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This special issue captures several threads in the ongoing evolution of sexual violence prevention. The articles that follow examine an empowerment evaluation process with four promising programs dedicated to preventing first-time male perpetration of sexual violence, as well as evaluation findings. Both the evaluation approach and the programs examined shed light on how sexual violence prevention can continue to be improved in the future.

Keywords: *empowerment evaluation; sexual violence prevention; capacity building*

> Without the perpetrator there is no act of abuse.
> Bernard Auchter, 2008

This simple, but powerful, observation characterizes the focus of recent efforts in the field of sexual violence prevention. Thirty-five years after the birth of the antirape movement of the 1970s, prevention efforts continue to evolve in new ways, including a greater focus on the prevention of perpetration and a gradual shift from confronting sexual violence as a political and criminal justice issue to understanding it as a public health hazard.

The antirape movement began with an emphasis on victim services and criminal accountability for perpetrators. Early efforts also demonstrated great faith that raising political and public awareness about sexual assault would mobilize communities to stop it. Although these measures continue to be important, they clearly cannot by themselves eradicate the underlying problem—perpetration.

After decades of effort, we still face unacceptable levels of sexual violence in our homes, schools, and communities. In response, advocates, researchers, and funding agencies have turned to a new perspective from which to address this problem—by harnessing knowledge gained in behavioral and health sciences. Informed by advances in prevention science, sexual violence prevention efforts have evolved from one-time awareness-raising sessions to ongoing programs, incorporated behavior change strategies proven effective in other fields, enacted policies encompassing all layers of social life, and applied increasingly sophisticated program evaluation methods to understand—and build on—"what works."

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BACKGROUND

Sexual violence is a public health burden that drains our nation's human, economic, and health resources.

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An estimated 683,000 rapes occur each year in the United States, a tragedy that disproportionately affects women and the very young (Tjaden & Thoennes, 2000). According to the National Violence Against Women Survey, 17.6% of women surveyed had been the victim of a completed or attempted rape at some time in their life; 21.6% were younger than age 12 when they were first raped, and 32.4% were between the ages of 12 and 17 (Tjaden & Thoennes, 2000). In other words, more than half (54%) of female rape victims were younger than age 18 when they experienced their first attempted or completed rape. In addition to physical injuries, victims of rape often experience chronic headaches, fatigue, sleep disturbances, recurrent nausea, decreased appetite, eating disorders, menstrual pain, sexual dysfunction, dramatically increased substance abuse, and suicidal behavior (Faravelli, Giugni, Salvatori, & Ricca, 2004; Resnick, Acierno, & Kilpatrick, 1997).

A public health perspective is appropriate for the issue of sexual violence, not only because of the health burden involved but because the public health model can guide responses to the issue (Krug, Mercy, Dahlberg, & Zwi, 2002). In addition to reliance on evidence-based approaches to policy and program development, and the integration of multiple disciplines, organizations, and communities, the public health model is distinguished by a focus on prevention (Basile, 2003; Mercy, Rosenberg, Powell, Broome, & Roper, 1993).

Currently, most efforts in the sexual violence field are focused on preventing repeated victimization or perpetration or on mitigating the negative effects of exposure to violence. In other words, most strategies are implemented *after* violence has already occurred. However, the U.S. Centers for Disease Control and Prevention's (CDC) Division of Violence Prevention is committed to reducing the human and economic costs associated with intentional injuries by promoting the development and widespread adoption of policies and practices that effectively prevent violence *before* it occurs.

Specifically, as this special issue illuminates, CDC identified and assisted programs that aimed to prevent first-time male perpetration of sexual violence. In addition to ensuring the safety of our youth, the prevention of first-time perpetration is particularly important because of the long-term behavioral consequences associated with this kind of violence. For example, patterns of male sexual aggression initiated in adolescence may be sustained in young adulthood (White & Koss, 1993). Moreover, women who reported being raped before age 18 were twice as likely to report being raped as an adult (Tjaden & Thoennes, 2000), further supporting the urgent need to interrupt violent pathways before they develop.

Research indicates that males are responsible for the overwhelming majority of sexual violence perpetrated against women, children, and other men (Tjaden & Thoennes, 2006). During the past decade, a variety of programs have been developed to focus on preventing first-time male perpetration. These programs focus on reeducating boys and men via empathy induction (Dean & Malamuth, 1997; Foubert, 2000; Schewe & O'Donohue, 1993), defining and understanding consent (Berkowitz, 1994), encouraging positive bystander behavior (Katz, 1995), and redefining the masculine role more generally.

Although these emerging programs appear promising, neither has a comprehensive catalog of sexual violence prevention activities been developed, nor has any assessment of which activities are most likely to be effective. Evaluation—the preferred mechanism for guiding practitioners' choice of prevention strategies—is particularly lacking. As a result, CDC is unable to identify and recommend well-evaluated sexual violence prevention programs to grantees and public health partners.

BUILDING CAPACITY AND EVIDENCE KNOWLEDGE

CDC's response to this gap in prevention programming involved two strategic decisions: the focus on a small number of established programs that aim to prevent first-time male perpetration of sexual violence and the use of empowerment evaluation. This twin approach offered the greatest possible benefit in building evaluation capacity among organizations in the field while expediting the development of an evidence base for prevention programs.

The first strategy guiding CDC's approach was the decision to work with *existing* programs to build a knowledge base that could expedite widespread use of evidence-based prevention efforts in practice settings. This decision was novel because, according to the public health model, the starting point of program

development and evaluation is often efficacy research, an approach with considerable merits (e.g., use of theory, knowledge of risk and protective factors, tightly controlled conditions, and ability to make causal inferences with random assignment designs). However, in this case, CDC chose to work with existing programs because of the growing recognition that most prevention efforts developed in research institutions (however effective they may be) do not get adopted in practice settings for myriad reasons (e.g., Institute of Medicine, 2001; Miller & Shinn, 2005; Wandersman et al., 2008). By working with extant programs, this project sampled from a universe of strategies with demonstrated real-world feasibility and appeal to practitioner audiences, two keys to promoting adoption and use of health innovations (Dearing, Larson, Randall, & Pope, 1998; Glasgow, Lichtenstein, & Marcus, 2003; Kim & Cho, 2000).

This approach also reduces the well-documented delay between "discovery" and "delivery" of effective prevention strategies, a delay that can exceed more than a decade (Institute of Medicine, 2001). Working with extant programs reduces the delay because it eliminates multiple years of efficacy research under conditions that do not approximate the real-world conditions that practitioners face every day in their communities. Therefore, the scientific knowledge base created by evaluating existing programs with "field credibility" (or "ecological validity") will speak more directly, and quickly, to the community of sexual violence prevention practitioners.

The second strategy guiding CDC's approach was to build capacity among existing programs by applying empowerment principles, a sensible method in a field characterized by a tremendous shortage of resources and no identified "effective" programs. These conditions require evaluation approaches that are sustainable, low cost, and flexible, and empowerment evaluation is ideally suited to these requirements. Empowerment evaluation is designed to "help people help themselves" and improve their programs through the use of self-evaluation and reflection (Fetterman, 1996; Fetterman & Wandersman, 2005). Program stakeholders conduct their own evaluations and typically act as facilitators; an outside evaluator often serves as a coach or additional facilitator. Key facets include training (evaluators teach stakeholders to conduct their own evaluations), facilitation (evaluators serve as coaches or facilitators to help others conduct a self-evaluation), collaboration (evaluation is a group activity, not the individual work of an evaluator), democracy (program staff and evaluators work as equals), and self-determination (the evaluation furthers the expressed goals and purposes of the program).

Empowerment evaluation principles have been applied successfully to a variety of public health programs. For example, empowerment evaluations have been useful in working with community-based programs to better understand sexual assault prevention (Campbell et al., 2004), child abuse and neglect (Lentz et al., 2005), health promotion programs (Goodman et al., 1998), quality of program delivery (Butterfoss, Goodman, & Wandersman, 1996), and community capacity for program promotion and implementation (Schnoes, Murphy-Berman, & Chambers, 2000). Major strides have been gained in both the theory of empowerment evaluation and concrete measures of program development (see, e.g., Fetterman, 2005; Livet & Wandersman, 2005).

Therefore, with the concurrent goals of creating an evidence base for prevention in real-world settings and building capacity, CDC decided not to develop a new prevention strategy or locate researchers who wished to further evaluate their own sexual violence prevention programs. Instead, the project looked directly to the practice field to systematically catalog ongoing efforts across the country and to offer support to four programs that may serve as leaders for the rest of the field. CDC was supported in this effort by a project team that included Robert Goodman, a nationally recognized expert in empowerment evaluation, and staff from RTI International.[1]

IDENTIFYING PROGRAMS AND SELECTING PARTICIPANTS FOR THE EMPOWERMENT EVALUATION

As noted earlier, no systematic catalog exists that focuses on the prevention of first-time male perpetration. As a first step in preparation for the empowerment evaluation, it was necessary to identify and describe these programs. To this end, the project team reviewed lists of experts, government documents, Web sites, published literature, and unpublished reports in the field of sexual violence prevention. Individuals and agencies identified through these activities were contacted for information about their programs. During these conversations, a snowball sampling approach was used to find additional programs, with 37 eventually identified. Publicly available information was supplemented via structured telephone interviews with program leaders to compile profiles for each program. The resulting summary included descriptions of the populations served, intervention approach, goals and objectives, theoretical frameworks, evaluation activities, and staff capacity (RTI International, 2003).

Each of the programs identified through this process were invited to apply to participate in the empowerment

evaluation process, with invitations also circulated on relevant list servers. A total of 17 applications were received and reviewed by an expert panel assembled by the project team. Selection criteria included the extent to which programs focused on prevention of first-time male perpetration in a multisession format, prior experience in evaluation, commitment to using evaluation for program improvement, and ability to commit staff resources to participation in the empowerment evaluation process. Following extensive review, four organizations were selected: GaDuGi Safe Center of Lawrence, Kansas (known at the time as Douglas County Rape Victim Survivor Services); Men Can Stop Rape of Washington, D.C.; Metropolitan Organization to Counter Sexual Assault (MOCSA) of Kansas City, Missouri; and SafePlace of Austin, Texas.

OVERVIEW OF THE SPECIAL ISSUE

The articles included in this special issue describe the empowerment evaluation process in which the four organizations participated, as well as selected findings from the evaluation.

The lofty goal of pursuing empowerment principles *sounds* appealing, but how would one actually do it? That is, what training or technical assistance is necessary to lead stakeholders through this process? In this issue, Goodman and Noonan describe how the empowerment evaluation engaged each of the four participating organizations in a technical assistance process based on the formative evaluation consultation and systems technique (FORECAST) model. They place the empowerment evaluation process in a methodological context and describe the implementation of the FORECAST model, including development of logic models, identification of evaluation markers and measures, interpretation of the meaning from evaluation data, and expansion of each program model into broader social ecological perspectives.

A central tenet of empowerment evaluation is that program stakeholders' engagement in the evaluation process will support program improvement, but how does this work in practice? In fact, the process by which insights gained through the evaluation process were applied to programs was demonstrated early in the empowerment evaluation. One component of the FORECAST process, the development of logic models, was particularly effective as a means of stimulating fresh perspectives on the relationships between program activities and goals. The article by Hawkins and colleagues describes how collaboration around logic model development in two of the participating organizations served as a catalyst for reconsidering certain longstanding policies and focusing on broader social ecological contexts.

When given a central role in the evaluation process, what kind of questions will stakeholders ask about their own programs? Each evaluation included collection of qualitative data and pre–post measures, using both cross-site and program-specific measures. The article by Ball and colleagues presents findings from a series of group interviews with participants in SafePlace's Expect Respect support groups for youth who have experienced dating and/or sexual abuse, as well as those who have been exposed to family violence. The article describes key program outcomes, as well as factors in its effectiveness, from participants' perspectives.

The decision to work with existing programs meant that the four participating programs were somewhat diverse in their approaches. What contributions to the knowledge base could be made with a cross-site analysis? Clinton-Sherrod and colleagues analyzed pre–post data from the four selected programs to assess the impact of implementation approaches and participant factors on both knowledge and attitudes related to sexual aggression. Their findings shed new light on the ongoing debate regarding the merits of single- and mixed-gender groups, and they highlight the importance of considering both presentation formats and group composition in relation to program objectives.

As these evaluated programs "grow up" and continue to spread, how will they be implemented? Because high-quality implementation (with fidelity to the core elements of the original model) is necessary to ensure that evidence-based programs will be effective when they are disseminated (Dusenbury, Brannigan, Falco, & Hasen, 2003; Dusenbury, Brannigan, Hansen, Walsh, & Falco, 2004), Noonan and colleagues explore what happens when these programs are picked up in new practice settings. Are the programs delivered in a manner that maintains the original content and delivery format? How should we measure fidelity of program implementation? These authors measure fidelity of implementation across new sites then suggest that program fidelity is not a simple monolithic construct but rather one that comprises many different dimensions ranging from staff selection to curriculum use. Some of these dimensions may be more important than others to maintain the integrity of the program model and, relatedly, program outcomes.

The empowerment evaluation process had dual objectives of building understanding around effective prevention approaches and enhancing participants' evaluation capacity, but how do we know if we were successful? The article by Gibbs and colleagues addresses this question by summarizing participants' feedback on

three critical dimensions of empowerment evaluation: satisfaction with the process, changes in evaluation capacity, and use of evaluation findings for programmatic improvement. They close with comments on the process and lessons learned from the technical assistance providers' perspective.

Finally, Graffunder wraps up by highlighting the often unarticulated benefits that emerged from building evaluation capacity with participants—both in terms of having engaged primary stakeholders so intimately in the analysis of their own programs and, through that involvement, having built capacities that are easily generalizable across other aspects of their work. The implications described are relevant not only to CDC's National Rape Prevention and Education Program but also to the broader sexual violence prevention field.

CONCLUSION

Without the perpetrator, there is no act of abuse. As the collection of articles in this issue illustrates, the quest to prevent perpetration—to free our communities, schools, and homes from sexual violence—has required prevention efforts that capitalize on best existing knowledge regarding health and behavioral sciences, program evaluation, and closure of the gap between research and practice. We hope that the empowerment evaluation process, and the findings contained in this special issue, will contribute to the growing body of knowledge dedicated to the ultimate goal: a world without sexual violence.

NOTE

1. RTI International is a trade name of Research Triangle Institute.

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