Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting May 2–3, 2007

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1. Introduction

For more than a decade intimate-partner violence and sexual violence against women have been recognized as major global public health problems, as well as serious human rights abuses. The impact of these forms of violence on acute and long-term health and well-being has been documented in publications such as WHO's *World report on violence and health* (Krug et al., 2002), the WHO *Multi-country study on women's health and domestic violence against women* (Garcia-Moreno et al., 2005), and various other population-based studies. Intimate-partner violence and sexual violence have a damaging impact on physical, mental and reproductive and sexual health, with consequences such as physical injuries, depression, post-traumatic stress disorder, suicide attempts, substance abuse, unwanted pregnancy, gynaecological disorders, sexually transmitted infections, increased HIV/AIDS risk, and others.

Intimate-partner violence, sometimes called domestic violence or spouse abuse, includes acts of physical aggression, sexual coercion, psychological/emotional abuse and controlling behaviours by a current or former partner or spouse (Heise & Garcia-Moreno, 2002). It can happen within marriage, long-term partnerships or short-term intimate relationships, and can be perpetrated by ex-partners when these relationships have ended. It has been documented as largely perpetrated by men against women, although such violence also occurs in same-sex couples and can be perpetrated by women against men. As a category of interpersonal violence, intimate-partner violence includes dating violence that occurs among young people, although the pattern of such violence may be different to that experienced in the context of long-term partnerships, and studies often examine the two issues separately.

Sexual violence occurs both within intimate partnerships and outside them. It has a significant impact on both girls and boys, although among adults women are at substantially greater risk of victimization than men. Sexually violent acts can be perpetrated by intimate partners, family members, friends, acquaintances, authority figures such as teachers or clergy, or strangers. In most communities however intimate partners and people known to the victim are by far the most common category of perpetrator. Sexual violence takes different forms over the lifecourse, from child sexual abuse to forced sexual initiation to sexual coercion within and outside intimate relationships.

Box 1.
Definitions from the *World report on violence and health*

Intimate partner violence: Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.

Sexual violence: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.

Source: Heise & Garcia-Moreno, 2002; Jewkes et al., 2002

There is no estimate of the global prevalence of either intimate-partner violence or sexual violence. Estimates vary by country, and according to study methodology (i.e. how these types of violence are measured), and which behaviours or experiences are included in the prevalence estimate. For example, estimates of the prevalence of intimate-partner violence based on physical abuse alone, miss important dimensions of intimate partner violence, and thus are lower than estimates that also include sexual and psychological abuse (Garcia-Moreno et al., 2005). Population-based studies from various countries indicate that between 10% and 69% of women report that an intimate partner has physically abused them at least once in their lifetime (Heise et al., 1999; Heise & Garcia-Moreno, 2002), and between 6% and 47% of women report attempted or completed forced sex by an intimate partner in their lifetime (Jewkes et al., 2002). According to international crime victimization surveys, between 0.8% and 8% of women aged 16 years and older report having experienced sexual assault in the previous five years (Jewkes et al., 2002).

Population-based studies indicate that young people—both girls and boys—experience significant levels of sexual coercion (Pinheiro 2006); studies of forced sexual initiation, for example, have found that between 7% and 48% of adolescent girls and between 0.2% and 32% of adolescent boys report that their first experience of sexual intercourse was forced (Jewkes et al., 2002). In fact a growing body of research suggests that the younger the age of sexual debut, the more likely it is that the first sexual experience is coerced (Dickson et al., 1998; Erulkar, 2004; Koenig et al., 2004; Garcia-Moreno et al., 2005).

WHO's *Multi-country study on women's health and domestic violence against women* supports the findings of other research that the prevalence of intimate-partner violence and sexual violence varies widely between and within countries and is disturbingly high in many places (Garcia-Moreno et al., 2005). This variance was found even after controlling for methodological comparability across sites, indicating that the variance was real and not simply the result of methodological differences. Based on interviews with more than 24 000 women from rural and urban areas in 10 countries, the study found that:

- Across the different study sites, between 13% and 61% of ever-partnered women reported physical abuse by a partner at some point during their lives, with results from most study sites falling between 23% and 49%.
- Lifetime prevalence of sexual violence by an intimate partner ranged from 6% to 59%, with the prevalence in the majority of study sites falling between 10% and 50%.
- Prevalence of sexual violence by a non-partner in those older than 15 years ranged from 1% to 12%.
- Prevalence of sexual abuse in those younger than 15 years ranged from 1% to 21%.

In recent years the findings of high levels of victimization of men by their intimate partners, in some industrialized countries, has resulted in a demand for an increased focus on male victims. Some studies, particularly among samples of students and couples in dating relationships, in high-income countries have found that a significant proportion of men experience physical aggression and violence from their intimate partners, some of which results in physical injury (Archer 2002; Straus in press). The high levels of men's victimization found in these studies, however, are not typical of the pattern of intimate-partner violence seen in low- and middle-income countries where women's status remains low. Rather cross-sectional studies show that higher levels of female intimate partner violence victimization are found in countries with less

gender equality, and higher levels of male intimate partner violence victimization in countries with greater gender equality (Archer, 2006). Furthermore, while sexual violence also appears to be predominantly perpetrated by males against females, there is growing evidence that boys and men are also victims of rape by other men. This needs to be studied more. While the situation of male victims is a concern, it is appropriate to retain policy and programme emphasis on intimate-partner violence and sexual violence against women in countries with lower levels of gender equality.

This paper explores what can be done to prevent violence against adolescent and adult women that occurs within intimate relationships, and sexual violence that occurs outside intimate relationships. While recognizing the high prevalence of child sexual abuse throughout the world, its impact on health and development, and the importance of child sexual abuse prevention for its own sake, this paper examines the prevention of child sexual abuse as a strategy for reducing involvement in and exposure to intimate partner violence and sexual violence during adolescence and adulthood.

1.1 What do we mean by primary prevention?

In a public health framework, primary prevention means reducing the number of new instances of intimate-partner violence or sexual violence by intervening before any violence occurs. The impact of primary prevention is measured at population level by comparing the frequency with which either victimization or perpetration occurs. This approach contrasts with other prevention efforts that seek to reduce the harmful consequences of an act of violence after it has occurred, or to prevent further acts of violence from occurring once violence has been identified. Primary prevention relies on identification of the underlying, or "upstream", risk and protective factors for intimate-partner violence and/or sexual violence, and action to address those factors. Its aim is to reduce rates of intimate partner violence and sexual violence.

The meaning of taking action "upstream" is illustrated by a scenario commonly taught in public health courses.[1] Some people are fishing on the riverbank. Suddenly they see a person swept by in the current, half-drowned and struggling to stay afloat and swim to shore. They wade into the water and grab hold of the person, who continues on her way by land once she has caught her breath and dried off a bit. Just as they get her to shore they see another person in trouble or hear a cry for help. All afternoon they continue saving people from drowning by pulling them out of the river, until someone decides to walk upstream to find out what is causing people to be swept away in the river in the first place. Taking action upstream to prevent intimate partner violence and sexual violence involves understanding and intervening against those factors that place people at risk for becoming victims and perpetrators of such violence.

One does not have to look far to find women struggling in the river of intimate partner violence and sexual violence. Advocates and activists from the women's movement have fought long and hard to gain recognition for these women and to establish their right to recognition, assistance, and justice. Their labour has placed violence against women on the international agenda and generated political will to address it. Without their efforts there would be no opportunity to contemplate primary prevention. The upstream approach does not mean discounting the

[1] The US CDC has applied this scenario to sexual violence in the publication *Sexual violence prevention: beginning the dialogue*.

importance of downstream interventions that occur "on the riverbank". The choice is not between primary prevention **or** interventions to assist survivors—both are needed. This paper gives particular emphasis to the primary prevention approach because it has received comparatively little attention, investment, and commitment internationally.

Several approaches commonly understood to be intimate partner violence and sexual violence prevention strategies do not fall under primary prevention as understood here, including working with known perpetrators to stop their use of violence, safety planning for women living in situations of ongoing violence, shelters for abused women, and risk reduction or self-defence strategies intended to prevent the completion of an act of violence. These approaches would be considered secondary and tertiary prevention in public health terminology. Unless otherwise stated, use of the term *prevention* in this paper refers exclusively to primary prevention.

Prevention approaches for intimate partner violence and sexual violence are not limited to programmes or policies whose stated objective is to reduce these forms of violence. Structural and policy approaches to improve gender equality are likely to have effects on rates of intimate partner violence and sexual violence, although their impact is not yet well understood and needs to have stronger scientific evidence. A broad understanding of approaches to the prevention of intimate partner violence and sexual violence requires examination of factors over the life course, as well as beyond the individual, which can be modified to result in less intimate partner violence and sexual violence (see section 2.1. on risk factors and the ecological model). For example, reductions in intimate partner violence and sexual violence may result from policy interventions to reduce alcohol-related harm, or early childhood strategies to prevent child maltreatment and promote healthy development.

1.2 A global picture of intimate-partner violence–sexual violence prevention

International responses to intimate partner violence and sexual violence against women have been grounded mainly in the human rights framework, which understands the pervasiveness of violence against women to be an obstacle to equality, development, and women's full enjoyment of their fundamental rights and freedoms (Beijing Declaration paragraph 112, 1995). A variety of international instruments and agencies provide a mandate for taking action to end violence against women. The call for prevention is not absent among them:

- The United Nations Declaration on the Elimination of Violence against Women calls on States to exercise due diligence to, among other things, prevent acts of violence against women whether they are perpetrated by the State or private actors (Article 4.c), and to develop comprehensive preventive approaches (Article 4.f).
- The Beijing Declaration and Platform for Action calls on States to take integrated measures to prevent and eliminate violence against women (Strategic objective D.1), and specifically to exercise due diligence to prevent acts of violence against women (124.b), to adopt, implement and review legislation to ensure its effectiveness in ending violence against women—emphasizing prevention (124.d), and to adopt measures to modify social and cultural patterns of conduct of men and women (124.k).
- United Nations General Assembly Resolution 61/143 - in response to the Secretary-General's in-depth study on all forms of violence against women (United Nations, 2006) - urges States to take positive measures to address structural causes of violence against women and to strengthen prevention efforts that address discriminatory practices and

social norms (8.f), and to exercise due diligence to prevent all acts of violence against women, including by improving the safety of public environments (8.h).

- UNIFEM, a United Nations agency that provides financial and technical assistance to foster gender equality and operates the UN Trust Fund to Eliminate Violence Against Women has noted that "Strategies to stop [violence against women] before it starts are essential, but lack resources and visibility." (See http://www.unifem.org/gender_issues/violence_against_women/at_a_glance.php.)
- The World Health Organization has called for increased attention to primary prevention of intimate partner violence and sexual violence, through the recommendations of the *World report on violence and health* (Krug et al., 2002), World Health Assembly Resolution 56.24 on implementing the report's recommendations (WHA 2003), and in the recommendations of the *WHO Multi-country study on women's health and domestic violence against women* (Garcia-Moreno et al., 2005).

In response to this call, remedies promoted by the international community have focused on recommendations such as legal and judicial reform, ending impunity for perpetrators, providing survivors with access to justice mechanisms, and improving access to services such as shelters for abused women and quality medico-legal care. These efforts are positive and have improved the situations of many women living with violence, but they may be of limited value in their ability to address the underlying factors that cause intimate partner violence and sexual violence. They may have value for preventing further acts of violence *after* violence has been disclosed, and for reducing harmful consequences, but there is little scientific evidence they can prevent new instances of intimate partner violence and sexual violence, due in part to a lack of evaluations.

The few primary prevention approaches that have been widely adopted include extensive advocacy campaigns and efforts to enact and implement laws to deter potential perpetrators. Other initiatives have emphasized interventions to protect and assist women who have already experienced violence. UNIFEM, for example, notes that its campaigns generated more demand for services for survivors than many countries could meet. Keeping in mind the downstream/upstream scenario, this type of response to awareness-raising is natural. When people become aware of the true extent of intimate partner violence and sexual violence, the instinct of most is to demand justice and care for the survivors, and punishment for the perpetrators. It is difficult to look beyond the sheer numbers of people who are struggling with violence now, to the more remote factors that would need to be altered to prevent more people from ending up in the position of being victims or perpetrators.

This paper discusses efforts being made around the world to stop new instances of intimate-partner and sexual violence occurring by addressing factors that can increase the risk of these acts. It is not intended to be a systematic review, but rather an overview of existing approaches, the evidence base behind them, and what is needed to scale up primary prevention, particularly in low- and middle-income countries.

2. Primary prevention framework

The public health approach to the primary prevention of intimate partner violence and sexual violence is grounded in four stages:

1. Define intimate partner violence and sexual violence and document their scope and magnitude.
2. Identify factors that increase the risk of intimate partner violence and sexual violence or have a protective effect.
3. Design prevention strategies using knowledge of risk and protective factors and grounded in social science theory for modification of those factors. Evaluate the impact of any strategy.
4. Implement proven and promising strategies on a larger scale, in various settings, continuing to monitor their impact.

2.1 Problem definition and measurement

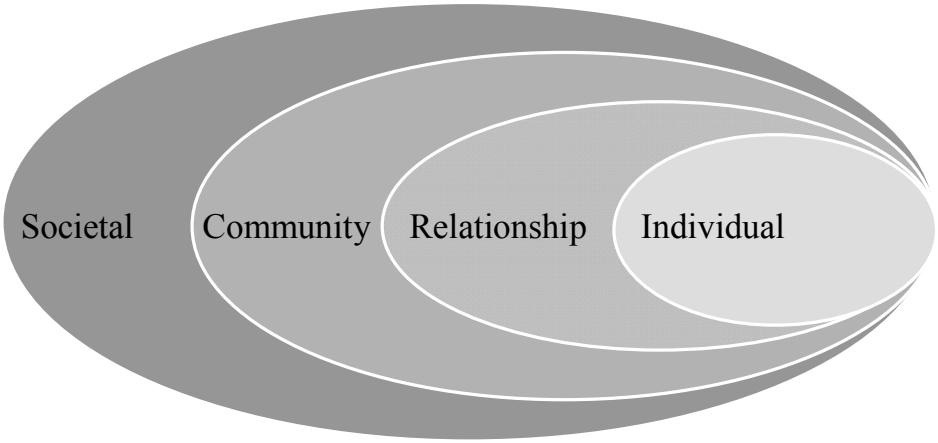
Globally, problem definition and measurement is the best-developed component. Awareness of intimate partner violence and sexual violence has sparked numerous initiatives to measure the extent of the problem, particularly of violence by intimate partners, in different countries. The global evidence base on prevalence and consequences, particularly of intimate partner violence, has expanded greatly in the last five years, including research such as the WHO *Multi-country study on women's health and domestic violence against women*, and the availability of data from an increasing number of Demographic and Health Surveys, Reproductive Health Surveys (led by the United States of America Centers for Disease Control and Prevention) and other national surveys of violence against women. Further work is needed to improve measurement and reach consensus on operational definitions, particularly in respect of sexual and emotional violence. Most recommendations for addressing intimate partner violence and sexual violence include recommendations for strengthening data collection and research. At a national level this may the first necessary step before the next stages can occur.

2.2 Risk factors

Although the global evidence base on the prevalence of intimate-partner and sexual violence is substantial, the same cannot be said for the global evidence base on risk and protective factors. Current understanding of factors associated with intimate partner violence and sexual violence derives mainly from research in high-income countries, and from cross-sectional studies that do not allow for determination of causality. Primary prevention strategies in low and middle-income countries would be much strengthened by more and better research on risk and protective factors in diverse socioeconomic and cultural contexts.

Intimate partner violence and sexual violence result from the interaction of a number of factors. No single factor can explain why some people are at a high risk while others are not or why it is more common in some contexts than in others. Figure 1 presents an ecological model for understanding this interplay of factors at various levels (Krug et al., 2002). This model illustrates how an individual's exposure to violence is influenced by factors at the individual, relational, community and societal levels. The *individual* level of the model encompasses biological factors, beliefs and attitudes, and personal history factors that influence an individual's likelihood of becoming a victim or perpetrator. The *relationship* level reflects how an individual's close social relationships influence the risk of violence. Factors at the *community* level relate to the settings of social relationships, such as neighbourhoods, workplaces and schools, and characteristics of those environments that contribute to or protect against violence. *Societal* level factors refer to those underlying conditions of society that either encourage or inhibit violence. The interaction of factors at various levels of the model must also be taken into account.

Figure 1. Ecological model for understanding intimate partner violence-sexual violence (Heise et al., 1998; Krug et al., 2002)



The Annex summarizes current knowledge about the causes and risk factors found to be associated with intimate-partner violence and sexual violence at the different levels of the ecological model.[2] Risk groups for both forms of violence include young people, people who have witnessed family violence as children, and people with a prior history of victimization or perpetration. Generally, women are at greater risk of victimization, and men at greater risk of perpetration. Little is known about the relative importance of these factors as underlying causes, and the role of various factors may differ from country to country. Some factors are unique to intimate partner violence or sexual violence, but there are several important factors in common:

- gender inequality;
- social norms supportive of traditional gender roles, intimate partner violence and sexual violence, and macho male gender roles;
- poverty, economic stress and unemployment;
- lack of institutional support from police and judicial systems;
- weak community sanctions;
- dysfunctional, unhealthy relationships characterized by inequality, power imbalance and conflict;
- alcohol and substance misuse; and
- witnessing or being a victim of violence as a child.

This overlap indicates the importance of addressing intimate partner violence and sexual violence in tandem rather than in isolation, while still giving attention to those factors unique to one or the other. Most of the research on factors associated with these forms of violence has been conducted in high-income countries and therefore needs to be tested to determine its relevance in low- and middle-income countries (Heise & Garcia-Moreno, 2002), especially given recent findings that the nature and strength of the association between intimate partner violence and sexual violence,

[2] Tables based on Heise & Garcia-Moreno, 2002; Jewkes et al., 2002; Abrahams et al., 2004; Kishor & Johnson, 2004; Sabol et al., 2004; Gage, 2005; Abrahams et al., 2006; Jewkes et al., 2006; Karamagi et al., 2006; Raghavan et al., 2006; U.S. Centers for Disease Control and Prevention, 2006, 2007.

and variables such as women's education levels and status disparities within the couple, varies from country to country (Kishor & Johnson, 2004).

With that caveat, the existing research suggests that effective primary prevention approaches for intimate-partner and sexual violence would include strategies to improve gender equality; to change social norms regarding violence, masculinity and gender roles and relationships; to reduce poverty and to strengthen economic and social safety nets; to promote healthy and equal relationships; to reduce alcohol and drug misuse; to have a particular focus on young people; and to prevent exposure to violence in childhood.

2.3 Design, evaluate and implement proven strategies

As mentioned above, efforts to prevent intimate-partner violence and sexual violence are being made and are becoming more numerous in certain regions. The majority of such approaches that are documented in the public domain, however, are not grounded in an understanding of risk factors or in social science theory regarding behaviour and social change. Furthermore, the evidence base for prevention approaches suffers from the following deficits (Krug et al., 2002; Dahlberg & Butchart, 2005):

- few outcome evaluations, and even fewer from low and middle-income countries;
- few systematic evaluations of the same programme over time;
- evaluation designs are often weak, relying on pre-test and post-test measurements of individuals' knowledge, attitudes and behavioural intent over short follow-up periods and without comparison groups. Efforts to measure the impact of interventions on actual violent behaviour and rates of intimate-partner violence and sexual violence are extremely limited;
- few evaluations of the impact of community and society-level change strategies.

The only prevention approaches implemented on a large scale thus far are public awareness campaigns and reforms of the criminal justice sector, but their impact is not well-understood. Evaluations of awareness campaigns too often stop at process indicators such as quantity of materials disseminated, exposure to materials, or measures of changes in knowledge only, and few attempts have been made to measure the impact of criminal justice responses on rates of intimate-partner violence or sexual violence. There is an urgent need for outcome evaluations of evidence-based strategies and a systematic approach to primary prevention that ensures widespread implementation of strategies delivered as early as possible at the appropriate developmental stage, over the life course, and addressing factors at all levels of the ecological model. The remainder of this paper explores several approaches currently used in prevention of intimate-partner violence and sexual violence.

2.4 Scale up effective interventions and monitor their effects

The fourth step of the public health approach is to implement effective and promising interventions in a wide range of settings and, through ongoing monitoring of their effects on the risk factors and the target problem, to evaluate their impact and cost-effectiveness. To date, as already noted, public awareness campaigns and reforms of the criminal justice sector are the only interventions implemented on a large scale, but their impact remains poorly understood due to inadequate monitoring and evaluation.

3. Primary prevention approaches

Although the complexity of prevention approaches for intimate-partner violence and sexual violence preclude neat categorization, several broad categories become apparent when examining the different programmes and strategies utilized to date. Current strategies for the primary prevention of intimate-partner violence and sexual violence, reviewed below, include early childhood and family-based approaches; school-based approaches; interventions to reduce alcohol and substance misuse; public information and awareness campaigns; community-based approaches such as community mobilization; and structural and policy approaches such as strengthening gender equality and improving criminal justice system responses. There is also a growing trend towards working with men and boys to prevent intimate-partner violence and sexual violence. Although this work relies on many of the approaches listed above, it is often treated as a separate approach in the literature, and is therefore reviewed separately in this paper.

3.1 Early childhood and family-based approaches

Experiences in early childhood have a major impact on physical, cognitive, emotional and social development throughout the lifespan. During the early years of life, children learn from their immediate family and community environment how to interact with the world and how to relate to other people. Although few early childhood development, health promotion or violence prevention programmes have the prevention of intimate-partner violence and sexual violence as an explicit goal, approaches that aim to develop physically, emotionally, and socially healthy children and reduce exposure to violence and other adverse events have the potential to significantly reduce the prevalence of all forms of violence, including intimate-partner violence and sexual violence.

The strength of the relationship between a child's exposure to maltreatment and risk of involvement in intimate-partner violence and sexual violence later in life suggests that the prevention of child maltreatment could be an important component of the prevention of intimate-partner violence and of sexual violence (Mercy, Sleet & Doll, 2005; Farrington, 2006). Strong evidence exists to support the effectiveness of home visits and parent training programmes in preventing child maltreatment (Olds et al., 1999, Oleg et al., 2005; Farrington, 2006).[3] To our knowledge, the impact of these strategies specifically on the risk of intimate-partner violence and sexual violence over the life course of the visited child has not been directly investigated.[4] However, these strategies may be effective in reducing intimate-partner violence and sexual violence by reducing child maltreatment and the cognitive, social and behavioural consequences of child maltreatment that affect risk. Olds and colleagues found that, 15 years after the intervention, children whose mothers were visited by nurses had been arrested fewer times, consumed less alcohol, and had fewer sexual partners than children whose mothers had not received the intervention (Olds et al., 1998). Given the association between delinquent behaviour, alcohol use, high-risk sexual behaviour and intimate-partner violence and sexual violence, one

[3] For a more comprehensive discussion of proven and promising strategies for prevention of child maltreatment, see WHO (2006). *Preventing child maltreatment: a guide to taking action and generating evidence*.

[4] The CDC Task Force on Community Preventive Services reported that there is insufficient evidence to conclude whether early childhood home-visitation programmes have a significant impact on intimate-partner violence among parents of visited children (Oleg et al., 2005), and there is evidence that violence in the home limits the treatment effects of home visitation.

might reasonably expect to find lower rates of intimate-partner violence and sexual violence as well.

Child maltreatment is not the only early childhood factor that influences later risk of intimate-partner violence and sexual violence. In early childhood children learn problem-solving, emotional management, and social skills that form the basis of their relationships later in life, and it is also the time when children form views on gender roles, relationships, and the acceptability of aggression and violence (Guttman et al., 2006). Children learn much of this from the people around them, so that positive parenting and home environments free from intimate-partner violence are crucial to the development of positive skills that facilitate pro-social behaviour and healthy relationships. Programmes that seek to reduce children's aggressive behaviour and promote the development of positive skills have been effective in thwarting the developmental trajectory of ongoing violent and delinquent behaviour (Farrington, 2006). Promising strategies include home visitation programmes; parent training programmes (covering positive reinforcement, non-violent disciplinary techniques, problem-solving and behaviour management skills); cognitive–behavioural skills training for children, social development programmes to reduce antisocial and aggressive behaviour; and multi-component programmes with some combination of training for parents, children and teachers (Mercy et al., 2002; Farrington 2006).

Early childhood interventions are important not only for securing the health and well-being of children, but for promoting healthy behaviour and social functioning—including non-violent intimate partnerships and respectful, consensual sexual activity—throughout the lifespan. Key elements of this approach include teaching parents to model healthy relationships, to manage their children's behaviour positively and without harsh physical punishment, and fostering children's anger management, impulse control, problem-solving, conflict resolution and social skills.

3.2 School-based approaches

School-based violence prevention programmes have been used to tackle a range of issues including child sexual abuse, bullying, dating violence, and sexual assault. These range from intensive, long-term programmes integrated into formal curricula to single-session activities.

School-based interventions with younger children have focused mainly on child sexual abuse. These interventions typically aim to build children's knowledge about child sexual abuse and their capacity to protect themselves. Such programmes have become widespread in high-income countries and are implemented in some low- and middle-income countries. Key components include educating children about different kinds of touch, self-esteem, secrets, and self-protection strategies such as shouting, insisting on being left alone, threatening to tell and telling a trusted adult. Examples of such curricula include Good-Touch/Bad-Touch® (USA), Feeling Yes, Feeling No (Canada), and My Body Belongs to Me (Thailand). The impact of these curricula has most often been evaluated using a pre-test/post-test design to measure changes in children's knowledge, attitudes and skills, and such evaluations have found the approach to be effective on these measures. The question remains, however, as to whether these programmes lead to actual reduction in victimization. The evidence on this is not clear. In a 1992 survey of a nationally representative sample of American 10–16 year-olds, Finkelhor, Asdigian and Dziuba-Leatherman (1995) found that children who had received the school-based prevention programmes—

compared to those who had not—had more accurate knowledge about sexual abuse, were more likely both to use the recommended self-protection strategies and to feel they were empowered to protect themselves, and were more likely to report abuse incidents. However, these children did not report lower levels of completed assault measured as a percentage of total attempted and completed assaults, and they experienced more injuries in the course of sexual assault.[5] Gibson and Leitenberg (2000) took this research a step further and undertook to determine whether sexual victimization rates differed between female university students who had and had not received child sexual abuse prevention training at school. They found that girls who had not participated in a child sexual abuse prevention programme were twice as likely to report that they had been sexually abused as a child.

International research increasingly shows that violence within intimate relationships is not a phenomenon unique to adulthood, but rather a disturbingly common feature of adolescent dating relationships (Pinheiro, 2006). To date the most common approach to preventing dating violence among adolescents in high-income countries has been school-based programmes with pre-adolescents and adolescents. A randomized control trial of the Safe Dates programme in the USA found that adolescents exposed to the intervention reported less perpetration of psychological, sexual and moderate physical dating violence, and less victimization involving moderate physical dating violence (Foshee et al., 2004). However, the programme showed no effects on severe physical violence. The effects of the programme on behaviour and mediating variables continued at four years' follow-up (Foshee et al., 2004). The programme needs to be further tested in diverse cultural contexts, but the results suggest that school-based interventions with adolescents can shift the norms and attitudes that influence violent behaviour in intimate relationships among some young people.

The high levels of sexual assault experienced by women at American universities have prompted the development of a number of rape prevention programmes. Some focus on increasing women's knowledge, self-protection skills, and awareness of available services for victims, while others seek also to address men's knowledge, attitudes and behaviour. Several evaluations comparing groups before and after they received such interventions have demonstrated an immediate positive effect on students' knowledge and attitudes towards rape, including decreased acceptance of rape myths. Evaluations that have included a follow-up assessment, however, have found that these changes are no longer in evidence at follow-up a few months after exposure to the programme (Gidycz et al., 2001). Few published evaluation studies measure change in behaviour as the dependent variable, focusing instead on changes in knowledge, attitude and behavioural intent. Those that have measured change in behaviour found that the positive effects of the programme on knowledge and attitude did not translate into changes in behaviour (Breitenbecher & Scarce, 1999; Gidycz et al., 2001), perhaps due in part to men's and women's (mis)perceptions of risk and of the personal relevance of the programme content.

[5] This survey also found that children who received comprehensive parental instruction on child sexual abuse scored even higher on measures of knowledge and use of protective behaviours, an effect that was independent of exposure to school-based instruction and mediated its effect.

The lessons learned from programmes using this approach are as follows:

- School-based programmes for prevention of childhood sexual abuse should be part of larger community-based prevention strategies. Children, however, should not bear the primary responsibility for protecting themselves from victimization.
- Gaining access to schools can be difficult (e.g. because programmes take time away from academic studies and parent's may raise objections).
- Multi-session programmes delivered over some time are more effective than single awareness-raising or discussion sessions.
- Programmes that aim to change attitudes and norms are more effective than those that solely provide information.
- Programmes should address both girls and boys, although the programme should use separate sessions for girls and boys.
- The effects of the programmes are greater when the intervention is age-appropriate and includes skill-building components that require the active involvement of participants.
- Programme efforts need to address the concerns of teachers and school staff to ensure their support and involvement.

Examples of school-based approaches are described in Table 1.

Table 1. Examples of school-based approaches for the prevention of rape and dating violence

Safe Dates, North Carolina, USA[a]		
Intervention	*Notes*	*Outcomes*
School-based programme to prevent adolescent dating violence (perpetration and victimization). Includes theatre production, 10-session curriculum, and poster contest.	First implemented (and tested) with rural population. Now used in several other settings.	Those exposed to the programme in grades 8–9 (13-15 years of age) reported less psychological, moderate physical, and sexual dating violence perpetration than controls up to four years later. Prevented perpetration by both sexes. Effects on severe physical perpetration moderated by prior involvement in severe physical violence. Significant reductions in moderate physical victimization. Programme effects mediated by changes in dating violence norms, gender norms, and awareness of community services.
Acquaintance Rape Prevention Program, USA[b]		
Intervention	*Notes*	*Outcomes*
Single session (1-hour) rape prevention programme for university students. Participants given		Gidycz et al., 2001 measured effect of programme on students' self-reported sexually aggressive behaviour and sexual victimization rates nine weeks after the programme. Intervention group reported

information about sexual assault statistics and legal definitions, then complete and discuss a worksheet on rape myths and facts. Case-studies used to illustrate points.		less acceptance of rape myths than in the comparison group, and women reported less acceptance than men. No difference by treatment group was reported in rates of victimization of women during the follow-up period, even when controlling for previous history of sexual victimization. The same was true for men's levels of sexually aggressive behaviour. In all groups prior history of sexual victimization and perpetration was associated with a significantly higher risk of victimization or perpetration in the follow-up period. The programme was not effective in reducing women's risk of victimization or men's sexually aggressive behaviour. Participant evaluation of the programme indicated that most women and men did not perceive the information as applicable to themselves.

[a]Foshee et al., 2004; Foshee & Reyes (in press).
[b]Pinzone-Glover et al., 1998; Gidycz et al., 2001.

3.3 Interventions to reduce alcohol and substance misuse

Alcohol and drug misuse is a situational factor that contributes to intimate-partner violence and sexual violence and increases their severity, rather than being a primary cause of such violence (Leonard, 2005). The relationship between alcohol and intimate-partner violence and sexual violence is mediated by social norms regarding gender, alcohol use, and violence. It can be difficult to determine whether alcohol is a situational factor contributing to intimate-partner violence and sexual violence, or a coping mechanism adopted in situations of ongoing violence, or both. While reduction of harmful alcohol and drug use is an important component of violence prevention, it does not address the root causes and therefore cannot, on its own, eliminate intimate-partner violence and sexual violence. Nonetheless, substantial gains in the prevention of intimate-partner violence and sexual violence may be achieved through general measures to reduce alcohol-related harm (WHO, 2006). Promising structural interventions to reduce alcohol-related harm include regulation of alcohol pricing and taxation, regulating alcohol availability and modifying drinking contexts (Babor et al., 2003). The impact of such measures on rates of intimate-partner violence and sexual violence has not been widely studied, but a few studies indicate promising results:

- *Pricing*: Markowitz (2000) estimated that a 1% increase in the price of alcohol would decrease intimate-partner violence against women by 5%.
- *Restricting availability*:
  - A community intervention in Australia that included restricting the hours of sale of alcohol reduced the number of victims of intimate-partner violence presenting to hospital (Douglas, 1998).

- In Greenland, a coupon-based alcohol rationing system implemented in the 1980s that entitled adults to the equivalent of 72 beers-worth of alcohol per month saw a subsequent 58% reduction in the number of police call-outs for domestic quarrels (Room, 2003).
- In Diadema, Brazil, prohibiting the sale of alcohol after 23:00 helped prevent an estimated 273 murders (almost all victims were male) over 24 months, and was associated with lowered rates of assaults against women leading to an estimated average reduction of nine such assaults per month (Pacific Institute, 2004).

3.4 Public information and awareness campaigns

Public information and awareness campaigns are a common approach to the primary prevention of intimate-partner violence and sexual violence. Public awareness campaigns have been used throughout the world to break the silence that surrounds these forms of violence, to inform, to try to influence individuals' attitudes and social norms about its acceptability, and to build political will to address the problem. Many have used a human rights framework. The 16 Days of Activism Against Gender Violence Campaign is a movement that has generated a variety of awareness-raising activities around the world. Approximately 1700 organizations in 130 countries have participated in the annual campaign since 1991, many organizing public awareness campaigns.[6] Such campaigns often disseminate messages through mass media channels (television, radio, newspapers, magazines, posters, and billboards) and may include other mechanisms such as town meetings or community theatre. Campaign goals might include raising public awareness (e.g. about the extent of the problem, about intimate-partner violence and sexual violence as violations of women's human rights, about men's role in ending violence against women), providing accurate information and dispelling myths and stereotypes about intimate-partner violence and sexual violence, and changing public opinion. These campaigns have the potential to reach large numbers of people. While good campaigns can increase knowledge and awareness, influence perceptions and attitudes, and foster political will for action, the link between public awareness campaigns and behaviour change is not at all well-established.

Basic principles of good communications practice should be applied to public awareness campaigns on intimate-partner violence and sexual violence. Effective campaigns are grounded in evidence of the problem and the risk and protective factors; define clear and measurable objectives; identify indicators to measure the impact of the campaign, how they will be assessed, and ensure baseline measurement is taken; select the intended audience; use consumer research with the intended audience to develop messages and identify the best sources, channels and materials to reach them; build in an evaluation mechanism from the start; and continuously use research to monitor impact and improve the campaign (NCI 2002; UNIFEM, 2003).

Campaigns that use a social marketing framework apply the principles of commercial marketing to develop and adapt communications strategies to effect behavioural and social change (NCI, 2003; Donovan & Vlais, 2005). The social marketing framework seeks to develop persuasive messages by understanding the behaviour of the intended audience and involving them in programme development, rather than focusing primarily on the dissemination of information, as many health communications efforts have done. This framework is increasingly being utilized to

[6] Center for Women's Global Leadership. *About the 16 days* (http://www.cwgl.rutgers.edu/16days/about.html, accessed April 11, 2007).

address men's social norms and behaviour, including in relation to intimate-partner violence and sexual violence (see section on working with men and boys).

Lessons learned about public awareness campaigns:

- Public information campaigns, in isolation, cannot normally effect sustained change in complex behaviours (NCI, 2002) such as intimate-partner violence and sexual violence, although they can reach large numbers of people. Campaigns targeting behaviour change should therefore be used in conjunction with other strategies for the primary prevention of intimate-partner violence and sexual violence.
- Campaigns should be based on social science theories and models of behaviour change and an understanding of the particular beliefs, perceptions, and behaviour of the intended audience.
- Communications strategies based on a social marketing framework are more likely to be effective in changing individuals' knowledge, attitudes, and social norms.

Examples of this approach are given in Table 2.

Table 2. Examples of public information and awareness campaigns

UN Inter-agency campaign to end violence against women[a]		
Intervention	*Notes*	*Outcomes*
Regional advocacy and mass media campaigns in Africa, Latin America and the Caribbean, Asia, and the Pacific with overarching goals of raising public awareness about violence against women as a human rights violation, celebrating women's rights achievements, bringing together efforts of the UN system to end violence against women[b]	Posters, theme songs, public service announcements, community events, T-shirts, badges, etc., using the slogan "A life free of violence: it's our right".	Extensive media coverage and government endorsement. Several countries undertook legislative reviews, passed new laws, and allocated funding for women's shelters. Impact on rates of violence and attitudes towards violence not determined.

Soul City and Soul Buddyz, South Africa[c]		
Intervention	*Notes*	*Outcomes*
Multi-media health promotion and social change project ("edutainment")	Has been broadcast in other African countries, Latin America and the Caribbean, and south-	In 1999 the 4th season of Soul City incorporated intimate-partner violence themes for six months. The programmes were broadcast in conjunction with a

centering on television and radio drama series with supplemental materials, advocacy and activities. Intimate-partner violence and sexual violence were included among several other themes.	east Asia.	multi-level intervention consisting of the series itself, print materials, a helpline, partnership with a national coalition on domestic violence, and an advocacy campaign directed at the national government with the aim of achieving implementation of the Domestic Violence Act (DVA) of 1998. The strategy aimed for impact at multiple levels: individual knowledge, attitudes, self-efficacy and behaviour; community dialogue; shifting social norms; and creating an enabling legal and social environment for change. The complex independent evaluation included a national survey before and after the intervention, and focus groups and in-depth interviews with target audience members and stakeholders at various levels. The programme had a positive impact on implementation of the DVA, changes in social norms, and changes in individual knowledge of where to go for help and on beliefs that domestic violence is a private matter. Attempts were made to measure impact on violent behaviour but numbers were not sufficient to determine the impact.

[a] http://www.undp.org/rblac/gender/execsum.htm
[b] UNIFEM, 2001.
[c] http://www.soulcity.org.za/; Usdin et al., 2005.

3.5 Community-based prevention

Community-level activism and leadership from the women's movement has been essential, specifically for increasing the visibility of violence against women and placing it on the international agenda. Likewise, community efforts will be key to the primary prevention of intimate-partner violence and sexual violence, particularly in settings where resources are limited. Two commonly used forms of community-based prevention include interventions targeted at subgroups of the population, and comprehensive community-wide interventions delivered in multiple settings. The former includes approaches such as group education sessions for people at risk of intimate-partner violence and/or sexual violence (e.g. Wolfe's Young Relationships Project; Wolfe et al., 2003).

Comprehensive interventions 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 an enabling environment for changing individual attitudes and behaviour. This approach often utilizes a combination of participatory education or training, public awareness campaigns, and social marketing techniques. Objectives may include improvement of communication and

relationship skills, promotion of equitable gender norms and respect for rights (especially women's rights), equipping bystanders to speak out and act to prevent violence, and challenging the social norms and individual beliefs at the root of intimate-partner violence and sexual violence. Community interventions in low and middle-income countries frequently use a human rights framework, may introduce intimate-partner violence and sexual violence as one of many issues, and can be effective in opening the door to talk about women's and children's status and their value as human beings (Raising Voices, 2005). Community *mobilization* (or empowerment) approaches emphasize the role of individuals as agents of change, rather than passive programme beneficiaries, and place priority on community ownership and leadership of the change process. The success of such programmes depends on the quality of the facilitator. If the facilitator is not perceived as trustworthy, capable of understanding the group, and a good listener, then programme objectives are unlikely to be achieved. Ideally facilitators should be able to model more equitable gender norms, healthier reflections on masculinity, and ways of relating that are based on respect and dialogue. Facilitators must be able to take a stand and hold the group accountable to certain standards of attitudes and behaviour, while at the same time maintaining rapport and not judging the group members harshly. This too presents a challenge, as it requires facilitators to be carefully chosen, well-trained and in most cases supervised. Evaluations of this approach in sub-Saharan Africa have found that it shows promise for having a positive impact on attitudes, social norms, and behaviour change (Raising Voices, 2005; Wallace, 2006; Jewkes et al., 2007).

Lessons learned from community-based approaches are as follows:

- Such approaches are most effective when there is community ownership, repeated exposure to ideas through multiple channels over time, and multiple components delivered in different community settings (e.g. combining media outreach with group education).
- Participatory methods are well-accepted and effective for engaging participants.
- Fostering an enabling social environment may increase the likelihood that positive behaviour change at the individual level will be sustained.
- The success of community programmes hinges on the quality of the facilitators, and high-quality training of facilitators can substantially increase programme costs.
- Effective social marketing strategies require preliminary research to identify existing norms and to identify the optimal messages and channels through which to reach the target audience.
- Follow-up is required to sustain changes brought about by the programme. In situations of unpredictable funding, staff turnover, and high levels of unemployment or residential mobility, this becomes difficult.
- Impact is heightened by combining activities aiming at education and individual change with wider advocacy and community mobilization activities.

The challenges posed by this approach include the following:

- Community mobilization approaches and community-driven programmes do not easily fit within donor timeframes.
- Measuring the programme effects specifically attributable to community-wide interventions can be difficult given the range of other influences and changes in community situations over time.

- There is a need to move beyond measuring individual behaviour change to measuring social change at the community level, and to determine how this could be done.
- Structured comprehensive interventions (e.g. Stepping Stones) are intended to be a coherent whole. However, they are sometimes implemented piecemeal, probably diminishing or even eliminating any beneficial impact.
- Programmes are time-consuming; consistent attendance is a challenge.
- Facilitators need adequate support to address their own beliefs and issues.
- These approaches can work well with men, but getting men involved can be difficult.

Examples of this approach are given in Table 3.

Table 3. Community-based prevention

Choose Respect, USA[a]		
Intervention	*Notes*	*Outcomes*
Targets 11–14 year-olds and their families and teachers. Media outreach and educational events using social marketing and a behaviour change model. Comprehensive long-term strategy, integrated communications approach (media plus community partnerships/mobilization to organize events, promotional partnerships).	Goal is to foster skills at the individual level to develop healthy, respectful relationships. Implemented in 10 major cities of the USA. Developed based on focus groups, literature searches, expert interviews, and a national youth survey to inform content and messages.	Important components for success identified in pilot study: strong violence prevention partners in community, strong school and community education focus; trained and respected spokespeople; teacher training; effective media component; engaging materials; incentive for participation. Currently under evaluation.
Center for Domestic Violence Prevention (CEDOVIP), Uganda[b]		
Intervention	*Notes*	*Outcomes*
Objectives are to mobilize communities to change attitudes and behaviours contributing to violence against women; to build capacity of local leaders and professionals; and to advocate for structural change in communities to create a more supportive environment for women's rights. CEDOVIP does this by working with	Based on the "Mobilizing Communities to Prevent Domestic Violence" model by Raising Voices (now used throughout East and Southern Africa).	Assessment of 180 community members (post-intervention) through in-depth interviews, focus groups and questionnaires (including people directly involved in the programme and people not involved). Women reported increased self-esteem and assertiveness and men reported increased accountability. Approximately half of both women and men reported that physical and

community volunteers, running a men's programme, training professionals and organizations, organizing multimedia campaigns, and developing educational materials.		emotional violence in their current relationship had decreased (in frequency and severity) over the past two years, although some reported increases in both types of violence. Forty-two per cent of women and 52% of men reported a decrease in sexual violence in their relationships.
Stepping Stones[c]		
Intervention	*Notes*	*Outcomes*
Participatory training package promoting communication and relationship skills in households and communities. Training in age/sex peer groups, also community meetings. Individual behavior change supported by peers and wider community change. Originally designed for HIV prevention although several communities have included violence prevention.	Used in over 40 low- and middle-income countries in Africa, Asia, Latin America, and Europe, although most have not incorporated violence against women as a theme.	Large effectiveness trial in rural South Africa showed proportion of men disclosing perpetration of severe intimate partner violence was lower in the intervention group than in the control group at 12 and 24 months (Jewkes et al., 2007). Large volume of consistent qualitative and anecdotal information indicating improved knowledge, communication (between spouses and between parents and children) and positive changes in relationships. Consensus derived from various evaluations is that it leads to changes in knowledge and attitudes around sexual behaviour and gender relations, with significant behaviour change, particularly among men, in some areas following from that.

[a] http://www.chooserespect.org/scripts/pressroom/pressrelease/cr_annualreport.pdf
[b] http://www.raisingvoices.org/cedovip.php
[c] Wallace, 2006; Jewkes et al., 2007; http://www.steppingstonesfeedback.org/

3.6 Structural and policy approaches

Given the societal factors that shape the behaviour of communities and individuals, it is widely believed by both public health and human rights advocates that structural interventions hold great promise for significant achievements in the prevention of intimate-partner violence and sexual violence. The promise of such approaches urgently needs testing. Four such factors are discussed below:

- fostering gender equality and women's empowerment;
- legal reform and strengthening criminal justice responses;

— integrating intimate-partner and sexual violence prevention into other programme areas;
— improving the safety of physical environments.

Foster gender equality and women's empowerment. Women's low status in society is closely linked with high rates of intimate-partner violence and sexual violence against women in a variety of ways (Heise and Garcia-Moreno, 2002; Garcia-Moreno et al., 2005; Archer, 2006). Fostering gender equality is therefore an integral part of the prevention of intimate-partner violence and sexual violence; some advocates even take the view that other approaches to preventing intimate-partner violence and sexual violence will not be effective without improvements in gender equality. It is beyond the scope of this paper to describe in detail the various measures that may be used to foster gender equality, but the following are some key points.

Women's human rights should be respected, protected and fulfilled. As a first step towards this, governments should honour their commitments to implement the Convention on the Elimination of all Forms of Discrimination against Women (1979), and various other human rights instruments, as well as the recommendations made in the Millennium Declaration (2000), the Beijing Declaration and Platform for Action (1995), the Cairo Programme of Action (1994), the Declaration on the Elimination of Violence against Women (1993), and the Vienna Human Rights Conference (1993), as well as other regional conventions and consensus agreements. Women's enjoyment of their rights to political participation, to education, to work, to social security, to adequate standards of living, to freely enter and end marriage, to various forms of financial credit, and to own and administer property correlates with their status in society and with the risk of intimate-partner violence and sexual violence. Legal reform and concrete social policy measures in the areas of education, employment, and social protection are needed to raise women's status, fulfil their rights, increase their access to and control over resources, and ensure that laws do not discriminate against them. Gender equality should be mainstreamed into the policy development process in these areas and into development and poverty reduction strategies.

As difficult as it can be to measure the impact of prevention programmes on rates of intimate-partner violence and sexual violence, understanding and measuring the impact of structural policy measures on both gender equality and these types of violence is even more challenging. There is a great need to develop a better understanding and a stronger evidence base on how laws and policies at different levels (e.g. from laws on property and inheritance rights to parental leave policies or policies to improve women's access to paid and safe employment) contribute to gender equality and to the empowerment of women and, in turn, the potential of these measures to reduce intimate-partner violence and sexual violence. An example of a structural approach is given in Table 4.

Table 4. A structural approach

Intervention with microfinance for AIDS and gender equity (IMAGE), South Africa[a]		
Intervention	*Notes*	*Outcomes*
Loans provided to poor women for income-generating activities, using group lending model. Participatory learning and action curriculum of 10 sessions on gender equality and violence prevention integrated into loan centre meetings, with an initial phase of individual training and a second phase of community mobilization.	Cluster-randomized trial designed to assess impact of involvement in intervention on household economic well-being, social capital, and empowerment, and reduction of vulnerability to intimate-partner violence. Follow-up at 2 and 3 years.	Among women who participated directly in the intervention, effect sizes were large and in the expected direction for 16 of 17 indicators, although the confidence intervals (CI) were wide and included 1.0 for three indicators (perhaps due to few clusters). Experience of intimate-partner violence among women in the intervention group was reduced by 55% (adjusted risk ratio, 0.45; CI, 0.23–0.91). Effect sizes among individuals living in the same houses as participants and randomly chosen community members were in the expected directions, but smaller than those of the intervention group. The gender training component is an essential element of the approach.

[a] Pronyk et al., 2006.

Legal reform and strengthening criminal justice system responses (including police training). Most criminal justice system responses to intimate-partner violence and sexual violence do not qualify as primary prevention, but rather are focused on intervening once violence is disclosed, to prevent further violence and to facilitate recovery and access to justice (e.g. sexual assault response teams, specialized police units, restraining orders and pro-charging policies). Legal protection against intimate-partner violence and sexual violence reinforces non-violent norms by sending the clear message that such acts will not be tolerated. The power of laws to act as a deterrent relies on their enforcement; if potential offenders perceive that their violent acts will be reported and they will be prosecuted, that perception might deter them. There is little evidence however regarding the deterrent effect of criminal justice system responses to intimate-partner violence and sexual violence (Dahlberg & Butchart 2005), and reporting and conviction rates continue to be minimal, particularly for sexual violence.

The criminal justice response must include clear laws and policies with effective enforcement; training for police, prosecutors and judges; appropriate sentences; input from women; and coordinated, interagency responses for victims. However, this should be part of a more comprehensive societal strategy, used in combination with other interventions discussed in this paper (Johnson, 2007).

Integrate prevention of intimate-partner violence and sexual violence into a range of programme areas. Intimate-partner violence and sexual violence cross-cut and interact with many other

health and development issues. Combined programming should therefore be considered where appropriate. It has been recommended that prevention of intimate-partner violence and sexual violence be integrated with programme areas such as HIV/AIDS prevention, sexual and reproductive health, adolescent health promotion, prevention of child maltreatment and youth violence, urban planning, poverty reduction, and development, as well as in post-conflict and refugee situations (Garcia-Moreno et al., 2005; United Nations, 2006). Several interventions described in this paper have occurred in the context of HIV/AIDS or adolescent health programming. The systematic integration of prevention in related programme areas can widen the scope of people reached by interventions and can create synergies by addressing critical intersections. The impact of such integration will need to be evaluated.

Improving safety of physical environments, both urban and rural. Aspects of the physical environment of communities may be altered to improve safety and prevent violence. Such strategies include improving street lighting and providing safe routes to communal water collection, bathing and toilet facilities, they are likely to have more impact on sexual violence by non-partners than on intimate-partner violence. However, very few outcome evaluation studies have investigated the impact of these strategies on violence rates. A systematic review of the effects of improved street lighting on violence and crime showed an overall reduction in crime of 20% after improved lighting in experimental areas compared with control areas. Violent crime (which some studies specified as including "sexual assault" and "sexual proposition") showed an equal level of decrease to other crimes, and since night-time crimes did not decrease more than daytime crimes, a theory focusing on the role of street lighting in increasing community pride seems more plausible than a theory focusing on increased surveillance. Future research should be designed to test the main theories of the effects of improved lighting more explicitly and should measure violent crime using police records, surveys of victims, and self-reports of offending (Farrington & Welsh 2002).

3.7 Working with men and boys

Over the past decade there has been growing recognition of the value of working with men and boys to prevent intimate-partner violence and sexual violence. Advocates of this approach propose that since most sexual violence and intimate-partner violence is perpetrated by men, men must be involved in the solution. Work of this nature is based on an understanding of power imbalances, inequitable gender norms, and norms related to masculinity as driving factors behind intimate-partner violence and sexual violence. Violence prevention may be the explicit goal of the intervention, or it might be only one of many objectives of a broader approach such as increasing men's involvement in sexual and reproductive health. Programmes working with men to promote gender equality and end violence against women have sprung up in many countries of all income levels around the world.

Working with men and boys to end violence uses many of the prevention approaches previously discussed, and frequently takes the form of school-based initiatives, community mobilization or public awareness campaigns. The objectives may include increasing individuals' knowledge, changing individuals' attitudes about gender norms and violence, and changing social norms related to masculinity, power, gender and violence. Programmes taking this approach often focus on adolescent males or younger boys, based on evidence that attitudes and norms related to gender and gender equality and violence may be more malleable during this time than later in life.

In addition to targeting reductions in violent behaviour, some interventions aim to develop the capacity and confidence of boys and young men to speak up and intervene against violence when they are not involved as perpetrator or victim, with the goal of changing the social climate in which violence occurs. This set of skills helps young men not to be silent or complicit when they are indirectly involved in violence as family, friend, or member of a group or crowd (Katz, 2006). Using these skills requires overcoming common attitudes such as "it's none of my business" and "this is something private between them".

Evidence regarding the effectiveness of group education work with young men and boys is sparse, but suggests this approach can have a positive impact on knowledge, awareness, and attitudes. Future evaluations should use longer follow-up periods to determine whether gains persist after the intervention, and should measure the impact on behaviour change.

In addition to working with men individually and in groups, some efforts in this area have included a component to address social norms. A social norms approach uses communication techniques such as social marketing to foster healthier norms regarding gender roles, relationships and violence, and sometimes to correct misperceptions men may have about their peers' social norms on these issues (Berkowitz, 2006). It can be universal or targeted to specific groups. The social norms approach has been effective in changing other unhealthy attitudes and behaviour. For instance, US research on young peoples' perceptions of alcohol and tobacco use by their peers shows that students overestimate the frequency of use and that these misperceptions are positively correlated with drinking and smoking behaviour.[7] The social norms approach has been used in schools and universities and has been successful in shifting attitudes and changing behaviour with respect to alcohol and tobacco use (Berkowitz, 2004). Similarly, a number of studies have shown that many young men in high school and universities overestimate the adherence of their peers to rape myths and underestimate the discomfort of their peers with remarks or actions demeaning to women, the importance they give to seeking consent in sexual relations, and their willingness to intervene to prevent sexual assault (Berkowitz, 2006). Misperceptions such as these may facilitate men's violence against women, and may reduce men's willingness to intervene as bystanders. Evaluations of several small pilot programmes—all in American universities—suggest that using a social norms approach to correct misperceptions and foster healthier norms and behaviour shows promise for altering attitudes and behaviours associated with intimate-partner and sexual violence, although the utility of an approach focused on correcting misperceptions of social norms may be limited in contexts where the prevailing social norm is permissive of intimate-partner violence and sexual violence.

The lessons learned from working with men and boys are summarized below:

- Men should be approached to play a positive role in the health and well-being of their partners, families, and communities (Mehta, Peacock & Bernal, 2007). Approaching men as abusers or potential abusers is not an effective way forward, since many men do not perceive such messages as relevant to them (Katz, 2006).
- Finding appropriate entry points that will facilitate open discussion, rather than cause men to become defensive or close up, is imperative. Mentors in Violence Prevention uses the

[7] A summary of existing research on misperceptions relating to a variety of behaviours can be found at http://www.socialnorms.org/Research/Misperceptions.php (accessed 31 March 2007).

concept of the empowered bystander as an entry point (Center for the Study of Sport in Society, 2001). The Guy to Guy project in Brazil found that so many of the young men they worked with had witnessed or experienced violence in their own home that family violence became a natural entry point for wider discussions of power, gender, and violence (Barker & Acosta, 2003). In her work with male university students, Hong (1999) found that group participants were much more prepared and open to discuss issues of gender and gender-based violence after there had been opportunity to discuss the violence they had faced in their own lives and families.

- Discussions of gender equality, power, and violence are most open and effective in single-sex groups. This presents a challenge, since young men and women alike may be sceptical about the need for and desirability of single-sex groups (Center for the Study of Sport in Society, 2001; Barker & Acosta, 2003).
- Social norms marketing may be more effective when based on an understanding of the nature and extent of men's misperceptions of norms related to gender, relationships, and violence, and the impact of these misperceptions. Methods for measuring the effects of social norms intervention deserve careful attention.

Examples of approaches to working with men and boys are shown in Table 5.

Table 5. Working with men and boys

Mentors in violence prevention, USA[a]		
Intervention	*Notes*	*Outcomes*
Training student athletes and student leaders to intervene as empowered bystanders. Goals: to raise awareness about level of men's violence against women; challenge thinking about gender, sex and violence; open dialogue; inspire leadership.	Small single-sex groups and mixed group discussions. Has expanded to professional sports teams and the US Marines.	Year two evaluation with pre-test, post-test and comparison groups showed a positive impact on knowledge and attitudes. Treatment group showed significantly increased levels of knowledge and awareness about gender violence compared to control group. The programme also had a positive impact on both males' and females' attitudes towards gender violence, and there was a high degree of satisfaction with the programme, especially with the trainers. Post-test was 2 weeks after intervention ended, so not clear if gains persist over long-term follow-up.
Men as Partners (MaP)/Engender Health, South Africa[b]		
Intervention	*Notes*	*Outcomes*
Community-based workshops aim to alter attitudes, values, and behaviour that	MaP South Africa and Engender Health in Kenya and India have done specific work on	MaP South Africa used group education with single-sex and mixed-sex groups in a variety of settings. Week-long workshops use a participatory approach and examine

compromise women's and men's sexual and reproductive health (violence included). The aim is to shift social norms and promote men's positive involvement in the prevention of sexually transmitted infections, HIV/AIDS, and "gender-based violence", and in maternal care and family planning.	gender-based violence.	gender roles broadly, as well as their effect on men's lives, so multiple issues are covered (e.g. violence, sexual and reproductive health, HIV/AIDS, parenting). Evaluation using pre-test and post-test design (four to six months after intervention, without comparison group) showed increased levels of gender-equitable attitudes.
Coaching Boys into Men – Family Violence Prevention Fund (FVPF), USA[c]		
Intervention	*Notes*	*Outcomes*
Public education/ awareness campaign. Public service announcements and posters, media campaign, online resources about fathering.	"Men have the power to teach boys that violence towards women is wrong". FVPF has also developed the Working with Men and Boys to Prevent Gender-Based Violence Tool Kit.	Ad Council general market tracking survey, six waves of random-digit dialled computer-assisted telephone survey, 500 interviews per wave. Awareness of "the wrong way around" public service announcement increased from 3% to 14% over 3 years. Over the six waves, there was a significant increase in proportion of men surveyed who had actually spoken to boys about violence against women (29% November 2001 to 41% February 2005) (but cannot be attributed to the campaign). In the last wave, 25% of people who had seen the advertisement were taking action as compared to 16% of people who had not seen it (Waitt Institute, 2005).

[a] http://www.jacksonkatz.com/aboutmvp.html; http://www.sportinsociety.org/vpd/mvp.php
[b] http://www.engenderhealth.org/ia/wwm/pdf/map-sa.pdf
[c] http://endabuse.org/programs/display.php3?DocID=9916; http://toolkit.endabuse.org/Home/

3.8 Key elements for successful prevention programmes

In a review of prevention programmes in the areas of substance abuse, risky sexual behaviour, school failure, and juvenile delinquency and violence, Nation and colleagues (2003) identified common characteristics of effective prevention programmes. The strengths, challenges and lessons reviewed in this paper indicate that these attributes are also characteristic of strong,

successful programmes for the prevention of intimate-partner violence and sexual violence. Effective programmes are:

- *Comprehensive*: multiple components affecting multiple settings and addressing a range of risk and protective factors.
- *Use varied teaching methods*: it is important to include a skill-development component and interactive/"hands-on" methods.
- *Provide sufficient dosage*: provide more contact with participants through longer sessions, multiple sessions, and follow-up. Participants at greater risk require a greater dosage.
- *Theory driven*: effective programmes are based in scientific theories of how problem behaviours develop and how behaviours can be changed.
- *Promote positive relationships*: foster strong, positive relationships between children and adults, intimate partners, men and women.
- *Appropriately timed*: participants are exposed to the programme during the developmental stage when it will have the most impact.
- *Socially and culturally relevant*: flexibility, adaptability, and content tailored to be relevant to cultural context of participants. This must go beyond translation and may require structural modifications to a programme.
- *Evaluated*: outcome evaluation should be included to measure the impact of the programme.
- *Use well-trained staff*: programmes delivered by staff who are sensitive, competent, trained, supported and supervised. A high turnover negatively affects the continuity and effectiveness of programmes.

Successful programmes for the prevention of intimate-partner violence and sexual violence also use participatory education and training approaches, well-trained and competent facilitators for group work, and build individual and collective efficacy. The ability to understand not only the gravity and extent of intimate-partner violence and sexual violence but also to be able to say "Now we know what to do" is important for enabling individuals and communities to take action.

The lessons learned from existing approaches yield some clear directions about what is required for future success in the prevention of intimate-partner violence and sexual violence.

- To achieve and sustain large reductions in rates of intimate-partner violence and sexual violence, social attitudes, norms and behaviour must be changed, particularly among men. Primary prevention strategies will not be effective if they focus on women and girls alone—men and boys must be included. Programmes working with men should approach men as partners and agents of change.
- Given that successful approaches are based on understanding of the norms and culture of the target population, and that social marketing approaches are more effective than traditional public education campaigns, scaling up prevention of intimate-partner violence and sexual violence requires a shift in the methods used to try to change people's knowledge and attitudes.
- Changes in behaviour at the individual level cannot be sustained without an enabling social environment; therefore attention must be given to fostering social change and not only change in individuals.

- Prevention efforts at all levels of the ecological model are required to produce systemic and long-lasting changes that will reduce the rates of intimate-partner violence and sexual violence.
- Much work is needed to determine the effectiveness of various policy and structural approaches, which have different characteristics to those of programmes delivered to individuals and groups.
- The gender dimensions of intimate-partner violence and sexual violence, including norms related to sexual relationships and norms related to masculinity, must be incorporated into any prevention approach.

4. Conclusion

In May 2007, WHO convened an expert meeting on the primary prevention of intimate-partner violence and sexual violence. The need to address gaps in the evidence base on intimate-partner violence and sexual violence was a major theme of the discussions. Participants noted that more and better research is needed to describe the non-injury health outcomes of intimate-partner violence and sexual violence, its costs, and its risk and protective factors—including their relative contributions to risk. Research is needed to identify what works for prevention and what can be done most effectively. There is a need for more rigorous outcome evaluation studies and a better understanding of how to present the results in a convincing way. These research needs apply worldwide, but the evidence gap is especially large for low- and middle-income countries. In addition to strengthening the evidence base, work is needed to identify a strategy for marketing primary prevention based on existing evidence, and for convincing community-based organizations to take a more evidence-based approach.

Discussions identified promoting gender equality and equity, creating enabling community environments, changing social norms (particularly norms that promote and reward macho, aggressive behaviour), reducing exposure to child maltreatment and promoting healthy child development, reducing harmful alcohol and drug consumption, and building skills for healthy relationships as key strategies for reductions in intimate-partner and sexual violence. The objective is to reduce aggressive behaviour by individuals, but change is required at the relationship, community and societal levels to catalyse and sustain such change.

WHO proposed, and meeting participants agreed, that the Organization's role in advancing primary prevention of intimate-partner violence and sexual violence includes several aspects:

1. Strengthen understanding of long-term health impacts, costs of this violence and cost-effectiveness of interventions, and provide technical assistance for measuring these.
2. Support international research on risk and protective factors, and assist with identification of what is universal and what is context-specific, as well as the relative importance of various factors in different contexts.
3. Promote the implementation of evidence-based and evidence-generating approaches to primary prevention to:
    - change individuals' knowledge, attitudes and behaviour;
    - promote healthy and equal relationships;
    - create enabling social environments including gender-equitable and non-violent social norms, and responsive and protective community institutions; and
    - promote gender equality and strengthen protective factors at the societal level.

4. Promote systematic primary prevention efforts:
    - Provide technical assistance for the development of plans of action for the primary prevention of intimate-partner and sexual violence or for incorporating primary prevention into plans of action to address violence against women.
    - Work on integrating prevention of intimate-partner violence and sexual violence into existing programmes such as those for reduction of HIV/AIDS and alcohol and substance abuse, adolescent sexual and reproductive health, and others, as appropriate.
    - Address intimate-partner violence and sexual violence as part of more integrated violence prevention programmes.
    - Continue advocacy for multisectoral action on factors at the individual, relationship, community, and societal level.

5. Build political will by advancing the dialogue on the prevention of intimate-partner violence and sexual violence.
    - Continue advocacy, at the local, national, regional, and global levels, to convince various stakeholders about the feasibility and desirability of primary prevention.

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Annex: Factors associated with intimate-partner violence and sexual violence

Table A1: Factors associated with intimate-partner violence

Factors associated with victimization	Factors associated with men's perpetration
Individual factors • history of intimate-partner violence • being female • young age • first sexual intercourse at young age • heavy alcohol and drug use • witnessing or experiencing violence as a child • lower education level • employment (association varies by country) • for women, having a greater education level than their partners • for women, having a verbally abusive, jealous, or possessive partner **Relationship factors** • couples with income, educational or job status disparities • dominance and control of the relationship by the male • marital conflict and instability **Community factors** • poverty and associated factors (e.g. overcrowding, neighbourhood disadvantage) • low social capital • lack of institutional support/weak community sanctions against intimate-partner violence (e.g. police unwilling to intervene) • social environment supportive of intimate partner violence **Societal factors** • traditional gender norms (e.g. women should stay at home and not enter workforce, should be submissive) • lack of gender equality	**Individual factors** • low self-esteem • low income • low education level • young age • aggressive or delinquent behaviour as a youth • heavy alcohol and drug use • depression • anger and hostility • personality disorders • prior history of being physically abusive • having few friends, being isolated • unemployment • economic stress • emotional dependence and insecurity • belief in strict gender roles • desire for power in relationships • prior history of physical or psychological victimization or witnessing family violence as a child **Relationship factors** • marital conflict • marital instability—divorces, separations • dominance of the male • economic stress • unhealthy family relationships **Community factors** • poverty and associated factors (e.g. overcrowding) • low social capital • lack of institutional support/weak community sanctions against intimate-partner violence (e.g. police unwilling to intervene) • social environment supportive of intimate-partner violence **Societal factors** • traditional gender norms (e.g. women should stay at home and not enter workforce, should be submissive) • lack of gender equality • economic inequality

Table A2: Factors associated with sexual violence

Factors associated with victimization	Factors associated with men's perpetration
Individual factors • prior history of sexual violence • being female • young age • heavy alcohol and drug use • high-risk sexual behaviour • poverty • involvement in sex work • higher level of education and economic empowerment (for sexual violence by intimate partner) **Relationship factors** • couples with age, income, educational or job status disparities • dominance and control of the relationship by the male **Community factors** • poverty and associated factors (e.g. neighbourhood disadvantage) • lack of institutional support from police and judicial system/weak community sanctions against sexual violence • social environment tolerant of sexual violence • high levels of crime and other forms of violence **Societal factors** • social norms supportive of sexual violence • social norms supportive of male superiority and sexual entitlement, and women's inferiority and sexual submissiveness • weak laws and policies on sexual violence and gender equality	**Individual factors** • heavy alcohol and drug use • attitudes and beliefs supportive of sexual violence (including coercive sexual fantasies) • impulsive and antisocial tendencies • preference for impersonal sex • hostility towards women • prior history of childhood sexual or physical abuse • witnessing family violence as a child • hyper-masculinity **Relationship factors** • association with sexually aggressive and delinquent peers • family environment characterized by physical violence and few resources • strong patriarchal relationship or family environment • emotionally unsupportive family environment • family honour considered more important than health and safety of the victim **Community factors** • poverty and associated factors (e.g. neighborhood disadvantage) • lack of employment opportunities • lack of institutional support from police and judicial system/weak community sanctions against sexual violence • social environment tolerant of sexual violence • high levels of crime and other forms of violence **Societal factors** • social norms supportive of sexual violence • social norms supportive of male superiority and sexual entitlement, and women's inferiority and sexual submissiveness • weak laws and policies on sexual violence and gender equality • economic inequality