

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 services³. 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 Perpetration⁴

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 public square to solve problems;
- Explanation of the process that was used to solicit input from 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:

<u>District 3, 11/12/08:</u>	Allen County/Ft. Wayne Afternoon meeting	Attendance: 22
<u>District 2, 11/13/08:</u>	Elkhart County/Elkhart Morning meeting	Attendance: 37
<u>District 8, 11/20/08:</u>	Monroe County/Bloomington Afternoon meeting	Attendance: 15
<u>District 9, 11/21/08:</u>	Dearborn County/Lawrenceburg Morning meeting	Attendance: 17
<u>District 7, 11/24/08:</u>	Putnam County/Greencastle Evening meeting	Attendance: 9
<u>District 10, 11/25/08:</u>	Vanderburgh County/Evansville Afternoon meeting	Attendance: 43
<u>District 4, 12/2/08:</u>	Tippecanoe County/Lafayette Morning meeting	Attendance: 4
<u>District 6, 12/3/08:</u>	Delaware County/Muncie Afternoon meeting	Attendance: 17
<u>District 5, 12/4/08:</u>	Hendricks County/Danville Morning meeting	Attendance: 30
<u>District 1, 12/11/09:</u>	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.