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## Report from the CDC

# Evaluability Assessment of the Rape Prevention and Education Program: Summary of Findings and Recommendations

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## ABSTRACT

**This paper describes an evaluability assessment of CDC's Rape Prevention and Education (RPE) Program conducted to establish a baseline description and understanding of the current activities and goals of the program, revisit and update program performance measures, and identify opportunities for CDC to provide training and technical assistance to states. Data were collected using (1) a web-based survey of all state and territory health departments, other government agencies involved in the administration of the program, and sexual assault coalitions, (2) in-depth interviews with the same respondents during site visits to a sample of 14 states, and (3) focus groups in 5 of these states with local providers. This paper highlights the findings and summarizes recommendations to improve the program. It concludes with examples of steps CDC is taking to implement the recommendations.**

## INTRODUCTION

Sexual violence is a major social and public health problem in the United States. Although sexual violence is commonly conceived of as rape, defined as completed or attempted penetration, sexual violence is much broader than rape alone. The Centers for Disease Control and Prevention (CDC) defines sexual violence to include completed or attempted penetration, abusive sexual contact without penetration (e.g., intentional touching of the groin), and noncontact sexual abuse (e.g., voyeurism, sexual harassment).[1] Sexual violence also encompasses systematic rape during times of war, sexual trafficking (the buying and selling of girls and women into prostitution and sexual slavery), and female genital mutilation (for a review of sexual violence in a global context, see ref. 2). Critical to the definition, sexual violence occurs when the survivor of the violence does not consent to the sexual activity or when the survivor is unable to consent (e.g., due to age or illness) or unable to refuse (e.g., due to physical violence or threats).[1]

Most national data on sexual violence focus specifically on rape. According to the National Violence Against Women Survey (NVAWS), an estimated 1 in 6 women and 1 in 33 men have experienced an attempted or completed rape at some point in their lifetime, and in 8 of 10 cases

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(83%), the perpetrator was someone the survivor knew.[3] According to the NVAWS, rapists of adult women are most likely to be intimate partners (62%) (intimate partners are defined in the NVAWS as current or former spouses, cohabitating partners, boyfriends, or dates), followed by acquaintances (21%), strangers (17%), and other relatives (7%). The large majority of survivors of rape and other sexual violence are female, and data show that most perpetrators are male.[3]

Most rape survivors are young. For example, one study found that for 71% of female survivors, the first rape occurred before the age of 18.[4] The NVAWS found that 54% of all first rapes of women occurred before the age of 18, and almost half of these occurred before age 12.[3] In light of these figures, rape and other sexual violence has been called a "problem of youth."[3,5]

Child sexual abuse, however, is an even larger problem than is estimated by studies that assess rape, as it includes other forms of violence, such as fondling and exhibitionism. A synthesis of findings from 16 studies estimated that 22% of U.S. women were sexually abused as children.[1]

## THE RAPE PREVENTION AND EDUCATION PROGRAM

Understanding the far-reaching impact of sexual violence and the importance of prevention, Congress passed the Violence Against Women Act (VAWA) in 1994, which established the CDC's Rape Prevention and Education (RPE) Program. Originally housed within the Preventive Health and Health Services Block Grant, the RPE program administration was moved in 2001 to the National Center for Injury Prevention and Control (NCIPC).

With approximate annual funding of $44 million, CDC provides national leadership on sexual violence prevention by supporting RPE Programs in all 50 states, the District of Columbia, Puerto Rico, and seven U.S. Territories. Funding is provided on a population-based formula to state/territory departments of health (DOH), which then fund sexual assault coalitions (SAC), local rape crisis centers, and other agencies and organizations. RPE Programs use funding to increase awareness about and prevent sexual violence through educational seminars (for professionals, the public, K–12 schools, colleges and universities), hotline operations, and development of informational materials. Other efforts include working with people with disabilities and other underserved communities. The bulk of grantee efforts involve engaging youth to change attitudes and beliefs that support sexual violence. For example, the RPE Program at the Kansas Department of Health is working to build strategies that prevent first-time male perpetration of sexual violence. These programs are reaching boys age 9–19 to try to change attitudes and behavior related to sexual harassment, abuse, rape, and other violent acts. The activities focus on such topics as bullying, gender violence, peer relationships, conflict resolution, problem solving, and decision making. The educational programming promotes hope, respect, and rights and responsibilities among the students through mentoring, classroom exercises, and activities, such as creating murals to illustrate and communicate students' concepts of respect.

## THE CURRENT STUDY

As the new stewards of the program, NCIPC was interested in establishing a baseline description and understanding of the current activities and goals of the program, revisiting and updating program performance measures, and identifying opportunities to provide training and technical assistance. To address these issues, an expanded evaluability assessment was conducted by an independent evaluation contractor, RTI International (Research Triangle Park, NC). The assessment was conducted from September 2001 through May 2004.

The evaluability assessment approach was developed by Joseph Wholey and associates at the Urban Institute (Washington, DC) as a method of determining if activities necessary for a successful outcome evaluation are in place, if the activities include program objectives that are well defined and plausible, and if the intended uses of information from evaluation have been clearly delineated.[7] Rutman[8] expanded on this by using an evaluability assessment to ask if a program can realistically achieve the intended goals or anticipated effects. Rutman described procedures to be used in addressing this question, including reviews of program documents, interviews with stakeholders, and collecting information from programs in the field.[8] NCIPC deemed that an evaluability assessment was the best approach to

better understand and improve the RPE Program (for the full report on this evaluability assessment, see ref. 9).

## MATERIALS AND METHODS

This assessment was focused in three main areas: (1) documenting the goals and objectives of the RPE Grant Program, (2) assessing the use of funds within states/territories, and (3) assessing the aids, barriers, and needs related to the implementation of the RPE grant.

Data collection methods included a web-based survey of all state and territory DOH, other state agencies (OSA) involved in the administration of the program, and SAC, as well as site visits to a sample of 14 states in which in-depth, face-to-face interviews were conducted with staff from the same organizations. In addition, focus groups were conducted in 5 of these sites with local RPE providers.

The web-based survey was used to provide an overall national description of states' and territories' perspectives as they relate to the three major areas of interest. Most questions were closed-ended. Overall, 100 of 119 (84%) eligible respondents participated in the web-based survey. Specifically, 50 (86%) of the DOH coordinators, 41 (80%) of the SAC directors, and 9 (90%) of the OSA representatives completed the survey. At least one survey was completed by 49 (98%) states and 5 (56%) territories, with 32 (60%) participating state/territories having completed surveys from all possible respondents.

Following the web-based survey data collection, site visits were conducted in 14 states. States were selected purposefully to provide balance across the following: census region, amount of grant award, whether the state has a pass through funding arrangement with another agency, and the role of the coalition (e.g., funded or a pass through). (In the RPE Program, some DOH have mechanisms, for example, interagency agreements, memoranda of understanding, in place to pass through all or part of the funds to an OSA or SAC to administer.) Balance was also sought for organizational location in the DOH, focus of RPE-funded activities, and the relationships between the DOH and the SAC. The purpose of this selection strategy was to assure variability in terms of geographic and organizational/operational differences. The purpose of the site visits was to provide an opportunity to gather more in-depth information about data collected in the survey. The average interview took approximately 3 hours using open-ended questions and was conducted separately with the state DOH RPE coordinator, the director of the state SAC, and a staff member from the OSA involved in the administration of the RPE Program, if applicable.

Focus groups with local RPE providers were conducted in 5 states to provide the perspective of those actually delivering the programs and services funded by the RPE grant. Each focus group ranged in size from four to seven individuals.

Web-based survey data were analyzed using SAS. Descriptive analyses (cross-tabs) were conducted by organization type and grant size. Interview and focus group data were analyzed using the qualitative program NVivo.

## HIGHLIGHTED FINDINGS

This section highlights the major findings of the evaluability assessment. Results are organized by the three main goals of the study and are discussed as a whole using data from the web-based survey, site visit interviews, and local service provider focus groups. The three main goals, as stated earlier, were (1) documenting the goals and objectives of the RPE Grant Program, (2) assessing the use of funds within states/territories, and (3) assessing the aids, barriers, and needs related to the implementation of the RPE grant. In addition, information is provided about options to enhance CDC's current reporting system.

### *Goals and related strengths and weaknesses of the RPE Grant Program*

Findings across all sources suggest that the overall perceived goal or purpose of the RPE Program is to reduce and prevent rape and sexual assault, primarily through funding of awareness or educational activities. This finding was consistent across all grant sizes (small, <$300,000; medium, $300,000–$800,000; and large, >$800,000) and agency types (DOH, SAC, and OSA). Several strengths of the RPE Program were identified, including the following: the availability of specific funding for sexual violence prevention, the high level of accessibility to CDC staff and other crit-

ical stakeholders, and the ability to foster partnerships to increase program capacity. Some of the weaknesses identified were unclear definitions of rape, prevention, and anticipated outcomes for demonstrating success; lack of information about effective programs and best practices; and lack of standardization with regard to data collection and surveillance.

*Use and impact of funds*

Disseminating informational materials and providing training were the most common activities reported by the DOH, SAC, and OSA respondents. Local service providers frequently conduct school-based and community-based rape prevention education. Respondents were asked if they have prevention activities designed specifically for underserved populations. Over 70% of states reported activities designed for people of color and rural communities. Between 50% and 70% of states reported activities designed for people with disabilities; lesbian, bisexual, gay, transgender (LBGT) communities; immigrant populations, and the elderly. However, some site-visit respondents indicated that agencies may have more of an open door policy (meaning equal access) for these underserved populations rather than specifically designed programs. Respondents reported several activities focused on males to prevent first-time male perpetration, including school-based prevention programs (31%), public media campaigns (22%), training (17%), and college campus prevention programming (13%).

Forty-two percent of web-based survey respondents reported that their agencies are conducting evaluations; however, findings suggest that evaluation activities are not very sophisticated. Among states conducting evaluations, the activities most frequently reported were program descriptions (44%), satisfaction assessments (33%), and program outcome assessments (25%). Public health surveillance activities are ongoing in at least one agency in 44% of states. The most common activity is assessing existing data, such as emergency department records (44%), followed by analyzing data (37%); adding questions to an existing survey, such as the Behavioral Risk Factor Surveillance Survey (BRFSS) (19%); and developing a new survey for surveillance purposes (16%).

*Aids, barriers, and needs*

Respondents were asked what things aid them in their work and what is considered a barrier. Community sensitivity around the topic of sexual violence was a significant barrier to implementing the RPE Program, reported by 87% of respondents. The strongest aid for program implementation, reported by 56% of respondents, was collaboration with other community-based agencies. In meeting state goals, the funding received from the RPE Program was viewed as an aid (85%), and the political environment within states/territories (54%) and access to and quality of data (52%) were seen as barriers.

Respondents have a broad range of technical assistance and training needs. The most common need was evidence-based prevention programming primarily for youth, reported by 92% of respondents. Other frequently requested needs were training on evaluation design (83%), presenting sexual violence as a public health issue (81%), information on risk factors for perpetration (75%), increasing community buy-in (75%), and data analysis and interpretation (75%).

*Alternative reporting options*

Respondents were asked to provide suggestions for how the system of data reporting by grantees to CDC could be improved. Many respondents suggested that CDC no longer ask grantees to report the incidence of rape and attempted rape because of the varying definitions of these terms and the inability of state agencies to accurately assess rape and attempted rape, given the high rates of nondisclosure. Regarding alternative ways to show program success, the most frequently reported information that could be used to indicate RPE Program success was curricula about sexual violence prevention and other prevention activities and assessments of their effectiveness.

## HIGHLIGHTED RECOMMENDATIONS

This section highlights many of the recommendations made to CDC by participants and RTI International for improving the administration of the RPE Program and for supporting effective program practice. Recommendations were made only if respondents in multiple states noted an issue and the issue appeared to be consistent across agency types and across the different data collection methods. The most compelling recommendations have been synthesized into four areas: performance measures and systematic data

collection, technical assistance and training, strategic planning, and evaluability.

*Performance measures and other systematic data collection*

One aspect of this evaluability assessment was to critique and make recommendations to improve the reporting system used for accountability purposes. Respondents expressed a need for a comprehensive plan that takes into consideration the purposes of the data collection, opportunities to build on current efforts, sharing information across states and among organizational levels (federal, state, and local), and improving the knowledge base for developing and implementing effective RPE programs. The current reporting system collects number and types of activities that are delivered and counts the number of individuals who participate and are recipients of those activities. The respondents encouraged CDC to develop a system in which current program activities could be enhanced by describing who is being reached, the type of intervention, and the effectiveness of that intervention. Making such data publicly available not only would allow states to identify potentially promising interventions but also would provide a mechanism by which a state can benchmark its activities with other similar states and use the data in program planning and priority setting.

Another concern was the lack of information on program context, such as the political environment or strength of relationships across agencies. Collecting data that are activity specific only presents part of a picture of a RPE program in a given state. Linking information on the context of program implementation with proximal and longer term outcome indicators and making it available to RPE grantees would help identify promising interventions for wider implementation. This would allow states to understand the context of a given intervention and make appropriate adaptations for their state. Finally, including federal partners in developing and coordinating this comprehensive information system could address respondents' frustrations about multiple reporting requirements of similar process information by various federal agencies.

*Technical assistance and training*

Communication and information sharing within the RPE Program needs to be considered as part of a broader communication plan. CDC should clarify current dissemination practices and should ensure communication to all levels (federal, state, and local) of the RPE Grant Program for access to relevant resources and information to improve program practice.

Priority needs to be given to building evaluation capacity among state and local RPE grantees. Current evaluation efforts are primarily descriptive in nature, with few impact evaluations being conducted. Evaluation is inconsistently defined, and approaches vary by state and local program. In order to support program accountability efforts and identification of effective programs, CDC should provide training in program evaluation design, implementation, and use for RPE grantees.

The sexual violence prevention field is looking to CDC to provide information on promising prevention strategies and programs. The recommendations addressing performance measures and accountability would garner information from RPE grantees on potentially effective strategies and programs. In addition, CDC should continue to identify promising programs and strategies for more rigorous assessment and evaluation.

*CDC strategic planning*

Funding support for the states under the current RPE granting mechanism is based on population size. With less populated states, there may be increased pressure to allocate as much funding as possible to local programs. This allows some states with little resident expertise and available resources at the state DOH to support such activities as program implementation, surveillance, and evaluation. With this situation in mind, CDC should consider set-aside support within the RPE grants to assure a certain level of basic capacity, regardless of a particular state's population.

Not all populations are at equal risk for sexual violence.[10] CDC should provide guidance on cross-cultural applications of programs and evaluations and should consider requirements on percentages of funding to be used for sexual violence prevention efforts with specific populations.

The issue of victim services and prevention is a particularly salient one for the RPE Program. There were differences among respondents about whether RPE funds should be used for victim services and whether victim services qualify as pre-

vention, given CDC's primary prevention focus (i.e., preventing sexual violence before it occurs). In addition, awareness and prevention activities increase the demand for victim services. Currently, there are no designated federal funds for sexual assault victim services, which creates a tension for state and local programs around intervention and prevention services. CDC should be clear on whether RPE funds can be used for victim service activities. Additionally, CDC should be clear about its definition of prevention and its vision for the RPE Program.

*Evaluability*

As the steward of the RPE funds, CDC is held accountable for results coming from this program. Central to this is evaluability of the program. The Program Assessment Rating Tool (PART) is currently being used by the Office of Management and Budget to link program performance with funding levels. This tool focuses on both the evaluability and evaluation results of federally funded programs. With regard to evaluability, PART considers three components: program purpose; specific, long-term performance measures; and baselines and annual targets.

In assessing program purpose, the findings suggest that there is consistency in the general idea of sexual violence prevention as the goal of the RPE program. However, there is much ambiguity and variance in what this goal means and how it is operationalized. CDC should consider efforts to make the RPE Grant Program more visible and its goals more salient both to those receiving funds and to the general public. Strategies for increasing visibility and clarifying goals can be addressed in part by better publicizing sexual violence prevention. It is also recommended that CDC consider creating a standard explanation of the RPE Grant Program that uses simple terminology and is distributed to all recipients of RPE funding.

As mentioned earlier, there must be more consistency across sites in terms of evaluation data being collected. There are varying levels of evaluation capacity and activities across the programs, leading to inconsistent evaluation data. Increasing evaluation capacity will enhance quality, quantity, and possibly, consistency of evaluation data, allowing some cross-site evaluation.

Access to public health surveillance measures and data could facilitate states' abilities to establish baseline and annual data. Respondents clearly indicated a need for accessible, higher-quality surveillance data. CDC should continue to develop tools to be shared with all agencies within states. Given the limited amount of surveillance funding available in the RPE Grant Program (2% of the state's total award), consideration should also be given to increasing the allowable amounts of the RPE funds that can be used for surveillance as well as greater use of existing standard modules for assessing violence, such as those available in BRFSS, and attitudinal information, as in the Youth Risk Behavior Survey (YRBS).

## IMPLEMENTING THE RECOMMENDATIONS

The RPE evaluability assessment provided CDC with important recommendations to improve the administration and efficacy of the RPE Program. The following examples showcase a few of the current and planned steps that CDC is taking to address these recommendations.

Findings of the evaluability assessment demonstrated the need to identify recommended practices or core components for RPE activities in order to support grantees in implementing evidence-based strategies and programs. In addition, the need for improved program accountability by identifying appropriate performance measures was clearly indicated. In response to this, CDC has begun a national strategic planning process to guide the strategic and programmatic growth of the program in addressing multiple levels of risk factors through a primary prevention orientation, to identify recommended practices for RPE activities, and to identify indicators and corresponding measures of success. In addition, the creation and implementation of a RPE strategic plan will assist in greater consistency and evaluability of the program.

In response to recommendations to provide additional support for sexual violence surveillance data, CDC committed $400,000 in FY 2004 funds to support the implementation of optional Sexual Violence and Intimate Partner Violence BRFSS modules by state DOHs.

Future efforts to respond to the recommendations from the RPE evaluability assessment include a commitment to fund an empowerment evaluation with eight to ten recipients of RPE

funding in order to build organizational evaluation capacity as well as identify potentially promising practices to share with the larger sexual violence prevention field.

## CONCLUSIONS

The RPE evaluability assessment has contributed to the successful transition and administration of the RPE Program. By providing a comprehensive characterization of the program, the evaluability assessment has enabled CDC to strategically allocate resources to support effective program practice. The identified barriers and needs have formed the basis of much of CDC's training and technical assistance efforts, and the findings as a whole have formed the platform of CDC's national RPE strategic planning initiative. Staff at CDC will review the report's recommendations on a regular basis to assess implementation progress and anticipate continued work with RPE grantees and other partners to broaden the reach and strengthen the impact of the RPE Program.

The successful administration of the RPE Program is important, as it has larger implications for prevention of rape and other sexual violence in communities. Prevention of sexual violence will not only help individual community members but will also reduce the burden on community systems, such as healthcare, social services, and law enforcement. Improvements to the RPE program that may come about as a result of this evaluability assessment should ultimately benefit community members and the systems that serve them.

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