Riding Tandem on the Pathway to Prevention

Ohio's experience in collaboratively preventing Intimate Partner Violence and Sexual Violence

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This paper discusses the advantages and challenges of conjoining the issues of intimate partner violence and sexual violence for the purposes of simultaneously advancing primary prevention. The paper is intended to help practitioners in each field better understand our shared work, guide public and private funding authorities in considering such endeavors, to assist state coalitions and agencies in providing leadership for similar efforts, and to support those implementing dual issue strategies.

Ohio Sexual and Intimate Partner Violence Prevention Consortium

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Sexual assault and intimate partner violence (also known as domestic violence) are experiences of violence which have much in common, and also have some areas of uniqueness that are important to acknowledge. There are many ways in which addressing both issues in tandem is powerful and effective. However, unless time is taken to clarify the areas of difference or prepare for predictable challenges we risk not addressing either issue sufficiently. Members of the Ohio Sexual and Intimate Partner Violence Prevention Consortium offer these insights gleaned from their foray into this concerted approach.

Background

The current sexual assault and domestic violence "movements" grew out of the women's movement of the 1970s, when women began talking very personally about their experiences and discovered that what many had been thinking of as a private tragedy of their own life was shared with many more women than they had previously realized. Women came together to support one another and then wanted to reach out and help others with similar experiences. So began the staffing and advertising of hotlines and shelters to support women experiencing these abuses. Archives suggest that traction for establishing Ohio's first sexual assault hotlines and rape crisis centers was being realized by the early 1970s. Ohio's earliest local domestic violence programs began providing shelter and supportive services in the mid-70s. State level non-profit agencies were organized across both movements in the mid 80s with the incorporation

Note to the reader: Terminology in the field has evolved over time. Readers may be familiar with "battering," "woman abuse," "spousal abuse," "domestic violence" and/or "intimate partner violence" with each term carrying similar meaning but with slight differences in connotation. When discussing the history of this movement the authors of this paper have opted to use "domestic violence," which had become the more familiar vernacular by the late 1970s used in state criminal codes and by first responders and organizers of shelters and programs. In later sections of this narrative, the term "domestic violence" is replaced with "intimate partner violence," which is rooted in public-health discourse and is the appropriate focus of these discussions. At times the word choice is determined by other contextual factors; for instance how a group or organization prefers to refer to itself as in the case of the state domestic violence coalition.

It should be noted that the term "intimate partner violence" intentionally implies a broader scope in that the violence may occur between partners or former partners, regardless of where they currently reside. Sexual violence can occur within either term and beyond this set, against a partner or ex-partner as in domestic and intimate partner violence, against other victims with whom there may have existed a familial, personal relationship, or acquaintance, or outside of any relationship as with a perpetrator unknown to the victim.

of a state sexual assault coalition (which later dissolved) and the 1988 founding of the state domestic violence coalition, the Ohio Domestic Violence Network, (ODVN). The Ohio Department of Health introduced its Women's Health Program (now the Sexual Assault and Domestic Violence Prevention Program-SADVPP) in the early 1980s. A new state sexual assault coalition later emerged and was introduced as the Ohio Alliance to End Sexual Violence, (OAESV), in 2009.

As conversations progressed in recent decades, the continuum of issues that came up included sexual harassment, sexual violence, child abuse, child sexual abuse and incest, intimate partner violence and human trafficking. Early activists and advocates made space for these conversations and acknowledged the links in risk and protective factors. This helped to frame the continuum and simultaneously focus the work. Although these issues have much in common, there are differences in the dynamics of each and in the needs of victims and survivors. As a result, many separate organizations were created to respond to each issue specifically. A broad term sometimes used for these concerns is "violence against women," but we have since learned that there are many ways in which men and boys, including but not limited to gay, bisexual and transgender men, are also victimized. Theory supports the ways in which, even when the violence is directed against males, it is a manifestation of underlying gender norms and gender role socialization within the culture that support men's violence against women. In 2007, the National Resource Center on Domestic Violence published a paper on *The Intersection of Sexism and Homophobia*. It explains: "Homophobia is based on devaluing female characteristics […]." The hyper-masculinity it encourages in many young men has much to do with the prevalence of domestic violence and formation of a rape culture "that accepts sexual violence and the fear of violence as the norm and knowingly or not, perpetuates models of masculinity, femininity, and sexuality that foster aggression, violence, and fear" (Allen, Branco, Burnett, & List-Warrilow, 2007, p. 2).

Most funding through the 20th century supported traditional intervention programming over prevention, meaning funds were historically dedicated to providing victims services. Few programs were funded to *prevent victimization* and far less to nearly none were funded to *prevent perpetration* of the violence from occurring in the first place. In 1992, the Centers for Disease Control and Prevention (CDC) publicly recognized the prevalence of Sexual Violence and Intimate Partner Violence as public health issues. This recognition coincided with the creation by the CDC of its Division of Violence Prevention. This division supports and funds public health prevention strategies at the state and local levels to reduce the incidence and prevalence of violence. It is from this division that Ohio receives funds for prevention support through two funding streams: The Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) award to the Ohio Domestic Violence Network (ODVN), and the Rape Prevention Education (RPE) Programs award to the Ohio Department of Health (ODH).

Ohio was the first state to use a tandem approach for jointly advancing the CDC's DELTA and RPE programs. State leadership recognized early that the power of a prevention system lies in its ability to promote a sustained, comprehensive and coordinated approach by a network of individuals, groups, and organizations. Ohio's plan for sexual *and* intimate partner violence prevention (reported in *Pathways in Prevention*, an Executive Summary) is

the culmination of three years of collaboration by more than sixty consortium members representing state organizations, non-profit organizations, foundations, universities, faith communities and individual members who accepted the call to help envision the roadmap for change in Ohio through the promotion of healthy sexuality and healthy relationships. A copy of *Pathways in Prevention* is available at http://www.odvn.org/prevention/prevention-plan.html.

RIDING TANDEM

Ohio was fortunate enough to be awarded two similar funding streams (DELTA and RPE) for primary prevention capacity building and strategic planning from the CDC within a relatively close time frame. ODH initially received RPE funds in 1997, but the original guidance allowed for a wide range of uses for these funds. A new five-year cooperative agreement issued in 2007 changed the focus to primary prevention of sexual violence and required the development of a five-year plan. At that point ODVN had already convened a DELTA-focused intimate partner violence prevention state planning group, and the ODH RPE coordinator was serving as a co-chair for that effort. A requirement of each funding stream was to convene a multi-disciplinary advisory group for conducting a statewide needs and resource assessment, and developing a strategic plan for building individual, community and organizational prevention capacity. Likewise, DELTA and RPE each required application of the public health model; it was clear the SADVP program at ODH would be committing human resources to both. While some states had similar circumstances, and in some cases operated dual domestic violence-sexual violence state coalitions, Ohio was unique in its early decision to form a high level of collaboration across DELTA, RPE, the two state coalitions and the state department of health.

Efficiency

For many people the term "tandem" almost instantaneously summons images of a bicycle-built-for-two or possibly more. The analogy is well-suited to describe the advantages and inherent limitations of coordinating statewide prevention and capacity-building on the intersecting issues of intimate partner violence and sexual violence. In cycling, a tandem ride weighs more, but the power-to-weight ratio is better than that of a single rider and has the ability to cover more ground with greater efficiency. Translating the metaphor, groups considering a tandem approach might be attracted for practical matters by a reasonable assumption that conducting work simultaneously leverages resources, saves costs and functions more efficiently. There are several examples in the Ohio experience that support this notion.

Just as with the lead state-level agencies, a large number of the other stakeholder agencies, organizations and/or individuals were called upon to join a state body to address either sexual violence or intimate partner violence, and many would have likely been called upon to join both due to stakeholder status in both movements. It was a concern of the leadership group that two groups would be convened to conduct such similar work, with overlapping membership, utilizing identical methodologies and nearly duplicate timetables. Due to the size and geography of Ohio, some representatives would be travelling two hours or each way to attend centrally located meetings, posing a strain on budgets and staff hours for many organizations that would be put in a position to choose one cause over the other or decline

participation in both. In addition, it was understood that requests from two advisory committees seeking responses to needs assessment surveys or training outreach would create confusion and reduce local provider engagement.

Leaders understood the value of having local and diverse representation among the consortium; they were also sensitive to the fact that they were asking stakeholders to make unfunded commitments to develop and implement a state plan. Savings to all were realized by reducing the number of meetings that would have otherwise occurred under two simultaneously operating statewide prevention initiatives. The larger pool of members assisted in accessing more meeting space for fewer scheduled meetings. The combined effort also resulted in lowering the number of guiding documents developed and published (state plans, needs and resource assessments, logic models) and reducing expenses for simple items such as copies of member materials by avoiding parallel and duplicative meetings. Perhaps more significantly it eliminated double expenses for consultants such as evaluators, facilitators, and graphic designers.

Committing to a tandem approach to gain efficiency and cover more ground through partnerships likewise commits the riders to its challenges. The challenges include negotiating the destination and route, managing the division of labor, and maintaining balance. In cycling, the front seat, the "steersman" is generally tasked with steering, shifting, braking and calling out bumps in the road, and the rear seat is the "stoker," the critical pedal power for starting up hills, the navigator and monitor of the broader landscape and conditions. Of utmost concern in either application, whether prevention or cycling, is the need for effective coordinated communication. The convening agencies distributed all available prevention staff across subcommittees and task groups to track progress and capture important conversations. Going tandem can be particularly beneficial for utilizing riders with differing skills and abilities. Such was the experience of the consortium, and it demanded ongoing attention to creating meaningful roles for members and stakeholders, changing seats as needed, and collectively learning many new skills while en route.

Skill-building and practice

Significant investments were made by many parties, not in the least the Consortium's partner organizations, which committed to the project without the leverage of federal mandates and in many cases in the absence of designated funds to support their participation. Thus, it was important that the collaboration offered some significant value to their causes. A great benefit to the tandem approach was the environment created for shared and cooperative learning in a supportive peer network.

All consortium members who participated in regular meetings and work groups (regardless of which discipline they represented) were encouraged to engage in planning and implementation activities to build individual, organizational and system capacity for primary prevention. The processes required by funders included application of the public health model, the aforementioned statewide needs and resource assessment, evaluation, and crafting a strategic plan, implementation plan, and sustainability plan. Consortium members participated, witnessed, approved, and then translated many of the products for adaptation within their own organization. Members began integrating technologies that were emerging at the time such as teleconferencing, online survey systems, webinars, wikis, online

document sharing and Web-based meeting scheduling tools. These approaches and business devices served to bolster competencies in both fields simultaneously while encouraging a fair distribution of work.

The DELTA initiative required and RPE supported the utilization of Empowerment Evaluation and therefore provided for it financially and through training resources. The HealthPath Foundation of Ohio (formerly Anthem Foundation of Ohio), an OSIPVP member, directed consortium leadership to the Technology of Participation© and paid for training a group of the facilitators. The influence that the funding authorities had was key to many successes, but it also involved instances that slowed or reversed course. At times the somewhat prescriptive designs were viewed as competing with local wisdom or in opposition of state empowerment goals. Feedback from Ohio among other states did result in adjustments by the CDC for a better state fit. Originally there was a requirement that the state plans submitted through DELTA must use Wandersman's *Getting to Outcomes*® model which was simultaneously being developed and reviewed for the violence prevention field (2005). However, DELTA states like Ohio were progressing in their planning faster than the CDC contractors of the *Getting to Outcomes*® model could prepare the guidance documents on it for state adaptation. This lack of synchronicity was a threat to sustaining empowered and engaged local partners among state advisory groups like Ohio's consortium, and the requirements were eventually relaxed by CDC. It is important for others contemplating a like-minded endeavor to address power differentials early, commit to dialogue between grantors, grantees and partners to establish reasonable and adaptable directives.

By inviting both fields to address their primary prevention plans through the same body, it opened up new avenues for delivering technical assistance, training and networking opportunities. It resulted in a broader community of practice which included shared learning and shared problem-solving. Examples from this joint community of practice include the development and presentation of a primary prevention basics course "Ready Set Go;" shared planning of an annual conference focusing on different key themes such as media literacy, working with youth serving organizations, and healthy relationships/healthy sexuality; implementation of teen dating violence prevention programs in support of new state-legislated requirements; and programming related to reproductive coercion and birth control sabotage. The consortium provoked conversations on evidence-based strategies and examined the few that did exist for applicability to each field and for impact on the selected risk-based populations. Many members co-developed products with their counterparts or willingly offered templates and technical assistance on program areas within their expertise. They compared strategies for collecting data on prevention efforts in Ohio and promoted technically accurate prevention language that resulted in improved funding applications from local programs across the state. Members cross advertised training announcements and coordinated event schedules to maximize attendance.

Although much was accomplished in jointly building skills and practice capacity, challenges existed here too. For one, readiness is not equal across the group or across both fields. Nationally and in Ohio, sexual assault advocates had embraced prevention thinking much earlier than intimate partner violence advocates, with activities visible in schools, on campuses and in communities as early as the 1980s. Yet, in the years just prior to the consortium there was the absence of an operating state sexual assault coalition in Ohio,

therefore there was no statewide entity offering a training institute comparable to the opportunities available through the state domestic violence coalition, no staff providing technical assistance and no collective voice advocating for the field's prevention goals at the time the science of prevention was expanding quickly.

Another challenge was that the timing of deliverables due under the RPE and DELTA cooperative agreements was not always moving along a parallel trajectory with each other or in sync with other state initiatives. In some cases local communities had recently completed similar work (for instance, training for developing evaluation plans) that was now being replaced by the state-driven processes. At times completing assignments for one aspect of the plan may have interrupted or delayed progress in another area. Energy interjected from an initiative in one field or the other could cause the consortium to pause and evaluate its potential meaning for the state plan. Many meetings were dominated by feedback processes and democratic approval as many members were anxious to spend their limited available time implementing strategies instead of planning. Managing double obligations and building consensus for unified actions made the pace of initiating change seem slow. Stakeholders and funders that allow for a tandem approach to these two issues for the sake of a unified process must prepare for shifting momentum and must exercise the patience for necessary pit stops by one rider or the other.

Plotting the course

Riding tandem for sexual and intimate partner violence prevention is a fairly literal exercise in planning an excursion with great friends. Each rider has an ideal itinerary of must-see stops and worthy views. Each rider often has varying budgets, timetables and changing stamina. To add to Ohio's challenge, the sexual violence prevention community led by a brand new coalition was in essence jumping on a bike already in motion.

At the point that sexual violence was added to Ohio's existing planning group, some work had already been done including preliminary vision and mission development. Through a facilitated meeting of the sexual violence prevention community, a list of issues was generated that would require special attention in order to strategically plan alongside Ohio's intimate partner violence prevention community. A similar conversation was held by the existing intimate partner violence prevention consortium. Both groups agreed through consensus to work together and determined that in the future the co-chairs of the consortium would represent one chair from the IPV community and one from the SV community. The new group revised the vision and mission to also reflect sexual violence.

The mission of the Ohio Sexual and Intimate Partner Violence Prevention Consortium is to promote the prevention of sexual and intimate partner violence by creating an infrastructure that connects state agencies and local communities in working together toward the elimination of gender inequality and other systemic oppression.

Concerns identified with regard to the two groups working together included issues of definition, issues of privilege and oppression (including addressing male victims), issues of history, philosophy and trust, concerns of DV overshadowing SV, turf and shared territory, differences of philosophy and goals, perceptions of DV/SV; issues of operation and resource distribution (economies of scale); issues of collaboration, education and action (ensuring non-family sexual violence is addressed, differences in protection laws); and issues of inclusiveness (men, youth, diversified communities, special populations).

Steering

Guiding primary prevention of sexual violence and intimate partner violence requires partners to frame their work by examining risk and protective factors for the issue. To use the public health approach, we must do our best to fully understand the dynamics of the problem we are trying to prevent. Doing this across two distinct but intersecting social problems (sexual violence and intimate partner violence) required precision guidance and a steady hand. As the process to examine the dynamics of both issues proceeded, it became clearer where the two fields of intimate partner violence and sexual violence could work together toward mutual prevention. Each field points to sexism and other forms of oppression as the underlying cause of the respective violence. Sexism and victim-blaming are directly connected to past tendencies of focusing prevention efforts on would-be victims rather than would-be perpetrators. Beyond root causes, the relationship of the two forms of violence is linked by shared victims, shared perpetrators, and shared responding systems such as law enforcement, criminal justice, health care, social services and advocacy organizations.

With regard to shared victims and perpetrators, it has been established that victims of intimate partner violence report sexual violence and sexual coercion by their abusive partner as a common control tactic; therefore a batterer in some cases may also be his partner's rapist. Based on the findings of one of the largest U.S. studies of violence against women to date, it is estimated that more than 7 million women have been raped by their intimate partners in the United States (Mahoney, Williams & West, 2001). In Ohio, like most states, the prosecution of rape is not exempted by a marriage relationship, but is rarely investigated or charged.

We also know that children of battered mothers have higher incidents of sexual abuse, most frequently by their mother's batterer. In a review of current literature, author and researcher Lundy Bancroft found that multiple studies (Herman, 1981; McCloskey et. al.; Paveza; Sirles and Franke; and Truesdell et. al.) have established the high overlap between battering and incest perpetration (2007). These studies, taken together, indicate that a batterer is about four to six times more likely than a non-batterer to sexually abuse his children. Further, according to the CDC, among risk factors for perpetration of sexual violence are: witnessing family violence as a child; and a family environment characterized by physical violence (Risk and Protective Factors for Sexual Violence, 2009).

The two fields also share common challenges that are relevant to planning successful prevention capacity building. Among these challenges are perceptions held by the public and

even service providers about victims of intimate partner and/or sexual violence and assumptions about perpetrators. Each field struggles to move the public, system responders, and in some cases advocates, past tendencies of classifying good victims and bad victims, deserving and undeserving, or boys being boys and hardcore bad guys. Both fields grapple to define safety and risk while advancing societal norms that interrupt violence in place of norms that support it. The prevalence of each form of violence is so profound that we are universally vulnerable to the massive community and multi-generational impact of these forms of violence, yet we are directed to select populations for our prevention efforts. Both fields give voice to confronting oppression (inextricably linked as a societal condition that supports violence) and aspire to reaching marginalized and underserved groups but are commonly detoured by dwindling budgets, competing public policy priorities and more timely political winds.

In Ohio's experience it was particularly crucial to acknowledge the complexities at the outset and employ processes that would steer the group toward opportunities for collaborative prevention strategies while respecting areas of distinction. For example, self-defense has been a strategy in the past that was included in discussions to prevent victimization of sexual violence and lasting partnerships have been built for that purpose, yet self-defense is not a prevention strategy advanced to the same degree in intimate partner violence due to safety concerns and the staggering number of victims erroneously identified as an aggressor and arrested and charged by law enforcement when using defensive tactics. There were also varied commitments and partnerships by member organizations to address the related issues such as trafficking, child abuse, and elder abuse.

Mechanisms that helped navigate the more confusing terrain were Memoranda of Understanding signed by consortium members and the adoption of 10 Principles of Empowerment Evaluation (Wandersman & Fetterman, 2005). Additionally, several staff members from ODVN, OAESV and other consortium member organizations received training to lead group facilitation, consensus workshops and strategic planning utilizing the Technology of Participation©. The Empowerment Evaluation principles together with the facilitation methods were instrumental in developing effective communication, engaging members, tapping group creativity, establishing ownership and accountability, and encouraging reflection.

10 Principles of Empowerment Evaluation

1. ***Improvement***
2. ***Community ownership***
3. ***Inclusion***
4. ***Democratic participation***
5. ***Social justice***
6. ***Community knowledge***
7. ***Evidence-based strategies***
8. ***Capacity-building***
9. ***Organizational learning***
10. ***Accountability***

With so many intersections and shared challenges, it was helpful to the consortium members to find their bearing using the public health model as the map. Primary prevention through the public health model requires us to go back to underlying causes and to the risk factors and protective factors for sexual and intimate partner violence, which are much the same for both issues. Risk factors include rigid gender roles, hyper-masculinity, cultural expectations of power in relationships, weak laws and policies confronting violence. Additional similarities can be viewed by accessing the CDC website and comparing the risk factors identified for each: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/riskprotectivefactors.htmlhttp://www.cdc.gov/ViolencePrevention/sexualviolence/riskprotectivefactors.html#1.

Applying the facilitation processes mentioned above to the overlapping risk and protective factors led the group to its vision, mission and strategic directions. A galvanizing concept was that true primary prevention is far more significantly associated with preventing *perpetration* than it is to preventing *victimization* and that the risk and protective factors are more mutually consistent across fields for perpetration than for victimization. With that, the Consortium was able to find agreement and focus its strategic plan in reference to corresponding universal and selected populations. The consortium defined Ohio's Universal Populations (populations identified without regard to specific risks for perpetration or victimization) are described as:

- All residents of the State of Ohio
- All Ohio youth ages 6 – 24
- All Ohio men and boys

Evaluating the findings from Ohio's Needs and Resource Assessment through the lens of shared risk factors for perpetration, the consortium elected to focus on the following selected populations:

Men and boys who have the following risk factors:
- Need for power and control in relationships
- Hostility and anger toward women
- Hyper-masculinity and/or beliefs in strict gender roles
- Exposure to violence (all types, across the entire social ecological model, and across the lifespan)

In addition to the shared vision and mission statements, risk and protective factors, and agreements on populations of focus, the consortium insisted upon one other mechanism for steering the work. consortium members from both fields demanded a commitment, a formal articulated assurance that primary prevention in Ohio was to be inclusive, transparent, and representative of Ohio's rich diversity. They requested a facilitated conversation to explore issues of cultural competence and the intersections of oppression and sexual and intimate partner violence prevention. This discussion led to the formation of a workgroup who conceptualized driving mechanisms for the expression of the consortium's commitment in this regard. The mechanisms include a Statement of Philosophy and accompanying definitions. To further ensure that the shared philosophy of inclusivity and cultural competence would permeate Ohio's prevention plan, the consortium's workgroups reviewed

and revised their subsequent eighteen goals and outcome statements using the consortium's shared values of inclusivity and cultural competence as regular waypoints.

Stoking

"Stoking" seemed a fitting word to apply to tandem analogy. While it is common vernacular in partnered cycling, it also means to fuel, to feed a furnace, to fire up, to stir, to poke, and casually defined, "stoked" is to be excited, enthusiastic or anticipating something positive. The consortium was stoked by its inherent heft, the inclusion of many organizations, system representatives, new energetic recruits and seasoned veterans. In Ohio, prevention was poked, stirred and fired up by discussions from multiple view points and passionate voices from the traditional sexual and intimate partner violence communities and newly emerging allies attracted by prevention. The work was fueled by its original driving CDC dollars, but would have not been successful without the commitment of member organizations in contributions of salaried professionals, mileage, countless hours and additional dollars. These various inputs that were so supportive in the development of the state strategic plan documented in *Pathways in Prevention* also revealed some truths about resources that were irreconcilable with a truly collaborative prevention plan.

Since 2002 when the first DELTA monies were awarded to Ohio, and 2007 when primary prevention became the full focus of RPE funds, primary prevention of violence (Intimate Partner Violence, Sexual Violence and Family Violence) has become a more visible priority for investment by many funders including the HealthPath Foundation of Ohio (formerly the Anthem Foundation of Ohio), the Ohio Children's Trust Fund, Futures Without Violence and the CareSource Foundation among others. Yet, funders and recipients of funds focused on prevention of sexual and intimate partner violence face a complex task to differentiate between the two issues while acknowledging the reality that, particularly where focused on primary prevention, the risk and protective factors, prevention strategies, and outcomes are the same or very similar. Funders often restrict the use of their funds to whichever particular area of focus they have identified (or in the case of federal agencies, purposes established by Congress), while implementing agencies may see the need for and receive requests to respond to a broader range of prevention needs. In an ideal situation a team representing various funding sources informed by providers could come together, each offering content related to their area, to approach prevention holistically. In reality, narrow and uncoordinated funding means an agency may be providing prevention for one issue within a community that is lacking funding to address other more urgent or more broadly defined prevention needs. Restrictions by funding sources can be very challenging when a group is committed to collaboration across silos.

The two most obvious tensions in terms of resources are felt between prevention and intervention approaches, and across disciplines of sexual violence and intimate partner violence. To a certain degree these tensions exist because of the history of how the movements organized or engaged allies, how they negotiated with decision makers or withheld from negotiating based on principle or philosophy.

Some observations of consortium members are useful here. Katie Hanna, Executive Director of the Ohio Alliance to End Sexual Violence writes: "Dedicated funding for domestic violence

shelters has been rooted in the system response, thanks to the advocacy of the domestic violence movement. Resource allocation for sexual assault response has not yet been embedded in the framework to respond to survivors with adequate core service infrastructure and sustainability. Nationally and in Ohio, there are many more shelters and a stronger statewide support system for domestic violence victims than for sexual violence survivors. And while the needs of survivors of both intimate partner violence and sexual assault are great, the resources remain disproportionate." Debra Seltzer, Program Administrator of the Sexual Assault and Domestic Violence Prevention Program at ODH adds: "Victims of intimate partner violence (who may leave an abusive environment) often need multiple systemic supports to address their victimization, including relocation and employment assistance, replacement of possessions, childcare and more. For these reasons, domestic violence shelter programs need to offer many resources to victims and therefore generally have more staff and money. However, the corresponding needs of sexual assault survivors may be different but equally significant."

Leaders across both disciplines avoid comparing numbers of victims, comparing which violence is more tragic, or what forms are most preventable. Leaders do express a persistent concern that promoting and providing resources for prevention activities is unethical where services for victims are not securely established. Consortium members were never fully at ease with planning statewide prevention capacity-building that consumed resources and would not accommodate even basic statewide intervention programming. "We know that in every audience that receives a prevention message there is most likely a victim of sexual or intimate partner violence, and probably more than one. We know that with that message, we should also identify local suitable services for those that have been impacted by the violence," explains Beth Malchus, Rape Prevention Coordinator at the Ohio Department of Health. The lack of resources to build and sustain even basic victim services that are culturally competent and inclusive will always restrain the potential of true prevention.

Hanna continues on the theme, "To truly make a difference in the lives of all victims and survivors and in all communities, we must work together to ensure that all survivors have access to the needed resources for safety and healing. The approach we must take collectively to eradicate sexual and intimate partner violence isn't an "either/or," but rather a "both/and" philosophy that embraces supporting all survivors with adequate resources, un-siloed collaboration and by meeting survivors where they're at. It also entails breaking out of mindsets requiring or assuming that all survivors should go to a domestic violence agency or rape crisis center, but instead fostering an understanding that culturally specific organizations play an important role in meeting the needs of underserved populations."

Rebecca Cline, Prevention Programs Director and DELTA Coordinator for the Ohio Domestic Violence Network, offers this summary insight which captures the consensus of the consortium membership: "As fortunate as we feel to have competed successfully for these important dollars, our message to funders is that this work needs to be reasonably supported. Assessing, planning and implementing well-conceived prevention plans require an investment that more closely matches the actual expenses. These projects whether done singularly or in tandem rely on having the appropriate resources in terms of people, technologies, equipment, training and so forth. Most critically, funds through cooperative agreements and other types of awards must allow for currently competitive salaries and

benefits for a sufficient number of paid staff so that grantees can attract the skill sets and retain qualified individuals to accomplish the objectives. In fields such as ours that overwhelmingly see their charge as addressing sexism to defeat violence, it is imperative to offer stable, livable and rewarding compensation to what is predominantly a female workforce. This notion of adequate resources should extend to supporting the necessary multi-year relationships demanded by these projects. Funds should be included to secure the engagement of invited collaborators and reimburse their expenses that are particularly burdensome for local programs with eroding budgets."

Garnering attention

While the combined issues of sexual violence and intimate partner violence seem like such a heavy load to carry, the demand for prioritizing their prevention among other worthy issues is harder to deny when the riders agree to lean the same way, travel together and arrive at the same destination. The efforts of the consortium to develop a unified strategic plan demonstrated a commitment to seeking out the most cost-effective means for ending the far too costly problems of sexual and intimate partner violence. The unified plan amplifies long-held claims regarding root causes and societal impacts. It points to common adversities that require better practices and institutional and systems change to realize better outcomes. When the tandem bicycle passes by, there are very few who do not take notice of it. So it might be for Ohio.

Through the primary prevention capacity built during the project and the relationships secured by the collaborative experience, Ohio has successfully competed for new funding to support IPV and SV prevention including funds for Project Connect from Futures Without Violence, and for a Community Connections Project to support the Consortium's Engaging Men work through the HealthPath Foundation of Ohio. Additionally, the CDC has visited Ohio stakeholders and tapped consortium leadership to deliver training and technical assistance to DELTA Prep states. The consortium's contracted Empowerment Evaluator, Dr. Sandra Ortega, was asked to present on evaluation at the National RPE Conference because Ohio was seen as leading the pack on collaborating to build a statewide evaluation infrastructure. Likewise, several consortium members representing local organizations have been invited to present on their state-of-the-art prevention programming at national events.

To gain the influence of decision-makers, the two communities are coordinating public policy and systems advocacy efforts that support the dissemination of best practices in prevention. With public policy updates established as a standing agenda item at consortium meetings, leaders from both movements have joined forces working together to pass legislation requiring prevention education in Ohio schools, protect juveniles through protection orders, and to establish the Barbara Warner Workplace Violence Prevention Policy in state agencies. Efforts in process now include creating a shared communication strategy and social norms messaging, outreach to youth serving organizations, a state project on engaging men in violence prevention, joint Campus Safety workshops across Ohio, joint public policy efforts to mobilize support for VAWA Reauthorization and shared efforts to partner with the anti-trafficking community on our common messages and goals.

In Ohio the *Pathways in Prevention* may have been paved by the OSIPVP Consortium, but it is clear they require the inclusion and support of all residents of Ohio so that together

Ohioans will achieve respectful, healthy sexuality and healthy relationships. Developing broad based, diverse partnerships and community readiness for the type of social and systems change that will eventually lead to the prevention of IPV and SV presents challenges and rewards for riding tandem. It is the hope of the consortium that Ohio's example will inspire innovations that benefit both fields as they approach capacity building and strategic planning for prevention. At times momentarily unsteady or awkward feeling, the ride has certainly been accomplished in great company. The teamed approach can make or break a relationship, and in Ohio's case it made *many* relationships that will serve prevention of sexual and intimate partner violence prevention far beyond the State Plan. Together Ohio's violence prevention community may soon know what tandem enthusiasts enjoy. As cycling bloggers John and Pamela Blayley explain, "Some hills may take longer to climb, but you can really fly on the flats, rolling terrain and downhill!"

Works Cited

Allen, M., Branco, Burnett, H., & List-Warrilow. (2007). *Lesbian, Gay, Bisexual and Trans (LGBT) Communities and Domestic Violence: Information and Resources.* Harrisburg: National Resource Center on Domestic Violence.

Bancroft, L. (2007). *The Connection Between Batterers and Children*. Retrieved from Lundy Bancroft: http://www.lundybancroft.com/?page_id=289Mahoney, P. W. (2001). Violence against women by intimate relationship partnerships. (J. E. C. Renzetti, Ed.) *Sourcebook on violence against women*, 143-178.

Risk and Protective Factors for Sexual Violence. (2009, January 27). Retrieved January 14, 2013, from Centers for Disease Control and Prevention, National Center for Injury prevention and Control, Division of Violence Prevention: http://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html

Wandersman, A., & Fetterman, D. M. (2005). *Empowerment Evaluation Principles in Practice.* New York City: The Guilford Press.