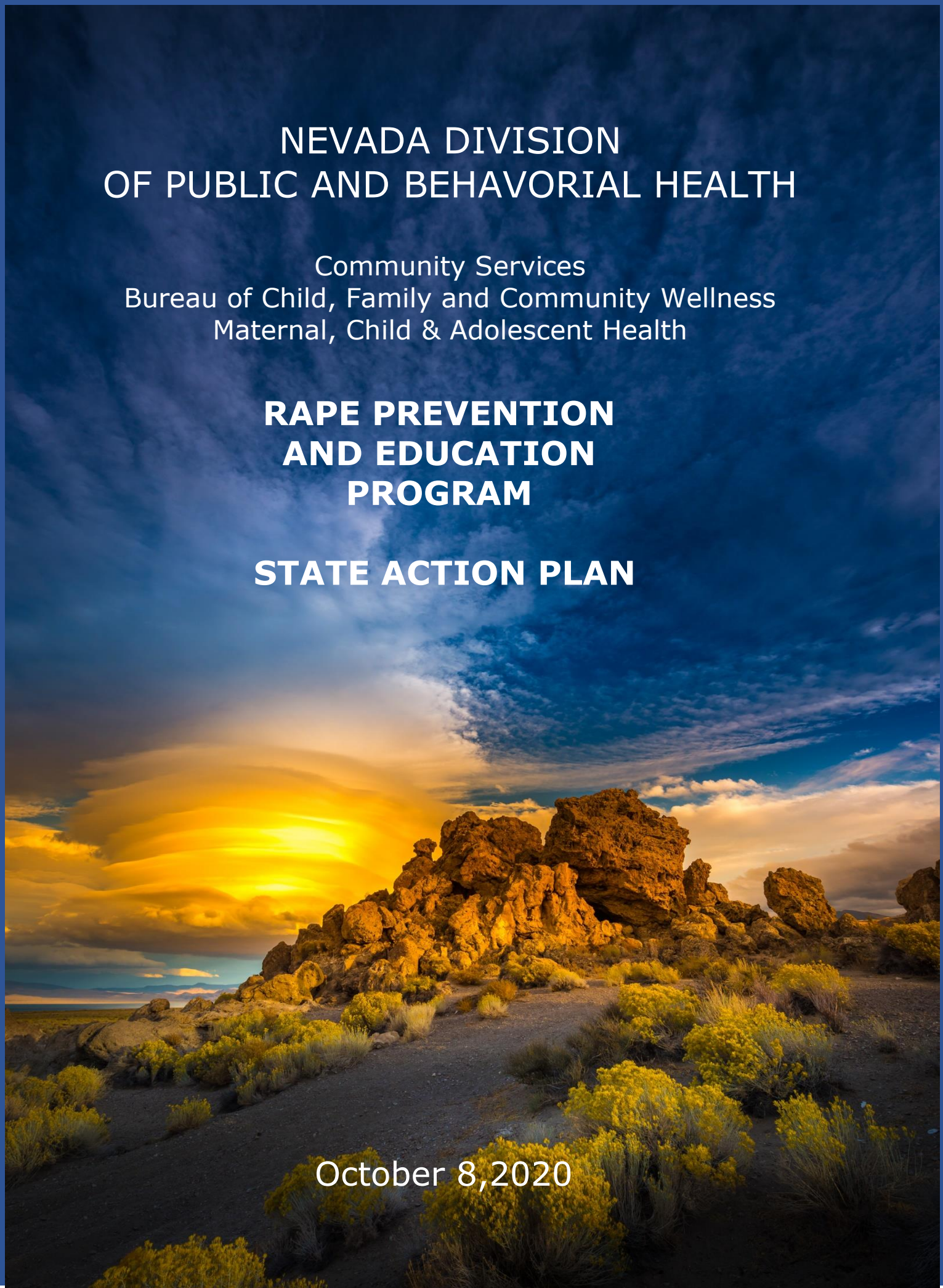

NEVADA DIVISION OF PUBLIC AND BEHAVORIAL HEALTH

Community Services
Bureau of Child, Family and Community Wellness
Maternal, Child & Adolescent Health

RAPE PREVENTION AND EDUCATION PROGRAM

STATE ACTION PLAN

October 8,2020

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Introduction

The Nevada Rape Prevention and Education (RPE) Program is part of a national effort launched by the Centers for Disease Control and Prevention (CDC) in response to the Violence Against Women Act of 1994 and continues through reauthorization and expansion of the original legislation. The RPE Program focuses efforts on preventing first-time perpetration and victimization by reducing modifiable risk factors and increasing protective health and environmental factors in the prevention of sexual violence. The RPE Program is funded by CDC, sexual violence set-aside through Preventive Health the Health Services (PHHS), and the Title V Maternal and Child Health (MCH) Program.

The Nevada State Action Plan (SAP) was developed by Nevada Rape Prevention and Education (RPE) Program and its partners. It describes a strategic approach and framework for implementing sexual violence (SV) strategies using the Public Health Approach, based on the best available evidence and data. The plan prioritizes the increased implementation of community/societal-level strategies, focuses on state and local-level data sources, and how SV indicators will be identified and tracked. The SAP also focuses on the key activities linking to the funding efforts. It describes strategies and activities implemented using RPE funding and how partners' efforts relate to the RPE-funded work. The contents of the SAP align and link to State RPE Program's logic model and evaluation plan.

Partnerships, capacity building activities, indicators, data, impact, and implementation are recurring topics in the SAP. Data are a central theme of the work, including how it is used to identify priority populations and address health disparities. Although no community is immune to violence, it is the most socioeconomically disadvantaged populations who face a disproportionate burden of violence. Demographics such as race, ethnicity, gender, educational inequality, intellectual disabilities, poverty, and employment status increase risk factors for priority populations.

Nevada's SAP recognizes while violence (sexual violence, intimate partner violence, explicit or implicit violence) can be prevented, prevention requires a cross-sector, public health approach. Violence prevention is more effective when public health, education, faith-based, nonprofit, housing, business, economic development, transportation, zoning and land use, and many other sectors and interests are involved.

The successful implementation of the SAP relies on identifying, establishing, and leveraging partnerships and resources while sustaining the work of the RPE Program beyond the current five-year cooperative agreement with the CDC. New partners and new ways of streamlining processes have emerged through the development of the SAP. As the plan is implemented, we expect to uncover further opportunities to increase the capacity of subrecipients and partners to work at the community and societal levels of the Social-Ecological Model (SEM) and ultimately change the Nevada context, decreasing sexual violence (SV) occurrence.

Over the next five years and beyond, the RPE Program, subrecipients, and partners expect to see the impact of working together as data show changes short-term (1-2 years), mid-term (2-5 years), and long-term (5 years and more).

Short to Mid Term	Long-Term Outcomes
Program and System Outcomes • Increased capacity of subrecipients and partners to implement relevant evidence-informed strategies • Increased number of partners working at community and environmental level • Increased capacity of partners to influence community and environmental change • Increased capacity from partnerships to access and use data and support • Demonstrated selection of sub-recipients based on data decision making • Increased alignment among state, subrecipients, and partners working to achieve the intermediate and long-term outcomes • Increased data-driven decision-making • Increased number of process and outcome evaluation activities from the evaluation plan • Demonstrated tracking of state-level data **Risk and Protective Factors** • Increased active bystander behavior • Reduced tolerance of sexual violence within the community • Increased feelings of safety in one's school, workplace, or neighborhood • Increased economic stability for women • Reduced excessive alcohol use at the community level*	**Program and System Outcomes** • OC 8. Increased use of partnerships to implement community/society level changes • OC 9. Demonstrated the use of indicator data to track implementation outcomes • OC 10. Demonstrated use of data-driven decision making **Desired Impact** • Reductions in SV victimization and perpetration • Reductions in the acceptability of SV • Reductions in the perpetration of related forms of violence (e.g., stalking, intimate partner violence, dating violence) • Increases in gender equality and the economic status of women • Reductions in alcohol-facilitated sexual assault at the community level*

*Currently, no strategies are focused on alcohol; however, this remains in the plan for future consideration.

Strategies and activities to achieve these results will be reviewed and considered annually as part of the RPE Program funding cycle. Strategies selected will be those capable of achieving short-term and mid-term outcomes, which include improving social norms (healthy relationships behaviors, active bystander behavior/action, positive attitudes towards girls and women, leadership skills, and opportunities for girls and young women, and economic opportunity and stability). The long-term outcomes will take many more years to achieve statewide.

Nevada's SAP is considered a "living document," recognizing the need for the RPE Program, its subrecipients, and partners to remain flexible and adapt to pursue opportunities as new partners, resources, research, and evaluation findings emerge from the work and the data. As such, it will be reviewed and regularly updated to reflect changing conditions.

The context for State Action Planning

Overview of Nevada

Nevada is a geographically large state with 17 counties. Two counties include two urban centers (Las Vegas and Reno) as well as rural areas, and the remaining 15 counties are primarily rural and frontier. According to the Census Bureau, the racial distribution in Nevada includes 74.6% individuals who identify as White, 9.8% individuals who identify as Black or African American, 8.8% as Asian, 4.3% as two or more races, 1.7% as Native American, and 0.8% as Native Hawaiian and Other Pacific Islander. In addition, 28.8% of Nevadans identify as Hispanic/Latinx. Approximately 23% of Nevadans are under the age of 18, 56% are between 18-64, and 15% are 65 or older (ACS). In 2019, the state's population was estimated at 3.08 million.

Rape and Sexual Assault

According to the 2015 National Intimate Partner Sexual Violence Survey, 43.6% of women (nearly 52.2 million) and a quarter of men (24.8% or 27.6 million) experienced some form of sexual violence in their lifetime. Those at greatest risk for intimate sexual violence are under 25 years old (y.o.), with the majority (81.3% or nearly 20.8 million) being female. An estimated 70.8% (2.0 million) of male victims report first attempted or completed rape occurring prior to age 25.

Definitions

"Sexual violence is sexual activity when consent is not obtained or not freely given. It is a serious public health problem in the United States. Sexual violence impacts every community and affects people of all genders, sexual orientations, and ages—anyone can experience or perpetrate sexual violence. The perpetrator of sexual violence is usually someone known to the victim, such as a friend, current or former intimate partner, coworker, neighbor, or family member."

The CDC providers further information about sexual assault as a public health problem:

- **Sexual violence is common.** 1 in 3 women and 1 in 4 men experienced sexual violence involving physical contact during their lifetimes. Nearly 1 in 5 women and 1 in 38 men have experienced completed or attempted rape, and 1 in 14 men were made to penetrate someone (completed or attempted) during his lifetime.
- **Sexual violence starts early.** 1 in 3 female rape victims experienced it for the first time between 11-17 years old, and 1 in 8 reported that it occurred before age 10. Nearly 1 in 4 male rape victims experienced it for the first time between 11-17 years old, and about 1 in 4 reported that it occurred before age 10.
- **Sexual violence is costly**. Recent estimates put the cost of rape at $122,461 per victim, including medical costs, lost productivity, criminal justice activities, and other costs.[1]

[1] https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html

Sexual Assault in Nevada

Reported Rape

Most instances of sexual violence are not reported to authorities; according to the National Crime Victimization Survey, in 2016, only an estimated 23.2% of rapes and sexual assaults were reported to police (Bureau of Justice Statistics, 2018). In Nevada, 1,865 rapes (both attempted and completed) were reported in 2017, the highest rate since 2013 and an 8.1% increase from 2016 (Nevada Department of Public Safety, 2018); however, it is estimated 8,039 rapes were completed or attempted in Nevada in 2017 when the 76.8% that go underreported are included (Bureau of Justice Statistics, 2018). Of the 1,865 reported rapes, only 21.3% resulted in an arrest. Most offenders arrested for rape in 2017 were male (95.2%) (Nevada Department of Public Safety, 2018). Most reported rapes occurred in the largest population center Clark County (81.2%), 11.9% occurred in Washoe County, and the remaining 6.9% occurred in one of the rural counties (see Table 2) (FBI UCR, 2018).

Youth Dating Violence

The percentage of student reporting dating violence is available, including both sexual and physical reports. The percentage of students reporting sexual violence increased between 2015 and 2019, while physical abuse reports decreased over the same time. Table A contains data from Nevada's Youth Risk Behavior Survey (YRBS) YRBS reports.

Table A- Student Populations by Year

Percentage of Nevada High School Students Reporting Sexual or Physical Dating Violence one or more times during the 12 months before the survey.	Sexual Dating Violence (being forced to do sexual things they did not want to do by someone they were dating or going out with, one or more times during the 12 months before the survey)	Physical Dating Violence (being physically hurt on purpose by someone they were dating or going out with, one or more times during the 12 months before the survey)
Nevada High School Students 2015	11.2	9.9
Nevada High School Students 2017	9.8	7.9
Nevada High School Students 2019	12.6 ↑	7.0

(↑) indicates a statistically significant change between 2017 and 2019.

The Nevada 2019 YRBS reported the prevalence of having experienced sexual violence one or more times during the 12 months before the survey was higher among female (18.0%) than male (6.8%) students, as well as physical dating violence of females (8.5%) opposed to males (5.4%) (Table B).

Table B- Sexual and Physical Dating Violence

Percentage of Nevada High School Students Reporting Sexual or Physical Dating Violence one or more times during the 12 months before the survey. (2019)	Sexual Dating Violence	Physical Dating Violence
Females	18.8	8.5
Males	6.8	5.4

*US data in parenthesis

Hispanic students or Latino (15.3%) and White (15.3%) were the only race category responses reported for high school students reporting sexual dating violence. (Table C).

Table C- Race and Ethnicity

Percentage of Nevada High School Students Reporting Sexual or Physical Dating Violence one or more times during the 12 months before the survey. (2019)	Sexual Dating Violence	Physical Dating Violence
American Indian/Alaska Native	5.7	17.3
Asian	7.8	4.4
Black	10.3	6.7
Native Hawaiian/Pacific Islander	9.7	4.0
White	12.5	7.0
Other/Multiple	12.4	9.1

*US data in parenthesis

Some regional differences were seen among individual counties. Note that differences in survey administration can influence reported rates. In 2019, the highest rate of sexual violence was reported in Douglas and Washoe counties, and the highest rates of physical dating violence were reported in Carson City.

Table D- Regions and Counties

Percentage of Nevada High School Students Reporting Sexual or Physical Dating Violence one or more times during the 12 months before the survey. (2019)	Sexual Dating Violence	Physical Dating Violence
Carson City (rural)	12.3	13.7
Douglas (rural)	13.4	7.0
Elko/White Pine/Eureka (rural)	11.7	7.5
Churchill, Humboldt, Pershing, and Lander (rural)	11.8	4.1
Lyon, Mineral, and Storey (rural)	12.7	7.4
Nye and Lincoln (rural)	11.1	7.3
Washoe (urban)	13.4	7.3
Clark (urban)	12.5	6.8

Youth Reporting Being Physically Forced to Have Intercourse

Nevada's high school YRBS reports the percentage of ever physically forced students to have sexual intercourse when they did not want to. In 2017, the percentage was 7.3, and in 2019 6.2%. This decrease was not statistically significant.

Nevada's middle school YRBS also reports the percentage of students who were ever physically forced to have sexual intercourse when they did not want to. This percentage was 3.9% in 2017 and 4.6% in 2019. This increase was not statistically significant.

Nevada Needs and Strengths Assessment

In 2018, a Needs and Strengths Assessment for the RPE Program was developed through the Nevada Institute for Children's Research and Policy (NICRP). The purpose of the study was to identify community perceptions of risk and protective factors associated with sexual violence, learn what community support services Nevadans know about, and understand barriers to accessing these services and identify needed services. The assessment also sought to identify new partners to engage in primary prevention work of the RPE Program.

Risk factors identified increasing the likelihood of sexual violence in Nevada included homelessness; mental health and substance use (including alcohol); lack of knowledge about community resources; neighborhood appearance and infrastructure, including the inability to walk safely in the community and number of bars; lack of community connectedness and help (neighbor to neighbor); transportation and isolation; family activities, resources and education; and, economy, workforce, and housing. Women and girls were more often at risk than men and boys, economically disadvantaged women, and African American women.

Suggested prevention efforts to increase protective factors included improving community infrastructure and access to key social services, educating youth in the community and in schools to recognize and support other youth, including offering referrals and active bystander behavior. Education recommendations also extended to the business community and parents, so they know how to identify and support prevention and intervention actions. Ongoing media campaigns and educational programming were recommended as consistent efforts that engage community members and survivors of sexual violence to change community norms and attitudes toward women and girls.

2020 COVID-19 Update

Since the start of the COVID-19 pandemic, experts have warned that intimate partner violence could increase dramatically, as research shows stress and social isolation can raise the risk of domestic violence. According to Harvard Medical School's Center for Primary Care, "…evidence shows that rates of sexual violence increase during states of emergency."[2]

These trends were observed in Nevada. According to one recipient,

- For example, the Executive Director of Safe Embrace noted when and after the Shelter in Place order was issued in Nevada (March 2020), the shelter's calls increased 400% for after-hours calls. Overall, Safe Embrace saw a 77% increase in request for services calls from March/April 2019 to March/April 2020.[2]
- Stay-at-home orders make it more difficult for survivors or victims to flee violent situations or file a protective order with police, which could force victims to stay in a dangerous situation. Additionally, shelters that can protect people may not be readily available due to closures or operating at a limited capacity to decrease the virus's risk. [3]

[2] (APA (2020) "How COVID-19 may increase domestic violence and child abuse" Retrieved at: https://www.apa.org/topics/covid-19/domestic-violence-child-abuse)
http://info.primarycare.hms.harvard.edu/blog/sexual-violence-and-covid

[3] https://www.samhsa.gov/sites/default/files/social-distancing-domestic-violence.pdf

In addition to these reports, Nevada's RPE work has been affected by the COVID-19 pandemic in profound ways. The tables below summarize challenges, resolutions, and realized opportunities from the crisis.

Challenges:

Challenge	**How it Was Resolved**
COVID related hiring freeze prevented the addition of an internal program evaluator.	An external evaluator who has familiarity with the RPE program was able to be engaged.
Shelter in place orders changed the work location for nearly all staff, subrecipients, and contractors.	Meetings, programming, and communication moved to online platforms.
Continued public health restrictions on safe gatherings have limited access to childcare and in-person education.	Staff have adjusted schedules and made other accommodations, including changing roles.
Staff lacks the right technology to work remotely.	When staff did not have the proper equipment (laptops, webcams, etc.), they could continue working but reduced efficiency. Others purchased equipment with personal funds or made other accommodations.
The state and other systems needed to divert staff time to help manage the crisis.	Staff time was temporarily re-allocated.

Despite major challenges, there were also ways in which the crisis revealed opportunities.

Opportunity	**Positive Results**
Moving programming online	Increased use and uptake of social media messaging, indicating increased reach of some messaging and campaigns. Increased confidence and competence in using online platforms for training. This is promising as many people find fewer barriers to attending training online as opposed to in-person.
The mandatory closure and related slow-down of the hospitality industry	Contributed to more time for owners and managers to engage in training. Some subrecipients working with clubs attributed the slow down to increased ability and willingness to engage in training.
Travel Suspended	Because nearly all meetings across the state and nationally have gone online, Coalition (and other partners) note connecting with more potential partners more easily and affordably than if they were trying to attend in person. Some of the large state barriers, including long travel times and the expense of attending meetings in different regions, have been eliminated using technology.
Telehealth	While not directly an RPE activity, improvements

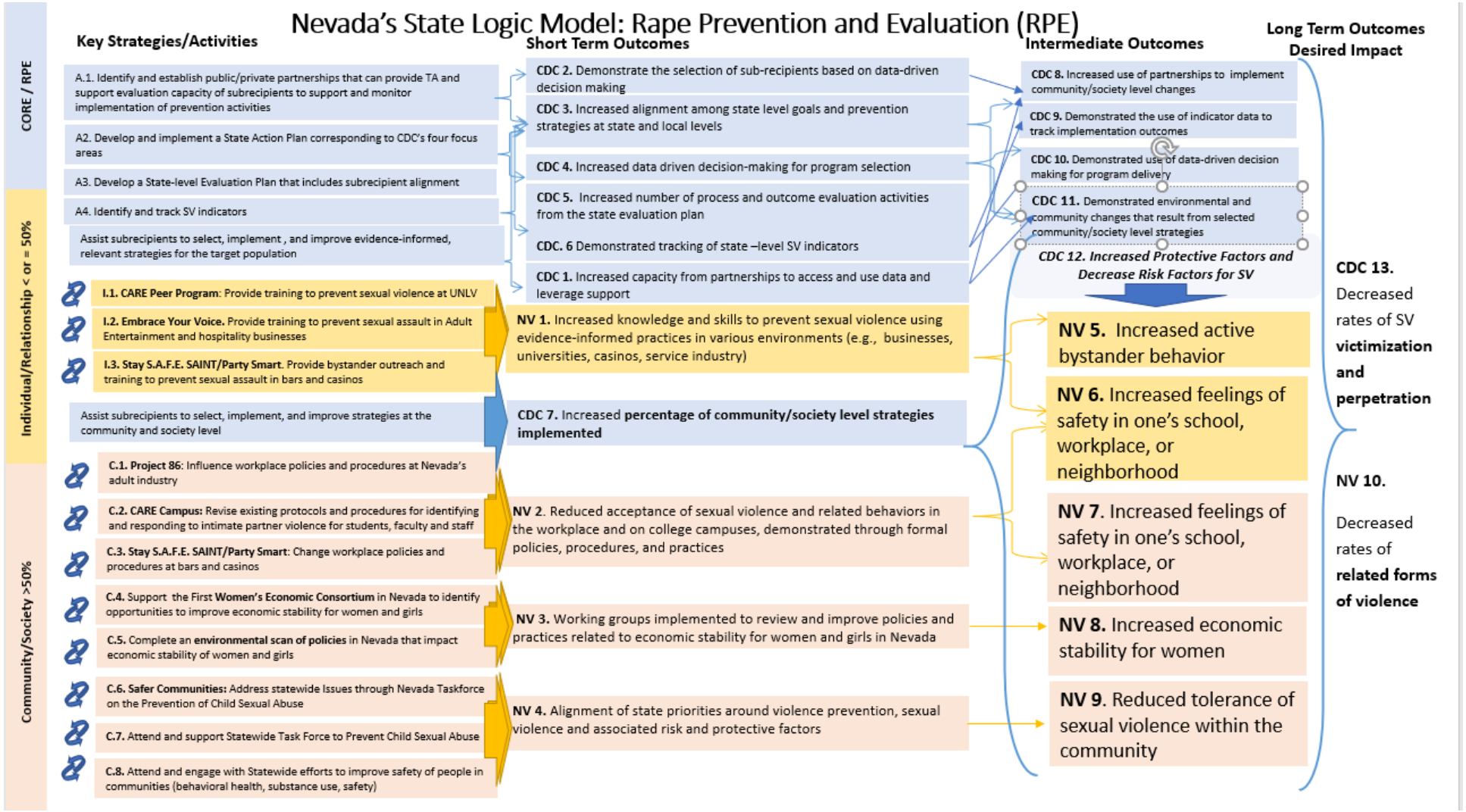
Opportunity	Positive Results
	to telehealth statewide, including mental and behavioral health services, may help more people access resources.
Increased attention to public health issues	At the state level, there is increased attention on public health and health equity. In August 2020, Governor Sisolak proclaimed racism as a public health problem.

Community and Societal Level Change Priorities

To sustain community change, primary prevention must prioritize community and societal level work. Community-level strategies target the characteristics of a setting (e.g., schools, workplaces, and neighborhoods) increasing risk for, or protecting people from, sexual violence.

This section of the SAP describes how the RPE Program, its subrecipients, and partners will prioritize primary prevention at the Social Ecological Model (SEM).

The RPE Program's approaches are grounded in the State RPE Program's logic model, shown on the next page.



*Strategies and outcomes focused on alcohol are shown in grey, as they are not currently active but remain an important priority over the logic model term.

Identifying, Selecting, and Implementing Primary Prevention at the Outer SEM Layers

The Nevada RPE Program used the first year (2019) of the five-year project period to transition RPE subrecipients from implementing strategies at the individual and relationship levels of the social-ecological model to strategies at the community and societal levels.

The RPE Program started moving in this direction in 2018 when RPE Program staff introduced training and technical assistance (TA) to help the subrecipients understand the different SEM levels and what changes would be needed to extend work into the outer layers of the SEM. This is considered part of capacity building, and these efforts will continue into the current year.

An *Indicator Selection Readiness Assessment* (readiness assessment), conducted in the last half of 2018, assessed the subrecipients' capacity and readiness to identify and select process and outcome indicators for RPE Program evaluation.

The readiness assessment considered 1) the subrecipients' ability to capture, track, analyze and report on process and outcome measures that align with RPE's short- and intermediate-term outcomes and 2) alignment with the RPE Program's work plan and the timeline for 2019-2020, the first year of the new 5-year collaborative agreement.

The readiness assessment found challenges remain with systematic data collection systems; data provided is often based on grant requirements rather than focusing on what is working well and outcomes. Most of the prevention work is happening at the program/project level. Other findings indicated:

- Subrecipients increased awareness of evaluation components for measuring impact while seeking additional TA support, resources, and guidance to operationalize.
- There has been some increased capacity for tracking indicators (program measures) among continuing subrecipients since the first evaluation readiness assessment (2015). However, new scopes of work and activities need to be aligned with the state's logic model.
- Barriers and capacity-building needs related to evaluation exist as subrecipients work to align their objectives and actions with the SEM to reduce risk factors and an increase in protective factors. Programs are adjusting outcomes to match activities.
- Subrecipients expressed interest and desire to know if and how their program activities make a difference for their target audiences, including changes at the community level.
- Subrecipients are open to working across disciplines. Some have established relationships outside of the SV/IPV community that can be leveraged to engage similar partnerships locally or expand to other state regions.
- Capacity building is needed to help subrecipients determine what and how to measure and identify and form data-sharing relationships with others working directly or indirectly in the SV and IPV arenas.
- Subrecipients value and benefit from having time to talk about their data show and how it links to a broader context, including how to move further out on the SEM.
- Additional support and technical assistance are needed to help programs move further out on the SEM for SV prevention.

During the indicator readiness selection assessment, each organization identified barriers with evaluation. Those barriers were due to tools, processes, knowledge, or understanding of what is expected and how to use the information once gathered. Even though partners identified barriers to evaluation or moving their work into the community and societal levels, they also expressed the desire to learn more. That included knowing whether their efforts are making a difference and what moving to the outer layers of the SEM would look like. They are open to learning and working together to advance evaluation capacity.

Ensuring the Minimum RPE Funding Requirement at the Community or Societal Levels

As the RPE Program and its partners and subrecipients identify strategies to achieve the long-term results, at least 50% of RPE funded strategies will be implemented as community/societal-level strategies. This may mean changing out individual and relationship level strategies or complementing those individual/relationship-level strategies with a community/societal level strategy to maintain a minimum of 50% of planned strategies at the outer layers of the SEM, as set by CDC. Additionally, to increase the number of partners working at the community and societal level, each subrecipient will obtain at least one (1) MOU (or similar formalized agreement), per focus area, with a partner committed to achieving similar outcomes. For example, if a subrecipient has three strategies in two focus areas, they would need to formalize two partnerships (one for each focus area).

This approach helps the RPE Program and its subrecipients link and streamline efforts for shared results. Beyond the RPE Program, as the subrecipients and partners work collaboratively toward any shared long-term outcomes, additional partners and opportunities will emerge.

Current State and Subrecipient Experience and Capacity to Implement Community and Societal Strategies

Advancing to the Outer Layers of the SEM

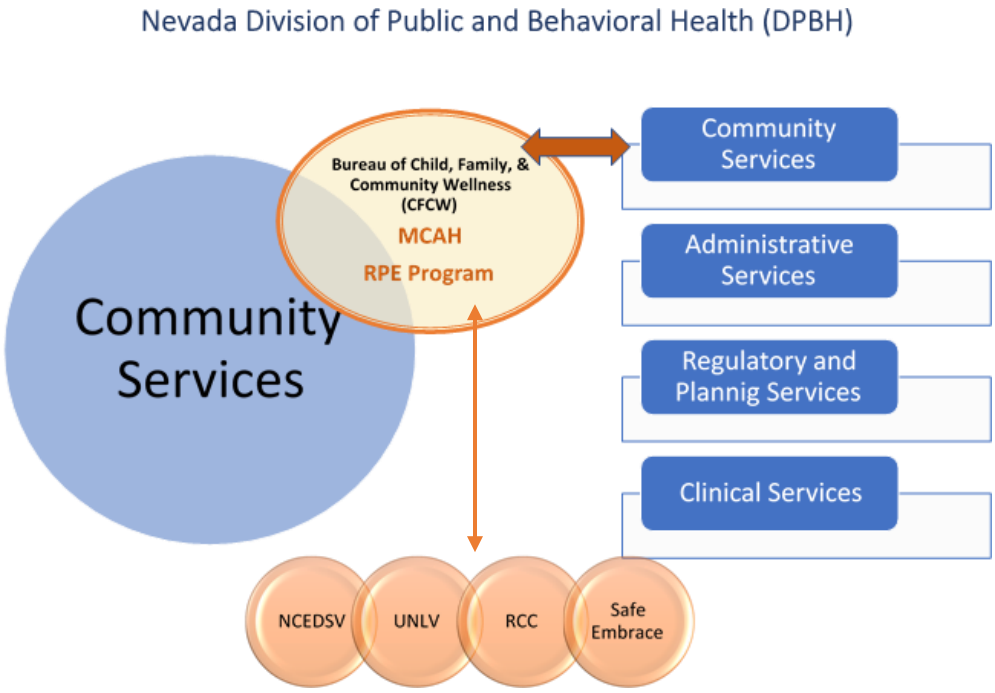
The work to move to the SEM community and societal levels begins by scaling down diverse individual program efforts to move toward collaborative and focused interventions directly impacting the priority populations and improving protective factors or reducing risk factors. The RPE Program's reach and impact will increase as subrecipients choose community strategies and build new partnerships to complement individual/relationship strategies already in place and showing results.

A step by step approach and process for choosing new strategies on the outer layers of the SEM was introduced in year one of the SAP. This approach asked subrecipients to complete a strategy selection assessment to determine if their proposed or current strategy will meet funder requirements. In addition to the assessment, subrecipients also provided the rationale for strategy selection and the specific risk and protective factors being addressed in the target population. By walking through this series of questions, agencies will learn how to determine if their current or proposed strategies align with the outcomes, funding requirements and address Nevada's target population's needs. The process also increases the focus on known risk and protective factors in the target population through new partnerships.

Building understanding and knowledge of how to work in the outer layers of the SEM began in 2018. In 2019, the RPE Program included subrecipients and prospective partners in discussions to develop the program logic model, identify mid-term and short-term outcomes aligned with the long- term results, and discuss, review and prioritize indicators to use moving forward. The first meeting oriented participants to RPE Program's 2019 deliverables, timelines, and engagement expectations, and obtained guidance and feedback on the logic model and the stakeholder outreach approach. A second meeting oriented the RPE subrecipients to RPE Program's Evaluation Requirements, including a State Action Plan, and shared CDC priorities for the RPE Program's future direction. Additional input and suggestions for the logic model outcomes and focus areas were gathered at this meeting. The third meeting involved an expanded group of participants, including prospective partners and other state programs, with a shared interest in the RPE Program results. This meeting was used to review the CDC requirements, the updated logic model and discuss outcomes and data sources. The meeting also produced valuable insights about leading indicators for bystander behavior and areas of need made available to this group, and opportunities to revise and streamline climate survey data to capture information tied to the RPE Program outcomes. After the third meeting, recommendations for indicators tied to the specific outcome areas were prioritized through an online survey process and used to inform this document and the evaluation plan. Organizations and participants involved in those conversations are listed in Appendix B.

State Experience and Capacity

The Nevada RPE Program resides within the Maternal, Child, and Adolescent Health Section (MCAH), Bureau of Child, Family, and Community Wellness (BCFCW), in the Nevada Division of Public and Behavioral Health (DPBH).



The DPBH commitment to public health is reflected in its mission statement, "*The Nevada DPBH*

protects, promotes, and improves the physical and behavioral health of the people in Nevada." DPBH possesses the required infrastructure to support sexual violence prevention efforts at the state level through access to state data and qualified staff to provide technical assistance.

The programs within DPBH and the BCFCW utilize the public health approach internally and with their partners. The focus has been driving community level and system/societal level changes within the state through grant-funded programs, including the RPE Program. The Nevada RPE Program maintains consistent staff who coordinated RPE activities over the last two 5-year project periods and was instrumental in establishing collaborations resulting in a state sexual violence coalition. Today, Nevada has a statewide coalition oriented to preventing sexual and domestic violence, an integral part of the RPE Program.

Maintaining partnerships and developing new ones is key to building Nevada's RPE Program to ensure program guidelines are being met. The Nevada RPE Program functions closely with various sections within the Bureau of Child, Family, and Community Wellness and organizations at the state and local level. The Public Health Approach has been incorporated into an ever-increasing number of programs, initiatives, and funding opportunities. This includes the RPE Coordinator meeting quarterly with the Nevada Office of the Attorney General, Nevada Coalition to End Domestic and Sexual Violence (NCEDSV), and the Division of Child and Family Services to support the implementation of Services Training Officers Prosecutors (STOP) and Sexual Assault Services Program (SASP) funds and review yearly grant proposals for STOP and SASP activities. Additional state partners and initiatives, such as the Department of Education (DOE) and the Nevada Prevention Coalition (the Coalition) bring expertise, data, and reach to the implementing community and societal strategies. The DOE and the Coalition have data, expertise, relationships, processes, and systems that can be leveraged for the RPE Program SAP implementation.

Subrecipient Experience and Capacity

The 2018 Indicator Readiness Assessment contained a series of steps to gauge subrecipient experience and capacity to deliver and evaluate prevention results. This work was comprised of key informant interviews, partner surveys, and document review. The process sought to identify the capacity for implementing the Nine Principles of Effective Prevention that includes: comprehensive strategies, varied teaching methods, sufficient dosage, theory-driven, appropriately timed, sociocultural relevant, well-trained staff, outcome evaluation; data capture (e.g., information on various activities funded by RPE, including changes in knowledge, skills, and behaviors of persons) and about the data systems used for collecting and reporting; systems or processes in place to collect process data regularly; and, identifying capacity-building needs. Those needs include:

- Improved and consistent tracking of process-level measures such as tracking staff participation in training by type, outcomes from meetings, and community training.
- Capturing short-term outcomes data. Only a couple of subrecipients regularly capture short-term outcome data, and those that typically do, focus on changes in knowledge and attitudes, and skills and behaviors of those served. Only one organization reported capturing pre/post data at 3, 6, or 12-month follow up.
- Tools and data capture processes. All partners have one or more systems/processes to collect and report client/outcomes data. Some are in place for the RPE Program, while others are used to report to specific funders, which does not allow for "connecting the dots" or streamlining efforts.
- Implementation of the public health model. Two of the subrecipients were new to the capacity assessment this year, while two others were able to update their 2015 'baseline' data about how they implement the public health model.
- All RPE subrecipients reported regularly using data in decision making, with most stating they use it "often or always." The exception is maintaining adequate staffing levels for evaluation planning. Only one of the four partners stated they did this often or always.
- Working across the social-ecological model. All organizations indicated there were areas where, with support and guidance, they could work deeper into the SEM.

The survey and key informant activities showed opportunities to expand prevention efforts on the SEM further. Examples include:

- Leverage the Nevada Coalition to End Domestic and Sexual Violence's (NCEDSV) broad reach of providers and stakeholders, which could be expanded to include nontraditional partners with a stake in the outcomes.
- Build upon the Rape Crisis Center's (RCC) stable relationships with the Las Vegas Metropolitan Police Department (LVMPD) and the local business community to share lessons learned and achieved through this partnership. This work could be shared with others throughout the state, including possible policy recommendations.
- Expand and build upon the positive relationships Safe Embrace has with the Hospitality Industry to provide policy development and institutionalize training to improve its employees' safety, especially female employees and clientele, mirroring some of the work started in Las Vegas.
- Work deeper with a subset of the UNLV student population to achieve impact and measure policy and practices changes within campus organizations.

The subrecipients have the expertise, relationships, and knowledge to advance the

prevention work and achieve impact and results in this plan with technical assistance and support from the RPE Program, CDC technical assistance, and contract evaluators.

Training and Technical Assistance to Build Capacity

Program evaluation within the DPBH will consist of the RPE Coordinator, contracted evaluators, and internal staff expertise.

Training and technical assistance were incorporated into developing Nevada's SAP, logic model, and evaluation plan. Subrecipients and partners were included in conversations and decision-making requiring education about purpose and process, and context informing the work. These conversations helped identify other areas of capacity building support and TA, which will be needed.

For instance, subrecipients expressed needing support in determining what to measure and how, ensuring needed resources are available, and understanding how their RPE-funded prevention work connects to the other work (intervention, direct services, advocacy, etc.). To this end, RPE evaluation's assisted subrecipients with identifying, refining, or developing data tools for tracking implemented activities.

To provide training and guidance for Nevada subrecipients, RPE Program staff invited NSVRC technical assistance providers to participate in statewide training to share successful community strategies being implemented in states with access to similar levels of resources. The RPE Program learned with other state-funded RPE Directors by attending regional RPE Director's training and RPE Leadership Training and the annual National Sexual Assault Conference in 2019. Additionally, the RPE Coordinator increased the length of the monthly TA calls with the subrecipients from 0.5 hours to 1.0 hour to incorporate the technical reports for training purposes.

Ongoing training and technical assistance will expand beyond the subrecipients in future years, including participation by collaborative partners and other allied funded programs.

Use of Data to Select and Prioritize Community and Societal Level Strategies

The RPE Program's process for selecting and prioritizing community and societal level strategies is driven by data within the context of Sexual Violence, as described in Context for State Action Planning.

A review of the RPE Programs indicator data and the 2018 Needs and Strengths Assessment provide insights as to which community and societal level strategies are needed.

The Strengths and Needs Assessment results, along with the Indicator Selection and Readiness Assessment findings, influence how the RPE Program directs funds in Nevada. RPE funds are used to implement and expand primary prevention strategies by targeting Nevada's teens and young adults, 13-24 y.o., who comprise an estimated 15.8% of the state's population (2018).

Current (2020) Nevada strategies for preventing future sexual violence include:

- Healthy relationship education and social norm change to prevent sexual violence on college campuses

- Bystander intervention training and awareness activities to people who work in bars and casinos
- Bystander intervention training and awareness activities to people who work in the hospitality industry
- Assistance to improve policies within the adult and hospitality industry
- Improved protocols and procedures for identifying and responding to partner violence on college campuses
- Holding an economic consortium to identify opportunities to improve economic stability
- Address statewide issues through the Nevada Taskforce on the Prevention of Child Sexual abuse
- Engaging with new partners to improve the safety of people in communities

As part of implementing the SAP, the RPE Program and subrecipients will build on what works while expanding partnerships and strategies to further work out on the SEM. The intention is to build capacity, achieve short and mid-term outcomes, and affect sustainable change and, ultimately, decreased sexual violence rates in Nevada.

Data and Strategy Selection

The RPE Program uses sole agency selection for identifying agencies to receive RPE funds (only one coalition and rape crisis center in the state). Agencies chosen to receive sole-source funds need to demonstrate the use of the public health approach when proposing evidence-informed strategies and activities and identify plans for collecting and tracking data, and collaboration with partner agencies.

Since the Nevada RPE does not use a FOA to determine RPE funding recipients, technical training is provided to current subrecipients to prepare them in advance of anticipated changes for 2020-2023.

The RPE Program will use capacity building approaches for selecting community and societal level strategies, as the RPE staff and subrecipients participate in monthly technical calls and complete quarterly reports together. This collaborative approach provides education for increasing community-level strategies through data-driven decisions and coaching about how to think through expanding work to the outer levels of the SEM. Also, bi-annual meetings, webinars, and evaluator technical support will focus on using data to select and prioritize community and societal level strategies.

State policy work and statewide training for sexual and domestic assault advocates and professional partners will be funded through the Nevada Coalition to End Domestic and Sexual Violence. Data from programs will drive the focus of advocacy and training, partners, local and state data, and emerging opportunities to operate at the community and societal levels to achieve short- and mid-term outcomes.

Health Disparities, Inequities, and Disproportionate Burden

The CDC defines health disparities as "differences in health outcomes and their causes among groups of people." Many health disparities are related to social determinants of health. Social determinants of health (SDOH) are conditions that affect a wide range of health outcomes. The CDC, along with Healthy People 2030, frame SDOH as:

- Healthcare access and quality
- Education access and quality
- Social and community context
- Economic stability
- Neighborhood and built environment

Related to this are health inequities, which, according to the WHO, are systematic differences in health outcomes of different population groups. Societal factors such as "education, employment status, income level, gender, and ethnicity have a marked influence on how healthy a person is…the lower an individual's socioeconomic position, the higher their risk of poor health."

RPE highlighted racial, ethnic, tribal, and LGBTQ+ populations in the NOFO. Nevada RPE has further refined the populations, as described in this section.

Addressing Health Disparities and Disproportionate Burden Using State or Local Level Data

To reduce sexual violence perpetration across the state, strategies will focus on where health disparities and inequities contribute to higher rates of sexual victimization. This approach recognizes sexual violence perpetration and victimization can impact anyone, regardless of age, gender, social status, etc. To make an impact, it is reasonable and important to focus efforts among specific populations where risk is highest. To begin this process, we will use available data to determine where health disparities exist and persist and use it to plan, implement, and evaluate strategies addressing health disparities with stakeholders. It is important to note that the approach to expand partnerships is a crucial component of reaching and addressing disparity, to ensure that any strategies are relevant and acceptable within the communities and cultures where efforts or interventions may be introduced.

There are many data sources currently available that uncover general health disparities and additional risks related to sexual violence. Examples of health disparities in Nevada include:

Race and Ethnicity

- In Nevada, the proportion of people with high health status is lowest among Hispanic/Latino (33.3%), followed by Black/African American (39.3%). As a comparison, 49.9% of people who are white have a higher health status.[4]

Disability

[4](America's Health Rankings, disparities by state)https://www.americashealthrankings.org/explore/annual/measure/healthstatus_disparity/state/NV

- One of the most pronounced sexual health disparities for young adults living with a developmental disability is a heightened vulnerability to sexual assault and abuse.[2] Significant sexual health disparities, including unplanned pregnancy, sexually transmitted infection (STI) rates, and the prevalence of sexual abuse, negatively impact this population's quality of life.[5] Children living with disabilities are three times more likely than children without being victims of sexual abuse. The likelihood is even higher for children with certain disabilities, such as intellectual or mental health disabilities.[6] Between 2009 and 2012, reported instances of rape/sexual assault against persons with a disability in the United States increased from 1.7 in 2009 to 3.6 in 2012.[7]

Gender and Identity

- In Nevada, the proportion of women who have high health status is 43.3%, compared to 45.1%
  of males (America's Health Rankings, disparities by state).
- Girls and women are at higher risk for sexual assault.[8]
- A special report of YRBS in 2015 disaggregated youth responses by those who identified as LGBT. Youth who identified as LGBT were nearly three times as likely to report having been forced to have sex in their lifetime, compared to their non-LGBT peers, and nearly three times as likely to have experienced sexual dating violence (one or more times during the 12 months before the survey by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey).[9]
- Based on national data, 47% of transgender people are sexually assaulted at some point in their lifetime, and these rates are higher among transgender people of color, and persons who are American Indian (65%), multiracial (59%), Middle Eastern (58%), and Black (53%).[10]
- Boys and men are also affected by sexual assault.

Socio-economic Status

- In Nevada, income correlates with health status. Among those with incomes less than $25,000 per year, only 27% have a high health status. Among those in the income bracket above $75,000 per year, 62.8% have high health status (America's Health Rankings)

Frontier, Rural, and Urban Geographies

- In Nevada, only 40.1% of rural and 41.5% of people in urban areas have high health status, compared to 51.3% of those living in suburban areas. (America's Health Rankings, disparities by state). The proportion of those with high health status is also lower for these groups than US rankings.
- Nevada has several areas which experience health provider shortages (HSPAs).

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[5] Lund, Emily M., and Vaughn-Jensen, J. (2012). "Victimization of Children with Disabilities." The Lancet, Volume 380 (Issue 9845), 867-869.

[6] Erika Harrell, Crime Against Persons with Disabilities, 2009 – 2012-Statistical Tables, (Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice, 2014), Table 1

[7] Goldman, R. L. (1994). Children and youth with intellectual disabilities: Targets for sexual abuse. International Journal of Disability, Development and Education, 41(2), 89-102.

[8] https://www.nsvrc.org/statistics

[9] https://www.unr.edu/Documents/public-health/2015%20Nevada%20HS%20YRBS%20Sexual%20Identity%20Analysis.pdf

[10] http://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF

These areas exist both within rural and urban areas of the state.

- As one indicator of sexual violence, the rates of reported rape per 100,000 (2016) were highest in Clark, Humboldt, Pershing, Lander, and Elko counties. Among cities, Las Vegas, Reno, and Elko had high rates of rape per 100,000.

Education

- Education correlates with health status in Nevada. Among those with less than high school education, only 21.4% have high health status, compared to 61.6% of college graduates (America's Health Rankings, disparities by state).
- Lack of employment opportunities is a risk factor associated with sexual violence in Nevada. Education is also linked to employment opportunities (and income).

Language and Immigration Status

- Nevada is home to a diverse population, including refugees, people seeking asylum, and other non-US national persons. Language and other factors can be barriers to accessing health care and other services.
- According to the PEW institute, Las Vegas has one of the highest rates of any city for people who are undocumented.[11] People who are undocumented or have an undocumented family member may be particularly fearful of using services or reporting crimes, including sexual violence. Quantitative data on this issue is not currently available.
- In 2019, the Trump Administration published the "Public Charge" rule, which expands the programs the federal government considers in public charge determinations (such as health, nutrition, and housing programs and Medicaid for non-pregnant adults). As a result, it is expected that immigrant families will be deterred from enrolling in public programs, increasing the uninsured rate, reduce access to care, and leading to worse health outcomes.

Age

- In Nevada, health status is highest among young people (49.6%) having high health status, and the lowest rate is among those aged 45-64 (38.3%). Among older adults age 65 and over, 40.8% report having a high health status. (America's Health Rankings, disparities by state).
- According to national statistics, people ages 15-35 y.o. are at greatest risk for sexual assault.[12]
- According to national statistics, college is a particularly difficult time for sexual assault. Nearly one in four (20% - 25%) of college women and 15% of college men are victims of forced sex during their time in college.[13]

Housing Status and Shelter

- There are thousands of people who are homeless or precariously housed in Nevada. This includes adults and unaccompanied youth. On any given day, 1,285 youth are homeless in Nevada. [14]
- People who are homeless are often not able to access health care for several reasons.
- While statistics are not readily available, information from those working with homeless people, including youth, report high rates of sexual assault. People who are homeless may have difficulty reporting, especially where homelessness is a crime.

Experiences of Sexual Abuse

[11] https://www.pewresearch.org/fact-tank/2019/03/11/us-metro-areas-unauthorized-immigrants/
[12] https://www.rainn.org/national-resources-sexual-assault-survivors-and-their-loved-ones
[13] https://www.nsvrc.org/statistics
[14] https://www.usich.gov/homelessness-statistics/nv/

- Having been previously raped or sexually abused is a risk factor for sexual violence. Working with youth and young people, prevention is part of a critical feedback loop. While specific data are not available at this time, future strategies may include working with populations at risk, including foster youth and children, youth survivors of trafficking, children in juvenile justice settings, and people in other criminal justice settings.

Adverse Childhood Experiences

- Rates of dating and other forms of violence were correlated with the number of Adverse Childhood Experiences (ACEs) among Nevada's high school youth. Those with more than 3 ACEs were at considerably higher risk for all types of violence, including dating violence.[15]

[15] https://www.unr.edu/Documents/public-health/2015%20NV%20HS%20ACE%20Final%20Report_ADA.pdf

Data Sources

Listed below are data sources available. These data will be used to review and discuss health disparities and be considered in prioritizing target populations and future strategies.

Demographics

- US Census & American Community Survey
- Nevada State Demographer
- Community Health Needs Assessments developed by Health Districts (CHAs)
- Community Health Needs Assessments developed by Hospitals (CHNAs)

Risk and Protective Factors

- MCH Block Grant
- Youth Risk Behavior Survey (YRBS) including disaggregated data by gender, race/ethnicity, and LGTQ status
- Census & ACS Data
- Climate Surveys (K-12), By School and District
- Climate Surveys (College Campus) NCSL
- Children's Cabinet
- Key Informant Interviews and Focus Groups (with data in existing, published reports)
- Nevada Department of Education
- Bureau of Labor Statistics
- Healthy Southern Nevada (multiple sources)
- Policy Map (multiple data sources)
- Adverse Childhood Experiences (ACES) and BRFSS
- Child Abuse and Neglect (State & Local Reports)
- Program Level Data – Subrecipients and Partners
- Nevada System of Higher Education
- Women's Law Center
- 500 Cities (Disease Burden and Disparity)
- Nevada Point in Time Count (Including Interviews)
- Vital Statistics (Teen births by age and area)

Victimization and Perpetration

- YRBS
- Safe Voice Tip Line (K-12)
- Uniform Crime Victimization
- Local Law Enforcement Reports
- Key Informant Interviews and Focus Groups (with data in existing, published reports)
- Department of Justice
- Child Abuse and Neglect (State & Local Reports)
- FBI UCR & DOJ
- Policy Map (multiple data sources)
- National Resources and Publications on Sexual Violence
- Hospital Data including Monthly ER Data Collected at the State Level
- Nevada 211, Crisis Call Center, and other Hot & Warm Lines

COVID-19

- CDC COVID Data Tracker
- Nevada Health Response

Health Disparities or Burdens Addressed

Current sexual violence strategies are based on state and subrecipient attention to evidence-informed practice and work at the outer levels of the SEM. Current strategies build on RPE strengths and assets. In Years 1 and 2, the State and other stakeholders will further align primary prevention strategies to address health disparities. The State, subrecipients, evaluation team, and new partners will all have a role in addressing the health disparities, burdens, or both.

In the table below, burdens are shown as they align with the risk and protective factors.

Burden	**Examples of Rationale & Data**	**Risk & Protective Factor Outcomes**
Define Healthy Relationships and Consent	• Rates of Sexual Violence on College Campuses	• Increased active bystander behavior
Victimization (Multiple Strategies)	• Sexual Assault by Age & Gender • Focus on Age, Socioeconomics • Sexual Assault by Identity • Sexual Assault in Specific Environments	• Increased active bystander behavior • Reduced tolerance of sexual violence within the community
Economic Disparity	• Housing Burden, especially FHH • Poverty, especially FHH with young children	• Increased economic stability for women
Weak or Ineffective Policies	• Students completing education each year by gender • Female wage gap • Women in leadership roles (e.g., legislature, women-owned businesses)	• Reduced tolerance of sexual violence within the community • Increased feelings of safety in one's school, workplace, or neighborhood
Lack of Community Safety and Connectedness	• Self-Reports of Hopelessness, Isolation, Safety	• Increased indicators of community connectedness • Increased feeling of safety
Sexual Assaults in Alcohol Established Venues	• Number of sexual assaults • Party Culture as an Identified Issue	• 24-hours access to alcohol • Social Norms promoting-irresponsibility when excessive alcohol is consumed

Populations to Be Selected

In years one and two (2019 and 2020), Nevada's youth and young adults will focus on primary prevention, with strategies to impact schools, college campuses, and other environments where youth and young adults are working. Also, in year one, the RPE Program and subrecipients will engage additional partners positioned to work with populations who are most at risk based on available data.

It is important to develop strategies for populations of interest to be one of engagement and inclusion with people within communities where interventions are being planned. This is critically important for efforts that may take place with Nevada's diverse racial and ethnic populations, including Native Americans, people who are LGBTQ+, and people who have disabilities. It is also important to develop partnerships with people working in the environments for strategy implementation, such as people already working in rural, frontier, and urban areas. The initial focus in year 1 will continue into year two. Current subrecipients have expertise and relevance, and partner relationships will be developed or strengthened so that future strategies and interventions will engage people from populations experiencing disparities to lead decision making about the interventions that are appropriate and relevant.

Burden	Risk & Protective Factor Outcomes	Current Population	Future Considerations
Define Healthy Relationships and Consent	• Increased healthy relationship behaviors • Increased active bystander behavior	• College Campus (UNLV) • High Schools (Washoe County) • Bars and Casinos (Clark County)	Populations who are at higher risk based on available data. (e.g., geography, identity, or by race/ethnicity, disability status, experience)
Victimization (Multiple Strategies)	• Increased active bystander behavior • Increased positive attitudes towards women and girls • Increased leadership skills for girls and young Women • Increased feelings of safety in one's school, workplace, or neighborhood	• College Campus (UNLV) • Bars and Casinos (Clark County)	Populations who are at higher risk based on available data. (e.g., geography, identity, or by race/ethnicity, disability status, experience)

Burden	Risk & Protective Factor Outcomes	Current Population	Future Considerations
Weak or Ineffective Policies	• Increased community support/connectedness • Increased feelings of safety in one's school, workplace, or neighborhood	• College Campus (UNLV) • Bars and Casinos (Clark County) • Service and Adult Industry employees	Populations who are at higher risk based on available data. (e.g., geography, identity, or by race/ethnicity, disability status, experience), particularly in the rural communities
Economic Disparity	• Increased economic stability for women	• Providers (reached through training and State Conference) • Policymakers and leaders engaged in identifying policy recommendations at the state level	Populations who are at higher risk based on available data. (e.g., geography, identity, or by race/ethnicity, disability status, experience)
Lack of Community Safety and Connectedness	• Increased indicators of community connectedness and feelings of safety	• Hospitality Industry employees with expanded community resources and services	Populations who are at higher risk based on available data. (e.g., geography, identity, or by race/ethnicity, disability status, experience)
Sexual Assaults in Alcohol Established Venues	• Reduced numbers of sexual assaults when excessive alcohol is a known factor	• Staff employed in bars, clubs, and casinos	Increase mandatory training for staff in venues serving alcohol*

*Not current being advanced (2020) but remains a state priority.

Strategies to Increase and Maintain Partner Coordination

This section of the SAP describes the RPE Program and its subrecipients' current and future partners. The purpose is to maintain and strengthen existing partnerships and identify new public/private partnerships to provide technical assistance and support for program implementation and evaluation. It is our intent to develop formal partnerships to improve the capacity to access and use data, increase implementation of community/societal-level strategies, and improve coordination of state SV prevention efforts. Therefore, this section also provides our plans for the continued engagement of current partners and new partners' recruitment.

Nevada RPE Program

The Nevada RPE Program resides within the Maternal, Child, and Adolescent Health Section (MCAH), Bureau of Child, Family, and Community Wellness (BCFCW), in the Nevada DPBH (see p.9).

DPBH possesses the required infrastructure to support sexual violence prevention efforts at the state level through access to state data and qualified staff to provide technical assistance. The Nevada RPE Program maintains consistent staff who coordinated RPE activities over the last two 5-year project periods and was instrumental in establishing collaborations resulting in a state sexual violence coalition.

The RPE Program uses a public health approach to reduce multiple forms of sexual violence in Nevada through leveraged Preventive Health and Health Services (PHHS) and Title V Maternal and Child Health (MCH) Block Grant funds. The MCAH Section in BCFCW is home to a number of women and children's wellness programs such as Early Hearing Detection and Intervention (EHDI), Children and Youth with Special Health Care Needs, Teen Pregnancy Prevention, Pregnancy Risk Assessment Monitoring System (PRAMS) Adolescent Health and Wellness, Home Visiting, and the Title V MCH Program.

Current RPE Program Partners and Subrecipients

Following is information about current RPE Program partners and subrecipients, including what they are currently funded to implement through RPE, their objective and target audiences, and direction of focus in 2020. This serves to set the stage for identifying additional partners and growing relationships throughout the state to advance the SAP.

The RPE Coordinator maintains strong relationships with the NCEDSV, RCC, and Nevada's Office of the Attorney General. As part of the upcoming 5-year project period, DPBH has contracted with an approved vendor experienced in program evaluation and analysis and will develop internal capacity to supplement training and technical assistance to subrecipients on selecting, implementing, and tracking data for continuous program improvement.

The RPE Program continues to build and strengthen internal state capacity through programs sharing the same risk and protective factors of violence prevention. The RPE Program continues to pursue internal partners for increasing collaborative efforts through leveraged Maternal and Child Health (MCH) Block Grant and Preventive Health and Health Services (PHHS) Block Grant funds. RPE collaborates internally with Children and Youth with Special Health Care Needs (CYSHN), Pregnancy Risk Assessment Monitoring System (PRAMS), Sexual Risk Avoidance Education (SRAE), Personal Responsibility Education Program (PREP), Home Visiting and Adolescent Health and Wellness (AHW) Program.

NCEDSV's policy work in 2020 can help the NDE determine modifications to the School Climate Survey so that results may yield information about changes in individual, relationship, community, and social norms over time.

The Nevada Department of Education (NDE) maintains the Office of Safe and Respectful Learning Environment (OSRLE). The mission of the Office Safe and Respectful Learning Environment is to train, empower, educate, collaborate, advocate and intervene to ensure that every student in Nevada, regardless of any differing characteristics or interests, feels fully protected physically, emotionally, and socially. As part of 2019 efforts, the RPE Program reached out to the Department of Education Office of Safe and Respectful Learning to pursue partnerships to ensure Nevada students' safety by decreasing incidences of sexual harassment and particularly electronic bullying. This partnership and collaboration may be an important aspect of data and evaluation and understanding trends in reported incidents within different geographic areas of the state. The Director of the Office of Safe and Respectful Learning Environment has offered the RPE Program, its subrecipients, and other interested persons to assist the Department of Education in building out the SafeVoice software program's response side. The system collects and reports on dating violence, sexual assault sexual misconduct, among other types of reports, which the RPE Program can use along with other data to inform strategies and program selection. RPE Program stakeholders are also asked to help determine the types of training teachers, and administrators receive around these issues, which will help to change social norms. In 2020, progress has been made to explore the use of this data source.

Nevada Coalition to End Domestic and Sexual Violence

The Nevada Coalition to End Domestic and Sexual Violence (NCEDSV) mission is to be a statewide voice advocating for preventing and eliminating violence by partnering with communities. The Coalition has a long history of serving rural areas as Nevada’s Network Against Domestic Violence before becoming Nevada’s designated dual sexual and domestic violence agency. NCEDSV targets individuals, organizations, and communities with specific characteristics for its regional training. The organization conducts an annual conference each year to provide legislative updates, trends in sexual violence prevention and victimization, and support equity and diversity education to reach high-risk populations.

In 2020, NCEDSV identifies policies and legislative recommendations for increasing gender equity in Nevada to empower and support women and girls. They have connected with various organizations in Nevada, working on economic justice issues that may or may not have connected economic justice and sexual violence. NCEDSV has met with or intends to meet with: Opportunity Alliance, PLAN, Nevada Women’s Lobby, Nevada Women’s Equity Coalition, Nevadans for the Common Good, Nevada Minority Health and Equity Coalition, Make it Work Nevada, and Make the Road Nevada.

NCEDSV researches statewide economic policies impacting women and girls, such as pay equity, childcare, education, and housing. Also, NCEDSV explores policy initiatives to help identify strategies to operationalize initiatives through changes to existing regulations, codes, and legislation. NCEDSV plans to identify given issues to focus on going forward and intends to hold virtual meetings with key players and interested parties in December 2020 and January 2021.

Rape Crisis Center

Nevada’s only Rape Crisis Center (RCCLV) located in Las Vegas, is funded to implement three main goals: 1) Increase safety and socio-emotional learning skills in children K-12 attending Nevada schools; 2) Increase collaborative partnerships with Nevada agencies; 3) Increase protective environments in Las Vegas hospitality venues to prevent sexual violence.

To achieve the first goal, RCCLV collects information to summarize the needs and barriers for Nevada schools to successfully implement new child safety standards and offer technical assistance for at least five schools. RCCLV adapted to the challenges brought forth by the COVID-19 pandemic by assisting schools and teachers in an online, virtual format.

RCCLV enhances collaboration with other agencies in Nevada to examine limitations and improvements to the current bullying statute. This work has helped form new allies in their efforts to prevent violence.

As part of their effort to create protective environments, RCCLV continues to implement the Stay Safe / SAINT program targeted to the hospitality industry. While the program was initially put on hold in March due to Nevada's shelter in place order, as businesses began to reopen, RCCLV held socially distanced and masked training promoting safety and security. Through the Stay Safe / SAINT program, RCCLV has worked to institutionalize relationships with MGM and Wynn and seek new partnerships to expand the safety practices. In the coming year, they plan to reach out to casinos, bars, and clubs to establish and formalize relationships for programming support.

Safe Embrace

Safe Embrace, with feedback from the State RPE Program, is moving away from school-based prevention to working with the Hospitality and Adult Entertainment Industry. They will provide training on policies and practices that identify and stop red-flag behaviors. The training will target staff and management through partnerships via an MOU or similar written agreement. The MOU will require ongoing training/onboarding, a no-tolerance approach, and periodic access to impact evaluation staff. The agreement will specify the ability to connect staff with community resources as needed. The women who work in these establishments and some of the women who frequent the clubs as customers will benefit from the safer environment created by increased knowledge and skills of staff and management.

Safe Embrace is currently working to assist entertainment and hospitality organizations in Northern Nevada to establish and strengthen zero tolerance and sexual harassment policies in the workplace.

In their work to create protective environments, Safe Embrace conducted outreach to new partners in the business community, highlighting how they could increase safety for staff and patrons. Since the program's start in late 2019, 12 establishments have MOUs in place and receive information, training, and policy guidance, while 25 additional establishments expressed interest in the program.

By January 2021, Safe Embrace will have 15 venues with updated or established workplace policies and procedures to prevent sexual harassment and sexual violence.

University of Nevada, Las Vegas

The University of Nevada, Las Vegas (UNLV) Women's Center works with sexual assault staff on the UNLV campus, leveraging resources from Greek life, women's athletics, student diversity, and justice offices, and counseling and psychological services to engage students about issues surrounding sexual violence and identifying harassment issues they may experience when entering the workforce. The two major goals UNLV has as part of their RPE work are to empower and support women in the UNLV community and create protective environments within the community. Starting in 2019, the UNLV Women's

Center collaborated with campus leaders to increase protective environments for women on campus and their future working environments. UNLV has committed to recommendations to the President's Advisory Committee on best practice measures on sexual violence prevention and advising on protocols and procedures to identify and respond to interpersonal violence.

In 2020, UNLV continued the CARE Peer Program (CPP), an individual/relationship level strategy, and the CARE Campus initiative focused at the community level. CPP is an empowerment-based 45-hour training curriculum with interactive modules focused on promoting social norms that protect against violence such as bystander approaches and healthy relationship/communication components. It is offered to all UNLV students with an outreach emphasis on priority populations of women, female-identified, and LGBTQI students. Graduates of the CPP can become CPP Leaders and graduate students eligible for scholarships, thereby improving both leadership skills and economic stability as they are supported in completing their education.

CARE Campus focuses on revising existing protocols and procedures to identify and respond to intimate partner violence (IPV) for students, faculty, and staff. This work will result in tools for tracking and monitoring policy findings over time. Due to COVID-19, UNLV has moved to virtual education, outreach, and training.

Engaging Our Current Partnerships

The RPE Coordinator is frequently communicating with the current partners, conducting monthly calls, bi-annual training sessions, sharing technical assistance and resource information, and involving partners in day to day action planning and evaluation planning processes.

Partners have recently been engaged in clarifying the target populations, specific outcomes to achieve at the program level, and training on moving the work to the community and societal levels. Current partners have been engaged in developing the RPE logic model, providing input on intermediate and short-term outcomes, and suggesting and prioritizing indicators to map to long-term results and intermediate progress.

Current partners will be involved in developing approaches for identifying, engaging, and connecting with new partners to update the SAP; and have been invited and encouraged to participate in the Safe Voice project and the Climate Survey update discussions with the Nevada Department of Education. This is a new role and opportunity for subrecipients to have a voice with the Nevada Department of Education to share what they know from working on the ground and help improve data collection statewide related to sexual violence in Nevada.

The RPE Program expects to increase knowledge and skills for implementing community change strategies and demonstrate the benefits of prioritizing and documenting changes in the target population. New partners offer the potential for assistance with developing and monitoring program indicators and providing external support for reporting.

New Partnerships

Establishing and maintaining new partnerships is an essential part of this plan for reaching RPE Program objectives over the project period. Subrecipients will be required to maintain at least one formal partnership per focus area strategy implemented. This includes engaging key leaders in prevention efforts as well as looking for nontraditional partnerships.

A list of **potential partners** and how they intersect with the RPE Program are shown below. This list was developed based on suggestions from the subrecipients, RPE Coordinator, and evaluator research and is meant to serve as a starting point for further discussions. Over the next few months, the RPE Program and evaluators will work with subrecipients to prioritize partners, especially non-traditional partners, and specific ways to contribute to achieving the long-term results of the RPE Program.

Prevent Child Abuse Nevada (PCANV)	PCANV works to build community commitment to safe, stable, and nurturing relationships for all children in Nevada. RPE shares the aims of violence prevention.
Office of Suicide Prevention	Nevada's Office of Suicide Prevention is engaged in several important cross-cutting initiatives, including Zero Suicide and Crisis Now. These endeavors share with RPE the potential to improve responses to crises, including those related to sexual assault.
Substance Abuse Prevention & Treatment Agency (SAPTA)	Nevada's SAPTA is engaged with many initiatives focused on prevention, intervention, treatment, and recovery for people experiencing substance abuse disorder. Addressing risk factors for this population, including drug and alcohol mediated sexual assault, is a place for potential collaboration.
Maternal Child and Adolescent Health	Nevada's MCAH is working on several projects that include data collection and activities to reduce adverse childhood experiences, a risk factor for negative health outcomes throughout the lifespan. RPE works alongside MCAH and will continue to identify partnership opportunities, including but not limited to, improving data systems.
Nevada ADSD	Nevada Aging and Disability Services Division (ADSD) in Nevada, Department of Health and Human Services, represents Nevada's elders, children, and adults with disabilities or special health care needs. They have staff expertise, data, and reach to help the RPE Program expand beyond its current reach and more effectively communicate messaging to populations that may not otherwise receive information at various SEM levels.
Nevada DHHS-Office of Analytics	Once indicators and data are finalized for the RPE Program evaluation plan, the RPE Coordinator and evaluation staff can continue to work with the DHHS Office of Analytics to determine the feasibility of establishing a schedule for pulling and sharing local and population-level specific to the RPE Program outcomes.
Nevada Statewide Coalition Partnership	The Statewide Coalition Partnership comprises 12 community coalitions from across Nevada with a primary focus on substance abuse prevention and community wellness. The Nevada Statewide Coalition Partnership's main purpose is to avoid duplication of efforts by facilitating statewide strategies and securing funding to support local coalitions in implementing these prevention strategies. The various coalitions have deep knowledge of and connections to their communities and are considered trusted partners due to their work over the past many years.

Nevada Disability Advocacy Law Center (NDALC)	The Nevada Disability Advocacy & Law Center (NDALC) is a private, statewide non-profit organization that serves as Nevada's federally mandated protection and advocacy system for human, legal, and service rights for individuals with disabilities. NDALC include, but are not limited to, information and referral services, education, training, negotiation, mediation, investigation of reported or suspected abuse/neglect, legal counsel, technical assistance, and public policy work. NDALC has offices in Las Vegas, Reno, and Elko, with services provided statewide. All services are offered at no cost to eligible individuals in accordance with NDALC's available resources and service priorities. The NDALC is an advocate for many of the RPE Program's target audiences and a likely partner moving forward.
Nevada Statewide Epidemiology Workgroup (SEW)	Each state in the nation has a Statewide Epidemiology Workgroup. The outcomes of this group are to provide epidemiology reports and disseminate data and special reports at the state, county, and coalition level, perinatal substance use reports, and needs assessments. The workgroup has access to data sources such as crisis calls, housing, tribal data, corner data, law enforcement, survey data, and Public and behavioral health data through its active partnerships. There is a crossover with partners and data that can benefit the RPE program.
UNLV Women's Research Institute of Nevada (WRIN)	WRIN is focused on a few overlapping areas with the RPE Program. They conducted Gender Equality in the Workplace Survey because of AB 423, which directed the Secretary of State to collect information about Nevada workplaces' equity practices. This focus aligns with the RPE Program's work to increase women's and girls' economic stability. WRIN's NEW Leadership™ is an award-winning national, nonpartisan program to educate college women about politics and leadership and encourage them to become effective leaders in the political arena. This links to increasing women's leadership opportunities. Also, WRIN offers National Education for Women's Leadership Nevada, which is a week-long summer program to educate any university person who aspires to be a leader.
Make It Work Nevada	Make It Work Nevada is an advocacy and policy organization working for safety and dignity, specifically for Safe Workplaces. They are working on expanding current law to every Nevadan – whether they are a nanny working for a single employer, an independent contractor, or an employee of a 10-person mom and pop retail store. This includes advocating all employers to provide sexual harassment training on their clear workplace policies to help prevent harassment before it happens and require employees to receive culturally competent "know your rights" training. Toward more economic stability for women, this group advocates for 7 paid sick days per year and childcare not exceeding 7% of income.
Nevada Hands & Voices	Nevada Hands & Voices supports families with children who are deaf or hard of hearing, as well as the professionals who serve them. The organization is a collaborative group that is unbiased towards communication modes and methods. This diverse group includes families who communicate orally, with signs, cue, and/or combined methods. Nevada Hands & Voices strives to help deaf and hard of hearing children birth to twenty-one statewide reach their highest potential. Nevada Hands and Voices is a trusted organization connected to a frequently left community out of critical conversations and planning, such as those the RPE Program conducting.

Additionally, the RPE Program will need to be aware of Nevada's interest in forming a statewide violence prevention task force/committee should the state decide to apply for CDC's Injury and Violence Prevention Grant in the future, link to achieving longer-term results for this plan.

Continued Engagement and Partner Recruitment: Gap Analysis and Use of Data

As noted above, there will be multiple opportunities to engage subrecipients, discuss working, how current partners contribute and prioritize new partners to advance the work. Each quarter, as process measures are captured and shared with subrecipients, facilitated conversations and peer to peer discussion will enhance results, identify new strategies, and ways data can be used to bring meaning out of what is occurring. Subrecipients and partners must discuss the cross-agency and cross-sector data and engage in conversations about the meaning and implications in both the short and long-term related to strategy and how to engage better and utilize partnerships.

Leveraging Partnerships and Resources to Increase Nevada's Primary Prevention Efforts

Process of Working with Partners and Use of Resources

NCEDSV will lead efforts to expand partnerships statewide. NCEDSV is the dual coalition for domestic and sexual violence and has a history of committing domestic violence, particularly in rural areas. RPE funds the NCEDSV to provide regional training on topics related to sexual and domestic violence. NCEDSV participates in quarterly meetings with the Nevada Office of the Attorney General and RPE staff and recipients of STOP and SASP Grants, which positions them at the forefront of cross-sector non-traditional partner conversations. Over these 5 years, NCEDSV will focus training on expanding to the outer layers of the SEM, including how to identify and work with non- traditional partners in achieving the RPE Program's long-term outcomes.

Primary prevention expansion will occur by engaging in national, state, and regional training to gain knowledge and skills for building internal capacity to implement community-level strategies.

The NCEDSV holds an annual state coalition conference to develop primary prevention approaches for domestic and sexual violence using available resources. A Women's Economic Consortium will allow agencies to work together to address barriers and approaches for strengthening women's and girls' economic footing in Nevada. This work will involve cross-sector partners from the state government, business sectors (finance, small business), education (higher education), and community organizers and advocacy groups, working to identify, recommend and help implement changes to existing regulations, code, or legislation that support women's economic parity and advancement.

Capacity Building and Technical Assistance

The New Partnerships section of this document described various potential partners who can help ensure primary prevention is expanded across Nevada. Once those and other prospective partnerships have been reviewed and prioritized by the RPE Program and subrecipients, participants will reach out to determine areas of greatest alignment, resources to be leveraged across and among partners, and specific roles each has (or could expand into) which are determined to advance RPE Program results.

In the first year to 18-months of SAP implementation, the focus is on building and strengthening capacity and technical assistance by working with Nevada Coalition to End Domestic and Sexual Violence, Nevada Department of Education, UNLV Women's Research Institute, the DHHS Office of Analytics, and the Nevada Statewide Coalition Partnership. These partners possess knowledge and capacity and maintain investment for decreasing rates of sexual violence in Nevada.

As capacity allows, the RPE Program and its subrecipients will continue to expand partnerships and extend technical assistance and training opportunities to and from a broader range of organizations and initiatives statewide.

Use of Data

Data will be used to help engage subrecipients and ensure partners are working toward shared aims. Data will be a critical component of engagement. Additionally, TA and coordination as described in the Capacity Building and Technical Assistance and Data Tracking and Use sections of this plan.

Data Tracking and Use

Structures, Functions, and Data Capacity

The State of Nevada RPE Program staff, with assistance from evaluators, used a multi-step process, informed by the STOP SV technical packet, sexual violence indicator database, and other sources to identify potential data for selection. The process for selecting data to track and report engaged stakeholders, including key staff at agencies, current subrecipients, and potential partners. This data has been reflected in the logic model and evaluation plan. These are living documents that may continue to be improved and refined based on the best available information. Data for collection fits within the STOP SV focus areas. It is grounded in the theory of sexual violence (SV) prevention and is intended to demonstrate the link between the program's theory to the actual outcomes addressing SV. Multiple data sources have been selected to help provide a stronger set of evidence to understand progress and challenges in preventing sexual violence in Nevada.

Nevada will build on action steps identified as part of RPE efforts to enhance evaluation capacity. Recommendations and updates are considered below.

Area 1: Data System
Recommendations for this area focus on ensuring the final list of SV indicators align with the needs assessment, the state's theory of change for SV, and the subrecipients' activities and objectives. Additionally, subrecipients and the RPE Program will receive technical assistance (TA), including updated data collection tools to be pilot tested with participants.

- Recommendation 1.1: Finalize the list of SV risk and protective factors, indicators, and data sources that reflect program priorities.
    - **Status:** The list of SV risk and protective factors have been identified with data sources that reflect priorities. These will continue to be refined and revised.
    - **Potential Action Step:** Investments in data systems for various public health projects and internal capacity. The existing data systems and contracted partners are adequate for the current RPE evaluation.
- Recommendation 1.2: Build a TA structure to support RPE and subrecipient evaluation expertise and support/improve tracking and reporting work.
    - **Status:** Technical assistance will be developed to meet RPE and subrecipients data and culture of learning.
    - **Potential Action Step:** Multiple and specific TA needs were identified through the process of assessment and planning. Data (collection, analysis, and informing decisions) will be integrated into the TA plan.
    - **Potential Action Step:** The TA structure and capacity-building efforts will be assessed through CQI to help meet emerging needs and ensure value.

Area 2: Staff and Consultants

The sole recommendation in this area is to build the evaluation capacity, including understanding what the data shows and how future strategies or activities should be modified or expanded to achieve results. As subrecipients have limited evaluation staff overall, the RPE Coordinator is supported by other staff or consultants to help build subrecipients and potentially their partners.

- Recommendation 2.1: Build the RPE Program and subrecipients' capacity to access and integrate data to track SV indicators over time and understand and use the evaluation results.
    - **Status:** Consulting support is in progress to help support the needs, including building capacity.
    - **Potential Action Step:** The TA structure and capacity building efforts will be assessed through CQI to help meet emerging needs and ensure value.

Area 3: Partnerships

Recommendation for area 3 focuses on building a robust network of partnerships actively working to capture, report, and provide data on prevention effort impacts. While the system does not need to be extensive, it needs to deliver reliable, regular data to guide those working on SV prevention.

- Recommendation 3.1: Expand formal, active partnerships providing information, data, and analysis to help RPE Program track SV indicators over time. (For future consideration)
    - **Status:** Initial conversations about data sharing are in progress. Several partners have indicated they have data to contribute to the RPE evaluation.
    - **Potential Action Step:** A network map of partners is a tool that can help show who is known to be working in alignment with RPE. This tool can also be used to document new partners and potential partners.
    - **Potential Action Step:** The RPE Program and subrecipients will pursue partnerships with groups already working with populations of interest in a culturally relevant way. These partnerships will provide a greater reach of the public health approach and RPE goals to populations of interest.

Area 4: Access and Integration of Data

The RPE Program's subrecipients work with a variety of organizations or businesses at the local level. Their ability to capture relevant data, track and evaluate changes, and share with partners and the community is essential to sustaining the work. Recommendations in this area work to build the RPE Program and subrecipients' access to and integrate data beyond their program activities.

- Recommendation 4.1: Build the capacity of the RPE Program and subrecipients to access and integrate data to track and evaluate changes in SV indicators over time. (For future consideration)

- Recommendation 4.2: Build the RPE Program and subrecipients' capacity and ability to communicate evaluation results with partners and stakeholders regularly. (For future consideration)
    - **Status:** Through the technical assistance and CQI process, RPE Program and subrecipients will improve their ability to communicate evaluation results with stakeholders.
    - **Potential Action Step:** The evaluation team will develop tools to communicate specific key indicators to a wide audience.
    - **Potential Action Step:** The RPE Program and subrecipients will be encouraged to share data for CQI purposes through monthly TA and quarterly meetings.

Area 5: Leadership

Currently, the work of SV prevention is largely driven by the RPE Coordinator, RPE

Director, Title V Manager, and subrecipient organizations. However, to achieve and sustain long-term, community-level results and see positive trends on selected indicator data, it will take key champions. That leadership needs to come from cross-sector individuals with a shared interest in reducing and eliminating sexual violence. The recommendation in this area is designed to move in that direction by focusing on data and trends.

- Recommendation 5.1: Build buy-in and engagement of cross-sector leadership in supporting and tracking indicators over time. (For future consideration)
    - **Status:** Technical assistance and communication between the RPE Program and subrecipients have helped to build leadership. Initial steps to engage new partners have also provided early progress toward strengthening cross-sector leadership.
    - **Potential Action Step:** Through the technical assistance and CQI process, RPE Program and subrecipients will improve their ability to communicate evaluation results with stakeholders.

Aligning Potential Indicators to Selected Outcomes

The selection of indicators took place following a stakeholder agreement about selected outcomes. The process engaged stakeholders to review a list of possibilities. Specifically, the draft logic model was developed with stakeholder opportunities for feedback. Next, using the identified and agreed-upon outcomes, evaluators used the indicator database and other sources to develop a list of possible indicators. Subrecipients and other partners then participated in a webinar to discuss the list and offer additions. Following this discussion, the subrecipients and partners were sent an electronic survey to refine the indicators further. They were asked to select the best indicators based on multiple criteria: the indicator's alignment to the outcome being measures (proxy power), the indicator's ability to be compelling and important to a large audience (communication power), and the availability/degree to which there is information available for this indicator (data power).

Further work is needed to ensure the selected indicators are available and meet standards for feasibility and accuracy. To complete this step, one of the first tasks is to collect and compile baseline data for the selected date and to document any limitations or additional considerations regarding their use. For example, the Youth Risk Behavior Survey (YRBS) data is collected every other year in Nevada. Differing consent models limit the ability to compare geographies without caution.

We also recognize perfect data are difficult to come by, and many sources will have limitations. To address this, multiple data sources and indicators, including qualitative measures, are under consideration, and RPE staff and evaluators will continue to refresh and communicate the list of indicators in communication with stakeholders.

Identifying and Accessing Data Sources to Monitor and Track Selected Outcomes

Nevada's RPE Program began a process of listing current data sources. The list includes suggestions from the CDC, and other technical assistance providers, web research, review of state and local reports and needs assessments, and suggestions from subrecipients and partners. We expect the list will continue to grow and will also refine our understanding of the best available data for the purpose at hand.

Most indicators selected are secondary and are publicly available. Many of these are lagging

indicators. Some leading indicators involving direct data collection or compilation were included in the plan. In general, this data can be collected in collaboration with the subrecipients and partners through simple surveys and checklists.

The evaluation considers qualitative and quantitative data, and suggestions for both are included in the evaluation plan. Whenever possible, the program will review more than one source of data to deepen the understanding of the issue or indicator.

The process of developing new data sources is also in progress. Some examples of activities include working with partners to suggest reports and data and developing a system map to document and visualize the expansion of the partner network. Additional tools, for example, aggregation of program data that could support monitoring of a protective factor such as "increased leadership opportunities for girls," will be developed in consultation with others working on similar aims (with the RPE network or within the state). These tools will also be developed as needed, given the work is developmental.

Barriers and Challenges

At this stage in planning and evaluation, there are both barriers and challenges identified. These include (but are not limited to):

- **Connecting Short and Long-Term Outcomes.** Many of the outcomes, especially short-term, may be difficult to see early results. Our ability to track data is in development, and many of the indicators selected are at the population level. Population-level indicators are largely influenced by contextual factors and are often lagging. As a solution to this issue, the evaluation team will focus on short and mid-term outcomes that can be quantified and qualified and use this information to help the stakeholders to both see progress and identify new opportunities to affect the ultimate outcomes of reducing sexual violence. The evaluation team will also engage with and learn from the CDC, other states, and practitioners working to measure prevention, learning, and leveraging knowledge and expertise toward shared goals.

- **Challenges with Language and Definitions.** Aligning data across systems can involve both adaptive and technical challenges. Among adaptive challenges, people already working in the field have working definitions that may not be consistent across partners. A technical challenge, when it comes to shared data, can include may issues related to definitions and measurement.

- **Quality and Comparability of Data Sources.** Limitations of existing data sources can make them difficult to compare. To address this, the evaluation will use more than one source of data (including qualitative measures) to understand trends and current situations. The team will also help to build capacity among all stakeholders to improve data collection, use, and analysis.

Current Primary Prevention Program and Policy Strategies

During Nevada's 2017 legislative session, new health standards were created to implement social-emotional learning and safety education into new Health curriculum standards for grades K-12. The efforts were a collaboration of Nevada stakeholders to fill a gap realized by a lack of comprehensive sexual health and safety education for students attending Nevada's public schools. RPE Director and Coalition staff on the Nevada Department of Education State Standards Committee drafted new state health standards, including reproductive health standards.

The NCEDSV annual conference, funded through the RPE Program, advances primary prevention work by building state capacity to implement primary prevention strategies within various communities and stakeholder groups. The NCEDSV annual conference each year provides legislative updates, national trends in sexual violence prevention and victimization and supports equity and diversity education aimed at reaching high-risk populations. In 2019, NCEDSV conference focused on addressing the root causes of poverty and inequity, particularly as experienced by women and girls, and highlight strategies for Nevada agencies to increase prevention programming into current and future work. The conference provides an opportunity for rural agencies to receive training and technical assistance, which are presently lacking in areas far from urban developments. The conference also allows for sharing successes and challenges of working in a state with limited resources.

Other Funding for SV Primary Prevention and Connection with RPE

This section of the plan describes additional funding sources the RPE Program, subrecipients, and partners receive to support SV primary prevention in the state, along with how the funds are administered and used at the state and/or local levels, including what strategies and activities are implemented. It also notes how those efforts support or enhance RPE-funded work.

RPE Program

The Title V Maternal, Child, Health (MCH) Block Grant provides salary support for the RPE Coordinator (25%) to oversee sexual and intimate partner violence prevention priorities affecting women's health in Nevada. The RPE Program and Title V MCH Program are in the Maternal, Child, and Adolescent Health (MCAH) Section within the Bureau of Child, Family, and Community Wellness (BCFCW). The RPE Program is part of the MCH Unit supervised by the MCH Program Manager and participates in MCH activities with MCH Unit and MCAH Section, which allows collaborative opportunities to leverage resources and support activities which seek similar outcomes and are tied to several risks and protective factors of sexual violence. The Adolescent Health and Wellness and Children and Youth with Special Health Care Need programs in MCH have shared demographic and risk and protective factors overlap, fostering leveraging of partnerships.

Rape Crisis Center

The Rape Crisis Center (RCC), a subrecipient, receives primary prevention funding through DCFS Grants Management Unit from the Children's Trust Fund for child self-protection training for prevention of child sexual abuse, as well as parent education training for child sexual abuse prevention. Total funding for the upcoming year is approximately $64,000.

Additionally, in 2018 RCC received a $10,000 grant/gift from Uber dedicated to prevention efforts with clubs, bars, hotels/motels. The strategies include active bystanders and understanding predatory behavior, and changing cultural norms in the security, hotel, motel, and club industry. These funds support the education of students in schools, education of parents and educators of young children, as well as security and food and beverage workers.

The RCC is a private nonprofit, and funds are administered and reported on per contract agreements and Financial Accounting Standards required of nonprofit organizations.

Connection with RPE

A PHHS Block Grant sexual violence set-aside, administered through the Chronic Disease Prevention and Health Promotion (CDPHP) Section of BCFCW, provides workshops for professionals and peer leaders, working with youth and young adults on healthy relationship education and identifying signs of relationship abuse. PHHS funds support efforts in Nevada to decrease sexual violence and sexual assault by providing tools to professionals working with parents and individuals living with developmental disabilities, as well as those working with LGTBQ youth. The decision to focus resources on populations experiencing disparities integrates priorities of the RPE Program and the Nevada Coalition to End Domestic and Sexual Violence, which currently implements training statewide.

- The RPE Program receives an annual sexual assault set-aside of $60,382 through the Preventive Health and Health Services (PHHS) Block Grant to provide educational workshops for professionals and peer leaders, working with teens and young adults on healthy relationship education and identifying signs of relationship abuse. *This work links to RPE focus and priority areas for increasing protective environments.*
- The RPE Program partners with the Nevada Coalition to End Domestic and Sexual Violence (NCEDSV) to support healthy relationship education to professionals and peer advocates serving Nevada youth and young adults 15-24 y.o. *This links to RPE focus and priority areas for addressing social norms through increasing healthy relationships; and increasing protective environments and feelings of safety in one's school, workplace, or neighborhood.*
- Outreach activities prioritize professionals overseeing the care of young adults living with a developmental disability. The decision to target professionals enhances RPE Program priorities by focusing on populations experiencing disparities and a lack of education of professions partnering in their care. Individuals with a developmental disability live with a heightened vulnerability for significant sexual health disparities, including unplanned pregnancy, sexually transmitted infection (STI) rates, and negative impacts on the individual's quality of life. *This work links to RPE focus and priority areas teaching active bystander behavior to prevent violence and increasing protective environments through increased community connectedness and feelings of safety in one's school, workplace, or neighborhood.*
- PHHS funding for prevention and disability training *supports RPE goals on prevention and identification of risk and protective factors and building capacity of stakeholders to work at the community and societal levels of primary prevention.*
- Nevada dual NCEDSV efforts and website resources link to RPE focus and priorities of building capacity. Their library of resources targets a wide variety of audiences, their data reports present trends in intimate partner violence, and NCEDSV works with its member partners and allies to develop a method of collecting data on sexual violence in Nevada. *This work aligns with the RPE Program focus on shared*

data tracking, reporting, and monitoring systems to tell the impact of the work throughout the state.

The Administration for Children and Families, Family and Youth Service Bureau (FYSB), funds the DPBH Sexual Risk Avoidance Education (SRAE) and Personal Responsibility Education Program (PREP) for adolescent pregnancy prevention via evidence-based curricula.

- PREP curricula offer comprehensive sex education and adulthood preparation programs including, but not limited to, subject topics on healthy relationships, including the development of positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage and family interactions, trauma-informed care, and positive youth development (PYD). *Connects to RPE work through improving social norms: Healthy relationships; increased feelings of safety in one's school, workplace, or neighborhood, increased bystander behaviors to prevent violence.*
- SRAE curricula offer effective strategies to educate youth on benefits associated with delaying sex and PYD. SRAE Programs also teach the benefits associated with self-regulation, success sequencing for poverty prevention, healthy relationships, goal setting, and resisting sexual coercion, dating violence, and other youth risks behaviors such as underage drinking or illicit drug use without normalizing teen sexual activity. *Connects to RPE work through improving social norms related to healthy relationships, increased economic stability for women, increased feelings of safety in one's school, workplace, or neighborhood, increased bystander behaviors to prevent violence.*

Positive Youth Development, or PYD, is based on a body of research suggesting certain protective factors, or positive influences, can help young people succeed and keep them from having problems. According to this research:

- Young people may have fewer behavioral issues and may be better prepared for a successful transition to adulthood if they have a variety of opportunities to learn and participate at home, at school, in community-based programs, and in their neighborhoods.
- Some of the elements that can protect young people and put them on the path to success include family support, caring adults, positive peer groups, a strong sense of self and self- esteem, and involvement at school and in the community.

The goal of both programs is preventing pregnancy and the spread of sexually transmitted infections (STIs) among adolescents of diverse backgrounds including, but not limited to, adolescents who are homeless, in foster care, living in rural areas or areas with high teen birth rates, and adolescents from minority groups, including sexual minorities. *Connects to RPE work through improving social norms related to healthy relationships, increased economic stability for women.*

RPE collaborates with SRAE and PREP. Both SRAE and PREP have similar target populations as RPE in terms of demographics and the promotion of efforts in educating youth on topics such as teen dating violence, healthy relationships, resisting sexual coercion, dating violence, including the development of positive self-esteem and relationship dynamics, friendships, dating, and romantic involvement.

SRAE and PREP programs are implemented in twelve urban and frontier counties around the state. The evidence-based programs (EBP) are administered through sub-awards to

local organizations located within the twelve counties.

SRAE and PREP Coordinators have access to training and webinars relating to prevention strategies for other forms of violence (intimate partner violence, teen dating violence, youth violence, and bullying to keep DPBH and sub-awardees updated and informed about referring adolescents to appropriate services and programs). All sub-awardees were given all applicable training, and all relevant webinars were shared. Coordinators have attended and shared webinars with grantees that have been shared by FYSB pertaining to Trauma-Informed Care, Healthy Relationships and Collaboration, Healthy Life Skills, Human Trafficking, Teen Dating Violence, Teen Dating Violence and Healthy Relationships in the Digital Age, Bullying, Cyberbullying, and Social Media Safety and Help Prevent Youth Dating Violence in Your Community webinars this fiscal period. *This work meets the RPE Program objectives for increasing partnerships using the public health model to enhance protection and reduce risk factors.*

Nevada SRAE and PREP work with sub-awardees to develop referral guides for specific issues related to adolescents. These referrals cover a wide variety of health and social services, which may be necessary for youth and their family as allowable under federal law. Sub-awardees can refer youth to specific healthcare services, social service agencies, voluntary agencies, and other services.

Connection with other Forms of Violence

RPE staff participates in quarterly meetings with the Office of the Attorney General, Division of Child and Family Services (DCFS), and the Nevada Coalition to End Domestic and Sexual Violence (NCEDSV), to support statewide sexual violence prevention and victim services. Quarterly meetings prioritize efforts to increase statewide infrastructure through partnership development and strategies for streamlining grant deliverables. Efforts to identify state priorities and desired outcomes are essential for changing policy at the community and societal level of the SEM. In addition, the RPE Coordinator participates in yearly grant review committees for administering the Office of Violence Against Women (OVW) STOP and SASP funds.

The PHHS Grant provides funding toward administering the Nevada Youth Risk Behavior Survey (YRBS). The YRBS provides useful biennial data for the RPE Program and subrecipients by identifying trends in behavior and attitudes related to multiple forms of violence. The University of Nevada, Reno (UNR) is responsible for collecting data and sharing overall state results, as well as for geographic regions.

Nevada Home Visiting (NHV) supports positive parenting and promotes healthy child development through regular home visits by trained professionals. The NHV Program provides screening for intimate partner violence and domestic violence as part of the home visit using a screening tool. The NHV Program resides within the MCAH Section, allowing the sharing of information and resources readily available to the RPE Program, and funds an evaluator who provides additional technical support to RPE staff as needed.

The Office of Suicide Prevention, partially funded through the Title V MCH Block Grant, addresses bullying and suicide prevention. Suicide prevention shares similar risk and protective factors with sexual violence. This approach includes communication, outreach, education, treatment, and support programs for youth and young adults in Nevada (school-

aged youth) who either have or are at risk of developing a serious mental illness or substance abuse disorder and could be at a higher risk for suicide. The Washoe County Safe Kids Coalition implemented a teen leadership opportunity through an adolescent task force focusing on peer prevention of teen suicide and the development of anti-bullying campaigns. Efforts to increase protective factors in youth-dominated communities are shown to reduce risk factors for suicide and sexual violence perpetration and victimization, as well.

RPE Sustainability Plan

As defined by the CDC in the 2019 NOFO, sustainability means

> "…ensuring that your program can have a lasting impact, with or without funding."

Sustainability is an essential component of planning because it focuses on sustaining benefits and results beyond any single program or strategy. It goes beyond finances to include building and sustaining partnerships, developing key champions, and embedding or institutionalizing policies and practices within systems. Sustainability planning accepts and expects things (funding, policies, attitudes, economics, etc.) **will change over time** and anticipates actions and strategies now that can build on the change that supports the long-term results or mitigates the effects of change negatively impact sexual violence in Nevada.

In the first year of the cooperative agreement (2019), the RPE Program staff's work on the sustainability plan focused on the approach the RPE Program and partners will use to develop a more detailed plan for sustainability in year 2.

The RPE Program staff will consider sustainability means different things to programs at different stages of development. Items to discuss and consider include whether newer programs need and want to concentrate on sustaining their activities or infrastructure should initial funding ends and whether more experienced programs want or need to enlarge their target population or reach, transfer their best practices to other programs, build new relationships with other agencies, or promote broader policy initiatives.

In the third year of the cooperative agreement, the RPE Program will produce a full sustainability plan reflecting the required elements as provided by the CDC in future guidance documents and webinars.

Sustainability of the SAP will be built out in future meetings with the RPE Program and subrecipients and pending feedback from the CDC during the July meeting in Atlanta.

Appendices

Appendix A: Steps to Program and Strategy Selection Process

The following process and series of questions are intended to be completed by the subrecipients to determine whether the proposed strategies will affect the underlying conditions, reduce risk factors, and increase protective factors. *Spaces and form functions have been removed for use in this appendix.*

The RPE Program subrecipients are looking for strategies that seek to change underlying factors across the levels of the ecological model (individual, relationship, community, society) that either make it more likely (risk factors) or less likely (protective factors) that sexual violence will occur.

Programs should focus on whether a strategy addresses the risk and/or protective factors for sexual violence, and not just on whether it addresses sexual violence directly.

STRATEGY SELECTION STEPS

1. Identify focus areas (Group and RPE Program)
2. Identify needs in the focus area (**Define the problem** using current data)
3. Identify desired outcomes (**Identify risk and protective factors**)
4. Identify indicators (linked to risk and protective factors you are hoping to change)
5. Identify partner/s (engage stakeholders)
6. Chose strategies (method/s for program delivery and at which layer of the SEM)
7. Develop the strategies (**Develop and test prevention strategies**)
   - ❖ Addressing risk and protective factors
   - ❖ Include data tracking tools (which kinds and what will you collect)
   - ❖ With whom will you share the information? **(Assure widespread adoption)**
   - ❖ Based on the best available evidence and data
   - ❖ Public Health Approach

STRATEGY SELECTION QUESTIONS

1. Which of your focus areas would this strategy help you meet?
2. What is the specific population you will target with this strategy?
3. Is there reliable and consistent data (indicators) for the outcome/s you are trying to reach?

If you answered "No," you may need to find a different strategy.

4. Is this strategy designed to address the risk and/or protective factors in this population?

If you checked "No," you may need to seek out different strategies.

5. List the risk factors addressed by this strategy.
6. List the protective factors addressed by this strategy.
7. Will this strategy be implemented at the community or societal level of the SEM? If the answer is "no," can you add a complementary community or societal-level strategy to meet the funder's 50/50 requirement to fund at least 50% of strategies at the community or societal-level of the SEM?

If you answered "No," your strategy, though possibly a good one, may not meet the community
prevention focus for this grant.

8. Have you identified a partner for this strategy who will collaborate resources and formalize an MOU or similar agreement stating agreement to work toward outcomes together?

You will need to have a minimum of (1) formal partnership for each focus area selected but may have several indicators working toward the same outcome.

9. If the strategy you are considering is education-based, is it consistent with the nine principles of effective prevention education?

   Criteria to consider:

   - Is this strategy consistent with the nine principles of effective prevention education?
   - Is it comprehensive?
   - Does it employ varied teaching methods?
   - Is it designed with a sufficient dosage in mind?
   - Is it theory-driven?
   - Does it foster positive relationships?
   - Is it appropriately timed?
   - Is it socio-culturally relevant?
   - Does it include outcome evaluation?
   - Would the training be required for the people who would be implementing this strategy?

Appendix B: Participants

Nevada Bureau of Child, Family and Community Wellness, Nevada Sexual Violence Prevention and Education
Nevada Coalition to End Domestic and Sexual Violence
Nevada Department of Education, Office of Safe and Respectful Learning Environment
Nevada Department of Health and Human Services, Office of Analytics
Nevada Division of Public and Behavioral Health, Maternal, Child and Adolescent Health
Rape Crisis Center
Safe Embrace
Southern Nevada Health District
University of Nevada Las Vegas, Jean Nidetch Women's Center

Appendix C: Work Plan

The RPE program continues to refine and adjust the work plan as new partners, subrecipients, and staff is onboarded. The process measures are refined, and outcome measures adjusted as the evaluation plan and logic model evolve. Following is the RPE work plan for the next program year.

Rape Prevention and Education Work Plan and Timeline

Goal 1: Increase the use of partnerships to implement community-level strategies and improve coordination of state SV-prevention efforts.			
Objective 1.1: Develop an approach to improve partner coordination as specified in the State Action Plan.			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ # and list of internal partners identified ▪ # of MOU's with external partners ▪ # of data use/share agreements ▪ # of collaborations with internal partners	▪ Number, type, and diversity of new/expanded partnerships working at the community and societal levels ▪ Number of State Action Plan implementation and evaluation activities supported by partners ▪ Increased alignment between state-level goals and local prevention strategies	*2/1/2021*	*1/31/2022*
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Prioritize external and internal partners to engage ▪ Expand partnerships through Rape Prevention Education (RPE) subrecipients ▪ Engage and enlist potential partners within DPBH (with focus on CDC funded programs) ▪ Work with partners to increase alignment and implementation of aligned sexual violence primary prevention strategies ▪ Discuss successful partner engagement strategies during TA calls, quarterly meetings, and biannual training sessions	▪ RPE Director ▪ Subrecipients	*2/1/2021*	*1/31/2022*
Objective 1.2: Implement an approach to improve partner coordination as specified in the State Action Plan.			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ # and list of Regional RPE Director training and conferences attended ▪ # of teleconferences attended with regional RPE Directors ▪ # and list of training with CDC technical partners ▪ # and list of new partnerships established from the prioritized list identified in the SAP plan	▪ Strategies and lessons learned with RPE Directors from other states	*2/1/2021*	*1/31/2022*

Goal 1: Increase the use of partnerships to implement community-level strategies and improve coordination of state SV-prevention efforts.			
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Attend the National Sexual Violence Resource Center (NSVRC) training (2 pieces of training, Spring 2020) ▪ Attend NSAC Prevention Track at National SA Conference in Anaheim, CA (September 2020) ▪ Attend RPE Director Regional Trainings ▪ Attend Prevent Connect Webinars ▪ Teleconference with regional RPE Directors ▪ Schedule training with CDC technical partners ▪ Participate in state and regional partner meetings ▪ Provide TA to subrecipients to prioritize prospective partnerships and establish relationships ▪ Implement and work through a prevention task force ▪ Establish a framework outlining partner responsibilities toward achieving shared goals, including evaluating progress	▪ RPE Director ▪ RPE Evaluator	*2/1/2021*	*1/31/2022*
Objective 1.3: NV RPE will provide technical assistance and oversight for RPE sub-award recipients to improve the quality of program delivery through understanding the public health approach to sexual violence prevention.			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ # of biannual meetings conducted with subrecipients ▪ # of subrecipients receiving STOP SV Technical Package ▪ # of TA and training on continuous quality improvement (CQI) for program improvements	▪ Improved training and oversight for RPE subrecipients ▪ Increased subrecipients implementing effective community-level strategies ▪ Increased program improvement cycles	*2/1/2021*	*1/31/2022*
Strategies	**Who is responsible**	***Start Date***	***End Date***
☐ Conduct biannual meetings for subrecipients o Sharing of implementation strategies between subrecipients o Provide training on violence as a public health issue o Provide technical assistance for implementing data-driven strategies o Share information on STOP SV Technical Package with new partners/subrecipients ☐ Refine CQI plan and provide implementation training to subrecipients on CQI processes	▪ RPE Director ▪ Evaluators ▪ Subrecipients	*2/1/2021*	*1/31/2022*

Goal 2: Increase the use of data-driven decision making for program delivery			
Objective 2.1: Increase the use of data for the selection of focus populations and prevention approaches.			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
☐ Data contracted evaluators hired/oriented ☐ Nevada Needs and Strengths Assessment used to focus work on priority populations ☐ State Action Plan (SAP) used as a framework for achieving results and orienting partners ☐ State-level RPE Evaluation Plan used to capture data, identify data gaps, and discuss and share results ☐ Prioritize recommendation(s) and implement one improvement for data tracking and use (structures, function and data capacity) prioritized and implementation started	▪ State and subrecipient indicators aligned, and data used to track short-term outcomes ▪ Realignment of efforts, coordination, and collaboration as detailed in the SAP ▪ Increased capacity from partnerships to access and use data to identify target populations ▪ Increased number of partners reporting activities and data to RPE	*Continuation*	*Continuation*
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Hire contracted evaluators for RPE 2020 deliverables ▪ Implement the SAP with evaluators and subrecipients ▪ Review and refine strategies based on RPE focus areas ▪ Review and update the Logic Model annually ▪ Develop process supporting data collection, analysis, and reporting ▪ Train subrecipients on data-driving decision making	▪ RPE Director ▪ Evaluators ▪ Subrecipients	*2/1/2021*	*1/31/2022*
Objective 2.2: Demonstrate the selection of sub-recipients based on data-driven decision making.			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ RFP grant application developed ▪ # and types of stakeholders/partners participating in RFP process ▪ # and list of 2021 subrecipients selected ▪ # and list of 2021 focus areas identified	▪ Data used to select and prioritize the target population in the RFP ▪ Data used to select and prioritize prevention strategies and outcomes in the RFP ▪ Expanded list of stakeholders and partners involved in the RFP process	*2/1/2021*	*1/31/2022*

Goal 2: Increase the use of data-driven decision making for program delivery			
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Develop an RFP for the 2021 grant application ▪ Engage stakeholders (partners, subrecipients) in the discernment of priority populations ▪ Select 2021 subrecipients using population-based data and focus area criteria ▪ Select 2021subrecipients based on the ability to implement community-level strategies	▪ RPE Director	*2/1/2021*	*1/31/2022*

Goal 3: Increase the use of indicator data to track program implementation and outcomes.			
Objective 3.1: Identify state-level indicators and data sources to include in the state evaluation plan			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ # and list of state indicator selected ▪ # and list of data sources identified for evaluation purposes	▪ Tracking and use of state-wide indicators (not limited to SV) ▪ State and partners prioritize primary prevention at the outer layers of the Social- Ecological Model (SEM) ▪ Increased primary prevention approaches implemented at community and societal levels	*2/1/2021*	*1/31/2022*
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Identify state indicators based on indicator selection readiness assessment tool ▪ Identify data sources based on indicator selection readiness assessment tool ▪ Monitor and update the State RPE Evaluation Plan annually	▪ RPE Director ▪ Evaluators	*2/1/2021*	*1/31/2022*
Objective 3.2: Track and report on indicators annually			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ Track and monitor indicators ▪ Agendas and meeting notes from training sessions for subrecipients and RPE program staff	• Annual indicator report submitted to the CDC • Subrecipients reporting data consistently on a quarterly basis	*2/1/2021*	*1/31/2022*

Goal 3: Increase the use of indicator data to track program implementation and outcomes.

Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Assist state-contracted evaluators in developing a plan to track and report on indicators ▪ Develop and finalize a reporting tool ▪ Provide training on the tool(s) to subrecipients ▪ Compile and report on indicators and result quarterly ▪ Assist evaluator in communicating and obtaining insights from subrecipients on indicators	• RPE Director • Evaluator	*2/1/2021*	*1/31/2022*

Goal 4: Create environmental and community changes that result from selected community-level strategies.			
Objective 4.1: Develop plans for implementation of environmental and community-level prevention strategies			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ Strategies identified including 1 protective factor and 1 community or environmental factor ▪ Identify plans to track indicators regularly. ▪ Include plans to track indicators in SAP and state evaluation plan	• Priority focus areas identified	*2/1/2021*	*1/31/2022*
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Analyze Needs and Strengths Assessment and technical assistance findings from RPE sub-recipient outcomes ▪ Develop at least 1 community or environmental strategy from CDC focus areas ▪ Identify at least 1 strategy to increase protective factors for reducing sexual violence	• RPE Director	*2/1/2021*	*1/31/2022*

Goal 5: Demonstrate changes in selected risk and protective factors.			
Objective 5.1: Increase the tracking of selected risk and protective factors.			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ # and list of tracked and measurable outcomes ▪ Measurable outcome baseline rates and progress	• Increases in protective/decrease risk factors related to sexual violence • Engage influential persons to change social norms • Strength economic supports for girls and women	*2/1/2021*	*1/31/2022*
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Analyze and adjust baselines created through the development of the 2018 Needs and Strengths Assessment for: o Sexual violence risk and protective factors within each county/region o Communities strengths and service gaps	• RPE Director	*2/1/2021*	*1/31/2022*
Objective 5.2: Implement a state-level evaluation plan with process and outcome measures.			
Process Measures	**Outcome Measures**	***Start Date***	***End Date***
▪ # of quarterly evaluation meetings with subrecipients ▪ # of subrecipients implementing CQI	• Progress on goals and objectives measured • Ensure activities align with state-level goals and outcomes as stated in the SAP • TA and evaluation processes evaluated and enhanced	*2/1/2021*	*1/31/2022*
Strategies	**Who is responsible**	***Start Date***	***End Date***
▪ Conduct CQI process to assess perceptions of quality for TA and evaluation support ▪ Meet quarterly with subrecipients to evaluate program implementation at the community-level	• RPE Director • Evaluator	*2/1/2021*	*1/31/2022*