Handbook for the documentation of interpersonal violence prevention programmes

WORLD HEALTH ORGANIZATION

GENEVA

2004

Contents

Acronyms

CDC   Centers for Disease Control and Prevention

GDP   Gross domestic product

HDI   Human Development Index

HIC   High income countries

HIV   Human immunodeficiency virus

LIC   Low income countries

LMIC Low and middle income countries

NGO Nongovernmental organization

STD   Sexually transmitted disease

UN   United Nations

WHO World Health Organization

Foreword

Over the past decades, we have been exposed almost daily to terrible images of human misery caused by deadly conflicts in Iraq, East Timor, Sierra Leone, Kosovo, Rwanda, and Democratic Republic of the Congo. The mass graves, mass rapes, and exodus of people are the most visible part of the "iceberg of violence". More discreet, but widespread, is the relentless daily suffering of children who are abused by their caregivers, women victimized by partners, elderly persons maltreated by caregivers, and youths who cannot attend school or go about their daily activities without risk of being threatened, beaten or shot. Public health is increasingly taking a stand against accepting violence as an inevitable part of the modern world and is taking action to prevent it. This handbook represents one initiative arising out of a campaign to stop violence, more specifically to halt interpersonal violence.

Interpersonal violence includes child maltreatment, intimate partner violence, sexual violence, youth violence and elder abuse. It takes place in the home, on the streets and in other public settings, in the workplace and in institutions such as schools, hospitals and residential care facilities. In the year 2000, homicides arising from interpersonal violence accounted for a global total of 520 000 deaths. Every death was accompanied by many more non-fatal cases, many requiring emergency medical treatment and a significant proportion resulting in longer term physical and mental health consequences. The direct costs of treating such injuries and their health consequences, and the indirect costs of lost productivity, represent an enormous economic burden to victims, families and society at large. Among these are the large indirect and human costs resulting from damage to the social fabric of communities.

In response to this problem, governments, non-governmental organizations and communities around the world are actively attempting to prevent interpersonal violence, and international agencies increasingly are providing financial, technical and policy support to strengthen prevention activities and make them more effective. For example, the *World report on violence and health*, published in October 2002 by the World Health Organization (WHO), included nine recommendations for violence prevention, and the World Health Assembly, African Union and World Medical Association have all adopted resolutions encouraging members to implement these recommendations.

This heightened awareness about the need to prevent interpersonal violence has brought with it the recognition that at local, national, regional and international levels there are serious gaps in our knowledge about prevention programmes. For instance, few countries have any systematic knowledge of how many prevention programmes operate in their different regions, what types of interpersonal violence and risk factors are addressed, which target populations these programmes serve, what intervention strategies they employ and how the programmes attempt to measure and monitor the effectiveness of their work. Such information is critical to strengthening interpersonal violence prevention capacity and improving its effectiveness by

identifying and reinforcing programmes that deliver proven and promising interventions, and ensuring that different programmes have consistent goals and methods so that they support each other's efforts.

To fill this information gap about interpersonal violence prevention activities, WHO's Injuries and Violence Prevention Department has developed this handbook for the systematic collection of information about interpersonal violence prevention programmes from diverse settings. The handbook aims to capture information about all types of programmes, irrespective of the type of interpersonal violence they deal with, the intervention strategies employed, the level at which they seek to intervene (i.e. individual, relational, community, societal), or the stage of development of the programme. It is applicable to programmes with or without formal mechanisms for monitoring, evaluating and documenting their effects.

Widespread application of this handbook, both in low-to-middle and high income societies, will do much to advance the interpersonal violence prevention field by making visible the important but unseen – and hence largely unacknowledged – work of prevention practitioners everywhere. We therefore encourage all agencies with an interest in strengthening interpersonal violence prevention capacity, to implement the handbook. This will make programmes more visible to policy-makers, donors and other violence prevention practitioners. In addition, the documentation process will assist individual programmes to strengthen their focus, seek to establish mutual goals, share intervention strategies and enable better coordination.

Etienne Krug
Director
Department of Injuries and Violence Prevention
World Health Organization
Geneva

Editorial committee and project team

University of South Africa (UNISA) and Medical Research Council (MRC), Crime, Violence and Injury Lead Programme

Sandra Marais

Mohamed Seedat

Health Policy Unit London School of Hygiene and Tropical Medicine

Dinesh Sethi

Jo Nurse

Injuries and Violence Prevention Department World Health Organization (WHO)

Alexander Butchart

Acknowledgements

We are grateful to the following advisors:

Naeema Abrahams – MRC, South Africa

Nancy Cardia – Centre for the Study of Violence, University of São Paulo, Brazil

Linda L. Dahlberg – Centers for Disease Control and Prevention, USA

Claudia Garcia-Moreno – WHO, Switzerland

Guru Gururaj – National Institute of Mental Health and Neuro-Sciences, India

Johann Mouton – University of Stellenbosch, South Africa

Ashley van Niekerk – MRC–UNISA Crime, Violence and Injury Lead Programme, South Africa

Alison Phinney – WHO, Switzerland

Ulla Salomäki – University of Helsinki, Finland

Garth Stevens – UNISA Institute for Social and Health Sciences, South Africa

Andrés Villaveces – WHO, Switzerland

Suggested citation

Sethi D, Marais S, Seedat M, Nurse J, Butchart A. *Handbook for the documentation of interpersonal violence prevention programmes*. Department of Injuries and Violence Prevention, World Health Organization, Geneva, 2004.

Executive summary

Rationale. Interpersonal violence is a leading cause of premature death and burden of disease. The little that is known about programmes for the prevention of violence is not widely shared. The purpose of this project is to systematically describe and compare interpersonal violence prevention programmes. The objective in doing so is to establish baseline information with respect to the prevention aims, target groups, intervention strategies and efforts at evaluation on the part of current programmes at the levels of communities and countries. This information can be used to facilitate efforts at strengthening interpersonal violence prevention programming by supporting programmes of promising and proven effectiveness and encouraging the development of new programmes to fill any prevention gaps that may be identified.

Aims. This handbook presents a framework and methodology for the identification, classification and documentation of programmes for interpersonal violence prevention. Documentation includes information on whether or not these programmes have been formally evaluated.

Methods. To inform the handbook design, a review of the published and grey literature was undertaken, a workshop was held to develop themes from the literature, and advice was taken from a number of experts in the field of violence prevention.

Target audience. The handbook is meant for: (a) implementation by violence prevention experts who will be contracted by WHO to identify and document violence prevention programmes; (b) use by practitioners in violence prevention programmes who may want to systematically document their programme and other programmes in their community, region or country, using the explicit criteria in the handbook.

Ethical considerations. In undertaking any work for this project, it is critical to ensure that the safety and livelihood of those involved in a documented programme are not compromised. It is important to clarify that the handbook is non-judgemental and is intended only to assist with the systematic documentation of violence prevention programmes, so that the resulting descriptions can be made available for others wishing to learn from them.

Definition of violence. The WHO has defined violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation". This handbook is concerned with interpersonal violence only, which encompasses violent behaviours that occur between individuals but are not planned by any social or political groups in which they participate.

What is a violence prevention programme? In this handbook a programme refers to a series of inter-related preventive activities, interventions or projects designed to reduce the level of interpersonal violence. The scope of the handbook is restricted to the identification and description of primary and secondary prevention programmes.

How is the information presented? The background to the subject and rationale for the handbook are introduced in **Chapter 1**. The public health

approach is presented in **Chapter 2** as the underpinning framework for violence prevention activities. Its four logical steps (defining the problem; identification of risk and protective factors; development and evaluation of interventions; and implementation) are discussed. The ecological model used in the *World report on violence and health* (Krug et al., 2002) is presented as a way of organizing the underlying risk factors for violence and the interventions that might be used to target these at the different levels of the model. The rationale for conducting systematic descriptive evaluations is then discussed followed by the criteria for the identification of violence prevention programmes.

Chapter 3 provides information on the actual process of documenting violence prevention programmes with advice on how the documenters should go about the task. Much of the chapter is devoted to item-by-item notes on how to complete the pro-forma *Instrument* for documenting data from individual programmes, which is included as Appendix I in an easily copied format.

The first part of **Appendix I** describes the *programme characteristics*: general identifying information; the geography and scope; the type of interpersonal violence; the types of intervention; the target populations; the level of preventive activities; the resources available, and the intensity of the activities. The second part includes items requesting details of how the programme attempts to evaluate itself. These items have been divided into information on programme planning, documentation of the implementation process and the outcomes of the programme, and whether these outcomes have been formally evaluated or not.

Appendix II is a model letter for use in identifying violence prevention programmes for possible documentation. The letter is designed to request information from individuals with a knowledge of programmes active in their country, province or community, so that an initial listing of known programmes can be drawn up, and from this a representative sample of programmes selected for fuller documentation.

1. Aims, scope and purpose of handbook

1.1 Background

Global mortality data for the year 2000 show that approximately 5 million people died from injuries, of whom an estimated 1.6 million died as a result of self-inflicted, interpersonal or collective violence. This amounts to an overall age-adjusted rate of 28.8 per 100 000 population. Of these violent deaths, 18% were due to war, 31.3% resulted from homicides, and 49.1% were suicides. Violent deaths in low-to-middle income countries (LMIC), which are mainly from homicides and war, occur at over twice the rate of those in high income countries (HIC), where suicide predominates (Krug et al., 2002). In LMIC there are a greater number and variety of hazards that expose inhabitants to violent death, but these countries have fewer resources for violence prevention, treatment of the resulting injuries and rehabilitation of people exposed to violence. Further, within-country differences show that the highest rates of violence tend to occur in the poorest communities with the fewest resources to cope with the financial, social and psychological strains produced by the resulting deaths and disabilities (Krug, 1999).

Fatalities represent only a fraction of the full violence problem, as there are many non-fatal cases for every death due to violence. Physical and sexual assaults occur daily, but precise national and international estimates are lacking, partly because of under-reporting. Much of what is known about non-fatal violence comes from special population-based surveys (Krug et al., 2002). While deaths and non-fatal injuries due to violence affect people of all ages from all walks of life, the majority of victims and perpetrators for homicides are aged between 15 and 40 years. This age range spans the period of greatest economic productivity, and for every one of the thousands of millions of dollars spent on direct medical care for victims of violence, many more financial resources are lost due to indirect factors such as time away from work and disruption of family routines. Clearly these are scarce resources, particularly in LMIC settings.

The root causes of violence and the majority of its consequences are located across different levels of society involving many individual, social, economic and political factors. Violence prevention work is therefore conducted at different levels by a range of international, national, local government and civic groups: the United Nations (UN), world economic agencies, human rights organizations, national governments, non-governmental agencies, local self-help groups, and concerned individuals, all of which have initiated prevention activities.

Some of the outstanding successes in preventing violence have been well documented whereas others, particularly those in LMIC settings, lack proper records. In view of the numerous and varied types of prevention programmes, a systematic methodology is required to document and collect descriptions of applied violence prevention programmes, so that a clear understanding in respect of prevention targets, interventions and the extent to which programmes try to evaluate themselves can be obtained at community, regional and national levels.

In this handbook, we present a framework and methodology for documenting and collating programmes for the prevention of interpersonal violence. We designed the handbook ultimately to enable the

development of a database, which will include violence prevention programmes from both HIC and LMIC settings.

1.2 Sources of information and methods

To inform the handbook, a review of the published and grey literature was undertaken using the following databases: Cochrane Controlled Trial Register, MEDLINE, EMBASE, CINAHL, CAB Abstracts, pyschinfo, social science search, PubMed, POPLINE, and the National Research Register. Over 2000 abstracts were identified and key articles were obtained which have been referenced in this handbook. Further searches for grey literature were conducted on the Internet, using Google and Alta Vista search engines. Grey literature searches were also conducted through the South African Studies Database and the African Health Anthology Database. Experts were contacted by e-mail to identify any unpublished work, and WHO collaborating centres and regional violence and injury prevention networks were used to identify additional literature from LMIC contexts. The literature review was used to generate definitions of violence and prevention, and identification criteria for prevention programmes.

A system for classifying such programmes was drawn up based on key dimensions in respect of organization, intervention type and target groups. Criteria for classifying interpersonal violence prevention programmes were formulated according to their internal consistency, social and ethical considerations.

Instructions for handbook users were developed by a panel of experts with experience of research in both HIC and LMIC settings. It was considered essential for the instrument to be inclusive and to capture the multilevel determinants of violence and the varied prevention programmes needed to address these different levels in settings ranging from very low-resource contexts to wealthy, high-resource settings. The handbook was also reviewed by an international expert group with experience in initiating and evaluating programmes in the field.

1.3 Objectives of the handbook

This handbook presents a framework and methodology for the identification, classification and documentation of programmes for interpersonal violence prevention. This consists of a standard set of indicators, which include whether and how a specific programme has been or is being evaluated.

The specific objectives of the handbook are to:

- specify criteria for the identification of interpersonal violence prevention programmes;

- specify a system for classifying these programmes;

- specify criteria for assessing whether programmes have been evaluated and, if so, how;

- provide a stepwise framework for the identification of potential programmes;

- provide instructions for the selection of programmes for documentation;

- provide instructions on how to document these programmes.

1.4 Purposes of the project to document interpersonal violence prevention programmes

The *first purpose* of this project is to provide easy access to existing knowledge and experience from violence prevention programmes in countries and contexts where many such programmes exist but few are systematically described in writing. As such, it is hoped that the handbook will also assist countries in meeting their commitments in terms of the year 2003 World Health Assembly resolution 56.24 on implementing the recommendations of the *World report on violence and health* (World Health Assembly, 2003). This resolution "encourages Member States to prepare… a report on violence and violence prevention that describes the magnitude of the problem, the risk factors, current efforts to prevent violence and future action to encourage a multisectoral response".

Prevention practitioners can learn from the experiences and successes of others, and so accelerate the development of their own programmes.

The *second purpose* of this project is therefore to help identify programmes that have been proven to be effective or which have a strong likelihood of being effective for use in advocacy and policy formulation by their dissemination. It is anticipated that this purpose will be served through the ultimate creation of databases at global, regional, and national levels.

The *third purpose* is to provide programme managers with some guidelines and criteria against which they can evaluate their own interventions. Many of the programmes for violence prevention that show evidence of effectiveness are from high-income countries. The appropriateness of transferring them to low-income countries would need to be considered carefully because of the different contexts. There is a lack of data about programmes, both with and without evidence of effectiveness, from low-income countries, and consequently a need to develop this database, so as to capture programmes from diverse socioeconomic, geographical and cultural settings. The handbook thus contains clear instructions on how to proceed with the task of identifying interpersonal violence prevention programmes and collating information on these using the prescribed framework.

1.5 Who is the handbook for?

The handbook is intended for use by two main target groups. The first group consists of individuals specifically contracted by WHO to identify and document interpersonal violence prevention programmes in their countries, so as to contribute to the development of national, regional and global compilations of violence prevention programmes. These may be violence prevention practitioners located in WHO's collaborating centres and other regional violence and injury prevention networks (e.g. Injury Prevention Initiative for Africa, Inter-American Coalition for the Prevention of Violence).

The second group consists of violence prevention practitioners working in individual programmes and programme networks, who may wish to use the handbook to develop more systematic and standardized descriptions of their own work or as a template for modifying components of their own programmes.

1.6 Ethical considerations

Several ethical considerations in collecting data on programmes must be taken into account. Paramount to these is ensuring that the safety and livelihood of those involved in the programmes are not compromised. Description of violence prevention programmes using the handbook introduces a level of transparency and makes evaluative information more widely available. It may be that some programmes have not previously worked in an evaluative culture, and so it would be important to reassure programme managers and staff that the main interest of the handbook is to improve documentation and not to be judgmental.

1.7 Outline and structure of the handbook

The handbook is organized around five main sections and a list of key references. The present Chapter 1 describes the rationale and scope of the handbook, and defines key terms. Chapter 2 presents the conceptual framework used to inform the programme documentation instrument, and provides criteria for the identification and classification of programmes for interpersonal violence prevention, and for establishing whether and how they have been evaluated. Chapter 3 provides guidelines on how to identify and document prevention programmes using the instrument presented in Appendix I, and includes a section which defines and describes each of the items in the instrument for the benefit of handbook users. Appendix II provides a model letter for use in requesting information about prevention programmes that might potentially be documented.

1.8 Definitions of key terms

1.8.1 Violence

The *World report on violence and health* (Krug et al., 2002. p. 5) defines violence as:

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.

The typology of violence used in the *World report* divides violence into three broad categories, according to who commits the violent act: self-directed violence, collective violence, and interpersonal violence. These three categories are further subdivided to reflect more specific types of violence.

- **Self-directed violence.** Self-directed violence is subdivided into suicidal behaviour and self-abuse. The former includes suicidal thoughts, attempted suicides and completed suicides. Self-abuse, by contrast, includes acts such as self-mutilation.

- **Collective violence.** Collective violence is the instrumental use of violence by people who identify themselves as members of a group against another group or set of individuals, in order to achieve political, economic or social objectives. It is subdivided into three categories, each suggesting possible motives for the violent acts: (a) Collective violence committed to advance a particular *social agenda* includes, for instance, crimes of hate committed by organized groups, terrorist acts and mob violence; (b) *politically motivated* violence includes wars and related violent conflicts, terrorist acts and state violence against groups in the country; (c) *economically motivated* violence includes attacks by larger groups with the purpose of disrupting economic activity, denying access to essential services, or creating economic division and fragmentation.

- **Interpersonal violence.** Interpersonal violence is subdivided into two categories (Figure 1.1). *Family and intimate partner violence* is that occurring between family members and intimate partners, usually, though not always, taking place inside the home. This category includes child abuse and neglect, intimate partner violence* and elder abuse. *Community violence* includes violence between unrelated individuals, who may or may not know each other, and generally, although not exclusively, occurs outside the home. This includes youth violence, random acts of violence, rape or sexual assault by strangers, and violence in institutional settings such as schools, workplaces, prisons and nursing homes.

Note that this handbook is concerned only with *interpersonal violence* and not self-directed or collective violence.

FIGURE 1.1 TYPOLOGY OF INTERPERSONAL VIOLENCE

---
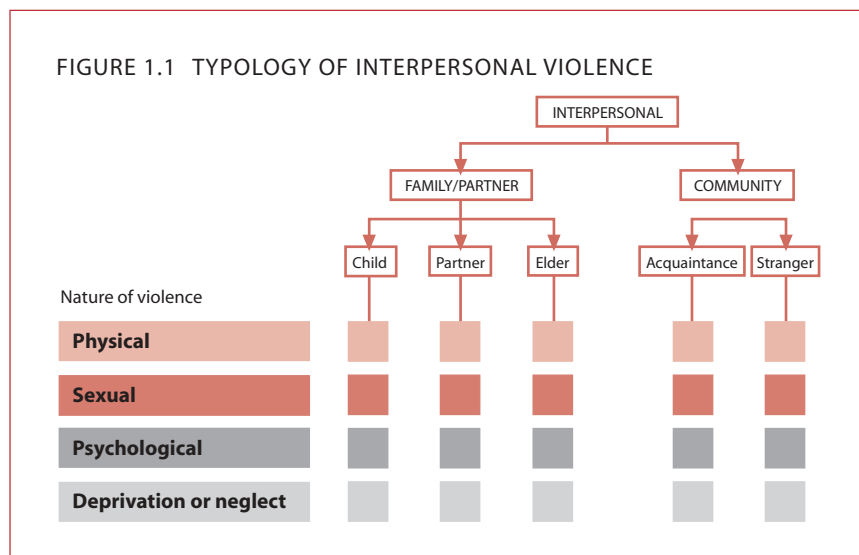
* "Intimate partner violence refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (Krug et al., 2002). Harm can be perpetrated by a partner or ex-partner and is usually by men against women.

The typology (Figure 1.1) also captures the nature of violent acts, which can be physical, sexual or psychological, or involve deprivation or neglect (Krug et al., 2002). This typology cuts across all settings, and while some subtypes of interpersonal violence may be more prevalent in some settings, all may occur in any setting.

1.8.2 Prevention

Prevention means to stop acts of interpersonal violence from occurring by intervening to eliminate or reduce the underlying risk factors and shore up protective factors, or to reduce the recurrence of further violence and its ill effects.

Violence prevention strategies and programmes can be classified along two dimensions. The first dimension concerns time, and classifies interventions according to where they are located in the chain of risk factors and situational determinants that stretch from long before the occurrence of violence to long after the attack has occurred and into the consequences incurred by victims and perpetrators. The second dimension relates to the target population, and ranges from prevention strategies that target everyone (universal) to interventions that address victims and perpetrators only, or high-risk groups.

On the time dimension, primary, secondary and tertiary prevention levels are identified. *Primary prevention* includes any programmes, interventions or strategies aimed at stopping violent events from taking place, and is thus related to the time before violence actually occurs. Examples of primary prevention include pre-school enrichment programmes, training in parenting, and the training of health professionals or teachers in how to prevent interpersonal violence. *Secondary prevention* includes any strategies aimed at minimizing the harm that occurs once a violent event is taking place and immediate post-violence intervention aimed at preventing re-victimization. Examples include interventions to reduce the duration of interpersonal violence events or damage inflicted, or the early identification

by health professionals of child abuse and subsequent interventions to prevent further abuse. *Tertiary prevention* includes all efforts aimed at treating and rehabilitating victims and perpetrators and facilitating their re-adaptation to society. Contrary to secondary prevention activities, which are usually in the short-term after the event, tertiary prevention activities are usually long-term.

The main focus of the handbook is on primary and secondary prevention programmes. Long-term rehabilitation programmes, trauma care and care for chronic disabilities are excluded.

Intervention

Universal interventions target everyone within the population without regard to their differences in the risk of becoming a victim or perpetrator of violence. For example, the enactment and enforcement of laws to regulate the consumption of alcohol. *Selective interventions* target people at enhanced risk of violence only, such as parent training and home visitation for all families in selected low-income settings. *Indicated interventions* are applied to individuals and groups that have already demonstrated violent behaviour and/or been victimized by perpetrators in an effort to reduce re-victimization and repeat offending.

1.8.3 Programme

For the purposes of this handbook, a programme is defined as a series of interventions, interrelated preventive activities, or projects, usually with a formal set of goals and procedures designed to have the desired outcome of reducing the level or consequences of violence.

Programmes can differ in terms of scope (degree of coverage), complexity (multiple levels and sites versus single level, single site interventions), and time frame (short-term and long-term interventions). A single programme can include more than one intervention. In Box 1.1 a comprehensive programme including several interventions is described. This Colombian programme was aimed at reducing high

BOX 1.1 ■ DESEPAZ in Colombia – a multi-intervention programme

In 1992, the mayor of Cali, Colombia helped the city set up a comprehensive programme aimed at reducing the high levels of crime there. Rates of homicide in Cali, a city of some 2 million inhabitants, had risen from 23 per 100 000 population in 1983 to 85 per 100 000 in 1991. The programme that ensued was called DESEPAZ, an acronym for *Desarrollo, Seguridad, Paz* (development, security, peace).

In the initial stages of the city's programme, epidemiological studies were conducted so as to identify the principal risk factors for violence and shape the priorities for action. Special budgets were approved to strengthen the police, the judicial system and the local human rights office.

DESEPAZ undertook education on civil rights matters for both the police and the public at large, including television advertising at peak viewing times highlighting the importance of tolerance for others and self-control. A range of cultural and educational projects were organized for schools and families in collaboration with local nongovernmental organizations, to promote discussions on violence and help resolve interpersonal conflicts. There were restrictions on the sale of alcohol, and the carrying of handguns was banned on weekends and special occasions.

In the course of the programme, special projects were set up to provide economic opportunities and safe recreational facilities for young people. The mayor and his administrative team discussed their proposals to tackle crime with local people, and the city administration ensured the continuing participation and commitment of the community.

With the programme in operation, the homicide rate in Cali declined from an all-time high of 124 per 100 000 to 86 per 100 000 between 1994 and 1997, a reduction of 30%. In absolute numbers, there were approximately 600 fewer homicides between 1994 and 1997 compared with the previous 3-year period, which allowed the law enforcement authorities to devote scarce resources to combating more organized forms of crime. Furthermore, public opinion in Cali shifted strongly from a passive attitude towards dealing with violence to a vociferous demand for more prevention activities.

(Krug et al., 2002)

levels of homicidal violence, and to reach this goal interventions such as education on civil rights, television advertising, restrictions on alcohol sales and the banning of carrying handguns on certain days were introduced.

Programmes, therefore, are planned activities directed towards bringing about specified changes in a target group or population (Owen, 1999). Features that characterize programmes, are:

— clearly defined goals and objectives;

— intended beneficiaries (the target group);

— some measures of success;

— programme components (i.e. the means to achieve the goals);

— programme infrastructure;

— a human resource base;

— stakeholders with a direct or indirect interest in the programme;

— a specific context (or setting) (Babbie & Mouton, 2001).

1.8.4 Building the evidence base of programmes

Clearly, violence prevention programmes are only worthy of implementation if they are effective in reducing the level or consequences of violence. This can only be scientifically proven if they have been evaluated rigorously. It may therefore be argued that only programmes with evidence of effectiveness should be documented. There are however some strong reasons why unevaluated programmes should also be included:

a. Whereas rigorous programme evaluation is considered to be best practice, it is a resource-intensive process and may not be carried out in all instances in LMIC settings (Gallagher, 2000).

b. Where programmes have not been evaluated it may nevertheless be possible to infer effectiveness, because these programmes have been based on interventions which have evidence of effectiveness in different settings.

c. It is crucial to document unevaluated programmes in order to build up the evidence base of prevention activities.

The first critical step of evaluation is to collect systematically information on what is being practised using a framework and indicators, such as those provided in this handbook. It could also be argued that the collection of data for this handbook would facilitate potential evaluations in the future.

The aim of the handbook is to collate the evidence base of violence prevention programmes. This will be achieved by identifying and systematically documenting prevention programmes in different settings, whether cities, towns, regions or countries. The process of systematic documentation will also help identify potential gaps and strengths in programmes, which may then be modified to bring more widespread benefit to communities. Such information can be used for: a) making recommendations for prevention; b) identifying individual elements to make a specific programme better; and c) determining whether the programme can be repeated or applied elsewhere. Without this knowledge, it is impossible to move the prevention field forward.

1.9 Conclusion

This chapter has outlined the rationale, aims and objectives of the handbook and how it is an essential part of the broader drive to prevent interpersonal violence. Key terms for interpersonal violence and violence prevention programmes have been defined. In the next chapter conceptual frameworks, principally around the public health approach to violence prevention, the ecological model for understanding the determinants of violence and the criteria for programme documentation are described.

2. Conceptual framework and programme documentation criteria
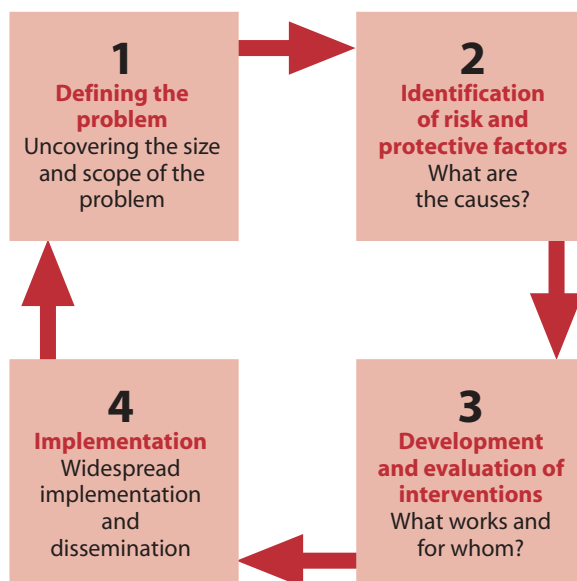
2.1 The public health approach

This section provides an overview of the public health approach to understanding and preventing violence. The public health approach is a science-based, multidisciplinary approach for use by the different actors in violence prevention, including educators, health care workers, police, NGOs, employers and government ministries responsible for social policy, and not just public health professionals. The public health approach follows the four-step logic illustrated in Figure 2.1.

Information arising from activities in steps 1 and 2 is vital for developing and evaluating interventions (step 3), and for widespread implementation and dissemination of proven and promising strategies (step 4). Violence prevention programmes will therefore

often entail all four steps. It is quite common, however, for interventions with evidence of effectiveness (step 3) to be adapted to programmes in broader and more diverse settings (step 4). Alternatively, programmes may be set up using interventions without evidence of effectiveness. This handbook is intended as a tool by which to collect information about interventions and programmes at steps 3 and 4 of the public health approach, so that the growing but still inadequate amount of work on problem definition and risk factor identification will be balanced by a systematic knowledge of who is doing what to prevent violence and which community or subgroups are being addressed.

The public health approach provides a theoretical rationale for why effective prevention programmes necessarily must be based on evidence. Its importance lies in the logic of the approach rather than its professional or disciplinary identity. Many programmes that employ the logic of the public health approach may be from diverse disciplines, and it is important that they too are identified and included if they fulfil the criteria specified in this handbook.

2.1.1 Defining the problem

In this step the public health model examines the *how, when, where, and what* of violence. It therefore involves developing case definitions of violence so that there is clear agreement on what is being studied and counted. This should take into account the typology of violence, according to the different forms of violence, whether physical, sexual, psychological or due to deprivation or neglect, and also take into

FIGURE 2.1   THE PUBLIC HEALTH APPROACH TO INTERPERSONAL VIOLENCE PREVENTION

1 Defining the problem
Uncovering the size and scope of the problem

2 Identification of risk and protective factors
What are the causes?

3 Development and evaluation of interventions
What works and for whom?

4 Implementation
Widespread implementation and dissemination

account the relevant information on the setting, and the relationship between the victim and perpetrator. Violence should be described in terms of the numbers and rates of new cases, the demographic characteristics of victims and perpetrators, the victim–perpetrator relationship, the mechanisms of violent injury, the involvement of weapons such as firearms and substances such as alcohol, and the temporal and geographical characteristics of violent incidents.

2.1.2 Identification of risk and protective factors

Risk factor identification looks at the *why* of violence. Risk factors are those that are shown to increase the possibility of becoming a victim or a perpetrator of violence. An example would be social isolation, which is a risk factor for many types of violence, including elder abuse, child abuse and intimate partner violence (Krug et al., 2002). Protective factors are those that reduce the risk of violence or its consequences. An example may be living in a society where there is high social capital and little income inequality (Krug et al., 2002).

No single factor can explain violence or explain why some people and groups are more protected from violence. Instead, violence is the outcome of a complex interaction among many factors that need to be examined at different levels. The *World report on violence and health* offers an ecological model to help understand the root causes and risk factors of violence that need to be identified and addressed by prevention strategies. This ecological model for understanding violence is shown in Figure 2.2. The model identifies risk factors at four levels: individual, relationship, community, and societal. Examples of risk factors at the different levels are given below.

a. At the individual level, personal history and biological factors influence how individuals behave and increase their likelihood of becoming a victim or a perpetrator of violence. These include early developmental experiences, demographic

FIGURE 2.2 ECOLOGICAL MODEL FOR UNDERSTANDING RISK FACTORS FOR VIOLENCE
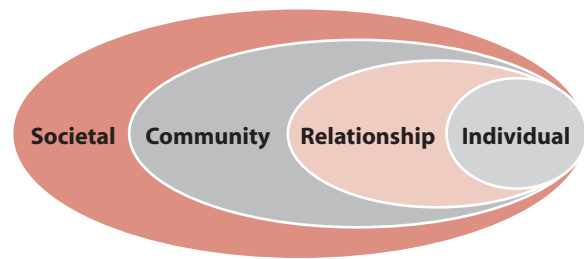
characteristics (age, education, income), psychological or personality disorders, substance abuse, and a history of behaving aggressively or having experienced abuse.

b. Personal relationships such as family, friends, intimate partners and peers may influence the risks of becoming a victim or perpetrator of violence. For example, having violent friends may influence whether a young person engages in or becomes a victim of violence.

c. Community contexts in which social relationships occur, such as schools, neighbourhoods and workplaces, also influence violence. Risk factors here may include the level of unemployment, population density, mobility, and the existence of a local drug or gun trade.

d. Societal factors influence whether violence is encouraged or inhibited. These include economic and social policies that maintain socioeconomic inequalities between people, the availability of weapons, and social and cultural norms such as those around male dominance over women, parental dominance over children, and cultural norms that endorse violence as a normal method to resolve conflicts.

The methods to determine magnitude, risks and determinants usually use routine data surveillance systems (e.g. hospital records, national vital statistics and police statistics), combined with special studies that employ cross-sectional, case–control and cohort designs. Problem definition, risk factor analysis, and

the determination of causes help to understand violence in relational terms by showing how the associations between people, products and the physical and social environment can lead on the one hand to contexts that produce very high levels of interpersonal violence, and on the other hand to contexts where there are very low levels of interpersonal violence.

"Whilst some risk factors may be unique to a particular type of violence, more often the various types of violence share a number of risk factors" (Krug et al., 2002). The ecological model is multilevel, allowing for the interaction of factors both between the different levels as well as at the same level. This implies that preventive programmes will also need to be multilevel, as discussed in the next step of the public health approach.

2.1.3 Development and evaluation of interventions

The effectiveness of strategies for preventing interpersonal violence will depend on a combination of the type of intervention, the timing of its delivery and the population at risk. Certain types of intervention will be specific to the developmental stage (e.g. infancy, adolescence, adulthood, old age) of the groups. For example, home visitation and parent training programmes are effective in preventing child maltreatment and later violence among male adolescents and young adults when delivered during infancy (ages 0–3 years), but are not designed for any later in the life-cycle. Step 3 of the public health approach therefore aims to identify effective prevention strategies by finding out what strategies work and for whom they are effective.

The ecological model helps to clarify the causes of violence and their complex interactions. It also suggests that to prevent violence it is necessary to develop interventions at the different levels. In this respect, programmes may assume a singular or multiple focus (e.g. youth violence, child abuse, violence against women by partners), targeting one or more at-risk environments (e.g. schools, recreational facilities), and risk factors (e.g. poverty, lifestyles), one or more at-risk groups (e.g. children, young men aged 15–24, the elderly) and one or more different levels (individual behaviour factors, close relationships, schools or other communities, or the larger cultural, social and economic factors).

To illustrate how this operates, a set of interventions to reduce youth violence could involve: the provision of support and incentives at the *individual level* to complete secondary schooling; at a *relationship level* working to prevent child abuse and intimate partner violence; at the *community level* targeting access to firearms and alcohol, and at the *societal level* focusing on employment and empowerment activities to address inequalities in gender and wealth. Alternatively, programmes could be devised which act across several levels at the same time. Interventions may either be targeted at sub-groups or whole populations, and the partial success of interventions intended to impact upon whole populations may manifest as a response in some subgroups alone.
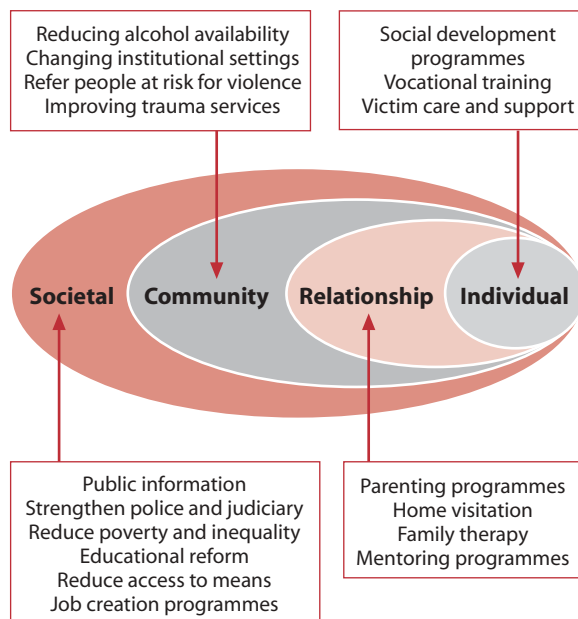
2.1.4 Implementation

The fourth step in the public health approach deals with dissemination and the diffusion of effective practices. It involves taking effective programmes and determining how acceptable and translatable they are to different populations and settings. It is concerned with the scaling up and sustained implementation of effective interventions and violence prevention practices. Typically violence prevention initiatives, including demonstration programmes, are utilized to inform public health policy and practice for violence prevention. Policy, institutional support and funding are vital for the implementation of violence prevention practices on a large scale. In short, this step deals with the translation of effective programmes into wide-scale implementation.

2.2 Prevention opportunities at multiple levels

A variety of prevention matrices were considered (Haddon, 1970; Lett et al., 2002) but the model adopted in the handbook is the ecological model (Krug et al., 2002). In this section the ecological model is used to identify and cluster prevention strategies at the four different levels at which prevention may be targeted. Just as there are multiple levels in the causation of violence (see Figure 2.2), so the opportunities for prevention can involve interventions at the individual, relationship, community and societal levels (Figure 2.3).

FIGURE 2.3 ECOLOGICAL MODEL FOR INTERVENTIONS TO PREVENT VIOLENCE

Reducing alcohol availability
Changing institutional settings
Refer people at risk for violence
Improving trauma services

Social development programmes
Vocational training
Victim care and support

Societal Community Relationship Individual

Public information
Strengthen police and judiciary
Reduce poverty and inequality
Educational reform
Reduce access to means
Job creation programmes

Parenting programmes
Home visitation
Family therapy
Mentoring programmes

2.2.1 Individual level approaches

These are primarily concerned with changing beliefs and behaviours of individuals. These could include educational programmes that provide adolescents and young adults with vocational training and educational support, or social development programmes to teach very young children social skills, anger management and conflict resolution, so as to prevent violence later in life (see Krug et al., 2002).

2.2.2 Relationship approaches

These aim to influence the types of relationships that individuals, as potential victims and perpetrators of violence, have with the people with whom they are most regularly in contact, and to focus on families and negative peer influences. Examples include training in parenting, where the bonding between parents and children is improved and more consistent child-rearing methods are taught to reduce the risk of child abuse; mentoring programmes to match young persons with caring adults to prevent antisocial behaviour; and home visitation programmes (see Krug et al., 2002).

2.2.3 Community based efforts

At this level efforts are geared towards raising public awareness about violence, stimulating community action and providing care and support for victims (Krug et al., 2002). Examples include media campaigns to target entire communities or educational campaigns for settings such as schools, workplaces and other institutions; modifications to the environment, such as improving street lighting and creating safe routes for children and youths on their way to and from school, and reducing the availability of alcohol. Such programmes may be enhanced by appropriate training for police, health professionals and teachers to help them identify and respond better to different types of violence, and improved trauma services to cope with the aftermath of violence.

2.2.4 Societal approaches

Prevention strategies at the societal level focus on cultural, social and economic factors related to violence, and include changes in legislation, policies and the larger social and cultural environment to reduce the risk of violence both in various settings as well as in entire communities. Thus, legislative and judicial changes such as criminalizing spouse abuse and efforts to improve the fairness and efficiency of the justice system are examples of these broad level changes, as are efforts to reduce access to the means

of committing acts of violence, such as the licensing and control of guns. Policy changes to reduce poverty and inequalities with improved support for families in need are also included, as are efforts to change societal and cultural norms to tackle gender-based or child abuse issues. Socioeconomic policies such as the control of alcohol use through pricing and licensing are also relevant here (Krug et al., 2002).
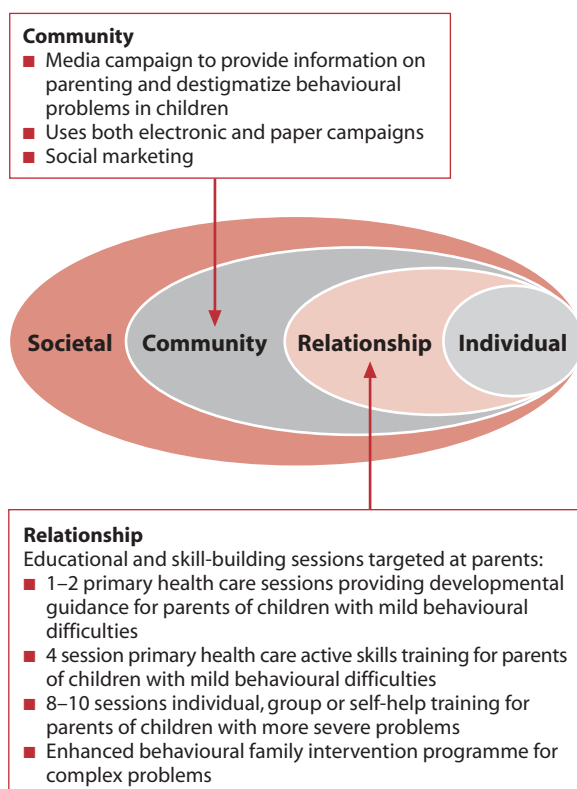
It is important to recognize that programmes may involve prevention strategies at more than one level, and that interventions may be intricately linked across the different levels. This is demonstrated by the example of the Triple-P Positive Parenting Programme developed in Australia (Sanders, 1999), which operates at both the relationship and community levels (Figure 2.4). This programme consists of a community-wide awareness campaign, a health care component that includes consultations between physicians and parents, and parent training and family support. It also includes interventions for different target populations (universal, selected and indicated). The programme, or elements of it, has been implemented in Hong Kong, Germany, New Zealand, Singapore, the United Kingdom and the United States of America.

2.3 Evaluation of interpersonal violence prevention programmes

Programme evaluation can be defined as the systematic process of collecting and analysing data using a science-based methodology to determine whether the programme is achieving its stated objectives. This handbook is concerned with the systematic collection of information on three aspects of a programme, namely the plan, the implementation process and its outcomes or impacts. The evidence may be qualitative or quantitative (Babbie & Mouton, 2001; Owen, 1999). We are concerned with collating information on programmes based on a set of items in the instrument included as Appendix I. Documenters are not asked to analyse and make judgements about the merit and worth of programmes, but only to record in the instrument whether or not a programme has been evaluated and, if so, how.

2.3.1 Why do we evaluate?

The most obvious purpose in evaluating programmes is to know what effect they are having on the problems that they attempt to impact.

There are essentially four main reasons for evaluation.

- To make decisions of quality or worth. Evaluations provide useful knowledge on whether the programme is run according to plan, whether it is cost-effective and whether it has achieved its stated objectives.

- To improve programmes. By identifying strengths and weaknesses, the programme can be modified and adapted to better benefit the group as planned.

- To generate knowledge. Information generated from evaluations of programmes is crucial for un-

FIGURE 2.4 THE TRIPLE-P POSITIVE PARENTING PROGRAMME (Sanders, 1999)

Community
- Media campaign to provide information on parenting and destigmatize behavioural problems in children
- Uses both electronic and paper campaigns
- Social marketing

Societal   Community   Relationship   Individual

Relationship
Educational and skill-building sessions targeted at parents:
- 1–2 primary health care sessions providing developmental guidance for parents of children with mild behavioural difficulties
- 4 session primary health care active skills training for parents of children with mild behavioural difficulties
- 8–10 sessions individual, group or self-help training for parents of children with more severe problems
- Enhanced behavioural family intervention programme for complex problems

derstanding the phenomenon of violence and how to deal with it in a practical way. Such information is also necessary for policy formulation on a higher level.

- To gain knowledge on whether the programme can be repeated effectively elsewhere.

2.3.2 What is evaluated?

The following areas need to be considered:

a. what is the programme, what are its objectives, and in what context does it exist;

b. what aspects of the programme will be considered when judging its performance;

c. what standards (i.e. type or level of performance) must be reached for the programme to be considered successful;

d. what evidence will be used to indicate how the programme has performed;

e. what conclusions regarding programme performance are justified by comparing the available evidence of the selected standards;

f. how will the lessons learned from the inquiry be used to improve its effectiveness?

2.3.3 What are the key components to evaluation?

The following steps are involved in evaluation practice (Centers for Disease Control and Prevention, 1999, accessed 31.1.03):

a. Engage the stakeholders, who are those involved, those affected by the programme, and the intended users of the evaluation.

b. Describe the programme in terms of need, the expected effects, the activities, resources, the stage of the programme, the context and the theoretical model.

c. Focus on the design of the evaluation by considering and agreeing on its purpose, how to engage the users, to what uses the evaluation will be put, the questions being asked, and the methods to be used.

d. Gather credible evidence. Consideration must be given to indicators, sources of information, its quality, its quantity, the logistics of obtaining it and whether attention has been given to potential sources of error, such as due to confounding and bias.

e. Justify the conclusions. Rigorous standards should be used, with a thorough analysis, unbiased interpretation, judgement on strengths and weaknesses, and recommendations.

f. Disseminate to the stakeholders with feedback and follow up.

2.3.4 Who is the evaluation for?

The evaluation of a programme is for all the stakeholders, including those directly involved in the programme such as staff, the target population, policy makers, donors and others involved in the violence prevention field. For example, prevention workers may wish to use the results in deciding whether to introduce a programme in their local setting or where to adapt or change programme targets, and funders may take decisions on whether to continue funding programmes on the strength of evaluation results.
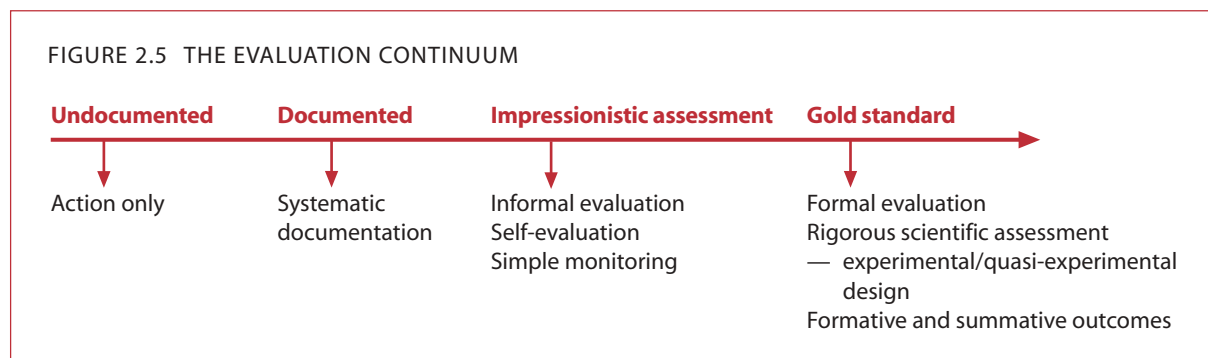
2.3.5 How is the evaluation used to strengthen prevention capacity?

The results of a rigorously conducted evaluation will highlight strengths and weaknesses of either the whole programme or specific interventions within the programme. These can be used to make modifications in order to strengthen the programme itself. In addition the programme and lessons from it may be transferable to other settings for different target populations.

2.3.6 The evaluation process

Basic questions that may be asked in evaluation studies are:

- *Relevance* – is there a need for this programme?

- *Quality* – how satisfactory is the process, that is,

FIGURE 2.5 THE EVALUATION CONTINUUM

Undocumented   **Documented**   **Impressionistic assessment**   **Gold standard**

Action only   Systematic   Informal evaluation   Formal evaluation
    documentation   Self-evaluation   Rigorous scientific assessment
        Simple monitoring   — experimental/quasi-experimental
            design
        Formative and summative outcomes

performance of activities? How satisfactory are the facilities, staff component and office space? How satisfactory are the outcomes, and have the desired effects been achieved?

- *Efficiency* – how efficiently are resources used?

- *Replicability* – can this programme be repeated elsewhere?

(Abramson & Abramson, 1999).

Use of this handbook to establish descriptive information about existing interpersonal violence prevention programmes is part of a long-term process aimed at providing feedback about prevention patterns and trends that will help to increase the proportion of well evaluated programmes. The handbook therefore assumes that these programmes will range from those that are undocumented and lack any type of evaluation mechanism, through programmes that include rudimentary efforts to measure their impact on the target problem, to "gold standard" programmes evaluated according to rigorous scientific criteria.

These stages can be considered as part of a continuum, and documenters and programme managers can consider where to place the projects at the appropriate point along the line (see Figure 2.5).

2.3.7 *Logic of prevention programme planning and implementation*

The planning and implementation of prevention programmes always follows a standard stepwise logic: 1) a problem is identified; 2) a programme is developed to "do something about it"; 3) the programme is implemented; and 4) an assessment is conducted to determine if the desired outcomes are achieved (see Figure 2.6). The questions listed above for evaluation studies are based on this logic of planning and implementing prevention programmes. Evaluation, whether internally or externally done, asks questions that cover all the stages of an intervention programme. Each stage should be recorded and monitored in a systematic way.

As already discussed, the evidence can include qualitative and quantitative information. Sources of

FIGURE 2.6 LOGIC OF PREVENTION PROGRAMMES

Problem   **What can be done**   **Action**   **Assessment**

What is the   What is the programme?   How can it be done?   What is the result?
problem?   Programme plan, aims,   Implementation based   Changes in behaviour;
    objectives, interventions,   on aims, objectives   percentage change in rates
    target population   of deaths, injuries, cases etc.
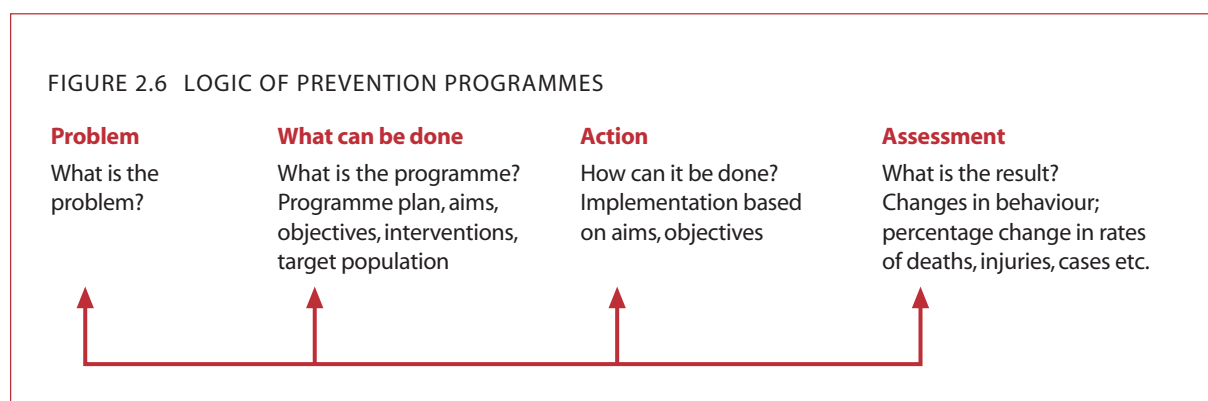
Box 2.1 ■ Outcome evaluation of a multi-component violence-prevention programme for middle schools: the Students for Peace project (USA)

Authors

Pamela Orpinas, Steve Kelder, Ralph Frankowski, Nancy Murray, Qing Zhang and Alfred McAlister

Abstract

This study evaluated the effect of Students for Peace, a multi-component violence-prevention intervention, on reducing aggressive behaviours among students of eight middle schools randomly assigned into intervention or control conditions. The intervention, based on Social Cognitive Theory, included the formation of a School Health Promotion Council, training of peer mediators and peer helpers, training of teachers in conflict resolution, a violence-prevention curriculum, and newsletter for parents. All students were evaluated in the spring of 1994, 1995 and 1996 (approximately 9 000 students per evaluation). Sixth graders in 1994 were followed through seventh grade in 1995 or eighth grade in 1996, or both ($n = 2\ 246$). Cohort and cross-sectional evaluations indicated little to no intervention effect in reducing aggressive behaviours, fights at school, injuries due to fighting, missing classes because of feeling unsafe at school or being threatened to be hurt. For all variables, the strongest predictors of violence in eighth grade were violence in sixth grade and low academic performance. Although ideal and frequently recommended, the holistic approach to prevention in schools in which teachers, administrators and staff model peaceful conflict resolution is difficult to implement, and, in this case, proved ineffective. The Students for Peace experience suggests that interventions begin prior to middle school, explore social environmental intervention strategies, and involve parents and community members.

Box 2.2 ■ Protecting school girls against sexual exploitation: a guardian programme in Mwanza, Tanzania

Authors

Zaida Mgalla, Dick Schapink, J Ties Boerma

Abstract

This paper presents a study in 1996 of a guardian programme in primary schools in two districts in Mwanza region, Tanzania, whose aim was to protect adolescent girls against sexual exploitation, which is thought to be common within educational institutions in Africa. The guardians were women teachers whose role was to help in cases of sexual violence or harassment, and act as counsellors on sexual health problems. About half of the girls in the highest three classes of these primary schools (mean age 15) had had sex. Sexual exploitation of schoolgirls by schoolboys, young men in their teens and 20s and teachers was common. The guardian programme has been well accepted and has already generated considerable public debate. One of the most important initial effects is that sexual abuse is less hidden, and abuse by teachers may have become more difficult than in the past. However, most guardians and other teachers were opposed to any sexual activity among girls, which limited their potential to encourage contraceptives use and preventing of STDs and HIV. In this context, the guardian programme should be only one component of a much broader effort to address the issue of adolescent sexuality.

TABLE 2.1   STAGES IN PREVENTION PROGRAMME PLANNING AND IMPLEMENTATION: THREE CASE STUDIES

	DESEPAZ Programme: Colombia	**Violence Prevention Programme: USA**	**Guardian Programme: Tanzania**
	(see Box 1.1)	(see Box 2.1)	(see Box 2.2)
1. Problem statement			
Theory/philosophy	Explicit: public health approach	Explicit: social cognitive theory	Implicit: feminist theory
Information to motivate study	High homicide rate Police, coroner and hospital-based information	Results from evaluated programmes and theory and research on behaviour change	Research findings and Information from TANESA – project on HIV/STDs in Tanzania
2. Programme plan			
Aims and objectives	Evaluate effects of ban on carrying firearms and alcohol consumption	Evaluate effect of multi-component intervention on aggressive behaviour	Intervention to protect adolescent girls against sexual exploitation
Interventions	Education on civil rights TV advertising on tolerance and self-control Interpersonal conflicts : schools, families Restrictions on alcohol sales Ban on carrying handguns	Violence prevention curriculum Peer mediation programme Training of teachers School Health promotion Council Newsletters to parents	Training of guardians Forming of guardian committees
Target population	General public	School students	Schoolgirls
3. Implementation	P R O C E S S R E C O R D E D I N D E T A I L		
4. Effects, outcomes	Decline in homicide rate	Little/no effect in reducing aggressive behaviours	Generated public debate Sexual abuse less hidden Conscientization process
5. The evidence			
Sources of information used	Pre- and post-intervention surveillance data	Data from a randomized control trial	Case history reports

information may range from case histories, self-reports, focus group discussions, interviews, documents and reports.

In Table 2.1 three examples of prevention programmes are analysed in terms of the logical stages followed in prevention programmes. The first is the DESEPAZ-programme in Colombia (see Box 1.1); the second is a multi-component violence prevention programme for school children in Texas, USA (Box 2.1, Orpinas et al., 2000); and the third is a guardian pro-

gramme to protect schoolgirls against sexual exploitation in Tanzania (Box 2.2, Mgalla et al., 1998). These examples illustrate how the programme logic, on which the evaluation of a programme is based, shapes practical evaluation efforts. It demonstrates the importance of systematic documentation and shows the value of putting in place even basic measures of impact.

2.4 How to identify interpersonal violence prevention programmes

The definitions of violence and prevention given in Chapter 1 and the overviews of the public health approach in this chapter enable specification of the ecological model, principles of evaluation and criteria for identifying interpersonal violence prevention programmes. Such programmes:

— are identified by local experts as programmes for preventing interpersonal violence;

— have clearly defined goals and objectives based on existing knowledge to explain the extent and nature of the problem;

— are aimed at primary and/or secondary prevention;

— are designed to address clearly identified risk factors at one or more different levels of the ecological model;

— are informed by a logical framework for prevention (e.g. the public health approach);

— are focused on clearly identified target populations (e.g. women, youth aged 15–24, the general population);

— have an administrative and logistic infrastructure.

Because of the multifaceted nature of violence and the complexity of its root causes, interpersonal violence prevention programmes can manifest great diversity in the number and type of risk factors they address. Some programmes may focus directly on one or two risk factors, such as the DESEPAZ-programme with its focus on alcohol consumption and carrying of firearms. Other programmes may have the prevention of violence as one among many aims, such as community empowerment programmes that focus on self-efficacy, autonomy and the development of skills for dealing with aggressive behaviour. Programmes such as pre-school enrichment programmes may not concentrate on violence prevention *per se*, but have been demonstrated to be effective in reducing youth violence or risk factors for youth violence (Krug et al., 2002).

2.5 Programme characteristics

Programme characteristics refer to the common dimensions on which different programmes can be described and compared to one another. Factors included in the classification of programme characteristics are:

- *Scope* – whether the programme is deployed locally, nationally or internationally.

- *Geographical location* – specific particulars of where the programme takes place.

- *Setting of the target population* – whether the programme operates in a rural, urban or peri-urban context.

- *Socioeconomic variables* – these are known risk factors for interpersonal violence (for example poverty) and it is therefore important to document them.

- *Type and nature of interpersonal violence* – information on the type of violence identifies whether the programme deals with child abuse and neglect, intimate partner violence, elder abuse, acquaintance violence and stranger violence, and whether the violence is of a physical, sexual or psychological nature, or involving deprivation and neglect.

- *Theoretical/philosophical orientation* – information about the programme's conceptual framework.

- *Nature and level of intervention and prevention* – whether the interventions are targeted at one or more levels of the ecological model (individual, relationship, community, society), and whether the interventions are at the primary or secondary level of prevention.

- *Target populations* – identify the populations that the programme aims to benefit in terms of characteristics such as age and sex, and whether they are victims, perpetrators or the general public.

- *Sites and settings* – identify in what settings the programme takes place, such as schools, neighbourhoods, workplaces, old age homes and so on.

- *Programme information* – general information about the programme will include whether it is a single or multiple site intervention, whether the programme focuses explicitly on violence or not, and details about resources used, for instance staff and physical resources available to the programme.

- *Information on the programme plan, implementation and outcomes* – this section includes information on the relevance of and support for the programme, methods of documenting the programme and its interventions, and on the outcomes and whether the programme has been evaluated. How information is disseminated should also be noted.

It is likely that the majority of programmes identified for documentation using this handbook will not, at the time of documentation, have been subject to a formal scientific evaluation. Accordingly, few will be able to provide empirical evidence of outcome and impact effectiveness. In such instances the documentation procedure will be limited to describing if and how such programmes are attempting to measure their effects and effectiveness.

2.6 Conclusion

This chapter provides the theoretical basis for understanding the programme documentation instrument (included as Appendix I). The public health approach has been presented as a guiding framework for violence prevention activities. Its four steps have been discussed (defining the problem; identification of risk and protective factors; development and evaluation of interventions; implementation). The ecological model has been described, which enables better understanding of violence and its risk factors at multiple levels. The rationale for conducting evaluations and criteria for the identification of violence prevention programmes have been discussed.

3. Documenting violence prevention programmes

Following the description of criteria for identifying, classifying, and evaluating violence prevention programmes, this chapter provides suggestions on how to proceed with the identification and selection of potential programmes and their documentation using the instrument provided in Appendix I. Figure 3.1 presents the steps involved in documenting a violence prevention programme. Each step is considered in more detail under the headings below.

1. Training of documenters

2. Identifying potential programmes for documentation

3. Selecting programmes for documentation

4. Contact programmes and obtain consent

5. Conduct documentation

6. Assessing data quality, gaps and feedback

7. Entering information into the database

8. Communicating with programmes

9. Keeping a field diary.

3.1 Training of documenters

Programme documenters should ideally have some background in violence prevention research, practice and evaluation. Documenters will need to be

FIGURE 3.1 STEPS IN THE DOCUMENTATION OF INTERPERSONAL VIOLENCE PREVENTION PROGRAMMES
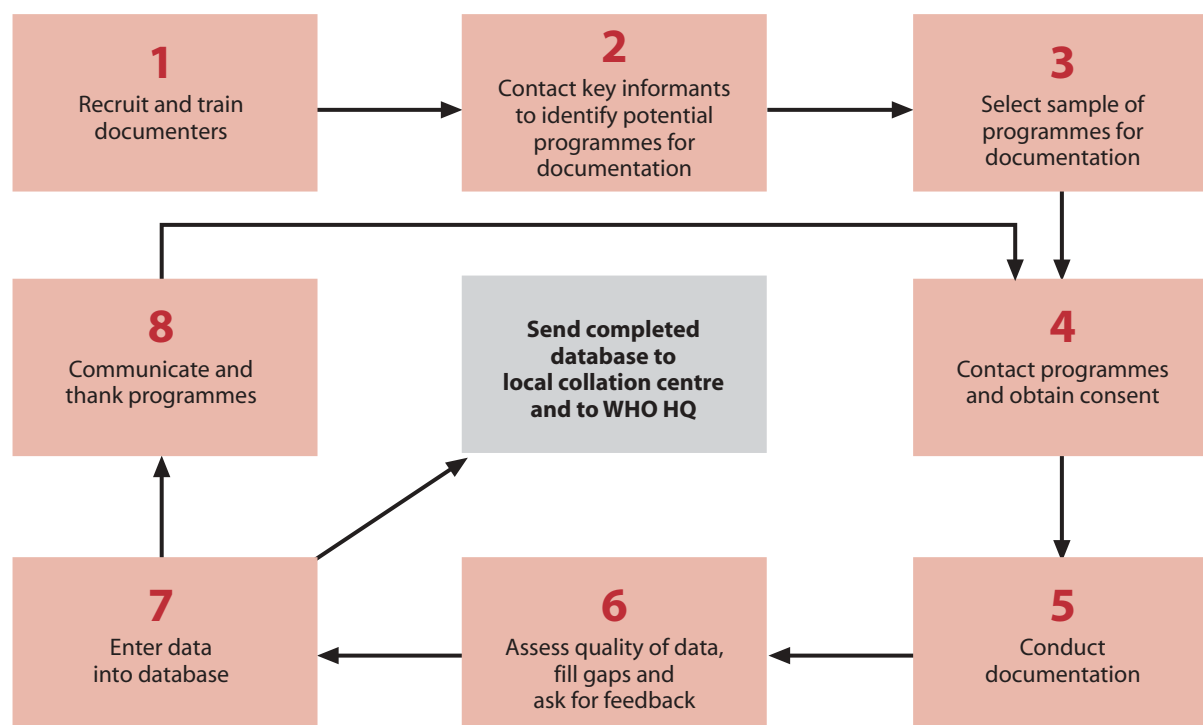
thoroughly trained to ensure that they are empowered with the requisite skills, and to ensure consistency and reliability among all staff. The contents of such a training course could include:

a. content review to cover the aims of the documentation initiative, case definitions, instrument and so on, so as to ensure a common understanding regarding the tasks

b. conceptual frameworks

c. principles of systematic documentation and evaluation

d. interpersonal skills: sensitivity to the context, issues of confidentiality, safety and ethics must be emphasized

e. pilot completions of the instrument

f. role play of telephone and face-to-face interviews

g. data collection and cleaning

h. analysis of data and report writing.

3.2. Identifying potential programmes for documentation

Potential programmes for evaluation should be identified by requesting key informants from relevant sectors (education, police, justice, health, human rights, universities, research councils, donors/funding agencies, violence prevention networks, youth workers, probation services, welfare or social services, NGOs) to identify violence prevention programmes as defined in this handbook.

A model letter and brief questionnaire for use by documenters in requesting this information from key informants is included in Appendix II.

Existing mailing lists, prevention networks and directories are useful additional resources that could be used to help identify programmes for possible documentation. Ultimately, the aim of programme documentation should be to present a systematic description of the typical prevention activities being carried out in the area surveyed.

3.3 Selecting programmes for documentation

Where few programmes exist, all should be documented. In situations where many programmes exist, the documenters will be faced with the challenge of how to select a sample of programmes that is representative of the diverse activity and contexts. In this situation staff should select an example of each subtype (by typology, target group, level and context). Where there is more than one programme in each subtype, the sampling should err on the side of programmes that are effective and well evaluated.

3.4 Doing the documentation
3.4.1 Contact with prospective programmes

Contact should be made with the senior management of prospective programmes, to explain the importance and aims of the documentation initiative with a view to securing their agreement to participate. It will be important to be positive and informative, in order to allay any concerns that programme staff may have about programme documentation. Consent will be needed, and this may be in the form of an information sheet and consent form explaining the aims of the project and how the data will be used. In some circumstances it may be necessary to make at least one site visit to meet with and obtain consent from senior staff.

3.4.2 Documentation

Whereas the combination of a site visit, interviewing programme staff and examining documents is one of the most reliable ways of collating information, this is resource-intensive and may have to be avoided, except for specific indications. A more practical but less reliable alternative is to interview programme staff by telephone, e-mail or fax and to support this with documentary evidence. This may be in the form of evaluation reports, or failing this, annual reports, progress reports, programme plans, reports for donors, and other supporting documents. The documenters should identify all possible information sources.

3.5 Using the documentation instrument

This section provides information and guidance on how to use the programme documentation instrument laid out in Appendix I. It describes the individual data items and the rationale for using them. The part numbering and headings therefore reflect those of the instrument itself.

ITEM 1. IDENTIFICATION AND CLASSIFICATION DETAILS

This item should contain the name of the programme in full, the contact details, and how the data were gathered. Ideally, a site visit should be involved, interviewing key personnel, examining documents, reports and publications, and looking at primary and secondary routine data collected. If a site visit is not possible, then telephone, fax, e-mail and post can gather these data. A brief description of the programme goals, activities, donors and stakeholders is also required.

ITEM 2. GEOGRAPHY AND SCOPE

2.1–2.2 Scope and geographical location

The scope of the intervention or programme indicates whether the programme is locally or more widely implemented (e.g. international, national, regional, district or local). Geographical location indicates where the intervention programme is implemented. Information is sought on the continent, country, region or province, district, city, town, or the nearest town if it is a rural location.

2.3 Setting of the target population

The type of community where the programme is implemented should be described by indicating whether it is urban, rural or peri-urban. Urban and rural settings can be distinguished from each other in two ways. The first is along official lines, using the boundaries for towns and cities drawn up by local authorities for the purposes of rendering services. Areas outside of these boundaries are defined as rural. The second distinction has to do with differences in lifestyles. Urban areas may be associated (but not always) with structural diversification, industry and social relationships that may be individually oriented and anonymous. Rural settings, by contrast, may be more stable, less diversified, agrarian, and traditional, with social relationships oriented towards a more collective lifestyle. Of course, the extent to which urban and rural sectors actually approximate to these stereotypes will vary widely between countries, and so it is important to note that this item's main aim is to indicate whether the programme is set in a city or town, or outside of these confines.

Peri-urban settings refer to communities of people who have recently moved from rural to urban areas, and may manifest lifestyles and socio-demographic processes that are transitional between rural and urban (Iaquinta et al., 2000). Such communities are often found in informal settlements located near cities and towns.

ITEM 3. INCOME LEVEL

Socioeconomic classification gives information on the social and economic status of an area and its inhabitants.

Criteria indicating socioeconomic status include per capita income, level of education and life expectancy, and may be measured by indices such as the Human Development Index (HDI). However, HDI data are often unavailable for particular target populations, and so this instrument measures socioeconomic status using per capita gross domestic product (GDP) of the country, the median income level of the families in the target population, and an impressionistic assessment of their income relative to the society as a whole.

ITEM 4. TYPE AND NATURE OF INTERPERSONAL VIOLENCE

This item describes the type (i.e. child, intimate partner, elder, acquaintance or stranger) and nature (i.e. physical, sexual, psychological, deprivation/neglect) of the interpersonal violence that the programme is

aimed at preventing, based on the WHO definition and typology described in Chapter 1 (see Figure 1.1). For example, if the programme aims to prevent child physical and sexual abuse, the documenter should tick the relevant boxes under type of violence (child abuse) and nature of violence (physical and sexual).

ITEM 5. THEORETICAL/PHILOSOPHICAL ORIENTATION

The answer to the question posed in this item establishes whether the programme is based on a specific philosophy or theoretical orientation. For example, a domestic violence prevention programme might be based on a feminist theory of patriarchy, or a youth violence prevention programme could be based on the public health approach.

ITEM 6. NATURE AND LEVEL OF INTERVENTION AND PREVENTION

This item identifies all interventions included in a programme, where possible by checking these against the interventions listed in Appendix I and indicating the preventive level at which each intervention is applied. Many programmes will include multiple interventions of different types, and the appropriate box should be ticked for each type of intervention.

Individual level interventions focus on changing the attitudes, beliefs and behaviours of individuals. *Relationship* level interventions seek to influence close relationships, such as between parents and children, between intimate partners and between peers. *Community* level interventions address community level risks and the physical and social characteristics of settings such as schools, hospitals, neighbourhoods and workplaces. *Societal* level strategies focus on cultural, social and economic factors related to interpersonal violence, such as public awareness and accurate information about interpersonal violence, social policies around welfare, education, employment and gender, legislation relating

to risk factors like alcohol and firearms, and criminal justice system reforms.

The following section provides brief descriptions of the intervention types listed in the programme documentation instrument and is designed to help the documenter identify and classify a programme's interventions. Note that inclusion of an intervention strategy in the programme documentation instrument and in the following list in no way implies that the intervention is either effective or ineffective, as the aim of this handbook is to document the *full range* of interventions employed.

6.1 Individual level
Interventions using treatment and rehabilitation

Treatment for adolescents with conduct disorders. Such interventions include education and skills training for adolescents on problem-solving, social skills, impulse control, assertiveness, sexual relationships, empathy, and perspective-taking.

Individual counselling and social casework. Individual counselling includes individual psychotherapy, counselling and social casework which combines these with close supervision of the target individual and coordinated social services (US Department of Health and Human Services 2001).

Treatment and rehabilitation services for victims of violence. These interventions focus on individuals who have experienced interpersonal violence and aim at preventing further re-victimization. They include interventions aimed at developing skills for identifying and avoiding risky situations (e.g. assertiveness skills, problem solving and communication skills). Also included are interventions for women who have experienced long-term abusive relationships and need more intensive support and skills training to be able to live independently. Rehabilitation services may include safe-houses or shelters, employment, education, housing, community resources, and legal services (Meyerson, 2001; Sullivan & Bybee, 1999).

Treatment and rehabilitation services for perpetrators of violence. This category consists of interventions with perpetrators using individual cognitive behaviour therapy, group therapy or family therapy aimed at curbing conflict behaviour and reducing violent behaviour. Some interventions may link alcohol and substance misuse treatment with anger management skills. These interventions may be offered as part of a community programme or located within a detention centre following conviction of violent offenders (Dunford, 2000).

Treatment of child abuse offenders. Child abuse offender interventions aim to reduce re-offending. Such interventions are usually provided for perpetrators during a period of detention, and may consist of individual or group psychological therapies. Cognitive behaviour interventions include improving social skills and modifying distorted cognition and beliefs. Sex hormones, anti-psychotic drugs, and surgical castration are among the interventions used to reduce re-offending (White et al., 2003).

Probation or parole programmes. Such interventions include probation or parole and meetings with prison inmates to make adolescents aware of the brutality of prison life (Krug et al., 2002).

Residential programmes in psychiatric or correctional institutes. These interventions are directed at modifying the behaviour, attitudes and insight of individuals within psychiatric or correctional institutes, and may involve individual as well as group psychotherapy and counselling.

Educational interventions
Educational interventions for the prevention of interpersonal violence are aimed at strengthening the educational level of individuals.

Providing incentives for youths at high risk of violence to complete secondary schooling. These interventions identify young people who are considered to be at risk of violence because of academic failure, low academic motivation, family and/or disciplinary problems and coming from families that receive welfare/social support. They can involve compensatory education through special tutoring, behavioural reinforcement of improved classroom behaviour, and working with parents and their children to strengthen the motivation to attend and do well in school (US Department of Health and Human Services, 2001).

Higher / vocational training. These are post-secondary school interventions that provide vocational training. They are aimed at providing young people with marketable skills that will help them to find employment.

Academic enrichment programmes (including pre-school enrichment). Academic enrichment programmes introduce young children and youth to the skills necessary for success in school and are aimed at increasing the likelihood of academic success (Krug et al., 2002).

Skills development programmes
Skills development interventions involve teaching the cognitive and social skills needed to develop and sustain positive, friendly and cooperative behaviour.

Skills programmes for younger children (5–12 yr). These include interventions that use education to raise awareness and change attitudes regarding the unacceptability of specific behaviours. They may also include efforts to teach children what to do when domestic violence occurs in the home, and anger management and conflict resolution skills (Wolfe & Jaffe, 1999).

Skills programmes for teenagers (13–18 yr). Educational interventions for teenagers may include multimedia, theatre groups, and classroom discussions facilitated by teachers or violence prevention professionals, and peer support groups, and include efforts to prevent dating violence (Foshee, 1998; Wolfe & Jaffe, 1999).

Sexual abuse prevention skills training. Interventions in this category include those specifically aimed at preventing sexual abuse by teaching pre-school and school age children personal safety awareness,

assertiveness training and practical self-protection skills. Examples include teaching children about their body parts, personal boundaries, which areas are acceptable to be touched ('good touch, bad touch'), and by whom. They may also involve training to distinguish between surprises and secrets and what to do if they are abused. (Conte, 1985; Tutty, 1997; Wurtele et al., 1989).

Life Skills Approach. Life skills training for violence prevention includes peace building and education for development, as well as training on anger management, conflict resolution, decision-making and critical thinking, and coping with stress and self-management (UNICEF 2003, accessed 28.09.2003).

Other individual-level interventions

Hotlines. Hotlines include telephone help lines that provide varied information, counselling, support and advice for people who have experienced or are still experiencing child abuse, domestic violence, sexual assault, rape or violent crimes. Hotlines may often only deal with one particular form of violence (e.g. child abuse, intimate partner violence) (Wolfe & Jaffe, 1999).

Training in safe use of guns. Gun training is usually directed at adolescents and adults, and involves teaching skills related to all aspects of owning, using and storing firearms.

Programmes modelled on basic military training. The primary aim of these interventions is to instil discipline, and they typically focus upon highly specific personal skills in the area of physical discipline (US Department of Health and Human Services, 2001).

Trying young offenders in adult courts. These justice system interventions assume that the nature of a crime or act of violence and not the age of the perpetrator should determine the consequences. They involve placing youths, who have been convicted of serious violent offending, in adult criminal institutions (US Department of Health and Human Services, 2001).

Social development programmes. Interventions to enhance social development involve strategies directed at reducing antisocial and aggressive behaviour. These include improving competency and social skills with peers and the promotion of behaviour that is positive, friendly and cooperative. Among the more specific areas usually covered are anger management, social problem solving, social perspective taking and moral development (Krug et al., 2002).

Conflict resolution and anger management. Conflict resolution interventions include education and training to provide insight into violent situations such as: the conflict cycle and the dynamics of a fight; violence avoidance versus confrontation; assertiveness skills and how to express anger without fighting; problem solving and communication skills; empathy and perspective-taking. Methods used to deliver these interventions may include teachers, community workers, peer educators, peer mediators or multimedia systems (e.g. interactive computer programmes). Anger management programmes are based on a similar design, and tend to be targeted towards people with an existing problem with anger (Durant et al., 2001).

6.2 Relationship level
Skills development

At the relationship level, skills development interventions involve teaching people the skills needed to change the behaviour of other people. The examples discussed in this section focus specifically on parents and teachers and their capacity to modify the behaviour of children in their care.

Parent skills training. Parent skills training interventions can be universal (e.g. antenatal classes for all new mothers), or selectively targeted at high-risk groups (e.g. young, single mothers) with the aim of preventing child abuse. Training programmes vary and may include education and skills development on care of the infant (e.g. breast-feeding, normal child development, health problems, sources of help) (Coren & Barlow, 2003).

Conflict resolution for child minders of pre-school children. Child care teachers of pre-school children and their parents are taught skills in self-awareness, cultural sensitivity, violence intervention for young children, disciplining children, communication and stress reduction techniques (Stevahn et al., 2000).

Mentoring. Mentoring based interventions aim to help young people develop non-violent, pro-social skills by providing at-risk individuals the opportunity to develop a supporting relationship with someone who can act as a positive role model (Krug et al., 2002).

Home–school partnership programmes to promote parental involvement. These interventions aim at linking the interests of families and teachers in ensuring children's success at school. They may involve schools-based skills training accompanied by efforts to make parents more sensitive to their children's needs and opportunities, and better able to provide support to their children and those who teach their children (US Department of Health and Human Services, 2001).

Peer mediation. Peer mediation interventions involve children, young people or adults who are selected as peer leaders and given training in conflict resolution skills. They are then meant to mediate in fights and arguments arising in their peer setting (e.g. schools, workplaces), with the aim of resolving conflicts (PAHO, 2000).

Peer linkage. Peer linkage involves pairing children who have experienced abuse with socially skilled peers in a classroom setting. The paired-off children are then encouraged to share classroom activities and play together, with the socially skilled child providing encouragement and a role model for the neglected child to engage in social activities. The aim of peer linkage programmes is to improve the social functioning of the abused child (Fantuzzo et al., 1996).

Peer education. Role models or leaders within a peer group are selected to conduct educational talks. The peer educators are usually trained in areas such as substance misuse, conflict resolution skills and sexual health. The peer educators may either take a passive role (e.g. leading by example, informal discussions with peers) or have a more active role (e.g. participating in the design of teaching programmes, teaching or facilitating group work sessions). The intensity of training, continued support and supervision of peer educators can be of variable quality and length (Guiliano, 1994).

Home visits, care groups, services
Interventions involving home visits usually involve prenatal and/or postnatal visits by health care professionals, para-professionals or volunteers who provide education, training and support in parenting skills. The purpose of home-visiting can vary and may include identifying and treating maternal depression, promoting breast-feeding and vaccination, providing care for common health problems, education on hazards in the home for young children, and identifying and providing support for families considered at high risk for abusing their children. Support and referral can also be given for intimate partner violence, and home visiting can be used for the prevention of elder abuse through assistance, support, and advice on care giving (Olds et al., 1997).

Parent education and home visitation. These interventions may involve working with parents regarded as being high-risk perpetrators of child abuse (e.g. young mothers, single parents, those of low socioeconomic status, those with a substance misuse problems), or may be targeted at all new parents. Interventions for parent education may be given within a number of settings, for example, within schools or educational settings, during hospital visits, and in the course of home visits.

Day care. Day care refers to the provision of care for pre-school age children (aged 0–4 years old), so that their parents can go out to work (Coren & Barlow, 2003; Olds et al., 1997; Zoritch et al., 2003).

Multidisciplinary intervention teams for caregivers of the elderly or disabled. To prevent the

abuse of those in their care, the caregivers of elderly or disabled people receive support and are trained on issues such as stress reduction methods, and may receive referrals for counselling or substance abuse treatment. Additional community support services may be provided; for example, home-visiting by health care professionals and extra support staff, provision of meals, day centres and respite care (Anetzberger et al., 2000; Foelker et al., 1990; Kurrle et al., 1997).

Interventions using treatment/therapy

Family therapy and additional support for at-risk families. Families identified as being at risk for child abuse (where one child may have already been abused) may receive additional social support and family therapy. Examples of these interventions include training to improve the communication and protective skills of mothers, following the removal of an abusive male partner. The aim of these programmes is to reduce child abuse and promote family wellbeing (Jinich & Litrownik, 1999).

Cognitive treatment for behavioural disorders in children. Cognitive behavioural therapy involves providing information and advice to parents on child behaviour and how to resolve behavioural disorders with cognitive behavioural techniques. These can involve individual behavioural therapy, group therapy or the use of such media as computers, leaflets, books and audio- or video-tapes (Montgomery, 2003)

Treatment for the families of adolescents with conduct disorders. These interventions focus on parents, families, peers or partners to change parenting practices, the dynamic of the family environment, the dynamic of relationships, or the negative influence of peer interactions. Such interventions may include training parents on family interactions, discipline and managing behaviour; family therapy aimed to restructure family relationships, and multisystemic therapy (Ensink et al., 1997; Henggeler et al., 1997; Woolfenden et al., 2003).

6.3 Community level
Empowerment

Empowerment involves developing community capacity to gain control over problems and to build social capital. Examples include developing community leadership and efforts to enhance community communication and support networks. Organizational empowerment aims to enhance the capacity of organizations that work to promote the empowerment of less advantaged groups. Community and organizational empowerment programmes may use methods similar to many community programmes (Kar et al., 1999).

Community empowerment interventions. These aim to address some of the underlying causes of violence (e.g. poverty or inequalities between men and women). Interventions often involve several elements running at the same time, such as education and skills training of individuals or groups, income-generating projects and campaigns to highlight the problem of violence (Schuler et al., 1998; Sullivan & Bybee, 1999).

Media campaigns

Community-wide public information campaigns for the prevention of interpersonal violence aim to increase knowledge, raise awareness and change attitudes and violent behaviour at community level by giving educational messages to the community via mass media (e.g. television, radio, posters, internet, newspapers). Some initiatives have incorporated messages within popular radio or television dramas (Muirhead et al., 2001).

Media campaigns may be directed at interpersonal violence in general, or at child abuse and neglect, youth violence, intimate partner violence, sexual violence and elder abuse.

Community based campaigns

These use participatory methods to develop and enact community campaigns for the prevention of violence (e.g. involving community members in organizing marches or demonstrations, creating local

theatre productions highlighting issues around violence, development of community support or action groups that may campaign for legal changes). Community campaigns may target certain parts of a community (e.g. young people) and can take the form of small local programmes; however they may also be connected to large national campaigns (Maciak et al., 1999; PAHO, 2000).

Rights-based campaigns. Community campaigns sometimes base themselves upon international human rights instruments (such as the Convention on the Rights of the Child, or the Declaration on the Elimination of Violence against Women). Such campaigns may focus on equality of rights for groups that are disadvantaged in society (e.g. children, women, the elderly, the disabled), on changing the legal system in a country or region, or on advocacy work with individuals or groups to improve conditions according to existing laws. Some rights based campaigns also have educational programmes to raise awareness of the appropriate issues (Usdin et al., 2000).

School violence prevention curricula. Interventions in this category involve the incorporation of violence-prevention materials into the school curriculum and/or the development of policies to alter high-risk features of school settings. Violence prevention classes are of variable intensity and may include anger management, impulse control, empathy development, social skills and conflict resolution. Some curricula also link violence prevention with alcohol and substance misuse prevention, anti-bullying and mental health promotion. Other programmes include multiple components and involve the surrounding community (Orpinas et al., 2000).

Reform of institutional settings

Interventions under this category refer to efforts at preventing interpersonal violence by changing institutional settings (e.g., schools, workplaces, hospitals and long-term care institutions for the elderly) through appropriate policies, guidelines and protocols.

Schools-based anti-bullying interventions. These are aimed at reducing bullying in schools by changing community, family, school and classroom environments. Methods may include raising awareness about bullying; yearly surveys on bullying prevalence; the development of school rules (including disciplinary procedures) for bullying; skills development to prevent bullying; greater school playground supervision, and the establishment of school committees for bullying prevention. Some programmes also set up parent discussion groups and involve parents or children who are either victims or perpetrators of violence (Stevens et al., 2001).

Workplace violence prevention. Refers to interventions aimed at preventing violence among and toward employees by linking violence prevention with organizational management and development. (Krug et al., 2002).

Reforming hospitals and long-term care institutions. Interpersonal violence prevention in hospitals and long-term care institutions involves the development of policies, guidelines and protocols designed to prevent the abuse of patients by staff, and violence toward staff by patients and those that accompany or visit them.

Screening in primary care settings

Screening for domestic violence. Screening interventions aim to identify women who have experienced domestic violence and provide support and referral to specialist services. Health care professionals in a variety of settings (e.g. emergency departments, antenatal care, primary health care settings) receive training in identifying women who have experienced domestic violence. Some health care settings also use a standard protocol to ask questions and document findings.

Screening for elder abuse. These are interventions to identify elder abuse, and involve training health care professionals in emergency departments or primary care settings. Some health care settings also use a standard protocol to ask questions and document

findings. The intention is to identify older people who have experienced abuse and provide support and referral to specialist and legal services (Paris et al., 1995)

Screening for youths at high risk for violence. These interventions involve training health workers to identify and refer youths at high risk for violence, both as perpetrators and as victims (Krug et al., 2002).

Strategies and special services to enhance community safety

This category refers to efforts at reducing interpersonal violence through the implementation of community level interventions that address the physical infrastructure, the social fabric, and exposure to risk factors such as alcohol, drugs and firearms. Examples include:

— community policing;
— police clampdown on gang activities;
— reducing the availability of alcohol;
— after-school programmes;
— buying back guns;
— increasing the availability and quality of child care facilities;
— increasing the availability and quality of preschool enrichment programmes;
— providing after-school programmes to extend adult supervision;
— improve lighting on dark streets;
— installing closed-circuit television (CCTV) cameras in high-risk areas;
— create safe routes for children and youth.
(Krug et al., 2002).

6.4 Societal level

Governments may launch broad programmes to benefit society, which may be aimed at reducing interpersonal violence either directly or indirectly. Examples of society level interventions include:

— reduction of income inequality;
— de-concentrating poverty;

— enforcing laws prohibiting the illegal transfer of guns;
— strengthening and improving police and judicial systems;
— reforming educational systems;
— establishing job creation programmes for the unemployed.
(Krug et al., 2002).

6.5 Types of interventions not listed above

If none of the violence prevention interventions listed above adequately describes those employed by your programme, briefly describe the interventions and prevention levels at which they are aimed.

ITEM 7. TARGET POPULATIONS

A target population is the population or group of people that the programme intends to benefit, and the indicators under Item 7 are designed to capture the characteristics of the target population. For instance, an intervention aimed at elderly male victims of violence would receive three ticks in the sub-items under category 7: for 7.1, age, "elderly (60+ yr)"; for 7.2, sex, "males only"; and for 7.3, victims/perpetrators "victims only".

ITEM 8. SITES AND SETTINGS

The choice of the site or setting for a particular programme provides crucial information on the demographics and the circumstances of that target population. Settings may include schools, health care facilities, old age homes, prisons, workplaces, neighbourhoods, households and other public facilities such as bars and clubs.

ITEM 9. PROGRAMME INFORMATION

This item requests general information about the programme, such as its scope of operation and the resources used in a given time period.

9.1 Single or multiple sites

Defines whether the programme encompasses one or more sites (e.g. communities, towns, districts).

9.2 Operational scope

This requests information on whether the programme focuses on only one type of intervention (e.g. parent training, individual counselling, mentoring programmes), or multiple types of intervention (e.g. the Triple-P programme discussed in Chapter 2 (section 2.2.4), which has several interventions directed at the relationship and community levels). The third option is for programmes that may not have an explicit aim to reduce violence, but may have a marked preventive effect by modifying risk factors for violence, such as unemployment or poverty.

9.3 and 9.4 Coverage and resources

The number of people reached by the programme in a given time as well as resources utilized indicate the magnitude of a specific programme. The resources used in the last or most recent 12 months of the programme (budget, human and physical resources) provide information on the resources needed to set up such a programme and indicate how adequately equipped a specific programme is.

ITEM 10. INFORMATION ON PROGRAMME PLAN, IMPLEMENTATION AND OUTCOMES

In Chapter 2, the logic of planning and implementing prevention programmes was emphasized. If the steps are well defined, well motivated, well documented and the programme has the support of stakeholders, it is more likely to be successfully implemented. It is therefore important to document the planning and the process of implementation of prevention programmes.

10.1 Programme planning

Important dimensions within programme planning are:

Triggering event. The motivation behind implementing the programme may have been an event (such as a murder involving a celebrity, a school shooting, or a high-profile rape incident), which acted as a trigger to mobilize the political, community and other stakeholder support needed to harness the necessary will and resources.

Needs assessment. A needs assessment may have been conducted to determine the type and scale of the problem. This may have been based upon routine information, a special survey or through consulting the stakeholders.

Stakeholder identification and consultation. Whether stakeholders were identified, consulted and agreement reached will influence the degree of support for a programme and ultimately whether it is implemented successfully. This process is also used to determine the type and importance of the problem for the affected communities.

Training. Training of programme staff and collaborating partners is important to ensure that they have the skills and knowledge necessary for the successful and sustainable implementation of the programme.

Appropriate institutional and political support. Support from the institutions involved and political powers is necessary for the successful and sustainable implementation of the programme.

Agreement. Agreement as to the goals and objectives of the programme by the different participating organizations is necessary for the programme to be successful.

Community participation. There should be evidence that the intervention was explained to the target group and accepted by both this group and by other stakeholders. In some programmes, the degree to which the community participates in the interventions is often an indication of the acceptability and credibility of the programme, particularly for community level interventions. Community participation is not part of all interventions (e.g. in the case of in-

dividual counselling), in which case you could tick the "not applicable" option.

Formal evaluation component. If the programme includes a formal science-based evaluation component, then Table 10.1 at the end of the instrument should be completed. This table collects the following information for each intervention in the programme: whether the evaluation was planned from the outset, evaluation design, process and outcome measures, major findings, evaluation time period and cost-effectiveness.

If there is no formal evaluation, then the documenter should record in what other way the programme manager attempts to monitor whether the programme is achieving its objectives. This may be entirely based on subjective impressions, or make use of routinely available information about the services delivered, such as the number of workshops given and number of participants reached.

10.2 Programme documentation

In this sub-item of the instrument, information is collected on whether there is routine documentation of programme activities: writing of progress reports; the existence of other sources of information to monitor progress of the programme; whether adverse events are monitored; funds are spent as intended; the outputs of the programme (such as curricula, protocols, evaluation tools). A copy of any documentation should be requested for verification of data collected on the programme.

10.3 Outcomes

This sub-item collects relevant information on whether the stated programme goals have been achieved. It also asks whether the programme should be repeated elsewhere, a recommendation that should be made only for scientifically evaluated programmes which show a positive impact on the problem.

10.4 Information dissemination

Programmes should try to disseminate the results of their endeavours to the communities in which they are active as well as to the wider community. This may be in the form of feedback meetings or workshops and fosters ownership. In addition there may be evidence of dissemination to policy-makers and the wider violence prevention community in the way of reports, presentations and peer review publications.

Conclusion

In this section the individual items of the instrument have been discussed and the rationale for using them explained. The focus is on the criteria for identifying and classifying programmes, and recording information on a programme's own level of evaluation and documentation.

3.6 Assessing data quality, gaps and feedback

The information recorded in the instrument (see Appendix I) should be reviewed to determine if there are any gaps. Gaps which are identified should then be addressed by a well-structured interview of personnel, obtaining and/or re-examining documentation, and if necessary (and feasible) site visits, and examining other sources of information including primary data.

Programme staff should be sent the information recorded on the instrument for review to ensure accuracy and completeness. This provides feedback on the systematic documentation of their programme and fosters ownership of the documentation process and its outcomes.

3.7 Entering information into the database

The documenter should ensure that data collected on the instrument for each programme are entered on to an electronic database for the community, city, province or country covered by the documentation

exercise. These data will also be collated by the Injuries and Violence Prevention Department of WHO in Geneva, Switzerland, as part of a global database of violence prevention programmes. This will make it accessible to violence prevention workers around the world.

3.8 Communicating with the programme

Communicate in writing with the programme management, thanking them for their participation and interest and informing them that they will receive details of how to access the local and global databases of violence prevention programmes when completed.

3.9 Keeping a field diary

It would be instructive for documenters to keep a field diary so as to record the programmes contacted, those selected, reasons for selection, and information on the process of getting to know the programmes and how the documentation was carried out.

3.10 Conclusion

This chapter contains an account of what documenters should do to identify and document violence prevention programmes. This will also require entry of the information collected into an electronic database, which will be collated to form a resource of global violence prevention programmes. This resource will constitute the evidence base of violence prevention programmes and will be accessible to those wishing to implement violence prevention programmes and those engaged in research.

References

Abramson JH, Abramson ZH (1999). *Survey methods and community medicine*. Edinburgh, Harcourt Brace.

Anetzberger GJ, Palmisano B, Sanders M et al. (2000). A model intervention for elder abuse and dementia. *Gerontologist*, 40(4): 492–497.

Babbie E, Mouton J (2001). *The practice of social research*. Cape Town, Oxford University Press.

Centers for Disease Control and Prevention (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report*, 48 (RR-11). Also available on the Internet at www.CDC.gov/Eval/framework.htm accessed 31.11.03.

Conte JR (1985). An evaluation of a program to prevent the sexual victimisation of young children. *Child Abuse and Neglect*, 9: 319–328.

Coren E, Barlow J (2003). Individual and group based parenting programmes for improving psychosocial outcomes for teenage parents and their children (Cochrane Review). In: *The Cochrane Library*, Issue 4. Chichester UK, John Wiley & Sons.

Dunford FW (2000). The San Diego Navy Experiment: an assessment of interventions for men who assault their wives. *Journal of Consulting and Clinical Psychology*, 68(3): 468–476.

Durant RH, Barkin S, Krowchuk DP (2001). Evaluation of a peaceful conflict resolution and violence prevention curriculum for sixth grade students. *Journal of Adolescent Health*, 28(5): 386–393.

Ensink K, Robertson BA, Zissis C et al. (1997). Conduct disorder among children in an informal settlement. *South African Medical Journal*, 87(11): 1533–1537.

Fantuzzo J, Sutton-Smith B, Atkins M et al. (1996). Community based resilient peer treatment of withdrawn maltreated preschool children. *Journal of Consulting and Clinical Psychology*, 64(6): 1377–1386.

Foelker GA, Holland J, Marsh M, Simmons BA. (1990). A community response to elder abuse. *Gerontologist*, 30(4): 560–562.

Foshee VA (1998). An evaluation of safe dates, an adolescent dating violence prevention programme. *American Journal of Public Health*, 88(1): 45–50.

Gallagher SS (2000) Program evaluation – balancing rigor with reality. *Injury Prevention*, 6(2): 78–79.

Giuliano JD (1994). A peer education program to promote the use of conflict resolution skills among at-risk school age males. *Public Health Reports*, 109(2): 158–161.

Haddon W (1970). On the escape of tigers: an ecological note. *American Journal of Public Health*, 60: 2229–2234.

Henggeler SW, Melton GB, Brondino MJ et al. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: the role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, 65(5): 821–833.

Iaquinta DI, Dreschler AW (2000). Defining peri-urban: understanding rural–urban linkages and their connection to institutional contexts. Presented at the Tenth World Congress, International Rural Sociology Association, Rio, August 1, 2000.

Jinich S, Litrownik AJ (1999). Coping with sexual abuse: development and evaluation of a videotape intervention for non-offending parents. *Child Abuse and Neglect*, 23(2): 175–190.

Kar SB, Pascual CA, Chickering KL (1999). Empowerment of women for health promotion: a meta-analysis. *Social Science and Medicine*, 49: 1431–1460.

Krug EG (1999). *Injury: a leading cause of the global burden of disease*. Geneva, WHO.

Krug EG, Dahlberg LL, Mercy JA et al., eds (2002). *World report on violence and health*. Geneva, WHO. Also available on the Internet at http://www.who.int/violence injury prevention/

Kurrle SE, Sadler PM, Lockwood K, Cameron ID (1997). Elder abuse: prevalence, intervention and outcomes in patients referred to four Aged Care Assessment Teams. *Medical Journal of Australia*, 166(3): 119–122.

Last JM (1983). *A dictionary of epidemiology*. Oxford, Oxford University Press.

Lett R, Kobusingye O, Sethi D (2002). A unified framework for injury control: the public health approach and Haddon's Matrix combined. *Injury Control and Safety Promotion*, 9: 1–7.

Maciack BJ, Guzman R, Santiago A et al. (1999). Establishing La Vida: a community-based partnership to prevent intimate violence against Latina women. *Health Education and Behaviour*, 26(6): 821–840.

Meyerson LA (2001). Sexual revictimisation prevention: an outcome evaluation. *Journal of Consulting and Clinical Psychology*, 69(1): 25–32.

Mgalla Z, Schapink D, Boerma JT (1998). Protecting school girls against sexual exploitation: a guardian programme in Mwanza, Tanzania. *Reproductive Health Matters*, 6(12): 19–30.

Montgomery P (2003). Media-based behavioural treatments for behavioural disorders in children (Cochrane Review). In: *The Cochrane Library*, Issue 4. Chichester UK, John Wiley & Sons.

Muirhead D, Kumaranayake L, Watts C (2001). Economically evaluating the 4th Soul City series. Report prepared for the Soul City Institute for Health and Development Communication, Centre for Health Policy, University of Witwatersrand, South Africa and Health Policy Unit, London School of Hygiene and Tropical Medicine, No. 4: 560–562.

Olds D, Eckenrode J, Henderson CR Jr et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. *Journal of the American Medical Association*, 278(8) Aug 27: 637–643.

Orpinas P, Kelder S, Frankowski R et al. (2000). Outcome evaluation of a multi-component violence-prevention program for middle schools: the students for peace project. *Health Education Research*, 15(1): 45–58.

Owen JM (1999). *Program evaluation – forms and approaches*. London, Sage publications.

PAHO (2000). *Juvenile violence in the Americas' Division of Health Promotion and Protection*. Washington DC, Pan American Health Organization.

Paris BE, Meier DE, Goldstein T et al. (1995). Elder abuse and neglect: how to recognise warning signs and intervene. *Geriatrics*, 50(4): 47-53.

Pencheon D, Guest C, Melzer D, Gray JAM, eds (2001). *Oxford handbook of public health practice*. Oxford, Oxford University Press.

Sanders MR (1999). Triple P-Positive Parenting Program: towards an empirically validated multi-level parenting and family support strategy for the prevention of behaviour and emotional problems in children. *Clinical Child [and] Family Psychology Reviews*, 2: 71–90.

Schuler SR, Hashemi SM, Badal SH (1998). Men's violence against women in rural Bangladesh: undermined or exacerbated by microcredit programmes? *Development in Practice*, 8(2): 148–157.

Stevahn L, Johnson DW, Johnson RT et al. (2000). Effects of conflict resolution training integrated into a kindergarten curriculum. *Child Development*, 71(3): 772–84.

Stevens V, De Bourdeaudhuij I, Van Oost P (2001). Anti-bullying interventions at school: aspects of programme adoption and critical issues for further programme development. *Health Promotion International*, 16(2): 155–167.

Sullivan CM, Bybee DI (1999). Reducing violence using community based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology*, 67(1): 43-53.

Tutty LM (1997). 'Child sexual abuse prevention programs: evaluating 'who do you tell'. *Child Abuse and Neglect*, 21(9): 869–881.

UNICEF (2003). *Life skills based education.* Available on the Internet at http://www.unicef.org/programme/lifeskills/whatwhy/index.html accessed 28.09.03.

US Department of Health and Human Services. (2001). *Youth violence: a report of the Surgeon General*. Rockville MD: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; and National Institutes of Health, National Institute of Mental Health.

Usdin S, Christofides N, Malepe L, Maker A (2000). The value of advocacy in promoting social change: implementing the new Domestic Violence Act in South Africa. *Reproductive Health Matters*, 8(16): 55–65.

White P, Bradley C, Ferriter M, Hatzipetrou L (2003). Managements for people with disorders of sexual preference and for convicted sexual offenders (Cochrane Review). In: *The Cochrane Library*, Issue 4. Chichester UK, John Wiley & Sons.

Wolfe DA, Jaffe PG (1999). Emerging strategies in the prevention of domestic violence. *Future Child* 9(3): 133–144.

Woolfenden SR, Williams K, Peat J (2003). Family and parenting intervention in children and adolescents with conduct disorder and delinquency aged 10–17 (Cochrane Review). In: *The Cochrane Library*, Issue 4. Chichester UK, John Wiley & Sons.

World Bank (2003). *World development report 2002*. Available on the Internet at http://www.worldbank.int/html/extdr/pubs.htm accessed 15.09.03.

Wright J (1998). *Health needs assessment in practice*. London, BMJ Books.

Wurtele SK, Kast LC, Miller-Perrin CL, Kondrick PA (1989). Comparison of programs for teaching personal safety skills for preschoolers. *Journal of Consulting and Clinical Psychology*, 57(4): 505–511.

Zoritch B, Roberts I, Oakley A (2003). Day care for pre-school children Cochrane Review) In: *The Cochrane Library*, Issue 4. Chichester UK, John Wiley & Sons.

Glossary

ACCESS – The ease with which a population is able to use a service (when it is needed). This can be measured in terms of geographical access (distance and availability of transport), or by considering barriers to the service (e.g. lack of information, waiting times, financial or cultural bars) (Pencheon et al., 2001).

APPROPRIATENESS – Refers to whether the intervention or programme provided is relevant to the needs of the target population (Pencheon et al., 2001).

BEST PRACTICES – Strategies, activities or approaches that have been shown, through research and evaluation, to be effective at preventing and/or delaying violence or other problem behaviours.

COMMUNITY PARTICIPATION – People's involvement in decision-making about what should be done and how; for example, in the implementation of a programme, sharing its benefits, and in the evaluation of a programme. The degree to which a community participates in an intervention is often used as an indicator of programme acceptance.

COST-EFFECTIVENESS – Sometimes referred to as economic efficiency, is a measure of the cost in resources that is incurred in achieving results. It is determined by the balance between what was put in (in time, manpower, equipment, etc. or their monetary equivalent) and what the results/outputs were. Something that is cost-effective achieves relatively high gains for relatively low costs.

EFFECTIVENESS – The extent to which a specific intervention, procedure, regimen or service, when deployed in the field, does what it is intended to do for a defined population (Last, 1983).

EFFICIENCY – The extent to which resources (financial, human, physical or time) that are used to provide a specific intervention or service of known efficacy and effectiveness are minimized (Last, 1983).

EVALUATION – A process that attempts to determine as systematically and objectively as possible the relevance, effectiveness and impact of activities in the light of their objectives (Last, 1983). Programme evaluation includes the phases of pre-intervention needs assessment; formative (or process-) assessment; and summative (or outcomes) assessment.

EXPERIMENTAL DESIGN – Usually exhibits random sampling with experimental and control groups. In evaluation research, it is often impossible to achieve such an assignment of subjects; a quasi-experimental design is used (i.e. a lack of random assignment) rather than forego evaluation.

GOOD PRACTICES – "Good" or "promising" practices refer to programmes that have met some but not all of the criteria in order to be considered a best practice programme.

INTERPERSONAL VIOLENCE – As distinguished from self-directed and organized violence, interpersonal violence can be subdivided into: a) family and intimate partner violence, which occurs between family members and intimate partners, usually, though not always, taking place in the home; this includes child abuse and neglect, intimate partner violence and elder abuse; b) community violence which includes violence between unrelated individuals, who may or may not know each other, and generally take place outside the home the latter includes youth violence, random acts of violence, rape or sexual assault by acquaintances or strangers, and violence in institutional settings such as schools, workplaces, prisons and nursing homes.

INTERVENTION – Interventions are sets of actions and decisions structured in such a way that their successful implementation would lead to clearly identifiable outcomes and benefits.

NEEDS ASSESSMENT – A systematic method of identifying unmet needs. It may involve one or more methods including epidemiological and qualitative approaches. The information from a needs assessment can be used to identify priorities and inform the development of a programme or services. (Wright, 1998).

PREVENTION – Violence prevention strategies and programmes are developed to stop violent events from happening (primary prevention), to minimize the harm that occurs once a violent event has taken place (secondary prevention), or to treat and rehabilitate victims and perpetrators to re-adapt to society (tertiary prevention). These strategies may target everyone in a population (universal interventions), or only those people with an enhanced risk of violence (selective interventions), or those individuals and groups that have already demonstrated violent behaviour and/or been victimized (indicated interventions).

PROGRAMME – A programme is a series of interrelated preventive activities, interventions, or projects with a formal set of procedures and features, designed to have the desired outcome of reducing the level of violence. Programmes in this sense can be regarded as a specific type of social intervention, varying in terms of scope, complexity, and time frame.

PUBLIC HEALTH APPROACH – This approach provides a theoretical rationale for why effective prevention programmes should necessarily be based on evidence. The importance lies in the logic of the approach, defined in four steps: define the problem and assess its magnitude; identify risk factors and causes of violence; develop and test interventions; implement best and good practices widely.

RISK FACTOR – An attribute or exposure that is associated with an increase in the probability of a specified outcome (e.g. experiencing or perpetrating interpersonal violence). Risk factors are not necessarily causal (Last, 1983). Examples of risk factors include: male gender, young age, alcohol and carrying weapons.

SCREENING – The systematic application of a test or inquiry to identify individuals at sufficient risk of a specific disorder to benefit from further investigation or direct preventive action (Pencheon et al., 2001).

SOCIOECONOMIC STATUS – Usually defined by both objective (i.e per capita income, educational level, life expectancy), and subjective (i.e. ascribed status, ethnicity, political history) criteria. Usually some index is used to determine socioeconomic status so that measurement/indication can be standardized.

SURVEILLANCE – The ongoing, systematic collection, collation and analysis of data with prompt dissemination of the resulting information to those who need to know, so that an action can result (Last, 1983).

SUSTAINABILITY – Sustainability of a programme points to the importance of its implementation and management in a socially, ecologically and economically viable manner, so that it can survive over time

TARGET POPULATION- The group of people for whom an intervention or programme is planned (Last, 1983).

VIOLENCE – The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (Krug et al., 2002).

WORLD BANK DEFINITIONS OF LOW, MIDDLE AND HIGH INCOME COUNTRIES – This handbook uses the World Bank classification of countries by economic status. They are calculated using the World Bank Atlas method, using an average over the last 3 years Gross National Income per capita per annum. The classification for 2002 is as follows ($ are US dollars):

Low income countries: $755 or less

Middle income countries: $756–$9265 (which is made up of lower middle and upper middle)

Lower middle income countries: $756–$2995

Upper middle income countries: $2,996–$9265

High income countries: $9266 or more.

An up-to-date list of the economic classification of each individual country can be found in the World Development Report on the Internet website:

http://www.worldbank.int/html/extdr/pubs.htm

APPENDIX I

The instrument for gathering information on violence prevention programmes

1. IDENTIFICATION AND CLASSIFICATION DETAILS

1.1   Name of programme (in full): _____

_____

_____

1.2   Contact details: _____

_____

_____

_____

1.3   Date of programme review   D | D | M | M | Y | Y | Y | Y

1.4   Date of start of programme   D | D | M | M | Y | Y | Y | Y

1.5   Intended termination date of programme   D | D | M | M | Y | Y | Y | Y

1.6   Site visit   ☐ Y   ☐ N

1.7   Interviews with programme managers   ☐ Y   ☐ N

1.8   Interviews with field workers   ☐ Y   ☐ N

1.9   Interviews with male community stakeholders   ☐ Y   ☐ N

1.10   Interviews with female community stakeholders   ☐ Y   ☐ N

1.11   Examination of reports   ☐ Y   ☐ N

1.12   Examination of data collected by the programme   ☐ Y   ☐ N

1.13   Other review methods (please specify): _____

_____

_____

1.14   Brief description of programme: _____

_____

_____

Why was programme initiated? _____

_____

_____

What are the main goals? _____

_____

_____

List interventions in the programme which aim to reduce violence _____

_____

_____

_____

Who is/are the donor(s)? _____

_____

_____

Who are the stakeholders? _____

_____

_____

2. GEOGRAPHY AND SCOPE

2.1 Scope

International ❑

National ❑

Regional ❑

District ❑

Local ❑

2.2 Geographical location

Continent _____

Country _____

Region/province _____

District _____

Town _____

Nearest town _____

2.3 Setting of the target population

Rural ❑

Peri-urban ❑

Urban ❑

3. INCOME LEVEL

3.1 What is the per capita GDP of country (express in US$)? _____

What is the median income level of families or participants served by the programme
(express in US$)? _____

3.2 How would you describe the target population's income relative to that of the country as a whole

Very poor ❑

Low income ❑

Middle income ❑

High income ❑

Mixed ❑

4. TYPE AND NATURE OF INTERPERSONAL VIOLENCE

(Tick both type and nature of violence – more than one box can be ticked)

4.1   Family / intimate partner

	Type of violence	Nature of violence			
		Phys.	**Sex**	**Psych.**	**Depri/Negl.**
Child abuse	❒	❒	❒	❒	❒
Intimate partner violence	❒	❒	❒	❒	❒
Elder abuse	❒	❒	❒	❒	❒

4.2   Community violence

Acquaintance violence	❒	❒	❒	❒	❒
Stranger violence	❒	❒	❒	❒	❒

5. THEORETICAL / PHILOSOPHICAL ORIENTATION

Is the programme explicitly based on any theoretical or philosophical assumptions, (e.g. public health approach, feminism, social cognitive theory, religion).   ❒ Y   ❒ N

If yes, please specify: _____

6. NATURE AND LEVEL OF INTERVENTION AND PREVENTION

(Tick both intervention type and level of prevention)

	Intervention type	Level of prevention		
		Prim.	**Sec.**	**Tert.**

6.1   Individual level

Interventions using treatment and rehabilitation

	Intervention type	Prim.	Sec.	Tert.
Treatment for adolescents with conduct disorders	❒	❒	❒	❒
Individual counselling and social casework	❒	❒	❒	❒
Treatment and rehabilitation services for victims of violence	❒	❒	❒	❒
Treatment and rehabilitation services for perpetrators of violence	❒	❒	❒	❒
Treatment of child abuse offenders	❒	❒	❒	❒
Probation or parole programmes	❒	❒	❒	❒
Residential programmes in psychiatric or correctional institutes	❒	❒	❒	❒

Educational interventions

	Intervention type	Prim.	Sec.	Tert.
Providing incentives for youths at high risk of violence to complete secondary schooling	❒	❒	❒	❒
Higher/vocational training	❒	❒	❒	❒
Academic enrichment programmes (including pre-school enrichment)	❒	❒	❒	❒

	Intervention type	Level of prevention		
		Prim.	Sec.	Tert.
Skills development programmes				
Skills programmes for younger children (5–12 yr)	❐	❐	❐	❐
Skills programmes for teenagers (13–18 yr)	❐	❐	❐	❐
Sexual abuse prevention skills training	❐	❐	❐	❐
Life skills approach	❐	❐	❐	❐
Other individual-level interventions				
Hotlines	❐	❐	❐	❐
Training in the safe use of guns	❐	❐	❐	❐
Programmes modelled on basic military training	❐	❐	❐	❐
Trying young offenders in adult courts	❐	❐	❐	❐
Social development programmes	❐	❐	❐	❐
Conflict resolution and anger management	❐	❐	❐	❐

6.2   Relationship level

	Intervention type	Prim.	Sec.	Tert.
Skills development				
Parent skills training	❐	❐	❐	❐
Conflict resolution for child minders of pre-school children	❐	❐	❐	❐
Mentoring	❐	❐	❐	❐
Home–school partnership programmes to promote parental involvement	❐	❐	❐	❐
Peer mediation	❐	❐	❐	❐
Peer linkage	❐	❐	❐	❐
Peer education	❐	❐	❐	❐
Home visits, care groups, services				
Parent education and home visitation	❐	❐	❐	❐
Day care	❐	❐	❐	❐
Multidisciplinary intervention teams for caregivers of the elderly or disabled	❐	❐	❐	❐
Interventions using treatment / therapy				
Family therapy and additional support for at-risk families	❐	❐	❐	❐
Cognitive treatment for behavioural disorders in children	❐	❐	❐	❐
Treatment for the families of adolescents with conduct disorders	❐	❐	❐	❐

	Intervention type	Level of prevention		
		Prim.	Sec.	Tert.

6.3   Community level

Empowerment

Community empowerment interventions	❐	❐	❐	❐

Media campaigns

Media campaigns for:

interpersonal violence in general	❐	❐	❐	❐
child abuse and neglect	❐	❐	❐	❐
youth violence	❐	❐	❐	❐
intimate partner violence	❐	❐	❐	❐
sexual violence	❐	❐	❐	❐
elder abuse	❐	❐	❐	❐
other	❐	❐	❐	❐

If other, please specify: _____

_____

_____

Community based campaigns

Rights-based campaigns	❐	❐	❐	❐
School violence prevention curricula	❐	❐	❐	❐

Reform of institutional settings

Schools-based anti-bullying interventions	❐	❐	❐	❐
Workplace violence prevention	❐	❐	❐	❐
Reforming hospitals and long-term care institutions	❐	❐	❐	❐

Screening in primary care settings

Screening for:

domestic violence	❐	❐	❐	❐
elder abuse	❐	❐	❐	❐
youths at high risk for violence	❐	❐	❐	❐

Strategies and special services to enhance community safety

Community policing	❐	❐	❐	❐
Police clampdown on gang activities	❐	❐	❐	❐
Reducing availability of alcohol	❐	❐	❐	❐
After-school programmes	❐	❐	❐	❐

	Intervention type	Level of prevention		
		Prim.	Sec.	Tert.
Buying back guns	❏	❏	❏	❏
Increasing the availability and quality of child care facilities	❏	❏	❏	❏
Increasing the availability and quality of pre-school enrichment programmes	❏	❏	❏	❏
Providing after-school programmes to extend adult supervision	❏	❏	❏	❏
Improve lighting on dark streets	❏	❏	❏	❏
Install CCTV cameras on high-risk areas	❏	❏	❏	❏
Create safe routes for children and youth	❏	❏	❏	❏

6.4   Societal level

	Intervention type	Level of prevention		
Reduction of income inequality	❏	❏	❏	❏
De-concentrating poverty	❏	❏	❏	❏
Enforcing laws prohibiting the illegal transfer of guns	❏	❏	❏	❏
Strengthening and improving police and judicial systems	❏	❏	❏	❏
Reforming educational systems	❏	❏	❏	❏
Establishing job creation programmes for the unemployed	❏	❏	❏	❏

6.5   Types of interventions not listed above

Please describe: _____

_____

_____

_____

_____

7. TARGET POPULATIONS

(more than one option may be ticked)

7.1   Age

All ages (general pop.)   ❏

Children (0–11 yr)   ❏

Young people (12–24 yr)   ❏

Adults (25–60 yr)   ❏

Elderly (60+ yr)   ❏

7.2   Sex

Males only   ❏

Females only   ❏

Males and females   ❏

7.3   Victims/perpetrators

Victims only ❐

Perpetrators only ❐

Both victims and perpetrators ❐

Others ❐

If others, please specify: _____

_____

_____

8. SITES AND SETTINGS

Schools ❐

Health care facilities ❐

Old age homes ❐

Prisons ❐

Workplaces ❐

Neighbourhoods ❐

Households ❐

Other facilities (e.g. bar, club) ❐

If others, please specify: _____

_____

_____

9. PROGRAMME INFORMATION

9.1   Single or multiple sites

Single ❐

Multiple ❐

If multiple, indicate number of sites: _____

9.2   Operational scope

Focused programme delivering only one type of intervention with explicit goal to prevent violence ❐

Comprehensive programme delivering multiple types of intervention with explicit goal to prevent violence ❐

Programme that addresses risk factors and does not explicitly aim to prevent violence ❐

9.3   How many people were reached by this programme in the last or most recent 12 months? _____

9.4 Resources

Estimated annual programme budget (express in US$): _____

Number of people directly involved in programme implementation
(volunteers and paid staff): _____

Staff employed:

number of administrative staff _____

number of fieldworkers _____

List number and type of fixed assets (e.g. computers, vehicles, office space, databases):

_____

_____

_____

_____

10. INFORMATION ON PROGRAMME PLAN, IMPLEMENTATION AND OUTCOMES

10.1 Programme planning

Was there an event which triggered the motivation to have the programme? ☐ Y ☐ N

If yes, please specify: _____

_____

_____

Was a needs assessment carried out to define the type and scale of the problem? ☐ Y ☐ N

If yes, specify findings: _____

_____

_____

Were stakeholders identified and contacted? ☐ Y ☐ N

Was agreement reached with stakeholders? ☐ Y ☐ N

— Was training done with programme staff and collaborating partners? ☐ Y ☐ N

— Was appropriate political support sought and obtained for your programme? ☐ Y ☐ N

If yes please explain: _____

_____

_____

_____

— Was appropriate institutional support sought and obtained for your
programme? ☐ Y ☐ N

If yes, was agreement reached between participating organizations on
objectives, goals, and definitions? ☐ Y ☐ N

— Did the community participate in any way? ☐ NA ☐ Y ☐ N

Does the programme include a formal evaluation component? ☐ Y ☐ N

If yes, please complete Table 10.1 at the end of the instrument.

If no, please indicate how the programme manager knows whether the programme is achieving its objectives: _____

_____

_____

_____

10.2 Programme documentation

Are intervention activities routinely documented?   ☐ Y   ☐ N

If yes, please indicate how often and in what manner: _____

_____

_____

_____

Are progress reports written?   ☐ Y   ☐ N

If yes, a copy of reports should be obtained

What other sources of information are there to monitor the progress of the programme?

_____

_____

_____

_____

Are adverse events or unintended harmful effects monitored?   ☐ Y   ☐ N

If yes, by whom: _____

Are funds being spent as planned   ☐ Y   ☐ N

List outputs from the programme (e.g. curricula, protocols, evaluation tools):

_____

_____

_____

_____

10.3 Outcomes

Were the goals achieved as planned?   ☐ Y   ☐ N

Explain: _____

_____

_____

_____

_____

What are the major achievements? Please list them:

_____

_____

_____

_____

Should this programme be recommended to be repeated elsewhere?
(only if scientifically evaluated) ❐ Y ❐ N

10.4 Information dissemination

Report distribution ❐

Meetings ❐

Conferences ❐

Media coverage ❐

Reporting to community ❐

Reporting to policy makers ❐

Journal publication ❐

List languages used:

_____

_____

_____

_____

_____

TABLE 10.1 MATRIX TO DESCRIBE FORMAL EVALUATION PROCEDURES AND MAJOR FINDINGS FOR EACH INTERVENTION WITHIN THE PROGRAMME.

Intervention	Evaluation part of programme from outset?	Design of evaluation	Process measures	Outcome measures	Major findings	Time period of evaluation	Cost-effectiveness (give details)

APPENDIX II

Template for use to identify programmes for documentation

This section has been written for use by documenters to help in identifying interpersonal violence prevention programmes for possible documentation. It consists of two parts, a letter and a template with a series of questions seeking essential information on programmes. The template suggested in Part 2 is for the initial identification of programmes of interpersonal violence prevention. On the basis of the information collated, the documenter can select programmes that are suitable for inclusion (see text Section 3.2). For those selected, detailed information can be obtained using the instrument in Appendix I

Part 1. Suggested letter to programme managers

Dear

Re: Documentation of Interpersonal Violence Prevention Programmes.

We are writing to you regarding the initiative by the WHO and ………. (local partner such as Ministry of Health) to identify interpersonal violence prevention programmes. This follows on from WHO's publication of the *World report on violence and health* in 2002 which shows that the burden of disease from violence is very high and that it affects the daily lives of millions of people.

There is a growing awareness that prevention programmes directed at interpersonal violence are effective measures in reducing deaths and trauma. However, many of these programmes have not been documented in a way that others working in the field of violence prevention who may want to implement similar programmes can easily access them. The purpose of our writing to you is to obtain some initial information about any interpersonal violence prevention programmes you may know of.

Interpersonal violence can be defined as "the intentional use of physical force or power, threatened or actual, against another person, that results in or has a high likelihood of resulting in death, injury or harm, which may be physical, sexual, psychological, or due to deprivation or neglect". We are therefore concerned with identifying programmes that work towards reducing these types of violence, whether they occur in the family (affecting children, partners or elders), or in the community between acquaintances or strangers.

In writing to you we are seeking to identify as many programmes as possible which are directed against interpersonal violence. The questions requesting the specific information we need are listed below. You may use the template provided. Where you can identify more than one programme, please supply the requested information for each of the programmes.

The information that you provide us will be shared only with people working in the violence prevention field. We may contact you later to get further details about the programmes you identify for potential documentation.

We would be happy to provide any further information that you may require.

Thank you for your kind attention. Please contact ………………………… on ………………………………

Yours sincerely,

Name

Position

Part 2. Please provide the following information on any interpersonal violence prevention programmes which you may be aware of by answering the following questions:

1. Name of programme : _____

    _____

2. Contact details: _____

    _____

    _____

    _____

3. Approximate date of start of programme: _____

4. Please provide brief description of programme: _____

    _____

    _____

    _____

5. What are the main goals of programme: _____

    _____

    _____

    _____

6. Geographical location of programme:

    Country _____   Region/province _____

    District _____   Town _____

    Nearest town _____

7. Setting of the target population

    Rural ❐   Urban ❐   Peri-urban ❐

8. Please mark type of interpersonal violence that the programme aims to prevent (more than one option may be ticked):

    Child abuse   ❐   Intimate partner violence ❐   Elder abuse ❐
    Acquaintance violence   ❐   Stranger violence   ❐   General   ❐

9. Please specify the target populations (more than one option may be ticked):

    All ages (general population) ❐   Children(0–11 yr)   ❐
    Youth (12–24 yr)   ❐   Adults (25–60 yr)   ❐
    Elderly (60+ yr)   ❐   Males & females   ❐
    Males only   ❐   Females only   ❐

10. Does the programme work with victims or perpetrators or both?

    Victims only   ❐   Perpetrators only   ❐
    Both victims & perpetrators   ❐

    Others, please specify:

    _____

    _____

11. Has the programme been evaluated?   ❐ Y   ❐ N