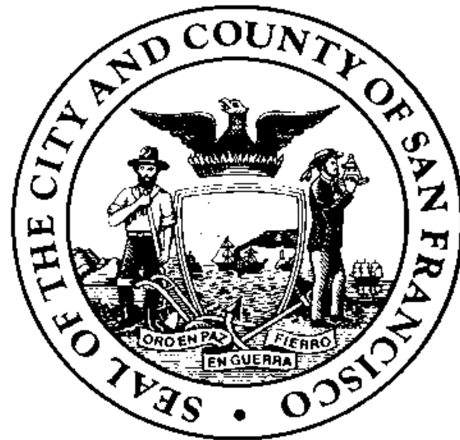
San Francisco
Department of Public Health



Intimate Partner Violence Strategic Plan 2003-2008

Community Health Education Section

October 2003

Nonviolence is not a garment
to be put on and off at will.
Its seat is in the heart, and it must be an
inseparable part of our being.

Gandhi

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Executive Summary

The San Francisco Department of Public Health (DPH) strives to protect and promote the health and safety of all San Franciscans. Within DPH, the Community Health Education Section (CHES) works at the community level to change social norms, attitudes, and behaviors that influence health and well-being. In 2002-2003, DPH was one of six California counties awarded a grant from the Epidemiology and Prevention for Injury Control Branch of the California Department of Health Services for the development of a strategic plan for violence prevention. This five-year plan focuses on primary prevention of intimate partner violence. CHES will use this plan as a guide for future policy development, coordination, and programmatic efforts aimed at nurturing safe, healthy intimate partner relationships. Based on the public health approach, the objectives in this plan integrate interventions across multiple levels including individual, community, organizational, and policy. While the plan is largely geared to DPH activities, we invite community agencies and other organizations to use this plan to guide, reinforce, and inspire their prevention efforts.

Mission

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans. The specific purview of the Community Health Education Section (CHES) is to promote the DPH mission through community-based primary prevention. CHES works with individuals and communities to assess factors that affect health status and to develop and implement culturally appropriate solutions.

Vision

All human beings; regardless of their gender, age, sexual orientation, social economic status, size, ethnicity, religious beliefs, marital/relationship status, and physical and mental ability; are entitled to safe, non-violent intimate partner relationships. The vision of this five-year strategic plan is a safe, peaceful community that embraces primary prevention of intimate partner violence. To realize this vision, we seek to change social norms, build community capacity, and create an environment where mutual respect, caring, and equality in relationships can flourish.

Introduction

Violence is a pervasive and integral part of American culture. Its omnipresence in popular television programs, news media, movies, music, and video games promotes social norms of tolerance and acceptance. The inevitable consequence of constant exposure to violence is a discourse that condones violence as an acceptable form of expression or conflict resolution in interpersonal and intimate partner relationships. Despite its constant presence and influence, violence is a learned behavior. As such, it can be prevented.

In the past, intimate partner violence (IPV) has been addressed primarily through social services and the criminal justice system. What was once considered a private matter between perpetrators and survivors/victims is now recognized as a serious public health concern with serious implications to the health and safety of society as a whole. According to the National Crime Victimization Survey (NCVS) (1999), persons aged 12 or older in the United States experienced approximately 791,000 violent acts by a current or former intimate partner.[i] Overall, 85% (671,000) of these incidents were committed against women. Across all ethnic groups, women between the ages of 16 and 24 experienced the highest per capita rate of nonfatal violence and women between the ages of 35 and 49 were more likely to be victims of homicide. Of the 1,642 persons murdered by an intimate partner, 1,218 (74%) of victims were female compared with 424 (26%) males.[1]

While IPV exists in all social groups defined by race, ethnicity, and economic status, the NCVS survey shows that African American women were most vulnerable to violent acts committed by an intimate partner as compared to white or Hispanic women. Further, women who were separated from their husbands are more likely to experience IPV than married, divorced, or never married women. In general, those who report

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[i] The National Crime Victimization Survey (NCVS) defines violent crimes as rape/sexual assault, robbery, aggravated assault and simple assault.

violent incidents are more likely to have fewer years of education, have a lower income, and live in urban areas.[2] Although specific rates for IPV in lesbian, gay, bisexual, and transgender (LGBT) relationships were not outlined in the NCVS survey, research has shown that IPV exists in approximately in 1 in 5 same-sex relationships.[3] Women who live with female partners experience less intimate partner violence than women living with male intimate partners. Men living with male intimate partners experience more violence than do men who live with female intimate partners.[4]

Consequences

IPV is directly related to many adverse consequences to physical and mental health. Physical outcomes of IPV include fatalities, lacerations, head trauma, bone fractures, abrasions, chronic pain, and gastrointestinal disorders. IPV is also associated with poor pregnancy outcomes such as miscarriage, premature labor, or low birth weight. The impact that IPV has on mental health is both a consequence and a precursor to violence. Post Traumatic Stress Disorder and low self-esteem may result from witnessing acts of violence and/or experiencing violence. Further, substance abuse by a perpetrator or victim/survivor of violence can lead to the onset or escalation of violence.[5]

Researchers estimate that the cost of IPV against women exceeds $5.8 billion nationwide each year. Approximately $4.1 billion of this total is for direct medical and mental health care costs.[6] While it may be possible to ascertain the cost of medical expenses and lost workplace productivity, it is impossible to place a dollar value on the damage IPV causes to victims/survivors of violence, their families, and society as a whole. IPV often leads to an ongoing cycle of violence that is passed from one generation to the next. Children who witness violence in their homes often grow up to become victims or perpetrators of violence in adulthood.[7] Positive community norms, and an environment that nurtures intimate partner relationships must replace attitudes and behaviors that condone violence.

Definition of Intimate Partner Violence

While this plan is specific to intimate partner violence, we feel that it is important to distinguish the difference between IPV and domestic violence. Domestic violence includes violent acts perpetrated by intimate partners as well as violence witnessed or experienced by children, elders, and siblings. For the purposes of this plan, the IPV definition previously created by the DPH Intimate Partner Violence Screening Policy Work Group will be used:

- IPV is perpetrated against current or former intimate partners with whom the perpetrator dated, married, or cohabited.
- IPV is a pattern of coercive behaviors that includes one or more of the following: physical abuse or the threat of physical abuse, psychological abuse, sexual assault, progressive social isolation, deprivation, intimidation, and/or economic coercion.
- Adults and adolescents - no matter what their gender, sexual orientation, class, religion, race, age, ability, or ethnicity - may perpetrate or be survivors/victims of intimate partner violence.

DPH Response to Intimate Partner Violence

The Community Health Education Section (CHES) works with individuals and communities to identify factors that influence community health, establish priorities, and implement solutions aimed at preventing injury and disease. CHES focuses on decision-making processes with a wide range of individuals from different backgrounds, perspectives, and disciplines based on data and best practices.[8] To address IPV in the community, CHES applied for and received a grant from the Epidemiology and Prevention for Injury Control Branch of the California Department of Health Services to develop a strategic plan aimed at violence prevention.

The goal of this strategic plan is to nurture safe, healthy intimate partner relationships. Based on a public health approach, this five-year plan focuses on primary prevention and seeks to address IPV on many levels

including individual, community, organizational, and policy. Each of the 13 objectives and accompanying strategies outlined in this plan will guide CHES and other Department sections' future policy development, coordination, and programmatic efforts related to fostering positive attitudes and social norms regarding intimate partner relationships in the community. DPH, community agencies, and other organizations can use this plan to hone in on or choose the most appropriate objectives for their current needs and environment. To the extent possible, local data pertaining to IPV have been included in this plan.

Public Health Approach

CHES uses a public health approach in all programs and services. This approach differs from the traditional medical model in which change is created by addressing one individual at a time. The public health approach seeks to eliminate the burden of disease in entire populations through the use of broad-based interdisciplinary methods. The underlying principle of this approach is that IPV is not caused solely by individual choices, but by community norms and environmental conditions that promote violence. CHES encourages communities to proactively take ownership of the issue by self-identifying problems, establishing priorities, and developing solutions.

Since IPV emerges from a multitude of complex personal, social, and economic factors, an integrated approach across individual, community, organizational, and policy levels is required to address IPV root causes and risk factors effectively. Collaborative efforts across this continuum produce sustained, long-term changes to public knowledge, attitudes, beliefs, and behaviors that in turn will reduce the burden of IPV related morbidity and mortality.[9]

Quantitative data are used in the public health approach to describe the nature of factors that affect physical, mental, and spiritual well-being. DPH collects epidemiological data on all severe injuries in San Francisco.[ii] These data are used to ascertain demographic and geographic characteristics as well as patterns and trends regarding violence. Epidemiological data serve as a basis for the development of focused interventions and policies aimed at preventing IPV. Further, they serve as a yardstick by which changes in morbidity and mortality can be measured over time.

[ii] Gerstman (1998) defines epidemiology as the study of the causes, transmission, incidence, and prevalence of health and disease in human populations and is the core science of public health.

Intimate Partner Violence Root Causes

Cohen and Swift (1993) cite oppression, poverty, and mental health as the root causes of violence in the United States. These root causes are extremely difficult to change and addressing them requires substantial re-ordering of social and political priorities. Further, these authors name alcohol and other drugs, firearms, witnessing acts of violence, media, and community deterioration as risk factors that exacerbate the frequency and severity of violence.[10] These root causes and risk factors are applicable to all forms of interpersonal violence including IPV.[iii]

Oppression

Oppression includes sexism, racism, ageism, and discrimination based on class, ethnicity, religious beliefs, social economic status, physical size, or sexual orientation. Over time, these forms of oppression have become entrenched within many facets of the dominant society. The inevitable outcome of such institutionalized oppression is social norms that can negatively affect perception, self-perception, ability to obtain employment or education, choice of housing, and interactions with law officials. The inequality and powerlessness that result from oppression are frequently underlying causes of violence.[11]

Poverty

Depressed economic conditions, such as unemployment and underemployment, can lead to significantly higher levels of violence within a given community.[12] It appears that certain ethnic groups have a higher proclivity for violent behavior; however, there is no scientific correlation between ethnicity and violence.[13] Ethnic minorities may experience higher rates of IPV because they are more likely to live in poverty than other ethnic groups. Poverty, not ethnic identity, is a root cause of IPV.[14]

[iii] The work of Cohen and Swift is also cited in the Roadmap for Preventing Violence. See Appendix A for details on the Roadmap.

Mental Health/Family Dynamics

A non-supportive home life can produce low self-esteem, anger, and hopelessness in both victims and perpetrators. For adults, lack of access to adequate mental health services increases the likelihood that these family dynamics will persist and that violence will occur. Children who live in a non-supportive environment may believe that poor family dynamics are the norm. Further, children who live in these conditions are at increased risk for perpetuating similar dynamics in intimate partner relationships in adulthood.[15]

Intimate Partner Violence Risk Factors

Alcohol and Other Drugs

Research does not generally support a causal link between illicit drug use and violence; however, with some drugs, there is a strong association with violent acts. The drug most frequently associated with violence is subsidized by the government and legally marketed to consumers: alcohol.[16] Alcohol has been shown to reduce cognitive ability and motor skills, and thus can prevent recognition of warning signals of violence and/or resistance to abuse.[17]

Firearms

Firearms are involved in the majority of IPV related homicides. The restriction or elimination of firearms in the community would significantly decrease firearm related morbidity and mortality.[18]

Witnessing Acts of Violence

Exposure to, or direct involvement in, violence is likely to create the belief that violence is a normal form of expression or a strategy for conflict resolution. Witnessing acts of violence may produce Post Traumatic Stress Disorder and other conditions that may negatively affect physical and mental health. Research has shown that children who witness or experience family violence are at increased risk for being victims or perpetrators of IPV in adulthood.[19]

Media

Mass media sensationalize violent acts and encourage the sexual objectification of women. The media also perpetuate and amplify negative racial and other oppressive stereotypes.[20]

Community Deterioration

Nationally, funding for many community services has been reduced or cut in recent years due to changes in economic conditions. The current situation follows a general trend spanning across several decades in which many urban areas, services, and communities have experienced noticeable deterioration. Schools, health and mental health services, libraries, recreational centers, and parks are all critical institutions that provide a buffer against the likelihood of violence. Communities simply cannot flourish if public institutions and environmental conditions are not adequately sustained.[21]

Incarceration

Instead of fulfilling their purported roles as deterrents, prisons are a training ground and communication center for perpetrators of violence. The building and maintenance of prisons uses resources that could be directed toward prevention efforts.[22]

Definitions of Prevention

A review of definitions for prevention may facilitate an understanding of the three tiers of prevention used by public health practitioners. Primary prevention is any measure taken to prevent illness or injury *before* it occurs.[23] The eradication of smallpox through vaccination, reduction of automobile fatalities due to seatbelt laws, and decreased smoking rates due to education and cigarette taxation are all examples of primary prevention. Other examples include proper sewage treatment, ergonomically correct furniture, and child-proof caps on medicine containers.[24]

In the sphere of IPV, primary prevention is any measure that promotes healthy relationships. Primary prevention may include broad-based efforts

to address, inform, and educate communities about violence and its inherent negative consequences. This all-encompassing approach recognizes that IPV is a societal problem and thus does not solely focus on at-risk individuals.[25] Primary prevention strategies can foster new values, attitudes, and behaviors that promote healthy, nonviolent intimate partner relationships in communities. The most effective primary prevention efforts are those that are sustained, coordinated, and integrated across multiple levels of society including individual, community, organizational and policy levels.[26]

Secondary prevention involves early detection and intervention strategies that prevent an injury or illness from recurring. This includes screening at clinics, counseling survivors/victims or perpetrators of IPV, and accessing services from shelters.[27]

Tertiary prevention minimizes the progression of disease and its sequelae.[28] Emergency health care, rehabilitation services such as physical therapy, and substance abuse treatment are examples of tertiary prevention aimed at survivors/victims or of IPV. For perpetrators, tertiary prevention includes arrest, adjudication, or incarceration.[29]

Spectrum of Prevention

The Spectrum of Prevention provides a framework for the development of a systematic approach to health promotion. This framework has been applied to a variety of disciplines including violence prevention. Developed by Larry Cohen in 1983, this framework delineates six levels of increasing scope that can be used simultaneously to produce positive health outcomes to individuals, communities, and society as a whole.[30] For the purposes of this strategic plan, slight modifications were made to the framework to better serve our needs. Generally, this framework commences with the "individual" and ends with "policy and legislation." However, we have reversed the order of the Spectrum so that it begins with the policy level. We feel that it is more strategic to place emphasis on advocacy and the development of policies that will ultimately produce more broad-scale change in the community.

The six levels of the Spectrum are:

Influencing Policy and Legislation	▪ Developing strategies to change laws and policies to influence health outcomes ▪ Using legislative and policy activities to produce the broadest environmental changes
Changing Organizational Practices	▪ Adopting regulations and shaping internal organizational norms that will improve health and safety within the organization and in the community
Fostering Coalitions and Networks	▪ Bringing together groups and individuals for broader goals and greater impact
Educating Providers	▪ Informing providers who will transmit skills and knowledge to others
Promoting Community Education	▪ Reaching groups of people with information and resources to promote health and safety
Strengthening Individual Knowledge & Skills	▪ Enhancing an individual's capability of preventing injury or illness and promoting safety

The above explanations are adapted from the Prevention Institute website: www.preventioninstitute.org/spectrum_injury.html.[31]

Key Areas Identified

Four key areas of concern were identified in the initial development phase of this strategic plan. These areas include pregnancy; the lesbian, gay, bisexual, and transgender community; youth; and alcohol. Each area was investigated through a literature review, informal interviews, and focus groups. With the exception of objectives related to alcohol, each objective in the strategic plan is neutral in the sense that it could apply to any one of the identified areas.

Pregnancy

Nationally, researchers estimate that 4% to 8% of pregnant women are subjected to violence by an intimate partner each year.[32] Results from the Pregnancy Risk Assessment Study (PRAMS) (1999) show that women who reported having been physically hurt 12 months prior to the delivery of their baby were more likely to be non-white, be less than 20 years of age, have completed less than 12 years of education, be single, and have received late or no prenatal care.[33]

IPV emerges from a perpetrator's desire to dominate his or her intimate partner through the use of power and control. Jealousy over the inability to control physical changes in a pregnant woman's body or resentment caused by an unplanned or planned pregnancy may lead to the onset or escalation of violence.[34] When IPV occurs during pregnancy, not only is a woman's physical and emotional health at risk, but so too is the health of her unborn fetus. Increased stress, maternal rates of depression, suicide attempts, and alcohol and other drug abuse are higher among women who have been abused during pregnancy compared with women who have not been abused.[35] Poor birth outcomes associated with IPV in pregnancy include miscarriage, premature labor, and low birth weight infants.[36]

In 1998, the DPH Intimate Partner Violence Policy Work Group developed a protocol that requires screening for IPV at all city clinics. Under this protocol, all females aged 12 and older who seek physician services must be screened. As work continues on IPV, this protocol could

be further enhanced to include primary prevention education in all physician visits including visits to obtain prenatal or postpartum care. Other options include the incorporation of primary prevention education in all home visits to new mothers or on a yearly basis for all female patients. Such protocols have the potential to reduce the incidence of IPV during pregnancy and improve birth outcomes.

Lesbian, Gay, Bisexual and Transgender Community

IPV in the lesbian, gay, bisexual, and transgender community needs to be recognized as a public health issue. Until recent years, there has been a dearth of research studies on the existence of violence among same-sex intimate partners.[37] This lack of research is attributed to the fact that society generally does not view women as perpetrators of violence or men as victims of violence. As previously mentioned, IPV occurs in approximately one in five same-sex relationships.[38] Statistics on IPV in relationships in which one or both partner(s) is transgender or intersexed are not available.

In addition to the risk factors previously described, there are other risk factors for IPV that are specific to the LGBT community. "Outing" or threatening to reveal an intimate partner's sexual orientation or gender identity to family, friends, religious institutions, police, or employers increases risk for IPV and discourages reporting of violent incidents.[39] Victims who lack positive social support networks or alternatives for housing and/or employment may feel that they have no other recourse but to endure violence.

People living with HIV/AIDS can be victims or perpetrators of violence. The emotional stress that often accompanies HIV disease can serve as a catalyst for perpetrators to initiate IPV or increase the frequency or intensity of existing violence in a relationship. People who have HIV/AIDS and are dependent on an intimate partner for financial or other support are extremely vulnerable to being victims of violence. Abuse or the threat of abuse of persons living with illness can further compromise already fragile immune systems.

Each year, the Community United Against Violence (CUAV), Queer Asian Women's Services of the Asian Women's Shelter (QUAWS), and the Lesbian, Bisexual, and Transgender Anti-Domestic Violence Program of Women Organized to Make Abuse Nonexistent, Inc. (W.O.M.A.N., Inc.) collaborate to collect and compile data on incidents reported to these agencies and other agencies that collect similar data.[iv] In 2002, there were 521 reported cases of IPV among members of the LGBT community in San Francisco. The majority of these incidents (63% or 326 cases) were reported by people who self-identified as gay or lesbian. Bisexual men and women reported 7% (35) of incidents and individuals who self-identified as heterosexual represented 12% (60) of cases.[v] Although ethnicity was not reported in 31% of incidents, in cases where victims chose to report ethnicity, African Americans, Latinos, and Asian Pacific Islanders accounted for 37% of all reported cases, and whites accounted for 33%.[40]

During the development phase of this strategic plan, interview and focus group participants felt that law enforcement officials, health care providers, and other service providers should increase their awareness of, and sensitivity to, the needs of people who experience IPV in the LGBT community. Many felt that provider communication during the provision of IPV services can evoke feelings of isolation or alienation among those who seek information or assistance with exiting abusive relationships.

[iv] Other agencies that facilitate data collection include La Casa de las Madres, the Riley Center, LYRIC, Proyecto ContraSIDA Por Vida, The Family Violence Project, and the San Francisco Domestic Violence Consortium.
[v] The sexual orientation for the remaining 100 cases reported by CUAV, WOMAN Inc, and QUAWS is unknown.

Youth

While violence occurs at all ages, national data have shown that young women are more vulnerable to IPV than older women and males. In 1999, the per capita rate of IPV committed against all women in the United States was 6 incidents per 1,000 women. The rate for women in the 20 to 24 age group was 16 incidents per 1,000 women compared to 9 incidents per 1,000 women in the 25 to 34 age group.[41] [vi] [vii]

Young women who report violence in their intimate relationships are less likely to negotiate the use of a condom or dental dam during sexual activity, thereby increasing the risk for HIV infection and unwanted pregnancy. Factors associated with increased vulnerability for IPV among young women include early menarche, becoming sexual active at a young age, a high number of sexual partners, risky sexual behavior, and a history of sexual abuse. For both victims and perpetrators, low income, heavy alcohol consumption, and/or use of other drugs are also correlated with a higher prevalence of IPV in youth dating relationships.[42] [viii]

There are a myriad of social and environmental factors that influence a young perpetrator's decision to commit violent acts. Witnessing and/or experiencing acts of violence during childhood and adherence to rigid gender roles promote attitudes and beliefs that condone violence. Further, exposure to media images that show violence, particularly against women and girls, has an indirect influence on the decision to become violent.[43] Programs that educate young people on rights and responsibilities in dating relationships and the promotion of positive social norms that foster safe, healthy intimate partner relationships will help to overcome these negative influences.

[vi] In this strategic plan, youth is defined as any individual below the age of 24.
[vii] According to A Report of the Coalition of Anti-Violence Programs (2002), 52% of IPV reported nationally in the LGBT community occurs in the 30 to 44 age group.
[viii] According to Centers for Disease Control and Prevention, heavy drinking is defined as consumption of 5 or more alcoholic beverages per day.

Alcohol

The relationship between alcohol and IPV is extremely complex and is not entirely understood.[44] While alcohol is not the cause of IPV, it is consistently associated with violent acts.[45] In fact, alcohol is reported in violent incidents more often than any other drug.[46] People who abuse alcohol are more likely to be perpetrators or victims of IPV than those who do not. This is true across all socio-economic levels and ethnic groups in the United States.[47]

The widespread availability of alcohol outlets, particularly in lower income communities, contributes to all forms of violence including physical or sexual assault and homicide. According to the State Alcohol Beverage Control (ABC), as of July 1, 2003, there were a total of 3,482 licensed alcohol outlets in San Francisco. Table 1 outlines, in descending order, the number of alcohol retail outlets in San Francisco by zip code.

Table 1. Retail Outlets Where Alcohol is Sold: San Francisco, 7/03

Neighborhood	Zip Code	Total Outlets	% to Total
Inner Mission/Bernal Heights	94110	345	9.9
North Beach/China Town	94133	325	9.3
Polk/Russian Hill	94109	302	8.7
Hayes Valley/Tenderloin/North of Market	94102	281	8.1
South of Market*	94103	248	7.1
Telegraph Hill/Embarcadero**	94105	229	6.5
Inner Richmond	94118	173	5.0
Castro/Noe Valley***	94114	172	4.9
Sunset	94122	159	4.6
Haight Ashbury	94117	150	4.3
Western Addition/Japantown	94115	148	4.3
Marina	94123	148	4.3
Potrero Hill	94107	147	4.2
Chinatown	94108	128	3.7
Outer Richmond	94121	126	3.6
Ingleside/Excelsior/Crocker Amazon	94112	109	3.1
Bayview/Hunter's Point	94124	69	2.0
Parkside	94116	61	1.8
St. Francis Wood/Miraloma Park	94127	53	1.5
Visitacion Valley	94134	46	1.3
Twin Peaks/Glen Park	94131	35	1.0
Lake Merced	94132	26	0.7
Daly City	94015	1	-
Treasure Island	94130	1	-
Total		**3482**	**100%**

**South of Market (94103) also includes 7th and Mission (94101)*
***Telegraph Hill/Embarcadero (94105) also includes 94119, 94104, and 94111*
****Castro/Noe Valley includes 94114 and 94113*

The Inner Mission/Bernal Heights (94110), North Beach/Chinatown (94133), and Polk/Russian Hill neighborhoods (94109) represent 28% of all alcohol retail outlets in San Francisco. These zip codes have a higher

proportion of low-income and ethnic minorities compared with other areas in the city. Further, there is a strong positive correlation between the density/number of alcohol outlets and violent crime.

In addition to the high density of alcohol outlets in at-risk neighborhoods, advertising directed toward low-income communities exacerbates the IPV problem. In San Francisco, there is a significant discrepancy by neighborhood in the number of billboards that contain alcohol advertising. When compared with predominantly white neighborhoods, African American neighborhoods have more than three times the number of billboards per resident and Latino neighborhoods have more than twice as many billboards per residents.[48] This discrepancy underscores the need for the development and implementation of policies aimed at a reduction in the amount of alcohol advertising in lower-income neighborhoods. Such policies can only serve to promote safe, healthy, intimate partner relationships.

Alcohol Advertising and Youth

Alcohol advertising directed at children and youth creates brand recognition at an early age. In 1998, a national survey concluded that youth between the ages of 6 and 17 identified Budweiser's cartoon advertisements as their favorite.[49] These advertisements ranked higher than advertisements for Pepsi, Nike, and other popular brands. Brand recognition has the potential to influence attitudes toward drinking and may increase the intention to consume alcohol.[50] According to the Health and Well Being of San Francisco Children Report, in 1997, 59% of middle school children, and 59% of high school students reported that they had tried alcohol at least once in their lives. Additionally, 21% of middle school students and 30% of high school students reported having consumed alcohol in the last 30 days.[51] Although these statistics are not directly related to marketing's influence on alcohol consumption among San Francisco youth, they do offer some insight on the overall level of consumption and support the need for tighter control on the amount of alcohol advertising directed specifically toward youth.

Limiting the availability of, and access to alcohol is an effective prevention strategy. San Francisco Supervisor Sophie Maxwell is currently involved with the development and implementation of a "good neighbor" policy in the Bayview/Hunter's Point community. In addition to increasing healthy food choices offered by local merchants, the aim of this policy is to reduce the amount of tobacco and alcohol sold in retail establishments in these neighborhoods. The implementation of a similar policy in other high-risk neighborhoods could lead to a reduction in the number of violent incidents reported in San Francisco each year. Further, encouraging alcohol-free community events is another effective prevention strategy that has the potential to reduce the incidence and prevalence of IPV in the community.

San Francisco Data on Intimate Partner Violence

The complex, often hidden nature of IPV has an impact on data collection, analysis, and reporting. Figure 1 represents the range of IPV reporting:

- Fatalities – IPV homicides
- Nonfatal injuries - injuries that need medical care or hospitalization
- Police Reports – IPV incidents reported by police
- Calls to hotlines – calls to SF domestic violence crisis hotlines.
- Unreported incidents - the majority of incidents are not reported. Approximately 20% of rapes, 25% of physical assaults, and 50% of stalkings perpetrated against women are reported to police. Even fewer violent incidents perpetrated against males are reported.[52] In general, reported incidents are physical in nature. Threats of abuse, psychological abuse, and economic coercion are seldom reported. Thus, the true extent of IPV is difficult to measure.

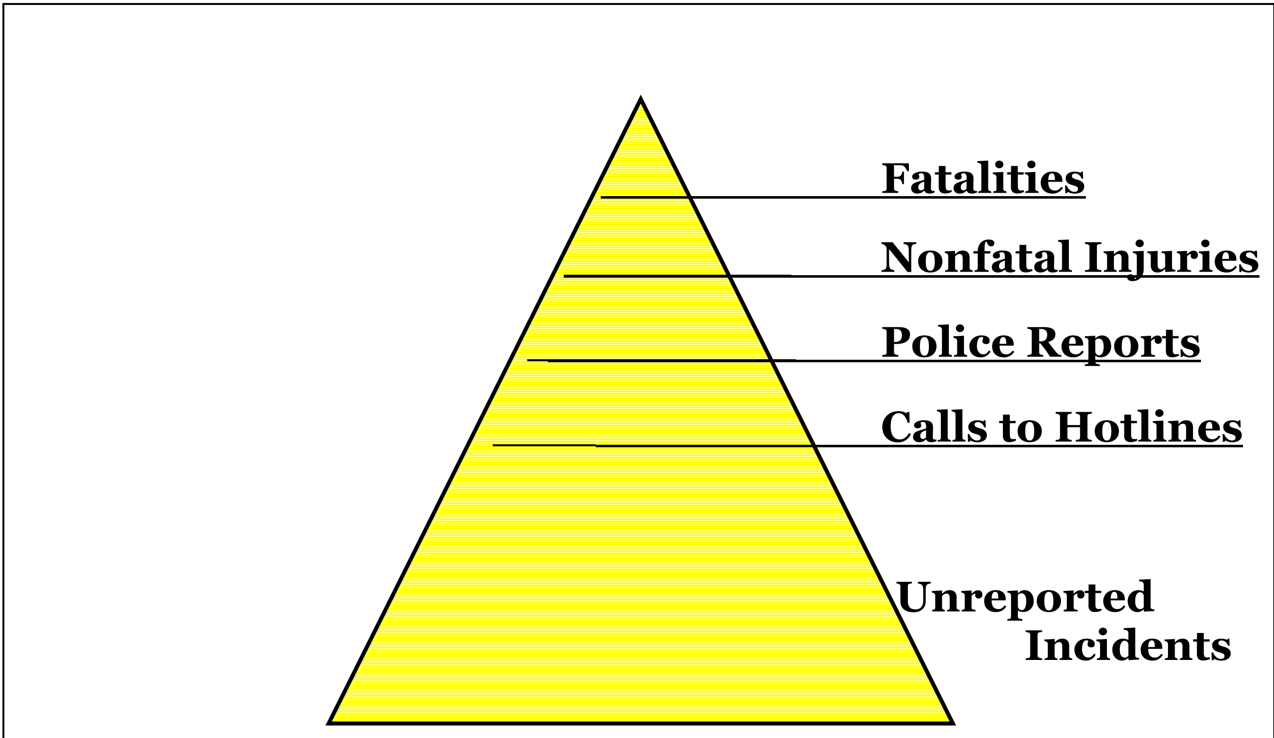


Figure 1. The Intimate Partner Violence Reporting Pyramid

Background on Violent Injury Reporting

The San Francisco Violent Injury Reporting System (SFVIRS) was established in 1998 as a joint effort between DPH and the San Francisco Injury Center at the University of California, San Francisco. This system links across multiple agencies and provides unprecedented levels of detail on deaths and injuries in San Francisco. Data sources include death certificates, San Francisco Police Department (SFPD) reports, and San Francisco General Hospital emergency department and trauma services. SFVIRS is one of 13 collaborating sites across the country that are collecting data on all homicides and suicides as part of Harvard University School of Public Health's National Violent Injury Statistics System (NVISS).[53] The data captured by SFVIRS are instrumental for the development of more effective interventions and policies aimed at violence prevention. The following are key preliminary findings from the SFVIRS report on *all* violence related injury incidents in 2001:

- The average cost of treating one firearm injury victim in San Francisco was $30,000
- Total charges for treating 101 victims was approximately $3 million
- 73% of homicides and assaults occurred between 6 p.m. and 6 a.m.
- The Inner Mission neighborhood had the most shootings and stabbings combined
- 44% of homicide and assault victims lived within 1 mile of the shooting location
- 18% of victims resided at the location where the violent incident occurred

Intimate Partner Violence Homicide

Loss of life is the greatest tragedy of IPV. Between 1991 and 2001, there were 43 homicides in San Francisco committed by a victim's current or former intimate partner. By ethnicity, 15 African Americans, 15 whites, 6 Hispanics, 6 Asians, and 1 person of 'other' ethnicity were killed. In general, homicides among males and females in San Francisco have declined in recent years; however, homicides specific to IPV are disproportionately higher among females. During the 11-year period, 79%

of victims were female. Due to the small number of IPV homicides, we are not able to publish a map that delineates the location of each homicide since this would jeopardize the victims' and their families' confidentiality.

Figure 2 shows that 17 of the killings were committed with a firearm, 14 with a knife, and 5 with a personal weapon.[ix] Data on the national level also show that these weapons are most commonly used in IPV homicides throughout the United States.[54] (The remaining killings were committed with a blunt object (4), by arson (2), and by unknown means (1).) These data underscore the need for reducing access to, and availability of, firearms.[x]

DPH adheres to the Centers for Disease Control and Prevention (CDC) guidelines for reporting in IPV injuries. Under these guidelines, injuries are reported as Domestic Violence (DV) because there is no distinct classification for IPV. Injuries sustained by children, family members, friends, or bystanders as a result of violent acts perpetrated against a victim's current or former intimate partner are included in this category. Each graph on the following pages is labeled as Domestic Violence to remain consistent with CDC reporting guidelines.

[ix] A personal weapon is any part of the body that can be used as a weapon. Examples include the use of hands, knees, legs, feet, or head.
[x] The Roadmap for Preventing Violence contains objectives specific to reducing access to, and availability of, firearms. See appendix A for more details.

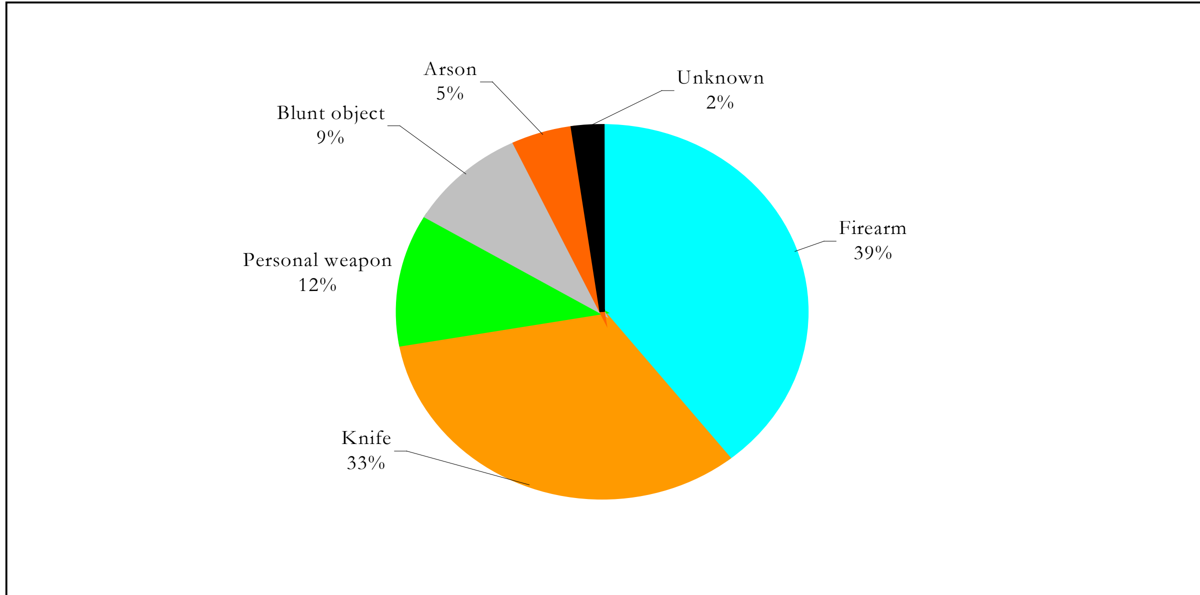


Figure 2. Weapon Used in Domestic Violence Homicide: San Francisco, 1992 – 2001 (n=43)

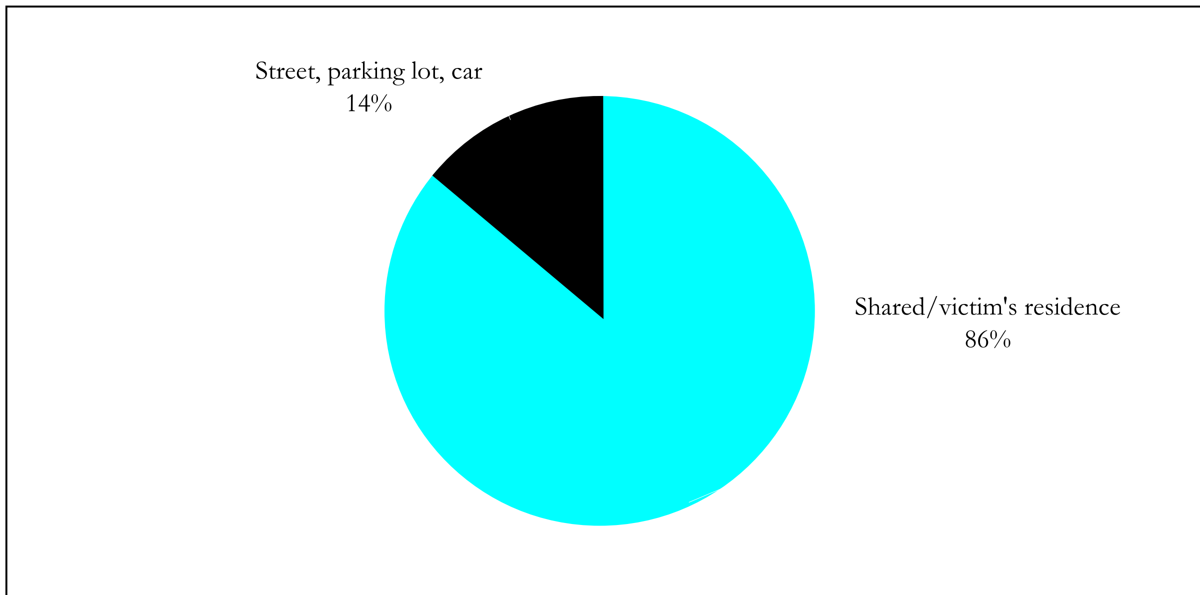


Figure 3. Location of Domestic Violence Homicide: San Francisco, 1992- 2001 (n=43)

Between 1992 and 2001, 37 (86%) IPV homicide victims in San Francisco were killed in their place of residence (Figure 3). This percentage correlates with the fact that the majority of IPV occurs in the home.[55]

During the same time period, 106,500 incidents were reported by SFPD. The peak of this period was 1994 when police responded to 10,000 incidents. It is important to note that during the same year, there was a peak in the total number of homicides in San Francisco. SFPD did not collect data from 1997 to 1999. Figure 4 shows the total number of incidents and the number of incidents where a weapon was involved.

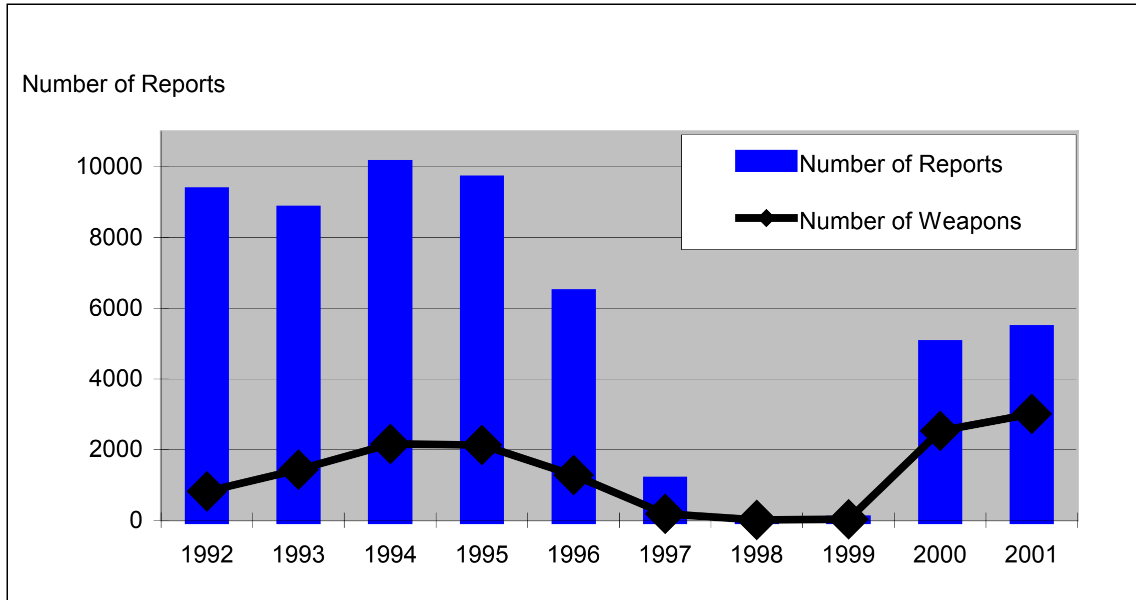


Figure 4. Domestic Violence Incidents Reported by SFPD: 1992 – 2001 (n=106,500)

Data Limitations

While data regarding IPV in San Francisco are accurate to the best of our knowledge, certain factors may circumvent our ability to fully gauge the magnitude of the problem. Such a predicament is not unique to San Francisco. According to Cohen and Swift (1993), a lack of reporting by the victim, statistical undercount, and possible issues with injury documentation are factors that affect data collection and accuracy in records of violence. Quite often, victims do not report incidents because of shame, fear of retribution, or fear of having one's sexual orientation revealed. For new immigrants or non-residents, fear of deportation or being reported to the Immigration and Naturalization Service (INS) may be a consideration in the decision to disclose personal experiences of violence.

Lack of English language skills or the perception that service providers are not sensitive to their needs may also preclude victims from reporting incidents.

Those who seek medical care for serious IPV related injuries may choose not to disclose the circumstances in which injuries were incurred. Further, it is possible that law enforcement, legal personnel, and clinicians may not document injuries as being related to IPV and/or downplay the true extent of injury. Lack of provider training, cutbacks in mental health and medical services due to budget constraints, and a medical care system that typically allows for 15-minute physician visits all inhibit thorough assessment and reporting of IPV injuries.

Data for severe injury and death are tracked and analyzed by SFVIRS; however, data regarding less severe physical injuries such as bone fractures or minor/moderate lacerations are not currently reported. Unfortunately, the establishment and maintenance of a reporting mechanism to capture such data is cost prohibitive and thus not feasible at this time. DPH continues to collaborate with the domestic violence unit of SFPD in order to identify and follow-up on all domestic violence injuries that occur in San Francisco.

Strategic Plan Development Process

A strategic plan enables an organization or a department within an organization to establish priorities and set realistic long-term goals and objectives. Such a plan outlines what will be done, when it will be done, who will do it, and how success will be measured. Typically, a strategic plan covers three to five years of activities. The San Francisco Department of Public Health Intimate Partner Violence Strategic Plan covers activities between 2003 and 2008. Further, this five-year plan will be revised as appropriate.

The planning process began when the IPV Core Group was recruited and convened. This Group was instrumental in providing project staff with direction throughout the development process. A number of steps were taken to gather both quantitative and qualitative data about IPV. A formal literature review on IPV root causes, risk factors, and prevention best practices was conducted in the early phase of the project. Further, over 20 interviews were held with DPH staff, community members, and CBO staff to ensure that CHES received the widest range of input. Quantitative data provided by the CHES epidemiologist enabled project staff to understand the scope of IPV in the community. Lastly, focus groups were held at the conclusion of the 2003 San Francisco Children and Families DV Free conference co-sponsored by DPH and SafeStart. Through the data collection, interview, and focus group process, staff were able to develop, refine, and prioritize objectives. Several imperatives emerged from interviews and focus groups:

Define a Healthy Relationship

Interview and focus group participants expressed the need for a definition of a model healthy relationship. Such a definition would need to be inclusive, empowering, and involve the input from the community. The model could promote consistency in the dialogue around primary prevention and IPV as well as provide an ideal to attain.

Develop Community-Based Programs with a Primary Prevention Focus

The need for community-based education programs with a primary prevention focus was a dominant theme. These programs would provide participants with a repertoire of relevant skills including conflict resolution, parenting, job, and stress management skills. Some participants felt strongly that programs offered in a one time or multi-week format were insufficient to change habits and behaviors that have accumulated over time. Ongoing programs that can be accessed as needed were suggested as a more effective means of promoting and maintaining behavioral changes. In addition to ongoing programs, some felt strongly that communities must encourage people to seek help whenever necessary. Programs aimed at primary prevention must be culturally appropriate and tailored to meet the needs of San Francisco's diverse communities. Many people expressed the need for having educational materials in English, Spanish, Chinese, Tagalog, Russian, and Vietnamese. Large print and Braille were recommended for people who are visually impaired.

Educate Children and Youth

Participants expressed the need for consistent violence prevention education in school programs. Many felt that learning to be respectful in interpersonal relationships must start in kindergarten and continue throughout high school and college. Participants felt that the development of conflict-resolution skills at an early age could play a crucial role in preventing intimate partner violence in adulthood. Though out of the specific purview of DPH, we encourage others to advocate for the development and implementation of curricula aimed at these areas.

Educate Communities

Many people commented that there is an opportunity for DPH to provide education and/or technical assistance to communities and CBOs that may not be familiar with primary prevention. Such education would increase awareness about primary prevention and promote positive community norms.

Access to Alcohol

Concern was expressed regarding the availability of alcohol in high-risk areas. Neighborhood participants desired a reduction in the number of retail outlets that sell alcohol in high-risk communities.

How to Use This Plan

The interview and focus group process enabled us to develop, refine, and prioritize objectives. Each of the 13 objectives on the following pages is designed such that neighborhood groups, public, and private organizations can work independently or in collaboration with DPH or others to achieve the goal of safe, healthy intimate partner relationships. Each objective is in matrix form and includes selected potential strategies, and evaluation methods.[xi] The objectives are not prioritized because it is important for those groups or organizations interested in their implementation to select what is best for their current needs or environment. The list of potential lead and contributing agencies serves as a guide for identifying allies in achievement of a particular objective.

Goals and Objectives

A brief review of basic definitions for goals and objectives may facilitate comprehension of the specific Intimate Partner Violence Strategic Plan objectives outlined on the following pages:

[xi] The design and layout of the objectives in this plan is similar to that of the Roadmap for Preventing Violence. See Appendix A for Roadmap details.

Goal: *A goal is a broad timeless statement that represents a desired long-range change or state.*[56]

Objective: *An objective represents a desired and measurable outcome or result that is essential for achieving a goal. An effective objective is SMART – specific, measurable, achievable, relevant, timely. This plan delineates process and outcome objectives to achieve our goal of safe, healthy intimate partner relationships.*[57]

Process Objective: *A process objective provides the necessary groundwork for the accomplishment of a goal. Examples include tasks, activities, and/or work plans that will facilitate implementation or evaluation of a program or approach.*[58]

Outcome Objective: *This type of objective specifies a priority population and outlines what will happen to the population as a result of an intervention or approach.*[59]

If you are interested in working on, or collaborating with DPH or others to implement one or more of the objectives or strategies outlined in this plan, please contact Isabel Auerbach, MPH, CHES by phone at (415) 575-5684 or email at Isabel.Auerbach@sfdph.org.

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
1. By 2008, CHES will implement policies that recognize primary prevention of intimate partner violence as a public health strategy and promote healthy intimate partner relationships. **Timeline for Completion** ▪ 2003-2004	1.1. CHES will develop and promote a model definition of an intimate partner relationship in which safety, respect, and caring flourish. **Selected Potential Strategies** i. Convene DPH groups ii. Get input from community members/agencies iii. Publish surveys in local newspapers to obtain input iv. Conduct focus groups in various communities v. Post draft policies online to solicit input	**Lead Agencies** ▪ DPH **DPH Work Groups** ▪ IPV core group ▪ VPN ▪ IPV screening policy work group **DPH Programs** ▪ Black Infant Health (BIH) ▪ 7Principles **Participating Agencies** ▪ DV agencies	i. Written policy ii. Focus group/meeting results iii. List of participating agencies iv. Compilation of suggestions ascertained from surveys v. Number of emails received vi. Research results

	vi. Research similar policies in other locales vii. Hold policy conference/meeting	▪ Youth groups ▪ Churches/ ▪ faith-based groups	

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
2. By 2008, CHES will implement policies that recognize primary prevention of intimate partner violence as a public health strategy and promote healthy intimate partner relationships. **Timeline for Completion** 1. 2003-2004	2.1 CHES will develop and promote a model definition of a healthy community that fosters social support, and promotes norms of safe intimate partner relationships. **Selected Potential Strategies** i. Convene DPH groups ii. Get input from community members/agencies iii. Publish surveys in local newspapers to obtain input iv. Conduct focus groups in various communities v. Post draft policies	**Lead Agencies** ▪ DPH **DPH Work Groups** ▪ IPV core group ▪ VPN **DPH Programs** ▪ BIH ▪ 7Principles **Participating Agencies** ▪ DV agencies ▪ Youth groups ▪ Churches/ ▪ Faith-based groups ▪ Neighbor-	i. Written policy ii. Focus group/meeting results iii. List of participating agencies iv. Compilation of suggestions ascertained from surveys v. Number of emails received vi. Research results vii. Qualitative reports of changes in workplace programs viii. Number of CBOs that use definition for basis of their work

	online to solicit input vi. Research similar definitions vii. Hold conference/meeting to solicit input viii. Create "healthy relationships" packets to distribute to community agencies and at local conferences ix. Create a community dialogue guide	hood groups ▪ CBOs	

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
3. By 2008, CHES will implement policies that recognize primary prevention of intimate partner violence as a public health strategy and promote healthy intimate partner relationships. **Timeline for Completion** ▪ 2003 - 2008	3.1 Enhance existing DPH screening protocol to include primary prevention education, resources, and referrals in all city clinics/services. **Selected Potential Strategies** i. Convene DPH groups ii. Research best practices/models in other locales iii. Write model draft protocol iv. Achieve consensus via focus groups/meetings to enhance existing protocol or develop separate new protocol	**Lead Agencies** ▪ DPH **DPH Work Groups** ▪ IPV core group ▪ VPN **DPH Programs** ▪ Community Health Network (CHN)	i. Written policy & protocol ii. Research results iii. Number of trainings conducted, educational materials and/or referrals distributed iv. Minutes from meetings

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
4. By 2008, access and exposure to alcohol within San Francisco will be reduced. **Timeline for Completion** ▪ 2003 - 2008	4.1 San Francisco will prohibit sponsorship of community events by alcohol companies **Selected Potential Strategies** i. Support alternative street fairs ii. Ensure that non-alcoholic beverage options are available at all community events iii. Identify alternative funding sources such as local corporations and merchants iv. Invite smaller sponsors to allow	**Lead Agency** ▪ Alcohol Policy Coalition **Participating Agencies** ▪ DPH ▪ CBOs ▪ Neighborhood groups ▪ Planning Department ▪ Local corporations ▪ Chamber of Commerce ▪ Event organizers ▪ Local Merchants	i. Reports that demonstrate increase in funding of events that do not serve alcohol ii. Reports that display funding sources for community events iii. Research results

	for community reinvestment v. Solicit health related products and/or sponsorship at community events vi. Promote responsible drinking vii. Research policies/best practices in other locales viii. Sponsor alcohol free weeks ix. Educate community about link between IPV and alcohol		

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
4. By 2008, access and exposure to alcohol within San Francisco will be reduced. **Timeline for Completion** ▪ 2003 - 2008	4.2 San Francisco will enact a 'good neighbor' policy to reduce alcohol sold in stores and/or reduce the number of outlets that sell alcohol. **Selected Potential Strategies** i. Convene DPH groups ii. Solicit input from community members/agencies iii. Research similar policies in other locales iv. Hold policy conference/meeting to increase awareness/support v. Further	**Lead Agencies** ▪ Alcohol Policy Coalition ▪ Board of Supervisors **Participating Agencies** ▪ DPH ▪ City Departments ▪ CBOs ▪ Youth groups ▪ Churches/ faith-based groups	i. Written policy ii. List of participating agencies iii. Research results

	research/analyze density of alcohol outlets and reported incidents of IPV vi. Post draft policies online to solicit input		

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
4. By 2008, access and exposure to alcohol in San Francisco will be reduced. **Timeline for Completion** ▪ 2003 - 2008	4.3 San Francisco will reduce the amount of alcohol advertising permitted on billboards and in retail outlets. **Selected Potential Strategies** i. Conduct focus groups in various communities ii. Solicit input from community members and agencies iii. Develop alcohol advertising policy standards/regulations	**Lead Agencies** ▪ Alcohol Policy Coalition **Participating Agencies** ▪ Churches/ faith-based groups ▪ CBOs and community centers ▪ Tobacco and alcohol industry **DPH Programs** ▪ Tobacco Free Project	i. Focus group results ii. Number of community and neighborhood activities initiated iii. Qualitative assessment of content and effectiveness of counter-advertising initiative

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
5. By 2008, media images in San Francisco will promote positive messages about women and girls. **Timeline for Completion** ▪ 2003 - 2008	5.1 San Francisco will advocate for the elimination of media images that depict violence against women and girls. **Selected Potential Strategies** i. Identify CBOs and centers to take action ii. Develop media standards/regulations iii. Define potential positive messages that can be conveyed in advertising iv. Develop neighborhood-based advertising campaign that promotes positive images of women.	**Lead Agencies** ▪ DPH ▪ City government agencies **Participating Agencies** ▪ Advertising Industry ▪ DV agencies	i. Written policy ii. Number of community and neighborhood activities initiated iii. List of messages that convey positive images of women and girls iv. Qualitative assessment of content and effectiveness of advertising initiative

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
6. By 2008, CHES will adopt internal policies/organizational practices that promote primary prevention of IPV. **Timeline for Completion** ▪ 2003 - 2008	6.1 CHES will implement an internal practice of incorporating a primary prevention framework in all programs and contractual relationships that address IPV **Selected Potential Strategies** i. Develop curricula and trainings on primary prevention ii. Pilot test curricula iii. Establish best practices for materials distribution and training	**Lead Agencies** ▪ DPH **Participating Agencies** ▪ CHES contractors	i. Written policy ii. Number of educational materials, referrals distributed iii. Number of trainings conducted iv. Program descriptions

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
7. By 2008, CHES will adopt internal policies/organizational practices that promote primary prevention of IPV. **Timeline for Completion** ▪ 2003 - 2008	7.1 CHES will seek funding on an ongoing basis to support programs, community teams, and pilot projects that address primary prevention of IPV **Selected Potential Strategies** i. Research funding opportunities ii. Network with internal and external sources to investigate potential funding opportunities iii. Collaborate with other agencies to apply for funding	**Lead Agencies** ▪ DPH **Participating Agencies** ▪ CBOs, particularly DV agencies	i. Amount of funding received ii. Number of RFA/RFP applications submitted for funding

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
8. CHES will continue to foster internal and external coalitions to inform policy and promote primary prevention of IPV. **Timeline for Completion** ▪ 2003 2008	8.1 CHES will continue to participate in existing violence related coalitions and will promote primary prevention as appropriate. **Selected Potential Strategies** i. Establish a collaborative planning group of medical, mental health, and social services providers to guide protocol development and training ii. Develop trainings for all city health services providers iii. Research existing	**Lead Agencies** ▪ DPH **DPH workgroups:** ▪ VPN **DPH Programs** ▪ BIH ▪ 7Principles **Participating Agencies** ▪ CBOs	i. Minutes from meetings ii. Results of research iii. Number of educational materials distributed iv. Number of referrals distributed and completed v. Number of trainings conducted vi. Number of people trained

	training models/best practices and educational materials		

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
9. By 2008, providers in San Francisco will adopt a primary prevention framework to IPV prevention. **Timeline for Completion** ▪ 2003 - 2008	9.1 Train providers to incorporate a culturally appropriate primary prevention framework into their practices. **Selected Potential Strategies** i. Convene DPH groups ii. Identify community agencies and faith-based groups that want to take action iii. Continue to research existing programs, training models/best practices used by faith leaders and community groups iv. Train youth, faith-based or other	**Lead Agencies** ▪ DPH **Participating Agencies** ▪ CBOs ▪ DV agencies ▪ Churches/faith-based groups ▪ Youth groups	i. Results of research ii. Number of trainings conducted iii. Number of providers trained

	community leaders to provide primary prevention education v. Promote standardized training of DPH health services providers vi. Develop and pilot curricula for training/educating providers vii. Conduct ongoing trainings (as appropriate) for providers on reporting protocols, procedures, resources, and referrals.		

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
10. By 2008, CHES will create within the community the capacity to foster and promote safe, healthy intimate partner relationships. **Timeline for Completion** ▪ 2003 to 2008 ✐ *See Appendix B for details on Community Action Model methodology*	10.1 CHES will train communities to use the Community Action Model (CAM) in pilot community projects that address IPV using a primary prevention framework. **Selected Potential Strategies** i. Research existing primary prevention models and best practices that may be used or adapted to serve as a framework for educating and mobilizing communities. ii. Identify CBOs and	**Lead Agencies** ▪ DPH **Participating Agencies** ▪ CBOs, particularly DV agencies ▪ Churches/faith-based groups ▪ Youth groups	i. CAM curriculum ii. Number of trainings iii. Number of people trained iv. List of CBOs, community leaders

	community leaders to train iii. Develop culturally appropriate curricula on topics such as safe relationships, dating, and healthy families. iv. Develop a 'tool box' kit on primary prevention v. Hold a Health Education Training Center (HETC) conferences on CAM methodology vi. Provide technical assistance to CBOs trained in CAM methodology		

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
11. By 2008, CHES will create within the community the capacity to foster and promote safe, healthy intimate partner relationships. **Timeline for Completion** ▪ 2003 - 2008 ✐ *See Appendix B for details on Community Action Model methodology*	11.1 CHES will build social support networks within community to foster expectations of safe, healthy relationships. **Selected Potential Strategies** i. Collaborate with CBOs, neighborhood groups, and community leaders ii. Conduct focus groups in various communities iii. Hold Town Hall meetings iv. Provide technical assistance to communities and agencies that want to	**Lead Agencies** ▪ DPH **DPH Programs** ▪ BIH ▪ 7Principles **Participating Agencies** ▪ CBOs, particularly DV agencies ▪ Churches/ faith-based groups ▪ Youth groups ▪ Office of Women's Health	i. Focus group results ii. Minutes from Town Hall meetings iii. Results of research iv. List of collaborating agencies v. Quantitative and qualitative results from agencies who received technical assistance

	address IPV root causes and risk factors v. Research best practices in other locales vi. Encourage on-going or ad hoc coalitions aimed at building social support networks		

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
12. By 2008, CHES will promote primary prevention education in the community. **Timeline for Completion** ▪ 2003 to 2008	12.1 San Francisco will develop a culturally appropriate social marketing campaign to educate communities about safe, healthy intimate partner relationships. **Selected Potential Strategies** i. Conduct focus groups in various communities to identify target audiences and how to communicate to these audiences ii. Administer a survey to measure baseline knowledge, attitudes, and behaviors, beliefs	**Lead Agencies** ▪ DPH ▪ DV agencies **Participating Agencies** ▪ CBOs, particularly DV agencies ▪ Youth groups	i. Focus group results ii. Pre-test survey results iii. Research results iv. Campaign message(s) v. Quantitative data on media source(s) and distribution vi. Post survey results vii. Number of PSAs, billboards placed, and pamphlets distributed

	about primary prevention iii. Research effective campaigns that have previously been utilized iv. Develop appropriate message v. Pilot test messages to assure cultural appropriateness vi. Identify appropriate media sources for delivering messages (e.g., television, PSAs etc.) vii. Post survey to measure effectiveness of campaign		

Process Objective	Sub-Objective and Selected Potential Strategies to Achieve	Potential Lead and Participating Agencies	Evaluation Tools
13. By 2008, CHES will promote primary prevention education. **Timeline for Completion** ▪ 2003 to 2008	13.1 CHES will make available primary prevention education, materials, and resources to individuals, as well as agencies and providers. **Selected Potential Strategies** i. Develop online resources and information regarding primary prevention of intimate partner violence (IPV) and include links to other sites. ii. Identify potential outside agencies to be linked to website	**Lead Agencies** ▪ DPH **Participating Agencies** ▪ DV agencies	i. Website ii. Number of hits on web-site iii. Educational materials iv. Number of educational materials distributed

	iii. Develop or use pre-existing educational print materials regarding primary prevention of intimate partner violence for distribution at various points within the community including city clinics and community agencies iv. Assure that training and technical assistance resources are available to community groups that work with individuals v. Develop appropriate referral mechanisms and resources		

Appendix A - CHES Violence Prevention Projects, Programs, and Coalitions

Roadmap for Preventing Violence

This strategic plan is preceded by the Roadmap for Preventing Violence. That work, published in 2001, provides guidance to communities, organizations, and neighborhood groups that are committed to violence prevention. The Roadmap uses a public health approach to prevent violence by addressing three core root causes/ risk factors for community violence: alcohol, firearms, and witnessing acts of violence. This strategic plan differs from the Roadmap in that it focuses on primary prevention and intimate partner violence. There is an overlap between some objectives that pertain to alcohol in both this plan and the Roadmap because alcohol is a risk factor for both community and intimate partner violence.

Children and Youth DV Free

This program, funded by the State Department of Health Services Maternal and Child Health Branch, provides community training to change the way people in San Francisco think and act around domestic and family violence. In addition to intimate partner violence among youth, Children and Youth DV Free addresses children who witness violence within their homes and the negative affects associated with witnessing such violence. For more details on this program please visit our website at: www.sfdph.org/CHPP/dvfree.htm.

San Francisco Violence Prevention Network (VPN)

The mission of the Violence Prevention Network is to facilitate collaboration and coordination in San Francisco by using a systematic public health approach to prevent violence and promote peace. This network consists of individuals, communities, community based non-profit organizations, and private organizations. Members meet monthly to share resources, data, and best practices. The VPN has held workshops, trainings, and conferences and has produced two editions of a Violence Prevention Resource Directory. In 2001, the network developed the

Roadmap for Preventing Violence. More information regarding the VPN can be obtains from our website: http://www.sfdph.org/CHPP/vpn.htm.

Youth Peaceful Organizer Working to Enact Results (YouthPower)

CHES was awarded a two-year strategic planning grant in 2000 from the Federal Substance Abuse Mental Health Services Agency (SAMHSA) to address violence in San Francisco's Bayview-Hunter's Point and Mission neighborhoods. This program is based on primary prevention, capacity-based assessment, and comprehensive outreach. YouthPower includes a neighborhood task force, citywide oversight committee, and a planning team. At the end of the planning process, a strategic plan will be developed for each neighborhood. The focus of each plan will be on youth violence, substance abuse prevention, and mental health promotion. Further, a financial plan will be developed to facilitate the implementation of objectives identified in each strategic plan. Our website: www.sfdph.org/CHPP/YouthPower.htm for more details on this program.

YouthPOWERII

YouthPOWERII received a Drug-Free Communities grant to utilize environmental prevention strategies to reduce alcohol and marijuana use among middle and high school-age youth in San Francisco's Bayview Hunters Point (BVHP). YouthPOWER has three primary goals:

1. To increase neighborhood capacity to create an environment conducive to positive youth development.

2. To promote positive mental health and reduce youth violence and substance use in the Mission District and Bayview Hunters Point.

3. To create a model for neighborhood/citywide planning that can be replicated and applied to other social, educational, economic, criminal justice and public health challenges.

The Drug-Free Communities project emphasizes environmental rather than individually based approaches to prevention, and recognizes and honors the central role neighborhood residents – including youth – have in creating healthy communities that effectively support and nurture young people. Two community action teams are currently working to address issues of substance abuse availability. The original YouthPOWER report and recommendations can be found at www.sfdph.org/CHPP/YouthPower.htm

San Francisco Violent Injury Reporting System (SFVIRS)

Firearms cause some 30,000 deaths every year in the United States--a rate five to ten times higher than that in other industrialized nations. In spite of the unusually heavy toll, little information is collected comprehensively on firearm deaths and injuries, either nationally or locally.

To overcome this lack of data, in 1998 the San Francisco Public Health Department initiated a cooperative agreement with the San Francisco Police Department, Medical Examiner's Office, San Francisco General Hospital, and the San Francisco Injury Center to comprehensively capture

every firearm-related injury occurring in the county into a single shared database. By working collaboratively, these agencies are more efficient and effective in assessing firearm-related injuries. Agencies are now equipped with a tool promoting a much better understanding of the scope of San Francisco's problem of firearm-related injuries. The data gathered through this collaborative approach will permit agencies to recognize trends in firearm-related injuries, identify "hot spots," develop appropriate prevention activities, and inform the community and policy makers more comprehensively so identified prevention programs can be implemented.

In the fall of 1999, supplemental funds were awarded by the Harvard School of Public Health for San Francisco to serve as one of the 11 pilot sites in the National Firearm Injury Statistics System (NFISS). The goals of the project are to support local firearm injury data-gathering efforts and to build a model national reporting system. The purpose of such a reporting system is to collect objective data on an ongoing basis for use in planning and in evaluating polices aimed at reducing firearm injuries.

Every police report, Medical Examiner's report, autopsy report, and San Francisco General Hospital Emergency Department and Trauma registry involving firearm-related injury or death is reviewed and data are extracted. Key variables are collected in a systematic and comprehensive manner. Detailed information is collected on the victims (e.g., demographics, substance use, relationship to suspected offender[s], circumstance leading to the injury, work-relatedness, criminal history), suspected offender[s] (e.g., demographics, work-relatedness, criminal history, any criminal charges), incidents (e.g., date, type of location, number of persons involved, narrative of the incident) and weapons (e.g., type, make, model, serial number, caliber, recovery of casings or bullets, safety features). An incident-based, relational database has been designed with a number of research and policy applications. For example, the system will provide information about the circumstances leading to accidental or suicidal shootings, the relationships and circumstances between the victim and suspect in assaults and homicides, referrals of victims of firearm-related

injuries to programs that will assist them to break the cycle of violence, and the prevalence of firearm-related injuries at public housing sites.

It became evident through analysis of the firearm death and injury reporting system that more comprehensive data regarding all violent deaths was needed. Violent homicide and suicide deaths take the lives of nearly 50,000 people in the United States each year, and are the third and fourth leading causes of death for people between the ages one and 39. As with firearm-related injuries, there is no comprehensive reporting system that provides information on when, where, and how these deaths occur. Without these data, communities cannot effectively identify strategies to prevent such deaths. Through supplementary funds from the Harvard School of Public Health, the San Francisco Public Health Department will begin to collect data on all violent death cases starting with the year 2000.

If you are interested in obtaining more information on violent injury reporting please visit www.NVISS.org or contact Carolyn Klassen at (415) 581-2417.

**The above text is adapted from the SFVIRS website. To obtain more information about SFVIRS, please visit our website at www.dph.sf.ca.us/CHPP/sfvirs.htm.*

Other Useful Reports/Data

Adolescent Health Plan

www.dph.sf.ca.us/Reports/2003-05AdolesHlthPlan.pdf

Women's Health Plan

http://www.dph.sf.ca.us/Reports/Misc/WomensHlthPlan200306.pdf

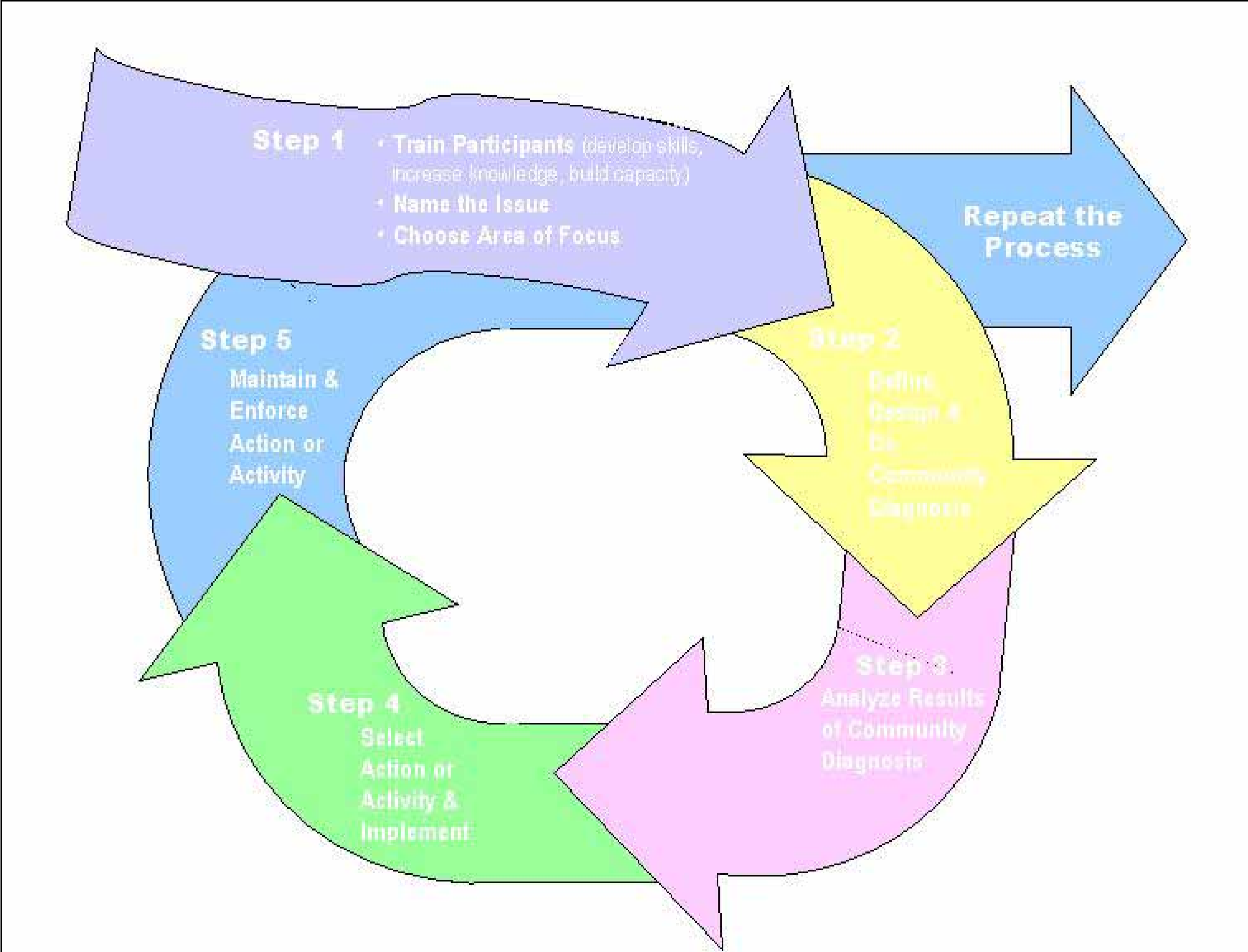
SFVIRS 2002 Annual Report

www.dph.sf.ca.us/Reports/Firearms/FinalReproductionFirearmReport 1999.pdf.

Appendix B - Community Action Model

The Community Action Model (CAM) creates change by building community capacity. The CAM is asset based and builds on the strengths or capacity of a community to create change from within. The CAM moves away from projects that focus solely on changing individual lifestyle and behavior to projects that mobilize community members and agencies to change environmental factors promoting economic and environmental inequalities. Fundamental to this model is a critical analysis that identifies the underlying social, economic, and environmental forces creating the health and social inequalities that the community wants to address.

The intent of the Community Action Model is to work in collaboration with communities and provide a framework for community members to acquire the skills and resources to investigate the health of the place where they live and then plan, implement and evaluate actions that change the environment to promote and improve health.


Step 1
• Train Participants (develop skills, increase knowledge, build capacity)
• Name the Issue
• Choose Area of Focus
Repeat the Process
Step 2
Define,
Design &
Do
Community
Diagnosis
Step 3
Analyze Results
of Community
Diagnosis
Step 4
Select
Action or
Activity &
Implement
Step 5
Maintain &
Enforce
Action or
Activity

The Community Action Model includes the following steps:

1. **Train Participants**: Community Action Team (CAT) members are recruited and trained to develop skills, increase knowledge and build capacity. The participants will use this knowledge and skills to choose a specific issue or focus and then design and implement an action to address it.

2. **Do a Community Diagnosis**: A community diagnosis is the process of finding the root causes of a community concern or issue and discovering the resources to overcome it.

3. **Choose an Action** to address the issue of concern. The Action should be: 1) achievable, 2) have the potential for sustainability, and 3) compel a group/agency/organization to change the place they live for the well being of all.

4. **Develop and Implement an Action Plan**: The CAT develops and implements an action plan to achieve their Action which may include an outreach plan, a media advocacy plan, development of a model policy, advocating for a policy, making presentations as well as an evaluation component.

5. **Enforce and Maintain the Action**: After successfully completing the action, the CAT ensures that their efforts will be maintained over the long term and enforced by the appropriate bodies.

To learn more about CAM or to obtain a copy of the CAM training schedule, please contact Isabel Auerbach at (415) 575-5684 or by email Isabel.Auerbach.sfdph.org

**The above text is adapted from the CAM website: www.dph.sf.ca.us/hetc/camodd.htm*

Appendix C - Healthy People 2010 Objectives

Healthy People 2010 is a set of health objectives for the Nation to achieve over the first decade of the new century. These objectives were developed through a broad-based collaborative effort among Federal, State, and Territorial governments, as well as hundreds of private, public, and nonprofit organizations.

Featuring 467 science-based objectives and 10 Leading Health Indicators, *Healthy People 2010* has two primary goals: to increase the quality and years of healthy life and to eliminate health disparities. The Leading Health Indicators are:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

With Respect to IPV, Healthy People 2010 seeks to reduce the number of physical assaults by current or former intimate partners from 4.4 per 1,000 persons aged 12 years or older to 3.3 physical assaults per 1,000 persons. The following are baseline data from which this objective is derived.

Persons Aged 12 Years or Older, 1998	Rate Per 1,000 Persons
Race and Ethnicity	
▪ American Indian or Alaska Native	DSU*
▪ Asian or Pacific Islander	DSU*
▪ Black or African American	5.1
▪ White	4.3
▪ Hispanic or Latino	3.4
▪ Not Hispanic or Latino	4.4
Gender	
▪ Female	7.2

▪ Male	1.3
Sexual Orientation	DNC**
Total	**4.4**

**DSU = Data are not statistically Reliable*
***DNC= Data are not collected*

Data source: National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics.

**The above text is taken from the Healthy People Website: www.healthypeople.gov.*

Appendix D - Suggested IPV Web Links

Organization Name	Web Address
Alcohol Beverage Control	www.abc.ca.gov
California Department of Health Services	www.my.ca.gov
Community Health Education Section	www.dph.sf.ca.us/CHPP/chesindex.htm
Community Toolbox	www.ctb.ku.edu
Community United Against Violence	www.cuav.org
End Violence Against Women	www.endvaw.org
Family Violence Prevention Fund	www.endabuse.org
Health Education Training Center	www.dph.sf.ca.us/hetc/default.htm
Institute on Domestic Violence in the African American Community	www.dvinstitute.org
IPV Strategic Plan Website	www.dph.sf.ca.us/CHPP
Jewish Women International	www.jewishwomen.org
Marin Institute	www.marininstitute.org
National Coalition Against Violence	www.ncadv.org
National Violence Against Women Prevention Research Center	www.vawprevention.org
National Youth Violence Resource Center	www.safeyouth.org
Prevention Institute	www.preventioninstitute.org
San Francisco Domestic Violence	www.dvcpartners.org/home.html

Consortium	
San Francisco Trauma Foundation	www.tf.org/
United States Department of Justice	www.usdoj.gov
Women's Reproductive Health Information Source	www.cdc.gov/nccdphp/drh/wh_violence.htm
Youth Leadership Institute	www.yli.org

Appendix E - Suggested Reading

In addition to the citations listed in the references section the following books/resources were invaluable during the research phase of this project. If wish to purchase, borrow, or view any of these materials, please inquire at your local library or bookstore.

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Appendix F - Glossary of Terms and Acronyms

A – L

BIH - Black Infant Health. A DPH program that focuses on African American infant mortality

CBO - Community Based Organization

CAM - Community Action Model – this model created by DPH, creates change by building community capacity

CHES Community Health Education Section

DV - Domestic Violence. Domestic violence includes violent acts perpetrated by intimate partners, as well as violence against children, elders, and siblings.

Epidemiology - The study of the causes, transmission, incidence, and prevalence of health and disease in human populations and is the core science of public health.

Goal - A goal is a broad timeless statement that represents a desired long-range change or state.[60]

Incidence - The probability of developing a disease or condition over a given period of time[61] (Can be measured as a proportion or rate).

IPV (Intimate Partner Violence)

- IPV is perpetrated against current or former intimate partners with whom the perpetrator dated, married, or cohabited.

- IPV is a pattern of coercive behaviors that includes one or more of the following: physical abuse or the threat of physical abuse, psychological abuse, sexual assault, progressive social isolation, deprivation, intimidation, and/or economic coercion.

- Adults and adolescents – no matter what their gender, sexual orientation, class, religion, race, age, ability, or ethnicity – may perpetrate or be survivors/victims of intimate partner violence

M - Z

n – subset of a population (e.g., homicides resulting from intimate partner violence)

N - total population (e.g., all homicides in San Francisco)

Objective - An objective represents a desired and measurable outcome or result that is essential for achieving a goal.

Outcome Objective - This type of objective specifies a priority population and outlines what will happen to the population as a result of an intervention or approach.[62]

Personal Weapon - Any part of the body that can be used as a weapon. Examples include the use of hands, knees, legs, feet, or head.

Prevalence - The probability of already having a disease or condition[63]

Primary Prevention - Any measure taken to prevent injury or illness before it occurs

Process Objective - A process objective provides the necessary groundwork for the accomplishment of a goal. Examples include tasks, activities, and/or work plans that will facilitate implementation or evaluation of a program or approach.[64]

Secondary Prevention - Early detection and intervention strategies aimed at preventing injury or illness from reoccurring.[65]

SFVIRS - San Francisco Violent Injury Reporting System

Tertiary Prevention - Measures taken to prevent death and disability. Examples include physical therapy and surgical procedures.

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