suggested these locations because there had not been any programme implemented here pertaining to violence against women and collaborations with local authorities were considered favorable (UNFPA Travel Report to Kampong Cham Province, 26 March 2016).

Evaluation

Study design

This study sought to conduct a formative evaluation to determine the feasibility, acceptability, accessibility, and promising impacts of the intervention as a proof of concept to practically inform further primary prevention policy and practice in Cambodia.

The overall objective of this study was to monitor and evaluate activities to understand the reception, experience, and impact of an intervention for the primary prevention of violence against women and girls.

The specific objectives were to:

1) Document the impact of the ***Shaping our Future: Developing Healthy and Happy Relationships*** intervention on the following outcome areas:

a) Young adolescent boys and girls:
- i) Gender-equitable attitudes
- ii) Violence acceptance attitudes
- iii) Parental/caregiver relationship quality
- iv) Communication and conflict-resolution behaviour
- v) Engagement in volunteerism

b) Adult caregivers/parents of adolescents:
- i) Gender-equitable attitudes
- ii) Violence acceptance attitudes
- iii) Relationship quality with teenager
- iv) Communication and conflict-resolution behaviour
- v) Engagement in volunteerism
- vi) Use of harsh punishment

2) Investigate participants' experiences of the intervention and their narratives of change related to these experiences in the context of their day-to-day lives to understand the acceptability, relevance and personal impact of the intervention

3) Provide recommendations to strengthen the intervention and potential scale up

This study conducted a quantitative and qualitative formative evaluation of the ***Shaping our Future: Developing Healthy and Happy Relationships*** intervention by (a) doing a quantitative within-group comparison of change using baseline and endline questionnaire data from intervention participants; (b) recording qualitative feedback about the intervention experience and impact from intervention participants at the end of the intervention; and (c) seeking qualitative feedback from key stakeholders/informants including the intervention facilitators (n=14) and supervisors (n=4) from each community in the intervention.

Table 3: Evaluation participation

	Baseline	Endline	Qualitative
Adolescents			
Girls	n =100	n=100	n=41
Boys	n=42	n=31	n=14
Caregivers			
Women	n=116	n=107	n=45
Men	n=24	n=20	n=7

This multi-method, within group comparison and qualitative feedback allowed us to gain a preliminary understanding of the intervention impact, acceptability, and feasibility within a very limited monitoring and evaluation budget that did not allow for a full randomized control trial or quasi-experimental evaluation of the intervention.

Study procedure and data collection

Quantitative data were collected from all intervention participants who consented to participate in the research activity. A self-report questionnaire adapted from the UN MCS for use in Cambodia[30] as well as other measures typically used in evaluation studies of similar interventions[31] gathered the following information:

1) Background information including sex, age, education, relationship status, family/ household socioeconomic status and childhood adversity
2) Gender attitudes
3) Violence acceptance attitudes
4) Relationship quality (with parents/caregivers for adolescents OR with adolescents for caregivers)
5) Communication and conflict-resolution behaviour
6) Engagement in volunteerism
7) Attitudes to school
8) Relationship control (adolescents only)
9) Harsh punishment (caregivers only)
10) Knowledge of support services
11) Attendance and acceptance of intervention.

These outcome areas were identified in the intervention model theory of change and thus are the key areas in which the intervention intended to effect change. All items in the questionnaire were previously validated in similar studies[32] (see above); therefore, there is good precedence for their validity and acceptability. All questionnaires were translated into Khmer and the translations were

30 Fulu, E., Warner, X. and Moussavi, S. 2013.

31 Mathews, C., Eggers, S.M., Townsend, L., Aarø, L.E., de Vries, P.J., Mason-Jones, A.J., ... De Vries, H. 2016; Jama Shai, N., Mahlangu, P., Gevers, A., Shamu, S., & Jewkes, R. 2015.

32 Mathews, C., Eggers, S. M., Townsend, L., Aarø, L.E., de Vries, P.J., Mason-Jones, A. J., . . . De Vries, H. 2016; Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A., & Duvvury, N. 2008. Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. BMJ 337: a506; Jewkes, R., Gevers, A., Shamu, S., Mahlangu, P., Shai, N., Lombard, C. & Chirwa, E. 2017. Outcome of the randomized controlled trial to evaluate the Skhokho violence prevention intervention in South African schools. SVRI 2017.

carefully checked and proofed to ensure that they could be easily understood by study participants and still maintain fidelity to the original items.

The questionnaire was administered before the intervention was implemented (baseline) and after the end of the intervention (endline) with adolescent and caregiver intervention participants.

After going through the full informed consent procedure, the study staff provided an orientation to the questionnaire and how to complete it. Questionnaire administration took place in groups of approximately 25 to 30 study participants in a data collection session, out of a total 142 adolescents and 140 caregivers. For the adolescent groups, girls and boys sat in separate groups. The study staff read the questionnaire for the group item by item to help all participants follow all questions and answer options to account for any struggles with literacy. Study staff provided support to participants who were illiterate but wanted to participate in the questionnaire.

At the end of the questionnaire (approximately 1.5 hours), all participants were given a sheet with information about referral sources of places or organizations to get help for issues related to violence or abuse, stress or mental health issues, alcohol or drug abuse, and general health social welfare services. Everyone was given the same information sheets in order to alleviate any suspicion or stigma and because study staff did not know what issues individuals reported in the self-report, anonymous questionnaire. In addition, the study staff who were trained to provide referrals were available after the session for the participants to discuss any specific issues that arose.

Participants then participated in the ongoing intervention, and intervention staff were trained to provide support and referrals to participants as needed through the 12-month implementation period. After the intervention period, 131 adolescents and 127 caregivers participated in the endline questionnaire research activity.

The research team collected qualitative data in focus-group discussions (FGDs) and in-depth interviews (IDIs) from the intervention participants (in 5 adolescent and 5 caregiver FGDs), the implementation facilitators (1 FGD) and supervisors (4 IDIs). The team also documented a case study from a caregiver and (separately) the children he cares for during IDIs. Participants who regularly attended the sessions were invited to share their experiences of the intervention including any challenges and/or benefits that they experienced from it. An inquiry guide was used to gather this feedback in focus group discussions. Individuals or groups could request that their feedback not be recorded for use in the research study. A study staff member recorded a summary of this feedback and it was translated into an English report for analysis by the research team. Workshop facilitators were not present at these feedback sessions in order to allow participants the opportunity to share honest feedback.

After the intervention implementation was completed, intervention facilitators (n=14) and intervention supervisors (n=4) agreed to share their experiences of implementing the intervention, the changes they noticed among themselves, participants, and across the community, and any recommendations they had to strengthen the intervention or scale it up.[33]

Ethical considerations

The quantitative baseline/endline study and qualitative endline study were conducted in line with ethical and best practices on researching violence against women, including the guidelines of the

33 30 facilitators and 5 Focal Points from the Commune Committees for Women and Children who acted as community liaisons were invited to participate in the qualitative component of the study; 14 were able to do so.

Sexual Violence Research Initiative and the World Health Organization.[34] The study team secured approval from the National Ethics Committee for Health Research from the Cambodian Ministry of Health.

Participation in this study was voluntary. Furthermore, participants could choose to stop participating in any research activity at any point during the data collection session and/or could decline to answer specific items without any penalty. There were no adverse consequences of choosing not to participate in any research activity or withdrawing or skipping any questions. All potential participants went through a standard informed consent procedure with the research team before any data collection began. Participants' confidentiality was protected by not recording any names, identifying information or specific locations in the research reports. Informed consent forms were securely filed separate from any study data or reports. All participants were given a list of resources to find referral or help sources. Individuals could participate in the intervention sessions without participating in any study activities.

All study staff were given training on the research instruments and protocols as well as ethical and sensitive research methodologies including being non-judgemental and maintaining strict confidentiality of participants and their information, providing referrals, and supporting participants who struggle with sensitive questions or with understanding the instruments.

Data processing and analysis

The quantitative data were pooled from all participants that participated in the baseline and/or endline study. Basic descriptive statistics for each round of quantitative data were generated including proportions and means. Comparisons between the baseline and endline data were conducted using a Wilcoxon signed rank test, with a 95 percent confidence interval.

The qualitative data were analysed thematically. Qualitative findings expanded on the quantitative findings and provided more context and nuanced detail to the intervention experience and impact on individuals' lives, as well as perceptions of community-level impact and recommendations for intervention strengthening or scale up.

Quantitative and qualitative findings were discussed and interpreted with the full study team including Partners for Prevention, the UNFPA Cambodia project team, the MOWA project team, and Kantar TNS, a Cambodian research agency. The study findings will be disseminated via the local study team and to a global audience primarily via technical reports.

Limitations

Qualitative study

Focus group discussion transcripts rarely provided any gender identifiers for participants so

34 Jewkes, R., Dartnall, E. & Sikweyiya, Y. 2012. Ethical and Safety Recommendations for Research on the Perpetration of Sexual Violence. Sexual Violence Rresearch Initiative, and Medical Research Council, Pretoria, South Africa,; World Health Organization. 2003. Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women,2nd ed. World Health Organization, Geneva.

qualitative findings could not be reported by gender. Focus group discussions were used in the evaluation because participants were already accustomed to talking together in groups during the intervention and because of budget constraints. It was not feasible to transcribe discussions in such a way that notations about speakers' genders might be included.

Because identifiers were not included in transcripts, it was also not possible to identify any patterns in individuals' responses or even to match any contextual responses with change responses. Indeed, it was not always clear how many participants responded to any given question. These uncertainties were considered in interpretation and analysis.

Qualitative findings relied on reported changes as no baseline study was conducted and no control group was used. Thus, findings rely on the subjective views of participants, facilitators, and supervisors about changes they experienced.

For various reasons, participants' responses may also be biased by factors such as desires to please the interviewers, to make themselves look good and to demonstrate their participation and change. These effects were mitigated by using professional interviewers independent of the intervention implementation teams.

Quantitative study

Because there was no control group used, it is not possible to conclusively attribute changes to the intervention.

The statistical power of the study was limited by small sample sizes. Because the samples were drawn from intervention participants, researchers could not control recruitment of the samples. For example, while 42 boys and 100 girls participated in the baseline, 31 boys and 100 girls participated in the endline as a result of attrition of boys.

Due to the very small number of matched cases (59 adolescents and 53 caregivers), it was not meaningful to include findings from matched sample baseline versus endline comparisons. Similarly, analyses regarding attrition were not meaningful.

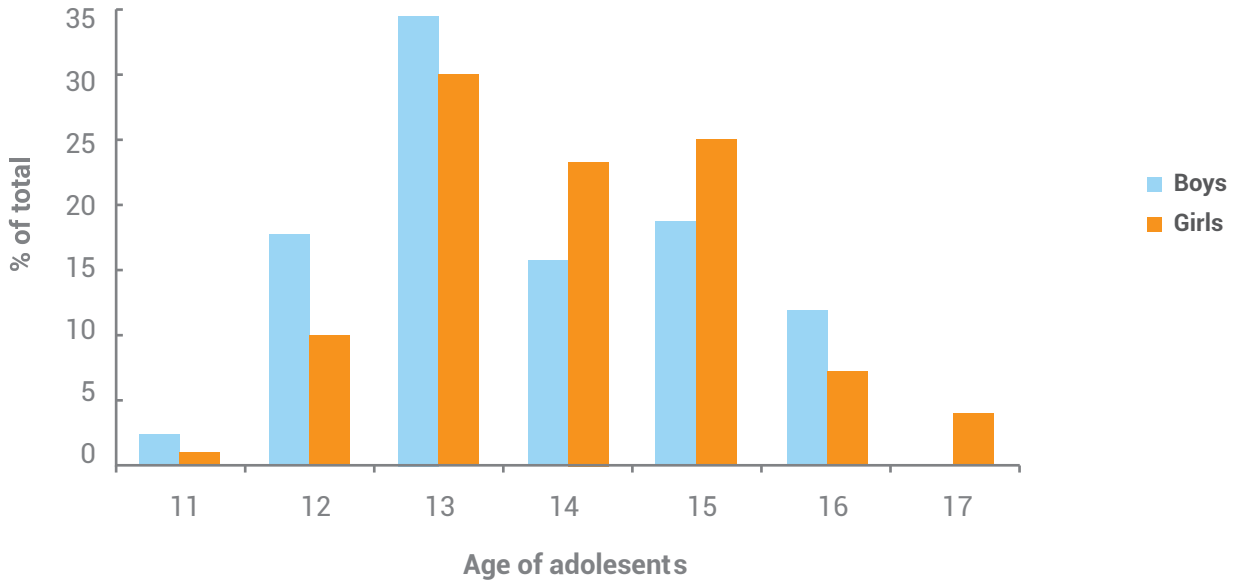
Results[35]

Adolescents

Description of study participants

Although the study originally hoped to focus on 12 to 14-year-old adolescents, challenges with recruitment resulted in endline participants ranging from 10 to 17 years old. Similarly, while 100 girls of an average age of 14.1 years old participated at endline, only 31 boys of an average age of 13.6 years old participated, compared with the original aim of 100 to 125 participants comprised of 50 percent girls and 50 percent boys.

Figure 1: Age of participants at endline

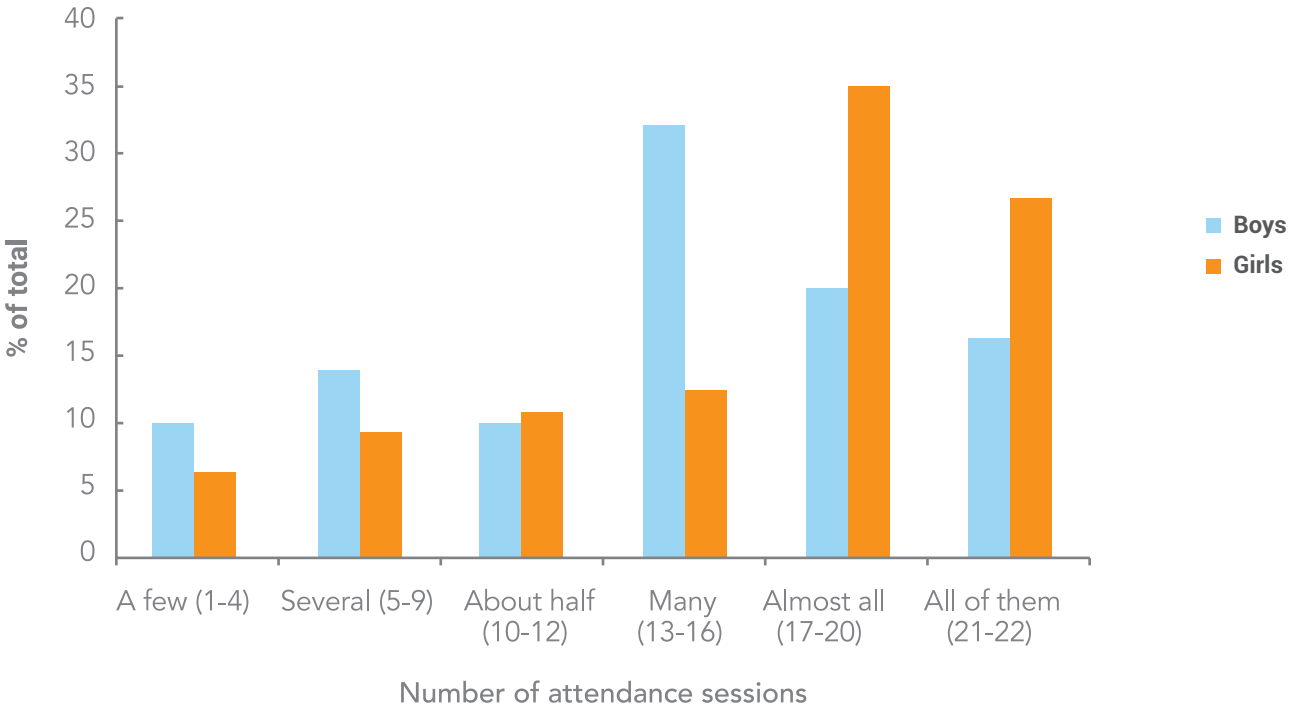


Of the 22 sessions comprising the intervention, 74 percent of girls and 67 percent of boys completed 13–22 sessions (59–100 percent of total sessions).[36] Most then, were exposed to at least half of the intervention content, with 62 percent of girls and 35 percent of boys attending at least 17–20 sessions (77 percent of the total).

Compared with a similar study, these attendance rates are high: a study on a South African adolescent HIV and IPV prevention programme found mean attendance rates of 8.02 out of 21 sessions, with girls (8.8) attending more sessions than boys (6.9) and 31 percent of girls and 22 percent of boys attended at least 15 sessions (68 percent of the total).[37] The study showed that benefits to participants' knowledge and behaviours began to accrue from attendance at one session and continued to increase with session participation.[38]

35 For further baseline and endline data on all participants, see Appendices.
36 Data on attrition bias were not reported due to very small sample sizes for matched cases.
37 Mathews, C., Eggers, S.M., Townsend, L., Aarø, L.E., de Vries, P.J., Mason-Jones, A.J., ... De Vries, H. 2016.
38 Ibid.

Figure 2: Number of boys and girls attending sessions



Nearly all of the participants in this Cambodian study were in school (92 percent of girls and 94 percent of boys at endline), described themselves as average or above average students (1 percent of girls and 13 percent of boys said they did below average in school), and expected to finish high school (12 percent of girls and 7 percent of boys did not expect to finish high school). Most participants at endline lived with approximately three adults, including their mother, father, and/or other relative.[39]

Experiences with violence

If participants noted past experiences with violence, interviewers then asked them to expand on their experiences with violence in their communities. Several adolescents described incidents of domestic violence in neighbours' households, including "cursing", "cutting" and "hitting". Here is how one adolescent described violence in their village:

> ***The husband hit his wife and children. Cut the children. Pre-arranged fight times between teenagers, something like that. Sometimes [husbands] came from drinking beer and they hit wife and children.***

Indeed, alcohol abuse was often mentioned alongside domestic violence. Another participant described violence in the community as a spectacle, reflecting what many participants said in other contexts about it feeling inappropriate to intervene in other families.

> ***They had a fight and everyone went to their place and watched them. Even taking pictures. It's almost like we were going to the concert. Then the head of the village came and talked with them. They calmed down for two or three days. After that, they would curse at each other again. Like every day.***

39 84 percent of girls lived with their mother, 82 percent with their father, and 76 percent with other adults who are caregivers. 84 percent of boys lived with their mother, 71 percent with their father, and 77 percent with other adults who are caregivers.

Changes in attitudes and practices

Gender-equitable attitudes and practices

Focus group discussions about gender attitudes and practices largely occurred in the context of discussions about gendered divisions of labour or about "real men" and "real women". But the responses often did not make clear whether adolescents were repeating content they had learned, presenting their own (cultural) observations, or whether they had changed their understandings of gender and gender practices. Thus, the relevant findings are presented with some reservation. However, there were some hopeful findings regarding gender-equitable attitudes among adolescents.

Data from focus group discussions demonstrated that adolescents had learned or understood that women and men have equal rights.

> ***Before, there is always a statement "Setrey vel jongkran men chum" ("Woman cannot go around the kitchen" is a Khmer expression that says woman cannot even complete household chores properly so why should she go out). But now women and men have equal rights.***
> **[We learnt]** ***boys and girls have equal rights. Girls can do housework, boy can also do it.***

Several adolescents also mentioned that there were no (inherent) gendered divisions of labour. When probed, nearly every participant stated that there were no jobs that must be carried out by either a man or a woman. And doing work typically associated with the opposite gender did not change the gender of that person, according to respondents.

Interviewer	***Will he still be a man if he helps to cook?***
Respondent	***Yes, he is, because it is good to help wife.***
Interviewer	***How about when woman cut wood or work outside the house?***
Respondent	***They are still women.***

One adolescent claimed that this was not a new understanding:

> ***We have never distinguished this is for girl and this is for boy. Never.***

However, a few adolescents qualified their comments about gendered division of labour, suggesting that this reported belief or change in attitudes is not yet fully accepted as evidenced in the continued labelling of tasks or jobs as "women's" or "men's" and also some perpetuation of gendered divisions of labour.

> ***Men can work and be a breadwinner of the family. Women can also do the same. When woman is pregnant, man can also help do the housework.***

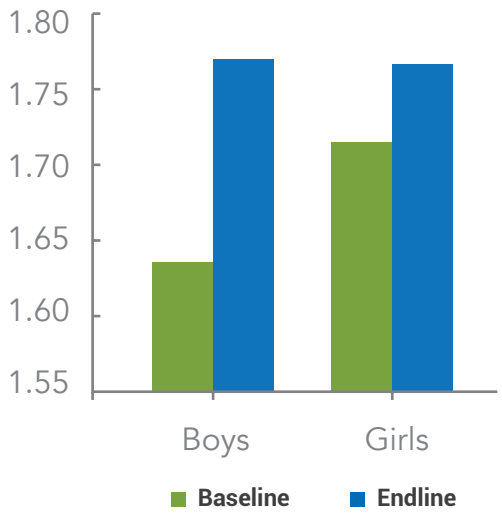
> ***Woman can do a man's job, but a man can do the job that requires much physical strength more properly than woman.***

While there was considerable talk about normative divisions of household labour, one adolescent boy spoke about having actually changed his role in the household as a result of what he had learned at the sessions.

Ideas about divisions of labour are only one aspect of participants' understandings of gender. Also, it is not known to what degree these responses are specific to the way the session was framed by facilitators who, as is reported elsewhere in the report, may not have well understood the aims of this session.

Comparing the baseline and endline samples, boys also reported significantly increased gender-equitable attitudes (baseline M=1.63, endline M=1.77, p=0.02) endline.[40]

Figure 3: Gender-equitable attitudes



*Note: *Indicates a significant difference between baseline and endline (p<.05)*

Each focus group also discussed a session topic referred to as "masculinity and femininity" or "real men and real women". For the most part, these discussions evidenced entrenched notions of gender as biological and binary. For example, the following are some responses to an interviewer asking about "characteristics" of a "real man" or "real woman" or how to be a "good man" or "good woman".

"Real Man"	"Real Woman"
Discipline and body language. Walk and talk like a real man. *Do the work that requires more physical strength and power.* *Cut wood, carry water.* *Men have short hair.* *A man has big muscles.* *A man can do a heavy work.* *Speak loudly and strongly.* *Gentle, polite, tender.* *Don't have a fight with other people.*	*A real woman should not flirt [with] men.* *Look after children, clean house, cook.* *Help to support family's living condition.* *Women have long hair.* *Woman cannot do a heavy work.* *Woman can get pregnant.* *For women, she can cook, fully support her husband, can speak politely, have gentle behaviour and good attitude, don't do gambling, provide enough nutrition for children, don't be angry with children a lot, try to say good words to children, allow children to go to school, educate children whose age are from 6 years old, teach them not to roam around much or quit class.*

40 There were no statistically significant changes for girls.

These responses illustrate the enduring patriarchal constructions of gender in adolescents' views. They may reflect shortcomings in the facilitation of the sessions, or the approach and materials used. One facilitator interviewed said that they were not certain about the intended lesson of the session on gender. This particular comment suggests that facilitators needed more time and support to transform their own understandings of gender and gender-equitable attitudes and practices and that the session materials need to be appropriately revised to address this need and present this complex issue in a more accessible way. Even though a UNFPA staff member spent considerable time with facilitators and helping to adapt material, it is clear that even more investment in facilitators' transformation around gender and gender equality is necessary so that they can best model and facilitate this transformation in the community. It is possible that in the face of confusion, facilitators fell back on their own understandings and cultural biases. In this quote, the facilitator describes their uncertainties about the session content:

> ***It was about "being a real man and woman". I was not sure whether it was exactly about the physical changes of woman and man. I think that lesson was a bit complicated which is hard to understand. Somehow, that lesson was about what real woman and man does. A real man will help his wife to do cooking, cleaning, washing and taking care of children and so on. That lesson seems to be mixed, so it was so complicated… It was just too broad. It was too hard to explain to the exact meaning. For example, I asked to those trainees how we consider a real man and woman, and they responded that real man must have big and strong muscles and have children, for woman also responded in similar way. For women, they said being a real woman, they must have big breast and so on. In fact, the lesson was to identify the equal rights between man and woman. Somehow, I also proposed to organization to reconduct this training in order for us to understand clearly on this lesson.***

Communication and conflict resolution

Out of all changes that participants reported implementing as a result of attending these sessions, they most often mentioned changes related to language use and other strategies to improve communication.

Glossary of terms used by participants
Heng/Haeng: a very impolite or casual way to address "You".
Hery: an exclamation word showing that a person is lazy, feel annoyed or does not want to follow anyone else's order or command
Hong: an impolite way to call a female person. It can be used to replace "you".
Khnhom: polite for "I", may be used to express "we-exclusive" (e.g. speaker refers to themselves together with a partner)
Oeun: "Anh" is an impolite or very casual way to address "I". In some contexts, it is also used to show aggression, authority and power.

Respectful Communication

Adolescent participants talked a lot about a shift to attempting to use "polite words", particularly "Khnhom" (polite for "I"[41]), with parents, siblings and friends. When interviewers asked adolescents

41 In Khmer language, there are two "I": Khnhom and Anh. Khnhom is polite and respectful and used specially to address older or senior people. Anh has been historically used more commonly. However, now it is promoted to not use Anh even with their peers, younger people or children.

about their use of "I" ("I" statements), all respondents had attempted to make this change in their everyday linguistic practice, a change that one adolescent described as changing a habit. As is discussed below in the caregiver results, there may be historical reasons for some of the linguistic norms that are mentioned in these transcripts and which some of the session content addressed.

Observations were mixed about whether this language change prompted any different responses from friends. At least one claimed that a friend did not respond to the change. A few adolescents remarked about social challenges associated with making this linguistic change.

Respondent	***But it's difficult when we say it. Mostly among friends, we rarely say "I". Usually "Anh Haeng [slang for 'I']" like that. We only address ourselves as "I" if we talk to someone who are not close to us. If people who are close to us, we will just say "Anh Hong, Haeng".***
Interviewer 1	***After you finished that lesson, have you tried saying that to someone close to you?***
Respondent	***Yes. But it's kind of uncomfortable. I only tried with these two. Besides these two, I will call their name. When I say "I", some people will say why you are so polite today. Have wrong medicine?***
Interviewer 2	***So you still use Anh?***
Respondent	***We have changed. Mostly we use "I". I feel like it's more polite than using "Anh Hong".***

Another reported that they were laughed at by peers for starting to use "Khnhom". As a result, some stopped using the term. One of those in the same group who continued using "Khnhom", however, reported positive feedback for doing so.

> ***There are some changes [after I started using "Khnhom"]. They (my friends) smiled and used "Khnhom [polite for 'I']" when they replied back to me.***

Several adolescent participants believed that some change in their relationships – feeling closer to a peer – was attributable to a change in the way they addressed one another.

> ***They are happy. Normally I used word "Anh [slang for 'I']" with them, but now I use "Khnhom [polite for 'I']", so they feel I value and have enough respect for them.***

Conflict resolution

> ***If you are younger than your friend and use [the] word "Anh [slang for 'I']", they would feel angry, but if you are at the same ages, then it is not a problem. Somehow, if you use "Khnhom [polite for 'I']", it can make them happy and like you more, so your relationship is also closer as well.***

> ***Before, I resolve conflicts using force and violence and now I resolve conflicts using my thinking.***

Adolescent participants described a shift away from both aggressive argumentation and physical violence in favour of polite language and conflict resolution strategies.

They claimed to have changed ways of talking and resolving arguments with friends and younger

siblings. For the most part, in giving examples of changes made with friends, adolescents described ways that they dealt with disagreements. When discussing changed behaviour attempted with siblings, they spoke about it in the context of disciplining or punishing younger siblings.

> ***Before, we always hit them [younger siblings], but now we try to avoid [that]. We rather use good word to deal with them. No more hitting.***

Adolescents identified two different ways that they improved conflict resolution with friends. First, several adolescents explained that they attempted to stop an escalating argument, primarily by "walking away" so that an argument did not continue in a context of heightened emotional responses.

> ***Before, we had an argument. We all were stubborn and wanted to win. But now if we have an argument, we don't talk and walk away. When we have calmed down, we'll talk to each other again.***

> ***We learn to stop the violence from happening… It's like how we calm ourselves … For example, we argue because of the words we say [small word but other find it offensive]. If we keep wanting to win or lose, it's worse. We can walk away and once we calm down we can talk again.***

That these individuals' behaviours are now aimed at finding means of communicating about a conflict shows that each understands something about how conflicts can escalate, perhaps resulting in violence. These quotes also illustrate reported changes in both regulating one's emotions and in recognizing the value of seeking solutions to disagreements. A few adolescents mentioned that they recognized a need for self-regulation of one's emotions.

> ***When we are stressful, we won't use our bad-tempered feeling or shout at our friends. We should find the solutions by ourselves.***

Second, some mentioned that when faced with an apparent disagreement they would now try to first understand why their friend did what they did before assuming that the other was somehow wrong.

> ***We learn to find the solutions for the conflict occurring between friends.***

> ***I practised the lesson which is about "forgiving each other" with friends. Like when we are mad at each other, we learn to be patient, understand each other, end it without a fight.***

This quote (and others above) again illustrates a change in the way that conflict was conceptualized. Whereas an argument was previously understood as a contest to be won or lost, some adolescents started to see other more valuable outcomes such as building understanding and finding solutions together.

> ***We asked for no reason [in the past], we just verbally argue and try to win.***

> ***Behaving politely means that when we have problem with each other, we should compromise ... in order to maintain our friendship.***

In these instances, the individuals chose to practise behaviours that would help to maintain or improve relationships.

While the adolescents did not mention any failed attempts or challenges in preventing violence at times of disagreement with friends, several mentioned that they had reduced, but not necessarily ceased the use of violence, with their younger siblings.

> ***At that time, when they did something wrong, we were likely to shout at them. We and our sibling are short-tempered. When it came to this, we made our parents sad. Because the kids didn't get along. But when we have studied and understood many things, when they do something wrong, we should say gentle words to them. When we have less argument, our parents aren't sad anymore. Their kids can get along well. Less fight.***

It is very encouraging that many adolescents so readily adopted linguistic changes that may help to prevent conflicts and that many had successfully tried strategies to more peacefully resolve conflicts with friends and family members.

Relationships with caregivers

Several adolescents reported that their relationships with caregivers had improved as a result of participating in the sessions. For most, this meant that they had chosen to change their behaviour towards a caregiver. Many explained that they learned from the sessions that they should improve their cooperation with their caregivers' requests. Many adolescents said that they were now more willing to help their caregiver immediately, rather than protesting or delaying their assistance, a practice which adolescents labelled "lazy". In other words, adolescents claimed a significant role in these changed relationships.

> ***I wasn't lazy like before. I just help them more. Before, when they ordered me to do something, I always said "Hery!", but now I stopped using that word.***

When an interviewer asked a group of adolescents about how children have practised a lesson about the roles of parents and children, one adolescent said they had started helping their caregivers at home more than before the sessions.

Respondent	***I did help. But not much. I helped but spent much time watching the drama too.***
Interviewer	***What happened when you helped them a lot?***
Respondents	***Not get scolded much.***
Respondent	***They might think that the session provided good knowledge. That's why when we came back home, we helped them a lot.***

This participant noted that their parents granted continued permission to attend the sessions because this participant had improved their behaviour at home. Several others also noted positive responses from their caregivers when participants started to take on more responsibility for household work.

Another participant explained that in the past they "talked back" to their mother, didn't listen at all, or would only respond "later". In response, their mother hit them. The participant said that they comply immediately with requests now, but also mentioned that their mother still hits when they answer "wait", so the changes are incremental. This highlights the importance of working with caregivers simultaneously in parallel sessions to the adolescent sessions.

> ***They compliment me. When they ordered me around, they scolded me. They said I was lazy. Now they order me, I go right away. They say I'm hardworking.***

> ***Before, because we are always lazy when they asked us to do something, that is why we always get scold. Now because we are not lazy anymore, so when they ask us to do anything, they also use sweet word with us.***

> ***In the past, when we met them and we were under stress, we would say something impolite or mean to them. Now we can talk gently and polite with them. Sometimes they will compliment: we have better personality.***

> ***Before when they ordered us, I said wait. Now when they order us, we go right away. If we don't behave, we will not get the money. Before "wait". Now there is no more "wait". Before they cut my allowances. Now they give me more than before.***
>
> ***Like before, when they ordered the kids and the kids did not go, they'd always threaten or scold. But now not anymore. Now when they order the kid, they talk sweetly and comfort the kids.***

The caregivers of a few participants also attended the sessions. One reported changes in their caregivers' language choices:

> ***Before they shouted at me a lot. Now they talk normally.***

This participant said that in response to the caregiver's relative calm, the participant also talks "normally" with the caregiver. In other words, the change in language use was reciprocated, yielding positive results for both the caregiver and the adolescent and it lead to improved relationships.

Another adolescent reported that her grandfather, a participant in the caregiver sessions, also changed his way of communicating with her.

> ***Before when he angry, he said "Ngaeng (impolite word to address female person) did this wrong, Ngaeng will be punished" … [Now] he said "Granddaughter, you did this wrong."***

This seemed to be a welcome change in language that led to an improvement in the relationship.

Harsh punishment

Hitting as a form of punishment within families was widely reported by adolescents. Many identified hitting as the normal way that their parent or other caregiver in their home addressed alleged disobedience, disrespectful talk and other behaviour with their children or dependents.

Some reported that their parents no longer hit them, but then explained that it was because hitting was only used to punish younger children.

When I was young, they'd hit me. But now I've grown up, they have stopped hitting me because it's embarrassing for me.

The transcripts did not offer any further explanation as to why older children may not be physically punished.

Most adolescents themselves also reported using the same ideas of punishment when interacting with younger siblings. Adolescents explained that if their younger sibling was being annoying or had done something wrong, for example, the older sibling would hit the younger one.

Like when we asked them to do something, but they did not follow us, so we hit them.

When I said something and they did not listen to me. They were too playful and stubborn. Then I just hit them … After hitting them, they were afraid of playing with me.

Every respondent explained they had greatly reduced (and some stopped) violent means of resolving conflicts or addressing behaviour with younger siblings.

Before we always hit them, but now we try to avoid [doing so]. We rather use good word to deal with them. No more hitting.

A few respondents could identify positive outcomes, including relationship strengthening, as a result of finding non-violent means of managing their younger siblings' behaviour.

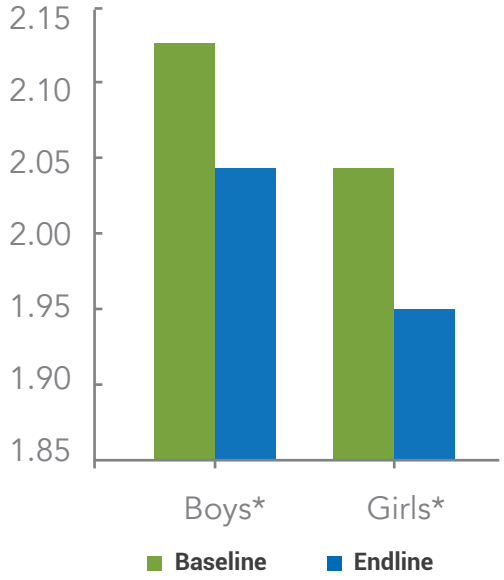
A few respondents could identify positive outcomes, including relationship strengthening, as a result of finding non-violent means of managing their younger siblings' behaviour.

Before, I used to scold and hit younger siblings without listening to the reason. Now, I start to listen to some of their reasons as well. But sometimes, they are really bad so I need to hit them.

We (siblings) have a really good relationship. However, sometimes, if they act wrong, I tried to talk. However, sometimes they were so headstrong so I used seldom some punishment by hitting them ... [The violence or punishment] actually reduces; approximately 50 percent.

This self-reported decrease in using harsh punishment ("hitting") with younger siblings is encouraging, especially when taken alongside questionnaire results about decreased acceptance of violence more broadly. Both girls (M=2.04 to 1.96, p=0.03) and boys (M= 2.12 to 1.95, p=0.05) showed significant decreases in violence acceptance attitudes between the averages at baseline and endline (Graph 4.) This means that after participating in the intervention, adolescents reported less agreement with statements such as "It is acceptable for a man to hit his partner" or "It is okay to punch or kick someone if they make me angry, take something from me, or disagree with me".

Figure 4: Acceptance of violence attitudes



*Note: *indicates that there is a significant difference between baseline and endline (p<.05)*

Beliefs about violence as an appropriate punishment for children were, however, also very entrenched. As described in the next section, caregivers found it difficult to abandon hitting altogether and even adolescents did not always see a need to cease such means of guiding children's behaviour. In these quotes, adolescents seemed to still support some level of harsh punishment.

I stop hitting very frequently but still curse them sometimes [she means replacing violence with swearing sometimes, so violence is reduced. However, both swearing and violence, overall, happens less frequently than before].

Interviewer	***So parents should hit their children, but just do not cause any injuries.***
Respondent	***Hit gently.***

Avoiding or dealing with violence

During focus group discussions, adolescents could readily list a few strategies to avoid situations that might become dangerous. The motivation for some seemed to be self-protection and for others it was to please their parents. The latter suggests that the dangers discussed may not seem relevant to their own lives or that they had not well understood some content about sexual violence.

If we see a gangster, we should walk away.

If we see strange car, we should not go closer as we [are] afraid they kidnap us. Sometimes, even ambulance, it can be kidnappers also.

We can negotiate that we want other friends to go with us too or I can say that I could not go because I need to do homework.

When I go to school, during break time, they called me to hang out at the pagoda. But I said I don't dare to go. I am afraid if someone kidnaps me or does something not good to me. They said it is not far from our house. Then I said "You two can go but I won't go."

Protecting oneself by staying away from situations in which danger may arise was a strategy that one facilitator also reported, more likely used by girls. They explained how some girls try to keep themselves safer by staying in larger groups.

Choosing safer situations did not always seem to be easy. One participant mentioned that friends would make fun of them for choosing not to go somewhere and another said that friends would be angry with them for not going. Clearly, peer pressure affected some adolescent's choices, in addition to or regardless of their concerns about safety.

It should be noted that these reported strategies emerged from the group discussions and may reflect long-held attitudes about gender. While they perpetuate the notion that the onus for preventing violence against women and girls lies with women, these statements may also be understood as girls recognizing that physical and sexual violence is not normal and that they have the capacity to act.

In addition, adolescents learned about where to seek help when they experienced or witnessed violence. Comparing the complete baseline and endline questionnaire results showed significant increases in knowledge about support services for both girls (baseline M=1.38, endline M=2.06, p=0.00) and boys (baseline M=1.46, endline M=2.13, p=0.00) who participated in the sessions (Graph 5).[42]

Figure 5: Adolescents who report being aware of support services

*Note: *Indicates a significant difference between baseline and endline (p<.05)*

Volunteerism

Volunteerism included extending impacts of the intervention by sharing the benefits and learnings with others in the family, school or community and continuing to promote change. Many adolescents in focus group discussions reported sharing some of what they learned with others, a sign that adolescents found the sessions useful and relevant to their lives. In line with the focus group discussions, the questionnaire results indicated that 68 percent of girls and 58 percent of boys would definitely feel confident to share what they learned with friends and family. Some only reported telling friends about the sessions and about those friends' interest in joining. Adolescents

42 These results reflect responses on a scale of 1 (definitely yes/yes I know) to 4 (definitely no/I don't know).

shared information with friends, parents and siblings. Content was shared as advice for a particular situation or as general knowledge. For those that shared content, they reported a varied response by peers and younger siblings, with some "following" shared advice and others "not following" information shared from the sessions.

> ***I told them (friends) that we studied about domestic violence and other things.***

> ***I told my siblings not to speak rude words to others, but they never listen to me.***

> ***Like when our friends were having a conflict, we told them not to argue and should rather talk and discuss the problem.***

> ***We helped to solve our family conflict and helped them… When they have argument against each other, we helped to explain them not to make a fight.***

> ***During class, I took note about the domestic violence, how to not having of domestic violence, respecting each other, value each other, learn to forgive … To make my parents see it so that they would not have argument. [Interviewee has seen parents reading it]***

Some adolescents tried to change their parents' behaviour or that of family members by sharing what they had learned.

> ***We bring the knowledge that we've learnt to share with them… They talk to us with good words… No more hitting or cursing.***

One adolescent talked about sharing session information with their parents and claimed that as a result the parent changed to guide the adolescent's behaviour verbally rather than harshly punishing them.

A few participants also described a positive response or even further discussion that was spurred by shared knowledge.

It is encouraging that other family members not only found session content useful, but that they listened to knowledge shared by a younger family member. This suggests that, at least within a family, sharing such knowledge may be easily accomplished and not necessarily subject to a hierarchy of authority (i.e. elders not being advised by adolescents) that might pose challenges to sharing outside the family.

> ***When they (parents) saw me coming back from studying, they asked. I told them that I have learnt about domestic violence … About not using drugs. I wrote what I have studied on the papers and hung or stick it on the wall. My mother said "you have to practise after you have studied it" … I practised it.***

Focus group discussions did not include much conversation about challenges that adolescents faced with sharing concepts and skills from the intervention. However, given that adolescents readily reported talking about the sessions with friends, parents and siblings, it is likely that those were the audiences with which they felt most comfortable sharing. Even then, a couple of adolescents were concerned about being perceived as "advising" their friends, such as the follow respondent.

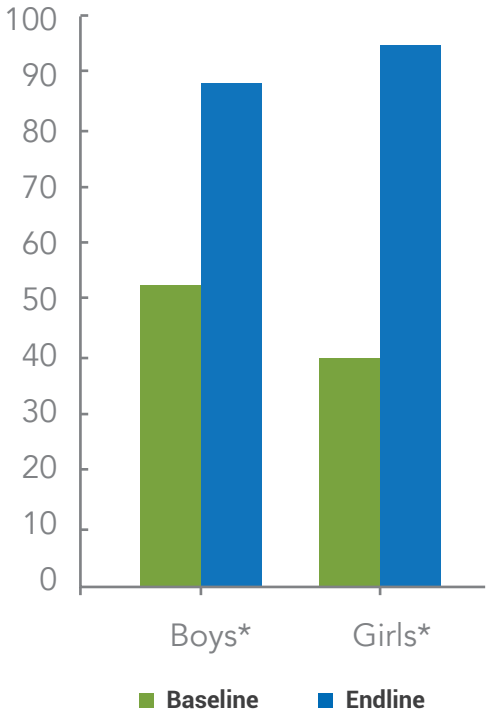
Thus, there seems to have been some impact of the intervention beyond the adolescent group itself as they reported readily sharing knowledge within their households and sometimes with friends. It seems that for adolescents, sharing that is directed towards a particular incident or individual's behaviour may be less readily received than sharing that is presented as simply sharing useful information. This is likely in part because of culturally specific ideas about who is understood to have status within society or family that makes it appropriate to advise others.

> ***They might blame us or criticize us if we teach them.***

Before the start of the intervention, 52 percent of boys and 40 percent of girls reported being involved in volunteer activities in the past six months that focused on issues of gender equality, healthy communication, conflict resolution, caring relationships and violence against women and girls. After the intervention, significantly more boys (87%, p=.01) and girls (95%, p<.01) indicated that they had been involved in such volunteer activities.

Some adolescents had experience with volunteer clean-up activities and one reported participating in a session about "immigration or trafficking of women".

Figure 6: Involvement in volunteer activities in the past six months



**Indicates a significant difference between baseline and endline (p<.05)*

When asked whether they would volunteer to share what they learned, one responded that they had done so, with parents and friends. No one in that group had considered volunteering to share information more formally, but all said they would participate in such sessions again.

One group of participants said they had plans to share what they had learned beyond their households and friends.

> ***We requested (from UNFPA) to have microphone. We requested to have action to parade in the village… To eliminate the women abuse, children abuse, drug ... Because only those who came to study knew.***

Their plans, while likely less effective than participatory approaches, again provide evidence that the information that the intervention aims to teach was deemed relevant by participants and important enough in their own lives that they wanted to teach it to others.

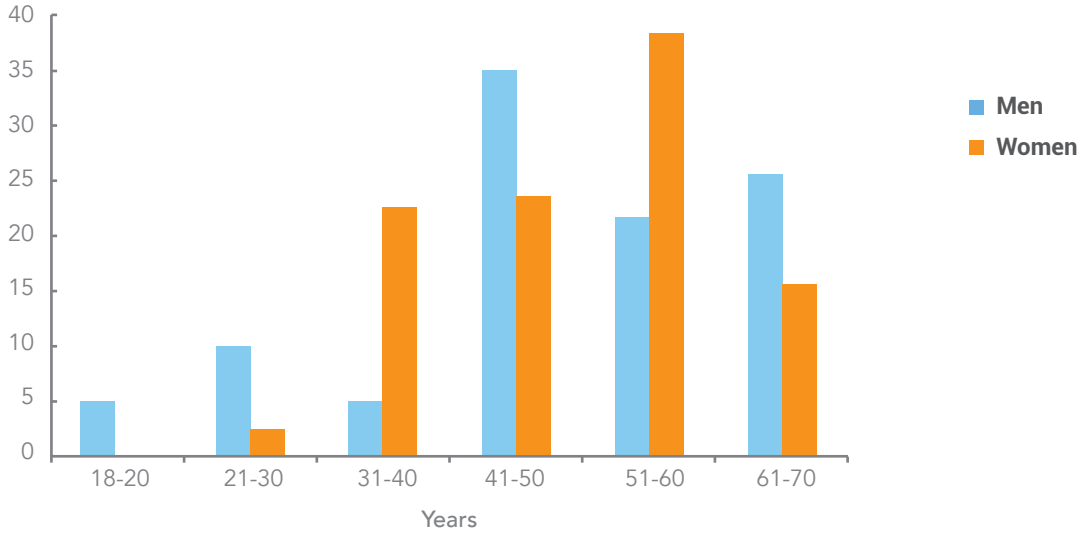
Indeed, 48 percent of boys and 57 percent of girls reported that they are definitely going to help planning or organizing volunteer activities in the community on the issue of men and women and healthy communication.

Caregivers

Description of study participants

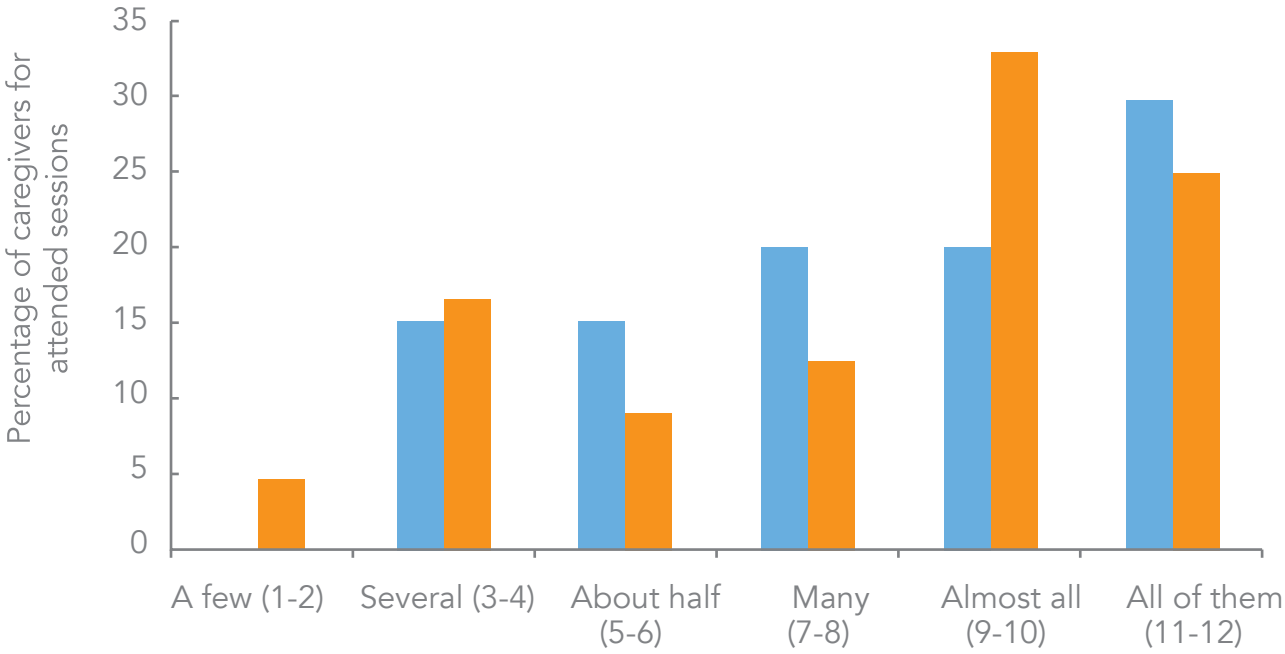
In total, 107 women and 20 men completed the endline questionnaire with an average age of 49.5 and 49.3 years old, respectively.

Figure 7: Age distribution of participants



Most of these participants did not attend all of the sessions. On average women attended 5.3 sessions while men attended 5.4 sessions. However, about half of women and men attended at least 75 percent of the full intervention.

Figure 8: Number of attended sessions by men and women



Most of the caregiver participants were parents (65 percent of women and 90 percent of men), while 37 percent of women and 10 percent of men were other close relatives of the adolescents. Female, caregiver participants reported living with an average of 1.59 children and 3 adults and male caregiver participants reporting living with 2.2 children and 4.2 adults. Most participants worked outside the home (88 percent of women worked in the previous 12 months and 70 percent of men) with most participants (56 percent of women and 45 percent of men) working seasonally. Most worked as farmers (65 percent of women participants and 45 percent of men).

Experiences with violence

Most caregiver participants described their home communities as fairly peaceful. Several participants attributed violence in their communities to "drinking" (alcohol abuse). Some spoke of a seasonality to violence because of alcohol consumed at festivals and ceremonies. This, they said, resulted in drunk and violent young people at public events and domestic violence by men.

Interviewer	***In the village, are there often any violence used between husband and wife? Arguments?***
Respondent	***There aren't any much of that now ... But there are often in May.***
Interviewer	***Why? Is it seasonal?***
Respondent	***Because there are many ceremonies, so the youngsters fight a lot.***
Interviewer	***Oh, so it is the youngsters who fight at the ceremony ... I was wondering.***
Respondent	***Even the husbands, when they are drunk, they also use violence when they are back at home.***
Respondent	***Even the youngsters, they drink a lot ... The season has a lot of drinking ... But now, there aren't any ... [Noise, mumble]... Sometimes there are violence when drunk, still have.***

Changes in attitudes and practices

Gender-equitable attitudes and practices

There were some encouraging findings regarding gender equality. While attitudes about gender equity are deeply entrenched and quantitative results did not show significant changes in caregivers' gender-equitable attitudes, there are some signs of change.

Several caregiver participants noted that men and women have equal rights, a concept that at least some learned via the sessions. Women's rights were sometimes described as something newly acquired and/or something for "the new generation".

Interviewer	***What about household chores like cooking, looking after the children and cleaning? Are they the men's or women's jobs?***
Respondent	***Women's jobs.***
Respondent	***Men still can help women with those chores. They can help each other. It doesn't matter if you're a man or a woman.***
Respondent	***For the older generation, they were absolutely women's jobs.***
Respondent	***Don't mention about the older generation. We're the new generation.***
Respondent	***Now we have the same rights, so we can do anything equally. If they can do it, we also can do it.***

Respondent	***Traditionally, daughters were not allowed to go anywhere far alone. We, elders, wouldn't allow it.***
Interviewer	***Why weren't women allowed to go outside alone, Uncle?***
Respondent	***In the past, there was no such thing as gender. And, we were afraid that the daughter may have a lover, and she could write a love letter to him. That was why female was not allowed to access high education level.***
Respondent	***Now, even the media also publicizes about it. It encourages women's rights. Traditionally, women cannot go anywhere as what we traditionally said "Women cannot walk around the kitchen." But now women can do anything.***
Respondent	***Now, our women earn more income than men.***

This last quote suggests that changes in gender-equitable practices are in process. This is also evidenced in various other parts of the focus group discussions.

> ***We should be equal. We have equal rights. But we still respect our husbands. He's like a breadwinner. He takes care of the family. We have to take care of him by serving food, etc.***

When a focus group included a discussion about "real women" and "real men", to solicit feedback about a particular session, participants listed traditional gender roles and stereotypes.

"Real Man"	"Real Woman"
The real man has short hair, wear pants and never skirts, has sex organ, has ears, nose, mouth as well, but man does not use things like perfumes, powder or something. *Real men are well-behaved, they do not care about make up. They only care about studying hard. They have clear goals.* *Real men are determined on their works.* *For example, like cutting woods, carry the water, have real occupation, clear job in the family. Have responsibility.* *Basically, have the responsibility in taking care of the whole family.*	*Wear skirt, wear lipstick, put some make-up, has sex organs.* *The responsibilities would be looking after their children, wash the clothes, cook rice, sweep the floor, advise the children. That's [a] real woman.* *In the morning, put makeup on, and sweep the floor, wash the dishes [laugh].* *What she taught us was that real women can handle all of their responsibilities, including taking care of the children, their clothing, their hygiene, etc.*

However, immediately following such discussion, participants also asserted that men and women now share responsibilities, including earning money, at least to some degree.

> ***In my hometown, women stay home, men go to the plantation. Women's works are just like men's works. They all cut the bananas, women wouldn't stay home, they would all go to the plantation, whenever they have the strength. Only when it comes to carrying heavy stuff: it is more suitable for men but women can also do the work that men do.***

This apparent discrepancy may simply reflect gender-equity attitudes in flux, that is to say that individuals could state or even imagine more equitable divisions of labour, but still see gender

differences as inherent. Or, as discussed earlier, it may also be that the facilitator(s) did not understand the session well and inadvertently reinforced stereotypes rather than teaching a lesson about gender equality and flexibility in constructions of gender. As mentioned above, this may have happened in one or more adolescent groups. One participant seemed to have described such a problem with her group's lesson:

> ***I noticed that the teacher made a mistake on that day. The lesson was on "Real Women and Real Men", wasn't it? She [a MoWA supervisor] was listening to the lesson from outside the window, and what the teacher taught us wasn't really correct. When she [the supervisor] came in to explain us the concept, it was much easier to understand. She told the teacher that what she said wasn't really true. Real women and real men are not identified based on their hair and stuff like that. Actually, what they wanted to teach us was that real women and real men are based on their responsibility in the family.***

Interestingly, one woman participant reported that she now does work that she used to ask her husband to do under the aim of sharing work in equitable ways.[43] This may reflect increased self-efficacy or an intent to improve their relationship.

Respondent	***Before when I talked with my husband, I'd be like, "Go and carry the water. It's heavy." Now I know if it's heavy, just use the small yoke to carry [the] water. We can help each other. But if it's about climbing the palm tree, it's kind of hard.***
Interviewer	***Anything else that [he] helps you [with]?***
Respondent	***We can help each other. Not waiting him to do things.***
Interviewer	***Sharing work.***
Respondents	***Yeah. Sharing work.***
Interviewer	***How do you share it? What does your husband do? What do you do?***
Respondent	***We are farmers. So my husband can go and take care of the rice field. I will cook at home and cutting grass and feed the cow.***
Respondent	***We learn to share work. We don't give all the hard work to husband anymore. If I can help, I'll help.***

While it was usually impossible to determine whether a speaker in a focus group discussion was a woman or a man, there were some instances where men spoke about changes they had made regarding gendered practices, usually about taking on some household tasks traditionally understood as "women's work". One man said that he did the household chores while his wife was delivering their baby and another woman reported that her husband similarly helped when she was pregnant. However, there were also more changes reported that had the potential to be lasting.

43 It is unclear whether there are multiple women talking about helping their husbands or whether the transcription is incorrect and the conversation is between one interviewer and one woman.

Previously, men did heavy chores, while women did housework, for example lunch preparation. But now, there is no division. We help each other. If I am free, I will cook. But, if I am busy, she will cook. Doing so, it will help the children to go to school faster. If we tend to rely on one another, kids will be late.

Men should help out because the wives can be busy. Thus, we should spare our time to help them. Like my daughter, she always goes to the plantation. When she comes back, she is always exhausted. Then, I would help with the cooking, and we can all eat. It is like that, helping each other's works. Nowadays, I wash dishes, cook rice. I would help because she usually washes my clothes already.

The following quote by a man mentioned his decision to stop abusing alcohol, and suggests that it was after he stopped using violence against his family that he and his wife were able to negotiate more equitable roles in their home.

After I've stopped, we learn how to help with each other's work. Say if my wife goes to the market, I'll cook the rice, wash the dishes. Whatever it is, I'll do. We don't just wait and expect the other to do it. That's called gender equality.

This was a particularly remarkable change in behaviour given that increased gender-equitable attitudes accompanied a cessation of domestic violence.

Some women participants reported that they told their husbands about some of the session content regarding gendered divisions of labour and then their husbands changed behaviours – this too, is remarkable, given that women felt empowered to have this discussion after participating in the intervention and that men, even though they were not part of the intervention, changed their behaviour based on the learning and ideas shared by their wives.

For example, in the past, when I was busy, he would do nothing to help. But now, when he sees that I'm busy, he helps me with the things that he can. This helps reduce some of my workload.

All of these instances of men who reported practising different roles in the household after attending the sessions and women who reported their husbands' changes are very encouraging. They evidence change beyond mere statements about more gender-equitable attitudes and suggest that men are willing to change with appropriate education and support. Further, these changes may occur in a social context that does not always support such change. For example, when an interviewer asked a woman whether neighbours comment when her husband helps with household work, another interviewee responded that not everyone sees such help as worthy of praise.

But some men are different. When they see men doing all those chores, they say to them, "you'll be looked down by women for doing those chores."

Similarly, one participant claimed that some men will refuse to do women's work.

Because they still mind that those are women's work. They still think women's work should be done by women, men's work should be done by men.

There may be other historical factors contributing to these changes that were not discussed in these focus groups that influence changing divisions of labour. For example, in making a claim that it was not remarkable that he helped his wife with housework, one male interviewee reported that many men now do housework because women work at a garment factory.

> ***Our community now is full of men doing housework because women go to work in [the] factory The men would look after the children and women do the work now. When arrived home, there's already food cooked.***

It is encouraging that at least some men take on these new roles in a changed economic context, rather than simply asserting that women must continue all household work in addition to working outside the home.

Communication and conflict resolution

Nearly everyone who participated in the caregiver focus group discussions described their attempt to practise using respectful, non-violent communication which they referred to as using "polite words". In particular, participants said they were taught to use the word "Khnhom" (polite form of "I"), but they also spoke more broadly about implementing the use of "sweet words" or "polite words". It was primarily with partners or children that they attempted these changes, but some also used "polite words" with peers and elders. "Sweet words", in particular, were most often used in instances when a woman spoke to her husband or when either parent spoke to their child. The FGD interviewers explained that were three different kinds of speech: impolite, polite and terms of endearment. When used in these transcripts, "sweet words" reflect the latter two types of speech.[44]

> ***For me, personally, when communicating with someone within our age or older, I try to use good words instead of using bad words to create a good conversation. Previously, I mixed bad and good words together, but now I changed, after the course.***

> ***I changed with neighbours. The change started from the way we addressed them in a very polite way. For example, I addressed them politely when I asked them to go to [the] pagoda or anywhere else.***

Initially, some participants reported that it felt strange to use such words or that others had remarked on the changed language. Several described their language changes as gradual and acknowledged challenges in consistently practising polite language.

> ***It's hard to change. But we tried really hard.***

> ***If we use it more frequently, it becomes normal.***

> ***All in all, it's not like we could change all immediately. But we tried to change slowly. Day by day.***

Everyone who discussed the use of polite language during the focus group discussions talked as though this was a permanent change, even if they continued to work at implementing it all the time.

44 Each of the ways in which "sweet words" were referenced in these transcripts – wife to husband, parent to child and never, for example, from peer to peer – begs the question of whether "sweet words" are used in particular hierarchical relations. The instances of use in these transcripts were too few to draw any conclusion.

At first I was shy … We got used to it. All in all, it's great to use it. It means we respect other people and they respect us.

After a long time, we got used to it.

Participants seem to have recognized benefits of this change and, indeed, few noted any negative experiences with this changed communication style. First, several caregivers noted that when they tried using this different language, others often responded back to them in the same way. In other words, others changed their speech to match the words and style of a participant's speech (linguistic style shifting)

There are some changes. They smiled and used word "Khnhom [polite for 'I']" when they replied back to me.

My husband also asked me what I have learnt from the training. During the training… I told [my husband] that I am taught to use the polite word of "Khnhom [polite for 'I']". One day when I got day off from training, and I asked him to cut the wood for me. I said to him, "Khnhom cannot make it, can you help me, please?" My husband said I seem to be strange today (laughing). Then he helped me out with that, and I brought cold water for him and told him, "You got a lot of sweat and I thanked for your help". He claimed that I was so ridiculous. I told him, "During the last day of the training, they asked us to talk to each other in polite way by saying the word 'khnhom', and same to this case I should use the polite word with you like, 'Thank you for your help and please drink cold water to cool your feeling.' Then I asked how he felt after I said those sweet words to him, and he said he felt strange. Later, he also tries to change the way he talks to me. Now, he always says to me with polite words by stop saying "Anh [slang for 'I'] in a hurry" and "Anh is nearly ready or let's have lunch." He also talked to his children with sweet words… He hasn't called me honey yet, but instead of the word mommy. Now, he calls me by the word "Mommy" while before he said, "hey, Anh in a hurry". Now he changes the way he talks. Since I joined the training I have shared to him and he also learnt a lot now.

Second, several participants believed that their linguistic change resulted in closer relationships.

For me, personally, I feel closer. When I talked calmly and closely with others, sometimes, they come and consult with me because we are understanding and approachable.

In the past, I've never asked them if there were any problems with their schooling or not, if they had a fight with their friends or not, and what they did during their free time. When I use nicer language with them, it's easier to communicate with them, because we don't just order. We also use reasoning.

I also brought my children to join the sessions. Their language is also nicer now. Both mother and children learned and understood, so it's easier to communicate. It would be even better if my husband could join.

Third, several participants also explained that they believed that using polite language prevented aggressive talk and reduced the potential for conflicts to become violent.

I think after I joined the training which has taught me on how to speak the word "I" instead of [a] bad word, how to communicate well and how to solve problems peacefully, I realized that my family is now happiness and not fighting anymore.

We have changed how we behave, act and talk. No more aggressiveness.

We've changed a lot. We have less fight when we talk.

Along with the change to polite language, several participants talked about strategies to stop an argument from escalating and regulating their own emotions to stop or prevent an argument. When one group was asked about how well the participants were now able to control their feelings, their responses varied from "once in a while" to "half" to "almost most of the time".

Now I have changed in a way that I talk instead. Or when I'm angry, I walk away, without causing any damage.

I used to fight back verbally when I was angry, but now I've stopped.

We scolded [our children] for every mistake. Now, we can hold it back.

I was very hot-tempered before. After the workshop, I'm more gentle. I've cut down some of my temper. From using a lot of bad words to using only good words.

I was very short-tempered before, both me and my husband. We fought back and forth. But now, when he is mad, I stay quiet. And when he stays quiet, I talk back… Now we understand, so we can stay calm.

We don't use bad words, and we solve them peacefully. When the other party is angry, we let them calm down first before we solve it. If not, we will end up getting into a fight. We also listen to each other actively to prevent further dispute.

My children, niece, nephew are difficult. At first they were aggressive, but when I have learnt about it, I know next time when they act rude to me I walk away. I don't want to respond. I live in happiness ever after.

Like one participant mentioned above, several caregivers said that they may "walk away" to prevent an argument from becoming worse. Their aim was to then talk calmly with the other person at a later time.

For some, it was also possible to suggest these language changes to other non-family members.

> ***They (villagers) are still rude with their words, and they still address each other rudely, even among the elder ladies. I often tell them not to call each other with those words since they are old already … Things like this still exist in our community. Not everyone understands. Only us, who join the workshop, do.***

> ***In the past, there used to be many domestic violence in our village. But then, this organization and others tried to cut it down. People in the entire village rarely have conflicts now. In the past, I couldn't sleep, because they often called me to help solve their conflicts. Sometimes, they didn't listen to me and just turned on their radio. But I told them to stopped listening to the radio and listen to me instead. Sometimes, they got angry, but after they listened to me, they realized that my words were reasonable.***

However, for some participants, advising others about language use or conflict resolution was not appropriate or others did not respond positively to suggestions by the participant.

> ***In the family, for the people of the same age, sometimes when I say something they wouldn't listen to me. But we must understand that if we have good feeling, we will solve the problems accordingly. If they oppose us or use violence on us, we walk away. If we're trying to talk about it, they wouldn't want to listen. I am not referring to teenagers or those under our guidance. I am referring to people of the same age.***

Overall, it is very encouraging that so many participants (seemingly all who spoke at the focus group discussions) wanted to and were able to implement changes in communication and conflict resolution, at least within their own homes and sometimes in their wider social circle. The several benefits or improvements resulting from these changes identified by participants may help to reinforce such changes and extend and sustain the impact.

These attempted changes and successes should also be considered in the context of the ways in which language has been politicized in Cambodia in the past, and how language affects social norms and feelings about them. When the Khmer Rouge came to power, language became a political matter as the regime aimed toward socialist ideas and the destruction of previous hierarchies.[45] They attempted to remove hierarchies from the language too, including titles, pronouns, and associated vocabulary.[46] For instance, language associated with urban, educated populations (e.g. foreign vocabulary such as "pa" and "ma" for "father" and "mother")[47] were prohibited in favour of terms associated with rural life (e.g. "*puk*" and "*mae*" for father and mother). In fact, "*puk*" and "*mae*" often

45 Hinton, A.L. 2005: 189.

46 For changes in pronoun use see: Marston, J. 1997. Cambodia 1991–1994: hierarchy, neutrality and etiquettes of discourse. Doctoral Dissertation, University of Washington: 159–160.

47 Marston, J. 1997: 162–164. He also described the use of terms for people of the same age or younger: mitt ("friend"). Marston further states that these changes of terms were perceived as evidence that the state had some rights to determine parent–child relationships.

came to replace other conventional terms of address for persons older than the speaker, although this was not endorsed by the Khmer Rouge, which favoured more egalitarian pronouns, such as *"mitt"* ("friend" or "comrade friend"). Indeed, children were encouraged to use "mitt" to refer to their parents. For many Cambodians consulted for one study, this change exemplified "how the Khmer Rouge spoke 'sweetly'".[48] In practice, linguistic distinctions of age were not wholly abandoned and even less so in home spaces where secrecy may have been assured.

Similarly, the use of the word "I", or *"khnhom"*, was discouraged to encourage a collective identity above an individual one. And using "thank you," "please," and "sorry" was deemed unnecessary as they implied indebtedness, invoking a hierarchy. Today, "I" is not typically used in every day talk and this may have some basis in the national past.

Relationships with children and discipline

Caregivers who had some information about content prior to the first session, or had continued attending the sessions, widely reported changes in the ways they engaged with and disciplined their children as a result of participation in the sessions. Many also reported that session content pertaining to the theme – "how to deal with teenage children" – was particularly valuable and often a primary reason they had joined.

Participants talked about learning to encourage children's positive behaviour, to guide them in making good or healthy choices, and to improve communication.

> ***We practise (what was learned at sessions) continuously. We do it step by step. To our grandchildren, we tell them to study, not to go for a walk.***

> ***It [the sessions] has helped me understand how to ask them to help and how to use proper language when talking to them. In the past, although I did encourage them sometimes, I also threaten them from time to time. Say, I would use threats once every three times I want to order them to do something. And now, I stopped using threats ... I use encouraging words so that they help us with our work, to make them do it happily and to encourage them. For example, when I asked them to get me some water, I told them "Now you follow what I tell you to do well, dear, much better than before."***

> ***I hit them (in the past). But now, I no longer dare to do that. Before I hit my grandchildren, but now I determine to stop. I comfort them. They also listen to us, that is why we go to the meetings.***

> ***Before I don't have any tips to solve the problem with my kids. Normally, I always act as their mother but after I joined the project, they provided me good tips. My relationship with kids and husband is better. I communicate with them in natural ways but now I have my better ways to communicate with them. Example, if they go out I said, "YOU CANNOT GO FOR A WALK, YOU NEED TO BE CAREFUL." I just threatened my kids. I keep them at home is not good. Going for a walk can be a problem but can be a pleasure too. They have their own issue which I didn't noticed before. I said "You can go out one or two hours my dear, you can eat something outside too."***

48 Marston, J. 1997: 165.

For my son, even he is not a good boy, he goes out late at night or doesn't pick up my call, but he always helps to wash my clothes. One day, when I came back from the training at the commune office, I shouted surprisingly, "who helped to wash my clothes?" Then, my son replied to me that it was me. I thanked him that he helped to wash my clothes. He said, "Why do you thank me this time as I washed for you most of the time?" I told him that I got the training, so I know how to say thank you.

Nearly every caregiver participant explained that when they shifted away from punishing children, usually by replacing threats or harsh punishment with "soft words", children were more responsive to the caregiver's request. In other words, the strategies presented at the sessions provided tools to help caregiver participants solve challenges they regularly faced with their children.

I used to scold my kids when they go out if they didn't answer my call. Now I changed my habit. Instead of scolding I convince them. I explain and give them reason. When we change, they change too. They don't go for a walk a lot as before. They know when they should go or shouldn't. They don't always go out whenever their friends call. They like and know how to drink but after we educate them, they change. After work they drink one or two bottle of beers at home with siblings during dinner and go to bed. By the way, after this course, parent or guardian change habit too. I used to hit and scold my kids but now reduce to 50 percent. They used to shout out loud from a very far distance. Whenever I want to hit or scold my kids, the lessons remind me not to do.

Before we shouted when we talked. Then they didn't listen and follow what we said.

When we talk in soft voice and comfort them, they listen to us more.

I told my neighbour that my son was so stubborn these days, but I would say to him, "Son, help fill in the water container for Daddy, please," instead of "You go fill in the water container for me!" He wouldn't go if I ordered him like that. When I say it differently, he will go.

Respondent	***For example, when our children come back from school, and they're tired and angry or having any problems, what kind of methods we should use to ask them in order to help them resolve their problems. We should not be quick to insult them, but we should give them some time to calm down. Then we should find a solution.***
Interviewer	***Did you try practicing this?***
Respondent	***I did.***
Interviewer	***How was the result?***
Respondents	***I got good result… It was a success…To me personally, I face this problem. My child was like that. My story is the same as in the lessons, so I followed what I learnt, I noticed that I got more success.***

For me, before I use "haeng" with my children. Now, I change to "kon eng" (my dear children), asking him where is he going and also ask him to tell me where he is heading. With my own children or in-laws, I used to use the word "haeng" to ask, that way, they didn't listen to me. Now, as I use gentler words, they listen to what I say ... He just smiles and walk away. He changes when he talk with us. He is quite embarrassed, so he doesn't use the word "khnhom [polite for 'I']" to reply back, but he also doesn't use "Anh [slang for 'I']" like before. Whenever he speaks now he would just skip the pronoun "anh" nor "khnhom". He is still shy … They would call me "mae ah oun" (child's mother).

My children, when I use good words with them they listen. Mostly daughters follow what we say.

Caregivers sometimes described part of their changed approach as one of newly showing interest in their children.

For me, I am fine with my married children, but I have problem with my single children. Somehow, I know the way to handle them. I always talk to them with the reason. For example, when my son stays late outside, I always tell him, "Firstly, I am not strict with you, but you have to think deeply that if you got accident at night, nobody will know. Secondly, if you go out at night at the time of policeman do their mission to catch drug addictive group, they might catch you as well as they might think you are from the same group even you are a good citizen." I just try to explain my children like that. Somehow, I know how to use sweet words with him such as baby and mommy. Now, he tries to reduce some even it is not at 100 percent yet, but it is also about 70 percent which makes me as a mom feeling happy.

Several noticed that their relationships with their children had improved as a result of implementing strategies they learned through the sessions. These changes resulted largely from improved communication, listening to their children as well as speaking politely.

By that we mean, for example, when our children did something wrong, we, as their mothers, always scolded them. They were not dare to talk back, so they stayed quiet. Sometimes, they came back from school late because they took extra classes, and they didn't tell us. We would scold them for coming home late even before asking what happened. Then, they would tell us that they took a one-hour extra class, but we had already scolded them. But now, after we've learned and understood, we don't scold them no matter what … We ask them first to know the reasons why.

At that time (before the sessions) I didn't really pay much attention to them. Now I pay attention to them. If they come late when he should come on time, I make them read the lesson or do the math multiplication.

We were not that close before. She didn't dare to because she didn't understand my feelings well. I love her, but she didn't know. But now, I advise her step by step. Then, we got closer ... I used nice words when I talked to her. That way, she felt closer with me, and she realized that I also used nice words with her. I didn't ignore her, so she felt closer with me and knew that I loved her.
If you love them and don't let them know that you do, they won't dare to be close to you. In the past, they were close to me, but sometimes, they didn't dare or weren't comfortable telling me about their personal problem. When we're close like now, they are close to me, and when there is something happens, they will tell me.

To me after I joined this project I think I have better relationship with kids. The way I speak to them, I think I am better. For example, before my kids never told me they go for a walk but now they tell me. I told my kids, you can go out but you should not go alone. You shall go with few friends.

Before joining the workshop, we didn't understand. After the workshop, we understand a lot. It helps me around 70 to 80 percent in terms of how to advise the kids. The kids also understand by 70 or 80 percent. So, if we add those up, it's a lot. In the past, let's say our understanding was 30 percent. But now, it has increased to 70 or 80 percent. So, it's easier to communicate.

There were reportedly children who did not respond positively to the caregiver attempting change and the caregivers explained this as a problem of each individual challenging child, as though they were inherently more difficult to effect through positive discipline. Male children, in particular, were perceived to be less prone to change despite caregivers' attempts at new strategies.

Some children are easily sullen. When we talk, sometimes, they may get angry.

Some children change. However, those who don't obey their mothers are not likely to change easily.

Before, sons did not listen to us. It made us angry. For daughters, when we talked to them, they listened to us. Better than the boys. But now we changed. But educating the sons is harder than educating the daughters.

Harsh punishment and physical violence

Participants who talked about physical violence in the focus group discussions primarily described "hitting" children as a form of punishment. There were a few instances of a man hitting his partner (and one casual mention of a woman hitting her husband) noted. These were primarily in the context of a woman describing how she had learned strategies to protect herself (see below).

All caregivers who participated in the focus group discussions talked about reducing or stopping harsh punishment of their children as a result of participating in the sessions and learning other strategies for guiding their children's behaviour.

For myself, back then, when my children didn't get the high score or good grade, I always hit them, but now I changed. I stop hitting them.

Respondent	***Traditionally, men tend to use harsh or heavy words to kids so that it will affect the kids. So, women will take this role to educate the kids. For instance, we usually talked to the kids that "Do not spread this wrongdoing to your father." However, now, since the training, men also need to do it but without violence.***
Interviewer	***So, uncles, do you really use violence?***
Respondent	***Yes. I used to. But now I never do that.***

Then it is about the teenager. Before we made some mistakes. Now we change and adapt in some situations. We cannot change 100 percent but at least 50 percent. Before we would want to hit our kids when we ordered them to do something for us and they didn't do like we said. But now we learned to calm down. Instead, we say good words, educate them, and comfort them.

There were a few encouraging reports in the focus group discussions of partners who had learned new strategies from partners who participated in sessions and who also shifted to non-violent forms of guiding children's behaviour. In these instances, the partner of a participant used what he learned from a participant to alter the way he interacted with their children.

He uses violence and grumbles less often after we've shared what we learned with them.

He also talked to his children with sweet words such as, "Baby, are you ready? I am so hungry, please wash your hands and have lunch together as your mommy served us already."

Before, when I called them for breakfast, and they didn't come immediately, my husband will take out his belt ready to hit them. He just hit the stuffs [hard surface such as door or wall], and when they hear the sound, they all get up quickly. Now he stopped doing that. I shared with him every day after each of the 10 days of training. I never expected that my husband has changed that much. Now he changed for not committing both mental and physical violence. Now I feel happiness. Before he was so haughty.

At least one caregiver participant mentioned that older children could not be hit, but no further explanation was given. This guideline about hitting older children was noted more often by adolescents in focus group discussions.

But now they are all teenagers. They can listen to us and understand when we talk to them. Besides we cannot hit them anymore.

Although caregivers reported trying to use non-violent discipline strategies with children, many remarked about the challenges of trying to guide the behaviour of children who "do not listen" and it was in such instances that participants reported that they may still hit children.

> ***It is actually because sometimes, the kids are too stubborn. So, I just lightly hit but it is not like I strongly punish him or act violently on him. So, it cannot reduce one hundred percent on kid violence.***

Harsh punishment may differ by the child's gender. Inherent gender differences were asserted by participants in discussing raising girl and boy children.

> ***The boys are harder to talk to than the girls.***

> ***The girls are faster to listen than the boys.***

> ***The boys are hot-tempered. If we don't talk easily with them, they will just burst out. For the girls, they don't reply back as much.***

Although it was not described in the focus group discussions, the likely outcome of these inequitable approaches to raising boy and girl children is that boy children likely experience more harsh punishment since that is how caregivers reportedly responded to challenging disciplinary situations.

One male participant credited the sessions with effectively changing his violent behaviour. He came to understand why he should not abuse alcohol and how it contributed to him choosing to use violence with his family. This man was reportedly able to stop abusing alcohol as a result.

> ***During the third session, I still drank a lot. Then, around the fourth or fifth session, I completely stopped. I began to understand the issue little by little. I understood that drinking too much is like bringing fire into my family. Violence built up in myself. After I've stopped, we learned how to help with each other's work.***

Avoiding and dealing with violence

A few women participants reported a reduction in domestic violence (usually verbal, but sometimes also physical) because they learned from the sessions to remove themselves from an escalating conflict, particularly if her husband was under the influence of alcohol. Most spoke about not engaging with a partner when he was angry, but some went so far as to leave their home for a period of time to wait in safety while their husband calmed down.

One participant reported that her husband used to destroy things in their home when he was drunk. Through the workshops she learned that she would rather patiently solve a problem to achieve happiness in the family, than to react or to try to "win" an argument.

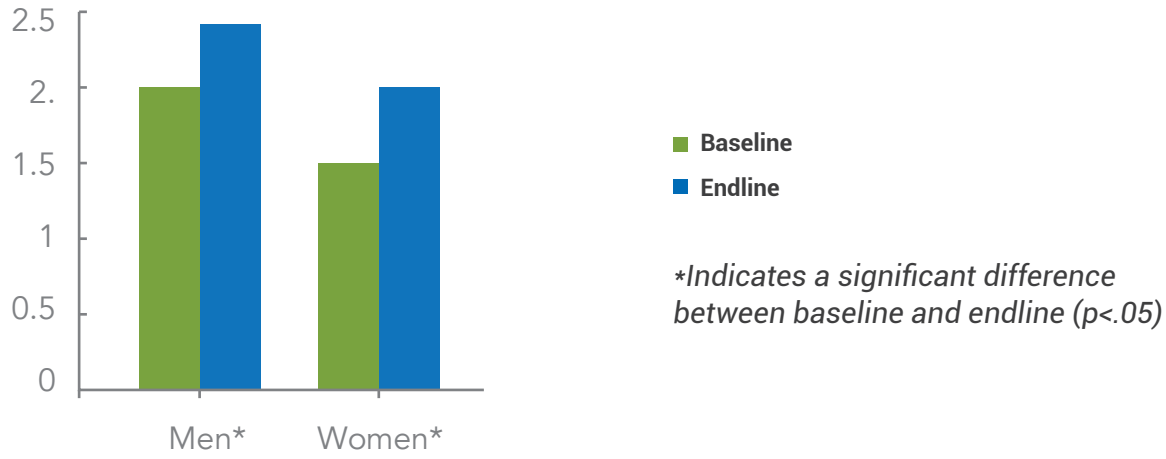
> ***But now, for example, when he comes back, like "you are not home these days". Then we don't talk back. Just do anything else. Cook for him. He'll just go sleeping. No more arguing. To be honest, in the past, I'd react back quickly if he picks a fight with me.***

For me personally, when my husband seems not okay with me, I would pack and go out.

When he got home drunk, I turned on the light and prepared dinner for him. Still he couldn't see and started to fight. Now I know and I can find a solution by catching a motorbike and go out waiting till he gets back to normal.

It appears that the strategies for conflict resolution that were discussed in the session may have been used by some women to escape from a situation they expected to become violent. Also, the endline questionnaire showed that on average, women who participated significantly increased their knowledge of support services (baseline mean =1.65, endline mean =2.02, p=0.00)) (Graph 9).

Figure 9: Caregivers who report awareness of violence support services



Finally, a few participants reported that because of the sessions, they learned and developed confidence in phoning the police when violence occurred in their communities.

Interviewer	***Before, whenever there's violence happening, did you stay silent and not reach out to the authorities?***
Interviewer	***No… I didn't dare to… It's the other family's business, I didn't dare to get involved. And now I dare to… Ever since I participated, I dare to explain the matter… Now, after they see the police coming to take action, they're scared… The person who called the police was not revealed by name. It's this convenient now we've got the phone.***

This interviewee believed that violence had been reduced in the community because perpetrators knew others might phone the police to intervene:

They are now scared since we can reach out to the police. Now there's hardly any problems.

Volunteerism

As was mentioned above, participants often shared what they learned in sessions with their families, particularly husbands and children, because they perceived the content to be very relevant

for their lives. Participants reported that husbands sometimes even asked what they had learned at sessions. Participants seem to have most often shared content related to child rearing and discipline, communication and conflict resolution.

Although the endline questionnaire data showed that the majority of both women (49%) and men (65%) felt confident to share their learnings with friends and family, the focus group discussions lend the impression that even more sharing was done within families. This may be because the questionnaire asked about sharing information with friends while the focus group discussions suggested that few felt that it was appropriate to do so.

> ***We can only use the knowledge to manage our family and share it with a few of our neighbours.***

> ***If they [neighbours] ask, we'll tell them. We never teach other people. We only talk if we are asked.***
> ***We have to set a good example in our family first. So that they won't say that we just give advice to others while things are still messy in our families. We can give others advice only if our families are living happily first.***

> ***If [we are] not so close, we shouldn't get involved. It's their business. If they fire back at me, it would be very unpleasant.***

> ***We can't just go and give them guidance. I can advise them only because I'm the vice village chief. In our village, if we just go and advise others, they will gossip about us.***
> ***We do not dare to talk with outsiders since we are afraid they will mock us, talk back and say, "You should make yourself look good first." So, we do not want to talk with outsiders – and are talking only with the family.***

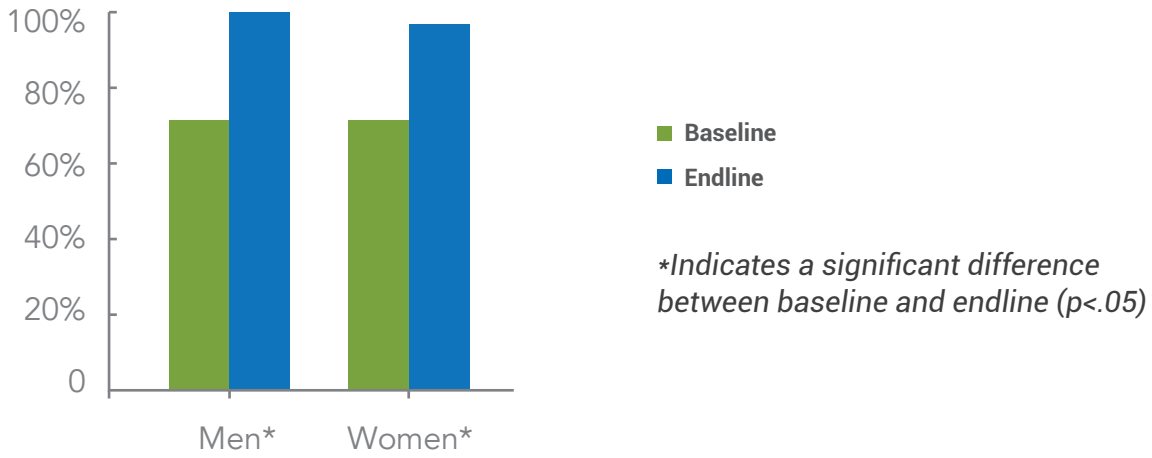
> ***If only my family understands the issue … For example, a household that is not related to me by blood. I cannot just go and explain them. In the village, only 20 to 30 [percent] understand the issue. The other 70 percent don't understand it. When they don't understand, it's difficult to communicate. If all of us understand the issue, and the organization comes to teach a lot of people, when all of us understand the issue, we will be able to live peacefully together.***

The comments by caregivers suggest that only particular members of a community, namely those affiliated with the village chief, may be able to influence others outside of close family members. The last quote suggests that if some common understanding is created by a leader or organization, then members of a community may find it easier to continue reinforcing non-violence. Partnerships with local respected community leaders or community organizations are important in implementing these interventions.

Very few caregivers reported previous experience with volunteering during the focus group discussions. However, in the baseline survey 67 percent of women and men reported to have been

involved in volunteer activities in the past six months that focused on equality of men and women and healthy communication. This significantly increased after the intervention, with 97 percent of women (p<.01) and 100 percent of men (p=.01) reporting to have been involved in such volunteer activities (Graph 10). It should be noted that part of the intervention was an opportunity for participants to become involved in volunteerism and that most participants took this opportunity, resulting on this strong increase in experience with volunteerism.

Figure 10: Involvement in volunteer activities in the past six months



While all participants wanted to see more people learn the session content, many did not feel they had the knowledge to continue teaching on their own , in the absence of a formal programme, and, as described above, did not believe they could influence anyone beyond their own families. Only the vice village chief could envision broader sharing: stopping by homes to educate people.

Although participants did not plan to continue teaching on their own, 60 percent of men and 53 percent of women indicated in the endline that, in the future, they would definitely help to plan or organize volunteer activities that focused on conflict resolution, caring relationships and violence against women and girls.

Lessons learned

Participant motivations and assessments of the intervention

Adolescents

Most adolescent participants heard about the sessions from an adult and many attended the first session without knowing much about the content. Many reported that they came "to gain knowledge". Once they had a better understanding of the programme, they continued to come because they believed the content would benefit them in the future. One adolescent expressed their interest in more detail:

> ***Because the organization provided a lot of good lessons that are related to our mentality or thinking and the braveness. They taught us how to communicate in the community. They taught us about violations, to be brave to seek for services to help when we are in trouble.***

In sum, adolescents were reportedly motivated by learning something new, learning something that would benefit them in the future, and/or they followed the suggestion of an elder.

Nearly all participants in the endline questionnaire indicated that they enjoyed most of the sessions (93% of girls and 93% of boys) and that they found the sessions quite useful or very useful (99% of girls and 97% of boys). This suggests that despite the rather different motivations for initially joining the sessions, those who continued found the content appropriate and relevant for their lives.

Some participants identified previous participation in a workshop or exposure to some content related to this programme via training. One reportedly attended a health workshop. Another attended a workshop related to human trafficking and had heard about domestic violence through that. A couple of adolescents mentioned that they had learned some of this programme's content – such as children's rights and something about violence – at school. For the most part, the content was new for the adolescents.

When asked about what they learned in the sessions that was new to them, many adolescents identified "domestic violence". Some mentioned learning about causes or prevention of domestic violence more specifically. Other topics that adolescents noted as new information included: managing stress, use of Khnhom (polite language), conflict resolution with friends and relationships (dating, how to protect oneself from sexual violence, communication with a partner, sexual assault, and where to seek support services). One adolescent summed up what their group had learned:

> ***It taught us to know how to protect ourselves, how to respect one another, give the rights to one another.***

Caregivers

Participants claimed that they came to the first session knowing very little about it. Many caregivers said they attended the first session for the chance to learn something. A few caregivers understood that the sessions would teach them about raising their teenage children and that sounded valuable, although they felt they had little sense of what the sessions would teach them.

> ***They did not tell us anything. They just say tomorrow go to a meeting at the pagoda, about making improvements in our family, how to advise teenagers.***

> ***Because we wanted to be educated and be informed.***

> ***We were curious and wanted to be more educated.***

While the focus groups do not provide enough information to better understand why so many people would attend a session often just for the sake of learning something, it is noteworthy that caregiver participants had completed little formal education with 3 percent of women and 20 percent of men (who completed the endline questionnaire) having finished high school. Women on average completed 4.1 years of schooling and men completed 5.4 years of schooling.

Caregivers who continued with sessions clearly found them useful in their own lives even if the aim of education also motivated them. From the endline questionnaire, 84 percent of women and 80 percent of men found the sessions "very useful" while 16 and 15 percent respectively found them "a little/quite useful". And nearly everyone (96% of women and 95% of men) enjoyed most or a lot of the sessions.

I forced myself because I am invited so if I don't go it means like I don't honour her… If I didn't go, I would look bad. That was why I forced myself to go just once, and I was determined not to go again … But after joining one workshop, I thought that the lessons that I got from it were good that I could use them in my family. So, I joined every time I got invited. I only missed two sessions.

I want to learn more. I want to know what would be something unique about each session, and what I can take into practice in my family.

First, we thought that we knew nothing. That's why we joined this project. Then after one another, we involved ourselves more. We received knowledge and gained the experiences to talk to our kids and the neighbours. It changes depending on the circumstances. Before we would say "Anh [slang for 'I']" "Ngaeng". Now I say "where are you going? Can you bring this with you?" The word "I" has a lot of meanings.

We felt happy. When we shared and discussed, it helped us to have more good ideas. We could exchange our ideas. When we saw the mistakes, we learned from them and changed slowly.

Then we just came to listen to know how to make our children good. We listen to each other, and when it looks right, we just follow one another to the meeting, so we can learn and understand.

The majority of comments about motivations to continue attending the sessions included that the individual had put information or skills learned at the sessions into practice and found them to be beneficial. That participants were so eager to try new practices in their families is particularly remarkable since nearly all reported that they simply joined for education without much information about the content of the programme sessions. It is also a strong reflection of the relevance of the sessions for participants' lives and for their challenges and concerns of everyday life.

Several caregivers had participated in related voluntary trainings or workshops in the past. The themes they reportedly learned about included: gender, violence against women, looking after children, health and human rights. However, the comments were too few to understand how participation in past training might have influenced their understanding in these sessions.

Participants commonly reported that all or nearly all session content was new to them. Most commented about learning non-violent strategies for dealing with children, or how to "coax" children, as many described it. The ideas that they learned for doing so included assigning light work as punishment, persuading children with monetary rewards, and improving ways of speaking with children. Some said that learning why to use "good words" as well as teaching or advising children was new to them.

When our children make a mistake, we have to correct and advise them by using good words, and not using violence with them

Several participants also noted that implementing the use of polite words was new for them.

They actually taught us to use polite "I" when addressing myself to talk with someone else, using pronounce "Dad" when addressing to our children. This was actually new since I never used something like this before. This is also a good point.

Some noted that they learned to value a form of conflict resolution that did not allow them to "win" an argument.

When we all argue, the result is not good for the family. When we learn to be patient, we can solve things calmly.

Useful content

As mentioned above, nearly all participants in the endline questionnaire indicated that they enjoyed most of the sessions and that they found the sessions quite useful or very useful (99% of girls, 97% of boys, 84% of women, 80% of men). In focus group discussions, participants provided little detailed information about what they liked.

Some examples of content that reportedly drew adolescents to attend and/or that they liked included:

- Sexual education
- Reasons for using violence
- The usage of alcohol and drugs
- Respecting each other's rights
- Good relations in the family
- Bad listeners and good listeners
- Polite speech: saying "Khnhom" or "I"
- Being a man and being a woman
- Gender
- Communication in the family

Judging from the way and context in which these responses were offered, it does not seem that any particular lessons drew the attention of adolescents. They also did not offer suggestions for content for any future workshops. They were most significantly motivated by the advice of elders or their wish to gain knowledge for the future "so we would not be cheated" (seemingly meaning that they did not want to miss an educational opportunity).

"I have noticed a change in the community too - people have cut down on the use of violence. We need to prevent passing on violent behaviours and mentalities from one family member to another. Husbands and wives and children must learn to use positive words and communicate better with each other."

-Bunthat, male facilitator

Although adolescents did not describe that the material learned was difficult, irrelevant or incomplete, it may be worthwhile to try to understand why they described the sessions as useful for the future, but did not mention that the sessions helped them deal with current life challenges

(as caregivers did) when discussing their motivations to attend. Their active engagement with the sessions might be strengthened if they better recognize how the content currently affects or could affect their lives.

Two supervisors were concerned about the inclusion of sexual and reproductive health as a theme in the adolescent sessions. They were concerned that parents might misconstrue the session as one that is teaching their children's sexual practices. However, there was no negative feedback reported in any focus group discussions with caregivers or adolescents about this theme. Further, all stakeholders in the project approved the full curriculum before the manual was finalized for this pilot.

A facilitator also noted that a session on "being a real man and women" was difficult. The perceived difficulty with this lesson may also stem from what it is trying to teach: abstract concepts that diverge from deeply entrenched understandings. If this facilitator's concern about whether they were teaching the intended lessons about "real women" and "real men" was widespread among facilitators, the lesson may have been taught differently than what was intended by the manual. Indeed, when focus group participants were asked to talk about this lesson, they all described stereotypical gender differences. This suggests that they did not understand the lesson as it was intended. This facilitator's comment provides some evidence that the facilitators' understandings of what they were to teach may be a contributing factor to the misunderstandings. Coupled with the very traditional notions of gender that emerged in discussions about this theme, this lesson should be redesigned and more time and activities should be invested in ensuring that facilitators' understandings of gender and gender equality are also transformed.

While adolescents imagined they were learning important information and strategies for the future, caregivers believed they were learning strategies that might immediately help to improve their lives.

> ***I can resolve more tensions in my family.***

> ***Then we just came to listen to know how to make our children good.***

A caregiver suggested a session on drugs might be helpful to add, but others did not have any particular suggestions other than that they would readily participate in future workshops.

> ***If they tell us what to study, then we will just study. If we have to answer what we should study next, we don't know what to answer.***

Session content that participants could readily imagine implementing in their own lives was the strongest motivator for caregivers continuing with sessions and for sharing knowledge with others.

Suggestions by local supervisors about expanding the programme also showed the acceptance of the sessions and relevance of its content.

> ***I would ask UNFPA to expand to other provinces … using the same model … It's not much widespread….. After we do it, and the Women's Affairs Officials think that it's good, they can use the materials to implement their future projects.***

One supervisor suggested that a "public promotion campaign" be carried out after the intervention to extend the programme's reach.

> ***By equipping with sound system, and any other methods to make it heard in public. And when there is such event, the villagers may say that 'oh it is the programme that my children also join it, and now they have campaign', so the people keep talking about the project from one to another through word of mouth.***

While a publicity campaign such as this might be useful for familiarizing community members with some basic terms or ideas, it would not substitute for a participatory session. But, this suggestion does demonstrate the relevance and value of the session in the eyes of community members.

Participatory methods

A few adolescents said they felt nervous for the first two to three sessions. At least in part, such nervousness seemed to be about imagining they needed to produce "right" answers.

Clearly, methods of learning that promoted active participation in group discussions were effective for helping adolescents to feel comfortable participating.

> ***When we came a lot of time, we stopped having nervous feeling or being fearful.***

> ***The session provided knowledge and made the participants became brave because what we said was not right or wrong. They pushed us to talk about what we understood.***

While some sessions were difficult for some to understand, all adolescents said that facilitators willingly explained any points they had questions about.

> ***It was not that difficult. It's just sometimes we did not understand clearly. The facilitators explained us clearly again and again to make it easier for us to understand.***

All adolescent participants said they liked the various methods of learning, but almost no one explained why.

> ***When I felt not good, I didn't have feeling to study. When I wanted to understand, but I felt so tense. When I played some games, I felt better, so I could feel better and laugh. Afterward, I can focus on the training again.***

Caregivers did not identify any particularly difficult sessions or problems in eliciting sufficient explanations from the facilitator. A few said it was difficult to retain the knowledge, such as when it came to applying what had been taught while in a stressful situation.

> ***When we learned, we understood. But sometimes when we're angry, we might forget what we learned. But when we have to advise our children, we remember how to do it again.***

Most caregivers also enjoyed the mixed pedagogical methods used in the sessions.

> ***Lecture and games, for me. So that we can remember more.***

> ***I prefer a mixture of lecture and activities, because it was fun in a way.***

> ***Games help us. Alongside teachers' outstanding lecturing, playing games helps us to quickly understand as well.***

Two participants preferred a more traditional style of learning. The first responses below suggest that some people may feel less sure that they're learning as intended if there is no right and wrong answer.

> ***I like the question and answer. No matter if my answer is wrong, or I am unsure about my answer, when I answer, I will get feedback from the teachers.***

> ***I want to reduce some games. But in case we play, the games should be educational games.***

> ***I don't like any games. But I like studying and reading books ... For me, I don't need the singing and dancing, so I let others do it.***

On the whole, the current approaches seemed to have been well received. It might be beneficial to further explain links between games and content, and increase opportunities to practise new skills to improve participants' learning.

Session logistics

Adolescents worked around their school and household chore schedules such as helping in rice fields, working in the house, or taking care of younger siblings in order to attend approximately two-hour long sessions. Mornings seemed to be a busier time for many.

One adolescent group did not have access to chairs and had to sit on the floor. They also had to use a flip chart lying on the monastery dining floor for writing. These inconveniences were distracting to some.

> ***We're all busy and have a lot to do in the morning. We're free in the afternoon since we take a break then.***

Caregivers also scheduled around work at home, but seemed to be content with the time of day and the approximately two-hour sessions they had experienced.

> ***If the class ends at three, it's fine. But, after three, it may lead to a little bit of complication since I need to prepare meals for my husband and kids. And, during rainy days, we need to take care of our rice crop as well.***

Indeed, several commented that they use the workshop as a break (when it's too hot to work anyway) and return to working in the fields after it is finished.

Another explained that mornings are good times for sessions for people at the markets. Clearly, a facilitator needs to carefully consider who would be included or excluded based on the time of day during which sessions are scheduled. A few mentioned that the facilitator contacted them shortly before to tell them about a scheduled session. This system for scheduling seemed to be acceptable to all caregivers. Some suggested two days' notice would be preferable.

Participants and recruitment

Adolescent participants wanted to see the programme continue. Some adolescents thought the intervention should be continued with more people in the same communes, while others thought the intervention should be implemented in other communes going forward.

A few caregiver participants did not like the lack of consistency among attendees.

> ***The teaching techniques and stuffs were all good, but the problem was that the participants didn't consistently join every session. This disrupted the flow of the sessions.***

One supervisor suggested that participants should be allowed to change with each session. This seemed to emerge out of a concern that sessions had not retained a significant number of participants throughout. However, the session is designed to lead participants through change processes and so the sessions are not suitable for occasional attendance. In addition, a constantly varying group will also mean that group cohesion – necessary to foster trust and support in order to engage in the deeply personal and sensitive topics and to personally transform – will be compromised. It is suggested to rather form a core group of participants and work consistently with the same group throughout the programme and to consider running parallel groups concurrently to reach more community members and have each group establish its own schedule.

When talking with caregivers about ideas for improvement, one broad message is that they would like to see more people around them trained as it will make it easier to implement changes among those who have learned common values.

> ***For me, if the organization will come and teach us again, I want the organization to teach more people in the village, so that we can understand each other, and live together in happiness.***

This suggestion also reflects the perceived limitations of sharing knowledge learned with others. Nearly all did not expect to be able to teach anyone outside their own families.

It was, in part, for a similar reason that a number of participants suggested that more men attend. Indeed, few men participated in the sessions.

Personally, I want to call men, in the age range of thirties to forties to participate and learn. If they would be able to be educated, they will apply; subsequently, our village will be better… Within that range, they tend to use lots of violence; they are quite more impulsive than women. So, we want to involve them in the class so that they can understand.

Previously, when he even had a little drink, because he is not highly educated, he tended to use lots of violence and didn't understand the impact of violence. He only knows his feelings. He tries to use force since he is the head of family that is responsible for earning income. If we educate him, he will understand. The education should be about what is a real man. Even though he is either the head of family or income-provider, he has the obligation and responsibility in managing the family.

For the most part, participants concluded that men were too busy to join the sessions.

Mostly, we women, when coming to decision-making, we rely on our husbands. If he is someone that cannot control his mind properly, the decision may go wrong. However, if he was educated about this properly, the family will be better in making decisions.

He said he's too busy. "You go," he said. Yes, he's really busy. After I come back from each session, he asks, and I just tell him what we've done during that session.

He said we could just join and share the lesson with him. He said he didn't have to join.

Two women participants claimed that their husbands did not feel comfortable coming to a group that was primarily comprised of women and/or older men.

He said coming here to learn with women is embarrassing. He doesn't dare to come.

He said the men here are older than him and that he is still young, so he doesn't dare to come.

While there was a question about establishing separate groups for men or devising themes that might interest them more – like "managing the family", there were no recommendations developed for how men might be better recruited and retained. However, their lesser participation is a significant gap given that they are more likely to perpetrate violence against their families. Including more men might be improved simply by tailoring the session schedule more closely around their availability and perhaps to concentrate sessions during times of year that might require less agricultural labour, freeing up time. In addition, targeted recruitment and mobilization efforts specifically to engage men need to be developed and implemented so more men join the sessions. Some formative research to understand men's needs and motivations may be helpful in designing this strategy.

Facilitators and recruitment

According to reports by adolescents and caregivers, facilitators generally did well in their roles. However, recruitment of capable facilitators was reported as a challenge by some. One supervisor voiced concern with the facilitator recruitment criteria in that there were not enough eligible individuals in the areas selected. It is not clear from the transcript or other study documentation whether the eligible individuals were insufficient or there was not sufficient time allowed to identify them (three visits were reported to select facilitators from five communities). The facilitators were a vital component of the sessions. More resources should be invested in recruiting and mobilizing facilitators, as it can be challenging to find the right people. Working with the issue of violence is emotionally demanding. For an adolescent to attempt to facilitate other adolescents' discussions around these issues would be especially challenging for that individual and might raise ethical concerns. In addition, there has been no research to suggest that peer-to-peer learning is effective with intimate partner violence or violence against women and girls interventions.

One supervisor suggested that the eligibility of each selected facilitator, based on key criteria, should be confirmed with a community leader, i.e. that a community leader should serve as a reference for each facilitator, confirming that that candidate fits the eligibility guidelines. This could be a useful reference for selecting facilitators, among others.

Facilitator training and support

A number of challenges were noted by supervisors and facilitators regarding the training of facilitators and the support they needed afterwards. The training was personally demanding in addition to the skills and knowledge that were to be learned. The facilitator training had three aims: (1) enable transformation among the facilitators, (2) develop their capacity to facilitate participatory community sessions, and (3) build their understanding of the session content, skills and methodologies. To achieve these outcomes, the training was conducted with a participatory, experiential approach that mirrored the kind of approach that facilitators were to use when conducting the sessions.

Training session with facilitators and supervisors. ©PartnersforPrevention

Although this training was conducted over two five-day periods, it was demanding of participants. First, achieving sufficient knowledge comprehension during the facilitator training proved difficult. This was attributed to the intensity of training that involved covering the full curriculum with many new concepts, skills and ideas over two five-day blocks. One participant believed that 10 days was not enough time to properly learn all that was asked of facilitators.

> ***I think 10 days is quick, because there are a lot of lessons. Despite having 10 days, it is a bit difficult for the learners to capture the knowledge. Not only the local community people, but even us as the governmental staff also find that it is a bit fast for us ... for example, there are 22 lessons for the adolescents, and sometimes we need to learn 2 lessons per day, so that means we learn a lot of things at the same time.***

One suggestion was to then make the training longer, such as 12 days. Another suggestion was that the initial training might be further divided into blocks or modules to allow time between trainings for facilitators to more thoroughly take in all that they learned and experienced in the training. This recommendation could also be implemented such that facilitators could be trained on a few sessions, conduct these sessions and then be trained again on the next sessions and so on. The following quote suggests that adolescent and caregiver facilitators should have common training, as was done for these sessions, so that they can take over for one another, if needed:

> ***Let me go back a bit, about sharing the knowledge in the village these days. If three of them are sick, those who need to teach the adults, then the adolescents [facilitator team] would come and help. They have good teamwork. Then, if the adolescents team is sick, the adults [team] would help as well.***

Second, supplemental training and continuous mentoring proved useful for this intervention and should be planned in further iterations of the intervention or scaling up. This ongoing training and support was part of the initial implementation plan, but the Provincial Departments of Women's Affairs could choose how to implement it. In this case, supplemental trainings were held the day before each session to re-teach the material and help each facilitator plan the lesson.

Third, these supplemental trainings responded to facilitators' struggles with understanding the lesson plans well enough to teach them. Supervisors and a facilitator believed that the lesson plans were too complicated. A facilitator requested the following support:

> ***If they want to teach other, they don't need to provide thick books like that. I cannot understand all those documents. If they summarize, we can understand easily. There are so many pages.***

> ***I want them to train me more details and not too fast.***

> ***Lesson 1 and Lesson 2 are too long, they need to summarize. I was new to the lessons so I know nothing.***

Supervisors explained how ad hoc training was developed for each lesson:

> ***[UNFPA] helped with making a shorter lesson plan. After she was done, she would send it to us via e-mail. After that, we used the shorter lesson plan for teaching. They would understand it better when they look at the shorter one.***

> ***[UNFPA] sent them the lessons beforehand. To see them first. She sent them three or four days beforehand. When we trained them before the day, they went to the community, it'd help them to understand clearly.***

Summaries are not the best solution as they would further winnow the scope of knowledge that the facilitators should be competent in to discuss with participants. In this case, these shortened lesson plans were developed by two individuals and it is not known whether or how the lessons were checked for consistency with the training manual. However, the facilitator's feedback and the training solutions that were derived point to a need for planned supplemental trainings to complement the facilitator training as well as continued development of intervention materials and the importance of recruiting community facilitators with strong literacy skills as well as facilitators

who are committed to the preparatory work necessary for each session.

One supervisor recommended that the roles of a multilevel organizing team should be more clearly defined. This suggestion also points to other kinds of support that might be helpful to not only secure an adequate support structure for facilitators, but to strengthen the effectiveness of the intervention, such as capacity-building and mentoring across all levels.

Discussion

Both adolescent and caregiver participants in the study described a number of changes – some with consistent implementation and some in process – in attitudes and practices related to gender equality, communication and conflict resolution, disciplining children, and physical violence against women and children. The findings are summarized below by participant group, followed by implications for the intervention.

Table 4: Summary of adolescent findings Summarized Adolescent Findings

Category	Change
Gender-equitable attitudes and practices	• Boys and girls understood that they have equal rights • Both understood that there are no (inherent) gendered divisions of labour or roles • At least one participant reported a change in household roles • Boys significantly increased gender-equitable attitudes • Girls' gender-equitable attitudes did not change significantly
Communication and conflict resolution	• Increased use of polite words with parents, siblings and friends that resulted in feeling closer to peers. • All respondents attempted to use "I" in their everyday linguistic practice which was considered more respectful • Some reciprocity from polite language used with peers • Improved ownership of their feelings and the confidence to share their experiences that enabled better communication. • Conflict-resolution strategies used to stop an escalating argument with peers • Recognized the value of seeking solutions to disagreements • Mutual agreement in conflict sought to maintain relationships • Reduced use of harsh language with younger siblings
Relationships with caregivers	• More willing to help caregiver or comply with requests • Caregivers reciprocated positive behaviour • Improved relationships with caregivers
Harsh punishment	• Greatly reduced or stopped violent means of resolving conflicts or addressed behaviour with younger siblings • Positive outcomes, included relationship strengthening with younger siblings • Significant decreases in violence acceptance attitudes for girls and boys. • Girls and boys significantly increased their knowledge of support services
Avoiding or dealing with violence	• Learned to identify and use strategies to avoid dangerous situations (i.e. sexual assault) • Girls and boys significantly increased their knowledge of support services
Volunteerism	• Many shared content with peers, parents or younger siblings • 68 percent of girls and 58 percent of boys would definitely feel confident to share what they learned with friends and family • Several positive responses of reciprocal behaviour from parents • More boys (87%, p=.01) and girls (95%, p<.01) indicated that they had been involved in related volunteer activities after the session. One group envisioned carrying out a publicity activity • 48 percent of boys and 57 percent of girls reported that they are definitely going to help planning or organizing volunteer activities in the community related to the session themes

Table 5: Summary of caregiver findings

Category	Change
Gender-equitable attitudes and practices	• Gender-equitable attitudes are transforming • Men and women both understood that they have equal rights • Participants asserted that men and women now share responsibilities (e.g. earning money and household chores such as cooking) • Some men (not in the intervention) who learned about gender equality from partners (who were in the intervention) changed their behaviour • Caregivers' gender-equitable attitudes did not change significantly
Communication and conflict resolution	• Widespread use of polite words, although change was often gradual • Others changed their speech to match the words and style of a participant's speech • Improved ownership of their feelings and the confidence to share their experiences that enabled better communication • Perceived closer relationships with children and partners • Prevention of aggressive talk and reduced potential for conflicts to become violent • Used strategies to stop an argument from escalating • Increased emotional regulation
Relationships with children and discipline	• Learned to encourage children's positive behaviour, to guide them in making good or healthy choices, and to improve communication • Some developed interest in their children • Improved relationships with children
Harsh punishment and physical violence	• Stopped or reduced harsh punishment of children • Some partners who had learned new strategies from participants also shifted to non-violent discipline • One report of ceased alcohol abuse which led to less violence
Avoiding and handling violence	• Some reports of conflict avoidance strategies used to avoid domestic violence (e.g. leaving the home when a husband returned drunk and irritable) • Women increased their knowledge of support services • Developed confidence in phoning the police about violence against women in the community
Volunteerism	• Many participants shared content with partners and children, and reported that partners adopted new positive practices • They believed they could not share content much beyond their own families due to sociocultural factors • Significantly increased involvement of women and men in related volunteer activities • Participants had no plans to initiate any voluntary extension of the sessions • 60 percent of men and 53 percent of women said they would definitely help to plan or organize related volunteer activities

It is very encouraging that so many adolescents and caregivers wanted to and felt able to make changes in their behaviour after learning alternatives (e.g. gender-equitable behaviour, respectful communication, positive discipline and relationship-building) in sessions. The uptake of changes was largely partial; there is still more transformation needed to realize the full adoption of positive social norms and practices, and the elimination of violence against women and girls. This was indicated by individuals' reports of their own challenges with fully implementing changes and also by seeming contradictions among reported understandings about gender equality, for example, or between expressed understandings and putting those understandings into practice. For example, participants could readily assert that women and men have equal rights, but struggled to conceptualize "women" and "men" without using normative roles and binaries. However, the findings show that participants were interested in implementing changed behaviours, felt empowered to do so with strategies learned via the intervention, and accomplished some changes in a relatively short span of time, particularly incremental changes.

The impact of this intervention is more readily visible when examined in light of the theory of change based on the social ecological model which aims to create an environment conducive to behavioural change. The intervention focused on the individual and interpersonal levels.

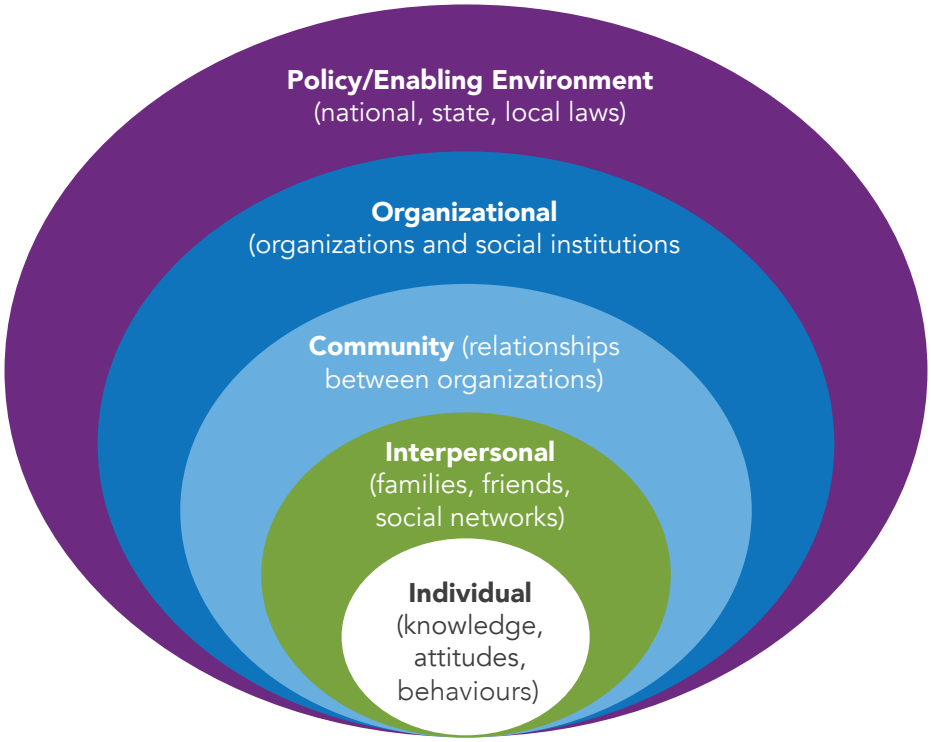


Figure 11: The Social Ecological Model[49]

This intervention focused on engaging adolescents in primary prevention efforts to sustainably change social norms based on the effectiveness of such an approach globally.[50] During early

49 Communication for Development (C4D), UNICEF, MODULE 1: What are the Social Ecological Model (SEM), Communication for Development (C4D)? https://www.unicef.org/cbsc/files/Module_1_SEM-C4D.docx. Accessed 6 January 2018.

50 Amin, A., & Chandra-Mouli, V. 2014. Empowering adolescent girls: developing egalitarian gender norms and relations to end violence. Reproductive Health, 11, 75. http://doi.org/10.1186/1742-4755-11-75.
Blum, R. W., Astone, N. M., Decker, M. R., & Mouli, C. 2014. A conceptual framework for early adolescence: a platform for research. International Journal of Adolescent Medicine and Health, 26(3), 321–331. http://doi.org/10.1515/ijamh-2013-0327.
FULU, E. & KERR-WILSON, A. 2015. What works to prevent violence against women and girls evidence reviews paper 2: In-

adolescence, gender socialization increases, experimentation with intimate or dating relationships begins, and individuals begin to form behaviours, attitudes, and normative understandings that they will build on into adulthood. It is also at this time (between 12 and 14 years old) that a significant percentage of men who rape will do so for the first time, according to the P4P MCS Cambodia findings.[51] Adolescence is then a critical point for interventions that wish to shape equitable and healthy norms, attitudes and behaviours. By engaging both boys and girls, the intervention stood to influence peer norms as well as to build complementary gender-equitable ideals and respectful relationship norms and skills among all members of a group that are likely to have ongoing social contact through school and community activities.

The theory of change for this intervention aimed to address risk factors for violence against women and girls identified in the P4P MCS Cambodia findings among adolescent girls and boys aged 12 to 14 years, a group found critical to changing social norms anywhere. The risk factors addressed by the intervention were:

(1) Gender-inequitable attitudes and problematic constructions of masculinities

(2) Poor anger management and poor emotional regulation (e.g. depressive or anxiety symptoms or outbursts)

(3) Not finishing secondary schooling, leisure boredom (i.e. raping for fun)

(4) Frequent quarrelling with partner or fights with peers

(5) Exposure to harsh punishment

(6) Having poor role models.[52]

Through this intervention, participants were intended to develop gender-equitable attitudes, low levels of violence acceptance attitudes, and become supported by their caregivers and communities. The intervention thus aimed to create communities of shared norms and behaviours as well as to enable adolescents to act as agents of change in their social environments.

Adolescent boys significantly increased their gender-equitable attitudes and all adolescents in focus group discussions had developed some common gender-equitable attitudes. There was also meaningful success reported with adolescents preventing conflicts and resolving conflicts with non-violent means. All had also made meaningful efforts towards reducing, if not stopping harsh punishment of younger siblings. Relationships were also reportedly strengthened across peers, caregivers and siblings.

On the whole, the outcomes of this intervention for adolescents were positive and encouraging, demonstrating the beginning of the transformation necessary to achieve the elimination of violence against women and girls.[53] Participants shared what they had learned with some peers and family members, which allowed for some social diffusion of changed attitudes. Especially encouraging were the reports of others changing their behaviour to match that of participants. In this way, new practices themselves were shared and may have started to be normalized. The focus group discussions did not include any talk that would allow assessment of whether or how "leisure boredom" as a risk factor may have been impacted by the sessions.

terventions to prevention violence against women and girls. Pretoria, South Africa: South African Medical Research Council. MATHEWS, C., EGGERS, S. M., TOWNSEND, L., AARØ, L. E., DE VRIES, P. J., MASON-JONES, A. J., . . . DE VRIES, H. (2016). Effects of PREPARE, a Multi-component, School-Based HIV and Intimate Partner Violence (IPV) Prevention Programme on Adolescent Sexual Risk Behaviour and IPV: Cluster Randomised Controlled Trial. AIDS and behavior, 20(9), 1821-1840. doi:10.1007/s10461-016-1410-1

51 Fulu, E., Warner, X. and Moussavi, S. 2013.

52 Fulu, E., Warner, X. and Moussavi, S. 2013.

53 Since the sample was reportedly comprised largely of average or above average students who were likely to finish high school, there was likely little direct impact by the intervention on the third risk factor listed above.

The intervention also engaged adolescents' caregivers to help to create an enabling environment for targeted adolescent change, the core of a social ecological approach to behaviour change. The intervention aimed to:

(1) Decrease the use of harsh punishment

(2) Increase supportive, positive parenting

(3) Encourage role model of positive behaviour and attitudes

(4) Provide prosocial, constructive opportunities to deflect youth leisure boredom in the community.

Findings from the caregiver groups suggest that components of the intervention directed at caregivers were quite effective. Focus group participants said they reduced or eliminated harsh punishments. They learned strategies for positive parenting and most, if not all, attempted to implement such strategies with their own children or grandchildren. That caregivers actively sought out better strategies for dealing with their adolescents, practised strategies at home with children and/or partners, and shared information learned with partners who did not attend sessions (at least several of whom also attempted to put these strategies into action) demonstrates that they were at least beginning to model more gender-equitable and non-violent attitudes and practices. Further, the reports of a few caregivers who followed the example set by an adolescent participant or vice versa shows the beginning of an enabling environment for changed practices.

A gap in the successful outcomes of this intervention with the caregivers groups was the relative absence of men. A number of (likely women) focus group participants identified this gap. They noted a need for more participation by men because they were perceived to be the most likely population to commit violence.[54] There was some impact of this intervention on men despite their comparatively low participation because of women participants sharing session content and strategies with their husbands, who, in several instances, began trying these new practices. In addition, results of the MCS findings from Cambodia suggest that women hold more gender-inequitable attitudes than men, so these changes among women are important and valuable. However, the creation of a broader enabling environment would certainly happen more swiftly if more men were engaged to a greater degree in the intervention.

Taken together, these outcomes show promise for change in terms of the social ecological model in several ways. First, if reported reductions in harsh punishment – both caregivers punishing children and children punishing younger siblings – continue, not only has an environment been created that is less accepting of violence, but intergenerational cycles of child maltreatment within families will be interrupted. The social benefits of eliminating harsh punishment are also many, including a decreased likelihood of boys perpetrating intimate partner violence in adulthood.[55]

Second, most participants described some form of positive reinforcement from peers or family members for their changed behaviours. They often received remarks that led participants to believe that their behaviour was valued or that the change was deemed valuable by others. Reinforcement is key to creating long-lasting changes.[56] Similarly, participants noted and described a number of

54 However, one 2017 study on corporal punishment found that women were more likely than men to support physical punishment. Nho, C.R. & Seng T. 2017. Predictors of Cambodian parents' perceptions of corporal punishment. Asian Soc Work Pol Rev. 2017; 11: 168–180.

55 Afifi, T.O., Mota, N., Sareen, J. & MacMillan, H.L. 2017. The relationships between harsh physical punishment and child maltreatment in childhood and intimate partner violence in adulthood. BMC Public Health, 17: 493

56 Elder, J. P., Ayala, G. X., & Harris, S. 1991. Theories and intervention approaches to health-behavior change in primary care. American Journal of Preventive Medicine, 17(4), 275-284; Barker, G. 2006. Engaging boys and men to empower girls: reflections from practice and evidence of impact. United Nations Division for the Advancement of Women (DAW) In collaboration

A gap in the successful outcomes of this intervention with the caregivers groups was the relative absence of men ©PartnersforPrevention

positive outcomes as a result of changing their behaviour that likely also served to reinforce the changes. For example, many reported closer relationships with family or peers that they attributed to changes in the way they treated others. Others described a "happy family" as a result of changes in language or conflict resolution.

Third, participants not only reported primarily positive responses from family and peers to their behaviour changes, but sometimes found that others also changed their behaviour. For example, a number of participants noticed that when they used "polite words", others responded similarly. There were also several reports that when participants told their partners about what they had learned, the partners also adopted the new practices. In these ways, participants effectively shaped their own social environments as others followed the models that participants practised, creating environments that might support change to less violence acceptance and more gender-equitable attitudes and behaviours.[57]

Fourth, participants described feeling able to make changes in their behaviour as a result of strategies learned through the intervention. Self-efficacy is one important component of individual level change. Although there remains significant scope for continued transformation, there is

with UNICEF Expert Group Meeting Elimination of all forms of discrimination and violence against the girl child. Florence: UNICEF Inneocenti Research Centre.

57 Marcus, R., & Harper, C. 2014. Gender justice and social norms- processes of change for adolescent girls. Towards a conceptual framework, 2 Overseas Development Institute Research reports and studies. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8831.pdf, accessed 3 December 2017; Raymond, L., Weldon, L., Kelly, D., Arriaga, X. and Clark, A.M. 2013. 'Making Change: Norms and Informal Institutions as Solutions to "Intractable" Global Problems'. First published in Political Research Quarterly, 29 January; Lewis, M. A., McBride, C. M., Pollak, K. I., Puleo, E., Butterfield, R. M., & Emmons, K. M. 2006. Understanding health behaviour change among couples: An interdependence and communal coping approach. Social Science & Medicine, 62(6), 1369-1380.

evidence that self-efficacy to prevent and address violence may have increased for some women and girls as a result of participation in the sessions. Adolescent girls learned a number of strategies to avoid potentially dangerous situations, particularly those that may increase the potential for sexual violence. Several women participants noted that they had successfully removed themselves from potential domestic violence situations in their own homes. A few also described a greater willingness to report violence against women in the community to the police. The possibility of someone phoning the police also became a threat that women believed had led to a decrease in violence against women in their communities.

©PartnersforPrevention

Such changes at the level of the individual, while not wholly transformed, did demonstrate positive incremental change. Although changes in gender attitudes were difficult to assess or illustrated a continued practice of traditional understandings of gender, it is hopeful that all focus group respondents were able to identify stronger gender-equitable attitudes and roles. For example, nearly everyone stated without qualification that women and men were "equal" or had "equal rights". While there is significant scope for increasing gender-equitable attitudes and bringing them into practice more meaningfully and fully, recognizing small improvements is also helpful. Indeed, incremental change is more likely to be successful in the face of resistance to change.[58]

While abstract ideas about gender were more difficult to transform, the reported examples of change illustrate that participants more readily changed (or attempted to change) attitudes or behaviours that were presented as concrete strategies or concepts. Also, many participants used "polite" words in making requests of others, but many also found it difficult to avoid dealing out

58 Marcus, R., & Harper, C. 2014. Gender justice and social norms- processes of change for adolescent girls. Towards a conceptual framework, 2 Overseas Development Institute Research reports and studies. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8831.pdf, accessed 3 December 2017

harsh punishment after that strategy failed to yield the desired outcome. In other words, they could implement a concrete practice, but had not transformed the underlying values enough to be able to improvise when faced with challenges. This observation illustrates that while full transformations are yet to be achieved, participants recognized the value of concrete strategies and put them into practice. Hopefully these incremental changes in the process of transformation will continue, effecting changes in values in the longer term and across the social-ecological spectrum.[59]

As was reflected in both quantitative and qualitative findings, nearly all participants said they enjoyed the sessions and found the content very useful. As further evidence that the intervention content was appropriate and useful, a number of participants put what they learned into practice in their own lives and shared what they learned with others. Key stakeholders from the Ministry of Women's Affairs also believed the programme should continue (with minor changes), another indication that the intervention was locally appropriate.

Participants in both groups generally liked the participatory methodologies used for teaching sessions. While a few participants did not enjoy or perhaps did not recognize the pedagogical value of the "games", most enjoyed such non-traditional learning methods. Several in both groups believed they learned better as a result of the combination of methods including facilitated discussions and experiential learning.

Attending sessions was scheduled around household responsibilities and, for adolescents, also school. When a participant missed a session, it was typically due to a household task or role that conflicted with the session. Everyone felt satisfied with how the schedule was created at each location. Sessions need to be scheduled around daily work patterns and sometimes adjusted according to the subpopulations that the facilitator wished to recruit.

One particularly useful suggestion from caregivers' discussions about ideas for improvement is that they would like to see more people around them trained. This will make it easier to implement changes among those who have learned common values. For this reason, several also wished that their husbands could attend the sessions. Such a strategy is already incorporated in the intervention design – parallel sessions for adolescents and caregivers, but it might be developed further.

Recruiting men for the caregivers groups was a challenge, but the reasons for this are not wholly clear. If the barrier is a lack of time, there might be different ways to schedule the sessions that may enable more men to join. If the barrier is that many or most men do not feel comfortable joining a group dominated by women, delivery of the intervention might need to be more carefully considered. Given the apparent success in some households, it might even be worthwhile to consider a greater role for wives and women partners of men in training them. Further research on specific strategies to engage men in this kind of intervention in the Cambodian context would be beneficial, as well as building on successful strategies to engage men in primary prevention interventions such as the Viet Nam male advocacy intervention,[60] SASA,[61] and a parenting programme in Uganda[62] which all emphasize the multiple benefits for participants of including men in programmes alongside women.

---

59 Munoz Boudet, A.M., Petesch, P. and Turk, C., with Thumala, A. 2012. On Norms and Agency. Conversations about Gender Equality with Women and Men in 20 Countries. Washington, DC: World Ban

60 Nguyen, H.T., Tran, P.K., Gevers, A. & Taylor, K. 2017. A Qualitative Endline Study of a Male Advocate Intervention to Prevent Violence against Women and Girls in Da Nang, Viet Nam. Available from: http://partners4prevention.org/resource.

61 Raising Voices 2015. Stronger together: Engaging both women and men in SASA! to prevent violence against women. Learning From Practice Series, No. 4: Research Perspectives. Kampala, Uganda: Raising Voices.

62 Siu, G.E., Wight, D., Seeley, J., Nametubi, C., Sekiwunga, R., Zalwango, F. & Kasule, S. 2017. Men's Involvement in a Parenting Programme to Reduce Child Maltreatment and Gender-Based Violence: Formative Evaluation in Uganda. The European Journal of Development Research: 1–21.

Although participants thought the facilitators performed their roles well, both facilitators and supervisors recognized the need for further support and training. It may be that the training simply tried to teach too much too quickly or that the ongoing support and mentoring needs must be prioritized and formally integrated into the implementation plan. Facilitators may feel challenged by the material and their ability to teach it simply because the content is new to them. But they may also require substantial changes in their own understandings in order to really comprehend and then facilitate discussions and learning activities in this new area. Such processes certainly need time and perhaps further support for their transformational processes.

Table 6: Implications for intervention

Findings	Implications for intervention
Nearly all participants enjoyed and found the content very useful, but men were difficult to engage.	• Determine men's concerns and motivations for this type of intervention and design strategies to address these. • Use a strong benefits-based framework for the intervention to encourage men to participate. • Investigate whether there are times and locations better suited for men to participate. • Consider other means of recruiting or providing for men that might increase their comfort with attending.
Focus group discussions about the session on "real women and real men" elicited lists of untransformed gender attitudes and confused at least one facilitator.	• The gender modules should be redesigned to better achieve learning aims. • Strengthen support for facilitators as they also transform their gender-equitable attitudes.
Methods of learning that focused on discussion were effective for helping adolescents to feel comfortable participating.	• Continue to emphasize open discussion and dialogue in sessions.
Most caregivers enjoyed the participatory methods (discussions, games, role plays) used in the sessions and believed they enhanced learning.	• To clarify the value of the "games", ask participants to discuss what they have learned. • Continue to build facilitators' skills in participatory methods.
Caregivers would like to see more people around them trained.	• Consider expansion or scale-up plans that include multiple rounds of intervention implementation within a community to reach a critical mass of people. • Consider whether and how diffusion of knowledge outside of families might be further supported and promoted. • Consider volunteerism efforts to help drive expansion and scale-up within communities.
Good facilitators were difficult to identify.	• **Allow sufficient time in planning for recruitment of facilitators.** • **Invest in good capacity-building and ongoing training, support and mentoring of facilitators throughout the implementation period.**

The training of facilitators did not result in sufficient knowledge comprehension or ease with teaching content.	• **The initial training might be lengthened or divided into sections to allow time for improved comprehension and personal transformation.** • **Ongoing training and support for facilitators is necessary throughout implementation.** • **Develop a structured process for considering and designing any content changes (e.g. shortened lessons) to ensure accuracy and consistency of lessons**

Conclusion

The *Shaping our Future: Developing Healthy and Happy Relationships* intervention aimed to sustainably promote changes in social norms among adolescents within an enabling environment to address local, modifiable risk factors for men's use of violence against women and girls. Using participatory methodology, the intervention worked with groups of adolescents and caregivers over a period of 12 months to build skills and knowledge to enable adolescents to develop healthy, non-violent interpersonal relationships and gender-equitable attitudes and behaviours with the support of influential people in their lives.

The intervention showed the strongest impacts in initiating transformation with regard to boys' gender-equitable attitudes; strengthening communication and conflict resolution skills among girls, boys, men and women; and closer relationships among family members. There were also encouraging reductions reported in harsh punishment by both adolescents and caregivers towards younger siblings and those being cared for, as well as increased emotional self-regulation.

The impact on behaviour change was very encouraging in regards to breaking down gendered divisions of household labour in practice, which may also imply increased gender-equitable attitudes. A number of caregivers and one adolescent reported that men had taken on some tasks of traditional "women's work" after learning about particular lessons from the intervention. A lot of information sharing was reported by participants; this had a ripple effect with the intervention's impact. Participants reported observed changed approaches to communication, conflict resolution and discipline among family members, particularly husbands, who had only heard about the intervention's discussions, ideas, games and skills via a participant.

Challenges remain in achieving transformations in social norms across all levels of the social ecology. Most visible were remaining inequitable gender attitudes. While some part of these findings may result from an inadequate session on gender, there are indications from the qualitative results that these attitudes are so ingrained in participants' worldviews that they are very slow and difficult to change.

Due to constraints with the study design, changes could not be wholly measured or conclusively attributed to the intervention. However, there are many hopeful trends in the findings that suggest the intervention likely had important impacts on the targeted attitudes and behaviours among direct beneficiaries as well as among their families and peers. Indeed, participants often described changes they implemented as trying behaviours they had learned in sessions.

Lessons learned from this intervention will also prove helpful for future planning for this intervention or for its scale-up. In particular, experiences with training facilitators suggest further training and support would be useful. The limited number of participants who were men in the sessions also points to a need to more carefully plan for their inclusion to ensure a wider base of common norms are developed. Overall, this intervention was effectively implemented and generated promising results and can be used as a basis for expanding the intervention to benefit more families and communities in Cambodia for the ultimate elimination of violence against women and girls.

Appendices

Appendix 1: Baseline and endline descriptives for adolescents

Table 7

	Boys		Girls	
	Baseline N=42	Endline N=31	Baseline N=10	Endline N=100
Age	M=13.7 SD=1.35	M=13.6 SD=1.52	M=13.9 SD=1.27	M=14.1 SD=1.46
Attend School	100%	94%	96%	92%
Grade in school	M=7.2 SD=1.51	M=7.1 SD=1.71	M=7.3 SD=1.27	M=7.5 SD=1.72
Ever repeated a year of school	73%	16%	87%	14%
Said they did below average in school	12%	13%	2%	1%
Said probably or definitely will not finish high school	10%	7%	10%	12%
Member of any clubs or community groups	29%	81%	22%	81%
Have girlfriend or boyfriend	0%	3%	6%	5%
Live with mother	79%	84%	85%	84%
Live with father	78%	71%	72%	82%
Other adults than parents who are caregivers	62%	77%	70%	76%
# adults in the house	M=3.1 SD=1.17	M=3.0 SD=1.81	M=3.2 SD=1.56	M=3.1 SD=1.37
# other children in the house	M=2.5 SD=1.95	M=2.7 SD=1.46	M=2.3 SD=1.03	M=2.5 SD=1.21
Not enough food				
• 2-7 days a week	12%	7%	8%	5%
• Seldom, one day a week	12%	10%	11%	14%
• Never	76%	84%	81%	81%
Transportation difficulties getting to school				

• never	58%	52%	45%	51%
• rarely	7%	7%	18%	14%
• sometimes	21%	36%	32%	30%
• often	12%	7%	5%	5%
Involved in any community activism?	52%	87%	40%	95%
How easy was questionnaire?				
Very easy or easy to understand	86%	90%	94%	97%
How honest were you in answering?				
Completely or very honest	93%	97%	96%	98%
How do you feel about answering the questions				
• Fine	93%	77%	75%	84%
• Painful but happy to answer	33%	13%	24%	15%
• Painful and I wish I had not done it	0%	10%	1%	1%

Table 8. Endline descriptives for adolescents

	Boy	Girl
Attended sessions/workshops		
1-4	10%	6%
5-9	13%	9%
10–12	10%	11%
13–16	32%	12%
17–20	19%	35%
All	16%	27%
How much did you enjoy the sessions?		
Not at all	7%	3%
A little	0%	4%
Most of it/a lot	93%	93%
How useful was the workshop?		
Not useful/waste of time	3%	1%
Quite useful/very useful	97%	99%
Felt comfortable to share experiences in workshop?		
Definitely no	3%	5%
Not really	0%	4%
Some/most of the time	29%	34%
Definitely yes	68%	57%
Topics clearly explained?		
Definitely no/not really	0%	7%
Some/most of the time	39%	31%
Definitely yes	58%	62%
Confident to share learnings with friends/family?		
Definitely no/not really	10%	3%
Probably yes	29%	29%
Definitely yes	58%	68%

Table 9. Baseline and endline descriptives for caregivers

	Women		Girls	
	Baseline N=116	Endline N=107	Baseline N= 24	Endline N=20
Age	M=45.3 SD=10.63	M=49.5 SD=10.26	M=48.1 SD=13.74	M=49.3 SD=14.85
Finish High School	3%	15%	17%	21%
Highest grade completed in school	N=24	Endline	M=7.3 SD=1.27	M=7.5 SD=1.72
What role fill as caregiver (%s do not add)				
Parent	78%	65%	88%	90%
Close relative	35%	37%	38%	10%
Other relative	8%	7%	13%	5%
School staff	7%	0%	4%	0%
Health care staff	2%	0%	4%	0%
Community leader	2%	1%	8%	0%
# Adults in the house	M=3.1 SD=1.15	M=3.0 S D=1.34	M=3.3 SD=1.33	M=4.2 SD=1.46
# children in the house	M=1.6 SD=1.06	M=1.59 SD=1.16	M=1.7 SD=1.23	M=2.2 SD=1.82
Not enough food				
• 2-7 days a week	33%	33%	25%	30%
• Seldom, one day a week	13%	23%	8%	15%
• Never	53%	44%	67%	55%
Have worked, earned money in 12 months	83%	88%	83%	70%
Transportation difficulties getting to school				
• Never worked	5%	7%	0%	15%
• Once in a while	11%	13%	17%	5%
• Seasonally	52%	56%	33%	45%
• Throughout year	32%	24%	50%	35%
Involved in any community activities?	61%	96%	75%	100%
Involved in any volunteer activities focused on equality etc?	67%	97%	67%	100%

How easy was questionnaire?				
Very easy or easy to understand	70%	73%	58%	80%
How honest were you in answering?				
Completely or very honest	88%	95%	96%	95%
How do you feel about answering the questions				
Fine	56%	61%	63%	75%
Painful but happy to answer	38%	37%	33%	20%
Painful and I wish I had not done it	6%	2%	4%	5%

Table 10. Endline descriptives for caregivers

	Women N=107	Men N=20
Attended sessions/workshops		
1–2	4%	0%
3-4	17%	15%
5-6	8%	15%
7-8	13%	20%
9–10	33%	20%
11–12	25%	30%
How much did you enjoy the sessions?		
not at all	0%	0%
A little	3%	0%
Most of it/a lot	96%	95%
Did not attend sessions	1%	5%
How useful was the workshop?		
Not useful/waste of time	0%	0%
A little/quite useful	16%	15%
very useful	84%	80%
Did not attend sessions	0%	5%
Felt comfortable to share experiences in workshop?		
Definitely no	3%	5%

Not really	6%	0%
Some/most of the time	32%	20%
Definitely yes	60%	70%
Did not attend sessions	0%	1%
Topics clearly explained?		
Definitely no/not really	2%	5%
Some/most of the time	40%	25%
Definitely yes	48%	65%
Did not attend sessions	0%	5%
Confident to share learnings with friends/ family?		
Definitely no/not really	10%	10%
Probably yes	40%	25%
Definitely yes	49%	65%
Did not attend sessions	1%	0%

Appendix 2 - Qualitative inquiry guide (intervention participants, facilitators and supervisors)

Aim: to summarise the skills and ideas learned during the community sessions and how they will influence participants' future choices, attitudes, and behaviour.

Description: Participants will brainstorm and share what they have learned during the community sessions.

Process:

1. Explain that we have arrived at the end of our community sessions and we need feedback from participants to understand their true feelings and experiences in the community sessions – the good and the bad.

You have had an experience together as a group through many discussions and activities. These group meetings are only the start of the changes YOU have all talked about such as strengthening our relationships, families, and communities in peaceful ways.

Let us take some time to reflect together on what we have experienced, what challenged us, what we gained, and ways in which we think these community sessions can be improved in the future. We want to hear from you about what you found helpful or good and unhelpful or bad about the intervention's community sessions. We will use this information to improve the community sessions and make recommendations about whether it should be used further. It is best if you speak openly and freely – please share both positive and negative things, whatever is true for you and your experience. You have the most important opinions so do not worry about pleasing me with your reports.

<TNS WILL PLAY AN ENERGISING GAME WITH PARTICIPANTS IF NEEDED>

2. Discuss the following topics:

THEME 1: YOUR FEELINGS ABOUT PARTICIPATING IN THE COMMUNITY SESSIONS

a. Why did you decide to come to the community sessions in the first place?

b. Why did you keep attending several community sessions?

c. How did you feel while participating in the community sessions?

[probe]: what makes you feel so? Please describe…

d. What did you like about the community sessions?

[probe]:

- Specific things that they like about the community sessions (i.e. topics/content, participatory approach, volunteerism, locations, time, environment/atmosphere, etc.)

- What makes them like it?

e. What did you not like about the community sessions?

[probe]:

- Specific things that they do not like about the community sessions (i.e. topics/content, participatory approach, volunteerism, locations, time, environment/atmosphere, etc.)

- What makes them dislike it?

THEME 2: YOUR REFLECTIONS ON THE CONTENT AND METHODOLOGIES OF THE COMMUNITY SESSIONSS (WHAT YOU LEARNED)

f. What do you remember most from the community sessions?

[probe]:

- to get the specific things (i.e. module or session, process, approach, social group support etc.)

g. What was new or surprising to you during the community sessions?

[probe]:

- What makes you say so?

h. What was the most challenging thing about the community sessions?

PROBE: What was difficult to understand? Did anything make you uncomfortable or scared or nervous? Were there any challenges that were positive?

i. What was the best or most exciting or inspiring thing about the community sessions?

THEME 3: CHANGES THAT YOU OR OTHERS HAVE EXPERIENCED BECAUSE OF YOUR PARTICIPATION IN THE COMMUNITY SESSIONS

j. Has anything within you or in your own life changed because of your experience in the community sessions? Can you share what has changed and how? [please describe…]

[probe]:

- Changes in ideas or attitudes about gender (how to be a man and how to be a woman; how you raise girls and boys)
- The changes on relationships with partners and others
- Ideas and attitudes changes regarding violence /abuse/maltreatment on girls and women
- Changes on conflict resolution
- Changes on discipline or being supportive
- Changes in terms of getting involved in volunteering activities

k. Have you learned new things or tried new things because of these community sessions – please describe? Do you think you will keep implementing these changes in your life in the future – why or why not?

l. How did you learn these new things?

PROBE: Was the methodology of the community sessions different from teaching or other workshops – how? What was the best way for you to learn these things? Is there a better way to learn new things?

m. Have you noticed any changes among your friends or family, or in your community since these community sessions began? Can you please describe these changes? What were reactions of people

who did not participate in the community sessions?

[probe]:

- Negative things or backlash from friends, family and community after their changes
- Positive things from their friends, family and community after their changes

THEME 4: VOLUNTEERISM

n. Have you, your family, friends or neighbours engaged in any volunteer activities in your community to make it a safer and happier place for everyone? What did you do?

[probe]:

- Specific activities they have been doing? As individual or group?

- How was the experience? Please share…

o. Have you experienced any benefits for yourself from doing this activity? (Please describe them).

p. How do you think this activity helped others?

q. Do you plan to be involved in future volunteer activities – in what way, where, what activities?

THEME 5: RECOMMENDATIONS FOR STRENGTHENING THE COMMUNITY SESSIONS

r. How can these community sessions be improved in the future? [Please elaborate…]

s. Do you think other communities should have the opportunity to do these community sessions? Why do you think the other communities should have this opportunity?

(If the discussion was done in small groups, ask each small group to share their points with the rest of the participants and the project staff member can record the responses only with their permission).

BACK UP ACTIVITY (to be used only if the group does not talk at all):

Ask participants to work together on a creative piece that communicates their thoughts and feelings about the community sessions and/or how they will take some of the important ideas and experiences of the community sessions forward. Participants may want to draw a picture or come up with a role play or a song – allow them to be creative and expressive. The project staff member can record these expressions as best possible and only with participants' permission.

Qualitative inquiry guide for facilitators – endline only

Aim: to understand facilitators' perspectives of the intervention.

Description: Participants will brainstorm and share what they have learned during the community sessions. Facilitators include 3 caregiver and 3 adolescent facilitators per commune.

Process for Facilitators and Supervisors:

1. Explain: A project called *Shaping our Future: Developing Healthy and Happy Relationships* has been going on in your community for quite some time. Now is your opportunity to share your views on the community sessions in order to strengthen it.

   Let us take some time to reflect together on what we have experienced, what challenged us, what we gained, and ways in which we think the community sessions can be improved in the future. We want to hear from you about what you found helpful or good and unhelpful or bad about the community sessions. We will use this information to improve the community sessions and make recommendations about whether it should be used further. It is best if you speak openly and freely – please share both positive and negative things, whatever is true for you and your experience. You have the most important opinions so do not worry about pleasing me with your reports.

<TNS TO INCLUDE ENERGISING GAME IF NECESSARY>

2. Topics for discussion

THEME 1: YOUR OVERALL FEELINGS ABOUT THE COMMUNITY SESSIONSS

a. Why did you want to be part of the *Shaping our Future: Developing Healthy and Happy Relationships* community sessions?

THEME 2: TRAINING AND PREPARATION, AND EXPERIENCE OF FACILITATION

b. Do you think you were adequately prepared for doing the facilitation work for these community sessions? How? Why/why not? What was the most helpful thing in training (or support from supervisors) that supported you to develop your skills and implement the community sessions successfully? [Please elaborate…]

c. How could the training be improved? How could the supervisor's support be improved?

   [Probe]:

   - Specific area of improvement (i.e. duration of preparation, documents, skills etc.)

d. Did you have any concerns about facilitating the community sessions?

   PROBE: What were you most concerned about before or during the community sessions?

e. What was it like to facilitate sessions? What helped you to facilitate well and what were the obstacles to facilitating well? [Please describe…]

THEME 3: CHANGES THAT YOU OR OTHERS HAVE EXPERIENCED BECAUSE OF THE COMMUNITY SESSIONS

f. What changes have you experienced or what have you learned during your time of being a facilitator of these community sessions? [Please describe the changes…]

g. How have others in your life (e.g., family, friends, neighbours) reacted to your role as facilitator of the community sessions?

   [Probe]:

   – positive and negative reaction toward their roles.

h. What changes have you seen in your community because of the community sessions?

i. THEME 4: REFLECTIONS ON THE CONTENT AND METHODOLOGIES OF THE COMMUNITY SESSIONS

j. What was surprising or very new about the community sessions in your community?

k. What was good or helpful or valuable about the community sessions?

l. What was challenging or problematic about the community sessions? Do you have any concerns about the community sessions – what are they? [Please share your experience…]

m. What do you think is the most important idea or skill that these community sessions are trying to promote? (e.g., most important module/session for adolescents and for caregivers)

n. What session was most interesting for participants (adolescents and caregivers) and which was most challenging (and why so?)?

THEME 5: RECOMMENDATIONS FOR STRENGTHENING AND EXPANDING THE COMMUNITY SESSIONS IN THE FUTURE

o. Do you think other communities would benefit from these community sessions – why or why not? How might they benefit?

p. How do you think the community sessions could be improved/what should be changed to make it better?

q. Do you have any plans to use what you have done or learned in the community sessions in the future? Please describe this.

r. In your views and experience, what do other communities or organisations need (or need to do or receive) in order to implement these community sessions successfully?

THEME 6: VOLUNTEERISM

s. What kinds of volunteer community activism or community service about VAWG issues did participants in your groups/communities engage in? How were you involved in these activities? What benefits or changes did you see because of these activities? Do you think you will be involved in future volunteer activities of this sort – why or why not?

Qualitative inquiry guide for supervisors – endline only

Aim: to understand supervisors' perspectives of the intervention.

Description: Participants will brainstorm and share what they have learned during the community sessions. Supervisors include 2 PDOWA staff and 5 CCWC/Commune Focal Point people.

Process for Facilitators and Supervisors:

1. Explain: A project called *Shaping our Future: Developing Healthy and Happy Relationships* has been going on in your community for quite some time. Now is your opportunity to share your views on the community sessions in order to strengthen it.

   Let us take some time to reflect together on what we have experienced, what challenged us, what we gained, and ways in which we think the community sessions can be improved in the future. We want to hear from you about what you found helpful or good and unhelpful or bad about the community sessions. We will use this information to improve the community sessions and make recommendations about whether it should be used further. It is best if you speak openly and freely – please share both positive and negative things, whatever is true for you and your experience. You have the most important opinions so do not worry about pleasing me with your reports.

<TNS TO INCLUDE ENERGISING GAME IF NECESSARY>

2. Topics for discussion

THEME 1: YOUR OVERALL FEELINGS ABOUT THE COMMUNITY SESSIONSS

a. Why did you want to be part of the *Shaping our Future: Developing Healthy and Happy Relationships* community sessions?

THEME 2: TRAINING AND PREPARATION, AND EXPERIENCE OF SUPERVISION

b. Do you think you were adequately prepared for doing the supervision work for the community sessions? How? Why/why not? What was the most helpful thing in training that supported you to develop your skills and supervise the successful implementation of the community sessions? [Please elaborate…]

   How could the training be improved? [Probe]:

   - Specific area of improvement (i.e. duration of preparation, documents, skills etc.)

c. Did you have any concerns about supervising and supporting the facilitators of the community sessions?

   PROBE: What were you most concerned about before or during the community sessions?

d. What was it like to supervise facilitators? What helped you to supervise and support well and what were the obstacles to doing supervision and support well? [Please share your experience with us…]

THEME 3: CHANGES THAT YOU OR OTHERS HAVE EXPERIENCED BECAUSE OF THE COMMUNITY SESSIONS

e. What changes have you experienced or what have you learned during your time of being a supervisor of these community sessions?

f. How have others in your life (e.g., family, friends, neighbours) reacted to your role as supervisor of the community sessions?

[Probe]:

– Positive and negative reaction toward their roles.

g. What changes have you seen in your community because of the community sessions? [Please describe in more details..]

THEME 4: REFLECTIONS ON THE CONTENT AND METHODOLOGIES OF THE COMMUNITY SESSIONS

h. What was surprising or very new about the community sessions in your community?

i. What was good or helpful or valuable about the community sessions?

j. What was challenging or problematic about the community sessions? Do you have any concerns about the community sessions – what are they? [please share more about your experience…]

[Probe:]

- How did you solve or overcome the challenge or problematic about the community sessions?

k. What do you think is the most important idea or skill that these community sessions are trying to promote? (e.g., most important module/session for adolescents and for caregivers)

l. What session was most interesting for facilitators or participants (adolescents and caregivers) and which was most challenging (and why so?)?

THEME 5: RECOMMENDATIONS FOR STRENGTHENING AND EXPANDING THE COMMUNITY SESSIONS IN THE FUTURE

m. Do you think other communities would benefit from these community sessions – why or why not? How might they benefit?

n. How do you think the community sessions could be improved/what should be changed to make it better?

o. Do you have any plans to use what you have done or learned in the community sessions in the future? Please describe this.

p. In your views and experience, what do other communities or organisations need (or need to do or receive) in order to implement these community sessions successfully?

THEME 6: VOLUNTEERISM

q. What kinds of volunteer community activism or community service about VAWG issues did participants in your groups/communities engage in? How were you involved in these activities? What benefits or changes did you see because of these activities? Do you think you will be involved in future volunteer activities of this sort – why or why not?

Appendix 3 - Information and consent forms (intervention participants, facilitators and supervisors)

ADOLESCENT INFORMATION AND ASSENT FOR BASELINE AND ENDLINE QUESTIONNAIRE AND PARTICIPATORY FEEDBACK SESSION

Dear Participant,

You are invited to participate in a project called Evaluation of *Shaping our Future: Developing Healthy and Happy Relationships* intervention. This project is being conducted by Partners for Prevention (P4P) in collaboration with Ministry of Women's Affairs, UNFPA, and UN Women in Kampong Cham province, Cambodia. The project is linked to the workshops that you will participate in, with your parent/caregiver's and your agreement. The evaluation project will help us to understand what impact the workshops have on those who participate.

We are now inviting you to participate in evaluation activities including: (1) a baseline and endline questionnaire, and (2) a participatory, group feedback session. This information leaflet will help you to decide if you are willing to participate in these activities. We are inviting ALL adolescents in the workshops to be part of these questionnaires and feedback sessions. We hope as many people as possible who were in the intervention workshops will also participate in these activities so that we can know whether the workshops are helpful, interesting, and enjoyable for young people.

The purpose of the questionnaire and feedback session is to understand what people think and how they experience *Shaping our Future: Developing Healthy and Happy Relationships* workshops so that we can know how to improve the workshops and see whether other people in other areas could benefit from them.

Participation in the questionnaires and feedback session will be on a voluntary basis - this means that no one is forced to participate and people can participate in the workshops without participating in any of the evaluation activities.

If you have any questions that this leaflet does not fully explain, please do not hesitate to ask.

What are the project activities?

Because you have expressed interest in taking part in the *Shaping our Future: Developing Healthy and Happy Relationships* workshops, we would like to ask you if you would be willing to take part in (1) the questionnaire at baseline (before the beginning of the workshops) and endline (at the end of the workshops), and (2) a participatory group feedback session (after the last workshop).

The questionnaire will take about 1,5 hours to complete and will include multiple choice questions exploring your experiences and challenges with being adolescent, your attitudes and opinions,

communication and conflict resolution with a boyfriend/girlfriend/best friend, and some aspects of your relationship with your parent(s) or caregiver. The baseline questionnaire is conducted once before the workshop sessions begin and the same questionnaire is used at endline after the last workshop session.

The participatory group feedback session will last about 2 hours and will give you (together with the others in the workshop group) an opportunity to share your thoughts, experiences, and ideas about what the workshop was like for you and how it has impacted on you. This feedback session will only occur once – after the last workshop session.

How will the evaluation project be beneficial?

The project will generate important knowledge on the impact of the workshops for adolescents and caregivers. We hope that you will benefit from the workshop sessions as you have discussed when you were invited to the workshop. We do not know yet exactly how young people may benefit from the intervention workshop sessions so your feedback will be very helpful for us to understand that.

Will anyone know what answers I give in the questionnaire or the group feedback session?

NO. Your name will not appear anywhere on the questionnaire so it will be impossible to know what any individual answers on it. No one but the project staff will be aware of your responses in the participatory group feedback session and the report from the feedback session will not include any participant's name. The findings of the evaluation project will be reported with that of all participants' answers combined; therefore your information will **NOT** be identifiable. You can feel free to be completely open and honest in your answers because no one will know what you answer and it is most helpful for us to understand young people's experiences and needs if we get true information.

What are the risks?

We do not anticipate any serious risks for you. However, there is a chance that you may feel emotional during the questionnaire. If this occurs, you will be able to talk with the project staff member who is in the room either during or after the questionnaire session. In addition, you can talk to a workshop facilitator because the workshops are linked with this evaluation project. Further, all evaluation project participants and all workshop participants will receive a list of places where people can go for help with different kinds of problems.

Do I have to participate?

No. Taking part in this study is completely voluntary. If you do not take part in the study, there will be no negative consequences. You may stop participating in the questionnaire or group feedback session at any stage. You do not have to answer the questionnaire in order to participate in the workshops. You can choose to answer only a few of the questions, or none at all. The questionnaire is entirely voluntary.

What about the results of the evaluation project?

No information will be given to anyone about any individual's involvement with any activities related to the evaluation project. The project staff will share the overall results of the evaluation project and this information will be shared with people, organisations, and government departments who are interested in helping young people.

Costs

There is no cost to you for participating in this study other than the time to complete the baseline and end line questionnaires (approximately 1,5 hours each) and/or the group feedback session (approximately 2 hours).

Compensation

You will not be financially compensated for the time spent in the baseline or end line survey or feedback session. Light refreshments will be provided during the discussion activities.

Endorsement

We have received endorsement from the Ministry of Women's Affair to conduct this project. If you have any questions about the study or something that you are not happy about, please feel free to contact:

H.E. Nhean Sochetra,

General Director of Social Development

Ministry of Women's Affairs

Tel: 012 758 986

Or

Sokroeun Aing

Gender Analyst

UNFPA Cambodia Country Office

Phnom Penh Center, Room 526 – North building (5th floor).

Tel : +85523215519/216295 ext. 118

Fax : +85523211339

Mobile : +855 12 575 161

aing@unfpa.org

Has this study received ethical approval?

The project has been ethically approved by the National Ethics Committee for Health Research of the Ministry of Health. (2nd May 2016)

Who can I ask if I have questions about the study?

If you have any questions about the project, please ask one of the project staff or contact one of the people noted above.

INFORMED ASSENT FORM

I hereby confirm that the person seeking my informed assent (agreement) to participate in this evaluation project has given me information to my satisfaction. She or he explained to me the purpose, procedures involved, risk and benefits and my rights. I have received the information leaflet for the evaluation project and have had enough time to understand it and ask questions if I wanted to. I feel that my questions regarding participation in the evaluation project have been answered to my satisfaction. I have been told that the information I give to the evaluation project will, together with other information gathered from other people, be anonymously processed into a report.

I am aware that it is my right to withdraw my assent in this evaluation project without any negative consequences. I hereby, freely and voluntary give my assent (agreement) to participate in the evaluation project.

Please place an X in the box to give assent (agreement) for each activity that you are willing to participate in	
	I agree to participate in the questionnaire at baseline and end line.
	I agree to participate in the group feedback activity at the end of the work-shops.

[Note: If the participant cannot read and write, an independent witness to the assent process will participate in the assent process to ensure the participant has fully understood the purpose of the evaluation project, including signing and filling the assent form on behalf of the participant.]

Participant name……..(Please print)

Participant signature……Date……

Staff name…….(Please print)

Staff signature……..Date……

Witness name……...(Please print)

Witness signature……Date……

Contact telephone: ……..

Evaluation of the *Shaping our Future*: ***Developing Healthy and Happy Relationships*** intervention in Cambodia

PARENTAL CONSENT FOR ADOLESCENT PARTICIPATION IN BASELINE AND ENDLINE QUESTIONNAIRE AND IN A PARTICIPATORY FEEDBACK SESSION

Dear Parent/Legal guardian,

Your child has been invited to participate in a project called Evaluation of the *Shaping our Future: Developing Healthy and Happy Relationships intervention in Cambodia.* This project is being conducted by Partners for Prevention (P4P) in collaboration with Ministry of Women's Affairs, UNFPA, and UN Women in Kampong Cham province, Cambodia. The project is linked to the workshops that your child will participate in, with your agreement. The evaluation project will help us to understand what impact the workshops have on those who participate.

We are now seeking your permission for your child to participate in evaluation activities, including: (1) a baseline and end line questionnaire, and (2) a participatory group feedback session. We are inviting ALL adolescents in the workshops to be part of these questionnaires and feedback sessions. We hope as many people as possible who were in the intervention workshops will also participate in these activities so that we can know whether the workshops are helpful, interesting, and enjoyable for young people.

The purpose of the questionnaire and feedback session is to understand what people think and how they experience *Shaping our Future: Developing Healthy and Happy Relationships* workshops so that we can know how to improve the workshops and see whether other people in other areas could benefit from them.

This information leaflet will help you to decide if you are willing for your child to participate in one or both of the evaluation activities. All adolescents participating in the workshops will be invited to participate in the questionnaires and feedback session on a voluntary basis – this means that no one is forced to participate and people can participate in the workshops without participating in any of the evaluation activities.

If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the project staff.

What are the evaluation project activities?

We seek your permission to invite your child to participate in (1) a baseline questionnaire and end line questionnaire and (2) a participatory feedback session.

The questionnaire will take about 1,5 hours to complete and will include multiple choice questions exploring your child's experiences and challenges with being adolescent, their attitudes and opinions, communication and conflict resolution with a boyfriend/girlfriend/best friend, and some aspects of their relationship with their parent(s) or caregiver. The baseline questionnaire is conducted once before the workshop sessions begin and the same questionnaire is used at endline after the last workshop session.

The participatory group feedback session will last about 2 hours and will give your child (together with the others in the workshop group) an opportunity to share their thoughts, experiences, and ideas about what the workshop was like for them and how it has impacted on them. This feedback session will only occur once – after the last workshop session.

Your child will be asked to give agreement for these activities. He or she can decline. Even if you and your child agree to participation in either or both of the evaluation activities, your child can still choose not to answer some of the questions for any reason or stop at any time.

How will the evaluation project be beneficial?

The project will generate important knowledge on the impact of the workshops for adolescents and caregivers. We hope that your child will benefit from the workshop sessions as you have discussed when your child was invited to the workshop. We do not know yet exactly how young people may benefit from the intervention workshop sessions so their feedback will be very helpful for us to understand that.

Will anyone know what my child answered in interviews?

No, his or her responses will be kept strictly confidential and his or her name will not appear anywhere on the questionnaire or the feedback session reports. Only the research staff will see the answers on the questionnaire or feedback in the reports. The findings of the evaluation project will be reported with that of all participants' answers combined; therefore your son/daughter's information will **NOT** be identifiable.

What are the risks?

We do not anticipate any serious risks for your child. However, there is a chance that he/she may feel emotional during the questionnaire. If this occurs, he/she will be able to talk with the project staff member who is in the room either during or after the questionnaire. In addition, he or she can talk to a workshop facilitator because the workshops are linked with this evaluation project. Further, all evaluation project participants and all workshop participants will receive a list of places where people can go for help with different kinds of problems.

Does my child have to participate?

No. Taking part in this study is completely voluntary. If your child does not take part in the evaluation project, there will be no negative consequences. Your child may stop participating in the questionnaire or feedback session at any stage. Your child does not have to answer the questionnaire in order to

participate in the workshops. Your child can choose to answer only a few of the questions, or none at all. The questionnaire is entirely voluntary.

What about the results of the evaluation project?

No information will be given to anyone about any individual child's involvement with any activities related to the evaluation project. The project staff will report the overall results of the evaluation project and this information will be shared with people, organisations, and government departments who are interested in helping young people.

Costs

There is no cost for your child participating in this study other than the time to complete the baseline and end line questionnaires (approximately 1,5 hours each) and/or the group feedback session (approximately 2 hours).

Compensation

Your child will not be financially compensated for the time spent in the baseline or end line survey or feedback session. Light refreshments will be provided during the discussion activities.

Endorsement

We have received endorsement from the Ministry of Women's Affair to conduct this project. If you have any questions about the study or something that you are not happy about, please feel free to contact:

H.E. Nhean Sochetra,

General Director of Social Development

Ministry of Women's Affairs

Tel: 012 758 986

Or

Sokroeun Aing

Gender Analyst

UNFPA Cambodia Country Office

Phnom Penh Center, Room 526 – North building (5th floor).

Tel : +85523215519/216295 ext. 118

Mobile : +855 12 575 161

aing@unfpa.org

Has this study received ethical approval?

The project has been ethically approved by the National Ethics Committee for Health Research of the Ministry of Health. (2nd May 2016)

Who can I ask if I have questions about the study?

If you have any questions about the project, please ask one of the project staff or contact one of the people noted above.

INFORMED CONSENT FORM

I hereby confirm that the person seeking my informed consent for my child to participate in this evaluation project has given me information to my satisfaction. She or he explained to me the purpose, procedures involved, risk and benefits and my and my child's rights. I have received the information leaflet for the study and have had enough time to understand it and ask questions if I wanted to. I feel that my questions regarding my child's participation in the evaluation project have been answered to my satisfaction. I have been told that the information my child gives to the evaluation project will, together with other information gathered from other children, be anonymously processed into a report.

I am aware that it is my right to withdraw my consent for my child to participate in this evaluation project without any prejudice. I hereby, freely and voluntary give my consent for my child to participate in the evaluation project.

Please place an X in the box to give consent for each evaluation project activity that you are willing for your child to participate in:	
	I agree for my child to participate in the baseline and end line questionnaire.
	I agree for my child to participate in the group feedback activity at the end of the workshops.

Note: If the participant cannot read and write, an independent witness to the consent process will participate in the consent process to ensure the participant has fully understood the purpose of the evaluation research project, including signing and filling the consent form on behalf of the participant.

Child's name……..(Please print)

Parent/Guardian name……..(Please print)

Parent/Guardian signature……Date……

Staff name…….(Please print)

Staff signature……..Date……

Witness's name……...(Please print)

Witness's signature……Date……

Contact telephone: ……..

Evaluation of the ***Shaping our Future: Developing Healthy and Happy Relationships*** intervention in Cambodia

CAREGIVER INFORMATION AND CONSENT FOR BASELINE AND ENDLINE QUESTIONNAIRE AND PARTICIPATORY FEEDBACK SESSION INFORMATION

Dear Parent/Legal guardian,

You are invited to participate in a project called Evaluation of *Shaping our Future: Developing Healthy and Happy Relationships* intervention. This project is being conducted by Partners for Prevention (P4P) in collaboration with the Ministry of Women's Affairs, UNFPA and UN Women in Kampong Cham province, Cambodia. The project is linked to the workshops that you will participate in. The evaluation project will help us to understand what impact the workshops have on those who participate in the workshops.

We are now inviting you to participate in evaluation activities including: (1) a baseline and endline questionnaire, and (2) a participatory, group feedback session. This information leaflet will help you to decide if you are willing to participate in these activities. We are inviting ALL caregivers (and adolescents) in the workshops to be part of these questionnaires and feedback sessions. We hope as many people as possible who were in the intervention workshops will also participate in these activities so that we can know whether the workshops are helpful, interesting, and enjoyable for adolescents and caregivers.

The purpose of the questionnaire and feedback session is to understand what people think and how they experience *Shaping our Future: Developing Healthy and Happy Relationships* workshops so that we can know how to improve the workshops and see whether other people in other areas could benefit from them.

Participation in the questionnaires and feedback session will be on a voluntary basis - this means that no one is forced to participate and people can participate in the workshops without participating in any of the evaluation activities.

If you have any questions that this leaflet does not fully explain, please do not hesitate to ask.

What are the project activities?

Because you have expressed interest in taking part in the *Shaping our Future: Developing Healthy and Happy Relationships* workshops, we would like to ask you if you would be willing to take part in (1) the questionnaire at baseline (before the beginning of the workshops) and endline (at the end of the workshops), and (2) a participatory group feedback session (after the last workshop).

The questionnaire will take about 1,5 hours to complete and will include multiple choice questions exploring your experiences and challenges with being a caregiver for adolescents, your attitudes and opinions, communication and conflict resolution, and some aspects of your relationship with adolescents. The baseline questionnaire is conducted once before the workshop sessions begin and the same questionnaire is used at endline after the last workshop session.

The participatory group feedback session will last about 2 hours and will give you (together with the others in the workshop group) an opportunity to share your thoughts, experiences, and ideas about what the workshop was like for you and how it has impacted on you. This feedback session will only occur once – after the last workshop session.

You will be asked to give agreement for these activities. You can decline. Even if you agree to participate in either or both of the evaluation activities, you can still choose not to answer some of the questions for any reason or stop at any time.

How will the evaluation project be beneficial?

The project will generate important knowledge on the impact of the workshops for adolescents and caregivers. We hope that you will benefit from the workshop sessions as you have discussed when you were invited to the workshop. We do not know yet exactly how people may benefit from the intervention workshop sessions so your feedback will be very helpful for us to understand that.

Will anyone know my answers in the questionnaire?

NO. Your name will not appear anywhere on the questionnaire so it will be impossible to know what any individual answers on it. No one but the project staff will be aware of your responses in the participatory group feedback session and the report from the feedback session will not include any participant's name. The findings of the evaluation project will be reported with that of all participants' answers combined; therefore your information will **NOT** be identifiable. You can feel free to be completely open and honest in your answers because no one will know what you answer and it is most helpful for us to understand young people's experiences and needs if we get true information.

What are the risks?

We do not anticipate any serious risks for you. However, there is a chance that you may feel emotional during the questionnaire. If this occurs, you will be able to talk with the project staff member who is in the room either during or after the questionnaire session. In addition, you can talk to a workshop facilitator because the workshops are linked with this evaluation project. Further, all evaluation project participants and all workshop participants will receive a list of places where people can go for help with different kinds of problems.

Do I have to participate?

NO. Taking part in this study is completely voluntary. If you do not take part in the questionnaire and/or feedback session, there will be no negative consequences. You may stop participating in filling the

questionnaire, or choose not to answer some questions on the questionnaire at any time. You do not have to answer the questionnaire in order to participate in the workshops. You can choose to answer only a few of the questions, or none at all. The questionnaire is entirely voluntary.

What about the results of the evaluation project?

No information will be given to anyone about any individual's involvement with any activities related to the evaluation project. The project staff will report the overall results of the evaluation project and this information will be shared with people, organisations, and government departments who are interested in helping young people and parents/caregivers.

Costs

There is no cost to you for participating in this study other than the time to complete the baseline and end line questionnaires (approximately 1,5 hours each) and/or the group feedback session (approximately 2 hours).

Compensation

You will not be financially compensated for the time spent in the baseline or end line survey or feedback session. Light refreshments will be provided during the discussion activities.

Endorsement

We have received endorsement from the Ministry of Women's Affair to conduct this project. If you have any questions about the study or something that you are not happy about, please feel free to contact:

H.E. Nhean Sochetra,

General Director of Social Development

Ministry of Women's Affairs

Tel: 012 758 986

Or

Sokroeun Aing

Gender Analyst

UNFPA Cambodia Country Office

Phnom Penh Center, Room 526 – North building (5th floor).

Tel : +85523215519/216295 ext. 118

Fax : +85523211339

Mobile : +855 12 575 161

aing@unfpa.org

Has this study received ethical approval?

The project has been ethically approved by the National Ethics Committee for Health Research of the Ministry of Health. (2nd May 2016)

Who can I ask if I have questions about the study?

If you have any questions about the project, please ask one of the project staff or contact one of the people noted above.

INFORMED CONSENT FORM

I hereby confirm that the person seeking my informed consent to participate in this evaluation project has given me information to my satisfaction. She or he explained to me the purpose, procedures involved, risk and benefits and my rights. I have received the information leaflet for the evaluation project and have had enough time to understand it and ask questions if I wanted to. I feel that my questions regarding participation in the evaluation project activities have been answered to my satisfaction. I have been told that the information I give to the evaluation project will, together with other information gathered from other people, be anonymously processed into a research report.

I am aware that it is my right to withdraw my consent in this evaluation project without any prejudice. I hereby, freely and voluntary give my consent to participate in the evaluation project.

Please place an X in the box to give consent for each activity that you are willing to participate in:	
	I agree to participate in the questionnaire.
	I agree to participate in the group feedback activity at the end of the workshops.

Note: If the participant cannot read and write, an independent witness to the consent process will participate in the consent process to ensure the participant has fully understood the purpose of the evaluation research project, including signing and filling the consent form on behalf of the participant.

Participant's name……..(Please print)

Participant's signature……Date……

Staff name…….(Please print)

Staff signature……Date……

Witness's name……...(Please print)

Witness's signature……Date……

Contact telephone: ……..

Evaluation of the ***Shaping our Future: Developing Healthy and Happy Relationships*** intervention in Cambodia

GROUP FACILITATORS, SUPERVISOR AND KEY INFORMANTS INFORMATION AND CONSENT FOR PARTICIPATORY FEEDBACK SESSION

Dear Group facilitator/supervisor and key informants,

You are invited to participate in a project called Evaluation of *Shaping our Future: Developing Healthy and Happy Relationships* intervention. This project is being conducted by Partners for Prevention (P4P) in collaboration with Ministry of Women's Affairs, UNFPA and UN Women in Kampong Cham province, Cambodia. The project is linked to the workshops that you have been involved in facilitating, supervising, or supporting in some way. The evaluation project will help us to understand what impact the workshops have on those who participate and implement the workshops.

You have been identified as an important stakeholder in the operations of the workshops. The purpose of this evaluation project is to understand your experiences and views of the workshops because they are very important to help us to understand how they worked, how to improve them, and whether or not to recommend that other communities also participate in them.

In order to determine if these workshops are helpful we would like to ask you to participate in a participatory feedback session in the form of a group discussion. This information leaflet will help you to decide if you are willing to participate in this evaluation project activity.

If you have any questions that this leaflet does not fully explain, please do not hesitate to ask.

What are the project activities?

You are one of the group facilitators/supervisors or another key informant (e.g., a community leader or policy maker or stakeholder) who have important experiences and/or views on the workshops. You are being asked to share your experiences and your views with us through a group discussion. In these discussions we will ask you questions about how you experienced and how you feel about the workshops; any changes you noticed within yourself, your group, or your community because of the workshops; your thoughts on how the workshops can be strengthened; and your recommendations about whether or not the workshops should be implemented in other places.

How will the evaluation project be beneficial?

The project will generate important knowledge on the impact and operations of the workshops for adolescents and caregivers. We do not know yet exactly how people and communities may benefit from the intervention workshop sessions or whether they are operationally feasible so your feedback will be very helpful for us to understand that.

Will anyone know my answers?

Your name or other identifying information will not be recorded in any of the notes from the discussion. However, during the discussion the other people in the group will know what you say but we will agree to maintain confidentiality, so that no one can share the identity or content of any participant's views. You will also have the option to write your feedback anonymously if you do not want to provide it during a discussion activity. Your name will not appear anywhere on the feedback reports or the final evaluation project report.

What are the risks?

We do not anticipate any serious risks during these activities.

Do I have to participate?

NO. Taking part in this evaluation project is completely voluntary. If you do not take part in the activities, there will be no negative consequences. You may choose not to answer some questions at any time. Or you may choose to write your feedback anonymously or you may choose not to participate at all.

What about the results of the evaluation project?

No information will be given to anyone about any individual's involvement with any activities related to the evaluation project. The project staff will report the overall results of the evaluation project and this information will be shared with people, organisations, and government departments who are interested in helping young people and parents/caregivers.

Costs

There is no cost to you for participating in this study other than the time to complete the group feedback session (approximately 2 hours).

Compensation

You will not be financially compensated for the time spent in the feedback session. Light refreshments will be provided during the discussion activities.

Endorsement

We have received endorsement from the Ministry of Women's Affair to conduct this project. If you have any questions about the study or something that you are not happy about, please feel free to contact:

H.E. Nhean Sochetra,

General Director of Social Development

Ministry of Women's Affairs

Tel: 012 758 986

Or

Sokroeun Aing

Gender Analyst

UNFPA Cambodia Country Office

Phnom Penh Center, Room 526 – North building (5th floor).

Tel : +85523215519/216295 ext. 118

Fax : +85523211339

Mobile : +855 12 575 161

aing@unfpa.org

Has this study received ethical approval?

The project has been ethically approved by the National Ethics Committee for Health Research of the Ministry of Health. (2nd May 2016)

Who can I ask if I have questions about the study?

If you have any questions about the project, please ask one of the project staff or contact one of the people noted above.

INFORMED CONSENT FORM

I hereby confirm that the person seeking my informed consent to participate in this evaluation project has given me information to my satisfaction. She or he explained to me the purpose, procedures involved, risk and benefits and my rights as a participant in the feedback discussion. I have received the information leaflet for the evaluation project and have had enough time to understand it and ask questions if I want to. I feel that my questions regarding participation in the study have been answered to my satisfaction. I have been told that the information I give to the evaluation project will, together with other information gathered from other people, be anonymously processed into a report.

I am aware that it is my right to withdraw my consent in this evaluation project without any prejudice. I hereby, freely and voluntary give my consent to participate in the evaluation project.

Please place an X in the box to give consent for each activity that you are willing to participate in	
	I agree to participate in a group feedback discussion.
	I would prefer to write my feedback anonymously on a form.

Note: If the participant cannot read and write, an independent witness to the consent process will participate in the consent process to ensure the participant has fully understood the purpose of the evaluation research project, including signing and filling the consent form on behalf of the participant.

Participant's name……..(Please print)

Participant's signature……Date……

Staff name…….(Please print)

Staff signature……..Date……

Witness's name……...(Please print)

Witness's signature……Date……

Contact telephone: ……..

Appendix 4 - Questionnaire

Note: The questionnaires (one for adolescent boys and adolescent girls, and one for adult caregivers) will be designed to be user-friendly for administration.

ADOLESCENT SURVEY		
Section 1: **Please answer the questions and statements below so that we can understand more about your background.**		
Item	**Question/Statement**	**Answer Options**
Q001	Are you a boy or a girl?	1 – boy 2 – girl
Q002	How old are you?	___ years
Q003	Do you attend school?	1 – no 2 – yes
Q004	What year/grade are you in this year at school? OR IF NO LONGER IN SCHOOL: What year/grade did you last finish at school?	
Q005	Have you ever repeated a grade/year at school?	1 – yes 2 – no
Q006	Last year, how well did you do in school work compared to others in your class?	1 – I was among the worst of my class 2 – I was below average 3 – I was about average 4 – I was better than average 5 – I was among the very best of my class
Q007	Do you think you will finish high school?	1 – definitely no 2 – probably no / I don't want to 3 – probably yes / I hope so 4 – definitely yes

Q008	What kind of house do you live in?	1 – house made of palm leaves or grass/thatch 2 – house made of wood with palm leaf roof 3 – house made of wood with a tin roof 4 – house made of wood with a tile roof 5 – house made of brick or concrete
Q009	How many adults (people over the age of 18 years) live with you in your home?	
Q010	How many children or adolescents (people under the age of 18 years) live with you in your home?	
Q011	Do you live with your mother in the same home?	1 – no 2 – yes
Q012	Do you live with your father in the same home?	1 – no 2 – yes
Q013	In the past 7 days, how often did you not have enough food in your home for everyone?	1 – Almost every day (6-7) 2 – Many days (4-5) 3 – A few days (2-3) 4 – Seldom (1) 5 – Never (0)
Q014	In the past 7 days, how often did you or others in your home go to bed hungry because there was no food in the house?	1 – Almost every day (6-7) 2 – Many days (4-5) 3 – A few days (2-3) 4 – Seldom (1) 5 – Never (0)
Q015	In the past 7 days, how often did you go to school without eating because there was no food in the house?	1 – Almost every day (6-7) 2 – Many days (4-5) 3 – A few days (2-3) 4 – Seldom (1) 5 – Never (0)

Q016	How often do transportation difficulties prevent you from going to school?	1-never 2-rarely 3-sometimes 4-often
Q017	Are you a member of any community groups or clubs where you participate in group activities or meetings regularly?	1 – no 2 – yes
Section 2: **Now we have questions that ask you about things you may have experienced in your life up to now, happy and sad or painful. Please remember that everything you say is strictly private.**		
Q018	Apart from your parents, are there other adults who you consider to be important caregivers in your life?	1 – no 2 – yes
Q019	IF YES: Who are the important other caregivers in your life?	1 – a relative (e.g., a grandparent, aunt/ uncle, older sibling, or older cousin) 2 – a close family friend 3 – a teacher 4 – a religious leader 5 – a community leader 6 – a healthcare person 7 – other (_____)
Q020	How often does your father or other male adult family member do the following things in the home: Prepare food.	1 – never 2 – sometimes 3 – often 4 – very often 5-no father or male caregiver
Q021	How often does your father or other male adult family member do the following things in the home: Clean the house.	1 – never 2 – sometimes 3 – often 4 – very often 5-no father or male caregiver

Q022	How often does your father or other male adult family member do the following things in the home: Wash clothes.	1 – never 2 – sometimes 3 – often 4 – very often 5-no father or male caregiver
Q023	How often does your father or other male adult family member do the following things in the home: Take care of you or your siblings/cousins, grandparents or other children in the family .	1 – never 2 – sometimes 3 – often 4 – very often 5- no father or male caregiver
Q024	Who has the final word in your house about decisions involving you and your siblings (and other children living in your house)?	1 – mother/female in the home 2 – father/male in the home 3 – both equally
Q025	Who has the final word in your house about decisions involved how money is spent on food and clothing?	1 – mother/female in the home 2 – father/male in the home 3 – both equally
Q026	Who has the final word in your house about decisions involving how money is spent on big things like buying a car, a house, or a household appliance?	1 – mother/ female in the home 2 – father/male in the home 3 – both equally
Q027	In the last 6 months, how often has someone in your family or another adult caregiver told you that you are beautiful or good?	1 – very often 2 – often 3 – sometimes 4 – never
Q028	In the last 6 months, how often has someone in your family or another adult caregiver encouraged you to make something of your life?	1 – very often 2 – often 3 – sometimes 4 – never

Q029	In the last 6 months, how often has someone in your family or another adult caregiver told you that you are lazy or stupid or ugly?	1 – very often 2 – often 3 – sometimes 4 – never
Q030	In the last 6 months, how often has someone in your family or another adult caregiver insulted or humiliated you in front of other people?	1 – very often 2 – often 3 – sometimes 4 – never
Q031	In the last 6 months, how often have you spent time outside your home and none of the adults at home knew where you were?	1 – very often 2 – often 3 – sometimes 4 – never
Q032	In the last 6 months, how often has one or both of your parents been too drunk or high to take care of you and the other children at home?	1 – very often 2 – often 3 – sometimes 4 – never
Q033	In the last 6 months, how often you had to stay in different homes with different people?	1 – very often 2 – often 3 – sometimes 4 – never
Q034	In the last 6 months, how often have you seen or heard your mother or female caregiverbeing beaten by her husband or boyfriend?	1 – very often 2 – often 3 – sometimes 4 – never
Q035	In the last 6 months, how often have you been punished at home by being beaten or hit every day or every week?	1 – very often 2 – often 3 – sometimes 4 – never

Q036	In the last 6 months, how often have you been beaten or hit at home with a belt or a stick or a whip or something else hard?	1 – very often 2 – often 3 – sometimes 4 – never
Q037	In the last 6 months, how often have you been beaten or hit so hard at home that it left a mark or bruise?	1 – very often 2 – often 3 – sometimes 4 – never
Q038	In the last 6 months, how often have you seen other children at school being beaten by a teacher?	1 – very often 2 – often 3 – sometimes 4 – never
Q039	In the last 6 months, how often have you been punished at school by being beaten or hit every week?	1 – very often 2 – often 3 – sometimes 4 – never
Q040	In the last 6 months, how often have you been beaten or hit at school with a belt or a stick or a whip or something else hard?	1 – very often 2 – often 3 – sometimes 4 – never
Q041	In the last 6 months, how often have you been beaten or hit so hard at school that it left a mark or bruise?	1 – very often 2 – often 3 – sometimes 4 – never
Q042	In the last 6 months,how often have you been bullied, teased, or harassed by other young people in school or in your community?	1 – very often 2 – often 3 – sometimes 4 – never

Q043	In the last 6 months, How often have you bullied, teased, or harassed other young people in school or in my community?	1 – very often 2 – often 3 – sometimes 4 – never
Section 3:		
You are doing very well, thank you. I will now ask you about your opinions and ideasabout men and women in society. There are no right or wrong answers – we are just interested in what <u>you</u> think. Please tell me whether you strongly agree, agree, disagree or strongly disagree with each of the following statements:		
Q044	A woman's most important role is to take care of her home and cook for her family.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q045	There are times when a woman deserves to be beaten.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q046	It is a woman's responsibility to avoid getting pregnant.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q047	A woman should tolerate violence in order to keep her family together.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q048	If someone insults a man, he should defend his reputation, with force if he has to.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q049	To be a man, you need to be tough.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q050	Women who work in entertainment venues, like karaoke and massage or beer promotion are decent women.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q051	I think that men should share the work around the house with women such as doing dishes, cleaning and cooking.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q052	I think that people should be treated the same whether they are male or female.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q053	I think that a woman should obey her husband.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q054	I think that a man should have the final say in all family matters.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q055	I think that a woman cannot refuse to have sex with her husband.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q056	I think that if a wife does something wrong her husband has the right to punish her	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q057	I think if a girl or woman dresses sexy or gets drunk, she is inviting men to rape her.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q058	I think that if a woman doesn't physically fight back, it's not rape.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Section 4:		
For the next questions we would like to know how much you agree or disagree with each statement about what you think is acceptable or unacceptable behaviour. Remember there is no right or wrong answer – we are interested in what YOU think. Also remember that your answers on this survey are completely private.		
Q059	I think it is ok to call someone bad names, insult them, make fun of them, threaten them, or say horrible stories about a person if we are in a conflict or disagreement.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q060	I think it is ok to hit or punch or kick someone if they make me angry, take something from me, or disagree with me.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q061	I think it is important to listen to and understand another person's point of view in a disagreement or conflict.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q062	I think it is a good idea to talk through a disagreement or conflict rather than fight about it.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q063	It is acceptable for a parent to hit a child.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q064	It is acceptable for a man to hit his partner	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q065	It is ok for a boy to hit his girlfriend if she did something to make him angry.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q066	Sometimes boys have to hit their girlfriends to get them back under control.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q067	If a girl/wife refuses to have sex with her boyfriend/husband, it is sometimes ok for him to hit her.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q068	If a boy hits a girlfriend, other boys would think he is a “real boy or man”.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q069	A boyfriend hitting a girlfriend is no big deal.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q070	In some rape cases, the victim did something to cause it.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q071	If a victim doesn't physically fight back, you can't really say it was rape.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Section 5:		
This section has questions to help us to understand your thoughts and feelings about adults who take care of you. **For these first questions in the section, please think of the adult woman in your life who does the most to take care of you – often this is a mother, but for some children and teenagers it is another adult such as a relative. Please think of the person who is your MAIN female caregiver – likely the person at home that you live with and who takes care of the household.**		
Q072	I have a caring and close relationship with my mother/female caregiver.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no mother/female caregiver
Q073	My mother/female caregiver does everything she can to support me.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no mother/female caregiver

Q074	My mother/female caregiver is always there for me.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no mother/female caregiver
Q075	If I have a problem I know I can talk to my mother/female caregiver no matter what it is.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no mother/female caregiver
For the next few questions, think of the adult man in your life who does the most to take care of you – often this is a father, but for some children and teenagers it is another adult such as a relative. Please think of the person who is your MAIN male caregiver – likely the person at home that you live with and who takes care of the household.		
Q076	I have a caring and close relationship with my father/male caregiver.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no father/male caregiver
Q077	My father/male caregiver does everything he can to support me.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no father/male caregiver
Q078	My father/male caregiver is always there for me.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no father/male caregiver

Q079	If I have a problem I know I can talk to my father/male caregiver no matter what it is.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 5 – no father/male caregiver
Now for the rest of the questions think about your parents/caregivers at home in general when you answer the next questions.		
Q080	How often does one of your parents/caregivers ask you how your day was?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q081	How often does one of your parents/caregivers ask about what you are learning at school or about your tests at school?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q082	How often does one of your parents/caregivers ask you how you are feeling or if anything is bothering you?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q083	How often does one of your parents/caregivers ask you about your friends?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day

Q084	How often does one of your parents/caregivers listen to you talk about something that is interesting or important to you?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q085	How often does one of your parents/caregivers ask you or talk with you about having a girlfriend or boyfriend?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q086	How comfortable do you feel talking to your parent/caregiver about your feelings?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q087	How comfortable do you feel talking to your parent/caregiver about your problems or worries?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q088	How comfortable do you feel talking to your parent/caregiver about school?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q089	How comfortable do you feel talking to your parent/caregiver about your friends?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q090	How comfortable do you feel talking to your parent/caregiver about dating or romantic relationships?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable

Q091	How comfortable do you feel talking to your parent/caregiver about sex, pregnancy, or HIV/AIDS?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable	
Section 6: **The questions in this section are about either a girlfriend or boyfriend OR a very close friend or best friend and the ways in which you talk to each other or deal with disagreements. Remember, there are no right or wrong answers because we are interested in understanding young people's true and real experiences. All of your answers here are kept completely private so you do not have to worry about someone finding out what you answered.**			
Q092	Have you had a girlfriend/boyfriend in the past one month?	1 – Yes 2 – No	
	IF YES – Answer all the questions below about this boyfriend/girlfriend that you had in the past month. IF NO – that's ok too! You don't have to have one. Answer all the questions below about your BEST OR CLOSEST FRIEND.		
		Boyfriend/girlfriend	Close friends
Q093	In the past one month, how often would you say that you argued with your girlfriend/boyfriend?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q094	In the past one month, how often have you kept silent when disagreeing or arguing with your girlfriend/boyfriend?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q095	In the past one month, how often have you ended up shouting when disagreeing or arguing with your girlfriend/boyfriend?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often

Q096	In the past one month, how often have you tried to talk the problem through with your girlfriend/ boyfriend when you've had a disagreement?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q097	In the past one month, how often have you tried to say what you feel when you disagreed with your girlfriend/boyfriend?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q98	In the past one month, how often have you felt free to discuss your hopes and dreams with your girlfriend/boyfriend?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q99	In the past one month, how often have you felt free to discuss your fears or worries with your girlfriend/boyfriend?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q100	In the past one month, how often have you felt free to talk with your girlfriend/boyfriend about problems or discomforts in your relationship?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q101	In the past one month, how often have you felt free to talk with your girlfriend/boyfriend about things that you think would make the relation-ship happier?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q102	In the past one month, how often have you felt free to discuss sex, condoms, pregnancy, or HIV/STIs with your girlfriend/boyfriend?	1 – Never 2 – Once 3 – Sometimes 4 – Often	1 – Never 2 – Once 3 – Sometimes 4 – Often
The next questions are about a conflict, disagreement, or argument situation you've been in with any other person.			

Q103	In the past one month during a conflict or disagreement/argument, how often have you started physically fighting with or tried to physically hurt the other person?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q104	In the past one month during a conflict or disagreement/argument, how often have you asked about and listened to the other person's point of view?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q105	In the past one month during a conflict or disagreement/argument, how often have you talked with the other person to find a solution you both agree on?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q106	In the past one month during a conflict or disagreement/argument, how often have you refused to talk to or ignored the other person about the problem?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q107	In the past one month during a conflict or disagreement/argument, how often have you walked off angrily during the argument?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q108	In the past one month during a conflict or disagreement/argument, how often have you said mean or hurtful things to the other person?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q109	In the past one month during a conflict or disagreement/argument, how often have you tried to calm yourself down before talking or doing something?	1 – Never 2 – Once 3 – Sometimes 4 – Often

Q110	In the past one month during a conflict or disagreement/argument, how often have you told the other person about how you feel and what is important to you in the situation?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q111	In the past one month during a conflict or disagreement/argument, how often have you asked lots of questions to try to understand the other person's feelings and view of the problem?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Section 7:		
You are moving through this questionnaire so well! Your answers help us a lot to understand young people better. Please tell us how much you agree or disagree with each of these statements about school:		
Q112	I try hard to concentrate in classes and do my school work well.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q113	I think it is ok to skip going to school on some days to do other fun things.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q114	I think that finishing school is worthwhile for me.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q115	I feel safe at school.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree

Q116	I feel good about going to school.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Section 8: **In this section we are interested in learning about what kinds of activities you do in your community or on social media as a volunteer. These are things that might help your community in some way or raise awareness about issues.**		
Q117	Have you been involved in any community activism or community service volunteer activities focused on issues of equality of men and women, healthy communication, conflict resolutions and caring relationships, violence against women and girls,?	1 – yes 2 – no
Q118	Approximately how many separate volunteer activities or events focused on equality of men and women, healthy communication, conflict resolutions and caring relationships, violence against women and girls have you participated in, in the past 6 months?	_____
Q119	Please describe the community activism or community volunteer activities that you have been involved in, in the table below: Column 1: Describe activity (what did you do)? Column 2: Who was at the event or who participated in the activity? Column 3: About how many people attended the event/activity? Column 4: Where was this activity conducted (in your community or another community; at a community or public venue like a school or library or church or community hall; at a private venue like someone's home or business)	

Q120	In the next 6 months, will you be involved in volunteer activities that someone else plans/ organises in your community (or other communities) on the issue of equality of men and women, healthy communication, conflict resolutions and caring relationships, and violence against women and girls?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no
Q121	In the next 6 months, will you be help to plan or organise volunteer activities in your community (or other communities) on the issue of equality of men and women, healthy communication, conflict resolutions and caring relationships, and violence against women and girls?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no
Q122	In the next 6 months, will you talk to friends, family members, or other community members about issues of equality of men and women, healthy communication, conflict resolutions and caring relationships, and violence against women and how to have a safe and vibrant community?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no
Q123	In the next 6 months, will you join a committee or organization that works to promote equality of men and women, healthy communication, conflict resolutions and caring relationships, and/or end violence against women and girls?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no
Section 9: **In this very short section (and very close to the end of the questionnaire), we would like to know if you know of different places where you or other young people could find help. Remember to answer honestly for yourself because your answers are private.**		
Q124	Do you know if there are any services available for people who have experienced violence by a boyfriend or another family member?	1 – definitely yes (yes, I know these services) 2 – probably yes (I think so) 3 – maybe no (I'm not really sure) 4 – definitely no (I don't know of these services)
Q125	Do you know how to contact any of these services that support victims of violence?	1 – definitely yes (yes, I know) 2 – probably yes (I think so) 3 – maybe no (I'm not really sure) 4 – definitely no (I don't know)

Q126	Would you feel comfortable telling a friend about support services for victims of violence if you found out that she/he has experienced some violence?	1 – definitely yes 2 – probably yes 3 – maybe no 4 – definitely no
Q127	Would you feel comfortable contacting these support services yourself if you experienced violence?	1 – definitely yes 2 – probably yes 3 – maybe no 4 – definitely no
FINAL SECTION: **These last few questions are just about this questionnaire itself. Please select whatever answer is true for YOUR experience.**		
Q128	How easy was it to understand the questions in this questionnaire?	1 – very easy to understand 2 – easy to understand 3 – difficult to understand 4 – very difficult to understand
Q129	Overall, how honest would you say you were in answering the questions in this questionnaire?	1 – completely honest 2 – very honest 3 – not very honest 4 – not honest at all
Q130	How do you feel about answering the questions in this questionnaire?	1 – I feel fine about it 2 – I found it painful or hard but I am happy to answer the questions 3 – I found it very painful or hard and wish I had not done it
Q131	Is there anything else that you would like to tell us about the questionnaire?	
Thank you very much for completing this questionnaire. It is very helpful for us to have teenagers tell us themselves about their experiences so that we can better understand young people. Remember that your answers will be private because you have not written your name anywhere on this survey and we will now put all the surveys together to understand the answers of young people as a group.		

Final question: When they finish the questionaire, can we give them 5 min to look over again for quality? Then once the team collects them, what do they do if the information is not good? They can't call the people since their codes are inside the envelope to follow up. Should they ask them to stay 5 min and they look quickly at each one and then invite people to come back in if there are errors?

ADULT/CAREGIVER SURVEY

Section 1:

Please answer the questions and statements below so that we can understand more about your background.

Item	Question/Statement	Answer Options
Q001	Are you a man or a woman?	1 – man 2 – woman
Q002	How old are you?	___ years
Q003	Did you finish high school?	1 – yes 2 – no
Q004	What is your highest level of education? (last grade completed in high school; or university degree)	
Q005	What role do you fill as a caregiver to teenager/s? Note: Please tick all that apply.	1 – parent 2 – grandparent, aunt/uncle 3 – other relative in the home 4 – school staff 5 – health care staff 6 – community leader 7 – other (_____)
Q006	What kind of house do you live in?	1 – house made of palm leaves or grass/thatch 2 – house made of wood with palm leaf roof 3 – house made of wood with a tin roof 4 – house made of wood with a tile roof 5 – house made of brick or concrete
Q007	How many adults live with you in your home?	
Q008	How many children live with you in your home?	

Q009	In the past 7 days, how often did you not have enough food in your home for everyone?	1 – Almost every day (6-7) 2 – Many days (4-5) 3 – A few days (2-3) 4 – Seldom (1) 5 – Never (0)
Q010	In the past 7 days, how often did you and others in your home go to bed hungry because there was no food in the house?	1 – Almost every day (6-7) 2 – Many days (4-5) 3 – A few days (2-3) 4 – Seldom (1) 5 – Never (0)
Q011	In the past 7 days, how often did you go to work or start your day without eating because there was no food in the house?	1 – Almost every day (6-7) 2 – Many days (4-5) 3 – A few days (2-3) 4 – Seldom (1) 5 – Never (0)
Q012	Have you worked or earned money in the last 12 months?	1 – yes 2 – no
Q013	Do you usually work throughout the year, seasonally, once in a while or you've never worked?	1 – throughout the year 2 – seasonally 3 – once in a while 4 – never worked
Q014	IF YOU HAVE WORKED AND EARNED MONEY IN THE PAST 12 MONTHS: Do you receive your main source of income daily, monthly, or once a year?	1 – daily 2 – monthly 3 – once a year
Q015	IF DAILY: How much do you earn per day?	1 – less than 5000RIELor US$1.25 2 – 5000-10000 RIELor US$1.25 - $2.5 3 – 10000-20000 RIEL or US$2.5 - $5 4 – more than 20000 RIELor US$5

Q016	IF MONTHLY: How much do you earn per month? (including remittent)	1 – Under 400,000 RIEL or US$100 2 –404,000-1,200,00 RIEL or US$101-$300 3 –1,204,00-2,400,00 RIEL or US$301-$600 4 – more than 2,400,00RIEL orUS$600
Q017	IF YEARLY: How much do you earn per year? (including remittent)	1 – less than 2 million RIEL or US$500 2 – 2-8 million RIEL or US$500-$2,000 3 – 8-15 million RIEL or US$2,000-$3,750 4 – more than 15 million RIEL or US$3,750
Q018	What kind of work do/did you normally do?	1 – professional (doctor, nurse, teacher) 2 – white collar (secretary, office work) 3 – blue collar (factory work, waiter) 4 – trading/business 5 – manual labour 6 – farmer/fishing 7 – security (policy, army, etc.) 8 – driver/taxi driver 9 – sex worker 10 – never worked / student 11- housewife

Q019	What is your annual family income?	1 – less than 2 million RIEL or US $500 2 – 2-8 million RIEL or US $500-$2,000 3 – 8-15 million RIEL or US$2,000-$3,750 4 – more than 15 million RIEL or US $3,750
Q020	Are you a member of any community groups or clubs where you participate in group activities or meetings regularly?	1 – no 2 – yes
Section 2:		
Now we have questions that ask you about things that happen in your home now. Please remember that everything your say is strictly private. Please select the answer that is true for YOU.		
Q021	How often does an adult male family member (or you, if you are a man) do the following things in the home: Prepare food.	1 – never 2 – sometimes 3 – often 4 – very often 5- there is no adult male family member
Q022	How often does an adult male family member (or you, if you are a man) do the following things in the home: Clean the house.	1 – never 2 – sometimes 3 – often 4 – very often 5- there is no adult male family member
Q023	How often does an adult male family member (or you, if you are a man) do the following things in the home: Wash clothes.	1 – never 2 – sometimes 3 – often 4 – very often 5- there is no adult male family member

Q024	How often does an adult male family member (or you, if you are a man) do the following things in the home: Take care of children in the house.	1 – never 2 – sometimes 3 – often 4 – very often 5- there is no adult male family member
Q025	Who has the final word in your house about decisions involving children living in your house?	1 – wife/female in the home 2 – husband/male in the home 3 – both equally
Q026	Who has the final word in your house about decisions involving how money is spent on food and clothing?	1 – wife/female in the home 2 – husband/male in the home 3 – both equally
Q027	Who has the final word in your house about decisions involving how money is spent on big things like buying a car, a house, or a household appliance?	1 – wife/female in the home 2 – husband/male in the home 3 – both equally
Section 3:		
You are doing very well, thank you. We will now ask you about your views on life and particularly on relations between men and women in society. There are no right or wrong answers – we are just interested in what <u>you</u> think. Please tell us whether you strongly agree, agree, disagree or strongly disagree with the following statements:		
Q028	A woman's most important role is to take care of her home and cook for her family.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q029	There are times when a woman deserves to be beaten.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q030	It is a woman's responsibility to avoid getting pregnant.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q031	A woman should tolerate violence in order to keep her family together.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q032	If someone insults a man, he should defend his reputation, with force if he has to.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q033	To be a man, you need to be tough.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q034	Women who work in entertainment venues, like karaoke and massage or beer promotion are decent women.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q035	I think that men should share the work around the house with women such as doing dishes, cleaning and cooking.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q036	I think that people should be treated the same whether they are male or female.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q037	I think that a woman should obey her husband.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q038	I think that a man should have the final say in all family matters.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q039	I think that a woman cannot refuse to have sex with her husband.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q040	I think that if a wife does something wrong her husband has the right to punish her.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q041	I think if a girl or woman dresses sexy or gets drunk, she is inviting men to rape her.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q042	I think that if a woman doesn't physically fight back, it's not rape.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Section 4:		
For the next questions we would like to know how much you agree or disagree with each statement. Remember there is no right or wrong answer – we are interested in what YOU think. Also remember that your answers on this survey are completely private.		
Q043	I think it is ok to call someone bad names, insult them, make fun of them, threaten them, or say horrible stories about a person if we are in a conflict or disagreement.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q044	I think it is ok to hit or punch or kick someone if they make me angry, take something from me, or disagree with me.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q045	I think it is important to listen to and understand another person's point of view in a disagreement or conflict.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q046	I think it is helpful to ask someone to assist in resolving a disagreement or conflict.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q047	I think it is a good idea to talk through a disagreement or conflict rather than fight about it.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q048	It is acceptable for a parent to hit a child.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q049	It is acceptable for a man to hit his wife or girlfriend.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q050	It is ok for a boy to hit his girlfriend if she did something to make him angry.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree

Q051	Sometimes boys have to hit their girlfriends to get them back under control.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q052	If a girl/wife refuses to have sex with her boyfriend/ husband, it is sometimes ok for him to hit her.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q053	If a boy hits a girlfriend, other boys would think he is a “real boy or man".	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q054	A boyfriend hitting a girlfriend is no big deal.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q055	In some rape cases, the victim did something to cause it.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Q056	If a victim doesn't physically fight back, you can't really say it was rape.	1 – strongly agree 2 – agree 3 – disagree 4 – strongly disagree
Section 5:		
Please think of your teenage child/children. If you do not have teenage children then think about the teenagers who you care for through your role in your work or in the community (e.g., teachers, youth leaders, healthcare providers, etc.). In the statements below we will refer to “teenagers I care for” to be applicable to both parents and other caregivers of teenagers. Please answer how much you agree or disagree with each statement according to <u>your own real experience</u> and not your wishes or expectations.		

Q057	I have a caring and close relationship with teenagers I care for.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q058	I do everything I can to support teenagers I care for.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q059	I am always available for the teenagers I care for.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q060	If teenagers I care for have a problem they know they can talk to me no matter what it is.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Now please tell us about your real experience with the teenager/s you care for in each of the following questions.		
Q061	How often do you ask the teenagers you care for how their day was?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q062	How often do you ask the teenagers you care for what they are learning at school or how they are doing on tests at school?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day

Q063	How often do you ask the teenagers you care for how they are feeling or if anything is bothering them?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q064	How often do you ask the teenagers you care for about their friends?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q065	How often do you just listen to the teenagers you care for talk about something that is interesting or important to them?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q066	How often do you ask or talk with the teenagers you care for about having a girlfriend or boyfriend?	1 – never 2 – sometimes, but not each month 3 – at least once a month 4 – every week 5 – every day
Q067	How comfortable do you feel talking to the teenagers you care for about YOUR feelings?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q068	How comfortable do you feel talking to teenagers you care for about THEIR feelings?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable

Q069	How comfortable do you feel talking to teenagers you care for about their problems or worries?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q070	How comfortable do you feel talking to teenagers you care for about school?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q071	How comfortable do you feel talking to teenagers you care for about their friends?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q072	How comfortable do you feel talking to teenagers you care for about dating or romantic relationships?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q073	How comfortable do you feel talking to teenagers you care for about sex, pregnancy, or HIV/AIDS?	1 – not at all comfortable 2 – not really 3 – somewhat 4 – fully comfortable
Q074	How often do you tell the teenager you care for that he/she is good, clever, or beautiful?	1 – very often 2 – often 3 – sometimes 4 – never
Q075	How often do you talk to the teenager you care for about the future and encourage him/her to make something good of his/her life?	1 – very often 2 – often 3 – sometimes 4 – never

Q076	How often do you tell the teenager you care for he/she is lazy or stupid or do you call him/her other negative names?	1 – very often 2 – often 3 – sometimes 4 – never
Section 6:		
Sometimes teenagers we care for do things that are annoying or dangerous or destructive or break rules in some way. And at those times parents or other caregivers are in the position of disciplining teenagers. We are interested in what types of discipline you use with teenagers you care for. Remember, in order to best understand families and communities in Cambodia we need you to answer whatever is true for you because there is no right or wrong answer here. Remember that all of your answers on this survey are kept private. **For each statement please rate how often you use a particular mode of discipline.**		
Q077	How often do you shout at the teenager?	1 – very often 2 – often 3 – sometimes 4 – never
Q078	How often do you embarrass or humiliate the teenager in front of others to make an example of him/her?	1 – very often 2 – often 3 – sometimes 4 – never
Q079	How often do you call the teenager disparaging names?	1 – very often 2 – often 3 – sometimes 4 – never
Q080	How often do you threaten to hurt or take something away from the teenager to scare or intimidate him/her but don't actually do what you threaten?	1 – very often 2 – often 3 – sometimes 4 – never
Q081	How often do you hit or slap or pinch or pull the ears or beat the teenager withyourhands or fists?	1 – very often 2 – often 3 – sometimes 4 – never

Q082	How often do you hit or beat the teenager using an object like a belt, a ruler, a cane or rod, a whip?	1 – very often 2 – often 3 – sometimes 4 – never
Q083	How often do you lock the teenager out of the house?	1 – very often 2 – often 3 – sometimes 4 – never
Q084	How often do younot let the teenager have food for a period?	1 – very often 2 – often 3 – sometimes 4 – never
Q085	How often do you make the teenager do tough manual labour?	1 – very often 2 – often 3 – sometimes 4 – never
Q086	How often do you talk to the teenager about what they did wrong and why?	1 – very often 2 – often 3 – sometimes 4 – never
Q087	How often do you ask the teenager what they think is a fair consequence or punishment of their action?	1 – very often 2 – often 3 – sometimes 4 – never
Q088	How often do you give the teenager a few extra chores?	1 – very often 2 – often 3 – sometimes 4 – never

Q089	How often do you take away luxuries that the teenager usually enjoys? (e.g., watching tv, cellphone, pocket money, time on the computer or tablet, wifi/internet time)	1 – very often 2 – often 3 – sometimes 4 – never
Q090	How often do you ask the teenager to apologise or write a letter of apology?	1 – very often 2 – often 3 – sometimes 4 – never
Q091	How often do you "ground" the teenager so that they can only be at school or at home but not out with friends or out in the community?	1 – very often 2 – often 3 – sometimes 4 – never
Section 7: **You are progressing through the sections very well! In the next section we would like to learn about things you say or do during a disagreement with teenagers. As with all the questions in this survey, there is no right or wrong answer so please pick the answer that is true for you. Remember your answers will be kept private.**		
Q092	In the past one month, how often would you say that you argued with teenagers you care for?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q093	In the past one month, how often have you kept silent when disagreeing or arguing with teenagers you care for?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q094	In the past one month, how often have you ended up shouting when disagreeing or arguing with teenagers you care for?	1 – Never 2 – Once 3 – Sometimes 4 – Often

Q095	In the past one month, how often have you tried to talk the problem through with teenagers you care for when you've had a disagreement?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q096	In the past one month, how often have you tried to say what you feel when you disagreed with teenagers you care for?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q097	In the past one month, how often have you felt free to talk with teenagers you care for about things that you think would make the relationship happier?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q098	In the past one month during a conflict or disagreement/argument with a teenager, how often have you started physically fighting with or tried to physically hurt the other person?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q099	In the past one month during a conflict or disagreement/argument with a teenager, how often have you asked about and listened to the other person's point of view?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q100	In the past one month during a conflict or disagreement/argument with a teenager, how often have you talked with the other person to find a solution you both agree on?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q101	In the past one month during a conflict or disagreement/argument with a teenager, how often have you refused to talk to or ignored the other person about the problem?	1 – Never 2 – Once 3 – Sometimes 4 – Often

Q102	In the past one month during a conflict or disagreement/argument with a teenager, how often have you walked off angrily during the argument?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q103	In the past one month during a conflict or disagreement/argument with a teenager, how often have you said mean or hurtful things to the other person?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q104	In the past one month during a conflict or disagreement/argument with a teenager, how often have you tried to calm yourself down before talking or doing something?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q105	In the past one month during a conflict or disagreement/argument with a teenager, how often have you told the teenager about how you feel and what is important to you in the situation?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Q106	In the past one month during a conflict or disagreement/argument with a teenager, how often have you asked lots of questions to try to understand the other person's feelings and view of the problem?	1 – Never 2 – Once 3 – Sometimes 4 – Often
Section 8:		
Please tell us how much you agree or disagree with each of these statements about school:		
Q107	I think that school is important and I encourage teenagers I care for to do well.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q108	I think that school is a waste of time for some teenagers.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree

Q109	I think it is ok for teenagers I care for to skip going to school on some days.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q110	I think that finishing school is worthwhile for teenagers I care for.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Q111	Teachers in our community school use physical punishments or humiliate teenagers in front of others to punish them.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 0-don't know
Q112	The students at the community school often get into physical fights or try to humiliate others.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 0-don't know
Q113	Teachers help to stop fights or humiliation among students at the community school.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree 0-don't' know
Q114	The school is a safe place for teenagers.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree

Q115	I feel good about teenagers going to our school.	1 – strongly disagree 2 – disagree 3 – agree 4 – strongly agree
Section 9: **In this section we are interested in learning about what kinds of activities you do in your community or on social media as a volunteer. These are things that might help your community or some way or raise awareness about issues.**		
Q116	Have you been involved in any community activism or community service volunteer activities focused onequality of men and women, healthy communication, conflict resolutions and caring relationships, and issues of violence against women and girls?	1 – yes 2 – no
Q117	Approximately how many separate volunteer activities or events focused on equality of men and women, healthy communication, conflict resolutions and caring relationships, and violence against women and girls have you participated in, in the past 6 months?	_____
Q118	Please describe the community activism or community volunteer activities that you have been involved in, in the table below: Column 1: Describe activity (what did you do)? Column 2: Who was at the event or who participated in the activity? Column 3: About how many people attended the event/activity? Column 4: Where was this activity conducted (in your community or another community; at a community or public venue like a school or library or church or community hall; at a private venue like someone's home or business)	
Q119	In the next 6 months, will you be involved in volunteer activities that someone else plans/organises in your community (or other communities) on the issue of equality of men and women, healthy communication, conflict resolutions and caring relationships, and/or violence against women and girls?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no

Q120	In the next 6 months, will you be help to plan or organise volunteer activities in your community (or other communities) on the issue of equality of men and women, healthy communication, conflict resolutions and caring relationships, violence against women and girls?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no
Q121	In the next 6 months, will you talk to friends, family members, or other community members about issues of equality of men and women, healthy communication, conflict resolutions and caring relationships, and/or violence against women and how to have a safe and vibrant community?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no
Q122	In the next 6 months, will you join a committee or organization that works on equality of men and women, healthy communication, conflict resolutions and caring relationships, and/or to end violence against women and girls?	1 – Definitely yes 2 – Maybe yes 3 – Probably no 4 – Definitely no
Thank you for answering the questions – we know they can sometimes be difficult. The information will be kept private and will be very helpful for us to understand how best to support young people and communities. Please feel free to ask any project staff member for additional support. You are almost finished with this survey – just a few more quick questions.		
Section 10: **In this very short section (and very close to the end of the questionnaire), we would like to know if you know of different places where you or other young people could find help. Remember to answer honestly for yourself because your answers are private.**		
Q123	Do you know if there are any services available for people who have experienced violence by a boyfriend or a husband or another family member?	1 – definitely yes (yes, I know these services) 2 – probably yes (I think so) 3 – maybe no (I'm not really sure) 4 – definitely no (I don't know of these services)
Q124	Do you know how to contact any of these services that support victims of violence?	1 – definitely yes (yes, I know) 2 – probably yes (I think so) 3 – maybe no (I'm not really sure) 4 – definitely no (I don't know)

Q125	Would you feel comfortable telling a teenager or a friend about support services for victims of violence if you found out that she/he has experienced some violence?	1 – definitely yes 2 – probably yes 3 – maybe no 4 – definitely no
Q126	Would you feel comfortable contacting these support services yourself if you experienced violence in your life?	1 – definitely yes 2 – probably yes 3 – maybe no 4 – definitely no
FINAL SECTION: **These last few questions are just about this questionnaire itself. Please select whatever answer is true for YOUR experience.**		
Q127	How easy was it to understand the questions in this questionnaire?	1 – very easy to understand 2 – easy to understand 3 – difficult to understand 4 – very difficult to understand
Q128	Overall, how honest would you say you were in answering the questions in this questionnaire?	1 – completely honest 2 – very honest 3 – not very honest 4 – not honest at all
Q129	How do you feel about answering the questions in this questionnaire?	1 – I feel fine about it 2 – I found it painful or hard but I am happy to answer the questions 3 – I found it very painful or hard and wish I had not done it
Q130	Is there anything else that you would like to tell us about the questionnaire?	
Thank you very much for completing this questionnaire. It is very helpful for us to have people tell us themselves about their experiences so that we can better understand how adults can support young people. Remember that your answers will be private because you have not written your name anywhere on this survey and we will now put all the surveys together to understand the answers of caregivers as a group.		

Appendix 5:
UNDP – Shaping Our Future
Case Study Guide for Adolescent (~1 hour)

KANTAR TNS

Section	Questions to ask
1. Introduction and warm up **(5 minutes)**	**Reassure of confidentiality, explain recording, purpose of the discussion etc.** ▪ Thank respondent for agreeing to take part in the study ▪ Introduce self, Kantar TNS and topic – 1 hour discussion - Respondent is the expert - No right or wrong answers, want your honest opinions. - Confidentiality & Anonymity - your identity and feedback are confidential and any personal data will not be disclosed - Audio taping for research purposes only – materials will be shared with people involved in the project only - Note to confidentiality regarding anything seen or ideas discussed today.
2. To understand participant's perception on the positive impacts of the intervention program **(45 minutes)**	**To understand participant's family and living condition** Before we continue to our discussion, would you please introduce yourself including your name, your occupation, and your age? Because I have already introduced myself, so I also would like to get to know you better as well. ▪ Which school are you going? What grade are you in? How long does it take travelling from your home to school? Are there any difficulties in travelling to school? Can you tell us about the school location? ▪ Could you tell us about your house location? Can you describe about your house? Do you like your neighborhood? Could you tell us one word describing your home situation? Do you wish to move out/live independently in the future? Why? Why not? ▪ How many people are there in your family? Are you an oldest son/ daughter? Is there any of your siblings got married? How is your relationship with your siblings? Are you close with anyone? ▪ What are the occupations of your parents and siblings? Could you please tell us? What is the main responsible person financially? ▪ Who usually takes care of you daily? - How is your relationship between you and your primary care giver? - In case main givers is not parent: How about the relationship between you and your parents? ▪ Could you tell us more about your neighborhood? Have you built any connection with your neighbors? Have you encountered any problems in your community? - If there is any problem: could you elaborate more on the situation? What did you do when that problem occurred? - Do you feel your your neighborhood is safe and comfort or not so safe and uncomforted?

	To understand participant's perception towards Building our Future: Supporting Healthy and Happy Relationships program and VAWG ■ What made you decide to join the community session? What attracted you to commit your time to the sessions? Could you tell us about that? ■ If you could go back to the beginning of the community session, would you still decide to join or reject? What make you say so? ■ Has there been any program conducted before similarly to this one? If any, what were they? - How similar and different it is between this one and other programs you have participated? (Probe: focus on key message the programs intend to deliver to see if respondent is influenced by any other program in term attitude and behavior toward gender equality) ■ What are your personal goals for participating this community session? - Have your personal goals been met? • If not, why? • Were you satisfied with the program conclusion? Why? Why not? **To understand participant's consequences in life after the program ended** ■ Have you seen any changes in yourself after participating in the program? Could you tell us about the changes in your life after the program? [Probe: Behavior in general and toward your sibling, parents and other adolescents; Relationship between you and your caregiver] - How do you feel about the changes? - Which parts of the program help you to make changes in your life? Could you specify the topic? - Why do you think these parts help you to make a change in your life? - Do you think you will go on behaving this way or do it differently in the future? Could you explain us more? What motivate you to do so? ■ After you and your parents/caregiver participated in the community session - Is there anything change that you notice in your caregiver/

	parents? Could you tell me more? [Probe: the way they talk and behave toward you and other children and between your parents, The way they deal with you in general, when you are doing something good, and when you make mistake]. - How about your family, any change you notice? [Probe: the way your family deal with tension or any difficulty, frequency of tension or any difficulty in family, household chore] • If there is any change, how do you feel about living in your family now and then? Which one do you prefer? What makes you say so? **To understand participant's advocate initiative using the practice from the program** ■ After participating in the community sessions, have you done anything that would generate positive influence not only in your family but also in your neighborhood (i.e. act to prevent VAWG, educate your friend, relative or neighbor, etc.) - If yes, what motivates you to do such thing? - Is there any impact you notice as a result of your action? - Do you plan to do anything in the future with all the knowledge/information you learnt from community sessions? - Since the program has already ended in your community, what do you think you, your family member, and people at the community should do to make sure the positive impact of the program remains or even expand?
3. Closing	This is the end of our discussion; do you have anything to add/ comment before we wrap up?

Appendix 6 - Intervention description and theory of change

Addressing modifiable risk factors (gender norms and constructions of gender identities; relationship building skills; mental health promotion and help-seeking skills; leisure boredom and school dropout; exposure to harsh punishments in the home or school; poor role models) among a critical group (young adolescent girls and boys aged 12-14 years) within an enabling environment (engagement with adolescent caregivers including parents/guardians, teachers, youth service providers, and key community stakeholders) in sustainable ways (promoting a volunteerism component and training a cadre of local and national facilitators and programme supervisors) will support social norm change in ways that challenge the acceptance of problematic gender and violence status quos and instead equip adolescents to have healthy, non-violent interpersonal relationships and gender equitable attitudes and behaviours that are supported and encouraged by influential people in their environment. In addition, increasing access to referral information for adolescents, parents/guardians and other project beneficiaries on health, counselling, and other social welfare services will further reinforce the enabling environment for beneficiaries to seek services for violence. The intervention will employ participatory methodology that has shown to be a key to effective primary prevention in existing intervention studies (e.g., PREPARE, Skhokho Supporting Success, SASA!) through delivery by trained and supported community facilitators.

The intervention addresses the feasibly modifiable, upstream risk factors identified in the P4P I MCS Cambodia results in ways that have been demonstrated to work in multiple other settings (e.g., PREPARE and Skhokho Supporting Success). The table below summarises the intervention aims related to each risk factor.

Risk factors identified for perpetration of violence against women and girls and intervention components that will address these factors

RISK FACTOR IDENTIFIED IN MCS CAMBODIA FINDINGS	INTERVENTION COMPONENT
Gender inequitable attitudes and problematic constructions of masculinities	▪ Promote gender equity and alternative, non-violent constructions of masculinity and assertive constructions of femininity ▪ Address issues of sexuality and sexual entitlement ▪ Address issues of control and power, domineering attitudes and promote respect and kindness towards everyone as an equal ▪ Promote compassion, empathy, and social support for women/girls, and alternative constructions of gender
Poor anger management and poor emotional regulation (e.g., depressive or anxiety symptoms or outbursts)	▪ Mental health promotion ▪ Build adaptive stress management and coping skills

Not finishing secondary schooling Leisure boredom (i.e., raping for fun)	▪ Promote a sense of belonging and a sense of purpose such as through volunteerism ▪ Promote school completion (specifically through promoting a sense of purpose and belonging; and aspirational framing and decision-making using adolescents' own identified hopes and dreams for the future; and identifying factors to help them succeed in the future) ▪ Human rights promotion including values of respect, caring/kindness and empathic concern
Frequent quarrelling with partner or fights with peers	▪ Communication skills ▪ Conflict resolution skills ▪ Healthy relationship ideals
Harsh punishments	▪ Positive discipline skills for educators and parents ▪ Communication and conflict resolution skills for parents
Poor role models	▪ Gender equitable ideals ▪ Supportive, caring mentor relationships with young people ▪ Promoting a sense of belonging and a sense of purpose amongst young people ▪ Understanding and supporting intervention goals and values (Among caregivers such as parents/ guardians, teachers, youth service providers, and other key community members)

CHANGE OBJECTIVES AND STRATEGIES

The overall intended outcome of the intervention is: Adolescent girls and boys aged 12-14 years have gender equitable attitudes, low levels of violence acceptance attitudes, and are supported by their caregivers and communities.

STRATEGIES FOR IMPLEMENTATION

Based on the finding that a significant proportion of men who rape first do so for the first time during adolescence, the intervention will focus on engaging and supporting young adolescents (age 12-14 years). Global evidence suggests that young people should be engaged in primary prevention efforts that seek to sustainably change social norms. Early adolescence is a prime time to address social norms, especially those around intimate relationships, because it is at this time that many individuals become interested and involved in intimate or dating relationships in some form as well

as going through intense gender socialization. Indeed, the experiences and norms established during this stage often continue to manifest throughout adulthood. Therefore, this is a key period during which to promote equitable and healthy norms, attitudes, and behaviours especially related to relationship skills and gender identities. It is important to engage both boys and girls to influence peer norms as well as build complementary gender equitable ideals and respectful relationship norms and skills among all members of a group that are likely to have ongoing social contact through school and community activities. In addition, the MCS findings from Cambodia suggest that many women hold more gender inequitable attitudes than men further supporting the need to engage both boys and girls, men and women.

From an ecological model perspective (e.g., Bronfenbrenner's social ecological model), the importance of an enabling environment through strategic intervention with influential individuals and institutions in adolescents' lives is illustrated. Therefore, this intervention will engage adolescent caregivers including parents/guardians of the adolescent participants, their teachers, local youth service providers, and any community members who are considered influential to young people within their setting will be engaged in a participatory programme that will run concurrent with the adolescent intervention. This programme will aim to decrease the use of harsh punishments and increase supportive, positive parenting; role modeling positive behavior and attitudes; and providing prosocial, constructive opportunities to deflect youth leisure boredom in the community.

The young adolescents and caregivers will also be encouraged and supported to engage in volunteer activities to share their learnings with peers and community members. This component will also promote the maintenance of the programme, encourage meaningful positive links between the adolescents and adults in the community, and provide activities that could promote school completion and reduce leisure boredom.

UNFPA organized a media campaign named 'Good Men Campaign' closely working with Peace and Development (PyD) and Ministry of Women's Affairs. 'Good Men Campaign' successfully raised awareness of boys and men of taking positive actions to prevent VAWG. UN Women developed an approach of 'Change Makers' which mobilizes youth volunteers to advance gender equality and preventing and eradicating violence against women and girls. In addition, Partners for Prevention, UNV Cambodia and UN Women Cambodia developed 'Ending Violence against Women: A Guide to Working with Volunteers' under the framework of the UN Secretary General UNiTE Campaign to End Violence against Women. These rich experience and knowledge of volunteer mobilization of UN agencies will be fully utilized for community mobilization for P4P implementation.

A Referral Directory and pamphlets will be developed and provided to adolescents and caregivers in the intervention to increase access to information and use of existing services to respond to VAWG, including health services, social services, and other relevant support services. During the development process of the referral directory and pamphlet, a stakeholder meeting with service providers will be held to raise their awareness of prevention of VAWG and to discuss how existing service will support the target groups of the project and their community.

The intervention will be implemented by a local implementing partner (e.g., Government and NGO) recruited and supported by the partner UN agencies. The implementing partner will contribute to intervention development; facilitator recruitment, training, and support; participant mobilization and recruitment; and, intervention session implementation and monitoring.

The intervention manual will be developed first by integrating existing materials from evidence-based interventions that address the intervention aims with the target groups identified for this

project. This draft manual will be adapted, contextualized, and translated for use in the local setting through a consultative workshop process that will include local stakeholders and experts, and international experts in primary prevention of VAWG. The final manuals will be available in English and Khmer. Facilitators and supervisors will be trained for the specific intervention including participatory facilitation skills. These facilitators will be recruited, supervised, and supported by the local implementing organization. P4P will lead the initial facilitator training, while on-going support, supervision, and booster trainings will be lead by the local UN agencies and implementing organization.

The multi-faceted intervention strategy is summarized in the table below:

	YOUTH COMPONENT	ADULT/COMMUNITY COMPONENT
Intervention	▪ 22 weekly or fortnightly sessions (approx. 2 hrs. each) delivered after school or over weekends over a 12 month period.	▪ 12 fortnightly or monthly sessions (approx. 3 hrs. each) delivered over weekends or on weekday evenings over a 12 month period.
Location and number of groups	▪ Kampong Cham province. ▪ 1 district in Kampong Cham with 1 group each in 5 communes. ▪ Total number of groups: 5	▪ Kampong Cham province. ▪ 1 district in Kampong Cham with 1 group each in 5 communes. ▪ Total number of groups: 5
Participants	▪ 12-14 year old adolescents (50% girls, 50% boys) in each commune. ▪ Group size 20-25 adolescents. ▪ Total participants: approximately 100-125 adolescents.	▪ Caregivers of adolescents including parents/guardians, teachers, youth service providers, other key community members in each commune. ▪ Group size 20-25 caregivers. ▪ Total participant: = approximately 100-125 adults.
Facilitators	▪ 3 local facilitators for each group. ▪ Total: 15 facilitators	▪ 3 local facilitators for each group. ▪ Total: 15 facilitators

Linking to services	Referral Directories will be developed and attached to the manuals for adolescents and caregivers and facilitators will be trained to make referrals to workshop participants. In addition, service providers who are already providing services on VAWG will be sensitized to the project.
Volunteerism	Volunteer facilitators will be trained and supported to implement the intervention with the manual guide. Promote adolescent-adult partnership volunteer community development project.

Appendix 7 - Understanding the effects of "Shaping our Future: Developing healthy and happy relationships"

Co-Principal Investigators:

Dr Anik Gevers

Consultant: Partners for Prevention

UNDP, UNFPA, UN Women & UNV Regional Joint Programme for Asia and the Pacific

26 Durham Street, Harfield Village, Claremont, 7708, South Africa

Telephone: +27 71 155 0785

Email: geversanik@gmail.com

Kathy Taylor

Manager, Partners for Prevention

UNDP, UNFPA, UN Women & UNV Regional Joint Programme for Asia and the Pacific

3rd Floor, UN Service Building

Rajadamnern Nok Avenue

Bangkok 10200 Thailand

Telephone: +66 2 304 9100 x 2760

Email: Kathy.taylor@one.un.org

Sokroeun Aing

Gender Analyst

United Nations Population Fund (UNFPA) Cambodia

Phnom Penh Center, Room 526 – North building (5th floor).

Telephone: +85523215519/216295 ext. 118

Fax : +85523211339

Mobile : +855 12 575 161

Email: aing@unfpa.org

Saky Lim

Monitoring and Evaluation/Local Governance Programme Officer

United Nations Population Fund (UNFPA) Cambodia

Phnom Penh Center, Room 526 – North building (5th floor).

Telephone: +85523215519/216295

Fax : +85523211339

Email: slim@unfpa.org

Summary

Background

The Partners for Prevention UN Multi-Country Study on Men and Violence carried out in Cambodia (and other countries in the Asia-Pacific region), documented men's use of violence and identified key risk factors for perpetration of VAWG with a particular focus on intimate partner violence (IPV) (Fulu, Warner, & Moussavi, forthcoming). The results of this questionnaire revealed that more than one half of men perpetrated emotional and/or economic IPV during their lifetime. More than one third of men perpetrated physical and/or sexual violence against a partner in their lifetime, with sexual violence (20% perpetration prevalence) more commonly reported than physical violence. The lifetime prevalence for non-partner rape was 8% and 5% for gang rape of a woman. Rape and gang rape of a man during their lifetime was reported by 4% and 3% of men respectively. More than half of all men who reported rape did so when they were teenagers and 25% of men who reported first committing rape before the age of 15 year old.

These findings indicate an urgent need for effective primary prevention interventions that will prevent such violence from occurring at all. UNFPA, UN Women, and UNV in Cambodia have partnered with the Ministry of Women's Affairs supported by Partners for Prevention (a regional, multi-agency project) to develop and pilot such an intervention. The proposed study aims to conduct a formative evaluation of this intervention pilot in order to provide high quality data to understand the acceptability, feasibility, relevance, and potential impact of the intervention.

Objectives

The overall objective of this study is to function as Monitoring and Evaluation activities to understand the reception, experience, and potential impact of a primary prevention of violence against women and girls (VAWG) intervention.

The specific objectives are to:

1) Document the impact of the *Shaping our Future: Developing Healthy and Happy Relationships* intervention on the following outcome areas:

    a) Young adolescent boys and girls:

        i) Gender equitable attitudes

ii) Violence acceptance attitudes

iii) Parental/caregiver relationship quality

iv) Communication and conflict resolution behavior

v) Engagement in volunteerism

b) Adult caregivers/parents of adolescents:

i) Gender equitable attitudes

ii) Violence acceptance attitudes

iii) Relationship quality with teenager

iv) Communication and conflict resolution behavior

v) Engagement in volunteerism

vi) Use of harsh punishments

2) Investigate participants' experiences of the intervention and their narratives of change related to these experiences in context of their day to day lives to understand the acceptability, relevance, and personal impact of the intervention

3) To use the formative evaluation findings to inform intervention strengthening and potential scale up

Methods

This study seeks to conduct quantitative and qualitative formative evaluation of the *Shaping our Future: Developing Healthy and Happy Relationships* intervention by (a) doing a quantitative within group comparison of change using baseline and end line questionnaire data from intervention participants (Adolescents n=100-125, Caregivers n=100-125); (b) recording qualitative feedback about the intervention experience and impact from intervention participants in a joint session at the end of the intervention (n=10 sessions); and (c) qualitative feedback sought after the end of the intervention from key stakeholders/informants including the intervention facilitators (for Adolescents n=15, for caregivers n=15) and supervisors (n=2-4) and (if possible) 1-2 community leaders (n=5-10) from each community in the intervention.

This multi-method, within group comparison and qualitative feedback allows us to gain a preliminary understanding of the intervention impact, acceptability, and feasibility within a very limited monitoring and evaluation budget that does not allow for a full randomized control trial or quasi-experimental evaluation of the intervention.

Ethical Considerations

In partnership with UNFPA, UN Women, and UNV, the national and provincial Ministry of Women's Affairs is implementing the intervention in 5 Communes, in 1 District, in Kampong Cham province. The adolescent and adult intervention participants will be invited to participate in questionnaires (baseline and end line) and focus group discussions (end line only). All research activities are voluntary. Adult participants will give informed consent and parents will provide informed consent for their adolescents and then adolescents will provide informed assent confirming agreement to participate before commencing any such activity. Participants' anonymity and confidentiality is protected and referral sources will be provided to all participants in the form of an information

sheet. In addition, individual participants who seek additional advice from project staff will be given referral counseling as needed.

Background Information and Rationale

Violence against women and girls (VAWG) is a worldwide public health, human rights and societal problem encompassing many forms of violence including: intimate partner violence (IPV), non-partner sexual violence, sexual abuse of girl children, female genital mutilation, sexual trafficking of women, child marriage and honour killings. Research spanning several decades has shown that nearly a third (30%) of women aged 15 and over globally experience physical or sexual intimate partner violence in their lifetimes (Devries et al., 2013). The global prevalence figure masks considerable variation between countries: in the World Health Organization (WHO) multi-country study on women's health and domestic violence, a range of lifetime prevalence of physical or sexual violence between 15% and 71% of ever partnered women was reported (Garcia-Moreno et al., 2005).

The health consequences of GBV are multiple. Globally, 38% of all murders of women are committed by intimate partners (Abrahams et al., 2013). Furthermore, abused women have a 16% greater likelihood of having a low-birth-weight baby, more than twice the likelihood of having an abortion, almost twice the likelihood of having depression, and, in some regions, are 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence (Jewkes et al., 2010). Research indicates that rape is disproportionately common among mental health service users and the prevalence of substance abuse, depression, suicidality and anxiety among women who have been raped or trafficked is much higher than those who have not (Filipas and Ullman SE, 2006, Kilpatrick et al., 1997, Abrahams N et al., in press, Seedat et al., 2005, Myer et al., 2008, Smit et al., 2006).

Children who have been physically or sexually abused have a greater risk of depression, suicidality, post-traumatic stress disorder, unwanted pregnancy, alcohol dependency and sexually transmitted infections (Turner et al., 2006, Felitti et al., 1998, Koss MP, 2003, Jewkes R et al., 2010). Exposure to abuse and neglect also increases the risk of developing anti-social and violent behaviour, including rape perpetration (Caspi A et al., 2002, Jewkes et al., 2011).

Gender-Based Violence in Cambodia

The 2014 Cambodia Demographic and Health Survey included a domestic violence module (National Institute of Statistics, et al., 2015). This survey found approximately 20% of women (between the ages of 15 and 49 years) had experienced physical violence at least once in their lives and 6% of women had experienced sexual violence in their lives. Among ever married women (between the ages of 15 and 49 years), 18% had experienced physical or sexual violence perpetrated by a spouse.

A WHO report documented that intimate partner violence is more common than non-partner violence against women in Cambodia (WHO, in press). Specifically, 21% of ever partnered women (15-64 years old) had experienced physical or sexual violence by a partner and 32% had experienced emotional partner violence victimization. Further, most women who experienced violence in an intimate relationship experienced severe and chronic or ongoing violence rather than moderate or single incident violent victimisation. For non-partner violence, 14% of women reported experiencing physical violence victimization by a non-partner and 4% experience sexual violence victimization by a non-partner.

The Partners for Prevention UN Multi-Country Study on Men and Violence (UN MCS) carried out in Cambodia (and other countries in the Asia-Pacific region), documented men's use of violence and identified key risk factors for perpetration of VAWG with a particular focus on IPV (Fulu, Warner, & Moussavi, forthcoming). The results of this questionnaire revealed that more than one half of

men perpetrated emotional and/or economic IPV during their lifetime. More than one third of men perpetrated physical and/or sexual violence against a partner in their lifetime, with sexual violence (20% perpetration prevalence) more commonly reported than physical violence. The lifetime prevalence for non-partner rape was 8% and 5% for gang rape of a woman. Rape and gang rape of a man during their lifetime was reported by 4% and 3% of men respectively. More than half of all men who reported rape did so when they were teenagers and 25% of men who reported first committing rape before the age of 15 year old.

An analysis comparing men who used IPV and those who did not elucidated specific risk factors associated with IPV perpetration. These risk factors included:

- low gender equitable attitudes;
- poor relationship building skills (frequent quarreling with partner);
- mental health challenges (depression, alcohol);
- childhood adversity (experiencing physical or sexual abuse during childhood; witnessing or other exposure to violence);
- involvement in other high risk behavior (being involved in fights with weapons, engaging in transactional sex, having two or more sexual partners); and
- lower levels of education (especially no secondary schooling).

For non-partner rape, risk factors included:

- mental health challenges (depression); and
- involvement in other violence and high risk behavior (including: drug abuse, involvement in gangs, fighting with weapons, engaging in transactional sex, having two or more sexual partners).

In addition, the questionnaire established the motivations for rape perpetration reported by men who had perpetrated such violence and these included (listed in rank order from highest to lowest):

- Sexual entitlement;
- anger/punishment (especially for partner rape);
- bored/fun (especially for non-partner rape); and
- drinking (least frequent for all types of rape).

The majority of men reported moderate gender equitable attitudes and women generally reported less equitable, more conservative, traditional gender attitudes in comparison. This finding notes the importance of conducting gender transformative work with both men and women to promote gender equity and alternative constructions of masculinities and femininities that are more open and flexible that hegemonic ideals that promote aggression and dominance of men and passivity and compliance of women. The study findings also indicated that individuals' gender attitudes were influenced by their parents' gender attitudes and roles in the home, and how these issues were addressed in teachings at school. Overall, attitudes to VAWG were not accepting; however, men in general reported feeling that the law was too harsh on punishing perpetrators of domestic violence suggesting some level of support for or understanding of such behavior. Most men reported high levels of trauma and adversity (e.g., emotional abuse, physical punishment, food insecurity) during

their childhoods. 43% of men were considered clinically depressed and 25% were considered highly depressed.

There are different types of services needed to support VAWG survivors such as health services, mental health services, legal assistance & human rights services, shelter, and social services which support survivors of violence in provincial level. Strengthening linkage between beneficiaries and such services is needed to increase safe access of survivors to the services.

Rationale

The findings that emerged from this study present an opportunity to engage in evidence-driven primary prevention of VAWG intervention development. That is, by understanding the modifiable underlying driving factors (the risk factors noted above) associated with VAWG perpetration an intervention can be designed to address these factors and thus potentially prevent VAWG before it ever begins.

Therefore, UNFPA in partnership with UN Women and UNV in Cambodia together with the Ministry of Women's Affairs and supported by Partners for Prevention have developed and plan to pilot a community-based intervention that engages young adolescents and key adolescent caregivers. This study seeks to conduct a formative evaluation to determine the feasibility, acceptability, accessibility, and promising impacts of the intervention as a proof of concept to practically inform further primary prevention policy and practice in Cambodia.

Objectives

The overall objective of this study is to function as Monitoring and Evaluation activities to understand the reception, experience, and impact of a primary prevention of VAWG intervention.

The specific objectives are to:

1) Document the impact of the *Shaping our Future: Developing Healthy and Happy Relationships* intervention on the following outcome areas:

    a) Young adolescent boys and girls:

        i) Gender equitable attitudes

        ii) Violence acceptance attitudes

        iii) Parental/caregiver relationship quality

        iv) Communication and conflict resolution behavior

        v) Engagement in volunteerism

    b) Adult caregivers/parents of adolescents:

        i) Gender equitable attitudes

        ii) Violence acceptance attitudes

        iii) Relationship quality with teenager

        iv) Communication and conflict resolution behavior

v) Engagement in volunteerism

vi) Use of harsh punishments

2) Investigate participants' experiences of the intervention and their narratives of change related to these experiences in context of their day to day lives to understand the acceptability, relevance, and personal impact of the intervention

3) To use the formative evaluation findings to inform intervention strengthening and potential scale up

Study Population

The study population includes residents of Kampong Cham province, and specifically the adolescent (approximately n=100-125) and adult participants (approximately n=100-125) in the *Shaping our Future: Developing Healthy and Happy Relationships* intervention.

Inclusion criteria

Individuals will be eligible for inclusion in the study if they meet the following criteria:

1) Participant in the *Shaping our Future: Developing Healthy and Happy Relationships* intervention (either the adolescent group or the caregivers group) OR a person identified as a key stakeholder or key informant for the *Shaping our Future: Developing Healthy and Happy Relationships* intervention

2) Adolescent in the intervention whose parent/legal guardian voluntarily gives informed consent and who also provide their own voluntary informed assent to participate in the quantitative questionnaires and/or qualitative inquiry sessions

3) Adult in the intervention or a key informant/stakeholder who voluntarily gives informed consent to participate in the quantitative questionnaires and/or qualitative inquiry sessions

Exclusion criteria

Individuals will be excluded from the study if they meet any of the following criteria:

1. Not participating in or a key stakeholder/informant for the *Shaping our Future: Developing Healthy and Happy Relationships* intervention; or

2. Does not agree (consent + assent) to complete the quantitative questionnaire or participate in qualitative inquiry sessions.

Confidentiality

All study participants will be assured confidentiality in the research study. Their anonymity will be protected in the repeated quantitative questionnaires by not linking or recording identifying information in the questionnaire. Instead, a randomly generated and randomly assigned seven digit numeric code will be provided for each participant. Three stickers with the same code will be inside

sealed envelopes that are attached to one another; upon assignment, the participant will write their name, birth date, address, and other contact information as relevant on the front of the envelope and sign across the back of the envelope so that they can see at each subsequent data collection period that the codes have not been removed. At each data collection point the participant will retrieve one envelope with their personal information on it and remove one code sticker from the envelope and stick it onto their questionnaire. The envelopes will be disposed of and destroyed separately at the end of the study so that there is no record linking identifying information and the code. Because the code is inside an envelope, the only way to identify the code of a specific person would be to compromise all participants' codes in the entire study before data collection has been completed. In order to prevent such a breach; the study manager will keep all envelopes locked and only the envelopes for the specific community where data collection will take place on any given day will be taken to data collection.

Participation in the study is voluntary and individuals will not be excluded from participating in the intervention should they choose not to participate in the research. Further, participants can choose to stop participating in any of the research activities at any point during the data collection session or the study, and/or they may decline to answer specific items without any penalty.

Informed consent will be administered to every participant both verbally and in writing. That is, every participant will receive an information sheet in writing and it will be read out and explained to them. The information sheet describes the study and study procedures in full including potential risks and benefits, explains voluntary participation and the option to decline or withdraw. Participants are given the opportunity to ask questions before making a decision on whether or not they would like to participate in the study. Individuals who agree to participate will be asked to sign an informed consent form to indicate that they understand what is being asked of them and consent to participate in the study activities. For those persons who are illiterate an independent witness to the consent process will participate in the consent process to ensure the participant has fully understood the purpose of the evaluation research project, including signing and filling the consent form on behalf of the participant. For adolescents, informed consent will be sought from their parent or legal guardian and informed assent will be sought from the young people themselves before they are enrolled in any study activity. These forms will be kept by the study manager and separate from the data to further protect individuals' privacy.

Study Design

This study seeks to conduct quantitative and qualitative formative evaluation of the *Shaping our Future: Developing Healthy and Happy Relationships* intervention by (a) doing a quantitative within group comparison of change using baseline and end line questionnaire data from intervention participants (Adolescents n=100-125, Caregiver n=100-125); (b) recording qualitative feedback about the intervention experience and impact from intervention participants at the end of the intervention (Adolescents n=100-125, Caregiver n=100-125); and (c) qualitative feedback sought from key stakeholders/informants including the intervention facilitators (n=30) and supervisors (n=2-4) and 1-2 community leaders (n=5-10) from each community in the intervention.

This multi-method, within group comparison and qualitative feedback allows us to gain a preliminary understanding of the intervention impact, acceptability, and feasibility within a very limited monitoring and evaluation budget that does not allow for a full randomized control trial or quasi-experimental evaluation of the intervention.

Study procedure and evaluation tools

Quantitative data will be collected from all intervention participants who consent to participate in the research activity. A self-report questionnaire adapted from the UN MCS used in Cambodia (Fulu, Warner, & Moussavi, forthcoming) as well as other measures typically used in evaluation studies of similar interventions (Mathews, et al., 2015; Shamu, et al., 2015) will gather the following information:

1) Background information including sex, age, education, relationship status, family/household socioeconomic status, childhood adversity'

2) Gender attitudes;

3) Violence acceptance attitudes;

4) Relationship quality (with parents/caregivers for adolescents OR with teenagers for caregivers)

5) Communication and conflict resolution behavior

6) Engagement in volunteerism

7) Attitudes to school

8) Relationship control (adolescents only)

9) Harsh punishments (caregivers only)

10) Knowledge of support services

11) Attendance and acceptance of intervention

These outcome areas were identified in the intervention model theory of change and thus are the key areas in which the intervention intends to effect change. All items in the questionnaire were previously validated in similar studies; therefore, there is good precedence for their validity and acceptability. All questionnaires will be translated into Khmer and the translations will be carefully checked and proofed to ensure that they can be easily understood by study participants and still maintain fidelity to the original items.

This questionnaire will be administered before the intervention is implemented (baseline) and after the end of the intervention (endline). The questionnaire will be completed by participants themselves in group settings where a fieldworker will read the questionnaire item by item to help those with low literacy levels.

After going through the full informed consent procedure, the study staff will provide an orientation to the questionnaire and how to complete it. Questionnaire administration will take place in groups of approximately 25-30 study participants in a data collection session. For the adolescent groups, girls and boys will sit in separate groups.. The study staff will read the questionnaire for the group item-by-item to help all participants follow all questions and answer options to account for any struggles with literacy. Study staff will provide support to participants who are illiterate but want to participate in the questionnaire.

At the end of the questionnaire (approximately 1,5hrs), all participants will be given a sheet with information about referral sources of places or organisations to get help for issues related to violence or abuse, stress or mental health issues, alcohol or drug abuse, and general health social welfare services. These information sheets are provided to all participants in order to alleviate any

suspicion or stigma (everyone is given the same sheet) and because the study staff will not know what issues individuals have reported in the questionnaire as they are being self-administered with anonymity by participants. In addition, the study staff will be available to study participants after the session to discuss specific issues that arose should individual participants wish to do so; these study staff will be trained to provide referral recommendations to participants. In addition, these participants will be engaged with the on-going intervention and the intervention staff will also be trained to provide support and referrals to participants as needed. Up to 131 adolescents and 127 caregivers will be eligible to be invited to participate in the questionnaire research activity.

The qualitative data will be collected from the intervention participants, the implementation facilitators and supervisors, and other key stakeholders or informants. The first will be during the final meeting of the intervention for each group. Participants (approximately Adolescents n=100-125, Caregiver n=100-125 will be eligible) will be invited to volunteer their experiences of the intervention including any challenges and/or benefits that they experienced from it. An inquiry guide (see Appendix 2) will be used to gather this feedback in focus group discussions. Individuals or groups can request that their feedback not be recorded for use in the research study. A study staff member will record a summary of this feedback and it will be translated into an English report for analysis by the research team. Workshop facilitators will not be present at these feedback sessions in order to allow participants the opportunity to share honest feedback.

Intervention facilitators (n=30) and intervention supervisors (n=2-4) will be invited to give feedback on their experiences of implementing the intervention after the intervention implementation has been completed, the changes they noticed among themselves, participants, and across the community, and any recommendations they have to strengthen the intervention or scale it up (see Appendix 2). Further, the monitoring reports filed by the facilitators and supervisors will provide qualitative data for insight into process factors to contextualize the data and findings on the impact of the intervention. In addition, community leaders will be invited to provide their feedback on the intervention including any community benefits they have noticed stemming from the intervention in their communities as well as their recommendations for future strengthening or scale up of the intervention. See Appendix 3 for the qualitative inquiry guides.

All study staff will be given training on the research instruments and protocols as well as ethical and sensitive research methodologies including being non-judgmental and maintaining strict confidentiality of participants and their information, supporting participants who struggle with sensitive questions, providing referrals, and supporting participants who struggle with understanding the questionnaire.

Data analysis/ statistical considerations

The quantitative data will be pooled from all participants and all time points. Basic descriptive statistics for each round of quantitative data will be generated including proportions or means calculated and presented with 95% confidence intervals calculated using standard methods. Comparisons between each time point will be conducted (t-test and chi-square test for simple comparisons of continuous and categorical variables respectively; a regression analysis to assess change over time while controlling for baseline).

The qualitative data will be analysed thematically and used to expand on the quantitative findings and to provide more context and nuanced detail to the intervention experience and impact on individuals' lives as well as perceptions of community level impact and recommendations for intervention strengthening or scale up.

Quantitative and qualitative findings will be discussed and interpreted with the full study team, and, where the local team deem necessary, in community fora where the intervention was implemented.

The study findings will be disseminated via the local study team and to a global audience via technical and academic reports.

Risks and Benefits

Potential risks

This research includes a number of personal topics. It is a concern that there is a potential for harm to participants in research on VAWG-related topics when researchers are not well trained and sensitive to the issues of this population. We will ensure that the staff involved in this study are well trained to sensitively and ethically conduct this evaluation and especially with young adolescents to minimize any such impacts. The most important concerns relate to the risk of re-victimisation, retribution, or stigmatization of participants and the risk of psychological distress to participants through being asked to re-remember traumatic events.

The World Health Organisation (WHO) and Sexual Violence Research Initiative (SVRI) developed guidance on safety in conduct of research in this area (WHO 2001; Sexual Violence Research Initiative, 2012). These documents recommend that the nature of gender-based violence research be concealed until after the completion of fieldwork. This is done by framing the study in more general terms. In this evaluation we are interested in a broader range of experiences and feedback as this study focuses on documenting and understanding people's experiences of and transformation related to an intervention that addresses some of the risk factors for VAWG, but we do not ask any participants directly about intimate partner violence experiences.

The risk of retribution against or stigmatization of any participant because of their answers is guarded against by using anonymous, self-completed questionnaires and not including any identifying data linked to the questionnaire responses as well as voluntary participation. For qualitative aspects of the research – no sensitive questions will be used for the qualitative feedback completed in groups.

Research from diverse global settings (such as Nicaragua and South Africa) has shown that women victims of violence are saddened by answering questions about their exposure to violence but overwhelmingly they welcome a chance to talk and many describe the research interview as a life changing occurrence indicating a very low risk of retraumatisation (Ellsberg et al 2001; Sikweyiya & Jewkes 2012; Salazar-Torres et al 2009). Indeed, similar research with adolescents has found very low risks of retraumatisation resulting from participation in ethically-conducted studies (McClinton Appolis, et al., 2014; McClinton Appolis, et al., 2015).

Further, all participants will be given a list of resources to find referral sources and the study and intervention staff will be trained to provide referrals to participants who ask them for additional help. Thus research has shown that if these guidelines are followed there are minimal risks attached to questionnaire research on VAWG (Sikweyiya & Jewkes 2011; Sikweyiya & Jewkes, 2012).

Any adverse events related to the evaluation project activities will be reported to the co-Principal Investigators who will file an adverse event report with the ethics committee. As noted, the anticipated risks for serious adverse events are very low because best practices are being followed in this evaluation project.

Known potential benefits

This study focuses on documenting the direct benefits of participation in an intervention; participants may feel empowered to participate in the research activities that prompt them to reflect on changes that they have undergone and reinforce prosocial changes such as engaging in volunteer activities

in their communities. Further, the data from the participants will directly inform both intervention strengthening and potential scale up.

Ethical considerations

Participation in this study is voluntary. Informed consent will be sought from eligible participants prior to any engagement in research activities. Adult participants will provide their own informed consents. Because adolescents are legally minors, the parent/guardian will first provide informed consent for their participation in the research study and then adolescents will be given the opportunity to provide informed assent before agreeing whether or not to participate. During the informed consent and assent process, eligible participants are informed about the study and the nature of the study activities, and they are given the opportunity to ask clarifying questions before deciding for themselves whether or not to agree to participate and signing the form to note their decision. Eligible participants are able to consent to all or only some of the research activities, and they are able to withdraw at any stage without providing a reason, and they are able to skip any question. There are no adverse consequences of choosing not to participate in any or all research activities, or withdrawing or skipping any questions.

All participants are assured that the information they provide in the study will be handled with complete anonymity.

This evaluation project will be conducted in line with ethical and best practices including alignment with the guidelines in the International Charter for Ethical Research Involving Children (http://childethics.com/charter/) and those of the WHO and SVRI mentioned above in the 'Potential Risks' section. All project staff will receive specific training to ensure their understanding and implementation of ethical practices including with young adolescent participants.

As noted in the 'Potential Risks' section above, best practices will be used to conduct this evaluation project to safeguard and support participants. These practices include: (a) training project staff to conduct the project sensitively and ethically – especially with young adolescents – as well as how to respond to potential participant concerns; and, (b) providing all participants with information about available help resources for a variety of concerns including where and how to report abuse.

Capacity development

Local involvement and participation: There are multiple ways in which this project is involving local organisations and individuals and building capacity in Cambodia. First, the evaluation project conceptualization was developed in partnership with national UN agency staff in Cambodia as well as with members of MoWA and local NGOs. Further, we will partner with local researchers to conduct this evaluation project. Therefore, there has been a high level of local involvement across multiple sectors throughout the development of this evaluation project and the intention is to continue such local partnerships through the implementation and results dissemination stages of the project.

Local capacity building: During the development stage of this project the capacity building focused on understanding the value of evaluating a violence prevention programme and learning about international best practice and then adapting these as needed to fit the local context. Thus, both the Cambodian and international participants benefited from this capacity building partnership. We were able to contribute to understanding and skills in monitoring and evaluation strategies for complex interventions (psychosocial-behavioural interventions are considered complex because the desired changes and approaches to create change are so nuanced) including using a multi-method approach and using findings to inform further work.

During the implementation of the evaluation project, capacity building of the local researchers (again with the aim of mutual sharing and capacity development in the partnership) will include

intensive in-country training workshops and regular contact throughout implementation to build skills (and knowledge of theory and methodologies) in multi-method programme monitoring and evaluation. This will include ethical considerations in evaluation, developing strong evaluation practices, analysing and interpreting quantitative and qualitative data, and disseminating the data/findings locally and internationally. In addition, quality control issues in both quantitative and qualitative data collection and management will be covered.

Community involvement, participation, impact and benefits: This evaluation project will benefit the community by generating important learning and evidence of the impact of the programme they are using in the community (namely, *Shaping our Future: Developing healthy and happy relationships*). The evaluation methodology includes a highly participatory, qualitative aspect for community members to share their perspectives and what they deem important for the evaluation. MoWA staff have been involved in the development of this evaluation project. A benefit of this evaluation project is the ability to highlight and document the work communities are doing.

Availability of study results: The analysis, interpretation, and preparation of results reports will be done within a partnership between local and international stakeholders that have already been involved in the development and will be involved in the implementation of this evaluation project. Further, this group will focus on the best methods for local dissemination of results and the results report will be made freely available online through Partners for Prevention upon receiving agreement on the final version from project partners.

Conflicts of interest

There are no conflicts of interest for the evaluation project team or the organizations that they work with.

Appendix 8 - Approved letter from ethics committee of the Ministry of Health

គណៈកម្មការសិក្សាផ្នែកសុខភាព
ក្រសួងសុខាភិបាល
National Ethics Committee for Health Research

លេខ.192.NECHR

រាជធានីភ្នំពេញ, ថ្ងៃទី 02 ខែ 05 ឆ្នាំ 2016

Dr. Anik Gevers

Project: Understanding the effects of Shaping our Future: Developing healthy and happy relationships.Version N° 1, dated 14th April, 2016

Reference: 29th April, 2016 NECHR meeting minute

Dear Dr. Anik Gevers,

I am pleased to notify you that your study protocol entitled "Understanding the effects of Shaping our Future: Developing healthy and happy relationships. Version N° 1, dated 14th April, 2016" has been approved by National Ethics Committee for Health Research (NECHR) in the meeting on 29th April, 2016. This approval is valid for twelve months after the approval date.

The Principal Investigator of the project shall submit following document to the committee's secretariat at the National Institute of Public Health at #80 Samdach Penn Nouth Blvd, Sangkat Boeungkok2, Khan Tuol Kork, Phnom Penh. (Tel: 855-23-880345, Fax: 855-23-881949):

- Annual progress report
- Final scientific report
- Patient/participant feedback (if any)
- Analyzing serious adverse events report (if applicable)

The Principal Investigator should be aware that there might be site monitoring visits at any time from NECHR team during the project implementation and should provide full cooperation to the team.

Regards,

Chairman

Prof. ENG HUOT

Works cited

Abrahams N., Jewkes R. & Mathews, S. 2013. Depressive symptomatology after a sexual assault: Understanding victim-perpetrator relationships and the role of social perceptions. *African Journal of Psychiatry*, 2013 Jul; 16(4): 288–93.

Abrahams, N., Mathews, S., Martin, L.J., Lombard, C. & Jewkes, R. 2013. Intimate partner femicide in South Africa in 1999 and 2009. *PLoS Med*, 10, e1001412.

Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., ... Watts, C. 2014. Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC medicine 12*(1): 122.

Afifi, T.O., Mota, N., Sareen, J. & MacMillan, H.L. 2017. The relationships between harsh physical punishment and child maltreatment in childhood and intimate partner violence in adulthood. *BMC Public Health*, 17: 493.

Amin, A., & Chandra-Mouli, V. (2014). Empowering adolescent girls: developing egalitarian gender norms and relations to end violence. Reproductive Health, 11, 75. http://doi.org/10.1186/1742-4755-11-75.

Blum, R. W., Astone, N. M., Decker, M. R., & Mouli, C. (2014). A conceptual framework for early adolescence: a platform for research. International Journal of Adolescent Medicine and Health, 26(3), 321–331. http://doi.org/10.1515/ijamh-2013-0327.

Caspi, A., Mcclay, J., Moffitt, T.E., Mill, J., Martin, J., Craig, I.W., Taylor, A. & Poulton, R. 2002. Role of genotype in the cycle of violence in maltreated children. Science, 297: 851-854.

Devries, K.M., Mak, J.Y., Garcia-Moreno, C., Petzold, M., Child, J.C., Falder, G., Lim, S., Bacchus, L.J., Engell, R.E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N. & Watts, C.H. 2013. Global health. The global prevalence of intimate partner violence against women. Science, 340: 1527–8.

Felitti, V., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M. & Edwards, V. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14: 245–258.

Filipas, H. & Ullman S.E. 2006. Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence*, 21: 652–672.

Fulu, E., Warner, X. and Moussavi, S. 2013. *Men, gender and violence against women in Cambodia: findings from a household study with men on perpetration of violence*. Phnom Penh: UN Women Cambodia.

Garcia-Moreno, C., Jansen, H.A.F.M., Ellsberg, M. & Watts, C. 2005. *WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial results on prevalence, health outcomes and women's responses.* Geneva, Switzerland: World Health Organization.

Hinton, A.L. 2005, *Why Did They Kill? Cambodia in the Shadow of Genocide*. Berkeley and Los Angeles, California: University of California Press.

Jama Shai, N., Mahlangu, P., Gevers, A., Shamu, S., & Jewkes, R. 2015. The effectiveness of a parent-teenager relationship strengthening programme in South Africa. SVRI Forum 2015: Stellenbosch, South Africa.

Jewkes, R., Dartnall, E. & Sikweyiya, Y. 2012. *Ethical and Safety Recommendations for Research on the Perpetration of Sexual Violence*. Sexual Violence Rresearch Initiative, and Medical Research Council, Pretoria, South Africa

Jewkes, R., Dunkle K., Nduna M. & Shai N. 2010. Intimate partner violence, relationship gender power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet 367: 41–48.

Jewkes, R., Gevers, A., Shamu, S., Mahlangu, P., Shai, N., Lombard, C. & Chirwa, E. 2017. *Outcome of the randomized controlled trial to evaluate the Skhokho violence prevention intervention in South African schools*. SVRI 2017.

Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A., & Duvvury, N. 2008. Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. *BMJ 337*: a506.

Jewkes, R., Sikweyiya, Y., Morrell, R. & Dunkle, K. 2011. Gender inequitable masculinity and sexual entitlement in rape perpetration South Africa: findings of a cross-sectional study *PloS One*, 6.

Kilpatrick, D. G., Acierno, R., Resnick, H. S., Saunders, B. E. & Best, C. L. 1997. A 2-year longitudinal analysis of the relationships between violent assault and substance abuse in women. *Journal of Consulting and Clinical Psychology,* 65: 834–847.

Koss, M. P., Yuan, N. P., Dightman, D., Prince R. J., Polacca M., Sanderson B., Et Al. 2003. Adverse childhood exposures and alcohol dependency among seven native American tribes. *Am J Prev Med*, 25: 238–244.

Marston, John 1997. *Cambodia 1991–1994: hierarchy, neutrality and etiquettes of discourse.* Doctoral Dissertation, University of Washington.

Mathews, C., Eggers, S.M., Townsend, L., Aarø, L.E., de Vries, P.J., Mason-Jones, A.J., ... De Vries, H. (2016). Effects of PREPARE, a Multi-component, School-Based HIV and Intimate Partner Violence (IPV) Prevention Programme on Adolescent Sexual Risk Behaviour and IPV: Cluster Randomised Controlled Trial. *AIDS and behavior, 20*(9): 1821–1840.

Myer, L., Smit, J., Roux, L.L., Parker, S., Stein, D. J. & Seedat, S. 2008. Common mental disorders among HIV-infected individuals in South Africa: prevalence, predictors, and validation of brief psychiatric rating scales. *AIDS Patient Care STDS*, 22: 147–58.

National Institute of Statistics. 2015. *Cambodia Socio-Economic Survey.* Ministry of Planning: Phnom Penh, Cambodia.

Nguyen, H.T., Tran, P.K., Gevers, A. & Taylor, K. 2017. A Qualitative Endline Study of a Male Advocate Intervention to Prevent Violence against Women and Girls in Da Nang, Viet Nam. Available from: http://partners4prevention.org/resource.

Nho, C.R. & Seng T. 2017. Predictors of Cambodian parents' perceptions of corporal punishment. *Asian Soc Work Pol Rev.* 2017; 11: 168–180.

Raising Voices 2015. *Stronger together: Engaging both women and men in SASA! to prevent violence against women.* Learning From Practice Series, No. 4: Research Perspectives. Kampala, Uganda: Raising Voices.

Seedat, S., Stein, D. J. & Carey, P. D. 2005. Post-traumatic stress disorder in women: epidemiological and treatment issues. *CNS Drugs*, 19: 411–27.

Seminar Report. Parenting in Cambodia. Friday 21 March, 2014. Phnom Penh. Available at: https://www.ics.nl/assets/ReportParentingSeminar_March 21 Phnom Penh_ICS RUPP.pdf, accessed 10 November 2017.

Siu, G.E., Wight, D., Seeley, J., Nametubi, C., Sekiwunga, R., Zalwango, F. & Kasule, S. 2017. Men's Involvement in a Parenting Programme to Reduce Child Maltreatment and Gender-Based Violence: Formative Evaluation in Uganda. *The European Journal of Development Research:* 1–21.

Smit, J., Myer, L., Middelkoop, K., Seedat, S., Wood, R., Bekker, L.G. & Stein, D. J. 2006. Mental health and sexual risk behaviours in a South African township: a community-based cross-sectional study. *Public Health*, 120: 534–42.

Turner, H., Finkelhor D. & Ormrod R. 2006. The effect of lifetime victimization on the mental health of children and adolescents. *Social Science & Medicine*, 62: 13–27.

World Health Organization. 2003. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women*, 2nd ed. World Health Organization, Geneva.

WHO and Cambodia Ministry of Women's Affairs 2015. *National Survey on Women's Health and Life Experiences in Cambodia:* 22.