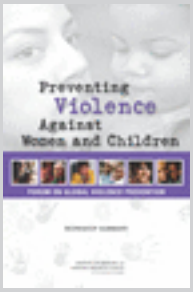

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Preventing Violence Against Women and Children

Workshop Summary

Deepali M. Patel, *Rapporteur*

Forum on Global Violence Prevention
Board on Global Health

INSTITUTE OF MEDICINE
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"Knowing is not enough; we must apply.
Willing is not enough; we must do."
—Goethe

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This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this report:

NAEEMAH ABRAHAMS, Senior Researcher, Gender & Health Research Unit, Medical Research Council of South Africa
MANUEL CONTRERAS, Gender and Public Health Specialist, International Center for Research on Women
LISA NAJAVITS, Professor of Psychiatry, Boston University School of Medicine
AGNES TIWARI, Associate Professor and Assistant Dean, School of Nursing, Li Ka Shing Faculty of Medicine of the University of Hong Kong

Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the final draft

of the report before its release. The review of this report was overseen by **Richard Krugman,** Vice Chancellor for Health Affairs and Dean, University of Colorado at Denver. Appointed by the Institute of Medicine they were responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the author and the institution.

Contents

1

Introduction

Violence against women and children is a serious public health concern, with costs at multiple levels of society. Although violence is a threat to everyone, women and children are particularly susceptible to victimization because they often have fewer rights or lack appropriate means of protection. In some societies certain types of violence are deemed socially or legally acceptable, thereby contributing further to the risk to women and children.

In the past decade research has documented the growing magnitude of such violence, but gaps in the data still remain. Victims of violence of any type fear stigmatization or societal condemnation and thus often hesitate to report crimes. The issue is compounded by the fact that for women and children the perpetrators are often people they know and because some countries lack laws or regulations protecting victims. Some of the data that have been collected suggest that rates of violence against women range from 15 to 71 percent in some countries and that rates of violence against children top 80 percent (García-Moreno et al., 2005; Pinheiro, 2006). These data demonstrate that violence poses a high burden on global health and that violence against women and children is common and universal.

On January 27-28, 2011, the Institute of Medicine's Forum on Global Violence Prevention convened its first workshop to explore the prevention of violence against women and children. Part of the forum's mandate is to engage in multisectoral, multidirectional dialogue that explores cross-cutting approaches to violence prevention. To that end, the workshop was designed to examine these approaches from multiple perspectives and at multiple levels of society. In particular, the workshop was focused on

exploring the successes and challenges presented by evidence-based preventive interventions and examining the possibilities of scaling up or translating such work in other settings. Speakers were invited to share the progress and outcomes of their work and to engage in dialogue exploring gaps and opportunities in the field.

The workshop was planned by a formally appointed committee of the Institute of Medicine (IOM), the members of which created an agenda and identified relevant speakers. Because the topic is large and the field is broad, presentations at this event represent only a sample of the research currently being undertaken. Speakers were chosen to present a global, balanced perspective, but by no means a comprehensive one. The agenda for this workshop can be found in Appendix A.

ORGANIZATION OF THE REPORT

This summary provides a factual account of the presentations given at the workshop. Opinions expressed within this summary are not those of the Institute of Medicine, the forum, or its agents, but rather of the presenters themselves. Statements are the views of the speakers and do not reflect conclusions or recommendations of a formally appointed committee. This summary was authored by a designated rapporteur based on the workshop presentations and discussions and does not represent the views of the institution, nor does it constitute a full or exhaustive overview of the field.

The workshop summary is organized thematically, covering the major topics that arose during the two-day workshop, so as to provide a larger context for these issues in a more compelling and comprehensive way. As well, the thematic organization allows the summary to serve as an overview resource of important issues in the field. The themes were chosen as the most frequent, cross-cutting, and essential elements that arose from the workshop, but do not represent the views of the IOM or a formal consensus process.

The summary begins with a brief introduction of the issue, followed by two parts and an appendix. The first part consists of four chapters that provide the summary of the workshop; the second part of the report consists of submitted papers and commentary from speakers regarding the substance of the work they presented at the workshop. These papers were solicited from speakers to provide further information of their work. The appendix contains additional information regarding the agenda and participants.

DEFINITIONS AND CONTEXT

Violence is defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself,

another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (WHO, 2002). When directed against women or children, this violence can take a number of forms, including, but not limited to, sexual violence, intimate partner violence, child abuse and neglect, bullying, teen dating violence, trafficking, and elder abuse. The majority of violence against women and children is perpetrated by partners, family members, friends, or acquaintances, so that most violence against women and children takes place in the form of intimate partner violence, family violence, or school violence (WHO and LSHTM, 2010).

These three types of violence, which are interconnected, are commonly referred to as being part of a "cycle of violence," in which victims become perpetrators. The workshop's scope was narrowed to focus on these elements of the cycle as they relate to interrupting this transmission of violence. Intervention strategies include preventing violence before it starts as well as preventing recurrence, preventing adverse effects (such as trauma or the consequences of trauma), and preventing the spread of violence to the next generation or social level. Successful strategies consider the context of the violence, such as family, school, community, national, or regional settings, in order to determine the best programs. Thus, the workshop operated in a multidimensional framework that integrated ecologic, public health, and trauma-informed paradigms to explore a comprehensive approach to violence prevention.

The next four chapters examine the four major themes that arose from participants' presentations and discussions: advancing research on co-occurrence of child maltreatment and intimate partner violence (Chapter 2), paradigm shifts and changing social norms (Chapter 3), the state of prevention research in low- and middle-income countries (Chapter 4), and prevention among multiple sectors (Chapter 5). The three chapters in Part 2 include the submitted papers, organized as (1) overviews of evidence, (2) global partnerships and government initiatives, and (3) examples of preventive interventions.

And finally the appendixes consist of the agenda (A), the speakers' biographies (B), the planning committee members' biographies (C), and the Forum on Global Violence Prevention members' biographies (D).

ACKNOWLEDGMENTS

The Forum on Global Violence Prevention was established to address a need to develop multisectoral collaboration amongst stakeholders. Violence prevention is a cross-disciplinary field, which could benefit from increased dialogue between researchers, policy makers, funders, and practitioners. The forum members chose the issue of violence against women and children

as the forum's first workshop theme because there is a pressing need to coordinate and collate the information in this area. As awareness of the insidious and pervasive nature of these types of violence grows, so too does the imperative to mitigate and prevent.

A number of individuals contributed to the successful development of this workshop and report. These include a number of Institute of Medicine staff: Tessa Burke, Marton Cavani, Rosemary Chalk, Kristen Danforth, Meg Ginivan, Wendy Keenan, Patrick Kelley, Angela Mensah, Elena Nightingale, Kenisha Peters, Lauren Tobias, Julie Wiltshire, and Jordan Wyndelts. The forum staff, including Deepali Patel, Rachel Pittluck, and Rachel Taylor, also put forth considerable effort to ensure this workshop's success. The staff at the Kaiser Family Foundation's Barbara Jordan Conference Center and Mind & Media provided excellent support for the live event and its webcast.

The planning committee contributed several hours of service to develop and execute the agenda, with the guidance of the forum membership. Reviewers also provided thoughtful remarks in the reading of the draft manuscript.

These efforts would not be possible without the work of the forum membership itself, an esteemed body of individuals dedicated to the concept that violence is preventable. Their names and biographies can be found in Appendix D.

And finally, the overall successful functioning of the forum and its activities rests on the foundation of its sponsorship. Financial support for the Forum on Global Violence Prevention is provided by the U.S. Department of Health and Human Services: Administration on Aging, Office of Women's Health; Anheuser-Busch InBev; Avon Foundation for Women; BD (Becton Dickinson, and Company); Catholic Health Initiatives; Centers for Disease Control and Prevention; Department of Education: Office of Safe and Drug-Free Schools; Department of Justice: National Institute of Justice; Fetzer Foundation; F. Felix Foundation; Foundation to Promote Open Society; Kaiser Permanente; National Institutes of Health: National Institute on Alcoholism and Alcohol Abuse, National Institute on Drug Abuse, Office of Research on Women's Health, John E. Fogarty International Center; Robert Wood Johnson Foundation; and the Substance Abuse and Mental Health Services Administration.

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Part I

Workshop Overview

2

The Co-Occurrence of Child Maltreatment and Intimate Partner Violence

A number of speakers in this workshop noted that violence against women and violence against children often occur together and share many common risk factors. For example, Mary Ellsberg, from the International Center for Research on Women, stated that "everything we know about family and community life would suggest that the two issues are intricately linked."

Speakers estimated the prevalence of child maltreatment and intimate partner violence using statistics from research in the United States, as much of the most recent data on the intersection of child maltreatment and intimate partner violence has come from the United States. A recent study using a nationally representative sample of children up to age 17 found that children who had witnessed intimate partner violence in the previous 12 months were 3.88 times more likely to experience maltreatment during those 12 months than children who had not witnessed intimate partner violence (Hamby et al., 2010). An earlier study found that approximately 35 percent of children in the United States between the ages of 14 and 17 have been exposed to intimate partner violence and that 40 percent of all child abuse victims report violence in the home between their parents (Finkelhor et al., 2009). Although not every child who is exposed to intimate partner violence is also a victim of maltreatment, or vice versa, the data from the United States suggest a spectrum of violence that cannot be easily parsed into its separate components.

Several presenters and workshop participants commented that historically there has been a dearth of data from low- and middle-income countries and that this dearth has begun to be addressed only recently.

International statistics for the co-occurrence of child maltreatment and intimate partner violence that are comparable to those reported for the United States and Europe are scarce. Indeed, most of the prevalence and incidence data discussed during the workshop concerning violence against women and children in low- and middle-income countries address the two issues separately. Some speakers pointed to the World Report on Violence and Health published by the World Health Organization (WHO) as a source of international data on violence against children (Krug et al., 2002). In particular, workshop speaker Claudia García-Moreno noted that this study estimates that 21 percent of urban schoolchildren and 65 percent of rural schoolchildren in Ethiopia report bruises or swelling due to parental beatings. Dr. García-Moreno also cited data from the WHO Multi-Country Study on Women's Health and Domestic Violence against Women, a study that she coordinated, which estimated the prevalence of intimate partner violence to be between 15 and 71 percent among women in the countries that were surveyed (García-Moreno et al., 2005). Although none of the workshop speakers cited international data focusing on the co-occurrence of violence against women and children, the sample statistics that were provided suggest the need for understanding and addressing violence within families rather than attempting to treat phenomena separately that are often associated with one another.

In addition to discussing the lack of data available from low- and middle-income countries, several speakers noted that efforts to understand and address violence against women are often artificially separated from similar efforts to understand and address violence against children. They noted that programming and funding often target specific populations (e.g., women but not children, or vice versa) rather than using an integrated approach that focuses on common risk factors. Concerns were also voiced about a lack of extant indicators that would allow researchers to collect data to measure the health and well-being of families as a whole, rather than breaking families down into component sub-groups of men, women, and children. Claire Crooks, from the Centre for Addiction and Mental Health, noted in her presentation that it is common practice to exclude from studies children who are exposed to more than one type of violence, as this polyvictimization is seen as a confounder. This presents an additional problem when women who are experiencing intimate partner violence are also perpetrating child maltreatment against their children. Dr. Crooks remarked that the complicated nature of violence within families results in very few programs and researchers "trying to understand the child and mother's exposure to violence together and figure out how to measure that, how to intervene with that."

A number of presenters spoke about efforts to address "family violence," as an attempt to bridge the traditional divide between intimate

partner violence and child maltreatment. Workshop speaker Denise Wilson of the Auckland University of Technology noted that in New Zealand family violence is defined as all violence and abuse occurring in close personal relationships. This can include child abuse and neglect, elder abuse, child-to-parent violence, and sibling violence. Although this terminology is less specific than violence against women and children, it speaks to the interconnected nature of these two problems.

Another attempt to integrate these types of violence is through a multisectoral approach to violence prevention. One example of a multisectoral approach on a national level is the Family Violence Initiative in Canada. Workshop speaker David Butler-Jones, Chief Public Health Officer at the Public Health Agency of Canada, described the Family Violence Initiative as a federal-level collaboration among 15 departments. "It isn't exclusively involved in departments federally," he added. "It engages provinces and territories, NGOs [nongovernmental organizations], and others at the same time."

THE CYCLE OF VIOLENCE

A central concept that underlies many of the discussions at the workshop is the cyclical nature of violence. The concept is particularly important in understanding the lifecourse implications as well as the intergenerational intersection of violence against women and children. In particular, workshop participants referred to the cycle of violence when describing the need to break down the silos that separate programming and funding for the prevention of violence against women from those for the prevention of violence against children. A number of speakers also referred to the cycle of violence in describing the implications of early exposure to violence, either directly or indirectly, throughout an individual's life. These effects include intergenerational transmission, in which individuals who experienced violence as children subject their own children to violence either through direct means, such as maltreatment, or through indirect means, such as exposure to intimate partner violence.

Dr. Crooks provided a graphic (Figure 2-1) during her presentation that depicted the cycle of violence. The understanding of violence illustrated in that figure demonstrates how individuals who are exposed to violence during various periods in their lives may eventually expose their own children to violence, thus perpetuating the cycle. Dr. Crooks explained that an important point in the cycle of violence is when an individual who has experienced violence exposes his or her own children to violence, either through perpetration or through exposure to intimate partner violence. However, she stressed that there are multiple pathways by which an individual can arrive at the point of intergenerational transmission of violence and that factors related to violence exposure earlier in life can play a significant role.

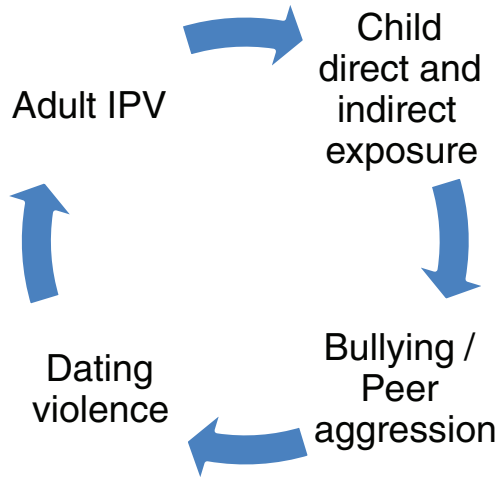

FIGURE 2-1 The cycle of violence.
SOURCE: Crooks, 2011.

A number of workshop participants stressed that although men are the primary perpetrators of violence against women and children, researchers and policy makers cannot ignore the fact that there are also women who abuse their children. Dr. Crooks also noted that not all children who are exposed to violence become perpetrators, although most perpetrators of violence were themselves victims of violence.

Dr. Crooks went on to describe a number of theories and frameworks that are important in understanding the psychosocial mechanisms behind the intergenerational transmission of violence. In particular, she highlighted contributions from the fields of attachment and social learning research. She explained that secure attachment is based on predictable, safe, and consistent caregiving. She further noted that attachment research has demonstrated the importance of very early relationship experiences, explaining that children can develop ideas, which they carry forward with them into adolescence and adulthood, about how safe the world is and about their place in relationships with others. Dr. Crooks commented that this can help to explain why people who experienced violence as children can grow up to do the same things to people in their adult lives.

Dr. Crooks also mentioned social learning theory, which explains that children learn unhealthy and coercive models about how to get their needs met when they are exposed to violence, either as witnesses or as direct victims. Children create models concerning effective strategies for various situations, and when they see that somebody's needs can be met in the family through abuse and violence, they are more likely to adopt similar strategies

for getting their own needs met, rather than employing good communication and problem-solving skills. The Fourth R curriculum, described by David Wolfe from the Centre for Addiction and Mental Health, is an example of a program that seeks to reduce violence by teaching conflict-resolution and communication skills to middle-school and high-school students. Dr. Wolfe reported that an analysis of the data found that the additional risk of violent delinquency that is normally associated with childhood maltreatment was reduced for students in intervention schools. Additional information on this program can be found in Chapter 8.

Dr. Crooks explained that as behaviors develop, attitudes develop to match. This process can result in what she referred to as "hostile attribution bias." For example, if an individual is living with violence, chaos, and trauma, that person learns to expect the very worst, and the worst-case scenario becomes the first thought because that is adaptive in dangerous situations. Even when that individual is in a safer environment, such as a school, it is difficult to suddenly disengage those adaptive behaviors. As a result, children with hostile attribution bias may interpret accidents, such as someone bumping into them, as attacks on their safety. They may eventually alienate their peers and be identified as aggressive by teachers. Dr. Crooks noted that this way of viewing the world can continue into adulthood and can contribute to the violence that is perpetrated against children by parents, who see their child's behavior as hostile in nature.

Many speakers referred to individuals who have been victims of violence eventually exposing their own children to violence. One example of data that have been interpreted as illustrating the cycle of violence came from workshop presenter Gary Barker of both the International Center for Research on Women and Instituto Promundo. According to an initial analysis of data from the International Men and Gender Equality Survey (IMAGES), which were collected from both rural and urban areas in a number of countries, men who reported witnessing violence in their home of origin are nearly twice as likely as other men to report using violence against a female partner later in life (Barker et al., 2011). In addition to this added propensity for violence perpetration and exposure later in life, Dr. Ellsberg said, statistics from the Demographic and Health Surveys (DHS) show that there are also physical health consequences for children whose mothers experience intimate partner violence, such as an increased risk for malnutrition and higher mortality rates.

COMMON RISK FACTORS FOR CHILD MALTREATMENT AND INTIMATE PARTNER VIOLENCE

Many workshop presenters noted that child maltreatment and intimate partner violence share a number of common risk factors. These comments

were often made in the context of discussions of efforts to prevent violence against women and children. As noted earlier, many participants challenged the wisdom of current violence prevention systems that maintain separate programming and funding streams for different target populations rather than making programming and funding decisions according to risk factors associated with various negative outcomes including violence against both women and children. As Dr. García-Moreno noted, "If we look at some of the risk factors for child maltreatment . . . there is quite some overlap with the [risk factors] that have been identified for intimate partner and sexual violence."

Two key types of risk factors emerged during discussions: social determinants and individual factors. The WHO's Commission on Social Determinants of Health describes social determinants as "the structural determinants and conditions of daily life" (Marmot et al., 2008). The participants of this workshop discussed a number of risk factors that are associated with the ways that governments and societies distribute resources. Hortensia Amaro, a workshop presenter from the Institute on Urban Health Research, remarked on the importance of "thinking about upstream factors across cultures and countries that are associated with toxic stress that children experience [and] are associated with highly strained communities and families." That statement captured a sentiment expressed by many workshop participants that individuals who are exposed to violence within their families tend to live in families that are experiencing a number of stressors on multiple levels.

Many of the stressors that were noted result from economic conditions and resource allocation at local, national, regional, and sometimes global levels. Some risk factors mentioned in this category include inequitable education systems, unemployment, marginalization of vulnerable populations, and poverty. Dr Barker said that data from the IMAGES study indicates that although, in aggregate, men often have power over women because of social norms, "low-income men perceive themselves as not very powerful or powerless even as they may have and often have more power than their female partners." Workshop presenter Rachel Jewkes, from the Medical Research Council of South Africa, offered a related remark. "Poorer men and women are likely to abuse and be victims," she said. "But it may be a manifestation of experiences from childhood." Her comment expressed a common sentiment—that risk factors, such as poverty, experienced in childhood are not only risk factors for childhood exposure to violence but also can carry through to adulthood and increase the risk of abuse and victimization.

Although many common risk factors are environmental in nature, a number of them are also somewhat more individual and have more to do with interactions among family and community members rather than macro-level systems. Most of these factors cannot be divorced from the

systems that affect them, but they may be considered more proximal to the individual who is either perpetrating violence or being victimized. For example, several workshop participants noted that untreated mental health conditions and substance abuse are strongly associated with violence exposure. Jacquelyn Campbell, co-chair of the forum, noted that the U.S. Human Resources and Services Administration (HRSA) has begun to incorporate intimate partner violence into its work on postpartum depression and depression during pregnancy interventions. Dr. Barker noted that data from the IMAGES study show that men's reports of feeling stressed or depressed because of a perceived lack of sufficient income or work are more strongly associated with the men engaging in intimate partner violence than were their reports of actual household income or monthly income. This speaks to the intersection between systems factors that contribute to unemployment and poverty and individual factors, such as an individual's ability to cope with stressful circumstances.

Although many workshop speakers spoke of psychosocial risk factors, a few participants also stressed recent advances in understanding of the biological mechanisms behind violence perpetration and the effects of violence exposure. Michael Phillips, a forum member and workshop participant from Shanghai Jiao Tong University, said, "There is a biological nature to impulsiveness, to alcoholism, to suicide, and to aggressiveness." And Julian Ford, a workshop presenter from the University of Connecticut Health Center Child Trauma Clinic, described some of the physiological components to violence that are associated with trauma. In particular, he described how, in situations that are perceived by an individual as life-threatening, an "alarm goes off in the brain," causing the brain to resort to a basic evaluation of safety. When this alarm has been triggered on a regular basis, the brain changes, creating a tendency to misperceive innocuous situations as dangerous, resulting in a fight-or-flight response, Dr. Ford said. "Violence, traumatic stress, life-threatening, life-changing experiences that are sudden, horrifying, overwhelming, these don't just change a person's frame of reference or way of thinking—they change their body."

Another risk factor that is a combination of environmental and individual risk factors is gender socialization. This topic received a great deal of attention from several presenters and was the focus of the presentation by Dr. Jewkes. Gender socialization of children is, she said, "essentially a process of learning social expectations about appropriate goals and practices for men and boys and for women and girls and concomitant expectations and experiences of power." She added that sources of socialization include social institutions, policies, and laws, as well as communities and families. Dr. Jewkes noted that violence within the home can be particularly harmful because it normalizes controlling and violent behaviors, which play a role in violence against both women and children.

Dr. Jewkes illustrated some of the effects of the coercive enforcement of gender norms with data from Julia Kim. Dr. Kim's data indicate that a microfinance intervention for women combined with a structured curriculum focused on women's empowerment decreased poverty and violence exposure, whereas the microfinance intervention alone had an effect on poverty but no effect on violence exposure. Data from the IMAGES study presented by Dr. Barker also spoke to the effects of gender norms. Those data indicate that men whose fathers engaged in domestic work when the men were growing up are more likely to engage in domestic work themselves once they become adults than men whose fathers did not engage in domestic work. Dr. Barker went on to explain that the significance of this finding, in terms of risk factors for violence against women and children, is that we can seek to help men change their behaviors in order to help them "pass on ways that show gender equality, respect for others, and nonviolence."

PROGRAMS TAKING AN INTEGRATED APPROACH

A number of speakers at the workshop had been asked to speak about particular initiatives or programs with which they have been involved. A number of those participants provided more detailed descriptions of those programs in papers that are included in Chapter 8 of this summary. Some of the programs specifically target violence against women and children, whereas others focus on some of the risk factors that were listed above and are therefore likely to reduce violence exposure among both women and children.

Some of the programs described at the workshop can be characterized as having been developed originally with a focus on preventing violence against children but eventually having incorporated elements that address violence against women, or vice versa. A number of the programs that were discussed also focused on common risk factors that are known to contribute to violence against both women and children. Most commonly, these programs had a strong gender socialization component and targeted social norms. These interventions seem to speak to the value of addressing power dynamics and societal norms around violence when working to reduce violence in families.

High-Risk Domestic Violence Conferencing

Dr. Crooks described a new Canadian initiative that has been launched by the Children's Aid Society in London, Ontario, to implement what they refer to as high-risk domestic violence conferencing. This is a significant development because the Children's Aid Society has historically been an agency that has focused on child protective services, and it is now taking

the lead in organizing various individuals and organizations to provide support for high-risk cases. These conferences are designed to reduce multiple risk factors, including those that might increase the risk for the batterer to perpetrate violence in the future.

Parenting Training for Domestic Violence Workers

One workshop attendee discussed a curriculum that was developed to give training in parenting strategies to individuals who work in intimate partner violence programs. She explained that the goal is for these individuals, who are working with women who have experienced intimate partner violence, to learn to help support the parenting, attachment, and development capacities of women and children who are in intimate partner violence programs.

Strengthening Families Program

Workshop speaker Judy Langford, from the Center for Study of Social Policy, described the Strengthening Families Program, a program that is based on resilience research and seeks to reduce child maltreatment. In her discussion of the protective factors that are included in the program's framework, she noted that several of the factors also address intimate partner violence. In particular, there is a focus on parental resilience, social connections, and having access to intensive services that a family might need when it is experiencing a crisis related to intimate partner violence, substance abuse, or untreated mental illness.

Parenting Program to Promote Couples' Communication Skills

Agnes Tiwari from the University of Hong Kong described a program that was initially designed to address both intimate partner violence and child maltreatment, although plans are under way for a cluster randomized controlled trial that will evaluate the efficacy of the program in improving couple relationship quality, enhancing parental sense of competence, and reducing postnatal depressive symptoms. Of particular importance in this intervention was the ability of the team that developed the curriculum to adapt an established curriculum to meet the cultural needs of the target population in China. This program used parent education, which was designed to be very hands-on in order to encourage participation by the fathers as well as the mothers, as a way to train parents about infant care and reduce the risk of child maltreatment. Additionally, through discussions that were centered around infant care and child rearing, the program's administrators were able to guide couples in improving their own communication skills and increasing their understanding of their own relationship styles.

Sexto Sentido and Bell Bajao

Workshop speaker Dr. Ellsberg described two initiatives that have been implemented in low- and middle-income countries, targeting permissive norms around the use of violence. *Sexto Sentido,* a television program, has become widely popular across Nicaragua. Storylines deal with issues of violence and risky behaviors, and characters model the benefits of having an open dialogue about the consequences of interpersonal violence and challenging accepted societal norms. In India, an organization called Breakthrough implemented the Bell Bajao campaign. The focus of this campaign was to challenge permissive social norms related to violence and to encourage people—especially men—to intervene when they see or hear violence being perpetrated.

Intervention with Microfinance for AIDS and Gender Equity (IMAGE)

On behalf of Julia Kim from the United Nations Development Programme, Dr. Jewkes discussed a microfinance program. In particular, she described a research study that looked at the effects of a microfinance intervention targeting women in a rural area of South Africa. Women in some towns received only the microfinance intervention, while women in other towns received the microfinance intervention as well as a women's empowerment curriculum. Women who received both reported lower rates of poverty and fewer problems in their households during and after participation in the program. Women who received the microfinance alone experienced reductions in poverty but no change in household problems.

KEY MESSAGES

Although traditionally research in this area has focused on violence against women and violence against children as separate issues, more recently researchers and program designers are exploring ways of integrating the two. In particular, a greater understanding of the intergenerational transmission of violence could be beneficial in furthering the work in preventing both these types of violence. As research becomes more plentiful and shows a high correlation of child maltreatment and intimate partner violence, as well as a number of common risk factors, emerging evidence suggests that implementing programs that address both simultaneously could yield greater results.

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Paradigm Shifts and Changing Social Norms in Violence Prevention

An important thread running through the workshop was the sense that the attitudes and norms concerning violence against women and children and its prevention are changing. There is a growing awareness of the magnitude of the issue as well as of the potential value of early intervention. Some of those intervention strategies involve the inclusion of men and boys as part of the solution instead of seeing them only as perpetrators to be punished. Speakers also felt that early intervention should include strategies that bolster resilience or mitigate future violence. Finally, speakers addressed the issue of complex stressors, the intersection of violence with other inequities, and the importance of addressing violence within a larger context.

Mary Ellsberg from the International Center for Research on Women remarked that violence is taking its place not only on the human rights agenda but also on the health and development agendas. As a result, efforts to reduce violence against women and children are involving multiple sectors and fields in bringing attention to the issue. Speaker James Lang from Partners for Prevention thought that communications for social change were an important part of the puzzle. Speaker Monique Widyono from PATH agreed with this point and added that these communication techniques can be harnessed to bring momentum to gender equity.

David Butler-Jones, the chief public health officer of Canada, said he felt that change requires not only ending violence but also making a cultural shift toward non-acceptance of violence. Dr. Ellsberg agreed, saying that people should be empowered to stop violence when they see it occurring. She referred to a program in Papua New Guinea in which women formed

a community policing group and created a safe haven for women and children experiencing abuse.

Gail Wyatt and Michael Phillips both stated that cultural relativity and sensitivity require particular attention: Norms and attitudes within cultures shape issues such as gender equality and the rights of children, but they also influence response. Rachel Jewkes agreed but added that nuances in what is accepted versus what is normalized can be important. She highlighted the importance of conversation with communities to understand what is truly culturally valued.

On the workshop's second day, speakers in the afternoon panel delved into violence and its relationship to trauma and the importance of understanding the intersection of these issues. Roger Fallot said that an important step in addressing violence is understanding trauma and bringing it into the mainstream of public health.

GROWING ACCEPTANCE OF THE MAGNITUDE OF VIOLENCE AGAINST WOMEN AND CHILDREN

Many speakers expressed the sense that violence against women and children has become a mainstream issue over the past few decades. Claudia García-Moreno of the World Health Organization said that when she first began working in this field, she was informed that violence was not a health issue but a social problem. Currently, researchers, particularly in public health, have begun to recognize and document the magnitude of these types of violence, though many gaps remain.

Only recently has evidence demonstrated that violence has an accumulated effect, and in many cases it starts early and continues throughout the lifespan. Little data exist from low- and middle-income countries, but studies are under way, and preliminary findings show high rates of abuse. In particular, Claudia García-Moreno mentioned a study in Swaziland conducted by the Centers for Disease Control and Prevention, which found that 33 percent of girls had been victims of childhood sexual abuse. The WHO Multi-Country Study shows that between 1 and 21 percent of women in the 10 countries included in the study experienced abuse in childhood, most commonly perpetrated by a family member (García-Moreno et al., 2005). She also referred to a study by Jeff Edleson of children's exposure to violence; the study found that up to 83 percent of children had overheard episodes of intimate partner violence (Edleson et al., 2003).

Dr. García-Moreno said that in the past 10 years the amount of data on magnitude and consequences has increased significantly, although much information is still missing on different types of violence against women and children (García-Moreno et al., 2005). According to the current state of knowledge, the majority of violence perpetrated against women is done

by an intimate partner, but the means and methods vary. Denise Wilson of the Auckland University of Technology mentioned statistics from New Zealand showing that 50 percent of homicides are related to family violence, and as many as 1 in 3 women in New Zealand experience some sort of lifetime physical or sexual abuse. Indigenous populations such as the Māori are at highest risk; 47 percent of women seeking safety are Māori, although this group only makes up 15 percent of the population (Wilson, 2011). Agnes Tiwari said that intimate partner violence in Hong Kong is relatively unrecognized, particularly as it tends to be emotional rather than physical abuse, which makes it difficult to determine rates of prevalence. Dr. García-Moreno added that the prevalence of other types of violence, such as female genital mutilation, does not seem to be lessening.

Finally, Dr. García-Moreno noted that in addition to the increasing body of knowledge concerning the prevalence of violence, there is also a growing body of evidence about the long-term effects, with evidence showing that consequences can continue for years after the violence itself.

GROWING ACCEPTANCE OF THE NEED FOR PREVENTION

Speakers generally felt that there was a growing recognition that prevention of violence was useful to multiple sectors in addressing health and social issues, and that this prevention included systemic changes in health systems as well as in legal systems. Claudia García-Moreno asked rhetorically why those in the health sector should care, as violence prevention efforts are often seen as competing with other interests. She felt that this state of affairs indicated the need for system-wide changes. Similarly, Roger Fallot talked about trauma-informed care as a new culture that has resulted from a systemic approach to addressing trauma that seeks to provide safety, address the potential for recurrence, and avoid replicating the violent situation. In addition, he said that a paradigm shift is needed in health service organizations and settings that would focus on supporting victims, such as an effort by health care providers to build trust with patients. Several speakers reiterated this point and said that addressing issues of violence and safety in communities and health-care systems would actually improve health-care providers' ability to provide services.

A number of speakers also spoke of the need for institutional, legal, regulatory, and policy changes to address violence. Denise Wilson described a number of pieces of legislation aimed at protecting women and children in New Zealand: the Domestic Violence Act of 1995; the Children, Youth, and Families Act in 1989; and the Care of Children Act in 2004. She also discussed the New Zealand Health Strategy of 2000, which included reduction of interpersonal violence as a goal and included family violence as a health problem.

Cheryl Thomas discussed the early stages of work performed in Central Asia in the early 1990s by a group that she led; in particular, she said, there were no provisions for domestic violence (no shelters, hotlines, or service providers, for example) and no research and no political or social will. In 1993 her group began work in Romania documenting domestic violence, which opened the door to research in the area. Through this work, she said, there has been a growing understanding that implementing laws criminalizing violence against women is essential, and many countries in Eastern Europe and Central Asia have begun to do so. In particular, Advocates for Human Rights has highlighted the importance of the role of an "order for protection." Ms. Thomas also noted that in Morocco the work of local implementing partners, particularly women's groups, has advanced the chances for implementation of a national domestic violence law greatly.

Finally, speakers explored the need for nuanced research into developing prevention and intervention strategies. David Wolfe pointed out that in self-reports of violence, girls state they hit as much as, if not more than, boys do, and the rationalizations they use reflect familiar language from men and boys from the 1980s (Wolfe et al., 2009). This is troublesome, he said, because the girls will often still end up the victim because the boy will often retaliate. Furthermore, the situation of girls-as-victims-only is less prevalent in adolescent abusive relationships than at the adult level, perhaps because adolescence is a training ground and teenage violence is somewhat peer-sanctioned. Thus, he surmised, interventions that address girls solely as victims miss a major piece of the growing understanding of adolescent relationships and will not be as successful.

Monique Widyono offered another example with her description of a tool called In Her Shoes, developed originally in Washington State, which allows people to "walk in the shoes" of women experiencing violence. The process allows policy makers, service providers, and others a chance to see the consequences of such violence and to diminish stereotypes or expectations of survivors of violence.

ENGAGING MEN AND BOYS

Gender equality and violence against women and children are intricately entwined, and advocates for reducing violence highlight the importance of increasing gender equality. Conversely, Kiersten Stewart discussed the reverse, describing how addressing violence can address gender inequality. James Lang said that violence is a "constitutive element of gender inequality" and that Partners for Prevention quickly became involved in engaging men and boys because they are the "gatekeepers of power" and primary prevention has to take that into account. However, Mr. Lang

warned against sliding into the paternalistic language of men and boys "saving" women and girls from violence or thinking about males solely as instruments of change.

Rachel Jewkes delved deeper into the nuances of gender equity, pointing out that simply involving more females in government is not enough; relationships between men and women must be addressed as well. She demonstrated the existence of a disconnect between gender equality and a lack of violence by describing a study done in South Africa in which 90 percent of men said women should be treated equally, but 50 percent of those surveyed admitted to committing physical violence against a female partner (Gender Links and South African Medical Research Council, 2010). Dr. García-Moreno also noted that there is a growing body of information from men about their own perpetration of violence.

Dr. Jewkes explained that gender socialization is a process of learning social expectations about the goals and practices of men and women as well as about their experiences of power. Mary Ellsberg highlighted the importance of social dynamics: Boys are raised to be "tough," and girls are raised to be pliant. Gender norms also influence the type of violence that children experience, with boys more likely to experience bullying and fights while girls are more likely to experience sexual and psychological violence and exclusion.

Thus in the process of growing up children discover that going against the dominant cultural model results in pressure, abuse, and violence. Dr. Jewkes used the example of the rape of lesbians in South Africa as a "corrective measure" to emphasize this point. Gary Barker agreed and suggested that changing gender norms should mean not only redefining the roles of men and women but also making people aware of the diversity of roles that already exist in various cultures.

Therefore, Dr. Jewkes concluded, addressing violence against women and children must include gender socialization. Various social institutions, such as schools, help define gender, but the home and family life are some of the earliest and strongest influences. If gender balances are unequal in the home or if partner violence is occurring, boys and girls are at greater risk of mimicking these models and finding themselves in abusive relationships again and again. Gary Barker reiterated this, mentioning the stress on men of being a provider, particularly during economic downturns, and suggested that perhaps early gender socialization that included alternative roles for men might reduce this stress. Dr. Jewkes, speaking for Julia Kim, said that giving women increased roles as providers does not always help, particularly if it is added to women's responsibilities for taking care of the home, because it can increase the stress on women. She noted that standards for feminine behavior in the developing context are often constructed around acquiescence to men's demands and that social structures often reward

women who fit into socially acceptable roles despite the increased risk of violence they must endure.

Dr. Jewkes referred to the hegemonic masculinity theory of Raewyn Connell, which states that power is not exercised through use of force but rather through the acquiescence of the powerless. A study in South Africa found that while the vast majority of men and women believe in equality, the majority of men and a smaller majority of women believe that a woman should obey her husband. This was true across races. One of the factors contributing to this situation is a lack of exposure to other culturally appropriate ways of being a woman. Dr. Jewkes also pointed out that, according to one study, women who strongly agree that a husband has a right to beat his wife are more likely to be beaten and that women who believe that beating is a sign of affection are also more likely to be beaten (Gender Links and South African Medical Research Council, 2010).

The International Men and Gender Equality Survey (IMAGES) described by Dr. Barker found that men report knowing about laws addressing gender-based violence but express sometimes contradicting views on such laws. One consensus among interviewees across countries was the feeling that the laws increase a sense of being observed or scrutinized, which Dr. Barker described as not only a symptom of the gender power balance being upset but also an indication that additional education might be needed to explain how these laws are protective and not punitive. Claire Crooks also expressed a concern about lack of services for men at risk of perpetrating violence aimed at preventing either violence or the recurrence of violence; most efforts are punitive instead of preventive.

To explain why some men experience similar risk factors but do not perpetrate violence, Dr. Barker showed responses from IMAGES suggesting that men are sensitive to positive cultural and social norms, including the influence of a respected elder, reflection on past abuse (as victim or perpetrator), and exposure to community spaces that promote non-violence.

Interventions that take into account these sensitivities often include involving men in the care of family. Dr. Crooks said that it is important not to assume that a program that works with mothers will work with fathers and that more effort should be put into designing programs that include men more actively.

Agnes Tiwari agreed, citing her work in including men in prevention efforts as active participants rather than as passive partners. In her Hong Kong study, men were included in a prenatal education intervention in which the discussion around parenting skills was used as an entry point to discussing couple relationships. This was more effective because the cultural barrier to discussing romantic relationship skills could be overcome. In particular, it was effective in reaching men and discussing both partner and father roles in a way that didn't seem "therapeutic."

INTERSECTION WITH OTHER INEQUITIES

Recent research in the field of violence prevention shows that violence does not occur in a vacuum; instead, it is highly co-occurring with certain factors such as poverty, food insecurity, the presence of infectious and chronic diseases, and lack of education. Addressing violence prevention in a comprehensive way requires looking at these other issues as well. Dr. Butler-Jones remarked that "poverty is a constellation" and can entail a lack not only of economic resources but also of relationships as well. Having stability, shelter, and adequate food means the difference between average health and good health, all of which affect resiliency.

Thus investing in preventing violence against women and children is not just about ending violence and promoting gender equality. As Dr. Ellsberg said, "We cannot hope to make significant progress in achieving the ambitious goals of ending poverty and hunger, achieving universal primary education, improving maternal and child health, and combating AIDS and other infectious diseases unless we are able to end violence against women and children." Brigid McCaw also said that it is important to identify co-morbidities and inequities (poverty, substance abuse, and so forth) because they may be more likely to bring the victim to the attention of the provider than the violence itself. For example, as Claudia García-Moreno pointed out, children experiencing violence at home often have difficulties, such as behavior problems, at school, and understanding this link can lead service providers to the violence even if no report is ever made.

These intersections are bi-directional: The increased risk of violence creates a suspicion of legal and medical authorities, while unstable social conditions can lead to an increased incidence of violence. Dr. Ellsberg pointed out, for example, that poverty and lack of access to health care prevent parents from accessing resources for addressing parenting and coping skills. Furthermore, those who fear the stigma of HIV and its associated violence—of which women are most at risk—fail to seek screening and care. Roger Fallot said that while violence increases the risk of homelessness, incarceration, and substance abuse problems, those outcomes in turn place people at risk of continued violence.

The context in which violence can occur is a major factor affecting the risk and severity of violence. Dr. Amaro suggested it might be useful to look further upstream at issues such as environmental factors and structural violence, a topic that had been touched upon by an earlier audience member who suggested that violence prevention efforts need to be incorporated into social studies curriculum in schools. Dr. Crooks said that the more types of violence a person experiences, the worse the outcome will be in terms of both future perpetration and health and psychosocial outcomes. Poverty and racism increase both the likelihood and the severity of violence and

also affect the impacts of violence. Denise Wilson underscored this point by bringing up the example of the Māori, who live in the most deprived neighborhoods in urban centers of New Zealand and who still experience barriers to access to health care and social services system because of racial discrimination. The Māori are disproportionately victims of violence, and they account for 50 percent of women and children in shelters. Dr. Wilson also described how the Māori culture has seen huge shifts over the past several decades, with the loss of traditional social structures that previously supported women's equality. Not all women have the same rights, Dr. Wyatt said, and ethnic and racial differences play a large role in who is exposed to or victimized by violence.

Promundo's IMAGES study shows that one major factor in predicting violence is whether men report feeling economic stress (as opposed to reporting of actual income), which is related to the social norms of men's traditional roles as providers. Dr. Jewkes referred to a study from South Africa in which women who report higher food insecurity report less equitable views of gender and men who report lower food security report higher rates of violence against a partner. A similar outcome was found in a study in India, which found that 49 percent of women who did not own property reported violence, as compared with 7 percent of women who did own property. In general, a lower ability to mobilize resources is correlated with a higher acceptance of violence, greater likelihood of being a victim or perpetrator, and lower likelihood of leaving a violent situation. This greater risk of violence leads to a continued cycle of violence in which victims find themselves re-victimized and sometimes become perpetrators themselves.

The context of violence also affects the severity of the outcomes. Julian Ford and Claudia García-Moreno paid particular attention to the concept of toxic stress and how continual exposure to violence both directly and indirectly creates a climate of chronic stress, which has been shown to have fundamental effects on cell growth in the brain. This is of particular importance for children, whose brain development can be significantly altered, resulting in secondary outcomes throughout their lives. Exposure to chronic stress affects language and communication ability and places an individual at increased risk of substance abuse. The development of trauma as a long-term outcome also has a complex relationship with violence, putting victims at additional risk of re-victimization as well as at risk of other adverse health outcomes. Dr. Amaro mentioned the high rates of co-occurrence of alcohol- and drug-related disorders with trauma and post-traumatic stress disorder (PTSD). Often the alcohol- and drug-related issues are methods of self-medicating that are used to deal with trauma, but such use intensifies the symptoms of PTSD, creating a cycle.

In the Boston Consortium study discussed by Dr. Amaro, an integrated system was created to address trauma and substance abuse issues in women.

This included treatment for the trauma (psychotherapy and skills building) as well as substance abuse treatment, both clinical and residential. The intervention involved careful attention to gender and racial linguistic usage because the population was primarily African-American and Latina women, and it paid close attention to addressing the roles of women in society and their relationship to violence. The intervention also included components to address integration with other services being provided, because many of the women involved had other issues, such as the loss of custody of children or a lack of economic empowerment.

Cris Sullivan applied her community advocacy model to discuss how empowering women has a strong effect on whether abuse recurs and on how capable women are of escaping the cycle of violence. She found in her intervention that providing an advocate who would support the woman with skills transfer and assistance empowered her to take control of her life.

PREVENTION THROUGH PROMOTION

The speakers also agreed on the importance of primary prevention and on moving even further upstream to address the environment in which violence occurs. Researchers felt that promoting resilience and protective factors provides individuals with skills to deal with the conflict and instability that breeds violence. Addressing many of the issues mentioned previously, such as gender equality and co-morbidities and the chronic stress on children, would be cost-effective and successful in the prevention of violence against women and children. Speakers felt that mitigating the climate of violence through social and legal programs often results in the greatest success.

Some of these legal interventions would involve laws and regulations that strengthen the rights of women and children, such as the international and country-level policies mentioned by Cheryl Thomas and Kiersten Stewart. Katrina Baum of the National Institute of Justice described the paradigm shift that occurs when including criminal justice in prevention, citing a case of a police chief referring to a stalking unit as a "homicide prevention unit," and Gary Barker noted that there is good evidence that community policing can play a role in preventing violence.

Prevention can also be addressed in programs that strengthen individual skills and family coping mechanisms. Bryan Samuels of the Administration on Children, Youth, and Families referred to research undertaken to inform program decision making that showed three important protective factors: "young people who have the ability to self regulate, young people who choose a particular way of coping with adversity, and young people who have a level of self efficacy that leads them to the belief that they can avoid the

bad things that are going on around them, and that they have got a skill set or a method for doing so." Dr. Fallot talked about G-TRIM (Loving Life), in which girls were given a space to talk about trauma, anger, and how to move forward.

David Wolfe said that prevention is cheaper and easier than treatment and noted that the Fourth R is designed around the promotion of healthy relationships in adolescence. Learning to relate starts early, and adolescents are curious and experimental, pushing at boundaries and becoming more exposed to risk factors. The Fourth R addresses management of these risk factors, strengthening the skills needed to make responsible choices and teaching students to balance "pro-abuse" messages with healthy messages. An important component of the program is involving youth in their own empowerment, particularly having older youth demonstrate the skills learned through the program in videos or other activities. One major outcome of the program is that boys who experienced maltreatment outside of school were less likely to engage in dating violence after this intervention. Risk factors are most noticeable at the middle school level, so addressing troubling relationships then makes sense. However, it could potentially be more effective to begin earlier with general information on the skills needed to build healthy relationships.

Judy Langford discussed Strengthening Families, which targets all families, not just those at risk, and aims to increase resilience and promote strengths. To easily reach out to families, the program is carried out at locations that they are likely to frequent. Strengthening Families is designed to support five essential protective factors that were identified through research and evaluation of successful programs. The first is parental resilience, which aids a parent's ability to maintain healthy relationships and handle individual and parenting challenges. The second is social connections and the ability to create a social network to prevent the damage caused by isolation as a result of or a precursor to susceptibility to violence. The third is knowledge of parenting and child development, which encompasses not only "official" information from parenting guides but also the unofficial information gleaned from family networks and cultural sources. The fourth is concrete support in times of need, both the basic needs required to maintain a stable household, such as economic stability, and access to services in crisis. The fifth protective factor is social and emotional development of children, because children with developmental delays and cognitive disabilities are more vulnerable to maltreatment than those with normal development. The importance of this work, Ms. Langford said, is highlighted by the number of states that expressed interest in learning about this framework, which in turn resulted in a number of interdisciplinary approaches being created and used in these states. Strengthening Families has been adopted by national and international nongovernmental organizations, parent groups,

administrators, and state child welfare agencies as a means to reduce violence and improve family relationships.

Gary Barker discussed an intervention strategy, Program H, designed to promote alternative masculine identities of non-violent or less violent men and directed at both men and women. The program ran a campaign including radio spots, TV ads, community theatre, and other media that highlighted positive aspects of masculinity. In Brazil the campaign resulted in attitude change; in India, it resulted in lower reported rates of gender-based violence. Preliminary data in the Balkans are being assessed, but one major obstacle to success there was the ingrained violence in all-male schools, a more difficult cultural context to overcome. A second intervention, Program M, is looking at changing these attitudes within schools, not only among students, but also among teachers as transmitters of these norms.

In the Intervention with Microfinance for AIDS and Gender Equity study in South Africa, which was conducted by Julia Kim and described by Rachel Jewkes, researchers sought to identify whether microfinance programs with added gender training elements resulted in women feeling more empowered and in men and women reporting fewer violent events. Women reported feeling more empowered collectively. There were also increases in food security and household assets and a reduction in loan defaults. The program also saw a 55 percent reduction in intimate partner violence two years after the intervention, through shifts in attitudes, including greater negotiating status of women, the ability of women to leave abusive relationships, and fewer conflicts over finances. In a comparison group without the gender training, there was no reduction in violence.

Finally, several speakers addressed the importance of education, given that higher levels of education correlate to low violence. Dr. Barker referred to cases in which the dropout rates for girls and boys in secondary school are high, suggesting that while the focus is mostly on girls, consideration should be given to addressing the issue with boys in order to keep them in school, which in turn would increase earning potential, reduce economic stress, and expose the boys to more positive gender role socialization.

KEY MESSAGES

The stigma of violence against women and children is diminishing, revealing important cultural and contextual elements that could be addressed. This paradigm shift involves increasing the evidence base, implementing programs that move further upstream and address contextual factors, and engaging men and boys, traditionally seen as perpetrators, as part of the solution. As well, as the violence prevention community produces further research and evidence of successful programs, the pervasive nature of

violence, and its relationship to other health and social inequities, continues to be illuminated.

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4

The State of Prevention Research in Low- and Middle-Income Countries

The state of research on prevention of violence against women and children was a central theme of the workshop. A number of speakers referred to advances in knowledge and practices while also pointing to various gaps in knowledge—particularly in low- and middle-income countries—as well as to challenges in the prevention research cycle. Figure 4-1, which is taken from an Institute of Medicine (IOM) report published in 1994, illustrates the five steps in the prevention intervention research cycle. As noted in the report (IOM, 1994), while the feedback loop is shown as connecting box 5 with box 1, in reality there should be a nearly continuous feedback loop between researchers and practitioners at all stages of the prevention research process. The illustration is provided in order to facilitate consistency throughout this section and should not be construed as a product of this workshop.

Discussion at the workshop focused mainly on data collection, translation, implementation, and dissemination efforts related to violence prevention. This summary will refer to the activities listed in boxes 1 and 2 of Figure 4-1 as *data collection*. This includes data on the prevalence and incidence of violence perpetration and victimization as well as similar information related to risk and protective factors. The term *translation* will be used to refer to the process by which research knowledge that is related to violence prevention either directly or indirectly is used to inform violence prevention activities and initiatives. This process is represented by the arrow connecting boxes 2 and 3. The term *implementation* refers to a specific set of activities that are designed to put an intervention into practice. This term will generally be used to refer to activities that have been described

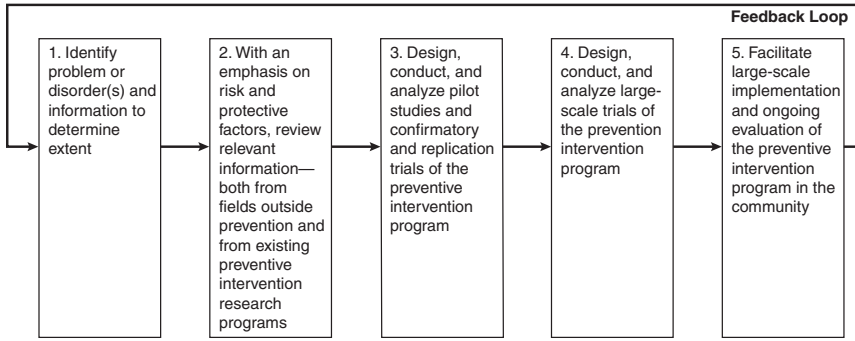

FIGURE 4-1 Preventive intervention research cycle.
SOURCE: IOM, 1994.

in sufficient detail that the intervention can be replicated as necessary, and it is represented by the arrow that connects boxes 3 and 4. The term *dissemination* refers to a set of activities that is intended to expand the usage of an intervention and is represented by box 5. The phrase "scaling up" was used frequently by workshop participants and is interpreted within this summary to refer to dissemination activities.

DATA FROM LOW- AND MIDDLE-INCOME COUNTRIES

The use of data was an important theme of the workshop, and a number of participants commented on the dearth of data available from low- and middle-income countries. Workshop speaker Claudia García-Moreno noted that the majority of the evidence base related to violence against women and children comes from high-income countries. Another workshop speaker, James Lang from the United Nations Development Programme, commented that the currently available data have a number of problems related to the methodologies and measurements used and the lack of longitudinal data. Workshop participants mentioned a number of implications that the limitations in data from low- and middle-income countries have for successful prevention of violence against women and children. These implications will be discussed later in this section.

Although workshop participants lamented the lack of data from low- and middle-income countries, many speakers also noted that significant progress has been made over the past decade. In particular, speakers mentioned a number of studies that have taken place in low- and middle-income countries in recent years as examples of high-quality studies with a focus on violence prevention, some of which were coordinated by the speakers and participants at the workshop. Three studies that were frequently cited

when discussing the incidence and prevalence data related to violence against women and children were the World Health Organization's Multi-country Study on Women's Health and Domestic Violence against Women (García-Moreno et al., 2005), which was coordinated by workshop speaker Claudia García-Moreno; the World Health Organization's *World Report on Violence and Health* (Krug et al., 2002); and the International Men and Gender Equality Survey IMAGES), conducted jointly by the International Center for Research on Women (ICRW) and Instituto Promundo and coordinated by workshop speaker Gary Barker (Barker et al., 2011).

A number of other high-quality studies in low- and middle-income countries were mentioned during the workshop. In addition to the IMAGES study, Dr. Ellsberg cited another ICRW study, *Intimate Partner Violence: High Costs to Households and Communities*, which provides data from Bangladesh, Morocco, and Uganda (Duvvury, 2009). She also noted that the U.S. Centers for Disease Control and Prevention (CDC) has produced reports on reproductive health in a number of low- and middle-income countries that have included data about violence against women and children. Dr. García-Moreno specifically cited one of the CDC studies that examines the health consequences of sexual violence against girls in Swaziland (Reza et al., 2009). Dr. Ellsberg also pointed to the Demographic and Health Survey (DHS) conducted by Macro International as an important source of data related to the prevalence and consequences of different forms of violence against women and children in low- and middle-income countries.

TRANSLATION

Another important step in the prevention research cycle that was discussed during the workshop is translation, which is the process of taking research findings and making that information relevant to programs and policies. This process is represented in Figure 4-1 as the arrow connecting the first two boxes, which correspond to important data collection activities, to box 3 which represents intervention development. Monique Widyono, from the Program for Appropriate Technology in Health (PATH), noted that translation is more effective when one understands what information will be helpful for program and policy leaders before collecting the data. In a similar vein, workshop participant and forum member Jim Mercy discussed Together for Girls, a collaborative initiative of United Nations agencies, the U.S. government, and the private sector aimed at addressing sexual violence among girls. He noted that one of the three main pillars of the program is to collect data that quantify and describe the problem of sexual violence against girls and that can then guide action, while also working with countries in translating that information to policies and prevention programs. Judy Langford of the Center for Study of Social

Policy described the practical implications of translation research, stating that facilitating high-quality programs that are based in research requires researchers to do a better job of distilling the data to discover "the kernel of truth" that is most central to the model that will be used to develop programs and policies.

IMPLEMENTATION

Several workshop speakers discussed the importance of implementation research and the implications that high-quality implementation efforts have for the effectiveness of programs and policies that are based on scientifically sound evidence. Workshop participant and forum chair Mark Rosenberg said, "As we are trying to develop interventions that can travel well and can be put in place in developing countries that don't have big budgets, it will become more and more important for us to move into this next stage of research, looking at implementation and delivery." As noted above, in this report *implementation* refers to a specific set of activities that are designed to put an intervention into practice and is represented in Figure 4-1 by the arrow connecting boxes 3 and 4. Some participants spoke about different aspects of implementation, while others gave specific examples based on their experiences with particular programs and initiatives.

Dr. García-Moreno framed the issue of interventions targeting violence against women and children with the statement, "We know that services for victims work." That point was emphasized by several workshop participants who stressed that there are many very good programs that are effective in reducing violence against women and children and in mitigating the negative health consequences that result from exposure to violence.

One of the most common themes related to implementation was the need to ensure that programs are implemented in a way that is appropriate for the particular communities that are being targeted. This issue is particularly salient for efforts in low- and middle-income countries given that, until very recently, most research on the prevention of violence against women and children has been conducted in high-income countries such as the United States. As Dr. Crooks commented, "When we talk about taking programs to other communities or even other cultures and countries, we can't assume that [just because] a program has really strong evidence in one setting [that it] is going to travel well." Workshop speaker Rachel Jewkes also commented that although a critical component of a program may be relevant in many different settings, the best way to achieve that component may differ from culture to culture. For example, she noted that although an intervention may call for building social participation, the best way to build social participation in a rural village in South Africa is likely to be different from the best approach in an urban area. This fact that cultures

can vary both within countries and across countries was mentioned by a number of workshop participants.

Several workshop participants and speakers described issues that are important to consider when implementing an intervention originally developed in a different setting or cultural context. Dr. Amaro said that there is very little scientific evidence that speaks to how to adapt interventions to different cultures, and various participants cautioned against thinking that simply translating the language in which the intervention is carried out should be sufficient when adapting interventions to other settings. For example, Dr. Ford noted during his presentation that the Trauma Affect Regulation: Guide for Education and Treatment (TARGET) curriculum was translated both in terms of language and in terms of culture in order to be relevant to the communities for which it was being adapted. Dr. Crooks echoed this point, noting that often "the manual gets changed in terms of the pictures in it, or people throw in a few cultural teachings or stories and think that is it, and it is essentially the same model." She also commented that people developing implementation efforts need to be open to identifying totally different approaches that build on culturally relevant protective factors in order to achieve the same ultimate outcomes. Discussing ways to address this challenge, workshop participant and forum member Michael Phillips said that there is a need for a more formalized approach to implementation that uses situation analysis to examine the various aspects of a setting that will help identify how best to adapt a particular intervention.

A number of workshop speakers shared examples that illustrated the importance of considering cultural values when implementing interventions, particularly interventions that are being adapted for different populations. Dr. Wilson offered an example of the consequences of failing to make sure that an intervention is culturally relevant. An initiative in New Zealand to address sudden infant death syndrome among the Māori communities was initially unsuccessful, she said, because the initiative had not incorporated Māori values. When the initiative was modified to take these values into account, it was much more successful. Dr. Tiwari also provided an example of cultural adaptation in her presentation. Describing two interventions that were implemented in Hong Kong, she explained how she and her colleagues were able to take an assessment tool that was in use in the United States and not only translate it but also take the time to validate the Chinese version. She also described developing a parenting program for expecting couples that addressed couple communication in the context of infant care education, taking into account the fact that a therapeutic label could be off-putting to Chinese couples while a focus on education was more in line with their cultural values. Finally, she noted that incorporation of Chinese health concepts and traditional stories was important because most of the couples were living in a dual world. "Many of them are very Westernized,"

she said, "but at the same time they have to cope with the Chinese traditional beliefs that are passed down by their parents."

In addition to Dr. Phillips' comments about the use of situation analysis as a tool to characterize communities more systematically in order to develop more effective adaptations of interventions, a number of participants and speakers spoke of the importance of engaging with community members. Dr. Jewkes said, "The best way of making sure you don't make mistakes over this is by using participatory methods." Dr. Barker discussed two initiatives in India and Brazil aimed at engaging men in efforts to reduce violence against women and children. He noted that participants in both countries helped to develop a symbol that could identify them as men who were questioning the use of violence against women and children. Dr. Barker also noted that most of the activities used to raise public awareness within their respective communities were developed by the group members, which made it more likely that they would be relevant and reach their intended audiences. Other examples of engaging with community members and leaders came from North America and New Zealand. During Dr. Wolfe's presentation on the Fourth R (see Chapter 8 for more detailed information on the program), he noted that schools and communities in North America are asked to involve their youth and some of their local teachers in modifying program implementation for their own communities. Dr. Wilson described how focus groups in New Zealand with Māori mental health nurses were important in efforts to make sure an intervention designed to provide women with resources related to intimate partner violence was appropriate for the target population.

In addition to discussing these various cultural concerns, workshop participants also noted that understanding the specific mechanisms that are most effective in a given intervention is crucial in guiding the implementation of previously researched interventions in new settings. Dr. Amaro said that there is a need for more research on the efficacy of interventions, including more controlled studies, in order to understand the important mediators and key program components. Dr. Edleson challenged participants to consider how to transport and diffuse evidence-based interventions without losing the strength of the original models. One particular example of this challenge was mentioned by a number of workshop participants: the nurse home visiting program developed by Dr. David Olds. Dr. Crooks said, "The original nurse visitation program developed by Olds has not necessarily replicated well or traveled or adapted as well. When this same program has been done using paraprofessionals, the outcomes have been more disappointing." Discussing replication challenges, Ms. Langford suggested that the Strengthening Families framework has been broadly successful because it provides a very simple research-based framework that is easy to apply across many settings. She remarked that the "most interesting part to me

has been the way that parents, parent leaders, have taken the protective factors framework and begun to create strategies to have conversations among themselves."

Bryan Samuels spoke of the need to evaluate program implementation efforts that involve modification to the original design. Much of the implementation research leaves one "with an understanding of whether a program worked or didn't work, and the impact that it had." However, he added, "What you don't come away with is an understanding of whether certain components of the program had a greater impact or not versus aspects of the program that didn't." Mr. Samuels also said that in moving forward there is a need to identify the relevant components of an intervention in order to know which components are most important to evaluate when implementing an evidence-based intervention. To that end, a workshop attendee noted that organizations often identify manualized interventions and then implement them without a plan to evaluate their efforts. He noted that opportunities exist for local evaluations that seek to marry quality research with quality program implementation. There are "not enough people coming in [to the National Institute of Drug Abuse] with applications for implementation and dissemination research, but they are high priorities for us," he said.

Another theme that arose during the workshop was the idea that in order for interventions to be implemented well, it will be important to establish the necessary public health infrastructure and workforce and also to better understand the impact of program implementation on those who are actually implementing the programs. Dr. Wyatt noted that an important part of implementation research is studying the impact of an intervention on the organizations that are implementing the interventions, including efforts to understand the effects on the staffs of those organizations. She also suggested that it is important for people to recognize that interventions can create a particular burden for a community and that costs of such interventions need to be more closely examined and better understood.

DISSEMINATION

The goal of developing a violence prevention workforce points directly to the final stage in the prevention research cycle. Dissemination refers to a set of activities intended to expand the usage of an intervention. As described by workshop speaker Monique Widyono, dissemination is "really about galvanizing action and momentum around work that is already happening on the ground and being able to share that [work]." Many of the concerns that were discussed in the section on implementation were also raised during conversations about dissemination, particularly concerns related to culturally relevant adaptations and the need to continually monitor

and evaluate an implementation. Indeed, implementation and dissemination can share many of the same activities conceptualized in the framework shown in Figure 4-1. Thus this section focuses primarily on the workshop's discussions about efforts to share information across settings and to scale up interventions.

Workshop participants discussed a number of initiatives that focus on dissemination activities as a part of their mission. In particular, workshop speaker Cheryl Thomas of Advocates for Human Rights noted that UN Women recently launched its Global Virtual Knowledge Centre to End Violence Against Women and Girls (UN Women, 2011). This initiative is intended to "encourage and support the efficient and effective design, implementation, monitoring and evaluation of evidence-based programming, to prevent and respond to violence against females." Ms. Thomas encouraged individuals to review the databases on the website in order to contribute to the centralized knowledge base that is being developed.

The InterCambios Alliance, described by Monique Widyono on behalf of Margarita Quintanilla, offers an example of efforts to engage in implementation and dissemination activities on a regional scale. Ms. Widyono noted that the alliance's work is not focused on the development of new materials but rather on sharing and adapting materials that have already been developed and have shown promise. The alliance also identifies programs that have already been evaluated in other settings, introduces them to the communities in which the members of the InterCambios Alliance work, tests them, and asks local organizations if the program seems like a good fit for their community. The final step in the process, Ms. Widyono said, is to engage in efforts to disseminate those programs widely. InterCambios' efforts to test and adapt programs that have already been proven to be successful in other settings illustrate what many workshop participants had noted about the importance of thoughtful dissemination. Workshop participants talked about various efforts to create centralized repositories of information related to successful violence prevention interventions and also spent time discussing the aspects of dissemination that deal with scaling up interventions so that they can be implemented on a larger scale. The importance of ensuring that interventions brought into new communities and new settings are adapted to meet the specific needs and values of the populations being targeted was a common theme in discussions of scaling up. A number of participants mentioned flexibility as an important characteristic of those interventions or models that can be successfully brought to large-scale implementation. Ms. Langford said that an important aspect of efforts to disseminate the Strengthening Families framework was to incorporate lessons from early adopters of the model and the adaptations that they found to be successful, while maintaining a focus on fidelity to the core components of the model. Similarly, Dr. McCaw noted that in scaling up the Family Domestic Violence Program among Kaiser

Permanente facilities in Northern California from 1 pilot facility to an eventual total of 46 facilities, she learned that it is important for the model to be "easy to understand and easy to customize."

Another theme that emerged from comments on how to facilitate successful large-scale implementation was the need to provide some specific guidance related to the implementation of a particular intervention. Dr. McCaw said that developing a set of tools helps to facilitate implementation in new sites and that it was important in her efforts to increase the number of Kaiser Permanente facilities offering the Family Domestic Violence Program. Similarly, Ms. Widyono noted that an important part of the work done by the InterCambios Alliance is to provide a set of curricula or tools to individuals and organizations that are seeking to adopt an intervention. Another example of how program developers can provide tools to facilitate large-scale implementation while also maintaining flexibility was provided by Dr. Wolfe's remarks about encouraging schools to adapt the Fourth R curriculum to meet the needs and values of their communities, including allowing parochial schools to emphasize abstinence.

Various workshop participants mentioned workforce and infrastructure development as ways that countries can further advance violence prevention efforts and, in particular, scale up proven interventions. Mr. Samuels said that, from his perspective as a policy maker, it is important to create "a supportive system that brings with it a set of generic skills that then allow training to augment the particulars of a program." Dr. Mercy suggested that additional efforts should be made to develop a "cadre of people who can understand the evidence base and can work at the ground and community level to work with people who are going to integrate these types of effective programs into their schools, their service programs or whatever." To that end, workshop participant Rosemary Chalk from the Institute of Medicine drew a parallel between the current need to adapt and implement evidence-based violence prevention interventions in communities and similar efforts a century ago to implement research-based agriculture techniques through the creation of the Agricultural Extension Service. Dr. Chalk remarked that it might be helpful to think about how people can work in local communities and build on local practices while at the same time not having to develop completely new programs for each community. Rather, she suggested there might be some benefit in creating family life extension agents and empowering a "corps that is charged with getting research into the hands of people where they are and where the local services are based."

KEY MESSAGES

Although data from low- and middle-income countries have traditionally been lacking, these gaps are rapidly being filled. As the body of

knowledge grows, a secondary gap remains regarding how best to translate and transport successful programs from one setting to another. Issues including appropriate cultural context, infrastructure, and trained health professional continue to provide impediments to the successful implementation of evidence-based violence prevention programs.

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5

Violence Prevention Among Multiple Sectors

As the field of violence prevention has evolved over the past few decades, the lack of coordination between related fields and a hesitation to engage in multisectoral response has posed a major obstacle to the field's success. Traditionally, various sectors have approached violence and its prevention from their own theoretical bases, without integration or collaboration, which has often resulted in duplicative work or unsustainable planning. Many workshop speakers felt strongly that collaboration and an integrated response are necessary for successful, long-term prevention programs. David Butler-Jones of the Public Health Agency of Canada described Canada's approach to public health as "the organized efforts of society to improve health and well being and to reduce inequalities" and said that the efforts include multiple sectors outside of health in order to offer a comprehensive approach. He stressed the important of this perspective in preventing missed opportunities both within and outside the health sector. He also said this perspective is useful in identifying the various roles that different agencies, sectors, and individuals can play.

A number of speakers observed that violence prevention, while divided into silos, is often its own silo as well. Integrating violence prevention interventions into broader programs aimed at improving health and well-being would lead to greater success. Dr. Butler-Jones emphasized the need to address violence as part of addressing health inequities: Two things that can mean the difference between average health and excellent health are a sense of self-determination and a sense of connectivity, and interventions for violence prevention and for health should promote both of these factors.

Mary Ellsberg cited a World Bank review that found that multisectoral response is a key to successful intervention. "Strategies must improve coordination between sector-specific approaches, civil-society initiatives, and government institutions," she said. "They must also take into account the need for change at all levels of society, from national laws, policies, and institutions to community-level norms and support networks and household and individual attitudes and behaviors." James Lang from Partners for Prevention listed three key components of any comprehensive strategy: an evidence base, building the capacity of local partners, and communications for social change.

Although the public health approach underscores the importance of collaborating across disciplines (particularly as prevention efforts move upstream), some speakers felt that further effort is needed to include such sectors as education, criminal justice, and international aid. For example, Claudia García-Moreno called for the provision of safe spaces in schools, laws that create equitable societal structure, and public education directed at changing norms. Kiersten Stewart said that an important objective of the International Violence Against Women Act is to coordinate violence prevention, gender equality, and international aid efforts that all seek similar goals. Ms. Stewart also mentioned the need to include the private sector not only as a partner in funding and programming, but also as an investor in the public good. Mary Ellsberg spoke of the evidence basis behind successful programs and said that the more successful programs have integrated efforts, such as home visitations for teaching parental skills. Several speakers commented that violence prevention and gender equality efforts need to be coordinated because addressing gender equality alone will not affect the prevalence of violence.

Another key element in ensuring the success of multisectoral responses will be to build on a foundation of evidence. Claudia García-Moreno suggested that prevention should move from small-scale programs to national and multi-country interventions, but the evidence base concerning such a translation is still weak. She also said that although awareness of the issue is growing, allocation of resources is still lagging for both research and evaluation. Dr. Ellsberg noted that political and social will are essential as well.

Ms. Widyono urged participants to remember that research in this area drives advocacy and policy and that the interventions that work best are ones based in evidence to show it. She also suggested that increasing the evidence base would result in greater buy-in from implementing partners—and that the buy-in would be even greater if the partners are included in the research and data gathering. In such cases, as demonstrated by Partners for Prevention, community partners are able to assist in the designing of interventions. By developing mutually beneficial best practices, researchers, implementers, and advocates all feel equally invested in the efforts.

Despite the will to increase coordination of efforts, however, various barriers persist. Forum member Evelyn Tomaswieski said that identifying relevant partners can be difficult, while forum member Arturo Cervantes questioned whether investing in various sectors would work without a mechanism for integration, which would includes buy-in from all partners. Gail Wyatt said that in addition to using comprehensive approaches, interventions must be built on comprehensive theories of complex traumas and multiple types of exposures because sequelae and even interventions can be different. Cheryl Thomas emphasized the need for agreement from the entire group not only on the cost-effectiveness of prevention and intervention, but also on the foundational theory of the violence and its risk and protective factors. A few speakers said that mechanisms for delegating responsibility among partners are key but that they can be difficult to implement. James Lang emphasized the lack of ideal integrated models for social change.

Speakers also expressed frustration with the existence of silos in research and in funding for research. One audience member said that there is a need for increased data sharing and stated that some partners are not always willing to share proprietary or confidential information. Several speakers said that funding for a coordinated and integrated response is rare and that researchers are often limited in these approaches by their funding sources. Dr. Wyatt suggested that researchers should demand integrated funding and design their interventions to facilitate collaborative funding.

Models for coordinated and sustainable programs do exist, and several presentations provided examples. One factor in a successful program is the integration of the intervention into pre-existing programs or activities. Judy Langford stressed this observation in her discussion of the Strengthening Families model, which promotes healthy behaviors in pre-existing settings, such as daycare. Such integration makes a model more sustainable and easier to implement for those on the ground. The Fourth R program followed a similar approach, integrating the intervention into physical education or health classes, thereby allowing students to practice what they were learning, much as they would in other classes. Agnes Tiwari's intervention used obstetricians and midwives in an integral way, which increased penetration into the community because most of the women were already using prenatal care. International Men and Gender Equality Survey (IMAGE) took an integrated approach by using a one-hour participatory group session into which was integrated messaging about gender equality, violence, and HIV; the messaging not only focused on the intersection among the three factors but also discussed how addressing all three together leads to measurable change. Hortensia Amaro and Roger Fallot went a step further to discuss

how integrating thinking about trauma into such existing programs would bolster them even further, particularly by providing training to service providers on trauma sensitivity.

The trauma-informed context also requires coordination. It is, by its nature, a model of integration as it views health care needs through the trauma lens. Roger Fallot discussed how this approach incorporates everything known about trauma and trauma response into existing systems of care. Such contexts facilitate healing by providing a more hospitable environment, a major result of which is reduced re-victimization.

Brigid McCaw described Kaiser Permanente's existing model of integration into a system of care, which makes it easy to implement system-wide models of change and to coordinate disparate sectors into one program. In particular, chronic care management offers a variety of lessons in this area. Another example is the Boston Consortium Model, an integrated intervention that addressed both trauma and substance abuse; when researchers tested whether this approach was more successful than substance abuse programs by themselves, they found that this was the case.

Partners for Prevention was able to overcome initial problems caused by a lack of coordination by addressing internal silos. Because United Nations efforts are not always coordinated, Partners for Prevention began by bringing together sectors within that agency. In doing so, the program was able to address external issues of lack of coordination because government ministries were already partnered with various UN agencies that were working together. In the same way, the InterCambios Alliance had similar success by bringing together the organizations working on the issues and coordinating with government agencies. Ms. Widyono stated that innovative work was happening but not being shared, and InterCambios helped develop the collaboration needed for technical capacity building. Both speakers stressed the need for flexibility and trust in ensuring that all partners' needs are being met.

Ms. Thomas mentioned an early model in this field. "I mentioned the Duluth Model of Coordinated Community Response," she said. "Everybody, I think, is just in agreement how critical it is that this multisectoral approach occurs where people understand. A judge can't sit up at the bench and issue an order for protection by himself and expect this work to keep a woman safe and hold an offender accountable. People have to be communicating in the system. The police have to know that it exists and how to enforce it. Shelters have to know that it exists. And if people are communicating about that we know now that that is where laws work when there is this coordinated community response, this holistic model, this multisectoral approach."

KEY MESSAGES

A holistic, integrated response requires participation from all essential stakeholders, because the ultimate aim is not only the reduction of violence but also the promotion of well-being. Overcoming barriers to successful comprehensive approaches include cooperation amongst partners, a foundation of evidence, and community and political will. It will also require addressing the stovepiping of funding and research, not only between sectors, but also within the health field, and violence prevention itself.

Part II

Papers and Commentary from Workshop Speakers

6

Papers on Research in Preventing Violence Against Women and Children

The science behind preventing violence against women and children has evolved greatly over the past several decades. Several speakers offered overviews of the research and described the growing awareness of the complexities of the causes, risk factors, and adverse effects of such violence. They also explored potential intervention points that were illuminated by this discussion.

The first paper is a reprint from the World Health Organization publication *Preventing Intimate Partner and Sexual Violence Against Women* (WHO and LSHTM, 2010b). The full report provides an overview of the magnitude of the issue; this workshop summary includes Chapter 3, which is an in-depth analysis of preventive interventions in low- and middle-income countries and was the basis for Claudia García-Moreno's presentation at the workshop.

The second paper is adapted from the International Men and Gender Equality Survey (IMAGES), a multi-country study that explored men's perspectives on gender norms and violence. The survey examined the evolving views of men on gender equality as well as whether these views affected men's sense of well-being and their commitment to reducing violence.

The third paper, by Claire Crooks from the University of Western Ontario and the Centre for Addiction and Mental Health, provides an overview of the intergenerational transmission of violence. It also explores the ways in which violence against children can have long-term impacts as well as what considerations are valuable in designing interventions to prevent child maltreatment.

The final two papers, from Roger Fallot and Julian Ford, explore secondary and tertiary prevention of the long-term effects of violence and associated trauma by including the "trauma lens" in the provision of social services as well as through the empowerment of individuals who are exposed to violence. Trauma-informed care and psychosocial empowerment are two means by which survivors of violence can overcome potential adverse outcomes and prevent the recurrence of violence.

PREVENTING INTIMATE PARTNER AND SEXUAL VIOLENCE AGAINST WOMEN: PRIMARY PREVENTION STRATEGIES[1]

Intimate partner and sexual violence are not inevitable—their levels vary over time and between places because of a variety of social, cultural, economic, and other factors. This can result in substantial differences between and within countries in the prevalence of intimate partner and sexual violence (WHO and LSHTM, 2010a). Most importantly, this variation shows that such violence can be reduced through well-designed and effective programs and policies. There are important factors related to both perpetration and victimization—such as exposure to child maltreatment, witnessing parental violence, attitudes that are accepting of violence, and the harmful use of alcohol—that can be addressed (WHO and LSHTM, 2010c).

At present, evidence on the effectiveness of primary prevention strategies for intimate partner and sexual violence is limited, with the overwhelming majority of data derived from high-income countries (HICs)—primarily the United States. Consequently, current high priorities in this field include adapting effective programs from high-income to lower-income settings; further evaluating and refining those for which evidence is emerging; and developing and testing strategies that appear to have potential, especially for use in low-resource settings, with rigorous evaluation of their effectiveness. At the same time, the dearth of evidence in all countries means that the generating of evidence and the incorporation of well-designed outcome evaluation procedures into primary prevention programs are top priorities everywhere. This will help to ensure that the efforts made in this area are founded upon a solid evidence base. Furthermore, program developers should be encouraged to explicitly base programs on existing theoretical frameworks and models of behavior change to allow underlying mechanisms to be identified and to make replication easier. Most of the evaluated strategies aimed at preventing intimate partner and sexual violence have

[1] Reprinted from World Health Organization and London School of Hygiene and Tropical Medicine. 2010. *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva, Switzerland: World Health Organization.

targeted proximal risk factors—primarily at the individual and relationship levels of the ecological model.

The Need for Upstream Action

In the public health framework, primary prevention means reducing the number of new instances of intimate partner and sexual violence by addressing the factors that make the first-time perpetration of such violence more likely to occur. Primary prevention therefore relies on identifying the "upstream" determinants and then taking action to address these. The impact of widespread, comprehensive programs can then be measured at the population level by comparing the rates at which such violence is either experienced or perpetrated. Given the lifetime prevalence of intimate partner and sexual violence, the hundreds of millions of women worldwide in need of services would outstrip the capacity of even the best-resourced countries (WHO and LSHTM, 2010a). A problem on this scale requires a major focus on primary prevention.

Upstream actions can target risk factors across all four levels of the ecological model. To decrease intimate partner and sexual violence at the population level, it is particularly important to address the societal or outer level of the model.

Such measures include national legislation and supportive policies aimed at social and economic factors—such as income levels, poverty and economic deprivation, patterns of male and female employment, and women's access to health care, property, education, and political participation and representation. It is sometimes even argued that programs that aim to reduce intimate partner and sexual violence against women without increasing male–female equity will ultimately not succeed in reducing violence against women. However, while many strategies involving legal and educational reform and employment opportunities are being implemented to increase gender equality, few have been assessed for their impact on intimate partner and sexual violence, making the evaluation of such strategies a priority. Any comprehensive intimate partner and sexual violence prevention strategy must address these sociocultural and economic factors through legislative and policy changes and by implementing related programs.

Creating a Climate of Non-Tolerance

Addressing risk factors at the societal level may increase the likelihood of successful and sustainable reductions of intimate partner and sexual violence. For example, when the law allows husbands to physically discipline wives, implementing a program to prevent intimate partner violence may have little impact. National legislation and supportive policies should

therefore be put in place to ensure that women have equal rights to political participation, education, work, social security, and an adequate standard of living. They should also be able to enter freely into a marriage or to leave it, to obtain financial credit, and to own and administer property. Laws and policies that discriminate against women should be changed, and any new legislation and policies should be examined for their impact upon women and men. Legislation and policies that address wider socioeconomic inequalities are likely to reduce other forms of interpersonal violence, which will in turn help to reduce intimate partner and sexual violence.

Legislation and policies that address wider socioeconomic inequalities can make a vital contribution to empowering women and improving their status in society; to creating cultural shifts by changing the norms, attitudes, and beliefs that support intimate partner and sexual violence; and to creating a climate of non-tolerance for such violence.

The human rights of girls and women need to be respected, protected, and fulfilled as part of ensuring the well-being and rights of everyone in society. As a first step toward this, governments should honor their commitments in implementing the following international legislation and human-rights instruments:

- Convention on the Elimination of All Forms of Discrimination Against Women (1979);
- The Convention on the Rights of the Child (1991);
- The Declaration on the Elimination of Violence Against Women (1993);
- The Beijing Declaration and Platform for Action (1995);
- The Millennium Declaration (2000); and
- The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belem do Para, 1994).

Legislation and criminal justice systems must also be in place to deal with cases of intimate partner and sexual violence after the event. These systems should aim to help prevent further violence, facilitate recovery, and ensure access to justice—for example, through the provision of specialized police units, restraining orders, and multi-agency sexual assault response teams. Potentially, legal protection against intimate partner and sexual violence helps to reinforce non-violent social norms by sending the message that such acts will not be tolerated. Measures to criminalize abuse by intimate partners and to broaden the definition of rape have been instrumental in bringing these issues out into the open and dispelling the notion that such violence is a private family matter. In this regard, they have been very important in shifting social norms (Heise and García-Moreno, 2002; Jewkes et

al., 2002). However, the evidence surrounding the deterrent value of arrest in cases of intimate partner violence shows that it may be no more effective in reducing violence than other police responses, such as issuing warnings or citations, providing counseling, or separating couples (Fagan and Browne, 1994; Garner et al., 1995). Some studies have also shown increased abuse following arrest, particularly for unemployed men and those living in impoverished areas (Fagan and Browne, 1994; Garner et al., 1995). Protective orders can be useful, but enforcement is uneven, and there is evidence that they have little effect on men with serious criminal records (Heise and García-Moreno, 2002). In cases of rape, reforms related to the admissibility of evidence and removing the requirement for victims' accounts to be corroborated have also been useful but are ignored in many courts throughout the world (Du Mont and Parnis, 2000; Jewkes et al., 2002).

Currently, on the whole, sufficient evidence of the deterrent effect of criminal justice system responses on intimate partner and sexual violence is still lacking (Dahlberg and Butchart, 2005). Dismantling hierarchical constructions of masculinity and femininity predicated on the control of women and eliminating the structural factors that support inequalities are likely to make a significant contribution to preventing intimate partner and sexual violence. However, these are long-term goals. Strategies aimed at achieving these long-term objectives should be complemented by measures with more immediate effects that are informed by the evidence base presented in this paper.

ASSESSING THE EVIDENCE FOR DIFFERENT PREVENTION APPROACHES

From the perspective of public health, a fundamental question is, "Do intimate partner and sexual violence prevention programs work?" That is to say, are there certain programs or strategies that are effective in preventing or reducing intimate partner and sexual violence? Effectiveness can only be demonstrated using rigorous research designs, such as randomized controlled trials or quasi-experimental designs. These typically compare the outcomes of an experimental group (which receives the program) with a control or comparison group (which is as equivalent as possible to the experimental group but which does not receive the program). One major concern is to be able to rule out alternative explanations for any observed changes in outcome in order to be confident that the changes really were due to the program and not some other factor.

Although "testimonials" are not a sound basis for evaluating the effectiveness of a program, they can provide insights into its running and on whether participants find it worthwhile. However, approaches that are based upon testimonials might expend significant resources and capacity on

programs that may be ineffective or may even make things worse (Dahlberg and Butchart, 2005). Various criteria have now been proposed to more systematically evaluate the effectiveness of different programs. The most stringent criteria involve program evaluation using experimental or quasi-experimental designs; evidence of significant preventive effects; evidence of sustained effects; and the independent replication of outcomes.

In spite of the emphasis on and visibility of efforts to promote gender equality and prevent intimate partner and sexual violence, very few of the programs reviewed in this paper meet all of these criteria, while others have not been subjected to any kind of scientific evaluation. Rigorous scientific evaluation of programs for preventing intimate partner and sexual violence are even rarer in low- and middle-income countries (LMICs). The field of intimate partner and sexual violence prevention must therefore be considered to be at its earliest stages in terms of having an established evidence base for primary prevention strategies, programs, and policies. The limited evidence base for intimate partner and sexual violence prevention has three important implications for this paper.

First, the paper extrapolates, when relevant, from the stronger evidence base for child maltreatment and youth violence prevention but clearly signals that these extrapolations remain speculative. Much, however, can be learned from the literature on youth violence and child maltreatment prevention.

Second, the paper describes those primary prevention programs that have the potential to be effective either on the grounds of theory or knowledge of risk factors—even if there is currently little or no evidence to support them or where, in certain cases, they have not yet been widely implemented. In the process, an attempt is made to draw attention to the underlying theories, principles, and mechanisms on which the programs are based. However, it is noted that a firm theoretical base and consistency with identified risk factors do not guarantee the success of a program.

Third, the paper includes programs developed in LMIC settings on condition that they have some supporting evidence (even if it is weak) or are currently in the process of being evaluated, that they appear to have potential on theoretical grounds, or that they address known risk factors. The inclusion criteria are designed on the one hand to avoid setting the bar of methodological standards too high—which would lead to the exclusion of many of the programs developed in low-resource settings on the grounds that they have no or low-quality evidence supporting them. On the other hand, setting the bar too low would run the risk of appearing to endorse programs unsupported by evidence. However, the limitations of the evidence presented are clearly spelt out and the need for rigorous outcome evaluation studies emphasized.

Although still in its early stages, there are sound reasons to believe that this field is poised to expand rapidly in coming years. Some programs have been demonstrated to be effective following rigorous outcome evaluations, evidence is beginning to emerge to support the effectiveness of many more, and suggestions for potential strategies have proliferated. Furthermore, tried and tested methods for developing effective evidence-based primary prevention programs and policies for other forms of interpersonal violence have been reported. The field of evidence-based intimate partner and sexual violence prevention now requires an open mind to promising approaches and to innovative new ideas at all stages of the life cycle.

SUMMARY TABLES OF PRIMARY PREVENTION STRATEGIES AND PROGRAMS

Table 6-1 summarizes the strength of evidence for the effectiveness of those strategies to prevent intimate partner violence and sexual violence for which some evidence is available. Strategies are grouped according to life stage. An important distinction must be drawn between a strategy and a specific program. Although specific programs may have been demonstrated to be effective, this in no way implies that all other programs categorized under the same strategy are also effective. For example, the Nurse Family Partnership, developed in the United States, is a home-visitation program that has been demonstrated to be effective in preventing child maltreatment. Nevertheless, it is the only program within the broader strategy of home visitation (which includes a multitude of different programs) that is supported by solid evidence of its effectiveness (MacMillan et al., 2009). The outcome measures of effectiveness are described in Box 6-1.

Strategies are ranked for their effectiveness in preventing intimate partner violence and sexual violence as follows:

- Effective: strategies that include one or more programs demonstrated to be effective. Effective refers to being supported by multiple well-designed studies showing prevention of perpetration and/or experience of intimate partner and/or sexual violence.
- Emerging evidence: strategies that include one or more programs for which evidence of effectiveness is emerging. Emerging evidence refers to being supported by one well-designed study showing prevention of perpetration and/or experience of intimate partner and/or sexual violence or studies showing positive changes in knowledge, attitudes, and beliefs related to intimate partner violence and/or sexual violence.
- Effectiveness unclear: strategies that include one or more programs of unclear effectiveness due to insufficient or mixed evidence.

- Emerging evidence of ineffectiveness: strategies that include one or more programs for which evidence of ineffectiveness is emerging. Emerging evidence refers to being supported by one well-designed study showing lack of prevention of perpetration and/or experience of intimate partner and/or sexual violence or studies showing an absence of changes in knowledge, attitudes, and beliefs related to intimate partner violence and/or sexual violence.
- Ineffective: strategies that include one or more programs shown to be ineffective. Ineffective refers to being supported by multiple well-designed studies showing lack of prevention of perpetration and/or experience of intimate partner and/or sexual violence.
- Probably harmful: strategies that include at least one well-designed study showing an increase in perpetration and/or experience of intimate partner and/or sexual violence or negative changes in knowledge, attitudes, and beliefs related to intimate partner and/or sexual violence.

As shown in Table 6-1, there is currently only one strategy for the prevention of intimate partner violence that can be classified "effective" at preventing actual violence. This is the use of school-based programs to prevent violence within dating relationships. However, only three such programs—described below—have been demonstrated to be effective, and these findings cannot be extrapolated to other school-based programs using a different approach, content, or intensity. At present, there are no correspondingly evaluated effective programs against sexual violence.

TABLE 6-1 Primary Prevention Strategies for Intimate Partner Violence and Sexual Violence for Which Some Evidence Is Available

Strategy	Intimate Partner Violence	Sexual Violence
During Infancy, Childhood, and Early Adolescence		
Interventions for children and adolescents subjected to child maltreatment and/or exposed to intimate partner violence	2	3
School-based training to help children recognize and avoid potentially sexually abusive situations	3	2
During Adolescence and Early Adulthood		
School-based programs to prevent dating violence	1	N/A
Sexual violence prevention programs for school and college populations	N/A	3

TABLE 6-1 Continued

Strategy	Intimate Partner Violence	Sexual Violence
Rape-awareness and knowledge programs for school and college populations	N/A	4
Education (as opposed to skills training) on self-defense strategies for school and college populations	N/A	5
Confrontational rape prevention programs	N/A	6
During Adulthood		
Empowerment and participatory approaches for addressing gender inequality: Microfinance and gender-equality training	2	3
Empowerment and participatory approaches for addressing gender inequality: Communication and relationship skills training (e.g., Stepping Stones)	2	3
Home-visitation programs with an intimate partner violence component	3	3
All Life Stages		
Reduce access to and harmful use of alcohol	2	3
Change social and cultural gender norms through the use of social norms theory	3	2
Change social and cultural gender norms through media awareness campaigns	2	3
Change social and cultural gender norms through working with men and boys	2	3

1—Effective: strategies that include one or more programs demonstrated to be effective; effective refers to being supported by multiple well-designed studies showing prevention of perpetration and/or experiencing of intimate partner and/or sexual violence;
2—Emerging evidence of effectiveness: strategies that include one or more programs for which evidence of effectiveness is emerging; emerging evidence refers to being supported by one well-designed study showing prevention of perpetration and/or experiencing of intimate partner and/or sexual violence or studies showing positive changes in knowledge, attitudes, and beliefs related to intimate partner violence and/or sexual violence;
3—Effectiveness unclear: strategies that include one or more programs of unclear effectiveness due to insufficient or mixed evidence;
4—Emerging evidence of ineffectiveness: strategies that include one or more programs for which evidence of ineffectiveness is emerging; emerging evidence refers to being supported by one well-designed study showing lack of prevention of perpetration and/or experience of intimate partner and/or sexual violence or studies showing an absence of changes in knowledge, attitudes, and beliefs related to intimate partner violence and/or sexual violence;
5—Ineffective: strategies that include one or more programs shown to be ineffective; ineffective refers to being supported by multiple well-designed studies showing lack of prevention of perpetration and/or experiencing of intimate partner and/or sexual violence;
6—Probably harmful: strategies that include at least one well-designed study showing an increase in perpetration and/or experience of intimate partner and/or sexual violence or negative changes in knowledge, attitudes, and beliefs related to intimate partner and/or sexual violence;
N/A—Not applicable.

BOX 6-1
Outcome Measures of Effectiveness

The effectiveness of a program can be evaluated in terms of three different types of outcome—each of which can be measured at different intervals after the program:

1. Changes in knowledge, attitudes, and beliefs regarding intimate partner and sexual violence. This is the weakest of the three outcomes because changes in knowledge, attitudes, and beliefs do not necessarily lead to changes in violent behavior. In this respect, even successful programs in this area cannot be assumed to be effective at preventing actual intimate partner or sexual violence without further research demonstrating corresponding reductions in violent behavior.
2. Reductions in the perpetration of intimate partner or sexual violence.
3. Reductions in the experience of intimate partner or sexual violence.

Intimate partner violence is not a unitary construct and can take different forms, including physical, sexual, and psychological violence. Despite this, outcome evaluations generally do not examine effectiveness in relation to these different types of violence—nor are programs generally designed to address specific types of intimate partner violence in particular. It is possible that programs considered to be effective or promising may only be so for certain forms of intimate partner violence (Whitaker et al., 2007a).

Table 6-2 lists those strategies for which there is currently no evidence or very weak evidence but that appear to have potential on the grounds of theory, known risk factors, or outcome evaluations that are methodologically of lower quality; it also includes some promising strategies that are currently undergoing evaluation.

All the strategies reviewed have been organized according to the main life stages. When strategies are relevant to more than one life stage, they have been categorized under the stage at which they are most often delivered. Strategies relevant to all life stages are described last. Because of the way programs are organized, intimate partner violence is considered here to include instances of sexual violence that occur within an intimate partnership, while sexual violence is used here to refer to sexual violence occurring outside intimate partnerships (i.e., perpetrated by friends, acquaintances, or strangers). Dating violence can be considered to incorporate both possibilities because dating partners can range from being little more than acquaintances to more intimate partners. However, in Table 6-1 and Table 6-2 dating violence is classified for the sake of convenience under intimate partner violence.

TABLE 6-2 Primary Prevention Strategies for Intimate Partner Violence and Sexual Violence with Potential

STRATEGY
During Infancy, Childhood, and Early Adolescence
Home-visitation programs to prevent child maltreatment
Parent education to prevent child maltreatment
Parent education to prevent child maltreatment
Improve maternal mental health
Identify and treat conduct and emotional disorders
School-based social and emotional skills development
Bullying prevention programs
During Adolescence and Early Adulthood
School-based multi-component violence prevention programs
During Adulthood
U.S. Air Force multi-component program to prevent suicide

During Infancy, Childhood, and Early Adolescence

Home-Visitation and Parent-Education Programs to Prevent Child Maltreatment

As noted in earlier sections of this document, a history of child maltreatment substantially increases the risk of an individual becoming either a perpetrator or victim of intimate partner violence and of sexual violence. It is therefore reasonable to assume that preventing child maltreatment has the potential to reduce subsequent intimate partner and sexual violence (Foshee et al., 2009). However, direct evidence of the effect of such programs on the levels of intimate partner violence is currently still lacking.

In general, however, reducing the risk of the different forms of child maltreatment reviewed in *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence* (WHO and International Society for Prevention of Child Abuse and Neglect, 2006) can contribute to reducing the intergenerational transmission of violence and abuse. The most promising strategies for preventing child maltreatment in this area include home-visitation and parent-education programs (Mikton and Butchart, 2009). However, neither type of program has been evaluated for its long-term effects on the prevention of intimate partner and sexual violence among the grown-up children of parents who were involved in such programs.

Improve Maternal Mental Health

Maternal depression (which affects at least 1 in 10 new mothers) can interfere with good bonding and attachment processes. This in turn

increases the risk of persistent conduct disorders in children (a key risk factor for the later perpetration of violence) by as much as five-fold (Meltzer et al., 2003). Effective approaches for addressing maternal depression include early recognition (antenatally and postnatally) followed by peer and social support, psychological therapies, and antidepressant medication (National Collaborating Centre for Mental Health, 2007). The long-term effects on the children of mothers treated for maternal depression in terms of their later involvement in intimate partner and sexual violence have not been assessed, but the approach appears to have potential.

Identify and Treat Conduct and Emotional Disorders in Children

Conduct disorders in childhood and adolescence—a precursor of antisocial personality disorder—are associated with an increased risk of experiencing and/or perpetrating intimate partner and sexual violence. Additionally, emotional disorders are associated with later depression and anxiety in adult years and can increase the risk of postnatal depression and persistent maternal depression. As outlined above, these in turn contribute to as much as a five-fold increased risk of emotional or conduct disorders in the children of mothers with poor mental health (Meltzer et al., 2003). The early identification and effective treatment of conduct and emotional disorders in childhood and adolescence could therefore be expected to reduce the occurrence of subsequent intimate partner and sexual violence.

Good evidence exists of the links between early conduct disorder and later involvement in violence as both victim and perpetrator and of the effectiveness of interventions to reduce conduct disorder and youth offending. However, despite their potential, there is at present no evidence showing that the strategy of identifying and treating conduct and emotional disorders in childhood or early adolescence leads to reductions in intimate partner and sexual violence during later adolescence and adulthood.

Interventions for Children and Adolescents Subjected to Child Maltreatment and/or Exposed to Intimate Partner Violence

Because children or adolescents who have been subjected to child maltreatment or exposed to parental violence are at increased risk of becoming the perpetrators and victims of intimate partner and sexual violence, interventions in this area are particularly important.

One meta-analysis examined 21 programs involving psychological interventions targeted at children and adolescents who had experienced child maltreatment (Skowron and Reinemann, 2005). Results suggested that psychological treatments for child maltreatment yielded improvements among participants: Some 71 percent of treated children appeared to be functioning

better than their non-treated counterparts. All of the interventions were designed to improve cognitive, emotional, and behavioral outcomes, with 11 of the studies considered to be experimental. A randomized trial of one of these programs used adolescent dating violence as an outcome and found a reduction in the experiencing and perpetration of physical and emotional abuse (Wolfe et al., 2003).

Psychological interventions for children and adolescents subjected to child maltreatment and/or exposed to intimate partner violence therefore appear to represent a strategy for the prevention of intimate partner violence supported by emerging evidence. Their effect on sexual violence remains unclear at present.

School-Based Social and Emotional Skills Development

Factors such as impulsiveness, lack of empathy, and poor social competence—which may be indicative of conduct disorder, a precursor of antisocial personality disorder—are important individual risk factors for perpetrating various forms of violence, including intimate partner and sexual violence. Cognitive-behavioral skills training programs and social development programs that address these factors in children and young adolescents are therefore promising strategies for preventing subsequent violence. These programs seek to promote pro-social behavior and to provide social and emotional skills such as problem solving, anger management, increased capacity for empathy, perspective taking, and non-violent conflict resolution. They can either be population-based or targeted at those at high risk and are typically delivered in schools. Although there is strong evidence that such programs can be effective in reducing youth violence and improving social skills, there is currently no evidence that they can reduce sexual and dating violence among adolescents and young adults or intimate partner and sexual violence later in life (Lösel and Beelmann, 2003). Nonetheless, they appear to have potential in preventing subsequent intimate partner violence and sexual violence.

School-Based Training to Help Children to Recognize and Avoid Potentially Sexually Abusive Situations

School-based programs to prevent child sexual abuse by teaching children to recognize and avoid potentially sexually abusive situations are run in many parts of the world, but evaluated examples come mainly from the United States. A recent systematic review of reviews found that although school-based programs to prevent child sexual abuse are effective at strengthening knowledge and protective behaviors against this type of abuse, evidence showing whether such programs reduce its actual

occurrence is lacking (Mikton and Butchart, 2009). Two studies that measured future experience of sexual abuse as an outcome reported mixed results (Finkelhor et al., 1995; Gibson and Leitemberg, 2000). Nonetheless, emerging evidence of their effectiveness in preventing subsequent sexual abuse victimization appears to support the use of such programs. Further research on the long-term impact on actual sexual abuse victimization is, however, required (Finkelhor, 2009).

Bullying Prevention Programs

Bullying has both immediate and long-term consequences on perpetrators and victims, including social isolation and the exacerbation of antisocial behavior that can lead to juvenile and adult crime (for perpetrators) and depression, suicidal ideation, social isolation, and low self-esteem (for victims). Some of these consequences may increase the risk of later involvement in intimate partner and/or sexual violence either as perpetrator or victim. A number of reviews have concluded that bullying prevention programs are effective in reducing bullying (Smith et al., 2004; Baldry and Farrington, 2007). A systematic review and meta-analysis of school-based programs to reduce bullying and victimization showed that, overall, school-based bullying prevention programs are effective in reducing both bullying and being bullied (Farrington and Ttofi, 2009). On average, bullying perpetration decreased by 20 to 23 percent and the experiencing of being bullied decreased by 17 to 20 percent.

Although such programs are likely to have broader potential benefits, evidence of their effect on the experiencing or perpetrating of intimate partner and/or sexual violence later in life is limited. A number of studies, however, have demonstrated an association between bullying and sexual harassment. Some sexual violence prevention programs in the United States include bullying prevention components for elementary- and middle-school-age children (Basile et al., 2009).

During Adolescence and Early Adulthood

School-Based Programs to Prevent Dating Violence

Dating violence is an early form of partner violence, occurring primarily in adolescence and early adulthood, and experienced within a "dating relationship." Dating violence prevention programs have been the most evaluated of all intimate partner violence prevention programs, with 12 evaluations of adolescent dating violence prevention programs, including 5 randomized trials (Foshee et al., 2008). Targeted at early sexual relationships, in contexts where marriage is usually entered into from about 20

years of age, these programs have been shown to prevent dating violence and sexual violence. Furthermore, dating violence appears to be a risk factor for intimate partner violence later in life and is also associated with injuries and health-compromising behaviors, such as unsafe sex, substance abuse, and suicide attempts (Smith et al., 2003; Wolfe et al., 2009). Accordingly, the prevention of dating violence can be assumed to be preventive of intimate partner and sexual violence in later life (Foshee et al., 2009).

One dating violence prevention program that has been well evaluated using a randomized controlled design is Safe Dates. Positive effects were noted in all four published evaluations (Foshee et al., 1998, 2000, 2004, 2005). Foshee et al. (2005) examined the effects of Safe Dates in preventing or reducing perpetration and victimization over time using four waves of follow-up data. The program significantly reduced psychological, moderate physical, and sexual dating violence perpetration at all four follow-up periods. The program also significantly reduced severe physical dating abuse perpetration over time, but only for adolescents who reported no or average prior involvement in severe physical perpetration at baseline. Program effects on the experiencing of sexual dating violence over time were marginal. Safe Dates did not prevent or reduce the experiencing of psychological dating abuse. Program effects were primarily due to changes in dating violence norms, gender role norms, and awareness of community services. The program did not affect conflict-management skills. The program was found to have had a greater impact upon primary prevention as opposed to preventing re-abuse among those with a history of previous abuse (Foshee et al., 1996, 1998, 2000, 2004, 2008).

Two school-based programs for preventing dating violence in Ontario, Canada, have also been evaluated (Wolfe et al., 2003, 2009). An outcome evaluation of The Fourth R: Skills for Youth Relationships used a cluster-randomized design and found that, based on self-reported perpetration at 2.5-year follow-up, rates of physical dating violence were 7.4 percent in the program group and 9.8 percent in the control group—a difference of 2.4 percent. However, for reasons not fully understood, this decrease of self-reported perpetration was found in boys (7.1 percent in controls versus 2.7 percent in intervention students) but not in girls (12.1 percent versus 11.9 percent). The program—evaluated by sampling more than 1,700 hundred students aged 14 to 15 years from 20 public schools—was integrated into the existing health and physical education curriculum and taught in sex-segregated classes. An underlying theme of healthy, nonviolent relationship skills was woven throughout the 21 lessons, which included extensive skills development using graduated practice with peers to develop positive strategies for dealing with pressures and the resolution of conflict without abuse or violence. The cost of training and materials averaged 16 Canadian dollars per student (Wolfe et al., 2009).

The other Canadian school-based program that has been evaluated is the Youth Relationship Project (Wolfe et al., 2003). This community-based program aimed to help 14- to 16-year-olds who had been maltreated as children to develop healthy non-abusive relationships with dating partners. The program educated participants on both healthy and abusive relationships and helped them to acquire conflict resolution and communication skills. A randomized controlled trial showed that the program had been effective in reducing incidents of physical and emotional abuse and the symptoms of emotional distress over a 16-month period after the program (Wolfe et al., 2003). These three school-based programs therefore appear to be effective for the prevention of physical, sexual, and emotional violence in dating relationships in adolescents and may also help to prevent intimate partner and sexual violence among adults. However, there are a number of necessary caveats concerning dating violence prevention programs. Although high-quality evaluations of the three programs described above found reduced violence at moderately long follow-up periods, the evaluations of most other programs have been of poor quality, used short follow-up periods, and only included knowledge and attitude changes as outcomes (for which some positive effects were found). Whether changes in knowledge and attitudes lead to corresponding changes in behavior is uncertain (Whitaker et al., 2006). Moreover, further research is needed to evaluate the effectiveness of dating violence prevention programs in the longer term, when integrated with programs for the prevention of other forms of violence, and when delivered outside North America and in resource-poor settings. A particular concern that has been raised about programs such as Safe Dates is the extent to which they are culture-bound to North America and hence may be of limited value in LMICs.

School-Based Multi-Component Violence Prevention Programs

Universal multi-component programs are the most effective school-based violence prevention programs (Dusenbury et al., 1997; Adi et al., 2007; Hahn et al., 2007). Such programs are delivered to all pupils and go beyond the normal components of curriculum-based teaching to include teacher training in the management of behavior, parenting education, and peer mediation. There can also be after-school activities and/or community involvement. One systematic review estimated that, on average, universal multi-component programs reduced violence by 15 percent in schools that delivered the programs compared to those that did not (Hahn et al., 2007).

School-based multi-component violence prevention programs have mostly focused upon bullying and youth violence as outcomes. Given that the risk factors for youth violence and intimate partner and sexual violence are to some extent shared, such programs would appear to have some

potential for preventing these latter forms of violence. However, there is currently no evidence of their effectiveness in these areas.

Sexual Violence Prevention Programs for School and College Populations

In the United States, the majority of programs for the primary prevention of sexual violence by strangers, acquaintances, and non-intimate dating partners have focused on college students—though they have also increasingly been delivered to high school and middle school pupils. In settings where few go into higher education this approach has obvious limitations. Developmentally, it makes sense to educate young people in appropriate and inappropriate sexual behavior at a time when their sexual identities are forming and their attitudes to romantic partners are beginning to take shape. However, once again there is a severe paucity of evidence to confirm the effectiveness or otherwise of such programs (Schewe, 2007).

Two recent systematic reviews in the United States have evaluated the effectiveness of specific primary prevention programs in this area. The first of these included college, high-school, and middle-school populations and found that programs usually included several components (most often the challenging of rape myths, information on acquaintance and date rape, statistics on rape, and risk reduction and protective prevention skills) (Morrison et al., 2004). Of the 50 studies reviewed, 7 (14 percent) showed exclusively positive effects on knowledge and attitudes, but none used the actual experiencing or perpetration of violence as outcomes; 40 (80 percent) reported mixed effects; and 3 (6 percent) indicated no effect. The studies also had a number of serious methodological limitations that led the reviewers to conclude that the effectiveness of such programs remains unclear. These limitations included the use of knowledge and attitude as the only outcome measures, studies of higher-quality design showing poorer results, and the positive effects of the programs being found to diminish over time.

The second systematic review examined 69 education programs for college students on sexual assault and found little evidence of the effectiveness of such programs in preventing such assaults or in increasing levels of rape empathy (the cognitive–emotional recognition of a rape victim's trauma) or awareness (Anderson and Whiston, 2005). However, the programs evaluated were found to increase factual knowledge about rape and to beneficially change attitudes toward it. The acute shortage of studies that use behavior as outcomes led the authors to conclude that more research using such outcomes was needed before definitive conclusions could be reached. The effectiveness of such programs, on the basis of these two reviews, is currently unclear. It has been found that the provision of "factual" information as part of addressing rape myths appears to have no effect on attitudes to rape or on the levels of empathy for its victims (Schewe, 2007).

Evaluation studies indicate that rape awareness and knowledge programs based on imparting such information rarely work. Similarly, educating women on effective self-defense strategies without teaching them actual self-defense skills has been found to be of questionable value and may even be potentially harmful in some contexts (Schewe, 2007). Two evaluations of programs that focused on a discussion of self-defense strategies without teaching the corresponding skills found no reduction in sexual assault risk at follow-up (Breitenbecher and Gidycz, 1998; Breitenbecher and Scarce, 2001). Rape prevention programs that use a style of personal confrontation with participants actually appear to be harmful. One study evaluating such a program found that it resulted in greater tolerance among men of the justifiability of rape (Fisher, 1986).

A number of other approaches have been tried for which there is presently very limited evidence of effectiveness. Encouraging victim empathy has been associated with both improvements and worsening of attitudes toward sexual violence and the acceptance of rape myths (Schewe, 2007). Educating women on how to avoid high-risk situations (such as hitchhiking, abusing alcohol, or becoming involved with older men) has also led to mixed results, and it too has been associated with greater acceptance of rape myths. To avoid the encouragement of victim-blaming, it is crucial that such education is delivered to female-only audiences. There have also been mixed indications of the effectiveness of programs that emphasize the negative consequences of sexual violence to men and that try to persuade them to see such sex as less rewarding than consensual sex.

Finally, several programs for preventing sexual violence have been proposed that have as yet been neither widely implemented nor evaluated. These include providing universal rape prevention education and parent education in sexual violence prevention throughout schools and workplaces, educating teachers and coaches about sexual violence and its prevention, and changing organizational practices to include activities such as mandatory training in the prevention of violence against women.

During Adulthood

Empowerment and Participatory Approaches to Reduce Gender Inequality

Empowerment is an approach that helps individuals and communities to identify their own problems and to develop, through participatory methods, the resources, skills, and confidence needed to address them. This approach emphasizes the role of individuals and communities as agents of change and prioritizes community ownership and leadership of the entire process. Comprehensive programs deal with the community as a whole or

with multiple subgroups of the population, have several components, and are designed to effect social change by creating a supportive environment for changing individual and community attitudes and behavior. Such approaches often utilize a combination of participatory rapid needs assessment, education or training, public awareness campaigns, and community action (Lankester, 1992).

Two examples of empowerment approaches for preventing intimate partner violence are the use of microfinance with gender-equality training and the Stepping Stones training package.

A number of initiatives involving microfinance have now been established to increase the economic and social power of women. These initiatives provide small loans to mobilize income-generating projects that can alleviate poverty. Stand-alone credit and rural development programs such as Grameen Bank and the Bangladesh Rural Advancement Committee target women and appear to show some promise in reducing intimate partner violence. However, the evaluation of such programs needs to take into account reports of lenders exploiting disadvantaged borrowers with very high rates of interest, which can trap people in debt and contribute to further poverty, as well as reports of increases in intimate partner violence (Kabeer, 2001; Rhyne, 2001). Disagreements over the control of newly acquired assets and earnings combined with women's changing attitudes toward traditional gender roles, improved social support, and greater confidence in defending themselves against male authority has sometimes led to marital conflicts and violence against women perpetrated by their partners (Schuler et al., 1996). Increases in violence following participation in credit programs have also been reported elsewhere, at least in the initial stages of membership (Rahman, 1999; Ahmed, 2005). Pre-existing gender roles appear to affect the violence-related outcomes of credit programs—in communities with rigid gender roles, women's involvement can result in increased levels of intimate partner violence not seen in communities with more flexible gender roles (Koenig et al., 2003). The outcome evaluations conducted to date of such stand-alone microfinance programs have not been as rigorous as that of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program described in Box 6-2.

Although microfinance programs can operate as discrete entities, IMAGE is an example of such a program that also incorporates education sessions and skills-building workshops to help change gender norms, improve communication in relationships, and empower women in other ways and has been shown to be effective at reducing intimate partner violence (Kim et al., 2009). Through education and skills building for women and engagement with boys and men and the broader community, IMAGE was effective in reducing intimate partner violence and supporting women. This was achieved without producing the type of negative effects seen in other

BOX 6-2
Intervention with Microfinance for AIDS and Gender Equity (IMAGE)

One of the most rigorously evaluated and successful microfinance and women's empowerment programs to date has been the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) in South Africa. This program targets women living in the poorest households in rural areas, and combines a microfinance program with training and skills-building sessions on preventing HIV infection, and on gender norms, cultural beliefs, communication, and intimate partner violence.

The program also encourages wider community participation to engage men and boys. It aims to improve women's employment opportunities, increase their influence in household decisions and their ability to resolve marital conflicts, strengthen their social networks, and reduce HIV transmission.

A randomized controlled trial found that two years after completing the program, participants reported experiencing 55 percent fewer acts of violence by their intimate partners in the previous 12 months than did members of a control group. In addition, participants were more likely to disagree with statements that condone physical and sexual violence toward an intimate partner (52 percent of participants versus 36 percent of the control group).

settings where cultural shifts and other changes have taken place in the absence of efforts to engage men.

The Stepping Stones training package is another participatory approach that promotes communication and relationship skills within communities. Training sessions are run in parallel for single-sex groups of women and men. Originally designed for the prevention of HIV infection, several communities have now incorporated elements of violence prevention. The approach has been used in 40 LMICs in Africa, Asia, Europe, and Latin America. Versions of the program have now been evaluated in a number of countries (Welbourn, 2009). The most thorough evaluation to date has been a randomized controlled trial in the Eastern Cape province of South Africa, with participants aged 15 to 26 years. This study indicated that a lower proportion of men who had participated in the program committed physical or sexual intimate partner violence in the two years following the program compared with men in a control group (Jewkes et al., 2008).

Furthermore, an evaluation in Gambia compared two villages where the program was carried out with two control villages and followed participating couples over one year. It found that, compared to couples not receiving the program, communication was improved and quarrelling reduced in participating couples. In addition, participating men were found

to be more accepting of a wife's refusal to have sex and less likely to beat her (Paine et al., 2002).

SASA! is an "activist kit" for mobilizing communities to prevent violence against women, focusing in particular on the connection between HIV/AIDS and violence against women. "Sasa" is a Kiswahili word meaning "now," and the kit includes practical resources; activities-monitoring and assessment tools to support local activism, media, and advocacy activities; and communication and training materials. It targets community norms and traditional gender roles and aims to change knowledge, attitudes, skills, and behavior to redress the power imbalance between men and women. It was created by Raising Voices, a Uganda-based nongovernmental organization that works in the Horn of Africa and Southern Africa. The London School of Hygiene and Tropical Medicine, Raising Voices, the Kampala-based Center for Domestic Violence Prevention, and Makerere University are currently conducting a joint randomized controlled trial to evaluate the effectiveness of the approach.

Thus evidence is emerging of the effectiveness in LMICs of empowerment and participatory approaches in preventing intimate partner violence through microfinance combined with gender-equality training and through the Stepping Stones training package.

The results of the SASA! evaluation are expected to provide further evidence on the effectiveness of this type of program, which seems to have potential for reducing intimate partner violence. There is a need to replicate and scale up this type of approach. Several other participatory and community-empowerment strategies to prevent intimate partner violence may be of value, although these have seldom been implemented as primary prevention strategies or rigorously evaluated. Couples counseling focuses on violence and/or substance abuse and may be effective for couples who have not resorted to intimate partner violence but who may be at risk. Family programs to promote positive communication and healthy relationships and prevent family violence might also be effective in preventing both intimate partner and sexual violence, given the importance of family factors in their development. In Ecuador one intimate partner violence prevention program that was implemented (but not evaluated) consisted of close friends or relatives being assigned to "monitor" newlyweds and to intervene should serious conflict arise. There is also some initial evidence that social cohesion among residents increases a community's capacity to manage crime and violence (by increasing "collective efficacy"), leading to decreases in both lethal and non-lethal intimate partner violence. Such community-level interventions can beneficially change community-level characteristics and warrant further evaluation.

Home Visitation Programs to Prevent Intimate Partner Violence

A systematic review of home visitation programs (Bilukha et al., 2005) identified only one evaluation study (Eckenrode et al., 2000) that examined the effect of home visitation on levels of intimate partner violence. No significant difference in the incidence of such violence among the program and control groups was found.

A five-year project (2007-2012) funded by U.S. Centers for Disease Control and Prevention is currently under way, which will develop, test, and evaluate a program to reduce intimate partner violence among low-income women enrolled in the Nurse Family Partnership during pregnancy and in the first two years postpartum. The Nurse Family Partnership is a nurse home visitation program of demonstrated effectiveness in reducing child maltreatment. The primary aims are to develop a model for an in-home intimate partner violence prevention program for enrolled mothers at risk of such violence, to test the feasibility and acceptability of the program, and in a randomized controlled study to compare the effectiveness of the approach to that of the Nurse Family Partnership alone.

An evaluation of the Hawaii Healthy Start Program—an early childhood home visitation program—found that when compared with a control group, the participation of mothers was associated with reduced perpetration and experiencing of intimate partner violence. The effect persisted for the first three years of a child's life, with small decreases in both the perpetration and experiencing of maternal intimate partner violence at follow-up when the child was seven and nine years old (Bair-Merritt et al., 2010). Evidence for the effectiveness of such programs can currently thus be considered to be unclear.

U.S. Air Force Multi-Component Program to Prevent Suicide

This program was primarily aimed at reducing the rate of suicide among U.S. Air Force (USAF) personnel but was also shown to reduce "family violence," which included both intimate partner violence and child maltreatment. The program was based upon:

- the full involvement of the USAF leadership to ensure the program had the support of the entire service;
- incorporation of suicide prevention into professional military education;
- community education and training of military personnel to identify risk factors, provide appropriate intervention, and refer individuals who were potentially at risk of suicide; and

- the creation of a multidisciplinary team consisting of mental health providers, medical providers, and chaplains who could respond to traumatic events at the community level, including suicides.

The program reduced the rate of suicide by 33 percent and the rates of severe and moderate family violence by 54 percent and 30 percent, respectively. Because of the combination of intimate partner violence and child maltreatment in the same outcome measure, it is not possible to determine the effect of the program on intimate partner violence specifically (Knox et al., 2003); hence this program is considered to have potential, rather than being supported by emerging evidence.

All Life Stages

Reduce Access to and Harmful Use of Alcohol

Harmful use of alcohol is associated with the perpetration of intimate partner and sexual violence (WHO and LSHTM, 2010c). It can therefore be hypothesized that reducing both access to alcohol and its harmful use will lead to reductions in intimate partner and sexual violence. However, the relationship between harmful use of alcohol and violence is complex—not everyone who drinks is at equally increased risk of committing violence, and intimate partner and sexual violence can occur at high rates in cultures where alcohol use is taboo. Furthermore, there is disagreement among experts on whether or not alcohol can be considered to be a "cause" of intimate partner and sexual violence or whether it is better viewed as a moderating or contributory factor. It seems clear, however, that individual and societal beliefs that alcohol causes aggression can lead to violent behavior being expected when individuals are under the influence of alcohol and to alcohol being used to prepare for and excuse such violence. To date, research focusing on the prevention of alcohol-related intimate partner and sexual violence is scarce. There is, however, some emerging evidence suggesting that the following strategies aimed at reducing alcohol consumption may be effective in preventing intimate partner violence:

- Reducing alcohol availability: In Australia, a community intervention that included restricting the hours of sale of alcohol in one town reduced the number of domestic violence victims presenting to hospital (Douglas, 1998). In Greenland, a coupon-based alcohol rationing system implemented in the 1980s that entitled adults to alcohol equivalent to 72 beers per month saw a subsequent 58 percent reduction in the number of police call outs for domestic

quarrels (Finnish Foundation for Alcohol Studies and World Health Organization, 2003).

- Regulating alcohol prices: Increasing the price of alcohol is an effective means of reducing alcohol-related violence in general (Chaloupka et al., 2002). Although research evaluating the effectiveness of this approach in reducing intimate partner violence specifically is scarce, one study using economic modeling estimated that in the United States a 1 percent increase in the price of alcohol may decrease the probability of intimate partner violence toward women by about 5 percent (Markowitz, 2000).
- Treatment for alcohol-use disorders: In the United States, treatment for alcohol dependence among males significantly decreased husband-to-wife and wife-to-husband intimate partner violence 6 and 12 months later, suggesting that such treatment may also be an effective primary prevention measure (Stuart et al., 2003).

Intimate partner and sexual violence may also be reduced through primary prevention programs to reduce the more general harms caused by alcohol (Anderson et al., 2009). Approaches for which effectiveness is well supported by evidence include:

- Making alcohol less available: This can be achieved by introducing minimum purchase-age policies and reducing the density of alcohol retail outlets and the hours or days alcohol can be sold. Such an approach has been shown to lead to fewer alcohol-related problems, including homicide and assaults (Duailibi et al., 2007).
- Banning of alcohol advertising: Alcohol is marketed through increasingly sophisticated advertising in mainstream media; through the linking of alcohol brands to sports and cultural activities; through sponsorships and product placements; and through direct marketing via the Internet, podcasting, and mobile telephones. The strongest evidence for the link between alcohol advertising and consumption comes from longitudinal studies on the effects of various forms of alcohol marketing—including exposure to alcohol advertising in traditional media and promotion in the form of movie content and alcohol-branded merchandise—on the initiation of youth drinking and on riskier patterns of youth drinking (Anderson et al., 2009). However, evidence showing that such measures reduce intimate partner and sexual violence is currently lacking.
- Individually directed interventions to drinkers already at risk: These include screening and brief interventions. Alcohol screening and brief interventions in primary health care settings have

> proven effective in reducing levels and intensity of consumption in LMICs and HICs (Finnish Foundation for Alcohol Studies and World Health Organization, 2003). However, their direct effect on alcohol-related intimate partner violence has not been measured. Evidence indicates that drinkers may reduce their consumption by as much as 20 percent following a brief intervention and that heavy drinkers who receive such an intervention are twice as likely to reduce their alcohol consumption as heavy drinkers who receive no intervention. Brief interventions include the opportune provision of advice and information in health or criminal justice settings (typically during a 5- to 10-minute period) but can also extend to several sessions of motivational interviewing or counseling (FPH, 2008; Sheehan, 2008).

School-based education on alcohol does not appear to reduce harm, but public-information and education programs (while again apparently ineffective at reducing alcohol-related harm) can increase the attention given to alcohol on public and political agendas (Anderson et al., 2009).

As with most primary prevention programs to prevent intimate partner and sexual violence, programs to reduce access to and harmful use of alcohol have mainly been conducted and evaluated in HICs, and little is known of their suitability or effectiveness outside such countries. For many LMICs, programs such as efforts to strengthen and expand the licensing of outlets could be of great value in reducing alcohol-related intimate partner and sexual violence. In many developing societies, a large proportion of alcohol production and sales currently takes place in unregulated informal markets. One study in São Paolo, Brazil, found that just 35 percent of alcohol outlets surveyed had a license of some form, and that alcohol vendors (whether licensed or not) faced few apparent restrictions on trading (Laranjeira and Hinkly, 2002). Furthermore, in many LMICs there are far fewer specialist health facilities, reducing the opportunities for alcohol treatment or screening. In such settings it may instead be beneficial to develop the role of primary health care workers or general practitioners in identifying and alleviating the harmful use of alcohol.

Although evidence for the effectiveness of measures to reduce access to and harmful use of alcohol is only beginning to emerge and high-quality studies showing their impact on intimate partner and sexual violence are still largely lacking, alcohol-related programs for the prevention of intimate partner violence and sexual violence appear promising. The strong association between alcohol and intimate partner and sexual violence suggests that primary prevention interventions to reduce the harm caused by alcohol could potentially be effective. Approaches to preventing alcohol-related intimate partner and sexual violence should also address the social acceptability of

excessive drinking as a mitigating factor in violence, while altering normative beliefs about masculinity and heavy drinking. There remains a pressing need for additional research to evaluate the effectiveness of such approaches in reducing intimate partner and sexual violence, especially in LMICs.

Change Social and Cultural Norms Related to Gender That Support Intimate Partner and Sexual Violence

Cultural and social gender norms are the rules or "expectations of behavior" that regulate the roles and relationships of men and women within a specific cultural or social group. Often unspoken, these norms define what is considered appropriate behavior, govern what is and is not acceptable, and shape the interactions between men and women. Individuals are discouraged from violating these norms through the threat of social disapproval or punishment or because of feelings of guilt and shame in contravening internalized norms of conduct. Often traditional social and cultural gender norms make women vulnerable to violence from intimate partners, place women and girls at increased risk of sexual violence, and condone or support the acceptability of violence (Box 6-3).

Efforts to change social norms that support intimate partner and sexual violence are therefore a key element in the primary prevention of these

BOX 6-3
Examples of Social and Cultural Norms That Support Violence Against Women

- A man has a right to assert power over a woman and is considered socially superior. Examples: India (Mitra and Singh, 2007), Nigeria (Ilika, 2005), and Ghana (Amoakohene, 2004).
- A man has a right to physically discipline a woman for "incorrect" behavior. Examples: India (Go et al., 2003), Nigeria (Adegoke and Oladeji, 2008), and China (Liu and Chan, 1999).
- Physical violence is an acceptable way to resolve conflict in a relationship. Example: United States (Champion and Durant, 2001).
- Intimate partner violence is a "taboo" subject. Example: South Africa (Fox et al., 2007).
- Divorce is shameful. Example: Pakistan (Hussain and Khan, 2008).
- Sex is a man's right in marriage. Example: Pakistan (Hussain and Khan, 2008).
- Sexual activity (including rape) is a marker of masculinity. Example: South Africa (Petersen et al., 2005).
- Girls are responsible for controlling a man's sexual urges. Example: South Africa (Ilika, 2005; Petersen et al., 2005).

forms of violence. Approaches have been adopted, although rarely evaluated, throughout the world to break the silence that often surrounds intimate partner and sexual violence, to try to inform and influence social attitudes and social norms on the acceptability of violence, and to build political will to address the problem. The use of research findings for advocacy has been shown to be promising in bringing attention to, and raising awareness of, the problem and in contributing to the shaping of reforms and policies (Ellsberg et al., 1997). Currently the three main approaches for changing social and cultural norms that support intimate partner and sexual violence are social norms theory (i.e., correcting misperceptions that the use of such violence is a highly prevalent normative behavior among peers), media awareness campaigns, and working with men and boys. Often several approaches are used in one program.

Social norms theory assumes that people have mistaken perceptions of other people's attitudes and behaviors. The prevalence of risk behaviors (such as heavy alcohol use or tolerance of violent behavior) is usually overestimated, while protective behaviors are normally underestimated. This affects individual behavior in two ways: (1) by increasing and justifying risk behaviors, and (2) by increasing the likelihood of an individual remaining silent about any discomfort caused by risky behaviors (thereby reinforcing social tolerance). The social norms approach seeks to rectify these misperceptions by generating a more realistic understanding of actual behavioral norms, thereby reducing risky behavior.

In the United States, the social norms approach has been applied to the problem of sexual violence among college students. Among such students, men appeared to underestimate both the importance most men and women place on sexual consent and the willingness of most men to intervene against sexual assault (Fabiano et al., 2003). Although the evidence is limited, some positive results have been reported. In one university in the United States, the A Man Respects a Woman project aimed to reduce the sexual assault of women, increase accurate perceptions of non-coercive sexual behavior norms, and reduce self-reported coercive behaviors by men. The project used a social norms marketing campaign targeting men, a theater presentation addressing socialization issues, and male peer-to-peer education. Evaluation of the campaign two years after its implementation found that men had more accurate perceptions of other men's behavior and improved attitudes and beliefs regarding sexual abuse. For example, a decreased percentage of men believed that the average male student has sex when his partner is intoxicated; will not stop sexual activity when asked to if he is already sexually aroused; and, when wanting to touch someone sexually, tries and sees how they react. However, the percentage of men indicating that they have sex when their partner is intoxicated increased (Bruce, 2002).

Media awareness campaigns are a common approach to the primary prevention of intimate partner and sexual violence. Campaign goals might include raising public awareness (for example, about the extent of the problem, about intimate partner violence, and sexual violence as violations of women's human rights and about men's role in ending violence against women); providing accurate information; dispelling myths and stereotypes about intimate partner violence and sexual violence; and changing public opinion. Such campaigns have the potential to reach large numbers of people. An example of a media-awareness campaign is Soul City in South Africa. This multimedia health promotion and change project examines a variety of health and development issues, imparts information and aims to change social norms, attitudes, and practice. It is directed at individuals, communities, and the socio-political environment. One of its components aims to change the attitudes and norms that support intimate partner and sexual violence. This multi-level intervention was launched over six months and consisted of a series of television and radio broadcasts, print materials, and a helpline. In partnership with a national coalition on preventing intimate partner violence, an advocacy campaign was also directed at the national government with the aim of achieving implementation of the Domestic Violence Act of 1998. The strategy aimed for impact at multiple levels from individual knowledge, attitudes, self-efficacy, and behavior to community dialogue, shifting social norms, and the creating of an enabling legal and social environment for change. An independent evaluation of the program included national surveys before and after the intervention, focus groups, and in-depth interviews with target audience members and stakeholders at various levels. It found that the program had facilitated implementation of the Domestic Violence Act of 1998, had positively impacted on problematic social norms and beliefs (such as that intimate partner violence is a private matter), and had improved levels of knowledge of where to seek help. Attempts were also made to measure its impact on violent behavior, but there were insufficient data to determine this accurately (Usdin et al., 2005).

As the Soul City project indicates, evidence is emerging that media campaigns combined with other educational opportunities can change knowledge, attitudes, and beliefs related to intimate partner and sexual violence. Although good campaigns can increase knowledge and awareness, influence perceptions and attitudes, and foster political will for action, evidence of their effectiveness in changing behavior remains insufficient (Whitaker et al., 2007a).

Working with men and boys—There has been an increasing tendency to focus efforts to change social and cultural norms on adolescent males or younger boys using universal or targeted programs that are delivered

through a variety of mechanisms, including school-based initiatives, community mobilization, and public awareness campaigns.

Objectives typically include increasing an individual's knowledge, changing attitudes toward gender norms and violence, and changing social norms around masculinity, power, gender, and violence. Some programs also aim to develop the capacity and confidence of boys and young men to speak up and intervene against violence, with the goal of changing the social climate in which it occurs (Katz, 2006). Failure to engage men and boys in prevention may result in the type of negative effects seen in some settings where cultural shifts and other changes have taken place in the absence of efforts to engage them (Box 6-4).

BOX 6-4
Nicaraguan Backlash Shows the Need to Engage Men as Well

Since 2000, Nicaragua has pioneered a number of initiatives to protect women against domestic violence. These have included:

- a network of police stations for women (Comisaria de la Mujer) where women who have been abused can receive psychological, social, and legal support;
- a ministry for family affairs (Mi Familia), which among other responsibilities ensures that shelter is available to women and children who suffer domestic violence; and
- reform of the national reproductive health program to address gender and sexual abuse.

During the same period, civil society groups have campaigned to promote the rights of women and to empower them to oppose domestic abuse. Because of these efforts, the reported frequency of intimate partner violence and sexual violence against women has increased dramatically. The more advocacy and awareness, the more likely women will report violence against them. For example, the number of reported cases of sexual violence received by the Comisaria de la Mujer rose from 4,174 (January to June 2003) to 8,376 (January to June 2004).

Researchers at the Universidad Centro Americana and the Institute for Gender Studies say a number of factors explain this increase—growing awareness among women that the cultural traditions that foster violence are no longer acceptable under international law and the Nicaraguan Domestic Violence Law, and better reporting of cases as women are encouraged to speak out. However, as Nicaraguan women have more actively opposed male hegemony, domestic conflicts have also increased and more men have resorted to intimate partner violence. These findings suggest that responses to intimate partner violence must not focus exclusively on women, but must also target men to prevent this type of backlash (Schopper et al., 2006).

A review of programs that work with men and boys to prevent violence against women (Barker et al., 2007) included 13 primary prevention programs, 5 of which were implemented in LMICs. Four of these programs were judged by the reviewers to be "effective," six "promising," and three "unclear." For example, one community outreach and mobilization campaign in Nicaragua judged to be effective was called Violence Against Women: A Disaster We Can Prevent as Men (Solórzano et al., 2000). This was aimed at men aged 20-39 years who were affected by Hurricane Mitch. The campaign's main messages addressed men's ability and responsibility to help prevent or reduce violence against their partners. Constructing masculinity without intimate partner violence was a group-education program aimed at men in periurban districts of Managua, Nicaragua (Welsh, 1997). The effect of the program was, however, unclear because of the weakness of the outcome evaluation.

Indeed, the methodological quality of most of the outcome evaluations was very low, and outcome measures consisted mainly of attitude changes and self-reported rates of gender-based violence, often using only small sample sizes. One campaign in New South Wales in Australia—Violence Against Women: It's Against All the Rules—targeted 21- to 29-year-old men and aimed to influence their attitudes. Sports celebrities delivered the message that violence toward women is unacceptable and that a masculine man is not a violent man. It also sought to enhance the community's capacity to challenge and address violence against women. A post-campaign survey indicated that the campaign achieved some positive results: 83 percent of the respondents reported that the message of the campaign was that violence against women is "not on," and 59 percent of respondents could recall the campaign slogan. However, 91 percent of the target group reported that the issue was not one they would talk about with their peers, irrespective of the campaign.

Similarly, in the United States Men Can Stop Rape runs a public education campaign for men and boys with the message: "My strength is not for hurting." This campaign runs in conjunction with Men of Strength (MOST) clubs—a primary prevention program that provides high-school-age young men with a structured and supportive space to learn about healthy masculinity and the redefining of male strength.

Although programs to alter cultural and social norms are among the most visible and ubiquitous of all strategies for preventing intimate partner and sexual violence, they remain one of the least evaluated. Even where evaluations have been undertaken, these have typically measured changes in attitudes and beliefs rather than in the occurrence of the violent behaviors themselves, making it difficult to draw firm conclusions on their effectiveness in actually preventing intimate partner and sexual violence. Nonetheless, some evidence is emerging to support the use of the three types of programs reviewed above in changing the social and cultural gender norms

that support intimate partner and sexual violence. However, these must now be taken to scale and more rigorously evaluated.

KEY MESSAGES

- To achieve change at the population level it is important to target societal-level factors in the primary prevention of intimate partner and sexual violence. Approaches include the enactment of legislation and the development of supporting policies that protect women, addressing discrimination against women, and helping to move the culture away from violence—thereby acting as a foundation for further prevention work.
- Currently, there are no strategies of demonstrated effectiveness for preventing sexual violence outside intimate partner or dating relationships. Only one strategy has been demonstrated to be effective in preventing intimate partner violence, namely school-based programs for adolescents to prevent violence within dating relationships—and this still needs to be assessed for use in resource-poor settings.
- Although it is too early to consider them proven, evidence is emerging of the effectiveness of several other strategies for the prevention of intimate partner and sexual violence, particularly the use of microfinance with gender equality training and of programs that promote communication and relationship skills within communities.
- Developing the evidence base for programs for the primary prevention of intimate partner and sexual violence is still very much in the early stages. But there is every reason to believe that rigorous outcome evaluations of existing programs and the development of new programs based on sound theory and known risk factors will lead to a rapid expansion in coming years.

INTERNATIONAL MEN AND GENDER EQUALITY SURVEY[2]

Gary Barker, Juan Manuel Contreras, Brian Heilman, Ajay Singh, Ravi Verma, and Marcos Nascimento

The International Men and Gender Equality Survey (IMAGES) is a comprehensive household questionnaire on men's attitudes and practices—as well as women's opinions and reports of men's practices—on a wide

[2] Adapted from: Barker, G., J. M. Contreras, B. Heilman, A. K. Singh, R. K. Verma, and M. Nascimento. 2011. *Evolving men: Initial results from the International Men and Gender Equality Survey (IMAGES)*. Washington, DC: International Center for Research on Women.

variety of topics related to gender equality. From 2009 to 2010, household surveys were administered to more than 8,000 men and 3,500 women ages 18 to 59 in Brazil, Chile, Croatia, India, Mexico, and Rwanda. Topics in the questionnaire included gender-based violence, health and health-related practices, household division of labor, men's participation in care-giving and as fathers, men's and women's attitudes about gender and gender-related policies, transactional sex, men's reports of criminal behavior, and quality of life. This report focuses on the initial, comparative analysis of results from the men's questionnaires across the six countries, with women's reports on key variables.

Methodology

IMAGES followed standard procedures for carrying out representative household surveys in each participating city, with the exception of Rwanda, where the survey is a nationally representative household sample. The survey was carried out in one or more urban settings in each country (and rural and urban areas in Rwanda) with men and women ages 18 to 59, guided by the following parameters:

- The men's questionnaire has approximately 250 items and took from 45 minutes to an hour to administer; the questionnaire for women is slightly shorter and took from 35 minutes to an hour to administer. The survey instruments were pretested in the participating countries, and the study protocol was approved by the institutional review board (IRB) of the International Center for Research on Women and by in-country IRBs, when such existed.
- The survey instrument was designed to be relevant for adult men and women in stable, co-habitating relationships as well as those not in a stable relationship; women and men who define themselves as heterosexual as well as men and women of different sexual orientations and practices; and women and men who have children in the household (biological or otherwise) and those who do not.
- Double-back translation of the questionnaire was carried out to ensure comparability and consistency of questions across settings. Some country-specific questions were included; some countries excluded items because of local political or cultural considerations.
- In Brazil, Chile, Mexico, and Rwanda the questionnaire was an interviewer-administered paper questionnaire. In India the questionnaire was carried out using hand-held computers, with a mixture of self-administered questions and interviewer-asked questions. In Croatia the questionnaire was self-administered (using a paper

questionnaire). Standard procedures were followed for ensuring anonymity and confidentiality.

- All research sites followed standard World Health Organization (WHO) practices for carrying out research on intimate partner violence in terms of offering referrals and information for services and special training of interviewers. Following these guidelines, men and women were not interviewed from the same household in any of the research sites.
- More sensitive questions were asked later in the questionnaire, and some key variables were included in multiple questions (to compare and thus be more informed in affirming validity). The questionnaire was pretested in all the settings prior to application.
- In all settings, male interviewers interviewed male respondents, and female interviewers interviewed female respondents, with the exception of Mexico, where some interviews with men were carried out by female interviewers (but only women interviewed women).
- Survey locations were chosen to represent different contexts in each country to achieve a mixture of major urban areas and a secondary city or cities. Within a survey location, neighborhoods or blocks were chosen based on population distributions from the most recent census data. Rural areas were included only in Rwanda and Croatia. Stratified random sampling and probability proportion to size sampling methods were used within each neighborhood or community to ensure the inclusion of adequate sample sizes by age and residence (and also socioeconomic status in the case of Chile).
- Although every participating country's questionnaire included questions on all the themes that make up IMAGES, the questionnaire is not identical in all countries; thus data are not available from every country for every question. The questionnaire in Rwanda was the most abbreviated of the six study countries because of the much larger sample size—and thus the sheer number of interviews—required to make the study nationally representative. In those cases where Rwandan data does not appear in a table or figure in this document, that particular question was not included in the Rwandan questionnaire.

Topics

The questionnaire covers key topics in gender equality, including intimate relationships, family dynamics, and key health and social vulnerabilities for men. Based on previous research that found associations between early childhood exposure to violence and different gendered practices related to childrearing, items on childhood antecedents to particular men's practices were included. Specific topics in the questionnaire include:

1. Employment. Employment experience; unemployment and underemployment; stress and reactions associated with unemployment; reaction by spouse/partner when unemployed; income differentials between men and women; perceived gender dynamics in the workplace; work–life balance; and job satisfaction.
2. Education. Educational attainment; perceived gender norms and patterns in school.
3. Childhood experiences. Victimization by violence as children; witnessing of gender-based violence; gender-related attitudes perceived in family of origin; changes perceived from previous generation to the present; gender balance in work/child care in family of origin; gender patterns of childhood friendships.
4. Relations at home (in current household). Marital/cohabitation status; division/participation in household chores; perceived satisfaction in family life; household decision making; time use in specific domestic chores and family care, including child care.
5. Parenting and men's relationships with their children (and with nonrelated children who may live in the household). Number of children; living situation of each child; time/money spent in care of each child; use of paternity/maternity leave; perceptions/attitudes toward existing parental leave in country; and child-care arrangements.
6. Attitudes toward women and masculinity. Attitudes toward gender equality (using the Gender-Equitable Men [GEM] Scale and other measures); attitudes toward various gender-equality policies that may have been implemented in each country.
7. Health and quality of life. Lifestyle questions (substance use, exercise, etc.); use of health services; sexual and reproductive behavior (contraceptive use, condom use); sexually transmitted infections, including HIV (past history, HIV testing); satisfaction with sexual relations; mental health issues (depression, suicide ideation); social support; use of/victimization by violence in other contexts; morbidity.
8. Partner relations and spousal relations. Current relationship status/satisfaction; use of services/help-seeking in times of violence or relationship stress; relationship history.
9. Relationship, gender-based violence, and transactional sex. Use of violence (physical, sexual, psychological) against partner (using WHO protocol); victimization of violence by partner (using WHO protocol); men's use of sexual violence against non-partners; men's self-reported purchasing of sex or paying for sex, including with underage individuals.
10. Sexual behavior. Sexual experience; sexual orientation; behaviors related to sexual and reproductive health, HIV/AIDS; use of health services related to sexual and reproductive health.

Analytical Strategy

The report focuses on men's attitudes and practices related to relationship dynamics, parenting and caregiving, health-related practices and vulnerabilities, violence (intimate partner violence and other forms), transactional sex, and attitudes toward existing gender equality policies. Women's reports of men's practices are included for some key variables.

The selection of questions in this initial data analysis was informed by previous research confirming the associations or impact of early childhood experiences, individually held gender-related attitudes, educational attainment, age (as a proxy of generational differences as well as developmental stage), social class (or income), and employment status and economic stress on women's and men's attitudes and practices in terms of their intimate relationships, their sexual practices, their use of violence, their domestic practices, and their health-seeking behaviors. Men's knowledge of and attitudes toward key policy issues related to gender equality are also included. The report focuses on descriptive statistics and bi-variate analyses of the associations between these practices and educational levels, economic or work-related stress, gender-related attitudes, and age. In all cases where statistically significant differences are reported, these are at the $p < .05$ level as assessed using the Pearson's chi-square test. As noted earlier, we also have an interest in understanding generational changes, or changes over time, in terms of men's practices. IMAGES is not a longitudinal study; nonetheless, by comparing responses stratified by age groups we can make some inferences about generational change.

Key Findings

Work-Related Stress

Work-related stress is commonplace in all survey sites. Between 34 percent and 88 percent of men in the survey sites reported feeling stress or depression because of not having enough income or enough work. Men who experienced work-related stress were more likely to report depression, suicide ideation, previous arrests, and use of violence against intimate partners.

Gender Attitudes

Men showed tremendous variation in their gender-related attitudes, with India and Rwanda showing the most inequitable attitudes. As a measure of men's and women's gender-related attitudes, IMAGES applied the GEM Scale. Rwandan and Indian men consistently supported the least

equitable norms among the settings studied. For example, for the statement "Changing diapers, giving kids a bath and feeding kids are the mother's responsibility," only 10 percent of men in Brazil agreed, whereas 61 percent in Rwanda and more than 80 percent in India agreed with the statement. Men with higher educational attainment and married men had more equitable attitudes; unmarried men had the least equitable attitudes. Homophobic attitudes were common, although they varied tremendously by context. Men who said they would be ashamed to have a gay son ranged from 43 percent of men in Brazil to a high of 92 percent in India. A slightly lower, but still high proportion of men said that being around homosexual men makes them uncomfortable, ranging from a low of 21 percent of men in Brazil to a high of 89 percent in India. Younger men and men with higher levels of education were generally less homophobic.

Relationship Dynamics and Domestic Duties

Younger men, men with more education, and men who saw their fathers do domestic work are more likely to carry out domestic duties. Nearly half of men in all the sites said they play an equal or greater role in one or more household duties—with the exception of India, where only 16 percent of men reported that they played an equal or greater role in household duties. These household or domestic duties included washing clothes, repairing the house, buying food, cleaning the house, cleaning the bathroom or toilet, preparing food, and paying the bills. The tasks that men said they play an equal or greater role in are those traditionally associated with men—namely repairing the house, paying bills, and buying groceries. Men reported higher levels of sexual and relationship satisfaction than women. Women who said their partners do more domestic work are more sexually satisfied. Men reported relatively high rates of sexual satisfaction with their current stable partners, ranging from 77 percent in Croatia to 98 percent in India. In all the countries except India, men who reported more gender-equitable attitudes were more likely to report being sexually satisfied with their current female partner. In India, Brazil, and Croatia, women who reported that their male partner plays an equal or greater role in one or more domestic duties also reported higher levels of overall relationship and sexual satisfaction.

Parenting and Involvement in Childbirth

The majority of men were neither in the delivery room nor in the hospital for the birth of their last child. In Chile, however, a dramatic generational shift is under way in men's presence at childbirth. Younger Chilean men reported much greater rates of presence in the delivery room

for the birth of their last child than older men. This shift is largely due to a national policy, aimed at "humanizing" the birth process, which encourages women to have a male partner or other person of their choice present during birth at public maternity wards. Men are taking few days of paid or unpaid paternity leave. Among men who took leave, the average duration ranged from 3.36 to 11.49 days of paid leave and from 3.8 to 10 days of unpaid leave. Younger men and men with more education were more likely to take leave. Close to half of men with children said they are involved in some daily care-giving. Unemployed men are dramatically more likely to participate in the care of children than employed men. For men with children under age four, play is the most common daily activity in which they participate (as affirmed by women and men).

Health Practices and Vulnerabilities

Men's rates of regular abuse of alcohol—defined as having five or more drinks in one night on a once monthly or greater basis—vary from 23 percent in India to 69 percent in Brazil and are significantly higher than women's reported alcohol abuse in all survey sites. In most sites, younger men and men with more inequitable gender attitudes are more likely to regularly abuse alcohol. High proportions of women who reported having sought an abortion affirmed that a male partner was involved in the decision to seek an abortion (ranging from 39 percent to 92 percent). Men reported high self-esteem, with the exceptions of Croatia and India; at the same time, men showed relatively high levels of depression and suicide ideation. The rates of experiencing depression at least once in the past month ranged from 9 percent in Brazil to a high of 33 percent in Croatia. The percentages of male respondents who reported having suicidal thoughts "sometimes or often" in the past month ranged from 1 percent in Brazil and Mexico to 5 percent in Croatia.

Violence and Criminal Practices

Men reported lifetime rates of physical intimate partner violence ranging from 25 percent to 40 percent, with women reporting slightly higher rates. Factors associated with men's use of violence were rigid gender attitudes, work stress, experiences of violence in childhood, and alcohol use. Men's reports of perpetration of sexual violence against women and girls ranged from 6 percent to 29 percent; in India and Mexico the majority of sexual violence took place against a current or former partner. Relatively high percentages of men reported ever having participated in criminal or delinquent acts; between 6 percent and 29 percent of men reported ever having been arrested. In terms of factors associated with

men's participation in criminal activity, men's socioeconomic situation was the most significant. Men who owned firearms or carried out violence or criminal behavior were also more likely to report having used intimate partner violence.

Transactional Sex

Between 16 and 56 percent of men surveyed said they have paid for sex at least once. Men with lower educational attainment and less gender-equitable attitudes and men who reported less sexual satisfaction with their current partner were more likely to have paid for sex.

Knowledge and Attitudes About Policies and Laws Related to Gender Equality

Men in all the countries, with the exception of India, were generally supportive of gender equality, with 87 percent to 90 percent agreeing that "Men do not lose out when women's rights are promoted." Even when asked about specific policies—quotas for women in executive positions, in university enrollment, or in government—men's support for such policies was reasonably high, with 40 percent to 74 percent of men supporting such quotas. Among themes related to gender equality, men reported the highest exposure to campaigns about gender-based violence. At the same time, across the sites, men showed negative attitudes toward laws related to gender-based violence.

Conclusion

Overall, IMAGES results affirm that gender equality should be promoted as a gain for women and men. Change seems to be happening as younger men and men with higher levels of education show more gender-equitable attitudes and practices. Men who reported more gender-equitable attitudes are more likely to be happy, to talk to their partners, and to have better sex lives. Women who reported that their partners participate in daily care work report higher levels of relationship and sexual satisfaction. Findings suggest that most men in most of the survey sites accept gender equality in the abstract even if they are not yet living it in their daily practices.

THE SCIENCE OF PREVENTION/ INTERRUPTING THE CYCLE OF VIOLENCE

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Overview

This summary describes what we know and, perhaps more importantly, what we don't know about intervening in the cycle of violence. It encompasses both direct child abuse and exposure to domestic violence. First, the term cycle of violence is clarified, as it is a term that has been adopted into the everyday lexicon without much clarity of concept. Next is a review of some of the key findings from comprehensive review papers summarizing child abuse prevention. Finally, five gaps are identified that indicate possible future directions for research into primary prevention in this domain.

What Is the Cycle of Violence?

The cycle of violence is a phrase used to describe the observed intergenerational pattern by which many children and youth who experience direct or indirect exposure to violence later come to perpetrate violence in their own relationships. For example, children who experience child abuse and are exposed to domestic violence are at an elevated risk for perpetrating dating violence and domestic violence. Essentially, there is a continuity in their relationships such that problems with violence are evident in different ways at different times. Researchers tend to look at this cycle from different vantage points depending on their main areas of interest. Bullying researchers, for example, might note that children who bully others are more likely to perpetrate dating violence as adolescents.[3] Dating violence researchers might look at the continuity of violence between dating and adult intimate partner relationships. The investigation of direct and indirect exposure to violence has even been segmented, with child abuse researchers tending to focus on the former and domestic violence researchers tending to take on the latter. The result is a greatly segmented landscape, but one that can be pieced together to depict the cycle shown in Figure 6-1.

[3] Bullying prevention programs have been researched quite extensively and are outside the purview of this summary. Bullying/peer aggression was included in the cycle of violence figure as a reminder that children exposed to family violence have difficulties in multiple settings and often perpetrate or experience violence in relationships outside their families. A holistic approach to the impact of violence on children's lives requires a commitment to beginning to piece together these formerly disparate areas of research.

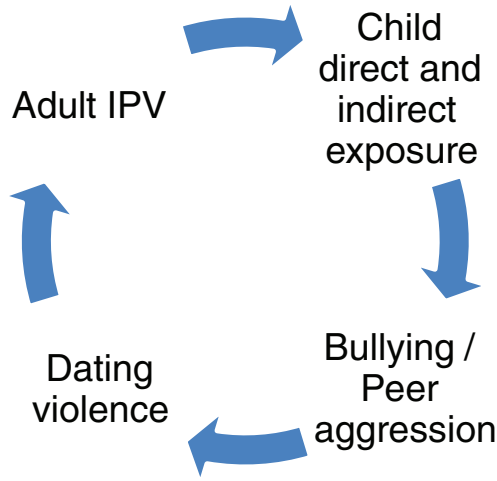

FIGURE 6-1 Cycles of violence.
SOURCE: Crooks, 2011.

It is crucial to understand that the cycle of violence is probabilistic, not determinative. That is, experiencing child abuse increases the risk for subsequently perpetrating violence in relationships, but there is significant variability in trajectories. There are a few important qualifiers for the cycle of violence idea, and they are discussed below.

Abusive Behavior Is Multiply Determined

There is no one pathway to abusive behavior. Rather, it is a final common pathway for a host of social, behavioral, biological, and personality risk factors. Results of a 20-year prospective study show that children's direct and indirect exposure to violence are important risk factors for perpetration of abusive behavior (Ehrensaft et al., 2001). Furthermore, the risk for experiencing intimate partner violence as an adult (as a victim or perpetrator) increases with the number of types of abuse and additional stressors experienced as a child (Whitfield et al., 2003). At the same time, many children and youth who are abused do not become perpetrators of abuse with their own children. A review of studies suggested that approximately one-third became seriously inept, abusive, or neglectful as parents of their own children; an additional one-third remained at risk for perpetrating child abuse because of their vulnerability to social stress; while the remaining one-third were not abusive (Oliver, 1993).

Experiences of Abuse Show a Dosage Response

The Adverse Childhood Experiences (ACE) Study[4] carried out jointly by the Centers for Disease Control and Prevention and Kaiser Permanente has conclusively demonstrated a dosage effect for child maltreatment. This ongoing longitudinal study has been analyzing the relationships between multiple categories of childhood trauma and negative health and behavioral outcomes later in life. David Finkelhor's work on poly-victimization is also instructive in identifying both the high frequency of poly-victimization and the relationship between multiple forms of abuse and poor outcomes for children (Finkelhor et al., 2009). Research with adolescents has documented this same relationship between multiple forms of abuse and the perpetration of violent delinquency as an adolescent, with each additional form of abuse translating to a 124 percent increase in the relative odds of engaging in violent delinquency (Crooks et al., 2007).

Co-Existing Adversities Increase the Likelihood of Negative Outcomes

Abuse affects different children differently. The ACE Study has documented the additive detrimental effects of experiences such as exposure to woman abuse, a parent with substance abuse or mental health problems, and incarceration of a parent. Low socioeconomic status can further compound difficulties for children who are experiencing child abuse. Conversely, access to protective factors (including at least one stable, nonviolent caregiver) can mitigate these impacts (Herrenkohl et al., 2008).

To summarize what we know about childhood experiences of abuse and exposure to domestic violence as a risk factor for perpetrating violence as an adolescent or adult, it is clear that childhood exposure to violence is a strong risk factor. However, there is still considerable variability among individual outcomes, and additional risk or protective factors can either exacerbate or mitigate the risk conferred by child abuse. Cumulative experiences of child abuse tend to lead to more negative outcomes, both in terms of perpetrating violence and a whole host of other negative social and physical health outcomes. The cycle of violence depicts the *what* of intergenerational transmission, but it does not explain the *how* or *why*. It is important to understand the cycle of violence in terms of *how* it works, because understanding the mechanisms underlying the intergenerational transmission of violence provides an important basis for understanding intervention opportunities.

[4] Results of the study are available at http://www.cdc.gov/ace/index.htm.

How Does the Cycle of Violence Work?

At a superficial level, the intergenerational transmission of violence seems counterintuitive—if someone knows how devastating it is to be abused as a child, how can he or she turn around and do the same thing as a parent? The answer lies in understanding the impact of child abuse on a developing child and understanding how experiences of child direct and indirect exposure to violence change how an individual sees the world and others around him or her. This understanding also explains why child exposure to violence is not something that a person can just "get over." Three particularly useful frameworks and theories for explaining the intergenerational cycle of violence are attachment, social learning theory, and trauma.

The Role of Attachment

Attachment refers to the quality of the relationship that develops between an infant and his or her primary caregiver(s) (Bowlby, 1980, 1990). Secure attachment emerges within the context of responsive caregiving. The extent to which an infant is fed when she is hungry, changed when she is wet and uncomfortable, and soothed when she is upset or afraid provides a basis for secure attachment. This first relationship becomes a template for future relationships and organizes the way an infant comes to see the world: Is it a safe and predictable place or a scary and bizarrely unpredictable one? Decades of research demonstrate that when attachment develops in a disorganized manner, an individual is at risk for ongoing difficulties in relationships with others. Child abuse and attachment are connected in a number of ways, including the development of attachment, the impacts of abuse, and the later perpetration of abuse (Bacon and Richardson, 2001). Experiences of direct and indirect child exposure to violence undermine the potential for secure attachment and provide an early experience of relationships as dangerous and unpredictable.

Although attachment is most often discussed in the context of parent–infant relationships, it continues to play an important role throughout a youth's development. Recent longitudinal research demonstrated that youth dually exposed to direct and indirect violence (i.e., child abuse and exposure to domestic violence) were less attached to their parents in adolescence than those who experienced only direct or only indirect exposure (Sousa et al., 2011). Furthermore, attachment to parents during adolescence played an important protective role against antisocial behavior, independent of abuse status.

Social Learning Theory

Social learning theory is a well-established paradigm that highlights the importance of reinforcement for promoting certain behavioral responses and inhibiting others (Bandura, 1977, 1986). Furthermore, our experiences with behavior and reinforcement come to shape our attitudes and attributions. One of the key tenets of social learning theory is that humans learn very well from modeling, that is, from what they see others do. This modeling is not indiscriminate. Children do not copy everything around them, but they copy what they see that works. When they are exposed directly and indirectly to violence, they learn harsh but effective lessons about power and may come to see the world as made up of victims and victimizers (Dodge et al., 1994). Given such a dichotomy, they may begin to model after the victimizer to avoid further abuse. These children develop a *hostile attribution bias*, which is a cognitive framework for expecting the worse, even in threat-neutral situations (Fontaine, 2010). As a result, these children seem hostile and aggressive to their peers, and may be rejected by their more pro-social peers (Dodge et al., 1990). There is some evidence that exposure to family violence is a bigger contributor to later pro-violence attitudes (such as comfort with aggression, aggressive responses to shame, excitement about guns, and violence as means of preserving power) than violence experienced in the school or community (Slovak et al., 2007). In addition to underscoring the importance of what children learn, social learning theory would also draw attention to what these children do not learn, namely, egalitarian relationships, non-violent approaches to conflict resolution, and emotional regulation skills.

Trauma

A third perspective that has been explored for understanding the cycle of violence is the trauma perspective. Based on his work with adolescent boys who have perpetrated lethal violence, James Garbarino has identified a process which he refers to as "hibernation of the soul" (Garbarino, 1999). Essentially, under conditions of severe, early, and chronic violence, these children may come to suppress their more humane aspects as a survival mechanism. The detachment from emotion and compassion that allows a person to survive chronic abuse is the same detachment that facilitates perpetration of severe violence without apparent remorse. Even in less extreme cases of trauma, the dysregulation of anger and arousal that develop create potent risk factors for the intergenerational transmission of violence. A significant literature has emerged to support these processes from a neurobiological perspective, which demonstrates that over-activation of the fight or flight response can result in a weak foundation for the development

of emotional regulation and self-soothing (van der Kolk and Greenberg, 1987).

In considering these three frameworks for understanding the cycle of violence—attachment, social learning, and trauma—it is evident that there are no quick fixes for breaking this cycle. Child abuse does not arise because of a lack of discipline; consequently, get-tough approaches with parents will not redress the risks. Similarly, it does not arise merely from a lack of parental support; as such, increasing support without targeting the underlying causes will not be very successful in preventing and reducing a child's direct and indirect exposure.

What Programs Are Effective or Promising?

In efforts to prevent child abuse and exposure to domestic violence, there are a number of points for possible intervention. Prevention in other areas is often divided into universal (or primary), selective (or secondary), and indicated (or tertiary). However, an argument can be made that using this type of classification locates the abuse with the victim and pathologizes the experience of abuse. Macmillan and colleagues have proposed an alternative schema for identifying intervention points, presented in Figure 6-2 (Macmillan et al., 2009). With this approach it is clear that one can work to prevent abuse before it occurs, to prevent abuse from recurring, and to prevent impairment following abuse. Each of these targets is necessary in a comprehensive approach, and different strategies will be effective at different points.

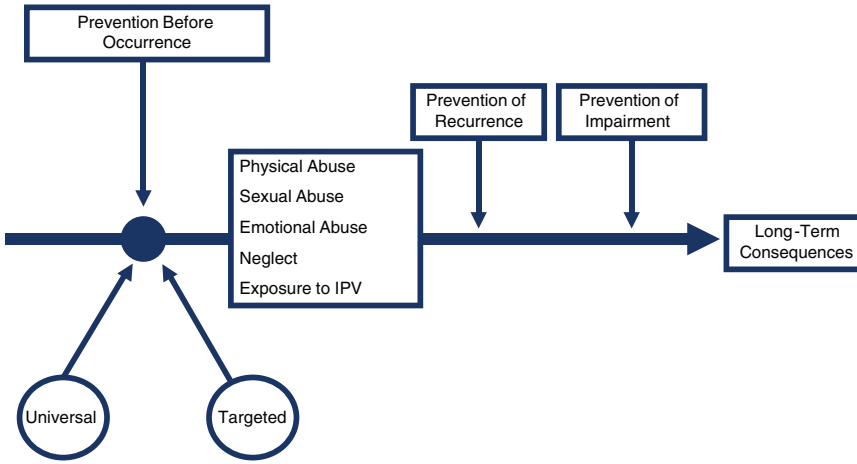

FIGURE 6-2 Intervention to prevent child maltreatment and associated impairment.
SOURCE: Macmillan et al., 2009.

Comprehensive reviews to identify what works to prevent child abuse or recurrence of child abuse follow one of two basic approaches. The first approach is to look across all previous summaries and reviews and amalgamate all of the existing evidence (Mikton and Butchart, 2009). This approach provides a somewhat bleak picture, because when studies are combined, results are generally mixed or disappointing. However, such an approach can be misleading because it includes studies that vary greatly in quality both in terms of the intervention and the research design. By contrast, the review by MacMillan and colleagues looks at high-quality programs that have shown good effects under reasonable research conditions but perhaps have yet to be replicated (Macmillan et al., 2009). Reviewing the existing studies in these two ways finds three approaches that can be considered effective or promising. Additional approaches may improve protective factors or reduce risk factors, but these three are the only ones that have been shown to prevent the occurrence or recurrence of abuse.

Home Visitation

Home visitation is the most effective child maltreatment prevention program to date (Macmillan et al., 2009). There is considerable variability in home-visiting interventions in terms of their models, service delivery, and home staffing. Two models, the Nurse-Family Partnership and the Early Start program, have been shown to be effective in reducing some indicators of child abuse. However, effects have not been uniform across other approaches to home visiting, and there are a few caveats for the success of home visiting. First, most of what we know is based on David Olds' pioneering work, and efforts to replicate his work have had mixed success. Second, home visitation has proved to be more effective when carried out by nurses than by paraprofessionals. Third, it may be more effective with certain types of families (such as first-time mothers) than others (Macmillan et al., 2009). Finally, the presence of domestic violence may undermine the effectiveness of home visiting. In the Elmira Home Visiting study the intervention reduced reports of child maltreatment, but not for families with mothers reporting more than 28 incidents of domestic violence (Eckenrode et al., 2000).

Parent Training and Education

The results for parent training and education in general are mixed, but there are two programs that have evidence supporting their use. First, the Positive Parenting Program (Triple P) has shown promise in one study for preventing abuse, and replication is currently under way. The Triple P uses multiple levels of social learning–based programs to meet the needs of different families and offers five levels of intervention with increasing intensity

to match higher-needs families (Prinz et al., 2009). Mark Chaffin and colleagues' work on Parent–Child Interaction Training has also been very promising in that it has been shown effective in lowering recurrence of physical child abuse (Chaffin et al., 2004). Parent–Child Interaction Training uses behavioral conditioning principles and provides immediate and detailed feedback for parents in their interactions with their children. It has been shown to both increase positive interactions and decrease recurrence of child abuse. Both of these programs warrant further investigation, particularly with larger samples of fathers, as most research has focused on mothers.

Educational Prevention of Abusive Head Trauma

The final effective strategy to date is education aimed at preventing abusive head injury (also known as shaken baby syndrome). Offered mainly through hospitals, this education offers normative information about babies' crying, coping strategies for parents, and the impacts of shaking an infant. There is a one study to date that found that the introduction of this program lowered the rates of abusive head trauma (Dias et al., 2005). Additional trials are under way. This program appears to be a cost-effective way to reduce one specific type of child abuse.

Interventions Lacking Empirical Evidence

Consistent with the general move to positive psychology, there has been much interest in interventions that build on parents' strengths. Many of these approaches use a mentoring or mutual support model of parents helping other parents in a way to normalize intervention and build informal support networks. The general benefits of mentoring and of encouraging strong social networks are widely accepted, but these approaches have not been found effective in the prevention of child exposure to direct or indirect violence (Macmillan et al., 2009). It is critical to recognize the distinction. A parenting program may increase parents' satisfaction with parenting, improve their social connections, and even lead to more positive attitudes and skills, and yet it may not reduce direct child abuse or exposure to domestic violence. If a program is being espoused as a child abuse prevention program, then the research must look at child abuse outcomes and not rely on proxies or interpret the promotion of positive parenting attitudes and skills as synonymous with the prevention of abuse.

Preventing Child Exposure to Direct and Indirect Violence: The Big Picture

A review of the state of the science of child abuse prevention reveals a number of basic facts. First, there are some effective and promising

interventions, but even these have limited evidence compared to many other areas of social and medical science. Second, it obscures the picture to collapse evidence across types of intervention (e.g., with meta-analytic techniques) with no consideration for the quality or features of the program. Quality of implementation matters, training of implementers matters, and matching the intervention to the risk level of the families matters. Third, at this point there is little available evidence concerning programs that are effective for preventing emotional abuse. Finally, there have not been any trials on programs to reduce exposure to domestic violence. Community-based approaches to preventing domestic violence have not been well researched, and there are no studies evaluating strategies for preventing exposure when domestic violence is occurring. On a more hopeful note, there are many innovative interventions in varying degrees of development and evaluation. It takes a long time to reach the point where a randomized controlled trial or multi-site replication is feasible.

Gaps and Challenges

A review of the state of the research shows clearly that while we have an emerging idea of effective practice in some specific areas, there are still many gaps. Below are five gaps in research and practice.

Where Are the Dads?

Much research has focused exclusively on mothers or not included enough fathers for useful subgroup analysis. This lack of representation in research mirrors the child protection policies and practices, which tend to focus on mothers and view fathers as either dangerous or irrelevant. The reality is that men who have perpetrated violence often remain part of their children's lives and require specific and intentional strategies to change attitudes and beliefs that support their abusive behavior, particularly when these men have also abused the children's mothers (Scott and Crooks, 2004). Furthermore, there is a dearth of programs that both address the gendered nature of violence and address men's abuse of their intimate partners and children concurrently. The Fathering After Violence initiative[5] for men who have been abusive to intimate partners and the Caring Dads program[6] for men who have been abusive to their partners and their children are exceptions to the rule.

[5] See http://endabuse.org/section/programs/children_families/_breaking_cycle.
[6] See http://www.caringdadsprogram.com.

Is Stopping the Violence Enough for Positive Child Outcomes?

When we look for successful outcomes in research, we often use the idea of recidivism or repeat violence as a sign of failure, but the corollary to that is that success is equated with no further violence. The reality is that, in the life of a child who has been victimized, just stopping the violence might not be good enough. There has been some discussion about restorative parenting and applying restorative justice models to the parent–child relationship, but we do not actually have a good sense yet about what that looks like or the implications for the child. Some work has been done in this area of child sexual abuse, but very little has been carried out that looks at father–child relationship restoration after domestic violence. There is a significant need to develop and evaluate protocols for deciding when it is safe to restore parent–child relationships post-violence and how this can be achieved with minimal risk to children.

Compartmentalization of Efforts

There have been some big strides in breaking down silos between types of abuse since the "Greenbook" was published as a model for collaboration between child protection and domestic violence sectors (Schecter and Edleson, 1999), but there is still too much compartmentalization within fields. Often researchers emphasize one type of abuse without looking at the complexities of poly-victimization or, what is even trickier, the co-occurrence of perpetration and victimization. For example, most research and programming for children exposed to domestic violence still does not inquire about the direct victimization experience of the children, particularly for abuse perpetrated by the victim parent. There are philosophical and practical reasons for these practices, but they hinder a fuller understanding and more effective response to children.

What Do Culturally Relevant Programs Look Like?

Virtually every paper or chapter ends with a plea for more culturally diverse and appropriate services, yet we have only scratched the surface in exploring what this really means. Is it merely resources translated into different languages? Is it trained therapists from the same ethnic or cultural background as the families? Is it program manuals that have different faces on them? It can be argued that we need to go much further than these superficial changes and that we have not done a good job of documenting or evaluating these processes of cultural adaptation. The challenge for cultural adaptation is further complicated when we look at implementing promising practices on a global scale, particularly in countries with less developed child protection or mental health systems.

What Is an Effective Specialized Response in the Highest Risk Cases?

Finally, for the most high-risk families, there is a complexity in terms of system involvement and information sharing that can only be addressed by collaboration across systems. Any comprehensive approach to preventing violence against children requires specialized responses that can be activated in the most high-risk cases. With the advent of domestic violence homicide review committees, a clearer picture of the risk factors for lethality to women and their children is emerging (Jaffe et al., 2003; Campbell, 2005; Jaffe and Juodis, 2006). In these cases, home visiting and parent education are not sufficient or appropriate for the degree of risk. In addition to developing clinical interventions for a wide range of families, we need to develop specialized collaborative protocols for the highest-risk cases.

In closing, although reviews that combine all interventions of a certain type tell a disheartening story, there are some bright spots in our search for effective interventions. Home visiting, parent education and training, and education approaches to abusive head trauma have all shown promise and a solid degree of evidence. The science is at the point where we know enough to know that there are no easy answers and no quick fixes. Different families need different types of support and intervention at different points in time, and we need to develop a comprehensive and coordinated system of care to ensure that no children fall between the cracks. It is a colossal task, but a vital one, because at the end of the day our children need to be safe from abuse and violence to develop to their full potential and grow into the type of adults who will contribute to a compassionate and productive society.

TRAUMA-INFORMED CARE: A VALUES-BASED CONTEXT FOR PSYCHOSOCIAL EMPOWERMENT

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Community Connections

We make a fundamental distinction between trauma-informed care and trauma-specific services (Harris and Fallot, 2001). Psychosocially empowering, trauma-specific interventions take as their primary goals ameliorating trauma-related difficulties and facilitating trauma recovery and healing. The Trauma Recovery and Empowerment Model, Seeking Safety, Trauma Affect Regulation: Guide for Education and Therapy (TARGET), the Boston Consortium Model, and Beyond Trauma, among others, are manualized approaches to helping women (and sometimes men as well) develop the skills necessary to cope more effectively with the impact of violence and abuse and to avoid revictimization (Harris, 1998; Najavits, 2002;

Covington, 2003; Ford and Russo, 2006; van Lier et al., 2009; Amaro, 2011). These interventions and many individual ones that focus primarily on post-traumatic stress disorder, such as exposure therapy, cognitive processing therapy, and other cognitive-behavioral approaches (e.g., Mueser et al., 2008), are an important component of trauma-informed care (Resick et al., 2008; Powers et al., 2010).

However, "cultures of trauma-informed care" refer to the programmatic, organizational, and community contexts that are necessary and valuable in supporting survivors and the staff who serve them. Any setting can be trauma-informed when it takes fully into account what we know about trauma, its impact, and the diverse, individualized paths to trauma recovery. In this way, not only behavioral health care settings but also primary care institutions, schools, and even correctional facilities can be trauma-informed. When an organizational culture becomes trauma-informed, it becomes more welcoming and hospitable for trauma survivors (as well as the rare individual who does not have a history of exposure to violence); it minimizes the possibility of revictimization; it indirectly facilitates healing, recovery, and empowerment; and it builds collaborations throughout the service system.

Trauma-informed care is important for a number of reasons:

- Trauma and, in particular, violent victimization are pervasive.
- The impact of trauma is broad, extending well beyond the post-traumatic stress disorders frequently perceived to be the most common outcome.
- The impact of trauma is often deep and life-shaping.
- Trauma, especially caused by interpersonal violence, is often self-perpetuating.
- Violence is even more common in the lives of those who are socially and politically vulnerable, including the poor, many racial and ethnic minorities, women and children, those diagnosed with mental health or substance abuse problems, and people who are developmentally disabled.
- Trauma affects the way people approach the human service setting, heightening fear and suspiciousness.
- The service system itself has too often been retraumatizing.

Retraumatization in the behavioral health care setting is one of the experiences that originally fueled awareness of the need for trauma-informed care (Jennings, 1998). Two types of retraumatization are noteworthy. First are the many ways in which traumagenic dynamics may be replicated in service provision. Examples include providers' lack of interest in traumatic violence or their disbelief of individuals' reports of violent victimization; both of these patterns may replicate earlier experiences, in which signs and

reports of violence were minimized or denied. Coercive approaches involving involuntary medication and hospitalization are still too common in many settings. And the presumption of incompetence (e.g., the inability to handle one's own finances) may be a part of standard operating procedure in many programs, a visible reminder of the ways in which survivors' skills are overlooked.

Second are instances of "sanctuary harm" (Robins et al., 2005). Consumers surveyed about their experiences in behavioral health care settings report violence and the fear of violence (including physical restraint and seclusion) as well as negative interactions with staff involving disrespect and humiliation. Taken as a whole, then, it is not surprising that one prominent psychiatrist has written that the past 30 years has evinced a continuing story of "destroying sanctuary" in the human services system (Bloom and Farragher, 2010).

As a counter to this destructive organizational culture, we have developed a model of trauma-informed care that builds on core values of safety, trustworthiness, choice, collaboration, and empowerment (Fallot and Harris, 2008, 2009). These values are key antidotes to the toxic effects of violence in the lives of consumers and staff members in human service delivery settings. For those who have been exposed to violence repeatedly and unpredictably, physical and emotional safety is a high priority. For those individuals affected by violence perpetrated by those who were supposed to be family or institutional caretakers, trustworthiness is a high priority. For those whose sense of voice and control has been attenuated by violent victimization, choice is a high priority. For those who have experienced the world as consistently arrayed in one-up, one-down relationships in which they have been the one down, the realistic offer to share power in a collaborative way is a high priority. And for those who have felt powerless to do anything about these other realities, empowerment is a high priority.

As a change in organizational culture, then, trauma-informed care extends far beyond any new service; it involves the physical setting, each contact, each activity, and each relationship in the organization. It extends beyond the training of clinical staff by engaging with all staff (including administrators, service staff, and support staff) and, importantly, all consumers to direct and monitor this change. Finally, trauma-informed care represents an opportunity to make these values into a routine part of the setting; it is broader than simply being "trained" in this approach.

Cultures of trauma-informed care balance trauma-specific emphases on individual empowerment and skills development with organizational emphases on safety, trustworthiness, choice, collaboration, and empowerment. This approach is consistent with other values-based approaches that have become prominent in the past two decades in behavioral health: recovery orientation, gender responsiveness, and cultural competence (Farkas et al.,

2005; Covington, 2007; Whitaker et al., 2007a). Furthermore, the core values of trauma-informed care are consistent with, and strongly supportive of, many evidence-based interventions, such as motivational interviewing, shared decision making, and psychosocial empowerment groups.

Basic shifts in both understanding and practice are fundamental in changing a traditional human service or community culture to one that is trauma-informed. Our protocol for developing a culture of trauma-informed care thus emphasizes both a paradigm shift in understanding and a thoroughly collaborative way to change practice (Harris and Fallot, 2001; Fallot and Harris, 2009). For instance, one of the key changes in understanding is establishing a "trauma first" mode of thinking about a consumer or staff member. Thus, we adopt a "trauma lens" through which other aspects of a person's life may be viewed. Rather than asking, implicitly or explicitly, "What is wrong with you?" or "What is your problem?" we ask "What have you been through?" and "How have you tried to cope with it?" This basic change in orientation affects the organization's view of not only consumers and staff members but also the nature of trauma itself, the services provided, and the relationship between consumer and provider. As the basic questions change, so do the approaches, from "Here is what I can do to fix you," to "How can you and I work together to further your goals for recovery and healing?" Collaborative decision making and planning pervade trauma-informed cultures; not only are consumers' opinions frequently sought and incorporated into individual service planning and organizational strategies, but also staff perspectives become central to administrators' thinking as well.

In putting these ideas into practice, we address six domains of organizational culture in human service settings; three are service-level domains, and three are at the systems-level (Fallot and Harris, 2009):

Services-level changes in a culture of trauma-informed care:

1. Informal service procedures and settings
2. Formal service policies
3. Trauma screening, assessment, service planning, and trauma-specific services

Systems-level changes in a culture of trauma-informed care:

1. Administrative support for developing and sustaining this culture
2. Staff training and education
3. Human resources practices

As an example, let us examine our approach to informal service procedures and settings. Here we ask agency workgroups representing all constituencies (upper-level administrators, supervisors and middle management, service staff, support staff, and consumers) to review the sequence of

settings, activities, and people to whom consumers are likely to be exposed from the time of their first call to their final visit. We sometimes recommend a walk-through, in which staff literally put themselves in the place of consumers by going through the same procedures as a new consumer would in entering the agency. Once each physical setting, activity, contact, and relationship has been outlined, we ask key questions related to the core values:

- How can we ensure physical and emotional safety for consumers throughout our organization and larger system of care?
- How can we maximize trustworthiness? Make tasks clear? Maintain appropriate boundaries?
- How can we enhance consumer choice and control?
- How can we maximize collaboration and the sharing of power with consumers?
- How can we prioritize consumer empowerment and skill-building at every opportunity?

Agencies have taken this task on with enthusiasm, developing creative solutions to identified problems in these domains. For example, one residential substance abuse setting had a large sign that read "Denial stops here" over the entrance to the residential areas of its building. Deciding that this sign did not create a hospitable or emotionally safe first impression of their setting, they replaced it with a "Welcome" sign that was much more inviting. Clearer and more positive signs, more comfortable waiting rooms (with adequate space and with minimal intrusion of security staff), more positive first contacts via phone or in person, better lighting in hallways and outdoors, and more private intake procedures—among many others—are examples of the sorts of changes organizations have made in efforts to create safer and more welcoming environments.

Once this process is completed, we ask organizational workgroups to follow the same procedure, this time with a focus on the staff's experiences of safety, trustworthiness, choice, collaboration, and empowerment. We have seen this "parallel process" with regard to trauma-related concerns played out repeatedly in a wide variety of settings. Simply put, only when staff members' experiences of physical and emotional safety, of trustworthy relationships (with their co-workers and with supervisors and administrators), of choice in how they go about their daily work, of collaborative power-sharing with administrators and supervisors (so that staff input is weighed significantly), and of empowerment (so that staff members have the resources they need to do their jobs well) are in place is the staff able to create similar experiences for consumers.

Trauma-informed cultures of care develop over time with the collaboration and support of administrators who recognize the invaluable

perspectives of both staff and consumers. We have gathered qualitative data in support of this shift in organizational cultures. Consumers report that they feel more accepted. One woman said, for example, "Before this initiative, I had to leave an important part of myself on the doorstep to this agency; now I can bring my whole self inside." Consumers, staff, and administrators frequently comment that the initiative fostered more collaborative relationships among them. Built on safety and trustworthiness and supported by valuing choice and empowerment, the capacity to share power meaningfully has become a hallmark of trauma-informed care.

As a values-based context strongly supportive of evidence-based trauma-specific interventions, trauma-informed organizational cultures represent a powerful source of engagement for women and their children who have been exposed to violence (Cocozza et al., 2005; Morrissey et al., 2005). (Also see the Substance Abuse and Mental Health Services Administration's Women, Co-Occurring Disorders, and Violence Study for related discussions and findings.[7]) To the extent that secondary and tertiary prevention of such violence relies on creating settings that are welcoming and engaging for individuals with complex histories of violent victimization, trauma-informed care is an increasingly central requirement for programs designed to assist women and children.

ENHANCING EMOTION REGULATION: A FRAMEWORK FOR PSYCHOLOGICAL EMPOWERMENT OF WOMEN AND CHILDREN EXPOSED TO VIOLENCE

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The health care and social service professions tend to approach the question of how to assist women and children who are victims of violence by doing research on, and developing practice guidelines for, the treatment of posttraumatic stress disorder (PTSD) (Forbes et al., 2010). Extensive surveys of scientifically validated and clinically promising PTSD treatments have been compiled by the International Society for Traumatic Stress Studies, the U.S. Department of Veterans Affairs, the Clinical Resource Efficiency Support Team (part of the Northern Ireland Health Service), the American Psychiatric Association, the British National Institute for Clinical Excellence, the Institute of Medicine, and the Australian Centre for Posttraumatic Mental Health at the University of Melbourne (CREST, 2003; APA, 2004; VA, 2004; NICE, 2005; IOM, 2006; Australian Centre

[7] Available at http://pathprogram.samhsa.gov/Resource/Women-Co-Occurring-Disorders-and-Violence-Study-Program-Summary-21101.aspx.

for Posttraumatic Mental Health, 2007; Foa et al., 2009). These guidelines were developed to address diagnostic criteria for PTSD in the *Diagnostic and Statistical Manual* (APA, 1997).

Although laudable in that they have made the possible benefits of carefully developed therapies for PTSD increasingly known to professionals who treat victims of violence, this medicalized approach to helping victims recover from violence has several key limitations. First, the very terms, "victim" and "treatment" suggest a degree of passivity and deficiency that does a grave injustice to the typically extremely courageous and resilient survivors of violence. Violence temporarily disempowers those who must survive it, but even prolonged and horrific violence does not strip the survivor of the capacity to be empowered. Being viewed as broken or defective and therefore in need of corrective treatment as a result of having suffered violence adds injury (as well as insult) to injury. Although therapeutic treatments can be empowering, this is the case only to the extent that they emphasize helping the violence survivor restore or build their strengths. PTSD therapies definitely have been shown through both scientific and clinical research to empower children and adults who have experienced violence (Courtois et al., 2009; Ford and Cloitre, 2009). However, PTSD treatments tend to provide education and therapy based primarily on a view of PTSD as a breakdown of courage (i.e., avoidance of trauma reminders or memories) or deficits in arousal and anxiety management (i.e., hyperarousal, hypervigilance).

Recent research provides a basis for a paradigm shift from a pathology/deficit perspective to a framework of psychological empowerment for interventions for survivors of violence. Women and children who have been exposed to violence often suffer from aftereffects that either do not fit the criteria for PTSD or that involve symptoms and difficulties in daily living that go well beyond PTSD (Rayburn et al., 2005; Schumm et al., 2006; Ford et al., 2008, 2009, 2010, in press-b; Gill et al., 2008; Mongillo et al., 2009; Briggs-Gowan et al., 2010; Seng et al., in review). Although these sequelae might at first glance seem to be consistent with the pathology perspective (e.g., depression, panic, dissociation, addiction, oppositional–defiance, eating disorders, personality disorders, guilt, shame, complicated bereavement), in fact what they demonstrate is the extreme degree of biological, psychological, and interpersonal adaptation required to survive violence (Ford, 2005; Ford and Cloitre, 2009; Ford et al., 2009). These adaptations require substantial strength and resilience, rather than being markers for or the results of pathology or deficiencies (Herman, 1992; Courtois et al., 2009).

As a result of this paradigm shift, in the past decade an impressive array of psychological empowerment interventions has been developed for children and adults who have experienced violence and related forms of complex trauma (Courtois et al., 2009; Ford and Cloitre, 2009). As summarized

by Courtois and colleagues, psychological empowerment interventions are built upon the following two central philosophical foundations:

1. *Recognizing the uniqueness of the individual.* The model is organized around recognition of the primacy and uniqueness of the individual and the maintenance of his/her welfare. Treatment is not one-size-fits-all; rather, each client is assessed, and treatment is planned differentially according to the specific needs of the individual. This is a phenomenological approach. . . . A "whole person" philosophy prevails: Although symptoms, deficits, and distress are reasons for seeking treatment and generally become the targets for intervention, the individual's strengths, resources, resilience, personalized needs, values, and contexts are identified and reinforced.

2. *Personal empowerment.* A strengths- and resilience-based philosophy of personal empowerment and self-determination encourages the therapist to seek to understand the individual's unique phenomenological experience and its specific meaning and its relationship to symptoms, distress, and treatment goals. The individual has authority over the meaning and interpretation of his/her personal life history, current needs and preferences, and goals for the future. The therapist functions as an active, empathic, and responsive listener and a guide to enable the client to openly voice, examine, and therapeutically work through feelings of confusion, shame, or other emotions that have been suppressed or forbidden. The therapist seeks to create relational conditions where the client is emotionally validated and is "seen" and appreciated, to counter the invalidiation experiences typically associated with attachment trauma and subsequent victimization and to encourage emotional expression and development. The therapist strives to create conditions within the treatment that are as egalitarian as possible and that encourage collaboration with and empowerment of the client; however, the responsibilities and inherent power differences in the treatment relationship are explicitly acknowledged. The therapist seeks to use power effectively on the individual's behalf while simultaneously encouraging the client's development and autonomy. Importantly, the therapist conveys an openness to the client's questioning of authority (including that of the therapist) and supports the client's ultimate authority over his/her life, memories, and therapeutic engagement and progress. Moreover, the therapist is careful to maintain appropriate boundaries and limitations and is responsible for avoiding dual relationships and situations in which the client might be subject to pressure, coercion, or exploitation intentionally or inadvertently by the therapist. *Treatment should be based in a shared plan that is systematic (not laissez-faire), utilizes effective strategies . . . organized around a careful assessment and a planned sequence of interventions that are hierarchically ordered and sequenced* (86-87; italics in original).

A recent meta-analysis of therapy outcome studies with adult survivors of childhood sexual abuse found that cognitive behavior therapy was superior to other modalities for anxiety, depression, and other internalizing problems but not for problems more specifically related to emotion dysregulation (e.g., externalizing or interpersonal problems) (Taylor and Harvey, 2010). Thus, some violence survivors, particularly those with extensive victimization histories, may respond best to therapy focused on enhancing emotion regulation. Survivors who have severe difficulties with emotion regulation and their therapists also may prefer not to engage in trauma memory processing or to not do so until the client has acquired emotion regulation skills (Cook et al., 2004; Cloitre et al., 2010). Three manualized psychosocial intervention models that do not include trauma memory processing have been designed to enhance skills for emotion regulation, anxiety management, and interpersonal functioning. Skills Training for Emotion and Interpersonal Regulation (STAIR) has shown promise in reducing PTSD and depression symptoms and in enhancing emotion regulation with women survivors of violence (Cloitre et al., 2010). Seeking Safety has shown promise in reducing PTSD and substance use problems with girls and women (Najavits et al., 2006; Zlotnick et al., 2009). Although STAIR and Seeking Safety address emotion regulation, they emphasize becoming more assertively aware and expressive of emotions as a way to overcome excessively negative emotion states and dysfunctional avoidance of trauma memories or reminders of those memories.

Trauma Affect Regulation: Guide for Education and Therapy (TARGET) acknowledges the extreme emotional distress (e.g., depression, anxiety, anger, guilt, shame, and grief) or emotionally numbed and shutdown feelings (e.g., dissociation) that violence survivors often suffer (Ford and Russo, 2006). However, these PTSD or trauma-related "symptoms" are currently viewed as adaptive, rather than maladaptive or dysfunctional, reactions which reflect a change in the stress response system in the body that is protective of the individual. TARGET teaches a single sequential skill set described by the mnemonic FREEDOM, designed based on research showing that emotion regulation involves recognizing, modulating, and recovering from negative emotion states as well as accessing and sustaining positive emotion states (Eisner et al., 2009; Kessler and Staudinger, 2009). Restoring affect regulation is described as requiring seven practical steps or skills denoted by FREEDOM: Focusing the mind on one thought at a time; Recognizing current triggers for emotional reactions; distinguishing dysregulated ("reactive") versus adaptive ("main") Emotions; Evaluations (thoughts); goal Definitions; behavioral Options; and self-statements affirming that taking responsibility for recovering from intense emotions is crucial not only to one's own personal well-being but also to Making a positive contribution to primary relationships (e.g., as a parent) and the community.

TARGET has been evaluated in a series of real-world effectiveness studies as a group therapy for women and men in substance abuse treatment as well as for incarcerated women, as a one-to-one therapy for low-income women with complex trauma histories and girls involved in delinquency, and as a combined group and milieu intervention for girls and boys placed in juvenile detention centers (Frisman et al., 2008, Ford et al., in press-b, in preparation; Ford and Hawke, in review). Group and milieu interventions enable participants to provide one another with peer modeling, support, and guidance as well as potentially enabling the program or community in which they take place to become "trauma informed" (Fallot and Harris, 2008). Consistent with this view, TARGET was found to enable women and men recovering from substance abuse to maintain a sense of realistic confidence and optimism ("sobriety self-efficacy"), where others who received substance abuse treatment as usual showed a marked decline in this important resilience factor (Frisman et al., 2008). The benefits to the entire setting were evident in findings from the evaluation of TARGET in youth detention centers, in which every session of TARGET received by a girl or boy was associated with a reduction in the number of behavioral incidents and punitive sanctions imposed by staff during the first two weeks of youths' stay in the facilities (Ford and Hawke, in review). On the other hand, many girls or women who have experienced violence may prefer the privacy of a one-to-one therapy intervention, and TARGET showed evidence of helping both underserved women and girls to not only reduce their PTSD symptoms but also to increase their ability to regulate emotions (Ford et al., in press-a, in press-b).

Implications of a Psychological Empowerment Approach for Violence Survivors

To the extent that knowledge is power, providing women and children who have experienced violence with de-stigmatizing explanations of why they are struggling with persistent emotional distress and how they can draw upon their inherent personal strengths to regain their emotional balance is a very direct and essential form of psychological empowerment. Equally, if not more, important is bringing this same knowledge to the many professionals, advocates, policy makers, funders, jurists, and regulators who determine how scarce societal resources will be allocated both to prevent violence and to restore the lives and well-being of survivors of violence. If violence changes how survivors' bodies respond to subsequent stressors (non-violent as well as violent), then traumatic stress disorders such as PTSD and its more complex variants are simply extreme versions of the out-of-balance emotional states that everyone experiences. Therefore, if recovery from the aftereffects of violence involves regaining or restoring

innate capacities for re-setting the body's stress reaction systems—and, in so doing, regaining or restoring the innate ability to regulate emotions and maintain a generally healthy balanced emotional state despite expectable perturbations—it is essential that not only violence survivors but also the public at large (including those key determiners and providers of services) are informed about why and how emotion regulation is essential not only for survivors of violence but also on a larger scale to prevent violence. With this perspective, it becomes possible to understand not only the aftereffects of violence but also violence itself as resulting at least in part from emotion dysregulation on a broad scale (e.g., uncivil discourse in politics or extreme economic and social disparities). Knowledge and skills regarding emotion regulation are essential not just for violence survivors, but for everyone.

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7

Papers on Global Partnerships and Government Initiatives

Preventing violence against women and children requires a comprehensive approach across all levels of society. Legal and regulatory structures that support gender equality, family empowerment, and skills building contribute to the reduction of violence at the international and national levels. Around the world, an increasingly large number of countries have implemented such laws and policies, as well as ones that address violence against women and children specifically. In the international and regional realms stakeholders have coordinated efforts to present systematic changes, share evidence of effective activities, and provide support for the development of policies and social norms to reduce violence. Speakers at the workshop presented several case studies to this effect, from continental and regional partnerships to initiatives at the national government level.

The first paper describes an example of a regional partnership in Latin America called InterCambios, which was created in an attempt to harness the collective power and success of several local groups and organizations. The partnership also serves to provide technical collaboration and critical analysis of both research and interventions in the region.

The second paper demonstrates the effectiveness of partnerships created between human rights experts and local organizations working toward policy change. It describes several successful attempts by Advocates for Human Rights, a nongovernmental organization (NGO) based in Minnesota, to partner with groups in Central Asia and Eastern Europe, areas that have typically had poor records of women's rights empowerment.

The final paper describes successful government initiatives to address violence in New Zealand, including various laws and regulations as well

as coordination efforts at the national level. It pays particular attention to efforts at addressing the needs of minority populations (in this case, the Māori populations) who are at greater risk for violence but often have lower access to resources or recourse.

THE INTERCAMBIOS ALLIANCE

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The InterCambios Alliance was created in 2003 with the aim of addressing existing gaps and facilitating greater collaboration and institutional coordination in the area of gender-based violence (GBV) in Latin America and the Caribbean.

Background

Despite compelling evidence that GBV is a serious health risk for women and a public health issue, research indicates that, although battered women use health services more than non-abused women, only a very small percentage of battered women are identified by health workers. Moreover, there is a lack of local services to which providers can refer women (Morrison et al., 2004). At a community level, there is often poor coordination between health providers and other important actors, such as community-based women's groups, criminal justice authorities, and local NGOs. Although there is increasing international recognition of the serious impact of GBV, investment in the field is still woefully inadequate. There is also a dearth of rigorous evaluations of promising interventions to inform policy and programs. Recent reviews of programs working in this field note the need for greater coherence among evidence, policy, and programs as well as for coordinated, community-based approaches to address violence from a public health perspective.

Worldwide evidence on the nature, prevalence, and consequences of gender-based violence is clear and convincing—but this is not enough. Although international attention has galvanized significant advocacy and action (usually by women's groups), such efforts have focused primarily on the areas of law and services and have not been sufficient to end violence perpetrated against women globally. Areas that need to be prioritized include developing local research capacity, particularly in resource-poor regions; improving monitoring and evaluation of GBV interventions to strengthen understanding of what works and what does not, especially in the area of prevention; supporting capacity building for entities engaged in addressing violence against women, including community-based

organizations, service providers, advocates, and policy makers; facilitating collaboration and coordination of efforts across sectors and regions; and scaling up promising local interventions.

The InterCambios Alliance

The alliance emerged from an expert meeting that PATH convened to identify gaps and challenges in addressing GBV in the region, particularly within the health sector, and to propose future collaborations to strengthen the field. The more than 25 experts and partner organizations at the meeting concluded that although Latin America was leading the way in terms of innovative policies and programs to prevent GBV, too much time and resources were spent "reinventing the wheel." This was largely due to the lack of opportunities to share experiences and lessons learned and a lack of critical analysis of programs to determine which approaches were most effective. Although several strong women's networks represented women's political interests on a regional level, participants felt there was a need for more technical collaboration and capacity building among groups. This assessment gave rise to the creation of the Inter-American Alliance for Health and the Prevention of Gender-Based Violence, known as InterCambios.

The alliance's goal is to help improve the capacities of the health sector in Latin America and the Caribbean to respond to violence against women from an integrated public health, human rights, and gender-equality perspective. Our strategy is based on the recognition of pioneering work already being carried out in the region by a diverse range of individuals, grassroots organizations, governments, NGOs, and international agencies. InterCambios brings these groups together to share knowledge and experience, to identify lessons learned, and to develop and disseminate new approaches in four key areas of action: research, information systems, and evaluation; public policy advocacy; strengthening care and training models; and communication for social change.

Working with a particular focus on Honduras, Nicaragua, El Salvador, and Guatemala, where rates of violence are known to be high, the alliance has provided technical assistance, training, tools, and information to policy makers, grassroots activists, and health professionals. The alliance includes several respected regional organizations known for their work in research, communications, service delivery, advocacy, and engaging men and youth in addressing violence against women, especially as a health concern. InterCambios also works closely with strategic partners including the Pan American Health Organization, the World Health Organization, the United Nations Development Fund for Women (UNIFEM), and the Latin American and Caribbean Women's Health Network.

InterCambios' Prevention Actions

Communication for Social Change

One of the lessons learned in the alliance's work has been the need for materials and methodologies that strengthen the work of those working on gender-based violence in Latin America and the Caribbean. From the start, InterCambios decided that the priority would not produce new materials but rather would identify materials that had received rigorous reviews and good feedback evaluation and then disseminate them widely in the different sectors.

In this sense InterCambios has aimed to promote and strengthen communication efforts that help to change paradigms, understanding violence as a systemic problem and employing an ecological approach. This is based on the identification and broad dissemination of validated educational materials, including videos, fact sheets, and brochures, on the issue of GBV in order for them to be incorporated into the work of institutions and organizations.

InterCambios's website, www.alianzaintercambios.org, has become a reference point for updated information on violence against women (VAW) for more than 1,500 contacts. From November 2006 to September 2010 it recorded a total of 177,382 visits, with the most visited sections being Events, Documents, News, and the newsletter. The most requested documents were *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*, a guide for addressing partner violence with health personnel and the community, and documents concerning participatory research on teaching and learning processes. The following are some examples of the materials that have been promoted:

- *For an End to Sexual Exploitation*: a manual developed by Promundo/InterCambios Alliance that aims to provide educators with a set of educational activities to stimulate critical reflection on these issues among groups of male adolescents between the ages of 10 and 14.
- *In Her Shoes*: an awareness-raising and training methodology developed by PATH InterCambios Alliance and adapted to the Latin American context. Monitoring and evaluation results show that the methodology allows analysis of VAW through personnel reflection, analysis of myths and prejudices related to VAW, identification of the role of institutions and support networks in facilitating or limiting women's decision making, and highlighting the link between GBV and other aspects of general and reproductive health

(e.g., sexually transmitted infections, HIV/AIDS, and unwanted pregnancy). A total of 1,450 sets of *In Her Shoes* have been disseminated, and 1,200 training workshops have been held in 12 countries on two continents. The document also has been adapted to the African context.

- *MenEngage*: a supporting initiative on masculinities in the region developed by Promundo/Puntos de Encuentro.

Promoting the Use of Evidence

In coordination with several stake-holders, Intercambios has helped improve approaches to VAW through conducting research and using evidence, facilitating access to both research findings and evaluation processes, and disseminating data and lessons learned in research methodology. A key element has been a course, based on the practical guide to researching violence against women, whose evaluation stresses "the putting into practice of the knowledge acquired to be used in everyday work, extend research beyond academic arenas, and strengthen organizations to use research tools to evaluate and monitor their work" (Ellsberg and Heise, 2005). Good examples of PATH's work to strengthen the use of evidence include strengthening the demographic and health surveys in Guatemala and Nicaragua through coordination with the U.S. Centers for Disease Control and Prevention, statistics institutions, and local women's networks; and strengthening understanding of femicide and promoting evidence-based plans of action (Widyono, 2009; COMMCA, 2010).

Lessons Learned

Through its prevention work, InterCambios has learned several lessons, which are:

- Because they already have communication and distribution channels, coordination with local networks and interagency commissions is the best path for successful distribution of materials and methodologies;
- Organizations and institutions have little time to dedicate to staying up to date on relevant research, so it is important to enable them to access information and evidence through "friendly" versions, e.g., the InterCambios' Violence and HIV CD; and
- Electronic mechanisms, such as newsletters, social networks, and webpages, are a good alternative for maintaining a consistent presence in the community.

Strengthening Training Capacities and the Quality of Care for Survivors of Violence

InterCambios works to strengthen the capacities and increase the quality of care available to survivors of violence. For example, it is working with the Metropolitan Health Region of Honduras to employ a participatory process to develop a model for the care and treatment of adults who experience domestic violence. Additionally, InterCambios has developed a toolbox to strengthen capacity-building processes related to violence against women. The toolbox gathers different reflections and methodologies that together generate synergy and strengthen capacity-building processes related to violence against women (training and awareness building). It provides suggestions and practical guidance to facilitators so that each training or awareness-building arena can provide an opportunity for reflection that helps change the attitudes and behaviors of people in contact with women experiencing—or that have experienced—violence in their lives. The toolbox contains the following materials: *Health Sector Response to Gender-based Violence: Resource Manual for Health Professionals in Developing Countries* (IPPF-RHO); a fact sheet on lessons learned in the training of health personnel; the *In Her Shoes* methodology; the María Luisa booklet; and interactive CDs on violence and HIV and on violence and maternal mortality.

Challenges and Lessons Learned from Working Regionally

The following challenges and related lessons learned have emerged since InterCambios began working regionally in Latin America and the Caribbean.

- Compared to local initiatives, regional work is slower, which hinders the organizations' more active participation in the processes.
- The identification of strategic allies (e.g., United Nations agencies or regional institutions) is vital to increasing the scope of the actions.
- Frequent changes in NGO personnel are common, which makes it necessary for the capacity-building processes to be ongoing.
- It is a challenge to coordinate with civil society networks and governments individually as well as with the two sectors together, and there are often suspicions when working with these actors; strengthening the "technical" issues is a mechanism for mitigating this obstacle.
- Sexual violence and its different expression on children and women is still a pending topic.

- A changing context where new variables are appearing—migration, organized crime, and drugs, among others—makes it necessary to think about new strategies and approaches where regional work plays a key role.

GLOBAL PARTNERSHIPS ON DOMESTIC VIOLENCE LEGAL REFORM

Cheryl A. Thomas, J.D.
The Advocates for Human Rights

Introduction and Background

Since 1993 the Advocates for Human Rights' Women's Program has been working with partners internationally to address domestic violence through an improved government response, particularly, better laws and more effective implementation of those laws. Many of these partnerships have become long-term collaborative efforts that respond to evolving needs and developments in a given country. We believe these partnerships have contributed to a better legal system response to domestic violence and to a new prioritization of victim safety and offender accountability.

Of all the forms of violence against women, domestic violence[1] is one of the most insidious and widespread throughout the world. The Council of Europe reports that domestic violence is the major cause of death and disability for women aged 16 to 44 and accounts for more death and ill health than cancer or traffic accidents (European Parliament Association, 2002). Nearly one in four women in the United States reports having experienced violence by a current or former spouse or boyfriend at some point in her life (CDC, 2008). On average, more than three women a day are murdered by their husbands or boyfriends in the United States (Catalano). A United Nations agency for women estimates that globally at least one of every three women will be beaten, raped, or otherwise abused during her lifetime. In most cases the abuser is a member of her own family (Family Violence Prevention Fund, 2011). A 2005 World Health Organization study found that

[1] For the purposes of this paper, the following definition of domestic violence provided by the United Nations is used: "Domestic violence is the use of force or threats of force by a husband or boyfriend for the purpose of coercing and intimidating a woman into submission. This violence can take the form of pushing, hitting, choking, slapping, kicking, burning, or stabbing." U.N. Centre for Social Development and Humanitarian Affairs. 2003. *Strategies for confronting domestic violence: A resource manual.* Available at http://www.unodc.org/pdf/youthnet/tools_strategy_english_domestic_violence.pdf (accessed April 30, 2011). This definition reflects data indicating that women are the primary victims of domestic violence.

the percentage of women who had experienced physical or sexual intimate partner violence in their lifetimes ranged from 15 percent in Japan to 71 percent in Ethiopia (Family Violence Prevention Fund, 2011).

Despite these alarming statistics, the United Nations reported in 2006 that 102 countries were not known to have any specific legal provisions on domestic violence (UN, 2006).

The mission of the Advocates for Human Rights (AHR) is to implement international human rights standards to promote civil society and reinforce the rule of law.[2] The work of AHR's Women's Program focuses on domestic violence as a violation of fundamental human rights. One of the most important components of efforts to address domestic violence is policy and law reform that promotes victim safety and offender accountability—which are principles articulated in numerous human rights instruments. This reform must be accompanied by reforms in all other sectors of government and civil society, including the health sector, social services, education, and the economic sector. This view is shared by our international partners and provides the basis for our collaborative efforts.

Partnerships to Document the Government Response to Domestic Violence

Global partnerships can strengthen efforts to address domestic violence. By bringing their own unique knowledge and experience to a collaborative effort, NGOs can empower each other, enrich the advocacy work, and move more efficiently toward the full realization of women's fundamental human right to be free from violence. Partnerships allow organizations to reach across local and international borders to share expertise, lessons learned, and strategies.

One contribution that AHR has brought to its partnerships has been the long-standing experience of Minnesota and the United States in addressing domestic violence.[3] To illustrate, many of AHR's partnerships have developed in countries in Central and Eastern Europe and in the former Soviet Union (CEE/FSU). In the early 1990s, when AHR first began working in the region, there was little experience in addressing domestic violence. There was minimal documentation of domestic violence in the legal system

[2] AHR was founded in 1983 by a group of Minnesota lawyers who recognized the community's unique spirit of social justice as an opportunity to promote and protect human rights at home and worldwide. The organization involves volunteers in research, education, and advocacy, building broad constituencies for human rights in the United States and select global communities. AHR holds special consultative status with the United Nations.

[3] The movement to address domestic violence began more than 30 years ago in the United States, and other countries have comparable legacies. Minnesota's efforts began in the early 1970s.

or research on the issue of any kind. There were also few, if any, services for victims, such as shelters, hotlines, or legal services. There were no particular laws on domestic violence, so victims were trying to access the justice system through criminal assault laws, divorce laws, and other laws not specific to domestic violence. Many legal system authorities were reluctant to use these laws in domestic violence cases, explaining that it was not their role to be involved in "family matters." There was no training for medical professionals, legal professionals, or civil society on effective responses to domestic violence. Frequently, legal professionals, advocates, and others would repeat myths or misinformation about domestic violence. A common belief, for example, was that the violence was caused by alcoholism.[4] Another frequently stated view was that couples counseling could resolve violent behavior.[5] These mistaken beliefs could result in ineffective policy making on domestic violence.

Many of our reforms in the United States were initiated in the 1970s, and by the early 1990s a great deal of knowledge and expertise on domestic violence had developed. One of the first battered women's shelters in the nation opened in St. Paul, Minnesota, in 1972. In this period several states passed laws specifically addressing domestic violence and offering a new order-for-protection remedy.[6] Minnesota passed its Domestic Abuse Act in 1979, which provided this remedy and included other reforms to Minnesota's laws. Beginning in the 1970s, criminal law reform resulted in new policies and procedures for police and prosecutors aimed at ensuring that domestic violence cases were treated more seriously than had been done in the past. In the same decade advocates and government officials in Duluth, Minnesota, created the Coordinated Community Response to domestic violence, often referred to as "the Duluth Model," which was a groundbreaking strategy to improve the community's response to domestic

[4] Although alcoholism can exacerbate violent behavior, studies show that it is not the cause of domestic violence. Cf. http://stopvaw.org/Other_Causes_and_Complicating_Factors.html.

[5] Research has in fact shown that counseling or mediation can be dangerous for domestic violence victims. Furthermore, counseling and mediation is often not an appropriate response to domestic violence cases because it presupposes that both the victim and perpetrator are equal when, in fact, we know that the offender exercises power and control over the victim. For further discussion of these issues, see http://stopvaw.org/Domestic_Violence_Explore_the_Issue.html.

[6] Laws containing the civil order-for-protection remedy were first introduced in the United States in the mid 1970s. The goal of these laws was to provide an immediate remedy to women and their children that would keep them safe while allowing them to stay in their home. As is the case today, many victims did not want to involve the criminal justice system and see their partners go to jail; rather, their priority was stopping the violence. These laws allow a victim to petition the court for an order directing the violent offender to leave the home. Cf. http://stopvaw.org/Orders_for_Protection.html.

violence.[7] These early reforms led to years of increasing experience by advocates and justice system officials in implementing laws on domestic violence. They also led to research and statistics on the nature and extent of domestic violence, its causes and consequences, and the strength and weaknesses of the new laws.[8] AHR has been able to share these resources with international partners through workshops, training sessions, consultations, and on-line technical assistance.

Another contribution AHR has been able to offer to its partners is the ability to raise the profile of local issues. As an international human rights organization with credentials in the United Nations, AHR's reports and recommendations can often reach a broader audience than the partners would be able to do alone.

Finally, international partners have been able to use AHR's expertise in documenting domestic violence as a human rights violation and advocating for change. Particularly in the early years of collaboration, when women's advocacy groups were new in CEE/FSU, AHR shared the resources and skills needed to document domestic violence as a human rights abuse and assisted in using that documentation to achieve changes in laws, policies, and practices.

In a successful global partnership, the leadership of local partners is essential to any domestic violence reform effort. The years of experience and the profile of international human rights groups would contribute little to real progress internationally without the vision and the hands-on work of local partners. In the context of legal reform, the knowledge and guidance of local partners is critical to a comprehensive understanding of the language of relevant current laws and the workings of the legal system. Many of AHR's local partners are lawyers with whom AHR has worked closely to parse through laws and legal procedures to identify weaknesses and areas for possible improvement.

Local advocates largely define and prioritize the needs and the appropriate advocacy strategy for their communities. They consider strategies that have been used in other communities and countries, but it is their firsthand information that provides critical guidance on any advocacy plan. That information includes the dynamics of the local legal system and other sectors, local and national social and political situations, inherent risks to victims with a given strategy, and other factors. Also, when the time comes for lobbying for changes to laws and policies, it is the local advocates who do

[7] The Duluth Model of Coordinated Community Response is now being replicated around the world. See http://stopvaw.org/Coordinated_Community_Response.html.

[8] Minnesota's Domestic Abuse Act has been amended every year since it passed in 1979—reflecting the developing knowledge about what legal system responses work to promote victim safety and offender accountability and what responses do not work.

the daily work of garnering support for the reform. As is illustrated in the examples below, all of AHR's early reports on domestic violence were created in response to an invitation of a local advocate who identified the need.

AHR's Early Partnerships to Draft Reports on Domestic Violence

Beginning in 1993, before many of the international efforts to reform laws on domestic violence began, AHR worked with partners to document domestic violence as a human rights violation. Over the years AHR has published 13 reports that include recommendations for changes to the governments' responses to this violence, including the legal system response.[9] Many of the partnerships forged through writing these reports are ongoing today and are focused on implementing their recommendations.

AHR's work in CEE/FSU began in 1994 at the invitation of the Romanian women's group, the Society for Feminist Analysis (ANA), when volunteer attorneys traveled to the region to conduct research for a report on domestic violence. ANA's goal was to expose domestic violence as a widespread and devastating problem in Romania that the government was ignoring. They believed that partnership with an international human rights organization would garner the problem more attention among officials both inside and outside their country, which could lead to greater improvements, and they appreciated the longstanding Minnesota experience of addressing domestic violence.[10]

The resulting report, *Lifting the Last Curtain: Domestic Violence in Romania,* was published in 1995 (Minnesota Advocates for Human Rights, 1995). It offered an analysis of the government response to domestic violence, tracked what happened to a victim of violence when she sought redress from the legal system, identified gaps and weaknesses in the system response, and offered recommendations. Since that time Romania has

[9] These reports are published at http://www.theadvocatesforhumanrights.org/Issues_Affecting_Women880.html. They analyze information gathered through review of laws and policies, research, and, most importantly, interviews with government officials, judges, prosecutors, police, lawyers, advocates, medical professionals, and others about domestic violence. In addition to the domestic violence reports, AHR has published six other reports on other forms of violence against women: sex trafficking, employment discrimination, and sexual assault. Most of these reports focus on other countries; however, in 2008, AHR published the report, *Sex Trafficking Needs Assessment for the State of Minnesota* and worked with advocates to lobby and pass improvements to the Minnesota criminal code on sex trafficking. In 2004 AHR published the report, *The Government Response to Domestic Violence against Refugee and Immigrant Women in the Minneapolis/St. Paul Metropolitan Area: A Human Rights Report* and worked with advocates and government officials to make changes that promoted victim safety and offender accountability.

[10] Since 1985 the Advocates for Human Rights has documented human rights abuses around the world and advocated for change. See www.theadvocatesforhumanrights.org.

passed a new law on domestic violence, training sessions have taken place, and new services have been established.[11]

Through their partnership, ANA and AHR forged new territory in the world of human rights advocacy. Women's rights, including the right to be free from violence, were not commonly viewed as human rights at that time, and violence against women was largely not addressed as a human rights issue.[12] International dialogue on this issue was vibrant in the early 1990s as activists pushed for a new recognition of women's rights as human rights and were inspired by the approaching United Nations Fourth World Conference on Women in Beijing. This aspect of the partnership between AHR and ANA proved to be particularly powerful with an impact beyond Romanian borders. The report highlighted domestic violence as exceptionally insidious and widespread with devastating consequences for women, children, families, and communities. The report clearly named domestic violence as a violation of human rights and called on the Romanian government to fulfill its obligation to prevent this violence, protect victims, and punish perpetrators. The report contributed to the growing recognition worldwide that women have a right to be free from violence in their homes and, through commitments to international human rights treaties and standards, governments have an obligation to prevent and punish this violence. Advocates throughout the region, who were accustomed to having their concerns dismissed by government officials, were empowered by this growing recognition of domestic violence as a human rights violation.

Following the publication of *Lifting the Last Curtain,* advocates from Bulgaria and Albania who had similar goals to those of the Romanians requested partnerships with AHR. The resulting reports, *Domestic Violence in Bulgaria* and *Domestic Violence in Albania,* identified weaknesses in the laws and legal process that were jeopardizing women's safety, preventing domestic violence victims' access to meaningful remedies, and undermining offender accountability (Minnesota Advocates for Human Rights, 1996a, 1996b). Both of these reports were eventually followed by new domestic violence laws in each country.

Soon after the publication of these two reports, AHR partnered with Albanian and Bulgarian advocates to organize two groundbreaking conferences. The goal of the first conference, organized in 1996 in collaboration

[11] Romanian domestic violence advocates do remain deeply concerned about gaps and weaknesses in the government's response to the problem, and they continue their advocacy efforts.

[12] For a further discussion of this issue, see Charlesworth, H., C. Chinkin, and S. Wright, 1991. Feminist approaches to international law. *American Journal of International Law*, 85:613-635; Thomas, D., and M. Beasley. 1993. Domestic violence as a human rights issue. *Human Rights Quarterly* 15:36-62; and Thomas, C. 1999. Domestic violence. *Women and International Human Rights Law* 1:242.

with the women's groups Reflexione and the Women's Center of Albania, was to build the capacity of new NGOs to respond to domestic violence with shelters, hotlines, other advocacy services, and to address the problem through public education. One of the presenters at this conference was Sharon Rice Vaughan, who founded one of the first battered women's shelters in the United States in 1972 in St. Paul, Minnesota. This conference included 50 participants from seven countries.

The Inter-Balkan Conference on Legal Strategies to Combat Domestic Violence was organized with AHR's partners from Albania and Bulgaria in 1997. This was the first conference of its kind in the region and included participants from 12 countries. The four-day conference brought together advocates from the Balkan region to discuss the legal systems' responses to domestic violence and to develop strategies for change. Advocates from the United States presented information about long-standing legal reform efforts in the civil and criminal systems that participants could consider as possible new reform strategies in their own countries. A focus of these presentations was the order-for-protection remedy, which was new to the region and which has now become a central feature of many of the new domestic violence laws in CEE/FSU.

After publishing the reports in Romania, Bulgaria, and Albania and convening conferences in the region, AHR continued its partnerships with advocates through reports, workshops, and training sessions. AHR developed a particularly long-standing partnership with the Bulgarian advocates, which is described below.

Recent Partnerships in Drafting and Implementing Domestic Violence Laws

Today, although though there is increasing acknowledgement internationally that domestic violence is a pervasive human rights violation with devastating consequences, there is still an urgent need for technical assistance in drafting and implementing new domestic violence laws and amendments to existing laws. AHR's more recent partnerships with local advocates are based on this need.

Although there is a great interest internationally in creating new domestic violence laws,[13] advocates and government officials involved in this process often do not have the information required to do so effectively. They have little information about how the dynamics of domestic violence complicate the legal system's response to this violence, about research on

[13] Although in the early 1990s there were few, if any, specific laws on domestic violence in the 29 countries of CEE/FSU, today most of these countries have either passed a specific law on domestic violence or are working on such laws.

strategies used throughout the world's legal systems, or about best practices in the legal system response to domestic violence.[14] They often do not have access to training materials or the language of longstanding laws from other jurisdictions. This information is critical to being able to draft and implement effective laws.

One way that AHR has contributed in this area is by consulting on the specific language of laws with the advocates and government officials who are drafting them. At the request of international partners, AHR has provided written commentary to draft laws from Armenia, Azerbaijan, Bhutan, Bulgaria, Georgia, Kazakhstan, Lithuania, Montenegro, Morocco, and Tajikistan.[15] These commentaries offer specific suggestions for ways to improve the laws to better promote victim safety and offender accountability. In support of these recommendations, AHR provides partners with model policies and practices that directly address the focus of the law under consideration.

In one example of how these commentaries have been used, draft laws from three countries in CEE/FSU initially provided police with authority to give one or more warnings to perpetrators before there were any consequences for violent behavior. After analyzing the draft laws, AHR provided commentary that pointed out the danger such laws present to victims and how these warnings would undermine offender accountability—in effect, allowing the offender one or more "free" assaults. Advocates are working to omit the warnings provisions from these laws. In another example, the draft laws in at least two countries referred to "victim behavior" or behavior that "provokes, results in, or creates conditions for violence." This language implies that the domestic violence victims may be blamed for the violence, dissuades them from seeking protection, and undermines offender accountability for the violence. The language referring to provocation—and, in the case of one country—the authority to cite victims for this behavior—has been removed from these two laws.

AHR's partners greatly appreciate and depend upon this expert commentary. In January 2011, a member of the Lithuanian Human Rights Committee wrote, "I would like to express my gratitude to your precious and prompt work on commenting the draft law. This is a very important legal act for us in Lithuania, done for the first time. Therefore, your comments help us identity the gaps in our first draft and make improvements."

[14] There is now a significant body of research on the dynamics of domestic violence. This research addresses batterers' use of power and control over their victims and victims' responses to these tactics, including the tendency to recant their allegations against batterers when cases go to court. For more information about the dynamics of domestic violence, see *Domestic Violence, Explore the Issue* at http://stopvaw.org/Domestic_Violence_Explore_the_Issue.html.

[15] Two examples of recent commentary that AHR has provided to draft laws can be found at http://bit.ly/fJKW8b (for Kazakhstan) and http://bit.ly/fUxHWB (for Armenia).

Other ways that AHR has worked with local partners to contribute to the drafting of laws are through roundtables, workshops, and on-line technical assistance. Two on-line resources in particular have contributed to the capacity of AHR's partners to work with government officials to develop new laws. In 2003 AHR launched the Stop Violence Against Women (StopVAW) website, www.stopvaw.org, a forum for information, advocacy, and change. StopVAW, which is focused on CEE/FSU, provides current research, news about promising practices, model laws, and training modules.[16] In response to the urgent need for technical assistance on legal reform on domestic violence, AHR is working currently with UNIFEM (recently re-named UN Women) to develop the legislation section of the newly launched Virtual Knowledge Center to End Violence Against Women (http://www.endvawnow.org/?legislation). This section provides expert guidance on drafting, advocating for, implementing, and monitoring national legislation in diverse regions around the world.[17]

Likewise, as partners have begun to apply new laws, they have appreciated AHR's training modules and model policies for police, prosecutors, and judges, which are provided both on-line and through in-country training sessions. AHR has worked with Minnesota police, prosecutors, and judges to develop training programs for their counterparts internationally and to travel together to countries to share expertise. Finally, a new focus of AHR's partnerships is the monitoring of the implementation of new laws to determine if they truly are effective in promoting victim safety and offender accountability.

A central component of recent partnerships with Bulgaria, Armenia, and Georgia has been drafting and monitoring the implementation of the new laws. The following sections offer descriptions of AHR's collaborative work in these countries.

Bulgaria

Based on the findings and recommendations of the report *Domestic Violence in Bulgaria,* published in 1996 and described above, Bulgarian advocates undertook a campaign for a new domestic violence law. They

[16] StopVAW has become a resource for individuals and community groups and government. In one month of 2009, 2,308 pages of StopVAW received 25,136 unique page-views. These visits came from 167 different countries, and 82 percent of these were new visits. Most site visitors visited two or three pages on the StopVAW website. For several years, AHR has worked with local advocates in the region to present their own country's response to violence against women in the Country Pages section of the website.

[17] For another resource on drafting effective domestic violence laws and legislation, see *Good Practices in Legislation on Violence Against Women,* United Nations Division for the Advancement of Women, United Nations Office on Drugs and Crime, Report of the Expert Group Meeting (November 2008). Available at http://bit.ly/gRqlLA.

felt that change could happen more swiftly in the civil system rather than in the criminal system, so their goal was to provide a new civil order-for-protection remedy for domestic violence victims. Bulgarian advocates, led by the Bulgarian Gender Research Foundation (BGRF), engaged not only AHR but also other partners both within and outside their country in the process of developing a new law. Genoveva Tisheva, BGRF's director, described the entire process as both a local and an international effort.[18]

AHR provided specific language for the new Bulgarian law on the civil order-for-protection remedy that has been used in the United States for many years. Experts in domestic violence legal reform, including judges and police, also traveled from Minnesota to Bulgaria numerous times to consult with legal officials, parliamentarians, and journalists about the need for new laws on domestic violence and about how the laws work as they are applied at the scene of an assault, in the courtrooms, and in the daily lives of victims. BGRF and AHR also partnered to organize several technical training sessions specifically for police, prosecutors, and judges on how to implement domestic violence laws.

The Bulgarian Law on Protection against Domestic Violence was passed in March 2005. It defines domestic violence for the first time in Bulgaria and creates a new civil order-for-protection remedy for domestic violence victims. The law allows courts to order violent offenders out of the home, and in emergency situations, where danger is imminent, both police and judges can direct offenders to leave the home (Advocates for Human Rights, 2008b). In May 2005, the police removed the first batterer from his home under the new law, and since that time, thousands of orders for protection have been issued by Bulgarian police and courts (Advocates for Human Rights, 2008b).[19]

In 2008, BGRF and AHR together published the report, *The Implementation of the Bulgarian Law on Protection against Domestic Violence: A Human Rights Report*. The report begins,

> In the two years since the entry into force of the Law on Protection against Domestic Violence (LPADV), its overall implementation has been positive. While challenges remain for all sectors and legislative amendments are needed, the response to domestic violence since the law passed in Bulgaria is encouraging. (Advocates for Human Rights, 2008b, p. 1)

The report evaluated all aspects of the government's implementation of the new law and made several recommendations for change. One recommendation was that an offender's violation of an order for protection under the new law should be criminalized so that the law had "teeth." The Parliament made this change in 2006.

[18] See Genoveva Tisheva, *Law on Protection Against Domestic Violence: Insights and History*, available at http://stopvaw.org/31May20055.html.

[19] See http://stopvaw.org/17May20053.html.

AHR's partnership with BGRF continues. In 2008 the two groups organized the Regional Conference on Domestic Violence Legal Reform. The conference had 100 participants from 29 countries.[20] In 2010 and 2011, AHR and BGRF have been working with partners in Croatia and Moldova to monitor new laws on domestic violence in those countries. Together they are also presenting workshops titled "Strategies for Monitoring the Application of Domestic Violence Legislation Workshop for Civil Society Organizations" for advocates from 24 countries in the region.

Georgia

After initial visits and exchanges with advocates in Georgia, which began in 2003, AHR invited the Georgian working group of government officials and civil society members who were in the process of drafting the new domestic violence law to visit Minnesota. This meeting occurred in February 2005 and forged a partnership with various advocates based in Tbilisi, in particular, the Anti-Violence Network of Georgia (AVNG). AHR organized a series of presentations, workshops, court observations, visits to service providers, police ride-alongs, and meetings with prosecutors and judges.[21] The goal was to offer Georgian officials the opportunity to observe a jurisdiction where domestic violence laws were working, with a system that took domestic violence cases seriously, that offered civil remedies to victims to promote their safety, and that arrested men and charged them with crimes for assaulting their wives.

The two-week visit offered the Georgians information and insights from many perspectives into the implementation of the domestic violence law in Minnesota that they could draw from in drafting their own law. The Law of Georgia on the Elimination of Domestic Violence, Protection, and Support of its Victims passed in 2006.[22] As with the Bulgarian law, this law defined domestic violence for the first time and focused on providing a civil order-for-protection remedy for victims.

The Georgian law was a huge step forward in addressing domestic violence but had significant weaknesses. For example, it gave police the authority to remove victims from their home—ostensibly to protect their safety—but did not provide explicit authority to remove violent offenders

[20] For more information, see http://stopvaw.org/regional_conference_on_domestic_violence_legal_reform.html.

[21] See *Minnesota Advocates for Human Rights Training Program Schedule for Georgian Working Group on Domestic Violence Legislation*, Jan. 24-Feb. 4, 2005. Minneapolis, Minnesota. For copies, contact the Advocates for Human Rights.

[22] See *Prevention of Domestic Violence, Protection of the Victims of Domestic Violence and their Assistance* (Legislative News of Georgia; Part 1; 2006; Art. 171).

from the home.[23] Georgian advocates understood the dangers of such language but believed that it was a compromise they must make in order for the law to pass.[24] The law was later amended to explicitly allow for the removal of the violent offender from the home. The new amendment states that this removal may occur despite the abuser's ownership of the property (Thomas, 2008). This amendment indicates the prioritization of a women's right to be free from violence over an abuser's property rights.

The Georgians faced difficult challenges in implementing the law. Under the new law the police were given greatly expanded authority to issue "restrictive orders" comparable to emergency orders in the United States. This authority has proven to be a burden, one police officer stated: "The district police are supposed to be social workers, psychologists and teachers" (Thomas, 2008, 3).

Despite the challenges with implementing the new law, it provides a remedy for domestic violence victims. Since the law passed, advocates report that hundreds of orders to protect victims have been issued by the police and judges.

Armenia

As with Bulgaria, AHR's partnership with Armenian advocates began with a collaboration to provide documentation of the government and community response to domestic violence. And, as with other countries throughout the region, in 2000 such response was negligible. AHR researched and published a report in collaboration with the Women's Rights Center in Yerevan (WRC), and AHR's work with WRC has continued to the present (Minnesota Advocates for Human Rights, 2000).

After the publication of the report and other initiatives to address domestic violence in Armenia,[25] WRC worked to create a group consisting

[23] Removing victims from their homes results, of course, in hardship and disruption in their daily lives and the lives of their children, including lack of access to personal belongings, the inability to safeguard such belongings from the violent offender, difficulties with access to work and school, and the loss of support systems close to home including friends and families.

[24] Drafters from other countries in CEE/FSU have included similar provisions in their laws, and advocates have explained that this is the result of prioritizing a man's property rights over a victim's right to be free from violence. In fact, one Polish advocate explained that the prioritization of men's property rights has been a major impediment to the passage of any order-for-protection remedy in her country. *Legal Reform on Domestic Violence in Central and Eastern Europe and the Former Soviet Union,* p. 3, available at http://www.un.org/womenwatch/daw/egm/vaw_legislation_2008/expertpapers/EGMGPLVAWpercent20Paperpercent20(Cheryl percent20Thomas).pdf. Armenia's draft law included a similar provision authorizing authorities to remove the victim from the home. This amendment passed in Georgia in 2009. Cf. http://stopvaw.org/Georgia.html.

[25] For example, in 2008 Amnesty International published a report on domestic violence in Armenia titled *No Pride in Silence: Countering Violence in the Family in Armenia.*

of representatives of the police, government ministries, judges, and NGOs to draft a new law on domestic violence. This group requested that AHR provide commentary on the Armenian Draft Law on Domestic Violence as drafts evolved. AHR provided three such commentaries (Advocates for Human Rights, 2008a).

In response to AHR's commentaries, critical language such as "provocative behavior" by the victim and "official warnings" to the perpetrator was removed, and other key language was added, such as the addition of "intimate partners" as a class of individuals to whom the law will apply. AHR also prepared training materials on advocacy and lobbying for the law and traveled to Armenia for meetings with the working group and other individuals involved in drafting and advocating for the law. As of January 2011, however, the law had not passed in Parliament.

WRC was also a valuable partner on the StopVAW website. Through the WRC's work, readers could follow the struggle for a domestic violence law, including working group meetings, roundtables, training sessions on advocacy for the draft law, study visits to other countries to witness the implementation of their laws, and analyses of human rights reports on domestic violence in Armenia.

Morocco

AHR's partnership with Moroccan advocates began in 2007—much later than the work in CEE/FSU. Moroccan women's NGOs were committed to leading the Arab world's reform of laws concerning violence against women legal reform and needed technical assistance in drafting a comprehensive violence against women act. Aided by Global Rights, a group based in Washington, DC, with offices in Morocco and around the world, AHR has provided information to these advocates, primarily in the area of domestic violence but also on sexual assault. Through training sessions, roundtables, and on-line consultation, AHR has delivered information to these advocates about model domestic violence laws and policies from around the world as well as highlights of civil and criminal legal reform efforts on domestic violence from the United States, Minnesota, and other jurisdictions.

In one week-long meeting facilitated by Global Rights, AHR and representatives from two countries with new and long-standing laws on violence against women provided technical assistance to Moroccan judges, prosecutors, police, health and education officials, and advocates as they prepared the first draft of their new law. Advocates are hopeful that this new law will be introduced in the Moroccan parliament in 2011.

Challenges to International Partnerships

Overall, while AHR's experience partnering with NGOs from other countries has been a very positive one, there have been notable challenges. One significant challenge has been obtaining funding for the work. Initiatives to address domestic violence, including efforts to change laws and policies and direct services to victims, are expensive. Many governments do not support these services or efforts in any significant way, so partner NGOs must rely on private foundations and donors. These funds are limited and often unpredictable, making it difficult to sustain the long-term projects that are necessary to achieve lasting systems change.

Another challenge AHR and its partners have faced is the urgency of domestic violence victims' needs. The requests for assistance to meet these needs can be overwhelming and can affect the spirit of the small organizations with which AHR works. Similarly, AHR encounters this challenge as it receives many more requests for information, technical assistance, and training sessions from around the world than it can possibly respond to.

The capacity and endurance of the NGOs are not, however, the greatest challenge faced by AHR and its partners. The most significant obstacle to achieving the goal of ending violence against women is convincing those with the power to make and enforce laws and policies reflecting the fact that women have the right to be free from violence in their homes. Despite the many efforts described in this paper, this right is not fully accepted in the world today.

Conclusion

AHR's experience partnering with NGOs from other countries to improve the government response to domestic violence has been a very positive one. AHR has been privileged to work with extraordinary women and men whose vision for ending domestic violence has propelled their countries forward and resulted in better laws and policies. Although significant work remains, AHR is confident that these changes will continue toward the ultimate realization of women's fundamental human right to be free from violence.

NEW ZEALAND'S EFFORTS TO ADDRESS VIOLENCE AGAINST WOMEN AND CHILDREN

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New Zealand has serious and concerning problems with violence against women and children, as is evidenced by the number of high-profile

deaths of children and women killed by partners or ex-partners. Nevertheless, a prevailing social acceptance of and willingness to turn a blind eye to violence against women and children has made getting traction on this problem difficult, frustrating, and at times torturous. Violence and abuse occurring in various close interpersonal relationships is called family violence in New Zealand and is broadly defined to include partner abuse, child abuse and neglect, elder abuse, child-to-parent violence, and sibling abuse. The predominant forms of family violence in New Zealand are male partner violence against women and child abuse and neglect. Although violence against women and children is evident across different ethnic and social groups, indigenous women and children are clearly overrepresented among victims and are at greater risk of being targets of family violence. A whole-government approach has been adopted by New Zealand in an effort to address violence against women and children at a governmental level. This paper provides an overview of some key New Zealand government initiatives, and it comments on how these approaches address issues for Māori (the indigenous peoples of New Zealand), given that they are overrepresented in the statistics for violence against women and children.

Statistics confirm that generally women and children are recipients of violence inflicted by men occurring in the home—86 percent of those arrested are male, and 92 percent of protection orders are made for women (New Zealand Family Violence Clearinghouse, 2007). More than 50 percent of all homicides are family violence related. From 2000 to 2004, 45 women were killed by a male or ex-partner, and 39 children were killed (26 by men; 15 by women). One study found that 33 to 39 percent of women experience physical or sexual abuse sometime during their lifetime, and 19 to 23 percent reported it being severe (Fanslow and Robinson, 2004). Another study reported that 35 percent of men reported being physically violent toward a partner sometime in a lifetime and 20 percent in the previous year (Leibrich et al., 1995). Fanslow and Robinson (2004) found that victims of partner abuse were twice as likely as non-victims to have visited a health care provider in the previous month.

In addition, New Zealand ranks third among Organization for Economic Co-operation and Development countries for child maltreatment and has 20 percent of children living in poverty (UNICEF, 2003). Among children living in New Zealand who were hospitalized, 4 to 10 percent reported having experienced physical abuse, while 11 to 20 percent reported having experienced sexual abuse (Duncanson et al., 2009). In 2008, 47 percent of notifications to the Child, Youth, and Family Service required further follow-up. Between 1996 and 2000, 49 children under the age of 15 died as a result of child maltreatment. For a country with a population of less than 4.4 million, this is unacceptable. On average 8 to 10 children die a year in New Zealand at the hands of someone who should protect

them from harm. Most at risk are those under 1 year of age and those older than 11 years.

Addressing family violence has been difficult, especially given the engrained social acceptance of violence against women and children within the context of families. The debate surrounding the repeal of Section 59 of the Crimes Act of 1966 illustrates the deeply engrained beliefs of many living in New Zealand. Section 59 stated, "Every parent or person in place of a parent of a child is justified in using force by way of correction towards a child if that force is reasonable in the circumstances." Although the aim of the repeal was to remove the statutory protection of parents and guardians who used physical force when disciplining their children, a highly charged and emotional public campaign was launched in opposition to the bill. A chief accusation was that "loving" parents would be criminalized for disciplining their children, along with accusations that the government was creating a "Nanny State" (by taking away the parental right to hit their children). Despite the intention of the repeal being to improve the safety and integrity of children, polls showed between 70 and 80 percent of New Zealanders did not support the repeal, reflecting a resistance to addressing child abuse when activities interfered with parental rights. The outcome was a substitution of Section 59 defining when parental control using force was justified to appease the public. Thus, parents or caregivers can use force in the prevention of harm to a child or another person, in preventing a child from committing criminal offences or engaging in offensive or disruptive behavior, and in "normal daily tasks" necessary for "good care and parenting." Additionally, ongoing monitoring is occurring to ensure parents are not needlessly criminalized. Interestingly, the United Nations Report on Children's Rights in New Zealand (2011) criticizes the repeal for not going far enough and banning corporal punishment for children.

Government Initiatives

Whole Government Approach

One of the 13 goals of the New Zealand Health Strategy was to reduce interpersonal violence (King, 2000). Not only did this signal the government's intention to put family violence on its agenda, but also it recognized family violence as a health issue. The 2000 Labor government required an "integrated, multi-faceted, whole-of-government and community approach to preventing the occurrence and reoccurrence of violence in families/whānau . . ." (Ministry of Social Development, 2002, p. 6). In 2002 the Te Rito New Zealand Family Violence Prevention Strategy was launched as an official government response and commitment to addressing all forms and degrees of violence, and it provided a framework for action. The

fundamental vision was for families to live free from violence. This strategy also recognized the unique cultural and contemporary structures of Māori as tangata whenua (people of the land) and the need for Māori to be provided for and fully engaged. Family violence prevention was viewed holistically and broadly and included all levels—primary prevention, secondary early identification and immediate intervention, and tertiary prevention of its reoccurrence. Communities were also given the right and responsibility to be involved in preventing family violence.

The Taskforce for Action on Violence within Families was established in June 2005 to advise the Family Violence Ministerial Team, which is composed of ministers of parliament, on improving how family violence is addressed and eventually eliminating it. This taskforce was composed of chief executive officers and other decision makers from government and nongovernment sectors, the judiciary, and various government agencies, such as social development, women's affairs, and health. Māori and Pacific reference groups were also established to support the task force and provide their perspectives. In 2009 the associate minister for social development and employment (and associate minister of health), the Honorable Tariana Turia, was given the responsibility for the national government's response to addressing and reducing the impact of family violence as well as the establishment of the Family Violence Ministerial Group (replacing the Family Violence Ministerial Team). This ministerial group meets quarterly and is responsible for the oversight of the whole-of-government approach and the alignment and coordination of responses. Ministers inform and consult with each other on developments and proposed family violence–related work within their respective portfolios. This group includes ministers of social development and employment, justice, health, police, education, Māori affairs, Pacific Island affairs, housing, women's affairs, ethnic affairs, and disability issues.

Legislation

Legislation aimed at protecting women and children includes the Domestic Violence Act 1995, which changed immensely the way women and children could be protected. This legislation removed the need for women to lay charges of assault against a partner before the police would intervene. Women wanting immediate protection from partners' abuse apply for a temporary protection order for a period of three months, and it is often issued without notice. After this time a partner can apply to the court for a hearing prior to making an order permanent. If the request for the order goes undefended, the order automatically becomes permanent. At the time a protection order is granted, orders can be made concerning occupancy or tenancy as well as furniture in order to enable women to stay in the home

and have some or all of the furniture. A woman's children are granted the same protection under these orders. This legislation stipulates that, when children live amid abuse and violence, it is considered violence against children. Still, the research of Roberston et al. (2007) concerning protection orders for women found that systemic gaps existed and breaches of protection orders were not always addressed.

More recently police have been allowed to issue police safety orders (PSOs) in situations where they have reasonable grounds to believe that family violence has occurred or may occur, with no right of appeal and without the consent of the person(s) at risk. PSOs aim to protect those at risk of violence, harassment, and intimidation and any children living at the residence. Abusers are required to leave the residence for up to five days, and they must not assault, threaten, intimidate or harass, follow, stop or contact their partner in any place, or encourage anyone else to do this. They must also surrender firearms and their firearms license to the police.

The Child Youth and Their Families Act of 1989 promotes the responsibility of parents, families, and family groups to prevent children from suffering harm, ill treatment, abuse, neglect, or deprivation. However, it is commonly associated with the Child Youth and Family Service's statutory duty to protect those children who are being harmed or neglected or who are at risk of being harmed or neglected. Despite the high demand on its services, the efficacy of the Child Youth and Family Service is often questioned in the media. The Care of Children Act of 2004 shifted a prior focus on parental rights to parental responsibilities. The key focus of this legislation is the welfare and best interests of the children where any dispute about them exists in order to keep the children safe and free from all forms of violence. However, where family violence exists, children still tend to be invisible beyond custody battles.

In addition to strengthening legislation to protect women and children, the government has initiated a number of campaigns aimed at addressing all forms of family violence. It is valuable to examine two such government-driven initiatives in some detail.

The It's Not OK campaign (www.areyouok.org.nz/) is a phased nationwide media campaign aimed at changing societal attitudes toward family violence and those living amidst it. Using a phased mass-media approach, the campaign began with "It's Not OK" (showing a range of unacceptable behaviors evident in society); followed by "It's OK to Ask for Help" (encouraging people to ask for help); and then the current campaign, "Are You OK?" (encouraging family, friends, and colleagues to ask if people are okay—not ignore a woman or child who may be abused, or a man who is angry, shouting at his children and wife, who are afraid of him including those doing the abuse or violence). Evaluation of the campaign

has demonstrated increased recall of the television advertisements with every survey. Ninety-five percent of the people surveyed in September 2008 recalled something from at least one of the ads. Recall was high for all groups, particularly Māori males (94 percent) and Māori females (98 percent). Of those surveyed, the advertisements helped 68 percent identify unacceptable behaviors and influenced 57 percent to see change is possible. As a result of seeing the ads, 22 percent reported taking action (McLaren, 2010). In addition, nongovernmental organizations such as Jigsaw (www.jigsaw.org.nz/), which coordinates various agencies working with families and children to promote their safety, have a campaign using high-profile men to promote a positive image of fathers with their children.

The Violence Intervention Program (VIP) promotes assessment for family violence among those using District Health Board (DHB) hospital services as well as assessment for child abuse (work is currently under way in the primary health care sector). VIP supports health-sector family violence programs throughout New Zealand based on the Child and Partner Abuse Guidelines (currently under review) and the Elder Abuse Guidelines (Ministry of Health, 2003, 2007). The government funds a national VIP manager and family violence intervention program coordinator (FVIPC) positions in all DHBs; these officials have contractual requirements to meet and report indicators to the Ministry of Health. In addition DHBs are evaluated annually to improve the quality of programs and facilitate benchmarking between DHBs (Koziol-McLain et al., 2010). Although the Ministry of Health supports this research and evaluation and offers technical advice and training support to health services committed to the program, the FVIPCs are responsible for promoting assessment and education of staff.

VIP has developed significantly to a point where there is now national standardization in training requirements and reporting formats. The Interdisciplinary Trauma Research Unit (ITRU) at the Auckland University of Technology evaluates each DHB annually. Steady progress has been made over 60 months, although some DHBs need further improvement. Importantly, evaluations demonstrate the importance of a dedicated family violence intervention coordinator to the program's sustainability and development (Koziol-McLain et al., 2010). Cultural indicators have also been evaluated, and although improvements have been made, the more challenging cultural indicators need further improvement.

Whānau Ora (Family Health and Well-Being)

The 2003 Māori health strategy, He Korowai Oranga, had as its goal *whānau ora*, or family health and well-being. *Whānau* is more than just a nuclear family—it is the wider extended family and may include grandparents,

aunts and uncles, and cousins. Like many indigenous peoples, Māori have a collective orientation with obligations and responsibilities to the members of their extended family. A key to resolving inequalities in health and social status—and in improving the family violence statistics—is to support whānau to develop the capacities to achieve health and well-being (Durie et al., 2010). Thus, the focus of whānau ora is on empowering whānau and ultimately reducing the inequalities Māori experience, and it requires service providers to demonstrate accountability and the efficacy of initiatives. Fundamental to this strategy is improving the health and well-being of both individual members and the collective whānau through culturally based interventions and determining their existing strengths; this involves capacity building to identify needs and improve access to appropriate services.

In summary, although there is still a long way to go in New Zealand to reduce the prevalence of violence against women and children, some exciting initiatives are happening. The whole government approach is an attempt to have a more cross-sectoral approach to addressing family violence, because the previous silo approach adopted by government departments meant that women and children reliant on help from services would fall through the chasms that existed. Furthermore, interwoven into the government initiatives are strategies to address violence against Māori women and children. The adoption of a mass media program to address societal attitudes and behaviors is also important, so rather than a stance that ignores the plight of women and children, they will be able to live free from violence.

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8

Papers on Preventive Interventions

Interventions to prevent violence against women and children are as varied as the settings and populations in which they operate. No matter what the setting, however, successful interventions demonstrate measurable reduction in violence as well as secondary effects such as increases in gender equality, economic empowerment, life skills development, community mobilization, resilience, and quality of life. Speakers presented a number of case studies of such interventions and provided thoughtful analysis of the possibility of transportation of such programs to alternate settings.

The first paper is an overview of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program in South Africa. Although economic empowerment of women is a common method of addressing structural inequities, IMAGE also incorporated gender-based violence and HIV prevention programming. The result was a successful multisectoral response that resulted in reduction of a number of adverse outcomes, including violence and HIV transmission.

The second paper describes the success of two programs to address intimate partner violence and child maltreatment in Hong Kong. Both programs use obstetricians and nurses who regularly come into contact with expectant parents to provide additional information and support on communication and parenting skills. Special attention was paid to addressing cultural norms.

The third paper is an analysis of The Fourth R, a school-based program originating in Canada and now offered in a number of settings in North America. The Fourth R integrates skills building and risk factor

management into current school programming, reaching adolescents at a crucial time of development.

The fourth paper summarizes the Community Advocacy Model aimed at women experiencing intimate partner violence. It is centered around a "family model" that assesses the strengths and needs of victims and provides them with social support to protect themselves and their children. The approach of this intervention is based on the relationship of women with their communities and the necessity in engaging the community to reduce norms condoning violence.

The final paper looks at the "systems change model" of Kaiser Permanente, an integrated health care system that incorporates all levels and aspects of health care delivery. Using this pre-existing structure, Kaiser Permanente has implemented a family violence prevention program meant to identify potential violence as victims and perpetrators access the health care system. It also provides training to its physicians and other health care staff, on-site resources, and linkages to community resources for violence prevention.

THE IMAGE PROGRAM: SUMMARY

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The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program[1] began in 2001 in rural Limpopo, South Africa, and is a community-based program that combines microfinance with a gender and HIV curriculum. It began as a partnership between the Rural AIDS and Development Research Program (RADAR) at the University of Witwatersrand; the London School of Hygiene and Tropical Medicine; and the Small Enterprise Foundation (SEF), a microfinance group based in Limpopo. The IMAGE program has shown that it is possible to address poverty, gender-based violence (GBV), and HIV together, underscoring the need for future investments to support multisectoral programming to address women's social and economic empowerment in order to reduce vulnerability to GBV and HIV.

The IMAGE intervention uses microfinance loans as a vehicle for empowering the poorest women in rural villages. The microfinance partner,

[1] IMAGE has received funding from Anglo American Chairman's Fund, Anglo Platinum, the Ford Foundation, the UK Department for International Development, the Henry J. Kaiser Foundation, the International Humanist Institute for Cooperation with Developing Countries, the MAC AIDS Fund, the South African Department of Health, and the Swedish International Development Cooperation Agency.

SEF, is based on the Grameen Bank model, whereby groups of five women aged 18 and older served as guarantors for each other's loans, with all five required to repay before the group is eligible for more credit. Loans are used to support a range of small businesses. Loan centers of approximately 40 women meet fortnightly to repay loans, apply for additional credit, and discuss business plans.

In addition to the microfinance component, the IMAGE intervention includes a participatory learning program called Sisters for Life (SFL), which is integrated into routine loan center meetings. It focuses on issues such as gender roles, cultural beliefs, domestic violence, power relations, self-esteem, sexuality, and HIV/AIDS. The SFL sessions are aimed at strengthening communication skills, critical thinking, and leadership. In the second phase, program participants are encouraged to facilitate wider community mobilization to engage both youths and men in addressing gender norms.

Evaluated as a cluster randomized trial in eight villages in rural Limpopo, the program assessed the impacts on poverty, women's empowerment, and risk of intimate partner violence (IPV), and HIV/AIDS. After two years the IMAGE study found that the risk of physical and sexual intimate partner violence among participants was reduced by 55 percent (Kim et al., 2007). Among young women participating in the program, several factors related to HIV risk were also positively affected, including an increase in communication about HIV, a 64 percent increase in voluntary counseling and testing, and a 24 percent reduction in unprotected sex (Pronyk et al., 2008). The study also found positive impacts on household economic well-being, including increased food security, expenditures, and household assets. In terms of impact on women's empowerment, the participants reported increased self-confidence, autonomy, social capital, collective action, and an ability to challenge gender norms (Kim et al., 2007). The program was also interested in exploring whether additional positive changes might diffuse to young people not directly participating in the intervention, but it did not find any changes in sexual behavior or HIV incidence among a random sample of young people living in the intervention villages (Pronyk et al., 2006).

In order to determine whether microfinance without the SFL training would have been as effective, researchers conducted a cross-sectional analysis comparing microfinance alone against the combined IMAGE intervention. Microfinance alone and IMAGE produced similar economic impacts, but only the IMAGE program showed benefits in terms of IPV, women's empowerment, and HIV risk behaviors (Kim et al., 2009). The study suggests that the combination of microfinance with gender training and community mobilization is important for generating synergy and broadening the social and health impacts of microfinance.

IMAGE has successfully been scaled up from a research pilot project to a sustainable and fully integrated program, which has now reached 12,000

women in 160 villages. Supporting the sustainability and expansion of the approach, the microfinance program is cost-neutral, with its operational costs being covered by the interest charged in the loan repayment process. In response to training requests from other microfinance and GBV organizations, the IMAGE program is currently exploring opportunities to develop as a best-practice learning site to support South-South learning and replication across different settings. Further research to inform the adaptation and replication of such models will yield important lessons.

There are a number of lessons that have been learned from the IMAGE program. The program presents encouraging evidence that it is possible to reduce IPV and to challenge gender norms and violence even when they appear to be "culturally entrenched" and resistant to change. Second, the IMAGE program shows the importance of meeting women's basic economic needs as part of a GBV/HIV intervention. Building on a pre-existing poverty alleviation program made it possible to maintain regular contact with a particularly vulnerable and difficult-to-reach group (impoverished rural women) for more than a year—an opportunity rarely afforded most stand-alone health /HIV interventions. Although this program focused on microfinance, other strategic entry points for women's economic empowerment could be explored, such as literacy programs and job skills training. Third, it is important to choose strong sectoral partners and to allow each to focus on what it does well. There are risks involved in HIV programs attempting to deliver microfinance, and in this case SEF focused on delivering the microfinance program while partnering with RADAR to develop the gender and health aspects. Finally, IMAGE showed that programs can work indirectly to affect the most vulnerable groups. Recognizing that young women are particularly vulnerable to HIV and IPV, the program worked with older women (who are often cultural gatekeepers) as well as their younger peers to challenge existing gender norms and increase communication across generations. Similarly, given the economic vulnerability of young women, the program aimed to improve household economic well-being through loans given to more mature women rather than putting loans directly into the hand of adolescent girls—an approach that can raise financial and programmatic challenges. Finally, recognizing the importance of engaging men, the program worked directly with microfinance clients, in order to empower them to reach out and engage men during the community mobilization phase (Kim et al., 2007).

In order for structural-level interventions to be most effective, programs should focus simultaneously on quick wins and long-term change. Ultimately, programmatic approaches such as IMAGE need to be supported and complemented by policy-level interventions that create an enabling environment for sustained change (Kim et al., 2008). Mainstreaming gender and HIV within national AIDS and development plans is one way to embed

structural interventions within this more long-term, policy-level approach. It is encouraging that studies such as IMAGE can contribute to policy-level change, such as the inclusion of microfinance and the empowerment of women in the South African government's Strategic Plan for HIV/AIDS. Further implementation and research focusing on multisectoral approaches to addressing intimate partner violence and HIV are needed.

INNOVATIVE PREVENTION INTERVENTIONS: ADDRESSING IPV AND POTENTIAL CHILD ABUSE AT PRENATAL CARE

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Intimate partner violence (IPV) during pregnancy adversely affects the health and well-being of pregnant women and their unborn infants. Yet, pregnancy also offers a unique opportunity for primary prevention of IPV as well as for interrupting the cycle of violence. In this paper two interventions are presented: the Positive Fathering Program, which was designed as a primary prevention strategy; and the Empowerment Intervention, which aims to interrupt the cycle of violence against pregnant women and their unborn infants.

The Positive Fathering Program

The Positive Fathering Program aims to engage expectant fathers in prenatal education in order to prepare them for transition to fatherhood while working in tandem with their intimate partners. Despite the name of the program, both men and their pregnant partners are actively involved in the program as couples. Couple involvement is essential in building a caring, committed, and collaborative intimate relationship within which the transition to parenthood is nurtured.

The need for engaging men in the transition to parenthood arises from the fact that such a transition can be a challenging time for men (Cowan and Cowan, 1995; Goodman, 2005). Specifically, men may have unrealistic expectations about involved fatherhood and develop role ambiguity as fathers (Doherty et al., 1998; Goodman, 2005). Such uncertainties may be further aggravated by the lack of role models or inadequate guidance to ease the transition to fatherhood (Goodman, 2005). Thus, adjustment to fatherhood may turn out to be distressing and frustrating for men and may strain couple relationships. Furthermore, with the development of a strong mother-infant relationship, some men may feel excluded and see the unborn infant as an intruder in their intimate relationships (Anderson,

1996). Jealousy and the perceived need to exert control over their partners may result in IPV during pregnancy (Campbell et al., 1993). Providing support and guidance to expectant fathers is, therefore, essential in order to help them develop realistic expectations of fatherhood and to improve their confidence as new fathers. Furthermore, engaging men in prenatal education is important so that they may jointly learn and prepare for new parenthood with their partners, instead of feeling excluded.

Although there is an array of prenatal education programs for childbirth, parenthood, or both, these programs focus primarily on the needs of expectant mothers. Indeed a recent Cochrane Review suggests that there are relatively few prenatal education programs that specifically address expectant fathers' needs (Gagnon and Sandall, 2008).

The Positive Fathering Program has been developed to address the gap in the engagement of men in prenatal education. The program is based on the theoretical framework of self-efficacy, which is the belief in one's ability to successfully perform a particular behavior (Bandura, 1982). Providing expectant couples with knowledge and skills related to caring for the baby and the mother as well as with opportunities to work together toward the transition to parenthood helps them acquire confidence in their abilities to carry out such tasks and also develops trust among the partners that each will be supportive of the other's efforts.

The program's focus on developing a couple's self-efficacy regarding care of the baby and mother in the postnatal period is deliberate because it provides something concrete and meaningful for engaging expectant fathers, a common goal that has practical applications for the couple, and a forum for listening and responding to one's partner.

As the program primarily targets Chinese expectant couples, cultural adaptation is also used to ensure that the program is culturally appropriate for the intended participants. The key features of the cultural adaptation are:

- discussing couple relationship issues in the context of raising children, which is generally more emphasized than marital issues in Asian cultures;
- adopting an experiential learning approach (which is honored in Asian cultures) to promote motivation and understanding;
- helping participants to understand their feelings instead of suppressing them and recognizing the need to understand their partner's inner world in order to make meaningful connections;
- appropriately using empirical research and theories, which are highly valued in Asian cultures, when delivering the teaching materials;
- using metaphors when explaining abstract or complicated concepts; and

- acknowledging a need to assess the extent to which participants have been influenced by Western culture and ensuring that the teaching is sensitive to Chinese cultural norms (Huang, 2005).

The Positive Fathering Program has four components: (1) engaging men as expectant fathers; (2) promoting parenting self-efficacy, including as a couple; (3) enhancing couple relationships through partnership and experiential learning; and (4) managing traditional cultural beliefs in a contemporary world.

To engage men in their roles as expectant fathers, the program uses "reality boosters" to bring them closer to their unborn infant, such as interacting with life-size dolls with the weight and texture of a newborn, feeling fetal movement, and listening to fetal heartbeats. The program also encourages the men to express their aspirations to be a supportive partner and responsible father, while inviting the women to validate their partners' expressed aspirations. Program administrators assist the expectant fathers in exploring their needs and how such needs can be met, both by themselves and with their partner.

In order to be more effective parents, couples learn to identify their infant's needs and understand appropriate infant care responses; learn and practice the behaviors that will best meet those needs, under supervision and with reinforcement; and explore how social support networks (including their families, neighbors, and friends) may enhance their capacity as new parents. The couple relationships are enhanced through partnership and experiential learning involving active listening and responding, learning to express their feelings, and understanding the inner world of the other person.

In addition, the program helps expectant couples manage traditional cultural beliefs in a contemporary world by identifying Chinese beliefs and practices relating to postpartum care and locating them in the context of research, theory, and reality. This allows participants to anticipate the impact of cultural practices on the new mother and infant and to respond constructively. Finally, couples are encouraged to talk through various strategies they can use to accommodate the involvement of in-laws in infant care and traditional postpartum practices.

The Positive Fathering Program was implemented, in combination with standard prenatal education, in a large public hospital in Hong Kong from August 2009 to February 2011. The differences between the two approaches are summarized in Table 8-1.

In practice, the Positive Fathering Program was delivered in three consecutive, evenly spaced sessions over a 14-week period starting at about 20 weeks of gestation. Each session took about three hours to complete, depending on the size of the group. In order to be included in the program,

TABLE 8-1 Differences Between Standard Prenatal Education and the Positive Fathering Program

Standard Prenatal Education	Positive Fathering Program
5 sessions totaling 10 hours	3 sessions totaling 9 hours
Focus on child birth, breastfeeding, infant care, pre- and postnatal emotions, and postnatal care	Focus on engaging expectant fathers, couple relationships and communication, parenting efficacy, in-law involvement, and cultural postnatal practices
Conducted as large classes (> 100/class)	Conducted as small groups (6-8 couples/group)
≦ 50% of the participants are couples	100% couple attendance
Content is based on well-established prenatal education	Content is based on identified needs
Teacher-centered, didactic teaching, one-way transmission of content	Couple-centered, two-way, interactive discussion and hands-on practice
Passive learning	Active learning
Minimal couple partnership in learning	Couple partnership in learning is the main theme of the program

the woman needed to be less than 20 weeks into her pregnancy at the time of recruitment, and the couple had to agree to attend all three sessions together. Participation was voluntary, and recruitment took place in prenatal clinics. The nature of the program and the process was explained to the potential participants. Those who agreed to participate were asked to provide a written consent because questionnaires would be administered at different points of the program for evaluation purposes.

A small group format was adopted in order to maximize active participation and to ensure adequate hands-on practice. Each group was facilitated by a designated nurse or midwife, assisted by at least two members of the research staff. The same facilitator would work with the group through all three sessions in order to ensure continuity and to build rapport with the participants. Meticulous training of the facilitators and research staff was vital in order to ensure that the program was delivered as planned and that the same standards were maintained across the groups. To this end, a two-day training session was provided prior to the start of the program that focused on the theoretical underpinning and intended outcomes of the program as well as on the knowledge and skills required for delivering the content. The facilitator's performance in delivering the sessions was assessed by the program leader, and re-training was provided until satisfactory performance was demonstrated.

The obstetrics department of the host hospital provided the venue (a large seminar room) and the facilities for the group sessions, including

hands-on practice in infant care and couple communication skills. Close collaboration between the program team and the clinicians ensured smooth recruitment of participants, implementation of the group sessions as planned, and referrals as necessary (e.g., midwives or obstetricians).

Over an 18-month period, 171 Chinese couples were recruited to the program. Program evaluation, which was conducted using chart reviews and self-reports elicited using instruments and telephone interviews, revealed the following:

- A total of 166 couples completed the program, for a completion rate of 97 percent.
- Five couples did not complete because they unexpectedly had to work on the days when the intervention was held.
- No adverse events in connection with the program were reported.
- A significant improvement in couple relationship adjustment, as measured by the Chinese version of the Dyadic Adjustment Scale comparing the baseline scores with those taken at six weeks post-delivery, was reported by the couples ($p < 0.001$) (Shek and Cheung, 2008).
- A significant reduction in depressive symptoms, as measured by the Chinese version of the Edinburgh Postnatal Depression Scale comparing the baseline and six weeks post-delivery scores, was also reported by the couples ($p < 0.001$) (Lee et al., 1998).
- A consumer satisfaction survey conducted at six weeks post-delivery found that a large majority of the couples rated the program as "extremely useful to useful." Specifically, 86 percent of couples reported that it was helpful in improving their intimate relationships, 77 percent reported that it enhanced their communication skills with the partner, and 94 percent reported that the program increased their confidence in caring for their new infant.
- Telephone interviews conducted with 10 percent of the couples also provided anecdotal accounts of the positive outcomes of the program in terms of couple relationships and care of the new infant.
- The cost of the program was about US$60 per couple.

To summarize, the Positive Fathering Program demonstrated acceptability and efficacy for 166 Chinese expectant couples using public prenatal care in Hong Kong. In the next stage of development, the program will be modified based on a hospital–community partnership model, which will combine the use of professional and non-professional caregivers over the pre- and postnatal period. The program's efficacy in improving couple relationships, enhancing parental sense of competence, and reducing postnatal depressive symptoms will be tested using a cluster randomized controlled trial.

The Empowerment Intervention

Background

The Empowerment Intervention, a secondary prevention program for early detection and reduction or elimination of violence against pregnant women by their intimate partners, is based on the premise that violence against women by an intimate partner is part of a pattern of coercive control (Dobash et al., 1992; Parker et al., 1999). Therefore, the intervention aims to increase abused women's independence and control (Parker et al., 1999). Dutton's (1992) empowerment model, which provides the theoretical basis for the intervention, includes: protection (with a focus on increasing abused women's safety) and enhanced choice making and problem solving (relating to making decisions about relationship, relocation, and other transitional issues). In addition, Parker and colleagues (1999) also adopt the approach that, because relationships are complex and multi-dimensional, the woman in the abusive relationship understands the situation best. Furthermore, the woman knows what is best for her and her children. What she needs is an opportunity to express her feelings to a nonjudgmental and empathic person and to be allowed to make her own decisions.

Methods

The modified Empowerment Intervention was tested on 110 abused Chinese pregnant women in a prenatal setting in Hong Kong in 2002 and 2003 using a randomized controlled trial (Tiwari et al., 2005). The participants were randomly assigned to the intervention group ($n = 55$) or the control group ($n = 55$). The intervention group received the Empowerment Intervention as described earlier, and the control group received standard care for abused women. Data were collected at study entry and six weeks postnatal.

Intervention

The modified Empowerment Intervention for abused Chinese women is based on the empowerment protocol of Parker and colleagues (1999) and on Walker's cycle of violence (1979), which explain how women become victimized and why it is so difficult for them to extricate themselves from abusive relationships (Tiwari et al., 2005). The intervention was carried out in a private 30-minute session as part of a larger 12-week advocacy intervention that consisted of 12 social-support telephone sessions based on Cohen's Social Support Theory as well as access to a 24-hour support hotline (Cohen, 1988; Tiwari et al., 2010). The 30-minute empowerment intervention was carried out in a one-on-one setting with an assurance of

confidentiality by a professional who had undergone training for this purpose and who was fully conversant with empowerment theory and with the modifications that had been made to ensure culture congruence.

The Empowerment Intervention includes the following three components: information on the cycle of violence, logistical information related to safety and legal recourse, and information for assessing the behaviors of the abuser for danger. The original intervention was modified for use among abused Chinese pregnant women in Hong Kong in order to ensure that it was consistent with the subscribed norms of Chinese women living in a "shame-oriented" culture (Tiwari et al., 2005). In particular, because of the fear of rejection or ridicule that many Chinese women perceive to be associated with revealing their abusive experiences, an additional component known as "empathic understanding" and based on Rogers' client-centered therapy (1951), was incorporated. Empathic understanding emphasizes the need for the helping professional to elicit the woman's perceptions and feelings in a nonjudgmental way. This approach is intended to help women who are participating in the intervention to positively value themselves and their feelings, which is an important consideration, especially if previous attempts to disclose IPV were ignored or ridiculed. The next three sections offer brief descriptions of the main components of the modified intervention.

Cycle of Violence

Women in the intervention were taught about the cycle of violence in order to facilitate their ability to describe their relationship and thus gain a sense of control over the abusive situation. The cycle of violence was described to the participants as consisting of three phases: tension building; violence; and reconciliation, or the "honeymoon phase" (Walker, 1979). During phase one, a woman typically works, consciously or unconsciously, to decrease the building tension in the relationship. By the end of phase one, she is exhausted and begins to withdraw from the relationship, fearing that she may inadvertently set off an outburst of violence. In response to her withdrawal, the abuser becomes violent, thus phase two begins. During phase two, the violent phase, the acute battering incident takes place and may last for minutes, hours, or days. During phase three, often called the "honeymoon stage," the abuser attempts to reconcile the relationship, showing love, tenderness, and remorse. The abuser's gestures of buying gifts, begging for forgiveness, or both may make it more difficult for the woman to take action against her abuser. She may even believe that if she is able to keep her abuser happy, they will live happily. Family members may also get involved. In the case of Chinese families, which emphasize the need to keep the family intact, the woman may be put under a great deal of

pressure to forgive or sacrifice herself for the good of the family. However, eventually this phase ends, and once again tension begins to build up.

Level of Safety

Another component of the modified intervention is determining the level of safety based on the indicators from the Danger Assessment instrument. This component is designed to assist participants in objectively evaluating the safety of their current relationship (Campbell et al., 2000). The women go through a process of recalling all the violent incidents (including a ranking of severity) associated with the relationship that had happened in the previous year by using a calendar. During this process, information about safety issues is also discussed, including signs of increased danger. In particular, participants are informed that the most dangerous time occurs when a woman leaves the relationship or makes it clear to the abuser that she is leaving for good. As social disharmony is often a taboo subject in Chinese society, and partner violence is frequently treated as a family affair not to be shared with outsiders, many abused Chinese women may not recognize the signs of increased danger; hence, time should be spent to ensure that she understands the warning signs. Based on the participant's assessment of the situation, a discussion of immediate safety and formulation of an escape plan can be initiated. As Chinese women may view the safety plan as a step closer to leaving their partners, reassurance should be provided that having a safety plan puts them in a better position to make decisions about their options, including the option to stay with the abuser. In keeping with the model of empowerment, it is not necessary for every woman to employ all of the safety behaviors. Rather, each woman should decide what is appropriate for her and how many of the behaviors she wishes to take at any one time. As a part of efforts to ensure cultural relevance of the intervention, helping professionals must not only keep in mind the Chinese cultural context when educating a participant about her options, but also remember that each abused woman has her own unique characteristics and, therefore, requires an individual safety plan, taking into account what works for her at different stages of the relationship.

Selecting an Option

Another component of the Empowerment Intervention is selecting an option, in which the helping professional assists the participant in objectively evaluating her relationship with her partner, including its inherent strengths and limitations. The woman may be in a state of intense confusion or feel conflicting loyalties. As a result, this component of the intervention

includes teaching each participant problem-solving and decision-making skills, while avoiding telling her what to do or criticizing the abuser. When working with Chinese women it should be recognized that traditional Chinese culture expects a woman to sacrifice herself for the greater good of the family and also that leaving her partner may mean that she is ostracized within the very community where she needs support. Thus, the woman may be very reluctant to leave her abuser. The options that are available to a Chinese woman who experiences IPV may include remaining in the home and seeking help for herself or her partner, or both; remaining in the home and attempting to anticipate the violence and protect herself and her children; or leaving the relationship either temporarily or permanently.

There are a number of cultural considerations to be made in educating women about their options. The following is a summary of some specific issues that have been considered during the modification of this intervention for Chinese women:

- Chinese women may be reluctant to disclose IPV to outsiders, so it is beneficial for them to think about whom they can trust and with whom they would share their abusive situation and their safety plan.
- Some Chinese women may have a fear of authority figures, given their past experience, so they may require close support of a trusted advocate.
- For many Chinese women, protective orders may be totally alien to them, so every care should be taken to ensure that they are properly informed regarding protective orders before making their decisions.

Results

Following the intervention, women in the intervention group reported significantly higher physical functioning and improved role limitation due to physical and emotional problems compared with women in the control group, as measured by the Chinese version of the Short Form Health Survey (SF-36) (Lam et al., 1998). The participants also reported less psychological abuse and less minor physical violence, as measured by the Chinese version of the Conflict Tactics Scale (Tang, 1994). Significantly fewer women in the intervention group reported postnatal depressive scores of 10 or more, as measured by the Chinese version of the Edinburgh Postnatal Depression Scale, compared with those in the control group (Lee et al., 1998).

In a recent Cochrane Review, this trial passed high evidentiary standards. The Empowerment Intervention has now been further modified for use in a community setting and tested in a randomized controlled trial (Ramsay et al., 2009; Tiwari et al., 2010). At present, a proposal is under

way to test the efficacy of the intervention in Hong Kong among immigrant women from China.

THE FOURTH R: A SCHOOL-BASED STRATEGY TO PREVENT ADOLESCENT DATING VIOLENCE

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Best Practices in School-Based Violence Prevention

This paper focuses on the prevention of adolescent dating violence, a significant and commonly occurring form of violence and aggression among this age group. The more common behaviors include insults, threats, and intimidation (i.e., mostly abusive but not violent), which are reported among a sizable minority of youths (25 to 35 percent). The significant rates of and consequences associated with adolescent dating violence warrant a public health approach focusing on promotion of healthy relationships and prevention of dating violence, rather than relying solely on identification and intervention with youths already perpetrating or experiencing dating violence. Accordingly, this paper discusses the rationale and evidence for school-based strategies to prevent adolescent dating violence and describes findings from the Fourth R program that has been evaluated and expanded in Canadian schools over the past five years (Wolfe et al., 2009).

Programs aimed at universal school-based violence prevention with children and youths have been expanding in numbers and sophistication since the early 1980s. Such programs have been delivered at all grade levels, from pre-kindergarten through high school, and generally offer knowledge and skills to all children in their own classroom settings (rather than special pull-out classes). A recent systematic review and meta-analysis concluded that there is strong evidence that universal school-based programs decrease rates of violence among all ages of children and youths. However, none of the 249 experimental and quasi-experimental studies of school-based programs aimed at aggressive or disruptive behavior examined by these reviews (all conducted prior to 2005) were aimed at reducing dating violence (Hahn et al., 2007; Wilson and Lipsey, 2007). Currently there are only two published controlled studies of universal school-based programs aimed at dating violence (Safe Dates and the Fourth R), both of which are described briefly below.

An advantage of school-based prevention is that programming can be geared to match developmental stages and demands. Because children who are aggressive in their relationships often progress from bullying to

harassment to dating violence as they age, school-based programming provides the opportunity to match this developmental trajectory and address the most salient forms of interpersonal violence at the appropriate developmental stage (Connolly et al., 2000; Chiodo et al., 2009). A further advantage is that programs can be delivered to all students by their teachers, which avoids the stigma of being selected to attend a special program and the cost of providing other resources.

Best-practice principles based on bullying and peer violence prevention have considerable significance for dating violence initiatives. Reports suggest that successful programs are comprehensive in nature, focus on skills, pick appropriate targets for change, use peers, include parents, and attempt to change the larger environment (Blueprints Violence Prevention Initiative, www.colorado.edu/cspv/blueprints; Office of the Surgeon General, 2001).[2] In general, effective school-based programs take a more holistic approach that recognizes the complexity and interrelatedness of different settings for youths and offer knowledge and assistance that is appropriately matched.

The most common feature of effective prevention programs is the provision of opportunities to develop interpersonal skills. Skills training usually involves modeling and practice in conflict management and problem-solving skills, often incorporating a role-play component to give students opportunities to increase their ability and comfort level with their newly developed skills. For example, students may role-play strategies to deal with or confront instances of bullying. In some programs, students meet in small groups to discuss and role-play positive alternatives to problem behaviors. Skills training is most effective if it is combined with accurate information about risks and consequences and it is action-oriented, not merely a passive discussion of behavioral options. Some promising prevention programs aimed at relationship-based violence also provide training in help-seeking behavior, such as learning about and navigating social service agencies in the community (Wolfe et al., 2003).

In addition to interpersonal and problem-solving skills, effective violence prevention programs target antisocial attitudes and beliefs associated with aggression and violence. Activities to change attitudes can include awareness-raising activities, such as information about violence against peers or dating partners, and empathy-building exercises. For example, students in the Bullying Prevention Program participate in such classroom activities as role-playing, writing, and small-group discussions geared toward helping them gain a better appreciation of the harm caused by bullying (Olweus and Limber, 2010).

[2] See Crooks et al. (2011) for further information.

Empirically Validated Dating Violence Prevention Programs

Given the relatively short history of dating violence prevention programs and the challenges of implementation and evaluation, it is not surprising that very few have been carefully evaluated with an appropriate randomized controlled design and sufficient measurement and follow-up. Short-term changes in attitudes and beliefs have been documented following classroom discussions or assemblies, but few have had sufficient follow-up with the participants or evaluated actual behavioral change. A critical review conducted in 2006 found only two effective programs that had been rigorously evaluated in a cluster randomized trial (Whitaker et al., 2006). One of these, the Youth Relationships Project, is a selected prevention program for youths considered to be at risk of dating violence because of histories of child maltreatment or exposure to domestic violence (Wolfe et al., 2003). The other, Safe Dates, is a program that was developed for universal implementation in schools (Foshee et al., 2005). Since that 2006 review, a cluster randomized trial conducted with the Fourth R was published, as described below (Wolfe et al., 2009).

Safe Dates is a school-based program based on the premise that changes in norms regarding partner violence and gender roles coupled with improvement in pro-social skills lead to primary prevention of dating violence. The stated goals of the program are to raise awareness of what constitutes healthy and abusive dating relationship, raise awareness of dating abuse and its causes and consequences, equip students with the skills and resources to help themselves or friends in abusive dating relationships, and equip students with the skills to develop healthy dating relationships. The skills component focuses on positive communication, anger management, and conflict resolution. Safe Schools is structured around nine 45-minute sessions in school, with additional community components. School strategies include curriculum, theater production, and a poster contest. Community components include services for adolescents in violent dating relationships and training for service providers. Teachers who implement the curriculum component receive 20 hours of training, and community service providers receive 3 hours. In a cluster randomized trial, Safe Dates reduced psychological, moderate physical, and sexual dating violence perpetration and moderate physical dating violence victimization at follow-up. The program seemed most effective with adolescents who were already involved in dating violence. Program effects were mediated by changes in dating violence norms, gender-role norms, and awareness of community services (Foshee et al., 2005).

The Fourth R: Skills for Youth Relationships is a curriculum-based program for youths aimed at preventing dating violence by promoting skills for healthy, non-violent relationships. The Fourth R is based on social learning and positive youth development theories that emphasize skills, accurate

information, and youth involvement to reduce risk behaviors and increase positive decision making in early adolescence. Unlike single-focused programs, the Fourth R integrates topics of dating violence, bullying, sexuality, and substance use by focusing on their underlying relationship connections rather than problem behaviors. The program is integrated into existing curriculum requirements for all students attending health and personal safety courses (typically in grades 8 or 9) and is taught by regular classroom teachers to reduce costs and increase sustainability and availability.

The Fourth R curriculum targets common elements of dating and peer violence (7 lessons), unsafe sexual behavior (7 lessons), and substance use (7 lessons) from a developmental and educational perspective. An underlying theme of healthy, non-violent relationship skills is woven throughout the units to increase generalization across risk situations and behaviors. There is extensive skill development using graduated practice with peers aimed at the development of positive strategies for dealing with pressures and the resolution of conflict without abuse or violence. Peer and dating examples are used interchangeably to increase relevance for youths who are not dating. Classroom activities enhance relationship skills through active learning and role modeling of appropriate behaviors and are accompanied by a Youth Safe Schools Committee and newsletters for engaging parents. The program is adaptable to meet the needs of different communities geographically and culturally.

Results from a recent cluster randomized trial of the Fourth R school-based program (1,722 students from 20 schools) indicated that teaching youths about healthy relationships as part of their required health curriculum reduced physical dating violence and increased condom use 2.5 years later, especially for boys, at a low $16 per-student cost. Specifically, from grade 9 to grade 11, physical dating violence (PDV) was significantly higher for students in the control schools than for those in the intervention schools (9.8 percent versus 7.4 percent, respectively; adjusted OR 2.42, $p = .05$). Further analyses showed that the effect of intervention differed significantly between boys and girls ($p = .002$). Boys in the intervention schools were less likely than boys in control schools to engage in PDV (2.7 percent versus 7.1 percent; adjusted OR 2.77). However, girls had similar rates of PDV in both groups (11.9 percent versus 12.0 percent). In addition, condom use among sexually active boys was greater in intervention schools (114 of 168, or 68 percent) than in control schools (65 of 111, or 59 percent).

How Universal Programs Prevent Violence Against Women and Children

Effective violence prevention programs empower young people to be involved in the work, which then becomes rewarding through the promotion of

cooperation and mutual support. To foster healthy adolescent development, simultaneous efforts to reduce or prevent risk behaviors are needed. These efforts need to be matched with an equal commitment to helping young people understand life's challenges and responsibilities and develop the necessary skills to succeed as adults. Youths need developmentally appropriate knowledge and education, delivered in a nonjudgmental and highly salient format, which emphasizes their choices, responsibilities, and consequences. Youths, especially at-risk youths, need education and skills to promote healthy relationships, to develop peer support, and to establish social action aimed at ending violence in relationships. They need to feel connected not only to their peers, but also to their schools, families, and communities. Such connections require a commitment to building capacity in each community to be inclusive of all youths and to perceiving each adolescent as a person rather than a potential problem. The ultimate act of inclusion is to empower youths to identify the critical issues they face and the solutions that are most meaningful to the reality of their lives and circumstances.[3]

In addition to providing improved skills and reducing dating violence, universal programs such as the Fourth R may serve to buffer the effects of poor relationship models that adolescents experienced while growing up (an important factor in reducing the cycle of violence). At post-test, youths who had reported a history of child maltreatment at pre-test engaged in fewer acts of violent delinquency, such as fighting or carrying a weapon, than youths with similar maltreatment histories but no school-based intervention (Crooks et al., 2007). Notably, this finding of reduced violent delinquency among youths with maltreatment histories was replicated two years later at follow-up (Crooks et al., in press). The differential impact of this program on youths with child maltreatment histories may be due to the emphasis on healthy relationships and positive relationship skills, and on the resulting focus on safe and respectful behavior in the school. That is, youths who have experienced maltreatment and been exposed to violent, coercive models of relationships in their families typically have not had opportunities to learn healthy alternatives, and they are the youths for whom opportunities to learn healthy, non-violent relationship skills and to attend school in an environment where these skills are emphasized are essential.

How These Efforts Can Be Applied in Different Settings and with Different Resources

Programs need to be designed with attention to details that increase their likelihood of implementation and sustainability from the outset. There

[3] See Wolfe et al. (2006) for discussion of theoretical and empirical support for youth involvement in violence prevention.

are a number of areas to consider in designing a program or approaching a school district to consider implementing a program. There are areas of potential alignment that increase the acceptability and potential sustainability of a program (e.g., aligning with curriculum expectations or state policies). There are also potential barriers that need to be identified and addressed prior to presenting a case for adoption of a program in a school setting (e.g., the costs of specialized training and school policies about not allowing non-teachers to present programs during school time). In some cases it is possible to deal with these barriers, and an awareness of them and the opportunity to identify possible solutions prior to meeting with educational partners can go a long way. Finally, identifying possible champions within the school system may facilitate the adoption of a program.

One significant challenge lies in examining cultural differences in the nature of dating violence and identifying how programs may need to be significantly revamped in addressing different populations. Beyond looking at a deficit-based model that identifies certain racial or ethnic groups as being at higher risk for dating violence, we need to look at ways that cultural strengths can be accessed as protective factors in interventions.

An implementation study of Canadian schools that have adopted the Fourth R revealed that a critical factor in administrators choosing this violence-prevention curriculum was the research base of the Fourth R and the perception of the program's potential to have a positive impact on students (Crooks et al., 2008). The curriculum-based nature of the program was also considered important. The greatest potential barrier was the time required to implement the program. We think that this response reflects the bias that violence prevention and health education is still seen as an add-on to the broader health and physical education domain rather than being viewed as an integral component worth 25 or 30 hours of instruction. The length of the program was based on the recommended guidelines of the Ontario Ministry of Education, and other provinces have similar guidelines. Thus, it is not that the program itself is lengthy compared to the mandated requirement; rather, people are still shifting their perceptions about the appropriate amount of health instruction in the classroom.

Since its evaluation was completed in 2007, the Fourth R has been implemented in more than 1,200 schools in Canada and more than 100 schools in the United States. Approximately 350 communities have implemented the program, with an estimated 100,000 students each year learning its lessons. In the 2009-2010 school year, approximately 450 new teachers were trained in 225 different schools, and, as a result, an estimated 20,000 new students have received the Fourth R curriculum in those teachers' classrooms. All 10 provinces and 3 territories in Canada have communities implementing the Fourth R. In the United States it has been distributed to various schools and agencies in Alaska, Idaho, Massachusetts, New York,

Illinois, Ohio, Texas, Missouri, Michigan, Alabama, California, Rhode Island, Washington, and Kansas. Four U.S. evaluation sites are currently using the program as part of the Robert Wood Johnson Start Strong teen dating violence prevention initiative: Bronx, New York; Providence, Rhode Island; Wichita, Kansas; and Boise, Idaho. The program also has been adapted for Canadian Aboriginal populations (First Nations, Metis, and Inuit), Catholic schools, and students in Alternative Education settings. The website www.youthrelationships.org has additional information on the program and research.

THE COMMUNITY ADVOCACY PROJECT: AN EVIDENCE-BASED PSYCHOSOCIAL INTERVENTION FOR WOMEN WITH ABUSIVE PARTNERS

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The Community Advocacy Project (CAP) is a 10-week psycho-social intervention for women with abusive partners, which has been shown to decrease women's risk of re-abuse and to increase their psychological and social well-being. The intervention involves providing trained advocates to work one-on-one with women, helping them generate and access the community resources they needed to reduce their risk of future violence from their abusive partners. Such resources include, but are not limited to, legal assistance, employment, education, housing, social support, and medical care. Like other interventions, CAP is grounded in a number of assumptions. An exhaustive review of the scholarly literature, coupled with numerous conversations with survivors of intimate male violence, led the author to the following conclusions that guide the intervention:

- Intimate male violence against women is too widespread to be attributed to intrapsychic dysfunction or "relationship problems."
- Women with abusive partners are by and large active help seekers who go to great lengths to protect themselves and their children.
- Positive social support and access to community resources protect women from risk of re-abuse.
- Intimate male violence against women is often tolerated, if not condoned, by many segments of the community, including the criminal legal system.
- The community response to domestic violence is a critical factor in whether a woman will be victimized (and re-victimized) by an intimate partner or ex-partner.

Development of the Program

CAP was designed as a family-centered model, focusing on the strengths and unmet needs of clients, as opposed to client "deficits" (Dunst et al., 1991; Sullivan and Bybee, 1999). The family-centered model requires that families guide the services they receive and that clients' natural support networks are involved in the advocacy process. The efficacy of the family-centered model and the positive implications for consumers served by a family-centered paradigm have been established across a number of different service domains (Marcenko and Smith, 1992; Scannapieco, 1994; Markle-Reid et al., 2006). Although some family-centered interventions employ professionals to work with families, paraprofessional volunteers have been found to be highly successful change agents for numerous populations. The use of paraprofessionals increases the generalizability of the intervention, as it is often easier and less costly for communities to locate, train, and supervise them. Therefore, the decision was made to train undergraduate female college students to serve as the paraprofessional advocates within this intervention.

Components of the Program

Advocates work one-on-one with women in the women's homes and community for 4 to 6 hours per week over 10 weeks. The two primary components of the advocacy intervention are to (1) help survivors of domestic violence protect themselves and their children from further violence and (2) actively advocate for women by generating and mobilizing community resources they report needing. Safety plans are discussed and individualized based on each woman's unique circumstances. Regardless of whether women are living with their assailants, advocates discuss what to do in case of emergencies, and they establish plans in case they are ever surprised by the assailants while working together.

The second component of CAP involves actively advocating for and supporting survivors to help them address their self-identified needs and concerns. A critical emphasis of this 10-week intervention is that the survivor decides what is worked on, and she guides all aspects of the intervention. The type of advocacy provided through this intervention consists of five distinct phases: assessment, implementation, monitoring, secondary implementation, and closure.

Assessment consists of two components: gathering important information regarding the woman's needs and goals and determining which community resources might appropriately meet those needs. After the unmet need has been determined and various community resources have been brainstormed, the advocate and woman move into the implementation phase of generating or mobilizing the community resources.

The implementation stage involves actively working in the community to obtain resources and to make the community more responsive to women's needs. If, for example, the woman is looking for new housing, the advocate's role is not simply to hand her information or make suggestions about next steps. Rather, the advocate would accompany the client through the entire process. This active participation has a number of beneficial outcomes: the client feels emotionally supported through difficult processes, the woman is sometimes treated more respectfully or expeditiously because she is accompanied by an advocate, and the advocate becomes a witness to events in case there is a later dispute between the woman and systems. Another benefit of this type of teamwork is that the advocate gains firsthand knowledge about the hassles and difficulties involved in obtaining many community resources, which often increases her respect for her client's diligence and determination.

Monitoring the effectiveness of the implemented intervention is accomplished by assessing whether the resource has been successfully obtained, and whether it is satisfactory to meeting the unmet need.

If it is not, then the advocate initiates a secondary implementation to meet the client's needs more effectively. For example, the advocate and client might obtain convenient and affordable child care for her preschool children. The advocate's role would be to continue to ask how the child care is working out: Do the children enjoy it? Is the mother satisfied? Is there a backup plan in case of emergency? If the resource is not as adequate as originally hoped, then a secondary implementation—generating or mobilizing a different community resource—is necessary.

Closure begins approximately 7 to 8 weeks into the 10-week intervention. During this phase, advocates work more intensively on transferring all of the skills they learned throughout training and supervision. Through role playing, coaching, and discussions, the advocate ensures the woman can effectively advocate on her own behalf with resistant or hostile community providers after the intervention ends.

Although the five phases of advocacy intervention have been described here as distinct stages for clarification purposes, in reality advocates engage in various phases simultaneously. Multiple interventions may occur throughout the 10 weeks, such that, for example, the advocate may be monitoring one intervention while initiating another.

Combining Systems Advocacy and Individual-Level Advocacy

Advocacy efforts are generally classified as either individual based—working specifically with or on behalf of individuals to ensure access to resources and opportunities—or systems based, which entails advocating to change and improve institutional responses. In reality, many advocacy efforts involve working to change systems and assisting individuals simultaneously.

CAP is designed to do exactly this by providing numerous individualized advocacy interventions and working with other community-based groups, with the intention of ultimately creating community-level change.

Evidence for the Effectiveness of the Intervention

A number of studies have been conducted to evaluate experimentally the effectiveness of this intervention over time. The initial feasibility study, funded by the George Gund Foundation (1986-1988), included 41 women (24 randomly assigned to work with advocates). Women were interviewed pre-intervention, post-intervention, and at a 10-week follow-up. Findings were positive, with women in the experimental condition being more successful in obtaining desired resources than were women in the control group. The feasibility study is described in more detail elsewhere and was promising enough that the author received funding from the National Institute of Mental Health (NIMH, 1989-1997) to continue the research on a larger scale (Sullivan and Davidson, 1991).

The larger-scale NIMH study included a true experimental, longitudinal design. Effectiveness of the advocacy intervention was examined by randomly assigning 278 women exiting a shelter to the advocacy (experimental) or services-as-usual (National Center for Injury Prevention and Control) condition. Participants were interviewed six times over two years, with interviews occurring pre-intervention, post-intervention, and at 6, 12, 18, and 24 months after intervention. An elaborate protocol was implemented to maximize retention of the sample over time, and this protocol resulted in retention rates at any given time of 94 percent or higher. Rates were not significantly different between the advocacy and control conditions. The specific components of the retention plan can be found in Sullivan et al. (1996).

The immediate impact of the advocacy intervention in helping women access resources was assessed post-intervention by a simple between-conditions comparison of women's ratings of their effectiveness. Women in the advocacy condition reported being more effective in reaching their goals than women in the control condition. The short-term impact of the advocacy intervention on the major outcome variables—experience of further physical violence, psychological abuse, depression, social support, and quality of life—was tested through multivariate analysis of covariance (MANCOVA). Physical violence and depression were lower in the advocacy condition, while quality of life and social support were higher.

Doubly multivariate repeated-measures MANOVA was then used to test for the persistence of experimental–control group differences on the major outcomes across the next two years. Women who worked with advocates reported higher quality of life and social support over time as

well as decreased difficulty obtaining community resources. Perhaps most importantly, women who worked with advocates also experienced less violence over time than did the women who did not work with advocates. Articles containing more detailed descriptions of the multivariate analyses and findings include Sullivan et al. (1992); Sullivan (2000, 2003); Bybee and Sullivan (2002, 2005); Goodkind et al. (2004); Beeble et al. (2009).

Adapting CAP to Other Communities

CAP can be adapted to meet a variety of a community's needs and to assist a wide range of domestic violence survivors. Although the project originated in a mid-sized city close to a university campus, it can be modified for larger cities as well as for more rural communities. Similarly, although the original studies focused on women who had used domestic violence shelter programs, CAP is equally applicable for women using non-residential support services or who are not receiving any community services at all (e.g., women exiting jails or prisons).

As more and more individuals consider replicating or modifying this program, questions arise regarding implementation issues. The most common concerns are discussed in the following sections.

How Do You Keep Women from Becoming Too Dependent on the Advocate?

For those individuals who are prone to becoming overly dependent on others, such dependency is minimized by the short time frame (10 weeks) of the intervention and the clearly delineated end date. It is important to note, however, that this question typically arises from individuals who view women with abusive partners as "not like me." We all depend on informal or formal advocacy-type assistance at various times in our lives (whether in the form of family helping us gain employment, friends accompanying us to the doctor, colleagues sharing information about opportunities or commodities, or something else). The more disenfranchised that individuals are from society, the fewer networks they have to rely on for such assistance. This advocacy model is predicated on the beliefs that we could all use more information about resources and how to obtain them and that we can all use a supportive person in our lives through difficult times.

We Don't Have a University in Our Area. Would This Type of Advocacy Project Work Using Volunteers Instead of Students?

An important next step in exploring the usefulness and generalizability of this intervention will be to investigate whether volunteers would

advocate for women as effectively as university students. One reason college students are preferable to volunteers is that they are paying for the experience (through tuition) and earning a grade and potential letter of recommendation for their efforts. This maximizes the likelihood they will work the required hours each week and make this intervention a priority in their lives. It is only natural that when busy individuals have to prioritize their time, it is their volunteer work that usually gets short shrift. A major concern in using volunteers as advocates is that they may be more likely to quit mid-way through the intervention or to put in fewer hours or less effort than is necessary to be effective.

On the other hand, volunteers are quite capable of becoming excellent advocates and, with appropriate training and supervision (ideally from a paid staff member), could do as well if not better than university students. Another advantage of using volunteers is that they may come from more diverse backgrounds than typical university students. Domestic violence service programs might consider aligning with church groups, community organizations, or other volunteer programs to obtain a paraprofessional advocacy workforce conducive to their individual needs.

Shouldn't an Intended Goal of the Project Be to Help Women Leave the Relationship?

It cannot be overemphasized that an integral component of this model is to follow the woman's lead in determining goals. Encouraging a client to make certain choices over others is not only disrespectful but is also likely to fail in creating lasting change. Individuals have multiple and complex reasons for making life choices, including relationship decisions. Ending the relationship not only does not necessarily end the violence, but also it sometimes escalates the violence (Sev'er, 1997; Fleury et al., 2000). The advocate's role must be to help women do what they can to protect themselves and their children, regardless of whether women are in or out of the relationship. Advocates can offer information to help women make decisions, but they should never push a woman toward one path over another. Working from a strengths perspective involves viewing individuals as naturally competent and capable, possessing valuable skills and abilities to make decisions and create positive change in their own lives.

Had we assumed in our research that leaving the relationship should be a desired outcome for all women, we would have analyzed whether women who worked with advocates were more effective in leaving the relationship than were women in the control group. This analysis would have indicated no differences between the two groups. However, when we looked at group differences only for women reporting they wanted to end the relationship, a significant difference emerged. Women who worked with advocates were

more effective in ending the relationship when they wanted to than were women in the control condition (96 percent versus 87 percent).

If a Major Goal of the Advocacy Intervention Is to Help Women Become Safe, Why Not Just Focus on Legal Advocacy?

Interestingly, only 72 percent of the women worked on legal advocacy issues during the NIMH-funded study, and not all of those issues pertained to the assailant. Some women, for example, were fighting their landlords in court or had been charged with other crimes themselves. Legal advocacy programs are important and necessary resources for women choosing to use the court system. However, many women choose alternatives to the criminal justice system to keep themselves and their children safe. Furthermore, women reported having a variety of interrelated concerns needing to be addressed, and this intervention was found to be equally effective regardless of the types or extent of such needs (Allen et al., 2004). The more generalized our advocacy efforts can be, the more lives we can effectively touch.

Importance of the Program's Underlying Philosophy

Although each advocacy intervention must be individualized to meet the unique needs of each participant, all interventions should be guided by three theoretical tenets that contribute to project effectiveness. First, the participant, not the advocate, should guide the direction and activities of the intervention. This relates to the second supposition, which is the belief that survivors are competent adults capable of making sound decisions for themselves. Third, the role of the advocate is to make the community more responsive to women's needs, and this involves active and pro-active work in the community.

USING A SYSTEMS-MODEL APPROACH TO IMPROVING IPV SERVICES IN A LARGE HEALTH-CARE ORGANIZATION

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Intimate partner violence (IPV) is a common and costly health problem associated with substantial medical and mental-health issues for victims and their children. Women, the most common victims of IPV, access the health care system frequently over the course of their lives for preventive and routine care as well as for trauma and abuse-related conditions. Thus, health care offers many valuable opportunities for early identification, tailored interventions, and primary prevention.

Despite these opportunities, identification and intervention for IPV is not a common or consistent practice in most health care settings. This is unfortunate, but not surprising. For many years clinical practice guidelines and recommendations from professional organizations focused primarily on the training of clinicians. Over time, however, it became clear that clinician-focused efforts had only limited success, producing little or no increase in the rates of identification and referral.

In 2001 the Institute of Medicine (IOM) urged health care delivery systems to develop and evaluate innovative programs that would go beyond traditional clinician training methods for addressing IPV. In a report titled *Confronting Chronic Neglect: The Education and Training of Health Care Professionals on Family Violence*, the IOM called attention to a 1998 pilot program, implemented by Kaiser Permanente Northern California, which had been associated with a significant increase in rates of screening, identification, and referral to mental-health clinicians and had been well accepted by clinicians. The IOM report noted that Kaiser Permanente had achieved these results by implementing a "systems-change model" in which clinician training was just one component of a larger intervention designed to make use of the entire health care environment—not just the doctor office visit—to address intimate partner violence.

Since its 1998 pilot Kaiser Permanente has disseminated the systems-model approach to medical centers throughout the Northern California region (serving 3.2 million members), and currently implementation is under way in eight additional regions across the country. Outside of Kaiser Permanente, the approach is being adapted for use in other clinical settings, both in the United States and abroad.

This summary will describe Kaiser Permanente's systems-model approach to delivering services for IPV, including how this approach has been implemented and evaluated. We will provide an update on Kaiser Permanente's progress over the past 10 years on the program's development and dissemination, giving special attention to what has been learned that may be of value to those who set out to implement this approach in other health care settings.

Organizational Setting: What Kaiser Permanente Brings to the Issue of IPV

Kaiser Permanente is one of the largest not-for-profit, integrated health care delivery systems in the United States, serving 8.7 million members in eight regions. The Kaiser Permanente workforce comprises more than 15,000 physicians and 164,000 employees.

Kaiser Permanente presents a unique opportunity for implementing IPV services and prevention because it provides the entire scope of care:

outpatient, inpatient, emergency, and behavioral health services. Kaiser Permanente has a fully implemented electronic health record system, extensive experience in management of chronic conditions, a team-based approach to care, recognized research expertise, and a strong commitment to prevention and health education—all grounded in a social mission. These elements make it an ideal "laboratory" for developing and implementing new models of care and addressing complex health issues.

The Kaiser Permanente Systems-Model Approach

The systems-model approach has five components: (1) a supportive environment (Sullivan et al.), (2) clinician inquiry and referral, (3) on-site IPV services, (4) linkages to community resources, and (5) leadership and oversight.

Figure 8-1 below depicts how each component is a necessary and interconnected piece of a coordinated health care response. It also lists the interventions used for each component.

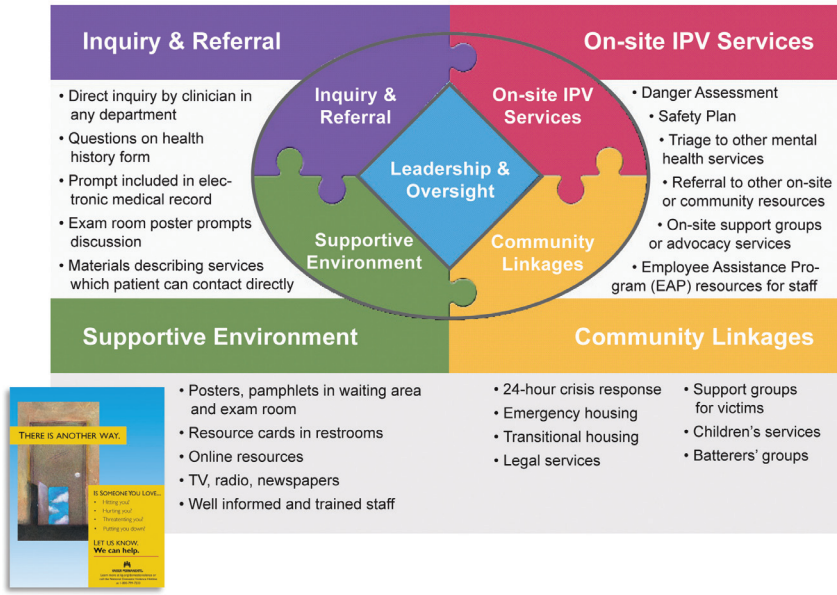

FIGURE 8-1 Systems model for intimate partner violence prevention.
SOURCE: McCaw, 2011.

Testing the Systems-Model Approach: The 1998-1999 Pilot

In 1998 funds were allocated to develop, implement, and test an innovative systems-model approach to improving IPV services in one small medical center (serving 70,000 members) in the Kaiser Permanente Northern California region. The idea was to go beyond the traditional approach of focusing primarily on didactic training of clinicians.

The systems-model approach makes use of the entire health care environment to address IPV prevention. This approach was chosen based on prior research showing the effectiveness of systems change for other clinical and safety issues (Thompson et al., 1995). The effectiveness of the pilot was evaluated based on evidence of actual change in clinician practice (increased IPV identification and referral) rather than on the traditional knowledge-and-attitude survey of clinicians.

The pre- and post-implementation evaluation of the pilot demonstrated a dramatic and statistically significant increase in screening rates, identification, and referral to a mental-health clinician, and the approach was well accepted by clinicians. In addition, after the implementation, more members recalled being asked about IPV, noticed IPV information available at the facility, and reported increased satisfaction with the health plan (McCaw et al., 2001; Kimberg, 2007).

In recognition of its success in boosting rates of IPV identification and referral, the Kaiser Permanente program was chosen by the American Association of Health Plans/Wyeth as the 2003 Gold Winner of its HERA award, presented each year to an exemplary program that advances quality in women's and children's health care.

Disseminating the Approach to Other Kaiser Permanente Medical Centers in Northern California

Over the next two years, the model was transferred to six more Kaiser Permanente medical facilities in Northern California through the guidance of a physician champion and a multidisciplinary team in each facility. This success led to identification of an "executive sponsor" and funding for a part-time medical director and project manager to facilitate rapid and efficient implementation across all 49 medical facilities in the Northern California region.

The job of the physician director and project manager was to provide consultation to medical facilities, identify and spread best practices, and ensure that IPV was integrated into region-wide operations—including scripts and protocols for use by nurses in the appointment-and-advice call center, data systems for quality improvement, the electronic health record, and on-line and printed resources for clinicians and members.

Tools developed to facilitate local implementation included a description of the roles and responsibilities of the physician champion and members of the multi-disciplinary team and a phased work plan for implementing the systems-model approach. Patient education materials, reviewed for readability and cultural appropriateness, were designed to be easily customized with local resource information.

Currently each Kaiser Permanente medical center in Northern California has a multi-disciplinary team led by a physician champion. These teams meet regularly, implement the systems-model approach at their medical facility, provide training to clinicians and front-line staff, respond to quality-improvement data, and ensure that IPV identification and referral is part of everyday patient care. Twice a year members of teams from every medical center come together for leadership development, sharing of innovative practices, updates on research, review of quality metrics, and development of annual goals and strategy.

Although medical facility–based teams ensure the local implementation of the systems-model approach, the role of regional leadership and oversight is also important to make certain that activities are coordinated among medical centers, that new research data is incorporated, and that "lessons learned" and best practices are widely disseminated. The regional medical director and program director meet regularly with other leadership groups and the executive sponsor to evaluate the progress of implementation, review quality-improvement metrics, and identify opportunities to integrate with other initiatives. Sponsorship from the top is critical in sustaining the momentum of the work. An executive sponsor can increase the program's visibility, assist with goal setting, identify and procure resources, and, when necessary, participate in problem solving (McCaw and Kotz, 2009).

Clinician training, although it is not the primary focus of the systems-model approach, is essential. To maximize its effectiveness, training is offered in multiple ways and venues including: lectures as part of continuing medical education, brief departmental updates, case presentations, on-line training tools, and reports on quality-improvement data. Clinicians are offered multiple options for incorporating IPV screening into their practices in a way that is comfortable and natural for them. Cultural considerations are incorporated into all training.[4]

[4] For further information, see McCaw, B. 2009. Intimate partner violence. In *A provider's handbook on culturally competent care: Women's health*. Kaiser Permanente National Diversity Council.

Tracking Progress Using Quality-Improvement Measures

In the initial 1998 pilot project, success was measured by tracking the number of patients identified and referred by clinicians. Later, during the dissemination of the systems-model approach to other Northern California medical facilities, an opportunity arose to track progress by using already existing quality and outcome measurement systems that are based on automated diagnosis databases. In 2002 Kaiser Permanente Northern California selected Improving IPV Prevention to demonstrate implementation of a behavioral health prevention guideline that shows coordination between primary care and mental health to meet an NCQA standard.[5]

The quality measures used to track progress toward Improving IPV Prevention are similar to those used for other health conditions, such as asthma, diabetes, hypertension, and depression. These measures provide data to monitor performance over time, between medical centers and departments, and to help teams focus their training and other improvement efforts.

The quality-improvement measures include both qualitative (process measures) and quantitative (measures based on clinical identification). The three process measures for each medical center are: (1) a physician or nurse practitioner champion, (2) a multi-disciplinary implementation team, and (3) an inter-departmental referral protocol for members experiencing IPV. The quantitative measures are designed to answer the following three questions:

1. How many members received the IPV diagnosis?
2. How does this compare to the estimated number of Kaiser Permanente members who are likely to be experiencing IPV?
3. Of the patients diagnosed, how many received appropriate referral and follow-up?

Data collection for the quantitative measures utilizes diagnosis codes from outpatient and emergency department medical visits, which are entered into an automated database. The number of members likely to be experiencing IPV is based on a prevalence estimate of IPV (in the previous 12 months) among women health-plan members aged 18–64 years. This estimate is drawn from a survey of health-plan members and from published prevalence estimates (McCaw and Kotz, 2005).

[5] For information about the NCQA standards, see http://www.innovations.ahrq.gov/content.aspx?id=2343.

What the Data Show

The data gathered through the quality-improvement measures show that from the program's inception in 2000 through 2010 there was a six-fold increase in women and men newly identified with IPV (see Figure 8-2). These results far exceed what might have been expected based on the promising 1998 pilot test.

Figure 8-3 shows the number of women and men newly diagnosed with IPV each year, by department. A notable trend is that identification has steadily shifted to less acute settings, such as primary care and mental health, suggesting that patients are being identified earlier, before more potentially serious injury occurs.

Although not shown in Figures 8-2 and 8-3, two additional findings from the data are notable: Of members newly diagnosed, more than 50 percent received follow-up mental-health services, and the IPV identification rate increased every year—that is, of the total number of Kaiser Permanente women members estimated to be experiencing IPV, an increasingly greater proportion were being identified.

Additional Lessons from Implementation

The Role of Technology

Over the 10-year implementation, "technology enablers" have proven invaluable. For example, clinicians can draw on tools embedded in the

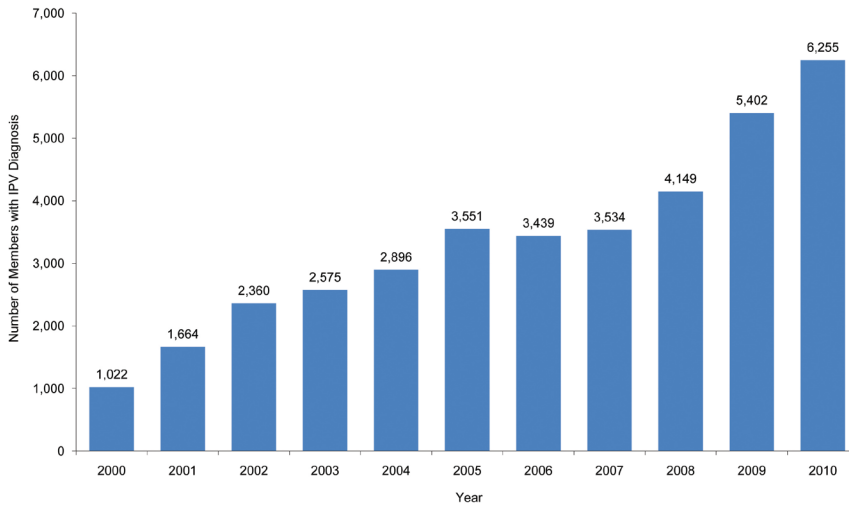

FIGURE 8-2 Members diagnosed with intimate partner violence, 2000-2010.
SOURCE: McCaw, 2011.

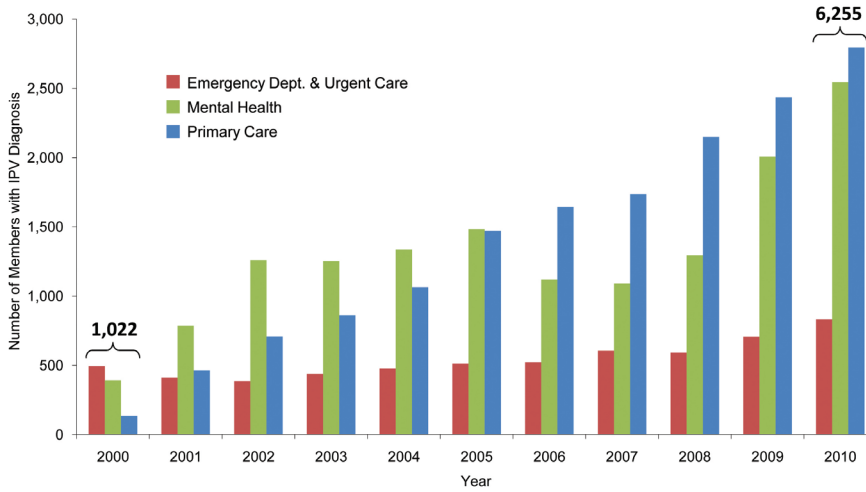

FIGURE 8-3 Number of women and men newly diagnosed with IPV.
SOURCE: McCaw, 2011.

Kaiser Permanente electronic health record to facilitate documentation of IPV, make referrals, and learn about best practices. Clinicians can also access point-of-care patient handouts about IPV and direct patients to Internet resources in both text and video formats. On-line video training allows clinicians to view demonstrations of how to provide caring, effective, and efficient interventions.

IPV services have also been incorporated into Kaiser Permanente's appointment-and-advice call center. Use of this service has increased dramatically over the past 10 years. Advice nurses, trained in how to inquire about IPV and equipped with IPV-related scripts and protocols, can respond immediately to members who contact the health care system by phone, directing them to the appropriate Kaiser Permanente venue of care as well as to community resource information.

Engaging the Kaiser Permanente Workforce

The demographics of most health care workforces (made up in large part by women of childbearing age) means that IPV is, unfortunately, a common issue for many employees and their families. Although initial implementation of the systems-model approach focused on providing resources and information to health-plan members, it quickly became clear that the Kaiser Permanente workforce was another key audience that needed information about resources available in the workplace. Over time

an additional benefit of this workplace outreach emerged: Employees who had learned about IPV became an essential aspect of the supportive environment provided for members.

One example of an innovative approach to reaching employees is the "Silent Witness Display"—a large exhibit that presents the real-life stories of Kaiser Permanente physicians, medical staff, and employees who have dealt with IPV. These stories of courage, hope, and survival reflect the diversity of the Kaiser Permanente workforce in age, career type, and ethnic background. The exhibit travels to every Kaiser Permanente medical facility and is regarded as a powerful tool for increasing awareness of IPV, its impact on employees and their families, and the resources available to both employees and members. The stories and the display are available at http://www.kp.org/domesticviolence/silentwitness/index.html.

Research Collaborations

From the very beginning clinician–researcher partnerships have been invaluable. The well-designed evaluation of the pilot program yielded findings that were both clinically meaningful and operationally useful. These findings helped to make the case for dissemination to other medical centers, justify the allocation of regional resources, and secure "buy-in" from front-line clinicians. The evaluation also generated additional information on women who experience IPV, including demographics, perceived health status, and reasons for accepting referral for follow-up (McCaw et al., 2002, 2007).

Over the past decade, engagement with other Kaiser Permanente researchers has led to inclusion of IPV as a risk factor in studies of diabetes and self-care, breast-cancer survivorship, incontinence, contraceptive use, and chronic pain. IPV has also been included in studies that have implications for improving health care delivery—such as the impact of electronic referral on mental-health services utilization and predictive modeling using regional call-center data (Ahmed and McCaw, 2010). A study is now under way to compare health care utilization by IPV women who receive an intervention in the health care setting to those who do not receive an intervention.

Challenges of Community Linkages

In contrast to other potentially life-threatening health conditions (for example, heart attack), victims of IPV may need life-saving interventions (such as emergency shelter and a restraining order) that are more appropriately provided outside the health care setting and that require the expertise of community advocates, law enforcement, and criminal justice. Thus, the development of strong partnerships between health care and community resources is a key element of the systems-model approach.

However, the development of community partnerships is often challenging because of the differing perspectives of health care providers and the staff of community agencies. Health care providers tend to view the medical center as a self-contained entity and may not know how—or why—to engage community partners in their work. For them, reaching out beyond the walls of the facility often requires a fundamental shift in thinking.

On the other hand, staff at community agencies may not be familiar with the "language" of health care—its quality-improvement metrics, organizational hierarchy, and clinic workflow. These contrasting perspectives grow out of differences in training, background, expectations, pressures, funding sources, and staff turnover. The result is that health care facilities vary widely in how well community partners are included in the planning and implementation of the systems-model approach.

Dissemination to Other Kaiser Permanente Regions: Scaling-Up and Sustainability

Over the past five years, the remaining eight Kaiser Permanente regions have embarked on implementing the systems-model approach. This scaling-up of the program was inspired by its successful adoption in the Kaiser Permanente medical facilities in Northern California and also by the compelling data showing improvement in IPV identification and referral. Each of the eight regions has designated a physician champion and formed a multidisciplinary team.

Although each region exercises some degree of autonomy in its implementation, an effort has been made to maintain consistency across regions. All regions have adopted the implementation tools developed for Northern California—for example, the phased "work plan"—and are using them successfully. All have adopted a single set of member-education materials that can be customized to each region. All are offering resources to their Kaiser Permanente workforces, including on-line manager training and the "Silent Witness Display" described above. In addition, a set of IPV "SmartTools" has been added to the program-wide electronic health information system to facilitate identification, evaluation, documentation, referral, and the provision of resource information and safety planning for members.

Quarterly conference calls among the regions' leadership also help to maintain consistency by providing an opportunity for regions to share best practices, learn about new research, leverage resources, explore interregional initiatives, and set common goals.

In the course of the dissemination throughout Kaiser Permanente, it has become clear that to be sustainable the IPV prevention services must be closely aligned with other Kaiser Permanente priorities: ensuring member safety, improving coordination of care, increasing efficiency, enhancing

service, and reducing health care disparities. Most importantly, IPV prevention services must be incorporated into the everyday care of members.

To the extent that IPV prevention can be aligned with these larger goals, executive decision makers will come to see the program as an imperative and a positive investment. This top-level support is evident in comments made at a 2007 CEO Roundtable by Robert Pearl, M.D., executive director and chief executive officer of the Permanente Medical Group: "IPV prevention is part of a strategic approach to quality, service, and affordability. By doing the right thing, we can improve quality outcomes, member satisfaction, and the personal lives of our patients, while also decreasing costs to employers and individuals."

Beyond Kaiser Permanente: Opportunities for Adoption of the Systems-Model Approach in Other Settings

In response to inquiries from other health care delivery organizations in the United States and abroad about how to implement the systems-model approach, information and tools have been made available at the Innovations Exchange operated by the Agency for Healthcare Research and Quality and on the United Nations website, the Virtual Knowledge Centre to End Violence Against Women and Girls (www.endvawnow.org). To facilitate implementation at facilities outside of Kaiser Permanente, it has been important to develop tools that are general enough to be easily adapted to new sites.

As the systems-model approach has been adopted by other sites, the implementation has been tailored to address a range of cultural issues including:

- age (messaging focused on teens),
- ethnicity (attention to differences in values and communication style),
- language (translations of the member education materials),
- sexual preference (gender neutral), and
- religion (inclusion of faith communities in community partnerships).

It is particularly exciting to see how the systems-model approach is being adapted in other countries. In the community clinics in Bangalore, India, where the approach is being used to improve the response to gender-based violence, the intervention also reaches out to the mothers-in-law of women identified as victims of violence. And, in lieu of the "on-site" services used in the Kaiser Permanente facilities, the clinics' community outreach workers are trained to offer IPV information and counseling as part of their routine home visits. Such cross-cultural adaptations of the systems-model approach open exciting opportunities for a bilateral exchange of learning.

The Way Forward

The list below highlights key "lessons learned" that have emerged from the 12-year evolution of the Kaiser Permanente systems-model approach to improving services to members experiencing intimate partner violence. It is hoped that these lessons will be of use to other health care delivery systems as they set out to implement, disseminate, and sustain programs to improve their response to intimate partner violence.

- Use a consistent approach based on systems-model thinking.
  - Select a clear conceptual model that is comprehensive and readily customized to available resources (for example, Figure 8-1).
  - Implement the approach with local physician or nurse practitioner champions and multi-disciplinary teams.
  - Provide organizational leadership to ensure consistency of services, alignment with other health initiatives, and dissemination of innovative practices.
- Identify qualitative and quantitative measures to ensure continuous quality improvement.
- Take advantage of "technology enablers" to improve services.
- Engage the health care workforce as a partner.
- Establish clinician-researcher partnerships to ensure a robust design for both the program and its evaluation, and to ensure that evaluation will yield credible findings that are clinically and operationally meaningful.

Summary

Over the next decade, health care organizations will be called upon to assume an increasingly important role in society's response to intimate partner violence and other forms of family violence—through primary prevention, early identification, and effective interventions. Over its 12-year evolution, the Kaiser Permanente systems-model approach has achieved a six-fold increase in the identification and referral of members experiencing intimate partner violence and has been successfully replicated throughout this large health care organization. Examples such as the Kaiser Permanente approach that demonstrate measurable results and that can be easily adapted for other settings are essential to propel the field forward.

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A

Workshop Agenda

WORKSHOP ON PREVENTING VIOLENCE AGAINST WOMEN AND CHILDREN

AGENDA

Approach: Using an ecologic framework that focuses on points of primary, secondary, and tertiary prevention and intervention, this workshop will assess violence along the lifespan of women and children. Each level will present the evidence basis of prevention, successful strategies, and promising interventions or emerging research that can potentially be applied in global settings. An interactive panel to explore ways forward will follow each segment.

Objective: To provide a comprehensive approach to the prevention of violence against women and children, focusing on early interventions.

DAY 1

8:15 Registration

9:00 **Introduction**
Jacquelyn Campbell, Ph.D., R.N.
Chair, Forum on Global Violence Prevention
Anna D. Wolfe Chair, Johns Hopkins School of Nursing

9:20 **Opening Remarks**
Judy Salerno, M.D., M.S.
Executive Officer, Institute of Medicine

9:30 **Lifetime Trajectory and an Ecological Approach: A Global View of Violence Against Women and Children**
What is the burden of violence? Where are the intersections of violence against women and violence against children? How can we move forward at primary, secondary, and tertiary prevention levels?
Claudia García-Moreno, M.D.
Coordinator, Department of Gender, Women, and Health
World Health Organization

10:00 **Q & A with Claudia García-Moreno**

I. GLOBAL: CONTEXT MATTERS

On the international and national stage, efforts toward recognizing the issues of violence against women and children have produced mixed results. What has been successful? Where has progress been made? Where do existing challenges lie? This segment will explore legislation to reduce violence against women and children, government initiatives, and partnerships that transcend borders.

Moderated by: Frances Ashe-Goins, R.N., M.P.H.
Acting Director, Office of Women's Health
U.S. Department of Health and Human Services

10:10 **Policy Advocacy as a Tool for Prevention**
Lessons Learned from the International Violence Against Women Act
Kiersten Stewart, M.A.
Director of Public Policy, Family Violence Prevention Fund

10:40 **Global Partnerships on Domestic Violence Legal Reform**
Cheryl Thomas, J.D.
Director, Women's Human Rights Program
Advocates for Human Rights

11:00 **Partners for Prevention: Asia and the Pacific**
James Lang
Programme Coordinator, Partners for Prevention
United Nations Development Programme

11:20 Break

11:35 **U.S. Government Initiatives to Respond to Violence Against Women**
Lynn Rosenthal
White House Adviser on Violence Against Women

12:05 **Canada's Family Violence Initiative**
David Butler-Jones, M.D., M.H.Sc.
Chief Public Health Officer, Public Health Agency of Canada

12:30 **Inter-American Alliance for the Prevention of Gender-Based Violence**
Monique Widyono for Margarita Quintanilla, M.D., M.P.H.
Nicaragua Country Director, PATH

12:45 **Q & A with Kiersten Stewart, Cheryl Thomas, James Lang, Joanne LaCroix (for David Butler-Jones), and Monique Widyono**

1:30 Lunch

II. COMMUNITIES: GENDER EQUALITY

Equal roles and rights of men and women contribute toward the reduction of violence against women and children. This segment will explore the impact of engaging men and boys and empowering women and girls.

Moderated by: Gary Barker, Ph.D.
Director of Gender, Violence, and Rights
International Center for Research on Women

2:15 **Keynote Address**
Ending Violence Against Women and Children: Investing in Solutions
Mary Ellsberg for Sarah Degnan Kambou, Ph.D., M.P.H.
President, International Center for Research on Women

2:45 **The Science of Gender Equality**
Why This Isn't Just About Working with Women
Rachel Jewkes, M.D.
Director, Medical Research Council of South Africa

3:15 **What Does an Understanding of Masculinities Bring to the Story?**
Engaging Men in Preventing Violence Against Women: Factors and Results
Gary Barker, Ph.D.
Director of Gender, Violence, and Rights
International Center for Research on Women

3:35 **Intervention with Microfinance for AIDS and Gender Equity**
Rachel Jewkes for Julia Kim, M.D., M.Sc.
Cluster Leader, Millennium Development Goals & Universal Access, United Nations Development Programme

3:55 Break

4:15 **The Way Forward**
Moderated by: Gary Barker
Full panel of speakers with moderator and audience participation to discuss ways in which existing programs can be scaled up, new approaches can be determined, or information gaps can be addressed.

5:00 Break

DAY 2

8:00 Registration

8:30 **Summary of Day 1**
Jacquelyn Campbell

8:35 **Government Initiatives to Reduce Violence: New Zealand**
Denise Wilson, Ph.D., R.N.
Associate Professor of Māori Health, Auckland University of Technology

III. FAMILIES: INTERRUPTING/PREVENTING THE CYCLE OF VIOLENCE—SECONDARY PREVENTION

Violence against children has strong linkages to violence against women. As well, violence within the family both directly against and witnessed by children, perpetuates a cycle. How can intervening early both

protect against and prevent violence? Where and when can these interventions be most effective?

Moderated by: Bryan Samuels, M.P.P.
Commissioner, Administration on Children, Youth, and Families

9:10 **Intervening in the Cycle of Violence**
What We Know, What We Don't
Claire Crooks, Ph.D.
Associate Director, Centre for Prevention Science
Centre for Addiction and Mental Health

9:40 **Case Studies: Innovative Prevention Interventions**
Addressing Intimate Partner Violence and Potential Child Abuse at Prenatal Care
Agnes Tiwari, Ph.D., R.N.
Associate Professor, University of Hong Kong
The Fourth R: Strategies for Healthy Youth Relationships
David Wolfe, Ph.D.
RBC Chair, Center for Addiction and Mental Health
Strengthening Families: An Integrated, Multi-Level Approach to Preventing Child Maltreatment
Judy Langford, M.S.Ed.
Associate Director, Center for Study of Social Policy

10:45 **Q & A with Claire Crooks, Agnes Tiwari, David Wolfe, Judy Langford, Jeffrey Edleson**

11:00 Break

11:05 **The Way Forward**
Moderated by Jeffrey Edleson, Ph.D.
Director of Research, University of Minnesota School of Social Work
Full panel of speakers with moderator and audience participation to discuss ways in which existing programs can be scaled up, new approaches can be determined, or information gaps can be addressed.

11:55 Lunch

IV. PSYCHOSOCIAL EMPOWERMENT

Interrupting the cycle of violence also requires addressing the trauma experienced by victims of violence, and strengthening women, children, and families. This section will focus on secondary and tertiary prevention of violence against women and children and long-term effects of trauma.

Moderated by: Brigid McCaw, M.D.
Medical Director, Family Violence Prevention Program
Kaiser Permanente

1:00 **Trauma-Informed Care: A Values-Based Context for Psychosocial Empowerment**
Roger Fallot, Ph.D.
Director of Research and Evaluation, Community Connections

1:30 **Case Studies**
Treatment of Trauma Among Women with Substance Abuse Disorders
Hortensia Amaro, Ph.D.
Director, Institute on Urban Health Research
Psychosocial Trauma Interventions in Children, Families, and Parents
Julian Ford, Ph.D.
Director, University of Connecticut Health Center Child Trauma Clinic
Community Advocacy Project: A Psychosocial Empowerment Intervention for Women with Abusive Partners
Cris Sullivan, Ph.D.
Director, Violence against Women Research and Outreach Initiative Michigan State University
A Systems-Model Approach to Improve Intimate Partner Violence Services in a Large Health Care Organization
Brigid McCaw, M.D.
Medical Director, Family Violence Prevention Program Kaiser Permanente

3:00 **Q & A with Brigid McCaw, Roger Fallot, Julian Ford, Hortensia Amaro, and Cris Sullivan**

3:10 Break

3:20 **The Way Forward**
Moderated by Jacquelyn Campbell
Full panel of speakers with moderator and audience participation to discuss ways in which existing programs can be scaled up, new approaches can be determined, or information gaps can be addressed.

4:35 **Closing Keynote**
What lessons Have We Learned and How Do We Proceed?
Gail Wyatt, Ph.D.
Associate Director, University of California, Los Angeles AIDS Institute

B

Speaker Biographical Sketches

Hortensia Amaro, Ph.D., is distinguished professor of health sciences and of counseling psychology and associate dean at the Bouvé College of Health Sciences at Northeastern University and director of the Institute on Urban Health Research. Dr. Amaro's research has focused on alcohol and drug use and addiction among adolescents and adults; the development and testing of behavioral interventions for HIV/AIDS prevention; substance abuse and mental health treatment for Latina and African American women and incarcerated men; alcohol and drug use among college populations; and behavioral interventions for HIV medications adherence. Her 1995 article "Love, Sex and Power" (*American Psychologist*) was a signal contribution to the field of HIV prevention among women and received the 1996 Scientific Publication Award from the National Association of Women in Psychology. Dr. Amaro has served on the editorial board of the *American Journal of Public Health* and other leading publications, and on several Institute of Medicine committees. Additionally, she has served on review and advisory committees to the National Institutes of Health, the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, and the U.S. Centers for Disease Control and Prevention. Bringing her research to the frontlines, Dr. Amaro has founded five substance abuse treatment programs for women in Boston and, for 14 years, served on the board of the Boston Public Health Commission. She is a member of the Institute of Medicine.

Frances E. Ashe-Goins, R.N., M.P.H., a registered nurse and policy analyst, is acting director of the Office of Women's Health at the U.S. Department

of Health and Human Services. Formerly, as deputy director and director of the Division of Policy and Program Development, she was responsible for numerous women's health issues, including HIV/AIDS, domestic violence, rape/sexual assault, lupus, diabetes, organ/tissue donation, minority women's health, international health, female genital cutting, mental health, homelessness, and young women's health. Mrs. Ashe-Goines also coordinated the regional women's health coordinators programs. She has written numerous articles, appeared on radio and television programs, been featured in magazine and newspaper articles, made presentations at national and international conferences and workshops, and received many awards and commendations. She is a featured author of a chapter on domestic violence in the book, *Policy and Politics in Nursing and Health Care, 4th edition.*

Gary Barker, Ph.D., M.P.P., is director of gender, violence, and rights at the International Center for Research on Women (ICRW). In this role he oversees ICRW's research, policy analyses, and programmatic work to develop solutions that address the underlying causes that lead to violence against women, including the involvement of men and boys. Dr. Barker is a social scientist with more than 15 years of experience researching gender equality, men and masculinities, sexuality, and HIV/AIDS. He also is an expert in exploring the links between men and violence in conflict and post-conflict settings in parts of Latin America, the Caribbean, sub-Saharan Africa, and South Asia. Prior to joining ICRW, Dr. Barker was founding executive director of Instituto Promundo, a nongovernmental organization based in Brazil that works to promote gender equality and reduce violence against children, youth, and women. He also has served as a consultant to the World Bank and many United Nations agencies. Dr. Barker was elected as an Ashoka Fellow in 2007 and awarded an Individual Projects Fellowship from the Open Society Institute. He is a founding co-chair of MenEngage, a global alliance of international organizations that work to engage men and boys to promote gender equality.

David Butler-Jones, M.D., M.H.Sc., Canada's first chief public health officer, heads the Public Health Agency of Canada, which leads the government's efforts to protect and promote the health and safety of Canadians. He has worked in many parts of Canada in both public health and clinical medicine and has consulted in a number of other countries. In addition to serving as chief public health officer, Dr. Butler-Jones is a professor in the Faculty of Medicine at the University of Manitoba as well as a clinical professor with the Department of Community Health and Epidemiology at the University of Saskatchewan's College of Medicine. From 1995 to 2002 he was chief medical health officer and executive director of the Population

Health and Primary Health Services Branches for the Province of Saskatchewan. He has served as president of the Canadian Public Health Association, vice president of the American Public Health Association, chair of the Canadian Roundtable on Health and Climate Change, international regent on the board of the American College of Preventive Medicine, member of the governing council for the Canadian Population Health Initiative, chair of the National Coalition on Enhancing Preventive Practices of Health Professionals, and co-chair of the Canadian Coalition for Public Health in the 21st Century.

Jacquelyn C. Campbell, Ph.D., R.N., is the Anna D. Wolf Chair in Nursing at the Johns Hopkins School of Nursing. Dr. Campbell's research addresses the risk factors for and the evaluation of interventions to prevent domestic violence. She has authored numerous articles on intimate partner violence, violence against women, and adolescent exposure to violence. Dr. Campbell has served on the National Institute of Mental Health Violence and Traumatic Stress Study Section and is a member of the American Academy of Nursing and the Institute of Medicine. She has been selected as the Simon Visiting Scholar at the University of Manchester in the United Kingdom and, most recently, the Institute of Medicine/American Academy of Nursing/American Nursing Foundation Scholar in Residence. Dr. Campbell has been active in the Institute of Medicine as a member of the Board on Global Health and has served as a member of two committees of the Board on Children, Youth, and Families.

Claire Crooks, Ph.D., is associate director of the Centre for Prevention Science at the Centre for Addiction and Mental Health and adjunct professor at the University of Western Ontario. She is one of the lead developers and researchers of the Fourth R, a relationship-based program aimed at preventing violence and related risk behaviors in adolescents that has been implemented in more than 1,000 schools in Canada and the United States. Dr. Crooks is also a co-founder of the Caring Dads program, a parenting intervention for men who have maltreated their children. In addition to being an author of the program manual, she has been involved with training, consultation, and research on the Caring Dads project. Dr. Crooks has co-authored more than 40 articles, chapters, and books on topics including children's exposure to domestic violence, child custody and access, child maltreatment, adolescent dating violence and risk behavior, intervening with fathers who maltreat their children, strength-based programming for Aboriginal youth, and trauma. She is actively involved with training judges, lawyers, and other court personnel through her work as a faculty member for the U.S. National Council of Juvenile and Family Court Judges. Dr. Crooks has testified before the Canadian Senate Committee on Human

Rights about the intersection between domestic violence and child custody as a children's rights issue.

Sarah Degnan Kambou, Ph.D., is president of the International Center for Research on Women (ICRW), a global think tank that focuses on making women integral to alleviating poverty worldwide. An accomplished social scientist and development practitioner with expertise in sexual and reproductive health, HIV/AIDS, and adolescent programming, Dr. Degnan Kambou has worked in 26 countries and dedicated more than 25 years to creating meaningful social change in the developing world. Prior to being named president, she served as ICRW's chief operating officer, and earlier, as ICRW's vice president of health and development, she oversaw research in HIV/AIDS, reproductive health, and nutrition as well as in gender, violence, and women's rights. In 2010 Dr. Degnan Kambou was appointed by U.S. Secretary of State Hillary Clinton to represent ICRW on the U.S. National Commission for the United Nations Educational, Scientific and Cultural Organization. Dr. Degnan Kambou joined ICRW after more than a decade living in sub-Saharan Africa, where she managed signature programs for CARE, a humanitarian relief and development organization. Prior to her work in Africa, Dr. Degnan Kambou cofounded and for eight years served as a director of the Center for International Health in the School of Public Health at Boston University.

Jeffrey L. Edleson, Ph.D., is professor and director of research at the University of Minnesota School of Social Work and director of the Minnesota Center Against Violence and Abuse. He is one of the world's leading authorities on children exposed to domestic violence and has published more than 100 articles and 10 books on domestic violence, groupwork, and program evaluation. Dr. Edleson is co-author, with the late Susan Schechter, of *Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice* (NCJFCJ, 1999). Better known as the "Greenbook," this best-practices guide has been the subject of six federally funded and numerous other demonstration sites across the country. Dr. Edleson also has conducted intervention research and provided technical assistance to domestic violence programs and research projects across North America as well as in several countries in other parts of the world. Dr. Edleson's research, policy, and practice interests have earlier focused on research on batterer intervention programs. In recent years, his work has focused primarily on the impact of adult domestic violence on children and how social systems respond to these children. Dr. Edleson is an associate editor of the journal *Violence Against Women* and has served on the editorial boards of numerous other journals. He is co-editor of the Oxford University Press book series on interpersonal violence. He is a licensed

independent clinical social worker in Minnesota and has practiced in elementary and secondary schools and in several domestic violence agencies.

Roger D. Fallot, Ph.D., is a clinical psychologist and director of research and evaluation at Community Connections, a private, not-for-profit agency providing a full range of human services in the District of Columbia. Dr. Fallot's professional areas of specialization include the development and evaluation of services for trauma survivors and the role of spirituality in recovery. The author of numerous clinical and research articles, he is a contributing author and co-editor, with Maxine Harris, of *Using Trauma Theory to Design Service Systems* (Jossey-Bass, 2001) and consults widely on the development of trauma-informed cultures of care in human services. A member of the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Advisory Committee for Women's Services, Dr. Fallot was principal investigator on the District of Columbia Trauma Collaboration Study, a SAMHSA-funded research project examining the effectiveness of integrated services for women trauma survivors with mental health and substance abuse problems. He and a group of clinicians at Community Connections have developed a men's version of the Trauma Recovery and Empowerment Model, a manualized group intervention for working with survivors of physical and sexual abuse. Dr. Fallot also is interested in the relationships among spirituality, recovery, and well-being; he edited and contributed chapters to *Spirituality and Religion in Recovery from Mental Illness* (Jossey-Bass, 1998).

Julian D. Ford, Ph.D., is professor of psychiatry at the University of Connecticut School of Medicine and director of the University of Connecticut Health Center Child Trauma Clinic and Center for Trauma Response Recovery and Preparedness. Dr. Ford developed the TARGET (Trauma Affect Regulation: Guide for Education and Therapy) intervention model for adult, adolescent, and child traumatic stress disorders and co-occurring substance use disorders. He conducts research on psychotherapy and family therapy, health services utilization, psychometric screening and assessment, and psychiatric epidemiology, including serving as the principal investigator on several federally funded studies evaluating TARGET and other evidence-based psychosocial interventions for families, adults, and youth. Dr. Ford has co-edited three recent books, *Treating Traumatized Children* (Routledge, 2008, with Danny Brom and Ruth Pat-Horenczyk), *Encyclopedia of Psychological Trauma* (Wiley, 2008, with Gilbert Reyes and Jon Elhai), and *Treatment of Complex Traumatic Stress Disorders* (Guilford, 2009, with Christine Courtois), and authored a textbook, *Posttraumatic Stress Disorder: Scientific and Professional Dimensions* (Elsevier/Academic Press, 2009).

Claudia García-Moreno, M.D., M.Sc., is a physician from Mexico with more than 25 years of experience in public health spanning Africa, Latin America, and parts of Asia. For the past 15 years her work has focused on women's health and gender in health, including contributing to gender and women's health initiatives at the World Health Organization (WHO). She has led WHO's work on women and HIV/AIDS and on violence against women and coordinated the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women, which includes more than 14 countries. She has been involved in setting up several initiatives such as the Sexual Violence Research Initiative. She is on the editorial board of *Reproductive Health Matters* and has published and reviewed papers on women's health for several international journals.

Kathy Greenlee, J.D., was appointed by President Obama as the fourth assistant secretary for aging at the Administration on Aging (AoA) within the U.S. Department of Health and Human Services and confirmed by the Senate in June 2009. Ms. Greenlee brings more than 10 years of experience advancing the health and independence of older persons and their families and advocating for the rights of older persons. AoA is mandated by the Older Americans Act (OAA) to be the focal point and lead advocacy agency for older persons and their concerns at the federal level. AoA's vision for older people, embodied in the OAA, is based on the value that dignity is inherent to all individuals and the belief that older people should have the opportunity to fully participate in all aspects of society and community life; be able to maintain their health and independence; and be free from violence, abuse, neglect, and exploitation. AoA works with its partners at the federal, state, and community levels to help strengthen the nation's capacity to promote the dignity and independence of older people. AoA works to stimulate programmatic and policy activity at the national, state, and local levels in order to advance the work of eliminating violence against older adults and elder abuse, neglect, and exploitation in the United States as well as with international organizations and researchers around the world. By doing so, AoA seeks to address the social, economic, and health impacts of violence against older adults and elder abuse, neglect, and exploitation.

Rachel Jewkes, M.D., is director of the Medical Research Council's Gender and Health Research Unit in Pretoria, South Africa. A public health physician, epidemiologist, and social researcher, she has spent the past 15 years researching the interface of gender inequity and gender-based violence and their intersections with health, particularly concerning HIV. She has spent many years developing the health sector response to rape in South Africa through research and policy development. She is secretary of the Sexual Violence Research Initiative of the Global Forum for Health Research and member of

the World Health Organization (WHO) Expert Advisory Panel on Injury and Violence Prevention and Control, WHO's Strategic and Technical Advisory Committee for HIV–AIDS, and the PEPFAR scientific advisory board. She has published articles on intimate partner violence and HIV in numerous international journals, including *The Lancet* and the *British Medical Journal*.

Julia Kim, M.D., M.Sc., is the cluster leader for universal access and the Millennium Development Goals in the HIV/AIDS group of the United Nations Development Programme (UNDP). She is an internal medicine specialist and public health researcher by training. Prior to joining UNDP, she was based in South Africa for 10 years, where she held joint appointments as a senior researcher and policy advisor within the School of Public Health at the University of the Witwatersrand and the Health Policy Unit of the London School of Hygiene and Tropical Medicine. Her research interests have included program and policy innovation to address gender-based violence and HIV/AIDS at multiple levels, including in the health, education, and criminal justice sectors. Dr. Kim's recent work has included intervention research on structural drivers of HIV, including the potential of strategies such as microfinance to address the intersections between poverty, gender inequalities, and HIV. She has served on numerous national and global advisory groups and published across a range of issues, including gender and development, HIV post-exposure prophylaxis, integrating reproductive health and HIV/AIDS, HIV/tuberculosis clinical services, rural health systems development, strengthening research utilization, and addressing social determinants of health.

James L. Lang is program coordinator of Partners for Prevention, the regional joint program of the United Nations Development Programme (UNDP), the United Nations Population Fund, UN Women, and UN Volunteers for the primary prevention of gender-based violence in Asia and the Pacific. Mr. Lang is a development practitioner, trainer, and author with special interests in gender-based violence prevention and engaging boys and men in working toward gender equality. He has worked on these issues for the United Nations family and nonprofit organizations since 1997. Previously, Mr. Lang served as the UNDP's regional gender advisor for the Asia-Pacific region and worked for UNDP in Laos and Sri Lanka. He has also worked with the Family Violence Prevention Fund in San Francisco, Oxfam Great Britain in the United Kingdom, and served as research coordinator for the UN International Research and Training Institute for the Advancement of Women and UNDP in New York. In addition to project management and training, Mr. Lang has published numerous articles, and edited books on the topics of poverty, men and gender, gender-based violence prevention, and other development issues.

Judy Langford, M.S.Ed., is senior fellow at the Center for the Study of Social Policy in Washington, D.C., where she provides technical assistance to foundations, governmental agencies, and private organizations on the development and implementation of family supportive practices and policies. She is currently leading the national implementation of Strengthening Families through Early Care and Education, funded by the Doris Duke Charitable Foundation, and serves on the Board of Directors for the Finance Project and the Southern Institute for Children and Families. Ms. Langford is former executive director of both the Family Resource Coalition and the Ounce of Prevention Fund. She has served as a consultant for the Pew Trusts Children's Initiative, the Robert Wood Johnson Foundation, the Edna McConnell Clark Foundation, the Ewing Marion Kauffman Foundation, the Arthur M. Blank Family Foundation, and the Casey Family Programs. She has served as chair of the Illinois Family Policy Task Force and member of the Illinois Child Welfare Advisory Board. Ms. Langford was previously an award-winning contributing editor for *Redbook* magazine and served as honorary chair of President Carter's Advisory Committee for Women from 1977 to 1981. Additionally, she was a founder of the AIDS Foundation of Chicago and a fellow of Leadership Greater Chicago.

Brigid McCaw, M.D., M.S., M.P.H., is medical director for the Family Violence Prevention Program at Kaiser Permanente (KP). Her teaching, research, and publications focus on developing a health systems response to intimate partner violence and the impact of intimate partner violence on health status and mental health. She is a fellow of the American College of Physicians. Kaiser Permanente, a large nonprofit integrated health care organization serving 8.6 million members in nine states and the District of Columbia, has implemented one of the most comprehensive health care responses to domestic violence in the United States. The nationally recognized "systems model" approach is available across the continuum of care, including outpatient, emergency, and inpatient care; advice and call centers; and chronic care programs. The electronic medical record includes clinician tools to facilitate recognition, referrals, resources, and follow-up for patients experiencing domestic violence and provides data for quality improvement measures. Over the past decade, identification of domestic violence has increased fivefold, with most members identified in the ambulatory rather than acute-care settings. The majority of identified patients receive follow-up mental health services. Kaiser Permanente also provides prevention, outreach, and domestic violence resources for its workforce. Violence prevention is an important focus for KP community benefit investments and research studies. The KP program, under the leadership of Dr. McCaw, has received several national awards.

Margarita Quintanilla, M.P.H., is currently the country representative of PATH in Nicaragua. Previously, she was coordinator of the Child Domestic Work and Sexual Exploitation Programs of the International Program on the Elimination of Child Labor. She has worked with the Ministry of Health of Nicaragua and the Finnish Foreign Affairs Ministry, where she was responsible for the project component on policies and legislation for women's health. Dr. Quintanilla is author of several publications on gender-based violence in the health sector including *Comprehensive Response to Domestic Violence in the Health Services: Care Manual for Health Personnel*; *Medico-Legal Care in Cases of Sexual Assault in Nicaragua*; and *Assessment of the Evidence Gathering, Submission, and Consideration Procedures in Cases of Intra-Family and Sexual Violence against Women, Children and Adolescents in Nicaragua* (co-author).

Lynn Rosenthal is the first-ever White House advisor on violence against women. She works with Vice President Joseph Biden and the White House Council on Women and Girls to coordinate efforts across federal agencies to address domestic violence and sexual assault. Her areas of focus since assuming this post include increasing resources in the federal budget, chairing the Interagency Policy Group on Violence Against Women, and coordinating with other White House offices to integrate these issues into other administration priorities. Previously, Ms. Rosenthal served as executive director of the National Network to End Domestic Violence, where she worked on the reauthorization of the Violence Against Women Act and assisted states and local communities with implementation of this groundbreaking federal legislation. She also worked closely with corporate partners to bring funding to local communities to respond to domestic violence. Ms. Rosenthal has been widely recognized for her efforts to address domestic violence at the national, state, and local levels. She has been a shelter director and leader of state domestic violence coalitions in Florida and New Mexico. In 2006, she was the first recipient of the Sheila Wellstone Institute National Advocacy Award.

Judith A. Salerno, M.D., M.S., was appointed executive officer of the Institute of Medicine of The National Academies in January 2008. From 2001 to 2007, Dr. Salerno served as deputy director of the National Institute on Aging at the National Institutes of Health, U.S. Department of Health and Human Services. In this capacity, Dr. Salerno had oversight of more than $1 billion in aging research conducted and supported annually by the institute, including research on Alzheimer's and other neurodegenerative diseases, frailty and function in late life, and the social, behavioral, and demographic aspects of aging. A geriatrician, Dr. Salerno is interested in improving the health and well-being of older persons and has designed public–private initiatives to address aging stereotypes, novel approaches to support training

of new investigators in aging, and award-winning programs to communicate health and research advances to the public. Dr. Salerno also serves on numerous boards and national committees concerned with health care issues ranging from the quality of care in long-term care to the future of the geriatric workforce.

Bryan Samuels, M.P.P., is commissioner of the Administration on Children, Youth and Families and has spent his career formulating service delivery innovations and streamlining operations in large government organizations on behalf of children, youth, and families. His commitment to public service is largely motivated by his own success in overcoming great personal hardship during his 11.5 years of growing up in a residential school for disadvantaged children. This experience helped shape his commitment to serve children who lived in foster care and reinforced his belief that dedicated people and well-designed programs can make a dramatic impact on the lives of at-risk youth. As chief of staff for Chicago Public Schools, Mr. Samuels played a leadership role in managing the day-to-day operations of the third largest school system in the nation. Prior to this role, he served as director of the Illinois Department of Children and Family Services, where he moved aggressively to implement comprehensive assessments of all children entering care, redesigned transitional and independent living programs to prepare youth for transitioning to adulthood, created a child location unit to track all runaway youth, and introduced evidence-based services to address the impact of trauma and exposure to violence on children in state care. Mr. Samuels has taught at the University of Chicago's School of Social Service Administration and also has provided technical assistance to state and local governments to improve human service delivery to vulnerable populations.

Kiersten Stewart is director of public policy and advocacy for the Family Violence Prevention Fund and manages its Washington, DC, office. In that capacity she advocates on behalf of abused women and children and works to prevent violence in our homes and communities here and around the world. Prior to joining the fund's Washington, DC, office, she was the chief of staff to U.S. Rep. Maurice Hinchey, handling his legislative work around women's issues, HIV/AIDS, civil rights, immigration, and poverty and managing his successful 1998 campaign.

Cris M. Sullivan, Ph.D., is professor of ecological/community psychology and director of the Violence Against Women Research and Outreach Initiative at Michigan State University (MSU). She also is associate chair of the psychology department and senior fellow of MSU's Office on Outreach and Engagement. In addition to her MSU appointments, Dr. Sullivan is the director of research and evaluation for the Michigan Coalition Against

Domestic and Sexual Violence and senior research advisor to the National Resource Center on Domestic Violence. Dr. Sullivan's areas of research expertise include conducting longitudinal, experimental evaluations of community interventions for abused women and their children; improving the community response to violence against women; and evaluating victim service programs. In addition to consulting for local, state, federal, and international organizations and initiatives, Dr. Sullivan also conducts workshops on effectively advocating in the community for women with abusive partners, and their children; understanding the effects of domestic abuse on women and children over time; improving system responses to the problem of violence against women; and evaluating victim service agencies.

Cheryl Thomas, J.D., is director of the Women's Human Rights Program, a program she founded at the Advocates for Human Rights (formerly Minnesota Advocates for Human Rights) in 1993. Since 1994 Ms. Thomas has traveled throughout Central and Eastern Europe, the former Soviet Union, and Morocco to work with local partners to promote women's human rights. She has provided consultation and training to government officials, legal professionals, and civil society groups in Armenia, Bosnia, Bulgaria, Georgia, Kazakhstan, Lithuania, Morocco, and Tajikistan on best practices in legal reform on violence against women. In 2008 she was selected to be 1 of 15 experts from around the world to participate in a United Nations expert group meeting and publish a report on good practices in legislation on violence against women. In 2009 she participated in a second UN Expert Group Meeting in Ethiopia focused on harmful practices against women, with a report published in 2010 (*Good Practices in Legislation on "Harmful Practices" Against Women*). She has published numerous articles and reports on violence against women as a human rights abuse, most recently a report titled *Sex Trafficking Needs Assessment for the State of Minnesota*. Previously, she was adjunct professor at the University of Minnesota Law School, where she taught women's international human rights, and executive director of WATCH, a court monitoring organization focused on cases of violence against women and children. Ms. Thomas was honored as a 2005 Changemaker by Minnesota Women's Press.

Agnes Tiwari, Ph.D., R.N., is an associate professor and assistant dean of the School of Nursing at Li Ka Shing Faculty of Medicine of the University of Hong Kong. More than a decade ago, Dr. Tiwari set up the first nurse-led health clinic providing health screening and interventions in a shelter for abused women in Hong Kong. To date, not only has the service been extended to more than half of the shelters, but also the health data gathered have provided much-needed information about the needs of Chinese women survivors of intimate partner violence in general and the mental health impact of psychological abuse on Chinese women in particular. Her decade-long

efforts to advocate for abused women, supported by her research program, have influenced the Hong Kong government to set up a territory-wide initiative providing crisis support services to families across Hong Kong, and she has been appointed as an advisor to the initiative. Dr. Tiwari has developed several models of intervention for abused women and evaluated their efficacy to promote resilience and prevent violence using randomized controlled trials. She also has designed and implemented different approaches of service delivery for primary prevention of violence against women and children in prenatal and community settings. Empowerment is a key feature of the models and approaches, which can be adapted to different settings, including those with resource constraints. The results of a recent randomized control trial that Dr. Tiwari led, focusing on advocacy intervention to improve the mental health of community-dwelling abused women, were published in the *Journal of the American Medical Association* (2010).

Monique Widyono, M.P.A., M.S.W., is a program officer for gender, violence, and rights at the Program for Appropriate Technology in Health (PATH). At PATH, she has focused on gender-based violence and developing a framework for understanding femicide. Previously Ms. Widyono was co-executive director of Equality Now, a New York-based women's rights organization, and has been on the staff of the U.N. Division for the Advancement of Women.

Denise Wilson, Ph.D., R.N., is associate professor at Māori Health AUT University and editor-in-chief of *Nursing Praxis* in New Zealand. Additionally, she is a member of the Ministry of Health Family Violence Advisory Committee, Korowai Atawhai Advisory Group, Wharangi Ruamano (Māori Nurse Educators), and the Nursing Network for Violence Against Women International. She is fellow of the College of Nurses Aotearoa (New Zealand) and Te Mata o te Tau (Academy of Maori Research & Scholarship). Dr. Wilson has served as a member of the 1998 Ministerial Taskforce on Nursing, the Nursing Council of New Zealand's Education Advisor, and a board member of Te Rau Puawai. Prior to commencing employment at AUT, Dr. Wilson was senior lecturer in Nursing (Maori Health) at Massey University. Before her academic career, Dr. Wilson was a registered nurse in various acute-care and community settings. She has an extensive background in undergraduate and postgraduate nursing education, teaching in the areas of Māori/indigenous health, nursing practice, research design and methods, cultural safety, and family violence. Dr. Wilson is of Ngati Tahinga Tainui Awhiro and Ngati Porou ki Harataunga descent.

David A. Wolfe, Ph.D., is a psychologist and author specializing in issues affecting children and youth. He holds the inaugural RBC Chair in Children's Mental Health at the Centre for Addiction and Mental Health (CAMH),

where he is head of the Centre for Prevention Science located in London. He also is professor of psychiatry and psychology at the University of Toronto and editor-in-chief of *Child Abuse & Neglect: The International Journal*. His recent book is entitled *Adolescent Risk Behaviors: Why Teens Experiment and Strategies to Keep Them Safe* (Yale University Press, 2006, with Peter Jaffe & Claire Crooks). Dr. Wolfe has broad research and clinical interests in abnormal child and adolescent psychology with a special focus on child abuse, domestic violence, and developmental psychopathology. He has authored numerous articles on these topics, especially in relationship to the impact of early childhood trauma on later development in childhood, adolescence, and early adulthood. Dr. Wolfe has been pioneering new approaches to preventing many societal youth problems such as bullying, relationship violence, and substance abuse. He recently received the Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science from the Canadian Psychological Association, and the Blanche L. Ittleson Award for Outstanding Achievement in the Delivery of Children's Services and the Promotion of Children's Mental Health from the American Orthopsychiatric Association.

Gail Elizabeth Wyatt, Ph.D., a licensed clinical psychologist and a board-certified sex therapist, is professor of psychiatry and biomedical sciences at the Semel Institute for Neuroscience and Behavior at the University of California, Los Angeles (UCLA). For the first 17 years of her career, Dr. Wyatt was the first ethnic minority to receive training as a sexologist. She received a prestigious K award from the National Institute of Mental Health to develop the expertise to develop culturally congruent measures, conceptual frameworks, and interventions to capture sexual decision making among ethnic minority men and women within a socio-cultural framework. She was the first African-American woman in California to receive a license to practice psychology and the first African-American woman Ph.D. in a school of medicine to reach full professor. Dr. Wyatt directs the Sexual Health Program, the National Institutes of Health–funded Phodiso Training Project in South Africa, and the HIV/AIDS Translational Training Program and is associate director of the UCLA CFAR/AIDS Institute. She has been internationally recognized for her work in Jamaica, Africa, India, and, most recently, South Africa where she conducts a longitudinal study of the aftermath of rape among South African women. She has published numerous books and journal articles, including the best-selling book *Stolen Women: Reclaiming our Sexuality Taking Back Our Lives* (John Wiley and Sons, 1997). Dr. Wyatt was instrumental in the Call for a State of Emergency by numerous state, community, and religious organizations to address the AIDS epidemic in black communities and subsequent health and mental health disparities that continue to fuel the virus.

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Planning Committee Biographical Sketches

Jacquelyn C. Campbell, Ph.D., R.N. (*Chair*), is the Anna D. Wolf Chair in Nursing at the Johns Hopkins School of Nursing. Dr. Campbell's research addresses the risk factors for and the evaluation of interventions to prevent domestic violence. She has authored numerous articles on intimate partner violence, violence against women, and adolescent exposure to violence. Dr. Campbell has served on the National Institute of Mental Health Violence and Traumatic Stress Study Section and is a member of the American Academy of Nursing and the Institute of Medicine. She has been selected as the Simon Visiting Scholar at the University of Manchester in the United Kingdom and, most recently, the Institute of Medicine/American Academy of Nursing/American Nursing Foundation Scholar in Residence. Dr. Campbell has been active in the Institute of Medicine as a member of the Board on Global Health and has served as a member of two committees of the Board on Children, Youth, and Families.

Clare Anderson, M.S.W., LICSW, is the deputy commissioner at the Administration on Children, Youth and Families (ACYF). Prior to joining ACYF, she was senior associate at the Center for the Study of Social Policy, where she promoted better outcomes for children, youth, and families through community engagement and child welfare system transformation. Ms. Anderson provided technical assistance through a federally funded child welfare implementation center and to sites implementing community partnerships for protecting children and the Annie E. Casey Foundation's Family to Family Initiative. She also conducted monitoring of and provided support to jurisdictions under court order to improve child welfare systems.

Ms. Anderson previously worked as a direct practice social worker as a member of the Freddie Mac Foundation Child and Adolescent Protection Center at Children's National Medical Center in Washington, DC. She was a consultant to and clinical director at the Baptist Home for Children and Families (now the National Center for Children and Families) in Bethesda, MD, and a member of the clinical faculty at the Georgetown University Medical Center, Department of Psychiatry's Child and Adolescent Services.

Gary Barker, Ph.D., M.P.P., is director of gender, violence, and rights at the International Center for Research on Women (ICRW). In this role, he oversees ICRW's research, policy analyses, and programmatic work to develop solutions that address the underlying causes that lead to violence against women, including the involvement of men and boys. Dr. Barker is a social scientist with more than 15 years of experience researching gender equality, men and masculinities, sexuality, and HIV/AIDS. He also is an expert in exploring the links between men and violence in conflict and post-conflict settings in parts of Latin America, the Caribbean, sub-Saharan Africa, and South Asia. Prior to joining ICRW, Dr. Barker was founding executive director of Instituto Promundo, a nongovernmental organization based in Brazil that works to promote gender equality and reduce violence against children, youth, and women. He also has served as a consultant to the World Bank and many United Nations agencies. Dr. Barker was elected as an Ashoka Fellow in 2007 and awarded an Individual Projects Fellowship from the Open Society Institute. He is a founding co-chair of MenEngage, a global alliance of international organizations that work to engage men and boys to promote gender equality.

Jeffrey Edleson, Ph.D., is professor and director of research at the University of Minnesota School of Social Work and director of the Minnesota Center Against Violence and Abuse. He is one of the world's leading authorities on children exposed to domestic violence and has published more than 100 articles and 10 books on domestic violence, groupwork, and program evaluation. Dr. Edleson is co-author, with the late Susan Schechter, of *Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice* (NCJFCJ, 1999). Better known as the "Greenbook," this best-practices guide has been the subject of six federally funded and numerous other demonstration sites across the country. Dr. Edleson also has conducted intervention research and provided technical assistance to domestic violence programs and research projects across North America as well as in several countries in other parts of the world. Dr. Edleson's research, policy, and practice interests have earlier focused on research on batterer intervention programs. In recent years his work has focused primarily on the impact of adult domestic violence on children

and how social systems respond to these children. Dr. Edleson is an associate editor of the journal *Violence Against Women* and has served on the editorial boards of numerous other journals. He is co-editor of the Oxford University Press book series on interpersonal violence. He is a licensed independent clinical social worker in Minnesota and has practiced in elementary and secondary schools and in several domestic violence agencies.

Claudia García-Moreno, M.D., M.Sc., is a physician from Mexico with more than 25 years of experience in public health spanning Africa, Latin America, and parts of Asia. For the past 15 years her work has focused on women's health and gender in health, including contributing to gender and women's health initiatives at the World Health Organization (WHO). She has led WHO's work on women and HIV/AIDS and on violence against women and coordinated the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women, which includes over 14 countries. She has been involved in setting up several initiatives such as the Sexual Violence Research Initiative. She is on the editorial board of *Reproductive Health Matters* and has published and reviewed papers on women's health for several international journals.

Joanne LaCroix, M.B.A., B.S.W., is manager of the Family Violence Prevention Unit of the Public Health Agency of Canada. Ms. LaCroix's background is in child welfare and family violence. She began her career as a front-line social worker and gradually held a number of supervisory and managerial positions in two of Canada's provinces, Quebec and Ontario. Much of her work as a manager at the provincial level involved building relationships that would foster concerted, coordinated responses to child abuse and family violence. In her current position in the federal government, she builds on the experience she has developed in the field to create and sustain connections among policy makers, researchers, and service providers and to continue to support and move forward the violence prevention agenda. The Public Health Agency of Canada leads and coordinates the federal Family Violence Initiative, a collaboration of 15 departments, agencies, and crown corporations. The initiative promotes public awareness of the risk factors of family violence and the need for public involvement in responding to it; strengthens the capacity of the criminal justice, housing, and health systems to respond; and supports data collection, research, and evaluation efforts to identify effective interventions.

Susan E. Salasin is director of the Trauma and Trauma-Informed Care Program at the Substance Abuse and Mental Health Services Administration (SAMHSA). For the past three decades Ms. Salasin served in federal government positions at the National Institute of Mental Health and at the Center

for Mental Health Services (CMHS) at SAMHSA. Through the SAMHSA Mental Health Transformation Program, she currently chairs the Federal Intergovernmental Committee on Women and Girls and Trauma, which includes more than 30 agencies and sub-agencies. Through CMHS in 2005 she created the National Center for Trauma Informed Care. Previously, she served as founding chair of the World Federation for Mental Health (WFMH) Scientific Committee on the Mental Health Needs of Victims of Violence. For this work she received an award from WFMH. She was co-editor of the book *The Mental Health of Women* (Academic Press, 1980) and editor of *Evaluating Victim Services* (Sage, 1981).

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Forum Member Biographical Sketches

Jacquelyn C. Campbell, Ph.D., R.N. (*Co-chair*), is the Anna D. Wolf Chair in Nursing at the Johns Hopkins School of Nursing. Dr. Campbell's research addresses the risk factors for and the evaluation of interventions to prevent domestic violence. She has authored numerous articles on intimate partner violence, violence against women, and adolescent exposure to violence. Dr. Campbell has served on the National Institute of Mental Health Violence and Traumatic Stress Study Section and is a member of the American Academy of Nursing and the Institute of Medicine. She has been selected as the Simon Visiting Scholar at the University of Manchester in the United Kingdom and, most recently, the Institute of Medicine/American Academy of Nursing/American Nursing Foundation Scholar in Residence. Dr. Campbell has been active in the Institute of Medicine as a member of the Board on Global Health and has served as a member of two committees of the Board on Children, Youth, and Families.

Mark L. Rosenberg, M.D., M.P.P. (*Co-chair*), is executive director of the Task Force for Global Health. Previously, for 20 years, Dr. Rosenberg was at the Centers for Disease Control and Prevention, where he led its work in violence prevention and later became the first permanent director of the National Center for Injury Prevention and Control. He also held the position of the special assistant for behavioral science in the Office of the Deputy Director (HIV/AIDS). Dr. Rosenberg is board certified in both psychiatry and internal medicine with training in public policy. He is on the faculty at Morehouse Medical School, Emory Medical School, and the Rollins School of Public Health at Emory University. Dr. Rosenberg's

research and programmatic interests are concentrated on injury control and violence prevention, HIV/AIDS, and child well-being, with special attention to behavioral sciences, evaluation, and health communications. He has authored more than 120 publications and recently co-authored the book *Real Collaboration: What It Takes for Global Health to Succeed* (University of California Press, 2010). Dr. Rosenberg has received numerous awards including the Surgeon General's Exemplary Service Medal. He is a member of the Institute of Medicine. Dr. Rosenberg's organization, the Task Force for Global Health, participated in the IOM-sponsored workshop Violence Prevention in Low- and Middle Income Countries: Finding a Place on the Global Agenda, and the Task Force remains interested in helping to continue the momentum of the workshop through the Forum on Global Violence Prevention. The Task Force is heavily involved in the delivery of a number of global health programs and sees many ways that interpersonal violence and conflict exacerbate serious health problems and inequities.

Clare Anderson, M.S.W., LICSW, is the deputy commissioner at the Administration on Children, Youth and Families (ACYF). Prior to joining ACYF, she was senior associate at the Center for the Study of Social Policy, where she promoted better outcomes for children, youth, and families through community engagement and child welfare system transformation. Ms. Anderson provided technical assistance through a federally funded child welfare implementation center and to sites implementing community partnerships for protecting children and the Annie E. Casey Foundation's Family to Family Initiative. She also conducted monitoring of and provided support to jurisdictions under court order to improve child welfare systems. Ms. Anderson previously worked as a direct practice social worker as a member of the Freddie Mac Foundation Child and Adolescent Protection Center at Children's National Medical Center in Washington, DC. She was a consultant to and clinical director at the Baptist Home for Children and Families (now the National Center for Children and Families) in Bethesda, MD, and a member of the clinical faculty at the Georgetown University Medical Center, Department of Psychiatry's Child and Adolescent Services.

Frances E. Ashe-Goins, R.N., M.P.H., a registered nurse and policy analyst, is acting director of the Office of Women's Health at the U.S. Department of Health and Human Services. Formerly, as deputy director and director of the Division of Policy and Program Development, she was responsible for numerous women's health issues, including HIV/AIDS, domestic violence, rape/sexual assault, lupus, diabetes, organ/tissue donation, minority women's health, international health, female genital cutting, mental health, homelessness, and young women's health. Mrs. Ashe-Goines also coordinated the regional women's health coordinators programs. She has written

numerous articles, appeared on radio and television programs, been featured in magazine and newspaper articles, made presentations at national and international conferences and workshops, and received many awards and commendations. She is a featured author of a chapter on domestic violence in the book, *Policy and Politics in Nursing and Health Care, 4th edition.*

Katrina Baum, Ph.D., is division director of the Violence and Victimization Research Division at the National Institute of Justice. Dr. Baum most recently was senior statistician at the Bureau of Justice Statistics, where she worked on the National Crime Victimization Survey. Her tenure there included research on juvenile victims, college students, school crime, and groundbreaking studies on identity theft and stalking. Her reports have been cited in the *New York Times* and other major newspapers, and she has appeared on a local television affiliate. Prior to joining the U.S. Department of Justice, Dr. Baum managed a variety of research projects in criminal justice. While working at the Cartographic Modeling Lab in Philadelphia, she developed the Firearms Analysis System, which is a geographic information system used to track firearm-related injuries using data from the Philadelphia Police Department and the National Tracing Center of the Bureau of Alcohol, Tobacco, Firearms and Explosives. She also served as the local evaluator for Weed & Seed and Safe Schools/Healthy Students grants.

Susan Bissell, Ph.D., serves as chief of child protection of the Programme Division at UNICEF. She previously worked on issues concerning education and children in especially difficult circumstances with UNICEF Sri Lanka and UNICEF in Bangladesh, where she also focused on child labor. Dr. Bissell has managed a number of reports, including a 62-country study on the implementation of the general measures of the UN Convention on the Rights of the Child and global research on the Palermo Protocol and child trafficking. As member of the editorial board of the report of the UN Secretary General's Study on Violence Against Children, which was released in 2006, she has also been involved in follow-up activities that will advance the implementation of the recommendations of the study. She has contributed to several articles on children's rights, including "Promotion of Children's Rights and Prevention of Child Maltreatment" (2009) and "Overview and Implementation of the UN Convention on the Rights of the Child" (2006), both of which were published in *The Lancet*.

Arturo Cervantes Trejo, M.D., M.P.H., Dr.P.H., serves as technical secretary of the National Council for Injury Prevention and general director of the National Center for Injury Prevention with the Mexican Ministry of Health. He also holds the Carlos Peralta Quintero Chair of Public Health

at the Faculty of Medicine of Anahuac University in Mexico. He is board certified by the National Council of Public Health in Mexico and is a member of the charter class of the National Board of Public Health Examiners in the United States. As head of the National Center for Injury Prevention, Dr. Cervantes has co-authored the National Specific Action Program for Road Safety and the National Specific Action Program for Violence Prevention as well as numerous analyses of morbidity and mortality from external causes of injury. Currently, he participates in the presidential task force Todos Somos Juárez, which is developing a strategy for violence prevention and social development for the city of Ciudad Juárez Chihuahua. Todos Somos Juárez is led by the federal government with the participation of the government of the state of Chihuahua, the municipal government of Juárez, and the city's civil society. The strategy includes 160 policy actions in health, labor, education, culture, economic, and security areas undertaken to address the underlying social and economic issues that fuel crime and insecurity in Ciudad Juárez, Mexico's eighth largest city and the most populous city on the Mexico–United States border.

XinQi Dong, M.D., M.P.H., is associate professor of medicine, behavioral sciences, and nursing at the Rush University Medical Center. Dr. Dong's research is focused on the epidemiological studies of elder abuse and neglect, both in the United States and China, with particular emphasis on its adverse health outcomes across different racial/ethnic groups. Dr. Dong is a recipient of the Paul B. Beeson Scholar in Aging Award, and his work has been recognized by the American Geriatric Society, American Public Health Association, and the Institute of Medicine of Chicago. He was awarded the Nobuo Maeda International Aging and Public Health Research Award and the Central Society for Clinical Research Award. He was the first geriatrician to be the recipient of the national Physician Advocacy Merit Award by the Institute of Medicine as a Profession (IMAP). Through culturally and linguistically appropriate ways, Dr. Dong actively works with the Chinese communities to promote understanding and civic engagement on the issues of elder abuse and neglect. He currently serves on the board of directors for the Chinese American Service League, the largest social services organization in the Midwest serving the needs of Chinese population.

Amie Gianino, M.S., is the representative of Anheuser-Busch InBev (ABI) to the Global Violence Prevention Forum. Ms. Gianino, the senior global director for the company's Better World efforts, began her career with the company in 1989. Evidence suggests that cultural factors play a strong role in determining whether and how violence manifests in a country's population. Individual factors, such as personality type, are also important predictors of violent behavior. Still, some posit that alcohol may be a cause

of violent behavior. As the world's largest brewer— and as the beer industry leader in social responsibility—ABI is especially interested in the dialogue surrounding the intersection of alcohol and violence. The company believes that measures to change negative cultural norms relating to violence and other risky behaviors are important goals. To this end, ABI has been supporting social norms initiatives for more than 10 years in the United States and Europe, with plans for further work in China and Latin America. ABI has also supported the Alcohol Medical Scholars Program (AMSP) since 1997. The AMSP helps train physicians to teach others in the medical community how to better diagnose and treat alcohol dependency issues. In addition, ABI has supported domestic violence prevention initiatives.

Kathy Greenlee, J.D., was appointed by President Obama as the fourth assistant secretary for aging at the Administration on Aging (AoA) within the U.S. Department of Health and Human Services and confirmed by the Senate in June 2009. Ms. Greenlee brings more than 10 years of experience advancing the health and independence of older persons and their families and advocating for the rights of older persons. AoA is mandated by the Older Americans Act (OAA) to be the focal point and lead advocacy agency for older persons and their concerns at the federal level. AoA's vision for older people, embodied in the OAA, is based on the value that dignity is inherent to all individuals and the belief that older people should have the opportunity to fully participate in all aspects of society and community life; be able to maintain their health and independence; and be free from violence, abuse, neglect, and exploitation. AoA works with its partners at the federal, state, and community levels to help strengthen the nation's capacity to promote the dignity and independence of older people. AoA works to stimulate programmatic and policy activity at the national, state, and local levels in order to advance the work of eliminating violence against older adults and elder abuse, neglect, and exploitation in the United States as well as with international organizations and researchers around the world. By doing so, AoA seeks to address the social, economic, and health impacts of violence against older adults and elder abuse, neglect, and exploitation.

Rodrigo V. Guerrero, M.D., Dr.P.H., serves as city counselor of Cali, Colombia. Previously, he has held the posts of professor, department head, dean of health sciences, and president at Universidad del Valle in Colombia, and he was mayor of Cali, Colombia. As mayor, Dr. Guerrero developed an epidemiological approach to urban violence prevention through the Program DESEPAZ, which has been successfully applied in several cities of Colombia and in other countries. After leaving the mayoral post, he joined the Pan American Health Organization in Washington, DC, where he started the Violence Prevention Program. Dr. Guerrero has written

numerous articles on youth violence and violence as a health issue. In addtion to his current post as city counselor, Dr. Guerrero dedicates his time to Vallenpaz, a nonprofit organization devoted to helping rural communities in conflict-ridden areas of Colombia. He is a member of CISALVA, the Violence Research Center of Universidad del Valle, and the Institute of Medicine.

John R. Hayes, M.D., is the global strategy leader for neuroscience medical affairs at Eli Lilly and Company. Before assuming his current position, Dr. Hayes served as vice president for Lilly Research Laboratories. Lilly has done extensive research into areas of suicidality and harmful behavior in the context of mental disorders and has provided significant support for independent research as well as professional and public education about these important and often controversial public health issues. Previously Dr. Hayes has held faculty positions at Texas A&M University and the Indiana University School of Medicine and was president of St. Vincent Hospitals and Health Systems and chief executive officer of Seton Health of Indiana. Dr. Hayes was chairman of the board of the Indiana Health Industry Forum and has served on the boards of 5 for-profit and 12 not-for-profit institutions. He has been president of the Academy of Psychosomatic Medicine and a director on the American Board of Family Medicine and of the American Psychiatric Foundation, and he is a Distinguished Life Fellow of the American Psychiatric Association. He has won national teaching awards, authored scientific publications, and served as visiting faculty at numerous medical institutions globally over the course of his career.

David Hemenway, Ph.D., is an economist and professor at Harvard School of Public Health (HSPH) and a James Marsh Visiting Professor-at-Large at the University of Vermont. Additionally, he is director of the Harvard Injury Control Research Center and the Youth Violence Prevention Center. He was president of the Society for the Advancement of Violence and Injury Research and in 2007 received the Excellence in Science award from the injury section of the American Public Health Association. He has received fellowships from the Pew, Soros, and Robert Wood Johnson foundations. Dr. Hemenway has written more than 150 journal articles and is sole author of five books. Recent books include *Private Guns Public Health* (University of Michigan Press, 2006) and *While We Were Sleeping: Success Stories in Injury and Violence Prevention* (University of California Press, 2009). Dr. Hemenway has received 10 HSPH teaching awards.

Frances Henry, M.B.A., serves as advisor to the F Felix Foundation. Previously, from 2005 to 2009, she created and directed Global Violence Prevention, a project that advanced the science-based prevention of violence in

low- and middle-income countries through a coalition of U.S. researchers and practitioners. Based on her experiences of childhood sexual abuse, she founded and for 13 years directed Stop It Now!, an organization dedicated to preventing the sexual abuse of children. She is author of *Vaccines for Violence*, a set of five essays exploring how she learned to counter violence by dealing with fear, by balancing accountability and compassion, and by increasing her capacity to connect to others. Ms. Henry's previous work includes owning a management consulting company and directing presidential and gubernatorial commissions for women. She served as staff for the U.S. Commission on International Women's Year.

Mercedes S. Hinton, Ph.D., is a program officer for the Initiative on Confronting Violent Crime at the Open Society Foundations (OSF), where she directs the program's Central America work. Previously, she worked as a consultant for the World Bank's conflict, crime, and violence team and served for seven years on the faculty of the London School of Economics in the United Kingdom. Dr. Hinton is a prize-winning author of a number of books and publications in the area of policing and democratization in the developing world. She is fluent in English, French, Portuguese, and Spanish. Her books include *Policing Developing Democracies* (Routledge, 2009; co-edited with Tim Newburn) and *The State on the Streets: Police and Politics in Argentina and Brazil* (Lynne Rienner Publishers, 2006), which was awarded the British Society for Criminology's prize for best book of 2006.

Larke Nahme Huang, Ph.D., a licensed clinical–community psychologist, is senior advisor to the administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) at the U.S. Department of Health and Human Services. In this position she provides leadership on national policy for mental health and substance use issues for children, adolescents, and families. She is also the agency lead on issues of behavioral health equity and eliminating disparities and for the administrator's Strategic Initiative on Trauma and Justice. In 2009 she did a six-month leadership exchange at the Centers for Disease Control and Prevention, where she was a senior advisor on mental health. For the past 25 years Dr. Huang has worked at the interface of practice, research, and policy. She has assumed multiple leadership roles dedicated to improving the lives of children, families, and communities. She has been a community mental health practitioner; a faculty member at the University of California, Berkeley and Georgetown University; and a research director at the American Institutes for Research. She has worked with states and communities to build systems of care for children with serious emotional and behavioral disorders. She has developed programs for underserved, culturally and linguistically diverse youth; evaluated community-based programs; and authored books

and articles on children's behavioral health and transforming systems and services. Her publications include "Advancing Efforts to Improve Children's Mental Health in America" (*Administration and Policy in Mental Health,* 2010) and *Children of Color: Psychological Interventions with Culturally Diverse Youth* (Jossey-Bass, 2003). In 2003 Dr. Huang served as an appointed commissioner on the President's New Freedom Commission on Mental Health.

L. Rowell Huesmann, Ph.D., M.S., is the Amos N. Tversky Collegiate Professor of Psychology and Communication Studies and director of the Research Center for Group Dynamics at the University of Michigan's Institute for Social Research. He is also editor of the journal *Aggressive Behavior* and past president of the *International Society for Research on Aggression*. His research over the past 40 years has focused on the psychological foundations of aggressive and violent behavior and on how predisposing personal factors interact with precipitating situational factors to engender violent behavior. This research has included several life span longitudinal studies showing how the roots of aggressive behavior are often established in childhood. One particular interest has been investigating how children learn through imitation and how children's exposure to violence in the family, schools, community, and mass media stimulates the development of their own aggressive and violent behavior over time. He has conducted longitudinal studies on the effects of exposure to violence at multiple sites in the United States as well as in Finland, Poland, Israel, and Palestine. These studies have shown that simply seeing a lot of violence (political violence, family violence, community violence, media violence) in childhood changes children's thinking and perceptions and increases the risk of interpersonal aggressive behavior later in life. He has also conducted research showing that interventions that change children's beliefs about the appropriateness of conflict and aggression can be effective in preventing aggression. In 2005 Dr. Huesmann was the recipient of the American Psychological Association's award for distinguished lifetime contributions to media psychology.

Kevin Jennings, M.A., M.B.A., is assistant deputy secretary for the Office of Safe and Drug-Free Schools at the U.S. Department of Education. Previously he was a high school history teacher, first at Moses Brown School in Providence, RI, and then at Concord Academy in Concord, MA, where he was chair of the history department. In 1995 Mr. Jennings left teaching to be the founding executive director of the Gay, Lesbian, and Straight Education Network (GLSEN), a national education organization working to make schools safe for lesbian, gay, bisexual, and transgender students, staff, and families. He held the position of executive director at GLSEN until 2008. Among his awards are the Distinguished Service Award of the

National Association of Secondary School Principals and the Human and Civil Rights Award of the National Education Association. He is the author of six books, the most recent of which—*Mama's Boy, Preacher's Son*—was named a book of honor by the American Library Association in 2007.

Carol M. Kurzig is president of the Avon Foundation for Women. Previously, she was president of the National Multiple Sclerosis Society's New York City chapter and director of public services and assistant to the president at the Foundation Center. She was a director and served as board chairman of the Support Center for Nonprofit Management and currently serves as a vice chairman of the Nonprofit Coordinating Committee Board of Directors. The Avon Foundation for Women was created in 1955 to "improve the lives of women" and is now the leading corporate-affiliated global philanthropy dedicated to women. Through 2009 Avon global philanthropy raised and awarded more than $725 million, all of which focused on women and their families (primarily for breast cancer, domestic violence, and emergency and disaster relief). Avon currently supports breast cancer and domestic violence programs in more than 50 countries. The foundation's grant-making programs include the Avon Breast Cancer Crusade, with goals to accelerate research and ensure access to care; women's empowerment programs, with an emphasis on domestic violence through its Speak Out Against Domestic Violence program; and special programs in response to national and international emergencies. Its extensive fundraising programs include the nine-city Avon Walk for Breast Cancer series and special events to raise awareness and funds for gender violence programs.

Joanne LaCroix, M.B.A., B.S.W., is manager of the Family Violence Prevention Unit of the Public Health Agency of Canada. Ms. LaCroix's background is in child welfare and family violence. She began her career as a front-line social worker and gradually held a number of supervisory and managerial positions in two of Canada's provinces, Quebec and Ontario. Much of her work as a manager at the provincial level involved building relationships that would foster concerted, coordinated responses to child abuse and family violence. In her current position in the federal government, she builds on the experience she has developed in the field to create and sustain connections among policy makers, researchers, and service providers and to continue to support and move forward the violence prevention agenda. The Public Health Agency of Canada leads and coordinates the federal Family Violence Initiative, a collaboration of 15 departments, agencies, and crown corporations. The initiative promotes public awareness of the risk factors of family violence and the need for public involvement in responding to it; strengthens the capacity of the criminal justice, housing,

and health systems to respond; and supports data collection, research, and evaluation efforts to identify effective interventions.

Jacqueline Lloyd, Ph.D., M.S.W., is a health scientist administrator in the Prevention Research Branch in the Division of Epidemiology, Services, and Prevention Research at the National Institute on Drug Abuse (NIDA) within the National Institutes of Health. Her program areas at NIDA include screening and brief interventions, youth at risk for HIV/AIDS, environmental interventions, peer interventions, women and gender research, and health communications research. Prior to joining the staff at NIDA, Dr. Lloyd held faculty positions at Temple University in the School of Social Administration and at the University of Maryland at Baltimore in the School of Social Work. She has taught courses in research methods, health, and mental health human behavior theory. Her own research activities have included evaluation of a community-based youth prevention program; investigation of HIV risk behaviors and substance use among youth; and investigation of the role of family, peer, and social network contextual factors on risk behaviors and treatment outcomes among youth and injecting drug users. Her many publications include "HIV Risk Behaviors: Risky Sexual Activities and Needle Use Among Adolescents in Substance Abuse Treatment" (*AIDS and Behavior,* 2010) and "The Relationship between Lifetime Abuse and Suicidal Ideation in a Sample of Injection Drug Users" (*Journal of Psychoactive Drugs,* 2007).

Brigid McCaw, M.D., M.S., M.P.H., FACP, is medical director for the Family Violence Prevention Program at Kaiser Permanente (KP). Her teaching, research, and publications focus on developing a health systems response to intimate partner violence and the impact of intimate partner violence on health status and mental health. She is a fellow of the American College of Physicians. Kaiser Permanente, a large nonprofit integrated health care organization serving 8.6 million members in nine states and the District of Columbia, has implemented one of the most comprehensive health care responses to domestic violence in the United States. The nationally recognized "systems model" approach is available across the continuum of care, including outpatient, emergency, and inpatient care; advice and call centers; and chronic care programs. The electronic medical record includes clinician tools to facilitate recognition, referrals, resources, and follow-up for patients experiencing domestic violence and provides data for quality improvement measures. Over the past decade, identification of domestic violence has increased fivefold, with most members identified in the ambulatory rather than acute-care settings. The majority of identified patients receive follow-up mental health services. Kaiser Permanente also provides prevention, outreach, and domestic violence resources for its workforce.

Violence prevention is an important focus for KP community benefit investments and research studies. The KP program, under the leadership of Dr. McCaw, has received several national awards.

James A. Mercy, Ph.D., is special advisor for strategic directions at the Division of Violence Prevention in the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (CDC). He began working at CDC in a newly formed activity to examine violence as a public health problem and, over the past two decades, has helped to develop the public health approach to violence and has conducted and overseen numerous studies of the epidemiology of youth suicide, family violence, homicide, and firearm injuries. Dr. Mercy also served as a co-editor of the *World Report on Violence and Health* prepared by the World Health Organization and served on the editorial board of the United Nation's Secretary General's Study of Violence Against Children. Most recently he's been working on a global partnership with UNICEF, the President's Emergency Plan for AIDS Relief, World Health Organization, and others to end sexual violence against girls. His recent publications include "Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, and Young Adult Intimate Partner Violence" (*Archives of General Psychiatry,* 2010) and "Sexual Violence and Its Health Consequences for Female Children in Swaziland: A Cluster Survey Study" (*Lancet,* 2009).

Peggy Murray, Ph.D., M.S.W., is senior advisor for the Institute on Alcohol Abuse and Alcoholism (IAAA) at the National Institutes of Health and is responsible for the institute's research translation initiatives in health professions education. She also serves as an adjunct professor at the Catholic University School of Social Work. She is co-author of A Medical Education Model for the Prevention and Treatment of Alcohol-Use Disorders, a 20-module curriculum and faculty development course for medical school faculty in the primary-care specialties. The model has been translated into five languages and implemented in eight countries to date. The relationship of alcohol misuse to aggressive behavior and violence is a complex one, and research has shown that this relationship is more than associative. In addition to alcohol misuse promoting aggressive behavior, victimization as a result of violence can lead to excessive alcohol consumption. Strategies to prevent violence must take this into account and, to be effective, must deal with the alcohol use of both the perpetrators and victims of violence. Alcohol affects the brain and behavior at many levels from the cell to the brain to the individual as a whole, to particular neighborhoods and micro cultures, to the global society. For more than 20 years, Dr. Murray has worked at the IAAA in positions that have led to collaboration with scientists across all of its divisions and offices. She hopes to bring a broad perspective on alcohol misuse to the identification of effective approaches to global violence prevention.

Michael Phillips, M.D., M.P.H., is currently director of the Suicide Research and Prevention Center of the Shanghai Mental Health Center, executive director of the World Health Organization (WHO) Collaborating Center for Research and Training in Suicide Prevention at Beijing Hui Long Guan Hospital, professor of psychiatry and global health at Emory University, professor of clinical psychiatry and clinical epidemiology at Columbia University, vice chairperson of the Chinese Society for Injury Prevention and Control, and treasurer of the International Association for Suicide Prevention. He is currently the principal investigator on a number of multicenter collaborative projects on suicide, depression, and schizophrenia. His recent publications include "Repetition of Suicide Attempts: Data from Emergency Care Settings in Five Culturally Different Low- and Middle-Income Countries Participating in the WHO SUPRE-MISS Study" (*Crisis*, 2010) and "Nonfatal Suicidal Behavior among Chinese Women Who Have Been Physically Abused by their Male Intimate Partners" (*Suicide and Life-Threatening Behavior*, 2009). Dr. Phillips is a Canadian citizen who has been a permanent resident of China for more than 25 years. He runs a number of research training courses each year; supervises Chinese and foreign graduate students; helps coordinate WHO mental health activities in China; promotes increased awareness of the importance of addressing China's huge suicide problem; and advocates improving the quality, comprehensiveness, and access to mental health services around the country.

Colleen Scanlon, R.N., J.D., has been senior vice president of advocacy at Catholic Health Initiatives in Denver, CO, since 1997. In this role Ms. Scanlon directs the development and integration of a comprehensive advocacy program within one of the largest Catholic health care systems in the country. Previously she was director of the American Nurses Association Center for Ethics and Human Rights in Washington, DC, and a clinical scholar in the Center for Clinical Bioethics at Georgetown University Medical Center. Ms. Scanlon's background includes a variety of clinical positions in palliative care, oncology, psychiatric care, and home health care nursing. She has been involved in the development of educational monographs and videos and co-authored a book entitled *Managing Genetic Information: Implications for Nursing Practice* (American Nurses Association, 1995). She is currently chair of the Catholic Health Association Board of Trustees and serves on the Board of Visitors of Georgetown University School of Nursing and Health Studies and the Catholic Medical Mission Board. She has received several awards, including an Honorary Doctorate and Distinguished Alumna Award from Georgetown University, the Mara Mogensen Flaherty Award from the Oncology Nursing Society, and the American Cancer Society Lane Adams Award.

Kristin Schubert, M.P.H., is a program officer for the Vulnerable Populations Portfolio at the Robert Wood Johnson Foundation. This Portfolio invests in ideas that have the potential to represent fundamental breakthroughs in the circumstances that affect vulnerable people. As a program officer, Ms. Schubert's chief responsibility is to create and manage scalable initiatives that recognize the critical relationship between health and where a person lives, works, learns, and plays. Her portfolio focuses on improving the health and well-being of vulnerable children, particularly adolescents, across a multitude of issues and systems, such as violence and juvenile justice. **Ms.** Schubert came to the Foundation in 2000 from Yale University, where she was a policy analyst for a Centers for Disease Control and Prevention–funded prevention research center. Her work focused on eliminating barriers to health among racial and ethnic groups and improving the health of adolescents. Earlier in her career she worked at Memorial Sloan-Kettering Cancer Center in New York City as a molecular biologist. Ms. Schubert holds an M.P.H. in health policy and administration from Yale University and a B.S. in molecular biology from Lehigh University.

Evelyn Tomaszewski, M.S.W., is a senior policy advisor within the Human Rights and International Affairs Division of the National Association of Social Workers (NASW), where she is responsible for implementation of the NASW HIV/AIDS Spectrum Project. This project addresses a range of health and behavioral health issues with a focus on HIV/AIDS and co-occurring chronic illnesses. Ms. Tomaszewski promotes the NASW Global HIV/AIDS Initiative through collaboration with domestic and international groups and agencies, most recently, completing a capacity and training needs assessment addressing the social work workforce, volunteers, and psycho-social care providers in collaboration with FHI—Ethiopia and Physicians for Peace. She staffs the National Committee on Lesbian, Gay, Bisexual, and Transgender Issues and the International Committee, and she previously staffed the Women's Issues Committee. She has expertise in policy analysis and implementation addressing gender equity, violence prevention, and early intervention; the connection of gender, equity, and risk for HIV/AIDS and other sexually transmitted infections; and public health approaches to interpersonal violence and community health. Ms. Tomaszewski has more than two decades of social work experience as a counselor, community organizer, educator/trainer, and administrator.

Elizabeth Ward, M.B.B.S., M.Sc., is a medical epidemiologist with years of public health experience in the Jamaican government health system. Dr. Ward is a consultant at the Institute of Public Safety and Justice at the University of the West Indies and chair of the board of directors of the Violence

Prevention Alliance Jamaica. She was formerly the director of disease prevention and control of the Health Promotion and Protection Division in the Ministry of Health. She has coordinated program development, research, and data analysis and has been responsible for disease prevention and control. She spearheaded the development of the Jamaica Injury Surveillance System, which tracks hospital-based injuries island-wide. Additionally, Dr. Ward has contributed to the development of Jamician government policies as a task force member for the National Security Strategy for Safe Schools and as a member of the working groups for the security component of the National Development Plan, the National Strategic Plan for Children and Violence, and the Strategic Plan for Health Lifestyles.