

**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**

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## 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<sup>1</sup>. CSA refers to the involvement of a child (i.e., less than 18 years old) in sexual activity that he or she does not fully comprehend, does not consent to, is unable to give informed consent to or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society<sup>2</sup>. This includes sexually inappropriate conduct directed towards children and youth by an adult or another child/adolescent of the same or different age. There has been attention to treatment for victims and criminal justice approaches for perpetrators, but less attention specifically to evidence-based primary prevention of CSA<sup>3,4</sup>. Therefore, there are limited effective, evidence-based strategies for proactively protecting children and youth from CSA even though CSA is preventable. Ensuring safe, stable, nurturing relationships and environments for all children is a priority to decrease violence, including CSA, and to promote 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. 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 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<sup>5,6</sup>*

**CSA is a serious public health problem.** Self-report data from 2013-2014 suggests that 3.7 million children are exposed to CSA each year in the US, with 1 in 4 girls and 1 in 13 boys experiencing CSA at some point during childhood<sup>7,8,9</sup>. CSA occurs across all ages of children and youth and in all socioeconomic classes, although rates are often higher among some age groups (e.g., ages 7-12, adolescents)<sup>10</sup>. Furthermore, it is widely accepted that available data on CSA victimization and perpetration, including official and self-report estimates, underestimates its prevalence due to under-reporting. Most victims of CSA delay or never disclose CSA to friends, family, or the authorities, especially because most CSA is committed by someone the child knows and trusts<sup>11,12,13</sup>. Although official police reports are available, they largely underestimate perpetration estimates,<sup>14</sup> given that most CSA victims never report the abuse. 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 and adult white male perpetrators. Self-reported victimization data suggests that most perpetrators of CSA are male<sup>15</sup>. 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 unwanted/unplanned pregnancies<sup>16</sup>, physical injuries<sup>17</sup>, and chronic health conditions such as heart disease, obesity, and cancer, among others<sup>18</sup>. Short- and long-term mental health consequences may include depression<sup>19</sup>, posttraumatic stress disorder (PTSD), substance abuse, and risky sexual behaviors, among others<sup>20</sup>. In addition, the odds of attempting suicide in their lifetime is six times higher for men and nine times higher for women with CSA histories when compared to individuals without a history of CSA<sup>21</sup>. Adults who have experienced CSA also report decreased health-related quality of life<sup>22</sup>, and nearly half are sexually revictimized in adulthood<sup>23</sup>. ***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<sup>24</sup>.

**CSA victimization and perpetration are associated with several risk and protective factors.** Although research is limited among some groups (e.g., adult perpetrators), a number of factors have been identified that either put people at risk for victimization or perpetration of CSA (i.e., risk factors) or protect against it (i.e.,

protective factors). CDC's work also highlights the fact that different forms of violence are connected and often share similar risk and protective factors<sup>25</sup>. Understanding the shared risk and protective factors for violence at different levels of the social ecological model (i.e., individual, relationship, community, societal; see Appendix 2) can help in prevention efforts. Factors most commonly identified as increasing risk for CSA victimization include child age and sex, and perpetrator sex and relationship to the victim<sup>26,27</sup>. For example, preadolescent and early adolescent females experience more risk, and most CSA cases (~90%) involve a perpetrator known to the child<sup>28</sup>. Though not an exhaustive list, other risk factors for victimization include prior victimization of the child and parent<sup>29</sup> (individual level), witnessing family conflict<sup>30,31</sup> (relationship level), poverty<sup>32</sup> (community level), and social norms and laws that promote inequality between men and women, or acceptance of child pornography<sup>33,34,35</sup> (societal level). While perpetrators of CSA are not a uniform group, examples of risk factors for both youth- and adult-perpetrated CSA include being male<sup>36</sup> (individual level), experiencing family conflict and hostility<sup>37,38,39</sup> (relationship level), having weak community sanctions against perpetrators of CSA<sup>40,41,42</sup> (community level), and societal objectification of women and girls and male sexual entitlement<sup>43,44</sup> (societal level). Known protective factors for victimization and perpetration are limited but may include higher education<sup>45</sup> at the individual level, and parental supervision<sup>46</sup> and supportive family<sup>47</sup> at the relationship level.

**CSA can be prevented.** Only 10% (or fewer) of the cases of CSA are perpetrated by a stranger<sup>48</sup>. Most perpetrators are someone the child knows or someone known to the child's family<sup>49,50</sup>. Preliminary evidence from research suggests that implementing certain programs decreases perpetration of CSA, thereby suggesting that the issue can be prevented<sup>51</sup>. 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 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 approaches; and track progress on reductions in CSA. A comprehensive approach to CSA prevention that includes preventive interventions at all levels of the social ecological model is critical to having a population-level impact<sup>52</sup>.

### ***Strategies for Preventing CSA***

The evidence base for the primary prevention of CSA is limited. Therefore, supporting the rigorous evaluation of promising prevention approaches would allow for development and evaluation of new preventive approaches 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)<sup>53</sup>. Although perpetrator management strategies (e.g., sex offender registries, sex offender laws) that were designed to protect communities and children may have an impact on preventing recidivism, tracking or monitoring known perpetrators do little to actually prevent CSA from happening in the first place. These strategies may also have unintended consequences that make communities less safe (e.g., potential offenders do not reach out for help)<sup>54,55</sup>. Likewise, while school-based educational programs (i.e., programs focused on teaching children to recognize CSA, establish appropriate boundaries, and avoid and report abuse) increase children's knowledge and skills, it is unclear whether the programs have an effect on actually preventing CSA<sup>56</sup>. Despite limitations and lack of evidence, these strategies continue to be used to prevent CSA. For example, over half of the states in the U.S. have enacted legislation requiring the implementation of these school-based educational programs without evidence of effectiveness<sup>57</sup>. 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<sup>58</sup>. The goal of these programs is to build adult and community responsibility for the prevention of CSA and to create protective environments for children; however, these programs lack evidence of effectiveness in preventing victimization or perpetration. Research on programs that aim to prevent adult-perpetrated CSA can address this gap in evidence.

**Youth-perpetrated CSA.** Research on youth-perpetrated CSA has increased in recent years, and some programs have resulted in reductions in CSA committed by adolescents against other adolescents. These programs may be delivered in a variety of settings, including school classrooms and community organizations. Several of the programs that reduce youth-perpetrated CSA teach children skills related to healthy, safe dating relationships, healthy sexuality, and social-emotional health<sup>59,60</sup>. Other programs aim to reduce the acceptability of violence, increase positive attitudes towards girls by engaging men and boys, and change social norms<sup>61,62</sup>. In addition, 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 youth-perpetrated CSA<sup>63</sup>.

### ***CDC's Current Efforts in CSA Prevention***

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

**Data for research and monitoring.** CDC's surveillance expertise has allowed for the collection of CSA estimates in a number of areas: (a) adult lifetime prevalence of CSA victimization is assessed in the National Intimate Partner and Sexual Violence Survey; (b) 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; and (c) the relationship between CSA and health-related risk behaviors is collected using the Behavioral Risk Factor Surveillance System. CDC also has provided support for the National Survey of Children's Exposure to Violence, which documents the incidence and prevalence of children's exposure to violence. In addition, CDC supports surveys on Violence Against Children globally to understand the magnitude, nature, and consequences of violence against children. These surveillance systems allow for victimization estimates, not perpetration estimates.

**Research to understand risk and protective factors and effectiveness of CSA prevention strategies.** Given the limited evidence base for CSA prevention, CDC has focused a portion of its 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 and Essentials for Childhood programs; however, neither of these practice initiatives has a primary focus on CSA. CDC also currently funds secondary data analyses to examine risk and protective factors for CSA perpetration by middle and high school students. Other projects funded in the past have examined what puts one at risk for or protects against CSA, developed media products for an adult education program (i.e., Stewards for Children) for CSA, and explored the unique and shared risk factors for delinquent behavior and adolescent perpetration of CSA.

**Dissemination and implementation of CSA prevention strategies.** CDC developed technical packages compiling the best available evidence for preventing child abuse and neglect and sexual violence to guide its practice initiatives<sup>64,65</sup>. 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 presented in CDC's technical packages, while still allowing for innovation, particularly at the community and societal levels of the social ecology where prevention 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 support over the years, a number of CSA prevention gaps remain across all areas of the public health model.

**The availability and quality of data for CSA vary and at times are contradictory and insufficient.** States and communities need data that enables them to monitor CSA in real-time (as opposed to assessing it retrospectively) and evaluate progress during implementation of the CSA prevention strategies. To accomplish this, the following gaps could be addressed: 1) improving the quality of prevalence studies (e.g., adopting standardized measurement and definitions across the field, ensuring data collection is as comprehensive as possible, determining best methods for collecting perpetration data); 2) use of large, representative, and randomly selected samples; and 3) annual public health assessments of prevalence of CSA victimization and perpetration, including prevalence data on youth- and adult-perpetrated CSA.

**A better understanding of the factors leading to CSA perpetration could inform the primary prevention of perpetration.** Longitudinal research, which includes repeated observations of the same respondents over time, could identify factors related to perpetration of CSA by youth and adults. Specifically, future work could do the following: 1) add to our understanding of the risk and protective factors for CSA perpetration; 2) examine the distinctions between the different types of CSA perpetrators; 3) recruit large samples to obtain sufficient power and assess risk and protective factors related to the initiation of CSA perpetration (e.g., the multiple pathways that may lead to CSA perpetration); 4) examine how risk and protective factors combine or interact in the overlap of CSA perpetration with other forms of violence perpetration; and 5) assess community- and societal-level factors associated with CSA perpetration<sup>66</sup>.

**Policies, programs, and practices for preventing perpetration of CSA are needed.** Strategies that show promise in preventing CSA focus on promoting social norms that protect against violence by engaging men and boys; creating protective environments by improving the safety and monitoring in schools and other environments; or teaching skills related to healthy, safe dating relationships, healthy sexuality, and social-emotional health<sup>67</sup>. Additional research could address the following areas: 1) effective approaches should be further evaluated in various communities and settings and with different populations; 2) research identifying programs and practices that reduce youth- and adult-perpetrated CSA; and 3) research evaluating programs that engage parents in CSA prevention.

**Dissemination of and implementation research on existing evidence-based strategies is needed.** Because CSA affects at least 3.7 million children each year<sup>68</sup>, it is an urgent public health problem that requires us to act on the best available evidence. Research could address 1) how to best scale up the implementation of existing evidence-based interventions; 2) how to best adapt the evidence-based CSA preventive interventions for different populations and settings; and 3) how to best communicate about CSA, preventing the perpetration of CSA, and evidence-based programs for CSA perpetration prevention.

## ***Conclusion***

**Childhood sexual abuse is an adverse childhood experience that affects millions of children annually; however, it is preventable.** Although official estimates suggest that CSA has declined over the years, self-report data suggest that it is consistently occurring at alarmingly high rates<sup>69</sup>. The majority of federal funding specific to CSA is from the Department of Justice and is directed at the criminal justice system response after CSA is reported. It is critical to make information on symptoms that may be experienced and where to go for help accessible for children who do not report, and equally important to prevent CSA from happening in the first place. The information provided in this report highlights the current state of research on CSA prevention and suggested next steps for research to move the field forward in the primary prevention of CSA. Additional efforts could address the gaps in CSA prevention, and better coordination and collaboration are needed among the many stakeholders focused on preventing CSA. Youth and family-serving organizations, public/governmental agencies, faith communities and others must have the information necessary for effective prevention strategies. CSA is preventable and CDC provides leadership, using a public health approach, to reduce children's exposure to sexual abuse and ensure safe, stable, nurturing relationships and environments for all children.

## I. Overview

In the conference report for 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 (CDC) prepared this report in response to this request from the House and Senate Appropriations Committees. 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 includes feedback from these reviewers, as well as from 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<sup>70,71</sup> and significant societal costs<sup>72,73</sup>. **The total lifetime economic burden of CSA in the U.S. is estimated to be \$9.3 billion<sup>74</sup>**, although this is likely an underestimate given the limitations of available data, as outlined below. In addition, currently there are limited effective, evidence-based strategies for proactively protecting children from CSA.

Sexual victimization can happen across the lifespan. CSA is sexual victimization that occurs during childhood (i.e., before the age of 18). Specifically, CSA refers to the involvement of a child (i.e., less than 18 years old) in sexual activity that he or she does not fully comprehend, does not consent to, is unable to give informed consent to or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society<sup>75</sup>. This includes sexually inappropriate conduct directed towards children by an adult or another child/adolescent of the same or different age, such as 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

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

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\* The definition of CSA for this report is intentionally broad to include activities that reflect the various forms of sexual victimization experienced by children, such as victimization by caregivers as well as non-caregivers, including both adults and children.

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<sup>76</sup>. Perpetrators may include parents or other adults/caregivers, dating partners, family friends, relatives, siblings, friends/peers, acquaintances, someone known only by sight, etc.<sup>77,78,79</sup>. CSA can occur online (e.g., via social media) and in person. CSA perpetration and victimization occur in all parts of society<sup>80</sup> and **about 90% of perpetrators are someone the parent or child knows and is often trusted by the child and family**<sup>81,82</sup>.

**CSA is preventable, but the evidence base for the primary prevention of CSA is currently limited; more research could help identify effective evidence-based prevention strategies.** 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.

### III. The Public Health Burden of CSA

As the nation's health protection agency, **CDC 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 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 such as state and local health departments 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. These four levels are nested and hierarchical such that individuals live in the context of relationships, relationships are embedded in neighborhoods and communities, and communities are nested within the larger socio-political structure. 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; because of the hierarchical nature of our ecology, individual solutions to systemic problems often fall short. This comprehensive approach is more likely to have a population-level impact and sustain prevention efforts over time than any single intervention<sup>83</sup>.

Prevention efforts often are categorized into three categories based on when the effort occurs: (a) primary prevention, (b) secondary prevention, and (c) tertiary prevention<sup>84</sup>. CDC's efforts are focused on the primary prevention of CSA and other forms of violence.

- **Primary prevention** refers to stopping violence before it occurs to prevent initial perpetration or victimization (e.g., perpetrator prevention programs).
- **Secondary prevention** refers to the immediate responses to violence to deal with the short-term consequences of exposure (e.g., emergency and medical care).
- **Tertiary prevention** refers to the long-term responses to deal with the consequences of exposure (e.g., sex offender treatment programs).

Estimating the incidence and prevalence of CSA can be challenging due to two main issues: (1) definitional differences and (2) reporting. First, while CDC published and uses uniform definitions and recommended data elements for sexual violence and child abuse and neglect, there is no consistent definition of CSA used in the literature<sup>85</sup>. Different definitions are used among the various sectors addressing CSA and across data systems and studies, which limits the utility and reliability of data. Second, there is an under-reporting of CSA, particularly in official 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<sup>86,87,88</sup>. Data from official sources also may misrepresent the types of people at risk and characteristics of the problem, as these also are often discordant from self-reports<sup>89</sup>. 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. 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,<sup>90</sup> thereby suggesting self-report studies may get us closest to the true prevalence of CSA.

According to CDC's National Intimate Partner and Sexual Violence Survey, which is a nationally representative study of lifetime and last 12 month experiences of intimate partner violence, sexual violence, and stalking victimization among U.S. adults, 8.4% of women (an estimated 10 million) reported in 2012 that they experienced rape or attempted rape under the age of 18<sup>91</sup>. While the 2012 rates for males are lower than females, 0.7% of men (estimated 791,000) reported rape or attempted rape and 1.6% of men (estimated 2 million) were made to penetrate or there was an attempt to make them penetrate someone<sup>92</sup>. A 2009 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<sup>93</sup>. 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 in 2013-2014, with the rate being 16.4% for girls and 9.4% for boys 14- to 17-years-old<sup>94</sup>. **Applied today, this means that 3.7 million children were likely exposed to CSA in the last year**<sup>95</sup>. Child welfare data collected annually by the Department of Health and Human Services, which is an official source of CSA victimization data, includes only cases of child abuse and neglect that are reported to and investigated by child welfare agencies. Based on this data, 8.6% of the 674,000 child victims experienced<sup>†</sup> CSA in 2016<sup>96</sup>. 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<sup>97</sup>; however, efforts to document trafficking within statewide child welfare information systems are ongoing<sup>‡</sup>.

An estimated 3.7 million children will be exposed to CSA each year in the United States.

**Rates of CSA often vary based on age**, with increases for females found after menarche, though younger children also may be victims<sup>98</sup>. Among a large sample of 15-17-year-olds assessed from 2013 to 2014, 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<sup>99</sup>. In CDC's 2010-2012 National Intimate Partner and Sexual Violence Survey, **approximately 1 in 3 female victims of 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**<sup>100</sup>.

Using CDC's 2017 national 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<sup>101</sup>. 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<sup>th</sup>-12<sup>th</sup> 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 in a 2010-2011 nationally

<sup>†</sup> "Experienced" refers to the total number of *substantiated* cases or those *confirmed* as CSA by child welfare agencies.

<sup>‡</sup> As per P.L. 114-22 Justice for Victims of Trafficking Act of 2015, child welfare agencies are collecting and reporting data on sex trafficking to the National Child Abuse and Neglect Data System. Sex trafficking data are being reported as a separate maltreatment type in the fiscal year 2018 data collection (currently ongoing) and data will be publicly released in the next *Child Maltreatment* report in early 2020.

representative survey<sup>102</sup>. In the same study of 7<sup>th</sup>-12<sup>th</sup> grade students, both girls and boys reported engaging in sexually harassing behaviors; 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<sup>103</sup>. Similarly, another study of 10-21-year-olds in 2012 found that 23% of male and 17% of female youth reported sexually harassing and victimizing others<sup>104</sup>. **Sexual harassment can create an environment that fosters more serious forms of CSA,**<sup>105</sup> and, as such, efforts to measure and track this through CSA surveillance could be considered<sup>106</sup>.

National survey estimates from 2003, 2008, and 2011 suggest that, for 17-year-old females, the lifetime rate of CSA perpetration was 17.8% by youth, 11.2% by adults, 19.6% by acquaintances, 5.5% by family members, and 3.0% by strangers. For 17-year-old males, the lifetime rate of CSA perpetration was 3.1% by youth and 1.9% by adults<sup>107</sup>. Using 2012 data from the National Intimate Partner and Sexual Violence Survey, 43.6% of perpetrators of female victims were acquaintances, 28.8% were intimate partners, 27.7% were family members, 4.5% were authority figures (e.g., teacher, coach), and 10.1% were strangers<sup>108</sup>. For males who experienced CSA in youth, over a third (35.1%) of the perpetrators were acquaintances<sup>109</sup>. These data suggest that **most CSA perpetrators are known to the victim rather than strangers and are often peers of the same age.**

### *Consequences of CSA*

Adverse childhood experiences, of which CSA is one form, have a graded dose-response relationship with 40+ outcomes to date, which suggests that **the more negative experiences a child has during childhood, the greater the likelihood of negative outcomes impacting health (e.g., obesity, diabetes, depression), health-related behaviors (e.g., smoking, alcoholism), and life potential (e.g., graduation rates, academic achievement)**<sup>110</sup>. Specifically, 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 research has been instrumental in documenting the biological associations between exposure to CSA and subsequent health conditions. Traumatic stress responses<sup>§</sup>, which often include strong emotional (e.g., guilt, fear, anger) and physical (e.g., rapid heartbeat, sleep disturbances) responses such as those associated with CSA exposure, impair brain architecture (both structure and function), immune status, metabolic systems, and cellular inflammatory responses<sup>111,112</sup>. Exposure to traumatic 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 (i.e., epigenetic effects)<sup>113</sup>. 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<sup>114</sup>. 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<sup>115</sup>.

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**<sup>116</sup>. 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**<sup>117</sup>. In adult women, lifetime prevalence of depression for those with a history of CSA can be as much as five times higher than those without a CSA history<sup>118</sup>. **Substance use disorders associated with CSA can start early in life and have a**

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<sup>§</sup> Traumatic stress is a specific type of stress that occurs after exposure to emotionally distressing events, including adverse childhood experiences, natural disasters, and motor vehicle accidents, among others. These events differ from other stressors as they cause excessive or prolonged activation of stress response systems in the body and brain.

**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<sup>119</sup>.

**Table 1. Consequences of CSA Victimization**

	Short-term	Long-term
<b>Physical Health Consequences</b>	Sexually transmitted infections <sup>120,121</sup> Genital pain and injuries <sup>122</sup> Sexualized behavior <sup>123,124</sup> Sleep disturbances <sup>125</sup> Stomachaches <sup>126</sup> Headaches <sup>127</sup> Unwanted/unplanned pregnancy <sup>128,129,130</sup>	Decreased health-related quality of life <sup>131,132,133,134</sup> Heart disease <sup>135</sup> Obesity <sup>136</sup> Pain disorders <sup>137</sup> Cancer <sup>138</sup> Frequent headaches <sup>139</sup> Non-epileptic seizures <sup>140</sup> Gynecological problems (e.g., chronic pelvic pain) <sup>141,142,143</sup> Increased use of health care services, especially for females <sup>144,145,146</sup>
<b>Mental/Emotional Health Consequences</b>	Post-traumatic stress disorder (PTSD) <sup>147</sup> Anxiety <sup>148</sup> Aggression <sup>149</sup> Depression <sup>150</sup> Low self-esteem <sup>151</sup> Suicidality <sup>152</sup> Substance abuse <sup>153</sup> Disordered eating <sup>154,155,156</sup> Risky sexual behaviors (e.g., higher frequency of sex while intoxicated, less condom use at last sex, more sex partners) <sup>157,158,159</sup> Early age at first sexual contact <sup>160</sup>	Depression <sup>161,162,163,164,165</sup> PTSD <sup>166,167,168,169,170,171</sup> Suicide, including suicidal ideation & attempts <sup>172,173,174</sup> Self-injurious behavior without suicidal intent <sup>175</sup> Anxiety <sup>176,177</sup> Low self-esteem & low self-efficacy <sup>178</sup> Eating disorders <sup>179</sup> Alcohol and substance use disorders <sup>180,181,182</sup> Risky sexual behaviors (e.g., unprotected sex, sex with multiple partners, sex trading) <sup>183,184,185</sup>
<b>Social, Cognitive, &amp; Economic Consequences</b>	Educational problems (e.g., learning difficulties, concentration & attention problems, declining grades) <sup>186</sup> Educational underachievement <sup>187</sup> Increased risk of impaired social functioning <sup>188</sup> Social restrictions & manipulation <sup>189</sup> Economic exploitation & debt-bondage <sup>190</sup> Occupational hazards & abusive living conditions <sup>191</sup> Arrest and detention <sup>192</sup> Inability to obtain needed legal services <sup>193</sup> Exposure to extreme environmental conditions <sup>194</sup>	Revictimization in adulthood <sup>195</sup> Risk for teen dating violence <sup>196,197</sup> Risk for intimate partner violence <sup>198</sup> Increased risk for later being trafficked for sex <sup>199,200,201</sup> Decreased life satisfaction <sup>202,203</sup> Significant economic problems in adulthood (e.g., unemployment & poverty) <sup>204</sup> Risk for perpetrating violence <sup>205,206,207</sup>

*Note.* This table is not an exhaustive list of consequences associated with CSA exposure. Short- and long-term consequences are identified as such based on when outcomes were assessed (e.g., teen dating violence is a long-term consequence for CSA in early childhood).

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<sup>208</sup>. **Females exposed to CSA are at a 2-13 fold increased risk of sexual victimization in adulthood compared to females without a history**<sup>209,210,211</sup>. Further, compared to other forms of childhood abuse and adversity, CSA has been shown to be the strongest predictor of sexual victimization in adulthood<sup>212</sup>. Revictimization is not limited to sexual violence – **individuals who experienced CSA are at twice the risk for non-sexual intimate partner violence**<sup>213</sup>. Exposure to CSA also increases risk for later being trafficked for sex<sup>214,215,216</sup>.

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<sup>217</sup>, and two times the risk of perpetration of intimate partner violence<sup>218</sup>. It is also a risk factor for perpetration of CSA in adulthood<sup>219</sup>. 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**<sup>220,221</sup>. Studies have found that youth perpetrators of CSA, although unlikely to reoffend as adults, are more likely to recreate behaviors reflective of their own victimization<sup>222</sup>.

Almost half of adults who experience CSA are sexually revictimized in adulthood.

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. 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)<sup>223</sup>. Although using different methodology, **the estimated lifetime economic burden of CSA is at least \$9.3 billion** (2015 US dollars)<sup>224</sup>. The lifetime economic burden of rape among the US adult population is nearly \$3.1 trillion (2014 US dollars) over victims' lifetimes<sup>225</sup>. 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<sup>226</sup>. Thus, the estimates of the economic burden of rape in the US are likely a conservative estimate of the problem.

The estimated lifetime economic burden of CSA is at least \$9.3 billion.

#### IV. 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<sup>227</sup>.

CSA appears to cut across all races and levels of income.

**Table 2. Risk and Protective Factors for CSA Victimization**

Ecological Level	Risk Factors	Protective Factors
<b>Individual</b>	Female gender <sup>228,229,230</sup> Age – preadolescent or early adolescent <sup>231,232,233</sup> History of child abuse & sexual exploitation <sup>234</sup> Substance use <sup>235</sup> Having a disability <sup>236</sup> Passivity <sup>237</sup> Quietness <sup>238</sup> Trusting-ness <sup>239</sup> Unhappy appearance <sup>240</sup> Depression <sup>241</sup> Sexual minority status <sup>242,243</sup>	Higher level of education completed <sup>244</sup>
<b>Relationship</b>	Maternal youth <sup>245</sup> Parental unwanted pregnancy <sup>246</sup> Parental death <sup>247</sup> Harsh parental punishment or poor parenting <sup>248,249</sup> Maternal sociopathy or impairment <sup>250,251</sup> Having a stepfather <sup>252,253</sup> Living without a natural parent <sup>254</sup> Male-dominated household <sup>255</sup> Witnessing family conflict <sup>256,257</sup> Few close friends <sup>258</sup>	Parental supervision <sup>259</sup> Positive parenting as a child <sup>260</sup> Supportive family <sup>261</sup>
<b>Community</b>	Community tolerance of sexual abuse <sup>262,263</sup> Neighborhood violence <sup>264</sup> Poverty, mediated through forms of crisis of male identity <sup>265,266</sup> Lack of employment opportunities <sup>267</sup> Lack of institutional support from police & judicial system <sup>268</sup> Media portrayals of children as sexual actors <sup>269</sup> Weak community sanctions against perpetrators of sexual violence <sup>270,271,272</sup>	
<b>Societal</b>	Inequality between men & women/patriarchal social systems & laws <sup>273,274</sup> Societal acceptance of child pornography, adult-child sex, or sexual violence <sup>275,276,277</sup> Societal objectification of women/girls & acceptance of male sexual entitlement <sup>278,279</sup> Weak laws & policies against sexual violence perpetration <sup>280,281</sup>	

*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.

**Approximately 90% of CSA cases that come to the attention of law enforcement involve a perpetrator known to the child<sup>282</sup>.** Perpetrators of CSA are not a uniform group, as there are adolescent/child perpetrators, adult perpetrators, intra-familial perpetrators, extra-familial perpetrators, perpetrators of child pornography, repeat perpetrators, pedophiles (i.e., those with a sexual preference for prepubescent children), contact vs. non-contact perpetrators, perpetrators with cognitive disabilities, etc.<sup>283,284,285</sup>. Moreover, the behaviors of perpetrators vary widely; some are rapists while others download or produce child pornography, are exhibitionists or peeping toms, or sext with another minor. 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**<sup>286,287,288,289</sup>. 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<sup>290,291</sup>. Moreover, the research also demonstrates that **whether or not past abuse puts someone at higher risk to perpetrate CSA depends on specifics of the abuse, resilience of the child, and environmental factors**<sup>292,293</sup>. Table 3 includes the individual, relationship, community and societal risk and protective factors that have been linked to CSA perpetration. Unfortunately, data on risk and protective factors for CSA does not clearly outline the risk and protective factors for the various forms of CSA; thus, the table below includes risk and protective factors for perpetration broadly.

**Table 3. Risk and Protective Factors for CSA Perpetration**

Ecological Level	Risk Factors	Protective Factors
<b>Individual</b>	Male gender <sup>294</sup> Exposure to CSA in childhood <sup>295,296,297,298,299,300</sup> Substance use <sup>301,302,303</sup> High impulsivity <sup>304,305,306</sup> Low self-esteem <sup>307</sup> Anger/hostility <sup>308,309,310</sup> Anxiety or depression <sup>311,312,313</sup> Loneliness <sup>314,315</sup> Poor coping strategies <sup>316</sup> Traditional beliefs about masculinity <sup>317</sup> Exposure to pornography <sup>318,319</sup> Dismissiveness of sexual harassment <sup>320,321,322</sup> Early sexual initiation <sup>323</sup> Sexual problems and deviancy <sup>324,325,326</sup> Cognitions tolerant of adult-child sex <sup>327,328</sup> Acceptance of rape myths <sup>329</sup> Cognitions that minimize perpetrators' culpability <sup>330</sup>	Higher level of education completed <sup>331</sup> Empathy <sup>332</sup> Resiliency <sup>333,334</sup>
<b>Relationship</b>	Family conflict & hostility <sup>335,336,337</sup> Poor attachment or bonding <sup>338,339</sup> Controlling coercive parenting <sup>340,341</sup> Difficulties with intimate relationships <sup>342</sup> Delinquent peer associations <sup>343</sup>	Parental monitoring <sup>344,345</sup> Healthy parenting <sup>346</sup> Supportive family <sup>347</sup> Social support <sup>348,349</sup> Sense of school belonging or connectedness <sup>350</sup>
<b>Community</b>	Neighborhood violence <sup>351,352</sup> Poverty, mediated through forms of crisis of male identity <sup>353,354</sup> Lack of employment opportunities <sup>355</sup> Lack of institutional support from police and judicial system <sup>356</sup> Media portrayals of children as sexual actors <sup>357</sup> Weak community sanctions against perpetrators of sexual violence <sup>358,359,360</sup>	

<b>Societal</b>	Inequality between men and women/patriarchal social systems & laws <sup>361,362,363</sup> Societal acceptance of child pornography, adult-child sex, or sexual violence <sup>364,365,366</sup> Societal objectification of women/girls & acceptance of male sexual entitlement <sup>367,368</sup> Weak laws & policies against sexual violence perpetration <sup>369,370</sup>	
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*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 or protected from 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.

CDC’s prior work in violence prevention has documented connections among the various forms of violence<sup>371</sup>. According to CDC’s Connecting the Dots framework, sexual violence, child abuse and neglect, suicide, intimate partner and teen dating violence, and youth violence share risk and protective factors that are common across them, thereby suggesting that **prevention of one form of violence such as CSA has the ability to prevent other forms of violence.** This framework notes the importance of addressing these shared risk and protective factors for achieving measurable reductions in violence<sup>372</sup>.

## V. Strategies for Preventing CSA

**Although the evidence for primary prevention of CSA is limited, the problem is large and costly and has many urgent consequences (as documented earlier). States and localities could consider implementing programs supported by evidence while also continuing to evaluate programs that are promising.** Listed below are strategies and approaches 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 and approaches. 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 approaches that incorporate multiple levels of the social ecology are necessary, as is coordination among multiple sectors working to address the issue.

**Table 4. Perpetrator Prevention Programs**

	Adult-Focused	Youth-Focused
Individual	Stewards of Children Kempe Perpetrator Prevention Program Prevention Project Dunkelfeld Stop It Now! <sup>+</sup> Enough Abuse Thorn	Responsible Behavior with Younger Children Second Step: Student Success through Prevention* Safe Dates*
Relationship	Parenting strategies	Bringing in the Bystander* Green Dot* Coaching Boys into Men*
Community	Situational Prevention Model	Shifting Boundaries – building level*
Societal		

*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. Also note the lack of prevention strategies at the community and societal levels.

## ***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<sup>373</sup>. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include education and life skills training<sup>374</sup>.

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 (Perpetrator Prevention Programs). 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<sup>375,376</sup>. A meta-analysis of school-based education programs found that the programs increased knowledge (at least in the short-term)<sup>377</sup>; however, the quality of the research is limited and it is unclear whether the programs reduce victimization<sup>378</sup>. 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<sup>379</sup>. Nonetheless, over half of the states in the U.S. have passed legislation mandating or encouraging CSA prevention training in schools (e.g., Erin's Law, Tara's Law, Jenna's Law), with many states also increasing emphasis on preventing the commercial sexual exploitation of children. Given limited resources, many schools will not implement the programs nor will they receive consequences for not implementing programs<sup>380</sup>. Other schools will implement the programs but with limited quality (e.g., skipping content, limiting the number of sessions), which likely will impact outcomes<sup>381</sup>. A key factor in moving forward will be to demonstrate that children's increased knowledge is maintained over time and this knowledge leads to safer communities for children.

A more practical, cost-effective, and measurable way to address CSA is by educating adults<sup>382</sup>. 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<sup>®</sup> program is an example. Research has found that adults who received the training had increased knowledge, improved attitudes, and positive change in child-protective behaviors<sup>383</sup>. The Kempe Perpetration Prevention Program teaches adults practical, goal-oriented strategies to reduce children's risk of harm to themselves and others<sup>384</sup>. More research could help to fully determine whether adult education programs influence rates of CSA victimization and perpetration.

Information and effectiveness research on programs that prevent youth- and adult-perpetrated CSA is limited. The few programs currently in place focus on reducing initial perpetration (and recidivism), such as Prevention Project Dunkelfeld<sup>385,386</sup>. 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<sup>387</sup>. 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<sup>388</sup>.

Stop It Now! is a program developed in 1992 that emphasizes adult and community responsibility for the prevention of CSA<sup>389</sup>. 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<sup>390</sup>. 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)<sup>391</sup>. 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<sup>392,393</sup>. Additional research is needed on the effectiveness of youth- and adult-perpetrated CSA prevention 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<sup>394</sup>. 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)<sup>395</sup> 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<sup>396</sup>. 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<sup>397</sup>. 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<sup>398</sup>.

A number of school-based prevention programs (e.g., Second Step: Student Success through Prevention, Safe Dates) have been effective at reducing sexual harassment and sexual violence among youth<sup>399</sup>. Second Step is a program for middle school students focused on reducing bullying and CSA 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 CSA perpetration and a 56% reduction in homophobic teasing victimization in one of the two sites where it was evaluated<sup>400</sup>. Safe Dates is composed of a 10-session curriculum focused on positive communication, anger management, and conflict management. Safe Dates among 8<sup>th</sup> and 9<sup>th</sup> graders is effective at reducing CSA perpetration and victimization within the dating context<sup>401</sup>. 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 evidence of effectiveness for preventing recidivism among youth 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<sup>402,403,404</sup>. More longitudinal research could help 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<sup>405</sup>.

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%)**<sup>406</sup>. 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<sup>407,408</sup>. 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<sup>409</sup>. 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<sup>410</sup>.

When discussing CSA with their children, over 90% of parents explained that potential abusers were strangers; fewer (65%) explained it could be someone the child knows.

Bystander intervention programs engage youth to promote social norms that protect against CSA. 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<sup>411</sup>. Bringing in the Bystander effectively increases one's self-efficacy and intention to intervene in situations involving sexual violence<sup>412,413</sup>. When schools implemented the Green Dot program, CSA victimization rates were 12%-13% lower in the intervention versus control high schools<sup>414</sup>. 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<sup>415</sup>. 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 (including sexual dating violence) and reduce negative bystander behaviors<sup>416,417</sup>. 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 could 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 (i.e., adult sexual perpetrators reintegrating into communities after incarceration)<sup>418</sup>. In the program, "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 (e.g., professionals, circle coordinator) provide friendship and support while also ensuring accountability for individual behavior; they have the ability to intervene if and when needed<sup>419</sup>. 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<sup>420</sup>. 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 (e.g., screening and selecting employees and volunteers, guidelines on interactions between employees/volunteers and youth) that aim to protect children and promote safe, stable, nurturing relationships and environments. Many of these policies and procedures were 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 youth, and the report outlines specific actions which can be taken to reduce perpetration by both of these groups<sup>421</sup>. At the time of publication, the recommended policies and procedures were based largely on clinical judgment and on best available evidence. In the years since this publication, there have been changes in technology (e.g., cell phones) as well as newly enacted state or local policies put in place with regard to CSA prevention. Research is needed to determine 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 youth-perpetrated violence<sup>422</sup>. Shifting Boundaries includes a building-level intervention that allows students to identify areas on their school grounds where sexual violence is likely to happen, which then allows for increased adult supervision of those areas. The building-level intervention was associated with a 40% reduction in youth-perpetrated CSA and a 34% reduction in sexual harassment perpetration among middle school students<sup>423</sup>. The situational prevention model is being used as a community-level strategy for preventing CSA in YSOs and other contexts<sup>424</sup>. It is unclear whether this strategy has an effect in preventing adult-perpetrated CSA. 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 (although these are not primary prevention approaches)<sup>425</sup>. 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”<sup>426(p. 5)</sup>.

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<sup>427</sup>. 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<sup>428</sup>. 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<sup>429</sup>. Several states also have passed legislation that requires mandated reporters to report CSA threats if the victim alleging past abuse is no longer in contact with the alleged perpetrator but the alleged perpetrator currently represents a credible threat to children under 18<sup>430</sup>. A majority of states have also implemented safe harbor laws that legally protect and assist children who have been exploited for labor or sex<sup>431</sup>. 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 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<sup>432</sup>. While many of these policies may be helpful in monitoring/tracking those who reoffend, they do not address the primary prevention of CSA perpetration<sup>433,434</sup>. These laws may make it difficult for perpetrators, including those adolescents who have to register as sex offenders, to access services, find employment and housing, and maintain supportive relationships with family and friends<sup>435</sup>, 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 current adolescent registration and notification policies have not found any public safety benefits. Offender policies do not reduce recidivism<sup>436,437</sup> or deter first-time offenses<sup>438</sup> in adolescents. In general, however, only a small percentage of adolescents reoffend as adults<sup>439</sup>. A recent meta-analysis found that more than 95% of adolescents did not reoffend within five years<sup>440</sup>, 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<sup>441</sup>. 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<sup>442</sup>. 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 important to learn more about what works to prevent CSA, while also increasing our understanding of 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 for 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. The Division'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, help identify high-risk groups, and monitor the effects of prevention programs<sup>443,444</sup>.

CDC also collects data on the prevalence of CSA through a number of surveys. These surveys are outlined in Table 5 below. These surveillance systems allow for victimization estimates, not perpetration estimates.

**Table 5. Surveys on CSA Currently Being Conducted or Sponsored by CDC**

Survey	Description
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 ongoing data on these important public health problems to 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 <a href="https://www.cdc.gov/violenceprevention/nisvs/index.html">https://www.cdc.gov/violenceprevention/nisvs/index.html</a>
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 causes 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 <a href="https://www.cdc.gov/healthyouth/data/yrebs/index.htm">https://www.cdc.gov/healthyouth/data/yrebs/index.htm</a> .
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 ACEs data from 42 states. These data allow CDC to examine relationships between CSA and health risk behaviors, as noted in Appendix 3. CDC will be supporting expansion of the BRFSS ACEs data collection to an additional six states beginning in 2019. For more information, see <a href="https://www.cdc.gov/brfss/index.html">https://www.cdc.gov/brfss/index.html</a> .
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 <a href="http://unh.edu/ccrc/projects/natscev.html">http://unh.edu/ccrc/projects/natscev.html</a>
Violence Against Children Surveys (VACS)	Violence Against Children Surveys (VACS), supported 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 <a href="https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/index.html">https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/index.html</a> .

***Research on Risk and Protective Factors for CSA***

CDC has ongoing research focused on risk and protective factors for CSA. CDC focuses on 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). Of note, however, is the fact that neither practice initiative has a primary focus on CSA. CDC currently funds a researcher to examine risk and protective factors for CSA perpetration by middle and high school students. The funding has allowed for analysis of previously collected longitudinal data 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 perpetrators<sup>445</sup>, (2) etiological models and moderators for middle school bullying and sexual violence<sup>446</sup>, and (3) a multilevel protective model of sexual violence perpetration<sup>447</sup>. More research could 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<sup>448,449</sup>. 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 could 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<sup>450</sup>, 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 also effective in preventing CSA.

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-to-practice gap by ensuring evidence-based approaches are effectively distributed and adopted in public health and clinical practice settings with attention to cultural context and adaptation based on population and setting. 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 in various settings. With all of 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. Other key factors that could 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 (RPE) 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 youth-perpetrated CSA. RPE programs are encouraged to implement strategies using the best available evidence. The new five-year RPE program funding, which began in early 2019, places an increased emphasis on selecting evidence-based programs that are represented in CDC's technical package on sexual violence prevention<sup>451</sup>, 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 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. Funded programs 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. Programs 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<sup>452</sup>. CDC supports enhancement of these states' program implementation, data collection, and evaluation activities related to familial opioid misuse and overdose.

### ***Other Activities***

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, the American Academy of Pediatrics, UNICEF and Together for Girls, 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 will help continue 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 across the field, and (b) ensuring data collection is as comprehensive as possible and includes all forms of CSA. Data, which includes a focus on perpetrators, including the characteristics and behaviors of perpetrators and how to best collect perpetration data, is also important to inform prevention efforts.
2. The use of randomly selected samples that are sufficiently large and representative to generate accurate estimates of CSA is important. Assessments of CSA within samples could include multiple methods and sources to minimize limitations of data quality.
3. Timely data, including data assessed in real time (or as close to real time as possible, e.g., last 12 months) is important. Thus, in addition to collecting ever in lifetime data to improve disclosure and understand the lifetime burden of CSA, the field would benefit from assessments of recent CSA experiences, such as comprehensive last 12-month data on CSA. Ongoing assessments of annual prevalence (or every other year) of CSA victimization and perpetration would 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 could help identify strategies and timing for primary prevention of perpetration. Increased knowledge of the factors associated with CSA could directly inform the content of prevention efforts. Moreover, identification of protective factors (e.g., assets and resources) that can effectively prevent CSA also is needed. 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 or perpetrators successfully prosecuted by the criminal justice systems<sup>453,454</sup>. These characteristics make it hard to assess temporal order (i.e., factors contributing to CSA) and generalizability across samples. Future work with self-report data could:

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<sup>455</sup>.
3. Recruit large samples to obtain sufficient power and assess risk and protective factors longitudinally (i.e., over time) to determine temporal order and the multiple pathways that may lead to CSA perpetration<sup>456</sup>. 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<sup>457</sup>.
4. Examine how risk and protective factors combine or interact and the overlap of CSA with other forms of violence victimization and perpetration<sup>458</sup>.
5. Assess risk and protective factors at the outer levels of the social ecology (i.e., community and societal levels), such as policies at the organizational and jurisdictional levels or the physical environments of schools and communities. This may be appropriate for faith-based organizations, YSOs, or other groups working with children.

### ***Research on Effectiveness of Strategies to Prevent CSA***

More research could examine individual, relationship, community, and societal strategies for preventing CSA. Strategies that show promise promote social norms that 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<sup>459</sup>. Additional research is needed in a number of areas, such as:

1. Strategies that prevent the perpetration of CSA among youth can be replicated and extended to additional communities and settings and with different populations, as applicable.
2. Programs and practices 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. 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 or risk factors do 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 a public health problem that requires action using the best available evidence. Research could explore 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; adaptation for different cultural contexts and environments); and



3. How to best communicate about CSA, preventing the perpetration of CSA, and evidence-based programs for CSA perpetrator 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. Other agencies within the Department of Health and Human Services and across the Federal government also are engaged in activities focused on CSA. Increased intra- and inter-agency collaboration as it relates to the prevention of CSA is needed to result in the types of changes necessary to decrease the number of children affected by this public health problem.

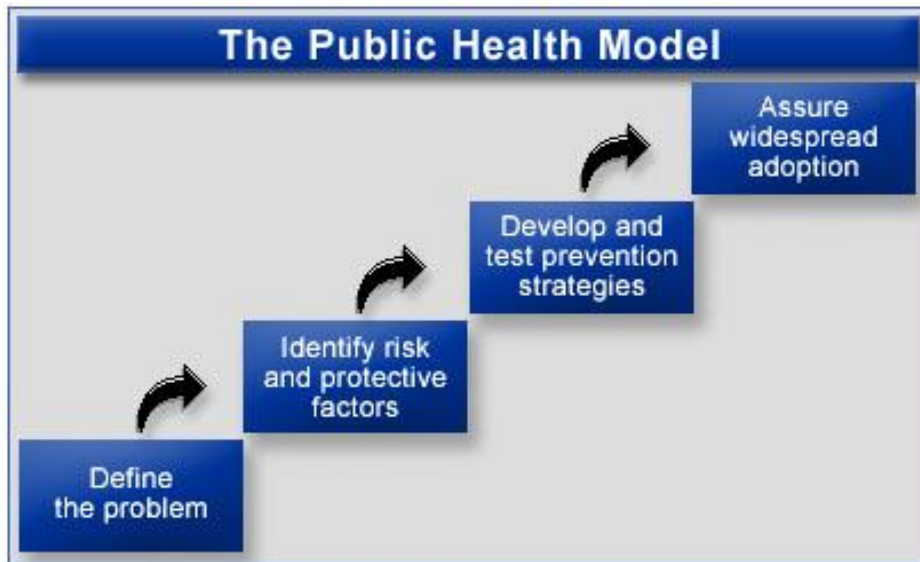
### *Addressing Gaps*

Support for research on the primary prevention of CSA (i.e., sexual violence victimization or perpetration under the age of 18) could provide 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, families, 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 knowledge that could be addressed to further inform our efforts moving forward. CDC will continue to support 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 could (1) collect data for research and monitoring of CSA, (2) identify modifiable factors that increase or reduce perpetration of CSA and strategies that address those factors, (3) identify effective, cost-efficient strategies for preventing CSA, particularly among those at highest risk, and (4) disseminate information about, and provide technical assistance for implementation of what works to prevent CSA.

## 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 or perpetrate 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 direct protection or is an indirect 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.

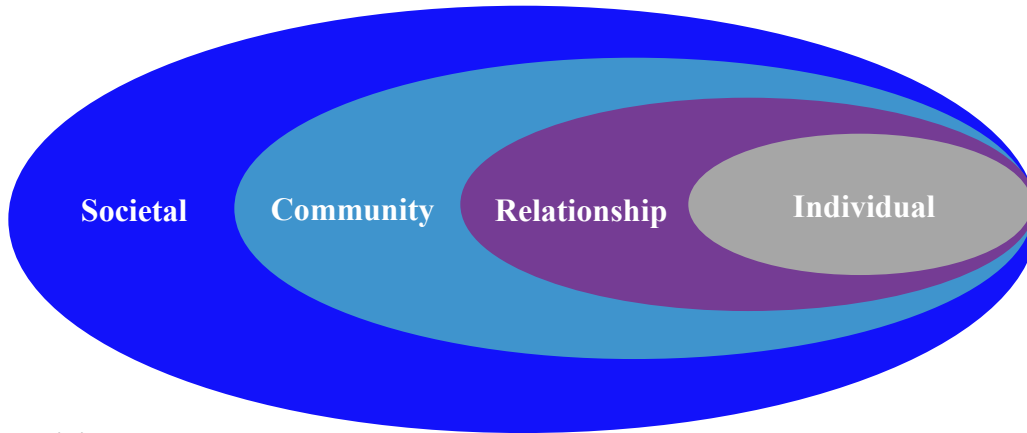
### **Step 4: Assure Widespread Adoption**

Once prevention efforts have been proven effective, they must be implemented and adopted more broadly. Communities are encouraged to implement evidence-based programs, policies, and practices and to evaluate their success. Dissemination techniques to promote widespread adoption include training, networking, technical assistance, and evaluation.

Dahlberg, L. L., Krug, E. G. (2002). Violence: A global public health problem (pp. 1-56). In E. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds). *World report on violence and health*. Geneva, Switzerland: World Health Organization.

## **Appendix 2: The Social-Ecological Model**

The ultimate goal is to stop CSA before it occurs. To do this, we have to understand the factors that influence CSA. CDC uses the four-level social ecological model to better understand CSA (and other forms of violence) and the effect of potential prevention strategies. A graphical depiction and further explanation of the model and the four levels are provided below.



### **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 becoming a victim or perpetrator of violence. 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, increase bystander behaviors, 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 community members becoming victims or perpetrators of violence. Prevention strategies at this level impact the social and physical environment – for example, 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.

Dahlberg, L. L., Krug, E. G. (2002). Violence: A global public health problem (pp. 1-56). In E. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds). *World report on violence and health*. Geneva, Switzerland: World Health Organization.

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

Outcome	Men			Women		
	n	Percent <sup>a</sup> (95% CI)	Adjusted <sup>b</sup> Odds Ratio (95%CI)	n	Percent <sup>a</sup> (95% CI)	Adjusted <sup>b</sup> Odds Ratio (95% CI)
<b>Lifetime Depression</b>						
No sexual abuse	8,332	12.8 (12.1, 13.6)	1.0 (ref.)	16,430	19.0 (18.2, 19.8)	1.0 (ref.)
Sexual abuse	1,311	29.0 (25.5, 32.6)	<b>2.7 (2.2, 3.2)</b>	6,587	42.8 (40.7, 44.8)	<b>2.9 (2.6, 3.2)</b>
Total	9,643	13.7 (13.0, 14.4)		23,017	22.4 (21.6, 23.1)	
<b>Frequent Mental Distress</b>						
No sexual abuse	4,537	6.5 (6.0, 7.1)	1.0 (ref.)	6,935	7.6 (7.1, 8.1)	1.0 (ref.)
Sexual abuse	698	16.9 (13.9, 19.8)	<b>2.7 (2.1, 3.3)</b>	3,148	19.2 (17.8, 20.7)	<b>2.6 (2.3, 2.9)</b>
Total	5,235	7.1 (6.5, 7.7)		10,083	9.3 (8.8, 9.7)	
<b>Frequent Physical Distress</b>						
No sexual abuse	6,845	10.1 (9.4, 10.8)	1.0 (ref.)	9,208	10.7 (10, 11.3)	1.0 (ref.)
Sexual abuse	751	17.8 (14.8, 20.9)	<b>1.8 (1.4, 2.3)</b>	3,057	20.1 (18.4, 21.9)	<b>2.2 (1.9, 2.5)</b>
Total	7,596	10.5 (9.8, 11.2)		12,265	12.0 (11.4, 12.6)	
<b>Fair/Poor Health</b>						
No sexual abuse	10,828	15.8 (15.0, 16.6)	1.0 (ref.)	13,544	15.6 (14.8, 16.3)	1.0 (ref.)
Sexual abuse	1,007	22.8 (19.4, 26.1)	<b>1.5 (1.2, 1.9)</b>	3,951	24.9 (23.1, 26.6)	<b>1.9 (1.7, 2.2)</b>
Total	11,835	16.2 (15.4, 16.9)		17,495	16.9 (16.2, 17.6)	
<b>Current Smoker</b>						
No sexual abuse	11,091	16.5 (15.7, 17.3)	1.0 (ref.)	11,095	12.5 (11.9, 13.2)	1.0 (ref.)
Sexual abuse	1,071	26.7 (22.5, 31.0)	<b>1.6 (1.3, 2.1)</b>	3,631	24.4 (22.5, 26.3)	<b>1.9 (1.7, 2.2)</b>
Total	12,162	17.0 (16.2, 17.8)		14,726	14.2 (13.6, 14.8)	
<b>Lifetime Asthma</b>						
No sexual abuse	6,619	9.7 (9.1, 10.3)	1.0 (ref.)	10,934	12.1 (11.4, 12.7)	1.0 (ref.)
Sexual abuse	611	14.5 (11.5, 17.5)	<b>1.6 (1.2, 2)</b>	3,348	20.5 (18.9, 22.1)	<b>1.8 (1.6, 2.0)</b>
Total	7,230	10.0 (9.4, 10.6)		14,282	13.3 (12.7, 13.9)	
<b>COPD</b>						
No sexual abuse	4,103	6.2 (5.7, 6.8)	1.0 (ref.)	6,032	7.0 (6.6, 7.5)	1.0 (ref.)
Sexual abuse	423	8.8 (6.7, 10.9)	<b>1.5 (1.1, 2.1)</b>	2,003	13.5 (11.9, 15.2)	<b>2.4 (2.0, 2.8)</b>
Total	4,526	6.4 (5.8, 6.9)		8,035	8.0 (7.5, 8.4)	
<b>Stroke</b>						
No sexual abuse	2,463	3.7 (3.3, 4.2)	1.0 (ref.)	3,193	3.8 (3.4, 4.2)	1.0 (ref.)
Sexual abuse	200	4.2 (3.0, 5.3)	1.2 (0.8, 1.7)	767	5.8 (4.4, 7.1)	<b>1.9 (1.5, 2.6)</b>
Total	2,663	3.7 (3.3, 4.2)		3,960	4.1 (3.7, 4.5)	
<b>Kidney Disease</b>						
No sexual abuse	1,886	3.0 (2.6, 3.3)	1.0 (ref.)	2,723	3.3 (2.9, 3.6)	1.0 (ref.)
Sexual abuse	163	3.5 (2.3, 4.8)	1.3 (0.8, 1.9)	693	4.6 (3.8, 5.4)	<b>1.6 (1.3, 2.0)</b>
Total	2,049	3.0 (2.7, 3.4)		3,416	3.5 (3.1, 3.8)	
<b>Heart Attack</b>						
No sexual abuse	5,283	8.0 (7.4, 8.5)	1.0 (ref.)	3,536	4.1 (3.8, 4.5)	1.0 (ref.)

Sexual abuse	390	9.9 (7.7, 12.2)	1.4 (1.0, 1.9)	705	5.6 (4.0, 7.2)	<b>1.8 (1.3, 2.5)</b>
Total	5,673	8.1 (7.5, 8.6)		4,241	4.3 (3.9, 4.7)	
<b>Heart Disease</b>						
No sexual abuse	5,001	7.7 (7.1, 8.3)	1.0 (ref.)	3,918	4.7 (4.2, 5.1)	1.0 (ref.)
Sexual abuse	391	9.1 (7, 11.2)	1.3 (1.0, 1.8)	895	6.8 (5.1, 8.4)	<b>2.0 (1.5, 2.6)</b>
Total	5,392	7.8 (7.2, 8.4)		4,813	5.0 (4.5, 5.4)	
<b>Arthritis</b>						
No sexual abuse	18,873	29.1 (28.0, 30.1)	1.0 (ref.)	31,351	37.1 (36.1, 38.1)	1.0 (ref.)
Sexual abuse	1,537	38.2 (33.5, 42.8)	<b>1.6 (1.4, 2)</b>	7,021	45.3 (43.3, 47.4)	<b>1.9 (1.7, 2.1)</b>
Total	20,410	29.6 (28.6, 30.5)		38,372	38.3 (37.4, 39.2)	
<b>Diabetes</b>						
No sexual abuse	8,525	12.6 (11.9, 13.3)	1.0 (ref.)	9,660	12.5 (11.7, 13.3)	1.0 (ref.)
Sexual abuse	630	15.3 (12.8, 17.9)	1.3 (1.0, 1.6)	2,032	14.6 (12.8, 16.4)	<b>1.4 (1.2, 1.6)</b>
Total	9,155	12.8 (12.1, 13.5)		11,692	12.8 (12.1, 13.5)	

<sup>a</sup> Percentages weighted to reflect the population of the 20 states included in the sample. <sup>b</sup> Odds ratios adjusted for age, education, and race/ethnicity. Data Source: 2011-2014 Behavioral Risk Factor Surveillance System. Significant effects are bolded – all outcomes are significantly associated with CSA for women and most are associated with CSA for men.

#### Appendix 4. Research Projects Currently Supported by CDC

Funding Year	Project Title, Investigator, & Institution	Project Abstract
2011	<p><b>Project Title:</b> Dating Matters</p> <p><b>Investigator &amp; Institution:</b> CDC-led project</p>	<p>Dating Matters is a comprehensive teen dating violence prevention initiative based on the current evidence about what works in prevention. The initiative focuses on 11- to 14-year-olds in high-risk, urban communities. It includes preventive strategies for individuals, peers, families, schools, and neighborhoods.</p>
2014	<p><b>Project Title:</b> Engendering Healthy Masculinities to Prevent Sexual Violence</p> <p><b>Investigator:</b> Dr. Elizabeth Miller</p> <p><b>Institution:</b> University of Pittsburgh</p>	<p>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).</p>
	<p><b>Project Title:</b> Preventing Sexual Aggression among High School Boys</p> <p><b>Investigator:</b> Dr. Lindsay Orchowski</p> <p><b>Institution:</b> Rhode Island Hospital</p>	<p>Rhode Island Hospital partnered with Day One of Rhode Island to conduct a randomized controlled trial evaluating the effectiveness of <i>Your Voice Your View</i>, 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: <i>Your Voice Your View</i> or wait-list control.</p>
	<p><b>Project Title:</b> Evaluating a Dating and Sexual Violence Bystander Prevention Program with High School Youth: A Cluster Randomized Control Trial</p> <p><b>Investigator:</b> Dr. Katie Edwards</p> <p><b>Institution:</b> University of New Hampshire</p>	<p>This research uses a cluster randomized controlled trial to evaluate the <i>Bringing in the Bystander-High School Curriculum</i>. 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.</p>
	<p><b>Project Title:</b> A Cluster-Randomized Trial of a Middle School Gender Violence Prevention Program</p> <p><b>Investigator:</b> Dr. Elizabeth Miller</p> <p><b>Institution:</b> University of Pittsburgh</p>	<p>This research is a cluster randomized control trial among middle school boys of <i>Coaching Boys into Men</i>, 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</p>

		male athletes in 26 middle schools before the program is implemented, at the end of the sport season, and again one year later.
	<p><b>Project Title:</b> Community Level Primary Prevention of Dating and Sexual Violence in Middle Schools</p> <p><b>Investigator:</b> Dr. Lindsay Orchowski</p> <p><b>Institution:</b> Rhode Island Hospital</p>	This study is 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 communication/consent, support for victims, and bystander intervention. Reductions in rates of dating and sexual violence and promoting change in community norms are being examined.
2016	<p><b>Project Title:</b> Testing the Efficacy of a Strengths-Based Curriculum to Reduce Risk for Future Sexual Violence Perpetration among Middle School Boys</p> <p><b>Investigator:</b> Ms. Sharisse Carter</p> <p><b>Institution:</b> Health Research, Inc./New York State Department of Health</p>	The New York State Department of Health is collaborating with Cornell University to evaluate the efficacy of a strengths-based curriculum called <i>Brothers as Allies</i> . 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 program activities.
	<p><b>Project Title:</b> Preventing Sexual Violence Through a Comprehensive, Peer-Led Initiative: A Process and Outcome Evaluation</p> <p><b>Investigator:</b> Dr. Katie Edwards</p> <p><b>Institution:</b> University of New Hampshire</p>	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, <i>Youth Voices in Prevention</i> , 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.
	<p><b>Project Title:</b> The Impact of Sources of Strength, a Primary Prevention Youth Suicide Program, on Sexual Violence Perpetration among Colorado High School Students</p> <p><b>Investigator:</b> Dr. Dorothy Espelage</p>	The University of Florida, the University of Rochester, Texas Tech University, and the Colorado Department of Public Health & Environment are collaborating on a randomized controlled trial of <i>Sources of Strength (SoS)</i> . <i>SoS</i> 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

	<b>Institution:</b> University of Florida	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 9 <sup>th</sup> -11 <sup>th</sup> grade students is being examined in 20 high schools.
	<b>Project Title:</b> A Randomized Trial of Wise Guys: The Next Level  <b>Investigator:</b> Dr. Kathryn Beth Moracco  <b>Institution:</b> University of North Carolina-Chapel Hill	This research is being conducted through a collaboration between the University of North 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 program, <i>Wise Guys: The Next Level</i> . 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.
	<b>Project Title:</b> Youth Empowerment Solutions for Healthy Relationships: Engaging Youth to Prevent Sexual Violence  <b>Investigator:</b> Dr. Poco Kernsmith  <b>Institution:</b> Wayne State University	Wayne State University, the University of Michigan, and the Michigan Rape Prevention and Education program are collaborating to adapt, implement and evaluate <i>Youth Empowerment Solutions: Healthy Relationships</i> , 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.
2017	<b>Project Title:</b> Evaluating the Prevention Effects of Men of Strength (MOST) Clubs on Sexual Violence and Teen Dating Violence Perpetration  <b>Investigator:</b> Dr. Marni Kan  <b>Institution:</b> Research Triangle Institute	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 <i>MOST Club</i> 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.
2018	<b>Project Title:</b> Expect Respect Middle School: Preventing Serious	<i>Expect Respect</i> is a gender-specific support group for middle school students with a history of exposure to violence. This program modifies beliefs



	<p>and Lethal Violence Among Youth with Prior Violence Exposure</p> <p><b>Investigator:</b> Dr. Elizabeth Miller</p> <p><b>Institution:</b> University of Pittsburgh</p>	<p>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 <i>Expect Respect</i> on dating violence, sexual violence, weapon carrying, physical fighting, sexual harassment, bystander behaviors, and suicidal behaviors relative to usual services.</p>
	<p><b>Project Title:</b> Adapting and Testing the myPlan App to Prevent Dating Violence with Adolescents</p> <p><b>Investigator:</b> Dr. Nancy Glass</p> <p><b>Institution:</b> Johns Hopkins University</p>	<p>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.</p>

**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 adult-perpetrated CSA prevention. These activities are outlined in the table below.

Recipient	Prevention Strategy	Prevention Strategy Description
1. District of Columbia	Speak Up Be Safe	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.
2. Iowa	Nurturing Healthy Sexual Development/Care for Kids	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>
3. Maine	Child Sexual Abuse Prevention Education and Awareness for Adults	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.
4. Massachusetts	Enough Abuse/Enough Abuse adaptation	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 & 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.
5. New Hampshire	NH Child Sexual Abuse and Youth Sexual Violence Prevention Project	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

Recipient	Prevention Strategy	Prevention Strategy Description
		<p>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 sexual violence programs, integrating effective sexual violence 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 sexual violence, including the STOP toolkit. The project is accomplished through the Injury Prevention Program (IPP) and coordinated by NHCADSV 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.</p>
6. Ohio	Stewards of Children - Engaging Adults Who Work With Youth	<p>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 on an active role in working with the youth to prevent sexual violence and promote healthy relationships.</p>
7. Oregon	Policy Education	<p>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, <i>Recommendations for Preventing Sexual Violence in Oregon</i>.</p>
8. South Carolina	Care for Kids Program	<p><a href="https://www.stsm.org/get-training/education-programs-youth">https://www.stsm.org/get-training/education-programs-youth</a>  Excerpted:  <b>“Our Approach:</b> 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</p>

Recipient	Prevention Strategy	Prevention Strategy Description
		<p>possible. The curriculum meets National Health and Safety Education Standards, and all education materials are in accordance with the South Carolina Department of Education as an awareness and prevention service provider.</p> <p>Prior to implementing the curriculum, a parent/caregiver workshop is conducted to provide parents with practical skills in educating their children about sexuality. In addition, a faculty and staff training is provided so they are able to provide consistent prevention messages to students in the school or organization.</p> <p><b>Lessons:</b> Care for Kids© lessons are age-appropriate and are tailored to meet the developmental needs of children. Through circle time, story time and an art project, children improve communication skills with adults and nurture social, emotional and physical development. •Asking for help •Feelings •Bodies •Babies •Asking for permission”</p>
9. South Dakota	Jolene's Law Task Force	<p>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.</p> <p>The RPE program will be partnering with Enough Abuse beginning in 2019.</p>
10. Vermont	Care for Kids We Care Elementary	<p>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.</p>
11. Virginia	Care for Kids	<p>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.</p>
	Nurturing Parents	<p>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.</p>
	Safe Church	<p>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</p>

Recipient	Prevention Strategy	Prevention Strategy Description
		of new comprehensive policies and practices to guard against child sexual abuse. 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.
	Stewards of Children	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. 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.
	Stewards of Children Train the Trainer curriculum	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 organization 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.
12. Washington	The Partnership 4 Safety	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.
13. West Virginia	Community Change - Coalition Building	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.
	Educational Seminars - Child Protection Unit	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

Recipient	Prevention Strategy	Prevention Strategy Description
		immediately report these situations to adults and how to assertively refuse 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 adult-perpetrated CSA prevention, although minimal.

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