DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

House and Senate Appropriations Committees

REPORT TO CONGRESS ON
CHILD SEXUAL ABUSE PREVENTION

Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention
Administrator
Agency for Toxic Substances and Disease Registry
Department of Health and Human Services

December 2018
Table of Contents

Executive Summary .................................................................................................................................................. 3
Introduction .......................................................................................................................................................... 3
Preventing Childhood Sexual Abuse is a Public Health Priority ................................................................. 3
Strategies for Preventing CSA ...................................................................................................................... 4
CDC’s Current Efforts in CSA Prevention ................................................................................................. 5
Addressing Gaps in CSA Prevention ........................................................................................................... 6
Conclusion ...................................................................................................................................................... 7

I. Overview ...................................................................................................................................................... 8

II. Introduction ................................................................................................................................................. 8

III. The Public Health Burden of CSA ......................................................................................................... 9

IV. Risk and Protective Factors for CSA Victimization and Perpetration .................................................. 13

V. Strategies for Preventing CSA ................................................................................................................ 15

VI. CDC’s Current Efforts in CSA Prevention .......................................................................................... 20

VII. Gaps in CSA Prevention ....................................................................................................................... 23

VII. Conclusion .............................................................................................................................................. 24

Tables

Table 1: Consequences of CSA victimization ................................................................................................. 11
Table 2: Risk and protective factors for CSA victimization ........................................................................ 13
Table 3: Risk and protective factors for CSA perpetration ......................................................................... 14
Table 4: Perpetrator prevention programs ................................................................................................... 15
Table 5: Surveys on CSA currently being conducted or sponsored by CDC ............................................... 20

Appendixes

Appendix 1: The public health model .......................................................................................................... 25
Appendix 2: The social-ecological model .................................................................................................... 26
Appendix 3: Prevalence and adjusted odds ratios for the relationship of childhood sexual abuse with health and health risk behaviors by sex ....................................................................................................................... 27
Appendix 4: Research projects currently being funded by CDC ................................................................. 29
Appendix 5: Adult-perpetrated CSA prevention activities in RPE-funded agencies .................................. 34
Appendix 6: Authors, CDC contributing staff, and external reviewers ....................................................... 34

References ..................................................................................................................................................... 40
Executive Summary

Introduction

Childhood sexual abuse (CSA) poses a serious threat to the health and development of our nation’s children – it affects millions of children annually and has significant impacts on society. CSA refers to any sexually violent behavior directed towards children and youth (under the age of 18) by an adult or another child/adolescent of the same or different age. Many resources have been invested in treatment for victims and criminal justice-oriented approaches for perpetrators, but comparatively little investment has been made specifically for evidence-based prevention of CSA. Thus, currently, there are limited effective, evidence-based strategies for proactively protecting children and youth from CSA. This is true even though CSA is preventable. Ensuring safe, stable, nurturing relationships and environments for all children is a priority for decreasing violence, including CSA, and promoting the health and prosperity of our nation.

This report describes the public health burden of CSA, including the range of outcomes that may be experienced by those exposed to CSA. Additionally, the report outlines factors that may increase or decrease risk for CSA victimization and perpetration, as well as strategies used for prevention, including those currently being implemented by the Division of Violence Prevention in the National Center for Injury Prevention and Control (NCIPC) at the US Centers for Disease Control and Prevention (CDC). The report concludes by outlining gaps that exist in research as well as activities that will be important in addressing the gaps.

Preventing Childhood Sexual Abuse is a Public Health Priority

CSA is a serious public health problem, although data underestimates its prevalence. It is widely accepted that available data on CSA underestimates its prevalence. According to child welfare data, approximately 676,000 children experienced CSA in 2016. Most victims of CSA, however, delay or never disclose CSA to friends, family, or the authorities. Self-report data suggests that 3.7 million children are exposed to CSA each year in the US, with 1 in 4 girls and 1 in 10 boys experiencing CSA at some point during childhood. CSA occurs across all ages and in all socioeconomic classes, although rates are often higher among some age groups (e.g., ages 7-12, adolescents).

Nationally representative CSA perpetration estimates are scarce. Although official police reports are available, they largely underestimate perpetration estimates, given that most CSA victims never report the abuse to authorities. Likewise, self-reported perpetration data on adult sexual interest in and behavior with children is limited, as is perpetration data for children and adolescents. Much of the information on perpetrators is based on self-reported data from victims. In those cases, most perpetrators of CSA are reported as being male. Same-aged peers and older adolescents are frequent perpetrators of CSA, as are family members and other adults (e.g., family friends, coaches).

The health and economic consequences of CSA are substantial. Short- and long-term physical health consequences of CSA may include stomachaches, headaches, unwanted/unplanned pregnancies, physical injuries, and chronic health conditions such as heart disease, obesity, and cancer, among others. Short- and long-term mental health consequences may include attention difficulties, depression, posttraumatic stress disorder (PTSD), learning and memory difficulties, suicide attempts, substance abuse, and risky sexual behaviors, among others. Lifetime prevalence of depression can be as much as five times higher for women with CSA histories than those without. Moreover, for those with CSA histories, the odds of attempting suicide in their lifetime is six times higher for men and nine times higher for women when compared to individuals without a history of CSA. Adults who have experienced CSA also report decreased health-related quality of life, and nearly half are sexually revictimized in adulthood. The total lifetime economic burden of CSA in the US is estimated to be $9.3 billion, although this is likely an underestimate given limitations on available data.
CSA victimization and perpetration are associated with several risk and protective factors. A number of factors have been identified that either put children at risk for victimization or perpetration of CSA (i.e., risk factors) or protect against it (i.e., protective factors). Factors most commonly identified as increasing risk for CSA victimization include child age and sex, and perpetrator sex and relationship to the victim\textsuperscript{19,22}. Most (~90%) CSA cases involve a perpetrator known to the child\textsuperscript{20}. Prior victimization of the child and parent\textsuperscript{21}, substance use (by parents)\textsuperscript{22}, and being disabled or handicapped\textsuperscript{23} are risk factors for CSA victimization. Certain relationship and familial factors also may increase risk, including young maternal age, unwanted pregnancy, presence of a stepfather in the home, and witnessing family conflict, among others\textsuperscript{19,22,23,26}. Community- (e.g., neighborhood violence, poverty, lack of employment opportunities, media portrayals of children as sexual actors, weak community sanctions against perpetrators of CSA) and societal-level factors (e.g., social norms and laws that promote inequality between men and women, acceptance of child pornography or male sexual entitlement) can also increase risk for victimization\textsuperscript{19,22,23,26}.

Perpetrators of CSA are not a uniform group; thus, it is imperative to distinguish clearly the risk and protective factors for each of the forms of CSA. Although research on the risk and protective factors for CSA perpetration is somewhat limited, risk factors, particularly for peer-perpetrated CSA, may include delinquency, lack of empathy, being exposed to pornography, and having traditional beliefs about masculinity\textsuperscript{24}. Family conflict and hostility, lack of social support and parental monitoring and childhood exposure to physical, sexual, and emotional abuse also may increase risk for perpetration, along with exposure to violence and a lower sense of belonging in school\textsuperscript{25,26,27}. Community- and societal-level factors that create inequitable conditions for men and women, reduce institutional supports, or promote sexual violence may increase risk for perpetration\textsuperscript{25,26,27}. Protective factors for CSA perpetration include empathy, school belongingness, and social support\textsuperscript{28,29,30}.

CSA can be prevented. Only 10% (or fewer) of the cases of CSA are perpetrated by a stranger. Most perpetrators are someone the child knows or someone known to the child’s family. Preliminary evidence from research suggests that implementing certain programs decreases perpetration of CSA; thereby suggesting that the issue can be prevented. Public health, whose goal is to create broad population-level impact, can play an important and unique role in preventing CSA and in complementing the criminal justice-oriented approaches already in place (see Appendix 1 for the public health model). Public health agencies have the expertise and resources to identify, track and analyze the problem; identify factors that increase or decrease risk; implement and evaluate preventive measures and approaches; assure widespread adoption of evidence-based strategies; and track progress on reduction in CSA. A comprehensive approach to CSA prevention that includes preventive interventions at all levels of the social ecological model (i.e., individual, relationship, community, societal; see Appendix 2) is critical to having a population level impact.

Strategies for Preventing CSA

To have the greatest impact on CSA prevention, we must take advantage of the best available evidence and focus on the strategies and approaches most likely to impact CSA. Currently, the evidence base for the primary prevention of CSA is limited; however, it is imperative that we invest in rigorous evaluation of promising prevention approaches and allow for development and evaluation of new preventive strategies based on the best available data.

Adult-perpetrated CSA. Adult-perpetrated CSA prevention has largely focused on two primary strategies: perpetrator management (to prevent perpetration) and school-based educational programs (to prevent victimization)\textsuperscript{31}. Although perpetrator management strategies were designed to protect communities and children, these strategies do little to actually prevent CSA and may have unintended consequences that make communities less safe\textsuperscript{32,33}. Likewise, while school-based educational programs increase children’s knowledge and skills, it is unclear whether the programs have an effect in actually preventing CSA\textsuperscript{33}. Despite limitations and lack of impact, these strategies continue to be used to prevent CSA. Over half of the states in the US have enacted legislation requiring the implementation of these school-based educational programs, and laws and policies without evidence of effectiveness continue to be supported for perpetrator prevention. In an attempt to put the primary responsibility for preventing CSA in the hands of adults rather than focusing solely on children and the
criminal justice system, some programs now focus on educating adults\textsuperscript{xlv}. The goal of these programs is to build adult and community responsibility for the prevention of CSA and to create protective environments for children. These programs lack evidence of effectiveness in preventing victimization or perpetration. Thus, research on programs that aim to prevent adult-perpetrated CSA is needed.

Peer-/juvenile-perpetrated CSA. Research on peer- and juvenile-perpetrated CSA has increased in recent years, and some programs have resulted in reductions in perpetration of SV. These programs may be delivered in a variety of settings, including school classrooms and community organizations. Several of the programs teach children skills related to healthy, safe dating relationships, healthy sexuality, and social-emotional health\textsuperscript{xlv,xlvi}. Other programs aim to reduce the acceptability of violence and increase positive attitudes towards girls by engaging men and boys and changing social norms\textsuperscript{xlvii,xlviii}. Programs that aim to create protective environments by improving the safety of schools (i.e., monitoring the physical and social environment) have shown positive effects in reducing peer-perpetrated CSA\textsuperscript{xlix}.

\textbf{CDC’s Current Efforts in CSA Prevention}

CDC’s use of the public health model in its violence prevention activities allows for monitoring of CSA, identifying factors that increase or decrease risk of CSA, implementing and evaluating programs, practices, and policies to prevent CSA, assuring widespread adoption of evidence-based CSA prevention strategies, and tracking progress on reductions in CSA. Current activities are included below.

\textbf{Data for research and monitoring.} CDC’s surveillance expertise has allowed for the collection of CSA estimates in a number of areas. Adult lifetime prevalence of CSA is assessed in the National Intimate Partner and Sexual Violence Survey (NISVS), exposure of students to CSA in their lifetime and in the last 12 months and exposure to sexual dating violence in the last 12 months is collected via the Youth Risk Behavior Survey (YRBS), and the relationship between CSA and health-related risk behaviors is collected using the Behavioral Risk Factor Surveillance System (BRFSS). CDC also has provided partial funding for the National Survey of Children’s Exposure to Violence (NatSCEV), which documents the incidence and prevalence of children’s exposure to violence. CDC also supports surveys on violence against children globally to understand the magnitude, nature, and consequences of violence against children. Unfortunately, however, these surveillance systems only allow for victimization estimates, not perpetration estimates.

\textbf{Research to understand risk and protective factors and effectiveness of CSA prevention strategies.} Given the limited evidence base for CSA prevention, CDC has focused its limited resources in the last four years on the development and evaluation of prevention approaches for CSA to inform more directly CDC’s ongoing practice initiatives, including the Rape Prevention and Education (RPE) and the Essentials for Childhood (EIC) programs. CDC also currently funds secondary data analyses to examine risk and protective factors for CSA perpetration in middle and high schools. Other projects funded in the past have examined what puts one at risk for or protects against CSA, media products for an adult education program (i.e., Stewards for Children) for CSA, and the unique and shared risk factors for adolescent perpetration of CSA, sexual assault, and delinquent behavior.

\textbf{Dissemination and implementation of CSA prevention strategies.} CDC’s Division of Violence Prevention developed technical packages of the best available evidence for child abuse and neglect and sexual violence to guide its practice initiatives\textsuperscript{xli}. The Rape Prevention and Education program supports health departments in all 50 states, the District of Columbia, Puerto Rico, and four U.S. territories to work with rape crisis centers, state sexual assault coalitions, and others to prevent sexual violence. Seven state health departments are funded for the Essentials for Childhood program to address child abuse and neglect. With each recipient in its grant-funded programs, CDC has emphasized the importance of selecting evidence-based programs that are represented in CDC’s technical packages, while still allowing for innovation, particularly at the outer levels of the social ecology where evidence is limited.
Addressing Gaps in CSA Prevention

CDC and others working to prevent CSA are invested in ensuring safe, stable, nurturing relationships and environments for all children. Although research on CSA has received some support over the years, the lack of dedicated and specific funding for assessment and prevention has resulted in a number of gaps across all areas of the public health model.

The availability and quality of data for CSA varies and at times is contradictory and inconsistent. Official data from child welfare and law enforcement are limited by reporting, which excludes large numbers of children exposed to CSA as they delay disclosure or never disclose their abuse. Thus, states and communities lack a data system that enables them to monitor CSA and evaluate progress in addressing it. Rates of self-reported CSA vary based on how CSA is defined in the research. The comparability of prevalence studies could be increased by adopting more standardized measurement and definitions and including all forms of CSA, such as the commercial sexual exploitation or trafficking of minors. Moreover, research could be improved by including samples that are randomly selected, sufficiently large, and representative to generate accurate estimates of CSA. To overcome some of the limitations associated with comparability across studies based on how questions are asked, studies could include multiple assessment methods. Moreover, methods that have been used globally to assess violence against children can be used in a domestic context to assess exposure to and impacts of CSA. Research also is needed on adult sexual interest in and behavior with children, as well as perpetration data for adolescents and same-aged peers.

A better understanding of the factors leading to CSA perpetration is needed to inform the primary prevention of perpetration. Longitudinal research is needed to identify factors related to perpetration in adolescence and adulthood. Much of the data that exists on perpetrators is based on information collected from victims or from research that is cross-sectional, based on small samples, or is of poor quality. More research is needed on protective factors that either directly influence perpetration or buffer risk factors for perpetration. Future work needs to examine the distinctions between the different types of CSA perpetrators (and how they differ from non-perpetrators) and the situational aspects of CSA perpetration to build the most effective and efficient prevention programs. In the absence of longitudinal research, a focus on variables that relate to the initiation of CSA perpetration also may be helpful in the development of prevention strategies. More information also is needed on how risk factors combine or interact, the overlap of CSA perpetration with other forms of violence perpetration, the multiple pathways that may lead to CSA perpetration, and the community- and societal-level factors associated with CSA perpetration.

Policies, programs, and strategies for preventing perpetration of CSA are needed. CDC’s Division of Violence Prevention has outlined strategies for preventing child abuse and neglect and sexual violence in their technical packages; however, the evidence base for CSA prevention is small. More research is needed to identify and evaluate individual-, relationship-, community-, and societal-level approaches for preventing the various forms of CSA perpetration, including adult-perpetrated CSA, CSA perpetrated by youth against same age and younger children, and the commercial sexual exploitation or trafficking of minors. Programs that show promise promote social norms and protect against violence by engaging men and boys; create protective environments by improving the safety and monitoring in schools; and teach skills related to healthy, safe dating relationships, healthy sexuality, and social-emotional health. Additional research is needed of public policies that may contribute to CSA prevention and to better understand how to alter norms and beliefs that contribute to CSA.

Dissemination and implementation is needed for existing evidence-based strategies. Although the evidence base is small, CSA is an urgent public health problem that requires us to act on the best available evidence. Research is needed on how to best scale up the existing evidence base, as well as how to best adapt the evidence-based CSA preventive interventions for different populations and settings. Given that sexual topics are often difficult to discuss or not discussed in families and communities, additional research is needed to understand how to best communicate about CSA and evidence-based programs for CSA prevention.
Conclusion

Childhood sexual abuse is an adverse event that affects millions of children annually; however, it is preventable. Although official estimates suggest that the problem has declined over the years, self-report data suggest that it is consistently occurring at alarmingly high rates. The majority of funding specific to CSA is directed at the criminal justice system response after CSA is reported. While this is necessary, it is equally important to prevent CSA from happening in the first place. The information provided in this report represents a call-to-action to support the primary prevention of CSA.

Moving forward, this effort will require increased coordination and collaboration among the many stakeholders focused on preventing CSA. We, as adults, must take the steps necessary to reduce children’s exposure to child sexual abuse. We all must have the shared vision of ensuring safe, stable, nurturing relationships and environments for all children. Because, when our children do well, so does our country.

One of the most powerful ways to change the world is to make it a better place for kids.

Jack P. Shonkoff, National Scientific Council for the Developing Child
I. Overview

In its report on the Fiscal Year (FY) 2019 appropriation for the Department of Health and Human Services (HHS), the House and Senate Appropriations Committees state the following:

Child Sexual Abuse Prevention.—It is estimated that 15 to 25 percent of girls and five to 10 percent of boys will experience child sexual abuse. While the Federal government has invested in treatment for victims and punishment for offenders, the Committee believes that more emphasis should be placed on prevention. The Committee requests that the Center report on its current activities related to the development and evaluation of primary public health interventions targeting child sexual abuse. Additionally, the Committee requests that the Center identify gaps in research that can be filled to promote child sexual abuse primary prevention. The Committee requests this report within 180 days of enactment of this Act. (House Report 115-862, Page 48).

Child Sexual Abuse Prevention.—It is estimated that 15 to 25 percent of girls and 5 to 10 percent of boys will experience child sexual abuse. While the Federal Government has invested in treatment for victims and punishment for offenders, the Committee recognizes the value of also investing in prevention. The Committee requests that the Center for Injury Prevention and Control report on its current activities related to the development and evaluation of primary public health interventions targeting child sexual abuse. Additionally, the Committee asks that the Center identify gaps in research that can be filled to promote child sexual abuse primary prevention, as well as what resources would be needed to conduct such research. The Center shall provide a report to the Committee within 180 days of enactment of this act. (Senate Report 115-289, Page 62).

The Centers for Disease Control and Prevention’s (CDC) Division of Violence Prevention (DVP) prepared this report in response to this request from the House and Senate Appropriations Committees. The CDC convened a writing group in December 2018 consisting of internal CSA subject matter experts. The writing group developed a draft report that was shared for feedback with external reviewers with diverse perspectives on CSA prevention. The final report included feedback from these reviewers, as well as staff within CDC and HHS.

II. Introduction

Child sexual abuse (CSA) is a serious public health problem that affects millions of children each year and results in a host of negative short- and long-term health and social consequences and significant societal costs. The total lifetime economic burden of CSA in the U.S. is estimated to be $9.3 billion, although this is likely an underestimate given the limitations of available data, as outlined below. Currently, there are limited effective, evidence-based strategies for proactively protecting children from CSA.

CSA broadly defined refers to all forms of sexual violence against children (i.e., individuals under the age of 18) by an adult or another child/adolescent of the same or different age. This includes rape (i.e., forced penetration or penetration when the victim is not able to consent), incest (i.e., sexual activities with a closely related family member), unwanted sexual touching, non-contact unwanted sexual experiences (e.g., verbal sexual harassment), internet-based sexual crimes, commercial sexual exploitation of children or trafficking, and alcohol or drug-facilitated sexual violence, among others. Perpetrators may include parents or other adults/caregivers, dating partners, family friends, relatives, friends, acquaintances, someone known only by sight, etc. CSA can occur online (e.g., via social media) and in person. CSA perpetration and victimization occur in all parts of society and about 90% of perpetrators are someone the parent or child knows and is often trusted by the child and family.

About 90% of perpetrators are someone the parent or child knows and is often trusted by the child and family.

As noted in the congressional requests for this report, the federal government has invested in treatment for victims and punishment for perpetrators of CSA, but little investment has been made specifically toward
prevention of CSA. In fact, the majority of resources are directed at intervention after CSA has been reported, which is the criminal justice system response.

III. Section 1: The Public Health Burden of CSA

As the nation’s health protection agency, the US Centers for Disease Control and Prevention can play an important and unique role in preventing CSA and in complementing the criminal justice-oriented approaches already in place. Public health agencies are able to bring critical leadership, expertise and resources to bear on all public health issues, including CSA. For issues such as violence prevention, the goal is to create broad population-level impact by preventing perpetration. This is done by collecting and disseminating data that identifies, tracks and analyzes the problem; identifying risk and protective factors; implementing and evaluating preventive measures and approaches; and tracking progress using the four-step public health approach (see Appendix 1). CDC and other public health agencies seek to understand the factors that influence violence using the four-level social ecological model (see Appendix 2). Widely used as a foundation for understanding comprehensive prevention, this model considers the interconnections among individual, relationship, community, and societal factors. It allows for understanding and intervening on the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The model also suggests that in order to prevent violence, it is necessary to act across multiple levels of the model at the same time. This comprehensive approach is more likely to have a population-level impact and sustain prevention efforts over time than any single intervention.

Estimating the incidence and prevalence of CSA can be challenging due to two main issues: (1) definitional differences and (2) reporting. First, there is no consistent definition of CSA in the literature. Different definitions are used among the various sectors addressing CSA and across data system and studies, which limits the utility and reliability of data. Second, there is an under-reporting of CSA in official and self-reported estimates. Most victims of CSA delay or never disclose CSA to friends, family, or the authorities, making it difficult to determine true estimates of the problem. Data from official sources also may distort descriptions of the type of persons at risk and characteristics of the problem, as these also are often discordant from self-reports. Consequently, studies relying on data from official sources likely underestimate the true magnitude of the problem and may not accurately reflect the groups at highest risk. Self-report surveys often provide a better estimate of the true magnitude of CSA, but they, too, can be an underestimate due to sampling biases and problems with memory. In light of this, however, a meta-analysis of the prevalence of CSA found that self-report studies yielded prevalence rates that were 30 times higher than rates based on official reports.

According to CDC’s National Intimate Partner and Sexual Violence Survey (NISVS), which is a nationally representative study of lifetime and last 12 month experiences of intimate partner violence, sexual violence, and stalking victimization among US adults, 8.4% (estimated 10 million) of women reported that they experienced rape or attempted rape under the age of 18. While the rates for males are lower than females, 0.7% (estimated 791,000) of men reported experiences of rape or attempted rape and 1.6% (estimated 2 million) of men were made to penetrate or there was an attempt to be make them penetrate someone. A meta-analysis comparing prevalence rates of CSA (defined more broadly than rape or attempted rape) across studies in the US found that, on average, 25.3% of females and 7.5% of males reported experiencing CSA. Another national survey, which assesses youth and their caregivers, found that 5.9% of girls and 4.1% of boys in the US experienced some form of CSA within the last year, with the rate being 16.4% for girls and 9.4% for boys 14- to 17-years-old. This means that 3.7 million children were exposed to CSA in the last year. Child welfare data collected annually by the US Department of Health and Human Services, which is an official source of CSA victimization data, includes

---

1 Other federal agencies, including the US Department of Education and the US Department of Justice, have led and published reports that were informative in drafting this response.
only cases of child abuse and neglect that are reported to and investigated by child welfare agencies. Based on this data, 8.5% of the 676,000 child victims experienced CSA in 2016\textsuperscript{xxxiii}. Unfortunately, the prevalence of trafficking minors for sex is understudied and hard to estimate. Currently, no credible estimates about the size of the problem exist\textsuperscript{xxxiv}.

Rates of CSA often vary based on age, with increases for females found after menarche, though younger children also may be victims\textsuperscript{xxxv}. Among a large sample of 15-17 year-olds, considerable risk for sexual assault and abuse occurred in late adolescence, with the rate rising from 16.8% for 15-year-old females to 26.6% for 17-year-old females and from 4.3% at 15 years to 5.1% at 17 years for males\textsuperscript{xxxvi}. In CDC’s National Intimate Partner and Sexual Violence Survey, approximately 1 in 3 female victims of completed rape experienced it for the first time between 11 and 17 years of age, while almost 1 in 9 reported that it occurred when they were age 10 or younger\textsuperscript{xxxvii}.

Using CDC’s Youth Risk Behavior Survey (YRBS), 11.3% of female youth enrolled in US high schools reported ever being physically forced to have sexual intercourse when they did not want to and 15.2% reported being forced to do “sexual things” (e.g., kissing, touching, or being physically forced to have sexual intercourse) by any perpetrator within the past 12 months. Approximately 10.7% of female high school students reported being forced to do “sexual things” by a dating partner or someone they were going out with within the past 12 months\textsuperscript{xxxviii}. Among boys in US high schools, 3.5% reported ever being physically forced to have sexual intercourse, 4.3% reported being forced to do “sexual things” by any perpetrators within the past 12 months, and 2.8% reported being forced to do “sexual things” by a dating partner within the past 12 months. Sexual harassment is even more prevalent, with 56% of 7-12th grade girls and 48% of boys reporting being victimized by in-person or on-line sexual harassment (e.g., unwelcome comments, touching, intimidated or forced to do something sexual) during the last school year\textsuperscript{xxxix}. Another nationally representative study of sexual harassment among 7th-12th grade students found that both girls and boys engage in sexually harassing behaviors, which can create an environment that fosters more serious forms of sexual violence among students. 14% of girls and 18% of boys reported perpetrating sexually harassing behaviors against another student within the past school year, with most female (92%) and male (80%) perpetrators also reporting experiences of sexual harassment by other students\textsuperscript{x}. Similarly, another recent study of 10-21-year-olds found that 23% of male and 17% of female youth reported sexually harassing and victimizing others\textsuperscript{x}. Sexual harassment may serve as a precursor to more serious forms of CSA and, as such, should be monitored.

Nationally representative perpetration estimates are limited, and like victimization data, official reports underestimate the true burden of the issue\textsuperscript{x}. National survey estimates suggest that, for 17-year-old females, the lifetime rate of CSA by juvenile perpetrators was 17.8%, by adult perpetrators was 11.2%, by acquaintances was 19.6%, by family perpetrators was 5.5%, and by strangers was 3.0%. For 17-year-old males, the lifetime rate of CSA by juvenile perpetrators was 3.1% and by adult perpetrators was 1.9\textsuperscript{x}. Using data from the National Intimate Partner and Sexual Violence Survey, 43.6% of perpetrators of female victims were acquaintances, 28.8% were partners, 27.7% were family members, 4.5% were authority figures (e.g., teacher, coach), and 10.1% were strangers\textsuperscript{x}. For males who experienced CSA in youth, over a third (35.1%) of the perpetrators were acquaintances\textsuperscript{x}. These data suggest that, contrary to media portrayals, most CSA perpetrators are known to the victim rather than strangers and are often peers of the same age.

Consequences of CSA

Victims of CSA are at increased risk for a wide range of consequences as compared to individuals without a CSA history. Effects can begin immediately after abuse and continue throughout the life course. Basic science has been instrumental in documenting the biological associations between exposure to CSA and subsequent health conditions. Traumatic stress, such as that associated with CSA, impairs brain architecture (both structure and function), immune status, metabolic systems, and cellular inflammatory responses\textsuperscript{xv}. Early exposure to toxic stress in childhood can confer lasting damage at the most basic levels of the nervous, endocrine, and immune systems, and such exposures can alter the physical structure of DNA (epigenetic effects)\textsuperscript{xv}. While these multifaceted gene-environment interactions may lead to negative health
consequences after exposure to chronic stress, they also appear to confer positive health consequences after exposure to early environments that are engaging and nurturing\textsuperscript{a}. Epidemiologic research complements these findings, demonstrating that early nurturing in the home leads to sustained positive economic and psychosocial consequences up to five decades later\textsuperscript{b}.

Table 1, while not an exhaustive list, includes other short- and long-term physical health, mental/emotional health, and social, cognitive, and economic consequences associated with CSA victimization. Depression and suicidal ideation are two common consequences associated with CSA exposure. Girls victimized during adolescence are almost six times more likely to report suicidal thoughts or attempts than adolescent girls who have not been victimized\textsuperscript{c}. Compared to those without a history of CSA, men with a history of CSA have six times the odds of attempting suicide over their lifetime, while women with a history of CSA have nine times the odds of attempting suicide over their lifetime\textsuperscript{d}. In adults, lifetime prevalence of depression in women with a history of CSA can be as much as five times higher than in women without a CSA history\textsuperscript{e}. Substance use disorders associated with CSA can start early in life and have a lifelong impact. For example, CSA has been associated with almost three times the odds of initiating illicit drug use before age 14, and two times the odds of having a lifetime history of illicit drug use\textsuperscript{f}.

Table 1. Consequences of CSA Victimization

<table>
<thead>
<tr>
<th>Physical Health Consequences</th>
<th>Short-term</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually transmitted infections\textsuperscript{g,h}</td>
<td>Decreased health-related quality of life\textsuperscript{i,j,k,l}</td>
<td></td>
</tr>
<tr>
<td>Genital pain and injuries\textsuperscript{m,n}</td>
<td>Heart disease\textsuperscript{o}</td>
<td></td>
</tr>
<tr>
<td>Sexualized behavior\textsuperscript{p}</td>
<td>Obesity\textsuperscript{q}</td>
<td></td>
</tr>
<tr>
<td>Sleep disturbances\textsuperscript{r}</td>
<td>Pain disorders\textsuperscript{s}</td>
<td></td>
</tr>
<tr>
<td>Stomachaches\textsuperscript{t}</td>
<td>Cancer\textsuperscript{u}</td>
<td></td>
</tr>
<tr>
<td>Headaches\textsuperscript{v}</td>
<td>Frequent headaches\textsuperscript{w,x}</td>
<td></td>
</tr>
<tr>
<td>Unwanted/unplanned pregnancy\textsuperscript{y,z}</td>
<td>Non-epileptic seizures\textsuperscript{aa}</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gynecological problems (e.g., chronic pelvic pain)\textsuperscript{ab,ac,ad}</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased use of health care services, especially for females\textsuperscript{ae,af,ag}</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental/Emotional Health Consequences</th>
<th>Short-term</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-traumatic stress disorder (PTSD)\textsuperscript{ah,ai}</td>
<td>Depression\textsuperscript{aj,ak,al,am}</td>
<td></td>
</tr>
<tr>
<td>Anxiety\textsuperscript{an}</td>
<td>PTSD\textsuperscript{ao,ap,aq,ar}</td>
<td></td>
</tr>
<tr>
<td>Aggression\textsuperscript{as}</td>
<td>Suicide, including suicidal ideation &amp; attempts\textsuperscript{at,au,av,aw}</td>
<td></td>
</tr>
<tr>
<td>Depression\textsuperscript{ax}</td>
<td>Self-injurious behavior without suicidal intent\textsuperscript{ax}</td>
<td></td>
</tr>
<tr>
<td>Low self-esteem\textsuperscript{ay}</td>
<td>Anxiety\textsuperscript{az}</td>
<td></td>
</tr>
<tr>
<td>Suicidality\textsuperscript{ba}</td>
<td>Low self-esteem &amp; self-efficacy\textsuperscript{bc}</td>
<td></td>
</tr>
<tr>
<td>Substance abuse\textsuperscript{bd}</td>
<td>Eating disorders\textsuperscript{be}</td>
<td></td>
</tr>
<tr>
<td>Disordered eating\textsuperscript{bf}</td>
<td>Alcohol and substance use disorders\textsuperscript{bg,bh,bi,bj}</td>
<td></td>
</tr>
<tr>
<td>Risky sexual behaviors (e.g., higher frequency of sex while intoxicated, less condom use at last sex, more sex partners)\textsuperscript{bj,ak,al,am}</td>
<td>Risky sexual behaviors (e.g., unprotected sex, sex with multiple partners, sex trading)\textsuperscript{bj,ak,al,am}</td>
<td></td>
</tr>
<tr>
<td>Early age at first sexual contact\textsuperscript{bk}</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social, Cognitive, & Economic Consequences

- Educational problems (e.g., learning difficulties, concentration & attention problems, declining grades)\(^{\text{xxi}}\)
- Educational underachievement\(^{\text{xxi}}\)
- Increased risk of impaired social functioning\(^{\text{xxi}}\)
- Social restrictions & manipulation\(^{\text{xxi}}\)
- Economic exploitation & debt-bondage\(^{\text{xxiv}}\)
- Occupational hazards & abusive living conditions\(^{\text{xxv}}\)
- Arrest and detention\(^{\text{xxv}}\)
- Inability to obtain needed legal services\(^{\text{xxv}}\)
- Exposure to extreme environmental conditions\(^{\text{xxv}}\)
- Revictimization in adulthood\(^{\text{xxvi}}\)
- Risk for teen dating violence\(^{\text{xxvii}}\)
- Risk for intimate partner violence\(^{\text{xxviii}}\)
- Increased risk for later being trafficked for sex\(^{\text{xxviii}}\)
- Decreased life satisfaction\(^{\text{xxviii}}\)
- Significant economic problems in adulthood (e.g., unemployment & poverty)\(^{\text{xxviii}}\)
- Risk for perpetrating violence\(^{\text{xxviii}}\)

Note. This table is not an exhaustive list of consequences associated with CSA exposure.

Another outcome commonly associated with CSA exposure is an increased risk of revictimization over the life course. In a recent meta-analysis, 47.9% of adult CSA survivors – nearly half – were sexually revictimized in adulthood\(^{\text{cxcii}}\). Females exposed to CSA are at a 2-13 fold increased risk of sexual victimization in adulthood compared to females without a history\(^{\text{cxciii,cxciv,cxcv}}\). Further, compared to other forms of childhood abuse and adversity, CSA has been shown to be the strongest predictor of sexual victimization in adulthood\(^{\text{cxcvi}}\). Revictimization is not limited to sexual violence – individuals who experienced CSA are at twice the risk for intimate partner violence\(^{\text{cxcvii}}\). Exposure to CSA also increases risk for later being trafficked for sex\(^{\text{cxcviii,cxcix,cc}}\). CSA survivors also may be more likely to perpetrate violence. CSA has been associated with verbal aggression towards friends, partners, and strangers in adolescence and adulthood\(^{\text{cci}}\), and two times the risk of perpetration of intimate partner violence\(^{\text{ccii}}\). It is also a risk factor for perpetration of CSA in adulthood\(^{\text{cciii}}\). Compared to the general population, both male and female adult sexual violence perpetrators have more than three times the odds of having been victims of CSA in their own childhoods\(^{\text{cciv,ccv}}\). Studies have found that juvenile perpetrators of CSA, although unlikely to reoffend as adults, are more likely to recreate behaviors reflective of their own victimization\(^{\text{ccvi}}\).

The economic burden of child maltreatment, CSA, and rape on the US population is substantial and highlights the urgency with which these issues need to be addressed. The CDC estimates the US population economic burden of child maltreatment to range from $428 billion (for confirmed/substantiated cases of child maltreatment) to $2 trillion (for reported/investigated cases; 2015 US dollars\(^{\text{ccvii}}\)). Although using different methodology, the estimated lifetime economic burden of CSA is at least $9.3 billion (2015 US dollars\(^{\text{ccviii}}\)). The lifetime economic burden of rape among the US adult population is nearly $3.1 trillion (2014 US dollars) over victims’ lifetimes\(^{\text{ccix}}\). The estimates for the cost of rape are based on data assuming the average age at first rape was 18 years; however, over 40% of females and close to 25% of males experience rape before age 18\(^{\text{ccx}}\). Thus, the estimates of the economic burden of rape in the US are likely a conservative estimate of the problem.
IV. Section 2: Risk and Protective Factors for CSA Victimization and Perpetration

The four-level social ecological model, when applied to violence research, suggests that there is a complex interplay between individual, relationship, community and societal factors that either place one at risk for victimization/perpetration (i.e., risk factors) or protect one against victimization/perpetration (i.e., protective factors). Much more is understood about factors that increase risk than factors that decrease or buffer risk. Table 2, although not exhaustive, includes the individual, relationship, community and societal risk and protective factors that have been linked to CSA victimization. It is important to note that ethnicity and socioeconomic status have not been consistently identified as risk factors for CSA, as CSA appears to cut across all races and levels of income.

<table>
<thead>
<tr>
<th>Ecological Level</th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>Female gender, Age – preadolescent or early adolescent, History of child abuse &amp; sexual exploitation, Substance use, Being disabled or handicapped, Passivity, Quietness, Trustingness, Unhappy appearance, Depression</td>
<td>Higher level of education completed</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td>Maternal youth, Parental unwanted pregnancy, Parental death, Harsh parental punishment or poor parenting, Maternal sociopathy or impairment, Having a stepfather, Living without a natural parent, Male dominated household, Witnessing family conflict, Few close friends</td>
<td>Parental supervision, Healthy parenting as a child, Supportive family</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>Community tolerance of sexual abuse, Neighborhood violence, Poverty, mediated through forms of crisis of male identity, Lack of employment opportunities, Lack of institutional support from police &amp; judicial system, Media portrayals of children as sexual actors, Weak community sanctions against perpetrators of sexual violence</td>
<td></td>
</tr>
<tr>
<td><strong>Societal</strong></td>
<td>Inequality between men &amp; women/patriarchal social systems &amp; laws, Societal acceptance of child pornography, adult-child sex, or sexual violence, Societal objectification of women/girls &amp; male sexual entitlement, Weak laws &amp; policies against sexual violence perpetration</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Risk and Protective Factors for CSA Victimization
Note. This table is not an exhaustive list of consequences associated with CSA exposure. Also note the limited (or lack of) data on protective factors, particularly at the community and societal levels.

Contrary to popular belief, perpetrators of CSA are not always ‘dirty old men’ nor are they strangers. Approximately 90% of CSA cases that come to the attention of law enforcement involve a perpetrator known to the child. Perpetrators of CSA are not a uniform group, as there are adolescent perpetrators, adult perpetrators, intra-familial perpetrators, extra-familial perpetrators, perpetrators of child pornography, repeat perpetrators, pedophiles, contact vs. non-contact perpetrators, etc. Thus, risk and protective factors for perpetration may vary based on CSA type. For example, a number of studies have found that exposure to CSA in childhood can be a risk factor for later CSA perpetration among both males and females. The evidence, however, is somewhat inconsistent and may vary according to the sample and type of CSA examined. Support for CSA victimization as a risk factor for perpetration has been found in studies of perpetrators of both children and adults, whereas studies that assessed perpetration against only peer victims (i.e., someone of a similar age) were less likely to find significant effects. Moreover, the research also demonstrates that whether or not the abuse cycle continues depends on specifics of the abuse, resilience of the child, and environmental factors. Table 3 includes the individual, relationship, community and societal risk and protective factors that have been linked to CSA perpetration.

Table 3. Risk and Protective Factors for CSA Perpetration

<table>
<thead>
<tr>
<th>Ecological Level</th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>Male gender</td>
<td>Higher level of education completed</td>
</tr>
<tr>
<td></td>
<td>Exposure to CSA in childhood</td>
<td>Empathy</td>
</tr>
<tr>
<td></td>
<td>Substance use</td>
<td>Resiliency</td>
</tr>
<tr>
<td></td>
<td>High impulsivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low self-esteem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anger/hostility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anxiety or depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loneliness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poor coping strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traditional beliefs about masculinity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exposure to pornography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dismissiveness of sexual harassment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Early sexual initiation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual problems and deviancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitions tolerant of adult-child sex</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acceptance of rape myths</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitions that minimize perpetrators’ culpability</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td>Family conflict &amp; hostility</td>
<td>Parental monitoring</td>
</tr>
<tr>
<td></td>
<td>Poor attachment or bonding</td>
<td>Healthy parenting</td>
</tr>
<tr>
<td></td>
<td>Controlling coercive parenting</td>
<td>Supportive family</td>
</tr>
<tr>
<td></td>
<td>Difficulties with intimate relationships</td>
<td>Social support</td>
</tr>
<tr>
<td></td>
<td>Delinquent peer associations</td>
<td>Sense of school belonging or connectedness</td>
</tr>
</tbody>
</table>
Community

- Neighborhood violence
- Poverty, mediated through forms of crisis of male identity
- Lack of employment opportunities
- Lack of institutional support from police and judicial system
- Media portrayals of children as sexual actors
- Weak community sanctions against perpetrators of sexual violence

Societal

- Inequality between men and women/patriarchal social systems & laws
- Societal acceptance of child pornography, adult-child sex, or sexual violence
- Societal objectification of women/girls & male sexual entitlement
- Weak laws & policies against sexual violence perpetration

Note. This table is not an exhaustive list of risk and protective factors for CSA perpetration. Also note the limited (or lack of) data on protective factors, particularly at the community and societal levels.

Although risk and protective factors provide information about who is most at risk for being a victim or perpetrator of CSA, these factors are not direct causes and cannot predict who will be a victim or perpetrator. A better understanding of the risk and protective factors for the different forms and different perpetrators of CSA, however, is important for designing preventive interventions that will be effective.

### V. Section 3: Strategies for Preventing CSA

Although the evidence for primary prevention of CSA is limited, the problem is too large and costly and has too many urgent consequences (as documented earlier) to wait for perfect answers. Listed below are strategies that are currently being evaluated for preventing the perpetration of CSA, have some evidence of effectiveness, or are being implemented but are largely unevaluated (and in need of research to examine their effectiveness). Table 4 outlines these strategies. As noted in the table, limited evidence of effectiveness exists across programs and levels of the social ecology. To be effective at preventing CSA, comprehensive strategies that incorporate multiple approaches at all levels of the social ecology are necessary, as is coordination among multiple sectors working to address the issue.

#### Table 4. Perpetrator Prevention Programs

<table>
<thead>
<tr>
<th></th>
<th>Adult-Focused</th>
<th>Youth-Focused</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>Stewards of Children</td>
<td>Responsible Behavior with Younger</td>
</tr>
<tr>
<td></td>
<td>Project Dunkelfeld</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>Stop It Now</td>
<td>Second Step: Student Success through Prevention*</td>
</tr>
<tr>
<td></td>
<td>Enough Abuse</td>
<td>Safe Dates*</td>
</tr>
<tr>
<td></td>
<td>Thorn</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td>Parenting strategies</td>
<td>Bringing in the Bystander*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Green Dot*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coaching Boys into Men*</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult Sex Offender Laws</td>
<td>Shifting Boundaries – building level*</td>
</tr>
<tr>
<td><strong>Societal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult Sex Offender Laws</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Juvenile Sex Offender Laws</td>
<td></td>
</tr>
<tr>
<td><strong>Secondary/tertiary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Circles of Support &amp; Accountability</td>
<td>Children with Problematic Sexual Behavior Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program: School-age Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multisystemic Therapy</td>
</tr>
</tbody>
</table>
Note: The asterisk (*) by programs indicates that the program has demonstrated some evidence of effectiveness in preventing CSA. The plus (+) by programs indicates that the program has components that may fall under multiple levels of the social ecology.

**Individual Level Prevention**

Individual level prevention programs focus on providing information, treatment, or training to individuals thus allowing them to alter or manage their behaviors. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include education and life skills training.

Perhaps the most well-known CSA prevention programs at the individual level are those directly targeting children to prevent victimization hence their exclusion from Table 4. While these programs vary, many focus on providing training that allows children to recognize CSA, establish appropriate boundaries, and learn skills to avoid and report abuse. A meta-analysis of school-based education programs found that these programs increased knowledge (at least in the short-term), however, the quality of the research is limited and it is unclear whether the programs reduce victimization. Moreover, several prior studies have reported harms connected to education programs such as increased fear of strangers, increased dependency behaviors, and more aggressive behaviors towards siblings and peers. Even with that information, over half of the states in the US have passed legislation mandating or encouraging CSA prevention training in schools, with an increasing emphasis on preventing the commercial sexual exploitation of children. Given limited resources in schools and the plethora of unfunded mandates, many schools will not implement the programs nor will they receive consequences for not implementing programs. Other schools will implement the programs but with limited quality (e.g., skipping content, limiting the number of sessions), which likely will impact outcomes.

As noted by Bernier, a more practical, cost-effective, and measurable way to address CSA is by educating adults. This focus also takes the responsibility for prevention of CSA off the shoulders of children. Adult-focused CSA prevention programs aim to build adult and community responsibility for the prevention of CSA, thereby creating protective environments. Darkness to Light’s Stewards of Children® program is an example. Research has found that adults who received the training have increased knowledge, improved attitudes, and positive change in child-protective behaviors. More research is needed, however, to fully determine whether adult education programs influence rates of CSA victimization and perpetration.

**Information and effectiveness research on programs that prevent adult-perpetrated CSA is limited.** The few programs currently in place focus on reducing initial perpetration and recidivism, such as with Prevention Project Dunkelfeld. This program focuses on those who self-identify with pedophilia or hebephilia (sexual preference for prepubescent and pubescent children, respectively) and recruits them to a treatment program to increase behavioral control and reduce risk factors. The program is two-step beginning with a media campaign to identify and recruit participants. In order to drive recruitment, the campaign focuses on empathy and understanding, does not use any discriminatory language relating to sexual preference, aims to reduce fear in the justice system, identifies as allowing for anonymity and confidentiality, and aims to reduce guilt and shame in those who self-identify with pedophilia or hebephilia. Those who contact the provided number undergo assessment to determine if participating in a professional treatment program is appropriate. Treatment is group-based, with a focus on relapse prevention.

Stop It Now! is a program developed in 1992 that emphasizes adult and community responsibility for the prevention of CSA. The program provides support and access to resources for adults who are concerned about inappropriate sexualized behaviors in another adult, adolescent, or child and to adults who are concerned about their own thoughts or behaviors. They offer a confidential helpline for individuals and families. Enough Abuse also aims to prevent CSA with an emphasis on collaboration among all sectors in the community (e.g., families, schools, youth serving organizations, early education and care professionals). Stop It Now! and Enough Abuse, have media campaigns as part of their programs that...
may impact community-level policies to prevent CSA. Stop It Now! was evaluated in Georgia, while the Enough Abuse campaign was evaluated in Massachusetts. Both states had reductions in CSA during the implementation of the campaigns; however, CSA was decreasing overall in the US at the time so it is unclear whether the reductions were the result of the campaign or the general decline observed in other states\textsuperscript{ccclxxii,ccclxxiii}. Additional research is needed on the effectiveness of adult-perpetrated CSA, including the implementation and evaluation of demand reduction programs.

Projects such as Thorn are online strategies aimed at preventing the spread of child pornography and trafficking of minors. The work is guided by three principles: (1) accelerate victim identification; (2) deter abusers; and (3) disrupt platforms\textsuperscript{ccclxxiv}. Tools developed by Thorn such as Project Vic (i.e., repository of identified CSA images), Spotlight (i.e., tool to help law enforcement find trafficking victims faster), and BEFREE text shortcode (i.e., option for texting suspicious behavior to the National Human Trafficking Hotline\textsuperscript{ccclxxv}) are innovative strategies that require additional research to determine effects on CSA prevention.

To date there are no evidence-based programs focused on reducing CSA perpetrated by youth against younger children; however, one program has been developed and is currently being evaluated\textsuperscript{ccclxxvi}. The program, Responsible Behavior with Younger Children, was designed to incorporate best practices (e.g., including males and females) and relevant risk factors for perpetration (e.g., including youth ages 11–13). It focuses on encouraging empathy towards children and educating youth on CSA, how to prevent it, and how to intervene\textsuperscript{ccclxxvii}. The program also incorporates parents and aims to increase parental awareness, encourage parent-child communication around CSA, and allow parent-child dyads to openly discuss appropriate and inappropriate sexual behaviors\textsuperscript{ccclxxviii}.

A number of school-based prevention programs (e.g., Second Step: Student Success through Prevention, Safe Dates) have been successful at reducing sexual harassment and sexual violence among youths\textsuperscript{ccclxxix}. The Second Step: Student Success through Prevention is a program for middle school students focused on reducing bullying and sexual violence perpetration. Content of the program focuses on bullying, problem-solving skills, communication and empathy, and substance abuse prevention. The program resulted in a 39% reduction in sexual violence perpetration and a 56% reduction in homophobic teasing victimization in one of the two sites where it was evaluated\textsuperscript{ccclxxx}. Safe Dates is composed of a 10-session curriculum focused on positive communication, anger management, and conflict management. Safe Dates among 8\textsuperscript{th} and 9\textsuperscript{th} graders is effective at reducing sexual violence perpetration and victimization within the dating context\textsuperscript{ccclxxxi}. Further research is needed to determine effects of youth-focused, school-based programs in different communities and settings.

Although not primary prevention programs, two individual-level treatment programs have good evidence of effectiveness for juvenile CSA perpetrators. For example, a 10-year prospective study of Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Program found that children with sexual behavior problems were less likely to reoffend (2%) when they completed the program compared to a play therapy group (10%). Likewise, a 1-year community-based effectiveness trial found that Multisystemic Therapy resulted in significant reductions in sexual behavior problems, delinquency, and substance use, among others\textsuperscript{ccclxxxii,ccclxxxiii,ccclxxxiv}. More longitudinal research is needed to examine whether the positive outcomes observed continue into adulthood and prevent perpetration during adulthood.

Relationship Level Prevention

The second level of the social ecology, the relationship level, examines relationships that may increase the risk of experiencing or perpetrating CSA. CSA prevention strategies at the relationship level may include parenting or family-focused prevention programs, and bystander, mentoring and peer programs designed to reduce conflict, foster problem solving skills, and promote healthy relationships\textsuperscript{ccclxxxv}.
Parents are an important source of information for their children and often need help in communicating with them about CSA. In the US, 79% of parents discussed CSA with their children; however, over 90% of parents explained that potential abusers were strangers while only 65% explained that it could be an adult the child knows and fewer explained it could be a relative (43%), parent (26%) or sibling (25%). Additional protective parenting behaviors (e.g., supervision and monitoring, open communication) can be strengthened to reduce the vulnerability of children to CSA, thereby creating safe/protective environments and developing a strong parent-child relationship. Parents also can indirectly protect children by promoting children’s self-esteem and competence, thus potentially reducing the likelihood that they are targeted for abuse and increasing the likelihood that they disclose abuse if it does occur. Although no specific evidence-based, parent-focused prevention programs have shown reductions in CSA victimization and perpetration, parents have enormous influence on their children’s behavior. Parental awareness and knowledge of risk factors may alert them to danger and allow them to be more effective gatekeepers.

Bystander intervention programs engage youth to promote social norms that protect against sexual violence. Bystander interventions have the potential to reduce the acceptability of violence, decrease negative attitudes about violence against women/girls, increase knowledge and recognition of CSA and dating violence, and decrease the many forms of sexual violence. Bringing in the Bystander effectively increases one’s self-efficacy and intention to intervene in situations involving sexual violence. When schools implemented the Green Dot program, sexual violence victimization rates were 12%-13% lower in the intervention versus control high schools. Further research is needed to determine effects of these programs in different communities and settings.

Other programs such as Coaching Boys into Men (CBIM) aim to change social norms relating to relationships, violence, and sexuality by encouraging men and boys to realize their role in preventing violence. In CBIM, boys involved in high school athletics are provided training by their coaches on how to ensure their relationships are healthy and non-violent. In evaluations it has been shown to reduce the perpetration of dating violence and reduce negative bystander behaviors. Further research is needed to determine effects of programs that mobilize men and boys. For programs such as CBIM that have shown effects in reducing perpetration, research should examine whether effects are sustained and among which specific populations and settings.

Although not a primary prevention program, the Circles of Support and Accountability (COSA) model, has shown promise at the relationship level in its ability to reduce recidivism in a high-risk, high-needs population. In COSA, “circles” are created to support the reintegration of the sexual offender into the community. Volunteers (who are highly trained to ensure they understand the roles and responsibilities of the program) and other members of the circle provide friendship and support while also ensuring accountability for individual behavior; they have the ability to intervene if and when needed. While this program only has preliminary evidence supporting its ability to reduce recidivism of high-risk CSA offenders, it does leverage common risk-factors of reoffending (e.g., social isolation) to reduce their impact. Further research is needed to determine the impact of these programs long-term in preventing recidivism among high-risk populations, such as those previously incarcerated for CSA.

Community Level Prevention

Community-level prevention seeks to identify and modify the characteristics of settings that increase or buffer against the risk for violence, particularly the social, economic, and environmental characteristics of neighborhood, school, and workplace settings. Modifications to the physical and social environment to create safe spaces where people live, work, go to school, and play is an example of a community level strategy that may prevent CSA.

Youth-serving organizations (YSOs) currently have in place a number of policies and procedures that aim to protect children and promote safe, stable, nurturing relationships and environments. Many of these policies
and procedures have been developed based on a 2007 CDC publication titled *Preventing Child Sexual Abuse Within Youth-serving Organizations: Getting Started on Policies and Procedures*. The included policies and procedures aim to reduce CSA perpetrated by both adults and juveniles, and the report outlines specific actions which can be taken to reduce perpetration by both of these groups. It is unclear whether implementation of these policies and procedures in YSOs effectively reduces CSA perpetration and victimization.

Community level prevention also includes activities that create protective environments and improve the safety of schools (i.e., monitoring the physical and social environment) to reduce peer-perpetrated violence. Shifting Boundaries includes a building-based intervention that allows students to identify areas where sexual violence is likely to happen at their school, which then allows for increased adult supervision. The building-based intervention was associated with a 40% reduction in peer sexual violence perpetration and a 34% reduction in sexual harassment perpetration among middle school students. Additional research is needed to determine effects of strategies to create protective environments in different communities and settings.

**Societal Level Prevention**

The fourth level of the social ecology, the societal level, examines the broad societal factors that support/encourage or inhibit/discourage CSA. These factors may include social and cultural norms that limit CSA disclosure, for example, or policies that aim to prevent recidivism in sexual perpetrators. As noted by Bernier, legislation or policies that focus on educating school personnel about how to identify victims and report CSA after it has occurred are being promoted as effective ways to prevent CSA; however, these efforts are often “too little and too late for most child victims”.

Several states have passed and implemented state-level school legislation to help protect youth from CSA. In fact, some states have passed legislation that allow school districts who dismiss or allow an employee to resign because of CSA to disclose this information to other school districts where the individual seeks employment. A recent study found that very few states have legislation that fully complies with the Prohibition on Aiding and Abetting Sexual Abuse provision of the Every Student Succeeds Act. Moreover, several states have closed loopholes so that perpetrators can no longer use the age of consent as a defense in criminal or civil proceedings. Several states also have passed legislation that requires mandated reporters to report CSA threats even if they are made by persons alleging past abuse if that person currently represents a credible threat to children under 18. A majority of states have also implemented safe harbor laws that legally protect and assist children who have been exploited for labor or sex. At the Federal level, a recent law, the Protecting Young Victims from Sexual Abuse and Safe Sport Authorization Act of 2017, amends the Child Abuse Act of 1990 and Title 18 of the United States Code to protect youth from CSA. More research is needed to determine the effects of these policies and legislative practices in preventing CSA perpetration and victimization.

Many legislators have supported the passage and implementation of sex offender laws and policies based on the notion that they will prevent CSA and/or deter perpetrators due to an individual’s fear of the legal system. Research suggests some laws and policies are based on public fear and misperceptions of perpetrator characteristics, and they may inadvertently make our children and communities less safe. These laws may make it difficult for perpetrators, including those juveniles who have to register as sex offenders, to access services, find employment and housing, and maintain supportive relationships with family and friends, which also decreases the likelihood that the perpetrator can focus on the types of issues addressed by most treatment interventions. Like the adult policies, evaluations of juvenile registration and notification policies have not found any public safety benefits. Offender policies do not reduce recidivism or deter first-time offenses in juveniles. In general, however, only a small percentage of juveniles reoffend as adults. A recent meta-analysis found that more than 95% of juveniles did not reoffend within five years, but the effects of policies can be long-lasting. Compared to non-registered children, registered youth have poorer mental health outcomes, including anxiety and depression; are four
times more likely to report a suicide attempt in the past 30 days; and report more experiences of victimization, including being five times more likely to have been approached by an adult for sex and nearly twice as likely to be sexually assaulted themselves. They also may be more likely to experience school problems, including not being able to attend school or being forced to switch schools; harassment and unfair treatment; and greater living instability, including living in a group home. Thus, future research is needed to identify and evaluate policies that will prevent CSA and deter future perpetration to successfully protect our children and communities.

Given that the field of CSA prevention is early in its development, no research currently exists on how evidence-based practices are effectively translated to and used in “real-world” (e.g., community, school) settings. It is imperative that we not only invest in what works to prevent CSA, but also in understanding how to disseminate and scale-up what works across the country.

VI. CDC’s Current Efforts in CSA Prevention

CDC’s efforts on CSA prevention are situated in the Division of Violence Prevention within the National Center for Injury Prevention and Control. The mission of the Division of Violence Prevention is to prevent violence and its consequences so that all people, families, and communities are safe, healthy and free of violence. The Division is committed to stopping violence before it begins through primary prevention efforts. Using the public health model (see Appendix 1), the Division works to (1) monitor violence-related behaviors, injuries, and deaths; (2) conduct research on the factors that put people at risk or protect them from violence; (3) create and evaluate the effectiveness of violence prevention programs, practices, and policies; (4) help state and local partners plan, implement, and evaluate violence prevention efforts; and (5) conduct research on the effective adoption and dissemination of violence prevention strategies. CDC’s efforts in each of these areas as it relates specifically to CSA are outlined below.

Data for Research and Monitoring of CSA

CDC has developed uniform definitions and recommended data elements to improve and standardize data collected for child abuse and neglect and sexual violence surveillance. Uniform definitions allow for better measurement of the magnitude of the problem, identify high-risk groups, and monitor the effects of prevention programs.

CDC also collects data on the prevalence of sexual violence through a number of surveys. These surveys are outlined in Table 5 below.

| Table 5. Surveys on CSA Currently Being Conducted or Sponsored by CDC |
|-------------------------------|------------------|
| **Adult-Focused** | **Youth-Focused** |
| National Intimate Partner and Sexual Violence Survey (NISVS) | The National Intimate Partner and Sexual Violence Survey (NISVS) is an ongoing survey that collects the most current and comprehensive national- and state-level data on intimate partner violence, sexual violence and stalking victimization in the United States. CDC developed NISVS to collect data on these important public health problems and enhance violence prevention efforts. The survey collects data on age at first sexual violence experience, which allows for calculation of lifetime prevalence of CSA. For more information, see [https://www.cdc.gov/violenceprevention/nisvs/index.html](https://www.cdc.gov/violenceprevention/nisvs/index.html) |
| Youth Risk Behavior Surveillance System (YRBSS) | The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading cause of death and disability among youth and adults. YRBSS includes a nationally representative biennial survey of US high school students (Youth Risk Behavior Survey) which includes questions to measure the frequency of sexual violence experienced by students in their lifetime and in the last 12 months and sexual dating violence experienced by students in the last 12 months. For more information, see [https://www.cdc.gov/healthyschools/data/yrbs/index.htm](https://www.cdc.gov/healthyschools/data/yrbs/index.htm). |
Research on Risk and Protective Factors for CSA

**Behavioral Risk Factor Surveillance System (BRFSS)**
- The Behavioral Risk Factor Surveillance System (BRFSS) collects state data annually regarding health-related risk behaviors, chronic health conditions, and use of preventive services. Questions on CSA and other adverse childhood experiences (ACEs) were included as an optional module in the BRFSS from 2009 through 2012 and as state-added questions beginning in 2013. CDC currently has a combined data set of BRFSS ACE data from 42 states. This data allows CDC to examine relationships between CSA and health risk behaviors, as noted in Appendix 3. CDC will be expanding expansion of the BRFSS ACE data collection to an additional six states beginning in 2019. For more information, see [https://www.cdc.gov/brfss/index.html](https://www.cdc.gov/brfss/index.html).

**National Survey of Children’s Exposure to Violence (NatSCEV)**
- The National Survey of Children’s Exposure to Violence (NatSCEV) is a survey of the incidence and prevalence of children’s exposure to violence. NatSCEV is funded by the Office of Juvenile Justice and Delinquency Prevention with support from CDC. For more information, see [http://unh.edu/ccrc/projects/natscev.html](http://unh.edu/ccrc/projects/natscev.html).

**Violence Against Children Surveys (VACS)**
- Violence Against Children Surveys (VACS), led by CDC as part of the Together for Girls partnership, measure physical, emotional, and sexual violence against girls and boys. CDC works with countries around the world to do these surveys to help them guide programs and policies to prevent violence before it starts. For more information, see [https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/index.html](https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/index.html).

Research on Risk and Protective Factors for CSA

**CDC has limited ongoing research focused on risk and protective factors for CSA.** Given limited resources, CDC decided in recent years to devote most of its research-related resources to the development and evaluation of prevention approaches (e.g., programs, policies, and practices) for child abuse and neglect and sexual violence to more directly inform our ongoing practice initiatives (e.g., the Rape Prevention and Education program, Essentials for Childhood). CDC currently funds an intergovernment personnel act (IPA) with a researcher to examine risk and protective factors for CSA perpetration in middle and high school. Although the longitudinal data collection was originally funded by CDC, the funding did not allow for extensive analysis of data. The IPA has allowed for subsequent data analysis and resulted in nine papers examining numerous risk and protective factors and their association with CSA perpetration, including prescription drug use; bullying, homophobic name-calling; empathy, social support, school belonging, and parental monitoring. Other past research examined (1) the risk for CSA by assessing adolescent perpetrator\(^{cdxxvi}\). (2) etiological models and moderators for middle school bullying and sexual violence\(^{cdxxvii}\), and (3) a multilevel protective model of sexual violence perpetration\(^{cdxxviii}\). More research is needed to identify potential risk and protective factors for CSA victimization and perpetration, especially at the community and societal levels, that can inform development of preventive interventions.

Research on Effectiveness of Strategies to Prevent CSA

Specific strategies and approaches that can create the context for healthy children and families and prevent child abuse and neglect and sexual violence (and CSA specifically) are outlined in CDC’s child abuse and neglect and sexual violence technical packages\(^{cdxxix,cdxxx}\). The technical packages include many of the strategies identified previously, but because the technical packages include programs, policies, and practices with the best available evidence, many strategies outlined previously are not included. Thus, future research will need to allow for innovation and evaluation of strategies for preventing CSA.

At present CDC is funding (or has recently funded) 13 evaluations of strategies for preventing CSA. These projects are described in Appendix 4. In general, the research initiatives are evaluating programs in middle and high schools that engage men and boys, change social norms, and/or engage bystanders. Given prior research on the shared risk and protective factors for the various types of violence\(^{cdxxxi}\), several of the research initiatives also are examining whether programs (e.g., Sources of Strength, Youth Empowerment Solutions) that previously demonstrated preventive effects for other forms of violence are effective in preventing CSA.

21
CDC also has provided funding in the past to evaluate programs such as Second Step: Student Success Through Prevention, Green Dot, Safe Dates, and Darkness to Light. These funding opportunities have been instrumental in moving the field forward and in accounting for the evidence base as it currently exists for CSA prevention.

**Dissemination and Implementation of CSA Prevention Strategies**

Dissemination and implementation research is important for overcoming the science-practice gap by ensuring evidence-based approaches are distributed and adopted in public health and clinical practice settings. CDC’s work with public health practitioners in the Rape Prevention and Education and the Essentials for Childhood programs (described next) provide opportunities for dissemination and implementation, as well as research specific to understanding what works to best disseminate and implement CSA prevention approaches. Other key factors that should be examined include adaptation to populations and settings, fidelity to program materials, core elements that account for program effectiveness, and cost-effectiveness.

Currently, at least 15 states being funded through CDC’s Rape Prevention and Education Program are using some funds for adult-perpetrated CSA-prevention-related activities (see Appendix 5). These activities are focused primarily on the individual level of the social ecology. At least one state also is focused on prevention of commercial sexual exploitation of children. In addition, all states are engaged in activities that focus on prevention of peer-perpetrated CSA. RPE recipients are encouraged to implement strategies using the best available evidence. While many states select evidence-based strategies, the flexibility to implement practice-based programs allows recipients to select and implement strategies that will best resonate with their communities. Several of these programs are undergoing evaluation, and others have been identified through a systematic screening and assessment process as being prime for more rigorous evaluation. The new five-year RPE funding, which begins in 2019, will place an increased emphasis on selecting evidence-based programs that are represented in CDC’s technical package on sexual violence prevention, while still allowing for innovation, particularly at the outer levels of the social ecology where evidence is limited.

Seven state health departments received support as part of the competitively funded state Essentials for Childhood: Implementation of Strategies and Approaches for Child Abuse and Neglect Prevention. From 2018 to 2022, these health departments will address state-specific needs related to the urgent public health problem of child abuse and neglect broadly, although primarily physical abuse and neglect. Recipients will implement statewide comprehensive strategies and approaches designed to reduce child abuse and neglect along with other adverse childhood experiences and related health consequences and disparities. Recipients will use funding to implement projects that aim to decrease child abuse and neglect risk factors and increase protective factors by leveraging multi-sector partnerships and resources. They will focus on implementation strategies and approaches derived from CDC’s technical package on child abuse and neglect.

**Other Activities**

CDC currently is working with the CDC Foundation to secure funding to update and expand CDC’s 2007 publication, *Preventing child sexual abuse within youth-serving organizations: Getting started on policies and procedures*. The purpose of this project is to conduct a systematic evaluation and identify policies and procedures that have evidence for protecting children and youth from CSA in YSOs. The proposed program evaluation will include a review of policies and procedures currently in place in YSOs and highlight those that appear to be most effective in protecting children from CSA.

CDC partners with a number of national and international organizations (outside of the federal government) in the prevention of CSA. These include the National Coalition to Prevent Child Sexual Abuse and Exploitation, the US Center for Safe Sports, Prevent Child Abuse America, the Redwoods Group, Boy Scouts USA, the INSPIRE working group, the Moore Center for the Prevention of Child Sexual Abuse, the National Association of County and City Health Officials, and the American Academy of Pediatrics, among others.
VII. Gaps in CSA Prevention

CDC’s research has greatly increased our understanding of what works to prevent CSA. Moreover, while research on CSA prevention is much further along than it was just 10 years ago, additional research and resources are needed to continue with the progress that has been made. In fact, research is still needed across all areas of the public health model.

Data for Research and Monitoring of CSA

The availability of epidemiologic data on the magnitude, nature, and causes of CSA has increased over the last 30 years; however, the availability and quality of data varies. Data are often contradictory and inconsistent or lacking altogether. For example, there are currently no credible national estimates on the commercial sexual exploitation of children. Improving the quality of data for research and monitoring depends on progress in several areas.

1. The quality of prevalence studies could be increased by (a) adopting more standardized measurement and definitions, and (b) ensuring data collection is comprehensive and includes all forms of CSA. As much as possible, data also should include a focus on perpetrators and characteristics of perpetrators, which is critical to informing prevention efforts.

2. The use of randomly selected samples that are sufficiently large and representative to generate accurate estimates of CSA should be promoted. Assessments of CSA within samples should include multiple methods and sources to minimize limitations of data quality.

3. Timely data is necessary. Assessments of annual prevalence (or at least every other year) of CSA victimization and perpetration will allow for evaluation of the impact of CSA prevention strategies. Domestic implementation of CDC’s violence against children surveys is one way CSA victimization could be assessed.

Research on Risk and Protective Factors

While much knowledge has been gained about risk and protective factors for CSA, a better understanding of the etiology of CSA perpetration is needed to identify strategies and timing for primary prevention of perpetration. This is an area of weakness in CDC’s current CSA portfolio of work; however, increased knowledge of these factors for CSA can directly inform the content of prevention efforts. Many of the studies to date assessing risk and protective factors are cross-sectional, assess lifetime histories of exposure to CSA, and have small sample sizes that often only include samples with reported CSA. These characteristics make it hard to assess temporal order (i.e., factors contributing to CSA) and generalizability across samples. Future work needs to

1. Distinguish the risk and protective factors for the different forms of CSA perpetration, with specific focus on protective factors across all levels of the social ecology.

2. Examine the distinctions between the different types of CSA perpetrators (and how they differ from non-perpetrators) and the situational aspects of CSA perpetration to build the most effective and efficient prevention programs.

3. Recruit very large samples to obtain sufficient power and assess risk and protective factors longitudinally (i.e., over time) to determine temporal order. In the absence of longitudinal research, a focus on variables that relate to the initiation of CSA perpetration also may be helpful in the development of prevention strategies.

4. Examine how risk and protective factors combine or interact, the overlap of CSA with other forms of violence victimization and perpetration, and the multiple pathways that may lead to CSA perpetration.

5. Assess risk and protective factors at the outer levels of the social ecology (i.e., community and societal levels), such as policies.

Research on Effectiveness of Strategies to Prevent CSA
More research is needed to examine individual, relationship, community, and societal strategies for preventing CSA. Strategies that show promise promote social norms and protect against violence by encouraging positive bystander behaviors and mobilizing men and boys; create protective environments by improving the safety and monitoring in schools; and teach skills related to healthy, safe dating relationships, healthy sexuality, and social-emotional health. Additional research is needed in a number of areas.

1. Positive findings for the prevention of CSA need to be replicated and extended to additional communities and settings and with different populations, as applicable.
2. Additional research also is needed on programs that reduce various forms of CSA perpetration, including adult-perpetrated CSA, CSA perpetrated by youth against younger children, and the commercial sexual exploitation or trafficking of minors.
3. Programs that engage parents are needed. Parents have the ability to encourage discussions of sex and sexuality with their children and change norms that will prevent perpetration and encourage disclosure if CSA does occur.

Research on Effective Dissemination and Implementation

To our knowledge, no research to date has focused on the adoption and dissemination of evidence-based CSA prevention strategies. Although the evidence base is small and there is still much to learn about strategies that are effective, CSA is an urgent public health problem that requires us to act on the best available evidence. Research is needed in several areas:

1. How to best scale up the existing evidence base (e.g., adoption of evidence-based strategies);
2. How to best adapt the evidence-based CSA preventive interventions that exist (e.g., identification of core components to inform adaptation and sustain effectiveness); and
3. How to best communicate about CSA and evidence-based programs for CSA prevention (e.g., acceptability, appropriateness, cost, feasibility, fidelity, sustainability).

CDC has a network that allows for the dissemination of effective strategies to public health agencies, practitioners, and other sectors working to prevent CSA. CDC’s work with state health departments and other grantees is one mechanism for ensuring that the latest available data is being implemented in practice.

Resources Needed to Address Gaps

Additional resources for research on the primary prevention of CSA (i.e., sexual violence victimization or perpetration under the age of 18) would allow CDC an opportunity to expand the evidence base and more quickly advance comprehensive CSA prevention efforts, thereby improving the health and well-being of children and youth.

VIII. Conclusion

CSA is a significant but preventable public health problem. It is costly and devastating for individuals and communities. CDC is leading the field to prevent CSA by championing research that informs public health prevention efforts in our states and communities. CDC’s research to date has greatly increased our understanding of what works to prevent CSA; however, there are still significant gaps in our knowledge that must be addressed. CDC will continue to invest in innovative research that improves what we know about CSA and how to prevent it, building on advances in research and practice from prior work. CDC is committed to (1) developing data for research and monitoring of CSA, (2) identifying modifiable factors that increase or reduce perpetration of CSA and strategies that address those factors, (3) finding effective, cost-efficient strategies for preventing CSA, particularly among those at highest risk, and (4) disseminating information about and encouraging implementation of what works to prevent CSA. Additional resources specifically dedicated to CSA prevention and aimed at filling the knowledge gaps outlined previously would be helpful to advance efforts in the field.
Appendix 1: The Public Health Model

Step 1: Define and Monitor the Problem
The first step in preventing violence is to understand the “who”, “what”, “when”, “where” and “how” associated with it. Grasping the magnitude of the problem involves analyzing data such as the number of violence-related behaviors, injuries, and deaths. Data can demonstrate how frequently violence occurs, where it is occurs, trends, and who the victims and perpetrators are. These data can be obtained from police reports, medical examiner files, vital records, hospital charts, registries, population-based surveys, and other sources.

Step 2: Identify Risk and Protective Factors
It is not enough to know the magnitude of a public health problem. It is important to understand what factors protect people or put them at risk for experiencing or perpetrating violence. Why are risk and protective factors useful? They help identify where prevention efforts need to be focused. Risk factors do not cause violence. The presence of a risk factor does not mean that a person will always experience violence. Victims are never responsible for the harm inflicted upon them.

- Risk Factor – Characteristic that increases the likelihood of a person becoming a victim or perpetrator of violence.
- Protective Factor – Characteristic that decreases the likelihood of a person becoming a victim or perpetrator of violence because it provides a buffer against risk.

Step 3: Develop and Test Prevention Strategies
Findings from the research literature and data from needs assessments, community surveys, stakeholder interviews, and focus groups are useful for designing prevention programs. Using these data and findings is known as an evidence-based approach to program planning. Once programs are implemented, they are evaluated rigorously to determine their effectiveness.

Step 4: Assure Widespread Adoption
Once prevention programs have been proven effective, they must be implemented and adopted more broadly. Communities are encouraged to implement evidence-based programs and to evaluate the program’s success. Dissemination techniques to promote widespread adoption include training, networking, technical assistance, and evaluation.

Appendix 2: The Social-Ecological Model

Individual
The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include education and life skills training.

Relationship
The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person’s closest social circle—peers, partners and family members—influences their behavior and contributes to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs, and mentoring and peer programs designed to reduce conflict, foster problem solving skills, and promote healthy relationships.

Community
The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level impact the social and physical environment—by reducing social isolation, improving economic and housing opportunities in neighborhoods, as well as the climate, processes, and policies within school and workplace settings.

Societal
The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

Appendix 3. Prevalence and adjusted odds ratios for the relationship of childhood sexual abuse with health and health risk behaviors by sex.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Percent* (95% CI)</td>
</tr>
<tr>
<td><strong>Lifetime Depression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>8,332</td>
<td>12.8 (12.1, 13.6)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>1,311</td>
<td>29.0 (25.5, 32.6)</td>
</tr>
<tr>
<td>Total</td>
<td>9,643</td>
<td>13.7 (13.0, 14.4)</td>
</tr>
<tr>
<td><strong>Frequent Mental Distress</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>4,537</td>
<td>6.5 (6.0, 7.1)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>698</td>
<td>16.9 (13.9, 19.8)</td>
</tr>
<tr>
<td>Total</td>
<td>5,235</td>
<td>7.1 (6.5, 7.7)</td>
</tr>
<tr>
<td><strong>Fair/Poor Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>10,828</td>
<td>15.8 (15.0, 16.6)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>1,007</td>
<td>22.8 (19.4, 26.1)</td>
</tr>
<tr>
<td>Total</td>
<td>11,835</td>
<td>10.5 (9.8, 11.2)</td>
</tr>
<tr>
<td><strong>Current Smoker</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>11,091</td>
<td>16.5 (15.7, 17.3)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>1,071</td>
<td>26.7 (22.5, 31.0)</td>
</tr>
<tr>
<td>Total</td>
<td>12,162</td>
<td>17.0 (16.2, 17.8)</td>
</tr>
<tr>
<td><strong>Lifetime Asthma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>6,619</td>
<td>9.7 (9.1, 10.3)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>611</td>
<td>14.5 (11.5, 17.5)</td>
</tr>
<tr>
<td>Total</td>
<td>7,230</td>
<td>10.0 (9.4, 10.6)</td>
</tr>
<tr>
<td><strong>COPD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>4,103</td>
<td>6.2 (5.7, 6.8)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>423</td>
<td>8.8 (6.7, 10.9)</td>
</tr>
<tr>
<td>Total</td>
<td>4,526</td>
<td>6.4 (5.8, 6.9)</td>
</tr>
<tr>
<td><strong>Stroke</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>2,463</td>
<td>3.7 (3.3, 4.2)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>200</td>
<td>4.2 (3.0, 5.3)</td>
</tr>
<tr>
<td>Total</td>
<td>2,663</td>
<td>3.7 (3.3, 4.2)</td>
</tr>
<tr>
<td><strong>Kidney Disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>1,886</td>
<td>3.0 (2.6, 3.3)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>163</td>
<td>3.5 (2.3, 4.8)</td>
</tr>
<tr>
<td>Total</td>
<td>2,049</td>
<td>3.0 (2.7, 3.4)</td>
</tr>
<tr>
<td><strong>Heart Attack</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sexual abuse</td>
<td>5,283</td>
<td>8.0 (7.4, 8.5)</td>
</tr>
<tr>
<td>Condition</td>
<td>No sexual abuse</td>
<td>Sexual abuse</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Sexual abuse</strong></td>
<td>390</td>
<td>705</td>
</tr>
<tr>
<td><strong>Heart Disease</strong></td>
<td>5,001</td>
<td>3,918</td>
</tr>
<tr>
<td><strong>Arthritis</strong></td>
<td>18,873</td>
<td>31,351</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>8,525</td>
<td>9,660</td>
</tr>
</tbody>
</table>

- **Sexual abuse**
  - 390 cases with a 9.9% (7.7, 12.2) incidence rate and an odds ratio of 1.4 (1.1, 1.9).
  - 705 cases with a 5.6% (4.0, 7.2) incidence rate and an odds ratio of 1.8 (1.3, 2.5).
  - Total: 5,673 cases with an 8.1% (7.5, 8.6) incidence rate and an odds ratio of 4.3 (3.9, 4.7).

- **Heart Disease**
  - No sexual abuse: 5,001 cases with 7.7% (7.1, 8.3) incidence rate and an odds ratio of 4.7 (4.2, 5.1).
  - Sexual abuse: 391 cases with 9.1% (7.7, 11.2) incidence rate and an odds ratio of 6.8 (5.1, 8.4).
  - Total: 5,392 cases with 7.8% (7.2, 8.4) incidence rate and an odds ratio of 5.0 (4.5, 5.4).

- **Arthritis**
  - No sexual abuse: 18,873 cases with 29.1% (28.0, 30.1) incidence rate and an odds ratio of 1.0 (ref.).
  - Sexual abuse: 1,537 cases with 38.2% (33.5, 42.8) incidence rate and an odds ratio of 1.9 (1.7, 2.1).
  - Total: 20,410 cases with 29.6% (28.6, 30.5) incidence rate and an odds ratio of 1.9 (1.7, 2.1).

- **Diabetes**
  - No sexual abuse: 8,525 cases with 12.6% (11.9, 13.3) incidence rate and an odds ratio of 1.0 (ref.).
  - Sexual abuse: 630 cases with 15.3% (12.8, 17.9) incidence rate and an odds ratio of 1.4 (1.2, 1.6).
  - Total: 9,155 cases with 12.8% (12.1, 13.5) incidence rate and an odds ratio of 1.4 (1.2, 1.6).

*a Percentages weighted to reflect the population of the 20 states included in the sample.*

### Appendix 4. Research Projects Currently Being Funded by CDC

<table>
<thead>
<tr>
<th>Funding Year</th>
<th>Project Title, Investigator, &amp; Institution</th>
<th>Project Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014</strong></td>
<td><strong>Project Title:</strong> Engendering Healthy Masculinities to Prevent Sexual Violence  &lt;br&gt; <strong>Investigator:</strong> Dr. Elizabeth Miller  &lt;br&gt; <strong>Institution:</strong> University of Pittsburgh</td>
<td>The University of Pittsburgh partnered with the Pennsylvania Department of Health, the YMCA, and Urban League of Greater Pittsburgh to implement and evaluate “Manhood 2.0” within community-based, youth-serving agencies. Manhood 2.0 is an intensive 18-hour program that engages male youth, ages 14-17, to explore social norms about masculinity and gender, develop healthy relationship skills and sexual behaviors, and practice bystander intervention skills. The recruited sites were randomized to one of two conditions: Manhood 2.0 or a job-readiness skills training program (comparison condition).</td>
</tr>
<tr>
<td></td>
<td><strong>Project Title:</strong> Preventing Sexual Aggression among High School Boys  &lt;br&gt; <strong>Investigator:</strong> Dr. Lindsay Orchowski  &lt;br&gt; <strong>Institution:</strong> Rhode Island Hospital</td>
<td>Rhode Island Hospital partnered with Day One of Rhode Island to conduct a randomized controlled trial evaluating the effectiveness of Your Voice Your View, an intervention that uses different approaches (e.g., classroom sessions, school-wide poster campaign) to change social norms and train bystanders to intervene and prevent violence. Over the study period, schools were recruited and randomized to one of two conditions: Your Voice Your View or wait-list control.</td>
</tr>
<tr>
<td></td>
<td><strong>Project Title:</strong> Evaluating a Dating and Sexual Violence Bystander Prevention Program with High School Youth: A Cluster Randomized Control Trial  &lt;br&gt; <strong>Investigator:</strong> Dr. Katie Edwards  &lt;br&gt; <strong>Institution:</strong> University of New Hampshire</td>
<td>This research uses a cluster randomized control trial to evaluate the Bringing in the Bystander-High School Curriculum. The impact of this program on dating and sexual violence-related attitudes, knowledge, and behaviors is being examined by surveying students and school staff in 26 high schools before the program is implemented, at the end of the program, and at five-month and one-year follow-ups.</td>
</tr>
<tr>
<td></td>
<td><strong>Project Title:</strong> A Cluster-Randomized Trial of a Middle School Gender Violence Prevention Program  &lt;br&gt; <strong>Investigator:</strong> Dr. Elizabeth Miller  &lt;br&gt; <strong>Institution:</strong> University of Pittsburgh</td>
<td>This research is a cluster randomized control trial among middle school boys of Coaching Boys into Men, a promising strategy that trains athletic coaches to modify gender norms that contribute to dating and sexual violence and to promote bystander intervention skills. The impact of this program on dating and sexual violence knowledge and perpetration, gender-related views of relationships, and bystander skills is being examined by surveying male athletes in 26 middle schools before the program is implemented, at the end of the sport season, and again one year later.</td>
</tr>
<tr>
<td></td>
<td><strong>Project Title:</strong> Community Level Primary Prevention of Dating and Sexual Violence in Middle Schools</td>
<td>This study examining the effectiveness of a social norms marketing campaign in affecting misperceptions about the acceptability of dating and sexual violence, gender roles, sexual activity, sexual</td>
</tr>
<tr>
<td>Investigator: Dr. Lindsay Orchowski</td>
<td>Communication/consent, support for victims, and bystander intervention. Reductions in rates of dating and sexual violence and promoting change in community norms is being examined.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Project Title:</strong> Testing the Efficacy of a Strengths-Based Curriculum to Reduce Risk for Future Sexual Violence Perpetration among Middle School Boys</td>
<td>The New York State Department of Health is collaborating with Cornell University to evaluate the efficacy of a strengths-based curriculum called <em>Brothers as Allies</em>. This program is designed to reduce risk for future sexual violence perpetration among middle school-aged boys aged 12-14 years. The impact of the program on a number of outcomes is being examined. Outcomes assessed include sexual assault perpetration, bystander behavior, attitudes related to gender roles and acceptability of sexual violence, interpersonal relationships, and youth-adult connectedness. Factors that may impact the implementation of the program will also be assessed, and results will be used to inform future RPE program activities.</td>
<td></td>
</tr>
<tr>
<td>Investigator: Ms. Sharisse Carter</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Institution:</strong> Health Research, Inc./New York State Department of Health</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Project Title:</strong> Preventing Sexual Violence Through a Comprehensive, Peer-Led Initiative: A Process and Outcome Evaluation</td>
<td>This research is being conducted in collaboration with the University of New Hampshire, the South Dakota (SD) Network Against Family Violence and Sexual Assault, Working Against Violence, Inc (WAVI), the SD Department of Health, Teen Up!, and Rapid City, SD area schools. A youth-led violence prevention initiative, <em>Youth Voices in Prevention</em>, is being implemented and evaluated via a quasi-experimental design in middle and high schools within Rapid City, SD. Examined program effects include sexual violence perpetration, bystander actions, and other behaviors, such as bullying and suicidality. Information is being collected from youth and school staff to understand how prevention messages are shared. A cost-analysis of implementing the program is being conducted to inform replication, dissemination, scalability, and sustainability efforts.</td>
<td></td>
</tr>
<tr>
<td>Investigator: Dr. Katie Edwards</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Institution:</strong> University of New Hampshire</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Project Title:</strong> The Impact of Sources of Strength, a Primary Prevention Youth Suicide Program, on Sexual Violence Perpetration among Colorado High School Students</td>
<td>The University of Florida, the University of Rochester, Texas Tech University, and the Colorado Department of Public Health &amp; Environment are collaborating on a randomized controlled trial of <em>Sources of Strength (SoS)</em>. SoS is a school-based program that builds connections between trained student leaders and adults to strengthen social connectedness, help-seeking, and healthy norms about behavior. Previous program evaluations have shown many benefits, including reducing risks and increasing supports for students with histories of suicidal ideation. The potential broader effects on sexual violence perpetration by 9th-11th grade students is being examined in 20 high schools.</td>
<td></td>
</tr>
<tr>
<td>Investigator: Dr. Dorothy Espelage</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Institution:</strong> University of Florida</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Project Title:</strong> A Randomized Trial of Wise Guys: The Next Level</td>
<td>This research is being conducted through a collaboration between the University of North</td>
<td></td>
</tr>
<tr>
<td>Investigator: Dr. Kathryn Beth Moracco</td>
<td>Carolina-Chapel Hill, the Children’s Home Society of North Carolina, and the North Carolina Coalition Against Sexual Assault. The study is evaluating an ongoing RPE-funded program, Wise Guys: The Next Level. This program seeks to reduce sexual violence perpetration by addressing known risk and protective factors, such as rape culture and unhealthy masculinity, gender stereotyping, communication, and consent in relationships. The study evaluates the program’s impacts on the perpetration of sexual violence, dating violence, bullying, and harassment as well as sexual risk behavior. The implementation costs are also being assessed to inform future prevention activities.</td>
<td></td>
</tr>
<tr>
<td>Institution: University of North Carolina-Chapel Hill</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Project Title: Youth Empowerment Solutions for Healthy Relationships: Engaging Youth to Prevent Sexual Violence | Wayne State University, the University of Michigan, and the Michigan Rape Prevention and Education program are collaborating to adapt, implement and evaluate Youth Empowerment Solutions: Healthy Relationships, a primary prevention strategy focused on influencing community-level change through youth empowerment and positive youth development. A group randomized trial is being used to examine the effects of the strategy on sexual violence and teen dating violence perpetration, youth empowerment, social connectedness, and social norms in six high schools in Wayne County, Michigan. |
| Investigator: Dr. Poco Kernsmith |
| Institution: Wayne State University |

2017 | Project Title: Evaluating the Prevention Effects of Men of Strength (MOST) Clubs on Sexual Violence and Teen Dating Violence Perpetration | Sexual violence and dating violence among high school students are significant public health problems, and increasing the availability of evidence-based primary prevention strategies is critical. The MOST Club is an after-school positive youth development program that encourages high school males to become “change agents” by promoting healthy masculinity and peer leadership within their school community. This promising sexual violence prevention strategy is being evaluated using a randomized controlled trial with 16 high schools. Examined program impacts include changes in the perpetration of sexual violence, teen dating violence, other forms of interpersonal violence, and bystander behaviors at six-month and one-year follow-ups. |
| Investigator: Dr. Marni Kan |
| Institution: Research Triangle Institute |

2018 | Project Title: Expect Respect Middle School: Preventing Serious and Lethal Violence Among Youth with Prior Violence Exposure | Expect Respect is a gender-specific support group for middle school students with a history of exposure to violence. This program modifies beliefs about violence, gender expectations that foster violence perpetration, and bystander behavior. A longitudinal, cluster-randomized study with 36 middle schools is examining the impact of Expect Respect on dating violence, sexual violence, weapon carrying, physical fighting, sexual harassment, |
bystander behaviors, and suicidal behaviors relative to usual services.

| Project Title: Adapting and Testing the myPlan App to Prevent Dating Violence with Adolescents | Sexual and physical dating violence among adolescents are common, can result in serious injury, and increase the risk for violence and other health problems in adulthood. The myPlan app is a web-based resource for young adults about dating relationships and safety planning. The myPlan app is being adapted for use by adolescents living in urban and rural communities and rigorously evaluated using a longitudinal, randomized study. Relative to other information resources, the myPlan app’s impact on victimization and perpetration of sexual and dating violence as well as safety, bystander behavior, and mental health is being examined. |
| Investigator: Dr. Nancy Glass | Institution: Johns Hopkins University |
Appendix 5: Adult-perpetrated CSA prevention activities in Rape Prevention and Education (RPE)-funded agencies

At least 15 states receiving RPE funding from CDC have communities engaged in activities for CSA prevention. These activities are outlined in the table below.

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Prevention Strategy</th>
<th>Prevention Strategy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. District of Columbia</td>
<td>Speak Up Be Safe</td>
<td>Childhelp Speak Up Be Safe helps children and teens learn the skills to prevent or interrupt cycles of neglect, bullying, and child abuse—physical, emotional, and sexual. In addition to increasing children’s ability to recognize unsafe situations or abusive behaviors and building resistance skills, lessons focus on helping children build a responsive safety network with peers and adults that the child identifies as safe.</td>
</tr>
<tr>
<td>2. Iowa</td>
<td>Nurturing Healthy Sexual Development/Care for Kids</td>
<td>Care for Kids is a strategy used with caregivers and parents of younger children (pre-K through elementary) to equip them with accurate information about healthy sexual behavior in children and how to recognize signs of abuse. A primary goal is to increase adults’ comfort in talking with young children about sexuality. Iowa also has a website called Parents for Prevention, which offers resources and tools for parents on how to create a protective environment for their children. (<a href="https://www.parentsforprevention.org/">https://www.parentsforprevention.org/</a>)</td>
</tr>
<tr>
<td>3. Maine</td>
<td>Child Sexual Abuse Prevention Education and Awareness for Adults</td>
<td>Maine’s funded programs include prevention programming for the youngest grades, in some cases beginning with pre-school audiences. Maine also has targeted adults to change the norms regarding how adults recognize and respond to potential perpetration behaviors – which is a key step in the primary prevention of abuse.</td>
</tr>
<tr>
<td>4. Massachusetts</td>
<td>Enough Abuse/Enough Abuse adaptation</td>
<td>Efforts to prevent child sexual abuse aim to reduce the risk factors for perpetration in communities. Enough Abuse aims to increase the capacity of families, childcare providers, and sexual/domestic violence advocates to recognize, prevent, and respond to CSA. Program staff also participate in the Prevention &amp; Education Work Group of the MA Governor’s Council to Address Sexual and Domestic Violence, which is working to address sexual and dating violence prevention within educational settings, pre-K through post-graduate college. Program staff also participate in the MA Child Sexual Abuse Prevention Task Force (MA CSAPTF). CSA prevention training for DPH-funded, youth-serving vendors has begun based on the recommendations of the MA CSAPTF. Activities are focused on changes or adoption of policies and practices by youth-serving organizations to prevent CSA (including creation of protective environments), with the training being given to groups of vendors (by type) funded by the MA Department of Public Health.</td>
</tr>
<tr>
<td>5. New Hampshire</td>
<td>NH Child Sexual Abuse and Youth Sexual Violence Prevention Project</td>
<td>This project is a collaboration of the NH Sexual Violence Prevention Advisory Committee (SVPAC). In 2016, SB460 was signed into law which reinforces the requirement of NH schools to include child sexual abuse prevention in health curricula. The advocates on the SVPAC developed the SB460 Task Force: the goal is to provide resources to schools and teachers on best practices for sexual violence prevention. This was modeled from several other states in which similar legislation was passed. The goal is to build sustainable prevention capacity at all schools in NH, to educate providers on sexual violence prevention and how to enact change in their</td>
</tr>
</tbody>
</table>

33
<table>
<thead>
<tr>
<th>Recipient</th>
<th>Prevention Strategy</th>
<th>Prevention Strategy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Communities, and to connect schools to local resources. The group was given access to the NH InspiRED Network, a teacher professional development platform, where we have uploaded resources on evidence of effective SV programs, integrating effective SV prevention programs into a school environment, and information on risk and protective factors. (Website: <a href="http://nh.getinspired.2revolutions.net/groups/10292">http://nh.getinspired.2revolutions.net/groups/10292</a>, Group: Child Sexual Abuse &amp; Youth Sexual Violence: Prevention and Response). SPVAC also built a set of model grade expectations, based on research distilled on risk and protective factors for SV, including the STOP toolkit. The project is accomplished through the Injury Prevention Program (IPP) and coordinated by NHCA/Dsv Prevention Coordinator. Membership includes staff from local sexual assault and domestic violence crisis centers, teachers at local high schools, and NH Dept of Education. Additional Advisory Committee support includes: NH DHHS, Prevention Innovations, NH Attorney General’s Office College Consortium Coordinator.</td>
</tr>
<tr>
<td>6. Ohio</td>
<td>Stewards of Children - Engaging Adults Who Work With Youth</td>
<td>Achieve a positive change in knowledge/attitudes/behaviors/skills towards prevention of sexual violence perpetration and promoting healthy relationships with youth. This goes beyond familiarizing the adults with information about work with youth - it includes engaging these adults to take an active role in working with the youth to prevent sexual violence and promote healthy relationships.</td>
</tr>
<tr>
<td>7. Oregon</td>
<td>Policy Education</td>
<td>Policy efforts include providing education and technical assistance to inform local school districts’ policies. For example, comprehensive sexuality education standards in schools, the Healthy Teen Relationship Act (HTRA), and most recently, Erin's Law on CSA prevention are policies that are already in place in Oregon. Using these existing policies, Oregon supports schools in meeting their requirements to develop policies around response and prevention. SATF currently serves on a health content panel for sex ed in Oregon. This work is centered around updating Oregon's Health Education Standards and Benchmarks to be more inclusive and to better incorporate HTRA and Erin's Law into the standards while also focusing on health promotion. SATF also provided support to the Oregon Department of Education on guidance they released in terms of implementing child sex abuse prevention from K-12 in trauma informed ways. This guidance, including a venn diagram created by SATF linking sexual health promotion, sexual violence prevention, and child sex abuse prevention, has been useful for educators, preventionists, and government officials throughout Oregon. SATF’s Prevention and Education Committee, has been working on creating a guidance document for practitioners on how to implement Oregon's statewide prevention plan, Recommendations for Preventing Sexual Violence in Oregon.</td>
</tr>
<tr>
<td>8. South Carolina</td>
<td>Care for Kids Program</td>
<td><a href="https://www.stsm.org/get-training/education-programs-youth">https://www.stsm.org/get-training/education-programs-youth</a>  Excerpted:  “Our Approach: Sexual Trauma Services of the Midlands offers Care for Kids© to schools and youth-focused organizations in Richland, Lexington, Newberry, Sumter, and Clarendon counties. Care for Kids© is a primary prevention program that promotes adult responsibility for the safety of children and their development. It is effective at reducing bullying and other adverse school outcomes in addition to increasing early reports of child sexual abuse so that children can get the help they need as soon as possible. The curriculum meets National Health and Safety Education</td>
</tr>
<tr>
<td>Recipient</td>
<td>Prevention Strategy</td>
<td>Prevention Strategy Description</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Jolene's Law Task Force</td>
<td>In 2014, Jolene’s Law Task Force was entrusted to study the prevalence and impact of child sexual abuse in the state. By the end of 2014, five major tenets set goals for improvement, implementation. In 2015, the task force continued for a second year. Seventeen members of child sexual abuse experts represented the executive and legislative branches, a state attorney, professionals from child advocacy centers, counseling, law enforcement, Federal Bureau of Investigations and tribal community. Additionally, Jolene Loetscher, victim of child sexual abuse and for whom the task force is named, is a member. In South Dakota annually, at least 4,000 children experience sexual abuse. The number is critically conservative. The 17 members understand that a coordinated system of response and early intervention must be developed. The RPE program will be partnering with Enough Abuse beginning in 2019.</td>
</tr>
<tr>
<td>Vermont</td>
<td>Care for Kids We Care Elementary</td>
<td>The coalition redirected a small portion of their funds to have member agency staff trained in Prevent Child Abuse evidence informed curriculum focused on CSA prevention. Trained staff will help implement these two curricula in schools throughout the state.</td>
</tr>
<tr>
<td>Virginia</td>
<td>Care for Kids</td>
<td>Care for Kids is a health-based primary prevention curriculum that helps adults understand the link between healthy sexuality education and child sexual abuse prevention, while fostering important protective factors in children ages 3-8. The program was developed by Prevent Child Abuse Vermont and incorporates repeated healthy sexuality messaging, reinforcement of messaging by parents and sensitivity to the developmental levels of children. The program includes a parent and child education component, both of which are intended to build protective factors for preventing both sexual abuse victimization and perpetration.</td>
</tr>
<tr>
<td>Nurturing Parents</td>
<td>Nurturing Parents is a multi-session curriculum based program for parents, guardians or youth service workers. The program teaches skills to prevent violence in the home and enhances the caregiver or youth service worker’s ability to prevent first time perpetration or victimization. The curriculum is recognized by the National Registry of Evidence-Based Programs and Practices.</td>
<td></td>
</tr>
<tr>
<td>Safe Church</td>
<td>Safe Church is aimed at empowering faith-based organizations to prevent child sexual abuse through adult focused education, identification of weaknesses and risks in current policies and the development and adoption of new comprehensive policies and practices to guard against child sexual</td>
<td></td>
</tr>
<tr>
<td>Recipient</td>
<td>Prevention Strategy</td>
<td>Prevention Strategy Description</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>abuse. This is an eleven month multi-part program where core teams from</td>
<td>This is an eleven month multi-part program where core teams from congregations meet regularly to receive comprehensive sexual abuse prevention training. In addition, weekly contact with core teams is maintained to develop and implement sound child protection policies and practices. Finally, the program reaches the entire adult congregation through presentations which shift the onus to adults to take proactive responsibility for the protection of children. Safe Church was developed with a grant from the Ms. Foundation for Women and is intended to be a comprehensive program which shifts the cultural norm of faith-based organizations to one of proactive primary prevention of child sexual abuse.</td>
</tr>
<tr>
<td>Stewards of Children</td>
<td>how to prevent, recognize, and react responsibly to child sexual abuse. It is</td>
<td>Stewards of Children is an evidence-informed program that teaches adults concerned about the safety of children. Participants will be able to: identify 5 Steps to Protecting our Children, identify two actions that can have far-reaching positive effects on prevention, and understanding that child sexual abuse can be prevented. Overall goal is to increase knowledge about the primary prevention of child sexual abuse and increase protective factors and decrease risk factors for abuse within youth-serving organizations.</td>
</tr>
<tr>
<td></td>
<td>designed for both youth serving organizations and for individuals concerned about the</td>
<td>This training certifies individuals to provide the Stewards of Children, child sexual abuse prevention program. Participants learn about CSA and how to implement the curriculum. Stewards of Children is an evidence-informed program that teaches adults how to prevent, recognize, and react responsibly to child sexual abuse. It is designed for both youth serving organizations and for individuals concerned about the safety of children. Overall goal is to increase knowledge about the primary prevention of child sexual abuse and increase protective factors and decrease risk factors for abuse within youth-serving organizations.</td>
</tr>
<tr>
<td>12. Washington</td>
<td>The Partnership 4 Safety</td>
<td>The prevention strategy includes skills building activities for youth with intellectual and developmental disabilities. Some activities take place in the classroom, and some activities take place at monthly movie nights. Monthly movie night provides youth an opportunity to practice what they've been learning in the classroom in a supportive and social environment. The organization plans to expand their strategy and target population to include early intervention providers (family resource coordinators) to participate in education and awareness activities to parents of children with IDD, birth to age three.</td>
</tr>
<tr>
<td>13. West Virginia</td>
<td>Community Change - Coalition Building</td>
<td>The goals of coalition building are to engage additional allies in preventing sexual violence, leveraging their resources and building partners' capacities as needed. Coalition compositions vary. A statewide campus initiative focuses on resource sharing and capacity-building around prevention programming. A state-level child sexual abuse prevention task force focuses on policy needs. The state sexual violence prevention committee examines data to help identify training and resource needs. Several local initiatives are community-specific, targeting activities to increase prevention efforts.</td>
</tr>
<tr>
<td></td>
<td>Educational Seminars - Child Protection Unit</td>
<td>The Child Protection Unit focuses on preventing and intervening in child abuse and/or neglect. The goal is to protect students from unsafe and abusive situations in and outside of school. Lessons teach students how to recognize unsafe and sexually abusive situations and touches, how to immediately report these situations to adults and how to assertively refuse</td>
</tr>
</tbody>
</table>
Recipient | Prevention Strategy | Prevention Strategy Description
--- | --- | ---
none | these situations. School staff learn specific skills for recognizing and reporting abusive situations and responding in a supportive way to students who disclose abuse. | 14. Wisconsin Darkness to Light's (D2L) "Stewards of Children" The Stewards for Children curriculum is implemented to educate teachers, parents and community members about the prevention of child sexual abuse. The goal of this strategy is to raise more awareness about child sexual abuse and engage adults in its prevention. A major message in this curriculum is that the role of prevention should lie heavily on adults rather than on children (the victims). These activities address the risk factor: sexual entitlement and cultural misperceptions about consent. 

Note. At least one other state is devoting efforts to CSA prevention, although minimal.
Appendix 6: Authors, CDC Contributing Staff, and External Reviewers

Authors
Beverly L. Fortson, PhD
Behavioral Scientist
Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Ruth Leemis
Behavioral Scientist
Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Lianne Estefan
Behavioral Scientist
Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Olivia Egen
ORISE Fellow
Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Kathleen Basile
Special Assistant to the Associate Director for Science
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Pam Brown
Public Health Analyst
Office of Policy and Partnerships
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Heather Dennehy
Public Health Analyst
Office of Policy and Partnerships
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

CDC Contributing Staff
James Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Jeffrey Herbst, PhD
Branch Chief
Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Debra Houry, MD
Director
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

External Reviewers

Elizabeth Letourneau, PhD
Director, Moore Center for the Prevention of Child Sexual Abuse
Professor, Johns Hopkins, Bloomberg School of Public Health

Angelo Giardino, MD, PhD
Chair, Department of Pediatrics
University of Utah

Joan Tabachnick, MBA
Fellow
Office on Sex Offender Sentencing, Monitoring, Apprehending, Registering, & Tracking
Office of Justice Programs
Department of Justice

Bart Klika, PhD
Chief Research and Strategy Officer
Prevent Child Abuse America

Karen Baker
CEO
Pennsylvania Coalition Against Rape

Jordan Posamentier
Director of Policy and Advocacy
Committee for Children

Jerry Milner, DSW
Associate Commissioner
Children’s Bureau
Administration on Children, Youth, and Families

Reviewer TBD
Trust for America’s Health


47


