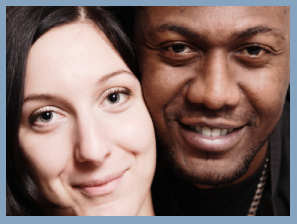

Building Capacity for Preventing Sexual Violence in New Mexico: A Three-Year Strategic Plan

November 1, 2009 to October 31, 2012

Office of Injury Prevention
Injury and Behavioral Epidemiology Bureau
Epidemiology and Response Division
New Mexico Department of Health

NEW MEXICO DEPARTMENT OF HEALTH

November 2009

Developed in collaboration with the
New Mexico Coalition of Sexual Assault Programs

and the
University of New Mexico Prevention Research Center

UNM
SCHOOL of MEDICINE
PREVENTION RESEARCH CENTER
Prevention & Population Sciences

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University of New Mexico Prevention Research Center

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We would like to extend our heartfelt thanks to the
many people in New Mexico who contributed
to the development of this Strategic Plan.

We would also like to acknowledge all the dedicated and caring
sexual violence service providers in New Mexico working to end sexual violence.

And finally, we would like to recognize all the individuals and their families
who have been impacted by sexual violence in New Mexico.
Your courage inspires us to do this important work.

We must unite. Violence against women cannot be tolerated, in any form, in any context, in any circumstance, by any political leader or government.
The time to change is now.
Only by standing together and speaking out can we make a difference.

U.N. Secretary-General Ban Ki-moon, 2008

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Letter from the New Mexico Domestic Violence Czar

State of New Mexico
Office of the Governor

Bill Richardson
Governor

January 27, 2010

To my fellow New Mexicans,

Sexual violence directly impacts close to one third of New Mexico's citizens, and indirectly impacts countless others who are parents, spouses, siblings, friends, and employers and have connections to those who have been sexually assaulted. It is a physically, emotionally and financially devastating public health problem, but fortunately it is also a preventable one.

We are privileged in New Mexico to have a dedicated and skilled workforce, through the New Mexico Coalition of Sexual Assault Programs, the New Mexico Department of Health, Rape Crisis Centers, Sexual Assault Nurse Examiners, law enforcement, counselors, the judicial system, advocates, child advocates and other professionals who are able to support and respond to those who have survived sexual violence. To comprehensively respond to sexual violence, however, we must also prevent it from occurring in the first place.

Building Capacity for Preventing Sexual Violence in New Mexico: A Three-Year Strategic Plan is a framework for organizations and communities in New Mexico to build their capacity to *prevent* sexual violence. It was developed with input from sexual violence service providers, other related professionals and concerned citizens throughout New Mexico, and reflects the collective effort and skills that are needed to prevent sexual violence and make our communities and families safer.

I urge you to read this Strategic Plan as a way to learn more about how sexual violence is impacting New Mexico, to understand what puts people at higher risk for being assaulted or being assaultive, to know what the scientific research says about how to prevent sexual violence and to be aware of what communities in New Mexico are saying about sexual violence and what they need to stop it. But implementation of this Strategic Plan is critical – as is the need for a consistent commitment of human and financial resources to support its implementation.

We can prevent sexual violence from happening in New Mexico. We must work together. We must take a stand. We must share the vision of a New Mexico that is sexual violence-free, and then take the action necessary to make that vision a reality. This Strategic Plan will help us move another step forward. Our citizens' lives and livelihoods are depending on it.

Sincerely,

Sharon L. Pino
Governor's Domestic Violence Czar
(505) 827-4694

State Capitol • Room 400 • Santa Fe, New Mexico 87501 • 505-476-2200 • www.governor.state.nm.us

Executive Summary

Sexual violence is a significant public health problem in New Mexico, where 25% of women and 5% of men will experience an attempted or completed rape sometime in their lifetime. Most sexual violence offenses in New Mexico (85%) are perpetrated by someone known to the victim, with family members committing the sexual assault 39% of the time. Most sexual violence victims in New Mexico are young; 70% of females and 84% of males are under 25 at the time of their assault.

Both national and local sexual violence data shows that certain populations, for a variety of reasons, are more susceptible to sexual victimization. Data shows that in New Mexico these vulnerable populations include children, people with disabilities, those living in rural communities, Native Americans and immigrant populations.

Research shows that the most effective way of reducing sexual violence is through primary prevention – implementing population-oriented prevention strategies aimed at stopping the violence *before* it occurs. Research also shows that primary prevention efforts must be comprehensive, addressing sexual violence at multiple socioecological levels, and must include strategies that work at environmental and policy levels as well as individual and relationship levels.

The national and local sexual violence data and sexual violence prevention research, which are the foundation for *Building Capacity for the Primary Prevention of Sexual Violence in New Mexico: a Three-Year Strategic Plan*, was supplemented with community level information about sexual violence in New Mexico gathered through a sexual violence services provider survey, focus groups and one-on-one interviews conducted with people throughout New Mexico. Certain themes emerged during this process which guided the development of the Strategic Plan: the need to build statewide capacity to provide primary prevention of sexual violence, including more training and technical assistance; the need for better coordination of primary prevention services; and the need for more funding and resources at both the state and local levels.

Based on these findings the Strategic Planning Advisory Group, the New Mexico Coalition of Sexual Assault Programs (NMCSAP), the New Mexico Department of Health (NMDOH) Office of Injury Prevention (OIP) and the University of New Mexico Prevention Research Center (UNM PRC) developed a three-year plan designed to increase the capacity of sexual violence prevention providers in New Mexico to understand and use primary prevention theories and strategies, to increase their ability to advocate for sexual violence prevention and to develop both organizational and community leadership for the primary prevention of sexual violence. This will be accomplished through the provision of a series of statewide trainings focused on the primary prevention of sexual assault, best practices and advocacy, followed by community and regional level technical assistance designed to reinforce what was learned in the trainings.

The creators of this Strategic Plan understand that building capacity for the primary prevention of sexual violence must be followed by the implementation of specific primary prevention strategies aimed at reducing risk factors and increasing protective factors among both the general population and populations most at risk. The development of a subsequent, more broadly-based and longer-term strategic plan aimed at continuing to move prevention efforts forward is recommended, the ultimate goal being to institutionalize primary prevention as one component of a comprehensive response to sexual violence in New Mexico.

Vision of a Sexual Violence-Free New Mexico

If New Mexico were free from sexual violence,
its people would live in a world where

- *There would be more respect*
- *There would be less fear*
- *People would feel supported*
- *People would be happier*
- *There would be equality*
- *There would be accountability*
- *People would care for each other*
- *People would be less isolated*
- *Everyone would participate fully in society*
- *Everyone's quality of life would improve*
- *People would be healthier*
- *People would be more active*
- *Parenting would be honored*
- *People would speak the truth*

The above vision is a synthesis of responses from sexual violence prevention providers from around New Mexico to the question, "What would a sexual violence-free New Mexico look like?"

Introduction

Sexual violence is an unspeakable crime. It strikes at the core of a person's being; her or his sense of self, sense of safety in the world and sense of having control over her or his own body. And it is personal. It is a deliberate act of violence committed by a person or group of people against another. It is hard to imagine and even harder to talk about; many believe it is something that happens somewhere else, in a neighborhood that is not safe, to a woman who was not careful enough. Yet in New Mexico 25% of women and 5% of men will experience an attempted or completed rape sometime in their lifetime. [1]

But the impact of sexual violence goes far beyond the physical act itself. Research has shown that those who have been sexually violated can also experience a host of physical problems, including sleeplessness, hypertension, fluctuations in weight, gastrointestinal problems, fatigue, migraines, chronic pain and recurrent infections. They can also suffer from post-traumatic stress disorder, depression, anxiety disorders and other mental health issues. These symptoms can last long after the attack occurred and can sometimes be debilitating.[2, 3] Other studies have shown that women who have experienced sexual violence are more likely to engage in high-risk behaviors such as substance abuse and unsafe sexual practices that could lead to sexually transmitted diseases, unwanted pregnancies, or put them at higher risk for subsequent physical and sexual assaults.[4]

Sexual violence can also be cyclical. Studies have shown that children who have been sexually abused, especially males, have a higher likelihood of becoming sexual offenders. Many adult offenders who were themselves abused as children began displaying sexual aggression in adolescence, and offenses tended to become more aggressive with age.[5] Research has also shown that people who are sexually abused as children or adolescents are almost twice as likely to experience sexual violence as adults than those who were not subjected to childhood sexual abuse.[6, 7]

So what can be done to stop sexual violence? How can New Mexico be made safer for the girls and boys, women and men who live here? One important way to end sexual violence is to stop it *before* it occurs – that is, to focus on primary prevention. *Building Capacity for the Primary Prevention of Sexual Violence in New Mexico: a Three-Year Strategic Plan* (The Plan) was developed as a preliminary step to preventing sexual violence. In the Plan we examine who is being harmed by sexual violence in New Mexico, who is most at risk and what research has shown can be done to reduce those risks. The Plan also looks at who is causing the harm and what can be done to stop the violence from occurring.

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1 Caponera, B. *Sex Crimes in New Mexico VII: An Analysis of 2007 Data from The New Mexico Interpersonal Violence Data Central Repository.* Albuquerque, NM: The New Mexico Department of Health. 2008.

2 Chrisler, J.C. & Ferguson, S. (2006). Violence against women as a public health issue. *Annals New York Academy of Sciences, 1087,* 235-249.

3 World Health Organization. *World Report on Violence and Health.* 2002.

4 Martin, S.L. & Macy, R.J. (2009). Sexual violence against women: impact on high-risk health behaviors and reproductive health. *VAWnet: The Online Resource Center on Violence Against Women,* www.vawnet.org.

5 Borowsky, W., Hogan, M. & Ireland, M. (1997). Adolescent sexual aggression: risk and protective factors. *Pediatrics, 100(6),* 1-8.

6 Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K. & Putnam, F. W. (2003). Revictimization and self-harm in females who experienced childhood sexual abuse: results from a prospective study. *Journal of Interpersonal Violence, 18(12)*, 1452-1471.

7 Barnes, J. E., Noll, J. G., Putnam, F. W. & Trickett, P. K. (2009). Sexual and physical revictimization among victims of severe childhood sexual abuse. *Child Abuse and Neglect, 33(7)*, 412-420.

Additionally, information was gathered through surveys, focus groups and individual interviews with people working to end violence against women in New Mexico, to learn how sexual violence is impacting communities, what is currently being done to stop it, and where to focus efforts to strengthen primary prevention.

Based on these findings, this Plan, developed under the leadership of the New Mexico Department of Health (NMDOH) and the New Mexico Coalition of Sexual Assault Programs (NMCSAP) with guidance from the Strategic Planning Advisory Group, focuses on the provision of training and technical assistance as identified through the focus groups and interviews as most necessary for building capacity to implement primary prevention strategies. **This Plan will lay the foundation for subsequent, targeted primary prevention interventions at both the state and community levels as part of a comprehensive plan to end sexual violence in New Mexico.**

What is sexual violence?

At its broadest level sexual violence can only be understood within the context of oppression; at its core it is an acute manifestation of power and control. Its roots lie in inequality and discrimination, often exhibited as sexism, racism, homophobia, classism or patriarchy, which support clearly defined roles of domination and subordination. [8, 9, 10, 11]

Within the international community, violence against women, including sexual violence, is widely recognized as a human rights issue. A study developed by the United Nations Secretary General declared:

> Violence against women is a form of discrimination and a violation of human rights. It causes untold misery, cutting short lives and leaving countless women living in pain and fear in every country in the world. It harms families across the generations, impoverishes communities and reinforces other forms of violence throughout societies. Violence against women stops them from fulfilling their potential, restricts economic growth and undermines development. The scope and extent of violence against women are a reflection of the degree and persistence of discrimination that women continue to face. It can only be eliminated, therefore, by addressing discrimination, promoting women's equality and empowerment, and ensuring that women's human rights are fulfilled. [12]

It is also widely understood that a key component to ending such human rights abuses is prevention, as recognized by the United Nations Declaration on the Elimination of Violence against Women, The Beijing

8 World Health Organization. 2002.

9 Cohen, L., Davis, R. & Graffunder, C. "Before It Occurs: Primary Prevention of Intimate Partner Violence and Abuse." In Salber, P.R. & Taliaferro, E. (Authors), *The Physician's Guide to Intimate Partner Violence and Abuse.* Volcano, CA: Volcano Press, 1995, pp. 89-100.

10 Lindhorst, T. & Tajima, E. (2008). Reconceptualizing and operationalizing context in survey research on intimate partner violence. *Journal of Interpersonal Violence, 23,* 362-388.

11 Pratto, F., Sidanius, J., Stallworth, L.M. & Malle, B.F. (1994). Social dominance orientation: a personality variable predicting social and political attitudes. *Journal of Personality and Social Psychology, 67(4),* 741-763.

12 *Ending violence against women: From words to action. Study of the Secretary-General.* Division for the Advancement of Women of the Department of Economic and Social Affairs of the United Nations Secretariat. October 2006.

Declaration and Platform for Action, United Nations General Assembly Resolution 61/143, and the World Health Organization's World Health Assembly Resolution 56.24.[13]

Sexual violence encompasses a broad spectrum of behaviors and actions. For the purposes of this Plan and as defined by the Strategic Planning Advisory Group, it is any intentional act of a sexual nature that is imposed on another person, regardless of their relationship, through physical force, coercion, intimidation, humiliation, causing or taking advantage of another's drug or alcohol intoxication, or taking advantage of another person's inability to consent. These acts can include a range of actions including but not limited to rape, unwanted touching, sexual harassment, threats of violence as related to sexual violence, threats of other consequences such as job loss, child sexual abuse, stalking, forced prostitution or human trafficking.

How do we prevent sexual violence?

Sexual violence does not exist in a vacuum. From an early age men and women receive powerful and pervasive messages about male privilege, which includes the right to be sexually aggressive. This privilege is widely supported across cultures, nationalities, races, ethnicities and classes and is often seen as normative and acceptable behavior.[14] Viewed in the context of this rape permissive culture, it becomes clear that prevention efforts must be comprehensive, addressing sexual violence at community and societal levels in addition to individual and relationship levels.[15]

The Socioecological Model illustrates how behavior is influenced in each of the socioecological spheres. Changes at any level may increase or decrease the likelihood of sexual victimization or perpetration. Additionally, because of the interconnectedness of the spheres of influence, interventions at one socioecological level may produce changes within the other levels (see Figure 1).[16]

Casey and Lyndhorst[17] identified six components necessary for successful socioecologically-based prevention efforts:

Comprehensiveness: Utilizing multiple strategies designed to initiate change at multiple levels (i.e., individual, peer and community), and for multiple outcomes (i.e., behavior and policy change).

Community engagement: Partnering with community members in the process of identifying targets for change and designing accompanying change strategies.

Contextualized programming: Designing prevention strategies that are consistent with the broader social, economic and political context of communities.

Theory-based: Grounding intervention design in sound theoretical rationales.

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13 Harvey, A., Garcia-Morenoz, C. & Butchart, A. *Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting.* World Health Organization. 2007.

14 Douglas, U., Bathrick, D. & Perry, P.A. (2008). Deconstructing male violence against women: the men stopping violence community-accountability model. *Violence Against Women, 14(2),* 247-261.

15 Lee, D.S., Guy, L., Perry, B., Sniffen, C.K. & Mixson, S.A. (2007). Sexual violence prevention. *The Prevention Researcher, 14(2)*, 15-20.

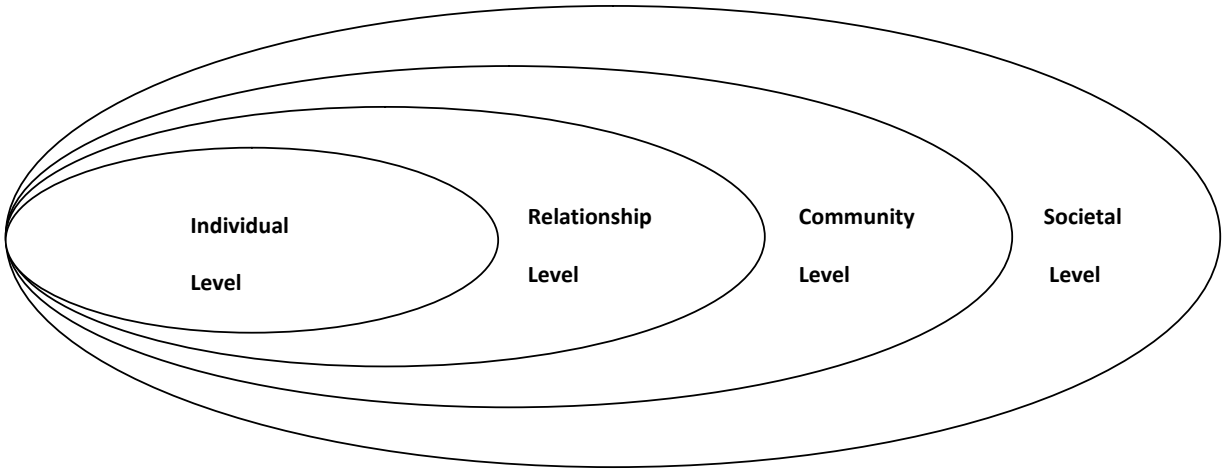
16 McLeroy, K.R., Norton, B. L., Kegler, M. C., Burdine, J. N. & Sumaya, C. V. (2003). Community-based interventions. *American Journal of Public Health, 93(4),* 529-533.

17 Casey, E. A. & Lyndhorst, T.P. (2009). Toward a multi-level, ecological approach to the primary prevention of sexual assault prevention in peer and community contexts. *Trauma, Violence & Abuse OnlineFirst,* published on April 20, 2009, 1-24

Health and strengths promotion: Simultaneously working to enhance community resources and strengths while addressing risk factors.

Addressing structural factors: Targeting underlying causes of social problems for change rather than individual behaviors, which are in essence "symptoms" of larger problems.

Figure 1: The Socioecological Model[18,19]



Individual Influences: attitudes and beliefs that support sexual violence; impulsive and antisocial behavior; childhood history of sexual abuse or witnessing violence; alcohol and drug use; hostility toward women.

Relationship Influences: association with sexually aggressive peers; family environment that is emotionally unsupportive, physically violent or strongly patriarchal.

Community Influences: general tolerance of sexual assault; lack of support from police or judicial system; poverty; lack of employment opportunities; weak community sanctions against perpetrators.

Societal Influences: larger, macro-level factors, including gender equality/inequality, religious or cultural belief systems, societal norms, and economic or social policies.

Another useful framework for understanding how to effect change at multiple levels of influence to help end sexual violence is The Spectrum of Prevention developed by Larry Cohen at The Prevention Institute.[20] Cohen describes the Spectrum of Prevention as having six levels at which prevention interventions can be implemented, each subsequent level impacting a wider number of people. The Spectrum demonstrates how prevention strategies implemented simultaneously at numerous levels have a much greater ability to change not only individuals but also their environment, and ultimately the norms that support violence against women. Activities at each level are informed by data and research, and evaluated for impact. Figure 2 illustrates The Spectrum of Prevention with examples of prevention activities within each area.

18 Cohen, L., et al. 1995.

19 Centers for Disease Control and Prevention. *Sexual violence prevention: beginning the dialogue.* Atlanta, GA: Centers for Disease Control and Prevention; 2004.

20 Davis, R., Parks, L.F. & Cohen, L. *Sexual Violence and the Spectrum of Prevention: Toward a Community Solution.* National Sexual Violence Resource Center. 2006.

Figure 2: The Spectrum of Prevention

Spectrum Level/Definitions	Examples of Prevention Activities
Strengthening individual knowledge and skills. Enhancing an individual's capability of preventing injury or crime.	• Provide multiple session skill-building programs that teach healthy sexuality and healthy and equitable relationships skills to high school students • Build the skills of bystanders to safely interrupt behavior such as sexist and homophobic harassment • Teach parents to address attitudes and behaviors in their children that support sexual violence
Promoting community education. Reaching groups of people with information and resources to promote health and safety.	• Hold religious and political leaders accountable for providing clear and consistent messages that sexual violence is not appropriate • Foster media coverage of sexual violence with a focus on underlying factors and solutions • Develop awards programs to publicly recognize responsible media coverage and community leadership to prevent sexual violence
Educating providers. Informing providers who will transmit skills and knowledge to others.	• Train little league coaches to build skills to interrupt and address athletes' inappropriate sexual comments and behaviors • Train prison guards on rape prevention • Train nursing home providers on sexual violence prevention practices
Fostering coalitions and networks. Bringing together groups and individuals for broader goals and greater impact.	• Foster partnerships between community providers and researcher/academics and to strengthen evaluation approaches • Engage grassroots, community-based organizations and sectors of government, including social services, health, public health, law enforcement and education • Engage the business sector to foster workplace solutions and build support among their peers
Changing organizational practices. Adopting regulations and norms to improve health and safety and creating new models.	• 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, complimented by community education and enforcement of policies • Encourage insurers to provide healthy sexuality promoting resources and materials
Influencing policy and legislation. Developing strategies to change laws and policies to influence outcomes in health, education and justice.	• Promote and enforce full implementation of the Title IX law • Establish policies at universities to provide sexual violence prevention curriculum to all students 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
Source: Sexual Violence and the Spectrum of Prevention: Toward a Community Solution.	

And finally, because sexual violence affects so many people in New Mexico and is an issue of public health, analyzing its prevalence, nature and consequences within a public health framework also serves to inform the development of effective, comprehensive primary prevention strategies.[21] This framework is important because it takes a systematic approach to addressing the problem, focuses on the health of the community rather than the individual, and prioritizes primary prevention – intervening before harm has occurred.[22]

There are four distinct steps in applying the Public Health Model:

Step 1 - Define the Problem: In this step the available national, state and local data are reviewed to develop an understanding of the magnitude of the problem; how and how often it is occurring and who is being affected by it.

Step 2 - Identify the Risk and Protective Factors: Risk and protective factors are not a matter of cause and effect, i.e. being emotionally unsupported at home, which is a known risk factor, does not cause an individual to sexually abuse another. Instead, understanding risk and protective factors helps us comprehend what convergence of circumstances may put people at higher risk for either perpetrating or experiencing sexual violence, or what may help protect them from either of those events.

Step 3 - Develop and Test Prevention Strategies: In this step prevention strategies based on what was learned in Steps 1 and 2 are developed to either reduce risk factors or strengthen protective ones. They should be based on prevention interventions shown through evaluation to be the most promising in preventing sexual violence.

Step 4 - Ensure Widespread Adoption: The final step is documenting and sharing what is learned so that others may benefit and the field of sexual violence prevention continues to advance. This can be as formalized as submitting a research paper to a peer-reviewed journal or as simple as providing a workshop on a locally implemented sexual violence prevention project to other community providers. Implementation of the Public Health Model is not a static process. After Step 4 the cycle should be repeated to ensure continued reduction in sexual violence risk factors and increases in protective factors across the socioecological spheres.

21 Kilpatrick, D.G. (2004). What is violence against women: defining and measuring the problem. *Journal of Interpersonal Violence, 19,* 1209-1234.

22 Guy, L. (2007). Public health theory for anti-rape advocates. *Partners in Social Change, 9(2)*, 4-6.

Implementation of the Public Health Model – Step 1: Defining the sexual violence problem in New Mexico

An overview of New Mexico:

Understanding sexual violence in New Mexico first requires insight into the unique qualities of New Mexico itself.

Frontier status: New Mexico is physically large, ranking fifth in size among all 50 states, but had a total population of less than two million people in 2008.[23] It is mostly rural and averages only 16 people per square mile compared with 86 people per square mile in the US. New Mexico has been designated a frontier state, which is based on population density per square mile and travel distance and travel time to the nearest service or market. Of its 33 counties, 26 have frontier status. New Mexico is third in the nation for percentage of frontier population (behind Texas and Arizona) with 42% of the state's population living in frontier counties. New Mexico is fourth in the nation for frontier area, behind Alaska, Texas and Montana.[24]

The largest metropolitan area is Albuquerque, located in central New Mexico in Bernalillo County, which has an average of 547 people per square mile. But outside of the Albuquerque area the population density drops considerably. The next two most densely populated counties are Los Alamos with 166 people per square mile, and Santa Fe which has 75 people per square mile, both of which are also located in the central portion of the state. Three quarters of the counties in New Mexico (25 out of 33) have fewer than 20 people per square mile.[25]

Racial and ethnic make-up: In 2007 the racial/ethnic make-up of New Mexico was 44.4% Hispanic, 42.3% White, 2.8% African American, 9.4% Native American or Alaskan Native, 1.4% Asian, and 0.1% Native Hawaiian or Pacific Islander.[26] This means that close to 60% of the population in New Mexico belongs to a racial or ethnic minority group. There are also 22 sovereign tribal nations within New Mexico: the Navajo Nation, the Mescalero Apache and Jicarilla Apache Nations and 19 Pueblos, each with their own distinct history, culture, traditions, languages, dialects and government.[27]

Employment and income: Preliminary results for the second quarter in 2009 showed an unemployment rate in New Mexico of 6.5% compared to a national unemployment rate of 9.4%. The unemployment rate ranged from a low of 2.7% in Los Alamos County to a high of 17% in Luna County.[28,29]

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23 US Census Bureau, Population Estimate Program. Retrieved from the World Wide Web September 3, 2009: http://factfinder.census.gov/servlet/ThematicMapFramesetServlet?_bm=y&-geo_id=01000US&-tm_name=PEP_2008_EST_M00090&-ds_name=PEP_2008_EST&-_MapEvent=displayBy&-_dBy=040&-_lang=en&-_sse=on#?231,296

24 National Center for Frontier Communities. Retrieved from the World Wide Web June 18, 2009: http://www.frontierus.org/defining.htm

25 US Census Bureau, Population Estimate Program.

26 Bureau of Business and Economic Research (BBER), University of New Mexico, NM Statistics at a Glance. Updated March 2009, Retrieved from the World Wide Web September 2, 2009: http://bber.unm.edu/econ/nm-sag.pdf

27 New Mexico Indian Affairs Bureau. Retrieved from the World Wide Web September 10, 2009: http://www.iad.state.nm.us/history.html

28 Bureau of Business and Economic Research (BBER), University of New Mexico. Unemployment Rate. Table released 7/17/09. Retrieved from the World Wide Web September 2, 2009: http://bber.unm.edu/econ/UnempRtQtr.htm

29 US Department of Labor Statistics. Retrieved from the World Wide Web September 2, 2009: http://www.bls.gov/eag/eag.us.htm

In 2007 the median household income in New Mexico was $41,509, 18% lower than the US median income of $50,740. Median incomes in New Mexico counties ranged from a high in Los Alamos County of $101,098 to a low in Sierra County of $23,387.[30]

Poverty: Many people in New Mexico live in poverty, which has been identified as one of the risk factors for sexual violence.[31] In 2007 the New Mexico poverty rate was 17.9%, compared with a US poverty rate of 13% for the same year. However, 16 of New Mexico's 33 counties had poverty rates higher than 20%. New Mexico ranked third highest (behind Mississippi and Louisiana) for children living in poverty in 2007. One quarter (25.2%) of New Mexico children under 18 years of age lived below the poverty level, while 18% of children in the US did. In 31 out of 33 New Mexico counties over 20% of the children lived in poverty in 2007 and in 16 of those counties over 30% of the children lived in poverty.[32]

Poverty rates for most minorities in New Mexico are significantly high. Almost one third (31.8%) of the Native Americans living in New Mexico and one quarter of Hispanics (23.2%) and African Americans (24.0%) lived below the poverty level in 2007, compared to 15.9% of Whites who lived in poverty.[33]

Poverty Status in the Last 12 Months by Race/Ethnicity
New Mexico
2005-2007 American Community Survey 3-Year Estimates
Percent Below Poverty Level

White	Hispanic	African American	Native American	Asian
15.9%	23.2%	24.0%	31.8%	10.0%

Source: US Census Bureau, 2005-2007 American Community Survey

Educational attainment and poverty: One contributing factor to poverty in New Mexico is low level of educational attainment. One third (34%) of New Mexicans aged 18 to 24 years do not have a degree beyond a high school diploma, which is similar to the national rate of 33.5%. But the percentage of New Mexicans aged 18 to 24 who never complete high school is higher than those not completing high school in the US (22.2% for New Mexico compared to 17.7% for the US). This greatly affects earning potential and poverty status, especially for women in New Mexico.[34]

Over one third (35.4%) of the women aged 25 years and older in New Mexico have less than a high school diploma. Over half (53%) have not attained higher than a high school diploma.

30 US Census Bureau, Small Area Income & Poverty Estimates. Last modified January 2, 2009. Retrieved from the World Wide Web September 2, 2009: http://www.census.gov/did/www/saipe/data/statecounty/data/2007.html
31 World Health Organization. 2002.
32 US Census Bureau, Small Area Income & Poverty Estimates.
33 US Census Bureau, 2005-2007 American Community Survey. Retrieved from the World Wide Web September 3, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=04000US35&-qr_name=ACS_2007_3YR_G00_S1701&-context=st&-ds_name=ACS_2007_3YR_G00_&-tree_id=3307&-redoLog=true
34 US Census Bureau, 2005-2007 American Community Survey. Retrieved from the World Wide Web September 3, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S1501&-ds_name=ACS_2007_3YR_G00_&-tree_id=3307&-redoLog=false&-_caller=geoselect&-geo_id=04000US35&-format=&-_lang=en

Educational Attainment and Poverty Rate

United States and New Mexico

2005-2007 American Community Survey 3-Year Estimates

Population 25 years and older	Total Population		Males		Females	
	US	NM	US	NM	US	NM
Less than high school diploma	23.6%	31.2%	19.5%	26.9%	27.7%	35.4%
High school diploma or equivalency	11.4%	15.1%	9.2%	12.4%	13.4%	17.6%

Source: US Census Bureau, 2005-2007 American Community Survey

The women in New Mexico with less than a high school diploma who have earned income in the past year have a median income of less than $12,000 a year and those with only a high school diploma earn around $18,000 a year.

Educational Attainment and Median Earnings in Past 12 Months

United States and New Mexico

2005-2007 American Community Survey 3-Year Estimates

Population 25 years and older with earnings	Total Population		Males		Females	
	US	NM	US	NM	US	NM
Less than high school graduate	$19,089	$15,899	$22,524	$19,555	$14,051	$11,992
High school graduate or equivalency	$26,712	$23,396	$32,462	$27,753	$21,031	$18,505

Source: US Census Bureau, 2005-2007 American Community Survey

Immigrant status and poverty: Another group disproportionately affected by poverty in New Mexico is immigrants. According to the American Community Survey 3-Year Estimates for 2005-2007, 9.4% of New Mexico residents are foreign born (meaning they were not US citizens at birth), compared to 12.5% of the population in the US. The majority of foreign born in New Mexico (78.3%) come from Latin American countries; 53.4% of all foreign born in the US come from Latin America. The majority of foreign born from Latin America living in New Mexico (92.3%) originate from Mexico.[35,36]

The poverty rate forforeign born in New Mexico is 27.7%, almost twice the poverty rate for foreign in the born US at 14.9%. For foreign born in New Mexico from Latin American countries the rate jumps to 32.3%, and for those with non-citizen foreign born status the poverty rate increases to 35.5%.[37,38]

35 US Census Bureau, 2005-2007 American Community Survey. Retrieved from the World Wide Web September 11, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S0506&-ds_name=ACS_2007_3YR_G00_&-CONTEXT=st&-tree_id=3307&-redoLog=false&-_caller=geoselect&-geo_id=04000US35&-format=&-_lang=en

36 US Census Bureau, 2005-2007 American Community Survey. Retrieved from the World Wide Web September 11, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S0501&-ds_name=ACS_2007_3YR_G00_&-CONTEXT=st&-tree_id=3307&-redoLog=false&-_caller=geoselect&-geo_id=04000US35&-format=&-_lang=en

37 US Census Bureau, 2005-2007 American Community Survey. Retrieved from the World Wide Web September 11, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S0506&-ds_name=ACS_2007_3YR_G00_&-CONTEXT=st&-tree_id=3307&-redoLog=false&-_caller=geoselect&-geo_id=04000US35&-format=&-_lang=en

38 US Census Bureau, 2005-2007 American Community Survey. Retrieved from the World Wide Web September 11, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S0501&-ds_name=ACS_2007_3YR_G00_&-CONTEXT=st&-tree_id=3307&-redoLog=false&-_caller=geoselect&-geo_id=04000US35&-format=&-_lang=en

Language: Over one third (36%) of the people living in New Mexico speak a language other than English at home, compared to 19.5% of people living in the US. Of those who speak a language other than English at home, 29.1% reported speaking English "less than very well." Over one quarter (28.4%) of New Mexicans speak primarily Spanish in their homes.[39]

The system for responding to sexual violence in New Mexico:

Prevention of sexual violence occurs at three levels. The first level is primary prevention, which is designed to decrease its incidence; to stop the behavior from ever occurring. The second level is secondary prevention, which is designed to decrease the prevalence of sexual violence in the population and reduce the likelihood of future violence. The third is tertiary prevention, which is designed to mitigate the effects of sexual violence once it has already occurred.[40] Currently in New Mexico most of the efforts within the sexual violence response system are focused on secondary and tertiary prevention.

The NMCSAP, with support from the NMDOH Office of Injury Prevention, leads the efforts to reduce sexual violence in New Mexico. The primary functions of the NMCSAP are to provide training and technical assistance to sexual assault service providers, law enforcement, medical practitioners and mental health professionals. NMDOH oversees the majority of federal and state funding designated for sexual violence prevention in New Mexico. It supports the functions of NMCSAP through the allocation of these funds, which in turn are distributed to community-based organizations designated to address sexual violence. Most of the funding is used to reimburse medical centers and SANE (Sexual Assault Nurse Examiners) programs for medical expenses incurred during sexual assault exams, and to support operational costs of Rape Crisis Centers (RCC) and SANE programs.

There are seven RCCs in New Mexico. Four of the centers, located in Taos, Santa Fe, Albuquerque, and Las Cruces, provide a full range of services, which include rape crisis services, therapy and advocacy. The other three, located in Farmington, Silver City and Portales, are in various stages of development regarding the services they provide. The NMCSAP recently created a new position, Coordinator for Sexual Assault Services, specifically for the purpose of assessing the resources and needs of individual RCCs and providing support and technical assistance to develop their services and potential.

SANE's are medical examiners with advanced training in conducting acute medical/forensic exams in response to a sexual assault. There are currently ten communities with SANE programs. In addition, three communities are linked with an existing SANE program so that services are provided to victims in those areas. Another two communities are midway through the process of developing their own SANE programs. Each SANE program must be active in their area Multi-Disciplinary Team (MDT), which reviews local sexual violence crimes for the purpose of making systemic improvements to response, investigation and prosecution through increased coordination, provision of training and the development of protocols. The training of SANE providers and development of SANE programs is overseen by a statewide SANE Coordinator housed within the NMCSAP.

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39 US Census Bureau, 2005-2007 American Community Survey. Retrieved from the World Wide Web September 3, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S1601&-ds_name=ACS_2007_3YR_G00_&-tree_id=3307&-redoLog=true&-_caller=geoselect&-geo_id=04000US35&-format=&-_lang=en

40 Meyer, J. (2000). *Perspectives on Sexual Violence Prevention,* Colorado Coalition Against Sexual Assault.

Another vital program in the sexual violence prevention system in New Mexico is the Para Los Niños Program at University of New Mexico Hospital. Staffed by a multi-disciplinary team, Para Los Niños provides medical exams of sexually abused and assaulted adolescents and children, crisis counseling, follow-up care for survivors, expert medical reviews of sexual abuse cases involving children or adolescents in other parts of the state, and training to social workers, law enforcement, District Attorney's offices, or other professionals in need of further education about child sexual assault.

The New Mexico Children's Safehouse Network includes nine Safehouse programs throughout the state. Though each program provides various services designed to best serve their communities, all of them provide forensic interviews to children who have witnessed violence or when there is a suspicion of abuse, and family advocacy services to the families of the children involved. The purpose of the Safehouse interview is to provide a forensically sound, age and developmentally appropriate interview which is recorded and then provided to law enforcement and district attorneys. These interviews aid in prosecution while reducing the trauma associated with recounting the abusive or violent incident multiple times to multiple audiences. Each Safehouse is part of an MDT which assists in the investigation of child abuse allegations.

Mental health centers throughout the state have Sexual Abuse Services Coordinators who are also part of the statewide system of sexual violence prevention. These coordinators are not funded through the NMCSAP, but instead are supported through the Behavioral Health Services Division of the New Mexico Human Services Department. Their purpose is to respond to survivors seeking mental health support in response to their victimization.

Though all of the other services provide training, awareness-raising activities, and advocacy to a greater or lesser degree within their own communities, the NMCSAP provides the most extensive training throughout the state. They do this both through their own staff and through contracted trainers, which allows them greater flexibility to provide trainers representative of their intended audience. The audiences for these trainings run the gamut from school personnel and students to law enforcement to community members to mental health and medical professionals. The trainings also vary widely and many are provided at the specific request of local communities or law enforcement. Within recent years one of the most successful trainings has been an intensive two-week training for mental health professionals on providing therapeutic treatment to juvenile sex offenders.

The judicial response to sexual violence in New Mexico is inconsistent. The NMCSAP has provided resources to the judges, such as a bench book, a self-directed video curriculum on the judge's role in cases involving sexual violence, and a manual on research regarding sexual assault and the legal system. However, it is up to the discretion of each judge as to whether or not the resources are used, and many judges are concerned that if they receive training their decisions will then become biased. Infrastructure for dealing with cases involving sexual violence throughout the state, including prosecutors, judges, court rooms and Safehouses, is lacking. Though there are attempts to bring cases involving children to trial within a year, it can often take up to two years for a sexual assault case involving an adult to be heard.

The New Mexico Intimate Partner Violence Death Review Team (NMIPVDRT) is a multi-disciplinary team which reviews cases of sexual assault and intimate partner violence (IPV) related death. It is modeled on Child Fatality Review teams, which have been effective in increasing the health and safety of children and reducing preventable child injuries and death. The purpose of the NMIPVDRT in reviewing these deaths is to increase

their understanding of risk and protective factors associated with IPV and sexual assault, especially in relation to the systems designed to serve or protect victims, and to make recommendations based on their findings to prevent future occurrences of IPV and sexual assault injuries and deaths.

The violence against women field in New Mexico is fortunate to have had consistent support from Governor Richardson and First Lady Barbara Richardson. Barbara Richardson was instrumental in establishing the Governor's Domestic Violence Advisory Board and the Office of the Domestic Violence Czar. Both the Governor and the First Lady have recognized that sexual violence, like domestic violence, is a significant issue which impacts many individuals and families in New Mexico, and have ensured that funding for sexual violence programs remains a legislative priority. Lieutenant Governor Diane Denish has also been committed to reducing sexual violence through legislative policies and advocacy, as have legislators in both the House and the Senate.

What the data tell us about sexual violence in New Mexico:

The local sexual violence data used in this Plan come from the New Mexico Interpersonal Violence Data Central Repository (the Repository) which is housed at NMCSAP. The Repository collects sex crimes data compiled by law enforcement, services providers and SANE programs.

In addition to these data sources, NMDOH Office of Injury Prevention (OIP) funded a statewide Violence Victimization Survey (VVS) in 2005, which was conducted using a random digit dialing telephone survey. Four thousand adults aged 18 years and older in New Mexico, including 2000 males and 2000 females, were interviewed about the prevalence of violence throughout their lifetimes.

Overview: The VVS revealed that one in four women and one in 20 men in New Mexico had experienced completed or attempted rapes,[41] as compared with one in six women and one in 33 men that had experienced completed or attempted rapes nationally.[42] Most survivors of rape were female (78%) while most perpetrators were male (85%). According to the VVS, the majority of rape survivors in New Mexico were adolescents and children 18 years old or younger (67%), with 44% being 12 years old or younger at the time of their victimization. The majority of offenders, however, (78%) were adults 19 years and older.[43] According to law enforcement statistics from 2007, almost half of the offenders (47%) were 19 to 35 years old at the time of their sexual offense.[44]

The VVS data also indicated that over half (53%) of the rape survivors in New Mexico were of White, non-Hispanic race/ethnicity, and another third (33%) were Hispanic.

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41 Caponera, B. *Sex Crimes in New Mexico V: An Analysis of Data from the Survey of Violence Victimization in New Mexico and The New Mexico Interpersonal Violence Data Central Repository, 2002-2005.* Albuquerque, NM: The New Mexico Department of Health. January 2007.

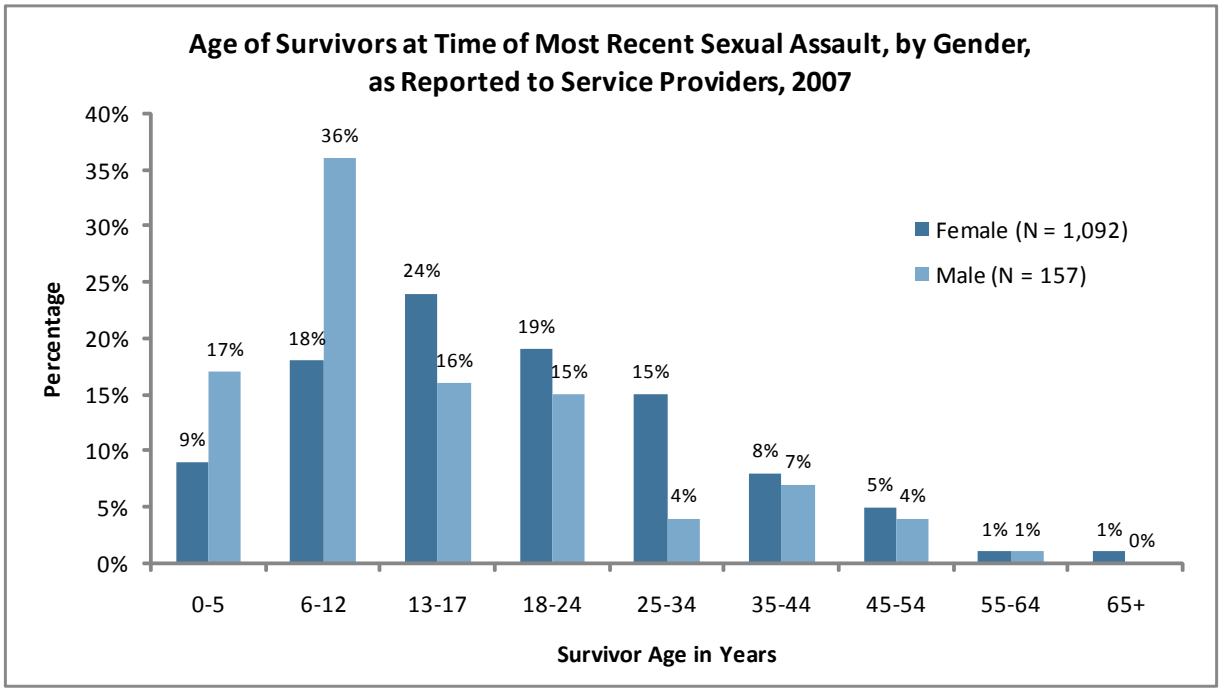
42 Tjaden, P. & Thoennes, N., November 2000. *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women, Findings from the National Violence Against Women Survey.* Washington D.C.: National Institute of Justice, Office of Justice Programs, US Department of Justice.

43 Caponera, B. January 2007.

44 Caponera, B. 2008.

Rape Survivor by Race/Ethnicity New Mexico Violence Victimization Survey 2005					
White (non-Hispanic)	**Hispanic**	**Native American**	**African American**	**Asian**	**Other**
53%	33%	5%	2%	1%	2%
Source: Sex Crimes in New Mexico V: An Analysis of Data from the Survey of Violence Victimization in New Mexico and The New Mexico Interpersonal Violence Data Central Repository, 2002-2005.					

Age of survivors: The National Violence Against Women Survey (NVAWS) indicated that sexual assault in the United States is primarily a crime committed against the young. It showed that 54% of survivors were less than 18 years of age at the time of their assault, and 83% were under the age of 25 years.[45] Data from service providers in 2007 support these findings in New Mexico; 27% of females and 53% of males who had been sexually assaulted in New Mexico were ages 12 years or under, 51% of females and 69% of males were under 18 years of age, and 70% of females and 84% of males were under age 25 years.



Source: Sex Crimes in New Mexico VII: An Analysis of 2007 Data from The New Mexico Interpersonal Violence Data Central Repository

In 2007 service provider data showed that among female rape victims, 47% of Whites, 52% of Hispanics, 45% of Native Americans and 44% of those of mixed race/ethnicity were under the age of 18 years at the time they received services. The percentage of African American females who sought services was equally divided between adults 18 years of age and over and children under 13 years of age, however the total number of assault victims was small (14) and therefore these numbers should be used with caution.[46]

45 Tjaden, P. Thoennes, N. (1998). *Prevalence, Incident, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey.* Washington, D.C.: National Institute of Justice, Office of the Justice Programs, US Department of Justice.

46 Caponera, B. 2008

Female Rape Victims by Race/Ethnicity Service Provider Data New Mexico, 2007						
	White (non-Hispanic)	**Hispanic**	**Native American**	**African American**	**Mixed Race/ Ethnicity**	**All Races**
Age > 17	53%	47%	54%	50%	57%	51%
Age 13-17	26%	30%	34%	0%	22%	28%
Age < 13	21%	22%	11%	50%	22%	22%
Total Number	**258**	**230**	**35**	**14**	**23**	**560**
Source: Sex Crimes in New Mexico VII: An Analysis of 2007 Data from The New Mexico Interpersonal Violence Data Central Repository						

Service provider data from 2007 indicated that males in New Mexico who sought services after their assault were more likely to be raped as children than adults. The data showed that the majority of White, non-Hispanic (42%) or Hispanic (52%) males who were victimized experienced the rape by the age of 12 years. It is unknown if this tendency would hold true for young males across race/ethnicities as numbers of male rape victims who were Native American or of mixed race/ethnicity were too small to factor, and there were no African American males who sought sexual assault services from providers in 2007.[47] Overall, 63% of males who sought services were under age 18 years.

Male Rape Victims by Race/Ethnicity Service Provider Data New Mexico, 2007						
	White (non-Hispanic)	**Hispanic**	**Native American**	**African American**	**Mixed Race/ Ethnicity**	**All Races**
Age > 17	36%	37%	*	*	*	37%
Age 13-17	21%	11%	*	*	*	16%
Age < 13	42%	52%	*	*	*	47%
Total Number	**33**	**27**	*	*	*	**60**
Source: Sex Crimes in New Mexico VII: An Analysis of 2007 Data from The New Mexico Interpersonal Violence Data Central Repository						

The New Mexico Youth Risk and Resiliency Survey, which assesses health risk behaviors and protective factors in high schools and middle schools throughout New Mexico, indicated that in 2007, 9.2% of the students responding to the survey reported being forced to have sex. Girls (11.6%) were more likely than boys (6.9%) to report having been forced to have sexual intercourse. Significantly more African Americans (15.9%) reported being forced to have sex than Hispanics (9.7%) or White, non-Hispanics (7.2%).[48]

Offenders: In 2007, service providers reported that sexual violence offenders were known to their victims in 85% of the cases. Of the sexual assaults where the offenders were known to their victims, family members

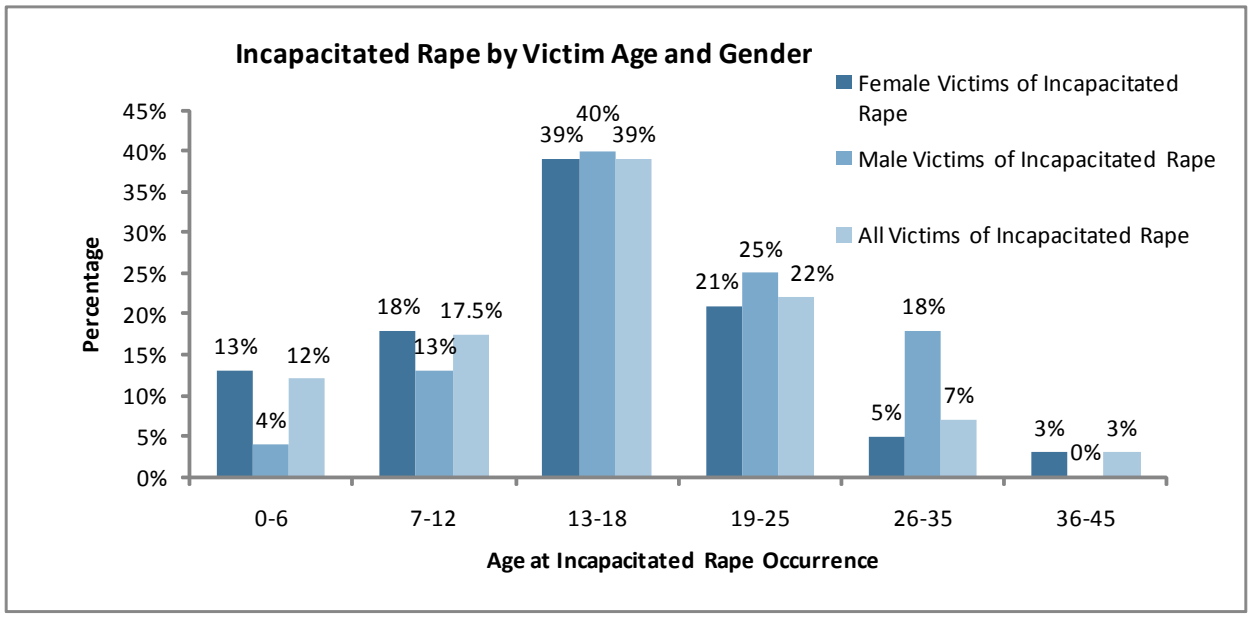
47 *Ibid*.

48 Green, D., Penaloza, L., & Ginossar, T. (2009). *Healthy Choices, Healthy Students: 2007 New Mexico Youth Risk and Resiliency Survey High School Results - Highlights.* University of New Mexico Health Sciences Center, Albuquerque, NM.

were the offenders 39% of the time, with fathers (23%), uncles (16.5%) and stepfathers (12%) accounting for over half of those offenses. Survivors who were victimized by a relative were less likely to seek medical services or allow forensic documentation of the crime. In 42% of the cases the offense was committed in the survivor's home, and another 22% were committed in the offender's home.[49]

Substance use and sexual violence: Though not primary causes of sexual violence, alcohol and drug use can be significant contributing factors to the incidence and severity of sexual violence.[50] In 2007, service providers reported that when survivors used alcohol or other drugs, they were twice as likely (in 45% of the cases) to be victimized by multiple offenders during their sexual assault as those who did not use alcohol or other drugs (22% of the cases), and twice as likely (in 25% of the cases) to be victimized by a stranger as those where alcohol or other drug use was not present (12% of the cases). Offenders were more often under the influence of alcohol or drugs at the time of their perpetration (63% of the time) than their victims were (26%). However, substance use was also present in almost half (46%) of the cases involving Native American survivors, about one quarter of White, non-Hispanic (25%) and Hispanic (27%) survivors, and 14% and 12% respectively in cases of sexual assault perpetrated against those of African American and mixed race/ethnicity.[51]

The VVS indicates that there is a high incidence of incapacitated rape in New Mexico, which means the survivor was very high, very drunk or passed out at the time the crime occurred. One in 12 adult females and one in 40 adult males have experienced incapacitated rape in New Mexico. However, the majority of incapacitated rapes (68.5%) happen not to adults, but to adolescents and children.[52]



Source: Sex Crimes in New Mexico V: An Analysis of Data from the Survey of Violence Victimization in New Mexico and The New Mexico Interpersonal Violence Data Central Repository, 2002-2005.

Reporting of sexual assault: The NVAWS indicated that the majority of rapes in the US are never reported to the police.[53] According to their statistics only 17.2% get reported, which is very similar to New Mexico where

49 Caponera, B. 2008.
50 Harvey, A., et al. 2007.
51 Caponera, B. 2008.
52 Caponera, B. January 2007.
53 Tjaden, P. & Thoennes, N., (July 2000). *Extent, Nature and Consequences of Intimate Partner Violence, Findings from the National*

17% of the rapes are reported according to the VVS.[54] People responding to the surveys gave a variety of reasons for choosing not to report. While there are similarities, more people responding to the NVAWS than the New Mexico victimization survey did not report because they felt the police could not do anything about the crime (13.2%), while more people responding to the VVS than the NVAWS did not report because they were too young when the assault was committed (17%).

Reasons Rapes Were Not Reported to Police

Reason	NVAWS	NM VVS
Too young/a child	3.5%	17%
Fear of Perpetrator	21.2%	16%
Police couldn't do anything	13.2%	3%
Wouldn't be believed	7.1%	6%
Too minor/not serious enough	20.3%	15%
Ashamed/embarrassed/thought it was my fault	16.1%	14%
Wanted to handle it myself	7.7%	5%
Victim or attacker moved away	-	1%
Attacker was a police officer	-	0.5%
Didn't want police involvement	5.8%	4%
Wanted to protect attacker/relationship/children	8.7%	6%
Not sure/other	-	15%

Note: Percentages total more than 100% as respondents could give more than one answer.

Sources: Sex Crimes in New Mexico V: An Analysis of Data from the Survey of Violence Victimization in New Mexico and The New Mexico Interpersonal Violence Data Central Repository, 2002-2005 and Extent, Nature and Consequences of Intimate Partner Violence, Findings from the National Violence Against Women Survey, 2000.

Gaps in sexual violence data: New Mexico Interpersonal Violence Data Central Repository (the Repository) which is housed at NMCSAP is fortunate to have the cooperation of many law enforcement agencies in capturing sex crimes statistics in New Mexico on a quarterly basis, as well as sexual assault reports from rape crisis centers, mental health centers and SANE programs. However, a more complete picture of sexual violence in New Mexico could be achieved if additional sexual violence data were collected and made accessible for analysis.

Two important data sets that are currently unavailable or incomplete regarding documentation of sexual assault are hospital inpatient discharge data (HIDD) and emergency department data. At present New Mexico does not have mandatory external cause of injury coding (E-coding), which would require hospitals and emergency rooms to document in medical records the cause of injury, the intent of the injury (rape is categorized as an intentional injury), and the place where the injury occurred. This information could help inform the development of prevention strategies. It would aid in further describing the incidence and scope of sexual violence in New Mexico and could provide some insight into the financial costs associated with this type of injury.

Violence Against Women Survey. Washington D.C.: National Institute of Justice, Office of Justice Programs, US Department of Justice.

54 Caponera, B. 2008.

New Mexico Income Support Division (NMISD) provides a variety of necessary services to low-income families. These services are designed to help families obtain adequate food, pay utility bills, provide emergency financial aid, pay for prescriptions and apply for Medicaid insurance, among other things. Additional services are available through an affiliate program known as the New Mexico Works Program. As part of increasing family members' employability, this program also offers counseling in the areas of job readiness, drug and alcohol abuse and domestic violence.[55] The families applying for services through NMISD, because of their reduced financial circumstances and related family stressors, are more vulnerable to sexual violence. Devising a means to collect additional, anonymous information about sexual violence from this segment of the population as part of their interview process could provide supplementary information which may not currently be captured through law enforcement or sexual violence service providers.

National data have indicated that Native American women are 2.5 times more likely to be raped than women of other race/ethnicities,[56] yet what we know of sexual victimization of Native Americans in New Mexico is limited. Information from those reporting their violation to participating city, county, and state law enforcement agencies or those seeking sexual violence services is collected for analysis, but most tribal law enforcement agencies have, so far, declined to provide this data to the Repository. The result, which is consistent with data gathered on a national level,[57] is that the information about sexual violence against Native Americans in New Mexico largely represents urban rather than reservation populations.

What the data tell us about vulnerable populations in New Mexico:

Research has shown that certain populations, for a variety of reasons, are more vulnerable to sexual violence. In New Mexico these populations include children, those with disabilities, those living in rural communities, Native Americans, and immigrants.

Children: As stated in the previous discussion of sexual violence, the majority of sexual assault crimes in New Mexico are committed against children. This is confirmed by sexual violence data collected by law enforcement, sexual violence service providers and through the Violence Victimization Survey. Data collected by SANE programs show that, of those receiving their services, slightly more were adults (53%) than children (47%) in 2007.[58,59]

Age in Years of Sexual Violence Victimization by Data Source

Data Source	Ages 0-12	Ages 13-17	*Total Under 18*	Ages 18+
Law enforcement data from 2007	37%	30%	67%	33%
Sexual violence service providers data from 2007	30%	23%	53%	47%
Violence Victimization Survey completed in 2005	44%	23%	67%	33%
SANE program data from 2007	25%	22%	47%	53%

Sources: Sex Crimes in New Mexico V: An Analysis of Data from the Survey of Violence Victimization in New Mexico and The New Mexico Interpersonal Violence Data Central Repository, 2002-2005 and Sex Crimes in New Mexico VII: An Analysis of 2007 Data from The New Mexico Interpersonal Violence Data Central Repository

55 New Mexico Human Services Department, Income Support Division. http://www.hsd.state.nm.us/isd/
56 Amnesty International. *Maze of Injustice: the failure to protect Indigenous women from sexual violence in the USA.* 2007.
57 *Ibid.*
58 Caponera, B. January 2007.
59 Caponera, B. January 2007 and Caponera, B. 2008.

Five Damaging Norms that Contribute to Child Sexual Abuse:

1. Traditional male roles, where society promotes domination, exploitation, objectification, control, oppression, and dangerous, risk-taking behavior in men and boys, often victimizing women and girls.

2. Limited female roles, where from a young age females are often encouraged, through subtle and overt messages, to act and be treated as objects, used and controlled by others. This includes the sexualization of childhood, where young people are sexualized through media and marketing starting at an early age, thus blurring the age of consent, encouraging girls to see themselves as sexual objects, and allowing boys to see themselves as the users and takers.

3. Power, where value is placed on claiming and maintaining control over others. Traditional power expectations promote the notion that children should be seen and not heard, making them an especially vulnerable population.

4. Violence, where aggression is tolerated and accepted as normal behavior and can be used as a way to solve problems and get what one wants.

5. Privacy, where norms associated with individual and family privacy are considered so sacrosanct that secrecy and silence is fostered, sexual violence against children is stigmatized, and those who witness violence are discouraged from intervening. Though changing, this value placed on privacy enables people in a shame-based culture to perpetuate the abuse, rendering victims and their families immobile in the face of public shame and stigma.

Source: Lyles, A., Cohen, L. & Brown, M. (2009). T*ransforming Communities to Prevent Child Sexual Abuse and Exploitation: A Primary Prevention Approach*. The Prevention Institute.

We also know that the majority of the time (85% according to service providers in 2007) the perpetrator is known to the survivor and in 39% of the cases (also service provider data from 2007) the person committing the crime is a family member.[60] Research has shown that the younger a person is when sex was first initiated the more likely it is they were coerced into having sex. Studies indicate that up to 48% of adolescent girls and up to 32% of adolescent boys have reported that their first sexual intercourse experience was forced.[61] Though children are often taught appropriate and inappropriate touch through schools, day cares and other venues, it is extremely difficult for children to enforce these boundaries when the person violating them is someone they likely know, love and trust, or is a respected person of authority.

People with disabilities: People with disabilities (i.e., physical or mental impairments that substantially limit one or more major life activities) are at a much higher risk for sexual victimization than the general population. A recent Bureau of Justice report indicated that they are sexually assaulted at twice the rate of people without disabilities,[62] while several other studies have found that women with severe disabilities are four times as likely to be sexually assaulted as those without disabilities.[63,64] Research has shown that survivors with disabilities know their perpetrators 92% of the time, and they are most often family members, caregivers or others with disabilities.[65]

60 Caponera, B. 2008.
61 Harvey, A., et al. 2007.
62 Rand, M. & Harrell, E. (2009). *Crime against people with disabilities.* Bureau of Justice Statistics Special Report. Washington D.C.: Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.
63 Casteel, C., Martin, S. L., Smith, J.B., Gurka, K. K. & Kupper, L. L. (2008). National study of physical and sexual assault among women with disabilities. *Injury Prevention, 14*, 87-90.
64 Martin, S. L., Ray, N., Sotres-Alvarez, D., Kupper, L. L., Moracco, K.E., Dickens, P.A., scandlin, D. & Gizlice, A. (2006). Physical and sexual assault of women with disabilities. *Violence Against Women, 12(9),* 823-837.
65 Balderian, N. (1991). Sexual abuse of people with developmental disabilities. *Sexuality and Disability, 9 (4)*, 323-335.

The high rates of victimization may be due to a variety of reasons: perpetrators may feel that those they are victimizing are powerless to resist due to the severity and circumstances of their disabilities; survivors may be easier to manipulate due to cognitive disabilities; communication difficulties may make it more challenging to disclose perpetration; and because perpetrators are often family members or caregivers, those with disabilities may have fears of having no one to take care of them if they disclose or that they may be forced to move out of their own home.[66]

Children with disabilities are 2.2 times as likely to be abused as children without disabilities. They are especially vulnerable because of their extreme dependence on their caregivers and their inability to make decisions for themselves or function independently. Children in general have a need for approval from caregivers and parents, and this is often exaggerated in children with disabilities. Inadequate or delayed communication skills may interfere with their ability to disclose abuse. Isolation due to their impairments can result in a lack of knowledge about sex or an unawareness that they are, in fact, being sexually abused.[67]

Research also indicates that children with the most severe disabilities are often the ones that suffer the most extreme forms of abuse. Their abuse is more likely to be chronic in nature, more intrusive and more often accompanied by threats or physical violence.[68]

In 2007 in New Mexico, 16.9% of the population five years old and older had some sort of disability, which could include physical, mental, sensory, self-care, or employment disability. Almost one quarter (24.1%) of those living with a disability in New Mexico live below the poverty level.[69]

Of the service provider reports in 2007 that documented disability of the survivor, 25% of the survivors had a disability at the time of their sexual assault. Two-thirds of those with a disability had chronic mental health problems, while the other third reported having a physical disability.[70] According to the VVS, adult victims of rape are six times more likely to suffer from a chronic mental health condition than the non-victimized adult population. In New Mexico in 2007, more adults with disabilities (37%) were sexual assault victims than were adolescents (19%) or children (24%) with disabilities.[71]

Rural communities: As stated previously in this report, New Mexico averages only 16 people per square mile in a state that is the fifth largest in size in the country (see page 13). The low population density in New Mexico poses significant issues for those who have experienced sexual violence. In small, rural communities often "everyone knows everyone" and options for shopping or other tasks related to maintaining a household are very limited. In those circumstances there is a strong likelihood that the survivor will encounter the perpetrator during routine activities or in social situations. Often there are no services within the community, resulting in the need to drive or be transported to another town to receive rape crisis interventions or medical care. Many in small communities in New Mexico do not have easily accessible transportation, which poses yet another barrier to seeking services or reporting. Research on sexual assault in rural communities has shown

66 *Ibid.*
67 Hershkowitz, I., Lamb, M.E. & Horowitz, D. (2007). Victimization of children with disabilities. *American Journal of Orthopyschiatry, 77(4),* 629-635.
68 *Ibid.*
69 US Census Bureau, American Community Survey 2005-2007. Retrieved from the World Wide Web September 3, 2009: http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S1801&-ds_name=ACS_2007_3YR_G00_&-tree_id=3307&-redoLog=false&-_caller=geoselect&-geo_id=04000US35&-format=&-_lang=en
70 Caponera, B. 2008.
71 *Ibid*.

that the reporting of sexual crimes is lower than in urban areas. This may be due to the lack of anonymity common in small communities, a fear of being stigmatized or blamed for the attack, or the discomfort of reporting to officials which may be acquaintances, business associates or relatives of either the perpetrator or victim.[72,73]

Native Americans: Native Americans or Alaskan Natives comprise 9.4% of New Mexico's population (see page 13). Studies have shown that one in three Native American women will be raped sometime during their lifetime, and they are 2.5 times more likely to be sexually assaulted than non-Native American women in the US. While most violent crime tends to be intraracial, a Bureau of Justice report from 2004 on crime against American Indians showed that 86% of the sexual violence against Native Americans is committed by a non-Native American individual.[74,75] This number may, however, actually be more reflective of the experience of sexual violence by Native Americans in urban populations, as Bureau of Justice data sources primarily capture sexual assaults that occur in urban rather than reservation settings.

The high incidence of sexual violence against indigenous people is one legacy of the historical and cultural oppression experienced by Native American communities after colonization in the US. Ostracized and vilified for their cultural practices and spiritual beliefs, Native Americans were portrayed as savages, primitive, murderous and untrustworthy. This laid the groundwork for a multitude of racist policies including genocide, removal of Native American children to boarding schools and seizure of Native American lands. Degradation of Native American women was widely supported by the dominant culture, and as the ongoing oppression became internalized, was propagated by both non-Native American and Native American men alike.[76,77]

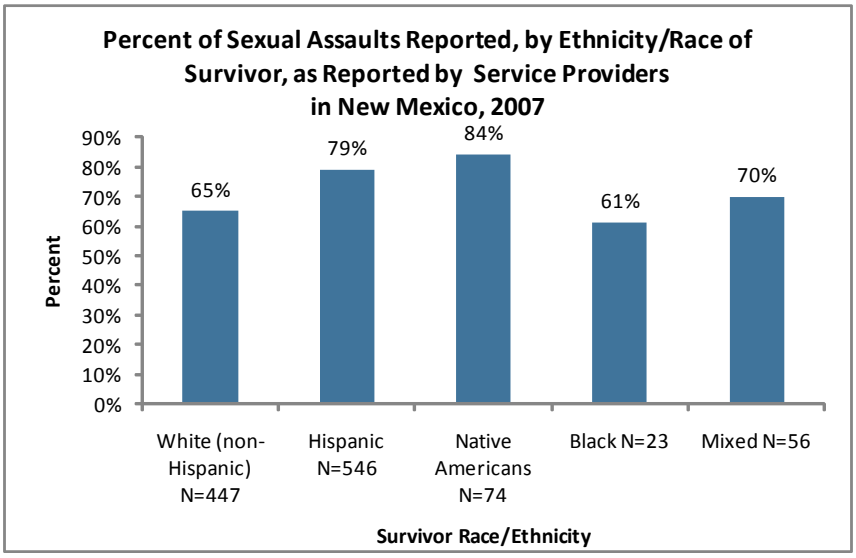
These discriminatory policies also have an ongoing impact on crime and punishment within tribal communities. While prosecution of sexual violence crimes is a difficult process at best, it is far more complicated when sex crimes take place on tribal lands or are perpetrated against Native Americans. Depending on where the crime is committed and whether or not the victim is Native American, tribal police, state police, Bureau of Indian Affairs officers or federal investigators may respond. And because jurisdictional boundaries may be difficult to clearly define, the result may be a delay in legal response or failure to respond at all. This has, in some cases, encouraged violence against indigenous people, as some perpetrators take advantage of opportunities to engage in criminal behavior with minimal consequences.[78,79]

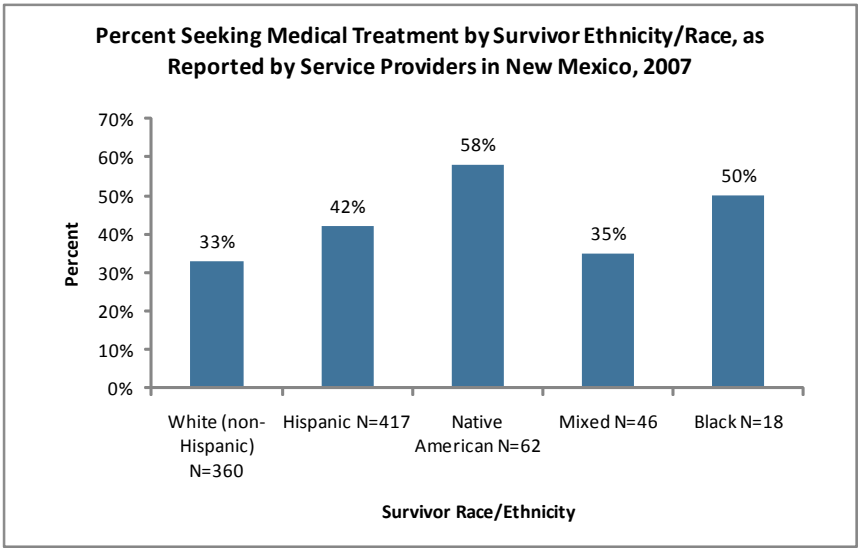
Native American sexual abuse survivors share some of the same issues that impact those in rural communities. They may be reluctant to report because they know their perpetrator and are afraid of being stigmatized or retaliated against within their own community. It is likely that they will, by necessity, continue to see and interact with their perpetrator at religious or community functions. The majority of survivors on tribal or reservation lands in New Mexico who wish to obtain sexual violence services must travel to other locations to receive treatment. Additional complications faced by Native Americans are language and communication barriers. Survivors may be deemed to be non-cooperative by law enforcement or service

72 Lewis, S.H. (2003). *Sexual assault in rural communities.*
73 Lewis, S.H. *Unspoken Crimes: Sexual Assault in Rural America.* National Sexual Violence Resource Center. 2003.
74 Amnesty International. 2007.
75 Perry, S. W. (2004). *American Indians and Crime: A BJS Statistical Profile, 1992-2002.* Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.
76 National Sexual Violence Resource Center. *Sexual Violence in Indian Country, Confronting Sexual Violence.* 2000.
77 Amnesty International. 2007.
78 Bachman, R., et al. 2008.
79 Amnesty International. 2007.

providers, when in fact the primary issue is differences in communication styles based on cultural norms. This miscommunication can result in survivors who choose to report feeling misunderstood, judged and disrespected. Native American survivors may also have an underlying lack of trust for law enforcement or others in authority based on hundreds of years of abusive policies.[80,81]

Although most sexual crimes against indigenous people are perpetrated by intimates, family members or other relatives,[82] Native Americans in New Mexico experienced stranger-perpetrated rape at least twice the rate (28%) of White, non-Hispanics (14%), Hispanics (13%), African Americans (11.5%) and those of mixed race/ethnicity (14%). This may to some degree account for why Native Americans seeking sexual assault services in New Mexico in 2007 were more inclined than those of other race/ethnicities to report their assault to law enforcement, rape crisis centers, emergency rooms, SANE Programs or social service agencies, and why they were more likely to seek medical treatment than those of other race/ethnicities (see graphs below).[83]





Source: Sex Crimes in New Mexico VII: An Analysis of 2007 Data from The New Mexico Interpersonal Violence Data Central Repository

80 National Sexual Violence Resource Center. 2000.
81 Amnesty International. 2007.
82 *Ibid.*
83 Caponera, B. 2008.

Immigrant communities: As noted on page 15, 9.4% of New Mexico's population are immigrants. People immigrate to the US for a variety of reasons, but typically it is to improve the standard of living for themselves and their families. But the transition from one country and culture to another can have an enormous impact on family security and structure, which can leave immigrants, particularly women and children, vulnerable to a variety of abuses, including sexual abuse.[84]

Many are confused about or are not familiar with the US legal system or their legal rights. This leaves them open to manipulation from abusers who use their immigration status and threats of deportation to sexually exploit and abuse them. In some cases husbands or intimate partners warn that if the abuse is reported the abuser could be deported, leaving the women and their children in an economically precarious position.[85]

Immigrant women in particular may be caught between the societal norms of their country of origin and the roles that are possible for them as US residents. By necessity they may take jobs outside of the home or pursue an education, which may cause stigmatization for taking on what may be considered traditionally masculine roles and leave them susceptible to violence directed at controlling their behavior. The current backlash of anti-immigrant sentiment may leave them fearful and mistrustful of reporting abuses or approaching those that may be able to assist them. The definitions of what constitutes rape from one culture to another are inconsistent. The portrayal of sexual violence within popular US culture and media are also inconsistent with messages from rape crisis centers and service organizations, which may lead to further confusion about the sexual violence they may be experiencing. There may also be cultural norms about family privacy; violence in the home may be considered too personal to share with anyone. This fear and shame can isolate immigrant women within their own communities as well as within the dominant culture, and maintaining silence about their sexual abuse may be further reinforced by traditional religious beliefs about their duty to husband and family.[86,87]

Over one third of New Mexico's residents speak a language other than English at home, and almost one third of those (29.1%) speak English "less than very well" (see page 16). The lack of English proficiency can be a significant barrier for sexual assault survivors living in New Mexico, which may be further complicated by divergent communication styles related to cultural differences.[88] Rape crisis service providers, law enforcement and the medical community who have not been trained in both best practices for sexual violence response and cultural competency related to language differences may contribute to further traumatization for those who have experienced sexual violence and are seeking services.

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84 *Building Bridges to Stop Violence Against Immigrant Women, Effective Strategies & Promising Models for Reaching and Serving Immigrant Women.* Albany, NY: Voices for Change: Immigrant Women & State Policy Center for Women in Government & Civil Society, University at Albany. 2004.

85 *Intimate Partner Violence in Immigrant and Refugee Communities: Challenges, Promising Practices and Recommendations.* The Family Violence Prevention Fund for the Robert Wood Johnson Foundation. 2009.

86 *Building Bridges to Stop Violence Against Immigrant Women, Effective Strategies & Promising Models for Reaching and Serving Immigrant Women.* 2004.

87 *Intimate Partner Violence in Immigrant and Refugee Communities: Challenges, Promising Practices and Recommendations.* 2009.

88 *Building Bridges to Stop Violence Against Immigrant Women, Effective Strategies & Promising Models for Reaching and Serving Immigrant Women.* 2004.

Costs of Sexual Violence:

It is extremely difficult to calculate the total societal cost of sexual violence. It is widely known that sexual assaults go largely unreported, so the incidence and prevalence of rape are far higher than what current data indicate. Survivors have more chronic health problems, significantly higher health care costs and more emergency room visits than those who have never been sexually assaulted. Violence, including sexual violence, has also been linked to other types of health care expenditures, such as treatment for depression, HIV/AIDS, sexually-transmitted diseases, unwanted pregnancies, alcohol and drug use and smoking, though these health care costs would be impossible to accurately include in estimates of the total cost of sexual violence.[89,90]

In 2003 the Centers for Disease Control and Prevention (CDC) issued a report that estimated that close to eight million women in the US are raped by an intimate partner at some point in their lives. In addition to subsequent medical and mental health care costs, they reported an average loss of 8.1 days of paid work per incident.[91] The US Department of Justice issued a report in 1996 that estimated that a single incident of sexual assault costs close to $90,000 a year for lost productivity, medical care, mental health care, law enforcement costs, victim services costs and property costs (in 1993 dollars). However, the majority of the cost (over $80,000) is estimated to be lost quality of life. For child sexual abuse the total is estimated to be almost $100,000 a year per incident, with almost $90,000 due to lost quality of life. The Department of Justice estimates that rape and sexual assault are the most expensive crimes, totaling $127 billion a year in 1993 dollars.[92] A report issued by the National Coalition to Prevent Child Sexual Exploitation projects the cost of child sexual abuse in the US to be $23 billion annually in 1993 dollars.[93]

Another consequence of sexual assault is the effect it has on both volunteers and paid staff that work with rape survivors, including service providers and law enforcement officers assigned to sexual assault cases. Providers and responders who have less organizational support within their agency, have more exposure to trauma through higher caseloads, are younger or are less experienced, can undergo burnout (emotional exhaustion and reduced job satisfaction), secondary traumatic stress disorder (similar in symptomology to post-traumatic stress disorder from listening to repeated stories of victimization), or vicarious trauma (intrusive thoughts and imagery). All of these conditions can lead to lower self-esteem, greater levels of interpersonal conflict, substance abuse and mental health issues.[94,95] This contributes to high staff turnover frequently experienced in the field of sexual violence prevention, which in turn factors into organizational costs related to filling staff positions, training new staff and loss of productivity.

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89 World Health Organization. 2002.

90 Bonomi, A. E., Anderson, M. L., Rivara, F. P., Cannon, E. A., Fishman, P. A., Carrell, D., Reid, R. J., & Thompson, R. S. (2008). Health care utilization and costs associated with childhood abuse. *Journal of General Internal Medicine, 23(3)*, 294-299.

91 *Costs of Intimate Partner Violence Against Women in the United States.* Atlanta (GA): Centers for Disease Control and Prevention; 2003.

92 Miller, T.R., Cohen, M. A. & Wiersema, B. (1996). *Victim Costs and Consequences: A New Look.* National Institute of Justice, Office of Justice Program, US Department of Justice.

93 National Coalition to Prevent Child Sexual Exploitation. *The National Plan to Prevent the Sexual Exploitation of Children.* 2008.

94 Baird, S. & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18(1)*, 71-86.

95 Way, I., VanDeusen, K. M., Martin, G., Applegate, B. & Jandle, D. (2004). Vicarious trauma: a comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence, 19(1)*, 49-71.

What communities tell us about sexual violence in New Mexico:

How the information was gathered: The NMDOH Violence Prevention Program in the Office of Injury Prevention contracted with the University of New Mexico Prevention Research Center (UNM PRC) to facilitate the development of a strategic plan for the primary prevention of sexual violence in New Mexico.

The NMCSAP assisted the UNM PRC in developing an Advisory Board of sexual violence services providers from around the state, which included those working in primary prevention, secondary prevention and tertiary services. The role of the Advisory Board was to assist with the development of the Plan in a variety of ways. They provided feedback on the planning process itself and on the tools used in gathering data for the Plan. They reviewed the findings from the planning process and, based on the findings, assisted with the development of goals and objectives for the Plan, and the subsequent Logic Model based on the goals and objectives. Finally, they reviewed draft copies of the Plan and provided oversight of its development.

Working with the NMCSAP and the Advisory Board, the UNM PRC developed a means for gathering local data about sexual violence prevention in New Mexico and for assessing assets and barriers to implementing primary prevention strategies. The methods used to gather data for the Plan were dissemination of a written provider survey, focus groups with sexual violence service providers and community members held regionally around the state and one-on-one interviews with sexual violence service providers conducted over the telephone. Focus groups and interviews were recorded with additional notes taken by hand. Participants were assured that the process was confidential, that all recordings and notes would be destroyed once the Plan was completed, and that any of the participants' remarks that appeared in the report would not be identifiable with names.

Survey, Focus Group and Interview Participants:

Surveys: The survey was distributed at a Sexual Assault Coordinators meeting in July 2008. The purpose of the survey was to learn which organizations were currently engaged in primary prevention, the type of primary prevention services provided, who received the services, if funding was obtained for primary prevention work and what the organizations needed to enhance their primary prevention work. Twenty organizations completed the surveys. The participating providers included Rape Crisis Centers and other sexual assault service providers, behavioral health providers, youth-serving organizations, child abuse services, health providers, consultants, the Corrections Department, SANE providers and organizations serving immigrant populations.

Focus groups: Under the recommendation of the Advisory Group, six focus groups were convened in New Mexico during April and May 2009. They were held in Las Cruces, Farmington, Taos, Albuquerque, Clovis and Dulce. They ranged in size from about seven participants to over 20, and lasted apporximately an hour and a half. Though the majority of representation was from a range of professional organizations and agencies, some focus groups also included individual members of the communities. Among the participants were:

City Council member
State police
College student
Safehouse interviewer
Faith based organization
Schools
Workforce Investment Act (NM Department of Labor)
Sheriff's department victim advocate
District Attorney offices
Rape Crisis Centers
Women's centers
Public health offices
Family crisis centers
Sexual assault service providers
Child abuse prevention and treatment
Federal Bureau of Investigation
City police departments
Community member
Counseling and mental health services
Domestic violence shelters
Parish priest
Juvenile detention center
Youth organizations
Juvenile probation and parole
Office of School and Adolescent Health (NM Department of Health)
Cannon Air Force Base personnel
Sexual Assault Nurse Examiners
NM Children, Youth and Families Department
Teen health center
Business owner
Tribal Council members
Tribal courts
Department of Health and Human Services
Tribal Department of Education
Regional medical center

One-on-one interviews: An initial list of 32 individuals working in the violence against women or child sexual abuse fields was developed as potential one-on-one interview participants. Some of those recommended to be interviewed by the Advisory Group no longer worked at their organization, some had moved out of state or were on extended leave, some never responded to the request to be interviewed and several declined to be interviewed for the Plan, feeling that their work did not specifically relate to sexual violence prevention. Nineteen individuals were ultimately interviewed, interviews lasted an average of 45 minutes, and interviewees represented the following types of organizations:

Rape Crisis Centers
Behavioral health services
Sexual assault services
New Mexico Coalition of Sexual Assault Programs
Behavioral health consultant
Native American-serving sexual and domestic violence services
New Mexico Coalition Against Domestic Violence
Legal services for immigrants
Child sexual abuse services
Adolescent sexual offender treatment
Sexual Assault Nurse Examiners
Adolescent residential treatment

Findings:

Findings from the surveys: (A copy of the survey is included as Appendix A on page 60.) The majority of the organizations completing the provider survey were primarily engaged in secondary or tertiary prevention activities rather than primary prevention, most identifying themselves as Rape Crisis Centers (49%), sexual violence agencies (30%) or mental health agencies (24%)(respondents were able to choose multiple answers). Most (73%) reported that their organization provided sexual violence prevention, sexual health promotion (52%), and domestic violence prevention services (52%), though many provided other types of prevention as well, such as sexually transmitted diseases and pregnancy prevention, diabetes prevention, family preservation and healthy parenting.

Asked about specific *primary prevention* strategies used to prevent sexual violence, the majority of respondents identified community mobilization (52%), many used specific curricula (42%) or provided public presentations (42%), and about one quarter (27%) worked on policy change.

Although further analysis needs to be done with specific organizations, as detail on the surveys was limited, it would appear from the survey responses many may actually be providing awareness-raising activities to certain groups of people or are working in areas of secondary prevention rather than participating in community mobilization efforts for *primary* prevention of *sexual violence*. For example, a sampling of written explanations of what issues the community was being mobilized around included "general awareness and prevention," "prevention education at schools," "changing norms around reporting," "domestic violence prevention," and "Take Back the Night."

In a similar vein, when reviewing answers regarding the use of primary prevention curricula, some met the criteria for theory-driven, research-supported programs that have been shown to impact risk and protective factors for sexual violence (i.e. *Safe Dates*), while other curricula listed have not received the same degree of evaluation in terms of preventing sexual violence. Several reported using curricula that are designed to impact related issues, such as racism or media literacy, but would need further evaluation to show their actual effect on *sexual violence*.

Findings were similar regarding public presentations for the *primary* prevention of sexual violence. It appears from the surveys that providers around the state have been diligent in conducting a variety of presentations addressing topics specific to sexual violence (sexual assault, rape myths), other violence issues (teen dating violence, bullying), root causes of sexual violence (gender roles, oppression), response to sexual violence (reporting laws, how to access services), and how to build infrastructure for sexual violence prevention (policy development, evaluation). But in general, one-time presentations are not considered to be *primary prevention* as they do not provide sufficient dosage to result in changes in behavior or attitudes over time.[96] They are however, important activities for raising awareness about sexual violence, which is a precursor to mobilizing the community to prevent sexual violence.[97, 98]

96 Schewe, P. A. "Interventions to Prevent Sexual Violence." In L.S. Doll, S.E. Bonzo, J.A. Mercy, & D.A. Sleet (Eds.), *Handbook of Injury and Violence Prevention.* New York, NY: Springer Science+Business Media, LLC, 2006, p.236.

97 Michau, L. 2007.

98 Townsend, S.M. *Primary Prevention Resource Kit.* Enola, PA: Pennsylvania Coalition Against Rape. 200?.

The surveys indicate that most providers who responded to the survey were focusing the majority of their prevention efforts within the first two levels of the Spectrum of Prevention: strengthening individual knowledge and skills and promoting community education. However, some (27%) also worked on policy-level changes, most within government organizations (local government 24%, state government 21% and tribal government 12%), while 24% helped develop school policies and 18% worked on policies for local organizations.

When asked what was needed to enhance their primary prevention work, 55% indicated funding and resources, 33% listed training, 18% said work time dedicated to primary prevention, and 15% mentioned dedicated staff for primary prevention.

Findings from the focus groups and interviews: (Copies of the focus group and interview questions are included as Appendices B and C beginning on page 64.) Those in the focus groups were asked a total of 13 questions while an additional five questions were asked of those being interviewed. The responses from both sets of questions are summarized jointly below, but a detailed list of responses is included as Appendix D on page 70.

The main findings were about:

a. Identification of state and local assets for primary prevention
b. How sexual violence is perceived by New Mexico communities
c. The need for more local champions for sexual violence prevention
d. The need for increased partnerships for primary prevention
e. The need to build statewide capacity for the primary prevention of sexual violence through training and technical assistance
f. The need for better coordination of primary prevention services
g. The need for more funding and resources at both the state and local levels
h. Policy recommendations
i. Findings from Native American communities

Bolded statements in quotation marks included in this section are responses from participants to either focus group or one-on-one interview questions.

a. State and local assets for primary prevention:

State assets –

When questioned about what people felt were the biggest assets for being able to provide primary prevention of sexual violence, by far the most identified asset at the state level was the NMCSAP. It was recognized for providing ongoing, statewide training that strengthened primary prevention knowledge, promoting the use of best practices in sexual violence prevention, and for providing funding to local communities, which allows providers to develop interventions that are considered both relevant to and respectful of their neighborhood communities.

Other organizations were also considered to be assets, including Rape Crisis Centers, SANE collaboratives, the Coalition to Stop Violence Against Native Women and The Network, a statewide collaborative of sexual and domestic violence providers, individuals within the criminal justice system, legal advocates and others working to end violence against women.

The Governor and First Lady were considered assets for elevating the status of sexual violence as a health and safety issue and ensuring ongoing financial and legislative support for services and prevention. The annual Advocacy in Action Conference held in Albuquerque was also listed as an asset because it provides both state- and national-level training to professionals in the fields of criminal justice, victim assistance, and mental health who provide services to sexual assault and domestic violence survivors and their families.

Local assets –

Local assets included strong community and personal values like love and respect, supportive families, and a willingness by some communities to learn about sexual violence and work towards ending it. Many specific organizations that address sexual violence and other types of violence were listed, and all of the people working at the local level were seen as assets. Also many felt that their work would be impossible without the networking and collaboration among community organizations that happens at the local level. Organizations approaching their sexual violence work by addressing root causes, such as oppression, discrimination and gender roles, were mentioned as assets as well. One participant felt that the working in primary prevention itself was beneficial:

"Primary prevention is itself an asset, because it is interesting and exciting and can re-engage those who are burned out on direct services or policy development."

b. How sexual violence is perceived by New Mexico communities:

One of the first questions discussed in both the focus groups and interviews was how violence against women is viewed in New Mexico and whether or not people think it is preventable. This question generated some of the richest discussions of any of the questions asked. The overwhelming response from participants was that most people in New Mexico believe that violence against women is not only normal, but to a large extent inevitable. Though acceptance of rape is documented through a wealth of research and is not unique to experiences in New Mexico,[99,100,101,102,103] it is clear from the stories this question generated that beliefs and attitudes justifying rape, sexual coercion and the sexual subordination of women and men in New Mexico has caused incalculable physical and psychological pain. Examples of these responses included:

"There is a feeling in the community like it's no big deal; it happened to my dad, it happened to me, it's part of life and we go on and get over it."

"I was told by my mother to be afraid of men, even men in my family, because maybe that would delay sexual violence, but it would still happen eventually."

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99 World Health Organization. 2002.

100 Weiss, K. (2009). "Boys will be boys" and other gendered accounts. *Violence Against Women, 15(7)*, 810-834.

101 Aosved, A.C. & Long, P.J. (2006). Co-occurrence of rape myth acceptance, sexism, racism, homophobia, ageism, classism, and religious intolerance. *Sex Roles, 55*, 481-492.

102 Michau, L. 2007.

103 Marciniak, L. M. (1998). Adolescent attitudes towards victim precipitation of rape. *Violence and Victims, 13(3)*, 287-300.

"Some women don't know they're being abused. Girls learn that it's normal so they don't recognize it as abuse. They see it as an expression of love."

"I don't think people see it as preventable – they think there are just 'bad people' out there. They don't realize that the bad people are family members, neighbors, acquaintances."

It is clear that all participants struggled with the enormity of this issue. Many recognized that undertaking primary prevention strategies was hampered by the topic of sexual violence itself: participants discussed how for many it is still too uncomfortable to talk about, there is too much stigma and shame associated with it, there are many cultural and religious barriers to speaking openly about it, and internalized racism and sexism continue to reinforce its acceptance as "the way things are." One participant described the problem in this way:

"The subject is difficult to talk about. There is so much misinformation, such a lack of understanding about the underpinnings of sexual violence and it's so uncomfortable for people. How do you have the conversation when people don't even have the language?"

There was also some discussion regarding the difficulty of educating community people on the value of prevention when they are struggling just to meet daily needs. As one participant stated:

"Prevention is the luxury of the non-oppressed."

c. The need for more local champions for sexual violence prevention:

Both focus group and interview participants were questioned about whom the local champions are who speak out against sexual violence in their communities. Several respondents recognized the difficulty of taking on this role, especially in smaller communities. As one person summarized:

"It's scary to speak out against sexual violence. It's unpopular. It's emotionally draining."

While most were easily able to identify someone willing to speak openly about sexual violence and challenge assumptions about who is affected by it and why it happens, such as legislators, local district attorneys, and their own organizational board members, the majority of champions listed were those already working within the sexual violence field. The most identified champions were employees of the NMCSAP, SANE providers or executive directors of local RCCs. A few felt that there were no local champions. Many respondents from smaller communities listed themselves as the only local champion. One stated:

"I'm the local champion through my agency. It's not something people talk about in the community."

d. The need for increased partnerships for primary prevention:

When asked about whom people partner with that are not in the sexual violence field, participants provided an extensive list of organizations, from traditional partners like domestic violence shelters and youth violence prevention organizations, to non-traditional partners like promotoras and organizations serving the homeless. The nature of the partnerships ranged from working together on the local sexual violence Multi-Disciplinary

Team to acting as co-presenters on violence topics to placing awareness-raising brochures in another agency's waiting room. The partnerships were recognized as being important for reasons such as: the root causes of violence are the same, there is strength in numbers, it helps to reduce professional burn-out, it helps to build trust with community members, and everyone has a role in making the community safer. As one person said:

"Any partnership is important because eventually all of us will be touched by sexual violence."

However, when asked about whom they partnered with for *primary prevention*, the response was very different. Though some listed domestic violence shelters, schools or the state sexual violence coalition, many indicated that they did not partner with anyone. There was also some discussion around the difficulty of partnering in some communities due to territorialism, suspicion of new ideas or mistrust of "outsiders." One participant talked about the investment of time needed to make new partnerships work:

"You can't jump right into primary prevention planning or training with new partners – you have to get to know them and understand the language they speak and the core foundations of their work. When you start to work on a brand new issue like this with brand new partners, spending some time just talking and understanding what the values are in that movement and in that field and seeing where you have common ground is important, and that takes a long time."

e. The need to build capacity for primary prevention through training and technical assistance:

Training –
The interview participants were asked about whether sexual violence service providers and communities would benefit from more training on primary prevention. The unanimous response from everyone was yes. Responses included:

"People need training on what primary prevention is and how it differs from intervention, and what effective strategies are."

"We need education on different [primary prevention] strategies and how to implement them."

"We can always benefit from learning more about primary prevention and techniques."

Some identified specific types of training they thought would be beneficial, such as:

"I would like training on sexual violence within the public health model and the ecological model."

Though some encouraged the use of webinars, as travel time and distance to training were seen as barriers, most felt that networking with others was helpful and wanted training that allowed interaction with other professionals. The following response was echoed by many:

"I like networking, sharing ideas with others. Webinars are really helpful but [I] also [like] getting people together to share information."

Once trained, many felt they could share their knowledge with others in the communities through train-the-trainer models.

Technical assistance –
Many felt, though, that training was not enough. They wanted more interaction with "experts" who could assist them in applying what they had learned, and the lack of available technical assistance was seen as a barrier at both the state and local levels to effectively implementing primary prevention strategies. As one participant stated:

"We need more one-on-one technical assistance to individual organizations."

Another said:

"We need hands-on examples of how it [primary prevention] could work – something that could be implemented in the communities, letting people practice it, letting experts provide immediate support. It needs to be more than theory; it needs to have a practical application."

f. The need for better coordination of primary prevention services:

Respondents in both focus groups and interviews were asked how well they thought primary prevention services were coordinated at both the state and local levels. Participants universally agree that coordination at both levels could be improved. Many are curious about what primary prevention activities are being implemented in other parts of the state, as evidenced in these comments:

"Things are not coordinated at the state level. I know some of the [sexual violence prevention] agencies through rape crisis services, but I don't know specifically what others are doing. We could benefit from knowing what others are doing that is successful."

"I think there are a number of prevention-minded organizations that don't know about each other. Services get replicated. We need more networking to improve services."

"It would be good if programs knew more about each other before new initiatives are started."

They want better communication between the NMCSAP and providers, and among providers themselves. As one said:

"It would be helpful to learn about each other. More communication would be good as everyone has their own protocols. More coordination would provide better service."

Participants want more opportunities to network, and many feel that regional meetings in addition to statewide gatherings would do much to strengthen coordination of primary prevention services, as regional meetings might allow for broader participation. Comments in this area included:

"Everything is centralized to Santa Fe or Albuquerque so they're often inaccessible to other parts of the state. In other states they have regional meetings in addition to state coalitions."

"I suggest that meetings should be held in different parts of the state rather than always in Albuquerque. Maybe we could rotate around the state so some meetings are easier to attend."

"Regional meetings would help. Opportunities should be more inclusive of the community, in other words, allow organizations to invite more than their own staff members to trainings, etc."

One respondent noted the connection between training and coordination for placing primary prevention work within a larger context:

"Things would be better coordinated if more were trained in primary prevention. Then we could have task forces or work groups working on concrete goals. Prevention should be more than people working in outreach."

g. The need for more funding and resources at both the state and local levels:

When questioned about barriers to implementing primary prevention of sexual violence at the state and local level, the lack of funding and resources was listed in both focus groups and interviews more than any other barrier. There was a strong sense that, though sexual violence impacts so many individuals and families in New Mexico, addressing it is not a priority for the state and prevention programs suffer. It is a source of frustration for those working in sexual violence prevention, as apparent in these comments:

"The biggest barrier is money. We have ideas about what to do in the community but have no staff or funding to implement them. It's an issue of priority – there is money for prisons but not prevention."

"Good programs get cut because of funding issues."

"Prevention is key. It's just as important as educating about social issues like smoking and DWI; sexual violence is right up there with them. We need more funding. The state needs to take the problem seriously."

"Even though there are state funds designated, the funding doesn't go far enough because the problem is so big. Everyone is maxed out so it's difficult for people to take on more or take leadership roles without the work being supported through funding. We're dependent on a system of volunteers."

Many programs try to incorporate some type of primary prevention services into their work though they do not get specific funding for it. Several piece together funding from multiple small grants to support primary prevention. As one participant stated:

"No one is 100% dedicated to sexual violence prevention because of a lack of funding. We have to wear many hats."

The organizations also spend a significant portion of time and energy trying to secure more funding for their agencies, but usually only a small portion, if any, can be dedicated to primary prevention. One participant described one of the reasons why primary prevention is so important:

"I wish we had money to dedicate to it [primary prevention]. Every bit of money that goes into prevention saves money in the long run."

h. Policy recommendations:

Participants were asked what sexual violence prevention policies they would recommend, and many want mandatory funding for primary prevention. One person talked about how designating money only for intervention without recognizing the interrelatedness between prevention and intervention can cause programs to be less effective:

"In prevention the biggest piece is funding guidelines so that they are able to spend the money on prevention activities. Sometimes we've seen, at the federal level, that funding sources have been very restricted to just the service pieces instead of bringing prevention into it. There is an intersection between prevention and intervention so the idea that the two are separate is not the case. There has to be a focus for the money, but siloing funding streams doesn't work in practice."

Other frequently mentioned suggestions were mandatory, comprehensive primary prevention curriculum in the schools at all grade levels with a component for staff as well as students, and mandatory training in sexual violence for all law enforcement, judges and others associated with the criminal justice system. Several others recommended expanding the scope of the Governor-appointed Domestic Violence Czar to include sexual violence and child sexual abuse. It was believed that this would advance the status of sexual violence, which could result in increased state or local funds to support primary prevention. One participant emphasized that state-level, mandated prevention policies should always have funding attached; otherwise it is unrealistic to expect consistent implementation. However, some warned that policy should be developed carefully to minimize unintended consequences, such as:

"We need policies that are less punitive. For instance zero tolerance in schools has been counterproductive."

"We need to have an analysis of existing policies that act as barriers, like No Child Left Behind. We should involve providers in the development of policies so policies are not detrimental."

"The current offender policy is not healthy in the state and needs to be revisited. I would highlight to the community the inadequacy of the sexual offender registry. For example some think they don't have to worry about sexual violence because there is a registry or they personalize it because there is an offender on their street, so the middle continuum gets lost. Offenders are uncles, brothers, fathers, friends, so we want them not to reoffend; the registry doesn't stop reoffending. The nature of the policy is punitive and isolating – it's not healing or therapeutic or inclusive."

i. Findings from Native American communities:

Though not specifically listed by nation in this Plan to help protect the confidentiality of participants, Native Americans from multiple New Mexico-based tribes were represented in both focus groups and one-on-one interviews. The information received from Native Americans in both the focus groups and interviews closely aligned with national reports regarding sexual violence in Native American communities (see page 26). The

purpose of speaking with people working in communities around the state was to learn more about the local status of primary prevention activities for sexual violence. However, the feedback from Native American participants indicates that it is especially difficult for Native American communities to focus resources on primary prevention when the provision of basic services, such as rape crisis, medical response, and criminal investigations, is minimal or nonexistent, and those who have been sexually assaulted become further marginalized within their own communities. Several participants summarized it this way:

"These questions [about primary prevention] don't apply to us."

"It's not a clear cut question [about whether sexual violence is preventable]; it's not preventable if there is no penalty for it. There is no protection for the victims."

It was evident in both the focus groups and one-on-one interviews that justice for survivors of sexual violence on tribal lands is of foremost importance. Much of the conversation focused on the lack of local services and the abysmal response of both criminal investigation and prosecution. The universal feeling was that if a sexual assault happens to a Native American, it is seen by the criminal justice system both on and off the reservation as a trivial matter, as "just the way it is," or too much bother because of jurisdictional issues. This perpetuates historical trauma, the underlying message that Native American people are somehow less deserving of the basic rights that others receive.[104] The deep concern and frustration from participants regarding justice for survivors is evident in the following sampling of comments:

"We're still at the mercy of federal prosecution – FBI, BIA – meaning that even if the community takes sexual violence seriously, [if] someone reports but [then] has to travel for a SANE exam, then has to get the US Attorney General to prosecute, which is pretty weak...so even if the community supports the person who has been traumatized, if the perpetrator is still allowed to stay in the community with no consequences, then the chance of future reporting is pretty low. If resources don't allow support of the victim then we won't get very far."

"It's possible to prevent it [sexual violence] but there is nowhere for people to go to get justice. The police force is untrained to handle the situation when it occurs without contaminating it or ruining the scene; there is no intervention from the outside, FBI, BIA, other agencies. They don't want anything to do with it."

"Many times police won't even respond to sexual assault calls on the reservation. They refuse to prosecute even with clear evidence of assault."

"There are no places for victims to go [for help], and the perpetrators get a slap on the wrist due to ineffective laws."

"There is lots of distrust of law enforcement so many things go unreported."

As in the rest of the state, people felt that coordination of prevention services was lacking, both within individual tribes, among tribes throughout the state and with other sexual violence prevention services across the state. There was a desire to know more about what others were doing in the area of primary prevention,

104 Amnesty International. 2007.

and a wish that there was better communication with others working in the sexual violence prevention field. Though statewide coordination was viewed as a way to improve services, one participant was not sure that it was even possible:

"There should be statewide coordination but there isn't because of sovereignty issues. We would have to give up some sovereignty to have a stronger relationship with the outside."

One felt that better coordination would only be possible when tribal leaders better understood sexual violence and supported prevention efforts:

"Besides the Rape Crisis Centers they [sexual violence prevention services in the state] aren't coordinated as well as they could be. [Native American communities] and rural areas are not well coordinated. [Native American communities] are not coordinated either among themselves or with other sexual violence providers around the state. [Successful coordination] comes from having well-trained leaders and getting them on board. If leaders and the powerful supported sexual violence prevention more changes would be made."

There was also recognition among Native American respondents that coordination for sexual violence prevention and response was sometimes hampered by territorialism. For example:

"It's more than a jurisdiction issue – it's very territorial, there is much denial of the issue [of sexual violence]. It's very frustrating and bureaucratic."

"All the tribal departments need to work together, there needs to be a group effort, men and women working together."

"People know each other. They grew up together. They won't work well together if they don't like each other."

"It's difficult to partner in our community due to the lack of trust and communication issues."

Findings from Native American respondents also indicate that there is a need for more training and technical assistance in Native American communities, in addition to improved coordination. As one person said:

"The barriers in the community are communication and collaboration, but we also need some expertise and technical support [to prevent sexual violence]."

Implementation of the Public Health Model – Step 2: Identifying Risk and Protective Factors

The second step in applying the Public Health Model is to identify the risk and protective factors associated with the public health issue at hand, in this case sexual violence. To a large extent males are at greater risk for sexual violence perpetration and females are at greater risk for victimization. Neither perpetration nor victimization is caused by any single influence. It is not always clear why someone initiates this violent act or is subjected to it, while another in similar circumstances is unaffected. However, it is known that the more risk factors present, the higher the likelihood that sexual violence will occur.

While risk factors for perpetration and victimization have been documented in numerous studies, protective factors for sexual violence are less well understood. Some research has been focused on protective factors against adolescent sexual aggression, but more scientific evidence must be gathered to support the development of primary prevention strategies focused on reducing sexual violence through increasing protective factors.

Both Casey and Lyndhorst (2009) and the World Health Organization (2002) have documented risk factors for sexual violence perpetration across the ecological spheres.[105,106] These include:

Individual level risk factors for sexual violence perpetration:

- Abuse experiences in childhood, especially sexual exploitation and physical abuse
- Negative, hostile or dominating attitude toward women
- Endorsement of traditional male gender roles
- Endorsement of rape myths
- Tolerance for interpersonal violence
- Nonintimacy-based approach to sexual intercourse
- Implicit theories about gender and sex, such as male entitlement or women as sex objects
- Deviant sexual arousal, such as a conditioned response to sexual violence or use of violent pornography which may act as disinhibitor to sexual aggression
- Alcohol as a tool of coercion or as a disinhibitor to sexual aggression
- Lack of empathy

Peer/Relationship level risk factors for sexual violence perpetration:

- Membership in social networks that support rape-supportive norms
- Association with peers who use alcohol as coercive tactics to gain sex
- Association with peers who reinforce hostile talk or behavior toward women
- Membership in fraternities or aggressive all-male sports teams among college males
- Family environment characterized by physical violence and few resources
- Strong patriarchal relationship or family environment
- Emotionally unsupportive family environment

105 Casey, E. A. & Lyndhorst, T.P. 2009.
106 World Health Organization. 2002.

Community level risk factors for sexual violence perpetration:

- Extreme patriarchal social structures
- High tolerance for violence
- Greater separation of sexes in labor or political institutions
- Lack of employment opportunities

Societal level risk factors for sexual violence perpetration

- Poverty
- Social norms supportive of sexual violence
- Lack of accountability for perpetrators
- Environments in which women hold subordinate status
- High levels of crime and other forms of violence

Risk factors for sexual violence victimization

The World Health Organization has also identified risk factors for sexual violence victimization,[107] which include:

- Being female
- Being married or co-habitating
- Being young
- Consuming alcohol or drugs
- Having previously been raped or sexually abused
- Having many sexual partners
- Involvement in sex work
- Becoming more educated and economically empowered, at least where sexual violence perpetrated by an intimate partner is concerned
- Poverty

Risk factors for intimate partner violence

Though intimate partner violence (IPV) includes many types of violence, it is worth mentioning risk factors associated with IPV as it is well-documented that sexual violence is often another tool for establishing power and control within these types of relationships.[108] These risk factors include:

- Being unmarried but cohabitating
- Being a minority
- Being of lower income
- Being less educated
- Couples with income, educational or occupational status disparities
- Experiencing or witnessing family violence in the family of origin
- Relationship dynamics which include power being concentrated in the hands of the male, the male making most of the decisions regarding family finances, and the male strictly controlling where the female is allowed to go

107 World Health Organization. 2002.
108 Tjaden, P. & Thoennes, N., July 2000

Protective factors for adolescent sexual aggression

Borowsky, Hogan and Ireland (1997) analyzed data from over 70,000 9th to 12th grade students who had completed the 1992 Minnesota Student Survey. They compared the results of those who had reported a history of forcing someone into a sexual act with those who had never forced someone into a sexual act.[109] Their analysis identified the following protective factors for adolescent sexual aggression:

- Having a caring relationship with a competent adult (for both males and females)
- School and family connectedness (for both males and females)
- Emotional health (for males)
- Connectedness with friends and adults in the community (for males)
- Higher academic performance (for females)

109 Borowsky, W. et al. 1997.

Implementation of the Public Health Model – Step 3: Developing and Testing Prevention Strategies

In this step of the Public Health Model the information learned from steps one and two drives the development of prevention strategies, which are also guided by scientific research relevant to the findings. Data from the Repository along with national research on populations vulnerable to sexual violence and best practices research on primary prevention emphasize the need for a well-organized, strategic response to sexual violence at multiple levels of intervention to decrease the impact of sexual violence in New Mexico.

However, the findings from the survey, focus groups and interviews indicate that there is some preliminary work in capacity building for primary prevention that should be done prior to taking the step of developing specific primary prevention strategies for particular populations in New Mexico. Research on capacity building, explained more fully in the following paragraphs, is congruent with these findings. It shows that building capacity, both at community and organizational levels, through training, technical assistance, the development of strong leadership and infrastructure is crucial for the sustainability and success of community-level prevention efforts. Additionally, research indicates that the community's readiness to engage in a process of change must also be fostered within the course of building capacity.

Building capacity for the primary prevention of sexual violence:

Community readiness –

Community readiness is an ongoing process whereby communities typically go through nine stages of advancing readiness to address an identified issue impacting them. In this process they move from the first stage of wide-scale tolerance of an identified problem to the ninth stage where they have sophisticated knowledge of risk and protective factors related to the problem, are highly supportive of prevention efforts and take leadership for addressing the problem.[110]

The many awareness-raising activities and presentations which have been implemented throughout the state, as discussed in the Findings section, lay valuable groundwork for moving communities in New Mexico from awareness of sexual violence to readiness for change.[111] Additionally, over half the respondents of the provider survey indicate they are involved in mobilizing their community, which is also an important component of effecting change across the socioecological model. Community mobilization moves beyond raising awareness to motivating action around a specific issue from diverse sectors of the community over a sustained period of time. Through community mobilization the citizens provide leadership throughout the process of change, rather than functioning as passive recipients of externally initiated programs, further supporting community readiness.[112,113,114]

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110 Edwards, R. W., Jumper-Thurman, P., Plested, B. A., Oetting, E. R., & Swanson, L. (2000). Community readiness: research to practice. *Journal of Community Psychology, 28(3)*, 291-307.

111 Townsend, S.M. 200?.

112 Centers for Disease Control and Prevention. *Community Mobilization Guide: A Community-Based Effort to End Syphilis in the United States.* Atlanta, GA: Centers for Disease Control and Prevention, Department of Health and Human Services.

113 Harvey, A., et al. 2007.

114 Michau, L. (2007). Approaching old problems in new ways: community mobilization as a primary prevention strategy to combat violence against women. *Gender and Development, 15(1)*, 95-109.

Why mobilize a community:

- It can infuse new energy into an issue through community buy-in and support.
- Expand the base of community support for an issue or organization.
- Help a community overcome denial of a health issue.
- Promote local ownership and decision-making about a health issue.
- Encourage collaboration between individuals and organizations.
- Limit competition and redundancy of services and outreach efforts.
- Provide a focus for prevention planning and implementation efforts.
- Create public presence and pressure to change laws, polices, and practices — progress that could not be made by just one individual or organization.
- Bring new community volunteers together (because of increased visibility).
- Increase cross-sector collaboration and shared resources.
- Increase access to funding opportunities for organizations and promote long-term, organizational commitment to social and health-related issues.

Source: Community Mobilization Guide: A community-Based Effort to End Syphilis in the United States. CDC.

Assessing and building both organizational and community readiness for the primary prevention of sexual violence is key for successfully reducing sexual violence across the state. Research shows that organizations that can assist communities in assessing their readiness for change and help move them through progressive stages of readiness will likely have better community-level outcomes for impacting identified issues, such as sexual violence.[115] As the capacity of providers to initiate primary prevention strategies is increased, so must the community's readiness and capacity to address sexual violence be increased.[116,117] Just as sexual violence is often viewed as "normal," people in the community must come to see that their involvement in the process of change is also "normal." [118]

Training and technical assistance –

As indicated in the findings from the provider survey, focus groups and interviews, most sexual violence prevention efforts in New Mexico are aimed at individual behavior change and community education, in spite of the acknowledged difficulty of even broaching the topic of sexual violence with many in the community, and the limitations of these approaches in having a broader impact on sexual violence through changing rape-supportive norms. This speaks of the need for training in primary prevention of sexual violence to help sexual violence service providers develop a more global understanding of how to approach sexual violence prevention, and a fuller comprehension of options for implementing primary prevention across the Spectrum of Prevention. Programs grounded in prevention theory and executed by well-trained staff are two characteristics that have been identified with successful prevention programs.[119] Additionally, MacDonald and Green (2001) indicate that having a strong theoretical basis in prevention is necessary for capacity building and can help to

115 Chinman, M., Imm, P. & Wandersman, A. *Getting to Outcomes 2004: Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation.* Santa Monica, CA: The Rand Corporation, 2004.

116 Sabol, W., Coulton, C.J., & Korbin, J.E. (2004). Building community capacity for violence prevention. *Journal of Interpersonal Violence, 19(322)*, 322-340.

117 Smith, N., Littlejohns, L. B. & Thompson, D. (2001). Shaking out the cobwebs: insights into community capacity and its relation to health outcomes. *Community Development Journal, 36(1)*, 30-41.

118 KU Work Group for Community Health and Development (2009). *Chapter 1, Section 3: Our Model of Practice: Building Capacity for Community and System Change.* Lawrence, KS: University of Kansas. Retrieved June 15, 2009, from the World Wide Web: http://ctb.ku.edu/tools/en/sub_section_main_1002.htm.

119 Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention: principles of effective prevention programs. *American Psychologist, 58*, 449-456.

keep practitioners from being drawn into intervention and response rather than prevention implementation and planning.[120]

Parks, Cohen and Kravitz-Wirtz (2007) found that technical assistance in addition to training is needed to successfully implement primary prevention. By combining training with focused technical assistance, groups who have developed some insight into the problem of sexual violence can learn what their options are for addressing it and then how to effectively apply interventions.[121]

Mitchell, Florin and Stevenson (2002) found that technical assistance should be linked to specific needs identified by the local community or organization, geared toward their particular level of readiness. Their research shows that involving the local entity in designing a technical assistance plan jointly with the technical assistance providers helps to ensure adequate levels of technical assistance "penetration." The technical assistance should also realistically reflect the community's or organization's level of commitment based on their resources. It should respect local understanding of what would be workable within the context of their socioeconomic, ethnic and political composition rather than rely solely on scientific knowledge about effective prevention programming. [122]

Leadership –

The findings show that the majority of local champions for sexual violence prevention are those already working in the sexual violence prevention field. This indicates that focused technical assistance and support may also be needed to foster the development of additional local champions.

Using an assets-based approach to develop local leadership (champions), both within organizations and within communities, is of primary significance for building capacity and mobilizing for positive change within a community. Lempa, Goodman, Rice and Becker (2008) list ten dimensions of community capacity: leadership, citizen participation, skills, networks, resources, sense of community, community power, understanding community history, values, and critical reflection. These dimensions underscore the importance of building relationships across levels of the socioecological framework, but the researchers emphasize that the cultivation of competent leadership is the most essential as it drives the success of the project.[123] Butterfoss (2004) also underscores the importance of leadership capacity within the community to assure the sustainability of efforts, as well as ongoing technical assistance to support increased capacity.[124]

Infrastructure –

The findings also discuss the need to develop more infrastructure across the state to support the primary prevention of sexual violence. Participants specifically mention issues related to coordination of sexual violence prevention programs, the desire for more opportunities to network with other providers and the need for increased funding.

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120 MacDonald, M. A. & Green, L.W. (2001). Reconciling concept and context: the dilemma of implementation in school-based health promotion. *Health Education and Behavior, 28*, 749-768.

121 Parks, L.F., Cohen, L. & Kravitz-Wirtz, N. *Poised for Prevention, Advancing Promising Approaches to Primary Prevention of Intimate Partner Violence.* Prepared for the Robert Wood Johnson Foundation by The Prevention Institute. 2007.

122 Mitchell, R. E., Florin, P. & Stevenson, J. F. (2002). Supporting community-based prevention and health promotion initiatives: developing effective technical assistance systems. *Health Education & Behavior, 29(5)*, 620-639.

123 Lempa, M., Goodman, R. M., Rice, J. & Becker, A. B. (2008). Development of scales measuring the capacity of community-based initiatives. *Health Education & Behavior, 35(3)*, 298-315.

124 Butterfoss, F. D. (2004). The coalition technical assistance and training framework: helping community coalitions help themselves. *Health Promotion Practice, 5(2)*, 118-126.

Improved coordination, including responding to the many requests for regional meetings, would strengthen the relationship between primary prevention providers in New Mexico. Studies verify the importance of these relationships as an integral part of capacity building and sustainability,[125,126] and show how they contribute to increased resources for planning and implementation.[127]

Participants also indicate that they typically do not partner with others on the primary prevention of sexual violence. Increasing coordination and networking opportunities could aid in the development of this type of collaboration. However, the participants' lack of identifiable partners for primary prevention may also be a result of the lack of dedicated primary prevention funding or staff positions that would allow their organizations to build stronger partnerships for primary prevention.

Just as capacity is dependent on well-trained staff, strong leadership and technical capabilities, so too is it dependent on adequate and sustained funding.[128] Insufficient funding for sexual violence prevention programs is pervasive in New Mexico, related to fiscal priorities at both the state and federal levels. The lack of funding for primary prevention is due, in part, to Rape Prevention and Education (RPE) funds, the only dedicated federal funds for sexual violence prevention, being financed at approximately half the amount authorized since the program's inception.[129] Though the motivation of sexual violence prevention providers in New Mexico to provide primary prevention of sexual violence is strong, without more dedicated funding, progress in ending sexual violence will continue to be incremental.

Capacity building within Native American communities –

While this Plan is intended to support the primary prevention of sexual violence in all communities throughout New Mexico, Native American respondents indicate that it may be premature for Native American communities in New Mexico to address capacity building for primary prevention when basic issues of justice and safety for sexual violence survivors have not been addressed. Further discussion and planning within and among Native American communities may be required to identify an appropriate course of action to address sexual violence, perhaps building capacity first for coordinated and effective criminal response and prosecution.

Additionally, Chino and DeBruyn (2006) suggest that capacity building within indigenous communities may require a different course of action than what is usually recommended. The danger of moving quickly into the process of building leadership and initiating action can lead to failure if historical trauma, racism and disparities are not acknowledged and treated in significant ways. Time must be devoted to building trust and effective communication between all partners. However, the sustained effort needed to address health outcomes in the long term may be difficult when immediate needs within tribal communities can be so great and human and fiscal resources at the local level can be inadequate in relation to the need. Chino and DeBruyn propose that a framework for capacity building developed by and for indigenous people would be beneficial for furthering public health within Native American communities,[130] and the possible necessity of

125 Wells, R., Ford, E. W., McClure, J. A., Holt, M. L. & Ward, A. (2007). Community-based coalitions' capacity for sustainable action: the role of relationships. *Health Education & Behavior, 34(1)*, 124-139.

126 McLeroy, K.R., Norton, B. L., Kegler, M. C., Burdine, J. N. & Sumaya, C. V. 2003.

127 Butterfoss, F. 2007.

128 Martin, S.L., et al. 2009.

129 Roe, K.J. (2004). *The Violence Against Women Act and Its Impact on Sexual Violence Public Policy: Looking Back and Looking Forward.* National Alliance to End Sexual Violence.

130 Chino, M. & DeBruyn, L. (2006). Building true capacity: indigenous models for indigenous communities. *American Journal of Public Health, 96(4)*, 596-599.

this should be a consideration as implementation of this Plan is initiated.

Furthermore, an unpublished report by the US Department of Justice on violence against American Indian and Alaska Native women indicates that the development of effective culturally-based prevention strategies would be significantly enhanced by the use of survey instruments implemented in local Native American populations, as most information about sexual violence against Native Americans reflects urban rather than reservation experiences. The report suggests that surveys would more accurately capture what happens to survivors of sexual assault in Native American communities, but recognizes that cost of this methodology is often prohibitive.[131] A collaborative process involving tribal communities, the Repository, the Coalition to Stop Violence Against Native Women, NMCSAP, academic institutions and other possible partners might make the development and implementation of a survey specific to Native American communities in New Mexico a viable future project. The information from the survey would both improve violence against women work in New Mexico and provide additional information about the capacity to prevent sexual violence in Native American communities.

How the findings in New Mexico compare with findings from the CDC:

It is interesting to compare the findings in this Plan with findings from a training needs assessment funded by the National Center of Injury Prevention and Control (NCIPC) at the CDC and conducted by the PREVENT Program (Preventing Violence Through Education, Networks and Technical Assistance) with states receiving Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) and Rape Prevention and Education (RPE) funding from the CDC. Through their assessment the PREVENT program identifies nine topics that those working in the DELTA and RPE programs most want to learn more about, which bear a strong resemblance to the findings from the survey, focus groups and interviews. The topics include:

- A clear understanding of what primary violence prevention is and is not
- How to work at a community or population level
- How to design, implement, and evaluate prevention activities
- How to identify effective violence prevention programs to use as models
- How to access, use, interpret, and present research data
- How to disseminate information to partners and stakeholders
- How to serve as a violence prevention resource to others
- How to obtain and maintain funding for prevention work
- How to maintain and enhance partnerships for violence prevention activities

Many participating in the CDC-funded study also indicate that they prefer face-to-face trainings to enhance networking, feel that regional meetings would be beneficial, and want organizational-level technical assistance in implementing primary prevention strategies.[132]

131 Bachman, R., Zaykowski, H., Kallmyer, R., Poteyeva, M. & Lanier, C. *Violence Against American Indian and Alaska Native Women and the Criminal Justice Response: What is Known.* Unpublished report by the US Department of Justice. 2008.

132 Martin, S.L., Coyne-Beasley, T., Hoehn, M., Mathew, M., Runyan, C.W., Orton, S. & Royster, L. (2009). Primary prevention of violence against women: training needs of violence practitioners. *Violence Against Women, 15(1)*, 44-56.

Recommendations:

In response to the findings from the surveys, focus groups and interviews, the Advisory Group, NMCSAP, NMDOH and the UNM PRC developed the following recommendations:

1. ***Sexual violence should be recognized in New Mexico as an issue of basic human rights.*** Sexual violence prevention in New Mexico is complicated by the general belief in most communities that sexual violence is acceptable and to a large extent inevitable. It cannot be impacted by the sexual violence prevention community alone but needs a coordinated response at both the grassroots and state levels, and across prevention and legal disciplines to be understood and addressed as a human rights issue.

2. ***The capacity for primary prevention of sexual violence should be increased across the state.*** Sexual violence prevention providers in New Mexico are functioning at many different levels in their fundamental understanding of what primary prevention of sexual violence is and how its strategies can be effectively implemented. Building capacity in the primary prevention of sexual violence would assure that it is being addressed comprehensively across the state while also strengthening the network of those working in primary prevention.

3. Anti-oppression training should be provided to sexual violence prevention providers throughout New Mexico. Sexual violence prevention providers in New Mexico do not all share a common language for discussing the root causes of sexual violence. Providing anti-oppression training in all communities would establish sexual violence within a larger context, expanding the framework from which the organizations work and increasing the possibilities of innovative partnership.

4. ***Statewide coordination of sexual violence prevention services should be strengthened.*** Sexual violence prevention providers in New Mexico do not feel well connected to their colleagues across the state who are engaged in the primary prevention of sexual violence. Strengthening statewide coordination through the NMCSAP and NMDOH would provide the support and networking that encourages collaboration, fosters the development of new ideas and encourages cross-training and sharing of local successes.

5. ***Advocacy skills for the primary prevention of sexual violence among sexual violence prevention providers should be increased through training and technical assistance.*** Inadequate funding for the primary prevention of sexual violence has been identified at both the state and local levels. Advocacy for the primary prevention of sexual violence, including advocacy for funding, should be enhanced through training, technical assistance and coordination, while opportunities for expanding and sharing current resources should be explored at all levels.

As stated previously, this Strategic Plan is intended to support the sexual violence prevention work in all communities throughout New Mexico, and is intended to be inclusive of all who are working to end sexual violence. However, the following recommendation was developed in recognition that the concerns expressed by tribal participants primarily centered on issues of sexual violence response and criminal justice.

6. ***Native American communities should be supported in identifying how best to address sexual violence in their communities.*** There are some commonalities among the issues described by sexual violence prevention providers in Native American communities in New Mexico and those non-Native American providers in the rest of the state, but the lack of prosecution of sexual crimes on Native American lands, complicated by jurisdictional issues between the state, counties, the federal government and Sovereign Nations seems to far outweigh those commonalities at this time. It may be that tribal communities may be better served to collaboratively develop among themselves a strategic plan for sexual violence prevention that reflects their own strengths, barriers and resources for responding to and preventing sexual violence. Should there be an interest among Native American communities or within individual Native American communities for exploring this option, support for the endeavor as identified by Native American communities as most beneficial to their process should be offered by NMDOH, NMCSAP and the sexual violence prevention community throughout the state.

Implementing the recommendations:

Based on the findings, research and recommendations, the Advisory Group, NMCSAP, NMDOH and the UNM PRC developed a three-year implementation plan designed to increase the capacity of sexual violence prevention providers to understand and use primary prevention theories and strategies, to increase their ability to advocate for sexual violence prevention and to develop both organizational and community leadership for the primary prevention of sexual violence.

This will be accomplished through the provision of a series of trainings on the root causes of sexual violence, the Spectrum of Prevention and other prevention models, what evidenced-based primary prevention strategies are and how to implement them, community and organizational readiness and advocacy. These trainings will ensure that there is a consistency among sexual violence prevention providers in approaching primary prevention, and will allow opportunities for increased networking within the sexual violence prevention community.

Beginning in year two, technical assistance based on the trainings will be implemented at the regional level. This will ensure that the knowledge gained can be translated from theory into practice, and will also improve communication between the state sexual assault coalition, NMDOH and local providers, beginning the process of increased coordination requested by focus group and interview participants.

There is much work to be done to address sexual violence in New Mexico. Building capacity for the primary prevention of sexual violence must be followed by the implementation of specific primary prevention strategies aimed at reducing risk factors and increasing protective factors among both the general population and populations most at risk. The development of a subsequent, more broadly based and longer-term strategic plan aimed at continuing to move prevention efforts forward is recommended; the ultimate goal being to institutionalize primary prevention as one component of a comprehensive response to sexual violence in New Mexico.

Implementation of the Public Health Model – Step 4: Ensuring Widespread Adoption

The final step in the Public Health Model is ensuring widespread adoption of the strategies. Building capacity through training, technical assistance and the development of competent leadership has already been well established as a proven methodology for programmatic success. Evaluation of the implementation plan will be ongoing throughout the three-year process. Results of the project will be shared with NMDOH, NMCSAP, the sexual violence prevention community and the CDC.

New Mexico Sexual Violence Primary Prevention Stratgic Plan

Goals and Objectives

November 1, 2009 — October 31, 2012

Activity	Leads	Outcome Measure	Time Line
GOAL 1: Build capacity for the primary prevention of sexual violence in New Mexico.			
Objective 1:1 Develop training for Rape Crisis Center providers and Tribal sexual assault service providers in New Mexico to increase their understanding of the root causes of sexual violence and primary prevention of sexual violence by March 31, 2010.			
A. Develop a common language and uniform message for describing comprehensive primary prevention in New Mexico.	Advisory Group* NMCSAP** NMDOH*** UNM PRC****	Consensus description of comprehensive primary prevention in NM	By February 28, 2010
B. Develop multi-year training outline including course content and list of potential trainers which focuses on root causes of sexual violence, the Spectrum of Prevention and other prevention models (Public Health Model, Socioecological Model and the Haddon Matrix) in year one; evidenced-based primary prevention strategies and implementation for universal and selected populations, evaluation and community and organizational readiness in year two; and advocacy for sexual violence prevention in year three.	Advisory Group NMCSAP NMDOH UNM PRC	Training outline	By March 31, 2010
C. Create plan for implementation of statewide trainings.	Advisory Group NMCSAP NMDOH UNM PRC	Training implementation plan	By March 31, 2010
Objective 1:2 Implement two statewide trainings for Rape Crisis Center providers and Tribal sexual assault service providers in New Mexico as identified in training implementation plan by October 31, 2010.			
A. Secure trainers.	UNM PRC	Training schedule	By April 30, 2010
B. Organize meeting logistics.	NMCSAP NMDOH UNM PRC	Planning meeting notes Documentation of meeting locations	By October 31, 2010
C. Implement two statewide trainings on root causes of sexual violence, The Spectrum of Prevention and other prevention models.	Trainers	Training agendas	By October 31, 2010

*Advisory Group – Strategic Planning Advisory Group
**NMCSAP – New Mexico Coalition of Sexual Assault Programs
***NMDOH – New Mexico Department of Health
****UNM PRC – University of New Mexico Prevention Research Center

Activity	Leads	Outcome Measures	Time Line
Objective 1:3 Provide matrix of best and promising practices strategies for the primary prevention of sexual violence to training participants by October 31, 2011.			
A. Develop matrix of best and promising practices strategies for sexual violence prevention.	NMCSAP NMDOH UNM PRC	Matrix	By April 30, 2011
B. Disseminate matrix to training participants.	Trainers	Matrix disseminated	By October 31, 2011
Objective 1:4 Implement two statewide trainings for Rape Crisis Center providers and Tribal sexual assault service providers in New Mexico as identified in training implementation plan by October 31, 2011.			
A. Secure trainers.	UNM PRC	Training schedule	By April 30, 2011
B. Organize meeting logistics.	NMCSAP NMDOH UNM PRC	Planning meeting notes Documentation of meeting locations	By October 31, 2011
C. Implement two statewide trainings on evidenced-based primary prevention strategies and implementation in universal and selected populations within a regional framework, evaluation and community and organizational readiness.	Trainers	Training agendas	By October 31, 2011
Objective 1:5 Provide technical assistance based on Year One and Year Two capacity building trainings to Rape Crisis Center providers and Tribal sexual assault service providers in New Mexico by October 31, 2011.			
A. Communicate with Rape Crisis Center providers and Tribal sexual assault service providers to identify technical assistance needs related to building capacity at the regional levels for primary prevention of sexual violence.	NMCSAP UNM PRC	Assessment responses	Within 2 months of completed trainings
B. Develop plan for responding to identified technical assistance needs at the regional levels.	NMCSAP NMDOH UNM PRC	Technical assistance plan	Within 2 months of completed trainings
C. Provide technical assistance at the regional levels for primary prevention of sexual violence, including assistance in identifying potential local sexual violence prevention champions.	NMCSAP NMDOH UNM PRC	Meeting agendas Conference call agendas E-mails exchanges with Rape Crisis Center providers and Tribal sexual assault service providers	By October 31, 2011

Activity	Leads	Outcome Measure	Time Line
Objective 1:6 Provide statewide advocacy training to teams comprised of Rape Crisis Center providers or Tribal sexual assault service providers, local sexual violence prevention champions and local media in New Mexico by February 28, 2012.			
A. Secure trainer.	UNM PRC	Scheduled training	By November 30, 2011
B. Organize meeting logistics.	NMCSAP NMDOH UNM PRC	Planning meeting notes Documentation of meeting location	By December 31, 2011
C. Implement statewide advocacy training.	Trainer	Training agenda	By February 28, 2012
Objective 1:7 Provide technical assistance in advocacy to Rape Crisis Center providers and Tribal sexual assault service providers and local sexual violence prevention champions by October 31, 2012.			
A. Communicate with Rape Crisis Center providers and Tribal sexual assault service providers to identify technical assistance needs related to advocacy at the regional levels for primary prevention of sexual violence.	NMCSAP UNM PRC	Assessment responses	Within 2 months of completed training
B. Develop plan for responding to identified technical assistance needs at the regional levels.	NMCSAP NMDOH UNM PRC	Technical assistance plan	Within 2 months of completed training
C. Provide technical assistance at the regional levels for advocacy of primary prevention of sexual violence.	NMCSAP NMDOH UNM PRC	Meeting agendas Conference call agendas E-mails exchanges with sexual violence service providers	By October 31, 2012
GOAL 2: Evaluate process for building capacity for the primary prevention of sexual violence in New Mexico.			
Objective 2:1 Evaluate Year One statewide capacity building trainings by October 13, 2010.			
A. Develop evaluation surveys.	NMCSAP NMDOH UNM PRC	Evaluation surveys	By training dates
B. Implement evaluation surveys with capacity building training participants.	Trainers UNM PRC	Completed evaluations	By training dates
C. Analyze evaluation responses.	UNM PRC	Evaluation analysis	By October 31, 2010

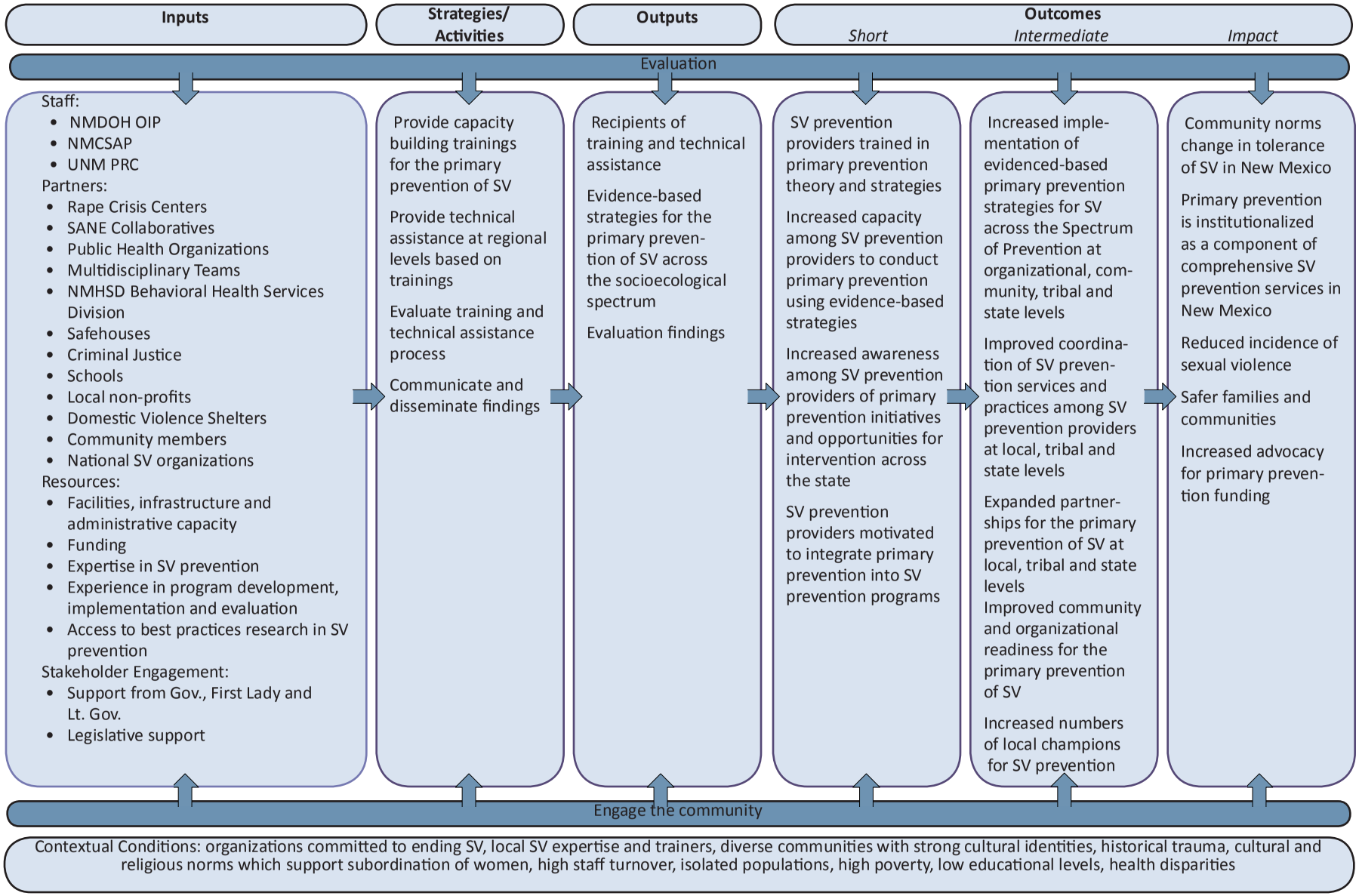
Activity	Leads	Outcome Measures	Time Line
Objective 2:2 Evaluate Year Two statewide capacity building trainings by October 31, 2011.			
A. Develop evaluation surveys.	NMCSAP NMDOH UNM PRC	Evaluation surveys	By training dates
B. Implement evaluation surveys with capacity building training participants.	Trainers UNM PRC	Completed evaluations	By training dates
C. Analyze evaluation responses.	UNM PRC	Evaluation analysis	By October 31, 2011
Objective 2:3 Evaluate technical assistance provided to Rape Crisis Center providers and Tribal sexual assault service providers in Year Two and increases in self-efficacy as a result of capacity building by October 31, 2011.			
A. Develop one-on-one interview questions.	NMCSAP NMDOH UNM PRC	Interview questions	By February 28, 2011
B. Conduct one-on-one interviews with Rape Crisis Center providers and Tribal sexual assault service providers receiving technical assistance in Year Two.	NMCSAP UNM PRC	Completed interviews	By September 30, 2011
C. Analyze interview responses.	UNM PRC	Interview analysis	By October 31, 2011
D. Revise technical assistance plan based on analysis as needed.	NMCSAP NMDOH UNM PRC	Revised technical assistance plan	By October 31, 2011
Objective 2:4 Evaluate Year Three advocacy training by October 31, 2012.			
A. Develop evaluation surveys.	NMCSAP NMDOH UNM PRC	Evaluation surveys	By training date
B. Implement evaluation surveys with capacity building training participants.	Trainer UNM PRC	Completed evaluations	By training date
C. Analyze evaluation responses.	UNM PRC	Evaluation analysis	By March 31, 2012
Objective 2:5 Evaluate technical assistance provided to Rape Crisis Center providers and Tribal sexual assault service providers and local sexual violence prevention champions in Year Three and increases in self-efficacy as a result of capacity building by October 31, 2012.			
A. Develop one-on-one interview questions.	NMCSAP NMDOH UNM PRC	Interview questions	By February 28, 2012

Activity	*Leads*	*Outcome Measures*	*Time Line*
B. Conduct one-on-one interviews with Rape Crisis Center providers and Tribal sexual assault service providers and local sexual violence champions receiving technical assistance in Year Three.	NMCSAP UNM PRC	Completed interviews	By September 30, 2012
C. Analyze interview responses.	UNM PRC	Interview analysis	By October 31, 2012
Objective 2:6 Develop summary report of capacity building process and recommendations for next steps for NMDOH and NMCSAP by December 31, 2012.			
A. Review analysis from Years One, Two and Three evaluations.	NMCSAP NMDOH UNM PRC	Analysis summary	By November 30, 2012
B. Develop next steps recommendations based on process and evaluations.	NMCSAP NMDOH UNM PRC	Next steps recommendations	By November 30, 2012
C. Develop summary report.	UNM PRC	Report	By December 31, 2012
D. Provide summary report to NMDOH and NMCSAP.	UNM PRC	Report disseminated	By December 31, 2012

Logic Model

Building Capacity for Sexual Violence (SV) Prevention in New Mexico

November 2009—October 2012



Appendices

A: Provider Survey

B: Focus Group Questions

C: One-on-One Interview Questions

D: Summary of Focus Group and One-on-One Interview Responses

Primary Prevention Activities among Organizations in New Mexico

This survey was developed by the University of New Mexico's Prevention Research Center in cooperation with the Statewide Sexual Violence Primary Prevention Team (SSVPPT). The purpose is to learn about local efforts to prevent sexual violence, specifically primary prevention efforts – activities aimed at preventing sexual violence before it occurs.

This survey is part of an initiative that is being undertaken by the NM Department of Health's Office of Injury Prevention to identify strengths, resources, and needs within the state with regard to **primary prevention** in the sexual violence prevention field. The information gathered by this survey will inform a strategic planning process that will involve the development of goals and objectives for promoting and enhancing sexual violence primary prevention activities in the state.

7/14/08

Identifying Information	
1.	Name of organization / agency:
2.	Position of the person completing this survey:
3.	What type of organization /agency is this? (Please check all that apply.) ☐ Rape Crisis Center ☐ Domestic violence/Intimate partner violence organization ☐ Sexual violence agency ☐ Public health agency ☐ Faith Based organization ☐ Educational agency ☐ Tribal organization ☐ American Indian organization ☐ Social justice organization ☐ Youth development organization ☐ Multi-service/Social service agency ☐ Mental health agency ☐ Hospital ☐ Health clinic ☐ Government agency (federal, state, county, city) ☐ Other (describe):
4.	Main type of geographic location served (Check all that apply): ☐ Urban ☐ Suburban ☐ Rural ☐ Tribal/Reservation
5.	What types of prevention and/or health promotion programming does your organization provide? (Check all that apply) ☐ Addictions Prevention (Alcohol, Tobacco and other Drugs) ☐ Bullying Prevention ☐ Gang Prevention ☐ Domestic violence/Intimate partner violence prevention ☐ Mentoring ☐ Sexual Health Promotion ☐ Sexual Violence Prevention ☐ Youth Development ☐ Other health-related prevention, please specify _____ ☐ Other violence-related prevention, please specify _____ ☐ Other, please specify _____ ☐ Does not apply -- this organization does not do prevention or health promotion work

Organizational Support and Capacity for *Primary Prevention* of Sexual Violence

Definition for this section:
Primary Prevention of Sexual Violence is defined as strategies that take place before sexual violence has occurred to prevent initial perpetration or victimization. Sexual violence primary prevention strategies may be aimed at changing people's and community's attitudes beliefs, attitudes, and behaviors or the social norms, environments, and systems that are related to sexual violence. Strategies may include, but are not limited to: community-based programs, media messages, multi-session trainings, and policy changes.

6. Which of the following categories best describes your primary prevention activities?
(Please check and fill in all that apply.)

☐ Use of specific primary prevention curriculum
Name the curriculum that is used: _____
What is the purpose of the curriculum? _____
Who is the intended audience? _____

☐ Community mobilization strategies
What communities do you work with? _____
What issue do you mobilize the community around? _____
_____

☐ Use of theatre or arts programming
Type of programming used: _____

☐ General public presentations (with a specific primary prevention message)
Topic(s) of presentation: _____
Who are the intended audiences? _____

☐ Advocacy for public or organizational policy change
Type of policy: _____
Level of policy change (check all levels that apply):
- ☐ local school(s) or school district
- ☐ local organizations
- ☐ local government
- ☐ state organization
- ☐ state government
- ☐ tribal organization
- ☐ tribal government
- ☐ national organization
- ☐ national government

☐ Another type of primary prevention strategy (please describe):

7. Of all the work conducted by your organization, what <u>percentage of staff time</u> would you say involves the **primary prevention** of sexual violence?

8.	What <u>percentage of your organization's budget</u> would you estimate supports your organization's work in the **primary prevention** of sexual violence?
9.	What do you **need** to enhance your **primary prevention** work (e.g., training, funds, other resources etc.)?
10.	Please feel free to provide **any additional information** you would like us to know in this space.
11.	We will be conducting **one-on-one interviews** with people working in sexual violence prevention in New Mexico to learn more about primary prevention activities in the state and to gather ideas for ways to promote and enhance sexual violence primary prevention. If you would be willing to be interviewed (in person or by phone), please provide your contact information. (Please print clearly). Name: Phone: E-Mail:

Thank you very much for taking the time to fill out this survey and for the work you do!

Appendix B: Focus Group Questions

Focus group introductory statement: My name is _____ and this is my colleague, _____. We work at the University of New Mexico's Prevention Research Center. The New Mexico Department of Health and the New Mexico Coalition of Sexual Assault Programs are working with sexual violence prevention providers from around New Mexico to develop a statewide, 5-year, Sexual Violence Primary Prevention Strategic Plan. We have been contracted to facilitate the strategic planning process.

The purpose of this focus group is to help us understand more about the primary prevention of sexual violence in your community and in your work. You are being asked to participate in this process because of the work you do and the information you can provide to help guide the development of the plan's goals and objectives. We don't expect you to know everything about what we ask you today but we know that you know a lot about what is happening in your community. We are conducting 6 focus groups around the state and conducting about 20 phone interviews with sexual violence prevention providers. We will present the information and ideas we hear to an advisory board of providers we are working with that has agreed to write the goals and objectives of the strategic plan - they will incorporate the ideas gathered from around the state into the plan.

The focus group will last about 90 minutes. Your involvement is voluntary and you may choose not to participate or to stop at any time. You can refuse to answer any of the questions at any time. There will be no negative consequences if you choose not to participate. We will be recording the focus group only to assist us in accurately capturing the information you are providing. The results of this focus group may be published but no quotes from today's session will be associated with your name or a specific description that will identify you. All information you provide will remain confidential. The tapes and our notes will be kept until we finish the project which we estimate will probably be by the end of the summer of 2009. At the end of the project the tapes and our notes will be destroyed.

Do you have any questions about what I just read to you?

If after today you have any questions about our session today or this project, I have a stack of my business cards here on the table. Please take one before you leave and feel free to call me at any time. You can also contact us by being in touch with the person who organized this session.

We won't take any formal breaks during the 90 minutes, so please feel free to get up when you need to stretch, use the restroom or get a snack.

Because we are focusing on primary prevention as part of a comprehensive approach to sexual violence prevention in our discussion today, I wanted to read you a definition of primary prevention that I would ask you to keep in mind when I refer to the term primary prevention in my questioning. I will read it now and give examples and please feel free to ask me to read it again at any time during our discussion.

Primary prevention *incorporates prevention approaches that take place* ***before*** *sexual violence has occurred to* ***prevent initial perpetration or victimization*** *(e.g., discussion groups among men to explore beliefs which support sexual exploitation; developing and implementing sexual harassment policies at a local business).*

I would like to begin with the first question:

1. When you describe the sexual violence work you do, how would you define the community in which you work – is it based on geographic boundaries, on racial or ethnic attributes, on a particular group of people that you serve?

2. Describe how you think your community views violence against women?
   Is sexual violence viewed differently than other types of violence, such as gang violence, murder or domestic violence?
   Do you think people understand that sexual violence is preventable?

3. Do you have any local champions that speak out against sexual violence?
   Who are they?
   Can you give an example of how they've spoken out?

4. What partners do you work with that are not in the sexual violence prevention field?
   Why is your partnership important?

5. Are there any groups that you have not been able to work with/provide services to/collaborate with, etc.? For instance, the disability community, LGBT (lesbian, gay, bisexual, transgendered) community, the immigrant community, etc?

The next set of questions will focus on primary prevention specifically as part of a comprehensive approach to sexual violence prevention. So I can re-read the definition of primary prevention that I read before if you would like me to.

Primary prevention *incorporates prevention approaches that take place* ***before*** *sexual violence has occurred to* ***prevent initial perpetration or victimization*** *(e.g., discussion groups among men to explore beliefs which support sexual exploitation; developing and implement sexual harassment policies at a local business).*

6. What do you think are the biggest assets/strengths in your community for doing work in the **primary prevention** of sexual violence?

7. What do you think are the biggest assets/strengths in the state for doing work in the **primary prevention** of sexual violence?

8. What do you think are the biggest barriers in your community for doing work in the **primary prevention** of sexual violence?

9. What do you think are the biggest barriers in the state for doing work in **primary prevention** of sexual violence?

10. How well do you feel that primary prevention activities for sexual violence are coordinated in New Mexico?

Do you know who else around the state is implementing primary prevention strategies?

Do you have opportunities to network with others providing primary prevention for sexual violence?

Do you have suggestions for how services might be coordinated differently?

11. Who would you like to partner with in your community to do primary prevention of sexual violence that you don't work with now?

Are there other groups working on primary prevention, for example, in youth violence prevention?

Can you give an example of how you might work with them?

How are young people involved in your primary prevention of sexual violence work?

How are men involved in your primary prevention of sexual violence work?

12. Would you recommend any policy that would help prevent sexual violence in New Mexico? Policy could mean laws, organizational policies, regulations, rules, guidelines, etc.

13. Is there anything else you would like to tell us about primary prevention of sexual violence?

Appendix C: One-on-One Interview Questions

One-on-one interview introductory statement: The New Mexico Department of Health and the New Mexico Coalition of Sexual Assault Programs are working with sexual violence prevention providers from around New Mexico to develop a statewide, 5-year, Sexual Violence Primary Prevention Strategic Plan. I work at the University of New Mexico's Prevention Research Center. The Prevention Research Center has been contracted to facilitate the strategic planning process.

The purpose of this interview is to help us understand more about the primary prevention of sexual violence in your community and in your work. We don't expect you to know everything about what we ask you today but we know that you know a lot about what is happening in your community and we are grateful for your time today and your help as we gather the information we need to guide the development of the Strategic Plan's goals and objectives. The interview will last about 45 minutes. Your involvement is voluntary and you may choose not to participate or to stop at any time. There will be no negative consequences if you choose not to participate. We will be recording the interviews to assist us in accurately capturing the information you are providing. The results of this interview may be published but no quotes from your interview will be associated with your name or a specific description that will identify you. All information you provide will remain confidential. The tapes and our notes will be kept until we finish the project which we estimate will probably be by the end of the summer of 2009. At the end of the project the tapes and our notes will be destroyed.

Because we are focusing on primary prevention as part of a comprehensive approach to sexual violence prevention in our discussion today, I wanted to read you a definition of primary prevention that I would ask you to keep in mind when I refer to the term primary prevention in my questioning.

Primary prevention *incorporates prevention approaches that take place* ***before*** *sexual violence has occurred to* ***prevent initial perpetration or victimization*** *(e.g., discussion groups among men to explore beliefs which support sexual exploitation; developing and implementing sexual harassment policies at a local business).*

1. When you describe the sexual violence work you do, how would you define the community in which you work – is it based on geographic boundaries, on racial or ethnic attributes, on a particular group of people that you serve?

2. Describe how you think your community views violence against women?
   - Is sexual violence viewed differently than other types of violence, such as gang violence, murder or domestic violence?
   - Do you think people understand that sexual violence is preventable?

3. What would a sexual-violence free New Mexico look like?

4. Do you have any local champions that speak out against sexual violence?
   - Who are they?
   - Can you give an example of how they've spoken out?

5. What partners do you work with that are not in the sexual violence prevention field?
   Why is your partnership important?

6. Are there any groups that you have not been able to work with/provide services to/collaborate with, etc.? For instance, the disability community, LGBT (lesbian, gay, bisexual, transgendered) community, the immigrant community, etc?

The next set of questions will focus on primary prevention specifically as part of a comprehensive approach to sexual violence prevention. So I can re-read the definition of primary prevention that I read before if you would like me to.

Primary prevention *incorporates prevention approaches that take place* ***before*** *sexual violence has occurred to* ***prevent initial perpetration or victimization*** *(e.g., discussion groups among men to explore beliefs which support sexual exploitation; developing and implement sexual harassment policies at a local business).*

7. What do you think are the biggest assets/strengths in your community for doing work in the **primary prevention** of sexual violence?

8. What do you think are the biggest assets/strengths in the state for doing work in the **primary prevention** of sexual violence?

9. What do you think are the biggest barriers in your community for doing work in the **primary prevention** of sexual violence?

10. What do you think are the biggest barriers in the state for doing work in **primary preventio**n of sexual violence?

11. Do you or someone in your organization provide primary prevention of sexual violence in your community right now?
   Do you get funding specifically for primary prevention of sexual violence?
   Where does the money come from?
   What primary prevention activities or programs do you do?
   Do you partner with any other organizations to do primary prevention?

12. If you don't do primary prevention of sexual violence in your community right now, what is keeping you from doing it?
   Would primary prevention fit within your organization's mission?
   What resources would you need to begin to implement primary prevention?

13. How well do you feel that primary prevention activities for sexual violence are coordinated in New Mexico?
   Do you know who else around the state is implementing primary prevention strategies?
   Do you have opportunities to network with others providing primary prevention for sexual violence?
   Do you have suggestions for how services might be coordinated differently?

14. Do you think you would benefit from more training or education on primary prevention of sexual violence or how to implement primary prevention strategies?

What would be most helpful?

Do you have suggestions for who could provide the training?

Do you have suggestions for how the training should be provided?

15. Do you think others in your community would benefit from training or education on primary prevention of sexual violence?

Who do you think would benefit?

Who do you think could or should provide the training?

16. Who would you like to partner with in your community to do primary prevention of sexual violence that you don't work with now?

Are there other groups working on primary prevention, for example, in youth violence prevention?

Can you give an example of how you might work with them?

How are young people involved in your primary prevention of sexual violence work?

How are men involved in your primary prevention of sexual violence work?

17. Would you recommend any policy that would help prevent sexual violence in New Mexico? Policy could mean laws, organizational policies, regulations, rules, guidelines, etc.

18. Is there anything else you would like to tell us about primary prevention of sexual violence?

Appendix D: Summary of Focus Group and One-on-One Interview Responses

Summary of Focus Group and One-on-One Interview Responses
Used in the Development of
Building Capacity for Primary Prevention:
A Three-Year Strategic Plan

Conducted by the University of New Mexico Prevention Research Center
April-June 2009

In Collaboration with
The Strategic Planning Advisory Group,
The New Mexico Coalition of Sexual Assault Programs
And
The New Mexico Department of Health Office of Injury Prevention

Summary Compiled by
Leona Woelk
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June 4, 2009

Background

Focus Groups: Six focus groups were conducted in New Mexico during April and May 2009. They were held in Las Cruces, Farmington, Taos, Albuquerque, Clovis and Dulce. They ranged in size from about 7 participants to over 20, and lasted about an hour and a half. The following types of organizations or individuals participated:

- City Council member
- State police
- College student
- Safehouse interviewer
- Faith based organization
- Schools
- Workforce Investment Act (NM Department of Labor)
- Sheriff's department victim advocate
- District Attorney offices
- Rape Crisis Centers
- Women's centers
- Public health offices
- Family crisis centers
- Sexual assault service providers
- Child abuse prevention and treatment
- Federal Bureau of Investigation
- City police departments
- Community member
- Counseling and mental health services
- Domestic violence shelters
- Parish priest
- Juvenile detention center
- Youth organizations
- Juvenile probation and parole
- Office of School and Adolescent Health (NM Department of Health)
- Cannon Air Force Base personnel
- Sexual Assault Nurse Examiners
- NM Children, Youth and Families Department
- Teen health center
- Business owner
- Tribal Council members
- Tribal courts
- Department of Health and Human Services
- Tribal Department of Education
- Regional medical center

One-on-One Interviews: Nineteen interviews were conducted with sexual violence prevention providers from around New Mexico during May and June 2009. Interviews lasted an average of 45 minutes. The interviewees represented the following types of organizations:

- Rape Crisis Centers
- Behavioral health services
- Sexual assault services
- New Mexico Coalition of Sexual Assault Programs
- Behavioral health consultant
- Native American-serving sexual and domestic violence services
- New Mexico Coalition Against Domestic Violence
- Legal services for immigrants
- Child sexual abuse services
- Adolescent sexual offender treatment
- Sexual Assault Nurse Examiners
- Adolescent residential treatment

Summary of Focus Group and Interview Responses

1. How would you define the community in which you work (focus group and interview question):
    - Defined by income
    - Defined by gender
    - Serves anyone that comes for services
    - Defined by geographic boundaries
    - Defined by age
    - Defined by population (i.e. disability community, juvenile offenders, alternative school students, immigrants, women transitioning out of penal system, etc.)
    - Defined by race and/or ethnicity
    - Sexual violence and/or intimate partner violence (IPV) victims
    - Those in the medical system
    - Those in the judicial system
    - Professionals (social workers, teachers, state agencies, etc.)
    - Parents
    - Sexual offenders

2a. What is your community's view of violence against women (focus group and interview question):
    - Sexual violence is caused by the woman's or adolescent's behavior – how she dresses, drinking, behaving provocatively, being with the "wrong crowd," making "bad choices"
    - Sexual violence against children is shocking
    - Sexual violence is rape committed by a stranger because of out-of-control sexual urges
    - Violence towards women is allowable if women aren't behaving correctly
    - Violence within marriage or relationships is normal and acceptable – "It's always been that way"
    - Sexual violence is inevitable, the best that can happen is postponing the violence through limiting contact with men
    - Violence against women is multigenerational so children grow up thinking it's normal
    - Women don't always recognize that they are being abused
    - People underestimate how often it happens
    - Violence is seen as a way to have power so young women are beginning to emulate physical violence
    - Traditional gender roles contribute to violence against women
    - Religious teachings that support subjugation of women contribute to violence against women
    - Sexual violence is seen as a personal rather than a public issue; people are less willing to interfere in people's personal lives or choices
    - Violence against women is normalized through popular media
    - Violence against women is normal when drugs and alcohol are used by either party
    - It's a shameful subject and shouldn't be talked about
    - There is no point in reporting it because nothing will be done (victim blaming by law enforcement, no or mishandled investigation, poor communication from law enforcement about the investigation, cases dropped by prosecution, no consequences for offenders) – especially true in cases involving Native American survivors

- Sexual violence is especially difficult in small communities where offenders and victims continue to live in close proximity

2b. Is violence against women preventable (focus group and interview question):

- Communities tend to believe that prevention is dependent on the woman changing her behavior
- Providers tend to believe prevention is dependent on changing community norms around violence
- Many believe that teaching children personal safety techniques will prevent sexual violence
- Violence against women must be addressed within the context of ending oppression, racism and discrimination to be successful
- Violence against women is not preventable because there will always be "bad people" who commit the violence
- Prevention is not possible without effective laws for prosecuting perpetrators

3. What would a sexual violence-free NM look like (interview question only):

- There would be respect for the human body
- Clear communication and boundaries
- People wouldn't have to fear unwanted sexual contact from anyone
- Those committing sexual violence would learn that it's unacceptable
- Don't know if it's even possible
- Would have a happier community where people would feel safer
- There would be equality between the sexes
- People would be held accountable for their actions
- People would come forward with the truth of their histories, whether they had been abused or had been an abuser
- People would be more active in their communities
- People would feel supported by their communities
- Oppression, racism and classism would be addressed
- Men and women would share the responsibility for prevention
- Women would be able to participate more fully in society
- There would be less stress-related health issues for men, women and children
- People would be more whole
- Quality of life would improve
- Parenting would be an honored profession
- People would watch out for each other
- People would be less isolated

4. Who are your local champions that speak out against sexual violence (focus group and interview question):

- Rape Crisis Centers
- Local Safehouse interviewers
- Office of School and Adolescent Health, Department of Health

- Women's Resource Centers
- Multidisciplinary Teams
- SANE nurses
- Victim's Advocates
- Community elders
- South Valley Male Involvement Project
- Past President of Native American Tribe (specific name of tribe removed for confidentiality)
- Anyone willing to speak publicly about their sexual violence experience
- Executive Director of NMCSAP
- Anti-Sexual Violence Education Specialist at Sacred Circle
- Clinical Coordinator at Para Los Niños
- Community Education and Outreach Director at Community Against Violence
- District Attorney for Sandoval, Valencia and McKinley counties
- Board Chair
- Certain legislators
- Law enforcement
- Mayor of Santa Fe
- Coordinated Community Response Council
- Governor
- None

5a. What partners do you have that are not in the sexual violence prevention fields (focus group and interview question):

- Women's Intercultural Center
- Universities
- Hospitals
- Schools
- Law enforcement
- Juvenile Justice
- Department of Health
- Local behavioral health collaboratives
- Local health councils
- Youth serving organizations
- Older gang members
- Student interns
- CYFD
- Domestic Violence Shelters
- Community organizations
- Nonprofit organizations
- Faith based organizations
- Local government
- Those who teach cultural traditions
- Public Health Offices
- Promotoras

- Court advocates
- Civil attorneys
- Volunteers
- Transitional living services
- Healthcare for the Homeless
- State, local and county offices
- NM Attorney General's Task Force
- Tribal Councils
- Co-workers
- Mental health service providers
- Substance abuse service providers
- Crime Victims Reparation Committee

5b. Why are the partnerships important (focus group and interview question):

- Everyone is touched by sexual violence eventually
- Sexual violence cuts across various disciplines, especially domestic violence
- Prevention work can't be accomplished alone
- Helps to support each other's work
- Helps to reduce professional burn-out
- Helps to build trust with community members
- Increases access to community leaders and decision-makers
- Helps to spread the word about what services are available and how to access them
- The root causes of violence are the same
- There is a shared common goal to make peoples' lives better
- There is strength in numbers
- Everyone has a role in making the community safer

6. Which groups have you not been able to work with/provide services to/collaborate with (focus group and interview question):

- Boy Scouts
- Boxing clubs
- Immigrant community
- Lesbian, Gay, Bi-Sexual and Transgendered community
- Office of Border Health
- Islamic community
- Military personnel
- Disability community
- Limited English proficiency
- Elderly
- Asian community
- Tribal communities
- Deaf and hard of hearing
- Faith-based communities

7. What are the biggest community assets for primary prevention of sexual violence (focus group and interview question):
    - Rape Crisis Center
    - Health clinics
    - District Attorney
    - Trainings provided by specific organizations
    - Collaboration within the community
    - Strong values of love and respect
    - Strong families that support each other
    - Statewide and national networking and collaboration
    - Youth-serving organizations
    - Having a strong connection to the community
    - That the community is willing to change
    - Activism groups
    - Youth Advisory Councils/youth serving on boards
    - Natural Helpers program (suicide prevention)
    - Promotoras
    - Schools
    - Teen Health Centers
    - Native Hope
    - Credibility of nurses in the community – they are the accessible health practitioner
    - Parents who want to protect their children
    - SANE programs
    - Children because they are sponges for information and are speaking out against violence
    - None – all resources dedicated to intervention
    - Primary prevention is interesting and exciting work, can re-engage those burned out on direct services or policy
    - All the people who work in sexual violence prevention
    - County and Tribal health councils
    - Community holding people accountable
    - Those working on issues of gender, oppression, discrimination and their links to violence
    - Those working with men on issues of masculinity

8. What are the biggest state assets for primary prevention of sexual violence (focus group and interview question):
    - Collaboration between agencies
    - Advocacy in Action Conference
    - NM Safe House Network
    - NM Coalition of Sexual Assault Programs
    - CYFD
    - Rape Crisis Centers
    - Coalition to Stop Violence Against Native Women
    - Networking

- SANE collaboratives
- A willingness to follow best practices and to look at what has been successful in other states
- The Network
- Governor and legislators – have dedicated funding for sexual violence services
- Funding people locally to do the work in their own community
- Governor's wife's decision to use discretionary funding for sexual violence prevention
- Gay Straight Alliances in the schools

9. What are the biggest community barriers to prevention of sexual violence (focus group and interview question):
    - Language barriers
    - Lack of transportation to services
    - Shame and stigma surrounding sexual violence
    - Jurisdictional boundaries
    - Territorialism
    - Lack of coordination between service providers, criminal justice system and law enforcement
    - Denial of sexual violence within the community
    - Historical trauma
    - Lack of prosecution
    - Taboos against discussing sexual violence
    - Inability to focus on prevention (overburdened staff in schools and service organizations, no funding specifically for prevention)
    - Sexual violence myths and inaccurate information
    - Unwillingness to work together due to past history (holding grudges)
    - Internalized racism and classism
    - Reluctance to accept "outsiders" or information that outsiders bring – response to gentrification leading to extreme poverty, fear of losing identity and being taken over by outsiders
    - Non-cooperation from schools, inability to access schools
    - Cultural and religious barriers about what is acceptable in marriage
    - No centralized sexual assault services in community
    - Inadequate or non-existent funding
    - Lax participation in community for addressing the issue
    - Lack of technical assistance or local expertise in implementing primary prevention
    - Issues of power and control not well understood when it comes to sexual violence
    - Family acceptance of sexual violence
    - Resistance of providers to learning new things
    - Difficult to get parents involved
    - Low staff wages
    - Uncomfortable topic
    - Lack of resources (i.e. culturally-competent staff)
    - Lack of training and education about sexual violence in community leaders
    - Perpetrators in communities in positions of power

- Lack of understanding of the root causes of sexual violence
- Lack of understanding of the profound and long-term ways sexual violence impacts people
- Male privilege

10. What are the biggest state barriers to prevention of sexual violence (focus group and interview question):
    - Division between northern and southern parts of the states – don't know what each other is doing
    - Law enforcement is not always aware of what the laws actually say regarding sexual violence or what services are available
    - No coordination of primary prevention of sexual violence services or service providers
    - Lack of communication between service providers and decision/policy makers
    - Belief by policy makers that funding domestic violence programs addresses sexual violence prevention needs
    - Lack of technical assistance from state regarding primary prevention of sexual violence
    - Jurisdictional issues between counties, the state, the federal government and sovereign nations
    - Language barriers
    - Lack of culturally appropriate services
    - Lack of communication within the sexual violence prevention network
    - Reluctance to talk about sexual violence at all levels
    - Lack of continuity due to yearly change in Tribal governments
    - Need to raise level of professionalism around primary prevention (as has been done for the SANE programs through the position of Statewide SANE Coordinator)
    - Not enough primary prevention efforts throughout the state
    - Lack of funding (sexual violence is one of the biggest issues in New Mexico, but no one wants to talk about it so it doesn't get the funding it needs)
    - No coordination between state and Tribal communities around sexual violence
    - Tribal communities not being well represented at discussions about sexual violence prevention (i.e. having representation from only one Tribal community)
    - Need more people trained in primary prevention of sexual violence
    - State leadership in addressing sexual violence
    - Glorification of violence through the media
    - People don't have the most current information about how to prevent sexual violence

11a. Does your organization provide primary prevention of sexual violence (interview question only):
    - Community education
    - Presentations for organizations
    - Presentations on mandatory reporting laws
    - Presentations on signs and symptoms of child abuse
    - 10 week curriculum with adolescents who have been sexually assaulted to prevent repeat victimizations
    - Programs that work with specific populations, i.e. children, young people, underserved

- Training on sexual violence
- Training on historical trauma
- Development of policy
- Provide mandatory trainings for Sexual Assault Coordinators funded through Behavioral Health Services Division
- Classroom presentations
- Provide education and resources on an individual level
- Contract with organizations around state to do primary prevention of sexual violence

11b. Do you get specific money for primary prevention of sexual violence (interview question only):

- Don't know
- No
- Through the NMCSAP
- Local city and county grants
- Children's Trust Fund
- Victims of Crime Act (VOCA) funding
- Department of Health
- Behavioral Health Service Division (mandates primary prevention from Sexual Assault Coordinators but does not specifically designate funding for primary prevention)
- CDC Rape Prevention and Education (PRE) Funds released to local rape crisis centers
- State funding released through RFP process to local community providers

11c. Do you partner with anyone to do primary prevention of sexual violence (interview question only):

- No — just organize speakers for presentations
- Don't partner with anyone
- Local domestic violence shelter
- Other organizations that are not specific to sexual violence prevention
- Schools
- NMCSAP

12. If you don't do primary prevention, what is the reason (interview question only):

- Provide intervention only
- Primary responsibility is to work with those already victimized
- It is not a core part of the organization's mission

13. How well are primary prevention activities coordinated in the state (focus group and interview question):

- Don't know who else in state is doing primary prevention or, if they are doing primary prevention, what exactly they are doing
- Don't have opportunities for networking with other providers
- Everything is centralized in Santa Fe or Albuquerque so is not always accessible for those in other parts of the state
- Would like regional meetings in addition to the statewide meetings

- NMCSAP has contracted with individuals to provide technical assistance and training — helps break down the barriers imposed by funders regarding who can be served or who can receive training
- More of the community should be included, i.e. organizations should be allowed to invite more than their own staff members to trainings so local capacity for primary prevention is increased
- Rape Crisis Centers and those funded through the NMCSAP have a better idea of what is happening around the state
- Need to strengthen communication system between NMCSAP and service providers
- Should explore whether or not the Multidisciplinary Team model could be replicated for primary prevention providers
- Would like more information about successful primary prevention strategies and what is considered best practices for preventing sexual violence
- Need better coordination around the state regarding training for law enforcement
- Need to make better use of technology to cut down on need to travel to meetings
- Need more follow-up after Coordinators' meetings to remind people what has been done
- No one person or agency is putting out a consistent message about sexual violence or how to prevent it
- Would like statewide sexual violence prevention conference
- Pueblos and Tribes are not well coordinated either with each other or with other sexual violence prevention providers
- Would like opportunities to cross-train with others providing primary prevention
- Would like way to receive organizational level technical assistance or feedback about how program is working or suggestions for improvement
- NMCSAP does a really good job of providing resources and training and responding to requests from sexual violence providers
- Governor's leadership commission on domestic violence could be expanded to include sexual violence, with a specific task force to address primary prevention
- Would be good to have a speakers' bureau
- Prevention should be more than outreach activities
- Primary focus in the state is on intervention and treatment
- Need to address the whole spectrum of prevention with constant training and support for providers

14a. Would you benefit from more training in primary prevention of sexual violence (interview question only):

- Yes! (from everyone)

14b. What type of training (interview question only):

- Primary prevention strategies and how to implement them
- Prevention of human trafficking
- Men and boys and the role they play in sexual violence

- Who is most at risk for sexual violence
- How to successfully work with different age groups
- How to engage parents in prevention
- Overview of different prevention curricula
- Models of prevention, i.e. The Ecological Model, The Public Health Model
- How primary prevention differs from intervention
- Teen dating violence and sexual violence
- Anti-oppression training

14c. Who could provide it (interview question only):

- Trainers from other states
- A man (training on men's and boys' roles in sexual violence)
- NMCSAP (either provide directly or identify appropriate state or national trainers)
- Organizations from around the state that are successfully doing primary prevention
- RPE and Delta (domestic violence programs) states that have successfully worked together in primary prevention
- SANE Coordinators
- Prevention Institute
- Prevention Connection — Violence Against Women Prevention Partnership

14d. How should it be provided (interview question only):

- Webinars
- Group training
- Train the trainer
- Technical assistance for individual organizations

15a. Do you think others in your community would benefit from primary prevention training (interview question only):

- Yes! (from everyone)

15b. Who would benefit (interview question only):

- Schools — entire staff from administrators to bus drivers to cafeteria workers
- Medical field
- Faith community
- Underserved communities — they are the recipients of most of the oppression and violence
- Rural areas
- Native American communities
- Law enforcement
- Other service providers
- Judicial system
- CYFD
- Parents

- Children of all ages
- Counselors
- Domestic violence providers
- Youth groups

15c. Who should provide the training and how should it be provided (interview question only):

- Experts in the field — group training
- Community organizations — train the trainer
- NMCSAP (either provide directly or identify appropriate state or national trainers)
- Sacred Circle
- Coalition to Stop Violence Against Native Women

16. Who would you like to partner with for primary prevention that you don't work with now (focus group and interview question):

- Boy Scouts and Girl Scouts
- Men
- Juvenile justice
- Schools
- Navajo Coordinated Health Grant (does prevention but not sexual violence prevention)
- San Juan Community Foundation (only focused on drug/alcohol prevention currently)
- Youth peer education programs
- Natural Helpers programs
- Youth Development, Inc.
- NM Forum for Youth in Community
- Parent Teacher Associations/Parent Teacher Organizations
- Other tribal departments
- Workforce Investment
- Boys' Project
- Multidisciplinary Team
- Youth
- Asian community
- Immigrant community
- Domestic violence providers
- Internet Crimes Against Children
- Law enforcement
- Judicial system
- People with power
- School-Based Health Centers
- Public Health offices
- Youth runaway shelters
- Gang prevention groups
- Churches
- County and Tribal health councils

- Youth Conservation Corp
- Community advocates
- Youth violence prevention groups

17. What policy recommendations do you have to prevent sexual violence (focus group and interview question):
    - Mandated training in sexual violence prevention for anyone licensed by the state — teachers, counselors, law enforcement, etc.
    - Mandated comprehensive prevention curriculum at all levels in schools, which would include human rights, respect, non-violence and media literacy
    - CEU requirements for judicial system and district attorneys related to sexual violence
    - Required prevention education for school administrators
    - Need to think carefully about policy, i.e. zero tolerance policies have been very punitive and counterproductive — policies need to support connectedness rather than exclusion
    - Need an analysis of current policies to identify those that are creating barriers
    - Policy needs to be supported by funding
    - Need increased education on media literacy
    - Policies mandating primary prevention must include clear definitions of primary prevention so that they are not victim blaming
    - Revision of the current offender policy — it's punitive and isolative rather than healing and therapeutic
    - Something like Crime Victims Reparation Committee for Tribal lands
    - Training of law enforcement and judicial system personnel on how not to revictimize those who have been assaulted
    - Expand Domestic Violence Czar's purview to include child sexual abuse and sexual violence
    - Have Attorney General's office focus on sexual violence in addition to intimate partner violence
    - Mandated training on sexual violence prevention for all school personnel
    - Policies that allow funding to be more fluid — prevention and intervention often work in conjunction and siloing funding does not work in practice
    - Organizational policies or organizational mission statements that include prevention so that prevention is embedded throughout the organization's work
    - Policy that mandates specific funding for prevention
    - School policies on bullying and violence
    - Mandated sexual harassment policies in businesses
    - Anything strengthening anti-oppression and anti-violence work

18. Do you have any final statements regarding primary prevention of sexual violence (focus group and interview question):
    - Prevention needs to start early and needs to include education for parents
    - Sexual violence and substance abuse are very intertwined — need to focus on both
    - Would like to see a list of everyone providing primary prevention of sexual violence throughout the state
    - It's an honor to work with the dedicated and caring people in New Mexico who work on violence against women

- It would be good to have a way to measure actual effectiveness of prevention programs and to hold organizations accountable for how they are spending their money
- Perpetrators need to know how to stop perpetrating
- Grateful for opportunities to go into communities and talk about prevention
- Wish there was more dedicated money for prevention and more people doing prevention
- State needs to take sexual violence prevention more seriously — it's as important a health issue as smoking and DWI
- Sexual violence won't be impacted until issues like oppression are addressed — every community could benefit from training on oppression
- Wish we could help kids have a strong sense of self — it's the vulnerable kids that get abused
- We're two generations behind the rest of the world in how we deal with sexual violence
- A core part of primary prevention work should be prevention of child sexual abuse — victims and perpetrators overlap when you're talking about youth
- Talking with individuals is the place to start
- It seems to be an epidemic