Exploring the Intersections of Domestic Violence and Sexual Violence

A Discussion Paper Informed by the February 2016 Knowledge Exchange

Western Education

LEARNING NETWORK

Centre for Research & Education on Violence Against Women & Children

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INTRODUCTION

Intimate partner sexual violence (IPSV)[1] refers to all forms of sexual violence which occur in the context of an intimate relationship, between current or former partners. Like other forms of violence, IPSV can involve a wide range of abusive behaviours, including coercion and control tactics as well as physical violence. Existing research indicates that a significant number of women experience IPSV.

In 2011, 17% of police-reported sexual assaults against women in Canada were committed by an intimate partner.[2]

It is estimated that 25-55% of women in the US experiencing physical IPV also experience sexual violence by the same partner[3].

Research also demonstrates that compared to survivors of non-partner sexual violence, survivors of IPSV experience longer-lasting trauma, higher levels of physical injury, higher incidences of multiple sexual assaults, financial dependency on the perpetrator, safety issues, and difficulty defining the act(s) as sexual assault[4]. Women who experience both sexual and physical violence by an intimate partner are also more likely to be deliberately exposed to sexually transmitted infection, more likely to be forced into pregnancy, and more likely to be killed[5].

Despite the prevalence and consequences of IPSV, the importance of identifying and naming this experience of violence is often under-recognized. IPSV is often included under domestic violence (DV) or equated with sexual violence (SV) only.

*In reality, IPSV is **both** sexual violence **and** domestic violence, not either/or.*

Though IPSV is receiving greater attention than in the past, it remains largely a hidden problem for many reasons including: the reluctance of society to acknowledge the issue of sexual violence perpetrated by the intimate partner of the survivor, the prevalence of myths and misconceptions, limited existing research, the absence of a dual focus in some areas of practice, and the

[1] Challenges to the use of intimate partner sexual violence to denote this form of violence were raised and discussed by Knowledge Exchange participants (see section on Language).

[2] Sinha, M. (2013). *Measuring violence against women: Statistical trends 2011*. Ottawa: Statistics Canada.

[3] Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: A review of terms, definitions, and prevalence. *Trauma, Violence and Abuse*, *16*(3), 316–335.

[4] Logan, T.K., Walker, R., & Cole, J. (2015). Silenced suffering: the need for a better understanding of partner sexual violence. *Trauma, Violence & Abuse*, *16*(2), 111-135.

[5] McOrmond-Plummer, L. (2009). *Intimate partner sexual violence: Sexual assault in the context of domestic violence*. Olympia, WA: Washington Coalition of Sexual Assault Programs.

history of DV and SV service development as separate sectors[6]

Furthermore, survivors of IPSV are frequently meet with disbelief, denial, minimization, and stigmatization, at least in part due to the many misconceptions surrounding IPSV[7].

The Continuum of IPSV is represented below[8]:

IPSV Power & Control Wheel

[6] McOrmond-Plummer, L. (2014). Preventing secondary wounding by misconception." In L. McOrmond-Plummer, P. Easteal, & J.Y. Levy-Peck (Eds.), *Intimate partner sexual violence: A multidisciplinary guide to improving services and support for survivors of rape and abuse* (pp.30-40). London: Jessica Kingsley Publishers.

[7] Ibid, 4

[8] McLeod, D. (2014). Real not rare: Cross-training for sexual assault and domestic violence workers to understand, recognize, and respond to intimate partner sexual violence. In L. McOrmond-Plummer, P. Easteal, & J.Y. Levy-Peck, *Intimate partner sexual violence: A multidisciplinary guide to improving services and support for survivors of rape and abuse* (Chapter 8). London: Jessica Kingsley Publishers.

Recognizing these challenges, the Learning Network, the Ontario Association of Interval and Transition Houses (OAITH), and the Ontario Coalition of Rape Crisis Centres (OCRCC) brought together members of the sexual violence (SV) and domestic violence (DV) sectors, survivors, system partners, and researchers to share experiences, exchange ideas, and build knowledge on the intersection of domestic and sexual violence.

The format of the event was a knowledge exchange, which involves dynamic information sharing between participating violence against women (VAW) stakeholders involved in research and/or practice. The purpose of a knowledge exchange is to create mutual learning through interaction between researchers and those involved in SV/DV practice. Specifically, ideas are exchanged between both groups so that each may be informed and enhanced by the work of the other. A knowledge exchange format was chosen over a conference, workshop, seminar, or similar approach in order to encourage engagement among the different kinds of knowledge and perspectives researchers and frontline advocates bring to a collective understanding of the issues. In this format, all participants are valued as experts who bring specific knowledge and experience to the conversation. The day was designed so that research presentations provided the context for ensuing discussion which gave space to community advocates to bring their perspectives and reflect on the implications of what researchers are finding and the work that they are doing.

The Knowledge Exchange was held on February 24, 2016 in Toronto, Ontario and attended by 56 participants. The goal of this event was to discuss issues related to IPSV; to learn from survivor voices; to engage with and inform current research; to develop considerations for training and education, the violence against women sector, and future research on IPSV; and to create an opportunity for collaboration between the SV and DV sectors.

The following day (February 25, 2016), OAITH and OCRCC brought a portion of the participants together to participate in discussions between the SV and DV sectors. The facilitated discussions aimed to further understanding of similarities and differences between their respective philosophies, service provision, advocacy, and system collaborations. In addition, the sectors discussed potential next steps and approaches for enhanced collaboration (learn more).

Organizations Participating in the Knowledge Exchange

The majority of participants were invited to the Knowledge Exchange based on their membership in the OAITH or OCRCC organizations. Some were selected by their membership organizations because of their work in the areas of both sexual violence and domestic violence. In addition, the Learning Network invited all members of their Provincial Resource Group (advisory group). OAITH and OCRCC gave the remaining spots to their system partners and ally organizations.

- Aboriginal Shelters of Ontario
- Aids Legal Network
- Centre for Research & Education on Violence Against Women & Children
- Chatham-Kent Sexual Assault Crisis Centre
- Durham Rape Crisis Centre
- EGALE Canada Human Rights Trust
- Elder Abuse Ontario
- Family Transition Place (Peel)
- HER Place Timmins
- Interim Place
- Kawartha Sexual Assault Centre
- Women's Legal Education & Action Fund
- Leeds & Grenville Interval House
- Luke's Place
- Metropolitan Action on Violence Against Women
- Ontario Native Education Counselling Association
- Ontario Council of Agencies Serving Immigrants
- Ontario Women's Directorate
- Ottawa Rape Crisis Centre
- Peterborough AIDS Resource Network
- Sandgate Women's Shelter of York Region
- Sexual Assault Centre of Brant
- Sexual Assault Centre Essex County
- Sexual Assault Centre Kingston
- Sexual Assault Centre Hamilton & Area
- Sexual Assault Centre London
- Sexual Assault Centre Quinte & District
- VOICES for Women
- White Ribbon
- WomenatthecentrE
- Women's College Hospital
- Women's Habitat
- Women's Multicultural Resource & Counselling Centre of Durham
- Women's Sexual Assault Centre of Renfrew County
- Women's Support Network of York Region

Following an opening traditional ceremony by Laureen (Blu) Waters, presentations were provided by Janelle Anderson, Irene, Dr. Janice Du Mont (Women's College Hospital), Dr. Wendy Norman (University of British Colombia), and Dr. Nadine Wathen (Western University).

This discussion paper, informed by the February 24 2016 Knowledge Exchange, includes key themes which emerged from the research presentations and discussions by participants (including submitted discussion sheets), as well as results and comments from the event's evaluation survey (see Appendix B).

A list of resources provided to participants is included (see Appendix A).

Three individuals (two students, one Learning Network team member) recorded participant discussions and additional information provided by the presenters. Transcripts were uploaded and coded in NVivo software to identify common themes and their respective frequencies.

It is important to note that one theme of the day was language, and in particular, finding appropriate terms to reflect survivor experiences as well as underlying causes of gender-based violence. This discussion paper uses the term intimate partner sexual violence, consistent with recent literature, but recognizes that this term is viewed as limiting or problematic by some (see section 6 on Language).

Presentation Summaries

Traditional Ceremony
Laureen (Blu) Waters

Blu lead a smudging ceremony to begin the day with good intentions, to balance energies, and to prepare all in the room for listening and learning. Blu spoke of teachings of kindness and nurturing, followed by words on the roots of violence, including historical and current oppressions, and a challenge to avoid judgement and to practice compassion and understanding.

Survivor Voices
Janelle Anderson and Irene

In this presentation, survivors spoke of their experiences of violence, which demonstrated the complexity of sexual violence in the context of an intimate relationship. Survivors spoke of feelings of confusion, of how they considered their situations being "much more grey" than traditional narratives of abuse. Both Irene and Janelle's stories highlighted how the relationship between the offender and the survivor can create additional difficulties for survivors. For example, dates or partners are more likely to use tricks, verbal pressure, threats, negative consequences, consequences to the relationship or victim-blaming rhetoric (i.e. "You know you wanted this"; "If you tell about what happened here, you will be in trouble") during episodes of sexual coercion. This inevitably impacts survivors' capacities to resist or report what happened – or even name incidences as violent. In turn, this can influence survivors' abilities to self-identify as abuse survivors, and to seek out and access SV or DV support services. Finally, Irene and Janelle's powerful stories revealed the personal consequences of IPSV as well as areas for services to be enhanced.

Sexual Assault by Intimate Partners: Are there Unique Characteristics, Sequelae, and Patterns of Service Utilization?
Janice Du Mont

This presentation reviewed common misconceptions around IPSV, followed by results from a current study that aimed to identify potential differences in acute care service-use between women sexually assaulted by a current/former partner and other sexual assault survivors. Consistent with previous research, it was found that survivors of IPSV tend to be older and to delay presenting for care. These women also tend to experience more severe forms of violence than other survivors of sexual assault, such as completed vaginal and/or anal rape. The presentation included implications for policy and practice, such as supporting survivors in a collaborative manner and educating the public on myths and misconceptions about sexual violence in the context of an intimate relationship.

Reproductive Coercion: What is it, and How Can We Help?
Wendy Norman

This presentation reviewed the health impacts of unwanted pregnancies, the characteristics of male partner reproductive coercion, and contraceptive options for women. Reproductive coercion includes pregnancy coercion, birth control

sabotage, and control of pregnancy options. Recommendations included empowering women through access to information on contraceptive options, asking women about their reproductive goals, and screening for unmet contraceptive needs in safety planning.

More than Just a Bed: A Mixed Methods Study of the Role of Shelters in the Lives of Abused Women

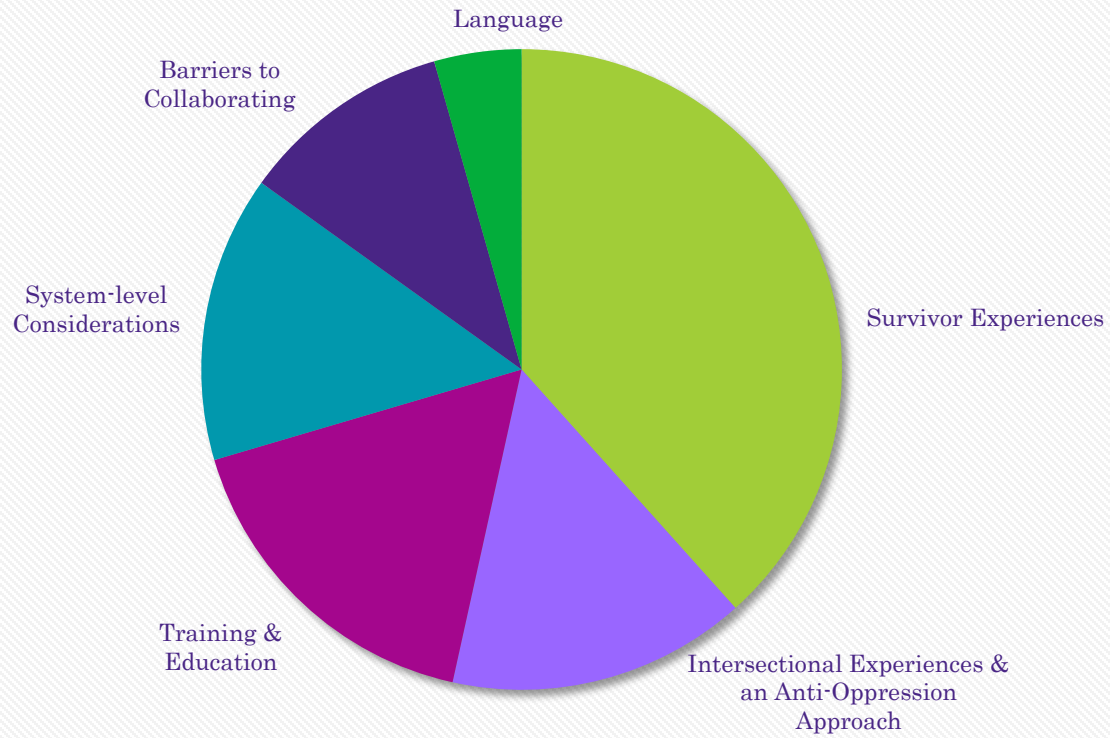
Nadine Wathen

This presentation explored the role of shelters as "system navigation hubs", reviewing research on what shelters provide to survivors. Shelters provide a wide range of services and supports for women (e.g. counselling, safety, risk assessment, shelter, advocacy and child/youth programming) in addition to information and system navigation support. A model of the central role of shelters was presented, which could be adapted to sexual violence work.

KNOWLEDGE EXCHANGE THEMES

Analysis of the Knowledge Exchange discussion revealed six major themes: survivor experiences, intersectional experiences and an anti-oppression approach, training and education, system-level considerations, barriers to collaborating, and ways in which terminology and language shape understandings of violence against women. The relative weight given to each theme throughout the event is depicted in Figure 1, and was determined by number of references.

Figure 1. Exploring the Intersections of Domestic Violence and Sexual Violence: Themes



1. Survivor Experiences

The experiences of survivors were a continuous theme throughout the Knowledge Exchange, with particular implications for identifying service gaps and improving outcomes for those affected by intimate partner sexual violence (IPSV). Survivor voices and reflection on survivor experiences also revealed the confusion or uncertainty that can exist regarding IPSV. It can be difficult for survivors to articulate what has happened to them, to define what they are experiencing in their intimate relationship as sexual violence, and to make sense their experiences of abuse. In fact, discussions revealed disconnect between existing discourse on sexual and domestic violence, and survivors' realities. The "buzzwords" and "warning signs" typically used in outreach, education and training on SV and DV do not always accurately reflect survivor lived experiences, especially if what they are experiencing is IPSV. Both survivors questioned whether their story "fit" with existing conceptualizations of violence. Survivors also recommended changes to the way violence is discussed in these and other contexts, for example, by identifying the nuanced ways in which violence can manifest in a relationship—including sexually–and by identifying subtle, non-physical and relational methods of coercion.

"The survivors' messages were profound."
Knowledge Exchange Participant

Participants from each sector, as well as the researchers present, also emphasized the provision of ongoing care and support to survivors, as necessary components of promoting survivor health and well-being. Survivors of IPSV face a number of potential adverse outcomes, such as emotional trauma, serious physical injury, not receiving prophylactic treatment for sexually transmitted infections, and unwanted pregnancy. Recognizing the relationship between the survivor and perpetrator of violence was suggested as key to providing appropriate care, in addition to encouraging early access to supports to improve outcomes. Survivors also noted the complex emotional impacts of being sexually violated – often repeatedly and routinely – by a loved one with whom the survivor may also have a long-term and otherwise trusting or collaborative relationship. Given some of the unique issues faced by survivors of IPSV, participants from the SV and DV sectors acknowledged the necessity of working in a collaborative manner to better support survivors.

100% of Knowledge Exchange participants felt survivor voices should be included in training on IPSV.

Research presentations and the discussions that followed each revealed issues surrounding access to services that reflect the complexity of IPSV and the history of service sectors as separate. Specific concerns included access to reproductive health services (e.g. abortion, contraception) as well as sexual violence/domestic violence services in general. These concerns were especially relevant for survivors living in northern or rural communities. For example, women in northern communities have limited access to prophylactic care. That

being said, participants also specified the importance of services being community–based, as moving services out of the community to hospitals, for example, can create additional accessibility barriers. Those present noted that community–based agencies offer comprehensive short and long-term supports, such as advocacy, trauma counselling, and frontline support in navigating health, criminal justice, and other systems. Community–based services for survivors are rooted in a comprehensive and socially contextualized analysis of violence against women. There is a clear sense among many community-based anti-violence workers that many survivors do not access medical services. Some access community-based supports only, as community counselling models differ in essential ways from medical and mental health frameworks for understanding sexual and domestic violence. For example, sexual assault centre and shelter counselling competencies may include such things as:

- a holistic, anti-oppression approach that goes beyond symptoms or diagnoses
- the ability to therapeutically frame sexual violence as a social problem, as opposed to a mental health malfunction that requires curing[9]
- an ongoing recognition of the skills and knowledge survivors bring to healing work[10]
- a recognition of widespread societal and sexual assault myths and misconceptions, which function to minimize sexual assault and its impact on women victim–survivors[11]
- a recognition that gender, race, age and other social determinants influence the targets of sexual violence[12]

As indicated in the research presentations, survivors of IPSV may be less likely to seek crisis intervention services, raising the issue of how to improve access to services for women. Participants outlined the difficulties in doing so given the prevalence of myths and misconceptions that exist around IPSV. Indeed, stigma – especially when sexual violence is involved – may inhibit survivors from accessing sexual violence services, and they may turn solely to domestic violence shelters. Discussion also pointed out that sexual assault centres tend to be viewed as "day services", whereas survivors of IPSV may require residential services more traditionally provided by DV shelters. Accordingly, increasing awareness of services available to survivors, and how these services can serve as "points of entry" to other needed services was deemed to be essential (e.g. that seeking help at a Sexual Assault/Domestic Violence Treatment Centre would enable a survivor to be linked to other relevant services). Given that one identified challenge for survivors in seeking help was not wanting to repeatedly access new services, it may be important to raise awareness of and promote the role of

[9] Bonisteel, M. & Linda Green. "Implications of the Shrinki at ng Space for Feminist Anti-violence Advocacy." Presented the 2005 Canadian Social Welfare Policy Conference. *Forging Social Futures, Fredericton*, New Brunswick, Canada, 40.

[10] Ibid, 25.

[11] The Learning Network. *Overcoming Barriers and Enhancing Supportive Responses: The Research on Sexual Violence Against Women – A Resource Document.* May 2012: 14.

[12] METRAC Sexual Assault Fact Sheet. Online: www.metrac.org/programs/info/prevent/ass_fact.htm

SV/DV services as "system navigation hubs" or "advocacy hubs".

2. Intersectional Experiences and an Anti-Oppression Approach

Related to the ways in which support to survivors of IPSV can be enhanced, was the recognition of how different survivors experience sexual and domestic violence differently, including systems, services and strategies for support meant to help survivors. Specifically, participants shared how survivors from intersecting racial, class, gender, age, and many other social identities have unique experiences of systems and services. This is particularly relevant when IPSV is involved, as numerous systems (e.g. health, criminal justice, crisis, counselling) and services (e.g. sexual assault centres, shelters, health promotion, outreach, prevention and education) exist to prevent violence and meet the needs of survivors. Foremost, participants spoke of how "the everyday experiences of women of colour, poor women… can exacerbate experiences of violence", as "triggers are everywhere." This theme emerged especially in discussions on reproductive coercion, as some reproductive options have historical connections to structural violence targeting racialized women in developed and developing countries over numerous decades. For example, participants spoke of how the birth control Depo-Provera has historically been used as a method of state reproductive control in black communities. Participants spoke of how birth control options must be "packaged as providing women with true choice, with no ulterior (genocidal) agenda."

Participants also drew attention to the contextual significance and value of reproduction in different cultural groups. For example, there may be different pressures on some populations of women beyond those of their partner alone (e.g. family members in immigrant or Indigenous communities). Participants noted that in some communities having children is connected to colonial resistance in addition to individual or family expectations. In this way, reproductive options and coercion must be understood from an intersectional and nuanced perspective. In addition, it is integral that frontline community and health workers have an understanding of how historical oppression and contexts informing women's reproductive lives "impact survivors now". For example, the experiences of reproductive coercion and injustice for Indigenous women, black women, and other women of colour are different than that of white women. In addition, further nuances and histories of oppression exist within different racialized communities.

> For marginalized women, *"triggers are everywhere."*
> Knowledge Exchange Participant

It is important to note that while not explicitly discussed, similar considerations shared by participants apply to many additional communities of women, such as poor women, trans* women, women with disAbilities, queer women, women living with HIV, South Asian women, and South American women. Certainly, survivors can vary along a number of socially–located dimensions, each of which come with

implications for experiences of violence and access to services and supports. Participants highlighted issues specific to women in rural communities, including poor cellular phone coverage, isolation, and transportation. They also emphasized that young women may face unique challenges in finding services tailored to their life stage, as well as stigma connected to sexual activity and/or sexual violence.

Overall, discussions revealed the importance of bringing intersectionality to the forefront of research on IPSV, particularly in the area of reproductive coercion, and of intentionally incorporating an intersectional, anti-racist, anti-oppression approach in work with survivors. Intersectionality is a pivotal framework in the gender-based violence sector, as it draws attention to how different forms of oppression (e.g. homophobia, racism, sexism, ableism, transphobia) interact. Different sets of identities (e.g. sexual orientation, race/ethnicity, gender, age) impact experiences of violence, prevalence or risk in being targeted for sexual or domestic violence, and one's experiences with systems and services. As echoed by participants throughout the day, survivors speak with many voices: it is critical to recognize which groups are and *are not* reflected in existing research, practice, learning forums (e.g. knowledge exchanges, conferences), and to intentionally question the reasons why. Participants agreed that social location has concrete impacts on one's experience of sexual and domestic violence. Moreover, community-based programs meant to support survivors are often less accessible to women from diverse age, racial and socio–economic populations.

Participants recognized that the literature on IPSV is in its early stages, and can be enhanced through an intersectional perspective. Research has begun to reveal the impacts of IPSV for survivors, the misconceptions and challenges surrounding IPSV, and strategies for practice; however, it is less developed in capturing the voices and experiences of diverse survivors. It is necessary to further understand how experiences of IPSV may vary for different groups of women and what that may mean for enhancing available supports and/or developing IPSV-specific responses. In addition, existing studies on the intersectional experiences of different sexual violence survivors and domestic survivors can be used to inform intersectional research on survivors of IPSV.

3. Training & Education

Reflection on diverse survivor experiences facilitated conversation around the development of training and education. Reproductive coercion as a form of sexual violence was identified as a critical component for future training and education activities, particularly from an intersectional perspective. Participants indicated that training on discussing reproductive coercion with women should integrate cultural sensitivity and better reflect the divergent reproductive justice histories and concerns of different groups of women, including but not limited to young women, women with disAbilities, immigrant women, Indigenous women,

black women and other groups of racialized women.

"[We must] package birth control as providing women with true choice, with no ulterior (genocidal) agenda."
Knowledge Exchange Participant

Learning about discrete birth control methods and emergency contraception methods was identified as essential for workers to be able to provide accurate and comprehensive information to women accessing services.

92% of participants felt incorporating reproductive coercion would enhance safety planning and risk assessment training.

Participants also wished for training to include guidelines for how to address reproductive coercion in risk and safety planning.

Training and education with professionals and the public ought to safeguard against euphemistic language that misidentifies and misconstrues sexual assault as benign, minor or a less severe form of violence. For example, participants expressed concern over and objection to the use of the medical community's term "forced sex". They stressed that there is sexual assault and consensual sex. In other words, sex does not fall on a continuum where force is one option.

Increasing public awareness on negotiating condom use and barriers to condom use (including intimate partner violence) and other methods of contraception within relationships were identified as important in education initiatives. Participants also noted the following key topics for education campaigns and resource development:

- Consent in the context of intimate relationships
- Continuum of abuse: what the various forms of IPSV look like
- Healthy sexuality and sexual rights
- Healthy relationships education: focusing on characteristics of a healthy relationship rather than just indicators of abuse
- Integrating knowledge on IPSV in one place/making it accessible (e.g. a comprehensive resource document)
- Sexual consent
- Methods of coercion

84 % of participants agreed that the information at the Knowledge Exchange event would help inform the development of future training programs.

A final consideration given by participants for training initiatives included the promotion of a sex positive culture in shelters. Participants spoke of the need to support women to talk about sex and to overcome the unspoken assumption that "when you get into a shelter, you essentially become a virgin." Participants noted that this is simply not accurate, and that there is a need to enhance the comfort of shelter workers in engaging women in discussions about sexual/reproductive health.

Participants felt it was important to remind women that "good sex is possible", and this learning is especially valuable in the case of IPSV.

4. System-Level Considerations

Suggestions for training and education further invoked conversation about next steps to be taken at a system level. Suggestions from the discussion component of the Knowledge Exchange were as follows:

- Ensuring community service providers initiate prompt and appropriate referrals for survivors of IPSV, regardless of the service door a woman accesses first.
- Integrating an intersectionality approach to all gender-based violence work, including frontline support to survivors.
- Developing services reflective of the unique challenges faced by women in northern and/or rural communities.
- Including reproductive safety planning in intake processes or safety planning practices overall, ensuring that questions are non-triggering, thoughtful, and reflective of an intersectional understanding of reproductive rights.
- Creating a public health intervention to promote asking reproductive-aged women the key question of "whether they want to become pregnant in the next year".
- Ensuring service models address women's needs individually and validate their experiences.
- Creating a relevant standardized data collection system.
- Improving system navigation for women experiencing sexual harassment in the workplace.

96% of participants agreed that survivors IPSV would benefit from enhanced system navigation.

Of participants who indicated on their evaluation surveys what next steps SV, DV, and ally sectors should take to enhance support for survivors, the majority felt collaboration between the sectors was paramount (see Figure 2). Specific suggestions here included: joint trainings for frontline staff, joint protocol development and enhancement, meetings between the sectors to highlight examples of best practices for collaboration, and "developing stronger partnerships with one another."

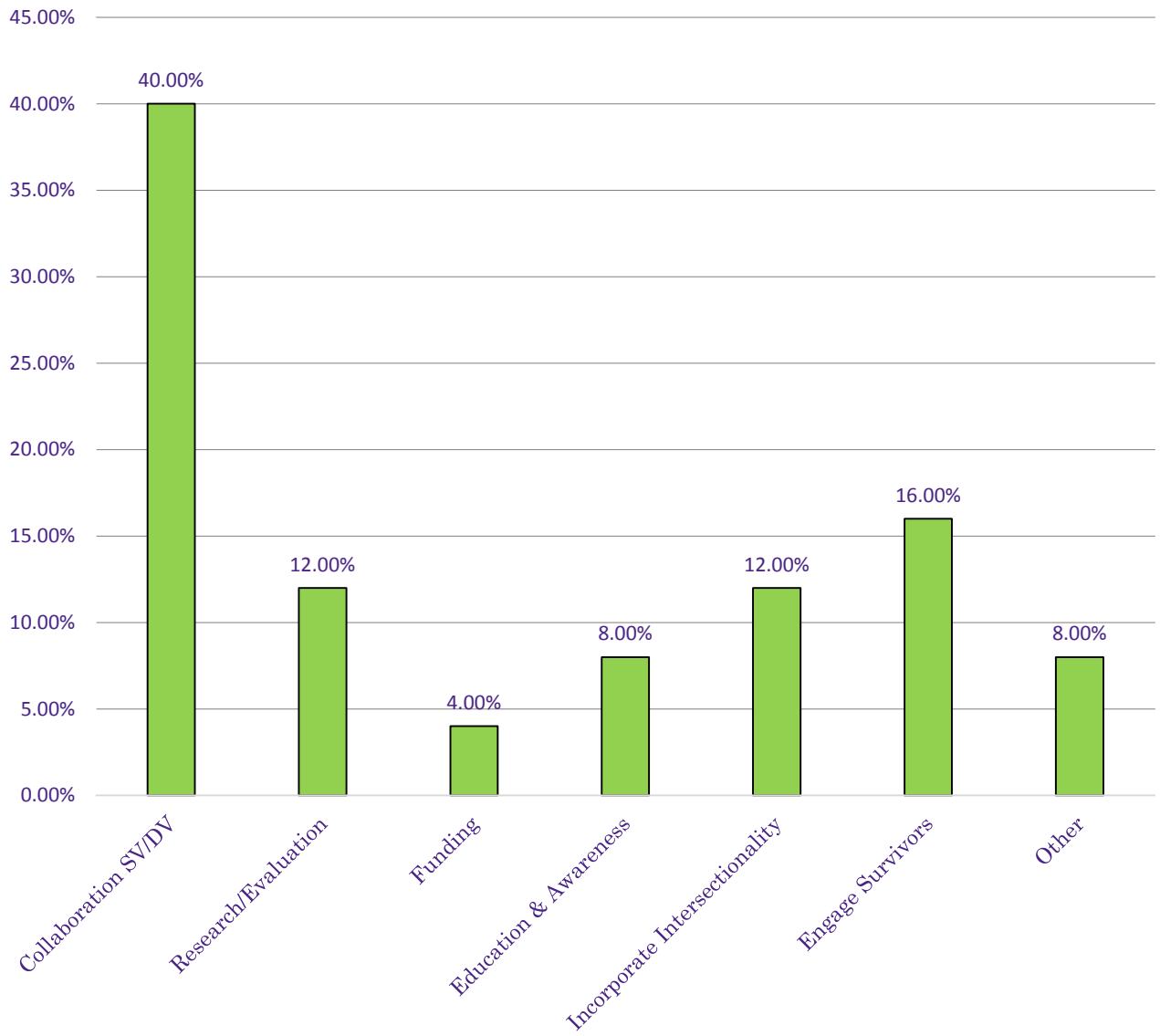
As one participant pointed out:

*"We are **all** here for women, **not** the other way around."*

Finally, participants expressed a desire for evaluating their own sexual violence and domestic violence services in a manner that reflects the strengths, competencies, and supports offered through the work of each sector. Participants noted that previous evaluation systems have impeded workers from doing their jobs, have failed to collect relevant data, or have collected data that was less useful to the sector. Accordingly, evaluations must reflect the context of the organizations doing the work, including what they bring to the lives of survivors from multiple perspectives (e.g. survivors, staff members, ally organizations). Participants also expressed interest in an evaluation of sexual violence services, similar to the Ontario Shelter Research Project.

The importance of doing "good" evaluations was stressed, along with improving questions on survey tools to reflect the concerns outlined above.

Figure 2. Next Steps for IPSV Work Identified by Participants



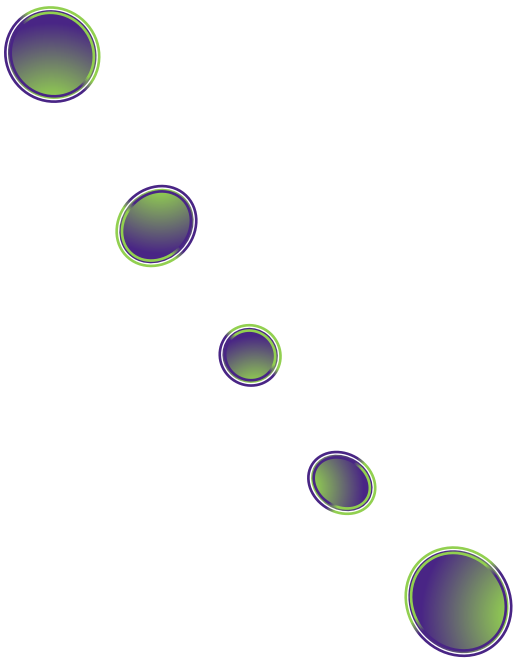
5. Barriers to Collaborating

While participants recognized enhanced connections between sexual violence and domestic violence sectors as necessary in improving outcomes for IPSV survivors, they also revealed the following challenges to collaboration between SV and DV sectors and with their allied partners:

- *Availability and access:* provision of services depends on location; amount of services provided dependent on size of community; transportation difficulties in remote areas.
- *Framing of systems:* DV shelters are often framed as "family-centred", but IPSV can also impact young women/women without children.
- *Limitations of collaborative work with other services*:
    - SV/DV sectors work with systems that can have conflicting mandates, philosophies, or approaches. For example:
        - Women do not return to shelters/other services because of concerns CAS will apprehend their children.
        - Survivor might face hostile cross-examination in court based on disclosed records (e.g. medical, counselling).
- *Complexity:* many different factors play into the complexity of advocacy, linkage and navigation, and many complex issues are involved in SV and DV work. For example:
    - SV/DV services operate in many *different contexts* (e.g. documentation practices can differ by individual service/shelter)
- *High level of expertise* required of shelter workers and SV advocates can be demanding (e.g. knowledge required on a range of complex legislation, various roles).
- *Competition for funding/resources* between sectors (e.g. limited donor dollars).
- Historical development and framing of DV/SV *services as separate.*

6. Language

An issue that emerged in discussions of barriers to collaborating and considerations for future work was that of finding a language with which to talk about IPSV that recognizes survivors' diverse experiences, that does not overlook the root causes of violence, and that does not produce or reproduce messages that minimize acts of violence.



Participants spoke of the power of words and the need to think carefully about IPSV discourse. For example, when some professions use the term "forced sex", the nature and consequences of sexual violence are obscured. It is also important to recognize that when speaking about "choice" and women's reproductive options, some groups of women may have past experiences and/or current realities where "choice has not been predicated by options." That is, constrained or lack of choice is a reality for many women. Finally, while inclusive of IPSV within same-sex relationships, there was some concern that the term "partner" minimizes the reality about men's violence against women. The same concern could also apply to the use of "domestic violence" or "gender–based violence".

Additional issues highlighted included, using survivors' language (e.g. "call him what she calls him"), and continuing to generate more conversation between the sectors to decide upon a shared language. This is certainly a concern shared by the research community, as existing work lacks consistency in terminology[13]. This can create additional barriers in practice as well as for survivors, as inconsistent terminology can add to the confusion and complexity surrounding IPSV.

Participants spoke of the power of words and the need to think carefully about IPSV discourse.

[13] Ibid 3

IPSV Future Considerations

Education & Awareness

- ✓ Develop education and awareness campaigns on consent in intimate relationships
- ✓ Develop programs focusing on healthy sexuality and sexual rights as well as healthy relationships overall
- ✓ Increase education campaigns and resources on the nuances of violence (e.g. subtle, non-physical methods of coercion; various forms of IPSV) in a variety of contexts (e.g. school courses, training programs)
- ✓ Address the importance of language in education initiatives for professionals and the public
- ✓ Develop education and awareness campaigns on negotiating condom use and barriers to condom use, with a particular emphasis on intimate relationships
- ✓ Promote existing sexual violence and domestic violence services as relevant to IPSV survivors and as "hubs" which can link survivors to other services

Training

- ✓ Develop curriculum on reproductive coercion that reflects the reproductive experiences and concerns of all women (e.g. black women, Indigenous women), with an emphasis on historical oppressions and cultural contexts
- ✓ Develop joint trainings for frontline staff of sexual violence and domestic violence sectors where appropriate
- ✓ Incorporating an intersectional perspective, build reproductive coercion into curriculum on risk and safety planning, with information on discrete birth control methods and emergency contraception methods
- ✓ Develop a public health intervention that promotes asking reproductive-aged women "whether they want to become pregnant in the next year"
- ✓ Ensure education programs recognize the additional complexities which may emerge in cases of IPSV as a result of the relationship between the survivor and perpetrator
- ✓ Enhance education of community service providers to ensure the initiation of prompt and appropriate referrals for survivors of IPSV

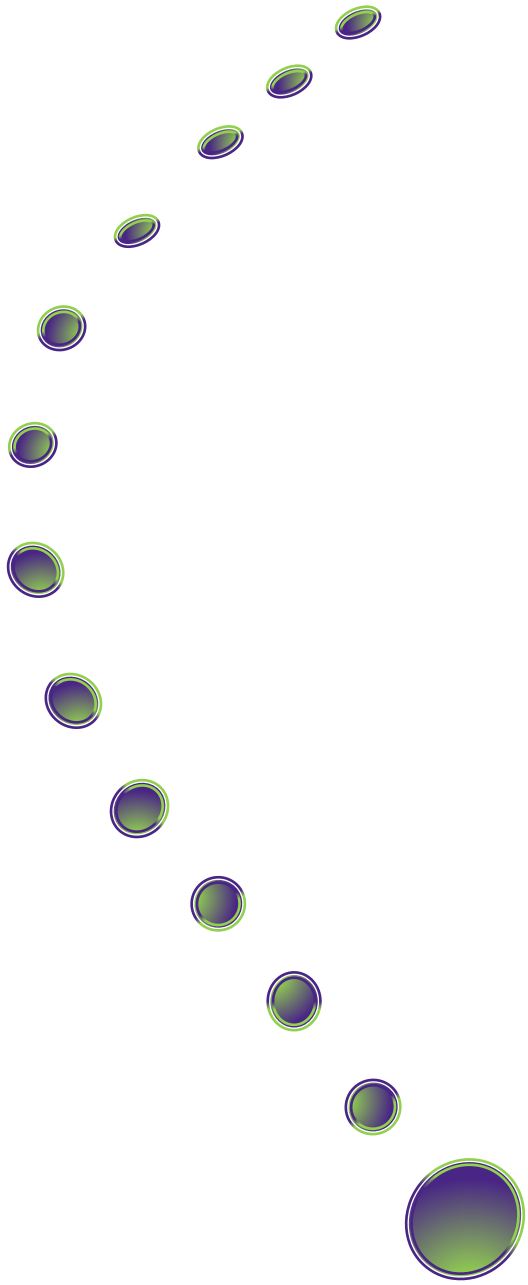
Practice

- ✓ Continue to integrate an intersectional, feminist, anti-racist/anti-oppression approach in gender-based violence work, including frontline support
- ✓ Include reproductive safety in intake processes or safety planning practices overall

- ✓ Enhance collaboration between sexual violence and domestic violence sectors (e.g. regular meetings between sectors to highlight examples of best practices for collaboration)
- ✓ Develop/promote a sex positive culture in shelters
- ✓ Develop services reflective of the unique challenges faced by young women and women in northern and/or rural communities

Research

- ✓ Identify how experiences of IPSV may vary for different groups of women
- ✓ Integrate an intersectional framework
- ✓ Create a relevant standardized data collection system
- ✓ Engage in evaluations of sexual violence and domestic violence services that reflect the context of the organizations doing the work, as well as what they bring to the lives of survivors



APPENDIX A: RESOURCES

GENERAL

Intimate Partner Sexual Assault Against Women: Examining the Impact and Recommendations for Clinical Practice

This 2012 article frames intimate partner sexual assault (IPSA) as a public health issue and provides an overview of its physical, psychological, and economic consequences for women survivors as well as its impact on children and on relationships with support networks. This article then provides recommendations for health care professionals and those working with IPSA survivors and their support networks. This is an abstract only. You can access the full article through the library, society membership, or by online purchase.

The Many Facets of Shame in Intimate Partner Sexual Violence

This 2012 research summary published by the Australian Centre for the study of sexual assault considers the multifaceted nature of shame in the context of intimate partner sexual violence and summarizes the available research on the role and impact of shame. Much of the literature reviewed identifies intimate partner sexual violence as a separate and distinct form of intimate partner violence with its own set of destructive impacts. Recommendations for health professionals include awareness of the damaging role shame plays in sexual violence in order to provide supportive, compassionate responses to women who suffer because of it.

Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women's Reproductive Control

This 2014 publication defines reproductive coercion within the context of intimate partner violence, and provides recommendations/policy implications. The article argues that in order to assist women and girls to mitigate the risks to their reproductive health caused by IPV and reproductive coercion, access to female-controlled contraceptive methods must be improved. In addition, reduction of IPV and reproductive coercion in the longer term requires ongoing and multiple-sector efforts to transform the social norms that maintain men's entitlement to control of women's and girls' bodies and their reproduction.

Healthy Moms, Happy Babies: A Train the Trainers Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed

This 2015 curriculum from Futures Without Violence provides training, tools, and resources to help home visitation workers address domestic violence, including issues of birth control sabotage, pregnancy pressure, and unintended pregnancy.

Reproductive and Sexual Coercion: A Toolkit for Sexual and Domestic Violence Advocates

This 2015 toolkit was developed by the Virginia Sexual and Domestic Violence Action Alliance to assist with screening for reproductive and sexual coercion within the context of intimate partner violence. The 9-part guide includes the following sections: implementing reproductive coercion assessment, understanding sexual coercion beyond reproduction, reproductive and sexual health resources, sample forms and policies, information on trauma-informed

services, information on reproductive justice, information on comprehensive sexual health, resources for home visiting programs, and resources for healthcare settings. Tips for strengthening partnerships with local health providers to respond to the related healthcare needs of survivors are featured throughout.

The Intersection of Domestic and Sexual Violence: A Review of the Literature
This 2012 report published by the Association of Alberta Sexual Assault Services reviews the intersection between domestic and sexual violence. Part 1 discusses domestic and sexual violence literature published since 2006 and Part 2 reviews seven key themes related to the intersection of domestic and sexual violence. Part 3 includes four recommendations to support the Association of Alberta Sexual Assault Services (AASAS) vision of an Alberta free from sexual assault and sexual abuse.

Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, and Reproductive Health Care Settings, Second Edition
This 2012 guide produced by Futures Without Violence provides information and strategies for addressing reproductive and sexual coercion with patients seeking reproductive health care services. Part 1 introduces background information, Part 2 discusses reproductive health effects of abuse, Part 3 offers guidelines for responding to IPV and reproductive coercion in the healthcare setting, and Part 4 outlines policy and system response implications.

Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention
This 2011 toolkit produced by the Feminist Women's Health Center and the National Coalition Against Domestic Violence provides information for women and individuals working in the domestic violence and reproductive health communities. The included chapters are designed to empower women to take control of their own reproductive health, and to help domestic violence and healthcare workers recognize the intersections between their fields and respond with practical solutions. The toolkit also includes fact sheets and assessment and intervention tools.

Considering the Differences: Intimate Partner Sexual Violence in Sexual Assault and Domestic Violence Discourse
The articles within this 2008 publication illustrate the complexities of intimate partner sexual violence (IPSV) and the necessity of a systematic response. By capturing the voices of survivors, advocates and legal leaders in this movement to end violence against women, this publication looks beyond traditional paths of service delivery and into the root causes of intimate partner sexual violence, expanding outreach to survivors.

Indigenous Women

Sexual and Reproductive Health, Rights, and Realities and Access to Services for First Nations, Inuit, and Métis in Canada
This 2012 joint policy statement was prepared by the Aboriginal Health Initiatives Sub-Committee and approved by the Executive Council of the Society of Obstetricians and Gynaecologists of Canada. The purpose of this statement is to "reaffirm the sexual and reproductive rights of FNIM and to reflect the realities they face in their communities." Recommendations include promoting awareness and developing cultural competence among health care providers.

The Coercive Sterilization of Aboriginal Women in Canada

This 2012 paper examines the coercive sterilization of Aboriginal women in both legislated and non-legislated form. Specifically, studies have confirmed that Aboriginal women were disproportionately targeted by enacted legislation in the province of Alberta.3 Sterilization measures were also implemented in the absence of formal legislation. Evidence indicates this practice was carried out by eugenically minded doctors in Ontario and Northern Canada, where Aboriginal women were the prime targets. While coercive sterilization policies have been recognized as racist, sexist, and imperialist, how this practice was carried out on Aboriginal women has yet to be fully understood within this larger context. This paper builds on existing scholarship and provides a historical and materialist critique of coercive sterilization, one which allows the practice to be understood within the larger relations of colonialism, the oppression of women, and the denial of indigenous sovereignty.

Sexual and Reproductive Health and Rights of Indigenous Peoples

This 2014 paper published by the United Nations Inter-Agency Support Group positions the sexual and reproductive health and rights of indigenous peoples as a critical development challenge in its own right, and as instrumental for the achievement of an equitable and sustainable development and gender equality. The paper reviews indigenous people's access to sexual and reproductive health information and services, violence against women inside and outside of indigenous communities, and examples of good practices.

Women with Disabilities

The Association between Disability and Intimate Partner Violence in the United States

This 2015 study seeks to examine the link between disability and IPV in a nationally representative sample of U.S. women and men. Compared to women without a disability, women with a disability were significantly more likely to report experiencing each form of IPV measured, including sexual violence and control of reproductive or sexual health. This is an abstract only. You can access the full article through the library, society membership, or by online purchase.

Take Charge! A Reproductive Health Guide for Women with Disabilities

This 2015 guide reviews issues related to reproductive health, rights, and justice for women with disabilities, including accessing health care services. Violence/abuse, mental health, and mothering are also explored. Resources for women with disabilities are included.

Racialized Women

Race and Reproductive Coercion: A Qualitative Assessment

This 2015 article examines whether racial differences in reproductive coercion impact African American women's disparate risk for unintended pregnancy. Semi-structured interviews were conducted with low-income, African American, and white women. African American women reported experiences of reproductive coercion more often than white women and were more likely than white women to attribute a current or prior pregnancy to reproductive coercion.

The authors recommend further research to understand the social and structural factors associated with these outcomes. This is an abstract only. You can access the full article through the library, society membership, or by online purchase.

Sterilization Racism and Pan-Ethnic Disparities of the Past Decade: The Continued Encroachment on Reproductive Rights

This 2010 article provides a history and analysis of sterilization racism with regard to American Indian and African American women. This is an abstract only. You can access the full article through the library, society membership, or by online purchase.

Racism and Disparities in Women's Use of the Depo-Provera Injection in the Contemporary USA

This 2011 article examines the sterilization abuse directed at women of color in the US in the 1960s and 1970s. The analysis finds that African American and American Indian women were more likely than European American women to use Depo-Provera, and discusses the complexities of studying racism with data on racial/ethnic disparities that were not designed for this purpose. This is an abstract only. You can access the full article through the library, society membership, or by online purchase.

Cultural Competence

Culture and Religious Beliefs in Relation to Reproductive Health

This 2015 article provides an overview of the implications of cultural and religious aspects for reproductive health patterns and disparities in health care. The article also highlights the limitations of existing research in acknowledging the experiences of Muslim individuals, and outlines the necessity of research in this area in order to improve health-care provision and health outcomes.

Developing Cultural Competence in Reproductive Health Care: Understanding Every Woman

This 2004 report outlines key recommendations for developing culturally competent services to address the specific reproductive health needs of women of color, low-income women, and immigrant women.

LGBT

Reproductive Coercion: Uncloaking an Imbalance of Social Power

This 2016 article presents an overview of the recent literature surrounding reproductive coercion and how it relates to the reproductive health outcomes of women, adolescents, and the lesbian, gay, bisexual, and transgender community. Men's experience with reproductive coercion is also discussed. Clinical implications and evidence-based strategies for assessment and intervention are identified.

Sexual Violence and Gay, Lesbian, Bisexual, Trans, Intersex, and Queer Communities

This 2012 resource sheet provides an overview of the current research on GLBTIQ sexual violence, including sexual violence within same-sex relationships. It also discusses the limitations of current research, identifies issues with service provision to GLBTIQ survivors, and explores key barriers to disclosing and reporting experiences of sexual violence.

Information Series on Sexual and Reproductive Health and Rights: Lesbian, Gay, Bisexual and Transgender and Intersex People

This 2015 resource published by the United Nations provides information on the sexual and reproductive health and rights of lesbian, gay, bisexual, transgender, and intersex people within an international context.

Differences by Sexual Minority Status in Relationship Abuse and Sexual and Reproductive Health among Adolescent Females

This 2014 article examines adolescent relationship abuse and related sexual and reproductive health among females who identify as lesbian or bisexual or engage in sexual behavior with female partners. Findings highlight the need for clinicians to ask about both sexual identity and behavior among youth and provide comprehensive testing and treatment for sexually transmitted infections framed within a discussion of healthy relationships. This is an abstract only. You can access the full article through the library, society membership, or by online purchase.

Young Women

Reproductive Coercion and Partner Violence among College Women

This 2015 article examines pregnancy coercion and birth control sabotage among college women, finding higher rates among women with histories of partner violence. Recommendations include assessing for reproductive coercion in college health settings and tailoring contraceptive discussions accordingly. This is an abstract only. You can access the full article through the library, society membership, or by online purchase.

Appendix B: Knowledge Exchange Evaluation Summary of Results

- 88% of participants felt the information shared during the Knowledge Exchange was relevant to their work.
- 92% of participants felt the speakers were knowledgeable about the topics on which they presented.
- 88% of participants indicated that the content of the event enhanced or reinforced their knowledge on IPSV.
- 84% of participants agreed that the information shared at the Knowledge Exchange would help inform the development of future training programs.
- 83% of participants agreed that more information on the characteristics of IPSV and patterns of service utilization would enhance training programs on IPSV.
- 92% of participants felt incorporating reproductive coercion would enhance safety planning and risk assessment training.
- 96% of participants agreed that survivors of IPSV would benefit from enhanced system navigation.
- 100% of participants indicated that survivor voices should be included in training on IPSV.
- 88% of participants agreed that the event was framed by a gender-based analysis.
- 38% of participants felt the event reflected diversity, 21% neither agreed nor disagreed, and 41% felt there was room for the inclusion of more diversity within the topic of IPSV.
- 77% of participants would recommend this Knowledge Exchange to colleagues.

KNOWLEDGE EXCHANGE EVALUATION SURVEY

Thank you for participating in this Knowledge Exchange event. We would like to know the extent to which this event has met your expectations. Your responses will remain completely anonymous and will help to inform the planning of future events. We greatly appreciate and value your time and feedback.

Please select the response option that best fits with your experience of this event.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. The information shared during this event is relevant to my work.	☐	☐	☐	☐	☐
2. The speakers were knowledgeable about the topics on which they presented.	☐	☐	☐	☐	☐
3. The content of this event enhanced or reinforced my knowledge on this topic.	☐	☐	☐	☐	☐
4. The information shared at this event would help inform the development of future training programs.	☐	☐	☐	☐	☐
5. More information on the characteristics of IPSV and patterns of service utilization would enhance training programs on IPSV.	☐	☐	☐	☐	☐
6. Incorporating reproductive coercion would enhance safety planning and risk assessment training.	☐	☐	☐	☐	☐
7. Survivors of IPSV would benefit from enhanced system navigation.	☐	☐	☐	☐	☐
8. Survivor voices should be included in training on IPSV.	☐	☐	☐	☐	☐
9. A gender-based analysis framed this event.	☐	☐	☐	☐	☐
10. This event reflected principles of diversity.	☐	☐	☐	☐	☐
11. I would recommend this knowledge exchange to colleagues.	☐	☐	☐	☐	☐

12. My stakeholder group/sector can best be described as:

- ☐ Domestic violence services
- ☐ Sexual assault services
- ☐ Health care
- ☐ Education
- ☐ Social Services
- ☐ Justice
- ☐ Government
- ☐ Students
- ☐ Survivors
- ☐ Stakeholder group/sector not listed (please specify): _____

13. Useful information I learned or had reinforced during this Knowledge Exchange included…
(Please give one or more examples)

_____

_____

_____

_____

14. I think the sectors (e.g. SV, DV, and ally services) should take the following steps to enhance support to IPSV survivors…

1._____

_____

2._____

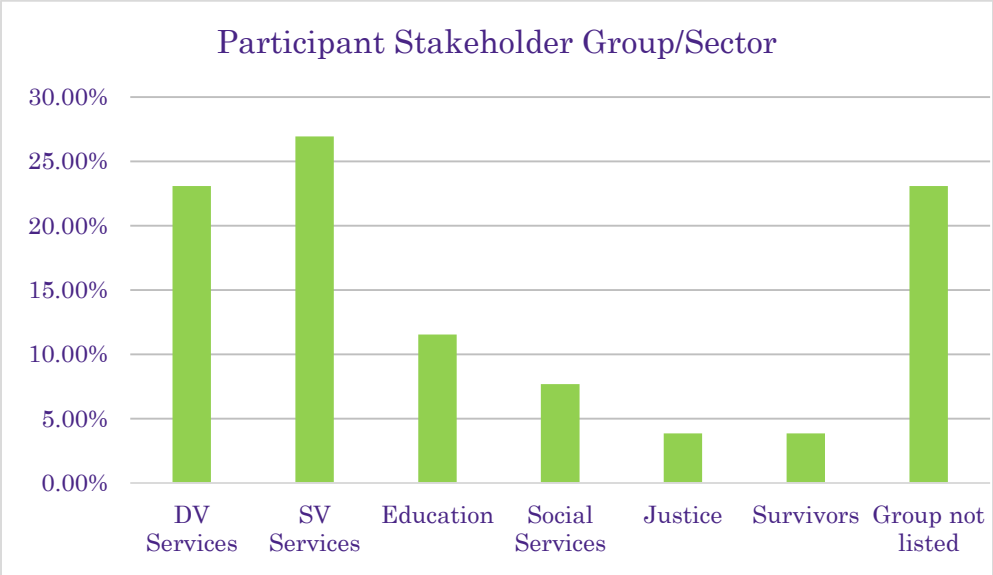
_____

15. Please provide any additional comments you wish to share with us.

_____

_____

PARTICIPANT DEMOGRAPHICS



- Participants who indicated "group not listed" identified themselves as belonging to both the domestic violence and sexual violence sectors, or that they represented a combination of the other sectors listed.

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