# Oregon Violence Against Women *Prevention Plan*

*Oregon Department of Human Services*
*Office of Disease Prevention and Epidemiology*

*For more information or to receive this report in an alternate format, please contact:*

DHS
Oregon Department of Human Services
Office of Disease Prevention and Epidemiology
Injury Prevention and Epidemiology Section
Intimate Partner Violence (IPV) Surveillance Project
800 NE Oregon Street, Suite 772
Portland, OR 97232

Phone : (971) 673-1111

Website : http://egov.oregon.gov/DHS/ph/ipv/

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# *Acknowledgments*


## *Literature Review and Technical Writing*

Marcia Hall, PhD, RN

## *Department of Human Services Injury Prevention and Epidemiology Staff*

Melvin Kohn, MD, MPH, Office of Disease Prevention and Epidemiology Administrator, State Epidemiologist

Lisa Millet, Injury Prevention and Epidemiology Section Manager

LeAnn Mederios, Intimate Partner Violence Surveillance Project Manager

Linda Drach, Intimate Partner Violence Surveillance Project Epidemiologist

## *Violence Against Women Prevention Plan Advisory Work Group*

Phyllis Barkhurst, Attorney General's Task Force on Sexual Assault

Nancy Glass, Oregon Health & Science University, School of Nursing

Carol Krager, Oregon Department of Human Services, Children, Adults and Families

Julie McFarlane, Oregon Department of Human Service, Office of Women's Health

Carmen Merlo, Oregon State Police, Criminal Justice Services

Cynthia Stinson, Oregon Department of Justice, Crime Victim's Assistance

Elaine Walters, Attorney General's Task Force on Sexual Assault

Denise Washington, Oregon Coalition Against Sexual and Domestic Violence

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## *Consultants*

Terry Anderson

Marlene Farnum

Stephanie House

Kay Sohl

# Oregon Violence Against Women *Prevention Plan*

## *Executive Summary*

Violence against women (VAW) is a serious public health problem in Oregon. In a survey of Oregon women age 20-55, nearly one-third (31%) reported that they had experienced one or more types of violent victimization — including threats of violence, physical assaults, sexual assaults, or stalking — during the five years preceding the survey.[1] One in ten women reported experiencing intimate partner violence (IPV) in the five-year period, and 13% said they had been stalked.[2] Two-thirds of the stalkers were former or current intimate partners.[3] These data indicate that in a span of 5 years, more than 85,500 Oregon women experienced IPV and 111,000 Oregon women were stalked. Data from a national survey reveal that one in six adult women in Oregon (about 230,000) has been the victim of forcible rape in her lifetime.[4] These estimates of the incidence and prevalence of VAW are conservative and likely represent just the tip of the iceberg. The problem of VAW is epidemic, with far-reaching health, social, and economic consequences.

In Oregon, grassroots efforts have resulted in the development of essential, life-saving interventions to alleviate the trauma associated with VAW and to hold offenders accountable for their actions. Battered women's shelters, support groups, crisis hotlines, criminal justice responses, and batterer treatment programs have made substantial progress in addressing VAW. Still, the rates of violence experienced by women and girls remain high. In order to eliminate VAW, energy must be focused on preventing the violence from ever occurring. The development of a statewide VAW prevention plan represents a new direction in efforts to address VAW – an emphasis on primary prevention, stopping VAW before it occurs.

The goals, strategies, and activities outlined in this plan are derived from three sources: multiple stakeholders involved in diverse work in the field of VAW in Oregon, research literature related to the prevention of VAW, and existing evidence-based prevention approaches identified by the Centers for Disease Control and Prevention and the World Health Organization.

# *Executive Summary*

The six major goals identified in the VAW Prevention Plan provide a structure for implementing a range of interventions that together create a comprehensive approach to preventing VAW in Oregon. No single prevention strategy can end VAW when implemented in isolation. The prevention goals focus activities at the societal, institutional, community, relationship, and individual levels. Strategies include working to reduce individual risk factors for victimization and perpetration, increase relationship skills for adolescents, build community capacity, and change institutional and social norms to prevent VAW.

## The six key goals identified in Oregon's VAW Prevention Plan are:

Goal 1: Identify and act to change societal factors that condone, perpetuate, or mediate VAW.

Goal 2: Increase institutional/sector capacity to prevent VAW.

Goal 3: Increase community capacity to prevent VAW.

Goal 4: Promote healthy non-violent relationships.

Goal 5: Increase the individual safety of girls and women in relationships and social environments.

Goal 6: Promote public health surveillance and epidemiology, program evaluation, and research

## Audience

The audience for the VAW prevention plan includes and reaches beyond the organizations currently working on VAW prevention and intervention efforts. Preventing VAW requires engaging the entire community, creating new partnerships, and coordinating efforts across multiple disciplines and sectors throughout the State. Everyone has a role to play in preventing VAW. Our hope is that this plan not only establishes a course of action, but also enables us to achieve a shared vision for VAW prevention in Oregon.

# *Table of Contents*

# Introduction

**Primary, secondary and tertiary prevention**

Public health interventions to prevent violence are typically characterized in terms of three levels of prevention:

- Primary prevention – Preventing violence before it occurs.
- Secondary prevention – Immediate responses to violence such as emergency or crisis services to minimize adverse consequences (e.g. STDs, acute trauma, additional violence).
- Tertiary prevention – Long-term care to ease trauma and reduce the lasting impact of violence.

**VAW Definition**

The working definition of VAW in this document is: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." Declaration on the Elimination of Violence against Women, United Nations General Assembly, December 1993.

VAW includes intimate partner violence (IPV), sexual violence* by any perpetrator, and other forms of VAW (e.g., physical violence committed by acquaintances or strangers).[17]

* The statewide plan, Recommendations to Prevent Sexual Violence in Oregon; A Plan of Action provides guidance about preventing sexual violence in Oregon. For a copy of this plan, please contact Jessica Duke in the DHS Office of Family Health, jessica.duke@state.or.us.

Violence against women (VAW) is a serious public health problem affecting as many as one in three women in the world today.[5] Globally, the health burden from VAW is comparable to that of major illnesses such as HIV infection, tuberculosis, sepsis during childhood, and cardiovascular disease.[6]

In the United States, an estimated 52% of women experience some type of violence in their lifetime. Annually, women in the U.S. are subjected to just under 900,000 rapes and 6 million physical assaults.[7] The health-related costs of rape, physical assault, stalking, and homicide by intimate partners in the U.S. are estimated to exceed $5.8 billion each year. Of this total, nearly $4.1 billion are for direct medical and mental health care services.[8]

VAW in Oregon contributes to severe injuries, mental and physical disabilities, and death. Between 1997 and 2003, 103 Oregon women, ranging in age between 14 and 86, were murdered by their intimate partners. Intimate partner homicides accounted for nearly half (46%) of all female homicides (103/223) in Oregon during this time period. Forty percent of intimate partner homicide victims had dependent children (n=89) living with them at the time of the homicide. Tragically, in 19 of these cases, one or more children witnessed the homicide and thirteen children were murdered along with their mothers in six separate "familicide" cases.[9]

The economic costs of intimate partner physical and sexual assault in Oregon are conservatively estimated at over $50 million each year, nearly $35 million of which is for direct medical and metal health services. The total annual costs of IPV in Oregon also include approximately $9.3 million in lost productivity from paid work for victims of nonfatal IPV and approximately $10.7 million in lifetime earnings lost of victims of IPV homicide.[10]

In a survey of Oregon women age 20-55, nearly one-third (31%) reported having experienced one or more types of violent victimization — including threats of violence, physical assaults, sexual assaults, or stalking — in the five years preceding the survey.[1] Data from that survey indicate that one in ten Oregon women (over 85,500) experienced IPV during the five-year period,[2] and 13% (about 111,000 women) were stalked. Two-thirds of the stalkers were former or current intimate partners.[3] Data from a national survey reveal that one in six adult women in Oregon (an estimated 230,000) has been the victim of forcible rape in her lifetime. Nationally, almost 60% of women who have been forcibly raped were first raped in childhood and nearly 30% were raped before age 11.[4] In a survey of young Oregon women, 30% of 11th grade females and 24% of eighth grade females said that an adult had intentionally hit, physically hurt, and/or had sexual contact with them.[11] Clearly, VAW affects women throughout the lifespan.

# *Introduction*

In 2001, a coalition of advocates and policy makers determined that $70 million per biennium was needed in the state General Fund to support core services to address VAW. This estimate did not include resources to support primary prevention goals and activities addressed in this plan. The token funding from federal and state resources available to address VAW reflects the denial and poor understanding of the widespread effects and costs of VAW to individuals, communities, and society as a whole. Much more is needed.

Critical interventions to support Oregonians impacted by VAW have been implemented. These services must be continued and expanded. However, no epidemic has been successfully controlled without preventing new cases.

In formulating the statewide VAW prevention plan, a new emphasis on primary prevention – preventing VAW from ever occurring – is being articulated. As with other social problems, VAW has largely been addressed and understood through responding to the aftermath of such violence. This is not to suggest that there have been no prevention efforts. The Women's Movement has supported prevention initiatives and programs to change social norms, build individual empowerment, and address underlying structures that perpetuate VAW.[12-14] The predominant focus, however, remains at the level of response.

Response efforts focus on developing crisis services, law enforcement interventions, and judicial sanctions. In contrast, primary prevention largely focuses on education and includes efforts to change individual attitudes and social norms – what a community views as acceptable behaviors for its citizens.[15] The education and healthcare sectors are uniquely positioned to play a role in preventing VAW through their ability to target large populations.

Prevention of VAW and response to VAW are intrinsically related. Each can enhance the effectiveness of the other, and both are required to end VAW. The VAW prevention plan is mindful of both the differences and the overlap between these efforts. The VAW prevention plan will focus attention on developing and implementing promising strategies and practices to prevent VAW from ever occurring.

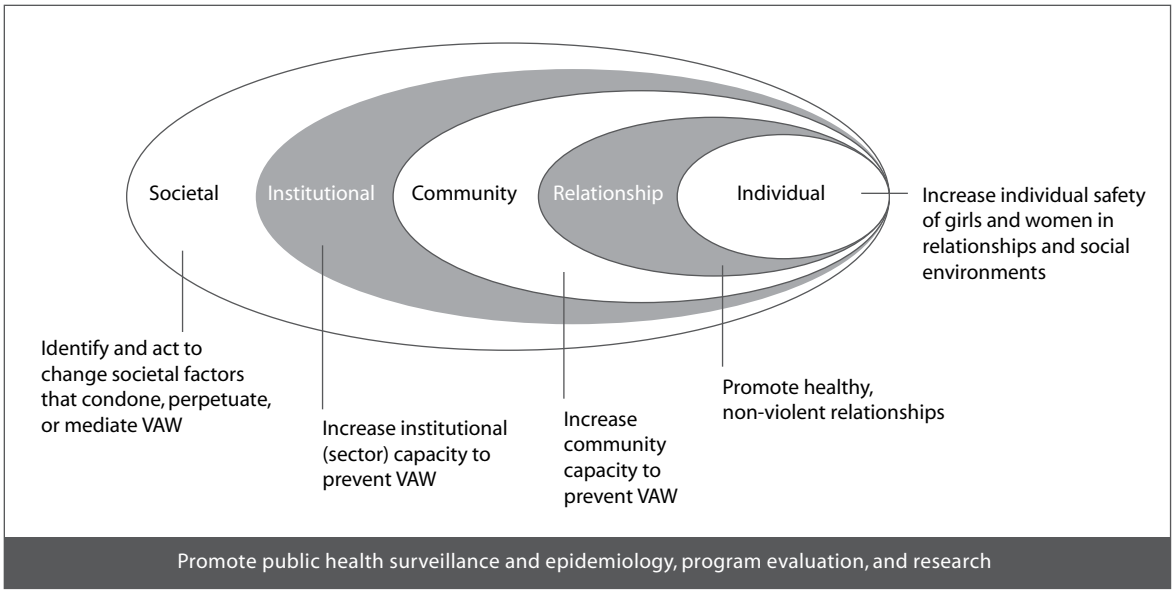
# *Ecological Model*

The World Health Organization, the Centers for Disease Control and Prevention (CDC), and the Pan American Health Organization, as well as individual researchers, increasingly use "the ecological model" to understand the complexity of VAW. The ecological model "explores the relationship between individual and contextual factors and considers violence as the product of multiple levels of influence on behavior."[17]

The ecological model is grounded in the science of human ecology, which focuses on the interrelationships between human beings and their environments. According to the model, the individual acts within the concentric spheres of relationships, community, institutions, and society. The ecological model has been used to understand human development and behavior,[18-20] study VAW,[21-23] describe training practice and policy applications in behavioral medicine,[24] and formulate practice guidelines for specific disciplines.[25, 26]

The levels of influence defined in the ecological model serve a "dual purpose" of identifying risk and protective factors and identifying "key points" of intervention/prevention.[17] The Oregon VAW prevention plan identifies six key prevention goals, each targeting a different level of the human environment. Each of the six prevention goals can incorporate different strategies based on identified needs, current practice, and existing research.

## VAW Prevention Goals Across the Levels of Influence in the Ecological Model




Adapted from Krug EG et al., World Report on Violence and Health. Geneva, World Health Organization, 2002.

# *Preventing VAW Across the Life Span*

Primary prevention strategies generally incorporate theories of child development and social learning and are targeted at specific stages of the life span, such as early childhood, adolescence, or adulthood.[27, 28] While a range of interventions implemented at various stages of development is needed to effectively prevent VAW,[27] programs targeted to reach young children and their families (i.e., home-visitation services and parent training) show greater potential for preventing VAW than those directed at adolescents and adults.[27, 29] Early childhood interventions can shape the attitudes, knowledge, and behavior of children while they are developmentally more open to positive influences.[28] In addition, early intervention may lessen deficits in neurodevelopment caused by neglect or abuse during the critical years of early childhood.[30, 31] Childhood exposure to such trauma is associated with increased risk of victimization or perpetration later in life.[30, 32, 33]

In the following VAW prevention plan, each of the six key goals is presented along with a rationale, strategies, and sample implementation activities. The six key goals are intentionally broad to allow for adaptation to specific populations based on age, gender, or identified risk or protective factors. The material is intended to guide government agencies, communities, and individuals in developing VAW prevention activities. The information has been generated through three sources: key stakeholders in Oregon, scientific literature, and national and international efforts to prevent VAW.

## Goal 1: Identify and act to change societal factors that condone, perpetuate, or mediate VAW.

Rationale: Societal level influences that contribute to VAW include:

- Historical and cultural norms and practices that support VAW,[5, 17, 34]
- Structural economic and political inequality,[5, 17, 35]
- Socially prescribed gender roles,[17, 21, 34] and
- Social policy and legislation.[5]

These themes of cultural beliefs and practices and institutionalized gender inequality provide foci for societal level prevention efforts.

Prevention efforts at the international, national, and local levels have adopted policy initiatives and media campaigns as universal approaches to changing social norms.[5, 17] The intent of the media campaigns is to educate the public by disseminating prevention messages that challenge established norms and attitudes that support VAW. One example of a media/communication strategy is the CDC's "Social Norms Campaign."[36] In creating this campaign, norms that support or discourage VAW were first identified through formative research, and then became the focus of media messages.

Although no empirical evidence currently exists that links media campaigns with decreased incidence or prevalence of VAW, the power of the media to reach and influence large segments of the population has been established. The success of public health media campaigns in achieving benefits in such arenas as tobacco prevention and seatbelt use supports the utility of media campaigns as a major strategy in societal level efforts to prevent VAW.

### Strategy 1: Adopt a public education campaign to change social norms regarding VAW and male violence.

*Sample Implementation Activities:*

- Explore models of successful prevention education campaigns in Oregon and in other states, as well as national and international projects, to address desired behavior and attitude changes.
- Identify appropriate messages for specific populations, neighborhoods, and communities using science-based social marketing techniques.

### Strategy 2: Advocate for improved policy and legislation to prevent VAW.

*Sample Implementation Activities:*

- Collaborate with the Oregon Alliance to End VAW to create new laws and modify existing legislation to prevent VAW in Oregon.
- Work to develop policies and resources to alleviate poverty and reduce gender inequality.

## Goal 2: Increase institutional/sector capacity to prevent VAW.

Rationale: Improving the policies and practices and increasing resources of institutions in the healthcare sector, public health, law enforcement, the legal/judicial system, education, and social services is key to preventing VAW.[5, 17] In addition to providing specific services to designated populations, institutions establish and reinforce standards for behavior and community values. Institutions can engage in practices and policies to prevent VAW for both employees and those served by the institutions.

Increasing institutional capacity to prevent VAW involves enhancing activities and changing norms within and between multiple institutions.[5, 20] Leadership, institutional policies, institutional culture, and performance measures have been repeatedly cited in the research literature as core components of institutional change.[5, 37, 38] Transforming institutional norms and cultures through training, policy, and practice is essential for prevention efforts: "little enduring change is usually achieved by short-term efforts to sensitize institutional actors, unless there are also real efforts to engage the whole institution."[5, 17]

One of the most widespread institutional level prevention strategies is universal screening for intimate partner violence in healthcare facilities.[39] Universal screening as a prevention approach offers the potential benefits of:

- Increasing institutional awareness of VAW,
- Demonstrating institutional commitment to the prevention of VAW,
- Motivating healthcare providers to acquire and apply skills in identifying VAW,
- Exposing patients to prevention and early intervention messages, and
- Generating data to describe VAW victimization and healthcare utilization.

Although no empirical evidence is currently available to link screening practices to an increase in women's safety,[40] medical authorities, such as the American Medical Association and the American College of Obstetricians and Gynecologists, and VAW experts, such as the Family Violence Prevention Fund recommend universal screening for female patients.

### Strategy 1: Promote attitudes and skills to prevent VAW among professionals working in institutions, including healthcare and public health, law enforcement, the legal/judicial system, education, and social services.

*Sample Implementation Activities:*

- Establish curricula that address VAW in law schools, medical schools, and other educational programs in healthcare, social work, psychology, law enforcement, and criminal justice.
- Expand specialized continuing education training in primary prevention of VAW for judges, prosecutors, law enforcement personnel, health professions, educators, and human services professionals.

Strategy 2: Develop leadership, policies, resources, institutional practices, and performance measures to promote safety and respect for women in both public and private institutions.

*Sample Implementation Activities:*

- Develop and implement policies in healthcare settings to universally screen patients for exposure to intimate partner violence.

*The Family Violence Prevention Fund's National Health Initiative on Domestic Violence provides resources for developing screening protocols.* (http://endabuse.org/programs/healthcare/)

- Disseminate workplace policies for violence prevention to institutions statewide to encourage adoption of appropriate practices for workplace prevention of and response to VAW

*The Corporate Alliance to End Partner Abuse provides information about workplace polices to address partner violence.* (http://www.caepv.org)

## Goal 3: Increase community capacity to prevent VAW.

Rationale: Community level strategies to prevent VAW have generally focused on incorporating primary prevention activities into local coordinated community response initiatives (CCRIs) and coordinating VAW prevention activities with efforts to prevent other types of violence, such as child maltreatment and youth violence. More recently, community engagement and mobilization strategies have been promoted as a critical aspect of VAW prevention.[17, 41, 42]

Coordinated community response initiatives (CCRIs) have called upon diverse sectors of the community to act in new ways to contend with the complexities of VAW.[43] To date, however, these efforts have championed building effective secondary responses rather than focusing on primary prevention. In fact, primary prevention and secondary prevention are often viewed as competing interests in a climate of limited resources rather than as complementary and equally important approaches to addressing VAW. There is another way. Integrating primary prevention into CCRIs and linking CCRIs to community mobilization efforts will build on existing collaboration, expertise, and structures while promoting new directions and energy.[44, 45]

Research has shown considerable overlap across gender-based violence, child maltreatment, and youth violence in terms of the populations affected as well as causal and preventative factors.[17, 29, 44] Little effort has been made, however, to link prevention efforts that utilize common strategies and coordinate resource utilization at the community level.[44] Community approaches to violence prevention are currently fragmented, and priority setting at the community level often focuses on "mediating competing interests rather than how to best maximize outcomes."[43] Strategies to link programs to one another and to research activities are essential in times of scare resources.[43, 44]

Community engagement moves beyond service delivery systems and focuses on supporting individual communities in developing viable strategies to prevent violence.[41, 42] Local leaders and residents come together to find sustainable solutions that address the needs of those impacted most by VAW – the families and communities that live with the violence.[41] Numerous studies indicate that victimized women are much more likely to turn to families, friends, and neighbors than to social service agencies, healthcare providers, or the criminal justice system. National organizations are currently conducting research to identify and compile information about promising community engagement strategies to prevent VAW.[41, 42]

### Strategy 1: Develop collaborative violence prevention efforts across the interrelated fields of gender-based violence, child maltreatment, and youth violence.

*Sample Implementation Activity:*

- Disseminate research describing the similar social and economic risk factors for domestic violence, child maltreatment, and youth violence to professionals and community leaders working in violence prevention.
- Pursue funding opportunities to develop collaborative efforts to prevent VAW, child maltreatment, and youth violence.

Strategy 2: Encourage coordinated community response teams to emphasize primary prevention.

*Sample Implementation Activity:*

- Promote discussion of primary prevention by local coordinating bodies, with an emphasis on potential linkages between prevention and response.
- Increase prevention activities in the various sectors involved in efforts to address VAW.

Strategy 3: Explore community engagement approaches to preventing VAW.

*Sample Implementation Activities:*

- Implement recommendations outlined in "The Community Engagement Continuum: Outreach, Mobilization, Organizing and Accountability"[41] and "Preventing Family Violence: Community Engagement Makes the Difference,"[42] such as building leadership and awareness within local communities to prevent VAW.

## Goal 4: Promote healthy non-violent relationships.

Rationale: The vast majority of all forms of VAW, including child sexual abuse, sexual assault, and domestic violence, occurs in the context of close interpersonal relationships.[17, 22, 46] The closeness of the relationship increases the risk for violent victimization and repetitive abuse.[17, 38, 47] Interpersonal relationship skills, attitudes, and behaviors are learned through observation, modeling, and reinforcement.[48] Young children learn to model parental behavior, while teens are much more likely to engage in activities and behaviors that are encouraged and reinforced through peer interactions and cultural norms. Victimization or witnessing violence in relationships during childhood increases risk for future perpetration or victimization throughout the lifespan. Strategies to prevent VAW at the relational level include parenting education and skill building to promote healthy, egalitarian, non-violent families;[17] school-based programs that build relationship skills to prevent dating violence;[49, 50] and interventions in sub-cultures where masculinity is defined and violence is prevalent, such as athletics and military contexts.[48]

### Strategy 1: Teach young people to engage in non-violent interpersonal behavior.

*Sample Implementation Activities:*

- Adopt developmental stage- and gender-specific programs, such as Coaching Boys into Men,[51] to teach children about gender equality and developing healthy relationship skills.
- Establish effective gender-based violence prevention education curricula for teens modeled after promising programs such as In Touch with Teens[52] and Project H.A.R.T. (Healthy Alternative Relationships among Teens).[53]

### Strategy 2: Identify and disseminate information about programs that teach non-violent parenting.

*Sample Implementation Activities:*

- Implement parent training interventions, starting when children are young (aged 0-12), with a strong focus on preventing patterns of excessive punishment and parental violence.[54]

## Goal 5: Increase the individual safety of girls and women in relationships and social environments.

Rationale: At the individual level, strategies that prevent the initial perpetration of violence by males or that empower females with protective factors against violence are essential.[17, 22, 50] In resilience research, resources are termed 'protective factors' and persons who overcome risk factors are 'resilient."[5] Primary prevention activities should both reduce risk and enhance protective factors.[5, 22, 55]

Primary prevention efforts at the individual level focus on two populations and associated activities: first, efforts to mitigate identified risk factors for the initial perpetration of violence among boys and men and second, efforts to mitigate risk factors for victimization among girls and women.[5, 17, 50, 56, 57] Empirical evaluations of prevention programs indicate that activities that seek to change knowledge and attitudes alone are less effective than strategies that also enhance resources and promote new behavioral skills.[58, 59] Prevention activities at the individual level have been geared toward introducing new values, thinking processes, and skills that promote non-violence.[17, 50, 56, 57]

Prevention of first-time male perpetration of violence is important because males are responsible for the vast majority of sexual violence against women, children, and other men,[7] and patterns of male sexual aggression initiated in adolescence are often sustained in young adulthood.[60] For males, mentoring programs, positive peer interaction, and enhanced social support have been identified as targets of prevention initiatives in schools and communities.[29, 50, 55] For females, a growing body of evidence demonstrates the specific value of personal safety/self-defense training in mitigating risk factors and increasing protective factors at multiple levels, particularly in the prevention of sexual assault.[5, 57-59, 61]

Universal activities to reduce individual risk of perpetration or victimization among the population at large can be augmented by targeting high-risk groups including children who have witnessed violence,[62] children who have been abused,[56] women with histories of cumulative trauma,[63] and individuals with disabilities.[64] Individual level strategies must be tailored to age, gender, culture, and setting.[50]

### Strategy 1: Implement and strengthen skill-building and empowerment approaches to address VAW.

*Sample Implementation Activities:*

- Implement promising skill-building approaches that enhance self-reliance, confidence, and protection skills among girls and women, such as self-defense training.[59, 61, 63]
- Implement programs designed to prevent initial perpetration of violence by males, such as the Mentors in Violence Prevention Project[65] and the White Ribbon Campaign.[66]

## Goal 6: Promote public health surveillance and epidemiology, program evaluation, and research

Rationale: Measurement of VAW is necessary to advance prevention policy development, practice, and program evaluation. Data are needed to describe the magnitude and scope of the problem, track trends over time, and identify target populations to focus prevention efforts. The Centers for Disease Control and Prevention have pointed out the critical need to develop systems to monitor violence based on uniform definitions of violent behaviors.[67] While discussion and debate continues among researchers and advocates concerning definitional terms and methods of measuring and tracking VAW,[68, 69] gathering credible data will advance both prevention and intervention efforts.

### Strategy 1: Conduct public health surveillance and epidemiology.

*Sample Implementation Activities:*

- Agree on critical information needed for research, service delivery, and funding, and identify potential means of collecting this information.
- Identify data currently collected at the local and state levels that are related to VAW.
- Establish a data clearinghouse to compile, analyse, and diseminate information relevant to VAW prevention and intervention.
- Encourage the use of common definitions and data elements across disciplines (health care, criminal justice, crisis services, funders).
- Observe policies and practices that protect against misuse of data and ensure individual privacy.
- Conduct periodic assessment and ongoing public health surveillance and epidemiology to monitor the effects of policy, practice, and trends in victimization and perpetration of violence.
- Disseminate epidemiological data in a "user friendly" manner to community programs, service providers, key collaborators, policy makers, researchers, and grant writers.

### Strategy 2: Evaluate prevention programs.

*Sample Implementation Activities:*

- Determine what outcomes define "success" in services to address VAW.
- Build on current state efforts to collect outcome-based evaluation data consistent with local program capacity.
- Provide technical assistance to help programs utilize evaluation results to refine program efforts and provide the most effective services.

Strategy 3: Promote VAW research in Oregon.

*Sample Implementation Activities:*

- Solicit input from researchers, government agencies, domestic violence and sexual assault services providers, and survivors/victims to identify focus areas for research, data collection, and analysis.
- Disseminate research results in a "user friendly" manner to community programs, service providers, key collaborators, policy makers, researchers, and grant writers.

# Conclusion

Violence against women is a serious public health problem that causes injuries, mental and physical disabilities, and even death among Oregonians. Preventing VAW requires focusing prevention strategies at the individual, relationship, community, institutional, and societal levels. While efforts to respond to VAW must be strengthened, primary prevention strategies to stop the violence from ever occurring are needed to end this epidemic.

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# *Appendix A: Data Summary of Violence Against Woment in Oregon*

Violence against women is pervasive in Oregon communities. Nearly one-third of Oregon women age 20-55 (31%) experienced one or more types of violent victimization—including threats of violence, physical assaults, sexual assaults, or stalking—in a five year period. Furthermore, 24% of surveyed women reported that they knew a victim of a recent physical or sexual violence (other than themselves).[1] Comparable proportions of younger women and girls in Oregon experience violence, as well. Thirty percent of 11th grade females and 24% of 8th grade females said that an adult had intentionally hit, physically hurt, and/or had sexual contact with them.[2]

There is no surveillance system that measures the vast phenomenon of violence against women, so data must be gleaned from multiple sources. State-specific data on all of the multiple forms of violence against women are limited, and available data tend to focus on subgroups at risk (e.g. teens, women age 20-55), rather than the entire population. Therefore, the following data summaries are not intended to be a comprehensive picture of violence against women. Rather, they represent the best available knowledge on three specific areas of concern for Oregon women: intimate partner violence (morbidity and mortality), sexual assault, and stalking.

## Intimate Partner Homicides

### *Data sources and limitations:*

Deaths by homicide for Oregonians age 12 and older were identified through death certificates. We used newspaper articles and obituaries to exclude homicides that were clearly not IPV-related and reviewed medical examiner files for the remaining cases. We defined intimate partners as current or former spouses, current or former boyfriends/girlfriends, or dates. Couples could be same-sex or opposite-sex.

Some intimate partner homicides may have been missed if the cause of death was classified as undetermined or was ruled to be an accident. Because of the nature of intimate partner homicides, it is unlikely that a high number of them are misclassified.

### *Overall numbers and context:*

Between 1997-2003, there were 748 homicides in Oregon and intimate partners committed 123 (17%) of them. Almost half of all female homicides (46%, 102/223) were committed by intimate partners, compared to 4% of male homicides (21/525). Overall, women were four times as likely to be killed by an intimate partner than were men (average annual, sex-specific intimate partner homicide rates were 1.0/100,000 for women >12 years compared to .24 for men >12 years).

### *Demographics of female victims:*

Victims ranged from age 14 to 86 years, with a median age of 37 years. They were predominantly non-Hispanic whites (n=107, 87%) and either married (n=54, 44%) or involved in a non-marital partnership (n=16, 16%). At least 4 of the victims were pregnant.

### *Perpetrator victim relationship:*

Most victims (67%) were killed by current intimate partners, either a spouse (n=40, 40%), non-marital partner (n=25, 25%), or a date (n=2, 3%). Two perpetrators were female same sex partners; the rest (n=101) were male. Sixty two percent of victims and perpetrators were living together at the time of the incident. Half of the victims had a documented history of IPV that preceded the homicide (e.g. a restraining order, police report).

### *Homicide circumstances:*

Between 1997-2003, 23 of 36 Oregon counties reported that a woman was killed by an intimate partner. Most cases occurred in metropolitan areas (n=88, 71%) and most (n=86, 70%) occurred in the victim's home.

Sixty percent of female victims (n=62) were killed with a firearm and 35% of the perpetrators (n=43, 42 men, 1 woman) committed suicide after the homicide.

## Intimate Partner Violence

### *Data sources and limitations:*

The following data are from the Oregon Women's Health & Safety Survey, conducted in 2001-2002 with a random sample of 2,962 Oregon women age 20-55 years. The survey provides population-based data on IPV. Data from hospital records, shelters, and/or law enforcement agencies provide biased samples, as not all women who experience IPV use those services and those who do may look different from those women who do not use them. Telephone surveys have limitations. For example, they cannot include women without telephones, non-English women, or women who do not answer the phone (e.g. those who screen out strangers with caller ID). However, of all the available data sources, they provide the best birds-eye view of the problem.

Although IPV can encompass a broad range of activities that one partner uses in order to control the other, this survey used a definition of IPV that was limited to physical and/or sexual assault by an intimate partner (current or former spouse, partner, or date). Therefore, these data alone provide a conservative estimate of the magnitude of IPV in Oregon communities.

### *Incidence and prevalence of IPV:*

One in ten Oregon women age 20-55 (n=85,576) experienced IPV in the 5 years preceding the survey and 3% (n=29,102) experienced IPV in the preceding 12 months. Physical assault was more common than sexual assault.

### *Survivor demographics and characteristics:*

Oregon women from all walks of life—including women from the highest and lowest educational and income levels, all racial and ethnic groups, and a variety of ages (only women age 20-55 were interviewed)—were affected by IPV. However, after controlling for other factors, women with chronic depression, anxiety, drug use, or sedative use were about twice as likely to have experienced IPV.

### *Demographics of perpetrators:*

Women who participated in the survey were asked about their partners and the demographics of partners who committed IPV were compared to those who did not. Most of the women in the survey had male partners (98%). Fewer than five women with female partners reported IPV, so differences in IPV status by gender could not be measured.

Compared to partners who did not commit IPV, the intimate partners of women who experienced IPV were significantly more likely to be unemployed, to have a high school education or less, and to have drank alcohol or used recreational drugs in the past 30 days.

### *Risk factors for physical and/or sexual assault by an intimate partner:*

Risk factors are characteristics or behaviors that are associated with an increased likelihood that a problem will occur. The presence or absence of a risk factor does not mean that a person will or will not develop the problem, only that the odds of developing it are greater or lesser than others who do not share the risk factor. Risk factors can assist in planning and targeting interventions.

After controlling for other factors:

- Women whose partners threatened violence against them were 42 times more likely to also physically or sexually assault them;
- Verbal and emotional abuse were also strongly linked to physical and sexual assault;
- American Indian women were about 4 times as likely to experience IPV as women of other racial backgrounds or Hispanic ethnicity; and
- Age appeared to be a protective factor for IPV; specifically, a woman's risk of IPV dropped by about 4% with each birthday.

### *Injuries from IPV:*

Thirteen percent of women who were physically assaulted by an intimate partner and 41% of those sexually assaulted sustained serious injuries after the most recent attack. For example, approximately one fourth of physical assault victims were knocked unconscious, 11% had bones broken or joints dislocated, 7% sustained head injuries, and 6% suffered lacerations or knife wounds. One third of sexual assault victims reported internal injuries.

Fewer than 2 in 5 physical assault victims and fewer than 1 in 5 sexual assault victims received medical care for these serious injuries. Of those who did seek care, about three fourths of women physically assaulted and half of those sexually assaulted disclosed to their medical provider that their injuries were the result of IPV.

### *Involvement with law enforcement:*

Most women who experienced IPV did not report the incident to law enforcement. Only 38% of physical assault victims and 27% of sexual assault victims made a report to police. Women who received medical care for injuries sustained during the event and those who had a child witness the event were significantly more likely to report the incident to police.

The three top reasons that women did not report IPV to police were feeling that the incident was too minor or not a crime, fear of the offender, and the belief that it was a one time incident and wouldn't happen again.

### *More information:*

More information on this survey can be found in the report "Intimate Partner Violence in Oregon: Findings from the Women's Health and Safety Survey," located at: http://www.dhs.stat.or.us/publichealth/ipv.

## Sexual Assault

### *Data sources and limitations:*

Data on sexual assault in Oregon come from three main sources: the "Rape in Oregon" report (derived from two national surveys), the Oregon Behavioral Risk Factor Surveillance System (BRFSS), and the Oregon Healthy Teens Survey. All of these are population-based telephone surveys, with the exception of Oregon Healthy Teen (OHT), which is a self-administered questionnaire that students complete in a participating sample of Oregon schools.

The "Rape in Oregon" report is based on data from the National Women's Survey (NWS) and the National Violence Against Women Survey (NVAWS). Both of these used large samples, focused solely on women's health and victimization issues, and used only female interviewers. The BRFSS is a telephone survey of adults that covers a wide range of health topics and uses both male and female interviewers. Likewise, the OHT covers a wide range of health topics, of which violence is only a small part. It is suggested that the best data on sexual assault would come from a statewide survey specifically focused on sexual assault and other types of violence.[3] As yet, no such survey has been conducted in Oregon.

### *Prevalence of rape in Oregon:*

- One in six adult women in Oregon (about 230,000 women) has been the victim of forcible rape in her lifetime.[3]
- The five-year prevalence of forced sex for Oregon women 20-55 who responded to the BRFSS was 3.2% (95% CI: 2.3%-4.4%).[4]
- 6% of Oregon's 8th grade females and 7% of Oregon's 11th grade females have been physically forced to have sex.[2]

### *Dynamics of rape:*

Most children, adolescents, and adult women are raped by someone they know. Nationally, almost 60% of women who have been forcibly raped were first raped in childhood (under age 18). Nearly 30% were raped before age 11[3]. Almost two-thirds of women raped as adults are raped by intimate partners.[5]

### *Effects of forcible rape on survivors:*

Rape is associated with many long-term and short-term health problems, including mental health conditions and substance abuse. For example:

- 30% of rape survivors will experience major depression at some point in their lives (an estimated 69,000 Oregon rape survivors), compared to about 10% of women never victimized by violent crime.[3]
- 33% of rape survivors experience serious suicidal thoughts at some time in their lives (over 48,000 Oregon rape survivors), compared to 6% of women never victimized by violent crime.[3]
- 13% of rape survivors will attempt suicide at some time in their lives (nearly 30,000 Oregon rape survivors), compared to only 1% of women never victimized by violent crime.[3]
- 31% of rape survivors develop post-traumatic stress disorder [PTSD] (about 71,000 Oregon rape survivors), compared to 5% of women never victimized by violent crime.[3]
- 15.5% of rape survivors will use cocaine at some time in their lives (over 35,000 Oregon rape survivors), compared to 2.6% of women never victimized by violent crime.[3]

## Stalking

### *Data source and limitations:*

The following data are from the Oregon Women's Health & Safety Survey, conducted in 2001-2002 with a random sample of 2,962 Oregon women age 20-55 years. Stalking is defined as repeated harassing or threatening behaviors toward a specific person that would make a reasonable person feel fear. The Oregon survey asked women if they had experienced one or more types of harassing behavior on more than one occasion, perpetrated by the same person. Harassing behaviors included unwanted contact (through letters, calls, or items), being followed or spied on, having property vandalized, or having a pet threatened, harmed, or killed. The survey did not measure the level of fear that the victim felt, so these data may not be directly comparable to other measures of stalking.

### *Prevalence of stalking in Oregon*

In a survey of Oregon women age 20-55, 13% (about 111,000 women) said they had been stalked in a 5-year period. Intimate partners stalked two third of the women who experienced stalking. Of those stalked by an intimate partner, 63% said it happened during the course of the relationship, while 37% said it only happened after the relationship was over.[1]

# *Endnotes*

[1] Oregon Women's Health & Safety Survey, 2001-2002. Available at http://www.dhs.state.or.us/publichealth/ipv.

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*For more resources on violence against women, please consult the following resources:*

- Oregon Department of Human Services, IPV Data Collection Project www.dhs.state.or.us/publichealth/ipv/index.cfm
- Centers for Disease Control and Prevention www.cdc.gov/
- Family Violence Prevention Fund www.endabuse.org
- Department of Justice, Violence Against Women Office www.ojp.usdoj.gov/vawo/

*To find out more about volunteer opportunities to help prevent violence against women, please call:*

- Portland Women's Crisis Line
  (503) 235-5333, crisis line
  1-888-235-5333, toll-free crisis line
  (503) 232-9751, office line
- Volunteers of America Home Free
  (503) 232-6562, crisis line
  (503) 771-5503, office line

*Angie Burr, Graphic Design*