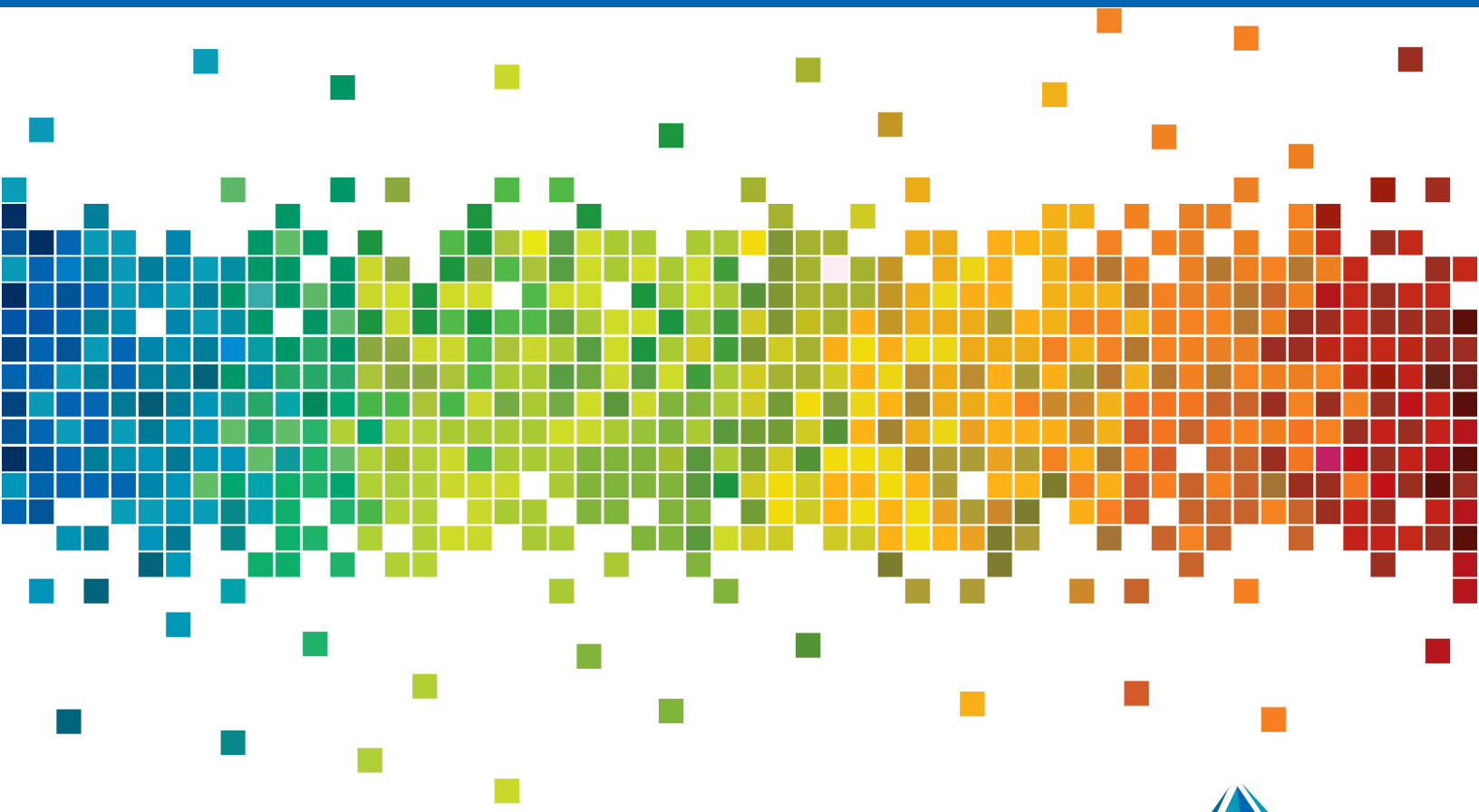
Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence



Virginia Sexual and Domestic Violence
ACTIONALLIANCE

Virginia's Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence is published by the Virginia Sexual & Domestic Violence Action Alliance.

Content generated by Virginia's Primary Prevention Guidelines Work Group (see names below), and coordinated/wordsmithed by Brad Perry, Kristi VanAudenhove, Liz Cascone, and Beth Leftwich. Layout and graphics by Kate McCord. Special thanks to Rebecca Odor and Jayne Flowers for their contributions, and to the Virginia Department of Health for helping to make this massive undertaking possible. Thanks also to the anonymous reviewers across Virginia and the nation whose feedback was integral to the quality of this document.

A huge THANK YOU to the work group participants who developed the foundation of this document! Virginia's Primary Prevention Guidelines Work Group members:

Pat Brown	Beth Leftwich
Liz Cascone	Rebecca Odor
Jayne Flowers	Lee Ogle
Hannah Foster	Rachel Patman
Angela Furrow	Brad Perry
Carrie Hart	Ilene Segal
Katie Kirby	Kristi VanAudenhove
Gwen Kitson	Trent Wagler

Address comments, questions, and requests for copies to Brad Perry at bperry@vsdvalliance.org.

Virginia Sexual & Domestic Violence Action Alliance
5008 Monument Avenue, Suite A
Richmond, VA 23230
Phone: 804.377.0335 • info@vsdvalliance.org • www.vsdvalliance.org

This publication was supported by the Cooperative Agreement Number 1 US4/CE001525-01 from The Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevent
Funded in part by the Virginia Department of Health, contract #704R72418.

Virginia Sexual and Domestic Violence
ACTIONALLIANCE

Table of Contents

Virginia Sexual and Domestic Violence ACTIONALLIANCE

I. Introduction

Over the past 35 years, the anti-rape and anti-domestic violence movements have established an impressive network of community-based organizations across the United States dedicated to raising awareness and providing direct services to victims. In Virginia, demand for the victim services provided by these organizations has generally increased over time (Action Alliance, 2006). With this continued high demand for their services, some sexual and domestic violence agencies began seriously considering what has been called "the best form of victim service" (Gariglietti, 2007): Preventing sexual and domestic violence before it ever occurs. "Primary prevention," a term originating in the field of public health, became the term used to describe this work.

The public health approach provides a vision of success for the primary prevention of sexual violence and intimate partner violence. "Violence can be prevented and its impact reduced, in the same way that public health efforts have prevented and reduced pregnancy-related complications, workplace injuries, infectious diseases, and illness resulting from contaminated food and water in many parts of the world. The factors that contribute to [violence]…can be changed" (Dahlberg & Krug, 2002, p.3). Sexual violence and intimate partner violence are perhaps more complicated than most of these other public health issues because of the intentionality of harm and social stigmas associated with their occurrence. But just as public health's systematic approaches have helped mitigate a range of threats to our well-being once thought to be completely intractable, they can also assist us in significantly reducing the prevalence of sexual violence and intimate partner violence.

The nation's top public health agency, the Centers for Disease Control & Prevention (CDC), began addressing sexual violence in 2001. The CDC has employed concepts and tools from both the public health field and the movements against sexual violence (SV) and domestic violence (also called intimate partner violence, or IPV). In many ways, primary prevention work is identical to the social change work originally envisioned by the anti-SV/IPV movements: encouraging new partnerships in communities, energizing people to organize against the root causes of SV/IPV, and connecting with underserved and marginalized groups. Indeed, it has

Introduction (continued)

been noted that the best SV/IPV prevention strategies "combine the socio-political analysis of the feminist...movement and the systematic approach to promoting healthy behaviors central to public health theory" (Lee, et al. 2007). As it relates to the current state of the anti-SV/IPV movements, the rise of primary prevention has widened our focus beyond reacting to these issues. It has provided a proactive paradigm: Helping us to articulate how we will nurture future generations to be less violent, healthier, and happier.

A defined collaboration between the Virginia Sexual and Domestic Violence Action Alliance (Action Alliance) and the Virginia Department of Health to build the capacity of Virginia communities to do primary prevention work has been on-going for several years. These guidelines are a product of this partnership, and will assist Virginia sexual and domestic violence agencies (and possibly other community organizations) in developing effective primary prevention initiatives. The guidelines and support materials contained herein are based on a combination of research (Nation, et al, 2003, for example) and experience from people who do SV/IPV primary prevention work on a daily basis. It is important to note that this document has not yet been officially adopted by the Action Alliance Membership, and as such is only meant to serve as a technical assistance tool in developing primary prevention initiatives at local sexual and domestic violence agencies.

These guidelines are meant to serve as an organizing philosophy rather than an irrefutable prescription for prevention work. Due to the enormous amount of resources needed to achieve all of these ideals, it is not realistic that prevention initiatives could "check off" all of the programmatic components contained in these guidelines. Rather, the questions posed by the guidelines are meant to act as benchmarks, facilitating constant improvement in primary prevention program development. It is our hope that this document will help every existing SV/IPV primary prevention program operate at its full capacity, and provide potential programs with information on how to build a foundation for primary prevention work. An increase in public and private resources for this work is anticipated, and this document will help ensure that all current and future SV/IPV primary prevention programs are able to use these resources to maximum effect.

II. Key Definitions

Primary Prevention of Sexual & Intimate Partner Violence:

Preventing sexual and intimate partner violence before they occur. Primary prevention efforts exist on a continuum (primary, secondary, and tertiary prevention – see CDC's Beginning The Dialogue*). These efforts seek to bring about change in individuals, relationships, communities, and society through strategies that: 1) Promote the factors associated with healthy relationships and healthy sexuality, and 2) Counteract the factors associated with the initial perpetration of sexual violence and intimate partner violence (see Appendix B). This work values and builds on the strengths of diverse cultures to eliminate the root causes of sexual and intimate partner violence, and create healthier social environments.

** http://www.cdc.gov/ncipc/dvp/SVPrevention.htm*

Intimate Partner Violence (Action Alliance):

Intimate partner violence is a pattern of abusive behaviors used by one individual to control or exert power over another individual in the context of an intimate relationship.

Sexual Violence (Action Alliance):

Sexual violence is conduct of a sexual nature which is non-consensual, and is accomplished through threat, coercion, exploitation, deceit, force, physical or mental incapacitation, and/or power of authority.

Key Definitions (continued)

Healthy Relationships & Healthy Sexuality:

Healthy Relationship: A connection between people that increases well-being, is mutually enjoyable, and enhances or maintains each individual's positive self-concept.

Healthy Sexuality: The capacity to understand, enjoy, and control one's own sexual and reproductive behavior in a voluntary and responsible manner that enriches individuals and their social lives. Sexuality is an integral part of the human experience with physical, emotional, intellectual, social and spiritual dimensions.**

Healthy relationships and healthy sexual expression are frequently characterized by:

- Communication
- Trust
- Respect
- Honesty
- Equality
- Choice
- Individuality
- Understanding
- Empathy
- Self-confidence
- Mutual support
- Enjoyment

** "Sexuality and Social Change: Making the Connection Strategies for Action and Investment" (2006). Ford Foundation: New York, NY.

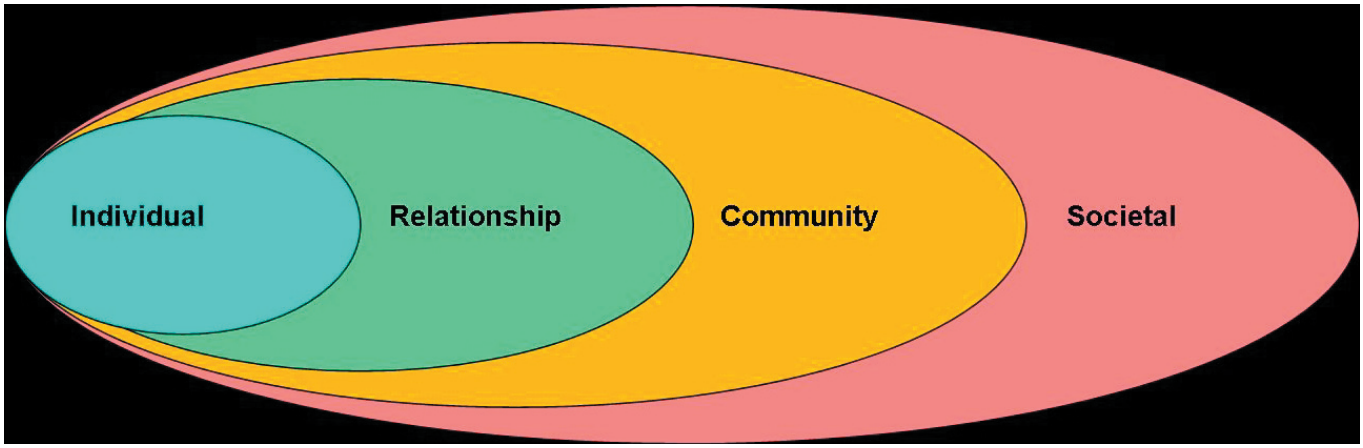
[*Note: For a more in-depth discussion of the concepts of primary SV/IPV prevention, healthy sexuality, and more, please visit www.vsdvalliance.org/secPublications/newsletters.html and download issues of Moving Upstream.*]

Key Definitions (continued)

The Social Ecological Model:

The Social Ecological Model is commonly applied to sexual violence and intimate partner violence prevention by those in the public health field. The Social Ecological Model explains the occurrence of sexual and intimate partner violence and helps identify potential prevention strategies on four levels (Heise, 1998): individual, relationship, community, and societal.

Individual level factors relate to a person's knowledge, attitudes, behavior, history, demographics, or biology. [NOTE: The risk factors considered in this document are limited to those domains that are modifiable, thus a person's biology and history are largely excluded here.] Risk factors such as adherence to beliefs that condone the use of violence and coercion, displaying a pattern of denigrating women exist– and would be addressed by strategies that operate on–the individual level (Carr & VanDeusen, 2004; Jewkes, Sen, & Garcia-Moreno, 2002). Relationship level strategies address the influence of parents, siblings, peers, and intimate partners. For example, boys who experience caring and connection from adults are less likely to perpetrate violence (Resnick, Ireland, & Borowsky, 2004), while men with peers who encourage sexual coercion are at a heightened risk for perpetration (Loh, Gidycz, Lobo, & Luthra, 2005). Community level strategies address norms, customs, or people's experiences with local institutions, such as schools, workplaces, places of worship, or criminal justice agencies. Societal level strategies address broad social forces, such as inequalities, oppressions, organized belief systems, and relevant public policies (or lack



Key Definitions (continued)

thereof). Because factors at one level are influenced by connected factors at other levels, primary prevention strategies should seek to operate on multiple levels of the social ecology simultaneously.

Example:

A DELTA-funded primary prevention project, based in Winchester, Virginia, determined that a partnership with the faith community would bring the most powerful influence on their population. Through feedback from adolescents in several selected faith communities, they found 4 key concerns to address:

- Unequal role division between boys and girls;
- Learned acceptance of unequal gender norms and stereotypes,
- Confusion about gender differences and acceptable vs. unacceptable behavior;
- Perpetration of the same behaviors that were modeled as children.

At the Individual Level, the DELTA committee teamed-up with several local churches to offer educational activities for adolescents in those faith communities. These activities examined gender norms and stereotypes, and promoted the development of healthy relationships. Also, pastors at each church utilized a new innovative faith based curriculum, "Love, All That and More", to teach youth about the importance of modeling healthy behaviors. The youth were given bracelets and flashlights with the slogan, "Love is Patient, Love is Kind." The workshops also included free food and door prizes. Post-tests indicated that 100% of the participants determined that it takes love, communication, and respect to make a relationship work.

At the Relationship Level, DELTA committee members partnered with representatives from the Coalition of Parrish Nurses. In an effort to promote healthy relationships, nurses met with parents of adolescents to teach them the importance of modeling respectful behaviors. They worked with the parents both individually and in group sessions to discuss positive communication skills, and how to appropriately handle stressful situations in the presence of your children. In this part of the project, parents in the faith community learned how their behavior influences their children, and that modeling healthy behavior will increase the chances that their children will desire healthy relationships. Most of the parents who participated in this level of the project had adolescent children who also participated in the aforementioned activities categorized under the individual level.

Key Definitions (continued)

At the Community Level, the DELTA committee members led presentations on the importance of modeling healthy relationships for the local Coalition of Parrish Nurses. The presentations focused on training the Coalition on how to train parents to be healthy role models for their children. Following the training, DELTA committee members worked with the nurses to revise their own training manual to include a section on helping families learn about healthy relationships. This revision is now a mandatory part of their regular training.

The goal for Societal Level strategies was to promote policy change in the churches such that these healthy relationship projects would be sustained and reinforced by the institutional power of the church. The local DELTA committee came up with the concept of inviting local churches to be "Healthy Relationship Churches". Healthy Relationship Churches are churches that employ the following prevention strategies:

- The pastor preaches a sermon on healthy relationship skills twice a year;
- The youth group focuses on healthy relationships twice a year;
- The women's organization hosts a program on healthy relationships once a year;
- The men's group hosts one program a year on healthy relationships; and
- The church offers a parents retreat once a year on an aspect of healthy relationships.

The DELTA project also offered resource incentives to the first 5 churches who signed up. The start-up kit, valued at $500, included: an additional copy of the "Love, All That and More" curriculum, a DVD on how churches can prevent domestic violence, a book on men's role in preventing violence against women, incentives (pens, mints, bracelets, and flashlights) that promote the Love is Patient, Love is Kind message and a full sized banner for the church to hang proclaiming "WE ARE A HEALTHY RELATIONSHIP CHURCH", and a framed certificate recognizing their commitment to the project. Several of the selected churches implemented these policy changes.

III. Guidelines for Implementing Sexual Violence & Intimate Partner Violence Primary Prevention Strategies

Guideline 1: Develop prevention strategies that promote protective factors.

- Effective prevention programs promote and sustain the development of healthy sexuality.
- Effective prevention programs support the development of healthy relationships amongst peers, and between youth and older role models who are invested in their well-being (e.g., parents and other family members, older siblings, caregivers, teachers, faith group leaders, youth-serving professionals, coaches, etc.).
- Effective prevention programs support the development of socially just institutions.

Example:

Care For Kids (CFK) was created to facilitate healthy sexuality and safety, rather than solely teaching children to avoid sexual abuse. Designed to be flexible, CFK has existed in many forms over the past 15 years, but the most well-tested version is a 7-session, Pre-K-Third Grade curriculum for children and its companion program for parents and other key adults. This version of CFK starts by securing buy-in from adults in a given school or child care setting. Generally one must establish a rapport with a school or child care facility (including the parents of the children), assess their capacity to implement CFK, train these adults about sexuality, child sexual abuse, and the CFK program itself, address relevant policies and practices of the school/child care facility, and finally implement the 7-session curriculum with the children.

CFK bolsters its effectiveness by attending to the community and relationship levels of the social ecology before attempting to work with children at the individual level. By first enhancing the knowledge, attitudes, and skills of key adults, and addressing the policies and practices of the school/child care facility, CFK is able to create a supportive environment for the messages in the 7-session child-focused curriculum. The curriculum itself has been carefully composed to impart messages in an affirming and developmen-

tally appropriate manner. Some of the messages that make CFK particularly unique include:

• Our bodies are good and special, deserving of care and respect (including our genitals).

• Boys and girls have many parts that are the same, and a few parts that are different. All body parts have names and can be talked about respectfully.

• Babies need a lot of help and deserve to be cared for and nurtured. Children, as they grow, can do more for themselves, but still need and deserve help with some things.

• Girls and women do not always have to be nice and helpful; Boys and men do not always have to be tough, and able to handle everything.

• Sometimes we like to be touched and sometimes we don't. It's OK to say no to any kind of touching.

• We don't touch a person who says 'no touching' or looks unhappy about being touched.

The aim of these messages is to empower children to become respectful, perceptive adults who understand the importance of everyone being able to develop an enriching sense of their own sexuality. For example, the purpose of the first message is to lay the foundation for the rest of the program, expressing the need for a positive outlook on sexuality versus one of shame and silence. The last two messages are age-appropriate versions of a theme common to many prevention programs for teens: The importance of correctly perceiving cues and respecting other people's boundaries.

Guideline 2: Develop prevention strategies that strive to be comprehensive.

- Strategies/programs should address multiple levels of the social ecology, while focusing on connected risk/protective factors across these levels.
- Within any given level of the social ecology, activities should take place in multiple settings (e.g., Individual level - curriculums implemented at both school and church).
- Prevention strategies at different levels of the social ecology should be designed to complement each other (e.g., a common set of risk/protective factors are addressed across the different levels of the social ecology and in multiple settings).

Example:

[NOTE - Very few SV/IPV prevention programs have the resources to implement sustained efforts at all levels of the social ecology. This example includes projects at the Individual, Relationship, and Community levels.]

Student Connections Clubs, projects of Collins Center in Harrisonburg, VA illustrate an initiative with multiple components taking place in multiple settings. The projects are occurring in 3 different high schools across the Harrisonburg/Rockingham area. On the individual level, high school students participate in multiple educational sessions to gain skills and knowledge about sexual violence, prevention concepts, and being active bystanders. On the relationship level, students become peer leaders who deliver educational sessions to other students and model appropriate responses to interrupt disrespectful behavior. In-service trainings for teachers and the PTA on these topics also constitute relationship level strategies. Community level efforts include conducting school-wide "healthy relationship" campaigns and gaining endorsement of the program by the school as an officially designated club. With activities on multiple levels, programs such as the Student Connections Club facilitate change in both individuals and the environment in which they live.

Guideline 3: Develop prevention strategies that are concentrated, and can be sustained and expanded over time.

- Effective prevention programs emphasize high contact/exposure with participants within a concentrated time-frame. Research has shown that one-time programs focused on raising awareness rarely produce behavioral change.

- Effective prevention programs include strategies for reinforcing the key messages over time. These follow-up strategies should remain consistent with the original messages in their theme/ rationale, and can be accomplished through a variety of activities promoting the continued use of the information and skills.

Example:

Expect Respect, a project of SafePlace in Austin, TX is an intensive, comprehensive dating violence prevention program. At the Individual Level, Expect Respect's 90-minute groups for at-risk boys and girls meet once per week for 24 weeks, and focuses on raising expectations and skills for healthy relationships, increasing safety and respect on school campuses, and supporting youth leadership in violence prevention. Follow-up activities throughout the rest of the school year include meetings about how the knowledge and skills are being used by the youth to develop violence prevention projects in the school.

At the Relationship Level, Expect Respect trains teens to become peer leaders. The "SafeTeens" youth leadership training helps students in 7th-12th grades learn how to take a stand against violence in interpersonal relationships. The 8 lessons (which often occur in the same school settings hosting the weekly Expect Respect groups) increase students' knowledge of the characteristics of healthy and abusive relationships. The first 6 sessions focus on how to recognize and confront potentially abusive situations. The last 2 sessions help students acquire the skills needed for peer support, advocacy and community action. After completing the lessons, students

identify a problem relating to violence in their school or community and create a prevention project. The messages and skills conveyed in the peer leader training tie back into the school-wide Expect Respect curriculum, which are in turn frequently reinforced by the peer leaders in informal situations.

SafePlace's example of highly concentrated prevention efforts extends to its Community Level initiatives. It provides training and technical assistance to engage all members of the school community in teaching and supporting positive relationship behaviors, improving the school climate, and increasing student safety. Strategies include training on school policy concerning bullying, sexual harassment, and dating violence; assessing school climate; and engaging students and caring adults in school-wide prevention activities. SafePlace implements these efforts on select school campuses through faculty/staff orientation, facilitator training for teachers and counselors who agree to conduct further activities (usually teachers connecting these lessons to their academic subjects areas), parent seminars, and assistance with campus-specific awareness activities. The amount of contact with a school's faculty, staff, and parents is relatively high, considering the scheduling and time-commitment obstacles typically associated with engaging these groups. Faculty and staff receive an initial in-service training, followed by additional trainings for faculty and staff agreeing to impart Choose Respect messages via their daily interactions with the students. Parents receive training through PTA/PTO meetings, parent support staff in the schools, and identified "parent leader groups".

Guideline 4: Develop prevention strategies that use varied teaching methods to address multiple learning processes.

- Effective prevention programs use active/interactive approaches to engage multiple learning styles.
- Effective prevention programs depend on more than sharing information and discussion - strategies should facilitate the development and practice of skills.
- Effective prevention programs are based on the idea that each of us can be both a teacher and a learner. An effective facilitator views "learners" as active participants, enabling others to make sense of the information in a manner that is most relevant to them.
- Effective prevention programs emphasize modeling healthy and respectful relationships in addition to imparting knowledge. Working with a group to set ground rules and maintaining respectful boundaries during the facilitation process can be as important as the information itself.

Example:

The Mentors in Violence Prevention program uses a variety of methods to teach peer leaders how to prevent IPV/SV in high school and college settings. Participants engage in self-directed learning and the practice of skills through role-playing scenarios that challenge them to address sexist/disrespectful behavior, and to intervene in high-risk situations. These scenarios can be made more realistic through the use of kinesthetic learning activities, in which participants are presented with some type of challenging behavior and have to act-out how they might constructively respond. Also, "fishbowl" processes can allow participants to share insights, stimulating a peer learning process.

Background knowledge about SV/IPV is imparted through media clips, interactive lecture, small group discussion, and written analyses of the aforementioned scenarios. Lastly, the certified trainers create a participatory and respectful learning environment, modeling respectful interactions.

Guideline 5: Develop prevention programs based on purposeful, logical rationale.

- Effective prevention programs are informed by our understanding of what increases or decreases the likelihood of IPV/SV. These could be "**etiological theories**" (see Appendix A for definition) or risk and protective factors informed by the field (see Appendix B). This will help ensure that all content and approaches are connected back to a common causal foundation (see Appendix A for definition).

- Effective prevention programs are informed by theories explaining how strategies will foster individual and environmental change ("**change theory**" – see Appendix A for definition).

- Effective prevention programs are based on a step-by-step process that describes in detail how the problem will be addressed. Such a system, sometimes called a "**process theory**" and often represented by a logic model, describes a "roadmap" of activities starting at current activities and resources, and moving towards the prevention of initial perpetration.

Example:

Based on the work of social psychologists and feminist scholars, it has been well established that sexual violence occurs in part because of peer support for sexually adversarial attitudes and behaviors (Etiological Theory) amongst groups of young men.

Men Can Stop Rape's Men Of Strength (MOST) Clubs utilize Social Learning Theory (Change Theory) to promote gender equity and build men's capacity to bond with each other in positive ways, and without being violent. MOST Clubs also help participants assess how masculinity is defined in our society, and how society's definitions of masculinity impact their behavior. The program is designed to facilitate peer-to-peer learning (example of Change Theory in action) where participants share stories, challenges, and successes, and receive reinforcement (example of Change Theory in action) from each other on adopting masculine behavior that is

affirming to themselves and not harmful to the women in their lives. The young men then "graduate" from the MOST Club and receive support in turning their new found awareness into community-based action (example of Change Theory in action), attempting to promote new social norms about masculinity and strength.

The structure and goals of MOST Clubs were established on the basis of existing resources and input from young men, and inform the activities of each group so that male peer support for sexual violence is reduced (Process of change Theory) while simultaneously promoting positive styles of male peer relationships.

Guideline 6: Develop prevention strategies that are developmentally appropriate.

- Because attitudes, beliefs, and habits begin forming early in life, the opportunity to instill lessons about healthy relationships and healthy sexuality **begins at birth**. Effective prevention strategies impact developmental stages **prior to** the emergence of **unhealthy behaviors**.
- Effective prevention strategies impact early developmental stages by **engaging young people** directly, and by engaging **adults of all ages** to create environments promoting the development of healthy relationships and healthy sexuality.
- Effective prevention programs are **developmentally relevant**, continuing throughout the lifespan, and are tailored to the intellectual, cognitive, and social development of a given group.

Example:

This early formation of attitudes and beliefs around issues affecting sexual assault prompted Family Resource Center (FRC) to refocus some of their prevention efforts on younger children. Traditionally, prevention programs for dating and sexual violence have been aimed specifically at teenagers. While the FRC program retained some focus there, they also made working with younger children a priority.

FRC sought to address the protective factors that lead to the formation of healthy relationships and inhibit the risk factors for the formation of abusive relationships. They examined developmental norms in determining the content and approach for a primary prevention curriculum, particularly the work of Jean Piaget and Benjamin Bloom.

Piaget's stages of cognitive development heavily influenced the choice of topics and creation of activities in FRC's curriculum. Piaget theorized four basic stages of cognitive development. The "sensorimotor" stage, from infancy to age two, is characterized by learning through the senses. The "preoperational" stage, from ages two to seven, is marked by concrete thinking and inability to empathize or see others' viewpoints. Beginning to understand abstract concepts typifies the third stage of "concrete operations", which includes ages seven to eleven. Children in this stage empathize, see others' perspectives and are beginning to exercise more sophisticated problem solving techniques. Finally, the stage of "formal operations", including ages twelve through adulthood, is marked by the use of abstract thinking skills. In all stages, learners do not move abruptly from one type of learning to the next, but rather in a pattern of utilizing more abstract thought as skills are acquired and rehearsed.

FRC's program begins with preschool and continues through high school, and thus takes all of Piaget's stages into account. For example, because children in the pre-operational stage have trouble empathizing with others, activities for preschoolers on the topic of feelings focus on appropriately expressing personal feelings, rather than the feelings of others. The program does not ignore the topic of empathizing with others, but rather waits until the next stage (around age seven), to really begin working with the concept. This way, the curriculum builds up to the concept at the age when children are cognitively ready to develop empathy as a protective factor.

The curriculum's treatment of respecting differences was also created with these stages in mind. The preschool material focuses on valuing concrete differences, emphasizing that boys can be friends with girls, children who are short and tall can play together, and so forth. While this type of activity may seem unrelated to sexual assault prevention, it lays the groundwork for further discussion of valuing differences in second grade, where children discuss difference-based bullying, and in fifth grade where children practice respecting others' viewpoints, even if they are different from their own. If children can begin practicing this skill in elementary school, they have a much better chance of later using it to respect differences of opinion in their dating relationships. Respecting differences is a protective factor that can begin developing in preschool and continue throughout life.

Complementing the work of Jean Piaget for this project, the work of Benjamin Bloom serves to further inform FRC's prevention program. Bloom theorized three "domains" of learning: the Cognitive (meaning mental skills), the Psychomotor (meaning physical skills), and the Affective (meaning growth in attitudes and feelings). Because an important aspect of primary prevention is about changing attitudes, feelings, and ultimately social norms, the affective domain was of particular interest. This domain organizes social learning into a five level pyramid: receiving, responding, valuing, organizing and internalizing.

"Receiving" means that when social learning occurs, new ideas must be listened to openly. This means that learning cannot begin without a captive audience, which is why every single lesson has an introductory activity with the goal of getting the students' attention so they are willing to openly hear and interact with the information. For example, the lesson teaching preschoolers to use hands to help others and not to hurt begins with a game that allows each child to show something fun he or she can do with his or her "helping hands". This activity invites them to respond, participating actively in what it means not to use hands to hurt.

The next level of learning involves assigning value or personal opinion to a given subject. For example, in the second grade curriculum children hear the story, The Paper Bag Princess, a tale about a princess who decides not to marry her betrothed prince because he is unkind to her. Then, children create paper bag puppets and write on their bags ways they would like to be treated by others. This activity allows children to assign the value of what it means to be "treated like royalty" in a relationship.

The organizational level follows the valuing level. This level requires a high level of abstract critical thinking skills, and is therefore included in the curriculum for older students, with the material for younger grades building up to it. The organizational level involves refining and qualifying personal beliefs based on interaction with new information. It also involves resolving conflicts that arise from exposure to new information that is deemed valuable at the previous level. Perhaps the best examples of this level in the curriculum are the sessions addressing assertive communication with teenagers. The curriculum defines assertive communication as communication that values both the self and others. Students are given a variety of scenarios in which to offer suggestions for assertive communication

possibilities, like having a friend ask to cheat on a test or facing peer pressure to go skinny dipping. As students create responses, they are resolving the conflicts inherent in valuing self and others at the same time.

Bloom's final level of the affective domain involves internalizing values. This is the level at which social change occurs, and what FRC hopes to accomplish. This is not the part you see in the classroom, and it's a bit difficult to quantify. Nonetheless, it can be seen when children write essays about the importance of valuing themselves in response to the lesson about self esteem.

Guideline 7: Develop prevention strategies in collaboration with diverse community members to include many cultural beliefs, practices, and community norms.

- Effective prevention programs tailor their content and approach to be **culturally appropriate and relevant** to its participants. This can only be effectively accomplished though the **direct involvement** of diverse community members/stakeholders in the planning of a program.

- Effective prevention programs demonstrate **inclusion** of diverse cultural beliefs, practices, and community norms, and may require an anti-oppression framework to be effective.

  ** See Appendix A for a glossary containing the terms "norm" and "anti-oppression framework". **

Example:

A sexual and domestic violence agency called Project Hope in Charles City, Virginia partnered with Samaria Baptist Church (SBC), the faith center for a large number of Native Americans from the Chickahominy Tribe in the Charles City area. Project Hope staff and church leaders formed an on-going IPV prevention workgroup, and conducted a needs and resources assessment. They found that in 1790, when the first federal census was taken, Charles City's population numbered 5,588. Today the population is 6,926, a population increase of only 1,338 over the course of 210 years. Understanding that change does not come rapidly to the community helped to remind them that they needed to allow plenty of time for the planning.

Through their discussions with the SBC leadership, they realized that any IPV prevention initiative would have to recognize the extent to which the community is highly invested in their church and the tribe. In fact, the church and tribal grounds are on the same land. Furthermore, the group found that SBC members experienced their Christian faith as equally influential and critical to their identity as their Native culture/customs.

These conclusions were the result of numerous discussions between the IPV prevention workgroup and members of SBC. Some of the leaders within SBC also began participating in the IPV prevention workgroup, providing input into the planning process for the eventual IPV prevention initiative that would be based at SBC. Without taking the time to examine the community context, specifically organizational culture, ethnic/racial identity, politics, religious identity, and broader social factors, the IPV prevention workgroup would not have gained the trust of the SBC community, and would not have been able to assess SBC's readiness, strengths, and weaknesses in relation to IPV prevention.

Eventually, the IPV prevention workgroup, in partnership with most of the church leadership, developed a prevention plan and selected a set of strategies focused on boys within the church.

Individual Level: Two 6-week curricula: One curricula was developed by the workgroup, and builds skills for general interpersonal relationships. The curriculum is the faith-based "Love: All That And More".

Relationship Level: Mentoring program with adult leaders in church, who were also the facilitators of the curricula at the individual level.

Community Level: Pastor of church and other church leaders took the steps necessary to permanently establish the IPV prevention program at SBC, and committed to deliver several sermons each year on healthy relationships and IPV.

Societal Level - Samaria Baptist Church is working with their regional association to institutionalize this program in other churches.

Guideline 8: Develop prevention strategies that include a systematic method to determine program effectiveness and promote continuous quality improvement*.

- Effective prevention programs incorporate an **evaluation strategy** to provide important ongoing feedback to the planning and implementation processes.
- Effective prevention programs **use the information** gathered from ongoing evaluation activities to continually improve* the planning and implementation processes, making positive outcomes more likely.
- The evaluation plan for a prevention program should contain both **process and outcome measures** (see Appendix A for definitions).

*See Appendix A for a glossary containing the term "continuous quality improvement".

Example:

Peer Solutions' STAND & SERVE project is an asset-based, peer-facilitated, prevention and intervention support program, which also seeks to promote protective factors amongst the peers themselves. They assess the impact the program has on the peers, and how the impact could be made greater by improving the program. Two tools used to assess potential improvements to the program are:

- Developmental Assets Survey: Conducted twice per year, it identifies which Developmental Assets are present in the peer's lives to determine if there is an increase in assets as the peers become more deeply involved in the program. Also indicates which assets are being activated by participation in the program.

- Qualitative survey with family: Shows how to include family in the program. Results from this survey frequently lead to changes in how Peer Solutions reaches out to and include family members. This helps facilitate buy-in from the peers' (and their families), while also activating Developmental Assets in the peers' family environment.

Guideline 9: Develop prevention strategies as an integral part of the agency mission to end sexual violence / intimate partner violence.

- Effective prevention programs are part of an organization's strategic plan.
- Effective prevention programs are given the financial and personnel resources needed to achieve the desired outcomes.
- Effective prevention programs are based on an agency-wide commitment to prevention in accordance with the aforementioned principles.

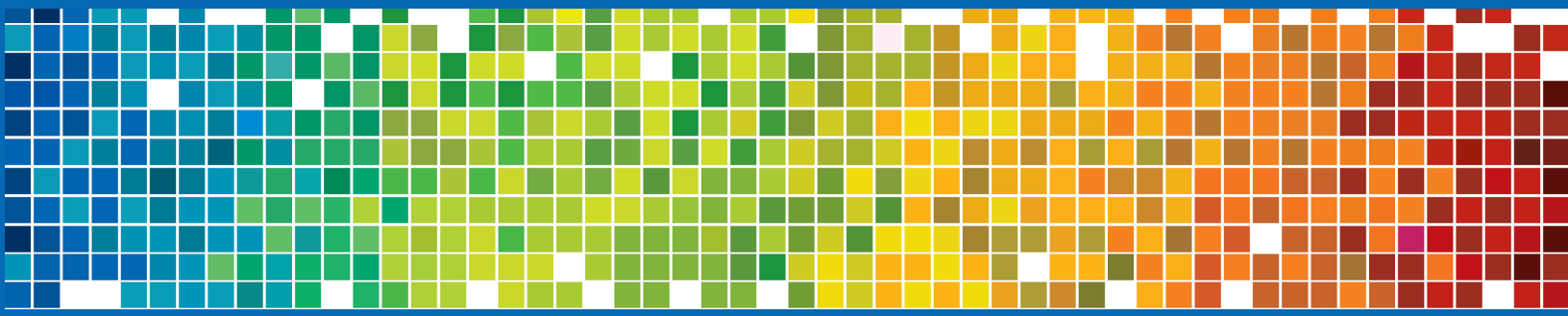
Example:

The Action Alliance has integrated prevention throughout the agency since its inception in 2004. The agency mission is to create a Virginia free from sexual and domestic violence - a mission with prevention at its core. While there is a profound commitment to ensuring that all survivors have access to safety, respect, justice and healing, much of the energy and passion that drives that work comes out of the belief that working together we can create communities that are free from sexual and domestic violence.

In 2005 the membership adopted a Strategic Plan that included seven goals. Preventing sexual and domestic violence is one of those goals, and it includes activities ranging from coordinating the DELTA project to promoting surveillance to drafting a formal position promoting affirmative consent for sexual activity. Prevention is also embedded in the objectives under each of the other seven goals. For example, the Public Awareness goal includes the development and implementation of a campaign focused on bystander responses to unhealthy dating behavior and promoting healthy dating relationships: The Red Flag Campaign.

Out of 25 Action Alliance staff members, there are 3 full-time staff whose principal duties are focused on primary prevention, 6 additional staff who

have significant responsibilities in carrying forward prevention objectives, and the 3 Co-Directors who commit a substantial portion of their time to providing support and guidance to the agency's prevention work. Almost all of the staff have participated in specialized prevention training, and in the upcoming year all new staff will be expected to complete our Principles of Prevention training. This shared understanding of prevention translates to a shared commitment - to healthy relationships, healthy sexuality and ultimately, to communities free of sexual and domestic violence.



Appendix A:

Glossary

Glossary

Anti-oppression framework: This framework can be defined by four key elements:

- Actively working to acknowledge and shift power towards inclusiveness, accessibility, equity and social justice.
- Ensuring that anti-oppression is embedded in everything that you do by examining attitudes and actions through the lens of access, equity and social justice.
- Being conscious and active in the process of learning and recognizing that the process as well as the product is important.
- Creating a space where people are safe, but can also be challenged.

Change Theories: Theories of change offer explanations as to how someone would choose a non-violent or healthy outcome instead of perpetrating IPV/SV. These theories can be divided into theories describing personal change (processes within individuals that explain their behavior change) and theories that describe social/community/group change (processes in an individual's social environment that explain their behavior change). See examples, pages 31-35.

Common Causal Foundation: The explanation of why SV and/or IPV occurs, on which a set of primary SV/IPV prevention strategies are based. For example, if a local SV/IPV collaborative decides to begin planning a sustained primary prevention program, then they should first come to consensus on what are the major causes of SV/IPV in their community/ies. This determination will help them select prevention strategies that fit their community context. A common causal foundation can consist of an etiological theory, multiple etiological theories, a collection of risk and/or protective factors, or any combination thereof. As a concept, "common causal foundation" is similar to the models of "component cause" and "causal pies" put forth by Powell, Mercy, Crosby, Dahlberg, and Simon (1999).

Glossary (continued)

Continuous Quality Improvement (CQI): The systematic assessment of feedback and evaluation information about planning, implementation, and outcomes used to constantly improve programs as they go.

Etiological Theory: In the context of this document, an etiological theory explains why initial perpetration of sexual and/or intimate partner violence occurs. Various theories about gender and learning have historically been used as etiological theories to explain SV/IPV. Because of both the enormity of the issue and the scarcity of resources, programs would likely use just one or two principal etiological theories to inform their primary prevention projects.

Logic Model: A logic model is a systematic and visual way to present the relationships among the resources you have to operate your program, the activities you plan to do, and the changes or results you hope to achieve. For a more in-depth explanation, visit: *www.publichealth.arizona.edu/CHW-toolkit/PDFs/LOGICMOD/chapter1.pdf*

Norm: A principle of right action binding upon the members of a group and serving to guide, control, or regulate proper and acceptable behavior.

Outcome Evaluation: An outcome evaluation attempts to document whether or not the program achieved the change described in the goals or objectives, and if so, how much and what kind. If a process evaluation answers "Did we do what we said we were going to do?" then an outcome evaluation answers "What happened as a result?" or sometimes, "Did we achieve the change we wished to achieve?"

Outcome evaluation is important because it provides evidence that your program accomplished its goals. It can answer such questions as:

- Did the program work?
- Should we continue the program?
- What can be modified that might make the program more effective?
- What evidence shows funding sources the program's effect?

Glossary (continued)

Primary Prevention: Preventing sexual and intimate partner violence before they occur. Primary prevention efforts exist on a continuum (primary, secondary, and tertiary prevention – see CDC's Beginning The Dialogue*). These efforts seek to bring about change in individuals, relationships, communities, and society through strategies that: 1) Promote the factors associated with healthy relationships and healthy sexuality, and 2) Counteract the factors associated with the initial perpetration of sexual violence and intimate partner violence (see Appendix B). This work values and builds on the strengths of diverse cultures to eliminate the root causes of sexual and intimate partner violence, and create healthier social environments.
** http://www.cdc.gov/ncipc/dvp/SVPrevention.htm*

Process Evaluation: A process evaluation assesses -

- What activities were implemented;
- The quality of implementation meaning, how well the program was received by participants as well as by the trainers (this might be done through debriefing, or gathering feedback from participants about how they feel about the program, did they buy-in to the objectives, etc.);
- The strengths and weaknesses of the implementation.

A well-planned process evaluation is developed prior to beginning a program and continues throughout the duration of the program. It can help strengthen and improve the program by indicating when and where to make mid-course changes to keep the program on track.

Knowing whether or not the implementation was done with quality can tell you whether the program is appropriate for the community or audience. If the process evaluation indicates high-quality implementation and then an outcome evaluation shows positive outcomes, you can assume that the program was effective. If the program does not show positive outcomes, but a process evaluation showed high-quality implementation, then there are likely to be problems with the program's theory or logic.

Protective Factor: A variable that creates a buffer against perpetration or victimization, while also facilitating a related positive outcome.

Risk Factor: A variable that increases the likelihood of perpetration or victimization.

Glossary (continued)

Selected Theories of Personal Change

Special thanks to Dr. Marc Mannes of The SEARCH Institute for his invaluable contributions to the summaries of the selected Change Theories.

Transtheoretical Model / Stages of Change: Synthesizing research from a variety of disciplines, Prochaska and his colleagues have proposed that behavior change can be broken into 5 basic stages: Precontemplation, Contemplation, Preparation, Action, and Maintenance.

- **Precontemplation:** When an individual becomes initially aware of a problem and begins to think about addressing it.

- **Contemplation:** When an individual's awareness of a problem grows to such an extent that he/she begins to seriously think about how to overcome it, but has not yet committed to taking action.

- **Preparation:** When an individual has established the intent to take action regarding the problem, but has not yet done so.

- **Action:** When an individual engages in personal behavioral change and/or endeavors to change the environment to resolve the problem.

- **Maintenance:** The stage at which an individual consolidates his/her work and continues the behavior change.

Health Belief Model: Describes 4 key factors influencing whether or not a person will seek to remedy unhealthy conditions or problematic behavior (e.g., rape culture or expressing rape supportive attitudes). The four factors are:

- **Perceived Threat:** When an individual obtains and maintains a subjective perception of the risk of experiencing the consequences of unhealthy conditions, and becomes concerned about not taking action to address it.

Glossary (continued)

• **Perceived Benefits:** When an individual perceives the benefit of strategies designed to reduce the threat of unhealthy conditions.

• **Perceived Barriers:** When an individual is aware of the potential negative consequences from taking action to deal with the unhealthy condition.

• **Cues to Action:** When an individual experiences events that prompts him/her to take action. The individual must first feel as though she/he has the capacity to make the desired behavioral changes.

Social Learning Model: Based on the work of Albert Bandura, social learning describes the interplay of personal factors, social environment, and behavior. Particular emphasis is placed on the mental processes a person uses to make sense of their social environment, and how this leads to behavior. These mental processes are influenced by "capabilities" (see below), and behavior is then reinforced (or not) by the perceived adverse effects and incentives that result from a behavioral choice (or from observing another person's choice and the associated outcomes).

Capabilities:

• **Symbolizing Capability:** How we process images and words around us into attitudes and behavior.

• **Vicarious Capability:** How we learn from observation and direct experiences of other's behaviors and their resulting consequences.

• **Forethought Capability:** How well we anticipate the potential outcomes of a behavior, and how that influences our choices. This anticipation of outcomes is influenced by assumptions that may or may not be accurate.

Glossary (continued)

Following the social learning model, a person would be more likely to engage in positive behavior change when he/she sees positive behaviors modeled and practiced, is able to increase his/her own capability and to implement new skills, is able to gain positive attitudes about implementing new skills, and experiences support from his/her social environment in order to use their new skills.

Diffusion of Innovation Theory: Provides a model of how people or groups embrace (or reject) and ultimately use (or ignore) a new idea. The model moves through 4 stages: Knowledge (gaining exposure to, an understanding of, and forming a positive or negative attitude toward a new idea); Decision (actions leading to the acceptance or rejection of the idea); Implementation (putting the idea into action); Confirmation (the reinforcement of previous decision about using the idea, or a reversal of a previous decision to accept or reject the idea because of exposure to conflicting messages about it).

The Diffusion of Innovation Theory also factors in the degree to which people generally accept and use new ideas. Scholars have identified 5 different "adopter categories", and have attached estimates of how commonly each category exists in the population: Innovators (2.5%); Early Adopters (13.5%); Early Majority (34%); Late Majority (34%); Laggards (16%). The final factor to consider in determining whether a new idea will be used is the extent to which the idea exhibits "key attributes" of a genuine innovation.

Key Attributes of Innovations:

- **Reflexive Advantage:** The degree to which an innovation is seen as better than the idea that preceded it.

Glossary (continued)

- **Compatibility:** The degree to which an innovation is perceived as consistent with existing values, past experiences, and needs of the potential adopters.
- **Complexity:** The degree to which an innovation is seen as easy or difficult to understand and use.
- **Trialability**: The degree to which an innovation can be experimented with on a limited basis.
- **Observability:** The degree to which the results of an innovation are visible to others.

Selected Theories of Social / Community / Group Change

Lifespan of a Social Movement:

Social change is often brought about through organized social change movements, and Curtis & Aguirre have proposed that such movements move through a "lifecycle" consisting of four stages.

Stages in the Lifespan of a Social Movement:

- **Preliminary Stage:** A period of unrest where those who feel most outraged by a set of conditions become leaders of a burgeoning movement.
- **Popular Stage:** A period of expanding excitement in which the movement spreads outward via the principles of social contagion.
- **Formal Stage:** The emergence of a formal organization with the movement developing criteria for membership, establishing a formal organizational structure and "chain of command".

Glossary (continued)

• **Solidification Stage:** The period of institutionalization wherein the goals and objectives of the movement are made concrete.

Theory of Collective Behavior (Emphasizing Social Change):

Similar to the "Lifespan of a Social Movement", Smeiser describes the necessary conditions and mechanisms for widespread social change, as well as how social change is institutionalized. Key components include:

• **Structural Conduciveness:** Social arrangements and social conditions are such that creating a movement and attempting a modification of norms is possible.

• **Strain:** There are strains within the social order which create demand for changes in the norms influencing and affecting the social situation and establish greater potential for a movement to coalesce.

• **Generalized Beliefs, Precipitating Factors, & Mobilization for Action:** Gaining a fuller insight into the forces and agents pressuring for a change in norms, and an understanding of what can be done to transform those norms. It is also important to recognize specific events that clarify the work that needs to be done, and how to then organize to make that work happen.

• **Social Control:** The way in which agencies and agents of social control are able to attend to the issues which have been raised and remove them from the emotional context from which they arose.

Dynamic Systems: Through the study of emergent behaviors – how new patterns of behavior are experienced, acquired, learned, and manifested – scholars such as Johnson and Kelly have shown that groups of people are influenced in a non-linear fashion. Rather than a logical "cause and effect" model, changes in group behavior are explained by the natural, autonomous interaction between social networks of people, the level of connectivity exhibited by these networks, and the manner in which people recognize and respond to new behavioral patterns within their networks. Peer-to-peer feedback within networks is an especially important factor to consider.

Appendix B:

Priority Risk & Protective Factors for Primary Prevention of Sexual & Intimate Partner Violence

Introduction to Appendix B:

Early in the process of developing this document it was decided that compiling a list of key risk and protective factors would be crucial. The definitions in Section II articulate common language for the "big picture" of primary SV/IPV prevention work. The Guidelines in Section III provide clarity on enhancing the effectiveness of primary SV/IPV prevention programs. In this context, the Priority Risk and Protective Factors offer a defined list of personal and social forces that our programs might be able to impact. There are innumerable factors that influence whether or not a person will choose to perpetrate SV/IPV (and whether or not a person will choose to make positive choices regarding relationships/sexuality/etc.). The Priority Risk and Protective Factors are meant to narrow down and organize these factors, prioritizing those that fit the best with a predetermined set of criteria.

These factors were compiled from the knowledge and experiences of SV/IPV specialists in Virginia, and from the limited scholarly work available on the topics of risk factors for perpetration of SV/IPV and protective factors against the perpetration of SV/IPV. Because this document is meant to be practitioner-friendly, any language that seemed overly academic or technical was modified to convey concepts more plainly. Criteria for inclusion on the final list was based on a potential factor's philosophical consistency with the Action Alliance and its member programs, face validity, research support, and modifiability (its ability to be impacted by a prevention program – thus, permanent factors, such as those related to biology or personal history, were excluded for the purposes of this list).

The main purpose of the Priority Risk and Protective Factors is to aid in the planning process of primary SV/IPV prevention projects. Feedback from the first few years of the DELTA project - a statewide project that funded the development and implementation of numerous local IPV prevention initiatives - indicated that one of the most critical steps in the planning process was the opportunity to determine what forces influence the perpetration of IPV in a given community. This determination allowed each community partnership to establish a foundation for subsequent program development, facilitating greater buy-in from partners as well as focusing program approaches and content. Similarly, it is hoped that the Priority Risk and Protective Factors will provide primary SV/IPV prevention projects a manageable "menu" of

important variables that they might impact. Spending time during the early stages of program planning to determine which item(s) on the menu is/are most relevant to a given project in a given community will be crucial to the program's effectiveness.

The research articles we consulted during the development of the Priority Risk and Protective Factors are too numerous to include in the References section. Most of the articles were found cited in CDC publications, or by searching the libraries of Emory University and the University of Virginia. Information from the SEARCH Institute about their Developmental Assets Framework was also invaluable in the conceptualization of the protective factors (Scales & Leffert, 1999).

Appendix B-1: Quick Reference for Priority Risk & Protective Factors

Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence

Risk Factors are conditions or characteristics that increase the likelihood of SV/IPV perpetration. Risk factors do not necessarily directly cause SV/IPV, but their presence increases the chance of perpetration. Risk factors can be characteristics of an individual or conditions present in the environment. Risk factors can be used to help focus prevention efforts. The following factors are supported by research and/or practical experience from the field.

Protective Factors are conditions or characteristics that decrease the likelihood of SV/IPV perpetration, while also facilitating a broad range of related positive outcomes. A single protective factor does not necessarily directly prevent SV/IPV, but the presence of multiple protective factors decreases the chance of perpetration. Protective factors can be characteristics of an individual or conditions present in the environment. Protective factors can be used to help focus prevention efforts. The following factors below are supported by research and/or practical experience from the field.

Societal level factors relate to broad social forces, such as inequalities, oppressions, organized belief systems, and relevant public policies (or lack thereof).

Risk Factor
Rigid gender roles stifle individuality while artificially promoting men as society's leaders and subjugating women to passive or supporting roles. Social norms governing "acceptable sexual behavior" correspond to these rigid gender roles, and create a sexually adversarial climate in which sexual violence and intimate partner violence can thrive.

Protective Factor
Developing and maintaining healthy relationships and healthy sexuality is a highly valued social norm.

Protective Factor
Shared responsibility across social institutions for developing and maintaining thriving communities in which healthy sexuality and healthy relationships are core values.

Risk Factor
Society devalues peaceful problem solving while honoring or promoting violence and coercion as an acceptable means to an end.

Protective Factor
Ensuring accountability and expectations of people to interact respectfully is a fundamental part of life.

Risk Factor
There are many policies and practices in our society that promote individual rights/accountability at the expense of collective rights/accountability.

Protective Factor
Culture equitably values and relies on experiences and leadership from all members of society, including persons of any gender, race, ethnicity, class, sexual orientation, age, ability, religion, or belonging to any other historically oppressed group that has experienced restrictions on their rights.

Risk Factor
Power differences between groups of people are interwoven in culture. These differences might take the form of sexism, racism, classism, and heterosexism. They create the opportunity for abuse of power, including perpetration of intimate partner and sexual violence.

Community level factors relate to norms, customs, or people's experiences with local institutions, such as schools, workplaces, places of worship, or criminal justice agencies.

Risk Factor
Institutions that entitle groups to maintain greater social status over others.

Protective Factor
Communities engage diverse people in activities promoting healthy relationships and healthy sexuality.

Risk Factor
Decision-making institutions within communities support an adversarial approach to relationships and sexuality.

Protective Factor
The principles and skills of healthy relationships and healthy sexuality are demonstrated across various institutions.

Risk Factor
Weak and/or inconsistent community sanctions for perpetration of intimate partner violence or sexual violence.

Protective Factor
The presence of just/fair boundaries and expectations about healthy relationships and healthy sexuality are applied consistently across community entities.

Risk Factor
Community norms that support the protection of family / peer group "privacy," regardless of harm being perpetrated by or within these groups.

Relationship level factors relate to the influence of parents, siblings, peers, and intimate partners.

Risk Factor
Reinforcement/pressure from family and friends to exercise entitlement.

Protective Factor
Families and/or other important figures provide a caring, open, and encouraging environment that actively promotes positive development, and fosters skills to lay the foundations for healthy relationships and healthy sexuality.

Risk Factor
Peer/family support for adversarial approaches to relationships and sexuality. That is, promoting "the battle of the sexes" as the normal way that boys/girls and men/women should relate to one another.

Protective Factor
Parents, adult authority figures, and peers of diverse backgrounds model and teach positive interpersonal relationship skills.

Risk Factor
Absence of role models who promote healthy relationships and healthy sexuality.

Protective Factor
Peers, families, and intimate partners effectively identify and respond to behaviors that are potential precursors to IPV or SV.

Risk Factor
Reluctance to hold others accountable when relationship is perceived as "private", often stemming from social norms that frame sexual and intimate partner violence as "private" or "family issues", and prohibit persons outside of the family or "private" group from intervening.

Individual level factors relate to a person's knowledge, attitudes, behavior, history, demographics, or biology.

Risk Factor
Internalized belief that certain groups of people have rights and benefits over other groups of people.

Protective Factor
Personal belief in the positive value of, and commitment to, caring, equality, and social justice.

Protective Factor
Presence of skills to experience healthy sexuality and engage in healthy relationships.

Risk Factor
Lack of empathy for intimate/sexual partners.

Protective Factor
Willingness and ability to be active participants in a thriving community in which healthy sexuality and healthy relationships are core values.

Risk Factor
Belief in rigid, stereotyped gender roles.

Risk Factor
Experience that violence and coercion are accepted and effective "means to an end".

Protective Factor
A personal belief in gender equality, and attitudes and behaviors consistent with that belief.

Risk Factor
Lack of social development.

Appendix B-2: Priority Risk & Protective Factors (with examples)

Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence

Risk Factors

are conditions or characteristics that increase the likelihood of SV/IPV perpetration. Risk factors do not necessarily directly cause SV/IPV, but their presence increases the chance of perpetration. Risk factors can be characteristics of an individual or conditions present in the environment. Risk factors can be used to help focus prevention efforts. The following factors are supported by research and/or practical experience from the field.

Protective Factors

are conditions or characteristics that decrease the likelihood of SV/IPV perpetration, while also facilitating a broad range of related positive outcomes. A single protective factor does not necessarily directly prevent SV/IPV, but the presence of multiple protective factors decreases the chance of perpetration. Protective factors can be characteristics of an individual or conditions present in the environment. Protective factors can be used to help focus prevention efforts. The following factors are supported by research and/or practical experience from the field.

Societal level factors relate to broad social forces, such as inequalities, oppressions, organized belief systems, and relevant public policies (or lack thereof).

Protective Factor

Shared responsibility across social institutions for developing and maintaining thriving communities in which healthy sexuality and healthy relationships are core values.

Example

The Responsible Education About Life (REAL) Act will award funding to states for medically accurate, age appropriate, comprehensive sexuality education. It will mandate every school teach skills for making responsible decisions about sex, including how to avoid unwanted verbal, physical, and sexual advances and how not to make unwanted verbal, physical, and sexual advances. This funding, combined with the REAL Act's educational mandate and various other legislative initiatives seeking to infuse the fundamentals of healthy relationship and healthy sexuality throughout various institutions (e.g., educational, medical, legal, etc.) represents a system-wide responsibility for developing and maintaining thriving communities.

Protective Factor

Developing and maintaining healthy relationships and healthy sexuality is a highly valued social norm.

Example

A social norm's value in American society can often be represented by the amount of resources – financial and otherwise – the public/government is willing to contribute in order to support that norm. For example, controlling the spread of infectious diseases is a highly valued social norm, and thus billions of dollars at the federal, state, and local levels go into supporting this norm, as well as the will of individuals who comply with inoculation requirements/recommendations. The same level and breadth of resources being directed at promoting healthy relationships and healthy sexuality would drastically decrease the prevalence of SV/IPV.

Societal level factors relate to broad social forces, such as inequalities, oppressions, organized belief systems, and relevant public policies (or lack thereof).

Protective Factor

Culture equitably values and relies on experiences and leadership from all members of society, including persons of any gender, race, ethnicity, class, sexual orientation, age, ability, religion, or belonging to any other historically oppressed group that has experienced restrictions on their rights.

Example

A social and political environment that is representative of the diverse experiences of all members of society promotes a positive identity for individuals. The representation of diverse experiences of all members of society may be evident in numerous domains, including:

- Societal value for diverse cultural traditions, such as holidays, rites of passage, languages, or other ways that people see value for their experiences;
- The arts and media include images and traditions from diverse experiences;
- Policy makers represent diverse backgrounds and belief systems, thus ensuring that the experiences of all members of society have a voice in policies and initiatives that promote positive self concept. Such an environment also creates a buffer against the oppression of any one group (see "Societal Risk Factors" for an example of how oppression breeds SV/IPV).

Protective Factor

Ensuring accountability and expectations of people to interact respectfully is a fundamental part of life.

Example

Social norms valuing respect and equality are mirrored in politics, religion, media, education, etc. Public policies are just and promote equality and diversity. Religious doctrines and practices promote collective accountability for healthy relationships and healthy sexuality. Television programs model respectful interactions between diverse groups of people. For instance, the Netherlands, France, and Germany have created massive improvements in sexual health outcomes by supporting nationwide, consistent, long-term public education campaigns using the Internet, television, films, radio, billboards, dance clubs, pharmacies, and health care providers. Adults value and respect adolescents and expect teens to act responsibly. Governments strongly support education and economic self-sufficiency for youth.

Societal level factors relate to broad social forces, such as inequalities, oppressions, organized belief systems, and relevant public policies (or lack thereof).

Risk Factor

Rigid gender roles stifle individuality while artificially promoting men as society's leaders and subjugating women to passive or supporting roles. Social norms governing "acceptable sexual behavior" correspond to these rigid gender roles, and create a sexually adversarial climate in which sexual violence and intimate partner violence can thrive.

Example

During childhood, many individuals are taught that male sexuality is active and female sexuality is passive. Boys learn to initiate sexual behaviors and "score", while girls learn that their sexuality is a "commodity" they have to regulate. Boys and girls are largely discouraged from exploring their own individual sexualities outside of these norms. This promotes shame and detaches sexuality from humanity. Once people view sexuality as a "thing", it becomes OK to "take sex" from another person. Also, those persons living outside of this male/female "gender binary" are marginalized, and thus at greater risk for experiencing sexual violence/intimate partner violence (i.e., both because many service/justice institutions do not recognize them as legitimate clients, and because some perpetrators may specifically target them as a way to punish them).

Risk Factor

There are many policies and practices in our society that promote individual rights/accountability at the expense of collective rights/accountability.

Example

Current policies for protecting communities from sexual violence place the responsibility for doing so on individuals. Individuals identified as sex offenders are required to register as such. The community members are notified and are then held accountable for protecting themselves from the identified offender. In this scenario, the community sees sexual violence as an individual problem, failing to account for every person's role in creating an environment which allows a person to perpetrate sexual violence in the first place. Likewise, there is also no collective responsibility to create a healthy and safe environment.

Societal level factors relate to broad social forces, such as inequalities, oppressions, organized belief systems, and relevant public policies (or lack thereof).

Risk Factor

Power differences between groups of people are interwoven in culture. These differences might take the form of sexism, racism, classism, and heterosexism. They create the opportunity for abuse of power, including perpetration of intimate partner and sexual violence.

Example

The United States has a history of legal support for husbands controlling wives. Up until the last century, many institutions did not recognize married women as independent citizens, and in some states, punishment for marital rape is less severe than other types of rape. While some groups of women have made significant gains toward equality, they are still devalued by the white-male-dominated establishment that has historically opposed these gains and oppressed women (women of color, lesbian women, and poor women might be even more devalued since they face multiple layers of oppression). This history of devaluation leads some people to believe that it is acceptable to control and violate women.

Risk Factor

Society devalues peaceful problem solving while honoring or promoting violence and coercion as an acceptable means to an end.

Example

Domination through force has historically been favored over authentic diplomacy by our national leaders. For instance, rather than using its vast resources to wage wars, the U.S. could use a large piece of those same resources to provide basic education and anti-poverty programs.

Community level factors relate to norms, customs, or people's experiences with local institutions, such as schools, workplaces, places of worship, or criminal justice agencies.

Protective Factor

The principles and skills of healthy relationships and healthy sexuality are demonstrated across various institutions.

Example

Workplaces have policies that promote healthy relationships and healthy sexuality, including family leave and benefits. Youth organizations include healthy relationship and healthy sexuality activities in their programming. Healthcare facilities promote protective factors for healthy sexuality and healthy relationships during health fairs and through routine screenings. It is more likely that such concepts and skills influence individual behavior when they are saturated throughout a person's immediate environment.

Protective Factor

Communities engage diverse people in activities promoting healthy relationships and healthy sexuality.

Example

Diverse members of a school community are represented and included in the planning, implementation, and evaluation of a school-wide program that promotes healthy relationships and healthy sexuality. School administrators, teachers, students, and other community representatives work together to develop a program that best fits the school community. Students from various backgrounds and experiences are engaged in the process. Such a process models connectedness, cooperation, and respect (concepts vital to healthy relationships / healthy sexuality), while also helping to ensure that many different types of people will be able to realize healthy sexuality and healthy relationships in a manner that is relevant to them.

Community level factors relate to norms, customs, or people's experiences with local institutions, such as schools, workplaces, places of worship, or criminal justice agencies.

Protective Factor

The presence of just/fair boundaries and expectations about healthy relationships and healthy sexuality are applied consistently across community entities.

Example

Within a community, norms surrounding healthy relationships and healthy sexuality remain conceptually constant across different groups of people, and are reflected and demonstrated in community systems such as schools and workplaces, or medical, social service, or criminal justice systems. Likewise, community sanctions are applied consistently regardless of historical privilege, such that a star athlete is expected to engage in healthy relationships and healthy sexuality and are held accountable in the same manner as a Mexican immigrant for doing so. For example, a school system requires that healthy relationship skills be taught to, and practiced by, "gifted students" in a magnet school just as they would be taught to, and practiced by, students in an "alternative school".

Community level factors relate to norms, customs, or people's experiences with local institutions, such as schools, workplaces, places of worship, or criminal justice agencies.

Risk Factor

Weak and/or inconsistent community sanctions for perpetration of intimate partner violence or sexual violence.

Example

When athletes are accused of intimate partner or sexual violence, it is often considered appropriate that their punishment take place within the athletic community as opposed to within the criminal justice system. This inconsistency suggests that certain people are exempt from community sanctions or that certain people are allowed to do things that others are not. Also, when state laws are not enforced consistently among local communities or within different populations (such as a difference in sanctions for rich people versus poor people), it weakens community perceptions about the nature and severity of intimate partner violence and sexual violence, and can send a message to the less-sanctioned groups that they can "get away with" (or are more entitled to use) SV/IPV.

Risk Factor

Decision-making institutions within communities support an adversarial approach to relationships and sexuality.

Example

When a local school board prohibits the inception of activities that recognize and respect diversity within the community, such as the development of a Gay Straight Alliance student organization. When such an organization is blocked, forced to disband, or otherwise harassed by a school institution, a strong message is sent that intimate relationships "in violation of" rigid gender roles and the corresponding norms governing sexuality are "wrong". Thus, heterosexual relationships made up of partners exhibiting strong gender roles (e.g., football captain and head cheerleader) are reinforced as "normal" and "right" while Gay/Lesbian/Bisexual/Transgender (GLBT) relationships of any kind are reinforced as "deviant" and "wrong".

Community level factors relate to norms, customs, or people's experiences with local institutions, such as schools, workplaces, places of worship, or criminal justice agencies.

Risk Factor

Community norms that support the protection of family / peer group "privacy," regardless of harm being perpetrated by or within these groups.

Example

If the community believes that violence "inside of the home" is a private matter that should be kept quiet, then an individual will not likely seek the support he/she needs to identify unhealthy behaviors as "red flags" for violence, and perpetrators will have a greater opportunity to commit violence/abuse.

Risk Factor

Institutions that entitle groups to maintain greater social status over others.

Example

Work environments and company policies that reinforce strict gender roles perpetuate power differences between men and women in which one partner is the breadwinner and the other is the caregiver. For example, the lack of balanced family-leave policies inhibits choices surrounding work and family, and can set-up strong, unfair gender expectations and economic dependency in intimate relationships. The perpetration of violence can be linked to both the gender expectations (which, when "violated", can create an excuse for violence/abuse), and the economic dependency (which gives one partner a powerful opportunity to use coercive tactics to control the relationship, since he/she controls the money). Having family leave for both partners, onsite childcare at work, or subsidization for at-home childcare could promote more balanced family roles.

Relationship level factors relate to the influence of parents, siblings, peers, and intimate partners.

Protective Factor

Peers, families, and intimate partners effectively identify and respond to behaviors that are potential precursors to IPV or SV.

Example

Examples of potential behavioral precursors might be an adult failing to respect the physical boundaries of others, or a man repeatedly endorsing the belief that women are inferior and should have limited authority in a relationship. The presence of skills to address these behaviors, and the expectation that they should be used to create healthier communities is important. For instance, when a mother notices her son constantly bossing his boyfriend around, she feels compelled and capable to effectively challenge the behavior. The mother provides an explanation as to why the behavior is unhealthy, and suggests a healthy set of alternatives for relating with the boyfriend.

Protective Factor

Families and/or other important figures provide a caring, open, and encouraging environment that actively promotes positive development, and fosters skills to lay the foundations for healthy relationships and healthy sexuality.

Example

Families understand the importance of promoting healthy relationships and healthy sexuality, and are aware of the developmentally appropriate skills needed to achieve both. Families engage in activities that develop and maintain healthy relationships / healthy sexuality, by fostering constructive and honest family communication (to model a connected relationship where it's OK to talk about anything), and educating themselves to teach each other pertinent concepts and skills. A child who grows up in a home where the her/his sexuality is viewed as a natural and important part of her/his humanity, and where she/he is provided with the support and knowledge to develop her/his own values about sexuality and intimate relationships will be more likely to treat intimate partners in a similar compassionate and connected manner, and will expect to receive such positive treatment from prospective intimate partners.

Relationship level factors relate to the influence of parents, siblings, peers, and intimate partners.

Protective Factor

Parents, adult authority figures, and peers of diverse backgrounds model and teach positive interpersonal relationship skills.

Example

When a child or adolescent witnesses a parent engaging in positive interpersonal relationships with an intimate partner, friends, and co-workers, the child or adolescent learns to value such relationships, and also gains exposure to the skills necessary to engage in such relationships. Likewise, a parent who learns to acknowledge and understand positive sexual development across the lifespan, and who are "askable" are able to model and teach children and adolescents to positively connect to their sexuality. A girl who reaches puberty and has been able to have an open dialogue about sexuality and sexual development with her parents, has been provided with (and encouraged to seek out) information in these areas, and has seen her parent(s) interact respectfully, assertively, and honestly with other adults (particularly in the context of intimate partners) is more likely to be prepared to deal with the biological and social forces of adolescence pertaining to sexuality and relationships.

Relationship level factors relate to the influence of parents, siblings, peers, and intimate partners.

Risk Factor

Absence of role models who promote healthy relationships and healthy sexuality.

Example

A girl who sees her parents handle disagreements by manipulating one another or behaving aggressively toward one another might come to believe that these unhealthy patterns of interactions are the norm for intimate relationships. Thus, she will likely be at a disadvantage to develop healthy relationship skills, given the unhealthy dynamics modeled by her parents. Likewise, if a girl sees her parents reacting negatively toward her sexual development (or each other's sexuality), this will likely impact her ability to experience sexuality in a state of well-being. That is, if she is shown that thinking about, asking about, or otherwise expressing her sexuality is shameful, she might be less able to articulate her own feelings about sexuality or understand that she has the final say in her own sexual decisions, including the expectation of respectful treatment in any kind of intimate encounter/relationship.

Risk Factor

Peer/family support for adversarial approaches to relationships and sexuality. That is, promoting "the battle of the sexes" as the normal way that boys/girls and men/women should relate to one another.

Example

A boy who witnesses his father control and abuse his mother may come to believe that relationships between men and women are struggles for control. As he develops, he will likely want to remain on the "winning" side of this dynamic which could mean perpetrating SV/IPV to assert that control. This idea is further reinforced through peer groups, particularly all-male peer groups that place an emphasis on "scoring," "pimping," or otherwise "winning the game against" women.

Relationship level factors relate to the influence of parents, siblings, peers, and intimate partners.

Risk Factor

Reluctance to hold others accountable when relationship is perceived as "private", often stemming from social norms that frame SV/IPV as "private" or "family issues", and prohibit persons outside of the family or "private" group from intervening.

Example

Friends and peers, extended relatives, neighbors, or co-workers may resist challenging unhealthy behaviors because of the belief that it is "none of their business." Perpetrators of IPV/SV are not held accountable by persons outside of their family. For instance, a woman's co-worker notices that she calls her girlfriend excessively and gets outrageously angry when she doesn't answer, but the co-worker does not bring her concerns to either the woman or the girlfriend because of the interpersonal dynamic that says it is "none of her business" (despite the fact that this unhealthy behavior is occurring in a public space).

Risk Factor

Reinforcement/pressure from family and friends to exercise entitlement.

Example

As he grows up, a young man senses that his peers and/or family members expect him to have authority over females; to "take charge" when relating with females. He sees this idea reinforced in the patterns of relating within his family. Thus, he is more likely to exercise this "authority" in intimate situations, such as "deciding" how his partner is "allowed" to spend his/her money and threatening violence if he/she fails to comply, or forcing a date to have sex regardless of her/his wishes.

Individual level factors relate to a person's knowledge, attitudes, behavior, history, demographics, or biology.

Protective Factor

Presence of skills to experience healthy sexuality and engage in healthy relationships.

Example

An individual who receives age- and developmentally-appropriate healthy sexuality and healthy relationship education is likely to develop the skills necessary to engage in both. An individual who receives these messages from early childhood through adolescence will develop a corresponding set of personal ethics, and activate the personal and interpersonal components required of healthy sexuality / healthy relationships.

Protective Factor

Personal belief in the positive value of, and commitment to, caring, equality, and social justice.

Example

Individuals will understand the connection between equality and social justice and healthy relationships and healthy sexuality. A middle-class teenager who volunteers at a homeless shelter or an organization like Boys & Girls Club is likely to see the humanity of people "different" from him/her in these programs, and note the injustices suffered by those who have been excluded from privileged society. Such an experience could translate into a more generally empathetic worldview, perhaps causing the teenager to "live" the values of respect, caring, and equality in his/her intimate relationships, and/or to help others in his/her own daily life (e.g., defending the rights of GLBT youth in his/her own school).

Individual level factors relate to a person's knowledge, attitudes, behavior, history, demographics, or biology.

Protective Factor

Willingness and ability to be active participants in a thriving community in which healthy sexuality and healthy relationships are core values.

Example

When an individual has a positive identity it is likely that they believe they can have a positive impact on their community and their relationships. Specific to this SV/IPV work, individuals who are taught to value and how to engage in behaviors consistent with healthy relationships / healthy sexuality will feel responsible and able to promote such behavior in others. Likewise, a person who knows how healthy relationship skills "look", and has observed and experienced their value will be able and willing to respectfully "step-in" to a situation where unhealthy or violent behaviors are playing out.

Protective Factor

A personal belief in gender equality, and attitudes and behaviors consistent with that belief.

Example

A boy/man who believes that girls/women should have the same rights and responsibilities as he would be less likely to behave in a manner that attempts to stifle or control a girl/woman's personal freedoms – less likely to perpetrate sexual or intimate partner violence. Such a boy/man would also be able to judge girl's/women's opinions as inherently not better or worse than those of boys/men, and everyone would enjoy richer cross-gender relationships as a result.

Individual level factors relate to a person's knowledge, attitudes, behavior, history, demographics, or biology.

Risk Factor
Belief in rigid, stereotyped gender roles.

Example
If a man who believes that he is "the provider" and his wife is "the caretaker", and that these gender roles are innate, he may feel obligated or justified to use violence if she behaves in a manner outside of this rigidity. Thus, her only choices are to adhere to this limiting gender role or be subject to his violence. Strict gender roles are based on inequality. They do not provide opportunities for individuality or uniqueness.

Risk Factor
Lack of empathy for intimate/sexual partners.

Example
A female college student joins a sorority, and begins pressuring her boyfriend to join a fraternity. He explains that he doesn't want to join a fraternity because he doesn't agree with the culture they usually promote. She brings it up constantly, expressing that she needs him to do it because she thinks it will help improve her status within the sorority. She also starts withholding affection, calling him names, and challenging his "manhood". She punctuates every argument by reiterating that she doesn't care what his reasons are, and that she will continue to make their life difficult until he does what she wants him to do.

Individual level factors relate to a person's knowledge, attitudes, behavior, history, demographics, or biology.

Risk Factor
Internalized belief that certain groups of people have rights and benefits over other groups of people.

Example
A white, male vice-president of a company sexually propositions a Guatemalan woman who cleans his office. He is fairly certain she won't refuse his advances because of his position in the company relative to hers, and he views her as just another "perk" that comes with his job.

Risk Factor
Lack of social development.

Example
Appropriate social development should ensure that by the time an individual begins having intimate and/or sexual relationships, he/she has a certain level of impulse control, self-esteem, and emotional independence. When these traits are missing, there is an increased risk for IPV/SV perpetration because the individual will likely rely on basic, one-sided, coercive methods of negotiating relationships and/or sexuality.

Risk Factor
Experience that violence and coercion are accepted and effective "means to an end".

Example
A boy who watched his father use the threat of violence to always "get his way" with others might then attempt similar tactics with peers (since it seemed to "work" for his father). These tactics might also "work" for him (they allow him to "get his way"), and thus reinforce the "utility" of violence or the threat thereof. Furthermore, perhaps this boy was also on the receiving end of his father's violence/threats. As he gets older, he might use these same tactics because he has learned that he would rather be on the side of the coercer than of the coerced. When an individual believes that violence and coercion are acceptable, he/she is at an increased risk to perpetrate violence and coercion. When these acts of violence/coercion are successful at getting the perpetrator what he/she wants, the notion that violence and coercion are effective tools is reinforced.

Appendix C: References

Carr, J.L., & VanDeusen, K.M. (2004). Risk factors for male sexual aggression on college campuses. Journal of Family Violence, 19, 179-189.

Dahlberg, L., & Krug, E. (2002). Violence – A global public health problem. In E. G. Krug, L.L. Dahlberg, J.A. Mercy, A.B. Zwi & R. Lozano (Eds.), World Report on Violence and Health (pp. 1-21). Geneva: World Health Organization.

Gariglietti, G. (2007). One last thought: Prevention is the most important form of victim services. Action Alliance's Revolution, 2 (Spring Issue), p. 21.

Heise, L.L. (1998). Violence against women: An integrated, ecological framework. Violence Against Women, 4, 262-290.

Jewkes, R., Sen, P., & Garcia-Moreno, C. (2002). Sexual violence. In E. G. Krug, L.L. Dahlberg, J.A. Mercy, A.B. Zwi & R. Lozano (Eds.), World Report on Violence and Health (pp. 147-181). Geneva: World Health Organization.

Lee, D., Guy, L., Perry, B., Sniffen, C., Alamo Mixson, S. (2007) Sexual Violence Prevention. The Prevention Researcher, 14(2), pp. 15-20.

Loh, C., Gidycz, C.A., Lobo, T.R., & Luthra, R. (2005). A prospective analysis of sexual assault perpetration: Risk factors related to perpetrator characteristics. Journal of Interpersonal Violence, 20, 1325-1348.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of Effective Prevention Programs. American Psychologist, 58, 449-456.

Powell K.E., Mercy J.A., Crosby A.E., Dahlberg L.L., Simon T.R. (1999). Public health models of violence and violence prevention. In: Kurtz, L.R., editor. Encyclopedia of Violence, Peace, & Conflict, Vol. 3. San Diego: Academic Press; 175-187.

Resnick, M.D., Ireland, M., & Borowsky, I. (2004). Youth violence perpetration: What protects? What predicts? Findings from the National Longitudinal Study of Adolescent Health. Journal of Adolescent Health, 35, 424-433.

Scales, P. & Leffert, N. (1999). Developmental Assets: A Synthesis of the Scientific Research on Adolescent Development. Search Institute: Minneapolis, MN.

Virginia Sexual & Domestic Violence Action Alliance (2006). A Report from Virginia's Sexual and Domestic Violence Agencies 2000-2004. Richmond, VA: Author.

Appendix D:

Virginia's Guidelines for the Primary Prevention of SV/IPV Assessment Tool

Introduction

Virginia's Guidelines for the Primary Prevention of Sexual Violence and Intimate Partner Violence will assist Virginia sexual and domestic violence agencies (and possibly other community organizations) in improving and developing effective primary prevention initiatives. This assessment is based on the programmatic components in each guideline, and is meant to serve as a technical assistance tool. The guidelines are an organizing philosophy – not an irrefutable prescription for prevention work. Due to the enormous amount of resources needed to achieve all of these ideals, it is not realistic to expect prevention initiatives to score high on all of the items contained in this assessment. Rather, the questions posed here are meant to act as benchmarks, facilitating on-going improvement in primary prevention programming. It is our hope that this document will help every existing SV/IPV primary prevention program operate at its full capacity, and provide potential programs with information on how to build a foundation for truly effective primary prevention work.

Guideline 1: Develop prevention strategies that promote protective factors.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. promote the development of healthy sexuality?	Program focuses almost entirely on sexual behavior to be avoided.		Program partially addresses the promotion of healthy sexuality, but still mostly focuses on sexual behavior to be avoided.	Program addresses the complexity of human sexuality and consensual sexual activity in a positive manner.	
b. promote the development of healthy relationships?	Program focuses almost entirely on problematic relationship dynamics, or the avoidance of hurtful interpersonal behavior.		Program partially addresses the promotion of healthy relationships, but still mostly focuses on problematic relationship dynamics, or the avoidance of hurtful interpersonal behavior.	Program promotes connections between people that enhance well-being and positive self-concepts, in addition to increasing personal safety.	
c. seek to foster socially just communities and institutions?	Program only addresses sexual and/or intimate partner violence, and is not informed by a social justice perspective.		Program acknowledges or partially addresses how its purpose is connected to a range of positive social outcomes, such as gender equity, racial equality, and economic justice.	Program demonstrates how its purpose is connected to a range of positive outcomes, such as gender equity, racial equality, and economic justice.	

Notes:

Guideline 2: Develop prevention strategies that strive to be comprehensive.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. address multiple levels of the social ecology?	Program works at 1 level effectively, or covers 2 levels in an incomplete manner.		Program works at 2 levels effectively, or covers more than 2 levels in an incomplete manner.	Program works at 3 or more levels effectively.	
b. work in multiple settings within (a) given level(s) of the social ecology?	Program is based in 1 setting within a given level of the social ecology.		Program is based in 2-3 settings within a given level of the social ecology.	Program is based in numerous settings within a given level of the social ecology.	
c. address a common set of risk facotrs / protective factors across prevention activities?*	Program fails to address, or only minimally addresses, a common set of risk/protective factors across prevention activities (e.g., it is difficult to determine connected themes in the content within and across levels of the social ecology).		Program adequately addresses a common set of risk/protective factors across a segment of prevention activities (e.g., content within and across levels of the social ecology is somewhat connected – later lessons in a curriculum reference former lessons, or the message of a poster campaign is consistent with training for youth leaders in a given setting).	Program adequately addresses a common set of risk/protective factors across all, or almost all, prevention activities (e.g., content within and across levels of the social ecology is all addressing a set of common themes – curricula content, parent/teacher/youth leader training, media, and changes institutional policy are all designed to impact a manageable set of risk and/or protective factors).	

Guideline 2: Develop prevention strategies that strive to be comprehensive.

*List risk factors or protective factors addressed by the agency's prevention project:

(Please limit to 2 paragraphs. Please use Action Alliance's "Priority Risk & Protective Factors" whenever appropriate).

Guideline 3: Develop prevention strategies that are concentrated, and can be sustained and expanded over time.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. emphasize high contact/exposure with participants within a limited time-frame?	Program provides a single opportunity, or few opportunities, for message exposure with the same group of participants (e.g., one-time prevention activities, such as assembly presentations, proclamations, etc.).		Program provides several opportunities for message exposure with the same group of participants (e.g., 3-5 activities with a specific population and setting over a one-year period).	Program provides many opportunities for message exposure with the same group of participants within a concentrated time frame (e.g., 8-10 activities with a specific population and setting over a three-month period).	
b. include follow-up activities connected to the theme/content of the original programming?	Program provides no reinforcement or follow-up.		Program provides minimal follow-up activities (e.g., sending posters to a school where a multi-session educational program was conducted).	Program provides numerous follow-up activities that are specific and purposeful (e.g., guided opportunities for participants to develop their own prevention activities based on the prior information).	

Notes:

Guideline 4: Develop prevention strategies that use varied teaching methods to address multiple learning processes.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. use active/ interactive approaches to engaging multiple learning styles?	Program uses formats where group participation is not promoted or easily achieved, and where only one or a few learning styles are taken into account.		Program uses varying formats, and includes some opportunities for group participation (e.g., educating a school's faculty, and staff about a new policy through in-service trainings and an article in a newsletter, as well as interactive exercises in an in-service training).	Program uses a highly engaging format (e.g., designed to facilitate the adoption of new attitudes /beliefs /knowledge through visual, auditory, kinesthetic, and experiential approaches) where group participation is highly valued and frequent.	
b. provide opportunities for the development of new skills?	Program does not provide any opportunities, or only provides minimal opportunities, to acquire or practice new skills.		Program provides some opportunities for acquiring new skills, including time for processing potential outcomes of skill application (e.g., a training curriculum for peer educators contains a session where participants role-play bystander intervention scenarios).	Program provides frequent opportunities for acquiring new skills, including time for processing outcomes of skill application. (e.g., a training curriculum for peer educators contains numerous sessions where participants role-play bystander intervention scenarios in various settings – based on the outcomes of these role-plays, the peer educators each create a personal "plan of action" to act as a behavioral template whenever they identify an at-risk situation).	

Notes:

Guideline 5: Develop prevention programs based on purposeful, logical rationale.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. address the prevention of IPV/SV from a common causal foundation*?	Program does not appear to be based on any identified casual foundation. –OR– Program is based on a causal foundation that is not well-established.		Some program components appear to be based on a sound causal foundation.	All program components are based on a sound common causal foundation.	
b. use a step-by-step planning process to inform the direction of prevention activities?	The prevention program is not informed by a strategic plan. –OR– A plan exists, but it doesn't include clear and achievable goals, activities, and outcomes.		The prevention program is informed by a strategic plan, but it is sometimes difficult to determine how it is connected to program components.	The prevention program is informed by a well-articulated strategic plan, and the manner in which it informs program components is clear.	

* Causal Foundation: The explanation of why SV and/or IPV occurs, on which a set of primary SV/IPV prevention strategies are based. For example, if a local SV/IPV collaborative decides to begin planning a sustained primary prevention program, then they should first come to consensus on what are the major causes of SV/IPV in their community/ies. This determination will help them select prevention strategies that fit their community context. A common causal foundation can consist of an etiological theory, multiple etiological theories, a collection of risk and/or protective factors, or any combination thereof.

Notes:

Guideline 6: Develop prevention strategies that are developmentally appropriate.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. address risk and protective factors prior to the developmental stage in which a problem behavior typically emerges?	Program focuses on risk and protective factors relevant to older adolescents or adults.		Program works with more than one age group, including focusing on risk and protective factors relevant to early adolescents or younger.	Program works with a variety of age groups, and particularly focuses on risk and protective factors relevant to young children.	
b. tailor content and format to be developmentally appropriate?	Program content and format reflect a "one-size-fits-all" model in that they are not tailored, or easily adapted, to the intellectual, cognitive, and social developmental level of any given group.		Program content and format has been somewhat modified to fit the target groups that most frequently participate in the program (e.g., program uses the same materials and methods when working with both middle and high school students, and somewhat modifies the high school language & concepts for middle school students).	Program content and format has been tailored to fit all target groups that participate in the program (e.g., program uses one set of materials and methods when working in day care, and a different – but connected – set of materials and methods when working with middle school students, and still another set when working with high school students).	

Notes:

Guideline 7: Develop prevention strategies in collaboration with diverse community members to include many cultural beliefs, practices, and community norms.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. develop its content and approach through the direct involvement of diverse community members/stakeholders?	Program was selected/developed without any involvement of diverse community stakeholders.		Program selection/development involved diverse stakeholders, but their input was not thoroughly integrated.	Program selection/development utilized meaningful input from diverse stakeholders. These stakeholders are recruited based on the intended impact of the program, and are involved in many phases of program selection/development and implementation (e.g., reviewing goals and intended outcomes, reviewing potential strategies or developing new ones, assessing fit and capacity, etc.).	
b. address the range of cultural beliefs, practices, and norms within a given set of participants?	Program content and format are narrow and operate from one set of beliefs, practices, and norms. Feedback from outside of this perspective is never/not usually incorporated into subsequent versions of the program.		Program content and format somewhat reflect the contributions and interests of various cultural and social groups.	Program content and format reflect and are continually informed by cultural and social groups impacted by the program, and often include an analysis or oppression and/or methods to empower historically oppressed groups of participants.	

Notes:

Guideline 8: Develop prevention strategies that include a systematic method to determine program effectiveness and promote continuous quality improvement.

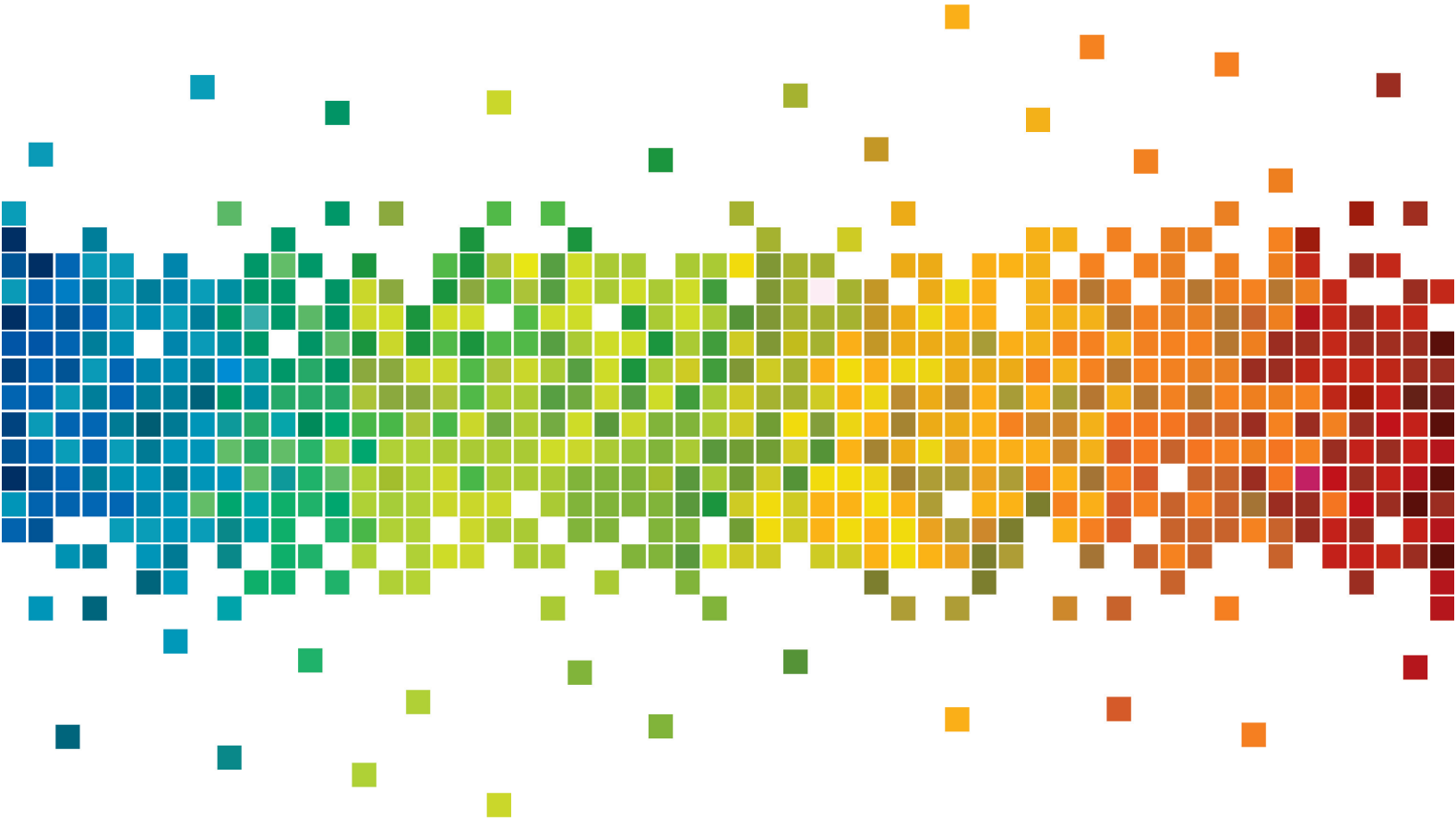
Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. have a mechanism in place to generate process measures?	Program does not use process measures or data, though there may be a cursory, informal process assessment.		Program may or may not have an established evaluation plan. Process evaluation is conducted, but the resulting data is only consulted occasionally to improve content and format.	Program has an established evaluation plan. Process evaluation is conducted, and the resulting data is used to continually improve content and format.	
b. have a mechanism in place to generate outcome measures?	Program does not use outcome measures or data, though there may be a cursory, informal outcome assessment.		Program may or may not have an established evaluation plan. Outcome evaluation is conducted, but the resulting data is only consulted occasionally to improve content and format.	Program has an established evaluation plan. Outcome evaluation is conducted, and the resulting data is used to continually improve content and format.	

Notes:

Guideline 9: Develop prevention strategies as an integral part of the agency mission to end sexual violence / intimate partner violence.

Does the program...	Low		Moderate or Mixed	High	
	1	2	3	4	5
a. demonstrate a commitment to prevention (as reflected in the strategic plan, mission, and agency practices)?	Primary prevention concepts are not at all, or only minimally, reflected in the agency's strategic plan, mission statement, and agency practices.		Some primary prevention concepts are reflected in the agency's strategic plan, mission statement, and agency practices.	Primary prevention is explicitly reflected in the agency's strategic plan, mission statement, and agency practices (e.g., prevention training for all staff, agency-wide involvement in prevention events, etc.).	

Notes:



Virginia Sexual and Domestic Violence
ACTIONALLIANCE