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

Introduction and Call to Action

Sexual violence impacts all Hoosiers…

Chances are you know a man, woman, or child in Indiana who has been sexually violated. The consequences of sexual violence range from loss of self-esteem to substance abuse; from unwanted pregnancy to long-term health, social, and interpersonal problems; from family and community strife to the economic costs of bringing a perpetrator to justice.

Sexual violence is a preventable public health problem!

The factors that contribute to sexual violence can be changed; however, this type of social change requires commitment and involvement from all parts of society. Because no one is untouched by this problem, everyone must be a part of the solution.

There is a community in Indiana dedicated to stopping sexual violence before it starts.

The Indiana Sexual Violence Primary Prevention Council is the driving force behind Indiana's 2010-2015 Sexual Violence Primary Prevention Plan. This statewide advisory council is comprised of members representing diverse disciplines and organizations, united by a shared desire to prevent sexual violence and its public health and social implications.

Our Vision: *A state free of sexual violence achieved through respect between and equity among all people.*

Our Mission: *To engage the people of Indiana in the primary prevention of sexual violence using state and community-based strategies for societal change.*

It is time for Indiana to take action.

Ending sexual violence is not and cannot be the responsibility of any one individual, community, institution, or government. True impact will be made when people and the communities and organizations in which they live commit to making prevention a priority.

This six-year plan serves as a blueprint to launch systemic sexual violence primary prevention efforts in Indiana. Read on to learn more.

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

Goals, Outcome Statements, Strategies and Action Steps, and Logic Models

Between December 2007 and October 2009, the Indiana Sexual Violence Primary Prevention Council created the road map for the next five years of sexual violence prevention efforts in Indiana through an extensive state planning process. Realization of the Council's vision: *a state free of sexual violence achieved through respect between and equity among all people;* requires commitment from diverse state and local-level partners. To ensure accountability and facilitate process and outcome evaluation, one agency, organization, or initiative has committed to serve as the lead for implementing and evaluating each outcome statement. The Indiana State Department of Health will monitor progress toward accomplishing outcome statements and provide state-level guidance, resources and support.

Goal #1: To facilitate stakeholder awareness of and participation in the implementation of the Indiana Sexual Violence Primary Prevention Plan.

Outcome 1: By December 2010, each Sexual Violence Primary Prevention Council member will distribute the key recommendations of the state plan to at least two existing or potential partners through available media, technology, and in-person outlets. *Lead agency: Indiana State Department of Health*

Outcome 2: By June 2011, the Sexual Violence Primary Prevention Council will create and distribute one state plan fact sheet that offers technical assistance on use of the state plan for each of the following groups of constituents: public health, medical, policymakers, primary and secondary education, youth and family-serving organizations, faith and community-based organizations, businesses, colleges and universities, media and judicial/law enforcement. *Lead organization: Indiana Coalition Against Sexual Assault*

Outcome 3: By January 2012, each of the aforementioned groups of constituents will hold at least one seat on the Sexual Violence Primary Prevention Council during the plan implementation phase. *Lead agency: Indiana State Department of Health*

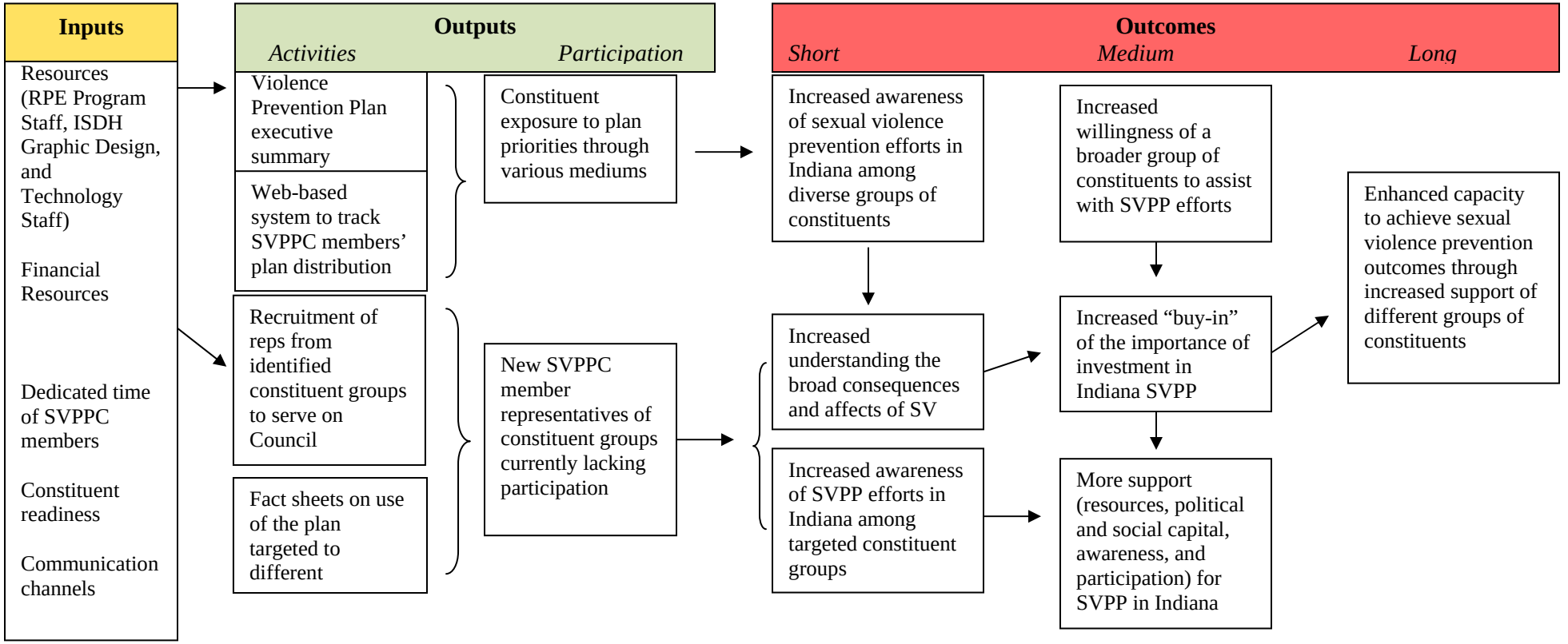
Strategies and Action Steps (Outcomes 1-3)

- *Create, design, and publish executive summary of plan for marketing purposes.*
- *Develop a system to track Sexual Violence Primary Prevention Council members' distribution of the plan and executive summary.*
- *Offer and publicize opportunities for interested constituents to speak with designated Council members about the state plan.*
- *Appoint 1-2 Council member(s) to be responsible for creating and distributing targeted fact sheets to each mentioned group of constituents.*

- *Appoint 1 Council member to recruit at least one representative from each mentioned group of constituents to serve on the Council.*

Logic Model: Goal #1

Goal Statement: To facilitate stakeholder awareness of and participation in the implementation of the Indiana Sexual Violence Prevention Plan.
Population: Indiana Constituents and Stakeholders in Sexual Violence Primary Prevention



Assumptions

Willingness of constituents to participate in SVPP efforts
Active participation of SVPP Council members

External Factors

Economic constraints on time and resources
Political and social climate

Goal #2: To build and strengthen capacity to prevent sexual violence in Indiana.

Outcome 1: By November 2011, the Sexual Violence Primary Prevention Council will produce a policy brief on the state of sexual violence laws and policies and economic impact in Indiana. *Lead agency: Indiana State Department of Health*

Strategies and Action Steps

- *Seek out a reputable expert or organization, unaffiliated with the Sexual Violence Primary Prevention Council, to research and write the policy brief.*
- *Provide the chosen individual or organization with background information and contacts needed for research and assist when needed during the research process.*
- *Plan a distribution strategy for the findings of the policy brief.*
- *Share appropriate pieces of information and data with relevant groups, including policymakers and businesses.*
- *Determine further steps based on data and information in the brief.*

Outcome 2: By June 2013, the Sexual Violence Primary Prevention Council will identify an additional $250,000 dedicated to state and local primary prevention initiatives. *Lead organization: Indiana Coalition Against Sexual Assault*

Strategies and Action Steps

- *Collaborate with state government staff to leverage existing resources to support state and community-level sexual violence primary prevention efforts.*
- *Allocate a portion of funds generated from the INCASA license plate to primary prevention programs.*
- *Use data and research to petition the private sector (corporate sponsors and foundations) to invest in prevention.*
- *Provide resources to community programs to help them solicit support from local businesses, foundations, and individuals.*
- *Develop a mechanism to track additional prevention funding.*

Outcome 3: By December 2013, at least one youth/family-serving organization with a statewide network will train local affiliates on implementation of a youth and parent/caregiver-specific sexual violence prevention/healthy relationships program. *Lead organization: Indiana Coalition Against Sexual Assault*

Strategies and Action Steps

- *Designate the Sexual Violence Primary Prevention Council member representing youth and family-serving organizations to approach several potential state-level youth and family-serving organizations to collaborate on the project.*
- *Designate the curriculum or comprehensive program to disseminate.*
- *Train state-level staff on curriculum/program implementation.*

- *Allocate resources for training local affiliates of the youth and family-serving organization.*
- *Develop an evaluation system to assess the extent of the use of the curriculum/program among local affiliates.*

Outcome 4: By December 2013, the state coalition, the Indiana State Department of Health, and the Indiana Department of Education will assess a minimum of four public school corporations' current curriculums and policies targeting risk factors for and protective factors against sexual violence. *Lead organization: Indiana Coalition Against Sexual Assault*

Outcome 5: By July 2014, the abovementioned partners will create a plan to advance the inclusion of sexual violence prevention/healthy relationships messages and activities into existing curriculums and programs in public school corporations in Indiana. *Lead organization: Indiana Coalition Against Sexual Assault*

Strategies and Action Steps (Outcomes 4 and 5):

- *Ensure Indiana Department of Education representation on the Sexual Violence Primary Prevention Council.*
- *Allocate funds for assessment and partner with a research entity to design and conduct assessment tool.*
- *Work with research entity to design a method for sample selection.*
- *Share and interpret findings from assessment.*
- *Engage stakeholders, including representatives from local school corporations, to research other states' and communities' collaborations with school corporations and prepare recommendations on what to adopt in Indiana.*
- *Present findings to decision-makers.*

Outcome 6: Thirty percent of Indiana colleges and universities will have engaged in sexual violence primary prevention programming that incorporates at least 4 of the following comprehensive programming approaches: male involvement, bystander intervention, social marketing, policy analysis, coalition-building, and data collection by June 2015. *Lead initiative: Indiana Campus Sexual Assault Primary Prevention Project*

Strategies and Action Steps

- *Build upon existing sexual violence prevention infrastructure among colleges and universities in Indiana.*
- *Continue to promote resources and technical assistance related to the six current components of comprehensive campus programming.*
- *Maintain knowledge of current research and trends in the abovementioned components and adapt resources and technical assistance accordingly.*
- *Enhance state-level support for data collection on college campuses.*

Outcome 7: By December 2015, the state coalition and the Indiana State Department of Health will complete a formal assessment of existing workplace sexual harassment and

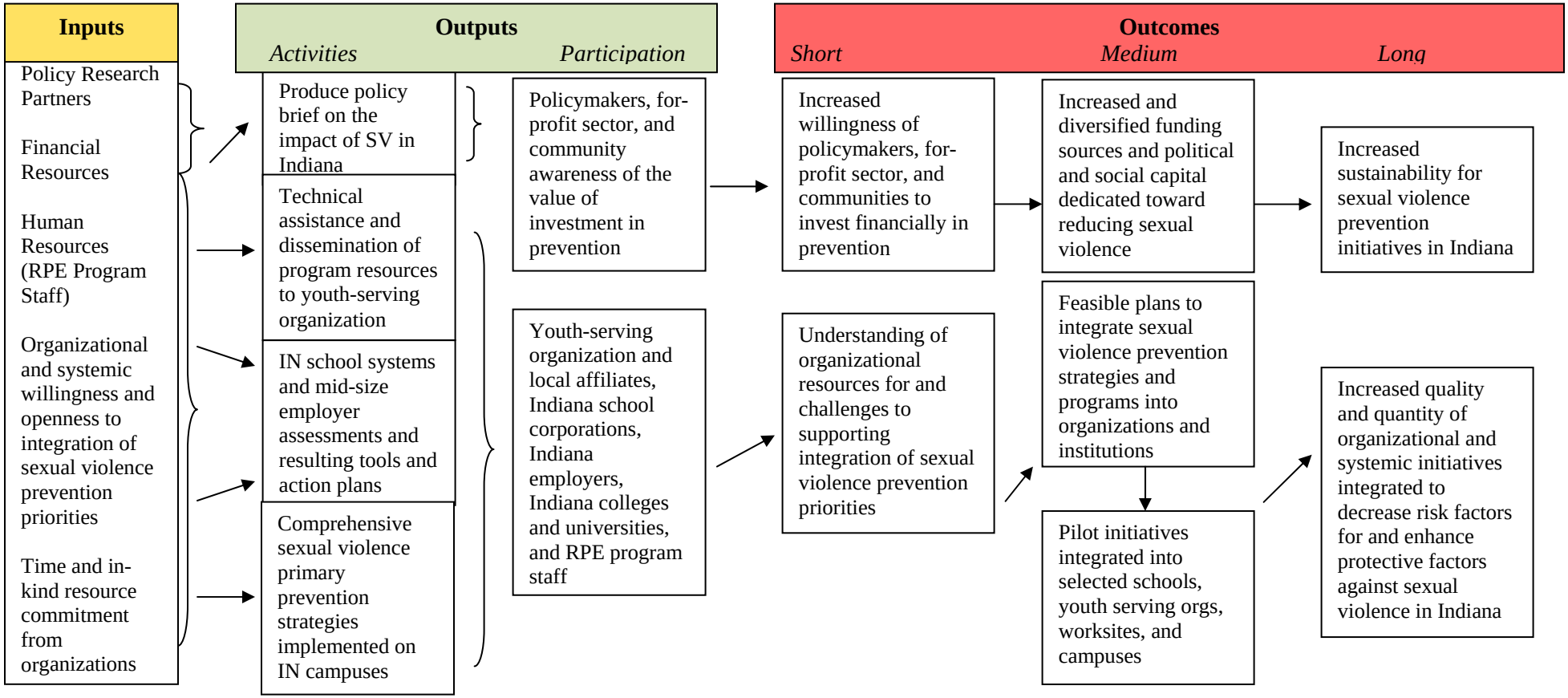
assault prevention approaches among at least three mid-size Indiana employers (1,000 or more employees) and offer tools and recommendations for enhancing those approaches.
Lead organization: Indiana Coalition Against Sexual Assault

Strategies and Action Steps

- *Ensure representation of the for-profit business sector on the Sexual Violence Primary Prevention Council.*
- *Recruit several Human Resources representatives from mid-size Indiana employers to participate.*
- *Engage Sexual Violence Primary Prevention Council and experts in identifying appropriate assessment tool.*
- *Discuss appropriate methods of dissemination of assessment.*
- *Disseminate assessment through HR departments.*
- *Review and analyze findings.*
- *Prepare and disseminate modifiable recommendations for mid-size Indiana businesses to address workplace violence and harassment.*
- *Offer technical assistance on customized use of recommendations.*

Logic Model: Goal #2

Goal Statement: To build and strengthen capacity to prevent sexual violence in Indiana.
Population: Systems, organizations, and institutions in which Indiana citizens live and work.



Assumptions
Openness to integration of sexual violence prevention priorities in state and community-level policy and organizational culture

External Factors
Economic constraints on time and resources
Political, social, and organizational climate

Goal #3: To support communities in using evidence-informed strategies and programs for sexual violence primary prevention through technical assistance.

Outcome 1: In January 2010 and annually thereafter, the state coalition will survey sexual violence primary prevention programs to identify the most important technical assistance needs. *Lead organization: Indiana Coalition Against Sexual Assault*

Outcome 2: By August 2011 and annually thereafter, the state coalition will provide three interactive regional training opportunities addressing the top primary prevention technical assistance needs identified through the prior year's survey. *Lead organization: Indiana Coalition Against Sexual Assault*

Strategies and Action Steps (Outcomes 1 and 2):

- *Develop an effective method to survey community-based prevention programs to identify technical assistance needs based on state-level defined focus areas.*
- *Prioritize training and technical assistance needs on a yearly basis.*
- *Recruit technical assistance providers with appropriate expertise in the prioritized training areas.*
- *Plan three regional training opportunities yearly.*
- *Explore continuing education options through alternative learning methods, including webinars and mentoring systems.*
- *Systemically evaluate training and implement continuous quality improvement.*

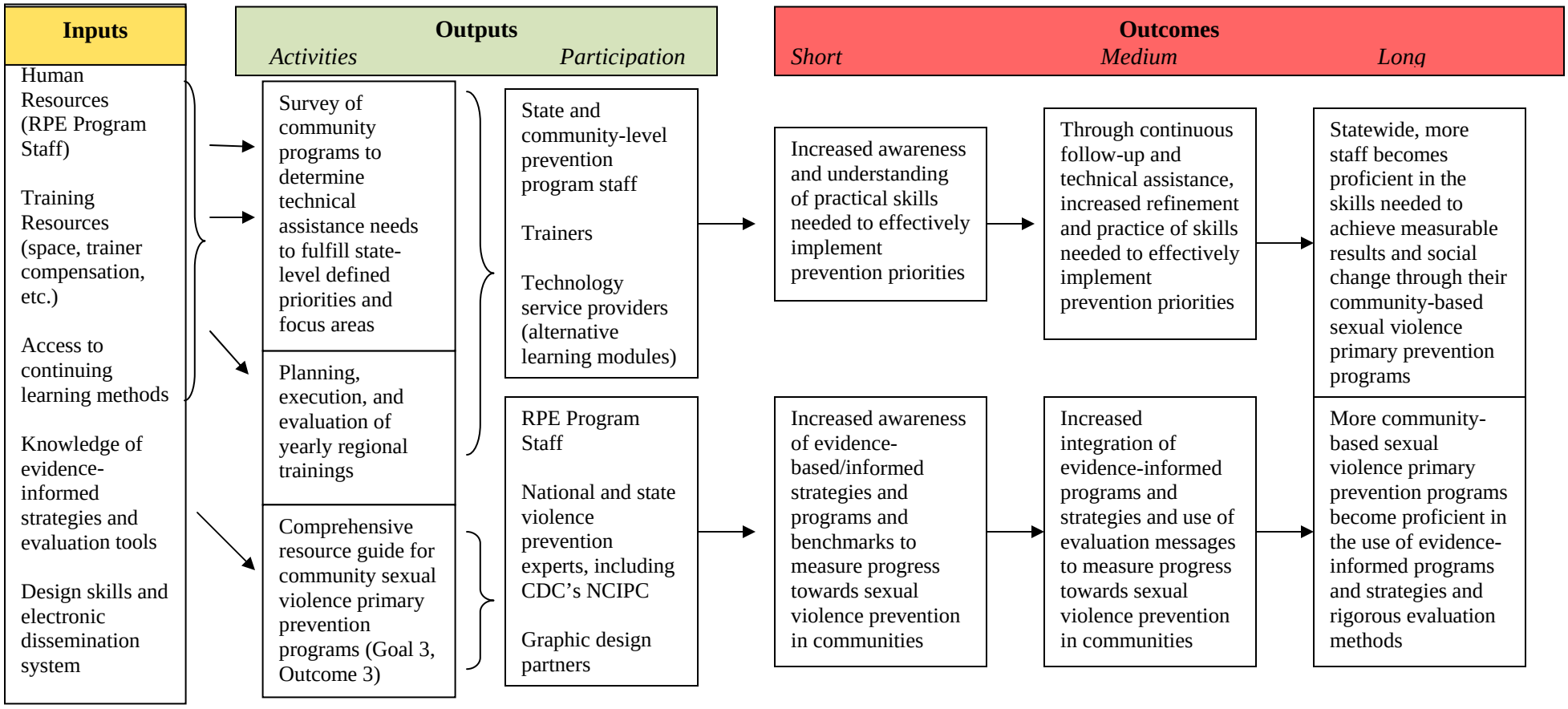
Outcome 3: By November 2013, the Sexual Violence Primary Prevention Council will develop and disseminate a comprehensive resource guide to communities to include evidence-informed curriculums, prevention strategies for youth and families, and research-based evaluation tools for sexual violence primary prevention programs, as well as examples of local model programs. *Lead organization: Indiana Coalition Against Sexual Assault*

Strategies and Action Steps

- *Review guidelines for effective programs and strategies and benchmarks of progress (for example, CDC's Indicators and Measures Project, Virginia's Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence) and determine which standards to use.*
- *Work with Centers for Disease Control and Prevention (CDC) and other national and state experts to identify programs, strategies, and curriculums that conform to the indicators, measures, and guidelines identified.*
- *Work with CDC and other national and state experts to identify research-based strategy and program evaluation tools.*
- *Design and compile a resource guide highlighting local implementation of model sexual violence primary prevention programs and evaluation tools.*
- *Disseminate resource guide to communities electronically and promote usage.*

Logic Model: Goal #3

Goal Statement: To support communities in using evidence-informed strategies and programs for sexual violence primary prevention through technical assistance.
Population: Indiana sexual violence primary prevention professionals and community-based program partners.



Assumptions
Ability of RPE program leadership to consistently guide focus areas for community programs
Willingness of community to adopt focus areas for technical assistance

External Factors
Availability of evidence-informed strategies and examples of model programs
Availability of trainers with needed expertise to fulfill technical assistance needs

Goal #4: To enhance social norms that promote sexual violence primary prevention.

Outcome 1: By July 2011, all Rape Prevention and Education community-based programs will identify social norms that contribute to sexual violence among males in their target populations through formal and informal assessment. *Lead organization: Indiana Coalition Against Sexual Assault*

Outcome 2: By November 2013, all RPE community-based programs will develop a custom plan to engage males in their target populations to modify the identified social norms that contribute to sexual violence. *Lead organization: Indiana Coalition Against Sexual Assault*

Strategies and Action Steps (Outcomes 1 and 2):

- *At the state level, set expectations for community-based programs priorities to assess social norms that contribute to sexual violence among males in their target populations*
- *At the state level, provide customized, on-site technical assistance in identifying social norms that may contribute to sexual violence among males in the target population (qualitative research techniques)*
- *Design a format for community-based programs to report their findings*
- *Provide a state-level framework for community-based programs to use in modeling their plans to address identified social norms*
- *Assist community-based programs in developing, implementing, and evaluating plans*

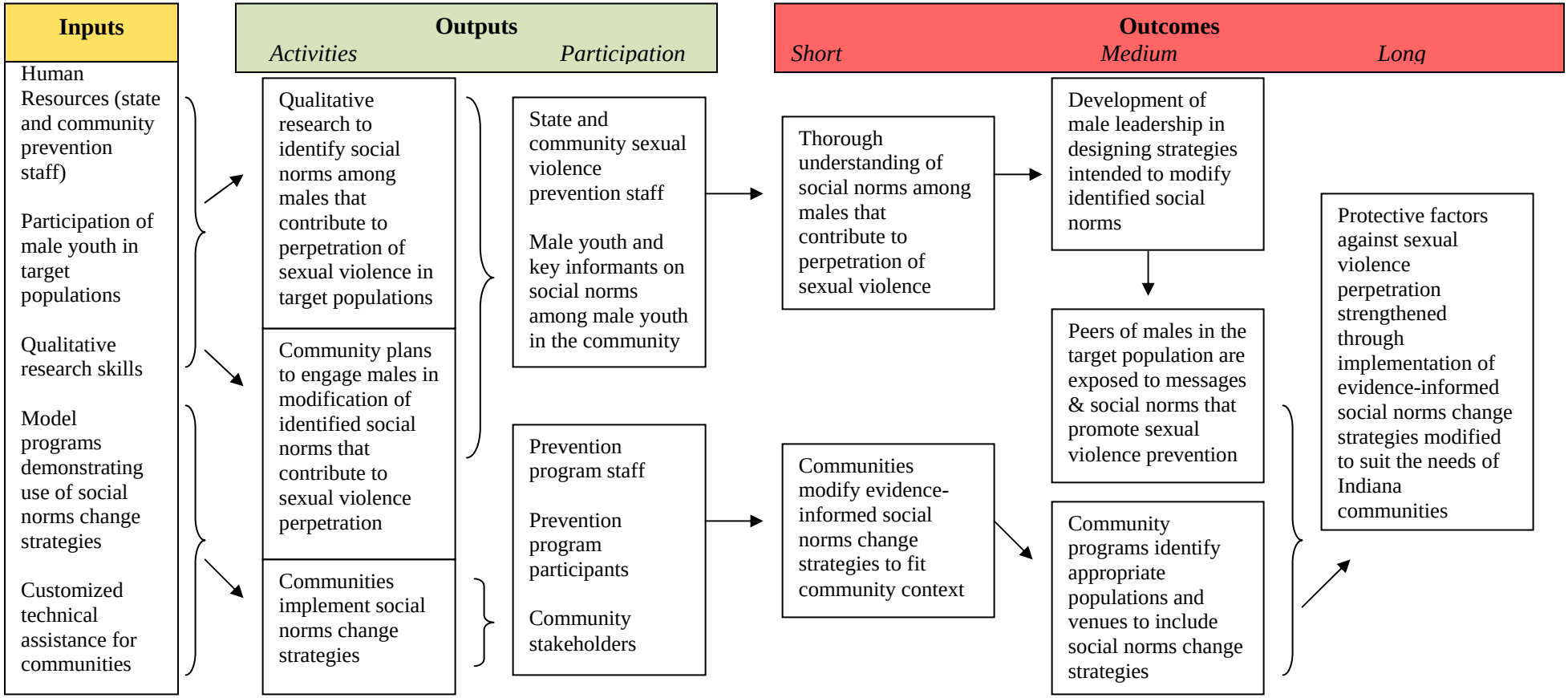
Outcome 3: By October 2014 and annually afterwards, all state and local RPE-funded partners will demonstrate inclusion of all of the following social norms change strategies into their sexual violence primary prevention initiatives: healthy relationships skill-building, bystander intervention, positive youth leadership development, and social marketing. *Lead organization: Indiana Coalition Against Sexual Assault*

Strategies and Action Steps

- *Set expectations for inclusion of the social norms change strategies mentioned into all RPE state and community-level programs*
- *Use the resource guide (mentioned in Goal 3) to highlight model programs that promote the strategies mentioned nationally and in Indiana*
- *Promote cultural competency in strategy inclusion for selected populations*
- *Include training and on-site technical assistance for the strategies mentioned in yearly training cycles*
- *Link state and community-level programs successfully implementing social norms change strategies and encourage resource-sharing*
- *Continue to promote evaluation strategies and usage of benchmarks/indictors of success*

Logic Model: Goal #4

Goal Statement: To enhance social norms that promote sexual violence primary prevention.
Population: Males, especially adolescent males, within the target populations of community-based sexual violence prevention programs.



Assumptions
Willingness and cooperation of male youth to participate in prevention
Sufficient resources and support for RPE community-based programs to use social norms change strategies

External Factors
Competing community priorities
Challenges of engendering youth leadership

Goal #5: To ensure the inclusion of priority populations in state and local sexual violence primary prevention efforts.

Outcome 1: By November 2012, a quantitative and qualitative statewide assessment will be completed to identify disparately impacted populations not reached through mainstream sexual violence primary prevention efforts. *Lead initiative: Multicultural Efforts to End Sexual Assault*

Strategies and Action Steps

- *Develop and/or identify quantitative and qualitative assessment criteria to be applied to different populations assessed*
- *Define "priority" to explain rationale behind selecting certain populations(for example, "historically oppressed"/ "limited resources or access to resources" in combination with magnitude of the population in Indiana, the magnitude of sexual violence in the population, and availability of appropriate prevention strategies/programs available to populations)*
- *Assemble a multidisciplinary assessment team*
- *Gather quantitative and qualitative data through appropriate avenues (quantitative data sets, surveys, focus groups, key informant interviews)*
- *Analyze and report quantitative and qualitative data in a position paper justifying a special focus on identified priority populations.*

Outcome 2: By November 2013, all Rape Prevention and Education-funded projects will receive training and ongoing technical assistance in tailored sexual violence primary prevention strategies for at least one identified priority population. *Lead initiative: Multicultural Efforts to End Sexual Assault*

Strategies and Action Steps

- *Assess capacity of each RPE-funded project to meet needs of identified priority populations and skill sets needed by projects to effectively reach out to priority populations*
- *Recruit appropriate trainers and collaborate with regional training series to integrate modules*
- *Evaluate training and provide ongoing technical assistance to projects on appropriate strategies for reaching priority populations.*

Outcome 3: By November 2014, leadership will be established and sexual violence prevention-focused infrastructure development will be initiated in at least three of the identified priority populations. *Lead initiative: Multicultural Efforts to End Sexual Assault*

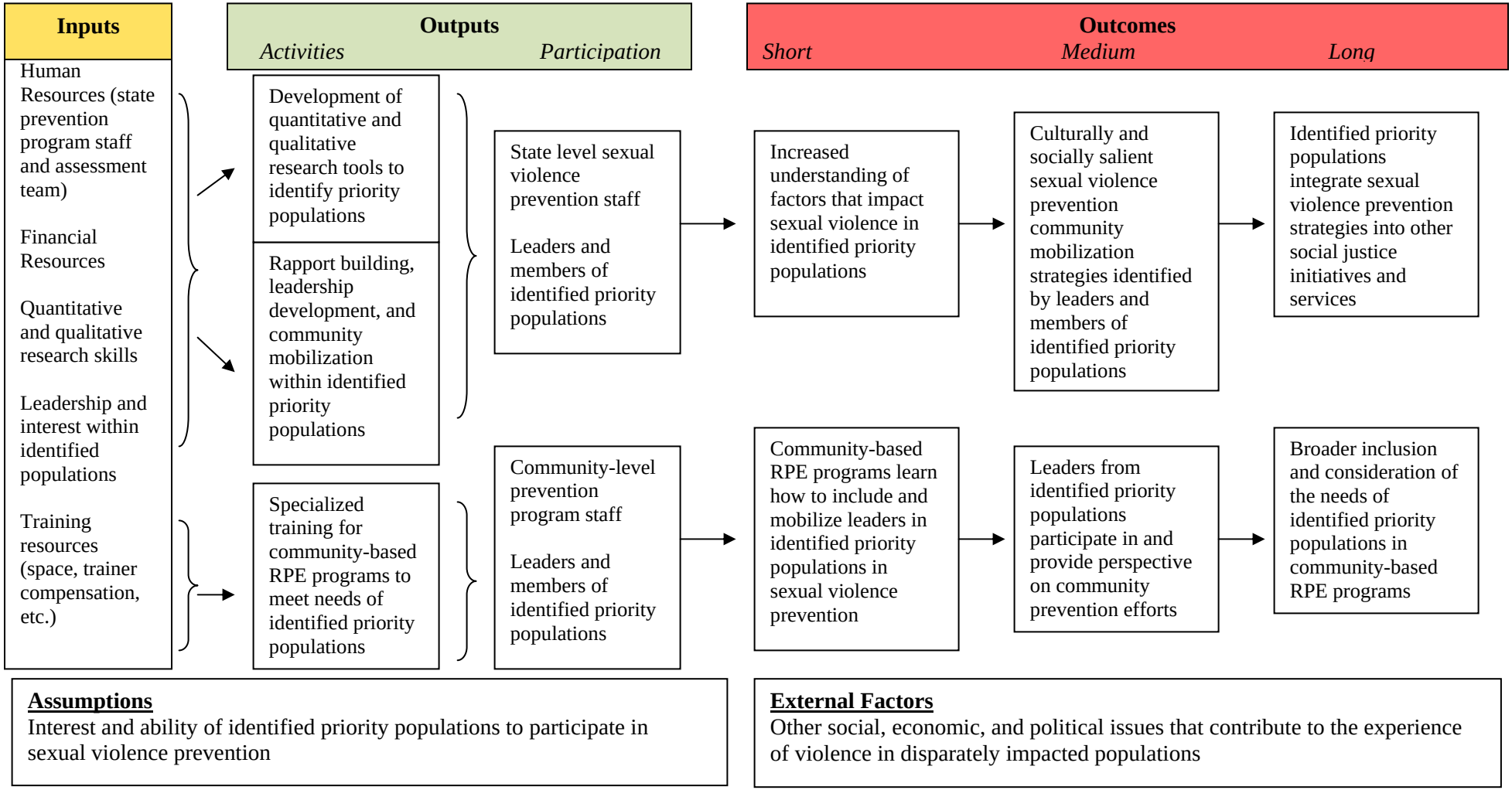
Strategies and Action Steps

- *Identify organizations that serve identified priority populations.*

- *Identify key stakeholders within those organizations.*
- *Prioritize rapport development with organizations, communities, and stakeholders.*
- *Train stakeholders on community organizing and mobilization.*
- *Identify/establish leadership opportunities within the community.*
- *Plan with community leaders to initiate at least one culturally salient sexual violence primary prevention strategy in their community.*

Logic Model: Goal #5

Goal Statement: To ensure the inclusion of priority populations in state and local sexual violence primary prevention efforts.
Population: Populations and communities in Indiana that are disparately impacted by sexual violence and currently are not reached through mainstream sexual violence primary prevention efforts.



Goal #6: To enhance sexual violence data collection, analysis, and sharing.

Outcome 1: By December 2010, the Indiana State Department of Health will establish baseline lifetime sexual violence prevalence data in Indiana based on data collected during the 2009 Behavioral Risk Factor Surveillance System (BRFSS). *Lead agency: Indiana State Department of Health*

Strategies and Action Steps

- *Work with epidemiologists to analyze, interpret and disseminate data.*
- *Evaluate priorities based on data.*

Outcome 2: By August 2010, the Indiana State Department of Health will explore possibilities and present recommendations for expanding epidemiological support around sexual violence. *Lead agency: Indiana State Department of Health*

Strategies and Action Steps

- *Explore short and long-term solutions to fulfillment of epidemiological needs, including: volunteer and student epidemiological support or a part-time contract position.*
- *Take steps necessary to secure assistance.*
- *Outline a work plan and specific tasks for epidemiologist.*
- *Ensure sustainability for support through Rape Prevention and Education funding.*

Outcome 3: In 2010 and annually thereafter, the Indiana State Department of Health will continually monitor and, to the extent possible, participate in existing and/or emerging sexual violence prevalence data collection systems to maintain knowledge of prevalence. *Lead agency: Indiana State Department of Health*

Strategies and Action Steps

- *Monitor national data collection initiatives and strategically assess the extent and feasibility of Indiana's participation.*
- *Participate in national data collection initiatives as resources and priorities allow.*
- *Identify and connect with organizations and service providers that have access to significant sexual violence incidence data.*
- *Develop, evaluate, and modify data sharing and usage strategies.*

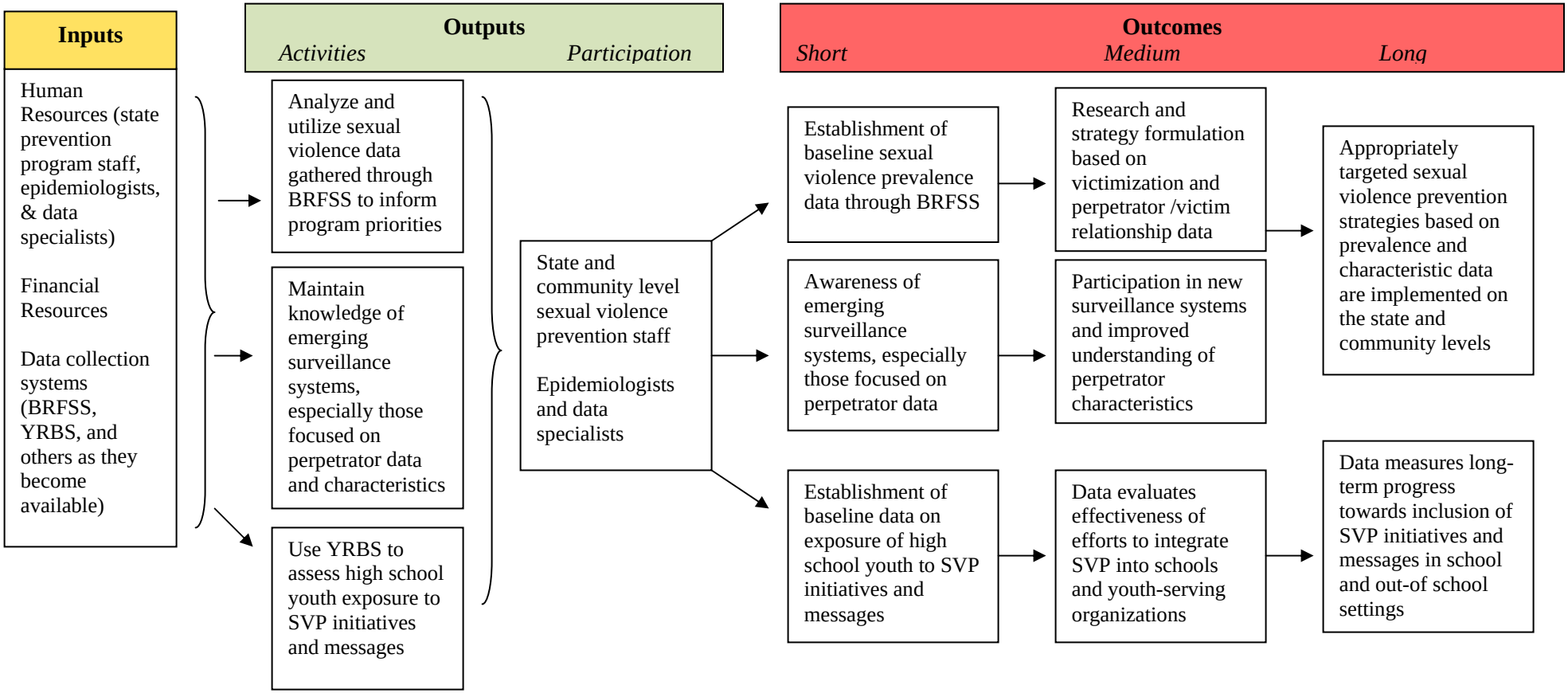
Outcome 4: In 2011 and biannually thereafter, the Indiana State Department of Health will include a question in the YRBS (Youth Risk Behavioral Survey) to assess the exposure of Indiana youth to sexual violence prevention and healthy relationships programs. *Lead agency: Indiana State Department of Health*

Strategies and Action Steps

- *Budget for question inclusion in the Youth Risk Behavioral Survey for 2011, 2013, and 2015.*
- *Justify the need for module inclusion to ISDH and Department of Education stakeholders.*
- *Issue Youth Risk Behavioral Survey biannually.*
- *Receive, disseminate, and use data to evaluate the extent to which youth are exposed to sexual violence prevention and healthy relationships methods and programs*

Logic Model: Goal #6

Goal Statement: To enhance sexual violence data collection, analysis, and sharing.
Population: Indiana's sexual violence prevention system and prevention professionals.



Assumptions
Continued technical assistance and leadership on data collection efforts from the Centers for Disease Control and Prevention

External Factors
Inherent limitations of all data collection systems

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

Goal Rationale and Needs Statements

Goal #1: To facilitate stakeholder awareness of and participation in the implementation of the Indiana sexual violence primary prevention plan.

Rationale/Needs Statement: In order for the Indiana Sexual Violence Primary Prevention Plan to truly make an impact in all of the various settings, organizations, and institutions targeted in subsequent goals of the plan, there must be an army of representatives from these groups to support it. These representatives must truly believe in the value of and need for investment into sexual violence prevention, and understand that their sectors can be used as a catalyst for social change.

Subsequent goals and outcome statements specifically target state-level policy, the schools systems and the Department of Education, the for-profit sector, and others. Some of the sectors mentioned in the goal are already integrally involved in plan development and implementation, but additional support and capacity can only improve the reach and impact of the plan. Through direct involvement of representatives from the sectors mentioned on the Sexual Violence Primary Prevention Council, as well as supplementary follow-up through personal conversations and easily accessible resources related to the plan, the Council will facilitate a broader cross-section of stakeholders represented in the plan. In turn, stakeholders will assist in opening doors and accomplishing plan outcomes.

Goal #2: To build and strengthen capacity to prevent sexual violence in Indiana.

Rationale/Needs Statement: The effectiveness of prevention efforts depends upon the existence of systemic and organizational support of violence prevention priorities. Because the risk factors for and protective factors against sexual violence can be impacted in the context of the many formal and informal organizations and systems in which people live their everyday lives, prevention professionals and service providers must engage these systems and build their capacity to support prevention.

Specifically:

- During the qualitative community-based data collection process, many forum participants emphasized that legislative and organizational policies designed to promote environments that foster healthy relationships are essential in laying the foundation for broad-based prevention efforts. The social ecological model, which shows that the societal/government level shapes the context of other levels of influence on people's lives, supports this data. Therefore, prevention practitioners should educate policymakers and stakeholders about the enormous economic, health and social impact of sexual violence on Indiana's population, and work to build financial and political support to make prevention a priority.

- Professionals identified insufficient funding for primary prevention as a major barrier to implementing comprehensive, evidence-informed initiatives and rigorous evaluation. Strengthening the funding arm of the prevention system must be a priority in the plan. Financial support for prevention cannot be entirely derived from government funding. Communities must continue to build their own networks of investment.
- The qualitative data collection process revealed many forum participants' belief that school systems are highly influential on youth behavior and development. While school systems and corporations cannot be the only avenue for reaching youth with prevention programs and messages, they do provide daily structure and focus for the majority of Indiana's children and young adults. Therefore, the Council and practitioners must understand the environment of and efforts in primary and secondary schools to target risk factors for and protective factors against sexual violence and strategize to enhance programs and messages delivered. Some Rape Prevention and Education community-based prevention programs are very involved in the corresponding local school systems, but on a state level, there is a lack of understanding and standardization of what is required and implemented.
- Youth spend a significant amount of time in school and are influenced by their school environment, but they also live with their families and are influenced by other organizational settings. In an effort to reach youth and their families outside of school with prevention programs and messages, youth and family-serving organizations are included in this goal.
- National data reveals that the risk of perpetrating or experiencing sexual violence among the college population is very high. The qualitative data collection process also revealed unique risk and protective factors among the college-aged population. As another system in which many young adults come to full maturity, there are many opportunities to foster healthy relationship development and influence beliefs, attitudes, and behaviors. A successful and long-standing comprehensive campus initiative (Indiana Campus Sexual Assault Primary Prevention Project) has existed for twelve years in Indiana, and will continue to expand its reach through this goal.
- Adults spend much of their time in another "system"—the workplace. There are many opportunities to improve a comprehensive approach to workplace violence and harassment and market tools and resources, but there is little knowledge of the extent of policies and programs that already exist among mid-size Indiana employers. Learning what exists and building upon existing successes will help advance prevention as a priority in workplaces.

Goal #3: To support communities in using evidence-informed strategies and programs for sexual violence primary prevention through technical assistance.

Rationale/Needs Statement: This goal encompasses several different concepts: increasing community efficacy to prevent sexual violence (identified as a protective factor in the literature and reinforced throughout the qualitative data collection process), assisting community-based programs in using the best evidence available to shape their

prevention programs, customization and tailoring of technical assistance to better meet practitioners' needs, and raising standards for program evaluation.

Specifically:

- Many forum participants in the qualitative data collection process, specifically, community-based practitioners and service providers, believed that community-based prevention programs and prevention-focused coalitions have the power to enhance protective factors against sexual violence perpetration and victimization. Capitalizing upon community resources and coalitions and enhancing effectiveness through training and technical assistance will be an effective way to ensure progress toward prevention.
- Professionals identified a lack of understanding of how to comprehensively implement evidence-based prevention strategies and programs as a barrier to measuring progress toward social change. As representatives of state-level entities that have access to the latest information and research about evidence-based approaches, the SVPPC should provide this framework.
- Professionals and Council members emphasized a need for training and technical assistance in creating and recognizing benchmarks for true social change. Demonstration of outcomes leads to continued momentum and sustainability of prevention initiatives. Indiana will look to the CDC's Indicators and Measures Project for guidance.
- With the recognition that resources are limited, alternative training and technical assistance methods will be explored, such as site visits, mentoring systems, and online learning.

Goal #4: To enhance social norms that promote sexual violence primary prevention.

Rationale/Needs Statement: Sociologists have defined social norms as the formal and informal rules that a group of people uses for appropriate and inappropriate values, beliefs, attitudes, and behaviors. Social norms can be implicit or explicit, and encourage positive or negative behavior. During the qualitative data collection process, including the public forums and focus groups with selected populations, participants identified social norms that they believe contribute to occurrence of sexual violence in their communities. Examples of social norms identified include: cultural and social expectations that implicitly condone sexual entitlement for males, a lack of feeling responsibility to intervene in situations, what types of crimes are ignored versus what types are prosecuted in communities, what types of problems are acceptable to discuss outside of the family and what types are not, and unspoken expectations of relationships between young men and women. Each community experiences different institutional and social norms that can be risk factors for sexual violence.

This goal aims to promote positive change in values and beliefs that were identified as encouraging sexual violence. Because different groups cited different social norms based on cultural, institutional, social and community context during the qualitative data

collection process, the SVPPC felt that it would be impossible to universally define the exact social norms to be addressed for each community. Instead, the outcome statements under this goal require communities to conduct their own qualitative data collection processes to identify social norms that may encourage sexual violence within their own populations. Then, communities will be asked to create an action plan to modify those social norms through strategies of healthy relationships skill-building, bystander intervention, positive youth development, and social marketing through appropriate organizations and venues.

Note: *The focus of this goal is identifying and addressing social norms among males that contribute to sexual violence. This is not meant to imply that women cannot be perpetrators of sexual violence. Women can and do commit acts of sexual violence. However, national and state data shows that men are the primary perpetrators of sexual violence. Because there is a more limited understanding of female perpetrators in Indiana and less capability to address the problem, the focus for the period of this state plan will be to address social norms among males. As awareness and understanding of female perpetrators increases, Indiana will be better positioned to explore social norms that contribute to sexual violence perpetration among females.*

Goal #5: To ensure the inclusion of priority populations in state and local sexual violence primary prevention efforts.

Rationale/Needs Statement: Throughout the history of sexual violence prevention efforts in Indiana, several populations have been engaged in prevention efforts through culturally compelling strategies that served their unique needs, most notably the migrant farm workers and the American Indian and Tribal population. Over the years, a strong rapport has developed between project staff and key stakeholders. Although the populations mentioned do experience unique and heightened risk factors for sexual violence perpetration and victimization, they represent a relatively small proportion of Indiana's population. Work with these selected populations was based on the expertise and connections of project staff.

Indiana's population dynamic is changing rapidly. There are many other culturally and socially diverse populations in Indiana that are disparately or differently impacted by sexual violence—including but not limited to different communities within the Latino population (5% of Indiana's population identifies as Hispanic or Latino, and growth is projected), African-American communities, the Mennonite faith community in rural northern and southern areas of the state, different immigrant neighborhoods and communities concentrated in the northeastern part of the state, people of diverse sexual orientation, developmentally disabled people, homeless people, and others who may not yet have been identified. It must be a priority to consciously consider the needs of these communities in state-level prevention efforts.

Different populations experience sexual violence differently, and prevention solutions must ultimately be generated and executed by the community the problem affects. In recognition of the fact that engagement of this nature requires significant time and

resources, the fifth goal calls for a strategic assessment of disparately impacted populations currently not being reached by mainstream primary prevention efforts, and subsequent leadership development to address sexual violence prevention in three of the prioritized populations.

Goal #6: To enhance sexual violence data collection, analysis, and sharing.

Rationale/Needs Statement: Reliable and accurate data informs the development of any effective public health intervention. It is the basis of knowing where to focus efforts, as well as a tool that can be used to garner support from policymakers and the general public. Data gathered for evaluative purposes also measures the effectiveness of prevention interventions. Enhancing Indiana's capacity for better sexual violence data collection, usage, and sharing is absolutely essential to increase understanding of sexual violence and prevention solutions.

Current data collection, analysis, and sharing systems in Indiana are insufficient for the purposes of pinpointing priority populations and assessing the impact of prevention efforts. Therefore:

- The Indiana State Department of Health (ISDH) will explore possibilities to expand epidemiological support for sexual violence.
- The ISDH will improve its knowledge of sexual violence prevalence among adult males and females through the Behavioral Risk Factor Surveillance System (BRFSS).
- The ISDH will maintain knowledge of and take steps to participate in the latest and most accurate methods of sexual violence data collection (for example, the National Intimate Partner Violence and Sexual Violence Surveillance System). Even the best data collection systems currently available do not offer enough insight into the dynamics of perpetration. Additionally, a lack of uniform definitions for different types of sexual violence poses problems for trend analysis and comparison. Nationally, top public health officials recognize these issues and are working to address them. Maintaining current knowledge of initiatives on the national level will assist Indiana in acquiring better data for program design and evaluation.
- The ISDH will collaborate with groups who hold reported incidence of sexual violence data to determine how to better share and interpret it.
- The ISDH will assess exposure of Indiana youth to sexual violence prevention and healthy relationship messages and initiatives (both in-school and out-of-school) through the Youth Risk Behavior Survey. Resulting data will help to evaluate progress towards inclusion of sexual violence prevention and healthy relationships messages and initiatives within both in-school and out-of-school curriculums and programs.

Conclusion

This section describes the rationale behind each goal as a priority in the state plan. Additional sections lay out the Centers for Disease Control and Prevention's scientific framework for sexual violence prevention, describe 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.

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

Background of Indiana's Planning Process and Needs and Resources Assessment Summaries

A. Context of the Planning Process

At the beginning of Year Two (December 2007) of Indiana's Sexual Violence Prevention and Education Cooperative Agreement with the Centers for Disease Control and Prevention, the Indiana State Department of Health (ISDH) faced two main tasks:

- To demonstrate leadership in the public health approach to sexual violence primary prevention; and
- To organize a statewide coalition around sexual violence primary prevention for the purpose of developing and implementing a state plan.

The Indiana Sexual Violence Primary Prevention Council convened for the first time in December 2007. Over the next year, Council members became acquainted with one another, learned how their work and the work of their colleagues aligned with preventing sexual violence, identified additional partners to bring to the table, and developed a common understanding of primary prevention of sexual violence. By bringing sexual violence prevention to the forefront as a public health issue, the ISDH was able to facilitate discussion around the importance of dedicating resources to primary prevention. The group agreed that it would be necessary to learn about the state of sexual violence in Indiana before formulating a prevention plan, and that a needs and resources assessment would be in order as the first step of the state planning process.

The Council used Step 1 (Needs and Resources Assessment) and Step 2 (Goals and Outcomes) of *Getting to Outcomes* (GTO), the CDC-recommended planning tool, to help guide the planning process. Although some of the recommendations provided in the first two steps of GTO were not applicable to Indiana's planning process, GTO provided a useful framework for the state plan. The Council also used some of the principles included in Step 3 (Selection of Evidence-Informed Strategies), Step 4 (Strategy Adaptation for State/Community Context), and Step 5 (Capacity Building for Strategy Implementation) to identify and contextualize state-level strategies to accomplish the identified outcomes.

Many Council members were involved from the very beginning and have actively assisted with the needs and resources assessment and with the formulation of the goals, outcomes, and strategies for the plan. Other Council members have been involved only briefly or on an "ad hoc" basis due to staff turnover, competing priorities, or the timeframe at which they became involved with plan development. As the ISDH oversees the implementation of the state plan, Council leadership will continually assess its

makeup to ensure appropriate representation from major stakeholders. Additionally, the Council will be restructured during the implementation phase to ensure that needed resources and expertise are allocated to accomplish the goals of the plan. (See Appendix A for acknowledgement of Council members).

B. The Needs and Resources Assessment Summaries

The Rape Prevention and Education Program Director led the needs and resources assessment in partnership with the Sexual Violence Primary Prevention Council and many other state and community-level stakeholders. The Council completed the majority of the work of the needs and resources assessment between September 2008 and April 2009.

Going through the needs and resources assessment process served the purpose of increasing stakeholders' involvement and analyzing quantitative and qualitative data about the dynamics of sexual violence in Indiana. The needs and resources assessment is comprised of six distinct components:

- Demographic and economic data;
- Current sexual violence primary prevention efforts in Indiana;
- Indiana sexual violence magnitude data/Data and surveillance assessment;
- Qualitative risk and protective factor data from Indiana citizens and professionals;
- Focus groups with selected populations; and
- Prevention system capacity assessments.

A very brief summary of each component and its findings is given below. (See plan appendices B through H2 referenced in the descriptions below for in-depth detail of the assessments' findings.)

B-1) Demographic and Economic Data[1]

The first step of the needs and resources assessment was to gather demographic and economic data for the state and for its eleven Economic Growth Regions, as defined by the Indiana Department of Workforce Development. Because research has shown that certain demographic and economic variables can serve as risk factors for or protective factors against being a perpetrator or a victim of sexual violence, the Centers for Disease Control recommended collecting this data to create a basic understanding of broad contextual factors in the state.

Indiana population data assisted in identifying certain age groups that should be addressed for sexual violence prevention efforts. More than a quarter of Indiana's population (34.5%) is between the ages of 0-24. Twenty-seven percent of the population

[1] Demographic and economic data obtained from the U.S. Census Bureau, U.S. Bureau of Economic Analysis, the Indiana Business Research Center, the Indiana Department of Education, the Indiana Family and Social Services Agency, and the Indiana Department of Workforce Development.

is classified as young adults (25-44 years). Older adults (45-64 years) comprise 26% of the population, and adults over 65 make up the remainder (12.5%). Youth are at greater risk for sexual violence than the general population, and violence prevention strategies are most effective when implemented over the lifespan, beginning at a young age when core beliefs and values are being formed. Therefore, youth are a priority population of Indiana's sexual violence prevention state plan. This is reflected in the outcome statements focusing on working through systems that serve youth: K-12 schools, youth and family-serving organizations, and colleges and universities.

Indiana's population has become more racially and ethnically diverse over the years. An expanded focus on culturally appropriate prevention strategies is necessary to better serve the Hispanic and Latino demographic (5% of the current population, and projected to grow in the future with the changing immigration and economic dynamics in the state). Additionally, 9% of Indiana's total population identifies as Black or African-American. This percentage is significantly higher in the urban regions of the state: 17.1% in Economic Growth Region 1 (includes Lake County) and 14.6% in Economic Growth Region 5 (includes Marion County).

The national economic conditions of the past two years have adversely affected every state's economy, and Indiana is no exception. The Centers for Disease Control and Prevention (CDC) has identified a lack of employment opportunities and poverty as risk factors for sexual violence perpetration. As is the case with every other state, the current economic recession has deeply impacted Indiana's unemployment rate. In January 2008, Indiana's seasonally adjusted unemployment rate was 5%; in January 2009, the unemployment rate had almost doubled to reach 9%. It will be important to recognize that psychological stress, financial hardship, and poverty can contribute to a host of social problems, including increased risk for sexual violence.

(See Appendix B for a detailed breakdown of state and regional demographic and economic data and noted influential contextual circumstances in Indiana.)

B-2) Current Sexual Violence Primary Prevention Efforts in Indiana

Another crucial step of the needs and resources assessment was to assess the quantity and quality of sexual violence primary prevention programming in Indiana. There are four agencies/organizations/initiatives whose efforts make up the state-level sexual violence primary prevention efforts in Indiana:

- Indiana State Department of Health (ISDH);
- Indiana Coalition Against Sexual Assault (INCASA);
- Multicultural Efforts to End Sexual Assault (MESA); and
- Indiana Campus Sexual Assault Primary Prevention Project (INCSAPPP).

The partners listed above will work to strengthen collaboration and coordination efforts with additional partners over the course of the plan. They will also be charged with ensuring program sustainability at state and community levels.

Indiana State Department of Health (ISDH)

The Indiana State Department of Health (ISDH) provides statewide leadership in the public health approach to sexual violence prevention. Several outcomes of the state plan are designed to maintain the ISDH's commitment to prevention efforts in Indiana: coordinating and managing the work of the Sexual Violence Primary Prevention Council, providing guidance on program and strategy implementation, informing policymakers, and cultivating state-level strategic partnerships that are critical to accomplishing many outcomes in the state plan.

Indiana Coalition Against Sexual Assault (INCASA)

The Indiana Coalition Against Sexual Assault (INCASA), serves four primary functions for statewide sexual violence primary prevention efforts: 1) Distributing funding to communities implementing primary prevention programs (thirteen community-based programs in 2010); 2) Providing professional training and technical assistance to providers; 3) Formulating and disseminating Indiana's sexual violence prevention social marketing campaign; and 4) Providing statewide leadership and support in engaging men to prevent sexual violence at the state level and in communities. INCASA serves as a primary prevention resource both for communities that receive CDC Cooperative Agreement funding and those who do not.

INCASA will take a leadership position on the majority of the outcomes for the state plan, including those set forth to build capacity to prevent sexual violence in various sectors, increasing the quality of technical assistance provided to communities, and supporting community and state-level efforts to engage men in the work of preventing sexual violence.

(See Appendix C for additional description of INCASA's work.)

Multicultural Efforts to End Sexual Assault (MESA)

Multicultural Efforts to End Sexual Violence (MESA) prioritizes engaging non-mainstream, marginalized populations in sexual violence prevention through a culturally appropriate framework. Currently, the demographics primarily served are Indiana's migrant farm workers and American Indian populations.

MESA has built a strong rapport with the special populations it has served over the years. These populations were chosen based on the expertise and connections of the MESA staff. The rationale behind the fifth goal of the state plan is to conduct further research to determine which selected populations are not included in mainstream sexual violence primary prevention efforts and prioritize leadership in violence prevention in those communities.

Indiana Campus Sexual Assault Primary Prevention Project (INCSAPPP)

The Indiana Campus Sexual Assault Primary Prevention Project (INCSAPPP) offers sexual violence primary prevention technical assistance to all Indiana campuses and mini-grants and specialized training to certain campuses working on one or more of the INCSAPPP's six components of comprehensive programming: social marketing, male involvement, bystander intervention, policy analysis, data collection, and coalition building.

The Indiana Campus Sexual Assault Primary Prevention Project has cultivated long-standing, strong relationships with many colleges and universities in Indiana. Five campuses have been designated "model campuses," working simultaneously on all six components. Others are focusing on one or more components. This model has worked well, and the state plan includes an outcome dedicated to increasing the percentage of Indiana's campuses that incorporate at least four of the six comprehensive approaches.

B-3) Indiana Sexual Violence Magnitude Data/ Data and Surveillance Assessment

An assessment of the magnitude, prevalence, and occurrence of sexual violence in Indiana's population was also necessary to gauge the true impact of the problem. Unfortunately, in Indiana as well as nationally, the true magnitude and impact of sexual violence on the population is difficult to assess because of fragmented data collection systems and under-reporting of sexual violence crimes.

Indiana is one of only three states that lack a centralized state crime data collection program certified by the Federal Bureau of Investigation (New Mexico and Mississippi are the other two). Additionally, there is no state legislation that mandates collection of crime data. Thus, law enforcement agency crime data collection is voluntary and unregulated. Crime reporting to the FBI's Uniform Crime Report varies considerably among Indiana law enforcement agencies and the jurisdictions they cover.[2] Under-reported crime data from local Indiana agencies, compounded by the incredibly low reporting of rape and sexual assault to law enforcement in general, compromises the accuracy of the Uniform Crime Report's figure of 1,720 rapes reported to participating law enforcement agencies in Indiana in 2008.[3]

Because of the limitations of reported crime data, prevalence surveys are often used to estimate the true magnitude of sexual violence. In 2007, the Indiana Coalition Against Sexual Assault partnered with the Indiana University Public Opinion Lab to design and conduct the first Female Victimization in Indiana Survey. The survey data provided lifetime prevalence rates of sexual assault, rape and other crimes among Indiana women over the age of 18, as well as the nature of the relationship between the victim and the perpetrator and whether or not the crime was reported to the authorities. The survey found 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

[2] Stucky, Thomas and Thelin, Rachel. "Timely and Accurate Data Reporting Is Important for Fighting Crime." Center for Urban Policy and the Environment. May 2007.
[3] "Indiana Crime Rates 1960-2008", Uniform Crime Report, Federal Bureau of Investigation

another type of sexual assault in their lives, and 20% reported experiencing attempted rape.[4]

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. (See Appendix C for a detailed analysis of the State Victimization Survey).

The major limitations of the Female Victimization in Indiana survey were threefold: 1) Prevalence of sexual violence against males was not measured; 2) Only those who had land-line telephones were eligible to be in the sample, leaving out a significant segment of the population (exclusive cell phone users and those without any telephone access); and 3) Geographic analysis was not used to map the results.

Some 2007 data on sexual violence prevalence among Indiana high school students is also available through the Youth Risk Behavior Survey, which included one question about forced sexual intercourse and another about intimate partner violence. This data confirms what has been documented in the research: sexual violence is affecting youth at alarming rates. The 2007 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. Data from the 2009 Youth Risk Behavioral Survey will be available soon.

Reliable and accurate data informs the development of any effective public health intervention. Sound data is the basis of knowing where to focus efforts, as well as a tool that can be used to garner support from policymakers and the general public and to evaluate the impact of interventions over time. Enhancing Indiana's capacity for better sexual violence data collection, usage, and sharing is absolutely essential in moving the understanding of sexual violence and potential prevention solutions forward. Therefore, the sixth goal of Indiana's state plan focuses on making the best use of available data collection and analysis tools to guide efforts, as well as keeping up with the newest and best tools that will emerge in the future to track the incidence and prevalence of sexual violence nationally and in Indiana.

(See Appendix D for the analysis report of the data currently available on sexual violence prevalence and magnitude in Indiana.)

B-4) Qualitative Risk and Protective Data from Indiana Citizens and Professionals

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

To gain greater insight into dynamics of sexual violence in Indiana, a qualitative data gathering process was planned as an important part of the needs and resources assessment. The parameters of the qualitative data gathered were defined by the Sexual Violence Primary Prevention Council and included: perceived risk factors for and protective factors against sexual violence in communities, potential prevention solutions, and suggestions for priorities to include in Indiana's sexual violence primary prevention plan. PeopleWork Associates, a consulting company experienced in issues pertaining to sexual violence, led this part of the needs and resources assessment. In partnership with the ISDH, local health departments, service providers, and other partners throughout the state, PeopleWork Associates planned and facilitated a series of ten public forums designed to capture the types of qualitative data mentioned above.

The ten geographically diverse forums took place in November and December 2008. The forums drew a broad attendance, including service providers (representatives from community rape crisis centers, law enforcement, members of the criminal justice system, medical professionals and public health professionals, etc), as well as many other stakeholders including: faith leaders, representatives from organizations serving marginalized populations (including the homeless) teachers and school administrators, college students, legislators, media representatives, and concerned community members. The Council assisted in planning the forums and inviting groups and individuals to attend. (See Appendix E for a detailed description of the process used to recruit forum participants.)

Forum participants made interesting observations about risk factors for sexual violence perpetration and victimization. (There was not a specific, targeted question about risk and protective factors during the forums, but some of this information emerged during responses to the question: Why do you think sexual violence occurs?) The majority of the observations about risk factors for sexual violence perpetration mirrored those that have been identified by the CDC, and additional discussion provided contextual perspective for Indiana. Risk factor themes that arose continuously during the forums are outlined in Table 1.

Table 1: Forum Participants' Identified Risk Factors for Sexual Violence Perpetration

Level of Social Ecological Model	Risk Factors: Sexual Violence Perpetration
Individual	• Alcohol and drug use • Low self-esteem and self-efficacy • Lack of empathy
Relationship	• Lack of supportive and positive family environments modeling healthy relationships and parenting • Poor peer influences
Community	• Lack of collective efficacy, positive role models and youth empowerment opportunities in communities • Lack of healthy relationships and bystander education opportunities in schools and other organizations • Poverty, economic disenfranchisement and unemployment • Lack of criminal justice system efficacy around the problems of sexual violence and other forms of crime
Society	• A culture that tolerates sexual entitlement and promiscuous behavior (for both men and women) • Societal and cultural norms in certain non-mainstream populations • Normalization of violence and linkage of violence and sexuality in the media

Often, forum participants who identified risk factors implied that the opposite of a risk factor would be a protective factor—i.e., while a lack of a supportive and positive family environment modeling healthy relationships and parenting would be considered a risk factor, the presence of such would be considered a protective factor.

Clearly, this large list of risk factors is too broad to address comprehensively in the next six years, and many of these factors go beyond the scope of what the state plan is able to address. The Sexual Violence Primary Prevention Council prioritized goals and outcomes to address identified risk factors that seem to be the most modifiable from a state-level, population-based standpoint. The Council gave careful consideration to public opinion on risk and protective factors when identifying plan priorities. At the same time, Council leadership applied practical knowledge about the scope and capabilities of the plan and capacity of the current infrastructure when making final decisions about goals and objectives.

While there were intensive efforts to recruit broad representation at the public forums, it is necessary to acknowledge the limitations of this method of collecting qualitative data. The individuals in attendance at the forums self-selected; that is, a scientific method of recruiting participants to reflect the demographics and dynamics of Indiana's population was not utilized. Most of the participants were highly educated and at least somewhat familiar with sexual violence and related issues, so the data collected cannot be assumed to be reflective of the beliefs and attitudes of Indiana's population. However, this methodology did provide an opportunity to gain insight on the dynamic and context of sexual violence prevention in Indiana.

(See Appendix E and its various attachments for a detailed report on the process and results of the public forums).

B-5) Focus Groups with Selected Populations

Council members and program staff solicited input from several different selected populations during the needs and resources assessment process. The MESA (Multicultural Efforts to End Sexual Assault) Director conducted a series of three focus groups with migrant farm workers and migrant farm worker service providers to examine farm workers and professional farm worker service providers' perceptions about sexual violence and how it could be prevented. The discussion concentrated upon the experiences of farm workers with sexual harassment and sexual violence in their work and personal lives. (Appendix F features a summary report of the qualitative data gathered from the migrant farm worker and farm worker service provider focus groups). The MESA director also conducted Talking Circles (a culturally relevant Native American technique for discussing issues and conducting research) with the intertribal American Indian community in Indiana to assess perceptions of and potential prevention solutions to sexual violence. The Talking Circles revealed how sexual violence intersects with different forms of economic and social oppression that the Native community experiences. In addition, Indiana's intertribal Native community has identified the need for healing from past abuses as the next step in moving prevention forward.

A representative of the Indiana Minority Health Coalition (IMHC) serves on the Sexual Violence Primary Prevention Council. The IMHC representative suggested that local coalitions would have valuable input on how to mobilize racial and ethnic minorities in the sexual violence prevention movement. On January 22, 2009, the ISDH hosted a small meeting for several local minority health coalitions to learn about sexual violence primary prevention efforts in the state of Indiana and give input on strategies to make sexual violence primary prevention programming and messaging culturally salient. A recurring point in this discussion was working through faith communities to reach many minority populations, particularly African-Americans and Latinos. (See Appendix G for the notes from the meeting with representatives from local minority health coalitions).

B-6) Prevention System Capacity Assessments

A survey for professionals working directly or indirectly in the field of sexual violence primary prevention was developed to assess the prevention system capacity in Indiana. It was distributed through the Sexual Violence Primary Prevention Council, as well as through various networks of other professionals who work either directly or indirectly in sexual violence prevention. Survey respondents were asked to answer a series of questions about their perceptions of the support system for sexual violence primary prevention efforts in Indiana, including financial resources, training and technical assistance, use of evidence-informed strategies/programs, evaluation capacity, partnerships and collaboration, policy, and data collection.

The survey was analyzed in two different ways: 1) Using all respondents' answers and 2) Using respondents who answered "yes" to the filtering question "Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?" The rationale for these two separate analyses was that those who were directly involved in a state or community-based comprehensive sexual violence prevention program would offer different insight than other professionals who work more indirectly on the issue. Those who answered affirmatively to the question stated above were directed to answer a more specific series of questions about evidence-informed strategies/programs, program evaluation capacity, and the strengths of partnerships and collaboration. All respondents answered questions about financial resources, training and technical assistance, policy, and data collection.

Findings of the survey as they relate to several components of Indiana's prevention system capacity are described below. Appendix H-1 is a summary of all respondents' answers. Appendix H-2 is a summary from respondents who affirmatively answered the filtering question "Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?"

<u>Current State and Local Evaluation Efforts and Capacity</u>

While the majority of respondents who were not directly involved in managing a sexual violence primary prevention program responded that they could not rate evaluation

efforts and capacity, those who were directly managing programs rated current state and local evaluation efforts as "somewhat strong." The majority indicated they understood "well" or "moderately well" how to use common program evaluation tools, such as process measures, pre/post tests, key informant interviews, focus groups, surveys, and magnitude, prevalence, and occurrence data. The majority cited a lack of financial resources as the main barrier to improved evaluation capacity.

An understanding of evaluation methods does not always translate into using them effectively. Outcome evaluation measures comprise the basis for quality improvement in a program. Process measures (activities conducted, numbers of participants reached, etc.) are important, but cannot capture whether or not an intervention has been successful in changing behaviors. A consultant who planned and conducted a primary prevention training series for Indiana in summer 2009 reported that among many local programs, process evaluation was strong, but outcome evaluation was weak.

State-level primary prevention efforts vary in terms of the level of evaluation capacity. To address the need to strengthen program evaluation in Indiana, trainings provided to community and state-level programs will include evaluation modules. The third goal of the plan includes an outcome charging the Sexual Violence Primary Prevention Council with developing a resource guide for state and local programs that includes evidence-based evaluation tools. Programs will be required to demonstrate how they plan to integrate these tools into their program evaluation methods, with the ultimate goal of being able to better assess the effectiveness of the strategies they are using to prevent sexual violence.

State Data and Surveillance Capacity

See page 5, Section B-3) Indiana Sexual Violence Magnitude Data/ Data and Surveillance Assessment.

State Prevention Funding Capacity

In Indiana, the main source of funding for sexual violence prevention originates from the Centers for Disease Control and Prevention in the form of the Rape Prevention and Education Cooperative Agreement. The estimated amount of Indiana's Cooperative Agreement for 2010 is a little more than $800,000. Currently, Indiana's state budget does not include any state dollars allocated to sexual violence prevention. State and community-level programs have become proficient in supplementing the CDC prevention funds by applying for grants from other sources, including local foundations and charities, soliciting support from businesses and individuals in the community, and partnering with other organizations to pool resources.

It has become increasingly clear that Indiana cannot continue to rely solely on the Sexual Violence Prevention and Education Cooperative Agreement funds to support prevention efforts for the entire state. For this reason, the Council prioritized increased funding for sexual violence prevention in the state plan (as an outcome under the second goal). There

are various strategies that stakeholders can employ to achieve this outcome, including presenting data on the economic impact of sexual violence to policymakers and businesses to encourage investment in prevention and collaborating with partners who have access to other funding streams to integrate sexual violence prevention priorities. Data and templates will be provided to community programs to assist them in leveraging resources on a local level.

The economic recession has created increased funding challenges. However, by demonstrating the value of investment in prevention, it is possible to increase support of primary prevention and emerge with a stronger funding system despite the economic downturn.

State-Level Training and Technical Assistance Capacity

Because the field of prevention science and the environments practitioners seek to impact evolve constantly and rapidly, continued learning and professional development is critical to the success of prevention initiatives. Currently, each of the three major components of the Indiana RPE program provides opportunities for professional trainings to their constituents and practitioners. Additionally, they provide on-site, customized technical assistance to community programs, college campuses, and other groups. The survey for professionals asked respondents involved in the management or execution of a state or community-based sexual violence primary prevention program (essentially, the recipients of INCASA, MESA, and INCSAPPP services) to assess the quality and quantity of training and technical assistance available to assist them in constantly improving their efforts.

Overall, the responses highlighted that training and technical assistance capacity was "somewhat strong." Respondents were asked to rate the quality and quantity of training and technical assistance on the following topics: male involvement/engagement in sexual violence prevention, special strategies for reaching diverse and special-needs populations, community collaboration/coalition building, policy development, funding and grant applications, use of evidence-informed strategies and programs, and program evaluation. On all of the topics, at least some of the respondents replied that they were not familiar with the quantity and quality of the training and technical assistance, and that they were unable to rate them. The majority of respondents said that the sufficiency of all but the topic of community collaboration/coalition building was "somewhat lacking" and that the quality was only "fair." This information was complemented by comments from professionals prioritizing a need for improved assistance with program evaluation and use of research and evidence-based strategies. Clearly, there is room for improvement in provision of training and technical assistance for sexual violence prevention in Indiana.

Conclusion

This section chronicles the strategic assessment process the Sexual Violence Primary Prevention Council went through to determine the strategic priorities for the state plan. Additional sections describe the rationale behind the goals of the plan, lay out the Centers

for Disease Control and Prevention’s scientific framework for sexual violence prevention and outline the goals, outcome statements, strategies and action steps, and logic models for Indiana’s sexual violence primary prevention state plan.

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.

[2]CDC. "Sexual Violence Prevention: Beginning the Dialogue". 2004

[3]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; 2002:1-56.

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

[6] Davis, 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 heath 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]

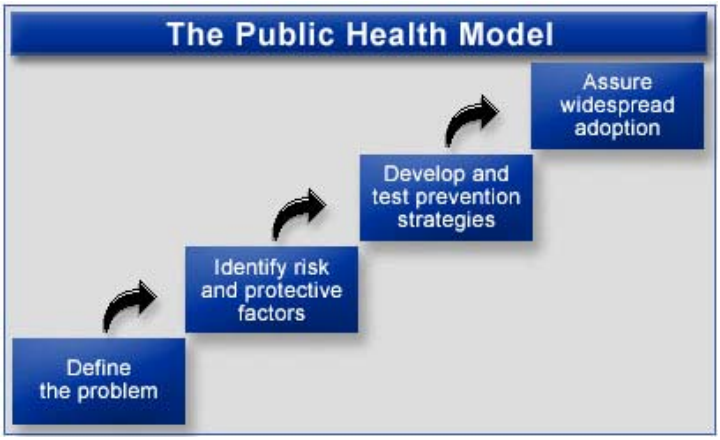
D. The Public Health Approach to Sexual Violence Prevention

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

[13] Centers 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]

---

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

[15] Tjaden, 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

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

[17] Sidenbender, 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]

---

[18]Tjaden, 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

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

[20]Kilpatrick, 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

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

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

[24]Bureau of Justice, 1996

[25]Pennsylvania Coalition Against Rape. "Poverty and Sexual Violence: Building Prevention and Intervention Responses." 2007. Accessed at: http://www.pcar.org/resources/poverty.pdf

[26]Brown 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

[27]Bassuck, 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.

[29]Tjaden, 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.

[30]Steven 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

[31]The 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	• 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	• 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	• 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	• 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.

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

Appendix A: Glossary of Injury and Violence Terms and Acronyms

The following list provides a general means to help with the interpretation of ICD-9 External Cause of injury codes (E-Codes). The definitions are not comprehensive.

Age-adjusted rate: Age-adjusted rates are a weighted average of the age-specific incidence or mortality rate from a targeted population with weights that are proportional to persons in corresponding age groups of a standard population (Year 2000 U.S. population), for purposes of making comparisons of rates over time or between populations.

Benzodiazepines: Central nervous system depressants used as sedatives, to induce sleep, prevent seizures, and relieve anxiety.

Cause of injury/ Mechanism of injury: The circumstances or activities or way in which the person sustained the injury.

Crude rate: The number of deaths, hospitalizations, or ED visits over a specified time period divided by the total population (per 100,000).

Cut/Pierce: Injury from an incision, slash, perforation, or puncture by a pointed or sharp instrument, object, or weapon, such as injuries from knives, power hand tools, and household appliances. This does not include bite wounds or being stuck by or against a blunt object.

Drowning/Submersion: Suffocation (asphyxia) from drowning and submersion in water or another liquid. The injury may or may not involve a watercraft. Examples include drowning in rivers, swimming pools, and bathtubs.

Drug abuse: Continued use of illicit or prescription drugs despite problems from drug use with relationships, work, school, health, or safety. People with substance abuse often experience loss of control and take drugs in larger amounts or for longer than they intended.

Drug overdose: When a drug is swallowed, inhaled, injected, or absorbed through the skin in excessive amounts and injures the body. Overdoses are either intentional or unintentional. If the person taking or giving a substance did not mean to hurt themselves or others, then it is unintentional.

Falls: Injury occurs when an individual descends abruptly because of the force of gravity and strikes a surface at the same or lower level. The unintentional falls category involves steps or stairs, ladders and scaffolds, and other falls from one level to another (including falls from a chair or bed. Falls by suicide are described as “jumping from high places” and homicide falls are described as “pushing from high places.”

Fire/Burn: Injury from severe exposure to flames, heat, or chemicals. This category can be further broken into injury from fire and flames, and from hot objects and substances. Examples include smoke inhalation to the upper and lower airways and lungs, structural fires, clothing ignition, burns caused by hot liquids and steam, caustics and corrosives.

Firearms: Force injury resulting from a bullet or projectile shot from a powder-charged gun.

Homicide: Injuries inflicted by another person with the intent to kill or injure. This broad category includes any means and excludes injuries due to legal interventions or operations of war.

Inhalation/Ingestion/Suffocation: Injury caused by the inhalation or ingestion of food or other objects that block respiration and by other mechanical means that hinder breathing (e.g., plastic bag over nose or mouth, suffocation by bedding, and unintentional or intentional hanging or strangulation).

Lifetime prevalence: The proportion of people in a population who have ever experienced a particular outcome, such as a particular form of violence.

Midwest: For the purposes of this report, the Midwest includes the following states: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

Motor vehicle traffic: Injury resulting from any vehicle (automobiles, vans, trucks, motorcycles, and other motorized cycles) incident known or assumed to be traveling on public roads, streets, or highways.

Motor vehicle traffic (motorcyclist): Injured person identified as a driver or passenger of a motorcycle involved in a collision, loss of control, crash or event involving another vehicle, an object, or pedestrian.

Motor vehicle traffic (occupant): Injury to a person identified as a driver or passenger of a motor vehicle involved in a collision, rollover, crash, or event involving another vehicle, an object, or pedestrian.

Motor vehicle traffic (pedal cyclist): Injury resulting from collision, loss of control, crash, or other event between a pedal cyclist and a motor vehicle or pedestrian on a public road or highway.

Motor vehicle traffic (pedestrian): Injury to a person struck by or against a vehicle such as a car, truck, van, buses, etc. where the person injured was not at the time of the collision riding in or on a motor vehicle, bicycle, motorcycle, or other vehicle being hit by a motor vehicle on a public road or highway.

Naloxone: A prescription drug that can reverse an opioid or heroin overdose if administered in time.

Opioid: Derived from the opium poppy (or synthetic versions of it) and used for pain relief. Examples include hydrocodone (Vicodin®), oxycodone (OxyCotin®, Fentora®), methadone, and codeine.

Pedal cyclist (other): Injury among pedal cyclists not involving a motor vehicle or pedestrian traffic incident, such as those being hit by a train, a motor vehicle while not in traffic, by other means of transport, or by a collision with another pedal cycle.

Pedestrian (other): Injury to a person involved in a collision, where the person was not riding in or on a motor vehicle, train, or other motor vehicle when the collision occurred.

Poisoning: Injury or death due to the ingestion, inhalation, absorption through the skin, or injection of a drug, toxin, or other chemical such as gases and corrosives. Examples of poisonings include harmful effects resulting from exposure to alcohol, disinfectants, cleansers, paints, insecticides, and caustics.

Prescription drug misuse: The use of prescription drugs in a manner other than as directed.

Struck By/Against: Injury resulting from being struck by (hit) or striking against (hitting) objects or persons. This category does not involve machinery or vehicles. Unintentional injuries specify being struck accidentally by a falling object and striking against or being struck accidentally by objects or persons. Homicide/assault include being struck by a blunt or thrown object and injuries sustained in an unarmed fight or brawl.

Suicide: Death caused by self-directed (self-inflicted) injurious behavior with any intent to die as a result of the behavior.

Suicide attempt: Non-fatal self-directed (self-inflicted) potentially injurious behavior with any intent to die as a result of the behavior.

Suicidal ideation: Thinking about, considering, or planning for suicide.

Years of Potential Life Lost (YPLL): A measure of premature mortality or early death. All deceased person's ages are subtracted from a standard age (e.g. 65 years) and totaled, the years lost, and then divided by the number of deceased persons in that cause category. This statistic excludes people who died at or older than the selected standard age.

Acronyms:

ACS: American College of Surgeons
BAC: Blood Alcohol Concentration
BRFSS: Behavioral Risk Factor Surveillance System
CCDF: Child Care Development Fund
CDC: Centers for Disease Control and Prevention
CFR: Child Fatality Review
CPS: Child Protective Services
CPT: Community Child Protection Team
DCS: Indiana Department of Child Services
DMHA: Division of Mental Health and Addiction
E-Codes: External-Cause of Injury Codes
ED visits: Emergency Department visits
EMS: Emergency Medical Services
FSSA: Indiana Family and Social Services Administration
IC: Indiana Code, found at http://iga.in.gov/
ICD-9: International Classification of Diseases- Ninth Revision
ICD-10: International Classification of Diseases-Tenth Revision
ICJI: Indiana Criminal Justice Institute
INSPECT: Indiana's prescription drug monitoring program
INVDRS: Indiana Violent Death Reporting System
ISDH: Indiana State Department of Health
MVT: Motor Vehicle Traffic
NAS: Neonatal Abstinence Syndrome
NHTSA: National Highway Traffic Safety Administration
NTDB: National Trauma Data Bank
OWH: Office of Women's Health
RTTDC: Rural Trauma Team Development Course
SAMHSA: Substance Abuse and Mental Health Services Administration
STEADI: Stopping Elderly Accidents, Deaths, and Injuries
SV: Sexual Violence
TBI: Traumatic Brain Injury
WISQARS: Web-based Injury Statistics Query and Reporting System
YPLL: Years of potential life lost
YRBS: Youth Risk Behavior Survey

Appendix B: ISDH Vital Statistics and Hospital Discharge Data

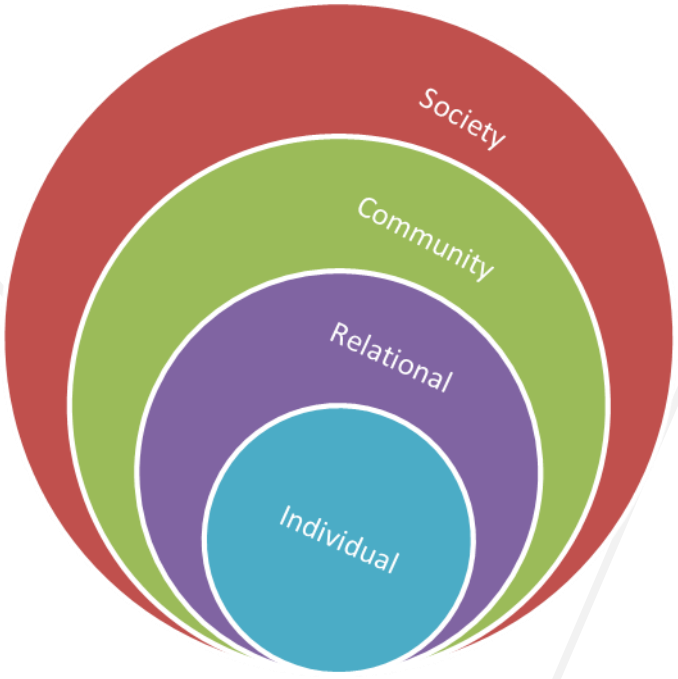
Death data, representing a portion of the data presented in this Resource Guide, relies upon the Indiana State Department of Health mortality reports, based on completion of death certificates. The cause-of-death section of the death certificate is organized according to the World Health Organization guidelines and coded with ICD-10. Death records data is collected from the ISDH Office of Vital Records.

The source agency for the collection of hospital discharge data is the Indiana Hospital Association, which collects hospital discharge data from Indiana hospitals. Beginning with year 2002, selected patient-level data has been sent to the ISDH Epidemiology Resource Center through a working agreement. The injury and external cause of injury codes were classified according to the ICD-9-CM. The criterion of data analysis is based on the recommendations from the Safe States to be used to determine if a patient record is defined as an injury hospitalization. Records can be characterized as patient-level hospital discharges whose principle reason for admission was the result of injury and whose record had at least one valid supplemental E-code.

Outpatient/Emergency Department visit data w**a**s also utilized in this report from the hospital discharge data. The same procedures from Safe States Alliance were followed for inclusion and exclusion of injury related data. The injury and external cause of injury codes were classified according to the ICD-9-CM. These records can be characterized as patient-level hospital discharges whose principle reason for admission was the result of injury and whose record had at least one valid supplemental E-code.

A significant part of the ISDH Division of Trauma and Injury Prevention's mission involves collecting data from Emergency Medical Services (EMS) providers, hospitals with emergency departments (ED) and rehabilitation facilities. The trauma registry is a core component of any statewide trauma system. The Indiana Trauma Registry is a repository into which statewide trauma data has been brought together to support three foundational activities: identification of the trauma population, statewide process improvement activities, and research. The Indiana Trauma Registry was implemented in 2007, with initial participation by the seven hospitals in Indiana that were verified by the American College of Surgeons as Level I or Level II trauma centers. Non-trauma hospitals in Indiana actively submit data to the state trauma registry. In 2013, the ISDH implemented the Indiana State EMS Bridge. The combination of EMS and trauma data allows Indiana to develop a more robust data system with which we can create a better patient care system. The rehabilitation component of the trauma registry began data collection in June 2014.

Data Analysis Notes: A **crude rate** is the number of deaths, hospitalizations, or ED visits over a specified time period divided by the total population (per 100,000). An **age-adjusted rate** is a weighted average of the age-specific incidence or mortality rate from a targeted population with a weight that is proportional to persons in corresponding age group of a standard population, for purposes of making comparisons of rates over time or between populations. A **count** is simply the number of deaths, hospitalizations or ED visits during a specified time. Depending on the data source and the injury topic, crude and age-adjusted rates and counts are provided to illustrate the burden within Indiana, a specific demographic or age group, and the burden on the healthcare system in Indiana.



Indiana Coalition Against Sexual Assault's Primary Prevention Efforts

Capacity, Collaboration and Change

4/20/2009

INCASA
INDIANA COALITION AGAINST SEXUAL ASSAULT

INCASA's Statewide Primary Prevention Efforts

- INCASA is a leading member of the Sexual Violence Primary Prevention Council (SVPPC), administered by the Indiana State Department of Health (ISDH) in the Office of Women's Health. The SVPPC, charged by the Centers for Disease Control and Prevention (CDC), is an interdisciplinary council that will create a State Plan to prevent sexual violence in Indiana.
    - ISDH in partnership with *PeopleWork* Associates, local health departments, and service providers across the state completed a series of ten public forums in November and December of 2008, gathering information and input from the local level that will serve as a baseline for the needs and resources assessment for the state plan.
    - Attendees at the public forums came together to converse about the root causes of sexual violence and brainstorm ideas for solutions and the prevention of it.
    - Meeting locations in Indiana included: Fort Wayne, Elkhart, Bloomington, Lawrenceburg, Greencastle, Evansville, Lafayette, Muncie, Danville and Gary.
    - INCASA authored the first state victimization survey in 2008 which will guide the quantitative data for the State Plan.

- INCASA, serves as an administrative pass through to community organizations that are funded through the Rape Prevention Education (RPE) grant to do primary prevention work.
    - INCASA provides training, technical assistance (TA) and administrative support to funded programs and communities throughout the state.
    - Educates stakeholders, service providers, community educators, youth workers, professionals working on behalf of victims of violence, and other interested parties on the definition and concept of primary prevention practices.
    - Provides tools to implement a community wide approach to preventing sexual violence under a primary prevention model.
    - Shares evidence based strategies and existing tools to practice primary prevention within the social ecological model of change.
    - Highlights effective national and statewide efforts

- INCASA continues to lead the statewide social media campaign in an effort to raise awareness of sexual violence.
    - Special media tools have been developed to address underserved and vulnerable populations such as individuals with disabilities and those who are elderly.
    - A year long awareness campaign is distributed statewide to assist communities with the integration of sexual assault awareness activities into diverse venues and other awareness efforts.
    - INCASA partnered with the Indianapolis Ice Hockey Team and filmed a PSA that promotes men as part of the solution to prevent sexual violence.

- INCASA is the state partner with the CDC for the national initiative to prevent teen dating violence, Choose Respect:
    - INCASA is provided with technical assistance by the CDC on utilizing new materials.
    - INCASA created and has facilitated three Back to School, Youth Rallies to *Pledge Against Violence*. This rally is recognized nationally as a best practice in community wide prevention efforts.
        - Over 20 youth serving organizations that offer positive support to young people come together and engage youth and their families in activities and share information about resources and services available.
        - Average attendance is 1000 youth and families.
    - INCASA piloted new materials for the Choose Respect Playbook.
    - INCASA will be listed as the TA support for organizations or individuals in Indiana who are interested in becoming Choose Respect communities.

- *Fever for Respect*-A partnership with the Indiana Fever - Year long Choose Respect Healthy Relationships program at Christel House Academy (a program of Christel DeHaan Foundation) offered to the sixth grade students.
    - Parent and student open house to launch Choose Respect and educate on the importance of healthy relationships.
    - Sixth grade teachers facilitate one Choose Respect activity each month throughout the entire school year.
    - Guest speakers come to the classes once a month to speak about topics such as healthy relationships, gender equality, and peer support.
    - End of year convocation to celebrate Choose Respect graduates and leaders are selected to be peer educators the following year.
    - Posters and banners are held throughout school. Materials, t-shirts are provided.
    - Goal to replicate this program and offer to school systems.

- INCASA houses an interdisciplinary Prevention Advisory Council (PAC) which is developing a new, promising, and best-practice training focused on primary prevention with an activity tool kit for young people ages 5-8 or grades K-3. The program is titled, *Listen to Me*. Members represent various communities: faith-based, disability, youth serving organizations, school systems, healthcare and nursing, public health, victim advocacy, child psychologists, and community educators:
    - Megan Brown, RN, SANE, Director of Center of Hope, St. Vincent Hospital
    - Camille Brugh, Senior Enrollment & Matching Specialist, Big Brothers Big Sisters of Central Indiana
    - Andrea Crozier, Children's Coordinator, Sheltering Wings
    - Sheila Day, MSW, Peyton Manning's Children's Hospital at St. Vincent
    - Karen Duncan,M.A., LMFT, Founder, Right to Be Safe, Inc
    - Renee Eusey, BSW, Director of Special Projects, INCASA
    - Caroline Fisher, RN, SANE, Director of Center of Hope, St. Francis
    - Abby Kelly-Smith, RPE Program Director, Indiana State Department of Health
    - Maria Larrison, CEO, Sheltering Wings
    - Amy Pomeranz-Essley, MSW, MPA, Director of Quality Assurance, Big Brothers Big Sisters of Central Indiana
    - Monica Ponce, M.Ed., Special Education, Rise Learning Center
    - Paula Reiss, RN,SANE, Methodist Hospital

- Andra Smith, SANE, St. Vincent
- Dr. Sheila Triplett, Ph.D. Director of Counseling and Visitation, Eastern Star Baptist Church
- Beth Snedeker, Child Mentor, Sheltering Wings
- Angie Turk, MSW, Director of Prevention Education, INCASA
- Leslie Weaver, SANE, Wishard Hospital
- Kyle Walke, MSW, Rise Learning Center

- INCASA continues to lead sexual violence prevention efforts in partnership with the United States Department of Defense, assessing intervention and prevention strategies within the U.S. Military Services.

- INCASA launched an online network, Hoosier Prevention Point:
  - Allows individuals to share, connect, and discuss resources for violence prevention
  - Post upcoming events and trainings
  - Post pictures and videos
  - Join network groups based on region or topic of interest
  - Accessible at: www.hoosierpreventionpoint.ning.com

- INCASA is present at international, national and statewide conferences, schools, and organization-wide staff development training, facilitating workshops on healthy relationships, child sexual abuse and rape prevention with audiences ranging from young people, to professionals, to the general community. 2008-09 Conferences w/ Prevention Focused Training:
  - National Federation of State High School Association Conference, Washington, DC; Indiana State High School Association National Leadership Conference; Girl Scouts of America International Leadership Conference; Indiana State High School Association State Conference; Indiana Coalition Against Domestic Violence State Conference; Indiana State Department of Health Youth Summit; Black Expo Youth Empowerment Summit; Indiana Department of Education Youth Conference-DePauw University; Ben Davis High School, Arlington High School, Indianapolis Peace Institute

- INCASA is the author of a five year plan to address sexual violence in Indiana which is available at www.incasa.org.

- INCASA organizes an annual statewide sexual violence conference with a special track for primary prevention.

For more information about sexual violence prevention efforts in Indiana contact:

Angie M. Turk
Director of Prevention Education
Indiana Coalition Against Sexual Assault
55 Monument Circle, Suite 1224
Indianapolis, IN 46205
P: 317-423-0233, ext.13
aturk@incasa.org

Indiana Coalition Against Sexual Assault
Rape Prevention and Education
Community Partners Efforts

The Indiana Coalition Against Sexual Assault (INCASA) serves as an administrative pass-through to community organizations that are funded through the Rape Prevention Education (RPE) grant to do primary prevention. INCASA provides training, technical assistance and administrative support to funded programs and communities throughout the state, while also sharing evidence-based strategies and existing tools to practice primary prevention within the social ecological model of change.

Currently, there are ten agencies that receive RPE funding in Indiana. Each grantee is committed to educating and providing resources to their communities regarding sexual violence primary prevention. Some grantees are in the implementation stage of their programs and have begun administering programs in their communities. Each program is committed to expanding their efforts on sexual violence primary prevention and will strive to achieve our ultimate goal to end sexual violence in Indiana.

Community Partners:

Hands of Hope:
Hands of Hope has been providing education about sexual violence prevention since 1997.Currently, Hands of Hope is one of two sites piloting the Center of Disease Control's Choose Respect playbook in various non-school settings. The primary prevention programs continue to educate their community on topics including healthy relationships, date rape drugs, bullying, and bystander intervention. The local Expect Respect Program media campaign provides public service announcements, posters, videos and billboards.

Hands of Hope is also targeting males to become more involved with primary prevention with the program Coaching Boys Into Men. Hands of Hope use a male-centered curriculum to focus on the male population in their community. All programs that Hands of Hope has administered have had a very positive response from the community, schools, parents and students. These programs give all who are involved the opportunity to educate themselves on complicated issues and allow them to speak openly about these complicated issues.

Crisis Connection:
Crisis Connection has been involved for educating their community regarding sexual violence primary prevention efforts for over ten years. Crisis Connection staff works in partnership with a variety of rural communities within Dubois, Perry and Spencer counties. The "Enough is Enough – Sexual Violence is Unacceptable" program involves males in the antiviolence movement and to help area youth develop the skills to become change leaders in the prevention of sexual violence. The program provides individual knowledge and skills, community education and education of professionals and community providers.

Crisis Connection staff have conducted sustainable curriculum within a classroom setting and other learning events such as health fairs, club meetings, teacher in-services, parent session etc. Crisis Connection presents age appropriate curriculum to ages ranging from Kindergarten age to Grade 12, the curriculum provided is on a various list of topics such as: Respect for Self

and Others, Child Safety, Self-Esteem, Self-Respect, Anti-Bullying, Bystanders, Internet Safety Change Management, Sexual Harassment; Female Empowerment, Gender Roles; Male Socialization, Acquaintance Rape, Bystanders, Predatory Drugs, Media Awareness, Change Management, Healthy Relationships, College Safety.

Alternatives Inc:

In 2008, Alternatives, Inc. in partnership with the Prevention Coalition issued the Madison County Sexual Assault Prevention Plan. This report clearly identified the communities need for sexual assault prevention programs. Alternatives and the Prevention Coalition made several recommendations on the best options for preventing sexual assault in their community. These recommendations were reported to target populations which include youth, parents, law enforcement, and bystanders. Alternatives' primary prevention efforts consist of school and community based multi-session educational programs; parenting skills classes for demonstration of healthy relationships; bystander intervention; and school and community anti-sexual violence mobilization through youth "peer prevention" groups.

Alternatives along with the support of the Prevention Coalition believe these activities are best suited to the unique needs of their community and will address the issue of sexual violence primary prevention effectively. Alternatives provides programs work with hospitals, schools, law enforcement, high risk neighborhoods, neighborhood watch groups, human resource personnel, parents and juvenile offenders.

Fort Wayne Police Department Victim Assistance:

The Fort Wayne Police Department Victim Assistance Program is implementing a program impacting a variety of underserved populations in the prevention and understanding of sexual violence. FWPD Victim Assistance has for many years worked collaboratively with other agencies, schools and colleges to facilitate crime prevention, education and recovery. While working with these programs they developed an initiative that addresses attitudes, behaviors, and policies that subject underrepresented populations to sexual violence.

FWPD Victim Assistance along with collaborative partners are working to increase the ability of existing programs to affect the factors that put universal and selected populations at risk for sexual violence. They are addressing barriers that prevent the target populations from accessing services and providing age appropriate educational sexual violence prevention sessions to children, adults and the community. FWPD Victim Assistance has trained facilitators and contractors on sexual violence primary prevention and has developed a brochure in English, Spanish, Arabic, Swahili and Burmese languages to provide education and resources to cultures with language barriers in their community. Facilitators are providing educational presentations to schools and faith-based organizations in these underserved populations.

The Middle Way House:

The Middle Way House has been providing primary prevention education to the young people in Monroe and Greene counties. The Middle Way house has recently expanded its message on prevention education to parents and children. As people develop their attitudes about sexuality and sexual violence early in life, prevention work with middle and high school students comprises an essential component of any strategy for reducing incidents of sexual violence.

The Middle Way house has developed parental educational materials, identified and developed social marketing materials that target adults and demonstrated how they can help youth form

healthy and respectful sexual relationships through out-of-school based programs. The Building Healthy Relationships program is a strong problem that people in their community have been responding well to for several years. The Middle Way House continues to expand their programs and curriculums to provide sexual assault primary prevention education in their community.

Other Community Partners:

Other programs are continuing to work on implementation of their programs in their communities. They have been targeting schools, parents, law enforcement, faith-based organizations and other organizations in their community to provide information, education, resources and technical assistance in their communities. Each grantee is dedicated to providing sexual assault primary prevention to the people in their community so we are able to achieve our ultimate goal to end sexual violence in the state of Indiana.

INCASA hopes to provide as much information, education, resources and technical assistance to as many organizations and communities as possible so we can expand sexual violence primary prevention in Indiana.

Appendix D: State, Regional and National Injury Prevention Organizations

The following organizations provide information and resources on injury prevention issues and innovative programs. The list is provided as a starting point and is not intended to be an exhaustive listing. Please note that a listing here is for the convenience of the Resource Guide and does not represent an endorsement by ISDH. URLs are subject to change.

	Organization	Website
State	American Automobile Association Hoosier (AAA)	https://www.hoosier.aaa.com/
	American Foundation of Suicide Prevention- Indiana Chapter	http://www.afsp.org/local-chapters/find-your-local-chapter/afsp-indiana
	Attorney General Prescription Drug Abuse Task Force	http://www.in.gov/bitterpill/
	Automotive Safety Program	http://www.preventinjury.org/
	Emergency Nurses Association (ENA)- Indiana Chapter	http://www.indianaena.org/
	Indiana Child Fatality Review Program	http://www.in.gov/isdh/26154.htm
	Indiana Coalition Against Domestic Violence (ICADV)	http://www.icadvinc.org/
	Indiana Criminal Justice Institute (ICJI)	http://www.in.gov/cji/
	Indiana Department of Child Services (DCS)	http://www.in.gov/dcs/2869
	Indiana Department of Mental Health & Addiction (DMHA)	http://www.in.gov/fssa/dmha/index.htm
	Indiana Department of Transportation (INDOT)	http://www.in.gov/indot/
	Indiana Fall Prevention Coalition (INFPC)	http://infallprevention.org/
	Indiana Injury Prevention Advisory Council (IPAC)	http://www.in.gov/isdh/25395.htm
	Indiana Perinatal Network (IPN)	http://www.indianaperinatal.org/
	Indiana State Suicide Prevention	http://www.in.gov/issp/
	Indiana State Trauma Care Committee (ISTCC)	http://www.in.gov/isdh/25400.htm
	Indiana Trauma Network (ITN)	http://www.in.gov/isdh/25966.htm
	Indiana's Rape Prevention and Education Program (RPE)	http://www.in.gov/isdh/23820.htm
	ISDH Division of Trauma and Injury Prevention	http://www.in.gov/isdh/19537.htm
	ISDH Falls Prevention Resource Center	http://www.state.in.us/isdh/25376.htm

	ISDH Maternal Child Health	http://www.state.in.us/isdh/19571.htm
	ISDH Office of Women's Health	http://www.state.in.us/isdh/18061.htm
	ISDH Sexual Violence Primary Prevention Program	http://www.state.in.us/isdh/23820.htm
	Prevent Child Abuse Indiana	http://pcain.org/
	Safe Kids- Indiana Chapter	http://www.safekids.org/coalition/safe-kids-indiana
Regional	Midwest Injury Prevention Alliance (MIPA)	http://www.midwestinjury.com/
National	American Automobile Association (AAA)	www.aaa.com
	AARP	http://www.aarp.org/
	American Academy of Orthopaedic Surgeons/ Orthopaedic Trauma Society	http://www.aaos.org/home.asp
	American Academy of Pediatrics (AAP)	https://www.aap.org
	American Association for the Surgery of Trauma (AAST)	http://www.aast.org
	American Association of Poison Control Centers (AAPCC)	http://www.aapcc.org/
	American Burn Association (ABA)	http://www.ameriburn.org/
	American College of Emergency Physicians (ACEP)	http://www.acep.org/
	American College of Preventive Medicine (ACPM)	http://www.acpm.org/
	American College of Sports Medicine (ACSM)	http://www.acsm.org/
	American College of Surgeons- Committee on Trauma (ACS-COT)	https://www.facs.org/quality-programs/trauma
	American Foundation for Suicide Prevention (AFSP)	http://www.afsp.org/
	American Medical Association (AMA)	http://www.ama-assn.org/
	American Occupational Therapy Association (AOTA)	http://www.aota.org/
	American Physical Therapy Association (APTA)	http://www.apta.org/

	American Psychological Association (APA)	http://www.apa.org/
	American Public Health Association (APHA)	https://www.apha.org/
	American Trauma Society (ATS)	http://www.amtrauma.org/
	Association of Maternal and Child Health Programs (AMCHP)	http://www.amchp.org/
	Association of State and Territorial Health Officials (ASTHO)	http://www.astho.org/
	Brain Injury Association of America (BIAA)	http://www.biausa.org/
	Brain Trauma Foundation (BTF)	https://www.braintrauma.org/
	Break the Cycle	http://www.breakthecycle.org/
	Center of Excellence on Elder Abuse and Neglect	http://www.centeronelderabuse.org/
	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/
	Child Injury Prevention Alliance (CIPA)	http://www.childinjurypreventionalliance.org/
	Children's Safety Network, Education Development Center	http://www.childrenssafetynetwork.org/
	Consumer Product Safety Commission	http://www.cpsc.gov/
	Council of State and Territorial Epidemiologists (CSTE)	http://www.cste.org/
	Directors of Health Promotion and Education (DHPE)	http://www.dhpe.org/
	Emergency Nurses Association	https://www.ena.org
	First Candle: Infant Suffocation	http://www.firstcandle.org/
	Futures without Violence	http://www.futureswithoutviolence.org/
	Injury Free Coalition for Kids	http://www.injuryfree.org/
	Juvenile Products Manufacturers Association (JPMA)	http://jpma.org/
	Kids in Danger	http://www.kidsindanger.org/

	National Alliance to End Sexual Violence (NAESV)	http://endsexualviolence.org/
	National Association of County and City Health Officials (NACCHO)	http://www.naccho.org/
	National Association of State Emergency Medical Service Officials (NASEMSO)	https://www.nasemso.org/
	National Association of State Head Injury Administrators (NASHIA)	http://www.nashia.org/
	National Association of Students Against Violence Everywhere (SAVE)	http://nationalsave.org/
	National Center on Domestic and Sexual Violence (NCDSV)	http://www.ncdsv.org/
	National Council on Aging (NCOA)	http://www.ncoa.org/
	National Domestic Violence Hotline	http://www.thehotline.org/
	National EMS Advisory Council	http://ems.gov/
	National Fire Protection Association	http://www.nfpa.org/
	National Highway Traffic Safety Administration (NHTSA)	www.nhtsa.gov/
	National Institute for Occupational Safety and Health (NIOSH)	http://www.cdc.gov/niosh/
	National Institute on Alcohol Abuse and Alcoholism (NIAAA)	http://www.niaaa.nih.gov/
	National Network to End Domestic Violence (NNEDV)	http://nnedv.org/
	National Physicians Alliance (NPA)	http://npalliance.org/
	National Safety Council (NSC)	http://www.nsc.org/
	National Sexual Violence Resource Center (NSVRC)	http://www.nsvrc.org/
	National Violence Prevention Network (NVPN)	http://www.preventviolence.net/
	Occupational Safety & Health Administration	https://www.osha.gov/
	PACER's National Bullying Prevention Center	www.PACER.org/Bullying
	Pediatric Trauma Society (PTS)	http://pediatrictraumasociety.org/

	Prevent Child Abuse America	http://www.preventchildabuse.org/
	Prevent Child Injury	http://preventchildinjury.org/
	Prevention Institute	http://www.preventioninstitute.org/
	Safe Kids Worldwide	http://www.safekids.org/
	Safe States Alliance	http://www.safestates.org/
	SafetyLit	http://www.safetylit.org/
	Society for Advancement of Violence and Injury Research (SAVIR)	http://www.savirweb.org/
	Society for Public Health Education (SOPHE)	http://www.sophe.org/
	Society of Trauma Nurses	http://www.traumanurses.org/
	Stopbullying.gov	http://www.stopbullying.gov/
	Striving to Reduce Youth Violence Everywhere (STRYVE)	http://vetoviolence.cdc.gov/apps/stryve/home.html
	Substance Abuse and Mental Health Services Administration (SAMHSA)	http://www.samhsa.gov/
	Suicide Awareness Voices of Education (SAVE)	http://www.save.org/
	Suicide Prevention Resource Center (SPRC)	http://www.sprc.org/
	The Safety Institute	http://www.thesafetyinstitute.org/
	ThinkFirst National Injury Prevention Foundation	http://www.thinkfirst.org/
	Trauma Prevention Coalition	http://www.aast.org/trauma-prevention-coalition
	Trauma Survivors Network (TSN)	http://www.traumasurvivorsnetwork.org/
	U.S. Consumer Product Safety Commission	http://www.cpsc.gov/
	Veto Violence	http://vetoviolence.cdc.gov/

Summary of Indiana State Department of Health District Forums For Indiana's Sexual Violence Primary Prevention Plan November-December 2008

"The traumatic experience of sexual violence in some ways is akin to the 9/11 experience in the feelings of betrayal, violation, mistrust, trauma. These kinds of events knock people off their path of potential and many can't get back to that path." –Physician participating in a district forum

Introduction—Sexual Violence as a Public Health Issue

Sexual violence is a social phenomenon that permeates all of society. No one is immune from its impact; all populations experience its devastating effects. Sexual violence does not discriminate based on age, gender, socioeconomic status, ability, race, ethnicity, sexual orientation or educational attainment. It can and does happen within every societal institution and social group. Although many times sexual violence remains hidden and is never exposed, it takes place in homes, neighborhoods, workplaces, schools, colleges and universities, youth organizations, social groups, faith-based communities, governments, child care centers, and many other places. Few families and no communities have been left untouched by sexual violence. For those who have experienced it, the physical, mental, emotional, and social effects can be devastating.

The Centers for Disease Control and Prevention (CDC)'s recognition of the primary prevention of sexual violence as a major public health issue is an addition to all the efforts to acknowledge the scope and far-reaching negative effects of the problem. It is an attempt to expose the magnitude of loss of health and human potential for individuals, families, communities and society. It also provides an opportunity to look for solutions to the problem of sexual violence through the lens of public health.

The field of public health focuses on matters that impact the health and well-being of populations. Population health is defined as "Health outcomes of a **GROUP** of individuals, including the distribution of such outcomes within the group."[1] Therefore, "Public health is ultimately concerned with approaches that address the health of a population rather than one individual…Based on this principle, a public health prevention strategy demonstrates 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. The public health approach also depends upon collective action."[2] Fundamental public health strategies for solving problems are based on data-informed, systemic change intended to make environments more conducive to health and well-being, working in tandem with efforts to change knowledge, beliefs, and behaviors and improve access to care. The CDC's National Public Health Performance

[1] Kindig D, Stoddart G. What is population health? *American Journal of Public Health* 2003 Mar; 93(3):380-3. Retrieved 2009-31-3.

[2] Centers for Disease Control and Prevention. "Sexual Violence Prevention: Beginning the Dialogue". Atlanta, GA: Centers for Disease Control and Prevention; 2004.

Standards Program has identified ten (10) essential public health services[3]. Each of these services has a distinct role to play in the prevention of and response to sexual violence:

1. Monitor health status to identify and solve community health problems;
2. Diagnose and investigate health problems and health status in the community;
3. Inform, educate, and empower people about health issues;
4. Mobilize community partnerships and action to identify and solve health problems;
5. Develop policies and plans that support individual and community health efforts;
6. Enforce laws and regulations that protect health and ensure safety;
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
8. Assure a competent public and personal health care workforce;
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services, and
10. Research for new insights and innovative solutions to health problems.

Public health encourages the study of risk and protective factors with the intention of looking at the greater (universal) population, as well as exploring contextual factors that affect specific (selected) sub-sets of the population and identifying unique risk and protective factors that impact those sub-sets. Through research and literature review, CDC has identified risk and protective factors for perpetration of sexual violence at the individual, interpersonal (relationship), community, and societal level:

Risk Factors for Sexual Violence Perpetration [4]

Individual Factors

- Alcohol and drug use
- Coercive sexual fantasies
- Impulsive and antisocial tendencies
- Preference for impersonal sex
- Hostility towards women
- Hypermasculinity
- Childhood history of sexual and physical abuse
- Witnessed family violence as a child

Relationship Factors

- Association with sexually aggressive and delinquent peers
- Family environment characterized by physical violence and few resources
- Strong patriarchal relationship or familial environment
- Emotionally unsupportive familial environment

Community Factors

[3] Centers for Disease Control and Prevention, National Public Health Performance Standards Program
[4] http://www.cdc.gov/ncipc/dvp/SV/svp-risk_protective.htm

- Lack of employment opportunities
- Lack of institutional support from police and judicial system
- General tolerance of sexual violence within the community
- Weak community sanctions against sexual violence perpetrators

Societal Factors

- Poverty
- Societal norms that support sexual violence—a culture of entitlement
- 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

Protective factors against perpetration of sexual violence include the observation of nonviolence and respect in the family and with peers, a healthy connectedness to family, school, and/or social networks, opportunities for positive youth development, collective efficacy of the community, and living in a society that supports gender equity.[5]

Less is known about risk and protective factors for victimization of sexual violence. However, a primary prevention approach focuses on preventing first-time perpetration or victimization, thus concentrating more on the factors that allow perpetration to occur than factors that make one more or less likely to be victimized.

Best practices in public health involve employing evidence-based/informed strategies for changes in policy and social norms, organizations, communities, and interpersonal networks within which people operate, and finally, individual behavior change, with the ultimate goal of creating a healthier population. This approach opens the possibility of concrete solutions for preventing sexual violence. It brings the topic into the public square, making the prevention of sexual violence the collective responsibility of the entire population on all levels of society. It also has important psychological and emotional implications as such thinking moves individuals and communities from attitudes of hopelessness and despair to attitudes of intent, action, and accountability. It serves as a reminder than many other public health issues have been, and are continuing to be, successfully addressed using this approach.

Two recent examples of public health issues that have made significant progress are smoking cessation and the increase of advocacy, research and treatment of breast cancer. Although smoking rates are still far too high, and smoking is still the number-one cause of preventable death in Indiana and in the United States, public health has made progress in the area of shifting policy and social norms around smoking. For example, the federal government and many states have raised taxes on cigarettes and other tobacco products to discourage youth from starting to smoke and as a strategy to encourage current smokers to quit. Many states and communities also have enacted smoking bans, which prohibit smoking in public places. Social marketing and a variety of tobacco cessation strategies have also helped make strides toward the goal of a

[5] Getting To Outcomes, Step 1—DELTA/Centers for Disease Control and Prevention

healthier population. There is still a long way to go, but social norms and policy around tobacco use have changed tremendously over the years. The hypothesis is that a change in social norms, environment, and support for smoking cessation will eventually trickle down to individual behavior change over time, resulting in a healthier population.

Until recently, a social stigma was attached to breast cancer, complicating the treatment and healing process with lack of viable support systems in place for those who had been diagnosed with the disease. Today, more breast cancer patients have strong support that aids in healing physically, psychologically and emotionally and developing the financial resources to fund prevention and treatment. Another key aspect of public recognition in dealing with breast cancer is moving patients from victims to survivors.

These two examples of public health issues that have progressed give hope for a public health approach to sexual violence primary prevention. Because sexual violence is an intensely personal, painful topic, it has long been shadowed in silence. By naming it as a public health problem, however, the CDC has recognized that preventing sexual violence is possible. Even more importantly, CDC has made a statement that every state, community, organization, and individual has an important role to play in curbing the problem, and that sexual violence primary prevention is a collective responsibility.

Rationale and Methodology of Planning District Forums

Each state and territory in the United States has engaged in a cooperative agreement with CDC for sexual violence primary prevention work through its Department of Health. This cooperative agreement includes financial assistance, training, technical assistance, and access to current research and trends. As a deliverable of this cooperative agreement, CDC has asked each state and territory to develop its own five-to-eight year strategic plan for the primary prevention of sexual violence. The plan is to be developed using a variety of input, in an inclusive manner, and to develop goals, objectives, and strategies that best apply in the context of the social, institutional, political, and economic landscape of each state.

Indiana's Rape Prevention and Education Program Director at the Indiana State Department of Health (ISDH) convened a state Sexual Violence Primary Prevention Council (SVPPC) in December 2007 for the purpose of developing the plan, gaining support and buy-in from key partners, and cultivating those partnerships for execution of the plan. It was agreed that public input was needed to get an accurate idea of the state's needs and ideas regarding the issue. Although there was some disagreement as to the best methods to solicit that input, it was decided that the Rape Prevention and Education Program Director and *PeopleWork Associates, LLC* (professionals in community development and mobilization) would facilitate ten district public forums to hear the voices of diverse community members all around the state. Although CDC has identified risk and protective factors for sexual violence perpetration and some evidence-informed strategies for prevention, the Council believed that it was important to see how this research was reflected in the context of the state of Indiana. By completing the district forums, it was found that much of what CDC has identified in the research correlated closely with what local partners saw as the issues in their own communities. The forums served the purpose of further contextualizing CDC-identified risk and protective factors and evidence-informed

strategies for prevention. (See "Summary of Participants' Responses", pages 9-10, for further detail on this topic).

The ISDH and its network of local health departments (LHDs) served as the primary network for organizing and hosting these public forums. There were several reasons for this choice of working through the network of the local health departments:

- ISDH's assumption of the leadership role positioned the agency to make substantial gains in eliminating sexual violence using a public health approach.

- It was logical for the ISDH to assume this role and use its influence to organize state entities and communities and its partnership with the network of LHDs. Sexual violence prevention has just recently been defined as a public health issue and there has not been enough time or resources to sufficiently educate Indiana's public health workforce about the relevance of sexual violence prevention to public health. Working through the LHD network presented an opportunity to educate and encourage the active involvement of more medical and public health professionals. It also provided an opportunity to bolster local public health officials' visibility within communities.

- LHDs would be educated about the public health approach for primary prevention of sexual assault and violence, in turn educating their communities and leading local efforts of primary prevention planning.

- Many local public health officials knew the key community leaders and stakeholders to invite. Several public health officers issued personal invitations to the meetings.

- Many LHDs were already engaged in various community collaborations involving community health and safety issues.

- Involvement allowed LHDs to connect with those in the community that work with sexual violence and child abuse prevention. This has the potential to assist LHDs and other agencies in collaborating with one another and maximizing resources.

- Because of the time and cost associated with conducting these forums, it was decided to conduct them by public health districts (there are ten public health districts in Indiana) rather than by county. This choice limited the amount of local input, but also served as a model project approach that can be modified by each county to serve future public health needs.

The ISDH staff identified key LHDs within each district that they thought might have the capacity to host these forums. Staff from these sites was contacted and self-selected into the project.

The project was explained to the LHDs using the ISDH phone conference system, allowing local staff to ask questions, express concerns, and volunteer to cooperate or to opt out. Letters describing the project and the need for support were mailed. News and information about the

project was posted on SharePoint, the in-house shared network communication system. This process provided useful information to strengthen the working relationship of ISDH and the LHDs in other areas of their respective work. The process brought awareness of more linkages between the state and local health departments, and helped both entities begin planning new ways of engaging cooperatively to further public health work in Indiana.

Nine LHDs of the ten regions volunteered to host and coordinate the district forums. ISDH was unable to find a LHD host in one district, so that particular forum was hosted by the local Continuum of Care (a group focusing on housing and homelessness issues). This contact was made through ISDH's connection with the local Minority Health Coalition.

See Appendices A-1, A-2, and A-3 *for copies of letters asking the LHDs to host the forums, the sample invitation for the LDH to send to community members and the ISDH forum press release.*

Observations of The Model

- This effort increased and strengthened the partnership of ISDH and LHD staff members.

- There are areas of weakness in communication between ISDH and the LHDs. For instance, state staff believed that SharePoint was an effective way to connect with LHD staff. However, it was determined that not all LHD staff has regular access to the system, and information was not always disseminated effectively. This was also true of written (e-mail) communication.

- ISDH asked the LHDs to assist in planning the forums, including securing a location, providing simple refreshments and recruiting community members to participate. This identified the stresses and workloads within several LHD who have seen budget cuts and decreased staffing, yet been given additional responsibilities. Some LHDs chose not to participate due to this lack of resources.

District Forum Process

Planning the district forums was quite a bit of work. Some important points about planning the forums:

- The LHD that hosted the district forum also shared in the expenses by providing host sites and simple refreshments for the forums and issuing invitations to community members and partners. Local staff also provided registration assistance and in some instances helped as small group facilitators.

- LHD staff chose the meeting date from the range of dates suggested as well as time of day for their host forum: morning, afternoon, evening.

- The Rape Prevention and Education Director worked with the ISDH Office of Public Affairs to use state media resources and networks, effectively announcing the district

forums. Some results included statewide and local radio, television, and newspaper coverage of the forums and interviews with the Rape Prevention and Education Director, as well as local project directors.

Each forum followed the same format and lasted for two and a half hours. The forum agenda included presentations from ISDH staff and facilitators from *PeopleWork Associates*. This agenda included:

- An overview of the need for a state sexual violence primary prevention plan, with emphasis on the definition of primary prevention;
- Available data on sexual violence in Indiana;
- How the input of the district forum participants would be utilized in developing the key strategies of the state plan;
- The task of the SVPPC to assist the ISDH in developing the state plan (the Council will consider the input from these forums);
- The context and importance of citizen/community member input and deliberation in the pubic square to solve problems;
- Explanation of the process that was used to solicit input form participants as quickly and respectfully as possible (emphasis was given to having participants record their thoughts to ensure their voices were heard and not modified by a facilitator);
- Participants recorded their answers on Post-It notes, verbally presented their responses to their small group and then notes were placed on flip chart paper and further discussed and clarified. Their responses were recorded exactly as worded (unless writing was illegible).

The district forum participants responded to the following questions:

1. Why do you think sexual violence occurs?
2. What do you think would help stop sexual violence in your community?
3. What can be done to prevent sexual violence on these levels:
    a. Individual
    b. Community
    c. Society
    d. Policy
4. In times of adversity, sexual violence increases. What can be done to address this?
    a. As an individual
    b. As a family
    c. As a community
    d. As a state
5. What is needed in a state sexual violence primary prevention plan?

Each question was allotted 15 minutes for thoughts and discussion.

See Appendices B-1 and B-2 *for the district forum PowerPoint and Agenda.*

A total of ten district forums were conducted in geographically diverse areas of the state:

District 3, 11/12/08:	Allen County/Ft. Wayne Afternoon meeting	Attendance: 22
District 2, 11/13/08:	Elkhart County/Elkhart Morning meeting	Attendance: 37
District 8, 11/20/08:	Monroe County/Bloomington Afternoon meeting	Attendance: 15
District 9, 11/21/08:	Dearborn County/Lawrenceburg Morning meeting	Attendance: 17
District 7, 11/24/08:	Putnam County/Greencastle Evening meeting	Attendance: 9
District 10, 11/25/08:	Vanderburgh County/Evansville Afternoon meeting	Attendance: 43
District 4, 12/2/08:	Tippecanoe County/Lafayette Morning meeting	Attendance: 4
District 6, 12/3/08:	Delaware County/Muncie Afternoon meeting	Attendance: 17
District 5, 12/4/08:	Hendricks County/Danville Morning meeting	Attendance: 30
District 1, 12/11/09:	Lake County/Gary (Host: NW Indiana Continuum of Care) Morning meeting	Attendance: 29

A total of 223 individuals participated in the ten district forums. Participants represented thirty-six of the ninety-two counties, as well as two other states (Kentucky and Illinois).

See Appendix C *for the demographics of forum participants.*

The ten district forums demonstrated both commonalities and unique characteristics. In general, those sites where the Public Health Officer was involved and issued personal invitations had greater attendance with more community leaders present. At those sites, the Public Health Officer welcomed the participants. The sites where Public Health Officers were involved were:

- District 3, Dr. Deborah McMahan
- District 2, Dr. Aixsa Pérez
- District 10, Dr. Raymond Nicholson
- District 5, Dr. David Hadley

The District 9 meeting took place in Dearborn County with attendance of 17. It was the notable exception of having an attendance that well represented the community and its leadership without the Health Officer's participation. At that site, the public health nurse and the LHD have a history of being actively involved within the community in a number of collaborative partnerships. The LHD and this nurse are perceived as leaders within the community. Among the attendees were concerned community members alongside the prosecutor and staff, circuit court judge, law enforcement, educators, and hospital staff.

The other four sites hosted by LHD staff willingly provided the necessary cooperation and organization to carry out these forums and also experienced success in getting local input from various community members. The site hosted by the local Continuum of Care group also provided a valuable forum for discussion.

The public health nurses and LHD health educators proved to be strong partners in the organization of this project. This was found at all sites where they organized and participated in the forums. Emergency room nurses also made significant contributions based on their observations and linkages within their communities. The linkages of nurses within organizations and communities may prove to be useful in gaining insight and planning strategies.

Summary of District Participants' Responses

The district forum participants responded to the process and questions very thoughtfully. As they worked in small groups, they listened to one another intently and respectfully. At the conclusion of the forums, a number of people took time to thank the ISDH staff and facilitators for the process and the assurances their voices were heard. Some 'hardened veterans' of group process indicated this was one of the most effective and respectful with which they had been involved.

Responses fell in the following categories:

- Societal and community factors that allow sexual violence to occur (gender inequality, socioeconomic conditions, a culture of entitlement, lack of institutional support for preventing the problem, etc).
- Societal and community norms
- Community collaborations/initiatives as solutions
- Educational interventions as solutions
- Individual factors as a cause for sexual violence
- Family—the role of the institution of the family in preventing sexual violence
- Media—the influence of media and negative, violent images of sexuality
- Law and Policy—solutions involving high-level, systemic change
- Treatment—secondary and tertiary prevention
- Miscellaneous

The scope and variety of the responses indicate the complexity of the issue, as well as the enormity of the task of sexual violence primary prevention planning. Many found it challenging to think about the broad scope of primary prevention and noted that it is generational work, with the need for persistence and perseverance, as outcomes will not quickly and easily be realized. The responses outlined the need for involvement of all levels and segments of society, with each targeting their own set of challenges while working interdependently. The responses also suggested the need to be open and create awareness about sexual assault and violence. Many participants expressed the opinion that many community and organizational leaders do not acknowledge that sexual assault is an issue on their watch and are not willing to seriously address it.

Many of the respondent's comments pointed to a need for change in community norms: the informal (social) rules defining acceptable behavior within a community, and within sub-populations in the community. Sometimes community norms do not always follow the law. Examples include what the community expects the prosecutor to prosecute or ignore, how juries make decisions, tolerance of underage drinking as a rite of passage, dating practices, letting "boys be boys", expectations of prom, and unhealthy behaviors in social networks such as fraternities.

Some of the responses conflicted with one another, but small group members respected these differences in the discussions. Respondents realized this issue will not be fixed with one or more government initiative(s), that the task goes beyond a grant cycle, and that all members and segments of the community must be involved contributing their time, skills and resources. Respondents also noted the move to a public policy approach is a step in the right direction because of the potential far-reaching effects.

See Appendix D *for each district's responses to each question (Questions 1-5), and other salient comments that were made during the process (Other).*

General Observations and Comments on the Process

- Participants noted that the questions progressively became more difficult. The first question produced many responses and much discussion, and as questions progressed, participants commented the questions were getting more difficult. This resulted in fewer comments and need to clarify meaning of words: policy, society, and community. Scope of understanding and input shifted, but participants remained very thoughtful and serious about responses.

- It was difficult to get some participants to discuss primary prevention, rather than secondary and tertiary prevention, judicial response, and serving victims. It became clear that primary prevention is a major paradigm shift, both for professionals working in the field and for the general public.

- ISDH staff and facilitators were able to pilot an effort that worked with the total public health system and its interrelated parts: i.e. relationship between state and local networks,

by district, within LHDs, and how communication systems are used. Staff needs to work better internally as well as within a community as a collaborator and/or lead organization. Staff/leadership development would be useful.

- The district forums were models of working in the public square. Inviting all to the table for planning, discussion, and input means putting private or organizational agendas aside and dealing with sexual violence in a straightforward manner. It takes patience and wisdom to respect differing viewpoints and find common ground from which to craft a workable, sustainable plan.

- Identifying sexual violence as a public health issue and the focus on primary prevention marks an important paradigm shift. It requires all who are involved to reframe thinking as evidenced by the responses of all the surveys and forums that have thus far been conducted. These activities help to reveal attitudes, beliefs, and needs of participants, both professionals in the field and the general public.

- People responded so positively that many sites discussed the need to develop and implement local prevention plans based upon additional local input and guidance from the state primary prevention plan.

Methodology and Results of Written Survey of Community Members

As a means of allowing input from those who could not attend a district forum, a written survey was developed. There were forty responses. The survey was lengthy with in-depth questions: people could choose to respond to the questions that they felt they were best able to answer. The questions asked what people viewed as the risk and protective factors for sexual violence and potential strategies to end sexual violence on all levels of the social ecological model. An additional section at the end of the survey asked about awareness of community resources and local prevention planning efforts.

The responses varied. Some people voiced strong opinions based on personal experience and definite perspectives, sharing personal or community stories. Other responses were somewhat more objective. Many of the responses about the causes of, risk factors for, and potential solutions to sexual violence correlated closely with what district forum participants expressed. Many who completed the survey identified gender inequity, social norms that encourage inequality and violence, negative male socialization, socioeconomic conditions, lack of education, negative media, poor parenting and relationships with peers, drug and alcohol abuse, and a lack of support systems as causes of sexual violence. Similar ideas for solutions also surfaced: social norms change, educational interventions, community and organizational support and collaboration for collective efficacy and healthy environments, increased accountability of perpetrators, and positive youth and family development and empowerment.

An important function of the survey as an addendum to the forums was to provide project staff an opportunity to listen to views that might be counter to what research data suggests. Considering this perspective will help to craft a plan that targets the real needs of citizens.

See Appendix E *for a copy of the survey tool and a summary of survey responses.*

Populations Missed in the District Forum Process

Because of the nature of the process, several crucial populations were missed. It is important to acknowledge that this model, targeted toward the general population and those able to be reached by traditional means of communication, did not succeed in reaching the following populations, and more that are not listed:

- Young adults, including college students (there were some young adults represented at the forums, but they were in the minority)
- Young men: needs to be facilitated by and for men
- Mennonite community and its colleges
- Some non-mainstream cultural and social groups
- Elderly
- Disabled
- Foster care system

Some of these populations were reached through alternative means. INCASA (Indiana Coalition Against Sexual Assault) manages a separate project to specifically address the needs of the disabled and their caregivers for sexual violence prevention. Separate focus groups were conducted with migrant farm workers in Indiana in spring 2009. (A report on this qualitative study is included in the needs and resources assessment). Additional focus groups in the form of Talking Circles are planned for the American Indian population in Indiana for summer 2009. Both of these activities will be conducted through Indiana's MESA program (Multicultural Efforts to End Sexual Assault). Finally, there are plans to conduct both focus groups through the Indiana Campus Sexual Assault Primary Prevention Project (INCSAPPP) and forums on college campuses in fall 2009. Efforts will continue to reach other populations for dialogue and prevention efforts.

Conclusion

Throughout the process of the district forums, it became evident that the participants and those with whom they live and work are deeply concerned about the impact of sexual violence on the people of Indiana. It was clear that many people are not yet ready to embrace the concept of primary prevention of sexual violence. At times, it was a struggle to keep the discussion focused on prevention as opposed to response and serving survivors. The major paradigm shift of the public health approach to sexual violence primary prevention does not happen quickly and individuals, organizations and communities cannot realistically be expected to grasp the concept immediately. Nor can they be expected to execute strategies for primary prevention without sufficient financial resources, policies that support primary prevention, and training and technical assistance. A comprehensive approach and collective action are necessary, involving both community-based systems for social change as well as leadership at the state level to ensure that efforts to make society and communities safer, healthier places for all people are successful.

During the forums, participants articulated a vision of a world free from sexual violence and supportive of healthy behaviors, relationships and families, and social justice. People are willing to work for this vision, if given the proper tools and guidance. It is the responsibility of the Indiana Sexual Violence Primary Prevention Council to lay out a strategic plan for the primary prevention of sexual violence in Indiana, and it is a collective responsibility for all citizens to embrace the principles of respect, equity, and nonviolence at home, in neighborhoods, in schools and workplaces, in faith-based communities, in social and cultural networks, and in government and policy. The strongest weapon against sexual violence is a shared value and commitment to ending it. The Indiana Sexual Violence Primary Prevention Plan is an important step in that direction, but the real work belongs to society as a whole. Sexual violence prevention is generational work, and will not be realized in a lifetime, but the first step is a commitment to working toward its elimination.

Farm Worker and Farm Worker Professional Service Provider perceptions of sexual violence and sexual violence prevention

DRAFT

By: Kimber J. Nicoletti
Director
MESA: Multicultural Efforts to end Sexual Assault

Introduction:

These focus groups examine farm workers and professional farm worker service providers' perceptions about sexual violence and how it could be prevented. The focus groups draw upon the experiences of farm workers involved in a farm worker participatory violence prevention theatre initiative, Lideres Campesinas. The facilitator uses performance-based methods as tools to engage the realities of research participants to gain clearer understanding opinions and experiences in and around protective and risk factors for sexual violence. Using an experiential learning model, the analysis focuses on participant perceptions of the activities and their verbal and non-verbal responses to the activities. The facilitator recommends that a performance-based approach to data collection, despite some limitations, offers a more expansive opportunity for participant expression. Due to the verbal and storytelling history of farm worker culture, this method provides a more culturally relevant means of capturing data than traditional approaches used in academia. In addition, due to higher levels of acculturation and education, the facilitator uses a more traditional focus group approach for use with farm worker professional service providers.

In the first part of this qualitative study, non-traditional focus groups were utilized to invite Latina migrant farm workers who were involved on some level with Lideres Campesinas to express their ideas about sexual violence prevention and how sexual violence prevention information could be delivered to other migrant farm worker women. Two focus groups composed of farm worker women (12 in the first group and 13 in the second) were conducted on February 22nd and March 22nd in Salinas, California. Due to lack of availability of Migrant Farm Workers in the State of Indiana during the early spring and the need for early data collection, the groups were conducted in California through a collaborative partnership with the National Effort to Combat Farm Worker Sexual Violence and Lideres Campesinas. However a third focus group was conducted on March 11th in Kokomo, IN with Migrant Farm Worker service professionals who have just arrived to prepare for Indiana's Migrant Farm Worker Season.

The purpose of the focus groups was to elicit information from farm workers to increase the understanding of migrant farm workers perception of the causes of sexual violence and how it could be prevented.

Participants of the first two groups were recruited by members of the Lideres Campesinas staff. Lideres Campesinas is a farm worker women advocacy organization based in California. Facilitator has no specific information about recruitment methods or group demographics. Based upon observations, all 12 participants appeared to be Mexican or from Mexican descent, female and ranging between the ages of 21-60 years old. In addition, three participants were representatives from California Rural Legal Assistance and two from Lideres Campesinas.

The major themes that emerged were: help-seeking behavior, issues with gender roles and community cultural values.

The Executive Director of Lideres Campesinas opened the groups by thanking members for their participation, explaining how this information would be utilized and introducing facilitator. Facilitator introduced herself to participants and explained that their participation was voluntary and that they could leave at any time. Facilitator also outlined rules for confidentiality and offered information on area resources should participants desire to seek outside support for any reason. The facilitator acknowledges her own assumptions to the group. The assumptions acknowledged by facilitator are that: 1. Facilitator is a university professional with a Masters degree in social work. 2. Facilitator identifies as a Chicana/Italiana. 3. Facilitator acknowledges some dialectal differences in her Spanish language word selection and accent.

Due to cultural taboos that exist around sexuality, participants were prepared for the focus groups using a series of interactive theater exercises. These exercises serve to reduce stress and increase group cohesiveness and group identity. Cultural social constructs for interaction in many Latino communities require a high level of group identity in order for the sharing of personal information to be socially acceptable. In many Latino communities, "la comunidad" or the community as a whole is valued over individualism and therefore, it is important to create an environment where it is acceptable to share personal opinions and ideas. In social settings with lower levels of cohesion or group identity, participants may experience inhibited social interactions, opinion sharing and conversation.

Two group activities were introduced and facilitated by facilitator in an open area of the room. In addition to building group rapport, these activities also established the relationship of the facilitator to the group while increasing group confidence.

Following activities, participants were seated at tables arranged in a "U" shape. Each participant was provided a small jar of play dough, access to crayons and markers, blank sheets of paper and a small container of bubbles. These supplies were available to facilitate dialogue, in addition to, reducing personal stress experienced by participants.

The focus group plan included the following questions:

Questions:

1. Where do you get information about health?
2. Which format of health information is more helpful? Why?
3. What do you think causes sexual violence?
4. What do you think would prevent sexual violence?
5. Are there actions that each of us can take to prevent sexual violence?
6. What are words or images that describe "safety" from sexual violence?
7. Participants were divided into groups: several groups of (2) and one group of (3) and asked to develop a skit between a farm worker woman and a provider. The provider needs to bring up the subject of sexual violence. How can they bring up the issue of sexual violence? How can the subject of sexual violence prevention be presented without being offensive?

Q: Where do you get information about health?

Responses:
Doctors, community members, Books, Pamphlets, looks for phone numbers for services, Lideres Campesinas Guide, Internet, doctor, police, wherever we can get help

Participants discussed where they went to look for information about health. Most of the participants acknowledged asking a healthcare provider when they needed health information. One participant stated that she would ask a family member or friend. Another participant stated that she looked up health information on the computer at the library. Several of the participants were reluctant to answer the question.

Q. The facilitator further clarified the question by sharing several examples of different types of information: cards, fotonovelas, pamphlets, booklets, brochures and asked participants if one of these examples was more helpful and why?

Responses:
Telephones, fotonovela with photos, child prefers comic-style fotonovela, call the police or ambulance

Several participants responded that they were able to get information from the various types of examples that were provided but there was a strong preference for the fotonovela. Most of the participants agreed that they preferred the colored photographs over the comic-book style fotonovela. Participants stated that they could understand additional information from merely looking at the pictures even if they had problems with literacy. One participant acknowledged that she could sit with her children and read the fotonovela with them. One participant indicated that depending on the situation a person might need to call the police if its life or death or an ambulance if you were sick instead of looking for printed information

Q. What do you think causes sexual violence?

Responses: -lack of knowledge, experiences of violence in their primary family, previous victimization, poverty, lack of jobs, resources, it's a chain reaction. They learn it and they live it, it's how men define masculinity, men feel it's their right to control others.

Participants responded that men were the main perpetrators of violence and that the social norms that define masculinity (machismo) supported their behavior. Several participants indicated that masculinity entitled men to control and have power over others. Participants also indicated that they felt like once men were grown that you could not change their social values and behavior. Participants also acknowledged issues around gender roles for men and woman as a cause of sexual violence. One of the participants stated that parents do not teach their children to respect others and that this was the main cause of sexual violence.

Q. What do you think would prevent sexual violence?

Responses: Reporting it. Telling the truth. Many people don't have information about violence prevention and we need to get more information out there about violence prevention. There is lot of different dialects/languages in which there is no information or education about sexual violence prevention. Many people are disempowered because they are not citizens and feel they cannot take action. If you are seeing a lot of violence, try to combat it. Ask for help. Parents need to teach their children in early childhood about gender role values and what is violence and when should someone ask for help. Teaching to men to respect women and to not taunt/make fun of women.

This question created a lot of conversation and many participants shared stories of personal experiences with their primary families and with their own children. Responses ranged from addressing issues around immigration and poverty to social concepts about gender roles. Many participants stated that men's attitudes had to change to prevent sexual violence; however, they felt there was little that could be done in this generation. Participants stated that preventing sexual violence starts when children are young and that parents had a responsibility to teach young children to not be violent.

Q. What does "safe" from sexual violence mean/what does it look like?
Several slides of artwork were introduced to the group to demonstrate the idea of how images can provide important information. Facilitator described the artwork and the types of messages the slides were trying to present before asking participants, "What images or words could convey safety from sexual violence?" Specifically, in developing primary prevention approaches for sexual violence against farm worker women, what images or words would best describe safety from sexual violence? Participants were asked to draw words or images that demonstrated "safety" from sexual violence using the markers and crayons on the table. Facilitator framed the activity by asking each participant to imagine she was an artist and this was for an art exhibit where each artist would be paid $1000.00 for their work. Participants joked back with the facilitator asking for an increased fee.

Responses:
Four images emerged that participants viewed as protective factors from sexual violence:

1. Respect-9 participants used the word or image of respect
2. Heart-3 participants drew an image of a heart
3. Human figures-10 participants utilized human figures
4. Family-3 participants used images or words suggesting family

After completing their drawings, participants had the opportunity to discuss their art work and explain their ideas. Ten participants elected to participate through sharing their ideas via drawing and explaining their picture. Three participants elected to express their ideas verbally and left their sheet of paper blank. The facilitator allowed each participant to select an item from a bag of gifts that she had brought with her after sharing their idea with the group. Throughout their explanations, several themes emerged, such as healthy families, personal value and respect, and supervisors/crew leaders. "Respect" was introduced in print in 9 of the drawings. However, all participants indicated "respect" was necessary to prevent sexual violence. In their discussions, participants indicated that mutual respect was necessary to prevent sexual violence. Participants expressed that mutual respect could change the emotional affect of the farm workers. In their drawings, participants indicated that farm workers would be happy when mutual respect was present by demonstrating figures with smiling faces. However when mutual respect was absent, farm workers would be sad or unhappy. This was indicated by drawing figures frowning or flat facial expressions. All participants indicated that being valued and respect were necessary elements to create an environment that was safe from sexual violence. Three of the participants used words or images of the family as a protective factor in sexual violence. All ten participants who participated with drawing used some form of human figures in their art work. The human figure was utilized as a protective factor such as family or community member in several pieces. Additionally, the human figure also represented a risk factor such as a potential perpetrator or supervisor in other drawings.

Q. How can a provider or professional introduce the subject of sexual violence?

There were five groups of (2) and one group of (3). Each group utilized theater skits to demonstrate how a provider could bring up the subject of sexual violence. Each group appeared to follow a format of rapport building, referral of service and 5 out of six groups identified the "crew leader" as the perpetrator.

1. Each group demonstrated an extended period of rapport building between provider and patient/client. This consisted of 5-6 interpersonal questions or exchanges about the patient/client, i.e., "How are you today?" "How is your family?" Though traditionally most providers might have a couple of exchanges, these examples clearly introduced the idea that a few more minutes needed to be offered to establish the Latino cultural value of

"personalismo" or where more value is placed on developing the context of the relationship rather then directly initiating the normal protocol of the appointment process.

2. After the initial rapport building part of the service provider interview, three themes emerged from the skits:

a. Help-seeking behavior –all six groups described various forms of help-seeking behavior that ranged from informal to formal and included friends who were supportive, contacting police and visiting service providers. Participants demonstrated a good knowledge of resources available that were geographically specific. Note: Due to exposure to information and trainings from Lideres Campesinas, it is not clear whether this knowledge would be consistent with farm workers in other geographic regions of the United States. Some geographic areas of the United States have very limited culturally-specific services for migrant farm workers.

b. Health-all six groups indicated some connection between health and presence of sexual harassment, violence and or abuse. Because health is viewed in a synergistic paradigm in many farm worker communities, it is not uncommon for stress, violence and health to be experienced in a holistic manner.

c. Supervisor/Crew Leader-Five of the six groups portrayed the crew leader or supervisor as the perpetrator and expressed scenarios where this supervisor is sexually harassing the farm worker woman. The supervisor is aware that the farm worker woman has few other employment options and therefore has a great need to maintain this job.

Second Group

The second focus group consisted of the same participants as the first group, with one additional farm worker woman. It was decided that it was important to share the information collected from the first group with participants as a means to empower them. All professionals involved in organizing groups shared stories of experiences with farm workers who were not allowed to be involved in the process and that in the spirit of primary prevention, it was important for them to have power over what data was collected about them.

Focus groups are becoming more widely used with low-income culturally diverse groups and recognized a valid method for collection of qualitative data. However, due to social norms and cultural taboos around the topic of sexuality specifically in farm worker settings, a non-traditional methodological process and approach was applied for data collection. Using an arts-based approach for data collection allows all participants to share and to be valued in the process. In farm worker communities, a large disparity frequently exists in abilities in the areas of literacy and spoken language. By using performance-based pieces, every participant could participate on some level. Due to the nature of these activities, everyone attending the group including staff from CRLA and Lideres Campesinas was asked to participate in activities.

1. Warming Up

The Executive Director of Lideres Campesinas opened up this focus group and introduced the facilitator and the staff members from Lideres Campesinas and CRLA.

The facilitator established the ground rules with participants, stating the need for the space to be safe, open and confidential. Participants were encouraged to take appropriate measures for self-care as needed and offered referrals for resources if needed. Facilitator thanked all participants and expressed what a great honor it was for their willingness to share their time, ideas and energy. Facilitator explained to participants that this group would also be arts-based sharing but utilizing a theater format.

Cover the Space

"Cover the Space" was the initial activity selected to warm up the group and to also help increase group confidence and rapport. This activity requires participants to silently keep the floor covered at all times. Participants are encouraged to look around the room to see if the floor is covered evenly. Facilitator tells participants to "Freeze!" Participants are asked if there are gaps in the space and if there is a volunteer who can help cover that space. This activity allows participants to engage and began moving around while maintaining self-awareness.

As the activity moved on, participants were asked to form various shapes such as circle, heart and two squares. After the activity, facilitator helped participants debrief the exercise using an experiential learning model: what did the participants experience, how participants could apply this experience and how that lesson could apply to other broader experiences.

Participants moved about and there was some nervous laughter and giggling. Participants had been propelled into this activity to encourage spontaneity and loosen inhibitions. In this way participants were encouraged to explore, discover and create, which not only allowed them to bond and connect with each other but very quickly defined the workshop as a space of interaction and performance.

"Boal handshakes"

During the second activity, participants were asked to meet all of the other participants which included CRLA and Lideres Campesinas Staff. As they hold one person's hand, they greet/introduce themselves to the other person. They must hold that person's hand until they have the hand of another. They cannot let go of one person' hand until they have the hand of another. Participants were encouraged to try to meet everyone in the room. It is important to understand that the purpose of the activities is to build group rapport and increase feeling of safety in the room. Participants shared their experiences and lessons learned following the activity.

Word Brainstorm

Participants were encouraged to brain storm to generate two separate lists of words under the categories of risk factor and protective factor from sexual violence. This activity would help generate words and concepts to explore in later activities. Additionally, this

activity helps group understand how they each relate to the concept of safety and sexual violence. Two volunteers from CRLA agreed to serve as the scribes for the list.

Image of the Word

In this activity, participants were asked to form a circle. Facilitator refreshed the group on the concept of how we learn information from images in picture. Facilitator selected a word and asked participants to raise their head and make an image of the word using facial expressions. After several rounds utilizing facial expressions, participants were asked to step into the empty space in front of them and make an image of the word using their bodies. Once everyone is in the space have the participants look around at the other images while holding their image. Relax and repeat.

Participants were asked to form a series of images using words from the risk factor list. Facilitator explored with participants what "fear or afraid" looked like and what other characteristics or feelings could be pulled from the image.

Sculpting Series

In the next series of activities, three volunteers at a time went to the center of the circle where they would form a pose from the sexual violence risk factors list of words. Participants were allowed to come forward (one person at a time) to mold the actors to change the essence of the word they were modeling. The participants were encouraged to mold/sculpt the actors from the sexual violence risk factor word list into a pose from the protective factors from sexual violence list. Initially volunteers came forward in groups of threes for this activity. For the final phase of the sculpting series, participants formed groups of 4-5 persons to create a pose from the sexual violence risk factors word list. As the actors held their pose, the facilitator engaged actors in:

Thought Tracking: A technique used to capture the thoughts, feelings or "inner monologue" of a character. When used with still images, the facilitator touches each character on the shoulder as a sign for the "actor" to say a few words, a sound, or a sentence that shows what their character might be thinking or feeling. When used with role-play, individuals can be asked to "shadow" the characters in the role-play. After each character speaks, the "shadow" says what the character is really thinking or feeling (sometimes what we say and what we feel are not the same!)

Dynamize: To bring an image to life (usually for 2-3 minutes) by asking those in the image to speak without interruption through their part of the image (i.e. to say out loud what their character or their part of the image is thinking or feeling). The actors are to remain frozen as they speak. Depending on the image, a dialogue may spontaneously develop, or the parts of the image may just recite their character's inner monologue.

Hot Seating: In order to learn more about a character's background, thoughts, and feelings, the group can pull a character out of a role play or an image and ask her questions about her life, her behaviors, her feelings, etc. The actor playing that character

must stay in role and answer the questions posed by the participants. If more than one character is hot seated at the same time and the topic being explored is a sensitive one, you may want to ask participants to imagine that the characters being hot seated are in separate rooms and cannot see or hear each other. This ensures that the characters will feel safe and be honest about their thoughts and feelings.

Discussion:

The results from the image work fell into three main categories: social context of sexual violence, plural understanding of risk and protective factors and help-seeking behavior.

Social context of sexual violence

In looking at community perspectives of sexual violence and safety, it is important to understand how traditional gender roles and their elements impact participants' perceptions of sexual violence prevention. Masculine and feminine behaviors exist along the continuum of Machismo and Marianisma. *Machismo* is a term used that implies traditional gender roles in Latino social structure. *Machismo* has become associated with patriarchal behavior of males. This often consists of controlling behavior towards women and children. It is also associated with conservative values where men oppose women's rights, or to pursue things that fall outside of their traditional gender role.

Traditional female gender role can be defined as Marianisma meaning, "Mary like", as in the Virgin Mary, as being kind, nurturing, dependent, predictable, quiet, docile, vulnerable, yet enduring of pain, virginal and without aspiration; self-sacrificing mother and wife.

The description also includes the acceptance of a double standard concerning sexual promiscuity and mutual acknowledgment of male superiority. Female roles include being gentle, delicate and protected. The female role also implies "comfort" and a boundless supply of love from the "outside" world. Often Latina women turn to another family member or her "comadre" or an elder female of the Latina social and family network.

Participant-actors were asked to select words from the sexual violence risk factor list which they had generated earlier in the day. Participants selected words such as stress, maltreatment, and hurt instead of stronger words such as rape or sexual harassment. Many of the terms given by participants under the sexual violence risk factor category during the brain storming activity were implied terms rather than direct actions. Cultural taboos around sexuality are interwoven even into the fabric of the language. Social norms and cultural taboos around sexuality make this a difficult subject to discuss and express even in private. Farm worker women's reluctance to address sexuality is one of the elements indicative of the use of a traditional gender role framework. Sensitivity to participants' reluctance to use stronger terms should be considered and reflected when developing any sexual violence prevention approaches targeted at farm worker communities.

Many of the sculptures posed by the actor participants display a tendency toward traditional gender roles. While current literature indicates some change in traditional gender roles in contemporary Latino communities, this is not indicated in most farm worker communities where access to resources, education and other forms of supports are more limited.

All of the sculptures portrayed male behavior as being "machismo" and oppressing the female actors in the sculpture. Actors made statements such as, "she's wearing tight pants," or "She wouldn't do what I told her to do," which further confirms the experience of traditional gender roles in the daily lives of this farm worker community, as with other rural farm worker communities. Additionally, machismo appears to be a paradigm that is socially accepted and endorsed by other farm worker men. In most scenes created by the women, there were multiple male perpetrators or one perpetrator who was supported by multiple male bystanders.

Plural Understanding of sexual violence prevention

This focus group aimed to answer the question, "how do farm workers view sexual violence and what are steps that can be taken to prevent sexual violence?" The main findings were that many women felt helpless from sexual violence and harassment as it was viewed as almost inevitable and that women needed to band together to stay safe which was their concept of "prevention", creating this plural understanding of safety. Women were encouraged to always travel in pairs or groups; and maintain close contact with family or friends. Most men seemed to be viewed as potential perpetrators. In earlier sessions, the crew leader was deemed as the most likely perpetrator; however, in this session participants indicated that "it wasn't always the crew leaders." Safety was indicated as something that needed to be evaluated in every situation or location.

Primary prevention seemed to be a far-off concept for farm worker women. When asked to develop a list of words that were indicative of "sexual violence prevention", it was described as free, autonomous, beautiful, optimistic, strong, satisfied, nice, cordial, relaxed and comfortable. Terms used to describe prevention were euphoric and ideal. Facilitator asked if "preventing sexual violence" might feel normal. Most participants did not imagine that feeling safe would feel "normal" but rather expressed relaxed or happy. Participants couldn't imagine real protective factors because sexual violence was viewed as inevitable.

The brainstorming activity on protective factors also contained words like ambulance, therapist, doctor and police. In the previous focus group session and in this session, many participant actors indicated that "calling the police" would be an act of safety. However, in this session, one of the participants contradicted herself, stating that the "police don't help." Other participant actors also confirmed her statement. Most of the participant-actors action steps for sexual violence prevention were in the form of help-seeking behavior.

Help-seeking behavior

The final aspect of this section of the focus group was to understand what elements of primary prevention the farm worker women found most useful. Though most of the responses fit under the category of secondary and tertiary prevention, it gives us insight into where the migrant farm worker community is in the development of primary prevention efforts, as well as identifying multiple risk factors that exist for this community. Throughout the imaging exercises and participant response sections, a great deal of conflict seemed to exist. Participant-actors who had previously stated the crew leader was the most likely perpetrator now expressed that "it wasn't always the crew leader." *Facilitator's note: male family members were not indicated as potential abusers. However, statistics around sexual violence indicate that the perpetrator could very well be a husband, father or brother as well. The common Latino value of familiarismo explains why family members might commonly be framed as a source of support. Familiarismo refers to the interdependence of and attachment to family members. This encouragement of closeness, interdependency and respect of the parental authority contrasts not only with anglo egalitarianism between parents and offspring that is often prevalent in the dominant society but also with the sense of autonomy that most members of the dominant society seek to achieve. However, this would explain why family members would always been framed as a source of support.*

Calling or communicating with someone was seen by most participants as a good act for staying safe. Participants indicated through their performances or statements that calling a friend, family members or other service providers would be a good action step to take. However "calling the police" which had been indicated as a good action step in a prevention plan was now being called into question because many participants felt like the police needed too much information and offered too few services.

In many Farm Worker communities, help-seeking behavior is informal. Help is sought out from a community or religious leader, family member or neighbor. These participants maintained that social norm and agreed that women family members or friends were regarded as safe confidantes if a woman felt unsafe or was being harassed by a man at work. Additionally the commonly held value of "comunidad" was encouraged by participant-actors as a form of support. Comunidad refers to the value of the community over the individuals. In the sculpting scenes, participants were asked how they could help actor playing role of victim. Participant-actors encouraged other women to offer help in the form of "being present" and listening to a woman who was reluctant to speak. Women felt that banding together provided a strong system for support and safety. Cell phones were seen as an essential tool in the safety plan to take pictures of perpetrators or harassers, as well as, to exchange numbers with older women, friends or colleagues for safety. Participant-actors indicated that it was most important for women to move in groups wherever they traveled; i.e. to the restroom, or making reports to supervisors. Another contradiction that existed was in reporting. Participant-actors indicated that women should take a stand to stop sexual violence by reporting but in other scenes or statements participants-actors indicated that there was reluctance to report for

fear of retaliation. i.e. being followed by perpetrator, losing their job. However one participant stated that "nothing was worth being abused or harassed, not even a job."

Trust:

There was a great deal of discussion and artistic expression about the aforementioned questions. In our previous groups and in the beginning of this group, several participants expressed strong support for calling police and making reports. However, in this group one of the same participants now stated that it is not always a good idea to call police because women are often not believed or there is lack of action. I clarified with this participant because she had previously taken a strong stand for calling the police. However she said that the truth is that calling the police is most often not very effective and that they provide little support.

There was also some discussion about the Crew Leader who had been previously identified as the most common perpetrator. Some participants stated that at times it was possible to go to the Crew Leader for support or assistance and at times it wasn't. Participants stated that some times the perpetrator is another worker and not the crew leader as previously stated. Participants felt they could most trust another woman or other women. They felt it was important to insist that you go no where alone and that another woman accompanies a woman everywhere.

They stated that "who you could trust" really varied from place to place. However that it was most important that they trust each other and that older women could help the younger women.

Third Group

Through a collaborative agreement with TMC Migrant Head Start, a third focus group was conducted on March 11th in Kokomo, Indiana with 32 experienced migrant farm worker professional service providers. Participants of the third group were recruited by TMC. Although no specific demographic data was collected, all 32 participants appeared to between the ages of 25-55. 25 participants appeared to be of Latina descent, 1 African-American and 1 Asian. 30 of the participants were women while two were male. Participants were informed that their participation was confidential and voluntary and that they could leave at any time. Additionally participants were provided with a list of resources available if the content was distressing and they needed to seek outside support.

Participants were asked three basic questions.

1. What was the cause of sexual violence?
2. What could be done to prevent sexual violence?
3. Did they think that it was important to prevent sexual violence?

Due to cultural taboos around the discussion of sexuality in most Latino communities, it was decided that the questions should be brief respecting participants' own personal comfort level with the discussion.

Most participants responded that poverty, lack of education, racism, oppression, and music/media were the root causes of sexual violence. There was no specific mention of gender roles or men as the cause of sexual violence. In fact, in this particular group, there was no mention of the word, "gender." In most Mexican or Mexican-descent communities, there is not a specific language or dialogue around gender or gender roles which can create some real challenges for using the current primary prevention approach in this community. Several participants felt like sexual violence was a real problem in the Farm Worker Community in Indiana due to limited availability of resources. However two participants did not feel like sexual violence was a problem and thought there was no major cause of sexual violence; rather they felt there were some individuals who had personal problems.

Participants were asked what we can do to prevent sexual violence. Participants' responses fell into these categories: increase awareness, build knowledge, education and skills in prevention, to not have it viewed as a taboo subject, teach prevention, understand contributing factors, increased resources and reduce barriers to prevention. One participant expressed that it was important to get involved and advocate for sexual violence prevention at the local level. Another participant felt that more needs to be done to teach respect and conflict resolution. All participants agreed that "respect" is necessary to prevent sexual violence on all levels.

When asked if it was important to prevent sexual violence, all participants strongly agreed that it was important. Most participants felt that it was important to prevent sexual violence against Migrant Farm Workers. One participant stated that we should continue with the sexual violence prevention education that is happening in the Migrant Farm Worker population. However one participant stated that there needed to be an increased understanding of what prevention is.

CONCLUSION

The data collected in this qualitative study on farm worker perception of sexual violence and how to prevent it provides important and useful information for all professionals working to prevent sexual violence in this community. For what could be the first time, farm workers have been asked to give voice to their concerns and ideas regarding the problem of sexual violence and primary prevention planning; and to collaborate with national service providers in determining the issues that should guide the development of a primary prevention planning and approaches for future interventions in the farm worker community.

The findings of these focus groups were similar to issues that have been found in other farm worker communities throughout the United States. The barriers and challenges to accessible, relevant resources, lack of knowledge/awareness on prevention strategies and

lack of training on culturally-specific sexual violence issues by professionals who work with this community have been found to be common on-going risk factors for sexual violence for migrant farm workers everywhere. In participant-actor scenes and dialogue, trust and reliance on professionals in most communities did not exist, meaning that currently available resources are not culturally salient. Mainstream programs and centers have limited ability to attract the migrant farm worker clients and in order to increase access more culturally specific programs are needed. By increasing access to primary prevention resources and through focus on a specific population, health disparities in outcomes can be decreased. The findings from this study have implications for future research and a need for additional funding to develop more extensive services for Migrant Farm Workers in Indiana.

IMHC SVP Key Informant Notes 1-22-09

Attendees:

- Calvin Roberson, Indiana Minority Health Coalition
- Elonda Wilder-Hamilton, Independent Consultant, Elkhart Minority Health Coalition
- Angela Goode, Marion County Minority Health Coalition
- Kimber Nicoletti, Multicultural Efforts to End Sexual Assault
- Angie Turk, INCASA
- Tory Bowen-Flynn, INCASA
- Katie O'Bryan, INCASA
- Abby Kelly-Smith, ISDH, Rape Prevention and Education Program Director
- Mary Boutain, ISDH, Office of Women's Health intern

Abby called the meeting to get perspective from minority health coalition partners and gather information and feedback on how to include minority community partners in the state sexual violence prevention plan.

Kimber Nicoletti gave an hour-long presentation on her many years of work with underserved ethnic populations in Indiana around sexual violence primary prevention. She has mobilized and educated many communities, and she discussed the different approaches that it is necessary to take with sexual violence prevention in these communities. She highlighted the difficulties of working with particular groups (one example was Muslim men) and how she learned to adapt her work with them to their religious beliefs and culture. The populations she has worked the most with recently are the American Indian/Tribal communities in Indiana and she has a long history with the migrant farm worker population. Her presentation inspired discussion and questions.

Abby Kelly-Smith presented after the lunch break on the public health concept of sexual violence primary prevention. Discussion followed the victimization risk factor slide presented by Abby. One participant wanted to stress the point that primary prevention is best when focused on the perpetrator (risk factors for perpetration were presented on a previous slide) and to develop programs that address risk factors of becoming a perpetrator (or the protective factors of not becoming a perpetrator). Another participant viewed the victimization slide and stated her situation was not represented there. An explanation was given that the slide was not created to explain why victims are victimized but rather to address factors that increases one's risk to becoming a victim. The larger social context in which individuals exist provides information of areas that can be addressed for primary prevention of sexual assault.

The group then began giving input on other partners that could be involved in sexual violence primary prevention in minority communities. The importance of working with faith communities was discussed. It was suggested that churches and faith communities work to shape or build values and could be a powerful ally. It was noted that it would be important to have discussions

with faith communities while developing programming, and to allow the faith communities to shape sexual violence primary prevention messages in the context of faith. It would not be well-received to develop programs for faith-based communities without their integral involvement.

Another participant suggested that churches are closed systems like schools and lessons learned about working with closed systems need to apply.

One participant suggested that some Black churches she was familiar with did not work on social action issues but rather restricted themselves to “moral’ issues or issues of faith. There was general consensus that other churches functioned in this way as well. One participant noted that experiencing sexual violence might cause a crisis of faith for church members.

A participant noted that some ministers are addressing issues such as HIV from the pulpit and should preach to those who are not “saved” or rather what they did before they were “saved”. It was suggested that pastors may not be prepared to deal with these issues (SV) and may welcome more information.

Another participant suggested the “First Ladies” group, made up of Indianapolis ministers’ wives, may be a good resource in the church where sexual violence primary prevention programming could be introduced.

A participant told of her experience of renouncing her faith following a sexual assault and her journey back to the church with help from a group called Stephen’s Ministers. She suggested this type of ministry was more effective for her than rape crisis counselors. Stephen’s Ministers are lay ministers trained in grief counseling and she suggested that directing educational efforts to this group of lay ministers may be beneficial as most large Christian churches have Stephen’s Ministers as part of the ministry team.

It was suggested by another participant that using the faith community’s teachings to address the issue of sexual violence prevention would be important. An example: Wives’ obedience to husbands—what does that mean and how does that translate to relationships today.

It was suggested that some of the churches would be easier to engage than others. PAW (Pentecostal Assemblies of the World) are historically very staunch and straight-laced. Methodist may have more social action involvement. Catholics may be based on individual priest.

A suggested approach would be “Help us better empower you to discuss/educate on this topic”.

Marion county faith-based community: churches are taking the lead on some topics. There is s hierarchy of churches. PAW headquartered in Indianapolis. It would be necessary to mobilize through leaders.

Understanding that mentality is different in rural and urban church members approach may need to be different.

There was some discussion on “Plan B” distribution at Catholic hospitals. Not sure if it was being distributed to rape victims at Catholic hospitals.

There was enthusiasm from the group regarding working with faith communities as many see it as a largely untapped resource in the community. May want to pilot a program with one church and see how it goes.

It was also suggested that child sexual assault be addressed in the State prevention plan. INCASA will provide information for the report and recommendations regarding the prevention of sexual violence to children.

Fraternities and sororities should be engaged. Most fraternities have headquarters in Indianapolis. Magazines are published for alumnae and members and this might be a good use of media.

Suggested that there might need to be subcommittee to put together contacts for these groups and start meetings with these communities.

Questions were raised about corporation involvement. Lilly, Wellpoint, Vectron connected with sexual harassment training that is already required at these companies.

André Carson, U.S. House of Representative for Marion county, is very interested in SV and DV issues.

YWCA/YMCA have some SV programs already. May want to tap into those networks and expand to churches.

Indiana Youth Institute could/should be a partner. Juvenile Justice?

Possible to make use of social networking sites such as FACEBook. INCASA may already be doing some of this.

Indiana Black Expo, NAACP, Athlete's organizations could also be valuable partners.

Indiana Sexual Violence Primary Prevention System Capacity Survey

1. Which of the following best describes your profession? (Please choose only one)

	Response Percent	Response Count
Sexual violence primary prevention educator/professional	6.9%	12
Sexual violence primary prevention educator/professional with expertise in working with marginalized and/or non-mainstream populations	1.7%	3
Victim advocate	9.7%	17
Prevention educator/professional AND victim advocate (shared duties)	2.3%	4
SANE (Sexual Assault Nurse Examiner)	0.6%	1
Medical doctor	0.0%	0
Counselor/therapist	**36.0%**	**63**
Other healthcare professional	2.3%	4
Public health professional	2.3%	4
Law enforcement	6.3%	11
Prosecutor	1.1%	2
Judge	0.0%	0
Business/Human Resources professional	1.1%	2
Educator (pre-K)	0.0%	0
Educator (K-12)	20.0%	35
College professor	1.1%	2
Faith leader	0.6%	1
Youth worker/youth leader	0.6%	1
Social service professional	5.7%	10
Local government official	0.6%	1

State government official		1.1%	2
		Other (please specify)	45
		answered question	**175**
		skipped question	**27**

2. Please indicate the Indiana county or counties in which you work.

		Response Count
		198
	answered question	**198**
	skipped question	**4**

3. Please rate the overall strength of the following components of Indiana's sexual violence primary prevention system.

	Strong	**Somewhat strong**	**Somewhat weak**	**Weak**	**Don't know**	**Response Count**
Financial resources	4.5% (9)	11.1% (22)	23.6% (47)	13.1% (26)	**47.7% (95)**	199
Training/Technical Assistance	5.1% (10)	26.2% (51)	19.5% (38)	8.7% (17)	**40.5% (79)**	195
Use of evidence-informed strategies/programs	6.1% (12)	24.5% (48)	14.8% (29)	10.7% (21)	**43.9% (86)**	196
Evaluation of strategies/programs	4.1% (8)	19.0% (37)	16.9% (33)	8.7% (17)	**51.3% (100)**	195
Partnerships and collaboration	15.7% (31)	**31.0% (61)**	18.3% (36)	4.1% (8)	**31.0% (61)**	197
Policy	6.6% (13)	25.9% (51)	15.2% (30)	5.6% (11)	**46.7% (92)**	197
Data collection	5.1% (10)	16.3% (32)	15.3% (30)	8.2% (16)	**55.1% (108)**	196
				answered question		**199**
				skipped question		**3**

4. How adequate are the financial resources available in Indiana to fund sexual violence primary prevention efforts?

	Response Percent	Response Count
More than adequate	0.0%	0
Adequate	7.8%	15
Somewhat lacking	28.5%	55
Severely lacking	21.8%	42
Don't know	**42.0%**	**81**
	answered question	**193**
	skipped question	**9**

5. In the past, where have you received sexual violence primary prevention training and technical assistance? (check all that apply)

	Response Percent	Response Count
CARe (Communities Against Rape) trainings	21.8%	34
INCASA (Indiana Coalition Against Sexual Assault) trainings	27.6%	43
INCSAPP (Indiana Campus Sexual Assault Prevention Program) trainings	15.4%	24
Local community sexual violence prevention programs	**38.5%**	**60**
Indiana State Department of Health	5.1%	8
Out-of-state conferences or trainings	17.9%	28
I have never received training or technical assistance on sexual violence primary prevention	35.9%	56
	Other (please specify)	23
	answered question	**156**
	skipped question	**46**

6. Please rate the overall sufficiency and quality of training and technical assistance available in Indiana for each of the following to violence primary prevention.

Sufficiency

	More than needed	Just enough	Somewhat lacking	Severely lacking	Don't
Male involvement	1.3% (2)	4.7% (7)	20.8% (31)	25.5% (38)	**47.7**
Special strategies for reaching diverse and special-needs populations	1.4% (2)	8.8% (13)	29.3% (43)	15.6% (23)	**44.9**
Community collaboration/coalition building	2.7% (4)	27.7% (41)	**30.4% (45)**	9.5% (14)	29.7
Policy development	3.4% (5)	12.8% (19)	19.6% (29)	6.8% (10)	**57.4**
Funding/grant applications	1.4% (2)	9.5% (14)	23.8% (35)	15.6% (23)	**49.7**
Using evidence-informed strategies and programs	1.4% (2)	15.0% (22)	22.4% (33)	12.9% (19)	**48.3**
Program evaluation	1.4% (2)	15.8% (23)	17.8% (26)	13.7% (20)	**51.4**

Quality

	Excellent	Good	Fair	Poor	Don't
Male involvement	0.7% (1)	14.1% (19)	19.3% (26)	12.6% (17)	**53.3**
Special strategies for reaching diverse and special-needs populations	3.0% (4)	7.5% (10)	23.9% (32)	12.7% (17)	**53.0**
Community collaboration/coalition building	9.6% (13)	20.6% (28)	25.7% (35)	10.3% (14)	**33.8**
Policy development	3.8% (5)	11.3% (15)	19.5% (26)	6.8% (9)	**58.6**
Funding/grant applications	2.2% (3)	11.9% (16)	14.8% (20)	17.0% (23)	**54.1**
Using evidence-informed strategies and programs	3.0% (4)	11.3% (15)	22.6% (30)	10.5% (14)	**52.6**
Program evaluation	2.3% (3)	11.4% (15)	18.9% (25)	13.6% (18)	**53.8**
					answered
					skipped

7. How could training and technical assistance for the sexual violence primary prevention professional community in Indiana be improved?

	Response Count
	100
answered question	**100**
skipped question	**102**

8. Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?

	Response Percent	Response Count
Yes	20.8%	33
No	**79.2%**	**126**
answered question		**159**
skipped question		**43**

9. Please indicate how familiar you are with evidence-informed strategies for sexual violence prevention.

	Response Percent	Response Count
Very familiar	25.0%	8
Somewhat familiar	**59.4%**	**19**
Not at all familiar	12.5%	4
Don't know/not sure	3.1%	1
answered question		**32**
skipped question		**170**

10. How well are you able to integrate evidence-informed sexual violence primary prevention strategies into your work?

	Response Percent	Response Count
Very well	12.9%	4
Moderately well	**67.7%**	**21**
Not very well	16.1%	5
I am unable to integrate evidence-informed sexual violence primary prevention strategies into my work	3.2%	1
answered question		**31**
skipped question		**171**

11. What are the barriers you face in integrating evidence-informed sexual violence primary prevention strategies into your work? (check all that apply)

	Response Percent	Response Count
I am not familiar with any evidence-informed strategies.	15.4%	4
I do not know how to incorporate evidence-informed strategies in a practical way.	11.5%	3
The evidence-informed strategies with which I am familiar do not apply to the population(s) I serve.	23.1%	6
I do not have sufficient financial resources to implement evidence-informed strategies.	**53.8%**	**14**
I do not have sufficient human resources to implement evidence-informed strategies.	26.9%	7
Other (please specify)		5
answered question		**26**
skipped question		**176**

12. Please indicate how well you understand how to use evaluation tools for sexual violence primary prevention efforts.

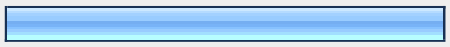
	Very well	Moderately well	Not very well	Poorly	I do not know what this tool is	Response Count
Process evaluation mechanisms	16.1% (5)	**38.7% (12)**	19.4% (6)	3.2% (1)	22.6% (7)	31
Pre/post tests	**56.3% (18)**	25.0% (8)	12.5% (4)	3.1% (1)	3.1% (1)	32
Key informant interviews	25.8% (8)	**41.9% (13)**	9.7% (3)	0.0% (0)	22.6% (7)	31
Focus groups	28.1% (9)	**37.5% (12)**	15.6% (5)	3.1% (1)	15.6% (5)	32
Surveys	**46.9% (15)**	31.3% (10)	9.4% (3)	3.1% (1)	9.4% (3)	32
Magnitude, prevalence, and occurence data collection and analysis	21.9% (7)	**34.4% (11)**	25.0% (8)	6.3% (2)	12.5% (4)	32
					answered question	**32**
					skipped question	**170**

13. Please specify any barriers you face in evaluating your sexual violence primary prevention strategies/programs (check all that apply).

	Response Percent	Response Count
I do not understand what program evaluation tools are.	16.7%	4
I do not know how to use program evaluation tools.	16.7%	4
I do not know how to interpert evaluation results to assess whether my programs or initiatives are effective.	12.5%	3
I do not have sufficient staff to evaluate my programs and initiatives.	54.2%	13
I do not have sufficient financial resources to evaluate my programs and initiatives.	**62.5%**	**15**
Other (please specify)		5
answered question		**24**

	skipped question	**178**

14. Overall, how well do you feel that your organization or entity collaborates with outside partners on comprehensive sexual violence primary prevention efforts?

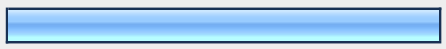
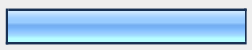
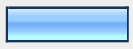
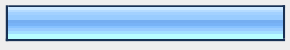
		Response Percent	Response Count
Very well		**48.4%**	**15**
Moderately well		29.0%	9
Not very well		19.4%	6
Poorly		3.2%	1
	answered question		**31**
	skipped question		**171**

15. Please indicate the strength of your organization's collaboration with each of the following types of external partners in your sexual violence primary prevention work.

	Strong	Somewhat strong	Somewhat weak	Weak	No collaboration	Don't know	Response Count
Indiana State Department of Health staff	28.1% (9)	21.9% (7)	3.1% (1)	9.4% (3)	**31.3% (10)**	6.3% (2)	32
Indiana Coalition Against Sexual Assault staff	28.1% (9)	**34.4% (11)**	12.5% (4)	3.1% (1)	21.9% (7)	0.0% (0)	32
INCSAPPP staff and graduate assistants	**25.0% (8)**	18.8% (6)	15.6% (5)	9.4% (3)	21.9% (7)	9.4% (3)	32
MESA (Multicultural Efforts to End Sexual Assault) staff	16.1% (5)	12.9% (4)	9.7% (3)	9.7% (3)	**41.9% (13)**	9.7% (3)	31
Rape crisis centers/domestic violence programs	31.3% (10)	**37.5% (12)**	6.3% (2)	9.4% (3)	12.5% (4)	3.1% (1)	32
Community-based organizations	25.0% (8)	**50.0% (16)**	12.5% (4)	6.3% (2)	6.3% (2)	0.0% (0)	32
Social service programs	25.0% (8)	**43.8% (14)**	12.5% (4)	3.1% (1)	15.6% (5)	0.0% (0)	32
Youth-serving organizations	25.0% (8)	**37.5% (12)**	6.3% (2)	6.3% (2)	18.8% (6)	6.3% (2)	32
Organizations working with men and boys	18.8% (6)	12.5% (4)	25.0% (8)	9.4% (3)	**28.1% (9)**	6.3% (2)	32

Organizations working with women and girls	18.8% (6)	**34.4% (11)**	15.6% (5)	9.4% (3)	21.9% (7)	0.0% (0)	32
Organizations serving diverse and/or marginalized populations	12.5% (4)	**31.3% (10)**	12.5% (4)	9.4% (3)	28.1% (9)	6.3% (2)	32
Colleges and universities	**34.4% (11)**	28.1% (9)	3.1% (1)	12.5% (4)	18.8% (6)	3.1% (1)	32
Faith-based organizations	15.6% (5)	25.0% (8)	15.6% (5)	12.5% (4)	**28.1% (9)**	3.1% (1)	32
Business community	3.1% (1)	31.3% (10)	15.6% (5)	9.4% (3)	**34.4% (11)**	6.3% (2)	32
Local government	15.6% (5)	**31.3% (10)**	18.8% (6)	9.4% (3)	18.8% (6)	6.3% (2)	32
						answered question	**32**
						skipped question	**170**

16. What are the barriers your organization faces in collaborating with outside partners on sexual violence primary prevention efforts? (check all that apply)

		Response Percent	Response Count
Outside partners do not see how sexual violence prevention pertains to them and are not interested in collaboration.		**47.8%**	**11**
Outside partners are interested in collaboration, but do not have the capacity to collaborate with us.		26.1%	6
My organization does not have the time to facilitate collaboration with partners.		13.0%	3
My organization does not have financial resources to facilitate collaboration with partners.		43.5%	10
My organization does not have human resources to facilitate collaboration with partners.		30.4%	7
		Other (please specify)	5
		answered question	**23**
		skipped question	**179**

17. Please rate the overall STRENGTH of policies in your COMMUNITY OR CAMPUS on the following topics. For the purpose of this survey, "policy" refers to legislation, codes, and ordinances, as well as organizational practices, standards, rules, and regulations.

	Strong	Somewhat strong	Somewhat weak	Weak	No policy exists	Don't know	Response Count
Bullying	17.1% (25)	**45.9% (67)**	14.4% (21)	9.6% (14)	3.4% (5)	9.6% (14)	146
Sexual harrassment	21.2% (31)	**40.4% (59)**	21.2% (31)	8.9% (13)	0.7% (1)	7.5% (11)	146
Policies setting sanctions on businesses promoting sexual disrespect and violence against women	11.0% (16)	**26.2% (38)**	19.3% (28)	8.3% (12)	9.7% (14)	25.5% (37)	145
Prohibition of advertising, media or messages promoting violence	17.1% (25)	**24.0% (35)**	21.2% (31)	12.3% (18)	7.5% (11)	17.8% (26)	146
						Comments:	18
						answered question	**146**
						skipped question	**56**

18. Please indicate how well policies in your COMMUNITY OR CAMPUS are ENFORCED regarding the following topics.

	Very well	Moderately well	Not very well	Poorly	Not at all	No policy exists	Don't know	Response Count
Bullying	15.9% (23)	**49.0% (71)**	13.8% (20)	4.8% (7)	2.8% (4)	3.4% (5)	10.3% (15)	145
Sexual harrassment	21.5% (31)	**46.5% (67)**	13.2% (19)	6.3% (9)	0.7% (1)	0.0% (0)	11.8% (17)	144
Policies setting sanctions on businesses promoting sexual disrespect and violence against women	13.9% (20)	26.4% (38)	17.4% (25)	4.2% (6)	2.1% (3)	6.9% (10)	**29.2% (42)**	144
Prohibition of advertising, media or messages promoting violence	18.8% (27)	**29.2% (42)**	17.4% (25)	6.3% (9)	2.8% (4)	4.9% (7)	20.8% (30)	144
							Comments:	9
							answered question	**146**
							skipped question	**56**

19. Please rate the overall STRENGTH of policies on a STATE level on the following topics.

	Strong	Somewhat strong	Somewhat weak	Weak	No policy exists	Don't know	Response Count
Bullying	8.3% (12)	**36.1% (52)**	11.1% (16)	6.9% (10)	2.8% (4)	34.7% (50)	144
Sexual harrassment	8.4% (12)	**37.8% (54)**	11.2% (16)	7.7% (11)	1.4% (2)	33.6% (48)	143
Policies setting sanctions on businesses promoting sexual disrespect and violence against women	4.2% (6)	18.1% (26)	11.8% (17)	12.5% (18)	4.2% (6)	**49.3% (71)**	144
Prohibition of advertising, media or messages promoting violence	2.8% (4)	14.7% (21)	9.1% (13)	17.5% (25)	4.2% (6)	**51.7% (74)**	143
						Comments:	5
						answered question	**144**
						skipped question	**58**

20. Please indicate the how well policies are ENFORCED on a STATE level regarding the following topics.

	Very well	Moderately well	Not very well	Poorly	Not at all	No policy exists	Don't know	Response Count
Bullying	3.5% (5)	20.1% (29)	16.0% (23)	11.1% (16)	1.4% (2)	2.1% (3)	**45.8% (66)**	144
Sexual harrassment	4.9% (7)	20.8% (30)	17.4% (25)	9.7% (14)	1.4% (2)	1.4% (2)	**44.4% (64)**	144
Policies setting sanctions on businesses promoting sexual disrespect and violence against women	2.1% (3)	13.9% (20)	14.6% (21)	9.7% (14)	2.1% (3)	2.8% (4)	**54.9% (79)**	144
Prohibition of advertising, media or messages promoting violence	1.4% (2)	12.6% (18)	10.5% (15)	12.6% (18)	2.1% (3)	3.5% (5)	**57.3% (82)**	143
							Comments:	3
							answered question	**144**
							skipped question	**58**

21. Please rate the overall strength of the STATEWIDE sexual violence incidence, prevalence, and magnitude data collection systems.

	Response Percent	Response Count
Strong	1.4%	2
Somewhat strong	16.7%	24
Somewhat weak	16.7%	24
Weak	9.7%	14
Don't know	**55.6%**	**80**
	answered question	**144**
	skipped question	**58**

22. Please rate the overall strength of YOUR COMMUNITY'S sexual violence incidence, prevalence, and magnitude data collection system(s).

	Response Percent	Response Count
Strong	3.4%	5
Somewhat strong	20.7%	30
Somewhat weak	11.0%	16
Weak	16.6%	24
My community has no sexual violence incidence, prevalence, or magnitude data collection system	4.1%	6
Don't know	**44.1%**	**64**
	answered question	**145**
	skipped question	**57**

23. Please indicate which organizations in your community collect sexual violence data.

	Response Percent	Response Count
Hospitals/emergency rooms	48.6%	70
Law enforcement	**58.3%**	**84**
Courts	30.6%	44
Rape crisis centers/domestic violence agencies	49.3%	71
College campuses	25.0%	36
Other social service agency	18.8%	27
Don't know	35.4%	51
Other (please specify)		9
answered question		**144**
skipped question		**58**

Indiana Sexual Violence Primary Prevention System Capacity Survey

1. Which of the following best describes your profession? (Please choose only one)

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Sexual violence primary prevention educator/professional	**27.6% (8)**	**27.6% (8)**
Sexual violence primary prevention educator/professional with expertise in working with marginalized and/or non-mainstream populations	6.9% (2)	6.9% (2)
Victim advocate	20.7% (6)	20.7% (6)
Prevention educator/professional AND victim advocate (shared duties)	6.9% (2)	6.9% (2)
SANE (Sexual Assault Nurse Examiner)	0.0% (0)	0.0% (0)
Medical doctor	0.0% (0)	0.0% (0)
Counselor/therapist	13.8% (4)	13.8% (4)
Other healthcare professional	0.0% (0)	0.0% (0)
Public health professional	3.4% (1)	3.4% (1)
Law enforcement	0.0% (0)	0.0% (0)
Prosecutor	0.0% (0)	0.0% (0)
Judge	0.0% (0)	0.0% (0)
Business/Human Resources professional	0.0% (0)	0.0% (0)
Educator (pre-K)	0.0% (0)	0.0% (0)

Educator (K-12)	3.4% (1)	3.4% (1)
College professor	0.0% (0)	0.0% (0)
Faith leader	3.4% (1)	3.4% (1)
Youth worker/youth leader	3.4% (1)	3.4% (1)
Social service professional	10.3% (3)	10.3% (3)
Local government official	0.0% (0)	0.0% (0)
State government official	0.0% (0)	0.0% (0)
Other (please specify)	6	6
answered question	29	**29**
	skipped question	**4**

2. Please indicate the Indiana county or counties in which you work.

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Count**
	33	33
answered question	33	**33**
	skipped question	**0**

3. Please rate the overall strength of the following components of Indiana's sexual violence primary prevention system.			
		Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
		Yes	**Response Totals**
Financial resources	**Strong**	9.1% (3)	
	Somewhat strong	**30.3% (10)**	
	Somewhat weak	27.3% (9)	
	Weak	21.2% (7)	
	Don't know	12.1% (4)	
		33	33
Training/Technical Assistance	**Strong**	9.1% (3)	
	Somewhat strong	**45.5% (15)**	
	Somewhat weak	24.2% (8)	
	Weak	9.1% (3)	
	Don't know	12.1% (4)	
		33	33
Use of evidence-informed strategies/programs	**Strong**	18.2% (6)	
	Somewhat strong	**39.4% (13)**	
	Somewhat weak	15.2% (5)	
	Weak	12.1% (4)	

	Don't know	15.2% (5)	
		33	33
Evaluation of strategies/programs	**Strong**	6.1% (2)	
	Somewhat strong	**42.4% (14)**	
	Somewhat weak	24.2% (8)	
	Weak	9.1% (3)	
	Don't know	18.2% (6)	
		33	33
Partnerships and collaboration	**Strong**	30.3% (10)	
	Somewhat strong	**42.4% (14)**	
	Somewhat weak	15.2% (5)	
	Weak	3.0% (1)	
	Don't know	9.1% (3)	
		33	33
Policy	**Strong**	15.2% (5)	
	Somewhat strong	**30.3% (10)**	
	Somewhat weak	**30.3% (10)**	
	Weak	6.1% (2)	
	Don't know	18.2% (6)	
		33	33

Data collection	**Strong**	12.1% (4)	
	Somewhat strong	**39.4% (13)**	
	Somewhat weak	24.2% (8)	
	Weak	3.0% (1)	
	Don't know	21.2% (7)	
		33	33
	answered question	33	**33**
		skipped question	**0**

4. How adequate are the financial resources available in Indiana to fund sexual violence primary prevention efforts?

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
More than adequate	0.0% (0)	0.0% (0)
Adequate	12.1% (4)	12.1% (4)
Somewhat lacking	**45.5% (15)**	**45.5% (15)**
Severely lacking	30.3% (10)	30.3% (10)
Don't know	12.1% (4)	12.1% (4)
answered question	33	**33**
	skipped question	**0**

5. In the past, where have you received sexual violence primary prevention training and technical assistance? (check all that apply)

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
CARe (Communities Against Rape) trainings	43.8% (14)	43.8% (14)
INCASA (Indiana Coalition Against Sexual Assault) trainings	50.0% (16)	50.0% (16)
INCSAPP (Indiana Campus Sexual Assault Prevention Program) trainings	37.5% (12)	37.5% (12)
Local community sexual violence prevention programs	**62.5% (20)**	**62.5% (20)**
Indiana State Department of Health	15.6% (5)	15.6% (5)
Out-of-state conferences or trainings	34.4% (11)	34.4% (11)
I have never received training or technical assistance on sexual violence primary prevention	0.0% (0)	0.0% (0)
Other (please specify)	5	5
answered question	32	**32**
	skipped question	**1**

6. Please rate the overall sufficiency and quality of training and technical assistance available in Indiana for each of the following to violence primary prevention.

Sufficiency

	More than needed	Just enough	Somewhat lacking	Severely lacking	Don't
Male involvement	3.2% (1)	3.2% (1)	**38.7% (12)**	35.5% (11)	19.4
Special strategies for reaching diverse and special-needs populations	0.0% (0)	6.5% (2)	**58.1% (18)**	12.9% (4)	22.6
Community collaboration/coalition building	3.2% (1)	**54.8% (17)**	32.3% (10)	6.5% (2)	3.2
Policy development	3.2% (1)	9.7% (3)	**41.9% (13)**	12.9% (4)	32.3
Funding/grant applications	0.0% (0)	29.0% (9)	**41.9% (13)**	16.1% (5)	12.9
Using evidence-informed strategies and programs	0.0% (0)	29.0% (9)	**35.5% (11)**	19.4% (6)	16.1
Program evaluation	0.0% (0)	29.0% (9)	**35.5% (11)**	16.1% (5)	19.4

Quality

	Excellent	Good	Fair	Poor	Don't
Male involvement	0.0% (0)	24.1% (7)	24.1% (7)	24.1% (7)	**27.6**
Special strategies for reaching diverse and special-needs populations	3.4% (1)	13.8% (4)	**37.9% (11)**	17.2% (5)	27.6
Community collaboration/coalition building	20.7% (6)	**34.5% (10)**	31.0% (9)	13.8% (4)	0.0
Policy development	10.7% (3)	10.7% (3)	28.6% (8)	17.9% (5)	**32.1**
Funding/grant applications	10.3% (3)	27.6% (8)	**31.0% (9)**	17.2% (5)	13.8
Using evidence-informed strategies and programs	10.3% (3)	20.7% (6)	**31.0% (9)**	17.2% (5)	20.7
Program evaluation	0.0% (0)	27.6% (8)	**37.9% (11)**	6.9% (2)	27.6
					answered
					skipped

7. How could training and technical assistance for the sexual violence primary prevention professional community in Indiana be improved?

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Count**
	25	25
answered question	25	**25**
	skipped question	**8**

8. Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Yes	**100.0% (33)**	**100.0% (33)**
No	0.0% (0)	0.0% (0)
answered question	33	**33**
	skipped question	**0**

9. Please indicate how familiar you are with evidence-informed strategies for sexual violence prevention.

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Very familiar	25.0% (8)	25.0% (8)
Somewhat familiar	**59.4% (19)**	**59.4% (19)**
Not at all familiar	12.5% (4)	12.5% (4)
Don't know/not sure	3.1% (1)	3.1% (1)
answered question	32	**32**
	skipped question	**1**

10. How well are you able to integrate evidence-informed sexual violence primary prevention strategies into your work?

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Very well	12.9% (4)	12.9% (4)
Moderately well	**67.7% (21)**	**67.7% (21)**
Not very well	16.1% (5)	16.1% (5)
I am unable to integrate evidence-informed sexual violence primary prevention strategies into my work	3.2% (1)	3.2% (1)
answered question	31	**31**
	skipped question	**2**

11. What are the barriers you face in integrating evidence-informed sexual violence primary prevention strategies into your work? (check all that apply)

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
I am not familiar with any evidence-informed strategies.	15.4% (4)	15.4% (4)
I do not know how to incorporate evidence-informed strategies in a practical way.	11.5% (3)	11.5% (3)
The evidence-informed strategies with which I am familiar do not apply to the population(s) I serve.	23.1% (6)	23.1% (6)
I do not have sufficient financial resources to implement evidence-informed strategies.	**53.8% (14)**	**53.8% (14)**
I do not have sufficient human resources to implement evidence-informed strategies.	26.9% (7)	26.9% (7)
Other (please specify)	5	5
answered question	26	**26**
	skipped question	**7**

12. Please indicate how well you understand how to use evaluation tools for sexual violence primary prevention efforts.			
		Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
		Yes	Response Totals
Process evaluation mechanisms	Very well	16.1% (5)	
	Moderately well	**38.7% (12)**	
	Not very well	19.4% (6)	
	Poorly	3.2% (1)	
	I do not know what this tool is	22.6% (7)	
		31	31
Pre/post tests	Very well	**56.3% (18)**	
	Moderately well	25.0% (8)	
	Not very well	12.5% (4)	
	Poorly	3.1% (1)	
	I do not know what this tool is	3.1% (1)	
		32	32
Key informant interviews	Very well	25.8% (8)	
	Moderately well	**41.9% (13)**	
	Not very well	9.7% (3)	

	Poorly	0.0% (0)	
	I do not know what this tool is	22.6% (7)	
		31	31
Focus groups	**Very well**	28.1% (9)	
	Moderately well	**37.5% (12)**	
	Not very well	15.6% (5)	
	Poorly	3.1% (1)	
	I do not know what this tool is	15.6% (5)	
		32	32
Surveys	**Very well**	**46.9% (15)**	
	Moderately well	31.3% (10)	
	Not very well	9.4% (3)	
	Poorly	3.1% (1)	
	I do not know what this tool is	9.4% (3)	
		32	32
Magnitude, prevalence, and occurence data collection and analysis	**Very well**	21.9% (7)	
	Moderately well	**34.4% (11)**	
	Not very well	25.0% (8)	
	Poorly	6.3%	

		(2)	
	I do not know what this tool is	12.5% (4)	
		32	32
	answered question	32	**32**
		skipped question	**1**

13. Please specify any barriers you face in evaluating your sexual violence primary prevention strategies/programs (check all that apply).

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
I do not understand what program evaluation tools are.	16.7% (4)	16.7% (4)
I do not know how to use program evaluation tools.	16.7% (4)	16.7% (4)
I do not know how to interpert evaluation results to assess whether my programs or initiatives are effective.	12.5% (3)	12.5% (3)
I do not have sufficient staff to evaluate my programs and initiatives.	54.2% (13)	54.2% (13)
I do not have sufficient financial resources to evaluate my programs and initiatives.	**62.5% (15)**	**62.5% (15)**
Other (please specify)	5	5
answered question	24	**24**
	skipped question	**9**

14. Overall, how well do you feel that your organization or entity collaborates with outside partners on comprehensive sexual violence primary prevention efforts?

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Very well	**48.4% (15)**	**48.4% (15)**
Moderately well	29.0% (9)	29.0% (9)
Not very well	19.4% (6)	19.4% (6)
Poorly	3.2% (1)	3.2% (1)
answered question	31	**31**
	skipped question	**2**

15. Please indicate the strength of your organization's collaboration with each of the following types of external partners in your sexual violence primary prevention work.

		Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
		Yes	**Response Totals**
Indiana State Department of Health staff	**Strong**	28.1% (9)	
	Somewhat strong	21.9% (7)	
	Somewhat weak	3.1% (1)	
	Weak	9.4% (3)	
	No collaboration	**31.3% (10)**	
	Don't know	6.3% (2)	

		32	32
Indiana Coalition Against Sexual Assault staff	**Strong**	28.1% (9)	
	Somewhat strong	**34.4% (11)**	
	Somewhat weak	12.5% (4)	
	Weak	3.1% (1)	
	No collaboration	21.9% (7)	
	Don't know	0.0% (0)	
		32	32
INCSAPPP staff and graduate assistants	**Strong**	**25.0% (8)**	
	Somewhat strong	18.8% (6)	
	Somewhat weak	15.6% (5)	
	Weak	9.4% (3)	
	No collaboration	21.9% (7)	
	Don't know	9.4% (3)	
		32	32
MESA (Multicultural Efforts to End Sexual Assault) staff	**Strong**	16.1% (5)	
	Somewhat strong	12.9% (4)	
	Somewhat weak	9.7% (3)	
	Weak	9.7% (3)	

	No collaboration	**41.9% (13)**	
	Don't know	9.7% (3)	
		31	31
Rape crisis centers/domestic violence programs	**Strong**	31.3% (10)	
	Somewhat strong	**37.5% (12)**	
	Somewhat weak	6.3% (2)	
	Weak	9.4% (3)	
	No collaboration	12.5% (4)	
	Don't know	3.1% (1)	
		32	32
Community-based organizations	**Strong**	25.0% (8)	
	Somewhat strong	**50.0% (16)**	
	Somewhat weak	12.5% (4)	
	Weak	6.3% (2)	
	No collaboration	6.3% (2)	
	Don't know	0.0% (0)	
		32	32
Social service programs	**Strong**	25.0% (8)	
	Somewhat strong	**43.8% (14)**	
	Somewhat	12.5%	

	weak	(4)	
	Weak	3.1% (1)	
	No collaboration	15.6% (5)	
	Don't know	0.0% (0)	
		32	32
Youth-serving organizations	**Strong**	25.0% (8)	
	Somewhat strong	**37.5% (12)**	
	Somewhat weak	6.3% (2)	
	Weak	6.3% (2)	
	No collaboration	18.8% (6)	
	Don't know	6.3% (2)	
		32	32
Organizations working with men and boys	**Strong**	18.8% (6)	
	Somewhat strong	12.5% (4)	
	Somewhat weak	25.0% (8)	
	Weak	9.4% (3)	
	No collaboration	**28.1% (9)**	
	Don't know	6.3% (2)	
		32	32
Organizations working with women and girls	**Strong**	18.8% (6)	

	Somewhat strong	**34.4% (11)**	
	Somewhat weak	15.6% (5)	
	Weak	9.4% (3)	
	No collaboration	21.9% (7)	
	Don't know	0.0% (0)	
		32	32
Organizations serving diverse and/or marginalized populations	**Strong**	12.5% (4)	
	Somewhat strong	**31.3% (10)**	
	Somewhat weak	12.5% (4)	
	Weak	9.4% (3)	
	No collaboration	28.1% (9)	
	Don't know	6.3% (2)	
		32	32
Colleges and universities	**Strong**	**34.4% (11)**	
	Somewhat strong	28.1% (9)	
	Somewhat weak	3.1% (1)	
	Weak	12.5% (4)	
	No collaboration	18.8% (6)	
	Don't know	3.1% (1)	

		32	32
Faith-based organizations	**Strong**	15.6% (5)	
	Somewhat strong	25.0% (8)	
	Somewhat weak	15.6% (5)	
	Weak	12.5% (4)	
	No collaboration	**28.1%** **(9)**	
	Don't know	3.1% (1)	
		32	32
Business community	**Strong**	3.1% (1)	
	Somewhat strong	31.3% (10)	
	Somewhat weak	15.6% (5)	
	Weak	9.4% (3)	
	No collaboration	**34.4%** **(11)**	
	Don't know	6.3% (2)	
		32	32
Local government	**Strong**	15.6% (5)	
	Somewhat strong	**31.3%** **(10)**	
	Somewhat weak	18.8% (6)	
	Weak	9.4% (3)	
	No	18.8%	

	collaboration	(6)	
	Don't know	6.3% (2)	
		32	32
	answered question	32	**32**
		skipped question	**1**

16. What are the barriers your organization faces in collaborating with outside partners on sexual violence primary prevention efforts? (check all that apply)

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Outside partners do not see how sexual violence prevention pertains to them and are not interested in collaboration.	**47.8% (11)**	**47.8% (11)**
Outside partners are interested in collaboration, but do not have the capacity to collaborate with us.	26.1% (6)	26.1% (6)
My organization does not have the time to facilitate collaboration with partners.	13.0% (3)	13.0% (3)
My organization does not have financial resources to facilitate collaboration with partners.	43.5% (10)	43.5% (10)
My organization does not have human resources to facilitate collaboration with partners.	30.4% (7)	30.4% (7)
Other (please specify)	5	5
answered question	23	**23**
	skipped question	**10**

17. Please rate the overall STRENGTH of policies in your COMMUNITY OR CAMPUS on the following topics. For the purpose of this survey, "policy" refers to legislation, codes, and ordinances, as well as organizational practices, standards, rules, and regulations.

		Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
		Yes	**Response Totals**
Bullying	**Strong**	12.5% (4)	
	Somewhat strong	**43.8% (14)**	
	Somewhat weak	12.5% (4)	
	Weak	18.8% (6)	
	No policy exists	3.1% (1)	
	Don't know	9.4% (3)	
		32	32
Sexual harrassment	**Strong**	9.4% (3)	
	Somewhat strong	**43.8% (14)**	
	Somewhat weak	34.4% (11)	
	Weak	6.3% (2)	
	No policy exists	3.1% (1)	
	Don't know	3.1% (1)	
		32	32
Policies setting sanctions on businesses promoting sexual disrespect and violence against women	**Strong**	9.7% (3)	

	Somewhat strong	**25.8% (8)**	
	Somewhat weak	**25.8% (8)**	
	Weak	9.7% (3)	
	No policy exists	16.1% (5)	
	Don't know	12.9% (4)	
		31	31
Prohibition of advertising, media or messages promoting violence	**Strong**	12.5% (4)	
	Somewhat strong	15.6% (5)	
	Somewhat weak	**25.0% (8)**	
	Weak	21.9% (7)	
	No policy exists	9.4% (3)	
	Don't know	15.6% (5)	
		32	32
Comments:		3	3
answered question		32	**32**
		skipped question	**1**

18. Please indicate how well policies in your COMMUNITY OR CAMPUS are ENFORCED regarding the following topics.			
		Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
		Yes	**Response Totals**
Bullying	**Very well**	9.4% (3)	
	Moderately well	**50.0% (16)**	
	Not very well	12.5% (4)	
	Poorly	6.3% (2)	
	Not at all	6.3% (2)	
	No policy exists	3.1% (1)	
	Don't know	12.5% (4)	
		32	32
Sexual harrassment	**Very well**	9.4% (3)	
	Moderately well	**50.0% (16)**	
	Not very well	18.8% (6)	
	Poorly	6.3% (2)	
	Not at all	0.0% (0)	
	No policy exists	0.0% (0)	
	Don't know	15.6% (5)	
		32	32

Policies setting sanctions on businesses promoting sexual disrespect and violence against women	**Very well**	15.6% (5)	
	Moderately well	**25.0% (8)**	
	Not very well	21.9% (7)	
	Poorly	9.4% (3)	
	Not at all	0.0% (0)	
	No policy exists	6.3% (2)	
	Don't know	21.9% (7)	
		32	32
Prohibition of advertising, media or messages promoting violence	**Very well**	12.5% (4)	
	Moderately well	**28.1% (9)**	
	Not very well	12.5% (4)	
	Poorly	15.6% (5)	
	Not at all	3.1% (1)	
	No policy exists	6.3% (2)	
	Don't know	21.9% (7)	
		32	32
	Comments:	2	2
	answered question	32	**32**
		skipped question	**1**

19. Please rate the overall STRENGTH of policies on a STATE level on the following topics.			
		Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
		Yes	**Response Totals**
Bullying	**Strong**	3.2% (1)	
	Somewhat strong	22.6% (7)	
	Somewhat weak	22.6% (7)	
	Weak	16.1% (5)	
	No policy exists	0.0% (0)	
	Don't know	**35.5% (11)**	
		31	31
Sexual harrassment	**Strong**	12.9% (4)	
	Somewhat strong	**35.5% (11)**	
	Somewhat weak	12.9% (4)	
	Weak	9.7% (3)	
	No policy exists	0.0% (0)	
	Don't know	29.0% (9)	
		31	31
Policies setting sanctions on businesses promoting sexual disrespect and violence against women	**Strong**	6.5% (2)	
	Somewhat strong	6.5% (2)	

	Somewhat weak	29.0% (9)	
	Weak	19.4% (6)	
	No policy exists	3.2% (1)	
	Don't know	**35.5% (11)**	
		31	31
Prohibition of advertising, media or messages promoting violence	**Strong**	3.2% (1)	
	Somewhat strong	9.7% (3)	
	Somewhat weak	16.1% (5)	
	Weak	29.0% (9)	
	No policy exists	3.2% (1)	
	Don't know	**38.7% (12)**	
		31	31
Comments:		2	2
answered question		31	**31**
		skipped question	**2**

20. Please indicate the how well policies are ENFORCED on a STATE level regarding the following topics.			
		Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
		Yes	**Response Totals**
Bullying	**Very well**	0.0% (0)	
	Moderately well	18.8% (6)	
	Not very well	25.0% (8)	
	Poorly	18.8% (6)	
	Not at all	0.0% (0)	
	No policy exists	0.0% (0)	
	Don't know	**37.5% (12)**	
		32	32
Sexual harrassment	**Very well**	9.4% (3)	
	Moderately well	21.9% (7)	
	Not very well	25.0% (8)	
	Poorly	9.4% (3)	
	Not at all	0.0% (0)	
	No policy exists	0.0% (0)	
	Don't know	**34.4% (11)**	
		32	32

Policies setting sanctions on businesses promoting sexual disrespect and violence against women	**Very well**	3.1% (1)	
	Moderately well	6.3% (2)	
	Not very well	31.3% (10)	
	Poorly	15.6% (5)	
	Not at all	0.0% (0)	
	No policy exists	3.1% (1)	
	Don't know	**40.6% (13)**	
		32	32
Prohibition of advertising, media or messages promoting violence	**Very well**	0.0% (0)	
	Moderately well	9.7% (3)	
	Not very well	19.4% (6)	
	Poorly	19.4% (6)	
	Not at all	0.0% (0)	
	No policy exists	3.2% (1)	
	Don't know	**48.4% (15)**	
		31	31
Comments:		0	0
answered question		32	**32**
		skipped question	**1**

21. Please rate the overall strength of the STATEWIDE sexual violence incidence, prevalence, and magnitude data collection systems.

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Strong	3.1% (1)	3.1% (1)
Somewhat strong	**34.4% (11)**	**34.4% (11)**
Somewhat weak	21.9% (7)	21.9% (7)
Weak	9.4% (3)	9.4% (3)
Don't know	31.3% (10)	31.3% (10)
answered question	32	**32**
	skipped question	**1**

22. Please rate the overall strength of YOUR COMMUNITY'S sexual violence incidence, prevalence, and magnitude data collection system(s).

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Strong	9.4% (3)	9.4% (3)
Somewhat strong	25.0% (8)	25.0% (8)
Somewhat weak	12.5% (4)	12.5% (4)
Weak	21.9% (7)	21.9% (7)
My community has no sexual violence incidence, prevalence, or magnitude data collection system	3.1% (1)	3.1% (1)
Don't know	**28.1% (9)**	**28.1% (9)**
answered question	32	**32**
	skipped question	**1**

23. Please indicate which organizations in your community collect sexual violence data.

	Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?	
	Yes	**Response Totals**
Hospitals/emergency rooms	64.5% (20)	64.5% (20)
Law enforcement	**83.9% (26)**	**83.9% (26)**
Courts	45.2% (14)	45.2% (14)
Rape crisis centers/domestic violence agencies	67.7% (21)	67.7% (21)
College campuses	41.9% (13)	41.9% (13)
Other social service agency	19.4% (6)	19.4% (6)
Don't know	9.7% (3)	9.7% (3)
Other (please specify)	1	1
answered question	31	**31**
	skipped question	**2**