

Before It Occurs: Primary Prevention of Intimate Partner Violence and Abuse

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HIGHLIGHTS

- Prevention is a systematic process that promotes safe, healthy environments and behaviors, reducing the likelihood or frequency of an incident, injury, or condition occurring.
- Primary prevention (taking action before a problem arises) has been successfully applied to other health-related conditions, such as tobacco use and car crash injuries.
- It is important to understand the determinants of IPVA and the role of norms.
- Health care professionals can use their tremendous influence and credibility to help tip the balance and more systematically prevent IPVA.

Primary prevention means taking action *before* a problem arises. It helps us answer the question: “What can be done to prevent the problem from occurring *in the first place?*” The goal of primary prevention in IPVA is to create environments in which we never need to question whether people are in danger in their relationships.

The women’s movement, in response to the immediate needs of women who were hurt or at risk, created shelters and safe houses and strengthened legal and medical services. At the same time they built a path toward more fundamental solutions by addressing oppression and gender inequity. To truly “unlock” the key to primary prevention of IPVA, we must build upon these efforts, engaging the entire community.

Healthcare professionals have a vital role to play that extends beyond direct patient care. Because they have seen the health consequences of IPVA firsthand, health care professionals are particularly effective when speaking about the issue to legislators, the media, and the broader public. They can also contribute to primary prevention by championing change in clinical practice,

change in organizational climate, and changes in policies and procedures, and by being willing to serve and be recognized as national, state, and community advocates and leaders.

This chapter presents a framework for initiating meaningful health sector involvement in stopping the violence *before* it occurs.

What is Prevention?

Prevention is a *systematic* process that promotes safe, healthy environments and behaviors, reducing the likelihood or frequency of an incident, injury, or condition occurring. Ideally, prevention addresses problems *before* they occur rather than waiting to intervene after incidents occur. This is called *primary* prevention. Examples of primary prevention include ensuring availability of healthy, affordable food in communities to help reduce frequency of chronic disease and developing and mandating child safety restraints in vehicles to prevent injury and death to young children.

- **Primary prevention** is distinguished from secondary prevention because it explicitly focuses on action *before* the condition of concern develops.
- **Secondary prevention** relies on physical changes, symptoms and/or abnormal tests to determine action. It focuses on responses that take place shortly *after* the condition has developed and/or is recognized.
- **Tertiary prevention** refers to treatment of, and rehabilitation from, the pathophysiologic consequences of the condition. It focuses on longer-term responses to ameliorate and/or prevent further negative health consequences.

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Table 10-1 outlines the prevention continuum as it applies to IPVA.

Efforts at all three levels are important and can be mutually supportive and reinforcing. Most organized and funded efforts to date have focused on secondary and tertiary responses to IPVA. Primary prevention efforts to date have not been substantial; however, health care professionals are well positioned to forge a shift toward more effective prevention before the onset of violence.

Over the last generation, there have been dramatic improvements in health status from primary prevention efforts related to other injuries and illnesses. These include traffic safety crash reduction (e.g., child restraint, DUI, and helmet laws), smoking prevention, immunizations, and reducing blood-lead levels in children. In the prevention of youth/community violence, physicians have played a pivotal role. For example, Dr. Deborah Prothrow-Stith, a Boston emergency physician, became frustrated by cleaning wounds and suturing so many young people. She reasoned that if violence was a learned behavior, then alternatives could also be learned. She developed the first significant violence prevention education program in the US and was a catalyst for partnerships in communities across the country. Her

effort was important not only for what it teaches young people, but also because it serves as a tool to educate America that this problem is not inevitable and that the community can work together to help reduce it.¹

At its core, primary prevention fosters environments in which violence would not occur in the first place. Although it's obvious, it is important to restate that *focusing on primary prevention is the only way to eliminate the violence.*

What must be done to achieve primary prevention? George Albee said it best: "No epidemic has ever been resolved by paying attention to the treatment of the affected individual."² This identifies the importance not only of working before the treatment is needed, but also that the unit of analysis must be the community or the population, not the individual.

Quality Matters

Effective primary prevention holds the promise of reducing the emotional, psychological, and physical trauma experienced as a result of intimate partner violence. Other potential benefits are outlined in Table 10-2.

TABLE 10-1. PREVENTION CONTINUUM: IPVA

Primary Prevention: Efforts aimed at preventing IPVA from occurring in the first place.	Example: Coaching boys to treat girls and women with respect and to find non-violent ways to express anger/frustration.
Secondary Prevention: Screening to establish the presence of IPVA; actions to minimize the consequences and reduce the likelihood of future violence.	Example: Routine screening for IPVA, providing validation of abused women's experiences, and development of safety plans.
Tertiary Prevention: Treatment and rehabilitation after IPVA has occurred.	Treatment of injuries, long-term therapy for physical and psychological aftermath of the violence; long-term treatment of batterers.

TABLE 10-2. BENEFITS OF PRIMARY PREVENTION

<ul style="list-style-type: none"> • Reductions in morbidity and mortality.
<ul style="list-style-type: none"> • Improved quality of life.
<ul style="list-style-type: none"> • Reductions in disparities in IPVA rates suffered by some groups by addressing the underlying factors that contribute to the disparity.
<ul style="list-style-type: none"> • Cost-effective use of resources, minimizing the associated costs such as medical care, mental health services, protection, criminal justice and incarceration, and lost productivity.
<ul style="list-style-type: none"> • Impact on related forms of violence such as child abuse and youth violence.
<ul style="list-style-type: none"> • Improvements in health status for conditions where IPVA is a known risk factor (e.g., maternal-child health or sexually transmitted diseases).
<ul style="list-style-type: none"> • Improvements in broader conditions that primary prevention may address (e.g., greater equity and opportunities in the workplace).

Despite the benefits and its many successes, primary prevention practice is often misunderstood, resulting in it being viewed as tangential and, therefore, underutilized. Many believe that prevention is delivered through messages. Thus, health care providers add teachable moments to exams, brochures are made available in waiting rooms, or public service announcements are developed. Frequently employed as an add-on to treatment, prevention might be based more on what fits into the treatment or medical model than what is known to be effective prevention. Of course, this misunderstanding impinges on the potential for far-reaching, long-term impact and consequently reduces the enthusiasm and commitment to prevention efforts.

Defining prevention as simply “patient education” is not only inaccurate, but also does not effectively address the complexity and nature of the problem. Awareness of a risk to health does not automatically lead to protective action because behavior is complex.³ Further, in many cases, when prevention is confused with education, practitioners and advocates jump from “What can we do *before* a problem?” to “Here is some information *about* the problem.” While important, information about the magnitude of the problem or the availability and importance of treatment services in and of itself does not foster healthy, equitable and nonviolent environments and behaviors.

IPVA prevention initiatives can build on the knowledge and successes of other types of prevention work that has a demonstrated track record. These efforts make prevention central, not tangential, focusing on the family, community, and societal context and emphasizing strategies rather than just a message. These prevention successes point to effective prevention strategies that can translate into the ultimate reduction of IPVA.

The Challenges of Garnering Support for Prevention

Despite the advantages of primary prevention, it can be challenging to maintain as a focus. In the real world, priorities are based on criteria such as urgency, time, funding, and achievability. To many, prevention can feel like a *distraction* given the urgency of helping people through trauma. Primary prevention often is seen as *ideally* important; however, preventive efforts are frequently diminished by the real and urgent pressure to meet the needs of women who have suffered from IPVA—and to ensure accountability for their perpetrators. This need defines the focal point for the vast majority of under-resourced, overworked service providers. These dedicated practitioners experience a lack of time and funding for prevention. Thus, for prevention to be supported by existing victim service resources seems antithetical

to meeting the human needs of survivors. As the science base grows, modest prevention funding streams are starting to emerge as evidenced by the US Centers for Disease Control and Prevention’s emphasis on the primary prevention of sexual assault, intimate partner violence and abuse, child maltreatment, and youth violence. However, the funding streams directed to primary prevention remain inadequate^{4,5,6}

A focus on primary prevention also raises questions about what is achievable and what really is effective. It’s easier to be sure about the needs of a woman who is suffering—emotional support, tangible services and resources, and opportunities to create alternatives for her future. In contrast, prevention can feel too “mushy” and there is still much research required to answer all the questions raised. The lack of a broad strategic vision for the primary prevention of IPVA that addresses norms and male behavior fundamentally relegates smaller and more modest efforts to a level of perceived inadequacy.

Powerful advocacy movements tend to arise from victims, survivors, and their families who have suffered and/or have been in need of services that were not available. In the case of primary prevention, the individuals who benefit have avoided experiencing pain and suffering in the first place. Consequently, there is not a ready constituency crying out for primary prevention. This makes it harder to garner the legislative attention and develop the political will. Thus, health professionals who bear witness to the suffering and strongly assert that it is unacceptable for anybody to experience that suffering ever again can play a pivotal role in fostering primary prevention efforts.

Lessons From Prevention Successes

As noted earlier, we have witnessed remarkable prevention successes. Though each is different from IPVA, there are lessons we can learn and apply in order to prevent IPVA before it occurs.

Take tobacco, for example. A generation ago virtually every public space was smoke-filled, and despite the Surgeon General’s pronouncement that tobacco smoke was risky for health, the norm was to light up or accept others lighting up around you. Education campaigns about the danger of smoke, even secondhand smoke, had little impact, and smoking cessation clinics had marginal success. In the early 1980s two cities limited smoking in sections of restaurants and public spaces, and these laws in Berkley and San Francisco were initially dismissed as “fringe tactics” from out-of-the-mainstream communities. Then a coalition formed to change the law in a more moderate county and its 18 different cities. Before long, the partnership between public health, the American

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Cancer Society, and the American Heart and Lung Associations became a model replicated in numerous spots across California, and then throughout the United States. Organizations started voluntarily restricting smoking, something they previously would have been reluctant to do. Although the space regulated was limited (e.g., sections of public places, such as restaurants), these efforts signaled a new norm. These modest behavioral changes engendered and rapidly led to momentum for more. As the norms changed, the spaces where smoking was limited increased, support for tax increases on cigarettes surged, and smoking rates dropped.⁷

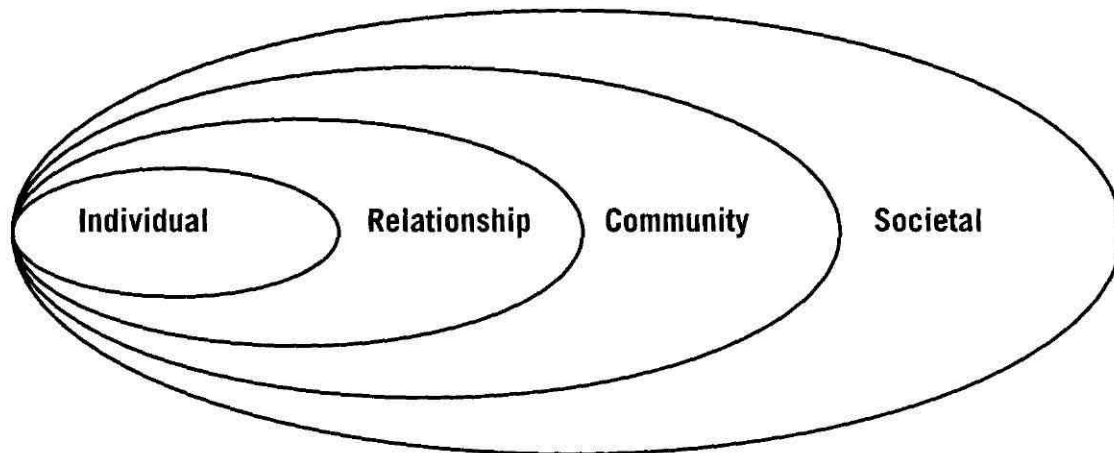
Similar stories can be told about most other prevention successes, providing similar clues to preventing IPVA. Mass behavior change never occurs because of information alone. Norms change, shaped by changes in policies and organizational practice, is generally the tipping factor to change behavior. Each prevention success is different from another, and perhaps IPVA is even more different. But in every case it took leaders who *believed it could and should change*. It took courage to

take on industry, lobbyists, and public opinion. It took moving from information to norms change through comprehensive approaches. It required overcoming obstacles so large they were described as insurmountable. In every single case, success was a product of focusing on changing the environment, which in turn influenced individual behaviors. In applying these lessons to IPVA, we must understand the environmental elements that are critical contributors to IPVA, and we must then take steps to make the necessary change.

The Determinants of IPVA

Violence arises out of a complex interplay of individual, relationship, social, political, cultural, and environmental factors. The socioecological model⁸ (see Figure 10-1) is a framework to understand how individual well-being is nested within family, community, and societal levels. Influences at any level can either increase or decrease the risk of perpetration or victimization.

FIGURE 10-1. SOCIOECOLOGICAL MODEL⁹



Individual level: biological and personal history factors. These can include empathy, self-esteem, impulse control, attitudes and beliefs about IPVA, alcohol and/or drug use, impulsive and other antisocial tendencies, hostility towards women, history of child maltreatment or witnessing IPVA.¹⁰

Relationship level: relations with peers, intimate partners, and family members that shape an individual's behavior and range of experiences. These can include the family environment (emotionally supportive or unsupportive) and egalitarian or patriarchal relationships.

Community level: community and social environments in which an individual has experiences and relationships such as schools, workplaces, and neighborhoods. These can include institutional policies and practices, poverty, lack of employment opportunities, and community sanctions against or tolerance of violence.

Societal level: larger, macro-level factors. These can include gender equality/inequality, religious or cultural belief systems, societal norms, and economic or social policies.

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This framework clarifies the influence of the societal and community environment on an individual and confirms why it is important to focus more broadly on the environment than on individual behavior change. Root factors like sexism, racism, homophobia, classicism, patriarchy, and other forms of oppression and power play out in our society. They do so by shaping societal and community factors that in turn influence relationships and individual levels. Figure 10-2 depicts this trajectory. Root factors shape environmental contributors, both of which are the determinants of IPVA. Environmental contributors, in turn, influence behavioral factors. The Institute of Medicine affirmed this influence in concluding, “It is unreasonable to expect that people will change their behavior easily when *so many forces* in the social, cultural, and physical environment *conspire* against such change.”¹¹ This combination of elements, both those that increase the risk of violence occurring and those that are protective and reduce the chances that violence will occur, are important determinants of whether or not IPVA will take place. Effective primary prevention alters them *before* there is a chance of violence occurring.

The Role of Norms

Because of how powerful the societal and community environment is in shaping behavior, it is critical to understand a major element in this environment—norms. Norms are regularities in behavior with which people generally conform, and disapprove of deviance.¹² They are shaped by root factors like other environmental contributors. Norms are more than habits. Often based in culture and tradition, they are attitudes, beliefs, and standards that are taken for granted. In other words, norms are behavior shapers. They can be described as the way the environment tells people what is okay and not okay to do. Norms describe what actually occurs (i.e., descriptive) and also signify a standard of proper behavior (i.e., normative or prescriptive).¹³

It is critical that a prevention strategy addresses norms because of their power in influencing behavior. If violence is typical and this expectation is reinforced by the

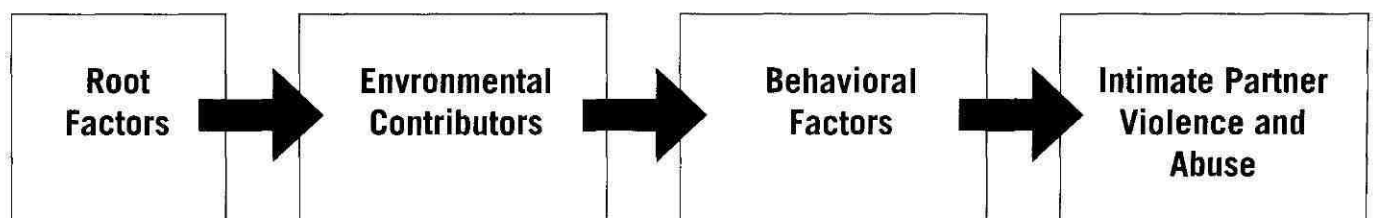
media, family, community, peers, or school, it is far more likely to occur, and with greater frequency and lethality. If norms discourage safe behavior or do not support healthy and safe relationships, then programs focused on individual change will not prevent IPVA unless related norms are changed as well. Thus, norms change is critical in preventing intimate partner violence.

There are at least four kinds of damaging norms that promulgate IPVA. They are norms about:

- Limited roles for and objectification and oppression of women.
- Violence as an acceptable way to solve problems.
- Traditional masculinity and male privilege.
- Privacy and secrecy (i.e., IPVA is a private matter).

In our society we glamorize violence, too often overlook it or turn away, accept it as a private family matter, and regularly encourage it through “egging” others on. Further, we objectify women and portray them as “less than equal.” While most people do not commit intimate partner violence, and therefore it is not *normal* behavior, the norms listed above and taken together imply a level of acceptance and a sense of reasonableness about IPVA. Given this, it is not surprising that some people behave on the extreme end, that is violently, and bystanders don’t speak up or act against it. In fact, given that violence seems so normal and common in our society, it is also not shocking that many assume that violence, such as IPVA, is very common and, therefore, the norm. Norms are sustained not necessarily because of what they *actually* are but rather what they are *perceived* to be.¹⁴ Therefore, on the one hand, fewer people commit IPVA than those who do not and therefore, IPVA itself is not *normal* behavior. However, we do have a set of norms that promulgate a toxic environment (oppression, violence is the answer, boys are tough, IPVA is private) in which IPVA is able to take place *and* inhibit appropriate action and promulgate inappropriate inaction. While it is certainly not the norm that IPVA is fully condoned or practiced, in total, we have a set of norms that in some

FIGURE 10-2. IPVA TRAJECTORY



ways encourages IPVA and inhibits people from speaking out against it. We must acknowledge these norms and change them if we are to make major strides in preventing violence.

Changing Norms

The good news about norms is that there is a propensity to conform. Therefore, by shifting both norms and the perception of them, we can decrease violence rates. Thus, “making novel behavior seem commonplace and familiar may be very important, even if initial compliance is mandated by a rule.”¹⁵ There are many reasons individuals comply with norms, including habit, fear of sanctions, and strategic considerations. “Cumulative individual deviations from a rule or norm . . . make possible the assertion of a new one.”¹⁶ Thus, once enough people start to follow the new pattern of behavior, it replaces the old norm (or at least coexists) and weakens the enforcement mechanism associated with the older norm. In other words, new norms emerge when enough people have made individual choices to change *that a tipping point is reached*.¹⁷ These individual choices are influenced by organizational practices, policies, and systems.

Norms both *shape* and *are shaped* by organizational practices and policies. Norms emerge when institutions prescribe behavior, when individuals agree voluntarily to a new norm, or in an evolutionary manner.¹⁸ Sometimes an institutional policy revision reflects a gradual change in attitudes and values or the discovery of new information, which changes the desirability of a given norm.¹⁹ Policy change can trigger norms change by altering what is considered acceptable behavior, by encouraging people to think actively about their own behavior, and by providing relevant information and a supportive environment to encourage change. The power of rules in triggering norms change is their ability to effectively enforce new expectations.

The key to preventing IPVA is to tip the norms that contribute to it. We can't ignore the problem or lay the blame and consequences solely on women and their perpetrators. We must build community-wide solutions. We *must* tip the balance in communities and replace current norms with norms that promote respect and equality. According to the Transforming Communities National Advisory Committee, “The prevention of violence against women and girls is a process of changing attitudes, behaviors, beliefs, and institutional norms of *acceptable* violence and discrimination, through an evolutionary and revolutionary process.”²⁰ This beckons for a primary prevention approach that can change the environment, including norms.

It's the Environment: How to Make Changes that will Prevent IPVA

The Spectrum of Prevention²¹ was designed for broad-scale change, not just focused on the individual but also on the environment. It enables individuals, agencies, organizations, or coalitions to develop a comprehensive plan that builds on existing efforts. Because there is no one group that can do everything required to prevent intimate partner violence, successful efforts necessarily involve a wide range of partners as depicted in Table 10-3. The Spectrum encourages people to move beyond the educational or “individual skill-building” approach to address broader environmental and systems-level issues. When the six levels of the Spectrum are used together, they can lead to systemic changes and changes in norms. Table 10-3 delineates examples of intimate partner violence prevention activities along the Spectrum.

Data and evaluation should inform all levels of Spectrum activities. Any proposed activity should be based on data showing that 1) the issue is important; 2) the target population is appropriate; and 3) the intervention is promising. Ongoing evaluation of the overall approach and of individual activities will provide the information needed to make adjustments as the strategies are implemented.

Evaluation and Primary Prevention

Evaluation myths related to primary prevention include that prevention is “invisible” and that “non-events” cannot be measured. These myths, however, emerge from an uninformed and overly simplistic view of what should and can be measured. Lessons learned from other public health issues or types of violence can be informative. Successful public health prevention efforts document and measure their impact by establishing and monitoring intermediate markers which are then tracked over time to determine the influence on the longer-term outcomes. In the case of smoking, rather than measuring cancer or heart disease reduction, increased price and reduced access are measured. These interim markers provide context for smaller, more modest efforts and assure that efforts are on the right track.

For IPVA prevention it is also important to establish and measure intermediate markers. For example, “mentor-like” efforts have been shown to be successful in engaging young men as change agents in preventing violence against women. Similarly, efforts directed at influencing bystander behavior are promising. In both of these cases, specific intermediate outcomes could be defined and measured. Other intermediate outcomes need to be defined at the organizational or societal levels. Organizational standards, regulations, and policies,

TABLE 10–3. THE SPECTRUM OF PREVENTION

SPECTRUM LEVEL / DEFINITION	IPVA EXAMPLES
<p>Strengthening individual knowledge and skills. Enhancing an individual’s capability of preventing injury or crime.</p>	<p>Training for teens to promote healthy dating.</p> <p>Home visitation by public health nurses.</p>
<p>Promoting community education. Reaching groups of people with information and resources to promote health and safety.</p>	<p>The Family Violence Prevention Fund’s Coaching Boys into Men campaign promotes positive examples of male behavior such as respect.</p> <p>The Five in Six Project, based in Cape Town, South Africa, uses a social norming approach to convey to men the fact that five in six men are not violent with their partners, questioning the assumption that “everyone is violent.”</p>
<p>Educating providers. Informing providers who will transmit skills and knowledge to others.</p>	<p>Training journalists to frame coverage on IPVA as a preventable problem.</p> <p>Take It to the Village: Prevention training for native and non-native health care practitioners in isolated Alaskan villages.</p>
<p>Fostering coalitions and networks. Bringing together groups and individuals for broader goals and greater impact.</p>	<p>Centers for Disease Control’s DELTA program (Domestic Violence Prevention Enhancement and Leadership Through Alliances) encourages including non-traditional partners (e.g., the faith community, civic and men’s organizations, the media and business) to coordinate community response efforts to address primary prevention.</p> <p>Men Can Stop Rape has a 50/50 club to help fund the organization through 50% of contributions from women and 50% from men, recognizing that we must <i>all</i> work together to end violence against women</p>
<p>Changing organizational practices. Adopting regulations and norms to improve health and safety and creating new models.</p>	<p>Men’s civic and athletic organizations develop positions, programs and resources to support and engage men in ending violence against women.</p> <p>Employers can foster egalitarian norms, develop and enforce strong anti-harassment and anti-violence policies, and increase public receptivity to prevention.</p>
<p>Influencing policy and legislation. Developing strategies to change laws and policies to influence outcomes in health, education and justice.</p>	<p>Cambridge, Massachusetts, passed a Domestic Violence-Free Zone, representing a citywide commitment to prevent domestic violence and resulting in an embedding of domestic violence prevention language and policy into all areas of city business.</p> <p>The US Violence Against Women Act raised awareness about the problem of violence against women and brought federal resources to the state and community levels.</p>

supported and enforced by management and leadership, could contribute to norms change and again could be measured. The presence or absence of policies or standards that require certain positive behaviors (training/skill building, increases in awareness related to language and behavior, etc.) and the awareness and enforcement of explicit and sanctioned consequences for noncompliance can be measured. Other strategies at the population level may include exploring proven strategies, such as effective teen pregnancy prevention, family planning, prenatal care, and home visitation for high-risk families, and measuring the potential contribution these might make to reducing IPVA. While the “big changes” may be hard to accomplish, progress on the interim markers will assure steady progress.

The learned (often referred to as cyclical) and socially reinforced nature of IPVA requires strategies that address the contexts that contribute to that learning and work to establish and reinforce new norms. Data supports that the majority of men are not abusive and do not condone abuse. However, men are generally unwilling to intervene with peers. Likewise, men and women may be unaware or unconcerned with the “subtle” conditions that reinforce and possibly even legitimize or promote abusive behavior (e.g., violence in the media, and socially and politically sanctioned objectification of women). Thus, the data available supports the need to direct efforts to those supportive norms as a key strategy to addressing the undesired behavior. This represents a major opportunity to answer the question, “What can be done *before*?” Evaluation can play a critical role in tracking these changes and informing us about what is most effective. Health care practitioners can play a lead role in catalyzing, modeling, and advocating for these changes.

What Health Care Professionals Can Do

Health care professionals are at the intersection of health, violence, and community. They are considered reasonable and engender trust within communities. They can insist on solutions to stop the problem *before* rather than having to deal with an endless stream of preventable crises. Given that practitioners spend a majority of their time providing clinical services, there are opportunities to integrate primary prevention within clinical practices—not as an add-on to treatment but as a new approach to providing clinical services beyond screening and referral. Further, practitioners can take the lead in advancing primary prevention efforts beyond the scope of clinical services.

Health care professionals have a tradition of looking beyond their focus of healing the sick and injured to

asking why a condition is happening and playing pivotal roles in effecting change. For example, in early tobacco prevention efforts, health care providers on the boards of the American Heart Association, the American Cancer Society, and the American Lung Association helped build momentum for the first multi-city nonsmoking laws, helped design prevention strategies, met with politicians, explained to the media why tobacco laws were critical for health, and provided testimony based on their experiences of treating those who had been most damaged by tobacco. Health care professionals also called for important institutional changes such as banning smoking in health care facilities, requiring patient counseling about the dangers of tobacco, and discouraging colleagues from advertising for tobacco manufacturers. Building on their unequivocal credibility, health care providers wielded their influence to catalyze and insist on changes that fundamentally would influence the population's health.

Health care professionals can use their tremendous influence and credibility to help tip the balance and more systematically prevent IPVA. In particular, they can not only integrate it into clinical services but also advance organizational practices and advocacy efforts.

Clinical Practice

Within clinical settings, practitioners play a critical role in IPVA related to intervention and treatment. In addition, they can also inject more of an emphasis on primary prevention, such as by talking with all patients about healthy relationships and fostering a norm that relationships should not be violent. As sources of credibility and regular interaction, health care professionals play an important role in the primary prevention of IPVA.^{22, 23, 24} However, before health care practitioners can effectively engage with women directly and indirectly, they must first question their personal attitudes that may serve to contribute to prevalent social norms that allow for abuse (i.e., blaming the victim). “Why won't she leave?” needs to be replaced with “What will make him stop?”^{25, 26, 27} Furthermore, practitioners can use a longitudinal, age-specific approach to engage women and girls developmentally to help reinforce messages throughout a woman's life stages.²⁸ Major clinical practices that support IPVA prevention include engaging women in an empowering way,^{29, 30, 31, 32} promoting healthy relationships and sexuality, and dialoguing with parents and parents-to-be.

Practitioners can engage patients as active participants during regular examinations through dialogue and a restructuring of the examination room. Providers can conduct the examination with comments and questions

such as, “You are the expert about your own body,” and “What things have you already tried, and how did your body respond?”^{33,34} Providers can empower and promote the self-esteem of both women and children by asking for permission to examine their bodies so patients learn about personal ownership of their own bodies. When adolescents are close to the age they begin dating, practitioners can explore compromising situations and feelings about power.³⁵

Health care professionals can engage in dialogue with parents or parents-to-be in order to impact women and men indirectly.^{36,37} Since parents and parents-to-be play an important role both as role models and as central child-rearing figures in the lives of their children, practitioners will effectively work against IPVA by working with them. Prenatal health care professionals may take the opportunity to have discussions about parenting, strategies to avoid burnout, and the role both partners can play in parenting and in preventing violence.^{38,39} Health care practitioners can also encourage parents to promote flexible sex-role socialization of their children by broadening the views of parents regarding behaviors considered “natural” for either gender.^{40,41} For example, boys can honor feelings while girls can be strong and assertive.

Organizational Practices

Since institutions shape and reinforce norms, it is critical that health care settings and professional associations establish and promulgate regulations, practices, and cultures that contribute to IPVA reduction. Areas of focus include training and policies, as well as reflecting an egalitarian culture and intolerance of violence and patriarchy.

Health care institutions can establish workplace policies that are in alignment with ending IPVA. These include anti-harassment policies and training on and modeling of egalitarian relationships and appropriate ways of handling conflict. Positive interactions among all staff can provide positive modeling for patients. For example, an egalitarian relationship between doctors and nurses will help model positive behaviors for patients in a way that counters power dynamics in a society.

Policies can also be established to enable health care practitioners to teach about IPVA in the community. For example, nurses have developed and taught community education programs on violence against women.⁴² Institutions can make information and resources available to patients. Waiting rooms and clinics are useful spaces to provide resources that give information about healthy relationships and raise clients’ consciousness of sexist attitudes in the media that promote sex and violence.^{43,44,45}

Both professional associations and health care settings should encourage ongoing professional development and continuing education on preventing IPVA that includes promoting healthy relationships and sexuality. Institutionalizing training can help health care practitioners become leaders in prevention planning, implementation, and prioritization. Additionally, most health care workplaces usually have a majority of female employees, and these women have an opportunity to become leaders in workplace excellence around IPVA. Among other primary prevention skills, it is vital that practitioners have the skills and knowledge to implement the clinical primary prevention efforts noted above. Medical associations have a key role in urging that violence prevention training be offered in medical, nursing, and dental schools, as well as within established health care facilities.

Spokesperson/Advocate

Health care institutions and providers can be powerful advocates for prevention. Providers must speak up in their clinical practices; in their organizations and associations; and broadly to the public, the media, and policymakers. By speaking up in public meetings, serving as experts to the media, and testifying to legislators, health care providers can shape issues, influence the debate, and challenge public and political discourse. Examples include advocating for decreases in the portrayal of violence in the media, supporting state and national legislative efforts, and petitioning for legal remedies designed to protect women.⁴⁶ Political strategies are fundamental to changing the societal context to promote primary prevention.⁴⁷

Health care institutions must play a role in supporting community action in addition to encouraging and supporting their staff. Organizational representatives can sponsor and support violence prevention legislation, write op-ed pieces and letters to the editor in support of IPVA prevention, meet with elected officials, and talk with the press about the fact that IPVA is not inevitable. They can also provide training on taking a political stance and on becoming advocates.

All of these efforts can help support primary prevention, and the greatest changes will come about when action is taken as part of an overall strategy to change the environment—especially norms. Since the Spectrum of Prevention⁴⁸ is a tool to help think strategically about the range of activities needed to achieve this, Table 10-4 provides some specific health care strategies for health care providers along the Spectrum.

**TABLE 10-4. IPVA PREVENTION ACTIVITIES FOR HEALTH CARE PROFESSIONALS
BASED ON THE SPECTRUM OF PREVENTION**

SPECTRUM LEVELS	EXAMPLES
<p>Strengthening individual knowledge & skills. Enhancing individual capacity.</p>	<ul style="list-style-type: none"> • Offer advice about appropriate and healthy relationships. • Raise awareness among parents about gender socialization. • Talk to parents about the consequences of viewing repeated violence in the media. • Screen for risk factors: <ul style="list-style-type: none"> ◦ Are family members safe in the home? ◦ Is there a firearm in the house? ◦ Is alcohol commonly used? ◦ Social history of witnessing IPVA or experiencing maltreatment as a child.
<p>Promoting community education. Reaching groups with information and resources.</p>	<ul style="list-style-type: none"> • Use credibility to be a spokesperson to speak about violence and its prevention. • Promote the notion that “intimate partner violence is a community concern.” • Speak out against sexism and provide role models of acceptable behavior. • Educate the community about pro-active bystander roles. • Help aggregate data from a community hospital, clinic, or practice to provide local data related to the problem and debunk the “not-here” myth.
<p>Educating providers. Informing providers who influence others.</p>	<ul style="list-style-type: none"> • Offer violence prevention training in medical, nursing, dental schools. • Provide ongoing professional development and continuing education in violence prevention. • Provide training for all staff on healthy and violence-free relationships.
<p>Fostering coalitions & networks. Convening groups and individuals for greater impact.</p>	<ul style="list-style-type: none"> • Be active in professional organizations and hold them accountable for helping to define and promote the necessary change. • Be active in local communities and community coalitions. • Work to ensure that community efforts include representation from the populations most at risk for IPVA. • Partner with businesses to raise awareness among employees and give them an understanding of what they can do.
<p>Changing organizational practices. Adopting regulations and shaping norms.</p>	<ul style="list-style-type: none"> • Encourage major health care institutions and schools to recognize violence as a major health issue. • Change the policies of institutions to ensure work across all levels of the Spectrum of Prevention. • Foster organizational cultures that are egalitarian and model healthy interaction and communication for clients and patients. • Speak out against media images that degrade women and promote violence. • Promote research efforts within health care institutions and partner organizations that will support and strengthen IPVA primary prevention efforts.
<p>Influencing policy & legislation. Developing strategies to change laws and policies.</p>	<ul style="list-style-type: none"> • Play a role in supporting laws and legislation to promote prevention, including writing letters and testifying. • Get professional health associations to sponsor violence prevention legislation such as that related to firearms, alcohol, media, and the safety of women. • Call for more research funding to be directed to primary prevention.

WRAPPING IT UP

Primary prevention has been successfully applied to other health-related conditions, such as tobacco use. The goal of primary prevention in IPVA is to create environments in which we never need to question whether people are in danger in their relationships. In order to initiate primary prevention programs we need to understand the determinants of IPVA and the role of norms in perpetuating or changing IPVA-related behaviors.

Although it can be difficult to garner support for primary prevention programs, health care professionals can use their tremendous influence and credibility to more systematically prevent IPVA.

For a listing of other literature dealing with primary prevention and other aspects of IPVA, see Appendix J.

Endnotes

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