Robert Wood Johnson Foundation

Poised for Prevention

Advancing Promising Approaches to Primary Prevention of Intimate Partner Violence

Prevention Institute

Putting prevention at the center of community well-being

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The Executive Summary and the full document are available at *www.preventioninstitute.org/vppubs.html#reports.*

Prevention Institute is a nonprofit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity and youth development.

This document was prepared by Prevention Institute.

Principal authors are:
Lisa Fujie Parks
Larry Cohen, M.S.W.
Nicole Kravitz-Wirtz

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Executive Summary

"We are still standing on the bank of the river, rescuing people who are drowning. We have not gone to the head of the river to keep them from falling in. That is the 21st century task."[1]

—Gloria Steinem

THE INTIMATE partner violence (IPV)* movement is now poised for a greater emphasis on, and an expanded notion of, prevention. Such an expansion honors and builds on the past successes of the movement and compliments the field's continued commitment to improving responses to IPV. In September 2006 the Robert Wood Johnson Foundation and Prevention Institute called together a group of IPV leaders for a national convening: *Poised for Prevention: Advancing Promising Approaches to Primary Prevention of Intimate Partner Violence*. This diverse set of local and national leaders urged an immediate and more coherent approach to primary prevention of IPV that builds on successes to date. Their work established the elements and vision from which a national primary prevention strategy can be built.

Prevention is a systematic process that promotes safe and healthy environments and behaviors, reducing the likelihood or frequency of an incident, injury or condition occurring.[2] Primary prevention addresses problems before they occur. Effective primary prevention must change the environmental factors–economic inequalities, sexism and media, and marketing practices–that dramatically shape behavior.

As important behavior shapers, norms are a critical element of environmental change. Although IPV may not be considered acceptable, harmful norms related to IPV create conditions conducive to, and tolerant of, such violence. Thus, changing norms that promote and permit IPV to those that discourage it is an essential strategy for prevention.

No single program can change the environmental factors and norms that contribute to IPV. Such enduring change will require comprehensive and multidisciplinary approaches that reframe the desired outcome of prevention as healthy behavior and healthy communities. Articulating the desired outcome of prevention as healthy relationships and healthy communities will engender new narratives about gender, power and relationships and encourage a positive approach to engaging people and organizations as partners.

* In recent years the term *intimate partner violence (IPV)* has been embraced as a term that includes violence between people in an intimate relationship who don't necessarily live in the same household, including ex-spouses, boyfriends/girlfriends, ex-boyfriend/girlfriend, or date, including same-sex relationships. While the term *domestic violence* is more publicly recognized, for the purposes of this report and the national convening, the broader term, *IPV*, will be used.

A comprehensive primary prevention strategy aims to influence the structural and economic factors that contribute to IPV and requires the participation of multiple sectors and stakeholders, including government, businesses, faith communities, the media, and schools. The *Spectrum of Prevention** offers a framework for developing such effective and sustainable primary prevention initiatives. While all levels of the Spectrum of Prevention are essential for sustaining change, environmental change requires an emphasis on the broadest levels of the Spectrum:

- Influencing policy and legislation (Level 6);
- Changing organizational practices (Level 5); and
- Fostering coalitions and networks (Level 4).

For example, policy change can help foster environments in which violence is less likely to occur[3] by altering the community-level factors that affect IPV, including the economic climate, housing and neighborhood conditions and media marketing practices. Policies at the federal, state and local levels can also help to generate much needed funding for communities to implement primary prevention initiatives. Additionally, organizational practice change has the potential to reach large numbers of people, proactively model healthy behaviors and profoundly alter family and community well-being by shifting the overall climate towards prevention. Policy and organizational practice change, however, can only be achieved with participation from key public and private organizations working in partnership with communities through coalitions and networks.

While IPV is present in all cultures, faiths and socioeconomic classes, a focus on IPV prevention may be particularly warranted within low-income immigrant communities facing additional disparities in multiple health and social outcomes. Comprehensive and multidisciplinary prevention efforts are critical within immigrant communities, not only to alter environments and norms, but also as a means to address such overall structural and systemic barriers that often exacerbate IPV, including limited access to housing, education, employment, and health care. Generally speaking, similar norms-change approaches can be applied in any community as long as the context, history and dynamics of the community are understood and addressed. Within immigrant communities, reframing prevention as building healthy relationships and healthy communities through new narratives and a positive approach can honor culture and foster community resilience and cultural pride. This paper briefly explores effective prevention efforts in immigrant communities. The intent is to highlight efforts that can guide our work in all communities across the nation. Additionally, the report briefly reflects dynamics related to immigrant communities.

No single program can change the environmental factors and norms that contribute to IPV. Such enduring change will require comprehensive and multidisciplinary approaches that reframe the desired outcome of prevention as healthy behavior and healthy communities.

*The *Spectrum of Prevention* was originally developed by Larry Cohen in 1983 while working as director of Prevention Programs at the Contra Costa County Health Department. It is based upon the work of Dr. Marshall Swift in preventing developmental disabilities. For more information, see page 8 of the main document or go to *http://preventioninstitute.org/tool_spectrum.html.*

While primary prevention efforts have increased and continue to expand through the great resourcefulness and creativity of communities across the country, advancing promising approaches and bringing them to scale will require:

1. greater people power;
2. resources and support for practice; and
3. learning, growing and assessing to refine the strategy.

Immediate steps should be taken toward these objectives. Leadership among key stakeholders can generate a significant level of interest and investment in primary prevention and signal a turning point at this historic juncture to collectively advance efforts from "poised" to "actualizing" prevention, and ultimately, to a dramatic reduction in rates of IPV.

Introduction

MORE THAN 30 years ago, domestic violence survivors and their allies across the country took groundbreaking steps to break silence and demand safety, healing and accountability. With courage and passion, groups of women transformed their personal pain and outrage into a national movement with a vision for social change. The movement has grown, expanding services and shelters, changing public policy and influencing societal norms. As guest editor, Gill Hague wrote in the June 2006 edition of the journal, *Violence Against Women*, "[Both] the way it is viewed and also legislative, policy, and practice responses to it have been transformed during the past 15 years [such that] combating domestic abuse has moved from the margins to the mainstream." While the vision has always been to affect broad social change, efforts to date have been primarily focused on meeting the immediate demand for shelter and safety. Yet despite its rapid growth, the service system has been unable to keep pace with widespread need, as staggering numbers of women and children turning to shelters have perpetually outpaced the growth of the movement.[4]

The movement's agenda has been principally shaped by the fundamental pursuit of safety for victims and accountability for perpetrators. Momentum for these crucial goals continues to build across the country. Attention to preventing intimate partner violence (IPV)* before it occurs has also grown in recent years. The IPV field is now poised for a greater emphasis on, and an expanded notion of, prevention.

Such an expansion honors and builds on the success of the movement and does not supplant the field's continued commitment to improving responses to IPV. Primary prevention of IPV–that is, taking action to prevent IPV before the threat or onset of violence–holds promise for dramatically reshaping our community environments and norms and is an important component of social change. Primary prevention has gained some traction nationally and in some local communities, but has yet to achieve widespread adoption. Policy and programmatic efforts to prevent IPV before it occurs are still in the early stages of development. Greater attention to advancing promising primary prevention approaches is essential to furthering the field and achieving dramatic reductions in rates of IPV.

Primary prevention of IPV—that is, taking action to prevent IPV before the threat or onset of violence—holds promise for dramatically reshaping our community environments and norms and is an important component of social change.

Building on this momentum, the Robert Wood Johnson Foundation (RWJF) and Prevention Institute called together a group of leaders for a national convening in September 2006: *Poised for Prevention: Advancing Promising Approaches to Primary Prevention of Intimate Partner Violence*. The convening was structured to encourage frank dialogue quickly and to achieve three specific objectives:

1. Identify promising elements of an environmental/norms-change approach to preventing IPV before the threat or onset of violence.

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2. Identify potential considerations and recommendations for applying an environmental/norms-change approach to IPV prevention in immigrant communities.
3. Identify actions needed to build broader momentum for primary prevention of IPV and advance promising environmental/norms-change approaches from occasional to wider spread use.

The diverse set of local and national IPV leaders, including representatives from community-based and national nonprofit organizations, government, foundations, academia, and the business sector (See Appendix A: Convening Participants), urged an immediate and more coherent approach to primary prevention of IPV that builds on successes to date.

This report was written by Prevention Institute as a summary of the preliminary conclusions from the national gathering. It integrates the convening outcomes, Prevention Institute and RWJF perspectives on the issue, themes from interviews conducted prior to the event with convening participants and a number of additional IPV experts, and a limited scan of the literature. The report includes a discussion of primary prevention of IPV, promising approaches to environmental/norms change, an examination of IPV primary prevention within immigrant communities, recommended actions to building momentum for primary prevention of IPV, and immediate next steps. The conclusions presented in the report are preliminary. The report is designed as a catalyst and call to action, to give a sense of direction and raise some issues for consideration.

"The stories of prevention are not of victims and perpetrators. They are of healthy relationships and healthy communities."

—Donald Gault, Healthy Communities section manager Saint Paul–Ramsey County Department of Public Health

What is Primary Prevention?

PREVENTION is a systematic process that promotes safe and healthy environments and behaviors, reducing the likelihood or frequency of an incident, injury or condition occurring.[5] Primary prevention addresses problems *before* they occur. Thus, it is distinct from efforts to modify the behavior of individuals who may already be violent or assist individuals already experiencing the threat or onset of violence. As with many other health and social issues, a major challenge in advancing primary prevention of IPV is that primary prevention is often misunderstood. For example, primary prevention is often confused with early intervention services for victims and perpetrators, such as universal screening in health care settings. These interventions may help to ameliorate trauma and potentially prevent future incidences, however, early identification depends on the violence or threat of violence occurring and seldom alters the broader community and societal environment in which the violence was generated. Hence, it is not primary prevention.[6]

"The majority of men disagree with violence against women, yet they remain silent about it."

—Don McPherson, founder and executive director Sports Leadership Institute, Adelphi University

The Role of Norms

IN ORDER to effectively address IPV we need a different approach: from a focus on intervention and treatment to one of primary prevention. Continuing to frame IPV primarily as individual behavior will preserve the present reliance on, and advancement of, largely individually-oriented strategies. While the occurrence of IPV is inherently behavioral, it is clear that focusing on one individual at a time will not produce significant reductions in the rates of IPV. George Albee said it best: "No mass disorder afflicting [humankind] is ever brought under control or eliminated by attempts at treating the individual."[7] Rather, achieving broad behavioral change requires a focus on the environments within which people operate, which in turn influences individual behavior. Violence arises out of a complex interplay of individual, family, community, and societal conditions. Effective primary prevention must change the environmental factors that shape behavior. Substantial reductions in IPV are more likely to be achieved when environmental influences are consistent with, and mutually reinforcing of, prevention efforts directed at individual behavior change.[8] The Institute of Medicine affirmed this powerful influence by concluding, "It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural and physical environment conspire against such change."[9]

Because the environment powerfully influences behavior, it is critical to understand and address a major element within it–norms. Norms are a key mechanism by which institutions and organizations shape behaviors, positively or negatively. Norms are standards that influence and provide a model for behavior.[10] They are regularities to which people generally conform[11] and are the specific way the environment translates and affects behavior through cues. Research has demonstrated the importance of changing norms to reduce major public health problems from HIV to smoking.[12] Although such past successes are different from IPV, there are relevant lessons we can learn and apply. Consider tobacco, for example. A generation ago virtually every public space was smoke-filled. The norm was to light up or accept others lighting up around you. Surgeon General's warnings and education campaigns about the danger of smoke, even secondhand smoke, had little impact until the 1980s, when a few fringe communities in California began to limit smoking in sections of restaurants and other public spaces. Before long, this became a model replicated (sometimes voluntarily and sometimes by regulation) by organizations across the country. New norms were fostered. As the norms changed, the spaces where smoking was limited increased, support for cigarette taxes surged, and smoking rates dropped.

Norms have the potential to have just as powerful an influence on shaping behavior related to violence. Even though IPV may not be considered acceptable, harmful norms related to IPV create conditions conducive to, or tolerant of, such violence. Therefore, changing the norms that promote and permit IPV is an essential strategy for prevention. There are at least five kinds of damaging norms that contribute to IPV. These are norms related to:

- Traditional gender roles of men in society, including those that promote domination, control and dangerous risk-taking behavior;

- Traditional gender roles of women in society, including those that promote objectification and oppression of women and girls;
- Power, where value is placed on claiming and maintaining control over others;
- Violence, where aggression is tolerated and blame is attributed to victims; and
- Privacy, where norms associated with individual and family privacy are considered so sacrosanct that secrecy and silence is fostered and those who witness violence are discouraged from intervening.[13]

These kinds of norms promulgate a toxic environment in which IPV is perpetrated, inhibit appropriate action and condone inappropriate inaction. It is important to understand how environment shapes behavior and what needs to change in order to reduce the influences that encourage IPV.

We must acknowledge and change one or more of these norms if we are to make major strides in preventing IPV. Don McPherson suggests that "the majority of men disagree with violence against women, yet they remain silent about it." A major emerging strategy to address this involves engaging men and boys to reshape or correct misperceptions about traditional norms about masculinity while changing norms about silence and inaction. One example is *Mentors in Violence Prevention*, a set of activities rooted in a strategy to change male peer culture through empowering bystanders.[14] Especially relevant within college settings, changing the norm of IPV to be more than just a private matter can foster environments in which roommates or fellow party-goers feel compelled to speak up if they witness violent behavior among their peers. Another strategy seeks to change norms related to women's roles and encourage women's educational and financial empowerment. For example, *Mujeres Unidas y Activas* empowers Latinas through education, economic development and social support and provides workshops on topics including IPV prevention and other health and safety issues.[15]

Norms are standards that influence and provide a model for behavior. They are regularities to which people generally conform and are the specific way the environment translates and affects behavior through cues. We must acknowledge and change norms if we are to make major strides in preventing IPV.

Section 1

Promising Approaches to Changing Community Environments and Societal Norms

Though primary prevention of IPV is in its nascent stages, guiding principles and promising approaches are beginning to emerge from diverse community contexts throughout the country. These principles and approaches are based on lessons from successes in IPV and other relevant prevention fields, and are rooted in practice, research and evaluation over the past few decades.

Changing environments and norms–particularly ones steeped in issues of power imbalance–involves broad-scale transformation and is without a doubt, a tall order. No single program can achieve such enduring change. Rather, a new focus and set of approaches are needed to: (1) reframe the desired outcome of change as healthy behavior and healthy communities; and (2) foster comprehensive and multidisciplinary prevention.

Guiding Principles for Primary Prevention of IPV

- Focus on changing norms to change behaviors.
- Foster comprehensive and integrated systems for prevention.
- Engage community leadership and be responsive to community strengths and needs.
- Promote and model the desired positive behavior.
- Invite, don't indict, men as stakeholders in prevention.
- Emphasize the role of bystanders in prevention.
- Start early/young.
- Focus on assets along with risk factors.
- Build on existing assets and efforts.

Reframe the Desired Outcome as Healthy Behavior and Healthy Communities

While ultimately we want to prevent a specific set of negative behaviors collectively understood as IPV, our focus in doing so must be about promoting a positive set of behaviors through the creation of environments and norms that promote and support those behaviors. IPV will cease when intimate relationships are healthy and equitable and violence is not perpetrated in the first place, and when communities take responsibility for nurturing and supporting those relationships. In other words, the desired change in prevention is not only fixing the problems, but also building and emphasizing assets: healthy behavior and healthy communities. Articulating the desired outcome of prevention as healthy relationships and healthy communities will encourage new narratives about gender, power and relationships and a positive approach to engaging people and organizations as partners in prevention.

New Narratives about Gender, Power and Relationships

Damaging norms that promulgate IPV are too often reinforced by cultural narratives, the historically and culturally grounded stories in a given culture that are told and retold to make sense of the world. Rigid gender expectations about power and relationships are fostered by narratives in which men don't cry; women live to please men; perfect princes conquer competitors, rescue helpless princesses and ride off into the sunset to live happily ever after. While these and other similar narratives may not directly condone violence in intimate relationships, they collectively cultivate a set of norms that contribute to IPV. Recent narratives in popular culture about intimate relationships are beginning to include stories of women escaping violence from their husbands, boyfriends and dates, and men being held accountable and punished for their crimes. However, narratives that foster healthy relationships rooted in equity, empathy, interdependence, mutuality, and reciprocity are still lacking.

According to Crystal Hayling, "We need to imagine and tell the story of what 'violence-free' looks like." These new narratives will in part draw on and help reconnect us to positive aspects of our existing cultural and community values, and in part involve new and evolved notions of gender, womanhood, manhood, and what it means to be in an intimate relationship. New narratives can help shape new norms and guide behavior toward what we want to see–that is, behavior in intimate relationships that is healthy, equitable and free of violence. As Don Gault emphasized, "The stories of prevention are not of victims and perpetrators. They are of healthy relationships and healthy communities." An additional element of the narratives should be the importance of healing. According to Oliver Williams, telling stories of healing through, for example, artistic expression at community events, challenges norms about what is private versus public and encourages healthy ways of honoring emotions.[16] These new narratives must place relationships in a healthy community context and include stories of community members and organizations taking responsibility for fostering healthy relationships, challenging harmful norms and embracing change with resilience and hope.

"We need to imagine and tell the story of what 'violence-free' looks like."

—Crystal Hayling, president and CEO Blue Shield of California Foundation

A Positive Approach to Engaging People and Organizations as Partners

According to Don McPherson, "Men too often feel accused of being perpetrators when they are engaged in a conversation about IPV. That makes the conversation difficult and the result is that most men don't feel compelled to examine their underlying beliefs and behaviors." As Esta Soler acknowledges, "Men have been indicted, not invited into the conversation." We need to approach the whole community, especially men, in a conversation about what is healthy in messages broader than "don't be violent." A positive approach to engaging people and organizations is important because people need a model for what a healthy relationship is, what responsible bystander behavior is, and how a variety of community stakeholders can foster healthy, non-violent community practices and

norms. Such an approach can also help break through the paralysis that women and men alike can feel when facing the magnitude of the IPV problem, its impact and the entrenched factors that perpetuate it.

Part of a positive approach involves highlighting the benefits that individuals and communities can gain through preventing IPV, including:

- reduced trauma;
- increased family and community cohesion;
- a greater overall sense of safety;
- reduced costs to individuals, families, government and businesses.

Crystal Hayling and Oliver Williams suggest highlighting positive outcomes associated with IPV prevention, such as improved child development, positive parenting and improved conditions for the community as much more effective than highlighting IPV as something bad.[17] Williams suggests that not only are initiatives that approach individuals and communities in this positive and hopeful manner more likely to become valued by the community, they are also less likely to be considered lower priority than issues such as discrimination, housing and employment.[18,19] Keisha Perkins expressed this idea as "weaving in IPV prevention as 'on the way' and not 'in the way' of our communities' priorities."

"Men have been indicted, not invited into the conversation."

—Esta Soler, executive director Family Violence Prevention Fund

Foster Comprehensive and Multidisciplinary Prevention

Environmental (community and societal level) risk factors associated with IPV include low social capital, poverty and associated factors such as overcrowding.[20] According to a recent National Institutes of Justice research brief, having financial problems in intimate relationships and living in an economically distressed neighborhood combine to create greater risk of injury and violence.[21] On the other hand, female empowerment, as manifested through higher income, education and status has generally been found to confer protection against IPV.[22] A comprehensive prevention strategy aimed at community and systems-level change requires participation from multiple sectors and stakeholders such as government, businesses, faith communities, the media, and schools and is needed to influence such structural and economic factors. Comprehensive prevention strategies have been behind numerous public health successes such as lead poisoning prevention and tobacco control, and the associated norms changes they have prompted. This approach is also contributing to recent gains in nutrition and physical activity promotion.

Practitioners and policy advocates frequently ask how such change can be envisioned and developed. The *Spectrum of Prevention** offers a framework for developing effective and sustainable IPV primary prevention initiatives that have

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the potential to affect community and systems-level changes. The Spectrum delineates a variety of complementary arenas for change. It is comprised of six levels of increasing scope. The inter-relatedness between levels of the Spectrum, or synergy, maximizes the results of each activity and creates a more transformative force. While all levels of the Spectrum are essential for sustaining change, community and systems-level change require efforts at the broadest levels of the Spectrum:

- influencing policy and legislation (Level 6);
- changing organizational practices (Level 5); and
- fostering coalitions and networks (Level 4).

The other levels of the Spectrum (Level 3: Educating providers; Level 2: Promoting community education; and Level 1: Strengthening individual knowledge and skills) contribute to, and build upon, this momentum for change. For example, policy change (Level 6) will have a better chance of being enacted when public awareness and support are garnered through educational efforts (Levels 1–3). Examples of efforts at all levels of the Spectrum are profiled below, along with ideas for potential future directions in these arenas.

"...violence against women is now so much in the public discourse, it's hard for any policy-maker to say it's not a priority."

—Leni Marin, managing director Family Violence Prevention Fund

Influence Policy and Legislation

Policy change is often a key tipping point to norms change. Fortunately, according to Leni Marin, "…violence against women is now so much in the public discourse, it's hard for any policy-maker to say it's not a priority." Policies shape the overall environment for everyone in a community and can enforce new norms, alter environmental factors and align resources toward prevention outcomes. By altering the community-level factors that affect IPV, such as the economic climate, health, neighborhood conditions, and media marketing practices, policy change can help foster environments in which violence is less likely to occur.[23] Policies at the federal, state and local levels can also help to generate much needed funding for communities to implement primary prevention initiatives.

- *Zoning Laws*

  In South Los Angeles, California, community groups organized to reduce the availability of alcohol, a risk factor for perpetration, through the reduction of outlets. Within a three-year period, a coalition was able to change zoning laws and prohibit 200 liquor stores from re-opening. Evaluation documented a reduction in violent crime within a four-block radius of each liquor store that was closed.[24] Zoning laws and planning ordinances can also influence issues such as housing density.

- *School Policy*

  The *Expect Respect Project* in Austin Texas exemplifies the power of school policy change. The project has demonstrated a positive influence on the social climate on campuses by implementing comprehensive bullying and sexual harassment prevention policies in schools.[25]

- *County Government Policy*
  Over 16 years ago the County Board of Supervisors in Ramsey County, Minnesota created a dedicated funding stream through their general budget to establish family violence prevention positions within the public health department and county administrator's office and fund IPV community and systems-level primary prevention efforts.[26] San Francisco County, California passed a local ordinance to implement the United Nations Convention on the Elimination of All Forms of Discrimination Against Women and is working systematically to promote gender equity through audits of all county department funding and services by gender.

- *Health Care Policy*
  Health care professionals are particularly effective when speaking about IPV to legislators because they have seen the health consequences of IPV firsthand. By speaking up, writing letters and testifying to policy-makers, health care providers can shape issues, influence the debate, and challenge public and political discourse. Health institution representatives can sponsor and support violence prevention legislation, write op-ed pieces and letters to the editor in support of IPV prevention, meet with elected officials, and talk with the press about the fact that IPV is not inevitable.

- *CJ System Policy Change*
  Funded by a federal Violence Against Women Act (VAWA) grant, a rural county in South Carolina established a domestic violence court, incorporating additional investigators for the Sheriff's Department, a prosecutor for the District Attorney's Office, a victim's advocate, and two mental health counselors to address substance abuse and mental health disorders. Perpetrators were typically granted suspended sentences contingent upon their completion of a 26-week, group-based cognitive therapy program and treatment for substance abuse or mental health disorders. The combination of stiffer penalties and greater emphasis on rehabilitation led to a significant 10 percent increase in arrests for domestic violence and a 50 percent reduction in perpetrator recidivism.[27]

Organizational settings offer the opportunity to reach large numbers of people, proactively model healthy behaviors and offer incentives and disincentives for behaviors to shape the overall climate toward IPV prevention.

Change the Practices of Organizations

Environmental change needs to take place in venues that are large enough to have a substantial impact, while at the same time at a small enough scale at which implementation is achievable. Organizational settings offer the opportunity to reach large numbers of people, proactively model healthy behaviors and offer incentives and disincentives for behaviors to shape the overall climate toward IPV prevention. While IPV is different from most other injury and health issues, in the area of norms change we can learn from effective strategies from other health areas in which they have relevance. For example, while education campaigns about the danger of smoke had little impact and smoking cessation clinics had marginal success, modest changes in restaurants and public institution environments–brought about through smoking restrictions–initiated a change in norms and

engendered support for further change, including tax increases on cigarettes, which financed further efforts to influence norms, and an eventual decline in smoking rates.[28]

Harmful practices, such as wage discrimination, encouraging people to devote themselves more to their work than their families, or promoting the notion that violence in the family is a private matter, can be transformed by organizations, whether they are small grassroots associations or large public agencies, to promote healthier alternatives. The Centers for Disease Control and Prevention, for example, developed the DELTA (Domestic Violence Prevention Enhancement and Leadership Through Alliances) program to support local nonprofit organizations in the adoption and integration of primary prevention principles and practices within their current efforts to address IPV.[29]

Examples of organizational practice change strategies for IPV prevention include:

Work Place/Business Sector

Businesses can foster safe workplace environments in which harassment and violence are not tolerated, and can embed IPV prevention in policies promoting positive parenting and healthy work/family life balance. Businesses can also reach consumers and support community initiatives. Examples include Verizon Wireless's domestic violence prevention *Hopeline* program and Liz Claiborne's *Love is Not Abuse* campaign and workplace program.[30,31] Deborah Lewis notes that engaging companies, big and small, is a great strategy for reaching people, including parents: "People spend most of their time at work, so we need to address businesses and workplaces."

Media, in its many forms, collectively represents one of the most powerful influences on norms and is therefore a critical venue for influencing practices.

Media

Media, in its many forms, collectively represents one of the most powerful influences on norms and is therefore a critical venue for influencing practices. *The Dangerous Promises* campaign focused on changing media advertising and successfully convinced the distilled spirits trade association to adopt a voluntary code of advertising discouraging the harmful association of alcohol with violence against women.[32] Engaging media outlets such as *Essence* and *BET* to portray healthy, violence-free relationships could be a powerful influence on norms, according to Oliver Williams.[33]

School-Based/Youth Settings

Some principals and administrators build IPV prevention consistently into their schools. They encourage open discussion as well as initiatives to change the school environment. Examples of such initiatives include the *Safe Dates* program, which engages middle and high school students in advocacy, education and arts to change gender-role norms and improve conflict resolution and peer support skills,[34] and the *Fourth R* program in Canada, which promotes healthy school environments by

working with educators and engaging students in developing healthy relationships and decision-making.[35] Jackie Campbell suggests that a focus on dating violence prevention using arts and youth engagement are particularly effective, as well as mentoring programs and peer conflict resolution/mediation programs that deal explicitly with gender dynamics.[36]

Health Care

Health care can play a vital role in promoting healthy relationship and gender role norms, including those related to positive and engaged fatherhood. Recognizing that people can become controlling and abusive during times of stress, Ramsey County Department of Public Health partnered with Health East to provide all new fathers of children born into the medical system with information and support via brochures and a men's helpline.[37]

Law Enforcement

Many law enforcement agencies have changed their organizational practices related to IPV intervention, such as adopting community policing practices and enhancing IPV training to include the impact of violence on whole families. Law enforcement agencies can also adopt primary prevention organizational practices, such as strong anti-harassment and anti-violence policies, healthy work/family life balance practices and incentives for law enforcement personnel to participate in mentoring and other community prevention programs.

"No important problem of our time is going to be solved by one sector alone."

—Jim S. Marks, senior vice president and director, Health Group Robert Wood Johnson Foundation

Foster Coalitions and Networks

As Jim Marks emphasizes, "No important problem of our time is going to be solved by one sector alone." Businesses, government, schools, health care, and other institutions have a major influence on community environments and norms. Therefore, IPV prevention requires participation from key public and private organizations working in partnership with communities. According to Keshia Pollack, it is important for organizations to function outside their silos: "IPV is a cross-cutting issue that requires a holistic view. If we look at IPV more holistically it becomes apparent that there are other injury issues and partners that we can engage." Fostering coalitions and networks is about bringing together groups and individuals for broader goals and greater impact. Working across disciplines and sectors through coalitions and networks also encourages a move away from the siloed thinking that separates intimate partner violence from other forms of interpersonal violence and from other related health and safety issues, toward a more integrated approach to effectively address multiple issues simultaneously.

- *Engaging Leaders as Partners*

  Engaging diverse community and systems leaders as partners is a key strategy for encouraging broader ownership of the problem of IPV and its solutions. While recognizing the vital importance of women's leadership, Esta Soler notes that

engaging men as leaders particularly outside of the IPV field is critical at this juncture: "If it's just women talking to women and advocates talking to advocates we won't be able to change social norms." According to Jackson Katz, "Engaging leaders at higher levels of institutional power will help to widen the reach and sustainability of primary prevention initiatives, and therefore is particularly important." Leadership from diverse segments within a community and informal grassroots networks are also critical for ensuring inclusiveness and responsiveness, particularly toward groups that are most socially and economically marginalized.

- *Partnerships Across Sectors*
  All of the policy and organizational practice change examples illustrated in this report involve partnerships across sectors and disciplines, including divisions of government branches such as public heath, planning, zoning and education, as well as businesses, health care, media, faith institutions and sports organizations.

- *Partnerships Across Violence Prevention Fields*
  IPV, sexual violence and child maltreatment are interrelated forms of violence that share common risk and protective factors and often co-occur within the same households.[38] Such a recognition points to the need for common purpose in prevention efforts and greater collaboration among initiatives.[39] Furthermore, the high correlation between witnessing or experiencing violence in childhood and subsequent victimization and perpetration suggests the need for, and benefits associated with, linking prevention strategies. Examples of partnerships across violence issues include the federal Violence Against Women Act (VAWA), which addresses IPV as well as sexual violence, stalking and numerous school-based prevention initiatives aimed at reducing bullying and dating violence. Specifically, the prevention provisions of VAWA provide services for families living with violence by integrating prevention initiatives into already existing programs such as home visitation, fatherhood mentoring and prisoner re-entry, and funding training for workers at Head Start, after-school and other programs serving children.[40]

- *Partnerships Across Related Health and Social Issues*
  Research also points to clear linkages between IPV and other health issues such as HIV and teen pregnancy as well as substance abuse and mental health problems, suggesting additional potential partnerships for prevention.[41]

The Spectrum of Prevention

Spectrum Level and Definition	
Strengthening individual knowledge and skills *Enhancing an individual's capability of preventing injury or crime*	■ Training for teens to promote healthy dating. ■ Home visitation by public health nurses.
Promoting community education *Reaching groups of people with information and resources to promote health and safety*	■ The Family Violence Prevention Fund's *Coaching Boys into Men* campaign promotes positive examples of male behavior such as respect. ■ *The Five in Six Project*, based in Cape Town, South Africa, uses a social norming approach to convey to men the fact that five in six men are not violent with their partners, questioning the assumption that 'everyone is violent'.
Educating providers *Informing providers who will transmit skills and knowledge to others*	■ Training journalists to frame coverage on IPV as a preventable problem. ■ *Take it to the Village*: Prevention training for native and non-native health care practitioners in isolated Alaskan villages.
Fostering coalitions and networks *Bringing together groups and individuals for broader goals and greater impact*	■ CDC's *DELTA* program (Domestic Violence Prevention Enhancement and Leadership Through Alliances) encourages partnerships and collaborations including non-traditional partners, e.g., the faith community, civic and men's organizations, the media and business efforts to address primary prevention. ■ Transforming Communities' *Faith in Violence Free Families* project brings together faith leaders and domestic violence agencies to increase the capacity of faith communities to respond to and prevent domestic violence.
Changing organizational practices *Adopting regulations and norms to improve health and safety and creating new models*	■ Men's civic and athletic organizations develop positions, programs and resources to support and engage men in ending violence against women. ■ Businesses develop and enforce strong anti-harassment and anti-violence policies that explicitly address IPV.
Influencing policy and legislation *Developing strategies to change laws and policies to influence outcomes in health, education and justice*	■ Cambridge, Massachusetts passed a Domestic Violence-Free Zone, representing a citywide commitment to prevent domestic violence and resulting in an embedding of domestic violence prevention language and policy into all areas of city business. ■ The U.S. Violence Against Women Act raised awareness about the problem of violence against women and brought federal resources to the state and community levels.

Section 2

Actions to Build Momentum for Primary Prevention of IPV

According to Crystal Hayling, "Slowly but surely, understanding towards prevention has changed. There are more people who are aware of its importance and want to do something." While primary prevention efforts have been and continue to expand through the great resourcefulness and creativity of communities across the country, none of the promising approaches described in this report can be fully explored and brought to scale without greater national momentum to advance them. As Jeane Ann Grisso emphasizes, "The timing is right to build on what has already been done and what already exists." It is essential to cultivate:

- greater leadership and advocacy;
- resources and support for practice; and
- learning, growth and assessment to refine strategies and develop tools.

Leadership and Advocacy

Leadership and advocacy is needed to foster a growing voice and resource base for primary prevention of IPV.

Leadership Development

Leadership development is needed for new and existing leaders to foster new ways to push the envelope of prevention. "We are poised for change. There is a readiness and openness for change. We need to train a new generation of leaders who think differently and connect the dots between issues and solutions that are interrelated," stated Dennis Hunt. A core of strong leaders within communities must be able to carry the same vision around prevention and focus on environmental change. This leadership should come from existing IPV-focused agencies, grassroots groups within communities, and from other fields and sectors, such as business, media, sports, faith-based organizations, health care, public health, and education. According to Lupe Serrano, "The field needs to continue to make room for communities of color to lead, so that we can get to a place of leading together."[42] The *National Network to End Violence Against Immigrant Women* has been successful in elevating informal community leaders to become national leaders.[43]

"If it's just women talking to women and advocates talking to advocates we won't be able to change social norms."

—Esta Soler, executive director Family Violence Prevention Fund

Advocacy and Mobilization for Prevention

The collective IPV movement is presently poised on so many different levels that a coherent national strategy is essential to moving forward. In order to advance promising approaches to primary prevention of IPV, there must be greater national attention and momentum focused on prevention. Over the next few years, the development of a highly visible national partnership initiative is needed to strengthen the prevention-focused arm of the IPV movement to build broad momentum for primary prevention. Prevention should be built into policy and organizational practice at a community, statewide, and national level. For example, full authorization, with resources, of the prevention components of the VAWA 2005 legislation would have

immense importance both in terms of its direct outcomes and also as a sign of greater mobilization. An initiative can include several components, including constituency building and mobilization, policy advocacy, pilot projects, and more, with specific objectives and timeframes.

Resource and Support for Practice

The practice of IPV primary prevention cannot be strengthened without greater resources and support.

Tool Development

As more and more groups have come to understand the need for comprehensive prevention and the importance of environmental/norms-change work, the need for practice tools has grown. One of the most effective ways to support practice is to share examples of successful or promising initiatives that people can draw inspiration and insights from in a user-friendly manner. A set of tools for practice could include:

- a brief *Profiles of IPV Primary Prevention* report that highlights innovative primary prevention efforts in diverse communities, with a focus on prevention in vulnerable populations; and
- an online database of strategies for IPV primary prevention on a local level, including current research, model policies and programs, hands-on tools, articles, and other publications.

Training and Technical Assistance

Training and technical assistance (T/TA) related to primary prevention and cultural competency is also needed. Oliver Williams noted, "Once people have insight on the problems and solutions, they need support to actualize their ideas. A facilitator can help groups make choices about what to do and where to start and how to move through the process."[44] T/TA can be focused on pilot projects to test out and build a base of knowledge of effective IPV primary prevention.

"'It's against the law' is not a good primary prevention approach."

—Crystal Hayling, president and CEO Blue Shield of California Foundation

Measure the Problem and Intermediate Effects

Evaluation myths related to primary prevention include the idea that prevention is invisible and that non-events cannot be measured. Successful public health prevention efforts document and measure their impact by establishing and monitoring intermediate markers which are then tracked over time to determine their influence on longer term outcomes. Such interim markers provide context for smaller, more modest efforts and assure that efforts are on the right track. For IPV prevention, efforts to influence bystander behavior and other mentor-like initiatives have specific intermediate outcomes that can be defined and measured. Similarly at the organizational or societal levels, the presence or absence of policies or standards that require certain positive behaviors (training/skill building, increases in awareness related to language and behavior, etc.) and the awareness and enforcement of explicit and sanctioned consequences for non-compliance can be measured intermediately.

Resource Development

Sustained funding streams for local efforts, for example, to adapt national campaigns, is much needed. Funding should be available for groups to test new ideas and should not be limited to evaluated programs. Jennifer Marguiles suggests that "funding is needed for both exploratory and evidence-based programs." Susan Sorenson emphasizes the need for multiyear funding for prevention: "One or two foundations doing something is not enough. There are so little funds for prevention of IPV. We need to build the infrastructure to sustain change, and that takes sustained resources."

Learning, Growing and Assessing to Refine the Strategy

The IPV prevention field needs to continue to learn and grow in areas such as framing and evaluation as well as build the broader research base to inform prevention.

Framing of IPV prevention for the public in a manner that can communicate urgency, hope, and patience is needed. Framing for the public is important because, according to Lisa Lederer, "Politicians won't do what the public won't support. We need to place priority on communicating hope and success and continue the energy to make change and keep going."

Research and evaluation is needed to build the evidence and practice base for primary prevention. Daniel Webster notes, "There are tons of research articles published about the problem of IPV, but very little on prevention."[45] Studies that can clearly inform prevention efforts, such as research on existing attitudes, behaviors and norms and the costs of IPV are needed. Secondary research can also be useful to further explore lessons from other prevention fields and analyze emerging information about promising primary prevention approaches. Jackie Campbell indicated that opportunities for research training for young investigators committed to this field are also needed.[46]

"The field needs to continue to make room for communities of color to lead..."

—Lupe R. Serrano, executive director Casa de Esperanza

As noted in the Institute of Medicine report, *Reducing the Burden of Injury*, very few IPV prevention efforts have been evaluated rigorously. Due to a number of factors (including the expense of evaluation, the bias of violence prevention evaluators for efforts that can be readily evaluated with the possibility of control groups, the bias toward linear strategies rather than multifaceted or multisector ones, and the relatively small number of efforts with the longevity and funding resources to be suitable for evaluation), for the most part, primary prevention programs that are evaluated tend to be singular programs that reach out to individuals (especially classroom-based curricula).[47] Rigorous evaluation of promising efforts is needed to build investment in primary prevention. Funders can provide greater support for evaluation and evidence building, as well as help to reframe measures of success.

Section 3

A Closer Look: Advancing IPV Primary Prevention in Immigrant Communities

The United States has a sizable immigrant population. In 2003 one out of nine persons in the United States was foreign-born[48] and according to 2000 census data, 20 percent of U.S. citizens had a foreign-born parent.[49] Immigrants from all over the world live in urban, suburban and rural communities across the country and are represented in all socioeconomic classes. There is no such thing as "the immigrant experience." Rather, the lives of immigrants are marked by considerable differences according to factors such as country of origin, motivations for emigration, length of time since immigration, and pervasiveness of racism and xenophobia encountered in the United States from the general public and from government systems. Due to these factors and RWJF interest in addressing health and social issues in immigrant communities, IPV primary prevention approaches in immigrant communities is briefly explored.

While IPV is present in all cultures, faiths, and socioeconomic classes, a focus on IPV prevention may be particularly warranted within communities that face disparities in multiple health and social indicators, such as low-income immigrant communities. Additionally, some immigrant communities may have higher rates of IPV. For example, based on a compilation of studies on domestic violence in various Asian communities, 41–60 percent of Asian women in the United States are estimated to experience domestic violence (physical and/or sexual) during their lifetime, suggesting an urgent need to address IPV in Asian communities, according to Chic Dabby.[50,51,*] However, it is important not to make generalizations about rates of IPV in specific Asian subgroups, let alone in immigrant communities as it may or may not be the case that a particular immigrant community has a higher rate of IPV compared to aggregate figures. What is consistently true is that immigrant communities, and in particular, low-income immigrant communities of color, face barriers to effectively addressing the issue.

Generally speaking, similar norms-change approaches described in this report can be applied within immigrant communities as long as the context, history and dynamics of the community are understood and addressed. Some of the context may involve issues related to language; legal status; isolation; racial, ethnic and/or religious discrimination; and fear and distrust of government systems, particularly law enforcement.[52] Mai Yang Moua notes that immigrant and refugee communities face a lot of issues adapting to a new environment while trying to retain their

"Ending IPV is about shifting norms in communities to support families and children in more nurturing ways. This is really about strategically supporting physical, mental, social and economic health and well-being of communities in an integrated way."

—Lupe R. Serrano, executive director Casa de Esperanza

* This estimate is based on studies of women's experiences of domestic violence conducted among different Asian ethnic groups in the United States; cited in the *Fact Sheet on Domestic Violence in API Communities* compiled by the Asian & Pacific Islander Communities compiled by the Asian & Pacific Islander Institute on Domestic Violence. The low end of the range is from a study by A. Raj and J. Silverman. "Intimate Partner Violence Against South-Asian Women in Greater Boston". *J Am Med Women's Assoc,* 57(2): 111–114, 2002. The high end of the range is from a study by M. Yoshihama, "Domestic Violence Against Women of Japanese Descent in Los Angeles: Two Methods of Estimating Prevalence." *Violence Against Women,* 5(8): 869–897, 1999.

culture.[53] Tensions, especially across generations, can arise when norms and values in the United States are discordant with those from the home country.

In many but not all immigrant communities, there is a conflicted relationship with law enforcement agencies. This conflicted relationship is one of many barriers faced by immigrants in interacting with government and helping systems in the United States. For example, according to Gail Pendleton, immigrants who are convicted of IPV are at risk for deportation. This creates a barrier for IPV victims to report or reach out for help. Jackie Campbell suggests that an over-reliance on criminal justice responses to IPV is problematic.[54]

Although some reliance on the criminal justice system may be necessary to counter gender power imbalances and create deterrents, alternatives to the criminal justice system are needed for primary prevention.[55] Mimi Kim suggests that the need for balanced power presents an opportunity for increased accountability through community rather than criminal justice sanctions against IPV.[56] "'It's against the law' is not a good primary prevention approach," reiterates Crystal Hayling.[57]

An additional issue is that other important concerns are apt to compete with IPV concerns and priorities in low-income immigrant communities. Daniel Webster notes that "on the one hand, immigrant communities may coalesce well given the current political climate. On the other hand, community leaders may feel they have 'bigger fish to fry' from external threats."[58] Oliver Williams and Leni Marin suggest that IPV initiatives need a strategy to become valued by the community in such a way that they are not seen as having a lesser priority than issues such as discrimination, housing and employment.[59,60] In fact, IPV is an issue with complex interrelationships with other vital community issues. Williams suggests, "Our message to largely poor communities of color must be that prevention of IPV contributes to healthy families and communities and is not a side issue."

An example of this interplay was pointed out by Gail Pendleton who highlighted the co-occurrence of workplace violence and exploitation and IPV among many of the low-income immigrants of color she works with. *ASISTA*, a collaborative technical assistance project addressing the intersection between immigration and domestic violence law, acknowledges that "the drive for dignity and self-respect are the core values that link prevention of all kinds of violence, abuse and oppression" and addresses IPV as part of a continuum of violence that is related to workplace violence. According to Lisa Lederer, *Líderes Campesinas*, a project with migrant farm work women in Southern California, also recognized that workplace issues were a big concern and effectively created a *Safe at Home and Safe at Work* campaign.[61]

"Slowly but surely, understanding towards prevention has changed. There are more people who are aware of its importance and want to do something."

—Crystal Hayling, president and CEO Blue Shield of California Foundation

Environmental Strategy and Norms-Change Approaches in Immigrant Communities

Strategies that are effective in changing environments and norms are the same in immigrant communities as in any other community. That is to say, successful primary prevention in immigrant communities will also require reframing the desired outcome as healthy behavior and healthy communities and fostering comprehensive and multidisciplinary prevention. Amy Sanchez remarked, "It's a mistake to think that all you need is one outreach coordinator. Immigrant communities require deep change too." She suggests that any primary prevention effort needs to be tailored to the uniqueness in each community, whether it is an immigrant community or not.

Reframing the Desired Outcome as Healthy Behavior and Healthy Communities

Reframing prevention as building healthy relationships and healthy communities through new narratives and a positive approach can honor culture and foster community resilience and cultural pride.

- *New Narratives Can Honor Culture and Foster Community Resilience*

  New narratives can be all the more important in marginalized communities, including immigrant communities of color, who face historic and current discrimination and harmful stereotypes entrenched in dominant U.S. society. For communities with histories of colonization, Ricardo Carrillo suggests that narratives can help the community relate to their traditional roots: "In today's world, we are told to hold our cell phones more sacred than our relationships. But Latino communities have a rich history of resilience and stories of sacred relationships and honorable manhood that have been passed through generations." This narrative approach was used in Ramsey County, Minnesota with the *Who Will I Become?* video, which chronicles the lives of several Hmong immigrants who have grown up in the United States surviving many challenges to become community leaders, business people and elected officials.

- *Positive Approaches Can Build Cultural Pride*

  A positive approach to engaging people and organizations as partners can be particularly important in communities that face discrimination and stigma from the larger dominant culture. Such communities may defend against and deny suggestions that IPV is a problem as a protective mechanism against further stigmatization. A positive approach to engaging immigrant communities in IPV prevention can build, rather than threaten community pride. For example, the *National Compadres Network* (NCN) seeks to strengthen the traditional extended family system and encourage the positive involvement of Latino males as fathers, sons, grandfathers, brothers, compadres, partners, and mentors in their families and community. At community forums, workshops, conferences, and recognition ceremonies, NCN addresses IPV and fosters Latino cultural pride through intergenerational dialogue about being "honorable men" in *Circulos de Hombres* (men's circles).[62]

"We are poised for change. There is a readiness and openness for change. We need to train a new generation of leaders who think differently...."

—Dennis J. Hunt, licensed clinical psychologist and executive director, Center for Multicultural Human Services

Foster Comprehensive and Multidisciplinary Prevention

Comprehensive and multidisciplinary prevention is critical in immigrant communities, not only as a means by which to influence environments and norms toward prevention, but also to reduce the overall structural and systemic barriers immigrants often face in matters including housing, education, employment, and health care, which exacerbate the IPV problem.

- *Influence Policy and Legislation*

  Policy change in IPV intervention is already improving the situation for immigrant victims of IPV. A 2005 study by the U.S. Department of Justice found that rates of family violence* declined by about half from 1993 to 2002,[63] suggesting, says Esta Soler, that "the resources we have put into services and solutions through VAWA and other initiatives are beginning to work." Title VIII of the 2005 VAWA improves and expands the immigration protections for battered women. Securing housing, navigating legal issues and obtaining economic independence can be complicated for immigrant families. Policy change can help to address the specific needs of immigrant communities. For example, immigrant women who face barriers in securing drivers licenses will have less independence and mobility for taking care of basic needs and escaping potentially harmful situations. Policy change can also help to address the fundamental structural and systemic barriers that immigrant communities face that contribute to IPV. For example, efforts could focus on compliance with the Equal Pay Act, establishing a living wage, improving working conditions and enabling immigrants to obtain drivers licenses more easily.

- *Change the Practices of Organizations*

  In immigrant communities, as in other communities, it is important that organizational practice change involve mainstream systems, as well as community systems. The practices of community organizations such as faith institutions, small businesses and other associations can have a dramatic impact on community norms related to IPV. For example, in the Hmong community in Minnesota, systems change means engaging the Hmong clan system and working with them to adopt and sustain practices to foster communities free from IPV.[64] Many practitioners report that cultural and religious institutions can be particularly effective in promoting healthy relationships and community responsibility for IPV prevention.[65] Organizational practice change must also occur within mainstream institutions. For example, organizations should ensure that their practices are welcoming of, and not discriminatory toward, immigrants. Services should be made accessible in multiple languages and agencies should ensure that their programs and services are culturally sensitive.

"There are so little funds for prevention of IPV. We need to build the infrastructure to sustain change, and that takes sustained resources."

—Susan B.. Sorenson, professor University of Pennsylvania

* In this study, family violence is defined to include abuse by current or former spouses, child abuse and abuse by another family member. Crime between current or former boyfriends and girlfriends is defined as "non-family" violence.

- *Foster Coalitions and Networks*

Successful IPV prevention efforts in immigrant communities, as in other communities, have begun by identifying and engaging stakeholders and, as stated by Oliver Williams, "getting the issue valued in the community." [66]

Partnerships within community systems

Partnerships within community systems are extremely important in addressing IPV within communities that may turn primarily to indigenous leaders and community-based organizations to address issues rather than institutions for the general public.[67] To reach more isolated groups, such as lesbian, gay, bisexual, and transgender immigrants, the need to work through trusted networks and associations is even greater.[68] Working within coalitions and networks at the community level involves listening and being responsive to the community and helping to mobilize and support community partners in enacting change. At *Casa de Esperanza*, community partnerships are rooted in the value of reciprocity. This means that, according to Amy Sanchez, "No one at Casa says 'we know what Latinas want.'" Rather, when women in the community said that they needed driver's licenses to be safe and independent, Casa partnered to work on that.

Partnerships across related health and social issues

Lupe Serrano suggests that partnerships with economic, housing and other community development efforts are necessary: "Ending IPV is about shifting norms in communities to support families and children in more nurturing ways. This is really about strategically supporting physical, mental, social, and economic health and well-being of communities in an integrated way." [69]

Fostering new organizations and leaders

It may turn out that some necessary partners or leaders are missing from a community effort or need to be strengthened. Therefore, a coalition approach may involve helping to create an institution within the community that can serve as an anchor and remain invested in addressing IPV.[70] It may also involve fostering greater community leadership on the issue from both women and men. According to Mimi Kim, leadership among women can be especially important in early stages of an IPV initiative to carry forward a commitment to the well-being of women.[71] Kim emphasizes that consistency in leadership is important: "We need leadership that really understands the issues and has a commitment to long term relationship building."

Partnerships with groups outside of the community

While it is important that local communities respond to the unique strengths and needs in their area, culturally-specific IPV efforts can also partner with national organizations and tailor broader campaigns to meet local needs. Lisa Lederer notes that community leaders may sometimes need to be convinced of the need to collaborate outside of the community: "It's important to encourage grassroots groups to also communicate outside their circle in ways that can bring in funding, influence with lawmakers and other resources." [72]

"Politicians won't do what the public won't support. We need to place priority on communicating hope and success and continue to make change and keep going."

—Lisa Lederer, president PR Solutions, Inc.

Specific Next Steps

THE NATIONAL Poised for Prevention convening served as a call for significant coordinated action to build momentum for primary prevention of IPV. The recommendations in this report are substantial but not impossible. The following immediate steps should be considered toward achieving the recommendations outlined for the general community as well as for immigrant communities:

1. Work with others to promote primary prevention strategies at the national, state, and local levels.
2. Additional IPV primary prevention leadership trainings are needed to prepare a new cadre of promising leaders from multiple sectors, including curricula for care providers.
3. Form a funders working group, building on the work of funders who participated in the Poised for Prevention convening, to coordinate initiatives and foster collaboration.
4. Develop "Profiles of IPV Primary Prevention," an online database of strategies for IPV primary prevention on a local level, including current research, model policies and programs, hands-on tools, articles and other publications, and other tools to communicate the feasibility of prevention and provide user-friendly resources to support practice.
5. As evidence-based practices emerge, develop a training and technical assistance project to offer assistance with initiative development, coalition building, policy advocacy, framing, and evaluation to aid innovative and emerging initiatives.
6. Disseminate learnings and findings from the Poised for Prevention convening through peer-reviewed and non peer-reviewed channels to increase understanding of primary prevention and generate interest in moving IPV primary prevention forward.

Conclusion

THE IPV movement is poised for a greater emphasis on, and an expanded notion of, prevention. A new focus on healthy behaviors and communities through comprehensive and multidisciplinary prevention is needed. In the words of the remarkable leader, Dr. Martin Luther King Jr.: "In the end, we will remember not the words of our enemies, but the silence of our friends." Leadership among key stakeholders can generate a significant level of commitment and investment in primary prevention and signal a turning point at this historic juncture to collectively advance efforts from "poised" to "actualizing" prevention, and ultimately, to a much needed dramatic reduction in rates of IPV.

"In the end, we will remember not the words of our enemies, but the silence of our friends."

—Dr. Martin Luther King Jr.

Endnotes

1 Steinem, Gloria. "A 21st Century Feminism" (The Commonwealth Club of California Speech, February 13, 2002). Available at *https://commonwealthclub.org/archive/02/02-02steinem-speech.html*.

2 Cohen L, Davis R and Graffunder C. "Before It Occurs: Primary Prevention of Intimate Partner Violence and Abuse." In *The Physician's Guide to Intimate Partner Violence and Abuse*, Volcano, CA: Volcano Press, 2006.

3 ibid.

4 Thomson G. "Domestic Violence." In *Encyclopedia of Public Health*, Breslow L (ed.), 2002. eNotes.com., Nov 2, 2006. Available at *http://health.enotes.com/public-health-encyclopedia/domestic-violence*.

5 Cohen et al.

6 ibid.

7 Albee GW. "Psychopathology, Prevention, and the Just Society." *Journal of Primary Prevention*, 4: 5–40, 1983.

8 Holder HD. "Prevention Aimed at the Environment." In *Addictions: A Comprehensive Guidebook*, McCrady BS and Epstein EE (eds.) New York: Oxford University Press, 1999.

9 "A Social Environmental Approach to Health and Health Interventions." In *Promoting Health: Intervention Strategies from Social and Behavioral Research*. Smedley BD and Syme SL (eds.) Washington: National Academy Press, 2000.

10 Culross P, Cohen L, Wolfe A, et al. *Creating Safe Environments: Violence Prevention Strategies and Programs*. Oakland, CA: Prevention Institute, 2006.

11 Cohen et al.

12 Department of Health and Human Services. Centers for Disease Control and Prevention. *CDC Injury Research Agenda*. Atlanta: National Center for Injury Prevention and Control, 2002.

13 Cohen et al.

14 Center for the Study of Sport in Society. *Mentors in Violence Prevention*. Available at *www.sportinsociety.org/vpd/mvp.php*.

15 Mujeres Unidas Y Activas. Available at *www.mujeresunidas.net*.

16 Williams O, personal communication, July 6, 2006.

17 ibid.

18 ibid.

19 Marin L, personal communication, July 6, 2006.

20 *Intimate Partner Violence: Fact Sheet*. Available at *www.cdc.gov/ncipc/factsheets/ipvfacts.htm*.

21 National Institutes of Justice. *When Violence Hits Home: How Economics and Neighborhood Play a Role*, 2004. Available at *www.ojp.usdoj.gov/nij/pubs-sum/205004.htm*.

22 Jewkes R. "Intimate Partner Violence: Causes and Prevention." *The Lancet 2002*, 359: 1423–29, 2002.

23 Cohen et al.

24 Manal A. *The Built Environment and Health: 11 Profiles of Neighborhood Transformation*. Oakland, CA: Prevention Institute, 2004.

25 *Expect Respect*. Available at *www.expect-respect.org.nz/*.

26 Ramsey County Public Health Department. *Sexual Violence Prevention*. Available at *www.co.ramsey.mn.us/ph/hb/initiative_sexual_violence_prevention.htm*.

27 Gover AR, MacDonald JM, Alpert GP. "Combating Domestic Violence: Findings from an Evaluation of a Local Domestic Violence Court." *Criminology & Public Policy*, 3: 109–132, 2003.

28 California Department of Health Services. *Adult Smoking*. Sacramento, CA: Tobacco Control Section, 2005.

29 Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. *Domestic Violence Prevention Enhancement and Leadership Through Alliances*. Available at *www.cdc.gov/ncipc/DELTA/default.htm*.

30 Verizon Wireless. *HopeLine*. Available at *http://aboutus.vzw.com/communityservice/hopeLine.html*.

31 Liz Claiborne. *Love is Not Abuse*. Available at *www.loveisnotabuse.com/*.

32 Institute for Public Strategies. *Advocating Responsibility in Sex-Themed Alcohol Ads*. National City, CA, 2002. Available at: *www.publicstrategies.org/pdfs/sdcw_june_02_ads.pdf#search =%22the%20dangerous%20promises%20campaign%20alcohol%20ads%22*.

33 Williams O, personal communication, July 6, 2006.

34 SAMHSA Model Programs. *Safe Dates*. Available at *www.modelprograms.samhsa.gov/template_cf.cfm?page=model&pkProgramID=228*.

35 *The Fourth R: Relationship Based Violence Prevention*. Available at *www.thefourthr.ca*.

36 Campbell J, personal communication, June 22, 2006.

37 Ramsey County Public Health Department. *Men's Messages Action Team*. Available at *www.co.ramsey.mn.us/ph/hb/initiative_mens_messages_action_team.htm*.

38 Department of Health and Human Services. Centers for Disease Control and Prevention. *CDC Injury Research Agenda*. Atlanta: National Center for Injury Prevention and Control, 2002.

39 Wolfe DA and Jaffe PG. *Prevention of Domestic Violence and Sexual Assault*. National Electronic Network on Violence Against Women, 2003.

40 Family Violence Prevention Fund. *VAWA Prevent: Adding Prevention to the New Violence Against Women Act*. Available at *www.endabuse.org/vawa/display.php?DocID=34003*.

41 Family Violence Prevention Fund. *The Facts on Reproductive Health and Violence Against Women*. Available at *www.endabuse.org/resources/facts/ReproductiveHealth.pdf*.

42 Serrano L, personal communication, July 19, 2006.

43 Family Violence Prevention Fund. *National Network to End Violence Against Immigrant Women*. Available at *www.endabuse.org/programs/display.php3?DocID=115*.

44 Williams O, personal communication, July 6, 2006.

45 Webster D, personal communication, June 21, 2006.

46 Campbell J, personal communication, June 22, 2006.

47 Culross P et al.

48 Larsen, LJ. *The Foreign-Born Population in the United States: 2003*. Current Population Reports, P20–551, Washington: U.S. Census Bureau, 2004.

49 Schmidley A and Dianne. *Profile of the Foreign-Born Population in the United States: 2000*. Current Population Reports, Series P23–206, Washington: U.S. Census Bureau, 2001.

50 Asian & Pacific Islander Institute on Domestic Violence. *Fact Sheet: Domestic Violence in Asian Communities*. Available at *www.apiahf.org/apidvinstitute/PDF/Fact_Sheet.pdf*.

51 University of Michigan, School of Social Work and the Asian & Pacific Islander Institute on Domestic Violence [Submitted to the National Institute of Justice]. *Justice System Responses to Intimate Partner Violence in Asian Communities*, 2005. Available at *http://capa-mi.org/pdf_files/2006_pdf/nij_abstract0604.pdf*.

52 Personal communications, June 20–August 21, 2006.

53 Moua M, personal communication, July 18, 2006.

54 Campbell J, personal communication, June 22, 2006.

55 Personal communications, June 20–August 21, 2006.

56 Kim M, personal communication, July 6, 2006.

57 Hayling C, personal communication, July 31, 2006.

58 Webster D, personal communication, June 21, 2006.

59 Williams O, personal communication, July 6, 2006.

60 Marin L, personal communication, July 6, 2006.

61 Lederer L, personal communication, August 3, 2006.

62 National Compadres Network. Available at *www.nationalcompadresnetwork.com/ ncn/index.php*.

63 Bureau of Justice Statistics. *Family Justice Statistics: Including Statistics on Strangers and Acquaintances*. Available at *www.ojp.usdoj.gov/bjs/abstract/fvs.htm*.

64 Ramsey County Public Health Department. *Hmoob ThajYeeb* (Hmong Peace). Available at *www.co.ramsey.mn.us/ph/hb/initiative_hmong_peace.htm*.

65 Warrier S. *Culture Handbook*. San Francisco: Family Violence Prevention Fund, 2005.
66 Williams O, personal communication, July 6, 2006.
67 Kim M, personal communication, July 6, 2006.
68 Utarti H, personal communication, July 14, 2006.
69 Serrano L, personal communication, July 19, 2006.
70 Kim M, personal communication, July 6, 2006.
71 Kim M, personal communication, July 6, 2006.
72 Lederer L, personal communication, August 3, 2006.

Appendix A

Convening Participants

1 Jacquelyn C. Campbell, *professor*, Johns Hopkins University, School of Nursing.

2 Yvonne Carrasco, *director*, Blue Shield Against Violence.

3 Ricardo Antonio Carrillo, *consultant*.

4 Larry Cohen, *executive director*, Prevention Institute.

5 Lissette Flores, *program coordinator*, Prevention Institute.

6 Lisa Fujie Parks, *program manager*, Prevention Institute.

7 Donald Gault, Healthy Communities *section manager*, Saint Paul–Ramsey County Department of Public Health.

8 Corinne Graffunder, *chief*, Program Implementation and Dissemination Branch, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

9 Jeane Ann Grisso, *senior program officer*, Robert Wood Johnson Foundation.

10 Crystal Hayling, *president* and *CEO*, Blue Shield of California Foundation.

11 Dennis J. Hunt, licensed clinical psychologist, *executive director*, Center for Multicultural Human Services.

12 Nicole Kravitz-Wirtz, *administrative assistant*, Prevention Institute.

13 Lisa Lederer, *president*, PR Solutions, Inc.

14 Debra Lewis, *manager of Public Affairs and Corporate Communications*,Verizon Wireless.

15 Jane Isaacs Lowe, *senior program officer*, Robert Wood Johnson Foundation.

16 Leni Marin, *managing director*, Family Violence Prevention Fund.

17 Jim S. Marks, *senior vice president and director*, Health Group, Robert Wood Johnson Foundation.

18 Don McPherson, *founder and executive director*, Adelphi University, Sports Leadership Institute.

19 Gail Pendleton, National Network to End Violence Against Immigrant Women, ASISTA.

20 Keshia M. Pollack, *assistant professor*, Department of Health Policy and Management, Johns Hopkins University, Bloomberg School of Public Health.

21 Amy Sánchez, *director* of Fund Development and Communications, Casa de Esperanza.

22 Esta Soler, *executive director*, Family Violence Prevention Fund.

23 Susan B. Sorenson, *professor*, University of Pennsylvania.

24 Daniel W. Webster, *associate professor and co-director*, Center for Gun Policy and Research, Johns Hopkins University, Bloomberg School of Public Health.

25 Oliver J. Williams, *executive director*, Institute on Domestic Violence in the African American Community.

26 Wendy L. Yallowitz, *program officer*, Robert Wood Johnson Foundation.

Appendix B

Interviewees

1 Sriram Ananthanarayanan, *outreach coordinator*, Asian Task Force Against Domestic Violence, Boston, MA

2 Carole Angel, *staff attorney*, Immigrant Women Program, Legal Momentum: Advancing Women's Rights, Washington, DC.

3 Jacquelyn C. Campbell, *professor*, School of Nursing, Johns Hopkins University, Baltimore, MD.

4 Firoza Chic Dabby-Chinoy, *institute director*, Asian & Pacific Islander Institute on Domestic Violence, San Francisco, CA.

5 Donald Gault, *manager*, Healthy Communities Section, Saint Paul-Ramsey County Department of Public Health, St. Paul, MN.

6 Cheryl Gee, *paralegal/domestic violence advocate*, Farmworker Legal Services of New York, Inc, Rochester, NY.

7 Crystal Hayling, *president* and *CEO*, and Yvonne Carrasco, *director*, Blue Shield Against Violence, Blue Shield of California Foundation, San Francisco, CA.

8 Lynette Hopson, DELTA & *training events coordinator*, Virginia Sexual and Domestic Violence Action Alliance, Charlottesville, VA.

9 Denis Hunt, PhD, *executive director*, Center for Multicultural Human Services, Falls Church, VA.

10 Jackson Katz, *director*, Mentors in Violence Prevention, Long Beach, CA.

11 Mimi Kim, *executive director*, Creative Interventions, Oakland, CA.

12 Lisa Lederer, *president*, PR Solutions, Washington, DC.

13 Leni Marin, *managing director*, Family Violence Prevention Fund, San Francisco, CA.

14 Jennifer Marguiles, *community organizing coordinator*, Texas Council on Family Violence, Austin, TX.

15 Don McPherson, *founder & executive director*, Sports Leadership Institute, Garden City, NY.

16 Lucy Melvin, *public policy specialist*, National Network to End Domestic Violence, Washington, DC.

17 Mai Yang Moua, *public health educator*, Hmoob ThajYeeb (Hmong Peace), Saint Paul-Ramsey County Department of Public Health, St. Paul, MN.

18 Gail Pendleton, *co-director*, ASISTA, Des Moines, IA.

19 Jane Randel, *vice-president*, and Dana Stambaugh, *director*, Corporate Communications, Love Is Not Abuse, Liz Claiborne, Inc., New York, NY.

20 Lupe R. Serrano, *executive director*, Casa de Esperanza, St. Paul, MN.

21 Esta Soler, *executive director*, Family Violence Prevention Fund, San Francisco, CA.

22 Aimee Thompson, *executive director*, Close to Home, Dorchester, MA.

23 Hediana Utarti, *coordinator*, Volunteer Program and Queer Asian Women's Services Program, Asian Women's Shelter, San Francisco, CA.

24 Daniel Webster, *associate professor & co-director*, Johns Hopkins Center for Gun Policy and Research, Department of Health Policy and Management at Johns Hopkins Bloomberg School of Public Health, Baltimore, MD.

25 Kim Wells, *executive director*, Corporate Alliance to End Partner Violence, Bloomington, IL.

26 Oliver Williams, Ph.D., *executive director*, Institute on Domestic Violence in the African American Community, Saint Paul, MN.

Robert Wood Johnson
Foundation

Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543-2316
www.rwjf.org

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