ARIZONA – ENDING SEXUAL VIOLENCE

June 2019

A Community-based Statewide Strategic Action Plan for Sexual Violence Primary Prevention 2020-2025

Sexual Violence Prevention and Education Program
Arizona Department of Health Services
Office of Women's Health

Arizona – Ending Sexual Violence

A COMMUNITY-BASED STATEWIDE STRATEGIC ACTION PLAN FOR SEXUAL VIOLENCE PRIMARY PREVENTION 2020-2025

ARIZONA DEPARTMENT OF HEALTH SERVICES

June 2019

By

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OUR VISION

An Arizona free of sexual violence

OUR MISSION

Prevent sexual violence through sustainable education, collaboration and advocacy

PHILOSOPHICAL FRAMEWORK

- Address social determinants of health
- Be trauma-informed
- Utilize evidence based practices
- Understand sexual violence as a form of oppression
- Work towards system change
- Change social norms

GUIDING VALUES AND PRINCIPLES

- Inclusivity
- Culturally competent
- Community driven
- Unity
- Equity
- Compassion
- Respect
- Scalability
- Accountability

EXECUTIVE SUMMARY

Arizona – Ending Sexual Violence: A Community-based Statewide Sexual Violence Primary Prevention Strategic Action Plan, 2020–2025 serves as a compass towards ending sexual violence in Arizona. This State Action Plan (SAP) is a framework that establishes a vision, mission, philosophical framework, guiding values and principles, goals and objectives for preventing sexual violence in our state. The plan is meant to be shared and used by a variety of agencies such as universities, colleges, community-based organizations, coalitions, non-governmental organizations (NGOs), policy-makers, prevention professionals, health and medical providers, K-12 educators and many other individuals and agencies interested in enhancing protective factors and reducing risk factors for sexual violence (SV) in Arizona.

SEXUAL VIOLENCE

Sexual violence is defined as a sexual act committed against someone without that person's freely given consent or against someone who cannot consent and/or does not have the ability to consent regardless of their relationship. Social norms pertaining to power, privilege, secrecy, privacy, gender roles, gender expression, and other social determinants of health (SDOH) help perpetuate sexual violence. Therefore, members of the following groups are especially at risk of SV: women, children, people of color, immigrants and refugees, older adults, people with disabilities, and lesbian, gay, bisexual, transgender, or questioning/queer, Intersex, Two-Spirited, + (LGBTQI2+) people. People who are members of more than one of these groups have an especially high risk of sexual violence victimization.

Sexual violence has a burdensome effect on survivors. These include physical injuries, psychological issues, stigmatization, victim-blaming, sexually transmitted diseases, unwanted pregnancy, and can lead to an increased risk of addiction to alcohol, food and substance abuse.[1] There are medical and mental health services that sexual assault survivors are impacted by such as chronic illnesses, post-traumatic stress disorder, injuries that can lead to reproductive and gastrointestinal health concerns.[2] There are also costs associated with job loss and/or taking off time from work and decrease in work productivity. The societal costs impact the criminal justice system such as increasing staff and time for criminal related matters, increasing the response of law enforcement and the costs associated with incarceration.

SEXUAL VIOLENCE IN ARIZONA

According to the National Intimate Partner and Sexual Violence Survey (NISVS) recently published in 2017 for 2010-2012, in Arizona, 41.3% of women and 19.9% of men have experienced some form of sexually violent contact during their lifetime. This is more than the national average of 33.6% women and 17.1% of men across the United States. Out of the 41.3% women in Arizona who reported sexual violence, 46.1% reported the perpetrator was an acquaintance, 44% reported it was a current or former intimate partner, 25.3% reported their perpetrator was a stranger and 10.8% indicated it was a family member.[3]

Arizona also has populations in which sexual violence occurs at disproportionately higher rates according to Hospital Discharge Data (HDD). The HDD reported at least 1,087 people sought treatment for sexual assault and violence injuries in 2017. According to the U.S. Census Bureau 2018, estimates, Arizona's population is about 7.1 million people and White/Caucasians make up about 54.9% of the population. Across racial groups, the HDD for White/Caucasian non-Hispanic reports 18.6 discharges per 100,000 hospitalizations. However, African Americans had the highest age-adjusted rate of 30.2 discharges per 100,000 hospitalizations while only representing 5% of the

[1] https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html
[2] https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html
[3] https://www.cdc.gov/violenceprevention/datasources/nisvs/index.html

state's population. Native Americans had the second highest rate of 19.7 discharges per 100,000 hospitalizations and they comprise 5.3% of Arizona's population.[4]

Moreover, SV is underreported in all populations and it is especially likely to remain unreported among individuals that identify with members that are immigrants and refugees, people with disabilities, LatinX, members of the LGBTQI2+ and sexual gender minority groups due to of fear of: unfamiliarity with law enforcement or the legal system, fear of retaliation, access to resources, stereotypical social norms regarding gender roles and many other factors.[5] This strategic plan includes additional documents of qualitative and quantitative data pertaining to sexual violence for each "priority population" in Arizona.

WE ALL HAVE A ROLE IN THE PRIMARY PREVENTION OF SEXUAL VIOLENCE

There is no easy answer or single reason why people commit sexual violence. There is research that indicates solutions must go beyond the individual characteristics or behaviors of people that are addressed in this report. Primary prevention focuses not only on individuals but also on the community and societal factors that increase the risk of sexual assault. To that end, primary prevention of sexual violence as conceptualized by the CDC, utilizes the social ecological model (SEM) for identifying and addressing risk and protective factors at multiple levels. Prevention strategies must be implemented at all levels of the SEM because there is a social context that surrounds sexual violence. The context may include but not limited to: social norms that condone violence, use of power over others, traditional constructs of masculinity, the subjugation of women, and silence about violence/abuse contribute to the occurrence of sexual violence. Oppression in all of its forms is among the root causes of sexual violence.

Although this can be difficult because of community and cultural norms, using strategies that both increase factors that protect against sexual violence victimization and decrease factors associated with a higher likelihood of perpetration is necessary. Sexual violence is preventable through collaborations of community members at multiple levels of society – in our homes, neighborhoods, schools, faith communities, workplaces and many other settings. The best approach is using the public health model framework. The public health model includes defining the extent of the problem; identifying who is most affected; developing and testing prevention strategies; and promoting wide-spread adoption of effective prevention strategies. We all play a role in preventing sexual violence and establishing norms of respect, safety, equality and helping others.

THE DEVELOPMENT OF THE 2020-2025 STRATEGIC PLAN

The Arizona Department of Health Services (ADHS), Bureau of Women's and Children's Health (BWCH) sought to develop a comprehensive sexual violence primary prevention strategic plan. This goal had been identified as a strategic priority for the Sexual Violence Prevention and Education Program (SVPEP). The strategic plan was developed by the Arizona Department of Health Services' Office of Women's Health with significant input and support of multiple community-based stakeholders and public citizens.

Prior to the development of the strategic plan, a recent assessment conducted by the Association of State and Territorial Health Officials (ASTHO) for Arizona in 2017, found that Arizona faced challenges to effectively engage and capture the needs of diverse communities and stakeholders when addressing sexual violence. As a result, a survey to prioritize underserved/unserved populations was distributed to community stakeholders in early 2018. After the survey had closed, an analysis determined that roundtable discussions would provide the best form of qualitative data collection to understand the impact of sexual violence perpetration and victimization throughout Arizona. This was an opportunity for the state to engage communities who are often not involved in critical conversations regarding sexual violence prevention.

[4] Gardner, Kyle, Office of Injury Prevention, Arizona Department of Health Services, Arizona Hospital Discharge Data 2017
[5] https://www.nsvrc.org/sarts/toolkit/6-5

Following the roundtable discussions, five statewide strategic action planning meetings were convened and consisted of representatives of the priority populations, community members, coalitions, service providers, survivors, victim advocates, self-advocates, businesses, medical and health professionals, educational institutions, non-profit organizations, content experts and others.

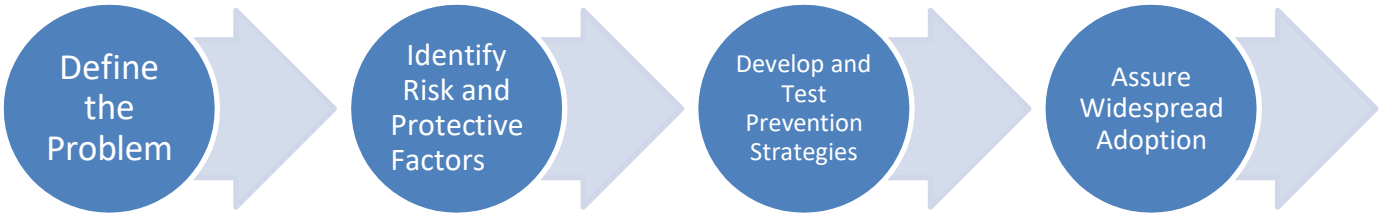
THEMES FROM THE STATEWIDE STRATEGIC ACTION PLAN MEETINGS

Six themes that consistently emerged from the five strategic action plan meetings:

1. The need to eliminate of sexual violence
2. Improve and enhance education and programming to prevent sexual violence
3. Build bridges between sexual violence prevention providers and community organizations to increase partnerships
4. Assure long-term stability of sexual violence prevention efforts
5. Increase awareness among the public to prevent sexual violence and reduce stigma among survivors
6. Evaluate efforts to assess impact and identify opportunities to modify, expand or improve sexual violence prevention strategies

THE PUBLIC HEALTH MODEL

The public health perspectives ask the foundational questions, where does this problem begin? There are multiple steps in the public health model approach,[6] with each step intentionally informing the next. While violence prevention practitioners may not be involved in all the steps, understanding each step and why they are necessary to ensure achievement of the desired impacts on community and population health is helpful in selecting and/or developing prevention strategies.



STEP 1: DEFINE THE PROBLEM

In order to prevent sexual violence, the first step is to understand: what, who, when, where and how to determine the problem of sexual violence.

Let's define sexual violence. Sexual violence is defined as a sexual act committed against someone without that person's freely given consent or against someone who cannot consent and or have the ability to consent. Perpetrators use physical force, coercion, intimidation, manipulation, use of drug and/or alcohol facilitated intoxication to attempt or complete sexual acts. There are many forms of sexual violence, some examples include: rape, child incest and molestation, intimate partner sexual assault, unwanted sexual contact and/or touching, sexual harassment, sexual exploitation, showing one's genital or naked body to other(s) without their consent, masturbation in public and watching someone in a private act without their knowledge or permission(s). The person responsible for the perpetration can be a friend, an intimate partner, co-worker, neighbor, family member or colleague. This is not an exhaustive list. For more specific definitions of sexual violence and related terms, see glossary page 65.

Sexual violence affects millions of people every year in the United States and throughout the world. Sexual violence affects individuals of varying ages from childhood to the elderly and is experienced across all races, ethnicities, spiritual beliefs and genders. Researchers know that the numbers reported do not adequately represent this significant problem as many cases go unreported. Victims may be ashamed, embarrassed, and or afraid to tell law enforcement, friends, family or a social service agency about the violence. Victims may also keep quiet because they feel they will not be believed, may have been threatened with further harm if they tell anyone and may think that no one will help them.

Sexual violence is prevalent. Nearly one in five women and one in 38 men have experienced completed or attempted rape and one in 14 men were forced to completely penetrate or attempted forced penetration during their lifetime[7]. Sexual violence can start early in life. NISVS also reports that about 30.5% of females experience attempted or completed rape for the first time between the ages of 11 and 17 years old; while 12.7% report that their victimization occurred before the age of 10[8]. Arizona HDD reveals that the age range with the highest rate per hospitalization for sexual violence victimization was between 15 to 24 years old and of that, most of the

[6] https://www.cdc.gov/violenceprevention/publichealthissue/publichealthapproach.html
[7] https://www.cdc.gov/violenceprevention/datasources/nisvs/2015NISVSdatabrief.html
[8] https://www.cdc.gov/violenceprevention/datasources/nisvs/2015NISVSdatabrief.html

sexual assault was perpetrated against females. Women, girls and boys show the highest numbers in victimization of sexual violence, while men and boys are the majority of the perpetrators[9].

The additional impact due to sexual violence is the health care costs associated with hospitalizations. The Arizona Department of Health Services, Injury Prevention Department under the CDC's State Violence and Injury Prevention Program (SVIPP) estimates costs using HDD. For sexual violence and injury related hospitalization captured in HDD in 2017, costs estimated a $4.2 million dollars. HDD separates costs by inpatient hospitalization and emergency department visits. The average cost for inpatient hospitalization related to sexual violence was $53,957 dollars and for emergency department visits the average cost was $3,176 dollars. There are some limitations to HDD, such as HDD does not identify if a patient may have been hospitalized more than once during the calendar year or costs that may be related to sexual violence such as mental health visits like counseling or psychiatric needs. Additional societal costs that are related to sexual violence include job wage loss if survivors miss work, criminal justice costs such as costs related to prosecution, law enforcement and incarceration.

We normalize the language around sexuality and sexual violence and sexual health. If we normalize that language and know what is developmentally appropriate and what's not appropriate, we can just talk about it. Because I think the biggest problem is, is that we don't talk about it.

Roundtable Discussion Participant

STEP 2: IDENTIFY RISK AND PROTECTIVE FACTORS

The second step of public health model is to "identify risk and protective factors". What are the reasons why one person or community experiences violence while another does not? The CDC defines, "risk and protective factors are those that either increase or decrease the likelihood of a person becoming a victim or perpetrator of sexual violence". Scientific research methods are used to identify the factors that increase the risk for violence (risk factor) and factors that decrease the likelihood of violence in the face of risk, called protective factors.

Before we take a further look at risk and protective factors of sexual violence, let's first understand the SDOH, which are the complex circumstances and conditions of the environments in which people are born, live, work, play and learn that can impact a wide range of health and quality of life outcomes.[10] They include intangible factors such as political, socio-economic and cultural constructs, as well as place-based living conditions such as accessibility to healthcare and education systems, safe environmental conditions, food resources and conditions of our biological genetics.[11]

The SDOH pertain to more than sexual violence; however, there is evidence that SDOH plays a strong role. As an example, poverty increases the risk of both non-partner sexual violence and intimate partner violence[12]. Poverty may make it more difficult to avoid unsafe environments and increase stress in the home. It may also make leaving a home in which sexual violence is occurring more difficult. According to the 2018 U.S. Census Bureau, Arizona has a population of approximately 7.1 million people; the majority of residents live in Maricopa County (population

[9] Arizona Department of Health Services, Injury Prevention Department, review of 2017 Hospital Discharge Data (HDD) using ICD-10-CM codes, Epidemiologist, Kyle Gardner
[10] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[11] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[12] http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf?ua=1

4,307,033). HDD reported that Maricopa County's sexual violence hospital discharge rate was 13.9 per 100,000 hospitalizations. However, Graham County, which represents 5% of Arizona's population, had a disproportionate number of hospitalizations related to sexual violence; where there were 16.2 discharges per 100,000 hospitalizations. In Graham County, about one-fifth (20.9%) of its population lives in poverty with a per capita income in the past 12 months of $17,784 dollars and in Maricopa county accounts for 8.1% living in poverty with a per capita income of $26,759 dollars[13]. Understanding the relationship between how population groups experience "place" and the impact of "place" on health is fundamental to the social of determinants of health.[14]

Reports from the Arizona Criminal Justice Commission (ACJC) extracted from the Arizona Computerized Criminal History (ACCH) for calendar year 2016 shows that there was a total of 1,461 sexual-assault related charges. Of those, there were 301 arrests with a total of 585 sexual-assault related charges. During the process, 140 sexual-assault related charges were filed and of those, 45 individuals were convicted of at least one sexual-assault related charge and 63 were convicted for other offense(s) not of sexual-assault related charges (see page 51 for additional details). Of those arrested of sexual assault related charges, the ACCH shows that the largest proportion was males at 98.6%.[15] Criminal sanctions reflect one factor in how our social environment places accountability on perpetrators. As of 2018, Arizona did not provide legal protective orders for sexual assault survivors from sexual assault perpetrators unless they have been assaulted by their intimate partner, a family member, impregnated by the perpetrator or someone they used to live with or currently live with[16]. This result has brought a legislative bill for Arizona this year to resolve protection orders for sexual assault survivors. Additional legislation activities will be addressed towards the end of this report.

Another example of SDOH is education and sexual health. Education policies, which provide accurate, evidence-based and appropriate sexual health information and counseling, will go a long way in reducing stigma and discrimination.[17] Figure 1 outlines the five key areas of SDOH using the Healthy People 2020 approach and examples of related social determinants of health. By working to establish policies that positively influence social and economic conditions and those that support changes in individual behavior, we can improve health at the population level in ways that can be sustained over time. Improving the conditions, in which we live, learn, work, play and the quality of our relationships will create a healthier population, society and workforce.[18]

[13] https://www.census.gov/quickfacts/fact/table/maricopacityarizona,grahamcountyarizona,az/IPE120217
[14] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[15] http://azcjc.gov/sites/default/files/pubs/2017_ARS_41-2406_Report_FINAL.pdf
[16] https://www.azcourts.gov/domesticviolencelaw/ProtectiveOrderForms.aspx
[17] https://apps.who.int/iris/bitstream/handle/10665/70501/WHO_RHR_HRP_10.22_eng.pdf;jsessionid=5CCDA4154FB8D7ECBBF8D8DB3183E868?sequence=1
[18] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Figure 1

Social Determinants of Health Framework

Neighborhood and Built Environment

- Access to Foods that Support Healthy Eating Patterns
- Crime and Violence
- Environmental Conditions
- Quality of Housing
- Recreational and Leisure Opportunities
- Availability of Transportation

Economic Stability

- Employment
- Food Security
- Housing Stability
- Income Level

Health and Health Care

- Access to Health Care
- Access to Primary Care
- Health Literacy

Social and Community Context

- Civic Participation
- Discrimination
- Incarceration
- Social Cohesion
- Racial Segregation

Education

- Early Childhood Education and Development
- Enrollment in Higher Education
- High School Graduation
- Language and Literacy

We must also consider the long-term studies and research related to Adverse Childhood Experiences (ACEs). ACEs are traumatic experiences that took place in a child's life before they're 18 years old. Experiencing several ACEs has been associated with negative health outcomes. The ACEs can vary and are attributed to:[19]

- Alcohol and or drug abuse in the home
- A parent/guardian who is treated violently or an absent parent
- Emotional, physical, and sexual abuse and or emotional and physical neglect
- A family member with mental health illness and or who went to prison

[19] https://www.azhealthzone.org/training/aces/story_html5.html

ACEs have a tremendous impact on potential future violence victimization and perpetration as well as, lifelong health and [socio-economic] opportunities for an individual.[20] ACEs have been linked to risky health behaviors, chronic health conditions, low life potential and early death.[21] The ACEs study began in 1995 and is a long-term collaboration between Kaiser Permanente's Health Appraisal Clinic in San Diego and the CDC to analyze this correlation. Children who have been exposed to sexual violence on ACEs may be at an increased risk for depression, anxiety, suicide, post-traumatic stress disorder, chronic health issues such as obesity, unsafe sex and HIV/STDS.[22]

As children grow, the environment around them plays a vital role in their development of resilience and cognitive and emotional skills. When prolonged childhood trauma exists, it activates the stress response system, disrupting brain and organ development and producing toxic levels of stress in children.[23] This toxic stress is defined as long-term changes in brain architecture and organ systems that develop after extreme, prolonged and repeated stress that is untreated.[24] Biology research of stress has shown toxic stress can lead to health and risky behaviors as an adult.[25]

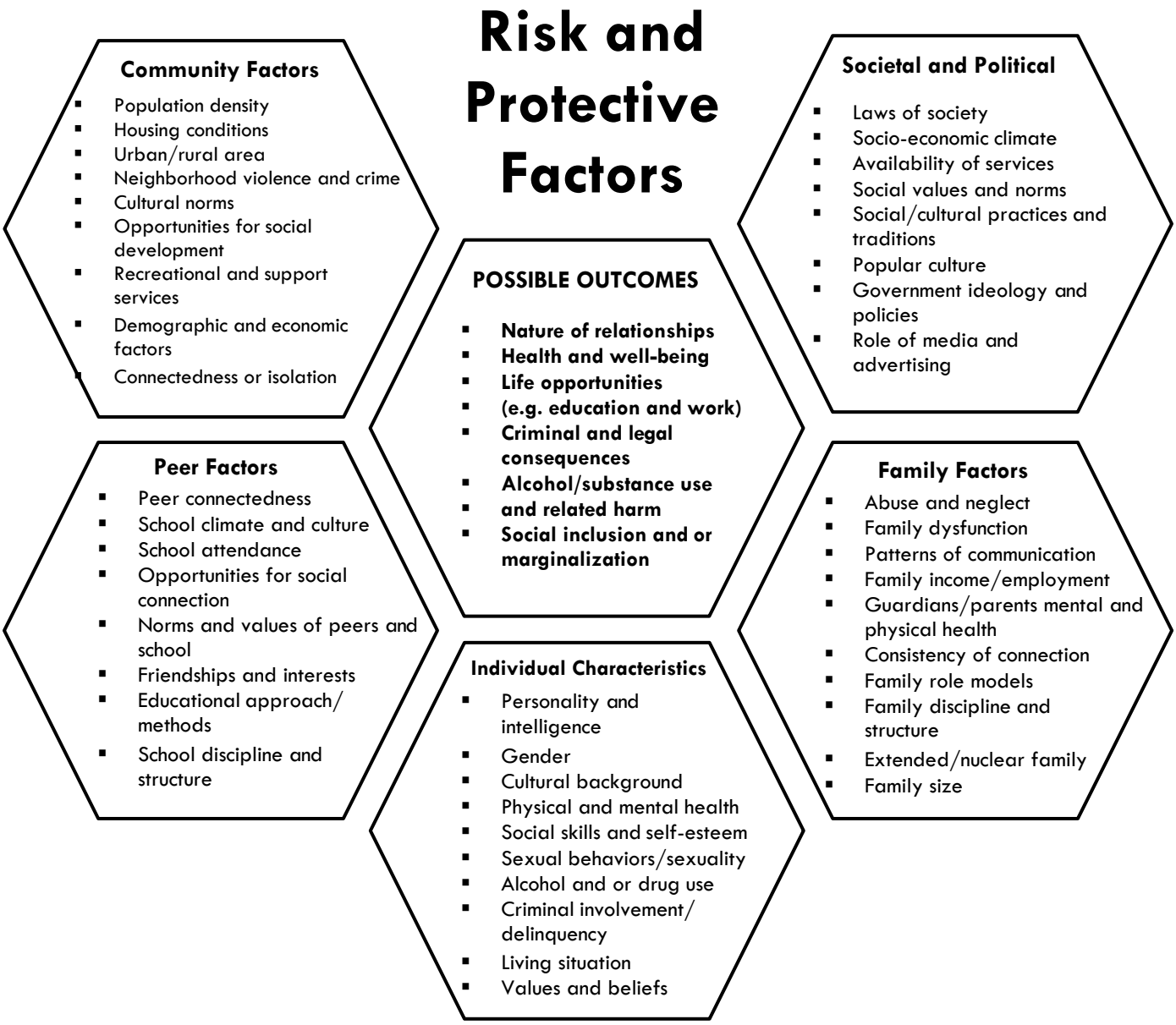
ACEs are one of the most difficult challenges that children face but may be preventable. It is important to address the conditions that put children and families at risk of ACEs so we can prevent ACEs before they happen or intervene to overcome the traumas and break the cycle. The presence of ACEs does not mean that a child will experience poor outcomes but children's positive experiences or protective factors can prevent children from experiencing adversity and can protect against many of the negative health and life outcomes.[26] Creating a stable and nurturing environment that focuses on safe relationships and trauma-informed care philosophies can minimize the long-term effect of ACEs.[27]

A combination of individual, relational, community and societal factors contribute to the risk of becoming either a victim or perpetrator and understanding these factors can help identify various opportunities for prevention.[28] A list of risk and protective factors is listed in Figure 2 on the next page and is adapted from a variety of sources including individuals who work in sexual violence prevention, the Centers of Disease Control (CDC), the National Sexual Violence Resource Center (NSVRC) and sexual assault coalitions around the nation. In the next step of the public health model, "develop and test primary prevention strategies", a deeper review of the social ecological model (SEM) can help determine particular prevention strategies for effective programming.

Risk factors are linked to a greater likelihood of sexual violence perpetration and victimization and are contributing factors (may not be direct causes) to becoming a victim or perpetrator. However, not everyone deemed as "at-risk" will become a victim or perpetrator. Protective factors are conditions and or attributes that eliminate and or reduce the effects of stressful life events; these factors increase an individual's ability to avoid risk or hazards and promote social and emotional competence to thrive in all aspects of life, now and in the future.[29]

[20] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html
[21] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html
[22] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4928741/
[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4928741/
[25] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4928741/
[26] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html
[27] http://www.ncmedicaljournal.com/content/79/2/95.full
[28] https://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html
[29] https://www.cdc.gov/healthyyouth/protective/index.htm

Figure 2. Risk and Protective Factors

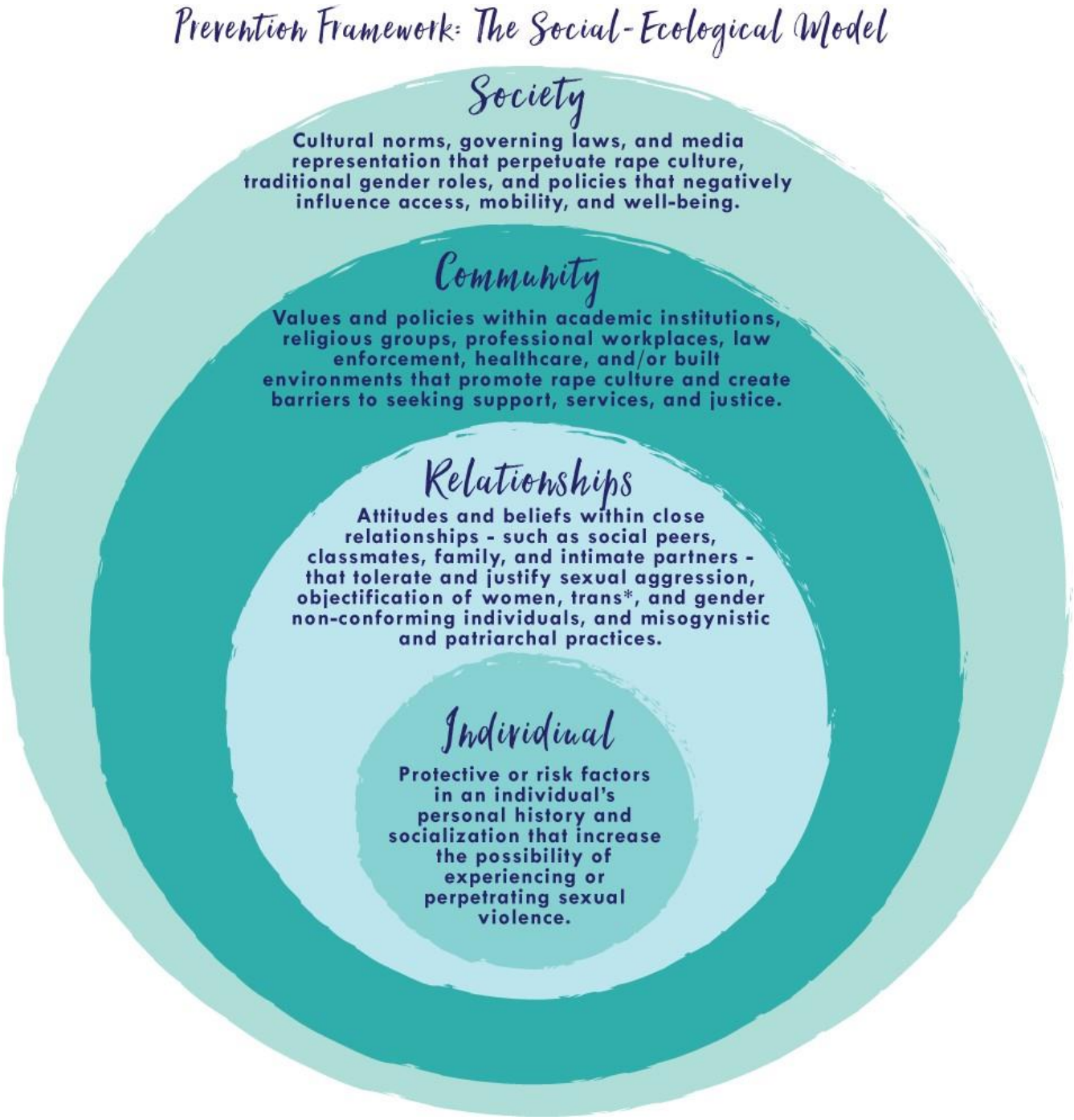


STEP 3: DEVELOP AND TEST PRIMARY PRVENTION STRATEGIES

In step three, research can help determine whether particular prevention programs are effective. Reviewing programs and their evaluation processes and outcomes, funding innovative interventions, sharing evidence-based/evidence-informed practices and tailoring strategies to meet culturally-relevant needs is one way to promote effective prevention strategies. Sexual violence is wide spread and preventing sexual violence is no simple task. There are theoretical models that have emerged to describe the cause of sexual violence that addresses all levels of the social ecological strata; the individual, relationship, community to the societal in order for prevention strategies to be the most effective. This includes the critical need to incorporate comprehensive

targeted approaches that prevent sexual violence from occurring in the first place. The CDC uses the social ecological model (SEM) to better understand the complicated factors associated with violence as a result of a combination of multiple influences on behavior.[30] Each level of the SEM can be thought of as a level of influence and a key point for prevention by offering a framework for program developers to determine where and how to focus prevention activities.[31]

Figure 3. Social Ecological Model



[30] https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html
[31] https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html

The CDC has incorporated the SEM and developed a technical package, titled STOP SV, a guide to reduce sexual violence victimization and perpetration. Although evidence-based/evidence-informed practices for sexual violence prevention are less developed in comparison to those for other public health topics such as HIV/STDs prevention and Tobacco cessation, the STOP SV approaches have profound impacts through rigorous evaluation to have shown impact on SV.[32] We must continue to invest rigorous evaluation of promising prevention approaches to achieve optimal population health and wellness. In the meantime, we must take advantage of what does exist to prevent of sexual violence.

For the next five years beginning in 2020, the STOP SV technical package is significant in creating a foundation for future ADHS-SVPEP solicitations in terms of targeting programs and services. The STOP SV strategies and approaches have demonstrated effects on sexual violence outcomes (such as reduction in perpetration and victimization) and represent all the different levels of the SEM. Some of these strategies and approaches intersect more than one level of the SEM but are intended to work in combination and reinforce each other to influence both the individual and environmental factors related to SV.[33]

Please see Table A to review examples (not an exhaustive list) of strategies and approaches within each particular context. Each community and organization working on SV prevention across the nation bring their own social and cultural context to the selection of strategies and approaches and will choose those most relevant to their population and settings. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches addressed here best suited for their context.

> "Sexual violence has always centered on issues related to gender equality and equity, anti-oppression and health and wellness. In the context of health and sexual violence prevention, equality refers to equal rights, responsibilities, and opportunities that enable all individuals to achieve their full rights and potential to be healthy, contribute to health development and benefit from the outcomes and results. It is important to recognize that some of the strategies and approaches may be binary in the sense of female and male in the way it is named (*Provide Opportunities to Empower and Support Girls and Women*); it is important to recognize and affirm identities that do not fit in to these binary categories and see gender and sexual orientation on a diverse spectrum. In this case, improve the social and economic status of girls and women addressing gender equality. The different approaches may be used as to influence social norms related to violence including gender norms."[34]

Being young and with technology, we're not only using technology to communicate with our friends, but we also use technology to see what others experience, so I think that is a benefit that we have . . . it's kind of like a publicity basically for the issue, kind of addressing it to your audience to spread the message.

Roundtable Discussion Participant

[32] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf
[33] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf
[34] https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

Table A

Summary of Strategies and Approaches to STOP SV

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		SV Perpetration	SV Victimization	Risk Factors for SV	
S Promote Social Norms that Protect Against Violence	**Bystander approaches**				Public Health Education
	Green Dot	✓	✓		
	Bringing in the Bystander			✓	
	Mobilizing men and boys as allies				Public Health Education
	Coaching Boys into Men	✓			
T Teach Skills to Prevent SV	**Social-emotional learning**				Public Health Education
	Second Step	✓	✓		
	Teaching healthy, safe dating, and intimate relationship skills to adolescents				Public Health Education
	Safe Dates	✓	✓		
	Promoting healthy sexuality				Public Health Education
	Strong African American Families–SAAF			✓	
	Safer Choices			✓	
	Empowerment-based training				Education Public Health Justice
	Enhanced Assess, Acknowledge Act		✓		
O Provide Opportunities to Empower and Support Girls and Women	**Strengthening economic supports for women and families**				Business/labor Government (local, state, Federal)
	Comparable worth policies			✓	
	Adequate work supports (subsidized child care, cash transfers, maternity benefits, other paid leave)		✓		
	Microfinance			✓	
	Strengthening leadership and opportunities for girls				
	Powerful Voices			✓	

[1] This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing the specific programmatic activities.

[2] Services are designed to provide support to victims and survivors.

[3] Treatments are designed to address psychological consequences of victimization.

Summary of Strategies and Approaches to STOP SV

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		SV Perpetration	SV Victimization	Risk Factors for SV	
Create Protective Environments	**Improving safety and monitoring in schools**				Public Health Education
	Shifting Boundaries Building-level Intervention	✓	✓		
	Establishing and consistently applying workplace policies				Business/labor Government (local, state, Federal)
	Proactive sexual harassment prevention policies and procedures		✓		
	Addressing community-level risks through envirnomental approaches				
	Alcohol policies (outlet density, pricing)		✓		
Support Victims/ Survivors to Lessen Harms	**Victim-centered services**				Community organizations *(rape crisis centers, SV coalitions)* Justice Social Services
	Crisis intervention, medical and legal advocacy, access to community resources	N/A[2]	N/A[2]	N/A[2]	
	Treatment for victims of SV				Health Care Social Services
	Trauma-focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PET)	N/A[3]	N/A[3]	N/A[3]	
	Treatment for at-risk children and families to prevent problem behavior including sex offending				Health Care Social Services Justice
	Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-Age Program (PSB–CBT)	✓		✓	
	Multisystemic Therapy–Problem Sexual Behavior (MST–PSB)	✓		✓	

[1] This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing the specific programmatic activities.

[2] Services are designed to provide support to victims and survivors.

[3] Treatments are designed to address psychological consequences of victimization.

Compared to other health issues, sexual violence cannot be prevented by simply treating one individual; it is important to act at all levels. The SEM allows us to address prevention strategies that affect us individually, relationally and at a community and societal level. Thus far, we have discussed the SEM, how SDOH impact health outcomes; that identifying risk and protective factors may increase or decrease risk for victimization or perpetration; reviewed how ACEs can influence future health and wellness of children into adulthood and CDC's STOP SV evidence-based/evidence-informed strategies and approaches for preventing sexual violence. We'll take a look at one final tool, named the spectrum of prevention. The spectrum of prevention is widely used for injury prevention and sexual violence that falls under this umbrella.

A tool developed by the Prevention Institute and tailored by the NSVRC was created to assist communities in developing comprehensive sexual violence prevention initiatives.[35] Communities are vital in the development of effective sexual violence prevention strategies. This tool is designed for broad scale change, its focuses not just on individuals, but also on the environment, including systems and norms that contribute to sexual violence.[36] "The spectrum's six levels for strategy development that identifies multiple levels of intervention and encourages people to move beyond the perception that prevention are about teaching healthy behaviors. The spectrum levels work interrelated to each other for greater effectiveness than by implementing any single or linear initiative."[37] Table B shows the spectrum of prevention levels with its definitions and sample activities provided by NSVRC. By working at all levels, the spectrum tool can build a design that promotes confidence, efficacy, structure and organization.[38]

STEP 4: ASSURE WIDESPREAD ADOPTION

The final step in the public health approach is assuring widespread adoption of strategies and approaches to prevent sexual violence. This includes tracking what is being implemented, any evaluation, documenting and sharing results of successful programs and services. This is not a linear process where the public health approach ends after the fourth step. It is necessary to continuously follow the public health approach to ensure that the state of preventing sexual violence is cyclical and that the most current and up-to-date approaches and strategies are being implemented.

Given that the act of sexual violence takes place between individuals but is supported by large community and societal norms that may implicitly or explicitly condone it, primary prevention efforts simultaneously directed at multiple levels of the socioecological will be most effective.[39] One strategy for promoting widespread adoption is at conferences, through webinars, various meetings with stakeholders and at public forums. The goal is to share information regarding evidence-based/evidence-informed strategies with diverse community members and encourage implementation of programs that fit their needs.

We need to have the same information out there constantly in our faces where you can't avoid seeing it because that's when everybody is going to know about it, and as soon as it's not a secret people are going to talk about it and it's going to be a lot easier to implement all those other programs if we could just erase the stigma.

Roundtable Discussions Participant

[35] http://www.nsvrc.org/sites/default/files/Factsheet_spectrum-of-prevention.pdf
[36] http://www.nsvrc.org/sites/default/files/Factsheet_spectrum-of-prevention.pdf
[37] https://www.preventioninstitute.org/tools/spectrum-prevention-0
[38] https://www.preventioninstitute.org/tools/spectrum-prevention-0
[39] Lee, B. D. S., Guy, L., Perry, B., Sniffen, C. K., & Mixson, S. A. (2007). Sexual violence prevention. *The Prevention Researcher, 14*(2), 15-20.

Table B. Spectrum of Prevention

Level 1: Strengthening Individual knowledge and skills

Definition: Enhancing an individual's capability of preventing violence and promoting safety

Activities

- Provided multiple session skill-building programs that teach healthy sexuality and health and equitable relationship skills to high-school students.
- Build the skills of bystanders to safely interrupt behavior such as sexist and homophobic harassment.

Level 2: Promoting Community Education

Definition: Reaching groups of people with information and resources to prevention violence and promote safety

- Teach parents to address attitudes and behaviors in their children that support sexual violence.
- Stage community plays that reinforce positive cultural norms portray responsible sexual behavior and model bystander action.

Develop awards programs to publicly recognize responsible media coverage and community leadership to prevent SV.

Level 3: Educating Providers

Definition: Informing providers who will transmit skills and knowledge to others and model positive norms

- Train little league coaches to build skills to interrupt and address athlete's inappropriate comments and behaviors that promote a climate condoning sexual harassment and sexual violence.
- Train health care providers, mental health professionals, educators, foster parents and other professionals on the principles of healthy relationships. Collaborate with musicians, song writers and artists about positively impacting young people.

Level 4: Fostering Coalitions and Networks

Definition: Bringing together groups and individuals for broader goals and greater impact

- Foster partnerships between researcher/academics and community providers to strengthen evaluation approaches
- Engage art organizations to promote community understanding and solutions.
- Engage the business sector to foster workplace solutions and build support.

Level 5: Changing Organizational Practices

Definition: Adopting regulations and shaping norms to prevention violence and improve safety

- Implement and enforce sexual harassment and sexual violence prevention practices in schools, workplaces, places of worship and other institutions.
- Implement environmental safety measures such as adequate lighting and emergency call boxes, complemented by community education and enforcement policies.

Level 6: Influencing Policies and Legislation

Definition: Enacting laws and policies that support healthy community norms and a violence-free society.

- Promote and enforce full implementation of Title IX law.
- Establish policies at universities to provide sexual violence prevention curriculum to all students and training to all staff and training to all staff and include funding as a line item in the university's budget.
- Pass middle and high-school policies to offer comprehensive sex education programs that include sexual violence prevention and address contributing factors in the school environment.

NEEDS ASSESSMENT

The Association of State and Territorial Health Officials (ASTHO)'s partnered with the CDC and the Safe States Alliance on a project to enhance the public health infrastructure to prevent sexual violence and strengthen health agency's leadership's role in elevating sexual violence prevention as a national public health issue. Most of ASTHO's systems change approach focuses particularly on the levers of data, policy, finance and partnerships. These four levers have shown to be necessary for successful public health system functioning, as identified in literature and practice.

Arizona reached out to ASTHO to support ADHS's SVPEP work to improve these four levers. ASTHO's existing systems needs assessment tool provides an opportunity for state teams and their partners to assess their state sexual violence prevention needs in the public health arena. Arizona participated in the ASTHO needs assessment in 2017 to examine the extent to which different stakeholders understand and think about different system components in sexual violence prevention work. An online survey was distributed to key state, local and community/clinical partners of ADHS. Respondents self-selected their role in relation to the ADHS and were automatically directed to a set of questions. For each question, respondents were asked to rate the degree in which they agreed with each question on a scale of 1 to 4.

There are seven systems components:
(1) Vision and Leadership **(2)** Infrastructure **(3)** Partnerships **(4)** Communication **(5)** Data and Evaluation **(6)** Policy **(7)** Technical Assistance

These components have shown to be critically necessary for successful implementation of a system-wide project that impacts many facets of policy and practice. This system needs assessment is *NOT* an evaluation of an initiative, but rather provides an analysis of how an entire system functions to support the successful adoption and implementation of evidence-based practices. The results of this state system profile needs assessment were incorporated into future priorities and funneled into this state action plan. The needs assessment supports Arizona to better understand the challenges and barriers so that state leaders can enhance their effectiveness to optimally implement, scale-up statewide and sustain current and future initiatives.

ASTHO found that Arizona had strengths in Vision and Leadership, Partnerships and Data and Evaluation. Arizona improvements could be made in the Infrastructure, Communication and Policy components. In addition, stakeholders noted that Arizona faced challenges with effectively engaging and capturing the needs of diverse communities when addressing sexual violence. ASTHO summarized that most stakeholders felt that "their state's health department does not foster strong partnerships between state and local-level stakeholders around sexual violence prevention and could do more to foster strong partnerships with state and local stakeholders around sexual violence prevention." Another stakeholder shared, "I think it [state] should be making more a priority to support sexual violence in rural areas, where there are a lot of indigenous people". Another recommended, "On-going work with agencies beyond the Coalition. On-going meetings with stakeholders to foster understanding."

Based on these findings, Arizona has responded by ensuring that the goals in the SAP to prevent sexual violence in primary prevention are developed by the community and for the community. Activities leading up to the SAP were intentionally planned to meet the needs as expressed by stakeholders, community and public members.

Yes, because if we can get one victim to come forward and stop a person, that one victim may save several others.

Roundtable Discussion Participant

COMMUNITY STAKEHOLDER SURVEY

SVPEP considers "health disparities as preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."[40] Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g. rural or urban) or sexual orientation. Health disparities are inequitable and are directly related to historical and current unequal distribution of social, political, economic and environmental resources.[41]

Following the needs assessment, a community stakeholder survey was developed in partnership with the Arizona Coalition to End Sexual and Domestic Violence and ADHS Office of Assessment and Evaluation. The purpose of the survey was to gain a better understanding from organizations, institutions and providers that work to address sexual violence throughout the state. The survey was built using Qualtrics and was distributed statewide through email and remained opened for six weeks. The survey did not solicit any personal self-identifying information. There was an estimated total email distribution to 600 individuals and 178 responded to the survey.

The survey respondents indicated the following populations to gain a greater understanding of the impact of sexual violence in these communities [Refer to appendix for survey tool and report].

PEOPLE WITH DISABILITIES

According to the U.S. Census Bureau, between 2013-2017, 8.5% (609,589 people) of the Arizonan's population under the age of 65 years old report they were with a disability[42]. People living with disabilities across the United States are at a much higher risk for sexual victimization than the general population.

The Bureau of Justice Statistics 2009-2015 Crimes Against Persons with Disabilities report that the rate of serious violent crime that includes rape, sexual assault, robbery and aggravated assault were more than three times (12.7 per 1,000) for persons with disabilities than the rate for persons without disability (4.0 per 1,000).[43]

From 2011-2015, persons with cognitive disabilities had the highest rates of serious violent crime, 35.6 per 1,000 among the disability types measured.[44] People with multiple disabilities are more frequently victims of rape and sexual assault compared to victims with only one form of disability. In 2013, 68% of rape/sexual assault victims had multiple types of disabilities.[45]

AFRICAN AMERICAN

Among race/ethnicity groups, African Americans had the highest age-adjusted hospitalizations at 30.2 discharges per 100,000 hospitalizations for sexual assault and violence related injuries. That is nearly twice as high compared to other categories in race/ethnicity groups in Arizona. In comparison, White non-Hispanic comprise of 54.9% (U.S. Census, 2017) of Arizona's population, but have an age-adjusted hospitalization rate of 18.6 discharges per 100,000 hospitalizations for sexual assault and violence related injuries.

A recent study by the National Sexual Violence Resource Center (NSVRC) published in 2016, "Among African American participants that reported post-traumatic stress disorder (PTSD), 88% had a history of rape and or sexual coercion." [46] According to the National Intimate Partner and Sexual Violence Survey (NISVS), 35% of Black women experienced some form of contact sexual violence during their lifetime. In addition,[47] 40% of confirmed sex

[40] CDC. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Services; 2008
[41] https://www.cdc.gov/healthyyouth/disparities/index.htm
[42] https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html
[43] https://www.bjs.gov/content/pub/pdf/capd0915st.pdf
[44] https://www.bjs.gov/content/pub/pdf/capd0915st.pdf
[45] https://ovc.ncjrs.gov/ncvrw2017/images/en_artwork/Fact_Sheets/2017NCVRW_PeopleWithDisabilities_508.pdf
[46] https://www.nsvrc.org/publications/key-findings-sexual-violence-victimization-and-health-community-sample-african-american-women
[47] https://www.cdc.gov/violenceprevention/datasources/nisvs/summaryreports.html

trafficking survivors in the U.S. are Black. [48] For every African American woman who reports her rape, at least 15 African American women do not report their rapes.[49]

NATIVE AMERICAN/INDIGENOUS

In the U.S, violence against indigenous women has reached unprecedented levels on tribal lands and in Alaska Native villages. Across the United States:

- More than 4 in 5 (84.3%) Native Americans and Alaska Native women have experienced some type of violence in their lifetime and more than one in three experienced any type of violence in the past year according to the National Institute of Justice funded study.[50]
- More than 1 in 2 (56%) have experienced at least one form of sexual violence in their lifetime.[51]
- About one-third (34%) of Native American and Alaska Native women will be raped in their lifetimes, compared to 19% African American women, 18% White women and 7% of Asian and Pacific Islander women.[52]
- Among Native women victims of rape or sexual assault, an average of 67% describe their offender as Non-Native.[53]
- In an average of 71% of rape and sexual assault victimizations against Native women, the perpetrator is reported to be known by the victim (with 38% as intimate partners, 33% as non-intimate but known).[54]

Native women suffer the highest rate of sexual assault in the U.S. among any other race/ethnicity.[55] The Arizona 2017 HDD reported that patients who identified as Native American/Indigenous hold the second highest inpatient and emergency department visits at 19.7 discharges per 100,000 hospitalizations. This number is over-represented when we look at the population of Arizona in comparison to hospitalizations for Whites non-Hispanic individuals.

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING, INTERSEX, TWO-SPIRITED, +

Sexual violence is extremely damaging to the health and wellness of LGBTQI2+ victims. Research shows that LGBTQI2+ communities face barriers to obtaining support from service providers who not indifferent to their sexual orientation and gender identity such as:

- Legal definitions of gender identities in institutions such as hospitals and courts.
- Disclosures and dangers of "outing" oneself when seeking help and the risk of rejection and isolation from family, friends and society.[56]
- Lack of knowledge and resources for LGBTQI2 friendly organizations and programs.[57]
- Potential homophobia and transphobia from service providers increasing risk for violence and ridicule.[58]
- Low confidence levels in the sensitivity and effectiveness of law enforcement officials and court staff for

[48] Banks, Duren and Kychkelhahn, Tracey, *Characteristics of Suspected Human Trafficking Incidents, 2008-2010*". Bureau of Justice Statistics, 2011
[49] Bureau of Justice Statistics Special Report. Hart and Rennison. 2003. U.S. Department of Justice
[50] https://nij.gov/journals/277/pages/violence-against-american-indians-alaska-natives.aspx
[51] https://indianlaw.org/issue/ending-violence-against-native-women
[52] http://www.ncai.org/attachments/PolicyPaper_tWAjznFslemhAffZgNGzHUqIWMRPkCDjpFtxeKEUVKjubxfpGYK_Policy%20Insights%20Brief_VAWA_020613.pdf
[53] https://www.ncjrs.gov/pdffiles1/nij/grants/223691.pdf
[54] https://www.ncjrs.gov/pdffiles1/nij/grants/223691.pdf
[55] Deer, S. *Beyond Prosecution: Sexual Assault Victim's Rights in Theory and Practice Symposium: Sovereignty of the Soul: Exploring the Intersection of Rape Law Reform and Federal Indian Law*. 455 (2005).
[56] https://williamsinstitute.law.ucla.edu/wp-content/uploads/Intimate-Partner-Violence-and-Sexual-Abuse-among-LGBT-People.pdf
[57] https://williamsinstitute.law.ucla.edu/wp-content/uploads/Intimate-Partner-Violence-and-Sexual-Abuse-among-LGBT-People.pdf
[58] http://www.ncdsv.org/images/NSVRC-PCAR_TheProcessOfComingOut_2012.pdf

LGBTQI2.[59]

RURAL COMMUNITIES

Underreporting of sexual violence in rural areas is a significant problem and makes it difficult to document the prevalence of sexual violence. There are many reasons for this underreporting including a lack of anonymity related to small population density and familiarity of community members with each other.[60] This lack of anonymity or privacy results in certain conventional behavioral expectations, as well as pressure to conform to them - for example traditional gender and generational role expectations in rural culture: if women or children want to change their roles in the perceived less rigid directions of mainstream culture, marital and family conflict result and community pressures generally collude with the person(s) resisting change. [61]

Survivors may not be comfortable reporting as perpetrators may be part of the same social network, social services are not nearby, lack of public transportation and/or phone and/or cellular service is limited or non-existent. Conventional attitudes of independence and self-reliance are survival values when living at distances from services and other people; these values have produced rather conservative ways of approaching life – when a person depends so much on themselves, they become more careful and considered in their decisions.[62]

In addition to the barriers of living in rural communities, the needs of rural populations when it comes to sexual violence are often limited to resources. Services such as medical, legal, social services, transportation and criminal justice access is due to the sparse geographic span of the land. In some areas, resources may be non-existent. When we think about our rural populations, we must also consider the socio-economic disparities as we address the community and societal levels of risk factors associated with sexual violence. The CDC lists: poverty, lack of employment opportunities, lack of institutional support from police and judicial system, general tolerance of sexual violence within the community, high levels of crime and other forms of violence as risk factors for sexual violence.[63]

YOUTH

Arizona's 2017 Youth Risk Behavior Survey (YRBS) by the Center of Disease Control (CDC) reported that 8.2% of high school students reported that they were physically forced to have sexual intercourse when they did not want to, of those 8.2%, 11.5% were female and 4.5% were male students. The Department of Public Safety's 2017 Crime Report reveals that 52 males 17 years old and younger were arrested for rape while 0 females 17 years and younger were arrested for rape.[64]

The Department of Child Safety (DCS) defines child sexual abuse as sexual abuse that occurs when sex acts are performed with children, using children in pornography, prostitution, or other types of sexual activity.[65] The DCS reports that from October 2017 to December 2018, there were 2,805 reports of for child sexual abuse in Arizona.[66] The DCS reports that during calendar year 2018, 1,677 child sex abuse reports were assigned for investigation and that 302 were substantiated, 57 were proposed for substantiation (see appendix for definition) and 1,300 were unsubstantiated.[67] The remaining 18 reports were not identified by DCS in the selected categories. About one in 10 children will be sexually abused before their 18th birthday.[68]

[59] https://williamsinstitute.law.ucla.edu/wp-content/uploads/Intimate-Partner-Violence-and-Sexual-Abuse-among-LGBT-People.pdf
[60] Lewis, S. (2003). *Unspoken crimes: Sexual assault in rural America*. Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved from http://www.vawnet.org/applied-research-papers/print- document.php?doc_id=419
[61] https://www.apa.org/practice/programs/rural/rural-culture.pdf
[62] https://www.apa.org/practice/programs/rural/rural-culture.pdf
[63] https://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html
[64] http://www.azdps.gov/sites/default/files/media/FINAL_Crime_in_Arizona_2017.pdf
[65] https://dcs.az.gov/reports-data/dcs-reports
[66] https://dcs.az.gov/reports-data/dcs-reports
[67] https://dcs.az.gov/reports-data/dcs-reports
[68] Townsend, C., & Rheingold, A.A. (2013). *Estimating a child sexual abuse prevalence rate for practioners:studies. Charleston Darkness to Light*. Retrieved from www.D2L.org

Early sexual violence victimization also increases the likelihood of sexual violence victimization during adulthood.[69] NISVS reports, there are significant associations between youth and subsequent adult SV; among female victims of rape (completed or attempted), 36.6% were raped as an adult who had experienced rape when they were 17 years old and young, compared with 11.8%, who reported they were not raped during youth but were raped as an adult.[70]

According to Arizona 2017 HDD, one-third of the hospitalization discharges for sexual violence and related injuries were among children between 0 to 17 years old.

- Hospitalization rates in 2017 for ages between 0-4 years old were 38% and for 15-17 years old was 28%).
- Of children ages 0-17 years of age, 42% of hospitalizations comprised of LatinX/Hispanic and 41% White Non-Hispanic.
- Sixty-one percent (61%) of all hospital discharges among children 0-17 years old occurred in Maricopa County.

MALES

The National Crime Victimization Survey in 2017 reported that 38% of rape and sexual violence among the 40,000 respondents were incidents against men,[71] 71% experienced their first victimization before age 25.[72] Perpetrators are usually known to their victims and according to NISVS, perpetrators of rape and unwanted sexual contact against male victims were mostly other men, while perpetrators of other forms of such as attempted rape and sexual coercion against men were most often women.[73]

- One in four girls and one in six boys will be sexually abused before they turn 18 years old [74] and about one-third (34%) of people who sexually abuse a child are family members.[75]
- Ninety-six percent (96%) of people who sexually abuse children are male and 76.8% of people who sexually abuse children are adults.[76]

As the priority populations are reviewed, there are noted multiple health disparities that are addressed such as socio-economic, environmental factors, inadequate access to resources, individual and behavioral factors and educational inequalities. The disproportionate risks observed in these populations and the considerations needed when implementing prevention efforts within these communities are described in the following sections. Public data and surveillance have reported significant over-representation in some communities and these findings are shared here.

[69] Ports K.A., Ford D.C., Merrick M.T., *Adverse Childhood Experiences and Sexual Victimization in Adulthood*. Child Abuse Negl. 2016; 15:313-322. http://doj.org/10.1016j.chiabu.2015.08.017 [PubMed: 26386753]
[70] Merrick, M. T., Basile, K. C., Zhang, X., Smith, S. G., & Kresnow, M. J. (2018). Characterizing Sexual Violence Victimization in Youth: 2012 National Intimate Partner and Sexual Violence Survey. *American journal of preventive medicine*, *54*(4), 596–599. doi:10.1016/j.amepre.2018.01.014
[71] https://www.bjs.gov/index.cfm?ty=dcdetail&iid=245
[72] https://www.cdc.gov/violenceprevention/datasources/nisvs/men-ipvsvandstalking.html
[73] https://www.cdc.gov/violenceprevention/datasources/nisvs/men-ipvsvandstalking.html
[74] Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics and risk factors. Child Abuse & Neglect 14, 19-28. doi:10.1016/0145-2134(90)90077-7
[75] National Sexual Violence Resource Center. (2011). Child sexual abuse prevention: Overview. Retrieved from http://www.nsvrc.org/sites/default/files/Publications_NSVRC_Overview_Child-sexual-abuse-prevention_0.pdf
[76] National Sexual Violence Resource Center. (2011). Child sexual abuse prevention: Overview. Retrieved from http://www.nsvrc.org/sites/default/files/Publications_NSVRC_Overview_Child-sexual-abuse-prevention_0.pdf

ROUNDTABLE DISCUSSIONS

The results of the survey guided the composition and format of the roundtable discussions. From the survey, stakeholders prioritized populations that were most impacted by sexual violence. The roundtable discussions would provide the best form of data collection to understand the impact of sexual violence perpetration and victimization throughout Arizona. The roundtable discussions would allow for respondents to provide their attitudes, feelings, beliefs, experiences and reactions to sexual violence; and shape the overarching vision for the Arizona sexual violence primary prevention statewide strategic action plan.

Any prevention efforts with the priority populations are most successful when individuals who are representative of the priority populations are involved in the planning efforts to inform program activities. They have the greatest insight into understanding their strengths, barriers and challenges, and cultural perceptions. Enlisting members of priority populations lead to prevention efforts consistent with principles of community empowerment (New Mexico Sexual Violence State Action Plan 2015-2020). These principles suggest that problems and potential solutions are best defined by the "community" (priority population) and that people who feel they are able to influence development of solutions to problems affecting their community are more invested in creating change and are disposed to prioritizing the rights, interests and well-being of their community[77].

To ensure the fidelity of the roundtable discussions, SVPEP submitted a scope of work to ADHS Human Subjects Review Board to approve the non-research focus group project (i.e. roundtable discussions). Six populations were prioritized: (1) African American, (2) People with Disabilities, (3) LGBTQI, (4) Rural, (5) Native American, (6) Youth. A seventh group, (7) males, was added in order to determine how to engage men and boys in preventing sexual violence in the state of Arizona.

Long standing community members (referred to as community navigators) in these selected populations were sought out who could speak credibly on behalf of their communities and provide technical assistance and guidance on recruitment of participants for the roundtable discussions. They also provided input on the moderator guide and facilitation methods. SVPEP also ensured that the moderators for each roundtable discussion were culturally appropriate by intentionally seeking and interviewing referred individuals in the community who had facilitation skills but also were familiar with the subject matter. In one case, SVPEP ended up contracting one moderator for one of the rural roundtable discussions based on time, geographic area and availability.

SVPEP was advised by community navigators in several respects when it came to facilitation logistics. First, recruitment materials would be distributed by community navigators and posted in public spaces they knew were safe community spaces for the priority population. In addition, postings on social media websites and online media allowed for larger reach potential. The participants followed a link which pulled up a set of screening questions for the potential participant to fill out. This screening tool was developed to ensure diversity among participants such as age, race, ethnicity, etc.

Selected participants were contracted either by email or by phone; based on the participant's preference. The contractor would provide the time, date and place of the venue where the roundtable discussions would be held. The contractor also provided all logistical information to participants. Venues were specifically held in designated places as recommended by the community navigator. Each roundtable discussion was about 60 to 120 minutes based on the group size and conversations taking place. The collection of roundtable discussions were voice recorded with consent by participants and then later transcribed. If there was a participant who did not consent to the voice recording than the roundtable discussion group was not recorded and instead a contractor manually took notes.

[77] Communities that Learn, Lead, and Last: Building and Sustaining Educational Expertise, Giselle O. Martin-Kniep, 2008.

Each group was staffed by a sexual violence victim advocate on stand-by and available to participants. In addition, the roundtable discussions were facilitated by a culturally specific moderator who self-identified with the priority population. Resources and referrals were available if participants sought them out. Interpretation was available including other relevant materials when requested such as plain language text documents, large print, technical devices if needed, as well as venue spaces that accommodated different abilities. If participants requested their caregiver was present, they would be available on-site but not in the discussion room. Alternatives to caregivers were provided by Ability360 if needed. Attendance throughout the roundtable discussion was voluntary and participants were given the option to leave as they pleased.

A total of fourteen (14) roundtable discussions were facilitated statewide (Table C). Participants of the youth roundtable discussions were between 14-17 years old and permission forms signed by their legal guardian(s) were required. Group sizes and ages varied. The different breakout in populations and geographic areas were informed by community navigators. Data was gathered on income range, education, race/ethnicity, gender, sexual orientation, primary language, self-identifying of behavioral, cognitive and or physical disability, and primary county residence.

Table C. Roundtable Discussions

Priority Population	Geographic Area	# in Group
Female Youth	Maricopa	20
Male Youth	Maricopa	
LGBTQI2 Youth	Maricopa	
LGBQ Sexual Orientation Adults	Maricopa	21
Transgender Adults	Maricopa	
General Males Adults	Maricopa	11
African American Male Adults	Maricopa	19
African American Female Adults	Maricopa	
Native American Adults All Genders	Maricopa	12
Native American Adults All Genders	Coconino	
Rural Adults All Genders	Santa Cruz	21
Rural Adults All Genders	Mohave	
People with Disabilities Female Adults	Maricopa	19
People with Disabilities Male Adults	Maricopa	
	Total	123

. . . . everything has happened generationally and conditionings are passed on to the next generation, so to undo the conditioning of people is really hard, which I'm working on with my kids, because I know there are certain things that I can't change about myself, so I let them know whatever you're learning from me, you're going to improve upon it because of the things that have happened to me in the past and happened to your grandma and Native Americans in general because it's all historical.

Roundtable Discussion Participant

PEOPLE WITH DISABILITIES

People living with disabilities across the United States are at a much higher risk for sexual victimization than the general population. Some risk factors may include a feeling of powerlessness, limited communication skills and inability to protect oneself due to lack of instruction and resources; individuals may live in an over-controlled and authoritarian environment(s); not given enough experiential opportunities to learn how to develop and use their own intuition[78]; severity of circumstances of their disabilities, easier to manipulate because of cognitive disabilities. In addition, because perpetrators are often family members or caregivers, those living with disabilities may fear having no one to take care of them or of being forced to move from their own home if they disclose an assault.[79]

The Arizona Developmental Disabilities Planning Council (ADDPC) published the, *2019 Legislative and Regulatory Recommendations for Prevention for Sexual Abuse of Arizonans with Developmental and Other Disabilities*.[80] This document was developed from multiple activities that included many community members, stakeholders, academic settings, state agencies, non-profits and community-based organizations which resulted in a cumulative effort for legislative recommendations. A summary of the recommended strategies (for full report see website: https://addpc.az.gov/):

1. Strengthen "Duty to Report" laws
2. Eliminate deemed status licenses for healthcare institutions that primarily service children and adults with cognitive disabilities or dementia.
3. Raise awareness of sexual abuse among people with disabilities
4. Fund sexual violence prevention and trauma-informed care
5. Establish protections for victims with disabilities who testify
6. Strengthen the legislative mandate for Adult Protective Services (APS)
7. Publicly post all residential monitoring report

Some of the specific actions proposed by the ADDPC and community stakeholders addressed these priorities in **primary prevention strategies** to consider:

- Increase effective sexual violence reporting among people with disabilities that is currently under-reported.
- Imminent need to improve surveillance of sexual violence within the disability community.
- Collaboration at all levels of state, community, public, organizational, medical and health and academic settings to enhance protective factors for people with disabilities.
- Awareness and education of sexual violence, sexual violence prevention and activities in our communities statewide.
- Creating trauma-informed organizations in providing services to people with disabilities.

[78] https://deldhub.gacec.delaware.gov/pdf/Intellectual%20Disablilites%20and%20sexual%20violence.pdf
[79] G. Lennox, N & Diggens, J. (2000). People with Developmental & Intellectual Disabilities.
[80] https://addpc.az.gov/

AFRICAN AMERICAN

Sexual violence in the African American community has a sociohistorical context with foundations in slavery, racism and the sexualization of African American female bodies in mainstream media. Sexual violence of slaves was viewed as a right instead of a crime and rape laws did not protect African American women. The legal end of slavery did not change the imbalance of power between White and African American people and sexual violence of African American women by White men went unpunished until the 1959 conviction of four men raping an African American college student in Florida. In addition, due to a long history of mistreatment/unequal treatment by the legal system, some African Americans may be hesitant about trusting the justice system when they are a victim of sexual violence.

On April 23, 1990, Congress passed the Hate Crime Statistics Act, which required the Attorney General (AG) to collect data "about crimes that manifest evidence of prejudice based on race, religion, sexual orientation or ethnicity." The URC Program collects hate crime data regarding criminal offenses motivated in whole or in part by the offender's bias against race, religion, disability, sexual orientation, ethnicity, gender or gender identity. Due to the difficulty of ascertaining the offender's subjective motivation, bias is to be reported only if the investigation reveals sufficient objective facts to lead to a reasonable and prudent person to conclude that the offender's actions were motivated in whole or in part by bias.[81] The 2017 Arizona Crime Report by the Department of Public Safety reported that anti-Black (uses Blacks instead of African American in this report) crimes were the highest among all types of hate crimes. There were a total of 95 hate crimes against African Americans out of 331 offenses. That makes up for a little over a quarter (28.7%) of the hate crimes in Arizona.

Community stakeholders informed the state action plan by identifying the following **primary prevention strategies**:

- Increase trust of government, law enforcement and social service organizations of sexual violence reporting among African American communities that is currently under-reported.
- Collaboration at all levels of state, community, organizational and academic settings to enhance protective factors for African American Communities.
- Awareness and education of sexual violence, sexual violence prevalence and activities in our communities statewide.
- Create trauma-informed organizations and safe community spaces that provide culturally-appropriate services to African American communities.
- Increase a greater understanding in the historical and lived individual and communal experiences of the African American population to appropriately design collaborative prevention efforts that are culturally specific and relevant to develop sexual violence prevention approaches.

It really starts with the families and how people were raised. The way my grandma and them did it back then, I just feel that families need to stop the stigma; somebody needs to stand up and say you can't have it, not today, and I think that's really the big issue. People are raised a certain way and they live by those same ways, and I just think it has to start there first or sexual violence is just going to continue and it will still be under the rug and that's that.

Roundtable Discussion Participant

[81] http://www.azdps.gov/sites/default/files/media/FINAL_Crime_in_Arizona_2017.pdf

NATIVE AMERICAN/INDIGENOUS

Native Americans comprise 5.3% of Arizona's population according to the 2017 U.S. Census. There are 22 federally recognized tribes in Arizona. The Navajo Nation is one of the largest Sovereign Nations in the United States with regards to land mass and population. Navajo Nation's lands spread across three states, Utah, New Mexico and Arizona. The majority of the Navajo Tribal lands are in northern Arizona. The Tohono O'odham Nation is the second largest Tribe in Arizona. Overall, Arizona is the state with the largest percentages of Native Americans in the United States.

We must consider the intersectional historical and present context of colonization, political, socio-psychological, economic, intergenerational and environmental aspects when it comes to Native Americans/Indigenous communities. Prior to colonization, tribal laws and norms were passed down from one generation to the next and any violence against women and on children was not tolerated.[82]

As colonization spread through Native American populations, communities and families were divided, lives were lost and sovereignty was weakened. Violence including rape was a tool used for power and control over Native Americans. High rates of addiction, suicide, mental illness, sexual violence and other ills among Native peoples might be, at least in part, influenced by historical trauma as, "many present-day health disparities can be traced back through epigenetics to a colonial health deficit, the result of colonization and its aftermath."[83]

The division of authority due to the political and colonial past created the complexity of tribal, federal and state governments when it comes to criminal jurisdiction. When a Native American Tribal member is a victim of sexual assault, it is often complicated by this division of authority. Only as recently as 2013, the U.S. Congress acknowledged tribal courts authority to handle certain domestic violence related cases involving non-Indian defendants only if the tribal court meets certain standards. In the usual situation, (greatly over-simplified version) Indian country criminal jurisdiction is largely determined by assessing three factors: 1) the status of the perpetrator (Indian or non-Indian), 2) the status of the victim (Indian or non-Indian) 3) the type of crime involved.[84]

Community stakeholders informed the state action plan by identifying the following **primary prevention strategies**:

- Increase resources and access to social service organizations for sexual violence in Native American/Indigenous communities especially on rural lands
- Collaboration at all levels of state, community, local, and organizational settings to enhance protective factors and decrease risk factors for Native American/Indigenous communities.
- Awareness and education of comprehensive health, sex and sexuality and sexual violence.
- Creating trauma-informed organizations that are safe community spaces, for example: talking circles for Native American/Indigenous communities
- Increase a greater understanding in the historical and lived individual/communal experiences of the Native American/Indigenous population to appropriately design collaborative prevention efforts that are culturally specific for sexual violence prevention approaches.

[82] Deer, S. *Beyond Prosecution: Sexual Assault Victim's Rights in Theory and Practice Symposium: Sovereignty of the Soul: Exploring the Intersection of Rape Law Reform and Federal Indian Law*. 455 (2005).
[83] Duran, B. Department of Health Services, University of Washington, School of Public Health and Director for Indigenous Health Research, Indigenous Wellness Research Institute.
[84] http://tribaljurisdiction.tripod.com/id8.html

YOUTH – 17 YEARS OLD AND YOUNGER

According to the 2017 U.S. Census, Youth and children, 17 years old and younger, make up 23.3% of Arizona's total population in Arizona.[85] Our youth are especially vulnerable when it comes to sexual violence (SV) because of the long-lasting consequences of physical and psycho-social health effects on the individual's future well-being, if they are victimized at a young age.

Violence in youth, without appropriate trauma-informed interventions can result in immediate and lifelong consequences, including physical, emotional, behavioral, and social challenges. They are also at increased risk of suffering future abuse or perpetuating the cycle in adulthood by abusing others.[86] Sexual violence can be prevented and efforts are best focused on stopping sexual violence before it starts.[87] The CDC reports that perpetrators of sexual abuse among youth are committed by someone they know. See Table C by CDC NISVS 2012.[88]

Most prevention programs for youth tend to focus on only one domain of violent behavior (e.g. sexual violence, dating violence, bullying), despite evidence that the same individuals often engage in multiple forms of violence, for examples, adolescent boys who engage in peer-directed violence are more likely to perpetrate sexual violence concurrently and at a one-year follow-up than non-violent boys.[89] Similarly, bullying behaviors in middle school predict subsequent involvement in sexual harassment.[90] Reviewing all levels of the SEM and the shared risk and protective factors on a matrix for violence among youth, points us to use research to improve the development of primary prevention strategies for our young people.

Table D. Perpetrators of sexual violence among victims who experienced sexual violence during youth

Perpetrators of Sexual Violence Among Victims Who Experienced Sexual Violence During Youth*	
Completed or Attempted Rape (Girls)	Completed or Attempted Made to Penetrate (Boys)
43.6% Acquaintance	35.1% Acquaintance
28.8% Current or former intimate partner	X
27.7% Family member	X
4.5% Person in a position of authority	X
10.1% Stranger	X

* Due to the possibility of multiple perpetrators, the sum of the percentages across all perpetrators may exceed 100%.
X Estimates are not reported. Too few males reported these forms of violence in 2012 to produce a reliable estimate for type of perpetrator

There are several evidence-based curricula for youth to address risk factors. Some examples of evidence-based curricula address; rape myths, attitude towards sexual violence, social norm and attitude change in adolescents such as *Safe Dates, Green Dot, Shifting Boundaries* and *Bringing in the Bystander*. These primary prevention approaches are some examples of rigorously tested strategies that produce short and intermediate outcomes.

[85] https://www.census.gov/quickfacts/AZ
[86] Liu, J., Lewis, G., & Evans, L. (2013). Understanding aggressive behaviour across the lifespan. *Journal of psychiatric and mental health nursing*, *20*(2), 156–168. doi:10.1111/j.1365-2850.2012.01902.x
[87] https://www.cdc.gov/violenceprevention/pdf/2012FindingsonSVinYouth-508.pdf
[88] https://www.cdc.gov/violenceprevention/pdf/2012FindingsonSVinYouth-508.pdf
[89] Ozer EJ, Tschann JM, Pasch LA, Flores E. *Violence perpetration across peer and partner relationships: Co-occurrence and longitudinal patterns among adolescents.*Journal of Adolescent Health. 2004; 34:64-71. DOI. 10.1016/j.jado-health.2002.12.001 [PubMed: 14706407]
[90] Espelage DL, Holt MK, Henkel RR. *Examination of peer-group contextual effects on aggressing during early adolescence.* Child Development. 2003; 74:205-220. DOI: 10.1111/1467-8624.00531 [PubMed: 12625446]

COLLEGE AGE

Although college age populations did not come in as one of the priority populations prioritized by community stakeholders, it is important to discuss the older age spectrum of adolescents, which has the highest rate for sexual violence victimization among all age ranges. Contributing factors include:

- **Alcohol and drugs**. Campus sexual assault often involves alcohol and drugs. One study found that 15% of young women experience incapacitated rape during their first year of college.[91] Incapacitated means these young women were raped when they could not give consent because they did not know what was happening.

- **Reporting sexual assault**. Sexual violence is common among female students of all ages, races and ethnicities and that one in five college age female will experience sexual assault.[92]

- **Peer pressure.** College age women often live with people their own age on campus rather than with older adults or parents. Students may feel peer pressure to participate in social activities like drinking, using drugs, going to parties or engaging in sexual activities that make them uncomfortable. Being forced into unwanted sexual activity for social acceptance is a type of sexual coercion.[93]

Nearly two-thirds of college students' experience some type of sexual harassment during their first year, yet less than 10% of these students tell a college or university employee about their experiences and an even smaller fraction officially report them to a Title IX officer.[94]

Community stakeholders informed the state action plan by identifying the following **primary prevention strategies**:

- Enhancement in sexuality and health education in K-12 school systems, improve to include information on consent, anti-violence messaging that is age and culturally appropriate and generate meaningful discussions.

- Leaders in the community, local celebrities and businesses should be active and vocal opponents of sexual violence to have a larger impact on communities by changing social norms.

- Increase mass media and marketing messaging of anti-sexual violence on technological devices for convenient access to social media, commercials, public service announcements, etc. to be shared widely and when creating anti-sexual violence messaging, tailor for appropriate ages but also make it a positive so people can ask more about it.

- Sexual violence awareness and education visualization and audio information should be in all organizations where they can be posted, seen and or heard in diverse community settings, including schools, stores, churches and public transportation.

[91] Kathryn Jones, M.S.W., Public Health Advisor, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC)
[92] Sharon G. Smith, Ph.D., Behavioral Scientist, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC)
[93] https://www.womenshealth.gov/relationships-and-safety/sexual-assault-and-rape/college-sexual-assault
[94] Hill, C., & Silva, E. (2005). Drawing the line: Sexual harassment on campus. Retrieved from the American Association of University Women: http://www.aauw.org/files/2013/02/drawing-the-line-sexual-harassment-on-campus.pdf

LESBIAN, GAY, BISEXUAL, TRANS, QUEER, INTERSEX, 2-SPIRIT, + (LGBTQI2)

Sexual and Gender Minority (SGM) is an umbrella term that encompasses the LGBTQI2+ populations as well as those whose sexual orientation, gender identity and expressions or reproductive development varies from traditional, societal, cultural or physiological norms; includes individuals with differences of sex development sometimes known as intersex also associated with the acronym LGBTQI2+.[95] It is critical to understand how the acronym's history has evolved as LGBTQI2+ communities forged their identities in the public arena moving away from the negative connotations associated with the word homosexuality due to homophobia and that homosexuality was not inclusive of those with varying identities in sexual orientation and or non-binary gender norms.

The National Sexual Violence Resource Center (NSVRC) examined and found correlations between sexual assault victimization and high-risk sexual behaviors, mood disorders (e.g. depression) and suicide attempts among individuals who identify as LGBTQI2+.[96] Since little is known about the national prevalence of sexual violence among LGBTQI2+, the National Institutes of Health has announced plans for advancing LGBT health research.[97] Healthy People 2020 also highlighted the need for additional research to document, understand and address the environmental factors that contribute to health disparities in the LGBTQI2+ community.[98] Because sexual orientation and gender identify questions are not asked on most national or state surveys, there are very few public surveillance surveys that captures data of sexual violence among LGBTQI2+. There are two national surveys, the 2012 NISVS and the 2015 Transgender Survey that have been able to provide some information.

NISVS reported that among LGB (differ from LGBTQI2+ since NISVS only captured LGB on survey) people:

- 44% of Lesbians and 61% of bisexual women experience rape, physical violence, or stalking by an intimate partner compared to 35% heterosexual women.
- Twenty-six (26%) percent of gay men and 37% of bisexual men have experienced rape, physical violence or stalking by an intimate partner compared to 29% of heterosexual men.
- Almost 40% of gay men and 47% of bisexual men have experienced sexual violence other than rape, compared to 21% of heterosexual men.

2015 U.S. Transgender Survey reported:

- Forty-seven percent (47%) of transgender people are sexually assaulted at some point in their lifetime.[99]
- One in five, (20%) of respondents who were incarcerated in jail, prison, or juvenile detention in the past year were sexually assaulted by facility staff during that time,[100]
- Seventeen percent (17%) of respondents who stayed at homeless shelters were sexually assaulted because they were transgender.[101]

In addition, an individual who identifies as SGM, may also identify from one or multiple communities of the priority populations named above which could cause further isolation, health disparity and discrimination. For example, gay men especially among communities of color are at higher risk for HIV and other STDs.[102]

[95] https://dpcpsi.nih.gov/sgmro
[96] https://www.nsvrc.org/sites/default/files/Publications_NSVRC_Research-Brief_Sexual-Violence-LGBTQ.pdf
[97] https://www.nih.gov/about-nih/who-we-are/nih-director/statements/plans-advancing-lgbt-health-research
[98] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
[99] https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF
[100] https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF
[101] https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF
[102] https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf

Community stakeholders informed the state action plan by identifying the following **primary prevention strategies**:

- Enhancement in sex, sexuality and health education in all school systems that is non-discriminatory.
- Mandate legislative workplace harassment policies implemented in all organizations and businesses.
- Create trauma-informed organizations that include criminal justice systems in providing victim services to LGBTQI2 communities with positive follow through and on-going training.
- Requiring campuses to have more victim advocates from diverse backgrounds.
- Increase a greater understanding of the lived individual and communal experiences of SGM population to appropriately design collaborative prevention efforts that are culturally specific and relevant to develop sexual violence prevention approaches.

We socialize and carry on family patterns, the way males are expected to be more sexual and to be more aggressive about their sexuality of where there is still the double standard where we expect women to be more demure. I know that is changing but we still tolerate some really bad behavior and just chalk it up to, "boys will be boys". I think changing those attitudes would be really helpful.

Roundtable Discussion Participant

RURAL POPULATIONS

Arizona is the 6th largest state in the U.S. with one of the fastest growing states by population according to U.S. Census Bureau 2017.[103] Arizona covers approximately 113,594 square miles, with people mostly living in the largest cities; Phoenix, Tucson and Mesa.[104] There are approximately 347,797 people living in rural areas with a per capital income of $33,388 dollars annually in comparison with urban areas at $42,744 dollars annually.[105] According to the American Community Survey (ACS) in 2017, 26.4% of rural populations lived at or under the poverty rate. Apache County has the highest poverty rate of 33.1% with Navajo County following at 26.4%, Gila County 24.01%, Santa Cruz County 23.6% and La Paz County and Graham County at 20.9%.[106] The U.S. Department of Agriculture reported that 26% of Arizonans live in census tracts designated as food deserts.[107] The ACS reported those living in the Arizona completed college in rural areas at 15.6% and urban at 29.1%. The unemployment rate is 7.6% in rural and urban at 4.8%.[108]

The socio-economic statuses (SES) of individuals can either hinder or support their health and well-being. SES encompasses income, educational attainment, financial security, and subjective perceptions of social status and

[103] https://www.census.gov/newsroom/press-releases/2018/estimates-national-state.html
[104] https://www.census.gov/quickfacts/fact/table/az/LND110210#LND110210
[105] https://data.ers.usda.gov/reports.aspx?StateFIPS=04&StateName=Arizona&ID=17854
[106] https://data.ers.usda.gov/reports.aspx?ID=17826
[107] United States Department of Agriculture. Economic Research Service. Food Access Research Atlas. Updated January 25, 2017
[108] https://www.ers.usda.gov/topics/rural-economy-population/employment-education/rural-employment-and-unemployment/

social class including poverty. There is not one single factor but rather characteristics of multiple physical and psychosocial stressors that may affect health outcomes using the social determinants of health framework.[109]

The focus on rural populations has increased over the years in community health related arenas, policy, social programs and medical care to meet more needs in rural areas. As technological advances become more accessible; internet platforms make it more convenient to access information, resources and virtual medical care in rural areas. Mobile domestic and sexual violence advocates, community health educators and home visiting programs have made significant strides in meeting rural individuals and their families near or at their homes. Satellite offices in rural towns where co-located victim providers in medical facilities, law enforcement agencies and legal offices are another alternative to access resources and support.

Community stakeholders informed the state action plan by identifying the following **primary prevention strategies**:

- Mandatory sex and health education in all school systems especially rural areas
- Creating trauma-informed organizations that includes criminal justice systems in providing victim services that are confidential in Rural communities
- Teaching about predators that groom in gaming systems, social media and in real life.
- Awareness and education of sexual violence in community spaces
- Parents/guardians, community members and leaders become more involved vocally and publicly in the anti-sexual violence movement; especially in their homes, un-silencing victims who come forward, do-away with victim blaming that happens in their communities.
- Increase mass marketing to be promoted on a larger scale that involves billboards, posters, ads; increase more partners and collaborations in community spaces, government, television, education systems, medical and health facilities, criminal justice, businesses, churches, etc.

MALES AND BOYS

Sexual violence can happen to anyone no matter age, sexual orientation, race/ethnicity, ability or gender identity. Male victims experience similar effects of sexual violence as their female counterparts such as shame, grief, anger and fear. Yet, the complexity of social norms on gender roles enforce socialized masculinity with perceptions that men and boys must be strong (physically and emotionally) prevents males and boys from reporting or even talking about their sexual violent experiences and victimization.

Here are some facts about male sexual violence: [110]

- Men can be raped as adults and sexually abused as children
- Men experience same symptoms as other survivors do after being sexually violated
- It is just as important for a man to receive counseling and supportive services just as it is for all survivors
- Sexual abuse does NOT cause homosexuality
- Being abused as a child does NOT mean you will grow up to be perpetrator

What can be unique to male survivors: [111]

- Belief in societal notions that early sexual experiences are a "normal" part of a boy's life
- Males may question their sexual orientation if they were sexually abused by a man.

[109] https://www.apa.org/pi/ses/resources/publications/violence
[110] https://www.nsvrc.org/sites/default/files/publications_nsvrc_factsheet_media-packet_statistics-about-sexual-violence_0.pdf
[111] https://www.nsvrc.org/sites/default/files/publications_nsvrc_factsheet_media-packet_statistics-about-sexual-violence_0.pdf

- Men may experience confusion and anger over loss of control of their body and any physical response they had to the assault.[112]
- Men who are being sexually assaulted may have an erection and may even ejaculate; however, these physiological responses do not equal consent.[113]

The reporting of male victimization of sexual violence and boys being sexually abused is being reported at increased levels than before. Examination of male and boy's sexual violence victimization, we must also address the large numbers of male perpetration of sexual violence as well.

According to NISVS, male perpetration among female victims was reported at high rates. Females reported their victimization of completed rape or attempted rape by male perpetrators ranged from 91.1% to 100% across the U.S.[114] In addition, female victims reported sexual coercion perpetrated by males ranged from 87.0% to 100%. The majority of male victims of completed or attempted rape reported 86.5% of their perpetrators were male.[115]

In 2017, according to the Department of Public Safety report, there were 3,279 rapes reported.[116] Of the total rapes reported, rape accounted for 3,043 offenses and attempted rape accounted for 236 offenses. Rape accounted for 10.7% of violent crimes in Arizona. A total of 305 persons were arrested for rape and 253 arrests accounted for adults, while 52 arrests accounted for juveniles. Of those arrested, 73.1% were White, 31.8% were Hispanics, 18.4% were African American/Blacks, 6.9% were American Indian/Alaskan Native and 1.6% were Asian. If we break this down to genders, 248 were male adults and 52 were juvenile males.[117]

The perpetration numbers are overwhelming yet we know that one in six boys will be sexually abused as a child. Recognizing that young boys may be victims and may perpetrate as adults, we must ensure that preventing sexual violence across the age spectrum is imperative. A 2004 Department of Justice study found that only 8% of rape education and prevention programs were designed especially for men and boys.[118] When we think about primary prevention programs across the age spectrum, the realization is that sexual violence is prevalent and targeting specific programs is essential if we are to decrease sexual violence victimization and perpetration in Arizona.

Community stakeholders informed the state action plan by identifying the following **primary prevention strategies**:

- Mandatory sex, sexuality, health education and anti-violence education that is tailored for age appropriateness throughout the age spectrum

- Creating safe spaces for males, men and boys to openly talk about their feelings, emotions and discuss these kinds of topics in our communities

- Increase marketing and advertising of anti-sexual violence commercials, ads, PSAs, phone numbers and resources using high profile celebrities, community leaders and athletes.

- Accountability by criminal justice systems; incarceration, rehabilitation, education, supplemental support and resources for offenders and to prevent perpetration.

[112] Lew, M. (2004). *Victims no longer: Men recovering from incest and other child sexual abuse* (2nd Ed.).New York, NY: Harper Collins Press
[113] Bullock & Beckson, "Male Victims of Sexual Assault: Phenomenology, Psychology and Physiology," 2011.
[114] https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf
[115] https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf
[116] http://www.azdps.gov/sites/default/files/media/FINAL_Crime_in_Arizona_2017.pdf
[117] http://www.azdps.gov/sites/default/files/media/FINAL_Crime_in_Arizona_2017.pdf
[118] https://www.ncjrs.gov/pdffiles1/nij/grants/207262.pdf

REVIEW OF PRIORITY POPULATIONS

Throughout the priority populations mentioned, there are some overlapping concerns and issues that come up imminently when it comes to sexual violence victimization and perpetration; social norms, oppression, health and wellness, criminal justice, education, socio-economic status and environmental factors. The risks observed in each of these populations are considered when reporting the data and statistics including some that were quite disproportionate. Prevention efforts with priority populations are most successful when individuals are included and represented in the conversations when it comes to planning efforts and program implementation for our diverse communities. The greatest strengths are when those identifying with a community can share their perceptions, experiences, challenges, successes and the cultural pieces of which they are a member of. We appreciate the valuable time the participants provided to inform the roundtable discussions to achieve the goals of the Arizona Sexual Violence Primary Prevention Strategic Action Plan.

If you have this utopian society where this didn't exist at all, you would have a community that is probably tight knit, close, people would trust each other, and there would be better communication and better values of the whole community. But because this is problematic, you're going to have people who may have experienced it that are going to act a certain way about it and not be part of the community as they would if they weren't. You're going to have people who fear it, and that makes them apprehensive to be part of the community and if they did it [perpetrate], then you may have that individual that you would hope is not in your community.

Roundtable Discussion Participant

ARIZONA'S SYSTEM FOR RESPONDING TO SEXYUAL VIOLENCE

The concept of prevention is central to the field of public health so when looking at Arizona's system for responding to sexual violence from a prevention lens, there are three levels that are typically categorized by the Centers of Disease Control: [119]

- Primary Prevention – Approaches that take place *before* sexual violence has occurred.
- Secondary Prevention - Immediate responses *after* sexual violence has occurred to deal with the short-term consequences of violence.
- Tertiary Prevention – Long-term responses *after* sexual violence has occurred to deal with the last consequences of violence and sex offender treatment interventions.

Many of us are familiar with secondary and tertiary prevention methods. These are services and programs that are provided to survivors of sexual assault or perpetrators *after* the violence have occurred. Some examples are crisis response teams, advocacy, counseling/therapy, rehabilitation, supportive services, medical exams, law enforcement, incarceration, forensics and community-based organizations that provide holistic services for survivors. Currently, most of Arizona's response system is targeted towards secondary and tertiary prevention methods.

Arizona's victim response system is unique. First of all, victim funding is administered through different state agencies shown here:

- Department of Public Safety – Victims of Crime Act (VOCA)
- Department of Economic Security – State Domestic Violence Fund
- Department of Housing – Operating subsidies for transitional housing for survivors
- Department of Health Services – Family Violence Prevention Services Act (FVPSA) and Rape Prevention Education (RPE) Grant
- Criminal Justice Commission – Local fines and fees
- Office of the Attorney General – Crime Victims' Rights
- Governor's Office of Youth, Faith and Family – Sexual Assault Services Providers (SASP) grant and Services, Training, Officers, Prosecutors (STOP) grant

All of these agencies are part of the Arizona State Agency Coordination Team (AZSACT) that collaborates to assess and develop plans and priorities to improve victim services throughout Arizona. As funding is funneled into awards, funds and or grants, The AZSACT team leads its efforts by working on the ground with its grantees and stakeholders to inform them to continually improve their efforts. Some detailed funding examples include medical reimbursements to medical facilities for Sexual Assault Nurse Examiners (SANE) medical expenses, funding victim advocates at police departments, the District Attorney's Office and community based organizations and centers. Other funding examples may be for supportive services such as housing assistance, emergency and temporary shelter, operating costs, personnel, training, response teams and transportation assistance.

[119] https://www.cdc.gov/violenceprevention/pdf/svprevention-a.pdf

Arizona also has 18 Family and/or Children Advocacy Centers located throughout the state.[120] Advocacy centers are comprehensive, victim-focused programs based in a facility that allows law enforcement, child protection professionals, prosecutors, victim advocates, forensic interviewers, medical professionals, and mental health providers to work together when intervening and interviewing violent crimes against children and adults.[121] Each center is designed to best serve its community in which they are located. The overall goal of advocacy centers is to ensure that the victims who are entrusted to the centers are not further victimized by the systems that are designed to protect them.[122] A comprehensive list of all family and child advocacy centers can be found at this website: http://acfan.net/advocacy-centers.htm.

While many states have rape crisis centers (RCC), Arizona does not have a stand-alone RCC. Traditionally, rape crisis centers are facilities that house sexual assault advocates, therapists, and sometimes forensic nurses, who are all specially-trained in working with sexual assault survivors and addressing sexual trauma. These facilities usually house a crisis hotline and are open to survivors 24 hours a day, 7 days a week. RCCs are unique in that they provide services and support groups to sexual assault survivors throughout the lifespan, regardless of who the perpetrator was or whether the survivor wants to report to law enforcement. These centers are distinct from Child and Family Advocacy Centers, which often house law enforcement, are open for specific business hours, may not have 24-hour sexual assault crisis line and/or provide long-term advocacy across the lifespan. Child and Family Advocacy Centers are appropriate for some survivors, particularly those who are interested in reporting to law enforcement, however, sexual assault survivors need and deserve options for services and healing. RCC's are often best supported by non-profit RCCs whose services are tailored to sexual assault survivors regardless of age, gender, background, type of sexual violence, citizenship status, or interest in the criminal justice systems.[123]

There are several fatality review teams that review deaths related to domestic and sexual violence throughout the state. These teams are multi-disciplinary teams that come together to increase the understanding of risk and protective factors associated with these crimes. These reviews make recommendations based on their findings to prevent future occurrences and look at possible improvements within systems, policies and infrastructure design on how to further protect victims and the communities in which they serve. The Arizona Coalition to End Sexual and Domestic Violence (ACESDV) also reviews fatalities of interpersonal violence. These can be found on their website at: https://www.acesdv.org/fatality-reports/.

Sexual Assault Response Teams (SART) are formalized teams organized by multi-disciplinary professionals in victim services with guidelines and agreements between agencies about the provision of sexual assault services and the roles and responsibilities of core responders.[124] Ultimately, protocols provide a way for team members to institutionalize interagency expectations in order to maintain high quality, consistent responses over the long term in which each agency on the team customizes their individual agency responses to an ideal multi-disciplinary, coordinated response to meet the needs of the victim.[125] Arizona has 8 SARTs across the state (for information on SARTS, contact www.acesdv.org).

In the state of Arizona, primary prevention for sexual violence is being funded by the Rape Prevention Education (RPE) grant, which is a federal grant. There is little funding for primary prevention and ensuring that programs provided to our most vulnerable communities in an impactful and meaningful way, is the RPE's essential focus. Current primary prevention approaches span across three cities; Phoenix Metro, Tucson and Flagstaff. These organizations provide:

[120] http://acfan.net/advocacy-centers.htm
[121] http://acfan.net/advocacy-centers.htm
[122] http://acfan.net/center-info.htm
[123] Menaker, Tasha, Arizona Coalition to End Sexual and Domestic Violence, May 2019.
[124] https://www.nsvrc.org/sarts/protocols-and-guidelines
[125] https://www.nsvrc.org/sarts/protocols-and-guidelines

- Single and multi-session workshops that increase skills to prevent sexual violence and promote social norms that protect against sexual violence such as: *What is a healthy relationship? What is consent? Rape myths and victim-blaming, Traditional gender roles, Emotional health and wellness, Increase skills in solving problems non-violently.*

- Providing opportunities to empower youth: *Youth work groups to prevent violence, Engaging young people in leadership opportunities.*

- Creating protective environments in universities and alcohol serving establishments that address bystander intervention of sexual aggression.

ADHS will be expanding its programs and will be using this state action plan as a tool to inform its priorities for program implementation. The following section shares the responses at the statewide strategic action plan meetings for the primary prevention for sexual violence.

DATA, SURVEILLANCE AND INFORMATION COLLECTION

Sexual violence reporting remains an under-reported problem and there is no one complete data source to paint the picture of the prevalence of sexual violence in Arizona. Data is important in public health delivery and can be used for critical purposes such as to address comparisons among specified determinants, demonstrate and evaluate impact of interventions, monitor progress, determine barriers of care, influence policy and be designed to develop effective programs and strategies for improvement.[126] There are limitations with data sources that may vary based on how and when the information was collected, but data can make profound differences in people's lives when put to practical use.

There are two categories of data; qualitative and quantitative. Qualitative data are characteristics and descriptors that cannot be easily measured but can be observed subjectively.[127] The roundtable discussions and strategic action plan meetings are examples of qualitative data collection. Quantitative data is working with numbers that can be measured objectively such as counting, measuring something and giving it value.[128] Some sources are public and free and some are associated with a cost. Examples of sources available to monitor sexual violence are reputable anonymous surveys facilitated and collected locally and nationally (e.g. NISVS, YRBS, BRFSS, ACEs), real-time data of sexual violence and related injuries after hospitalization, crime reporting to law enforcement, criminal court cases, incarceration reports, published articles in well-known journals and local data collected from organizations providing direct services.

There are multiple sources available to monitor sexual violence across different access points and some of them are collected in this document. The SVPEP will continue to provide data, surveillance and information collection on sexual violence to Arizonans in a smaller document annually.

[126] https://www.ncbi.nlm.nih.gov/books/NBK221227/
[127] https://methods.sagepub.com/book/introduction-to-educational-research/n12.xml
[128] https://methods.sagepub.com/book/introduction-to-educational-research/n12.xml

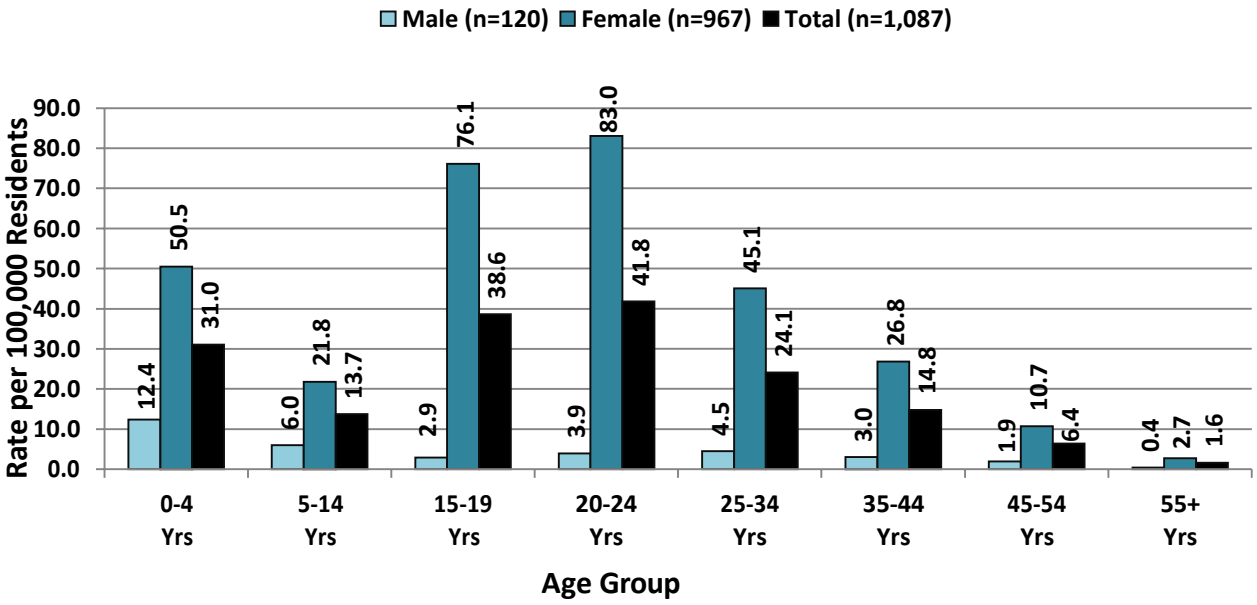
HOSPITAL DISCHARGE DATA

HDD is a valuable source of information about patterns of care, public health and the burden of chronic disease and injury morbidity. ADHS collects hospital discharge records for inpatient and emergency department visits from all Arizona licensed hospitals. This collection is required by Arizona Revised Statutes (A.R.S. §36-125-05, and Administrative Code Title 9, Chapter 11, Articles 4 and 5).[129] Of the 140 hospitals in Arizona, 126 are required to report to the state. Tribal and Federal facilities are not required.

The ADHS utilizes HDD to understand the hospital burden of sexual violence across the state. When sexual assault survivors need help, they may look to medical professionals instead of social service organizations because of the imminent medical need such as accessing SANE to complete a confidential rape kit, bodily physical injuries, health concerns such as gynecological complications, reproductive and gastrointestinal pain, sexually transmitted infections/diseases, possible pregnancy and or human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS).

The following figures shared are a snapshot of sexual violence in Arizona using 2017 HDD. In Arizona's efforts to end sexual violence, understanding its impact from several resources are pertinent to gain a greater insight on how sexual violence is affects our communities.

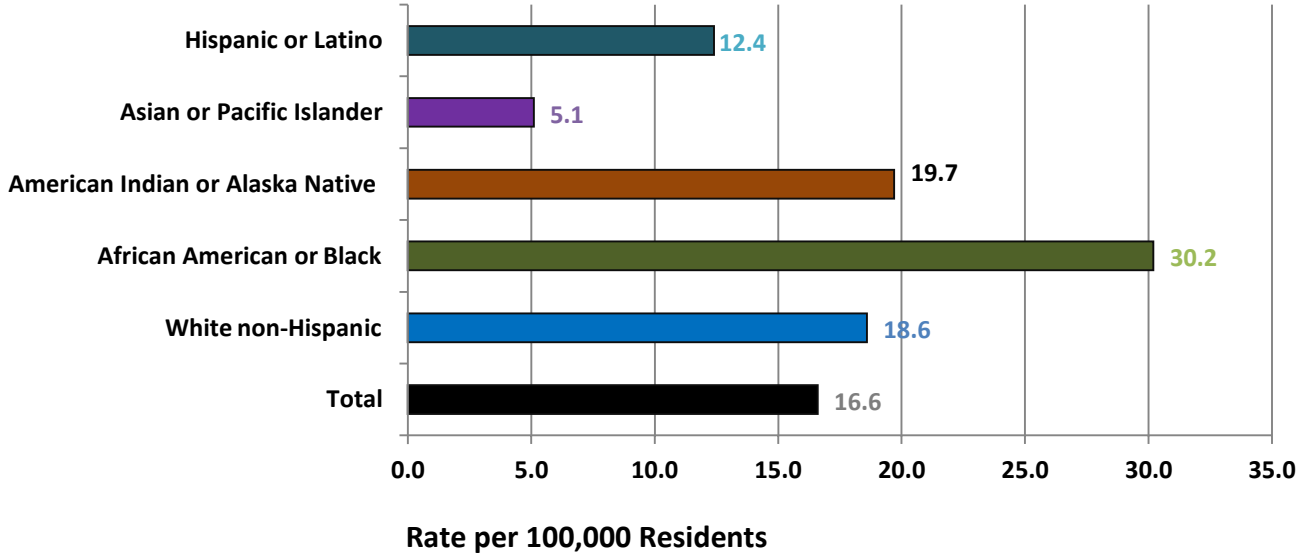
Figure 3. Sexual violence and injury related hospital discharge rates, by age group and gender, AZ, 2017



ADHS identified at least 1,087 hospitalizations who were patients of sexual violence and related injuries (SVRI). Of the 1,087 identified 89% were females (n=967). Females between the ages of 15-34 years of age were twice likely to experience SVRI than males. The highest rates for females were those 20-24 years old and for males between 0-4 years old, 12.4.[130]

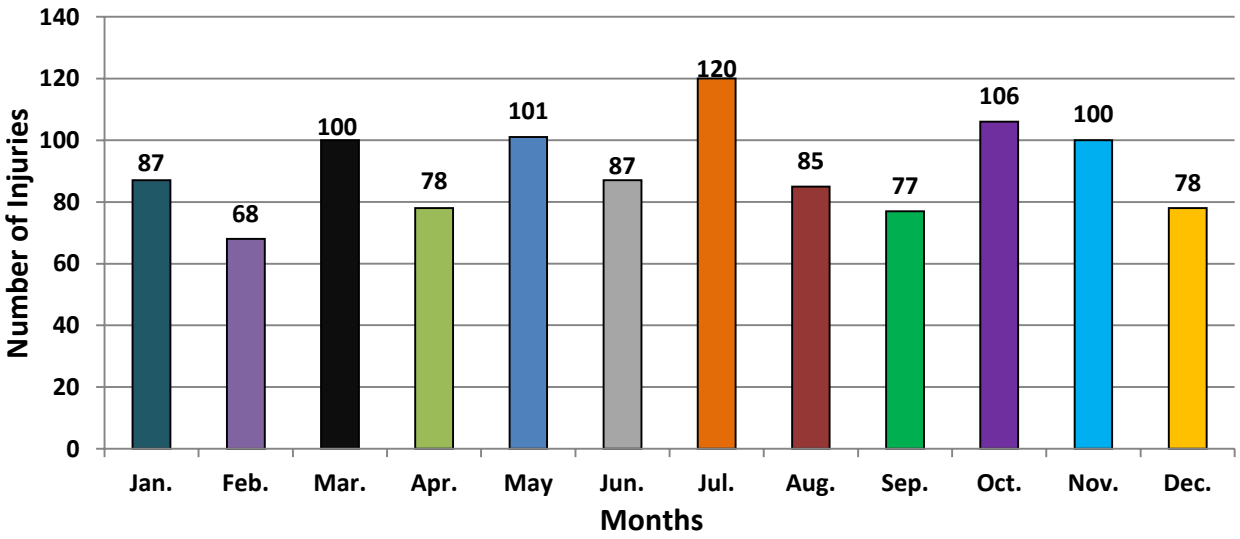
[129] https://www.azdhs.gov/preparedness/public-health-statistics/hospital-discharge-data/index.php
[130] Gardner, Kyle, Office of Injury Prevention, Arizona Department of Health Services, Arizona Hospital Discharge Data 2017

Figure 4. Age-adjusted Sexual violence & injury related hospital discharge rates, by Race/Ethnicity Group, AZ, 2017
***Multiple/Other Ethnicity not included (n=10)**



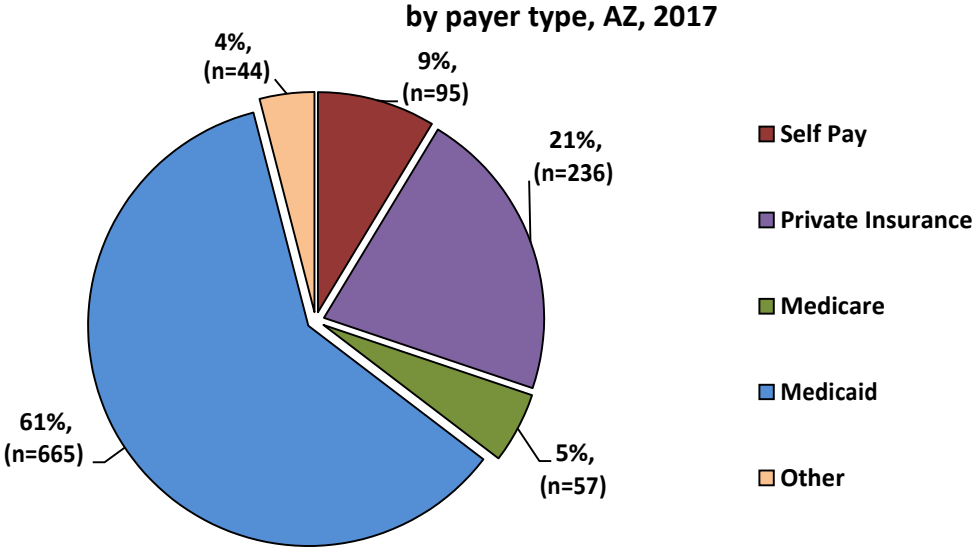
Among race/ethnicity groups, African Americans or Black patients had the highest age-adjusted rate (30.2 discharges per 100,000 hospitalizations), nearly twice as high compared to other of race/ethnicity groups.

Figure 5. Frequency of sexual violence & injury related hospital discharges, by month, AZ, 2017



July had the highest number of SVRI among Arizona hospitalizations in 2017. March, May, October, and November were other months that had over 100 SVRI hospital discharges

Figure 6. Percentage of sexual violence & injury related hospital discharges, by payer type, AZ, 2017

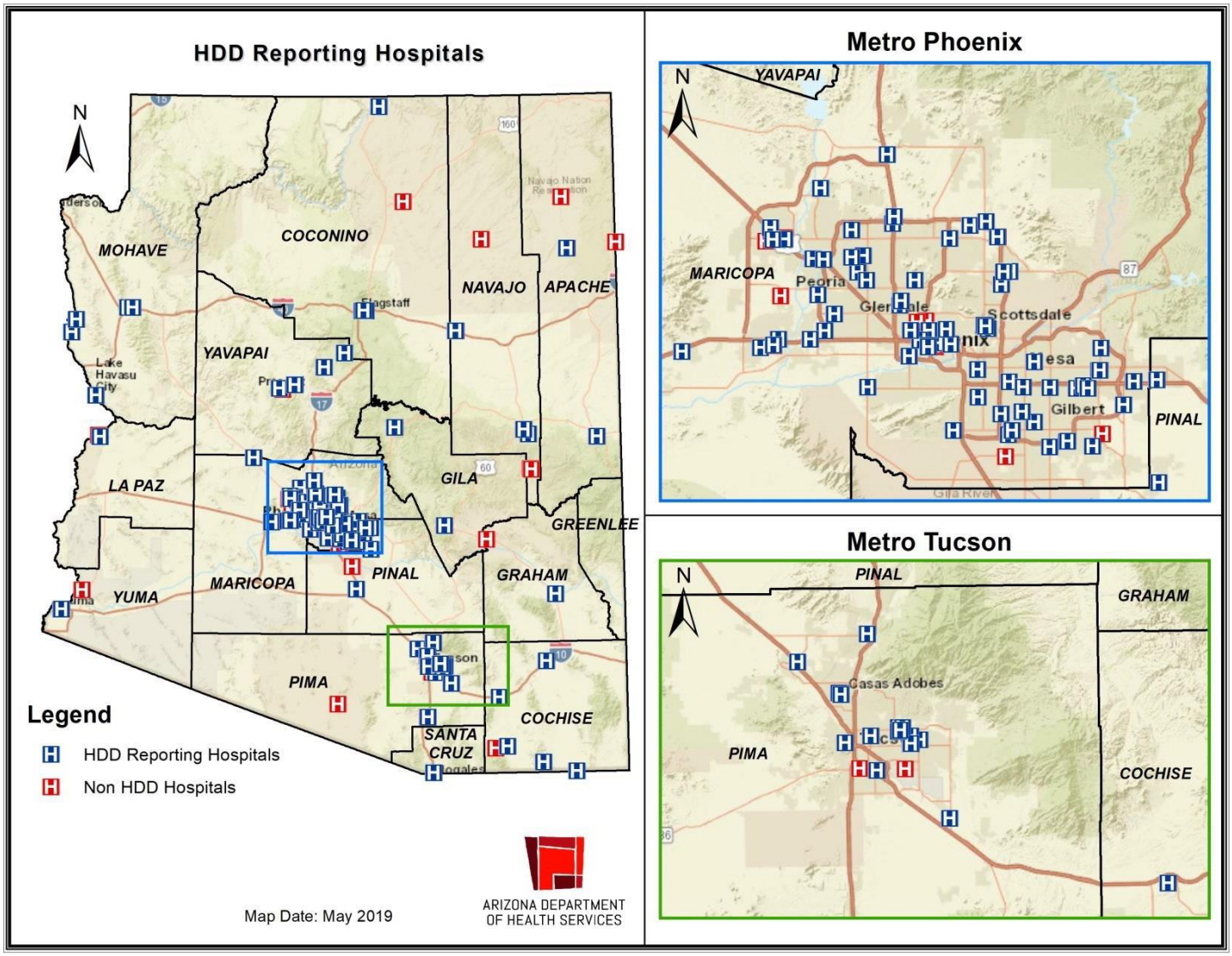


Sixty-one percent (n=665) of residents who were victims of sexual assault and sexual violence related injuries hospital were covered by Medicaid.

Figure 7. Number of sexual violence & related injuries hospital discharges by county, AZ, 2017

County	SVRI per 100 *counts less than 6	% of population	Total Population
Apache	*	1.0%	71,606
Cochise	11.7	1.8%	124,756
Coconino	4.8	2.0%	140,776
Gila	17	80.0%	53,501
Graham	16.2	50.0%	37,456
Greenlee	*	10.0%	9,455
La Paz	*	30.0%	20,601
Maricopa	13.9	61.4%	4,307,033
Mohave	15.3	3.0%	207,200
Navajo	19.9	1.6%	108,956
Pima	36.1	14.6%	1,022,769
Pinal	13.9	6.1%	430,237
Santa Cruz	16	60.0%	45,212
Yavapai	8	3.2%	226,168
Yuma	6.1	3.0%	207,534
Arizona			7,013,260

Figure 8. Hospital locality by county in Arizona, 2019



Map of Arizona where HDD is captured by county. The blue H's are current hospitals that report into HDD and the red H's are current hospitals that do not report into HDD.

SEXUAL HARASSMENT

Sexual harassment employment laws in Arizona are governed by the Arizona Civil Rights Act (ACRA). Notably, in Arizona, sexual harassment charging parties (complainants) can file a complaint with the Arizona Civil Rights Division (ACRD) even if there is only one employee other than the charging party who works for the business. Under federal law, (Title VII of the Civil Rights Act of 1964), there has to be a minimum of 15 employees to file a complaint. Sexual harassment cases against a business with more than 15 employees filed with the ACRD are dual-filed with the Equal Employment Opportunity Commission (EEOC) which could result in a charging party getting relief under the ACRA and Title VII.

Sex-based discrimination charges include two types of discrimination, those that are sexual in nature and those that are not sexual in nature. The term sexual harassment refers to allegations of verbal or physical harassment that are sexual in nature. Complaints for sex-based discrimination charges filed with the ACRD increased from 177 cases in FY17 to 224 cases in FY18. Of the 224 allegations of sex-based discrimination, almost 50% of the allegations (111) consisted of sexual harassment charges. Roughly 10% of employment related allegations of discrimination were sexual harassment charges.

The Arizona Attorney General's Office, Civil Rights Division, litigated the following sexual harassment cases in FY2018. All cases are confidential prior to filing a lawsuit:

a. *State v. Rumors Sports Bar & Grill, LLC* – In two employment cases involving sex discrimination, an owner/supervisor subjected two female bartenders to unwelcome verbal and physical conduct of a harassing nature. The harassing conduct was sufficiently severe or pervasive that it altered the terms and conditions of employment for both female employees. Defendant owner made sexually explicit comments while intoxicated on a daily basis, propositioned one female bartender for dates on multiple occasions, physically groped one female bartender on multiple occasions, and physically groped the other on one occasion. The sexual harassment culminated in termination for both female employees. The State settled the lawsuit with a Consent Decree that included monetary damages to the employee for back pay with injunctive relief to help prevent future civil rights violations.

b. *State v. Sparky's Investments, LLC* – In this employment case involving sex discrimination, an owner/supervisor subjected the sole, female employee to unwelcome verbal and physical conduct of a harassing nature. The harassing conduct was sufficiently severe and pervasive that it altered the terms and conditions of her employment, with weekly sexually offensive comments, text messages, and physical touching, creating a hostile work environment. Defendant touched the female employee's back, hips, and smacked her buttocks, viewed a pornographic video at work in her presence, and responded to her text messages with sexually-explicit comments and propositions. The State settled the lawsuit with a Consent Decree that included monetary damages to the employee for back pay with injunctive relief to help prevent future civil rights violations.

c. *State v. GEO* – In this employment class action involving sex discrimination, female employees were subjected to sexual harassment, a sexually hostile work environment, and retaliation. The employees were subjected to various forms of sexual harassment ranging from inappropriate sexualized comments to unwelcome sexual physical contact. The State settled the lawsuit with a Consent Decree. GEO agreed to pay $550,000 in compensatory damages and back pay along with injunctive relief to help prevent future civil rights violations.

To initiate a complaint with the Arizona Civil Rights Division, you may call (602) 542-5263 or fill out an intake form found at www.azag.gov.

Sexual harassment section provided by the Arizona Attorney General's Office, Civil Rights Division.

NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY (NISVS)

The NISVS is an on-going survey that collects the most current and comprehensive national and state level data on intimate partner violence, sexual l violence and stalking victimization in the United States. The CDC developed NISVS to collect data on these important public health problems to enhance violence prevention efforts. [131] The most recent reports for Arizona key findings:

- 41.3% of women and 19.9% of men experienced some form of sexual violence contact during their lifetime. This is more than the national average.
- 20.9% of Arizonan women reported attempted or completed rape by any type and of those, 96.9% reported that their perpetrators were male.
- 9.6% of Arizonan women reported a completed rape by penetration that was alcohol/drug-facilitated.
- Of the 41.3% of women who reported sexual violence contact by a perpetrator:
  - 46.1% reported the perpetrator was an acquaintance
  - 44.0% reported the perpetrator was a current/former intimate partner
  - 25.3% reported the perpetrator was a stranger
  - 10.8% reported the perpetrator was a family member

YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults. These include:[132]

- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and STDs/HIV
- Alcohol, drug and tobacco use
- Unhealthy dietary behaviors and inadequate physical activity

Refer to Table D, a look at categories of sexual behaviors, alcohol use and behaviors that contribute to violence.

Table D. Arizona 2017 YRBS questions related to sexual behaviors, alcohol use and behaviors that contribute to violence

Question	Total	Female	Male
Were ever physically forced to have sexual intercourse	8.2%	11.5%	4.5%
Seriously considered attempting suicide in the last 12 months	19.2%	23.8%	14.0%
Usually got the alcohol they drank by someone giving it to them	38.8%	44.6%	32.5%
Were currently sexually active within the last 3 months	24.9%	24.0%	26.1%
Did not use birth control pills if were currently sexually active	80.4%	80.2%	80.5%
Drank alcohol or used drugs before last sexual intercourse	18.2%	16.4%	20.1%

For more information, you can go to the Centers of Disease Control and Prevention website: https://nccd.cdc.gov/youthonline/app/Results.aspx?LID=AZB

[131] https://www.cdc.gov/violenceprevention/datasources/nisvs/index.html
[132] https://nccd.cdc.gov/youthonline/app/Results.aspx?LID=AZB

CHILD SEXUAL ABUSE REPORTING

Arizona Legislation passed the Senate Bill 1518 in 2018 that the consolidation of the Semi-Annual Child Welfare Reporting Requirements and Semi-Annual Financial and Program Accountability Report resulted in changing of reporting periods from the federal fiscal year to the state fiscal year.[133] The SVPEP will collect child sexual abuse numbers by the Department of Child Safety (DCS) in their public report that is published every six months of the calendar year. These numbers by DCS will show number of reports called in, number of assigned allegations for investigation and number of investigations completed.

A report of suspected child abuse, neglect, exploitation or abandonment is a responsible attempt to protect a child. Arizona law requires certain persons who suspect that a child has received non-accidental injury or has been neglected to report their concerns to DCS or local law enforcement (A.R.S. §13-3620(A)). Children often tell a person with whom they feel safe about abuse or neglect. If a child tells you such experiences, you can report the abuse to a toll free Arizona Child Abuse Hotline at 1-888-767-2445.

Mandated Reporting

Mandated reporters are required by law, as defined by A.R.S. §13-3620 to report all concerns of child abuse or neglect. DCS provides a secure website for mandated reporters of child abuse and neglect to report non-emergency concerns. Non-emergency concerns are those in which a child is not at immediate risk of abuse or neglect that could result in serious harm. To access website: https://extranet.azdes.gov/DCYF/CHILDS/communication/des/Register.aspx?ReturnUrl=

Once a call is made to the Child Abuse Hotline, DCS will complete an investigation of the parent, guardian or custodian involved and they will receive a letter stating whether or not the information found during the DCS investigation concludes that there is reason to believe the allegations of abuse and/or neglect are true. This is referred to as either a "substantiated" or "unsubstantiated" finding. If the finding is substantiated, that means there is reason to believe the abuse/neglect did take place.[134]

An unsubstantiated finding means there was insufficient evidence to conclude the abuse or neglect took place. If the DCS Specialist is considering a substantiated finding, the parent, guardian or custodian involved will also receive a letter explaining how an appeal of the decision may be requested. This letter will also inform the parent, guardian or custodian how they can request a copy of the DCS report which contains the information reported to DCS alleging abuse and/or neglect.

Proposed for Substantiation (Prop sub) means that the DCS Specialist who completed the investigation found enough evidence to submit a proposal that the allegations be 'substantiated' (i.e. the allegations are true). This triggers the DCS review team to gather all the necessary evidence and notify the parents of the proposed substantiation. This allows an opportunity to contest the finding and then ultimately validate a 'substantiated' finding of abuse and/or neglect. At any point along the way, the DCS review team can determine if there is not enough evidence to substantiate or determine that the family does not have the right to appeal the finding (such as if the finding is being heard in a criminal or other court).

In calendar year 2018, there were 1,775 reports of child sexual abuse. Of those, 1,667 were assigned for investigation. Out of the 1,677 investigations, 1,273 were unsubstantiated, 40 prop sub and 299 were substantiated. For additional information or details of the report, please see weblink: https://dcs.az.gov.

[133] https://www.azleg.gov/legtext/53leg/2R/laws/0110.pdf
[134] https://dcs.az.gov/

ARIZONA UNIFORM CRIME REPORT FBI 2017[135]

Arizona Town/City	Population	Violent crime	Rape[1]	Arizona Town/City	Population	Violent crime	Rape[1]
Apache Junction	40,672	80	0	Paradise Valley	14,629	6	2
Avondale	84,041	257	27	Parker	3,022	257	0
Buckeye	67,147	32	3	Patagonia	872	32	0
Bullhead City[3]	40,039		5	Payson	15,504	58	4
Camp Verde	11,299	33	0	Peoria	165,889	414	66
Chandler	249,355	647	130	Phoenix	1,644,177	12,511	1,142
Clarkdale	4,304	8	0	Pima	2,527	3	0
Coolidge	12,645	39	3	Pinetop/Lakeside	4,392	35	1
Cottonwood	12,116	49	1	Prescott	42,975	157	11
Douglas	16,443	41	0	Prescott Valley	43,891	86	20
Eagar	5,001	12	0	Safford	9,617	23	1
El Mirage	35,611	85	21	Sahuarita	29,373	28	10
Eloy	17,552	90	4	San Luis	32,823	44	3
Flagstaff	72,388	307	35	Scottsdale	251,840	396	103
Florence	25,623	19	0	Show Low	11,163	60	6
Gilbert	242,090	207	39	Sierra Vista	42,859	191	24
Glendale	249,273	1,217	97	Snowflake-Taylor	10,025	45	0
Globe	7,349	126	2	Somerton	15,082	19	0
Goodyear	79,419	210	27	Springerville	2,000	9	0
Holbrook	5,077	44	0	St. Johns	3,581	11	1
Jerome	457	2	0	Superior	3,026	7	0
Kearny	2,096	6	0	Surprise	135,345	120	18
Kingman	29,181	131	12	Tempe	186,086	883	151
Lake Havasu City	53,937	120	21	Thatcher	5,054	1	0
Marana	45,123	40	7	Tolleson	7,289	68	5
Maricopa	47,466	91	10	Tucson	532,323	4,268	498
Mesa	492,268	2,047	252	Wickenburg	6,979	20	5
Miami	1,774	31	0	Willcox	3,471	45	0
Nogales	19,878	43	0	Williams	3,181	30	5
Oro Valley	44,251	17	2	Winslow	9,764	67	2
Total	**2,021,507**	**6,095**	**702**				

[1] The figures shown in this column for the offense of rape were reported using only the revised Uniform Crime Reporting (UCR) definition of rape. See the data declaration for further explanation.
[3] The FBI determined that the agency did not follow national UCR Program guidelines for reporting an offense. Consequently, this figure is not included in this table.

[135] https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-8/table-8-state-cuts/arizona.xls

ARIZONA CRIMINAL JUSTICE COMMISSION 2012-2016

The ACJC is required to report all police reports, charges filed, convictions, and sentences for A.R.S. §13-1406 sexual assault charges. This report combines A.R.S. §13-1406 and A.R.S. §13- 1423 (violent sexual assault) arrest and disposition information to form one sexual assault offense category. For purposes of this report by ACJC, 'sexual assault-related arrest' refers to an arrest incident with at least one charge at either arrest or disposition. The following summarizes the findings from CY2012 to CY2016 for all sexual assault arrest and disposition information available in the Arizona Computer Criminal History (ACCH):[136]

- There were 1,496 sexual assault-related arrests with a total of 3,169 sexual assault arrest charges were recorded in the ACCH. Charges were filed by the prosecutor for 895 of the total 1,496 arrests over the five-year period, including 667 in which charges were filed for sexual assault.
- A total of 338 arrests resulted in at least one conviction for sexual assault, and an additional 396 arrests ended with convictions for other offenses only.
- As of July 2018, 434 (29.0%) of the 1,496 sexual assault records in the ACCH were pending or missing disposition information for all arrest charges.
- Approximately three out of every four arrestees for a sexual assault offense were White/Caucasian males; 62.3% of arrestees were 35 years of age or younger at the time of arrest.
- Seventy-nine percent (79%) of cases with at least one sexual assault conviction resulted in a prison sentence compared to 45.2% of cases with other offense convictions only.
- There were 270 records with at least one sexual assault arrest charge flagged for domestic violence in the ACCH. 68 arrests resulted in a sexual assault conviction and 86 arrests led to convictions for other offenses only. Of the 68 cases with a sexual assault conviction, 52 (76.5%) resulted in a prison sentence. A total of 64 domestic violence-related sexual assault records had no disposition information available for any arrest charges.

According to the ACCH data, 1,490 arrests included at least one sexual assault charge for a total of 3,169 sexual assault charges (see Table D). An additional six arrests had at least one charge that was later amended by the prosecutor to a sexual assault charge.

Table D. Arrest and Conviction Information for Sexual Assault Records in the ACCH, CY 2012-2016

Arrest Records	2012	2013	2014	2015	2016	Total
Sexual Assault Records	313	278	295	306	304	1496
Records with at least one sexual assault arrest charge	311	277	295	304	303	1490
Records with other offense arrests only	2	1	0	2	1	6
Total Sexual Assault Arrest Charges	656	603	666	659	585	3169
Records Leading to Charges Filed	196	180	198	181	140	895
Records Leading to Convictions	166	149	163	148	108	734
Records with at least one conviction for sexual assault	87	63	81	62	45	338
Records with at least one conviction for other offense only	79	86	82	86	63	396
Records Pending All Disposition Information						
Number	64	66	77	99	128	434
Percent of total sexual assault records	20.4%	23.7%	26.1%	32.4%	42.1%	29.0%

[136] http://www.azcjc.gov/publications

For additional information in regards to sexual assault arrests, convictions and criminal cases, please go visit website: http://www.azcjc.gov/publications or contact the Arizona Criminal Justice Commission.

Table E. Sexual Assault Arrest Records Overview, CY2012-2016					
Arrest Records	**2012**	**2013**	**2014**	**2015**	**2016**
Records with sexual assault charges filed or amended	147	127	157	138	98
Records with sexual assault charges not filed/referred for prosecution	74	54	36	37	35
Records pending all sexual assault charge disposition information	92	97	102	131	171
Total Records	313	278	295	306	304
Records with sexual assault charges filed or amended	**2012**	**2013**	**2014**	**2015**	**2016**
Conviction (sexual assault)	87	63	81	62	45
Conviction (other offense only)	35	40	47	47	29
Acquittal (sexual assault or other offense only)	1	1	3	1	3
Case Dismissed (sexual assault or other offense only)	24	23	26	28	21
Records with sexual assault charges not filed/referred for prosecution	**2012**	**2013**	**2014**	**2015**	**2016**
Conviction	21	23	17	9	6
Acquittal	0	0	0	1	0
Case Dismissed	1	4	1	1	1
No other charges filed/referred for prosecution[8]	52	27	18	26	28
Records pending all sexual assault charge disposition information	**2012**	**2013**	**2014**	**2015**	**2016**
Conviction (other offense only)	23	23	18	30	28
Acquittal	0	0	0	0	1
Case Dismissed	4	3	5	2	6
Other charges not filed/referred for prosecution	1	5	2	0	8
Pending all disposition information	64	66	77	99	128

Table F. Highest Level of Sentencing for All Sexual Assault (SA) Records and Records with a Domestic Violence (DV)-Related Sexual Assault Arrest, CY2012-2016				
	All SA Records		**Records with a DV-related SA Arrest**	
	At Least One SA Conviction	Conviction for Other Offense(s) Only	At Least One SA Conviction	Conviction for Other Offense(s) Only
Prison	267	179	52	29
Jail	35	108	7	27
Other	36	109	9	30
Total	**338**	**396**	**68**	**86**

LEGISLATION

There have been many bills related explicitly to sexual violence and victims sponsored in the 2019 First Regular Session of the 54th Arizona State Legislature. Some have gained passage while others have not, but the efforts of policy makers and community members have been critical in primary prevention. The societal level looks at broad social factors that help create a climate in which violence is inhibited or encouraged.[137] Societal factors include the health, economic, education and social policies that help maintain economic or social inequalities between groups in society.[138] The advocacy and research activities of policy makers and community members can influence social norms over time and more likely sustain sexual violence prevention efforts.

A summary by the Arizona Coalition to End Sexual and Domestic Violence (ACESDV) and the Attorney General's Office, Office of Victim Services provides a brief overview of the bills that passed and bills that did not pass that are related to sexual violence. The Arizona Legislative session ended on May 28, 2019. For review and details of all legislative bills, see weblink: https://www.azleg.gov/.

Executive Order 2019-03[139]

Relating to Enhanced Protections for Individuals with Disabilities
Signed by the Governor on February 6, 2019
1) The Arizona Health Care Cost Containment System (AHCCCS), Arizona Department of Health Services (ADHS), and Department of Economic Security (DES) in conjunction with disability advocates, shall review current protocols and jointly develop training on prevention abuse and neglect, recognizing the signs and symptoms of abuse and neglect and reporting abuse and neglect for both providers for people with disabilities and for parents and guardians.

2) AHCCCS, ADHS and DES shall ensure that all state contracts related to the care of individuals with disabilities include a requirement that all staff, contractors and vendors who have indirect interaction with members with disabilities shall annually undergo training in preventing, recognizing and reporting abuse and neglect.

3) AHCCCS, ADHS and DES, shall ensure that all state contracts for residential, group homes and day programs for individuals with disabilities include a requirement for the prominent posting of signage which includes department approved language on how to report abuse and neglect.

4) AHCCCS, ADHS and DES shall ensure that all state contracts related to the care of individuals with disabilities include a requirement that a check of the Adult Protective Services Registry before someone is hired.

5) AHCCCS, ADHS and DES shall convene a working group that includes individuals with disabilities, disability advocacy organizations, providers and family members. This workgroup shall consider additional steps that can be taken to protect and improve care for individuals with disabilities and shall make recommendations and submit a report to the Governor's office by November 1, 2019.

Bills Passed Senate Bill (SB) House Bill (HB)
SB1250 – Injunction Against Harassment; Sexual Violence
Signed by the Governor on April 22, 2019
The statute governing injunctions against harassment (IAH) has expanded the definition of "harassment" to include one or more acts of "sexual violence" (as defined in statute). Fees of service for process are prohibited from being

[137] https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html
[138] https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html
[139] https://azgovernor.gov/governor/news/2019/02/governor-ducey-issues-executive-order-strengthening-protections-people

charged for a petition for an injunction against harassment that arises out of sexual violence. The IAH will be available to any sexual violence survivor to request from the courts for a single act of sexual violence within one year of the incident for no fee. Effective January 1, 2020.

SB1315 – Victims' Rights; Refusal of Interviews

Signed by the Governor on May 13, 2019

Except in cases involving a dismissal with prejudice or an acquittal, the right of a victim and a victim's representative to refuse an interview, a deposition of any other discovery request by the defendant, the defendant's attorney or any other person acting on behalf of the defendant remains enforceable beyond a final disposition of the charges.

SB1538 – Relating to Adult Protective Services

Passed, pending signature by Governor

Establishes the "Adult Protective Services (APS) central intake unit" as a unit of specialized staff within APS that is responsible for receiving and screening reports of alleged abuse, neglect or exploitation of vulnerable adults and making the necessary referrals. The list of persons with a duty to report a reasonable belief that a vulnerable adult has been the victim of abuse, neglect or exploitation is expanded to include various health care and emergency personnel and employees of the Department of Economic Security.

HB2008 – Amended Section 13-3620, A.R.S. Duty to Report; Supervisor; Administrator

Signed by the Governor on April 11, 2019

Requires the immediate or next-higher-level supervisor or administrator of a person responsible for the care or treatment of a minor other than a parent, step-parent, or guardian to report a reasonable belief of abuse, physical injury, neglect or deprivation of care developed in the course of employment.

HB2080 – Civil Rights Restoration; Application; Procedures

Signed by the Governor on April 30, 2019

Notable changes: Requires that DPS place a notation on criminal history reports that the person's rights have been restored; Grants victims the right to be present and speak at hearings to restore civil rights; and requires that the State provide notice of the hearing. Automatically restores first time offenders' civil rights without requiring a petition. Requires the court to forward applications for restoration to the county attorney.

HB2466 – Civil Action; Assault; limitation; applicability

Signed by the Governor on May 27, 2019

An emergency measure that creates a statute of limitations of 12 years after a plaintiff reaches 18 years of age for lawsuits involving minor victims of unlawful sexual conduct and sexual contact.

HB2570 – Establishing a Study Committee on Missing and Murdered Indigenous Women and Girls

Signed by the Governor on May 14, 2019

The study committee on missing and murdered indigenous women and girls is established consisting of named members.

HCR2009 – Pornography; Public Health Crisis

Signed by the Govenor on March 22, 2019

Non-binding resolution that asserts that the members of the legislature denounce pornography as a public health crisis.

Bills that failed

SB1251 - Schools; Sexual Abuse Prevention Education.

Mandates that by the 2020-2021 school year, districts and charter schools shall establish an education and training program on sexual abuse prevention for employees and students based on guidelines and curricula developed by the department of education.

Introduced but was not heard in committee

SB1252 – Schools; Sex Education Curriculum

Creates an opt out sexual education instruction for K-12 students that is medically accurate, age appropriate and teaches disease prevention, healthy relationships and consent for sexual activity.

Introduced but was not heard in committee

SB1253 – Establishing a study committee; Missing and murdered Indigenous women and girls

The study committee on missing and murdered indigenous women and girls is established consisting of named members.

Introduced and passed the House but not the Senate

HB2156 – Amending A.R.S. by adding and amending sections in Title 23 related to employment; training; termination, conditions; discrimination

All employers shall provide the following for new employee training regarding workplace counseling, sexual harassment, and other items not related to sexual violence. Allowance for employees to be terminated for any act of sexual harassment or any felony offense.

Introduced but was not heard in committee

HB2206 – Amending A.R.S. 13-4443; Title 13, Chapter 40; Related to Sexual Assault Survivor Rights

Defined sexual assault survivors' rights and formed a study committee with key stakeholders about the rights of sexual violence survivors.

Introduced but was not heard in committee

HB2613 – Sex Offender Registration; Termination

Modifies sex offender registration termination requirements and permits additional offenders to apply for termination. Specifically; (1) defendant was under 22 years of age at the time of offense, (2) Victim was 15, 16, 17 years of age at the time of the offense and etc.

Introduced and passed the House but not the Senate

HJR2001 - Sexual Exploitation; Trafficking; Health Crisis

Declares sexual exploitation and sex trafficking to be a public health crisis in Arizona.

Introduced but failed in the House

HB2300 – Sex Offender Registration; Early Termination

Allows for a person to be removed from the sex offender registry 10 years after registration if over 18 years old or 5 years if under 18 years old, if no other offenses has occurred.

Introduced but was not heard in committee

HB2666 – Health Care Institutions; Education Abuse

Provides mandatory education and training for medical staff on abuse, including sexual abuse, with additional requirements to post information regarding abuse in healthcare facilities

Introduced but was not heard in committee

HB2738 – Parent-Child Relationship; Termination; Grounds

A person conceives a child as a result of sexual violence, the survivor of the violence could file to terminate parental rights of the perpetrator based on clear and convincing evidence, rather than requiring a felony conviction.

Introduced but was not heard in committee

I had to learn everything about my identity online, which is a dangerous place for a 15-year-old. I was very lucky that I didn't find too much that was inappropriate for a 15-year-old for lack of a better term, but it was kind of scary because I felt like I was…I obviously wasn't alone because there were people talking about it, but there was no one around me who could teach me because no one knew anything. And that also goes along with not only a lack of education but a refusal to be educated about it.

Roundtable Discussion Participant

THE SEXUAL VIOLENCE PRIMARY PREVENTION STRATEGIC ACTION PLAN MEETINGS

After the completion of the community stakeholder survey, meetings with community navigators, the roundtable discussions, presentations throughout the state and the finale of the statewide sexual violence prevention conference, SVPEP gathered new, veteran and potential stakeholders to participate in the five statewide strategic action plan meetings. These meetings are particularly important to the state action plan because it was its first to invite public members to participate in the planning for a statewide sexual violence primary prevention action plan.

An invitation was distributed statewide to email listservs and fliers were distributed at the conference. Each meeting held 40 participants maximum in order for everyone to have the opportunity to be actively engaged in the process. Careful consideration to space and facilitation was intentional to encourage inclusivity of voices and perspectives of participants. Diverse representation was a high priority therefore a questionnaire was distributed during registration. Interpreters were present for Spanish and American Sign Language, including providing large print and plain language documents including technological devices if needed.

During the meetings, participants worked in groups to identify the vision, mission, goals and objectives for the state plan. There were similar themes repeated across all the strategic action plan meetings. The collection and analysis of all materials in the meetings were conducted. Refer to Table G to review top goal areas identified.

Table G. Goals Areas for State Action Plan	Meeting 1	Meeting 2	Meeting 3	Meeting 4	Meeting 5	Total
Societal/Community Level						
Collaboration	7	4	15		3	29
Sustainability and Resources	16	10	10	9	2	47
Funding				15		15
Policy/Advocacy	10	15	12	9	8	54
Social Norms		5				5
Education and Awareness	11	17	20	18	11	77
Evaluation/Research/Assessment	3	8	3			14
Population specific/Inclusivity		10				10
Communication				9		9
Relationship Level						
Collaboration	7	4	15		3	29
Education and Awareness	16	17	20	18	11	77
Individual Level						
Education and Awareness	16	17	20	18	11	77

RESULTS

Reviewing the thoughts, ideas and information of responses shared in the meetings, provided insight for approaching our next five years (2020 to 2025) of the sexual violence primary prevention action plan goals and objectives. Societal and community level sexual violence prevention strategies are at the forefront of a shared consensus among meeting participants that align with roundtable discussion participants.

The **six themes** that consistently emerged from the five strategic action plan meetings were:

- The need for the elimination of sexual violence,
- Improve and enhance education and programming to prevent sexual violence,
- Build bridges between sexual violence prevention providers and community organizations to increase partnerships,
- Assure long-term stability of sexual violence prevention efforts,
- Increase awareness among the public to prevent sexual violence and reduce stigma among survivors, and
- Evaluate efforts to assess impact and identify opportunities to modify, expand or improve sexual violence prevention strategies for Arizona.

ELIMINATION OF SEXUAL VIOLENCE

All community stakeholders that participated in the various projects for the state action plan recognized that everyone must work from a public unified voice in order to end sexual violence. Everyone recognized that sexual violence affects individual, their families, loved ones, their local community and society as a whole when sexual violence is perpetrated. The elimination of sexual violence is a shared outcome.

IMPROVE AND ENHANCE EDUCATION AND PROGRAMMING TO PREVENT SEXUAL VIOLENCE

Many participants in the roundtable and strategic meetings reflected on their own personal experiences growing up on the subject matter of learning about sex, sexuality, anti-violence and health education. They realized for the most part that it was selective and as they were into their adolescent years and even in adulthood, that some of them did not know how to discuss this with their parents or children, their peers or seek out a trusted individual to express their questions or needs around this topic. Some that did seek advice or consult shared that they felt judged, shut-down and or discriminated. There was an expressed need to have spaces and programs to provide this kind of learning but also having safe and confidential resources that were anonymous as well.

BUILD BRIDGES BETWEEN SEXUAL VIOLENCE PREVENTION PROVIDERS AND COMMUNITY ORGANIZATIONS TO INCREASE PARTNERSHIPS

Everyone agreed that building collaborations and partnerships was ideal to bridging the gap in sexual violence. This included addressing risk factors such as poverty, economic opportunities and affordable housing to businesses becoming more involved in the anti-sexual violence activities. Partnerships could be as informal as neighbors making agreements to ensure the safety of their neighborhood by reporting suspicious activities or organizations implementing policies to non-tolerance of sexual harassment and or aggressive behavior in public and private establishments. It also could be building stakeholders to move policies into legislation to prevent sexual violence in its different forms.

ASSURE LONG-TERM STABILITY OF SEXUAL VIOLENCE PREVENTION EFFORTS

The importance of continual resources, funding and realistic efforts to ensure sustainability was shared by participants. Part of long-term stability and sustainability is looking at partnerships with agencies, groups and entities whose missions are not directly related to sexual violence such as businesses, neighborhood and merchant associations, sports teams, clubs, faith-based organizations and many more. Engage and increase male involvement and develop culturally appropriate and relevant public campaigns that include community leaders and members who self-identify as part of the intended audience.

INCREASE AWARENESS AMONG THE PUBLIC TO PREVENT SEXUAL VIOLENCE AND REDUCE STIGMA AMONG SURVIVORS

Reducing stigma and decreasing myths of victim blaming on survivors was popularly shared by all participants. The short and long-term health effects of the socio-psychological health to survivors impact their health and wellness to success and healing. This includes the five factors associated with the social determinants of health. It is important to note that when people were asked to define sexual violence in their own words, some people shared words such as:

tricked - shame – silenced – trauma – guilt – confusion – nightmare – terror – loss of self-confidence – worthlessness – suicide – prison – hurt – preyed – manipulated

EVALUATE EFFORTS TO ASSESS IMPACT AND IDENTIFY OPPORTUNITIES TO MODIFY, EXPAND OR IMPROVE SEXUAL VIOLENCE STRATEGIES

Stigma related attitudes and beliefs around sexual violence survivors have greatly affected the trust of reporting and sharing of survivor's traumatic experiences. As programs are selected to target priorities for sexual violence prevention, participants responded that there must be a method to evaluate the efforts that are put forth in the activities to identify how they are impacting the intended audience. Stakeholders would also like to explore opportunities when they are available to expand and improve sexual violence prevention statewide. This state action plan, the community survey, the roundtable discussions, strategic action plan meetings and a state evaluation plan for sexual violence primary prevention are some activities that have taken place to improve sexual violence prevention strategies in Arizona. There has also been some legislation to protect survivors and some task forces and work groups working towards sexual violence prevention as well. We look forward to working with, hearing from and sharing with our stakeholders, community members and partners in this sexual violence prevention work.

… it's something that affects everyone whether you realize it or not, and the way that you're raised, even if you have never been a victim of sexual violence or you've never perpetrated it. There are still certain social norms that you are raised around, and if you don't have an awareness of those because there's no discussion about it, you can't care and then you perpetuate that and or you don't act against and or you don't challenge those norms when you see them happening.

Roundtable Discussion Participant

VISION

An Arizona free of sexual violence

MISSION STATEMENT

Prevent sexual violence through sustainable education, collaboration and advocacy

GOALS AND OBJECTIVES

Goal 1: Education (1-2 years)
Increase comprehensive education and awareness of sexual violence prevention from the individual and relationship level to the societal/community level.

Goal 2: Advocacy (1-2 years)
Increase Arizonans' engagement and mobilization in sexual violence prevention.

Goal 3: Collaboration (1-3 years)
Expand partnerships between sexual violence prevention practitioners at the state, local and national level in sexual violence prevention.

Goal 4: Sustainability (2-5 years)
Assure the long-term stability of sexual violence prevention efforts by building organizational capacity, community ownership and funding opportunities.

Goal 5: Evaluation (2-5 years)
Enhance evaluation activities and efforts to assess impact of sexual violence prevention strategies to track and improve and sustain future programming and resources.

To keep in alignment with the public health model and the SEM, the primary prevention of sexual violence goals and objectives are formulated to connect to the plan's short and intermediate goals with the intended outcomes shown in Table H. Arizona state plan for the prevention of sexual violence goals, strategies and outcomes. Overarching activities within each strategy have been informed by community stakeholders from multi-disciplinary backgrounds and the public. The SVPEP sub-recipients will align their approaches to aim to meet the needs of the Arizona strategic action plan for the primary prevention of sexual violence. In all, the plan focuses on a comprehensive impact that is meaningful to Arizonan communities that will be tailored to specific populations and social norm changes that will result in increased safety, health and well-being for all.

It's all about educating people. It makes me think about one of my friends I've known for over 30 years, and she just told me about two weeks ago that her 27-year-old son came out and told her that his brother, who has a different mom but same dad, that his brother had molested him when he was little. He held it in all this time, and he barely just told his mom. That just broke my heart and I started crying, and I said are you serious? That is his brother. I can't believe he did that him so long ago. That goes to show you that it's still going on and it needs to stop.

Roundtable Discussion Participant

Table H. Arizona State Plan for the Prevention of Sexual Violence Goals, Strategies, and Outcomes

Objectives and Strategies Across the Social Ecological Model	Short-Term Outcomes (Years 1-3)	Intermediate Outcomes (by 2025)	Long-Term Vision
Goal 1. Increase comprehensive education and awareness of sexual violence prevention from the individual and relationship level to the community and societal level.			
Individual Level Arizonan youths, young adults and adults in our communities have knowledge, skills and information to address the risk and protective factors associated with sexual violence prevention. **Relationship Level** Arizonan youths, young adults and adults in our communities have knowledge, skills and information to understand the risk and protective factors associated with sexual violence prevention to have positive engaging conversations in regards to sexual violence prevention. **Community/Societal Level** SVPEP increase funded programs in Arizona implement primary prevention strategies for sexual violence tailored to specific communities to have the tools, knowledge, skills and information to prevent sexual violence.	Arizona's victim systems and its partners strengthens its capacity for effective primary prevention programming across the state Youth, young adults and adults engage in sexual violence primary prevention activities (RPE funded programs) in their communities.	Youth and young adults gain skills, knowledge and information to address and prevent sexual violence Arizonan communities have knowledge and information to have positive engaging conversations about sexual violence prevention	Decrease sexual violence perpetration and victimization in Arizona
Goal 2. Increase Arizonans' engagement and mobilization in sexual violence prevention.			
Relationship Level *Askable adults use accurate information to support sexual violence prevention among youths and young adults **Community/Societal Level** Arizonans understand protective factors and risk factors related to sexual violence perpetration and victimization and how it intersects with other multiple forms of violence	Communities dialogue and put in practice positive social norms to decrease and prevent sexual violence	Promote safety, empathy, equality and respect for all Arizonans	Decrease sexual violence perpetration and victimization in Arizona

*Askable adult means that young people see you as approachable and open to questions. *Askable* is important because research shows that youth with the least accurate information about sexuality and sexual risk behaviors may experiment more and at earlier ages compared to youth who have more information. https://advocatesforyouth.org/resources/health-information/are-you-an-askable-parent/#references

Goal 3. Expand partnerships between sexual violence prevention practitioners at the state, local and national level in sexual violence prevention.			
Community/Societal Level Enhance collaboration and integration across the Sexual Violence system to strengthen prevention strategies Consistently address the unique needs of vulnerable populations in primary prevention activities	Increase partnerships with non-traditional organizations and programs to diversify sexual violence prevention programming for specified populations	Veteran sexual violence prevention practitioners and culturally-specific communities reciprocate in providing support and TA to new partnerships in sexual violence prevention	Decrease sexual violence perpetration and victimization in Arizona

Goal 4. Assure the long-term stability of sexual violence prevention efforts by building organizational capacity, community ownership and funding opportunities.			
Community/Societal Level AZ SVPEP funded colleges and universities develops and implements model policies for anti-sexual violence trainings and programs to be sustained beyond RPE funding Communities increase resources and opportunities to own their sexual violence primary prevention efforts and sustain their activities	Intercollegiate workgroups inform and leads campus-based primary prevention sexual violence Integrating sexual violence prevention activities in communities for community cohesion and connectedness	Policy implementation in colleges and universities see sexual violence primary prevention as necessary Communities identify funding opportunities from non-traditional funders for future activities	Decrease sexual violence perpetration and victimization in Arizona

Goal 5. Enhance evaluation activities and efforts to assess impact of sexual violence prevention strategies to track and improve and sustain future programming and resources.			
Community/Societal Level Identify indicators to measure programs impact on prevention of sexual violence Implement state evaluation plan to enhance evaluation of sexual violence prevention strategies Ensure sexual violence prevention programs reaches the intended audience	Evaluation strategies measured annually for impact using identified Sexual violence indicators	Evaluation outcomes Provided through qualitative and quantitative data improve and enhance sexual violence primary prevention strategies and activities	Decrease sexual violence perpetration and victimization in Arizona

CONCLUSION

For the last year, listening to the diverse voices of Arizona's community members and practitioners who work to prevent sexual violence in our communities, has been an imminent and critical component in developing Arizona's – Ending Sexual Violence, first community-based strategic action plan for sexual violence primary prevention. The information and data collected from the needs assessment, the community stakeholder survey, roundtable discussions, feedback from the statewide conference and state action planning meetings were a process of intentional cumulative projects that has evolved for the community and is presented into this one document.

Participants in all of these projects ranged from enthusiastic to skeptical when asked to share about their experiences, ideas, opinions and thoughts to create a state plan that would cover the entire state of Arizona. Some were excited to see next steps and become more involved in the upcoming opportunities in preventing sexual violence; some participants will wait to see what happens from here on out as this state plan progresses. Most of all, participants felt that their voices were heard. The intention of the sexual violence strategic action plan process was to inspire innovation, spark potential activities that would motivate our communities in the hopes to end sexual violence. In response, the state action plan's goals and objectives are written to be flexible to enable organizations and communities to honor the unique strengths and challenges of their communities on the path to end sexual violence.

Although, we understand that ending sexual violence may not come right away or even within the next ten years, we can say that as a result, a current framework is provided to prevent sexual violence for the next five years in Arizona. Everyone's contribution to this document in the last year has been no less than amazing for this work may cause vicarious trauma, is complex and nuance, because it is larger than ourselves and takes more than an individual to prevent sexual violence. We encourage your programs and organizations to feel free to use this state action plan to guide your activities in violence prevention. Let's continue to work together to end sexual violence.

Again, thank you for all your assistance and support.

The Sexual Violence Prevention and Education Program (SVPEP)
Prevention Office of Women's Health
Arizona Department of Health Services

GLOSSARY

CENTERS FOR DISEASE CONTROL SEXUAL VIOLENCE UNIFORM DEFINITIONS[140]

Sexual Violence — Overall Definition
Sexual violence is defined as a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; non-physically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party.

Sexual violence involves a lack of freely given consent as well as situations in which the victim is unable to consent or refuse:

Consent
Words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact.

Inability to Consent
A freely given agreement to have sexual intercourse or sexual contact could not occur because of the victim's age, illness, mental or physical disability, being asleep or unconscious, or being too intoxicated (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.

Inability to Refuse
Disagreement to engage in a sexual act was precluded because of the use or possession of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, intimidation or pressure, or misuse of authority.

Sexual violence is divided into the following types:

- Completed or attempted forced penetration of a victim
- Completed or attempted alcohol/drug-facilitated penetration of a victim
- Completed or attempted forced acts in which a victim is made to penetrate a perpetrator or someone else
- Completed or attempted alcohol/drug-facilitated acts in which a victim is made to penetrate a perpetrator or someone else
- Non-physically forced penetration which occurs after a person is pressured verbally or through intimidation or misuse of authority to consent or acquiesce
- Unwanted sexual contact
- Non-contact unwanted sexual experiences

Penetration
Penetration involves physical insertion, however slight, of the penis into the vulva; contact between the mouth and the penis, vulva, or anus; or physical insertion of a hand, finger, or other object into the anal or genital opening of another person.

Penetration of Victim
Penetration of the Victim by Force - Includes completed or attempted unwanted vaginal (for women), oral, or anal insertion through use of physical force or threats to physically harm toward or against the victim. Examples include pinning the victim's arms, using one's body weight to prevent movement or escape, use of a weapon or threats of use, and assaulting the victim.

140 https://www.cdc.gov/violenceprevention/pdf/sv_surveillance_definitionsl-2009-a.pdf

Penetration of Victim by Alcohol/drug-facilitation - Includes completed or attempted unwanted vaginal (for women), oral, or anal insertion when the victim was unable to consent due to being too intoxicated (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.
Victim was made to Penetrate:

- *Victim was Made to Penetrate a Perpetrator or Someone Else by Force* - Includes times when the victim was made, or there was an attempt to make the victim, sexually penetrate a perpetrator or someone else without the victim's consent because the victim was physically forced or threatened with physical harm. Examples include pinning the victim's arms, using one's body weight to prevent movement or escape, use of a weapon or threats of use, and assaulting the victim.

- *Victim was Made to Penetrate a Perpetrator or Someone Else by Alcohol/drug-facilitation* - Includes times when the victim was made, or there was an attempt to make the victim, sexually penetrate a perpetrator or someone else without the victim's consent because the victim was unable to consent due to being too intoxicated (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.

Non-physically Pressured Unwanted Penetration
Victim was pressured verbally or through intimidation or misuse of authority to consent or acquiesce to being penetrated. Examples include being worn down by someone who repeatedly asked for sex or showed they were unhappy; feeling pressured by being lied to, or being told promises that were untrue; having someone threaten to end a relationship or spread rumors; and sexual pressure due to someone using their influence or authority (this is not an exhaustive list).

Unwanted Sexual Contact
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. Unwanted sexual contact can be perpetrated against a victim or by making a victim touch the perpetrator. unwanted sexual contact could be referred to as sexual harassment in some contexts (e.g., school or workplace).

Non-Contact Unwanted Sexual Experiences
Sexual violence that does not include physical contact of a sexual nature between the perpetrator and the victim. This occurs against a person without his or her consent, or against a person who is unable to consent or refuse. Some acts of non-contact unwanted sexual experiences occur without the victim's knowledge. This type of sexual violence can occur in many different venues (e.g., school, workplace, in public, or through technology).

Non-contact unwanted sexual experiences include acts such as:

- unwanted exposure to sexual situations - pornography, voyeurism, exhibitionism (this is not an exhaustive list)
- Verbal or behavioral sexual harassment - making sexual comments, spreading sexual rumors, sending unwanted sexually explicit photographs, or creating a sexually hostile climate, in person or through the use of technology (this is not an exhaustive list)
- Threats of SV to accomplish some other end such as threatening to rape someone if he or she does not give the perpetrator money; threatening to spread sexual rumors if the victim does not have sex with them (this is not an exhaustive list)
- unwanted filming, taking or disseminating photographs of a sexual nature of another person (this is not an exhaustive list)

Tactics
Methods used by the perpetrator to coerce someone to engage in or be exposed to a sexual act. The following are tactics used to perpetrate SV (this is not an exhaustive list):

nse or threat of physical force toward a victim in order to gain the victim's compliance with a sexual act (e.g., pinning the victim down, assaulting the victim)

Administering alcohol or drugs to a victim in order to gain the victim's compliance with a sexual act (e.g., drink spiking)

- Taking advantage of a victim who is unable to provide consent due to intoxication or incapacitation from voluntary consumption of alcohol, recreational drugs, or medication
- Exploitation of vulnerability (e.g., immigration status, disability, undisclosed sexual orientation, age)
- Intimidation
- Misuse of authority (e.g., using one's position of power to coerce or force a person to engage sexual activity)
- Economic coercion, such as bartering of sex for basic goods, like housing, employment/wage immigration papers, or childcare
- Degradation, such as insulting or humiliating a victim
- Fraud, such as lies or misrepresentation of the perpetrator's identity
- Continual verbal pressure, such as when the victim is being worn down by someone who repeatedly asks for sex or, for example, by someone who complains that the victim doesn't love them enough
- False promises by the perpetrator (e.g., promising marriage, promising to stay in the relationship, etc.
- Nonphysical threats such as threats to end a relationship or spread rumors
- Grooming and other tactics to gain a child's trust
- Control of a person's sexual behavior/sexuality through threats, reprisals, threat to transmit STDs threat to force pregnancy, etc.

Incident
A single act or series of acts of SV that are perceived to be connected to one another and that may persist over a period of minutes, hours, or days. One perpetrator or multiple perpetrators may commit an incident.

Examples of an incident include a husband forcing his wife to have unwanted sexual acts but only one time, a stranger attacking and sexually assaulting a woman after breaking into her apartment, a man kidnapping a female acquaintance and repeatedly assaulting her over a weekend before she is freed, a college student forced to have sex by several men at a fraternity party, a man forcing his boyfriend to have unwanted sex, or a family member touching the genitalia of a child during a visit.

Involved Parties
Victim: Person on whom the SV is inflicted. *Survivor* is often used as a synonym for a *victim* who is not deceased.

Perpetrator: Person who inflicts the SV

Terms Associated with the Circumstances and Consequences of Violence according to CDC
Control of Reproductive or Sexual Health
Includes controlling or attempting to control a partner's reproductive health and/or decision making. This also includes SV behaviors by the perpetrator that increase the risk for sexually transmitted diseases and other adverse sexual health consequences (e.g., unintended and frequent pregnancies). Examples include not allowing the use of birth control, coerced or forced pregnancy terminations, and forced sterilization because of abuse.

Disability
The Americans with Disabilities Act defines a disability as "a physical or mental impairment that substantially limits one or

more major life activities." Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, maintaining emotional stability, communicating, and working.

Illness
An abnormal process in which aspects of the social, physical, emotional, or intellectual condition and function of a person are diminished or impaired compared with that person's previous condition. Illness can be a short- or long-term condition

Law Enforcement
Police, as well as tribal authorities, prison authorities, and campus authorities (not an exhaustive list).

Medical Health Care

- *Inpatient:* Treatment by a physician or other health care professional related to the physical health of the victim who has been admitted to a hospital or other health care facility.

- *Outpatient:* Treatment by a physician or other health care professional related to the physical health of the victim who has not been admitted to a hospital or other health care facility. Includes treatment in an emergency department.

Mental Health Care
Includes individual or group care by a psychiatrist, psychologist, social worker, or other counselor related to the mental health of the victim. It may involve inpatient or outpatient treatment. Mental health care excludes substance abuse treatment. It includes pastoral counseling if such counseling is specifically related to the mental health of the victim.

Physical Evidence Collection
Collection of hairs, fibers or specimens of body fluids from a victim's body or garments that may aid in the identification of the perpetrator.

Physical Injury
Any physical harm, including death, occurring to the body resulting from exposure to thermal, mechanical, electrical, or chemical energy interacting with the body in amounts or rates that exceed the threshold of physiological tolerance, or from the absence of such essentials as oxygen or heat. Examples of physical injuries are bruises and vaginal or anal tears attributable to an incident of SV.

Physical Violence
The intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts.

Pregnancy Impact
Pregnancy resulting from SV or loss of an existing pregnancy following SV.

Psychological Functioning
The intellectual, developmental, emotional, behavioral, or social role functioning of the victim. Changes in psychological functioning can be either temporary (i.e., persisting for 180 days or less), intermittent, or chronic (i.e., likely to be of an extended and continuous duration persisting for a period greater than 180 days).

Examples of changes in psychological functioning include increases in or development of anxiety, depression, insomnia, eating disorders, post-traumatic stress disorder, dissociation, inattention, memory impairment, suicidal ideation, self-medication, self-mutilation, sexual dysfunction and hypersexuality.

Residential Institution

A location where the victim or perpetrator resides. Includes settings such as a nursing home, a college campus, a retirement home, or a jail/prison (not an exhaustive list).

Sexual Trafficking

The recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. In order for a situation to be considered trafficking, it must have at least one of the elements within each of the three criteria of process, means, and goal. If one condition from each criterion is
met, the result is trafficking. For adults, victim consent is irrelevant if one of the means is employed. For children, consent is irrelevant with or without the means category.

- Process: Recruitment, transportation, transferring, harboring, or receiving.
- Means: Threat, coercion, abduction, fraud, deceit, deception, or abuse of power.
- Goal: Prostitution, pornography, violence/sexual exploitation, or involuntary sexual servitude.

Substance Abuse

Abuse of alcohol or other drugs. This also includes alcohol or other drug dependence.

Substance Abuse Treatment

Any treatment related to alcohol or other drug use, abuse, or dependence.

Victim Advocacy

Services provided by someone trained in violent crime response that usually occurs by phone, in person or in a hospital setting. The services may include crisis response, information, support and referral.

Psychological Functioning

The intellectual, developmental, emotional, behavioral, or social role functioning of the victim. Changes in psychological functioning can be either temporary (i.e., persisting for 180 days or less), intermittent, or chronic (i.e., likely to be of an extended and continuous duration persisting for a period greater than 180 days).

Askable Adult – An Askable adult means that young people see you as approachable and open to questions. *Askable* is important because research shows that youth with the least accurate information about sexuality and sexual risk behaviors may experiment more and at earlier ages compared to youth who have more information.[141]

Department of Public Safety (DPS) Background of AZ UCR Crime Report and Terms[142]

The Arizona DPS is responsible for administrating the nCR program and providing necessary assistance and training to the contributing law enforcement agencies. In 1992, Arizona legislative session, participation in the nRC program became mandatory. Arizona revised statute (A.R.S.) § 41-1750(A)(2) states that the DPS shall, "collect information concerning the number and nature of offenses known to have been committed in this state and of the legal steps taken in connection with these offenses, such other information that is useful in the study of crime and in the administration of criminal justice and all other information deemed necessary to operate the statewide uniform reporting program and to cooperate with the federal government nRC program." Further, A.R.S. § 41-1750(D) states, "The chief executive officers of law enforcement agencies of this state or its subdivisions shall provide to the central state repository such information as necessary to operate the statewide uniform crime reporting and to cooperate with the federal government nRC program."

[141] https://advocatesforyouth.org/resources/health-information/are-you-an-askable-parent/#references
[142] http://www.azdps.gov/sites/default/files/media/FINAL_Crime_in_Arizona_2017.pdf

Statistics are received from local police agencies, county sheriff's offices, college and university campus police, and state police agencies. Federal agencies and tribal police agencies do not report to the Arizona nRC program and therefore, are not included in the publication.

Arizona Criminal Justice Commission[143]

Arizona Revised Statutes (A.R.S.) §41-2406(B) requires the Arizona Criminal Justice Commission (ACJC) to compile information from all Arizona criminal history records relating to sexual assault. The Arizona Department of Public Safety (DPS) provides the ACJC with the criminal history records needed to meet this reporting requirement on a biannual basis. The ACJC uses this data to compile an annual sexual assault report and provides the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of State.

Data used to complete this report are extracted by the DPS from the Arizona Computerized Criminal History (ACCH) repository. Local law enforcement agencies, prosecutors, and the courts are required by statute to submit all arrest and subsequent case disposition information for all felony offenses, as well as sexual, driving under the influence, and domestic violence-related misdemeanor offenses to the ACCH repository.

143 http://www.azcjc.gov/publications

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APPENDIX

A. The Public Health Approach to Violence Prevention

The Public Health Approach to Violence Prevention

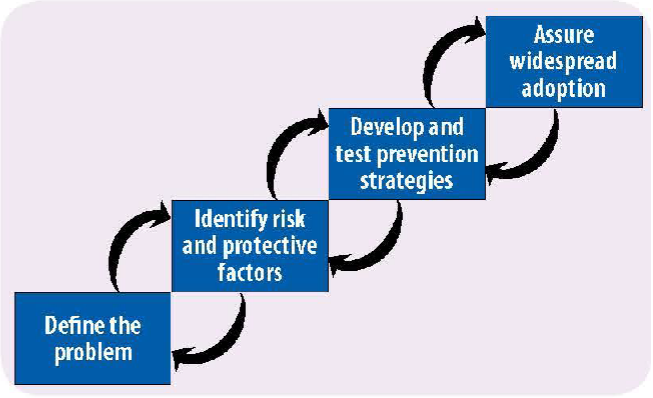
The public health perspective asks the foundational questions: Where does the problem begin? How could we prevent it from occurring in the first place? To answer these questions, public health uses a systematic, scientific approach for understanding and preventing violence[1]. While violence prevention practitioners may not be involved in all steps, understanding each step and why they are necessary to assure the desired impact on community health is helpful in selecting and/or developing prevention strategies.

The Public Health Approach

There are multiple steps in the public health approach, with each step informing the next. Many people, organizations, and systems are involved at each step along the way. Think of it as a relay team for prevention. The prevention practitioner usually takes up the baton in the fourth step, but overall success depends upon all of the other teammates and how they run their legs of the race

The Public Health Approach

In **step one**, the problem is defined. This involves systematically collecting data to determine the "who", "what, "where," "when," and "how." Data are typically gathered from a variety of sources such as death certificates, medical or coroner reports, hospital records, child welfare records, law enforcement or other records. Data can also be collected using population-based surveys or other methods.



In **step two**, the reasons why one person or community experiences violence while another does not are explored. Scientific research methods are used to identify the factors that increase the risk for violence (risk factors). Factors that may buffer against these risk factors are also identified; these protective factors decrease the likelihood of violence in the face of risk. The goal of violence prevention is to decrease risk factors and increase protective factors.

In **step three**, prevention strategies are developed and rigorously tested to see if they prevent violence. This information is shared with others, usually through activities related to step four.

Step four is where the rubber meets the road. The strategies shown to be effective in step three are disseminated and implemented broadly. While many prevention practitioners may not have the skills or resources necessary to conduct steps one, two, and three, knowing where to look for the findings of others, such as registries for evidence based practice in the field, will satisfy similar goals for implementation. Training and/or technical assistance often is offered to practitioners when implementing effective strategies or programs to ensure that the strategies are implemented as they were intended. Though this is considered the final step of the public health model, it doesn't mean that the process is complete. Additional assessments and evaluation are done to assure that all components of the strategy fit within the particular community context and have the desired effect of preventing violence.

Putting it all together

So what does this mean for the decision making process on the ground? How does knowing about the four steps help in selecting prevention strategies? One way to look at it is that the Public Health Approach offers a framework for asking and answering the right questions. The tool on the next page will help you to do just that.

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National Center for Injury Prevention and Control
Division of Violence Prevention

CS221239B

Use the tool below to think through a violence-related problem you would like to impact in your community or organization. The issue of Shaken Baby Syndrome, one form of abusive head trauma, is used as an example to demonstrate the tool. Fill in the shaded areas on the table with examples from your community or organization.

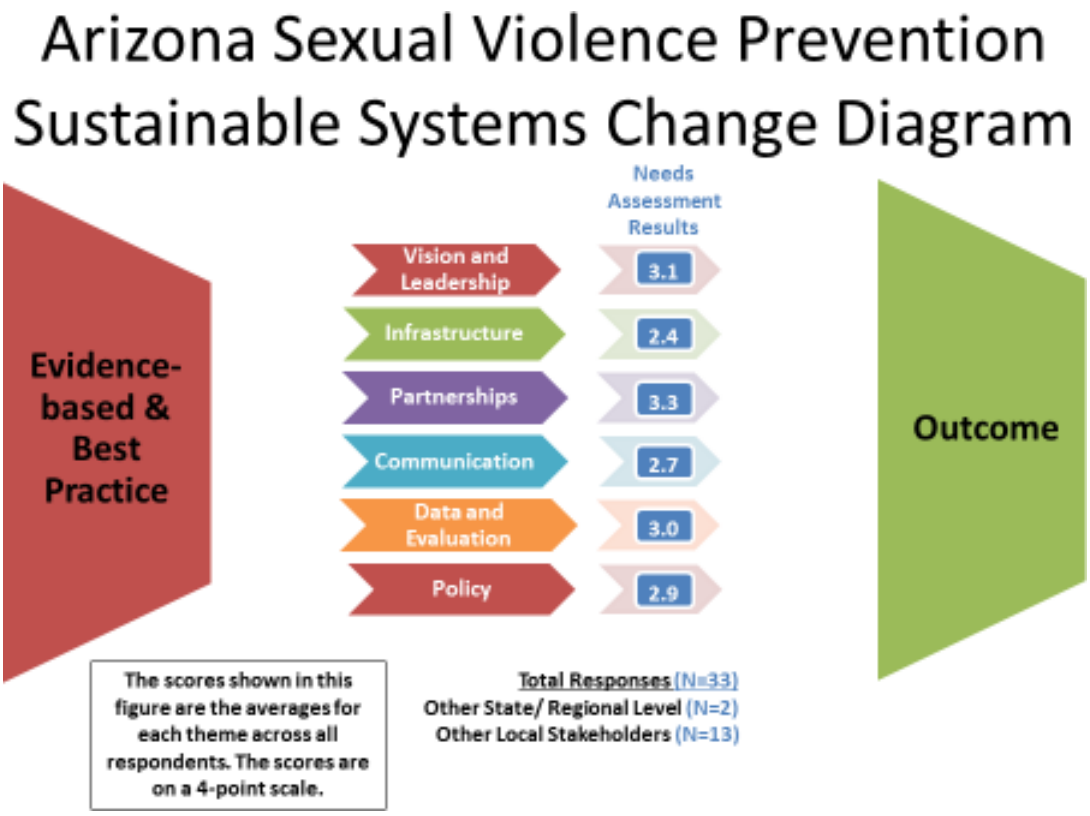
Using the Public Health Approach			
Steps	**Guiding Questions**	**Potential Resources**	**Example/Exercise**
Step One Define the Problem	What (violence-related) problem do I want to prevent? What data are available to describe the scope and burden of the problem? • How many people are affected by the identified problem? • Who is experiencing the problem? • When and where is the problem occurring?	National Violent Death Reporting System - http://www.cdc.gov/ViolencePrevention/NVDRS/index.html Web-based Injury Statistics Query and Reporting System (WISQARS) - http://www.cdc.gov/injury/wisqars/index.html Kids Count Data Center - http://datacenter.kidscount.org/?gclid=CMHYqI_7oqMCFcpd2godz3wZ4Q ALSO: State and local crime statistics, health statistics, child welfare data, etc.	*Example: Abusive head trauma (AHT), including Shaken Baby Syndrome (SBS) is a leading cause of child abuse deaths in the United States. According to a study of North Carolina AHT cases, as many as three to four children a day experience severe or fatal head injury from child abuse in the United States.* *Your turn:*
Step Two Identify Risk and Protective Factors	Where do I find research to answer: • What are the risk factors for the problem? • What are the protective factors for the problem?	Division of Violence Prevention (NCIPC/CDC) - http://www.cdc.gov/ViolencePrevention/index.html	*Example: Caregiver frustration or anger resulting from inconsolable crying and limited social supports are primary risk factors for shaking a baby.* *Your turn:*
Step Three Develop and Test Prevention Strategies	Where do I find information to answer: • Are there existing, effective strategies based on best available evidence? • If none exist, what resources do I need to develop a new strategy based on what was learned in steps one and two? • Where can I find research partners to help evaluate the selected strategy? • Is the strategy effective – did it do what was intended?	The Community Guide to Prevention Services - http://www.thecommunityguide.org/about/methods.html Blueprints for Violence Prevention - http://www.colorado.edu/cspv/blueprints/ California Evidence-Base Clearinghouse http://www.cachildwelfareclearinghouse.org/scientific-rating/scale Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence - http://www.nrepp.samhsa.gov/about-evidence.asp	*Example: A promising or model home visitation program. http://ibs.colorado.edu/cspv/blueprintsquery* *Your turn:*
Step Four Assure Widespread Adoption (Dissemination and Implementation)	• Who would benefit from this strategy (parents, educators, policy makers, etc.)? • How do I get this strategy to the people who need it? • Where can I find assistance and support for implementing an effective strategy and on-going monitoring and evaluation of the strategy?	National Implementation Research Network - http://www.fpg.unc.edu/~nirn/ FRIENDS National Resource Center - http://www.friendsnrc.org/ University of Kansas Community Toolbox - http://ctb.ku.edu/en/default.aspx	*Example: Implementation of a home visitation program that includes a focus on specific parental behaviors and modifiable environmental conditions associated with adverse outcomes for children.* *Your turn:*

Assessment Profile: Arizona

Key Findings/Executive Summary

- Fifteen respondents provided feedback on the needs assessment: two state/ regional level stakeholders and thirteen other local stakeholders.
- Overall *partnerships (3.3), vision/leadership (3.1), and data and evaluation (3.0)* are strengths for the Arizona team.
- The average scores across stakeholder groups on the *policy (2.9), infrastructure (2.4), and communication (2.7)* sections indicated opportunities for state health leaders to work with partners more closely on refining these systems components in collaboration with all participating stakeholder groups.

**All scores are averages on a 4-point scale*



BACKGROUND AND INTRODUCTION

ASTHO's systems needs assessment tool provides an opportunity for state teams and their partners to assess the necessary components, as identified in literature and practice, for successful public health system functioning. These systems components include:

- Vision and Leadership;
- Infrastructure;
- Partnerships;
- Communication;
- Data and Evaluation;
- Policy;
- Technical Assistance.

These components have been shown to be critically necessary for successful implementation of a system-wide project that impacts many facets of policy and practice, such as ASTHO's Sexual Violence Prevention Project.

ASTHO's systems needs assessment examines the extent to which different stakeholders understand and think about these different systems components, as well as how they perceive their engagement with these systems themes. The systems needs assessment *is not an evaluation* of an initiative, but rather provides an analysis of how an entire system functions to support the successful adoption and implementation of evidence-based practices.

Using the critical systems components listed above, this state system profile will describe areas of strength for the state, as well as opportunities for further focus. The results of this state system profile could be incorporated into future action plans to better understand challenges and barriers, so that state leaders can enhance their effectiveness to optimally implement, scale up statewide, and sustain their initiative.

METHODS

An online needs assessment was distributed to key state, local, and community/clinical partners of the Arizona Department of Health Services (ADHS). ASTHO created an online survey using Qualtrics, and sent the survey URL to key partners as identified by the ADHS staff. Respondents self-selected their role in relation to the ADHS and were automatically directed to the appropriate set of questions. Role choices included:

- State Health Agency Staff (e.g. state health department leadership and staff)
- State Coalitions
- Other State/Regional level Stakeholder (e.g. other state agencies BESIDES state health department, such as a state academic institution, professional association, state non-profit organization, etc.)
- Local Public Health Agency Staff (e.g. local health department leadership and staff)
- Local Coalitions
- Other Local Stakeholder (e.g. other local agencies BESIDES local health department, such as a local/private academic institution, school districts, healthcare systems, local non-profit organizations, etc.)

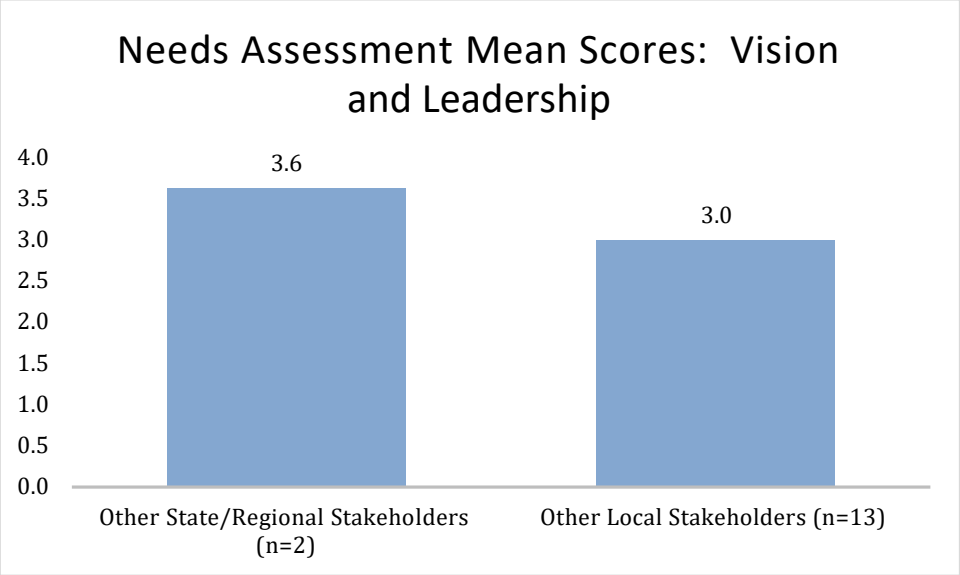
Respondents were asked to rate the degree to which they agreed with each question on a scale of one to four (1=no; 2=not really; 3=for the most part; 4=yes). Respondents could indicate "don't know" and these responses were excluded from the calculation of the means.

SYSTEM COMPONENTS STRENGTHS AND OPPORTUNITY AREAS

The following sections take a deeper dive into the seven systems components. For each system component, we provide the overall rating, followed by the breakdown of ratings by stakeholder group. We then look across stakeholder roles to see which areas were rated highest and which areas were rated lowest within the system component. This information is included as well as some clarifying qualitative data from the stakeholders.

VISION AND LEADERSHIP

Overall, stakeholders rated *vision and leadership* (3.1), with the following stakeholder distribution:



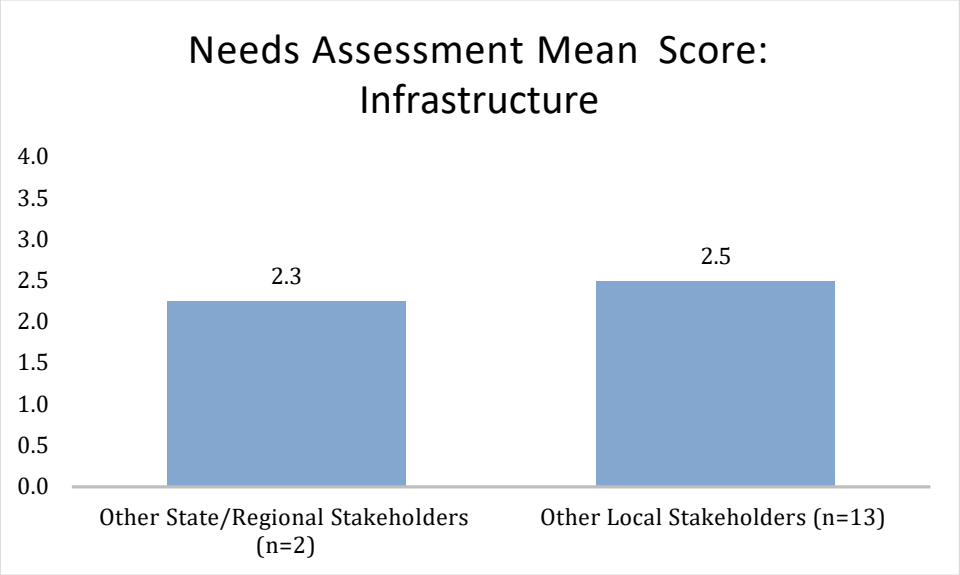
Other State/Regional Level Stakeholder:
Other state/ regional level stakeholders believe that the state health department has clearly articulated a vision for sexual violence prevention and one believed that sexual violence prevention is included in the state's health department's strategic plan. One stakeholder suggested that the role of the state health department in preventing sexual violence is "[p]roviding strategic direction for the prevention of sexual violence according to evidence-informed practices. Setting goals for improvement in the state metrics for sexual violence prevention. Keeping and disseminating those metrics."

Other Local Stakeholder:
Other local stakeholders do believe that sexual violence prevention is included in their state's health department's strategic plan, and they feel that their organizations could play a role in meeting those goals. However, other local stakeholders do not feel that the state's health

department has clearly articulated a vision for sexual violence prevention or that the health department is recognized as a strong leader in sexual violence prevention across the state. One stakeholder suggested that the state health department's role should be "[t]o provide funding, resources, and support to those out in the field providing direct primary prevention services."

INFRASTRUCTURE

Overall, stakeholders rated *infrastructure* (2.4), with the following stakeholder distribution:

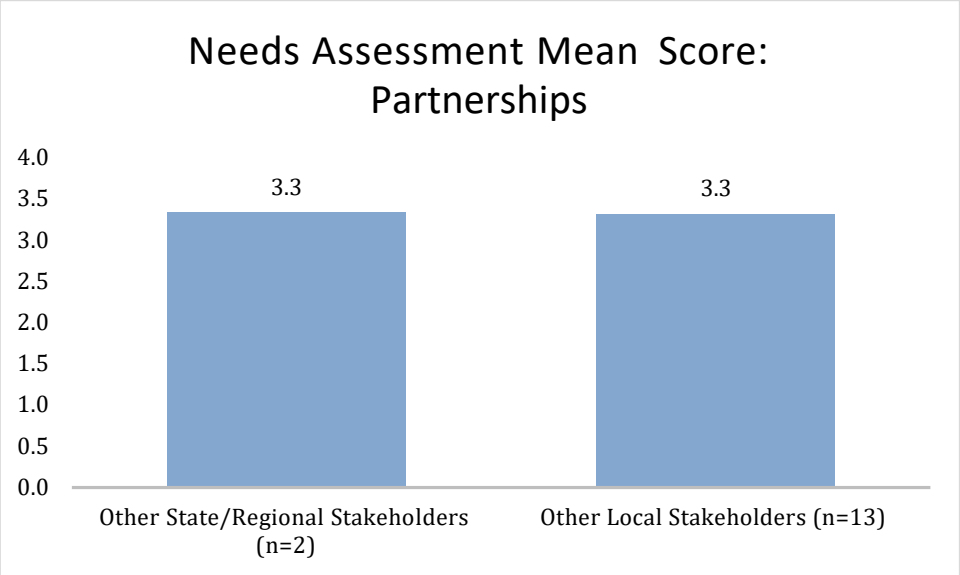


Other State/Regional Level Stakeholder:
Other state/ regional level stakeholders do not think that the state's health department has the appropriate resources or adequate capacity to effectively address sexual violence. One stakeholder mentioned, "The SVPEP grant is not very much money to address this issue statewide. Also, being that they are a government entity, the priority and attention to SV will change depending on the Governor and appointed DHS director." However, other state/ regional level stakeholders are aware of how sexual violence prevention initiatives within the state are funded.

Other Local Stakeholder:
Some of the other local stakeholders in AZ are aware of how sexual violence prevention initiatives within the state are funded, but many do not feel that the state's health department has adequate capacity to effectively address sexual violence prevention. Additionally, other local stakeholders feel that that their state's health department does not have the appropriate resources to effectively address the state's sexual violence burden. One stakeholder noted that they "[n]eed funding for outside organizations implementing primary prevention services."

PARTNERSHIPS

Overall, stakeholders rated *partnerships* (3.3), with the following stakeholder distribution:



Other State/Regional Level Stakeholder:

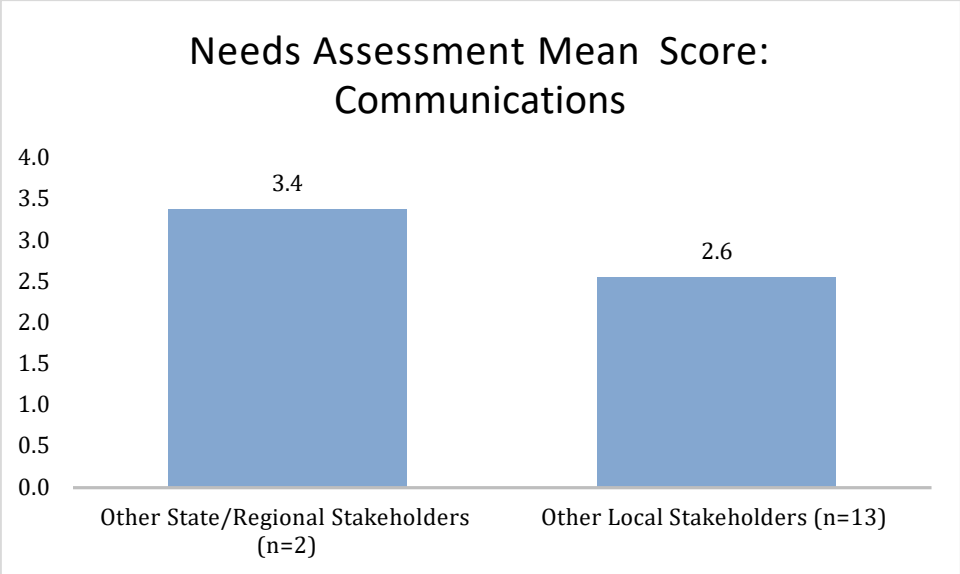
One of the responding other state/ regional level stakeholders felt that the state's health department fosters strong partnerships among state-level stakeholders around sexual violence prevention, and one felt that their state's health department could do more to foster strong partnerships with state and local stakeholders around sexual violence prevention. One stakeholder suggested the following: "Building in-roads to schools and to school based programs. Linking up with state university researchers to help them be successful in scaling out research studies to address sexual violence in k-college environments. Linking up with business partners to identify donors to sponsor evidence-based sexual violence prevention programs in schools, communities, recreation facilities, businesses, etc. Bringing together agencies and communities to cross-pollinate efforts, and to build out community plans together."

Other Local Stakeholder:

Other local stakeholders work with other state-level stakeholders and partners besides the state's health department on violence prevention initiatives. Stakeholders cited partnerships with and outreach to other states, local agencies, schools, LGBT groups, youth organization, and coalitions. However, most feel that their state's health department does not foster strong partnerships between state and local-level stakeholders around sexual violence prevention and could do more to foster strong partnerships with state and local stakeholders around sexual violence prevention. One stakeholder noted, "I think it should be making more of a priority to support sexual violence prevention in rural areas where there are a lot of indigenous people." Another recommended "Ongoing work with agencies beyond the Coalition. Ongoing meeting with stakeholders to foster understanding. Funding to researchers and/or research programs to validate methods and approaches shown to be effective or shown to be 'promising.'"

COMMUNICATION

Overall, stakeholders rated *communication* (2.7), with the following stakeholder distribution:



Other State/Regional Level Stakeholder:

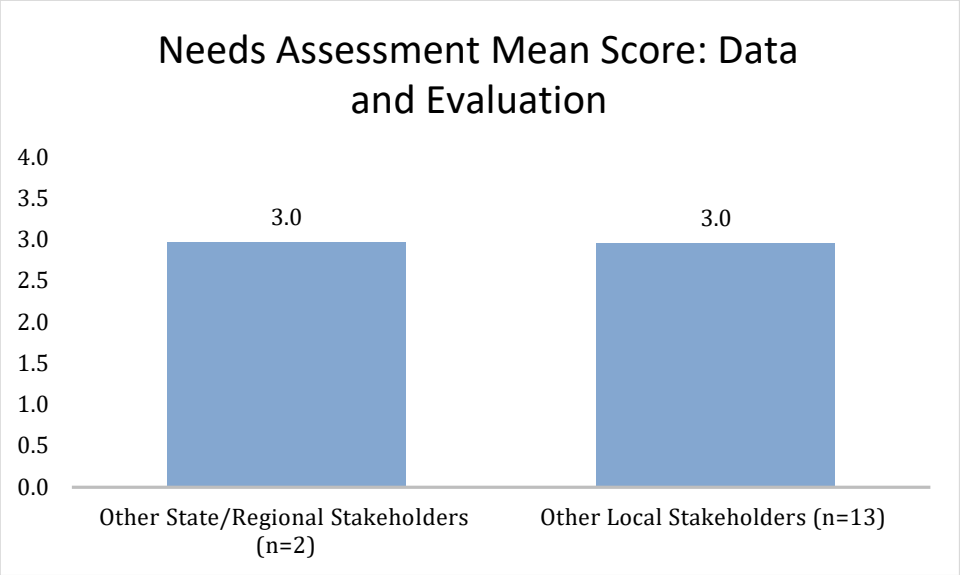
Other state/ regional level stakeholders regularly receive communication from their state's health department about sexual violence prevention activities. They also feel that when they do receive communication materials, the appropriate terminology for their target populations/ audiences is used and that they were invited to provide input into their state's health department communications around sexual violence prevention. One stakeholder noted, "The language focuses on the public health model, primary prevention methods, evidence-based practices, etc. We use similar definitions for consent, what is primary prevention, etc. The state's health department could lead in the public communication/ dialogue space to bring attention to what efforts are going on around the state."

Other Local Stakeholder:

Other local stakeholders generally feel that if they were invited to provide input into their state's health department communications around sexual violence prevention, their input was well-received and incorporated into their state's health department communications. However, many stakeholders feel that they do not regularly receive communication from their state's health department around sexual violence prevention activities and that they weren't invited to provide input into their state's health department communications. One stakeholder stated, "They make sure to send us any information about educational trainings that can improve our program. It would be great to have a sort of monthly newsletter about what all the sub-awardees are doing in their local efforts." Multiple stakeholders recommended inclusivity in state health department communications. Additionally, only some of the other local stakeholders feel that they regularly communicate with their state's health department or other state stakeholders about their organizations own sexual violence prevention activities.

DATA AND EVALUATION

Overall, stakeholders rated *data and evaluation* (3.0), with the following stakeholder distribution:



Other State/Regional Level Stakeholder:

Other state/ regional level stakeholders use data to inform their organization's sexual violence prevention initiatives. They also feel that the sexual violence prevention measures and data sources used by their health department are meaningful to their organization's work. However, they do not think their state's health department has data systems in place that are optimal for sexual violence prevention implementation and evaluation. One stakeholder stated, "There is data collected on outputs of efforts, but I'm not sure if they have concrete tools to measure things such as community norms and institutional culture." Additionally, they feel that there are ways their state's health department could strengthen how it uses data to inform policy, practice, or programs. A stakeholder noted, "Existing departmental data is not well utilized on a regular basis." The stakeholders also confess that they do not routinely share sexual violence prevention data with their state's health department in a format that is useful for them. One stakeholder admitted, "We need training on effective prevention data collection and analysis."

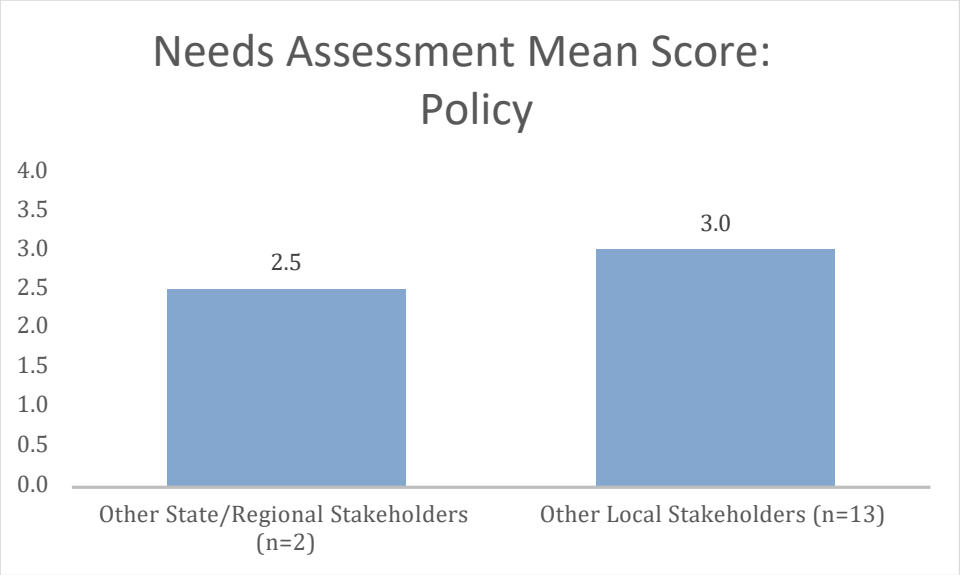
Other Local Stakeholder:

Other local stakeholders use data to inform their organization's sexual violence prevention initiatives. However, some of the stakeholders feel that there are ways their state's health department could strengthen how it uses data to inform policy, practice, or programs. One stakeholder noted that their state's health department should try to get data from "more diverse populations." Additionally, they do not regularly receive data from their state's health department or from other state or local organizations. One stakeholder stated "It is unclear what information [the state health department has] access to and if it can be shared." Another stakeholder commented, "We don't have a lot of data. We try to use the limited bits we do have. We don't hear much about useable or actionable data from the state. It would be helpful

to not just get state or national data, but have help collecting/accessing more localized data to help drive local programming."

POLICY

Overall, stakeholders rated *policy* (2.9), with the following stakeholder distribution:



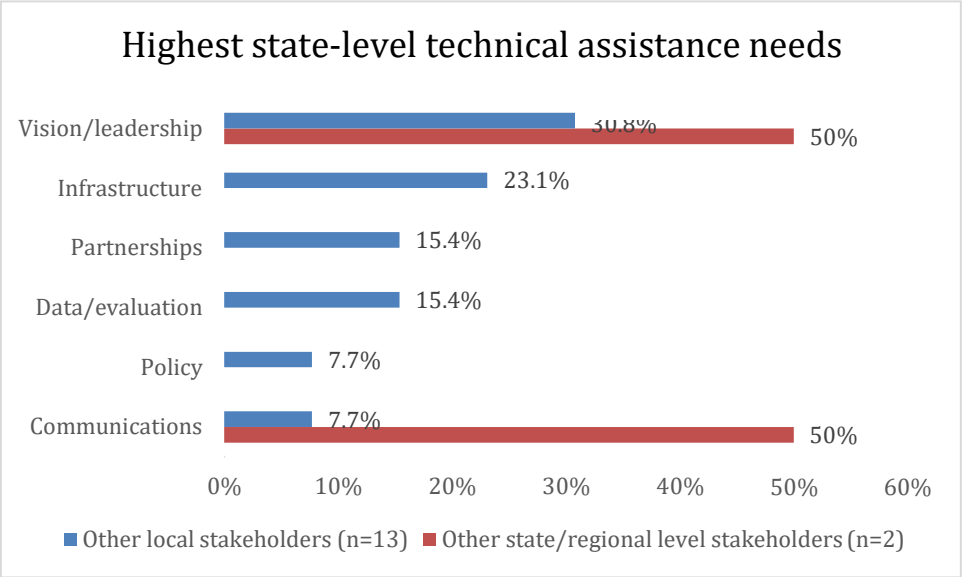
Other State/Regional Level Stakeholder:
One state/regional level stakeholder felt that their organization has policies around sexual violence prevention and that those policies align with their state health department's policies, but another did not feel their agency had such policies in place.

Other Local Stakeholder:
Other local stakeholders do think that their organization has policies around sexual violence prevention and they feel that those policies align with their state health department's policies. One stakeholder noted, "In my classroom, I try and share data regarding sexual violence and provide a platform for healthy conversation and provide resources." Some local stakeholders also believe that their organization either partnered with or engaged their state's health department when creating those policies.

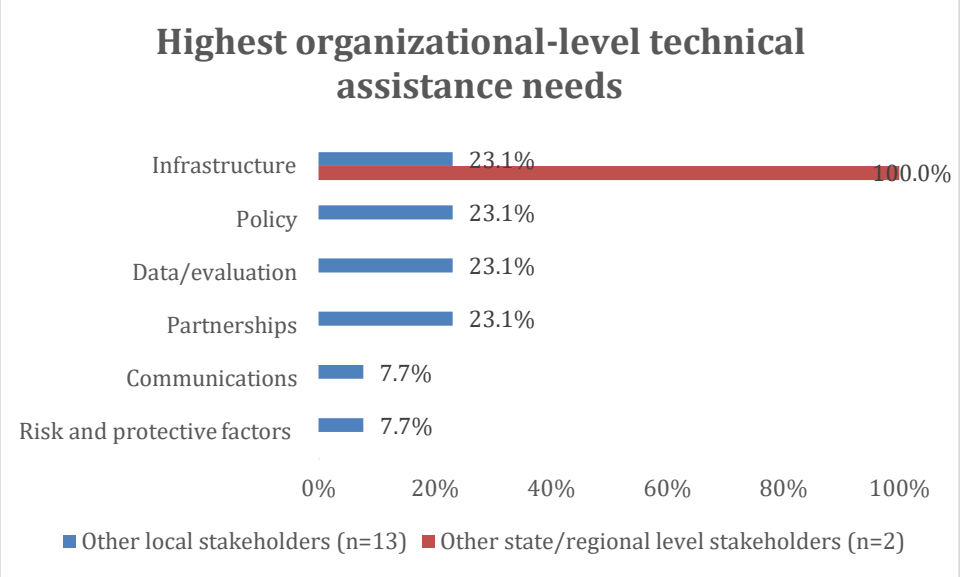
TECHNICAL ASSISTANCE

Stakeholder groups listed the top technical assistance areas where the state of Arizona as well as their organization could use more support. The following displays the distribution of their responses:

Highest State-level Technical Assistance Needs:



Highest Organizational-level Technical Assistance Needs:



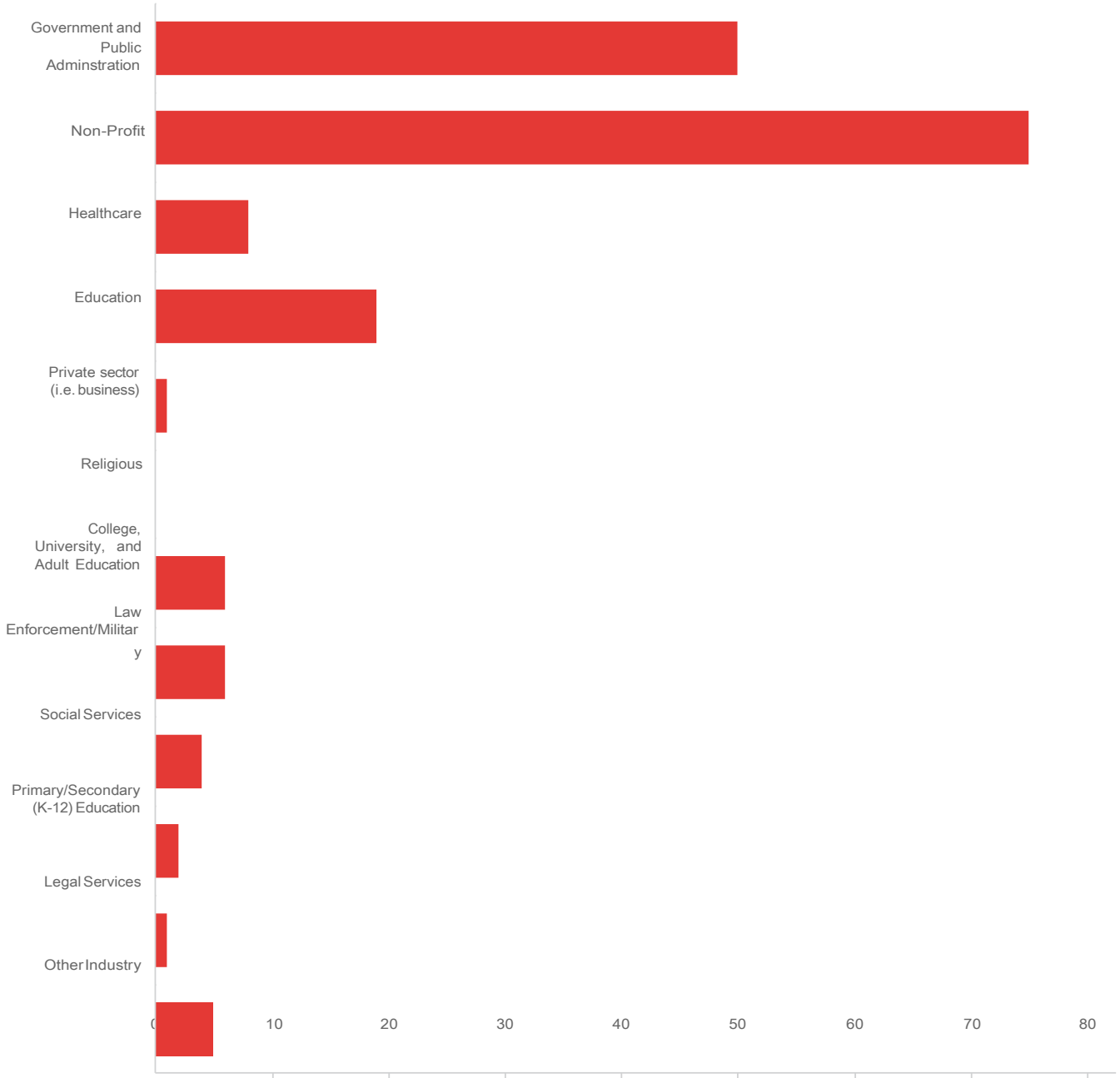
End of Report

Default Report

SVPEP-Strategic Plan Priority Groups

December 27, 2018 5:08 PM GMT

Q1 - What type of organization do you work for?

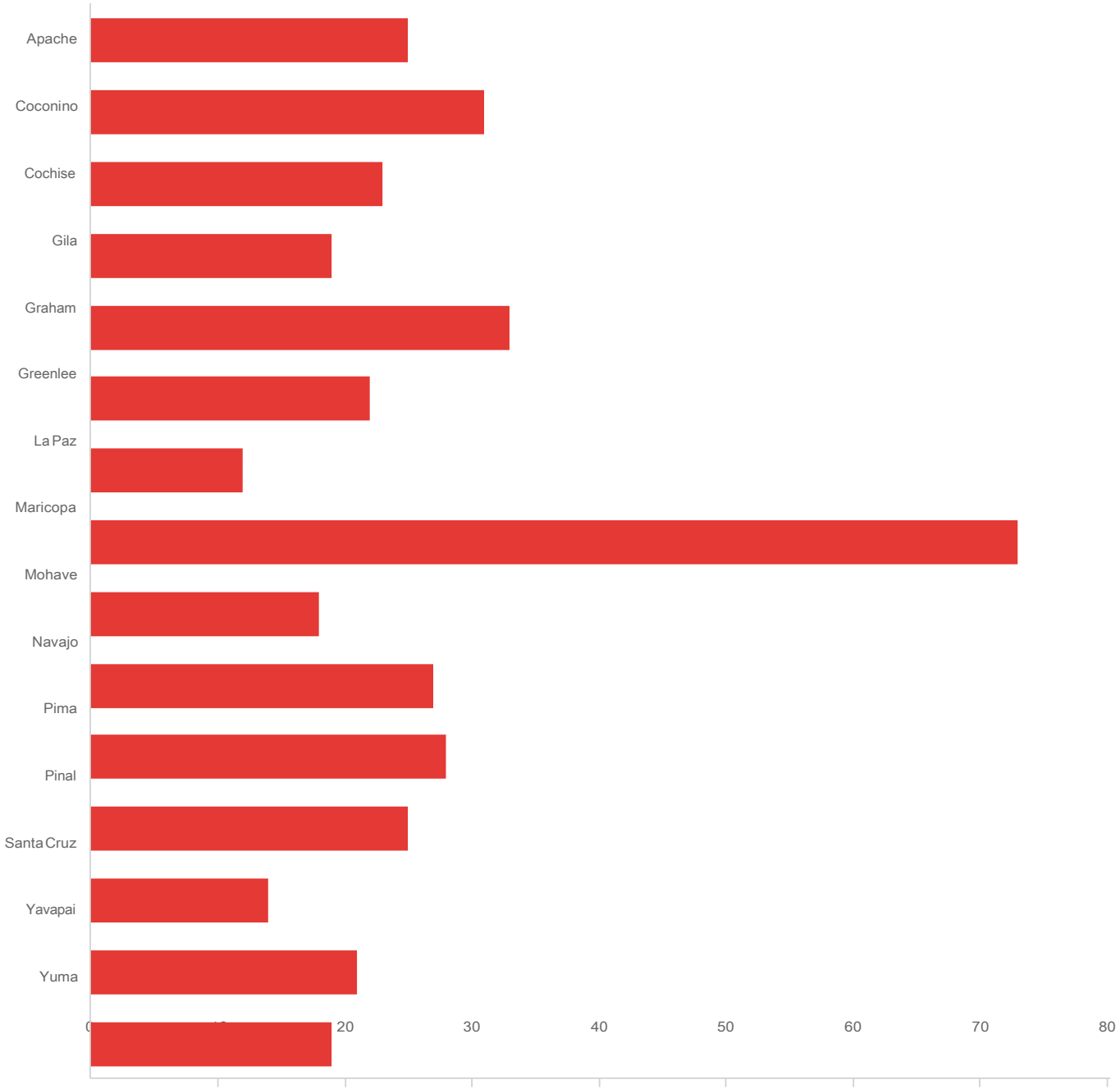


#	Field	Choice Count
1	Government and Public Adminstration	28.25% 50

2	Non-Profit	42.37%	75
3	Healthcare	4.52%	8
4	Education	10.73%	19
5	Private sector (i.e. business)	0.56%	1
6	Religious	0.00%	0
7	College, University, and Adult Education	3.39%	6
8	Law Enforcement/Military	3.39%	6
9	Social Services	2.26%	4
10	Primary/Secondary (K-12) Education	1.13%	2
11	Legal Services	0.56%	1
12	Other Industry	2.82%	5
			177

Showing rows 1 - 13 of 13

Q2 - What county or counties does your organization provide support or services in?

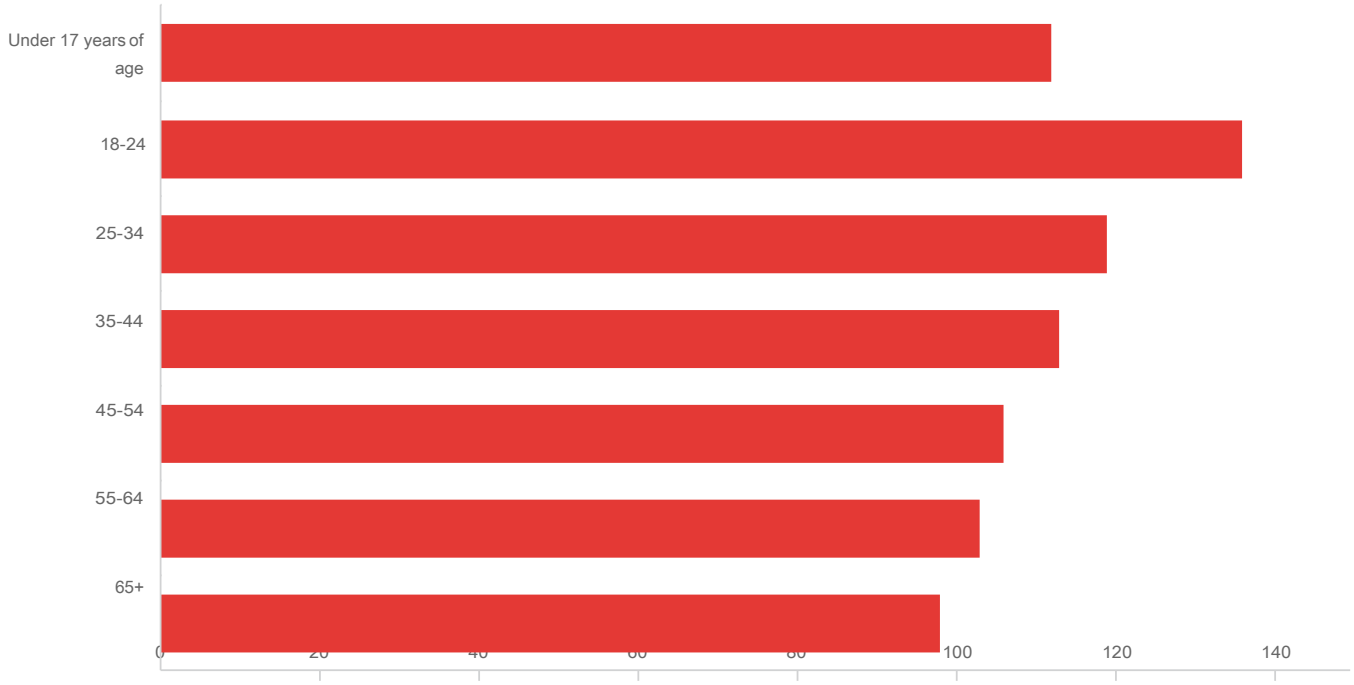


#	Field		Choice Count
1	Apache	6.41%	25
2	Coconino	7.95%	31
3	Cochise	5.90%	23

4	Gila	4.87%	19
5	Graham	8.46%	33
6	Greenlee	5.64%	22
7	La Paz	3.08%	12
8	Maricopa	18.72%	73
9	Mohave	4.62%	18
10	Navajo	6.92%	27
11	Pima	7.18%	28
12	Pinal	6.41%	25
13	Santa Cruz	3.59%	14
14	Yavapai	5.38%	21
15	Yuma	4.87%	19
			390

Showing rows 1 - 16 of 16

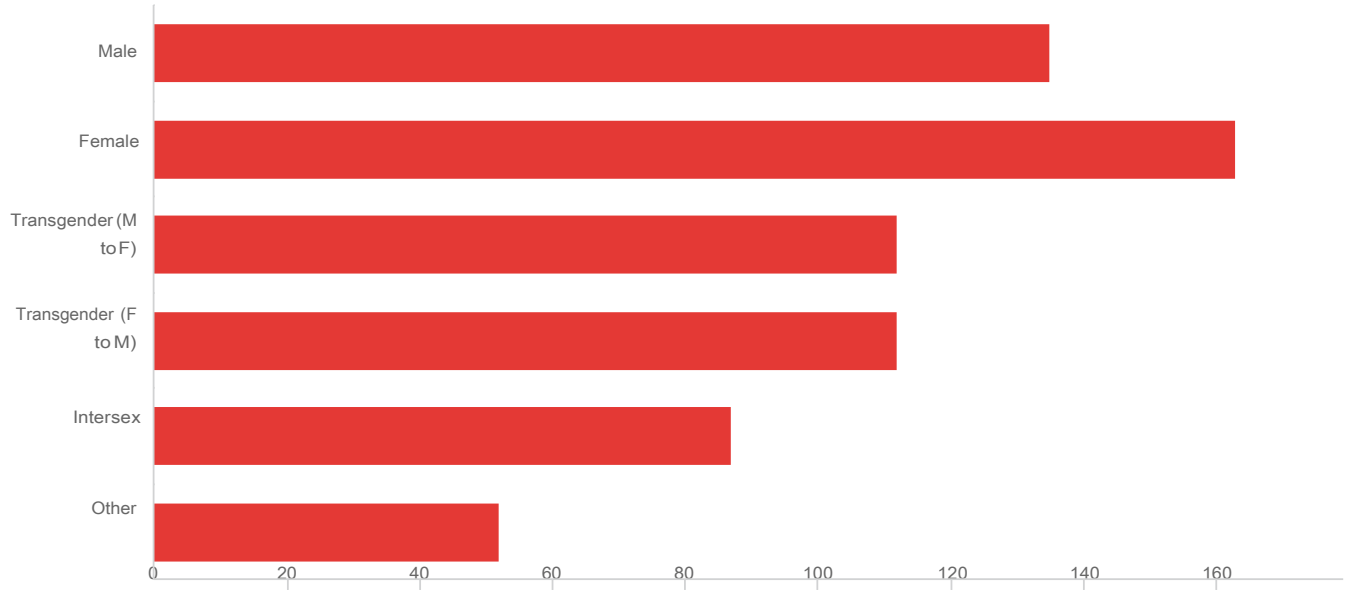
Q3 - Age Group



#	Field	Choice Count	
1	Under 17 years of age	14.23%	112
2	18-24	17.28%	136
3	25-34	15.12%	119
4	35-44	14.36%	113
5	45-54	13.47%	106
6	55-64	13.09%	103
7	65+	12.45%	98
			787

Showing rows 1 - 8 of 8

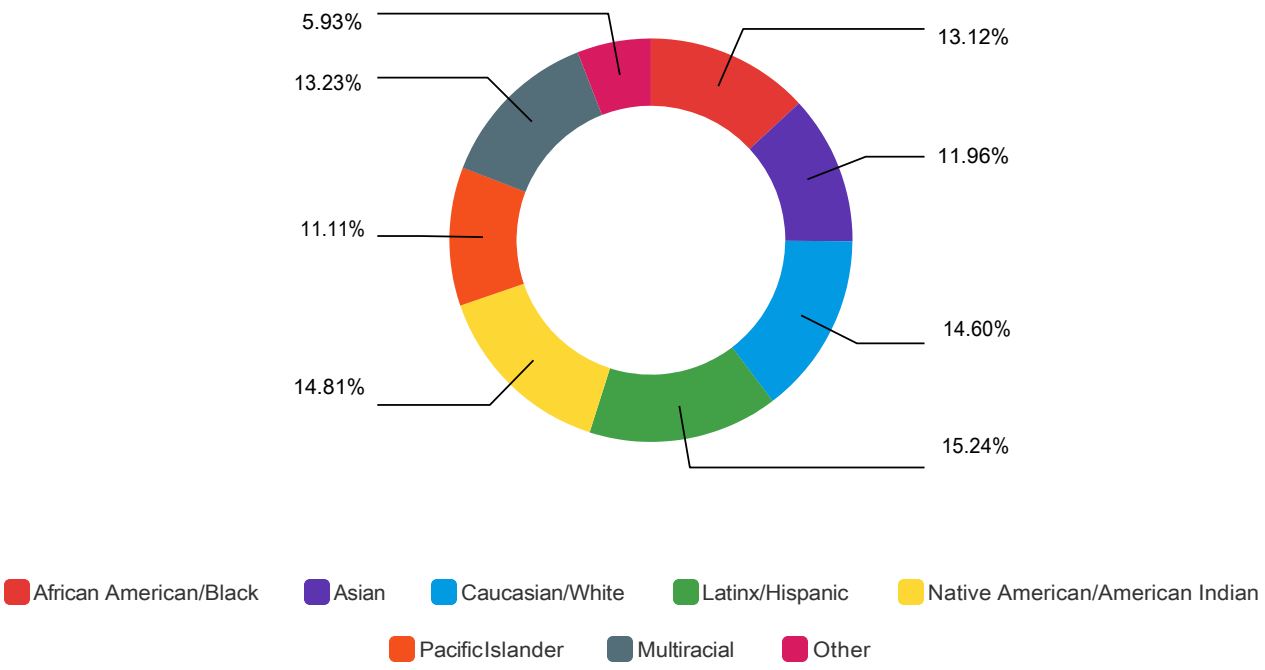
Q4 - Gender Identity



#	Field	Choice Count	
1	Male	20.42%	135
2	Female	24.66%	163
3	Transgender (M to F)	16.94%	112
4	Transgender (F to M)	16.94%	112
5	Intersex	13.16%	87
6	Other	7.87%	52
			661

Showing rows 1 - 7 of 7

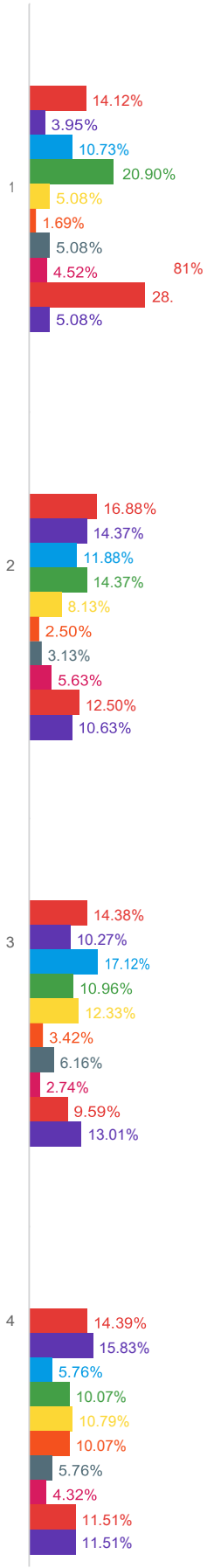
Q5 - Race/Ethnic Groups



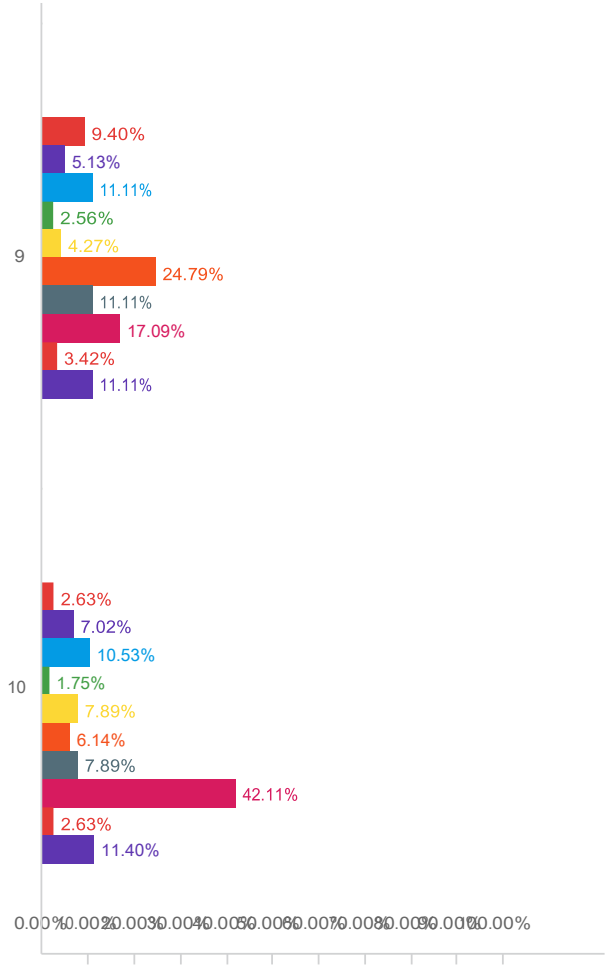
#	Field	Choice Count	
1	African American/Black	13.12%	124
2	Asian	11.96%	113
3	Caucasian/White	14.60%	138
4	Latinx/Hispanic	15.24%	144
5	Native American/American Indian	14.81%	140
6	Pacific Islander	11.11%	105
7	Multiracial	13.23%	125
8	Other	5.93%	56
			945

Showing rows 1 - 9 of 9

Q6 - Please rank the following according to priority from 1 (highest) to 10 (lowest)



5
8.89%
14.07%
7.41%
8.89%
16.30%
7.41%
11.11%
11.85%
5.93%
8.15%
6
5.56%
12.70%
9.52%
10.32%
15.87%
13.49%
10.32%
5.56%
7.94%
8.73%
7
4.20%
6.72%
11.76%
9.24%
6.72%
17.65%
21.85
5.04%
4.20%
12.61%
%
8
5.79%
9.92%
4.96%
6.61%
9.92%
18.18%
19.83
8.26%
5.79%
10.74%
%
Lesbian, Gay, Bisexual, Transgender and Queer/Questioning Community
People Living with Disabilities
Rural Communities
Native American Communities
Immigrant/Border Communities
African American Communities
Latinx Communities
Men
Youth
Homeless



#	Field	1		2		3		4		5		6	
1	Lesbian, Gay, Bisexual, Transgender and Queer/Questioning Community	18.12%	25	19.57%	27	15.22%	21	14.49%	20	8.70%	12	5.07%	7
2	People Living with	5.15%	7	16.91%	23	11.03%	15	16.18%	22	13.97%	19	11.76%	16
3	Rural Communities	13.77%	19	13.77%	19	18.12%	25	5.80%	8	7.25%	10	8.70%	12
4	Native American	26.62%	37	16.55%	23	11.51%	16	10.07%	14	8.63%	12	9.35%	13
5	Immigrant/Border Communities	6.87%	9	9.92%	13	13.74%	18	11.45%	15	16.79%	22	15.27%	20
6	African American	2.27%	3	3.03%	4	3.79%	5	10.61%	14	7.58%	10	12.88%	17
7	Latinx Communities	6.87%	9	3.82%	5	6.87%	9	6.11%	8	11.45%	15	9.92%	13

8	Men	5.97%	8	6.72%	9	2.99%	4	4.48%	6	11.94%	16	5.22%	7
9	Youth	36.96%	51	14.49%	20	10.14%	14	11.59%	16	5.80%	8	7.25%	10
10	Homeless	6.57%	9	12.41%	17	13.87%	19	11.68%	16	8.03%	11	8.03%	11

Showing rows 1 - 10 of 10

Q7 - Please provide any additional feedback that you would like at this time.

Please provide any additional feedback that you would like at this time.

No data on disabilities, but higher likelihood of being victimized, yet rarely addressed

I think the more everyone is aware of sexual abuse and violence -the better

The rank ordering process is not a fair assessment, there are several groups that are equally affected with respect to transgender and gender non-conforming people. To say that any People of Color group is less disadvantaged in our community is forcing a racial choice that is not statistically supportable within the transfemme classification. Then, too, any choice between disabled and homeless people is forcing a false human value judgement that we in our organization and among our network of people see as inappropriate. Finally, separating border and immigrant issues off from people of collor issues is allowing a racial and nationalistic bias to define human value

na

We serve Native American/Reservation communities and resources are very scarce. We are serving the four corners area. and we have received clients from Phx metro area.

Information as well investigation into missing and exploited Indigenous women should be explored.

More shelter for DV victims

Please ensure that ultimate planning decisions made include survivor feedback from the specific popluations you named on the ranking screen, programs can help facilitate this if needed. Please do not assume that just because the statistics indidcate Advocates are survivors that their opinions should count as survivor opinions for the purpose of this project. I have hear that rationale and I don't fully agree with it as an Advocate survivor myself. Thanks

If you had a category for "foster care or homeless youth" I would have ranked them #1

IT is important to bring awareness to the communities.

I have been providing extensive prevention programs on healthy relationships in the southwest part of Maricopa county for the past 5 years with great success. I am willing to share results and curriculum that I have developed.

We enjoy the resource fairs and all that you do for our school and community. Thank you.

Have not worked much with LGBTQ, Black or Native American communities so I don't have experience of DV levels in them.

need to protect victims and give them justice

We need more research and developmenet in appropriate law enforcement intervention - in which the survivor is not re-vctimized, and perpetrators are apprpriately prosecuted. Human trafficking is an ecomomic problem and survivors need long-term support in creating a life sustainability plan.

Sexual Violence Prevention strategies should be targeted towards potential offender populations. Potential victim populations shouldn't be responsible for violence prevention. I'm surprised and frustrated that the survey question was posed in a way that insinuated that populations of victims need to be targeted for prevention strategies.

BLOOM365 reaches over 10,000 Arizona teens a year in schools and youth organizations with a comprehensive multi-dose prevention education curriculum that is backed up by research and impact data, as well as offers direct youth advocacy services and peer to peer activism. We are starting to scale across Arizona by training advocates and adult allies to implement our 3-Step strategy in their local communities. We would love to share our data with potential partner organizations.

very difficult to 'rank' the need for different populations, not sure i agree with my own rankings for 6-10, tried it several ways, looking as much at 'most vulnerable' as 'most prevelant.

The ranking question was not easy because ranking them comes from the work I do and my own perspective, when in actuality, everyone on that list needs to be addressed and some cross over (a male who is Latin and gay and living in rural time) so the question was not one that I answered and felt definite on.

N/A

It is a concern that the caucasian population was not included in the statistical data.

Safety at Home material

I find it difficult to rank which minority groups should be targeted in developing such policies. Rather, any policies or endeavors going forward should strive to address the needs of all of these groups.

Th information is based on my observation and on the reservation we see a lot of the sexual abuse unreported.

Youth and LGBTQ+ persons are under served and over looked in this area. We are doing our communities a disservice by not including them more readily in this conversation.

I think any effort to address sexual violence needs to include both active and retired military, as well. Cultural differences, and characteristics of faith communities (for example) shape much of how we talk about sexual violence; however, willingness to even begin talking often depends on how the subject is first introduced.

sexual assault seems to be rising -but also people are becoming more aware how great the problem is

Women weren't listed on the previous slide of ranking sexual violence prevention strategies. WTF?

There are not enough sexual assault programs in the state for victims to acess

I believe that to some degree children need a level of awareness/empowerment (tailored to their age group) in this area also

It's hard to rank the importance because they are all important.

N/A

Need housing for single women

none

Having to rank these groups was very difficult. It is a priorty for everyone

I feel that awareness and prevention is probably most effective starting at the junior high age, regardless of race, sex, gender, etc. Every child needs to be made aware of what is okay and what is not okay, and what to do if they are getting into a situation with an adult who may be abusing them or trying to start abusing them, what they can do to protect themselves, what they should or shound not do, that it is not their fault, and who they can trust or go to if a situation is occuring. Knowledge is power, and unfortunately it needs to start very young.

thank you

Showing records 1 - 37 of 37

End of Report

ADHS SVPEP Sexual Violence Primary Prevention Round Table Discussions
Participant Screening Tool

1. Have you participated in a market research group, focus group, or one-on-one interview within the last 12 months?

2. Do you or does any member of your household work for:
   1. Advertising agency or media company (TV, radio, magazine)
   2. Marketing research company or marketing department within a company

   If "yes" to any of the above, thank and terminate.

3. Following are some social issues. For each one, please indicate how big of a problem it is in your community, if at all.

	Serious Problem	Moderate Problem	Minor Problem	Not a Problem at all	Don't know
People or Kids who carry guns					
People who are being hurt against their will					
Having Healthy Relationships					
People who abuse drugs					

4. Have you or do you know someone who has been hurt?

	Myself	Know someone who has	Don't know
School Gun Use			
Drug Abuse			
Forced to have sex against their will			
Was hurt by someone you thought cared about you			

The following questions will be used to help us recruit different people for our group conversations. Your honest responses are appreciated.

5. Are you . . . ?
   1. Under 14 years
   2. 14 to 17
   3. 18 to 25
   4. 26 to 35

5. 36 to 45
6. 46 to 55
7. 56+

6. In which county do you live?

Apache	Maricopa	Yuma
Cochise	Mohave	
Coconino	Navajo	
Gila	Pima	
Graham	Pinal	
Greenlee	Santa Cruz	
La Paz	Yavapai	

7. What is your primary language?
   1. English
   2. Spanish
   3. Both
   4. Other (specify)

8. What is your race?
   1. American Indian/Alaskan Native/Native American
   2. Asian / Native Hawaiian or Other Pacific Islander
   3. Black or African American
   4. White
   5. Don't know
   6. Prefer not to answer

9. Which of the following best describes your highest level of education?
   1. Less than 9th grade
   2. 9th to 12th grade, no diploma
   3. High school graduate (INCLUDES EQUIVALENCY)
   4. Completed technical or trade school
   5. Some college (NO DEGREE)
   6. Associate's degree
   7. Bachelor's degree
   8. Graduate or professional degree

10. What was your total household income before taxes in 2017?
    1. Less than $25,000.
    2. $25,000 to $34,999.
    3. $35,000 to $49,999.
    4. $50,000 to $74,999.
    5. $75,000 to $99,999.
    6. $100,000 to $149,999.
    7. $150,000 to $199,999.

8. $200,000 or more

11. Do you consider yourself to be:
    1. Heterosexual or straight
    2. Gay or lesbian
    3. Bisexual
    4. Prefer to self-describe
    5. Prefer not to answer

12. Do you identify as transgender?
    1. Yes
    2. No
    4. Prefer to self-describe
    3. Prefer not to answer

13. Which gender do you identify with:
    1. Male
    2. Female
    3. Non-Binary
    4. Prefer not to answer

14. Do you have a mental (e.g. bipolar, PTSD, depression, panic and anxiety, etc.) health disability?
    1. Yes
    2. No
    3. Prefer not to answer

15. Do you identify as having a cognitive disability?
    1. Yes
    2. No
    3. Prefer not to answer

16. Do you identify as having a physical disability (this sometimes cross with developmental disabilities as well or after the fact of an accident, can include, limitation to a person's physical function such as mobility, dexterity or stamina, impairments which limit facets of daily living such as blindness, Hard of Hearing, Deaf)?
    1. Yes
    2. No
    3. Prefer not to answer

If you are selected to participate, please let us know if you will need accommodations?

If you have you attendant come with you, they will be seated separately in a different room and we will provide an attendant during the group.

Did someone help you complete this screening questionnaire?

_____

(AFTER Selection) We would like to invite you to participate in a roundtable discussion about various social issues of importance to our community. This roundtable discussion is simply a small group discussion with 8 to 12 participants. We are only interested in your opinions…at no time will you be asked to purchase anything. Most people find these discussions informative.

The groups will be held on_____at_____and will last approximately two hours or less. The group will be held at:Locations TBD

Will you be able to attend?

1. Yes
2. No

Great! I just need to confirm the exact spelling of your name and get some other information. We will send you a confirmation letter or email (whichever you prefer) with the address and directions to the group. We will also call to remind you of the group a day or two beforehand.

Appendix E

ADHS Sexual Violence Roundtable
Discussion Guide

Objectives:

- Gauge understanding of "sexual violence"
- Gauge degree to which various populations consider sexual violence as a public health problem.
- Discuss impact of sexual violence on communities as well as ways to mobile communities to prevent the occurrence.
- Assess the awareness and effectiveness of various prevention efforts.
- Obtain feedback and reactions to proposed prevention strategies.
- Assess awareness of community programs that address sexual violence.

Introduction: Timing 0:00 – 0:10

Do not skip. This is important to introduce why this is being done and how important it is for the state to be transparent in working with communities.

My name is_____and I work at_____. This is my colleague _____, who works at_____. The Arizona Department of Health Services is collaborating with organizations and individuals throughout Arizona to develop a 5-year, statewide, Sexual Violence Primary Prevention Strategic Plan.

We are conducting round table discussions like the one today around the state with different communities and groups. The purpose of these discussions is to help us understand more about the prevention of sexual violence in your community, in your work, and in Arizona. You are being asked to participate in this process because of information you can provide that will help guide the development of the overall plan's goals and objectives. We welcome varying opinions about sexual violence prevention and encourage the respectful expression of different perspectives on the topics we discuss today.

The discussion will last about an hour and a half to two hours. Your involvement is voluntary. You may choose not to answer any question, not to participate at all, or to stop participating at any time without any negative consequences. With your permission, we will be recording the discussion only to assist us in accurately capturing the information you are providing. The results of all of the group discussions will be combined and published. At no time will your comments be associated with you or a specific description that will identify you.

Our discussion may bring up some difficult topics that may cause some participants distress. If this happens for you, and you would like to talk to someone, there is an advocate available at (insert where the advocate will be i.e., "down the hall in this room") this time. In addition, there will be pamphlets and brochures of resources for those who would like to take these home with them.

Ground Rules: Timing 0:10 – 0:12

- Speak one at a time
- Please be respectful of differing opinions
- Confidentiality
- Candor
- No right or wrong answers
- Talk to each other as well as to me
- Please turn off your cell phones

Does anyone have any questions about what I've just reviewed?

Self-Introductions/Warm up - 0:12 – 0:15

- Name
- How long you've lived in Arizona

There are a couple of words/concepts we need to clarify for the purpose of this discussion. (Written on Flip Chart and displayed the entire time)

Community: *A community can be defined as a group of people living in the same place or having certain characteristics, or doing certain activities in common. Many of us feel like we do not have just one, but multiple communities. For example, we many have a work community, an ethnic community, a community around a hobby, etc. In our discussion today the focus will be on sexual violence* ***prevention*** *in the (African American male, African American female, Native, LGBTQI, or other community reference).*

(Primary) Prevention: *a systematic process that promotes healthy environments and behaviors and reduces the likelihood of sexual violence from happening in the first place.*

NOTE TO MODERATOR: TURN RECORDER ON AFTER PERMISSION GIVEN AND AFTER INTRO

Engaging Discussion - 0:15 – 0:30

1. What do you think of when you hear the term "sexual violence"? Please remember, there is no right or wrong answers, just your opinions. (WRITE ON FLIP CHART)

[Moderator: After collecting answers, summarize briefly. Next, refer to flip chart page with CDC definition of sexual violence.]

The CDC defines sexual violence like this: *(For groups other than youth groups . . .)*

"Sexual violence (SV) is any sexual act that is perpetrated against someone's will. SV 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)."

If needed:
Perpetrated = committed/performed
Nonconsensual=not agreed to by one or more of the people involved
Threatened=bullied, pressured, coerced

Present stats on sexual violence in the specific community being facilitated.

Will be displayed on flip chart

According to the Center of Disease Control's (CDC) National Intimate Partner and Sexual Violence Survey (NISVS) most recent publication in 2017 (for 2010-12 data that was analyzed) for those reporting in the U.S.:

- ✓ Nearly 1 in 5 women and 1 in 71 men have been raped in their lifetime.
- ✓ One in 2 women and 1 in 5 men has experienced severe sexual violence victimization other than rape at some point in their lives.
- ✓ Approximately 80% of female victims experienced their first rape before the age of 25 and almost half experience the first rape before age 18.
- ✓ Among male victims, 28% were first raped when they were 10 years old or younger.

Community - 0:30 – 0:55

2. How does sexual violence affect your community? (Probe: What are the ways in which you think <<focus community>> are unique with respect to sexual violence?)

   Examples if participants are quiet: **WRITE ON FLIP CHART**
   - lack of education on the topic, poverty
   - 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
   - culture that supports male superiority
   - little or no access to resources, gender inequality, etc.

3. As discussed, how could we address those unique characteristics through primary prevention strategies?

If not mentioned . . . how about . . .

- Educate on what sexual violence includes
- Teach healthy relationship skills
- Promote social norms that protect against violence
- Design school curriculum to reduce intimate partner violence
- Media campaign to raise awareness of SV and its impact on the community

Strengths & Challenges of Prevention – 0:55 - 1:20

4. What do you think are some of the challenges in (focus community) that need to be addressed when working to prevent sexual violence? (Probe: What do you think are the causes of sexual violence?)

5. What are some of the strengths of the (focus community) in terms of preventing sexual violence in your community? (Probe: How can these be built upon when doing work in primary prevention of sexual violence?)

6. How would you involve community partners whose mission may not be directly or obviously related to sexual violence prevention? (Probe: such as schools, businesses, community centers, etc.) What are the benefits? What are the challenges?

7. What do you think are some first steps that can be taken in community(ies) to move forward with primary prevention in sexual violence? What do you think are their limits to be involved?

Input to Statewide Initiative - 1:20 – 1:45

Your voice matters in the statewide action plan for sexual violence primary prevention. We want to make sure that the plan we are developing covers the entire state as best as we can based on resources and reflects your ideas about what needs to be done to prevent sexual violence from happening in the first place.

8. What goals do you think should be included in the statewide action plan? (Probe: Are your goals specific to the (insert focus community?)

9. Of all the ideas that you all came up with, which goal would be possible in the first 2 years? In the next 5 years? What are the challenges?

10. We recognize that not all men are perpetrators of sexual violence (yes there are women/females that have also perpetrated), yet most perpetrators are men. We would like to hear what you think can be done with boys and men in your community to prevention sexual violence?

    (this may not need to be asked for the males and men's group depending if the conversation hasn't come up already.)

11. How would you know if the community was making progress in preventing sexual violence? What would be some of the key indicators? (Probe: signs of momentum in Arizona in sexual violence prevention, what does it look like if one of the goals were achieved)

a. Example if group is quiet/stuck (The community wanted to see more campaigns on sexual violence awareness and prevention on media (television, social media, movies, commercials, etc.) and that was made possible, how would we measure that your community had a decrease in sexual violence?)

Summary & Close - 1:40 – 1:45

Our discussion will be wrapping up, one final question:

12. Does anyone have any final thoughts, comments to share before we end?

Resource table for participants at a nearby station.

Thank you so much for participating today. Your ideas, thoughts and perspectives are greatly valued and will contribute to making the state plan. If you have any additional thoughts and or comments, we have advocates that are available to talk with you some more.

ARIZONA COALITION TO END SEXUAL & DOMESTIC VIOLENCE

Sexual and Domestic Violence Resources in Arizona

STATEWIDE AND NATIONAL HOTLINE RESOURCES	
Arizona Coalition to End Sexual and Domestic Violence **-Sexual and Domestic Violence Services Helpline**: (*M-F, 8:30am – 5pm)* **-Chat Line**: *M-F, (8:30am – 5pm)*	602-279-2900 / 800-782-6400 TTY 602-279-7270 www.acesdv.org/chat
Centralized Screening: 24 hour	480-890-3039
Arizona Community Information and Referral: (*M-F, 9am – 5pm)*	211, (877) 211-866
Arizona Teen Lifeline: *24 hour*	800-248-8336
Child Abuse Hotline: *24 hour*	888-767-2445
The National Domestic Violence Hotline Deaf Services: *24 hour*	800-787-3224(TTY) (Video Phone) 855-812-1001
National Domestic Violence Hotline & Chat Line: *24 hour* **Chat Line:** *24 hour*	800-799-7233 (SAFE) TDD: 800-787-3224 www.thehotline.org
National Human Trafficking Hotline: *24 hour* **Chat when advocates are available**	SMS: 233733 (Text "HELP" or "INFO") 888-373-7888 TTY 711
National Indigenous Women's Resource Center: (*8am-5pm)*	406-477-3896 Toll-Free: 855-649-7299
National Suicide Prevention Hotline*: 24 hour*	800-273-8255(TALK) Espanol:1-888-628-9454 Deaf & Hard of Hearing: 800-799-4889
National Teen Dating Abuse Helpline: *24 hour* **Text, Phone, and live chat services**	866-331-9474 TTY 866-331-8453 Text Love is to 22522
National Sexual Assault Hotline (RAINN)*: 24 hour*	800-656-4673(HOPE)
National Sexual Assault Online Chat Service*: 24 hour*	online.rainn.org
Substance Abuse and Mental Health National Helpline (SAMHSA)*: 24 hour*	Helpline: 800-662-4357(HELP) Toll Free: 877-726-4727(SAMHSA) TTY: 800-487-4889
STRONGHEARTS Native Helpline: (*M-F, 9am – 5:30pm)*	844-762-8483
Teen-2-Teen through Bloom365: *24 hour* **-Individual Crisis Counseling by appointment only** **-Peer to Peer Advocacy**	Text or call:602-799-7017 Helpline: 888-606-4673(HOPE)
Trevor Lifeline Suicide Hotline (LGBTQ): *24 hour* **Life Line Chat** *24 hour***: https://suicidepreventionlifeline.org/chat/**	866-488-7386 800-273-8255 Espanol: 888-628-9454 Deaf & Hard of Hearing: 800-799-4889

Sexual and Domestic Violence Resources in Arizona

DUAL SEXUAL AND DOMESTIC VIOLENCE PROGRAMS/SERVICES			
COUNTY	**CITY**	**AGENCY NAME**	**PHONE NUMBER**
Apache	Chinle	ADABI (Ama Doo Alchini Bighan)	928-674-8314 877-698-0899
Cochise	Sierra Vista	Cochise Family Advocacy Center	520-515-4444
Coconino	Flagstaff	Chilhelp Mobile Advocacy Center of Northern Arizona (Children Only)	602-271-4500
	Flagstaff	Northland Family Help Center	928-527-1900 877-634-2723
	Flagstaff	North Country HealthCare (Northern Arizona Care and Services After Assault)	24 Hour Crisis Line 928-527-1900 877-634-2723
	Flagstaff	Victim/Witness Services for Coconino County	928-679-7770
Gila	Payson	Childhelp-Gila Children's Advocacy Center	928-978-2490
Graham	Safford	Mt. Graham Safe House *(Crisis Line)*	Text: 626-733-8431 888-296-9104 Other Languages: 928-348-9548
La Paz	Parker	Colorado River Regional Crisis Shelter	928-669-8620
Maricopa	Chandler	Chandler Family Advocacy Center	480-782-4210
	Fort McDowell	Fort McDowell Yavapai Nation Domestic Violence Program	480-789-7678
	Glendale	A New Leaf Faith House	623-939-6798
	Glendale	Glendale Family Advocacy Center	623-930-3720
	Glendale	La Frontera EMPACT	480-784-1514
	Mesa	Mesa Family Advocacy Center	480-644-4075
	Phoenix	Childhelp Children's Center of Arizona (Children Only)	602-271-4500
	Peoria/Sun City	Eve's Place	623-537-5380 844-301-7908
	Phoenix	BLOOM365	888-606-4673 (HOPE)
	Phoenix	Phoenix Family Advocacy Center	602-534-2120 888-246-0303
	Scottsdale	Scottsdale Family Advocacy Center	480-312-6300
	Tempe	La Frontera EMPACT	480-784-1514
	Tempe	CARE 7	480-350-8004

Sexual and Domestic Violence Resources in Arizona

DUAL SEXUAL AND DOMESTIC VIOLENCE PROGRAMS/SERVICES			
COUNTY	**CITY**	**AGENCY NAME**	**PHONE NUMBER**
Mohave	Bullhead City	North Country HealthCare Clinic	928-704-1221
	Kingman	Kingman Aid to Abused People KAAP Child & Family Advocacy Center	928-753-6222
	Lake Havasu	Creason Counseling	928-733-5009
	Lake Havasu	H.A.V.E.N. Family Resource Center	928-505-3153
Navajo	Holbrook	North Country HealthCare Clinic	928-524-2851
	Keams Canyon	Hopi Domestic Violence Program	928-738-1115/1116
	Show Low	Navajo County Show Low Family Advocacy Center (FAC Mobile)	928-524-4283 928-242-6565
Pima	Tucson	Southern Arizona Center Against Sexual Assault (SACASA)	Office: 520-327-1171 Crisis Line: 520-327-7273
	Tucson	Southern Arizona Children's Advocacy Center (Children Only)	520-724-6600
Pinal	Apache Junction	Community Alliance Against Family Abuse	Office: 480-982-0196 Crisis Line: 480-982-0196
	Casa Grande	Against Abuse, Inc.	520-836-0858
	Eloy	Pinal County Family Advocacy Center	520-866-7500
	Maricopa	City of Maricopa Family Advocacy Center	520-316-6800
	Maricopa	La Frontera EMPACT	480-736-4949
	San Tan Valley	San Tan Valley Family Advocacy Center	520-866-7020
	San Tan Valley	La Frontera EMPACT	520-866-7020
Yavapai	Cottonwood	Verde Valley Sanctuary *(Crisis Intervention Hotline)*	928-634-6255 or 928-634-2511
	Prescott Valley	Yavapai Family Advocacy Center	928-775-0669
Yuma	Yuma	Amberly's Place	928-373-0849
	Yuma	Safe House Shelter	928-782-0044 Hotline: 877-440-0550

Sexual and Domestic Violence Resources in Arizona

DOMESTIC VIOLENCE PROGRAMS/SERVICES			
COUNTY	**CITY**	**AGENCY NAME**	**PHONE NUMBER**
Apache	St. Johns	New Hope Ranch	928-337-5060
Cochise	Douglas	House of Hope	520-364-2465
	Douglas	Chiricahua Community Health Center	520-364-6987
	Sierra Vista	Forgach House	520-515-4444
Gila	Globe-Miami	Gila Safe Haven Domestic Violence Safe Home	928 961 6163
	Payson	Time Out, Inc.	928-472-8007
	San Carlos	San Carlos Apache Healthcare Corporation Social Services	928-475-2313
Maricopa	Chandler	Catholic Charities My Sisters' Place	480-821-1024
	Chandler	Catholic Charities Pathways	DV Counseling: 480-287-6503 Victim Advocacy: 602-819-0082
	Goodyear	New Life Center	623-932-4404
	Mesa	A New Leaf Autumn House	480-835-5555
	Phoenix	Area Agency on Aging, Region One DOVES	602-264-2255
	Phoenix	Chicanos por La Causa, DeColores	602-269-1515
	Phoenix	Chrysalis	602-955-9059
	Phoenix	Jewish Family and Children's Services Shelter Without Walls	602-452-4640 Spanish Speaking: 602- 534-3087 Office: 602-279-7655
	Phoenix	Sojourner Center	602-244-0089 888-886-8793 TTD: 602-889-1610 888-886-8794
	Phoenix	UMOM	602-957-1903
	Scottsdale	Arizona South Asians for Safe Families	877-723-3711
	Tempe	Agnes' Centers for Domestic Solutions	480-664-6554
Mohave	Bullhead City	Safe House	928-763-7233
Navajo	Kayenta	Tohdenasshai Committee Against Family Abuse	928-697-8591
	Second Mesa	Hopi-Tewa Women's Coalition to End Abuse	928-737-9000

Sexual and Domestic Violence Resources in Arizona

DOMESTIC VIOLENCE PROGRAMS/SERVICES			
COUNTY	**CITY**	**AGENCY NAME**	**PHONE NUMBER**
Navajo	Winslow	Alice's Place	928-289-3003 Toll Free: 888-531-7233
Pima	Green Valley	Hands of a Friend/Genesis House	520-648-3589
	Tucson	Emerge! Center Against Domestic Abuse	520-881-7201
Pinal	Sacaton	On Eagle's Wings/Gila River	520-562-2740
Santa Cruz	Nogales	Nuestra Casa/Our House	520-508-0917
	Nogales	Domestic Violence Advocacy Program	520-375-6050 Ext. 1329

ARIZONA COALITION TO END SEXUAL & DOMESTIC VIOLENCE

Arizona Medical Forensic Exam Facilities

VICTIM/SURVIVOR RIGHTS
Under the Violence Against Women Act (VAWA), adult victims/survivors of sexual assault have the right to a medical forensic exam, at no cost to them, regardless of whether they report to law enforcement. For more information on victim/survivor rights, medical and advocacy options, what to expect during a medical forensic exam, and the decision to report to police, see our Arizona Sexual Assault Forensic Exam Factsheet, or you can speak with an advocate on the phone or chat online at our **Sexual and Domestic Violence Services Helpline: 602-279-2900/800-782-6400/TTY 602-279-7270/acesdv.org**

LEGEND	
◈	Serves **adolescent/adult** patients
♦	Serves **pediatric** patients
❖	Provides services to victims/survivors of **sexual violence**
✦	Provides services to victims/survivors of **domestic violence and/or strangulation**

CITY	FACILITY	PHONE NUMBER	SERVICES
Chandler	Chandler Family Advocacy Center	480-782-4210 480-312-6339*	◈(14 and older) ❖✦
Chinle	Chinle Comprehensive Health Care Facility—Emergency Department	928-674-7001	◈❖✦
Eloy	Pinal County Attorney's Office Family Advocacy Center	520-866-7500	◈♦❖✦
Flagstaff	North Country Healthcare Clinic (Northern Arizona Care and Services After Assault)	24 Hour Crisis Line: 928-527-1900 or 1-877-634-2723	◈ (16 and older) ❖✦
Flagstaff	Safe Child Center	928-773-2053	♦ (15 and younger) ❖
Fort Defiance	Fort Defiance Indian Hospital/ Tsehootsooi Medical Center	928-729-8600	◈♦❖✦
Glendale	Glendale Family Advocacy Center	623-930-3720 480-312-6339*	◈❖✦
Goodyear	Southwest Family Advocacy Center	623-333-7900 480-312-6339*	◈♦❖✦
Holbrook	North Country Healthcare Clinic (Northern Arizona Care and Services After Assault)	928-773-7670	◈(13 and older) ❖✦
Kingman	Kingman Aid to Abused People	24 Hour Crisis Line: 928-753-4242	◈♦❖✦

ARIZONA COALITION TO END SEXUAL & DOMESTIC VIOLENCE

Arizona Medical Forensic Exam Facilities

CITY	FACILITY	PHONE NUMBER	SERVICES
Lake Havasu City	H.A.V.E.N Family Resource Center	928-505-3153	◈♦❖✦
Maricopa	City of Maricopa Family Advocacy Center	520-316-6800 (Police Department)	◈♦❖✦
Mesa	Mesa Family Advocacy Center	480-644-4075 480-312-6339*	◈♦❖✦
Page	Canyonlands Urgent Care (Northern Arizona Care and Services After Assault)	928-527-1900 or 1-877-634-2723	◈(13 and older) ❖✦
Phoenix	ChildHelp Children's Advocacy Center of Arizona	602-271-4500	♦(13 and younger) ❖
Phoenix	Phoenix Family Advocacy Center	602-534-2120 480-312-6339*	◈(13 and older) ❖✦
Polacca	Hopi Health Care Center	928-737-6240	◈❖✦
Prescott Valley	Yavapai Family Advocacy Center	928-775-0669	◈♦❖✦
San Tan Valley	Pinal County Attorney's Office Family Advocacy Center	520-866-7020	◈♦❖✦
Scottsdale	Scottsdale Family Advocacy Center	480-312-6340 480-312-6339*	◈♦❖✦
Show Low	Navajo County Show Low Family Advocacy Center (Northern Arizona Care and Services After Assault)	928-527-1900 or 1-877-634-2723	◈(13 and older) ❖✦
Sierra Vista	Cochise Family Advocacy Center	520-515-4444 (24 Hour Line)	◈♦❖✦
Springerville	North Country Healthcare Clinic (Northern Arizona Care and Services After Assault)	928-527-1900 or 1-877-634-2723	◈(13 and older) ❖✦
Tuba City	Tuba City Regional Health Care Corporation	928-607-9089	◈♦❖✦
Tucson	Southern Arizona Children's Advocacy Center	520-243-6420	♦❖
Tucson	Tucson Medical Center (Southern Arizona Center Against Sexual Assault)	24 Hour Crisis Line: 1-800-400-1001 or 520-327-7273	◈♦❖✦
Yuma	Amberly's Place	928-373-0849	◈♦❖✦

*This phone number is for individuals who want a medical forensic exam, but do not want to report the incident to law enforcement in **Maricopa County**. Victims/survivors who participate in a VAWA (non-report) exam have the option to report to police at a later date.