CREATING A CLIMATE OF ZERO TOLERANCE

SEXUALITY EDUCATION AS AN INSTRUMENT OF INTIMATE PARTNER VIOLENCE PREVENTION

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PART I

THE USE OF STUDIES ON INTIMATE PARTNER VIOLENCE RISK FACTORS FOR IMPROVEMENT OF SEXUALITY EDUCATION CURRICULA

Introduction

This document presents results of an analysis on what IPV risk factors could be prevented by introducing specific topics in sexuality education programs as part of their program content. This document is designed primarily for readers with backgrounds in education, criminology, or public health. In the document an international approach has been adopted, which is justified by different, innovative attitudes, and implementation of varying policy instruments to prevent intimate partner violence and educate adolescents about human sexuality.

There are many policy documents, scientific publications and legislation about intimate partner violence risk factors and about sexuality education. However, the issue of primary IPV prevention within sexuality education programs has not been properly addressed so far. This document aims to find out those IPV risk factors that could be embraced in sexuality education, and to disseminate the idea of multifaceted approach of the primary prevention of IPV that includes sexuality education as an instrument of IPV prevention.

Key Definitions

'Intimate Partner Violence' (IPV) is defined here as any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. For the purpose of this document IPV includes also dating violence that can

emerge in long-term partnerships, but can also be exerted by friends or even strangers.

'Primary IPV prevention' is a type of prevention that aims to hinder IPV before it occurs rather than seeking to achieve early detection of cases or prevent recurrence.

'Sexual health' is the integration of the somatic, emotional intellectual, and social aspects of sexual well-being in ways that are positively enriching and that enhance personality, communication and love[1].

'Sexuality education' is instruction on issues relating to human sexuality, including emotional relations and responsibilities, human sexual anatomy, sexual activity, sexual reproduction, reproductive health, reproductive rights, safe sex, birth control and sexual abstinence.

Background

Young age has consistently been found to be a risk factor for committing violence against an intimate partner (IPV), and for experiencing this type of violence.[2] According to representative studies, violence against adolescent girls from dating partners is prevalent.[3] In the WHO multi-country study 2–45% of women reported that their first sexual experience was forced, and for a majority of respondents this occurred

[1] World Health Organization (1975) Education and Treatment in Human Sexuality: The training of health professionals. Technical Report Series 572, 1975.

[2] WHO/LSHTM (2010). Preventing intimate partner and sexual violence against women: taking action and generating evidence: 27. http://apps.who.int/iris/bitstream/10665/44350/1/9789241564007_eng.pdf (last accessed: 27 April 2016); Vest JR et al. (2002). Multistate analysis of factors associated with intimate partner violence. American Journal of Preventive Medicine., 22(3):156-164; Romans S et al. (2007). Who is most at risk for intimate partner violence? A Canadian population-based study. Journal of Interpersonal Violence, 22(12):1495-1514; Kim HK (2008). Men's aggression toward women: A 10-year panel study. Journal of Marriage and Family. 70(5):1169–1187.

[3] Bowen E et al. (2013). Northern European Adolescent Attitudes Toward Dating Violence. Violence and Victims, 28(4):619-634; Valois RF et al. (1999). Relationship between number of sexual intercourse partners and selected health risk behaviors among public high school adolescents. Journal of Adolescent Health, 25(5): 328-335; Kreiter SR et al. (1999). Gender differences in risk behaviors among adolescents who experience date fighting. Pediatrics. 104(6):1286-1292; Silverman JG et al. (2001). Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. JAMA, 286(5):572-579.

during adolescence.[4] Women are more likely than men to experience fatal outcomes due to IPV, so this project focuses on women, but it is worth to note that the Centers for Disease Control and Prevention (CDC) have conducted studies demonstrating the prevalence and the need to also address IPV against women, perpetrated by other women and against men, perpetrated by either women or other men.[5] Rates of IPV are generally underestimated, often because of lack of awareness of what constitutes an IPV or the perceived lack of confidentiality in reporting. Adolescent girls who experience dating violence are more likely to exhibit high-risk behaviours.[6] According to studies, compared to their non-abused peers, abused women have higher rates of sexually transmitted infections (STIs), substance abuse, mental disorders and problems with access to medical care.[7] When IPV occurs during pregnancy, it may be associated with adverse pregnancy events such as miscarriage, pre-term births and stillbirths.[8]

However, teens are typically not targeted by IPV prevention efforts, because intimate relationships are not recognized prior to adolescence.[9] There is a consistent

[4]Garcia-Moreno C et al. (2005). WHO Multi-Country study on women's health and domestic violence against women, 14, http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf (last accessed: 27 April 2016). In fact a growing body of research suggests that the younger the age of sexual debut, the more likely it is that the first sexual experience is coerced: Osorio A et al. (2012) First Sexual Intercourse and Subsequent Regret in Three Developing Countries. Journal of Adolescent Health, 50(3):271-278; Dickson et al. (1998). First sexual intercourse: age, coercion, and later regrets reported by a birth cohort. BMJ, 316:29-33; Erulkar AS (2004). The experiences of sexual coercion among young people in Kenya. International Family Planning Perspectives, 30(4):182-189; Koenig M et al. (2004). Coerced first intercourse and reproductive health among adolescent women in Rakai, Uganda. International Family Planning Perspectives, 30(4):156–163.

[5] http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf (last accessed: 27 April 2016).

[6] Decker M. et al. (2005). Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis Among Adolescent Females. Pediatrics, 116(2):e272-e276.

[7] Plichta SB et al. (2001). Prevalence of violence and its implications for women's health. Women's Health Issues, 11(3):244-258; Vos T et al. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. Bulletin of the WHO 84(9):739-744; Campbell JC et al. (2008). The intersection of intimate partner violence against women and HIV/AIDS: a review. Int J Inj Contr Saf Promot., 15(4):221-231, Dunkle KL et al. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet, 363:1415-1421.

[8] Boy A et al. (2004). Intimate partner violence and birth outcomes: a systematic review. International Journal of Fertility and Women's Medicine, 49:159-164; Campbell JC (2002). Health consequences of intimate partner violence. Lancet, 359:1331-1336.

[9] Furman W et. al. (1999). The development of romantic relationships in adolescence. New York: Cambridge University Press.

call in the scientific literature to target prevention efforts on younger age groups.[10] Early interventions can be very effective in fostering skills at the individual level to develop healthy, respectful relationships. It was recommended that teens should be educated about appropriate and inappropriate sexual behavior during the formation of their attitudes to sex and romantic partnerships.[11] Moreover, WHO advised that IPV prevention should be integrated with program areas such as HIV/AIDS prevention, sexual and reproductive health or adolescent health promotion.[12] Sexuality education policies remain currently an urgent concern - the debates over how to properly educate young people on matters of sex and sexuality has increased in recent decades. There is no clear agreement within society about what type of curricula are the most suitable. Nevertheless, it would be difficult to dissent today that there is a need to prevent violence against women, and that this need could also be addressed through sexuality education. Effective prevention efforts require, however, an understanding of what works to prevent the violence that women experience. This study focuses on how to adopt some of the evidence-based strategies of IPV primary prevention to the research on sexuality education in order to improve the delivery of sexuality education and to also be effective in preventing IPV.

Need for interdisciplinarity

The project "Creating a climate of zero tolerance. Sexuality education as an instrument of intimate partner violence prevention" is placed within two scientific fields: criminology and public health. Criminology is a discipline that deals with nature, causes and prevention of criminal behaviour. It is interdisciplinary and links criminal law, psychology and sociology. Public health is also interdisciplinary, and deals with preventing disease and promoting health. Criminology and public health share a

[10] WHO/ LSHTM (2010). Preventing intimate…*op.cit*:33; Whitaker DJ et al. (2013). Effectiveness of Primary Prevention Efforts for Intimate Partner Violence. Partner Abuse, 4(2):175-195; Mercy JA et al. (1993). Public health policy for preventing violence. Health Affairs, 12(4):7-29.
[11] Whitaker DJ et al. (2013). Effectiveness of Primary Prevention Efforts for Intimate Partner Violence. Partner Abuse, 4(2):175-195.
[12] Garcia-Moreno C et al. (2005). WHO Multi-Country …*op.cit*: 24.

preventive approach – in both disciplines it is widely believed that prevention is better than addressing the consequences of human behaviours. Criminal justice systems and good legislations must be in place to properly manage IPV cases after it occurs. However, even in countries with the best laws against IPV, the problem is still prevalent and on the rise. The prevention of IPV is not only a criminological concern, but also a public health priority. The public health approach to IPV is science-driven and population-based. It aims to provide the maximum benefit for the largest number of people, while criminology focuses often on individuals. Linking public health and a criminological perspective into the prevention of IPV can extend safety from violence in the society to entire populations, but without ignoring the problems of individual women. Ultimately, there is a need for cooperative efforts of criminologists and public health experts to design effective science-based IPV prevention programs. Moreover, the public health approach to addressing IPV calls for a stronger focus on primary prevention[13] in contrast to secondary or tertiary prevention efforts typical of criminology. Primary IPV prevention aims to prevent IPV before it occurs rather than seeking to achieve early detection of cases or prevent recurrence. Until recently primary IPV prevention has been relatively neglected in the field. As Whitaker DJ et al. (2013) noticed, this discrepancy can also be seen at the community level - most communities have shelters for abused women and programs for court-ordered perpetrators of IPV, but relatively few offer preventive services.[14] Today, there is a clear consensus in the literature on the need for increased IPV primary prevention efforts.[15]

State-of-the-art

The prime concern in the field of sexuality education revolves around the idea of reducing the number of STIs and teen pregnancies but obviously includes other aspects related to reproductive and sexual health. Teaching about IPV during sexuality education is relatively new, but many sexuality education curricula include some

[13] Whitaker DJ et al. (2013). Effectiveness of Primary …*op.cit*.
[14] *Id.*
[15] Graffunder CM et al. (2004). Through a public …*op.cit*; Whitaker DJ et al. (2013). Effectiveness of …*op.cit*; WHO/LSHTM (2010). Preventing intimate …*op.cit*.

elements of IPV prevention that encourage positive social norms and non-violent behaviour towards intimate partners. Studies that examined the effectiveness of these interventions are scarce. Primary IPV prevention is increasingly acknowledged as a necessary and important complement to IPV prevention strategies. In spite of the emphasis, primary IPV prevention programs remain rare. The difficulty in preventing partner violence speaks to the etiologically complex nature of this behaviour and the multiple contributors. Review findings are relatively consistent that, next to young age, other IPV risk factors include: being a member of a minority group, low education, financial stress, lower income, lack of employment, alcohol or drug use/abuse, various personality disorders, depression, suicide-attempt history, sexual jealousy, impulsivity, attitudes and beliefs hostile to women, approval of IPV, exposure to parental IPV, child victimization, low bonding to parents and low parental monitoring, engagement in peer violence, general aggression, low relationship satisfaction and relationship discord.[16] Results on the association of collective efficacy (such as weak community sanctions against IPV) are mixed.[17]

Most popular primary IPV prevention programmes are dating violence prevention programmes such as *Safe Dates* (www.crimesolutions.gov/ProgramDetails.aspx?ID=142) or *Break the Cycle* (www.breakthecycle.org). These interventions teach skills to develop healthy, non-abusive relationships with dating partners, conflict resolution, communication skills and techniques for seeking help. Some of these programmes are integrated with education about sexual health and substance use prevention. Most of them are carried out in school settings and are universal interventions, but some target specific populations (athletes, homeless youth, young parents, members of minorities, or members of fraternities and sororities).

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[16] Schumacher JA et al. (2001). Risk factors for male-to-female partner physical abuse. Aggression and Violent Behavior, 6:281-352; Capaldi DM et al. (2012). A systematic review of risk factors for intimate partner violence. Partner Abuse, 3(2):231-280; Kantor GK et al. (1998). Dynamics and risk factors in partner violence. In: Jasinski JL, Williams LM, eds. Partner violence: a comprehensive review of 20 years of research. Sage:1-43; Vagi KJ et al. (2013). Beyond correlates: a review of risk and protective factors for adolescent dating violence perpetration. J Youth Adolesc. 42:633-49; Stith SM et al. (2004). Risk factor analysis for spouse physical maltreatment: a meta-analytic review. Aggression and Violent Behavior, 10:65-98.

[17] Capaldi DM et al. (2012). A systematic review …*op.cit*.

Evidence on the effectiveness of primary IPV prevention strategies is limited and only a few programmes have been subjected to a scientific evaluation. A majority of higher-quality studies is derived primarily from North America, but less rigorous evidence is available also from other countries. Dating violence prevention programmes have been the most evaluated of all IPV prevention programmes. Systematic reviews indicate that the effectiveness of these programmes looks promising. Whitaker DJ et al. (2006) systematically reviewed 11 studies that aimed at the prevention of IPV perpetration.[18] The objective of this study was to review adolescent partner violence prevention programmes that specifically target perpetration of partner violence in individuals who have not previously been known to be violent to their partners. Authors searched for articles published in the English language between 1990 and March 2003. Only two studies used randomized designs. The review discussed recommendations regarding the content and evaluation of dating violence prevention programs and summed up that conclusions about the overall efficacy of dating violence interventions are premature, albeit promising. Foshee VA et al. (2009) provided empirical findings related to efficacy of such programmes based on randomized trials, and concluded that although these studies look promising, more research is needed to provide conclusions and make recommendations for a widespread implementation of particular programs.[19] Similarly, Hickman LJ et al. (2004) assessed evaluations of adolescent dating violence prevention programs and urged for additional investment in high-quality basic research.[20]

One of the programmes that have been well researched is *Safe Dates*. It has been evaluated using a randomized controlled design, and positive effects were noted in all published evaluations.[21] Teens exposed to the programme reported less physical and

[18] Whitaker DJ et al. (2006). A critical review of interventions for the primary prevention of perpetration of partner violence. Aggression and Violent Behavior, 11:151.
[19] Foshee VA et al. (2009). Approaches to preventing psychological, physical, and sexual partner abuse. In O'Leary D, Woodin E, eds. Psychological and physical aggression in couples: Causes and Interventions. Washington DC, American Psychological Association:165-190.
[20] Hickman LJ et al. (2004). Dating violence among adolescents: prevalence, gender distribution, and prevention program effectiveness. Trauma Violence & Abuse, 5(2):123-142.
[21] Foshee VA et al. (1998). An evaluation of Safe Dates, an adolescent dating violence prevention program. American Journal of Public Health, 88(1):45-50; Foshee VA et al. (2000). The Safe Dates program: 1-year follow-up results. American Journal of Public Health, 90(10):1619-1622; Foshee VA, et al. (2004). Assessing

sexual dating violence perpetration and victimization than controls four years after the intervention.[22] In Canada Wolfe DA et al. (2003) evaluated two school-based programmes for preventing dating violence. A randomized-controlled trial showed that the intervention was effective in reducing incidents of physical and emotional abuse and symptoms of emotional distress over-time.[23] The other evaluated programme used a cluster randomized trial with 2.5-year follow-up, and it was found that the teaching of youths about healthy relationships as part of their required health curriculum reduced the violence.[24] There was a difference of 2.4% in the rates of physical dating violence between the programme group and the control group.[25] A study delivered by lawyers on an intervention that aimed to deliver information on how to get legal help in IPV situations showed improved knowledge, but no differences in recent abusive/fearful dating experiences or violence victimization or perpetration.[26]

A review of programmes working with men and boys by Barker G et al. (2007) included 13 primary prevention programmes.[27] Four of the reviewed programmes were assessed to be "effective", six "promising" and three "unclear". Programmes that work with men and boys to change their attitudes are promising, but more evaluation research is needed in order to ascertain whether these programs have an impact on IPV prevention. In the literature sets of best practices have been identified and recommendations have been made with respect to improving effectiveness of primary prevention.[28] For example Nation et al. (2003) identified nine principles of effective

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the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. American Journal of Public Health, 94:619-624; Foshee VA et al. (2005). Assessing the effects of the dating violence prevention program "Safe Dates" using random coefficient regression modeling. Prevention Science, 6: 245-258.

[22] Foshee VA, et al. (2004). Assessing the long-term effects …*op.cit*.

[23] Wolfe DA et al. (2003). Dating violence prevention with at-risk youth: a controlled outcome evaluation. Journal of Consulting and Clinical Psychology, 71(2):279-291.

[24] Wolfe DA et al. (2009). A school-based program to prevent adolescent dating violence: a cluster randomized trial. Archives of Paediatrics & Adolescent Medicine, 163:692-699.

[25] *Id.*

[26] Jaycox LH et al. (2006). Impact of a school-based dating violence prevention program among Latino teens: Randomized controlled effectiveness trial. Journal of Adolescent Health, 39(5):694-704.

[27] Barker G et al. (2007). Engaging men and boys in changing gender based inequity in health: evidence from programme interventions. WHO, http://www.who.int/gender/documents/Engaging_men_boys.pdf (last accessed: 27 April 2016).

[28] Krug EG et al. (2002). World Report on Violence and Health. WHO http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf (last accessed: 27 April 2016):15-17; Mercy JA et al. (1993). Public health policy…*op.cit.*

prevention programs: comprehensive, varied teaching methods, sufficient dosage, theory driven, positive relationships, appropriately timed, socio-culturally relevant, outcome evaluation, well-trained staff.[29] Small et al. (2009), drawing on existing research, highlighted eleven principles of program effectiveness: theory driven, sufficient dosage and intensity, comprehensive, actively engaging, developmentally appropriate, appropriately timed, socio-culturally relevant, well-qualified, trained and supported staff, focused on fostering good relationships, well-documented, committed to evaluation and refinement.[30]

Other primary IPV prevention programmes train men and boys to prevent violence against women: e.g. *Mentors in Violence Prevention* (www.jacksonkatz.com/aboutmvp.html), *Men Can Stop Rape* (www.mencanstoprape.org), *Coaching Boys into Men* (www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men) or *Men's Program* that showed promising evidence of behaviour change.[31] The purpose of these programs is to teach men and boys skills to change unhealthy attitudes and behaviours and increase the likelihood of bystander interventions. Although many of these programmes typically target changes in attitudes and knowledge (as they hypothetically lead to changes in violent behaviour) it is uncertain if these variables are relevant to prevention of IPV.[32] Rape education programmes that are often implemented have been shown to be ineffective.[33] There is currently limited empirical evidence linking legal or sexual knowledge to sexual violence perpetration.[34]

To sum up, IPV is prevalent and is a serious problem, yet it remains not fully clear which primary interventions effectively reduce the violence. Comprehensive programmes are usually considered more effective than those that focus merely on

[29] Nation M et at. (2003). What works in prevenion. Principles of effective prevention programs. American Psychologist, 58(6/7): 449-456.
[30] Small AS et al. (2009). Evidence-Informed Program Improvement: Using Principles of Effectiveness to Enhance the Quality and Impact of Family-Based Prevention Programs. Family Relations, 58(1):1-13.
[31] Foubert JD et al. (2007). Behavior differences seven months later: effects of a rape prevention program. NASPA, 44(4):728-749.
[32] Whitaker DJ et al. (2013). Effectiveness of Primary …*op.cit*.
[33] WHO/LSHTM (2010). Preventing intimate …*op.cit*.:66.
[34] Tharp AT et al. (2011). Commentary on Foubert, Godin, & Tatum (2010) the evolution of sexual violence prevention and the urgency for effectiveness. Journal of Interpersonal Violence, 26(16): 3383-3392.

delivery of knowledge and altering attitudes, while overlooking other IPV risk factors. However this problem is so multifaceted that it is likely to benefit from different approaches and objectives being implemented simultaneously and to different target populations. Moreover, the research on effectiveness of the programmes is mostly delivered in North America, might be culture-bound, and may have limited extrapolation value to other settings. The field of IPV primary prevention is considered to be at its earliest stages in terms of having an established evidence base.[35] Whitaker DJ et al. (2013) called to expand the understanding on which programs are effective, why they are effective, and how to disseminate them broadly without compromising effectiveness.[36] However, while the evidence base is being built the programs with limited evidence may need to be disseminated and implemented.[37]

Sexuality education can be an efficient instrument for addressing IPV, in addition to other resources, as it is relevant for all four categories of risk factors developed by the CDC: individual (e.g. emotional dependence), relationship (e.g. lack of assertiveness skills), community (e.g. being a bystander), and societal (e.g. adherence to harmful traditions, gender norms).[38] Sex education programs are pretty widespread nowadays, and the need for their implementation are widely accepted, although there can be controversy on specific contents. This is an opportunity for sex education to also play an important role in the multifaceted approach of the primary prevention of IPV. It would be useful to identify what risk factors of IPV can be widely accepted to educators and introduced in sex education programs so that they would end up being widely spread. A second approach would include studying the evidence on the effectiveness of spreading such messages and skills through sex education.

Objective

[35] World Health Organization/London School of Hygiene and Tropical Medicine (2010). Preventing intimate …*op.cit*.:37.
[36] Whitaker DJ et al. (2013). Effectiveness of Primary …*op.cit*.
[37] Tharp AT et al. (2011). Commentary on Foubert, …*op.cit*.
[38] http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/riskprotectivefactors.html (last accessed: 27 April 2016).

The overall aim of the project "Creating a climate of zero tolerance. Sexuality education as an instrument of intimate partner violence prevention" is to **give insights into how sexuality education can better serve as an instrument of IPV prevention**. The specific objective from Work Package I is to **examine what IPV risk factors could be prevented by introducing specific topics in sexuality education programs as part of their program content**.

Method

The project "Creating a climate of zero tolerance. Sexuality education as an instrument of intimate partner violence prevention" is transdisciplinary and situated at the intersection of mainly public health and criminology, but also law, psychology and education. Sexuality education and IPV prevention have many dimensions and therefore several approaches and data sources need to be combined in its study. The first of these dimensions is an analysis of studies that have evaluated risk factors of IPV. We identified those risk factors that are applicable to core content of curriculums of sexuality education programs. These sex-education-related risk factors, and thus the issues to work on during sexuality education programs, have been summarized in a table. They have been chosen taking into account the operational definitions of sexual health and sexual education.

Findings

A list of IPV risk factors has been identified on the website of the American Centers for Disease Control (CDC): http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/riskprotectivefactors.html.

The CDC is one of the major operating components of the Department of Health and Human Services in the United States.[39] It is the national health protection

[39] http://www.cdc.gov/about/organization/cio.htm. 27 April 2016

agency.[40] To accomplish its mission, CDC conducts critical science and provides health information that protects against expensive and dangerous health threats, and responds when these arise[41]. It is known internationally for the quality of their scientific contribution to public health research. This served as an assurance that the CDC classification can be considered as a reliable source and is based on sufficient scientific evidence.

The CDC offers the following classification of IPV risk factors:

Risk Factors for Intimate Partner Violence

Individual Risk Factors

- Low self-esteem
- Low income
- Low academic achievement
- Young age
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Anger and hostility
- Antisocial personality traits
- Borderline personality traits
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Desire for power and control in relationships

[40] http://www.cdc.gov/about/organization/cio.htm. 27 April 2016
[41] http://www.cdc.gov/about/organization/cio.htm. 27 April 2016

- Perpetrating psychological aggression
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child

Relationship Factors

- Marital conflict-fights, tension, and other struggles
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other
- Economic stress
- Unhealthy family relationships and interactions

Community Factors

- Poverty and associated factors (e.g., overcrowding)
- Low social capital-lack of institutions, relationships, and norms that shape a community's social interactions
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

Societal Factors

- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

Next, the authors looked into systematic reviews. The reviews have been chosen based on the quality of their scientific impact. The following reviews have been chosen for the analysis:

1) Capaldi DM, Knoble NB, Shortt JW, Kim HK. A Systematic Review of Risk Factors for Intimate Partner Violence . Partner abuse 2012(3): 231-280. doi:10.1891/1946-6560.3.2.231. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384540/

2) Julie A Schumacher, Shari Feldbau-Kohn, Amy M Smith Slep, Richard E Heyman. Risk Factors for Family Violence. Aggression and Violent Behavior 2001(6):281–352. Available at: http://www.sciencedirect.com/science/article/pii/S1359178900000276

Two experts (public health expert and a criminologist) have agreed on the choice of the risk factors, and thus the issues to work on during sexuality education programs. The risk factors have been chosen taking into account the operational definitions of sexual health and sexual education. In the light of these definitions, the experts looked at these risk factors that relate to keywords: "emotional", "social" "personality", "communication", "responsibility" and "rights".

The following IPV risk factors have been chosen:

1) CDC classification:

Individual Risk Factors

- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Desire for power and control in relationships

Relationship Factors

- Dominance and control of the relationship by one partner over the other
- Unhealthy family relationships and interactions

Community Factors

- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

2) Capaldi DM, Knoble NB, Shortt JW, Kim HK. A Systematic Review of Risk Factors for Intimate Partner Violence . Partner abuse 2012(3): 231-280. doi:10.1891/1946-6560.3.2.231. From this article the following risk factors have been added:

- hostile attributions, attitudes, and beliefs
- hostility
- social and emotional support
- school context

3) Julie A Schumacher, Shari Feldbau-Kohn, Amy M Smith Slep, Richard E Heyman. Risk Factors for Family Violence. Aggression and Violent Behavior 2001(6):281–352. From this article the following risk factors have been added:

- permissiveness in respect to aggression
- approval of aggression
- low in masculinity
- stereotyped sex-role attitudes
- attributing negative intentions and selfish motivation to their partner
- negativism
- low self-esteem
- anxiety over abandonment
- avoidance of dependency
- discomfort with closeness
- feeling less related to others
- poorer general verbal ability (communication)
- less positive communication
- more demand in communication

The following IPV risk factors have been summarized in the Table 1 presented below including information to what type of risk factors they belong according to CDC classification.

Table 1. Risk factors that could be prevented in sexual education programs and indication of where they belong in the CDC classification of IPV 4 risk factor groups.

Risk factor for IPV	Type of risk factor according to CDC classification
Emotional dependence and insecurity	individual
Belief in strict gender roles (e.g., male dominance and aggression in relationships)	individual
Desire for power and control in relationships	individual
Unhealthy family relationships and interactions	relationship
Dominance and control of the relationship by one partner over the other	relationship
Weak community sanctions against ipv (e.g., unwillingness of neighbors to intervene in situations where they witness violence)	community
School context	community
Social and emotional support	community
Hostility	individual
Hostile attributions, attitudes, and beliefs	individual
Negativism	individual
Low self-esteem	individual
Anxiety over abandonment	individual
Avoidance of dependency	individual
Discomfort with closeness	individual
Feeling less related to others	individual
Poorer general verbal ability (communication)	individual
Less positive communication	individual
More demand in communication	individual
Attributing negative intentions and selfish motivation to their partner	individual
Stereotyped sex-role attitudes	individual
Low in masculinity	individual
Approval of aggression	individual
Permissiveness in respect to aggression	individual

The evidence of the scientific grounding of these risk factors has been first assessed through analysis of the literature available on the CDC website. Their bibliographies have been reviewed for additional relevant articles. The risk factors connected with affective dependency have been reviewed in more detail. The results of the review are presented in the table below. The table presents the name and source of the study, main findings and risk factor that the study addressed.

Table 2. Retrieved studies and their findings with indication of the risk factor they address and

AUTHOR, YEAR	STUDY DESIGN/METHODS	FINDINGS	RISK FACTOR/S ADRESSED
Frieze, Browne, 1989[42]	Literature review	• studies are not consistent what power means • husbands violent when they did not get their way • white male married to non-white women tend to be violent • underachievers use more violence	power
Coleman, Straus 1986 [43]	Data on a nationally representative sample of 2,143 couples are used to study the relationship to marital violence of the power structure of	Controlling men are more violent	controlling freedom of movement controlling finances monitoring place of stay

[42] Frieze, I., A. Browne, "Violence in Marriage," in Family Violence, eds. L. Ohlin and M. Tonry, Chicago: University of Chicago Press, 1989: 163– 218.

[43] Coleman, Diane H.; Straus, Murray A. "Marital Power, Conflict, and Violence In a Nationally Representative Sample of American Couples", Violence and Victims, Volume 1, Number 2, 1986, pp. 141-157(17).

	marriage, power norm consensus, and the level of marital conflict. The couples were classified as equalitarian, male-dominant, female-dominant, or divided power.		
Levinson, D., 1989[44]	Review of cross-cultural studies	„Overall, hostility toward women by men, and attitudes approving of or justifying IPV by either men or women, are low to moderate proximal predictors of IPV."	hostility attitudes
Frieze, Browne, 1989[45]	Review of empirical studies	aggression-tolerant attitudes and hostile couple relationships were significantly related to dating aggression involvement after controlling for gender and overall risk	hostile talk about women
Connolly, 2010.[46]	cross-national comparison	hostility toward women accounted for a small amount of	hostility toward women

[44] Levinson, D., Violence in Cross-Cultural Perspective, Newbury Park, California: Sage Publications, 1989

[45] Irene Hanson Frieze, Angela Browne, Crime and Justice,163-218, University of Chicago Press, University of Chicago, Violence in Marriage, volume 11, 1989

[46] Connolly J, Nocentini A, Menesini E, Pepler D, Craig W, Williams TS. Adolescent dating aggression in Canada and Italy: A cross-national comparison. International Journal of Behavioral Development. 2010;34(2):98–105

		variance in MFPV (1%) in the presence of other factors (e.g., demographics, child abuse, anger/impulsivity), but hostility toward men did not account for variance in FMPV.	
White, 2001[47]		reciprocal IPV, in particular, was likely to be associated with attitudes approving of IPV	attitudes approving of IPV
McKinney, 2009 [48]	Survey using multistage cluster sampling	approval of violence against spouses and children was related to the frequency of perpetrating IPV	approval of violence against spouses and children
Markowitz, 2001[49]	Latent- variable measurement models	attitudes approving of marital violence were a correlate for the men's and women's reports of MFPV	approving of marital violence

[47] White JW, Merrill LL, Koss MP. Predictors of premilitary courtship violence in a Navy recruit sample. Journal of Interpersonal Violence. 2001;16(9):910–927

[48] Childhood family violence and perpetration and victimization of intimate partner violence: findings from a national population-based study of couples. McKinney CM, Caetano R, Ramisetty-Mikler S, Nelson S
Ann Epidemiol. 2009 Jan; 19(1):25-32

[49] Markowitz FE. Attitudes and family violence: Linking intergenerational and cultural theories. Journal of Family Violence. 2001;16(2):205–218

Kalmuss,1982.[50]	Study on a representative sample	High subjective dependency scores were associated with an increased likelihood of physical aggression (e.g., "threw something at [partner]", "slapped [partner]"), whereas high objective dependency scores were associated with an increased likelihood of severe abuse or life-threatening violence (e.g., "threatened [partner] with a knife or gun").	subjective dependency objective dependency
Strube, 1983.[51] Strube, 1984.[52]	Studies on a representative sample	1983 - sample consisted of 98 women who had contacted the domestic violence counseling unit of a county attorney's office + nonoverlapping 1984 sample consisted of 251 women who had sought domestic violence counseling from various sources.	subjective dependency

[50] Kalmuss, D. S., & Straus, M. A. (1982). Wife's marital dependency and wife abuse. *Journal of Marriage and the Family*, *44*, 277–286

[51] Strube, M. J., & Barbour, L. S. (1983). The decision to leave an abusive relationship: Economic dependence and psychological commitment. *Journal of Marriage and the Family*, *45*, 785–793

[52] Strube, M. J., & Barbour, L. S. (1984). Factors related to the decision to leave an abusive relationship. *Journal of Marriage and the Family*, *46*, 837–844

		In both samples, subjective dependency scores were weakly (and nonsignificantly) related to relationship termination decisions. subjective dependency scores were based on questionnaire responses tapping a range of dependency domains	
Watson, 1997. [53]	The abused women were people who reported that they had been abused and who had either a) participated in programs for domestic abuse survivors or b) been identified as victims of domestic abuse after an interview with a licensed psychologist. The comparison group were women who denied having received services from programs for abused women	Abused women were recruited through therapists and domestic abuse survivors' groups; control participants were community volunteers. Although Watson et al. found only a modest (and statistically nonsignificant) increase in DPD (dependent personality disorder) prevalence rates in abused women relative to controls, $\chi^2(1, N = 183) = 2.41$, $p = .10$, they obtained a strong relationship between DPD	dependent personality disorder

[53] Watson, C. G., Barnett, M., Nikunen, L., Schultz, C., Randolph-Elgin, T., & Mendez, C. M. (1997). Lifetime prevalences of nine common psychiatric/personality disorders in female domestic abuse survivors. *Journal of Nervous and Mental Disease*, *185*, 645–647

		symptom levels and severity of physical abuse within the abused sample (r = .69, p < .01)	
Hastings,1988.[54]	controlled comparison	Millon Clinical Multiaxial Inventory (MCMI) dependency scores of 125 male spouse abusers participating in a domestic violence treatment program and 43 nonabusing men recruited from marriage and family therapy clinics. Abusers in Hastings and Hamberger's sample obtained slightly (but not significantly) lower MCMI dependency scores than control participants.	dependency
Beasley, 1992[55]	Eighty-four men in abusive or nonabusive but distressed relationships completed the Millon Clinical Multiaxial Inventory-H (MCMI-II)	reported no differences in MCMI–II dependency scores between 49 male spouse abusers recruited from a support group and 35 men in	dependency

[54] Hastings, J. E., & Hamberger, L. K. (1988). Personality characteristics of spouse abusers: A controlled comparison. *Violence and Victims*, *3*, 31–48

[55] Beasley, R., & Stoltenberg, C. D. (1992). Personality characteristics of male spouse abusers. *Professional Psychology: Research and Practice*, *23*, 310–317

		nonbattering relationships who had initiated contacts with marriage clinics or a university counseling center.	
Porcerelli, 2004[56]	Shedler Westen Assessment Procedure (SWAP-200) to contrast DPD symptom levels in 25 physically abusive men and 27 martially distressed men with no history of partner abuse.	Physically abusive mens sample obtained slightly (but not significantly) lower DPD symptom ratings than maritally distressed, nonabusive men.	dependency
Gondolf, 1999[57]	MCMI–III to contrast the prevalence rates of DPD in three groups: (a) 1,012 Canadian and American men participating in voluntary and court-ordered batterer treatment programs, (b) 100 substance-abusing men from an outpatient treatment program, and (c) 600 men and women undergoing outpatient treatment for other psychiatric disorders.	Gondolf found that the base rate of DPD in partner abusers (14%) was significantly lower than that in substance abusers (38%) and other psychiatric outpatients (48%).	dependency

[56] Porcerelli, J. H., Cogan, R., & Hibbard, S. (2004). Personality characteristics of partner violent men: A Q-sort approach. *Journal of Personality Disorders*, *18*, 151–162

[57] Gondolf, E. W. (1999). MCMI-III results for batterer program participants in four cities: Less "pathological" than expected. *Journal of Family Violence*, *14*, 1–17

Hart, 1993 [58]	DPD was assessed via questionnaire (i.e., the MCMI–II) or interview (i.e., the Personality Disorder Examination [PDE])	low DPD prevalence rates in court-referred and self-referred male abusers (*n* = 85) regardless of whether DPD prevalence rates sample were 2.5% and 0.0%, respectively, when assessed with the MCMI–II and the PDE.	dependency
Murphy, 1994.[59]	Compared dependency levels in three groups of men: (a) 24 partner-assaultive men requesting treatment, (b) 24 nonviolent men in discordant marriages, and (c) 24 nonviolent men in happy or satisfying marriages. Participants in the latter two groups were recruited through newspaper advertisements; questionnaire measures of marital adjustment and relationship dynamics were completed by potential volunteers to confirm group classification.	Partner-assaultive men obtained significantly higher IDI and SSDS scores than did the men in either control group, $F(2, 69) = 12.86$ and $F(2, 69) = 12.02$, respectively, both *p*s = .001.	dependency
Holtzworth-Monroe, A.,	SSDS-derived dependency scores	Violent-distressed partner-	dependency

[58] Hart, S. D., Dutton, D. G., & Newlove, T. (1993). The prevalence of personality disorder among wife assaulters. *Journal of Personality Disorders*, *7*, 329–341

[59] Murphy, C. M., Meyer, S. L., & O'Leary, K. D. (1994). Dependency characteristics of partner assaultive men. *Journal of Abnormal Psychology*, *103*, 729–735

1997.[60]	in three groups of men that paralleled those of the earlier study: (a) 58 violent-distressed, (b) 36 nonviolent-distressed, and (c) 22 nonviolent-nondistressed.	assaultive men had higher SSDS scores than did members of the other two groups, $F(2, 118) = 12.23$, $p < .001$, $d = .69$; link between dependency and abuse status than between jealousy and abuse status ($d = .42$). Three indices of adult attachment (i.e., anxiety over abandonment, discomfort with closeness, and avoidance of dependency) also showed weaker relationships with abuse status than did SSDS dependency scores (ds were .48, .53, and .28, respectively).	
Kane, 2000.[61]	IDI scores in three groups of men	Abusive men had significantly higher IDI scores than men in the other two groups, $F(2, 76) = 10.36$, $p < .001$, $d = .74$.	dependency
Waltz, 2000.[62]	MCMI–II dependency scores in 40 FO, 17 BD, and 18 GVA men	No differences in dependency levels across the three groups.	dependency

[60] Holtzworth-Monroe, A., Stuart, G. L., & Hutchinson, G. (1997). Violent versus nonviolent husbands: Differences in attachment patterns, dependency, and jealousy. Journal of Family Psychology, 11, 314–331.
[61] Kane, T. A., Staiger, P. K., & Ricciardelli, L. A. (2000). Male domestic violence: Attitudes, aggression, and interpersonal dependency. Journal of Interpersonal Violence, 15, 16–29
[62] Waltz, J., Babcock, J. C., Jacobson, N. S., & Gottman, J. M. (2000). Testing a typology of batterers. Journal of Consulting and Clinical Psychology, 68, 658–669

	(defined using a battery of interview, questionnaire, and archival measures),	Moreover, MCMI–II dependency scores in the three batterer groups did not differ from those in a control sample of 32 maritally distressed nonviolent men (F = 1.13, ns).	
Babcock, 2004.[63]	Proximal Antecedents to Violent Episodes (PAVE) scale—to assess men's likelihood of exhibiting physically aggressive behavior in response to various partner-specific events and interactions	. Factor analysis of PAVE items revealed three distinct abuse-eliciting situations: (a) Violence to Control the Partner, (b) Violence Out of Jealousy, and (c) Violence Following Verbal Abuse. Babcock, Costa, et al. then administered the PAVE to 70 maritally distressed violent men classified according to Holtzworth-Monroe and Stuart's (1994) typology, finding that FO batterers (n = 41) obtained significantly higher scores than BD (n = 17) or GVA (n = 12) batterers on the Violence Out of Jealousy scale, $F(3, 97) = 3.66$, $p < .05$, $d = .39$. Moreover, FO batterers	control jealousy communication

[63] Babcock, J. C., Costa, D. M., Green, C. E., & Eckhardt, C. I. (2004). What situations induce intimate partner violence? A reliability and validity study of the Proximal Antecedents to Violent Episodes (PAVE) scale. Journal of Family Psychology, 18, 433–442

		obtained lower scores than BD or GVA batterers on the Violence to Control the Partner and Violence Following Verbal Abuse scales, suggesting that proximal increases in jealousy may be uniquely predictive of partner abuse episodes in highly dependent men.	

CONCLUSIONS & OUTLOOK

The classification provided at the CDC website was a good starting point for the research on risk factors. Especially useful were “additional resources”. Sexuality education is relevant for all four categories of risk factors developed by the CDC: individual (e.g. emotional dependence), relationship (e.g. lack of assertiveness skills), community (e.g. being a bystander), and societal (e.g. adherence to harmful traditions, gender norms). The classification has been additionally supported with relevant systematic reviews. Their bibliographies were extensive and gave opportunity to expand the research to new resources and find many titles, which address directly the problem of IPV risk factors. Most reviewed articles call for more research on this topic. The IPV risk factors have been summarized in the Table 1, which includes information to what type of risk factors they belong according to CDC classification.

Affective dependency is a good example of an IPV risk factor that can be addressed via sexuality education, and successfully applied to core contents of sexuality education programs. Based on the literature analysis it was possible to uncover theoretical proposed framework for dependency being an IPV risk factor. The first type of dependency is the one experienced by the abused partner - dependence model of commitment in intimate relationships. In this model people stay in certain relationships because they believe these relationships provide rewards that cannot be obtained elsewhere. The dependency can be subjective (fear of abandonment and rejection) or objective (e.g. economic dependency). This is different from dependency-possessiveness model where the emotional dependency increases the likelihood that this person will physically abuse the other member of the relationship. Emotionally dependent person with defective affectivity posits high levels of jealousy and possessiveness, coercive control, difficulty managing anger and other negative emotions. According to the results of this review trait dependency scores predict likelihood of abuse perpetration in men, but dependent personality disorder symptoms do not.

The examination of the IPV risk factors showed that they are quite diverse and science-based. Some of them could be prevented by introducing specific topics in sexuality education programs as part of their program content.

PART II

PREVENTION OF INTIMATE PARTNER VIOLENCE IN SEX EDUCATION PROGRAMS

Introduction

This document presents results of a search of literature on sex education programs that include contents to prevent IPV. Sex education is perceived today and carried out in a traditional way, which focuses mainly on reproductive health, prevention of pregnancies and STIs[64]. However, sex education can be also become an efficient instrument for addressing IPV. The aim of the review is to find studies of sex education programs that include content to prevent IPV and evaluate what evidence of effectiveness to prevent IPV these studies present. Therefore the review is mostly focused on academic journals, but newsletters have also been taken into account.

Objectives

The specific objectives from Work Package II are to **search for literature on sex education programs that include contents to prevent IPV, evaluate what evidence of effectiveness these programs have to prevent IPV and summarize this literature analysis in a combined manner (programs, specific contents following CDC classification and coding of level of evidence).**

[64] See e.g. http://www.unfpa.org/comprehensive-sexuality-education.

Method

In the first phase of the study, literature review has been carried out using the terms related to intimate partner violence and sex education. The terms have been chosen depending on the database thesaurus[65]. In the second part of the study instead of the terms related to intimate partner violence, terms related to IPV risk factors, enlisted in WP 1 have been utilized. The following MeSH terms have been chosen: "gender roles", "affective/romantic relationships", "immaturity" and "dominance". To link those two fields the connector "AND" has been utilized. The following databases have been reviewed: Google scholar, Jstor and SSRN and databases for given disciplines: public health (PubMed, Web of Science), psychology (PsychInfo, Psych net), law (LexisNexis Academic, Index to foreign legal periodicals) and criminology (National Criminal Justice Reference Service)[66]. In most cases the option "advanced search" or its equivalents has been used. In LexisNexis Academic the database International legal research was searched using Power Search "Term and connectors" type and "Search in at least 5 occurrences." Books have been searched through Google books and WorldCat. The second phase has been restricted to PubMed database.

Signing up for newsletters is important to reach the objectives, as the newsletters are good sources of relevant information. Although they are not academic, in contrast to journals, newsletters contain up-to-date information.

The most relevant newsletters in the field of sex education:

Contemporary Sexuality www.aasect.org

Sex, Etc. Magazine www.sexetc.org

The most relevant newsletters in the field of violence prevention:

Cure Violence cureviolence.org

[65] E.g. MESH terms Intimate partner violence, Sexuality education, Intimate partner abuse have been used in those databases that use the MESH terms.

[66] The following databases were not available at UNAV: Criminal Justice Abstracts, Criminal justice periodical index, ASSIA, PsychExtra, Academic search premier.

Violence Prevention Works www.violencepreventionworks.org

Findings

In order to perform the literature review, appropriate terms had to be identified. For **intimate partner violence** the following phrases have been chosen:

intimate partner violence

partner violence,

domestic violence,

spouse abuse,

sexual abuse,

partner abuse,

battered women,

dating violence,

dating abuse,

partner aggression,

violence,

aggression

abuse

For **sex education** the following phrases have been chosen:

sex education

sexuality education

For IPV risks the following MeSH Terms have been chosen:

gender roles

affective/romantic relationships

immaturity

dominance.

After the first phase, altogether 21 books and articles on sex education and IPV prevention have been found, but none of them includes evaluation of programs with contents to prevent IPV. Therefore it was not possible to evaluate what evidence of effectiveness these programs have to prevent IPV and summarize this literature analysis in a combined manner (programs, specific contents following CDC classification and coding of level of evidence). One of the articles (Haberland, 2015) included literature on various reproductive health-related programs that include content on gender and power in sexual relationships. The aim of her study was to explore whether the inclusion of content on gender and power matters for program efficacy. The author does not specifically define terms "gender" and "power", but accounts for lack of clarity of these terms. She conducted electronic and hand searches to identify rigorous sexuality and HIV education evaluations from developed and developing countries published between 1990 and 2012. Abstinence-based programs were excluded from the study without explaining why. Intervention and study design characteristics of the included interventions were disaggregated by whether they addressed issues of gender and power.

Haberland identified the following articles:

- Allen JP et al., Preventing teen pregnancy and academic failure: experimental evaluation of a developmentally based approach, *Child Development,* 1997, 68(4):729–742.
- Cowan FM et al., The Regai Dzive Shiri project: results of a randomized trial of an HIV prevention intervention for youth, *AIDS,* 2010, 24(16):2541–2552.
- DiClemente RJ et al., Efficacy of an HIV prevention intervention for African American adolescent girls: a randomized controlled trial, *Journal of the American Medical Association,* 2004, 292(2):171–179.
- DiClemente RJ et al., Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for African

American adolescent females seeking sexual health services: a randomized controlled trial, *Archives of Pediatrics & Adolescent Medicine,* 2009, 163(12):1112–1121.

- Dupas P, Do teenagers respond to HIV risk information? Evidence from a field experiment in Kenya, *American Economic Journal: Applied Economics,* 2011, 3(1):1–34.
- Jewkes R et al., Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial, *BMJ,* 2008, doi: 10.1136/bmj.a506, accessed Oct. 15, 2008.
- Nicholson HJ and Postrado LT, A comprehensive age-phased approach: Girls Incorporated, in: Miller BC et al., eds., *Preventing Adolescent Pregnancy: Model Programs and Evaluations,* Newbury Park, CA: Sage Publications, 1992, pp. 110–138.
- Philliber S et al., Preventing pregnancy and improving health care access among teenagers: an evaluation of the Children's Aid Society–Carrera program, *Perspectives on Sexual and Reproductive Health,* 2002, 34(5):244–251.
- Ross DA et al., Biological and behavioural impact of an adolescent sexual health intervention in Tanzania: a community-randomized trial, *AIDS,* 2007, 21(14):1943–1955
- Thurman AR et al., Preventing recurrent sexually transmitted diseases in minority adolescents: a randomized controlled trial, *Obstetrics & Gynecology,* 2008, 111(6):1417–1425.

The article by Thurman AR et al. describes project SAFE. The Project was developed for use in public health clinics, it is a three session cognitive-behavioral intervention designed to reduce STD infections among Hispanic and African American women[67]. Sessions are designed to facilitate skill development to avoid infections while increasing awareness that STDs (including AIDS)

[67] http://www.socio.com/srch/summary/happa/hap10full.html

disproportionately affect minority women[68]. The intervention also helps build decision-making and communication skills, and encourages participants to set risk reduction goals. Participants gain mastery through role-play, group discussion, and behavioral skills exercises[69].

The program described by Philliber S et al. talks about Adolescent Pregnancy Prevention Program. Adolescent Pregnancy Prevention Program helps young people learn about themselves and their bodies in an age and stage appropriate fashion. Adolescent Pregnancy Prevention Program staff are professional educators, and act as mentors and advisers on issues related to reproductive health and safety, healthy relationships, and general well-being[70]. Trained CAS-Carrera adolescent sexuality professionals develop a long-term relationship with young people towards the goal of building trust, reducing risk-taking and reinforcing that parenthood is best after a college education[71]. Adolescent Pregnancy Prevention Program Educators lead weekly holistic sexuality education sessions that take a common sense approach with an emphasis on the importance of abstinence and informed decision-making[72].

Haberland established criteria for classifying curricula as addressing gender—gender norms, gender equality, and harmful or biased practices and behavior driven by gender—and power inequalities in intimate relationships[73]. Specifically, curricula had to go beyond the conventional content on resisting sexual advances (refusal skills) to include at least one explicit lesson, topic or activity covering an aspect of gender or power in sexual relationships—for example, how harmful notions of masculinity and femininity affect behaviors, are perpetuated and can be transformed; rights and coercion; gender inequality in society; unequal power in intimate relationships; fostering young women's empowerment; or gender

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[68] Id.
[69] Id.
[70] http://stopteenpregnancy.childrensaidsociety.org/our-program/family-life-and-sexuality-education
[71] Id.
[72] Id.
[73] Id.

and power dynamics of condom use.[74] The classification of an intervention as addressing gender and power was first determined by assessing the description provided in the primary article, and when available, related articles[75]. If this was insufficient, the curriculum or curriculum summaries were obtained; in some instances, the authors were contacted for details on program content. Notes describing the way that gender and power were addressed in the intervention were taken as needed. This content review was conducted by three researchers other than the author and was blind, i.e., information on the results of the program was not provided to the researchers[76].

In the conclusion Haberland underlined that addressing gender and power should be considered a key characteristic of effective sexuality and HIV education programs. She did not specify which contents about gender and power should be included in sex education programs. Haberland concluded, "the inclusion of gender and power content exerted a powerful effect on program outcomes[77]". However, rather than a proof of a "powerful effect" of gender and power content on pregnancy, childbearing or STIs prevention, the significant decreases in health outcomes in 8 programs that Haberland detected could be due to other factors such as adopting a more healthy lifestyle.

Most popular primary IPV prevention programmes are dating violence prevention programmes such as *Safe Dates* (www.crimesolutions.gov/ProgramDetails.aspx?ID=142) or *Break the Cycle* (www.breakthecycle.org). These interventions teach skills to develop healthy, nonabusive relationships with dating partners, conflict resolution, communication skills and techniques for seeking help. Some of these programmes are integrated with education about sexual health and substance use prevention (for example *Safe Date or Break the Cycle*). Most of them are carried out in a school setting and are universal interventions, but some target specific populations (athletes, homeless youth, young

[74] Id.
[75] Id.
[76] Id.
[77] The list for the programs is provided on page 6-7.

parents, members of minorities, or members of fraternities and sororities).

One of the programmes that have been well researched is *Safe Dates*. It has been evaluated using a randomized controlled design, and positive effects were noted in all published evaluations.[78] Teens exposed to the programme reported less physical and sexual dating violence perpetration and victimization than controls four years after the intervention.[79] *Safe Dates* is a school-based prevention program for middle and high school students designed to stop or prevent the initiation of dating violence victimization and perpetration[80]. Adolescents in the program reported perpetrating less psychological and sexual abuse at all four follow-up periods, compared with youths in the control group. There was a moderate effect of treatment on physical violence victimization[81]. The Safe Dates program includes a curriculum with nine 50-minute sessions, one 45-minute play to be performed by students, and a poster contest. It can be inferred from the curriculum that it covers some of the CDC risk factors . The sessions include:

1. *Defining Caring Relationships.* Students are introduced to Safe Dates and discuss how they wish to be treated in dating relationships. This point might cover following CDC risk factors:

- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Perpetrating psychological aggression
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other

[78] Foshee VA et al. (1998). An evaluation of Safe Dates, an adolescent dating violence prevention program. American Journal of Public Health, 88(1):45-50; Foshee VA et al. (2000). The Safe Dates program: 1-year follow-up results. American Journal of Public Health, 90(10):1619-1622; Foshee VA, et al. (2004). Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. American Journal of Public Health, 94:619-624; Foshee VA et al. (2005). Assessing the effects of the dating violence prevention program "Safe Dates" using random coefficient regression modeling. Prevention Science, 6: 245-258.
[79] Foshee VA, et al. (2004). Assessing the long-term effects …*op.cit*.
[80] https://www.crimesolutions.gov/ProgramDetails.aspx?ID=142
[81] Id.

- Unhealthy family relationships and interactions
- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

2. *Defining Dating Abuse.* Discussing scenarios and statistics, students clearly define dating abuse. This point might cover following CDC risk factors:

- Aggressive or delinquent behavior as a youth
- Perpetrating psychological aggression
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

3. *Why Do People Abuse?* Students identify the causes and consequences of dating abuse through large- and small-group scenario discussions. This point might cover following CDC risk factors:

- Aggressive or delinquent behavior as a youth
- Perpetrating psychological aggression
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

4. *How to Help Friends.* Students learn why it is difficult to leave abusive relationships and how to help an abused friend through a decision-making exercise and dramatic reading. This point is aimed at improving weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence), but can also respond to other risk factors.

5. *Helping Friends.* Students use stories and role-playing to practice skills for helping abused friends or for confronting abusing friends. This point is aimed at improving weak community sanctions against IPV (e.g., unwillingness of

neighbors to intervene in situations where they witness violence), but can also respond to other risk factors.

6. *Overcoming Gender Stereotypes.* Students learn about gender stereotypes and how they affect dating relationships through a writing exercise, scenarios, and small-group discussions. . This point might cover following CDC risk factors:

- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)

7. *Equal Power Through Communication.* Students learn the eight skills for effective communication and practice them in role-plays. . This point might cover following CDC risk factors:

- Emotional dependence and insecurity
- Perpetrating psychological aggression
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other
- Unhealthy family relationships and interactions
- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

8. *How We Feel, How We Deal.* Students learn effective ways to recognize and handle anger through a diary and a discussion of "hot buttons," so that anger does not lead to abusive behavior. This point might cover following CDC risk factors:

- Emotional dependence and insecurity

- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Perpetrating psychological aggression
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other
- Unhealthy family relationships and interactions

9. *Preventing Sexual Assault.* Students learn about sexual assault and how to prevent it through a quiz, a caucus, and a panel of peers[82].. This point might cover following CDC risk factors:

- Perpetrating psychological aggression
- Dominance and control of the relationship by one partner over the other
- Unhealthy family relationships and interactions
- Aggressive or delinquent behavior as a youth
- Anger and hostility
- Emotional dependence and insecurity

Safe Dates involves family members through the use of parent letters and parent brochures, which provide information about resources for dealing with teen dating abuse. In addition, schools can get parents more involved by hosting parent education programs or by talking one-on-one with parents of youth who are victims or perpetrators of dating abuse. Teachers are encouraged to connect with community resources by locating and using community domestic violence and sexual assault information, products, and services that provide valid health information.[83]

In Canada Wolfe DA et al. (2003) evaluated a school-based programme for preventing dating violence. The evaluated programme - Youth Relationships Project is an 18-session program that uses a health-promotion approach to preventing

[82] Id.
[83] Id.

violence in dating relationships by focusing on positive alternatives to aggression-based interpersonal problem-solving and gender-based role expectations[84]. The intervention draws from skill- and learning-based approaches described previously, as well as from feminist theories regarding societal values that maintain inequality and promote gender-based violence, such as violent and sexist media, sex-role stereotyping, and gender socialization[85]. The curriculum involves three components: (a) education and awareness of abuse and power dynamics in close relationships, (b) skill development, and (c) social action[86]. No information is provided if this program responds to any particular IPV risk factors. The component (a) education and awareness of abuse and power dynamics in close relationships might cover following CDC risk factors:

- Aggressive or delinquent behavior as a youth
- Anger and hostility
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Perpetrating psychological aggression
- Marital conflict-fights, tension, and other struggles
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other
- Unhealthy family relationships and interactions
- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

The component (b) skill development might cover following CDC risk factors:

[84] Wolfe DA et al. (2003). Dating violence prevention with at-risk youth: a controlled outcome evaluation. Journal of Consulting and Clinical Psychology, 71(2):279-291.
[85] Id.
[86] Id.

- Aggressive or delinquent behavior as a youth
- Anger and hostility
- Emotional dependence and insecurity
- Perpetrating psychological aggression
- Marital conflict-fights, tension, and other struggles
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other
- Unhealthy family relationships and interactions
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

The component (c) social action might cover following CDC risk factors:

- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Perpetrating psychological aggression
- Marital conflict-fights, tension, and other struggles
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other
- Unhealthy family relationships and interactions
- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

A randomized-controlled trial showed that the intervention was effective in reducing incidents of physical and emotional abuse and symptoms of emotional distress over-time.[87] The other evaluated programme used a cluster randomized trial with 2.5-year follow-up, and it was found that the teaching of youths about healthy

[87] Id.

relationships as part of their required health curriculum reduced the violence.[88] There was a difference of 2.4% in the rates of physical dating violence between the programme group and the control group.[89] A study delivered by lawyers on an intervention that aimed to deliver information on how to get legal help in IPV situations showed improved knowledge, but no differences in recent abusive/fearful dating experiences or violence victimization or perpetration.[90]

Many primary IPV prevention programmes train specifically men and boys to prevent violence against women: e.g. *Mentors in Violence Prevention* (www.jacksonkatz.com/aboutmvp.html), *Men Can Stop Rape* (www.mencanstoprape.org), *Coaching Boys into Men* (www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men) or *Men's Program* that showed promising evidence of behaviour change.[91] The purpose of these programs is to teach men and boys skills to change unhealthy attitudes and behaviours and increase the likelihood of bystander intervention. Although many of these programmes typically target changes in attitudes and knowledge (as they hypothetically lead to changes in violent behaviour) it is uncertain if these variables are relevant to prevention of IPV.[92] According to Whitaker, "Given the limited duration of many of the interventions, it is unclear how well new behaviors or skills could have been learned[93]."

Rape education programmes that are often implemented have been shown to be ineffective.[94] There is currently limited empirical evidence linking legal or sexual

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[88] Wolfe DA et al. (2009). A school-based program to prevent adolescent dating violence: a cluster randomized trial. Archives of Paediatrics & Adolescent Medicine, 163:692-699.

[89] *Id.*

[90] Jaycox LH et al. (2006). Impact of a school-based dating violence prevention program among Latino teens: Randomized controlled effectiveness trial. Journal of Adolescent Health, 39(5):694-704.

[91] Foubert JD et al. (2007). Behavior differences seven months later: effects of a rape prevention program. NASPA, 44(4):728-749.

[92] Whitaker DJ et al. (2013). Effectiveness of Primary …*op.cit*.

[93] Whitaker DJ et al. (2013). Effectiveness of Primary …*op.cit*.

[94] WHO/LSHTM (2010). Preventing intimate …*op.cit*.:66.

knowledge to sexual violence perpetration.[95] Evidence on the effectiveness of primary IPV prevention strategies is limited and only a few programmes have been subjected to a scientific evaluation.

A majority of higher-quality studies is derived primarily from North America, but less rigorous evidence is available also from other countries. Dating violence prevention programmes have been the most evaluated of all IPV prevention programmes. Systematic reviews indicate that the effectiveness of these programmes looks promising. Whitaker DJ et al. (2006) reviewed systematically 11 studies that aimed at the prevention of IPV perpetration.[96] Only two studies used randomized designs. The review discussed recommendations regarding the content and evaluation of dating violence prevention programs and summed up that conclusions about the overall efficacy of dating violence interventions are premature, but such programmes are promising. The review recommended to include culturally sensitive and more specific programs, develop targeted interventions, include measurements of the skills that intervention strategies intend to change in order to understand whether changes in specific skills are ultimately responsible for behavior change and develop a new setting for interventions.

Foshee VA et al. (2009) provided empirical findings related to efficacy of such programmes based on randomized trials, and concluded that although these studies look promising, more research is needed to provide conclusions and make recommendations for a widespread implementation of particular programs.[97] Similarly, Hickman LJ et al. (2004) assessed evaluations of adolescent dating violence prevention programs and urged for additional investment in high-quality basic research.[98]

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[95] Tharp AT et al. (2011). Commentary on Foubert, Godin, & Tatum (2010) the evolution of sexual violence prevention and the urgency for effectiveness. Journal of Interpersonal Violence, 26(16): 3383-3392.

[96] Whitaker DJ et al. (2006). A critical review of interventions for the primary prevention of perpetration of partner violence. Aggression and Violent Behavior, 11:151.

[97] Foshee VA et al. (2009). Approaches to preventing psychological, physical, and sexual partner abuse. In O'Leary D, Woodin E, eds. Psychological and physical aggression in couples: Causes and Interventions. Washington DC, American Psychological Association:165-190.

[98] Hickman LJ et al. (2004). Dating violence among adolescents: prevalence, gender distribution, and prevention program effectiveness. Trauma Violence & Abuse, 5(2):123-142.

A review of programmes working with men and boys by Barker G et al. (2007) included 13 primary prevention programmes.[99] Four of the reviewed programmes were assessed to be "effective", six "promising" and three "unclear". Programmes that work with men and boys to change their attitudes are promising, but more evaluation research is needed in order to ascertain whether these programs have an impact on IPV prevention. In the literature sets of best practices have been identified and recommendations have been made with respect to improving effectiveness of primary prevention.[100] For example Nation et al. (2003) identified nine principles of effective prevention programs: comprehensive, varied teaching methods, sufficient dosage, theory driven, positive relationships, appropriately timed, socioculturally relevant, outcome evaluation, well-trained staff.[101]

Small et al. (2009), drawing on existing research, highlighted eleven principles of program effectiveness: theory driven, sufficient dosage and intensity, comprehensive, actively engaging, developmentally appropriate, appropriately timed, socioculturally relevant, well-qualified, trained and supported staff, focused on fostering good relationships, well-documented, committed to evaluation and refinement.[102] These principles have been followed by IPV prevention programs, e.g. by a Canadian school-based program to prevent dating violence[103]. The intervention is a 21-lesson curriculum delivered during 28 hours by teachers with additional training in the dynamics of dating violence and healthy relationships[104]. Dating violence prevention was integrated with core lessons about healthy relationships, sexual

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[99] Barker G et al. (2007). Engaging men and boys in changing gender based inequity in health: evidence from programme interventions. WHO, http://www.who.int/gender/documents/Engaging_men_boys.pdf (last accessed: 1 Sep. 2015).

[100] Krug EG et al. (2002). World Report on Violence and Health. WHO http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf (last accessed: 1 Sep. 2015):15-17; Mercy JA et al. (1993). Public health policy…*op.cit.*

[101] Nation M et at. (2003). What works in prevenion. Principles of effective prevention programs. American Psychologist, 58(6/7): 449-456.

[102] Small AS et al. (2009). Evidence-Informed Program Improvement: Using Principles of Effectiveness to Enhance the Quality and Impact of Family-Based Prevention Programs. Family Relations, 58(1):1-13.

[103] Wolfe DA, Crooks C, Jaffe P, et al. A School-Based Program to Prevent Adolescent Dating Violence: A Cluster Randomized Trial. *Arch Pediatr Adolesc Med.* 2009;163(8):692-699. doi:10.1001/archpediatrics.2009.69.

[104] Id.

health, and substance use prevention using interactive exercises[105]. Relationship skills to promote safer decision making with peers and dating partners were emphasized. This intervention could be an example of the possibility of including IPV risk factors prevention in a sex education program.

In the second part of the study the search for MeSH Terms "dominance" and "sex education" resulted in 6 items, and for "dominance" and "sexuality education" no results have been found. The search for MeSH Terms "immaturity" and "sex education" resulted in 8 items and for "immaturity" and "sexuality education" in 18 items. The search for MeSH Terms "gender roles" and "sex education" resulted in 5 items and for "gender roles" and "sexuality education" in 35 items. No results have been found in searches for "affective/romantic relationships" for both "sexuality education" and "sex education".

The results have been slightly more fruitful compared to the results retrieved in phase 1. Armistead et al conducted a 6-session intervention that targeted general parenting (relationship quality, parental monitoring, and involvement), gender roles, and parent–youth communication about sex (content and quality).[106] Parents and youth were assessed at baseline, postintervention, and 6-month follow-up. The study found that parents' reports at postintervention indicated larger effect sizes for general parenting than youths' reports[107]. Parents' reports showed medium to large effects for all sex communication outcomes at postintervention and the 6-month follow-up. Youth reports demonstrated small to medium effects for most communication variables and these effects lasted through the 6-month follow-up period[108].

More results may be obtained from three articles listed below. In the first one "Population Education in Secondary Schools project (phase III) reviewed" discusses a review of educational programmes conducted in 25 provinces and municipalities in China. The purpose of this review was to "ensure systematic vertical and

[105] Id.
[106] Armistead L et.al, Preliminary results from a family-based HIV prevention intervention for South African youth. Health Psychol. 2014 Jul;33(7):668-76. doi: 10.1037/hea0000067.
[107] Id.
[108] Id.

horizontal substantive coverage in grades 4-12, revise the scope and the sequence of material in the curricula offered, and introduce material on aging, sexually transmitted disease (STD) and acquired immunodeficiency syndrome (AIDS), migration, urbanization, and gender roles".[109] Evaluation of programmes on sexual knowledge and gender roles may perhaps also be found in the article by Grassel H. et al "[Sexual knowledge and concept of gender roles in pre-school children]" (Translated from German")[110] and in Colombia's "National Project for Sex Education"[111].

Moreover, the search in the second part also revealed that studies on teachers have been done[112]. The study "The gendered nature of South African teachers' discourse on sex education" was a qualitative study of 25 Life Orientation teachers in the South African Free State Province[113]. Semi-structured interviews to explore the ways in which these teachers understand gender to be a factor in learners' experiences of sexuality. The study revealed a tendency for teachers to cast boys as largely predatory and girls as victims of sexual predation, either by their peers or by older boys or men[114].

The article "Gender implications of teaching of relationships and sexuality education for health-promoting schools" describes a qualitative study of 25 male post-primary teachers[115]. The teachers took part in five focus groups. Two of the groups consisted of men who had participated in Relationships and sexuality

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[109] [No authors listed], "Population Education in Secondary Schools project (phase III) reviewed". Popul Educ Asia Pac Newsl Forum. 1994;(39):12-3.

[110] Grassel H. et al "[Sexual knowledge and concept of gender roles in pre-school children]", Arztl Jugendkd. 1983 Apr;74(2):110-20. PMID: 6880975.

[111] Martinez Mendez Z. et al., Colombia's "National Project for Sex Education".SIECUS Rep. 1996 Feb-Mar;24(3):13.

[112] De Palma et al. The gendered nature of South African teachers' discourse on sex education. Health Educ Res. 2014 Aug;29(4):624-32. doi: 10.1093/her/cyt117. Epub 2014 Jan 10; McNamara PM et al, Gender implications of teaching of relationships and sexuality education for health-promoting schools. Health Promot Int. 2011 Jun;26(2):230-7. doi: 10.1093/heapro/daq046. Epub 2010 Aug 12.

[113] De Palma et al. The gendered nature of South African teachers' discourse on sex education. Health Educ Res. 2014 Aug;29(4):624-32. doi: 10.1093/her/cyt117. Epub 2014 Jan 10.

[114] Id.

[115] McNamara PM et al, Gender implications of teaching of relationships and sexuality education for health-promoting schools. Health Promot Int. 2011 Jun;26(2):230-7. doi: 10.1093/heapro/daq046. Epub 2010 Aug 12.

education (RSE) training, which was introduced in Irish schools in 1995. The other three groups were with men who had not participated in the training. The analysis of the data suggested that there was reluctance on the part of male teachers to teach RSE, and that they feel under threat about their personal and professional identity[116].

Conclusions from the search

The search of literature on sex education programs that include content to prevent IPV in order to evaluate what evidence of effectiveness do these programs have to prevent IPV did not yield any results – no studies on sex education programs that include contents to prevent IPV have been found. When IPV is addressed in literature on sex education programs, it is usually limited to sexual violence, within a larger context of rape prevention. It is unlikely that a more extensive literature search (e.g. adding new databases) could be more successful.

Another option to find sex education programs including IPV prevention could be a bottom-up search that would involve changing the methodology. First step of this search could be to look for rigorous studies that examined efficacy of sex education programs and secondly, to look into their content if they aim to prevent IPV. It is worth to note that introducing IPV prevention to the content of sex education programs is very rare. Still a traditional view on sex education is prevalent, which focuses mainly on reproductive health, prevention of pregnancies and STIs.

[116] Id.

PART III

The case for Primary Prevention of Intimate Partner Violence in Sexuality Education. International Policies

1. Introduction

This document presents results of research on how international policies address the issue on intimate partner violence prevention within sexuality education programs. It is designed primarily for scholars and policymakers with backgrounds in criminology, education or public health. The international approach is justified by different, innovative attitudes, and adoption of varying policy instruments to prevent intimate partner violence and educate adolescents about human sexuality.

There are many policy documents, scientific publications and legislation about intimate partner violence and about sexuality education. However, the issue of primary IPV prevention within sexuality education programs has not been properly addressed so far in international policies. This document aims to find out more information about this issue and disseminate the idea of multifaceted approach of the primary prevention of IPV that includes sexuality education as an instrument of IPV prevention.

Sexuality education is an efficient instrument for addressing IPV, in addition to other resources, as it is relevant for all four categories of IPV risk factors developed by the Centers for Disease Control and Prevention: individual (e.g. emotional dependence), relationship (e.g. lack of assertiveness skills), community (e.g. unwillingness to intervene) and societal (e.g. adherence to harmful traditions and harmful gender

norms).[117] Sexuality education programs are pretty widespread nowadays, and the need for their implementation is widely accepted, although they might vary on contents.

This review is based on the following sources: scientific articles and books, governmental documents, United Nation documents, newsletters, NGOs and governmental websites and databases. Only sources published in English have been reviewed and this paper is designed for English speaking reader.

Key Definitions

'Intimate Partner Violence' (IPV) is defined here as any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. For the purpose of this document IPV includes also dating violence that can emerge in long-term partnerships, but can also be exerted by friends or even strangers.

'Primary IPV prevention' is a type of prevention that aims to hinder IPV before it occurs rather than seeking to achieve early detection of cases or prevent recurrence.

In this document we adopted a definition of sexuality education by WHO. According to this definition '**sexuality education'** is 'learning about the cognitive, emotional, social, interactive and physical aspects of sexuality'.[118]

Method

A literature and document review has been carried out using the following international polices databases:

- **Academic search premier**

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117 http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/riskprotectivefactors.html (last accessed: 12 April 2016).

118 WHO Regional Office for Europe and BZgA, Standards for Sexuality Education in Europe. A framework for policy makers, educational and health authorities and specialists, 2010.

- **Index to foreign legal periodicals**
- **Legal Trac**
- **Access UN**
- **United Nations – Office of Legal Affairs**
- **Public Affairs Information Service**
- **World Treaty Index**
- **UN Treaty Collection database**
- **UN Depositary Notifications**
- **Tufts Multilaterals Project.**

In the second part of the study non-legal documents such as guidelines of sex education and IPV have been searched via internet.

Findings and Conclusion

There is significant support in the area of international laws and policies for the idea of primary prevention of intimate partner violence in sexuality education. For example violence against women is protected by CEDAW (The Convention on the Elimination of all Forms of Discrimination Against Women). This document was adopted in 1979 by the UN. It has been ratified by 189 states, but over fifty countries have ratified the Convention with reservations, including 38 countries who rejected article 29. This article addresses means of settlement for disputes concerning the interpretation or application of the Convention. The treaty has not been signed, but ratified by the US and Palau.

The Convention on the Elimination of all Forms of Discrimination Against Women talks about the following issues:

- non-discrimination,
- sex stereotypes,
- sex trafficking

- women's rights in the public sphere with an emphasis on political life, representation, and rights to nationality
- economic and social rights of women, i.e. education, employment, and health
- special protections for rural women
- women's right to equality in marriage and family life along with the right to equality before the law
- establishes the Committee on the Elimination of Discrimination against Women as well as the states parties' reporting procedure
- describes the effects of the Convention on other treaties, the commitment of the states parties and the administration of the Convention.

According to General Recommendation No. 12 (eighth session, 1989) The Committee on the Elimination of Discrimination against Women established that the Convention require the States parties to act to protect women against violence of any kind occurring within the family, at the work place or in any other area of social life. The Committee recommended to the States parties that they should include in their periodic reports to the Committee information about:

1. The legislation in force to protect women against the incidence of all kinds of violence in everyday life (including sexual violence, abuses in the family, sexual harassment at the work place etc.);

2. Other measures adopted to eradicate this violence;

3. The existence of support services for women who are the victims of aggression or abuses;

4. Statistical data on the incidence of violence of all kinds against women and on women who are the victims of violence.

General Recommendation No. 19 (1992) discusses "violence against women." Specifically, it states that "[t]he definition of discrimination includes gender-based

violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It states in Article 1 that "gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men". The Committee concluded that not all the reports of States parties adequately reflected the close connection between discrimination against women, gender-based violence, and violations of human rights and fundamental freedoms. "The full implementation of the Convention required States to take positive measures to eliminate all forms of violence against women (at 4). The Committee suggested to States parties that in reviewing their laws and policies, and in reporting under the Convention, they should have regard to the following comments of the Committee concerning gender-based violence (at 5)". The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence".

The recommendation also specifies the links between GBV and human rights:

> According to point 7. "Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention. These rights and freedoms include:
>
> (a) The right to life;
>
> (b) The right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment;

(c) The right to equal protection according to humanitarian norms in time of international or internal armed conflict;

(d) The right to liberty and security of person;

(e) The right to equal protection under the law;

(f) The right to equality in the family;

(g) The right to the highest standard attainable of physical and mental health;

(h) The right to just and favourable conditions of work."

According to the Recommendation "traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion, such as family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision. Such prejudices and practices may justify gender-based violence as a form of protection or control of women. The effect of such violence on the physical and mental integrity of women is to deprive them the equal enjoyment, exercise and knowledge of human rights and fundamental freedoms. While this comment addresses mainly actual or threatened violence the underlying consequences of these forms of gender-based violence help to maintain women in subordinate roles and contribute to the low level of political participation and to their lower level of education, skills and work opportunities (at 7)" Traditional attitudes have been extended in the document to "the propagation of pornography and the depiction and other commercial exploitation of women as sexual objects, rather than as individuals" (at 12).

According to the Committee especially Rural women are at risk of gender-based violence "because traditional attitudes regarding the subordinate role of women that persist in many rural communities. Girls from rural communities are at special risk of violence and sexual exploitation when they leave the rural community to

seek employment in towns". Point 23 talks about Family violence which has been described as "one of the most insidious forms of violence against women". The Committee continues: "It is prevalent in all societies. Within family relationships women of all ages are subjected to violence of all kinds, including battering, rape, other forms of sexual assault, mental and other forms of violence, which are perpetuated by traditional attitudes. Lack of economic independence forces many women to stay in violent relationships. The abrogation of their family responsibilities by men can be a form of violence, and coercion. These forms of violence put women's health at risk and impair their ability to participate in family life and public life on a basis of equality". The Committee on the Elimination of Discrimination against Women recommends that: "States parties should take appropriate and effective measures to overcome all forms of gender-based violence, whether by public or private act".

Gender equality education is supported by Council of Europe Convention - the Convention on preventing and combating violence against women and domestic violence (Istanbul Convention). This Convention requires States parties to prevent violence against women and children, protect victims and prosecute the perpetrators.

According to Paragraph 1 of the Article 14 of the Convention "States shall take, where appropriate, the necessary steps to include teaching material on issues such as equality between women and men, non-stereotyped gender roles, mutual respect, non-violent conflict resolution in interpersonal relationships, gender-based violence against women and the right to personal integrity, adapted to the evolving capacity of learners, in formal curricula and at all levels of education". Paragraph 2 of this Article ensures "the necessary steps to promote the principles referred to in paragraph 1 in informal educational facilities, as well as in sports, cultural and leisure facilities and the media".

Preventive intervention and treatment programmes are ensued by Article 16. According to this Article states "shall take the necessary legislative or other

measures to set up or support programmes aimed at teaching perpetrators of domestic violence to adopt non-violent behaviour in interpersonal relationships with a view to preventing further violence and changing violent behavioral patterns".

Participation of the private sector and the media is discussed in Article 17, according to which states "shall encourage the private sector, the information and communication technology sector and the media, with due respect for freedom of expression and their independence, to participate in the elaboration and implementation of policies and to set guidelines and self-regulatory standards to prevent violence against women and to enhance respect for their dignity. States shall develop and promote, in co-operation with private sector actors, skills among children, parents and educators on how to deal with the information and communications environment that provides access to degrading content of a sexual or violent nature, which might be harmful". The Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) monitors the implementation of the Convention.

WHO standards for sex education[119] promote a "respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence". According to the document Sexual rights "embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements". Sexual rights should be "free of coercion, discrimination and violence".

WHO suggests for people who are 15 and up to be given information about sexual and gender-based violence; recognize violations of rights and speak out

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http://www.bzgawhocc.de/?uid=20c71afcb419f260c6afd10b684768f5&id=home.

against discrimination and this type of violence. One of the Principles and outcomes of sexuality Education decided by WHO is "To be able to build (sexual) relationships in which there is mutual understanding and respect for one another's needs and boundaries and to have equal relationships. This contributes to the prevention of sexual abuse and violence." (principle 10). Sexual violence has been also named by WHO European Region among many challenges with regard to sexual health.

WHO guidelines "Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines[120]" aim to provide "evidence- based guidance to health-care providers on the appropriate responses to intimate partner violence and sexual violence against women, including clinical interventions and emotional support". Their standards can serve as the basis for national guidelines, and "for integrating these issues into health-care provider education, as well as helping health-care providers to be better informed about the care of women experiencing sexual assault and intimate partner violence".

The EU guidelines on prevention of violence against women[121] are based on milestones of which are the UN Secretary-General's in-depth study on all forms of violence against women (2006). They aim to encourage the implementation of projects to prevent of violence against women and girls financed by the European Instrument for Democracy and Human Rights.

Also, OSCE's youth projects and education programs are being implemented by the organization to promote its objectives. These projects include gender education, human rights, as well as tolerance education.

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[120] http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf.

[121] http://www.consilium.europa.eu/uedocs/cmsUpload/16173cor.en08.pdf.

As presented above, international not strictly binding laws and policies make a strong case in favor of implementation of the idea of primary prevention of intimate partner violence in sexuality education. Gender equality, youth education, prevention of violence are crucial for international bodies for the development of the ideas of democracy and human rights based approach to international policies. The implementation of these ideas is secured by international committees such as GREVIO or CEDAW. Additionally, there is evidence of activities of international organizations that are directed towards education and violence prevention.

National Conference of State legislatures, USA has proposed thefollowing state Policies on Sex Education in Schools :

- HB 3754 Provides that sexual health education should help students develop the relationship and communication skills to form healthy relationships free of violence, coercion, and intimidation . Also stipulates that education should help students develop the relationship and communication skills to form healthy relationships free of violence, coercion, and intimidation. Provides that the department of elementary and secondary education shall establish age-appropriate guidelines for child exploitation awareness education.

- SB 2594 Requires Mississippi school districts to adopt a sex education curriculum that includes medically accurate, complete, age and developmentally appropriate information and to provide information about the prevention of unintended pregnancy, sexually transmitted infections (including HIV), dating violence, sexual assault, bullying and harassment.

- SB 713 Creates the Teen Dating Violence Prevention Education Act to provide students with the knowledge, skills, and information to prevent and respond to teen dating violence. Authorizes school districts and charter schools to provide teen dating violence education as part of the sexual health and health education program in grades seven through 12 and to establish a related curriculum or materials. Also allows age appropriate instruction on domestic violence.

- HB 1507 Provides that school districts may provide programs to students in grades 7 through 12 addressing sexual violence, domestic violence, dating violence and stalking awareness and prevention. The programs may address the issue of consent to sexual activity and educate students about the affirmative consent standard.

- HB 246 Requires the state board of education to establish curriculum with instruction in comprehensive human sexuality education which includes evidence-based information about topics such as human reproduction, all methods to prevent unintended pregnancy and sexually transmitted diseases and infections (including HIV and AIDS) and sexual or physical violence.

- SB 5506 Adds information on sexual assault and violence prevention and understanding consent to existing health education requirement.

PART 2

Objective: **reviewing sex ed programs from international agencys to verify if they include something about IPV prevention.**

Agency	**Sex Education Program /Policy**	**Inclusion of IPV prevention**
Public Health- Seattle & King County	Family Life and Sexual Health (F.L.A.S.H.)	Comprehensive sexual health education curriculum
Developed by Planned Parenthood League of Massachusetts and published by ETR	Get Real: Comprehensive Sex Education That Works	This program does cover the topic of IPV (Grade 8, lesson 8-2) Healthy and Unhealthy Relationships:"Students explore the characteristics of healthy versus unhealthy relationships. They are introduced to two diagrams that present the different characteristics associated with power and control in unhealthy relationships and those associated with equality in healthy relationships. Then they analyze scenarios to identify the aspects of power and control and/or equality depicted in each. To personalize the learning, students make their own plan for having a healthy relationship".
Sexuality Information	Guidelines for	"Relationships and Interpersonal

and Education Council of the United States	Comprehensive Sexuality Education: Kindergarten-12, Grade,	Skills: Sexuality education seeks to help young people develop interpersonal skills, including communication, decision-making, assertiveness, and peer refusal skills, as well as the ability to create reciprocal and satisfying relationships. Sexuality education programs should prepare students to understand sexuality effectively and creatively in adult roles. This includes helping young people develop the capacity for caring, supportive, non-coercive, and mutually pleasurable intimate and sexual relationships. " Program content – children will learn how to interact with all genders in respectful and appropriate ways.
Planned Parenthood	Sexuality education in Europe - a reference guide to policies and practices	Proposal to include violence in eighth through twelfth grades (ages 14 to 19)
Population Council	Rethinking Sexuality Education	no
Future of Sex Education Initiative.	National Sexuality Education Standards: Content and Skills,	„There is also a pressing need to address harassment, bullying and relationship violence in our schools, which have a significant impact on a student's emotional and physical well-being as well as on academic success". By the end of the 12th grade,

		students should be able to: „Compare and contrast situations and behaviors that may constitute bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence"
Te Kete, New Zealand	Sexuality education: a guide for principals, boards of trustees, and teachers	„It sits within the broader area of relationship education, which also includes social and emotional learning (SEL), and violence prevention education." Skills: • understandings and skills to enhance relationships, for example in relation to friendships, intimate relationships, love, families, and parenting • critical thinking, reflection, and social-action skills related to issues of equity, gender, body image, sexualisation, risk, and safety. • personal and interpersonal skills and related attitudes, including: Years 7–8: Intimate relationships and sexual attraction will be discussed and respect and communication skills highlighted Students will develop assertiveness skills and recognise instances of bullying and discrimination and question and

		discuss gender norms. Years 11-13: At this level students will critically analyse a wide range of issues relating to gender, sexuality, and sexual health.
Council of Europe	Sex – sexuality education, Personal development for the prevention of discrimination and violence (SEXED). Gender and sexuality stereotypes in textbook image	The purpose of this training is to help teachers to analyze in textbooks images stereotypes based on gender and sexuality, and to identify their symbolic meanings.

CONCLUSION

The table presents a review of sex education programs to see if they include anything about IPV. The programs usually teach how to have respectful, free of violence relationships, how to defend themselves from being a victim of violence, communicate violence to authorities. Some programs, like the one from the Council of Europe, are aimed to fight gender stereotypes. It seems that there are various documents on this topic and programs that have been implemented, but still it is not common to include IPV is sex education.