North Dakota Domestic & Sexual Violence Coalition

Ready to Rise

Assessing the North Dakota Domestic & Sexual Violence Coalition's Capacity for Leading Health Equity-Focused Sexual Violence Prevention Efforts

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Wise Action CONSULTING

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OVERVIEW

North Dakota Domestic & Sexual Violence Coalition (NDDSVC, formerly CAWS North Dakota) is a nonprofit, nongovernmental organization that serves as North Dakota's statewide coalition[1] for addressing sexual and domestic violence. Through its strategic focus on identification, intervention, and prevention it works to "support and present a unified voice for 20 crisis intervention centers across North Dakota." [2] Its origins date back over forty years when North Dakotans working to provide services to battered women and rape survivors identified a need for statewide networking, information sharing, training and education, and legislation. [3]

A key funding source for sexual violence primary prevention work is Rape Prevention and Education (RPE) Act funding administered by the U.S. Centers for Disease Control and Prevention (CDC). In 2023, NDDSVC received funding to assess its capacity to lead sexual violence primary prevention efforts by focusing on information about their role, context, and organizational capacities in five key areas: staffing and resources, staff skills and expertise, training and technical assistance, collaboration and partnerships, and data and evaluation. A mixed methods approach was used to gather information from 2013 to 2023 relating to NDDSVC activities in each of these capacity areas. This report is the result of that assessment.

This assessment showed that NDDSVC is exploring how a health equity focus within sexual violence primary prevention can best fit the North Dakota context. Through their collaborations with the North Dakota Department of Health and Human Services (NDDHHS) and the First Nation Women's Alliance, NDDSVC identified several populations in North Dakota that experience a high and disproportionate impact of health inequities. They have used that information to inform the design of two projects for the coming four-year cycle of Rape and Prevention Education Act (RPE) funding.

In doing this work, NDDSVC staff are mindful of the socio-political climate of North Dakota, one that is described in their history books as the most complex in the country.[4] Their unique role as an intermediary organization--one that both serves and leads; one that considers the whole of North Dakota, while also focusing on the uniqueness of each community and member program; one that both implements funder priorities and works to shape them requires significant skills.

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[1] Every state and U.S. Territory has a sexual assault coalition that is recognized by the federal government to both support and represent the state's community-based sexual assault services programs. Sometimes these organizations work to address sexual assault or sexual violence along with other crime areas like domestic violence, teen dating violence and stalking. Sometimes there are separate and distinct coalitions for sexual and domestic violence. There are also twenty Tribal Coalitions that work to end violence across Indian Country and in Tribal lands. First Nation Women's Alliance is a Tribal Coalition also addressing sexual violence in North Dakota.

[2] Retrieved from https://www.NDDSVCnorthdakota.org/about-NDDSVC/ on June 29, 2024.

[3] See "our history" at https://www.NDDSVCnorthdakota.org/about-NDDSVC/mission/.

[4] From the curriculum found at: https://www.ndstudies.gov/gr8/content/unit-iv-modern-north-dakota-1921-present/lesson-4-alliances-and-conflicts/topic-2-two-party-political-system/section-1-introduction)

NDDSVC has been engaged with sexual violence primary prevention work across the state for many years, but their emphasis on this work declined for a while due to a combination of factors including funding shifts and staff turnover. While there is widespread support for them to return to a leadership role, the impact of significant staff turnover in multiple staff positions has had a significant impact on all the capacity areas assessed. Due to this turnover, expertise was lost, partnerships were sometimes strained, some priorities shifted, and remaining staff were significantly stretched by covering for vacant positions and managing all aspects of the coalition. Within the last 12 months, stability is returning, and key informants expressed hope and optimism that the current expertise and leadership will, in time, grow NDDSVC into the state leader in sexual violence identification, intervention, and prevention that it needs to be.

PROJECT DESIGN, IMPLEMENTATION, and LIMITATIONS

Design

This sexual violence primary prevention capacity assessment was designed by NDDSVC as a yearlong project to learn more about their own potential growth areas regarding sexual violence primary prevention, including attention to addressing health inequity as central to primary prevention. Funding from the Centers for Disease Control (CDC) under the Rape Prevention and Education Act (RPE) supported the project. The work plan focused the review on identifying trends and patterns in NDDSVC's approach to sexual violence prevention in five strategy areas from 2019 to 2023. Those strategy areas were: 1) staffing and resources, 2) skills and expertise, 3) training and technical assistance, 4) collaboration and partnerships, and 5) data and evaluation.
These areas closely relate[5] to the five domains of a survey called the General Capacity Assessment for Violence Prevention (see Appendix A), part of the CDC's VetoViolence® resource package, which describes them as "key areas necessary for organizations to implement, evaluate, and sustain violence prevention strategies.[6]" The work plan designated a mixed methods approach of reviewing documents, surveying staff and partners, and interviewing staff and partners as the primary information-gathering activities. External consultants Laura Williams and Melissa Petrangelo Scaia of Wise Action Consulting were contracted to conduct the assessment. More information about their background can be found in Appendix B. They are the authors of this report.

Implementation

The project was conducted in eight months from November 2023 through June 2024. Williams and Scaia received and cataloged over 600 **documents**[7] including meeting minutes; training

[5] There are slight variances between the two, with Leadership being a distinct category in the Veto Violence Capacity Assessment survey and Training and Technical Assistance being a primary strategy area in the NDDSVC workplan.

[6] Veto Violence Capacity Assessment Report, page 1.

[7] These documents were provided by the Programs Coordinator and Administrative Director at NDDSVC, and the Domestic Violence/Rape Crisis Program Coordinator at NDDHHS. Williams and Scaia also identified additional background and reference documents for context.

agendas and materials; grant documents; emails; guidance and technical assistance materials provided to NDDSVC; and resources, reports, and materials that reflect the training, technical assistance, and data collection around sexual violence conducted by NDDHHS and NDDSVC during the study time period. **Surveys** were sent to around 44 people[8] in four key stakeholder groups: NDDSVC staff, NDDHHS staff who work on the primary prevention of sexual violence, First Nation Women's Alliance staff (the Tribal Coalition in North Dakota), and members of the Primary Prevention Partners group or their organizations. Nineteen surveys were returned and analyzed–including eight from NDDSVC staff, three NDDHHS staff, two staff of the First Nation Women's Alliance, and six members of the Primary Prevention Partners (PPP) group. Twenty-three people from these same stakeholder groups were **interviewed**, which included a mix of people who did and did not complete the survey. Nearly 75% (14 of 19) of those who completed the survey were interviewed including all the staff from NDDSVC, NDDHHS, and First Nation Women's Alliance who returned the survey. Nine additional interviews were conducted with persons who did not complete the survey including a First Nation Women's Alliance staff member and staff from member programs that varied in size and location. The authors also facilitated three different in-person dialogue sessions in May 2024 with member program directors, NDDSVC staff, and domestic and sexual violence program advocates[9] to gather additional information and explore select themes arising in the assessment.

The authors also participated in at least three check-in meetings with CDC grant managers, attended or reviewed several training sessions by national RPE Training and Technical Assistance providers (e.g., Prevent Connect, NSVRC), and held routine check-in meetings with the NDDSVC project leader. These meetings were used to track and facilitate project progress and to better understand both the history and the ongoing development of NDDSVC's primary prevention work over the course of the project.

Collected information and materials were reviewed to look for themes, trends, and patterns that might provide insight and context to the central study question(s) which addressed NDDSVC's capacity to advance sexual violence prevention, particularly one with a focus on addressing health equity. Interviews and transcripts were cleaned and coded by themes, and interviewees were contacted regarding quotations. To support anonymity, each interview was assigned a random number for the purposes of citation. In an instance where, in the authors' opinion, the context of the statement could suggest the identity of a speaker, the interview number and reference were omitted.

This report does not provide, nor does it intend to provide, a full accounting or evaluation of any one or more of the sexual violence prevention, primary prevention, or health equity activities conducted in North Dakota by NDDSVC, any collaborative partner, or any other stakeholder.

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[8] Twenty-eight people connected to member programs and/or the Primary Prevention Partners group were invited by email in early December 2023, and at least three First Nation Women's Alliance members, four persons associated with administering and/or supporting NDDHHS' Rape Prevention and Education (RPE) funding, and eight NDDSVC staff members were invited to complete the survey. An additional staff from a member program was invited to complete the survey prior to an interview in June 2024.

[9] These sessions were held at the May 13-14, 2024 NDDSVC Membership Meeting (2.5 hours), the May 16, 2024 DVSAN meeting (2 hours), and a NDDSVC staff session (4 hours) on May 15, 2024.

Limitations and Adaptations

The main limitations to the data gathering relate to a shortened period for project implementation, incomplete data related to staff who are no longer at NDDSVC, and specific limitations with the survey tool and its administration.

The shortened project period resulted in a more selective review of documents and a determination to not pursue a case study activity that had originally been proposed. After an initial scan and cataloging of documents, materials selected for deep review and coding were survey results, interview transcripts, and Primary Prevention Partner meeting minutes spanning the study period (2019-2023). Other materials were reviewed and referenced for providing context, determining themes, and identifying interview and meeting questions. The proposed case study activity was meant to evaluate partnerships but was replaced with the in-person facilitated discussion sessions in May 2024. Due to a high degree of staff turnover during the period of review, project leaders decided not to invest project time to find and review data (e.g., resumes) on staff no longer at NDDSVC. Time distribution forms were not examined for any staff, as it was jointly determined between the contractors and the NDDSVC project leader that such an activity would not return a significant benefit for the investment of time required for collection and analysis.

The survey results should be understood in the context of limitations in the tool itself and how it was administered. The General Capacity Assessment for Violence Prevention is a general violence prevention survey tool, not specific to sexual violence prevention, nor to a state sexual violence coalition context.[10] It also does not significantly include questions targeting health equity and makes no distinctions between staff and board leadership and skills. Thus, while survey results provide a valuable starting point for exploration and discussion about NDDSVC's capacity around sexual violence primary prevention, the view provided is limited. For these reasons, questions were added to interviews and facilitated dialogue sessions on two additional key areas: the North Dakota sociopolitical context for health equity-focused prevention work and a state sexual assault coalition's role in advancing that work. Interviews provided an opportunity to clarify responses for those who were interviewed.

The survey tool was initially administered by the Programs Coordinator at NDDSVC through a convenience sample to facilitate quick returns as the project had experienced a delayed start. An invitation to participate was emailed to prospective participants with the survey link and a request to return the completed survey to her. She then forwarded the completed surveys to the contracted consultants. Since survey respondents were not anonymous, it is possible that this affected some responses. The consultants attempted to account for this by providing opportunities for respondents to discuss their responses in private interviews. Through these interviews, it also became clear that respondents had varied understandings of whom to think about when answering questions about "my community leaders" and that a rating of 3 (on a scale

[10]As the website states "This assessment is not specific to one type of violence. It can be used to assess capacity in any organization with a mission or programs dedicated to preventing sexual violence, intimate partner violence, youth violence, teen dating violence, or child abuse and neglect." Retrieved on June 29, 2024 from https://vetoviolence.cdc.gov/apps/capacity-assessment-tool/#/.

of 1 to 5) was applied in varied circumstances (e.g., I don't know, sometimes). While a respondent's intent could be clarified through interviews, it did not change the numerical assignment for a statement or domain and thus those results need to be understood accordingly. It is also unclear that survey respondents were always answering for the 2019-2023 timeframe of the study.
Interviews with survey respondents provided a chance to account for many, but not all, of these limitations.

NDDSVC'S ORGANIZATIONAL CONTEXT

As noted above, NDDSVC is a nonprofit, nongovernmental organization that serves as North Dakota's statewide coalition[11] for addressing sexual and domestic violence. It both serves and leads twenty sexual and domestic violence intervention programs that serve North Dakota communities. Through its activities, it works to advance the identification, intervention, and prevention of both sexual and domestic violence. Its origins date back over forty years when North Dakotans working to provide services to battered women and rape survivors identified a need for statewide networking, information sharing, training and education, and legislation.[12]

Today, state coalitions continue these roles as they work in both directions–training and supporting local programs--and advocating on behalf of these same programs and the survivors they serve, in policy, funding, and public awareness efforts. They also work to build partnerships across all sectors that engage in their strategic areas of focus and advance their mission on behalf of survivors across the state. Understanding NDDSVC's origins, the roles they play as a coalition, and the current climate for this work in North Dakota provides an important context for considering its capacity to advance sexual violence primary prevention in the state.

Since NDDSVC expressed interest in reclaiming a leading role in this work, consultants asked key stakeholders what roles they thought a statewide coalition[13] should adopt regarding sexual violence primary prevention. They were asked this in interviews and in polling at a Membership Meeting attended by directors of coalition member programs. In both interviews and polling, a list of common roles for coalitions was shared (see Figure 1). While prioritization varied among respondents, there was agreement that each role had its place in some circumstances. The roles that were most often cited were training and technical assistance, lobbying, promoting a

[11] Every state and U.S. Territory has a sexual assault coalition that is recognized by the federal government to both support and represent the state's community-based sexual assault services programs. Sometimes these organizations work to address sexual assault or sexual violence along with other crime areas like domestic violence, teen dating violence, and stalking. Sometimes there are separate and distinct coalitions for sexual and domestic violence. There are also twenty Tribal Coalitions that work to end violence across Indian Country and in Tribal lands. First Nation Women's Alliance is a Tribal Coalition also addressing sexual violence in North Dakota.

[12] See "our history" at https://www.NDDSVCnorthdakota.org/about-NDDSVC/mission/.

[13] A coalition can be variously understood as the non-profit organization itself or that organization and its member programs. Both these understandings were used at various times in the project to explore the concept of capacity. In the instance of identifying specific 'roles,' the understanding of the non-profit organization of NDDSVC was used in interviews and the May 14, 2024 NDDSVC Membership meeting.

statewide voice, coordinating/facilitating/linking information and people, and sharing expertise on sexual assault knowledge, research, and resources.[14]

Specific skills to carry out this work require the ability to identify and work with significant variation among programs due to their differences in size, location, degree of local support, levels of expertise, etc. A coalition must consider the whole of a state while also focusing on the uniqueness of each community and member program in it. It both implements funder priorities and works to shape them; guides local programs and follows their lead.

Figure 1

List of Common Coalition Roles

Fulfilling these roles to achieve success and mitigate unintended outcomes also require sensitivity and awareness of the context in which the work is done. This assessment identified two key features–the North Dakota climate for sexual violence work, and the North Dakota climate for primary prevention and health equity work– that shape NDDSVC's work and thus how its capacity might be best understood. [15]

Climate for Work to Address Sexual Violence

As data collected in this project and in Community Readiness Assessments show, a strong norm of privacy and silence around sexual violence prevails in North Dakota. Indeed, the number of North Dakotans who think sexual violence is a problem in the state has actually gone down.[16] Interview participants confirm that victim-blaming is a significant problem with attitudes being referred to as "old school" and "stepping back into the good old boys club."[17] These attitudes and subsequent silencing of survivors lead many to believe sexual violence is not a significant issue in North Dakota. These attitudes prevail at the same time that program directors report the number and severity of sexual assault cases are increasing. They have also recently learned that a funding source that significantly supports their response services is likely decreasing.[18]

These program directors also note that the COVID-19 pandemic led to significant staff turnover in agencies they and survivors rely upon (e.g., law enforcement, prosecution, medical). In many communities[19] this turnover led to a sharp decline in partner expertise, with positions often filled

[14] Analysis of themes from 23 interviews and results of Mentimeter polling from May 14, 2024, NDDSVC Membership meeting.
[15] In interviews, participants were asked what came to mind when they heard the terms "sexual violence," "North Dakota," and "health equity" individually and together.
[16] NDDHHS personnel indicated that recent results from the Behavioral Risk Factor Surveillance System showed this downward trend in the number of people in the state who believe sexual assault happens here.
[17] Discussed in interviews 7, 13, and 9.
[18] NDDSVC Membership Meeting, May 14, 2024. VOCA or Victims of Crime Act funding is likely to decrease. VOCA funds come from the criminal fines and penalties collected by the federal government and are distributed to states to enhance their services to crime victims.
[19] Also worth noting is the state's decision to centralize its social work response–impacting collaborative opportunities around sexual assault identification, intervention, and prevention.

by people with less knowledge and experience in their own discipline's sexual violence response and in a community-coordinated response to sexual violence. This is acutely felt in rural North Dakota where resources are especially limited, and victim-blaming is high.

A few interviewees also commented on the racialized climate around sexual violence and harassment. indicating that most perpetrators of Indigenous women are white men and that some newer North Dakota female legislators of color have been subjected to harassment. Several interviewees commented about how Indigenous women are disproportionately impacted by sexual violence in North Dakota. Further, as both NDDSVC and First Nation Women's Alliance have noted,[20] there is a historical and cultural context of colonialism at play in North Dakota that has enforced historical and contemporary oppression resulting in multiple forms of intersecting and compounding violence in the form of racism, sexual violence, domestic violence, homicide, and abduction.

Climate for Work on Primary Prevention and Health Equity

Among the twenty coalition member programs, only a few have the staff size and funding to have dedicated staff to build competency around primary prevention. For this reason, some interviewees noted that the climate they face around sexual violence response is directly linked to their sense of pragmatism about the scope and sustainability of prevention efforts. In other words, if the police, prosecutors, judges, and others in community leadership do not take sexual violence seriously and do not endorse prevention efforts, why would others?[21] Some programs with resources and experience delivering prevention efforts do feel a strain but are also heartened by steady growth in community participation. They note that this engagement took several years to build. While some communities note this progress, most report significant barriers to doing primary prevention work in the state.

Regarding health equity, program directors shared that in the North Dakota context the word and focus on 'equity' equates for many to a 'woke' or politically liberal approach to addressing a social issue. They further noted that after the COVID-19 pandemic response the federal government and particularly Centers for Disease Control response is held suspect. This reality impacts how they shape their messaging on sexual violence primary prevention and the degree to which they think an explicitly focused health equity approach to primary prevention is feasible for them. At the same time, interviews showed that understandings of health equity vary among stakeholders demonstrating a lack of consensus on a definition. The staff from NDDSVC and the NDDHHS provided definitions closest to the one provided by the CDC. However, the rest of the practitioners' understanding of what "health equity" is generally focused on thinking about access to medical health resources and eliminating physical health disparities. A few practitioners described it as "upstream approaches," "leaving no one behind" or "economic independence." Many interviewed thought that the general public would not connect addressing health equity to sexual violence prevention. For those interviewed who had a general understanding of the CDC definition, they often stated that addressing it takes a lot more time and money than the CDC and NDDHHS give in resources. They also described the sustained time and commitment needed to address health equity. Practitioners who work with many Native American survivors understand how health inequity contributes to and supports racial injustice in North Dakota. Several people interviewed.

[20] See 2024 application narratives for RPE funding.

[21] Interviews 15 and 22.

discussed the lack of attention to the overall health and well-being needs of Indigenous women and, in particular, Indigenous survivors of sexual violence.

Notwithstanding the challenges posed to advancing sexual violence prevention work in this context, directors of coalition member programs believe in the value of prevention work. When asked if resources were not an issue, how they would distribute their program attention to the coalition's three strategic values of identification, intervention and prevention, their response for prevention went from lowest (14%) to highest (45%).[22] This suggests it would be a mistake to assume they are not interested in prevention, or that resources are not a significant factor.

PROJECT QUESTIONS, FINDINGS, AND CONSIDERATIONS

Results of the assessment along with ideas for NDDSVC on next steps for building each capacity area are reported below by each guiding question.

Question 1: What staffing and resources do NDDSVC have devoted to sexual violence prevention efforts and health equity?

The first domain of the capacity assessment is related to identifying the staffing and resources NDDSVC has devoted to its sexual violence primary prevention efforts from 2019-2023. Several themes emerged from surveys and interviews: sexual violence prevention funding amounts are too low and not aligned with the scale of the work; funding shifts and past leadership decisions led NDDSVC away from a significant focus on prevention work for many years that they are now attempting to reverse; and staff turnover during the five year period reviewed (2019-2023) had significant and far-reaching effects on NDDSVC's standing as a leader on sexual violence primary prevention–both for member programs and others statewide.

From 2019 through 2023 at NDDSVC, sexual violence prevention funds ranged from 2.8% of the total budget to nearly 4% of the total budget. This represents a range of around $45,909.00 to $68,671.00[23]. These funds supported sexual violence primary prevention level staffing ranging from .45 to .5 of a full-time position, which was primarily allocated to the Sexual Assault Coordinator Position.[24] At times, when project activities or circumstances necessitated it (e.g. gaps in funding cycles, staff turnover) the funding has supported hours for prevention work by other staff positions.

Prior to 2019, NDDSVC had sufficient funding to dedicate a full-time staff position to sexual violence prevention work. Interviews indicate that previous NDDSVC leadership opted out of pursuing some prevention-related funding. Funders also shifted some of their funding away from coalitions. Determining why this occurred was beyond this study's focus, but it is clear from interviews that it impacted NDDSVC's capacity to lead on sexual violence prevention for many

[22] NDDSVC Membership Meeting, May 14, 2024.

[23] Based on calculations provided by NDDSVC Administrative Director in June 2024.

[24] Information from Programs Coordinator, Suzanne Kramer-Brenna, 14 June 2024.

years to follow. In response, NDDHHS took a stronger role in both funding and training and technical assistance with coalition member programs. This is addressed further in relation to question three below. One interviewee noted about this time that "money talks" and the shift made room for other funders–those without historic ties to work in the sexual and domestic violence field to step in.[25]

Across stakeholder groups interviewed, there is a recognition that funding levels for sexual violence primary prevention are low for everyone.[26] This impacts the salaries available to attract and retain staff in their positions,[27] and the scale and scope of what can be addressed. Directors of local member programs also expressed frustration at how often funders change what they fund in ways that seem disconnected from what local practitioners know works. Among all interviewed there is a sense that addressing the factors that shape and influence sexual violence[28] and health inequities in rural communities requires deep and sustained commitment. As one interviewee asked, "…how long are the prevention supporters, even nationally, going to be willing to be part of this very long-term comprehensive, deep, socially, culturally, all of that [change] effort?" She went on to say: "I hope they're in it for real and for the long haul, but that's what it has to be."[29]
As is the case in many organizations, high staff turnover has impacted NDDSVC's work. During the five years under review, NDDSVC experienced a staff turnover rate of 30% across all positions, with the highest rate of turnover occurring in the last year of the COVID-19 pandemic (2022-2023). The organization has hired four different Executive Directors, three different Sexual Assault Program Coordinators, and four different Domestic Violence Program Coordinators between 2019 and 2023. The relatively young civil legal program also experienced staff turnover. In a small staff, any turnover directly impacts other staff who may have to cover other work. At minor and manageable levels, this can increase awareness and insight about each other's roles. However, significant and frequent turnover may prompt a 'survival mode' with less time for exploration, innovation, and cross-functional exploration that can drain staff that stay.[30] Some stakeholders who have also experienced significant turnover and challenges in their own agencies expressed sympathy for NDDSVC, indicating that they understand and hope that they can return to stability. Further discussion about the impact of NDDSVC staff turnover is discussed in the survey results section below.

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[25] Interview 26.

[26] Interviews 4, 8, 13, and 21.

[27] Interview 13.

[28] Rural Town Hall Listening Session hosted by the Centers for Disease Control and Prevention's (CDC) Violence Prevention Practice & Translation Branch, March 11, 2024; Navigating Sexual Violence Prevention in Rural Communities: Challenges, Needs, and Strengths, Prevent Connect Blog by Ashleigh Klein-Jimenez, March 27, 2024, for comment on the need to address the intersecting factors that contribute to sexual violence, including patriarchy, and engage with marginalized populations. See also the discussion in Dekeseredy (2009) that patriarchy is a patterned feature of rural social structure that results in support of rural woman abuse if not contested. He does note that it is not the sum total or rural culture as "norms and values promoting abuse exist side by side in rural places with norms and values that can be used to prevent and deter abuse."

[29] Interview 4.

[30] This was evidenced by several staff not feeling they had enough knowledge to answer some statements on the survey. A few commented that during this period of high turnover, time and space to support staff growth were limited—for example to check in on each other in a holistic way, or to explore differences in perspective or opinions being raised by newer staff.

Survey results

Per the Capacity Assessment Survey, respondents identified the Staffing and Resources Domain as the weakest (or lowest score) with an average score of 68% across all respondents. By grouping of respondents, the scores from NDDSVC staff were (70%), ND Health Department (53.3%), Primary Prevention Partners/Others (73.3%), and First Nation Women's Alliance (70%).

Scoring highest (strongest agreement with the statement) was "my organization's violence prevention strategies are part of a collaborative effort with other agencies to prevent violence," and "collaborate well with other units/staff in my organization to accomplish common goals," both scoring an average of 4 out of 5. Scoring lowest (strongest disagreement with the statement) was "staff turnover at my organization does not interfere with implementing a violence prevention strategy" with an average score of 2.6, and "staff time allocated to a violence prevention strategy is protected (i.e. staff members would not be pulled away to do other work)," with an average score of 2.8.

Interviews confirm that staff have been pulled away to work on other projects due to gaps in funding cycles,[31] staff turnover, and, at times, lower prioritization of prevention work by past NDDSVC leadership.[32] The sense that prevention hasn't been a priority, is a reflection of past leadership decisions not to seek additional funding for prevention.[33] Others outside of NDDSVC indicated it was an awareness that the small staff size of NDDSVC overall that led them to assume that staff would be pulled to do other things.[34]

Survey results and interviews indicate that staff turnover has had the biggest impact on NDDSVC's role as an identified leader of sexual violence primary prevention. The impact, which has been felt both inside and outside the organization, has been far-reaching. One interviewee noted "I think that staff turnover has hurt the organization a lot."[35] Others said:

"We've had turnover. So that's been really hard, both in the director and in leadership and in our sexual assault coordinator who does prevention work. We've had so much turnover just in the [time] that I've been with NDDSVC. So that also makes it hard to get things done."[36]
"I think that that's been a big piece of it is there's been such a turnover rate. For one is that a) you don't know who the staff is sometimes, and b) you don't even know what they're capable of doing any more, because you don't know if they have a staff to fill that position... when you really don't know who's going to answer the phone, or they can't answer your question because they've only been there for two days, and they might only be there for another two days, you know that that puts a really big damper in how you see things through."[37]
At the same time, some staff at NDDSVC have a long tenure at the agency and contribute significant institutional knowledge–an Administrative Director who has been at NDDSVC for over 20 years, and an accountant who has been at NDDSVC for over 5 years. A former NDDSVC employee did return after several years away and brings exceptional and recognized expertise in

[31] Interviews 2, 17, and 19.
[32] Interviews 17 and 19.
[33] Interviews 17, 21, and 23.
[34] Interview 9.
[35] Interview 5.
[36] Interview 19.
[37] Interview 18.

sexual assault and domestic violence intervention and prevention. These staff have dedicated considerable time and investment in mentoring newer and younger staff in accordance with their roles, and the new Executive Director is attentive to rebuilding staff energy.

This new rebuilding has caught the attention of stakeholders and there is genuine optimism about the current direction of NDDSVC and its future. As one external interviewee shared "I think it's getting much, much better, and I think we're on the right track."[38]

Considerations

- Continue strengthening funding and attention consistent with the role NDDSVC chooses regarding sexual violence prevention. Recent conversations indicate that the role of prevention has been included in 2024 NDDSVC Strategic Planning conversations and there is work to identify additional funding sources. Continue these efforts to build and sustain capacity.
- Dedicate and protect staff time on sexual violence primary prevention while also supporting all staff in developing a working understanding of prevention concepts. This can reduce the loss in expertise during times of staff transition and turnover.
- Explore where and how existing and future funding can support staff building thoughtful connections with people and communities disproportionately impacted by sexual violence relative to any project area. Invite input and insight into how these communities see NDDSVC might engage or support them in sexual violence primary prevention strategies.

Question 2: What relevant skills and expertise have past and present NDDSVC staff been able to bring to sexual violence primary prevention and health equity?

The second domain of the capacity assessment is related to identifying the relevant skills and expertise of NDDSVC staff to engage in sexual violence primary prevention, and with a focus on health equity. Staff whose work was directly funded by RPE and those in a supervisory/leadership role during the years 2019-2023 were the intended focus, however, given the level of staff turnover in these key positions, a focus on the skills of *current* staff members was deemed most useful.

There is a mix of expertise on staff regarding sexual violence prevention work, with key staff positions including both a highly experienced staff person and a person newer to the field of sexual violence intervention and prevention work. The rate of staff turnover (addressed above) has created a particularly challenging climate for inexperienced staff to step into as member programs and partners are weary. However, significant mentoring from experienced staff and support from collaborative partners are being offered to support new staff who have shown dedication and tenacity to learn the necessary skills.

Overall, the current staff of NDDSVC have earned the confidence of member programs and the NDDHHS for sexual violence primary prevention work. One NDDSVC member program staff stated, "I think that they are a blend of expertise at this point between very new to very

[38]Interview 22.

experienced. I'm excited for where things are going with a new director at the helm. So, I think he'll, he'll be a great leader, and he seems to really be passionate about the overall mission of NDDSVC."

The newer NDDSVC staff focused on sexual violence prevention has a grounded and emerging understanding of primary prevention, spectrum of prevention, and health equity theory and practice. There are some opportunities for ongoing training and technical assistance to increase knowledge and skills in primary prevention. Long-term NDDSVC staff have a firm foundation in primary prevention, spectrum of prevention, and health equity theory and practice. NDDSVC does have an agency procedure that requires that they engage in a specific number of ongoing training and technical assistance to maintain and/or increase their skills. NDDSVC staff mentioned various ways that NDDSVC and member organizations implement health equity strategies within activities. However, most focused on the individual level and did not give examples of extending to the larger community and society. NDDSVC staff reported that limited funding, training, and resources needed for activities in the outer layers of the Social Ecological Model (SEM) make it challenging to implement.

Survey Results

In the Capacity Assessment surveys received, the domain of Staff Skills and Expertise was the most highly rated domain among survey respondents with an average rating of 84%. Stakeholder groups' overall section ratings were as follows: NDDSVC staff (85%), NDDHHS (66.7%), First Nation Women's Alliance (70%), and PPP members (96.7%).

Seven of the eleven statements in this domain received an average rating of 4.0 or above (on the 1-5 scale), indicating significant agreement with the statements. The two most highly rated statements were "knowledgeable about violence" (4.7), and "knowledgeable about evidence-based violence prevention programs" (4.4). The two lowest were "are experienced overseeing community-level prevention efforts" (3.7), and "can influence laws and policies related to risk and protective factors for violence" (3.8).[39] These lower ratings are understandable given that most prevention projects in the state have historically been focused at the individual or relationship level, and that both staff turnover and a less-than-receptive political climate have likely impacted legislative efforts. At the same time, ratings for "understand the importance of developing and enhancing policy related to violence prevention" (4.2) and "are knowledgeable about when, why, and how to develop partnerships" (4.3) were also noted as strengths. These strengths suggest an important capacity NDDSVC might draw upon to advance prevention and health equity work.

The Capacity Assessment surveys did not focus on health equity. In individual interviews, each staff member of NDDSVC was asked to define "health equity." In addition, during an in-person meeting with all of NDDSVC' staff, we facilitated a discussion about health equity as a social justice approach to preventing and ending sexual violence. Amongst the NDDSVC staff, there are varying degrees of understanding of health equity and its role in sexual violence primary prevention. The NDDSVC staff that work on sexual violence prevention do have a clear understanding and the skills and expertise to infuse a health equity approach to sexual violence primary prevention.

[39] Scoring slightly lower than the other statement rated at 3.8 when carried out to the hundredths of a point. See Appendix 1 for the full results of this section.

From 2019-2023, NDDSVC staff attended training, education opportunities, and webinars in sexual violence primary prevention, evidenced-based programs, and related health equity work. The skills and expertise of Coalition staff will have an impact on the role of NDDSVC and its collaboration and partnerships with member programs and others. Through interviews and the capacity assessment surveys, we learned that the current skills and expertise of NDDSVC are rated high. However, staff turnover at NDDSVC impacts the stability of NDDSVC's capacity for skills and expertise. In order to be seen as a leader in addressing sexual violence, NDDSVC needs less turnover and to continue to invest in staff with skills and expertise.

Considerations

- Determine the roles NDDSVC will fulfill moving forward regarding sexual violence primary prevention and determine the staff skills and expertise needed to fulfill those roles.
- In light of the complex climate for doing sexual violence prevention work in North Dakota, NDDSVC will likely need to hold and navigate many tensions to develop a cohesive and home-grown statewide approach to sexual violence prevention in North Dakota. Consider supporting staff members' development and use of dialogue[40] and inquiry[41] techniques. These techniques are also taught by Praxis International as part of the Advocacy Learning Center[42].
- Facilitate dialogue discussions between staff with extensive experience in the movement to end sexual violence and those newer to it grounded in curiosity and inquiry. Explore the similarities and differences between the public health understanding of health equity and the movement's understanding of systemic oppressions and intersectionality.
- Expand the support available to newer staff by supporting them to reach out to find additional mentors/teachers to augment the mentoring they receive internally. Experienced staff may have suggestions or ideas as to valuable resource people.
- Support the growth of a useful level of understanding about prevention and health equity insights among all staff to facilitate the intersections of the work. Dedicate and/or seek out specific resources for less experienced staff to deepen their knowledge and experience regarding health equity, sexual violence, and sexual violence prevention work.
- Continue to look for ways that all staff can build knowledge and skills around non-majority populations and populations of high impact in order to better fulfill their training and technical assistance roles.

During a time when NDDSVC had instability in its leadership, it impacted the view of partners and member programs' experience and perception of the skills and expertise at the Coalition. With additional funds and resources, NDDSVC's ability to further increase its skills and expertise can grow.

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[40] If not already known, consider learning the Freirean dialogical method. One source for further information on this approach is: https://headconf.org/wp-content/uploads/pdfs/5471.pdf.
[41] For both a discussion and practical resources see: https://www.hsdinstitute.org/resources/resources-inquiry.html
[42] Praxis International provides training on the dialogue techniques through its Advocacy Learning Center. In particular, the Individual Advocacy segment focuses on dialogical techniques for advocates. More information is available at: https://praxisinternational.org/advocacy-learning-center/

Question 3: How has NDDSVC incorporated health equity into its training and technical assistance around sexual violence prevention?

The third area of this capacity assessment examined the training and technical assistance for sexual violence primary prevention provided by NDDSVC during the 2019-2023 period of the study. In particular, the goal was to learn how NDDSVC's training and technical assistance incorporates a health equity focus into its prevention programming. This assessment shows that as NDDSVC has reprioritized sexual violence prevention by securing additional funds for primary prevention work, building staff expertise, and continuing its partnership with NDDHHS in its training and technical assistance role. While NDDSVC's position as the training and technical assistance leaders around sexual violence primary prevention diminished during the period studied, they did remain engaged. Today, all stakeholders agree that a *primary way* NDDSVC can support advancing sexual violence primary prevention in North Dakota is by providing technical assistance and training.

As noted above, shifts in prevention funding (which started over a decade ago) and staff turnover combined to create a gap in coalition leadership around sexual violence primary prevention in the 2019-2023 period. When funding shifted, NDDSVC supported member programs prevention work, but seemed to some as if they opted out of leading a statewide response. In response, the NDDHHS reported taking up a role as both funder and training and technical assistance provider to local programs for sexual violence prevention work. Emails and grant reporting indicate that NDDSVC staff were included in training, orientations, and connection meetings with these grantees and were often identified as additional sources for technical assistance.[43]

NDDHHS also reports initiating the Primary Prevention Partner meetings to facilitate coordination, information sharing, and training and technical assistance among those doing or interested in doing primary prevention work. NDDSVC staff were included in these meetings, and minutes and emails indicate they were visible, involved, and identified to participants as an additional resource for technical assistance.

Over the five years reviewed, meeting participants updated each other on over 30 different prevention programs they were implementing (or reviewing for implementation) in their communities. The most widely used prevention programs were Safe Dates, Green Dot, Coaching Boys Into Men, Athletes as Leaders, and consistent attention by First Nation Women's Alliance of Be a Good Relative and the Butterfly Project. Programs also shared news and ideas regarding awareness-raising activities–including events for Sexual Assault Awareness Month and Domestic Violence Awareness Month. These awareness-raising events challenge a predominant social norm around silence about sexual assault in North Dakota.

The group also became a primary way for the NDDHHS and NDDSVC to offer training and technical assistance to these programs–which they did in the form of resource recommendations, webinars, toolkits, centralizing data and prevention resources on websites, a statewide media

[43] North Dakota Department of Health and Human Services FY20 Rape Prevention and Education Report.

campaign, local fact sheets and resources, and delivering training in meetings and in special events.[44]

Minutes show that health equity began being discussed in the Primary Prevention Partners' meetings in July 2020, but a much more significant focus began in 2023. Overall, eight presentations were documented in the minutes during this time period.[45] Health Equity in sexual violence primary prevention was also significantly addressed at the September 2023 Primary Prevention Summit. NDDSVC co-hosted and/or participated in these events.

Today, these meetings are co-hosted and co-facilitated by NDDSVC and NDDHHS and include a broad range of coalition member programs (including First Nations Women's Alliance). In the meeting minutes, NDDSVC, NDDHHS, and First Nation Women's Alliance all mention the health equity focus of their assessments and future grants. The collaboration of these three entities and the Primary Prevention Partners group is further described in question four below.

Survey Results

While the capacity assessment survey did not contain a domain-specific to technical assistance and training, twelve questions across the domains of Leadership (L Questions 1 and 7), Skills and Expertise (SE Questions 1-4, 6, and 9), Collaboration and Partnerships (CP Question 3), and Data and Evaluation (DE Questions 1,3, and 7) shed light on how NDDSVC staff and external stakeholders rate this capacity. Seven statements indicated significant strengths with average scores of 4 or above (SE 1, SE2, SE 6, SE 9, CP3, L1, L7). Two statements indicate good strengths with average scores of 3.9 and higher (SE 3, DE 1). The remaining three statements indicate capacity areas that are fairly strong with average scores of 3.7 (SE 4, DE3, DE7).

Also of note, is that while some questions such as "have skills in selecting and adapting prevention programs that reflect the needs of the population," and "have sufficient data on the needs and resources of the population being served" are relevant to skills needed to advance health equity, the survey did not focus much on identifying capacities that would be unique to this area.

[44] Training events held in the five years reviewed include: Focus, Framing, and Facts: Effective Messaging for Our Work (2019), Green Dot Webinars (2019), Advanced Concepts in Prevention (2020), Orientation for state Sexual Violence Prevention Grantees (2020), Launching and Supporting Community Prevention Teams (2021), Green Dot Certification Training (2023), and a Sexual Violence Prevention Summit (2023).

[45] Presentations mentioned included: Health Equity and Prevention Presentation by Krissie Guerard, North Dakota Department of Health, Health Equity Director (July 2020), A local community prevention team hosted a presentation from public health on health equity (July 2022), What is Health Equity? presentations (April, July 2023)--includes examples, equity assessments, organizational capacity, implications for prevention, Measurement and Health Equity Presentation (April 2023), Health Equity and Prevention Plans agenda item (April 2023), Prevent Connect's Health Equity in Practice Webinar Series mentioned (July 2023), Health Equity Corner with updates/presentations, including a definition of health equity, and examples of strategies in the field (July, November 2023).

Considerations

Since widespread agreement exists that a key role for NDDSVC is as a provider of training and technical assistance,[46] NDDSVC is encouraged to continue to explore and strengthen this role. Toward that end, NDDSVC may want to discuss how they plan to strengthen this focus with member programs and their collaborative partners–particularly First Nation Women's Alliance and the NDDHHS–and other training and technical assistance providers in the state. Based on information gathered, other next steps for consideration include:

- Continue building staff competencies and experience to facilitate their ability to identify and lead useful training and technical assistance strategies.
- Facilitate information sharing between collaboration partners, Primary Prevention Partner group participants, coalition members, and those involved in implementing the proposed 2024-2028 RPE program strategies.
- Review training materials for proposed fit and broaden cultural understandings and references (e.g. "good relative" as an alternative to "bystander," denoting whether the evidence base shows suitability for rural environments, using case studies and/or focus group feedback indicate the link between sexual violence, the population in focus, and the social determinants of health (SDOH).
- Provide training experiences that benefit both new and long-serving advocates and preventionists.[47]
- Consider training and technical assistance resources such as the toolkit, newsletters, and website and explore how PPP members, member programs, and other collaborative partners use these materials in light of 'viral' and unplanned moments when sexual violence and/or sexual violence prevention are common conversation.[48] Quickly convene and/or equip local programs and prevention leaders with the information they need to make a difference. Consider statewide visibility at those moments as well.
- Keep people informed of national trends and data in addition to state-level information.[49]
- In light of the state and national training and technical assistance resources routinely and consistently shared with PPP members, explore what is useful and how to develop a long-term strategy for partners, community members, and staff.

[46] This sentiment was expressed in interviews and in polling results of member program directors at the May 14, 2024, NDDSVC Membership Meeting when asked to identify coalition roles.

[47] Interview 15.

[48] Director at the May 14, 2024, NDDSVC Membership meeting noted a recent discussion that was trending on social media which centered around the question to women: "if you were alone walking in the woods, would you rather encounter a man or a bear?" This led to many women disclosing experiences of sexual violence in citing why they would rather encounter a bear. See more at: https://www.forbes.com/sites/conormurray/2024/05/03/man-or-bear-many-women-say-theyd-rather-be-stuck-in-the-woods-with-a-bear-in-latest-viral-tiktok-debate/.

[49] Feedback in Mentimeter polling from a participant in the May 14, 2024, NDDSVC Membership meeting.

Question 4: To what extent has NDDSVC engaged partners in sexual violence prevention and how are/are not these meeting North Dakota's current and future needs for health equity focused sexual violence primary prevention?

The fourth area of this capacity assessment examined NDDSVC's collaboration and partnerships related to sexual violence primary prevention during the 2019-2023 period. Specifically, the goal was to learn how NDDSVC developed and engaged in collaboration and partnership to address the future needs of a health equity-focused sexual violence primary prevention. This assessment shows that NDDSVC has strong collaborative partners and is working to focus its efforts on sexual violence primary prevention on health equity.

From 2019-2023, NDDSVC's prevention-related partnerships were local member programs, NDDHHS, and First Nations Women's Alliance. The quality of these partnerships and their collaborative work around sexual violence primary prevention is built on a long history of collaboration. Staff turnover at NDDSVC has strained these partnerships at times. More recently, interviews with both collaborative partners indicate support and optimism for NDDSVC's work in general, and with regard to sexual violence prevention work. They are also incorporating health equity into their conversations and sharing their health equity-focused sexual violence primary prevention goals.

NDDSVC is known nationally as being one of a few statewide coalitions that have a working partnership with a federally designated Tribal Coalition and a state department of health. Collaboration and partnership include the sharing of opportunities with each other, one-on-one meetings between NDDSVC staff and NDDHHS staff, and the development of a health equity state action plan for sexual violence primary prevention. At times they formally come together as the State Capacity Building Team. In the recent past, NDDSVC has been a subgrantee to NDDHHS staff as well as a collaborative partner. Interestingly, a few interview respondents pointed out that when an entity funds or has oversight for grant activities, it can be difficult to be in a fully collaborative or independent relationship with that same entity. It is unclear if this has been the case with NDDSVC's relationship with NDDHHS, but it is worth noting that a dual relationship between partners requires special navigation.

The relationship between NDDSVC and First Nation Women's Alliance has also been a long one. Interviews indicate that some (unmentioned) events strained the relationship at some point, but that now NDDSVC is working hard to rebuild and repair trust. Communication is flowing between both groups and a collaborative project was chosen for the next round of RPE funding. Unfortunately, the lower amount of RPE funding available to tribal coalitions–particularly considering the focus on health equity –was noted as a frustration by more than one stakeholder. This could constrain their ability to collaborate as fully as they may wish.

Primary Prevention Partners meetings have also been a key collaboration between NDDSVC and NDDHHS during 2019-2023. Both entities co-host the group, which is attended by preventionists (coalition member program staff and others) from around the state. As noted above in the discussion of question three, these quarterly meetings are a primary venue and connection point for strengthening partnerships with preventionists and delivering training and technical assistance on sexual violence prevention and health equity. In turn, these preventionists are actively

engaging a range of partners at the local level through awareness activities and prevention programs. During the 2019-2023 timeframe, meeting minutes show that at least Primary Prevention Partners members and their organizations engaged around 45 different entities in at least 15 distinct types of organizations across North Dakota.[50] These represent a breadth of potential collaborators available to the coalition as a whole. NDDSVC might consider its potential role in elevating and supporting these connections across the state to grow engagement in sexual violence prevention and health equity work.

In the interviews conducted, one consistent theme was on prevention work being done in the larger cities of Minot, Bismarck, Grand Forks, and Fargo. While this work was applauded, some expressed a desire for a broader diversity of rural voices to have space in meetings. In the interviews, there is also thinking that domestic violence prevention work has been prioritized over sexual violence prevention in collaboration and partnerships.

According to interviews with NDDSVC staff, NDDSVC previously had more and stronger partnerships with state agencies. However, NDDSVC has recently developed a new partnership with the Community Action Partnership of North Dakota (CAPND) and the statewide housing coalition. This new partnership was formalized as part of its joint efforts for their upcoming RPE project. NDDSVC also joined the Multi-Partner Health Collaborative (MPHC) as part of NDDSVC's upcoming RPE project which focuses on promoting housing and economic stability.

Survey Results

In the Capacity Assessment surveys received, the domain of Collaboration and Partnership was rated as an average of 75%. Overall domain ratings by stakeholder groups were NDDSVC staff at 72.50%, NDDHHS staff at 60%, First Nation Women's Alliance staff at 70%, and Primary Prevention Partners/Others at 86.67%.

Respondents had a significant agreement with four statements–applying an average rating of 4.0 or above. The top two highly rated statements were "are part of a network of organizations committed to preventing violence," and "share ideas or information about violence prevention with other organizations and groups." The two statements receiving the lowest average scores were "are part of a community where groups do not have turf conflicts about violence prevention efforts" (scoring 3.4), and "are part of a community where elected or appointed figures are supportive of violence prevention efforts" (scoring 3.2). These ratings indicate respondents felt these specific capacity areas are only fairly strong.

Interviewees also noted that many elected and appointed leaders do not understand sexual violence as a problem in North Dakota, and thus are also less engaged in strategies to prevent it. While many individual member programs talk with their local representatives, there is significant agreement on NDDSVC playing a lead and visible role in lobbying and building relationships with these leaders.[51]

[50] These included health care facilities, colleges and universities, local government, funding agencies, schools, criminal justice partners, community agencies, businesses, social service agencies, state government agencies, and Tribal government and Tribal Coalition partners.

[51] Mentimeter polling results from May 14, 2024, NDDSVC Membership meeting and multiple interviews.

Related to the survey statement about turf conflicts, no stakeholders described any such conflicts outside of the dual relationships and role conversations addressed above. It would be foreseeable, however, that as NDDSVC reclaims a role as a lead training and technical assistance provider and a statewide leader on sexual violence primary prevention that this may disrupt some patterns formed between collaborative partners during a period when NDDSVC was less in the forefront. As these shifts happen, NDDSVC may want to explore with partners ways to navigate tensions that arise in ways that harness the energy from differences while minimizing unnecessary conflict.

Considerations

- Facilitate experts or leaders from within a particular sector speaking to their counterparts in other areas of the state (one example given was a supportive mayor in one community speaking to other mayors).
- Consider the role young people and survivors can play in guiding and/or advancing primary prevention work and NDDSVC's role in elevating these voices.
- Continue supporting all NDDSVC staff in their connections with member programs. This contributes to an overall impression that NDDSVC is a valid and valuable partner that can support connections around prevention and health equity work as well.
- Grow connections with diverse and non-majority communities in meaningful ways. NDDSVC staff expressed an interest in this in interviews. Within NDDSVC, explore how sexual violence impacts these communities and the role they may want to play in designing prevention responses.

Q5. What data does NDDSVC use (and how do they use it) to identify and reach populations in North Dakota who are experiencing high impact of health inequities and sexual violence?

The fifth domain in the capacity assessment (Strategy 5) centered around NDDSVC's knowledge and understanding of sexual violence prevention and health equity data collection to inform decision-making and activities.

As part of the State Capacity Building Team and the Primary Prevention Partners, NDDSVC joined the NDDHHS and First Nation Women's Alliance in data collection efforts including Community Readiness Assessments conducted in 2011, 2017, and 2022 and Organizational Capacity Assessments conducted in 2012 and 2019. These extensive assessments provided both statewide and community-specific data around, for example, risk factors and protective factors, existing prevention efforts, issues related to leadership within prevention, the community's knowledge of the issue, and the local sexual assault programs' capacity to advance prevention efforts.[52] According to interviews, grant applications, and other materials reviewed, some of the other data sources reviewed/used by NDDSVC are the Behavioral Risk Factor Surveillance Survey (BRFSS), the Youth Risk Behavior Surveillance System (YBRSS), and the National Intimate Partner and

[52] See the North Dakota Community Readiness Assessment Statewide Fact Sheet, the North Dakota Planning PowerPoint of October 2022 by Obinna Solutions, Primary Prevention Partners Meeting slides of October 26, 2022, and the Organizational Capacity Assessment Fact Sheets.

Sexual Violence Survey (NSIVS) from the CDC, and North Dakota specific crime data, population data, and health data.[53] NDDSVC also refers to a data dashboard that the NDDHHS shares with them.

These collaborative data collection efforts led the State Capacity Building Team to identify high-impact populations or 'those who are being left behind," as people with disabilities, LGBTQ+ individuals, youth in foster care, and Indigenous women. Of particular concern were those in poverty and those precariously housed.[54] It also identified elements of the community climate for prevention efforts including, as discussed above, social norms around privacy, silence, and accepted violence against women.[55]

NDDSVC used this information to propose its two programmatic efforts in the next round of RPE funding (July 2024 to June 2028). One project is designed to address economic and housing stability specifically with Indigenous women, rural women, and lesbian, gay, and bisexual persons. Its second project is focused on 'men and boys as allies' by supporting the delivery of the Coaching Boys into Men curriculum in several local communities. Significant data about the health inequities and social norms each project is designed to address is discussed in the proposal's narrative. These selections conform with CDC guidance for primary prevention work from a health equity lens.[56]

NDDSVC staff have also used data to evaluate the suitability of specific primary prevention projects suggested by national technical assistance providers. A notable example was their assessment of a 'Greening and Growing' strategy as not a particular fit for most of North Dakota. Greening and Growing is a prevention strategy that focuses on the development of green spaces or community gardens as a means of building social cohesion. NDDSVC noticed that the primary evidence base for this strategy was research done in an urban environment. While social cohesion is identified as a protective factor, research[57] NDDSVC shared during this capacity assessment suggests that social cohesion in rural settings can actually reinforce or promote woman abuse. More exploration of this point is left for other discussions. This example is shared here to highlight NDDSVC's current capacity to find and use data.

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[53] Including: University of North Dakota School of Medicine and Health Sciences. (2023). Seventh Biennial Report: Health Issues for the State of North Dakota. Retrieved from: https://med.und.edu/about/publications/biennial-report/_files/docs/seventh-biennial-report.pdf and Callaghan, T., Kassabian, M., Johnson, N., Shrestha, A., Helduser, J., Horel, S., Bolin, J. N., & Ferdinand, A. O. (2023). Rural Healthy People 2030: New decade, new challenges. Preventive medicine reports, 33, 102176. Retrieved from https://doi.org/10.1016/j.pmedr.2023.102176

[54] North Dakota Community Readiness Assessment (CRA) 2022-2023 Statewide Interview Analysis, North Dakota Planning PowerPoint of October 2022 by Obinna Solutions.

[55] This assessment about the climate for addressing sexual violence both in intervention and prevention was confirmed in multiple interviews across all stakeholder groups: NDDSVC Staff, NDDHHS, First Nation Women's Alliance, and Primary Prevention Partners.

[56] Center for Disease Control and Prevention, Division of Violence Prevention, Prevention Practice and Translation Branch (PPTB) (n.d) Baking It In: Integrating Health Equity into Violence Prevention. Internal guidance document for grantees.

[57] See Dekeseredy, Donnermeyer, and Schwartz, 2009.

Survey Responses

Survey responses generally support findings that NDDSVC staff have and do use data on the needs and resources of the population being served, use data to drive decisions about priorities, resources, and staffing, and support using staff time to evaluate the effectiveness of violence prevention strategies. The average overall rating for the Data and Evaluation Domain was 73%, with the breakdown in subgroups as follows: NDDSVC at 72.5%, NDDHHS at 53.3%, PPP at 86.67%, and First Nation Women's Alliance at 60%. The two statements garnering the highest average rating were "support using staff time to evaluate the effectiveness of violence prevention strategies" (4.1) and "have sufficient data on the needs and resources of the populations being served" (3.9). The two statements with the lowest ratings were "link our data system with other relevant agencies' data systems" (3.2), and "routinely share data across the public health system" (3.2). Interviews with staff at NDDHHS indicate that NDDSVC does share service utilization data, but that seems to be the main data shared. Since NDDHHS-funded prevention programs report directly to them and information is shared between collaborative partners on the State Capacity Building Team, it is unclear what additional data should be shared.

While the survey provided some insight into this capacity area, the general sentiment of member programs around the use of data sheds more light on the complexity of the context in which NDDSVC is working with regard to disseminating data on prevention.
NDDSVC is working in a climate where there is not universal agreement on the value and nature of the data to be used to inform primary prevention planning. Specifically, some directors of member programs–including some with post-doctorate level training with data–have raised concerns about the complexity of assessing and evaluating primary prevention causal factors. For example, at a recent coalition members meeting (May 2024), directors were asked about their use of data. Reactions were mixed with some providing examples of how they collect and use evaluation data on their prevention programs and service utilization, and others emphasized how unhelpful it was to use data to change opinions with regard to sexual violence and prevention in North Dakota.

Directors also noted that their ability to focus on primary prevention right now feels like "a luxury" considering an increase in the number and severity of cases which makes it "feel like it's more life and death than it's ever been."[58]

> *"Six years ago, we had the luxury of considering primary prevention. In the last few years, we would see 120 victims a year in the emergency room. In March we saw 24…primary prevention now, it is like "good luck."— member program director*

There was consensus on this point by large and small programs.

Directors noted that they see a gap between the needs they see and the preferences of funders. They find it incredibly frustrating that the evidence they do have about their local community needs and what works (e.g., visitation centers) does not lead to the resources they need. Instead, there is a sense that they need to constantly change their language to match the interests of funders who are chasing the "shiny, new, sexy thing." These sentiments reflect a climate within which NDDSVC staff work to bring data-driven decision-making to bear. From this

[58] May 14, 2024, NDDSVC Membership meeting.

assessment, it seems clear that NDDSVC has the expertise and experience to find, use, and apply data.

Considerations

- Continue to explore what kind of data, shared in what way, is useful to member programs and preventionists. Include stories as well as numbers. As they are able, involve them in interpreting what the data might mean for them in their local communities as well as what it might mean for the coalition and prevention across North Dakota.
- Where appropriate facilitate the exchange of learning of how and when member programs and preventionists use data to inform what they do.
- Design the evaluation and data collection for the upcoming RPE projects to collect relevant examples and stories about how attention to the areas of focus (e.g., economic stability and social norms) make a difference.
- Explore and identify what factors in program design and implementation seem to be "differences that make a difference" to build skills around evaluative thinking and capacity to facilitate adaptation.

ADDITIONAL DISCUSSION TOWARD A 'WHOLE STATE' STRATEGY

Despite significant work by NDDHHS and NDDSVC on incorporating health equity information into recent primary prevention meetings and training, there remain varied understandings among stakeholders as to what health equity is[59] and whether a programmatic focus on *community and social level* health equity-focused sexual violence primary prevention work fits for local member programs. As noted above, hesitations expressed were about insufficient resources, the community climate regarding sexual violence, and more fundamentally whether their programs were the best suited to solve these systemic, historical, and cultural inequities. To be clear, there is no consensus on these points, yet the gathered data does not support a conclusion that there is no support for sexual violence prevention work or health equity work. In fact, many interviewed voiced support for work in each of these areas. This suggests room for further clarifying conversations. Since stakeholders support NDDSVC's role of being a statewide voice in sexual violence primary prevention, these are conversations they can lead.

In this section, the authors propose a Prevention Landscape to facilitate discussion toward coherence (not unanimity) among key stakeholders and use this view to introduce two strategies to develop further prevention capacity across the state.

[59]Stakeholders were asked in interviews how they thought of the following three sets of terms individually and together: sexual violence, North Dakota, and health equity. Understandings of health equity varied from a focus on equal access to healthcare to the broader understanding of equal access to the conditions that lead to health (e.g., the Social Determinants of Health).

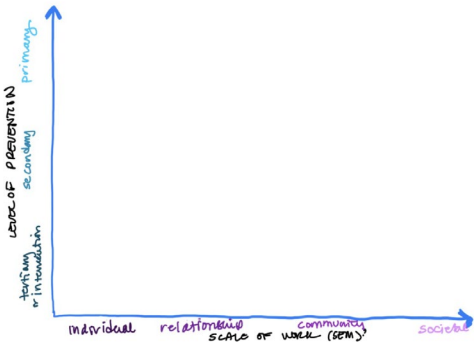
The Prevention Landscape

Three prevention-related concepts are at the heart of the current discussion in North Dakota:

1. The Social Ecological Model[60] identifies the various scales of the work: societal, community, relationships, and individual
2. The Prevention Continuum[61] is also referred to as prevention levels: primary, secondary, and tertiary.
3. Health inequity and health equity as key understandings and features of primary prevention strategies[62]

The first two of these models are associated with creating the Prevention Landscape (see Figure 2). On the graph the 'scale' of the work, as identified in the Social Ecological Model appears on the horizontal x-axis, while the level or type of prevention work appears on the vertical y-axis. They meet at the origin point of individual, tertiary prevention work, which can be thought of as intervening to care for individual sexual assault survivors. This work is a primary mission of local sexual assault and domestic violence programs.

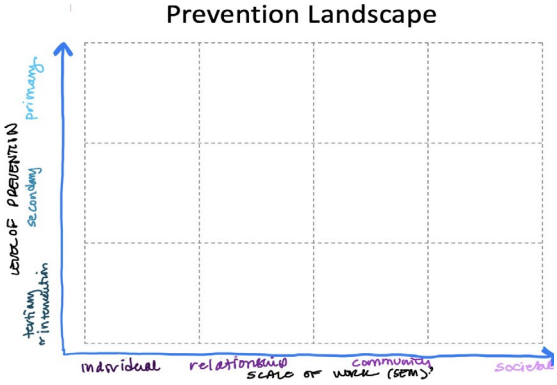
Figure 2
Prevention Landscape



As the other areas of the chart intersect, one could imagine lines showing a 'box' for each area of the landscape, as in Figure 3.

Within the 2019-2023 period studied, local programs were involved in studying or delivering over 30 different sexual violence primary prevention programs–most at the individual and relationship level, with some beginning work at the community level with the development of community prevention collaboratives.

Figure 3
Prevention Landscape



Within the Primary Prevention Partners conversations in the past year, an encouragement to move sexual violence primary prevention strategies to community or societal-level work and to infuse the work with health equity approaches is evident. This was in preparation for the CDC's 2024 Notice of Funding Opportunity for RPE that required applicants to address social and structural determinants of health (SDOH) at the

[60] CDC Violence Prevention definition of the social ecological model. Available at: https://www.cdc.gov/violence-prevention/about/index.html

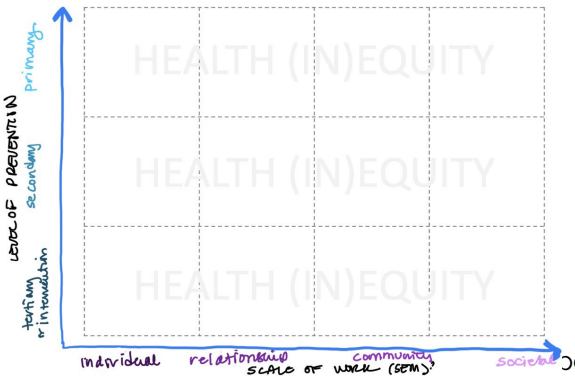
[61] See http://www.ndhealth.gov/injury/ND_Prevention_Tool_Kit/PrimaryPrevention.html,

[62] Primary Prevention Partner Meeting Minutes and presentations including Measurement & Health Equity for Primary Prevention Partners, April 26, 2023.

community and societal levels in order to be eligible for funding.[63] What is less clear is whether this move is primarily a funder's choice and prerogative or whether the public health field has determined this is the best approach to primary prevention of sexual violence. This needs further discussion as well, a discussion that might benefit from identifying where each stakeholder group sees health inequity/health equity (the third conceptual model at play) fitting on the Prevention Landscape.

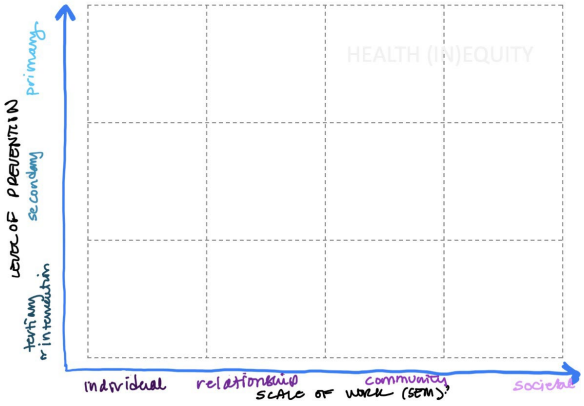
One view might suggest the one in Figure 4, which demonstrates that however they are formed, health inequities exist at every level and therefore opportunities to improve health equity exist across the entire landscape.

Figure 4



An alternate view might suggest that *by definition,* health equity is a concept about addressing the *systemic and structural barriers* that manifest in unequal access to what people need to be healthy (i.e., the social determinants). In this case, health equity would show up on the landscape at the intersection of primary prevention and the community/societal level spaces on the map (Figure 5).

Figure 5
Prevention Landscape



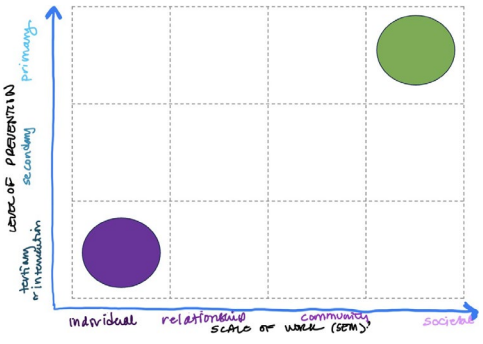
oe impacts the perceived options for action. We call for further discussion on this among stakeholders.

Assessment Feedback and the Prevention Landscape

Using the Prevention Landscape, one can see that the current emphasis on SDOH-primary prevention-focused strategies at the community or societal level is actually, for local member programs, the furthest trip across the landscape (see Figure 6). According to the Primary Prevention Partners meeting minutes, many have done or are doing prevention work (e.g., primary prevention at the relationship level) that fits into boxes closer to where their organizations live. Others do tertiary and secondary prevention work while responding to sexual violence in their communities. A move to add or change strategies to focus primarily on community or societal-level work involves the biggest stretch of time, resources, and expertise. Feedback gathered in this assessment suggests this distance might be behind the sentiment for some member programs that these new directions are beyond the scope of what their programs were designed to do.

[63] See CDC's Notice of Funding Opportunity number CDC-RFA-CE-24-0068, page 5.

Figure 6



NDDSVC and the State Capacity Building Team might explore whether this is the only way member programs can lead or contribute meaningfully to sexual violence prevention in the state.

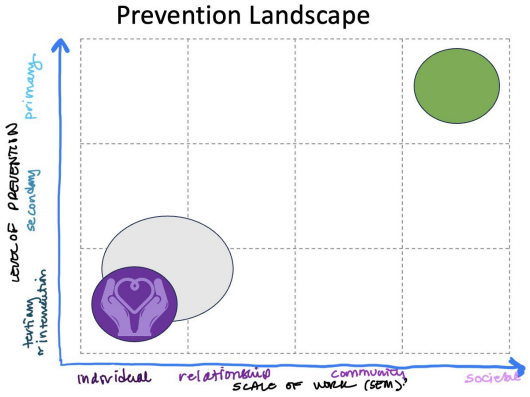
Facilitating Discussion with the Prevention Landscape

The authors recommend NDDSVC use the Prevention Landscape to engage in conversations with other stakeholders–including funders--about a 'whole state' strategy. In doing so, the following should be considered:

One strategy may impact more than one "box."

For example, the City of Duluth (Minnesota, USA) adopted an Earned Sick & Safe Time ordinance[64] that explicitly required employers to allow an employee to use earned sick and safe time to be away from work due to domestic abuse, sexual assault, or stalking of the employee or the employee's family member. This is a secondary prevention strategy at the community level. However, might it also be a primary prevention strategy? As the employee gets time to deal with the consequences of the violence they experienced, they can better engage with personal and community support systems. And as that happens, their children can benefit (receive protective factors) from a parent who is significantly less stressed. It is also possible that employee-survivors who know they will not lose their jobs for taking time off to go to the hospital, give a police statement, testify in court, etc. may feel able to more fully participate in the prosecution of a case, which in turn increases the chances of holding an offender accountable. That can also send a wider community message that this violence has real impacts and deserves a community response.

Figure 7



Conversely, as an advocate provides individual support and advocacy to a sexual assault survivor, do they move into secondary prevention when they also support that survivor in getting stable housing and SNAP benefits (a.k.a food stamps)? Are they assisting primary prevention for the children she parents by supporting her ability to provide key protective factors? Figure 7 provides one view of how those activities fit into the Prevention Landscape.

Bundled into programs or not–how could these activities fit into and fuel a 'whole state' prevention strategy? Where can health equity be addressed?

The *relationship between strategies* that fit each box may be as important as *where the strategies fit* into the landscape.

This point addresses the flow of information and resources between each 'box.'
Related to the example above, how do survivors learn this leave is available to them? If an

[64] See https://employees.aleroninc.com/wp-content/uploads/2020/01/duluth-mn-paid-earned-sick-and-safe-time-summary-and-poster-eff-1-1-2020.pdf for more information. After the state of Minnesota passed a more sweeping law, the City of Duluth repealed the ordinance indicating it was no longer necessary.

employer disregards the law or makes it difficult for an employee, where does the employee turn? When and where is there an opportunity through this strategy to broaden employers understanding of the impact and consequences of sexual violence? How do we learn if the policy leads to unintended consequences that actually interfere with the preventative impact for one or more groups of people? Likewise, what capacities and processes does the coalition grow to enable information learned from survivors about the obstacles they face to shape meaningful 'upstream' strategies? Since the relationship between a prevention strategy and its impact is non-linear and complex, discussions and stories about the relationships that we do see matter.[65]

The Prevention Landscape, and the distinctions it may help us see, is useful until it is not.

It may be that spending time discussing where a strategy does or does not fit on the landscape is useful in that it helps people describe what they see and understand about how prevention may work, identify gaps in our thinking, and discover opportunities for useful connections. That said, models are not reality. They inform our sense-making of the reality we experience, but there may be insights, pressures, tensions, and challenges that current prevention concepts have not yet successfully addressed. When the Prevention Landscape no longer seems able to describe or explain something known to be true, it is time to add to it, modify it, or find a new model.

The Prevention Landscape diagram can support NDDSVC in facilitating conversations about how to see, understand, and influence prevention work across the state. The goal would be for people to positively influence patterns of health and health equity–regardless of a programmatic affiliation and their professional position on the landscape.

SUMMARY

NDDSVC role as a statewide sexual and domestic violence coalition positions it to be leader in the state around sexual violence primary prevention. At the invitation of NDDSVC, Laura Williams and Melissa Scaia were invited to conduct an assessment on the organization's capacity for work related to sexual violence primary prevention, particularly with a health equity focus. Funded through Rape Prevention and Education Act (RPE) funding, the time period reviewed was 2019-2023. As NDDSVC will be leading two significant projects around sexual violence primary prevention in 2024-2028, the findings and considerations offered in the assessment are intended to inform NDDSVC's strategic growth as a statewide leader.

In addition to assessing the organization's capacity in five key areas, Williams and Scaia gathered key stakeholders' views on two additional topics: the role of a statewide coalition in primary prevention work, and prevailing attitudes in the state toward addressing sexual violence and health equity.

Central to the assessment was a Capacity Assessment Survey that was sent to NDDSVC staff and key stakeholders identified as collaborative partners: staff of the North Dakota Department of Health and Human Services, First Nation Women's Alliance (the Tribal Coalition), and members of

the Primary Prevention Partners meeting group. Williams and Scaia interviewed 14 of the 19 respondents who returned the survey. They also reviewed hundreds of documents provided by NDDSVC and NDDHHS and conducted a series of in-person meetings with coalition member program directors, NDDSVC staff, and a group of sexual and domestic violence program advocates.

The assessment found strengths and potential growth areas in all five areas of assessment: Staffing and Resources, Staff Skills and Expertise, Training and Technical Assistance, Collaboration and Partnerships, and Data and Evaluation. The full report details the findings and considerations for each area.

The area targeted for most attention is reducing staff turnover (in all positions). Significant staff turnover during the 2019-2023 period has had a broad and powerful impact on stakeholders' experience of NDDSVC's ability to be a statewide voice and leader for sexual violence prevention work. During the five years under review, NDDSVC experienced a staff turnover rate of 30% across all positions, with the highest rate of turnover occurring in the last year of the COVID-19 pandemic (2022-2023). The organization has hired four different Executive Directors, three different Sexual Assault Program Coordinators, and four different Domestic Violence Program Coordinators between 2019 and 2023. Stakeholders discussed how this turnover impacted each assessment area.

At the same time, "staff skills and expertise" was the assessment area stakeholders' rated most highly. While there is a mix of relevant experience among staff (some very new to the work and some with many years of experience), there is optimism and hope that stability in these positions will give new staff time to develop relevant skills and knowledge. Overall, stakeholders want the coalition to reclaim its role as a training and technical assistance provider connecting expertise across the coalition, delivering training for both new and experienced advocates, and continuing to identify resources that fit for North Dakota.

All interviewed indicate how poorly resourced sexual violence prevention work is--at every level-given the challenge they face in doing prevention work. These challenges include insufficient resources to attend to the growth in the number and severity of sexual assault cases, and the attitudes that abide sexual violence. Accordingly, many interviewed also see lobbying as a key role for NDDSVC and believe that the coalition is best situated to lead that effort for statewide visibility and impact.

Recently, a key prevention funder has shifted its focus to community and societal level prevention strategies that address health equity. This has shaped much of the sexual violence primary prevention training and technical assistance for the last year. This assessment found that despite training and attention in this direction, stakeholders hold varied understandings of health equity and how it relates to sexual violence. Further there is no consensus that investing in health equity-focused primary prevention at community and societal level will impact sexual violence in the state. Despite this lack of consensus, there remains strong interest in prevention from coalition members, as program directors indicate that if "resources were not an issue" they would focus nearly half their program's time on prevention work.

Ultimately, the capacity assessment finds that NDDSVC has strengths in each of the capacity areas explored. Given a period of stability and sufficient resources, NDDSVC is ready to rise to become the statewide leader on sexual violence primary prevention that stakeholders' desire and North Dakotans need.

APPENDICES

Appendix A: General Capacity Assessment Survey Report

Veto Violence® General Capacity Assessment for Violence Prevention
Available from: https://vetoviolence.cdc.gov/apps/capacity-assessment-tool/#/

Capacity Assessment Report

Organization Name: Aggregate Responses for CAWS ND Date of Assessment: 12/2023- 1/2024

Your Capacity: The Big Picture

The General Capacity Assessment for Violence Prevention assessed five areas of capacity that your organization might need to implement violence prevention interventions. This graph summarizes the capacity scores for each area.

Overall Capacity:

- Leadership
- Collaboration & Partnerships
- Staffing & Resources
- Data & Evaluation
- Skills & Expertise

How do I interpret my report?

This assessment is organized into five overarching domains: LEADERSHIP, STAFFING, SKILLS, COLLABORATION, and DATA. These five sections are key areas necessary for organizations to implement, evaluate, and sustain violence prevention strategies (see Figure 1).

This report provides the overall score for each capacity area. The score for each capacity area is given as a percentage. For example, the highest possible score on LEADERSHIP is a 5. If your average score was a 3, your organization received a 60% (or 3/5) of the maximum score. If your group got a 4 in this area, you got 80%, and so on. Each section also includes a record of the responses to individual questions within each section.

Note that there is no cutoff number for a "good score" or a "bad score." Scores are designed to identify areas with relatively high or low capacity. The scores can serve as a tool to start conversations and help prioritize areas to build capacity. You can leverage your organization's strengths, assets, and opportunities to implement and evaluate your violence prevention efforts.

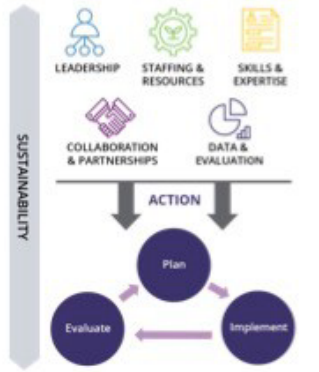


FIGURE 1

How do I use my report?

Once you have reviewed your Capacity Assessment Report, it may be helpful to prioritize capacity areas that you would like to focus on. Additionally, your organization or community may also want to implement capacity-building activities for areas with the lowest scores. It may also help to use this report to guide discussions among leadership and staff at your organizations. There are many important factors to consider as you plan your capacity-building efforts.

1

- How important is this capacity area to the success of your prevention work? Is it an area that your organization or community values? Will it help enhance your community's ability to implement prevention programming?
- How feasible is it to make changes in each capacity area? For example, are resources available to help build capacity in this area? Can those changes be made on a timeline that will benefit your organization?

Resources

Below is a link to resources that may help your organization build capacity for your violence prevention efforts. The information provided is not intended to be comprehensive or applicable only to violence prevention. The purpose of providing these resources is to provide you with tools and approaches that may be relevant and appropriate for your work in building capacity to prevent, evaluate, and sustain prevention efforts in your communities.

Capacity Area Resources: https://vetoviolence.cdc.gov/apps/capacity-assessment-tool/resources

In addition, a more comprehensive list of resources can be found in the tool Violence Prevention in Practice at https://vetoviolence.cdc.gov/apps/violence-prevention-practice/resources/

Notes

For this North Dakota Project:

Surveys were sent out to staff at CAWS ND, the North Dakota Department of Health and Human Services in the Domestic Violence and Rape Crisis Program area, First Nation Women's Alliance (the Tribal Coalition), and selected member programs--particularly persons participating in the Primary Prevention Partners meetings.

Nineteen surveys were returned with the breakdown as follows:
- 8 CAWS ND Staff
- 3 ND Health and Human Services Staff
- 2 First Nation Women's Alliance Staff
- 6 Staff from various local member programs

Around 75% of these respondents were reached for interviews, and some additional interviews were conducted with people who did not complete this survey.

Note: See the main body of the paper to understand the survey instructions and implementation limitations.

In particular, note that in interviews, respondents indicating using a rating of "3" for various meanings, including "I don't know" or "sometimes."

2

Leadership

This domain assesses organizational leadership's commitment and knowledge. Leadership is defined as a person or group of people who have the primary responsibility to be spokespeople and decision-makers. Questions also assess community leaders and their support for violence prevention efforts.

Scores in this area could range from 20% - 100%.

Overall Section Score: 78%-average across all survey respondents

My organization's leaders are:	1	2	3	4	5
Knowledgeable about violence prevention.				4.3	
Committed to preventing violence.				4.6	
Able to obtain the necessary financial resources for prevention.			3.7		
Strong advocates for violence prevention.				4.4	
Motivated to ensure that violence prevention strategies are a success.				4.3	
Supportive of staff implementing violence prevention strategies.				4.2	
Able to effectively communicate violence prevention messages to stakeholders.				4.2	
Able to gain support from elected or appointed officials when needed.				4.0	
Able to develop new opportunities for younger persons and newer staff to take on leadership roles.			3.8		

My community leaders:	1	2	3	4	5
Exhibit a strong commitment to violence prevention.			3.6		
Are strong advocates for violence prevention.			3.8		
Share a common vision or plan for violence prevention.			3.5		
Understand cultural context and systemic factors that cause and perpetuate violence in their communities.			3.7		

Notes

Average responses for each survey statement are rounded to the nearest tenth.

3

Staffing & Resources

This domain assesses general organizational set-up, staffing, and management.

Scores in this area could range from 20% - 100%.

Overall Section Score: 68%-average across all survey respondents

Staff who work or will work on a violence prevention strategy:	1	2	3	4	5
Are quick to ask for help and help one another when needed.			3.8		
Know which activities to implement and how to implement them.			3.8		
Collaborate well with other units/staff in my organization to accomplish common goals.				4.0	

Resources:	1	2	3	4	5
There are enough staff members at my organization to implement a violence prevention strategy.			3.0		
Staff turnover at my organization does not interfere with implementing a violence prevention strategy.		2.6			
My organization has the fiscal resources to implement a violence prevention strategy.			3.0		
My organization includes violence prevention efforts in the annual budget.			3.7		
My organization has multiple funding sources for violence prevention.			3.2		
My organization has at least one staff position devoted to violence prevention efforts.			3.2		
Staff time allocated to a violence prevention strategy is protected (i.e., staff members would not be pulled away to do other work).		2.8			

Sustainability	1	2	3	4	5
There will be or are opportunities for violence prevention to be integrated with other health-related prevention programs.			3.6		
My organization is planning for the sustainability of our violence prevention strategies.			3.7		
My organization is looking for other funding resources to support violence prevention.			3.6		
My organization's violence prevention strategies are likely to be sustained.			3.6		
My organization is committed to the long-term goals of the community's violence prevention strategies.				4.0	
My organization's violence prevention strategies are part of a collaborative effort with other agencies to prevent violence.				4.0	
Violence prevention efforts supported by our community have demonstrated sustainability.			3.5		

Average responses for each survey statement are rounded to the nearest tenth.

4

Skills & Expertise

This domain assesses staff and leadership knowledge and experience related to violence prevention.

Scores in this area could range from 20% - 100%.

Overall Section Score: 84%-average across all survey respondents

My organization has staff who:	1	2	3	4	5
Are knowledgeable about violence.				4.7	
Are knowledgeable about evidence-based violence prevention programs.				4.4	
Have skills in selecting and adapting prevention programs that reflect the needs of the population.			3.9		
Are experienced in overseeing community-level prevention efforts.			3.7		
Are encouraged to attend training specific to violence prevention.				4.4	
Have the necessary skills to support violence prevention at the community level.				4.0	
Are knowledgeable about when, why, and how to develop partnerships.				4.3	
Have the ability to distinguish between levels of partnerships (i.e., communication, cooperation, coordination, and collaboration) and identify when each is appropriate in various circumstances.			3.8		
Can effectively monitor the implementation and effectiveness of violence prevention programs and strategies.				4.0	
Can influence laws and policies related to risk and protective factors for violence.			3.8		
Understand the importance of developing and enhancing policy related to violence prevention.				4.2	

Notes

Average responses for each survey statement are rounded to the nearest tenth.

5

Collaboration & Partnerships

This domain assesses the type and level of partner relationships and community unity among key stakeholders involved with preventing violence. Community partnerships are important for success. Working together with partners to share ideas and resources can help make violence prevention efforts more effective.

Scores in this area could range from 20% - 100%.

Overall Section Score: 75%-average across all survey respondents

My organization has staff who:	1	2	3	4	5
Are part of a network of organizations committed to preventing violence.				4.2	
Have strong relationships with community leaders.			3.8		
Share ideas or information about violence prevention with other organizations and groups.				4.2	
Work with community groups in the area with a history of successful collaboration to address violence prevention.				4.1	
Have community groups in the area with a history of successful collaboration to address violence prevention.			3.8		
Have community groups that may disagree over ideas, but these disagreements do not typically lead to a breakdown in the progress of violence prevention efforts.			3.8		
Have a community plan for violence prevention that guides the work of multiple organizations.			3.6		
Are part of a community that can accomplish its violence prevention goals.				4.0	
Are part of a community where groups do not have turf conflicts about violence prevention efforts.			3.4		
Can demonstrate the existence of partnerships with diverse communities and those not usually involved in violence prevention.			3.5		
Are part of a community where elected or appointed figures are supportive of violence prevention efforts.			3.2		

Notes

Average responses for each survey statement are rounded to the nearest tenth.

Data & Evaluation

This domain assesses staff knowledge and understanding of data collection, performance monitoring, and using data to inform organizational decisions and policies. An important part of identifying strategies that fit your community needs and tracking results is having access to local data on violence and the expertise and capacity for program evaluation. Data could include surveillance data, administrative or program data, evaluation results, interviews, and other pieces of available information.

Scores in this area could range from 20% - 100%.

Overall Section Score: 73%-average across all survey respondents

My organization has staff who:	1	2	3	4	5
Have sufficient data on the needs and resources of the population being served.			3.9		
Link our data system with other relevant agencies' data systems.			3.2		
Access data about violence outcomes and related risk and protective factors in the community.			3.7		
Routinely share data across the public health system.			3.2		
Use data to drive decisions about priorities, resources, and staffing.			3.8		
Have processes in place to monitor implementation to ensure violence prevention activities are being carried out as they were intended.			3.7		
Use data, evaluation results, and feedback to make adjustments when implementation challenges are identified or when intended effects are not obtained.			3.7		
Support using staff time to evaluate the effectiveness of violence prevention strategies.				4.1	

Notes

Average responses for each survey statement are rounded to the nearest tenth.

7

Appendix B: Authors' Background

External Consultants and Report Authors: Laura Williams and Melissa Petrangelo Scaia

Laura Williams, MPA, HSDP is the founder and lead consultant at Wise Action Consulting. Most recently, Ms. Williams served as the Director of Systems Advocacy for Global Rights for Women, working on systems reform projects addressing gender-based violence in the U.S. and around the world. In this position she co-wrote numerous reports and papers with Ms. Scaia
including a paper for UN Women's Regional Office for Asia and the Pacific, titled *Beyond Training: Changing the Institutional Response to Violence Against Women and Girls*, which discusses this approach to systemic reform as a means of implementing the essential services[75] needed for women and girls subjected to violence; and *Many Voices ND: A Needs Assessment on North Dakota's Response to Domestic Violence,* examining North Dakota's response to domestic violence.

Prior to joining GRW, Ms. Williams worked both within the context of prevention and in leadership in the movement to end sexual violence. For over five years, Laura has worked with the Institute for Community and Adolescent Resilience (ICAR-US, LLC), featuring the development and teaching of a Full Color Web of Support framework for youth development, which brings multiple concepts and theories into a single framework to see, understand, and influence a young person's developmental ecology. In this context, she has reviewed prevention literature on resilience, mentoring, and connection, supported training and evaluation efforts, and designed community initiatives.

In the work to end sexual violence, Ms. Williams led the Sexual Violence Justice Institute (SVJI) at the Minnesota Coalition Against Sexual Assault for over 8 years, focusing on best practices, leadership, and coordination practices to address sexual violence. In that role, she trained in Minnesota and nationally on the tools for communities to assess their response, create protocols and policies to improve their response and evaluate their efforts. She also led the data and evaluation subcommittee for the Minnesota Department of Health's Sexual Violence Prevention Network. Prior to her work at SVJI, Ms. Williams worked for 13 years in a local sexual assault response program in direct services, volunteer management, training, coordination, and special projects –including the 5-year model project that led to the creation of SVJI at MNCASA. She is experienced in designing and implementing projects to navigate complex systems focusing on principles of complex change and building adaptive capacity.

Melissa Petrangelo Scaia, MPA has addressed gender-based violence (GBV) for nearly 25 years. She works part-time for Domestic Abuse Project in their men's perpetrator program as a group facilitator/mental health practitioner and coordinates the Minneapolis Coordinated Community Response (CCR) for domestic violence. She has also organized and led three other Coordinated Community Responses (CCRs). She is an international consultant for UN Women on GBV. As a researcher, international trainer, and co-author of *Domestic Violence Turning Points*, she focuses on addressing women's use of violence in a CCR and non-violence program. She also co-wrote a curriculum for working with perpetrators as fathers entitled, *Addressing Fatherhood with Men Who Batter*. She is the former Director of International Training at Global Rights for Women and former executive director of Domestic Abuse Intervention Programs (DAIP), also known as "the Duluth

[75] See The United Nations' Essential Services Package for Women and Girls Subject to Violence for more information.

Model." In that capacity she led training and systems reform assessments around the world, co-authoring a number of reports and manuals. She started as an advocate and then became the executive director of Advocates for Family Peace (AFFP) where she worked for 17 years. Her master's was on the effects of domestic violence on children and wrote her doctoral dissertation proposal on addressing post-separation domestic violence through supervised visitation. She serves on the steering committee for the US's National Network of Abuse Intervention Programs. Recently she was given the COMPASS award for her work on women's use of violence. She is also a court expert witness on domestic violence. Recently, she was awarded the Lifetime Achievement Award for Women in Public Service from Hamline University.

References

Advocacy Learning Center Training Manual- The Core Activities of Advocacy Applied to Systems Advocacy - Praxis International and Manavi - Original materials from Domestic Abuse Intervention Project and Praxis International CCR Curriculum - Available at: www.praxisinternational.org

Brennan Ramirez LK, Baker EA, Metzler M. (2008). Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Center for Disease Control and Prevention, Division of Violence Prevention, Prevention Practice and Translation Branch (PPTB) (n.d) Baking It In: Integrating Health Equity into Violence Prevention. Internal guidance document for grantees.

Center for Disease Control and Prevention (n.d.) Rape Prevention and Education: Enhancing Capacity for Sexual Violence Prevention Across State and Territory Sexual Assault Coalitions, Notice of Funding Opportunity. Opportunity number: CDC-RFA-CE-24-0068.

DeGue, S., Valle, L., Holt M.K., Massetti, G.M., Matjasko, J.L., Tharp, A.T. "A Systematic Review of Primary Prevention Strategies for Sexual Violence Perpetration." *Aggression and Violent Behavior* 19, no. 4 (July 2014): 346–62. https://doi.org/10.1016/j.avb.2014.05.004.

DeKeseredy, W. S., Donnermeyer, J.F., Schwartz, M.D. "Toward a Gendered Second Generation CPTED for Preventing Woman Abuse in Rural Communities." *Security Journal* 22, no. 3 (July 2009): 178–89. https://doi.org/10.1057/sj.2009.3.

Klein-Jimenez, A, March 27, 2024, Navigating Sexual Violence Prevention in Rural Communities: Challenges, Needs, and Strengths. Blog. Available from Prevent Connect. Available from: https://www.preventconnect.org/2024/03/navigating-sexual-violence-prevention-in-rural-communities-challenges-needs-and-strengths/.

Munala, L., Allen, E.M., Beall,O.M., Phi. K.M. "Social Justice and Public Health: A Framework for Curriculum Reform." *Pedagogy in Health Promotion* 9, no. 4 (December 2023): 288–96. https://doi.org/10.1177/23733799221143375.

North Dakota Department of Health and Human Services (2023). North Dakota Community Readiness Assessment (CRA) 2022-2023 Statewide Interview Analysis.

North Dakota Department of Health and Human Services (2023). Community Readiness Assessment Statewide Fact Sheet.

North Dakota Department of Health and Human Services and NDDSVC, Primary Prevention Partner Meeting Minutes 2019 through 2023.

North Dakota Department of Health and Human Services and NDDSVC, Primary Prevention Partners Meeting Slides of October 26, 2022.

North Dakota Department of Health and Human Services and NDDSVC, Prevention is Possible Campaign: Organizational Capacity Assessment Statewide Fact Sheet.

North Dakota Department of Health and Human Services FY20 Rape Prevention and Education Report.

Obinna, J. (2022). North Dakota Planning PowerPoint. Obinna Solutions and the North Dakota Department of Health and Human Services.

Obinna, J., LLapa, F.J. (April 26, 2023). Measurement and Health Equity. Slide Presentation for Primary Prevention Partners meeting. North Dakota Department of Health and Human Services and NDDSVC.

Veto Violence:® Resources for Violence Prevention. General Capacity Assessment Tool. Centers for Disease Control and Prevention. https://vetoviolence.cdc.gov/apps/capacity-assessment-tool/#/

Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute.