SEXUAL VIOLENCE PREVENTION RESEARCH PRIORITIES

Problem Description

Sexual violence (SV) is a serious public health problem affecting millions of people each year. SV involves a range of acts, including attempted or completed forced or alcohol- or drug-facilitated sexual penetration (i.e., rape), being made to penetrate someone else, nonphysical pressure that results in penetration (i.e., sexual coercion), unwanted sexual contact, and unwanted noncontact sexual experiences (e.g., technology-facilitated SV, verbal sexual harassment). SV victimization can occur at any age, in person or online, and includes experiences of child sexual abuse (CSA) in which a child (< 18 years old) is involved in sexual activity that they do not fully comprehend or for which they are unable or do not give informed consent.[1] SV can be perpetrated by peers and acquaintances, dating or intimate partners, parents or caregivers, other trusted adults, or strangers, although it most often involves someone the victim knows.

SV victimization is associated with adverse health consequences and risk for other forms of violence exposure, and the burden of SV victimization disproportionately impacts some groups. Women and girls, people from some racial/ethnic groups (e.g., American Indian/Alaska Native women, Black women and girls, multiracial women and men), sexual and gender minority individuals (e.g., bisexual women, transgender people), people with disabilities, adolescents, and young adults (18-24 years old) continue to experience higher rates of SV than other groups.

CDC's research will continue to expand what is known about risk and protective factors for SV and rigorously evaluate strategies to address them. To maximize the impact on the broader population and address the inequitable burden of SV on some groups, a focus of CDC's research will be on identifying and addressing factors at the community- and societal-levels of the **social-ecological model** that contribute to SV perpetration and disparities in risk for SV victimization. Of particular interest are social and structural factors, such as sexism, racism, heterosexism, economic and physical conditions in communities, social policies and systems, and social norms that increase the risk for perpetration or vulnerability to victimization. Research will also focus on informing and evaluating approaches to increase the quality, reach, and effectiveness of implementation for evidence-based approaches, especially in geographic, demographic, or sociocultural communities most at risk.

[1]Consistent with the CDC definition of SV, CSA is included as a subtype of SV. However, CSA has often been examined independently from other forms of SV (e.g., rape by an acquaintance or partner) in the research literature and, as such, there are differences in the nature and extent of evidence on the etiology and prevention of CSA compared to other forms of SV. In some cases, priority gaps specific to CSA prevention are noted in the text and example research questions. In all other cases, priorities addressing SV broadly are intended to be inclusive of CSA.

Research Gaps and Priorities

Identify and increase understanding of **modifiable risk and protective factors** for SV perpetration, emphasizing community and societal factors.

Continued research is needed to identify modifiable risk and protective factors across the social ecology to inform the development of prevention strategies with potential for population-level impact. Examination of factors at the community- and societal-levels, including social and structural determinants of health, is limited. Research on protective factors is needed at all levels but, in particular, at the community- and societal-levels to inform prevention approaches that create social and physical conditions that protect against SV. Research on individual- and relationship-level factors remains important for some forms of SV, such as CSA perpetration where the evidence is more limited. Measurement of risk and protective factors should also consider the unique characteristics of people who experience a high risk of SV or subtypes of SV (e.g., culturally specific risk or protective factors, factors specific to adult-perpetrated CSA). Additionally, improved understanding of shared and unique risk and protective factors across types of sexual and other violence (e.g., technology-facilitated SV, CSA, community violence) and other areas of public health (e.g., mental and sexual health) would inform the development of prevention approaches that address multiple related outcomes.

Another research gap needing prioritization is the examination of the temporal (i.e., whether the factor preceded the violence) and causal (i.e., whether the association is causal rather than correlational) relationship between risk and protective factors and SV outcomes. When possible, research utilizing innovative designs to examine causal mechanisms and how factors interact across SV type, social-ecological level, and time will be prioritized to advance actionable knowledge on the etiology of SV perpetration. Such research may also help identify empirically supported SV indicator measures to serve as proxy outcomes in evaluations of community- and societal-level approaches when local, state, or national data on SV are unavailable.

Examples of research questions include:

- Which modifiable physical, social, or economic characteristics of communities (e.g., physical and online environments, policies and norms that support gender equality, alcohol policies, social norms related to SV perpetration, economic supports, and collective efficacy) serve to increase or decrease the risk for SV perpetration at the community-level?
- What factors protect against SV perpetration (e.g., school or community connectedness, healthy sexuality, gender relationship norms, employment, or economic stability) among individuals exposed to known risk factors for violence?
- To what extent do different forms of SV perpetration share modifiable risk and protective factors with each other and with other types of violence and other public health issues (e.g., sexual health)?
- What mechanisms and processes influence how social and structural determinants of health (e.g., economic and physical conditions, social policies, systems, social norms, racism, sexism, heterosexism) operate to impact the risk for SV perpetration and contribute to disparities in SV victimization?
- How do risk and protective factors interact, over time and across levels of the social ecology, to increase or buffer against risk for SV perpetration and victimization?

This research will advance the etiological evidence base to inform the development of cross-cutting, multi-level prevention strategies with the potential for population-level impact.

Evaluate the **effectiveness of innovative approaches** to prevent SV perpetration, prioritizing approaches that reduce or protect against risk at the community- and societal-levels.

Evidence of effective prevention approaches for SV perpetration has increased significantly in the last decade. However, many of these approaches focus on characteristics of individuals and their relationships. More research is needed to develop or identify effective approaches that address community and societal factors, supporting the implementation of multi-level interventions. Such research may include rigorous evaluations of research- or practice-based programs, policies, or practices that focus on or include components addressing community or societal factors. To ensure that the approaches will be relevant to community needs, research that develops or identifies approaches with community input, evaluates promising approaches being implemented in communities, and engages community-based prevention organizations as research partners is a priority. In addition, there is a continued need for rigorous evaluation research of innovative approaches—at all levels of the social ecology—that go beyond existing models for SV perpetration prevention (e.g., beyond school-based programs, social norms change, skills training) and expand the range of evidence-based strategies available to communities. This includes cross-cutting approaches that address shared risk and protective factors for multiple violence or public health outcomes. Finally, evaluation of the cost-effectiveness of prevention approaches is needed to inform prevention investments at the national, state, and local levels.

Examples of research questions include:

- To what extent are technology-based approaches (e.g., social media policies, SV prevention-related apps or games, web-based resources for those concerned about their or others' sexual thoughts or behavior toward children) effective at reducing risk for SV perpetration both in person and online?
- How do organizational or public policies (e.g., school safety policies, workplace policies, social welfare policies, policies that promote gender or health equity) that address characteristics of the social, physical, or structural environment impact rates of SV at the population level?
- To what extent do approaches focused on reducing risk and building resilience in families prevent CSA victimization, SV perpetration, and perpetration of other problematic and/or harmful sexual behaviors by youth? Examples of such approaches include building safe, stable and nurturing parent/caregiver-child relationships and providing economic and structural support for women and families.
- How effective are approaches that create protective community environments by addressing the physical environment, economic or social incentives (or consequences) for behavior, or other characteristics of the community (e.g., alcohol outlet density, creation and enforcement of laws or policies that reinforce norms against SV perpetration, "greening" initiatives, approaches to improve community connectedness and collective efficacy) in reducing SV perpetration?
- To what extent do community-level or multi-level approaches that promote sexual health (e.g., policies that require comprehensive sexual education parent/caregiver training on sexual health communication combined with school-based sexual health programs) prevent SV and related public health outcomes by addressing shared risk and protective factors?

Addressing these critical gaps in knowledge will provide communities with a broader set of effective approaches that can be integrated into multi-level strategies to prevent SV perpetration, maximizing the potential for population-level reductions in SV.

Identify factors and approaches that influence **implementation quality, reach, and effectiveness** for existing evidence-based SV prevention approaches.

As knowledge of SV prevention expands, additional focus is needed on ensuring the widespread adoption of effective programs, policies, and practices in communities. More research is needed to understand the conditions and practices that increase use and facilitate quality implementation of evidence-based approaches. For example, aspects of implementation such as dose, pedagogical approach, facilitator type, implementation context and fidelity, facilitator training, and community leadership buy-in can impact the effectiveness of an intervention. In addition, more work is needed to understand the potential benefits of combining evidence-based prevention approaches at different levels to increase their effectiveness (e.g., individual- and community-level approaches) and to identify essential elements of effective interventions to inform adaptation efforts as evidence-based approaches are implemented in new communities. Although this implementation research will prioritize approaches with existing high-quality evidence of effectiveness for preventing SV, measuring implementation factors in evaluations of emerging approaches can also accelerate progress in this area. Implementation research that examines approaches operating at the community- and societal-levels will be prioritized when possible.

Examples of research questions include:

- To what extent are evidence-based SV prevention approaches focused on the individual- and relationship-levels (e.g., healthy relationships programs, bystander training, approaches engaging men and boys) more effective when combined with community-level approaches (e.g., policy, built environment approaches, social norms change)?
- Which elements of evidence-based SV prevention approaches must be retained to prevent SV as modifications to the approach (e.g., linguistic or cultural factors, accessibility) are made to increase uptake and cultural relevance for different communities?
- Which implementation supports (e.g., technical assistance, implementation or adaptation guidance, practitioner and community partner networks) are effective for improving SV prevention approach quality, reach, and outcomes and achieving buy-in from communities?
- How do adaptations to the modality of delivery (e.g., online vs. in-person), implementer type, or setting impact the effectiveness of evidence-based SV prevention approaches?
- What are significant barriers to implementing and scaling up SV prevention approaches, and how can these barriers be mitigated?

Implementation research on evidence-based SV prevention approaches will facilitate the development of best practices for dissemination and implementation that address the unique needs of different communities while reducing rates of SV.

Advance etiologic, evaluation, and implementation research on the **social and structural determinants of health** that contribute to inequities in risk for SV victimization and perpetration.

Women and girls, multiracial, American Indian/Alaska Native, Black persons, sexual and gender minority persons, and people with disabilities are disproportionately impacted by SV victimization. In addition, there is evidence that social, economic,

and structural inequities like bias, economic inequality, and access to housing and healthcare can influence risk for violence victimization and may also impact risk for SV perpetration within or against these populations. At the same time, some social and structural determinants of health, such as economic stability or education, may serve as effective buffers against these inequities, protecting individuals and communities from risk for SV victimization and perpetration. More inclusive research is needed to understand the experiences of populations most impacted, how social and structural determinants of health affect patterns and risk for SV victimization and perpetration, and what works to address those factors and prevent SV across diverse communities. Prioritizing research that addresses inequities through social and structural determinants of health and incorporates the perspectives of those with lived experience has the potential to advance progress on reducing rates of SV victimization and perpetration in communities that experience disproportionate burdens to enhance health equity. Understanding inequities in risk for SV victimization can inform the development of approaches focused on preventing SV perpetration against vulnerable or marginalized populations.

Example research questions include:

- What aspects of social and structural determinants of health (e.g., access to healthcare, built environment, economic stability, supportive social context, education) protect against risk for SV victimization and perpetration in communities experiencing inequitable risk for SV (e.g., marginalized racial/ethnic groups, sexual and gender minority individuals, or individuals with disabilities)?
- How do social, economic, and political structures impact risk for SV victimization or perpetration?
- To what extent do policies or programs that address economic inequality (e.g., housing access, income supports, wage equity policies) reduce inequities in risk for SV victimization or perpetration?
- To what degree do prevention approaches that address historical, collective community, or intergenerational forms of trauma (e.g., adverse childhood experiences, community violence, structural racism, patriarchal social structures) reduce SV victimization or perpetration outcomes within marginalized communities?
- How do implementation characteristics (e.g., modality, facilitator type, setting) affect outcomes for evidence-based SV prevention approaches implemented in communities experiencing inequitable risk for SV (e.g., marginalized racial and ethnic minority persons, sexual and gender minority persons, or persons with disabilities)?

Intentionally advancing research, evaluation, and implementation science to better address the social and structural inequities contributing to disparities in risk for SV will grow the SV prevention evidence base and ultimately inform the implementation of effective multi-level SV prevention efforts in all communities.

CDC's National Center for Injury Prevention and Control (the Injury Center) advances research to prevent injuries and violence and reduce their consequences. Research includes identification of factors that increase or decrease risk and rigorous evaluation of innovative prevention strategies. The Injury Center translates science into effective policies and programs and guides how to adapt evidence-based strategies to community needs to increase widespread use. The research priorities strategically focus on research gaps that the Injury Center can address to strengthen public health action and impact. The Injury Center research priorities are updated as research and public heath needs evolve.

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