Memorandum of Understanding
Between the Ohio Department of Health and the Ohio Domestic Violence Network

This Memorandum of Understanding (MOU) details an agreement between the Ohio Department of Health (**ODH**), a state agency whose address is 246 North High Street, Columbus, Ohio 43215, and the Ohio Domestic Violence Network (**ODVN**), a non-profit
Corporation whose address is 4807 Evanswood Drive, Suite 201, Columbus, Ohio 43229. This MOU pertains to macro management issues with regard to programs funded by two separate sources by the Centers for Disease Control and Injury Prevention, National Injury Prevention Center for Ohio: the Violence Against Women Act/Rape Prevention Education (RPE) Program, as handled by **ODH,** and the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Program, as handled by **ODVN.**

Specifically, this MOU documents the manner in which **ODH** and **ODVN** will share in creating and sustaining a collaborative process that includes reorganizing the Ohio Intimate Partner Violence Prevention Consortium (Consortium) and in authoring "The Ohio Intimate Partner and Sexual Violence Prevention Plan" or two separate documents pertaining to the respective programs.

For the purposes of this MOU, the term "party" means **ODH** and **ODVN** respectively and "parties" means **ODH** and **ODVN** collectively.

ODH and **ODVN**, in consideration of the mutual promises expressed below, agree to the following provisions.

I. **ODVN** will ensure that the Consortium, a group of persons working together under the aegis and control of the **ODVN** DELTA Program, will expand its membership to include representatives of the Sexual Violence Prevention movement, a group of persons working under the aegis of the **ODH** RPE Program.

II. **ODH** will ensure that representatives of the Sexual Violence Prevention, a group of persons working under the aegis of the **ODH** RPE Program, seek membership in the Consortium.

III. The Consortium will be co-chaired by a representative of the **ODH** RPE Program recommended by **ODH** and a representative of the **ODVN** DELTA Program recommended by **ODVN**.

IV. Representatives of **ODH** and **ODVN** will work with the co-chairs of the Consortium on the structure of the Consortium including:

A. Reviewing and revising the name of the Consortium as appropriate;

B. Setting meeting dates and agendas, including committee tasks;

C. Providing leadership for the Consortium and its committees;

D. Other logistical responsibilities such as finding meeting locations, reproducing documents, and ongoing contact with members.

V. Staff members of **ODH** and **ODVN** will provide support and administrative assistance to the Consortium.

VI. **ODH** and **ODVN** will freely share data compiled for the Needs and Resources
Assessment between themselves and with the Consortium members.

VII. **ODH** and **ODVN** will guide the Consortium through a reporting and planning
process that will be continuously negotiated between the two parties and Consortium
members.

VIII. **ODH** and **ODVN** will collaborate on authoring "The Ohio Intimate Partner and
Sexual Violence Prevention Plan" or two separate documents pertaining to the
respective programs of the parties, as agreed upon between the parties

IX. **ODH** and **ODVN** will each have final authority over the sections of the final plan
or plans relevant to their respective projects.

The signatures below indicate the commitment of the Ohio Department of Health (**ODH**) and the Ohio Domestic Violence Network (**ODVN**) to fulfill these agreements to the best of their abilities:

____

____

Alvin D. Jackson, M.D., Director	Nancy Neylon, Director
The Ohio Department of Health	The Ohio Domestic Violence Network

________________________ ______________________

Date	Date

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Pathways in Prevention: A Roadmap for Change

Ohio's Plan for

Sexual and Intimate Partner Violence Prevention

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 Acknowledgements

The authors would like to thank past and current members of the Ohio Sexual and Intimate Partner Violence Prevention Consortium (the Consortium) for their faith in, support for, and encouragement that a state level strategic plan would result from their collaboration with the Ohio Department of Health (ODH) and the Ohio Domestic Violence Network (ODVN). In September 2005 when the ODVN began this endeavor with the Ohio Intimate Partner Violence Prevention Consortium, it looked like an impossible undertaking. It has been through your thoughtful feedback, input, and contributions that this prevention plan was created.

In particular, we offer our thanks and gratitude to former and current Chairs of the DELTA Advisory Committee and/or Co-chairs of the Consortium. Former Chairs include: Sarah Corpening, J.D., C.E.O., Family and Child Abuse Prevention Center, Jane Hoyt-Oliver, M.S.S.A., L.I.S.W., Ph.D., who was at that time the Chair of the Social Work Department at Malone College, and Debra Seltzer, M.P.A. of the Ohio Department of Health. Current Chairs are: Connie Allgire, Ohio Business and Professional Women, formerly of Women & Family Services in Defiance, Ohio and Julianna Nemeth, Prevention Director of the Helpline of Delaware and Morrow Counties. Your partnership, guidance and attention to process helped guide us through many packed agendas.

While membership has been and continues to be fluid due to changes of state leadership and turnover/attrition of agency leadership, ODVN and ODH have worked together to create a Consortium that operates by consensus and represents a variety of state level agencies, state professional associations, educational institutions, foundations, local programs, and other key stakeholders.

Ohio Sexual and Intimate Partner Violence Prevention Consortium Current Membership:

- Chrystal Alexander, Office of Criminal Justice Service, Columbus, Ohio
- Connie Allgire, Ohio Business and Professional Women, Defiance, Ohio
- Andrea Barker, Ohio Resource Network, Cincinnati, Ohio
- Jennifer Batton, Global Issues Resource Center, Cuyahoga Community College, Highland Hills, Ohio
- David Berenson, Sex Offender Services, Ohio Department of Rehabilitation and Correction, Columbus, Ohio
- Tim Boehnlien, Domestic Violence Center, Cleveland, Ohio
- Lisa Bottoms, Cleveland Foundation, Cleveland, Ohio
- Max Bucey, Public Children's Services Association of Ohio, Columbus, Ohio
- Nita Carter, Independent Consultant, Columbus, Ohio
- Rebecca Cline, Ohio Domestic Violence Network, Columbus, Ohio

- Sheryl E. Clinger, Columbus Coalition Against Family Violence, Columbus, Ohio
- Rosemary Creedon, Children Who Witness Violence Program, Cleveland, Ohio
- Donna Dickman, Partnership for Violence Free Families, Lima, Ohio
- Zita Duffy, Children's Hospital Behavioral Health, Columbus, Ohio
- Jasmine Finnie, Ohio Domestic Violence Network , Columbus, Ohio
- Sally Fitch, Institute for Human Services, Columbus, Ohio
- Mary Jane Frank, Ohio Department of Mental Health, Columbus, Ohio
- Monica Frechette, Attorney at Law, Logan, Ohio
- Gary M. Heath, Buckeye Region Anti-Violence Organization, Columbus, Ohio
- Mary Hendrickson, New Directions, Mt. Vernon, Ohio
- Janet Hoffman, Abuse and Rape Crisis Shelter of Warren County, Lebanon, Ohio
- Jane Hoyt-Oliver, Malone University, Canton, Ohio
- Sandy Huntzinger, Ohio Attorney General's SAFE Program, Columbus, Ohio
- Linda Johanek, Domestic Violence Center, Cleveland, Ohio
- Chris Kane, Ohio Department of Education, Supportive Learning Environments, Columbus, Ohio
- Dorothy Kane, Tri-County Prevention of Family Violence Coalition, Youngstown, Ohio
- Steve Killpack, Community Endeavors Foundation, Cleveland, Ohio
- Alexander Leslie, Cleveland Rape Crisis Center, Cleveland, Ohio
- Sharon Marcum, Ohio Department of Health, Columbus, Ohio
- Sondra Miller, Cleveland Rape Crisis Center, Cleveland, Ohio
- Julianna Nemeth, Helpline of Delaware and Morrow Counties, Delaware, Ohio
- Nancy Neylon, Ohio Domestic Violence Network, Columbus, Ohio
- Barbara Oehlberg, Child Trauma and Educational Consultant, Solon, Ohio
- Linda Ondre, Brown County Family and Children First Council, Mt. Orab, Ohio
- Sandra Ortega, Empowerment Evaluation Consultant, Westerville, Ohio
- Cindy Pisano, Family and Child Abuse Prevention Center, Toledo, Ohio
- Diana Ramos-Reardon, Supreme Court of Ohio, Columbus, Ohio
- Sharon Richardson, Violence Free Coalition, Warren County, Ohio, Lebanon, Ohio
- Mack Sanders II, Ohio Department of Alcohol and Drug Addiction Services, Columbus, Ohio
- Debra Seltzer, Sexual Assault and Domestic Violence Program, Ohio Department of Health, Columbus, Ohio
- Kristin Shrimplin, Hamilton County Family Violence Prevention Project, Cincinnati, Ohio
- Jo Ellen Simonsen, Ohio Domestic Violence Network, Columbus, Ohio
- Jamie Smith, Knox County DELTA Project, Mt. Vernon, Ohio
- Kenneth Steinman, The Ohio State University, Columbus, Ohio
- Amanda Suttle, Sexual Assault and Domestic Violence Program, Ohio Department of Health, Columbus, Ohio
- Bill Teideman, Ohio Department of Health, Columbus, Ohio
- Candace Valach, Ohio Children's Trust Fund, Columbus, Ohio
- Sarah Wallis, Ohio Commission on Dispute Resolution and Conflict Management, Columbus, Ohio

- Cindy Webb, National Association of Social Workers, Ohio Chapter, Columbus, Ohio
- Kalitha Williams, Ohio Domestic Violence Network , Columbus, Ohio
- Torrianna Williams, Lucas County DELTA Project, Toledo, Ohio
- Theresa Wukusick, Anthem Foundation of Ohio , Cincinnati, Ohio

Allies and Alternates:

- Lennise Baptiste, Bureau of Research and Evaluation, Kent State University, Kent, Ohio
- Robert Canning, The Ohio Resource Network, Cincinnati, Ohio
- Sarah Corpening, Family and Child Abuse Prevention Center, Toledo, Ohio
- Cliff Davis, Consultant, Mt. Vernon, Ohio
- Jill Jackson, Ohio Department of Education, Supportive Learning Environments, Columbus, Ohio
- Cheryl Kish, Ohio Department of Education, Supportive Learning Environments, Columbus, Ohio
- Melissa Knopp, Specialized Dockets Section, Supreme Court of Ohio, Columbus, Ohio
- Linda Kurella, Knox County DELTA Project, Mt Vernon, Ohio
- Wendy Perkins, Warren County, Ohio, Lebanon, Ohio
- Ivan Rosa, Casa Alma/Casa Maria, Cleveland, Ohio,
- Rev. Christine Schutz, Trinity Episcopal Church, Findlay, Ohio
- Deborah J. Stokes, Retired, Columbus, Ohio

We would like to thank and acknowledge current and former Consortium members who gave their time generously to our planning process by reviewing documents, providing input and feedback, and keeping true to the Consortium's mission and vision.

In addition, thanks go to staff members of the Ohio Department of Health and the Ohio Domestic Violence Network who agreed to facilitate, lead, and guide Consortium Work Groups through countless meetings, iterations of goals and outcome statements, and through a final product. We can not thank you enough for your contributions that went above and beyond your job descriptions and agency responsibilities. Many thanks go to:

Rebecca Cline, Prevention Programs Director, ODVN
Jill Endres, former Sexual Violence Prevention Technical Assistant / Trainer, ODVN
Jasmine Finnie, current Sexual Violence Prevention Technical Assistant / Trainer, ODVN
Debra Seltzer, Program Administrator, ODH
Jo Simonsen, Prevention Trainer and Technical Assistant, ODVN, and,
Amanda Suttle, Prevention Coordinator, ODH

And, many thanks to the Prevention Programs Assistants, Jasmine Finnie and Kalitha Williams. In January, 2009 Kalitha replaced Jasmine Finnie who was promoted to Sexual Violence Technical Assistant/Trainer. Both Jasmine and Kalitha helped prepare for Consortium meetings, took copious meeting notes and distributed them back to members. Thank you, also to Becky Mason for her keen proof reading of our final draft.

We would like to thank Ohio's sexual violence prevention projects, Ohio's local DELTA Projects, and Anthem Foundation of Ohio's Family Violence Prevention Coalitions for their time and talents in helping us bring forward the best possible prevention plan.

We would also like to thank the Centers for Disease Control, specifically Margaret Brome, Kaili McCray, and Jocelyn Wheaton, for their support and timely responses to our questions as we sought their technical assistance. We so appreciated having them present for the July 17, 2008 Consortium meeting. Thank you for recognizing the "high level of collaboration" that the ODH and ODVN engage in along with Consortium members.

Thank you to Kent State University's Bureau of Research and Evaluation for their assistance with data analysis at both the state and local level and to Mary I. Stoudenmire, B.A.S.W., Malone University who, at the very last minute, went back through our statistics and updated them with current and more relevant information.

Finally, we offer a thank you in advance and an invitation to participate for all of those who will contribute both at the local and state level to the ongoing implementation of this plan. Without your assistance this prevention plan would be pointless.

Thank you all so very much!

Debra Seltzer, Rebecca Cline, and Sandra Ortega

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Introduction

Work to end sexual and intimate partner violence in Ohio is progressing. Rape crisis centers and domestic violence shelters started by reaching out, one survivor at a time, to people in crisis. These efforts can best be represented as the work of a lifeguard standing on the shore of a river, struggling to rescue people as they pass by, swept along in turbulent waters. Our current challenge is to seek out the source of the problem, to find the point in the broken bridge from which people are entering the dangerous waters and prevent the problems that create the danger. How will our world be different when that bridge is fixed? What will it look like when our work to prevent sexual and intimate partner violence from happening in the first place is successful? It will change the words we use to communicate with one another, what we see around us, and our relationships with one another.

Some visions for that future (or at least steps along the way):

An editor who works for a large advertising agency in Ohio prepares copy for their next big project. Since the agency has become a "Partner in Violence Prevention" she is keenly aware of the sometimes subtle and too often glaring messages that advertising sends young girls and boys about femininity and masculinity. She has begun to hold back copy that she thinks sends an inappropriate message. When colleagues challenge her, she provides them with information about sexual and intimate partner violence, teen dating violence and sexual harassment and asks them to attend the next company Violence Prevention Task Force meeting.

A magazine editor working for the same company goes for her annual mammogram and when the technician asks about the bruises on her upper arms, she smiles and explains about her fiancé's large and unruly dog. The technician shares a similar dog story, and quietly checks to be sure that the "healthy relationship" materials are where they are supposed to be in the discharge packet, knowing that universal approaches that include every patient like this have been shown to be effective.

When the editor gets back to work, she reviews an ad that has a picture of a woman in very revealing clothing. She writes on the copy "Let's not use that picture. It seems inappropriate given all of the efforts we've made as a workplace to send more positive messages."

The photographer goes back through his pictures and finds one he really liked but had been a bit shy to use; it shows two men enjoying a quiet moment together. He sends it through for approval.

Walking by the ad on a billboard weeks later, one boy says to another as he points to the ad "Hey look, that's so gay!" and his friends say "Hey man, what … you talkin' about! That's not cool! Knock it off!!"

The boys meet up with some girls at a local fast food eatery to enjoy some time together after school. One of the boys starts telling jokes he heard from the captain of the baseball team that disparage girls. Some of the kids, boys and girls, start laughing. One of them says, "Dude, watch it! That could be my sister you're talkin' about. Those jokes are so lame. Stop dissin' girls! How would you like it if I joked like that about your girl?! Another boy says, "Yeah, your mother would have a heart attack after she washed your mouth with soap if she heard you telling those kinds of jokes! That's really not cool."

In the restrooms of this eatery and most other places young people gather in this community, posters that support healthy relationships for teens and adults are prominently displayed. When young people get school physicals, healthcare providers routinely ask about their sexual activity and provide education about consensual sex. Healthy sexuality and healthy relationships literature is provided to all patients of all ages and abilities every time they come in for a doctor visit.

In this community, healthy relationships literature is provided at schools, places of worship, community recreation centers, movie theatres, restaurants, and everywhere people gather. Local news media have begun to focus attention on promoting healthy relationships as well as more accurately describing incidents of domestic violence and sexual assault. However, since the community has been working hard on promoting healthy relationships, there has been a remarkable downturn in crimes of this nature.

In Ohio, state systems now collect data on risk and protective factors, social norms, as well as the usual crime statistics in an effort to use scarce resources in a more thoughtful manner.

To make this come to pass in Ohio, we must begin thinking about changing our approach to ending sexual and intimate partner violence. The contents of this prevention plan lay the ground and framework for such an approach.

The Ohio Sexual and Intimate Partner Violence Prevention Consortium: Historical Context

Ohio Domestic Violence Network

In September 2002, the Ohio Domestic Violence Network (ODVN) was awarded one of nine cooperative agreements to work with the Centers for Disease Control and Prevention (CDC) on a primary prevention initiative called the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Program. CDC funded an additional five states in January of 2003, bringing the total number of DELTA states to fourteen. CDC funding allowed ODVN to act as an intermediary organization between the CDC and local programs, to provide prevention-focused training and technical assistance, and to provide funding to local communities. The first three years of funding were dedicated to adding a significant prevention focus to existing Coordinated Community Response (CCR) teams.

In March 2003, ODVN convened a DELTA Advisory Committee to assist with guiding the DELTA Program as well as with awarding funding to local communities. In April, 2003 ODVN issued a request for awards aimed at assessing local domestic violence programs' capacity to engage in community collaboration as well as primary prevention. After local DELTA awards were made, the DELTA Advisory Committee continued to meet quarterly to discuss the challenges of moving local communities toward primary prevention and to provide insight to ODVN's DELTA Coordinator about monitoring local community's progress.

The original DELTA Advisory Committee members were:

- Nita Carter, Independent Consultant, Columbus, Ohio
- Rebecca Cline, Ohio Domestic Violence Network, Columbus, Ohio
- Sarah Corpening, Family and Child Abuse Prevention Center, Toledo, Ohio
- Jane Hoyt-Oliver, Malone University, Canton, Ohio
- Staci Kitchen, Ohio Coalition on Sexual Assault, Columbus, Ohio
- Sharon Marcum, Ohio Department of Health, Columbus, Ohio
- Nancy Neylon, Ohio Domestic Violence Network, Columbus, Ohio
- Ruben Nieto, Ohio State University Extension Services, Columbus, Ohio
- Barbara Oehlberg, Child Trauma and Education Consultant, Solon, Ohio
- Linda Ondre, Brown County Family and Children First Council, Mt. Orab, Ohio
- Deborah Stokes, Ohio Department of Health, Columbus, Ohio
- Michael Stringer, Ohio Department of Alcohol and Drug Addiction Services, Columbus, Ohio
- Sue Williams, Office for Children & Families, Ohio Department of Job and Family Services, Columbus, Ohio
- Theresa Zink, University of Cincinnati, College of Medicine, Cincinnati, Ohio

With the assistance of the DELTA Advisory Committee, ODVN provided funding to the following local fiscal agencies and communities in August of 2003:

- Tri County Help Center – Belmont, Harrison, and Monroe Counties
- New Directions – Knox County
- Family and Child Abuse Prevention Center – Lucas County
- Abuse and Rape Crisis Shelter of Warren County – Cities of Franklin and Carlisle.

ODVN, along with these local communities, worked on and continue to work on building individual and organizational capacity to engage in planning, implementation, and evaluation of intimate partner violence prevention strategies and activities. As a result of these efforts, the Anthem Foundation of Ohio invited ODVN in November 2003, to submit an application for funding to provide technical assistance to Ohio family violence prevention coalitions. In February 2004, ODVN hired staff to provide prevention focused training and technical assistance to four family violence prevention coalitions in Ohio and more broadly to Ohio communities. This funding was directed to build local community, statewide, and ODVN organizational capacity for family violence prevention.

Accomplishments during the first three years of DELTA funding include:

- Establishment of four local DELTA Projects that convened or reconvened a local coalition, including new members committed to implementing the DELTA Project. In addition, each local project wrote a vision and mission statement and a strategic plan that was implemented during the subsequent years.
- With the support from the Anthem Foundation of Ohio, ODVN established a Prevention Team consisting of an Executive Director, Prevention Programs Director, and a Prevention Trainer and Technical Assistant. Additionally, a Sexual Violence Prevention Technical Assistant / Trainer and the Prevention Programs Assistant were later added to the Team to provide a holistic approach to intimate partner violence prevention.
- Creation of a logic model that expresses the Prevention Program's short-, intermediate-, and long-term outcomes as well as vision and mission statements for said program.
- Development of two prevention focused workshops, *Peaceful Relationships for Teens* and *Communicating Social Change.*
- Two statewide conferences offered to prevention practitioners across the state in 2004 and 2005 with Donna Garske of Transforming Communities and Bob Goodman, Ph.D. respectively.

In February 2005, the CDC issued a second round of three-year funding for the DELTA Program, which included a requirement for grantees to convene a state level DELTA steering committee to engage in a state planning process. Each state was also required to use *"Getting to Outcomes"* (Chinman, et.al, 2004) as a model for formulating, implementing, and evaluating its planning process. Simultaneously, CDC has been engaged in adapting "Getting to Outcomes" from the field of substance abuse prevention to intimate partner violence and sexual violence prevention.

As ODVN began exploring how to best use its influence and resources to convene a DELTA state level steering committee, it decided to expand the original DELTA Advisory Committee to include other state agency representatives, local DELTA and Anthem Project Coordinators or Directors, and other key stakeholders. In September 2005, ODVN convened its first DELTA state steering committee meeting. Debra Seltzer, Administrator of the Sexual Assault and Domestic Violence Prevention Program at the Ohio Department of Health (ODH) agreed to serve as the steering committee's chair. A significant accomplishment of the initial meeting was the committee's adoption of its formal name, Ohio Intimate Partner Violence Prevention Consortium (OIPVPC).

Ohio Department of Health

The Sexual Assault and Domestic Violence Prevention Program (SADVPP) at ODH is Ohio's designated recipient of the CDC's Rape Prevention Education Funds (RPE). These funds are allocated as a part of the Violence Against Women Act funds. Although the initial purpose of the RPE funds allowed support of sexual violence intervention and prevention programs, the CDC announced in the spring of 2007 a significant shift in the purpose of the RPE funds. This required states to focus on primary prevention of sexual violence and develop a state sexual violence prevention plan. This latter charge resembled closely the one given to the states participating in the DELTA Program. Realizing how closely the work and responsibilities of the two federally funded programs aligned, ODVN and ODH began discussions about the possibility of combining resources and efforts to create an all inclusive state plan.

A critical concern of ODVN and ODH during the initial discussion to merge efforts was to ensure that domestic violence issues did not overshadow or minimize the importance of sexual violence. To address this concern, ODH convened a meeting of sexual violence program stakeholders to discuss the idea of merging efforts with the domestic violence community to create a holistic prevention plan for Ohio. The group identified important issues regarding domestic and sexual violence communities working together to create a strategic plan for primary prevention in Ohio. They asked Consortium members to keep these issues in mind as they moved forward with the development of the plan. The sexual violence program stakeholders reached consensus that the benefits of collaborating with the domestic violence community outweighed the possible risks. See Appendix E for the full description of the sexual violence community's discussion.

The question of developing one holistic sexual and intimate partner violence prevention plan was presented to the original members of the OIPVP Consortium, who agreed to expand the focus of the plan. A Memorandum of Understanding (See Appendix H) was executed and set forth the business relationship between ODH and ODVN for the purpose of developing a unified sexual and intimate partner violence prevention plan. Membership to the OIPV Consortium was expanded to include key stakeholders from Ohio's sexual violence prevention community. As an integral part of maintaining authenticity to the expanded focus of the Consortium, a vision and mission statement was adopted to integrate sexual violence and intimate partner violence prevention (See Shared Prevention Values). The expanded group is known as the Ohio Sexual and Intimate Partner Violence Prevention Consortium, hereinafter referred to as the Consortium.

During 2006, ODVN's sister coalition, the Ohio Coalition on Sexual Assault (OCOSA) closed its doors. With OCOSA's closing, there was a need for a statewide base from which to provide a broad range of prevention technical assistance services to ODH's local funded RPE programs. In November 2006, ODH awarded funding to ODVN to provide this technical assistance to its sexual violence prevention programs located across Ohio. As a result of this funding, in January 2007, ODVN hired two additional staff members: a Prevention Programs Assistant and a Sexual Violence Prevention Technical Assistant/Trainer.

Thus, ODH and ODVN have come to collaborate on creating the state plan contained herein.

Shared Definition of Sexual Violence and Intimate Partner Violence

In April 2007, the Consortium agreed to adopt the CDC's definitions of both Sexual and Intimate Partner Violence. Note: These definitions are different from the legal Ohio definitions as found in the Ohio Revised Code and may also be different from those used in other data sources.

They are as follows:

Definition of Sexual Violence from the CDC

Sexual Violence — Overall Definition

Sexual Violence is nonconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse.

Sexual violence is divided into five categories:

- A completed sex act (as defined below) without the victim's consent, or involving a victim who is unable to consent or refuse (as defined below).
- An attempted (non-completed) sex act without the victim's consent, or involving a victim who is unable to consent or refuse (as defined below).
- Abusive sexual contact (as defined below).
- Non-contact sexual abuse (as defined below).

- Sexual violence, *type unspecified.* – That is, there exists inadequate information to categorize into one of the other 4 categories.

Other Relevant Definitions:

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

Inability to Consent
A freely given agreement to have sexual intercourse or sexual contact could not occur because of age, illness, disability, being asleep, or the influence of alcohol or other drugs.

Inability to Refuse
Disagreement to have sexual intercourse or sexual contact was precluded because of the use of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, real or perceived coercion, intimidation or pressure, or misuse of authority.

Sex Act (or Sexual Act)
Contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object.

Abusive Sexual Contact
Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse.

Non-Contact Sexual Abuse
Sexual abuse that does not include physical contact of a sexual nature between the perpetrator and the victim. It includes acts such as voyeurism; intentional exposure of an individual to exhibitionism; pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; using coercion or abuse of authority to engage or force a person into exhibitionism or pornography, or taking nude photographs of a sexual nature of another person without his or her consent or knowledge, or of a person who is unable to consent or refuse.

Incident
A single act or series of acts of sexual violence that are perceived to be connected to one another and that may persist over a period of minutes, hours, or days. One perpetrator or multiple perpetrators may commit an incident. Examples of an incident include a husband forcing his wife to have unwanted sexual acts but only one time, a stranger attacking and sexually assaulting a woman after breaking into her apartment, a man kidnapping a female acquaintance and repeatedly assaulting her over a weekend before she is freed, a college student forced to have sex by several men at a fraternity party, a man forcing his

boyfriend to have unwanted sex, or a family member touching the genitalia of a 6-year-old child.

Definitions of Parties Involved:

Victim
Person on whom the sexual violence is inflicted. *Survivor* is often used as a synonym for *victim.*

Perpetrator
Person who inflicts the sexual violence.

Intimate Partner (In the context of sexual violence)
Current legal spouses, current common-law spouses, current boyfriends/girlfriends (opposite or same sex), former legal spouses, former common-law spouses, separated spouses, or former boyfriends/girlfriends (opposite or same sex). Intimate partners may or may not be cohabiting. Intimate partners may or may not have an existing sexual relationship. If the victim and the perpetrator have a child in common but no current relationship, then by definition they fit into the category of former legal spouse, former common-law spouse, or former boyfriend/girlfriend. States differ as to what constitutes a common-law marriage. Users of the Recommended Data Elements will need to know what qualifies as a common-law marriage in their state.

Current or Former Legal Spouse
Someone to whom the victim is or was legally married, as well as a separated legal spouse.

Another Current or Former Intimate Partner
Someone, besides a legal current, former, or separated spouse, with whom the victim has or had an ongoing intimate relationship, such as a common-law spouse, former common-law spouse, separated common-law spouse, cohabiting intimate partner, former cohabiting intimate partner, boyfriend/girlfriend, former boyfriend/girlfriend (opposite or same sex).

Another Family Member
Someone sharing a relationship by blood or marriage, or other legal contract or arrangement (i.e., legal adoption, foster parenting). This includes current as well as former family relationships. Therefore, though not an exhaustive list, stepparents, parents, siblings, former in-laws, and adopted family members are included in this category. This category excludes intimate partners.

Person in Position of Power or Trust
Someone such as a teacher, nanny, caregiver, foster care worker, religious leader, coach, or employer (not an exhaustive list).

Friend/Acquaintance
Someone who is known to the victim but is not related to the victim by blood or marriage, and is not a current or former spouse, another current or former intimate partner, another family member, or a person in a position of power or trust. Examples are a co-worker, neighbor, date, former date, or roommate (not an exhaustive list).

Another Non-Stranger
Someone who is known by sight but is not a current or former spouse, another current or former intimate partner, another family member, a person in a position of power or trust, or a friend/acquaintance. Examples include guards, maintenance people, or clerks (not an exhaustive list).

Stranger
Someone unknown to the victim

Definition of Intimate Partner (Domestic) Violence:

For the purpose of this plan, the Consortium agreed in April 2007 to adopt a combined definition of intimate partner violence rather than the ODVN or CDC definition alone. This decision was based on a more comprehensive CDC definition that included perpetration of one time events. Members felt that adopting the CDC definition made a strong statement that the Consortium was interested in promoting healthy relationships among all types of relationships including first dates.

Intimate partner domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. Intimate partner domestic violence is not an isolated, individual event, but rather a pattern of multiple tactics and repeated events. Unlike stranger-to-stranger violence, in domestic violence the assaults are repeated against the same victim by the same perpetrator. These assaults occur in different forms: physical, sexual, and psychological. The pattern may also include economic control as well. While physical assault may occur infrequently, other parts of the pattern may occur daily. One battering episode builds on past episodes and sets the stage for future episodes. All tactics of the pattern interact with each other and have profound effects on the victims.

Intimate partner domestic violence includes a wide range of coercive behaviors with a wide range of consequences, some physically injurious and some not; however, all are psychologically damaging. Some parts of the pattern are clearly chargeable as crimes in most states (e.g., physical assault, sexual assault, menacing, arson, kidnapping, harassment), while other battering episodes are not illegal (e.g., name-calling, interrogating children, denying access to the family automobile, control of financial resources). While the intervening professional sometimes must attempt to make sense of one specific incident that resulted in an injury, the victim is dealing with that one episode in the context of a pattern of both obvious and subtle episodes of coercion.

For the purpose of the DELTA Project and the Consortium, the above definition is expanded to include acts of intimate partner domestic violence that may represent first time perpetration and/or victimization. That is, an act of violence for which the full context of "a pattern of assaultive and coercive behaviors" has not yet been established is considered intimate partner violence. This may include physical, sexual, and/or psychological violence that occurs on a first date but does not occur again because a second date does not occur. In this context, a pattern of abusive behaviors cannot be established: however, an act of intimate partner domestic violence has occurred.

It is the goal of the Consortium to prevent all forms of sexual and intimate partner domestic violence, whether forms are perpetrated as a pattern of abuse and violence or whether the assault is perpetrated on a first date.

The purpose of the strategic primary prevention plan is to:

- Institutionalize sexual and intimate partner violence prevention within and throughout Ohio's local communities as well as state governmental agencies, statewide professional associations, and other state level organizations;
- Continue to build Ohio's individual, organizational, community, and institutional capacity for primary prevention through implementation and evaluation of this strategic plan; and,
- Ultimately, to impact the incidence and prevalence of sexual and intimate partner violence in Ohio.

Shared Prevention Values

The Consortium by consensus agreed to adopt vision and mission statements that reflect a holistic approach to the prevention of sexual violence and intimate partner violence.

In addition to a shared vision and mission statements, a primary commitment of Consortium members is to articulate assurance that primary prevention in Ohio is inclusive, transparent, and represents Ohio's rich diversity. As a result of a facilitated discussion in July of 2008, the Consortium members began to explore issues of cultural competence and the intersections of oppression and sexual and intimate partner violence prevention. This discussion led to the formation of a work group who conceptualized mechanisms for the expression of the Consortium's commitment in this regard. The mechanisms include a statement of philosophy and accompanying definitions. Wanting to ensure that our shared philosophy of inclusivity and cultural competence permeates Ohio's prevention plan, the Consortium's content workgroups reviewed and revised their goals and outcome statements to ensure these were informed and molded by the Consortium's shared values of inclusivity and cultural competence.

Vision

The vision of the Ohio Sexual and Intimate Partner Violence Prevention Consortium is that sexual and intimate partner violence is universally recognized and rejected. Freedom from such violence is a fundamental human right. We seek to create communities where:

- Intimate Partner and Sexual Violence is recognized as a preventable public health issue;
- Women and men work together to promote healthy and safe attitudes and beliefs about sexuality and intimate relationships;
- Social norms and cultural systems, both formal and informal, that tolerate violence will be challenged;
- Those who witness violence are empowered to speak out;
- The root causes of violence in our society are addressed;
- The importance of raising the status of women and girls is acknowledged while simultaneously addressing the roots of male violence; and,
- Emerging social norms and cultural systems reflect a commitment to healthy relationships.

Mission

The mission of the Ohio Sexual and Intimate Partner Violence Prevention Consortium is to promote the prevention of sexual and intimate partner violence by creating an infrastructure that connects state agencies and local communities in working together toward the elimination of gender inequality and other systemic oppression.

Statement of Philosophy for Inclusivity and Attention to Diverse Communities as we Promote the Prevention of Sexual and Intimate Partner Violence in Ohio

The elimination of gender inequality and other systemic oppression are an integral part of sexual and intimate partner violence prevention work. Our ultimate goal is to achieve human rights and social justice for all Ohioans. Our intention is to develop a plan that is both inclusive and attentive to diverse communities in Ohio. The Consortium's plan aspires to encompass the universal population of the state, while consciously taking into account the varied range of experiences which affect each individual's ability to create the vision we seek to achieve.

We recognize the need to expand organizational capacity to incorporate cultural competence, inclusiveness and appropriateness, and to encourage ourselves, our colleagues and allied partners in anti-oppression work to increase organizational as well as individual capacity. Within the scope of cultural competence, inclusiveness, and appropriateness are included but not limited to the following: culture, ethnicity, race, religion, age, socio-economic status, ability, sexual orientation, gender and gender identity.

Our task requires that the plan challenges and raises consciousness of flawed social norms to achieve our vision of social justice and human rights. We recognize that

achieving cultural competence, inclusiveness and appropriateness requires our collective desire and effort to be open, accepting and respectful of Ohio's diversity and mindful of its constant evolving nature.

Consortium Planning Process

From the Consortium's evolution from an Advisory Committee in 2005, members agreed to adopt the principles of empowerment evaluation as guideposts for work conducted during full Consortium meetings and in between meetings by work groups convened on behalf of the Consortium. Empowerment evaluation as a concept integrates empowerment of individuals and organizations with program, process, and outcome evaluation practices. A core component of empowerment evaluation is building the capacity of organizations such that they become better able to conduct elements of evaluation independent of an outside expert. As a practice, empowerment evaluation includes conducting business by keeping at the forefront principles of inclusion community knowledge, and social justice. (See Appendix F for Empowerment Evaluation Principles.)

At the beginning of each full Consortium meeting, Co-Chairs remind members that empowerment evaluation principles are guiding principles. Principles are displayed on an enlarged poster and available at meetings for member's review in document form. As business moves along, whenever relevant, references to specific principles are made to keep empowerment evaluation principles front and center of Consortium business. In addition to these mechanisms, use of Group Facilitation Methods brought forth the principles of democratic participation, community ownership and knowledge, inclusion and encouraged members to engage in the process along the way.

"You created an inclusive process, where all opinions were recognized and you made the effort to include all related stakeholders in the process. In addition, the process itself was well facilitated, fun, engaging and effective. Also, the processes you used made a very large picture manageable so while it can't help but be overwhelming at times, we were able to move forward. "

Sarah Wallis, Director of Education Programs

Ohio Commission on Dispute Resolution and Conflict Management

In addition to empowerment evaluation principles and in collaboration with the CDC, Getting to Outcomes (GTO) Steps 1 - 6 for SV and IPV Prevention were used to provide the framework for the Consortium's planning processes. Using GTO posed numerous challenges as the Steps were in the process of being created by CDC while the Consortium was in the process of implementing them. It is hoped that our lessons learned will inform the broader field and become part of the evidence for state level coalition based planning for sexual and intimate partner violence prevention within a GTO framework while using Empowerment Evaluation principles and practices.

Members of the Consortium were asked to commit to work jointly toward the development of an Ohio Sexual and Intimate Partner Violence Prevention Plan, in support of the programmatic goals of the RPE Program of the ODH and the DELTA Program of the ODVN. As the Consortium continued to meet, it developed a culture of decision making by consensus with a vote taking place only after discussion and when decisions needed to be explicit to move processes forward. In addition, per the memorandum of understanding between ODH and ODVN, two co-chairs were appointed to represent the sexual violence and intimate partner violence communities. The Consortium Co-chairs along with ODH and ODVN staff liaisons to the Consortium became a leadership team that convened before each meeting to plan the content and processes for meeting agendas. As work groups of the Consortium were formed and convened in between full Consortium meetings, ODH and ODVN staff members committed to facilitating those meetings. From time to time, work group facilitators and the Leadership Team (Consortium co-chairs, ODH and ODVN staff liaisons) met to discuss Consortium business and guide its processes.

"This has been one of the most inclusive, collaborative processes I've ever been involved with – and we've produced a living, working plan for the prevention of sexual and intimate partner violence which has the support from local practitioners to state level governmental agencies. May this be the beginning of the evolution of peaceful relationships for all in the State of Ohio."

Julianna Nemeth, Co-Chair
OSIP-VP Consortium

When it became necessary to "codify" decision making processes as well as roles and responsibilities of Consortium members, participants were asked to **commit** to the following:

- Participation that is respectful and constructive and that honors all participants' diverse and equally important voice
- Integration of issues of diversity in all approaches and activities

- Participation in an innovative approach to strategic planning, community mobilization, and empowerment evaluation which incorporates the following guiding principles:
    a. Focus on primary prevention of sexual and intimate partner violence (i.e. *before* rather than *after* violence has occurred)
    b. Emphasis on the development of assets rather than a sole focus on problems and needs
    c. Use of a public health approach to prevent intimate partner and sexual violence (i.e. a community–oriented approach that takes the onus from victims and advocates and encourages the entire community to prevent sexual and intimate partner violence)
    d. Use of the ecological model (i.e. one that works to develop innovative and effective ways to prevent intimate and sexual violence that addresses individual, relationship, community, and societal influences)
    e. Use of an empowerment approach to assessment, planning, and evaluation (i.e. focusing on program improvement, ownership, and social justice).

- The Consortium will strive to engage in conversations for SV and IPV Prevention that honor similarities between the issues while at the same time are respectful and realistic about the differences.
- The Consortium will strive to provide equal agenda time to both SV and IPV issues.
- Committees created by the Consortium may be formed to address both SV and IPV issues jointly or separately as the Consortium deems appropriate.
- The Consortium will utilize the Ohio Sexual Assault Task Force (OSATF) report "A Call to Action: Ending Sexual Assault in Ohio" as a basis for the sexual assault needs assessment planning component.

Decision Making Processes

For decisions of the collaborative, the Consortium strives to take all members perspectives into account. We prefer to make decisions by consensus; where there is disagreement, we will ask those who would choose to vote "no" against a proposal to clarify their concerns and we will attempt to incorporate a response to their concerns into a final decision. Because we are under time constraints, and with the agreement of the group, we may at times default to a "majority rules" decision making process.

Full Consortium Meeting Decision Making Process

- At least two weeks before meetings, a specific agenda developed by the Leadership Team will be sent to all members. Each member will be asked if they are able to attend the meeting.

    - If a member is unable to attend, their input, comments, and/or concerns are encouraged to be delivered to ODH or ODVN staff liaisons prior to the meeting regarding the agenda and/or specific agenda items.
- Members that are present at the meetings will make decisions regarding agenda items with input from those not in attendance through concerns brought to the attention of ODH and ODVN staff liaisons prior to meetings.
    - Decisions will be distributed to each member within one month after the Consortium meets. Members not in attendance have the opportunity to comment on decisions via email or phone within one month of the meeting notes being distributed.
    - After all opinions have been given, and discussions have ended, the final decision will be made. Consideration will be given to the importance of the decision at hand and if there is a need for a follow-up meeting.
- ODH and ODVN staff liaisons in collaboration with the Leadership Team will be given the charge of making and communicating final decisions or bringing issues before the full Consortium for further discussion and decision.

Work Group Meeting Decision Making Process

1. Clarify proposed decision
2. Discussion
3. Check for consensus

In seeking consensus, ensure that there is time for all voices to be heard. Ask participants to actively respond to the call for consensus. An option for participants will be that they are not in full agreement with the decision but they will not block the decision.

If there is disagreement or uncertainty

First, clarify the issues then determine if more information and discussion is needed. Can a decision be delayed? If yes, refer to committee.

If a decision must be made and there is not consensus, seek agreement from the group to default to a majority vote decision making process. With this agreement, re-cap perspectives and call for a vote.

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Note: ODH and ODVN staff liaisons to the Consortium found these processes to work well, invited participation and ownership of the planning process.

In addition to these processes, during 2007 and 2008, ODVN staff received training from Institute for Cultural Affairs in the Technology of Participation: Group Facilitation Methods and Participatory Strategic Planning. These facilitative leadership processes based on identifying and building on group consensus were especially valuable to the Consortium's identification of strategic areas of accomplishment. Throughout the planning process, having the organizational capacity to bring forth the Consortium's consensus contributed to the creation of the plan set forth herein.
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Forward to the Plan

The Consortium recognizes the importance of endeavoring to move the conversation and commitment for reducing perpetration and victimization of sexual and intimate partner violence upstream. Recognizing that resources to continue working downstream have historically been inadequate and the need for infrastructure improvements in the realm of intervention remain, we acknowledge that the effort to begin moving toward an upstream approach should never be at the expense of services for those who survive or have been victimized by sexual and intimate partner violence. At the state and local levels, together we will strive to create a continuum of services that meet the needs of all Ohio residents. However, the plan set forth in this document addresses Ohio's first effort to create a statewide infrastructure for *primary prevention* of sexual and intimate partner violence.

Needs and Resources Assessment Process and Content

Process

During the April, 2006 meeting of the full Consortium, members were asked to sign up for two work groups. One work group was focused on developing vision and mission language and the other work group was charged with guiding the process of developing a needs and resources assessment for the State of Ohio. Original members of the Needs and Resources Assessment work group included:

- Andie Barker, Ohio Resource Network
- Rebecca Cline, Ohio Domestic Violence Network
- Kathy Gagin, DELTA Project Coordinator for Tri-County Help Center
- Mike Gregory, Commission on African American Males
- Melissa Knopp, Supreme Court of Ohio
- Mack Sanders, Ohio Department of Drug and Alcohol Addiction Services
- Debra Seltzer, Ohio Department of Health
- Jewel Woods, Empowerment Evaluation Consultant

The work group met face to face and via teleconference a number of times and by November 2007, a Community Profile including a description of conditions in Ohio and resources available for sexual and intimate partner violence prevention in the State of Ohio was adopted by the Consortium. Ohio's Community Profile provided the platform

for a consensus building process during which five areas of accomplishment were identified as the Consortium's planning priority foci.

Content

See Appendix D: Ohio's Community Profile for a complete description of Ohio's population. Please note, the Community Profile is just that, a description of Ohio's population. To find a description of Ohio's needs and resources related to sexual and intimate partner violence please see the "Conditions in Ohio," Chapter of this Plan.

Outstanding among data collected for the Community Profile and of particular interest to the Consortium are indicators of specific risk groups in Ohio. Among those indicators are Ohio's large (over 1/3 of its total) population of young people under 26 years of age. Statistics indicate that sexual and intimate partner violence are most prevalent among those ages 14 - 21. In addition, disparities in educational attainment and income are of great concern. Risk factors at the relationship and community level are associated with low educational attainment as well as low income and high poverty rates. Please see the Chapter on "Risk and Protective Factors" for more information.

Magnitude of Sexual and Intimate Partner Violence in Ohio

Reliable data with regards to sexual and intimate partner violence is problematic for a number of reasons. The most available source for data is incidents reported to law enforcement by medical personnel. Sexual and intimate partner violence is highly stigmatized, and survivors often prefer not to tell anyone that this has happened to them. Perpetrators seek out victims who are vulnerable, and that vulnerability may include a disinclination to seek help from professionals for a variety of reasons. Some specific populations are not comfortable talking to police for historical reasons related to their cultural or economic background, or there may have been complicating factors making the victim both vulnerable and uncomfortable with law enforcement such as if drugs or alcohol were involved, the victims is a minor who was not following previously set rules, or the victim may have a personal history of negative experiences with law enforcement or medical personnel. So reports to these sources are more likely to include only cases where due to the circumstances or their injuries the victim can not avoid official intervention to their situation, or if their background and the circumstances of the violence fit societal expectations they may be more likely to report.

In the absence of rape crisis centers or domestic violence services, survivors are much less likely to seek out professional assistance. They also may not identify what happened to them as a crime and worthy of support services. They also may know of others who had similar experiences followed by insensitivity and lack of support when they attempted to report their experience.

In some ways a more reliable source of data are phone surveys that allow for a random sampling of the population who are able to respond to sensitive questions in privacy and anonymity. There are concerns with this method also. Although relatively private, respondents may be reluctant to discuss these difficult issue even over the phone, both because they may just have a hard time talking about it at all and they may feel emotionally unready to discuss their experience. They also may not have confidence in the anonymity of the responses and may not be in a safe place to talk about these issues. Furthermore, as discussed above perpetrators seek out victims who are vulnerable and that vulnerability may include lack of access to a phone for a variety of reasons – not able to afford a phone, working multiple jobs and not available to answer the phone, no access to phones due to being in an institutional setting of some sort (nursing home, group home, prison or halfway house) limited English or language skills, etc. Younger people and people who are low income are more and more likely to use cell phones rather than landlines, and most phone surveys still rely on landlines for contact numbers though they are beginning to explore ways to reach people who only use cell phones.

Because the data is unreliable, changes in data are really difficult to interpret. If reports to police go up dramatically, is that because there really is an increase in events, because there is someone providing rape crisis services in the community which really support those who were previously unwilling to report to do so, or because of something on TV or in the news that encourages community members to identify what has happened to them as a crime and have some hope that seeking services will be a benefit to them. If reports to police decrease, is that a true decrease, or was there a recent event that made survivors doubt the likelihood of a positive outcome if they report.

Ohio ranks 16th nationally in prevalence of forcible rape of adult women. Based on FBI statistics for Ohio as in the "Sourcebook on Criminal Justice Statistics", 4,548 rapes were reported to law enforcement in Ohio in 2006. This is a rate of 39.6 forcible rapes per 100,000 Ohioans. The rate for the United States nationwide for 2006 was 30.9 forcible rapes per 100,000 inhabitants. This rate has remained relatively steady in both the U.S. and in Ohio, although Ohio's rate of forcible rape has consistently been higher than the national average. A report released in 2003 by the CDC National Violence Against Women Research Center entitled "Rape in Ohio: A Report to the State," revealed that 14.3 percent of adult women in Ohio have been victims of one or more completed forcible rapes during their lifetime. This is higher than the national average of 13.4 percent. The report estimates that about one in seven adult women in Ohio, nearly 635,000 has been a victim of forcible rape sometime in their lifetime.

Specific data for the State of Ohio that describes the magnitude of IPV does not exist. However, in 2006, the Health Policy Institute of Ohio located at The Ohio State University was commissioned by the Anthem Foundation of Ohio to author a White Paper on Improving Family Violence Prevention in Ohio (Steinman, K. 2006). The paper reported that in 2006, an estimated 166,000 people were physically or sexually assaulted by an intimate partner in Ohio. Furthermore, the White Paper reports that 64,000 children under the age of 18 were abused or neglected and 29,000 elders were abused or neglected. The authors of the report surmise that each year, family violence directly costs Ohio more than 1.1 billion in health care and social services (2008, Health Policy

Institute of Ohio.)" The costs and impacts of intimate partner violence on workplaces and on individuals in terms of adverse health outcomes are not included in these costs or the amount would no doubt be much higher.

The National Violence Against Women Survey (NVAWS) of 8,000 women and 8,000 men conducted by the National Institute of Justice (NIJ) and CDC in 1995/96 found one in six women and one in thirty-three men in the U.S. experienced a completed or attempted rape as a child and/or as an adult. This translates into 18% of the surveyed women and 3% of surveyed men. In addition, the NIJ/CDC study found that only 31% (less than one in every three) of rapes and sexual assaults were reported to law enforcement. One can use the national statistics reported in the NVAWS on rapes and sexual assaults to project the statistics for Ohio. However, due to fact that many rapes go unreported to the police, the actual number of rapes in Ohio is most certainly much higher than that reflected by the above FBI statistics. For instance, one indicator of the continued increase is that in spite of the drop in the number of rapes reported to law enforcement from 1999 through 2001, rape crisis programs reported no decline in the number of hotline calls or individuals served

According to the 1999 National Crime Victimization Survey (NCVS) 89% of rape victims are female and 11% are male. This survey also found that young people continue to be at greater risk of rape and sexual assault than any other age group. For example, the victimization rate for teens 16-19 was 6.9 per 1,000 while the rate for those aged 35 and older was one per 1,000. The NIJ/CDC NVAW Survey reported similar findings in that 54% of the female rape victims and 71% of the male victims identified by the survey were 17 or younger when they experienced their first attempted or completed rape.

Rape is also disproportionately experienced by African American women and poor women. A Bureau of Justice Statistics, U.S. Department of Justice study in 1994 found that 81% of rape victims are white; 18% are African American (while only 12.3% of the population is African American) and 1% is of other races. A study by the same department in 1996 found that those with a household income under $7,500 were twice as likely as the general population to be victims of sexual assault.

Beyond numbers, the toll of rape and other forms of sexual assault is extensive having profound and long lasting effects on the physical and mental health of victims. An article in *Obstetrics & Gynecology* 2000; 96:473-480 found that “the negative health consequences of rape and physical assault are severe and chronic.” The study focused on women specifically and found that women who were raped were more likely to report chronic health problems and use prescription drugs for emotional problems. They also “reported severely decreased health-related quality of life, with limitations of physical and emotional health, educational and financial attainment, and severe, recurrent problems with work and social activities”. This finding was echoed by a study completed by Bonomi and associates in 2006. Their research determined that compared to women with no IPV in their adult lifetime, more pronounced adverse health effects were observed for women with recent IPV. Moreover, longer duration of IPV was associated with incrementally worse health outcomes (Bonomi, Thomson, Anderson, Reid, Carrell,

Dimer and Rivara, 2006).

A study completed in 2007 compared healthcare utilization and medical care costs of women with a history of intimate partner violence compared to women without a history of IPV (Rivara, Anderson, Fishman, Bonomi, Reid, Carrell & Thompson, 2007). The researchers determined that women with a history of IPV had significantly higher healthcare utilization and costs continuing long after IPV ended. They concluded that based on prevalence for IPV of 44%, the excess costs due to IPV are approximately $19.3 million per year for every 100.000 women age 18-64. A current project of the Sexual Assault and Domestic Violence Prevention Program (SADVPP program) is the implementation of core competencies for mental health professionals to increase the mental health response to both sexual and domestic violence.

Several gaps are identified in Ohio's communities' ability to track the magnitude of IPV and/or SV. As has been reported by other sources, reporting accurate data on the magnitude of SV/IPV is difficult for the reasons previously described. One resource for information on rape in Ohio is from a report to the State by Drs. Kenneth Ruggerio and Dean Kirpatrick in 2003. They report that at the state and local level, most of the information about rape comes either from police reports or from agencies such as rape crisis centers that provide services to sexual assault victims. By their very nature, police reports only include information about recent cases of sexual assault that have been reported to law enforcement. Yet, research suggests that only 1 in 6 rapes are reported to law enforcement (Kilpatrick, Edmonds & Seymour, 1992). Likewise, a significant percentage of sexual assault victims do not seek services from rape crisis or other sexual violence services agencies. Therefore, data from police reports or sexual violence services agencies clearly can not provide a comprehensive picture of the new cases of sexual assault that occur each year within a state. In addition, the effects of rape upon its victims are often profound and persistent. These effects of rape on women's physical and mental health can last for years, for decades, or even for a lifetime. Thus, any attempt to measure the magnitude of a state's rape problem should not be limited to an estimate of how many recent rape cases have occurred or how many women have been recently raped. Instead, it is important to determine the number of women within a state that have ever been raped because many of these women may still be having problems associated with the assault that require services.

At the national level, there are two U.S. Department of Justice-sponsored sources of information about rape that provide data on recent rape cases that occur each year. The FBI Uniform Crime Reports includes information about a subset of new rapes that occur each year that are reported to police. The National Crime Victimization Survey also provides information about new cases of rape that occur each year and includes unreported as well as reported cases. However, both the FBI Uniform Crime Reports and the National Crime Victimization Survey have methodological problems that result in substantial underestimates of the number of new rape cases each year. Unfortunately, neither of these two sources is designed to measure whether a woman has ever been a victim of rape. For these reasons, the FBI Uniform Crime Reports and

the National Crime Victimization Survey data are not particularly useful for determining the magnitude of the rape problem within a specific state.

Most experts agree that the best way to obtain estimates of rape prevalence (i.e., the percentage of women in the population who have ever been raped) is to conduct a well-designed victimization survey. Briefly described, such surveys involve obtaining a representative sample of the groups of people you wish to study and asking them a series of questions that inquire about rape experiences that they may have had within specific time frames. Research indicates that rape is more difficult to measure than many other types of crime in victimization surveys because women are more reluctant to disclose rapes than other crimes. For this reason, there are a number of technical challenges to measuring rape properly in a victimization survey. Among the many challenges victimization surveys must address are obtaining a representative sample of women to survey, using proper screening questions that measure the types of rape experiences you wish to detect, and establishing a private and confidential environment for the interview that encourages women to disclose their rape experiences to the interviewer.

However, at the national level, there have been two major victimization surveys that are widely viewed as being the best studies yet conducted with respect to providing information about rape prevalence among adult women. The first study is the National Women's Study (NWS). The NWS generated the information that was used in the *Rape in America* report (Kilpatrick, et al., 1992), and has resulted in numerous scientific and professional publications (see following website for a list of NWS publications: http://www.musc.edu/cvc/NIDApubs.htm). The NWS was a peer reviewed research project that was funded by the National Institute of Drug Abuse. The second study on rape prevalence is the National Violence Against Women Survey (NVAWS, Tjaden & Thoennes, 2000), another peer reviewed research project funded by the National Institute of Justice and Centers for Disease Control and Prevention. Both of these studies used large, nationally representative samples of adult women. Both studies used well-designed, virtually identical screening questions that measured forcible rapes women had experienced throughout their lives. Both studies used only female interviewers and other procedures to insure that women could complete the interviews in private, confidential settings. Both studies have yielded numerous high quality publications to the scientific literature. In short, the NWS and NVAWS provide the best national information available about the prevalence of forcible rape among adult women in America.

These studies can be used to get a snapshot of the condition of intimate partner and sexual violence in Ohio. Incidents and prevalence of IPV and SV based on the National Violence Against Women Survey conducted in 2000 are presented in Table 1 as extrapolated through an analysis of the national data conducted by Kent State University Bureau of Research and Training Services.

Table 1. Intimate Partner Rape and or Physical Assault in Counties with IPV/SV Prevention & State of Ohio For Women and Men Over the Age of 18

	Survey Data %

COUNTIES WITH IPV PREVENTION	LIFETIME		IN LAST 12 MONTHS	
Type of Violence	Women	Men	Women	Men
Rape	7.7%	0.3%	0.2%	no estimate
Physical Assault	22.1%	7.4%	1.3%	0.9%
Rape and/or Assault	24.8%	7.6%	1.5%	0.9%
Stalk	4.8%	0.6%	0.5%	0.2%
STATE OF OHIO	**LIFETIME**		**IN LAST 12 MONTHS**	
Type of Violence	Women	Men	Women	Men
Rape	7.7%	0.3%	0.2%	no estimate
Physical Assault	22.1%	7.4%	1.3%	.9%
Rape and/or Assault	24.8%	7.6%	1.5%	.9%
Stalk	4.8%	0.6%	.5%	.2%
Total N 18+	**4,430,424**	**4,034,377**		

Note: % from NVAW Survey 2000, Ohio County demographics from US Census 2000

Source: Kent State University Bureau of Research and Evaluation, 2008.

The survey data results specific to the counties with IPV/SV prevention programs indicate that 7.7% of women and .3% of men have experienced a rape in their lifetime. Almost a quarter of the women reported being a victim of a physical assault (22.1%) and a rape and or physical assault (24.8%); this compares to about 8% of the men reporting being a victim of physical assault and a rape or assault. When these percentages are computed using the population of the state age 18 and over, the numbers are stark. As presented in Table 2 over a million Ohioans 18 years old or older have experienced rape and or assault at some point in their life. Moreover, in the last twelve months, over 100,000 of Ohio's adults have experienced rape or assault.

Table 2: Intimate Partner Rape and/or Physical Assault by Assault Type for Women and Men Over the Age of 18

	Survey Data %	
TYPE OF ASSAULT	**WOMEN**	**MEN**
Total % of Physical Assault by	22.1%	7.4%

Intimate Partner		
Threw something	8.1%	4.4%
Pushed, grabbed, shoved	18.1%	5.4%
Pulled hair	9.1%	2.3%
Slapped, hit	16.0%	5.5%
Kicked, bit	5.5%	2.6%
Choked, tried to drown	6.1%	0.5%
Hit with object	5.0%	3.2%
Beat up	8.5%	0.6%
Threatened with gun	3.5%	0.4%
Threatened with knife	2.8%	1.6%
Used gun	0.7%	0.1%
Used knife	0.9%	0.8%
STATE OF OHIO		
	WOMEN	**MEN**
Total Number of Physical Assaults by Intimate Partner	979,124	298,544
Threw something	358,864	177,513
Pushed, grabbed, shoved	801,906	217,856
Pulled hair	403,168	92,791
Slapped, hit	708,868	221,891
Kicked, bit	243,673	104,893
Choked, tried to drown	270,256	20,172
Hit with object	221,521	129,100
Beat up	376,586	24,206
Threatened with gun	155,065	16,138
Threatened with knife	124,051	64,550
Used gun	31,013	4,034
Used knife	39,874	32,275
Total N 18+	**4,430,424**	**4,034,377**

Source: Kent State University Bureau of Research and Evaluation, 2008.

Table 2 looks a bit more closely at the specifics of the IPV based on the National Violence Against Women Survey (2000). Twenty-two percent of women and 7.4% of men in the counties with IPV/SV prevention reported being a victim of some type of physical assault. Women reported most often being pushed, shoved or grabbed (18.1%) and slapped, hit (16.0%). Men reported most often being slapped, hit (5.5%) and pushed grabbed, shoved (5.4%). Again, these figures provide some insight into the magnitude of

the problem of intimate partner violence and sexual violence in Ohio but must be interpreted with caution since these data do not necessarily accurately represent the incidence and prevalence of SV and IPV in Ohio.

Other indicators of the magnitude of the problem are data collected by the State's Attorney General. According to the Ohio Attorney General's Office in 2007 law enforcement responded to 76, 760 domestic dispute calls and documented 60,733 victims of those dispute calls. The Ohio Incident-Based Reporting System (OIBRS) is Ohio's version of the FBI's National Incident Based Reporting System (NIBRS). OIBRS is a voluntary crime reporting program managed by Ohio Criminal Justice Services (OCJS) in which Ohio law enforcement agencies can submit crime statistics directly to the state and federal government in an automated format (http://www.oibrs.ohio.gov/, extracted April 20, 2009). This process has replaced the Uniform Crime Report/Summary reporting process in many areas of the state. Information volunteered about domestic violence and sexual assaults in Ohio for 51% of law enforcement agencies covering 67% of the population for 2007 indicate 37,455 domestic violence incidents and 8334 sexual assaults. Again, these data represent only those instances of intimate partner violence during which the police were called.

Some types of sexual violence are particularly difficult to track and have very unique circumstances; responses to all these forms of sexual violence are a necessary part of reaching the final goal of stopping the origins of these forms of violence. A longitudinal study of dating violence among adolescent and college-age women underscores the necessity for promoting a preventative approach to physical and sexual victimization. Smith and colleagues (2003) investigated the physical assault in dating relationships and its co-occurrence with sexual assault from high school through college. The findings suggest that women who were physically assaulted as adolescents were at grater risk for revictimization during their freshman year of college. Moreover, with each subsequent year, women who experienced violence remained at greater risk for revictimization than those who had not been assaulted. The researchers concluded that adolescent victimization was a better predictor of college victimization than was childhood victimization. They strongly recommended the need for dating violence prevention in high school and college (Smith, White, Holland, 2003).

Human trafficking is a form of modern-day slavery. Victims of human trafficking are young children, teenagers, men and women. Approximately 600,000 to 800,000 victims annually are trafficked across international borders worldwide. Victims of human trafficking are subjected to force, fraud, or coercion, for the purpose of sexual exploitation or forced labor (United States Department of Health and Human Services, Administration for Children and Families).

The FBI considers northwestern Ohio one of the "top recruiting locations" in the U.S. for underage prostitution. A recent series of FBI raids freed 45 people who had been trafficked; 18 were from Ohio (Columbus Dispatch, Wednesday March 25, 2009).

Sexual assault within the prison population has too often been the subject of jokes; people may think it is satisfying to think that someone convicted of crime might become a victim of sexual assault in jail or prison. In addition to the absolute injustice of allowing rape to

happen to anyone, no matter how much wrong they themselves have done, there is the fact that it is not those who have done the worst wrongs that are victimized, but, as with all sexual assault, it is those who are most vulnerable who are usually victims – those who are young, attractive, short, either slender or overweight, and/or a first time offender. Furthermore, both the victims and the perpetrators of sexual violence most likely will be released to live in our communities. Prevention and timely intervention within the prisons and adequate support for the victims of prison rape when they turn to our victim services for assistance and support are essential, and equally essential is the importance of sending a clear message to all inmates, including perpetrators but perhaps more importantly the many bystanders who see clearly the sexual violence that is occurring, that sexual violence is wrong and will not be tolerated in any way inside or outside of the prisons

According to the best available research, 20 percent of inmates in men's prisons are sexually abused at some point during their incarceration. The rate for women's facilities varies dramatically from one prison to another, with one in four inmates being victimized at the worst institutions (Just Detention International).

Finally, some other indicators of the scope and magnitude of sexual and intimate partner violence are related to Ohio's young population. According to the Ohio Youth Risk Behavior Survey (OYRBS), 2007:

- 9.7 % of Ohio high school students report dating violence.
- 10.2% of Ohio high school students reported having been "physically forced to have sexual intercourse."
- Latino students (18.6 percent) were significantly more likely than white students (9.1 percent) to have been forced to have sexual intercourse.

Conditions in Ohio that Highlight the Need for a State Plan that Addresses Sexual and Intimate Partner Violence Prevention

Ohio is a rust-belt state. During the Industrial Revolution and into the 1970's Ohio enjoyed a healthy, robust industrial economy coupled with a strong agricultural sector. Agriculture was and remains one of Ohio's largest revenue generators. However, during the 1980's, 90's and into the 2000's, Ohio has experienced a decline of its manufacturing based industry. In Appalachian Ohio, coal mining was a leading industry and now, because Ohio's coal is not as highly refined as other types of coal, a decline in that industry has significantly impacted the Appalachian population. American auto manufacturers are closing plants across the state, industry continues to relocate to other states or countries, and Ohio residents continue to live with an increased tax burden, a significant loss of employers and a depressed economy. According to the U.S. Census Bureau, Ohio lost 239,362 employees during the period between 2000 and 2005 and 459 employers (US Census, 2007). In an article published in the Cleveland Plain Dealer on June 2, 2007, these numbers indicate that "Ohio lagged far behind the nation in creating businesses during the first five years of the 21st century." In June, 2008, Ohio's

unemployment rate was 6.3 percent compared to 5.6 percent in the previous year. In May, 2008 the national unemployment rate was 5.5 percent and it is currently over 7 percent and rising. Economic conditions impacting the nation will very likely increase Ohio's unemployment rate.

The economic and other conditions that impact the lives of Ohioans and should be considered in the State IPV/SV plan include:

- Ohio is one of the nation's leaders in housing foreclosures and predatory lending. This is having a major impact on Ohio's urban core areas where housing markets have been taken over by sub prime lenders. As interest rates skyrocket when loans convert to flexible monthly rates, homeowners are caught between paying their mortgages and buying groceries. It is also a known fact that victims of intimate partner violence and sexual violence are often trapped by economic considerations. Too often, they are unable to leave violent situations due to lack of resources, housing, and access to transportation.

- Ohio's school funding has been declared unconstitutional by the United States Supreme Court and Ohio's General Assembly has yet to legislate an alternative school funding method. Currently, Ohio schools are funded through property taxes and limited state funding. The burden for school funding is on each municipal school district and therefore creates an inequitable educational system, i.e., school systems in wealthy areas can afford higher property taxes and therefore fund schools at higher levels. Schools in impoverished areas, whether they are rural, urban, or Appalachian, do not have the property tax base that supports a high level of per pupil spending. The discrepancy between the highest per pupil spending and lowest is in thousands of dollars. On the individual level, a risk factor for intimate partner violence is low academic achievement which may be supported by the school funding climate in Ohio.

- Ohio is a conceal carry state. This alone may have an impact on incidents of SV and IPV as carrying weapons becomes a social norm.

- College is becoming increasingly unaffordable for Ohio residents as well as for those who might come to Ohio to attend college. Tuition rates have continued to increase over the past 10 years as funding for state institutions is cut from the biannual State budget. Again, on the individual level, low academic achievement places Ohioans at risk for perpetration or victimization of intimate partner violence. On the relationship level and community level an uneducated population increases the likelihood of economic stress due to low educational attainment and thus lower paid jobs.

- In 2004, the total population of Ohio adults in the corrections system was 301,400, 27% higher than the national average. Ohio ranks fifth in the nation in adult prison population. In 2005 Ohio's incarceration rate was 400/100,000 adults, the same as the national average and 2,746/100,000 adults were under the supervision of probation which was 44% higher than the national average (2007, National Institute of Corrections website: http://www.nicic.org/Features/StateStats/State=OH). Statistics about prison rape in Ohio indicate that it is a problem in Ohio. When prisoners are

released to the community resources dedicated to assisting with their adjustment and healing are scarce.

- The Ohio Coalition on Sexual Assault closed its operation in July 2006. This created a chasm for the sexual violence community in Ohio, i.e., to operate without a federally recognized coalition of organizations and members committed to ending sexual violence. Currently there is a grassroots effort underway to re-establish such a statewide sexual violence coalition.

The Condition of Children and Families in Ohio points to some critical risks for Ohio's children in that:

- 24% of Ohio's population is under the age of 18
- 32% of all households are two parent families
- 86,009 grandparents are raising their grandchildren in Ohio
- New unduplicated reports of child abuse totaled 93,251 for 2005
- 56,469 children ages birth-3 years received Help Me Grow services
- An estimated 60,000 children ages birth through five do not have health insurance.
- Statewide, poverty increased to 16.9% in 2004 compared with 10.6 in 2000.
- Child poverty rates indicate that over 1 in 5 Ohio children are living in poverty
- In 2003, Ohio's teen birth rate was 53.4 per one thousand teens compared to 41.6 on the national level
- 29,595 Ohio children were living in custody of child protective services during 2005
- 16% of Ohio's estimated 2005 population of those 5 years of age or older are living with one or more disabilities.

Source: 2007-2008 Public Children's Services Association of Ohio Factbook, 8th edition

Base on what little is currently known about risk factors for sexual and intimate partner violence, these data indicate that Ohio's youth are at vulnerable for multiple adverse outcomes.

Other important statistics based on the 2005 Ohio Behavior Risk Factor Surveillance System (BRFSS), a random sample telephone survey of those 18 and older found that:

- 10.8 % of males surveyed reported an intimate partner had hit, slapped, punched, kicked or physically hurt them EVER
- 17% of females surveyed reported an intimate partner had hit, slapped, punched, kicked or physically hurt them EVER
- 5.4% of males 18 years old or older have EVER had someone attempt to rape them
- 1.4% of males have been raped by a current or former intimate partner
- 15% of females 18 years old or older have EVER had someone attempt to rape the
- 11.3% of females had EVER been raped by a current or former intimate partner

- Latino students (18.6 percent) were significantly more likely than white students (9.1 percent) to have been forced to have sexual intercourse.

Until recently, little was known about the prevalence of behaviors practiced by young people that put their health at risk. The Youth Risk Behavior Survey (YRBS), developed by the Centers for Disease Control and Prevention (CDC), now provides such information. The YRBS provides information on risk behaviors among young people grades 9 through 12 to more effectively target and improve health programs.

The YRBS is conducted every two years and Ohio has participated in the YRBS since 1993. The Ohio Department of Health, Ohio Department of Alcohol and Drug Addiction Services, and the Ohio Department of Mental Health jointly sponsor the Ohio YRBS. Most recently it was found that:

- 28% of Ohio teens report being harassed or bullied by other students in the past 12 months
- 9% of Ohio teens report attempting suicide (a recent study found a high association between dating violence and suicide attempts for teens)
- Nationally, 9% of students report being victims of dating violence

In acknowledging Ohio's weaknesses we must also acknowledge the State's strengths and resources. Ohio has several strong resources available to assist with ameliorating the problem of SV and IPV. The following resources are available to assist with prevention of sexual and intimate partner violence:

Sources of Prevention Funding:

1. As a Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Program state, Ohio's domestic violence coalition, the Ohio Domestic Violence Network, receives funding from the Centers of Disease Control and Prevention (CDC). A significant portion of annual funding has been pass-through funding for local communities. Specifically, this funding is for implementation of innovative intimate partner violence prevention strategies and activities. Four local communities received DELTA funding originally and the current three DELTA communities are:
    - Knox County through New Directions
    - Lucas County through Family and Child Abuse Prevention Center; and
    - Warren County through Abuse and Rape Crisis Shelter of Warren County.

2. The Anthem Foundation of Ohio provides funding for four local community coalitions and the Ohio Domestic Violence Network to implement creative strategies and activities focused on family violence prevention. The four coalitions involved with this initiative are:
    - Hamilton County Family Violence Prevention Project
    - Lima/Allen Partnership for Violence Free Families
    - Tri-County Prevention of Family Violence Coalition (Columbiana, Mahoning, and Trumbull Counties)

- Warren County United Against Family Violence

3. The Ohio Department of Health (ODH) receives funding from the Centers for Disease Control and Prevention for Rape Prevention through the Violence Against Women Act. Twenty-three Rape Prevention programs are funded across Ohio along with ODVN. The primary focus of these programs is sexual violence prevention programming, with a limited amount of funds allowable for use to fund operation of the local rape crisis hotline. Projects use these funds to support provision of programming in schools, colleges, communities, public awareness campaigns using social marketing strategies, and community planning and training to increase the community sexual violence capacity. Funded projects are:
    - Lima/Allen Council on Community Affairs, (Allen County)
    - Appleseed Community Mental Health Center, (Ashland County)
    - Tri-County Mental Health and Counseling (Athens County)
    - First Step Family Violence Intervention Services,(Coshocton County)
    - Cleveland Rape Crisis Center (Cuyahoga County)
    - Women and Family Services, Inc. (Defiance County)
    - Helpline of Delaware and Morrow Counties
    - Impact Safety Program (Franklin County)
    - Buckeye Region Anti-Violence Organization (Franklin County)
    - OhioHealth Corporation's Sexual Assault Response Network of Central Ohio (Franklin County)
    - Planned Parenthood of Southwest Ohio Region (Hamilton County)
    - YWCA of Greater Cincinnati (Hamilton County)
    - Upper Ohio Valley Sexual Assault Help Center (Jefferson County)
    - New Directions (Knox County)
    - Lake County Prosecuting Attorney
    - Mental Health America of Licking County
    - Toledo Hospital (Lucas County)
    - Townhall II (Portage County)
    - Children’s Hospital Medical Center (Summit County)
    - Compass Inc. (Tuscarawas County)

- Abuse and Rape Crisis Shelter of Warren County
- Eve., Inc. (Washington County)
- Rural Opportunities (Wood County)

4. The Office of Criminal Justice Services (OCJS) distributes federal funds received through the "Family Violence Prevention Services Act". These funds are primarily used for domestic violence crisis intervention but can also be used for prevention and education. Of the sixty-eight programs that received funding in 2007, twenty include some level of community education and/or prevention activities as an objective. Only one of those, Helpline of Delaware and Morrow Counties, focuses exclusively on prevention and has a clear focus on primary prevention of sexual and intimate partner violence. The others range from a very general education/awareness focus to a few that specifically work with youth in schools.

Several state agencies and processes that align throughout Ohio contribute to prevention of intimate partner and sexual partner violence in Ohio. First, the State of Ohio and many of its agencies subscribe to a document entitled, "Ohio's Shared State Agency Prevention Framework" authored by ODADAS that articulates many of the principles of prevention and the social ecological model to which the CDC funded entities subscribe. This document has helped create common language regarding primary prevention and its importance to stemming the tide of perpetration and victimization in Ohio. However, language adopted that describes prevention definitions differs from CDC definitions which has resulted in confusion among agency leaders with regard to what is primary, secondary, and tertiary prevention as well as how to apply prevention science to universal, selected, and indicated populations.

Secondly, Ohio Department of Alcohol and Drug Addiction Services (ODADAS) whose mission is "to provide statewide leadership in establishing a high quality addiction prevention, treatment and recovery services system of care that is effective, accessible and valued by all Ohioans," is a potential resource for prevention education of SV and IPV in school settings given overlapping risk factors of substance abuse and IPV/SV.

A third state agency, The Ohio Department of Mental Health (ODMH), receives a Transformation State Incentive Grant (TSIG) from the Substance Abuse and Mental Health Services Administration. The influx of funding has encouraged collaboration among non-traditional partners and expanded strategic partnerships across the State to include consumers of mental health services, governmental agencies, private non-profit organizations, and professional associations. Focus group interviews on the issue of early childhood trauma and its consequences for Ohio's service delivery system have been a significant output of ODMH as well as the work of its Childhood Trauma Task Force. The Childhood Trauma Task Force is committed to providing a continuum of services including those that will contribute to primary prevention of childhood trauma.

Fourth, The Ohio Children's Trust Fund – (OCTF) was created by the Ohio Legislature in 1984 to maintain a focus on preventing child abuse/neglect, and to serve as a vehicle for distributing funding to support primary and secondary prevention programs throughout Ohio. The OCTF has supported local programs including Child Assault

Prevention Programs (CAP) that provide training to children in schools as well as parents and teachers, and the Darkness to Light programs that focus on training adults to prevent child abuse.

Fifth, The Ohio Commission on Dispute Resolution and Conflict Management - Established by the Ohio Legislature in 1989 provides dispute resolution and conflict management resources, training, and direct services to Ohio schools, communities, courts, and state and local government. Programming includes training on bullying prevention;

Sixth, Ohio is a state that is richly resourced with colleges and universities that can partner with local communities and state agencies and organization to provide myriad services. Ohio has more colleges and universities per capita than any other state in the nation. And finally,

The Ohio Department of Education (ODE) offers a variety of bullying-prevention resources for families, schools and communities. They are currently engaged in a Safe Schools planning process and have recently produced a "Bullying, Harassment and Intimidation Prevention Policy" in response to recent legislation that requires Ohio schools to have policies in place to address the issue of bullying.

Ohio also hosts several non-profit agencies and professional associations that are committed to primary prevention of intimate partner and sexual violence.

- The Ohio Domestic Violence Network (ODVN) has become a leader in providing training and technical assistance for intimate partner, family, and sexual violence. Funded by CDC, the Anthem Foundation of Ohio, and the Ohio Department of Health, ODVN has expanded its organizational capacity exponentially and is working with local communities in Ohio to expand their individual, organizational, and systems level capacity.
- Ohio Resource Network for Safe and Drug Free Schools and Communities is funded by the ODADAS and supports administrators, teachers, parents, prevention professionals, faith leaders and others working across Ohio to establish safe disciplines, and drug-free schools and communities. The Network is a point of contact for information, training, and research as it relates to keeping communities and schools safe.
- The Ohio Sexual Assault Task Force (OSATF) was convened in 2002 by the ODH to conduct a statewide needs assessment and create a plan of strategic action related to the identified needs. "A Call to Action: Ending Sexual Violence in Ohio," was published in 2002 and the Task Force is convened on a regular basis to discern their progress toward action items. The Task Force Prevention Subcommittee has identified men and boys as a priority area and expects to conduct focus group interviews for a statewide media campaign that markets healthy relationship messages to boys ages 10 – 14 as a rape prevention strategy.
- Ohio Sexual Violence Prevention Network (OSVPN) is a grassroots network of prevention practitioners across Ohio that meets during the summer for the purpose of networking, strategies, and promoting best practice models for primary prevention of

sexual violence. Currently, OSVPN is convened by the Sexual Assault Prevention Program Director of the Help Hotline of Delaware and Morrow Counties.

- The Ohio Sexual and Intimate Partner Violence Prevention Consortium (the Consortium) is convened by the ODVN DELTA Project and the ODH SADVPP. The Consortium is responsible for articulating a statewide plan for primary prevention of intimate partner and sexual violence in accordance with funding from the CDC. Membership of this group includes state agency leaders, professional associations, non profit organizations, and local prevention projects. Membership in the Consortium includes those who represent Ohio's geographic, gender and ethnic diversity.
- Prevent Child Abuse Ohio offers a wide range of services. Their work that is most directly related to sexual violence prevention is the HUGS program, which offers information to parents and community members on how to identify types of child abuse, their warning signs and indicators, tips to safely and effectively intervene in a stressful parent child interaction, and referral to parenting and child abuse/neglect prevention and intervention resources.
- Public Children's Services Association of Ohio (PCSAO) is a proactive coalition of public children services agencies that promotes the development of sound public policy and program excellence for safe children, stable families, and supportive communities. Members of the association and staff do their work through advocacy, research, training, consultation, and technical assistance.

The organizations highlighted above are far from an exhaustive list of contributors to statewide prevention efforts. For example, many of Ohio's local domestic violence shelters engage in community education, awareness, and prevention activities. In addition, the Columbus Urban League and other Urban Leagues around the state provide prevention services to their constituents as do a myriad of local agencies. The needs and resources assessment pointed to several gaps in primary prevention services throughout the State of Ohio that guided the creation of *Pathways in Prevention: A Roadmap for Change, Ohio's Plan for Sexual and Intimate Partner Violence Prevention*.

Given the conditions and resources that currently exist in Ohio, sexual and intimate partner violence prevention efforts are insufficient to meet the growing need. Those efforts that do exist are operating in an economic climate of budget cuts and funding decreases that will ultimately impact the provision of prevention services. Because sexual and intimate partner violence prevention efforts are in their early stages of development, program evaluation data that indicate promising and best practices are just beginning to emerge. Wise use of limited prevention resources coupled with better coordinated state and local evaluation efforts will likely assist with the development of a body of evidence on what works and does not work regarding sexual and intimate partner violence prevention. However, without prevention resources in terms of funding for both state and local initiatives, forward movement will be hampered.

In addition to scarce prevention resources, there is a lack of coordination among and between various governmental systems, state agencies, non-profit organizations and associations, and local communities that could be viewed as natural allies for prevention efforts beyond sexual and intimate partner violence prevention. The Consortium has

become a model of collaboration among many of these agencies and will continue its collaborative efforts as this Plan is implemented. However, collaboration in and of itself is not enough. Allied state agencies, non-profit organizations and associations, and local communities must commit time and resources for building their capacities to better understand sexual and intimate partner violence and its prevention. Data systems must be developed that help sexual and intimate partner violence prevention practitioners at all levels better understand perpetration and not just victimization as is the current situation in Ohio. Currently, in Ohio, we have very little data that links specific risk factors or social norms to perpetration of sexual or intimate partner violence. Additionally, data about protective factors and factors that support health promotion are missing.

Future Forecast:

It is anticipated that the future of Ohio's prevention efforts will impact both directly and indirectly the results of the Consortium's work including:

- Legislation for protection orders that can be accessed by teens who are involved in violent dating relationships.
- Legislation that will mandate 7 - 12 grade public schools to include in health curriculums content about dating violence and its prevention.
- Continued efforts to mobilize men and engage young men in ending sexual and intimate partner violence.
- Annual statewide conferences aimed at providing prevention practitioners with knowledge and skills to do the best possible job on behalf of Ohio communities.
- Regional meetings convened to provide prevention practitioners with the opportunity to network, learn, and grow.
- Caucuses that bring together a myriad of family violence prevention practitioners to provide them with updates regarding state level organizations and processes.
- Better data collection for SV and IPV that will better inform the State about the magnitude of the issue as well as data that better supports risk and protective factors.
- Continued relationship building with governmental agencies, non-profits, professional associations, and other organizations at the state and local level.
- Greater access to free and low cost technology such as webcasts, video conferencing, wikipedias, and social networking to enable greater access of Ohio residents to participation in SV and IPV prevention.

In Ohio today there exits a good and growing foundation of prevention services. The foundation includes the ODH Sexual Assault and Domestic Violence Prevention Program and its funded local programs, the ODVN DELTA Program and funded local programs, the Anthem Foundation of Ohio and its continued interest in funding family violence prevention efforts. On that foundation stands the OSIP-VP Consortium and the high

level of collaboration that is modeled through its processes. As this Plan is implemented, it is hoped that the girders of a strong sexual and intimate partner violence prevention system will be erected. One day, in Ohio, all the necessary components of that system will be in place to better establish current needs and resources. Ohio will be a recognized leader in the development of a growing body of culturally inclusive and relevant evidence based best practices for sexual and intimate partner violence prevention. Through these efforts, perhaps one day in Ohio social norms will reflect a commitment to healthy relationships.

Ohio's Universal and Selected Populations to be Addressed by the Prevention Plan

According to CDC prevention definitions and commonly held prevention science, the following are approaches to prevention:

- **Universal Approaches:** *are applied to everyone within the population without regard to their differences in the risk of becoming a victim or perpetrator of violence.* In the field of violence prevention this term is often used synonymously with primary prevention.

- **Selected Approaches:** *are applied only to individuals and groups at enhanced risk of violence.* This approach is often associated with secondary prevention. Selected approaches can also be used for primary prevention strategies based on risk and protective factors present and if violence has not yet occurred.

- **Indicated Approaches:** *are applied to individuals and groups that have already demonstrated violent or seriously delinquent behavior or have been victimized by the behavior.* In the realm of prevention, this approach is secondary or tertiary meaning that victimization or perpetration necessitates intervention.

Applying these definitions to Ohio's needs and resources assessment and through discussions with the CDC, the Consortium agreed that for the purpose of this plan, Ohio's *Universal Populations* (populations identified without regard to specific risks for perpetration or victimization) are described as:

- All residents of the State of Ohio
- All Ohio youth ages 6 – 24
- All Ohio men and boys

The universal population of youth ages 6 - 24 was identified because over one-third of Ohio's population is included in this age range. Furthermore, accessing this population of youth through Ohio's educational institutions will likely be easier because most are in elementary, middle, high school or some sort of post secondary education. On the public

policy level, the Ohio House of Representatives has introduced a bill that if passed by both the House and Senate, will mandate education about teen dating violence and its prevention in grades 7 - 10. "All Ohio men and boys" was selected as another universal population since all relevant data about sexual and intimate partner violence perpetration point to men as most likely to perpetrate and boys as most likely to become perpetrators. Further, Ohio's selected population (population identified based on specific risk factors for perpetration or victimization.) is described below. For the purpose of this Plan, Consortium members have agreed to focus on perpetration of SV/IPV rather than victimization.

Men and boys who have the following risk factors:

- Hostility and anger toward women
- Hyper masculinity and/or beliefs in strict gender roles
- Exposure to violence (all types, across the entire social ecological model, and across the lifespan)

While there is a dearth of relevant social norms data that describe Ohio's populations, it is commonly understood that in a large portion of Ohio's rural communities as well as in Ohio's urban areas women are viewed through the particular lens of strict gender roles and men are viewed in traditional roles that can lead to hyper-masculine beliefs. There is less Ohio data available about "hostility and anger toward women" as a risk factor for SV and IPV perpetration. With regard to exposure to violence, all Ohio children are vulnerable to traumatic events that may include exposure to family violence, community violence, violence that is portrayed through media, the violence of natural disasters, and acts of domestic and/or international terrorism. As Ohio's economy continues to suffer and the social fabric continues to disintegrate opportunities for violence to manifest increase. It is expected that there will be an increase in sexual and intimate partner violence as well.

Therefore, the Consortium recommends working on reducing these risk factors through outreach to our universal population. Knowing that the selected population is a subset of the universal population and that within the universal population people are on a continuum across the risk factors. The goal in intervening will be to move populations from where they are currently toward more protective factors and less risk factors. Thus, toward reduced risk of perpetration of SV and IPV.

However, knowing that the universal population contains members of the selected population is not enough. In Ohio, we must find a way to identify men and boys who are at most risk for perpetrating sexual and intimate partner violence and provide them with effective preventive services to increase protective factors. It behooves us to work with juvenile justice systems, foster care systems, and child protection systems to those ends. Similarly, it makes sense that data systems will be developed to help identify those at most risk for perpetration of sexual and intimate partner violence such that prevention interventions may be implemented well before the possibility of perpetration occurs.

Risk and Protective Factors for Sexual and Intimate Partner Violence Perpetration

Risk factors are traits, characteristics, or circumstances that increase the likelihood that an individual will become a victim or perpetrator of violence. Risk factors can be traits or characteristics of the individual or of their environment, such as their family, school, community, or society.

Protective factors are those factors that may either reduce the risk of violence or provide individuals with alternative responses to violence. Protective factors are similar to assets, which are positive factors that promote young people's healthy development and are correlated with nonviolence. Similar to risk factors, protective factors can be traits or characteristic of the individual or of their environment, such as family, school, community, or society.

Based on the data compiled in the needs and resources assessment and the social - ecological model, the following risk factors have been prioritized for the purpose of Ohio's sexual and intimate partner violence prevention plan. Please note, these risk factors pertain to perpetration of sexual and intimate partner violence as this is the focus of Ohio's plan.

Sexual and Intimate Partner Violence Risk Factors

Table 3. Risk factors for SV and IPV Perpetration

Individual Level Risk Factors: • Hostility and anger toward women • Hyper-masculinity and/or beliefs in strict gender roles • Exposure to violence (all types across the social ecological model and across the lifespan)
Relationship Risk Factors: • Stress on families that may stem from economic factors • Stress on families that may stem from unhealthy and disintegrating relationships • Peer norms related to aggression and dominance
Community Risk Factors • Poverty and lack of employment opportunities • General tolerance of abuse and violence • Lack of strong sanctions for perpetrators of sexual and intimate partner violence
Societal Risk Factors • Social norms that support beliefs in strict gender roles

Source: Virginia Sexual and Domestic Violence Action Alliance, 2009.

Sexual and Intimate Partner Violence Protective Factors

Little is known about what factors can lessen the likelihood of IPV or SV victimization or perpetration. The following protective factors for IPV/SV perpetration are supported by limited research and/or practical experience from the field. These factors have been compiled by the Virginia Sexual and Domestic Violence Action Alliance.

The Consortium identified these protective factors and distributed them to members. As plan implementation moves forward, these protective factors will inform actions. For example, one of the goals is to identify recommended practices. These protective factors will be a component of the assessment and evaluation of the proposed recommended practices.

Table 4. Protective Factors for SV and IPV Prevention

Individual Level Protective Factors
• Personal belief in the positive value of, and commitment to, caring, equality, and social • Justice • Presence of skills to experience healthy sexuality and engage in healthy relationships • Willingness and ability to be active participants in a thriving community
Relationship Level Protective Factors
• Parents, adult authority figures, and peers of diverse backgrounds model and teach positive interpersonal relationships across diverse populations • Families and/or other important figures provide a caring, open, and encouraging environment that actively promotes positive development • Peers, families, and intimate partners effectively identify and respond to unhealthy/problem behaviors
Community Level Protective Factors
• Diverse people are engaged within their communities in activities promoting healthy relationships and healthy sexuality • The principles and skills of healthy relationships and healthy sexuality are demonstrated across various institutions • The presence of just/fair boundaries and expectations about healthy relationships and healthy sexuality are applied consistently across community entities
Society Level Protective factors
• Social norms strongly support the development and maintenance of healthy relationships and healthy sexuality • Shared responsibility for developing and maintaining thriving communities • Ensuring accountability and expectations of people to interact respectfully is a fundamental part of life • Culture equitably values and relies on experience and leadership from all members of society, including persons of any gender, race, ethnicity, class, sexual orientation, ability, religion, or belonging to any other historically oppressed group that has experience systemic restriction on their rights.

Source: (Virginia Sexual and Domestic Violence Action Alliance, 2009.)

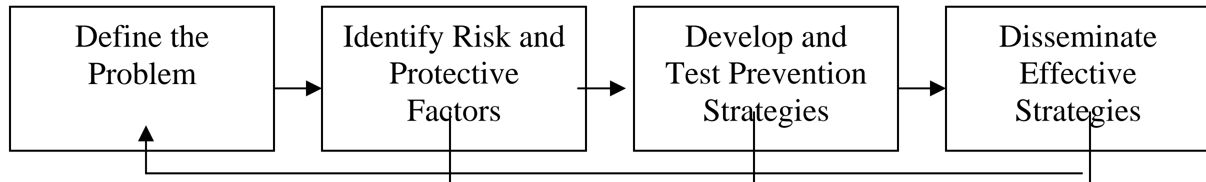
Prevention System Capacity: An Assessment

According to the CDC, the sexual and intimate partner violence primary prevention system is the network of organizations and individuals at the state or community level that supports and expands the work of the 4-Step public health approach to addressing SV/ IPV.

Use of the public health model begins with defining the problem. Once the problem is fully defined the next step is to identify risk and protective factors that contribute to the

problem. Next comes developing and testing (evaluation) prevention strategies and finally, disseminating effective strategies for future use. Each step feeds back into the preceding step to create a continuous feedback loop that informs future initiatives.

Figure 1: The Public Health Model



This network is referred to as a prevention system because:

- the responsibility to prevent SV and IPV does not belonging to any singular organization, group, or individual
- the network has a dynamic nature that is influenced by internal and external issues
- the whole system is greater than the sum of its parts.

The SV and IPV primary prevention system within each state and community is composed of many organizations and individuals, the relationships among these organizations and individuals, the leadership within and among these organizations and the community or state, and the processes that link these organizations.

In February 2008, staff of ODH and ODVN conducted a multi-dimensional assessment of the capacity of Ohio's fledgling SV and IPV Primary Prevention System. Among the dimensions assessed were leadership, strategic planning, information and data systems, community and constituency foci, human resources, operation of the system, and evaluation of near and long-term outcome indicators. In general, on a scale of 1 - 5, one being low and five being high, the assessment indicated scores of 2 - 4 on most markers with more scores in the range of 2 - 3 than 4.

Discussion about Ohio's prevention system has also taken place at the Consortium level. As a result, many of the goals and outcomes articulated in this plan are aimed at strengthening Ohio's prevention system. In addition to goals and outcomes of the plan, an unintended consequence of engaging Consortium members to assist in the planning process has led to the formation of new and/or strengthened relationships between agencies responding to different statewide prevention foci. Previous statewide efforts to develop a "state prevention shared framework" did not include sexual and intimate partner violence efforts. A representative from ODADAS has actively contributed to our efforts, but further work remains to be done to more closely align our prevention efforts with those of ODADAS. Previous attempts to involve ODE in sexual and intimate partner violence efforts were unsuccessful. As we began work on the state sexual and intimate partner prevention plan, we were able to first work with the Ohio Commission on Dispute Resolution and Conflict Resolution and the Ohio Resource Network, who were providing bullying prevention resources for state distribution, and from those contacts we were able to meet and exchange information with the appropriate ODE staff members.

Similar efforts to meet with staff from Prevent Child Abuse Ohio, the Ohio Children's Trust Fund, and Ohio Network of Child Advocacy Centers have been mixed, with some contact, but due primarily to high turnover in staff at these agencies participation in our state planning efforts has been limited. The creation of the Governor's Office for Women's Initiatives and Outreach, an initiative of Governor Ted Strickland, has also provided opportunities for new collaboration in building system capacity.

Another overlap has been the work the ODMH, has initiated as part of a larger effort to "transform mental health in Ohio." ODMH has convened a Childhood Trauma Taskforce which is developing recommendations in three areas; public awareness and education, screening and assessment, and training and evidence-based best practice.
The needs and resources assessment clearly points to some gaps in information, services, and capacities for coordinated efforts in primary prevention of sexual and intimate partner violence Along with several economic and demographic conditions that are anticipated to impact the future resources and needs of Ohioans these factors must be considered in developing the strategic plan for SV and IPV prevention. The needs and resources assessment findings were the platform for choosing the five strategic directions and their goals and outcomes that become guideposts for Ohio's SV/IPV prevention work for the next five years and beyond as submitted to the CDC.

Introduction of the Plan: Goals and Outcomes

After the completion of the Needs and Resource Assessment, a meeting of the Consortium was convened to review the findings and to establish strategic directions for the State Plan. ODVN staff, who had received training from the Institute for Cultural Affairs consultants in the *"Technology of Participation: Group Facilitation Methods"* and *"Participatory Strategic Planning"* facilitated the preliminary discussion. These facilitative leadership processes were especially valuable to the Consortium's identification of strategic directions that were arrived at by consensus. Each of the five areas of focus identified as a result of this facilitated conversation became a workgroup; the workgroups then met over a period of approximately 18 months to create goals, outcomes and action steps that would implement the intent of the strategic direction.

Evidence-based prevention strategies and/or programs for Ohio's universal and selected populations do not exist although there are emerging program evaluation findings that indicate that MOST Clubs and Expect Respect support groups may be effective prevention strategies for the selected population. However, to establish the evidence base for strategic directions listed below, the authors used the method of drawing from multiple scientific disciplines to develop a theory basis to inform our strategies, with the intent of moving toward an evidence base for prevention work in Ohio.
Workgroup sessions were guided by the GTO framework. In particular, the needs and resources work informed the workgroups regarding prioritized goals, outputs and

outcomes on which to focus. Each outcome statement was informed by a thoughtful dialogue on evidence-based strategies, fit and capacity and the overarching philosophy of inclusiveness agreed upon by the Consortium members.

Each workgroup worked closely with the empowerment evaluator, and established a theoretical framework as described with each workgroup below for the recommendations which contributed to the development of the final plan. Each Strategic Direction is assigned a color that coincides with specific action steps and strategies described on the timeline that follows in Appendices B and C. It was agreed by the Consortium to separate the actions step from the goal and outcome statements below to increase read-ability and to decrease redundancy of similar action steps related to similar outcomes statements. Please note: Each goal statement below includes (in parentheses) whether it addresses the universal or selected population or Ohio's sexual and intimate partner violence prevention system capacity.

Strategic Direction: Effective Youth SV and IPV Prevention Recommended Practices:

This work group is focused on identifying recommended prevention practices that have a proven theory basis, history of evaluation showing they are effective, or at best have been proven to be evidence based.

Statement of Need: In Ohio, efforts to prevent SV and IPV for youth are fragmented. Ohio is a home-rule state where each county government and school district reserves the right to develop its own rules for operation as long as they do not conflict with state law. Although Ohio currently has several primary prevention mandates (i.e., a legislative mandate that requires schools to have bullying prevention, and a pending mandate to require schools to offer healthy relationships and teen dating violence awareness curriculums) school districts or counties frequently have their own prevention programs but no means of assuring that those programs are measured against a list of guiding primary prevention principles that; 1) reflect best available evidence, and 2) have been vetted by key stakeholders. The Consortium believes it is in the best interest of Ohio's universal and selected populations to provide leadership for the development of a vetted set of primary prevention principles that will allow Ohio to both make better use of existing primary prevention program models that are successfully measured against this set of principles, and to develop promising primary prevention models and practices that match the guiding set of principles. Ohio's statewide SV and IPV primary prevention recommended practices must be research-based, culturally inclusive and competent.

Goal 1: (Universal Population): The goal is to create effective culturally competent, inclusive and appropriate statewide SV and IPV primary prevention recommended practices for youth age 6-24.

Outcome Statement: By the end of 2013 the Consortium will create and distribute effective statewide SV and IPV primary prevention recommended practices for youth age 6-24. Refer to Communications Plan.

Goal 2: (Selected Population) :The goal is to create effective culturally competent, inclusive and appropriate statewide SV and IPV primary prevention recommended practices for men and boys with hostility towards women.

Outcome Statement: By the end of 2013, the Consortium will create and distribute effective statewide SV and IPV primary prevention recommended practices for men and boys with hostility towards women for youth ages 6-24

Goal 3: (Selected Population): The goal is to create effective culturally competent, inclusive and appropriate statewide primary prevention recommended practices for men and boys with hyper-masculinity.

Outcome Statement: By the end of 2013, the Consortium will create and d distribute effective statewide SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity for pre-youth ages 6-24.

Goal 4: (Selected Population): The goal is to create effective culturally competent, inclusive and appropriate statewide SV and IPV primary prevention recommended practices for men and boys with exposure to violence (all forms across the lifespan.

Outcome Statement: By the end of 2013, the Consortium will create and distribute effective statewide primary prevention recommended practices for men and boys with exposure to violence (all forms across the lifespan) for youth ages 6 24.

Strategic Direction: Integrated Intra-State Collaboration

The strategic direction advised by the work group on Integrated Intra-state Collaboration prioritized goals where existing resources and infrastructure would increase the likelihood for sustainable and replicable success. Each of the identified areas (prevention capacity for human service professionals, workplace policies and programming, and media advocacy efforts) expands upon activities which have been tested at local or organizational levels. The group narrowed the many needs identified by the Consortium through its assessment and consensus processes to those which matched available resources and were best suited for the state prevention climate. For example, the implementation of workplace policies and programs is particularly promising given the accessibility of tested resources, adaptability for size and system, and a recent precedent ordered by the Governor of Ohio to establish similar programs in state offices. The work group was especially attracted to strategies that would result in the engagement of the target audience (human service professionals, workplaces and the media) as next generation change agents for building prevention systems capacity.

Statement of Need: Currently, the capacity of Ohio's SV and IPV primary prevention system is marginal at best. As evidenced by completion of the system capacity questionnaire, there exists the need to increase that capacity. The Integrated Intra-State Collaboration work group strives to increase Ohio's system capacity by leveraging already existing prevention and system resources. Working on multiple systems levels, this strategic direction addresses the need for increasing key collaborator's knowledge base and skill set, increasing policy efforts related to SV, IPV and sexual harassment, to

support related public policy efforts, and to impact the media discourse surrounding SV and IPV in Ohio.

Goal 1: (Prevention System Capacity): The goal is to improve the knowledge and skills of education, health and human services professionals in relation to SV and IPV primary prevention.

Outcome Statement: By the end of 2012, at least three professional associations/organizations and one college/university will have implemented SV and IPV primary prevention training.

Outcome Statement: By mid 2013, resources related to SV and IPV primary prevention will be broadly available for professional education.

Goal 2: (Prevention System Capacity): The goal is to increase the number of government agencies (municipality, county, state) private sector and non-profit employers that adopt SV, IPV, and sexual harassment prevention policies that are both inclusive and attentive to diverse communities in Ohio.

Outcomes Statement: By mid 2011, three government agencies, private sector or non-profit employers/networks identified by the Consortium will adopt SV, IPV, and sexual harassment Workplace Policies.

Outcome Statement: By mid 2013, at least one government agency, private sector or non-profit employer will champion the adoption of SV, IPV, and Sexual Harassment Workplace Policies with similar industries.

Goal 3: (Prevention System Capacity): The goal is to identify and support culturally responsive public policy efforts that are in the interest of SV and IPV primary prevention and to increase the Consortium's understanding of those efforts.

Outcome Statement: By end of 2013, and continuing onward, Consortium members will support statewide public policy organizing and advocacy efforts and encourage further local dissemination.

Goal 4: (Prevention System Capacity): The goal is to leverage and make available those resources that will positively influence media discourse (and, therefore, public opinion) related to SV and IPV and opportunities for SV and IPV primary prevention.

Outcome Statement: By the end of 2013, three local SV and IPV programs will have institutionalized media advocacy strategies within their Communications Plan or their organization.

Strategic Direction: Leveraging Resources for Maximizing Sustainability

The caveat: "Sustainability includes institutional capacity building such that implemented strategies are sustained by policy/procedure and not necessarily by funding," provides the framework within which this work group conducted its business. Looking to the literature on sustaining efforts such as the Consortium's four approaches emerge that help community and coalition based efforts sustain their work. "With multiple approaches we

can begin to think of sustainability as being more than just maintaining our funding and staff (2004, Institute for Community Peace)."

The four approaches are:

1. Institutionalization – initiatives are incorporated into existing community institutions;
2. Policy change – changes in rules, regulations, and laws;
3. Community ownership, changing community norms – mobilizing community members to be the change and promote the change broadly;
4. Resources – the most commonly used definition of sustainability, resources encompasses finding additional monetary support for prevention efforts.

While it is agreed by Consortium members that funding for implementation of said strategies is important, institutionalization is equally important and the strategies outlined are consistent with this approach.

Statement of Need: To continue to build a sexual and intimate partner violence prevention system including building capacity of said system such that it can recommend prevention practices, it can collaborate more effectively, it can collect and analyze data appropriately, and it will empower local communities to engage with state efforts, requires sustainability. Any state level endeavors that occur without subsequent planning for leveraging resources to maximize sustainability are short sighted and will be short-term. As stated in the framework above, and based on the need to build Ohio's SV and IPV prevention system from one of fledgling to maturity, requires efforts to institutionalize prevention through collaboration and public policy efforts as well as by empowering collaborators and local communities to own the process and products of this State Plan. In an ideal world, funding opportunities would be available and ample sources for Ohio efforts. In the current economic climate, we may find ourselves relying less on funding and more on other mechanisms for sustaining efforts while understanding that without a plan to diversify funding and available funding opportunities, prevention efforts may plateau for the immediate future.

Goal 1 (Prevention System Capacity): The goal is to leverage resources for maximizing sustainability of culturally competent, inclusive and appropriate SV and IPV primary prevention efforts in Ohio.

Outcome Statement: By the end of 2013, a unified concept for SV and IPV primary prevention will be articulated and broadly disseminated in Ohio.

Goal 2 (Prevention System Capacity): The goal is to develop a public, representative of Ohio's diverse communities that is knowledgeable about and supportive of SV and IPV primary prevention efforts in Ohio.

Outcome: By the end of 2013, Ohio's diverse public has demonstrated an increase in knowledge and support for SV and IPV primary prevention.

Goal 3 (Prevention System Capacity): The goal is to create and maintain the necessary infrastructure and resources to ensure the process of implementation of the Plan, with attention to the needs of Ohio's diverse communities.

Outcome Statement: By 2013, the SV and IPV primary prevention Plan will be implemented on schedule and the infrastructure and resources for culturally competent, inclusive, and appropriate primary prevention in Ohio will be maintained beyond 2013.

Strategic Direction: Integrated Strategic Evaluation and Data Collection:

By definition, the work of this committee is theory based as it is intended to increase the effectiveness, amount, and quality of evaluation and data that will be used to support and analyze the work of the prevention plan

Statement of Need: Currently in Ohio, data is available that suggests sexual and intimate partner violence is a problem. However, this data does not describe the full extent or magnitude of the problem and fails to depict the incidence of the problem from the local level or perspective. Because sexual and intimate partner violence crosses disciplines, meaningful data collection must occur from various systems in a coordinated and integrated fashion. In this context, meaningful data refers to information stringently collected and evaluated to be used for the strategic purpose of preventing sexual and intimate partner violence in Ohio. Otherwise, the incomplete picture of the incidence and impact of sexual and intimate partner violence will persist in Ohio. Data collected by various systems could help better identify the selected population to more thoughtfully aim prevention efforts. For example, juvenile justice statistics, Job and Family Services statistics, and foster care statistics may help us better identify Ohio's selected population. However, knowing where to find such data, gaining access to data, and having the expertise to analyze these data is beyond the current capacity of the Consortium or its convening agencies. Social norms data that would help in the development of prevention efforts aimed at increasing protective factors is also missing. The current capacity of Ohio's data collection system is inadequate and is in its beginning stages of development. Fortunately, the Consortium's convening agencies have partnered with Health Policy Institute at The Ohio State University. It is hoped that this partnership will strengthen and others will be formed to impact Ohio's sexual and intimate partner violence prevention data collection and analysis capacity. Building data collection and analysis capacity will result in the identification of primary prevention risk and protective factors and a better defined picture of the magnitude of sexual and intimate partner violence perpetration in Ohio.

Across Ohio, local sexual and intimate partner violence prevention programs struggle with few resources dedicated to program evaluation. By implementing the activities recommended by the Integrated Strategic Evaluation and Data Collection Work Group, the capacity to engage in thoughtful evaluation practices should increase dramatically. Through leadership at the Consortium level, it is anticipated that program evaluation guidelines, protocols, and perhaps even evaluation instruments will be shared from state

to local levels. Ultimately, helping Ohio's sexual and intimate partner violence prevention programs practice based on the best available evidence.

Goal 1: (Prevention System Capacity): The goal is to create a centralized strategy for collecting inclusive statewide evaluation data on SV and IPV primary prevention efforts in Ohio.

Outcome Statement: By the beginning of 2013, the Consortium will create and distribute a directory of evaluation measures that have been assessed for cultural competency and accurate measurement of SV and IPV prevention outcomes. Refer to Communications Plan.

Outcome Statement: By mid-2013, Ohio local SV and IPV prevention efforts demonstrate increased capacity for using evidence based practices.

Goal 2: (Prevention System Capacity): The goal is to create a centralized strategy for collecting statewide data on the incidence and prevalence of SV and IPV in Ohio.

Outcome Statement: By mid-2013, the Consortium will create a comprehensive tool for the collection of statewide data on the incidence and prevalence of SV and IPV in Ohio. Refer to Communications Plan.

Strategic Direction: Empowered Local Communities:

The work of this committee builds on the theory of diffusion of innovations to support and guide the implementation of primary prevention of SV and IPV for agencies working with youth throughout Ohio. This theory supports the concept that as an innovation becomes known, adopted by opinion leaders, and shown to be effective, the use of that innovation will become widespread. Our concept is to identify and work with a limited number of state and regional youth serving organizations to focus and demonstrate the effectiveness of our efforts in anticipation of more widespread involvement as our success grows.

Statement of Need: The needs and resource assessment identified that in the 2000 census, 33% of Ohio's population was age twenty-four or younger. The capacity of our prevention system to reach these youth is very limited. Funded sexual and intimate partner violence prevention programs reach only a limited geographic range in Ohio; within those communities not all youth are served, and even youth who receive some prevention information would benefit from duplication of the message. Awareness and recognition of our sexual and intimate violence prevention plan by youth serving social and community organizations will ensure that prevention messages are more broadly disseminated and are reinforced for participating youth. We also recognize the importance of involving youth directly in these efforts, since involvement of representatives of the population to be reached is critical to successful implementation of services. Involving youth will assist to ensure authenticity in the voice of youth in materials created and distributed.

Goal 1 (Prevention System Capacity): The goal is to establish a culturally competent, inclusive and appropriate program that generates awareness and recognition of the Plan

among state level youth serving social and community organizations and their local affiliates.

Outcome Statement: By the end of 2012, youth serving organizations at the state and local level have integrated SV and IPV culturally competent, inclusive and appropriate primary prevention messages.

Outcome Statement: By the end of 2012, through the distribution of a toolkit, a statewide kickoff event, and regional replication, communities across Ohio will access and utilize identified primary prevention messages through the following organizations which may include but are not limited to: 4H/Extension agencies, Boy Scouts, Girl Scouts, sports including both community sports and school based athletics, United Way, Family and Children First groups, YW/YMCAs, Boys/Girls clubs, Big Brothers/Big Sisters, church groups, Jewish groups, other religious associations, etc.

Goal 2 (Universal Population): the goal is to engage youth and ensure their voices are reflected in the final toolkit and kickoff event.

Outcome Statement: By mid-2012, increase youth engagement as leaders and role models in being actively intolerant of abuse and violence in their communities.

Summary and A Call to Action

As demonstrated by the data reflected and data missing from this Plan as well as the tremendous costs of sexual and intimate partner violence in terms of dollars and lives in Ohio, it behooves all Ohioans to take action to prevent this violence. Every day in Ohio, someone is victimized by sexual or intimate partner violence. More likely, many are victimized. For the most part, these crimes primarily committed against Ohio women citizens, go undetected, unreported, and are relegated into the collective unconsciousness. Those crimes that are recognized and given media attention are related to as somehow different from the sexual assaults and domestic violence incidents that occur every day. For the most part, they are not different - save for the demographics that cause the focus of attention on select few annual incidents.

Where is the outrage? Where is the collective and political will to end this shameful scourge? When will fathers, brothers, uncles, and all Ohio men unite and stand together to stop the perpetration of these countless acts of violence? The women and men who contributed to this Plan know that unless and until men in Ohio and across the country are empowered to stand up for their sisters and mothers, and all women in Ohio, victimization will continue and likely increase as risk factors across the social ecology increase.

The goals and outcomes as articulated above provide a pathway for us to begin working toward the Consortium's vision for Ohio. It is a vision we hope can inspire and be adopted by all Ohioans. No matter how large or small an action may be, whether the action is joining with the Consortium to help achieve its goals or the action is to be an

engaged bystander who will no longer tolerate sexist or homophobic jokes, only collectively can a difference be made that will transform the current conditions into that of freedom, justice, and equality for all Ohio citizens.

We hope you are inspired to participate and to make a contribution to ending sexual and intimate partner violence in Ohio. We welcome your contribution. Below is contact information for the Ohio Department of Health Sexual Assault and Domestic Violence Prevention Program and the Ohio Domestic Violence Network's DELTA Program:

Ohio Department of Health: 614-728-2176, ask for Debra Seltzer

Ohio Domestic Violence Network: 800-943-9840, ask for Rebecca Cline

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Appendix A: Definitions of Cultural Competence

Attention to cultural competence, inclusiveness and appropriateness is a priority for the Consortium. We adapted and established shared definitions for related phrases used in the Plan, listed below. A key concept for the implementation of the work of the Consortium is that attention to these issues is a constant, on-going responsibility that requires action, not just intent.

Culturally Competent: (adjective)
Organizations have demonstrated the capacity and responsibility, in an on-going, proactive and reflective way, to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference (including differences in people, systems and practices), (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve (Cross, et al., 1989).

Cultural Competence: (noun)
Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (Cross et al., 1989) Achieving cultural competence is a developmental process by which individuals and systems respond respectfully and effectively to all people in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each. (National Association of Social Work, 2001)

Linguistic Competence: (noun)
The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is inclusive and understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures and dedicated resources to support this capacity. (Good & Jones, 2000)

Cultural Inclusiveness: (noun)
Including, embracing and practicing an all encompassing approach to persons of all cultures.

Cultural Appropriateness: (noun)

I. Being sensitive to and respectful of people from different cultures; providing services and programs that are culturally sensitive to clients, organizations and communities with the most effective services and programs.
II. Recognizing the importance of the knowledge of the social and cultural contexts in which people live to ensure that learning experiences are meaningful, relevant, and respectful for the clients and their families as well as the organizations and communities in which people work, learn and live. (Adapted from: Wisconsin Model Early Learning Standards, Wisconsin Department of Public Instruction, 2008 Edition.)

Social Justice: (noun)
I. The distribution of advantages and disadvantages within a society. (Webster's Millennium, 2007)
II. Fair and proper administration of laws conforming to the natural law that all persons, regardless of ethnic origin, gender, race, religion, sexual orientation, etc. are to be treated equally and without prejudice. (Business Dictionary, 2008).

Systemic oppression:
Systemic is defined as "of, relating to or common to a system." Oppression means unjust or cruel exercise of authority or power, or something that oppresses especially in being an unjust or excessive exercise of power (Merriam-Webster, 2009). Issues of oppression are

pervasive throughout all aspects of our societal system and often hamper efforts to prevent violence.

Appendix B: Goals, Outcomes, and Action Steps

Strategic Direction: Effective Youth SV AND IPV Prevention Recommended Practices

A. Goal 1: (Universal Population): The goal is to create effective culturally competent, inclusive and appropriate statewide SV and IPV primary prevention recommended practices for youth age 6-24.

A-1. Outcome Statement: By the end of 2013 the Consortium will create and distribute effective statewide SV and IPV primary prevention recommended practices for youth age 6-24. Refer to Communications Plan.

1. Action Step: By mid 2009, formulate research question.
2. Action Step: By the end of 2009, determine research approach.
3. Action Step: By mid 2010, compile and analyze existing SV and IPV primary prevention recommended practices.

4. Action Step: By the end of 2010, create a draft of effective youth SV and IPV primary prevention recommended practices.
5. Action Step: By mid 2011, determine key informants representative of Ohio's diverse communities, who will review the draft of effective youth SV and IPV primary prevention recommended practices.
6. Action Step: By the end of 2011, have key informants representative of Ohio's diverse communities, review the draft of effective youth SV and IPV primary prevention recommended practices.
7. Action Step: By mid 2012, revise draft, as necessary.
8. Action Step: By mid 2012, assess existing curricula against effective youth SV and IPV primary prevention recommended practices, creating an annotated bibliography.
9. Action Step: By the end of 2012, revise, as necessary.
10. Action Step: By mid 2013, create dissemination plan for effective youth SV and IPV primary prevention recommended practices.
11. Action Step: By mid 2013, create dissemination plan for annotated bibliography of curricula measured up against the recommended practices.
12. Action Step: By the end of 2013, evaluate the effectiveness of dissemination plan.

B. Goal 2: (Selected Population) :The goal is to create effective culturally competent, inclusive and appropriate statewide SV and IPV primary prevention recommended practices for men and boys with hostility towards women.

B-1. Outcome Statement: By the end of 2013, the Consortium will create and distribute effective statewide SV and IPV primary prevention recommended practices for men and boys with hostility towards women for youth ages 6-24.

1. Action Step: By mid 2009, formulate research question.
2. Action Step: By the end of 2009, determine research approach.
3. Action Step: By mid 2010, compile and analyze existing SV and IPV primary prevention practices for men and boys with hostility towards women.
4. Action Step: By the end of 2010, create a draft of effective SV and IPV primary prevention practices for men and boys with hostility towards women.
5. Action Step: By mid 2011, determine key informants representative of Ohio's diverse communities, who will review the draft of effective youth SV and IPV primary prevention recommended practices.
6. Action Step: By the end of 2011, have key informants representative of Ohio's diverse communities, review the draft of effective SV and IPV primary prevention recommended practices for men and boys with hostility towards women.
7. Action Step: By mid 2012, revise draft, as necessary.
8. Action Step: By mid 2012, assess existing curricula against effective SV and PV primary prevention recommended practices for men and boys with hostility towards women, creating an annotated bibliography.
9. Action Step: By the end of 2012, revise, as necessary.

10. Action Step: By mid 2013, create dissemination plan for effective SV and IPV primary prevention recommended practices for men and boys with hostility towards women.
11. Action Step: By mid 2013, create dissemination plan for annotated bibliography of curricula measured up against the SV and IPV primary prevention recommended practices for men and boys with hostility towards women.
12. Action Step: By the end of 2013, evaluate the effectiveness of dissemination plan.

C. Goal 3: (Selected Population): The goal is to create effective culturally competent, inclusive and appropriate statewide primary prevention recommended practices for men and boys with hyper-masculinity.

C-1. Outcome Statement: By the end of 2013, the Consortium will create and distribute effective statewide SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity for pre-youth ages 6-24.

1. Action Step: By mid 2009. formulate research question.
2. Action Step: By the end of 2009, determine research approach.
3. Action Step: By mid 2010, compile and analyze existing SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity.
4. Action Step: By the end of 2010, create a draft of SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity.
5. Action Step: By mid 2011, determine key informants representative of Ohio's diverse communities, who will review the draft of effective primary prevention recommended practices for men and boys with hyper-masculinity.
6. Action Step: By the end of 2011, have key informants representative of Ohio's diverse communities, review the draft of effective SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity.
7. Action Step: By mid 2012, revise draft, as necessary.
8. Action Step: By mid 2012, assess existing curricula against effective SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity, creating an annotated bibliography.
9. Action Step: By the end of 2012, revise, as necessary.
10. Action Step: By mid 2013, create dissemination plan for effective SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity.
11. Action Step: By mid 2013, create dissemination plan for annotated bibliography of curricula measured up against the SV and IPV primary prevention recommended practices for men and boys with hyper-masculinity.

12. Action Step: By the end of 2013, evaluate the effectiveness of dissemination plan.

D. Goal 4: (Selected Population): The goal is to create effective culturally competent, inclusive and appropriate statewide SV and IPV primary prevention recommended practices for men and boys with exposure to violence (all forms across the lifespan.

D-1. Outcome Statement: By the end of 2013, the Consortium will create and distribute effective statewide primary prevention recommended practices for men and boys with exposure to violence (all forms across the lifespan) for youth ages 6 24.

1. Action Step: By mid 2009, formulate research question.
2. Action Step: By the end of 2009, determine research approach
3. Action Step: By mid 2010, compile and analyze existing SV and IPV primary prevention recommended practices for men and boys with exposure to violence.
4. Action Step: By the end of 2010, create a draft of SV and IPV primary prevention recommended practices for men and boys with exposure to violence.
5. Action Step: By mid 2011, determine key informants representative of Ohio's diverse communities, who will review the draft of effective SV and IPV primary prevention recommended practices for men and boys with exposure to violence.
6. Action Step: By the end of 2011, have key informants representative of Ohio's diverse communities, review the draft of effective SV and IPV primary prevention recommended practices for men and boys with exposure to violence.
7. Action Step: By mid 2012, revise draft, as necessary.
8. Action Step: By mid 2012, assess existing curricula against SV and IPV primary prevention recommended practices for men and boys with exposure to violence, creating an annotated bibliography.
9. Action Step: By the end of 2012, revise, as necessary.
10. Action Step: By mid 2013, create dissemination plan for effective SV and IPV primary prevention recommended practices for men and boys with exposure to violence.
11. Action Step: By mid 2013, create dissemination plan for annotated bibliography of curricula measured up against the SV and IPV primary prevention recommended practices for men and boys with exposure to violence.
12. Action Step: By the end of 2013, evaluate the effectiveness of dissemination plan.

Strategic Direction: Integrated Intra-State Collaboration

A. Goal 1: (Prevention System Capacity): The goal is to improve the knowledge and skills of education, health and human services professionals in relation to SV and IPV primary prevention.

A-1. Outcome Statement: By the end of 2012, at least three professional associations/organizations and one college/university will have implemented SV and IPV primary prevention training.

1. Action Step: By the end of 2009, the Consortium will identify a broad spectrum of professional associations/organizations that are willing to integrate training on SV and IPV prevention within their professional development or educational opportunities or at their annual meetings. Refer to Communications Plan.
2. Action Step: By mid 2010, the Consortium will identify a broad spectrum of colleges and universities with relevant programs (Nursing, Allied Health Professions, Social Work, Education, etc.) that are willing to integrate training on SV and IPV prevention within their educational opportunities.
3. Action Step: By mid 2011, the Consortium will identify resources related to SV and IPV primary prevention for professional education.
4. Action Step: By mid 2013, the Consortium will disseminate resources related to SV and IPV primary prevention for professional education to the identified organizations above (i. and ii.)

A-2. Outcome Statement: By mid 2013, resources related to SV and IPV primary prevention will be broadly available for professional education.

1. (Same as Goal A, Action StepsA-1,3) Action Step: By mid 2011, the Consortium will identify resources related to SV and IPV primary prevention for professional education.
2. Action Step: By mid 2013, the Consortium will advertise availability of identified professional education resources.

B. Goal 2: (Prevention System Capacity): The goal is to increase the number of government agencies (municipality, county, state), private sector and non-profit employers that adopt SV, IPV, and sexual harassment prevention policies that are both inclusive and attentive to diverse communities in Ohio.

B-1. Outcomes Statement: By mid 2011, three government agencies, private sector or non-profit employers/networks identified by the Consortium will adopt SV, IPV, and sexual harassment Workplace Policies.

1. Action step: By mid 2010, the Consortium will identify resources that support the adoption of SV and IPV and sexual harassment) Workplace Policies by all levels of government and private sectors employers.
2. Action step: By end 2010, the Consortium will promote available national, state and/or local resources that support the adoption of SV, IPV and sexual harassment workplace policies. Refer to Communications Plan.

B-2. Outcome Statement: By mid 2013, at least one government agency, private sector or non-profit employer will champion the adoption of SV, IPV, and Sexual Harassment Workplace Policies with similar industries.

1. Action step: By 2011, identify multiple agencies that demonstrate readiness to champion such adoption.

2. Action step: By mid 2013, utilizing available Consortium resources, provide technical assistance on how the agencies identified (2.b.i., above) might champion such adoption.

C. Goal 3: (Prevention System Capacity): The goal is to identify and support culturally responsive public policy efforts that are in the interest of SV and IPV primary prevention and to increase the Consortium's understanding of those efforts.

C-1. Outcome Statement: By end of 2013, and continuing onward, Consortium members will support statewide public policy organizing and advocacy efforts and encourage further local dissemination. Refer to Communications Plan.

1. Action step: By end of 2009, the Consortium will identify who is involved in reviewing and analyzing existing and proposed public policy (ODVN, Health Policy Institute of Ohio (HPIO), state sexual assault coalition, others) and identify the key issues on which they focus.
2. Action step: By mid 2010, information will be shared with Consortium members. Refer to Communications Plan.
3. Action step: By mid 2011, representatives of the Consortium will identify an appropriate legislative event (i.e. breakfast, luncheon, other).
4. Action step: By mid 2012, representatives of the Consortium will collaborate on a joint legislative event with other key stakeholder organizations.

D. Goal 4: (Prevention System Capacity): The goal is to leverage and make available those resources that will positively influence media discourse (and, therefore, public opinion) related to SV and IPV and opportunities for SV and IPV primary prevention.

D-1 Outcome Statement: By the end of 2013, three local SV and IPV programs will have institutionalized media advocacy strategies within their Communications Plan or their organization.

1. Action step: By mid 2010, the Consortium will identify resources to support the adoption of media advocacy strategies by local SV and IPV programs.
2. Action step: By end of 2010, the Consortium will promote and disseminate resources to local SV and IPV programs to encourage the adoption of media advocacy strategies. Refer to Communications Plan.
3. Action step: By end 2011, the Consortium will assist in providing technical assistance to local SV and IPV programs to encourage the adoption of media advocacy strategies.

Strategic Direction: Leveraging Resources for Maximizing Sustainability

A. Goal 1 (Prevention System Capacity): The goal is to leverage resources for maximizing sustainability of culturally competent, inclusive and appropriate SV and IPV primary prevention efforts in Ohio.

A-1. Outcome Statement: By the end of 2013, a unified concept for SV and IPV primary prevention will be articulated and broadly disseminated in Ohio.

1. Action Step: By mid 2009, and ongoing though 2013, encourage and support the formation of or inclusion in already existing community based coalitions, collaborative efforts, and coordinated community response teams of culturally competent, inclusive and appropriate SV and IPV primary prevention principles, concepts, and practices. This effort will be aligned with efforts of the Empowered Local Communities work group.
2. Action Step: By the end of 2009, conduct an assessment of existing resources in governmental agencies and other organizations directed toward primary prevention activities including SV and IPV primary prevention policies and procedures, advocacy efforts, and sources of funding.
3. Action Step: By mid-2010, the Consortium will develop and publish a list of endorsements of the state plan by its members and other statewide allied associations. Endorsers will be provided the opportunity to participate at the Consortium level and/or provided technical assistance about SV and IPV primary prevention. Refer to Communications Plan.
4. Action Step: By the end of 2011, develop mechanisms for linking SV and IPV primary prevention to other already existing state and local prevention efforts. These efforts will align collaboration between state government, non-profit SV and IPV primary prevention organizations, non-profit and for profit organizations, and the education sector in Ohio for effective use of primary prevention resources. This effort will be aligned with the Recommended Practices work group.
5. Action Step: By the end of 2012, create and implement an online service directory that will connect practitioners, educators, state agencies and governmental organizations, funding entities, non-profit, and for profit organizations interested in or practicing SV and IPV primary prevention. Disseminate culturally competent, inclusive, and appropriate recommended practices for those interested in implementing SV and IPV primary prevention. Refer to Communications Plan.

B. Goal 2 (Prevention System Capacity): the goal is to develop a public, representative of Ohio's diverse communities that is knowledgeable about and supportive of SV and IPV primary prevention efforts in Ohio.

B-1. Outcome: By the end of 2013, Ohio's diverse public has demonstrated an increase in knowledge and support for SV and IPV primary prevention.

1. Action Step: By the end of 2009, create an SV and IPV primary prevention Communications Plan that encompasses all the potential news releases, products, and services of the Plan* and that provides for culturally competent, inclusive, and appropriate communication. The communication plan will overarch all external communications mentioned throughout this plan.
2. Action Step: By the mid 2010, while keeping the selected population in the forefront, identify existing media campaigns and explore their efficacy and evidence base for possible adaptation by local communities in Ohio. Refer to Communications Plan.

3. Action Step: By mid-2011, explore and identify potential funding sources for a professionally developed statewide public education campaign for SV and IPV primary prevention that addresses the needs of Ohio's diverse communities. Refer to Communications Plan.
4. Action Step: By the end of 2013, implement a professionally developed statewide public education campaign for SV and IPV primary prevention. Refer to Communications Plan.
5. Action Step: By the end of 2013, establish evaluation indicators for the statewide public education campaign. Coordinate with other components of evaluation of the Plan.

C. Goal 3 (Prevention System Capacity): The goal is to create and maintain the necessary infrastructure and resources to ensure the process of implementation of the Plan, with attention to the needs of Ohio's diverse communities.

C-1. Outcome Statement: By 2013, the SV and IPV primary prevention Plan will be implemented on schedule and the infrastructure and resources for culturally competent, inclusive, and appropriate primary prevention in Ohio will be maintained beyond 2013.

1. Action Step: By mid-2009, create a Funding and Resource Development standing committee of the Consortium.
2. Action Step: By mid 2010, explore diversified funding for agencies primarily responsible for dissemination and implementation of the Plan and regularly report back to the Consortium about potential funding opportunities.
3. Action Step: By the end of 2010, create an action plan, if indicated, to address diversification of funding.
4. Action Step: From mid 2009 through 2013, the Consortium will support efforts to acquire adequate resources for adoption and institutionalization of SV and IPV primary prevention practices across Ohio's social ecology. This will be measured by an increase of state agencies and local communities that access funding or allocate resources for SV and IPV prevention between 2009 and 2013.
5. Action Step: From mid-2009 and ongoing through 2013, as appropriate for Consortium members and their respective agencies will engage in legislative education and advocacy to secure federal and state funding for SV and IPV primary prevention capacity building, planning, implementation, and evaluation at state and local levels, as well as securing funding for intervention and advocacy services in Ohio.

Strategic Direction: Integrated Strategic Evaluation and Data Collection

A Goal 1: (Prevention System Capacity): The goal is to create a centralized strategy for collecting inclusive statewide evaluation data on SV and IPV primary prevention efforts in Ohio.

A-1. Outcome Statement: By the beginning of 2013, the Consortium will create and distribute a directory of evaluation measures that have been assessed for cultural competency and accurate measurement of SV and IPV prevention outcomes. Refer to Communications Plan.

A-2. Outcome Statement: By mid-2013, Ohio local SV and IPV prevention efforts demonstrate increased capacity for using evidence based practices.

1. Action Step: By the end of 2009, the Consortium will compile a baseline, on-line directory of SV and IPV primary prevention efforts in Ohio. Refer to Communications Plan.
2. Action Step: By mid-2010, the directory of SV and IPV primary prevention efforts in Ohio will contain evaluation measures currently in use by those programs.
3. Action Step: By mid-2010, the Consortium will research and analyze existing evaluation measures in use by SV and IPV primary prevention programs nationwide, which have been assessed for cultural competence and accurate measurement of SV and IPV primary prevention outcomes.
4. Action Step: By mid-2010, the Consortium will identify gaps in the existing evaluation measures in use by SV and IPV primary prevention programs nationwide that have been assessed for cultural competence and accurate measurement of SV and IPV primary prevention outcomes.
5. Action Step: By the end of 2011, the directory of evaluation measures used by Ohio SV and IPV primary prevention efforts will be assessed for cultural competence and accurate measurement of SV and IPV primary prevention outcomes.
6. Action Step: By mid-2012, technical assistance and training will be made available to Ohio SV and IPV primary prevention efforts such that they increase their capacity for evaluation.

B Goal 2: (Prevention System Capacity): The goal is to create a centralized strategy for collecting statewide data on the incidence and prevalence of SV and IPV in Ohio.

B-1 Outcome Statement: By mid-2013, the Consortium will create a comprehensive tool for the collection of statewide data on the incidence and prevalence of SV and IPV in Ohio. Refer to Communications Plan.

1. Action Step: By the end of 2009, the Consortium will operationally define incidents and prevalence of SV and IPV for the purpose of data collection in Ohio.
2. Action Step: By the end of 2010, the Consortium will research and analyze existing SV and IPV data collection strategies and databases in use in Ohio and nationwide.
3. Action Step: By the end of 2012, the Consortium will develop state level mechanisms for the collection of SV and IPV incidence and prevalence data.

Strategic Direction: Empowered Local Communities:

A. Goal 1 (Prevention System Capacity): The goal is to establish a culturally competent, inclusive and appropriate program that generates awareness and recognition of the Plan

among state level youth serving social and community organizations and their local affiliates.

A-1 Outcome Statement: By the end of 2012, youth serving organizations at the state and local level have integrated SV and IPV culturally competent, inclusive and appropriate primary prevention messages.

A-2 Outcome Statement: By the end of 2012, through the distribution of a toolkit, a statewide kickoff event, and regional replication, communities across Ohio will access and utilize identified primary prevention messages through the following organizations which may include but are not limited to: 4H/Extension agencies, Boy Scouts, Girl Scouts, sports including both community sports and school based athletics, United Way, Family and Children First groups, YW/YMCAs, Boys/Girls clubs, Big Brothers/Big Sisters, church groups, Jewish groups, other religious associations, etc.

1. Action Step: By mid-2009, assess established relationships of Consortium members with youth serving state organizations that are potential partners in SV and IPV prevention work (network analysis).
2. Action Step: By the end of 2009, assess the needs of local SV and IPV groups – who are they already working with/want to work with, and determine how at the state level we can support their work.
3. Action Step: By the end of 2009, identify three to five statewide youth serving associations for whom the Consortium goals and objectives align.
4. Action Step: By the end of 2010, assess the needs of youth and of staff of youth serving associations for considerations to keep in mind as we identify and create an effective IPV and SV prevention toolkit
5. Action Step: By the end of 2010, engage three to five communities in the process of adopting and/or adapting the Consortium's goals and outcomes for their regions.
6. Action Step: By the end of 2010, mobilize participation of local representatives of the previously identified statewide youth serving organizations in three to five local regional planning efforts
7. Action Step: By the end of 2011, consider the SRG focus group report and the completed assessment from youth and staff who work with youth and review national IPV and SV toolkit components to identify considerations and resources to use in identification and creation of effective SV and IPV prevention toolkits.
8. Action Step: By mid-2012, create culturally appropriate and inclusive toolkits for IPV and SV prevention practice for youth serving organizations. These toolkits should be informed by the work on recommended practices for IPV and SV prevention (created as a separate part of this plan).
9. Action Step: By the end of 2012, 3 – 5 youth serving social and community organizations, representing as much as possible the diverse populations of Ohio, will work in conjunction with appropriate national efforts to implement a statewide kick-off event during which there will be a release of toolkit to participants.

10. Action Step: By the end of 2013, work with state, regional, and local groups to implement education and distribution of toolkits in specific communities.

B. Goal 2 (Universal Population): the goal is to engage youth and ensure their voices are reflected in the final toolkit and kickoff event.

B-1. Outcome Statement: By mid-2012, increase youth engagement as leaders and
role models in being actively intolerant of abuse and violence in their communities.

1. Action Step: Monitor implementation of Goal 1 to identify need to convene a youth advisory group to inform the creation of the toolkit and any other products or programs.
2. Action Step: As youth serving organization become engaged with our work, engage their youth as leaders and role models to inform the creation and final approval of the toolkit.
3. Action Step: Identify ways to support and enhance youth experiences as leaders in IPV and SV prevention work. (i.e. service learning credit, awards, networking opportunities).

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* "Plan" refers to the Pathways in Prevention: A Roadmap for Change, Ohio's Plan for Sexual and Intimate Partner Violence Prevention.

Appendix C: Timeline for Implementation of Plan Activities

Year I

January – June 2009	**July – December 2009 By end of…**
Pathways in Prevention: A Roadmap for Change, Ohio's Plan for Sexual and Intimate Partner Violence Prevention was being refined and delivered to the Centers for Disease Control during the first 6 months of 2009.	Effective Youth SV and IPV Prevention Recommended Practices: • Determine research approach(es) (same for all 4 goals). • Formulate research question(s) (same for all 4 goals). Integrated Intra-State Collaboration Actions: • The Consortium will identify a broad spectrum of professional associations/organizations (e.g. NASW, PCSAO, SPHE, Local Health Commissioners, Ohio Professional Licensing Boards, etc.) that are willing to integrate training on IPV and SV prevention within their professional development or educational opportunities and their annual meetings. Refer to Communications Plan. • The Consortium will identify who is involved in reviewing and analyzing existing and proposed public policy (ODVN, Health Policy Institute of Ohio (HPIO), state sexual assault coalition, others) and identify key issues on which they focus. Leveraging Resources for Maximizing Sustainability: • Ongoing through 2013, encourage and support the formation of or inclusion in already existing community based coalitions, collaborative efforts, and coordinated community response teams, IPV and SV primary prevention principles, concepts, and practices. These efforts will be aligned with efforts of the Empowered Local Communities work group. • Create a Funding and Resource Development standing committee of the Consortium. • Consortium will support efforts to acquire adequate resources for adoption and institutionalization SV and IPV primary prevention practices across Ohio's social ecology. This will be measured by an increase of state agencies and local communities that access funding or allocate resource for SV and IPV prevention between 2009 and 2013. • Ongoing through 2013, as appropriate for Consortium member agencies, engage in legislative education and advocacy to secure federal and state funding for SV and IPV primary prevention capacity building, planning, implementation, and evaluation at the state and local levels, as well as securing funding for intervention and advocacy services in Ohio. • Conduct an assessment of existing resources in governmental agencies and other organizations directed toward prevention activities including SV and IPV primary prevention policies and procedures, advocacy efforts, and sources of funding.

Year I (con't)

January – June 2009 By mid…	July – December 2009 By end of…
	Integrated Strategic Evaluation and Data Collection: • The Consortium will compile a baseline, on-line directory of SV and IPV primary prevention efforts in Ohio. Refer to Communications Plan. • Consortium will operationally define incidents and prevalence of SV and IPV for the purpose of data collection in Ohio. Empowered Local Communities: • Assess established relationships of Consortium members with youth serving state organizations that are potential partners in SV and IPV prevention work (network analysis). • Consider data from youth and staff who work with youth and review national IPV and SV models to identify considerations and resources to use in identification and creation of effective IPV and SV prevention models.

Year II:

<table>
<tr><th>January – June 2010
By mid…</th><th>July – December 2010
By end of…</th></tr>
<tr><td>Effective Youth SV and IPV Prevention Recommended Practices:
• Compile and analyze existing primary prevention recommended practices, and existing primary prevention practices for men and boys with hostility toward women, men and boys with hyper-masculinity, and men and boys with exposure to violence.

Integrated Intra-State Collaboration Actions:
• The Consortium will identify a broad spectrum of colleges and universities with relevant programs (Nursing, Allied Health Professions, Social Work Education, etc.) that are willing to integrate training on SV and IPV primary prevention within their educational opportunities.
• The Consortium will identify resources that support the adoption of SV and IPV (including sexual harassment) workplace policies at all levels of government and private sector employers.
• Information will be shared with Consortium members. Refer to Communications Plan.
• The Consortium will identify resources to support the adoption of media advocacy strategies by local SV and IPV programs.

Leveraging Resources for Maximizing Sustainability:
• Create an SV and IPV primary prevention Communications Plan that encompasses all the potential news releases, products, and services of the Plan* and that provides for culturally competent, inclusive and appropriate communication. The Communication Plan will overarch all external communications mentioned throughout this plan.
• Develop and publish a list of endorsements of the state plan by Consortium members and other statewide allied associations. Endorsers will be provided the opportunity to participate at the Consortium level and/or provided technical assistance about SV and IPV primary prevention. Refer to Communications Plan.
• While keeping the selected population in the forefront, identify existing media campaigns and explore their efficacy and evidence base for possible adaptation by local communities in Ohio. Refer to Communications Plan.</td><td>Effective Youth SV and IPV Prevention Recommended Practices:
• Create a draft of effective youth SV and IPV primary prevention recommended practices, and recommended practices for men and boys with hostility toward women, men and boys with hyper-masculinity, and men and boys with exposure to violence.

Integrated Intra-State Collaboration Actions:
• The Consortium will promote available national, state, and/or local resources that support the adoption of SV and IPV (including sexual harassment) workplace policies. Refer to Communications Plan.
• The Consortium will promote and disseminate resources to local SV and IPV prevention programs to encourage adoption of media advocacy strategies. Refer to Communications Plan.

Leveraging Resources for Maximizing Sustainability:
• Explore diversifying funding for agencies primarily responsible for dissemination and implementation of the Plan and regularly report back to the Consortium about potential funding opportunities. This may include partnering with men's and women's organizations.
• Create an action plan, if indicated to address diversification of funding.</td></tr>
</table>

Year II: (Con't)

January – June 2010 **By mid…**	**July – December 2010** **By end of…**
Integrated Strategic Evaluation and Data Collection: • Consortium will research and analyze existing evaluation measures in use by SV and IPV primary prevention programs nationwide, which have been assessed for cultural competence, inclusiveness and appropriateness and accurate measurement of SV and IPV primary prevention outcomes. Empowered Local Communities: • Assess the needs of local IPV and SV groups – who are they already working with/want to work with, and how can we at the state level support their work. • Identify three to five statewide youth serving associations for whom the Consortium goals and objectives align.	Integrated Strategic Evaluation and Data Collection: • The directory of SV and IPV primary prevention efforts in Ohio will contain evaluation measures currently in use by those programs. • Consortium will research and analyze existing SV and IPV data collection strategies and database in use in Ohio and nationwide. Empowered Local Communities: • Assess the needs of youth and of staff of youth serving association for considerations to keep in mind as we identify and create an effective SV and IPV prevention tool kit. • Engage three to five communities in the process of adopting and/or adapting the Consortium's goals and outcomes for their region. • Mobilize participation of local representatives of the previously identified statewide youth serving organizations in three to five local regional planning efforts.

Year III:

January – June 2011 By mid…	July – December 2011 By end of…
Effective Youth SV and IPV Prevention Recommended Practices: • Determine key informants representative of Ohio's diverse communities, who will review the draft of effective youth SV and IPV primary prevention recommended practices, and recommended practices for men and boys with hostility toward women, men and boys with hyper-masculinity, and men and boys with exposure to violence. Integrated Intra-State Collaboration Actions: • The Consortium will identify resources related to SV and IPV primary prevention for professional education. (See 1.as and 1.b.) • Representatives of the Consortium will identify an appropriate legislative event (i.e., breakfast, luncheon, other). Leveraging Resources for Maximizing Sustainability: • Explore and identify potential funding sources for a professionally developed statewide public education campaign for SV and IPV primary prevention that addresses the needs of Ohio's diverse communities. Refer to Communications Plan. Integrated Strategic Evaluation and Data Collection: o Empowered Local Communities: o	Effective Youth SV and IPV Prevention Recommended Practices: • Have key informants representative of Ohio's diverse communities, review the draft of effective youth SV and IPV primary prevention recommended practices, and recommended practices for men and boys with hostility toward women, men and boys with hyper-masculinity, and men and boys with exposure to violence. Integrated Intra-State Collaboration Actions: • Indentify multiple agencies that demonstrate readiness to champion such adoption of workplace policies. • The Consortium will assist in providing technical assistance to local SV and IPV programs to encourage the adoption of media advocacy strategies. Leveraging Resources for Maximizing Sustainability: • Develop mechanisms for linking SV and IPV primary prevention to other already existing state and local prevention efforts. These efforts will align collaboration between state government, non-profit SV and IPV prevention organizations, non-profit and for-profit organization, and the education sector in Ohio for the effective use of primary prevention resources. This effort will be aligned with the Recommended Practices work group. Integrated Strategic Evaluation and Data Collection: • The directory of evaluation measures used by Ohio SV and IPV primary prevention efforts will be assessed for cultural competence, inclusiveness and appropriateness and accurate measurement of SV and IPV primary prevention outcomes. Empowered Local Communities: • Consider the SRG focus group report and the completed assessment from youth and staff who work with youth and review national SV and IPV toolkit components to identify considerations and resources to use in identification and creation of effective SV and IPV prevention toolkits.

Year IV:

January – June 2012 By mid…	July – December 2012 By end of…
Effective Youth SV and IPV Prevention Recommended Practices: • Revise draft (of SV and IPV primary prevention recommended practices), as necessary. • Evaluate effective youth SV and IPV primary prevention recommended practices, and recommended practices for men and boys with hostility toward women, men and boys with hyper-masculinity, and men and boys with exposure to violence.	Effective Youth SV and IPV Prevention Recommended Practices: • Revise draft (of SV and IPV primary prevention recommended practices related to evaluation), as necessary.
Integrated Intra-State Collaboration Actions: • Representatives of the Consortium will collaborate on a joint legislative event with other key stakeholder organizations.	Integrated Intra-State Collaboration Actions: ○
Leveraging Resources for Maximizing Sustainability: •	Leveraging Resources for Maximizing Sustainability: • Create and implement an online service directory that will connect practitioners, educators, state agencies and governmental organizations, funding entities, non-profit, and for-profit organizations interested in or practicing SV and IPV primary prevention. Disseminate culturally competent, inclusive, and appropriate recommended practices for those interested in implementing SV and IPV primary prevention. Refer to Communications Plan.
Integrated Strategic Evaluation and Data Collection: • Technical assistance and training will be made available to Ohio SV and IPV primary prevention efforts such that they increase their capacity for evaluation.	Integrated Strategic Evaluation and Data Collection: • The Consortium will develop state level mechanisms for the collection of SV and IPV incidence and prevalence data.

Year IV (Con't)

January – June 2012 By mid…	July – December 2012 By end of…
Empowered Local Communities: • Create culturally appropriate and inclusive toolkits for IPV and SV prevention practice for youth serving organizations. These toolkits should be informed by the work on recommended practices for IPV and SV prevention (created as a separate part of this plan). • Create models for SV and IPV primary prevention practice for youth serving organizations. These models should be informed by the work on recommended practices for SV and IPV prevention (created as a separate part of this plan).	Empowered Local Communities: • Youth serving social and community organizations will work in conjunction with appropriate national efforts to implement a statewide kick-off event during which there will be a release of a toolkit to participants. • Three to five youth serving social and community organizations, representing as much as possible the diverse populations of Ohio, will work in conjunction with appropriate national efforts to implement a statewide kick-off event during which there will be a release of toolkit to participants.

Year V:

January – June 2013 **By mid…**	**July – December 2013** **By end of…**
Effective Youth SV and IPV Prevention Recommended Practices: • Create a dissemination plan for effective youth SV and IPV primary prevention recommended practices, and recommended practices for men and boys with hostility toward women, men and boys with hyper-masculinity, and men and boys with exposure to violence. • Create dissemination plan for annotated bibliography of curricula measured up against the recommended practices, and recommended practices for men and boys with hostility toward women, men and boys with hyper-masculinity, and men and boys with exposure to violence. Move to Over to July- December 2013	Effective Youth SV and IPV Prevention Recommended Practices: • Evaluate effectiveness of dissemination plan. Could possibly moved to 2014
Integrated Intra-State Collaboration Actions: • The Consortium will disseminate resources related to SV and IPV primary prevention for professional education to the identified organizations above (i. and ii.) • The Consortium will advertise availability of identified professional education resources. • Utilizing available Consortium resources, provide technical assistance on how agencies identified (2.b.i., above) might champion such adoption.	Integrated Intra-State Collaboration Actions:
Leveraging Resources for Maximizing Sustainability: ○	Leveraging Resources for Maximizing Sustainability: • Implement a professionally developed statewide public education campaign for SV and IPV primary prevention. Refer to Communications Plan. • Establish evaluation indicators for the statewide public education campaign. Coordinate with other components of evaluation of the plan.
Integrated Strategic Evaluation and Data Collection: ○	Integrated Strategic Evaluation and Data Collection:
Empowered Local Communities: Should there be something added here or should it be deleted? ○	Empowered Local Communities: • Work with state, regional, and local groups to implement education and distribution of toolkits in specific communities.

* "Plan" refers to the Pathways in Prevention: A Roadmap for Change, Ohio's Plan for Sexual and Intimate Partner Violence Prevention.

Appendix D: Community Profile

During the April, 2006 meeting of the full Consortium, members were asked to sign themselves up for two work groups. One work group was focused on developing vision and mission language for and the other work group was charged with guiding the process of developing a needs and resources assessment for the State of Ohio. Original members of the Needs and Resources Assessment work group included:

- Andie Barker, Ohio Resource Network
- Rebecca Cline, Ohio Domestic Violence Network
- Kathy Gagin, DELTA Project Coordinator for Tri-County Help Center
- Mike Gregory, Commission on African American Males
- Melissa Knopp, Supreme Court of Ohio
- Mack Sanders, Ohio Department of Drug and Alcohol Addiction Services
- Debra Seltzer, Ohio Department of Health
- Jewel Woods, Ohio Domestic Violence Network, Empowerment Evaluation Consultant

The work group met face to face and via teleconference a number of times and by November 2007, a Community Profile for the State of Ohio was adopted by the Consortium. Ohio's Community Profile provided the platform for a consensus building process during which five areas of accomplishment were identified as the Consortium's planning priority foci.

Community Profile: Assessment of Ohio's Population

Ohio consists of 40,948 square miles and it could be said that the State is more geographically diverse than its population. Ohio rests on the southern shore of Lake Erie where miles of beautiful sandy beaches can be found. In addition to the sandy beaches, there are remnants of a once booming steel and manufacturing industry that capitalized on Ohio's Lake Erie ports of entry (Cleveland, Lorain, Toledo, and Ashtabula). Ohio is also located on the western edge of the Appalachian Mountain Range. Twenty-nine of Ohio's 88 counties are distinguished by the U.S. government as Appalachian and much of its eastern/southeastern geography includes foothills, a coal-mining economy, and Appalachian culture. The central and western/northwestern topography of Ohio begins the Midwest breadbasket and is characterized by rolling plains of corn and soybean fields. Over half of Ohio's acreage is considered agricultural with most of the land in farms. Agriculture generated $4,662,233,000 in total cash receipts for Ohio's economy in 2000 (Ohio Department of Development, Office of Strategic Research, 2004).

Ohio ranks seventh in population among the 50 states with a total estimated population in 2007 of 11,466,919. Its population growth has been on a steady upward trend since

1800; with the exception of exponential growth that occurred between1880 – 1930 when population increased by nearly 3.5 million people in five decades, from 3,198,062 to 6,646,697. During the 1950's the State experienced another exponential growth spurt, adding over 1.8 million individuals in 10 years from 7,946,627 to 9,746,627. Since the 1960's Ohio's population growth has remained fairly steady although the increases in population from decade to decade have slowed significantly. For example, Ohio's population grew from 11,353,145 in 2000 to an estimated 11,501,181 in 2005, but then declined in 2007 to 11,466,919 in 2007. Population estimates indicate that while Ohio's growth will continue on the incline the days of exponential growth are over. Between 2005 and 2010 an increase of just over 165,673 is estimated according to the Ohio Department of Development, Office of Strategic Research, 2008, with another 149,314 between 2010 and 2015. (Table 5: Projected Population to 2030; Ohio County Indicators 2008; Ohio Department of Development; 06/08).

As other states outpace Ohio in population growth, Ohio is likely to lose its ranking as 7th among the 50 states. Should this occur, Ohio's non-profit and governmental agencies that compete for federal funding, will likely be competing for a smaller share of the available resources due to the decline in ranking and the manner in which federal funds are allocated by state population size. Table 1 below represents a comparison of the population demographics by race for the State of Ohio, comparing the 2000 U.S. Census figures with the estimates for 2007. As of 2007, the population is estimated to be predominantly White (85.0%) with 17.1% of the population estimated to be minority, of which 12.0% are African American.

Table 1: General Ohio Population: Race
NOTE: Minority Population Data Estimate is from 2006; Percentage based on 2006

Ohio Population of 11,478,006.

	2000 CENSUS		**2007 ESTIMATE**	
	Number	**Percent**	**Number**	**Percent**
Total Population	**11,353,140**	**100**	**11,466,917**	**100**
White	9,749,017	86.0%	9,730,889	85.0%
African-American	1,318,013	12.0%	1,377,629	12.0%
Native American	25,574	0.0%	28,083	0.0%
Asian	135,633	1.0%	180,588	2.0%
Pacific Islander	3,143	0.0%	3,915	0.0%
Hispanic or Latino	217,123	2.0%	283,755	2.0%
Two or More Races	121,760	1.0%	145,813	1.0%
Not Hispanic (may be of any race)	11,136,017	98.0%	11,183,162	98.0%
Total Minority Population	1,707,687	15.0%	1,963,685*	17.1%*

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2007 Statistics: Table 3: Annual Estimates of the Population by Sex, Race, and Hispanic Origin for Ohio: April 1, 2000 to July 1, 2007 (SC-EST2007-03-39); Ohio Department of Development, Office of Statistics and Research, 5/2008.

In addition, the median age of the state's population is 37.8 years (Appendix C, Table 3), and 24% of the population 25 years of age and over holds a bachelors degree or higher (Appendix C, Table 4). The median household income is $46,597 compared to the median household income for the U.S. of $50,740 (Appendix C, Table 5). And according to the 2007 estimates, more than 13.1% of the population lives in poverty (American Community Survey 1 Year Estimates for Ohio: 2007; US Census Bureau).

Appalachian Ohio:

As of 2009, thirty-two of Ohio's 88 counties were deemed Appalachian, just over one-third of all Ohio counties according to the U.S. Congress Appalachian Region Commission.. "In response to persistent poverty and economic despair, the Appalachian Regional Commission identified counties in thirteen states along the Appalachian Mountain Range that might benefit from federal aid." In Ohio, the counties of Adams, Ashtabula, Athens, Belmont, Brown, Carroll, Clermont, Columbiana, Coshocton, Gallia, Guernsey, Harrison, Highland, Hocking, Holmes, Jackson, Jefferson, Lawrence, Mahoning, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Trumbull, Tuscarawas, Vinton, and Washington are currently deemed Appalachian by the U.S. Congress upon recommendation of the Commission.

The purpose of the Commission and the designation "Appalachian" was to enhance economic development for an economically deprived region through federal legislative initiatives. Ohio's Appalachian Region spans from Northeast Ohio, Ashtabula County, and follows along the Ohio River to Clermont County in Southwest Ohio. The land mass consists of 14,227.7 square miles, not including Ashtabula, Mahoning and Trumbull counties, which is just over one-third of the state's entire land mass. (2007, Appalachian Regional Commission's website: http://www.arc.gov/index.do?nodeId=7).

Since 1880, Appalachian Ohio has experienced steady population growth and continues to grow although the growth rate appears to be declining. In 2000, the U.S. Census reported a total population of 1,455,313 in Appalachian Ohio. In 2007, the estimated population was 1,466,388 (2,021,424 with Ashtabula, Mahoning and Trumbull Counties included) and is projected to be 1,515,136 in 2010 (2,084,596 including Ashtabula, Mahoning and TrumbullCounties). Based on 2004 estimates from the Ohio Department of Development, Office of Strategic Research, Ohio's Appalachian population is predominantly White (or nearly 96% of the 1,396,320). African-Americans make up just over 2% of the population with other minorities making up the rest. Refer to Tables 7 and 8 in Appendix C for a detailed breakdown of the Ohio Appalachian region population by age and by educational attainment respectively.

On age markers, Ohio's Appalachian population is consistent with the broader population; median age of 35.7 compared to Ohio in general at 36.2 years. However, with regard to educational attainment, Appalachian Ohio compares with 17% of Ohioans in general who do not have a high school diploma and 36.1% who are high school graduates. However, when it comes to higher education the tables turn. Three percent more of Ohio's population have attended college, but have no degree and nearly twice as many of those 25 and over have achieved a bachelor's or master's degree in the state's general population in comparison to 18% of Appalachia Ohio. It could be said, based on these numbers that possible cultural barriers may exist that curtail the attainment of higher education and advanced degrees in Appalachian Ohio. It must be noted that Holmes County's large Amish population accounts for lower high school graduation rates, as it is a cultural norm to attend school only through 8th grade; those who have an associates degree, bachelor's degree or master's degree and reside in Holmes County is estimated at 12.2% (US Census Bureau, 2005-2007 American Community Survey).

In addition to lower educational attainment, Appalachian people earn a median household income that is $34,452, nearly $5,500 lower than the median income of Ohio which was estimated at $46,597 in 2007. The poverty rate is 13.9% compared to 13.1% for Ohio with an unemployment rate of 6.75, including Ashtabula, Mahoning and Trumbull Counties (6.77 without them) compared to 5.6% for the state in 2007.

Non-Appalachian Rural Ohio:

Four rural counties were included for the purpose of comparison for this profile. To qualify as a rural Ohio county, the county had to be located outside of Ohio's Appalachian Region as well as outside a Metropolitan Statistical Area (MSA). Metropolitan Statistical Areas are defined by the United States Office of Management and Budget and are assigned that status based on U.S. Census data. An MSA is defined by a "substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core (Ohio Department of Development, 2004)."

As of 2000, 15 MSAs exist in Ohio, some of which are outlying areas for population cores in contiguous states. Forty-eight of Ohio's 88 counties lie outside of an MSA. Of the 48 rural counties in Ohio, 4 were used to describe the "picture" of rural Ohio in addition to one rural DELTA county. The counties are: Clinton, Darke, Hardin, and Defiance.

The estimated 2007 populations for these four counties range from a high of 52,205 in Darke County to a low of 31,650 in Hardin County. Clinton and Defiance Counties had a 2007 estimated population of 43,071 and 38,543 respectively. Three of the counties are projected to increase in population from 2000 – 2030: Clinton, from 40,543 to 53,725; Defiance, from 39,500 to 40,182; and Hardin, from 31,945 to 32,830. Darke County is expected to decline from 53,509 to 52,711 with a slight estimated gain in 2015 and 2025. (Table 5: Projected Population to 2030; Ohio Department of Development; Ohio County Indicators July 2008).

Rural Ohio mirrors Appalachian Ohio in ethnic and racial characteristics with a predominately White population. According to Clinton County's White population, 95.8%, is the lowest percentage of White inhabitants in the rural counties and Holmes County has the highest of 98.8%. Of note is that a large part of Holmes County's White population is Amish. The median age from lowest to highest is Hardin (34.0), Clinton (36.3), Defiance (38.7), and Darke (39.5).

Median household income in order from lowest to highest is Hardin ($40,541), Darke ($45,072), Defiance ($45,645) and Clinton ($46,103. The median household income for all Ohio households is $46,296. (US Census Bureau, 2005-2007 American Community Survey)

Based on the 2005-2007 American Community Survey Estimates by the U.S. Census Bureau,16.8% of Hardin County's population was living below poverty level, which represents nearly 1 out of every 5 people and places Hardin County as the poorest in Ohio. In Clinton County, 13.2% of the population was living below poverty level; in Defiance County 11.1% of the population was estimated to be below poverty level followed by Darke County at 9.0%. Poverty levels appear to correspond to levels of household income. In counties where median household income is high, fewer people are living at poverty level and vice versa.

High school graduation rates, including equivalency, for those over 25 years of age range from a low in Clinton County of 45.6% (up from a previous 20.1%) to a high of 51.8% for Hardin and 51.1% for Defiance Counties. Darke County's rate was 46.9%, up from a previous 15.8%. (US Census Bureau, 2005-2007 American Community Survey).
From 2004 to 2007, Defiance and Hardin Counties experienced a 0.1% and a 0.4% increase in unemployment respectively in 2007 from 2004, while Clinton experienced a decrease of 0.5% from 2004 and Darke experienced a 0.5% decrease from 2004. Each of the rural Ohio counties profiled have experienced a decrease in unemployment from 2004 that averages 2.5% over the four year period from 2004-2007. These numbers reflect an increase of .4% higher than the 5.6% 2007 estimated unemployment rate for the State of

Ohio overall. (See Appendix C, Table 13: Five Year Unemployment Rate for Rural Comparison Counties.)

Amish Ohio

Holmes County and several other Ohio Counties not included in this profile are heavily populated by Amish people. The Amish live in a fairly closed community and do not participate in mainstream culture, attend local schools (they have their own schools that educate members through 8th grade), or typically vote on local or national issues. Amish Ohio is secluded much further than Appalachian Ohio in that members of Amish communities have their own newspapers and typically do not have access to mainstream media (television, radios, newspapers) although for business purposes many Amish use computers and cell phones outside of their homes. It could be conjectured that counties with large Amish populations like Holmes County have lower poverty and unemployment rates because a significant portion of the population exists outside the human service delivery system and accesses it only when absolutely necessary. As previously noted, these counties also have noticeably lower educational attainment.

Urban Ohio

Six of the Ohio counties that are included in Metropolitan Statistical Areas and are the core population centers, will be included in this profile. In order of population density the counties included are: Cuyahoga, Franklin, Hamilton, Montgomery, Summit, and Lucas Counties. Please refer to Tables 14-19 which represents selected statistics from each of the counties in urban Ohio.

According to the Ohio County Indicators July 2008 report for 2006, urban areas are where racial and ethnic diversity is represented in Ohio with all six urban counties having a significant percentage of minority populations. In Summit County, minorities make up 18% of the total 2006 population which represents the lowest percentage of minority representation among these counties. Cuyahoga County has the largest percentage of minorities in its 2006 population with 36%. Hamilton County is next largest with 30% followed by Franklin County (29%), Lucas County (26%) and Montgomery County (25%).

The population trend in Ohio's urban communities is downward. Except for Franklin County, the county in which the state capital is located, and Summit County, each urban county is experiencing significant population decline. Four of the six counties are projected to shrink in population by 2030. All but Lucas County has a higher percentage of those living below the poverty level as well (Appendix C, Table 20).

Educational attainment in Ohio's urban areas is on average higher than Ohio as a whole, higher than in rural areas, and much higher than in Appalachian Ohio. Residents who have a bachelor's degree or higher in Franklin County (35.30%) is more than 11.3 percentage points higher than Ohio (24.0%) in general. In comparison, other urban counties follow Franklin in regards to residents that have a bachelors degree or higher;

Hamilton at 32.16% is 8.16% higher, Cuyahoga at 27.80% is 3.8% higher, Summit at 28.90% is 4.9% higher and Montgomery at 25.40% is 1.4% higher. Only Lucas County at 23.40% is 0.6% lower than Ohio as a whole. In general, perhaps this is due to urban areas serving as magnets for those who have higher educational attainment because of more opportunities for employment. Specifically, in Franklin County, educational attainment is likely higher due to the nature of the state government being located within the county coupled with the location of the largest university in the state. The educational attainment data is presented in Appendix C, Table 22.

In summary, Ohio's declining population and therefore increasing likelihood of decreasing federal funding for social programs, coupled with increasing economic and educational disparities especially in rural and Appalachian Ohio, contributes to a profile of an Ohio that based solely on these data, is at risk for continued and perhaps increasing sexual and intimate partner violence perpetration and victimization. Linking these data to what is known about risk factors for perpetration of sexual and intimate partner violence on the relationship and community level (see discussion of Risk and Protective Factors, page 42) a dire picture of Ohio emerges that supports the Consortium's efforts to create a strategic plan that addresses primary prevention. While it is beyond the scope of this report to find solutions to all of Ohio's problems, maintaining high level collaboration among governmental agencies and state level institutions will likely impact how sexual and intimate partner violence are viewed and resourced. Today, linking Ohio's social and economic climate to the incidents and prevalence of sexual and intimate partner violence is a leap. An outcome of continued collaboration will be a strengthened system of prevention that bridges gaps in data systems and helps state efforts and local communities provide prevention services based on the best available evidence.

The tables below, 2 – 22, provide the specific demographics for the discussion above. The list of tables and their descriptions precede the data tables.

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Table 2: General Ohio Population: Race and Gender

Table 3: General Ohio Population: Age

Table 4: General Ohio Population: Educational Attainment

Table 5: General Ohio Population: Household Income Comparison 1999 to 2007

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Table 9: Ohio Rural Counties: Clinton County: Characteristics of Age

Table 10: Ohio Rural Counties: Darke County: Characteristics of Age

Table 11: Ohio Rural Counties: Defiance County: Characteristics of Age.

Table 12: Ohio Rural Counties: Hardin County: Characteristics of Age

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Table 14: County Race and Age Characteristics: Cuyahoga County

Table 15: County Race and Age Characteristics: Franklin County

Table 16: County Race and Age Characteristics: Hamilton County

Table 17: County Race and Age Characteristics: Lucas County

Table 18: County Race and Age Characteristics: Montgomery County

Table 19: County Race and Age Characteristics: Summit County

Table 20: Comparison of the Median Household Income, Percentage of Unemployed and Percentage of Persons living in Poverty for the Six Largest Ohio Counties

Table 21: Population Projections for Ohio's Six Largest Counties since the 2000 Census for years 2010 and 2030.

Table 22: Educational Attainment for Ohio's Six Largest Counties.

Table 2: General Ohio Population: Race and Gender

	Total	2000 Census Male	% Male	Female	% Female
Total Population	**11,353,140**	**5,512,262**	**48.6**	**5,840,878**	**51.4%**
White	9,749,017	4,748,463	86%	5,000,554	86%
African American	1,318,013	624,293	11%	693,720	12%
Native American	25,574	13,138	0%	12,436	0%
Asian	135,633	66,037	1%	69,596	1%
Pacific Islander	3,143	1,569	0%	1,574	0%
Hispanic or Latino	217,123	112,265	2%	104,858	2%
Two or More Races	121,760	58,762	1%	62,998	1%
Not Hispanic (may be of any race)	11,136,017	5,399,997	98%	5,736,020	98%

	Total	2007 Estimate Male	% Male	Female	% Female
Total Population	**11,466,917**	**5,591,161**	**49%**	**5,875,756**	**51%**
White	9,730,889	4,760,474	85%	4,970,415	85%
African American	1,377,629	654,291	12%	723,338	12%
Native American	28,083	14,448	0%	13,635	0%
Asian	180,588	89,183	2%	91,405	2%
Pacific Islander	3,915	1,976	0%	1,939	0%
Hispanic or Latino	283,755	147,607	3%	136,148	2%
Two or More Races	145,813	70,789	1%	75,024	1%
Not Hispanic (may be of any race)	11,183,162	5,443,554	97%	5,739,608	98%

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2007 Statistics: Table 3: Annual Estimates of the Population by Sex, Race, and Hispanic Origin for Ohio: April 1, 2000 to July 1, 2007 (SC-EST2007-03-39); Ohio Department of Development, Office of Statistics and Research, 5/2008.

Table 3: General Ohio Population: Age

	2000 Census	Percent	2007 Estimate	Percent
Total Population	**11,353,140**	**100**	**11,466,917**	**100**
Under 5 years	754,930	7%	736,416	6%
5 to 14 years	1,644,157	14%	1,516,581	13%
15 to 24 years	1,545,796	14%	1,573,926	14%
25 to 44 years	3,325,210	29%	3,052,646	27%
45 to 64 years	2,575,290	23%	3,042,263	27%
65 to 84 years	1,330,961	12%	1,323,262	12%
85+ years	176,796	2%	221,823	2%
Median Age	**36.2**		**37.9**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); 2007 Statistics: Annual Estimates of the Population by Sex and Five Year Age Groups for Ohio: April 1, 2000 to July 1, 2007; (SC-EST2007-02-39). Ohio Department of Development, Office of Statistics and Research, 5/2008.

Table 4: General Ohio Population: Educational Attainment

	2000	Percent	2007	Percent
Persons 25 years and over	**7,411,740**	**100.0%**	**7,627,615**	**100%**
No high school diploma	1,262,085	17.0%	987,542	13%
High school graduate/For 2007 include GED	2,674,551	36.1%	2,805,856	37%
Some college, no degree	1,471,964	19.90%	1,450,070	19%
Associate degree	439,608	5.90%	548,843	7%
Bachelor's degree	1,016,256	13.70%	1,161,216	15%
Master's degree or higher	547,276	7.40%	674,088	9%

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); 2007 Statistics: American Community Survey 1 Year Estimate (Factfinder.census.gov).

Table 5: General Ohio Population: Household Income Comparison 1999 to 2007
Note change in Income Spread for 2007.

1999	Total	Percent	2007 Estimate	Total	Percent
Total Households	**4,446,621**	**100.0%**	**Total Households**	**4,505,995**	**100.0%**
Less than $10,000	406,698	9.1%	Less than $10,000	372,482	8.30%
$10,000 to $19,999	571,868	12.9%	$10,000 to $14,999	277,936	6.20%
$20,000 to $29,999	609,368	13.7%	$15,000 to $24,999	520,632	11.60%
$30,000 to $39,999	577,653	13.0%	$25,000 to $34,999	522,769	11.60%
$40,000 to $49,999	494,751	11.1%	$35,000 to $49,999	696,419	15.50%
$50,000 to $59,999	426,570	9.6%	$50,000 to $74,999	892,851	19.80%
$60,000 to $74,999	478,753	10.8%			
$75,000 to $99,999	444,599	10.0%	$75,000 to $99,999	531,473	11.80%
$100,000 to $149,999	289,049	6.5%	$100,000 to $149,999	449,115	10.00%
$150,000 to $199,999	71,062	1.6%	$150,000 to $199,999	133,514	3.00%
$200,000 or more	76,250	1.7%	$200,000 or more	108,804	2.40%
Median Income:	**$40,956.00**		**Median Income:**	**$46,597.00**	
			Median Income for the United States based on 112,377,977 Households	**$50,740.00**	

Source: 1999 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source 2007 Statistics: American Community Survey 1 Year Estimate (Factfinder.census.gov).

Table 6: Ohio Family Status: Type of Household, Presence of Related Children under age 18; Non-family Households

1999	Number	Percent
Total Families	**3,007,207**	**100%**
Married couple, with related children	45,556	19.4%
Male householder, no wife present, with related children	16,044	6.8%
Female householder, no husband present, with related children	124,213	52.9%
Families with no related children	49,213	20.9%
2007	**Number**	**Percent**
Total Households	**4,505,995**	**100%**
Family households (families) with own children under 18 years	1,345,473	29.9%
Married couple family, with own children under 18 years	891,323	19.8%
Male householder, no wife present, with own children under 18 years	106,103	2.4%
Female householder, no husband present, with own children under 18 years	348,047	7.7%
Non-family households	1,543,692	34.3%
Householder living alone	1,304,363	28.9%
65 years and over	451,383	10.0%

Source: Ohio Department of Development, Office of Strategic Research, 2004; USCensus.gov.; Source; 2007 American Community Survey 1-Year Estimates; Social Characteristics in the United States 2007, factfinder.census.gov.

Table 7: Composite Age Characteristics for Ohio Appalachian Counties

Ohio Appalachian Counties
(Does not include Ashtabula, Mahoning and Trumbull Counties)

	2000 Census			2010* Estimate	
	Number	Percent		Number	Percent
Total Population	**1,455,313**	**100**	**Total Population**	**2,068,180**	**100**
Under 6 years	112,477	8.6%	Under 5 years	126,100	6.1%
6 - 17 years	253,979	16.5%	5 to 14 years	265,290	12.8%
18 to 24 years	137,899	11.7%	15 to 24 years	292,590	14.1%
25 to 44 years	412,647	33.5%	25 to 44 years	515,380	24.9%
45 to 64 years	339,452	20.0%	45 to 64 years	506,940	27.4%
65 and more	198,859	9.8%	65 to 84 years	260,650	12.6
			85+ years	41,17	2.1%
Median Age	**35.7**		**Median Age**		

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); 2005-2007 Statistics: American Community Survey 3 Year Estimate (Factfinder.census.gov).

Table 8: Ohio Appalachian: Educational Attainment

Note: This table represents only 27 Ohio Appalachian Counties. Harrison, Monroe, Morgan, Noble and Vinton were not included in the ACS 3-Year Survey as their populations were under 20,000 peoples.

	2000	Percent	2005-2007* (Includes GED)	Percent
Persons 25 years and over	**950,958**	**100%**	**1,317,882**	**100**
No high school diploma	207,783	21.8%	66,929	5.1%
High school graduate	415,752	43.7%	735,674	55.8%
Some college, no degree	157,353	16.5%	230,129	17.5%
Associate degree	52,922	5.6%	89,478	6.8%
Bachelor's degree	74,937	7.9%	126,840	9.6%
Master's degree or higher	42,211	4.4%	68,831	5.2%

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); 2005-2007 Statistics: American Community Survey 3 Year Estimate (Factfinder.census.gov).

Table 9: Ohio Rural Counties: Clinton County: Characteristics of Age.
NOTE: Difference in age spread for 2005-2007 Three Year Estimate.

Clinton County

Total Population	2000 Census		Total Population	2005 -2007 Three Year Estimate	
	40,543	100			
	Number	Percent	Population by Age	Number	Percent
Under 6	3,401	8.4%	Under 5 years	3,052	7.2
6 to 17 years	7,296	18.0%	5 to 14 years	5,913	13.9
18 to 24 years	4,126	10.2%	15 to 24 years	5,775	13.5
25 to 44 years	11,889	29.3%	25 to 44 years	10,089	28.3
45 to 64 years	8,918	22.0%	45 to 64 years	10,448	3.9
65 years or more	4,913	12.1%	65 to 84 years	4,564	10.7
			85+ years	844	2
Median Age:	**35.3**		**Median Age:**	**36.3**	

Source: 2000 Statistics: UScensus.gov; Source for 2005-2007 Three Year Estimate: American Community Survey 2005-2007 3Year Estimates; (Factfinder.census.gov).

Table 10: Ohio Rural Counties: Darke County: Characteristics of Age.
NOTE: Difference in age spread for 2005-2007 Three Year Estimate.

DARKE COUNTY

Total Population	2000 Census		Total Population	2005 -2007 Three Year Estimate	
	53,309	100		52,399	100
	Number	Percent	Population by Age	Number	Percent
Under 6	4,246	8.0%	Under 5 years	3,435	6.6%
6 to 17 years	9,724	18.2%	5 to 14 years	7,013	7.2%
18 to 24 years	4,133	7.8%	15 to 24 years	6,552	12.5%
25 to 44 years	14,655	27.5%	25 to 44 years	13,142	25.6%
45 to 64 years	12,434	23.3%	45 to 64 years	13,751	26.3%
65 years or more	8,117	15.2%	65 to 84 years	6,931	13.2%
			85+ years	1,305	2.5%
Median Age:	**37.4**		**Median Age:**	**39.5**	

Source: 2000 Statistics: UScensus.gov; Source for 2005-2007 Three Year Estimate: American Community Survey 2005-2007 3Year Estimates; (Factfinder.census.gov).

Table 11: Ohio Rural Counties: Defiance County: Characteristics of Age.
NOTE: Difference in age spread for 2005-2007 Three Year Estimate.

defiance County

Total Population	2000 Census		Total Population	2005 -2007 Three Year Estimate	
	39,500	100		38,607	100
	Number	Percent	Population by Age	Number	Percent
Under 6	3,167	8.0%	Under 5 years	2,617	6.8%
6 to 17 years	7,281	18.4%	5 to 14 years	5,044	13.1%
18 to 24 years	3,626	9.2%	15 to 24 years	5,080	13.1%
25 to 44 years	10,809	27.4%	25 to 44 years	10,036	26.0%
45 to 64 years	9,551	24.2%	45 to 64 years	10,477	27.1%
65 years or more	5,060	12.8%	65 to 84 years	4,841	12.5%
			85+ years	512	1.3%
Median Age:	**36.5**		**Median Age:**	**38.7**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2005-2007 Three Year Estimate: American Community Survey 2005-2007 3Year Estimates; (Factfinder.census.gov).

Table 12: Ohio Rural Counties: Hardin County: Characteristics of Age.
NOTE: Difference in age spread for 2005-2007 Three Year Estimate.

hardin County

Total Population	2000 Census		Total Population	2005 -2007 Three Year Estimate	
	39,500	100		31,695	100
	Number	Percent	Population by Age	Number	Percent
Under 6	2,574	8.1%	Under 5 years	2,057	6.5%
6 to 17 years	5,186	16.2%	5 to 14 years	3,949	12.4%
18 to 24 years	4,965	15.5%	15 to 24 years	6,265	19.8%
25 to 44 years	8,311	26.0%	25 to 44 years	7,846	24.8%
45 to 64 years	6,770	21.2%	45 to 64 years	7,503	23.7%
65 years or more	4,139	13.0%	65 to 84 years	3,506	11.1%
			85+ years	569	1.8%
Median Age:	**33.3**		**Median Age:**	**34**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2005-2007 Three Year Estimate: American Community Survey 2005-2007 3Year Estimates; (Factfinder.census.gov).

Table 13: Five Year Unemployment Rate for Rural Comparison Counties

Percent of unemployment of civilian labor force	2004	2005	2006	2007
State of Ohio	**6.1**	**5.9**	**5.4**	**5.6**
Clinton	6.0	5.4	4.8	4.8
Darke	6.0	5.8	5.7	5.7
Defiance	6.2	6.0	5.6	5.7
Hardin	6.2	5.9	5.6	6.0

Source: Ohio County Indicators: Table 29: Annual Civilian Labor Force and Unemployment Rates Estimates, 2002 -2007; Ohio Department of Development, Office of Strategic Research; July 2008. Development.ohio.gov.

Table 14: County Race and Age Characteristics: Cuyahoga County
NOTE: Difference in age spread for 2007 Year Estimate.

cUYAHOGA COUNTY: By Race

	2000 Census			2007 Estimate	
	Number	**Percent**		**Number**	**Percent**
Total Population:	**1,393,978**	**100.0%**	**Total Population**	**1,295,.958**	**100**
White	939,658	67.4%	White	866,818	66.8%
African American	380,189	27.3%	African American	385,234	29.7%
Native American	2,429	0.20%	Native American	7,780	0.0%
Asian	25,831	1.9%	Asian	34,015	2.6%
Pacific Islander	306	0.0%	Pacific Islander	975	0.0%
Hispanic or Latino	21,185	1.5%	Hispanic or Latino	52,960	4.0%
Two or More Races	24,380	1.7%	Two or More Races	15,208	1.1%
Hispanic (may be of any race)	46,484	3.3%	Hispanic (may be of any race)	31,164	3.3%

CUYAHOGA COUNTY: BY AGE

	2000 Census			2007 Estimate	
	Number	**Percent**		**Number**	**Percent**
Total Population	**1,393,978**	**100.0%**	**Total Population**	**1,295,.958**	**100**
Under 6 years	109,978	7.8%	Under 5 years	80,284	6.2%
6 - 17 years	238,028	17.1%	5 to 14 years	168,878	13.0%
18 to 24 years	110,451	7.9%	15 to 24 years	166,759	12.8%
25 to 44 years	410,675	29.5%	25 to 44 years	325,119	25.10%
45 to 64 years	308,296	22.1%	45 to 64 years	359,135	27.7%
65 and more	217,177	15.6%	65 to 84 years	134,864	12.7%
			85+ years	30,919	2.4%
Median Age:	**37**		**Median Age:**	**40.1**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2007 1-Year Estimate: American Community Survey 2007 Year Estimates; (Factfinder.census.gov).

Table 15: County Race and Age Characteristics: Franklin County
NOTE: Difference in age spread for 2007 Year Estimate.

franklin COUNTY: By Race					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population:	**1,068,978**	**100.0%**	**Total Population**	**1,118,107**	**100**
White	807,104	75.5%	White	837,032	74.8%
African American	188,318	17.6%	African American	231,509	20.7%
Native American	3,552	0.3%	Native American	7,385	0.6%
Asian	32,912	3.1%	Asian	49,412	4.4%
Pacific Islander	362	0.0%	Pacific Islander	355	0.0%
Hispanic or Latino	9,909	.09%	Hispanic or Latino	41,125	3.6%
Two or More Races	26,821	2.5%	Two or More Races	20,802	1.8%
Hispanic (may be of any race)	24,121	2.3%	Hispanic (may be of any race)	27,869	0.2%

FRANKLIN COUNTY: BY AGE					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population	**1,068,978**	**100**	**Total Population**	**1,295,.958**	**100**
Under 6 years	91,743	8.6%	Under 5 years	85,261	7.6%
6 - 17 years	176,113	16.5%	5 to 14 years	154,098	13.7%
18 to 24 years	124,804	11.7%	15 to 24 years	162,405	14.5%
25 to 44 years	357,916	33.5%	25 to 44 years	341,837	30.6%
45 to 64 years	214,118	20.0%	45 to 64 years	266,009	23.7%
65 and more	104,284	9.8%	65 to 84 years	96,108	8.6%
			85+ years	12,389	1.1%
Median Age:	**32.5**		**Median Age:**	**34.5**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2007 1-Year Estimate: American Community Survey 2007 Estimates; (Factfinder.census.gov).

Table 16: County Race and Age Characteristics: Hamilton County
NOTE: Difference in age spread for 2007 Year Estimate.

HAMILTON COUNTY: By Race					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population:	**845,303**	**100.0%**	**Total Population**	**842,369**	**100**
White	616,624	72.9%	White	611,017	72.5%
African American	197,718	23.4%	African American	215,781	25.6%
Native American	1,710	0.2%	Native American	4,336	0.5%
Asian	12,652	1.5%	Asian	18,080	2.1%
Pacific Islander	245	0.0%	Pacific Islander	0	0.0%
Hispanic or Latino	4,667	0.6%	Hispanic or Latino	14,505	0.9%
Two or More Races	11,687	1.4%	Two or More Races	12,804	1.5%
Hispanic (may be of any race)	9,143	1.1%	Hispanic (may be of any race)	12,954	1.6%

HAMILTON COUNTY: BY AGE					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population	**845,303**	**100.0%**	**Total Population**	**1,295,.958**	**100**
Under 6 years	68,237	8.1%	Under 5 years	56,527	6.70%
6 - 17 years	149,904	17.7%	5 to 14 years	111,336	13.20%
18 to 24 years	81,114	9.6%	15 to 24 years	120,590	14.30%
25 to 44 years	251,146	29.7%	25 to 44 years	216,099	25.60%
45 to 64 years	180,887	21.4%	45 to 64 years	224,272	26.70%
65 and more	114,015	13.5%	65 to 84 years	94,956	11.30%
			85+ years	18,589	2.2%
Median Age:	**35.5**		**Median Age:**	**38.0**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2005-2007 Three Year Estimate: American Community Survey 2007 Estimates; (Factfinder.census.gov).

Table 17: County Race and Age Characteristics: Lucas County

NOTE: Difference in age spread for 2007 Year Estimate.

Lucas COUNTY: By Race

	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population:	**455,054**	**100.0%**	**Total Population**	**441,910**	**100**
White	352,261	77.4%	White	347,625	78.7%
African American	76,721	16.9%	African American	84,767	19.2%
Native American	1,296	0.3%	Native American	4,756	1.1%
Asian	5,326	1.2%	Asian	7,621	1.7%
Pacific Islander	76	0.0	Pacific Islander	657	0.1%
Hispanic or Latino	8,167	1.8	Hispanic or Latino	23,167	5.2%
Two or More Races	1,1207	2.5	Two or More Races	10,426	2.4%
Hispanic (may be of any race)	20,658	4.5	Hispanic (may be of any race)	13,913	3.1%

LUCAS COUNTY: BY AGE

	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population	**455,054**	**100.0%**	**Total Population**	**1,295,.958**	**100**
Under 6 years	37,712	8.3%	Under 5 years	30,463	6.9%
6 - 17 years	81,579	17.9%	5 to 14 years	60,430	13.6%
18 to 24 years	4,4471	9.8%	15 to 24 years	65,605	14.80%
25 to 44 years	133,402	29.3%	25 to 44 years	114,545	25.90%
45 to 64 years	9,7886	21.5%	45 to 64 years	115,148	26.10%
65 and more	59,734	13.1%	65 to 84 years	47,217	10.7%
			85+ years	8,592	1.9%
Median Age:	**35**		**Median Age:**	**36.7**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2007 1- Year Estimate: American Community Survey 2007 Estimates; (Factfinder.census.gov).

Table 18: County Race and Age Characteristics: Montgomery County
NOTE: Difference in age spread for 2007 Year Estimate

Montgomery COUNTY: By Race					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population:	**559,062**	**100**	**Total Population**	**538,104**	**100**
White	427,862	76.5%	White	412,604	76.7%
African American	111,188	19.9%	African American	113,963	21.2%
Native American	1,329	0.2%	Native American	4,338	0.8%
Asian	7,190	1.3%	Asian	9,759	1.8%
Pacific Islander	259	0.0%	Pacific Islander	214	0.0%
Hispanic or Latino	2,186	0.4%	Hispanic or Latino	9,550	1.0%
Two or More Races	9,048	1.6%	Two or More Races	8,518	1.6%
Hispanic (may be of any race)	6,413	1.1%	Hispanic (may be of any race)	9,100	1.7%

MONTGOMERY COUNTY: BY AGE					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population	**559,062**	**100**	**Total Population**	**538,104**	**100**
Under 6 years	44,533	8.0%	Under 5 years	34,705	6.4%
6 - 17 years	83,185	16.7%	5 to 14 years	69,855	13.0%
18 to 24 years	54,245	9.7%	15 to 24 years	73,657	13.70%
25 to 44 years	162,977	29.2%	25 to 44 years	138,772	25.70%
45 to 64 years	127,336	22.8%	45 to 64 years	142,266	26.40%
65 and more	76,786	13.7%	65 to 84 years	67,798	12.60%
			85+ years	11,051	2.10%
Median Age:	**36.4**		**Median Age:**	**38.8**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2007 1- Year Estimate: American Community Survey 2007 Estimates; (Factfinder.census.gov).

Table 19: County Race and Age Characteristics: Summit County
NOTE: Difference in age spread for 2007 Year Estimate

summit COUNTY: By Race					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population:	**542899**	**100.0**	**Total Population**	**543,487**	**100**
White	452810	83.4%	White	452,586	83.3%
African American	71120	13.1%	African American	80,538	14.8%
Native American	1184	0.2%	Native American	3,636	0.7%
Asian	7735	1.4%	Asian	11,513	2.1%
Pacific Islander	144	0.0%	Pacific Islander	0	0.0%
Hispanic or Latino	1777	0.3%	Hispanic or Latino	6,403	0.7%
Two or More Races	8129	1.5%	Two or More Races	5,938	1.1%
Hispanic (may be of any race)	4491	.08%	Hispanic (may be of any race)	4,143	0.8%

SUMMIT COUNTY: BY AGE					
	2000 Census			2007 Estimate	
	Number	Percent		Number	Percent
Total Population	**542899**	**100**	**Total Population**	**543487**	**100**
Under 6 years	43099	7.9%	Under 5 years	33000	6.1%
6 - 17 years	92902	17.1%	5 to 14 years	72518	13.4%
18 to 24 years	44253	8.2%	15 to 24 years	70653	13.0%
25 to 44 years	161502	29.7%	25 to 44 years	141707	26.0%
45 to 64 years	124398	22.9%	45 to 64 years	149782	27.50%
65 and more	76745	14.1%	65 to 84 years	65684	12.0%
			85+ years	10143	1.90%
Median Age:			**Median Age:**	**39.0**	

Source: 2000 Statistics: Ohio Department of Development, Office of Strategic Research, 2004; (USCensus.gov); Source for 2007 1- Year Estimate: American Community Survey 2007 Estimates; (Factfinder.census.gov).

Table 20: Comparison of the Median Household Income, Percentage of Unemployed and Percentage of Persons living in Poverty for the Six Largest Ohio Counties

County	Median Household Income		% of Unemployed			% of Persons Living in Poverty	
	2000	2007	2000	2004	2007	2000	2007
Cuyahoga	$39,168.00	$44,358.00	4.0%	6.2%	6.1%	13.1%	15.5%
Franklin	$42,734.00	$47900.00	3.2%	5.4%	4.7%	11.7%	16.3%
Hamilton	$40,964.00	$48416.00	3.7%	5.6%	5.0%	11.8%	12.8%
Montgomery	$40,156.00	$43939.00	4%	6.5%	6.2%	11.3%	14.8%
Summit	$42,304.00	$47333.00	4.2%	6.1%	5.4%	9.9%	14.1%
Lucas	$38,004.00	$44704.00	4.5%	7.4%	6.7%	13.9%	16.7%

Source: Ohio Department of Development, Office of Strategic Research, 2004; Table 29: Annual Civilian labor Force and Unemployment Rate Estimates, 2002-2007; USCensus.gov.; ACS Economic Characteristics: 2007; American Community Survey; factfinder.census.gov.

Table 21: Population Projections for Ohio's Six Largest Counties since the 2000 Census for years 2010 and 2030.

	Census 2000	Projected 2010	Increase or Decrease	Projection 2030
State of Ohio	**11,353,145**	**11,666,854**	(+) **313,709**	**12,317,613**
Cuyahoga	1,393,845	1,332,544	(-) 61,301	1,274,016
Franklin	1,068,978	1,155,911	(+) 86,933	1,326,184
Hamilton	845,303	807,562	(-) 37,741	730,571
Lucas	455,054	444,873	(-) 10,181	417,873
Montgomery	559,062	540,418	(-) 18,644	524,062
Summit	542,899	557,659	(+) 14,760	564,212

Source: Ohio County Indicators: Table 5: Projected Population to 2030; Ohio Department of Development, Office of Strategic Research; July 2008. Development.ohio.gov

Table 22: Educational Attainment for Ohio's Six Largest Counties

2000												
	CUYAHOGA		FRANKLIN		HAMILTON		LUCAS		MONTGOMERY		SUMMIT	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Persons 25 years and over	**936,148**	**100.0%**	**676,318**	**100**	**546,048**	**100**	**291,022**	**100**	**376,099**	**100**	**362,645**	**100**
No high school diploma	171,962	18.4%	96,422	14.3%	94,207	17.3%	49,699	17.1%	60,595	16.5%	51,876	14.3%
High school graduate	281,264	30.0%	183,287	27.1%	151,759	27.8%	94,008	32.3%	111,685	30.4%	121,705	33.6%
Some college, no degree	198,044	21.2%	143,897	21.3%	106,901	19.6%	64,245	22.1%	84,136	22.9%	78,808	21.7%
Associate Degree	49,465	5.3%	37,532	5.5%	33,969	6.2%	21,200	7.3%	26,865	7.3%	19,160	5.3%
Bachelor's Degree	145,980	15.6%	143,053	21.2%	101,046	18.5%	40,243	13.8%	52,685	14.4%	60,675	16.7%
Master's Degree or higher	89,433	9.6%	72,127	10.7%	58,166	10.7%	21,627	7.4%	31,133	8.5%	30,421	8.4%
2007												
	CUYAHOGA		FRANKLIN		HAMILTON		LUCAS		MONTGOMERY		SUMMIT	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Persons 25 years and over	**880,037**	**100**	**716,343**	**100**	**553,916**	**100**	**285,502**	**100**	**359,887**	**100**	**367,316**	**100**
No high school diploma	126,932	14.4%	83,508	11.6%	72,442	13.1%	37,724	13.2%	45,078	12.6%	37,034	10.0%
High school graduate (includes equivalency)	277,057	31.5%	198,282	27.7%	166,537	30.1%	91,671	32.1%	113,174	31.4	129,998	35.4%
Some college, no degree	169,937	19.3%	135,449	18.9%	99,519	18.0%	64,264	22.5%	82,235	22.9%	69,038	18.8%
Associate Degree	61,212	7.0%	45,929	6.4%	37,213	6.7%	25,127	8.8%	28,109	7.8%	24,905	6.8%
Bachelor's Degree	143,330	16.3%	163,557	22.8%	111,499	20.1%	43,263	15.2%	57,494	16.0%	68,379	18.6%
Master's Degree or higher	101,569	11.5	89,618	12.5%	66,706	12.0	23,453	8.2%	33,797	9.4%	37,962	10.3%

Source: Ohio Department of Development, Office of Strategic Research, 2004; Source: Social Characteristics in the United States, 2007; American Community Survey 1 Year Estimates; factfinder.census.gov.

Appendix E: Meeting results

Sexual Violence Prevention Community Collaboration Meeting
State Library of Ohio
February 22, 2007; 10 AM – noon

What are the issues/concerns we need to pay attention to with regard to the Domestic and Sexual Violence Communities working together to create a strategic plan for primary prevention in Ohio?

Issues of definition	Issues of privilege and oppression	Issues of history, philosophy and trust	Issues of operation and prioritization of resource distribution.	Issues of collaboration, education, and action	Issues of inclusiveness
Violence is Violence: DV + SV = Violence	DV & SV both are issues of societal and individual oppression.	SA will be pushed farther into a dark corner	Economics of scale	Ensure non-family sexual violence is addressed.	Men in the movement
Violence is Violence	Ensure male victims feel included	DV overshadowing SV	Funding for consortium efforts	Collaboration/Education vs "Words"	Youth needed
Power & control gender rarely the issue		Trust/turf issues between SV & DV	Resources for men empowerment redirect to women	Prevention education is different.	Relationship between local and state
Violence – Risk to all individuals should be addressed (men, women, children, elderly)		SV statewide coalition lost – SV voice?	Resources	Focus on strength based intervention. Developing skills in individuals and families	Diversified communities in Ohio
		Goals to end IPV and SV may be different	Timeline	Protection laws are different.	Planning lacks under representation of special populations: Wm of Color, Men of Color, Appalachian, etc.
		Is there a philosophical difference?	Be clear about vision and mission	Primary prevention without victim blame	
		Consensus on perception of DV/SV. Who? How?	Prioritization of needs	Education can be broader and more consistent	
		Territory (Don't do/take mine!)	Coordination of activities	Consensus – evidence based strategies for DV/SV prevention	

Issues of definition	Issues of privilege and oppression	Issues of history, philosophy and trust	Issues of operation and prioritization of resource distribution.	Issues of collaboration, education, and action	Issues of inclusiveness
		Equal time for both DV & SV? Goals SV and DV are equally important issues – one should not trump the others	More accountability/less duplication Alignment/facilitation of local needs assessment Benefit – increased voice for both SA and DV Who's collecting data? How will it be combined? More efficient, better use of resources, less duplication	Difference in media representation	

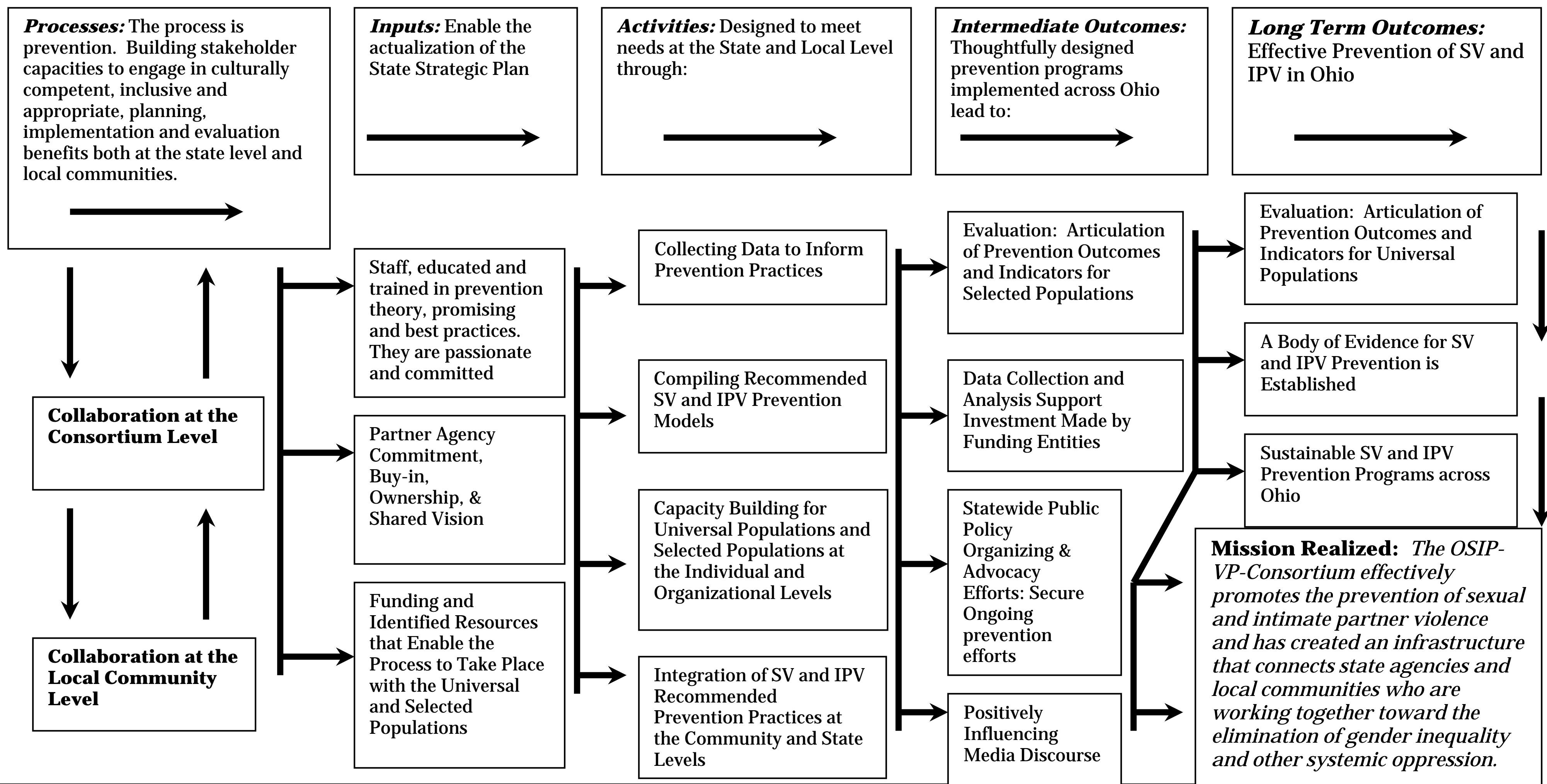
Follow up questions:
What has become clear (issues/concerns)?

- **The consensus decision is to collaborate with the DV community for strategic planning purposes.**
- **We need to make a conscious effort not to push the SV community aside; the SV community needs to be reassured that they will not be overshadowed.**

What decisions still need to be made?

- **Who from the SA task force will be involved in the OIPVPC?**

Appendix F: Building Ohio's Capacity to Prevent SV and IPV Through Statewide Planning, Implementation, and Evaluation
The Ohio Sexual and Intimate Partner Violence Prevention Consortium Logic Model
(Created on June 23, 2008 for efforts implemented through 2013, version 6)



Considerations for Cultural Competence: The Plan challenges and raises consciousness of flawed social norms to achieve our vision of social justice and human rights. We recognize that achieving cultural competence, inclusiveness and appropriateness requires our collective desire and effort to be open, accepting and respectful of Ohio's diversity and mindful of its constant evolving nature.

Contextual Considerations:

- Collaboration is supported by technical assistance and training the infuses primary
- Social norms of Ohio are accepting and tolerant of SV and IPV and other forms of oppression
- Collaboration changes as resources get tighter
- Collaboration changes as the political landscape changes
- Implementation of the state SV and IPV Primary Prevention Strategic Plan depends upon federal funding opportunities

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Appendix G:

Empowerment Evaluation Guiding Principles

Principle	Description
Improvement	Tools help programs, organizations, and communities plan, implement, and self-evaluate programs so that they are more likely to achieve results.
Community Ownership	The program, organization, community, or coalition has control over the evaluation process. The ultimate authority and responsibility for conducting the evaluation lies with the stakeholders.
Inclusion	Direct participation of all key stakeholders is valued. A stakeholder is anyone who has an investment in a particular program or strategy including those who develop and implement, those who participate, those who fund programs, and community members.
Democratic Participation	A collaborative process facilitates opportunities for stakeholders to voice their questions, and concerns. Each voice is valued, heard and represented.
Social Justice	Making a difference with an eye toward the larger social good. The potential impact of a program is positive, ethical and designed to help address social inequities whenever possible or feasible.
Evidence-based Practice	Evidence-based strategies are strategies that have been shown to work either through research studies or by programs that have been evaluated. Evidence-based strategies should be adapted (with care) to fit each state and local context.
Community Knowledge	Community-based knowledge and wisdom are valued, promoted, and embraced. Community members are in the best position to understand problems in their communities and to generate solutions to those problems.
Capacity Building	Stakeholders learn the basic steps and skills involved in conducting program evaluation and use results for program improvement. The capacities developed are used in many other settings and programs in the future.
Organizational Learning	A culture of learning is fostered within the program, organizations, communities, and coalitions that participate. A community of practice emerges.
Accountability	Process and outcome objectives are established to determine whether the program or strategy achieved its goals. Positive and negative results are seen as valuable and inform program improvement to produce better outcomes.

Appendix H: MOU Between ODH and ODVN