

Central America

Community-Based Approaches to IPV

The Case for Community Mobilization Interventions to Prevent Intimate Partner Violence: A review of Evidence

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THE CASE FOR COMMUNITY MOBILIZATION INTERVENTIONS TO PREVENT INTIMATE PARTNER VIOLENCE: A REVIEW OF EVIDENCE

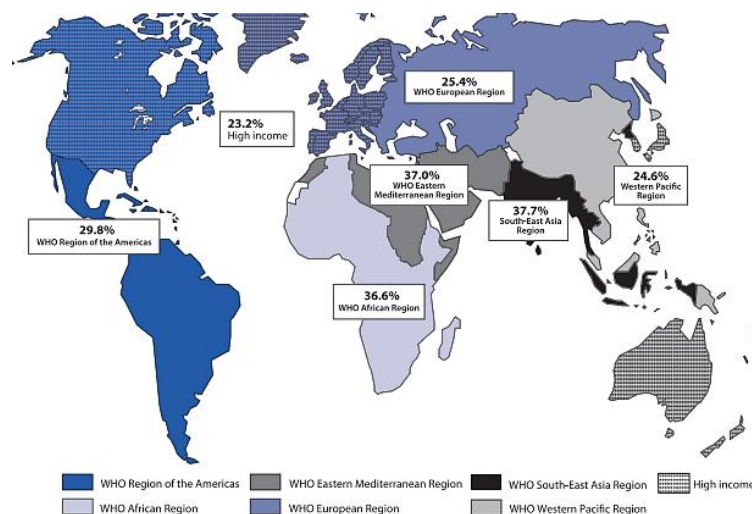
Table of Contents

Introduction	5
Objective	6
Summary of What Works to Prevent Intimate Partner Violence	8
Transforming Social Norms through Community Mobilization Interventions.....	9
An Ecological Framework	9
Examples of Effective Community Mobilization Interventions	11
<i>SASA! (Raising Voices)</i>	<i>12</i>
<i>Somos Diferentes, Somos Iguales (Puntos de Encuentro)</i>	<i>12</i>
<i>Stepping Stones (Various Organizations)</i>	<i>13</i>
<i>Engaging Men to Prevent Gender Based Violence (Grameen Vikas Jan Sahbhagita Trust Jaunpur and Ujala Welfare Society)</i>	<i>14</i>
Other Community-Based Interventions	14
Adaptations	15
Some Examples of Specific Adaptations	15
Recommendations	16
Resources	19

Introduction

Intimate partner violence (IPV) is a serious global health concern and a human rights violation that affects millions of people worldwide, particularly women.¹ The World Health Organization (WHO) defines IPV as “behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors.”² Recent estimates indicate that the prevalence of physical and sexual IPV against women ranges from 16.3 percent in some countries in East Asia to as high as 65.6 percent in countries in Central Sub-Saharan Africa.¹ Globally, over one in three women will experience violence at the hand of their partner or ex-partner at some point in her lifetime.² Figure 1, below, illustrates recent prevalence estimates of intimate partner violence by region.

Figure 1 - Recent prevalence estimates of intimate partner violence by region.



Source: World Health Organization, London School of Hygiene and Tropical Medicine, Medical Research Council. (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: World Health Organization.

The alarming rates of IPV have significant physical, psychosocial, and economic costs for the survivor and their family, as well as society as a whole.²⁻⁴ In the United States alone, researchers from The Centers for Disease Control and Prevention (CDC) estimate that the financial costs of IPV, including health care expenses, loss of productivity, and loss of lifetime earnings, totals approximately US\$6 billion annually.⁵

The health consequences faced by female survivors of IPV span physical, psychological, and sexual and reproductive outcomes. Women who experience IPV are more likely to engage in high-risk behaviors such as smoking and substance abuse, suffer chronic pain syndrome, and have overall poor subjective health.⁷ A systematic review of studies in South Asia revealed a strong link between poor physical and mental health outcomes among women who experienced physical violence.⁶ These women were at greater risk of experiencing behavioral health issues, including post-traumatic stress disorder, anxiety, and depression.⁸

In terms of reproductive health, a review of studies in Western countries (Campbell, 2002) found that gynecological problems are consistent and longer lasting in battered women.⁹ Another study in India found that negative reproductive health outcomes resulting from IPV included unwanted pregnancies, sexually transmitted infections (STIs), gynecological disorders, and pelvic inflammatory disease.⁷ The same study further showed that women who experience IPV are 52 percent more likely to contract HIV, 61 percent more likely to contract syphilis, and 81 percent more likely to contract chlamydia or gonorrhea.¹⁰ Importantly, the health consequences of violence also deter women from entering the labor force or impairing job performance, ultimately impacting productivity in a variety of sectors. Women experiencing IPV are impacted by fear, geographical isolation, and a lack of economic resources that prevent them from seeking health services, with negative consequences for themselves and their children.⁷

The negative health impacts do not stop at the survivor, continuing to affect current and future children.¹¹ A recent systematic review on health consequences of IPV found that IPV is significantly associated with low birth weight and preterm birth through a variety of pathways.¹² These data are but a small subset of the full range of the harmful, long-term, and inter-generational effects that are a direct or indirect result of experiencing IPV. In addition, the negative effects of witnessing IPV against mothers have been well documented. There are clear connections between a child's experience of violence as a witness and the likelihood to perpetrate or experience IPV as an adult.

There have been many attempts in recent decades to address violence against women and girls (VAWG), especially the violence perpetrated by women's male partners. Most efforts to address violence have focused on providing health and legal responses to IPV survivors. However, recent research and programs are starting to emphasize violence prevention involving community mobilization which are particularly effective.^{3-5,12,13} The aim of this note is to document the lessons stemming from the most effective IPV prevention programs, to inform policymakers, stakeholders, and decision makers working in development and women's rights issues.

Objective

To achieve its aim, the paper highlights several examples of effective community mobilization interventions to prevent IPV. It underscores the basic components that must be considered to adapt successful interventions to different contexts and collectively serve as a methodological guide on programming.¹

This review focuses specifically on IPV against women, as opposed to VAWG more broadly, for several reasons.¹³ Partner violence is the most prevalent form of violence against women globally: a woman is at the greatest risk for suffering violence in her own home by someone she knows. A recent systematic review found that most of effective evaluations and programs on VAWG have been directed to IPV.¹⁵ Finally, authors such as Heise and Kostadam (2015) argue that by specifically focusing on IPV, program implementers gain access to a strategic entry point (the family) to address harmful social norms and behaviors that influence other

¹ Studies show that one in four women (22.3 percent) experienced severe physical violence by an intimate partner, while one in seven men (14 percent) have experienced the same. Although we recognize that men experience IPV, this note will focus solely on women.¹⁴

forms of VAWG. While all forms of VAWG share similar characteristics and underlying risk factors, addressing IPV specifically allows program implementers to build strong, evidence-based tools that can later be adapted to address other types of VAWG.^{2,13}

The field of public health identifies three levels of violence prevention programs: primary, secondary, and tertiary.¹⁶ Primary prevention refers to programs that aim to stop the problem before it begins. For example, *SASA!* is a community-based mobilization program that builds capacity among a group of community advocates to discuss issues related to gender equality and power dynamics. By addressing the underlying risk factors of intimate partner violence, *SASA!* advocates have helped to change harmful attitudes and behaviors that perpetuate violence and prevent it from happening in the first place.¹⁷

Primary interventions aim to address root causes and target communities rather than working at the individual level. Secondary prevention programs address the immediate needs of the survivor after a violent incident has occurred with the aim of reducing rates of re-victimization.¹⁶ For example, IPV screening (when done appropriately) in health care settings, such as during the antenatal care period, provides women with a confidential and safe space to disclose violence.¹⁸ The health care provider can then treat any immediate injuries and refer women to a counselor for psychosocial support and/or to a domestic violence advocate who can liaise with the legal sector, as well as assist in finding temporary or transitional housing. Secondary interventions aim to minimize harm caused by a specific incident and provide the survivor with the necessary services to prevent a reoccurrence. Tertiary prevention refers to programs that help minimize the long-term consequences faced by survivors of violence, including those that focus on rehabilitation and reintegration.¹⁶

Historically, IPV programming in high-income countries has centered on secondary and tertiary prevention, otherwise known as response programming.¹⁹ These programs include the provision of support services for survivors across multiple sectors, including health, legal, and judicial. Other response programs include interventions that aim to strengthen the justice system, for example by reducing perpetrator impunity. While these interventions may produce positive outcomes, including improved mental health, treatment of injuries, and access to justice, there is little evidence that as standalone programs they lead to significant reductions in rates of IPV victimization or perpetration.^{16,20}

In response to the growing evidence base from high-income countries on what constitutes an effective intervention to reduce levels of IPV, the international community has started to shift towards primary prevention. Evidence emerging from low- and middle-income countries (LMICs) also influenced this transition in programming. For example, the public health community has become increasingly aware of the intersection of violence and vulnerability to HIV,¹⁹ and increasingly incorporates messaging and programming that addresses partner violence as a risk factor in interventions aimed to prevent HIV contraction. Examples include well-known primary prevention community-based interventions, such as *Somos Diferentes*, *Somos Iguales* in Nicaragua, *IMAGE* in South Africa, *SHARE* and *SASA!* in Uganda, *Program H* in India, and *Stepping Stones* in several countries around the world. These programs all share fundamental principles that allow them to be successful in reducing the prevalence of IPV.

² The authors recognize the importance of addressing other forms of violence against women and girls, particularly through strengthening the evidence base.

This paper emphasizes results of these and other primary prevention programs, not because secondary and tertiary prevention programs are ineffective,¹⁹ but because primary prevention programs allow for macro-level programming that targets root causes of violence, such as harmful gender norms, to create generations of men, women, boys, and girls who not only no longer accept violence, but also feel empowered to eliminate it.¹³

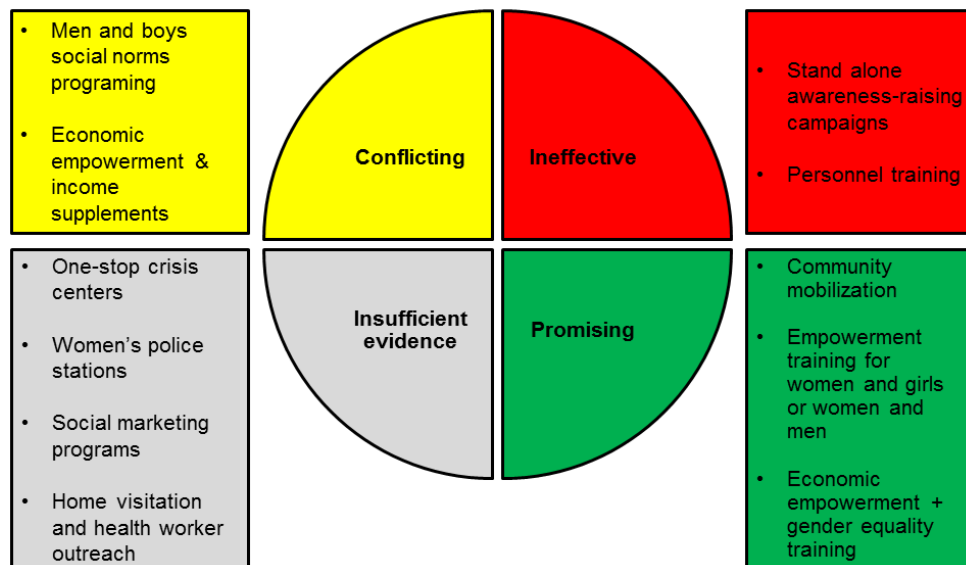
Summary of What Works to Prevent Intimate Partner Violence

Over the past decade, several literature reviews have been conducted to evaluate what works to prevent intimate partner violence.^{4,13,15,16,19-21} While their methodologies differ, the reviews concur that the evidence base on IPV is lacking. Part of the problem is that the geographical distribution of studies is overwhelmingly skewed towards high-income countries, primarily the United States, with a large proportion of studies that have been conducted in schools, universities, and colleges. More rigorous evaluations, particularly from low- and middle-income countries, are needed to improve our understanding of how programs can effectively reduce rates of IPV and collective knowledge about the attitudes and behaviors that perpetuate violence.^{13,15,16,19} Going forward, results from these and other evaluations should be disseminated widely to ensure researchers are not duplicating efforts, or worse, repeating interventions that have harmful, unintended consequences.

Interventions use multiple approaches to prevent IPV, including economic empowerment programs, women-centered support services, legal reforms or other system-wide approaches, multi-sectoral strategies, community-based interventions, awareness-raising campaigns, and group-based training, among others.^{4,13,15,16,19-21} Recent reviews suggest that programs involving community mobilization and/or economic empowerment paired with gender equality training (otherwise known as economic empowerment plus), significantly reduce rates of IPV.^{4,13,15,19,20} There are also numerous school-based programs, primarily from high-income countries, that have been effective in reducing rates of dating violence.^{16,19}

A review conducted by the World Health Organization (WHO) and the London School of Hygiene and Tropical Medicine (LSHTM) looks more broadly at outcomes, noting that many interventions are successful in changing the knowledge, attitudes, and behaviors that drive violence. In addition to those mentioned above, promising programs include prolonged media awareness campaigns that address social and cultural gender norms, participatory group discussions and empowerment trainings, and trainings around gender norms for both women and girls and men and boys.¹⁶ A summary of the evidence base from the most recent review can be seen in Figure 2.¹⁹

Figure 2 - A summary of the evidence of IPV interventions in low- and middle-income countries.



Collectively, the evidence reviews suggest that programs achieving the most success in preventing IPV include the following elements:

- Cutting across and collaborating with multiple sectors (i.e. education, citizen security, disaster response, health, judicial, etc.) in an integrated manner to coordinate comprehensive prevention and response efforts;
- Involving multiple stakeholders, such as health service providers, legal authorities, community leaders, community members (both men and women), and government representatives to mobilize communities and create fostered sustainability;
- Challenging the acceptability of violence among communities, through creating constructive and culturally sensitive dialogues about harmful gender norms and unbalanced power dynamics;
- Supporting participants in developing new skills to empower them to make healthy choices and improve conflict resolution skills;
- Investing in implementing the intervention over a prolonged period of time (at minimum six months).

Transforming Social Norms through Community Mobilization Interventions

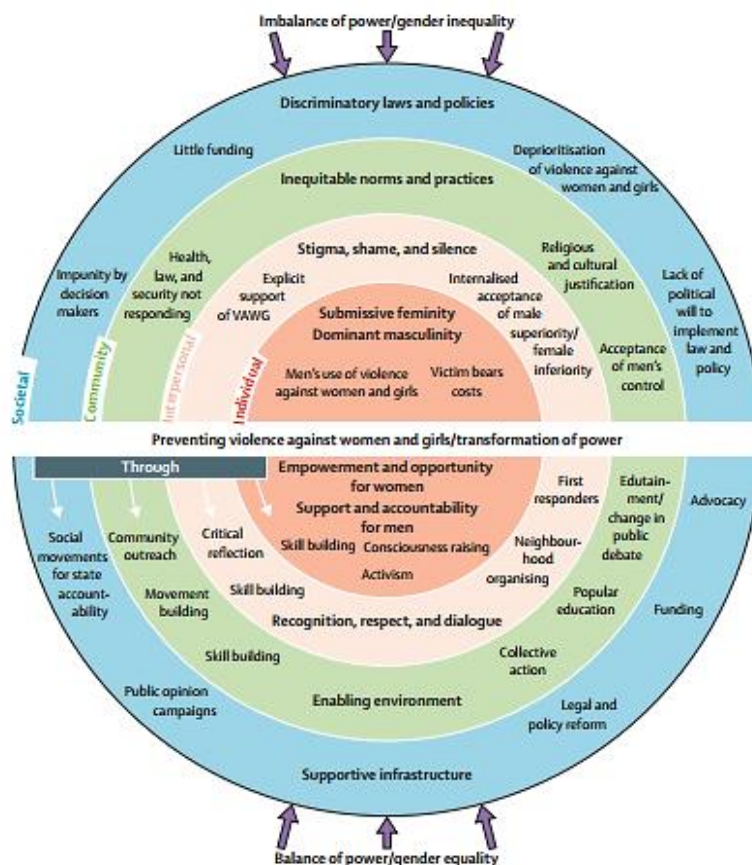
An Ecological Framework

In order to truly understand how to effectively prevent IPV, it critical to analyze the root causes of the problem. IPV is distinctively challenging to eliminate because of its multiple causal layers. .^{15,22} This is best explained by the ecological framework originally developed by Urie Bronfrenbrenner²³ which has since then been adapted by Lori Heise²² for violence

against women (VAWG). This most recent adaptation of the ecological model presents the causes of IPV at the macro social, community, interpersonal, and individual levels. At the macro social level, gender inequality (as measured through composite indicators, economic rights, discriminatory family laws, among others), cultural factors (for example, a gender value emphasis on purity), and economic factors (such as a country's development status), all contribute to the perpetuation of IPV. At the community level, harmful norms, such as the acceptability of wife beating, and neighborhood factors, including crime, poverty, and unemployment levels, can lead to IPV. At the partner level, a man is more likely to perpetrate IPV if he was abused as a child or witnessed IPV during childhood, if he abuses alcohol or other harmful substances, or if he holds certain harmful attitudes. Causal factors are similar at the individual level, where exposure to violence as a child, attitudes of gender inequality, and poor support networks, contribute to IPV. The partner and individual factors interact at the relationship level, where conflict resolution, communication, and situational triggers play an important role.¹⁵ Indeed, all ecological levels interact to perpetuate IPV, and a positive intervention on one level can be undone or neutralized by a risk factor on another level.

Lori Michau and colleagues have produced a model on how to effectively address each causal layer of VAWG by transforming the balance of power and promoting gender equality, as seen in figure 3, below.²²

Figure 3 - How the transformation of power across the ecological model can prevent VAW. Source: Michau, L., et al. (2014) "Prevention of violence against women and girls: lessons from practice". *The Lancet, A Special Series on Violence against Women and Girls*.



At the macro social level, gender inequality takes the form of discriminatory laws and policies

that fail to prioritize VAWG as a pertinent issue and allow for continued impunity for perpetrators. This can be mediated through catalyzing social movements to hold governments accountable, ultimately leading to effective reforms of laws and policies that create legal infrastructure that prioritizes survivor-centered response and prevention efforts.²⁴ For example, change in healthcare policy could mean the development and implementation of standardized guidelines and protocols that use evidence-based methods to respond to both the physical and mental health needs of survivors.²⁵

At the community level, inequitable norms and practices play the most significant role. These norms are often perpetuated by religious or cultural justification, deterring action by stakeholders who are critical to addressing IPV prevention. Michau and colleagues argue that inequitable norms can be addressed by fostering collective action through education and capacity building. Such programs allow participants to feel empowered to make the necessary changes that will lead to an environment in which a significant part of the population practices and advocates for gender equality.²² Similarly, norms that perpetuate gender inequality and drive violence can be addressed in the healthcare sector by carrying out educational and behavior change interventions among community members and health care professionals.²⁵

Finally at the interpersonal level, issues related to stigma, shame, and silence can be resolved through prolonged and sustained capacity building, creating networks, and reflecting critically on IPV. Where gender inequality is demonstrated at the individual level in the form of submissive femininity and dominant masculinity, interventions to expand women's opportunities and enhance their agency and empowerment.²⁴ These models clearly demonstrate the multi-faceted nature of IPV prevention, further emphasizing the need for holistic and integrated programs that focus on the multiple drivers of violence.

Analyses using this ecological framework indicate that harmful social norms are among the most significant macro-level predictors of IPV. For example, Heise and Kostadam (2015) found that norms justifying male authority over female behavior and those justifying wife beating are strongly and significantly associated with IPV, and suggest a highly plausible causal link.²⁶ Community mobilization work has been shown to be most effective in addressing these and other harmful social norms.²⁴

Michau (2012) describes community mobilization as “a highly systematic approach that involves all levels of a community over an extended period of time. It requires engaging, inspiring and supporting a diverse range of community members, groups, and institutions. [It] elicits critical thinking, develops skills and inspires action to replace negative norms perpetuating violence against women with positive norms supporting safety, non-violence and the dignity of women and men”.²⁷ Community mobilization interventions are successful in transforming harmful gender norms, leading to reductions in IPV, for several reasons. These types of interventions demonstrate both the key principles of effective programs and the application of the trans-theoretical model of health behavior change, whereby change occurs through six key stages: pre-contemplation, contemplation, preparation, action, maintenance, and termination.²⁸ By building programs around this framework, community mobilization efforts assist individuals and communities to move through these stages in an organic and empowering manner.²⁷ Below, we elaborate on examples of successful community interventions to prevent IPV.

Examples of Effective Community Mobilization Interventions

SASA! (Raising Voices)

SASA! is a well-known intervention that has been adapted and implemented in a number of countries. Originally designed and implemented by Raising Voices in Uganda, SASA! consists of a series of community mobilization activities that address the balance of power in intimate partner relationships and broader community dynamics. There are four steps in the overall intervention: Start, Awareness, Support, and Action. Stakeholders from many levels of the community, including community leaders, local government representatives, community activists, and health service providers participate in each step of the intervention. For example, during the first step, Start, interested community members are recruited and trained to become a cadre of activists engaging the broader community in discussions on gender equality and HIV prevention during the following three steps. The idea behind SASA! is to create an enabling environment to ultimately develop a critical mass to change knowledge, attitudes, and behaviors that perpetuate harmful gender norms.¹⁷

A rigorous evaluation of SASA! recently demonstrated the intervention's effectiveness in reducing levels of partner violence within participating communities.²⁹ Researchers measured the impact SASA! made in a total of eight communities, randomized into treatment and control groups in a pair-matched cluster design from 2007 to 2012. Data were collected through a cross-sectional survey designed using the WHO Multi-Country Study on Women's Health and Domestic Violence and the Uganda Demographic and Health Survey.^{30,31} Researchers surveyed men and women at baseline and after approximately three years of program implementation. The primary outcomes measured included: (1) acceptability of IPV; (2) acceptability that women can refuse to have sex; (3) past year physical intimate partner violence; (4) past year sexual intimate partner violence; (5) appropriate community responses to women experiencing past year physical and/or sexual IPV; and (6) past year concurrent sexual partners.²⁹

Statistically significant reductions were observed in the acceptability of physical intimate partner violence among women and past year concurrent sexual male partners.³ There were also statistically significant improvements among both men and women regarding the acceptability that a woman can refuse sex. Additionally, there were improvements in appropriate community response to survivors of intimate partner violence. These favorable results of reduced acceptability of violence and healthier, more balanced relationships were confirmed through simultaneous qualitative research, which involved 40 in-depth interviews. Finally, in terms of IPV experience among participating women, SASA! resulted in a 52 percent reduction in physical violence and a 33 percent reduction in sexual violence.⁴ The results indicate that SASA! has been effective in changing key attitudes and norms that underlie partner violence and shows tremendous promise in reducing levels of IPV within participating communities.^{29,32}

Somos Diferentes, Somos Iguales (Puntos de Encuentro)

³ This refers to non-polygamous men who had a partner in the last 12 months.

⁴ While a large effect was observed, changes were not statistically significant. Evaluators observed an increase in variations of physical IPV levels among control sites at follow-up compared to baseline. This reduced the power to observe statistical significance when analyzed by cluster.

Somos Diferentes, Somos Iguales (SDSI, or “We are different, we are equal” in English), a communication strategy designed to promote healthy relationships and HIV prevention, was implemented throughout Central America from 2000 to 2005. Puntos de Encuentro, a feminist organization based in Nicaragua, created and implemented this strategy through a series of programs to empower individuals and inspire social change around gender equality and sexual health. The main components of SDSI included: (1) a national-level multi-media campaign, which included a soap opera and radio series (*Sexto Sentido*) showcasing sensitive themes around gender and sexuality; (2) regional workshops to build capacity of youth leaders and other community leaders by strengthening analytic and leadership skills around relevant issues; (3) coordination among youth groups, government and non-governmental organizations, and media outlets in Nicaragua and other countries to generate discussions around healthy relationships at a national and regional level; and, (4) distribution of informational materials.³³

The intervention is based on a conceptual model through which mass communication results in changes in knowledge, attitudes, and norms, while also shifting the social context. These shifts then empower individuals, as well as the community as a whole, to increase their efficacy in responding to violence and HIV prevention, which ultimately creates an enabling environment for positive behavior change and increased agency at the individual level. All of these processes are part of a series of complex pathways that are interconnected and continuously evolving.³³

SDSI was evaluated through a mixed-methods study conducted in four Nicaraguan cities. Both the quantitative and qualitative components were carried out in Estelí, Juigalpa, and León. Qualitative research was also conducted in Bilwi. Researchers followed a longitudinal design and administered three surveys to 3,099 individuals over the course of two years. A total of 91 percent of those interviewed had heard of at least one of the components of SDSI. Impact results showed statistically significant changes in positive attitudes that reflect gender equality, reductions in stigma associated with HIV, improved knowledge and use of health services, increased knowledge of HIV and prevention, and greater interpersonal communication, among others. Using a widespread communications strategy that engaged and empowered community members, SDSI was able to have a meaningful impact on the knowledge, attitudes, and behaviors that underpin the perpetuation of violence.³³

***Stepping Stones* (Various Organizations)**

Stepping Stones was originally developed as a community-mobilization intervention to reduce rates of HIV in Uganda, and has since been adapted and evaluated in many countries. The program consists of multiple training sessions implemented over several weeks that involve participatory and active learning approaches, such as role-playing and role-modeling, for both men and women. While its ultimate goal is to prevent HIV, *Stepping Stones* addresses gender equality, healthy relationships, and effective communication, all of which are contributing factors to IPV prevention.³⁴

In South Africa, researchers evaluated the impact of *Stepping Stones* using a cluster randomized trial. The study had two components: (1) one group received the *Stepping Stones* training manual and (2) one group received a standalone three-hour session on HIV and safe sex practices. Both qualitative and quantitative methods were used to evaluate results among both groups, and participants were followed up with at 12 and 24 months. The

evaluation indicated a statistically significant reduction in the number of men who disclosed severe partner violence perpetration after two years of follow-up among those who received the *Stepping Stones* intervention compared to those who did not.³⁵ Similarly, a mixed-methods cross-sectional evaluation conducted to determine the impact of *Stepping Stones* in India demonstrated that the program influenced knowledge, attitudes, and behaviors pertaining to gender equality and healthy relationship dynamics.³⁶ While *Stepping Stones* has been evaluated and adapted in other contexts,³⁵ these two studies demonstrate the significant impact a prolonged community-mobilization intervention can have on improving the sexual health of the participants and supporting healthier relationships.

Engaging Men to Prevent Gender Based Violence (Grameen Vikas jan Sahbhagita Trust Jaunpur and Ujala Welfare Society)

Grameen Vikas jan Sahbhagita Trust Jaunpur and Ujala Welfare Society in India implemented the community-based intervention, Engaging Men to Prevent Gender-Based Violence, to engage local male leaders to promote change in attitudes and behaviors related to violence among male youth.⁶ The intervention uses youth groups, advocacy campaigns, and community outreach to provide education on the harmful effects of gender-based violence in India. Their goal is to create gender equity and sensitivity at the leadership level in order to influence change within the community.

A quasi-experimental study of this program found significant changes in men and women's attitudes and behaviors towards harmful gender norms. More than 1500 youth were educated on the consequences of gender-based violence (GBV) and the ways in which they can help prevent it. They explored themes concerning violence against women, sexuality, masculinity and gender.⁶ After participating in the workshops, there was an increase in positive attitude changes related to household relationships.⁶ Men self-reported being more willing to participate equally in household responsibilities and boys self-reported advocating for their sister's rights to an education.³⁷ Additionally, participants developed individual plans to address violence against women in their own lives after brainstorming community education plans and demonstrating increased knowledge of laws that promote gender equality and improved understanding of gender-equitable role expectations.⁶

Other Community-Based Interventions

Other effective community-based interventions that encompass the key principles mentioned above include *Program H*, *SHARE*, and *IMAGE*, among others. *Program H*, developed by Promundo, has shown promising results in transforming attitudes and behaviors that promote gender equity in its adaptation in India.³⁸ The *SHARE* (Safe Homes and Respect for Everyone) model, which resembles *SASA!*, is a community mobilization intervention that addresses the intersection of IPV and HIV through multiple components.³⁹ A recent evaluation of the program in Uganda demonstrated a statistically significant reduction in reported both past-year physical and sexual IPV when comparing intervention groups to control groups two years following the initial intervention.⁴⁰ Finally, *IMAGE* (Intervention with Microfinance for AIDS and Gender Equity) is another community-based, multi-modal intervention that aims to reduce both IPV and HIV by combining gender training with microfinance activities. A cluster randomized trial conducted in South Africa revealed a 55 percent reduction in reported rates of IPV.⁴¹ All three of these interventions actively engage community members over a prolonged period of time and provide individuals with the tools

they need feel empowered to make the change towards more gender-equitable behaviors.

Adaptations

Many of the aforementioned community-based interventions have been adapted in a variety of contexts. When adapting successful interventions or promising practices, it is important to ensure that interventions are culturally appropriate or adaptable before transferring interventions from one country or region to another.⁴² Some programs can be empowering for women in certain contexts and can contribute to increases in intimate partner violence in others.¹³ In addition, program cycles and budget frameworks should be adapted to specific contexts, for example by considering the local norms and the institutions that perpetuate them. Culturally-adapted interventions have a higher chance of success by encouraging the involvement and buy-in of members of the target community.⁴³

Decades of development work around the globe have taught us that interventions are not one-size-fits-all. When the setting is different, interventions need to be adapted to take into account specificities of the context in which they will be placed. A well-adapted intervention needs to show understanding of culture and the values that allow one to construct one's identity within it. An intervention that is culturally adapted increases the relevance and effectiveness of project activities, increases the involvement and participation of members of the target community, and builds support and buy-in for the program by those with which need to be engaged. Adapting an intervention in a participatory way will increase the chances for success, leading to the attainment of intended outcomes and impacts.⁴³

Literature pertaining to the research and medical fields describes various stage models specifying the process of adapting interventions to specific cultural groups.⁴⁴ All these models adopt an empirically supported intervention as the foundation for replicating the intervention within a different context, but also consider the context-specific cultural determinants of norms and values that permeate individual beliefs, behaviors and communication patterns, and perceptions and interactions with broader structures and institutions.⁴⁵

The practice of cultural adaptation can range from minor modifications, such as changes to the images and terms used in the work material (surface structure changes), to more substantial adaptation of the core prevention components (deep-structure adaptations).⁴⁵ All adaptations strive to achieve a balance between some degree of fidelity to the original intervention and the necessary changes to fit a different cultural environment. Although the adaptation of interventions requires time, resources, and close collaboration with the targeted community, this investment increases the likelihood of achieving desired program impacts and the ability to bring the program to scale.⁴⁵

Several of the effective programs outlined above have been tested in their original setting, but lack rigorous evaluations in the settings to which they have been adapted. Therefore, there is little literature on successfully adapted interventions meant to prevent and respond to IPV, and the methodology of successful adaptation is also non-existent.

Some Examples of Specific Adaptations

a) In Her Shoes

In Her Shoes, originally developed in the United States by the Washington State Coalition Against Domestic Violence (WSCADV), is a community education tool about domestic violence. It engages with a broad cross-section of society, including people who may never have experienced violence in their home or community. This toolkit is designed to help increase empathy for those who have experienced violence against women. Participants move, act, think, and experience the lives of battered women using a role-playing activity. Participants are assigned the role of a woman and then move through a series of experiences and challenges “in her shoes” by making decisions about when to seek help, from whom to seek help, and other experiences commonly faced by women.⁴⁶

The Inter-American Alliance for the Prevention of Gender-based Violence from a Health Perspective (InterCambios) adapted *Caminando en Sus Zapatos* (the Spanish adaptation of the original In Her Shoes) to the Latin American context. *Caminando en Sus Zapatos* contains unique characters and stories that illustrate for example, the particular challenges facing Latin American immigrant women who are battered.⁴⁷ The Latin American version draws upon stories derived in a consultation workshop involving 25 women from 11 countries, organized by PATH and InterCambios.⁴⁸

The African Gender-Based Violence (GBV) Prevention Network has adapted an English translation of InterCambios’ Latin American version of In Her Shoes to a Sub-Saharan African context.⁴⁸ Although the Gender-Based Violence Prevention Network created different stories for the toolkit, it pursued the same fundamental goals as the original In Her Shoes program: increasing knowledge and awareness of the difficulties faced by women who experience violence; illustrating that violence against women is both a community and global problem; analyzing the capacities of different institutions to support women who are living in or confronting situations of violence and seeking help; and encouraging participants to actively think of ways they can work to prevent violence against women.⁴⁹ The methodology of this English-language, African version was presented in the English-speaking Caribbean, where a process is now underway to adapt it to the reality of Caribbean women.⁴⁸

b) SASA! Uganda

In Haiti, Beyond Borders is working with translators, cultural consultants, long-time activists in violence against women, Haitian artists and graphic designers to adapt, test, design and print components of the SASA! program originally implemented in Uganda. According to Beyond Borders, “to respect the original spirit and intent of SASA! and help the materials be truly Haitian sometimes required rewriting, changes in color and form of drawings, and even including a new character in the community dramas—in addition to translation into Haitian Creole.”⁵⁰ Activists in Haiti have found that adapting materials to the Haitian worldview and reality, rather than simply translating them, created a higher level of excitement and engagement within community members.⁵⁰

Recommendations

The programs and adaptations highlighted above present evidence of effective community mobilization interventions. Community mobilization efforts are successful because they permeate multiple levels of society. Through educational and behavior change interventions, these programs foster collective action and build community capacity to challenge gender norms, leading to reductions in IPV. This capacity building can generate momentum within society by increasing the call for effective reforms of laws and policies that prioritize

survivor-centered response and prevention efforts. Successful community-based interventions also provide empowerment activities for participants, supporting them as they build the skills necessary to make healthy choices and improve conflict resolution.

Adaptations of effective interventions achieve a balance between maintaining the essential characteristics of the original intervention and cultural relevance to a different setting. The most successful adaptations encourage participation across multiple groups and sectors of society. They also allow sufficient time and resources to effectively adapt and implement an intervention, resulting in sustained capacity building and the creation of networks that are critical to reducing IPV.

To adapt successful interventions to different contexts, we provide the following specific recommendations:

Ensure local stakeholders' participation in the adaption of community-based interventions. Activities such as meetings and events with community members, discussions on the intervention design, and high-level meetings with authorities should be included in budget and program cycles, allowing local stakeholders to be involved fully in the intervention from its beginning. This engagement is integral to the successful design and sustainability of a community-based prevention program. This also helps to design and implement interventions that are culturally appropriate for the specific context.

Engage multiple segments of the community. Community-based interventions impact a broad range of individuals. The most effective programs involve all community members, including women and men, boys and girls, youth and elders, and professionals and non-professionals. This involvement creates a sense of ownership and enacts change at both the community and individual levels.

Evaluate adaptations in different settings to build the evidence base. The adaption of any community-based intervention to a new setting should involve a plan for monitoring and evaluation. Rigorous documentation will help to build evidence on improving, adapting, and scaling up an intervention for future programs.

Increase access to survivor-centered secondary prevention care and services. Community mobilization must be complemented with multi-sectoral, survivor-centered secondary prevention efforts. For example, accessible and survivor-centered services must be available prior to an intervention to properly respond to the increase in reports of violence and other factors that can occur as a result of the interventions.

Promote cooperation and exchange among implementers. Many successful community-based interventions are being implemented in low- and middle-income countries. Agencies working on similar issues should collaborate and exchange experiences to help produce more substantial, evidence-based programming.

Invest in violence prevention efforts at the community level. Organizations working to implement community-based interventions require longer-term and sustainable funding. Investment should prioritize prevention efforts that address social norms and concepts of gender equality while engaging women, men, and key community members.

Focus on comprehensive, long-term responses. Effecting social change requires programs to address deeply held beliefs and attitudes about gender equality. Many promising efforts of violence prevention are too short in duration to produce significant results. Longer-term responses addressing the root causes of violence against women can strengthen program results and impact the entire community.

Capacity Building. Community-based interventions should include a capacity-building component at the local level in order to ensure the sustainability of the programs implemented. Strengthening capacities can include providing peer-to-peer learning initiatives, making evidence-based interventions widely available, and encouraging the development of technical advisory groups to support program implementation. In addition to benefitting the community, capacity building can also promote change at the policy level.

Resources

1. Devries, K.M., et al. (2013). "The Global Prevalence of Intimate Partner Violence Against Women." *Science* 30:1527-28.
2. World Health Organization, London School of Hygiene and Tropical Medicine, Medical Research Council. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva, Switzerland: World Health Organization.
3. Duvury, N., Callan, A., Carney, P., and Raghavendra, S. (2013). "Intimate Partner Violence: Economic Costs and Implications for Growth and Development." *Women's Voice, Agency, & Participation Series: The World Bank* 3.
4. Klugman, J., et al. (2014). *Voice and Agency: Empowering Women and Girls for Shared Prosperity*. Washington, DC: World Bank Group.
5. National Center for Injury Prevention and Control. (2013). *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta, GA: Centers for Disease Control and Prevention.
6. Solotaroff, J, Pande, R.P. (2014). *Violence Against Women and Girls Lessons from South Asia*. South Asia Development Forum. Washington, DC: World Bank Group.
<http://documents.worldbank.org/curated/en/2014/09/20206575/violence-against-women-girls-lessons-south-asia-vol-1-2-main-report>
7. Velzeboer, M., et al. (2003). *Violence Against Women: The Health Sector Responds* Pan American Health Organization (PAHO) Occasional Publication No. 12. Washington, DC: Pan American Health Organization, 2003.
8. Taft, A.J., Watson, L.F. (2008). "Depression and Termination of Pregnancy (Induced Abortion) in a National Cohort of Young Australian Women: The Confounding Effect of Women's Experience of Violence" *BMC Public Health* 8(75): 1-8.
9. Campbell, J., et al. (2002). "Intimate Partner Violence and Physical Health Consequences," *Archives of Internal Medicine* 162(10), 1157-1200.
10. Weiss, H.A., et al. (2008). "Spousal Sexual Violence and Poverty Are Risk Factors for Sexually Transmitted Infections in Women: A Longitudinal Study of Women in Goa, India." *Sexually Transmitted Infections* 84(2):133-139.
11. Coker, Amy (2007). "Does Physical Intimate Partner Violence Affect Sexual Health?: A Systematic Review." *Trauma, Violence & Abuse* 8(2), 149-177.
12. Hill, A., Pallitto, C., McCleary-Sills, J., and Garcia-Moreno, C. (To be published) "Intimate Partner Violence as a Risk Factor for Low Birthweight and Preterm Birth: A Systematic Review and Meta-analysis."
13. Heise, L. (2011). *What Works to Prevent Partner Violence: An Evidence Overview*. London, UK: STRIVE Research Consortium, London School of Hygiene and Tropical Medicine.

14. Breiding, M.J., et al. (2014). Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011. *Morbidity and Mortality Weekly Report. Surveillance Summaries* 63(8), 1-18.
15. Arango, D.J., Morton, M., Gennari, F., Kiplesund, S. and, Ellsberg, M. (2014) “Interventions to Prevent or Reduce Violence against Women and Girls: A Systematic Review of Reviews.” *Women’s Voice and Agency Research Series: The World Bank* 10.
16. World Health Organization, London School of Hygiene and Tropical Medicine. (2010). *Preventing Intimate Partner and Sexual Violence against Women: Taking Action and Generating Evidence*. Geneva, Switzerland: WHO.
17. Raising Voices. (2015). SASA! <http://raisingvoices.org/sasa/>
18. Chamberlain, L. (2011). *A Prevention Primer for Domestic Violence: Terminology, Tools, and the Public Health Approach*. Harrisburg, PA: National Resource Center on Domestic Violence.
19. Ellsberg, M., et al. (2014). “Prevention of Violence against Women and Girls: What Does the Evidence Say?” *The Lancet, A Special Series on Violence against Women and Girls*.
20. What Works. (2014). *A Summary of the Evidence and Research Agenda for What Works*. What Works to Prevent Violence Global Programme.
21. Jewkes, R. (2002). “Intimate partner violence: causes and prevention.” *The Lancet* 359:1423-29.
22. Heise, L. (1998). “Violence Against Women: An Integrated, Ecological Framework.” *Violence against Women* 4: 262-290.
23. Bronfenbrenner, U. (1994). Ecological Models of Human Development. In *International Encyclopedia of Education, Vol 3, 2nd, Ed*. Oxford: Elsevier. Reprinted in: Gauvain, M. & Cole, M. (Eds.), *Readings on the Development of Children, 2nd Ed* (1993, pp 37-43). NY: Freeman.
24. Michau, L., Horn, J., Bank, A., Dutt, M., Zimmerman, C. (2014). “Prevention of Violence against Women and Girls: Lessons from Practice.” *The Lancet, A Special Series on Violence against Women and Girls*.
25. Gennari F., McCleary-Sills, J., Arango, D.J., and Hidalgo, N. (2014). *Violence Against Women and Girls (VAWG) Resource Guide: Health Sector Brief*. Washington, DC: The World Bank, Global Women’s Institute, Inter-American Development Bank.
26. Heise, L., Kostadam, A. (2015). “Cross-national and Multilevel Correlates of Partner Violence: An Analysis of Data from Population-based Surveys.” *The Lancet Global Health* 3: e332-40.
27. Michau, L. (2012). *Community Mobilization: Preventing Partner Violence by Changing Social Norms*. Bangkok, Thailand: UN Women.
28. Prochaska, J.O., Velicer, W.F. (1997). “The Transtheoretical Model of Health Behavior Change.” *Am J Health Promotion* 12(1):38-48.

29. Abramsky, T., et al. (2014). "Findings from the SASA! Study: A Cluster Randomized Controlled Trial to Assess the Impact of a Community Mobilization Intervention to Prevent Violence against Women and Reduce HIV Risk in Kampala, Uganda." *BMC Medicine* 12:122.
30. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH: Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet* 2006, 368:1260–1269.
31. Uganda Bureau of Statistics, Macro International Inc: Uganda Demographic and Health Survey, 2006. Maryland: Calverton; 2007.
32. Kyegombe, N., et al. (2014). "SASA! is the Medicine That Treats Violence. Qualitative Findings on How a Community Mobilisation Intervention to Prevent Violence against Women Created Change in Kampala, Uganda." *Global Health Action* 7.
33. Solorzano, I., Bank, A., Pena, R., Espinoza, H., Ellsberg, M., and Pulerwitz, J. (2008). *Catalyzing Individual and Social Change around Gender, Sexuality, and HIV: Impact Evaluation of Puntos de Encuentro's Communication Strategy in Nicaragua*. Washington, DC: Population Council.
34. Jewkes, R., et al. (2007). *Evaluation of Stepping Stones: A Gender Transformative HIV Prevention Intervention*. Pretoria, South Africa: MRC.
35. Bradley, J.E., Bhattacharjee, P., Ramesh, B.M., Girish, M., and Das, A.K. (2011). "Evaluation of Stepping Stones as a Tool for Changing Knowledge, Attitudes and Behaviours Associated with Gender, Relationships and HIV risk in Karnataka, India." *BMC Public Health* 11:496.
36. Skevington, S.M., Sovetkina, E.C., and Gillison, F.B. (2013). "A Systematic Review to Quantitatively Evaluate 'Stepping Stones': A Participatory Community-based HIV/AIDS Prevention Intervention." *AIDS and Behavior* 17(3):1025-1039.
37. Instituto Promundo. (2012). "Engaging Men to Prevent Gender-based Violence: A Multi-Country Intervention and Impact Evaluation Study." Report for the UN Trust Fund. Washington, DC: Promundo.
38. Promundo. (2015). *Program H* <http://promundoglobal.org/programs/program-h/>
39. Jewkes, R.K. (2015). "SHARE: A Milestone in Joint Programming for HIV and Intimate Partner Violence." *The Lancet* 3: e2-3.
40. Wagman, J.A., et al. (2015). "Effectiveness of an Integrated Intimate Partner Violence and HIV Prevention Intervention in Rakai, Uganda: Analysis of an Intervention in an Existing Cluster Randomised Cohort." *The Lancet Global Health* 3: e23-33.
41. Pronyk, P.M., et al. (2006). "Effect of a Structural Intervention for the Prevention of Intimate-partner Violence and HIV in Rural South Africa: A Cluster Randomised Trial." *The Lancet* 368: 1973-83.
42. Violence Against Women and Girls Resource Guide. (2014). *Innovate*. Washington, DC: The World Bank, Global Women's Institute, Inter-American Development Bank. <http://www.vawgresourceguide.org/innovate>

43. University of Kansas Work Group for Community Health and Development, “*Choosing and Adapting Community Interventions.*” in *Community Toolbox Chapter 19.*
<http://ctb.ku.edu/en/table-of-contents/analyze/choose-and-adapt-community-interventions/cultural-adaptation/main>
44. Okamoto, Scott K., et al. (2014). “Toward Developing Culturally Focused Prevention Interventions: From Adaptation to Grounding.” *The Journal of Primary Prevention* 35(2): 103–112.
45. Szapocznik, J., Coatsworth, J. D. (1999). “An Ecodevelopmental Framework for Organizing the Influences on Drug Abuse: A Developmental Model of Risk and Protection”, in M. Glantz & C. Hartel (Eds.), *Drug Abuse: Origins and Interventions*: 331–366. Washington, DC: American Psychological Association.
46. Washington State Coalition against Domestic Violence, *In Her Shoes*
<http://wscadv2.org/resourcespublications.cfm?aid=6388541a-c298-58f6-02a2a6cf514e6448>
47. La Alianza InterCambios. (2007). *Caminando en Sus Zapatos*
<http://alianzaintercambios.org/noticia?idnoticia=11>
48. La Alianza InterCambios. (2007). Por los Caminos de Caminando
<http://www.alianzaintercambios.org/noticia?idnoticia=24>
49. GBV Prevention Network/Raising Voices and Program for Appropriate Technology in Health (PATH). (2011). *In Her Shoes, Sub-Saharan Africa Version* <http://preventgbvafrica.org/in-her-shoes/>
50. Beyond Borders. *Rethinking Power Adaptation of SASA!*
<http://beyondborders.net/what-we-do/ending-violence-against-women-girls/rethinking-power-adaptation-of-sasa/>

Annex I

Six Essential Steps to Adapting Community-Based Programs to Prevent Intimate Partner Violence

Table of Contents

Introduction	25
Six Steps to Adapting Community-Based Programs to Prevent IPV	26
Step One: Understanding violence in the program setting, violence prevention approaches, and the particular methodology and model to adopt	26
Step Two: Select program locations thoughtfully.....	27
Step Three: Develop a network of local partners	27
Step Four: Formalize a locally appropriate program and evaluation design	28
Formalize the approach	28
Formalize the strategies.....	29
Formalize the intended participants and beneficiaries	30
Formalize the evaluation design	31
Formalize the budget and timeline.....	31
Step Five: Prepare the program materials	31
Step Six: Finalize the outreach and dissemination plan as early as possible	32
Conclusion.....	32
References	33
Appendix A: Criteria for Selecting Intervention Municipalities and Communities	35
Appendix B: SASA! Criteria for Selecting Intervention Partners in Central America	36

Introduction

This methodological annex complements the review of evidence on community mobilization interventions to prevent Intimate Partner Violence (IPV). The document aims to support individuals and organizations that are implementing or investing in projects involving violence prevention by providing recommendations that can be integrated at different times throughout the project design and adaptation phases. It highlights the root causes and prevalence of IPV, prevention methodology—including basic components essential to the prevention planning phase—and the logistics that must be considered when adapting a program to a new setting, including program cycles and budget framework. Rigorous documentation of the process by those implementing interventions will help to build evidence on improving, adapting, and scaling up an intervention for future programs.

The most effective IPV prevention programs are those involving community mobilization.^{3-5,7,8} As detailed in the review of evidence, programs including *SASA!*, *Somos Diferentes*, *Somos Iguales*, *Engaging Men in GBV Prevention*, *Stepping Stones*, *Program H*, *SHARE*, and *IMAGE* vary in methods but encompass key principles of effective programs, providing individuals with the tools they need to feel empowered to choose more gender-equitable behaviors.

Effective interventions are based on common principles that can be adapted to individual settings and cultures. Evidence shows that community-based interventions to prevent IPV are successful at reducing violence because they permeate multiple levels of society, engaging key stakeholders and fostering collective action to challenge gender norms within entire communities. Community-based, multi-sectoral and culturally-adapted interventions increase ownership of outcomes, thereby securing longer-term involvement of differing levels of stakeholders in adaptation. Long-term investment in intervention programs allows for more sustained capacity building and the creation of networks that are critical for reducing IPV.

An increasing number of practitioners, including stakeholders, donors and policymakers, seek to replicate effective community-based interventions in new settings. *SASA!*, a community mobilization program designed and implemented by Raising Voices in Uganda, is a well-known intervention that has been adapted and implemented in a number of countries. Community mobilization programs such as *SASA!* work at all levels of the ecological framework originally developed by Uri Bronfenbrenner¹³ and adapted for violence against women and girls (VAWG) by Lori Heise.¹⁴ This framework presents IPV at the individual, partner, community, and societal levels.

To plan effectively for the costs and logistics required in program implementation, program designers, donors and decision makers must have a nuanced understanding of the implications involved in adapting a model in different settings. Organizations working to implement community-based interventions require long-term and sustainable funding that prioritizes prevention efforts targeting social norms and concepts of gender equality while engaging women, men, and key community members in the planning and implementing processes.

Six Steps to Adapting Community-Based Programs to Prevent IPV

To guide practitioners in effectively implementing IPV prevention programs, this note presents six essential steps to successfully adapt a community-based program to prevent intimate partner violence. They include: (1) understanding violence in the program setting, violence prevention approaches, and the particular methodology and model to adopt; (2) selecting program locations thoughtfully; (3) developing a network of local partners; (4) formalizing a locally appropriate program and evaluation design; (5) preparing the program materials; and (6) finalizing the outreach and dissemination plan as early as possible. These steps may or may not occur chronologically; in many cases, the six steps occur concurrently.

Step One: Understanding violence in the program setting, violence prevention approaches, and the particular methodology and model to adopt

While intimate partner violence is a pervasive global crisis, the dynamics of violence look different in every setting. The first step to adapting an IPV prevention program is conducting formative research that collects both quantitative and qualitative data to understand the nature, prevalence, and dynamics of IPV in an individual setting. Data collection should aim to answer the following questions:

1. *What types of violence occur in a study site? Who are the perpetrators and who are the victims? How does violence affect men, women, boys, and girls differently? What are the most common forms of violence? In what kind of circumstances does this violence occur? Where? When?*
2. *How do families and communities respond to survivors of IPV?*
3. *What types of resources, such as health, legal, security, safety, religious, cultural institutions, are available to survivors of IPV? Which entities provide these services? How are they accessed, if at all? What reasons are cited for accessing or not accessing available resources?*
4. *What are the political and legal frameworks for addressing IPV at the national and local levels? What are the main achievements and challenges of policies targeting women's rights and IPV?*
5. *What other organizations are working on IPV prevention in a specific context? What do these programs entail? How are these programs described by different participant groups?*

UNDERSTANDING PREVENTION

Primary prevention refers to programs that work to reduce violence at a community, rather than an individual level. For example, the SASA! community-based mobilization program builds capacity among a group of community advocates to discuss issues related to gender equality and power dynamics. By addressing the underlying risk factors of intimate partner violence, SASA! advocates are able to change harmful attitudes and behaviors that perpetuate violence, thereby reducing overall levels of violence in the community.

Secondary prevention refers to programs that address the immediate needs of the survivor after the violent incident has occurred in order to reduce rates of re-victimization. For example, IPV screening (when done appropriately) in health care settings, such as antenatal care, provides women with a confidential and safe space to disclose violence. The health care provider can then treat any immediate injuries and refer women to a counselor for psychosocial support and/or a domestic violence advocate who can liaise with the justice and legal sectors, as well as assist in finding temporary or transitional housing. The aim of these interventions is to minimize any harm caused by the incident and provide the survivor with the necessary services to prevent it from happening again.

Tertiary prevention refers to programs that help minimize the long-term consequences faced by survivors of violence. This includes programs that focus on rehabilitation and reintegration.

Program designers must also thoroughly review the latest literature on violence prevention interventions, including available program evaluation reports and scholarly articles. Particular attention should be given to program components that have proven effective, as well as lessons learned during the implementation process. Practitioners may interview pertinent organizations or other experts or programmers experienced in IPV prevention.

Program designers can use this information to construct an informed list of program models, elements, and lessons that will inform the selection of which program model or combination of model to adopt. If the programmers' funding mechanism requires a program design proposal prior to conducting formative research, the programmers should negotiate for the ability to shift, adjust, and revise the proposed program based on the results of the formative research.

Step Two: Select program locations thoughtfully

Community-based violence prevention initiatives are not viable in every municipality or neighborhood. It is essential to identify suitable, high-priority locations by considering community need and readiness, such as the presence of certain basic services and support structures without which the program will struggle.

The process of vetting municipalities or specific neighborhoods should occur in conjunction with the formative research. Annex A, below, contains a comprehensive checklist of criteria for identifying suitable municipalities and neighborhoods. In general, the most suitable municipalities will be those where:

- *leaders are eager to be part of the initiative;*
- *a history of collaboration across sectors to address intimate partner violence exists;*
- *statistics on the prevalence of violence are available; and*
- *locally respected actors, including NGOs or other agencies, are working on the issue of intimate partner violence.*

The most suitable neighborhoods or “communities” for such interventions will be those where:

- *public spaces are accessible and comparably safe for program staff;*
- *a sense of history and connection among most residents exists;*
- *a well-functioning network of neighborhood leaders already exists; and*
- *some amount of services for survivors of violence are available.*

Step Three: Develop a network of local partners

After identifying the leading activists, nonprofits, service providers, government agencies, and other stakeholders involved in violence prevention and response in a selected setting, program designers must garner the support of key local stakeholders. Most importantly, programmers must establish a formal relationship with a lead implementation partner to oversee the day to day work of the community-based initiative. The precise nature of a local partner or partners will vary depending on program location. A variety of partners should be engaged early in the program process to improve the likelihood of program success. For example:

- Local political authorities can lend credibility to the project, or create obstacles if they are not included in program design.

- Local community and religious leaders may extend program reach, and lend legitimacy to a program.
- Local women's groups can also help with outreach while specifically addressing women's rights.
- Local donors or charities may be interested in affiliating with and complementing a well-designed new prevention program.

A program's most important partner is the local implementing organization. Unless the implementing organization has sufficient local presence, legitimacy, and capacity, it will need to collaborate closely with a local organization that can oversee the day-to-day program functioning. A local implementing partner should meet the following criteria: (a) violence prevention work is central to the organization's mission; (b) the organization has necessary legal status and has functioned successfully for a number of years; (c) organizational leadership commits to regular, sustained attendance by the same staff members at all trainings, workshops, and technical advisory sessions held by program implementers ; (d) the organization practices sound, transparent management of funds and resources.

A local partner organization should also demonstrate a strong legal and financial status; conceptual understanding of the issue of violence (where a more thorough understanding of gender, power, and prevention is beneficial); implementation capacity (where a more professional, better trained staff of program managers with skills in writing, training, data collection, and outreach is beneficial); and leadership (where a solid commitment from the organization to prioritize the program is beneficial). Appendix B contains a list of mandatory and desirable characteristics for an implementation partner that was developed specifically for adapting the aforementioned SASA! methodology to Central America.

CAPACITY BUILDING STRATEGIES

- Forming research advisory groups
- Developing and using multimedia tools to provide interactive workshops
- Facilitating residential workshops with local researchers, practitioners, and activists
- Making research methodologies widely available and freely accessible
- Providing mentorship and peer-to-peer learning initiatives
- Making evidence-based interventions to address IPV widely available and accessible
- Providing support on how to adapt community-mobilization interventions
- Forming technical advisory groups to support program development
- Including key stakeholders in national and international meetings on VAWG research

Step Four: Formalize a locally appropriate program and evaluation design

Step four involves formalizing the details of the program design and evaluation, including the approach, strategies, intended participants and beneficiaries, evaluation design, budget and timeline. This step is the most complex, since it is impossible to duplicate any of these elements from a prior iteration of an existing program.

Formalize the approach

Community mobilization programs to address intimate partner violence work almost always transform existing social gender norms by aiming to allow women, girls, and all community members to live free of violence, which is their right. To do so, these

programs rely on the leadership and creativity of community members themselves, as opposed to an external authority. Therefore, the design of community mobilization programs to address intimate partner violence entails a (1) a gender analysis component, (2) a human rights component, and (3) a participatory component.

A gender analysis approach to program design holds as a basic principle that men's and women's roles in society are socially rather than biologically determined. As such, these roles can be changed. This approach observes that women's socially-determined position in society has historically been disadvantaged as compared to men's, and that this imbalance in power at all levels of society is a root cause of intimate partner violence as well as other abuses of women's rights. A community mobilization program that does not emerge from this philosophy will not be effective in fundamentally altering the root causes of violence.

A human rights approach to community mobilization work operates from the basic principle that all people have the right to live free of violence, as is established in international law and human rights conventions. According to Lori Michau, this framework "creates a legitimate channel for discussing women's needs and priorities and holds the community accountable for treating women as valuable and equal human beings."¹⁵ A community mobilization program that does not use this approach is comparably toothless, since, again, it does not address the root causes of violence, instead relying on participants to change their perspectives and actions purely out of their own good will.

A participatory approach to community mobilization requires community members to lead the effort. Experience indicates that community members' commitment, creativity, and capacity in program execution produces transformative changes that may be impossible for external actors to achieve on their own. A program cannot accurately be labeled "community mobilization" if it does not place community members' own leadership and creativity at its core.

Step four involves embodying these three approaches into program design documents.

Formalize the strategies

After finalizing program design, programmers must formalize specific strategies to be used in program execution. To this end, programmers should be aware that community mobilization is not itself a strategy, but the desired outcome of several strategies aimed at social change. Common strategies of community mobilization programs include:

- Local activism, including grassroots initiatives that engage family, friends and neighbors. Examples include: drama, quick chats, door-to-door discussions, community conversations and public events.
- Media dissemination, using traditional and new media to target public perceptions on gender roles. Examples include: soap operas, films, newspaper articles and comics, radio programs, and television.
- Advocacy to influence local, national or international leaders. Examples include: one-on-one meetings, petitions, policy analysis and lobbying.
- Engagement with stakeholders, particularly with community members who promote gender equality at local levels.

- Communicative art dissemination to illustrate ideas. Examples include: artistic graphics, posters, comics, games, murals, flyers and picture cards.
- Interactive training to explore issues in depth. Examples include: workshops, seminars, teach-ins and mentoring.¹⁰

Leading scholars and practitioners involved in community mobilization understand that change in communities' approach to partner violence occurs in stages. Experience suggests that certain strategies are better suited for implementation at certain points within these stages. Table 1, below, draws upon the Stages of Change theory as applied to community mobilization work by Lori Michau and Dipak Naker, to illustrate the kinds of strategies associated with phases of community mobilization and stages of change.¹⁶

Table 1: Strategies and Stages of Change Associated with Community Mobilization

	"Stages of Change"	Phases of Community Mobilization	Potential Strategies
1	Pre-contemplation	<i>Community Assessment:</i> a time to gather information on community attitudes and beliefs about intimate partner violence and to start building relationships with community members and professional sectors.	Advocacy, Training
2	Contemplation	<i>Raising Awareness:</i> a time to increase awareness about intimate partner violence, such as why it happens and its negative consequences for women, men, families, and the community.	Local activism, Media, Advocacy, Communications materials
3	Preparation for Action	<i>Building Networks:</i> a time for encouraging and supporting general community members and various professional sectors to consider taking action to uphold women's right to safety. Community members can come together to strengthen individual and group efforts to prevent domestic violence.	Advocacy, Training
4	Action	<i>Integrating Action:</i> a time to take action against intimate partner violence part of everyday life in the community and within institutions' policies and practices.	Local activism, Advocacy, Training, Communications materials
5	Maintenance	<i>Consolidating Efforts:</i> a time to strengthen actions and activities for the prevention of intimate partner violence to ensure the sustainability, continued growth, and progress of prevention program.	Local activism

Whether or not programmers apply the Stages of Change theory, they must formalize the precise rationale for chosen strategies and intended outcomes. The theory of change will become a core component of program evaluation design as well, and can take many forms. Regardless of whether programmers use a logical framework, results-based framework, or a kind of visual presentation of the theory of change, the core program team must clearly and convincingly articulate how and why the program will bring about change. Theories of change emphasizing transformations in power relationships and other structural drivers of intimate partner violence will be particularly convincing if evidence-based.

Formalize the intended participants and beneficiaries

The selection of program location involves the identification of its intended participants and beneficiaries. However, it is also important to identify program participants

holistically in terms of the individual, relationship, community and society, and to consider the social norms that apply to each level. Figure 3 of the literature review on how the transformation of power across the ecological model can prevent VAW (page 8) identifies the social norms—and strategies for shifting them—that apply to these four levels of the ecological model.

Formalize the evaluation design

A community-based program to address intimate partner violence should produce reliable evaluation results to benefit both the programming team and the broader field of violence prevention work. Teams may select different criteria for program evaluation, with some favoring real-time insights of more nimble designs, while others prefer experimental or other rigorous designs that produce more scientifically reliable evidence. In either case, program teams must invest the energy and resources to formalize an impact evaluation design. Multiple resources are available to help guide this effort, including evaluation design and specific guidelines on data collection instruments and processes¹⁷⁻²⁰, with particular attention paid to protection of participants' safety. Any type of program evaluation should clearly define the program's intended outcomes (both short- and long-term) and goals.

Formalize the budget and timeline

Budget and timeline considerations will have enormous influence over all the decisions in Step 4, and must be articulated clearly. Programmers should allow adequate time for all the stages of program adaptation and implementation. It is unrealistic to expect any participant community where violence against women has occurred at significant levels for generations to move through stages of transformative change in a matter of months. A budget and timeline should allow for at least three, but ideally five, years of total program implementation for a successful community mobilization initiative.

Step Five: Prepare the program materials

When adapting materials from an existing IPV prevention program, such as manuals, posters, radio scripts, graphics, or short films, programmers must undertake a thorough process of contextual adaptation of these materials. Adopting materials used in other prevention programs can be helpful and time efficient, but only if they are adapted to the local context to instill a sense of authentic leadership and momentum.

To this end, programmers should translate the existing materials into the language of their program site (if necessary), then work through the materials to make necessary adjustments to details, storylines, references, names, and other details in a careful process of cultural adaptation. It may be necessary to hire illustrators or other artists to adjust the graphics included in these materials. The people, buildings, communities, natural surroundings and other details of the graphics must look like “our community” to people involved in the program.

Programmers should pilot a first draft of the adapted program materials before fully implementing the program. For example, programmers may ask a sample of program participants to use the materials for a short time, then survey participants to assess the

utility and appropriateness of the adapted the text, discussion prompts, graphics, storylines, etc. Programmers should then revise materials as necessary before formally launching the program.

Step Six: Finalize the outreach and dissemination plan as early as possible

Programmers should plan to disseminate the results of their interventions at local, national and international levels. The earlier in the process programmers define key audiences and dissemination channels, the easier it will be to take necessary steps throughout the program implementation process to produce the most compelling, useful final products.

A common dissemination plan involves initial reports of formative research and baseline results, as well as regular intermediate reports throughout program implementation. Once the program is completed, programmers can consider producing a wide array of products, such as articles in peer-reviewed journals, policy notes, working papers, and other documents. Any products should be prepared both in print and electronic form. Participants and stakeholders involved in the program must also be included in the results dissemination plan. Program teams should also create materials and presentations for dissemination to the program participants and stakeholders.

At the very least, programmers should produce a final report presenting the most relevant findings and the viability of adapting the program approach to other settings. Programmers may also consider giving presentations (workshops, conferences, seminars, etc.) at the national and international levels. These may include presentations at the Commission on the Status of Women, appropriate global seminars and international events on prevention, community safety, women's rights, children's rights, and urban planning, governance and safety, as well as through regional events organized by local networks working in IPV and public safety.

Conclusion

This methodological annex outlines the steps involved in adapting to new settings a community-based intervention to prevent intimate partner violence. While the precise nature of these steps will vary depending on the setting in which they are applied, the core ethical and effectiveness considerations here should remain true regardless of location. The authors hope that this note will help programmers worldwide to successfully transform community norms and prevent intimate partner violence. We thank you for your much-needed efforts.

References

51. World Health Organization, London School of Hygiene and Tropical Medicine, Medical Research Council. (2013). *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence*. Geneva, Switzerland: World Health Organization.
52. Duvury, N., Callan, A., Carney, P., Raghavendra, S. (2013). *Intimate Partner Violence: Economic Costs and Implications for Growth and Development*. Women's voice, agency, and participation research series; no. 3. Washington DC; World Bank. <http://documents.worldbank.org/curated/en/2013/11/18486239/intimate-partner-violence-economic-costs-implications-growth-development>
53. Klugman, J., et al. (2014). *Voice and Agency: Empowering Women and Girls for Shared Prosperity*. Washington, DC: World Bank Group.
54. Heise, L. (2011). *What Works to Prevent Partner Violence: An Evidence Overview*. London, UK: STRIVE Research Consortium, London School of Hygiene and Tropical Medicine.
55. Arango, D.J., Morton, M., Gennari, F., Kiplesund, S., Ellsberg, M. (2014). "Interventions to Prevent or Reduce Violence against Women and Girls: a Systematic Review of Reviews." *Women's Voice and Agency Research Series: The World Bank* 10.
56. World Health Organization, London School of Hygiene and Tropical Medicine. (2010). *Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence*. Geneva, Switzerland: World Health Organization.
57. Ellsberg, M., et al. (2014). "Prevention of Violence against Women and Girls: What Does the Evidence Say?" *The Lancet*, Volume 385, Issue 9977, 1555-1566. doi: [http://dx.doi.org/10.1016/S0140-6736\(14\)61703-7](http://dx.doi.org/10.1016/S0140-6736(14)61703-7).
58. What Works. (2014). *A Summary of the Evidence and Research Agenda for What Works*. What Works to Prevent Violence Global Programme.
59. Jewkes, R. (2002). "Intimate Partner Violence: Causes and Prevention." *The Lancet* 359:1423-29.
60. Michau, L. (2012). *Community Mobilization: Preventing Partner Violence by Changing Social Norms*. Bangkok, Thailand: United Nations Women.
61. Prochaska, J.O., Velicer, W.F. (1997). "The Transtheoretical Model of Health Behavior Change." *Am J Health Promotion* 12(1):38-48.
62. Abramsky, T., et al. (2014). "Findings from the SASA! Study: a Cluster Randomized Controlled Trial to Assess the Impact of a Community Mobilization Intervention to Prevent Violence against Women and Reduce HIV risk in Kampala, Uganda." *BMC Medicine* 12:122.
63. Bronfenbrenner, U. (1994) Ecological Models of Human Development. In *International Encyclopedia of Education, Vol 3, 2nd ed*. Oxford: Elsevier. Reprinted in: Gauvain, M. and Cole, M. (Eds.), *Readings on the development of children, 2nd ed*. (1993) NY: Freeman, 37-43.

64. Heise, L. (1998). "Violence Against Women: An Integrated, Ecological Framework." *Violence against Women* 4; 262-290.
65. Spangaro, J., Adogu, C., Ranmuthugala, G., Powell Davies, G., Steinacker, L., & Zwi, A. (2013). What Evidence Exists for Initiatives to Reduce Risk and Incidence of Sexual Violence in Armed Conflict and Humanitarian Crises? A Systematic Review. *PLOS ONE*, 8(5).
66. Michau, L., and Naker, D. (2003). Mobilizing Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and Southern Africa. Nairobi, Kenya: Raising Voices (raisingvoices.org). doi: 10.1186/1745-6215-13-96
67. World Health Organization. (2007). WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva, Switzerland: WHO.
68. Ellsberg, M. & Heise L. (2005). Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington DC, United States: World Health Organization, PATH.
69. Ellsberg, M., Heise, L., Peña, R., Agurto, S., & Winkvist, A. (2001). Researching Domestic Violence Against Women: Methodological and Ethical Considerations. *Studies in Family Planning*, 32(1), 1-16.
70. Department for International Development. (2012). *Guidance on monitoring and evaluation for programming on violence against women and girls*. Violence against Women and Girls CHASE Guidance Note Series.

Appendix A: Criteria for Selecting Intervention Municipalities and Communities

Municipalities

- Municipality wants to be part of the initiative
- Municipality has a history of supporting work and collaborating in other sectors
- Multiple sectors within a municipality currently demonstrate responsiveness to intimate partner violence, for example, by providing protection services, access to legal system, mental health services, etc.
- The municipality is capable of providing safety during the development and implementation of program activities
- Statistics on violence (or other important indicators) are available
- The program supports the municipality's short- and long-term social, political, and economic processes and goals
- Municipality employs stakeholders who are working on issues related to intimate partner violence or other types of violence
- Program leaders are well-respected and trusted in the community, increasing the likelihood that they will be supported throughout the implementation of the program

Communities

- There is an evidence base that can help inform the program design and implementation
- The community is geographically accessible
- There is safe access to the community
- There is a strong understanding of community dynamics that will help contribute to the design of this program
- There is a presence of community leaders, activists, and other networks to support the program
- Community leaders have experience in coordinating programs
- There is evidence of prior community mobilization, increasing the likelihood of participation
- Violence is addressed using a gender lens and with a good understanding of power dynamics
- There are sufficient services for women and adolescents who have experienced intimate partner violence
- It is feasible to implement the program within a timeline of at least three years

Appendix B: SASA! Criteria for Selecting Intervention Partners in Central America

Choosing a local implementing organization is the most important factor to a program's success. Below are criteria to use when selecting intervention partners.

Operational Capacity

- Prevention of IPV and SASA! fit within the implementing partner's strategic plan, programs, and objectives of the organization
- Implementing partner's management and administrative teams are prepared to support the capacity building of the organization, for example via conference calls and other electronic communication
- Implementing partner agrees to provide at least two senior staff to help train other team members on the Prevention Model for IPV/SASA!
- Implementing partner leaders and other staff agree to send the same staff to participate in training and follow-up visits
- Implementing partner has a legal status
- Implementing partner has been operating for at least two years
- Implementing partner has sufficient staff dedicated to the project to help ensure implementation of SASA!

Financial and Legal Status

- Implementing partner is transparent and can show accountability in executing programs over the last two years
- Implementing partner has a sufficient budget allocated to prevention programs
- Implementing partner has transparent financial and operating policies

Conceptual Understanding and Implementation Capacity

- Implementing partner staff analyze IPV using a gender and human rights framework
- Implementing partner understand what SASA! is and what is needed for successful adaptation and implementation of the program
- Implementing partner has experience designing and implementing prevention programs to address IPV or other forms of violence using a gender and human rights framework
- Implementing partner is capable of producing high-quality narrative reports
- Implementing partner staff working on implementing programs has experience working with IPV prevention programs
- Implementing partner has established respectful relationships within the target community and has activists or advocates to ensure a successful implementation
- Implementing partner has experience with advocacy at the political and community level

Leadership and Team Capacity

- The implementing partner has the human and financial resources to sustainably support the implementation of IPV prevention activities
- The presence of strong institutional support at various levels of the organization to support the adaptation of SASA!
- Implementing partner has established networks with other civil society organizations and government institutions
- Implementing partner has experience understanding community dynamics, including safety and security issues

