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A QUALITATIVE STUDY OF SEXUAL VIOLENCE PREVENTION STRATEGIES THAT ENGAGE MEN AND BOYS

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An Abstract of a thesis submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements of the degree of Master of Public Health in the Executive MPH program
2014

ABSTRACT

A QUALITATIVE STUDY OF SEXUAL VIOLENCE PREVENTION STRATEGIES THAT TARGET MEN AND BOYS

By

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Abstract

This qualitative study was conducted to find out more about Rape Prevention Education (RPE) programs implemented across the United States that focus on targeting men and boys as a primary prevention strategy for sexual violence. RPE programs are programs at the State Department of Health in all 50 states and United States territories that receive funds from the RPE program, which resides at the CDC, Division of Violence Prevention. Each state then provides funding to programs that deliver sexual violence prevention programs at the community level. These local programs are comprised of a variety of organizational types with some being created and managed by the state as a state program and others being independent, nonprofit entities that engage in sexual and domestic violence prevention activities.

This study examined four primary research questions: 1) What does implementation for the selected strategies look like in practice; 2) What, if any, evaluation is being conducted; 3) What are the facilitators/barriers to evaluation and; 4) What types of technical assistance do programs need to conduct evaluation. These questions were selected because of an ongoing effort within the RPE program to assist grantees in evaluation, and in implementing effective programs to prevent sexual violence in their communities.

Four participant sites that implement RPE programs focused on men and boys were selected as part of a convenience sample. The programs of interest were Coaching Boys into Men (CBIM), Mentors in Violence Prevention (MVP) and My Strength. Interviews with the four sites were conducted in April, 2014 and findings were compiled using a cross-site matrix to look at differences and/or commonalities across emerging themes.

Findings revealed that local level programs are not conducting evaluation on the effectiveness of their strategies outside of general data collection from pre-post survey results. The reasons for this are multifaceted, but one of the major findings is that there is a lack of expertise and financial and human resources that impede evaluation. A set of recommendations, with associated intended outcomes, to alleviate some of the barriers is proposed for both state level RPE grantees and the CDC RPE program.

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CHAPTER 1: INTRODUCTION

Introduction and Rationale

The Centers for Disease Control and Prevention (CDC), Division of Violence Prevention (DVP) administers programs to prevent sexual violence. Sexual violence (SV) is defined as any sexual act that is perpetrated against the will of another and can include activities and behaviors such as, a nonconsensual sex act (rape), attempted rape, abusive sexual contact (unwanted touching), and non-contact sexual abuse (verbal harassment or threats) (Basile and Saltzman, 2002). The Rape Prevention Education (RPE) program is the sexual violence prevention program the CDC administers under the recently reauthorized Violence against Women Act (Black et al, 2011). In addition, the CDC funds the National Sexual Violence Resource Center that supports state and local efforts to end SV.

RPE activities concerning primary prevention of SV are funded through VAWA in all fifty states and nine United States territories. The primary goals are to reduce risk factors that may contribute to rape perpetration and victimization (Table 1), determine protective factors that contribute to the prevention of SV, develop and use the best available evidence for planning, implementing, and evaluating prevention programs, incorporate social change theories into prevention practices and evaluate programs for evidence of effectiveness in rape prevention (Black et al, 2011).

For many years, programs have primarily focused on victim protection and treatment and although these services are of great necessity, the real policy-driven goal of the RPE program is

To prevent SV before it occurs. According to the CDC, the working definition of SV prevention for the RPE program is "population-based and/or environmental and system-level strategies, policies, and actions that prevent sexual violence from initially occurring" (Centers for Disease Control and Prevention, 2004). Primary prevention efforts aim to prevent SV by modifying or removing factors that promote sexually violent behaviors, attitudes, or actions, and that are accepted by individuals and within at-risk populations (Centers for Disease Control and Prevention, 2004). Therefore, there is general agreement that in order to stop SV, resources must be engaged in primary prevention strategies that target perpetration.

Since the landmark implementation of the VAWA and the RPE program at the CDC, SV prevention programs have grown tremendously across the United States. State and local efforts focus on activities that identify risk factors associated with potential perpetration, the changing of social norms and beliefs about sexuality and gender, engaging bystanders in preventing SV, conducting research and surveillance activities to determine viable protective factors, and educating the community on how to identify risk factors among youth (Black et al, 2011).

Unfortunately, there is a lack of evidence-based knowledge about what really works to prevent SV. The RPE program has implemented guidance for state grantees to assist programs in developing robust evaluation plans as part of their program design process. Some organizations have developed strong evaluation capacity, while others are still struggling to develop and implement evaluation plans that measure the effectiveness of their chosen prevention strategies. Therefore, there is a gap in evidence of effectiveness of the many strategies programs use to prevent SV.

In addition, there is also a lack of knowledge regarding what SV prevention strategies are currently being implemented, how those strategies work on the ground, and what if any type of

evaluation is occurring (Tharp et al, 2011). This effort is the first step in collecting data on how local programs-those who are implementing SVP strategies on the ground- are working to prevent SV.

This study examines SV prevention strategies specifically focused on men and boys because they are the most common perpetrators of rape and are believed to be the most significant agents for preventing SV (World Health Organization, 2002). Strategies that target men and boys are focused on changing social norms, attitudes, beliefs, misconceptions and personal views on gender roles and equality (Miller et al, 2012). In addition, the RPE program recently requested that grantees submit inventories of the prevention strategies they currently fund in their local programs. This information will be used to develop a better understanding of what is happening on the ground, and where evaluation efforts should be elevated.

Purpose

The purpose of this study is to examine the SV prevention strategies of four local programs across the United States focused on men and boys. The study includes interviews with a convenience sample of local level SV prevention programs funded by RPE through the state SV prevention program offices. The study asked questions about selected SVP strategies, how they are implemented in the community, and how these strategies are evaluated. The long-term intent of this study is to use data about specific strategies to determine how programs may benefit from additional technical assistance in developing enhanced evaluation capacity and improved program effectiveness.

The study will explore four primary questions to build a better understanding of what kinds of strategies are currently in implementation and evaluation phases within RPE funded organizations:

- *How are sexual violence prevention strategies aimed at men and boys implemented by RPE programs?*
- *What, if any, evaluation is being conducted on the selected program strategy?*
- *What are the facilitators and/or barriers to evaluating the effectiveness of the strategy?*
- *What types of technical assistance would better prepare RPE/SV PREVENTION grantees in developing evaluation capacity, or in conducting evaluation of their program?*

My intent with these questions is to provide a meaningful understanding of what is actually happening on the ground in SV prevention across the United States.

Significance

Because there is a unified voice in the field that evaluation efforts need to produce real evidence of effectiveness, it is also imperative to know what kinds of facilitators and/or barriers programs face in implementing and evaluating programs. The hope is that the results of this study will produce more detailed evidence of what local programs are doing to change attitudes, behaviors and sexual norms of men and boys, and community-level members to stop SV before it occurs.

Improving evaluation of SV prevention programs targeted at men and boys will strengthen the field by creating stronger evaluation capacity among programs. All states' departments of health have developed SV prevention plans that include evaluation plans and

requirements. A major gap in the efforts to improve evaluation of all forms of SV is that some state and local programs are further along in these efforts and have the capacity to develop robust evaluations of their program and strategies. Others are not as far along, primarily because of resource constraints at the state level and organizational infrastructure, and capacity and talent to develop high level evaluation. In that regard, this study will provide context in order to explain the gaps and highlight any barriers to evaluation efforts.

The results of this study will seek to address the knowledge gap referred to above by providing more detailed data on what programs need to ensure that RPE programs are producing effective programming and what evidence exists regarding actual prevention of SV. Knowing that some strategies may improve attitudes and beliefs during short-term exposures to a strategy is a start, but evidence that prevention is occurring is needed to continue to build robust SV prevention programming that can be disseminated broadly. Although this study will not conduct any actual evaluation, the insightful and detailed information will expectantly lead to knowledge that will enhance training, technical assistance, or even lead to innovative approaches in conducting consistent evaluation.

Objectives

The goals of this study is to provide the CDC/RPE program detailed and rich qualitative information that can be used to improve program implementation and effectiveness, increase data about program efforts with men and boys, and provide information that will enhance technical assistance to grantees to conduct evaluation. This will be accomplished through the following objectives:

- Objective 1: Determine what the specific components of the strategy are and how those strategies may change behaviors, beliefs and attitudes about sexual violence.

- Objective 2: Examine how the strategy is implemented in the local setting and if adaptations were made, or are there barriers to proper implementation and;
- Objective 3: Collect information on what, if any, evaluation is occurring and what may facilitate or hamper evaluation efforts.

The results of this study will provide detail that is currently lacking from program survey data, or from the RPE Inventory of Local Programs. It will allow the RPE program to have a small sample of data on very specific strategies, allow comparisons of SV prevention strategies being implemented across program types, and help determine where additional technical assistance could enhance evaluation across all RPE programs.

Problem Statement

Sexual Violence (SV) is a significant public health issue in the United States and across the globe. According to the World Health Organization's (WHO) *Report on Sexual Violence* women are overwhelmingly the victim of SV; which is most often perpetrated by males, occurs before the age of 25, is often a forced initiation to sexual activity and is commonly committed by a known person; such as a spouse, boyfriend, family member or acquaintance (World Health Organization, 2002).

In the United States 1 in 5 women and 1 in 71 men report a completed rape at some time during their lifetime (Black et al., 2011). Therefore, women experience rape nearly 15% more than men (20% vs. 1.4%); with 98.1% reporting that the violence occurred at the hands of a male perpetrator (Black et al., 2011). In addition, males are also the primary perpetrator of SV of other males. SV impacts the health of women in dramatic ways, including long-term physiological and psychological issues across the life span. In fact, SV has serious health implications including severe depression, anxiety, suicidal behaviors and ideation, drug abuse, increased risky sexual

behavior, gynecological pain and complications, and even increased risk for high blood pressure and heart attack (World Health Organization, 2002 and Black et al., 2011). In the United States, nearly 22 million women report being raped at some point in their lifetime. The most common forms of rape reported were forced penetration at 12.3 %; alcohol/drug supported rape at 8 %; and attempted rape at approximately 5.2% (Black, et al, 2011).

Men and boys also suffer from significant long-term health impacts as a result of SV. In 2002, the World Health Organization reported that SV and rape against men and boys is a significant problem that is vastly underreported. In the United States, nearly 1.6 million men, or 1 in 71, report being raped at some point in their lifetime (Black, et al, 2011). Males who were subjected to SV experience many of the same short and long-term health impacts as women. In addition males may also develop antisocial behaviors, commit crimes such as stealing, and have an increased risk for violent behavior (World Health Organization, 2011). Although SV against men and boys is significant, and prevention efforts should also focus on this group, this study is particularly interested in reviewing and collecting data on prevention strategies that target men and boys as potential perpetrators. The rationale is that primary prevention strategies that focus on male perpetration of females is needed because preventing sexual violence before it occurs prevents victimization-the goal of primary prevention in public health. To explore how these strategies are implemented, this study will look at four federally-funded SV prevention programs that focus on primary prevention efforts targeted toward men and boys.

In the early 2000s, the Division of Violence Prevention (DVP) at the CDC, shifted the focus of SV prevention from one focused on preventing victimization, to one focused on preventing perpetration (DeGue et al, 2012a). This shift adjusted the focus from the traditional view on SV victimization and risk avoidance toward a more upstream approach at preventing

perpetration; and therefore victimization (DeGue et al, 2012a). Current state and local efforts that are funded by RPE through the CDC have implemented specific strategies for primary prevention of SV in their communities. Now, more attention and resources are being directed toward perpetrators and potential perpetrators of SV in an effort to stop SV before it occurs. Many of these programs are developed around strategies that target men and boys with a particular emphasis on changing attitudes, beliefs and behaviors associated with SV perpetration. Ideas about female roles in society, gender equity, appropriate dating behaviors, and changing social norms about women and relationships are some of the goals for prevention of SV.

Evidence further supports the need to focus prevention efforts on males at risk for perpetration, but also who can help stop the cycle by being supportive members in preventing SV in their own communities. It is increasingly known that men's use of violence is a result of generally learned behavior as learned through socialization from adolescence into adulthood. For example, ideas of masculinity play a crucial role in shaping SV against women at every level of the social-ecological framework. Michael Flood (2011) reports that meta-analysis studies have shown that "men's adherence to sexist, patriarchal, and/or sexually hostile attitudes is an important predictor of their use of violence against women (Murnen, Wright, and Kaluzny 2002; Sugarman and Frankel 1996; Schumacher et al. 2001; Stith et al. 2004)." Attitudes are one factor, but another is dominance itself. Flood (2011) also found that both economic and household decision-making dominance in the family is also a strong predictor of violence against women (Heise 1998, Heise 2006, 35). Therefore, there is a growing consent that in order to prevent SV against women, men and boys must be included in prevention efforts. Not just as potential perpetrators, but also as willing participants involved in building gender equality (Flood, 2011).

The CDC provides funding to all U.S. State and Territory health departments that in turn fund state and local efforts in primary prevention of SV. The programs use a variety of manualized strategies, such as *Coaching Boys into Men*, homegrown programs developed by state domestic and sexual violence coalitions, and combination programs where components of two different strategies may be used to develop a tailored prevention approach. For example, Iowa is currently working on implementation of a combination program that incorporates aspects of the *Coaching Boys into Men* program with the *Mentors in Violence* program, which is a mentoring program that also incorporates bystander education strategies (Katz, 2014). California has implemented the *My Strength* program, which is a SV prevention social media advocacy campaign aimed at high school boys that promotes bystander behaviors (California Coalition against Sexual Assault, 2013). These programs are a small example of what is currently implemented across the country.

A major issue at the forefront in the SV prevention community is that many of the strategies have not undergone rigorous evaluation to determine effectiveness, or to see what aspects of a strategy may be generalizable to a larger population. Michael Flood examined some of the evaluation studies on SV prevention and found mixed results (2011). Many were not able to prove effectiveness in preventing SV because they cannot properly evaluate their efforts (Flood, 2011). The CDC has also recognized this gap and is providing technical assistance and guidance on developing strong evaluation plans for SV prevention programs. In fact, the RPE program incorporated a requirement into the funding mechanism that all programs develop strong evaluation capacity and infrastructure (Centers for Disease Control and Prevention, 2013). The 2014 grant application guidelines state that a primary focus of the current funding opportunity is for programs to “improve program evaluation infrastructure and capacity”

(Centers for Disease Control and Prevention, 2013). This is a directive in the field of SV prevention because the literature points to a significant lack of rigorous evaluation, especially as is available for preventing the incidence of SV as perpetrated by men.

Flood, M. (2011); Berkowitz, A.D. (2004a), (2004b); and Morrison, S. (2004) refer to the lack of evidence of long-term effectiveness of SV prevention programs in preventing SV from occurring. Most evaluations on SVP strategies have only assessed changes in attitudes and shown only partial efficacy for strategies focused on men boys. The current evaluation literature points to a lack of data on impacts of these strategies toward preventing SV and rape; and other factors that may play a role as mediators in changing attitudes and behaviors (Flood, 2011).

Because of the lack of evidence pointing toward what strategy is effective in changing behaviors in men and boys and in actual prevention of SV, it is also important to know what strategies are preferred by SV prevention programs, and what if any evaluation is planned or ongoing. For this to occur, the CDC is making an extended effort to collect programmatic and evaluation data from the RPE funded programs. For example, RPE grantees recently reported the Inventory of Local Programs to the CDC; which is an inventory intended to capture primary prevention strategies being used in the field. Although this information is incredibly useful, it is somewhat limited in what local programs report regarding how they implement and evaluate these strategies. This study examined four programs in an attempt to collect more information on how these strategies are used for primary prevention efforts. The information will be used to help programs develop and implement strong evaluation plans and increased capacity for evaluation, which in turn should provide additional data on what is working in the field.

Theoretical Framework

Although this qualitative study seeks to answer specific questions about what programs are currently doing in terms of evaluation of SVP strategies, there is an underlying theoretical framework that guides program design and implementation. For all SVP work that is funded through the RPE program, including state level evaluation plans in SVP, the Social Ecological Model (SEM) serves as the foundation for program design, implementation and evaluation. The SEM is used to develop SVP strategies that have the potential to reduce or prevent risk factors associated with sexual violence (Table 1). These risk factors are present throughout the Model, which considers the complex interactions between individual, interpersonal, community, and societal factors.

Table 1: Risk Factors for Sexual Violence (CDC)

Individual	Interpersonal	Community	Societal
Alcohol and drug use	Association w/sexually aggressive peers	Underemployment/ unemployment	Poverty
Coercive sexual fantasies	Family violence history (child/sex abuse)	Poor institutional support from law enforcement	Societal norms that support sexual violence
Impulsive and antisocial tendencies	Strong patriarchal relationship or familial environment	General tolerance of sexual violence in the community	Societal norms that support male superiority and sexual entitlement
Preference for impersonal sex	Emotionally unsupportive familial environment	Weak community sanctions against sexual violence perpetrators	Societal norms that maintain women's inferiority and sexual submissiveness
Hostility towards women			Weak laws and policies related to gender equity
Hypermasculinity			High tolerance levels of crime and other forms of violence
Childhood history of sexual and physical abuse			

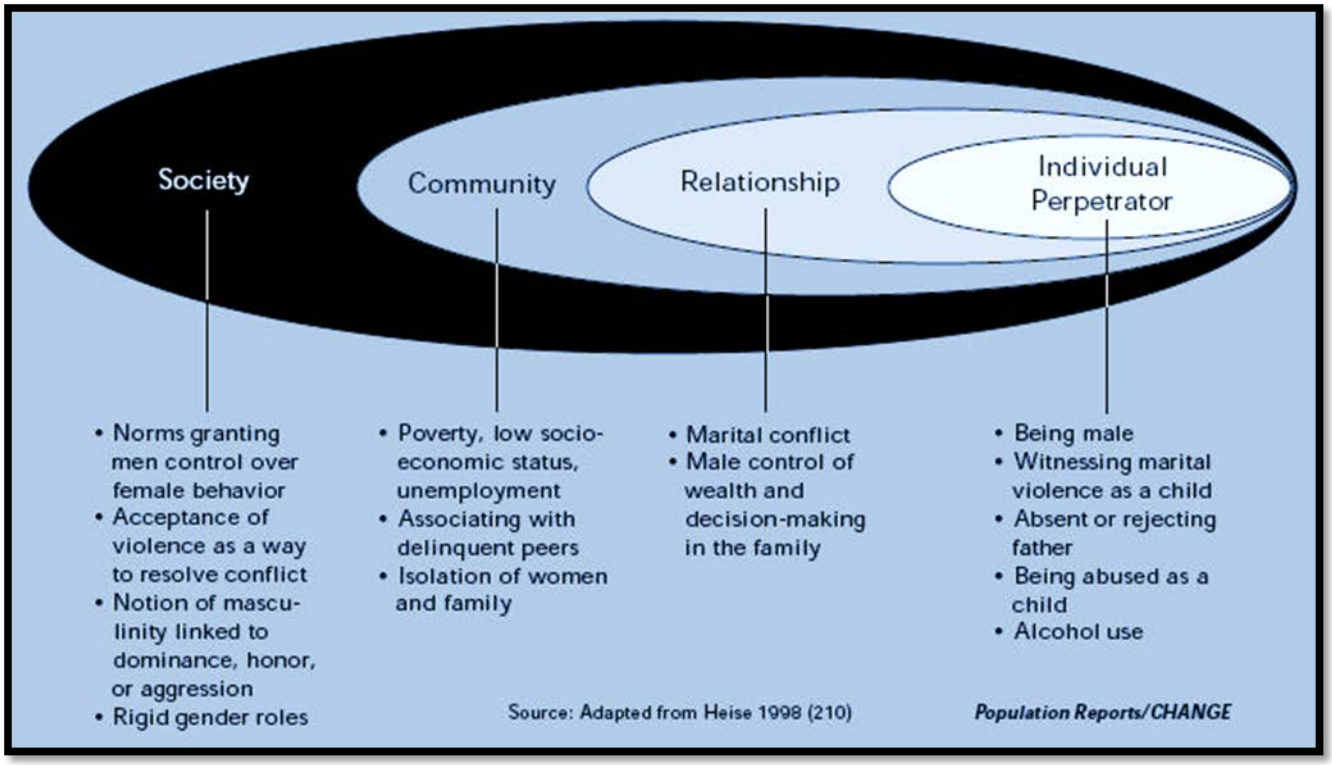
Source: Centers for Disease Control and Prevention, *Sexual Violence Risk and Protective Factors.* 2014 from http://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html

Social Ecological Model (SEM)

Each SVP strategy is effectively based on a theoretical model or "theory of change". In other words, what is the expected change that will occur in the subject receiving the intervention, and how is that theory applied. For all three strategies, the level of application is important as well because many SVP researchers are calling for more attention to be paid to prevention at the community level of the SEM framework, a place where little work or evaluation has occurred (Casey and Lindhorst, 2009). For MVP, My Strength and CBIM, the intent of the strategies is to impact participants at all levels of the social ecological framework (individual, relationship, community and societal) where things such as sexual norms, gender norms, attitudes about women's role in society and individual behavior change are key targets. The short term effect tends to be at the individual and relationship levels, while the longer term effects are assumed to be at the community and societal levels as community structures adjust to address issues of SV, and broader societal level cultural norms shift away from negative stereotypes that contribute to gender inequity.

The importance of linking SVP strategies to the social ecological framework is that it provides a theoretical model that can explain how a strategy should work, at what level it works best, what is does to change attitudes, behaviors or societal level norms and what impact I may have on policy. The SEM was designed as a tool to assist in designing public health interventions that have broad and lasting impacts. The following model (Figure 2), borrowed from the Prevent Connect Network, shows the levels of change expected at each level of the model (Heise, Ellsberg and Gottemoeller, 1999).

Figure 2: Social Ecological Model for SVP Risk Factors



Source: Prevent Connect, 2014 from http://wiki.preventconnect.org/Ecological+Framework

The findings from all four interviews is that SVP strategies, although focused on primary prevention and preventing sexual violence before it occurs, does not influence prevention at the community level, which is important for overall prevention effectiveness. That is not to say that the work currently being done is not effective in changing individual attitudes and behaviors, although little to no evidence currently exist on effectiveness in actual prevention of rape, however, it does point to a gap in the field where strategies are not adequately designed to derive maximal impact on preventing sexual violence across the spectrum.

Definition of Key Terms

CDC: Centers for Disease Control and Prevention

Coaching Boys into Men (CBIM): CBIM [is] a sexual violence prevention primary prevention tool implemented as a Coaches Leadership Program that partner with athletic coaches to help young male athletes practice respect towards themselves and others. CBIM equips coaches to talk with their athletes about respect for women and girls and that violence doesn't equal strength.

DVP: Division of Violence Prevention is a division house within the National Center for Injury Prevention and Control.

Evaluation Capacity: The ability of a program to develop the infrastructure, planning and data collection/analysis resources to evaluate program strategies for effectiveness in the goals of prevention for a particular health problem.

Mentors in Violence Prevention (MVP): MVP is a sexual violence prevention primary prevention tool that provides the leadership necessary, within sport and beyond, to address the global issues of sexism – especially men's violence against women.

My Strength: The My Strength Campaign was developed by Men Can Stop Rape, a nonprofit organization in Washington DC. The campaign revolves around the theme "My Strength is Not for Hurting" and encourages young men to take action to end sexual violence and to build healthy relationships.

Rape Prevention Education Program (RPE): The RPE program is administered by the Centers for Disease Control and Prevention, Division of Violence Prevention, and funded by the Violence Against Women Act (1994), Reauthorized in 2013.

Sexual Violence(SV): Sexual violence, which is defined by the CDC as any sexual act that is perpetrated against the will of another and can include activities and behaviors such as, a

nonconsensual sex act (rape), attempted rape, abusive sexual contact (unwanted touching), and non-contact sexual abuse (verbal harassment or threats) (Basile and Saltzman, 2002).

Sexual Violence Prevention (SVP): Sexual violence prevention is defined as the strategies used within the sphere of public health prevention and injury prevention programs that seek to prevent sexually violent acts before they occur. There are three tiers of prevention primary, secondary and tertiary.

- *Primary Prevention*: activities or strategies to prevent perpetration of victimization that are implemented before sexual violence occurs by reducing the factors that put people at risk for experiencing violence.
- *Secondary Prevention:* activities or strategies implemented immediately following a sexually violent act that seeks to address the short-term impacts of the violence.
- *Tertiary Prevention*: strategies that are implemented after the violence has occurred that seek to address the long-term health/psychological impacts of sexual violence and Sex offender treatment programs (CALCASA Prevent Connect, 2014).

CHAPTER II: REVIEW OF THE LITERATURE

Introduction

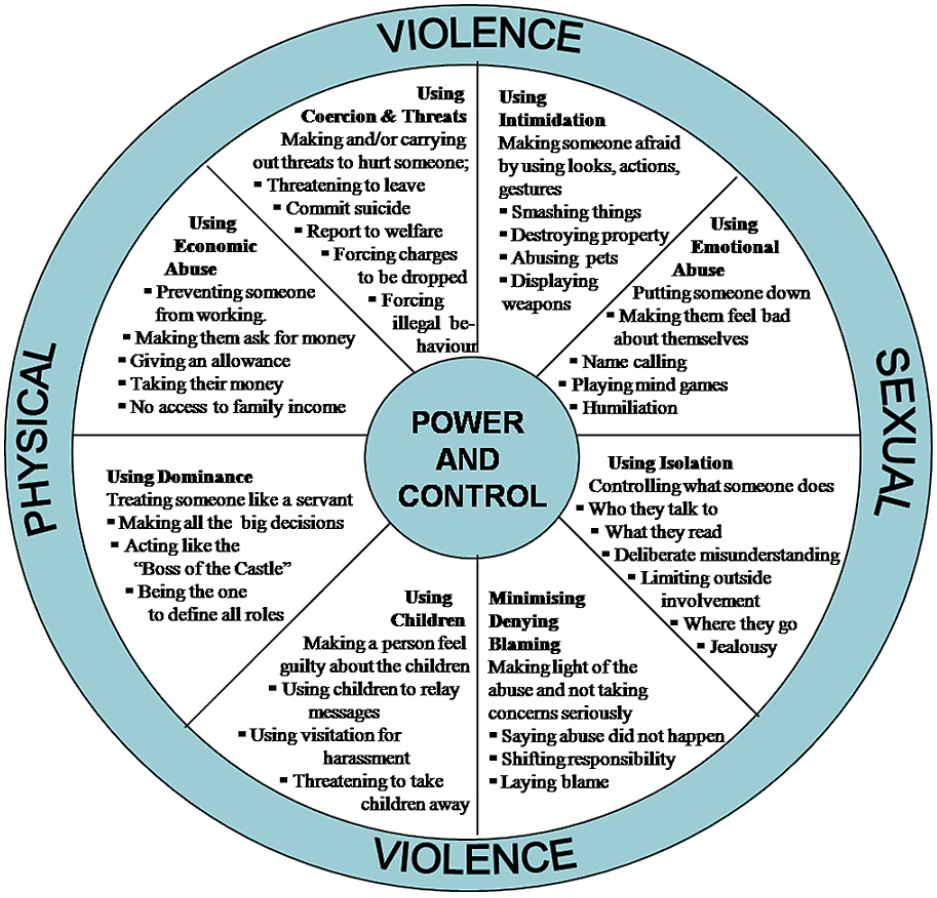
Sexual violence is a serious and costly public health problem that affects individuals, families, communities and society as a whole. There are physical, mental and financial costs that span a victim's lifetime. As a country, we are just emerging from the shadows of what sexual violence is and how it has negatively impacted millions of lives. The dialogue of what to do to prevent sexual violence is finally in the public sphere of conversation and policy decision makers are beginning to address this issue in both political and legal platforms.

Sexual violence, or threats to commit sexual violence, is part of the larger context of other forms of abuse. Physical and sexual abuse is the most apparent forms of domestic violence. However, regular use of other abusive behaviors is often reinforced by one or more acts of physical violence. All forms of physical and sexual assaults instill the threat of future violence; allowing the abuser to take control of the woman's life (National Center on Domestic and Sexual Violence, 2014).

The Power & Control Wheel or Duluth Model (Figure 3) is a particularly helpful graphic in understanding how abusive behaviors are related and how the perpetrator establishes and maintains control over the victim (Domestic Abuse Intervention Programs, 2014). Very often, one or more violent incidents are accompanied by an array of these other types of abuse, and therefore may be less easily identified, However, there is considerable overlap between the different vectors of the wheel and common behaviors exhibited by perpetrators of all forms of domestic abuse. The right hand side of the wheel specifically describes behaviors and beliefs associated with people who commit SV. Intimidation, isolation and emotional abuse are common

behaviors that exert tremendous control over the victim (National Center on Domestic and Sexual Violence, 2014).

Figure 3: Power and Control Wheel (Duluth Model)



Source: Domestic Abuse Intervention Programs (DAIP). 2014. *The Duluth Model.* http://www.theduluthmodel.org/stop-violence/index.html

The Problem of Sexual Violence

Sexual violence is a world-wide, human rights issue that is just as common in the United States as it is in both developed and under-developed nations. According to the World Health Organization Multi-Country Study on Women's Health and Domestic Violence against Women

(World Health Organization, 2005). The prevalence of SV based on an international survey of 24,000 women between the ages of 15-49 ranged between 6% to 59%. This rate does not include prevalence rates within the United States and were highest in Ethiopia and Peru at 70% (World Health Organization, 2005). Discussions of causal factors fit best within an ecological model. For example, risk factors for victimization among college students exist at all levels of the ecological model and include both relationship and community level variables such as past history of abuse and the facilitation of alcohol use-a situational predictor of SV perpetration and victimization (Banyard, Plante and Monyihan, 2004).

Prevalence rates collected from survey data and self-reported victimization in the United States are more complete than data on international prevalence because survey data is more reliable and individuals tend to report more often than in underdeveloped countries (World Health Organization, 2005). The National Intimate and Sexual Violence Survey collects detailed prevalence data on all forms of sexual violence. Although, it is well documented that 1 in 5 women in the United States experience rape at some time in their lifespan (Black, M.C. et al., 2011) more detailed prevalence data on twelve month and lifetime estimates are alarming (Table 4). According to the data displayed below, more than 1.2 million women reported a rape in the last twelve months, of which 12.3% were a completed, forced incidence of rape (Black, M.C. et al., 2011). In addition, prevalence of other forms of SV, such as sexual coercion and unwanted sexual contact, were reported by 53,174,000 women, or 44.6% of women in the United States. These data clarify the situation for women and the problem of SV in this country as an epidemic of violence.

Table 4: Sexual Violence Prevalence Rates for U.S. Women at 12-Month and Lifetime

Lifetime and 12 Month Prevalence of Sexual Violence, NISVS 2010				
	Lifetime		12 Month	
	Weighted %	**Estimated # of Victims**	**Weighted %**	**Estimated # of Victims**
Rape	18.3	21,840,000	1.1	1,270,000
Completed forced penetration	12.3	14,617,000	0.5	620,000
Attempted forced penetration	5.2	6,199,000	0.4	519,000
Completed alcohol/drug facilitated penetration	8.0	9,524,000	0.7	781,000
Other Sexual Violence	44.6	53,174,000	5.6	6,646,000
Made to penetrate	*	*	*	*
Sexual coercion	13.0	15,492,000	2.0	2,410,000
Unwanted sexual contact	27.2	32,447,000	2.2	2,600,000
Non-contact, unwanted sexual experiences	33.7	40,193,000	3.0	3,532,000
*Estimate is not reported; relative standard error >30% or cell size is ≤20				

Source: Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Consequences of SV and Impact on Victims

Because of the secretive and taboo nature of SV and the power and control dynamics between perpetrator and victim, many of the impacts of SV are hidden. Research from the World Health Organization (2010) shows that women experience short and long-term health effects from SV, including physical, mental and sexual health problems (Heise & Garcia-Moreno, 2002; Jewkes, Sen & Garcia-Moreno, 2002).

Women who have experienced SV have higher rates of depression, suicide ideation, reproductive health problems, STD's and HIV and drug and alcohol abuse (World Health Organization, 2010). Additionally, children who witness SV in the home are also affected by

long-term mental health and risky behaviors that can lead to poor health outcomes (World Health Organization, 2010).

Data about nonfatal Intimate Partner Violence (IPV), which is associated with and includes non-fatal SV victimizations and resulting health care service use, were collected through the National Violence Against Women Survey (NVAWS), funded by the National Institute of Justice and Centers for Disease Control. Based on NVAWS data, "an estimated 5.3 million IPV victimizations occur among U.S. women ages 18 and older each year (National Center for Injury Prevention and Control, 2003)." In addition, IPV victims also lose a total of nearly 8.0 million days of paid work—the equivalent of more than 32,000 full-time jobs—and nearly 5.6 million days of household productivity as a result of the violence (National Center for Injury Prevention and Control, 2003).

The health and economic costs associated with SV and related domestic abuse reduces the quality of life for individuals and their families and contributes to high costs in the health, legal and social services areas of the economy. Health outcomes for individuals who experience sexual violence are multifaceted and long-term. In order to truly address SV in the United States and across the globe, society must address issues around gender norms, the role of women and the importance of preventing violence against women.

The Current Status of Sexual Violence Prevention Effectiveness

The discussion of promising strategies presented below do show consistent, but preliminary, data that some strategies may indeed change attitudes and beliefs regarding sexual violence, norms of masculinity and even misconceptions about sexual relationships. However, the programs have not been evaluated in a manner in which rigor and longitudinal evidence can point toward effectiveness in primary prevention of SV. In fact, the only program that has

undergone multiple rigorous evaluations is the Safe Dates program, which is a program focused on the prevention of teen dating violence (Foshee et al., 2005). After initial evaluation in 1998 and two follow up evaluation studies, the Safe Dates program is known to be effective for teen dating violence prevention among teens.

Of the three programs examined for this study only the Coaching Boys into Men program has undergone initial evaluation around actual prevention. Results of this evaluation show that over a 3-month period with additional follow-up, male athletes in the participant group showed positive changes in attitudes towards bystander intervening behaviors (Miller, E et al., 2012). However, changes in gender-equitable attitudes, recognition of abusive behaviors and dating violence perpetration were not found to be significant (Miller, E et al., 2012) This may suggest that additional follow up evaluation is needed, or that the dosage amount of three months is not sufficient to effect the desired change.

The stakes for showing effectiveness of SVP programs are high due to the extent of the problem and the lack of proven strategies that move the field forward towards prevention. Evaluation experts at the CDC have examined the state of evidence produced in the field and there is concern that practitioners are unable to prove that the strategies they use sufficiently meet the nine principles of effective programs. The principles are based on foundational characteristics that established effective programs in areas such as substance abuse and violence and delinquency have exhibited. Programs that meet the nine principles include:

- A comprehensive program design
- Variation in teaching methods
- A theoretical framework
- Strategies that promote positive relationships

- Timeliness in development and implementation
- Sociocultural relevance
- Outcome evaluation to assess/improve the program
- Well-trained staff to implement the program and;
- Sufficient dosage to ensure behavior change

(Nation et al, 2003).

Programs that are able to implement these principles into their SVP strategies and overall design may be better prepared to develop strong evaluation capacity. The CDC is currently working with all the RPE grantees to determine programmatic capacity to evaluate effectiveness and provide programs with technical assistance in strengthening capacity. This is incredibly important in moving SVP programs to a point where they can measure the impact of their program(s) in regards to primary prevention.

A major issue regarding evaluation of SVP programs is that although a few programs have been evaluating outcomes for a number of years, the evaluation design does not follow an evaluation continuum. In other words, once a program is able to identify some promising strategies there should be a more rigorous evaluation to follow that includes either a randomized control trial or a strong comparison group (Tharp et al, 2011). In other words, the same qualitative and/or pre-post designs are being used over and over again without advancing the evaluation to higher level of examination. Therefore SVP programs, with the exception of Safe Dates mentioned earlier cannot be proven effective because the evaluations are not based on scientific standards (Tharp, et al).

In 2011, the Division of Violence Prevention (DVP) housed within the Center for Injury Control at the CDC, engaged an external review panel of experts to assess SVP work over the

2000-2010 decade. The review found several things that DVP was doing well in regards to expanding the public health urgency of SV, and in moving the focus from treating the victims to primary prevention strategies. However, the panel identified areas of improvement to expand the ability of the CDC to implement, fund and evaluate SVP work. One of recommendations was to increase the knowledge base of effective SVP strategies at all levels of the social ecology, especially community and societal level impacts. The review found that most of the evaluation to date has been focused on the individual and relationship levels and has been conducted over short time frames with little to no effect (DeGue et al., 2012b). The recommendations went further to suggest that in order for the DVP to use limited resources wisely by targeting the most effective strategies, it will be necessary to promote rigorous evaluation that evaluates promising strategies targeted to all levels of the social ecology (DeGue et al., 2012b).

The literature clearly points to the need to improve evaluation of existing SVP strategies, but also to embed additional efforts in rigorous evaluation. The shift towards primary prevention only occurred in the mid-2000s, and there has been enormous success in providing state level agencies with technical assistance in developing state plans for primary SVP and in conducting evaluation. However, little is still known about what types of strategies many local level agencies are using, how and if they are evaluating the strategies, and whether there is capacity to conduct more rigorous evaluation. This study will assist the CDC, and hopefully the field of SVP, in identifying what is happening on the ground and where practitioners may need additional technical assistance in producing evidence of promising or effective practice in SVP.

Although pressing, the need for evidence and further research in all these areas does not precludes taking action now to prevent SV. Programs, such as Safe Dates, that currently show evidence supporting their effectiveness should be implemented. Those that show promise or

appear to have potential can also play an immediate role – providing effort is made to conduct rigorous evaluations. It is only by taking action and generating evidence that sexual violence will be prevented and the field of evidence-based primary prevention of such violence will successfully mature.

Men and Boys and Masculinity

Historically, the issue of SV prevention has primarily focused on the victims, which in the majority cases are women (World Health Organization, 2010). However, more recent work has stressed the need to engage men in the prevention of all forms of violence against women. The perpetration of SV in the United States by men and boys is a problem rooted in traditional views of gender roles, masculinity and the role of women in the home, community, and society. Of the women who reported a rape in 2010, 98% were committed by a male perpetrator (Black et al, 2011). Clearly this is a disturbing tale in a time when women are making significant strides in society regarding career and post-modern views on family and home.

In 2007, the World Health Organization (WHO) published a report highlighting the role of gender inequity and male-dominant cultural and societal norms, and the associated impacts regarding oppression and violence against women and children. The report was built around the notion that inequitable gender norms contribute to a host of negative health outcomes including sexual and domestic violence, HIV transmission and other forms of physical violence for women and children (World Health Organization, 2007). The WHO reviewed other studies that examined survey research that used attitudinal scales to measure beliefs and attitudes regarding gender norms and the role of women in society. The findings confirmed that where men and boys are exposed to and adhere to more rigid norms of masculinity such as, believing that men

need women to give them sex whenever they seek it , or that men should control women, are more likely to report perpetration of violence against a partner (WHO, 2007).

SV prevention is moving toward inviting men and boys to participate in removing traditional views about gender roles through Bystander education programs, men as mentors in male communities, and changing gender beliefs and behavioral aspects among youth as it relates to all forms of violence against women. Two, predominate strategies are in current practice: 1) Where groups of men or boys gather as clubs where traditional beliefs and behaviors towards women are challenged and new beliefs supplant previous misconceptions and; 2) Structured programs targeted to boys, such as high-school age athletes in the Coaching Boys into Men program where mentoring and scenarios are delivered by a respected authority figure in a peer environment.

Traditionally, men and boys are not included in developing solutions to SV. One reason is defined within the movement to end violence against women as an issue of male power and control over females. Reasons for lack of participation were; they had not been asked to help, they felt that men had been vilified as perpetrators, or they simply didn't know how they could help (Crooks et al, 2007). Another reason related to male attitudes regarding sexual violence and gender norms is associated with acknowledgement that the act is wrong, but a reluctance to step in when they witness violent behaviors and acts (Men Can Stop Rape, 2011). Alan Berkowitz in his research on social norms theory and bystander behaviors, asserts that 80 % of college age males express feelings of uneasiness when they witness mistreatment of women, but they believe they are the only ones experiencing this feeling so they do not intervene (Gidycz, Orchowski and Berkowitz, 2011). Furthermore, males do not participate in SVP programs because they embrace negative stereotypes of gender roles and accept the beliefs and myths associated with power and

control that contribute to sexual violence (Figure 2: Power and Control Wheel). For example, Schwartz and Nogrady (1996) studied the importance of gender and sexual norms within the broader community of men for "things such as patriarchal attitudes, rape myths, and attachment to friends who themselves have engaged in sexual coercion or violence" (Banyard, Plante and Moynihan, 2004.) An example would be the accepted "rape prone" culture that exists among fraternity members on college campuses (McMahon, 2007 and Schwartz and Nogrady, 1996).

Variables that influence the possibility of a male perpetrator committing a sexual assault also include socialization experiences and whether males are exposed to negative or positive views on sexuality and gender equality (Loh, Gidycz, Lobo and Luthra, 2005). Notions and beliefs associated with rape myths, patriarchal attitudes and socialization experiences are all addressed within social norms theory; whereby "individuals behave in a manner that they deem to be consistent with a norm of behavior (Loh et al., 2005)." Malamuth, Sockloskie, Koss, & Tanaka (1991) described this further as, males who believe their peers use coercive behavior to obtain sex are likely to exhibit the same behaviors in their relations with women; and will advocate that behavior further within their peer group (Loh et al., 2005).

Feminist theory provides a framework for the positive engagement of men and boys in prevention efforts. First, is the condition that men and boys are the primary perpetrators of SV so it must be men who work towards changing that norm (Casey, Beadnell and Lindhorst, 2009). Secondly, ideas of masculinity and how that is defined are embedded in individual, interpersonal relationships and community level acceptance of these norms and societal level ideas that support sexual and gender power of men over women (Flood, 2011). Third, there is new insight that men have a positive role to play in changing norms and beliefs that contribute to SV and that the changes must occur at all levels of the social-ecological framework. By engaging men at all

levels, including community and societal levels of change, there is growing expectation that engaging men in this process will have long-term, positive impacts in preventing SV, including rape (Flood, 2011).

Connell (1995) discusses how the role of males in preventing SV is rooted in the idea that rewards currently enjoyed by males-such as material and interpersonal privilege received from the gendered structures of society-are not the only things that motivate men toward attitudes of gender inequality/equality (Flood, 2011). Other factors could motivate men to address issues of violence against women such as; women's personal well-being, relational interests and interpersonal values, collective and community interests and principles (Flood, 2011). For example, through the interest of personal well-being, men can free themselves of the "costs of conformity" to follow traditional views of masculinity (Flood, 2011). Additionally, men and boys can also be motivated by relational interests associated with the women and girls in their lives that they love (Flood, 2011). Collectively, men can also be motivated by community needs by seeking to alleviate the impact of violence and by addressing the attitudes about masculinity and gender inequality that lead to violence against women (Flood, 2011). And finally, principles and values associated with personal, ethical and political motivations that promote gender equality (Flood, 2011). All of these factors point to positive and reinforcing motivations that may encourage engagement of men in ending SV.

The WHO report (2007) assessed program and project interventions aimed toward boys and men and found that programs that were "gender transformative" evaluated as either effective or promising strategies. Gender transformative strategies are based on changing attitudes and beliefs about culturally sanctioned gender roles through promotion of an understanding of "gender-equitable relationships between men and women." In the WHO report (2007), 41% f

programs with a gender-transformative framework, were evaluated as effective strategies. These strategies tended to be either group strategies that included a facilitator and were up to 16 weeks in length, or integrated strategies that included empowerment for women and girls as part of creating gender-transformative changes that have short-term impacts at the individual level and longer-term impacts at the community/societal level (WHO, 2007).

Engaging men and boys in self-reflection and moving them through a model of changing views of masculinity is not an easy task and may not be fully embraced by many. A possible solution is to approach this from the perspective of where men and boys may be in this process of changing perspectives of masculinity. In the literature and within models employed in the field, there is some indication that men must come into SV prevention with already adjusted attitudes about masculinity and that much of the challenging work to get there has already been completed (Crooks et al, 2007). An alternative view to this notion is that men should be given a "starting point" or a set of actions on where to begin their efforts in engaging in SV prevention; and through these actions they may reevaluate their views on masculinity and gender equality (Crooks et al., 2007). Berkowitz (2004a) suggests that traditional views of masculinity could be expanded and redefined to include ideals of universal social justice. Through this perspective, men's roles in SV prevention could mean that they "don't personally engage in violence, they practice intervening behaviors in preventing violence (bystander motivations), and they can participate in addressing the root causes of SV within society (Berkowitz, 2004b). In other words, what types of interventions or models will move men and boys toward an end product of a nonviolent and nonaggressive masculinity that supports women and equalizes gender roles in society?

The challenges inherent in inviting and bringing boys and men into the SVP discussion are rooted in societal views that have been in the making for centuries. Changing these norms presents a longer term challenge, but the some of the solutions and promising strategies discussed above may provide shorter term impacts that lead into a longer-term societal level change. We are already seeing some of this in the United States with anecdotal and self-reported evidence of young men who report engaging in bystander behaviors or within the Coaching Boys in Men program where survey data shows evidence of short-term changes in behavior and attitudes on gender norms.

The three programs examined for this study: Coaching Boys into Men (CBIM). My Strength, and Mentors in Violence Prevention (MVP) are all designed around the "gender transformative" model discussed in the WHO report (2007) and include strategies that are group-based and facilitator led. A description of these commonly used strategies is described below.

Strategies for Men and Boys: Program Reviews

For the purposes of this study, the focus is three programs currently implemented by several RPE grantees that have had some form of preliminary evaluation. The three programs are Coaching Boys into Men (CBIM), Mentors in Violence Prevention (MVP), and the My Strength. These programs are commonly used across the United States and are getting some traction at the local level. All three have been through some informal evaluation to date and show some promising evidence of effectiveness in changing attitudes and behaviors associated with the harmful acts of sexual violence. However, there is overall agreement that the results are either preliminary, or can be somewhat inconclusive in determining strong evidence for effectiveness. The CDC, Division of Violence Prevention is currently conducting a systematic review of SVP strategies on MVP and My Strength so additional evaluation information will be forthcoming.

CBIM is one of the few programs focused on men and boys that underwent rigorous evaluation. The following review is to briefly describe what has is currently known in the field as effective practice in SV prevention for men and boys, to discuss where evaluation efforts could be improved, and to adapt this knowledge to actual strategies currently implemented in local rape prevention education programs in the United States.

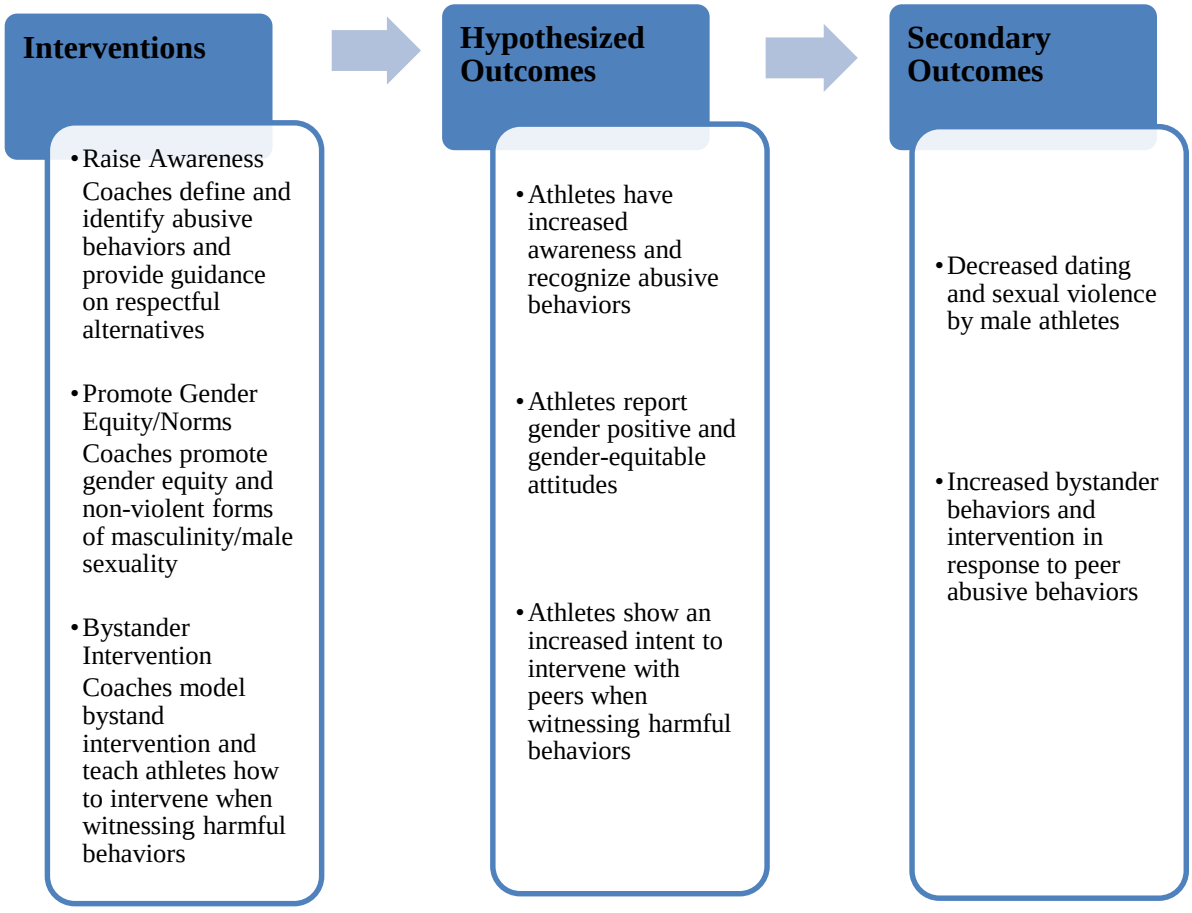
Coaching Boys into Men

The Coaching Boys into Men (CBIM) program, developed by Futures without Violence, has been implemented across the country in middle school and high school athletic programs, as well as some youth sports programs associated with community centers. CBIM enlists male coaches and mentors to deliver messages about respecting peers and girls through a 12-session playbook. The coaches and mentors teach male athletes that violence against women is not a sign of strength, but a sign of disrespect (Futures without Violence, 2014). CBIM seeks to change norms that foster SV and dating violence against women and girls through a series of violence prevention strategies. CBIM consists of one-hour trainings with the coaches and a "Coaches Kit" that includes strategies presented on twelve "playbook flashcards" for opening up the conversation with athletes about SV and dating relationships (Miller et al, 2012). The program intensity can vary, but initial evaluation shows a positive effect when at least nine of the twelve cards are used during the sessions. If the programs are implemented as prescribed, they last throughout preseason training and competition (Miller et al, 2012).

The program has been promoted widely across the country as male high school athletes are a sizeable, young and collective target population who have the potential to significantly impact the incidence of SV. The CBIM model is based on "Social Norms Change Theory", which states that much of people's behavior is influenced, through and by, the behaviors and

beliefs of their peers and social groups; and that individual behavior is heavily influenced through the either positive or negative perceptions within that social dynamic (Linkenbach et al, 2002). As related to "Social Norms Change Theory", CBIM's aim is to translate behavior change into measureable positive changes in the athlete's attitudes towards gender based violence. The actions prescribed in CBIM also translate well to all forms of SV since SV plays a significant role in dating violence behaviors. The CBIM program has three primary short or mid-term outcomes and two secondary outcomes expected to result with successful implementation in practice (Figure 5).

Figure 5: CBIM Intervention Components and Relational Outcomes



Source: E. Miller et al. / Journal of Adolescent Health 51 (2012) 431–438.

Miller et al (2012) conducted one of the best known and rigorous evaluations of the CBIM program. Her team designed a clustered-randomized study of 2,006 high school athletes with 1,008 receiving the CBIM intervention and follow up evaluation surveys.

Results found supportive evidence of effectiveness for the CBIM program intervention as a promising strategy in changing attitudes and behaviors toward SV and dating violence among high school athletes (Miller et al, 2012). For example, CBIM participants were more likely than the control group to report increased awareness and intentions to exhibit positive behaviors toward females and to intervene in peer situations where violence or harmful behaviors occur (Miller et al). Additionally, the intensity of the intervention also played a role in improved or changed attitudes and behaviors, including bystander behaviors. Where the intensity was sustained using the full course prescription, changes toward positive attitudes and intentions were significant over the control group who did not receive the CBIM intervention (Miller et al, 2012).

Mentors in Violence Prevention

The Mentors in Violence Prevention (MVP) model was developed in Boston, Massachusetts at Northeastern University, Center for the Study of Sport in Society. The program is designed for the prevention of gender-based violence, bullying, and school violence with an emphasis on promoting the "bystander" as an empowered intervener in the prevention of violence (Katz, n.d.). The original program began in 1993 with funding from the Department of Education with the goal of training male college and high school athletes in speaking out against rape, battering, sexual harassment, gay-bashing and all forms of SV (Katz). Since the 1990's the MVP model has transformed to include all college and high school populations, and although

still rooted in athletic social groups, has expanded training efforts to have a broader impact on SV prevention efforts.

The program is based on a "peer-leadership" model that is focused on potential perpetrators and victims (so an added female component) and those who may be bystanders to acts of SV (Cissner, 2009). The focus on empowering the bystander brings the issue of SV prevention back to engaging men and boys in the process by teaching them to engage in preventing SV before it occurs. It is different from the CBIM program in that the primary focus is on creating a bystander community that includes men and women in preventing violence among their peers, family members and in their community. In this model, a bystander is defined as a friend, family member, teammate, classmate, coworker-or anyone that is tied to an individual relationally through home, school, work, or social environments (Katz, n.d.).

The MVP program has shown some initial evidence of effectiveness in changing attitudes regarding bystander myths, but more data is needed to show actual impact on SV prevention. One study that looked at several types of gender-based violence prevention programs and bystander interventions, found that internal evaluations conducted in the early 2000's on the MVP programs showed changes in attitudes of certain groups, such as high-school aged male and female participants (Baynard, Plante and Moynihan, 2004).

Another evaluation study of the MVP program was conducted at Syracuse University in 2008 as both a process and impact evaluation of the newly implemented program. The program was implemented over a two-year period with process evaluation occurring during implementation and impact evaluation occurring at the end of the two-year implementation phase (Cissner, 2009). The findings showed that there was a significant change in sexist attitudes between the participant and comparison groups ($p<.001$).

This is one of few studies that actually tracked whether a reduction in SV acts, i.e. rape, occurred as a result of the intervention. However, a number of limitations were expressed:

- reliability of baseline numbers in the year prior to MVP program implementation
- the intervention population subset was small (only 4% of the total population) which impacts generalizability and;
- the MVP program may have the unintended effect of increasing the number of reported cases of SV (Cissner, 2009).

Despite these limitations, there was a 20% reduction in reported cases of SV on the Syracuse campus during the MVP program period. Although this cannot be totally attributed to the effect of the MVP program, there is still an assumption that the positive changes in sexist attitudes and increased bystander self-efficacy would eventually translate to a reduction in SV across the campus.

This study, although localized and on a small scale, does show that the MVP model may be an effective approach to SV prevention. However, larger scale evaluation is needed in order to test for proven effectiveness as a SV prevention method that can be broadly disseminated.

My Strength

The My Strength program was originally designed by Men Can Stop Rape (MCSR); a Washington, D.C. based national organization that seeks to mobilize men to use their strength for positive sexual behaviors towards women (Wells et al., 2013). My Strength programs include the My Strength Club (MOST) where men are engaged in discussion and action to define new perceptions of masculinity. The program is designed to increase awareness of men's "dominant

stories of masculinity" that may lead to violence against women and to develop a "counter story of masculinity" where men develop a more positive and nonviolent masculinity that is shaped to make men's strength a positive masculine characteristic (Wells et al., 2013). Men gather in a structured and supportive space where ideas and perceptions can be feely shared and new definitions of masculinity that promote healthy relationships develop.

The My Strength program is a primary SVP strategy implemented in selected high schools in California through the California Coalition against Sexual Violence (CALCASA). Funding for the program is provided by the Rape Prevention Education (RPE) program, administered by the California Department of Public Health, Epidemiology and Prevention for Injury Control Branch (CDPH). The CDPH receives funding for primary SVP programming from the CDC, and is one of the largest RPE programs in the country.

CALCAS has taken the MOST club concepts and materials and adapted it into the My Strength program, which targets male high-school students statewide. The program includes both a social marketing media campaign that includes posters and other popular media designed for the target population, as well as the MOST component that is delivered via rape crisis centers. Trained professionals from the rape crisis centers deliver the My Strength content, conduct focus group discussions with participants, and deliver programmatic activities aimed at changing high school males' perceptions of masculinity (California Coalition against Sexual Assault, 2013).

In 2008, CDPH conducted an evaluation of the My Strength campaign to assess the effectiveness of the social marketing campaign and MOST clubs on attitudes regarding sexual violence. The evaluation included five pilot-site high schools and one comparison high school. Qualitative and quantitative data were collected by school site staff through pre-post surveys and focus groups to measure attitude and awareness changes related to the social media campaign

messages and the MOST clubs (Kim and White, 2008). Additionally, the evaluation defined two primary exposures to assess:

- Exposure 1: Statewide media campaign-did the respondent see or hear the My Strength message of *My Strength is Not for Hurting* and;
- Exposure 2: MOST Clubs in pilot sites-what level of awareness does the respondent exhibit toward knowing about the MOST Clubs

(Kim and White, 2008).

A brief review of the findings shows statistically significant changes in knowledge, beliefs and behaviors regarding masculinity and sexual violence. Additional exposure to the MOST Club content could produce higher rates of change in attitudes, beliefs and behaviors further enhancing the impact of My Strength and Most Clubs.

Available evaluations do show some promising strategies that impact individual attitudes with a longer-term aim of influencing broader social norms, especially as it relates to changes in beliefs and attitudes toward norms of masculinity. The results above create a set of assumptions that change in attitudes will result in social norms change that in turn will reduce SV-related behavior. Evidence of actual changes in behavior, or the avoidance of sexually violent or inappropriate behaviors is not currently present in the literature and further analysis of these strategies over time is needed to determine whether My Strength/MOST clubs have the capacity to prevent sexual violence.

Summary

Due to the lack of evidence-based strategies currently implemented by RPE grantees there is an opportunity to advance the evidence base if more resources and effort is dedicated toward rigorous evaluation of promising strategies such as CBIM, MVP and My Strength. In

order to do this, it is necessary to understand what is happening on the ground, what types of data local programs are currently collecting and what barriers there are to both program implementation and collection of data for evaluation practice. The body of knowledge in this area is limited but growing, as more emphasis is placed on increasing the evidence-base of practice for preventing sexual violence in the United States and abroad. Although WHO has conducted some preliminary studies of programs and projects globally, the United States and the CDC has an opportunity to improve practice in preventing all forms of violence against women, but first evidence is needed to reveal what works best in a variety of settings.

CHAPTER III: METHODOLOGY

Introduction

This qualitative study collected and assessed current sexual violence prevention strategies implemented as part of the Rape Prevention Education (RPE) program administered by the Centers for Disease Control and Prevention. The target population for the strategies focused on the primary prevention of sexually violent behaviors for populations of men and boys. The study addressed four primary questions about SVP strategies in order to determine the strategy's intent, how the strategy is implemented on the ground, and what, if any, program evaluation is occurring. There are thousands of local sexual violence prevention programs across the country operating at the community level. The purposeful sample was designed to select prevention strategies focused on engaging boys and men in the primary prevention of sexual violence-e.g., before the violence occurs. In addition, the sample was further delineated by only selecting SVP strategies that are called pre-packaged, in other words programs that have been designed around particular strategies that include manuals and tools to address specific aspects of gender norms, sexually inappropriate and appropriate behaviors and scenarios that elicit group discussion and reflection. Some examples of pre-packaged approaches are bystander models, mentoring of young men by coaches and other male authority figures and behavior change models that seek to change attitudes, beliefs and behaviors. These strategies were chosen for cross program comparisons as opposed to homegrown strategies that local level SVP programs may develop to address sexual violence in their communities because the models may have some similarities in program design and offer predesigned evaluation tools.

The methodology will describe the sites selected, how and why they were chosen, the data collection procedures and design, how the analysis was conducted and any limitations to the design that might have an impact on the results and recommendations.

Site Selection Criteria

This study utilized two levels of sampling in order to pull from a good subset of program types. First, this was a convenience sample selected from a short list of local programs across the United States that implement sexual violence prevention strategies focused on men and boys. Second, this was a purposive sample because it was also important to pull the correct SVP strategy types as implemented by the subset of programs. Because these sites are funded by the Rape Prevention Education (RPE) program administered by the CDC, Federal Program Officers (FPOs) from the CDC assisted in identifying appropriate sites based on the intent of the study and the three program types of interest. The FPOs first communicated with the state health departments that administer sexual violence prevention state plans to solicit suggestions for local programs that may be interested in the study.

Study sites were eligible for participation if they had one of three programs focused on engaging boys and men in primary prevention efforts: Coaching Boys into Men (CBIM), Mentors in Violence (MVP) and My Strength.

Study Recruitment

Originally, there nine sites were identified for recruitment in the study. An email invitation with information on the study was sent to the nine local programs. Four local programs agreed to participate in the study. At least one representative from each of the four sites accepted to participate in the interviews. In three of the four cases a single Program Coordinator participated in the interview. One program allowed an interview with the one Program

Coordinator and the organizational manager. Interviews were conducted with the local program staff because it was assumed they would have the most in depth knowledge of how SVP programs are implemented on the ground, as opposed to state level Health Department staffs that may not have specific knowledge about local implementation.

The local programs that participated were from the following states: California, Iowa and Massachusetts. Two local programs from Massachusetts with different target populations elected to participate. Three SVP primary prevention strategies focused on men and boys are being implemented by the four participant sites, with one strategy per site (Table 6).

Table 6: Program Site Location and SV Prevention Strategy Implemented

RPE Funded Local Program Location	Sexual Violence Prevention Strategy
Martha's Vineyard-Massachusetts	MVP-Mentors in Violence Prevention
Silicon Valley-California	My Strength
State of Iowa	CBIM-Coaching Boys into Men
Cape Cod-Massachusetts	MVP-Mentors in Violence Prevention

Data Collection Instrument

Data was collected on the four primary research questions below

- *How are sexual violence prevention strategies aimed at men and boys implemented by RPE programs?*
- *What, if any, evaluation is being conducted on the selected program strategy?*
- *What are the facilitators and/or barriers to evaluating the effectiveness of the strategy?*
- *What types of technical assistance would better prepare RPE/SV PREVENTION grantees in developing their evaluation capacity, or in conducting evaluation of their program?*

A semi-structured interview protocol that included guiding questions was used to conduct one-hour phone interviews with each of the four sites. The questions were open-ended and the entire process was designed to allow for maximum flexibility. The intent was to foster open discussion to elicit rich detail in responses. The questions were based on the theoretical framework of the study, which are the main research questions that influenced the study as follows:

- General programmatic and contextual background
- SVP strategy implementation description
- Expected or observed program effects (intended and unintended)
- Evaluation Capacity and Evaluation Intent
- Technical Assistance Issues

(APPENDIX A: Interview Protocol and Questionnaire**)**

The interview protocol, which includes the interview guide and process was reviewed and approved by the CDC RPE team members and the field advisor for this project. The study description was reviewed and exempted by the CDC IRB (ADS) office. The interview protocol included eighteen questions that addressed the four study areas described in the framework above to allow enough time for additional probing discussion. One question: *Will you please provide for me feedback on the RPE evaluation requirements in the FOA (Funding Opportunity Announcement) and how those requirements have impacted your SVP efforts?*, was omitted during the first interview and subsequent interviews because it was extraneous to the target population, as they have little to no knowledge about the funding structure for the RPE program and are not involved in applying for state funding to the CDC.

Data Collection

Once the interviews were scheduled, each participant received an email with information on the intent of the study, the interview process and an opportunity to opt of the process at any time. No participants dropped out. Interviews lasted between 45-56 minutes and handwritten notes were taken along with an audio recorded transcript of the interviews using a fee-based online service. The interviews were reviewed twice in order to ensure some level of verbatim response and to fill in any gaps and clarify responses in hand written notes for accuracy. The four participant sites were interviewed during the month of April 2014 during four 1-hour phone interviews. The interviews were recorded and transcribed by the interviewer.

The information was entered into matrices designed around the four primary research questions for this study and organized into the categorization listed above. A total of 17 questions made up the interview protocol and participants responded well to all the questions with the exception of two in the evaluation section. Once the data was entered and reviewed within the matrix, all responses were coded based on the original research question. The codes themselves served only as an organizational tool and did not contribute to the overall analysis. This method of descriptive coding is illustrated in Miles and Huberman (1994), as the first step toward data analysis.

Upon completion of transcription and coding of responses, the responses were clustered within the four primary research questions (APPENDIX A: Interview Protocol). Miles and Huberman (1994), suggest that clustering responses within an organized framework can assist in data analysis and in generating meaning from the responses more easily. This was done twice during this study; once in the beginning when the interview questions were organized under each of the four primary research questions and then a second time when responses were coded.

Data Analysis

The analytic approach included data display and reduction to identify key themes across the four participant sites (Miles and Huberman, 1994) First, interviews were transcribed and reviewed to identify data to include in the Interview Matrix. As described above, the matrix was designed around the four primary research questions and included each of the 17 individual questions in the interviews. Second, descriptive data were entered into a matrix developed for each site (APPENDIX B: Interview/Response Matrix). The matrix was used to derive themes that overlapped each site and determine gaps in the responses and similarities across responses. The matrix also allowed for organization of themes that aligned with the theoretical framework, a full analysis of the content, and simplification of the coding process for each response as it relates to the four primary research questions (Miles and Huberman, 1994).

The data analysis followed a basic coding mechanism designed to be descriptive in nature and assist with organization of the data. Descriptive codes allow for the attributing a "characteristic or class of phenomena to a segment of text" (Miles and Huberman, 1994). The descriptive codes in this study were used to describe what the participants are "doing on the ground" in their SVP programs. (APPENDIX C: Code List and Definitions).

Themes were derived from multiple reviews of the data and by looking across participant site responses within the matrices. Each site was given a separate matrix in order to keep quotes and content organized. An example of an emerging theme would then be examined to see if it was unique to that site, or if a common theme was emerging across more than one site. Under each primary research question, several themes emerged and are reported in subsequent chapters.

Limitations

The codes were developed by first using descriptive codes for each question. Then those codes were clustered, based on the four research categorizations. The codes were then applied within each matrix and each question. An area of concern using this methodology is that a few questions were either not answered or asked because an earlier response indicated that data collection and evaluation were not occurring. In order to resolve this conflict for analysis, the study highlights the "lack of evaluation capacity", or the "ability to conduct evaluation of program effectiveness", as a major finding of the study. This will be fully discussed in Chapter 4.

Another limitation is that a single investigator was used. Therefore, it was not possible to assess inter-rater reliability. Having a single investigator may affect the interpretation of the findings. To attempt to alleviate this issue, two rounds of review and coding occurred to ensure that transcription and interpretation reflected as much true response and objective interpretation as possible.

CHAPTER IV: FINDINGS

Introduction

This chapter presents findings from four interviews conducted in April 2014 with program staff who implements Rape Prevention Education (RPE) programs focused on men and boys. Study participants were RPE program staff working at the local level and identified by state public health departments that receive funding from the Centers for Disease Control and Prevention, Rape Prevention Education program (i.e. RPE grantees).

The study's four primary research questions were addressed through sets of interview questions included in the study's interview guide with 17 questions. The complete interview guide, along with the matrix used to analyze responses and draw conclusions is included in the Appendices. The findings are organized here by the four primary research questions with necessary reference to the associated subgroup questions and responses and to the SVP strategy being implemented (MVP, My Strength or CBIM).

Findings

Research Question 1: *How are sexual violence prevention strategies aimed at men and boys implemented by RPE programs?*

Table 7 includes a description of the selected strategies, setting, target audience, facilitator and adaptations made during implementation. All four programs reported that they follow the intended purpose and design of the program closely, with little change. However, when participants were asked if they made any adaptations to the programs in order to address particular needs of the target audience, or the context within which the program is delivered, all four participants discussed adaptations they have made during implementation.

Table 7: Description of SVP Strategies and Implementation Contexts

Intervention	Description	Facilitator	Target Audience	Setting	Adaptations to Program Design
CBIM	Curriculum is delivered by coaches using the CBIM Playbook Flash Card Series =15 hours during the season-sessions occur weekly	Coaches Mentors	HS male Athletes MS male Athletes CBIM site in Iowa also targets female athletes Covers ¼ State of Iowa	Locker room, field, court Classrooms	Language or scenarios may be adjusted for younger athletes (e.g. middle school age) Also using MVP with CBIM, but in the classroom setting
MVP	Curriculum emphasizes is on the active bystander approach and healthy relationships. Program delivered in all day sessions 2-4 times a year.	Trained facilitators (Coed is preferred)	MS and HS males and females. Some applications used with athletes Each program implements in two high schools in MASS	Classrooms Community Centers with the Men's Group	One MVP program in Massachusetts is adapting this model for adult males in a community setting A second MVP program has supplemented the curriculum with Safe Dates. Additional adaptations include age-appropriate content

My Strength	Curriculum is focused on developing "male-positive" character of strength that is focused on a non-violent message and challenges traditional roles of masculinity Bystander approach and health relationships free of violence and coercion Year-long program occurring weekly for 1 hour	Trained facilitators (YWCA in this program)	9th graders and HS students Implemented in 2 HS in Silicon Valley	Classrooms Community Centers	Adapts content to suit younger audiences Adapts messages to engage new students differently than repeat students Adapts to include lesson on what gender-based violence is before diving into the content

Adaptations Made During Implementation

The major findings for this research question is that each program adapts the chosen strategies' curriculum to deliver content to a younger audience, include an audience that the curriculum was not originally designed for (e.g. females and adult men), and supplement the curriculum with an additional SVP strategy with the intent of reaching more students with the messages and adjusting the messages to suit different audiences (e.g. combining MVP with Safe Dates).

Although study participants consistently reported that they do not make many adjustments to the pre-packaged program they implement, they also reported several adaptations to program content and delivery to improve participants understanding and engagement, as well as adjust for different target audiences.

Coaching Boys into Men (CBIM)

The strategy focuses on training coaches and other related mentors to deliver messages through the CBIM Playbook. The CBIM curriculum consists of a series of coach-to-athlete trainings that illustrate ways to model respect and promote healthy relationships. The CBIM card series instructs coaches on how to incorporate themes associated with teamwork, integrity, fair play, and respect into their daily practice and routine. The coaches are trained by a CBIM facilitator and then they deliver the content through their mentoring and coaching activities with the athletes. Content is delivered throughout the athletic season in approximately 12 weekly sessions, or in the case of the Iowa program, 15 hours of weekly sessions.

According to the CBIM program facilitator in Iowa, CBIM is a "training model where the trainer works with the Area Education Agency (AEA) to work with coaches and schools on issues around changing attitudes and behaviors associated with negative gender stereotypes and attitudes about healthy sexual relationships." CBIM has a bystander component where male athletes are taught to "call out" their peers when they see negative or potentially harmful behaviors from their teammates. In addition, the male athletes may mentor younger athletes, such as freshman team members.

The local program representative who implements CBIM in Iowa explained why he has made adaptations to CBIM. One adaptation was increasing the number of cards delivered each week due to scheduling challenges.

> "We had the coaches teach two cards per setting because of schedules and accommodations and other conflicts. These is usually a once a week intervention schedule. You have to make accommodations for things out your control, such as weather cancellations and other scheduling issues."

A second reported adaptation was combining CBIM with another intervention, in this case MVP. The MVP program occurs in a classroom versus sports team setting, and the local program representative believed that the two programs reinforce violence prevention messages for the athletes that may be exposed to both interventions. So, one student may get CBIM at football practice and again in health or Physical Education class through MVP.

Another important finding is that the CBIM program site in this study also uses the model for female athletes as well. This is notable because the program is designed for male athletes and messages address attitudes and gender norms that influence males' behaviors toward females. Therefore, materials would need to be adapted to be germane to females. However, the study participant did not report what these specific adaptations were.

Mentors in Violence Prevention (MVP)

The MVP model is designed to work with coed high school students in a classroom setting. The curriculum is focused on presenting students with scenarios of healthy versus unhealthy relationships and engaging them in discussion where they can explore their own beliefs about a particular topic. There is also an active bystander component that is taught to students so they can respond when witnessing unhealthy behaviors among their peers.

MVP content is delivered 2-4 times a year (depending on school schedules) during a full-day session. The two MVP programs in this study use the high school curriculum. There also are curricula designed for athletic programs, military and college students. The programs in Massachusetts provide at least one monthly follow-up meeting after the regular session, again depending on what the school schedule will allow. The sessions are interactive with student-led discussions and group activities that are guided by the facilitators.

The two sites in Massachusetts implementing MVP reported they implement the model with little adaptation. However, both programs adapt the model in four ways. For example, both programs have struggled to find coed facilitators, which is a suggested design feature since the target audience is coed high school students. In those situations the sessions tend to be facilitated by females only. Another important finding is that the MVP model has been adapted in one program setting to include a session for adult males. These sessions are held within the community as a group called the *Vineyard Men's Prevention Group*. They are adapting MVP to engage more men to deliver the strategy with male/female co-facilitators, which is the best practice for this model. However, those efforts have been challenging, making it difficult to work effectively with adult male populations. In fact, the program facilitator stated in the interview that:

> "This (the Vineyard Men's group) has not been very successful because it's difficult to find like-minded, good men."

Another adaptation made by one program is that the program supplements the MVP curriculum with components of Safe Dates-an evidence-based strategy used in teen dating violence prevention programs (Foshee et al, 2004). Safe Dates may have been selected because of its demonstrated effects preventing multiple forms of TDV for boys and girls. It has been used in middle school settings and the curriculum is age appropriate for younger audiences (Centers for Disease Control and Prevention, 2014). According to one MVP program facilitator in Massachusetts, "Safe Dates is an adaptation when the audience and topics are relevant to its use." It is assumed what they mean here is that the school has requested a session related to teen dating violence, or the program staff has determined that the audience would benefit if Safe Dates curriculum was used to supplement the MVP curriculum.

And finally, the programs will adapt the MVP curriculum to deliver to younger audiences, such as middle school age children. Since the original design is aimed at high school age audiences, the MVP staff indicated that changing language or reworking scenarios that are age appropriate works, and that the younger children are responsive. One of the program facilitators explained it as:

> "Not many adjustments, we only have adjusted for the younger students in middle school where a more age appropriate content is administered."

My Strength

The My Strength program is designed to create "male positive" messages and change attitudes and behaviors regarding dominant norms of masculinity. The program's goal is for boys and young men to recognize negative behaviors and "to de-escalate behaviors through direct and indirect ways" (such as through the bystander model). The sessions are delivered throughout the school year, one time a week for 1-hour in at least one classroom per school. Typically, the program is scheduled for each semester so sessions are for 12 weeks in the fall and spring. The My Strength program that participated in this project is implemented in two high schools in Silicon Valley, California.

The findings for the My Strength program suggests there are three adaptations the facilitator will make based on the target audience. The first major adaptation is changing the language or scenarios to work with a younger audience, or an audience the facilitator feels needs more introductory instruction on what is sexual violence, what are common norms around masculinity and how does that play into healthy and unhealthy relationships. For example, many of the students in this program are from cultural backgrounds that promote objectification of women and where views on sex are "no means yes".

As the facilitator explained about the target audience he works with:

> "So pressures to have sex propel these young men to discount young women... this girl looks like this and I just want to have sex with her." "Those kinds of things I see regularly and I see it every day in the high schools." "I am driving in the truck with my dad and big brother, so why wouldn't I whistle at a girl if my dad does?"

The facilitator uses these observations in his sessions to illustrate behaviors that are negative. This is an adaptation based on his observations and not necessarily included in the curriculum design.

Another adaptation is that the facilitator adjusts content based on his assessment of the audience. For example, some students repeat the program because they failed a grade. In this situation, the facilitator adds new content for returning students to keep them engaged. Or, if the students seem particularly disengaged or immature he will also make adjustments so that the initial content is relevant to those students.

Research Question 2: *What, if any, evaluation is being conducted on the selected program strategy?*

Findings across all four participant sites reveal that data collection is limited and may not be collected in a way that programs could systematically track implementation or outcomes. Although two programs (CBIM in Iowa and MVP in Cape Cod) attempt to collect student self-assessment data on attitudes, gender norms and behaviors, it is not using that data to inform evaluation. For example, data collected in the CBIM program in Iowa is being used to assess general understanding of program elements, perceptions of SV behavior and gender roles, and likelihood to intervene as a bystander to prevent sexually violent behaviors, but no overall

evaluation plan is in place. Both the Martha's Vineyard MVP and the Silicon Valley My Strength programs get verbal feedback from the student's but the information is not recorded or reported upon.

The My Strength program has adjusted ways it collects feedback from participants because the canned My Strength assessment tool is a lengthy survey that students just "bubble in" their answers. The My Strength facilitator indicated "I do not use the canned survey tool because the data collected would not be useful." Instead, he developed another method for collecting anecdotal and qualitative information through individual interviews and feedback sessions. However, this data is not part of any type of formalized evaluation plan and is only used at a very basic level to determine if students understand the material, if the materials are relevant and if there is evidence of a change in behavior or beliefs regarding gender roles.

As reported by the Cape Cod MVP program, the pre-post student self-assessment administered is only used to collect data requested by the state. The program facilitator for Cape Cod said:

> "A pre-post student self-assessment is collected, but analysis is general…and the use of the current self-assessment is to collect data for reporting requirements to the state. The assessment is focused on knowledge, awareness, and behaviors. It's developed on a 5-point scale and only looks for increases in those measures."

Because the other participant sites had limited data collection processes, the focus for this section will be on the CBIM program in Iowa.

CBIM Data Collection

In Iowa, where the CBIM and MVP are implemented in different settings (field vs. classroom) and somewhat different populations (athletes vs. non-athletes), there is some survey

data collected along with homegrown surveys and feedback sessions, but these are not part of an overall evaluation plan. The Iowa CBIM program uses data to measure individual components of the intervention strategy, but does not conduct evaluation of the strategy. The CBIM facilitator indicated a desire to improve data collection, develop ways to measure how CBIM and MVP work together and to develop an evaluation plan for CBIM in particular.

The program implements annual pre-post surveys developed for CBIM's intervention study investigator, to look at participant knowledge and understanding of the model and how peers relate the information to issues regarding dating abuse, dating violence, and sexual orientation/gay bashing. These survey data are reviewed by the program facilitator and an academic partner at the University of Northern Iowa, who assists in data collection. The surveys are intended to measure knowledge of intervening behaviors and if program participants are actually practicing these bystander behaviors. According to the CBIM facilitator, the program is trying to measure "What does [bystander behavior] look like in practice…are the students collaborating with other students in these behaviors?"

Although a pre-post survey is part of an "evaluation" piece for this project, the program facilitator indicated that he would like to "be more diligent with the pre/post assessment with CBIM." It was indicated in the interview that the surveys are not consistently applied and he is working toward developing a stronger pre-and-post survey instrument and process.

Since the local program in Iowa implements the MVP Model in conjunction with CBIM they also survey the student mentors about mentee engagement in the material and ask questions of the mentees to test their level of engagement/interest. The program also collects data from 9th graders who receive the MVP curriculum in the classroom to measure the utility of MVP.

The program facilitator said they would like to know: *"Did the MVP program help them (9th graders) understand healthy versus unhealthy relationships? Did they understand the content and scenarios? Was it relevant to them? Did they feel comfortable with material and the topic?"*

Research Question 3: *What are the facilitators and/or barriers to evaluating the effectiveness of the strategy?*

Because the four programs included in the study are not currently evaluating their SVP strategies, study participants did not identify facilitators. However, participants consistently indicated interest in finding ways to track what is working in their program.

Evaluation expertise is lacking at the local program level across all four program sites in the areas of data collection, analysis and evaluation expertise. Although Iowa is collecting some data in the pre-post assessment surveys, it is unclear how that data is stored and analyzed, and what kind of information the data provides. Another important gap is that collaboration in evaluation, such as an organization collaborating with a University that has evaluation expertise, only occurs within the Iowa CBIM program. The other programs (MVP and My Strength) said they do not have any partnerships that would assist them with data collection and analysis for evaluation.

All programs express constraining resources for training in evaluation practice, or for hiring facilitators with evaluation skills as a reason for not conducting evaluation of their strategies. And finally, a need to understand what is working elsewhere, what are the protective factors and where can they network with other local programs to share this information would assist them in building evaluation capacity.

Desire to Build Evaluation Capacity amidst Limitations

Although participants indicated that their programs lack sufficient evaluation capacity, they expressed an interest in knowing what works well in their programs and being able to use evaluation data to improve program implementation and long-term outcomes in preventing SV. For example, the MVP programs are interested in developing robust evaluation plans and implementing those in the field; however they do not have the expertise, or time to do so. As one program facilitator explained:

> "We have 10 good ideas but not enough staff to do any of them. We need some kind of information resource for ideas exchange, a blog or something else to learn what others are doing or experiencing. Evaluation of prevention is difficult...if there were some stats on prevention then it would help".

Participants identified several barriers five most common themes discussed by participants were time, money, knowledge, isolation and training.

Time

All participants expressed that they do not have enough time to implement their strategies, develop data collection tools and collect and analyze the data. This finding translates to a significant limitation that is also related to overall staff capacity to do the preliminary work of evaluation-data collection.

The two MVP programs in Massachusetts indicated that time is a major issue regarding data collection and evaluation. The Cape Code MVP program implementing the program in two high schools, wants to know the long-term impact the program has in preventing sexual violence; however a very small staff of three people will only allow for a pre-post-test survey. The survey doesn't provide enough of, or the right type of data that might indicate future prevention

effectiveness. For example, even though this program is collecting some survey data the program facilitator indicated that: “the analysis remains general”. And, that she would “like to conduct a longer-term evaluation but there is not enough time or staff to carry out this task.”

Money and Staff Resources

Participants also reported that low funding levels and limited staff resources are significant barriers to conducting evaluation. As one program facilitator suggested:

> “We have ten good ideas, but not enough staff to do any of them. Our program needs to have the resources to conduct evaluation. A former employee did build an evaluation model that we use to look at any change in knowledge, awareness, behaviors, but they do not know if actual change has occurred.”

This sentiment was also reflected in the other interviews when respondents were describing how they implement the strategies and collect data. In California, the My Strength program is limited to the number of trained facilitators and many of the facilitators are not properly trained to work with the content, or with student populations.

The My Strength facilitator explained:

> “Lack of appropriate staff resources shows when student’s express, they didn’t really learn anything when the other facilitator taught the My Strength content.”

Knowledge of Evaluation Practice

Financial and Human Resources is directly related to -Knowledge of Evaluation Practice. Program participants indicated they needed additional tools to conduct evaluation. Participants indicated that a primary reason they are not conducting evaluation of their SVP strategies has to do with staff knowledge of how to design an evaluation, collect data, do the required analysis and publish the results. Staff members working within local programs currently do not have this

expertise and many express the desire to know if what they are doing works. For example, the Cape Cod MVP program in Massachusetts stated that:

> "We would like to conduct robust evaluation of our programs, but we don't have the resources to do so."

This MVP program does use a pre-post survey with their MVP participants that measures changes in knowledge and awareness of appropriate behaviors regarding sexual relationships and gender, and sends those survey results to the state.

Lack of Evaluation Partnerships

Participants were asked if they have collaborations or partnerships to build their SVP evaluation. Only one of the four programs currently partners with a University to assist with data collection and analysis. The University of Northern Iowa works with the state RPE coordinator to collect and analyze CBIM survey data. However, these data appear to be used only to measure individual level changes in attitudes and behaviors of CBIM participants, but is not used to systematically track outcomes. For example, the CBIM facilitator in Iowa may use this information to see if a short-term change in attitudes toward females or positive bystander behavior is evident.

Perceived Isolation from What Others Are Doing

Connected to a lack of evaluation knowledge and expertise is a perceived isolation from knowing what others are doing in the field, and if there is the potential for shared resources that might improve not only evaluation capacity at the local level, but just knowledge about how best to implement their programs into the community.

One of the unexpected findings in the study is that program facilitators feel that they are implementing these strategies without knowledge of what others in their field are doing around

evaluation. In three of the four interviews, the participants expressed that they "would like to know what others are doing". One participant stated:

> "We would like to collaborate with other local agencies in and out of the state to see how others are evaluating their programs, what the evaluation design looks like and how they are measuring the results."

Programs requested more access and collaboration to other RPE programs both within and outside their respective states. One participant suggested that: "A conference where colleagues could network and exchange information would be helpful."

Research Question 4: *What types of technical assistance would better prepare RPE/SV PREVENTION grantees in developing their evaluation capacity, or in conducting evaluation of their program?*

This question was asked of interviewees to determine where gaps in training, knowledge, skills and abilities as it relates to program implementation and evaluation may exist. During an earlier project where all 50 RPE grantee state level institutions were asked to respond to an evaluation capacity assessment instrument developed by CDC RPE staff, it became apparent that some state level and probably many local level organizations working in SVP were not equipped to properly and rigorously evaluate their programs.

Three of the four participants reported on three main types of technical assistance needs related to program implementation and evaluation. .

- Staff training in evaluation design, data collection and analysis
- Information exchange resource where program staff can network remotely
- Expanded staff for broader reach

Staff training

Training in evaluation planning, design and analysis was indicated as a needed resource for local SVP programs. With the exception of Iowa, the other interviewees talked a lot about their lack of preparedness, lack of knowledge, lack of time and general lack of resources to evaluate their SVP strategies. The Iowa project did not indicate training as a primary need, although based on the interviews it appears they are not prepared to conduct a rigorous evaluation of CBIM.

The two MVP programs in Massachusetts explained that they do not have the expertise on staff, relationships with an external evaluator, or knowledge on how to develop an appropriate evaluation tool for their program. As one MVP facilitators described, they have, a desire to "make evaluation a priority and create a measurement tool, but we don't know what to do or what to evaluate." These comments tie into the need to understand what is going on in the field, where evidence of best practices may exist, and what they could/should be doing to build their evaluation capacity.

Staff training was highlighted by three of the program sites as a primary need in order to develop the capacity to evaluate their SVP programs. For example, the Martha's Vineyard MVP facilitator said:

> "Any training we can get and guidance on best practices to see if what we are doing does work. We would like help with measuring the "internal change" that occurs. We want to know what has worked elsewhere."

Likewise, the program facilitator of My Strength in Silicon Valley stated:

> "My program would be better prepared to conduct evaluation if I had someone who is a trained evaluator, or who can show me how to properly design an evaluation to look at overall program effectiveness-would be very helpful."

Information exchange and networking

Three participants recommended having information exchanges between local level programs and state and national networking opportunities. , For example, both the program sites in Massachusetts expressed a need to know what others are doing in terms of evaluation. One participant explained:

> "We need to make evaluation a priority and create a measurement tool, but we don't know what to do or what to evaluate, so it would be helpful to know what other programs are doing to measure effectiveness of MVP."

Another MVP program in Massachusetts discussed how sharing with others in the field may advance their evaluation capacity, one program facilitator from Cape Cod said:

> "Because prevention is so difficult and hard to pin down (measure), how do we really know if we have prevented a rape, or act of sexual violence?"

Furthermore,

> "If we had the evidence in the field (what others are doing in their programs to collect data and develop evaluation plans) we could use that to build stronger community efforts."

In relation to more networking resources, the My Strength program facilitator in California expressed a need for more conferences or other networking events, stating:

> "They used to have conferences for My Strength where other facilitators shared stories. It would be good to know what specific things others are using that work well with the students and are really poignant."

Expanded staff resources

This relates back to overall evaluation capacity of local level programs as it relates to small staffs, limited expertise in evaluation and very limited resources to train or hire new staff with knowledge of evaluation practice.

While the other programs stated that small staffs keep them from expanding their programs to more sites, the real need appears to be having the staff that is able to assist with data collection, analysis and evaluation, or at least the resources to collaborate with another organization with that expertise. The CBIM program in Iowa is fortunate to have resources available at the University of Northern Iowa that assists the program facilitator with survey analysis. The other programs do have those resources.

Summary

The findings reveal concrete needs of local programs in regards to both implementation and evaluation. Some of these needs can be addressed through additional technical assistance from the SVP State level program offices and the RPE program. Chapter five provides additional discussion of these findings and associated implications and recommendations to improve evaluation capacity for SVP programs in the future. It is important to reiterate that the following Discussion and Recommendations are based on a small scale study that may not be generalizable to the larger content of SVP work across the United States.

CHAPTER V: DISCUSSION, IMPLICATIONS and RECOMMENDATIONS

Introduction

Sexual Violence Prevention (SVP) refers to all activity where consent is not freely given including non-contact sexual behaviors such as sexual harassment and contact sexual behavior including rape. This study examined SVP strategies focused on men and boys are currently being implemented, what those strategies look like in practice, the extent to which those strategies are evaluated and what types of technical assistance and training local level program staff need to effectively implement and evaluate their work.

The four research questions that drove this inquiry produced interesting findings that merit further discussion. Study findings indicate that significant gaps in data collection and evaluation exist among participant programs, and study participants identified specific implementation and evaluation capacity needs.

Discussion: Overview of Findings

Research Question #1 Implementation

The major findings for this research question is that each program adapts the chosen strategies' curriculum to deliver content to a younger audience, includes an audience that the curriculum was not originally designed for (e.g. females and adult men), and supplements the curriculum with an additional SVP strategy with the intent of reaching more students with the messages and adjusting the messages to suit different audiences (e.g. combining MVP with Safe Dates).

When the participants were asked this question, all responded with a similar answer of not really any changes or no changes. However, they then began to describe what adaptations

they had made in order to provide the content to a different audience or supplement the content to incorporate related messages to teens about healthy relationships.

The interesting aspect of this finding is that these changes may not be clearly documented, which would impact a program's ability to systematically collect data and evaluate the information against the stated objectives of the program design. For example, the CBIM program in Iowa is using MVP in addition to CBIM. Some of the athletes may receive both interventions, or some may receive only one. This is an issue for determining which intervention may have caused the behavior change. In Massachusetts, one of the MVP programs indicated they have used components of Safe Dates along with MVP "when appropriate". They did not elaborate on this, but the effect of this adaptation versus using just the MVP curriculum may not be known if a method for collecting data on this adaptation separately isn't in place.

This is not to imply that adaptation is a bad thing, but it does point to the fact that the pre-packaged curricula is designed around a determined set of learning objectives that has some method to measure outcomes. If the curriculum strays too far away, data collection could be problematic and evaluation may not deliver good data that can be used for program improvements.

The final point is that local programs make changes to their RPE strategies, but not necessarily based on any evidence of what works. This appears to be because they implement the program and then get a feel for what is working and not working. Then they try new things to keep the students engaged and keep the content interesting. If that means supplementing MVP with Safe Dates then that's what is done. If it means that 9th graders receive different messages on healthy versus unhealthy relationships then that is what is implemented on the ground.

Research Question #2 Evaluation

The main finding under research question #2 regarding evaluation found that the four participant sites reported that they are not conducting evaluation of their selected strategies and little implementation data is collected by participants' programs. This is not entirely unexpected because the literature on sexual violence prevention strategies regarding evaluation is limited. Also, local programs themselves would not conduct an effectiveness study, such as what has been done with Safe Dates and CBIM. However, what is expected is that each program would be collecting data in a somewhat systematic fashion; using that to inform implementation and have some measures for program outcomes.

Prior to 2012, only the Safe Dates program, an evidence-based program that targets male and female teens about appropriate and inappropriate dating behaviors, had undergone multiple, rigorous evaluations to measure potential effectiveness. In addition, Elizabeth Miller et al. (2012), has since conducted two evaluations on the Coaching Boys into Men program. And, other less rigorous evaluations have been conducted on the MOST (Men of Strength Program, now My Strength) and MVP, although these are not yet recognized as evidence-based practice in SVP. Still, these programs are widely implemented across the United States as individual and interpersonal level strategies in preventing SV. Since there is existing evidence of effectiveness, or at least promising evidence, it would benefit these programs tremendously if they knew whether their implementation plans were working. The only way they can do this is through a well-timed and systematic way to collect, analyze and report on data that informs the successful implementation of their chosen strategy. This is especially important if programs are implementing more than one strategy as a supplement, or as a second intervention. It would be important to know whether it is the combination of the strategies, or if one strategy works better

than the other in changing attitudes and behaviors regarding SV. For example, in the case of the Massachusetts program, that at times supplements the MVP curriculum with components of Safe Dates, is the combination of those two strategies more effective in creating bystander behaviors?

There are a few reasons that the local programs are not evaluating their strategies. A good example is illustrated by the My Strength program in California. The program facilitator stopped using the survey instrument that that is included with the program implementation packet because the surveys were too long and offered little utility for determining any real change in behavior, or beliefs of male students who participate. He stated that, "the student's just bubble in the answers", with little interest in participating. Instead this facilitator uses individual interviews and smaller feedback sessions to determine if students are receiving the messages. This may be an effective way to get thicker description of how a program is impacting attitudes and beliefs, but the data is not collected in any systematic way or reported upon.

Alternatively, the CBIM program in Iowa is collecting data that could be used to inform future evaluation efforts. Currently, the data is being used to measure individual components of the intervention strategy, but does not conduct evaluation of the strategy. According to the CBIM facilitator, "the program implements annual pre-post surveys to look at participant knowledge and understanding of the model and how peers relate the information to issues regarding dating abuse, dating violence, and sexual orientation/gay bashing. The facilitator wants to know if what he does is working, so he is in the process of improving data collection and developing ways to measure and evaluate CBIM.

There is a desire across programs to evaluate these strategies within the context of their implementation sites. As noted above by the efforts in Iowa, some programs are further along in the process of building evaluation capacity, while others such as the two MVP programs in

Massachusetts, need additional assistance in developing plans for evaluation. Some of the barriers to evaluation are described in the next section.

Research Question #3 Facilitators and Barriers for Evaluation

For this study, there were no facilitators because evaluation is not currently conducted. The findings reveal significant barriers to evaluation of RPE strategies focused on men and boys within local programs. SVP programs implemented at the local level state that they are implementing these strategies with fidelity, but they don't actually collect data to support this. Therefore, there is no data to measure any change in participant behaviors or long-term impact that results in prevention of sexually violent behaviors, acts of rape or sexual assault. Knowing what factors facilitate or impede program evaluation of SVP strategies focused on men and boys, is key to understanding what resources may be needed to move toward building evaluation capacity. The findings reveal that time, money and staff resources, knowledge of evaluation practice and lack of evaluation partnerships are the primary barriers to conducting evaluation among this set of participant sites.

Time

All participants expressed that they do not have enough time to implement their strategies, develop data collection tools and collect and analyze the data. This finding translates to a significant limitation that is also related to overall staff capacity to do the preliminary work of data collection. The issue of time cannot necessarily be addressed with technical assistance, or even more staff. However, it is an indicator that is related to a staff's capacity to conduct the work of implementation, have the capacity to build data through a systematic data collection process and have the resources available to spend on evaluating implemented strategies.

The programs reviewed are implemented in community settings, which mean staff, have to travel to where target populations are located. In the case of high school settings, these institutions can be difficult to schedule sessions with because they have demanding academic schedules mandated by their state or county Departments of Education which must be met first. Once a program sets a schedule, it can be challenging to add new classes, or time slots. All this has tremendous demands on time for the small staffs in SVP work. The additional time needed for professional development, working on additional community partnerships, collecting and analyzing data tends to reside on the back burner-the priority it delivering the interventions.

Some ways to address time as a barrier to evaluation is to include local level staff training and building partnerships within the state to work on data collection plans and evaluation. As suggested in the recommendation below, this could be a leveraged resource that the state is able to provide as part of their RPE evaluation planning.

Money and Staff Resources

Adding additional staff to address issues related to time and small staff size is typically not a viable solution. In the case of the RPE program federal funding has decreased significantly over the last three years and is not expected to increase in the near future, which heavily impacts the availability of state funds to pay for items such as staff. Local programs already operate on very small budgets so when say they don't have the resources to fully implement program strategies or evaluate those activities they are usually talking about funding issues. This includes the human resources needed to get the full range of work and activities done that make a community-based program successful. This will always be a barrier for small, local programs no matter what the social problem is they seek to remedy.

However, there are solutions that do not require additional staff or program funding. Many resources are currently available where SVP professionals can share and find out what others are doing-for both implementation and evaluation. The National Sexual Violence Resource Center (NSVRC) has an excellent website, resource library, blog space and podcasts, highlighting what others are doing and what may be innovations in practice within their own diverse communities (National Sexual Violence Resource Center, 2014). Prevent Connect, a Californian Coalition against Sexual Assault web-based resource provides blogs, eConferences and eLearning opportunities and a direct link to RPE state grantees with updates on what is happening in SVP work (Prevent Connect, 2014). Prevent Connect, seeks to "advance the primary prevention" of SVP by building an online community of practice that program staff can access anytime (California Coalition against Sexual Assault, 2014). In addition, Prevent Connect is designed to address evaluation capacity as well as assist those working in violence prevention in determining best practices. This resource may be underutilized as none of the interviewees indicated they were accessing this resource for assistance. In addition, there is the National Sexual Violence Prevention Conference held in a different city each August where professionals have the opportunity to network with their colleagues, attend workshop sessions and learn more about what is working in SVP.

Knowledge of Evaluation Practice

The finding here is significant because it really speaks to the real reason local programs are not conducting evaluation. Participants indicated that a primary reason they are not conducting evaluation of their SVP strategies has to do with staff knowledge of how to design an evaluation, collect data, do the required analysis and publish the results. Staff members working

within local programs currently do not have this expertise and many express the desire to know if what they are doing works.

There is a real need in the local level programs to have this expertise available. Either in the form of training for current staff, the availability of state level resources, or expanded partnerships with a University where this expertise exists is key to building evaluation capacity. There is a desire within the programs to have this knowledge internally. Training staff in data collection alone would improve the systematic treatment of data. If programs are able to collect data on each strategy and store it consistently and systematically, evaluation becomes more accessible.

To address this finding it will be important for the state level RPE office and the local level program leadership to work closely together in building a data collection plan and determining where evaluation resources will be derived.

Lack of Evaluation Partnerships

One interesting observation related to lack of partnerships is that at no time did local programs discuss a relationship between their own program and a state level RPE program. The local programs are provided SVP through the RPE funding from the state RPE coordinating office to conduct their programs. Even in the sections on evaluation there was no indication that the state Public Health Department had implemented reporting requirements, data collection parameters, or training in what local programs should be doing regarding evaluation. Purposefully, a question about such a relationship with a state Public Health Department, RPE program was omitted from the interview guide in order to encourage interviewees to discuss their local programs only. This may have been overlooked because that question was not directly

asked of respondents so they did not consider mentioning the state RPE coordinating office as a partner.

No intention at revealing any gaps between state plans and local work was intended or assumed. In fact, it was assumed that states would be asking for some local data. To remain objective regarding this observation, it is suggested that more discussion and interviews occur around this question since the relationship appears unclear. Since this was such a small sample, and a targeted question regarding a state's RPE evaluation procedures was not asked, then it is possible that systematic reporting exists and that states have future plans of implementing more robust evaluation efforts at the local level.

Research Question #4 Technical Assistance

During this study it became clear that staff need and desire additional assistance with both understanding the impacts of what they implement and evaluating individual strategies like CBIM, MVP and My Strength. Three primary issues are highlighted below where technical assistance from the state level RPE program or the CDC/RPE program working with the state can provide the necessary tools needed to address these issues. The recommendations chapter provides a set of feasible solutions that includes the issues below.

Staff Training

Staffing issues, such as training and providing external human resources need to be addressed at the state level so that RPE programs can build evaluation capacity at the local level. Because staffing is a limitation of the programs, current staff does not have the resources of time, expertise in data collection, or experience in evaluation practice to evaluate their RPE strategies. The two MVP programs in Massachusetts explained that they do not have the expertise on staff,

relationships with an external evaluator, or knowledge on how to develop an appropriate evaluation tool for their program.

If staff were provided technical assistance in understanding evaluation, collecting data in the field and storing data for analysis, the evaluation could be conducted by a trained evaluator. This resource could be a leveraged state resource, or a partnership with a University where evaluation expertise exists. The concern is that programs will continue to do the work currently prescribed in working with men and boys in RPE, but they will not know whether their efforts have any long-term impact in preventing rape and sexual violence.

Information Exchange and Networking

The finding here highlights the need for better communication between state level RPE program coordinators and local level programs. Three of the four participants requested that opportunities for networking with other SVP programs in their state and across the country would allow them to assess what others may be doing in regards to data collection and evaluation. They suggested blogs, regional training events, and improved access to national conferences as ways to increase their knowledge for what works.

One of the MVP programs stated they would like more access to research and knowledge of protective factors in SVP work. Although knowledge of evidence-based protective factors is not currently available, there a number of promising strategies in the literature that is accessible for programs to use as a guide. It appears that local level programs need more communication about where to find existing resources. For example there a number of resources available through Prevent Connect and the National Sexual Violence Resource Center, including research references, webinars and active blogposts.

Expanded staff

The study findings indicate that local programs want to evaluate what they are doing, but do not have the capacity and resources to conduct systematic evaluation activities. Staff capacity can affect the scope of SVP strategies and the longer term impacts these programs may have in prevention of sexual violence. For example, three of the four participant sites were only serving a small number of high schools in a larger regional area. They stated that more resources would allow them to go into more schools, serve program participants for more sessions and provide the prevention materials to younger audiences who need to hear the message before they reach high school. The current strategies are adaptable to younger participants and SVP staff recognizes the importance of introducing the concepts of appropriate sexual behavior and gender norms at an earlier age. However, getting into educational institutions takes time, effort, resources and extensive relationship building meaning that current staff levels are pressed to reach the target populations.

Implications for the Rape Prevention Education Program (RPE)

The RPE community consists of national, state and local level organizations working to end sexual violence. The majority of work being done in RPE across the country is conducted through a variety of organizational types with some collaboration with law enforcement, the legal system, health care professionals and other groups working in domestic violence and child abuse and neglect. This creates an intricate network of organizations that operate both inside and outside the SVP/RPE landscape. The CDC funds State Health Departments RPE programs that are either directed out of a state office, or authorized for funding local level partners who deliver SVP programming in their community.

A commonality found among three of the four participant sites, regardless of the SVP program they were implementing, was that their reach was somewhat limited. It was reported that three of the four sites are only implementing in one or two schools. Only Iowa is working through a state plan within the Area Education Agencies (AEA), which covers high schools and a handful of middle schools in one quarter of the state. Staffs were as small as one, so getting beyond two high schools or a few community centers was impossible. In addition, this limitation suggests that local level impacts are small because the programs cannot reach all schools in a district, or have the time to provide a higher dose of the program. In addition, staff size and expertise were limited for all programs because of the time and effort put into scheduling and delivering programming.

Implications for Public Health and Community Involvement in Sexual Violence Prevention

Although local programs are working diligently to get into as many schools and classrooms as possible, they have difficulty reaching adult populations. Engaging men in the prevention of sexual violence has important implications for public health because of the extent of the problem across all communities and the world. In Massachusetts, the Mentors in Violence Prevention (MVP) Program do have an adult male component that is built upon engaging men in the dialogue and process of SVP. These strategies include individual level norms and behavior change, as well as interpersonal and community level change such as Healthy Bystander models and building a community of men who work to end SV. Both MVP programs in Massachusetts have community events to raise awareness about SV prevalence in the community that includes men as both mentors and as engaged citizens in ending SV. However, the numbers of engaged men is very small and one program facilitator expressed it as “it’s difficult of find like-minded, good men” who want to participate. Engaging men in the process of SVP is a somewhat new

approach that could positively impact SV at the community level-an area of the sociological model that has not been adequately addressed. Men have influence within their familial, social and work environments that position them to use their masculinity and power as a positive force against SV. These programs could have broader and more long-term impacts on engaging men if they had the capacity to build their programs and allocate more resources toward this population. In addition, the RPE program could have a broader impact as well if more grant resources and technical support were geared toward engaging men in all levels of SVP.

Men also play a key role in SVP for younger males within the community. The CBIM, MVP and My Strength programs all use either a coed model or primarily male mentor model of facilitation. The CBIM is primarily male coaches who are trained and then facilitate the instruction with their athletes and in some cases in the classroom if they are also faculty. The MVP model strives to have coed facilitators, but as stated earlier it had proved challenging to engage men. The My Strength program also relies heavily on a coed facilitation, but finding and selecting well-trained facilitators is also a challenge. These facilitators can either have an enormous impact if they are seen as a peer or mentor to young men and women. For example, the CBIM program works to influence athletes who generally look to their coaches for guidance and advice on things both on and off the field. This is an ideal relationship that allows frank discussion about healthy and unhealthy sexual beliefs and behaviors.

The real implication to the public's health is that SVP is an important community and societal level goal that cannot be accomplished without the engagement of boys and men. This group, more than any other, has the power to change beliefs, behaviors and norms related to views of themselves, women and healthy relationships. The role of the Centers for Disease Control, state Health Departments and government is to provide the resources needed to have

long lasting impact. Much of that work has been done and there is currently heightened interest in the problem of SV in the country. However, the impacts of current SVP strategies are largely unknown and local programs do not have adequate resources or technical assistance to have real impact in their communities.

Recommendations

The recommendations discussed below are intended as suggested enhancements to encourage more technical assistance by the Centers for Disease Control and Prevention Rape Prevention and Education (RPE) program for RPE grantees and the local programs they fund. The study findings obtained from the interviews may be used by the RPE program to identify specific technical assistance resources for RPE grantees, increase knowledge of how RPE strategies focused on men and boys are implemented, and gain an understanding of what, if any, program evaluation is taking place. This isn't to imply that current work in the field by the RPE program or through national level nonprofits is not having a positive effect. Indeed, without the current resources and increased efforts in determining what is happening in the field and what works there would be very little prevention efforts occurring. However, this is a time of growth, awareness and opportunity that has not previously existed and efforts at all levels should be heavily engaged in determining what is working and what can be done to increase overall impact in prevention.

The following recommendations are based on the information and needs expressed through the interviews. They are also influenced by the investigator's personal knowledge of program development and grantsmanship of community programs. The inclusion of recommendations is to assist the field of SVP and shared objective insight into what local programs need to enhance and improve their SVP programs.

Recommendation 1: *Technical support from state level RPE programs to provide workshops for local level grantee organizations on evaluation capacity building.*

All four programs interviewed for this study expressed both a desire and need for more guidance on how to properly evaluate their SVP strategies and improve program implementation. The facilitators see their program having an impact as they engage in one-on-one or group work with high school students, athletes and men. However, they don't know if the work they are doing with these groups acts as a protective factor by preventing SV before it occurs.

The RPE program officers at the state level could develop a standardized training that is part of the grant activities for local level staff and facilitators to attend. This could be designed as bi-annual, regional conference training or an online module that can be accessed at any time. For example, the National Sexual Assault Conference is held annually and includes workshops for both state and local agencies to learn new practices and share ideas about sexual violence prevention and response. The training could be facilitated through the state level office who receives the funding from the CDC, RPE program as a way to further develop relationships between the local and state level groups. The workshop content could include emerging research in evaluation practice, data collection methods, use of qualitative forms of data collection and development of program level evaluation plans.

The intended outcome of Recommendation 1 is to provide technical expertise to field level SVP facilitators who have limited knowledge and experience with data collection, analysis and evaluation practice.

Recommendation 2: *Coordinate information resources and training content among SVP advocacy groups, nonprofits and public health programs to enhance local program use, provide opportunities for local programs to network and build a community of best practice.*

In addition to an organized effort at the national and state levels to provide more technical assistance to local level SVP programs, there is a desire and need to feel connected to what is going on in other programs. During the interviews, there was a consistent message that program staff are eager to communicate with other programs across the country and have open dialogue about what works in their community, what is happening that is new and innovative and how do they measure their success. However, interview respondents indicated they didn't feel "connected" to their peers, or that they really knew what else was being done in the field beyond their own community. The CDC resources such as, Prevent Connect and the National Sexual Violence Resource Center, could assist local programs with technical information, tools and resources for sexual violence prevention practitioners. The existing infrastructure of these resources could also be used to deliver evaluation support and connect local program with one another. The World Health Organization and the Violence against Women Electronic Network also provide information and tools for practitioners. ,

One way CDC could improve access to existing resources would be to develop a communication and information dissemination plan that targets state grantees and their local RPE funded programs. A formal communication plan aimed at local level SVP programs may address the issue and provide those working in the field with valuable resources to assist them with program improvements and in building evaluation capacity.

The intended outcome of Recommendation 2 is to build the knowledge base of local level SVP staff about program implementation and evaluation and to strengthen the SVP community through enhanced resource sharing and information exchange.

Recommendation 3: *A prevention education campaign embedded in a small grant opportunity targeted at developing strategies that engage men and boys; and that develop evaluation criteria.*

The three programs in this study (CBIM, MVP and My Strength) are intended for primarily male audiences and are designed for high school age students and athletes. There is some flexibility in the design where activities and content can be redesigned to serve a younger audience such as middle school children, but in general the programs are delivered at the high school level.

What is absent, and this was alluded to in the interview discussions, is knowledge of best practice in engaging adult men in the prevention of SV. This was not a major finding in the study, but of the four participant sites only one was trying to engage men by adapting MVP curriculum. The program facilitator for the Martha's Vineyard MVP program said engaging men is difficult and that they are not having much success. She indicated that it would be helpful to know what others are doing regarding engaging adult men.

A small grants competition designed for local level programs to implement and test strategies for engaging men at the community level would assist those struggling to reach this important population. The grant program would provide resources for program development, implementation, staff training and evaluation plan design. Programs are very limited in whom they can reach and the level of intensity they can implement chosen prevention strategies,

therefore more resources in this area could produce promising practices that could be disseminated broadly.

Another way this could be done is by identifying other programs currently funded by RPE who are also trying to work with adult males and provide them resources for partnering with an evaluation expert. The evaluator could assist a program in developing a formative evaluation for the intervention focused on adult men. This would allow programs to fine tune their strategies and build evaluation capacity for more in depth outcomes assessment.

The intended outcome of Recommendation 3 is to provide resources for local programs to engage men in SVP strategies at the individual, interpersonal and community level of the sociological spectrum, and to have a broader societal impact in preventing SV.

Recommendation 4: *Expand research opportunities in the field through a small grant program focused on producing rigorous evaluation of promising programs for prevention of sexual violence.*

As examined in a 2012 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention Report entitled, *Looking Ahead Toward Community-Level Strategies to Prevent Sexual Violence,* more theoretical work is needed to understand what works in SVP (DeGue et al., 2012b). In fact, interview respondents indicated they were unaware of any protective factors currently identified that they could work into their program design, and they indicated that prevention of SV is "complicated" to address at all levels. There is a real need for guidance from the research and development of theories of practice that RPE staff can implement in the field.

A grant program for state level offices and/or consortia with leaders in academic and nonprofit institutions that is focused on expanding theory and practice in SVP/RPE may provide

a body of evidence that could build what is known and unknown in the field. Research could be restricted to evaluating promising practices in order to expand the knowledge base and develop strategies for moving theory to practice.

Additionally, this recommendation could be expanded to work with specific state and local programs who have identified SVP strategies focused on men and boys that been implemented but not evaluated. This could include pre-packaged interventions such as CBIM, MVP and My Strength and homegrown strategies used in RPE funded sites.

The intended outcome of Recommendation 4 is to provide both state and local level RPE programs to look more closely at the programs they have implemented, develop evaluation tools and inform other SVP programs of what is working in their own programs through dissemination of evaluation results.

Conclusion

The Results of this study are limited because of the small sample size and by the qualitative nature of the research conducted. Additional interviews, surveys and focus group work would provide more depth to the findings and distinguish more detailed picture of what local level programs need regarding program implementation, data collection and evaluation capacity.

SVP strategies focused on men and boys are a relatively new area, and little research currently exists regarding effectiveness. Prevention in and of itself is difficult to track because a change in behavior, or the development of protective factors against sexual violence could happen at any time after an individual has experienced the prevention program. If programs are primarily implementing CBIM, My Strength and MVP in local high schools, it will be important to track those students starting in 9th grade to see a net effect once they complete high school.

Currently, programs are only getting a snapshot from students through informal feedback sessions, surveys and group activities using case studies. This type of work can only report if an individual has had a change in beliefs or behaviors in the short term. Therefore, what is needed is more attention and effort towards training in evaluation practice at the local level so that permanent impacts can be measured. Ultimately, it is important to know if SVP strategies *prevent* sexual violence from occurring in the first place.

Program staff face several barriers in being able to collect data on program strategies and if those strategies have any impact on the long-term community and societal levels. The strategies may impact young people at the onset, but once they graduate and move on to college or into adult life, do these messages and efforts stick with them? How do they know what they do next week, has an impact the following year, the next three years and beyond. Local programs need more tools and assistance so they can evaluate their efforts on the ground.

Two major factors that should be addressed through technical assistance is enhanced communication efforts by state level SVP offices (state health departments with violence prevention responsibilities) about available resources for information on SVP prevention, and training in evaluation design and data collection. The communications piece will provide local programs with access to recent research in the field, new strategies for working with their target populations (e.g. men and boys), and new relationships with other practitioners across the country. The training will help build evaluation capacity for RPE funded programs across the country and provide state level offices with more reliable data on what is happening within their funded communities of SVP practice. Without such support, local programs are without the knowledge they need to improve their efforts, or capitalize on their strengths in the prevention of sexual violence.

BIBLIOGRAPHY

Banyard V.L., Plante E.G. and Monyihan M.M.. (2004). Bystander Education: Bringing a broader community perspective to sexual violence prevention. *Journal of Community Psychology*, Vol. 32, No. 1, 61–79. DOI:10.1002/jcop.10078

Basile KC, Saltzman LE. Sexual violence surveillance: uniform definitions and recommended data elements version 1.0. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2002. Retrieved from: http://www.cdc.gov/ViolencePrevention/pub/SV_surveillance.html

Berkowitz, A. D. (2004a). Working with men to prevent violence against women (Part One) National Resource Centre on Domestic Violence: VAWnet Applied Research Forum, October. Retrieved from http://www.vawnet.org/summary.php?doc_id=413&find_type=web_desc_AR

Berkowitz, A. D. (2004b). Working with men to prevent violence against women (Part Two) National Resource Centre on Domestic Violence: VAWnet Applied Research Forum, October. Retrieved from http://www.vawnet.org/summary.php?doc_id=414&find_type=web_desc_AR

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/violenceprevention/nisvs/

California Coalition Against Sexual Assault (CALCASA). 2014. Prevent Connect. Types of Prevention: Primary, Secondary, Tertiary. Retrieved from http://wiki.preventconnect.org/Primary%2C+Secondary%2C+Tertiary+Prevention

California Coalition Against Sexual Assault (CALCASA). 2013. Retrieved from http://www.calcasa.org/what-we-do/prevention/mystrength/

Casey EA., Beadnell B. and Lindhorst T.P. (2009). Predictors of Sexually Coercive Behavior in a Nationally Representative Sample of Adolescent Males. *Journal of Interpersonal Violence*. July 24:7 1129-1147. DOI:10.1177/0886260508322198.

Centers for Disease Control and Prevention (n.d.). Dating Matters: Strategies to promote healthy teen relationships. Retrieved from: http://www.cdc.gov/violenceprevention/

Centers for Disease Control and Prevention, Sexual Violence Risk and Protective Factors. (2014). Retrieved from http://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html

Centers for Disease Control and Prevention. Sexual violence prevention: beginning the dialogue. Atlanta, GA: Centers for Disease Control and Prevention; 2004. Retrieved from http://www.cdc.gov/Violenceprevention/RPE/index.html

Cissner A.B. (2009). Evaluating the Mentors in Violence Prevention Program Preventing Gender Violence on a College Campus. Report U.S. Department of Education. Center for Court Innovation, New York. Retrieved from: http://njlaw.rutgers.edu/cj/gray/subjectinfo.php?keyword=Gender%20Violence

Connell, R. W. 1995. Masculinities. Sydney, Australia: Allen and Unwin.

Crooks C.V., Goodall G.R., Hughes R., Jaffe P.G. and Baker L.L. (2007). Engaging Men and Boys in Preventing Violence Against Women: Applying a cognitive-behavioral model. *Violence Against Women. March 13: 217-239.* DOI: 10.1177/1077801206297336.

DeGue S., Simon T.R., Basile K.C., Yee S.L., Lang K. and Spivak H. (2012a). Moving Forward by Looking Back: Reflecting on a Decade of CDC's Work in Sexual Violence Prevention, 2000–2010. *Journal of Women's Health.* 21:12. DOI: 10.1089/jwh.2012.3973.

DeGue S., Holt M.K., Massetti G.M., Matjasko J.L., Tharp A.T. and Valle L.A. (2012b). Looking Ahead Toward Community-Level Strategies to Prevent Sexual Violence. *Journal of Women's Health.* Jan, 21: 1, p1-3. DOI: 10.1089/jwh.2011.3263.

Domestic Abuse Intervention Program (DAIP). (2014). What it the Duluth Model? Retrieved from: http://www.theduluthmodel.org/about/index.html

Flood, Michael. (2011). Involving men in efforts to end violence against women. *Men and Masculinities.* 14(3) 358-377. DOI: 10.1177/1097184X10363995.

Foshee V.A., Bauman K.E., Ennett S.T., Benefield T. and Linder G.F. (2005). Assessing the effects of the dating violence prevention program "safe dates" using random coefficient regression modeling. *Prevention Science.* Sep;6(3):245-58.

Foshee V.A., Bauman K.E., Ennett S.T., Linder G.F., Benefield T. and Suchindran C. (2004) Assessing the Long-Term Effects of the Safe Dates Program and a Booster in Preventing and Reducing Adolescent Dating Violence Victimization and Perpetration. *American Journal of Public Health*: April, 94: 4, pp. 619-624.

Futures Without Violence (2014). Coaching Boys into Men Playbook. Retrieve from: http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/

Gidycz C.A., Orchowski L.M., Berkowitz A.D. (2011). Preventing Sexual Aggression Among College Men: An Evaluation of a Social Norms and Bystander Intervention Program. *Violence Against Women.* June, 17:6 720-742. DOI: 10.1177/1077801211409727.

Heise L, Garcia-Moreno C (2002). Violence by intimate partners. In: Krug EG et al.,eds. *World report on violence and health*, pp. 87–121. Geneva, World Health Organization.

Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). Ending violence against women. Baltimore, MD: Population Information Program, Center for Communications Programs, The Johns Hopkins University School of Public Health.

Jewkes R, Sen P, Garcia-Moreno C (2002). Sexual violence. In: Krug EG et al., eds. *World report on violence and health*, pp. 149–181. Geneva, World Health Organization.

Katz J. (2014). Mission and Goals of Mentors in Violence Prevention (MVP). Retrieved from http://www.mvpnational.org/program-overview/mission-goals/

Kim A.N. and White M.L. (2008). Evaluation of California's My Strength Campaign and MOST Clubs: Summary of preliminary findings on attitudes and school climate. California Department of Public Health Epidemiology and Prevention for Injury Control Branch. Retrieved from: http://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/MOSTClubsEvaluation-EPIC.pdf

Linkenbach J., Berkowitz A., Cornish J., Fabiano P., Haines M., Johannessen K., Perkins H.W. and Rice, R. (2002). A practical easy to use resource for social norms for practitioners who want to generate coverage of their projects and the social norms approach in general. In, *The Main Frame: Strategies for Generating Social Norms News.* Retrieved from: http://www.socialnorm.org

Loh C., Gidycz C.A., Lobo T.R. and Luthra R. (2005). A Prospective Analysis of Sexual Assault Perpetration Risk Factors Related to Perpetrator Characteristics. *Journal of Interpersonal Violence.* October 20:10 1325-134. DOI: 10.1177/0886260505278528.

McMahon S. (2007). Understanding Community-Specific Rape Myths: Exploring student athlete culture. Affilia Winter 22:4 357-370. Rutgers State University. DOI: 10.1177/0886109907306331.

Malamuth N.M., Sockloskie R.J., Koss M.P. and Tanaka J.S. (1991). Characteristics of aggressors against women: testing a model using a national sample of college students. Journal of Consulting and Clinical Psychology. Oct. 59(5):670-81. PubMed ID: PMID: 1955602.

Men Can Stop Rape. (2011). Who We Are: Primary Prevention. Retrieved from: http://www.mencanstoprape.org/Primary-Prevention/

Miles M.B., and Huberman M.A. (1994). *Qualitative Data Analysis* (2nd ed.). California: Sage Publications, Inc.

Miller E., Tancredi D.J., McCauley H.L., Decker M.R., Virata, M.C.D., Anderson, H.A., Stetkevich N., Brown E.W., Moideen F. and Silverman J.G. (2012.) Coaching Boys into Men. A cluster-randomized controlled trial of a dating violence prevention program. *Journal of Adolescent Health* 51: 431–438. DOI:10.1016/j.jadohealth.2012.01.018.

Morrison S., Hardison J., Mathew A., and O'Neil J. (2004). An Evidence-Based Review of Sexual Assault Preventive Intervention Programs. (U.S. Department of Justice Document No. 207262-unpublished grant report).

Nation M., Crusto C., Wandersman A., Kumpfer K.L., Seybolt D., Morrissey-Kane E. and Davino K. (2003). *American Psychologist*, 58(6-7), Jun-Jul, 449-456. http://psycnet.apa.org/doi/10.1037/0003-066X.58.6-7.449

National Center of Domestic and Sexual Violence. (2014). "Wheels" adapted from the Power and Control Wheel Model. Retrieved from: http://www.ncdsv.org/publications_wheel.html

National Center for Injury Prevention and Control. Costs of Intimate Partner Violence Against Women in the United States. Atlanta (GA): Centers for Disease Control and Prevention; 2003. Retrieved from: http://www.cdc.gov/violenceprevention/pdf/ipvbook-a.pdf

Schwartz, M.D., & Nogrady, C.A. (1996). Fraternity membership, rape myths, and sexual aggression on a college campus. *Violence Against Women*, 2:2 148–162. DOI: 10.1177/1077801296002002003.

Tharp A.T., DeGue S., Lang K., Valle L.A., Massetti G., Holt M. and Matjasko J. (2011). Commentary on Foubert, Godin and Tatum (2010). The evolution of sexual violence prevention the urgency for effectiveness. *Journal of Interpersonal Violence:* 26, 16 3383-3392.

Wells, L., Lorenzetti, L.,Carolo, H., Dinner, T., Jones, C., Minerson, T.,&Esina,E.(2013). Engaging men and boys in domestic violence prevention: Opportunities and promising approaches. Calgary AB:The University of Calgary, Shift:The Project to End Domestic Violence.

World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization, 2010. Retrieved from http://www.who.int/violence_injury_prevention/violence/activities/intimate/en/

World Health Organization. Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. Geneva, World Health Organization, 2007. Retrieved from: http://www.who.int/gender/documents/men_and_boys/9789241595490/en/

World Health Organization. Multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva, World Health Organization, 2005. Retrieved from: http://www.who.int/gender/violence/who_multicountry_study/en/

World Health Organization. World report on violence and health: summary. Geneva, World Health Organization, 2002. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/

APPENDIX A: INTERVIEW PROTOCOL AND QUESTIONNAIRE

Interview Guide and Questions for CMPH Thesis
Cynde K. Lowe, MPA, MPH Candidate 2014
Rollins School of Public Health, Emory University, Atlanta, GA

I. Introduction

Hello, this is Cynde Lowe with the Rollins School of Public Health at Emory University. Thank you for agreeing to be interviewed for this study of SVP strategies focused on men and boys. I just want to give you a brief background on the purpose of the interview and how the information I gather will be used. More detailed information was given in the invitation email I sent to you.

The purpose of this study is to learn more about SV prevention strategies that engage men and boys. I am particularly interested in how programs are implemented locally, what kinds of information is collected on the strategy implemented, and if programs have or will be conducting evaluation of their programs.

Your participation will not affect your funding from the RPE program in any way. You also may end the interview at any time without penalty. The information collected here will be used to complete a thesis manuscript entitled, "A Qualitative Study of Rape Prevention Education (RPE) Strategies that Engage Men and Boys." The completed project will be submitted to the Rollins School of Public Health, Emory University in Atlanta, Georgia.

So first, do you have any questions about the interview procedure or the purpose of the interviews?

Do you have any updates to the Inventory of Local Programs questions I sent to you in the email? If necessary, you may have until the end of April 10, 2014 to complete any updates to those general questions.

II. Interview Questions

A. General Background Questions

1. Do you mind taking a moment to describe the strategy (name the strategy or strategies specific to each program (i.e. MVP, MOST, My Strength, or CBIM) you have implemented targeted to men and boys?
2. What is the demographic or descriptive breakdown of your target population? In other words, would you say your target population is primarily African American vs. White or Latino, high school athletes, college age males, or all males of a particular age group?

B. Prevention Strategy Implementation

1. For the strategy you currently use to target men and boys what does the strategy look like in practice? In other words, please describe for me how the program is delivered?
2. For the description you just provided, which activities within that strategy work best with your target population?
3. What types of program adjustments or changes to the strategy have you made to address particular issues within your community?

4. Please describe for me in detail any facilitators or barriers to implementing your program strategy focused on men and boys.

C. Expected or Observed Program Effects

1. What factors or conditions do you think influence SV in general, and in particular for your community?
2. What are some other SVP strategies you would like to implement that may enhance the current work you conduct with men and boys in your community?
3. What has been the community's reaction to your efforts to work with men and boys on SV issues (please include program participants as part of the community)? In other words, does your community respond to the program in a way that shows engagement and acceptance, or is there some reluctance, or cultural resistance to address issues around SV?
4. Please discuss for me how you collaborate with other agencies, or community groups to implement your program and achieve results (e.g. do you work with local law enforcement, schools, churches, half-way houses, prisons, or DV/IPV/support/counseling groups)?

D. Evaluation

1. Please describe how you currently collect and use information or data on your SVP strategies focused on men and boys?

2. If your program has implemented SVP strategies focused on men and boys for at least two years, please describe the process for, or the future plan for evaluating effectiveness.
3. Describe any collaborations or partnerships you have been able to build around SVP evaluation. (E.g. do you work directly with your state health department, a University or research facility, or an independent consultant)?
4. Please talk to me about the facilitators and/or barriers to your evaluation efforts, and what, if any effect these have had on your SVP program?

E. Technical Assistance

1. What are some resources or processes that would improve your capacity for evaluating the strategies that target men and boys?
2. Are there areas where you feel your team would benefit from additional training in planning, designing and conducting evaluation of your strategies?
3. Outside of evaluation, what other technical assistance would aid your organization in developing effective primary SVP programs targeted for men and boys?

III. Other Concerns

Please take a moment to present any additional comments, or clarify any earlier statements.

IV. Closing

I thank you for your time today and hope that this discussion will be helpful to your work in the future. If you need to contact me, or have any concerns moving forward, please feel free to email me at cynde.lowe@emory.edu or cklowe@comcast.net

APPENDIX B: INTERVIEW/RESPONSE MATRIX (Excerpt from 1 site)

INTERVIEW QUESTIONS	CODE	RESPONSE SUMMARY	DESCRIPTION
A. General Background Questions			
1. Do you mind taking a moment to describe the strategy (name the strategy or strategies specific to each program (i.e. MVP, MOST, My Strength, or CBIM) you have implemented targeted to men and boys?	STRYID	a. "Sociological understanding" of where attitudes on masculinities come from and how that may be harmful and dangerous. b. Goal is to recognize negative behaviors and "to de-escalate behaviors through direct and indirect ways" (bystander education, language about gender). c. "male-positive" bystander, the language they use, their interaction with their classmates. *TOC: behavior/perception change of masculinity, ideas about women's role, harmful notions of male/female interaction and relationships. Employs a bystander model with a "male-positive" message.	General ID of strategy name and a brief description of its purpose in SVP.
2. What is the demographic or descriptive breakdown of your target population? In other words, would you say your target population is primarily African American vs. White or Latino, high school athletes, college age males, or all males of a particular age group?	TRGDEM	a. High school age (14-18) b. Large Latino population of males-but from other backgrounds as well c. classroom environment 1 x week in 1 class period a week for 1 hour at 2 high schools (Oak Grove and Andrew Hill HS). This is a "year-long program set up where students get dismissed out of class for 1 hour per wk.	Description of the demographics of the target population for the intervention. Demographics include high school athlete or not athlete, age, race/ethnicity.

B. Prevention Strategy Implementation Questions	**CODE**	**RESPONSE**	**DESCRIPTION**
1. For the strategy you currently use to target men and boys what does the strategy look like in practice? In other words, please describe for me how the program is delivered?	PRACTH	a. Recruiting process-works like a club and participate in classroom presentations-hold an event at lunch and students can join and they do classroom presentations b. Introductory course includes discussion about SV in general: meet with one class for students who failed classes in Freshman year. c. He does do the program a little different for returning students. new students he will do an "intro course on gender-based violence and what it means, what are the precursors". d. "in the beginning we'll talk about male privilege, discuss masculinity and how guys are boxed into certain gender norms and how women are objectified, intersexuality of gender and how people are ostracized for what they look like, who they are." If "students already understand the conceptualizations around gender norms/roles" etc... he will teach differently than if the class seems more immature or younger in age.	This question is looking for how the strategy is implemented in practice, or "on the ground". Looking for descriptions of activities association with the strategy and how the strategy is delivered to the target population.

2. For the description you just provided, which activities within that strategy work best with your target population?	WRKBST	a. music, videos, sketches, spoken word, etc…works well with the students is using videos in the classroom. "Comedians/humor to introduce some of these themes around gender-based violence. "	Which activity or activates work best as far as how the target pop relates to that activity. Is a single activity or arrangement/pairings of activities that make the strategy work? Are there props or other "tools" that the strategy relies on?
3. What types of program adjustments or changes to the strategy have you made to address particular issues within your community?	PRCHNG	a. Not really any changes in implementation b. one thing is the presentations for recruiting is an add on and makes the school community aware of what MS does	The context of where and under what circumstances the strategy is implemented could impact the delivery, which may cause the SVP program implementer to change some aspects, language or tweak an activity to make it more suitable for the target population.
4. Please describe for me in detail any facilitators or barriers to implementing your program strategy focused on men and boys.	FABAIM	a. facilitators: "the schools and teachers see SV and bad language and they get it. " Also, the students who already have this awareness, or "some level of sociological understanding of gender etc...are engaged. At the community level they see this as a trend and how negative these behaviors are, some supervisors at nonprofits and other agencies don't see the value in MS or see it as "an agent of change". b. barriers: the students who don't understand SV or know what it means are "kind of checked out." It's	Looking for things/situations/attitudes/perceptions that occur internally and externally to the project that is a roadblock, or a facilitator to properly implementing the program. What institutions, community links, individuals, groups etc…?

		hard for them to understand and sometimes this can have a negative effect-"a group of guys who think SV isn't about them might say this isn't me, or I don't do that kind of stuff" and those students check out and don't participate. Some guys "don't feel connected".	
C. Expected or Observed Program Effects	**CODE**	**RESPONSE**	**DESCRIPTION**
1. What factors or conditions do you think influence SV in general, and in particular for your community?	SVFACT	a. seeing older hs guys see women as an object that one can have or not have so the more women one has it's a social status. So pressures to have sex propels these young men to discount young women and reading like "no means yes". "This girl looks like this and I just want to have sex with her." "Those kind of things I see these things regularly and I see it every day in the high schools." b. "I am driving in the truck with my dad and big brother, so why wouldn't I whistle at a girl if my dad does?" c. Aggressive sexual behavior and mentality, "no means yes".	Looking for personal statement, but also within the context of the community where the strategy is implemented.

2. What are some other SVP strategies you would like to implement that may enhance the current work you conduct with men and boys in your community?	SVADDL	a. expanding the time he can have with the students, one hour just isn't enough time, with more time you could do longer lesson plans. Depending on the kind of students you have, a lot of things happen in their lives so they may forget some of the things they heard the week before. b. Give students more time to open up where they share their experiences more and he could delve deeper into topics and issues. Part of the issue is that schools just can't spare the additional time. budgets, etc...take the extra time. This program is extraneous to the core things students need to do and the school has the time to provide.	Is there a need to add another program, or merge some aspects of one intervention such as CBIM with another one such as My Strength to address a large target population, or both men and high school athletes. Or, are there just some other strategies that are home grown that would improve overall program design or delivery?
3. What has been the community's reaction to your efforts to work with men and boys on SV issues (please include program participants as part of the community)? In other words, does your community respond to the program in a way that shows engagement and acceptance, or is there some reluctance, or cultural resistance to address issues around SV?	COMMAT	It takes a while to get the schools on board sometimes because you have "some administrators who get it and some who don't really think it's important in the context of their own community". "So, I suppose I would say the community is supportive in that they don't want to see women raped or harmed in some way, but there is still some cultural apathy toward what is sexual harassment, or inappropriate sexual behavior."	Looking for an honest assessment of perceptions on SV and SVP in the community, especially as perceived by men and boys. Also want to know if some community leaders have embraced this as a community problem, or if they appear to not be engaged in any dialogue about the urgency or existence of SV in their community, schools, etc...

4. Please discuss for me how you collaborate with other agencies, or community groups to implement your program and achieve results (e.g. do you work with local law enforcement, schools, churches, half-way houses, prisons, or DV/IPV/support/counseling groups)?	COLLAB	a. they don't really work in the community beyond the high schools.	Does this program use additional resources from other agencies doing similar work? Do they refer to one another, or work collaboratively to address SVP and other forms of sexual violence?
D. Evaluation	**CODE**	**RESPONSE**	**DESCRIPTION**
1. Please describe how you currently collect and use information or data on your SVP strategies focused on men and boys ?	DATACO	a. MS has a manual and in it is an evaluation process (pre/post surveys); however, the evaluation is lengthy and the students just "bubble in", they don't ready the questions and don't answer the questions honestly. He's event tried to "bribe them with food." b. Invite a different facilitator to interview the students. Instead, he is "taking students out the class for one-on-one interviews asking them "what do you think about the program?", "does what we are talking about make sense to you?", "have you noticed any changes with you or members of the community?". Maybe write one or two sentences about particular ideas. The idea is to get them to be "really really frank". c. Be direct with them gives an idea of how the program is working. The surveys are not useful.	Want to know if local organizations have an organized framework around data collection and what types of data they collect. Also, the timing of data collection is important, such as are they conducting pre/post surveys or interviews? Are there regular sessions where participants are asked about their experience with the intervention, their understanding of the materials, etc....where does that information go and is it used in some way?

2. If your program has implemented SVP strategies focused on men and boys for at least two years, please describe the process for, or the future plan for evaluating effectiveness.	EVALPLN	SKIP	Is there an evaluation plan that the program is expected to implement in the coming year, or is there ongoing evaluation currently.
3. Describe any collaborations or partnerships you have been able to build around SVP evaluation. (e.g. do you work directly with your state health department, a University or research facility, or an independent consultant).	COLLEVL	Not really any partners or collaborations.	Want to know if there are external partnerships used to do the program evaluation.
4. Please talk to me about the facilitators and/or barriers to your evaluation efforts, and what, if any effect these have had on your SVP program?	FABAEV	a. Some of the other facilitators are not as well educated about sociological factors around gender issues. b. Students have expressed to him that they aren't really learning anything in the other programs like the women's program "Our Strength". The students don't connect with the facilitators who don't engage them and only lecture to them.	Are there facilitators or barriers to conducting evaluation and what are they?

E. Technical Assistance	CODE	RESPONSE	DESCRIPTION
1. What are some resources or processes that would improve your capacity for evaluating the strategies that target men and boys?	RESEVAL	a. those who are overseeing the program don't really know what evaluation is, and don't know if things are effective or not. B. someone who is a trained evaluator or who can show them how to properly design an evaluation to look at their program effectiveness would be very helpful.	Would like to find out what the SVP program staff needs to improve capacity to collect data, analyze data, conduct evaluation and use results.
2. Will you please provide for me feedback on the RPE evaluation requirements in the FOA and how those requirements have impacted your SVP efforts?	FOAFDB	NA-DO NOT ASSESS	This question was supposed to get at SVP staff opinions regarding the evaluation requirements in the FOA. However, because I went with local programs they were really not aware of those requirements because the grants are written at the state level.
3. Are there areas where you feel your team would benefit from additional training in planning, designing and conducting evaluation of your strategies?	TATRAIN	a. more access to resources for training in evaluation and data collection methods to see what works. B. the facilitators are very part-time and not really interested in this kind of work-"for me I have been trained in my undergraduate work, but doing a training for other facilitators who do not have this background about things such as notions on gender identity, masculinity, patriarchy, historical	Looking for specific guidance on what programs really need in regards to training in evaluation, or in designing an evaluation plan for their program.

		perceptions of women's oppression would be helpful so when they are working with the students they could provide some knowledge that would make the experience for students more engaging."	
4. Outside of evaluation, what other technical assistance would aid your organization in developing effective primary SVP programs targeted for men and boys?	TAOTHER	a. "they used to have conferences for MS and where other facilitators share stories. It would be good to know what specific things or strategies are others using that work well with the students and are really poignant." b. "Be able to meet with others more often as a regional or national level conference. "The only way he can find out is by doing a lot of research. It would be cool and really nice to engage with others across the country to see what everyone is doing." c. "some facilitators are very passionate about their work so it would be good to have training or knowledge of what others are doing."	What other technical assistance could assist your organization in implementing and evaluating SVP efforts?

F. Open Ended Discussion-not otherwise directed				
	OPENED	Pavel would like to see what I come up with in the end.		

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APPENDIX C: CODE LIST OF DEFINITIONS

Code	Description	Thematic Pattern
STRYID	SVP strategy identification	NA
TRGDEM	Target demographic for ID strategy	Look for variances in target population that receives program-e.g. if it's a CBIM program that is also being used with female athletes.
PRACTH	Adjustments to how strategies are actually implemented in practice. Adjustments may occur to address particular perceived or known needs of the target population.	This question is looking for how the strategy is implemented in practice, or "on the ground". Looking for descriptions of activities association with the strategy and how the strategy is delivered to the target population.
WRKBST	Which activities within the strategy appear to work best with the target population.	e.g. Is a single activity or arrangement/pairings of activities that make the strategy work? Are there props or other "tools" that the strategy relies on?
PRCHNG	Are strategies adapted to suit different target groups?	The context of where and under what circumstances the strategy is implemented could impact the delivery, which may cause the SVP program implementer to change some aspects, language or tweak an activity to make it more suitable for the target population.
FABAIM	Are there facilitators or barriers to implementing the strategy? What are they?	Looking for things/situations/attitudes/perceptions that occur internally and externally to the project that is a

Code	Description	Thematic Pattern
		roadblock, or a facilitator to properly implementing the program. What institutions, community links, individuals, groups etc…?
SVFACT	Factors that play a role in reducing or increasing sexual violence in your community. Does your community support your work and are they supportive of SVP programs in general.	Looking for personal statement, but also within the context of the community where the strategy is implemented.
SVADDL	Additional strategies do programs use in their prevention portfolio that is focused on primary prevention of SVP	Is there a need to add another program, or merge some aspects of one intervention such as CBIM with another, such as My Strength to address a large target population, or both men and high school athletes. Or, are there just some other strategies that are homegrown that would improve overall program design or delivery?
COMMAT	Community perceptions and attitudes toward SV.	Looking for an honest assessment of perceptions on SV and SVP in the community, especially as perceived by men and boys. Also want to know if some community leaders have embraced this as a community problem, or if they appear to not be engaged in any dialogue about the urgency or existence of SV in their community, schools, etc...

Code	Description	Thematic Pattern
COLLAB	Do programs collaborate to get the work done on SVP in the community. Who do they collaborate with?	Does this program use additional resources from other agencies doing similar work? Do they refer to one another, or work collaboratively to address SVP and other forms of sexual violence?
DATACO	What kind of data is collected and how is it collected?	Want to know if local organizations have an organized framework around data collection and what types of data they collect. Also, the timing of data collection is important, such as are they conducting pre/post surveys or interviews? Are there regular sessions where participants are asked about their experience with the intervention, their understanding of the materials, etc....where does that information go and is it used in some way?
EVALPLN	Is there an evaluation plan that the program is expected to implement in the coming year, or is there ongoing evaluation currently.	If programs are working on a plan or implementing a new plan-OR no plan at all.
COLLEVL	Do programs collaborate with other institutions or individuals to evaluate their strategies?	If programs can't do it themselves are they working with someone in the community, or at a university with this expertise?

Code	Description	Thematic Pattern
FABAEV	What are the facilitators and barriers to conducting evaluation of program strategies?	Are there particular things that are internal or external to the program that promote or impede evaluation?
RESEVAL	Available resources for evaluation.	Would like to find out what the SVP program staff needs to improve capacity to collect data, analyze data, conduct evaluation and use results.
TATRAIN	What types of training or technical assistance would be needed to improve or enhance evaluation efforts?	Looking for specific guidance on what programs really need in regards to training in evaluation, or in designing an evaluation plan for their program.
TAOTHER	Are there other technical assistance needs outside of evaluation?	What other technical assistance could assist your organization in SVP focused on men and boys?