

**EXPERT MEETING ON THE PRIMARY PREVENTION OF
INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE
MAY 2-3 2007, GENEVA, SWITZERLAND
Meeting Report**

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WHO Expert meeting on the primary prevention of intimate partner violence and sexual violence, May 2-3 2007, Geneva, Switzerland
Meeting report

Introduction

The women's movement has long highlighted intimate partner violence and sexual violence as forms of discrimination resulting from and perpetuating women's low status in society. In addition to recognizing these forms of violence as serious human rights concerns, for more than a decade now the significant acute and long-term health impact of intimate partner violence and sexual violence also have been recognized. Intimate partner violence and sexual violence¹ have a damaging impact on physical, mental, reproductive and sexual health, resulting in 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 more.

To date, most responses to IPV-SV have focused on ensuring safety and care for known victims/survivors, rather than focusing on strategies to prevent new occurrences of IPV-SV. Responses promoted by the international community have emphasized 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 do not address the underlying factors that facilitate IPV-SV and therefore do not reduce overall levels of IPV-SV.

The World Health Organization's work in relation to IPV-SV occurs in the context of broader violence prevention. Efforts have included advocacy, research and data collection, improving health services for victims, policy development and capacity development (see Annex). In the coming years the World Health Organization plans to give increased attention to strategies for preventing new instances of IPV-SV occurring. As a first step WHO must determine how it can best promote evidence-based policy options and programmes for the primary prevention of intimate partner and sexual violence, and determine what norms and standards should be promoted. To begin this process, in May 2007 WHO brought together a small group, including WHO staff and experts from outside the organization, to take stock of existing global evidence related to the primary prevention of intimate partner violence and sexual violence and to identify WHO's role and the next steps for WHO in this area.

Primary Prevention Framework

The meeting's discussions were grounded in a public health understanding of primary prevention: to stop intimate partner violence and sexual violence from occurring by addressing the causes and risk factors that underlie perpetration and victimization. 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 analysis of the underlying risk and protective factors for IPV-SV, and action to address those factors. Its aim is to lower the incidence and overall rates of IPV-SV. Primary prevention includes both strategies that address groups without regard to individual risk

¹ Hereafter abbreviated as IPV-SV.

(e.g. schools-based life skills training for all children of a certain age), and strategies for groups considered to be at heightened risk for violence (e.g. training in parenting for low-income families, programmes targeting children in households with domestic violence). It excludes strategies that target known perpetrators or victims of IPV-SV (e.g. treatment for sexual violence offenders, shelters for battered women).

The public health approach to primary prevention of IPV-SV takes into account strategies across all stages of human development (a life course perspective) and is by necessity multidisciplinary and multisectoral. It comprises four stages:

- 1) Define IPV-SV and document its scope and magnitude
- 2) Identify factors that increase risk of IPV-SV or have a protective effect
- 3) Design prevention strategies based on knowledge of risk and protective factors and that are grounded in social science theory. Evaluate the impact of the strategy.
- 4) Implement proven and promising strategies on a larger scale, in various settings, continuing to evaluate their impact.

An individual's experience of violence, whether as victim or perpetrator, is influenced by factors at the individual, relational, community and societal levels. Comprehensive primary prevention approaches require strategies to intervene with factors at all of these levels, and the interaction of factors at various levels must also be taken into account.

Although the global evidence base on prevalence and consequences of IPV-SV has become more robust in recent years, the same cannot be said for the global evidence base for risk and protective factors. Current understanding of these factors derives mainly from research in high-income countries (HIC), and even in HIC there have been few longitudinal studies, making it difficult to determine causality. The relevance of HIC risk and protective factor research in low and middle-income countries (LMIC) must be assessed.

Participants commented that the tables of factors associated with IPV-SV (see Annex 2) presented in the background paper would be more helpful if they gave an indication of which factors are situational and which are probably causal, or if some attempt was made to determine the relative weights of various factors.

Some factors are unique to either IPV or SV, but the number of common underlying and situational factors is striking. :

- Gender inequality
- Social norms supportive of traditional gender roles, IPV-SV, and associating masculinity and violence
- Poverty, economic stress, and unemployment
- Weak community sanctions
- Lack of institutional support from police and judicial systems
- Alcohol and substance misuse
- Dysfunctional, unhealthy relationships characterized by inequality, power imbalance and conflict

This overlap indicates the importance of addressing IPV and SV in tandem rather than in isolation, while still giving attention to those factors unique to one or the other. Risk groups for both IPV and SV include young people, people who have witnessed family violence as a child, and people with a prior history of victimization or perpetration. Generally, women and girls are at greater risk of victimization, and men at greater risk of perpetration².

In some societies few programmes to prevent IPV-SV are implemented because communities and high-level decision-makers have not acknowledged the problem and welcomed action. Efforts to prevent IPV-SV that are documented in the public domain generally are not grounded in an understanding of risk factors or in social science theory regarding behaviour and social change. The evidence base for primary prevention approaches suffers further from the following deficits (Dahlberg and Butchart 2005; Krug et al 2002):

- Few outcome evaluations, 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 IPV-SV are extremely limited;
- Few evaluations of the impact of community and society-level strategies.

There is an urgent need for a systematic approach to primary prevention that ensures widespread implementation of strategies delivered at the appropriate developmental stage, over the lifecourse, and addressing factors at all levels of the ecological model. Prevention strategies need to be based on evidence of effective approaches and evaluated in a way that allows for measurement of their impact, as well as any process evaluations.

During the meeting, participants discussed the evidence base for various primary prevention strategies including early childhood approaches, school-based programmes, measures to address alcohol and drug misuse, working with men and boys, participatory training, community mobilization, and macro-level approaches such as economic empowerment of women, development and social policy measures, and criminal justice system reform. In addition to effectiveness, discussion focused on lessons learned and the feasibility of implementation in resource-constrained settings and obstacles and opportunities for scaling up.

Primary Prevention Approaches

Early childhood approaches

Dr Vangie Foshee³ began by providing a presentation of early childhood approaches to preventing dating abuse and partner abuse in the United States. Three approaches were reviewed:

² There is research that suggests men experience physical and emotional partner violence more than originally thought, particularly in dating relationships in higher income countries. The pattern in low and middle income countries, however, is different in nature and more commonly involves male perpetration against women. Sexual violence, whether partner or non-partner, is mainly perpetrated by males.

³ Dr Foshee was asked, at very late notice, to give this presentation in lieu of Richard Tremblay, who was unable to participate due to competing commitments.

1. Parenting/family-based approaches for altering family-related characteristics that have been associated with dating abuse and partner abuse
2. Programmes for preventing behavioural precursors to dating abuse such as bullying and aggression
3. Prevention programmes for children/teens who have been exposed to family violence

All three approaches have some evidence of effectiveness for reducing or promoting the primary target behaviours. For example, key outcomes from randomized controlled trials (RCTs) of home visitation programmes included decreasing corporal punishment, improving parent-child interaction, improving emotional support by parents, decreasing number of emergency room visits for child, and reducing verified cases of child abuse and neglect. RCT evidence suggests that school-based bullying prevention programmes can reduce bullying behaviours, and there is some evidence that programmes for children/teens who have been exposed to family violence can reduce incidents of physical and emotional abuse. The direct impact of these approaches, however, on IPV-SV by or against the child participant later in life has not been measured. It was noted that home visitation approaches show great promise, but the cost of the intervention may be a significant obstacle. Home visitation for parent training and child maltreatment prevention may be able to be integrated with other existing programmes of home health visits (e.g. for family planning or tuberculosis control) where such programmes exist. Participants affirmed the importance of early childhood and family approaches for preventing IPV-SV, and agreed that these approaches should receive more attention.

School-based programmes

Dr Vangie Foshee presented a review of the effectiveness of school-based approaches to the prevention of adolescent dating abuse. Of 11 published evaluations, seven measured programme effects on attitudes and four measured effects on behaviour. Only five studies used an experimental design. The evidence reviewed indicates that school-based programmes can have a positive impact on dating abuse-related norms and attitudes, and that these changes in norms and attitudes can lead to reductions in perpetration and victimization. School-based programmes can reach large numbers of adolescents, can incorporate both primary and secondary prevention, and can potentially be low-cost if teachers are trained to deliver the programme. These programmes need to expose adolescents to sufficient dosage (i.e. one hour is not enough). There may be resistance from school personnel when schedules are busy and they are asked to integrate multiple issues into the curriculum.

Participants agreed that the ability to maintain healthy and respectful relationships is an important life skill that is arguably a responsibility of school systems to address. It was suggested that teacher fatigue and resistance to this type of programme may be alleviated by combining dating abuse prevention with other violence prevention programmes, e.g. youth violence prevention. In low-income countries many children do not make it to secondary school, so it is important to develop interventions that can be delivered in primary school settings. To qualify as primary prevention the content of school-based approaches must aim to change knowledge, attitudes and norms with the objective of reducing rates of dating abuse, rather than focusing solely on raising awareness of the problem and how to seek help. It was suggested that media literacy (i.e. skills for critical analysis of media content and messages) should be a component of school-based IPV-SV prevention programmes.

Reducing alcohol and drug misuse

Dr Kate Graham spoke about preliminary results from a multinational study on gender, alcohol and culture in about 40 countries. This study examined the relationship between gender and drinking patterns, as well as the interaction of gender and alcohol consumption in relation to issues such as social and health consequences of drinking, intimate partner violence (IPV), depression, and social roles. Although the study was not specifically on IPV, it included a number of questions related to physical aggression in intimate relationships. Data suggest that alcohol use, while not causal, at the time of the incident is associated with more severe aggression.

Research focusing on the prevention of alcohol-related IPV-SV is scarce. However, generic strategies that tackle IPV and those that aim to reduce harmful use of alcohol in the population both play important roles in prevention. Such measures include addressing societal tolerance towards intimate partner violence, acceptance of excessive drinking as a mitigating factor, and normative beliefs about masculinity and heavy drinking. IPV may also be reduced through interventions to moderate alcohol consumption through a number of measures such as those outlined in the book *Alcohol: No Ordinary Commodity*, including reducing availability and raising prices. One study in Australia with Aboriginal communities showed that 'having a dry Thursday' and closing the bottle shop decreased the number of violent crimes in the community as well as domestic violence incidents. (Thursday is the day of the week when people receive the welfare payments). One study in Sweden showed that closing bottle shops earlier on specific days reduced criminal offences of domestic violence. Dr Graham also presented a situational crime prevention model that may be applied to IPV-SV prevention as an approach for identifying cultural and situational factors that increase the probability that IPV will occur.

Dr Mark Bellis, as respondent to the presentation, highlighted some key points. He noted that it can be difficult to determine whether alcohol misuse functions as a coping mechanism in situations of ongoing violence, as a situational factor, or as both. Perpetrators often are viewed as less culpable if they'd been drinking at the time of the violence. He also noted that the relationship between alcohol use and IPV-SV varies by country, mediated by social norms around gender, alcohol use and violence.

Participants agreed that reducing alcohol and drug misuse is an important component of IPV-SV prevention, but that alcohol/drug use is a situational or contextual factor that contributes to IPV-SV and increases its severity, rather than being a primary cause of IPV-SV. Participants noted that any guidance from WHO on this matter should be clear that reducing alcohol and drug consumption alone will not eliminate IPV-SV because this approach does not get at the root causes. It was also recognized that the links between violence and alcohol misuse appear to be even stronger in countries where alcohol consumption is not the norm and that reducing harmful alcohol consumption might be a good harm reduction approach while undertaking work to improve gender equality and social norms. Participants also noted the importance of considering the role of drugs in IPV-SV.

Working with men and boys

Mr Jackson Katz began by acknowledging women's leadership in the field of IPV and SV, noting that without the work of the women's movement these issues would not even be on the agenda.

IPV and SV cannot be presented only as women's issues, however, given that in most cases the perpetrators are men. Mr Katz emphasized the importance of using gendered language--talking and writing about men's violence, rather than talking or writing about women who are victimized, or IPV-SV that "happens" to women. He challenged WHO to lead on this issue by avoiding gender-neutral language when describing violence. He also urged that IPV-SV prevention must be institutionalized by prioritizing it through buy-in at the highest levels of leadership. Mr Katz also described the Mentors in Violence Prevention (MVP) model that he developed for working with student athletes and the U.S. military. The MVP model focuses on changing the peer culture that allows violence to thrive. MVP trains both men and women to speak out and act as empowered bystanders. It operates on the understanding that most men who abuse are not sociopaths, and that many men who disapprove of violence do not speak up or take action because they don't know what to do. Mr Katz stressed the importance of approaching men as change agents and partners, rather than perpetrators or potential perpetrators, explaining that even men in court-mandated batterer intervention programmes often do not perceive themselves as perpetrators.

Discussion of this issue was lively and led to the following conclusions:

- There needs to be more research on perpetration of IPV-SV. We know little about perpetrators.
- "Working with men and boys" is an increasingly visible funding stream, although to date there are no systematic outcome evaluations of the impact of such interventions on rates of IPV-SV. Such studies should be prioritized to help ensure that this new funding stream is directed in the most promising directions.
- Mainstreaming work with men and boys into general programming is likely to be a more effective approach than adding on small, specialized programme components.
- It is a challenge to involve men and get them to take responsibility without taking a paternalistic/chivalrous approach (e.g. women need you to protect them). Work with men & boys must have gender equality as the underlying tenet.
- The bystander model may not work as well in contexts where IPV-SV is highly normative.
- Men's own experience of violence can be a strategic entry point for helping them understand women's experiences.
- While it is important to get buy-in and leadership from men in top positions of hierarchical and patriarchal structures (e.g. military), it is not enough. There must also be work done to increase the number of women in positions of power and leadership.
- Male leaders can play an important role in challenging gender norms and in breaking the silence around IPV-SV.

Community-based approaches

Ms Lori Michau presented a community mobilization approach to IPV-SV prevention. Raising Voices uses both human rights and primary prevention as guiding frameworks. The approach aims to involve all levels of a community, foster activism and change the value systems that perpetuate violence against women. Principles of action include repeated exposure to ideas (sufficient dosage), taking a holistic, benefits-based approach, facilitating a process of change (not just awareness-raising), and building community ownership. Evaluation has shown this approach to have a positive impact on individuals' attitudes and norms, the quality of communication among couples, social support networks, community activism, and tolerance of

violence in the community. Some programme participants reported reductions in IPV-SV. Key elements for the success of community mobilization include programme planning based on an understanding of how people change, integral involvement of men, promotion of healthy and safe relationships--not just violence prevention, community ownership, and sustained engagement with a community. Meaningful change takes time and occurs through an organic process, which doesn't always fit neatly with donors' plans.

Ms Faith Kasiva presented the work of Kenya's Coalition on Violence against Women (COVAW). The coalition originally focused on awareness-raising and service provision for survivors, but in 2003 decided they needed to be more proactive than reactive and build capacity to prevent VAW. COVAW takes a grassroots approach to building the capacity of communities to adopt proactive measures to prevent violence against women and develop local strategies to respond to incidents of violence against women. The advocacy programme works with community-based organizations to foster dialogue that breaks the silence on the issue of VAW. It also works through school programmes and with community leaders. COVAW has broken the silence about VAW in the communities where it works, fostered a sense of community ownership, and engaged male leaders on the issues. Challenges include the slow pace of change, the high demand for services generated by increased awareness, and the considerable initial outlay of resources required. COVAW has learned that all communities--regardless of literacy levels--are capable of running programmes, and that networking and institutional capacity building are key to success.

Dr Rachel Jewkes presented the results of a cluster randomized trial of the programme Stepping Stones in South Africa⁴. Stepping Stones is an HIV-prevention programme that aims to improve sexual health by building healthier, more gender-equitable relationships, using participatory learning approaches. Stepping Stones South Africa has incorporated IPV-SV as one of its topics. Quantitative findings include reductions in men's risky sexual behaviour and men's reported IPV incidents (physical or sexual). The qualitative findings indicate significant changes in relationships including improved communication between partners and between generations and a new awareness--of both men and women--that violence is wrong. Stepping Stones shows great promise but faces challenges for scaling-up, including the length and intensity of the programme. Success depends heavily on the facilitator, making facilitator training and support a key aspect of the programme. Facilitator training takes substantial time and investment to be effective. Dr Jewkes noted that the programme needs to be delivered as a whole, rather than extracting individual sessions, although it may be possible to reduce the number of hours (50 in the study).

Discussion points included the following:

- Even when the focus of community-based programmes is primary prevention, the availability of services needs to be considered, since primary prevention programmes often lead to increased demand for such services.
- There is a need to explore ways to combine IPV-SV prevention with other issues such as youth violence or HIV/AIDS.

⁴ While Stepping Stones is an intervention that works with (groups of) individuals, it was included among community-based approaches since it is delivered in community settings and in the context of school curricula.

- Increased funding for primary prevention research is desperately needed. This is not just true in the IPV-SV field--a lack of interest in/funding for behavioural interventions for HIV prevention was noted.
- We need to develop a strategy for using the existing evidence base, with all its flaws, to make a strong case for action. There needs to be a better understanding of what speaks to policy-makers in this area.
- Participants suggested that WHO might develop a methodology for showing the value of primary prevention, i.e. the costs of IPV-SV and the cost-effectiveness of prevention in particular.

Building capacity for prevention among practitioners

Dr Pam Cox and Ms Karen Lang described how IPV-SV work in the USA has traditionally focused on secondary and tertiary prevention. The US Centers for Disease Control and Prevention has developed two programmes (DELTA and RPE⁵) to build individual, organization and community capacity to engage in primary prevention. The programmes aim to prevent first-time perpetration and victimization, to reduce the risk factors associated with IPV and SV, and to promote protective factors. They use an evidence-based approach and behaviour and social change theories to guide programme design, and emphasize programme evaluation. The main emphasis is on promoting desired behaviours, rather than on deterrence or risk reduction. Working with existing networks and coalitions that have focused more on responses to IPV-SV has its pros and cons. The DELTA and RPE approach has led to stronger public-private partnerships, stronger interface between science and practice, and the development of a primary prevention movement in the USA. Building institutional capacity has been equally as important as building individual capacity, so that institutions and networks can retain the capacity even if trained individuals move on to different work. A major challenge in the US is that IPV and SV are treated as separate fields, each with its own funding stream and sometimes in competition with each other for state-level funding.

Reflections

Dr Jamela Al-Raiby reflected on the day's presentations in the context of her experiences in Yemen, noting that inattention to primary prevention is not a problem unique to IPV-SV, and that it is important not to talk about prevention without talking about services too. Dr Al-Raiby commented that home visitation programmes most often focus on mothers, and it is important to find a way to address fathers and involve them in parenting programmes. She noted that capacity development, women's empowerment, budget allocation to back political commitments, the promotion of healthy relationships and the involvement of religious leaders and institutions are all critical to successful prevention efforts.

Dr Pimpawun Boonmongkon offered her reflections based on her experience in Thailand, noting that all the strategies must be used to optimize prevention impact. She mentioned that community-based parent training programmes have been implemented successfully under the concepts of positive parenthood and child rights protection in a few places in Thailand, but they are expensive. She agreed with Dr Al-Raiby that early childhood and family programmes must find a way to involve men. Thailand has a strong concept of family as the social institution that

⁵ DELTA stands for Domestic Violence Prevention Enhancement and Leadership through Alliances. RPE stands for Rape Prevention and Education Program.

can facilitate a preventive environment. However, it should not be over-emphasized, and society must not insist that a couple must maintain the family even if IPV-SV continuously persists in it. Sexuality and sexual violence are still taboo issues and work must be done to raise awareness about sexual violence, to break the silence and change victim-blaming attitudes and harmful norms related to masculinity.

Empowerment of women, including economic

Dr Charlotte Watts discussed the primary prevention effects of economic empowerment of women on IPV-SV, with a special focus on microfinance as one mechanism. Microfinance is a development strategy that provides credit and savings services to poor, and often rural, women for income generation, with evidence of a wide range of health benefits also resulting. Some studies indicate microfinance lending to women reduces IPV, while others note that it can increase a woman's risk by challenging gender norms and triggering conflict. Dr Watts summarized a cluster randomized trial of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE study) in South Africa. IMAGE used a two-pronged approach of microfinance as a prevention tool to address poverty and economic inequality-related vulnerability, combined with a mandatory participatory training for loan recipients on gender, HIV, domestic violence and life skills. The community mobilization aspect of the programme was also important. The programme was effective in improving women's economic well-being and other measures of empowerment such as communication skills, attitudes towards violence and self-confidence. Experiences of IPV in the past year were reduced by 55%. Those involved in the study consider the gender training aspect to be critical to the programme's success.

Criminal justice sector responses

Dr Holly Johnson presented an overview of policing and criminal justice responses to IPV-SV, noting that existing responses do not map well to primary prevention. There is a limit to what the criminal justice system can do to prevent IPV-SV beyond reinforcing non-violent norms. The deterrent effect of criminal justice responses is not well understood. The International Violence Against Women survey indicates that between 7% and 31% of IPV cases and less than 10% of sexual assaults are reported to the criminal justice system. Police officers, prosecutors and judges make decisions based on rape myths and bias, and societal belief in false accusations is high. Criminal justice responses to IPV-SV occur in response to a sexual assault or IPV incident, making them secondary rather than primary prevention. Responses to sexual assault include Sexual Assault Response Teams (SART) that provide integrated health, forensic and legal services to victims, and all-female police units, which can improve reporting rates. Responses to IPV include specialized police units; pro-charging policies, operating on the assumption that arrest is a greater deterrent than warning; pro-prosecution policies, which take the decision to press charges out of the victim's hands; and specialized courts that have training and experience in IPV. All these approaches have strengths and have been seriously criticized. Dr Johnson closed by reiterating the three main functions of criminal justice systems (justice, deterrence and removal of threat from society) and emphasized that the criminal justice system should not be the first or only resort for primary prevention. Rather, criminal justice responses to IPV-SV must be part of a comprehensive societal strategy. It was noted that in some settings indigenous and other alternative justice mechanisms must also be considered.

Macro policy considerations

Dr Bernice von Bronkhorst presented IPV-SV as a development issue related to poverty, social development and economic growth. This is evidenced by the direct and indirect costs of IPV-SV, its impacts on performance in school, increased probability of delinquency as both juvenile and adult, association with substance abuse, and higher probability of committing family violence as an adult. She emphasized the need for more cost-effectiveness research and the importance of multisectoral approaches (versus integrating IPV-SV sector by sector) for public policy.

Operational entry points must be identified. In resource-poor communities it is imperative to think strategically about packages that address the full range of violence, rather than having separate programmes for each type of violence, and that link violence to other key development issues. Dr von Bronkhorst emphasized that work with men and on masculinities must not focus narrowly on IPV-SV. She described three pilot projects of the World Bank on integrating crime and violence prevention into urban upgrading projects in Brazil, Jamaica and Honduras.

Force field analysis

Participants undertook a Force Field Analysis to identify what factors are driving primary prevention of IPV-SV, what factors are restraining it, and what can be altered to advance the field from the current situation where it is not a priority and in some places there is active opposition, to a future state where primary prevention is widely accepted, funded and implemented as part of a systematic and comprehensive approach to IPV-SV. On balance, the restraining forces appeared stronger in the analysis, though it was acknowledged that the meeting itself provides evidence of a shifting balance.

Lack of funding and perceptions (e.g. perception that primary prevention is expensive or ineffective, perception that focusing on primary prevention means reducing available services for victims/survivors, misperceptions about what primary prevention is) were identified as key barriers to primary prevention. To increase demand for primary prevention of IPV-SV these perceptions must be addressed and funding must be available. It was recognized that the current limited evidence base is not necessarily as great a restraining force as one might expect; lack of evidence for effective and cost-effective secondary and tertiary prevention approaches to IPV-SV has not stopped their expansion. There is a need to understand what arguments can convince policy-makers and funders, and can increase the size of the pie so that funding for primary prevention does not mean less funding for services. It was also apparent from the analysis that better efforts to link IPV-SV prevention with other health and development issues, as well as with other prevention initiatives, could yield large advances, though not without risk. It was clear from the exercise that any conceptual framework must be accompanied by advocacy efforts, or else there will be little demand for it. It may be helpful to consider the stages of change model for individuals and organizations in these advocacy efforts.

Summary and conclusions

The need to address gaps in the IPV-SV evidence base was a major theme of the discussions. Better research is needed to describe the non-injury health outcomes of IPV-SV, its costs, and its risk and protective factors--including their relative contributions to. Research is needed to identify what works for prevention and what can be done most effectively. There needs to be more rigorous outcome evaluation studies, along with 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 LMIC. 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 related to predominant masculinities that promote and reward macho, aggressive behaviours), reducing exposure to childhood trauma, reducing alcohol and drug consumption, and building skills for healthy relationships as key strategies for reductions in IPV-SV. The objective is to reduce aggressive behaviour by individuals, but to do this change is required at the relationship, community and societal levels to catalyze and sustain such change.

WHO's role

Participants agreed that WHO's role in advancing primary prevention of IPV-SV includes the following:

- 1) Strengthen understanding of long-term health impacts, costs of IPV-SV and cost-effectiveness of interventions, and provide technical assistance for measuring these.
- 2) Support international research on risk and protective factors.
 - Analysis and dissemination of Multi-country Study on VAW data on risk and protective factors
 - Technical assistance to countries for risk factor research, with careful attention to risks for both victimization and perpetration
 - Identify what is universal and what is context specific with regards to risk factors, and indicate the relative importance of various factors as drivers or situational elements.
- 3) Promote the implementation of evidence-based and evidence-generating primary prevention approaches to change individuals' knowledge, attitudes and behaviour; to promote healthy and equal relationships; to create enabling social environments including gender-equitable and non-violent social norms, and responsive and protective community institutions; and to promote gender equality and to strengthen protective factors at the societal and community level.
 - Provide technical assistance for programme/policy design and evaluation
 - Support and encourage rigor in outcome evaluation studies
 - Advocate for increased funding for implementation and evaluation of evidence-based approaches, especially in LMIC.
- 4) Promote systematic primary prevention efforts.
 - Provide technical assistance for development of IPV-SV primary prevention plans of action and/or for incorporating primary prevention into VAW plans of action
 - Integrate IPV-SV prevention into existing programmes such as those for HIV/AIDS, alcohol/substance abuse, adolescent sexual and reproductive health, and others, as appropriate.
 - Address IPV and SV as part of more integrated violence prevention programmes
 - Continue advocacy for action at the individual, relationship, community and societal level.
- 5) Build political will by advancing the dialogue on IPV-SV prevention.

- Continue advocacy to convince various stakeholders about the feasibility and desirability of primary prevention

The group advised WHO to begin by developing a conceptual framework to guide countries in primary prevention efforts, and also a shorter advocacy document to raise policy-makers' awareness about the concept and benefits of primary prevention.

Guiding principles for a conceptual framework

During the discussions several consensus points were reached regarding the conceptual framework:

- The framework should focus more on process rather than content, give guidance on "how to do" rather than specific detail on "what to do". It should be as practical as possible.
- It should be framed around goals for a healthy society rather than ecological levels of interventions (although there was debate about how specific the goals should be), while still emphasizing the importance of intervention at all levels of the model.
- Careful attention must be given to cultural specificity and how to account for it, without using cultural norms or practices as justification for IPV-SV.
- It must promote a comprehensive, intersectoral approach, making the linkages between IPV-SV and other health, development and human rights issues clear, and emphasizing the importance of addressing factors at all ecological levels. It should give guidance on how this multi-level, intersectoral approach can be implemented.
- It should give guidance for intervening with various age groups across the lifespan and by sex, taking gender issues into account.
- It should take care to retain an emphasis on safeguarding human rights and fostering social change, rather than taking a reductionist approach limited solely to reducing violent acts.
- It should present specific examples of approaches that have been effective but be explicit that these approaches may not achieve the same effectiveness in different settings, and may require adaptation according to local context.
- It should present some strategies that can lead to "quick wins" but emphasize commitment and investment over the long term for substantial and sustainable change. The decades-spanning process that has led to changes in policy, social norms, attitudes and behaviour around smoking was raised as an example.
- Risk factors should not be presented as a simple "laundry list". Some effort should be made to separate contextual or situational factors from underlying risk factors. Framework should also urge local assessment of risk and protective factors.
- It should make clear what changes can and cannot be expected by taking certain approaches (e.g. focusing exclusively on reducing alcohol consumption may lead to fewer incidents or incidents of less severity, but may not lead to large reductions in prevalence if the root causes of IPV-SV are not being addressed).
- Careful thought should be given to language with regard to gender equality and with regard to reframing the language around primary prevention to something more positive. The framework should be explicit about behaviours and norms to promote and not just behaviours to prevent.
- Some guiding principles as to appropriate content of specific interventions should be given. Promoting school-based strategies or work with men is not enough without giving some guidance on content.

- There should be some discussion of the importance of properly choosing and training the people who will function as facilitators in behaviour-change interventions.
- Basic evaluation strategies should be included so that evaluation is seen as integral part of programme planning.

Next steps

As immediate follow up to the meeting, WHO has prepared this report and will finish the background paper, condense it, and incorporate the main discussion points and outcomes of the meeting. The enhanced background paper will be made public and disseminated widely. Over the coming year WHO will draft the conceptual framework and the advocacy document, calling upon this network for input as needed. The goal is to have a draft framework available for review at the 9th World Conference on Injury Prevention and Safety Promotion in Mexico, in March 2008.

Annex 1: WHO Violence Prevention Resources

General:

- Krug EG et al., eds. World report on violence and health. Geneva, World Health Organization, 2002 (<http://whqlibdoc.who.int/hq/2002/9241545615.pdf>).
- Preventing violence: a guide to implementing the recommendations of the World report on violence and health. Geneva, World Health Organization, 2004 (<http://whqlibdoc.who.int/publications/2004/9241592079.pdf>).
- Butchart RA et al. Preventing child maltreatment: a guide to taking action and generating evidence. Geneva, World Health Organization, 2006 (http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf).
- Schopper D, Lormand JD, Waxweiler R (eds). Developing policies to prevent injuries and violence: guidelines for policy-makers and planners. Geneva, World Health Organization, 2006 (http://www.who.int/violence_injury_prevention/publications/39919_oms_br_2.pdf).

IPV-SV:

- Addressing violence against women and achieving the Millennium Development Goals. Geneva, World Health Organization, 2005 (<http://www.who.int/entity/gender/documents/MDGs&VAWSSept05.pdf>).
- Garcia-Moreno et al. WHO Multi-Country Study on Women's Health and Domestic Violence against Women. Geneva, World Health Organization, 2005. (http://www.who.int/entity/gender/violence/who_multicountry_study/en/index.html)
- Addressing violence against women and HIV testing and counseling: a meeting report. Geneva, World Health Organization, 2007. (http://www.who.int/entity/gender/documents/VCT_addressing_violence.pdf)
- Guidelines for medico-legal care of victims of sexual violence. Geneva, World Health Organization, 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>).
- Clinical management of survivors of rape: a guide to the development of protocols for use in refugee and internally displaced person situations. Geneva, World Health Organization/Office of the United Nations High Commissioner for Refugees, 2002 (WHO/RHR/02.08; http://whqlibdoc.who.int/hq/2002/WHO_RHR_02.08.pdf).
- Ellsberg MC, Heise L. Researching violence against women: a practical guide for researchers and activists. Washington, DC, PATH/Geneva, World Health Organization, 2005.
- Intimate partner violence and HIV/AIDS. Geneva, World Health Organization, 2004 (Critical Intersections Information Bulletin Series, No. 1; <http://whqlibdoc.who.int/un aids/2004/a85591.pdf>).
- Putting women first: ethical and safety guidelines for research on domestic violence against women. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.1; http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf).
- Violence against women and HIV/AIDS: setting the research agenda. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.08; http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.08.pdf).

For further information, please visit the web sites of the following WHO departments:
Gender, Women and Health (<http://www.who.int/gender/>)
Injuries and Violence Prevention (http://www.who.int/violence_injury_prevention/).

Annex 2: Factors associated with IPV and SV (from background paper)

These lists include factors identified in various studies. Because the relevance and significance of each varies from study to study, it is not possible to assess their relative importance at a global level at this time. A better understanding of the role of these factors at national and local levels is imperative for effective prevention.

Table 1: Factors associated with intimate partner violence

<u>Factors associated with victimization</u>	<u>Factors associated with men's perpetration</u>
<p>Individual Factors</p> <ul style="list-style-type: none"> • Prior history of IPV • Being female • Young age • Young age at first union • 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 partner's • For women, having a verbally abusive, jealous, or possessive partner <p>Relationship Factors</p> <ul style="list-style-type: none"> • Couples with income, educational, or job status disparities • Dominance and control of the relationship by the male • Marital conflict and instability <p>Community Factors</p> <ul style="list-style-type: none"> • Poverty and associated factors (e.g., overcrowding, neighbourhood disadvantage) • Low social capital • Lack of institutional support/weak community sanctions against IPV (e.g., police unwilling to intervene) • Social environment supportive of IPV <p>Societal Factors</p> <ul style="list-style-type: none"> • Traditional gender norms (e.g., women should stay at home and not enter workforce, should be submissive) • Lack of gender equality • Social norms that condone use of violence against women (e.g. as chastisement) 	<ul style="list-style-type: none"> • Individual Factors Low self-esteem • Low income and unemployment • 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 • Economic stress • Emotional dependence and insecurity • Belief in strict gender roles • Desire for power and control in relationships • Prior history of physical or psychological victimization or witnessing family violence as a child <p>Relationship Factors</p> <ul style="list-style-type: none"> • Marital conflict and instability—divorces, separations • Dominance of the male • Economic stress • Unhealthy family relationships <p>Community Factors</p> <ul style="list-style-type: none"> • Poverty and associated factors (e.g., overcrowding) • Low social capital • Lack of institutional support/weak community sanctions against IPV (e.g., police unwilling to intervene) • Social environment supportive of IPV <p>Societal Factors</p> <ul style="list-style-type: none"> • Traditional gender norms (e.g., women should stay at home and not enter workforce, should be submissive) • Lack of gender equality • Economic inequality (e.g. as measured by the Gini Coefficient)

Table 2: Factors associated with sexual violence

<u>Factors associated with victimization</u>	<u>Factors associated with men's perpetration</u>
<p>Individual Factors</p> <ul style="list-style-type: none"> • Prior history of SV • Being female • Young age • Heavy alcohol and drug use • High-risk sexual behaviour • Poverty • Involvement in sex work <p>Relationship Factors</p> <ul style="list-style-type: none"> • Couples with age, income, educational, or job status disparities • Dominance and control of the relationship by the male <p>Community Factors</p> <ul style="list-style-type: none"> • Poverty and associated factors (e.g., neighbourhood disadvantage) • Lack of institutional support from police and judicial system/weak community sanctions against SV • Social environment tolerant of SV • High levels of crime and other forms of violence <p>Societal Factors</p> <ul style="list-style-type: none"> • Social norms supportive of SV • Social norms supportive of male superiority and sexual entitlement, and women's inferiority and sexual submissiveness • Weak laws and policies on SV and gender equality 	<p>Individual Factors</p> <ul style="list-style-type: none"> • Heavy alcohol and drug use • Attitudes and beliefs supportive of SV (including coercive sexual fantasies) • Impulsive and antisocial tendencies • Preference for impersonal sex • Hostility towards women • Prior history of childhood sexual or physical abuse • Witnessed family violence as a child • Hypermasculinity <p>Relationship Factors</p> <ul style="list-style-type: none"> • 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 <p>Community Factors</p> <ul style="list-style-type: none"> • Poverty and associated factors (e.g. neighborhood disadvantage) • Lack of employment opportunities • Impunity: lack of legal frameworks or community sanctions against SV/weak police and judicial system • Social environment tolerant of SV • High levels of crime and other forms of violence <p>Societal Factors</p> <ul style="list-style-type: none"> • Social norms supportive of SV • Social norms supportive of male superiority and sexual entitlement, and women's inferiority and sexual submissiveness • Weak laws and policies on SV and gender equality • Economic inequality (e.g. as measured by the Gini Coefficient)