Upcoming Public Health Grand Rounds Sessions

- Global Tobacco Control – July 24, 2012
- High-Impact HIV Prevention – August 21, 2012
- Explaining the Unexplained - September 18, 2012

For Public Health Grand Rounds previews, archives, and related content:
http://www.cdc.gov/about/grand-rounds
Grand Rounds Continuing Education (CE)

- Receive continuing education credits or contact hours for watching broadcasts of Public Health Grand Rounds

- Register at: [http://www2a.cdc.gov/TCEOnline](http://www2a.cdc.gov/TCEOnline)
  - The course code for PHGR is **PHGR10**.
  - Thirty days from the initial session the course number will change to **WD1640** and will be available for continuing education for two years after initial presentation date.
Newborn screening is the practice of testing every newborn for certain harmful or potentially fatal conditions, such as hearing loss and certain genetic, endocrine, and metabolic disorders that typically are not otherwise apparent at birth. Newborn screening in the United States began in the 1960s. Universal newborn screening has become a well-established, state-based, public health system involving education, screening, diagnostic follow-up, treatment and management, and system monitoring and evaluation (7). Each year, >90% of approximately 4 million newborns in the United States are screened (2,3). Through early identification, newborn screening provides an opportunity for treatment and significant reductions in morbidity and mortality (2,3).

Uniformity of Newborn Screening

In 2006, The American College of Medical Genetics (ACMG), under the auspices of the Health Resources and Services Administration (HRSA), convened a group of experts to address the substantial variation in the number of disorders screened for in each state. The experts evaluated scientific and medical information related to screened conditions and recommended a uniform screening panel of 29 core (or primary) conditions to be included in state newborn screening panels: 20 inborn errors of metabolism, three hemoglobinopathies, and six other conditions (4). This panel was endorsed by the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDCN) and designated by the Secretary of the U.S. Department of Health and Human Services as a national standard for newborn screening programs (4). Its adoption has led to increased uniformity of screening in the United States and its territories (Figure 1) (2,9). Additional conditions for screening continue to be identified and nominated for inclusion in the panel.

Expansion of Newborn Screening

ACHDCN reviews nominations of conditions to be included in the uniform panel. The committee encourages nominations by persons and organizations with expertise on the condition being nominated. The nomination process is transparent, allows for public commentary, and follows a systematic protocol for evidence-based review (5). Since adoption of the core panel of 29 conditions, nine additional conditions have been submitted and reviewed. ACHDCN recommendations to include two of the conditions, severe combined immunodeficiency and critical congenital heart disease, into the uniform newborn screening panel were approved by the Secretary in 2010 and 2011, respectively. Six of the conditions submitted for inclusion have been forwarded for an external review, and four have been referred back to nominators for additional studies.

Public Health Burden

Of the 4 million infants who are screened each year, approximately 12,500 are diagnosed with one of the 29 core conditions of the uniform screening panel. The five most commonly diagnosed conditions in the United States are: (1) hearing loss, (2) primary congenital hypothyroidism, (3) cystic fibrosis, (4) sickle cell disease, and (5) medium-chain acyl-CoA dehydrogenase deficiency (Table 3). Newborn screening can help prevent death or disability if treatment follows (4,8). Each year, for example, one in 2,000 newborns is diagnosed with congenital hypothyroidism. Screening followed by thyroid hormone treatment can prevent intellectual disability (intelligence quotient [IQ] score <70) (7,8). Congenital hearing loss occurs in one to three newborns per 1,000 live births. Each year, newborn hearing screening identifies hearing loss in >5,000 infants. Without screening, these children might have delayed language acquisition, low educational attainment, increased behavioral problems, decreased psychosocial well-being, and poor adaptive skills (9). Untreated phenylketonuria can result in severe cognitive impairment. Prompt initiation of treatment following newborn screening is essential for optimal development and prevention of disability (10).

FIGURE 1. Number of states screening for the core biomedical conditions in the Recommended Uniform Screening Panel (RUSP)

- United States, 2004–2009

Source: Data extracted from National Newborn Screening and Genetics Resource Center, Available at: http://genes-r-us.nih.gov.
Science Clips Selections: Intimate Partner Violence


Off the Beaten Path: Violence, Women and Art

- June 6 to September 9, 2011

- Presented the work of 28 contemporary artists from 24 countries, including:
  - Yoko Ono (Japan)
  - Louise Bourgeois (France)
  - Wangechi Mutu (Kenya)
  - Mona Hatoum (Palestine)
  - Hank Willis Thomas (USA)

Photo by: Hung Liu, From the Field, 2008

www.cdc.gov/museum
Today’s CDC Speakers

Dr. Howard Spivak

Dr. E. Lynn Jenkins
Today’s Partner Speakers

Kristi VanAudenhove  Debbie Lee
BREAKING THE SILENCE: PUBLIC HEALTH’S ROLE IN INTIMATE PARTNER VIOLENCE PREVENTION

- Howard R. Spivak, MD
  Director, Division of Violence Prevention, National Center for Injury Prevention and Control
  Societal Burden of IPV and Public Health’s Relevance in Prevention

- E. Lynn Jenkins, PhD
  Chief, Etiology and Surveillance Branch, National Center for Injury Prevention and Control
  The National Intimate Partner and Sexual Violence Survey

- Kristi VanAudenhove
  Co-Director, Virginia Sexual and Domestic Violence Action Alliance
  Building Coalitions to Prevent Intimate Partner Violence

- Debbie Lee
  Senior Vice President, Future without Violence
  National Opportunities for Preventing Intimate Partner Violence
Societal Burden of IPV and Public Health’s Relevance in Prevention

Howard R. Spivak, MD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Sarah
What is Intimate Partner Violence (IPV)?

- Physical violence, sexual violence, threats of physical or sexual violence, and psychological abuse by a current or former partner

12 million victims each year

www.cdc.gov/ViolencePrevention/NISVS/index.html
IPV: Intimate Partner Violence
Approximately 10% of Students Report Physical Dating Violence
Lifelong Health Consequences of IPV

Mental Health
- Depression
- Anxiety
- PTSD
- Suicidal thoughts
- Suicidal behavior

Physical
- Injuries
- Asthma
- Diabetes
- Heart disease
- Complex pain syndromes

Sexual and Reproductive Health
- Unintended pregnancy
- Pregnancy complications
- Gynecological disorders
- Unsafe abortions
- STI/HIV

PTSD: Post-traumatic stress disorder
Economic Burden of IPV

$ = 8.3$ billion each year

In medical, mental health services, and lost productivity costs alone

CDC: Costs of Intimate Partner Violence in the United States, 2003
www.cdc.gov/ViolencePrevention/pub/IPV_cost.html
Risk Factors for Perpetrating IPV

- Individual beliefs and behaviors
- Family history and relationship dynamics
- Social and economic conditions
- Cultural and social norms

Data to Drive Action

Collection of data is needed to
- Identify groups at risk
- Inform prevention efforts
- Monitor the problem and assess trends over time
- Track impact and outcomes of prevention efforts

NVDRS records an average of 450 IPV-related homicides each year
Research to Inform Prevention Efforts

- **Research is needed to:**
  - Elucidate risk and protective factors
  - Identify effective programs, practices, and policies, including those related to:
    - Reducing alcohol outlet density and availability
    - Promoting economic development
    - Alleviating social and economic stressors linked to IPV
  - Determine how best to scale-up effective approaches
Building the Foundation to Prevent IPV

- Data-driven planning
- Strengthening connections on the ground
- Tools, training, and assistance to identify, implement and evaluate strategies

CDC’s Domestic Violence Prevention Enhancements and Leadership Through Alliances Program (DELTA)
What Works to Prevent Partner Violence?

- Many programs change knowledge and attitudes
- Few programs change behaviors
- Types of strategies
  - Youth-focused
  - Parent-focused
  - Couple-focused
  - Community
  - Policy

Dating Matters Comprehensive Strategy Across the Social Ecological Model

Evidence-Based Student Programs, including: 
*Safe Dates*

Evidence-Based Parent Programs, including: 
*Parents Matter!*
*Families for Safe Dates*

**Dating Matters** 
Educator Training

Local Policy Development And Enhancement

Communication Strategies 
- Social Networking
- Brand Ambassadors

Intensive Technical Assistance to Local Health Department

Cross-site Outcome, Process, Implementation Evaluation and Cost Analysis
Partnerships as the Cornerstone of Success

- Intimate partner violence cannot be addressed by single programs or in isolation
- Collaboration across all sectors
- Leadership at all levels
- Special role of public health

*We all have a responsibility to take action*
The National Intimate Partner and Sexual Violence Survey (NISVS)

E. Lynn Jenkins, PhD

Chief, Etiology and Surveillance Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Unique Strengths of NISVS

- Health context
- >60 behavior-specific questions
- Sample includes landline and cell phone numbers
- National and state estimates
NISVS Implementation

2010: Initial year of data collection

- 16,507 U.S. adults
  - 9,086 females
  - 7,421 males
- Approximately half cell phone, half landline
- Support from National Institute of Justice and Department of Defense

Data collection is ongoing
1 in 4 women and 1 in 7 men in the United States have experienced severe physical violence by an intimate partner at some point in their lifetime.

Severe Physical Violence

<table>
<thead>
<tr>
<th>Percent</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NISVS, 2010  www.cdc.gov/violenceprevention/nisvs
>1 in 3 U.S. women have experienced physical violence, rape, and/or stalking by an intimate partner at some point in their lifetime

- 72% report being fearful
- 62% were concerned for their safety
- 28% missed at least one day of work or school

NISVS, 2010  www.cdc.gov/violenceprevention/nisvs/
Intimate Partner Violence Starts at Young Age—U.S. Women

NISVS, 2010  cdc.gov/violenceprevention/nisvs
>1 in 4 U.S. men have experienced physical violence, rape, and/or stalking by an intimate partner at some point in their lifetime.

- 18% report being fearful
- 16% were concerned for their safety
- 14% missed at least one day of work or school

NISVS, 2010  www.cdc.gov/violenceprevention/nisvs
Intimate Partner Violence Starts at Young Age—U.S. Men

Figure 4.6 Age at time of First IPV* Experience Among Men Who Experienced Rape, Physical Violence, and/or Stalking by an Intimate Partner—NISVS 2010

NISVS, 2010  www.cdc.gov/violenceprevention/nisvs
Types of IPV Reported Differ Between Men and Women

<table>
<thead>
<tr>
<th>FORMS OF INTIMATE PARTNER VIOLENCE</th>
<th>WOMEN</th>
<th>MEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Violence Only</td>
<td>57%</td>
<td>92%</td>
</tr>
<tr>
<td>Rape Only</td>
<td>4%</td>
<td>--</td>
</tr>
<tr>
<td>Stalking Only</td>
<td>3%</td>
<td>--</td>
</tr>
<tr>
<td>Rape &amp; Physical Violence</td>
<td>9%</td>
<td>--</td>
</tr>
<tr>
<td>Physical Violence &amp; Stalking</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>Rape, Physical Violence &amp; Stalking</td>
<td>13%</td>
<td>--</td>
</tr>
</tbody>
</table>

IPV: Intimate Partner Violence
NISVS, 2010 http://www.cdc.gov/violenceprevention/nisvs
Immediate and Long-Term Impacts of IPV

- 81% of women and 35% of men who experienced IPV reported at least one health-related or other impact.
- Of women with lifetime IPV experience:
  - 42% reported injuries
  - 63% reported PTSD symptoms
- Of men with lifetime IPV experience:
  - 14% reported injuries
  - 16% reported PTSD symptoms

IPV: Intimate Partner Violence
PTSD: Post-Traumatic Stress Disorder
NISVS, 2010  www.cdc.gov/violenceprevention/nisvs
Multiple Long-Term Health Consequences

- Women with lifetime victimization experience were significantly more likely to report having
  - Asthma
  - Irritable bowel syndrome
  - Diabetes

- Both women and men with lifetime victimization experience were significantly more likely to report
  - Frequent headaches
  - Chronic pain
  - Difficulty sleeping
  - Activity limitations
  - Self-assessed poor physical and mental health

NISVS, 2010  www.cdc.gov/violenceprevention/nisvs
Prevention Must Begin Early

- Preventing physical violence, rape, and stalking will save lives, reduce health impacts, and save money

- Next Steps
  - Sexual Orientation Report
  - Intimate Partner Violence Report
NISVS Information

www.cdc.gov/violenceprevention/nisvs
Building Coalitions to Prevent Intimate Partner Violence

Kristi VanAudenhove  
Co-director  
Virginia Sexual and Domestic Violence Action Alliance
DELTA: The Dawn of a New Day in Virginia

- Before DELTA
- Opportunity for state domestic violence coalitions
- 10 years of capacity building
- Nationally, part of building prevention infrastructure in coalitions and local communities
The Commonwealth of Virginia

- 12 most populated state (>8 million people)
- Mid-Atlantic: From Atlantic Ocean to Appalachia
- Shaped by the founding fathers with strong traditional values
### Lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>National for women</td>
<td>35.6%</td>
</tr>
<tr>
<td>Virginia for women</td>
<td>31.3%</td>
</tr>
<tr>
<td>National for men</td>
<td>28.5%</td>
</tr>
<tr>
<td>Virginia for men</td>
<td>22.1%</td>
</tr>
</tbody>
</table>
IPV in Virginia: A Year in the Life

~64,000 Domestic Violence Hotlines Calls

~21,000 Face-to-Face Services

~6600 Emergency Shelter
DELTA
Building the Prevention Infrastructure in Virginia

- Funding
- Time
- Structure
- Expertise
Moving Upstream

- Changing the narrative around prevention
- Making effective use of precious resources beyond “pulling people out of the river”
  - Working across all levels of the social ecological model
  - Planning, planning, and more planning
  - A common understanding of the problem that is based on data
  - Defining achievable outcomes
  - Strategies likely to bring about change
Building a Community of Practice

**Structural Supports**
- Regular in-person meetings
- Listserve for CDC to coalitions + peer-to-peer communication
- Bi-weekly Project Coordinator calls
- National, regional, and in-state training

**Coalition Teams**
- Require participation of Executive Directors and Project Coordinators
- Add the Empowerment Evaluators
- Encourage cross-training within staff
- Encourage board training
Supporting the planning, implementation, and evaluation of evidence-informed statewide and local prevention initiatives

VA state-level initiatives

- Bystander strategies with college students
- Promoting protective factors among youth 14-16
- Addressing unique risks for African-American youth

Community-level initiatives

- 4 Virginia communities
Bridging Science and Action

- Empowerment evaluation
- Evidence as a basis for decision-making
- Using the experience of survivors and communities as part of program evaluation
The training, support, and opportunities the CDC has provided for state coalitions, we have in turn provided for our local project partners

- Introducing the public health model of primary prevention
- Bridging science and action
- Building a community of practice amongst advocates and community
- Supporting the planning, implementation, and evaluation of evidence-informed prevention initiatives
Impact on Communities beyond DELTA partners

- Better planning; outcomes more likely to be defined and evaluated
- Engagement of domestic violence and campus programs in primary prevention
- DELTA coalition staff provide training, technical assistance, and resources
Impact on Coalition beyond DELTA Staff

- Appreciation for partnerships has improved all work and opened eyes to opportunities
  - Law Enforcement and Perpetration Data
  - Fatality Database Review
  - Healthy Relationship Education for Parents of Adults with Developmental Disabilities
Impact on Statewide IPV Prevention

- New coalition vision statement
- New partnerships with health care providers, anti-poverty organizations, and other prevention professionals (HIV/suicide/bullying)
- Expansion of prevention initiatives in our Strategic Plan
- New funding for prevention
National Opportunities for Preventing Intimate Partner Violence

Debbie Lee
Senior Vice President
Futures Without Violence
Deputy Director, National Program Office
Start Strong: Building Healthy Teen Relationships
Futures Without Violence

- Social change organization with 30 year history
- San Francisco, DC, and Boston Offices
- Name change last year from Family Violence Prevention Fund to reflect broader and international mission

Programs
- Reach new audiences (men and youth)
- Transform the way health care providers, police, judges, employers, and others address violence
Partnership with CDC

- Shift from service provider model to include prevention
- DELTA and Dating Matters (CDC funded)
- Start Strong: Building Healthy Relationships and DELTA PREP (Robert Wood Johnson Foundation Funded)
  - Work to change social norms
  - Move beyond the individual level
- Leveraging work between Futures and CDC
  - Changing YRBS questions

YRBS: Youth Risk Behavior Survey
Outline of Topics

- Health Care Progress and Opportunities
- Programs to Reach Youth and Men
- Youth Progress and Opportunities
Health Care: Progress and Opportunities

- Since 1993, Futures Without Violence has been the DHHS National Health Resource Center on Domestic Violence
- Built national consensus guidelines with health care providers and leaders
  - Education, training, and system changes
- Affordable Care Act built on this work to create policy and practice change

National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care settings, 2002
http://fypfstore.stores.yahoo.net/natconguidon.html

Identifying and Responding to domestic Violence: Consensus Recommendations for Child and Adolescent Health, 2002
http://fypfstore.stores.yahoo.net/idandrestodo.html

Health Care: National Opportunities

- **Affordable Care Act Implementation**
  - Women’s preventive health: Screening and counseling for IPV
  - Insurance discrimination
  - Home visitation programs
  - Teen pregnancy prevention
  - National prevention strategy

- **Health Practice Opportunities**
  - Interventions in reproductive health settings
Clinical and Community Prevention Recommendations

- Support existing programs and services based on age/developmental stage/gender norms
- Clinical guidelines for violence prevention, which promote assessment, brief counseling and referral, should be
  - Incorporated into school based health centers
  - Incorporated in the Annual Well Woman visit and during other key visits
  - Incentivized in payment reform efforts
Start Strong: Building Healthy Teen Relationships

- **Investment:** $18 million over 4 years (2008-2012)
- **In 11 communities**
  - Atlanta, Austin, Boston, Bridgeport, Bronx, Idaho, Indianapolis, Los Angeles, Oakland, Rhode Island, and Wichita
- **Uses a social ecological model**
  - Educate and engage youth in and out of school
  - Educate/engage influencers
  - Change policy and environmental factors
  - Social marketing and social norms

Start Strong Insights and Strategic Direction

- Importance of middle school
- Identifying and utilizing influencers is key
- Bullying intervention may be key entry point
Start Strong Insights and Strategic Direction

- Schools are focal points for youth
- Youth-informed social marketing is crucial
- Social media and mobile technology are key
Innovative Strategies to Engage Youth

- Pop Culture Teachable Moments: 2009 Chris Brown and Rihanna dating violence
  - Survey of Boston youth found substantial proportions blamed either the woman or both partners

- Break-up Summit
  - Promote healthy “face-to-face” interactions

Boston Public Health Commission, Start Strong
www.bphc.org/programs/cafh/violenceprevention/startstrong/Pages/Home.aspx
Digital abuse awareness campaign by DOJ’s Office on Violence Against Women, The Ad Council, and Futures Without Violence

Target audience 13-15 years

$43.2 million worth of donated media space

More than 2 million visitors
Coaching Boys Into Men

- Engage men to talk to boys that violence against women and girls is wrong
- A 12-lesson curriculum on respect, integrity, and non-violence
- Results of randomized controlled trial indicates boys in the program are more likely to take action when witnessing disrespectful or abusive language or behavior

www.CoachesCorner.org

National Policy and Practice Opportunities

- **Violence Against Women Act (VAWA)**
  - New teen dating violence (TDV) prevention program lowering age to 11 for youth programs
  - Continued funding for health and prevention programs to **engage men** and reach children exposed to violence
  - New state formula grants for **prevention and education**

- **Other youth-focused programs**
Public health has helped to transform how the health field addresses Intimate Partner Violence. Advocates and providers are using evidence-based programs and trying innovative strategies for youth and new audiences. The next phase of violence prevention may be looking across the lifespan with a new focus on youth, and children and men.
BREAKING THE SILENCE: PUBLIC HEALTH’S ROLE IN INTIMATE PARTNER VIOLENCE PREVENTION

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