# National and Global Agendas on Violence Against Women: Historical Perspective and Consensus

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Koss, M.P., & White, J.W. (2008). National and global agendas on violence against women: Historical perspective and consensus. *American Journal of Orthopsychiatry*, *78*(4), 386-393. DOI: 10.1037/a0014347.



## Abstract:

A policy analysis of II national and global institutions' violence against women agendas spanning 1990 to 2006 is presented. Analysis revealed 85 distinct recommendations. The highest percentages of them referenced prevention (29%); data, design, and measurement (21%); and psychotherapy and support (19%). Consensus (percentage of recommendations for future activities included in four or more agendas) was highest for advocacy (75%), funding (50%), prevention (48%), and data, design, and measurement (44%). Changes in emphasis over time, aims that have been abandoned, and observations contrasting U.S. and global agendas are also examined. The results create a context to inform the agendas currently in development within psychology, criminal justice, medicine, nursing, public health, and other disciplines. Next steps to guide future policy work include investigation of advocates', practitioners', researchers', and policymakers' perceived progress in implementing existing recommendations, empirical cataloguing of achievements that demonstrate progress toward aims, constituent input on reprioritization of activities, and contemporizing action steps.

## Article:

An agenda is "an outline or plan of things to be done" (Webster's Ninth New Collegiate Dictionary, 1985, p. 63). An agenda is an indispensible component of policy decisions when it is consensually developed by appropriate key informants through a valid process of information gathering and deliberation, and promulgated by a credible national or international entity. Agendas have been seen as "an urgent call to action" (U.S. Department of Justice, 2000). An agenda provides a rationale on which to ground difficult decisions that arise from finite resources and to respond to the volume of competing requests that arise inevitably among committed groups who differ in values, scope, and the subjectivity of their perceptions. Agendas have the power to elevate an issue to a priority through raising public awareness and political will for change. To the extent that they are well-developed and visionary, agendas can unite constituencies to work synergistically to achieve agreed upon objectives and can excite potential donors to contribute resources to realize aspirations.

This article reports a policy analysis of II national and global interpersonal violence agendas published between 1990 and 2006. The material was briefly presented as a keynote address at the American Psychological Association Summit on Violence and Abuse in Relationships: Connecting Agendas and Forging New Direction (Koss, February 29, 2008). The aim of the

analysis was to extract the set of specific recommendations contained in the agendas, qualitatively categorize them, use descriptive statistics to identify areas of emphasis, consensus, and divergence, discuss the chronology of introduction and abandonment of priorities, and consider potential nuances in perspective between U.S. and global agendas. The practical goal of the study is to create a historical context to inform newer agendas that are currently in development a result of the Presidential Initiative on Violence against Women and Children of Alan Kazdin of the American Psychological Association (APA). The article concludes with thoughts about the next steps in policy research that logically follow from the findings. We do not discuss state-of-the art methods for agenda development here. The analysis was limited to agendas that address what has been variously labeled violence against women (VAW), intimate partner violence (IPV), or gender-based violence (GBV). Generally, these terms are used synonymously and define the range of acts that constitute psychological, physical, and sexual maltreatment of women inside and outside the home, and in the case of GBV include acts against children as well such as selective sex abortion, trafficking, and genital mutilation.

## METHOD

The scope was not inclusive of every available agenda. The primary aim was to represent the medical, mental health, public health, and justice systems, when possible obtaining multiple agendas from the same source across time, to capture change in emphasis and direction. A further aim was to work with the products of major national and global organizations. The agendas were identified by searching the websites of the U.S. Department of Justice (DOJ), U.S. Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO). Bibliographic databases were also searched using the terms “violence against women,” “intimate partner violence,” “gender-based violence,” “sexual violence,” and “domestic violence” combined with the word “agenda” for any time period and included publications in journals and books. The final sample consisted of 11 agendas spanning the time period 1990 to 2006. The following documents were selected for inclusion:

*APA Women’s Mental Health Research Agenda: Violence Against Women* (Koss, 1990).

APA Taskforce on Male Violence Against Women report, *No Safe Haven: Male Violence Against Women at Home, at Work, and in the Community* (Koss, Goodman, Fitzgerald, Russo, & Keita, 1996 ).

National Academy of Sciences (NAS) report *Understanding Violence Against Women,* which was developed by a committee selected by the National Research Council (Crowell & Burgess, 1996).

DOJ monograph *Ending Violence Against Women: An Agenda for the Nation* (2000) prepared by the National Advisory Council on Violence Against Women under the leadership of Attorney General of the United States Janet Reno.

CDC Injury Research Agenda (2002).

World Health Organization book. *The World Report on Violence and Health* (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).

Agenda of the Sexual Violence Research Initiative (SVRI) developed under the direction of the WHO and now funded by the Global Forum (2003).

CDC report. *Sexual Violence Prevention: Beginning the Dialogue* (2004).

Discussion section of the WHO publication reporting results from the multicountry study on women's health and domestic violence against women (2005).

*California Statewide Policy Recommendations for the Prevention of Violence Against Women,* which was a final report to the CDC based on input from 22 states and coalitions (2004, 2006).

There are omitted documents that we would like to recognize and provide a rationale for their exclusion. The *Journal of Interpersonal Violence* under guest editor Carol Jordan published a two-part special issue titled. *Toward a National Research Agenda on Violence Against Women: Continuing the Dialogue on Research and Practice* (Jordan, 2004a, b). The introduction states that the editor "does not presume to set the nation's research agenda on violence against women (VAW), nor is it the first attempt to contribute to how that agenda might be informed" (p. 1367). In honor of this request and because the recommendations of the authors who contributed articles must be viewed as their own, they are excluded. Also excluded was an agenda developed by the Department of Defense (Stith, 2006) as it was restricted in application to a specialized population and institutional culture. *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health* (Burchart, Phinney, Check, & Villaveces, 2004) was omitted because this indispensible publication is not an agenda in and of itself, but rather contains action steps to realize the WHO agenda. The analysis omitted the agenda from the website of the Violence against Women and Family Violence Office of National Institute of Justice (accessed January 16. 200X. at www.ojp.usdoj.gov/nij/vawprog/mission.html) as it consists of only six general emphasis areas. For the same reason the priorities of the U.S. Department of Justice, National Institute of Justice are omitted (www.ojp.usdoj.gov/nij/topics/crime/rape-sexual-violence/ongoing-research.htm). The Policy Forum on Male Violence Against Women published in *American Psychologist* (1993), by Koss, Goodman, Fitzgerald, Russo, and Keita is omitted because its recommendations formed the basis for the book edited by Koss, Goodman et al. (1996) that is included. The nursing agenda by McBride (1992) was not included as it represented only the views of the author.

Each of the 11 agendas was read and identifiably separate recommendations were extracted. Although the word "recommendation" was the most widely used in the documents, other terms encountered that were considered equivalent included directions for future work, actions or action steps, strategies, principles, priorities, focus areas, objectives, and aims. Initially every recommendation was extracted from each agenda in the words used in the source document. Then, the list was reduced by harmonizing the language of duplicate or overlapping recommendations. The final inclusive list of conceptually distinct recommendations consisted of 85 items. These are available in Appendix I to the article (supplemental materials). Next, categories were created qualitatively from iterative sorting of the recommendations until each could be subsumed within a set of related items. Following this step the other aims of the article

were undertaken including identifying areas of consensus, studying change over time, and comparing national and global perspectives.

**Table 1:** *Recommendations Appearing in Four or More Violence Against Women Agendas, 1990-2006*

| Consensus recommendations across 11 agendas[2] | Identity of organization endorsing each recommendation[1] | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Data, design, and measurement | | | | | | | | | |
| Improve database | 1 | 2 | 6 | 7 | 8 | 9 | 10 | | |
| Plan to collect ongoing representative prevalence statistics | 1 | 2 | 3 | 5 | 6 | 7 | 9 | | |
| Improve, standardized measurement and new assessment tools | 4 | 6 | 7 | 9 | 10 | | | | |
| Develop standardized terminology | 4 | 6 | 7 | 9 | 10 | | | | |
| Include special populations (race, poverty, ethnicity, sexual orientation; trafficking, those in conflict areas, female genital cutting, children, adolescents, seniors) | 1 | 2 | 3 | 4 | 7 | 11 | | | |
| Assess life span experiences and inter-relatedness of forms of VAW | 1 | 2 | 4 | 5 | 6 | 7 | 9 | | |
| Examine cultural supports for violence including attitudes including economic, legal, religious, and social institutional practices that support and perpetuate violence | 2 | 5 | 6 | 7 | 8 | 10 | | | |
| Strengthen government coordination of database development | 2 | 3 | 6 | 8 | 10 | | | | |
| Medical Responses | | | | | | | | | |
| Train medical professionals to provide victim sensitive, nonstigmatizing health care (avoid revictimization); monitor responsiveness | 1 | 2 | 4 | 5 | 6 | 7 | 10 | | |
| Improve emergency response—written medico-forensic protocols and referral to specialized services | 1 | 2 | 5 | 7 | 10 | | | | |
| Research mental and physical health impact | 1 | 5 | 6 | 7 | | | | | |
| Integrate violence care into emergency, reproductive, antenatal, family planning, post abortion, mental health, HIV/AIDS, and adolescent medicine services | 2 | 4 | 6 | 10 | | | | | |
| Psychotherapy and support | | | | | | | | | |
| Develop culturally and linguistically informed interventions inclusive of special populations and located in areas of greatest needs | 2 | 4 | 6 | 9 | 11 | | | | |
| Target high-risk groups of offenders and victims with secondary prevention, especially youth | 1 | 2 | 8 | 10 | | | | | |
| Strengthen formal and informal support systems for women living with violence including safe housing, child care, and financial assistance | 2 | 4 | 6 | 9 | | | | | |
| Document and evaluate community-based services | 1 | 6 | 7 | 10 | | | | | |
| Foster coordination of medical, mental health, and justice | 1 | 4 | 10 | 11 | | | | | |
| Improve evaluation of treatment effectiveness and impact on reduction of future violence | 1 | 2 | 5 | 10 | | | | | |
| Justice Responses | | | | | | | | | |
| Determine effectiveness of retributive responses, extent they are actually applied, and offenders' perception of stigma and risk punishment | 2 | 4 | 6 | 7 | 9 | 11 | | | |
| Identify justice barriers and increase justice options for rape victims from existing criminal and civil processes including flexible or alternative sanctions such as use of restorative justice methods | 2 | 4 | 7 | 10 | | | | | |
| Prevention | | | | | | | | | |
| Develop and evaluate theoretically-based interventions to change social norms for individuals, professionals, families, communities, and broader society | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Research risks for victimization and create risk profiles, focusing on features amenable to change | 2 | 5 | 6 | 7 | 9 | 10 | | | |
| Research risks for perpetration including conditions that channel individual motivation into violent action, determinants of decision making, and factors that foster maintenance, escalation, reduction, or desistence | 2 | 5 | 6 | 7 | 9 | 10 | | | |
| Create multisectoral, multimethod action plan involving medical, justice, and public health systems and family, friends, community organizations, business, military, unions & faith community | 1 | 2 | 4 | 5 | 6 | 8 | 10 | 11 | |
| Collect systematic data on injuries and biomechanical profile of specific injuries that characterize IPV and CM | 2 | 5 | 8 | 10 | | | | | |
| Emphasize primary prevention | 2 | 5 | 8 | 10 | | | | | |
| Prioritize primary prevention with children including prevention of child abuse | 4 | 5 | 6 | 8 | 10 | 11 | | | |
| Identify high-risk families and offer parenting interventions on how to address SV promoting attitudes as well as reduce both intergenerational transmission and revictimization of parents. | 2 | 4 | 10 | 11 | | | | | |
| Create sustained, long-term antiviolence curriculum in schools, starting in elementary grades; include neediest school initiatives; although with different information and balance of same sex and mixed sex interventions using age appropriate approaches; eradicate corporal punishment | 2 | 6 | 8 | 10 | 11 | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Make physical environment and schools safer for girls; hold "Take Back the Nights" rallies; use youth as change agents | 6 | 8 | 10 | 11 | | | | | |
| Use media for prevention deliver consistent messages to change norms, inform about treatment, lessen stigma, promote self-identification as perpetrator; reduce violence in media | 2 | 4 | 6 | 8 | 11 | | | | |
| Share assessable, evidence-based summaries of research findings with communities/service sectors | 2 | 3 | 5 | 6 | 7 | | | | |
| Advocacy | | | | | | | | | |
| Use knowledge-based advocacy to educate legislators and public speaking out | 2 | 3 | 7 | 8 | 10 | | | | |
| Strengthen national commitment and strategic planning; identify service gaps | 4 | 8 | 9 | 10 | 11 | | | | |
| Promote human rights, gender and socioeconomic equality | 2 | 4 | 7 | 8 | 10 | 11 | | | |
| Funding | | | | | | | | | |
| Increase funds for prevention, particularly school-based | 2 | 8 | 10 | 11 | | | | | |
| Increase funds for service provision and shelters | 1 | 2 | 4 | 10 | 11 | | | | |
| Increase research and evaluation funding and use it to encourage collaborations and interdisciplinary work | 1 | 2 | 3 | 4 | 7 | 8 | 9 | 10 | 11 |

*Note*. The numbers within the boxes link the recommendations to the organizations by which they were endorsed. The legend for the numbers is the following:

1 = American Psychological Association, *The women's mental health research agenda: Violence against women,* Koss (1990).

2 = American Psychological Association, *Male violence against women: Current research and future directions,* Koss et al. (1993).

3 = National Academy of Sciences, *Understanding violence against woman,* Crowell & Burgess (1996).

4 = U.S. Department of Justice. National Advisory Council (2000), *Ending violence against women: An agenda for the nation.*

*5* = Centers for Disease Control and Prevention (2002), *CDC Injury Research Agenda*.

6 = The World Health Organization, *The world report on violence and health.* Krug et al. (2002).

7 = The Global Forum's *Sexual Violence Research Initiative Agenda,* (2003).

8 = Centers for Disease Control and Prevention, *Sexual violence prevention: beginning the dialogue* (2004).

9 = National Academy of Sciences, *Advancing the federal research agenda on violence against women: Steering Committee for the Workshop on Issues in Research on Violence Against Women,* Kruttschnitt et al. (2004).

10 = World Health Organization. *WHO multi-country study on women's health and domestic violence against women summary report of initial results on Prevalence, health outcomes and women's responses* (2005).

11= *California statewide policy recommendations for the prevention of violence against women: A final report to the Center for Disease Contra/and Prevention.* 2004, revised 2006).

## RESULTS

The 85 conceptually distinct recommendations could be categorized under the following headings: (a) data, design, and measurement; (b) medical response; (c) psychotherapy and support; (d) criminal justice response; (e) prevention; (f) advocacy; and (g) funding. The percentages of the 85 recommendations that fell within each category provided a rough estimate of relative emphasis. The percentage of total recommendations contributed to the total by each content category was as follows: data, design and measurement (21%); medical response (12%); psychotherapy and support (19%); criminal justice response (7%); prevention (29%); advocacy (5%); and funding (7%). The extent of consensus was assessed by using the tally of which agendas included each of the 85 items. Our operational definition of consensus was inclusion of a recommendation in four or more agendas. Of the 85 recommendations, 38 (45%) reached consensus. Table 1 presents these widely endorsed recommendations. Consensus from highest to lowest was as follows: advocacy (75%), funding (50%), prevention (48%), data, design, and measurement (44%), psychotherapy and support (38%) and justice responses (33%). The note at the foot of table 2 links each number to the corresponding agenda.

The agendas were arranged chronologically to assign the numbers. Agendas numbered 1, 2, and 3 in Table 1 date from 1996 or earlier (early years). Agendas numbered 4, 5, 6, and 7 date from 2000 to 2003 (middle years), and agendas 8 through 11 were issued between 2004 and 2006 (contemporary). The early years were a fertile period that generated 32 of the 38 (84%) consensus recommendations. The middle years saw the introduction of 6 new recommendations (16%). The consensus recommendations in the four agendas issued since 2004 all had their roots in earlier documents. An example of interpreting the material reported in Table 1 is the following: the recommendation to collect ongoing representative prevalence statistics was

present in 7 of 11 agendas. It was first made by APA in 1990 (1) and most recently reaffirmed by the NAS in 2004 (9).

The highest level of consensus as defined by inclusion in 7 of 11 agendas was seen in data, design, and measurement where three items met this criterion: (a) improve prevalence database, (b) collect ongoing representative prevalence statistics, and (c) assess violence exposure throughout life and examine the interrelatedness of various forms of IPV. Two prevention recommendations were widely endorsed: (a) develop and evaluate effective, theoretically based interventions to change social norms and (b) create multisectoral, multimethod action plans involving medical, justice, and public health systems and diverse groups ranging from family to broader society. Consensus in the funding category focused on increasing research and evaluation funding and using it to encourage collaborations and interdisciplinary work. Only one recommendation within medical responses reached near uniform consensus; it aimed to train medical professionals to provide victim sensitive, nonstigmatizing health care, avoid revictimization, and monitor responsiveness. None of the recommendations on psychotherapy and support, justice responses, or advocacy met criteria for ubiquitous endorsement.

Table 2 lists the recommendations contained in earlier documents but absent from WHO 2005 or CAS 2006. We have labeled these recommendations as abandoned. Among the 85 total recommendations in Appendix 1 (supplemental materials), 22 met the criterion for abandonment (26%). By category the percentage of earlier recommendations that fail to appear in contemporary agendas are as follows: data, design, and measurement (22%), medical responses (20%), psychotherapy and support (25%), justice responses (50%), prevention (32%), advocacy (9%), and funding (0%). As a sidelight we also identified items that were found in only a single agenda. We labeled these one-time recommendations as solo. Of the 10 solo recommendations, half appeared in contemporary agendas (CDC, 2004; NAS, 2004; WHO, 2005), 33% were from the middle years, and 20% dated to the earliest period. Some of the solo items clearly represent new emphases including implementing standard ethical guidelines and confidentiality, and integrating VAW into existing prevention programs focused on HIV/AIDS while addressing gender, power, and consent within behavioral prevention. Others appear to be actions worthy of reconsideration including (a) screening for violence exposure as part of psychological assessment (APA, 1996); (b) examining interactions with substance abuse (CDC, 2002); and (c) studying firearm control and VAW (WHO, 2002).

We were also interested in comparisons of the contemporary U.S. agendas (CDC, 2004; NAS, 2004; CAS, 2006) to global agendas aimed at low and middle income countries (SVRI, 2003; WHO, 2005). We examined this question using two approaches. First, we identified the number of recommendations from among the total of 85 presented in Appendix 1 (supplemental materials) that diverged, meaning they were endorsed only by U.S. agendas or by global agendas. Divergence overall was quite high across the full set of recommendations (37 of 85). Specifically, the percentage of divergent recommendations was: data, design, and measurement (33%); medical responses (80%); psychotherapy and support (56%); justice responses (83%); prevention (28%); advocacy (25%); and funding (17%). The interested reader can identify the discordances from inspection of Appendix 1 (supplemental materials).

**Table 2:** *Abandoned and Solo Recommendations in Violence Against Women Agendas, 1990-2006*

| Recommendation | First appearance | Last appearance | Solo objective |
|---|---|---|---|
| Data, design, measurement | | | |
| Document sensitivity and specificity, reliability, validity, and success of eliciting disclosure of relevant data | APA 1990 | SVRI 2003 | |
| Implement standard ethical guidelines and confidentiality | | | WHO 2005 |
| Press for change in U.S. National Crime Victimization Survey | APA 1990 | APA 1996 | |
| Study effect of women's victimization on women's offending | | | NAS 2004 |
| Investigate interdependence of men's violence and women's violence perpetration and integrate VAW with study of other forms of violence | | | NAS 2004 |
| Measure costs of violence including those due to globalization | DOJ 2000 | CDC 2004 | |
| Implement longitudinal designs (trajectory of violence IPV vs. general violence) | CDC 2002 | NAS 2004 | |
| Medical responses | | | |
| Implement screening and recognition of signs of violence | APA 1996 | WHO 2002 | |
| Describe informal and formal help-seeking by victims and document factors and exacerbate distress and facilitate recovery | WHO 2002 | SVRI 2003 | |
| Psychotherapy and support | | | |
| Assess cognitive and/or emotional impact of victimization | | | WHO 2005 |
| Screen and document violence exposure as part of psychological assessment | | | APA 1996 |
| Innovative and expand psychotherapy especially for delayed and compounded trauma | APA 1990 | APA 1996 | |
| Develop and evaluate perpetrator interventions | APA 1996 | CDC 2004 | |
| Organize multi-site studies of treatment effectiveness | APA 1990 | APA 1996 | |
| Justice responses | | | |
| Create special units of police, prosecutors, and victim advocates and police protocols for response/investigation; monitor them | APA 1996 | NAS 1996 | |
| Enact laws and policy that increase women's safety; extend rape shield, double penalties for rape, obtain state payment for forensic exams; federalize DV under interstate travel law; achieve multi-state enforcement of protection orders; legally define as child abuse violence committed in presence of children; involuntary joint custody policies | APA 1996 | WHO 2002 | |
| Increase accountability for date rape and accurate reporting of statistics on college campuses | APA 1996 | CDC 2004 | |
| Prevention | | | |
| Study interactions with substance abuse | | | CDC 2002 |
| Identify impact of community and environmental stressors and settings where rates of violence are high or rapidly changing | CDC 2002 | NAS 2004 | |
| Firearm control | | | WHO 2002 |
| Develop date rape prevention curriculum and coordinate services on college campuses | DOJ 2002 | CDC 2004 | |
| Target high risks for perpetration—men, male athletes, fraternities, refugees, migrants, unemployed, alcoholics, separating and divorced | APA 1996 | CDC 2004 | |
| Integrate VAW into existing prevention programs (HIV/AIDS) and address gender, power, consent | | | WHO 2005 |
| Mount awareness campaigns for highly stressed groups and families—refugees, immigrants, and caregivers | WHO 2002 | CDC 2004 | |
| Adapt and test successful programs more widely and in diverse settings | DOJ 2000 | SVRI 2003 | |
| Share assessable, evidence-based summaries of research findings with communities and among service sectors | APA 1996 | SVRI 2003 | |
| Foster widespread adoption of effective prevention | | | CDC 2004 |
| Evaluate cost-effectiveness: prevention and dissemination | | | |
| Strengthen government coordination of knowledge base development focused on prevention | CDC 2002 | WHO 2002 | |
| Advocacy | | | |
| Evaluate effectiveness of policies and monitor adherence to treaties | CDC 2002 | NAS 2004 | |
| Funding | | | |
| Create three to four research centers within academic settings to support research and training programs on violence against women | | | NAS 1996 |

*Note.* Tables 1 and 2 do not total 85 recommendations. Those recommendations omitted were present in the most current agendas, but did not reach the standard for designation as a consensus recommendations.

Finally, we narrowed our focus only to the consensus recommendations presented in Table 2. Examining the extent of agreement on major directions using Table 1, which focused on consensus recommendations revealed that approximately a third (12 of 38) were discrepant. Discrepancy could occur because consensus was achieved by widespread endorsement in U.S. documents that is not reflected internationally or vice versa. That appeared to be true in two categories. Discrepancies stemming mainly from presence on the U.S. agendas and not in the global documents were observed in data, design, and measurement (4 of 6 consensus recommendations gained that status through endorsement limited to U.S. agendas). Discordance stemming from presence only on the global agenda was clustered in recommended medical responses. Among the most recent global agendas, 8 of 8 consensus medical responses were no longer included on U.S. agendas. There were no systematic trends in differences between national and international recommendations in the categories of prevention, advocacy, and funding.

The specific recommendations highlighted only in U.S. documents included: (a) plan to collect ongoing representative prevalence statistics; (b) include special populations (defined by race, poverty, ethnicity, sexual orientation, or age [children, adolescents, seniors]; those in conflict areas, or those experiencing trafficking or female genital cutting,); (c) assess life span experiences, and interrelatedness of forms of VAW; (d) develop culturally and linguistically informed interventions inclusive of special populations and located in areas of greatest needs; (e) strengthen formal and informal support systems for women living with violence including safe housing, child care, and financial assistance; and (f) determine effectiveness of retributive responses, extent they are actually applied, and offenders' perception of stigma and risk of punishment.

Recommendations that were globally salient were (a) train medical professionals to provide victim sensitive, nonstigmatizing health care (avoid revictimization); monitor responsiveness; (b) improve emergency response-written medico-forensic protocols and referral to specialized services; (c) integrate violence care into emergency, reproductive, antenatal, family planning, post abortion, mental health, HIV/AIDS, and adolescent medicine services; (d) document and evaluate community-based services; (e) improve evaluation of treatment effectiveness and impact on reduction of future violence; and (f) identify justice barriers and increase justice options for rape victims from existing criminal and civil processes, including flexible or alternative sanctions such as use of restorative justice methods.

## CONCLUSIONS

Examination of a range of violence agendas supports a number of summary statements and raise questions to stimulate future work. We conclude that the earliest agendas contained substantially the same recommendations as those produced today; 84% of consensus recommendations were first placed in the literature prior to 1996. Taken literally, this finding raises the question of whether movement toward these goals has occurred in the past quarter century. Clearly, progress has been made, but the field is using language that fails to communicate a higher level of nuance and new levels of complexity at which we are now addressing our priorities.

There were a number of potential partnerships identified in the recommendations—academics with practitioners, violence specialists with a range of medical settings, justice and public health

personnel with policymakers, integration of prevention activities with efforts directed at factors known to be associated with or exacerbate violence, including substance abuse, unsafe sex, and firearm availability. Progress has been made in these areas such as the creation of federally funded national resource centers in sexual (e.g., National Sexual Violence Resource Center) and domestic violence (e.g., National Resource Center on Domestic Violence), as well as online resources to translate and foster practical use of research findings (e.g., VA Wnet.org; SVRI.org). Future recommendations regarding collaboration would benefit from acknowledging that this priority dates from the earliest agendas. That there must be more nuanced ways to express it, acknowledge progress, made and become more concrete in how these efforts can be further nurtured and sustained.

### *United States versus Global Emphases*

The United States is focusing quite strongly on improvements in quantitative methodology and emphasizing the need for standardization and improved measurement and design. These goals are indeed important. They may reflect the level of methodological and statistical sophistication in the U.S. context, as seen in, for example, the requirement of training in advanced statistical methods in many doctoral programs. We might be asking as future priorities are set in the global context whether there ways that measurement and design could be approached that would make more of a contribution to addressing the serious gaps in knowledge that exist in low and middle income countries and not focus exclusively on what is needed to move basic research forward in developed settings.

Medical responses at the present time are almost exclusively emphasized outside the United States. This finding raises a number of questions. Are the models being implemented in low to middle income countries appropriate to their settings, where the accessibility and workforce capacity for specialized care will be much less for the foreseeable future? It is legitimate to question whether emphasizing sophisticated forensic exams that require large capital outlays for equipment and trained personnel is a reasonable starting point for a low income country, especially without a clear-eyed look at evaluations of how these methodologies influence the survivor welfare and access to justice in the developed world (see Koss & Achilles, 2008). Another point for consideration is whether in the developed world context the de-emphasis of priorities within medical response means that goals have been achieved, or that there has been insufficient attention to what the next steps should be to build on the progress made. The latter seems to be the case based on the recommendations of the Academy on Violence and Abuse's blueprint for advancing professional health education (Mitchell et al., 2008).

Within justice, there appears to be a stark difference in approach to violence nationally and internationally. In the United States, recommendations focus on retribution, whereas global agendas speak of identifying the obstacles to justice and devoting creativity to offering survivors of violence more choices in achieving a just outcome. The U.S. VAW workforce would benefit from greater familiarity with empirical evaluations of the progress that has been made through retributive justice so that we may move away beyond reflexively restating recommendations that may not be achieving the desired outcomes.

### *Limitations*

There are a number of limitations to the present analysis. The selection of agendas was not exhaustive. Neither the qualitative nor the quantitative analyses were sophisticated. For example, the recommendations were extracted from the original sources without attempting to interpret what the authors might have meant or had been implying, but instead focused only on the surface meaning of the text as written. Some of the findings about relative emphases and lost strands may be somewhat artifactual because the institutions producing them have changed over time. The earliest agendas were stimulated by organizations such as the APA that predictably approached violence against women in the context of a mental health agenda (Koss, 1990). As the field progressed, both public health and justice agencies became active in producing comprehensive violence prevention agendas such as NAS, 1996; DOJ, 2000; and WHO, 2002.

The most recent agendas have all come from public health organizations, which necessarily influence the rise in emphasis on primary prevention and the de-emphasis of justice models of understanding and preventing violence. Although there is a need for detail in specific recommendations that will move efforts in primary prevention, justice, and health care forward, the field itself might find synergy in the agendas produced during the mid-1990s to the early 2000s that were integrative and attempted to consider how the recommendations could be realized through collaboration.

The future promises new agendas to work with that may create a balance of perspectives and the synergy of systems working together. New agendas are anticipated from the APA, nursing organizations, and the U.S. Department of Justice, National Institute of Justice, as well as CDC. Nevertheless, there is value in the analyses presented in this particle because new agendas hopefully advance the field rather than restate the same goals that have been on the table for a long period. Language is needed that acknowledges the present state of knowledge and bases recommendations on where the gaps are now. In addition, action steps to realize the agenda should be contemporary, practical, clearly described, and measurable. The implementation guide to WHO (2002) is a good example of an enhanced level of specificity to facilitate goal attainment.

A number of steps would add to the ability of the present findings to inform agenda building efforts. First, we suggest that there be a study to determine the extent to which practitioners, researchers, advocates and policymakers believe that the recommendations identified here have progressed over their careers. To the extent that progress is perceived, what are the factors that promoted it? Alternatively, if many recommendations are perceived as lagging in realization, what are the perceived obstacles to moving ahead? Second, it would be helpful to produce a coordinated empirical evaluation of what the field has already achieved in each of the general areas identified in this article within both physical and sexual violence. How recommendations are phrased and the actions steps expressed should ideally be based on a sound assessment of progress already made.

Lastly, it is widely recognized that agenda setting must be collaborative (Hague, 2005; Jordan, 2004a, b) and represent multiple partners from the academic, practice, policy, survivors, and advocacy community. The perspectives of those who have specialized expertise in single forms of violence and those that have viewed the effects of violence in diverse communities must be

brought together to realize an agenda that makes the necessary connections across the life span and breaks down the fences that have functioned to keep violence studies fragmented, depriving the field of cross-fertilization. Methodological advances, theoretical developments, models of behavioral change, and prevention and intervention models clearly have application beyond our fenced yards and would enhance the entire neighborhood, nation, and the world.

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