



# **PROGRAMS FOR MEN WHO HAVE USED VIOLENCE AGAINST WOMEN: Recommendations for Action and Caution**

# I. INTRODUCTION

Population-based data for over 90 countries (UN Women, 2011) and numerous studies worldwide affirm the magnitude and prevalence of violence committed by a male partner and against a female partner (violence against women, and specifically intimate partner violence, or IPV). Recent IMAGES research found that 25 to 40 percent of men reported using IPV, while women reported experiencing slightly higher rates of IPV (lifetime rates across six countries) (Barker, et al. 2011). The WHO ten-country study (García-Moreno, et al. 2005) found women's lifetime reports of IPV were between 10 and 70 percent (with most estimates between 30 and 60 percent).<sup>3</sup> Since that study, over ten additional WHO national reports have been created.

The emergence of shelters and other services for survivors of IPV marked the first responses to domestic violence as part of the movement to end violence against women. From this beginning, the question emerged of what to do with men who have used IPV. Programs for men who have used IPV — referred to as PM-IPV for the purpose of this paper — emerged in the 1970s in the U.S. and parts of Europe, and more recently are being implemented in parts of the Global South. A number of low- and middle-income countries, primarily in Latin America (Brazil, Mexico, and the Dominican Republic) have started to provide public resources for such programs as part of a multisectoral response to gender-based violence (GBV). There are ongoing debates about the effectiveness of PM-IPV, however, and thus whether they are worthy of investment. Given the limited resources for prevention of violence against women and remediation, the

**Programs for Men who have used IPV – referred to throughout this briefing paper<sup>1</sup> as PM-IPV<sup>2</sup> – refers to programs for men who have used violence with their female intimate partners (physical, sexual, psychological / emotional violence, threats of violence, and other forms of controlling behavior).**

question of whether and in what conditions PM-IPV work is a critical ethical issue in the field of IPV.

What works to hold men who have used violence accountable and prevent further abuse? The WHO in 2003 led a global review of PM-IPV (Rothman et al.). In 2010, UN Women, as part of their work with men and boys, created a knowledge module on the subject that included a review of further evaluation research on PM-IPV internationally (Guedes, 2010). Both documents noted the dearth of evaluation evidence from the Global South and limitations of PM-IPV programs in the Global North.

Similarly, the principal findings of this paper are that the effectiveness of such programs ranges from low to moderate, and that the evidence largely comes from models developed and implemented in North America and Western Europe (for data describing this range of effectiveness, see Futures Without Violence, Carter, 2010, and Gondolf, 2004, 2009, for recent leading work based in North America). To date, there is far less understanding of practices and evidence in diverse international settings, particularly in low-income and Global South settings. In these places, as efforts to end violence against women have expanded, there has been a growing

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<sup>2</sup>PM-IPV are also called batterer intervention programs, or programs for perpetrators. Men who participate in these interventions may have also used violence, such as sexual or physical violence, against non-intimate partners, but they have entered programs for their use of IPV, most often in the domestic sphere. This paper also focuses on group programs rather than on individual counseling, and on those directed toward heterosexual men (a growing number of programs also address IPV committed within same-sex relationships). During this review, MenEngage colleagues noted that practitioners of PM-IPV across the world were concerned about a reductionist meaning in the labels of “batterer” or “perpetrator.” The avoidance of those terms and the naming of programs according to “PM-IPV” does not seek to reduce the responsibility or take away from the seriousness of the act, but tries to give a more complex view of men whose lives are more complicated than their acts of violence and who themselves have often been victims or witnesses of violence. From this perspective, men can change to become ‘men who do not use violence,’ or see themselves as someone other than a batterer or perpetrator.

<sup>3</sup>The initial six countries included in the International Men and Gender Equality Survey (IMAGES) were Brazil, Chile, Croatia, India, Mexico, and Rwanda. Findings from the following ten countries were presented in the WHO 10-country report cited: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and Tanzania. IMAGES collected data on women's and men's perceptions of gender equality outcomes, including IPV, and the WHO study focused on women's experiences of violence.



emergence of PM-IPV. Some of these programs, however, have emerged with little planning, resources, expertise, or evaluation. Under well-intentioned but precarious conditions, there is concern that standards may not be in place to ensure the safety of women and family members, or that programs may be ineffective. Also, while the literature on best practices for cultural relevance to racial/ethnic minority and immigrant groups in the Global North is expanding and has salient implications for the design of culturally relevant programs in Global South countries, programs from the Global North cannot simply be replicated in the Global South.

Some evidence has shown positive changes for men who consistently participate in PM-IPV that apply current best practices (such as reduced or eliminated violence), but more research is needed into both program efficacy and what best practices should be. For example, programs should monitor for risk escalation; in many cases, such monitoring may not otherwise occur. Indeed, it is this moment of growth — accompanied by a mix of promise, concern, and slowly emerging research — that prompted MenEngage and its partners to develop this briefing paper on the subject.

One of the reasons for the difficulty of the question “*Are PM-IPV effective in reducing the recurrence of IPV?*” is its complexity, since the factors underlying IPV vary widely depending on context, the nature of the relationship between perpetrator and survivor, and the individual perpetrators or survivors themselves. To better understand the drivers of IPV, many researchers and program staff currently use the ecological model, which stresses that personal, relationship, family, community, and broader social dynamics, including culturally salient gender norms and power structures, are all factors contributing to IPV. To be well-designed, PM-IPV must take these complex interpersonal and contextual interactions into account and apply a variety of approaches. This complexity also poses major challenges to controlling for variables in PM-IPV evaluations.

This briefing paper is directed toward UN agencies, government staff and policymakers, donors, practitioners and researchers in the field of IPV and its prevention and treatment. It is neither an implementation manual nor a comprehensive or Cochrane-style evaluation review, but rather aims to identify trends and to inform programming and

## The Methodology for this Briefing Paper

- Literature review (over 75 peer-reviewed articles, reports, and grey literature, with over 120 titles identified)
- Phone and Skype interviews with staff who work in three categories of interventions (total n = 17):

### 1) Programs for men who have used IPV:

- Brazil (ISER – SERH program)
- Denmark, Iceland, Norway, Sweden (Alternatives to Violence)
- Mozambique (HOPEM)
- Nicaragua (BPBV)
- United Kingdom (RESPECT)

### 2) Services focused on women, children, and youth survivors that in recent years have added interventions for men who have used IPV:

- Honduras (Casa del Bien Estar)
- Indonesia (Rifka Annisa Women’s Crisis Center)
- South Africa (Mosaic Training, Service & Healing Center for Women)
- Vietnam (Center for Applied Sciences in Gender – CSAGA)

### 3) Researchers and experts from the following institutions: the National Latin@ Network for Healthy Families and Communities, Casa de Esperanza, U.S.; Center for Security and Citizenship Studies (CESeC), Brazil; Men for Gender Equality, Sweden; the Child and Woman Abuse Studies Unit, London Metropolitan University, England; the Department of Community Health Sciences, Boston University, U.S.; the Mid-Atlantic Addiction Training Institute, U.S.; CulturaSalud, Chile; and Rutgers WPF, the Netherlands.

research, and to provide a word of caution in implementing PM-IPV.<sup>4</sup> It also intends to provide an updated literature review that builds on two primary reviews conducted previously: the WHO review (Rothman et. al., 2003), and the UN Women Virtual Knowledge Centre for Ending Violence against Women and Girls, which includes a review, up to 2008, of programs for men who use IPV (Guedes, 2010).

<sup>4</sup>In order to prepare this review, we interviewed organizations and individuals who would have insights into the challenges and complexities that arise in diverse settings. Statistically, most men who are known to have used IPV are heterosexual men, so programming and research have focused on the violence committed by these men. Further research and interventions are needed on women’s use of IPV, and among same-sex couples. We sought case study examples from diverse regions, but do not cover all programming worldwide.

## Organization of this Briefing Paper

Beginning with *preconditions necessary for effective PM-IPV*, the paper follows with a *review of the literature* on models, approaches, and program components common to PM-IPV. This section summarizes the evidence emerging from programs, including evaluation trends. A section dedicated to *implications for Global South* settings follows. Two annexes are provided: a summary of evaluation reviews and literature on program approaches and effectiveness (Annex A); and guidance on prioritizing ethical standards, including the safety of women and children — a point MenEngage highlights as a necessary condition for PM-IPV — with additional recommendations from providers of services for women survivors of IPV (Annex B).

## II. MenEngage’s Preconditions for the Implementation Of PM-IPV

Given these challenges and considerations, MenEngage affirms the following as preconditions for the implementation of PM-IPV; if these components are not in place, programs should not proceed. These preconditions were identified based on this paper’s literature review and on interviews with researchers and practitioners who implement PM-IPV.

**1) Position and implement PM-IPV as part of an integrated approach, and develop a community-coordinated response.** An integrated approach means engaging the health sector and other vital government sectors for comprehensive services, including primary prevention services and referrals for legal and psychosocial support for women, men, and children who have experienced or are experiencing violence (in order to avoid isolating PM-IPV). *Research shows that PM-IPV (and interventions such as mandatory arrest and prosecution policies) reduce return to prison most effectively when they are part of a coordinated community and criminal justice system response that monitors compliance of men who have used IPV with terms of probation and with attendance in PM-IPV* (Shepard, 2005; WHO and Sonke, 2012). An integrated approach also entails promoting nonviolent, equitable, and positive forms of masculinity and involving men as part of the solution, such as through support for fatherhood and caregiving.

**2) Develop quality minimum standards for the development and delivery of such programs to ensure women’s safety is prioritized and for consistency of programming on PM-IPV.** In some Global North settings, standards have been developed at the regional, national, and state levels. RESPECT, an umbrella organization, developed the most rigorous accreditation system we identified. At the time of the review, RESPECT had accredited ten programs throughout the U.K. (Todd interview, 2012). Standards were also identified within the Council of Europe (Kelly, 2008), and in Australia, where they were established by the Queensland government and by No To Violence<sup>5</sup> as part of an integrated response to family violence. Standards have also been developed within most U.S. states, but U.S. state program standards are poorly implemented, according to two studies (California, 2006 and Labriola et al., 2007 in Gondolf, 2009).

**3) Prioritize ethical standards and the safety and well-being of women and children.** First, PM-IPV, overall, should be *guided by the principle ‘Do no harm.’* ‘Do no harm’ is an ethical standard used to ensure that humanitarian and development interventions are sensitive, responsive, and cognizant of the ways in which they may unintentionally cause harm.<sup>6</sup> Several interviewees remarked that they have at times seen programs do more harm than good,

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<sup>5</sup> For the example of minimum standards created by No To Violence, see: <http://ntv.org.au/what-we-do/mens-behaviour-change/standards-and-guidelines/standards-of-practice/minimum-standards/>

<sup>6</sup> A practitioner in South Africa gave the example of unintended consequences from incarceration, separation, or deportation of a man, leaving his wife and children without vital income. Survivors often must be provided with support in generating new forms of income and in adjusting to changes in gendered structures within a household. Even if a PM-IPV cannot be solely responsible for these broader failures, practitioners should be aware of social justice movements and the full range of potential risks and benefits for the men involved and their family members.

such as by inappropriately placing men who have used violence and survivors in the same room. Rutgers WPF, with partner organizations in South Africa and Indonesia, have developed approaches and tools to promote safety throughout PM-IPV.<sup>7</sup>

**4) Conduct risk assessments and develop a risk management plan,** both of which can help professionals and women to better understand, and better equip them to manage the potential for danger and their degree of risk (Campbell et al., 2003). Assessment tools should include a safety plan, a client assessment, an aggression questionnaire, a substance dependency assessment, and a behavior-monitoring box. A dedicated risk assessment framework seeks to assess and monitor the likelihood that IPV will repeat or escalate (see Rutgers WPF 2012a: 163). Particular attention should be paid toward the beginning of treatment, which has been identified as the most dangerous (but not the only) time for re-assault. Risk management can also include systematic contact with survivors, periodic reevaluations of safety, and additional support services as necessary (Gondolf, 2002). The Spousal Assault Risk Assessment (SARA) is a tool, designed to predict physical injury, that could be used with others to assess control and risk (Kropp & Hart, 2000).<sup>8</sup>

**5) Develop a model and train staff in the principle of holding men accountable for having used IPV, for completing programs, and for ending their use of violence while also believing in their potential to change.** Practitioners shared several examples of ways to hold men accountable without diminishing their belief in their potential for change. First, a Nicaraguan practitioner described the need to balance believing in a man's ability to change with, at the same time, holding him accountable and not treating him with "silk gloves." Programs in two countries held men accountable by targeting specific groups of men. In an example from one of those countries, Honduras, Casa de Bienestar reached out to coordinators of organized taxi drivers, who formed a committee and referred men they knew were using IPV. In turn, the coordinators created contracts with drivers, who had to pay a fine if they did not attend sessions. Also in Honduras, if men did not regularly attend PM-IPV, they were required by the justice system to perform community service (or other form of "castigo social") such as street sweeping. At a practical level, this recommendation means that facilitators should state and uphold the objective of holding men accountable without humiliating or alienating them (Guedes, 2010).

**6) Use gender transformative approaches to train staff in addressing men's childhood experiences and personal background, issues of societal tolerance of violence, and norms around masculinity, including men's justifications for violence.** Models may include a variety of theoretical orientations and methods, but they should in some way use gender transformative approaches (Greene & Levack, 2010) that promote gender-equitable attitudes and practices among women and men. This entails introducing alternative forms of masculinity and redefining manhood such that new perceptions about relationships, intimacy, women, shared responsibility, and happiness can result. In addition to dominant notions of masculinity, violence is often related to the very real psychological harm caused by men's experiences of violence growing up. Numerous household surveys, including IMAGES, have confirmed that a strong contributing factor to men's use of IPV is having witnessed violence against their mothers by a man when they were growing up (Barker et al., 2011 and Contreras et al., 2012). Thus PM-IPV must create spaces in which men can discuss and acknowledge violence they have experienced or witnessed as children – never as an excuse for their use of violence but as a means of understanding where violence comes from and how they can overcome it.

It is also important to examine how gender is tied to societal tolerance of violence and norms around masculinity, and how a man's lack or attainment of social power in other spheres (work, community, etc.) influences his social entitlement and use (or non-use) of violence with an intimate partner. The Gender Violence Institute (U.S.) has found that participants often

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<sup>7</sup>In 2007, Rutgers WPF, a Dutch NGO promoting sexual and reproductive health and rights with an office in Indonesia, identified counseling of men in the context of IPV as the focus of a joint collaboration with three partners: Mosaic, Training, Service & Healing Centre for Women in South Africa, and the Rifka Annisa and Cahaya Perempuan Women's Crisis Centres, both in Indonesia. The partners developed and piloted a *Toolkit for Men: Male Counselling in the Context of Intimate Partner Violence*, available online (see Rutgers WPF 2012a and 2012b). In addition to safety and risk assessment tools, the Toolkit includes training and counselor's workbooks and other tools to adapt, implement, monitor, and evaluate interventions.

<sup>8</sup>Regarding partner reports throughout PM-IPV, two critical caveats must be kept in mind: (1) *women may not report recurrences of IPV, and (2) violence against women may take place with new partners.* Further guidance for protecting the safety of women and children in the context of PM-IPV are provided in Annex B.

cite the function and benefits of violence as reasons for their use of it. In a group exercise, facilitators filled two chalkboards when listening to male participants list reasons for their use of violence. Violence against a female partner is used to enforce entitlements and to punish any suggested transgression on her part; these notions are grounded in male domination, entitlement, and control, which are, in turn, grounded in social norms of masculinities. Understanding these justifications can help practitioners and participants find avenues toward deconstructing violence (Derry, personal communication, 2013).

**7) Know the IPV situation in your country.** The factors that support and sustain IPV differ by country and should be well understood by staff who implement PM-IPV. UN Women, for instance, offers population-based data showing differences in prevalence of IPV in 90 countries (UN Women, 2011). Other literature and experts should also be consulted to develop a knowledge base. Similarly, staff should reflect upon their theoretical model of what drives IPV. Practitioners in South Africa and Brazil discussed the far-reaching implications of PM-IPV, which cannot be effective without **an understanding of the broader structures that have exposed and may expose men to further violence.** For example, in many settings incarceration exposes men to further violence (as well as to tuberculosis, and HIV/AIDS and other sexually transmitted infections).<sup>9</sup> Recognizing the conditions of prisons, Sonke, an NGO in South Africa, opted to do prison reform work, in addition to their work in violence prevention and treatment. Depending on the country, participation in PM-IPV may offer reduced sentences and represent a restorative rather than punitive approach of incarceration.

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<sup>9</sup>For example, see Ghanotakis et al., 2007, Spiegler, 2012, and Johnstone-Robertson, 2011 about prison risks in South Africa.

# III. LITERATURE ON THE EFFECTIVENESS OF PROGRAMS FOR MEN WHO HAVE USED VIOLENCE AGAINST AN INTIMATE PARTNER (PM-IPV)

## Program Models and Approaches

The first PM-IPV emerged in the late 1970s from the battered women’s movement in the United States, and by 1987, the first PM-IPV was established in Europe (Alternatives to Violence in Norway). Early programs also emerged in Canada, Australia, in other European countries, and in a handful of Global South countries. The 2003 World Health Organization report (Rothman et al.) identified PM-IPV in nearly every region of the world, but to date there is far less evaluation of and research on practices in the Global South and in contexts with limited resources and weak or unsupportive justice systems.

## Common Threads

PM-IPV are characterized by three common features: (1) a theoretical orientation (i.e., what they believe ends men’s use of IPV); (2) the voluntary or mandatory nature of men’s participation (i.e., the extent of the justice system’s role, including with attrition); and (3) the degree of coordination with related health sector services, the criminal justice system, and the community, referred to as a coordinated community response (CCR). The interventions discussed in this paper take place almost exclusively in a group setting. Individual counseling does take place in many countries as well, including in Norway, Indonesia and Fiji (as identified in this review), where work with abusive male partners stemmed from individual counseling with women survivors of IPV.

## Combining Diverse Approaches and Theories

In spite of these commonalities, most programs use a combination of approaches and theories, with a great deal of overlap between cognitive-behavioral, psychotherapeutic, and gender-based or feminist approaches. Descriptions of each of these varying approaches — which should be understood as almost never applied in isolation — follow.



First, *cognitive-behavioral approaches* view violence as a learned behavior that can be unlearned. Most men who have used IPV do not show evidence of psychological or personality disorders, and most PM-IPV require or encourage men to accept responsibility for past use of IPV (Guedes, 2010). The majority of interventions are also framed within a gender analysis of the belief system in which men feel entitled to control women in a relationship. Research suggests that when this belief system is not questioned, men who use IPV may merely switch from using physical violence, for which they have been held accountable, to using emotional abuse toward women and children (Mullender and Burton, 2000).

One of the most prevalent models that combines *cognitive-behavioral approaches* with *gender analysis* is the Duluth model, developed in Minnesota (U.S.) in the early 1980s. The Duluth model has been replicated in all 50 U.S. states and an estimated 17 countries. Its curriculum includes the use of a “power and control wheel” to make men aware of the violent and nonviolent control tactics they may use. The Emerge model (from Boston, U.S.) combines generating awareness of abusive behaviors with cognitive restructuring. Most commonly, thematic group discussion sessions are held on relevant themes (e.g., on fatherhood, on work-related stress, sometimes on religion/spirituality, etc.).

*Psychotherapeutic models* have been dominant in Norway and Brazil. Central to the Norwegian approach has been examining the intersection of society’s tolerance of violence, including gender norms, with men’s personal histories of violence. One study of men voluntarily attending therapy in Norway found that 60 percent had experienced family violence growing up or at some point in their lives, and that these past experiences were associated with their different uses of violence as adults (e.g., physical abuse with psychologically controlling behavior, sexual abuse, sexual violence, etc.) (Askeland et al., 2010). In Brazil, psychotherapeutic models, called *reflective men’s groups* (“programas reflexivos” in Portuguese), are run by a two-person team of a man and a woman, with at least one psychologist.<sup>10</sup> The approach, among other features, stresses a horizontal group dynamic

in which facilitators encourage men to reflect and arrive at their own awareness of the harm they have caused, rather than the facilitators imposing their views. Programs using the Emerge model similarly found that a non-confrontational, Socratic approach is particularly effective for participants from immigrant groups in the U.S. (Saunders, 2008).<sup>11</sup>

In the Caribbean (Grenada, Trinidad and Tobago, St. Lucia, Jamaica, and Belize), a *psycho-educational model*, similar to psychotherapeutic models, called Partnership for Peace (PfP) has also emerged. PfP is a court-mandated, 16-week program facilitated by a mixed sex team, in which men confront harmful notions about women and about masculinity, examine unequal power relationships that fuel violence, and accept responsibility for ending their violent behavior.

*Programs based on typologies of men who have used violence* are increasingly being implemented, acknowledging that some men show more episodic use of violence, while others use more long-term and severe forms of violence (Holtzworth-Munroe & Meehan, 2004; National Institute of Justice, 2003). Prospective participants undergo a psychological assessment and are then classified by level of risk, based on their substance abuse and other factors that help indicate an appropriate intervention. *Trauma-based approaches* focus on the past experiences of men who have used violence, while *family systems theories* are more controversial in that they are sometimes understood as placing blame on the victim (Saunders, 2008).

A final and more recently emerging program type (and typically one that is integrated with other models) involves *parenting interventions* that target fathers who have used IPV. Recent research by Scott (2012a, 2012b) has assessed findings based on parenting programs and PM-IPV, and identified, from the literature, key recommendations for program content and organization, e.g., inclusion of trainers with relevant experience, use of a mix of behavioral and attitudinal approaches, extension of program length beyond two to three months, combining individual and group sessions, and management of risk — particularly over time.

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<sup>10</sup>See examples from Instituto Noos (Acosta et al, 2004 and Texeira, 2011), and from the NGO Iser: Souza Neves et al, 2010 and at <http://www.iser.org.br/site/imprensa/serh-em-destaque>.

<sup>11</sup>The HOPEM program in Mozambique also adopted several components of the Brazilian model, namely the non-confrontational approach. Psychotherapeutic models were cited as more commonly used in Italy. Ultimately, caution must be taken not to excuse, skirt, or diminish the seriousness of violence, but to communicate in ways that lead to the desired attitude and behavior changes and that are meaningful and relevant to men. Juan Carlos Areán, a leader in the field in developing programs for men who have used IPV and initiatives among Latino men in the U.S., stressed that understanding how to reach and create change among men comes from asking them what their values are and working from there. The same problems can be addressed using positive, non-violent concepts that have meaning to the men involved.

## Additional Program Details

PM-IPV also vary greatly in the numbers of men they reach. In North America and Europe, some programs admit several hundred men each year, whereas others may be run by a private psychologist, for instance, who holds one small group per year. There are an estimated 1,500–2,500 programs in the U.S., accounting for this range of services. In other countries, program sizes also vary (Carter, 2010).

Other program components that vary across PM-IPV include standards and guidelines to ensure quality and safety of women and children, duration, recruitment and attrition mechanisms (volunteer or court referrals and monitoring), the role of justice systems, and contact with the partner. Recruitment mechanisms, in particular, vary, from mandated referrals in Brazil, the U.K., and U.S. (with some voluntary participants in each of these countries) to voluntary referrals in Nordic countries that rely more on social service referrals. In Mozambique and some other countries, PM-IPV began as voluntary programs and were later linked to the justice system. Evaluation data from a 12-session program in Brazil found that men wanted more sessions, and that there was a need for follow-up to monitor men's progress beyond completion of the program (Texeira, 2011). This follow-up after program completion was a need identified worldwide, and providing it was a common challenge.

## Coordinated Community Response

The evidence reviewed affirms that the effectiveness of PM-IPV is contingent upon the programs' degree of *integration* among complementary services and support systems. The evidence suggests that these services should work in tandem through a *coordinated community response (CCR)*, a concept that is gaining attention in evaluation research and in PM-IPV implementation (Gondolf, 2009; Hart, 2009; Adams, 2009).<sup>12</sup>

Although complex to manage, CCRs offer multiple pathways for men to enter PM-IPV, by broadening referral, support and accountability mechanisms. They engage relevant

stakeholders, including social service providers, to improve access to appropriate services for victims and men who have experienced violence themselves. By counting on a wider network, if developed effectively, CCR can support mechanisms to manage risks; promote mechanisms to strengthen accountability; regulate court and police actions such as arrests, probation supervision or protection orders; and be used to develop potential solutions toward resolving many of the challenges identified in this paper.

## Evidence of Effectiveness

Primarily because of the risks involved, programs in the Global North for men who are known to have used IPV have been subject to more rigorous evaluation standards than have programs that involve primary prevention of IPV among men and boys who have not necessarily used IPV. Criteria for men entering PM-IPV vary: a judge may decide to refer a man to a PM-IPV instead of to jail, or a woman may decide to stay with her partner depending upon whether or not he participates in a program (Guedes, 2010).

More than 40 studies have attempted to measure the effectiveness of PM-IPV (Gondolf, 2004) using various evaluation designs: (1) quasi-experimental; (2) experimental, including randomized control trials (RCTs); (3) alternative, non-experimentally designed studies; and (4) meta-analyses, which assess multiple interventions (see Annex A).

An overall finding of this review is that the evidence for effectiveness of PM-IPV is "ambiguous," and "inconclusive," as described by researchers interviewed and as reflected in much of the literature reviewed. Several other experts interviewed asserted that there is some evidence of effectiveness but that there is a need for (1) basic standards for programs, (2) standardized indicators of effectiveness, (3) cost-benefit analyses, and (4) rigorous pilot-testing and more impact evaluations in Global South and resource-poor settings.

Some evidence of PM-IPV suggests minimal or no effect (Feder & Wilson, 2005; Babcock et al., 2004). Other evidence shows substantial re-reductions in violent behavior



<sup>12</sup>Several examples illustrate current CCR initiatives. The new MenCare+ initiative, a partnership emerging from the MenCare campaign, connects PM-IPV to and is evaluating PM-IPV among a broader set of prevention and maternal, sexual, and reproductive health services, as well as other initiatives that leverage PM-IPV and vice versa. Similarly, Partnership for Peace in the Caribbean engages groups of psychologists, human rights lawyers, and social workers, as well as the justice system in court-mandated programs.



by men who complete these programs (Gondolf, 2002, 2004). Four quasi-experimental studies in North America reviewed by Aldorando (2009) showed mean recidivism rates of 32 percent as reported by women whose partners had completed programs, compared with 46 percent as reported by women whose partners did not complete programs. The figures for recidivism rates tend to be much lower when only police reports are relied upon, suggesting that it is more accurate to use partner reports as well. Evaluation must account for women who are not reporting (including women with new partners who may or may not be violent), as well as for men who drop out of PM-IPV.<sup>13</sup>

According to other reviews, PM-IPV have proved to have at least a small effect on the recurrence of violence, suggesting that such programs are at least moderately successful at preventing further violence by abusers (Babcock et al., 2004; Gondolf, 2004).

## Methodological Challenges and Insights

Methodological challenges have posed problems for interpreting the results of impact evaluations of PM-IPV (World Report on Violence and Health, 2002), and there are debates as to what constitutes a rigorous study design. For instance, a Canadian review of ten studies considered only one to be rigorous, and questioned the applicability to the general public of the findings of that study (Wathen and MacMillan, 2003a). Results of meta-analyses, in particular, must be analyzed carefully, as they are often interpreted with a limited knowledge of methodological applications or caveats (Gondolf, 2004).

Researchers interviewed for this paper also warned of a problematic tendency on the part of practitioners to misinterpret research in such a way as to either detract from or support PM-IPV without knowledge of how to objectively interpret and apply evaluation findings. Furthermore, findings often cannot be meaningfully compared because of differences in the way IPV is measured and reported. In addition, some meta-analyses show little to no treatment effect when victim reports were used over official reports (which underestimate re-victimization), or had a limited range of study participants

because consent from judges and several members of the criminal justice system was a prerequisite to participation (Feder & Wilson, 2005; Babcock et al., 2004). It is important to note that dropouts (men who abandon PM-IPV before completion) and women who do not report violence may be unaccounted for in some evaluations. The challenges are similar to those faced by researchers in other areas of sexual and reproductive health, such as sexuality education, HIV-prevention programs, and many other areas in which behavior is complex, determined by multiple factors, and strongly tied to cultural norms and expectations.

This review also yielded insights for the recommended methodology for evaluation of PM-IPV. First, there is a general consensus that evaluation studies should use broad definitions of IPV — and in particular, rely on victim reports rather than official reports — and follow up with at least 80 percent of participants. Studies are also starting to measure providers' competency and "treatment integrity" (i.e., factors related to program dosage and quality) and to address other problems identified in many evaluations (Saunders, 2008). Second, this review recommends that what are considered indicators of efficacy be expanded beyond recidivism, given that even if physical violence stops, harmful forms of domination and control can persist or emerge within a relationship (Westmarland et al. 2010; Carter, 2010).

Furthermore, qualitative data, such as that gathered from focus groups and interviews, could be used more often to complement quantitative data (Gondolf interview, 2012). For example, qualitative methods can enhance evaluations of efficacy conducted with quantitative methods only by illuminating the complex mechanisms that lead to success or failure, and revealing what elements work, and when, why, and for whom they work. Quantitative data alone can merely confirm or contradict a program's impact. For example, Instituto Noos in Brazil used focus group discussions in addition to quantitative data collection to generate analysis and recommendations for improving their programs (Texeira, 2011).

Confounding the methodological challenges of evaluating PM-IPV are their varying missions: their goals, their scope, and type of model, i.e., whether as a medical or public

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<sup>13</sup>A review of interventions on violence against women with women and men in North American settings found that evidence is also limited in terms of effectiveness of interventions for women. The authors did not consider evidence of suitable quality to evaluate the effectiveness of shelter programs in terms of preventing re-abuse, but they did find evidence that shelter stay for one night, with advocacy counseling resulted in decreased re-incidence and improved quality of life (Wathen and MacMillan 2003a). Analyses of services for women must look beyond shelters.

health model using clinical outcomes; as a criminal justice intervention (leading to reduced recidivism); or as part of a wider systems or CCR approach. According to Aldorando (2009), there is a “misguided proclivity by some IPV researchers to approach interventions with men who batter as discrete medical procedures rather than as social policies and practices intended to respond to individual, domestic, and social needs.” Another criticism is that both experimental and quasi-experimental designs are often unrealistic and fail to account for the larger context in which such programs exist. According to Gondolf, regarding a PM-IPV as a social intervention entails carrying out an evaluation that looks at the “program effect” as embedded in the system as a whole, rather than as a medical model or an isolated treatment (Gondolf interview, 2012).

## IV. CONSIDERATIONS FOR PM-IPV IN THE GLOBAL SOUTH

It is clear from a review of existing evaluations that current data are overwhelmingly from the Global North (most published evaluation literature is from the U.K. or North America). According to Morrison, Ellsberg, and Bott (2007), speaking of gender-based violence interventions more broadly, “the dearth of high-quality evaluations means that policy recommendations in the short run must be based on emerging evidence in developing economies (process evaluations, qualitative evaluations, and imperfectly designed impact evaluations) and on more rigorous impact evaluations from developed countries.”

PM-IPV are being implemented in large numbers in the Global South, but, because they are newer and because of limited resources, there has been a lack of rigorous evaluations. Promising evaluations have nevertheless been identified in Hong Kong and India (Rothman et al., 2003), and are underway in Vietnam (CSAGA), in the Dominican Republic

(Centro de Intervención Conductual para Hombres), and in Brazil (ISER, and Instituto Noos). In Brazil, evaluations were conducted of a PM-IPV in Rio de Janeiro (Souza Neves et al., 2010; Texeira, 2011), and another evaluation has assessed programs for sexual violence offenders (Tonelli, 2007).

The methods used to produce this section included a systematic analysis of the literature and interviews conducted with practitioners and researchers (a description of the full methods can also be found in the introduction section). The goal of this section is to elicit considerations for Global South settings. Similar findings may apply to and be shared with low-resource settings in the Global North (the two should not be seen as mutually exclusive); however, the impetus for a dedicated section on Global South implications, identified by practitioners and researchers consulted for this paper, was a gap — a paucity of knowledge and understanding of what is happening and what works or is promising for these settings. The section begins with perspectives from staff who implement services focused on women, children, and youth survivors, recognizing that these perspectives are critical to an understanding of the full picture of PM-IPV. The remainder of the section covers implications for resource-poor settings, the role of justice systems, and alternative and complementary practices, as well as resistance and other challenges that come with implementing PM-IPV.

### (1) Perspectives from Women’s and Children’s Service Providers

Practitioners were interviewed in several countries whose organizations focused on providing services for women, children, and youth survivors, and who in recent years have added interventions for men who have used violence.<sup>14</sup> The practitioners in these women’s organizations described similar rationales for beginning to work with men who have used IPV.

First, they recognized that IPV could not be eliminated by working with women alone. As a Honduran practitioner said, “If we only work with women and empower them, but don’t work with men, they’ll go back to the same lives. We

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<sup>14</sup>Practitioners were interviewed from the following organizations: in Honduras, Casa del Bien Estar (“house of well-being”); Rifka Annisa Women’s Crisis Center in Indonesia; Mosaic Training, Service & Healing Center for Women in South Africa; and the Center for Applied Sciences in Gender (CSAGA) in Vietnam. It should be noted that in addition to these organizations, we reached out to over ten organizations that do not provide services to men (i.e., the sole focus of their services is on women and children survivors), but did not receive a response. The interviews revealed some challenges in beginning work with men, but also reflected organizations’ willingness to begin interventions with men in the first place and undergo organizational shifts. Perspectives from organizations that do valuable work exclusively with women and children would expand our understanding of the challenges and potential of working with men, and should be gathered to inform future programming and policy.

wouldn't be doing complete work with the shelter otherwise; there wouldn't be shelter for them." In Vietnam, services to achieve gender equality and eliminate violence on a broader scale were also discussed.<sup>15</sup>

Second, some women's organizations sought to match client demands, namely, to consider what women and children need and request beyond shelter (e.g., income-generating support services for women and trained medical staff to screen for domestic violence). Some providers learned that many women did not want to leave their partners, but wished to stay safe and find ways for their partners to be less violent.<sup>16</sup> According to Mills et al. (2006), regarding Global North contexts, there is no consistent evidence of how many women survivors leave their partners, but some sources estimate as many as half remain in their relationships. If they do leave, it is usually a process that unfolds over time. Even if survivors have left the relationship, they often remain connected to their former partners through children or through other family and community commitments.

Initial challenges with starting PM-IPV included training staff and generating a "mindshift" within the organization. In South Africa, counselors — who often had experienced violence themselves — had to learn new skills and challenge internal attitudes and perceptions, including the dichotomous conception of women as victims and men as perpetrators. In this case, working with men came as part of a deliberate, researched effort (via roundtable discussions and focus groups) to find ways to eliminate domestic violence from different angles, and to involve both women and men. Both Honduras and Vietnam framed their approach around family therapy.

Interviewees reported, anecdotally, the reasons that they were given by other organizations that continued to focus on women (i.e., their reasons for not beginning work with men). These reasons mostly focused on resource priorities — the idea that services for women needed to be the priority, and the concern that work with men would divert scarce

resources. Other reasons reported were the realization that new alliances would have to be formed in order to support and generate funding for PM-IPV, and insufficient evidence of effectiveness.

The interviewees from organizations that had started to work with men felt that initiating work with men was bringing positive outcomes for both women and men. Practitioners felt better equipped to counsel female clients having gained perspective on the complexity of relationships. Beginning work with men also led them to revisit safety and ethical issues, and thus provided an opportunity to strengthen safety measures as with Mosaic's and Rutgers WPF's creation of safety tools. Recommendations from interviews with providers of services for women are included in Annex B.

## **(2) Implementing PM-IPV in Resource-Poor Settings**

Domestic violence pervades all socio-economic classes, but, among low income groups, services are particularly lacking, and the impacts of IPV on some aspects of life are disproportionately felt. Effective and inclusive programs must consider how economic stress contributes to IPV, and which measures should be put in place to account for the realities of low-income male participants. There is a strong association between men's reports of economic stress — in particular, the pressure that men feel to play the expected provider role — and lifetime use of IPV. This suggests the need for greater efforts to develop interventions that account for poverty, work, and economic marginalization and their relationships to men's practices of and women's vulnerability to IPV (Barker et al., 2011:48; Krishnan, et al., 2010).

Poverty and resource scarcity, both for programs and participants, present challenges to the ability of Global South organizations (in particular) to implement PM-IPV. Practitioners described the precarious conditions in which they held groups. Even with government funding, a program

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<sup>15</sup>As the director of CSAGA in Vietnam described, if the goal is to have a gender equal society, equality among family members must come first. If a man cannot have a good relationship when he goes home, he cannot have good relationships with politicians or other colleagues who are women. CSAGA also described the challenge of introducing the concept of domestic violence, which is regarded as a private issue. Because CSAGA was the first organization to provide services of this kind in Vietnam, launching the program meant that staff revisited the bigger picture of gender equality in the country.

<sup>16</sup>The experience in South Africa (Mosaic) and Indonesia (Rifka Annisa), in collaboration with Rutgers WPF, showed that the majority of female clients did not want to end their relationships, but rather the violence in the relationships. Similar experiences were shared from Brazil. The experiences of these women's organizations showed that women were not able to radically transform their situation as long as their partners did not change. Therefore, the involvement of men was considered to be an essential strategy for stopping the violence and saving the relationship. The leadership of programs and organizations were crucial in committing to achieve this expansion in programming.



practitioner in Brazil reported that, in the first year, the group moved to four different meeting spaces, including a garage with no door that exposed men to the street, and an uncomfortably hot room at the top of a building with no elevator. Programs have responded to the needs of low-income men by offering transportation vouchers, and by providing information on services of interest to low-income men, in addition to offering alternative ways of coping with economic pressures. Men who are less educated and/or unemployed also tend to drop out at a higher rate (DeMaris, 1989; Rooney & Hanson, 2001; Saunders & Parker, 1989 in Saunders, 2008), reinforcing the need for services that facilitate low-income men's ability to reach sessions.

### **(3) The Role of Justice Systems**

The role of the justice system in PM-IPV ranges from such programs being an integrated part of court referrals, to having weak or no ties. In Brazil, the U.S., and U.K., for example, nearly all men participate through mandated court referrals, whereas in Mozambique and Norway men appear voluntarily (in Mozambique no court system mechanisms have been established, and in Norway and other Nordic countries most referrals come from social services or men's own initiative). Often it is a combination, such as in Australia.

One important role — but one that was often identified as weak or inconsistent — was that of the justice systems' follow-up and enforcement of men's completion of programs. As Babcock et al. note (speaking of a U.S. context), "even the best court-mandated treatment programs are likely to be ineffective in the absence of a strong legal response in initial sentencing and in sanctioning offenders who fail to comply with treatment" (Babcock et al., 2004:1049). However, having watched PM-IPV develop over ten years in Pittsburgh, U.S., researcher Edward Gondolf noted that programs can, and typically do, start without adequate ties to the justice sector (Gondolf interview, 2012).

Interviewees reported two kinds of barriers from judges: (1) a lack of knowledge or sensitivity surrounding domestic violence, and (2) resistance to sending men to PM-IPV.

For instance, with courts and a law dedicated to domestic violence prevention, and PM-IPV in operation for over five years, Brazilian researchers and practitioners still described discrimination by judges, or dismissive attitudes toward the relational aspect of gender, such as a judge who remarked: "Isn't the [domestic violence] law about women? So why are you talking about men?" The facilitator of a PM-IPV group in Brazil added that some men had expressed interest in having judges visit the group; as a participant in this group observed, "[The judges and officials] don't come here to get to know the program, to hear our situation." Visits from judges and legal staff can also facilitate transparency (Areal interview, 2012).

At the same time, legislation on domestic violence or GBV has supported, at least on paper, the existence of PM-IPV. In Vietnam, once GBV and domestic violence laws were passed, local authorities were less able to deny the need for PM-IPV, according to an interview with CSAGA. In Indonesia, while the Domestic Violence Act enacted in 2003 makes provisions for the referral of men who use IPV to services, until recently hardly any such services were available. Local NGOs, using the Rutgers WPF's Men's Counseling Toolkit launched in 2012, are beginning to fill this gap, but advocacy and awareness-raising in the justice system are still needed.

Several cases also indicate that countries do not need to wait for policies that provide comprehensive specifications about PM-IPV. Brazil's domestic violence law (Maria da Penha) mentions that PM-IPV should be in place, but does not specify how. Several major shifts have had to take place in the Brazilian legal system, starting with the practice of criminalizing men for committing domestic violence in the first place, followed by the development of a referral system. As a primarily punitive law, Maria da Penha offers limited room for restorative or educational interventions for men (Soares, 2011). Several NGOs in Brazil are advocating for a specific public policy that would dedicate resources to PM-IPV and serve to move beyond a "project-by-project" phenomenon, something of which practitioners worldwide have complained.<sup>17</sup>



<sup>17</sup>Chile is an example where the judicial and executive branches together supported initiatives. The Bachellet administration opened five centers for men who have used violence (under the Interfamily Violence Law), followed by five centers under the current president backed by the Ministry of Justice. There are an additional six centers throughout Chile that follow the Duluth model, coordinated by the national women's service. Teams working with men who have used violence were nonetheless described as working in isolation, with a tendency not to evaluate or document experiences (Aguayo and Sadler, 2011).

## (4) Alternative and Complementary Practices

Acknowledging the challenges faced by PM-IPV, this paper advocates the testing and evaluation of other strategies to hold individual men accountable (aside from conviction, sentencing, and mandated programs), such as creating prevention spaces where men who feel they may use IPV can talk about violence before they use it. There has been limited evaluation of alternative and complementary approaches, and they should be considered with caution and as ways to complement rather than replace PM-IPV:<sup>18</sup>

- **Hotlines that offer support to men who perceive they are going to use violence and want to talk to someone.** A hotline in Sweden and another implemented by an NGO (WEM) in Costa Rica were designed to offer such support. One drawback is that these require that men be sufficiently self-aware that they may use violence, as well as willing to seek help.
- **Restorative/collective justice models:** The Gacaca courts in Rwanda, and community or restorative justice models in countries such as New Zealand, Australia, East Timor, and others should be considered as ways to hold men accountable for violence. Canada has several restorative justice models worth exploring, such as Circle Sentencing, in which judges and respected elders oversee the case in the community in which it occurs (SFU Centre for Restorative Justice, 2001). Similar mediation and restorative justice practices have been implemented in Aboriginal communities of Australia, along with individual and group counseling, night patrols, community education, traditional healing circles, and women's shelters (Cripps, 2007 and Memmott, et al., 2006 in Arney and Westby, 2012). These approaches should be considered with caution, as there have been no systematic evaluations of most types of restorative and collective justice mechanisms.
- **Alternative therapies:** A variety of other therapies have also emerged: anger management (an adaptation of cognitive-behavioral treatment), dialectical counseling, neuropsychological treatment, and couples

counseling (Gondolf, 2004). The major risk associated with using anger management as the basis for any therapeutic approach to programs for men who have used IPV is that the use of such violence is largely associated with power and control, rather than (or to a greater degree than) anger. Research on mediation for addressing IPV is largely negative and highlights the dangers of re-victimization. Generally, mediation and anger management were not well recommended in the evaluation literature, nor was couples counseling, unless safeguards are in place that ensure women feel safe and have not suffered severe violence (Saunders, 2008; Stith et al., 2003).

- It is clear in several settings that couples have expressed interest in joint counseling, but further evaluations are needed, including to understand when such counseling is appropriate and safe. In the interim, practitioners should proceed with caution. NGOs, such as Mosaic and NIRCO in South Africa, offer couples counseling in some cases, among other options. Other avenues to involve couples, but not in joint counseling, have also been explored. In Brazil, the NGO ISER said that both women victims and men participants expressed interest in mixed male-female discussion groups (although partners would not be in the same room); and the Noos Institute in Brazil held parallel groups for women and men.
- **Peer support models:** Creating positive, non-violent, male peer support, such as by training men as allies to support men who have recently completed PM-IPV, or matching men and women survivors with sponsors, may have a potentially positive role in reducing domestic violence (Hart, 2009). In Mozambique, HOPEM has stressed gathering men around activities they already participate in and meet around, such as going to bars on Fridays, which are popularly described as "men's day." Establishing support networks for men is also relevant given research that has noted men at times feel isolated from peers when they question or reject masculinities that may be dominant across those groups. Similarly, the group Abatangamuco in Burundi creates peer networks of men who hold other men accountable for their use of violence against female partners. This includes inviting a group of men (who are known to have used violence) to group discussions, offering them a chance to talk about

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<sup>18</sup>For more on the debates and controversy surrounding some alternative interventions, see: <http://www.endvawnow.org/en/articles/898-restorative-justice-programmes-remain-controversial.html>.

their stresses and frustrations, and identifying ways — with support and critiques from the group — to overcome violence.

## (5) Programming Challenges

- The interviews carried out for this review suggested the challenge of **naming programs** for “men who have used IPV,” particularly in settings where there is high IPV prevalence and where such violence is normalized and thus surrounded by silence. Taboos and sensitivity exist, including a reluctance to advertise “feminist” approaches, even if programs see gender roles as fostering violence (Rothman et al., 2003: 18). Similarly, many programs, including Rutgers WPF, use terms like “male clients” or “men who have used violence” instead of perpetrator/abuser to better reflect and encourage men’s potential for change.
- **Specificity according to culture, race, and ethnicity.** Openly criticizing culturally-endorsed, dominant notions of masculinity and norms of women’s acceptance of violence was a consistent challenge and priority shared by practitioners and researchers alike. Several respondents stressed that culture must not be used to justify violence (e.g., wife beating as an ancient custom), nor to place the responsibility on women (see UNFPA, 2007 for an example of a men’s group in Bangladesh). At the same time, PM-IPV must be relevant in their design and implementation, whether in Global North or South settings, according to diverse cultures, races, and ethnicities.<sup>19</sup> For example, a recent report by Arney and Westby (2012) discusses the problems with applying Western IPV program approaches with Aboriginal men in Australia, finding that the Western approaches overlook local family and community

dynamics, among other factors (also see McCalman et al., 2006).

- **Men’s attrition** is one of the greatest obstacles to effective PM-IPV, according to the literature on PM-IPV (see World Report on Violence and Health, 2002). Evidence from the U.S. shows that court mandates do not necessarily increase attrition (Daly and Pelowsky, 2000), but attendance-checking by partners or social services or legal personnel may.
- **Resistance** to PM-IPV — whether from governments and judicial systems, women’s rights advocates, men who have used violence, society as a whole, or some combination — is, unsurprisingly, highest in societies that have the greatest tolerance of domestic violence, and where governments have been slow to develop legislation or sign international treaties. In parts of Asia Pacific, Southeast Asia, and the Middle East (among other regions), PM-IPV are considered so taboo by society and government that they are not discussed; such settings have not adequately acknowledged men’s use of violence against women as a problem. Among male participants, taking responsibility for violence and recognizing non-physical forms of violence were also noted as forms of men’s own resistance.
- Related to resistance, difficulty obtaining adequate **funding for PM-IPV** was the most widespread challenge for researchers and practitioners alike. Even in countries in which government funding, however limited, is allocated, PM-IPV are vulnerable to being discontinued when resources are scarce or if there is a perception that services for victims will be reduced. Respondents suggested several funding strategies, including identifying areas that are receiving support and linking PM-IPV to those agendas, such as the funding “stream” in the U.S. for fatherhood programs.<sup>20</sup>

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<sup>19</sup>Racial/ethnic-specific models have been adapted for Pakistani, Indian, and Arabic-speaking immigrant men in the U.K., and for Latino and South East Asian men in the U.S. (Adams, 2009), in addition to groups tailored toward Native American and African-American men in the U.S. (Donnelly, Smith, & Williams, 2002; EMERGE, 2000; Smith, 2002 in Saunders, 2008). Practitioners generally agreed that the role of a skilled facilitator became fundamental in managing differences when holding separate groups for members of each population is not possible (for example, a practitioner explained the dilemma when over 100 languages are spoken in London). There are three types of culturally-specific programs, according to Williams and Becker (1994), who developed interventions for African-American men in the U.S.: color-blind programs that claim ‘differences don’t make a difference’; culturally centered programs that focus on the historical and contemporary experiences of certain cultural groups; and those that place a particular culture at the core of treatment and use culturally significant rituals. A man also must identify with the particular culture from which the intervention emerges for such an intervention to be meaningful to him. Programs must also consider minority male participants’ histories of discrimination (e.g., discrimination due to race, ethnicity, or immigrant status), and men’s resentment toward the criminal justice system and/or society at large, for the discrimination they have suffered (Saunders, 2008).

<sup>20</sup>Other suggestions included requiring men to pay, even if minimally, for PM-IPV. One U.K. researcher also mentioned taxing marriage licenses. Other programs with extremely limited funding started with prevention groups for men, and look to slowly develop small programs for men who are known to have used violence, as staff and funding capacity increase.



# Additional Considerations

In addition to the requisite conditions above and the need for more information and research in a relatively new field, MenEngage and partners recommend the following:

## **(1) Develop effective partnerships and networks**

for coordinated community responses. Engagement with four different sectors was identified as relevant: (1) to raise awareness about IPV and PM-IPV among judges and the judicial system, and police; (2) healthcare and social work professionals and substance abuse services, so their staff can make referrals when they encounter uses of IPV; (3) groups for women and children and other types of organizations working with the same goal of ending violence against women; and (4) the staff of similar PM-IPV and violence prevention programs.

## **(2) Invest significantly in improvement of staff training and capacity to implement PM-IPV.**

Training should include space for practitioners to challenge their own potentially harmful or biased views (Rothman et al., 2003) and follow gender-transformative approaches. For some PM-IPV in Indonesia and South Africa, this also entailed shifts in thinking among female counselors trained to work with women survivors. Staff skills should also include facilitating groups in ways that improve participation and hold men accountable without humiliation or alienation (Guedes, 2010). Healthcare, social service workers, and other providers who may come across men who have used violence should be trained to recognize and address violence against women — including domestic violence, IPV, and GBV — so that they can refer men to and help maximize the impact of PM-IPV. Worldwide, and especially in Global South countries, basic knowledge and sensitivity around GBV is lacking among service providers. For instance, a recent study in Guinea showed that less than one-third (28 percent) of healthcare providers interviewed had ever received training on GBV (The RESPOND Project, 2012).

## **(3) Consider formal certification to professionalize the PM-IPV field, and develop regional or national coordinating bodies.**

Such bodies, once established, should begin by consolidating best practices for a given region, and prioritize implementing standards for PM-IPV. Creating such coordinating bodies could enhance accountability of participants attending programs and program quality, develop standards or accreditation, and create joint strategies for lobbying and fundraising.

## **(4) Carry out additional research and program evaluations on PM-IPV.**

Research should be prioritized in settings where PM-IPV are emerging — in the Global South and in resource-poor settings, in particular. This includes enabling practitioners to be “evaluation-ready,” such as by increasing the number of participants in order to have a large enough sample; and enhancing evaluation capacity in Global South settings. Donors, UN agencies, and other organizations could support these evaluations and partnerships. Recognizing that there are very few Global South evaluations, colleagues with whom we spoke affirmed the need to be cautious about making inferences from one setting to another. Specific areas of research that still need to be addressed include:

- the effectiveness of mandated groups versus those not being monitored by courts or other authorities (Wathen & MacMillan, 2003);
- approaches to reducing dropout rates;
- addressing the effects of men’s childhood experiences of and exposure to violence given these experiences’ impact on adult use of violence (Barker et al., 2011 and Contreras et al., 2012);
- program length (Saunders 2008);
- ensuring cultural and racial-ethnic appropriateness;
- understanding women’s lack of reporting (due to cultural norms, normalization of violence, fear or lack of access);
- optimal coordination with services for women and children and CCR;
- implementing PM-IPV in settings of high urban violence, and conflict and post-conflict settings, exploring psychosocial and trauma-based approaches;
- cost-benefit analysis.

Ultimately, experimental and/or the most rigorously designed evaluations should be understood as important investments in impact measurement. When such evaluations are not feasible or programs are not at a stage at which such an evaluation is possible, however, practitioners and researchers should nonetheless collect important monitoring and evaluation data and apply that data toward improving PM-IPV, rather than wait to implement the most rigorous evaluation. Researchers should seek a balance between exploring appropriate study designs that may cater to diverse evaluation needs and capacity (i.e., operational and implementation research, process evaluations, and forms of theory-based evaluation) and, at the same time, seeking to measure impact as rigorously as possible to ensure credibility and to develop indicators of preventing and stopping violence and otherwise effective programs and overall program effectiveness.



## V. CONCLUDING REMARKS

If programs for men who have used IPV are going to continue to be implemented in the absence of consistent evidence of their effectiveness (as they almost certainly will), how can they be evaluated to identify best practices and eliminate IPV in settings across the world? Research conducted to date does offer considerable information for understanding some of the root causes and associated factors that must be integrated into interventions for men who have used IPV. The IMAGES study confirms previous research on men's use of IPV and their economic and work-related stress, their childhood experiences of violence, their inequitable attitudes about gender, and their alcohol use (Barker et al. 2011: 48). There are known benefits to PM-IPV such as reduced recidivism and allowing for monitoring of participants so that if risk escalates there is opportunity to take action to protect victims. Additional research is needed, however, to bring into focus the programming implications of these risk factors, particularly in resource-poor settings, and to expand

research in areas such as those mentioned here. GBV/ domestic violence national laws in isolation are insufficient without an examination of how they are implemented and how they limit or encourage PM-IPV, and according to which kinds of measures.

We know that comprehensively challenging men's violence entails, among other factors, wider change at the socio-cultural and political levels; deconstructing dominant forms of masculinity and entitlement that have traditionally been linked to violence and control over women at the household level and beyond; and identifying and fostering alternative forms of masculinity (Booznaier, 2008), including as non-violent partners, fathers, and caregivers. Clearly PM-IPV will not be able to achieve this multi-level change in isolation, but they can, when implemented with the considerations presented in this paper, be part of an integrated and coordinated response to reducing men's violence against their intimate partners in settings worldwide.

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## VII. ANNEX A

### A SUMMARY OF EVALUATION LITERATURE ON PM-IPV

This table represents a sample of major program evaluations conducted in the past decade, but is not exhaustive. Criteria for inclusion were publication in peer-reviewed journals and use of quasi-experimental designs and meta-analyses. The evaluation reviews demonstrate the range of outcomes and the number and complexity of variables to be controlled for during an evaluation. Additional types of reviews are included to demonstrate that, currently, programs in contexts worldwide must look to a variety of sources in order to develop practices and increase their capacity for rigorous evaluation. This review and others demonstrate the concentration of evaluations that have taken place in North America, reinforcing the need for evaluations to be developed in Global South contexts in particular. Further noteworthy evaluations are taking place, particularly in Latin America. These include an evaluation of the Centro de Intervención Conductual para Hombres in the Dominican Republic that has collected data on a number of indicators of program effectiveness (UN Women and UNFPA, 2013).

### QUASI-EXPERIMENTAL EVALUATIONS

Of the quasi-experimental and experimental (RCT) studies, the former are the most common. They compare program completers, or those who receive a certain dose in terms of attendance, to a group of program dropouts or 'no shows.' Critiques include the argument that such studies are comparing unlike groups (that is, that men who participate in the PM-IPV are different from those who do not). Experimental designs are sometimes considered more scientific and therefore a 'gold standard' for measuring success. There are also implementation challenges, such as finding a pure control group for such interventions (Gondolf, 2004). The three most comprehensive and rigorous evaluations of PM-IPV identified to date are as follows:

- Gondolf (2004) conducted perhaps the largest-scale quasi-experimental study with men who have used IPV. It entailed a large, naturalistic, comparative design across multiple sites in the U.S., with quasi-experimental studies within each of four sites and four-year follow-up. Results indicated that some programs were effective in stopping assault and abuse, that batterer intervention approaches show promise, and that the predominant, gender-based CBT approach may be appropriate for the majority of men in the study group.
- Labriola and colleagues conducted a randomized trial with a quasi-experimental comparison in the U.S., focusing on judicial monitoring in New York. Mandating offenders to batterer programs did not necessarily produce lower rates of re-abuse, which was in keeping with the findings of previous trials, but did increase victim satisfaction with the sentence.
- Feder and colleagues, focusing on the context of the U.S. criminal justice system shed light on the problems of uncontrolled variables within evaluation research. For instance, partners of men who drop out of PM-IPV may seek additional help at a shelter. Thus, women's seeking of protection, rather than (or in addition to) men's participation and retention or drop-out in PM-IPV – would need to be accounted for to explain any reductions or increases in IPV incidences.

Gondolf, 2004 (U.S.); Labriola et al., 2005 (U.S.); Feder & Dugan, 2002; Feder, Jolin, & Feyerharm, 2000 (U.S.)

## EVALUATION REVIEWS AND REVIEWS OF PROGRAM APPROACHES

Rutgers WPF conducted this review of program models and their effectiveness in order to inform the development of a male counseling program with partner organizations in South Africa and Indonesia. Literature worldwide was systematically surveyed. Among several conclusions and recommendations, the review found that a standardized, one-size-fits-all approach does not seem to be appropriate and that it may be too soon to know which model, if any, is superior. CBT and feminist approaches were found to have some positive effects, but results were mixed. The review concluded that participation in any program is better than receiving no treatment at all, in that it stops violent behavior in at least some men. Numerous risk factors are likely to be reduced if interventions take place on a multitude of levels.

Boonzaier, 2008 (International review)

This review of program types commissioned by the WHO delineates types of interventions occurring in different countries, describes approaches and training of interventionists, and communicates the results of evaluations. It indexes 56 programs for men who batter, including programs in high-, middle-, and low-income countries worldwide. Conclusions include identification of the need to establish process and outcome evaluations that will demonstrate how programs function effectively and in what ways they fall short. To prevent extenuating harm to victims and minimize potential waste of financial and human resources, expertly-designed, independently-conducted program evaluations are essential.

Findings from evaluation research surveyed in this study indicate that batterer intervention programs are at least modestly successful at preventing further abuse (Gondolf, 2002; Saunders, 1996). Reviews of U.S. and U.K. evaluations found that 50 to 90 percent of program completers remain nonviolent for six months to three years (Eisikovits & Edleson, 1989; Rosenfeld, 1992; Tolman & Bennet, 1990). One large-scale evaluation found program completers to be two-thirds less likely to physically re-assault their partners than those who drop out, even controlling for demographic and behavioral factors that might otherwise explain this difference (Gondolf, 2002). Intervention also inhibits renewed acts of nonphysical abuse by participants, although nonphysical forms of abuse are prevalent among program completers (e.g., 72 percent of men are verbally abusive 15 months after completing a program) and tend to increase in the years following program completion (Gondolf, 2002).

Rothman et al., 2003 (International review)

This meta-analytic evaluation review examined the findings of 22 U.S. studies of the efficacy of domestic violence treatment for men. The outcome literature of controlled quasi-experimental and experimental studies was reviewed to assess the relative impact of the Duluth model, CBT, and other treatment types on recidivism. Results showed little difference between CBT and Duluth Model effects. Overall, effects due to treatment were small, meaning that current interventions have a minimal impact on reducing recidivism. The authors note, however, that some people are able to dramatically transform their lives following substance abuse or battering interventions. Results showing little effect of treatment on violence abstinence do not imply that we should abandon our current intervention programs. Promising directions for increasing treatment efficacy include targeting treatments to specific subsamples, such as different ethnic minority groups, batterers who are chemically dependent, batterers at different motivational stages, different types of batterers (e.g., family-only, borderline, and antisocial/generally violent types). Practitioners should develop alternative techniques and collaborate with researchers to evaluate efficacy and develop evidence-based practices. Researchers need to also become aware of and analyze coordinated community responses (CCR) to domestic violence. Treatment programs are just one component of a CCR; police response, prosecution, and probation can also affect recidivism.

Babcock, Green, & Robie, 2004 (U.S.)



Morrison et al. reviewed 20 North American evaluation studies, and of those considered rigorous and/or which relied on victims' reports (fewer than 13), 55 percent were found to have a positive effect. Of all of the studies, one showed a negative effect, two-thirds showed a positive effect, and two showed no effect (criteria for showing a "positive effect" included demonstrating at least one positive effect and no negative effects).

Morrison et al., 2003 (North America)

The Canadian Task Force on Preventive Health Care reviewed 11 evaluation studies from Canada and found conflicting evidence, insufficient to recommend programs.

Wathen & MacMillan, 2003a, 2003b (Canada)

The authors reviewed four experimental and six quasi-experimental studies of court-mandated interventions in the U.S. Quasi-experimental studies that had a no-treatment comparison had inconsistent findings, indicating an overall small harmful effect. Quasi-experimental studies using a design that accounts for treatment drop-out showed a large, positive mean effect on domestic violence outcomes. They found a moderate effect when using official reports, and almost no effect when using victim reports, similar to what other meta-analyses have found.

Feder & Wilson, 2005 (U.S.)

A review of the evidence-based literature of PM-IPV (among victim services and others) focused on risk factors for IPV re-abuse in the U.S. It surveyed literature in the areas of batterer treatment effectiveness, the effectiveness of criminal and civil court remedies, the evaluation of victim services, and the course of violent relationships over time, absent any intervention. The article concluded that, while official reports indicated positive effects on violence cessation, victim reports do not; that traits and circumstances of men who have used violence seem to interact with the treatment type; and that women are accurate in predicting their risk regardless of whether it is assessed in close temporal proximity to an abuse episode. The conclusions were based on small samples.

Cattaneo & Goodman, 2005 (U.S.)

In *Programa Contexto* (University of Valencia), Spanish practitioners presented work done in the fields of research and training, as well as intervention for those convicted of domestic violence following the passing of Spain's GBV law (*Ley Orgánica 1/2004*). The authors describe the program's main characteristics and guidelines for intervention, in conjunction with its structure and different phases; the training provided, and the training activities developed by the team members; and the main lines of research guiding the work of the program team and their preliminary results. Though it is not an evaluation review, the article provides examples of program approaches and research, intervention and training.

Lila et al., 2010 (Spain)

## VIII. ANNEX B

This annex provides guidance about **prioritizing ethical standards and the safety and well-being of women and children** throughout PM-IPV, which are among MenEngage's conditions necessary for effective programs.

- One way of promoting the principle of 'Do no harm' (see Anderson, 1999) is to conduct **conflict sensitivity analyses**, mapping in two columns: (1) dividers and tensions affecting the program, and (2) connectors, or 'capacities for peace' working in favor of programs that aim to end violence. These could include relationship dynamics (positive and negative), services, or other external factors. The final step would be to identify how the program influences, positively or negatively, participants, staff, partners and others.
- Conflict sensitivity analyses should include **assessments of the justice system and wider structures in terms of potential risk to women, children and other family members**. It includes understanding referral and protective mechanisms, as well as judges' and legal staff's knowledge and attitudes surrounding PM-IPV. In Nicaragua and Brazil, practitioners described pressures that lead women to retract their charges — financial or emotional dependence on the man, distrust of or cynicism about the justice system, and not wanting to expose him to incarceration and its related risks. In Nicaragua, when women charge their partner with IPV, they are given an order and told to give that order to their partner. Because of this, the Nicaraguan practitioner stressed the need for personnel throughout the justice system who are able to address IPV with sensitivity.
- **Assess risk to women of armed domestic violence and partner homicide**. As part of assessing risk, the Danger Assessment Instrument (Campbell, 1986) screens for the risk of armed domestic violence and homicide. Application of this tool has shown that women in the U.S. who were threatened or assaulted with a gun or other weapon were 20 times more likely than other women to be murdered (Campbell et al., 2003). In the U.S., women are killed by intimate partners — husbands, lovers, ex-husbands, or ex-lovers — more often than by any other category of killer (Mercy et al. 1989, Bailey et al. 1997, Bachman et al. 1995 in Campbell et al. 2003).

Mullender and Burton (2000) provide the following recommendations for protection of women in the context of PM-IPV:

- inform the woman when her partner or ex-partner starts a program;
- keep her informed of his attendance, particularly if he drops out or is asked to leave before completion;
- warn her if they believe she is in any danger;
- check with her periodically about her safety (i.e., via risk assessments);
- inform her about the program and about ways in which the man may use it against her to reinterpret her behavior;
- tell her about other agencies and crisis services open to her;
- make her aware of the degree of change she can realistically expect, and ensure that she is never given false hope;
- offer her confidential contact at anytime;
- take a believing approach towards her;
- respect her confidentiality; and
- do not guarantee complete confidentiality to the man who has used violence or anyone else if this would place the woman at risk.

In safety planning, an abuser's access to a gun, threats with a weapon, or threats to kill should be assessed and taken extremely seriously (Campbell et al., 2003).

- **Identify sources and levels of risk to women, and provide ongoing support**. Steps such as these are vital. RESPECT, for instance, provides instructions for a woman victim on removing Internet tracks to prevent her abuser from seeing that she sought help. Often, attention is removed from the man once the woman is sheltered, but practitioners and researchers reaffirmed that mean track down their partners (Todd interview and others, 2012). According to Mills et al. (2006), assessment tools may help guide professionals, but should not be the only measures used to gauge the likelihood of violence or its magnitude. Programs must provide ongoing risk assessment and case management support, for the man who has used violence and for the survivor.

- **Where appropriate, support protection orders for high-risk cases.** Examples were given of when additional measures were needed: a man participating in a PM-IPV waited for his partner outside of a group for women survivors (Nicaragua); other men have come without an appointment to a women’s shelter, causing the shelter staff to call the police (Honduras). Each program should develop procedures for responding to high-risk cases, as appropriate to the context. In some settings (primarily in the Global North), this entails coordinating with the law enforcement or justice system around issuing and enforcing protection orders. Inevitably, the capacity of police to address IPV, practices around protection orders in a country, and women’s degree of trust in police will all affect the effectiveness of police responses to high-risk events and IPV.
- **Carefully assess whether contact should be made between the survivor/victim and her partner,** how it contact should be made, where, and at which points throughout PM-IPV (if any). “Victim liaisons” support and are present during these points of contact in the U.S. and several other countries.
- **Use client contracts with program participants and facilitators to set standards and establish limited confidentiality before interventions begin.** Contracts may include a professional code of conduct for facilitators/counselors, a client contract, and a limited confidentiality policy. The client contract entails men attesting and signing that they will engage in no violent behavior while participating in the program — toward partners and children, but also toward anyone they come into contact with (Rutgers WPF, 2012a). Practitioners interviewed agreed that confidentiality must be broken if a man is putting himself, his partner, or others at risk. The terms of confidentiality should be made explicit, and in a way that fosters trust within a group (Kelly, Amado interviews, 2012).
- **Incorporate risk assessment and ethics into monitoring and evaluation.** Even if they recognize the need for women’s and children’s safety, Mills and

colleagues (2006) point out that, in practice, “most batterer intervention programs and probation services have inconsistent contact with victims and often rely on a one-time contact. Rarely do they conduct more comprehensive safety assessments...” (Mills et al., 2006: 364). Safety/risk assessments must be systematic and ongoing. Rutgers WPF’s monitoring and evaluation tools include behavior monitoring, being attentive to indicators of change, using daily evaluation forms, and supervision/case presentation.

- **Involve women survivors in designing their own safety plans.** Their proximity to the man who has used violence and their experience with past incidents put women in a unique position to assess escalating danger and participate in creating a more comprehensive plan (Davies et al., 1998). A survivor’s assessment of her safety has been shown to be an accurate prediction of future violence (Mills et al., 2006).

## **Additional Recommendations from Interviews with Providers of Services for Women Survivors of Violence:**

- Exchange information between counselors of men’s and women’s groups, such as by having a female counselor sit in on a men’s group, with the participants’ permission, to better understand their experiences. In Vietnam, knowing a women’s group and a men’s group existed in the same province, for example, provided a basis for each group to discuss with the other, and thus strengthen each.
- Conduct home visits to ensure safety, enhance accountability, and assess the well-being of couples within their environment.
- Maintain central discussions of the power men possess, and the socialization of men. As the Honduran practitioner described, this deconstructing subsequently could provide room for constructing new, positive conceptions of what power, and shared power, could mean.<sup>21</sup>

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<sup>21</sup>Practitioners working with both women’s and men’s interventions conveyed similar ideas in terms of “starting points” or broaching the conversation with men who have used IPV: begin by asking men what they want in relationships, and by asking them about their own childhoods, families, and personal histories. A practitioner working with Latino men in the U.S., and the women’s organization in South Africa described that when asking men about what they wished for in a relationship, they often responded with desires such as love, peace, or stability in the home. The question then became how to get there, which required men to give up power that they were taking from their female partners (Arian interview, 2012).



- Recommendations similar to those shared by practitioners of men's groups included: to develop safety standards and hold men responsible; to raise awareness of and increase capacity to address domestic violence, particularly within the justice system and among healthcare workers; and to develop prevention programming for boys and male youth.
- Work with local leaders and authorities to establish strong partnerships (especially in more remote areas)

in order to elicit and foster support from them and, ultimately, hand the work of PM-IPV over to them.

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## MenEngage



MenEngage is a global alliance of NGOs and UN agencies that seeks to engage boys and men to achieve gender equality. MenEngage has a global steering committee with representation from all over the world and different regional networks in Sub-Saharan Africa, Latin America and the Caribbean, North America, South Asia and Europe. The coalition believes in working with boys and men from a positive perspective and encouraging them to be full partners in fostering a world where peace is possible, violence is reduced and equality is achieved.

## MenCare+



In Brazil, Indonesia, Rwanda, and South Africa, MenCare+ partners are working with the public health system to implement counseling/group therapy with men who have used violence. These interventions are part of a program with six components:

- Group education with young men on sexual and reproductive health rights (SRHR), gender equality, and caregiving
- Group education with fathers and their partners on SRHR/maternal health (MH, gender equality, and caregiving)
- Counseling/group therapy with men who have used violence
- Workshops with health sector workers on the importance of engaging men in SRHR and MH services
- MenCare Community campaigns focused on raising broader-level awareness of men's roles in fatherhood and caregiving
- Advocacy and alliance building with organizations/government who are working on these issues

The MenCare+ model corresponds to a key finding that emerged from this briefing paper: to include interventions as part of an integrated set of services and approaches in the context of a coordinated community response for ending intimate partner violence. Promundo, Rutgers WPF, and other partners are developing and testing evidence-based approaches to the preparation of public health systems for the incorporation of MenCare+ initiatives into their services in the next three years. These services include primary prevention and referrals for legal and psychosocial support for women and children who have experienced, or are experiencing, violence. The program is supported by the Ministry of Foreign Affairs of the Netherlands.

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