WOMEN'S HEALTH WATCH

Association of Maternal & Child Health Programs

AN ANNUAL WOMEN'S HEALTH REPORT

November 2008

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Executive Summary

For over 70 years, the Association of Maternal & Child Health Programs (AMCHP) has worked to protect the health and well-being of America's families, especially those that are low-income and underserved. A national, non-profit association, AMCHP represents public health leaders serving at the highest levels of state government, including directors of maternal and child health (MCH) programs, directors of programs for children with special health care needs, adolescent health coordinators and other government officials. AMCHP's mission of "healthy children, healthy families in healthy communities" is realized through the active participation of its members and vital partnerships with government agencies, families and advocates, health care purchasers and providers, academic and research professionals and others at the national, state and local levels.

Women's health has an intimate connection to the health of children and families. In recent years, the purview of maternal and child health (MCH) has expanded as MCH researchers and advocates have come to recognize that women's health experiences over the life course — and not just during the perinatal period —have a profound effect on maternal and birth outcomes and subsequent child health.*

AMCHP's Women's and Infant Health Program addresses issues that affect women as they progress through their primary reproductive years, defined internally as women ages 25-44.** The program aims to advance the field of women's health and to build and strengthen Title V program*** capacity to carry out three broad public health activities:

1) assessing the prevalence of conditions that adversely impact reproductive-age women and infants;

2) developing policies to support women's and perinatal health; and

3) assuring that high-quality perinatal health services are available and accessible to all women within states.

AMCHP's *Women's Health Watch* is an annual report that highlights the association's efforts to achieve these goals and also provides an overview of some of the most compelling women's health issues today. While there are a multitude of critical women's health issues, this version of *Women's Health Watch* focuses on smoking cessation and intimate partner violence (IPV). This report will provide new resources on smoking cessation and IPV, as well an insightful perspective from states and other partners on these important issues, which have a profound impact on the health and well-being of women and children nationwide.

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Introduction

Women who quit smoking before or early in a pregnancy can significantly reduce their risk for adverse health outcomes. In addition, women who continue to abstain from smoking postpartum reduce their risk and their infant's risk for smoking-related and second-hand smoke-related health consequences, respectively. Smoking cessation counseling programs can target specific populations to increase program effectiveness. Many states are integrating and implementing programs that improve smoking cessation counseling services for pregnant and postpartum women, such as state tobacco Quitlines. State Title V agencies play an important leadership role in moving smoking cessation for programs and policies towards a focus on pregnant and postpartum women.

As part of the Title V Block Grant, states report on maternal and child health (MCH) 18 national performance measures annually. Since states report on the percentage of women who smoke in the last three months of pregnancy, reducing maternal smoking has become an even bigger state priority. The 2006 map on page three shows the percentage of women who smoked during the last three months of pregnancy by state.

Each State also reports on seven to 10 state performance measures that they develop and have approved by the Maternal and Child Health Bureau (MCHB). These state performance measures report progress toward the goals that are specific to each state. Twenty-one states and territories developed a performance measure to further address tobacco use during pregnancy. Some states developed performance measures that address tobacco use during both pregnancy and postpartum periods. For example, Oregon measures the percent of smoking women who quit smoking during their pregnancy and did not begin smoking postpartum.

As an important priority at the national and state levels, AMCHP has worked to address and reduce tobacco use among women of reproductive age, focusing specifically on pregnant and postpartum women. This first article in the 2008 Women's Health Watch will highlight innovative strategies to reducing tobacco use among women. It will demonstrate the need, use, and success of smoking cessation counseling in helping pregnant and postpartum women quit smoking. The article will also discuss a new pregnancy and postpartum toolkit along with state examples of smoking cessation counseling programs to demonstrate strategies that increase provider and public awareness of state tobacco Quitlines, including a provider fax-referral to Quitline program.

HEALTH EFFECTS AND RATES OF SMOKING DURING PREGNANCY AND POSTPARTUM

There has been a steady decrease in the number of women who smoke while pregnant during the last 15 years. This is partly due to an overall decline in smoking rates among all women of childbearing age and partly due to interventions targeting women during the prenatal period. However, while many women quit smoking during pregnancy to protect their unborn children from the effects of tobacco, more than half will resume smoking within a few months of giving birth.[1]

The negative health effects caused by smoking and inhaling second hand smoke are well known. Women who smoke before, during and after pregnancy have an increased risk of adverse health effects for both mother and infant. Women who smoke prior to pregnancy are about twice as likely to experience a delay in conception and have approximately a 30 percent higher risk of being infertile. Women who smoke during pregnancy are about twice as likely to experience premature rupture of membranes, placental abruption and placenta previa during pregnancy.[2]

Tobacco use is also the single most preventable cause of poor birth outcomes. Babies born to women who smoke during pregnancy have a 30 percent higher risk of being born prematurely. They are more likely to be born with low birth weight (less than 2500 grams or 5.5 pounds), increasing their risk for illness or death. Infants born to

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mothers who smoked during pregnancy can weigh an average of 200 grams less than infants born to women who do not smoke and are 1.4 to 3.0 times more likely to die of Sudden Infant Death Syndrome (SIDS).[3]

As reflected above, women who quit smoking before or early in pregnancy can significantly reduce risks for several adverse outcomes. While many women may quit smoking during pregnancy, they are also very likely to relapse to smoking after birth. Smoking postpartum causes health risks for both mother and child: the mother will be at risk for smoking-related health consequences and, if exposed to tobacco smoke, her infant will be at increased risk for SIDS, bronchitis, pneumonia, asthma and ear infections.[4] Addressing smoking and tobacco use throughout the pre-pregnancy and postpartum periods is crucial to a woman's health and the health of her newborn.

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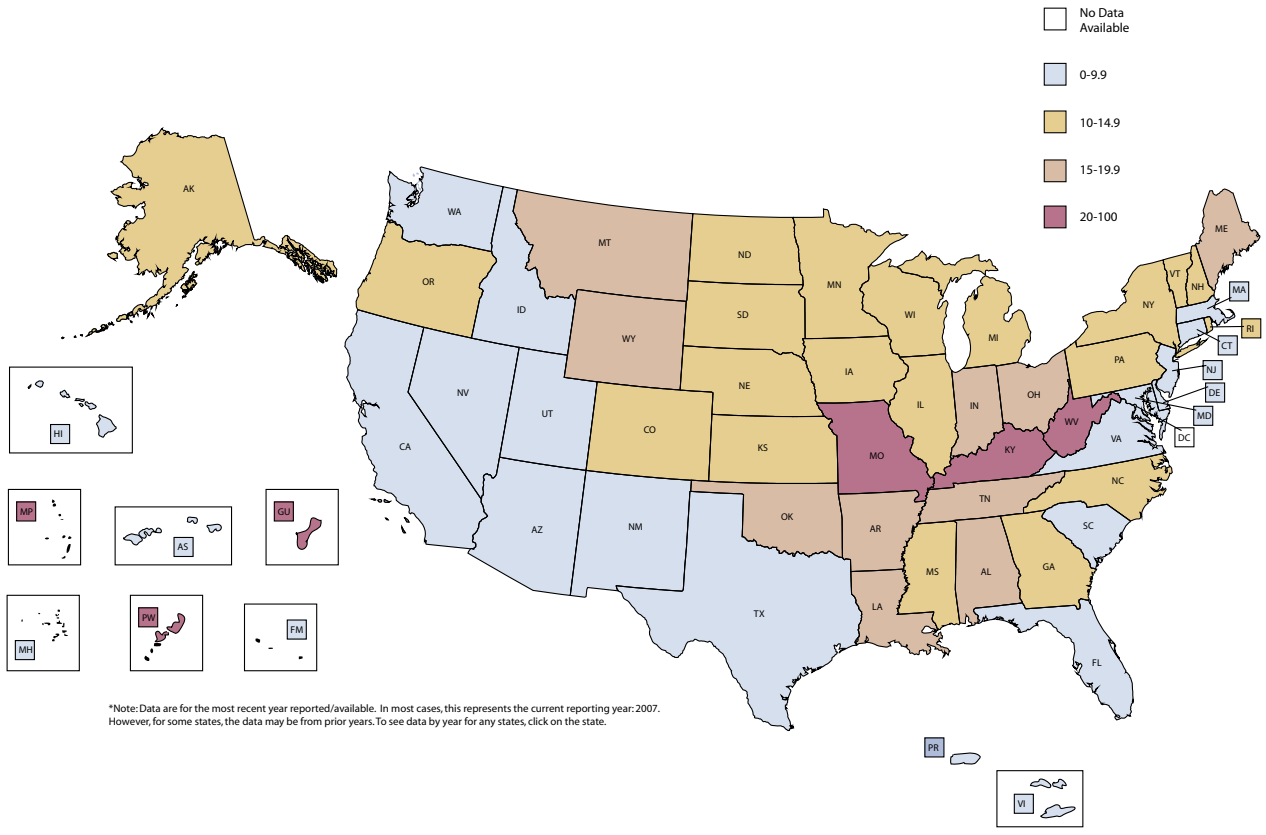
According to Dr. Cheryl Healton, President and CEO of the American Legacy Foundation, "Many women smokers are able to quit successfully when they find out they are pregnant. They have the best motivation there is — having a healthy baby. Temptation often returns after the baby arrives, often brought on by stress, and with such high relapse rates among women who start smoking after giving birth, it was critical that we develop a protocol focused on encouragement and relapse prevention."[5]

A new protocol guide, the Pregnancy and Postpartum Quitline Toolkit, addresses tobacco addiction in the first few months post partum, protecting infants from

Maternal and Child Health BureauTitle V Block Grant • 2009 Application Data

National Performance Measure 15



*Note: Data are for the most recent year reported/available. In most cases, this represents the current reporting year: 2007. However, for some states, the data may be from prior years. To see data by year for any states, click on the state.

exposure to second hand smoke, and encouraging women to stay tobacco-free. It was developed by a collaborative that includes the American Legacy Foundation, American Cancer Society, Environmental Protection Agency, American College of Obstetricians and Gynecologists, American Academy of Pediatrics and The National Partnership for Smoke Free Families (of which AMCHP is a partner). This new toolkit will continue the effort based on the American Legacy Foundation's Great Start® initiative, which was launched in 2001 as the first national Quitline and media campaign to help women quit smoking during pregnancy.[6]

The new toolkit focuses on relapse prevention, risks of secondhand smoke exposure and the health benefits of quitting smoking for mother and infant. It also emphasizes the potential and underlying issues related to relapse including postpartum depression, stress and miscarriage. An appendix for counselors to use as a reference tool during counseling sessions is also included in the toolkit. The toolkit contains materials that can be integrated into existing Quitline services to better address and reduce tobacco use for pregnant and postpartum women, as well as fact sheets on the health benefits of smoking cessation during pregnancy and postpartum, the effectiveness of Quitlines in addressing tobacco addiction, and the cost savings from treating tobacco use. An informative and practical guide for states, the toolkit offers best practice Quitline protocols and operation issues, information on how to promote pregnancy and postpartum counseling services in states, and additional relevant materials and resources.[7] According to the collaborative, "all states have Quitline services for people who use tobacco, but many of them do not include information that is specific for both pregnant and postpartum smokers and their families."[8] This toolkit enables states to incorporate pregnancy and postpartum specific information into their Quitline practices.

CESSATION COUNSELING SERVICES

Cessation counseling services, such as tobacco Quitlines, need to be comprehensive in addressing the underlying issues such as depression and stress and offer support and encouragement. In a study from the University of North Carolina Department of Family Medicine, researchers interviewed pregnant women attending prenatal clinics in central North Carolina who had quit smoking before 30 weeks gestation. Of the 94 women enrolled in the study, 43 had remained smoke-free and 51 had relapsed when interviewed at four months postpartum. Important factors and characteristics emerged to differentiate the two groups of women. Those who remained smoke-free postpartum had strong social support, strong internal belief systems, strong beliefs in postpartum health benefits of not smoking, negative experiences with a return to smoking, and concrete strategies for dealing with temptations. Women who relapsed postpartum were undermined by easy access to cigarettes, reliance on cigarettes to deal with stress, lack of financial resources, lack of resources for childrearing and low self-esteem. The study demonstrated that any new program aimed at improving Quitlines must be comprehensive in nature – it must give women the tools to acquire new skills, deal with addiction and improve life circumstances, socially and financially.[9]

SUCCESS OF QUITLINES AS A CESSATION COUNSELING SERVICE

According to the United States Department of Health and Human Services (US DHHS), telephonic cessation-counseling services have the potential to reach a large number of smokers. State Quitlines can be resources that provide social and financial support (in the form of pharmacological therapy). Quitlines are staffed by counselors trained to deliver information, advice, support and referrals to tobacco users. Individuals can access tobacco Quitlines in all states by calling1-800-QUIT-NOW, regardless of their geographic location, race/ethnicity, or economic status.[10] Using Quitlines to assist smokers through the quitting process is a common component of many comprehensive tobacco control programs.

Studies of proactive Quitline counseling have demonstrated positive outcomes. A meta-analysis conducted by the US DHHS found that proactive telephone counseling (defined as the process wherein once initial contact is made to the Quitline by the smoker or her health care provider, all subsequent calls are made on a proactive, outbound basis) increases the chances of quitting by 20 percent.[11]

PROVIDER FAX-REFERRAL TO QUITLINES SYSTEM

Jeanne Mahoney of the American College of Obstetricians and Gynecologists (ACOG) discusses state quitlines and the purpose and use of the postpartum protocol: "The protocol was designed for the state Quitlines. Counseling services work just as well when sitting across from someone as they do on the phone. The sad part about Quitlines is that they are underutilized. Pregnant women are afraid they will be lectured about their smoking; as they have been lectured in the past."

A fax-referral system, as specified in the new protocol, may be the key to helping pregnant and postpartum women quit smoking. The fax-referral system allows a clinician to fax contact information for an identified smoker, who gives consent, directly to the Quitline. After receiving the fax, the Quitline counselor will make a proactive, outbound call to the smoker within 48 hours to encourage participation in the telephone-based cessation program. The new protocol highlights the need for a fax-referral system with proactive recruitment to increase the continuity of care, removes the clinician burden to 'assist' smokers to quit and has been shown to significantly increase the number of smokers who receive cessation services.[15] This evidence-based, easy to use referral source was demonstrated in the 2008 AMCHP Smoking Cessation for Mini-Grant Program.

STATE SUCCESS STORY: OKLAHOMA

The Oklahoma State Department of Health (OSDH) and Tobacco Use Prevention Service (TUPS) have worked very hard to address the needs of pregnant and postpartum women. The $5 million Oklahoma Tobacco Quitline is now one of the most comprehensive helpline services in the nation. Through provider and public education and awareness, OSDH and TUPS have been able to ensure effective Quitline referrals and counseling to pregnant and postpartum women. Oklahoma has funded their Quitline vendor to extend counseling sessions from five calls for the general population to a specialized 10 call format for pregnant and postpartum women.

Sally Carter, Director of Planning & Administration and Executive Director of the Oklahoma Tobacco Use Prevention & Cessation Advisory Committee, states that, "we have worked with the Ohio Health Care Association (OHCA) to ensure that providers are reimbursed for providing tobacco cessation services." The first Oklahoma Medicaid service providers to reimburse for tobacco counseling services were providers of pregnant women. These providers are now reimbursed for up to fours sessions, with a maximum of eight sessions in a twelve month period as well as two rounds of pharmacology therapy.

AMCHP Mini-Grant Initiative with ACOG and PPFA: Smoking Cessation for Women of Reproductive Age

Mini-grants of up to $5000 were awarded to Kentucky, Michigan and Rhode Island, to meet the objectives of the 2007-2008 mini-grant program, including 1) the formation of a state team comprised of state MCH, Planned Parenthood and ACOG representatives who would lead an effort to increase the use of the state Quitline, and 2) the development of an action plan to accomplish the goal of increasing use of the state tobacco Quitline. Teams were invited to participate in technical assistance calls regarding the evaluation plans for their initiatives and to answer project related questions. Kentucky, Michigan and Rhode Island were also matched with former mini-grantees who served as mentor states and provided insight and experience to these new state teams.

In addition, state teams were invited to attend a grantee meeting in June 2008 to present on the work conducted in their state and to discuss strategies on sustaining their efforts. Teams met together in a series of facilitated break-out sessions to discuss accomplishments, to identify strategies that were working, as well as

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strategies to use to address current and anticipated challenges, and to receive additional feedback on their action plans. Specific state projects included:

- Use of Academic Detailing Model to train obstetricians on 5As and Quitline fax referral. This included developing and implementing a "lunch n' learn" series to increase physician knowledge of the 5As counseling method and the state's Quitline, as well as developing a pilot system that integrates the 5As with referral to the Quitline into everyday practice.
- Implementation of the 5As in clinics.
- Completion of a needs assessment that helped to define the current practices helping pregnant and breast-feeding women quit smoking and prevent relapses, and determine the need for programmatic changes to increase effectiveness.
- Completion of a needs assessment as a basis for action planning to improve infrastructure supporting smoking cessation during pregnancy and breast-feeding.

The state teams identified three recommendations for states interested in replicating their work: 1) focus on building a strong partnership; 2) establish team roles and responsibilities, and 3) connect with colleagues doing similar work in other states. Jeanne Mahoney of ACOG said, "These mini-grant initiatives can help to break the silos of services. Perinatal associations have connections between the women and physicians. It is important to bring the state smoking cessation divisions to the table with women's health and policy initiatives. The mini-grant partnership is so helpful because of that."

Conclusion

Research has shown that while many women quit smoking during pregnancy, they often relapse within a few months of giving birth. There is a need for comprehensive smoking cessation counseling services for women during pregnancy and postpartum periods. This article in the *Women's Health Watch* report demonstrates the importance of provider and public education and awareness, and the development of non-traditional partnerships to ensure effective Quitline referrals and counseling to pregnant and postpartum women. It is important that state Quitlines incorporate pregnancy and postpartum specific information to callers to help women maintain long term smoking cessation

The National Maternal and Child Health Bureau (MCHB) Title V legislation directs states to conduct a maternal and child health needs assessment every five years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children and children with special health care needs.[13] While there is no National Title V performance measure for violence in maternal and child health (MCH) populations, states can select seven to 10 additional priorities for focused programmatic efforts over the succeeding five years.[14] Nationally, seven states and territories (Guam, Kentucky, Missouri, Nevada, New Mexico, Texas and Washington) have violence as a priority measurement and 10 states and territories (Alaska, California, District of Columbia, Guam, Massachusetts, Missouri, Nevada, New Mexico, New York and Texas) have violence as a priority need. Several of these states specify the need to reduce violence against women.

This article demonstrates the negative impact of domestic violence on health and the need to collaborate within and across states to reduce violence against women. The Violence Against Women Act has improved coordination of services for women among state domestic violence agencies and organizations. State Title V agencies play an important role in integrating public health into domestic and sexual violence prevention in order to improve women's health and promote safe motherhood.

THE IMPACT OF INTIMATE PARTNER VIOLENCE ON WOMEN AND HEALTH

According to the United States Department of Justice, intimate partner violence (IPV) has declined in the United States since 1993. Despite the success of this decline, IPV remains a significant problem. Each year women experience about 4.8 million intimate partner related physical assaults and rapes.[17] For many women it is fatal: on average, more than three women are murdered by their husbands or boyfriends in the United States every day. In addition, women experience two million injuries from intimate partner violence (IPV) each year.[15] The immediate physical trauma caused by abuse is further compounded by the number of chronic health care problems experienced as a result of IPV including depression, alcohol and substance abuse, sexually transmitted diseases, anxiety, suicidal thoughts or suicide, low self esteem, lack of trust and/or healthy attachment, violent and/or antisocial behavior, and others.[16] It can also limit a woman's ability to manage chronic illnesses such as diabetes and hypertension. Furthermore, homicide is the leading cause of traumatic death for pregnant and postpartum women in the United States, accounting for 31 percent of maternal injury deaths. According to the CDC, as many as 324,000 pregnant women each year are abused in an intimate partner relationship and four to eight percent are abused at least once during their pregnancy.[17] The health-related costs of rape, physical assault, stalking and homicide committed by intimate partners exceed $5.8 billion each year.[18]

UNITED TO FIGHT DOMESTIC VIOLENCE: THE HISTORY OF VAWA

Initially passed in 1994, The Violence Against Women Act (VAWA) is the first comprehensive federal legislative response to violent acts committed against women.[19] The authorization of VAWA was a distinct turning point in legislation demonstrated a federal commitment to addressing domestic and sexual violence. VAWA unites the criminal justice, social service and public health systems in an effort to address and prevent domestic violence, dating violence, sexual assault, and stalking within communities.[20]

VAWA 1994 fostered collaboration between state and federal governments to expand services for underserved populations.[20,21] The authorization for the original VAWA provisions expired in 2000 and Congress completed its efforts in the fall of 2000 with the passage of the Violence Against Women Act of 2000.[22] The final version of VAWA 2000 further enhanced VAWA 1994 by identifying the crimes of dating violence and stalking and expanding protection for immigrants experiencing domestic violence.[20] Congress reauthorized VAWA 2000 and 2005 and the Act became law in January 2006. After more than a decade of progress addressing these issues, the federal government renewed its commitment to the safety and security of victims of domestic and sexual violence and their families.[22]

VAWA 2005 REAUTHORIZATION INCLUDED:

- Creation of the Sexual Assault Services Program, which is the first federal funding directed to services for victims of sexual assault.

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- Prevention programs that provide early intervention to children who have witnessed domestic violence, support of young families at risk for violence, and targeted interventions to change social norms with men and youth
- Built a spectrum of prevention and intervention efforts to support women, men and children living in healthy and safe lives.
- Addressed gaps in prevention services, housing, health care and employment issues related to domestic and sexual violence.[23]

THE IMPACT OF VAWA

Since VAWA was first passed in 1994 there has been a 51 percent increase in domestic violence reporting. The rate of non-fatal intimate partner violence against women has decreased by 61 percent. The number of women killed by an intimate partner has decreased by 26 percent. States have passed more than 660 laws to combat domestic violence, sexual assault and stalking. Since 1996, the National Domestic Violence Hotline has answered over 1.8 million calls. The Hotline answers over 19,500 calls a month and provides access to translators in 170 languages. Nearly $14.8 billion dollars was saved on medical, legal and other costs by spending only $1.6 billion for VAWA Programs.[22]

In June 2008, the House bill increased VAWA appropriations from $400 million (in Fiscal Year 2008) to $435 million.[23]

CREATING A COLLABORATIVE PUBLIC HEALTH APPROACH: VAWA TITLE V- HEALTH CARE COMPONENT

Federal and state governments have addressed IPV from a criminal perspective and these interventions have helped to assemble resources, coordinate law enforcement, improve response time and provide help for victims. However, these vital measures need to be a part of a comprehensive approach to addressing IPV. The public health community and the health ca re system play a crucial role in IPV prevention; and it is only when the issue of IPV is addressed with a preventive strategy that interventions will be most meaningful to communities. The greatest opportunity for prevention occurs in the clinical setting, where nearly every woman interacts with the health care system at some point in her life. Screening for IPV provides a critical opportunity for disclosure of IPV. It also provides a woman and her health care provider the chance to develop a plan to protect her safety and improve her health.[24]

Unfortunately, there is often lack of provider screening and referral for women of reproductive age that are in IPV relationships. A recent study found that 44 percent of victims of IPV talked to someone about the abuse; 37 percent of those women talked to their health care provider.[25] Additionally[26], in four different studies of survivors of abuse, 70 to 81 percent of the patients reported that they would like their healthcare providers to ask them privately about IPV.[26] The Journal of the American Medical Association found that only 10 percent of primary care physicians routinely screen for intimate partner abuse during new patient visits and nine percent routinely screen during periodic checkups. Recent clinical studies have proven the effectiveness of a two minute screening for early detection of abuse of pregnant women.[26]

Federal legislation can impact and drastically improve how the health care system responds to IPV. In the 2005 reauthorization of VAWA a health care strategy was included, called Title V. Title V includes provisions in VAWA that would improve the health care system's response to domestic and sexual violence and increase the number of women who are properly identified and treated for lifetime exposure to violence. These provisions have been approved by Congress, but have never been funded.

VAWA Title V Health Care component includes:

- Training of Health Professionals in Domestic and Sexual Violence.
- Grants to Foster Public Health Responses to Domestic Violence, Dating Violence, Sexual Assault and Stalking.
- Research on Effective of Interventions in the Health Care Setting.[26]

The programs outlined in VAWA Title V Health Care component would provide the necessary training for health care professionals to properly identify, treat and refer victims of domestic violence. For example, when a provider screens and treats a victim of domestic violence, referral programs would be available to the victim for subsequent follow-up treatment and

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counseling. VAWA Title V aims to improve the necessary health care services for victims by promoting collaborations between providers, health departments, and advocates.

While it is extremely important to create training programs that will help public health professionals better address the needs of IPV victims, strengthening the provider-patient relationship is also critical According to Kiersten Stewart, Public Policy Director at the Family Violence Prevention Fund, a primary focus should be on provider-patient relationships. "When providers understand this important relationship, the providers are able to provide much better health care. Integration of assessment lifetime exposure to violence into what providers are already doing will help them to make more informed healthcare decisions."

Another important aspect of VAWA Title V Health Care component is linking lifetime exposure to violence with research and interventions in health care settings in order to prevent and address domestic violence. This would enable health care professionals the opportunity to use the research and interventions funded under VAWA Title V as a way to enhance service coordination and systems integration. This could lead to earlier detection and screening for domestic violence, thus providing public health professionals with the tools they need to further support their clients.

STATE EXAMPLE - MISSOURI: IMPACT OF VAWA REAUTHORIZATION ON TITLE V - MATERNAL AND CHILD HEALTH BLOCK GRANT

Missouri is one of few states to set an additional state priority measure for reducing the incidence of domestic violence in maternal and child health populations. The state of Missouri Title V Program has developed a state performance measure to reduce the incidence of domestic violence per 100,000 population. The reauthorization of VAWA has made dramatic changes to court and law proceedings which, consequently has had a positive impact in Missouri. For example, undocumented individuals are able to receive help as a result of the reauthorization; polygraphs of rape victims can no longer be given; and fire arms can no longer be purchased or owned by individuals who have a full order of protection against them, have a misdemeanour domestic violence conviction, or other federal conviction. VAWA has also provided funding for training of staff at domestic violence shelters, law enforcement, and court system employees to improve the level of these working relationships. The most significant impact VAWA has made in Missouri is, increasing awareness of services to assist victims of domestic violence and reducing improper management of domestic violence cases by legal systems.

AMCHP Mini-Grant Initiative with the Family Prevention Fund (FVPF): Safe Families and Violence Prevention

The Association of Maternal and Child Health Programs (AMCHP) and the Family Violence Prevention Fund (FVPF) are working with states to build the knowledge and capacity of state-level maternal and child health (MCH) professionals and their community partners to integrate family violence prevention, assessment and intervention into state-level initiatives on safe motherhood and perinatal disparities among minority and underserved populations. With funding from the Centers for Disease Control and Prevention, AMCHP partnered with FVPF to accept four state teams; Massachusetts, Maine, Missouri, and New Mexico, for participation in the October 2006 Safe Families Action Learning Lab (ALL). The ALL was based on continuous quality improvement methodology, a planning and improvement process that has proven effective in

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making systems-level changes. The Safe Families ALL continues to build upon VAWA Title V Health Care component to integrate public health into domestic and sexual violence prevention without the federal funding.

SAFE FAMILIES ALL ACTIVITIES WERE DESIGNED TO RESULT IN NEW OR IMPROVED:

- Partnerships across key agencies and/or community groups that can impact violence and disparities;
- Provider or public awareness of existing resources and effective interventions to address family violence;
- State capacity to collect, analyze or share relevant violence and disparities data;
- Tools to screen for violence in clinical and MCH program settings and to assess system capacity to address violence and disparities.

ACCOMPLISHMENTS OF THE SAFE FAMILIES ALL TEAMS INCLUDED:

- Trained over 500 WIC staff in the state of Massachusetts
- All of the Massachusetts Department of Public Health-funded family planning programs (over 170 staff at 75 sites across the state) were trained on screening for lifetime exposure to violence
- Changed policy on WIC training and service provision in Massachusetts
- Improved identification and referral rates of domestic violence in health settings in Maine
- Evaluated and improved a statewide assessment questionnaire in New Mexico
- CDC adopted recommended changes to PRAMS (Pregnancy Risk Assessment Monitoring System) data collection for states to optionally add to their state PRAMS survey.

By educating providers and the public and increasing awareness, the Safe Families teams have made significant strides in addressing IPV and perinatal health disparities throughout their respective communities. As a result of their efforts, hundreds of providers and professionals have increased their knowledge around screening, are equipped with the necessary tools to provide women with high quality services, and have identified strategies to integrate multiple factors that effect how violence is addressed.

Conclusion

Screening for IPV at all stages of a women's life presents the greatest opportunity for early detection, intervention, referrals to appropriate services and resources, and can have a positive and long-term impact on the lives of women. Research has shown that women who are victims of IPV have a high prevalence of chronic health issues spanning from severe depression to alcohol and substance abuse. The passage of VAWA, the progress of a coordinated response to IPV, and training for health care professionals has brought about significant strides in developing a preventative approach to end the cycle of violence against women. AMCHP recognizes that screening is a vital part of building a comprehensive and systematic response to addressing violence against women. We are committed to continued work in this area to further improve the health and well-being of women.

Notes

* See, for example, Wilcox LS. Pregnancy and women's lives in the 21st century: the United States Safe Motherhood movement. *Mat Child Health J* 2002;6:215-20.

** Other AMCHP programs target youth ages 10-24 and infants and children ages 0-5, as well as those with special health care needs from birth through age 24. The association emphasizes disease prevention and wellness promotion during these earlier stages to ensure better birth outcomes, as well as optimal health for women as they age.

*** Although states may organize their MCH programs differently and give them different names, such as community health or family health, they share a common source of federal funding—the Maternal and Child Health Services Block Grant, authorized under Title V of the Social Security Act. In recognition of this primary federal funding source, state MCH programs are synonymously called *Title V programs*.

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Healthy children, healthy families in healthy communities

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Leadership
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Integrity
Partnership &
Empowerment
Honesty