

Violence Against Women

<http://vaw.sagepub.com>

Primary Prevention of Violence Against Women: Training Needs of Violence Practitioners

Sandra L. Martin, Tamera Coyne-Beasley, Mary Hoehn, Mary Mathew, Carol W. Runyan, Steve Orton and Leigh-Anne Royster

VIOLENCE AGAINST WOMEN 2009; 15; 44 originally published online Nov 12, 2008;

DOI: 10.1177/1077801208327483

The online version of this article can be found at:
<http://vaw.sagepub.com/cgi/content/abstract/15/1/44>

Published by:



<http://www.sagepublications.com>

Additional services and information for *Violence Against Women* can be found at:

Email Alerts: <http://vaw.sagepub.com/cgi/alerts>

Subscriptions: <http://vaw.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations <http://vaw.sagepub.com/cgi/content/refs/15/1/44>

Primary Prevention of Violence Against Women

Training Needs of Violence Practitioners

Sandra L. Martin

Tamera Coyne-Beasley

University of North Carolina at Chapel Hill

Mary Hoehn

Georgetown University

Mary Mathew

Carol W. Runyan

Steve Orton

University of North Carolina at Chapel Hill

Leigh-Anne Royster

Elon University

Practitioners in domestic violence and sexual assault programs have been encouraged by the National Center for Injury Prevention and Control to enhance their activities in violence prevention; however, many practitioners have not been trained in prevention concepts and strategies. Therefore, a needs assessment was undertaken with practitioners in the Domestic Violence Prevention Enhancement and Leadership Through Alliances and the Rape Prevention and Education programs to determine training needs. Results show that practitioners are very interested in primary prevention. They want to learn about working at the community level (rather than the individual level), developing and evaluating prevention activities, and identifying effective primary prevention programs.

Keywords: *domestic violence; prevention; sexual assault; training; violence; women*

Although violence against women, including domestic violence and sexual assault, has been recognized as an important public health problem, most programs and services have focused on responding to violent incidents after they

Authors' Note: This work was supported by funding from the National Center for Injury Prevention and Control to the University of North Carolina Injury Prevention Research Center on behalf of the National Training Initiative for Injury and Violence Prevention (Cooperative Agreement U81/CCU423267). The authors would like to thank the following persons for their help in the production of this research: Phyllis Fleming, Corinne Graffunder, Carol Gunther-Mohr, Jennifer Middlebrooks, and all of the violence practitioners who participated in this project.

occur rather than on preventing the violence from occurring in the first place (i.e., the primary prevention of violence). This is despite the fact that public health has a long history of designing preventive interventions based on sound program development and evaluation principles (Glanz, Rimer, & Lewis, 2002; Green & Kreuter, 2005). Moreover, the idea of "evidence-based public health practice" (i.e., using research findings, behavioral science theory, and program planning models as the foundation for the development and evaluation of public health programs and policies) has gained prominence in the past decade, building in part on the promotion of evidence-based medicine (Brownson, Baker, Leet, & Gillespie, 2003). Even so, the concept of using evidence-based strategies for the primary prevention of violence against women has not been universally adopted by practitioners who work in the field of violence; thus, there is a dearth of effective, evidence-based, primary prevention public health approaches to avert such violence (Schewe, 2006; Whitaker, Baker, & Arias, 2006).

The paucity of effective evidence-based programs aimed at the primary prevention of violence against women is understandable when one considers the etiology of this violence, the research base concerning this problem, and the training and orientation of many of the community-based practitioners who work in the field of violence against women. The etiology of violence against women is extremely complex, resulting from a variety of forces that operate on several levels, including that of the individual, the family, the community, and the society (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Therefore, no single, simple intervention will be sufficient for the prevention of such violence. There has been little research funding available to foster the design, implementation, and evaluation of programs for the primary prevention of violence against women. As a result, the knowledge base concerning effective preventive interventions in this area is extremely limited. Also, the practitioners working within community-based agencies focused on violence against women, such as domestic violence programs and sexual assault programs, typically concentrate their efforts on the provision of needed therapeutic and legal services after violence occurs rather than on activities to prevent the violence before it starts. Even when these practitioners develop a preventive component to their work, they often have limited training on the science of prevention, limited resources to undertake ambitious prevention efforts, and little experience with rigorous methods to evaluate the results of their interventions.

In recognition of these issues, and to further a public health agenda addressing the prevention of violence against women, the National Center for Injury Prevention and Control (NCIPC) increased its emphasis on violence primary prevention initiatives by funding the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program and the Rape Prevention and Education (RPE) program. NCIPC has funded 14 DELTA programs that are housed within state domestic violence programs. These DELTA programs provide support for local coordinated community responses focused on reducing the incidence of intimate

partner violence (NCIPC, 2006a). NCIPC also has funded RPE programs in all 50 states, the District of Columbia, and the U.S. territories (one program per geographic unit) aimed at strengthening sexual assault prevention efforts through increasing awareness, providing education and training, and operating telephone hotlines (NCIPC, 2006b). Most of these RPE programs are housed in state sexual assault coalitions or state health departments.

NCIPC recognized that the DELTA and RPE practitioners needed additional training concerning the science of primary prevention to develop, implement, and evaluate their primary prevention activities; therefore, NCIPC established funding for what has become the PREVENT Program (Preventing Violence through Education, Networks, and Technical Assistance; Runyan et al., 2005). PREVENT is supported through a cooperative agreement with the University of North Carolina Injury Prevention Research Center on behalf of the National Training Initiative in Injury and Violence Prevention. Although PREVENT currently addresses the prevention training needs of practitioners working in many areas of violence (e.g., youth violence, child maltreatment, suicide), PREVENT's initial focus was on practitioners concerned with violence against women, with a particular focus on those working within the DELTA and RPE programs.

PREVENT personnel recognized that developing a training program on primary prevention that adequately addressed the needs of the DELTA and RPE practitioners would benefit from a needs assessment focused on these issues (Tannenbaum & Yukl, 1992; Taylor, O'Driscoll, & Binning, 1998). This article describes the questions posed in this needs assessment, the procedures used to implement the needs assessment, and the findings of the needs assessment.

Method

Study Questions

To learn more about the DELTA and RPE practitioners and their programs, the following questions were addressed by the needs assessment:

1. What are some characteristics of the practitioners working within the DELTA and RPE programs, such as their education levels and the number of years they have worked in the field of violence?
2. What are some characteristics of the agencies that house the DELTA and RPE programs, including state domestic violence coalitions, state sexual assault coalitions, and state health departments?
3. What topics would the DELTA and RPE practitioners like to learn more about?
4. What modes of training (e.g., in-person workshops, distance education) would the DELTA and RPE practitioners prefer?
5. What barriers to training are experienced by the DELTA and RPE practitioners?

Procedures

Because needs assessments focused on the training requirements of persons in multiple organizations generally involve a variety of methods to collect information (Chan et al., 2003; Gould, Kelly, White, & Chidgey, 2004; Haigh, 2006; Ringstad, Skaarup, Henriksen, & Davis, 2006), several procedures were used to collect data for this needs assessment of DELTA and RPE practitioners. Document reviews were used to collect information concerning the characteristics of the DELTA and RPE practitioners and the characteristics of the agencies that house these programs. Key informant interviews were used to collect information concerning the characteristics of the DELTA and RPE practitioners, the characteristics of the agencies that house these programs, the topics that the practitioners would like to learn more about, the modes of training they would prefer, and perceived barriers to training. Focus groups were used to collect information about the topics that the practitioners would like to learn more about, the modes of training they would prefer, and perceived barriers to training.

Publicly available documents describing the DELTA and RPE programs were obtained by searching the programs' Web sites and by contacting some of the leaders of these organizations by e-mail or telephone to request descriptive information. Sixty unique documents were supplied to the team, including 30 Web sites and 30 paper documents. These documents included the end-of-year reports of the DELTA and RPE programs from 14 states as well as other types of information from 25 other organizations, groups, or meetings (e.g., the Centers for Disease Control and Prevention [CDC], conference proceedings). Acquired information was reviewed independently by two PREVENT team members using a standard form to abstract information.

Key informant interviews were conducted with executive directors and/or program coordinators of some of the DELTA and RPE programs. Selection of participants for these interviews began by compiling a list of the executive directors and program coordinators. This list was then stratified according to the type of program and the type of agency in which it was housed (i.e., DELTA programs set within state domestic violence coalitions, RPE programs set within state sexual assault coalitions, and RPE programs set within state health departments), the size of the state, the size of the program, and the regional geographic location of the state. CDC staff also provided recommendations concerning key informants who had knowledge about their programs. Potential key informants were then selected from each of the strata and were invited to participate in the interviews. Invitations were extended to personnel of 17 programs (5 DELTA programs set within state domestic violence programs, 6 RPE programs set within state sexual assault coalitions, and 6 RPE programs set within state health departments). Data were collected from 17 persons, representing 13 programs, with 14 persons completing the interview by telephone and three using a pencil-and-paper instrument that was either faxed or e-mailed to them. Each of these procedures took approximately 45 to 60 minutes for participants to complete.

On finishing the document review and the key informant interviews, several focus groups were conducted via telephone conference calls. Potential focus group participants

included executive directors and/or program coordinators of the DELTA programs (who composed one focus group), executive directors and/or program coordinators of RPE programs set within state sexual assault coalitions (who composed a second focus group), and executive directors and/or program coordinators of RPE programs set within state health departments and other state agencies (who composed a third focus group). Persons who had participated in the key informant interviews or surveys were not eligible to participate in the focus groups. This restriction on participation was used to include a wider variety of participants in the needs assessment. Invitations to participate in the focus groups were extended to personnel of 41 programs (9 DELTA programs set within state domestic violence coalitions, 21 RPE programs set within state sexual assault coalitions, and 11 RPE programs set within state health departments/other agencies). Twenty persons participated in the focus groups, representing 19 of the 41 programs. The first focus group was composed of seven persons, the second of nine persons, and the third of four persons. A set of questions was sent to each focus group participant before the focus group began, so that participants would be able to think about the issues prior to participating in the group. Each of the three focus groups was facilitated by two PREVENT staff, with an additional staff member acting as a scribe. In addition, each focus group was audiotaped and later transcribed. These transcripts were independently reviewed by two members of the PREVENT team, each identifying pertinent themes related to the needs assessment questions.

Human Participants Concerns

All procedures used in the PREVENT needs assessment were reviewed and approved by the School of Public Health Institutional Review Board at the University of North Carolina at Chapel Hill.

Results

Characteristics of the DELTA and RPE Practitioners

Table 1 presents information about the characteristics of the DELTA and RPE practitioners based on the document reviews and the key informant interviews. Most of the executive directors and/or program coordinators involved with DELTA and RPE programs have education at the master's level. Most had been in their current positions for some time (the mean ranging from 5 to 7 years), and they had been working in the violence field for even longer (the mean ranging from 10 to 15 years). Most of the DELTA and RPE staff members have at least a bachelor's level of education. Although the percentage of staff with training in violence prevention varied, most programs had at least some staff members who had such training.

Table 1
Characteristics of the Domestic Violence Prevention
Enhancement and Leadership Through Alliances (DELTA)
and Rape Prevention and Education (RPE) Practitioners and
the Agencies in Which the DELTA and RPE Programs Are Set

DELTA Programs Set Within State Domestic Violence Coalitions	RPE Programs Set Within State Sexual Assault Coalitions	RPE Programs Set Within State Health Departments
DELTA executive directors and coordinators Most have master's degrees Years in current position: range = 1-22 years, M = 7 years Years in the violence area: range = 2-25 years, M = 15 years	RPE executive directors and coordinators Most have master's degrees Years in current position: range = 5-7 years, M = 6 years Years in the violence area: range = 9-11 years, M = 10 years	RPE executive directors and coordinators Most have master's degrees Years in current position: range = 1-14 years, M = 5 years Years in the violence area: range = 1-20 years, M = 11 years
Other staff in violence prevention Most have at least a bachelor's degree Percentage of staff trained in violence prevention varies, but at least some have such training	Other staff in violence prevention Most have at least a bachelor's degree Percentage of staff trained in violence prevention varies, but at least some have such training	Other staff in violence prevention Most have at least a bachelor's degree Percentage of staff trained in violence prevention varies, but at least some have such training
Setting: State domestic violence coalitions Statewide 501(c)(3) nonprofit coalitions that address domestic violence issues in the state 6-31 paid staff members (M = 15) The ultimate goal is to end domestic violence, with interim goals being to provide education and support to local domestic violence programs and domestic violence initiatives	Setting: State sexual assault coalitions Statewide 501(c)(3) nonprofit coalitions addressing sexual violence issues in the state 6-9 paid staff members (M = 7) The ultimate goal is to end sexual violence, with interim goals being to provide education and support to local rape crisis centers and sexual assault programs	Setting: State health departments Statewide government agency responsible for improving the people's health 8-20 paid staff members in the injury and violence prevention units The goal of injury and violence prevention units within the department is to reduce intentional and unintentional injuries along with resultant disabilities and deaths

Characteristics of the Agencies in Which the DELTA and RPE Programs Are Set

Table 1 also summarizes information gathered during the document reviews and key informant interviews concerning the characteristics of participating DELTA programs

set within state domestic violence coalitions, RPE programs located within state sexual assault coalitions, and RPE programs within state health departments. Both domestic violence coalitions and state sexual assault coalitions are statewide, nonprofit programs with the long-term goals of ending domestic violence and sexual assault. The domestic violence coalitions are often larger than the sexual assault coalitions, with the number of paid staff averaging 15 in the domestic violence coalitions and 7 in the sexual assault coalitions. These coalitions usually do not provide direct services to violence victims. Instead, the coalitions provide services to their local domestic violence and/or sexual assault programs that are responsible for the direct provision of victim services. The coalitions work with their local programs by providing technical assistance and training. In addition, the coalitions are often involved with referral hotlines, awareness campaigns, and resource centers and do advocacy work aimed at improving their state's procedures and policies concerning domestic and/or sexual assault. Although domestic violence coalitions and sexual assault coalitions are usually independent of one another, 18 states and territories have combined domestic violence and sexual assault coalitions.

Some of the RPE programs are set within state health departments that have a designated section (e.g., bureau, department, branch, unit, program) to specifically address injury and violence prevention. These injury and violence prevention sections are of variable sizes and are set within different levels of their health department's organizational hierarchy. The sections are involved with activities outlined by their national organization, namely, the State and Territorial Injury Prevention Directors Association (2003). Activities undertaken by the injury and violence prevention sections include policy development, advocacy, research and surveillance, funding, coalition building, public outreach, and training and the provision of technical assistance to local service providers and to allied professionals. The state health departments distribute RPE funding to various state and local programs for a variety of sexual assault prevention activities.

Topics That Would Be Useful to the DELTA and RPE Practitioners

As shown in Table 2, information from the key informant interviews and the focus groups showed that the DELTA and RPE practitioners (including executive directors and program coordinators) expressed interest in learning more about the primary prevention of violence. Most acknowledged the current trend toward primary prevention as it is being promoted by the CDC and the public health community. They noted that this is not an area in which they have had sufficient training and experience. For example, a practitioner reported, "Prevention is a new area for us, as it is for most coalitions . . . but we see it certainly related to the work of ending violence against women." Another said, "At a baseline level, the interest in a prevention curriculum is very, very high. But then when you get to defining what we mean by primary prevention, the interest is still high, but there's not as much of an understanding." Yet another noted, "I think there would be a lot of interest in well-developed, primary prevention training." However, it was clear that funding and resources would need to be available to support their

Table 2
**Common Topics That Practitioners in Domestic Violence
 Prevention Enhancement and Leadership Through Alliances
 Programs and Rape Prevention and Education Programs
 Would Like to Learn More About**

Would like a clear understanding of what primary violence prevention is and isn't
How to work at a community or population level
How to design, implement, and evaluate prevention activities
How to identify effective violence prevention programs to use as models
How to access, use, interpret, and present research data
How to disseminate information to partners and stakeholders
How to serve as a violence prevention resource to others
How to obtain and maintain funding for prevention work
How to maintain and enhance partnerships for violence prevention activities

prevention efforts. One participant noted, "Unless there is money that is given out that goes along with this [prevention] . . . it's going to be extremely difficult."

The DELTA and RPE practitioners expressed interest in learning about a wide variety of activities that would help them in their prevention work. They wanted to learn about working at a community or population level rather than at the level of the individual. In addition, they wanted to learn about how to design, implement, and evaluate prevention activities. As stated by one participant who knew that evaluation of her program was important but also knew that she and her staff did not have adequate training in evaluation, "It's a constant battle regarding evaluation." In addition, the practitioners wanted to learn how to identify existing evidence-based programs and promising trends in primary violence prevention work. Other suggested areas for skill and knowledge development include how to access, analyze, and present research and data; disseminate information to stakeholders, policy makers, and the media; serve as a violence prevention resource to others; obtain and maintain funding for prevention work; and maintain and enhance prevention partnerships with other agencies and organizations in their communities.

Modes of Training Preferred by DELTA and RPE Practitioners

Information obtained from the key informant interviews and the focus groups indicated that the DELTA and RPE programs were open to a wide range of training modes, including in-person workshops, distance-based training (including teleconferences and webcasts), computer-based training modules (e.g., PowerPoint presentations that can be downloaded), and one-to-one technical assistance. Most DELTA and RPE personnel reported having access to personal computers that were networked with high-speed Internet and e-mail access and capable of downloading large files (e.g., 5MB). In addition, all of the programs indicated that they have

the equipment and office space necessary to conduct team conference calls. Many individuals stated that they prefer face-to-face training in prevention (e.g., one-on-one technical assistance, regional workshops) to enhance networking. Some preferred computer-based training modules or distance-based training to avoid travel and costs. As noted by one focus group participant,

Financially, we can't send everyone away, but for something like prevention, it's probably going to be more successful if we have a broader set of friends and allies than just internally here. You learn from each other and there's an opportunity to network.

Barriers to the Training of DELTA and RPE Practitioners

Information from the key informant interviews and focus groups showed that the DELTA and RPE practitioners perceived several barriers to receiving training. The most common of these included lack of time, lack of money to attend trainings, inability to travel, and the scarcity of training opportunities. As noted by one participant, "Our plates are so full. . . . Time is the main problem. We all have things we want to read, but we don't have time." Another noted how recent cuts in travel budgets affect training activities by saying,

We've been on pretty strict lock down mode for the last couple of years, which is why we are so pleased with the Web cast and all the other stuff because literally we can't get out of the state that much, and it's getting harder to travel within the state.

Discussion

This needs assessment found that the practitioners who work in the field of domestic violence and sexual assault, including those in the DELTA programs and the RPE programs, welcomed the opportunity to learn more about primary prevention issues so they could incorporate more prevention activities into their work. The personnel of these programs are well prepared to receive such training in that they are highly educated, with most having master's or bachelor's degrees, and they typically have many years of experience working within the violence field. Furthermore, the settings of the DELTA and RPE programs, including state domestic violence coalitions, state sexual assault coalitions, and state health departments, have goals consistent with that of violence prevention.

The participants in this needs assessment expressed interest in accessing training to gain a clear understanding of the concept of violence prevention as well as how to design, implement, and evaluate primary violence prevention activities. They were receptive to various modes of training (e.g., in person workshops, distance-based learning); however, they also described many barriers to training (e.g., lack of funding to attend trainings, inability to travel).

The findings of this needs assessment are best viewed in light of the study's methodological limitations. These needs assessment data are limited to the extent that they may not represent all practitioners but rather rely on existing documents, key informants, and focus groups of volunteers. Although an effort was made to recruit a diverse and representative sample of respondents from across the country, the short time frame of the needs assessment and the busy schedules of participants made it difficult to recruit large numbers of respondents. Because our initial focus for the PREVENT program was on participants in the DELTA and RPE programs, we did not include representatives of other programs addressing violence against women, such as domestic violence programs that do not currently have DELTA funding.

Despite these limitations, this assessment clearly indicates that there is a large group of practitioners working in the field of violence against women who have an interest in building their skills and knowledge to enhance their ability to do primary violence prevention work. Although some domestic violence and sexual assault programs may be better positioned than others to extend their activities into the realm of primary prevention, most appear ready to take steps in this direction. In light of these findings, the PREVENT training program was designed to address the needs of these practitioners while overcoming the barriers to training. One of the most common barriers expressed by participants is the lack of financial resources to pay for course registration fees, travel to the teaching site, and hotel accommodation. PREVENT alleviates this barrier by providing stipends to participants to offset these costs. PREVENT provides different types of training opportunities, including workshops and institutes. Because it is important that the violence prevention practitioners attending PREVENT training have support from their supervisors for both their participation in the training and the later use of the concepts learned in their actual practice, persons applying for training must obtain a letter from an organizational leader who articulates support for this training. Because coordinated community responses of various organizations and agencies within a community may be helpful in promoting health within the community (Butterfoss & Kegler, 2002), individuals interested in PREVENT training are encouraged to attend in multidisciplinary, multicultural, and multiorganizational teams to foster collaboration.

The findings of the needs assessment were used to design the content and format of the PREVENT training program. Included are seminars on the public health concept of primary violence prevention and what it means to participate in social change work at the community or population level. In addition, information is offered concerning promising violence prevention models, how to obtain data and use research in their own work, and how to plan and evaluate their own programs. Finally, because it is important that practitioners learn to share their experiences with others, information is presented on the dissemination of programs to policy makers and other key stakeholders.

Not only does the PREVENT program offer seminars, but it also takes an "action learning" approach (Orton, Umble, Rosen, McIver, & Menkens, 2006) by requiring

that each of the teams design a violence prevention plan for their own communities as part of their PREVENT experience. Therefore, these multidisciplinary team members must have established some sort of working relationship with each other prior to attending PREVENT training to demonstrate that they can work together successfully. During the course of the training, each team develops its plan for a primary violence prevention project. The project can be in any area of violence (e.g., domestic violence, sexual assault, youth violence, child maltreatment, suicide). This aspect of the program gives the participants the opportunity to learn from violence practitioners in other areas and enhances their understanding regarding the interconnectedness among various types of violence and fosters collaboration between the groups. The concepts learned during the program are actively incorporated into participants' projects, resulting in a viable violence prevention plan that they can implement in their own communities. Each team is assigned a "coach" to help facilitate this process during the training program. The coach stays in contact with the team even after the training to facilitate the actual implementation of the team's violence prevention plan.

In addition to providing engaging, action-oriented, adult learning, and face-to-face training in the forms of workshops and institutes, PREVENT also provides a variety of other training modes, including fact sheets, distance learning, hands-on exercises and activities, train-the-trainer tool kits, ongoing technical assistance, and networking. All of the training opportunities and products of PREVENT are being evaluated to determine their effectiveness and ability to meet the needs of the participating violence prevention practitioners.

This needs assessment clearly demonstrates that many practitioners in domestic violence and sexual assault programs welcome training to enhance their understanding concerning the primary prevention of violence so they may extend their activities into the prevention area. The PREVENT training program was specifically designed to offer these practitioners this type of opportunity. Although we anticipate that such training will be extremely helpful in promoting the development and evaluation of violence prevention programs, we also recognize that this is just one step toward promoting a more peaceful world.

References

- Brownson, R. C., Baker, E. A., Leet, T. L., & Gillespie, K. N. (2003). *Evidence-based public health*. New York: Oxford University Press.
- Butterfoss, F., & Kegler, M. (2002). Toward a comprehensive understanding of community coalitions. In R. J. DiClemente, R. A. Crosby, & M. C. Kegler (Eds.), *Emerging theories in health promotion practice and research: Strategies for improving public health* (pp. 157-193). San Francisco: Jossey-Bass.
- Chan, F., Leahy, M. J., Saunders, J. L., Tarvydas, V. M., Ferrin, J. M., & Lee, G. (2003). Training needs of certified rehabilitation counselors for contemporary practice. *Rehabilitation Counseling Bulletin*, 46, 82-91.
- Glanz, K., Rimer, B. K., & Lewis, F. M. (2002). *Health behavior and health education: Theory, research, and practice*. San Francisco: Jossey-Bass.

- Gould, D., Kelly, D., White, I., & Chidgey, J. (2004). Training needs analysis: A literature review and reappraisal. *International Journal of Nursing Studies, 41*, 471-486.
- Green, L. W., & Kreuter, M. W. (2005). *Health program planning: An educational and ecological approach* (4th ed.). Boston: McGraw-Hill.
- Haigh, V. (2006). Clinical effectiveness and allied health professionals: An information needs assessment. *Health Information and Libraries Journal, 23*, 41-50.
- Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health*. Geneva, Switzerland: World Health Organization.
- National Center for Injury Prevention and Control. (2006a). *Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)*. Retrieved May 15, 2006, from <http://www.cdc.gov/ncipc/DELTA/default.htm>
- National Center for Injury Prevention and Control. (2006b). *Rape Prevention and Education Grant Program*. Retrieved May 15, 2006, from <http://www.cdc.gov/ncipc/profiles/rpe/default.htm>
- Orton, S., Umble, K., Rosen, B., McIver, J., & Menkens, A. (2006). Management Academy for Public Health: Program design and critical success factors. *Journal of Public Health Management and Practice, 12*, 409-418.
- Ringsted, C., Skaarup, A. M., Henriksen, A. H., & Davis, D. (2006). Person-task-context: A model for designing curriculum and in-training assessment in postgraduate education. *Medical Teacher, 28*, 70-76.
- Runyan, C. W., Gunther-Mohr, C., Orton, S., Umble, K., Martin, S. L., & Coyné-Beasley, T. (2005). PREVENT: A program of the National Training Initiative on Injury and Violence Prevention. *American Journal of Preventive Medicine, 29*, 252-258.
- Schewe, P. A. (2006). Interventions to prevent sexual violence. In L. S. Doll, S. Bonzo, J. Mercy, & D. Sleet (Eds.), *Handbook of injury and violence prevention* (pp. 223-240). New York: Springer.
- State and Territorial Injury Prevention Directors Association. (2003). *Safe states, 2003 edition*. Atlanta, GA: Author.
- Tannenbaum, S. I., & Yukl, G. (1992). Training and development in work organizations. *Annual Review of Psychology, 43*, 399-441.
- Taylor, P. J., O'Driscoll, M. P., & Binning, J. F. (1998). A new integrated framework for training needs analysis. *Human Resource Management Journal, 8*, 29-50.
- Whitaker, D. J., Baker, C. K., & Arias, I. (2007). Interventions to prevent intimate partner violence. In L. S. Doll, S. Bonzo, J. Mercy, & D. Sleet (Eds.), *Handbook of injury and violence prevention* (pp. 203-221). New York: Springer.

Sandra L. Martin, PhD, is an epidemiologist who is a professor and associate chair for research in the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill and is a core faculty member at the University of North Carolina Injury Prevention Research Center. Her research, teaching, and public health service focus on the health of women and children, with particular attention paid to the role that violence plays in their lives.

Tamera Coyne-Beasley, MD, MPH, is an epidemiologist who is an associate professor in the Departments of Pediatrics and Internal Medicine and a lecturer in health education and health behavior at the University of North Carolina at Chapel Hill. She is also a core faculty member at the UNC Injury Prevention Research Center. Her clinical activities, research, teaching, and public health service focus on youth and adolescent health, with particular attention paid to injury and violence prevention.

Mary Hoehn, MPH, is director of the Office of Research Administration at the Georgetown University School of Nursing and Health Studies, where she works in proposal development and grants management pertaining to public health research. Prior to working at Georgetown University, she worked on research projects at the University of North Carolina Injury Prevention Research Center, including the Court

Ordered Protection Evaluation Study and Preventing Violence through Education, Networking and Technical Assistance Program.

Mary Mathew, MSPH, is a program manager at the Tobacco Prevention and Evaluation Program, based at the University of North Carolina School of Medicine in Chapel Hill. She previously practiced as a pediatric occupational therapist and has a background in maternal and child health. She currently specializes in evaluating statewide tobacco prevention and cessation initiatives targeting teens and young adults.

Carol W. Runyan, PhD, is director of the University of North Carolina Injury Prevention Research Center, a professor of health behavior and health education, and a professor of pediatrics at the University of North Carolina. She is the principal investigator on the PREVENT Project.

Steve Orton is deputy director of the Office of Executive Education at the North Carolina Institute for Public Health. He has helped develop and direct executive education programs including the PREVENT program; the Management Academy for Public Health; the Emerging Leaders in Public Health program; and a customized leadership program for Novant Health in Winston-Salem. He has published articles on public health management and training and is currently writing a book about business planning in public health.

Leigh-Anne Royster is the director for personal health programs at Elon University in Elon, NC. She received her BA from UNC Chapel Hill in political science and sociology. She completed her MPA at the University of Colorado at Denver in the Graduate School of Public Affairs' Program on Domestic Violence. She has more than 10 years of experience working with response and prevention of sexual and intimate partner violence. Before heading up these efforts at Elon University, she worked at the University of North Carolina on the PREVENT program. She is a leader in integrating community and university approaches to raising awareness about sexual violence. She believes in addressing intersections of oppressions as one critical aspect of sexual violence awareness on college campuses.