

Indiana's Commitment to Primary Prevention: A State Free of Sexual Violence ~ 2010-2015

Centers for Disease Control and Prevention Framework and Etiology of Sexual Violence

In order to understand the priorities set forth in the state plan, it is helpful to be aware of the context in which they were created. This section provides an overview of the Centers for Disease Control and Prevention's (CDC's) framework of sexual violence prevention.

A. The Definition of Sexual Violence

For the purpose of Indiana's Sexual Violence Primary Prevention Plan, the Sexual Violence Primary Prevention Council has adopted the Centers for Disease Control and Prevention's definition of sexual violence.

Sexual violence (SV) is any sexual act that is perpetrated against someone's will. Sexual violence encompasses a range of offenses, including a completed nonconsensual sex act (i.e., rape), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment). These four types are defined in more detail below. All types involve victims who do not consent, or who are unable to consent, or refuse to allow the act.

- **A completed sex act** is defined as contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object.
- **An attempted (but not completed) sex act** also constitutes sexual violence.
- **Abusive sexual contact** is defined as intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse.
- **Non-contact sexual abuse** does not include physical contact of a sexual nature between the perpetrator and the victim. It includes acts such as voyeurism; intentional exposure of an individual to exhibitionism; unwanted exposure to pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; or taking nude photographs of a sexual nature of another person without his or her consent or knowledge, or of a person who is unable to consent or refuse.¹

¹ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Reference: Basile KC, Saltzman LE. Sexual violence surveillance: uniform definitions and recommended data elements version 1.0. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2002.

B. Primary Prevention of Sexual Violence

Primary prevention of sexual violence is defined as: “Approaches that take place *before* sexual violence has occurred to prevent initial perpetration or victimization.”² This definition may seem simple, but when applied to violence prevention or any other public health problem, it becomes more complex. Primary prevention aims to change the root cause of a problem. It involves asking questions about why sexual violence occurs in the first place. When answering these questions, many researchers and practitioners look to the identified risk factors for and protective factors against sexual violence. After identifying the root causes of the problem, the next step is to formulate solutions to address these multiple and intersecting root causes.

For example, primary prevention does not include training women in self-defense courses because this strategy does not truly address any of the root causes of sexual violence. This strategy may indeed prevent someone from being sexually assaulted, but it does not impact the norms and systems that allow sexual violence to occur in the first place. In order to get to the root causes of sexual violence, strategies that seek to change attitudes, norms, beliefs, and behaviors must be implemented and systems that support the protective factors and decrease the risk factors for sexual violence must be developed and strengthened. (See Section D, Step 2 for identified risk factors for and protective factors against sexual violence perpetration).

Sexual violence prevention is the responsibility of the entire community and of society, not just the responsibility of individuals. Prevention efforts taking place in multiple settings should mutually reinforce each other to ensure a comprehensive approach to primary prevention.

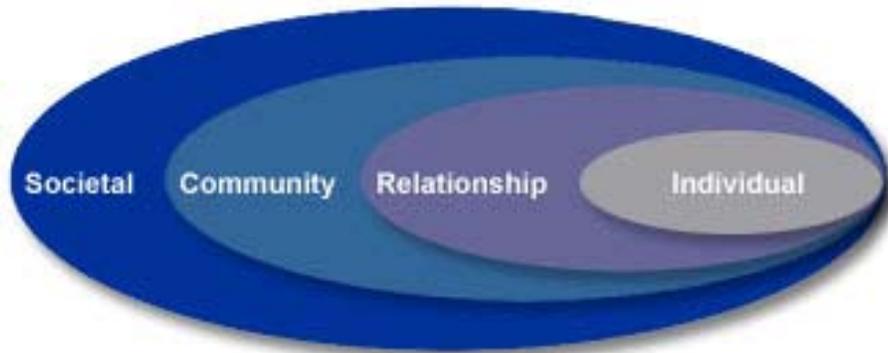
The following two models provide a useful framework for understanding the dynamics of primary prevention.

The Social Ecological Model

CDC uses a four-level social-ecological model to better understand the root causes of violence and the effect of potential prevention strategies.³ This model considers the complex interplay between individual, relationship, community, and societal factors. Prevention efforts taking place in multiple setting should mutually reinforce each other to ensure a comprehensive approach to primary prevention.

²CDC. “Sexual Violence Prevention: Beginning the Dialogue”. 2004

³Dahlberg LL, Krug EG. “Violence-a global public health problem”. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1-56.



Individual Level

The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. For example, factors such as alcohol and/or drug use; attitudes and beliefs that support sexual violence; impulsive and other antisocial tendencies; preference for impersonal sex; hostility towards women; and childhood history of sexual abuse or witnessing family violence may influence an individual's behavior choices that lead to perpetration of sexual violence.⁴

Relationship Level

Relationship or interpersonal level influences are factors that increase risk as a result of relationships with peers, intimate partners, and family members. A person's closest social circle—peers, partners, or family members—can shape the individual's behavior and range of experience. Risk factors at this level include association with sexually aggressive peers; family environment that is emotionally unsupportive; and a strong patriarchal family environment.

Community Level

Community-level influences are factors that increase risk for sexual violence perpetration based on community and social environments and include an individual's experience and relationships with schools, workplaces, and neighborhoods. For example, a lack of sexual harassment policies in the workplace can send a message that sexual harassment is tolerated, and that there may be no consequences for those who harass others. Other social circumstances such as poverty can contribute to violence in neighborhoods and communities.

Societal Level

The fourth level looks at the broad societal factors that help form a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that either implicitly or explicitly promote or discourage violence and gender equity in both universal and selected populations. For example, rape is more common in cultures that promote male sexual entitlement and support an ideology of male superiority. Other contextual societal factors that have been linked to increased violence include the health,

⁴ Dahlberg LL, Krug EG. "Violence-a global public health problem". In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002

economic, educational and social policies that help to maintain economic or social inequalities between groups in society.⁵

A comprehensive approach to primary prevention includes working within multiple levels of the social ecological model. Thus, ideally, prevention interventions should include strategies that target risk and protective factors at all levels of the social ecological model.

The Spectrum of Prevention

The Spectrum of Prevention, developed by the Prevention Institute, is another model often used to frame the concept of sexual violence primary prevention. Grounded in the belief that a single individual or sector cannot address the problem of sexual violence alone, the Spectrum of Prevention provides a model for comprehensive prevention strategies. Prevention strategies can target any level; however, they are most effective when working at multiple levels.

- 1) Strengthening Individual Knowledge and Skills—Enhancing an individual’s capability of preventing violence and promoting safety.
- 2) Promoting Community Education—Reaching groups of people with information and resources to prevent violence and promote safety.
- 3) Educating Providers—Informing providers who will transmit skills and knowledge to others and model positive norms.
- 4) Fostering Coalitions and Networks—Bringing together groups and individuals for broader goals and greater impact.
- 5) Changing Organizational Practices—Adopting regulations and shaping norms to prevent violence and improve safety.
- 6) Influencing Policies and Legislation—Enacting laws and policies that support healthy community norms and a violence-free society.⁶



⁵ Dahlberg LL, Krug EG. “Violence-a global public health problem”. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002

⁶Davis, Rachel, Parks, Lisa Fujie, and Cohen, Larry. “Sexual Violence and the Spectrum of Prevention: Towards a Community Solution. National Sexual Violence Resource Center 2006.

C. Sexual Violence as a Public Health Problem

Public health is “fulfilling society's interest in assuring conditions in which people can be healthy.”⁷ This definition, and ultimately the practice of public health, emphasizes that many conditions influence health and wellness. Public health is broad in nature, exploring the social, economic, political, and medical care factors that affect health and illness; and is fundamentally grounded in the premise that improving the health status of others provides benefits to all. The field of public health is interdisciplinary in its approach and methods, its emphasis on preventative strategies, its linkage with government and political decision-making, and its dynamic adaptation to new problems placed on its agenda. Above all else, public health is a collective effort to identify and address the unacceptable realities that result in preventable and avoidable health and quality of life outcomes, and it is the composite of efforts and activities that are carried out by people and organizations committed to those ends.⁸

Public health is ultimately concerned with approaches that address the health of a population rather than individuals. This principle distinguishes public health from other approaches to health-related issues (for example, medicine focuses on helping the individual). Based on this principle, a public health prevention strategy strives to achieve benefits for the largest group of people possible, because the problem is widespread and typically affects the entire population in some way, either directly or indirectly.⁹

Public health approaches problems from a multidisciplinary perspective, and can be effective in addressing violence prevention in general and sexual violence in particular.¹⁰ Drawing from many different disciplines, including medicine, epidemiology, sociology, criminology, psychology, and policy, has allowed public health to successfully respond to a wide range of health issues around the world, including violence.

Sexual violence negatively impacts physical and mental health outcomes, and intersects with other widespread public health challenges, such as chronic disease, sexually transmitted diseases, and substance abuse.

- Sexual violence causes or contributes to many physical and mental health problems, including but not limited to: physical injuries and disability, unwanted/unplanned pregnancy, sexually transmitted diseases, gynecological problems, chronic pain, eating disorders, substance abuse, depression, fear and anger, post-traumatic stress syndrome, and suicide.¹¹
- Sexual violence is linked to other negative health behaviors—victims and perpetrators of sexual violence are more likely to abuse substances, be affected by chronic disease, and/or engage in risky sexual behavior than the general

⁷ Institute of Medicine, 2008

⁸ Turnock, Bernard J. Public Health: What it Is and How it Works, 4th Ed. Sudbury: Jones and Bartlett Publishers, 2009.

⁹ CDC. “Sexual Violence Prevention: Beginning the Dialogue”. 2004

¹⁰ World Report on Violence and Health, World Health Organization, Geneva, 2002

¹¹ <http://www.cdc.gov/ncipc/pub-res/images/SV%20Factsheet.pdf>

- population. Additionally, sexual violence has a major social impact on its victims, including strained relationships with friends, family, and intimate partners and less contact with and emotional support from friends and family.¹²
- The Adverse Childhood Experiences (ACE) study indicates that childhood physical, emotional, and sexual abuse, neglect, trauma, and/or household dysfunction are correlated with negative health outcomes later in life. The ACE Score is a count of the total number of ACE experiences reported. The ACE Score is used to assess the total amount of stress during childhood and has demonstrated that as the number of ACE increases, the risk for the following health problems increases in a strong and graded fashion:
 - Alcoholism and alcohol abuse;
 - Chronic Obstructive Pulmonary Disease (COPD);
 - Depression;
 - Fetal Death;
 - Health-related quality of life;
 - Illicit drug use;
 - Ischemic heart disease (IHD);
 - Liver disease;
 - Risk for intimate partner violence;
 - Multiple sexual partners;
 - Sexually transmitted infections (STIs);
 - Smoking;
 - Suicide attempts; or
 - Unintended pregnancies.¹³

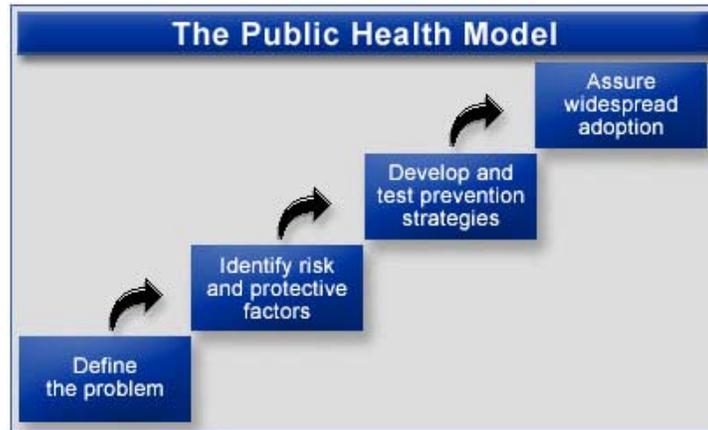
D. The Public Health Approach to Sexual Violence Prevention

The National Center for Injury Prevention and Control advocates the use of a four-step public health approach to address sexual violence prevention, as well as other health problems that affect populations. This model starts at the basic level of understanding and defining the public health problem and then advances to the dissemination of effective solutions. The four steps of the approach are:

- Define the problem;
- Identify risk and protective factors;
- Develop and test prevention solutions; and
- Ensure widespread adoption.

¹²<http://www.cdc.gov/ncipc/dvp/SV/svp-consequences.htm>

¹³Centers for Disease Control and Prevention. "Adverse Childhood Experiences Study: Major Findings." Updated 2005. Accessed at: <http://www.cdc.gov/nccdphp/ACE/findings.htm>.



Step 1—Define the Problem

Each step in the public health prevention model builds upon the previous one, as shown in the diagram above. Defining the problem is a fundamental, necessary first step. Quantifiable data are absolutely essential to program planning for health behavior change. However, as important as quantitative measures are, a true understanding of the impact and consequences of sexual violence on the population must look beyond the numbers. Sexual violence incurs health, social, interpersonal and economic costs that can be devastating to communities, families, and individuals. Even though it is difficult to gauge the true magnitude of sexual violence in the population because of under-reporting and fragmented data collection systems, many of the health, social, and interpersonal consequences of sexual violence have been well-documented by CDC and others.

Statistically speaking, most victims of sexual violence are women, girls and boys and most perpetrators are men. **However, it is important to acknowledge that men can be victims and women can be perpetrators of sexual violence.** The current strategies practitioners use to prevent sexual violence focus not on protecting one gender from the other, but rather seek to foster circumstances where respect and equity is promoted between all people and sexual violence is not tolerated.

Although it may seem tactless to assess the magnitude of sexual violence in all its forms in the context of economic impact, identifying figures in terms of dollars and cents can assist policymakers and citizens in comprehending the financial “cost” sexual violence imposes on taxpayers and on society. As with other data on sexual violence, economic impact data is difficult to obtain, but some studies have attempted to estimate how much sexual violence costs society. Public and private funds are spent on crisis medical, mental health, and social services and responses from law enforcement and the criminal justice system. Workdays are lost because of injury and illness. Businesses lose money through employee absences and sexual harassment lawsuits. The costs for offenders’ prosecution, incarceration, probation, rehabilitation, and other services further augment the total monetary burden of sexual violence.

Currently, no Indiana-specific data exists on the economic impact of sexual violence. However, in July 2007, the Minnesota Department of Health released an estimate of the

economic costs of sexual violence to their state, based on 2005 data. According to 2008 U.S. census data, Indiana's population is greater than Minnesota's by approximately one million people, and its geographical landscape and demographic makeup are fairly similar. While Minnesota's data cannot simply be extrapolated to provide comparison to Indiana, it can provide a general idea of the economic scope of the issue.

Minnesota estimated that sexual violence cost the state \$8 billion in 2005, or \$1,540 per Minnesota resident. According to the study, "The largest cost was due to the pain, suffering, and quality of life losses of victims and their families, and related breakdowns in their lives and relationships. Medical care, mental health care, victim work loss, sexually transmitted diseases, unplanned pregnancy, suicidal acts, substance abuse, and victim services cost \$1.3 billion. Criminal justice and perpetrator treatment cost \$130.5 million."¹⁴

While no one is immune from sexual violence, it has been demonstrated that certain demographic groups of the population are disproportionately affected. Because public health relies on data to make decisions about prevention strategies and prioritize populations, it is important to understand which demographic groups are most affected.

Females

Statistically speaking, being female makes one more susceptible to sexual violence victimization. In 1996, The National Violence Against Women Survey sampled 8,000 women and 8,000 men and found that 1 in 6 women (17 percent) and 1 in 33 men (3 percent) reported experiencing an attempted OR completed rape at some time in their lives.¹⁵ Weighted data gathered from the 2007 Female Victimization in Indiana Survey, which measured the self-reported lifetime prevalence of various crimes perpetrated against Indiana women, indicate that 13% of Indiana women over the age of 18 have experienced a completed rape at some point in their lives. Eighteen percent of the sample reported experiencing another type of sexual assault in their lives, and 20% reported experiencing attempted rape.¹⁶

Consistent with what is known nationally about the relationships of sexual assault perpetrators to victims, the 2007 Female Victimization in Indiana Survey found that most women who reported being a victim of attempted and/or completed rape knew the perpetrator, most often as a friend. Only 12.3% of the women who experienced a completed rape actually reported the crime to legal authorities.¹⁷

¹⁴Costs of Sexual Violence in Minnesota. Minnesota Department of Health, released July 2007. Available at http://www.pire.org/documents/mn_brochure.pdf.

¹⁵Tjaden, Patricia and Thoennes, Nancy. "Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey." November 2000. Accessed at: <http://www.ncjrs.org/pdffiles1/nij/183781.pdf>

¹⁶Sidenbender, S., Wolf, J., & Jolliff, A. "Female Victimization in Indiana-2008: Summary of Methods and Findings". Survey Research Center at IUPUI. 2008.

¹⁷Sidenbender, S., Wolf, J., & Jolliff, A. "Female Victimization in Indiana-2008: Summary of Methods and Findings". Survey Research Center at IUPUI. 2008.

It is important to note that men can be victims of sexual violence also. Although there is virtually no quantifiable state-level Indiana data on the prevalence of male rape, many experts believe that current national male rape statistics vastly under-represent the actual number of males age 12 and over who are raped each year. Male victims can be raped both by females and by other males. Male rape victims also face special barriers in reporting and recovering from sexual assault.

Youth

Young people are vulnerable due to a lack of experience, knowledge, and access to resources. This vulnerability increases the risk of experiencing sexual violence. In 2007, the Youth Risk Behavioral Survey found that 9.4% of Indiana high school students (grades 9-12) reported having been physically forced to have sexual intercourse when they did not want to. Breaking the question down by gender, 13.2% of female high school students and 5.3% of male high schools students indicated that they had been physically forced to have sexual intercourse.

National data also supports that youth are at a higher risk of experiencing sexual violence than the general population. According to the National Violence Against Women Survey, many American women are sexually assaulted at an early age. Of the 17.6% of all women surveyed who reported having been a victim of attempted or completed rape at some point in their lives, 21.6% were younger than age 12 when they were first raped, and 32.4% were between the ages of twelve and seventeen.¹⁸ Thus, more than half of the female rape victims surveyed were younger than 18 years of age when they experienced their first completed or attempted rape.

The college population is also at an increased risk for experiencing sexual violence. A study of a college-based sample found that 13.7% of undergraduate women had been victims of at least one completed sexual assault since entering college. Almost five percent had been victims of physically forced sexual assault. Almost eight percent of women were sexually assaulted after voluntarily consuming drugs and/or alcohol, and 0.6% were sexually assaulted after having been given a drug without their knowledge.¹⁹

Additionally, a national-level study of college women found that approximately 673,000 of nearly 6 million current college-aged women (11.5 percent) have been raped, and only approximately twelve percent of these rapes were reported to law enforcement.²⁰

¹⁸Tjaden, Patricia and Thoennes, Nancy. "Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey." November 2000. Accessed at: <http://www.ncjrs.org/pdffiles1/nij/183781.pdf>

¹⁹Krebs, Lindquist, Warner, Fisher, and Martin, 2007, retrieved from the National Institute of Justice Web site

²⁰Kilpatrick, Resnick, Ruggiero, Conoscenti, and McCauley, 2007, retrieved from the National Institute of Justice Web site

Developmentally Disabled

A “developmental disability” is a severe, chronic disability which originated at birth or childhood, is expected to continue indefinitely, and substantially restricts the individual’s functioning in several major life activities.²¹ Examples of common developmental disabilities include autism, disorders resulting from traumatic brain injury, cerebral palsy, Down’s syndrome, fetal alcohol syndrome, mental retardation, and spina bifida.

Nationally, among developmentally disabled adults, approximately 83% of females and 32% of males have been victims of sexual assault.²² Some reasons for this appallingly high rate of victimization among the developmentally disabled include: social isolation, difficulty in communicating, difficulty in understanding and trusting feelings, financial and social dependence on caregivers who may be perpetrators, lack of education about sexuality and appropriate boundaries, learned compliance, desire to please, institutional risk factors, inability to get away, and lack of resources to call upon for help.²³

Perpetrators of the developmentally disabled are often their caretakers. They view disabled individuals as “easy prey,” believing the victims cannot or will not tell about the sexual abuse.

Lower Socioeconomic Status

Poverty increases vulnerability for experiencing sexual violence. It has been demonstrated that people with an annual household income less than \$7,500 are twice as likely as the general population to be victims of sexual assault.²⁴ The inability to provide for one’s basic needs, such as food, shelter, transportation, and clothing, can lead to dependence on others for survival and thus, make one less able to control sexuality or consent to sex and more likely to engage in high-risk survival activities. Coping with multiple layers of oppression in all areas of social life, including poverty, heightens the risk of perpetrating or experiencing sexual violence.²⁵

Additionally, there is a strong relationship between sexual violence and homelessness. One of the largest and most in-depth studies on this topic revealed that 92% of a racially diverse sample of homeless mothers had experienced severe physical and/or sexual violence at some point in their lives.²⁶ The relationship between sexual violence and homelessness is complex, with either experience potentially laying the groundwork for

²¹ Section 102(8) of the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 160-402) of 2000

²²Johnson, I., Sigler, R. 2000. ”Forced Sexual Intercourse Among Intimates,” Journal of Interpersonal Violence. 15 (1).

²³Voices Ignored: Sexual Assault of People with Developmental Disabilities. Discussion Guide: The Center for Child and Family Studies.

²⁴Bureau of Justice, 1996

²⁵Pennsylvania Coalition Against Rape. “Poverty and Sexual Violence: Building Prevention and Intervention Responses.” 2007. Accessed at: <http://www.pcar.org/resources/poverty.pdf>

²⁶Brown and Bassuk, 1997, retrieved from “No Safe Place: Sexual assault in the lives of homeless women” (September 2006) VAWnet: The National Online Resource Center on Violence Against Women.

the other. A number of studies have emphasized the correlation between child sexual abuse and homelessness in adult women. In one study, 65% of chronically homeless women reported child sexual abuse.²⁷ Homelessness also makes one more likely to experience sexual violence as an adult. This is due to a lack of safety living on the street or in homeless shelters, a lack of nurturing social connections, and participation in potentially dangerous activities to meet survival needs. The homeless population in general is also more likely to suffer from substance abuse and/or mental illness than the general population, which compounds the risk of victimization.²⁸

Racial and Ethnic Minorities

Generally speaking, national data indicates that racial and ethnic minority groups experience sexual violence at similar rates as the Caucasian population, with one notable exception.²⁹ American Indian/Alaskan Native women are victims of rape and sexual assault at more than two times the rate of other racial groups.³⁰ In at least 86% of reported cases of rape and sexual assault against American Indian or Alaskan Native women, survivors report that the perpetrator was a non-Native man. For other victims of sexual violence, the majority of victims and perpetrators are of the same race and ethnicity.³¹

Many racial and ethnic minority communities face culturally specific challenges and barriers when seeking to prevent and respond to sexual violence. An understanding of the multiple layers of oppression that racial and ethnic minorities may face in mainstream communities and society is necessary to comprehensively address sexual violence prevention within these populations.

Step 2—Identify Risk and Protective Factors

Public health encourages the study of risk and protective factors with the intention of formulating primary prevention strategies that either reduce risk factors or strengthen protective factors. Because the public health approach to sexual violence prevention focuses more on the factors that allow perpetration to occur than factors that make one more or less likely to be victimized, risk factors for and protective factors against sexual violence perpetration have been documented more extensively than risk factors for and protective factors against victimization. Through research and literature review, the

²⁷Bassuck, Ellen, Purloff, Jennifer, and Dawson, Ree. "Multiply Homeless Families: The Insidious Impact of Violence". *Housing Policy Debate*. Vol 12, Issue 2, 2001

²⁸"No Safe Place: Sexual assault in the lives of homeless women" (September 2006) VAWnet: The National Online Resource Center on Violence Against Women.

²⁹Tjaden, P. & Thoennes, N. (2006). [Extent, Nature, and Consequences of Rape Victimization: Findings From the National Violence Against Women Survey](#). Special Report. Washington, D.C.: National Institute of Justice and the Centers for Disease Control and Prevention.

³⁰Steven W. Perry, "American Indians and Crime: A BJS Statistical Profile, 1992-2002", U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2004, publication NCJ 203097. Available at: <http://www.ojp.usdoj.gov/bjs/abstract/aic02.htm>

³¹The Maze of Injustice: the Failure to Protect Indigenous Women from Sexual Violence in the USA, Amnesty International, New York, NY, 2007.

Center for Injury Prevention and Control within the CDC has identified the etiology of sexual violence as outlined in Table 2. Risk factors for and protective factors against sexual violence perpetration exist at all levels of the social ecological model. As the number of risk factors an individual experiences increases, so does the risk of sexual violence perpetration.

Protective factors against sexual violence perpetration have been researched and documented less frequently. There is some evidence that indicators of equal status of women in society (gender equity), collective efficacy of the community, and positive youth development aimed at developing individual and environmental assets can serve as protective factors against sexual violence perpetration.³²

³² Getting to Outcomes, Step 1—Needs and Resources Assessment. DELTA/Centers for Disease Control and Prevention.

Table 2: CDC-Identified Risk Factors for Sexual Violence Perpetration

| Level of Social Ecological Model | Risk Factors: Sexual Violence Perpetration ³³ |
|----------------------------------|--|
| Individual | <ul style="list-style-type: none"> • Alcohol and drug use • Coercive sexual fantasies • Impulsive and antisocial tendencies • Preference for impersonal sex • Hostility towards women • Hypermasculinity • Childhood history of sexual and/or physical abuse • Witnessed family violence as a child |
| Relationship | <ul style="list-style-type: none"> • Association with sexually aggressive and delinquent peers • Family environment characterized by physical violence and few resources • Strong patriarchal relationship or family environment • Emotionally unsupportive familial environment |
| Community | <ul style="list-style-type: none"> • Lack of employment opportunities • Poverty • Lack of institutional support from the police or justice system • General tolerance of sexual violence within the community • Weak community sanctions against sexual violence perpetrators |
| Society | <ul style="list-style-type: none"> • Poverty • Societal norms that support sexual violence • Societal norms that support male superiority and sexual entitlement • Societal norms that maintain women’s inferiority and sexual submissiveness • Weak laws and policies related to gender equity • High tolerance levels of crime and other forms of violence |

³³ Centers for Disease Control and Prevention, Center for Injury Prevention and Control, Division of Violence Prevention. A complete listing of sources used in CDC’s literature review is available at: www.cdc.gov/ncipc/dvp/SV/svp-risk_protective.htm

Step 3—Develop and Test Prevention Strategies

After risk and protective factors have been identified, interventions to influence these factors can be developed and tested for effectiveness. At this time, there are very limited “evidence-based” strategies and programs proven to prevent first-time perpetration of sexual violence. However, practitioners do use “evidence-informed” and “unproven” strategies. Such strategies are generally based on theories that have been validated by research and/or practice to lead to social or behavioral change. In the field of public health, these theories are the Health Belief Model, the Theory of Reasoned Action, Diffusion of Innovation, and the Transtheoretical Model.³⁴

Commonly used “evidence-informed” strategies for sexual violence primary prevention include, but are not limited to:

- Male mobilization for a more positive, healthier concept of masculinity and promotion of gender equity;
- Bystander intervention and healthy relationships education and skill-building in various settings;
- Educating youth and families on healthy relationships and non-violent conflict resolution;
- Positive youth development and empowerment;
- Social marketing campaigns;
- Policy initiatives to affect factors that either reduce risk factors for or strengthen protective factors against sexual violence perpetration.

The types of strategies mentioned above can be evaluated for effectiveness in changing knowledge, beliefs, attitudes, and environments, and to some degree, behaviors.

Step 4—Assure Widespread Adoption

When prevention strategies and programs have been proven to be effective based on evaluation, they can be disseminated, adopted and replicated in different settings. Dissemination techniques to promote widespread adoption of the strategy or program include training, technical assistance, networking, and sharing evaluation results.

Prevention strategies and programs may have to be modified depending upon the context in which they are implemented. When implementing strategies, it is important for states and communities to balance adherence to “evidence-informed” or “unproven” strategies with potential compatibility to the context of the state or community. Strategies may be modified in four different ways:

- Deletions or additions (enhancements) of strategy core components,

³⁴“Third Edition, Guidance Document for the Sexual Violence Prevention and Education Cooperative Agreement CE07-701 (Rape Prevention and Education, DRAFT August 2008, Department of Health and Human Services Public Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention.

- Modifications in the nature of components included,
- Changes in the manner or intensity of administration of strategy core components called for in manual, curriculum, or core components analysis, or
- Cultural and other modifications required by local circumstances.³⁵

Even the strongest evidence-informed strategies can fail to produce an expected outcome when implemented in contexts outside of which the strategy has proven to be effective.³⁶ Therefore, when testing these strategies in different communities, it is important to make the necessary modifications in a small setting before widespread dissemination. One social factor that can be uniquely different across communities is the way in which sexual violence is understood, explained, or experienced. It is essential to take into consideration the history, norms, and needs of communities when seeking to implement a strategy.

Strategy adaptation is warranted when the overall framework of the strategy would work well with the community context, but modifications that incorporate cultural, social, environmental, historical and psychological forces are needed to best serve the community. The six main categories of population contexts that may need strategy modification are:

- Racial and Ethnic Identity
- Religious Identity
- Sexual Orientation and Gender Identity
- Income
- Education
- Social Norms

Conclusion

The scientific background of sexual violence prevention has been explored throughout this section. Additional sections offer a summary of the Sexual Violence Primary Prevention Council's planning process and outline the goals, outcome statements, strategies and action steps, and logic models for Indiana's sexual violence primary prevention state plan.

³⁵“Third Edition, Guidance Document for the Sexual Violence Prevention and Education Cooperative Agreement CE07-701 (Rape Prevention and Education, DRAFT August 2008, Department of Health and Human Services Public Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention.

³⁶Ganju, V (2003). Implementation of evidence-based practices in state mental health systems: Implications for research and effectiveness studies. *Schizophrenia Bulletin*, 29(1), 1179-1189.