SUPPORTING STATEMENT: PART A

OMB# 0920-0822

The National Intimate Partner and Sexual Violence Survey (NISVS)

November 27, 2017

Point of Contact:
Sharon G. Smith, PhD
Behavioral Scientist
Contact Information:
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
4770 Buford Highway NE MS F-64
Atlanta, GA 30341-3724
phone: 770.488.1363
email: zhp5@cdc.gov

CONTENTS

L NISVS Workgroup Summary

SUMMARY TABLE

This revision request is to extend the currently approved NISVS Survey in order to complete the next phase of data collection which begins in March 2018 and extends through March 2019.

- Goal of the study.
  The National Intimate Partner and Sexual Violence Survey (NISVS) collects lifetime and past-year information about individuals' experiences of sexual violence, stalking and intimate partner violence and information about the health consequences of these forms of violence. NISVS produces national and state level prevalence estimates of these types of violence.
- Intended use of the resulting data.
  These public health data are used by local, state and national governments and organizations to inform prevention programs and policy making related to intimate partner violence, sexual violence and stalking.
- Methods to be used to collect data.
  NISVS is a dual-frame (landline and cell phone) random digit dial (RDD) telephone survey.
- The subpopulation to be studied.
  Non-institutionalized, English and Spanish speaking men and women aged 18 years or older in the United States.
- How data will be analyzed.
  Data are analyzed using appropriate statistical software to account for the complexity of the survey design to compute weighted counts, percentages, and confidence intervals using both national and state level data.

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

Background:
Intimate partner violence, sexual violence, and stalking endanger the health and well-being of women and men across the United States. As described below, more than two decades of research demonstrate that IPV, SV, and stalking are major public health problems with serious long-term health consequences and significant social and public health costs (Basile, et al., 2006; Black & Breiding, 2008; Breiding, Black, & Ryan, 2008; Tjaden & Thoennes, 1998). Extensive literature provides evidence indicating IPV, SV, and stalking substantially contribute to negative mental health outcomes, including depression, chronic mental illness, and post-traumatic stress disorder (e.g., Breiding, Black, & Ryan, 2008, Bonomi, et al., 2006; Vos, et al., 2006).

Intimate Partner Violence. IPV is violence committed by a spouse, ex-spouse, current or former boyfriend or girlfriend or dating partner; it includes physical violence, sexual violence, stalking and emotional aggression and has an estimated annual cost of $5.8 billion for medical care and lost productivity (National Center for Injury Prevention and Control, 2003). Both women and men are victims of IPV, and it can occur among heterosexual and same-sex couples. Using combined data years of 2010-2012, the National Intimate Partner and Sexual Violence Survey (NISVS) estimated that 37.3% of U.S. women and 30.9% of U.S. men reported experiencing IPV (contact sexual violence, physical violence and/or stalking) during their lifetime (Smith, et al., 2017). This translates into approximately 44.9 million U.S. women and 35.2 million U.S. men who experienced contact sexual violence, physical violence and/or stalking by an intimate partner during their lifetime. In addition, approximately 7.9 million women and 7.3 million men experienced these types of violence by an intimate partner within the 12 months prior to the survey. Both women and men have increased risk for long term health problems (Black & Breiding, 2008). However, women are more likely than men to suffer severe physical violence and/or IPV-related impacts such as concerns for safety and symptoms of PTSD (Smith, et al., 2017). Women are also significantly more likely than men to be killed by an intimate partner (Catalano, Smith, Snyder, & Rand, 2009).

In addition, several studies have shown that victims of IPV are more likely to report a range of negative mental and physical health conditions that are both acute and chronic in nature (Black, 2011; Crofford, 2007; Pico-Alfonso, Garcia-Linares, Celda-Navarro, Herbert, & Martinez, 2004). For example, victims of IPV are more likely to engage in behaviors such as smoking, heavy/binge drinking, and behaviors that increase the risk of HIV and to endorse other unhealthy behaviors (Breiding, Black, & Ryan, 2008). Furthermore, a systematic review of the literature found that IPV victimization is a risk factor for depression and suicide attempts, especially in women (Devries, et al., 2013).

Sexual Violence. SV has a profound and long-term impact on the physical and mental health of the victim. In addition to injury, SV is associated with immediate and long term increased sexual and reproductive problems (Basile & Smith, 2011; Jewkes, Sen, & Garcia-Moreno, 2002). Furthermore, victims are more likely to report serious health conditions (e.g., stroke, asthma, joint disease) and health risk behaviors (e.g., HIV risk behaviors, smoking, excessive alcohol use) (Smith & Breiding, 2011). NISVS data from 2010-2012 indicate that about 1 in 5 women and 1 in 67 men were victims of completed or attempted rape during their lifetime; and about 1 in 17 men were made to penetrate someone else at some point in their lives. In addition, about 1 in 3 women and 1 in 6 men have experienced some form of contact sexual violence in their lifetime (including rape, being made to penetrate, sexual coercion, or unwanted sexual contact), and almost 1 in 3 women and about 1 in 8 men have had non-contact unwanted sexual experiences. A recent study found that the U.S. lifetime cost of rape is $122,461 per victim which converts to a population economic burden of approximately $3.1 trillion over the victims' lifetimes (Peterson, DeGue, Florence, & Lokey, 2016). According to the Bureau of Justice Statistics (BJS), rape is one of the most underreported crimes (Bachar & Koss, 2001), due in large part to the high level of social stigma and shame associated with rape. In fact, BJS statistics indicate that in 2009, only 32% of rape or sexual assaults against women were reported to the police (Planty, Langton, Krebs, Berzofsky, & Smiley-McDonald, 2013). Therefore, general population surveys such as NISVS play a critical role in determining the actual burden of sexual violence victimization.

Stalking. The NISVS 2010-2012 state report released in 2017 showed that that 15.8% of women and 5.3% of men in the United States experienced stalking during their lifetime in which they felt very fearful or believe that they or someone close to them would be harmed or killed (Smith, et al., 2017). This translates into approximately 19 million women and 6.1 million men in the United States. Stalking can result in severe and even fatal outcomes for victims because it often occurs with other kinds of partner violence. NISVS data from 2010 found that over 4 million women experienced rape, physical violence, and stalking by the same perpetrator (Breiding, Chen, & Black, 2014). Evidence also suggests that women who are stalked by ex-partners may be at high risk for homicide or attempted homicide (McFarlane, Campbell, Wilt, Sachs, Ulrich, & Xu, 1999). The estimated economic cost of stalking of women in 1995 was $342 million (Max, et al., 2004). Adjusted for inflation, this cost was $438 million in 2005 (Sahr, 2014).

The CDC is the lead federal agency for public health objectives related to injury and violence. The *Healthy People 2020* report (Healthy People, 2020) lists several objectives that pertain directly to IPV, SV, and stalking. Applicable objectives include objectives IVP39: "reduce the rate of physical assault by current or former intimate partners"; "reduce sexual violence by a current or former intimate partner"; "reduce psychological violence by a current or former intimate partner"; "reduce stalking by a current or former intimate partner." Also applicable are objectives IVP40: "reduce the annual rate of rape or attempted rape"; "reduce sexual assault other than rape"; "reduce non-contact sexual abuse." Authority for CDC's National Center for Injury Prevention and Control to collect these data is granted by Section 301 of the Public Health Service Act (42 U.S.C. 241) (Attachment A). This act gives Federal health agencies, such as CDC, broad authority to collect data and carry out other public health activities, including this type of study.

Current Request:

This is a revision request for the currently approved National Intimate Partner and Sexual Violence Survey - OMB# 0920-0822, expiration date 07/31/2018 for the next period of data collection. The National Intimate Partner and Sexual Violence Survey (NISVS) has been conducted annually since 2010. Data collection in the 2018-2019 cycle is slated to begin in mid-March 2018. Data will be collected in two periods. The first collection will be March 2018 through mid-September 2018 and the second collection will be mid-September 2018 through mid-March 2019.

Primary changes to the 2018-2019 Data Collection

- The 2018-2019 data collection will use the version of the survey used for the 2016-2017 data collection period. The 2016-2017 instrument benefited from enhancements over the earlier NISVS survey by reducing instrument complexity in order to reduce respondent burden and make the data available to the public sooner. The 2018-2019 survey instrument adds the following small revisions:

    - Added text to brief introductory script about CDC's mission;
    - Added a clarification question about county of resident;

- Added a group relationship code;
- Added text to the soft check to confirm an age at first that is older than the current age;
- Removed 4 questions from the normative behaviors section (Section J) that showed limited variability in the response options;
- Shortened 1 item in Section J to reduce redundancy; and
- Consistent with the completion of the DoD sponsored component, questions for active duty women and men in the military and wives of active duty men have been removed.

- We are also planning to modify data collection protocols to improve response rate and reduce non-response bias in response to recommendations provided by a methodology workgroup convened at the request of OMB (described below). These Program Changes and Adjustments are further described in Attachments J.1. and J.2.

- In response to recommendations from the NISVS Methodology Workgroup and to continue to improve the NISVS system, we anticipate conducting multiple studies to understand and address reasons for nonresponse and potential sources of bias. For instance, depending on the availability of funding, we anticipate conducting studies to examine alternative modes of, and strategies for, data collection (e.g., web-based data collection, address based sampling); conducting follow-up calls with previous survey respondents and potential follow-up texting or calls with non-respondents to study some potential sources of nonresponse bias; focus groups with representatives of the study population to understand alternative formats and modes; cognitive and pilot testing of alternative modes (e.g., web version of the questionnaire) and sampling. We will submit a change request(s) for these studies accordingly, as we anticipate the work will be within the scope of this clearance. Estimates of burden are included in the burden table.

- For the data collection year 2018-2019, the periodicity of the administration of the NISVS instrument remains biennial. Biennial data collection was incorporated for the 2016-2017 data collection cycle to increase the number of interviews from a minimum of 12,500 interviews collected annually to at least 25,000 interviews during a 12 month period. For the 2018-2019 data collection cycle, CDC has already allocated funding in its current contract to increase the 12,500 NISVS interviews conducted in each data collection cycle by as much as 2,500 per 6-month period so that as many as 15,000 interviews will be collected per 6-month period and up to 30,000 per year. Additionally, the compressed, biennial schedule also will increase the statistical precision of IPV, SV, and stalking prevalence estimates provided by NISVS and provide more statistical power to detect and characterize rare but pivotal experiences. The frequency with which these data are collected will continue to allow us to evaluate the effectiveness of prevention programs on a national scale by providing solid information about changes in trends over time.

Response to OMB Terms of Clearance (2015 and 2016)

In 2015, CDC initiated the process that led to the changes described above. The overarching goal of this effort was to enhance the ability of NISVS to provide timely data that are more easily accessed and used by those groups that have the greatest potential to take actions that can prevent IPV, SV, and stalking, particularly grantees and state-level prevention partners. To achieve this goal, CDC, in close collaboration with its partners and stakeholders, completed work to:

1. Revise the content of the NISVS data collection tool to provide information that is useful for guiding action at the state level.
2. Enhance the system's data collection methods to allow for increased precision, sensitivity, and representativeness.
3. Ensure that NISVS data are collected and managed in a way that allows for timely analysis and dissemination.

Examples of actions taken in pursuit of these objectives include but are not limited to:

a. Providing funding to increase the total number of completed interviews to be acquired via the NISVS contract.
b. Transitioning the system to use of a format where data collection occurs every other year that would enable substantial increases in the sample size during data collection years and create more time for generating data sets for public use and for generating data reports for use by prevention stakeholders.
c. Collaborating with the Bureau of Justice Statistics (BJS) to initiate a series of expert panel meetings to obtain guidance on how to improve the survey design (e.g., methods, sampling frame, recruitment, mode of administration) to increase response rates, reduce non-response bias, and maximize opportunities across Federal surveys for covering populations of interest. This effort began in early 2017 and was completed in July 2017. This work has informed modifications to the survey design both for the 2018-2019 data collection cycle as well as administration in future years.

To comply with the OMB's primary terms of clearance for 2015 and 2016, CDC collaborated with BJS in convening a workgroup to obtain expert feedback and input on how to enhance the NISVS survey methodology. Workgroup participants provided guidance on how to improve the system's survey design (e.g., methods, sampling frame, recruitment, mode of administration, etc.) with the goals of increasing response rates, reducing non-response bias, and maximizing the collaborative opportunities across Federal surveys for covering populations of interest. Four meetings of the workgroup, which included a representative from OMB and a representative from CDC's Board of Scientific Counselors, began in February of 2017 and were completed in July of 2017.

Recommendations from the workgroup have been used to inform both the 2018-2019 efforts as well as plans for a substantial re-design of the survey design and administration after 2019. The primary recommendations provided by the workgroup along with CDC's proposed activities to address the recommendations (Attachment L) were presented to the National Center for Injury Prevention and Control's Board of Scientific Counselors (BSC) in September 2017. The proposed activities were met with support for their potential to reduce non-response bias and increase response rate and are described in further detail in SSB.B3 and Attachment J.1. Further, the BSC provided additional ideas for opportunities to learn about other Federal agencies'

advances and experiments related to survey methods, as well as ideas for collaboration across Federal agencies, which CDC staff are currently pursuing.

NCIPC has also worked to improve the performance of the NISVS data collection tool (without altering its core content on IPV, SV, and stalking prevalence), decrease the level of burden on respondents, and reduce the time required to complete data processing, validation, and packaging for public release. In addition, our inclusion of questions in the NISVS data collection tool, about child exposure to physical or psychological IPV; normative beliefs about IPV, SV, and bystander intervention; and barriers to bystander intervention, further aligns NISVS surveillance approaches with stakeholder needs and demonstrates responsiveness to their expressed recommendations for surveillance improvement.

Before the revised NISVS data collection was deployed in September 2016, cognitive testing was completed to characterize the survey's performance in real interview situations and to identify potential sources of response error. Specifically, in February 2016, the contractor for NISVS conducted interviews with both victims of intimate partner violence, sexual violence, and stalking victimization as well as non-victims to gather feedback related to modifications of existing questions and the addition of new questions in the NISVS survey. The goal of gathering this feedback was to ensure that the terms and concepts used were universally understood by respondents and that the process of answering the survey questions was not overwhelming from a cognitive, time, or emotional burden perspective. In particular, we wanted to understand and address any sources of confusion related to revisions, including edits to introductions to the questions, the formatting and sequencing of questions, and the transition to the new questions. Cognitive interviews were conducted with 30 participants. The information collected was used to further refine and improve the NISVS survey to help ensure that the instrument effectively and efficiently measures the types of victimization of central interest in the surveillance system.

A.2. Purpose and Use of Information Collection

The specific aims of NISVS are to collect consistent and reliable data on the incidence, prevalence, and nature of IPV, SV, and stalking at the state and national level among U.S. women and men on an ongoing basis. NISVS data are widely used in many settings, such as state public health departments (e.g., ISDH, n.d.), state coalitions (e.g., NJCASA, 2014), federal partners, universities, and local community programs for a variety of purposes such as training materials, factsheets, policy briefs, and violence prevention campaign materials. NISVS data have previously been used by the CDC, its state grantees and the White House (e.g., CDC, 2016). Additionally, NISVS data were collected for the DoD in 2010 and 2016/17 to understand the prevalence of these types of violence for active duty females and males and wives of active duty males (e.g., Black & Merrick, 2013), and for NIJ to examine IPV, SV, and stalking in the American Indian/Alaska Native population (Rosay, 2016). In addition to federal and state use of these data, public use data sets are developed to promote the use of these data by external researchers.

Ongoing surveillance is critical in the further development of prevention and intervention programs to reduce the prevalence and incidence of IPV, SV, and stalking. Stable and precise

annual lifetime and past 12-month prevalence estimates were produced at the national level for data years 2010-2012. Prevalence estimates were produced for a subset of states where estimates were statistically reliable using data from 2010 (Black, et al., 2011), and again for additional states using data from 2010-2012 combined (Smith, et al., 2017). Currently, for the vast majority of states, the data provided by NISVS are the only population-based information regarding the prevalence of IPV, SV, or stalking.

The need for an ongoing surveillance system is reflected in the fact that the lack of comparable state-specific prevalence data has limited the ability of national and state public health officials to measure the impact of IPV, SV, and stalking in individual states. Improved surveillance helps guide the most effective use of limited prevention resources. More detailed and frequent information guides intervention and prevention strategies at both the national and state levels.

Continuing to document and monitor the incidence and prevalence of IPV, SV, and stalking is a critical step to improving the health status of individuals, making communities safer, and reducing the social and healthcare costs currently burdening state and federal governments and programs. NISVS data help inform public policies and prevention strategies and help to guide and evaluate progress towards reducing the substantial health and social burden associated with IPV, SV, and stalking.

Finally, there are several benefits of this second (2018-2019) data collection period. First, these data will be used to update national prevalence that can inform actions to prevent IPV, SV, and stalking. Additionally, the combination of the 2018-2019 and 2016-2017 data will increase the sample size. This larger sample increases the potential for statistically reliable past 12-month national prevalence estimates for males as well as state-level lifetime prevalence estimates for more outcomes not presented in the NISVS 2010-2012 state report for both males and females due to small numbers.

A.3. Use of Improved Information Technology and Burden Reduction

All interviews have been conducted over the telephone, using c1omputer-assisted telephone interviewing (CATI) software. The use of CATI reduces respondent burden, reduces coding errors, and increases efficiency and data quality. The CATI program involves a computer-based sample management and reporting system that incorporates sample information, creates an automatic record of all dial attempts, tracks the outcome of each interview attempt, documents sources of ineligibility, records the reasons for refusals, and locates mid-questionnaire termination.

The CATI system also includes the actual interview program (including the question text, response options, interviewer instructions, and interviewer probes). The CATI's data quality and control program includes skip patterns, rotations, range checks and other on-line consistency checks and procedures during the interview, assuring that only relevant and applicable questions are asked of each respondent. Data collection and data entry occur simultaneously with the

CATI data entry system. The quality of the data is also improved because the CATI system automatically detects errors and ensures that there is no variation in the order in which questions are asked. Data can be extracted and analyzed using existing statistical packages directly from the system, which significantly decreases the amount of time required to process, analyze, and report the data.

A.4. Efforts to Identify Duplication and Use of Similar Information

Prior to NISVS, the most recent national health survey on IPV, SV, and stalking (National Violence Against Women Survey, NVAWS), jointly sponsored by NIJ and CDC (conducted by Schulman, Ronca, Bucuvalas, Inc (SRBI), and was completed in 1996 (Tjaden and Thoennes, 1998). Prior to NVAWS, there had been no similar national health surveys with a specific focus on IPV, SV, and stalking. These are also the types of outcomes that are least likely to be disclosed in crime surveys.

When NISVS was originally designed, CDC consulted with other federal agencies (e.g., National Institute of Justice, Department of Defense) and other leading experts and stakeholders in the fields of IPV, SV, and stalking. NCIPC convened a workshop "Building Data Systems for Monitoring and Responding to Violence Against Women" (CDC, 2000). Recommendations provided by those in attendance are reflected in the design of NISVS. As discussed in the Data Systems workshop, surveys that ask behaviorally specific questions that are couched in a public health context have much higher levels of disclosure than those couched within a crime context (as in the National Crime Victimization Survey (NCVS) conducted by the BJS).

Although NISVS and NCVS collect similar information, they are complementary in nature. Key characteristics of both systems are listed below.

NISVS

- Public health context.
- Eligible respondents are non-institutionalized adults aged 18 and older.
- Interviews are conducted by telephone.
- Employs behaviorally-specific language as recommended by the National Research Council (National Research Council, 2014).
- Focused on sexual violence, intimate partner violence, and stalking.
- Questions cover a range a behaviors experienced by victims.
- Timeframe of victimization is lifetime and the 12 months preceding the survey.
- Data provide lifetime and 12-month prevalence estimates that can be used to generate national and state-specific estimates.
- Data provide information on the characteristics of victims and perpetrators.
- Data are used to describe associations between victimization and health conditions
- Data on the age at first-time victimization can be used to understand guide prevention efforts among children and adolescents.

NCVS

- Crime-based context.

- Eligible respondents are all members of U.S. households age 12 or older and non-institutional group living facilities.
- Interviews are conducted in person and by telephone.
- Employs criminal justice terminology.
- Focused on nonfatal violent and property crime.
- Timeframe of victimization is past calendar year.
- Data provide counts and rates of victims, incidents, and victimizations,
- Data provide information on the characteristics of victims and perpetrators.
- Data can be used to measure trends over time.

In our ongoing assessment of NISVS, CDC is working closely with the BJS discussing the complementary nature of NISVS and NCVS. This includes demonstrating the ways that these systems provide unique data on victimization and the consequences, exploring options for collaborative, and continuing enhancement of both systems. CDC and BJS participate in regular meetings to discuss the lessons learned and implications for continued improvement of the systems. CDC and BJS have also collaborated to develop a summary document that explains the unique and complementary nature of these and other systems for measuring sexual violence. The summary will help users of the data to better understand the survey options that are available and to make an informed decision about which data source to use to address specific questions. The document is complete and is currently undergoing clearance review at each agency.

Although the Behavioral Risk Factor Surveillance System (BRFSS) included optional IPV and SV modules in 2005, 2006, and most recently in 2007, fewer than half of the states administered the module during any one year. Furthermore, the information collected in the optional modules was limited to a small number of relatively simple questions [IPV (n= 7) and SV (n=8)] and limited to physical and sexual violence. Because financial support from CDC's Division of Violence Prevention no longer exists for the optional modules, few (if any) states continue to collect IPV or SV data.

.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A.6. Consequences of Collecting the Information Less Frequently

We propose to continue collecting NISVS data biennially. The primary consequence of collecting these data less frequently is that stakeholders would have access to less timely data on national and state prevalence estimates of SV, IPV, and stalking. In order to generate state-level

estimates, data from across data collection years must be compiled. Thus, reducing the frequency of data collection would greatly impact the nation's and states' ability to track and monitor trends in these outcomes over time and to therefore use timely data to inform prevention and program evaluation efforts.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

The request fully complies with the regulation 5 CFR 1320.5.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A.8.a) Federal Register Notice
A 60-day Federal Register Notice was published in the *Federal Register* on September 20, 2017 vol. 82, No. 181, pp. 43988-43989 (Attachment B).

A.8.b) Efforts to Consult Outside the Agency
In the past, CDC participated in discussions involving federal researchers involved in the study of violence against women (documentation included in Attachment C). NCIPC convened a workshop "Building Data Systems for Monitoring and Responding to Violence Against Women" (CDC, 2000). Recommendations provided by those in attendance are reflected in the design of NISVS.

When NISVS was originally designed in 2007, CDC consulted with other federal agencies (e.g., National Institute of Justice, Department of Defense) and other leading experts and stakeholders in the fields of IPV, SV, and stalking. Additionally, NCIPC invited a panel of experts to attend a meeting in November 2007 to discuss preliminary findings from the 2007 methodological study (referred to as the NISVS Pilot, although it was not a pilot test of the NISVS survey itself) and to discuss the planned directions for NISVS. The review panel consisted of federal and non-federal subject matter experts with expertise in IPV, SV, and stalking.

In 2008, staff within the Departments of Justice (DOJ) and Defense (DoD) served as technical reviewers for the proposals submitted in response to CDC's Funding Opportunity Announcement for NISVS. As part of the review team, they participated in the selection of the contractor to do the work and approved the proposed statement of work. DOJ and DoD were also integrally involved in the design of the interview instrument as described below. As described in Section A.4, CDC worked closely with the DoD, NIJ, and other federal agencies in the development of the NISVS. Numerous presentations were made in 2008, 2009 and 2010 to vet the proposed NISVS among a range of interested stakeholders, including victim advocates, family advocacy programs, Title IX Task Force authorized under the 2005 VAWA, and a number of other conferences and public meetings. Further, CDC staff remain engaged in ongoing discussions with Federal colleagues from DoD related to the collection of special population data from military personnel. In 2015 and 2016, staff within the DoD collaborated with CDC in the development, review and approval of the proposed statement of work for the 2016-2017 data collection contract. Data collection for the DoD was conducted in February of 2017 through August 2017. Collaboration between CDC and the DoD was initiated to facilitate collection of military subpopulation data during 2017.

NCIPC recruited a panel of experts to attend a meeting in February 2017 to begin discussions regarding the NISVS study design and to discuss the planned directions for current and future NISVS surveys. The review panel consisted of federal and non-federal subject matter experts with expertise in survey methodology, statistics, IPV and SV research, survey question design, and respondent safety concerns. Attachment K provides a list of those individuals who participated in the meeting and provided recommendations regarding survey design and administration during three webinars and one 2-day in-person meeting between February and July, 2017.

For the current survey, NCIPC staff actively engaged NCIPC's Rape Prevention and Education (RP) and Domestic Violence Prevention Enhancements (DELTA) program grantees and other stakeholders to obtain feedback regarding processes implemented to enhance the ability of NISVS to provide timely data that are more easily accessed and used by those groups that have the greatest potential to take actions that can prevent IPV, SV, and stalking, particularly grantees and state-level prevention partners.

In compliance with OMB guidance, NISVS staff have been engaged in the OMB Sexual Orientation and Gender Identity Working Group to ensure that NISVS is using appropriate measures to identify sexual minority populations.

Lastly, in response to recommendations of the workgroup to maximize collaborative opportunities across Federal surveys, CDC has engaged a number of Federal partners to learn about ongoing experiments being conducted in Federal surveys to improve response rates, to assess the feasibility of partnering to conduct mutually beneficial experiments, and to learn from methods being implemented by other Federal surveys. Since July 2017, CDC has consulted with or referred to publications and work from other Federal and non-Federal partners (including BJS, CDC–BRFSS, CDC–National Survey of Family Growth (NSFG), CDC–National Health Information Survey (NHIS), National Highway Traffic Safety Administration (NHTSA), National Science Foundation (NSF), Census Bureau, National Center for Health Statistics (NCHS), American Association for Public Opinion Research (AAPOR), Office of Juvenile Justice and Delinquency Prevention's redesign of the National Survey of Children's Exposure to Violence, and Research Triangle Institute (RTI)) to learn more about studies that are currently in the field or pending and that could have implications for NISVS. For instance, CDC has engaged BRFSS staff to gain a better understanding of BRFSS RDD calling methods (e.g., how many follow-up calls BRFSS conducts before considering a phone number "fully worked", considering cell phones as personal devices and thereby immediately excluding minors under the age of 18 who answer a cell phone number), methods for calculating response rate (e.g., determining whether other Federal survey statisticians are using survival methods to calculate response rate), and to discuss experiments involving address based sampling methods and efforts to push potential survey respondents to a web-based survey, to return a phone call, or to reply by mail. Further, CDC has engaged a number of partners, including AAPOR members, RTI, NHTSA, and NHIS staff in discussions regarding novel technologies that may be greatly impacting response rates. For example, at the 2017 Annual AAPOR meeting, survey methodologists discussed advancements in technology that have allowed for a proliferation of phone applications that block repeated calls from 800 numbers. Thus, after discussions with RTI, AAPOR scientists,

CDC staff, and NCIPC's BSC, CDC proposed to add additional 800 numbers as well as numbers local to the Atlanta CDC area (770/404) for outbound calls, which would allow for outbound phone numbers to be changed more frequently to avoid being inadvertently blocked by the phone applications designed to block repeated calls from numbers suspected of being marketers. This may reduce the problem of erroneous flagging and blocking of the study phone number as spam by cell phone carrier applications and increase the number of survey participants.

CDC has also engaged Federal partners to learn more about incentives offered to survey respondents and how a range of incentive types and reminder letters, postcards, and other materials may be used to improve response rates. For instance, CDC engaged in conversations with NHIS, NHTSA, BRFSS, and RTI to learn about relatively inexpensive options that potential respondents could be mailed along with an advance letter, which would serve as a reminder to participate in the survey.

The suggestions from the methodology panel and CDC's efforts to consult with Federal and non-Federal partners outside the agency have resulted in a number of ideas for activities to integrate into the data collection period beginning in March 2018, which may yield improved response rates and reductions in non-response bias. At the same time, consultation with outside entities has strengthened our partnerships and improved our ability to call on our partners to discuss opportunities for collaboration and to learn from each other's research and investments.

A.9. Explanation of Any Payment or Gift to Respondents

The incentive structure proposed in this request is exactly the same as the one used in previously approved information collections requests (OMB# 0920-0822) for 2010-2012 and 2015-2017 with the exception that the respondents are no longer allowed to donate their incentives to charity.

Since its origin, NISVS has employed a two-phase survey design with Phase 1 being the main data collection period and Phase 2 specifically targeted at increasing response rates and reducing nonresponse bias. During Phase 1, all respondents are offered a $10 incentive to complete the survey.

Upon completion of the first phase a random subsample of non-respondents who did not participate during the main data collection period is drawn (Phase 2). Non-respondents were those who gave soft refusals (e.g., declined due to lack of time or interest, etc.) and those where contact was not made (e.g., rang but no answer, answering machine, busy signal, etc.). The subsampling rate of all non-respondents for Phase 2 is approximately 0.50. Respondents in Phase 2 are re-contacted and offered a higher incentive of $40 to encourage their participation.

During the 2012 NISVS data collection cycle, respondents in Phase 2 were randomly assigned to receive incentive amounts of either $25 or $40 in order to determine the impact the lower amount could have on the response rate. It was found that decreasing the amount from $40 to $25 during Phase 2 decreased the response rate by 17% for landlines and 7.7% for cell phones. It appears that that a decrease in the amount offered would negatively impact the response rate.

A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

The CDC Office of the Chief Information Officer has determined that the Privacy Act does apply. The applicable System of Records Notice (SORN) is 0920-0136 Epidemiologic Studies and Surveillance of Disease Problems. Published in the Federal Register on December 31, 1992. Volume 57, Number 252, Page 62812-62813. The Privacy Impact Assessment (PIA) is attached (Attachment G).

At no time will CDC have access to or receive potentially identifiable information. During data collection, the contractor collects names and addresses of those respondents who wish to be mailed a promised incentive. At no time is this information linked or linkable to survey information. Only limited demographic information is requested (e.g., race, zip code, year of birth). Once an interview is completed, the telephone number is eliminated from the database in an overnight batch process.

The data are collected anonymously. The measures used to insure confidentiality in the approved IRB protocol (Attachments D) closely follows the IRB and OMB approved National Intimate Partner and Sexual Violence Survey (NISVS) (OMB # 0920-0822).

During the verbal informed consent process and throughout the interviews the respondents are informed that their participation is completely voluntary and reminded that they can stop the interview at any time. They are also informed and reminded that they can skip any question that they do not want to answer (Attachment E).

Following recommended guidelines (Sullivan & Cain, 2004; WHO, 2001) a graduated verbal informed consent protocol is used. Specifically, to ensure respondent safety and privacy, the initial person who answers the telephone is provided general non-specific information about the survey topic. The specific topic of the survey is only revealed to the individual respondent selected. After a single adult respondent in the household is randomly selected to participate, the interviewer administers the IRB-approved verbal informed consent, which provides information on the voluntary and confidential nature of the survey, the benefits and risks of participation, the survey topic and the telephone numbers to speak with staff from the CDC or project staff from the contractor (Attachment E). Potential respondents are informed 1) of the purpose for the data collection; 2) that their data will be treated in a secure manner and will not be disclosed; and 3) that all information collected will be pooled with responses from other participants. Literature regarding the ethical and safe collection of research data on IPV offers many reasons for obtaining verbal informed consent in a graduated manner (WHO, 2001; Sullivan & Cain, 2004). In addition to safety and ethical considerations, a graduated consent process allows the interviewer to build rapport and increases the likelihood of gaining the participant's trust, the key to minimizing non-participation and under-reporting. Carefully conducted studies with well-trained interviewers who are able to build rapport and trust with potential participants are essential both to the collection of valid data and the well-being of respondents.

All data will be maintained in a secure manner throughout the data collection and data processing phases in accordance with NIST standards and OCISO requirements. Only contractor personnel, who are conducting the study, will have study-specific access to the temporary

information that could potentially be used to identify a respondent (i.e., the telephone number and address). All project staff have signed the project specific security agreement (Attachment F). While under review, data will reside on directories that only the project director can give permission to access. All computers will reside in a building with electronic security and are ID and password protected.

Although some sensitive questions on social behaviors and victimization are asked using a RDD telephone survey, respondents' first name or initials only are used for the interview process. The name "resident" is used to send the advanced informational letter prior to the interview and the incentive check is addressed as the respondent specifies after his/her participation. To maximize human subject protection, the letter has been carefully written to provide only general information about the survey. The lack of detailed study information in the advance letter is intentional for the protection of the prospective study participant. If the prospective study participant is in a relationship where IPV is present, we do not want the advance letter to raise suspicion or incite potential perpetrators.

Upon completion of the survey, respondents may choose to receive or waive receipt of an incentive check. If the respondent does choose to receive the incentive, it is sent to their specified mailing address. Following survey completion, the interviewer asks for the respondent's name and mailing address. The respondent is informed that this information is being collected for the sole purpose of sending the incentive and that it will not be stored with their survey responses (Attachment E). If the respondent is not comfortable giving this information to the interviewer, the interviewer then offers to have the respondent give the information to her supervisor. If the interviewer thinks that further reassurance is needed, she can offer that her supervisor will not know how the respondent answered any of the questions. If the respondent is still not comfortable with giving their contact information to a call center supervisor, the interviewer will offer to transfer the respondent to a voice mail box to leave their information. The toll-free project hotline number is also offered to respondents so they can call if they experience problems leaving their information.

The mailing contact information is initially recorded in the case management database, a database separate from the survey data. The phone number, address, and name information are subsequently removed from the database during an overnight batch process. By utilizing a two-step process, identifying information that is potentially linkable is removed quickly and respondent privacy is maintained.

The contractor has procedures in place to protect against data loss and down time in the event of equipment failure. These include regularly scheduled back up of data, redundant services in case of server failure, and uninterruptible power supplies to bridge a temporary loss of power. Under normal operating conditions, a complete backup of all files on every disk are written to tape weekly. Every business day, a differential backup is performed of all files created or modified since the last complete backup. In the event of a hardware or software failure, files can be restored to their status as of the time of the last differential backup, usually the evening of the previous business day. Tapes from complete backups are kept for approximately 3 months. Tapes or CD-R drives are used for long-term data archiving. Several additional measures have been implemented to ensure data security. The CATI system includes a compartmentalized data

structure, in which personally identifying information are maintained separately from the actual questionnaire responses. Once an individual has completed his/her survey, all identifying information including first name, and telephone number are transferred to an Excel file, stripped from the data files and destroyed in an overnight batch process. These measures safeguard the privacy of participants – once their interview has been completed, it does not have any personal identifiers.

Before any data are released (e.g., in disseminated reports), all demographic information that could potentially lead to identification of an individual are stripped and the information destroyed. The database is configured so that it is not possible to retrieve individual responses or potentially identifying information.

A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions

IRB Approval

CDC's IRB has deferred to the contractor's IRB. The IRB approval obtained through the study contractor is presented in Attachment D. IRB Approval is updated annually, and the most current expiration date is November 14, 2018. As approved in the study protocol, CDC will not have contact with study participants, nor will CDC have access to PII.

Justification for Sensitive Questions

Because very few people report IPV, SV, or stalking to officials and very few injuries are reported to health care providers, survey data provide the best source of information regarding the prevalence of IPV, SV, and stalking. It is critical that respondent safety remains the primary concern for any data collection asking about violence, particularly IPV, SV, and stalking. Such measures have been well described (Sullivan & Cain, 2004) and are addressed in the interviewer training.

Attachment E contains the NISVS survey instrument and associated supporting materials. Questions included in the current NISVS are closely modeled after questions that were used in the NVAWS, earlier NISVS, and other studies regarding IPV, SV, and stalking.

A.12. a) Estimates of Annualized Burden Hours and Costs

There are two types of households included in the burden table: the non-participating households that are screened and are not eligible or do not wish to participate and the households that are eligible and agree to participate. For the 2018-2019 survey, the estimated number of non-participating screen households is 204,000. It will take approximately 3 minutes to determine their eligibility and participation status. It is estimated the total burden for this group to be 10,200 hours.

The number of participating households will be up to 30,000 over a 12 month data collection period. This is an increase of 5,000 surveys from the last data collection. It is anticipated that

most respondents will take approximately 25 minutes to complete the survey including reviewing instructions. We estimate the total burden for this group to be 12,500 hours.

The total burden for this study is estimated at 22,700 hours. This is derived from the total burden hours for non-participating households and eligible households based on an average response of 3 minutes for screened households and 25 minutes for respondents that complete the survey.

Even though there is an increase of 3,784 burden hours due to the increase in the number of surveys to be collected for the general population in 2018-2019, overall, the annual burden hours for the survey decreased by 4,406. The estimated burden hours are down from 27,106 hours in 2016-2017 to 22,700 hours for the 2018-2019 data collection period. This decrease is due to the completion of the data collection for the DoD sponsored survey of active duty military personnel and wives which accounted for 8,190 burden hours out of the 27,106. Revisions to the 2018-2019 survey may reduce the average time per response, but to provide a conservative estimate, we have continue to use the same average time per response that we did in previous clearance years.

Additionally, we have calculated burden for developmental testing related to NISVS. This estimate includes as many as 5 focus groups of 10 people each for 90 min (i.e., 75 hours) + up to 3 waves of cognitive testing with up to 50 respondents per wave for 90 min each (i.e., 225 hours) + 5000 web survey respondents at 25 min each (i.e., 2083 hours) + 200 phone surveys at 25 min each (i.e., 83 hours) + 300 text back questions at 10 min each (i.e., 50 hours), for a total of 2516 burden hours.

Table 1. Estimated Burden Hours for 2018-2019 Data Collection

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Non-Participating Household (Screened)	NISVS Survey Instrument. First section non-participating (Att. E - For respondents Screened)	204,000	1	3/60	10,200
Eligible Household (Completes Survey)	NISVS Survey Instrument. Section for participating (Att. E - For respondents completing survey)	30,000	1	25/60	12,500
Developmental Testing	NISVS web instrument, focus group	5,700	1	Varies according to	2516

	questionnaires, and text message questions			method described above (focus groups - ; cognitive testing – 90 min; web survey – 25 min; phone survey – 25 min; texting – 10 min)	
				Total	25,216

A.12.b) Estimated Respondent Burden Costs for 2018-2019 Data Collection

For the general population, it is estimated the annual burden cost will be $665,810 for 36,000 completed interviews. This cost was derived by using 204,000 as the expected number of non-participating households screened; an additional 30,000 eligible households completing the survey; and additional 5,700 people engaging in developmental testing related to NISVS.

The estimates of individual annualized costs are based on the number of respondents interviewed and the amount of time required from individuals who were reached by telephone and agreed to the one time interview. The average hourly wage was obtained from the 2017 U.S. Bureau of Labor Statistics. It takes up to 3 minutes to determine whether a household is eligible to complete the verbal informed consent. For those who agree to participate, the total time required is approximately 25 minutes, on average, including screening and verbal informed consent. The average hourly earnings for those in private, non-farm positions are $26.42 (Department of Labor, 2017).

Table 2. Estimated Burden Costs for 2018-2019 Data Collection

Type of Respondent	No. of Respondents	Hourly Wage Rate (in dollars)	Total Respondent Cost
Non-Participating Household (Screened)	204,000	$26.42	$269,484
Eligible Household (Completes Survey)	30,000	$26.42	$330,250
Developmental testing	5,700	$26.42	$66,473
Total			$666,207

A.13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

This data collection activity does not include any other annual cost burden to respondents, nor to any record keepers.

A.14. Annualized Cost to the Government

The contract to conduct the survey was awarded to RTI, International through competitive bid in October of 2015. The total cost for the 2018-2019 data collection is $7,557,388, including $6,667,629 in contractor costs and $879,709 in annual costs incurred directly by the federal government (Table 3).

Costs for this study include personnel for designing the study, developing, programming, and testing the survey instrument; drawing the sample; training the recruiters/interviewers; collecting and analyzing the data; and reporting the study results. The government costs include personnel costs for federal staff involved in the oversight, study design, and analysis, as presented in detail in Table 3.

Table 3. Estimated Cost to the Government for 2018-2019 Data collection

Type of Cost (New Version)	Description of Services	Annual Cost
Government Statistician (2 FTEs)	•Project oversight, study and survey design, sample selection, data analysis, and consultation. •Provide review/input into all statistical aspects of the study design and conduct, including but not limited to study design, sample selection, weighting, total survey error, non-response bias, and response rate. •Survey instrument testing, data analysis and consultation, provide oversight of the QA process.	$296,283
Government Computer Programmer (.5 FTE)	Process data, produce code for complex quality assurance checks	$73,948
Government Data Manager (.5 FTE)	•Data storage, documentation, quality assurance checking and reporting •Suggests timetables associated with the data collection and analysis plan •Collaborates with investigators to write plans	$37,607

Type of Cost (New Version)	Description of Services	Annual Cost
	pertaining to the design of data collection and analysis •Develops plans to ensure quality control of data collection and analysis processes	
Government Behavioral Scientist (1.6 FTEs)	•Project oversight, study and survey design, sample selection, data analysis, and consultation. •Discusses different data collection methods and statistical approaches •Applies theories of psychology, sociology, and other behavioral sciences to the development of data collection instruments and methodological approaches •Designs tools and materials for data collection •Communicates research findings to professional audiences and agency staff using appropriate methods (e.g., manuscripts, peer-reviewed journals, conferences)	$259,590
Government Epidemiologist (.9 FTE)	•Describes sources, quality, and limitations of surveillance data •Defines and monitors surveillance system parameters (e.g., timeliness, frequency) •Defines the functional requirements of the supporting information system •Tests data collection, data storage, and analytical methods •Evaluates surveillance systems using national guidance and methods •Recommends and implements modifications to surveillance systems on the basis of an evaluation •Communicates research findings to professional audiences and agency staff using appropriate methods (e.g., reports manuscripts, peer-reviewed journals, conferences)	$112,812
Government Public Health Analyst (.6 FTE)	•Project management including oversight of budget and administration •Applies knowledge of the acquisition and grants lifecycle •Manages and monitors the implementation of interagency agreements, and contracts •Applies methods and procedures for funding acquisitions	$99,470
Subtotal, Government Personnel		$879,709

Type of Cost (New Version)	Description of Services	Annual Cost
Contracted Personnel and Services[1]	Study design, interviewer/recruiter training, data collection and analysis	$6,677,629
		$7,557,338

[1]Contracted personnel and services cost estimates are based on estimated funds available during Option Year 2 and Option Year 3 (24 months, September 2017 – September, 2019). The contract is funded for multiple years with data collected on a biennial basis. The total contract amount is anticipated to be $24,878,242. The government expects that this task order will be incrementally funded; based upon satisfactory performance and availability of funds, the contract may be renewed for the third option year..

A.15. Explanation for Program Changes or Adjustments

CDC requests a Revision to complete the 2018-2019 data collection cycle using the current survey instrument with the changes described in Section A.1. (i.e., (a) add text to brief introductory script about CDC's mission, (b) add language asking cell phone respondents for permission to send text with survey information, (c) add a clarification question about county or resident, (d) add a group relationship code, (e) adding text to the soft check to confirm an age at first that is older than the current age, (f) remove 4 questions from the normative behaviors section (Section J) that showed limited variability in the response options, (g) shortened 1 item in Section J to reduce redundancy, and (h) remove questions for active duty women and men in the military and wives of active duty men, as they will not be a part of the next wave of data collection.) We are also requesting a continuation of data collection among non-institutionalized adult men and women aged 18 years or older in the United States assessing lifetime and past 12 month experiences of intimate partner violence (IPV), sexual violence (SV) and stalking. Finally, we are requesting to modify data collection protocols to improve response rate and reduce non-response bias in response to recommendations provided by the NISVS methodology workgroup and after consultation with federal and non-federal partners and the current contractor (described in SSB.B3).

These Program Changes and Adjustments are described in detail in a Description of Program Changes and Adjustments Based on NISVS Workgroup Recommendations (Attachment J.1.) and a Crosswalk of Survey Changes (Attachment J.2.).

A.16. Plans for Tabulation and Publication, and Project Time Schedule

Table 4. Data Collection & Report Generation Time Schedule

Data Collection Period	**Activities**	**Time Schedule**
One	Letters sent to respondents	Beginning 5 weeks immediately after OMB approval
	Initiate telephone contact	Beginning 5 weeks immediately after OMB approval
	Clean and edit 1st period data set	Beginning six months after telephone contacts are initiated
Two	Initiate telephone contact	Beginning six months after the start of

	and data collection	data collection period one
	Clean and edit 2nd period data set	Beginning six months after initiation of data collection period two
	Conduct analyses	Beginning six months after initiation of cleaning and editing for period two data set
	Prepare and distribute reports	Beginning one year after initiation of analyses.

To determine the prevalence of IPV, SV, and stalking among women and men bivariate analyses are conducted using SUDAAN, version 11.0. Weighted estimates of 12-month and lifetime victimization prevalence are calculated annually. Separate estimates have been produced for population subgroups (e.g., sex, race/ethnicity, sexual orientation and age groups) and will continue to be produced on a regular basis. Chi square tests have been performed on weighted percentages to formally test for statistically significant differences between proportions and will be produced on a regular basis. Additional multivariable logistic regression analyses have been used to adjust the data and further evaluate associations between the outcomes and potential risk factors.

Data from each biennial data collection will be stored in password protected files. Various summary and special topic reports will be distributed to stakeholders. Public use data sets will also be made available to state and national researchers and practitioners.

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is not inappropriate.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

REFERENCES

Bachar K, & Koss MP. (2001). From prevalence to prevention: Closing the gap between what we know about rape and what we do. In: Renzetti C, Edleson J, Bergen RK, editors. Sourcebook on Violence Against Women. Thousand Oaks (CA): Sage Publications.

Basile KC, Black MC, Simon TR, Arias I, Brener ND & Saltzman LE. (2006). The Association between self reported lifetime history of forced sexual intercourse and recent health risk behaviors: findings from the 2003 National Youth Risk Behavior Survey. *Journal of Adolescent Health, 39*, 752.el -752.e. https://doi.org/10/1016/j.jadohealth.2006.06.001

Basile KC & Smith SG. (2011). Sexual violence victimization of women: Prevalence, characteristics, and the role of public health and prevention. *American Journal of Lifestyle Medicine, 5*(5), 407–417.

Black MC. (2011). Intimate partner violence and adverse health consequences: Implications for clinicians. *American Journal of Lifestyle Medicine*, *5,* 428–439.

Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, & Stevens MR.. (2011). The National Intimate Partner and Sexual Violence Survey: 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Black MC & Black RS. (2007). A public health perspective on the ethics of asking and not asking about abuse. *American Psychologist, 62*, 328- 329.

Black MC & Breiding, MJ. (2008) Adverse health conditions and health risk behaviors associated with intimate partner violence – United States, 2005. *MMWR*, 57, 113-117.

Black MC, Kresnow M, Simon TR, Arias I, & Shelley G. (2006). Telephone survey respondents' reactions to questions regarding interpersonal violence. *Violence and Victims*, *21,* 445-459.

Black MC, & Merrick MT. (2013). Prevalence of intimate partner violence, stalking, and sexual violence among active duty women and wives of active duty men-comparisons with women in the US general population, 2010. Centers for Disease Control and Prevention, Atlanta GA: National Center For Injury Prevention And Control. Retrieved from: http://www.sapr.mil/public/docs/research/2010_National_Intimate_Partner_and_Sexual_Violence_Survey-Technical_Report.pdf

Bonomi AE, Thompson RS, Anderson M, Reid RJ, Carrell D, Dimer JA, & Rivara FP. (2006). Intimate partner violence and women's physical, mental, and social functioning. *American Journal of Preventive Medicine*, *30,* 458-466.

Breiding MJ, Black MC, & Ryan GW. (2008). Prevalence and risk factors of intimate partner violence in Eighteen U.S. States/Territories, 2005. *American Journal of Preventive Medicine, 34,* 112-118.

Breiding MJ, Chen J, & Black MC. (2014). *Intimate partner violence in the United States — 2010.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Carley-Baxter L, Black ML, & Twiddy S. (2007). The Impact of Incentives on Survey Participation and Reports of Intimate Partner and Sexual Violence. Paper presented at the American Association for Public Opinion Research Annual Conference, Anaheim, CA. Retrieved from: http://ww2.amstat.org/sections/SRMS/Proceedings/y2007/Files/JSM2007-000412.pdf

Catalano S, Smith E, Snyder H, Rand M. (2009). Female victims of violence (NCJ Publication No. 228356). Retrieved from Bureau of Justice Statistics: https://www.bjs.gov/content/pub/pdf/fvv.pdf

Centers for Disease Control and Prevention (CDC). (2000). Building data systems for monitoring and responding to violence against women: Recommendations from a workshop. *MMWR 49,* No. RR-11).

Centers for Disease Control and Prevention (CDC). (2016). Sexual violence in youth: Findings from the 2012 National Intimate Partner and Sexual Violence Survey. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/2012FindingsonSVinYouth.pdf

Crofford LJ. (2007). Violence, stress, and somatic syndromes. *Trauma, Violence, & Abuse, 8,* 299–313.

Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, ... & Watts CH. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Medicine*, *10*(5), e1001439. https://doi.org/10.1371/journal.pmed.1001439

Healthy People 2020 [internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. [Accessed June 20, 2017]. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention

Holbrook A., Krosnick J.A., & Pfent A. (2007). The causes and consequences of response rates in surveys by the news media and government contractor survey research firms. In J.M. Lepkowski, C. Tucker, J.M. Brick, E. de Leeuw, L. Japec, P.J. Lavrakas, M.W. Link, & R.L. Sangster (Eds.), *Advances in telephone survey methodology* (pp. 499-528). Hoboken, NJ: John Wiley & Sons, Inc.

Indiana State Department of Health (ISDH). (n.d.). Sexual violence. Indiana Injury Prevention

Resource Guide. Retrieved from: https://www.in.gov/isdh/files/Sexual_Violence.pdf

Jewkes, R., Sen, P., & Garcia-Moreno, C. (2002). Sexual violence. In E. G. Krug, L. L. Dahlberg, J. A., Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp. 147-181). Geneva: World Health Organization.

Max W, Rice DP, Finkelstein E, Bardwell RA, & Leadbetter S. (2004). The economic toll of intimate partner violence against women in the United States. *Violence and Victims, 19(3),* 259-72.

McFarlane JM, Campbell JC, Wilt S, Sachs CJ, Ulrich Y, & Xu X. (1999). Stalking and intimate partner femicide. *Homicide Studies*, *3*(4), 300-316.

National Center for Injury Prevention and Control (NCIPC). (2003). Costs of intimate partner violence against women in the United States. Atlanta (GA): Centers for Disease Control and Prevention.

National Research Council. (2014). *Estimating the incidence of rape and sexual assault.* Panel on Measuring Rape and Sexual Assault in Bureau of Justice Statistics Household Surveys, C. Kruttschnitt, W.D. Kalsbeek, and C.C. House, Editors. Committee on National Statistics, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

New Jersey Coalition Against Sexual Assault (NJCASA). (2014). What is sexual violence? Understanding and responding to abuse and assault. Retrieved from: http://www.nj.gov/dcf/women/archive/What.is.Sexual.Violence.pdf

Peterson C, DeGue S, Florence C, & Lokey CN. (2016). Lifetime economic burden of rape Among U.S. adults. *American Journal of Preventive Medicine, 52(6),* 691-701. https://doi.org/10.1016/j.amepre.2016.11.014

Pico-Alfonso MA, Garcia-Linares MI, Celda-Navarro N, Herbert J, & Martinez M. (2004). Changes in cortisol and dehydroepiandrosterone in women victims of physical and psychological intimate partner violence. *Biological Psychiatry*, *56*, 233–240.

Planty M, Langton L, Krebs C, Berzofsky M, & Smiley-McDonald H. (2013). Female victims of sexual violence, 1994-2010 (NCJ Publication No. 240655). Retrieved from Bureau of Justice Statistics: https://www.bjs.gov/content/pub/pdf/fvsv9410.pdf

Rosay AB. (2016). Violence against American Indian and Alaska Native women and men: 2010 findings from the National Intimate Partner and Sexual Violence Survey (NCJ Publication No. 249736). Retrieved from https://www.ncjrs.gov/pdffiles1/nij/249736.pdf.

Sahr R. (2014). Consumer Price Index (CPI) conversion factors to convert to 2013 dollars.

(Revised April 8, 2014). Retrieved at: http://liberalarts.oregonstate.edu/sites/liberalarts.oregonstate.edu/files/polisci/faculty-research/sahr/inflation-conversion/pdf/cv2013rsx1.pdf

Singer E. & Ye C. (2013). The use and effects of incentives in surveys. *The Annals of the American Academy of Political and Social Science, 645*, 112-141.

Smith SG, & Breiding MJ. (2011). Chronic disease and health behaviors linked to experiences of nonconsensual sex among women and men, *Public Health, 125*(9), 653-659.

Smith SG, Chen J, Basile KC, Gilbert L, Merrick MT, Patel N, Walling M, & Jain A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 state report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Sullivan CM & Cain D. (2004). Ethical and safety considerations when obtaining information from or about battered women for research purposes. *Journal of Interpersonal Violence, 19*, 603-18.

Tjaden P & Thoennes N. (1998). Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey. (NCJ Publication No. 172837). U.S. Department of Justice, Office of Justice Programs, Washington, DC,

U.S. Department of Labor. Bureau of Labor Statistics. (2017). Table B-8. Average hourly and weekly earnings of production and nonsupervisory employees on private nonfarm payrolls by industry sector, seasonally adjusted. Retrieved at: https://www.bls.gov/news.release/empsit.t24.htm

Vos T, Astbury J, Piers LS, Magnus A, Heenan M, Stanley L, Walker L & Webster K. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organization*, *84*(9), 739-744

World Health Organization (WHO). (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women*. Geneva: World Health Organization.