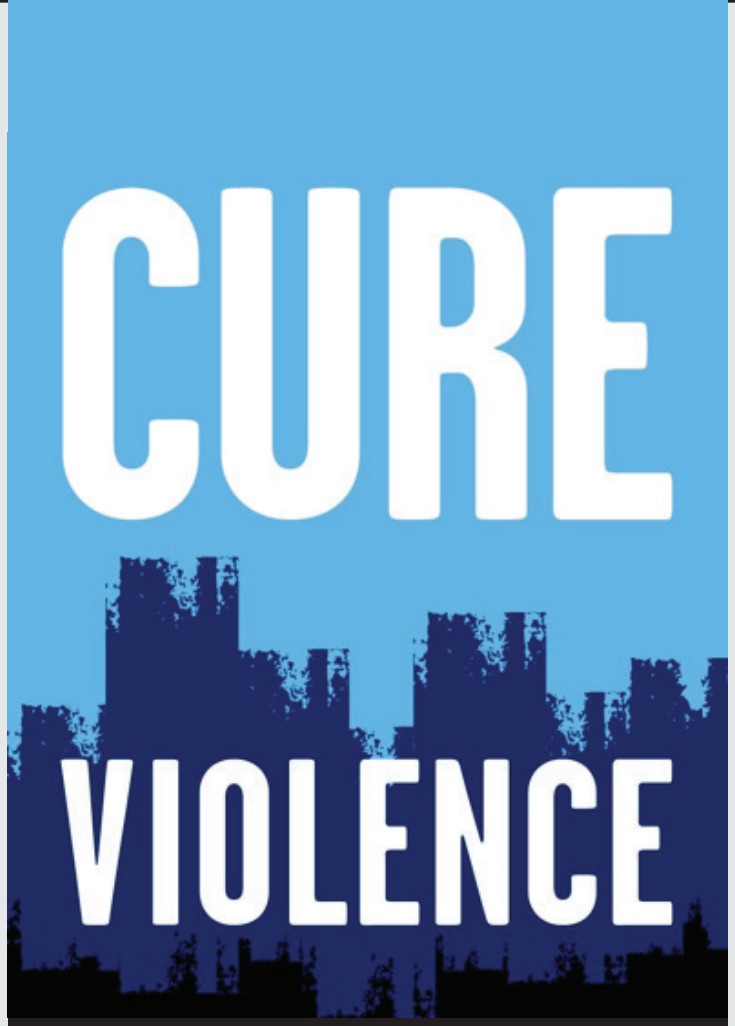

Strategic Plan 2014-16

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Executive Summary

Cure Violence envisions a world without violence. Our mission is to reduce violence globally using disease control and behavior change methods. We are guided by clear understandings that violence is a health issue, that individuals and communities can change for the better, that community partners and strategic partnerships are keys to success, and that rigorous, scientific, professional ways of working are essential for effectiveness.

The Cure Violence approach to reducing killings and shootings has been implemented since 2000 in more than 25 cities, seven states and eight countries. Over that period, the public understanding and acceptance of violence as a health issue has increased dramatically, impacted in part by independent evaluations showing the Cure Violence model associated with (often dramatic) reductions in shootings and killings. Public and political willingness to treat violence as a health issue has never been greater.

In its first 13 years, Cure Violence focused on testing and improving its model for reducing shootings and killings using a health approach, and on building a network of partners effectively implementing the Cure Violence model. Our focus now is on scaling the approach in order to have a much larger impact. With this in mind, we are placing a much greater emphasis in the coming period on changing public and policy thinking and practice as it relates to violence, while at the same time continuing to reduce violence in key hot spots both in the United States and internationally.

2014-16 Strategic Goals

Reducing Violence

1) by refining our model through research and development

2) through the adaptation of the model to other forms of violence, situations and cultural contexts

3) by implementing the model in targeted U.S. cities, leading to acceptance of the Cure Violence approach as "regular practice," and

4) establishing a global violence interruption network, starting in Latin America and the Caribbean, and in the Middle East and North Africa.

Shifting Public Thinking

1) through a systematic campaign to change societal norms and public policy in the United States, leading to institutionalization of the health approach in practice and budgets

2) accomplished through creation of a global network centered around a common mission: reducing violence through a health approach - both in the US and abroad

About Cure Violence

Vision: A world without violence

Mission: To reduce violence globally using disease control and behavior change methods.

Guiding Principles

Health focus: Violence is a health issue that can be effectively addressed using a disease-control approach that includes behavior change.

Transformation: Individuals and communities can - and do - change for the better.

Partnering: Our success depends on partnering with like-minded individuals and organizations focused on the common mission of reducing violence through a health approach.

Community-driven: Our work is grounded in the communities most affected by violence, and led by community partners who incorporate our approach into their efforts to build a healthy community.

Rigorous, Scientific, and Professional: We are a research and data-driven organization, focused on the right neighborhoods, the right individuals, and the right situations to get maximum results. We set high standards of conduct and product.

Introduction

Cure Violence is an international NGO that uses a health approach to reducing shootings and killings in places that experience the highest levels of violence. To date, our efforts have focused on interrupting and stopping the spread of violence in major hotspots in the United States and a handful of sites globally.

Having successfully implemented the Cure Violence model since 2000 and with three external evaluations, we now know that the approach works, and how it works. We have determined that in its next phase, Cure Violence will continue to reduce violence by replicating its model, while focusing greater emphasis and resources on changing public and policy thinking and practice as it relates to addressing violence.

Lessons learned in the Ashoka Globalizer program show that organizations can increase their impact 100 fold while only doubling the organization's size. This is accomplished through building "smart networks" centered around a common mission (rather than the organization), with the organizing entity relinquishing some control over the process.

By engaging and harnessing the energy of others, we have a much greater chance of realizing the global, systemic change we seek. This understanding has guided our thinking as we developed this strategic plan.

Partnerships will be a key element of how we do business in the coming years. The partnerships will vary, depending on their focus, be it implementing the model, research, public education, or policy advocacy -- all contributing in some way to the larger mission of reducing violence globally.

The ultimate result we seek is a world in which violence is viewed differently than it is today and in which societal norms as they relate to violence have been fundamentally changed. Cure Violence will no longer be one of a few organizations using the health approach but rather one of many. Additionally, Cure Violence envisions the development of a new ecosystem in which universities and other organizations treat violence as an infectious process. And these organizations will work together toward a common vision of a world without violence.

Our History

Cure Violence began (as CeaseFire Chicago) in 2000 with the goal of reducing shootings and homicides in Chicago. From 2000-2008, Cure Violence (then CeaseFire Chicago) focused its activities in the United States, starting in Chicago but quickly expanding to Baltimore, New York, New Orleans, Oakland, Puerto Rico and other sites. In 2008, Cure Violence began its first international adaptation and replication of the methodology in Basrah, Iraq. Since then, international programs have been added in South Africa (Hanover Park), United Kingdom (London), Kenya (Nairobi and Rift valley), Honduras (San Pedro Sula), and Colombia (Barranquilla).

The Cure Violence sites in Chicago, Baltimore, and New York have all been externally evaluated, demonstrating strong results across the board. These evaluations and other successes of the model have contributed to an increased interest and demand in the Cure Violence health approach. The release of the movie The Interrupters in 2011 and the 2012 ranking of Cure Violence (then still CeaseFire Chicago) as #30 on the Global Journal's list of Top 100 NGOs worldwide increased this demand even further. In 2013, Cure Violence moved up to 9th place on the Global Journal's list, ranking first among organizations dedicated to reducing violence.

This increased interest in and demand for the approach has been most pronounced internationally, with expressions of interest coming from places such as Uganda, Jamaica, Colombia, El Salvador, Kenya, Jordan, Israel, Palestine, México, Brazil, Guatemala, Ecuador, and Canada. The organization's ability to respond to this increased demand is currently extremely limited, forcing us to not pursue some opportunities.

At the same time, there is increased recognition in the United States that there needs to be a new approach to dealing with violence and an openness to the health approach that underpins the Cure Violence methodology. The increased debate about violence in the aftermath of the Newtown, Connecticut school shooting has created a new opportunity to influence the U.S. approach to interrupting and preventing violence from a purely law enforcement approach to a more comprehensive approach that includes the health approach. Unfortunately, the Cure Violence's ability to really drive this debate is also limited by current organizational capacity constraints.

The Cure Violence Approach

Following more than 10 years of fighting health epidemics in Africa and Asia, Cure Violence founder Gary Slutkin, M.D. returned to the United States and began to notice parallels between the trajectory of violence plaguing U.S. cities and the trajectory of diseases plaguing the communities in which he previously worked abroad. He observed, for example, that a cholera outbreak in Somalia shows the same epidemiological curve as the 1994 mass killings in Rwanda and that killings in US cities, which appear as a wave sitting on top of a wave, resemble outbreaks of tuberculosis in Europe centuries ago.

Dr. Slutkin came to realize that the issue of violence had been fundamentally misdiagnosed –having been seen as a moralistic issue with reduction strategies applied based upon totally outdated thinking. The public and policy-makers had simply not taken into account how violence really behaves—as a contagious, or epidemic process, or disease. Even those in the health community who referred to violence as a health problem had not yet applied specific epidemic control techniques.

When violence is recognized as an epidemic disease, it can be treated and prevented with specific epidemic control methods. Doing this makes it possible to be much more effective in reducing the epidemic of violence. When their epidemic and contagious nature became identified and the strategies revised to conform to science, these diseases became a thing of the past.

Violence has the characteristics of an infectious disease in how it is transmitted from person-to-person and how it is spread neighborhood-to-neighborhood and community-by-community. It must be physically interrupted before it takes hold of the minds and bodies of those affected by it. Additionally, thinking and attitudes must be changed to prevent the cycle of violence from repeating itself, before the behaviors that trigger violence become cultural norms.

Cure Violence approaches violence in an entirely new way – like a disease. The Cure Violence model uses the same science-based strategies being used globally to fight other epidemic diseases. Carefully selected members of the community — disease control workers who are trusted insiders — are trained to anticipate where shootings and killings may occur and to intervene before it erupts—just as one might use health workers to find early cases of tuberculosis, SARS, or even bird flu. Other very highly-trained health or epidemic-control workers take on the specific tasks of behavior change, and changing norms. Transmission is averted and spread limited.

The Cure Violence understanding of and approach to violence is a scientific one, which is that violence is an acquired behavior that is reinforced by social norms -- and that this "social learning" occurs from person to person, or group to group, within families and in and across communities. This results in the spread of the behavior like other contagious processes. Interrupting violence and its spread, and changing peer expectations, behaviors and norms reduces the perpetuation (and therefore the rates) of violence in a community, city or country.

As behaviors are largely driven by peers, they are likewise reversed through well trained peers, who are carefully selected and trained to systematically help

reverse the process through persuasion, modeling, and behavior change and norm changing methods. The Cure Violence approach is adapted to local circumstances, culture, and type of violence in every location where it operates.

Cure Violence prevents violence through a three-prong approach:

1. Interrupt transmission: The Cure Violence model deploys violence interrupters who use a specific method to locate potentially lethal, ongoing conflicts and respond with a variety of conflict mediation techniques both to prevent imminent violence and to change the norms around the need to use violence. Cure Violence hires culturally-appropriate workers who live in the community, are known to high-risk people, and often have backgrounds similar to the populations they serve, but have made a change in their lives and turned away from violence. Interrupters receive specific training on a method for detecting potential shooting events, mediating conflicts, and keeping safe in these dangerous situations.

2. Identify and change the thinking of highest potential transmitters: Cure Violence employs a strong outreach component to change the norms and behavior of high-risk clients. Outreach workers act as mentors to a caseload of participants, seeing each client multiple times per week, conveying a message of rejecting the use of violence, and assisting them to obtain needed services such as job training and drug abuse counseling. Outreach workers are also available to their clients during critical moments – when a client needs someone to help him avoid a relapse into criminal and/or violent behavior. The participants of the program are of highest risk for being a victim or perpetrator of a shooting in the near future, as determined by a list of risk factors specific to the community. In order to have access and credibility among this population, Cure Violence employs culturally appropriate outreach workers, similar to the indigenous workers used in other public health model

3. Change group norms: In order to have lasting change, the norms in the community, which accept and encourage violence, must change. At the heart of Cure Violence's effort to change community norm is the idea that the norms can be changed if multiple messengers of the same new norms are consistently and abundantly heard. Cure Violence uses a public education campaign, community events, community responses to every shooting, and community mobilization to change group and community norms related to the use of violence.

Additional Elements for Implementation

- Data and monitoring are used with each of these components to measure and provide constant feedback to the system.
- Workers engage in extensive training to ensure that they can properly carry out their duties. This includes an initial training before they are sent out on the streets, follow up trainings every few months, and regular meetings in which techniques for effective work are reviewed.
- Programs implement a partnership with local hospitals so that workers are notified immediately of gunshot wound victims admitted to emergency rooms. These notifications enable workers to respond quickly, often at the hospital, to prevent retaliations

Strategic Plan

In early 2013, the Cure Violence leadership engaged in a strategic planning exercise with a goal of identifying strategic priorities both its U.S. and international work. This initial effort has since been expanded to include a complete strategic review resulting in this new strategic plan.

In its first 13 years, Cure Violence focused on testing and improving its model for reducing urban street violence using a health approach, and on building a network of partners effectively implementing this model. Our focus now is on scaling the approach in order to have a much larger impact. With this in mind, we are placing a much greater emphasis in the coming period on changing public thinking, policy and practice as it relates to violence, while at the same time continuing to reduce violence in key hot spots both in the United States and internationally.

Our goals for 2014 - 2016 are twofold:

- Reduce violence
- Shift public thinking, policy and practice as it relates to violence

We recognize there may be tension between these two goals. On the one hand, we seek to ensure that all implementing partners replicate the Cure Violence model with fidelity. On the other hand, we seek broad partnerships with a wide variety of organizations that share our overarching health approach and can be instrumental in changing thinking and/or practice related to how violence is addressed.

Goal 1: Reduce Violence

Our primary goal is to reduce violence -- using the Cure Violence approach.

In order to address this problem and systematically and strategically reduce violence, Cure Violence will focus on the following objectives over the next three years:

- Refine the Cure Violence model through research & development
- Adapt the Cure Violence model to other forms of violence, situations and cultural contexts
- Implement the model in strategic U.S. cities, leading to acceptance of the Cure Violence approach as "regular practice
- Adapt and implement Cure Violence in key regions globally

Violence keeps children from concentrating on their studies and indoors on days they should be playing in the park. It drives businesses from communities, placing essential goods and services beyond the reach of residents. It makes seniors afraid to walk to a corner store for a newspaper. It drives health care costs up – hospital treatment of a gunshot victim costs $42,000 in the United States -- if s/he doesn't have to be admitted or need further surgery. It chases parishioners from the neighborhoods where they grew up and thought they'd live all their lives. And, as homicide disproportionately affects persons aged 10–24 years in the United States and consistently ranks in the top three leading causes of death in this age group[1] - it is robbing cities of their young and our societies of their future leaders.

1 Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010. Centers for Disease Control.62(27); 545-548.

Overview: Reduce Violence

Our primary goal is to reduce violence -- using the Cure Violence approach.

Objectives	Outcomes
1: Refine the Cure Violence model through research & development	• Active research network established as part of new health approach ecosystem • Studies related to the model underway or completed in a minimum of five universities in addition to UIC
2: Adapt the Cure Violence model to other forms of violence, situations and cultural contexts	• At least two implementation partnerships working on adaptations to new situations • At least two additional international proof points (i.e., supported by an external evaluation) established • At least one proof point showing that the Cure Violence approach can be used to address other types of violence beyond urban street violence • Training materials adapted for international work
3: Implement the model in strategic U.S. cities, leading to acceptance of the Cure Violence approach as “regular practice”	• Cure Violence model being implemented in at least 10 of the 25 largest cities having the highest homicide rates • Levels of violence in target areas reduced by a minimum of 20% by year three of implementation • Chicago program optimized for effectiveness, growth, and sustainability • Independent social media platform in place that enhances interruption and pro-social modeling • Library of training materials available for sites implementing model with fidelity
4: Adapt and implement Cure Violence in key regions globally	• Violence reduction networks established in Latin America/Caribbean and Middle East/North Africa • Regional training centers in LAC and MENA

OBJECTIVE 1: Refine the Cure Violence Model through Research and Development

A key focus of work in the 2014-2016 period will be the identification and systematic answering of a series of questions that will result in a more effective model and related self-guided implementation materials that will reduce reliance on staff for assistance with launching the model at a new site. This should keep costs down while allowing implementation at multiple sites, some of which may only be interested in part of the model.

Cure Violence's experience on the ground offers significant hope that the current high levels of violence can be reduced. Multiple evaluations have associated the model with reductions in shootings and killings in areas that had been disproportionately negatively impacted by violence, suggesting those most at risk of involvement in shootings can change the way they think and behave, and that conflicts that would otherwise lead to violence can be mediated. All this – and more – has been learned since the first outreach workers were hired in 2000 to work in the West Garfield Park neighborhood of Chicago. That first team of workers, concentrating their efforts in a single part of a larger community, demonstrated they could contribute to significant reductions in shootings and killings in that area. Their success was noted, and more funds were made available to try to replicate this result in other parts of Chicago. Once again, Cure Violence (then CeaseFire) added value to the efforts of community members and law enforcement who were working hard to reclaim these neighborhoods.

What began on paper as a close partnership between the community and justice system actors was modified to put some distance between law enforcement and field staff when workers with close ties to the highest risk came on board and stated they would not be able to reach the those most likely to be involved in a shooting if they were closely identified with law enforcement. The role of faith leaders was also re-thought when faith leader involvement proved difficult in some neighborhoods. As the number of shootings and killings continued to fall in areas with limited faith leader involvement, faith leaders came to be seen as one of many community partners who could fill a number of roles to support the outreach workers.

Other changes were made over time as well: outreach worker training expanded from a half day to three days to forty hours; mediating conflicts was no longer just one of the duties of outreach staff but became the primary responsibility of violence interrupters; specialized training was developed for program managers and supervisors; data- and research-driven criteria for identifying the highest risk were adopted; the game plan was added to assist sites in describing and thinking through the problems they were confronting and how to address them; the hospital response component was added and shown to be an invaluable access point to victims and their friends and family members who might retaliate; and, of course, more and more data was collected and fed back to the sites to both inform implementation and measure outcomes.

Throughout, even while our core purpose – stopping shootings and killings – didn't change, we continued to refine what we do and how we do it. And research by others studying how the brain works, how stress impacts individual behavior, how people can be motivated to change and other relevant topics, has continued over the past thirteen years as well; these studies too offer insights that have prompted us to pay greater attention to and make adjustments to particular aspects of the model.

We know more than we ever did about why people do

what they do, how they can be influenced to change, and what might make situations better – or worse. We believe, based on available research, evaluations of our own work and the experience of staff in Chicago and other cities across the United States, that those who wish to replicate the Cure Violence model must adhere to certain aspects of the model in order to be effective. We consider these to be the 'critical elements' of the model.

Critical Elements

- Focus on "hot spots" - areas of concentrated violence - using mapped data from multiple years;
- Partner with organizations that are committed to ending violence and have a history of providing effective services and close ties to the community to be served;
- Hire and properly train and hold accountable "credible messengers" to interrupt the spread of violence and engage and influence those who are actively involved in violence in a timely manner;
- Focus on highest risk individuals using criteria for identifying those most likely to be involved in a shooting or killing based on relevant data and research;
- Have and follow a game plan for identifying individuals who are associated with violence and events that give rise to violence;
- Utilize an approach shown to result in changes in both individual thinking and behavior regarding the use of violence and in group and community norm change; and
- Collect data in a timely fashion to inform and monitor implementation and measure impact.

As of December 2012, we had had three independent evaluations of our work: in Chicago, Baltimore and Crown Heights, NY[1] – and a fourth evaluation of a site in Pittsburgh that claimed to be implementing the model with fidelity[2] but wasn't - from which we learned key lessons detailed within. (See "Key Lessons Learned" on page 14)

Clearly, we know and have learned much that has helped us refine and improve the Cure Violence model.

Even so, there is much we still need to learn that would:

(1) help Cure Violence workers to be even more effective, and

(2) simplify implementation for replicators and adaptors. Chief among the challenges we face is the "unpacking" of the model to learn which of the core components[3] – independently or in combination – contribute to the results we have seen in multiple sites.

And there is much to be learned about each component. (See "Key Questions for Our Program Components" on page 15)

Answers to these questions will enable Cure Violence to work smarter and more efficiently. Answers will also allow for the development of materials that prospective implementers can rely on to implement key parts of the model, thereby reducing reliance on Cure Violence training and technical assistance staff.

Thus a key focus of work in the 2014-2016 period will be the identification and systematic answering of a series of questions that will result in a more effective model and related self-guided implementation materials that will reduce reliance on staff for assistance with launching the model at a new site. This should keep costs down while allowing implementation at multiple

1 Skogan, W.G., Hartnett, S.M., Bump, N., & Dubois, J. (2008). Evaluation of CeaseFire Chicago. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. Webster, D. W., Whitehall Mendel, J., Vernick, J. S., & Parker, E. M. (2012). Evaluation of Baltimore's Safe Streets Program. Johns Hopkins Bloomberg School of Public Health. Whitehall, J. M., Webster, D. W., & Vernick, J. S. (2012). "Street conflict mediation to prevent youth violence: Conflict characteristics and outcomes." Injury Prevention. Picard_Fritsche, S. & Cerniglia, L., (2012). Testing a Public Health Approach to Gun Violence. NY: Center for Court Innovation.

2 Wilson, J.M., S. Chermak, & E.F. McGarrell. (2010). Community-based violence prevention: An assessment of Pittsburgh's One Vision One Life Program. Santa Monica, CA: RAND

3 Behavior change, interruption and mediation, community mobilization, and public education.

Key Lessons Learned

- When implemented with fidelity, the model is associated with a significant reduction in shootings and killings in the target areas.
- The impact of work in specific target areas extends beyond them to adjacent areas (often referred to as the 'diffusion effect').
- Those recruited as participants must meet 4 or more criteria that classify them as at high risk of involvement in a shooting or killing.
- Working with low-risk youth does not lead to reductions in violence.
- The "right workers" – individuals who are properly trained and credible to those who are most likely to be involved in shootings or killings – are essential to the model's success.
- Workers are important role models for participants – second only to their parents.
- Participants reported receiving the services they requested or felt they needed.
- Mediated conflicts not only change the behavior and thinking of those who are directly involved in the mediation but those who observe or learn about the mediation.
- More workers are associated with greater reductions in shootings and killings.
- Greater numbers of mediations are associated with greater reductions in shootings and killings.
- Community members feel empowered to take actions that can reduce violence in their neighborhood.

sites, some of which may only be interested in part of the model.

This approach will also advance the field by adding to the research base so that others interested in utilizing a public health approach to violence can learn from our experience - particularly if we are able to engage researchers from various departments of the University of Illinois system and other universities.

To develop a list of questions and gather information about how best to prepare for the analyses that would be needed to answer them, Cure Violence staff are working with the team hired by the Robert Wood Johnson Foundation to evaluate the model in a new site. We expect some studies to be completed at sister sites in other states as well as in Illinois. We also plan to form a research advisory board or generate a list of researchers to act as advisors to us as we begin the process of answering questions that will advance our work.

The database that is currently being populated by Illinois sites and a number of sites from other cities was developed seven years ago. It thus pre-dates full-scale implementation of the hospital component, enhancements to our tracking of mediations and a number of other changes that have been made to our work. Technology has advanced as well. "Smart phones" have become more widely available, enabling field staff to report work in close to real time – if we have a system prepared to accept their reports. We therefore need to completely re-think what information we collect, how we collect it, when it's shared and with whom, and how it's used.

Going forward, we will continue to refine the model, working with external researchers and, possibly, creating a national and international research network. We seek to establish at least one additional proofpoint in the United States, conduct a minimum of five small evaluations/research projects in the United States to inform implementation, improve and professionalize the training materials, update the curriculum, and develop 3-5 new booster curricula.

Key Questions for Our Program Components

Target Areas

How do we best determine the size of a target area? When might we be able to step down services in a target area? What, if any services, should be offered in an area once shootings have been reduced, and for how long should these services (i.e., outreach, mediations, etc.) be offered?

Target Population

How do we estimate the population at risk in a particular target area? What's the optimal ratio of workers to target area population? What's the optimal worker to participant ratio? What other factors should be considered in deciding staff size? What percent of the high-risk population do we need to engage in order to "tip" the neighborhood so it has rates of violence more in line with low-risk neighborhoods in the host city?

Staff recruitment, selection, and training

Which parts of field staff and managers/supervisors training are most relevant to the staff duties? Are staff mastering the skills they need to do their jobs? How can we measure skill mastery? How can we improve the training? What is the best way to do recruitment? What is the most important criteria and methods of selection?

Behavior change

How do we change the acceptance and use of violence as part of the everyday life of high-risk individuals? Are some workers more effective with certain groups of youth? Are some youth more receptive than others? Are there differences between African American and Latino youth? Which is more powerful: one-on-one work or group work or a combination?

Conflict resolution

Are we more successful at resolving some types of conflicts? How can we be more effective with more types of conflicts?

Public education

Does public education make a difference? What mechanisms, messages and messengers are more effective with high-risk individuals, community members, stakeholders and champions?

Changing Group and Community Norms

What are the best ways to shift norms among the highest-risk individuals? What information and skills need to be transferred? How do we change social expectations? How do we best use group dialogue and other sessions? What role do gender norms play in this? How can we best use deputies or other agents to diffuse new norms?

OBJECTIVE 2: Adapt the Cure Violence model to other forms of violence, situations, and cultural contexts

The Cure Violence approach has been implemented internationally in a variety of cultural and social contexts since 2008. This has allowed us to examine how the approach needs to be adapted in order to be effective in these differing situations and as relates to different types of violence. While we have not had any external evaluations of our international work, we have learned several important lessons that inform our thinking and our future planning. One of the most important lessons we have learned is that in order to achieve real measurable drops in violence, this needs to be the main focus of the program. This might seem apparent but many organizations focus on underlying issues that contribute to the violence but not on actually interrupting and stopping the spread of the violence.

A second valuable lesson that reinforced something we already knew from our United States program is the importance of selecting the right local partner. Additionally, we learned that this local partner really needs to be local -- based in and/or from the community -- and not just an international organization that has an office in the country/city in question. While it is possible that an international organization can be a good local partner, this is best determined based on its reach into the community experiencing the violence and credibility with that community.

Similarly, we learned that when implementing the Cure Violence approach internationally, we may not always be able to implement all three aspects of the approach (detect and interrupt; change the behavior of the most at-risk; and change community norms) initially -- and sometimes not at all. This depends on the local cultural and societal norms and the level of violence. In Iraq, for example, we had a much heavier emphasis on outreach to at-risk individuals and to community members than on interruption. At the same time, because of the high levels of violence and cultural norms, we were not able to organize community responses to violent incidents. Instead, our partner worked with local faith leaders to talk about the violence in their weekly sermons/addresses. Another lesson in Iraq is that we had to rely much more on third-party mediation than what we usually see in the U.S. context. In Honduras, the situation is different and required a different initial approach. There, because of the extremely high levels of violence, we started with just the interruption and not the outreach or the community norm change.

From our experience to date, the program seems to make the most sense internationally when it is part of a larger city- or country-wide strategy which reflects the principles outlined previously. The program in Cookham Wood-London, Cape Town, The mayor's office Barranquilla (and Colombia in general) or Recife, Brazil are good examples of the model being discussed as part of larger strategies that reflect Cure Violence's values. As we are learning in Honduras, the US policies in the region may not align themselves with our approach (e.g., insisting on a certain level police involvement in the program when it is widely accepted that the police are involved in a great percentage of the killings taking place). These larger political and policy issues need to be taken into account as we move ahead with international programming.

In each place where we work internationally, we conduct a thorough assessment mission that looks at all aspects of the violence, sources of information, and potential partners. We then identify the best local partner and, together with that partner, agree on the best adaptation of the methodology for that specific location.

Thus far, we have had the opportunity to try the Cure Violence approach to interrupt different types of violence ranging from post-conflict sectarian violence in Iraq to election-related violence in Kenya to inside the juvenile detention system in the United Kingdom. We have begun a project focused on key influencers from inside Syria. This program seeks to empower Syrian actors to understand that (a) violence increases during a conflict or post-conflict situation and (b) this (non-conflict related) violence can be prevented. This project is not focused on the current civil war but rather on interrupting the other violence that is on the rise in communities throughout Syria as a result of the exposure to violence over the past two plus years.

By 2016, we seek to establish two additional international proof points (i.e., supported by an external evaluation) and adapt our training materials for international work. At least one of these additional proof points will show that the Cure Violence approach can be used to address other types of violence beyond urban street violence. The best candidates for finding this additional proof point for a different type of violence are the existing program in the United Kingdom youth detention centers and the still-new joint effort in London, Ontario, Canada focused on adapting the Cure Violence approach to address honor-related violence. By the end of this three-year period we expect to have sufficient evidence to document the effectiveness of the Cure Violence approach and an understanding of exactly how the methodology needs to be adapted for this other type of violence.

Our international work is informed by the latest research and development described above and adapted to the local situation where the program is being implemented. Similarly, our international work feeds back into the research and development work, thus making a continuous feedback loop that informs and improves the development of the model.

OBJECTIVE 3: Implement the model in strategic U.S. cities selected for greatest potential impact and large-scale norm change

A Google search of "Public Health Approach to Violence" yields more than 51 million hits. And cities from Los Angeles to Boston and Baltimore report they have adopted a public health approach to violence, with other cities are following their lead – and that of Cure Violence.

Clearly, the train has left the station. No longer does Cure Violence need to convince civic leaders about the benefits of a different approach to their violence problems. Instead, our task is to identify, recruit and support those who offer the right "fit" for the Cure Violence model so that we may achieve more "proof points" of our work and promote adoption of key components -- resulting in a national reduction in homicides. This means that we need to be strategic about how and where we allocate our resources.

Support to Sites Committed to Implementing the Cure Violence Model

Cure Violence recognizes its model is unlike other models. To assist implementers, we have developed an extensive training and technical assistance protocol that begins with orientation visits by a Cure Violence team to the prospective implementing site, and by a team from the prospective team to Chicago or a sister City. These visits have proven valuable as they give implementers a truer understanding of what the model looks like "on the ground" and a more in-depth view of what is involved in implementation. Once a site decides to move forward, a member of the Cure Violence staff is assigned as point for the site. This person participates in hiring panels for the staff who will be tasked with the daily work of the model,

including program managers and supervisors, violence interrupters and outreach workers. Cure Violence provides on-site training for selected staff: 40 hours of basic training for interrupters and outreach workers, 40 hours of training for managers and supervisors, and regular, on-site, two to three day booster sessions that build on the topics introduced in the training. All training is hands-on to build both knowledge and the skills they needs to do their jobs. Weekly phone calls with the manager and outreach supervisor affirm key points made in the training and afford an opportunity to address issues as they arise.

Training and technical assistance will be offered to new sites and sites that are already implementing the model but want to expand it as follows.

|Expansion of Effort

Over the next three years, we will seek to implement the Cure Violence model in 5-7 new cities in the United States bringing the total number of cities with Cure Violence replications to a minimum of 15. We will look to expand our reach to more cities that: 1) Lead the nation in homicides; 2) Have disproportionately high rates of homicides; and/or 3) Have concentrations of violence in limited hotspots that – if addressed – could significantly improve the quality of life in the impacted neighborhood and lay the foundation for economic and community development. Priority will be given to cities that are committed to and have engaged an evaluation partner.

|Going Deeper at Established Sites

While expanding the program into new cities, we will also seek to go deeper -- increase sites and numbers of workers -- in at least three existing sites. Before doing this, however, we must ask and answer several questions.

Going Deeper - Questions

- Are we having the impact we want?
- If not, what is keeping us from achieving significant reductions in shootings and killings?
- Are we working in the right location(s)?
- Do we need a greater presence in some locations?
- Are we working in enough areas to have a citywide impact or at least a demonstrable impact that will encourage local leaders to expand efforts to other hot spots?
- Do we have the right staff?
- Do we have enough staff?
- Are we reaching the highest risk?
- If yes, in large enough numbers to impact the problem?
- Have we reached a plateau such that we cannot realistically expect shootings and killings to go any lower?.

Answers to these questions and others will allow sites to determine if efforts need to be intensified in the identified target area, the approach adjusted, or some or all staff moved to another site. We do not anticipate a targeted area being left altogether; rather we expect efforts would be scaled back, phasing out the outreach caseload but continuing to interrupt and mediate conflicts as necessary, continuing to respond to any shootings that occur and continuing to work on norm change. We expect this approach will both stabilize the area, leave a corps of committed residents to carry the work forward, and maximize the impact of limited resources by focusing outreach and interruption activities where they are most needed.

Concurrently, we need to work with local health departments to institutionalize support for work in the community and, to the extent possible, engage health

department staff and early identifiers of emerging problems so the local leaders can apply other less costly interventions and preventive actions. As we increasingly work with health departments, which in turn support implementation of the model by community organizations, we will need to develop a training module that prepares health department staff to work with grassroots groups that are long on heart but may lack the ability to successfully manage a staff and a program. Drawing on our experience in Chicago and Baltimore, we have already developed an agenda for an initial session which we piloted in New York City.

An important consideration will be integrating the Cure Violence model with the other programs or initiatives of the health department so that synergies and economies of scale can be achieved across the programs and maximum benefit can be derived from timely delivery of needed services to those who qualify. For example, if an outreach worker has a participant who is about to become a father, he may be able to access prenatal services for his partner and parenting classes for both of them through the health department early in the pregnancy. Other health departments may offer healthy relationship groups for young women – something several Cure Violence sites have offered themselves because there was an unmet need. If Cure Violence was fully integrated into a health department, there could be an opportunity for a referral or co-leading of a group with a colleague who has training and experience in the areas of teen dating and domestic violence.

Broadening Our Base: The Role of Public Education

Stopping violence is not the responsibility of a single person or organization. Everyone – whether they live in a neighborhood with elevated violence or not – needs to get involved. Those who live in or serve impacted areas need to become active partners of Cure Violence to change the norm that violence is an intractable part of their community. Those who live outside these areas must recognize that violence impacts them as well. Therefore, an increased emphasis on public education is critical to expanding the work of Cure Violence.A locally-implemented public education campaign targets community and city leaders, high and at-risk individuals, and neighborhood residents, showing that violence acts like a contagious disease and can be prevented.

In most cities where we operate, our first task has been building name recognition citywide -- but most importantly in the community targeted for implementation of the model. In the target area, we have relied on time-tested techniques to inform people of our work: door-to-door canvassing, posters, distribution of pamphlets in libraries or other places people visit, and hosting of events to talk about our work, what we are trying to accomplish and how they can become involved. When the model is first being implemented in a community most of this work is organized by the site's program manager with limited assistance of other staff until volunteers can be recruited. We look to initially engage high-risk individuals and groups through in-person contact with outreach workers or violence interrupters who carry ice breaker cards with information that can help open a conversation and begin a dialog that leads to changes in thinking and behavior.

Going forward, we will place an increased emphasis on public education in all of our sites not just to build name recognition (although that is important for building trust in the community) but also to change the thinking beyond the target area. We will seek partners to ensure that the messages being delivered by Cure Violence staff are affirmed and amplified by other individuals and organizations with whom the high-risk youth come in contact. Both city-wide leaders and residents need to help spread the message that violence is a behavior that can be changed – like smoking or

driving while intoxicated – and that they have a role in setting the norms that will help lead to that desired change in behavior.

Measuring the impact of public education campaign is very difficult. Nevertheless, over the next three years we will seek to execute highly-visible public education campaign resulting in measured behavior change in 3 -5 cities in the United States.

OBJECTIVE 4: Adapt and implement Cure Violence in key regions globally

Violence occurs on every continent and in every city of the world. But the highest levels of violence are concentrated in a handful of countries largely found in Latin America and the Caribbean, the Middle East and North Africa, Africa, and Southeast Asia. Given that we cannot implement programs everywhere, we will focus on where we believe we can have the most impact. Our thinking on this was guided by a practical analysis of our strengths as an organization and where we think there is the greatest likelihood of receiving funding for international programs.

Therefore we propose to establish a Global Violence Reduction Network, focused in two regions. In order to have the impact that we would like to have, we need to work with other partner organizations who have reach into the communities where we want to work. These partners will be carefully selected and trained to implement the Cure Violence approach in specific sites in our priority geographic areas. Identifying and training these potential partners is an ongoing priority.

|Latin American and Caribbean (LAC)

Organizationally, we are best positioned to expand our operations in the Latin America and Caribbean (LAC) region. The reasons for this are five-fold: proximity to the United States, similarities between the type of violence in the U.S. and in the LAC region, availability of Spanish-speaking staff, some of the highest rates of violence in the world (particularly in Honduras, El Salvador, Guatemala, Colombia, México, Jamaica, and Brazil), and availability of funds from the U.S. government as well as international financial institutions such as the Inter-American Development Bank and the World Bank. As such, we have determined to make the LAC region our top priority for international expansion over the next three years.

Our first priority in Latin America and the Caribbean is to prove the model in Honduras and Colombia. This is the main focus for program implementation in 2014. In this first year, we will continue our ongoing discussions with potential partners and funders in Mexico, Brazil, and El Salvador, with the intention of beginning programming in 2014 in at least one city in each country. At the same time, we will continue our discussions with potential partners for future work in Guatemala and Jamaica, and be prepared to move forward if/when the funding for the program in Trinidad and Tobago is released. In 2015, we will go deeper in both Colombia and Honduras, and start new programs in Guatemala and Jamaica while maintaining the new (in 2014) programs in Mexico, Brazil, and El Salvador. By 2016, we will add additional sites in Mexico, Brazil, and El Salvador while maintaining existing programs in the remaining countries of the region. These goals are summarized in the chart below.

|Middle East and Africa

A second priority for expanded international work is the Middle East and North Africa. This priority is driven as much by international politics as it is by high levels of violence. Additionally, it provides the opportunity to test the Cure Violence methodology in a new cultural context and in a conflict or post-conflict situation. Our ability to successfully adapt the methodology for implementation in these other contexts would significantly improve our ability to accomplish our vision of a world in which violence is a thing of the past.

Our top priority in 2014 for the Middle East and North Africa region is to continue and deepen our work with Syrian nationals.

We hope to receive additional funding to continue and expand our work with key influencers inside Syria focused on interrupting and preventing the spread of non-conflict-related violence both now and after the end of the conflict. A top priority for this effort will be to prevent retaliatory violence both now and after the end of the conflict. A second priority for 2014 will be to begin work inside the Zaatari refugee camp in Jordan. During this period, we will continue to explore the possibility of creating an interruption network inside Syria. Also in 2014, we will continue to explore the possibility of new programs in Jordan, Libya, Yemen, Egypt, Israel, and the West Bank. In 2015, we will continue our Syria programming (beginning the network inside the country if that has not already happened) and begin programming in at least two additional countries in the region, probably Israel and Jordan (based on current conversations). We will also continue to explore the possibility of programming in at least two additional countries by the end of 2016.

Funding for our program in Iraq ran out in September 2013 and, at present, we do not have any leads on additional programming in that country. We remain convinced, however, that the Cure Violence approach could be effective in Iraq and, as such, will continue to explore possible funding and partners for future programming in that country. These goals for the Middle East and North Africa are summarized in the chart below.

|Other Areas

Outside the two priority geographical areas cited above, Cure Violence will continue its existing programming in the United Kingdom, Canada, and South Africa. In the United Kingdom, the focus will continue to be our work in the youth detention system, with the goal to expand to at least four additional youth detention centers by the end of 2016.

In **London, Ontario (Canada)**, we will continue our work with our local partner to adapt the methodology to apply to honor-based violence and begin implementation of the pilot program. In 2014, we will begin a four-year program in Halifax, Nova Scotia (Canada) funded by the government of Canada. This program will focus on community violence similar to what we find in the United States.

We will continue our existing program outside Cape Town, South Africa. Funding for the current program ends in 2015, but we will seek to expand to a second site in South Africa by the end of 2016. In addition, we will continue to examine the possibility of applying the methodology in other African countries (e.g., Kenya), when and where resources are made available.

In order to achieve scale in the priority regions, we will need to create the capacity to train and monitor a large number of violence interrupters, outreach workers, and program managers. As such, it is our intention to establish regional centers in both Latin America and the Caribbean and the Middle East and North Africa that can provide both training and monitoring services. The goal would be to have at least one fully functional training center in each of these two regions by the end

of the three-year period. Through these regional centers we will create a network of violence interrupters in our two priority geographic regions.

As an evidence-based approach, we will continue to place a high priority on ensuring sufficient monitoring to maintain the integrity of the model. The regional centers will be trained in the latest methodological application of the model and receive regular booster training as necessary. At the same time, the regional centers will be charged with collecting regional data on how the program is implemented and adapted in each region in order to provide this information back to the main training center in Chicago. As with our U.S. program, we will continually seek opportunities to have external evaluations of our international work in order to establish additional proof points for the efficacy of the model in different cultural and situational settings.

5 Phase Plan - LAC & MENA

	2014	2015	2016
Latin America & Carribean	**Honduras:** prove the model; see if current funders want to expand to other cities or in SPS; Explore cellular work with Praekelt **Colombia:** establish and prove the model in Barranquilla; Explore cellular work with Praekelt **Mexico / Brazil / El Salvador**: determine partnership and begin **Guatemala / Jamaica:** continue to explore partnership for future programming **Trinidad and Tobago:** start implementation (caveat: depends on GOTT progress on its budget) *Identify local partner organization(s) to become regional training center for Cure Violence*	**Colombia and Honduras:** additional 1-2 sites in each country **Mexico/Brazil/El Salvador:** Continue implementation in first city **Guatemala/ Jamaica:** determine partnership and begin implementation in one city **Trinidad and Tobago:** Continue implementation (if started); start implementation (if not yet started) *Train local partner organization(s) to become regional training center for Cure Violence*	**Colombia / Honduras:** Continue implementation **Mexico, Brazil, El Salvador:** additional 1-2 sites in each country; **Guatemala / Jamaica**: continue implementation in first city; **Trinidad and Tobago:** Continue implementation *External Evaluation: By the end of the three year period we hope to have at least one external evaluation in progress in the LAC region*
Middle East & North Africa	**Syria:** Continue and expand work with key influencers; begin work inside Zaatari refugee camp **Jordan:** continue conversations with USAID and local partners about possible work in Jordanian schools **Israel:** Continue conversations with Salam Institute and USAID about possible work in Arab villages in Israel **Syria and Libya:** Begin work with Praekelt on large-scale messaging using cellular devices. *Explore possible programming opportunities in Libya, Yemen, Egypt, and the West Bank*	**Syria:** Continue work with Syrian key influencers and inside the refugee camp; begin work inside Syria (if not yet started) **Jordan:** begin implementation of programming in Jordan either in schools or in vulnerable communities (or both); *Identify local partner organization(s) to become regional training center for Cure Violence* **Israel:** Begin implementation of joint program with Salam Institute (if bid successful); otherwise continue to seek opportunities to work in Israel *Continue to explore opportunities to work in Libya, Yemen, Egypt, and the West Bank*	**Syria:** Continue programming inside Syria and in the refugee camps **Jordan:** continue programming in Jordanian schools **Israel:** Continue programming (if started); otherwise, continue seeking opportunities *Start new programs in two additional MENA countries (most likely: Libya, Yemen, Egypt, or the West Bank)* *Train local partner organization(s) to become regional training center for Cure Violence* *External Evaluation: By the end of the three year period we hope to have at least one external evaluation in progress in the MENA region*

5 Phase Plan - Other

	2014	2015	2016
UK	Continue implementation of the program in Cookham Wood youth detention center and expand to at least one additional center.	Add another two youth detention centers	Expand to a fourth youth detention center
Canada	**London, Ontario (Canada):** Continue collaborative work with MRCCSI on adapting the model to address honor-related violence **Nova Scotia (Canada):** Begin implementation of pilot program	**London, Ontario (Canada):** fully implement the model based on 2014 research and adaptation **Nova Scotia (Canada):** Continue implementation of program in xx sites.	**London, Ontario (Canada):** continue implementation of pilot program **Nova Scotia (Canada):** Continue implementation of program in xx sites.
Africa	**South Africa:** Continue implementation of program outside Cape Town; begin work with Praekelt on large-scale messaging using cellular devices.	**South Africa:** Continue implementation of the existing program (current funding ends in 2015); look for opportunities to expand to one additional site; continue work with Praekelt on large-scale messaging using cellular devices. **Mozambique and South Sudan:** Begin work with Praekelt on large-scale messaging using cellular devices.	**South Africa:** begin implementation of the model in a new site; continue work with Praekelt on large-scale messaging using cellular devices. **Mozambique and South Sudan:** Continue work with Praekelt on large-scale messaging using cellular devices. *External Evaluation: By the end of the three year period we hope to have at least one external evaluation in progress outside of LAC or MENA.*
Myanmar	Begin work with Praekelt on large-scale messaging using cellular devices.		

Goal 2: Shift public thinking, policy and practice as it relates to violence

Our second goal for this three-year period is to shift public thinking, policy and practice as it relates to violence -- both in the United States and internationally.

We have developed an ambitious five-phase plan to change the national conversation about and response to violence that capitalizes on and accelerates the momentum sparked by the success of the dual health/ law enforcement approach in key US cities and applies current research and scientific principles.

The key activities of this plan are to:

- Shift the policy to include a public health response to violence as part of regular practice
- Unlock funding to support adoption of health response to violence at the federal, state and local levels.

There is already growing acceptance of and evidence for the notion that violence is a behavior that can be changed – just like smoking, drug use or sexual practice. Consequently, cities such as Baltimore, Chicago, Kansas City and New York City are utilizing a combination of law enforcement and health-driven activities – and experiencing reductions in shootings and killings as a result. Despite this, most cities with high levels of violence continue to respond as though violence was primarily a criminal justice system problem – the acts of "bad people" - rather than a behavior-driven problem warranting a multi-system response that includes accountability and treatment.

A key to shifting thinking and practice internationally is the establishment a global network of like-minded partners (individuals and organizations) focused on changing the thinking and practice.

Overview: Shift public thinking to help create policy change

Our second goal for this three-year period is to shift public thinking, policy and practice as it relates to violence -- both in the United States and internationally.

Objectives	Outcomes
1: Change societal norms and public policy in the United States, leading to institutionalization of the health approach in practice and budgets	• National Pub-Ed campaign(s) • Explicit policy endorsement of health approach by at least three U.S. law enforcement and/or health organizations • Health framework and disease-control approach the accepted standard and practice in 10 health departments across the US • Line item in federal budget (Justice, Health) • In a minimum of 10 city and/or state budgets • Established practice in 20 major cities • Integrated norm-change program in 20 major cities (includes pub-ed campaign, summits/group norm change, and social media) • Independent evaluation of campaign effectiveness • A new ecosystem exists in which universities and other organizations treat violence as an infectious process
2: Change societal norms and public policy internationally, leading to institutionalization of the health approach in policy and practice	• Health framework and disease-control approach the accepted standard and practice • International Pub-Ed campaign(s) • Violence reduction networks established in at least three countries in LAC or MENA • Large-scale messaging campaign implemented in at least three countries • A new ecosystem exists in which universities and other organizations treat violence as an infectious process

OBJECTIVE 1: Change societal norms and public policy in the United States

In the United States, we will focus on creating a "super norm change" through a two-pronged approach that seeks on the one hand to change the policy and discourse as it relates to violence while at the same time seeking to institutionalize this change by securing legislation supporting this approach and, ideally, appropriating funds to implement this approach in a number of cities or states.

As noted elsewhere in this document, there is already growing acceptance of and evidence for the notion that violence is a behavior that can be changed – just like smoking, drug use or sexual practice. Consequently, cities such as Baltimore, Chicago, Kansas City and New York City are utilizing a combination of law enforcement and health-driven activities – and experiencing reductions in shootings and killings as a result. Despite this, most cities with high levels of violence continue to respond as though violence was primarily a criminal justice system problem – the acts of "bad people" - rather than a behavior-driven problem warranting a multi-system response that includes accountability and treatment.

Word of mouth, conference presentations, media coverage and modest appropriations by one or two federal agencies that support the implementation of programs in a handful of cities have all contributed to the increase in awareness, and the adoption and impact of anti-violence models such as Cure Violence that are based on a health framework. These will continue, and, gradually, more cities will begin to include health strategies in their overall approach to violence. While this form of diffusion of a new practice may result in change nationally over time, it is not sufficient to achieve wide-scale change in how the United States, as a nation, views and responds to violence in the near term. More must be done now to educate and motivate, on a large scale, cities of all sizes with shooting and killing hot spots to take actions that will reduce violence now and prevent its future occurrence. Only with large scale adoption of health-driven practices to complement the efforts of law enforcement will significant reductions in homicides be achieved in urban centers and nationally. Only with federal leadership will cities and states have the confidence to add a new way of addressing violence in their communities.

We have developed an ambitious five-phase plan to change the national conversation about and response to violence that capitalizes on and accelerates the momentum sparked by the success of the dual health/law enforcement approach in key US cities and applies current research and scientific principles.

The key activities of this plan are to:

- Shift the policy to include a public health response to violence as part of regular practice
- Unlock funding to support adoption of health response to violence at the federal, state and local levels.

Throughout the process, we will seek to create partnerships with allies and champions (with commitments) who share the same objectives and who will work with us toward adoption of resolutions from key national organizations, publication of media articles and policy reports supporting this approach, and public hearings to create a platform for the discussion about this approach.

5 Phase Plan

Phase 1: Planning and Fact Finding

Outcomes: *List of allies/champions (elected, associations, health organizations, celebrities, justice, etc.) with active connections to any; key information to use in recruiting documents; various documents to recruit allies and champions.*

- Determine scope of effort (i.e., Limit to street violence or something broader? Start with street violence and add other forms of violence at later time?).
- Gather data, research, information re: influential/ stakeholders relative to the scope.
- Identify allies and champions (National? National and local?) – key individuals/groups and organizations.
- Determine who in our network has relationships with or connections to allies and champions.
- Identify what will ring the bells of (i.e., engage in a strong way) allies and champions and other stakeholders; prepare relevant materials.

Phase 2: Creating a Support Base

Outcome: *List of committed allies/champions and their commitments.*

- Identify and energize local stakeholders to call for change/support new allies/champions.
- Specify "asks" of each champion/ally; develop separate strategy for engaging each ally.
- Stage "asks" (approach most likely to say "yes") so those who come on board can be used to leverage others; probably engage individuals before organizations so individuals can bring organizations along.
- Re-group/re-assess on regular basis whether timing continues to be right to move agenda forward.
- Decide whether to bring in other allies; if so, who, how, when?

Phase 3: Broaden Support Base

Outcomes: *Resolutions from key organizations, OpEds from key individuals in high profile publications, journal articles affirming health approach to violence, etc.*

- Secure key speaking opportunities (those that will engage key audiences, lead to resolutions in support of approach, put issue in front of elected officials and resource allocators) for Cure Violence leadership and champions.
- Publish articles authored by champions in key online or print association magazines, professional journals and blogs with significant followings to mainstream approach (leveraging available data, research, and evaluations as appropriate) and impact of violence on families, communities, taxpayers, businesses (i.e., the cost of not taking action).
- Develop strategy for pushing out information to larger audience – especially decision makers in cities/states concerned about violence.

Phase 4: Create the Record for Policy Change

Outcome: *Report on which to base policy change and use as source document for implementation of new policy.*

- Champions call for public hearings on violence.
- Surgeon General and Attorney General co-host hearings in 3-4 key cities; each on different aspect of the problem.
- Congressional hearing in DC?
- Final report presented to President and Congressional leadership.

Phase 5: Secure Passage of Legislation

Outcome: Data and research driven balanced approach to violence that results in safer communities across the United States.

In order to ensure sustainable change, we seek to institutionalize the health approach in practice. This means that we need to work toward federal legislation appropriating funds to implement a public health / disease control approach to violence. Short of this, however, we seek to ensure that a number of health departments are using this approach at the local level (target goal of at least 20 city/state health departments using the approach by the end of 2016) and that funding for this work is incorporated into the city/state health budgets in at least half of these places

Objective 2: Change societal norms and public policy internationally

On the international front, we will seek to influence the discussion through promotion of and participation in international conferences and workshops addressing violence. Through this participation, we will seek public endorsements of a health approach to violence which complements other approaches (such as law enforcement). At the same time, we will increase efforts to publish media articles and scholarly papers in international papers and journals as a part of our effort to influence this discussion on an international level.

Recognizing that we will not reach tipping point through local replication of the model, and that we can take advantage of technological advancement, we will also experiment with changing thinking and practice as relates to violence through the use of large-scale messaging via cellular devices. Working with Praekelt, we will seek to harness the power of mobile technology to change behavior on a population scale (i.e., hundreds of millions) in specific target countries. Praekelt works with brands, mobile network operators, content creators, user experience specialists, and digital technologies to create platforms, applications and campaigns that engage and inspire change. Working with Praekelt, Cure Violence will identify a top-ten list of places where we want to work based on an agreed set of metrics (e.g., number of homicides per 100,000, mobile penetration, cost of mobile access, history of violence, role of mobile technology in flaming violence, type of violence). From this top ten list of places, we will begin to explore possible messaging campaigns designed to change the way behavior is viewed in those societies. Our goal would be to implement this large-scale messaging campaign in at least three countries by the end of 2016.

Key to shifting thinking and practice internationally is the establishment a global network of like-minded partners (individuals and organizations) focused on changing the thinking and practice. Cure Violence will actively initiate or join in global campaigns such as the forthcoming "Living Peace" campaign aimed at helping men understand and realize their potential role interrupting violence and promoting peace. Our current international partners in this arena include the World Bank, the Bernard van Leer Foundation, Promundo, the World Health Organization, the International Working Group on Chronic Violence, and International-Alert.

Implications of the Plan

In order to achieve the goals and objectives that we have set out for ourselves above, we need to change how we do business.

These changes will impact program implementation, communications strategies, and how we use technology. These, in turn, will have implications for organizational structure and fundraising strategies. This section attempts to summarize the main changes that will need to be made in order for us to accomplish the goals that we have set for ourselves.

IMPLICATIONS

In order to achieve the goals and objectives that we have set out for ourselves above, we need to change how we do business. These changes will impact program implementation, communications strategies, and how we use technology.

Area	Implications
Organization & Structure	• Knowledge Center, with Advisory Board, coordinating research and training, established • Independent NGO, with Governing Board, established
Resources	• Revenue-generating sources (game? training? mobile apps? license branding?) • Comprehensive fundraising program • Engaged boards/volunteers • Champions
Monitoring & Evaluation	• At least two additional independent evaluations for both national and international programs • Comprehensive database for all 20 U.S. cities (standardized across sites) • Digital hot-spot mapping platform and national trend monitor • Web-based international monitoring system of hot spots showing trends and responses to hot spots
Technology	• Population-level norm change via cell technology • Increased worker efficiency via technology

The first major realization is that to have the impact we propose, we need to focus on scaling our idea as opposed to our organization. To do this, we will aggressively seek partnerships with like-minded organizations, both to implement programs and to change thinking and practice as it relates to violence. Identifying, pursuing, nurturing, and managing these partnerships must be a priority for all staff in management positions. We will elaborate and implement a strategic partnership policy, and establish procedures that will encourage and guide this process.

As we increase our reliance on partner organizations to implement the Cure Violence model, we will need to further professionalize our training operation. This will include updating our training materials for each category of worker, and creating and implementing a training certification process that is linked to the latest research and ensures a continuous feedback loop between research and program implementation. Sites and cities will be considered licensed Cure Violence sites when they have reached a level of fidelity to the model according to criteria determined by the training and technical assistance unit. Specific criteria will be developed and applied to this process. (If application of the name is used in a manner inconsistent with the philosophy and approach, the entity may be asked to cease and desist). This will have implications for program implementation, communications, and technology -- and organizational structure and resource development.

Our desire to fundamentally change the thinking as it relates to violence means that we will more aggressively seek opportunities to participate in national and international events where violence is being discussed. We will align ourselves with other organizations who share the understanding that violence is a behavior that can be changed (and not that people who do violence are "bad" people). We will use all means of communication to talk about the public health approach to violence, and seek more opportunities to publish articles in papers, journals, and on blogs. This means we need to allocate additional resources for both communications and travel, and that we must prioritize such activities in the portfolios of senior staff.

Implementing the ambitious goals laid out in this strategic plan requires significant additional personnel in each of the organization's existing areas of work (research, national, international, communications, fund development) and in the areas of expansion (advocacy, training and certification). A process is already in motion to recruit and hire a Chief Operating Officer to manage the day-to-day administrative operations. The Chief Program Officer will focus on professionalizing the training materials, exploring a certification process, expanding program implementation, and directing the research work. The Executive Director will focus on providing visionary leadership, advancing the Cure Violence mission in the public sphere, building our smart network, and fundraising. In the international division, in additional to hiring additional full-time staff, we will develop a roster of consultants that for project-specific additional needs.

The increased focus on changing thinking and practice -- with an emphasis on policy and legislative changes -- requires expanding our presence in Washington, DC. We will enhance our capacity to represent Cure Violence's vision and mission with the three branches of the U.S. government and with international financial institutions and NGOs headquartered in Washington, DC. This office needs both communications and policy advocacy functions; some new hires focused on international work and fund development may be housed here. Given the anticipated growth of the DC functions, we believe that it is important to add administrative support and open a physical office where we can host meetings and which can serve as an

operations base for visiting Cure VIolence staff.

In addition to the expanded presence in Washington, DC, we plan to develop over the next three years representational capacity in the San Francisco Bay Area, New York, and London. These "offices" may be virtual, with representation by board members or implementing (or other) partners. In addition, we will develop over the next three years demonstration sites in the United States and internationally that people can visit to see our work in action.

The increased emphasis on changing the thinking and practice as it relates to violence also has significant implications for the communications division. Our increased work with partners necessitates the creation of a public education toolkit that can be shared easily. We need to more aggressively disseminate research findings related to the theory behind our work as well as success stories. The communications team needs to create opportunities for web-based engagement with the wider public, including through webinars and increased use of social media.

Many of the goals that we have set out have implications for technology. Training and certifying workers in the Cure Violence model/approach would be aided by an online platform. The work of violence interrupters and outreach workers would be aided by uniform cell devices that facilitate their communication and which are linked to a new unified database -- which also needs to be built. In addition, we envision a web-based international monitoring system of hot spots (with links drawing from multiple sources) showing trends and responses to hot spots (this provides overview of global situation and responses) and whether we are making progress toward vision

As a data-driven, evidence-based organization, we must not only increase our ability to conduct and disseminate research related to violence, but also seek to encourage additional research by other organizations and individuals. To this end, we plan to create a research advisory board and consider providing incentives to bring researchers together to work on this issue. We need to take additional steps to ensure a continuous feedback loop between research and program implementation.

The strategic directions outlined in this plan will require organizational restructuring to allow Cure Violence to more effectively and efficiently achieve its goals. One option under exploration is creating a Cure Violence knowledge/research center at the University of Illinois at Chicago while establishing a separate non-profit for advocacy and training and technical assistance functions. This would pair the strength of the university with the nimbleness and flexibility that comes with an independent non-profit organization. Also being considered is how best to optimize the Chicago program's effectiveness, growth, and sustainability.

Significant volunteer and financial resources are also required to implement this plan. Over the next three years, Advisory Board members will be key to building a smart network and the partnerships required to scale Cure Violence's work and increase its impact. Board members must have reach, influence and the ability to impact key thought leaders and policy makers, as well as the means to contribute financially and help secure financial resources. In addition, we will actively seek to identify and nurture relationships with key influencers who will advance the Cure Violence approach in the public and governmental spheres.

Both board and staff need additional training and tools to be effective fundraisers on behalf of Cure Violence. A focused fundraising effort will require a strong, written case for support. with clear identification of how funds would be utilized to ensure that donors can see the full impact of their prospective gift(s). Cure Violence needs to broaden and deepen its base of philanthropic supporters, drawing from current donors, existing prospects and suspects, and high-net worth individuals (and foundations) who could, should or ought to be interested in Cure Violence's mission.

1603 W. Taylor Street, MC 923, Chicago, IL 60612
312-996-8775, info@cureviolence.org
facebook.com/CureViolence
@CureViolence