A COMMUNITY RESPONSE TO
REPRODUCTIVE COERCION

Assessing organizational knowledge and capacity to provide trauma-informed support to individuals experiencing Reproductive Coercion

August 2018
Prepared for:
Planned Parenthood Ottawa
Ottawa Coalition to End Violence Against Women
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Capacity</td>
<td>1</td>
</tr>
<tr>
<td>Project Purpose</td>
<td>1</td>
</tr>
<tr>
<td>Project Scope</td>
<td>2</td>
</tr>
<tr>
<td>Methodology</td>
<td>2</td>
</tr>
<tr>
<td>Literature Review - Past</td>
<td>3</td>
</tr>
<tr>
<td>Literature Review - Current</td>
<td>3-4</td>
</tr>
<tr>
<td>What is Reproductive Coercion?</td>
<td>4</td>
</tr>
<tr>
<td>Demographic &amp; Target Group</td>
<td>5</td>
</tr>
<tr>
<td>Impacts of RC &amp; Screening Opportunities</td>
<td>6</td>
</tr>
<tr>
<td>Silos: Health and Community</td>
<td>6</td>
</tr>
<tr>
<td>Potential Intervention Models</td>
<td>8</td>
</tr>
<tr>
<td>Structural: Ecological Model</td>
<td>8</td>
</tr>
<tr>
<td>Image: Ecological Model</td>
<td>9</td>
</tr>
<tr>
<td>Individual Interventions</td>
<td>10</td>
</tr>
<tr>
<td>Key Findings</td>
<td>10</td>
</tr>
<tr>
<td>Awareness &amp; Screening</td>
<td>10</td>
</tr>
<tr>
<td>Needs</td>
<td>11</td>
</tr>
<tr>
<td>Gaps</td>
<td>11</td>
</tr>
<tr>
<td>Systemic Barriers</td>
<td>11-12</td>
</tr>
<tr>
<td>Immediate Gains - Learning Network</td>
<td>12</td>
</tr>
<tr>
<td>Recommendations</td>
<td>12-13</td>
</tr>
<tr>
<td>References</td>
<td>13-14</td>
</tr>
<tr>
<td>Appendix: Survey Findings</td>
<td>15</td>
</tr>
</tbody>
</table>
## ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>RC</td>
<td>Reproductive Coercion</td>
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<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>IPV</td>
<td>Intimate Partner Violence</td>
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<tr>
<td>VAW</td>
<td>Violence Against Women</td>
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<tr>
<td>WoC</td>
<td>Women of Colour</td>
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<tr>
<td>LGBT2Q</td>
<td>Lesbian, Gay, Bisexual, Transgender, Two-Spirited, Queer/Questioning</td>
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<tr>
<td>PPO</td>
<td>Planned Parenthood Ottawa</td>
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<tr>
<td>OCTEVAW</td>
<td>Ottawa Coalition to End Violence Against Women</td>
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<tr>
<td>RJ</td>
<td>Reproductive Justice</td>
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ORGANIZATIONAL CAPACITY

Since 2012, Planned Parenthood Ottawa (PPO) and the Ottawa Coalition to End Violence Against Women (OCTEVAW) have collaborated with diverse stakeholders from the Sexual and Reproductive Health (SRH) and Gender Based Violence (GBV) sector with the goal of furthering the awareness of Reproductive Coercion (RC). Most notably in 2012, PPO, OCTEVAW and Canadians for Choice and the Canadian Federation of Sexual Health co-develop the Bridging Services for Women: Coordinating a Community Response to Violence Against Women and Sexual & Reproductive Health project. The purpose of the project was to identify current responses to those experiencing RC, and develop preliminary recommendations on how to increase the consistency and quality of services. The project results highlighted the following needs:

- To build sustainable systemic mechanisms to more meaningfully connect the SRH and GBV community;
- To increase knowledge building opportunities for service providers on RC and how it manifests;
- To create sustainable systemic change we need to incorporate an intersectional analysis which understands that sexism, misogyny, transphobia, racism, homophobia, and colonialism are the underpinnings of GBV and RC.

PPO and OCTEVAW have continued to enhance their local, provincial, and national networks and progress in their intersectional approach to identifying and advocating for systemic transformation. Further to this, OCTEVAW has gained valuable knowledge regarding the necessary elements to create sustainable systems change through the use of the ecological and social change model. As partners, PPO and OCTEVAW, are well equipped with the knowledge and networks to progress the awareness of RC, and develop best practices and sustainable systemic enhancements.

PROJECT PURPOSE

The purpose of the needs assessment is to:

i) to further define the current gaps between GBV and SRH services in order to improve access and response to those experiencing RC;

ii) understand the intersectional knowledge needs of SRH/GBV services providers in order to better support those from marginalized communities;

iii) identify systemic barriers for individuals accessing to services;

iv) identify current screening and care practices.
PROJECT SCOPE

The needs assessment was designed to gather information specifically from the perspective of the service provider versus service user. Local, provincial and national SRH and GBV organizations were asked to complete an online survey with the intention of further defining organizational capacity, available services, knowledge level of RC, and existing systemic barriers. In addition, training evaluations were also completed after workshops to assist in providing a snapshot of existing knowledge, and whether the specific workshops were supportive in enhancing awareness and knowledge.

A key interest for the online survey and evaluation was also to provide further information on the service user demographics to collect data on who were being supported, as the project has a primary interest of developing practices which take the lived experience of those often marginalized from the analysis (i.e. Queer and Trans* folks, young mothers, individuals with disabilities, Women of Colour, and those living with HIV).

The data results of both evaluations will support the development of core knowledge building tools, and be used to inform best practices across different service delivery sectors.

METHODOLOGY

The methodology included two parts. The first was the completion of a literature review which included open source material such as academic research and community based resources. The second was the analysis of the online survey and workshop evaluation results. The online bilingual survey and evaluation was designed to gather specific information from the service provider versus service user.

Surveys

A data collection tool was developed for the project “A Community Response to Reproduction Coercion” to assist with the work of advancing best practices and implementation protocols to reduce the impact of gender-based violence on sexual and reproductive health.

The data collected from the tool were both qualitative and quantitative. For quantitative data, the method of analysis was descriptive statistics such as counts, percentages and weighted averages. For qualitative data such as open-ended survey questions and comments, the responses were grouped in categories, themes or became part of a database of information.

The tool has two parts; part 1 collected information about the organizations for the purposes of creating a national map of services and a learning network. The seven questions in part 1 were open text, multiple choice and “yes” or “no” questions. Part 2 of the data collection tool aimed at helping PPO get a better understanding of the service delivery network available
nationally and organizational interests in knowledge-sharing and training. The 15 questions that made up this part of the information collection tool included multiple choice, “yes” or “no” questions, Likert scale and matrix questions as well as open text.

The questions in the data collection tool were created using a Gender-Based Analysis plus (GBA+) lens in that it recognizes groups of people are not homogenous and that their experiences are affected by intersecting parts of their identity. The question considered identity factors such as ethnicity, age, education, language, income, geography, culture and sexual orientation.

The tool was hosted in Simple Survey and the electronic form was sent to over 90 organizations in the Violence Against Women and Sexual and reproductive Health sector across Canada. The list of organizations had been generated from previous done for the 2013 report “Bridging Services for Women”. To ensure a satisfactory completion rate for the tool, the program coordinators contacted were contacted individuals by phone, and emailed the organizational leads to encourage completion. As of August 1 2018, there had been 42 respondents who completed the information request and responded to the questions in the tool.

PAST LITERATURE REVIEW

FINDINGS

In 2012 PPO and OCTEVAW performed a similar literature review as part of the Building Services for Women (Marriner, 2012) project, therefore it was most appropriate to build on the past findings to create a mapping of current knowledge and best practices. In 2012, the Building Services for Women project highlighted the following:

- The majority of the research regarding RC is coming from a small cluster of researchers, which provided information on capacity building;
- Resources are being developed by grass roots organizations to raise awareness of RC (i.e. intersectional perspective to care)

CURRENT FINDINGS

Since 2012 there has been some growth in research and community resources focused on exploring the dynamics of RC. Similar to that of 2012, the majority of the sources continue to be from the United States, with some from Canada and Australia. Additionally, there continues to be a core group of academic researchers exploring this issue, however there did appear to be some growth. Trends in the research which were most notable included:
• An expanded definition of RC as connected to both relationships and systemic influences which impact reproductive autonomy (i.e. service provider or laws);

• The existing academic and community research does re-confirm the connection between IPV and RC;

• The demographic information continues to be statistically low, and research tends to focus on cis gender women, with limited academic research focused on understanding this issue from an intersectional perspective (i.e. understanding that race, gender identity and immigration status impact care);

• Health care providers would benefit from being trained on: GBV red flags, screening tools, safety planning, identifying and challenging implicit biases; harm reduction (i.e. undetectable birth control), and provided with local community resources;

• Models for health care screening of RC are emerging, along with best practices to care for those most marginalized (i.e. WoC, Queer and Trans* individuals and those with disAbilities).

• Interventions (i.e. screening) and support (i.e. harm reduction) of those experiencing RC must be developed with an understanding of the underpinnings which allows RC and other forms of GBV to exists; some of which include sexism, misogyny, transphobia, racism, colonialism.

• There are structural models which could be used to further frame RC and create a cluster of interventions which address the structural influencers that impact care (i.e. The Ecological Model).

WHAT IS REPRODUCTIVE COERCION?
Reproductive Coercion (RC) is an under reported and often silence form of violence, which is rooted in power and control. It includes behaviours which impact and individual’s reproductive autonomy and agency. It is most commonly experienced within an intimate partner relationship, however it has been broaden to include harm perpetrated by service providers, legislation or within a larger family contexts (Marie Stopes Australia, 2018).

Within a relationship RC is often considered a subset of Intimate Partner Violence (IPV) which intersects with Sexual and Reproductive Health (SRH) and Sexual Violence.
RC is recognized as an umbrella term for primarily three categories of behaviours which include:

i) **pregnancy pressures** (i.e. refusal to wear a condom or forcing a person to have multiple pregnancies in a short time);

ii) **birth control sabotage** (i.e. removal of a condom during sex and hiding birth control);

iii) **controlling pregnancy outcomes** (i.e. threats to disclose someone’s gender or sexual orientation if they do not comply with pregnancy outcomes) (American College of Obstetricians and Gynaecologists, 2013).

Systemically, RC is most closely connected to reproductive autonomy, which is assessed by the degree in which an individual was empowered, impeded or influenced by systemic barriers. Some examples of harm or impediments include: forced sterilization, access to abortions or laws forbidding abortion) (Grace and Anderson, 2016). Reproductive autonomy is often influence by social norms, law, and policies which impact equitable choice regarding one’s reproductive health or ability to parent. As will be discussed in the promising practices section of this report, the Reproductive Justice (RJ) movement has worked to advocate for this broader understanding of RC, as system transformation to eliminate oppressions such as sexism, racism, transphobia, homophobia, and ablism will dramatically impact available choice and the respect of those choices.

Health related outcomes when RC exists in a relationship include: higher rate of unplanned pregnancy, higher rate of young birth parents, more frequent births than those who are not experiencing IPV, higher risk of STIs (Miller et al., 2010).

**DEMOGRAPHICS & TARGET GROUP**

Within the literature women, specifically young women, Women of Colour (WoC), and those in a dating relationships tended to experience higher rates of RC (Grace & Anderson, 2016; Chamberlain & Levenson, 2013; Miller et al, 2018). As noted previously, formal research has not explored this issues from a strong intersectional perspective, therefore these demographics should be read with caution as there is a likelihood that populations equally affected are not being captured in the current data. RC intersects with IPV and other forms of GBV (i.e. sexual violence), which means that there is knowledge which could be titrated in order to provide a broader understanding of at-risk populations. For example, Trans PULSE noted:

*According to the Trans PULSE Project, which researches the social determinants of health for transgender and gender diverse individuals in Ontario, 20% of all trans Ontarians “had been physically or sexually assaulted for being trans, and another 34% had been verbally threatened or harassed but not assaulted” (G. R. Bauer & Scheim, 2015)*
Egale: Human Rights Trust additionally noted that the majority of incidents are under reported. (Bucik, (2016). Under reporting is a consistent feature of GBV, and this is further compounded when there are various intersecting oppressions. For example, Aboriginal women are affected by sexual violence at high rates as well as racism (GBV Benoit et al., 2003). These two factors combined to further decrease reporting as typically past experiences have consistently devalued their needs and caused revictimization.

IMPACTS OF RC & SCREENING OPPORTUNITIES

Some of the physical and emotional impacts of RC identified in the literature include the following:

- Feeling of powerlessness and increase acceptance of harm
- Markers of depression or anxiety
- Fear
- Impact on self-esteem
- Young women who have contracted an STI have a higher likelihood that they are in or experienced dating violence
- Higher likelihood for births close together
- Increase number of abortions (Futures without Violence, 2013; Mechanic, 2008)

Futures without Violence does suggest that these impacts should be used as cues to encourage service providers to discuss RC.

SILOS: HEALTH AND COMMUNITY

There continues to be a gap in available research and publicly available resources, which discuss best practices in a holistic, and cross-sectoral approach. The result is the creation of ‘knowledge creation silos’ between community support workers, advocates and health practitioners (i.e. doctors and health researchers). Health oriented researchers such as Elizabeth Miller and Thiel de Bocanegra et al (2010), along with other US based research from as Lindsay E. Clark et al. (2014), Jeanna Park et al. (2016), Melissa A. Sutherland et al. (2015), Raj Silverman (2014), and William A. Fisher, PhD are the primary researchers exploring how RC manifests and piloting screening tools. Their recommendations for the health care field include:

- continuing to build clinical awareness and knowledge of GBV;
- develop tested screening tools and they have suggested regular intervals for screening (i.e. annual appointments)
- have the knowledge and skills to complete a safety plan, or refer to appropriate community services;
• provide information of harm reduction methods (i.e. undetectable forms of birth control). (Miller et al., 2018).

The health and mental health sectors are moving towards understanding GBV from a trauma-informed approach, which is defined as:

“**Trauma informed**” services and “**trauma specific**” services are not the same. **Trauma informed services are informed about, and sensitive to, the potential for trauma related issues to be present in patients, regardless of whether the issues are directly or obviously related to the presenting complaint or condition** (Butler et al., 2011).

However, as RC involves both partners, family and infringements on reproductive autonomy by systems, the Reproductive Justice (RJ) framework is being presented as a best practice in developing care resources and interventions. RJ is defined as a holistic approach to reproductive services and advocacy, which takes into consideration the physical, mental, spiritual, social and economics status of individuals when it comes to their reproductive autonomy. Further it provides a wider lens to the issue of RC, which includes the systemic impacts of reproductive health, and that choices are build on access to services and community supports. It recognizes the inequity, particularly of Indigenous women and WoC, and that their reproductive decisions are made within multiple systemic constraints (i.e. racism, socio-economic status etc.) (SisterSong Women of Color Reproductive Health Collective).

**RESEARCH LIMITATIONS**

In a meta study conducted by Grace and Fleming (2018) it was identified that various gaps exist within the academic research which restrict the full understanding of how RC manifests in a larger socio-political context. The following gaps in research were identified:

• Limited research which examines RC from an intersectional perspective (i.e. exploring how gender, sexual orientation, immigration status and race);

• A lack of international data from various regions which explores the impacts of access to reproductive services and how RC manifests;

• A lack of research which identifies protective factors and provides information on how to capitalized on these to provide optimal care.
POTENTIAL INTERVENTION MODEL

There are a section of key intervention and framing models which have been highlighted in community practice and academic research. The following discussion outlines two key models which could assist in framing RC and encourage a holistic approach to individual care and structural change.

STRUCTURAL FRAMING

The ecological model, most notably promoted by the World Health Organization, suggests that interventions and prevention needs to be considered in tandem:

*The ecological framework is based on evidence that no single factor can explain why some people or groups are at higher risk of interpersonal violence, while others are more protected from it. This framework views interpersonal violence as the outcome of intersections amount many factors at four levels: the individual, the relationship, the community and the societal* (World Health Organization, 2018).

It emphasizes that each level is important and therefore should all be given equal attention. The most helpful aspect of this framework is that it assists in developing a cluster of interventions (World Health Organization, 2018). When conceptualizing RC from an ecological framework the following could be one example of the outcomes:

- **Societal Change:** Recognizing the systemic harm to vulnerable populations over time (i.e. force sterilization) and the existence of racism and colonialism.

- **Community:** this acknowledgement leads to interventions such as training and consistent exploration of implicit biases which leads to stronger community services.

- **Personal Relationships:** having conversations about RC could allow for exploration of harmful relationship patterns.

- **Individual:** When services providers actively challenge implicit biases, it improves care. Therefore an increase in those often marginalized will benefit from this care.

In the ecological model, contextual factors such as misogyny, sexism, poverty, socio-economic status, and race are not seen as peripheral, but rather as an integral aspect of the model; that shifting problematic social norms allows for the development of more effective interventions. (Dahllberg and Krug, 2002).
**SOCIETAL**

These factors create the environment where gender-based violence (GBV) can exist, and influences how we address this issue on a wider systemic level and on the individual level. This includes social/cultural norms, economic and social policy.

**Recognition that Implicit Biases exist and impact services**

**COMMUNITY**

Prevention strategies at the community level target the social and physical environment.

**Training**

**Screening**

**Organizational Protocols**

**RELATIONSHIP**

This explores the impact of close relationships as protective factors or as contributing to harm.

**Pamphlets:**
- harm reduction
- healthy relationships
- parenting options

**INDIVIDUAL**

This includes individual demographic factors. It must be recognized that when such societal factors such as implicit biases exist then this will directly impact the individual and determine the quality of care received and whether they will seek care.

**Education on implicit biases & building of awareness of RC.**
INDIVIDUAL INTERVENTION

Miller (2016) suggested a specific individual intervention model which has, since its development, shown to reduce harm outcomes in RC cases. Referred to as the ARCHES (Addressing Reproductive Coercion in a Health Settings) model. The model includes the following:

- Education on RC
- Risk Assessments (Screening at regular intervals)
- Harm Reduction Counselling (i.e. undetectable birth control)
- Referrals and Self-assessment resources (i.e. pamphlets and community resources)

KEY FINDINGS

The online survey obtained 42 responses from a wide variety of sectors some of which included: shelters, hospitals, sexual assault/rape crisis centres, community centres, addiction supports, and newcomer/immigrant organizations. This combined with the 20 responses from the workshop evaluations and the literature review resulted in the following key findings:

AWARENESS & SCREENING

- There is an awareness of reproductive coercion with 76% of respondents have heard of it and 78% know enough about it that they can recognize it in the clients that they serve. However, this awareness has not translated into the actions of actually screening clients when they come in for services. 76% of respondents do not screen for reproductive coercion.

- The existing PPO training on RC was successful in increasing knowledge of RC markers and confidence to provide trauma-informed support to someone experiencing RC.

NEEDS

- Referrals are the top services offered by organizations. Because referrals are so critical to services offered, the goal of having improved referral practices among VAW & SRH organizations would be relevant and of value to the sector as a whole.
• Screening tools which are informed by the SRH and GBV community, and grounded in Reproductive Justice knowledge.

• There is a need to find ways in which to breakdown the silos between the SRH, GBV and health sector. This will encourage collaboration and allow for more consistent practices.

GAPS

• From the online survey the most regular training is trauma-informed, the least training is in Reproductive Justice and Pro-choice.

• The survey identified that Francophone women (27%), Justice-Involved (32%) and under-housed women (37%) are the least targeted population for services.

SYSTEMIC BARRIERS

The survey results notes number systemic barriers to support which include:

• Systemic barriers to disclosure (i.e. including fear of child apprehension, compromised confidentiality, threat of criminalization) (80%);
• Lack of knowledge of services that understand reproductive coercion (80%);
• Stigma or judgement (76%);
• Lack of services (i.e. primary care providers, housing etc.) (71%);
• Past negative experiences accessing reproductive health services (63%);
• Implicit biases (i.e. radicalized and marginalized individuals) (56%)
• Lack of inclusivity (visual representation) (54%);
• Language barriers (54%);
• Services did not clearly identify their approaches (i.e. feminist/pro-choice) (51%)
IMMEDIATE GAINS & OPPORTUNITIES
ACTION: DEVELOPMENT OF A LEARNING NETWORK

• The online survey highlighted that respondents were interested in being part of the learning network, and they identified that webinars would be an accessible learning method to increase knowledge.

• As the existing training did show knowledge gains it would be a strong next step to translate this training into a webinar, or video to be disseminated widely.

• A secondary topic proposed was to discuss how RC manifests outside of a partner or family relationships.

• The survey identified that 73% of organizations screen for violence using a number of direct questions and talk about their safety. The literature review proposed a piloted screening tool, and this could be a preliminary action item in the process of creating inter-agency protocols.

RECOMMENDATIONS

• The creation of a local advisory focused on advising the remaining outcomes for the project. It would be recommended that those on the advisory include individuals with expertise in SRH, GBV, health care practices, and reproductive justice to ensure the framing of all tools is intersectional.

• The key findings illustrate that service users have a basic to intermediate knowledge of the nuances of RC. Therefore attention should be paid to enhancing knowledge of all aspects of RC (i.e. reproductive autonomy, ecological model, SRH interventions) as this is a foundational aspect to creating sustainable systemic change.

• Develop a screening tool which is trauma-informed and includes a Reproductive Justice framing to ensure it is representative of the variety of ways in which RC manifests. It would be further recommended that this then be brought to the wider SHR and GBV community for consultation and then piloted for a brief period before a wider launch.

• Continue to use the ecological model to frame this issue and continue the in-
corporation of Reproductive Justice tenets to ensure that the project does not exclude the experiences of those most marginalized.

- Using the existing training, translate this into a webinar to be offered to those in a variety of sectors.

- To continue to reach out to organizations in priority (i.e. underserved) populations such as Francophone women, justice involved and under housed.

- As referrals are noted as a key services, it would be suggested that the project partners explore efficacy based ways to both encourage referrals and execute these referrals. Then it would be advised that this is sent to the knowledge network and/or advisory or consultation and piloting
REFERENCES


APPENDIX
1. INTRODUCTORY NOTES

• The purpose of this data collection is to gather information from organizations to help gain an understanding of what capacity, services, knowledge and barriers that currently exist across Canada for women and girls experiencing reproductive coercion. The results will help inform knowledge-sharing across different sectors of service delivery.

• An online data collection tool was used for a set of 24 questions available in both French and English. The questions were mainly close-ended, using Yes or No answers, Likert Scales and choice selection. Some open-ended questions and text-box collected organization-specific information. Both qualitative data and quantitative data were collected.

• Data collection participants were from the VAW and SRH sectors and were selected based on previous work done for the “Bridging Services For Women (BSFW)” report issued in 2013.

• The online data collection tool was released to the network in May 11, 2018.

• The goal was to have close to 100% of the 90+ target organizations and the effort to drive completion included emailing, phoning and face-to-face requests. As a result of these efforts as of August 1, 2018, there were 42 completed responses.

• It is recommended to leave the survey open and continue to build up the database of information over the next year. If the decision is made to leave the survey open, some changes are needed to the welcome page.
2. KEY FINDINGS

1. Referrals are the top services offered by organizations. Because referrals are so critical to services offered, the goal of having improved referral practices among VAW & SRH organizations would be relevant and of value to the sector as a whole.

2. The organizations that responded to the survey have a wide range of affiliations particularly to institutional organizations. (shelters, hospitals, centres, police, schools, etc.).

3. Francophone women (27%), Justice-Involved (32%) and Underhoused women (37%) and the least targeted population for services.

4. Populations that are actually served by the responding providers indicate mainly those experiencing, fleeing from or witnessing violence, including adults of all genders, all adult women, girls aged 16+, youth, trans and GNB folks, and children.

5. 90% of organizations are funded by provincial governments.

6. About half the responding organizations plan to add new services in the next two years. The services vary from housing, to resources, learning and new programs.

7. 95% of organizations refer clients to other services available in the community if those services are not available in-house.

8. Respondents shared some of their referral practices, however in-depth interviews would help to better understand and clarify these practices.

9. 63% of participants would like to see improved referral practices. The recommended improvements include a formalize referral path that is smooth and consistently done, using a standardized form. Although referral improvements would include a better understanding of, collaboration with and partnerships among the network of service providers.

10. 88% of the responding organizations receive training or skill building on a “Regular” (44%) or “Occasional” (44%) basis.
11. 93% of responding organizations have a service delivery framework, many of them use all the service delivery frameworks suggested in the data collection questionnaire including feminist, anti-oppression, anti-racist, trauma-informed, pro-choice and strength based. Some other frameworks included harm reduction and child welfare focused.

12. The most regular training is trauma-informed, the least training is in Reproductive Justice and Pro-choice.

13. Responding organizations do screen for violence (73%) using a number of direct questions to the client about their safety.

14. There is an awareness of reproductive coercion, 76% of respondents have heard of it and 78% know enough about it that they can recognize it in the clients that they serve. However, this awareness has not translated into the actions of actually screening clients when they come in for services. 76% of respondents do not screen for reproductive coercion.

15. The top three barriers to support as understood by the respondents include:
   1. Systematic barriers to disclosure (i.e. including fear of child apprehension, compromised confidentiality, threat of criminalization) (80%),
   2. Lack of knowledge of services that understand reproductive coercion (80%)
   3. Stigma or judgement
3. LOCATION

Survey Respondents by Province

There were 42 Respondents to the Survey until August 1, 2018

41 Anglophone respondents and 1 Francophone respondent. One Anglophone respondent did not fully complete the survey. As a result, for some questions the “total” calculation is out of 41 respondents, not 42.

<table>
<thead>
<tr>
<th>Province</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Ontario</td>
<td>32</td>
<td>76%</td>
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<td>New Brunswick</td>
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<tr>
<td>Alberta</td>
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<td>Nova Scotia</td>
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<tr>
<td>Saskatchewan</td>
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<td>2%</td>
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**TOTAL**

|   | 4     | 100%   |

Respondent by Province
Survey Respondents by City

The top three cities for responses were, Ottawa, Thunder Bay and Brantford

<table>
<thead>
<tr>
<th>City</th>
<th>Count</th>
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<tbody>
<tr>
<td>Ottawa</td>
<td>9</td>
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<td>Thunder Bay</td>
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<td>Brantford</td>
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<td>Calgary</td>
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<tr>
<td>Halifax</td>
<td>1</td>
</tr>
<tr>
<td>Kingston</td>
<td>1</td>
</tr>
<tr>
<td>Kirkland Lake</td>
<td>1</td>
</tr>
<tr>
<td>Kitchener</td>
<td>1</td>
</tr>
<tr>
<td>London</td>
<td>1</td>
</tr>
<tr>
<td>Mississauga</td>
<td>1</td>
</tr>
<tr>
<td>Oakville</td>
<td>1</td>
</tr>
<tr>
<td>Regina</td>
<td>1</td>
</tr>
<tr>
<td>Seaforth</td>
<td>1</td>
</tr>
<tr>
<td>St. Catharines</td>
<td>1</td>
</tr>
<tr>
<td>St. John's</td>
<td>1</td>
</tr>
<tr>
<td>Stratford</td>
<td>1</td>
</tr>
<tr>
<td>Sussex</td>
<td>1</td>
</tr>
<tr>
<td>Windsor</td>
<td>1</td>
</tr>
</tbody>
</table>
TOTAL  42
4. ORGANIZATIONAL CAPACITY

76% of the organizations that responded are not volunteer-driven and most employees are full-time.

A volunteer-driven organization is one where volunteers plan and carry out most of the services or do much of the work. Is your organization volunteer-driven?

<table>
<thead>
<tr>
<th></th>
<th>Anglo</th>
<th>Franco</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>17%</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>0</td>
<td>34</td>
<td>81%</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>41</td>
<td>1</td>
<td>42</td>
<td>100</td>
</tr>
</tbody>
</table>

Please complete the organizational information URL # of paid, full-time employees# of paid, full-time employees

<table>
<thead>
<tr>
<th></th>
<th># of paid, full-time employees</th>
<th>Min</th>
<th>Max</th>
<th>Avg FT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time</td>
<td>941</td>
<td>1</td>
<td>400</td>
<td>23</td>
</tr>
<tr>
<td>Part time</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. SERVICES

What services do you offer?

- Public Education and referrals are the top services offered by organizations.
- If referrals are so critical to services offered, the endeavour to have improved referral practices would be relevant and of value.

<table>
<thead>
<tr>
<th>Service</th>
<th>Anglo</th>
<th>Franco</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public education</td>
<td>36</td>
<td>36</td>
<td>86</td>
<td>86%</td>
</tr>
<tr>
<td>Referrals</td>
<td>35</td>
<td>1</td>
<td>36</td>
<td>86%</td>
</tr>
<tr>
<td>Advocacy</td>
<td>32</td>
<td>32</td>
<td>64</td>
<td>76%</td>
</tr>
<tr>
<td>Crisis</td>
<td>30</td>
<td>1</td>
<td>31</td>
<td>74%</td>
</tr>
<tr>
<td>Accompaniment</td>
<td>27</td>
<td>1</td>
<td>28</td>
<td>67%</td>
</tr>
<tr>
<td>Screening for intimate partner violence (IPV)</td>
<td>26</td>
<td>26</td>
<td>52</td>
<td>62%</td>
</tr>
<tr>
<td>Support groups</td>
<td>25</td>
<td>1</td>
<td>26</td>
<td>62%</td>
</tr>
<tr>
<td>Professional counselling</td>
<td>23</td>
<td>23</td>
<td>46</td>
<td>55%</td>
</tr>
<tr>
<td>Screening for gender-based violence (GBV)</td>
<td>21</td>
<td>21</td>
<td>42</td>
<td>50%</td>
</tr>
<tr>
<td>Screening for coercion</td>
<td>16</td>
<td>16</td>
<td>32</td>
<td>38%</td>
</tr>
<tr>
<td>Other (see below)</td>
<td>13</td>
<td>13</td>
<td>26</td>
<td>31%</td>
</tr>
<tr>
<td>Peer-to-peer counselling</td>
<td>12</td>
<td>12</td>
<td>24</td>
<td>29%</td>
</tr>
<tr>
<td>Sexual and reproductive health (SRH) clinical services</td>
<td>7</td>
<td>1</td>
<td>8</td>
<td>19%</td>
</tr>
</tbody>
</table>

The following is a list of the other services provided:

- Other: Safety Planning  
- Other: Child Welfare  
- Other: Children, Family and Men's Programs  
- Other: Court Orientation  
- Other: Drop in Programs  
- Other: Sexual Assault Nurse Examiner Program  
- Other: SRH education & health promotion  
- Other: Various  
- Accompagnement (tribunal, services de santé etc.)  
- Services de crise
<table>
<thead>
<tr>
<th>Other: Bystander Intervention</th>
<th>Références</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other: Housing</td>
<td>Groupes de soutien</td>
</tr>
<tr>
<td>Other: residential program</td>
<td>Services cliniques pour santé sexuelle et reproductive</td>
</tr>
</tbody>
</table>
### 6. AFFILIATIONS

Do you have affiliations?

<table>
<thead>
<tr>
<th>Service</th>
<th>ANGLO</th>
<th>FRANCO</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelters</td>
<td>34</td>
<td>1</td>
<td>35</td>
<td>85%</td>
</tr>
<tr>
<td>Sexual assault centre and rape crisis centres</td>
<td>34</td>
<td>34</td>
<td>34</td>
<td>83%</td>
</tr>
<tr>
<td>Violence against women and/or child protection liaison workers</td>
<td>34</td>
<td>34</td>
<td>34</td>
<td>83%</td>
</tr>
<tr>
<td>Community health centres</td>
<td>33</td>
<td>33</td>
<td>33</td>
<td>80%</td>
</tr>
<tr>
<td>Addictions services, including harm reduction programs</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>73%</td>
</tr>
<tr>
<td>Hospitals and medical centres</td>
<td>28</td>
<td>28</td>
<td>28</td>
<td>68%</td>
</tr>
<tr>
<td>Youth-service agencies</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>66%</td>
</tr>
<tr>
<td>Anti-human trafficking interventions</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>63%</td>
</tr>
<tr>
<td>Health service providers for marginalized and homeless populations, and those living in poverty</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>61%</td>
</tr>
<tr>
<td>Agencies for newcomer, immigrant, refugee and visible minority women</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>59%</td>
</tr>
<tr>
<td>Services for people with HIV/AIDS</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>54%</td>
</tr>
<tr>
<td>Others</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>34%</td>
</tr>
</tbody>
</table>

The following is a list of the other services provided:

- Other: Community Sexual Assault Services
- Other: Police
- Other: Housing
- Other: Police
- Other: Housing Access Center, Legal Aid, Ontario Works
- Other: Police
- Other: indigenous agencies
- Other: Police and Court
- Other: Legal Agencies
- Other: probation, parole, police
- Other: mental health
- Other: school boards, correctional facilities, library, public health, ASPSH...
Other: mental health/schools

Other: For our Be More Than A Bystander program we have partnerships with The Hamilton Bulldogs, McMaster Athletics, The Hamilton Tiger-Cats and The Hamilton Tiger-Cat Cheerleaders; Child Welfare: Police Services/Victim Services; Francophone; Housing

### 7. TARGET POPULATION

What is/are the target population(s) that you aim to serve?

<table>
<thead>
<tr>
<th></th>
<th>ANGLO</th>
<th>FRANCO</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal, First Nations, Métis, Inuit and indigenous women</td>
<td>29</td>
<td>29</td>
<td>71</td>
<td>71%</td>
</tr>
<tr>
<td>Human trafficking</td>
<td>26</td>
<td>1</td>
<td>27</td>
<td>66%</td>
</tr>
<tr>
<td>Women living in poverty</td>
<td>26</td>
<td>1</td>
<td>27</td>
<td>66%</td>
</tr>
<tr>
<td>Youth</td>
<td>27</td>
<td></td>
<td>27</td>
<td>66%</td>
</tr>
<tr>
<td>Newcomers, Immigrant, refugee, and visible minority women</td>
<td>25</td>
<td>1</td>
<td>26</td>
<td>63%</td>
</tr>
<tr>
<td>Pregnant and parenting women (including young women)</td>
<td>25</td>
<td>1</td>
<td>26</td>
<td>63%</td>
</tr>
<tr>
<td>Rural women</td>
<td>25</td>
<td>1</td>
<td>26</td>
<td>63%</td>
</tr>
<tr>
<td>Those identifying as sex workers or working in sex work</td>
<td>25</td>
<td>1</td>
<td>26</td>
<td>63%</td>
</tr>
<tr>
<td>Women experiencing addictions</td>
<td>25</td>
<td>1</td>
<td>26</td>
<td>63%</td>
</tr>
<tr>
<td>Persons identifying at as queer/trans</td>
<td>24</td>
<td></td>
<td>24</td>
<td>59%</td>
</tr>
<tr>
<td>Those identifying as disAbled, differently-abled, or persons with disabilities</td>
<td>23</td>
<td></td>
<td>23</td>
<td>56%</td>
</tr>
<tr>
<td>Homeless or under-housed women</td>
<td>21</td>
<td></td>
<td>21</td>
<td>51%</td>
</tr>
<tr>
<td>Criminalized women, and/or those at risk of becoming justice involved</td>
<td>19</td>
<td>1</td>
<td>20</td>
<td>49%</td>
</tr>
<tr>
<td>Women living with HIV/AIDS</td>
<td>17</td>
<td>1</td>
<td>18</td>
<td>44%</td>
</tr>
<tr>
<td>Francophone women</td>
<td>15</td>
<td>1</td>
<td>16</td>
<td>39%</td>
</tr>
</tbody>
</table>
Populations actually served

**Responses**

- 9200 per year
- Adult survivors of sexual violence of all genders
- Adult women age 18 to 60
- Anyone aged 16+ who has been impacted by sexual violence.
- Anyone over the age of 16 who have been victimized by crime
- Anyone that identifies as a woman that is fleeing Intimate Partner Violence
- First Nations aboriginals
- Gender Based Intimate Partner Violence in the Anti-Violence Program, but there are numerous other agency programs including the Sexual Assault Network staff
- General population initiatives with targeted activities for the populations identified above
- Homeless and at-risk youth ages 16-19.
- Human trafficking - those at risk, experiencing
- People with Low income
- Pregnant and/or parenting women 14 - 21 years old, including those who have ever been pregnant or have ever been a parent.
- Rural women
- Sexual health services to youth
- Survivors of sexual violence, all genders and identities 13yrs+
- Those who are victims of sexual assault and/or intimate partner violence
- Trans folks, GNB folks, & all women who have experienced sexual violence.
- Victims of Crime or tragic circumstances
- Vulnerable (at risk) youth and adults; school students; professionals (teachers, health care providers, service providers) and parents
- We work with all populations of women in #7 who have experienced abuse/violence.
- women
- Women (and their children) who have experienced gender-based/intimate partner violence
- women 16+ who have experienced sexual assault/abuse
- women and children fleeing abusive situations
- women and children who have intimate partner violence issues and needing shelter, safety planning or housing options
- Women and families impacted by domestic violence and homeless women and families
- Women and their children who experience intimate partner violence
- Women and trans people facing an unplanned pregnancy
- Women experiencing abuse, low-income families, seniors, youth
- Women experiencing violence (not limited to intimate partner violence), homeless women, counseling for people who have experienced sexual violence (this is available for women, non-binary identified, and men) women living with addictions and mental illness, women involved in the criminal justice system, newcomers/immigrants/refugees
- Women who have experienced violence and their children.
- Women who have experienced an abusive relationship
- women with children who have experienced family violence
- women with historical sexual abuse
- Women, Trans, and Non-binary survivors of sexual assault aged 16 and over, occupying multiple, intersecting identities as listed above
- Youth, Children and Families that meet the eligibility requires of the CYFSA
- Femme et enfant
The word cloud reflects the frequency of word use:
8. FUNDING

What is your primary source of funding?

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>AN-GLO</th>
<th>FRANCO</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial funding</td>
<td>37</td>
<td></td>
<td>37</td>
<td>90%</td>
</tr>
<tr>
<td>Donations</td>
<td>16</td>
<td>1</td>
<td>17</td>
<td>41%</td>
</tr>
<tr>
<td>Grants</td>
<td>12</td>
<td>1</td>
<td>13</td>
<td>32%</td>
</tr>
<tr>
<td>Municipal funding</td>
<td>6</td>
<td></td>
<td>6</td>
<td>15%</td>
</tr>
<tr>
<td>Private</td>
<td>4</td>
<td></td>
<td>4</td>
<td>10%</td>
</tr>
<tr>
<td>Federal</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td></td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Other: United Way</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>
9. NEW SERVICES
Do you plan to offer additional services in the next 2 years?

• Half of the responding organizations said they were planning to offer additional services in the next two years
• No respondents said they were planning on cancelling any of their current services

<table>
<thead>
<tr>
<th></th>
<th>ANGLO</th>
<th>FRANCO</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>20</td>
<td>1</td>
<td>21</td>
<td>51%</td>
</tr>
<tr>
<td>YES</td>
<td>19</td>
<td></td>
<td>19</td>
<td>46%</td>
</tr>
<tr>
<td>No Answer</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>

The following is a list of the other services to be provided:
• advocacy worker
• attachment groups, housing workshops
• Increase our services to women who have been trafficked.
• Increased Human Trafficking awareness and supports
• Legal advocacy
• more children's and men's services
• Online E-counselling, other forms of therapeutic counselling that require certification
• parenting program for moms and children on experiencing and witnessing abuse
• peer mentorship program through a grant from Trillium foundation
• plans to add second stage housing
• public education
• second-stage housing
• Sexual health clinic
• Support Groups, Counselling
• Survivors ages 12 and up
• Transhealth care
• transitional housing
• We are hoping to be offering a resource center and family reconnect program

10. REFERRALS

Do you refer clients to affiliated organizations?

<table>
<thead>
<tr>
<th></th>
<th>ANGLO</th>
<th>FRANCO</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>38</td>
<td>1</td>
<td>39</td>
<td>95%</td>
</tr>
<tr>
<td>NO</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>5%</td>
</tr>
</tbody>
</table>

If yes, please describe your referral practices.

• addictions treatment, housing, parenting support
• Based on needs assessment
• CAS, CHC, CRC, OPS VCU/PAU/SAU, OTTAWA HOSPITAL SAPACP, RIDEAUWOOD, SHELTERS, DOCTORS, LAWYERS, VWAP, ELIZ FRYE, SEXUAL HEALTH,
• casual referral by sharing cards or other contact information
• emergency shelter space for women fleeing abuse/violence.
• Child protection, mental health, transitional house, AIDS New Brunswick(etc.)
• If we don’t have the services, we give folks resources to get the help they need elsewhere.
• If women are calling for space do not meet mandate we offer other safe shelter options; we also provide women with counselling referrals in the community, and any other type of service they are needing; we may provide the contact information for women directly, or make a call with women; sometimes their assigned counselor may accompany them to an appointment
• Inform clients of other agencies or assist them in making the call
• informal via phone or email
• Link the client to a worker in another organization
• mental health, psychiatric, police, housing, Ontario works, ODSP...
• mental health/transition houses
• One of our staff team will connect with a staff person from the affiliated org. and will assess/create a plan to serve the survivor.
• other shelters and community services as women wish to work with
• PreNatal care, methadone clinic, Mental health, Addictions First explain and then get their consent to refer them to the appropriate agencies. depending on their need.
• Provide contact information and introduction, provide promotional materials
• Provide information and resources about affiliated services, allow client to determine if service is applicable, connect client and affiliated organization
• provide phone numbers to clients, make initial phone calls to referral location, get release of information signed by client.
• public heals or CMHA
• refer for psychiatric consultation, refer for shelter services, Criminal Injuries Compensation Board to name a few - women's choice
• refer with contact information
• Referrals directly to support workers at relevant agencies
• Referrals out to the community as we are an immediate crisis response and connect clients to follow up services in the community.
• Specialized services needing higher level care greater than primary
• telephone
• Telephone contact
• Typically, needs are identified by the client or in consultation with the client. Workers then support clients with self-advocacy, where possible, or will make the referral on behalf of the client.
• Warm handover if possible, assist with calling, booking etc.
• we do case management referring clients to other services they require
• We identified need and refer to mental health, sexual assault clinics, abortion clinics, child protection services, shelters, etc.
• We often offer to help the woman call the organization with her or attend appointment if she wishes, or provide the contact information and describe the services that organization provides.
• We operate from a client centered approach and assist in filling out the appropriate forms and/or assisting with whatever the individual needs.
• We refer clients to hospital/medical services, and victim's/police services
• When a need cannot be addressed by our own services, we refer out
• When a need is identified by the client or the child protection worker either a direct referral is made or information is provided to the client
• Wherever whenever. Whatever is needed.
• Accompagnement
Would you like to see improved referral practices in your community?

<table>
<thead>
<tr>
<th></th>
<th>ANGLO</th>
<th>FRANCO</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>63%</td>
</tr>
<tr>
<td>NO</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>37%</td>
</tr>
</tbody>
</table>

- A formal referral path
- a more centralized intake model
- Better communication and willingness to work together
- centralized consent forms
- coordinated processes and collaborative approaches
- Depends which one. It’s nice when we know who to refer to (a person) and have their contact, rather than intake services
- Formalization and streamlined referrals with easy access to the appropriate person (ideally a Sexual Assault Response Team SART)
- Forms
- Having more gathering events for local organizations to improve networking and awareness of the various services that are available
- health care/mental health care/housing
- if entering into a sector, a basic training informing of other community services/referrals
- information sharing with sister shelter within our community
- Keep up-to-date training
- Less wait times for services
- More drug/alcohol treatment centres, larger Detox with a direct flow to treatment facility, housing for homeless women and children
- More knowledge of available services.
- more partnership with other agencies, and more training.
• need more formalized process. Do not have a sexual assault centre in county so clients have to travel/leave community for support, no local sexual assault experts

• Nobody knows about our services or they misunderstand or fear our intersectional feminism.

• Our community is quite collaborative and we have worked hard at maintaining great networking and resources. There are always ways to improve, particularly with the over-demand for emergency shelter space for women.

• Quicker response to referrals

• smooth process

• take referrals from community partners as well as self-referrals as requested

• we find that women are not always referred to us (SAC)

• We would like to see a one stop shop where individuals would be connected to any and all services they require without having to be referred out.

• Would appreciate mandatory referrals to our program from police partners.
11. TRAINING

How often does your organization engage in training or skill building on topic related to SRH or GBV?

<table>
<thead>
<tr>
<th></th>
<th>ANGLO</th>
<th>FRANCO</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly</td>
<td>18</td>
<td>0</td>
<td>18</td>
<td>44%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>17</td>
<td>1</td>
<td>18</td>
<td>44%</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>7%</td>
</tr>
</tbody>
</table>

A service delivery framework is a set of principles and policies that guides the standards and consistency of service delivery. Do you have a service delivery framework?

<table>
<thead>
<tr>
<th></th>
<th>ANGLO</th>
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- all of the above mentioned.
- All of the above, client/patient driven care provided from a feminist understanding.
- All of the mentioned.
- Anti-oppression and now developing trauma-informed
- Anti-racist, anti-oppressive, feminist framework
- ARAO Fem
- Child welfare focused
- Each program has a service delivery framework - the Anti-Violence Program leans towards a feminist, anti-oppression, anti-racism, pro-choice, trauma-informed approach along with a variety of different clinical approaches which may be developmental, CBT, Brief-solution focussed, etc.
• Faye is a feminist, anti-oppressive, anti-racism and trauma-informed agency.
• feminist agency
• Feminist anti-oppressive anti-racist survivor driven
• feminist client based approached - client led
• Feminist, anti-oppression, anti-racism framework.
• feminist, anti-oppression, anti-racism, pro-choice, trauma-informed, strength based, research based
• feminist, intersectional, trauma-informed, trauma specific
• Feminist, pro-choice/ repro justice
• Feminist, strengths-based, trauma-informed practice. We work from a case management-based model where clients are active participants and lead their service planning.
• If yes, please describe your organization’s service delivery approach and how it is implemented?
• inclusive community-based feminist organization, anti-racism/anti-oppression framework.
• Intersectional feminist organization dedicated to providing leadership, education advocacy and trauma-informed support to end sexual violence and harassment - provide individual crisis appointments and long-term group-based program toward healing from sexual assault, public education, advocacy, peer-based mentoring program, bi annual survivor conference program (@50 women)
• Not quite sure how to answer this.
• Ottawa Victim Services (OVS) provides emotional support, practical assistance, referrals and advocacy to individuals who have been victimized as a result of a crime or tragic circumstance, without judgment in order to lessen the impact of victimization. OVS is a community-based agency committed to treating individuals with courtesy, compassion and with respect for their dignity, privacy and diversity.
• Our service delivery approach consists of feminist, pro-choice, and trauma-informed practices that are implemented through our policies and continuing education among our staff and volunteers
• Our services are feminist, pro-choice, and trauma-informed. We meet people where they are at and offer non-judgmental supports that are guided by the needs of the survivor.

• Our VAW services have a feminist approach. We mention it to each client on their first counseling session, and explain what this means for us (i.e. we respect each client’s choices, they are the expert in their own life, etc.) When relevant, we discuss abuse with clients as a wider societal issue, based on inequalities and privilege.

• pro-choice, anti-racism, working toward trauma-informed

• threw ongoing training

• Trauma-Informed

• Trauma-informed - ongoing training with a specialist on staff. All the other frameworks, mentioned above, are also part of our service delivery.

• Trauma-informed delivery of care

• Trauma-informed, all staff are trained and certified and receive regular supervision on this approach

• Trauma-informed, client centered

• trauma-informed, sex positive, harm reduction, plain language, inclusive language, cultural competency - our orientation spends some time teaching about each of these practice approaches; they are mentioned at the beginning of each lesson plan our educators use, we receive regular training about them

• we are pro-choice and trauma-informed

• we have policy and procedures in place as well as our vision, mission, and value statements that reflect directing into our work. These components are reviewed frequently.

• we have services delivery approach to the provision of sexual health services to youth in schools

• We operate from an intersectional feminist anti-oppressive harm reduction and trauma-informed approach. We use this framework to be mindful of the ways in which intersecting identifies result in women having different lives experiences and to honor this and meet them where they are at. We believe that women are the experts in their own lives, and center women’s plan of action around what she wants to achieve while staying in shelter.
• We operate from an anti-oppressive and are headed towards trauma-informed framework. We will be designing a training for trauma-informed practice. Currently we have policies in place to ensure we are operating within an anti-oppressive framework.

• woman's choice to do what she wishes in her healing journey, policy on harm reduction, feminist organization with set values
The image reflects the frequency of word use. It is easy to see that feminist is the most prominent framework, followed by pro-choice, anti-oppressive, trauma-informed and anti-racism.
Training Frequency per Service Framework

- **Anti-oppression**
  - 49%
  - 27%
  - 22%
  - 0%

- **Feminist**
  - 41%
  - 34%
  - 22%
  - 2%

- **Reproductive Justice**
  - 39%
  - 39%
  - 34%
  - 7%

- **Other**
  - 54%
  - 37%
  - 7%
  - 0%
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Other service delivery approaches and frequency of training

- ACT, CBT, Sexual Assault/Legal justice once occasionally
- harm reduction
- Harm reduction-regular training
- harm reduction, regularly
- indigenous, cultural, immigrant, refugee, harm reduction - yearly training
- LGBTQ, addictions/harm reduction - topics vary each year
- my team of 8 nurses are 100% trained in the above however as an organization (hospital) is not
- ongoing and informal - comes across the workplace by articles, workshops attended, reading
- ongoing discussion and "pop-up" education at teachable moments
- Our training is typically skills based which are formed by these delivery approaches
- Restorative Justice and Indigenous-specific training.
- violence against women, mindfulness, empowerment, safe talk (suicide) grievance...
- We do annual staff training and the training topics are directed from staff, client, community survey
12. Screening for violence and reproductive coercion

Do you screen for violence when clients come to your organization for services?

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If yes, please explain how you support clients experiencing reproductive coercion.

- All clients with appointments will have connected with our staff/volunteers for support. We assess the risk of violence in the initial call and implement any necessary security measures.
- All of our assessment criteria are based around violence as we are a VAW shelter.
- All of our clients have experienced sexual assault.
- Are you safe right now?
- Can you tell me what happened that made you decide to reach out to us? Is there someone who makes you feel unsafe?
- Complete a needs assessment with the client (basic necessities) and complete a safety plan as required. Allow the client to disclose if they feel comfortable, we don’t pressure for disclosures.
- danger assessment form
- Do you feel safe in your relationship?
- Has your partner assaulted/threatened you, your children, or anyone else before? Are you afraid of your partner, their friends, etc.? Do you believe your partner is capable of severely injuring or killing you?
- have you experienced any form of violence during the last year?
- I ask if they are in a health relationship? has the had present past experience with sexual, verbal, physical, emotional violence
• I use the danger assessment tool provided by province.

• in education, it's less about individual screening and more about assumption that individuals in the group may need support so share resources. Our clinical services specifically screen, and another staff will complete the survey from that branch of our service

• Is there anyone hurting you

• Is your partner abusive? Identifying the types of abuse, if partner has been charged, current and past abusive experiences, areas related to abuse they need support with

• Odara besafer

• our intake is done over the phone - have you ever had a sexual experience you didn't want?

• Please describe your history of abuse. Have you experienced abuse in your current relationship (please describe)

• Questions regarding Domestic Violence are a part of the screening tool utilized by all Children's Aid Societies

• reason for request for service - identified by woman. discussion on their relationship, affect and impact of interactions, etc.

• Risk Assessment over telephone

• Risk assessment tool used, intake process

• There is no formal screening process although we engage in conversation with every client around safety and risk factors

• This is not done systematically, but the Intake workers are familiar with dynamics of power and control

• type of trauma, current situation and risk assessment, safety plan…

• Under revision currently

• Use Routine Universal Comprehensive Screening: We know that many women experiences harm from their relationships and that it affects their health. As part of our health assessment we ask every woman about her relationship with her partner in order to offer help if needed. Everything you share with me is confidential unless you were to tell me that you may hurt yourself, someone else or where child abuse or neglect is a concern. May I ask you a couple of questions?
• We ask direct questions related to family history and exposure to violence right up to asking if they have ever been aggressive and/or violent. We also ask about involvement with the law and to what extent.

• We don’t have direct questions about specific ways in which women have been violent, but if a woman presents as agitated/aggressive when coming to shelter, we assess whether or not she is able to control this and live in a co-operative living environment, or if there is a continuing safety concern. We have advisory warnings about past residents that have been aggressive with staff (mainly verbally aggressive), resulting in some women not being able to access shelter for a period of time (with other service options listed that women can go to instead), or specific criteria that woman needs to meet to ensure that the woman has a more successful stay.
There is an awareness of reproductive coercion, 76% of respondents have heard of it and 78% know enough about it that they can recognize it in the clients that they serve. However, this awareness has not translated into the actions of actually screening clients when they come in for services. 76% of respondents do not screen for reproductive coercion.

Before reading this definition, had you heard of or recognized reproductive coercion?

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Do you screen clients for reproductive coercion when they come to your organization for services?

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Examples of questions you use to screen clients for reproductive coercion

- Do you feel you have choice in your reproductive health
- Has anyone pressured you or said they would break up with you if you didn’t make this decision?
- Has your partner threatened to take the children/infant from you? Has your partner forces sex or raped you? Were you ever physically abused while pregnant?
- If they access the care of the SADV team then they are screened. Screening through the (hospital) organization is not completed
- In Anti-Violence Program it would be screened for - can’t say for other programs
In your practice, have you encountered clients experiencing reproductive coercion?

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Please explain how you support clients experiencing reproductive coercion.

- Adults requesting that their daughter end her pregnancy
- Assessment covers sexual abuse and if reproductive coercion is identified then a review of services are discussed and woman is supported
- Client centered - showing choice, accompaniment
- Counselling
- Educate them that it is a form of abuse and the decisions they make for their bodies are their own.
- Empower women that it is their choice to make informed decisions re: their reproduction.
- Forced abortion. No allowing access to birth control. Not allowing access to factual info on sexual health.
- I always tell the client it’s their choice and their choice alone.
- I do intake, don’t see clients.
- I have clients whose partners have ejaculated inside of them without their consent, or have pressured them into having an abortion/not having one
- In part of spectrum of support for a woman within a relationship with elements of coercion - safety, education, awareness, advocacy, support
- In particular we see this in indigenous populations and minority populations
- Inform the client of their choices and support them in the decisions that they make.
• legal advocacy
• Offer intervention
• Referrals to relevant community supports, often counselling or sexual assault crisis center for support.
• Safety planning, supporting their decision, connecting them to VAW outreach worker
• some women have spoken of pressure to abort, violence to end pregnancies
• support her decision to make her own choice.
• Supports, resources are provided to each patient based on needs.
• talk about it;
• Tell them it is not their fault, they do not deserve to be treated that way.
• Their worker would support them and provide education about coercion and her options. We would also bring in public health, hospital, domestic violence team, sexual assault workers and police if appropriate. We also provide shelter should the woman need to be away from the perpetrator.
• There have been a few instances where women have disclosed this. We do a risk assessment that includes questions around sexual violence, but not specifically reproductive coercion. If a woman discloses this, we ask her what support she is needing and let her take the lead on how she wants to move forward
• trauma specific counselling modalities, resource distribution, referrals
• Validate their feelings towards this form of control, educate women about this form of control in abusive relationships.
• We actually bring it up during discussion of birth control and/or relationships. Many clients will nod, or seem surprised that other people "know about this topic" and express relief that they are seen and known. We discuss ways to access support and even discuss some birth control that can be used in certain situations
• We aim to ensure their safety and empower them to make the decision suited to what they feel is the best choice for them.
We have witnessed several youth experience reproductive coercions from family, friends, service providers, and partners. Our practice is to ensure that the youth understands all options available to them and we do not give our opinions and/or advice. We simply give them the information and will support their decision regardless of their choice. We also ensure that the individual is aware that the choice is theirs and theirs alone.

We support women who experience abuse, this sometimes includes reproductive consider. We discuss with them power and control dynamics to lead them to a better understanding, we give them tools, and we support their choices.

We talk with woman about her options and she chooses. We talk with woman about the support she believes she needs and provide it based on our mandate or other referring agency options.

We would make referrals to other community and health organizations in order to ensure the best possible service to our clients.
13. BARRIERS TO SUPPORT

What barriers to support do you perceive exist for clients experiencing reproductive coercion?

| Systemic barriers to disclosure (i.e. including fear of child apprehension, compromised confidentiality, threat of criminalization) | 32 | 1 | 33 | 80% |
| Lack of knowledge of services that understand RC                        | 32 | 1 | 33 | 80% |
| Stigma or judgement                                                    | 30 | 1 | 31 | 76% |
| Lack of services, including primary-care providers, access to housing or shelter beds, long-term counselling | 28 | 1 | 29 | 71% |
| Past negative experiences accessing reproductive/sexual health services | 25 | 1 | 26 | 63% |
| Implicit biases (particularly for racialized and marginalized women & girls) | 22 | 1 | 23 | 56% |
| Lack of cultural competency                                            | 22 | 1 | 23 | 56% |
| Lack of inclusivity (visible representation of marginalized group)       | 21 | 1 | 22 | 54% |
| Language barriers                                                      | 21 | 1 | 22 | 54% |
| Services not clearly identifying their approaches (i.e. feminist, pro-choice) | 20 | 1 | 21 | 51% |
| Others                                                                 | 5  | 0 | 5  | 12% |

• Financial reasons
• Lack of education on what it is
• Lack of service provider knowledge and skill in screening
• Lack of trauma-informed systemic organizations
• Self-doubt created by psychological abuse
14. LEARNING NETWORK

What else would you expect to learn or receive as a member of a learning network?

• A list of pro-choice organisations that provide family planning/reproductive health services
• Avalon Sexual Assault Centre
• Continual training to ensure that we are aware of how RC can manifest in relationships, and outside of relationships as well.
• Education opportunities for those a part of the network, but also training standards that can be disseminated organizationally
• Have information on possible upcoming training courses in the area
• How to assist with a proper referral i.e. to where?
• I’ll take whatever come my way.
• Interval House of Hamilton
• Learning about best practices that are being used within the network.
• Mainly keep up to date with trainings, issues/trends identified, relevant events
• Mentorship and collaborations
• n/a
• online workshops and webinars and availability of a consultant should we have a difficult case and require more information or services.
• Regular and accessible training and resources to use with clients
• resources, education
• SAVIS of Halton
• Sexual Assault Centre Kingston
• Sexual Health Centre Lunenburg County
• Sexual Health Options, Resources & Education Centre
• share best practices, screening tools, Quality assurance tools
• sounds good
• webinars and other online education?
• when conferences would be held and where for sexual/reproductive health