Through a Public Health Lens. Preventing Violence Against Women: An Update from the US Centers for Disease Control and Prevention

Corinne M. Graffunder, M.P.H.; Rita K. Noonan, Ph.D.; Pamela Cox, M.P.H.; Jocelyn Wheaton, M.P.H.

J Womens Health 13(1):5-14, 2004.

Posted 03/29/2004

Abstract and Introduction

Abstract

Over the past two decades, the Centers for Disease Control and Prevention (CDC) has been a key contributor to the growing public health effort to prevent violence. Although CDC and its partners are proud of their many successes, much work remains to be done. Violence continues to be a leading cause of death worldwide for people aged 15–44. Moreover, although many forms of violence garner national concern and resources, much more violence occurs in private domains and receives less attention. These hidden health hazards silently drain our nation's human, economic, and health resources. In this paper, we highlight the current efforts of the Division of Violence Prevention (DVP), housed within CDC's National Center for Injury Prevention and Control (NCIPC), to use a public health approach to the prevention of one key hidden health hazard: violence against women (VAW). Building from a recently developed strategic plan and a research agenda, we explain how four core public health principles—emphasizing primary prevention, advancing the science of prevention, translating science into effective programs, and building on the efforts of others—drive current programmatic activities in VAW prevention. Several current programs and projects are described. Finally, we conclude with recommendations for future prevention work by deepening our vision of leadership, expanding our partnerships, pursuing comprehensive approaches, and using evidence-based strategies.

Introduction

Twenty years ago, the words "violence" and "prevention" were rarely used in the same sentence. Today, the idea that violence can be prevented is more widely recognized, thanks to the traditions and concepts of public health: a commitment to prevention, the application of the tools of science to achieve this goal, and the firm belief that effective public health actions require collaboration and cooperation across scientific disciplines, civic organizations, societal sectors, and political entities at all levels.[1]

Over the past two decades, the Centers for Disease Control and Prevention (CDC) has been a key contributor to the growing public health effort to prevent violence. In 1994, the CDC's National Center for Injury Prevention and Control (NCIPC) funded the Division of Violence Prevention (DVP) to offer public health leadership in the prevention of injury, death, and disability associated with violence. Notably, DVP currently employs the largest collection of experts in the world fuly devoted to violence prevention. CDC and its partners are justifiably proud of the progress made to date in bringing violence to the attention of the public health community. However, these successes should not overshadow the fact that much work remains to be done.

Around the world each year, more than a million people lose their lives, and many more suffer nonfatal injuries as a result of self-inflicted, interpersonal, or collective violence. Overall, violence is among the leading causes of death worldwide for people aged 15–44.[2] Moreover, although many forms of violence have been made visible by modern technology and thus have become public issues (e.g., war, terrorism, or riots), much more violence occurs in private domains and receives far less public attention. These hidden health burdens (e.g., violence against women [VAW], child maltreatment, and suicide), silently drain our nation's human, economic, and health resources.

CDC is dedicated to the prevention of all forms of violence, including those that are hidden from view. This paper highlights some of the current efforts at DVP to use a public health approach to the prevention of one key hidden health hazard: VAW. First, we explain why VAW is a pressing public health problem that merits greater attention. Second, we outline key public health priorities and principles that promise to lead to greater prevention of VAW. These key priorities are the result of DVP's extensive strategic planning process and the development of a research agenda. Third, we describe how DVP's current programmatic activities address these key public health priorities. A select sample of recently funded programs and projects is highlighted. We close by discussing challenges and suggesting some of the actions necessary to shift the paradigm toward ending, and not simply responding to and treating, VAW.

Background: Violence Against Women as A Public Health Problem

VAW is a staggering problem that includes intimate partner violence (IPV) and sexual violence (SV) committed by acquaintances or strangers. IPV is actual or threatened physical, sexual, psychological, or emotional abuse by a current or former spouse (including common-law spouse), dating partner, boyfriend, or girlfriend. Intimate partners can be of the same or opposite sex.[4] SV is committed by an intimate or nonintimate perpetrator, such as a spouse, family member, person in position of power or trust, friend, acquaintance, or stranger. Although there is some overlap between IPV and SV, SV is committed by a wider range of perpetrators. SV includes completed or attempted sex acts against the victim's will or involving a victim who is unable to consent, abusive sexual contact, and noncontact sexual abuse, including sexual harassment and stalking.[5]

Although statistics cannot capture the magnitude of human misery that results from VAW, they nonetheless speak clearly. According to the National Violence Against Women Survey:[3]

- Approximately 1.5 million women are raped and/or physically assaulted by an intimate partner each year.
- Nearly 25% of women have been raped and/or physically assaulted by an intimate partner at some point in their lives, and more than 40% of the women who experience partner rapes and physical assault sustain a physical injury.
- Nearly two thirds of women who reported being raped, physically assaulted, or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend, or date.
- One of six U.S. women and 1 of 33 U.S. men have experienced an attempted or completed rape as a child and/or adult.

- Of the women who reported an attempted or completed rape in their lifetimes, >21% were younger than age 12 when they were first raped, and 32% were ages 12–17.

Obviously, VAW may cause death, physical injury, or increased use of health services, but this is just the tip of the iceberg. It is well documented that abused girls and women often suffer many of the following consequences: (1) adverse mental health conditions, such as depression, anxiety, and low self-esteem, (2) poor physical health consequences, such as gynecological complications, chronic headaches, sleep disturbances, nausea, and a host of other poorly defined somatic complaints that often lack a clearly identified medical cause, and (3) behavioral problems that further damage their health or risk their lives, such as substance abuse, alcoholism, and increased risk of suicide attempts.[1,6]

The Public Health Approach

In 2000, Saltzman et al.[7] described CDC's approach to addressing VAW as a 4-step process: step 1 being definition and measurement, step 2 being identification of risk and protective factors and development of interventions based on these factors, step 3 being evaluation of public health interventions to determine the impact, and step 4 being dissemination of promising strategies to ensure the widespread adoption of these strategies by practitioners working to prevent VAW. Subsequent to this paper and its description of various CDC efforts, two significant developments have contributed to the CDC's current focus related to VAW —the development of a strategic plan and a research agenda. This section provides an overview of DVP's strategic plan, the research agenda, and a sample of current DVP activities being conducted in the area of VAW that are consistent with each.

The Strategic Plan

CDC's strategic approach to violence prevention (Fig. 1) articulates the mission, guiding principles, activity areas, and summary goals and objectives.

Medscape® www.medscape.com

At-a-Glance Strategic Plan for Violence Prevention

Mission	Prevent violence-related injuries and death through surveillance, research and development, capacity building, communication and leadership		
Guiding Principles	•An emphasis on primary prevention •A commitment to advancing the science base for the field and basing everything we do on sound science •A focus on the practical application of scientific advances thereby translating science into effective programs and policies •A commitment to avoid duplication by complementing and building on the efforts of others and by addressing gaps or needs		
Activity Areas	**Current action steps**	**Objectives for the next two to five years**	**Goals for ten or more years**
Surveillance	•Evaluate current surveillance methods to identify gaps •Begin implementing National Violent Death Reporting System	•Collect high-quality data on fatal, nonfatal and related behaviors •Pilot test National Violent Death Reporting System in three to four states	•Develop a high-quality, comprehensive surveillance system using uniform definitions
Research and Development	•Implement key research studies consistent with CDC's *Injury Research Agenda*	•Understand modifiable risk factors •Develop and evaluate interventions based on modifiable risk factors •Improve dissemination and implementation of proven interventions •Understand the impact and cross effects of interventions and policies	•Understand modifiable risk factors •Identify effective programs through evaluation
Capacity Building	•Identify high-priority training information needs at state and local levels	•Support and expand state and local violence prevention capacity •Respond to identified training and information needs	•Develop a frontline violence prevention infrastructure across the country
Communication	•Develop specific communication strategies, including messages, channels, partners, products and goals	•Continue to disseminate effective violence prevention programs •Achieve measurable changes in knowledge, beliefs, and attitudes about violence prevention	•Understand and disseminate information on risk factors •Shift social norms about violence •Widely disseminate information, tools and resources to support the adoption of effective programs
Partnership	•Work with partners to implement and disseminate research agenda •Assess current partnerships and identify opportunities	•Collaborate effectively with new partners	•Public health is a well-recognized partner in violence prevention •Collaboration is routine •Reduce duplication of effort
Leadership	•Identify specific initiatives, partners to achieve them and next steps	•Work with partners to achieve specific initiatives •Convene violence prevention community to review progress and gather input on future initiatives	•Create consensus about effective approaches to violence prevention

Figure 1. Division of Violence Prevention strategic plan, CDC, 2001.

The Research Agenda

Concurrent to the development of the strategic approach to violence prevention, the NCIPC finalized and released its research agenda.[8] This agenda broadly identifies priority research areas that are consistent with the organization's mission (Table 1). In addition, the agenda includes specific research priorities related to VAW (Table 2).

Key Public Health Principles that Guide Activities

Most importantly, the realization of both the strategic plan and the research agenda will affect future decision making and resource allocation. To ensure that NCIPC's future action steps are consistent with long-term public health priorities, our key activity areas for violence prevention (surveillance, research and development, capacity building, communication, partnership, and leadership) are led by four guiding principles: (1) an emphasis on primary prevention, (2) a commitment to advancing the science of prevention, (3) a focus on translating scientific advances into practical application through effective programs and policies, and (4) a commitment to building on the efforts of others by addressing gaps or needs.[9] Brief descriptions of select program efforts provide examples of the strategies being developed to support DVP's guiding principles.

An emphasis on primary prevention: DELTA and the social norms media campaign. CDC is moving the field toward primary prevention by exploring ways to prevent VAW before it can occur. CDC's Domestic Violence Prevention Enhancement and

Leadership Through Alliances (DELTA) program is one example of an effort to build capacity and support the development of state-level leaders in VAW prevention. Similarly, the social norms media campaign is an environmental strategy designed to change adolescent attitudes and beliefs that promote teen dating violence. Such environmental strategies aim to prevent violence by altering the social context that makes violence possible in the first place.

DELTA. CDC's DELTA program focuses on building a primary prevention emphasis within a coordinated community response (CCR). CCRs focus on coordinating the efforts of the criminal justice system and social service agencies in VAW cases such that effective management of these cases is demonstrated by improved communication between criminal justice and social service agencies, the implementation of appropriate protocols for responding to these cases by the various agencies involved, and community education efforts that increase awareness regarding the various issues related to VAW. CCRs seek safety for victims and accountability for batterers by recognizing the multifaceted dynamics of VAW and respecting the sometimes divergent goals and mandates of the criminal justice system and social service agencies.[10] A primary prevention emphasis would integrate activities designed to prevent domestic IPV from initially occurring into the CCR model, such that CCRs are able to implement the full spectrum of domestic IPV prevention activities within their communities. Traditionally, the CCR model to address domestic IPV has focused criminal justice and victim services after the violence has occurred to those victimized, has promoted the prosecution of those who have perpetrated VAW, and has worked to increase public support for these responses.

In early 2002, CDC examined the domestic violence field to assess the types of organizations that were already supporting the development and maintenance of the CCR model within each state. These findings indicated that many state domestic violence coalitions support the model through training and technical assistance provided to local CCRs. This assistance typically is designed to provide information about promising practices for criminal justice interventions and victim services or is directed to operational aspects associated with CCR functioning. Building on this existing training and technical assistance infrastructure, CDC funded 14 state domestic violence coalitions to enhance their support of the CCR model by developing and implementing primary prevention activities that can be integrated into CCRs or similar community-based collaborations. These state domestic violence coalitions will provide prevention-focused technical assistance, training, and funding to CCRs operating within their state. Funded coalitions include Alaska, California, Delaware, Florida, Kansas, Michigan, Montana, New York, North Carolina, North Dakota, Ohio, Rhode Island, Virginia, and Wisconsin.

DELTA addresses three key areas of violence prevention: leadership, capacity building, and partnership. DVP is providing leadership and building capacity by providing training and technical assistance to the state domestic violence coalitions on primary prevention strategies and public health approaches to primary prevention, which these organizations will use to build the capacity of local CCRs in these areas. A partnership framework has been employed whereby the 14 state domestic violence coalitions and DVP have jointly prioritized the project's core focus areas (e.g., faith community), populations (e.g., men and boys), and implementation strategies. This partnership framework provides consistency regarding primary prevention efforts across the 14 states while still providing each state the flexibility it needs to address its own priorities.

In addition to supporting the program development and implementation of DELTA, a cross-site evaluation is being conducted to assess the program's success in developing, disseminating, and sustaining prevention-oriented enhancements within the CCR model. As many CCRs have operated for years without funding to support their criminal justice and victim services efforts, the sustainability facet of the evaluation will not focus solely on sustainability of funding but rather on sustainability of the primary prevention concept within the local CCR regardless of funding availability. In addition, this evaluation will include a nationwide environmental scan designed to document the status of CCR efforts within each state.

Social norms media campaign. Another project designed to prevent VAW before it occurs is CDC's social norms media campaign for 6th, 7th, and 8th grade boys and girls. In an effort to prevent teen dating violence, this media campaign is designed to correct the perceptions of a small sub-group of young people who believe it is acceptable to physically or verbally abuse their partner. We also aim to reinforce positive and healthy relationship values among the majority. The audience for this media campaign was selected after an extensive review of existing literature on IPV and SV among adults and adolescents. DVP also convened a panel of scholars and practitioners in the field of VAW prevention who confirmed what the literature review suggested: the best way to effect social change is to begin teaching healthy attitudes and behaviors to young people.

By using social norming approaches—correcting misperceptions that people have about the attitudes or behaviors of their peer group—the campaign is designed to reach this audience with a message that dating violence is unacceptable and falls outside the norm.[11,12] Correcting misperceptions among adolescents promises to yield great prevention returns for two reasons. First, because most members of peer groups prefer conformity to nonconformity, misperceptions may discourage men and boys from challenging offensive or hurtful peer behavior. Second, misperceptions may also serve to pressure young men to conform to a false norm. For example, Muehlenhard and Cook[13] found that over two thirds of men engaged in unwanted sexual activity with women at some point in their lives as a result of the pressure they felt from other men. More recently, Kilmartin et al.[14] found that men overestimated the extent to which other men engaged in coercive sex with women than they did themselves. Therefore, it is important to launch a campaign for adolescents that will correct misperceptions surrounding dating violence early in their relationship development when their norms are being developed and tested.

A commitment to advancing the science of prevention: evaluation assistance to programs designed to prevent first-time male perpetration of sexual violence. A persistent frustration among public health and violence prevention practitioners is the lack of validated VAW prevention program models. Although these models are extremely limited, there are an increasing number of efforts that direct resources and programming to prevent the perpetration of violence. To better understand the various models and approaches being applied to the prevention of sexual violence, CDC is conducting a collaborative evaluation project to identify and characterize programs that are designed to prevent first-time male perpetration of sexual violence. Additionally, CDC is offering training and technical assistance to a small sample of these programs in order to increase the evaluation capacity of programs in this field.

Prevention of first-time male perpetration is important for at least three reasons. First, research indicates that males are responsible for the overwhelming majority of sexual violence perpetrated against women, children, and other men.[3] Second, patterns of male sexual aggression initiated in adolescence are often sustained in young adulthood.[15] Finally, women who reported being raped before age 18 were twice as likely to report being raped as an adult.[3] Therefore, one of DVP's goals is to identify and evaluate approaches that may prevent sexual violence from occurring in the first place.

In the past decade, various prevention programs have been developed, emphasizing male responsibility for the vast majority of sexual violence perpetration. These programs focus on reeducating boys and men via empathy induction,[16–18] defining and understanding consent,[12] discouraging passive bystander behavior,[19] and redefining the masculine role more generally. Unfortunately, however, there is neither a systematic catalog of these programmatic activities nor any summary of efforts that appear most promising or effective. Program evaluation is necessary in order to enable prevention staff from CDC, state and local agencies, or other community-based organizations to better identify and develop sound strategies for program improvement.

To address these shortcomings, DVP conducted a comprehensive literature review and expert panel feedback process that yielded 37 programs designed to prevent first-time male perpetration of sexual violence. Information on these programs has been compiled into a catalog that characterizes and describes these efforts. The identified programs range from one-time awareness and educational sessions to community level or environmental change strategies.[20]

To address the dearth of evaluation findings on sexual violence prevention, DVP is conducting an empowerment evaluation with four of these identified programs. An empowerment evaluation means that participating programs learn all the steps necessary to conduct their own evaluation, and CDC offers evaluation training and technical assistance. According to Fetterman,[21] an empowerment evaluation is the use of evaluation concepts, techniques (including both quantitative and qualitative methods), and findings to foster program improvement and program self-determination. It is designed to "help people help themselves" and improve their programs using a form of self-evaluation and reflection. Program participants conduct their own evaluations and typically act as facilitators. An outside evaluator often serves as a coach or additional facilitator. Therefore, an empowerment evaluation is an ideal way to gain scientific insights and build capacity in the field.

We expect that the insights from this evaluation will inform both the scientific agenda at CDC and the wide range of practitioners in the field of violence prevention. Fortunately, DVP is charged with the oversight of a major national program, the Rape Prevention and Education program, which is an optimal dissemination vehicle for innovative practices in the field of SV prevention.

A focus on translating scientific advances into practical application through effective programs and policies: The Rape Prevention and Education (RPE) program. The RPE works primarily through state health departments (for the purposes of this section, "state" refers to any U.S. state or territory), state sexual assault coalitions, local rape crisis centers, and other state and local organizations and partners to address the prevention of sexual assault. Authorized under the Violence Against Women Act (PL 106-386, October 28, 2000), this program funds the 50 states, the District of Columbia, and the U.S. territories to support educational seminars, hotline operations, training programs for professionals, informational materials, and other efforts designed to increase awareness of sexual violence. The core activities of this program are enumerated by the authorizing legislation, although the specific program components vary considerably. Some state programs are engaged in surveillance, and the funding is restricted to no more than 2% for such activities. Figure 2 provides an overview of the distribution of funds across the legislatively permitted activities. CDC allocates the RPE funds based on a population-based formula. This funding formula results in substantial variation in funding levels and contributes to programmatic variation.

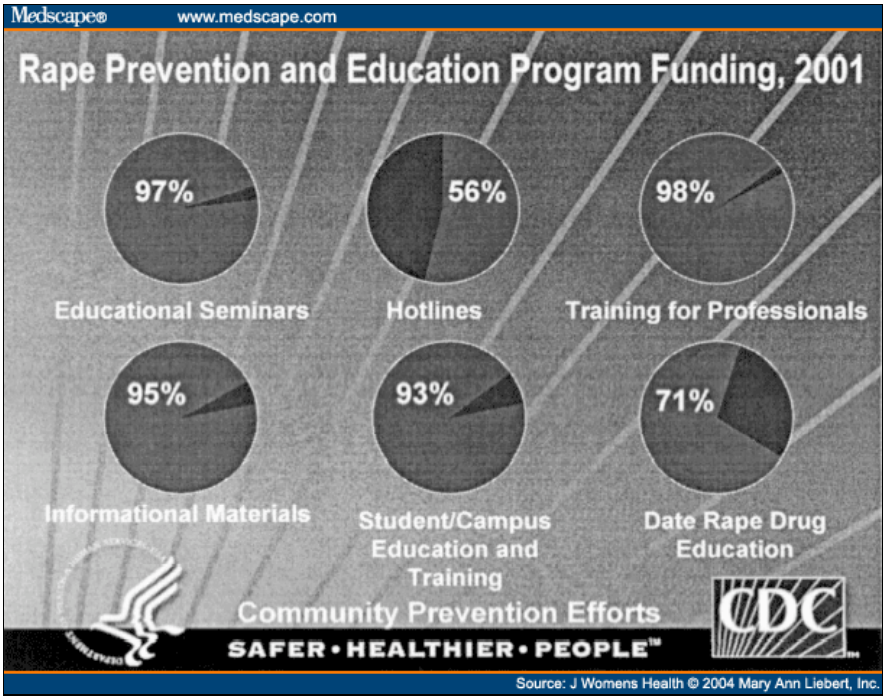

Figure 2. Percentage of RPE programs (n = 59) allocating funds to each of the legislatively permitted activities.

In an effort to translate scientific advances in the field in a programmatically relevant manner and to build capacity for prevention activities, DVP supports the RPE programs by facilitating cross-program exchanges, training, and conferences. For example, DVP designed and hosted a satellite videoconference held on April 3, 2003, entitled "Sexual Violence Prevention: Building Leadership and Commitment to Underserved Communities." (To view an archived version, visit: www.phppo.cdc.gov/PHTN/webcast/svprev/default.asp.) This training event had two primary goals: to assist participants in identifying strategies that contribute to the prevention of sexual violence in underserved communities using a public health approach and to create opportunities to initiate dialogue among new partners. The live satellite program was received in 48 states, D.C., Puerto Rico, and Canada. Approximately 225 sites viewed the program via satellite downlink, and an additional 158 viewed it via webcast sites. More impressively, 61 sites representing 35 states hosted discussions with viewing participants for up to 2 hours after the broadcast.

A commitment to building on the efforts of others by addressing gaps or needs: state health agency VAW planning and implementation efforts. In addition to working with state health agencies regarding sexual violence, CDC is committed to helping develop leadership and partnership opportunities between state public health agencies and other organizations working to prevent all forms of VAW. The preponderance of criminal justice and victim-focused activities has often caused either a nonexistent or a minimal role for the public health community. To help states elevate VAW as a public health priority, DVP funded the health agencies in California, Connecticut, District of Columbia, Hawaii, Iowa, Kentucky, Maine, Marshall Islands, Missouri, New Hampshire, Oregon, Texas, Virginia, and Pueblo of Isleta to plan VAW prevention activities. Asked to engage other state and community partners to conduct an assessment of current VAW prevention efforts, state health departments develop an action plan that documents strategies for sustaining and enhancing VAW prevention activities.

In addition, CDC funded the health departments of Alabama, Arkansas, Georgia, Illinois, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Utah, Vermont, Washington, West Virginia, and Wisconsin to implement state initiatives that address the prevention of VAW. This funding was based on action plans that had been developed previously for the prevention of VAW where states were ready to implement priority activities. These planning and implementation programs were to conduct their activities in collaboration with the state's injury departments in order to establish a linkage to injury-related resources that could provide data on incidence, prevalence, and risk factors to better understand victimization and perpetration in their communities.

The planning and implementation activities being conducted by the states are all unique, although common themes and priority foci emerge. Planning efforts focus primarily on assessing gaps in state level policies, surveillance and data, programs, and services directed to underserved and minority populations and the lack of prevention programming. Likewise, common implementation themes include enhancing the healthcare and health providers' response to VAW; cross-training of various sectors including substance abuse, mental health, and VAW service providers; and addressing data needs. Appendix A and Appendix B provide brief summaries of these activities by state.

To assess the effectiveness of this approach to capacity building, DVP monitored the progress of the initial 21 states that received funding for VAW planning by conducting technical assistance telephone calls. Three in-depth phone calls were conducted with each planning coordinator over the course of 18 months to evaluate the process of conducting a needs assessment, creating coalitions of partners to sustain efforts, and developing a state action plan. These technical assistance calls were then compared to better understand the facilitators, barriers, and lessons learned for future work in this area. Some early and immediate outcomes relate to CDC's work with state health departments, including suggestions regarding how best to specify the use of funds, support state-level efforts, and facilitate knowledge transfer across various grantees. Thus, CDC now has a better understanding of program dynamics and program effectiveness at the level of state health departments and has gained useful information about how the federal agency can work with states to support their program performance.

Discussion and Recommendations

CDC's strategic approach for VAW includes a focus on primary prevention through a commitment to advancing the science of prevention, focusing on translating scientific advances into practical application through effective programs and policies, and building on the efforts of others by addressing gaps or needs. The program and research efforts described provide examples of the intersections among the CDC's violence prevention research agenda, the strategic plan, and the guiding principles, which are realized through the various key activity areas. However, the activities highlighted in this paper represent only a small sample of CDC's VAW prevention portfolio. For a complete listing and overview of the CDC's VAW efforts, go to www.cdc.gov/ncipc.

Essential to CDC's success in the prevention of VAW is the ability to build on the lessons learned and experience of other successful prevention initiatives. In reviewing the literature and various websites dedicated to the practice of prevention, a common set of themes emerges as critical to success. We believe these themes will drive our success in moving forward with both research and programmatic priorities. These four themes, leadership, partnership, comprehensive approaches, and evidence-based strategies, must form the foundation on which all of DVP's activities are built.

Each of these themes presents unique challenges for the prevention of VAW. For example, the World Health Organization's recent *World Report on Violence and Health* discusses the widespread belief that violence is inevitable.[2] In response, VAW leadership must demand that our social understanding of violence shift from one of inevitable human nature to socially created and, therefore, preventable human behavior. That demand must then include science, programs, and policies designed to end the violence. Therefore, leadership must demand that our efforts and resources are not dedicated solely to the support of victims/survivors or the incarceration of offenders. Such restricted efforts will never end violence.

Our partnerships must also demand a new paradigm for the prevention of VAW. These partnerships need to be much more than an expansion of committed and interested parties. They must also be strategically designed to build and, when necessary, expose the failings of community and political will to end VAW.

The inclusion of comprehensive approaches for the prevention of VAW poses a particularly daunting challenge in an area that historically has lacked funding for primary prevention. As a result, the VAW prevention field lacks research or program models that are truly both primary prevention in nature and comprehensive. However, even with this reality, opportunities exist to embrace models that stimulate priority setting and may ultimately influence resource distribution. A variety of models, including the ecological model (Krug et al. 2002:12–15) and the Spectrum of Prevention (www.preventioninstitute.org), begin to provide the necessary frameworks on which experimentation must begin. These comprehensive approaches go above and beyond the treatment of particular individuals to include the context in which individuals behave—their peer groups, schools, families, communities, legislative environments, and other policy arenas. VAW is a social problem that must be addressed at all levels of social life.

Finally, the challenge of applying evidence-based strategies, which are currently in short supply, to all aspects of VAW prevention is probably the most difficult task for this next decade. The lack of empirically tested strategies reinforces the importance of ensuring that newly developed strategies are driven by sound science and theory. Moreover, the paucity of empirically tested strategies highlights the importance of evaluation as a core component of any VAW prevention initiative. A commitment to the identification and translation of externally valid strategies to prevention research priorities is critical to advancing the knowledge and base of support ultimately available for practice and policy development.

In sum, the challenges described take into consideration the state of the field of VAW prevention and the reality of resources being directed to this area. However, as CDC expands its base of evidence and moves toward the development of intermediate markers of success at various levels of analysis (e.g., the individual level, the neighborhood level), the impact of primary prevention in the overall prevention of VAW may not only begin to be quantified and measured but also to be realized.

Tables

Table 1. Priority Research Areas to Prevent Violence[8]

Table 2. Specific Research Priorities Related to VAW[8]

Evaluate the efficacy and effectiveness of interventions and policies to prevent perpetration of IPV and SV

Identify social norms that support IPV and SV and evaluate strategies to change them.

Evaluate training programs about IPV and SV for health professionals

Evaluate the health consequences of IPV and SV across the life span

Examine the development of IPV and SV perpetration to identify at-risk populations, modifiable risk and protective factors, and optimal times and settings for intervention

Develop and evaluate surveillance methods for IPV and SV

Evaluate the efficacy and effectiveness of interventions and policies for preventing IPV and SV victimization and its consequences

Evaluate models for integrated community responses to IPV and SV

Examine the development of IPV and SV victimization to identify at-risk populations, modifiable risk and protective factors, and optimal times and settings for intervention

Study the role(s) of substance use and abuse as precursors to and consequences of IPV and SV perpetration

Evaluate the impact of extreme community and environmental stressors on IPV and SV

Describe service delivery use, impact, and costs of interventions for IPV and SV

Appendix A. Violence Against Women State Action Plan Project Descriptions

State	*Proposed project*
California	**California Department of Health Services:** Assess policy gaps and develop an inventory of VAW-related data sources.
Connecticut	**Connecticut Department of Health Injury Prevention Program:** Establish a diverse state VAW advisory board to review VAW programs and services. Develop and disseminate a VAW prevention plan.
District of Columbia	**District of Columbia Department of Health:** Investigate approaches that support protection-seeking behaviors around violence. Identify cultural issues of diverse populations relative to VAW.
Hawaii	**Hawaii Department of Health:** Assess the needs and barriers to prevention among hard-to-reach women, such as immigrants, Native Hawaiians, gays and lesbians, women with disabilities, elderly women, and women in rural areas.
Iowa	**Iowa Department of Public Health:** Assess key data and review curricula for health professional VAW education programs. Assess school-based prevention programming in kindergarten-college institutions.
Kentucky	**Kentucky Cabinet for Health Services:** Assess VAW prevention practices in local health departments. Build and foster collaboration among the state health department, local health departments, and community agencies, such as rape crisis centers and domestic violence shelters.
Maine	**Maine Department of Health and Human Services:** Convene stakeholders to define and discuss improved VAW coordination mechanisms and locate possible sources of funding for additional planning and implementation of the strategic plan.
Marshall Islands	**Ministry of Health and Environment (MOHE) of the Republic of the Marshall Islands (RMI):** Assess reporting and documentation protocols for agencies reporting violence against women and the legal framework currently in existence to determine whether or not appropriate policies and programs are in place to protect and provide a supportive environment for victims of VAW.
Missouri	**Missouri Department of Health and Senior Services (MDHSS):** Conduct coordinated surveillance activities assessing the extent of VAW and identify disparate populations. Investigate evidence-based strategies and best practices to prevent VAW.
New Hampshire	**New Hampshire Office of Community and Public Health (OCPH):** Develop and publish a VAW injury surveillance report 1997–2000. Publish a state VAW plan with recommendations to improve effectiveness of surveillance and prevention activities. Gain support from the Governor's Commission Against Domestic and Sexual Violence.
Oregon	**Oregon Department of Human Services, Health Services (DHS):** Develop a plan that prioritizes strategies for reducing VAW through five areas: data collection, policy development, prevention programs, intervention programs, and evaluation activities.
Pueblo of Isleta	Social Services Department of the federally recognized tribal government, **Pueblo of Isleta:** Develop a culturally specific tribal data collection assessment tool to evaluate prevention and intervention utilization. Enhance collaboration with the Isleta Police Department, Tribal Courts, and community members to combine more accurate statistics and identify needs.
Texas	**Texas Department of Health, Bureau of Women's Health:** Conduct a survey of current community-based, public health-oriented VAW prevention programming in the state and conduct a survey to collect recommendations from experts in the field.
Virginia	**Virginia Department of Health:** Identify gaps in data collection and service needs. Convene internal and external partners, including health providers, to develop a strategic plan for addressing the identified gaps.

Appendix B. Violence Against Implementation Project Descriptions

State	Proposed project
Alabama	**Alabama Department of Public Health:** Develop a judicial training curriculum to address the identified need to provide Alabama's court system with a better understanding of the public health implications of domestic violence and sexual assault and the potential risk and lethality of these crimes.
Arkansas	**Arkansas Department of Health:** In collaboration with the **Arkansas Commission on Child Abuse, Rape and Domestic Violence**, address the need to train health professionals who have frequent contact with sexual or domestic violence victims by developing a comprehensive curriculum that addresses sexual assault and domestic violence issues.
Georgia	**Georgia Department of Health:** Identify gaps in VAW data collection. Develop strategies for providing technical assistance to expand the capacity of existing VAW service providers to reach underserved populations.
Illinois	**Illinois Department of Public Health:** Enhance training tools and training opportunities to improve awareness among the health system response to VAW among healthcare professionals, including a Spanish version of a VAW-related poster displayed in physician and clinic offices.
Massachusetts	**Massachusetts Department of Public Health:** Address the need to train maternal and child health providers by developing a comprehensive curriculum that will include information about domestic violence and sexual assault; language and cultural accessibility issues; disability issues; skill-building activities; community resources and referrals; safety issues for clients, children, and providers; legal issues; pregnancy-related issues; and basic screening documentation.
Michigan	**Michigan Department of Community Health:** Build a strong, state-level network for working with and responding to the media, and develop a sexual violence media guide for all types of journalists. Develop and implement a plan to provide training and technical assistance to local sexual violence programs on working and building positive relationships with the media.
Minnesota	**Minnesota Department of Health Injury Prevention Program:** Provide technical assistance to state services and programs that promote "healthy intimate/dating relationships" by producing and disseminating a resource packet to public health and community-based organizations throughout the state.
Nebraska	**Nebraska Department of Health and Human Services:** Provide training to two regional areas in rural Nebraska on physical and sexual trauma for domestic violence (DV) and sexual assault (SA) centers, substance abuse services, and mental health service providers
Nevada	**Nevada Department of Human Resources:** Train healthcare workers to improve the recognition of violence against women, referral, and treatment.
New Mexico	**New Mexico Department of Health:** Offer two types of cross-training. The first cross-training will bring the substance abuse treatment community, mental health providers, and VAW service providers together to address screening, referrals, and treatment for violence. The second cross-training will target law enforcement officers, attorneys, prosecutors, judges, victim advocates, and other professionals who respond to VAW.
North Carolina	**North Carolina Department of Health and Human Services:** Publish and distribute a training manual, *Responding to Violence Against Women: A Guide for Local Health Departments*. Conduct regional training workshops to support utilization of the manual.
North Dakota	**North Dakota Department of Health:** Address the need for improved data collection and analysis of pertinent violence against women data by developing a statewide data collection and analysis infrastructure.
Ohio	**Ohio Department of Health:** Disseminate the state action plan to state agencies and professional organizations and address the need for training mental health professionals on sexual assault issues.
Utah	**Utah Department of Health:** Develop a statewide sexual assault reporting system and hold a training conference for professionals.
Vermont	**Vermont Department of Health:** Develop a training program for primary care, emergency room and obstetrics/gynecology providers to increase knowledge around screening patients for domestic violence, documenting suspected cases, and referring victims to community resources for assistance.
Washington	**Washington State Department of Health:** Address the need to add an emphasis on sexual assault in an existing domestic violence curriculum. The revised training will be tested with two groups of providers—perinatal providers and providers from community and migrant health centers.
West Virginia	**West Virginia Injury Prevention Program:** Address the prevention of sexual assault on college campuses and expand the sexual assault nurse examiner program to underserved counties.
Wisconsin	**Wisconsin Department of Health and Family Services:** Document the findings and develop trainings from focus groups held with community stakeholders discussing the state's violence against women initiatives and specifically how to address the barriers experienced by underserved populations.

References

1. Mercy JA, Krug E, Dahlberg LL, Zwi AB. Violence and health: The United States in global perspective. Am J Public Health 2003;92:256.
2. Krug E, Dahlberg LL, Mercy JA, Zwi, AB, Lozano R, eds. World report on violence and health. Geneva, Switzerland: World Health Organization, 2002.
3. Tjaden P, Thoennes N. Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey. Washington, DC: U.S. Department of Justice, 2000.
4. Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate partner violence surveillance uniform definitions and recommended data elements. Atlanta GA: Centers for Disease Control and Prevention, 1999.
5. Basile KC, Saltzman LE. Sexual violence surveillance: Uniform definitions and recommended data elements. Atlanta, GA: Centers for Disease Control and Prevention, 2002.
6. Coker AL, Amith, PH, Bethea, L, King MR, McKeown RE. Physical health consequence of physical and psychological intimate partner violence. Arch Fam Med 2000;9:451.
7. Saltzman LE, Green YT, Marks JS, Thacker SB. Violence against women as a public health issue: Comments from the CDC.

Am J Prev Med 2000;19:325.
8. Centers for Disease Control and Prevention. CDC injury research agenda. Atlanta, GA: National Center for Injury Prevention and Control, 2002.
9. Centers for Disease Control and Prevention. Preventing violence against women: Program activities guide. Atlanta, GA: National Center for Injury Prevention and Control, 2003.
10. American Prosecutors Research Institute (APRI) and National Council of Juvenile Family Court Judges (NCJFCJ). Confronting violence against women: A community action plan. Alexandria, VA: APRI.
11. Berkowitz A. College men as perpetrators of acquaintance rape and sexual assault. J Am Coll Health 1992;40:175.
12. Berkowitz A. Men and rape: Theory, research, and prevention programs in higher education. San Francisco: Jossey-Bass Publishers, 1994.
13. Muehlenhard CL, Cook SW. Men's reports of unwanted sexual activity. Sex Res 1988;24:58.
14. Kilmartin CT, Conway A, Friedberg A, McQuiod T, Tschan P, Norbet T. Using the social norms model to encourage male college students to challenge rapesupportive attitudes in male peers. Paper presented at the Virginia Psychological Association spring conference, Virginia Beach, VA, 1999.
15. White JW, Koss MP. Adolescent sexual aggression with heterosexual relationships: prevalence, characteristics, and causes. In: Barbaree HE, Marshall WL, Hudson SM eds. The juvenile sex offender. New York: Guilford Press, 1993:182.
16. Dean KE, Malamuth NM. Characteristics of men who agress sexually and of men who imagine aggressing: Risk and moderating variables. J Pers Soc Psychol 1997;72:449.
17. Foubert JD. The longitudinal effects of rape-prevention programs on fraternity men's attitudes, behavioral intent, and behavior. J Am Coll Health 2000;48;158.
18. Schewe PA, O'Donohue W. Sexual abuse prevention with high risk males: The roles of victim empathy and rape myths. Violence Victims 1993;8:339.
19. Katz J. Reconstructing masculinity in the locker room: The Mentors in Violence Prevention Project. Harvard Educ Rev 1995;65:163.
20. RTI International. Evaluation assistance for projects designed to prevent first-time male perpetration of sexual violence: Final report on identification of programs. Durham, NC: RTI, 2003.
21. Fetterman DM. Empowerment evaluation: An introduction to theory and practice. In Fetterman DM, Kaftarian SJ, Wandersman A, eds. Empowerment evaluation: Knowledge and tools for self-assessment & accountability. Thousand Oaks, CA: Sage Publications, 1996:3.

Acknowledgements

We thank Alida Knuth and Janet Saul for helpful comments on earlier versions of this paper.

Reprint Address

Address reprint requests to: Rita K. Noonan, Ph.D. Centers for Disease Control and Prevention 4770 Buford Highway NE Mailstop K-60 Atlanta, GA 30341 E-mail: Rnoonan@cdc.gov

Corinne M. Graffunder, M.P.H., **Rita K. Noonan, Ph.D.**, **Pamela Cox, M.P.H.**, **Jocelyn Wheaton, M.P.H.**, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia.